TRI-CITY HEALTHCARE DISTRICT **REVISED**
AGENDA FOR A REGULAR MEETING
December 11, 2025 – 3:30 o'clock p.m.
Assembly Rooms 1, 2 & 3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

The Board may take action on any of the items listed below, unless the item is specifically labeled "Informational Only"

https://us02web.zoom.us/j/87052190109?pwd=cFWdsBLXmDM9735e2JHmKSdh0BzX17.1

Meeting ID: 870 5219 0109
Passcode: 359180

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Roll Call / Pledge of Allegiance	2 min.	Standard
3	Approval of Agenda	2 min	Standard
4	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 19-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
5.	Presentation and consideration of the approval of the VMG Fair Market Value Appraisal in accordance with Health & Safety Code 32121(p)(2)(A)(vi)	15 min.	CEO
6.	a) A presentation and discussion of Affiliation, Transfer, and Lease Agreements between the Tri-City Health Care District, and Sharp Healthcare District – Jeff Scott, Board Counsel b) Comments from Members of the Public	15 min	Board Counsel TBD
7.	Board Consideration of Resolution No. 829 Approving the Affiliation, Transfer, and Lease Agreements Between the Tri-City Healthcare District, Sharp Healthcare, and Sharp Tri-City Medical Center Corporation Dated December 12, 2025	10 min	Chair
8	Special Presentation – a) Stroke Survey Results – Ryan Rabold, Stroke Coordinator	10 min.	CNE

Note: This certifies that a copy of this agenda was posted in the entrance to the Tri-City Medical Center at 4002 Vista Way, Oceanside, CA 92056 at least 72 hours in advance of the meeting. Any writings or documents provided to the Board members of Tri-City Healthcare District regarding any item on this Agenda is available for public inspection in the Administration Department located at the Tri-City Medical Center during normal business hours.

Note: If you have a disability, please notify us at 760-940-3348 at least 48 hours prior to the meeting so that we may provide reasonable accommodations.

	Agenda Item	Time Allotted	Requestor
9.	October 2025 Financial Statement Results	10 min.	CFO
10	New Business –		
	a) Consideration to approve Resolution No. 830, a Resolution of the Tri-City Healthcare District Board of Directors to approve the Title VI Program and Policies including a Language and Assistance Plan and Pubic Participation Plan	10 min.	CNE
	b) Consideration to approve the Office Lease Agreement with Sycamore Ave II, LLC for a sixty-four (64) month term beginning on February 1, 2026 and ending May 31, 2031, for a maximum total expense for the term not to exceed $749,719.	5 min.	COO
	c) Consideration to approve an Office Lease Agreement between Tri-City Healthcare District and Tri-City Healthcare Cardiology and Arrythmia Services Inc., at 6260 El Camino Real, Suite 105 for a 12-month term.	5 min.	COO
	d) Consideration to approve an Office Lease Agreement between Tri-City Healthcare District and Abinav Sharma, M.D., at 6260 El Camino Real, Suite 105 for a 12-month term.	5 min.	COO
	e) Consideration to approve Professional Services Agreements between Richard Smith, M.D. Inc., and Tri-City Healthcare District for a 1206(b) Infectious Disease Clinic.	5 min.	COO
	f) Consideration to approve Professional Services Agreements between Paul W. Hinshaw, D.O., Inc; Natalia Babkina M.D. Ph.D., Inc., and B. Cizmar, M.D., Inc and Tri-City Healthcare District for a 1206(b) OB/GYN clinic.	5 min.	COO
	g) Consideration and possible action to elect Board of Director Officers for calendar year 2026 1) Chairperson 2) Vice Chairperson 3) Secretary 4) Treasurer 5) Assistant Secretary 6) Assistant Treasurer 7) Board Member	10 min.	Chair
	h) Consideration of proposed 2026 Board Meeting Schedule	5 min.	Chair
	i) Consideration to award a Board Scholarship to the Tri-City Hospital Auxiliary in the amount of $10,000.	10 min.	B. McElliot, Aux. President
11	Old Business – None		

	Agenda Item	Time Allotted	Requestor
12	Chief of Staff – a) Consideration to approve the November 2024 Credentialing Actions and Reappointments Involving the Medical Staff by the Medical Executive Committee on November 24, 2025 as well as the General & Vascular Surgery Clinical Privilege Form	5 min.	COS
13	Consent Calendar (1) Board Committee **(a) Finance, Operations & Planning Committee Director Younger, Committee Chair** 1) Approval of an expenditure, not to exceed $1,020,000, to facilitate the addition of Elsie Ross, M.D., MSc, FAHA, a Vascular Surgery physician to practice medicine in the communities served by the district. This will be accomplished through an independent physician recruitment agreement (not to exceed a two-year income guarantee with a three-year forgiveness period) between Tri-City Healthcare District, and Elsie Ross, M.D., MSc, FAHA. 2) Approval of the renewal of a Medical Directorship agreement with Jamil Alkhaddo, M.D. for the Diabetes Program for a term of 12 months, beginning, February 1, 2026 through January 31, 2027 for a total term cost not to exceed $28,800. 3) Approval of an agreement with Physician Assistant Specialist California, Inc. (PASCAL) for Physician Assistant surgical scrub support for a term of 24 months, beginning, December 1, 2025 and ending, November 30, 2027, for an annual cost of $250,000 and a total term cost not to exceed $500,000. 4) Approval of the agreement with Dr. Mohammad Jamshidi-Nezhad, as Cardiovascular Health Institute – Operations Committee member for a term of 12 months, beginning, November 1, 2025 and ending, October 31, 2026, not to exceed 2 hours per month at an hourly rate of $210 for an annual and total term cost of $5,040. 5) Approval of the renewal of an agreement with Dr. Richard Smith as the Medical Director for Infection Prevention & Control and Antimicrobial Stewardship Program for a term of 36 months, beginning December 1, 2025 and ending November 30, 2028, at an hourly rate of $176, for an annual cost not to exceed $63,360, and a total term cost not to exceed $190,080. 6) Approval of the renewal of the agreement with Vizient, Inc. for Group Purchasing contracts which includes supply purchases and service contracts, for a term of 36 months, beginning on January 1, 2026 and ending on December 31, 2028, for a total term not to exceed cost of $81,621,000.	10 min.	Chair

	Agenda Item	Time Allotted	Requestor

7) Approval of the renewal of the agreement with CORE Laundry Services for TCHD's linen and laundry services with a historical annual spend of $840,000 a year and total spend of $2,520,000 for a term of 36 months beginning January 1, 2026 and ending on December 31, 2028.

8) Approval of an agreement with Direct Difference, Inc. to perform abstraction services for cardiology/quality services for a term of $350,000 of 24 months, beginning November 6, 2025 and ending November 5, 2027, for an annual cost of $175,000 and a total cost for the term of $350,000

9) Approval of the addendum with Iodine Software, LLC for a subscription and services agreement for a term of 36 months beginning January 1, 2026 and ending December 31, 2028 for a total term cost of $975,314.

10) Approval of an Office Lease Agreement with 161 Thunder MOB, LLC for a 127-month term beginning approximately July 1, 2026 ending January 31, 2037. This proposal remains within the current fair market value full service gross rental rate of $3.14 per square foot for a monthly expense of $27,151, for a maximum total expense for the 127-month term of $4,595,140.

(2) Policies & Procedures

A. Patient Care Services

1) Black Box Warnings, Drugs with Policy
2) Bronchoscopy Nursing Procedure
3) Communicating with Physician / Allied Health Professional Using the Process SBAR Policy
4) Consent for Minors Policy
5) Defibrillator Checks
6) Discharge from Outpatient Post-Anesthesia Service Standardized Procedure
7) Disposal of Chemotherapy Waste Procedure
8) Documentation in the Medical Record Policy
9) Enteral Feeding Preparation, Storage, Distribution, and Administration Policy
10) Epilepsy Monitored Unit (EMU) Procedure
11) Food and Nutrition Relationships with Other Departments
12) Holds, Evaluation and Treatment of Involuntary Patients Pol
13) Incentive Spirometer (IS) Instruct and Monitoring Procedure
14) Infusion Pumps, Intravenous Therapy Policy
15) Meals, Patients - Times, Menus, Substitutions, & Nourishments Policy
16) Medical Examiner Notification Policy
17) Medical Record, Making Corrections to Documentation Procedure
18) Minors Attempting to Leave Without a Parent-Domestic Partner-Legal Guardian Policy
19) Nutrition Education of Patients Policy
20) Patient Food Refrigerators/ Freezers Procedure
21) Patient Leave of Absence, Temporary Policy
22) Physician / Allied Health Professionals (AHP) Orders for Outpatient Services

	Agenda Item	Time Allotted	Requestor
	23) Pre-Operative Education Medication Instructions to Surgical Patients Standardized Procedure 24) Privacy Code Policy 25) Private Duty Staff, Patient Acquired Policy 26) Referrals to Social Services for Patients Identified to be of High-Risk Policy 27) Reporting Suspected Child Abuse/Neglect 28) Reporting Suspected Dependent Adult/Elder Abuse/Neglect 29) Staffing, Registry-Traveler Usage Policy 30) Swallowing, Food and Nutrition Considerations for Patients with Oro-pharyngeal Dysphagia Policy 31) Team NICU Response Plan 32) Vaccination Administration **B. Administrative District Operations 200s** 1) Clinical Product Review/New Products 297 2) Legal Documents 294 3) Mandatory Reporting Requirements 236 4) Parking Program 261 5) Quality Assessment Performance Improvement (QAPI) Plan **C. Administrative 300s Patient Care** 1) Medicare Change of Status Notice **D. Administrative 400s Human Resources** 1) Employment of Relatives – 406 2) Performance Evaluations – 426 3) Reduction in Work Force – 448 **E. Administrative 500s Compliance** 1) Advanced Beneficiary Notification 503 2) EMTALA Emergency Medical Screening 506 **F. Administrative 600s Information Technology** 1) Incident Response Policy **G. Cardiac Cath Lab** 1) Angiojet Procedure 2) D-Stat Flowable Procedure 3) Manual Aspiration Extraction of Coronary Thrombus Procedure 4) Right Heart Catheterization and Prep of a Pulmonary Artery Catheter Procedure 5) Scheduling Cardiac Catheterization Cases Policy **H. Food & Nutrition** 1) Clinical Nutrition Dietitian Staffing Policy 2) Food Allergens Policy 3) Food Safety and Department Cleaning Policy 4) Food Service Employee Health-Work Restrictions for Personnel with Infectious Disease Policy 5) Identification of Patients Not Receiving Oral Intake Policy 6) Nutritional Care and Assessment for Infants Admitted to NICU 7) Protocols for Nutrition Care **I. Infection Control** 1) Aerosol Transmissible Diseases and Tuberculosis Control Plan		

	Agenda Item	Time Allotted	Requestor
	2) Bloodborne Pathogen Exposure Control Plan **J. Laboratory General** 1) QSE.06 Laboratory Information Management Quality System Essentials 2) QSE.07 Laboratory Document and Records Quality System Essentials 3) QSE.11 Laboratory Customer Service Quality System Essentials **K. Laboratory Point of Care** 1) Point of Care Quality Assurance Policy **L. Outpatient Behavioral Health** 1) Abbreviations 2) Admission and Eligibility Criteria 3) Admission Assessment 4) Age Appropriate Care 5) Clinical Assessment 6) Contraband 7) Co-treatment of Patients Policy 8) Daily Progress Notes 9) Discharge Planning & Discharge 10) Laboratory Services 11) Medical Emergencies 12) Organizational Structure 13) Physician Admission Order 14) Psychiatric Evaluation for Higher Level of Care 15) Referral and Admission Screening 16) Role of the Therapist 17) Scope of Services 18) Smoke Free Environment 19) Standards for Clinical and Professional Practice 20) Substance Abuse 21) Suicide Assessment 22) Treatment Planning **M. Rehabilitation** 1) Behavior Management/Supervision Technique 2) Job Site Assessment 609 (3) Minutes a) Regular Meeting – October 30, 2025 b) Special Meeting – October 30, 2025 c) Special Meeting – October 30, 2025 d) Special Meeting – November 6,2025 e) Special Meeting – November 7, 2025 f) Special Meeting – November 12, 2025 g) Special Meeting – November 13, 2025 h) Special Meeting – December 3, 2025 (4) Reports – (Discussion by exception only) a) Building Lease Report – (October, 2025) b) Reimbursement Disclosure Report – (October, 2025)		
14	Discussion of Items Pulled from Consent Agenda	10 min.	Standard

	Agenda Item	Time Allotted	Requestor
15	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
16	Comments by Chief Executive Officer	5 min.	Standard
17	Board Communications (three minutes per Board member)	18 min.	Standard
18	Total Time Budgeted for Open Session	2 hours	
19	Adjournment		

FMV (Real Estate) Analysis of:

Tri-City Medical Center and Carlsbad Medical Offices

Appraisal Report

Appraisal Date: September 26, 2025
Distribution Date: December 8, 2025

Prepared For:

Dr. Gene Ma, MD
CEO & President
Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056

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Appraisal Report

Transmittal Letter

December 8, 2025

Dr. Gene Ma, MD
CEO & President
Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056

Re: FMV Analysis of Tri-City Medical Center and Carlsbad Medical Offices

VMG Holdings LLC d/b/a VMG Health ("VMG") has completed valuation and transaction advisory services at the request of Tri-City Medical Center ("TCMC" or "Client"). VMG's analysis is presented within this valuation report ("Appraisal Report") along with the attached exhibits ("Exhibits").

Overview: Subject Identification & Background

At Client's request, VMG performed a current fair market value ("FMV") analysis of certain real estate (the "Subject Property") associated with Tri-City Medical Center, which is identified as follows:

Tri-City Medical Center (Hospital Campus)											
Subject Property	**#**	**Address**	**County**	**City**	**State**	**Property Description**	**Land Size (SF)**	**Land Size (Acre)**	**Building Size (Sq.Ft.)**	**Year Built**	**Tax ID**	**Owner**
Hospital - Main	1	4002 Vista Way	San Diego County	Oceanside	CA	Hospital Campus	1,349,053	30.970	450,545	Varied	166-010-31-00	Tri- City Medical District
Hospital - Outbuildings	2	Varied	San Diego County	Oceanside	CA	Outbuildings	Inc. Above	Inc. Above	39,028	Varied	Inc. above	Tri- City Medical District
New (Shell) Campus MOB	3	4004 Vista Way	San Diego County	Oceanside	CA	MOB	Inc. Above	Inc. Above	57,476	2013	166-010-31-00	Tri- City Medical District
Business Dev. & OP Forensics - CONDO	4	3925 Waring Ct. Ste. A, B, & C	San Diego County	Oceanside	CA	MOB- Condo	25,253	0.58	7,215	1976	166-560-23-01, 166-560-23-02	Tri- City Medical District
PHF Building (Behavioral Health)	5	3996 Vista Way	San Diego County	Oceanside	CA	Behavioral Health	87,991	2.02	13,560	2024	166-010-37-00	Tri- City Medical District
Vacant Site	6	4000 Vista Way	San Diego County	Oceanside	CA	Vacant	36,155	0.83	N/A	N/A	166-010-43-00	Tri- City Medical District
Off-Campus - 3617 Vista Way, #5	7	3617 Vista Way	San Diego County	Oceanside	CA	Outpatient Infusion Center	24,500	0.56	7,000	2008	165-36-23-600	Tri- City Medical District (owns 25%)
						Totals:	1,522,952	34.96	574,824			

Notes:

1) For purposes of Cost Approach, utilized 3.5 : 1.0 LTB to account for effective land area associated with the MOB condos (3925 Waring Ct) and 3617 Vista Way.

2) Year built sourced from client-provided information, CoStar, and online sources. This analysis includes the psych/behavioral health building which is subject to a ground lease and will eventually revert ownership to Tri-City.

Tri-City Medical Center (Carlsbad Properties)											
Subject Property	**#**	**Address**	**County**	**City**	**State**	**Property Description**	**Land Size (SF)**	**Land Size (Acre)**	**Building Size (Sq.Ft.)**	**Year Built**	**Tax ID**	**Owner**
MOB - 6250 El Camino Real	1	6250 El Camino Real	San Diego County	Carlsbad	CA	Fitness Center	334,976	7.690	57,252	2008	213-110-01-00	Tri- City Medical District
MOB - 6260 El Camino Real	2	6260 El Camino Real	San Diego County	Carlsbad	CA	MOB	Inc. Above	Inc. Above	23,863	2010	213-110-01-00	Tri- City Medical District
						Totals:	334,976	7.690	81,115			

Additional details of the subject property are presented later in this report.

Engagement: Purpose, Use & Disclosure

The purpose of this engagement is to assist Client with regulatory compliance and internal planning. VMG's valuation report ("Report") may only be used for the purpose stated within the Report. Client may provide a copy of a Report to its legal counsel, the Internal Revenue Service, or the Office of Inspector General. However, Client may not provide the Report to any other third party without VMG's written consent. Such consent shall be timely and not unreasonably withheld.

VMG Health: Summary of FMV Conclusions

VMG Health toured the Subject Property on **September 26, 2025**, which is the effective date of value. VMG's conclusion of value for the Subject Property is presented on the following table. As shown below, we have adjusted the pre-Seismic indicated FMV to account for the necessary seismic compliance costs.

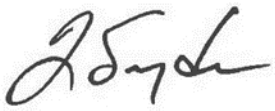
SUMMARY OF VALUE CONCLUSIONS

Tri City Medical Campus - Primary Campus - Oceanside			
			FMV Conclusion
		Indicated Value, pre Seismic Adjustment	**$161,300,000**
		Less Seismic Adjustment (Total)[1]	**-$106,357,000**
		Rounded	**$54,900,000**
Sq Ft =	*574,824 (Bldg)*	*per sq ft*	*$95.51*
Acres =	*34.96 (Land)*		
		Land Value (Included Above):	$48,150,000
		Value Indication w/o Land Value:	$6,750,000

Tri City Medical Campus - Wellness Center / MOB - Carlsbad			
			FMV Conclusion
		Indicated Value	**$50,000,000**
		Less Seismic Compliance	N/A
		Indicated Value (adjusted)	**$50,000,000**
		Rounded	**$50,000,000**
Sq Ft =	*81,863 (Bldg)*	*per sq ft*	*$610.78*
Acres =	*7.69 (Land)*		
		Land Value (Included Above):	$10,720,000
		Value Indication w/o Land Value:	$39,280,000

1) Seismic retrofit costs are based on the combined 106,357 square feet for the Center Tower (54,380 sq ft), South Tower (48,715 sq ft), and Electrical Building (3,262 sq ft). Cuningham indicated that these three buildings are the three primary buildings which need to be addressed for seismic compliance. VMG has recently (in Q3 2023) been involved in a hospital project in southern California which required seismic compliance costs amounting to ~$437/SF. VMG completed another hospital real estate valuation project (in 1Q 2024) involving seismic retrofitting wherein costs were estimated at a range of $500 to $1,000 per sq ft. In this case, VMG has assumed **$1,000/SF** in costs. Subsequent information concerning a more precise estimate of the cost of seismic compliance could result in changes to these value conclusions.

Respectfully submitted,



Frank Fehribach, MAI, MRICS
Director – Real Estate Services

Larry Snyder, MAI
Director – Real Estate Services

Exhibit A: Overview

Report Format

This is an Appraisal Report which complies with the reporting requirements set forth under Standards Rule 2-2(a) of the Uniform Standards of Professional Appraisal Practice for an Appraisal Report. The report presents discussions of the data, reasoning, and analyses that were used in the appraisal process to develop the appraiser's opinion of Fair Market Value for the subject property. Supporting documentation concerning the data, reasoning and analyses is retained in our files. The depth of discussion contained in this report is specific to the needs of the client and for the intended use stated within this report.

Identification of Property

The subject property is identified as the Tri-City Medical Center, along with associated properties on and near the campus in Oceanside, CA, plus two medical office buildings (Carlsbad MOB and Wellness Center) in Carlsbad, CA. Additional details regarding the subject properties are provided in the *Improvements Description* section of this report.

Purpose of the Appraisal

The purpose of the appraisal is to provide our opinion of the Fair Market Value of the premises fully identified in this Appraisal Report.

Property Rights

Regarding our Fair Market Value analysis, the property rights appraised are those of the Fee Simple Estate in the subject property. Fee Simple Estate is defined in *The Dictionary of Real Estate Appraisal, Seventh Edition* as follows:

"Absolute ownership unencumbered by any other interest or estate, subject only to the limitations imposed by the government powers of taxation, eminent domain, police power, and escheat."

Client and Intended Use of the Appraisal

The intended user (client) of this Appraisal Report is Tri-City Medical Center. It is our understanding that the intended use of this appraisal is to assist Client with regulatory compliance and internal planning. The purpose of our analysis is to provide an opinion of the Fair Market Value of the subject property. VMG Health is not responsible for the unauthorized use of this Appraisal Report.

Effective Date of Valuation

Larry Snyder, MAI conducted a physical tour of the property on September 25 and 26, 2025. The effective date of value(s) for the purposes of this assignment is September 26, 2025.

Definitions

The following is a list of definitions applicable to this assignment.

The implications of defining FMV correctly are crucial to most healthcare arrangements between referring parties. Regulatory constraints imposed by the IRS on tax-exempt buyers and certain sellers, as well as by Stark laws, require FMV as a standard. Published definitions of FMV are similar amongst the business valuation

industry and healthcare's regulatory environment. However, healthcare regulations provide additional guidance as it relates to methodologies and data.

The standard of value will be fair market value ("FMV"), generally defined by the International Glossary of Business Valuation Terms as the price, expressed in terms of cash equivalents, at which a property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arm's length in an open and unrestricted market, when neither is under compulsion to buy or sell and when both have reasonable knowledge of the relevant facts.

In a healthcare setting, FMV has additional considerations associated with the Anti-Kickback Statute and the Stark Law. Under the Stark Law, FMV is generally defined as the value in arm's-length transactions consistent with the "general market value" ("GMV") defined by 42 CFR §411.351.

Real Estate and Equipment Leases

For real estate and equipment leases, GMV is defined as the price that rental property would bring at the time the parties enter into the rental arrangement as the result of bona fide bargaining between a well-informed buyer and seller that are not otherwise able to generate business for each other. [85 Fed. Reg. 77553-77554, Dec. 2, 2020]

The Dictionary of Real Estate Appraisal defines "market rent" as the most probable rent that a property should bring in a competitive and open market reflecting all conditions and restrictions of the lease agreement including permitted uses, use restrictions, expense obligations, term, concessions, renewal and purchase options, and tenant improvements. This definition implies the following conditions:

- Lessee and lessor are typically motivated.
- Both parties are well informed or well advised and acting in what they consider their best interests.
- A reasonable time is allowed for exposure in the open market.
- The rent payment is made in terms of cash in United States dollars and is expressed as an amount per time period consistent with the payment schedule of the lease contract.
- The rental amount represents the normal consideration for the property leased unaffected by special fees or concessions granted by anyone associated with the transaction.

SCOPE OF ENGAGEMENT

The results of this investigation are presented in an Appraisal Report. The following scope was completed by VMG Holdings LLC d/b/a VMG Health ("VMG") for this assignment:

1. Analyzed regional, city, neighborhood and market area.
    - Gathered current and relevant data related to demographic, economic, governmental and environmental forces that have a direct or indirect influence on the subject property.
    - Provided supporting comments and appropriate conclusions to describe the influence of these factors on the subject property.
    - Market data was gathered from a variety of sources including local, regional and national healthcare real estate professionals, brokers and online sources.
2. Completed a physical observation of the subject property and the market area or neighborhood relevant to the subject property.

- The physical inspection of the subject property involved observing the subject site and improvements. Photographs were taken of the subject property's existing improvements as of our inspection date. The physical observation of the site included the type and condition of walkways, curbs, sidewalks, parking surfaces, security lighting and fencing, the quality and abundance of landscaping and the observed adequacy of water drainage and runoff, as pertinent.
- The physical observation of the market area or neighborhood included driving the adjacent roadways and the major thoroughfares in the area. The adequacy and condition of area improvements (including condition and appeal, occupancy and competitive properties, and any adverse influences) were also observed.
- Reviewed relevant supporting data. The appraiser's physical observation was supported by the review of the available building and site plans.
- Reviewed data regarding taxes, utilities and city services.
- The availability or existence of all utilities, easements and city services was determined by physical observation and data provided by management.

3. Analyzed the data and applied the applicable approaches to value.
    - The value opinions presented in this Appraisal Report are based on review and analysis of the market conditions affecting real property value, including the attributes of competitive properties and rental data for similar properties.
    - The appraiser performed a market analysis for the subject's market area. VMG Health's conclusion of Highest and Best Use is based primarily on logic and observed evidence.
    - Three traditional approaches are typically used to arrive at an opinion of value of real property: the Sales Comparison Approach; the Cost Approach; and the Income Capitalization Approach. Regarding Market Rent, the derivative of these three approaches is the Rent Comparables Approach, the Return-on-Depreciated Cost Approach, and the Rent Coverage Ratio approach. We have considered all three approaches within our analysis and applied those we deemed most appropriate.
4. The following is not included within the scope of this real estate analysis as presented herein: a) fairness opinion; b) commercial reasonableness opinion; c) fixed asset valuation and d) due diligence or quality of earnings analyses. A business valuation is also not part of this report, but a business valuation was performed in a separate valuation report by VMG Health.

Specific attention is drawn to the Assumptions and Limiting Conditions for further understanding of the scope of the appraisal. The subject site and improvement descriptions are based on a physical tour of the property and a review of provided data. The physical tour is not a substitute for thorough engineering studies.

COMPETENCY STATEMENT

Frank Fehribach, MAI, MRICS has extensive experience with the valuation of various medical projects throughout the United States, including acute care hospitals, ambulatory surgery centers, medical office buildings, etc. Mr. Fehribach, MAI, MRICS has valued over 100 acute care hospitals in the last six years. Frank Fehribach holds the MAI designation and is a member of the Royal Institution of Chartered Surveyors. Mr.

Fehribach also is a Certified General Real Estate Appraiser in the State of California (AG044542). Accordingly, the appraiser possesses the professional competency required to appraise the subject property.

Larry Snyder, MAI, has extensive experience with the valuation of medical projects throughout the United States, including rehabilitation, behavioral, and acute care hospitals, along with a variety of outpatient care facilities. The appraiser holds the MAI designation with the Appraisal Institute. Accordingly, the appraiser has the professional competency to appraise the subject property.

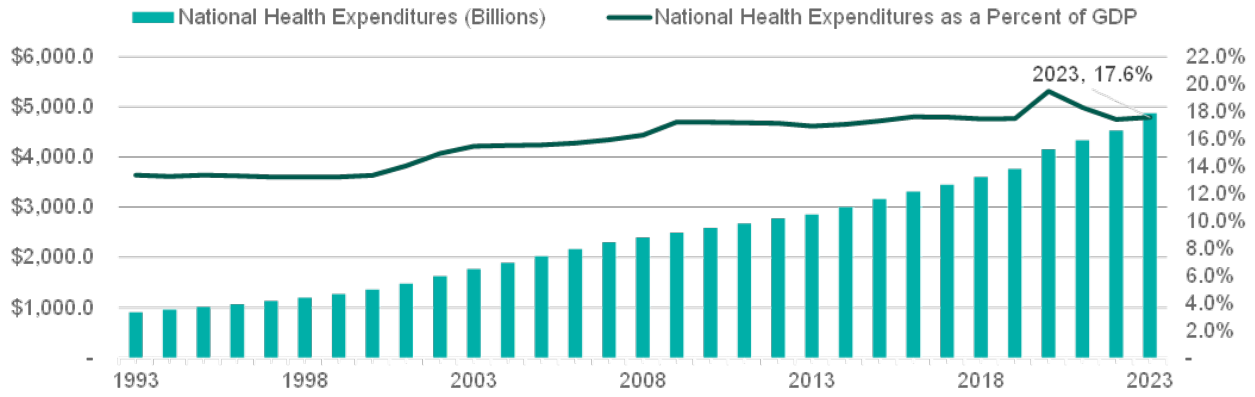
Property History

According to public records, the subject property is owned by Tri-City Medical Center or an affiliated entity. To the best of our knowledge, there have been no transfers in the last three years, and the subject property is not currently being marketed for sale.

Exhibit B: Healthcare Market Overview

United States Healthcare System

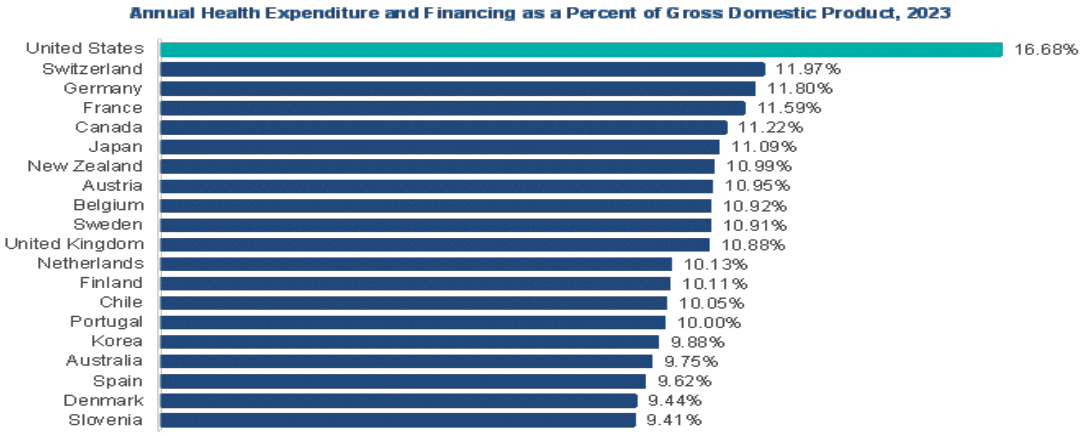
According to the Centers for Medicare & Medicaid Services ("CMS"), total national healthcare expenditures over the last 30 years have grown at a compound annual growth rate of 5.7% from approximately $914.9 billion in 1993 to approximately $4,866.5 billion in 2023. Most recently, total national health expenditures grew 7.5% from approximately $4,525.8 billion in 2022 to approximately $4,866.5 billion in 2023. Healthcare spending as a percentage of gross domestic product ("GDP") over the last 30 years has increased from a low of 13.2% in 1997 to a high of 19.5% in 2020. More recently, healthcare spending was approximately 17.6% of GDP in 2023, an increase of approximately 0.9% from 2022 healthcare spending as a percentage of GDP of approximately 17.4%.



Notes and Sources

1. *Table 1. National Health Expenditures; Aggregate and per Capita Amounts, Annual Percent Change, and Percent Distribution. Calendar Years 1960 to 2023. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical*
2. *National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2023. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical*
3. *Federal Reserve Bank of St. Louis, National Bureau of Economic Research ("NBER")-Based Recession Indicators for the United States from the Period following the Peak through the Trough ("USREC"). FRED, Federal Reserve Bank of St. Louis. Data retrieved February 1, 2025. https://fred.stlouisfed.org/series/USREC*
4. *VMG notes that data for 2024 has not yet been released.*

According to the Organisation for Economic Co-Operation and Development ("OECD"), the United States spends more on healthcare, both per capita, and as a share of GDP, than any other country in the world. The chart below presents the top twenty OECD countries in terms of annual health spending as a percentage of GDP in 2023.

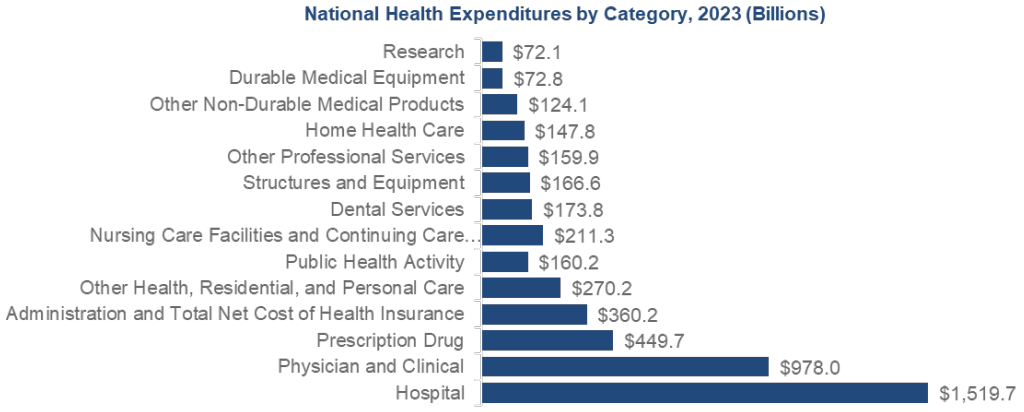


Notes and Sources

1. *Organisation for Economic Co-Operation and Development. Data retrieved February 3, 2025. https://stats.oecd.org/Index.aspx?DataSetCode=SHA#*
2. *VMG notes that data for 2024 has not yet been released.*

Healthcare Spending by Category

From 2022 to 2023 total national health expenditures increased 7.5% from approximately $4,526 billion in 2022 to approximately $4,866 billion in 2023. In 2023 Hospital and Physician and Clinical were the largest spending categories, accounting for approximately $2,498 billion, or 51.3%, of total health expenditures. From 2013 to 2023 overall healthcare spending increased at a compound annual growth rate of approximately 5.5%. Over this time frame, Other Professional Services and Public Health Activity experienced the largest growth in spending, at compound annual growth rates of approximately 7.4% and 7.0%, respectively, from 2013 to 2023.

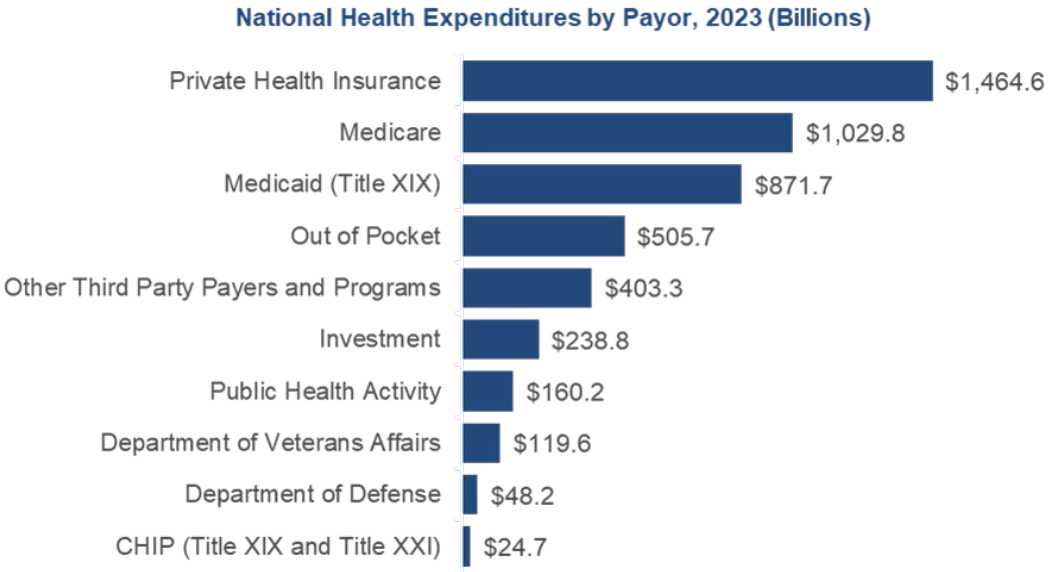


Notes and Sources

1. *National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2023. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical*
2. *VMG notes that data for 2024 has not yet been released.*

Funding Overview

Multiple private and public sources combine to finance healthcare expenditures in the United States. Overall public sources of funding (CHIP (Title XIX and Title XXI), Department of Defense, Department of Veterans Affairs, Public Health Activity, Investment, Medicaid (Title XIX), Medicare) accounted for approximately 51.2% of national health expenditures during 2023.

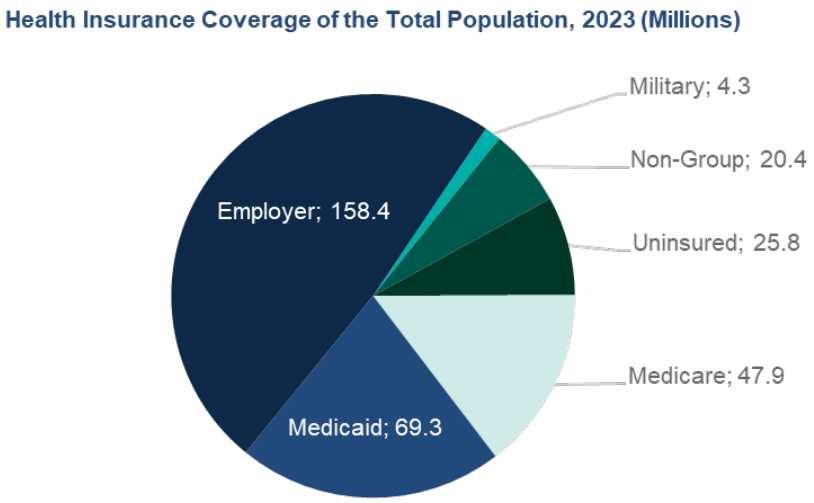


Notes and Sources

1) *National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2023. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical*
2) *VMG notes that data for 2024 has not yet been released.*

Government Funding

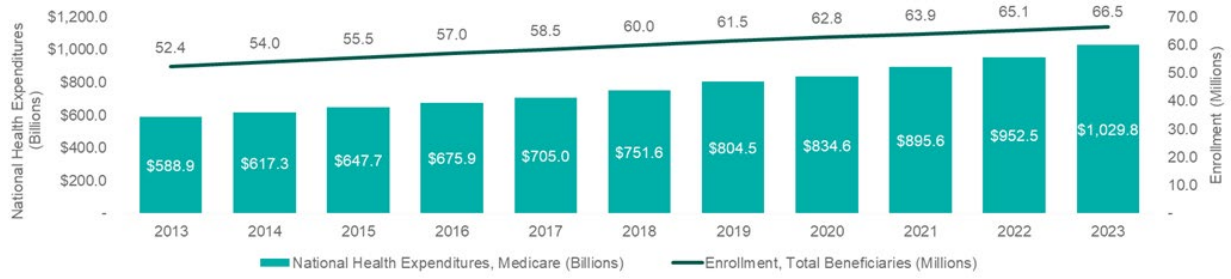
Most Americans under the age of 65 have health coverage through a private insurance provider. According to the Kaiser Family Foundation ("KFF"), during 2023 approximately 48.6% of Americans had Employer-based private insurance, while approximately 6.2% obtained private insurance through the individual plan market. The largest government payors, Medicaid and Medicare, covered approximately 21.2% and 14.7% of Americans, respectively, in 2023.



Notes and Sources

1) *Kaiser Family Foundation ("KFF") estimates based on the 2008-2023 American Community Survey, 1-Year Estimates. Data retrieved February 3, 2025. https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D*
2) *The count of people with Medicare excludes those who report having both Medicare and Medicaid coverage, also known as dual eligibles. If these individuals were instead categorized as having Medicare, the total number of people with Medicare would increase.*
3) *VMG notes that data for 2024 has not yet been released.*

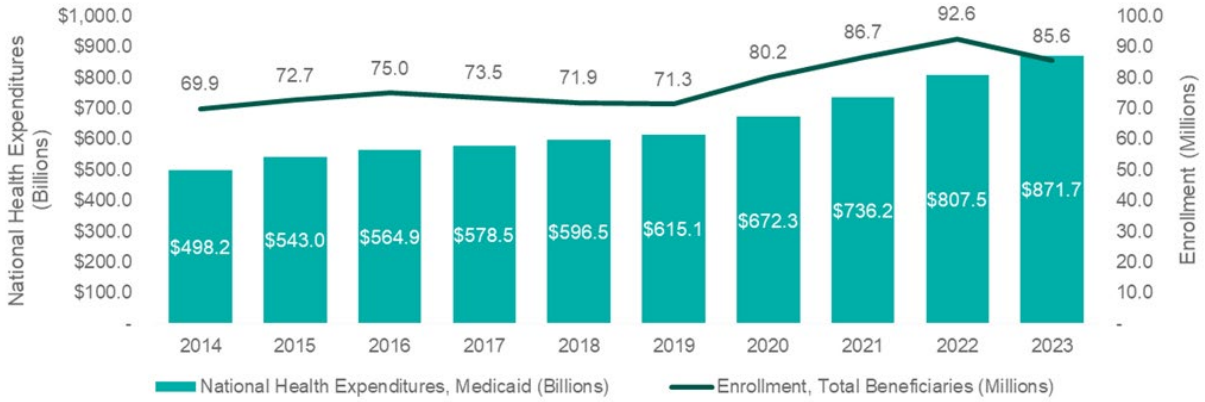
As of September 2024, Medicare provides federal health insurance for approximately 68.0 million beneficiaries who are elderly, disabled, have end-stage renal disease, or amyotrophic lateral sclerosis (also known as Lou Gehrig's disease). Individuals become eligible for Medicare when they reach the age of 65; certain disabled individuals also become eligible for Medicare 24 months after they become eligible for benefits under the Social Security Disability Insurance Program. Since 2013, Medicare spending has grown approximately 5.7% compounded annually from approximately $588.9 billion in 2013 to approximately $1,029.8 billion in 2023. More recently, total Medicare spending increased 8.1% from approximately $952.5 billion in 2022 to approximately $1,029.8 billion in 2023.



Notes and Sources

1) *National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2023. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical.*
2) *Medicare Monthly Enrollment, Centers for Medicare & Medicaid Services. Data retrieved February 3, 2025. https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment*
3) *VMG notes that data for 2024 has not yet been released.*

Medicaid is a joint federal-state program that pays for healthcare services for a variety of low-income individuals. The Medicaid program, created in 1965 by the same legislation that created Medicare, replaced an earlier program of federal grants given to states to provide medical care to low-income residents. As of October 2024, approximately 79.3 million people were enrolled in the Medicaid program. It should be noted that certain individuals, often referred to as dual-eligible, are covered by both Medicaid and Medicare. Since 2014, Medicaid spending has grown 6.4% compounded annually from approximately $498.2 billion in 2014 to approximately $871.7 billion in 2023.



Notes and Sources

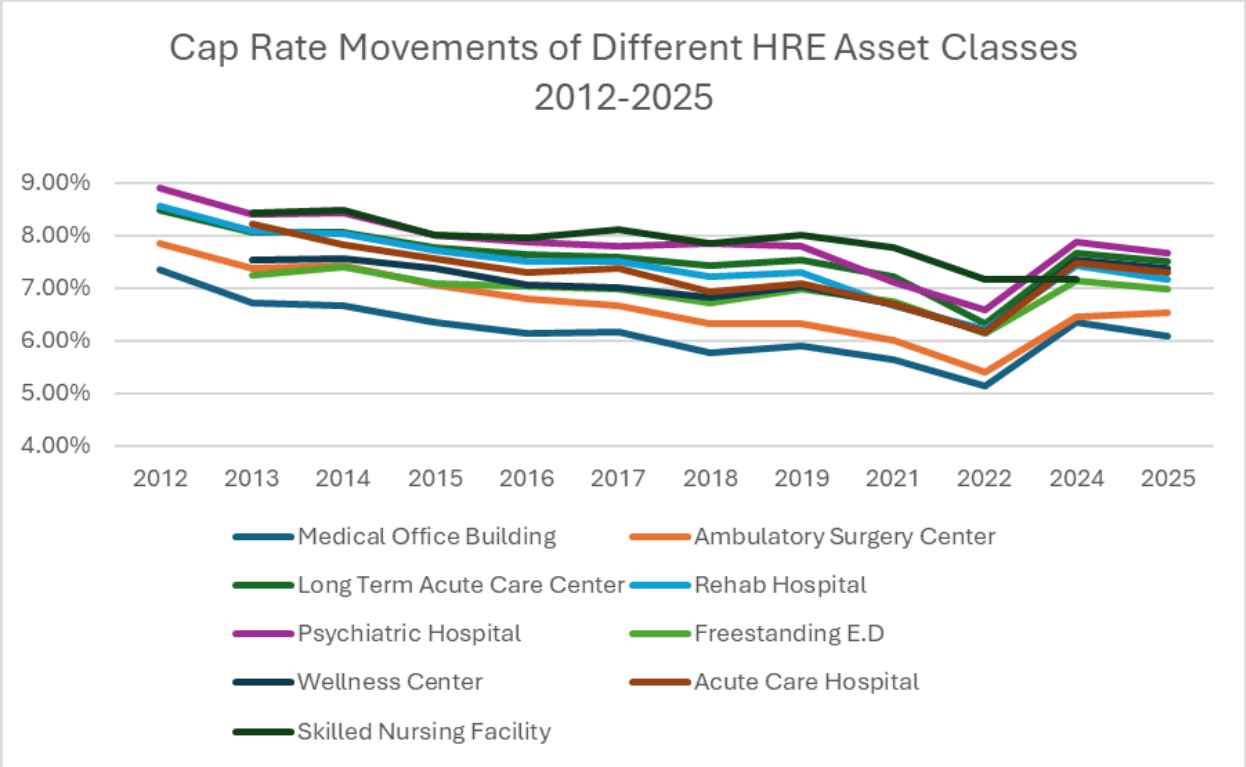
1) *National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2023. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical.*
2) *"Total Monthly Medicaid & CHIP Enrollment and Pre-ACA Enrollment." Kaiser Family Foundation. Data retrieved February 4, 2025. https://www.kff.org/affordable-care-act/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D*
3) *VMG notes that data for 2024 has not yet been released.*

Healthcare Real Estate

After more than a decade of low interest rates and cap rate compression, the period from 2022 through 2024 witnessed an increase in both capitalization and interest rates. CBRE's 2025 Investor & Developer Survey Results noted the following: "Single-tenant MOBs are expected to remain the most competitively priced asset types with 74% of respondents anticipating a market cap rate of less than 6.50%, up from 67% in 2024. Additionally, 32% of investors believe cap rates for single tenant MOB's will start with a 5-handle. Ambulatory surgery centers follow close behind with 52% pricings ASCs below a 6.50% cap rate, like 55% of investors in 2024".

The following chart illustrates the spread between office and medical office from 2012 to 2025 (which illustrates that, while cap rates have increased, they still generally remain below 2012-2017 levels).

Indicated Capitalization Rates Across Various Sectors of Healthcare Real Estate (HRE)



Notes and Sources

1. *Source: CBRE Investor & Developer Survey Results 2025*

The following chart illustrates the relative percentage indications of investors projected capitalization rates for the varying asset classes from the same CBRE 2025 survey.

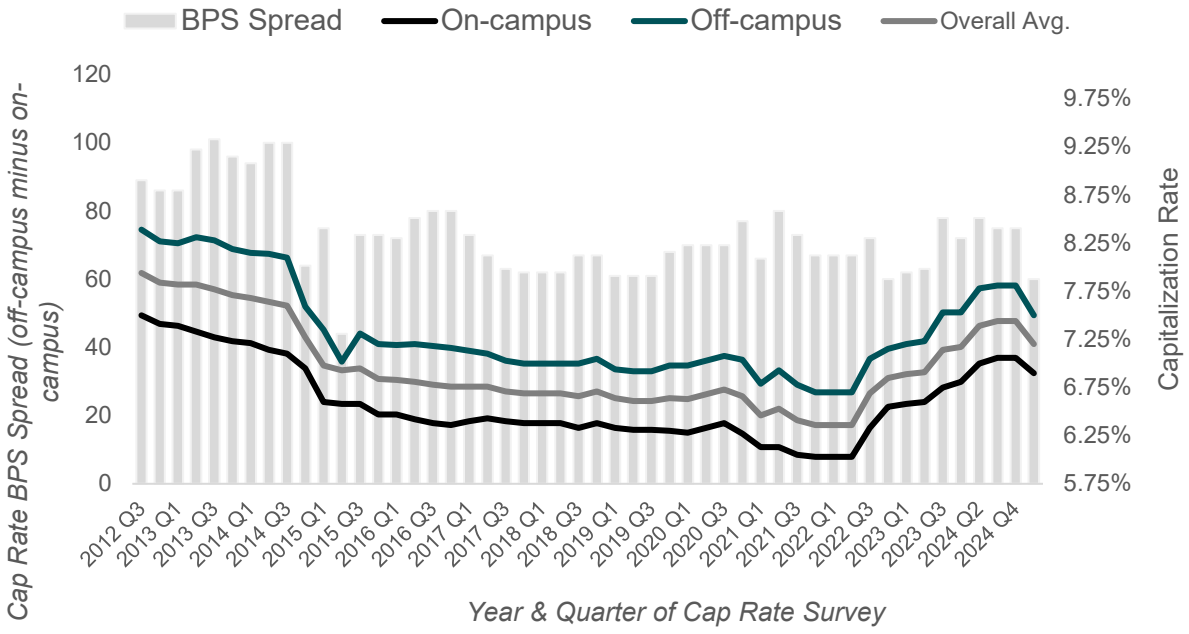
CAP RATE	Above 9.00%	8.50% - 8.99%	8.00% - 8.49%	7.50% - 7.99%	7.00% - 7.49%	6.50% - 6.99%	6.00% - 6.49%	5.50% - 5.99%	5.00% - 5.49%	Below 5.00%
Single-Tenant MOB	0%	0%	2%	0%	2%	19%	42%	28%	4%	0%
Freestanding Emergency Department	1%	3%	6%	7%	35%	19%	17%	10%	0%	0%
Ambulatory Surgery Center	0%	1%	1%	4%	11%	31%	37%	11%	4%	0%
Wellness Center	3%	4%	8%	23%	31%	25%	4%	1%	0%	0%
Acute Care Hospital	3%	4%	14%	23%	17%	19%	16%	1%	3%	0%
Long-Term Acute Care Hospital	9%	10%	20%	23%	14%	14%	4%	4%	0%	0%
Rehabilitation Hospital	1%	3%	11%	20%	26%	26%	8%	4%	1%	0%
Behavioral Hospital	4%	8%	18%	28%	19%	14%	6%	3%	0%	0%
Life Sciences	6%	0%	9%	9%	22%	25%	14%	12%	3%	0%

Notes and Sources

1. *Source: CBRE Investor & Developer Survey Results 2025*

Overall capitalization rates (since 2012) in the medical office market are profiled in the following chart (with delineation between on- vs. off-campus cap rates). Additional industry specific cap rate information will be presented (as applicable) within the Valuation sections of this report.

ON- VS OFF-CAMPUS MOB CAPITALIZATION RATES



Notes and Sources

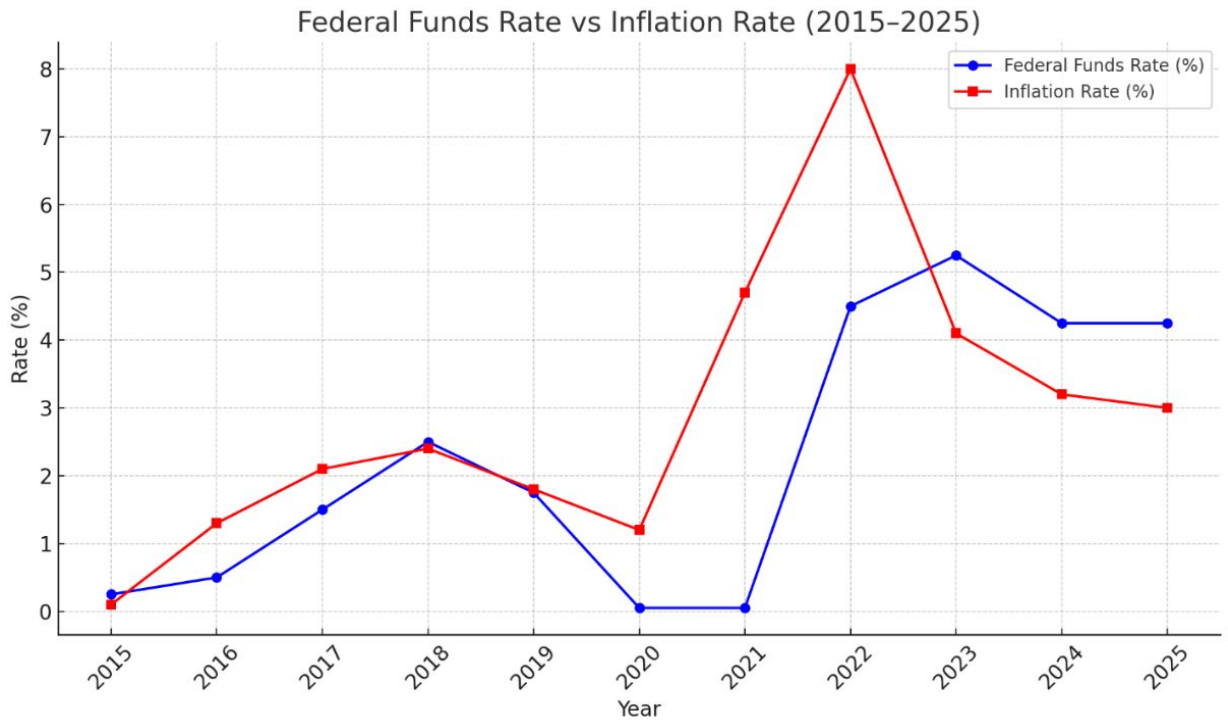
1. *Source: Q1 2025 PWC Investor Survey*

Healthcare Real Estate Market Update: Recent Trends

The COVID-19 public health emergency was officially declared over as of May 2023, but the economic ramifications of COVID-19 created significant volatility and uncertainty across the entire economy, including the real estate market. As of the start of Q2 2025, the economic impacts of COVID-19 remain.

Prior to the pandemic, the Federal Funds Rate generally ranged from 1.0% to 2.50%. The onset of the pandemic in 2020 witnessed a significant lowering of the federal funds rate to record low levels, which effectively added significant amounts of relatively "free" money into the economy. Interest rates and capitalization rates for commercial (and residential) real estate significantly decreased in 2020 and 2021 as governments around the world attempted to bridge the economic gap of closing certain portions of the economy. This led to enhanced pricing for real estate from 2020 through Q1 2022. An unexpected offshoot of this easing monetary policy was high levels of inflation across all sectors of the economy, which significantly impacted construction costs for new real estate development.

The Federal Reserve was forced to deal with rapidly escalating inflationary pressures by increasing the federal funds rate significantly from Q2 2022 through 2024, with a slight lowering of the rate in late 2024. The following chart illustrates the Federal Funds Rate and the inflation rate from 2015 to present, which clearly indicates the cause-and-effect relationship of COVID-19 monetary policy.



Notes and Sources

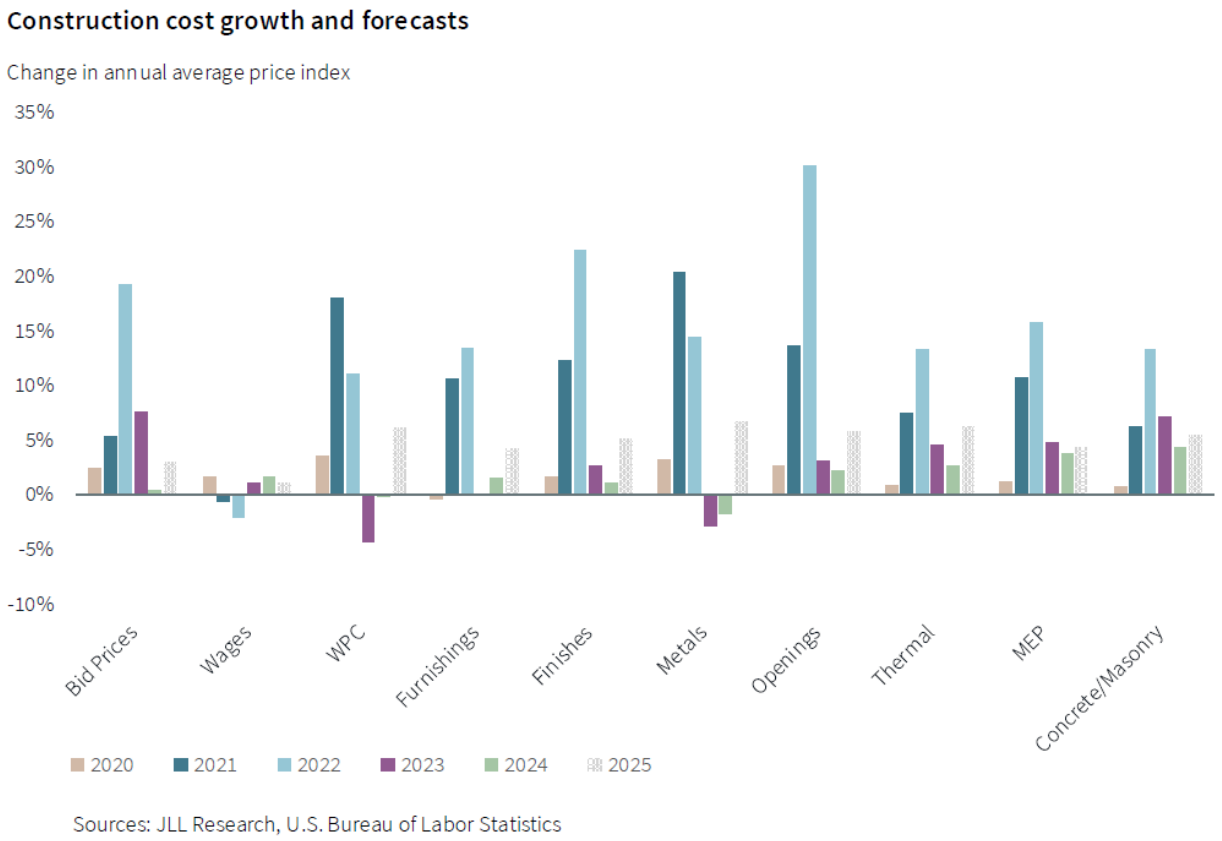
1. *Source: Federal Reserve & BLS*

Construction Costs

JLL's 2025 U.S. Construction Outlook notes "After a respite in 2024, construction materials and costs are poised to resume growth, signaling a pivotal moment for commercial real estate decision-makers. Although elections introduced uncertainty around environmental and energy policies, the push for green building practices, energy efficiency and reduced carbon footprints will continue shaping project requirements through local regulations and client targets.

Data centers, healthcare and advanced manufacturing have embraced sustainability as integral to growth, putting extensive pressure on related materials. With added shocks from natural disasters, prices are set to rise in 2025 across a broader range of inputs. Having the right technologies and team is critical for managing costs. However, technical capacity is in short supply within the construction industry and corporate real estate function as well."

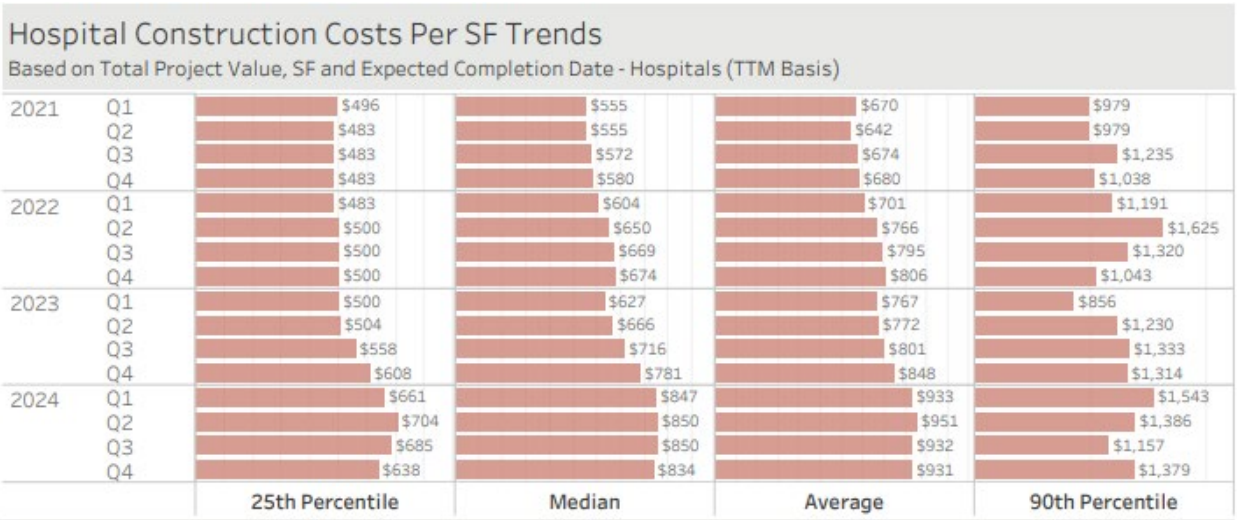
The following graph illustrates the significant construction cost inflation since 2020 across a variety of inputs (this data reflects not solely healthcare real estate, but rather the entire U.S. construction cost market).



Notes and Sources

1. *Source: JLL 2025 US Construction Outlook*

The following chart was presented the RevistaMED Subscriber Webcast 4Q24, indicating that while construction costs (specifically, the data in the following chart pertains to hospitals, but this is true for other types of construction as well) did show signs of leveling out/stabilizing in 2022 and in the first half of 2023, additional inflationary pressures commenced in 3Q2023 through the end of 2Q2024 and then showed signs of stabilization and potentially even decline in the second half of 2024.



Construction Costs Per Bed and SF by Construction Type and Status

(uses all hospital construction cost data)

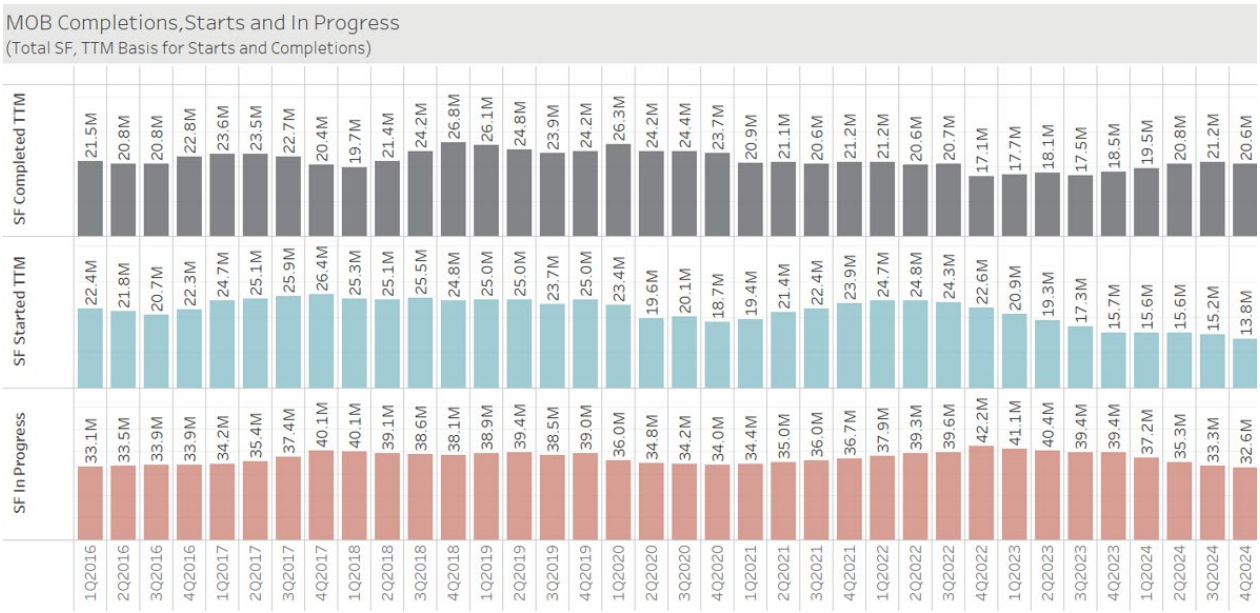
		Median Construction Value/SF	Median Construction Value/Bed
Completed	Expansion	$515	$1,217,720
	New	$538	$1,700,000
	Replacement	$592	$1,800,000
In Progress	Expansion	$850	$2,372,995
	New	$850	$2,966,667
	Replacement	$911	$2,970,085
Planning	Expansion	$850	$1,793,028
	New	$850	$2,833,333
	Replacement	$850	$2,893,125

Notes and Sources

1. *Source: RevistaMED Subscriber Webcast 4Q24*

Additional levels of uncertainty surrounding construction cost pricing have recently (1Q2025) appeared as it relates to US fiscal policy on tariffs on imported goods and construction materials from countries outside the US. The tariffs have been reported to range anywhere from 10 to 40%, depending on which country the imported goods are coming from. The uncertainty regarding tariffs has resulted in many contractors that are currently bidding projects to have a "market price or tariff price" line item in construction budgets, given the rapidly evolving political landscape and tariff % negotiations between countries.

As would be expected given the rapidly escalating construction costs the last several years, coupled with increasing interest rates/development yields, medical outpatient construction activity is at a cyclical low (as illustrated in the following chart).

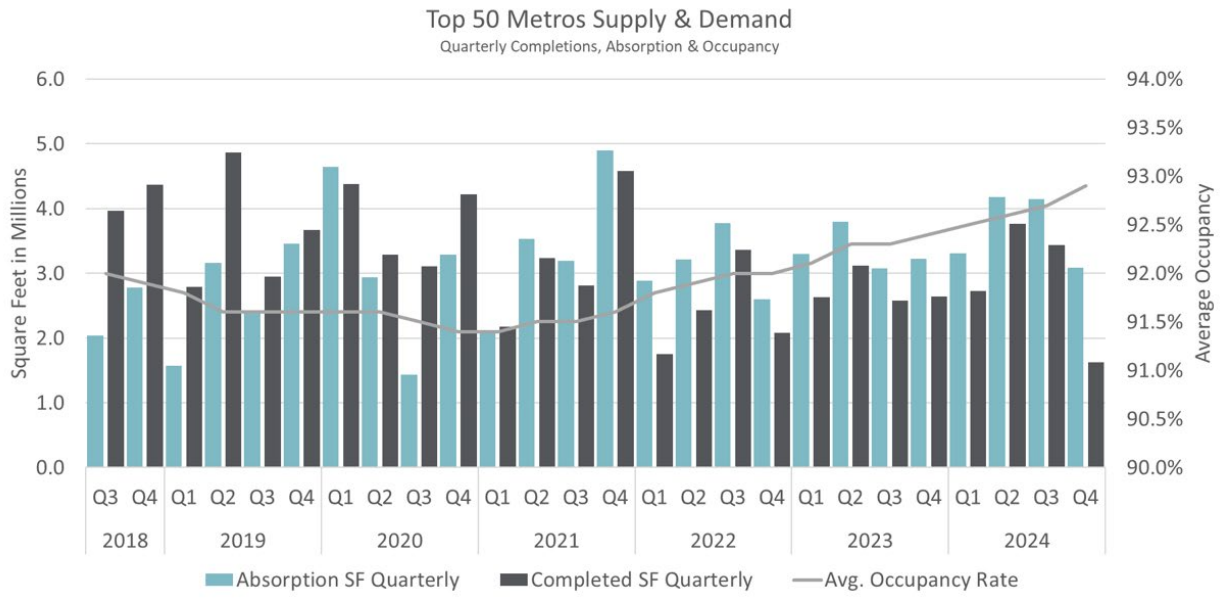


Notes and Sources

1. *Source: RevistaMED Subscriber Webcast 4Q24*

Occupancy and Rental Rates

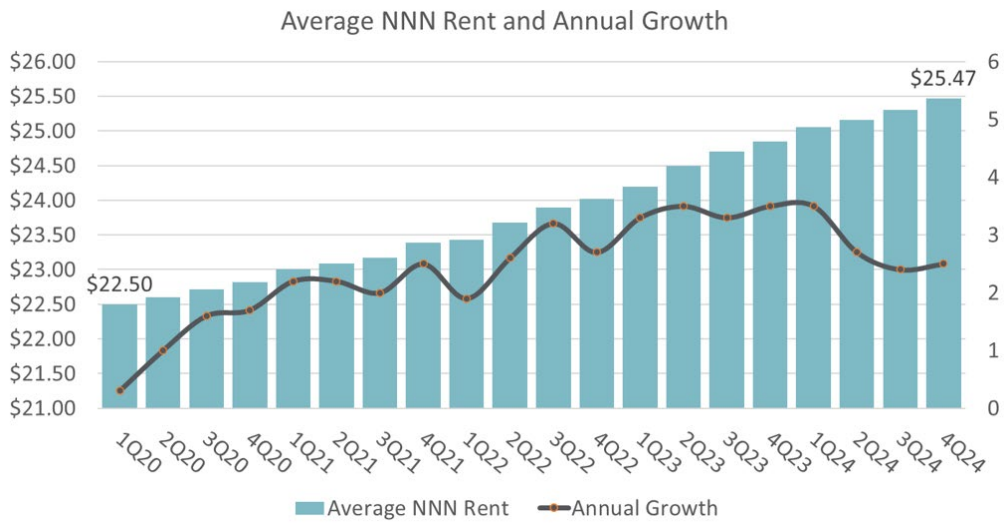
Revista's February 2025 webinar noted that the medical office sector has continued to remain relatively strong from 2022 through 2024, with continued increases in occupancy levels and strong levels of absorption, as illustrated in the following table. Occupancy is also positively impacted by less MOB construction.



Notes and Sources

1. *Source: RevistaMED Facts & Figures 1Q25*

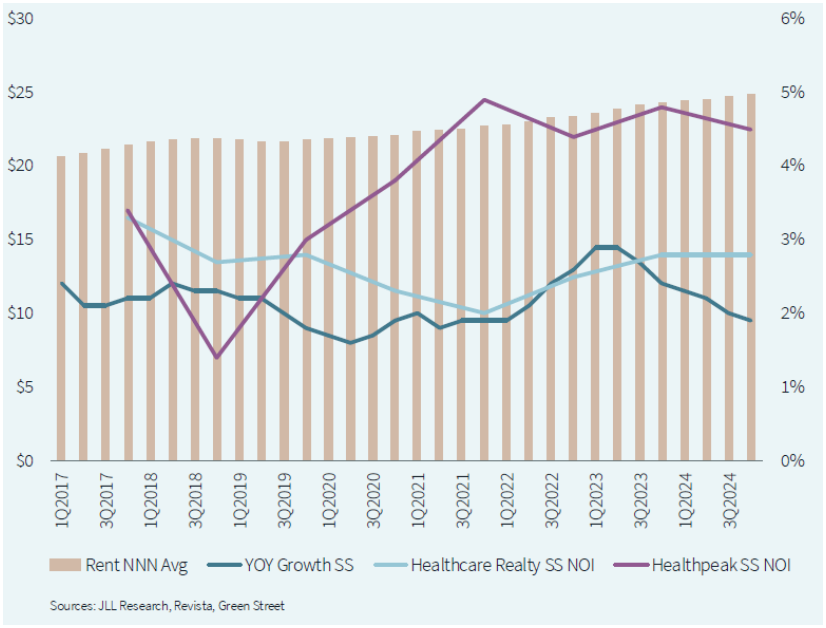
The following charts show average NNN rent in the top 50 metros over the past five years. The average NNN rent has escalated 13.2% since 2020, although annual percentage increases have shown signs of moderating off recent highs in 2024.



Notes and Sources

1. *Source: RevistaMED Facts & Figures 1Q25*

A majority of medical tenants renew in place, with MOB-focused REITs posting retention rates of over 80% in Q3 2024 according to Green Street. Healthcare REITs continue to see steady net operating income (NOI) growth. Escalations for new leases in 2024 averaged around 3%, according to JLL data, and with lease terms averaging 107 months for new leases, investors generally have steady rent increases locked in. With increasing cost pressures on tenants, same-store MOB rent growth is projected to continue to remain steady.

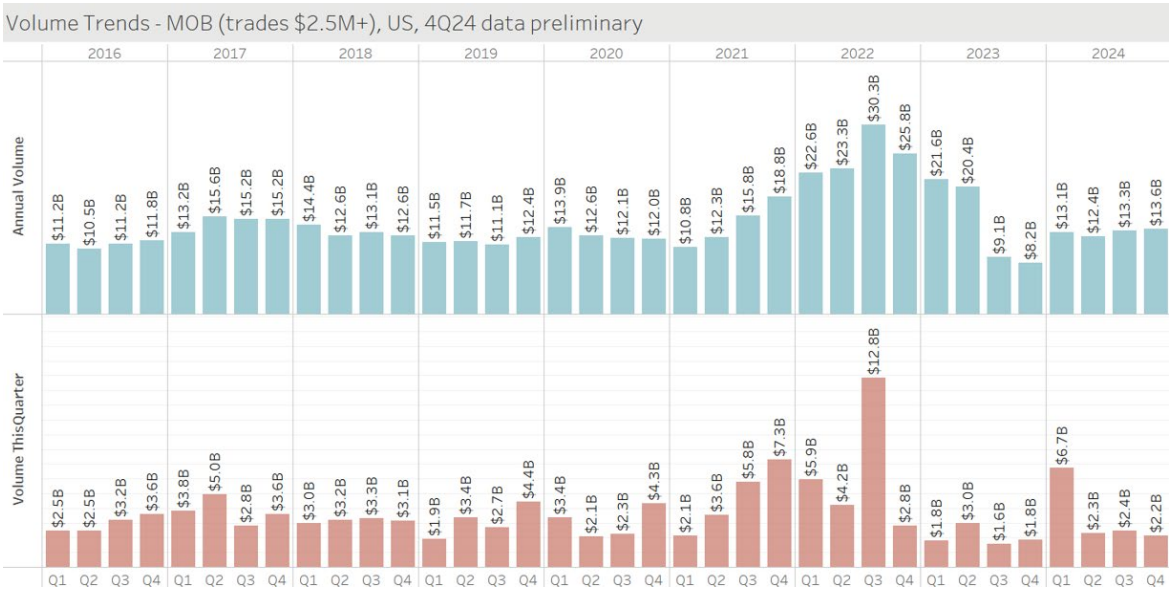


Notes and Sources

1. *Source: JLL 2025 Medical Outpatient Building Perspective*

Capitalization Rates and Debt Financing

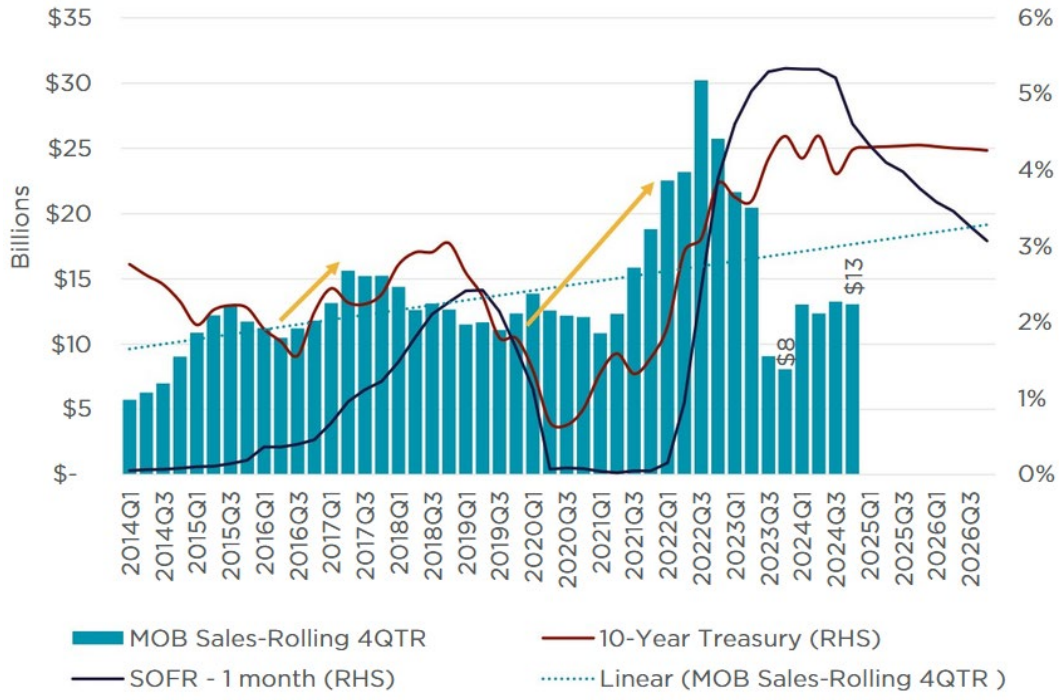
The following chart depicts the investment transaction data for the MOB sector from 2016 to present. As would be expected given the loosening of capital markets and debt markets, an uptick from the lows witnessed in 2023 occurred, as the market showed signs of stabilization in 2024 with regard to transaction activity. Based on VMG conversations with industry participants in late 2024 and into 2025, most are projecting a further uptick in 2025 transaction activity.



Notes and Sources

1. *Source: Revista 4Q 2024 Subscriber Webcast*

Cushman & Wakefield's Healthcare Capital Markets 2025 Outlook projects an increasing amount of transaction activity as the Federal Reserve "has signaled a cautious approach to rate cutting, citing inflation risks. While the pace of rate cuts may be slower than previously expected the Fed projects another 50 basis points (bps) of cuts in 2025 and another 50 bps in 2026". As of the most recent Federal Reserve meeting in March 2025, Federal Reserve officials were still indicating two 25 bps rate cuts in 2025.



Source: RevistaMed, U.S. Board of Governors of the Federal Reserve System (FRB); Moody's Analytics Forecasted

Note: Sales volume includes entity level transactions; 2024 sales data is preliminary

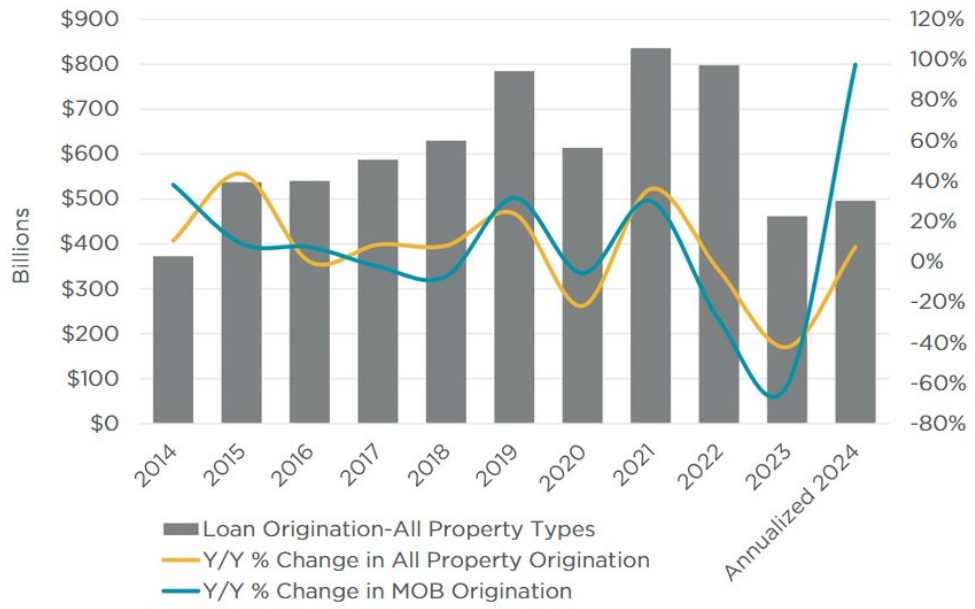
Notes and Sources

1. *Source: Cushman & Wakefield Healthcare Capital Markets 2025 Outlook*

C&W further supports increased transaction activity based on the following:

- The worst of the lender pullback appears to be over, with loan origination volume up 7.4% year-over-year (Y / Y) across major lender groups for all property types. However, 2024 volume still trails the 2017-2019 average by 25%.
- Healthcare origination nearly doubled in 2024. However, like all property origination, lending in the healthcare sector lags the 2017-2019 average by approximately 20%.

The following chart illustrates Loan Originations and Y / Y% change in All Property and MOB specific originations.



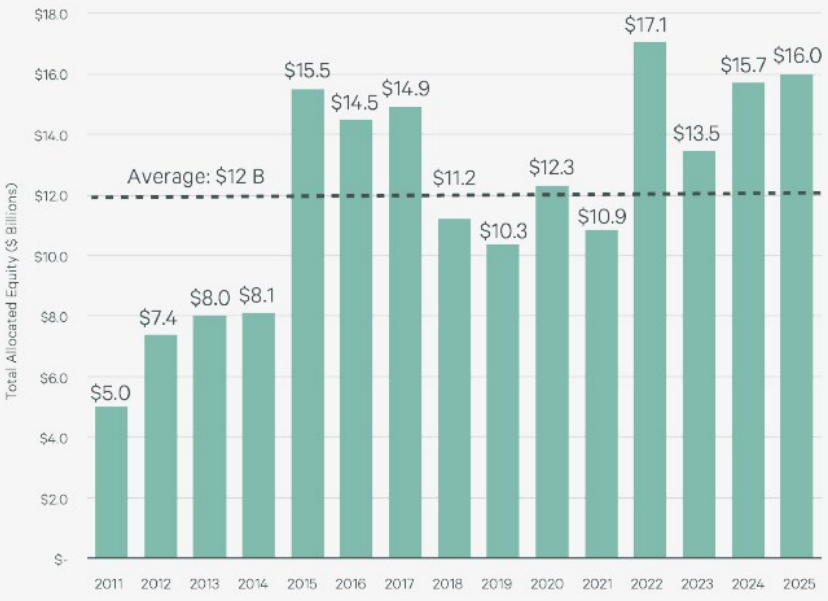
Source: MSCI Real Capital Analytics (data through November 2024); includes all sectors. Updated January 2025.

Notes and Sources

1. *Source: Cushman & Wakefield Healthcare Capital Markets 2025 Outlook*

CBRE's Investor & Developer Survey Results 2025 further reinforces the industry view of expected increases in transaction activity, as indicated capital allocations to healthcare real estate in 2025 are expected to increase over 2024 and 2023 levels.

Figure 1: Capital Allocation to Healthcare Real Estate



Notes and Sources

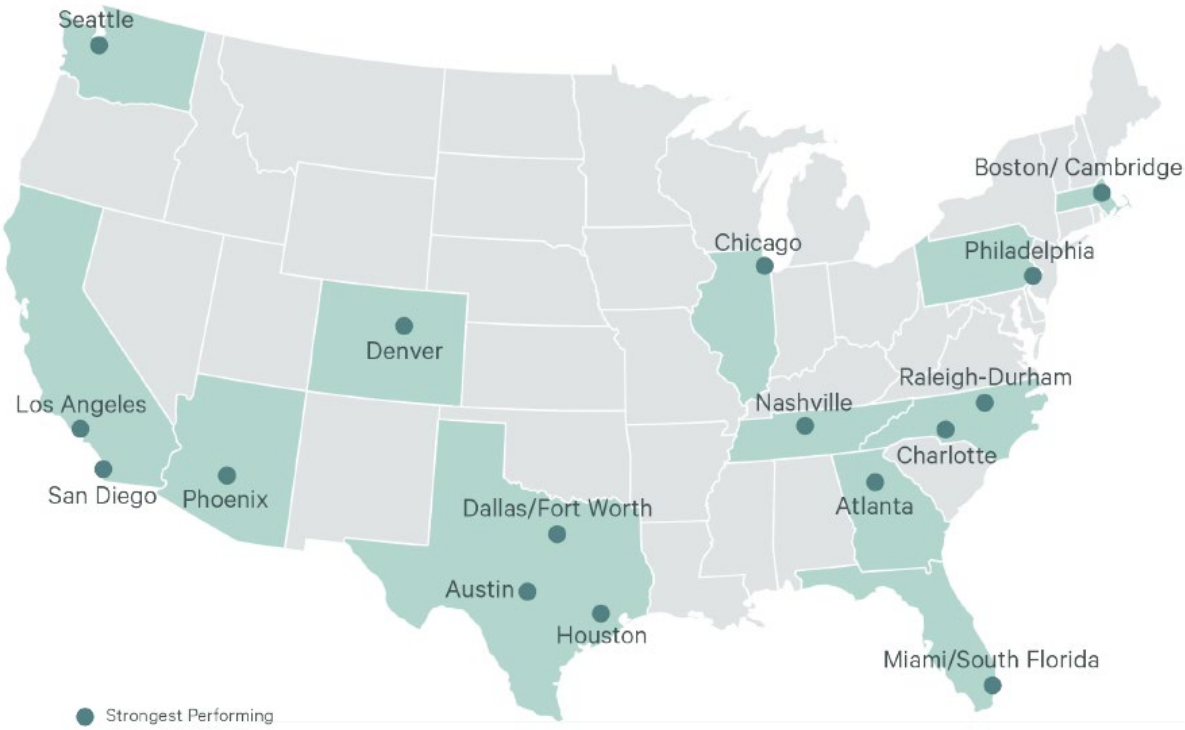
1. *Source: CBRE Investor & Developer Survey Results 2025*

Top Performing Markets

The same CBRE survey noted "In 2025, investors continue to be drawn to high-performing markets in the Sun Belt region, with Dallas/Fort Worth, Phoenix, Atlanta, Nashville, and Miami/South Florida all ranked as favorites for the second year in a row.

The Sun Belt has experienced continual growth due to its business-friendly environment, lower cost of living and mild climate. Currently the Sun Belt region represents approximately 50% of the national population, making it an attractive destination for investment opportunities.

Other Cities that saw better positioning in 2025 include Houston, Boston, San Diego and Chicago".



Ranking

1. Dallas/Fort Worth, TX
2. Phoenix, AZ
3. Atlanta, GA
4. Nashville, TN ▲+1
5. Miami/South Florida, FL
6. Houston, TX ▲+4
7. Raleigh-Durham, NC
8. Charlotte, NC
9. Los Angeles, CA
10. Denver, CO
11. Boston/Cambridge, MA ▲+1
12. San Diego, CA ▲+1
13. Austin, TX
14. Seattle, WA
15. Chicago, IL ▲+1
16. Philadelphia, PA

46%

expect Dallas/Fort Worth to be a top performing market

▲ Advancement on list in 2025

Notes and Sources

1. *Source: CBRE Investor & Developer Survey Results 2025*

Conclusion and Takeaways

While the Covid-19 pandemic officially ended in May 2023, the economic ramifications are still being dealt with in the commercial and healthcare real estate markets. MOB transaction activity rebounded in 2024 from the 2023 lows and is poised to grow further in 2025 as interest rates are projected to decrease and lending activity continues to loosen up. Pricing levels also rebounded in 2024 from 2023 lows and are expected to further increase in 2025. Some key highlights include:

- Capitalization rates remain attractive relative to risk-free options.
- Developers, operators, institutional investors and real estate private equity (REPE) advisors are expected to be the most active buyer groups in 2025.
- Significant opportunities exist, particularly in high occupancy markets across the country.
- Core assets (e.g., those affiliated with strong hospital systems or situated in premium locations) have been more insulated from pricing pressure.
- Value-add properties, such as off-campus, older buildings in tertiary markets, have been more likely to experience negative pricing pressure due to more stringent underwriting standards or a diminished buyer pool interested in these asset types.

Pricing pressures caused by rising construction costs and increased interest rates / development yields resulted in de novo facilities to proforma rental rate expectations more than 30 to 40% higher than 2022 levels. This significant increase in lease rates for new facilities has caused numerous health systems to delay (or outright cancel) several planned projects, unless the facilities are deemed essential for patient care. In addition, CMS reimbursement rates over the same period have only increased by 10 to 15%. This pricing differential has put economic strain on operating margins for health systems and physician groups. In addition, structural changes to payor mixes in certain markets, or permanent changes in consumer and provider behavior regarding telehealth, are also impacting medical office markets.

Debt financing appears to be loosening and is allowing for properties to trade, albeit at lower levels than witnessed in 2021 and 2022. Rent growth in the medical outpatient sector has generally remained strong and continues to increase in top metros, further enhancing the thesis that medical outpatient buildings are viewed as more recession resistant than other CRE asset classes. An improved prognosis for capital markets that began to stabilize in 2024, with growth projected by numerous entities for 2025, has most pundits projecting optimism for 2025.

As CRE is projected to continue its gradual recovery, healthcare real estate and medical outpatient buildings are expected to be a preferred alternative asset class, supported by strong fundamentals (as previously discussed) and demographic drivers.

Exhibit B-1: Industry Overview – Acute Care Hospital

A Hospital is a general term used to describe a facility which provides a wide variety of inpatient and outpatient healthcare services to patients. The most common hospital type is a general short-term acute care hospital, however there are different types of general acute care hospitals and other specialty hospitals (rehabilitation, behavioral, long term, and children's). Most of the hospitals operate as part of a network of hospitals and outpatient facilities designed to provide comprehensive health services to patients within the community. Below is a brief description of the different types of hospitals.

General Acute Care Hospitals – Also known as short terms hospitals, these hospitals provide a wide range of medical and surgical services including inpatient, intensive, trauma, neo-natal, cardiac, and other specialty care along with emergency diagnostic services. Care is intended to be on a short-term basis with most hospital stays lasting three to six days. In addition, general acute care hospitals provide a wide range of outpatient services including surgery, physician services, primary care services, laboratory, diagnostic imaging, cardiology, and physical therapy among others. Outpatient services can be provided in hospital outpatient departments, freestanding facilities, or combination of the two. General acute care hospitals are generally separated into two categories: urban and rural hospitals. Urban hospitals tend to be larger as measured in terms of total revenue and number of beds. In addition, urban hospitals are more likely to have additional designations for trauma, cardiology, neurology, or other types of specialty emergency services. Of the approximately 7,000 Medicare licensed hospitals as of 2022, 3,468 (49.4% of the total Medicare licensed hospitals) were general acute care hospitals. This includes a segment of general acute care hospitals that specialize in one line of care such as surgery, cardiac care, or orthopedics and excludes Critical Access Hospitals (discussed below).

Critical Access Hospital – The "Critical Access Hospital" designation was created by the Balanced Budget Act of 1997 in response to a string of rural hospital closures. In order for a hospital to be classified as a Critical Access Hospital, it must meet the following requirements: the hospital must have 25 acute care inpatient beds or fewer, provide emergency care services 24/7, maintain an annual average length of stay of 96 hours or fewer, and be located at least 35 miles away from another hospital. The primary advantage of the Critical Access Hospital designation is that the provider is reimbursed on a cost-based methodology as opposed to a prospective payment system. In general, critical access hospitals can provide a limited range of services as compared to general acute care hospitals. Patients requiring intensive emergency or specialty care must be transferred to larger urban hospitals. In 2022, there were 1,359 Medicare licensed critical access hospitals (19.4% of the total Medicare licensed hospitals).

Non-Participating Provider – A non-participating hospital accepts Medicare patients but does not agree to accept the Medicare approved amount as full payment. However, there are limits on the amounts that non-participating providers can charge for services. There are approximately 774 non-participating hospitals as of 2019 (11.0% of the total Medicare licensed hospitals). A majority of these hospitals are operated by the Department of Veteran Affairs or the Indian Health Service.

Rehabilitation Hospital – Also known as an inpatient rehabilitation facility ("IRF"), a rehabilitation hospital is a specialized facility type focused on restoring a patient's physical and cognitive abilities. Patients in these hospitals have significant physical and cognitive disabilities due to an array of medical conditions such as strokes, hip fractures, brain injuries, spinal cord injuries, orthopedic problems, neuromuscular disease, and

debilitating neurological conditions. IRFs can operate as a freestanding hospital or a hospital within a hospital ("HIH"). A HIH is a facility which will lease space from a general acute care hospital and then operate as a separately licensed hospital, while freestanding IRFs operate independently. The majority of rehab hospital patients are transferred from general acute care hospitals. IRFs differ from general acute care hospitals in that their patients typically have a longer length of stay with conditions that require rehabilitative services on an inpatient basis. In addition, IRFs tend to have an older patient base as compared to acute care hospitals. CMS reimburses IRFs based on a separate fee schedule known as the IRF Prospective Payment System ("IRF PPS"). In order to be reimbursed under the IRF PPS, the facility must meet a number of criteria regarding the severity of patients that are admitted to the hospital. As of 2022 there were approximately 348 freestanding IRFs (5.0% of total the Medicare licensed hospitals).

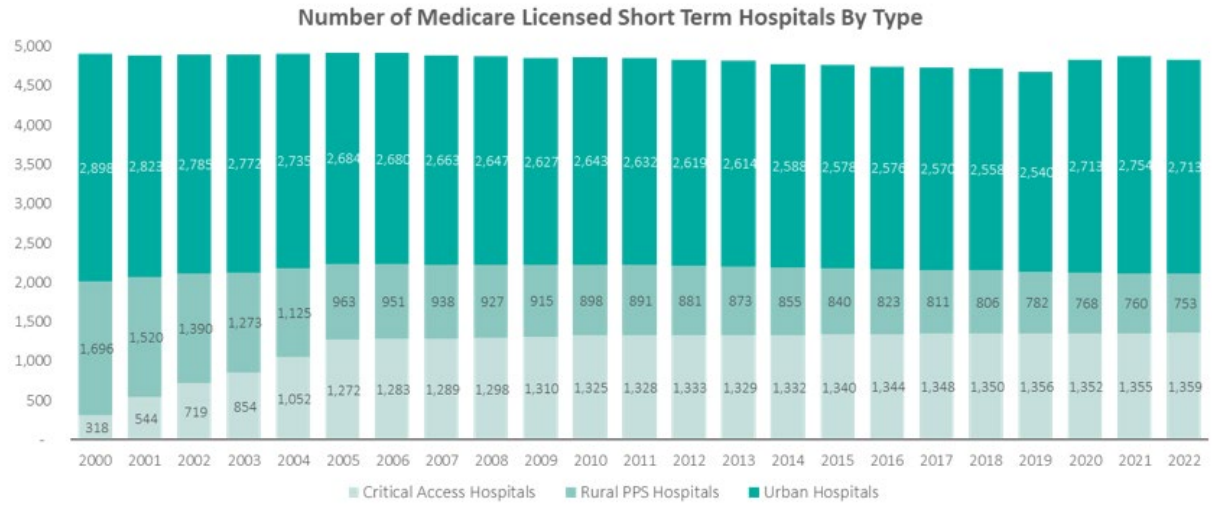
Behavioral Hospital – Behavioral hospitals specialize in the treatment of individuals with mental illness and behavioral issues. For behavioral hospitals, there are often different types of facilities that treat patients with different mental or behavioral problems. An acute inpatient psychiatric facility provides high levels of care to patients with mental illness. Sometimes these patients may be a harm to others or themselves; therefore, there is 24-hour monitoring and treatment by a psychiatrist. Special treatment facilities treat patients with specific or severe behavioral disorders, such as an eating disorder. These facilities classify and treat patients by severity of condition. Comprehensive treatment centers specialize in the use of medication and abstinent-based treatment. This treatment when combined with behavioral therapy are used to help patients with substance abuse problems and addiction. Residential treatment centers treat patients in a non-hospital setting. This includes social activities and outdoor programs, making these facilities less intensive and demanding. As of 2022 there were approximately 633 inpatient behavioral hospitals (9.0% of the total Medicare licensed hospitals).

Long Term Acute Care Hospital ("LTACH") – These hospitals are designed to meet the needs of patients with serious medical problems that require a longer hospital stay and more focused medical treatment. The average patient stay at an LTACH is between 20-30 days. As with IRFs, LTACHs can operate as a HIH or freestanding facility. Both types of LTACHs receive their patients on referral from general acute care hospitals. These patients have serious and complex medical issues usually stemming from complex infectious disease, heart failure, respiratory failure, pulmonary disease, renal disease, trauma, or a complex surgery that requires a long recovery. As of 2022 there were approximately 341 LTACHs (4.9% of the total Medicare licensed hospitals).

Children's Hospital – Focus on the care and treatment of children (this includes any patient from infancy to 18 years of age). All medical physicians working within the hospital have experience caring for children and all doctors are specially trained. As of 2022 there were approximately 92 children's hospitals (1.3% of the total Medicare licensed hospitals).

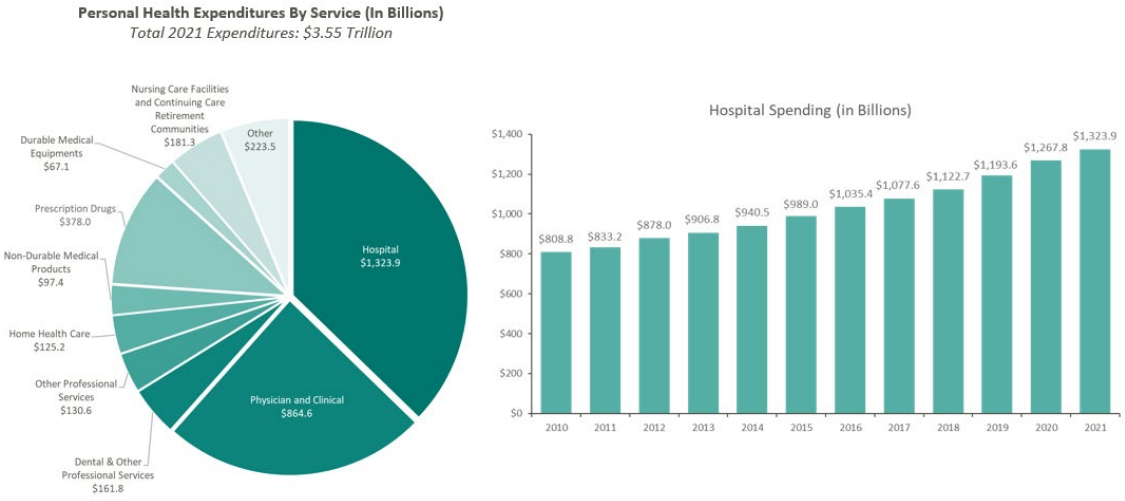
Presented in the chart below is the number of Medicare licensed general acute care hospitals (including critical access hospitals) by type from 2000 to 2022, excluding specialty hospitals and nonparticipating providers as defined on the previous page. As of 2022, there were a total of 4,825 general acute care hospitals (including critical access hospitals). Of the total licensed hospitals, approximately 56.2% were urban hospitals and 43.8% were rural hospitals. Rural hospitals are further segmented into rural hospital hospitals that bill under the prospective payment system (herein referred to as "Rural PPS" hospitals) and Critical Access Hospitals which are reimbursed on a cost basis. Overall, the total number of Medicare licensed hospitals has declined 0.1% compounded annually from 4,912 in 2000 to 4,825 in 2022. Over the same time period, the number of urban hospitals declined 0.3% compounded annually while the number of rural hospitals increased 0.3% compounded

annually. The number of critical access hospitals increased significantly from 2000 to 2006 as rural hospitals converted to the newly created critical access designation. It should be noted that multiple hospitals can be operated under a single Medicare certification.

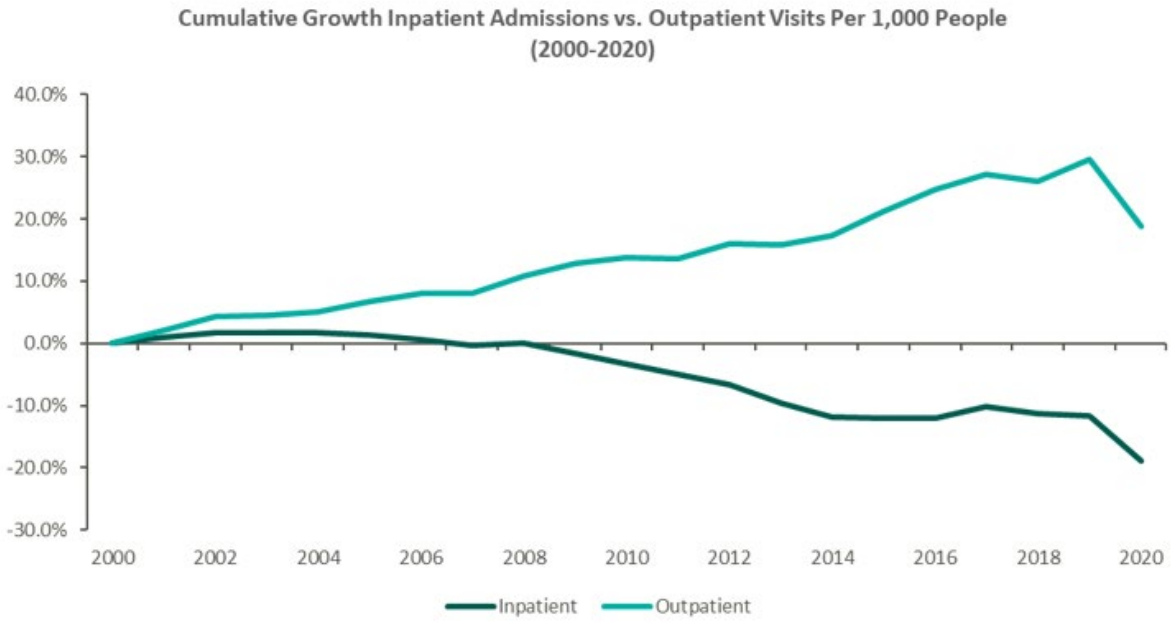


Source: 2022 Medicare Provider of Services File

According to the national health expenditure data published by CMS, spending on hospital services accounted for the largest percentage of total personal health expenditures. Personal health expenditures represents health expenditures spent directly for patient care. During 2021, total expenditures on hospital services were approximately $1.3 trillion or approximately 37.3% of total national personal health expenditures. Total hospital spending has increased 5.1% compounded annually, from $808.8 billion in 2010 to $1.3 trillion, in 2021. The growth in hospital spending has accounted for a significant portion of growth in total national healthcare expenditures in recent years.

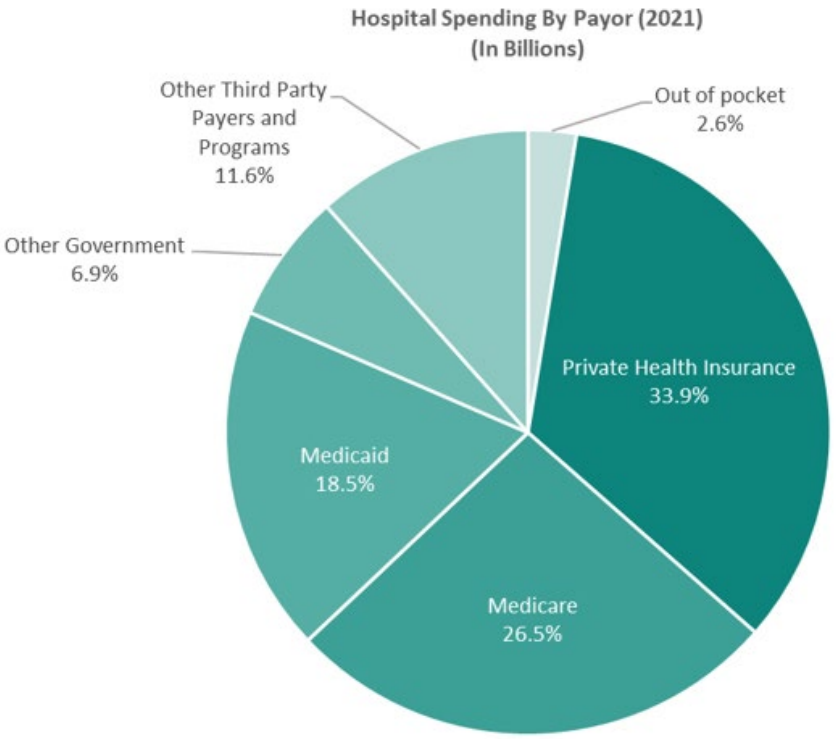


As mentioned previously, acute care hospitals provide a variety of inpatient and outpatient services. Presented in the chart below is the cumulative growth in inpatient admissions vs. outpatient visits per 1,000 people from 2000 to 2020 based on data published by the American Hospital Association. Since 2000, the number of inpatient admissions per 1,000 people has decreased 18.9% cumulatively. Over the same time period, the total number of outpatient visits per 1,000 individuals has increased 18.7% cumulatively from 2000 to 2020. These volume trends are the result of an increased migration of services from the inpatient setting to the outpatient setting due to technological advances and pressure from payors and patients to reduce costs.



Source: American Hospital Association

Presented in the chart below is the percentage of total hospital spending by payor for 2021 based on data published by CMS. As illustrated in the chart below, hospital spending was comprised primarily of private health insurance, Medicare, and Medicaid which accounted for approximately 33.9%, 26.5%, and 18.5%, respectively of the total 2021 hospital spending. Payment rates from private health insurers are negotiated with the individual payors and typically are paid a predetermined rate per diagnosis, per-diem, discount of charges, or other contractual arrangements. The following pages give additional detail on the Medicare reimbursement methodology.



Source: CMS

The Patient Protection and Affordable Care Act ("PPACA") and the Health Care and Education Reconciliation Act, signed into law on March 23, 2010, have significantly changed the way that healthcare services in the United States are covered, delivered, and reimbursed. The overall goal of this comprehensive legislation is to extend health coverage to millions of uninsured legal U.S. residents through a combination of private sector health insurance reforms and public program expansion. In order to fund the expansion of insurance coverage, PPACA contains measures designed to promote quality and cost efficiency in health care delivery in order to generate budgetary savings for the Medicare & Medicaid programs. The statutes and regulations of the PPACA have been the subject of various administrative appeals and lawsuits; however, some of the key provisions of the legislation include:

Individual Mandate: The legislation originally contained an "Individual Mandate" which requires most Americans to maintain "minimum essential" health insurance coverage. Those that did not comply with the mandate were required to make a "shared responsibility payment" to the federal government in the form of a tax penalty. It should be noted that the Tax Cuts and Jobs Act passed by Congress in December 2017 eliminated the Individual Mandate penalty effective as of January 1, 2019.

Health Exchanges: To assist individuals who are not exempt from the individual mandate and who do not receive health insurance through an employer or government program in obtaining insurance coverage, PPACA established health exchanges. Health exchanges are government regulated organizations which provide competitive markets for buying health insurance for individuals and small employers. Certain states have established their own health exchanges while other states have chosen to utilize the federal government's health insurance exchange. Individuals who purchase a plan through the exchange may be eligible for a premium credit or cost sharing subsidy.

Employer Mandate: The employer mandate provision of PPACA requires the imposition of penalties on employers with over 50 employees that do not offer affordable health insurance to employees working 30 or more hours per week. In February of 2014, the implementation of the employer mandate was delayed until January 1, 2016 for companies with 50 to 100 employees. For companies with more than 100 employees, the percentage of full-time workers required to be covered was reduced to 70% in 2014 & 2015. In 2016 and subsequent years employers with over 100 employees must offer health coverage to 95% of employees. Affordable health insurance is defined as premiums of no more than 9.5% of an employee's income and the employer must pay 60% of the actuarial value of a worker's coverage. Companies that fail to comply with the employer mandate can face fines of up to $2,000 for each employee not covered.

Medicaid Expansion: PPACA extended eligibility under Medicaid to almost all individuals under the age of 65 with incomes up to 138% of the Federal Poverty Limit ("FPL") beginning in 2014. Under PPACA the federal government will pay 100% of the cost of Medicaid expansion in 2014 through 2016. Federal funding was reduced to 90% over the course of a four year period from 2017 through 2020 and will remain at 90.0% after 2021. Historically, the income levels for Medicaid eligibility were determined by the state and were typically around 106% of the FPL. Initially, PPACA required all states to expand Medicaid coverage or face possible reductions in existing funding for the Medicaid programs. However, the constitutionality of this mandate was challenged in September of 2011 in the court case of the National Federation of Independent Businesses vs. Sebelius (Secretary of the Department of HHS). The Supreme Court ruled that Congress had no authority to require the states to expand their respective Medicaid programs. Congress may offer grants to the individual states for expanding Medicaid coverage but existing Medicaid funding cannot be threatened. As a result of the ruling, the individual states were given the choice to expand Medicaid coverage. Please see the following page for additional detail on the states that elected to expand Medicaid and the resulting increase in enrollment.

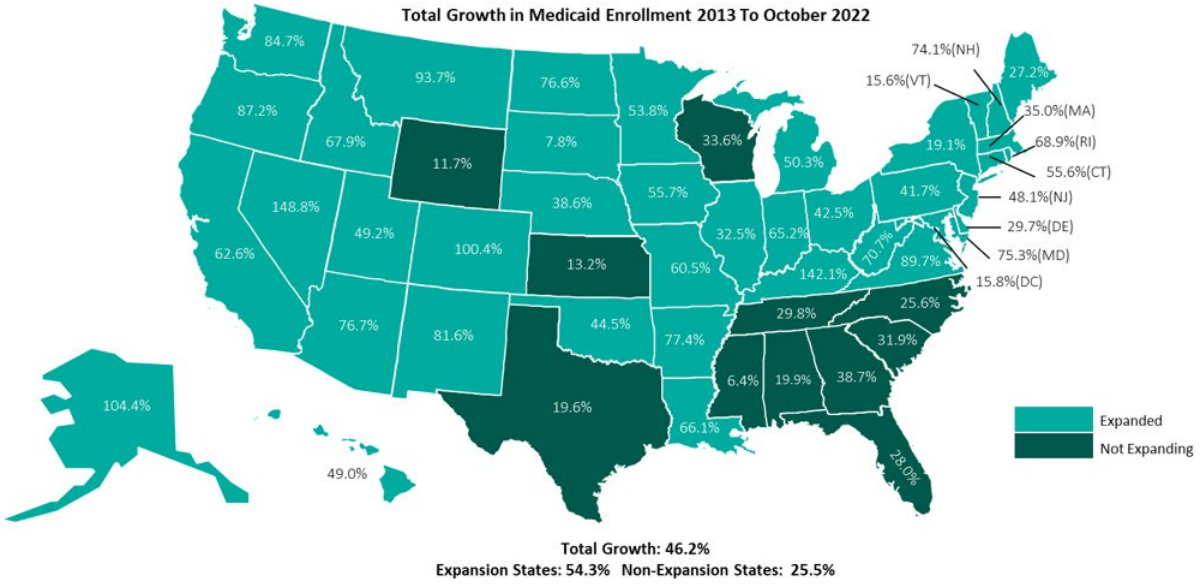
PPACA also contains a number of provisions designed to improve the quality and efficiency of medical care provided to Medicare and Medicaid beneficiaries. These provisions include: the prohibition of Medicare or Medicaid funds from paying for the treatment of Hospital-Acquired Conditions ("HACs"); reductions in reimbursement for hospitals with excessive readmissions; creation of the Medicare value-based purchasing program; and the creation of the Center for Medicare & Medicaid Innovation to further explore potential hospital payment bundles.

PPACA also establishes a number of additional health insurance reforms including:

•Establishes a minimum medical loss ratio of 85% for large group plans and 80% for small group plans.
•Health insurers may not establish lifetime or annual limits on the dollar value of benefits.
•May not rescind coverage of any enrollee except in instances of fraud.
•Health insurers must reimburse hospitals for emergency services provided to enrollees without the need for prior authorization and without regard to whether or not there is an existing contract with the provider.
•Extends dependent coverage until the age of 26

Presented in the chart below is the total growth in Medicaid enrollment by state from 2013 through October 2022. Medicaid enrollment in states that have chosen to expand Medicaid coverage has increased 54.3% from 2013 to 2022. Over the same time period, Medicaid enrollment in states that have not elected to expand

Medicaid coverage has increased 25.5%. Redetermination will be a factor in 2023 as the Kaiser Family Foundation ("KFF") estimates that between 5 million and 14 million will lose coverage as the continuous enrollment provision in the Families First Coronavirus Response Act ("FFCRA") ended March 31, 2023. Please note, as of March 27, 2023, the North Carolina governor enacted legislation that would expand Medicaid contingent upon appropriations in the State biennial budget.



Source: data.medicaid.gov October 2022, kff.org

PPACA also contains a number of provisions designed to reduce Medicare and Medicaid program spending. These provisions include negative adjustments to the annual inflation updates for the Medicare fee schedules and reductions to the Medicare and Medicaid Disproportionate Share Hospital Payments ("DSH"). Beginning in 2010, CMS has made negative adjustments to the annual market basket updates for Medicare's IPPS, OPPS, LTACH PPS, and IRF PPS fee schedules. Below is a summary of the proposed changes to the Medicare and Medicaid DSH programs:

Medicare DSH Payments: In addition to payments made under the inpatient prospective payment system for services provided directly to beneficiaries, Medicare makes payments to hospitals which treat a disproportionately high share of low-income patients. Prior to October 31, 2013, Medicare DSH payments were made based on statistical information defined by CMS and calculated as a percentage add-on to the MS-DRG payments. PPACA revised the DSH adjustment effective for discharges occurring on or after October 31, 2013. Under the revised methodology, hospitals will receive 25% of the amount they previously would have received under the pre-PPACA formula. This portion is referred to as the "Empirically Justified Payment".

Hospitals that qualify for the Empirically Justified Payment are also eligible to receive additional payments for uncompensated care, referred to as the "UC DSH Payment". The UC DSH payment comprises the remaining 75% of the total DSH payments that would have been paid under the historical formula. Each eligible hospital will receive a UC DSH payment based on its share of uninsured low income days (which is the sum of the Medicaid days and Medicare SSI days). The total UC DSH payments are calculated at 75% of DSH payments that would have been made under previous methodology and will be reduced annually by the percentage change in uninsured individuals under the age of 65.

Medicaid DSH Payments: In addition, CMS makes Medicaid DSH payments to states who then determine the methodology for distributing the payments to the individual hospitals. Federal law requires that state Medicaid programs make DSH payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. In the fiscal year 2016, Medicaid DSH payments totaled approximately $19.1 billion. The PPACA called for reductions in Medicaid DSH payments beginning in 2014. However, the decision not to expand Medicaid coverage by certain states resulted in several delays in the Medicaid DSH cuts. The Bipartisan Budget Act of 2018 pushed back Medicaid DSH payment reductions to FY 2020, when Medicaid DSH payments were scheduled to be reduced by $4.0 billion increasing to $8.0 billion annually from FY 2020 to FY 2025. More recently, the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") eliminated the proposed $4.0 billion in Medicaid DSH payment reductions in 2020. In addition, the CARES Act reduces the proposed DSH cuts in 2021 by an additional $4.0 billion and the Consolidated Appropriations Act in 2021 delayed implementation of reductions until FY 2024 when reductions of $8.0 billion will resume annually through FY 2027.

Sources: MedPac and Medicaid & CHIP Payment and Access Commission

Below is a summary of COVID-19 related specific major legislation and developments relevant to acute care hospitals. This is not intended to be a comprehensive analysis of all COVID-19 legislation and interventions.

Coronavirus Aid, Relief and Economic Security Act (the "CARES Act")

•Total funding of $2.3 trillion, including $180 billion of healthcare-specific funding

•Loan Programs

−Expansion of Medicare Accelerated Payments (access to revenue in advance to help alleviate short term cash flow issues)

−Paycheck Protection Program Lending: Funding of approximately $350 billion, incentivizes small businesses to retain employees

•Direct Funding and Grants

−Public Health and Social Services Emergency Fund: $100 billion in funding to reimburse providers for costs or lost revenues who are involved in the diagnosis, testing, or care of individuals with possible or actual cases of COVID-19

−FQHC Funding: $1.32 billion for the prevention, diagnosis, and treatment of COVID-19 to Federally Qualified Health Centers

•Relief From Spending Cuts & Additional Reimbursement

−Medicaid Disproportionate Share Hospital Cut Abatement

−Elimination of the Medicare Sequester for 2020 (temporarily listing the Medicare sequester based on the Budget Control Act of 2011, which reduces payments to providers by 2.0%. The Protecting Medicare and American Farmers from Sequester Cuts Act made a 1% payment adjustment from April 1 through June 30, 2022 and a 2% payment adjustment beginning July 1, 2022.

−Diagnosis Related Group Add On Payment: increases Medicare reimbursement for any discharge with a diagnosis of COVID-19 by 20.0%

•Tax Provision Changes

−Employer Payroll Tax Deferment: allows employers to deter payment of the 6.2% Social Security tax on employee payroll through the end of calendar year 2020

−Employee Retention Tax Credit: 50% tax credit against the employer portion of federal payroll taxes incurred on qualified wages during the COVID-19 pandemic

−Net Operating Loss Modifications: suspends the 80% income limitation on the use of net operating losses to offset taxable income & net operating losses arising in a tax year beginning in 2018, 2019, or 2020 may now be carried back five years

−Business Interest Expense Limitation Changes: increases the deductible amount of business interest expense from 30% to up to 50% of EBITDA for tax years 2019 and 2020

Blanket STARK Waivers

Modifications or waiving certain Medicare/Medicaid/CHIP/HIPPA requirements during the emergency declaration with the following goals: sufficient hospital capacity, expanded healthcare workforce, increase access to telehealth, expand COVID-19 testing, and give temporary relief from many paperwork, reporting, and audit requirements.

Key provisions for acute care hospitals include option to provide inpatient care at temporary expansion sites, allow care to hospital patients via telemedicine, expanding workforce, and reducing requirements for post-acute provider admissions to reduce acute care patient load.

Medicare payments for inpatient services are made per the Inpatient Prospective Payment System, known as (“IPPS”). Under the IPPS, hospitals are paid a pre-determined amount for each hospital discharge based on the patient’s diagnosis, called a Diagnosis Related Group (”DRG”). DRG payments are based on national averages and not on specific hospitals costs, but DRG payments are adjusted by a predetermined geographic adjustment factor assigned to the hospital’s locale. DRG rates are adjusted by an update factor each federal fiscal year, which begins October 1st annually. The index used to adjust the DRG rates is referred to as the market basket index. This index gives consideration to the inflation experienced by hospitals in purchasing its required goods and services.

The majority of hospital outpatient services furnished to patients are paid by Medicare through the Outpatient Prospective Payment System (“OPPS”). These outpatient services are classified into Ambulatory Payment Classifications (“APCs”). A patient may be assigned into a single or multiple APCs depending on the service ordered during the patient encounter. Medicare pays a set price for each group, regardless of the actual costs incurred in providing care. Medicare sets the payment rate for each APC based on historical median cost data and adjusts the payment for geographic location. Similar to the payments based on DRGs, APC payments are updated each federal fiscal year based on the market basket index. The following services are paid based on other fee schedules established by Medicare: physical, occupational and speech therapy; durable medical equipment; diagnostic laboratory services; and services at freestanding surgical centers and diagnostic facilities.

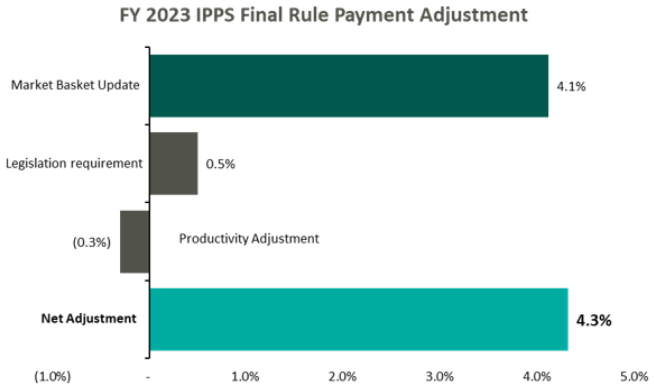
CMS adopted a final rule on August 22, 2007 that established Medicare Severity DRGs ("MS-DRGs"). The rule's goal was to refine the DRG weighting system to fully capture differences in severity of illness among patients, replacing 538 DRGs with 745 MS-DRGs. The switch to the MS-DRG system was intended to be budget neutral in that total Medicare payments to hospitals should not increase or decrease solely due to changes in documentation and coding practices. In order to ensure that improvements in coding and documentation do not lead to an increase in aggregate payments without a corresponding growth in patient severity, CMS will initiate a negative coding adjustment every fiscal year.

IPPS FY 2023 Final Rule

On August 1, 2022, the Centers for Medicare and Medicaid Services released the Inpatient Prospective Payment System fiscal year (FY) 2023 final rule which called for a **4.3% increase** in hospital operating payments for hospitals reporting quality data and are meaningful users of EHRs.

The increase is the result of the following adjustments:

- Market Basket Update (Inflation) – The hospital market basket update for FY 2023 of positive 4.1%.
- Legislative Requirement – Documentation and coding increase of 0.5% mandated by the Medicare Access and CHIP Reauthorization Act of 2015.
- Productivity Adjustment – The productivity adjustment for FY 2023 is negative 0.3%.



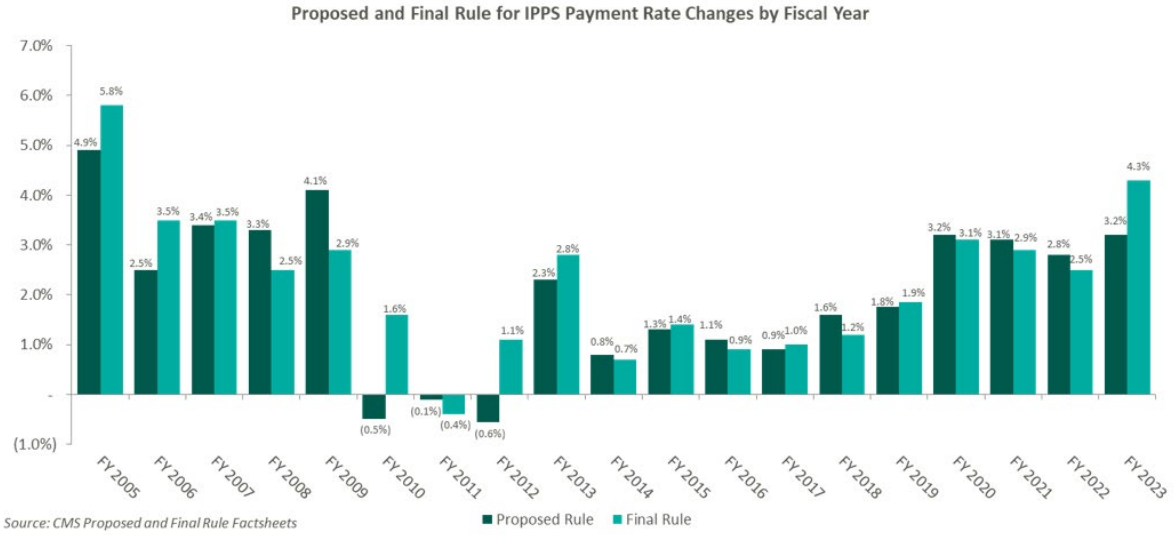
Changes to DSH Payments

In the FY 2018 IPPS final rule, CMS made two changes to the calculation for uncompensated care payments to DSH hospitals. First, CMS finalized the proposal to incorporate data from the National Health Expenditure Accounts into its estimate of the percentage change in the rate of uninsurance. The percentage change in the rate of uninsurance is utilized in calculating the total amount of uncompensated care payments available to be distributed. In addition, CMS will incorporate uncompensated care cost data from worksheet S-10 of the cost reports, in combination with the Medicare and Medicaid low income days, to determine the distribution of uncompensated care payments to individual hospitals. In FY 2023, CMS estimates that they will distribute approximately $6.8 billion in uncompensated care payments which is a $0.3 billion decrease from FY 2022 due to the CMS Office of the Actuary's estimate that incorporates the estimated impact of the COVID-19 pandemic.

Sources: CMS FY 2023 IPPS Final Rule Fact Sheet

Historical IPPS Reimbursement

Presented in the chart below are the net proposed and final IPPS payment increases for the past eighteen years. Since FY 2010, the average annual payment increase has been approximately 1.8%, which is below the average annual increase for the five prior years of 3.6%. The decrease in the annual updates is primarily due to the productivity adjustment mandated by the PPACA and the documentation and coding adjustment mandated by the American Taxpayer Relief Act. It should be noted that payment increases presented below do not reflect any DSH or outlier payment adjustments.



Source: CMS Proposed and Final Rule Factsheets

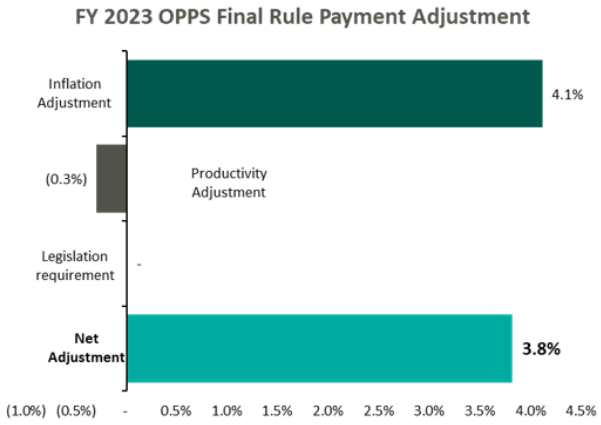
OPPS CY 2023 Final Rule

On July 15, 2022, CMS released the CY 2023 OPPS final payment update which called for an **increase of 3.8%** for hospital outpatient departments ("HOPDs"). The increase is the result of the following adjustments:

- Inflation Update – The OPPS market basket update for CY 2023 is positive 4.1%.
- Productivity Adjustment – The multi-factor productivity adjustment for CY 2023 is negative 0.3%.

Other miscellaneous payment provisions from the CY 2032 final ruling include:

- Finalizing an update to 340B rates to continue for specific drugs obtained through the program at Average Sales Price ("ASP") plus 6% after the Supreme Court's decision in American Hospital Association v. Beccera.
- The establishment of a new Medicare provider type called Rural Emergency Hospitals ("REHs") so that CMS could propose rates specifically to these entities. This would allow hospitals in rural areas to provide services and care under new payment rates that are beneficial to rural communities.



Sources: CMS CY 2023 OPPS Proposed Rule Fact Sheet

Exhibit C: Regional/Neighborhood Analysis, Property Identification & History

Regional Analysis

The value of real property reflects and is influenced by the interaction of four basic forces that motivate human activity. These forces are divided into four major categories: environmental considerations, governmental controls and regulations, social forces, and economic conditions.

Geographic Location

The City Oceanside is in San Diego County which comprises the San Diego-Chula Vista-Carlsbad, CA Metropolitan Statistical Area ("San Diego MSA"). The San Diego MSA is located in Southern California, between the Pacific coastline to the west and the Anza Borrego Desert to the east. The San Diego MSA borders Mexico, which is directly south. In 2024, the San Diego MSA had an estimated population of approximately 3,298,799 residents. Furthermore, the City of Oceanside had a 2024 population estimate of approximately 170,941 residents. The San Diego MSA's position within California is noted on the accompanying map and will be the primary focus of this analysis.

Transportation

Transportation in the San Diego MSA is oriented toward the automobile. The two key links in the San Diego freeway system are Interstate 8 and Interstate 5.

Interstate 8 is the major east-west freeway connecting the region with the eastern communities of La Mesa and El Cajon, as well as Imperial County and Arizona. It runs through Mission Valley and serves as the primary artery to and from that hotel, commercial, and office center. Interstate 5 is the major north-south freeway connecting the region with coastal North County communities as well as Orange County and Los Angeles to the north. It originates at the Mexico border and serves as a primary connecting route between Tijuana and San Diego.

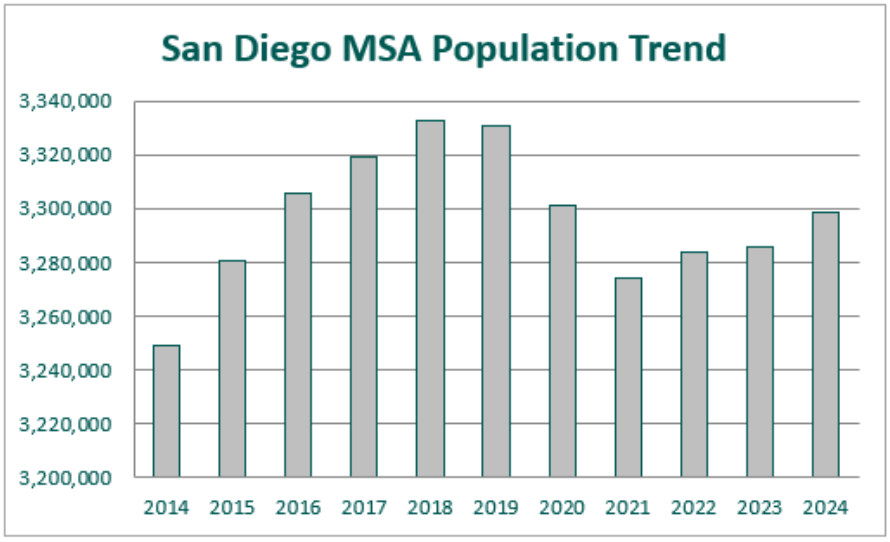
Interstate Highway 15 is currently improved to freeway standards from Interstate 8 north to the county line. State Highway 163 connects with Interstate 15 in Kearny Mesa and runs south to downtown San Diego. Interstate 15 connects San Diego with Riverside County to the north, serving North County communities such as Escondido, Poway, Carmel Mountain Ranch, and Rancho Bernardo along the way. Interstate 15 also connects with Interstate 8 in Mission Valley and Interstate 5 south of downtown San Diego. Interstate 805 is a regional connector which originates at the Mexico border and bisects San Diego between Interstate 5 in Sorrento Valley just south of the city of Del Mar. This freeway serves the east San Diego communities with numerous interchanges. It connects with Interstate 8 in Mission Valley and serves the Kearny Mesa and University City areas to the north.

The San Diego MSA is served by several rail services including AMTRAK, Metrolink, and The Coaster. The San Diego Trolley, San Diego Metropolitan Transit System, Sprinter, and the North County Transit District are other local transit systems that serve the region as well. The Mid-Coast Corridor Transit Project, completed in November 2021, extended Trolley service from Santa Fe Depot in Downtown San Diego to the University City community, serving major activity centers such as Old Town, the University of California, San Diego (UCSD), and Westfield UTC.

San Diego International Airport (Lindbergh Field) is the region's major public airport. San Diego International is the busiest single runway commercial airport in the United States, seeing roughly 25 million passengers a year.

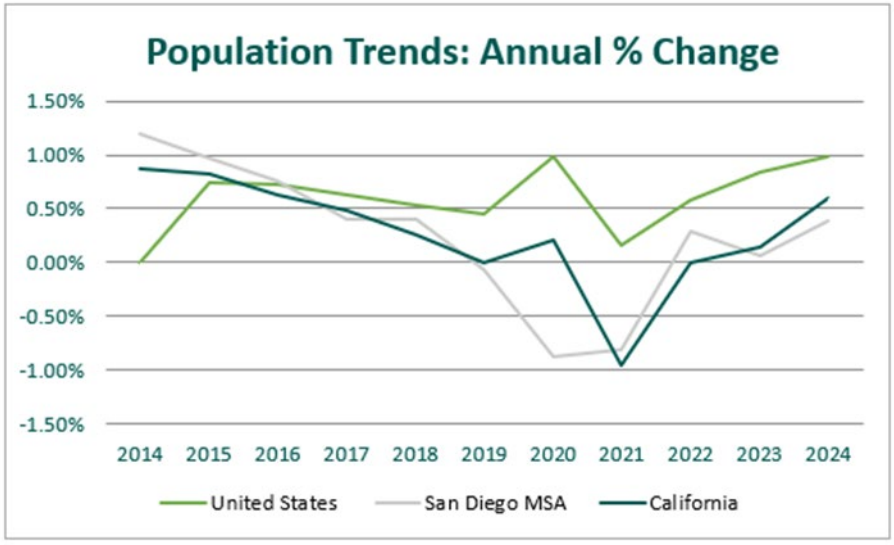
Social

The primary social trends that directly influence real estate values are related to population. Over the last decade, the population in the San Diego MSA has experienced varied growth with an average annual growth rate of 0.40%. As of 2022 (most recent available), the San Diego MSA featured a total population of approximately 3,276,208 residents. The following chart illustrates population totals for the San Diego MSA over the past ten years.



Source: United States Census Bureau

The graph below compares population growth rates for the United States, California, and the San Diego MSA over the past ten years.



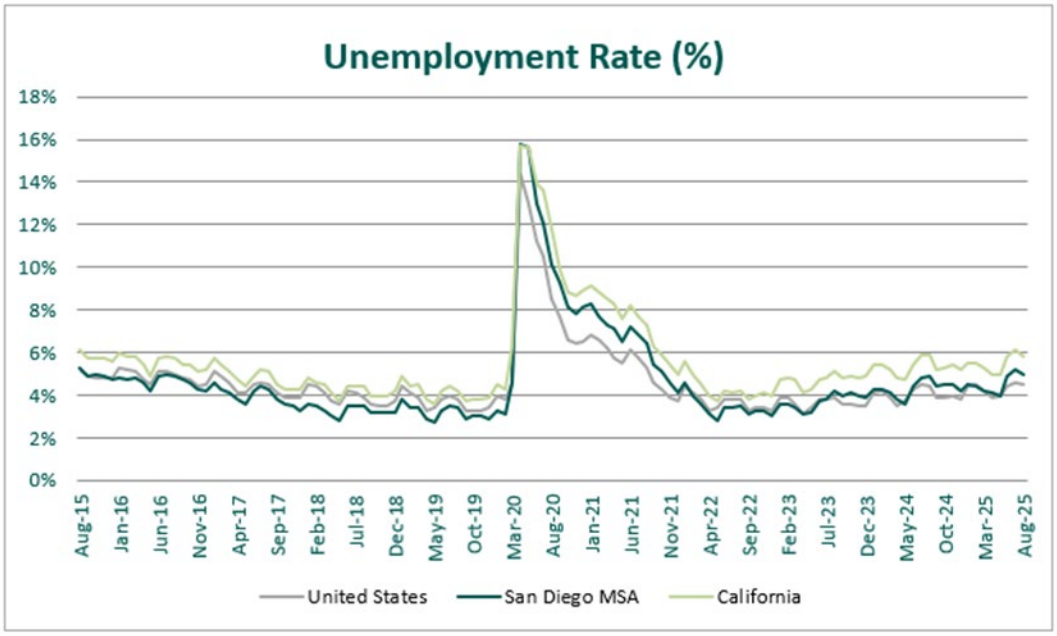
Source: United States Census Bureau

Economic

Economic conditions influencing the value of the subject property include labor and employment, the economic base and trends of the region, and current economic real estate market conditions. The chart below illustrates the major employers in the San Diego MSA. As depicted in the chart, the area is primarily reliant upon education, U.S military, and healthcare sectors.

Ranking	Employer
1	Naval Base San Diego
2	University of California, San Diego
3	San Diego County
4	Sharp HealthCare
5	San Diego Unified School District
6	Qualcomm
7	Scripps Health
8	City of San Diego
9	Kaiser Permanente
10	San Diego Community College District

The following chart illustrates historical unemployment rate trends for the San Diego MSA, the State of California, and the United States (Civilian Unemployment Rate).



Source: U.S. Bureau of Labor Statistics

As illustrated in the previous chart, the San Diego MSA has recently featured an unemployment rate mostly in line with the national rate and slightly below the state rate of unemployment. As of August 2025, The United States, the State of California, and the San Diego MSA featured unemployment rates of 4.5%, 5.8% and 5.0%, respectively.

Healthcare

The region features a sprawling healthcare network with 11 short-term acute care facilities (per AHD) available in a 30-mile radius of the subject zip code. The table below summarizes the hospitals located within 30 miles of the subject zip code. Revenue data and patient days are sourced from the American Hospital Directory and have not been adjusted.

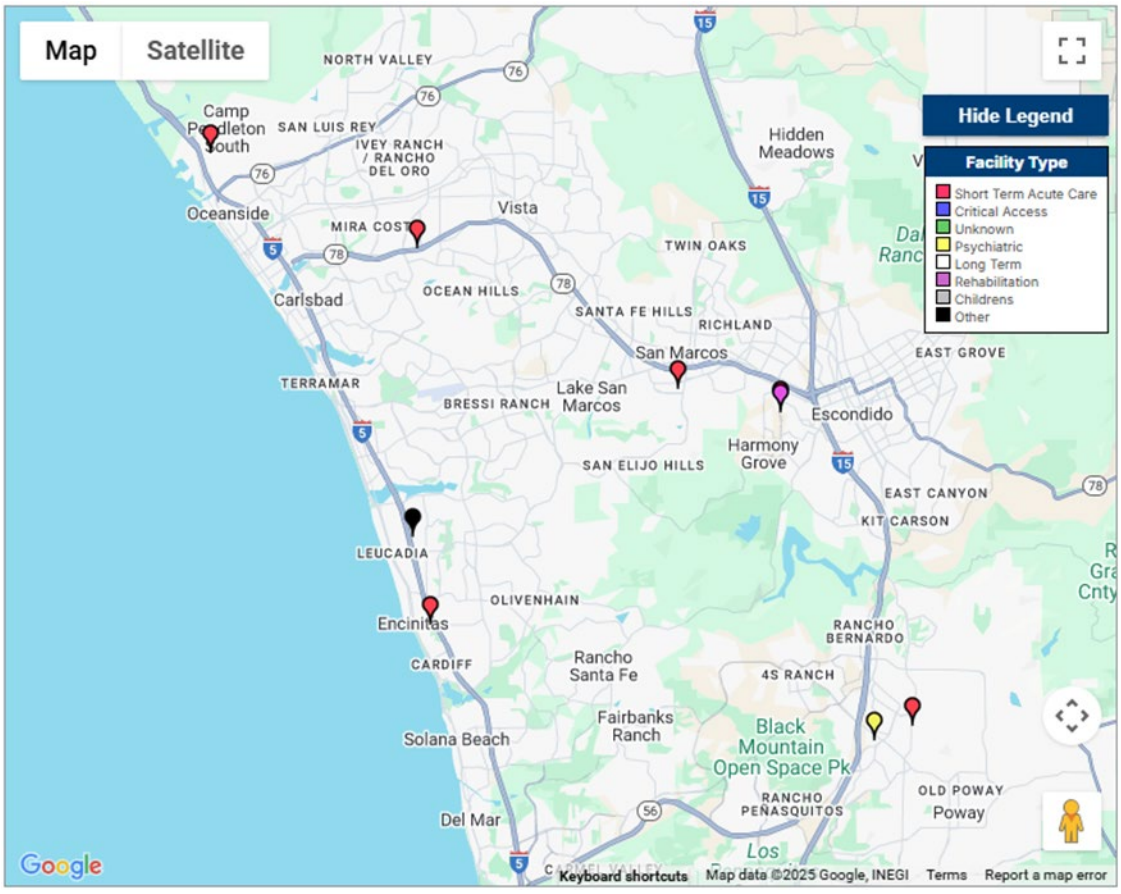
Area Hospital Statistics (Most Recent Annual Reporting Period): 20-Mile Radius from Subject Zip Code

Hospital Name	Beds	City	State	Zip	Gross Revenue	Discharges	Patient Days	Occupancy
Aurora Behavioral Health Care San Diego	101	San Diego	CA	92128	$67,763,375	2,489	31,297	84.9%
Kaiser Permanente San Marcos Medical Center	168	San Marcos	CA	92078	$1,167,821,477	7,284	25,988	42.4%
Palomar Health Rehabilitation Institute	52	Escondido	CA	92029	$93,159,905	1,289	15,221	80.2%
Palomar Medical Center Escondido	292	Escondido	CA	92029	$4,184,631,910	18,887	87,370	82.0%
Palomar Medical Center Poway	248	Poway	CA	92064	$1,142,263,022	5,133	21,553	23.8%
Scripps Memorial Hospital Encinitas	174	Encinitas	CA	92024	$2,395,132,805	14,441	61,182	96.3%
Tri-City Medical Center	273	Oceanside	CA	92056	$1,206,688,384	7,667	40,493	40.6%
Total	**1,308**				**$10,257,460,878**	**57,190**	**283,104**	**59.3%**

Source: American Hospital Directory (October 2025)

The hospitals depicted in the preceding chart are also displayed on the following map.

Map of Hospitals within a 20-mile Radius of Subject Zip Code



Area Medical Office Market Overview

An analysis of CoStar's database revealed a total medical office inventory of 1,175 buildings and approximately 18.3 million square feet in the San Diego MSA. This analysis also revealed a current vacancy rate of 6.6% and a market rent of $39.16 per square foot (though we do note that CoStar does not appear to deliniate between FSG, NNN, and MG rates in delivering its reported averages within the MOB sector).

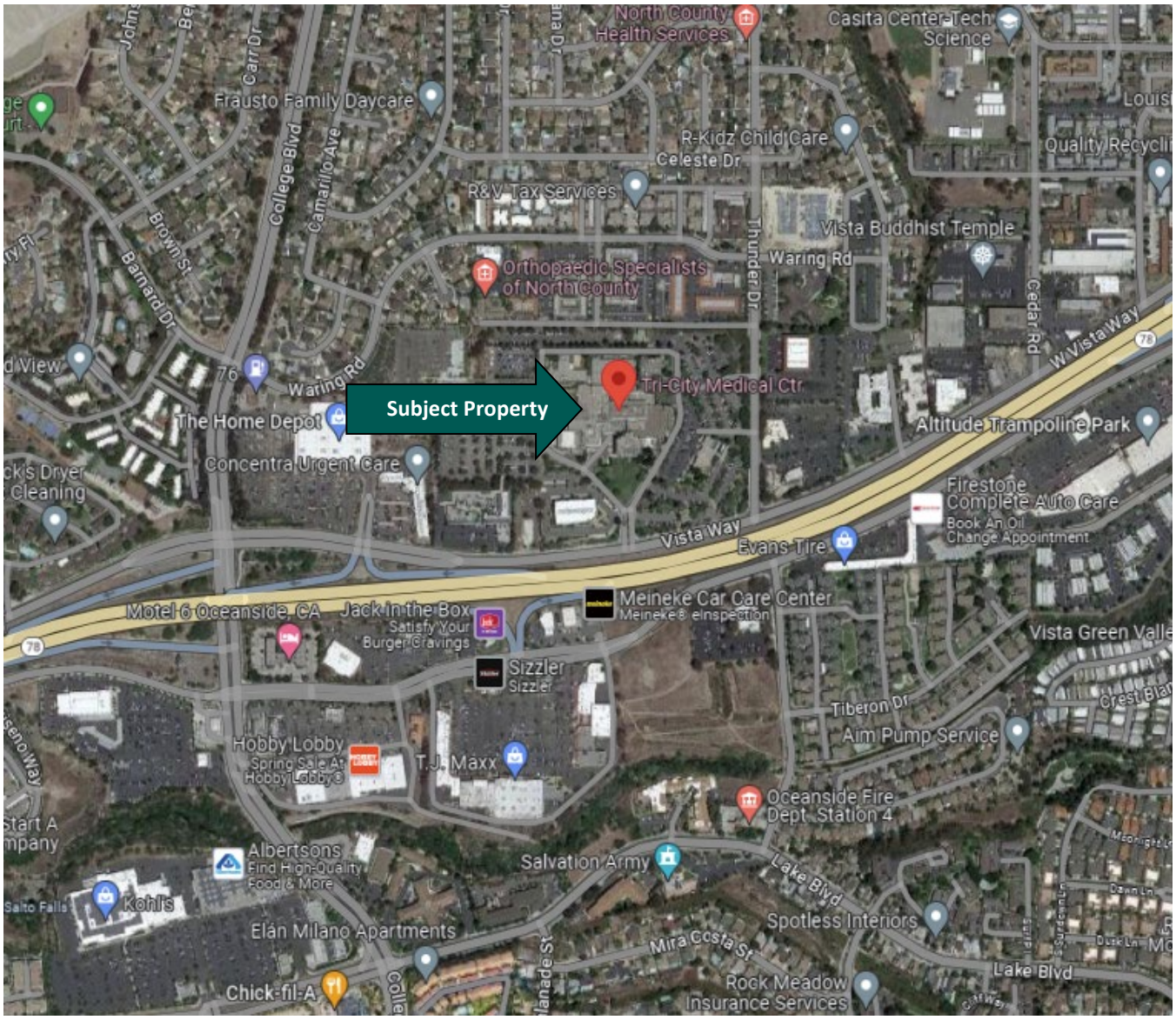
Conclusion (Regional)

Overall, the outlook in the San Diego MSA is positive, with continued moderate growth expected. The San Diego MSA economy is based heavily on education, U.S Military, and healthcare sectors. Quality of life is centered around the amenities typical of a coastal metropolitan area. The area's healthcare market is characterized by an adequate number of healthcare facilities located within the region. It is expected that the San Diego MSA will see continued slow growth through the foreseeable future.

Neighborhood Analysis

Location

The following map illustrates the location of the Subject Property relative to the immediately surrounding area.



Note: the Carlsbad MOB/Wellness properties are approximately 6 miles south of the Tri-City Medical Center campus

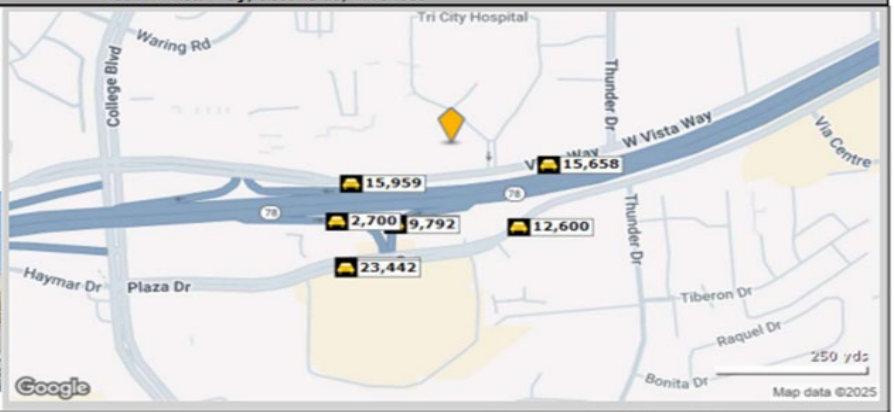
Transportation & Accessibility

The subject property is situated within a developed submarket in northern San Diego. Considering the local highway network, access to and from the subject's immediate neighborhood is good. Access within the subject neighborhood is also facilitated by local streets and connecting arteries. Overall, the subject neighborhood is well-connected to the surrounding region. Traffic counts (as reported by CoStar) follow.

Traffic Count Report

Tri-City Medical
4002 W Vista Way, Oceanside, CA 92056

Building Type: **Class B Office**
Class: **B**
RBA: **57,474 SF**
Typical Floor: **19,158 SF**
Total Available: **57,474 SF**
% Leased: **0%**
Rent/SF/Yr: **Negotiable**

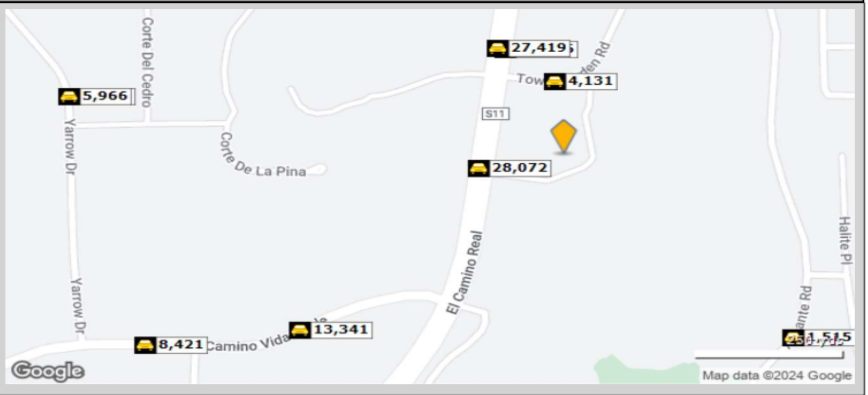


	Street	Cross Street	Cross Str Dist	Count Year	Avg Daily Volume	Volume Type	Miles from Subject Prop
1	W Vista Way	Tri City Hospital	0.06 W	2025	15,576	MPSI	.10
2	W Vista Way	Tri City Hospital	0.06 W	2024	15,658	MPSI	.10
3	Hwy 78	College Blvd	0.27 W	2024	9,803	MPSI	.10
4	Hwy 78	College Blvd	0.27 W	2025	9,792	MPSI	.10
5	W Vista Way	Tri City Hospital	0.13 E	2024	15,929	MPSI	.10
6	W Vista Way	Tri City Hospital	0.13 E	2025	15,959	MPSI	.10
7	Plaza Dr		0.00	2025	12,600	MPSI	.11
8	Hwy 78	College Blvd	0.21 W	2025	2,700	MPSI	.14
9	Plaza Dr		0.00	2024	23,530	MPSI	.17
10	Plaza Dr		0.00	2025	23,442	MPSI	.17

Traffic Count Report

Tri-City Wellness Center
6250 El Camino Real, Carlsbad, CA 92009

Building Type: **Class B Office**
Class: **B**
RBA: **58,000 SF**
Typical Floor: **29,000 SF**
Total Available: **58,000 SF**
% Leased: **0%**
Rent/SF/Yr: **Negotiable**



	Street	Cross Street	Cross Str Dist	Count Year	Avg Daily Volume	Volume Type	Miles from Subject Prop
1	el Camino Real	Town Garden Rd	0.11 N	2022	28,072	MPSI	.08
2	Town Garden Rd	Metropolitan St	0.03 E	2022	4,131	MPSI	.09
3	el Camino Real	Town Garden Rd	0.03 S	2020	28,946	MPSI	.14
4	el Camino Real	Town Garden Rd	0.03 S	2022	27,419	MPSI	.14
5	Alicante Rd	Pyrite Ave	0.07 N	2022	1,515	MPSI	.31
6	Cam Vida Roble	Las Palmas Dr	0.10 W	2018	13,341	MPSI	.33
7	Cam Vida Roble	Las Palmas Dr	0.05 E	2018	8,010	MPSI	.46
8	Cam Vida Roble	Las Palmas Dr	0.05 E	2022	8,421	MPSI	.46
9	Yarrow Dr	Corte de la Pina	0.03 S	2020	5,764	MPSI	.48
10	Yarrow Dr	Corte de la Pina	0.03 S	2022	5,966	MPSI	.49

Immediate Surroundings

Land uses adjoining the subject hospital* are summarized as follows:

North: North of the primary hospital building are medical offices, north of which are mixed use (multi-family, SFR, and low intensity commercial uses).

East: East of the primary hospital buildings are medical offices, east of which are single-story commercial buildings.

South: South of the hospital campus is Vista Way and Highway 78 (Ronald Packard Parkway). Across the highway are several fast food restaurants (Jack in the Box, McDonald's) and a TJ Maxx-anchored shopping center. Asking rent at the shopping center was unknown. However, a portion of the center (42,646 SF) sold in July 2022 for $12.8 million, or $300.15/SF, at a reported 5.70% cap rate (implying $17.11/SF/Yr NOI).

West: West of the subject hospital campus is a Home Depot.

*Note: the Carlsbad MOB/Wellness buildings are located approximately six miles south of the hospital campus; immediately west and north of these buildings is a light industrial area, whereas to the south and east are vacant land and single family residential, respectively.

Neighborhood Demographics

Pertinent demographics in the immediate area of the subject, including population trends, median household income, and median home values, are depicted on the following chart(s).

Within the healthcare real estate sector, a location with a high over-65 population is generally considered desirable, as older residents tend to consume more healthcare per capita. As such, pertinent age-related demographics, presented in one-mile, three-mile and five-mile demographic rings, as obtained from CoStar, are located on the following chart. According to the United States Census Bureau, 16.63% of the U.S. population is over-65; comparatively, 19.56% of the population within a three-mile radius of the subject is over-65.

Demographic Detail Report

Tri-City Medical

4002 W Vista Way, Oceanside, CA 92056

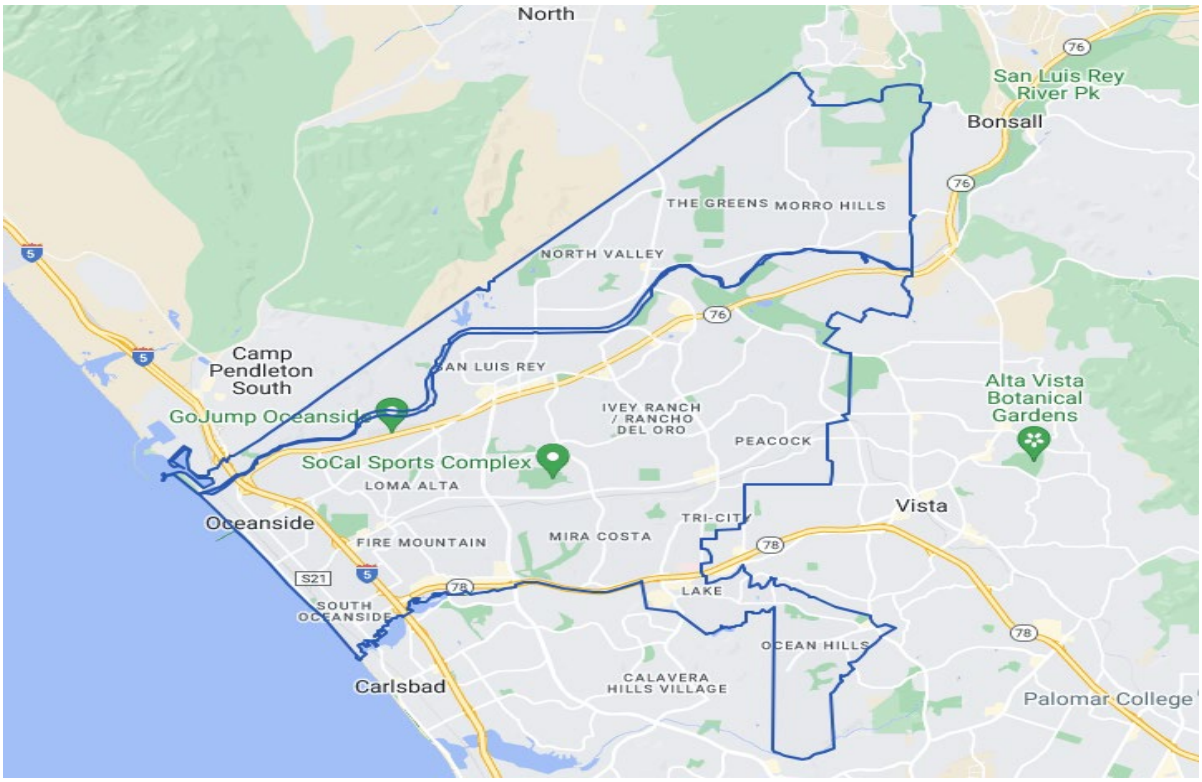
Building Type: **Class B Office**
Class: **B**
RBA: **57,474 SF**
Typical Floor: **19,158 SF**

Total Available: **57,474 SF**
% Leased: **0%**
Rent/SF/Yr: **Negotiable**

Radius	1 Mile		3 Mile		5 Mile	
Population						
2029 Projection	18,867		120,740		310,988	
2024 Estimate	19,075		122,073		313,355	
2020 Census	19,600		125,452		316,545	
Growth 2024 - 2029	-1.09%		-1.09%		-0.76%	
Growth 2020 - 2024	-2.68%		-2.69%		-1.01%	
2024 Population by Age	**19,075**		**122,073**		**313,355**	
Age 0 - 4	1,081	5.67%	6,838	5.60%	17,959	5.73%
Age 5 - 9	1,060	5.56%	6,762	5.54%	17,633	5.63%
Age 10 - 14	1,150	6.03%	6,954	5.70%	18,436	5.88%
Age 15 - 19	1,209	6.34%	7,120	5.83%	18,929	6.04%
Age 20 - 24	1,283	6.73%	7,437	6.09%	19,445	6.21%
Age 25 - 29	1,374	7.20%	8,135	6.66%	21,541	6.87%
Age 30 - 34	1,435	7.52%	8,829	7.23%	23,758	7.58%
Age 35 - 39	1,318	6.91%	8,606	7.05%	22,909	7.31%
Age 40 - 44	1,269	6.65%	8,324	6.82%	21,629	6.90%
Age 45 - 49	1,175	6.16%	7,433	6.09%	19,290	6.16%
Age 50 - 54	1,105	5.79%	7,142	5.85%	18,672	5.96%
Age 55 - 59	1,064	5.58%	7,167	5.87%	18,635	5.95%
Age 60 - 64	1,080	5.66%	7,450	6.10%	19,077	6.09%
Age 65 - 69	988	5.18%	7,016	5.75%	17,321	5.53%
Age 70 - 74	851	4.46%	6,036	4.94%	14,157	4.52%
Age 75 - 79	684	3.59%	4,769	3.91%	10,750	3.43%
Age 80 - 84	454	2.38%	3,035	2.49%	6,680	2.13%
Age 85+	494	2.59%	3,020	2.47%	6,533	2.08%
Age 65+	3,471	18.20%	23,876	19.56%	55,441	17.69%
Median Age	**38.60**		**40.20**		**39.10**	
Average Age	**39.80**		**40.80**		**39.90**	

The subject properties are in a submarket identified by CoStar as the "Oceanside submarket" to the north of San Diego. Third-party data (via CoStar) specific to office market trends in this submarket is presented on the following page, followed by information related to the broader San Diego medical office market (via C&W).

"Oceanside" Submarket – OFFICE MARKET

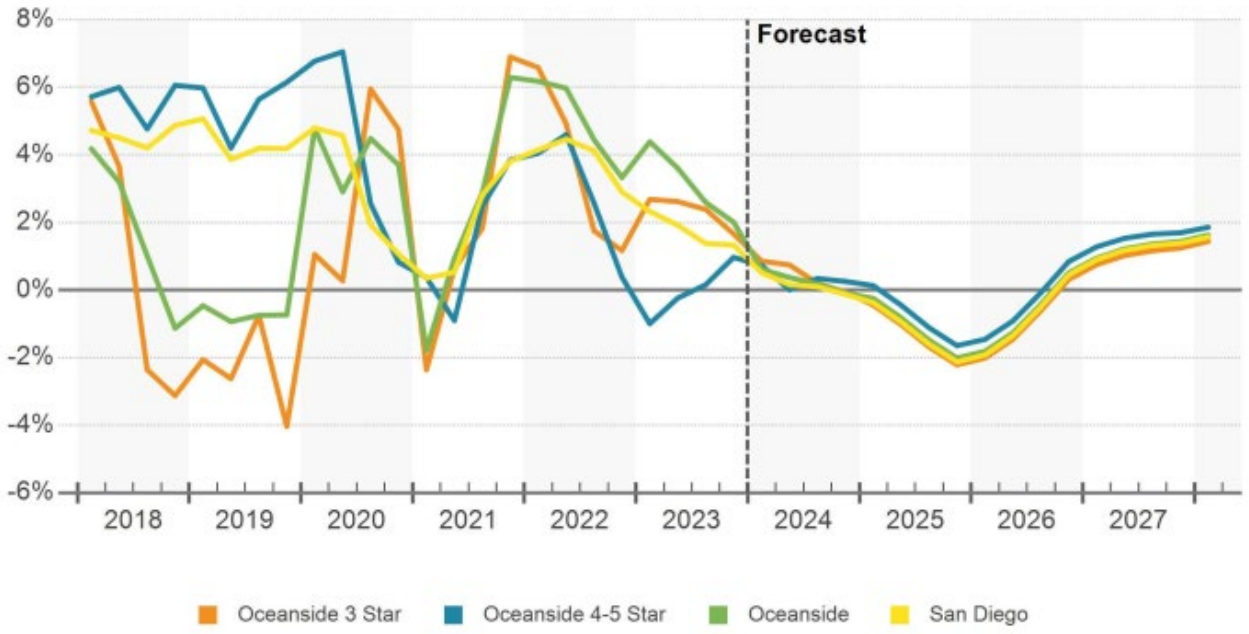


OVERALL RENT & VACANCY

	Market Asking Rent				Vacancy		
Year	Per SF	Index	% Growth	Vs Hist Peak	SF	Percent	Ppts Chg
2028	$31.03	122	2.1%	1.9%	195,770	10.2%	-0.7%
2027	$30.40	120	1.4%	-0.2%	209,329	10.9%	-0.7%
2026	$29.97	118	0.5%	-1.6%	223,232	11.6%	0%
2025	$29.82	118	-2.0%	-2.1%	224,419	11.7%	1.7%
2024	$30.43	120	-0.1%	-0.1%	192,627	10.0%	1.4%
YTD	$30.40	120	1.5%	-0.2%	175,504	9.1%	0.5%
2023	$30.46	120	2.0%	0%	166,441	8.6%	0.5%
2022	$29.86	118	3.3%	-2.0%	156,791	8.1%	-0.2%
2021	$28.89	114	6.3%	-5.1%	160,661	8.3%	-2.8%
2020	$27.19	107	3.7%	-10.7%	215,018	11.1%	3.1%
2019	$26.21	103	-0.7%	-13.9%	140,259	8.0%	0%
2018	$26.41	104	-1.1%	-13.3%	139,709	8.0%	-1.3%
2017	$26.71	105	5.2%	-12.3%	162,289	9.3%	-2.6%
2016	$25.39	100	9.1%	-16.6%	208,552	11.9%	-0.8%
2015	$23.27	92	2.4%	-23.6%	222,562	12.7%	-2.1%
2014	$22.72	90	5.8%	-25.4%	254,267	14.8%	0.4%
2013	$21.47	85	3.1%	-29.5%	244,583	14.4%	-0.4%
2012	$20.82	82	2.7%	-31.6%	242,169	14.8%	-3.1%

Source: CoStar – Oceanside Office Submarket

MARKET ASKING RENT GROWTH (YOY)



MARKET ASKING RENT PER SQUARE FEET

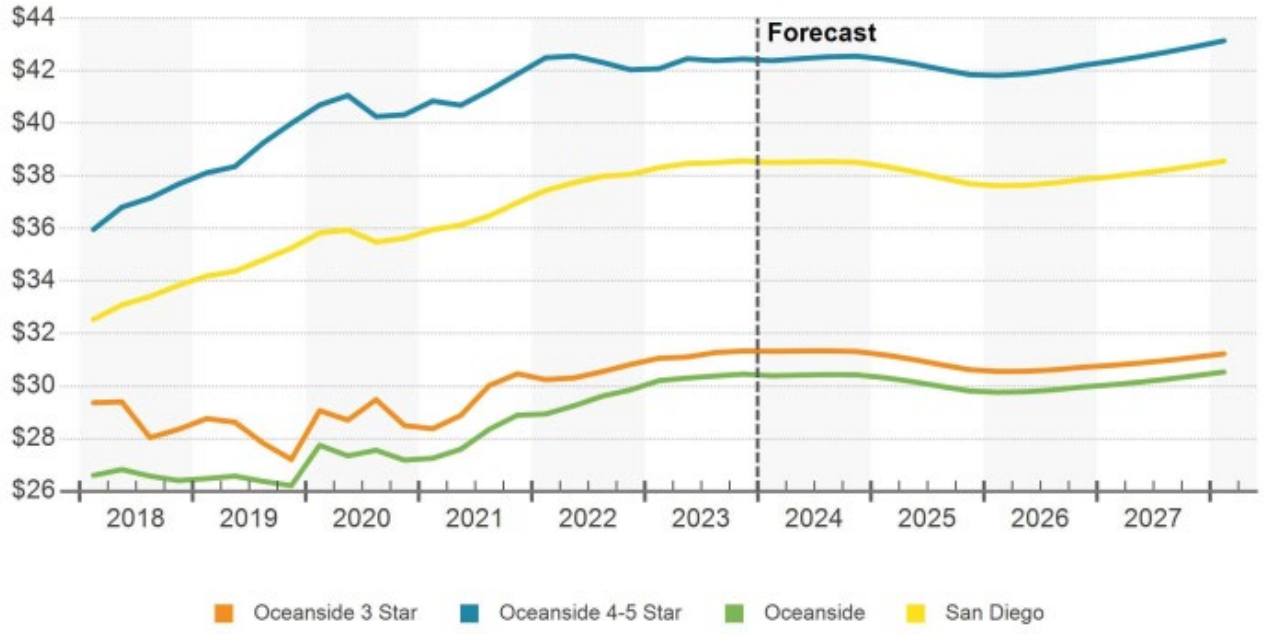


Exhibit D: Subject Site & Improvements Description

HOSPITAL CAMPUS

Tri-City Medical Center (Hospital Campus)												
Subject Property	**#**	**Address**	**County**	**City**	**State**	**Property Description**	**Land Size (SF)**	**Land Size (Acre)**	**Building Size (Sq.Ft.)**	**Year Built**	**Tax ID**	**Owner**
Hospital - Main	1	4002 Vista Way	San Diego County	Oceanside	CA	Hospital Campus	1,349,053	30.970	450,545	Varied	166-010-31-00	Tri- City Medical District
Hospital - Outbuildings	2	Varied	San Diego County	Oceanside	CA	Outbuildings	Inc. Above	Inc. Above	39,028	Varied	Inc. above	Tri- City Medical District
New (Shell) Campus MOB	3	4004 Vista Way	San Diego County	Oceanside	CA	MOB	Inc. Above	Inc. Above	57,476	2013	166-010-31-00	Tri- City Medical District
Business Dev. & OP Forensics - CONDO	4	3925 Waring Ct. Ste. A, B, & C	San Diego County	Oceanside	CA	MOB- Condo	25,253	0.58	7,215	1976	166-560-23-01, 166-560-23-02	Tri- City Medical District
PHF Building (Behavioral Health)	5	3996 Vista Way	San Diego County	Oceanside	CA	Behavioral Health	87,991	2.02	13,560	2024	166-010-37-00	Tri- City Medical District
Vacant Site	6	4000 Vista Way	San Diego County	Oceanside	CA	Vacant	36,155	0.83	N/A	N/A	166-010-43-00	Tri- City Medical District
Off-Campus - 3617 Vista Way, #5	7	3617 Vista Way	San Diego County	Oceanside	CA	Outpatient Infusion Center	24,500	0.56	7,000	2008	165-36-23-600	Tri- City Medical District (owns 25%)
						Totals:	1,522,952	34.96	574,824			

Notes:

1) For purposes of Cost Approach, utilized 3.5 : 1.0 LTB to account for effective land area associated with the MOB condos (3925 Waring Ct) and 3617 Vista Way.

2) Year built sourced from client-provided information, CoStar, and online sources. This analysis includes the psych/behavioral health building which is subject to a ground lease and will eventually revert ownership to Tri-City.

Tri-City Medical Center (Hospital Campus)																
Subject Property	**#**	**Property Type**	**Building Size (Sq.Ft.)**	**Year Built**	**Actual Age (Years)**	**Effective Age (Years)**	**Basement (Y/N)**	**# of Stories (above & below grade)**	**Elevator (Y/N)**	**Roof Structure**	**Roof Cover**	**Framing**	**Foundation**	**Exterior Walls**	**Floor Covers**	**Ceiling**	**Sprinklered (Y/N)**
Hospital - Main	1	Hospital Campus	450,545	Varied	N/A	37	Y	Up to 5	Y	Flat	Built-up, Membrane	Concrete / Steel	Concrete Slab	Masonry, glass	Standard for use (LVP, tile, comm. carpet)	Acoustic Tile	Y
Hospital - Outbuildings	2	Outbuildings	39,028	Varied	N/A	29	N/A	Mostly 1	N/A	Flat	Built-up, Membrane	Primarily wood	Concrete Slab	Brick, masonry, glass	Standard for use (LVP, tile, comm. carpet)	Acoustic Tile	Y
New (Shell) Campus MOB	3	MOB	57,476	2013	12	10	N/A	2	Y	Flat	Built-up, Membrane	Steel	Concrete Slab	Masonry, glass	Standard for use (LVP, tile, comm. carpet)	Acoustic Tile	Y
Business Dev. & OP Forensics - CONDO	4	MOB- Condo	7,215	1976	49	30	N/A	1	y	Flat	Built-up, Membrane	Wood	Concrete Slab	Brick	Standard for use (LVP, tile, comm. carpet)	Acoustic Tile	N
PHF Building (Behavioral Health)	5	Behavioral Health	13,560	2024	30	35	N/A	1	y	Flat	Built-up, Membrane	Concrete / Steel	Concrete Slab	Brick	Standard for use (LVP, tile, comm. carpet)	Acoustic Tile	Y
Vacant Site	6	Vacant	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Off-Campus - 3617 Vista Way, #5	7	Outpatient Infusion Center	7,000	2008	17	15	N/A	1	N	Flat	Built-up, Membrane	Concrete / Steel	Concrete Slab	Brick, masonry, glass	Standard for use (LVP, tile, comm. carpet)	Acoustic Tile	Y

Notes:

(1) The descriptions of the subject improvements are based upon information provided to the appraisers by the client, public record, and the appraisers' inspection of the properties listed. The descriptions of the subject improvements are assumed to be accurate, and should they prove to be inconsistent with actual conditions, the values contained herein could be impacted.

Tri-City Medical Center (Hospital Campus)									
Subject Property	**#**	**Land Size (Acre)**	**Land Size (Sq.Ft.)**	**Configuration***	**Topography***	**Flood Zone**	**Zoning**	**Zoning Jurisdiction**	**Utilities**
Hospital - Main	1	30.970	1,349,053	Irregular	Sloping	X	C-P, Commercial	Oceanside	All Available
Hospital - Outbuildings	2	Inc. Above		Irregular	Sloping	X	C-P, Commercial	Oceanside	All Available
New (Shell) Campus MOB	3	Inc. Above		Irregular	Sloping	X	C-P, Commercial	Oceanside	All Available
Business Dev. & OP Forensics - CONDO	4	0.580	25,253	Irregular	Sloping	X	C-P, Commercial	Oceanside	All Available
PHF Building (Behavioral Health)	5	2.020	87,991	Irregular	Sloping	X	C-P, Commercial	Oceanside	All Available
Vacant Site	6	0.830	36,155	Rectangular	Sloping	X	C-P, Commercial	Oceanside	All Available
Off-Campus - 3617 Vista Way, #5	7	0.560	24,500	Irregular	Level	X	C-P, Commercial	Oceanside	All Available

CARLSBAD MOB/WELLNESS BUILDINGS

Tri-City Medical Center (Carlsbad Properties)												
Subject Property	**#**	**Address**	**County**	**City**	**State**	**Property Description**	**Land Size (SF)**	**Land Size (Acre)**	**Building Size (Sq.Ft.)**	**Year Built**	**Tax ID**	**Owner**
MOB - 6250 El Camino Real	1	6250 El Camino Real	San Diego County	Carlsbad	CA	Fitness Center	334,976	7.690	57,252	2008	213-110-01-00	Tri- City Medical District
MOB - 6260 El Camino Real	2	6260 El Camino Real	San Diego County	Carlsbad	CA	MOB	Inc. Above	Inc. Above	23,863	2010	213-110-01-00	Tri- City Medical District
						Totals:	334,976	7.690	81,115			

Tri-City Medical Center (Carlsbad Properties)																
Subject Property	**#**	**Property Type**	**Building Size (Sq.Ft.)**	**Year Built**	**Actual Age (Years)**	**Effective Age (Years)**	**Basement (Y/N)**	**# of Stories (above & below grade)**	**Elevator (Y/N)**	**Roof Structure**	**Roof Cover**	**Framing**	**Foundation**	**Exterior Walls**	**Floor Covers**	**Ceiling**	**Sprinklered (Y/N)**
MOB - 6250 El Camino Real	1	Fitness Center	57,252	2008	17	10	N	2	Y	Flat	Built-up, Membrane	Steel	Concrete Slab	Masonry, glass	Standard for use (LVP, tile, comm. carpet)	Acoustic Tile	Y
MOB - 6260 El Camino Real	2	MOB	23,863	2010	15	10	N	2	Y	Flat	Built-up, Membrane	Steel	Concrete Slab	Masonry, glass	Standard for use (LVP, tile, comm. carpet)	Acoustic Tile	Y

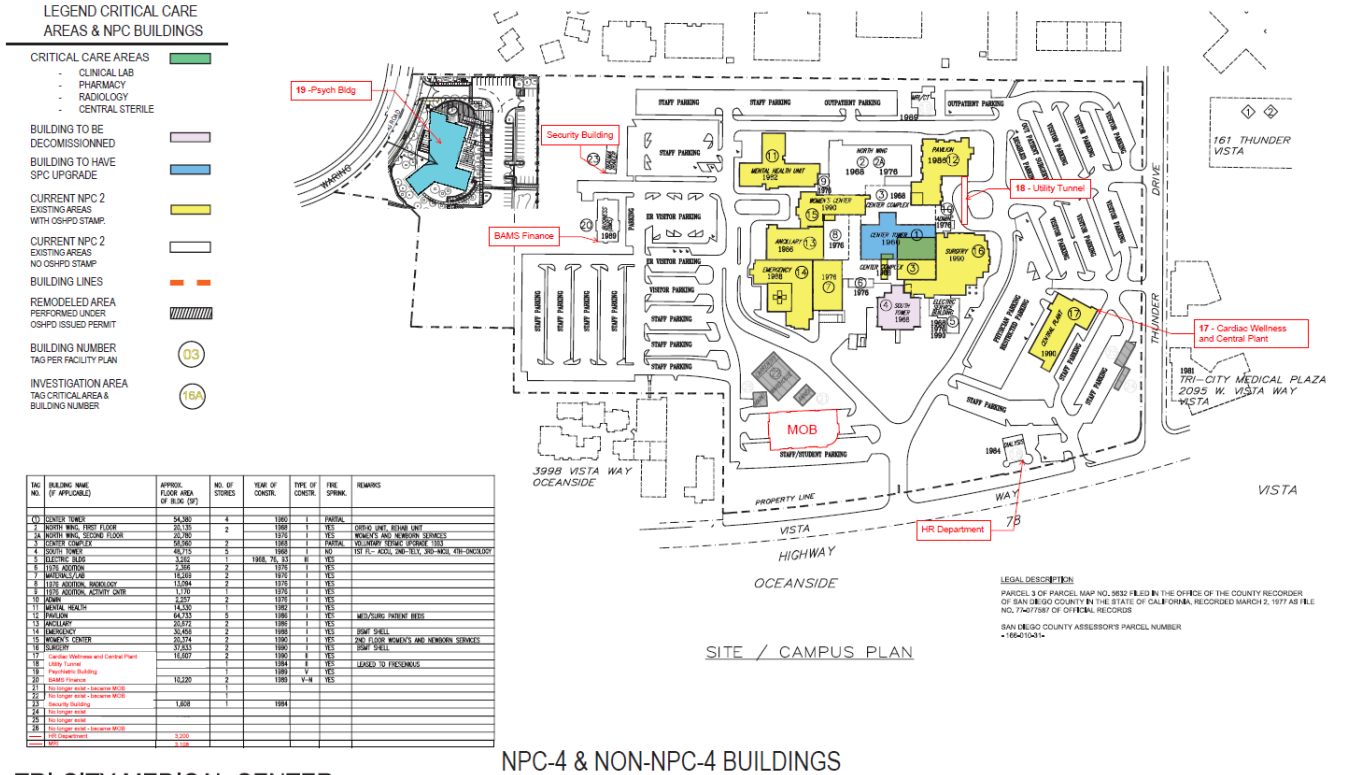
Notes:

(1) The descriptions of the subject improvements are based upon information provided to the appraisers by the client, public record, and the appraisers' inspection of the properties listed. The descriptions of the subject improvements are assumed to be accurate, and should they prove to be inconsistent with actual conditions, the values contained herein could be impacted.

Tri-City Medical Center (Carlsbad Properties)									
Subject Property	**#**	**Land Size (Acre)**	**Land Size (Sq.Ft.)**	**Configuration***	**Topography***	**Flood Zone**	**Zoning**	**Zoning Jurisdiction**	**Utilities**
MOB - 6250 El Camino Real	1	7.69	334,976	Irregular	Level	X	P-C, Planned Community	Carlsbad	All Available
MOB - 6260 El Camino Real	2	Inc. Above		Irregular	Level	X	P-C, Planned Community	Carlsbad	All Available

* Configuration and topography reflects the configuration and topography of the entire site.

Site Plan – Hospital Campus



TAG NO.	BUILDING NAME (IF APPLICABLE)	APPROX. FLOOR AREA OF BLDG (SF)	NO. OF STORIES	YEAR OF CONSTR.	TYPE OF CONSTR.	FIRE SPRINK.	REMARKS
(1)	CENTER TOWER	54,380	4	1960	I	PARTIAL	
2	NORTH WING, FIRST FLOOR	20,135	2	1968	I	YES	ORTHO UNIT, REHAB UNIT
2A	NORTH WING, SECOND FLOOR	20,780		1976	I	YES	WOMEN'S AND NEWBORN SERVICES
3	CENTER COMPLEX	56,060	2	1968	I	PARTIAL	VOLUNTARY SEISMIC UPGRADE 1993
4	SOUTH TOWER	48,715	5	1968	I	NO	1ST FL – ADOL. CHD.-TELE, 3RD–NICU, 4TH–ONCOLOGY
5	ELECTRIC BLDG	3,282	1	1968, 76, 83	III	YES	
6	1976 ADDITION	2,366	2	1976	I	YES	
7	MATERIALS/LAB	16,693	2	1976	I	YES	
8	1976 ADDITION, RADIOLOGY	13,094	2	1976	I	YES	
9	1976 ADDITION, ACTIVITY CNTR	1,170	1	1976	I	YES	
10	ADMIN	2,257	2	1976	I	YES	
11	MENTAL HEALTH	14,330	1	1982	I	YES	
12	PAVILION	64,733	5	1986	I	YES	MED/SURG PATIENT BEDS
13	ANCILLARY	20,972	2	1986	I	YES	
14	EMERGENCY	30,458	2	1988	I	YES	BSMT SHELL
15	WOMEN'S CENTER	20,174	2	1990	I	YES	2ND FLOOR WOMEN'S AND NEWBORN SERVICES
16	SURGERY	37,633	2	1990	I	YES	BSMT SHELL
17	Cardiac Wellness and Central Plant	16,007	2	1990	II	YES	
18	Utility Tunnel		1	1994	II	YES	LEASED TO FRESENIUS
19	Psychiatric Building		1	1989	V	YES	
20	BAMS Finance	10,220	2	1989	V-H	YES	
21	No longer exist - became MOB		1				
22	No longer exist - became MOB		1				
23	Security Building	1,608	1	1994			
24	No longer exist						
25	No longer exist						
26	No longer exist - became MOB						
	HR Department	3,200					
	MOB	9,108					

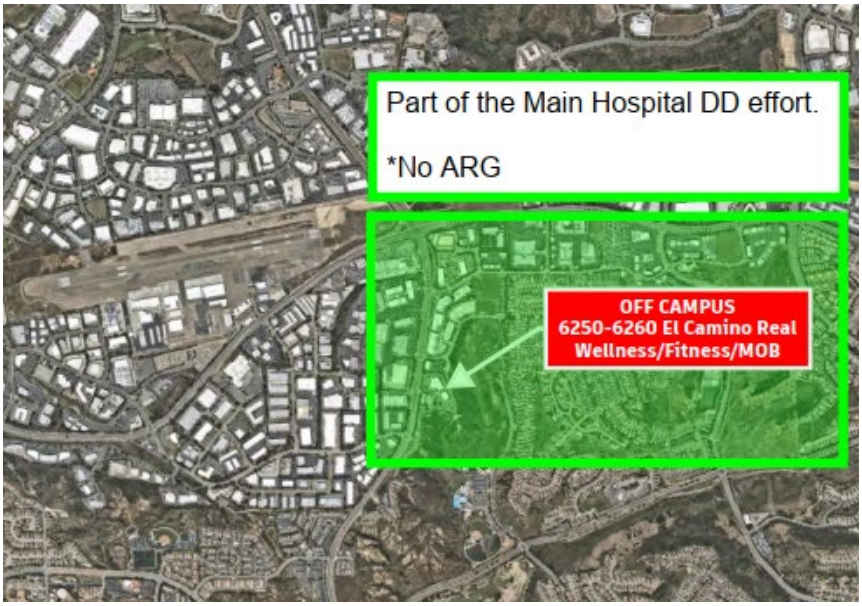
TRI-CITY MEDICAL CENTER
4002 Vista Way, Oceanside CA 92056

NPC-4 & NON-NPC-4 BUILDINGS
OVERALL PLAN

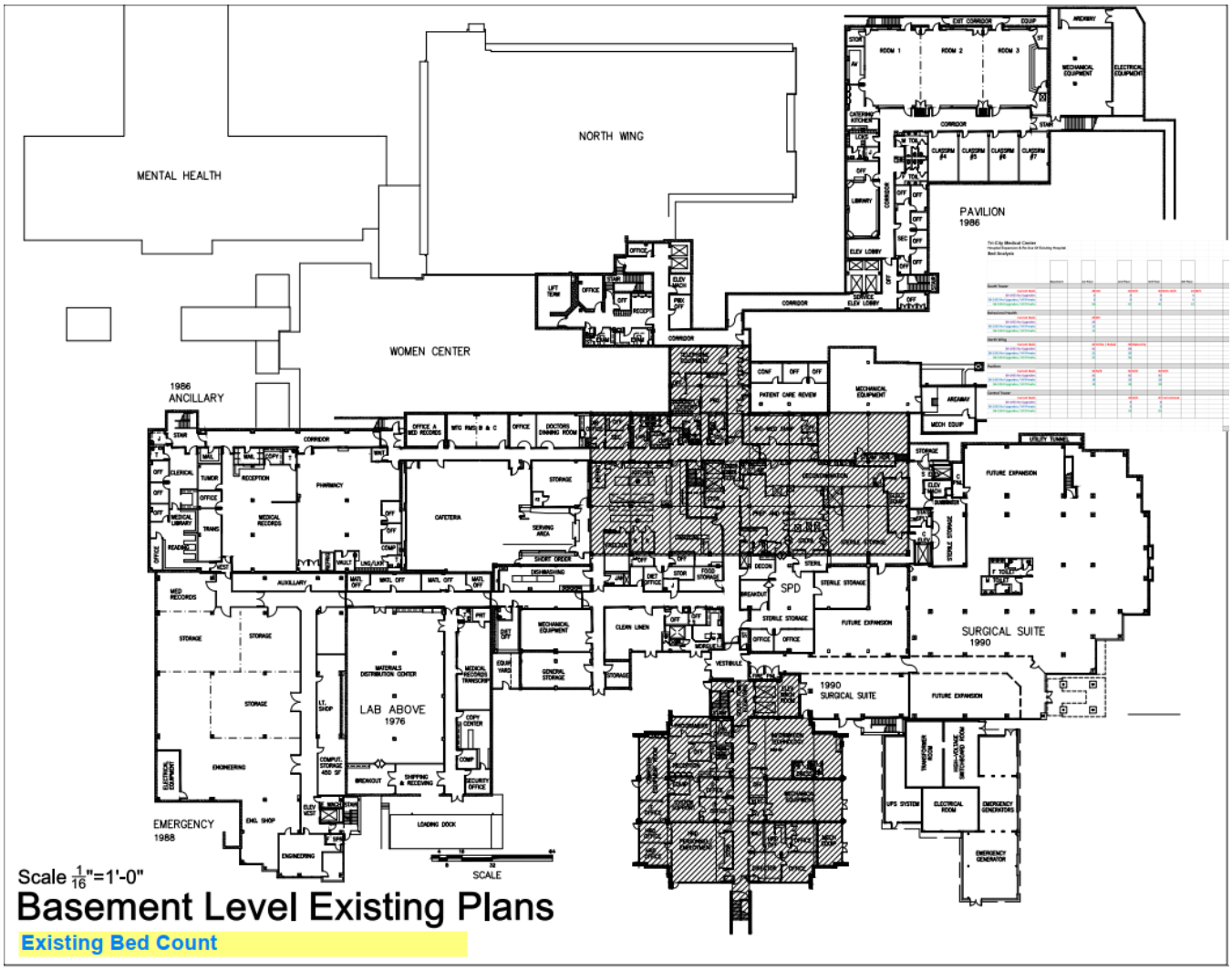
SITE PLAN
01 / 04 / 2024

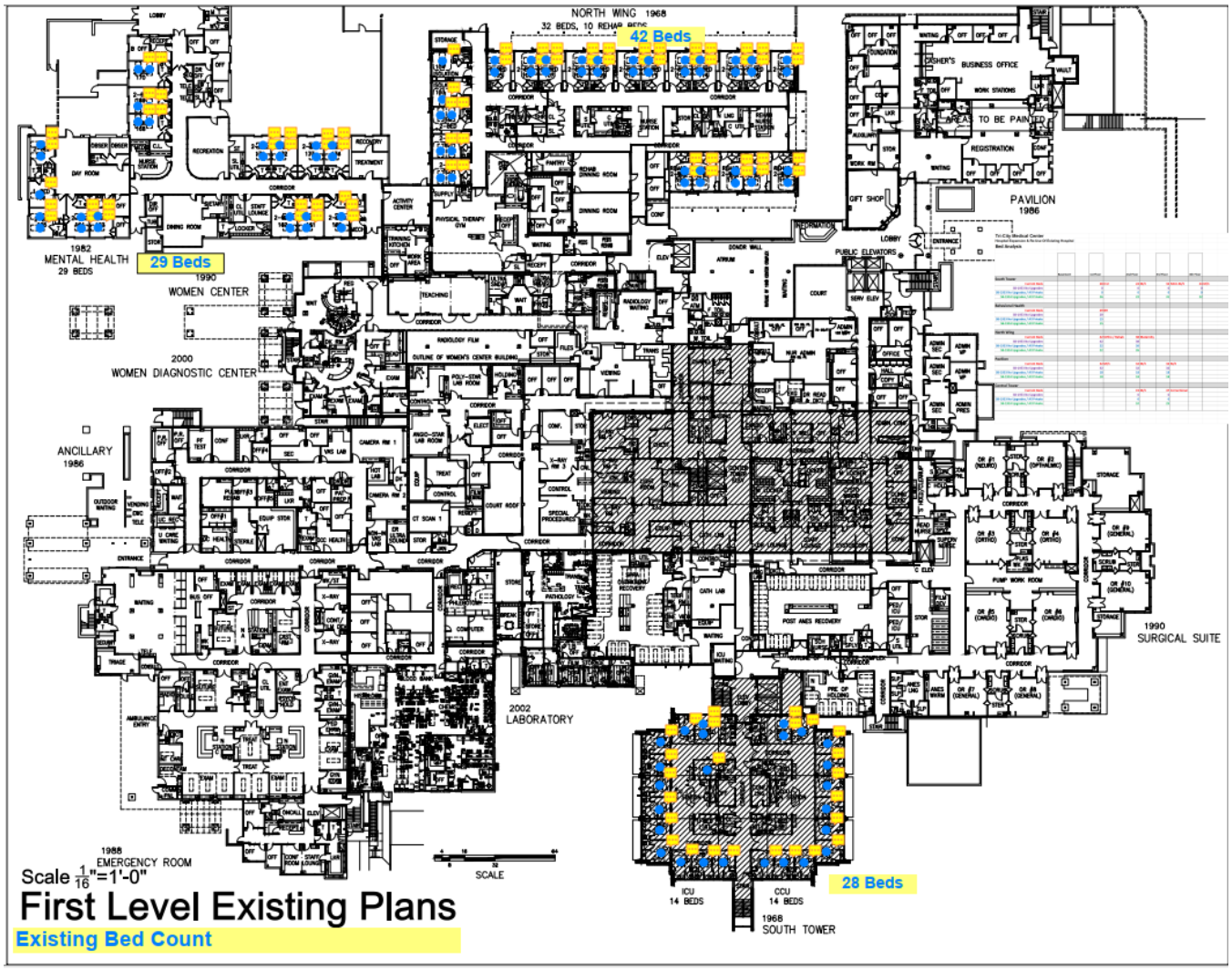
Aerial, Primary Hospital Buildings

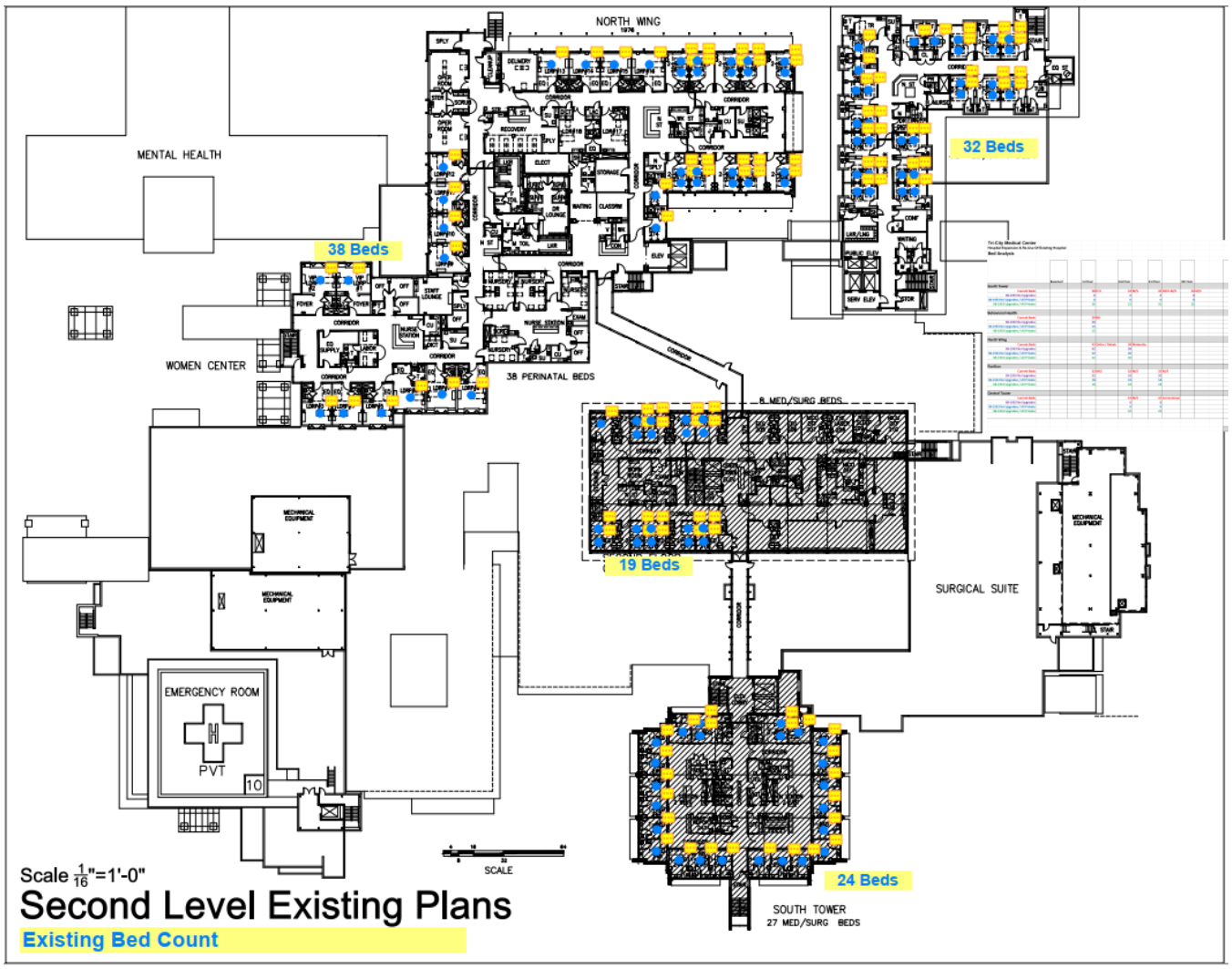
Tri-City Medical Center, Owned Properties



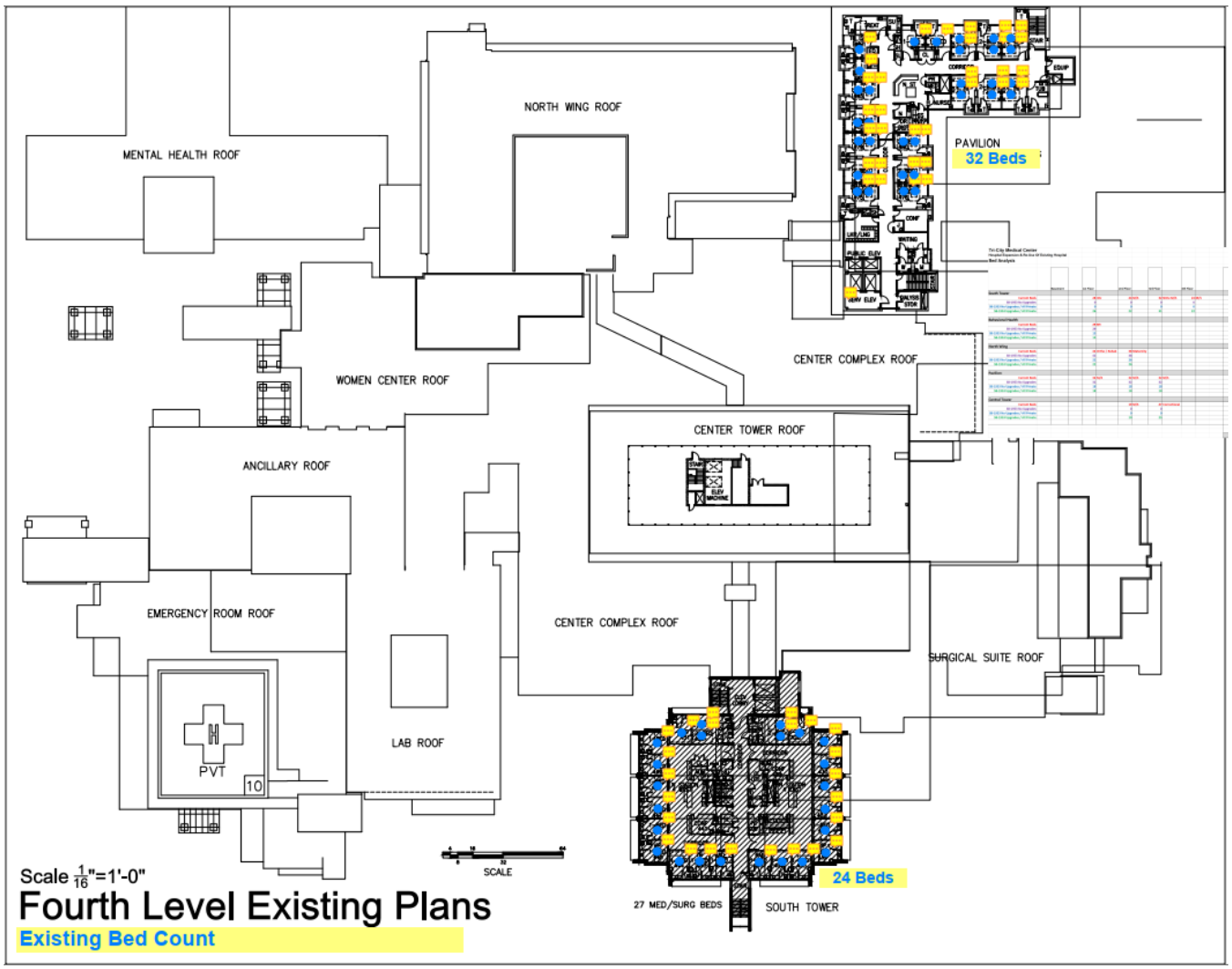
Floor Plans - Hospital




NORTH WING 1968
42 Beds
1982
MENTAL HEALTH
29 BEDS
29 Beds
1990
WOMEN CENTER
2000
WOMEN DIAGNOSTIC CENTER
ANCILLARY
1986
1988
EMERGENCY ROOM
2002
LABORATORY
PAVILION
1986
1990
SURGICAL SUITE
28 Beds
ICU
14 BEDS
CCU
14 BEDS
1968
SOUTH TOWER
Scale 1/16"=1'-0"
First Level Existing Plans
Existing Bed Count


NORTH WING
1976
MENTAL HEALTH
38 Beds
WOMEN CENTER
38 PERINATAL BEDS
32 Beds
8 MED./SURG. BEDS
19 Beds
SURGICAL SUITE
MECHANICAL EQUIPMENT
EMERGENCY ROOM
PVT
10
SCALE
24 Beds
SOUTH TOWER
27 MED/SURG BEDS
Scale 1/16"=1'-0"
Second Level Existing Plans
Existing Bed Count

NORTH WING ROOF
MENTAL HEALTH ROOF
PAVILION
32 Beds
CENTER COMPLEX ROOF
WOMEN CENTER ROOF
ANCILLARY ROOF
THIRD FLOOR
CENTER TOWER
47 MED/SURG BEDS
47 Beds
EMERGENCY ROOM
ROOF
CENTER COMPLEX ROOF
SURGICAL SUITE ROOF
LAB ROOF
PVT
10
SCALE
20 Beds
12 Beds
20 NICU BEDS
14 MED/SURG BEDS
SOUTH TOWER
Scale 1/16"=1'-0"
Third Level Existing Plans
Existing Bed Count


NORTH WING ROOF
MENTAL HEALTH ROOF
PAVILION
32 Beds
WOMEN CENTER ROOF
CENTER COMPLEX ROOF
CENTER TOWER ROOF
ANCILLARY ROOF
EMERGENCY ROOM ROOF
CENTER COMPLEX ROOF
SURGICAL SUITE ROOF
LAB ROOF
PVT
10
SCALE
24 Beds
27 MED/SURG BEDS
SOUTH TOWER
Scale 1/16"=1'-0"
Fourth Level Existing Plans
Existing Bed Count

Property History

Per historical plaques posted at the hospital:

- *1961-1971: On July 16, 1961, Tri-City Hospital, as it was called then, opened its doors with 87 patient beds and care provided by 42 physicians[…].*

- *1972-1981: Throughout the 1970s, Tri-City Hospital underwent a continual expansion of services including the additions of a helipad for expedited access to air ambulance services, a new cardiopulmonary lab to elevate cardiac care for the region, and the creation of a new 46-bed tower, building out the 56-bed north wing, along with additional surgical suites and a 42-bed maternity unit, bringing the total bed count to 231[…].*

- *1982-1991: In the 1980s, the cities of Carlsbad, Oceanside, and Vista grew by more than 80 percent, thus expanding the need for increasingly sophisticated healthcare services. In response, Tri-City Hospital added a four-story wing and remodeled existing facilities. By 1985, the official name of the hospital was changed to Tri-City Medical Center to reflect its growth into a comprehensive, regional facility. Patients were able to receive modern medical services and benefit from advances in technology, as Tri-City Medical Center performed its first heart surgeries, developed a magnetic resonance imaging (MRI) center, built out a Neonatal Intensive Care Unit (NICU) and updated its emergency department. In 1988, Tri-City Medical Center opened a specialized neurology unit focused on providing advanced treatments to stroke patients and those suffering from other neurological disorders.*

- *1992-2001: For three years in a row, TCMC was recognized as a Top 100 Hospital in the country. TCMC expanded critical services and programs including another expansion of the emergency department, opened a new outpatient surgery center, established the innovative Beatrice Riggs French Women & Infants Center and led a new stroke screening community outreach program.*

- *2002-2011: Key healthcare projects included establishing the Cardiac Wellness Center, the Center for Wound Care and Hyperbaric Medicine, the Edgar & Jo Anne Jones Women's Diagnostic Center and the John S. Middlekauf Outpatient Radiology Center. TCMC also expanded the NICU and the emergency department's imaging and diagnostic capabilities by adding a then industry-leading 64-slice CT scanner. TCMC also opened the Cardiovascular Health Institute in 2009, which offers end-to-end cardiovascular care – from prevention and early intervention to surgery and cardiac rehabilitation. In 2011, TCMC added the da Vinci Surgical System.*

- *2012-2021: TCMC grew its robotic surgery capabilities with the addition of the Mazor X Robotic Guided Surgery System. In late 2019, Tri-City Medical Center launched the COASTAL Commitment, a wide-ranging, award-winning outreach initiative with nearly 60 partner organizations serving our three cities. And in both 2020 and 2021, Tri-City Medical Center was named by Healthgrades as one of the 100 Best Hospitals for Spine Surgery.*

Photographs of the Subject Property are presented on the following page(s).

Exhibit D-1: Subject Photographs

Subject exterior

Subject exterior

Subject exterior

Subject exterior (PFH)

Subject exterior (4004 Vista Way)

Subject exterior

Subject interior

Subject interior

Subject interior

Subject interior

Subject interior – 3996 Vista building

Subject exterior – 4004 Vista Way (Campus MOB, Shell)

Subject interior – 4004 Vista Way (Campus MOB, Shell)

Subject exterior – 6250 El Camino Real

Subject exterior – 6260 El Camino Real

Property Taxes & Prior Sales

Most of the hospital campus appears to be tax exempt. Regarding recent sales, to the best of the appraiser's knowledge, no arm's length sales of the Subject Property (either the primary hospital campus or the Carlsbad properties) have occurred within the past three years. The two Carlsbad buildings (81,115 sq ft) reportedly sold from ECR Corporate Center LP (Carltas Development) to Tri-City Healthcare District in July 2013 for ~$47M ($579/SF)[1]. Tri-City reportedly leased these buildings prior to this purchase, though terms of the pre-2013 lease were not known.

The preceding pages include an overview of property taxes, current assessment, sale history data, and photos for the subject property. Regarding property taxes, VMG notes that in a typical triple-net lease structure, taxes would be passed through to the tenant entity.

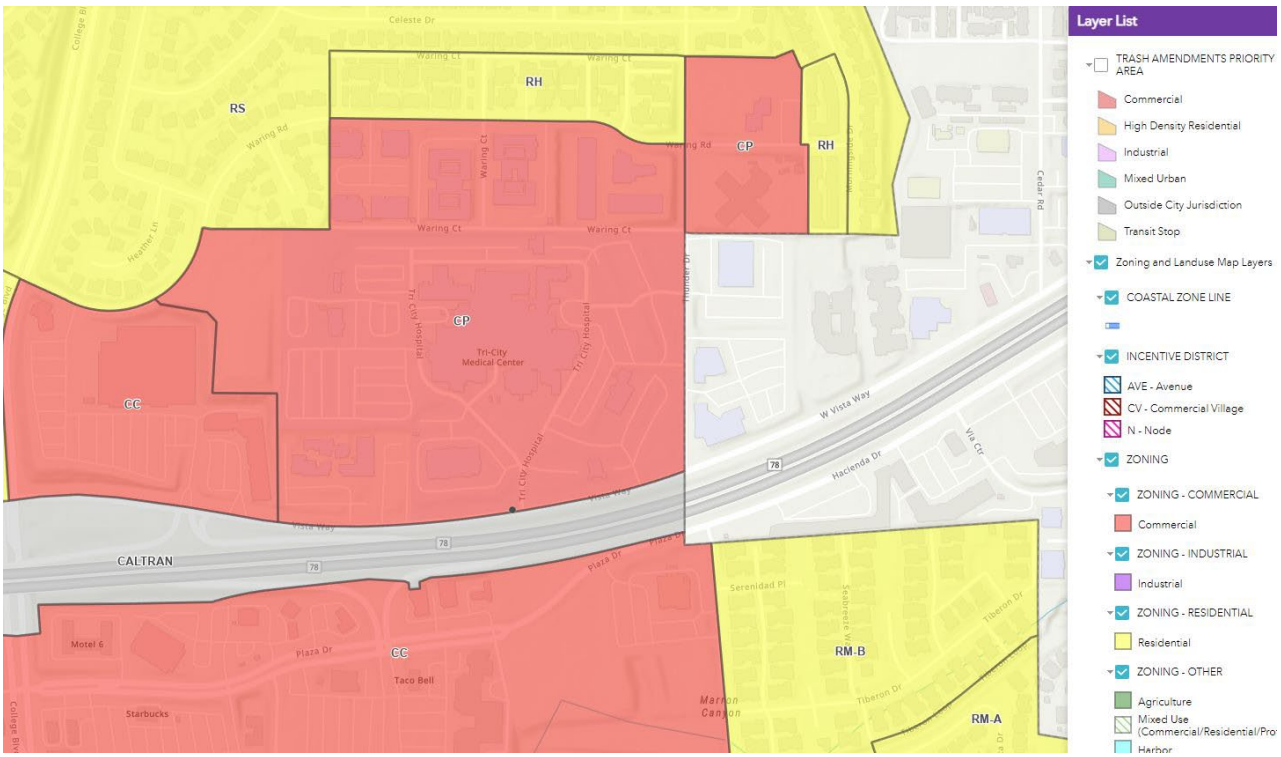
Public and Private Land Use Controls / Zoning

A zoning map is presented on the following page. VMG notes that usage of property may be limited by public or private land use controls. Public land use controls include zoning regulations; subdivision rules and regulations; board of health covenants (typically related to water and sewer services); wetland regulations; floodplain water resource and aquifer protection districts; endangered species act legislation; and/or county planning commissions and other overlay or floating districts. We assume that each of the subject buildings represent conforming (or legally non-conforming) uses. However, prior to making any business decision regarding the

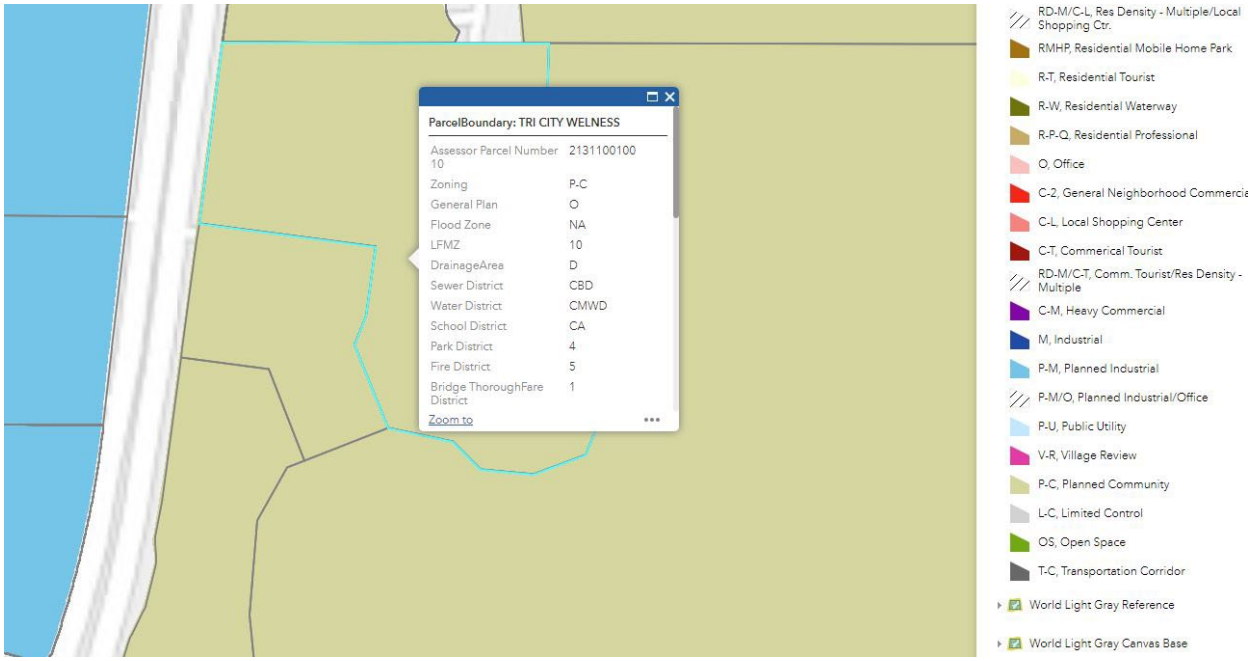
[1] https://www.tricitymed.org/2013/07/tri-city-purchases-wellness-center-medical-office-building/

subject property, it is urged that a competent professional be retained to fully understand and translate the existing land use requirements.

Zoning Map – Oceanside (Hospital Campus)



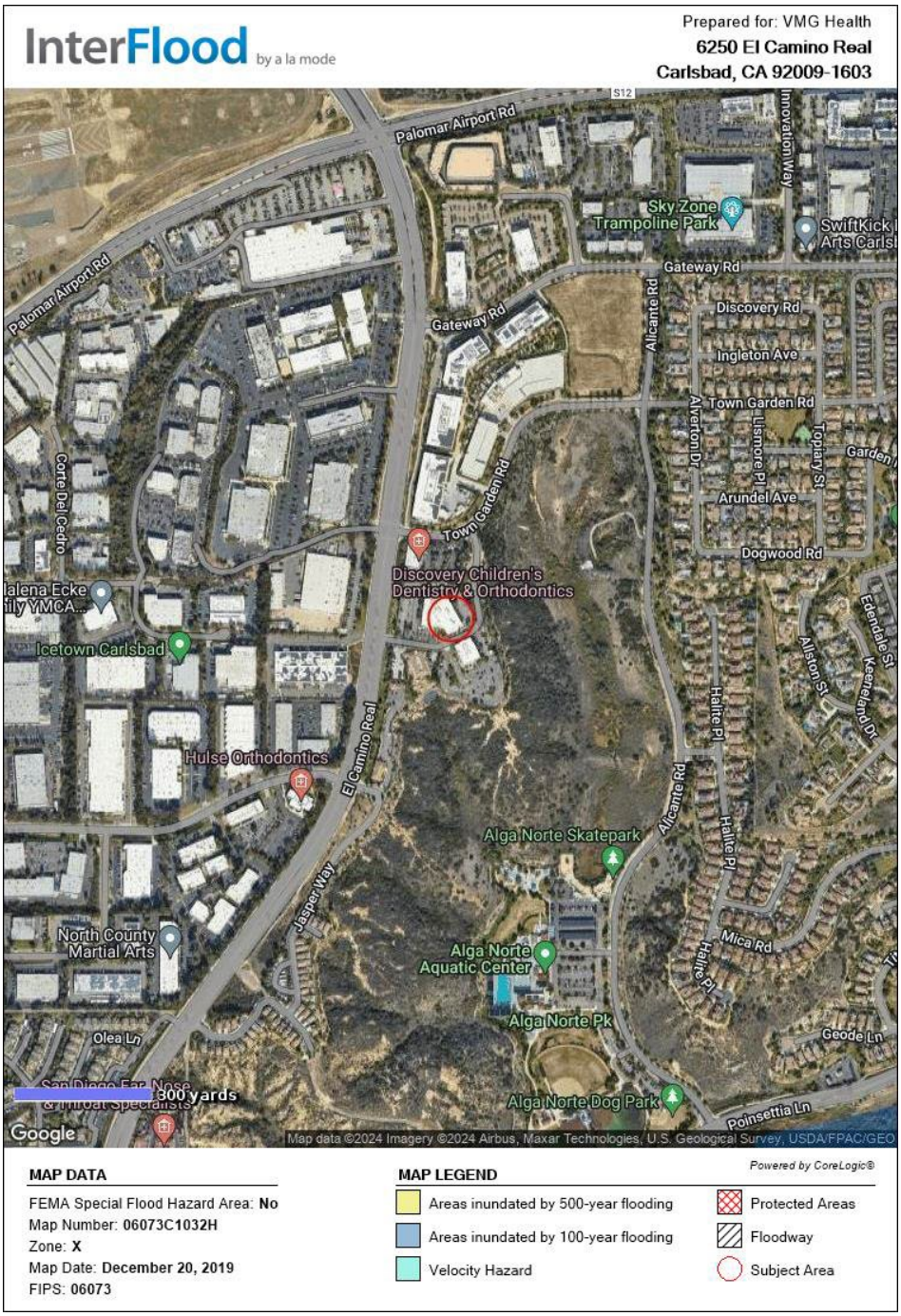
Zoning Map – Carlsbad Properties



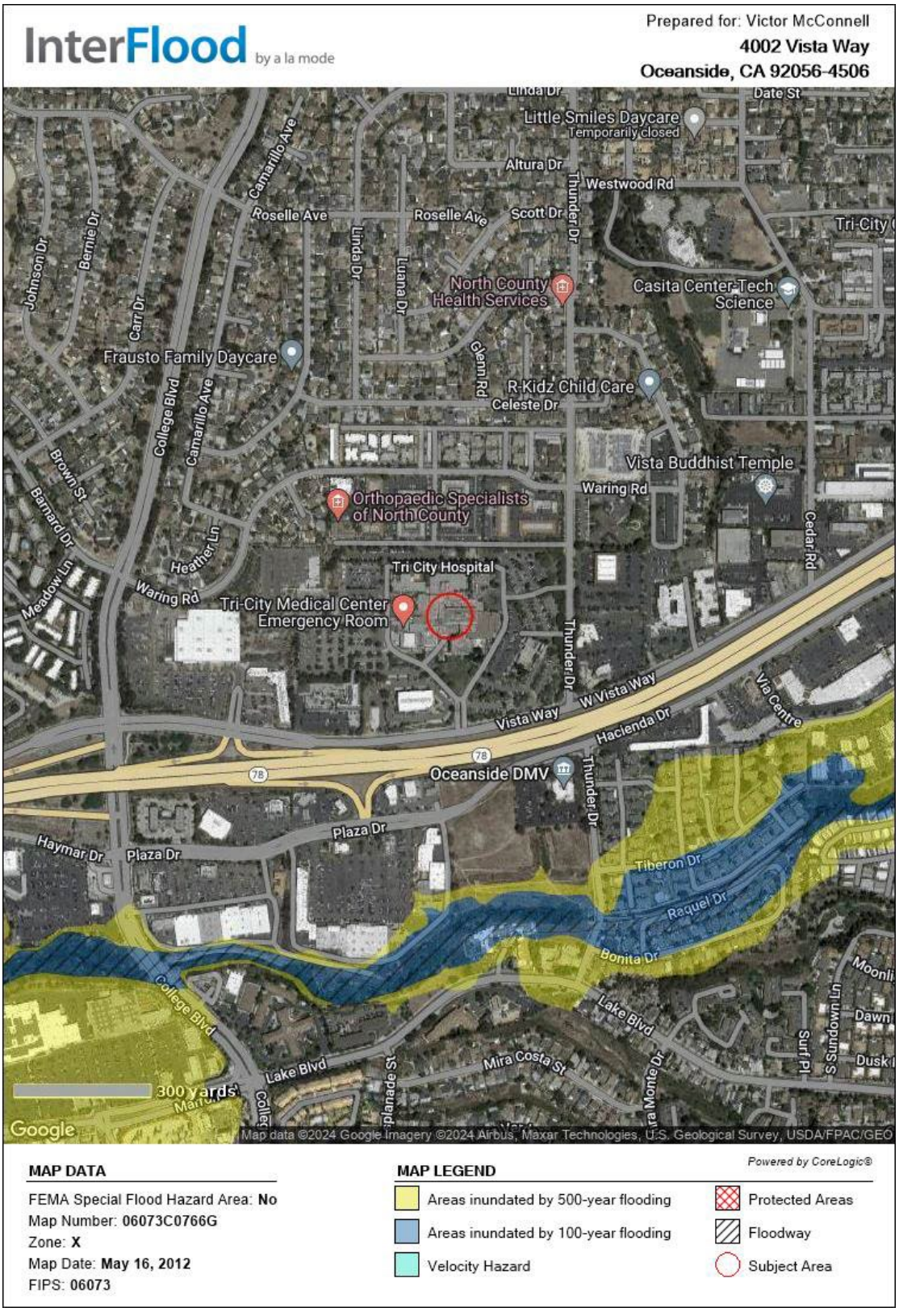
Topography

The subject sites feature a sloping terrain. Flood maps are presented as follows. However, the determination of the floodplain zone is beyond the expertise of the appraiser. Prior to making a business decision on the subject property, it is recommended that a professional engineer's opinion be obtained.

Flood Map – Carlsbad Properties



Flood Map – Oceanside (Hospital Campus)



Seismic Activity & Ground Stability

All properties in California are subject to some degree of seismic risk. The Alquist-Priolo special Studies Zone Act of 1972 was enacted by the State of California to regulate development near active earthquake faults. The Act required the State Geologist to delineate "special studies zones" along known active faults in California. Cities and Counties affected by the identified zones must limit certain development projects within the zones unless geologic investigation demonstrates that the sites are not threatened by surface displacement from future faulting.

In 1994 the Alfred E. Alquist Hospital Facilities Seismic Safety Act was amended under SB 1953 (Chapter 740, Statutes of 1994. Seismic Mandate). The seismic mandate established five structural (SPC) and five non-structural (NPC) classifications of hospital building seismic-safety levels, as well as deadlines for some classification upgrades. The purpose of the two categories was for life safety through the prevention of collapse and the ability of the hospital to continue to operate after a seismic event. It should be noted that this is an unfunded mandate.

The original timeline was to have life safety (prevention of collapse) by 2008 and resiliency of operation by 2030. Over time the 2008 deadline has continued to be moved back but the 2030 date has not changed. In addition to seismic upgrades, if a building is going through seismic upgrades the building will need to be upgraded to the current code (including all ADA standards). For older buildings, this can be a sizable undertaking.

VMG is not certified or qualified to assess seismic-related risk. Information concerning seismic retrofit costs is presented later in this report within the valuation section.

With regard to ground stability, VMG is not qualified to assess soil or subsoil conditions. However, we note the existing and surrounding structures as evidence of the adequacy of the area soil and subsoil for commercial construction. Nonetheless, a professional engineer's opinion as to the stability of the soil and subsoil is recommended.

Hazardous Materials/Toxic Waste

There were no known hazardous materials observed during an inspection of the property. It is assumed that no toxic wastes are present within the soils. However, VMG Health is not qualified to detect the presence or absence of such materials. If further evidence is needed regarding the lack of danger from hazardous materials or toxic wastes, authorities with expertise in detecting these conditions should be consulted.

Easements/Encroachments

There are no known easements or subsurface restrictions that would adversely affect the utility of the property.

Utilities

Water, sewer, gas and electric services are all available to the subject site and installed in sufficient supply that all types of development are possible.

Exhibit E: FMV Analysis – Real Estate (USPAP Reporting Requirements)

APPRAISAL REPORT REPORTING REQUIREMENTS (IN ACCORDANCE WITH THE UNIFORM STANDARDS OF PROFESSIONAL APPRAISAL PRACTICE)

Report Type / Format	Appraisal Report, as defined by USPAP.	**Premise of Value**	Fair Market Value (further discussed in the attached Report)
Date of Inspection	Stated in Transmittal Letter.	**Effective date of Value**	Stated in Transmittal Letter.
Client (or Counsel)	Stated in Transmittal Letter.	**Property Rights Appraised**	Fee Simple Estate[2].
Date of Report Distribution	Noted in Transmittal Letter.	**Intended User / Intended Use**	The intended user is the Client(s). Intended use is noted in the "Engagement: Purpose, Use & Disclosure" section of the Transmittal Letter.
Property Identification & Description	The subject property is fully identified within this report.	**Scope of Work**	VMG's scope of work included analysis of regional and neighborhood data. VMG noted relevant facts concerning the location and physical condition. VMG collected and analyzed comparable transactions. Additional information concerning VMG's scope of work for the analysis is retained in our work file(s).
Property History	Presented within the attached report.	**Market Analysis**	Summary information is presented within this report.
Site Description	The subject site is identified and described within this report.	**Improvements Description**	The subject improvements are identified and described within this report.

Marketing & Exposure Time

Marketing Time

The Uniform Standards of Professional Appraisal Practice ("USPAP") address reasonable marketing time, which is defined as follows:

The reasonable marketing time is an opinion of the amount of time it might take to sell a real or personal property interest at the concluded market value or at a benchmark price during the period immediately after the effective date of an appraisal (Advisory Opinion, USPAP, 2024).

The key factor in marketing time is that it is presumed to occur after the effective valuation date.

[2] While VMG acknowledges that some of the owned properties valued herein include leases to third parties, this analysis assumes that the lease rates are within market parameters (or do not have term lengths sufficient to result in material favorable or unfavorable leasehold positions). Furthermore, Client has NOT asked VMG to analyze any of the in-place contractual lease arrangements for favorable/unfavorable leasehold positions.

Reasonable Exposure Time

USPAP requires the derivation of reasonable exposure time, defined as follows:

An opinion, based on supporting market data, of the length of time that the property interest being appraised would have been offered on the market prior to the hypothetical consummation of a sale at market value on the effective date of the appraisal (Definitions, USPAP, 2024).

According to PwC's National Medical Office Building Investor Survey (3rd Quarter 2025), the average marketing period for investment grade medical office buildings ranges from 1 month to 12 months, with an average of 6.0 months. It is noted that PwC's provided range has consistently been 1 month to 12 months over the last three years, though the average has generally ranged between 4 months and 6 months. These statistics reflect investment marketing time for medical office properties. We have also interviewed members of the healthcare real estate brokerage community regarding marketing and exposure time for a variety of healthcare assets.

The marketing period for specialized facilities varies widely and is generally longer as compared to the MOB sector. This is supported by interviews conducted with individuals active in the marketing of specialty healthcare real estate (such as acute care and specialty hospitals or biomanufacturing facilities), as well as by our review of transactions involving various specialty healthcare properties.

For built-to-suit projects, the specific requirements of an end user and the high cost of conversion can create a limited market for a specific property. Often, a landlord will market a property for an extended period, searching for a second-generation user. VMG has reviewed marketing periods associated with a variety specialty healthcare assets, including within the ASC sector, radiation oncology sector, biomanufacturing sector, and hospital sector.

Ultimately, in the specialty healthcare real estate sector, if a specific building suits a specific tenant, a property can be leased or sold relatively quickly. If not, it can remain vacant for an extended period. Furthermore, the longer a property remains vacant, the less desirable it becomes, with older specialty buildings requiring more updates to keep pace with new technological developments. Thus, a landlord often faces the decision of whether to significantly discount their asking rate in order to lease or sell a property within a reasonable period, or seek to maximize their lease rate or sale price and face the prospect of potentially waiting for an extended period. The risk in the latter course of action from the landlord's perspective is that it is not uncommon for a property to be marketed for years unsuccessfully before being sold or leased at a discount. Thus, the landlord may incur significant holding costs in maintaining and marketing the property and then ultimately lease or sell the property for a price significantly below cost (or return on cost).

The primary subject property is currently built out as an acute care hospital (this analysis also includes ancillary properties, such as the Carlsbad Wellness/MOB).

Considering the size and location, we have determined that a reasonable marketing period and an exposure period for the subject properties would generally range from 12 to 18 months.

Highest & Best Use

Highest and Best Use may be defined as, "the reasonably probable use of property that results in the highest value." Because the use of land can be limited by the presence of improvements, Highest and Best Use is determined separately for the site as though vacant and available to be put to its Highest and Best Use, and for the property as improved. Highest and Best Use must meet the following four criteria: 1) Physically possible; 2) Legally permissible; 3) Financially feasible; and 4) Maximally productive.

VMG has assumed that a medically-oriented or other commercial use is physically possible and legally permissible. Furthermore, VMG has assumed projected financial performance is sufficient to support the underlying tangible assets, including the real estate. Accordingly, VMG has concluded

	continuation of existing use as hospital facility to be the highest and best use of the Subject Property.
Valuation Discussion	The valuation of real property usually calls for employment of the three basic approaches to value: the Cost Approach; the Sales Comparison Approach; and the Income Approach. A discussion of the valuation approaches as utilized herein is presented within this report.
Value Reconciliation	VMG considered all three approaches to value; each of the methodologies outlined herein were given consideration within the value reconciliation. Further discussion is presented in the attached report.
Extraordinary Assumptions & Hypothetical Conditions	General assumptions and limiting conditions are noted in this report. Within this specific assignment, we have relied upon provided building area(s). Should the size of the subject property vary significantly from that which is utilized herein, the appraiser(s) reserve the right to modify the contents of this report, including the value conclusion(s) (upon just compensation). VMG's valuation as presented within this report is focused on the real estate and assumes operational projections are sufficient to support the underlying tangible assets at the value conclusions presented herein**.** Other assumptions (**such as seismic retrofit costs**) relied upon are stated in the appropriate section of this report. These extraordinary assumptions might have affected the assignment results No hypothetical conditions were relied upon within this analysis.

Exhibit F: FMV Analysis – Real Estate

In other sections of this Appraisal Report, the valuation problem and property characteristics are defined. Information regarding the interaction of four basic forces that motivate human activity (environmental conditions, governmental controls and regulations, social forces, and economic conditions) and how they affect the overall commercial market as well as the subject property are analyzed. Additionally, the Highest and Best Use of the subject property is established. In the following section of this Appraisal Report, general and specific data gathered will be analyzed to determine an opinion of a reasonable range of the Fair Market Value of the subject property.

The valuation of real property usually calls for employment of the three basic approaches to value. These approaches to value are identified as follows:

THE COST APPROACH

THE SALES COMPARISON APPROACH

THE INCOME APPROACH

The Cost Approach is based upon the proposition that the informed purchaser would pay no more than the cost of producing a substitute property with the same utility as the subject property. The Cost Approach is particularly applicable when the property being appraised involves relatively new improvements which represent the Highest and Best Use of the land or when relatively unique or specialized improvements are located on the site and for which there exists no comparable properties in the marketplace.

The Sales Comparison Approach is based upon the proposition that an informed purchaser would pay no more for a property than the cost of acquiring an existing property with the same utility. This approach is applicable when an active market provides sufficient quantities of reliable data which can be verified from authoritative sources. The Sales Comparison Approach is relatively unreliable in an inactive market or in estimating the value of properties for which no real comparable sales data is available.

The Income Approach is a procedure in appraisal analysis which converts the anticipated benefits (dollar income or amenities) to be derived from the ownership of property into a value estimate. The Income Approach is widely applied in appraising income producing properties. In this approach, an estimate of potential income for the subject property is first projected. From this amount, deductions are made for typically-incurred costs involved with ownership of the property, resulting in a net operating income estimate. An appropriate capitalization rate is then applied to the net operating income to derive an indication of value.

Income producing real estate is a capital good which is typically bought and sold primarily on the basis of the net income produced from the property. In all economic and investment analyses, of which real estate appraisal is an integral part, the value of a capital good is established and measured by calculating, as of a particular date, the present value of the anticipated future benefits (all sources of net revenue) to the owner over a specified period.

Similar to the previous discussion, there are generally three approaches for estimating a market rent. One of these approaches, a Return-On-Depreciated-Cost analysis, consists of performing a cost approach analysis and then estimating a market derived return of and on the subject's depreciated improvement cost and land value using a capital return methodology.

Another method, called a market rent comparables approach, consists of analyzing the rental rates of actual leases and/or current offerings of comparable properties.

A rental rate can also be developed through an analysis of the subject's financial operations. This method is a variation of the income capitalization approach in that historical financial statements are reviewed and analyzed and a projection for the upcoming year is completed. From this amount, earnings before interest, taxes, depreciation, amortization, and rent ("EBITDAR") are estimated, and a rent coverage ratio that indicates how much rent can be supported within the EBITDAR amount is selected.

We considered each of the methodologies outlined above and applied those we deemed most appropriate; our analysis is summarized in the following pages.

COST APPROACH

The Cost Approach is based on the principle of substitution, which states that a prudent purchaser would not pay more for a property than the amount required to purchase a similar site and construct similar improvements, without undue delay, to produce a property of equal desirability and utility. The return on and of the capital expenditures (less any applicable depreciation) required to develop the property can be estimated to derive a rent rate indication.

The Cost Approach procedure begins by estimating the value of the subject site at its Highest and Best Use. The next step involves estimating the current replacement cost of the improvements and their accrued depreciation from all causes. The final step in the Cost Approach involves adding the depreciated value of the improvements to the estimated land value.

Land Valuation

Land valuation in an urban market can be complex, as development potential varies widely based upon zoning and other factors (while the subject is not in a dense downtown area, it is in the outlying portion of the San Diego market). Furthermore, larger parcels such as the subject allow for a variety of development options, particularly if developers believe that the potential exists for zoning change or certain entitlements. A summary of the land sales and an adjustment grid follow.

Tri-City Medical Center (Hospital Campus)
Land Sales Summary

4002 Vista Way, Oceanside , San Diego County, CA

Comp.	Location	Land Area	Sale Price	Sale Date	Grantor / Grantee	Shape / Topography	Zoning / Utilities	Unit Price	Comments
L-1	**943 E Barham Dr** **San Marcos** **California**	476,546 Sq Ft 10.94 Acres	$9,600,000	Jun-22	Dale L Schreiber and Donna E Schreiber Sloping	Irregular Slightly sloping	MU All	$20.14 per Sq Ft $877,514 per Acre	This 10.94 acre site sold in June of 2022 for $20.14/sf. This site is located a 1.5 miles from Palomar Medical Center, a hospital with approximately 332 beds. The land is sloping but appears to be mostly vacant. Site has frontage along highway and had conceptual plans for senior care site.
L-2	**El Camino Real & College Blvd** **Carlsbad** **California**	766,656 Sq Ft 17.60 Acres	$28,500,000	Jul-23	Wal Mart Stores, Inc. SUNNY CREEK DEVELOPMENT PARTNERS LP	Mostly Rectangular Slightly sloping	C-1 All	$37.17 per Sq Ft $1,619,318 per Acre	This 17.6 acre site sold in July of 2023 for $37.17/sf. This site was sold from Walmart and surrounding use is mostly residential. The site appears to be mostly level and vacant. It is also located at a moderately busy intersection.
L-3	**Oceanside Blvd & Melrose Rd** **Oceanside** **California**	398,574 Sq Ft 9.15 Acres	$13,000,000	Dec-23	Walmart Inc Mill Creek Residential	Irregular Slightly sloping	CN All	$32.62 per Sq Ft $1,420,765 per Acre	Walmart sold this site and the buyer intended to develop multi-family units on the property. The site has good access and exposure.
L-4	**Bella Vista Dr** **Encinitas** **California**	439,956 Sq Ft 10.10 Acres	$11,963,000	Mar-25	Kira Family Living Trust Shea Homes	Rectangular Slightly sloping	R1 All	$27.19 per Sq Ft $1,184,455 per Acre	This site is to be developed with single-family residences, similar to the surrounding uses. The plan is to develop 17 units.
L-5	**2675 Melrose Dr** **Vista** **California**	135,907 Sq Ft 3.12 Acres	$4,000,000	Jun-23	Franz-Vista Melrose LLC MC- Pacific II LLC	Rectangular Slightly sloping	Commercial All	$29.43 per Sq Ft $1,282,051 per Acre	This 3.1 acre lot sold in June of 2022 for $29.43/sf. This was a 1031 exchange sale and the lot reportedly sold with entitlements for a 128 room hotel.
L-6	**1023 Grand Ave** **San Marcos** **California**	342,382 Sq Ft 7.86 Acres	$13,126,000	Mar-25	Aoa San Marcos LLC Paloma Townhomes	Irregular Mostly level	SPA All	$38.34 per Sq Ft $1,669,975 per Acre	The buyer is planning to develop a 102-lot SFR townhome project. The property has good access and it appears mostly level.

Tri-City Medical Center (Hospital Campus)
Land Sales Adjustment Grid

As of September 26, 2025

Comparable Number	Subject	L-1		L-2		L-3		L-4		L-5		L-6	
LOCATION	4002 Vista Way Oceanside, California	943 E Barham Dr San Marcos		El Camino Real & College Blvd Carlsbad		Oceanside Blvd & Melrose Rd Oceanside		Bella Vista Dr Encinitas		2675 Melrose Dr Vista		1023 Grand Ave San Marcos	
SALE PRICE		$9,600,000		$28,500,000		$13,000,000		$11,963,000		$4,000,000		$13,126,000	
Land Area in Sq. Ft.	1,498,452	476,546		766,656		398,574		439,956		135,907		342,382	
Sale Price per Sq. Ft.		$20.14		$37.17		$32.62		$27.19		$29.43		$38.34	
VALUE ADJUSTMENTS													
PROPERTY RIGHTS CONVEYED													
Adjusted Price per Sq. Ft.		*$20.14*	0%	*$37.17*	0%	*$32.62*	0%	*$27.19*	0%	*$29.43*	0%	*$38.34*	0%
FINANCING TERMS													
Adjusted Price per Sq. Ft.		*$20.14*	0%	*$37.17*	0%	*$32.62*	0%	*$27.19*	0%	*$29.43*	0%	*$38.34*	0%
CONDITIONS OF SALE													
Adjusted Price per Sq. Ft.		*$20.14*	0%	*$37.17*	0%	*$32.62*	0%	*$27.19*	0%	*$29.43*	0%	*$38.34*	0%
EXPENDITURES AFTER SALE (Per SF)		$0.00		$0.00		$0.00		$0.00		$0.00		$0.00	
Adjusted Price per Sq. Ft.		*$20.14*		*$37.17*		*$32.62*		*$27.19*		*$29.43*		*$38.34*	
MARKET CONDITIONS	Sep-25	Jun-22		Jul-23		Dec-23		Mar-25		Jun-23		Mar-25	
Adjustment		16%		11%		9%		3%		11%		2%	
Adjusted Price per Sq. Ft.		*$23.36*		*$41.26*		*$35.56*		*$28.01*		*$32.67*		*$39.11*	
PHYSICAL CHARACTERISTICS													
Location	Good	Inferior	20%	Comparable	0%	Comparable	0%	Comparable	0%	Inferior	5%	Comparable	0%
Visibility / Frontage / Access	Good	Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%
Topography	Sloping	Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%
Shape	Irregular	Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%
Size (SF)	1,498,452	Superior	-10%	Comparable	0%	Superior	-10%	Superior	-10%	Superior	-15%	Superior	-10%
Zoning		Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%
Improvements	As If Vacant	Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%
Utilities	All Available	Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%	Comparable	0%
ADJUSTED SALES PRICE PER SF		$25.70	10%	$41.26	0%	$32.00	-10%	$25.21	-10%	$29.40	-10%	$35.20	-10%

COMPARABLE STATISTICS

Maximum	$41.26
Minimum	$25.21
Mean	$31.46
Median	$30.70

LAND VALUATION

Land Area (Square Feet)			Concluded Value (Square Feet)		Concluded Value	
1,498,452	sf	x	$32.00	=	$47,950,000	***Main Campus***
24,500	sf	x	$32.00	=	$195,000	***Plus 25% interest in 3617 Vista Way site (25,000 sf @ $32 psf * 25%)***
			Rounded	=	**$48,150,000**	

COST OF REPLACEMENT

Cost of Replacement New is defined in The Dictionary of Real Estate Appraisal, Seventh Edition as "The estimated cost to construct, at current prices as of a specific date, a substitute for a building or other improvements, using modern materials and current standards, design, and layout."

The cost of replacement new is estimated utilizing the Calculator method. The Calculator method is based on the Marshall Valuation Service. The Marshall Valuation Service is a nationally recognized cost estimating service which publishes current costs for various building types and components.

The Marshall Valuation Service also considers typical contractors' overhead and profit. Overhead is divided into two categories: general overhead costs and job overhead costs. General overhead includes all costs that cannot be charged to any particular job, including office rent, office supplies and equipment, utilities, advertising and salaries for office personnel. Job overhead includes costs which can be charged directly to the jobs at hand but which cannot be charged directly to materials, labor or equipment. Such items include temporary buildings, barricades, permits, surveys and on-site utilities. Every contractor is entitled to a profit from construction projects. Contractors' overhead and profit, expressed as a percentage of the sum of materials and labor, are based upon extensive surveys of numerous major markets.

After applying the refinements to the base cost, we calculated the total adjusted cost per square foot and applied that indicator to the building area.

Costs not included in the Marshall Valuation Service direct cost estimate include the indirect costs of property taxes during construction, contingency reserves and legal fees. We have analyzed indirect costs associated with a variety of healthcare real estate projects. Indirect (soft) costs for hospital (and other specialty) projects in California are significantly higher than most other locations nationally; we have taken this into account within our selected percentage of **30%** for indirect costs.

ENTREPRENEURIAL INCENTIVE/PROFIT

Entrepreneurial profit is defined as "A market-derived figure that represents the amount an entrepreneur receives for his or her contribution to a project and risk; the difference between the total cost of a property (cost of development) and its Fair Market Value (property value after completion), which represents the entrepreneur's compensation for the risk and expertise associated with development." Entrepreneurial incentive is defined as "The amount an entrepreneur expects to receive for his or her contribution to a project. Entrepreneurial incentive may be distinguished from entrepreneurial profit (often called developer's profit) in that it is the expectation of future profit as opposed to the profit actually earned on a development or improvement."

It should be noted that, over a large enough sample, entrepreneurial profit and entrepreneurial incentive should be roughly equivalent. Analysis indicates that real estate developers have historically required an anticipated profit yield of 5% to 20% of total project costs, though select projects feature entrepreneurial incentive or profit higher than this range.

Based upon market surveys and research, with consideration given to the subject property's location, we have selected **20%** entrepreneurial profit.

Accordingly, the combined Soft Costs & Entrepreneurial Incentive percentage was selected at **50%.**

DEPRECIATION

PHYSICAL DEPRECIATION

Accrued depreciation is calculated on a straight-line basis, and economic life estimates are taken from Marshall Valuation Service's published cost manual. The site improvements were also accounted for, with depreciation applied on a straight-line basis. Site improvements generally have a combined economic life of 20 years.

Building history and a blended estimate of chronological age and effective age based on information provided by Client is presented as follows.

Tri-City Medical Center (Hospital Campus)
HOSPITAL BUILDING AGE CALCUATION

Hospital Physical Depreciation Calculation							
Building Name	SF	Pro Rata	Year Built	Chronological Age	Weighted Chron. Age	Effective Age (Estimate)	Weighted Effective Age
Center Tower	54,380	12.07%	1961	64	7.7	40	4.8
North Wing, First Floor	20,135	4.47%	1970	55	2.5	40	1.8
North Wing, Second Floor	20,780	4.61%	1979	46	2.1	40	1.8
Center Complex - North & South	58,960	13.09%	1970	55	7.2	40	5.2
South Tower & S Tower Stair Shaft	48,715	10.81%	1970	55	5.9	40	4.3
Electrical Building	3,262	0.72%	1970	55	0.4	40	0.3
Electrical Building Addition	2,366	0.53%	1995	30	0.2	25	0.1
Center Complex Addition	1,170	0.26%	1978	47	0.1	40	0.1
Materials Laboratory	18,269	4.05%	1978	47	1.9	40	1.6
Radiology Addition	13,094	2.91%	1978	47	1.4	40	1.2
Activity Center	1,170	0.26%	1976	49	0.1	40	0.1
Administrative Building	2,257	0.50%	1978	47	0.2	40	0.2
Behavioral Health Unit	14,330	3.18%	1984	41	1.3	35	1.1
Pavilion Building	64,733	14.37%	1986	39	5.6	30	4.3
Ancillary Building	20,672	4.59%	1986	39	1.8	30	1.4
Emergency Room Addition	30,458	6.76%	1988	37	2.5	30	2.0
Perinatal Unit Women's Center	20,374	4.52%	1990	35	1.6	30	1.4
Surgery Addition 1 and 2	37,833	8.40%	1990	35	2.9	30	2.5
Central Plant / Cardiac Wellness	16,607	3.69%	1990	35	1.3	30	1.1
Utility Tunnel	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Miscellaneous (to adjust to total from client)	***980***						
	450,545	**100%**	**Total:**	**Chron. Age:**	**46.7**	**Effective Age:**	**35.3**
						Rounded (Years):	**35.0**

*Utilized 45-year effective age for 1960-1975; 40-year effective age for 1976-1980; 35-year for 1981-1985; 30-year for 1986-1990; and 25-year for 1991-1995.

Hospital - Outbuildings

Building Name	SF	Pro Rata	Year Built	Chronological Age	Weighted Chron. Age	Effective Age (Estimate)	Weighted Effective Age
HR Dept (formerly dialysis)	2,662	6.82%	1997	28	1.9	15	1.0
MRI / CT Scan Building	2,685	6.88%	1990	35	2.4	30	2.1
Business Management Services (BMS)	33,681	86.30%	1990	35	30.2	30	25.9
	39,028	**100%**	**Total:**	**Chron. Age:**	**34.5**	**Effective Age:**	**29.0**
						Rounded (Years):	**29.0**

The effective ages above consider the CIP at the facility (ED renovation, etc.).

FUNCTIONAL OBSOLESCENCE

Functional obsolescence is categorized into two major classifications - curable functional obsolescence and incurable functional obsolescence. Curable functional obsolescence is defined in The Dictionary of Real Estate Appraisal, Seventh Edition as "An element of depreciation; a curable defect caused by a flaw in the structure, materials, or design, which can be practically and economically corrected." Incurable functional obsolescence is defined in The Dictionary of Real Estate Appraisal, Seventh Edition as "An element of depreciation; a defect caused by a deficiency or superadequacy in the structure, materials, or design that cannot be practically or economically corrected."

Due to the increasing shift to outpatient care, as well as other pertinent shifts within the healthcare market, functional obsolescence in acute care hospitals is common. Additionally, the subject has several underutilized areas. There are several methodologies by which to estimate functional obsolescence in a hospital. A summary of our analysis is presented as follows.

Functional Obsolescence: Square Feet Per Staffed Bed

We analyzed potential functional obsolescence based on square foot to bed ratio. VMG has conducted a survey of recently constructed acute care hospital facilities. The size-to-bed ratios indicated by these modern acute care hospital facilities were analyzed and compared to the size-to-bed ratio of the subject property. The results of the survey of recently constructed acute care hospital facilities are shown in the following table:

Acute Care Hospital Size-Bed Ratio Summary

Name	Address	City	State	Year Built	Building Size (Sq. Ft.)	No. of Beds	Size per Bed (Sq. Ft.)
Temecula Valley Hospital	31700 Temecula Pkwy.	Temecula	California	2013	177,600	140	1,269
Mercy Medical Center	333 Mercy Ave.	Merced	California	2010	267,000	186	1,435
Chinese Hospital	835 Jackson St	San Francisco	California	2015	99,181	76	1,305
Salem Hospital	890 Oak St., SE	Salem	Oregon	2009	350,000	381	919
Walnut Hill Physician's Hospital	7502 Greenville Ave	Dallas	Texas	2013	199,182	100	1,992
Loma Linda University Medical Center	28062 Baxter Rd	Murrieta	California	2011	248,706	106	2,346
Texas Regional Medical Center	231 S. Collins Rd	Sunnyvale	Texas	2008	117,715	70	1,682
Bay Area Regional Medical Center	200 Blossom Street	Webster	Texas	2008/2014	243,807	104	2,344
Forest Park Medical Center	5500 Frisco Square Blvd	Frisco	Texas	2012	137,000	54	2,537
Texas Childrens Hospital	(Proposed - 2017)	The Woodlands	Texas	2017	548,000	200	2,740
Grandview Hospital	800 Montclair Rd	Birmingham	Alabama	2015	1,000,000	372	2,688
Jennie Sealy Hospital	N/A	Galveston	Texas	2016	765,000	310	2,468
Forest Park Medical Center of Fort Worth	5400 Clearfork Main St.	Fort Worth	Texas	2014	150,600	54	2,789
Childrens Hospital of Savannah	Waters Avenue	Savannah	Georgia	2020	86,000	50	1,720
Crystal Clinic Orthopedic Hospital	3557 Embassy Pkwy	Akron	Ohio	2021	100,000	60	1,667
Lee County Hospital	270 Grand Island Dr.	Albany	Georgia	2021	100,000	50	2,000
Bellevue Medical Center	2510 Bellevue Medical Center Dr.	Bellevue	Nebraska	2010	266,527	100	2,665
						Min.	919
						Max.	2,789
						Avg.	2,033
						Median	2,000

As shown in the above survey, the recently constructed acute care hospital facilities indicate size-to-bed ratios ranging from 919 to 2,789 square feet per bed with an average of 2,033 square feet per bed. It is noted that some information published by developers and architectural firms feature a standard of 2,000 square feet per bed, though it is also noted that Kaiser Permanente has published guidelines in 2011 for a smaller, more efficient 150-bed hospital at 1,500 square feet per bed. The higher square foot per bed ratios tend to be large,

urban campuses which may include a significant amount of outpatient care and other services as part of the total square footage.

Additionally, it is noted that national occupancy rates tend to be in the mid-60s (percent) within the acute care hospital sector. It was reported during VMG's site visit that typical average daily census (ADC) is around **124.** We have calculated a functional obsolescence adjustment via "right sizing" the facility, summarized as follows.

Functional Obsolesence: Via ADC / Occupancy			
Licensed beds:	368	Sq Ft/Bed:	1,330
Square Feet:	489,573		
ADC Estimate:	124		

# of Beds Methodology			
Occupancy:	60%	65%	70%
Implied Bed Requirement:	207	191	177
Implied F.O. Adj. (Beds):	-44%	-48%	-52%

Sq Ft Per Bed Methodology			
Implied Bed Requirement:	207	191	177
Sq Ft Per Bed	1,800	1,800	1,800
Implied Size (Sq Ft)	372,600	343,800	318,600
Actual Size (Sq Ft), Hosp & Outbuildings	489,573	489,573	489,573
Implied F.O. Adj. Via % Diff.	-24%	-30%	-35%

Selected F.O. Adjustment:	40%

Considering the preceding, we have selected a functional obsolescence adjustment between the two indications of 40%.

ECONOMIC OBSOLESCENCE

Economic obsolescence ("EO") results from factors and influences that are outside of the property. Examples of economic obsolescence include government fees and regulations and market conditions that do not support development costs.

VMG's separate business valuation contains data related to transactions involving hospital going concerns (i.e. sales involving business enterprise, working capital, equipment, and real estate). Based on an analysis of the enterprise operations, we have included an adjustment for EO and 13% (please refer to the business valuation group analysis).

INDICATED VALUE OF IMPROVEMENTS

The following tables show the calculation of the depreciated cost of the subject property and pricing support for miscellaneous items and land improvements, as well as a summary of the Cost Approach as applied herein. As will be seen, we have included an adjustment based on $1,000 per square foot of certain building areas for seismic retrofit. The client indicated the costs could be as low as $80 million and possibly as high as $125 million (or more). Based on the historical seismic cost information we have seen at other similar properties, we have estimated the seismic costs at $1,000 per square foot.

Tri-City Medical Center (Hospital Campus)

Building Cost Development

As of September 26, 2025 *MVS DATE: September 2025*

BUILDINGS

Building Name		**Hospital - Main**		**Hospital - Outbuildings**		**New (Shell) Campus MOB**		**Business Dev. & OP Forensics - CONDO**		**PHF Building (Behavioral Health)**		**Off-Campus - 3617 Vista Way, #5**
Address		***4002 Vista Way***		***Varied***		***4004 Vista Way***		***3925 Waring Ct. Ste. A, B, & C***		***3996 Vista Way***		***3617 Vista Way***
Occupancy Number & Name	331	General Hospitals	344	Office Buildings	492	Shell Office	341	Medical Office Buildings	313	Convalescent Hospital	341	Medical Office Buildings
Section Number & Page	15	24	15	17	15	34	15	22	15	26	15	22
Construction Class & Quality	A	Average	D	Average	A	Excellent	D	Average	A	Good	D	Good
Gross Building Area (SF)		450,545		39,028		57,476		7,215		13,560		7,000
Average Perimeter (Linear Ft) (estimate)		N/A		Varied		675		N/A		620		370
Number of Floors & Height per Story (Ft)	Up to 5	N/A	Mostly 1	N/A	2	N/A	1	N/A	1	N/A	1	N/A
Base Cost - Square Foot		$430.00		$149.00		$248.00		$189.00		$393.00		$249.00
Refinements - Square Foot												
HVAC		$0.00		$0.00		$0.00		$0.00		$0.00		$0.00
Elevator		$0.00		-$3.23		$0.00		-$3.44		-$8.36		-$5.63
Sprinkler System		$2.93		$4.36		$5.58		$0.00		$5.92		$6.77
Basement	FN 1	$0.00		$0.00		$0.00		$0.00		$0.00		$0.00
Shell Space Adjustment	FN 2	$0.00		$0.00		$0.00		$0.00		$0.00		$0.00
Seismic	FN 3	$300.00		$0.00		$0.00		$0.00		$300.00		$0.00
		$732.93		**$150.13**		**$253.58**		**$185.56**		**$690.56**		**$250.14**
Refinements - Multipliers												
Number of Stories		1.000		1.000		1.000		1.000		1.000		1.000
Height per Story		1.000		1.000		1.000		1.000		1.000		1.000
Floor Area & Perimeter	FN 4	0.871	Typical	0.950		0.906	Typical	0.950		0.956		0.997
Current Cost Multiplier	S99P3	1.080		1.040		1.080		1.040		1.080		1.040
Local Cost Multiplier	S99P6 - SD	1.190		1.200		1.190		1.200		1.190		1.200
Net Multiplier		1.119		1.186		**1.164**		**1.186**		**1.229**		**1.244**
Replacement Cost New (CRN)												
Adjusted Cost - Square Foot		**$820.15**		**$178.05**		**$295.17**		**$220.07**		**$848.70**		**$311.17**
Extended Base Cost		$369,514,482		$6,948,935		$16,965,191		$1,587,805		$11,508,372		$2,178,190
Misc. Bldg. Components Pricing Support (see table)		$864,779		$0		$0		$0		$0		0
Subtotal		$370,379,261		$6,948,935		$16,965,191		$1,587,805		$11,508,372		$2,178,190
Soft Costs (Indirect)	**30.0%**	$111,113,778	**30.0%**	$2,084,681	**30.0%**	$5,089,557	**30.0%**	$476,342	**30.0%**	$3,452,512	**30.0%**	$653,457
Subtotal		$481,493,039		$9,033,616		$22,054,748		$2,064,147		$14,960,884		$2,831,647
Entrepreneurial Profit	**20.0%**	$96,298,608	**20.0%**	$1,806,723	**20.0%**	$4,410,950	**20.0%**	$412,829	**20.0%**	$2,992,177	**20.0%**	$566,329
CRN		$577,791,647		$10,840,339		$26,465,698		$2,476,976		$17,953,061		$3,397,976
CRN Rounded		**$577,790,000**		**$10,840,000**		**$26,470,000**		**$2,480,000**		**$17,950,000**		**$3,400,000**
CRN per Square Foot		**$1,282.42**		**$277.75**		**$460.54**		**$343.73**		**$1,323.75**		**$485.71**
Depreciation												
Year Built		Varied		Varied		2013		1976		2024		2008
Chronological (Physical) Age		N/A		N/A		12		49		1		17
Effective Age		35		29		10		30		1		15
Economic Life		45		45		50		35		50		40
Remaining Useful Life		10		16		40		5		49		25
Physical Depreciation (Age/Life)	77.8%	$449,520,620	64.4%	$6,980,960	20.0%	$5,294,000	85.7%	$2,125,360	2.0%	$359,000	37.5%	$1,275,000
CRN less Physical Depreciation		$128,269,380		$3,859,040		$21,176,000		$354,640		$17,591,000		$2,125,000
Functional Obsolescence	**40.0%**	$51,307,752	0.0%	$0	0.0%	$0	0.0%	$0	0.0%	$0	0.0%	$0
less Functional Obsolescence		$76,961,628		$3,859,040		$21,176,000		$354,640		$17,591,000		$2,125,000
Economic Obsolescence*	**13.0%**	$10,005,012	13.0%	$501,675	13.0%	$2,752,880	13.0%	$46,103	13.0%	$2,286,830	13.0%	$276,250
less Economic Obsolescence	.	$66,956,616		$3,357,365		$18,423,120		$308,537		$15,304,170	***FN 5***	$1,848,750
****Addressed in VMG's BEV report.***											***25.0%***	***$462,188***
Depreciated Cost		**$67,000,000**		**$3,360,000**		**$18,420,000**		**$310,000**		**$15,300,000**		**$460,000**
per Square Foot		**$148.71**		**$86.09**		**$320.48**		**$42.97**		**$1,128.32**		**$65.71**

Tri-City Medical Center (Hospital Campus)
Footnotes - Cost Approach - Building Cost Development

4002 Vista Way
Oceanside, California
As of September 26, 2025

Footnotes to Cost Approach

Footnote	Description
1	Hospital has lower level but it is fully finished out for clinical and administrative uses (thus, no adjustment was applied). Additionally, we note that the central plant building is separate from the main campus; the central plant building includes admin, plant area (boiler/chiller etc), as well as a cardiac wellness outpatient area - however, square footage breakdown of each of those areas was not provided. Therefore, we included the central plant/cardiac wellness building within the overall main hospital square footage (we would note that the base MVS RCN per sq ft for the General Hospital category would generally include the central plant area).
2	No shell space was noted in the primary hospital; the YOC 2013 on-campus MOB was in shell condition and was analyzed as such.
3	A seismic cost adjustment of $300/SF has been applied to the MVS base cost. The selected cost is based on VMG's cost benchmarking information. It is noted that some seismic cost data specific to retrofitting rather than new construction reflects higher costs per sq ft, as retrofitting is often more expensive.
4	Precise perimeter measurements for each floor and building were not available for the primary campus. VMG performed a measurement of the entire primary campus via aerial, resulting in approximately 200,000 SF of 1st fl and ~2,000 LF perimeter; utilizing MVS (100,000 SF and 1,000 LF perimeter), 0.871 was utilized.
5	The 25% allocation used for 3617 Vista Way considers that Tri-City owns 25% of that building and we have allocated 25% of the value to this property, with no minority discount.

MISCELLANEOUS BUILDING COMPONENTS & LAND IMPROVEMENTS

Tri-City Medical Center (Hospital Campus): 4002 Vista Way, Oceanside, California

MISC. BUILDING COMPONENTS COST PRICING SUPPORT

Description	Quantity	Unit	Unit Cost	Current Cost Multiplier	Local Multiplier	Total Cost	Source
Porte Cochere	880	SF	$175.00	1.080	1.190	$197,921	VMG Research - Contractor Interviews (Turner Construction et al)
Porte Cochere	1,733	SF	$175.00	1.080	1.190	$389,769	VMG Research - Contractor Interviews (Turner Construction et al)
Porte Cochere	1,232	SF	$175.00	1.080	1.190	$277,089	VMG Research - Contractor Interviews (Turner Construction et al)
	Replacement Cost New:					$864,779	

Note: sizes based upon estimates derived from appraiser's observations and aerial and plan measurements.

LAND IMPROVEMENTS COST DEVELOPMENT

Cost of Replacement New (CRN)	**3.0% (of Total Replacement Cost)**	**$19,167,900**
CRN Rounded		**$19,170,000**

Effective Age	10	
Economic Life	20	
Remaining Useful Life	10	
Physical Depreciation (Age/Life)	50.0%	$9,585,000
CRN less Physical Depreciation		$9,585,000
Functional Obsolescence	0.0%	$0
less Functional Obsolescence		$9,585,000
Economic Obsolescence	13.0%	$1,246,050
less Economic Obsolescence		$8,338,950
Depreciated Cost (Rounded)		**$8,340,000**

Notes

1) Exact square footage amounts for curbs, landscaping, and concrete were unknown. These were estimated by the appraiser.

2) As noted within our Appraisal Report, a 20-year life is typical for site improvements on a blended basis. Separate lives for each item were not utilized as the implied precision of affixing separate lives to each site improvement would not result in a materially different total value for the site improvements. Additionally, our treatment of the land improvements is similar to the buildings where an HVAC system has a different economic life than a foundation but both items are blended into a single building economic life.

Our value conclusion via the Cost Approach is summarized as follows.

Tri-City Medical Center (Hospital Campus)
Oceanside, California
Cost Approach Summary

As of September 26, 2025

#	Building Name	GBA (SF)	Eff. Age	Econ. Life	Physical Depreciation (Age/Life)	Cost of Replacement New (CRN)	Accrued Depreciation	CRN less Physical Depreciation (Rounded)	Less Functional Obsolescence	Less Economic Obsolescence	Total (Rounded)
1	**Hospital - Main**	450,545	35	45	77.78%	$577,790,000	$449,520,620	$128,270,000	$51,307,752	$10,005,012	$67,000,000
2	**Hospital - Outbuildings**	39,028	29	45	64.44%	$10,840,000	$6,980,960	$3,860,000	$0	$501,675	$3,360,000
3	**New (Shell) Campus MOB**	57,476	10	50	20.00%	$26,470,000	$5,294,000	$21,180,000	$0	$2,752,880	$18,420,000
4	**Business Dev. & OP Forensics**	7,215	30	35	85.71%	$2,480,000	$2,125,360	$350,000	$0	$46,103	$310,000
5	**3996 Vista Way**	13,560	1	50	2.00%	$17,950,000	$359,000	$17,590,000	$0	$2,286,830	$15,300,000
6	**3617 Vista Way**	7,000	17	40	37.50%	$3,400,000	$1,275,000	$2,130,000	$0	$276,250	***$460,000***
	TOTALS	*574,824*				*$638,930,000*	*$465,554,940*	*$173,380,000*	*$51,307,752*	*$15,868,750*	*$104,850,000*
	Land Improvements		10	20	50.00%	$19,170,000	$9,585,000	$9,585,000	$0	$1,246,050	$8,340,000

Total Buildings	$638,930,000	$465,554,940	$173,380,000	$51,307,752	$15,868,750	$104,850,000
Plus: Land Improvements	$19,170,000	$9,585,000	$9,585,000	$0	$1,246,050	$8,340,000
Total Improvements	$658,100,000	$475,139,940	$182,965,000	$51,307,752	$17,114,800	$113,190,000
Plus: Land Value	$48,150,000					$48,150,000
TOTAL	$706,250,000	*$1,229 per sq ft*				$161,340,000
			Rounded			***$161,300,000***

	Low	Mid	High
Indicated Value via Cost Approach, pre Seismic Adj.	**$156,500,000**	**$161,300,000**	**$166,100,000**
Less Seismic Compliance (Total)	**-$106,357,000**	**-$106,357,000**	**-$106,357,000**
Indicated Value via Cost Approach (adjusted)	**$50,143,000**	**$54,943,000**	**$59,743,000**
Rounded	$50,100,000	$54,900,000	$59,700,000

Cost – Test of Reasonableness

To test the reasonableness of our preceding cost analysis, VMG previously performed a cost benchmarking analysis utilizing Revista's published construction dataset, focused solely on hospital projects within the state of California, where development costs for hospitals are extremely high relative to national averages[3]. The benchmarking indicators from this dataset are presented in the following chart.

Cost Benchmarking Analysis - Indicators

	Building Size (SF)	Beds	Start Date	Completion Date	Cost ($)	Cost PSF ($)	Cost Per Bed ($)
5th Percentile	128,000	53	Jan-08	May-14	$80,000,000	$500	$647,500
10th Percentile	149,654	75	Feb-10	Nov-14	$117,160,000	$500	$780,752
25th Percentile	200,000	104	Jan-12	Dec-16	$180,000,000	$750	$1,548,913
Median	269,050	169	Apr-18	Aug-21	$314,000,000	$1,174	$2,754,498
Mean	379,947	186	Mar-17	May-21	$537,806,752	$1,397	$4,731,812
75th Percentile	435,900	253	Dec-21	Jul-25	$700,000,000	$1,708	$4,138,021
90th Percentile	732,000	315	Oct-23	May-27	$1,000,000,000	$2,437	$7,723,540
95th Percentile	908,000	348	Oct-24	Aug-29	$1,320,000,000	$2,855	$9,179,167

Notes:

(1) Construction data from Revista for all hospital projects within California, larger than 50,000 sq ft and above $50M in cost (in progress or completed). Not adjusted or verified by VMG Health.

(2) The variables depicted in the above chart are each independent of each other. For instance, the minimum size illustrated and the minimum cost PSF illustrated do not necessarily represent the same project; rather, the two figures represent the minimum for that specific indicator within the dataset.

N=89

The replacement cost new (RCN) indications per square foot derived from the above data range from a 10th percentile of $500/SF to a 90th percentile of $2,437/SF[4]. It is noted that these cost indications have not been adjusted for time. Furthermore, Revista's data features limited granularity; thus, it is unknown if many of the reported costs are inclusive of all-in costs or only some portion of costs (e.g. including or excluding soft costs, land acquisition costs, or equipment costs). Thus, the data is utilized as a test of reasonableness. Within the preceding cost approach, VMG's indicated replacement cost new (for solely the real estate, excluding equipment but including land) was **$706,250,000**, or **$1,229 per sq ft**. Considering the subject's location as well as the time period during which the benchmarking dataset was constructed, VMG's RCN indication is considered reasonable[5]. The data from which the preceding cost benchmarking analysis was developed is presented on the following pages.

[3] https://www.scripps.org/news_items/7609-the-high-cost-of-building-california-hospitals

[4] As is discussed later in this report, VMG is also aware of a confidential surgical hospital redevelopment project in southern California scheduled for construction in 2024-2025 which has a reported all-in development cost (including land and soft costs) of $2,482/SF for a ~55,000-square-foot facility.

[5] VMG also reviewed a 2019 study (the "Rand Study") performed by the Rand Corporation which showed a retrofitting cost for seismic upgrades for California hospitals ranging from a 5th percentile of $51,684 per bed to a 95th percentile of $1,853,037 per bed, with an average of $462,155 per bed. VMG has not (as of September 26, 2025) been provided with projected costs for seismic compliance for the subject, thus we were unable to compare the projected actual cost to range indicated by the Rand Corporation's study. The Rand Study also noted a per bed cost for new construction ranging from $800,526/bed to $6,685,466/bed, with an average of $3,068,767/bed (this average is between the mean and median noted by the Revista data).

Cost Benchmarking Analysis

No.	Property Name	Address	City	State	Building Size (SF)	Beds	Start Date	Completion Date	Cost ($)	Cost PSF ($)	Cost Per Bed ($)
1	SANTA BARBARA COTTAGE HOSPITAL	400 W PUEBLO ST	SANTA BARBARA	CA	713,000	N/A	Jun-06	Nov-18	$820,000,000	$1,150	N/A
2	MILLS PENINSULA MEDICAL CENTER	1501 TROUSDALE DR	BURLINGAME	CA	700,000	311	Jun-06	Jun-10	$618,000,000	$883	$1,987,138
3	SUTTER MEDICAL CENTER - OSE ADAMS MEDICAL PAVILION	2825 CAPITOL AVE	SACRAMENTO	CA	544,050	274	Jun-07	Aug-15	$62,000,000	$114	$226,277
4	SUTTER MEDICAL CENTER - ANDERSON LUCCHETTI WOMEN'S &	2825 CAPITOL AVE	SACRAMENTO	CA	395,241	242	Jun-07	Jun-15	$750,000,000	$1,898	$3,099,174
5	SEQUOIA HOSPITAL	170 ALAMEDA DE LAS PULGAS	REDWOOD CITY	CA	148,270	104	Nov-07	May-14	$275,000,000	$1,855	$2,644,231
6	WASHINGTON HOSPITAL	2000 MOWRY AVE	FREMONT	CA	200,000	N/A	Jun-08	Jun-12	$148,000,000	$740	N/A
7	SANTA CLARA VALLEY MEDICAL CENTER	751 S BASCOM AVE	SAN JOSE	CA	393,000	168	Sep-09	Dec-17	$465,000,000	$1,183	$2,767,857
8	ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL	1001 POTRERO AVE	SAN FRANCISCO	CA	360,000	284	Oct-09	May-16	$887,400,000	$2,465	$3,124,648
9	CHILDRENS HOSPITAL OF ORANGE COUNTY (CHOC)	1201 W LA VETA AVE	ORANGE	CA	426,000	N/A	Nov-09	Sep-15	$560,000,000	$1,315	N/A
10	HIGHLAND HOSPITAL	1411 E 31ST ST	OAKLAND	CA	450,000	169	Mar-10	Dec-19	$682,000,000	$1,516	$4,035,503
11	KAISER PERMANENTE SAN LEANDRO MEDICAL CENTER	2500 MERCED ST	SAN LEANDRO	CA	435,900	216	Apr-10	Jun-14	$600,000,000	$1,376	$2,777,778
12	MARIAN REGIONAL MEDICAL CENTER	1400 E CHURCH ST	SANTA MARIA	CA	239,560	191	Jun-10	Jun-12	$210,000,000	$877	$1,099,476
13	UCSF BENIOFF CHILDREN'S HOSPITAL AT MISSION BAY	1975 4TH ST	SAN FRANCISCO	CA	400,000	183	Oct-10	Feb-15	$683,000,000	$1,708	$3,732,240
14	UCSF BETTY IRENE MOORE WOMEN'S HOSPITAL	1855 4TH ST	SAN FRANCISCO	CA	184,000	36	Oct-10	Feb-15	$314,000,000	$1,707	$8,722,222
15	SUTTER SANTA ROSA REGIONAL HOSPITAL	30 MARK WEST SPRINGS RD	SANTA ROSA	CA	183,200	84	Oct-10	Oct-14	$284,000,000	$1,550	$3,380,952
16	KAISER PERMANENTE REDWOOD CITY HOSPITAL	1100 VETERANS BLVD	REDWOOD CITY	CA	280,000	213	Jan-11	Dec-14	$210,000,000	$750	$985,915
17	SAINT JUDE MEDICAL CENTER	101 E VALENCIA MESA DR	FULLERTON	CA	200,000	N/A	Feb-11	Dec-14	$312,000,000	$1,560	N/A
18	TORRANCE MEMORIAL MEDICAL CENTER	3330 LOMITA BLVD	TORRANCE	CA	390,000	256	Mar-11	Nov-14	$480,000,000	$1,231	$1,875,000
19	ADVENTIST HEALTH TULARE	869 N CHERRY ST	TULARE	CA	115,000	100	Jun-11	Dec-21	$135,000,000	$1,174	$1,350,000
20	KAISER OAKLAND MEDICAL CENTER	3600 BROADWAY	OAKLAND	CA	650,000	349	Aug-11	Jul-14	$961,319,681	$1,479	$2,754,498
21	COMMUNITY MEMORIAL HOSPITAL OF SAN BUENAVENTURA THE OCEAN	147 N BRENT	VENTURA	CA	355,000	250	Sep-11	Dec-18	$285,000,000	$803	$1,140,000
22	GOOD SAMARITAN HOSPITAL	1225 WILSHIRE BLVD	LOS ANGELES	CA	193,000	N/A	Oct-11	Dec-16	$80,000,000	$415	N/A
23	REGIONAL MEDICAL CENTER OF SAN JOSE	225 N JACKSON AVE	SAN JOSE	CA	700,000	N/A	Jan-12	Jan-14	$350,000,000	$500	N/A
24	JACOBS MEDICAL CENTER AT UC SAN DIEGO HEALTH	9300 CAMPUS POINT DR	LA JOLLA	CA	509,500	245	Jan-12	Nov-16	$943,000,000	$1,851	$3,848,980
25	RIDEOUT REGIONAL MEDICAL CENTER	726 4TH ST	MARYSVILLE	CA	220,000	104	Apr-12	Jan-17	$245,000,000	$1,114	$2,355,769
26	WEED ARMY COMMUNITY HOSPITAL	390 N LOOP RD	FORT IRWIN	CA	216,000	34	Sep-12	Sep-17	$211,000,000	$977	$6,205,882
27	SAN ANTONIO REGIONAL HOSPITAL	999 SAN BERNARDINO RD	UPLAND	CA	160,000	92	Oct-12	Jan-17	$160,000,000	$1,000	$1,739,130
28	RIVERSIDE COMMUNITY HOSPITAL	4445 MAGNOLIA AVE	RIVERSIDE	CA	292,000	N/A	Mar-13	Nov-17	$420,000,000	$1,438	N/A
29	STANFORD HOSPITAL (NEW)	500 PASTEUR DR	PALO ALTO	CA	824,000	368	May-13	Nov-19	$500,000,000	$607	$1,358,696
30	VENTURA COUNTY MEDICAL CENTER	300 HILLMONT AVE	VENTURA	CA	232,000	272	Jun-13	Jul-17	$305,000,000	$1,315	$1,121,324
31	LOS ROBLES REGIONAL MEDICAL CENTER	215 W JANSS RD	THOUSAND OAKS	CA	232,000	113	Jun-13	Dec-15	$245,000,000	$1,056	$2,168,142
32	MARTIN LUTHER KING JR COMMUNITY HOSPITAL	1680 E 120TH ST	LOS ANGELES	CA	280,000	120	Jul-13	Jul-15	$281,000,000	$1,004	$2,341,667
33	CHINESE HOSPITAL	845 JACKSON ST	SAN FRANCISCO	CA	141,000	76	Sep-13	May-16	$180,000,000	$1,277	$2,368,421
34	CALIFORNIA PACIFIC MEDICAL CENTER VAN NESS & GEARY	1101 VAN NESS AVE	SAN FRANCISCO	CA	740,000	274	Oct-13	Mar-19	$2,100,000,000	$2,838	$7,664,234
35	CENTINELA HOSPITAL MEDICAL CENTER	555 E HARDY ST	INGLEWOOD	CA	110,000	N/A	Mar-14	Mar-16	$55,000,000	$500	N/A
36	KAISER PERMANENTE SAN DIEGO MEDICAL CENTER	9455 CLAIREMONT MESA BLVD	SAN DIEGO	CA	617,000	321	Jun-14	Apr-17	$900,000,000	$1,459	$2,803,738
37	CALIFORNIA PACIFIC MEDICAL CENTER MISSION BERNAL CAMPUS	3555 CESAR CHAVEZ ST	SAN FRANCISCO	CA	215,000	120	Sep-14	Aug-18	$550,000,000	$2,558	$4,583,333
38	LUCILE PACKARD CHILDREN'S HOSPITAL AT STANFORD	725 WELCH RD	PALO ALTO	CA	521,000	149	Jan-15	Nov-17	$1,200,000,000	$2,303	$8,053,691
39	WASHINGTON HOSPITAL	2000 MOWRY AVE	FREMONT	CA	269,050	116	Feb-15	Sep-18	$339,029,752	$1,260	$2,922,670
40	UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND	747 52ND ST	OAKLAND	CA	183,000	N/A	Apr-15	Jun-20	$180,000,000	$984	N/A
41	LOMA LINDA UNIVERSITY MEDICAL CENTER	11234 ANDERSON ST	LOMA LINDA	CA	950,000	288	May-16	Aug-21	$1,200,000,000	$1,263	$4,166,667
42	MARINHEALTH MEDICAL CENTER	250 BON AIR RD	GREENBRAE	CA	260,000	190	Jul-16	Aug-20	$435,000,000	$1,673	$2,289,474
43	HENRY MAYO NEWHALL MEMORIAL HOSPITAL	23845 MCBEAN PKWY	VALENCIA	CA	160,000	142	Oct-16	Nov-19	$151,000,000	$944	$1,063,380
44	SHARP CHULA VISTA MEDICAL CENTER	751 MEDICAL CENTER CT	CHULA VISTA	CA	197,000	138	Nov-16	Oct-19	$244,000,000	$1,239	$1,768,116

Cost Benchmarking Analysis

No.	Property Name	Address	City	State	Building Size (SF)	Beds	Start Date	Completion Date	Cost ($)	Cost PSF ($)	Cost Per Bed ($)
45	EL CENTRO REGIONAL MEDICAL CENTER	1415 ROSS AVE	EL CENTRO	CA	200,000	N/A	Apr-18	May-20	$100,000,000	$500	N/A
46	CLOVIS COMMUNITY MEDICAL CENTER	2755 HERNDON AVE	CLOVIS	CA	250,000	144	May-18	Sep-23	$430,000,000	$1,720	$2,986,111
47	CHA HOLLYWOOD PRESBYTERIAN MEDICAL CENTER	1300 N VERMONT AVE	LOS ANGELES	CA	174,954	N/A	May-18	Nov-20	$291,000,000	$1,663	N/A
48	CALIFORNIA HOSPITAL MEDICAL CENTER	1401 S GRAND AVE	LOS ANGELES	CA	150,000	N/A	Jan-19	Aug-21	$215,000,000	$1,433	N/A
49	KAISER PERMANENTE - MURRIETA HOSPITAL	KELLER RD	MURRIETA	CA	845,000	114	Jul-19	Jul-23	$590,000,000	$698	$5,175,439
50	OROVILLE HOSPITAL	2767 OLIVE HWY	OROVILLE	CA	158,299	78	Oct-19	Nov-23	$200,000,000	$1,263	$2,564,103
51	PROVIDENCE CEDAR-SINAI TARZANA MEDICAL CENTER	18321 CLARK ST	TARZANA	CA	223,000	190	Feb-20	Aug-23	$542,000,000	$2,430	$2,852,632
52	KAISER RAILYARDS MEDICAL CENTER	RAILYARDS BLVD	SACRAMENTO	CA	303,000	300	Jun-20	Jun-24	$720,000,000	$2,376	$2,400,000
53	WASHINGTON HOSPITAL	2000 MOWRY AVE	FREMONT	CA	400,000	N/A	Jun-20	Jun-25	$350,000,000	$875	N/A
54	FRENCH HOSPITAL MEDICAL CENTER	1911 JOHNSON AVE	SAN LUIS OBISPO	CA	105,000	N/A	Jul-20	Jul-24	$125,000,000	$1,190	N/A
55	CITY OF HOPE CANCER HOSPITAL	FIVEPOINT	IRVINE	CA	400,000	73	Dec-20	Jun-25	$700,000,000	$1,750	$9,589,041
56	HARBOR UCLA HOSPITAL (REPLACEMENT)	1000 W CARSON ST	TORRANCE	CA	468,000	346	Dec-20	Jun-27	$893,000,000	$1,908	$2,580,925
57	KAISER SAN MARCOS HOSPITAL	400 CRAVEN RD	SAN DIEGO	CA	300,000	206	Dec-20	Dec-23	$150,000,000	$500	$728,155
58	SCRIPPS MEMORIAL HOSPITAL LA JOLLA	9888 GENESEE AVE	LA JOLLA	CA	401,000	332	Apr-21	May-24	$200,000,000	$499	$602,410
59	SCRIPPS MERCY HOSPITAL CHULA VISTA	435 H ST	CHULA VISTA	CA	250,000	N/A	Jun-21	Jun-24	$125,000,000	$500	N/A
60	SCRIPPS GREEN HOSPITAL	10666 N TORREY PINES RD	LA JOLLA	CA	250,000	N/A	Jun-21	Jun-24	$125,000,000	$500	N/A
61	SETON MEDICAL CENTER	1900 SULLIVAN AVE	DALY CITY	CA	720,000	192	Aug-21	Aug-23	$360,000,000	$500	$1,875,000
62	CEDARS-SINAI MARINA DEL REY HOSPITAL	4650 LINCOLN BLVD	MARINA DEL REY	CA	269,000	133	Oct-21	Aug-26	$100,000,000	$372	$751,880
63	UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND	747 52ND ST	OAKLAND	CA	400,000	N/A	Oct-21	Oct-25	$270,000,000	$675	N/A
64	INLAND VALLEY MEDICAL CENTER	36485 INLAND VALLEY DR	WILDOMAR	CA	800,000	N/A	Oct-21	May-24	$400,000,000	$500	N/A
65	UNIVERSITY OF CALIFORNIA DAVIS MEDICAL CENTER	2315 STOCKTON BLVD	SACRAMENTO	CA	1,000,000	400	Nov-21	Nov-30	$3,750,000,000	$3,750	$9,375,000
66	UC MEDICAL CENTER - IRVINE	BIRCH ST & JAMBOREE RD	IRVINE	CA	350,000	144	Nov-21	Sep-25	$807,000,000	$2,306	$5,604,167
67	ADVENTIST HEALTH BAKERSFIELD HOSPITAL NORTHWEST	COFFEE RD & BRIMHALL RD	BAKERSFIELD	CA	250,000	200	Dec-21	Dec-24	$125,000,000	$500	$625,000
68	MERCY HOSPITAL SOUTHWEST	400 OLD RIVER RD	BAKERSFIELD	CA	160,000	120	Mar-22	Mar-24	$350,000,000	$2,188	$2,916,667
69	EMANATE HEALTH QUEEN OF THE VALLEY HOSPITAL	1115 S SUNSET AVE	WEST COVINA	CA	120,000	84	Apr-22	May-24	$99,000,000	$825	$1,178,571
70	HOAG SUN FAMILY HOSPITAL IRVINE	16200 SAND CANYON AVE	IRVINE	CA	120,000	155	Oct-22	Oct-25	$1,000,000,000	$8,333	$6,451,613
71	MERCY HOSPITAL OF FOLSOM	1650 CREEKSIDE DR	FOLSOM	CA	140,000	N/A	Nov-22	Nov-24	$70,000,000	$500	N/A
72	KAISER PERMANENTE ROSEVILLE MEDICAL CENTER	1600 EUREKA RD	ROSEVILLE	CA	272,000	174	Apr-23	Apr-27	$1,000,000,000	$3,676	$5,747,126
73	SCRIPPS MEMORIAL HOSPITAL ENCINITAS	354 SANTA FE DR	ENCINITAS	CA	224,000	64	Jun-23	Jun-25	$263,000,000	$1,174	$4,109,375
74	KAISER PERMANENTE RIVERSIDE MEDICAL CENTER	10800 MAGNOLIA AVE	RIVERSIDE	CA	291,494	72	Jul-23	Jul-25	$735,400,000	$2,523	$10,213,889
75	DIGNITY HEALTH ELK GROVE HOSPITAL	8220 WYMARK DR	ELK GROVE	CA	200,000	100	Aug-23	Aug-26	$230,000,000	$1,150	$2,300,000
76	KAISER PERMANENTE SAN JOSE MEDICAL CENTER (REPLACEMENT)	284 HOSPITAL PKWY	SAN JOSE	CA	242,900	297	Aug-23	Aug-25	$121,450,000	$500	$408,923
77	LOMA LINDA UNIVERSITY MEDICAL CENTER	11234 ANDERSON ST	LOMA LINDA	CA	158,823	48	Sep-23	Sep-25	$135,000,000	$850	$2,812,500
78	CNU NORTH NATOMAS MEDICAL CENTER	1 SPORTS PKWY	SACRAMENTO	CA	730,000	263	Sep-23	Sep-25	$1,500,000,000	$2,055	$5,703,422
79	HENRY MAYO NEWHALL MEMORIAL HOSPITAL	23845 MCBEAN PKWY	VALENCIA	CA	200,000	N/A	Sep-23	Sep-25	$170,000,000	$850	N/A
80	ANTELOPE VALLEY MEDICAL CENTER (REPLACEMENT)	AVENUE J W	LANCASTER	CA	356,000	230	Oct-23	Oct-25	$800,000,000	$2,247	$3,478,261
81	UCSF HELEN DILLER MEDICAL CENTER (REPLACEMENT)	PARNASSUS AVE	SAN FRANCISCO	CA	1,500,000	628	Nov-23	Nov-30	$4,300,000,000	$2,867	$6,847,134
82	RADY CHILDREN'S HOSPITAL	3020 CHILDRENS WAY	SAN DIEGO	CA	1,647,058	14	Nov-23	Nov-27	$1,400,000,000	$850	$100,000,000
83	PROVIDENCE SOUTHERN CALIFORNIA - SAINT MARY MEDICAL	AMARGOSA RD	VICTORVILLE	CA	249,376	128	Jun-24	Jun-28	$1,000,000,000	$4,010	$7,812,500
84	SCRIPPS MERCY HOSPITAL	4077 5TH AVE	SAN DIEGO	CA	1,078,590	N/A	Jun-24	Jun-26	$916,801,500	$850	N/A
85	KAWEAH DELTA MEDICAL CENTER (REPLACEMENT)	421 ACEQUIA ST	VISALIA	CA	550,000	240	Feb-25	Jun-30	$550,000,000	$1,000	$2,291,667
86	KAISER PERMANENTE - DUBLIN HOSPITAL	NEXT TO INTERSTATE 580	DUBLIN	CA	400,000	N/A	Mar-25	Mar-35	$300,000,000	$750	N/A
87	CANYON SPRINGS HEALTHCARE CAMPUS HOSPITAL	EUCALYPTUS AVE & DAY ST	RIVERSIDE	CA	224,000	186	May-25	May-27	$190,400,000	$850	$1,023,656
88	DIGNITY HEALTH FOLSOM RANCH MEDICAL CENTER	E BIDWELL ST & ALDER CREEK PKV	FOLSOM	CA	160,000	100	Jun-25	Jun-28	$80,000,000	$500	$800,000
89	GILL WOMEN'S MEDICAL CENTER	11000 N WEST LN	LODI	CA	140,000	100	Jan-30	Jan-32	$70,000,000	$500	$700,000

Note: construction data may be estimated (sourced from Revista and neither adjusted nor confirmed by VMG)

SALES COMPARISON APPROACH

To estimate the Fair Market Value in the subject property via the Sales Comparison Approach, a search was conducted for arm's length sales of comparable properties. The selected comparable improved properties are generally considered to provide a range of unit prices within which the current real estate market is operating. Adjustments are then typically made to account for the differences between the subject property and the market comparables. Each of the market indicators is adjusted for: 1) property rights conveyed; 2) financing terms; 3) conditions of sale; 4) expenditures after sale; 5) non-realty items; 6) market conditions (time); 7) location; and 8) physical characteristics.

Tri-City Medical Center (Hospital Campus)
Improved Sales Summary

	Subject Property	Improved Sale No. 1	Improved Sale No. 2	Improved Sale No. 3	Improved Sale No. 4	Improved Sale No. 5
Name	Tri-City Medical Center (Hospital Campus)	Parkview Community Hospital	Hoag Hospital Irvine	Inland Valley Medical Campus	St. Francis Medical Center	Bakersfield Heart Hospital
Address	4002 Vista Way	3865 Jackson Street	16200 Sand Canyon Avenue	36485 Inland Valley Drive	3630 E. Imperial Hwy	3001 Sillect Ave.
City	Oceanside	Riverside	Irvine	Wildomar	Lynwood	Bakersfield
State	CA	California	California	California	California	California
Property Type		Acute Care Hospital	Acute Care Hospital	Acute Care Hospital	Acute Care Hospital	Surgical Hospital
Transaction Date		7/9/2019	5/28/2021	5/12/2022	8/13/2020	5/31/2023
Net Rentable Area:	574,824	167,421	239,559	164,377	587,291	85,971
Land Acres	34.400	9.800	14.910	13.160	11.417	9.350
Land-to-Building Ratio	2.64	1.29	2.71	3.49	0.85	4.74
Parking	Surface	Surface	Surface	Surface	Parking Garage and Surface	Surface
Year Built	1961 - 1990	1959-1978-2019	1990	2009	1941, 1989-2000	2000
Sale Price		$49,000,000	$215,700,000	$79,600,000	$300,000,000	$55,216,000
Price per SF		$292.68	$900.40	$484.25	$510.82	$642.26
Capitalization Rate		N/A	N/A	3.33%	N/A	6.50%
NOI per SF		N/A	N/A	$16.11	N/A	$41.75
No. of Beds:	368	193	154	130	384	47
Sq. Ft. Per Bed:	1,562	867	1,556	1,264	1,529	1,829
Price per Bed		$253,886	$1,400,649	$612,308	$781,250	$1,174,809
Net Revenue1		$151,914,300	N/A	N/A	$541,248,116	$65,003,157
Net Revenue per Bed		N/A	N/A	N/A	$1,409,500	$1,383,046
Operating Margin1		-1.0%	N/A	N/A	7.2%	-14.1%
EBITDAR1		$5,261,004	N/A	N/A	$82,004,161	-$14,763,608
EBITDAR Per Bed		$27,259	N/A	N/A	$213,553	-$314,119

(1)Subject data taken from provided financials. Comparable data provided by American Hospital Directory and was not adjusted. Data was taken from closest reporting period prior to sale date.

Tri-City Medical Center (Hospital Campus) Improved Sales Adjustment Grid						
	Subject Property	**Improved Sale No. 1**	**Improved Sale No. 2**	**Improved Sale No. 3**	**Improved Sale No. 4**	**Improved Sale No. 5**
Name		Parkview Community Hospital	Hoag Hospital Irvine	Inland Valley Medical Campus	St. Francis Medical Center	Bakersfield Heart Hospital
Address	4002 Vista Way	3865 Jackson Street	16200 Sand Canyon Avenue	36485 Inland Valley Drive	3630 E. Imperial Hwy	3001 Sillect Ave.
City	Oceanside	Riverside	Irvine	Wildomar	Lynwood	Bakersfield
State	CA	California	California	California	California	California
Sale Price per SF		*$292.68*	*$900.40*	*$484.25*	*$510.82*	*$642.26*
Property Rights Conveyed		0%	0%	0%	0%	0%
Adjusted Sale Price per SF		*$292.68*	*$900.40*	*$484.25*	*$510.82*	*$642.26*
Financing Terms		0%	0%	0%	0%	0%
Adjusted Sale Price per SF		*$292.68*	*$900.40*	*$484.25*	*$510.82*	*$642.26*
Conditions of Sale		0%	0%	0%	0%	0%
Adjusted Sale Price per SF		*$292.68*	*$900.40*	*$484.25*	*$510.82*	*$642.26*
Expenditures After Sale		$0.00	$0.00	$0.00	$0.00	$0.00
Non-Realty Items		$0.00	$0.00	$0.00	$0.00	$0.00
Adjusted Sale Price per SF		*$292.68*	*$900.40*	*$484.25*	*$510.82*	*$642.26*
Market Conditions	9/26/2025	6%	4%	3%	5%	2%
Adjusted Sale Price per SF		*$310.24*	*$936.42*	*$498.78*	*$536.36*	*$655.11*
Location/Physical Adjustments						
Location		0%	-5%	10%	0%	5%
Age/Condition		-10%	-40%	-40%	-25%	-25%
Construction Quality		0%	-5%	-5%	-5%	-5%
Hospital Percentage		5%	10%	0%	0%	0%
Functional Issues		10%	0%	0%	0%	0%
Land-to-Building Ratio		0%	0%	0%	5%	0%
Building Size (SF)	574,824	0%	0%	0%	0%	-5%
Parking		0%	0%	0%	-5%	0%
Operational Indicators		0%	0%	0%	0%	0%
Net Adjustments		5%	-40%	-35%	-30%	-30%
Adjusted Sale Price		***$325.75***	***$561.85***	***$324.21***	***$375.45***	***$458.58***

Adjusted Unit Indicators (Per SF of GBA)			**Concluded Range of Value**		
Population Size	5		**Low**	**Mid**	**High**
Minimum Adjusted Unit Price:	$324.21	***PSF:***	**$320.00**	**$330.00**	**$340.00**
Maximum Adjusted Unit Price:	$561.85	**Total (Rounded):**	**$183,900,000**	**$189,700,000**	**$195,400,000**
Median Adjusted Unit Price:	$375.45	***Seismic Adjustment***	**-$106,357,000**	**-$106,357,000**	**-$106,357,000**
Mean Adjusted Unit Price:	$409.17	***Indicated Value***	**$77,500,000**	**$83,300,000**	**$89,000,000**

The range of price per square foot observed in the above dataset is from $324.41/SF to $561.85/SF, with the unit value concluded toward the lower end of the range at $320 to $340 psf of building area. It is noted that seismic requirements can have a dramatic effect on the value of hospital real estate in California.

INCOME APPROACH

Income-producing real estate is a capital good which is typically bought and sold primarily on the basis of the net income produced from the property. In all economic and investment analyses, of which real estate appraisal is an integral part, the value of a capital good is established and measured by calculating, as of a particular date, the present value of the anticipated future benefits (all sources of net revenue) to the owner over a specified period.

The Income Capitalization Approach is applied to analyze a property's capacity to generate benefits and converts these benefits into an indication of value. Application of this approach begins with the estimation of the potential gross income a property is capable of generating. Income levels may then be adjusted for vacancy and collection losses, resulting in the effective gross income. The applicable expenses of operating the property are then deducted from the effective gross income resulting in the net operating income estimate (NOI).

Direct capitalization uses a single year's stabilized NOI as a basis for a value indication by dividing the income by a capitalization rate. The rate chosen accounts for a recapture of the investment by the investor and should reflect all factors that influence the value of the property, such as tenant quality, property condition, neighborhood change, market trends, interest rates, and inflation. The rate may be extracted from local market transactions or, when transaction evidence is lacking, obtained from trade sources.

A discounted cash flow analysis focuses on the operating cash flows expected from the property and the proceeds of a hypothetical sale at the end of a holding period (the reversion). The cash flows and reversion are discounted to their present values using a market-derived discount rate and are added together to obtain a value indication. Because benefits to be received in the future are worth less than the same benefits received in the present, this method weights income in the early years more heavily than the income and the sale proceeds to be received later. The strength of the discounted cash flow method is its ability to recognize variations in projected net income, such as those caused by inflation, stepped leases, neighborhood change, or tenant turnover. Its weakness is that it requires many judgments regarding the actions of likely buyers and sellers of the property in the future.

In some situations, both methods yield a similar result. The discounted cash flow method is typically more appropriate for the analysis of investment properties with multiple or long-term leases, particularly leases with cancellation clauses or renewal options. It is especially useful for multi-tenant properties in volatile markets. The direct capitalization method is normally more appropriate for single-tenant properties and/or properties with relatively stable operating histories and expectations.

Considering that the Subject Property is not subject to a long-term lease (and considering the expected significant renovation and seismic retrofitting costs), we have not performed an Income Approach within this analysis.

VMG's analysis of the business enterprise contains data related to transactions involving hospital going concerns (i.e. sales involving business enterprise, working capital, equipment, and real estate). It should be noted that, in some instances, hospital acquisitions occur at prices (relative to net revenue or EBITDA) that appear disconnected from the financial performance; these transactions can be driven by underlying real estate values, well-located facilities that are attractive to buyers for strategic/defensive purposes, or other factors.

Carlsbad Properties – Wellness/MOB

VMG also performed a valuation of the Carlsbad Wellness/MOB buildings. Our valuation analysis for these properties is presented as follows.

Cost Approach

Tri-City Medical Center (Carlsbad Properties)
Building Cost Development

As of September 26, 2025 *MVS DATE: Setember 2025*

BUILDINGS

Building Name		**MOB - 6250 El Camino Real**		**MOB - 6260 El Camino Real**
Address		***6250 El Camino Real***		***6260 El Camino Real***
Occupancy Number & Name	341	Medical Office Buildings	341	Medical Office Buildings
Section Number & Page	15	22	15	22
Construction Class & Quality	A	Good	A	Good
Gross Building Area (SF)		57,252		23,863
Average Perimeter (Linear Ft) (estimate)		800		480
Number of Floors & Height per Story (Ft)	2	N/A	2	N/A
	(35k sf 1st Fl footprint)		(14k sf footprint)	
Base Cost - Square Foot		$351.00		$351.00
Refinements - Square Foot				
HVAC		$0.00		$0.00
Elevator		$0.00		$0.00
Sprinkler System		$4.83		$5.64
Basement		$0.00		$0.00
Shell Space Adjustment		$0.00	FN 2	-$46.35
Misc.		$0.00		$0.00
		$355.83		**$310.29**
Refinements - Multipliers				
Number of Stories		1.000		1.000
Height per Story		1.000		1.000
Floor Area & Perimeter	FN 1	0.904	FN 1	0.938
Current Cost Multiplier	S99P3	1.080		1.080
Local Cost Multiplier	S99P6 SD	1.190		1.190
Net Multiplier		1.162		1.206
Replacement Cost New (CRN)				
Adjusted Cost - Square Foot		**$413.47**		**$374.21**
Extended Base Cost		$23,671,984		$8,929,773
Misc. Bldg. Components Pricing Support (see table)		$0		$0
Subtotal		$23,671,984		$8,929,773
Soft Costs (Indirect)	**30.0%**	$7,101,595	**30.0%**	$2,678,932
Subtotal		$30,773,579		$11,608,705
Entrepreneurial Profit	**20.0%**	$6,154,716	**20.0%**	$2,321,741
CRN		$36,928,295		$13,930,446
CRN Rounded		**$36,930,000**		**$13,930,000**
CRN per Square Foot		**$645.04**		**$583.75**
Depreciation				
Year Built		2008		2010
Chronological (Physical) Age		17		15
Effective Age		10		10
Economic Life		50		50
Remaining Useful Life		40		40
Physical Depreciation (Age/Life)	20.0%	$7,386,000	20.0%	$2,786,000
CRN less Physical Depreciation		$29,544,000		$11,144,000
Functional Obsolescence	**0.0%**	$0	0.0%	$0
less Functional Obsolescence		$29,544,000		$11,144,000
Economic Obsolescence	**0.0%**	$0	0.0%	$0
less Economic Obsolescence	.	$29,544,000		$11,144,000
Depreciated Cost		**$29,500,000**		**$11,140,000**
per Square Foot		**$515.27**		**$466.83**

Tri-City Medical Center (Carlsbad Properties)
Footnotes - Cost Approach - Building Cost Development

6250 El Camino Real
Carlsbad, California
As of September 26, 2025

Footnotes to Cost Approach

Footnote	Description
1	Perimeter adjustment was applied based on aerial measurement for the north building (6250 El Camino Real - 800 LF perimeter for 35k sq ft 1st FL footprint) and the south building (6260 El Camino Real - 480 LF and ~14k sq ft 1st FL footprint).
2	We understand that the south building (6260 El Camino Real) has ~7k sq ft of shell space. Class A Good Shell per MVS = $193/SF. Adjustment calculated as follows: ($351/SF minus $193/SF = $158/SF. $158/SF x 7,000 sq ft = $1,106,000 / 23,863 SF = $46.35/SF negative adjustment).

For the land value we have relied on the comparable sales presented earlier and have concluded the unit value at $32 psf, as used in the prior analysis of the main campus. The underlying land value is as follows, which is included in the Cost Approach Summary.

LAND VALUATION

Land Area (Square Feet)			Concluded Value (Square Feet)		Concluded Value
334,976	sf	x	$32.00	=	$10,720,000
334,976			**Rounded**	=	**$10,720,000**

Tri-City Medical Center (Carlsbad Properties)
Carlsbad, California
Cost Approach Summary

As of September 26, 2025

#	Building Name	GBA (Sq. Ft.)	Effective Age	Economic Life	Physical Depreciation (Age/Life)	Cost of Replacement New (CRN)	Accrued Depreciation	CRN less Physical Depreciation (Rounded)	Less Functional Obsolescence	less Economic Obsolescence	Total (Rounded)
1	**MOB - 6250 El Camino Real**	57,252	10	50	20.00%	$36,930,000	$7,386,000	$29,540,000	$0	$0	$29,500,000
2	**MOB - 6260 El Camino Real**	23,863	10	50	20.00%	$13,930,000	$2,786,000	$11,140,000	$0	$0	$11,140,000
	TOTALS	*81,115*				*$50,860,000*	*$10,172,000*	*$40,680,000*	*$0*	*$0*	*$40,640,000*
	Land Improvements		10	20	50.00%	$2,540,000	$1,270,000	$1,270,000	$0	$0	$1,270,000

Total Buildings	$50,860,000	$10,172,000	$40,680,000	$0	$0	$40,640,000
Plus: Land Improvements	$2,540,000	$1,270,000	$1,270,000	$0	$0	$1,270,000
Total Improvements	$53,400,000	$11,442,000	$41,950,000	$0	$0	$41,910,000
Plus: Land Value	$10,720,000					$10,720,000
TOTAL	$64,120,000					$52,630,000
			Rounded			***$52,600,000***
	Indicated Value Range (Rounded)					**$50,000,000 To $55,200,000**

As illustrated above, the midpoint indication via the Cost Approach was **$52,600,000, or $648.46 per square foot.** VMG analyzed the reasonableness of this indication via both rental data as well as sale data for MOBs in the area.

The comparable data utilized is presented as follows.

MOB Sale and Rent Comps

MOB: Sale Data

#	Name	Address	City	State	Sale Date	Sq Ft	Sale Price	$/SF	Cap Rate	NOI/SF/Yr	NOI/SF/Mo
1	Madison Medical Center	1955 Citracado Pky	Escondido	CA	Nov-21	44,261	$26,000,000	$587.42	5.20%	$30.55	$2.55
2	UCSD Medical Building	330 Lewis St	San Diego	CA	Jan-21	25,653	$17,200,000	$670.49	5.40%	$36.21	$3.02
3	Pomerado OP Pavilion	15611 Pomerado Rd	Poway	CA	May-21	160,979	$102,700,000	$637.97	N/A	N/A	N/A
4	Palomar Health Phase II	2130 W Citracado Pky	Escondido	CA	Mar-21	80,064	$53,600,000	$669.46	5.25%	$35.15	$2.93
5	Torrey Hills Medical Plaza	4765 Carmel Mtn Rd	San Diego	CA	Dec-20	47,596	$37,400,000	$785.78	5.20%	$40.86	$3.41
6	Vista Medical Plaza	2067 W Vista Way	Vista	CA	Jul-21	54,703	$26,750,000	$489.00	N/A	N/A	N/A
7	Anchor MOB	9095 Rio San Diego Dr	San Diego	CA	Apr-21	81,236	$25,300,000	$311.44	5.80%	$18.06	$1.51
8	Tri-City Medical Building	3998 Vista Way	Oceanside	CA	Oct-23	37,488	$12,500,000	$333.44	N/A	N/A	N/A
9	Tri-City Medical Arts Bldg	161 Thunder Dr	Vista	CA	Dec-21	33,914	$8,300,000	$244.74	N/A	N/A	N/A
10	Madison Place	2111 S El Camino Real	Oceanside	CA	Mar-23	10,538	$2,910,000	$276.14	N/A	N/A	N/A
11	Fresenius	3300 Vista Way	Oceanside	CA	Feb-22	13,036	$7,140,000	$547.71	6.58%	$36.04	$3.00
12	Sycamore Health Center	910 Sycamore Ave	Vista	CA	Dec-21	20,282	$11,250,000	$554.68	N/A	N/A	N/A
13	Pomerado Prof.	15706 Pomerado Rd	Poway	CA	Jul-20	47,188	$17,000,000	$360.26	5.80%	$20.90	$1.74
14	National City Medical Center	22 W 35th St	National City	CA	May-25	19,717	$9,050,000	$458.99	9.15%	$42.00	$3.50
15	Medical Office Building	7808 Clairemont Mesa Blvd	San Diego	CA	Aug-24	11,794	$5,700,000	$483.30	N/A	N/A	N/A
16	Medical Office Building	875 El Cajon Blvd	El Cajon	CA	Feb-25	42,824	$22,385,500	$522.73	N/A	N/A	N/A

Min	Jul-20	10,538	$2,910,000	$244.74	5.20%	$18.06	$1.51
Median	Nov-21	40,156	$17,100,000	$505.87	5.60%	$35.59	$2.97
Mean	May-22	45,705	$24,074,094	$495.85	6.05%	$32.47	$2.71
Max	May-25	160,979	$102,700,000	$785.78	9.15%	$42.00	$3.50

As illustrated in the preceding chart, the sale data ranged from $244.74/SF to $785.78/SF, with a median and mean of $505.87/SF and $495.85/SF, respectively. Considering the age, condition, quality, and occupancy of the MOB subject buildings in Carlsbad, the preceding indication of value via the Cost Approach was considered reasonable relative to the sales data.

Additionally, we note that the in-place NOIs per square foot within the preceding dataset of sales transactions ranged from $1.51/SF to $3.50/SF/Mo. We reviewed additional rent rate data, as follows.

MOB: Rent Data

#	Address	City	State	Rent Date	Sq Ft (Bldg)	Sq Ft (Suite)	YOC	$/SF/Mo, NNN	Comments
1	2125 Citracado Pky	Escondido	CA	Mar-22	75,000	21,286	2018	$2.95	$70/SF TIA, 12 mo free, 10 yr term, 2.8% esc. Bldg sold in Feb 2019 for $47.3M ($630.67/SF) at a 5.1% cap rate.
2	3144 El Camino Real	Carlsbad	CA	May-19	27,894	1,797	2005	$3.30	$0/SF TIA, 2 mo free, 3% esc., 5 yr term.
3	17190 Bernardo Center Dr	San Diego	CA	May-19	66,769	9,306	1974 / 2008	$3.54	$4.04/SF MG (adj to $3.54/SF NNN equiv); $0/SF TIA, 0 mo free, no esc.
4	9095 Rio San Diego Dr	San Diego	CA	Apr-23	81,236	Varied	2005	$3.10	Building sold in Apr 2021 for $25.3m at reported 5.8% cap rate and 81% occ. Thus, in place NOI for occupied space of $22.30/SF. Bldg purchased to convert from POB to MOB. Apr 2023 asking rate was $3.10/SF/Mo NNN, w/ LL offering $150/SF in TIs for 10 yr term. Esc 3-4% annually.
5	4033 3rd Ave	San Diego	CA	Apr-20	31,605	1,735	1990	$2.56	1990 YOC bldg that had 1,735 sq ft spac leased in Apr 2020 for $2.56/SF/Mo NNN with 3.0% esc for 3 yr term.
6	7625-7675 Mesa College Dr	San Diego	CA	May-22	24,900	3,167	1996 / 2014	$3.57	This building was remodeled in ~2014 after being constructed in 1996. 2,082 sq ft shell space being marketed for lease for $3/SF/Mo NNN in mid yr 2023. Previously, 3,167 sq ft space leased for 5 yr term for $3.57/SF NNN with $75/SF TIA, 0 months free rent, and 3% esc.

Min	May-19	24,900	1,735	1990	$2.56
Median	Mar-21	49,187	3,167	2005	$3.20
Mean	Feb-21	51,234	7,458	2005	$3.17
Max	Apr-23	81,236	21,286	2018	$3.57

Utilizing the preceding rental rate data, we selected a rent rate above the median indication (considering that the two subject MOBs feature good construction quality and were built in 2008-2009). The selected rent rate indication was then utilized within our direct capitalization analysis, which is presented on the following table. We have also considered vacancy and collection loss (10%), along with replacement reserves and management fees, plus potential expenses during vacancy. The cap rate is based on the sales and market data, concluded at 6.0% to 7.0%.

Direct Capitalization Approach
Tri-City Medical Center (Carlsbad Properties)
6250 El Camino Real
Carlsbad, California

NRA:	81,115 Square Feet					
Potential Gross Income (Building):	81,115 S.F.	@	$4.00 P.S.F. =			$3,893,520
Less Vacancy and Credit Loss:				10.0%	-389,352	
Effective Gross Income:						$3,504,168
Expenses:						
(Non-reimbursable)						
Misc./Replacement reserves	81,115	@	$0.50 P.S.F. =		-40,558	
Management	as % of EGI	@	3.0% =		-105,125	
						-145,683
(Reimbursable)						
Opex:	81,115 S.F.	@	$15.00 P.S.F. =		1,216,725	
(Taxes, Ins., Util, R&M, R&G, Jan., Sec.):						
					1,216,725	
				Vacancy Factor @	10%	
						-121,673
					Net Operating Income	$3,236,812
					Overall Capitalization Rate	6.00%
					Indicated Value	$53,946,867
					Rounded	**$53,900,000**
					Rounded Value/SF	**$664.49**
					Midpoint:	6.50%
					Indicated Value	$49,797,108
					Indicated Midpoint Value (Rounded):	***$49,800,000***
					Rounded Value/SF	***$613.94***
					Overall Capitalization Rate	7.00%
					Indicated Value	$46,240,171
					Rounded	**$46,200,000**
					Rounded Value/SF	**$569.56**

Value Reconciliation

Within this analysis, we placed primary emphasis on the Cost Approach, with the Sales Approach (and, in the case of the Carlsbad MOBs, the Income Approach) serving as a test of reasonableness. Our value conclusions are summarized in the following table.

SUMMARY OF VALUE CONCLUSIONS

Tri City Medical Campus - Primary Campus - Oceanside		
		FMV Conclusion
	Indicated Value, pre Seismic Adjustment	**$161,300,000**
	Less Seismic Adjustment (Total)[1]	**-$106,357,000**
	Rounded	**$54,900,000**
Sq Ft = 574,824 (Bldg)	*per sq ft*	*$95.51*
Acres = 34.96 (Land)		
	Land Value (Included Above):	$48,150,000
	Value Indication w/o Land Value:	$6,750,000

Tri City Medical Campus - Wellness Center / MOB - Carlsbad		
		FMV Conclusion
	Indicated Value	**$50,000,000**
	Less Seismic Compliance	N/A
	Indicated Value (adjusted)	**$50,000,000**
	Rounded	**$50,000,000**
Sq Ft = 81,863 (Bldg)	*per sq ft*	*$610.78*
Acres = 7.69 (Land)		
	Land Value (Included Above):	$10,720,000
	Value Indication w/o Land Value:	$39,280,000

1) Seismic retrofit costs are based on the combined 106,357 square feet for the Center Tower (54,380 sq ft), South Tower (48,715 sq ft), and Electrical Building (3,262 sq ft). Cuningham indicated that these three buildings are the three primary buildings which need to be addressed for seismic compliance. VMG has recently (in Q3 2023) been involved in a hospital project in southern California which required seismic compliance costs amounting to ~$437/SF. VMG completed another hospital real estate valuation project (in 1Q 2024) involving seismic retrofitting wherein costs were estimated at a range of $500 to $1,000 per sq ft. In this case, VMG has assumed **$1,000/SF** in costs. Subsequent information concerning a more precise estimate of the cost of seismic compliance could result in changes to these value conclusions.

Exhibit F-1: Assumptions & Limiting Conditions – Real Estate FMV Analysis

The real estate valuation by VMG Holdings LLC d/b/a VMG Health ("VMG") is subject to and governed by the following Assumptions and Limiting Conditions:

1. Any legal description reported herein is assumed to be accurate. Any sketches, surveys, plats, photographs, drawings or other exhibits are included only to assist the intended user to better understand and visualize the subject property and assume no responsibility in connection with such matters.

2. The appraiser(s) has not conducted any engineering or architectural surveys in connection with this appraisal assignment. Information reported pertaining to dimensions, sizes, and areas is either based on measurements taken by the appraiser(s) or the staff or was obtained or taken from referenced sources and is considered reliable. No responsibility is assumed for the costs or preparation or for arranging geotechnical engineering, architectural, or other types of studies, surveys, or inspections that require the expertise of a qualified professional.

3. No responsibility is assumed for matters legal in nature. Title is assumed to be good and marketable and in fee simple unless discussed otherwise in the report. The property is considered to be free and clear of existing liens, easements, restrictions, and encumbrances, except as noted.

4. Unless otherwise noted herein, it is assumed there are no encroachments or violations of any zoning or other regulations affecting the subject property and the utilization of the land and improvements is within the boundaries or property lines of the property described.

5. VMG assumes there are no private deed restrictions affecting the property which would limit the use of the subject property in any way.

6. It is assumed the subject property is not adversely affected by the potential of floods.

7. It is assumed all water and sewer facilities (existing and proposed) are or will be in good working order and are or will be of sufficient size to adequately serve any proposed buildings.

8. Unless otherwise noted within the report, the depiction of the physical condition of the improvements described herein is based on an on-site visual observation. No liability is assumed for the soundness of structural members since no engineering tests were conducted. No liability is assumed for the condition of mechanical equipment, plumbing or electrical components, as complete tests were not made. No responsibility is assumed for hidden, unapparent or masked property conditions or characteristics that were not clearly apparent during our on-site observation.

9. If building improvements are present on the site, no significant evidence of termite damage or infestation was presented, unless so noted on the report. No termite inspection report was available, unless so noted in the report. No responsibility is assumed for hidden damages or infestation.

10. Any proposed or incomplete improvements included in this report are assumed to be satisfactory and completed in a workmanlike manner or will be thus completed within a reasonable length of time according to plans and specifications.

11. No responsibility is assumed for hidden defects of for conformity to specific governmental requirements, such as fire, building safety, earthquake, or occupancy codes, except where specific professional or governmental inspections have been completed and reported in the Appraisal Report.

12. The property is assumed to be under financially sound, competent and aggressive ownership.

13. The appraiser(s) assume no responsibility for any changes in economic or physical conditions which occur following the effective date of this report that would influence or potentially affect the analyses, opinions, or conclusions in the report. Any subsequent changes are beyond the scope of the report.

14. The value estimates reported herein apply to the entire property identified and analyzed herein. Any proration or division of the total into fractional interests will invalidate the value estimates, unless such a proration or division of interests is set forth in the report.

15. Any division of the land and improvement values estimated herein is applicable only under the program of utilization shown. These separate valuations are invalidated by any other application.

16. Unless otherwise noted in the report, only the real property is considered, so no consideration is given to the value of personal property or equipment located on the premises or the costs or moving or relocating such personal property or equipment.

17. Unless otherwise stated, it is assumed ownership includes subsurface oil, gas, and other mineral rights. No opinion is expressed as to whether the property is subject to surface entry for their exploration or removal. The contributing value, if any, of these rights has not been separately identified.

18. Any projections of income and expenses, including the reversion at time of resale, are not predictions of the future. Rather, they are our best estimate of current market thinking of what future trends will be. No warranty or representation is made that these projections will materialize. The real estate market is constantly fluctuating and changing. It is not the task of an appraiser(s) to estimate the conditions of a future real estate market, but rather to reflect what the investment community envisions for the future in terms of expectations of growth in rental rates, expenses, and supply and demand.

19. Unless subsoil opinions based upon engineering core borings were furnished, it is assumed there are no subsoil defects present, which would impair development of the land to its maximum permitted use or would render it more or less valuable. No responsibility is assumed for such conditions or for engineering which may be required to discover them.

20. VMG representatives are not experts in determining the presence or absence of hazardous substances, defined as all hazardous or toxic materials, wastes, pollutants or contaminants (including, but not limited to, asbestos, PCB, UFFI, or other raw materials or chemicals) used in construction or otherwise present on the property. We assume no responsibility for the studies or analyses which would be required to determine the presence or absence of such substances or for loss as a result of the presence of such substances. Appraiser(s) are not qualified to detect such substances. The client is urged to retain an expert in this field.

21. VMG is not an expert in determining the habitat for protected or endangered species that may be present on the property. We assume no responsibility for the studies or analyses which would be required to determine the presence or absence of such species or for loss as a result of the presence of such species.

22. No environmental impact studies were either requested or made in conjunction with this analysis. The appraiser(s) hereby reserves the right to alter, amend, revise, or rescind any of the value opinions based upon any subsequent environmental impact studies, research and investigation.

23. The appraisal is based on the premise that there is full compliance with all applicable federal, state, and local environmental regulations and laws unless otherwise stated in the report; further that all applicable zoning, building, and use regulations and restrictions of all types have been complied with unless otherwise stated in the report; further, it is assumed that all required licenses, consents, permits, or other legislative or administrative authority, local, state, federal and/ or private entity or organization have been or can be obtained or renewed for any use considered in the value estimate.

24. Although the appraiser(s) has made, insofar as is practical, every effort to verify as factual and true information and data set forth in this report, no responsibility is assumed for the accuracy of any information furnished the appraiser(s) either by the client or others. If for any reason, future investigations should prove any data to be in substantial variance with that presented in this report, the appraiser(s) reserves the right to alter or change any or all analyses, opinions, or conclusions and/or estimates of value.

25. If this report has been prepared in a so-called “public non-disclosure” state, real estate sales prices and other data, such as rents, prices, and financing, are not a matter of public record. If this is such a “non-disclosure” state, although extensive effort has been expended to verify pertinent data with buyers, sellers, brokers, lenders, lessors, lessees and other sources considered reliable, it has not always been possible to independently verify all significant facts. In these instances, the appraiser(s) may have relied on verification obtained and reported and on interviews with market participants. It is suggested the client consider independent verification as a prerequisite to any transaction involving sale, lease, or other significant commitment of funds to the subject property.

26. This report is null and void if used in any connection with a real estate syndicate or syndication, defined as a general or limited partnership, joint venture, unincorporated association, or similar organization formed for or engaged in investment or gain from an interest in real property, including but not limited to a sale, exchange, trade, development, or lease or property on

behalf of others or which is required to be registered with the U.S. Securities and Exchange Commission or any Federal or State Agency which regulates investments made as a public offering.

27. The American Disabilities Act of 1990 (ADA) sets strict and specific standards for handicapped access to and within most commercial and industrial buildings. Determination of compliance with these standards is beyond appraisal expertise, and therefore has not been attempted by the appraiser(s). For purposes of this appraisal, we are assuming the building is in compliance; however, we recommend an architectural inspection of the building to determine compliance or requirements for compliance. We assume no responsibility for the cost of such determination and our appraisal is subject to revision if the building is not in compliance.

28. The right is reserved by the appraiser to make adjustments to the analysis, opinions, and conclusions set forth in this report as may be required by consideration of additional or more reliable data that may become available. No change of this report shall be made by anyone other than the appraiser or appraisers. The appraiser(s) shall have no responsibility for any unauthorized change(s) to the report.

29. Physical characteristics of the property were obtained from tax assessment records, available plans, if any, descriptive information, and interviewing the client and other knowledgeable persons.

30. Use of this appraisal constitutes acknowledgement and acceptance of the general assumptions and limited conditions, special assumptions (if any), extraordinary assumptions (if any), and hypothetical conditions (if any) on which this estimate of market value is based.

Exhibit F-2: Certification(s) of the Appraiser

It is hereby stated that, to the best of my knowledge and belief:

The statements of fact contained in this report are true and correct.

The reported analyses, opinions, and conclusions are limited only by the reported assumptions and limiting conditions and are my personal, impartial, and unbiased professional analyses, opinions, and conclusions.

I have no present or prospective interest in the property that is the subject of this report and no personal interest with respect to the parties involved.

I have performed no services, as an appraiser or in any other capacity, regarding the property that is the subject of this report within the three-year period immediately preceding acceptance of this assignment.

I have no bias with respect to the property that is the subject of this report or to the parties involved with this assignment.

My engagement in this assignment was not contingent upon developing or reporting predetermined results.

My compensation for completing this assignment is not contingent upon the development or reporting of a predetermined value or direction in value that favors the cause of the client, the amount of the value opinion, the attainment of a stipulated result, or the occurrence of a subsequent event directly related to the intended use of this appraisal.

My analyses, opinions, and conclusions were developed, and this report has been prepared, in conformity with the Uniform Standards of Professional Appraisal Practice, the Code of Professional Ethics and Standards of Professional Appraisal Practice of the Appraisal Institute.

I have NOT made a personal inspection of the property that is the subject of this report.

No one provided significant real property appraisal assistance to the person signing this certification.

The appraisal assignment was not based on a requested minimum valuation, a specific valuation, or the approval of a loan.

The use of this report is subject to the requirements of the Appraisal Institute relating to review by its duly authorized representatives.

As of the date of this report Frank Fehribach, MAI, MRICS has completed the continuing education program for Designated Members of the Appraisal Institute.

Frank Fehribach, MAI, MRICS
Director – Real Estate Services
VMG HEALTH
California Certified General Real Estate Appraiser #AG044542

Certification(s) of the Appraiser

It is hereby stated that, to the best of my knowledge and belief:

The statements of fact contained in this report are true and correct.

The reported analyses, opinions, and conclusions are limited only by the reported assumptions and limiting conditions and are my personal, impartial, and unbiased professional analyses, opinions, and conclusions.

I have no present or prospective interest in the property that is the subject of this report and no personal interest with respect to the parties involved.

I have performed no services, as an appraiser or in any other capacity, regarding the property that is the subject of this report within the three-year period immediately preceding acceptance of this assignment.

I have no bias with respect to the property that is the subject of this report or to the parties involved with this assignment.

My engagement in this assignment was not contingent upon developing or reporting predetermined results.

My compensation for completing this assignment is not contingent upon the development or reporting of a predetermined value or direction in value that favors the cause of the client, the amount of the value opinion, the attainment of a stipulated result, or the occurrence of a subsequent event directly related to the intended use of this appraisal.

My analyses, opinions, and conclusions were developed, and this report has been prepared, in conformity with the Uniform Standards of Professional Appraisal Practice, the Code of Professional Ethics and Standards of Professional Appraisal Practice of the Appraisal Institute.

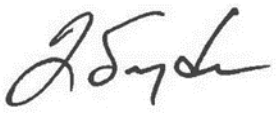
I have made a personal inspection of the property that is the subject of this report.

No one provided significant real property appraisal assistance to the person signing this certification.

The appraisal assignment was not based on a requested minimum valuation, a specific valuation, or the approval of a loan.

The use of this report is subject to the requirements of the Appraisal Institute relating to review by its duly authorized representatives.

As of the date of this report, I, Larry Snyder, MAI, have completed the continuing education program for Designated Members of the Appraisal Institute.



Larry Snyder, MAI
Director – Real Estate Services
VMG HEALTH

Exhibit G: Qualifications of the Appraiser(s)

Frank Fehribach, MAI, MRICS

Director of Real Estate Services

VMG HEALTH

BIOGRAPHY

Frank A. Fehribach is a Director in the Real Estate division at VMG Health and is located in the Dallas office. He has substantial experience in valuing healthcare-related properties including acute care, surgical, behavioral and rehab hospitals, surgery centers, imaging centers, cancer centers, medical office buildings, and other real-estate related facilities.

Fehribach's experience includes valuations in the context of Stark compliance, fair value analysis (ASC 805, ASC 360) for financial reporting, fair market value analysis for sale/leaseback transactions, fairness opinions, rental rate analyses, collateral valuations for financing transactions, and valuations for insurance purposes. His clients include for-profit and not-for-profit health systems, real estate investment trusts (REIT), other publicly owned and privately held healthcare entities and various law firms.

In addition to healthcare valuations, Fehribach has performed valuations for various types of businesses including high-tech manufacturing entities during his 30+ year career. Fehribach has provided opinions of value under various premises including for exchange in the open market, for forced liquidation, in use assuming economic viability of the associated business entity and as a going concern. Fehribach has served on foreign assignments including activities in Mexico, Canada, Europe, Middle East, Asia, and South America.

Fehribach is a State Certified General Real Estate Appraiser in the following states: Arizona, Arkansas, California, Colorado, Georgia, Illinois, Iowa, Kentucky, Michigan, New York, Pennsylvania, Washington, Minnesota, and Texas.

COURT EXPERIENCE

Fehribach has testified as an expert witness for property tax and condemnation purposes in Texas, Arizona, Kansas, Idaho, Wisconsin, and California.

EDUCATION

- University of Texas at Arlington - Master of Science - Real Estate
- University of Dallas - Master of Business Administration - Industrial Management, Bachelor of Arts – Economics

LICENSES/ASSOCIATION MEMBERSHIPS

- MAI Designation, Appraisal Institute
- Member of Royal Institution of Chartered Surveyors
- Fehribach is a State Certified General Real Estate Appraiser in the following states: Arizona, Arkansas, California, Colorado, Georgia, Illinois, Iowa, Kentucky, Michigan, New York, Pennsylvania, Washington, Minnesota, and Texas.

2515 McKinney Avenue, Suite 1500, Dallas, TX 75201 • (972) 616-7818 • frank.fehribach@vmghealth.com

PUBLICATIONS & PRESENTATIONS

- "Remember When an Operating Lease Was Just an Expense?" -VMG Health
- *The Complete Guide to Fair Market Value Under the Stark Regulations* – Published by Business Valuation Resources, LLC
- "Built to Suit: Constructing a New Building? Transaction Structuring, FMV and Compliance Considerations – Part 4: Conclusion and Additional Resources" -VMG Health
- "Built to Suit: Constructing a New Building? Transaction Structuring, FMV and Compliance Considerations – Part 3: Build-to-Suits and Capital Markets" -VMG Health
- "Built to Suit: Constructing a New Building? Transaction Structuring, FMV, and Compliance Considerations – Part 2: Credit Ratings and BTS Healthcare Assets" – VMG Health
- "Built to Suit: Constructing a New Building? Transaction Structuring, FMV, and Compliance Considerations" – VMG Health
- "Scaling Down the Hospital." *Healthcare Finance News*, July 24, 2014
- "The Details of Hospital Transactions and Real Estate Deals." *Becker's Hospital Review*, May 22, 2014
- "An Analysis of the Determinants of Industrial Property Valuation" Co-authored with Dr. Ronald C. Rutherford and Dr. Mark Eakin, The Journal of Real Estate Research, Vol. 8, No. 3, Summer 1993, p. 365.

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Larry D. Snyder, MAI

VALUATION EXPERIENCE

Larry D, Snyder, MAI is a director of real estate services for VMG Health. He has real property appraisal experience in various states, including extensive experience with the valuation of healthcare related properties. Mr. Snyder's valuation experience includes determining Fair Market Value for Stark Law compliance, financing, possible sale or purchase, allocation of purchase price and internal planning purposes. Mr. Snyder has performed valuation assignments for numerous healthcare-related entities. Clients served include Medical Properties Trust, Inc., Hospital Corporation of America (HCA), Community Health Systems (CHS), CHRISTUS Health, USPI, Centura Health, Bluefield Regional Medical Center, McLeod Health, Blessing Hospital System, Marshfield Clinic Health System, Geisinger, Hospital Sister's Health System, Ascension, Alliance Oncology and others. Mr. Snyder has also provided valuation services to a variety of healthcare law firms, including Kutak Rock LLP, Moore & Van Allen PLLC, Hall Render Killian Heath & Lyman, P.C., and Reed Claymon Meeker & Hargett, PLCC.

Types of medically oriented properties analyzed include cancer clinics, medical offices, ambulatory surgery centers (ASCs), diagnostic imaging facilities, hospitals, critical access hospitals, behavioral facilities, and senior care facilities. Mr. Snyder's valuation experience also includes non-healthcare properties such as: resort casinos (appraised over 200 gaming properties in various states), neighborhood shopping centers, warehouse/distribution centers, restaurants, convenience stores, apartment complexes, office buildings, parking garages, and self-storage facilities, along with vacant land, leasehold analyses, and various triple-net leased properties

Mr. Snyder graduated from Kent State University in 1984 and began his valuation career with a boutique commercial real estate firm in 1986. He has an MAI designation from the Appraisal Institute (since 1994) and has served various board positions on the Las Vegas Chapter of the Appraisal Institute, also serving on the Clark County Board of Equalization (Nevada). Mr. Snyder also was a Partner/Owner, Valuation Consultants, Inc., Las Vegas, NV, 8/1998 – 4/2006 | 1/2013 - 12/2014 and the Owner/Operator, Snyder Valuation, Las Vegas, NV, 4/1994 – 8/1998 | 10/2008 – 1/2013. Prior appraisal experience included working with CBRE, Las Vegas, NV 4/2006 -10/2008 and with Timothy R. Morse and Associates, Las Vegas, NV, 9/1988 - 9/1994. His career began with Martin Valuation and American Property Analysts, Toledo, OH, 5/1987 - 9/1988. Mr. Snyder has provided court testimony in Clark County Nevada.

PROFESSIONAL AFFILIATIONS/ASSOCIATION MEMBERSHIPS

Appraisal Institute – Designated Member (MAI)
State Certified General Real Estate Appraiser – Nevada, Tennessee, Mississippi, Pennsylvania, Illinois, South Carolina, Kentucky, Florida, Georgia, Iowa, Michigan, Utah, Arizona, and Alaska.

EDUCATION

Kent State University – Bachelor of Science (Geology)

APPRAISAL AND SPECIAL EDUCATION

Litigation Appraising: Specialized Topics & Applications
The Appraiser as Expert Witness: Preparation & Testimony
Complex Litigation Appraisal Case Studies
Attacking and Defending an Appraisal
Highest & Best Use and Market Analysis
Separating Real & Personal Property
Cap Theory & Technique – Part A
Cap Theory & Technique – Part B
15-Hour National USPAP
Uniform Appraisal Standards for Federal Land Acquisitions
Valuation for Financial Reporting
Various Seminars & Symposiums

Tri-City Medical Center

Fair Market Value Analysis Schedules

Final Report

Distributed on Monday, December 8, 2025

Valuation Date Monday, June 30, 2025

Prepared for Tri-City Medical Center

Attorney-Client Privileged Communication

Final Report

Tri-City Medical Center

Valuation Engagement Overview

Attorney-Client Privileged Communication

Valuation Engagement Overview

VMG Holdings LLC d/b/a VMG Health ("VMG") has been engaged by Tri-City Medical Center ("TCMC" or "Client") to provide a third-party, independent fair market value ("FMV") analysis of Tri-City Medical Center ("Hospital"). The purpose of this analysis is to provide an FMV opinion, as of a current date, for management planning and regulatory compliance to support a potential transaction.

This analysis is a "Valuation Engagement" prepared in accordance with the Professional Standards ("Professional Standards"), developed, interepreted, and amended by the National Association of Certified Valuation Analysts ("NACVA"). Pursuant to NACVA guidelines, a Valuation Engagement requires that a member/credentialed designee apply valuation approaches or methods deemed in the member's/credentialed designee's professional judgment to be appropriate under the circumstances and results in a Conclusion of Value.The analysis performed has been disclosed herein in a manner consistent with the requirements of a "Summary Report", as defined by NACVA Professional Standards.

Appraisal Firm	VMG Holdings LLC d/b/a VMG Health ("VMG")
Signatory Appraiser	Clinton Flume, CVA
Contributing Appraiser(s)	Lance Whitty; and Joshua Miner
Client	Tri-City Medical Center ("TCMC" or "Client")
Client Contact(s)	Dr. Gene Ma, Jeremy Raimo, & Anh Nguyen
Intended Users	Only TCMC is the intended user of, and may rely on, VMG's report. No third party shall have the right of reliance on this report, and neither receipt nor possession of this report by any third party shall create any express or implied third-party beneficiary rights. This report may not be distributed, in whole or in part, to any third party without written consent from VMG.
Identification of the Subject Being Valued	Tri-City Medical Center (the "Hospital")
Description of the Interest Being Valued	A controlling equity interest ("CEI") in the equity of the Hospital
Purpose of NACVA Valuation Engagement	The purpose of this engagement is to provide a FMV opinion of marketable, controlling equity interest ("CEI") in the equity of the Hospital, a public healthcare district, for management planning and regulatory compliance to support a potential transaction
Valuation Date	Monday, June 30, 2025
Report Distribution Date	Monday, December 8, 2025
Standard of Value and Definition	Fair Market Value ("FMV"); See Page 4 for Definition
Premise of Value	Going Concern Value
Material Matters Considered	See Page 6 for Qualifying Assumptions
Site Visit Disclosure	The following appraisers personally inspected the subject property of this Summary Report: Larry Snyder, MAI

Standard of Value

The standard of value relied upon for the purposes of this engagement is fair market value ("FMV"). According to Revenue Ruling 59-60, 1959-1, C.b. 237, fair market value is defined as "...the price at which the property would change hands between a willing buyer and a willing seller when the former is not under any compulsion to buy and the latter is not under any compulsion to sell, both parties having reasonable knowledge of relevant facts. Court decisions frequently state in addition that the hypothetical buyer and seller are assumed to be able, as well as willing, to trade and to be well informed about the property and concerning the market for such property." (1)

The International Glossary of Business Valuation Terms defines fair market value as "the price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arms length in an open and unrestricted market, when neither is under compulsion to buy or sell and when both have reasonable knowledge of the relevant facts." (2)

Further, a determination of fair market value, being a question of fact, will depend on the circumstances of each case. In reaching the Conclusion(s) of Value, we considered the following factors cited from Revenue Ruling 59-60, 1959-1, C.b. 237:

(a) The nature of the business and the history of the enterprise from its inception.

(b) The economic outlook in general and the condition and outlook of the specific industry in particular.

(c) The book value of the stock and the financial condition of the business.

(d) The earning capacity of the company.

(e) The dividend-paying capacity.

(f) Whether or not the enterprise has goodwill or other intangible value.

(g) Sales of the stock and the size of the block of stock to be valued.

(h) The market price of stocks of corporations engaged in the same or a similar line of business having their stocks actively traded in a free and open market, either on an exchange or over-the-counter.

Additionally, VMG considered the legal and regulatory environment surrounding healthcare. Because Medicare funding could trigger a review of transactions between referring parties, several relevant bodies of law guide the determination of value. The federal Anti Kickback Statute, which prohibits paying for patient referrals, and the Stark self-referral law (“Stark Law”), which limits certain physician referrals, are two laws guiding healthcare’s legal and regulatory environment. Within these bodies of law, the government stipulates that stated value in agreements between referring parties must be set at FMV.

Based on the guidelines established by the Stark regulations, VMG has expanded the definition of FMV to encompass general market value (“GMV”). Under Stark, FMV is defined as "the value in an arm's-length transaction, consistent with the general market value of the subject transaction", and GMV is defined as "the price that an asset would bring on the date of acquisition of the asset as the result of bona fide bargaining between a well-informed buyer and seller that are not otherwise in a position to generate business for each other." (3) (4)

Valuation Methodologies

To follow the general guidelines in IRS Revenue Ruling 59-60, the Stark Law, and the Anti-Kickback Statute, VMG's investigation and analysis included the following:

- Interviews with management about past, present, and prospective operating results of the Hospital;
- Analysis of the financial condition and historical operating and financial performance of the Hospital;
- Consideration of the general economic outlook and the outlook for the Hospital's specific specialty and market area; and,
- Estimates of the earning and dividend-paying capacity of the Hospital, with the assistance of company personnel.

The appraisal of any asset, security, or service is a matter of informed judgement. In arriving at the Conclusion(s) of Value, VMG applied generally accepted valuation procedures based on economic and market factors. Specifically, three generally accepted methodologies were considered: the Cost Approach, the Market Approach, and the Income Approach. These three approaches are outlined as follows:

- **Cost Approach**: The Cost Approach is a general way of determining a value indication of an individual asset by quantifying the amount of money required to replace the future service capability of that asset.
- **Market Approach**: The Market Approach is a general way of determining a value indication of a business, business ownership interest, security or intangible asset by using one or more methods that compare the subject to similar businesses, business ownership interests, securities or intangible assets that have been sold.
    - **Guideline Public Company Method**: The Guideline Public Company ("GPC") Method is a method within the market approach whereby market multiples are derived from market prices of stocks of companies that are engaged in the same or similar lines of business, and that are actively traded on a free and open market.
    - **Merger and Acquisition Method**: The Merger and Acquisition ("M&A") Method is a method within the market approach whereby pricing multiples are derived from transactions of significant interests in companies engaged in the same or similar lines of business.
- **Income Approach**: The Income Approach is a general way of determining the value indication of a business, business ownership interest, security or intangible asset using one or more methods that convert anticipated future economic benefits or revenue into a present value single amount.

Notes and Sources

(1) Source(s): Rev. Rul. 59-60; 1959-1 C.B. 237

(2) Source(s): https://www.nacva.com/glossary

(3) Source(s): 42 CFR 411.351 "Fair market value", https://www.ecfr.gov/current/title-42/part-411/section-411.351#p-411.351(Fair%20market%20value)

(4) Source(s): 42 CFR 411.351 "General market value", https://www.ecfr.gov/current/title-42/part-411/section-411.351#p-411.351(General%20market%20value)

Amendment of any assumption qualified below could materially impact any Conclusion(s) of Value presented herein.

Notable Items Influencing the Valuation Engagement

1. VMG reviewed the Hospital's financials for the last three fiscal years and through June 30, 2025. Therefore, the Valuation Date is June 30, 2025.

2. VMG utilized the June 30, 2025 balance sheet in the FMV analysis. In the event of a transaction, all balance sheet adjustments (e.g., net working capital, interest-bearing debt outstanding, non-operating balance sheet items, off-balance sheet liabilities, etc.) will need to be updated as of the transaction date.

3. While we have tax-affected the earnings of the Hospital, we have not considered any historical net operating losses in the calculation of the Hospital's projected earnings after income taxes for the purposes of our analysis.

4. A corporate income tax of 27.98% was utilized in the analysis, which we have calculated to be reflective of a blended federal and state rate of United States income earned in California. Discount rates used in the valuation are market-based and derived, in part, from publicly traded companies. These for-profit companies result in a market-based discount rate after-tax. Therefore, Normalized Base Year earnings of the subject entity are tax-affected using the tax rate in order to match the expected future cash flows with the cash flow stream being discounted.

5. The indications of Fair Market Value presented in this analysis assume a transaction involving a Control level of value.

6. Included within the FMV indication are all operating assets including normalized cash-free working capital, fixed assets, and intangible assets. Normalized cash-free working capital includes supplies, inventory, accounts receivable, and other current assets, less current liabilities, that permit a business to conduct day-to-day operations and maintain liquidity. Based on financial data provided by Client and our experience in the subject's industry, the normalized cash-free working capital is estimated at 5.4% of normalized net operating revenue as of the Valuation Date.

7. In addition to illustrating the Hospital's Business Enterprise ("BEV"), the value of the Hospital's total equity is also shown, which was derived by subtracting interest-bearing debt outstanding from the BEV. It is our understanding that the Hospital has interest-bearing debt outstanding of approximately $109,019,000 as of June 30, 2025.

8. A weighted average cost of capital ("WACC") of 12.5% was utilized in the valuation of the Hospital. The WACC is the starting point for establishing an appropriate discount rate for an entity's assets, and was calculated utilizing the Capital Asset Pricing Model ("CAPM") method. The WACC represents the weighted average return attributable to all of the assets of the Hospital.

Amendment of any assumption qualified below could materially impact any Conclusion(s) of Value presented herein.

Disclosure of Subsequent Events

Events or transactions sometimes occur subsequent to the balance sheet date, but prior to the issuance of the financial statements, that have a material effect on the financial statements and therefore require adjustment or disclosure in the statements. These occurrences are referred to as "subsequent events." The following subsequent events have been identified for the purposes of this analysis:

1. Per discussions with Hospital management, there have been no material changes in the outlook, financial position, or business operations of the Hospital as of the Valuation Date.

Hypothetical Conditions

According to USPAP, "Hypothetical conditions are contrary to known facts about physical, legal, or economic characteristics of the subject property; or about conditions external to the property, such as market conditions or trends; or about the integrity of data used in an analysis." A hypothetical condition may be used by a valuation analyst in an assignment if (1) use of the hypothetical condition is clearly required for legal purposes, for purposes of reasonable analysis, or for purposes of comparison; (2) use of the hypothetical condition results in a credible analysis; and, (3) the appraiser complies with the disclosure requirements set forth in USPAP for hypothetical conditions. The following hypothetical conditions were utilized for the purposes of this analysis:

1. No hypothetical conditions were utilized for the purposes of this analysis.

Extraordinary Assumptions

According to USPAP, an extraordinary assumption is defined as "…an assumption, directly related to a specific assignment, as of the effective date of the assignment results, which, if found to be false, could alter the appraiser's opinions or conclusions." An extraordinary assumption may be used by a valuation analyst in an assignment if (1) it is required to properly develop credible opinions and conclusions; (2) the appraiser has a reasonable basis for the extraordinary assumption; (3) the use of the extraordinary assumption results in a credible analysis; and, (4) the appraiser complies with the disclosure requirements set forth in USPAP for extraordinary assumptions. The following extraordinary assumptions were utilized for the purposes of this analysis:

1. Completion of a more detailed, precise estimate of seismic compliance costs from a third-party firm with expertise in this area could result in changes to this report, including the value conclusions presented herein. Please see VMG's real estate appraisal report of the owned assets associated with Tri-City Medical Center ("VMG Real Estate Analysis") for additional information. Should the seismic compliance costs vary from what is assumed therein, the conclusions contained here within could be materially impacted.

Notes and Sources

(1) Source(s): "2014-2015 Uniform Standards of Appraisal Practice," Appraisal Standards Board The Appraisal Foundation (2014)

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Conclusion(s) of Value	*Footnotes*	Value Indication
Fair Market Value of the Business Enterprise ("BEV"), Control Level	*1*	**$138,718,000**
Plus: Cash and Cash Equivalents	*3*	22,416,000
Fair Market Value of the Hospital's Total Invested Capital ("TIC")		**$161,134,000**
Plus: Excess / (Deficit) Net Working Capital	*2*	(32,892,000)
Plus: Non-Operating Assets		
Board-Designated	*3*	425,000
Notes Receivable	*3*	903,000
Restricted Mortgage Reserve Fund	*3*	11,159,000
Other Assets	*3*	1,987,000
Right-of-Use Lease Assets, Net	*3*	(1,014,000)
Restricted Cash and Investments	*3*	298,000
Adjusted Fair Market Value of the Hospital's TIC		**$142,000,000**
Less: Debt and Other Liabilities Assumed		
Long-Term Debt	*3*	(96,951,000)
Current Maturities of Long-Term Debt	*3*	(3,389,000)
Line of Credit	*3*	(8,679,000)
Adjusted Fair Market Value of the Hospital's Equity		**$32,981,000**

Implied Market Multiples	Financial Metric	Value Indication
BEV / NBY Total Net Operating Revenue	$353,628,377	0.4x
BEV / NBY EBITDA	$24,453,651	5.7x

Notes and Sources

(1) Business Enterprise Value ("BEV") includes all operating assets, comprising fixed assets, identified intangible assets, and normalized cash-free working capital. Cash-free working capital is defined as current assets excluding cash (supplies, inventory, accounts receivable, etc.) minus current liabilities (trade payables, accrued short-term liabilities, etc.). Total Invested Capital ("TIC") is defined as BEV plus Cash and Equivalents. TIC is also defined as equity plus interest-bearing debt (current and long term). Therefore, equity can be computed by subtracting interest-bearing debt from the value indication. We understand no interest bearing debt will be contributed.

(2) The Conclusion(s) of Value assumes the Hospital has a normalized level of cash-free working capital as of the transaction date. If the Hospital's actual working capital is materially different from this normalized level at the time of any proposed transaction, the Conclusion(s) of Value may need to be adjusted accordingly. The working capital calculations are shown in the exhibits.

(3) Estimated book value based on the June 30, 2025 balance sheet.

(4) Please note that all dollar figures presented above are rounded.

Value Indications by Methodology		Value	Weight	Conclusion	Key Assumptions
Income Approach	*Discounted Cash Flow Multi-Period Method*	$43,310,097	-	-	*12.5% Estimated Weighted Average Cost of Capital; 3.0% Estimated Long-Term Growth Rate*
Cost Approach	*Build-Up Approach*	$138,718,332	100.0%	$138,718,332	*= Normalized Working Capital + Fixed Assets*
Market Approach	*Merger and Acquisition Method*	$141,451,351	-	-	*0.4x Revenue*

Notes and Sources

(1) Three distinct approaches to value were considered in accordance with generally accepted valuation methodologies; These approaches include the Cost, Market, and Income Approaches. Ultimately, reliance was placed upon the Cost Approach to value the Hospital, as it is the approach most often utilized in situations where the estimated FMV of the entity's identifiable tangible and intangible assets produces a value that is greater than the entity's discounted projected cash flow stream.

(2) All value indications include a normalized level of cash-free working capital.

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Balance Sheet	Footnotes	Jun. 30, 2022	Jun. 30, 2023	Jun. 30, 2024	Jun. 30, 2025	Common Size Historical Balance Sheet Jun. 30, 2022	Jun. 30, 2023	Jun. 30, 2024	Jun. 30, 2025
Assets									
Current Assets									
Cash and Equivalents	2	$30,274,440	$8,957,966	$12,647,263	$1,968,834	12.1%	3.4%	5.1%	0.8%
Short-Term Investments		6,807,413	9,491,155	6,804,924	20,447,027	2.7%	3.6%	2.8%	8.6%
Restricted Cash and Investments		298,000	298,000	298,000	298,000	0.1%	0.1%	0.1%	0.1%
Patient Accounts Receivable		58,802,376	55,725,241	52,728,928	51,351,904	23.4%	20.9%	21.5%	21.6%
Other Receivables		470,087	524,867	3,825,594	4,143,216	0.2%	0.2%	1.6%	1.7%
Supplies Inventory		12,300,641	11,751,375	8,717,586	7,477,168	4.9%	4.4%	3.5%	3.1%
Prepaid Expenses and Other Assets		4,730,676	4,097,242	3,861,139	4,441,844	1.9%	1.5%	1.6%	1.9%
Estimated Third-Party Payor Settlements	3	4,444,723	11,000,392	-	702,640	1.8%	4.1%	-	0.3%
		118,128,356	101,846,238	88,883,434	90,830,633	47.1%	38.1%	36.2%	38.2%
Fixed Assets									
Land and Land Improvements		24,686,017	24,686,017	24,686,017	24,686,017	9.8%	9.2%	10.0%	10.4%
Buildings and Improvements		205,830,808	219,935,500	219,935,500	214,323,603	82.0%	82.3%	89.5%	90.2%
Equipment		186,577,618	187,798,623	189,430,502	193,613,907	74.3%	70.3%	77.1%	81.5%
Construction in Progress		13,698,085	18,518,278	21,584,355	23,942,762	5.5%	6.9%	8.8%	10.1%
Accumulated Depreciation		(340,678,281)	(348,212,907)	(354,624,731)	(360,939,707)	(135.7%)	(130.3%)	(144.3%)	(151.9%)
Right-of-Use ("ROU") Lease and SBITA, Net	4	-	37,032,617	29,442,136	32,129,110	-	13.9%	12.0%	13.5%
		90,114,247	139,758,128	130,453,779	127,755,692	35.9%	52.3%	53.1%	53.7%
Other Assets									
Board-Designated		422,359	423,317	424,286	425,077	0.2%	0.2%	0.2%	0.2%
Notes Receivable	5	2,580,223	2,383,004	1,570,007	902,598	1.0%	0.9%	0.6%	0.4%
Restricted Mortgage Reserve Fund	6	9,005,216	9,515,176	10,203,609	11,159,273	3.6%	3.6%	4.2%	4.7%
Other Assets		21,277,607	3,743,370	4,754,959	1,986,563	8.5%	1.4%	1.9%	0.8%
Goodwill		9,529,430	9,529,430	9,529,430	4,629,430	3.8%	3.6%	3.9%	1.9%
		42,814,835	25,594,297	26,482,291	19,102,941	17.1%	9.6%	10.8%	8.0%
Total Assets		$251,057,438	$267,198,663	$245,819,504	$237,689,266	100.0%	100.0%	100.0%	100.0%
Growth		*n/a*	*6.4%*	*(8.0%)*	*(3.3%)*				

Notes and Sources

(1) Sources: We have utilized audited financials provided by Hospital management for the time periods presented.

(2) The Hospital's cash balance has declined due to several events. In FY 2021, the Hospital received $30.1 million in Medicare accelerated payments and $4.36 million in CARES Act funds, which were repaid in FY 2022 and FY 2023. COVID-19 also reduced patient volumes and increased contract labor costs, pressuring cash flow. In FY 2024, a cyber incident caused an estimated $8.0 million loss of net revenue and delayed billing and collections, further reducing liquidity.

(3) The approximately $11.0 million decrease in estimated third-party payor settlements reflect adjustments related to prior-year Quality Incentive Pool (QIP) performance initiatives. This was partially offset by a $3.3 million increase in other receivables associated with the settlement of a cybersecurity business interruption insurance claim.

(4) "Right-of-use lease and subscription-based information technology arrangement (SBITA) assets, net," totaled $29.4 million as of June 30, 2024, compared to $37.0 million as of June 30, 2023. The decrease primarily reflects scheduled monthly amortization expense.

(5) "Notes receivable" relates to a physician recruitment loan. If physicians breach the contract, they will have to pay back the loan amount.

(6) "Mortgage reserve funds" (MRFs) represent restricted deposits required under the U.S. Department of Housing and Urban Development (HUD) guaranteed loan program.

Tri-City Medical Center

Historical Operations Analysis | Balance Sheet

Balance Sheet	Footnotes	Jun. 30, 2022	Jun. 30, 2023	Jun. 30, 2024	Jun. 30, 2025	Common Size Historical Balance Sheet Jun. 30, 2022	Jun. 30, 2023	Jun. 30, 2024	Jun. 30, 2025
Liabilities and Net Position									
Current Liabilities									
Line of Credit	2	-	$12,116,733	$7,033,083	$8,678,515	-	4.5%	2.9%	3.7%
Accounts Payable and Accrued Liabilities		59,377,540	90,674,755	79,679,429	61,234,982	23.7%	33.9%	32.4%	25.8%
Accrued Payroll and Related Expenses		19,862,891	20,708,183	17,446,431	20,181,488	7.9%	7.8%	7.1%	8.5%
Current Maturities of Long-Term Debt		3,032,695	5,568,841	5,936,740	3,388,687	1.2%	2.1%	2.4%	1.4%
Other Current Liabilities	3	4,239,578	2,228,062	2,808,563	383,799	1.7%	0.8%	1.1%	0.2%
ROU Lease and SBITA Liabilities, Current		-	7,278,134	6,723,823	6,811,736	-	2.7%	2.7%	2.9%
Estimated Third-Party Payor Settlements	4	-	-	1,927,454	-	-	-	0.8%	-
Short-Term Debt		5,613,145	-	-	-	2.2%	-	-	-
Medicare Accelerated Payments, Current		19,334,749	-	-	-	7.7%	-	-	-
		111,460,598	138,574,708	121,555,523	100,679,207	44.4%	51.9%	49.4%	42.4%
Long-Term Liabilities									
Long-Term Debt	5	73,278,972	72,461,430	99,724,691	96,950,819	29.2%	27.1%	40.6%	40.8%
Workers' Compensation and Comprehensive Liability	6	8,679,700	9,501,402	9,351,819	10,460,991	3.5%	3.6%	3.8%	4.4%
ROU Lease and SBITA Liabilities, Long-Term		-	30,350,064	23,831,381	17,458,185	-	11.4%	9.7%	7.3%
Property Lease, Net		7,760,532	-	-	-	3.1%	-	-	-
		89,719,204	112,312,896	132,907,891	124,869,995	35.7%	42.0%	54.1%	52.5%
Deferred Inflows of Resources									
Deferred Inflows of Resources	7	-	-	-	8,873,319	-	-	-	3.7%
		-	-	-	8,873,319	-	-	-	3.7%
Net Position									
Invested in Capital Assets, Net of Related Debt	8	17,773,237	18,824,515	33,872,137	27,512,877	7.1%	7.0%	13.8%	11.6%
Restricted Assets, Net Position	9	10,450,413	10,720,593	11,438,823	12,402,551	4.2%	4.0%	4.7%	5.2%
Unrestricted		21,653,986	(13,234,049)	(53,954,870)	(36,648,683)	8.6%	(5.0%)	(21.9%)	(15.4%)
		49,877,636	16,311,059	(8,643,910)	3,266,745	19.9%	6.1%	(3.5%)	1.4%
Total Liabilities and Net Position		$251,057,438	$267,198,663	$245,819,504	$237,689,266	100.0%	100.0%	100.0%	100.0%
Growth		*n/a*	*6.4%*	*(8.0%)*	*(3.3%)*				

Notes and Sources

(1) Sources: We have utilized audited financials provided by Hospital management for the time periods presented.

(2) The Hospital has access to capital through a revolving line of credit of approximately $15.4 million, which is repaid with collections on patient accounts receivable.

(3) "Other current liabilities" includes deferred revenue and accrued interest payable.

(4) "Estimated third-party payor settlements" reflect adjustments related to prior-year Quality Incentive Pool (QIP) performance initiatives.

(5) "Long-term debt, net of current portion," totaled approximately $99.7 million, reflecting a $27.2 million increase primarily due to a $33.2 million loan received under the California Distressed Hospital Loan Program (DHLP), partially offset by scheduled principal repayments.

(6) "Workers' compensation and liability insurance reserves" represent estimated obligations for reported and incurred-but-not-reported (IBNR) claims, with required levels determined through semiannual actuarial analyses.

(7) "Deferred Inflows of Resources" represent lease income associated with the Medical Office Building that is expected to be recognized in future periods.

(8) "Invested in capital assets, net of related debt" represents capital assets net of accumulated depreciation, reduced by outstanding borrowings used to finance their acquisition or construction.

(9) "Restricted net position" includes amounts not owned by the District related to ASCO and certain specialty institutes, as well as mortgage reserve fund (MRF) deposits required under the Hospital Regulatory Agreement with HUD.

Based on Net Charges	Current	31 - 60	61 - 90	91 - 120	121 - 150	151 - 180	181 - 210	210+	Balance	Days and Months Outstanding	
										Days	Months
Total Accounts Receivable	$19,944,051	$10,413,851	$7,946,505	$5,289,549	$4,011,948	$2,750,499	$2,622,434	$7,604,381	$60,583,217	66.5	2.2
Percentage by Age	*32.9%*	*17.2%*	*13.1%*	*8.7%*	*6.6%*	*4.5%*	*4.3%*	*12.6%*	*100.0%*		

Notes and Sources

(1) Source: The Total Accounts Receivable presented above is based on Hospital management's Accounts Receivable report dated as of July 31, 2025.

Tri-City Medical Center

Historical Operations Analysis | Reported Net Working Capital

Reported Net Working Capital	Jun. 30, 2022	Jun. 30, 2023	Jun. 30, 2024	Jun. 30, 2025
Current Assets				
Cash and Equivalents	$30,274,440	$8,957,966	$12,647,263	$1,968,834
Short-Term Investments	6,807,413	9,491,155	6,804,924	20,447,027
Patient Accounts Receivable	58,802,376	55,725,241	52,728,928	51,351,904
Other Receivables	470,087	524,867	3,825,594	4,143,216
Supplies Inventory	12,300,641	11,751,375	8,717,586	7,477,168
Prepaid Expenses and Other Assets	4,730,676	4,097,242	3,861,139	4,441,844
Estimated Third-Party Payor Settlements	4,444,723	11,000,392	-	702,640
	$117,830,356	$101,548,238	$88,585,434	$90,532,633
Current Liabilities				
Accounts Payable and Accrued Liabilities	$59,377,540	$90,674,755	$79,679,429	$61,234,982
Accrued Payroll and Related Expenses	19,862,891	20,708,183	17,446,431	20,181,488
Other Current Liabilities	4,239,578	2,228,062	2,808,563	383,799
Estimated Third-Party Payor Settlements	-	-	1,927,454	-
	$83,480,009	$113,611,000	$101,861,877	$81,800,269
Reported Net Working Capital	$34,350,347	($12,062,762)	($13,276,443)	$8,732,364
Total Net Operating Revenue	$348,829,567	$348,829,567	$340,026,040	$353,628,377
Reported Net Working Capital as a Percent of Total Net Operating Revenue	*9.8%*	*(3.5%)*	*(3.9%)*	*2.5%*
Reported Net Working Capital, Cash-Free, as a Percent of Total Net Operating Revenue	*1.2%*	*(6.0%)*	*(7.6%)*	*1.9%*
Key Ratios				
Current Ratio	1.4	0.9	0.9	1.1
Days Cash on Hand	40.6	18.7	19.9	24.9
Reported Net Working Capital Turnover	9.2	(26.6)	(23.4)	38.1
Accounts Receivable Turnover	5.4	5.8	5.9	6.5
Days Inventory on Hand	59.2	53.1	41.3	34.2
Days Payables Outstanding	n/a	338.9	403.8	321.8

Notes and Sources

(1) Sources: We have utilized audited financials provided by Hospital management for the time periods presented.

	Expected Cost		
Major Capital Projects	FY 2025	FY 2026	Category
1. ED Renovation	$3,000,000	$1,800,000	*Building Improvements*
2. Hospital Chiller	2,000,000	500,000	*Fixed Equipment*
3. Telemetry Monitors	1,200,000	-	*Major Moveable Equipment*
4. Hospital Beds	600,000	-	*Major Moveable Equipment*
5. SPD Sterilizer Unit	600,000	1,000,000	*Major Moveable Equipment*
6. Elevator #1	600,000	-	*Building Improvements*
7. Hybrid OR Room Project	-	3,500,000	*Building Improvements*
8. MRI Project	-	1,800,000	*Major Moveable Equipment*
9. Fuel Tank Project	-	1,400,000	*Building Improvements*
10. Alaris Infusion Pump System	-	1,200,000	*Major Moveable Equipment*
11. Ion Robot System	-	1,000,000	*Major Moveable Equipment*
12. Pulmonary Scope Project	-	650,000	*Major Moveable Equipment*
13. SPD Sink Project	-	480,000	*Fixed Equipment*
14. Nuclear Medicine System	-	400,000	*Major Moveable Equipment*
15. Contingency	4,000,000	4,130,000	*Excluded*
Total Capital Projects	**12,000,000**	**17,860,000**	

Total Capital Projects, less Contingency	**$8,000,000**	**$13,730,000**

Notes and Sources

(1) Source: "4-FY25-Capital Budget" File.

Tri-City Medical Center

Historical Operations Analysis | Income Statement

Income Statement	Footnotes	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	Common Size Income Statement FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Net Operating Revenue											
Gross Revenue		$1,445,279,712	$1,322,603,534	$1,183,311,824	$1,206,688,384	$1,635,600,310	418.1%	379.2%	348.0%	385.8%	462.5%
Adjustments and Refunds		(1,130,315,049)	(1,002,164,321)	(872,061,972)	(927,276,757)	(1,303,157,681)	(327.0%)	(287.3%)	(256.5%)	(296.4%)	(368.5%)
Net Patient Service Revenue	*1*	**314,964,663**	**320,439,213**	**311,249,852**	**279,411,627**	**332,442,629**	**91.1%**	**91.9%**	**91.5%**	**89.3%**	**94.0%**
Growth		*n/a*	*1.7%*	*(2.9%)*	*(10.2%)*	*19.0%*					
Premium Revenue	*2*	15,350,665	12,193,638	11,267,183	12,235,986	2,980,718	4.4%	3.5%	3.3%	3.9%	0.8%
Other Revenue		3,000,355	3,133,638	3,198,627	5,898,725	2,276,656	0.9%	0.9%	0.9%	1.9%	0.6%
District Tax Revenue	*3*	12,366,122	13,063,078	14,310,378	15,252,798	15,928,374	3.6%	3.7%	4.2%	4.9%	4.5%
Total Net Operating Revenue		**345,681,805**	**348,829,567**	**340,026,040**	**312,799,136**	**353,628,377**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Growth		*n/a*	*0.9%*	*(2.5%)*	*(8.0%)*	*13.1%*					
Operating Expenses											
Employee Salaries and Wages											
Salaries and Wages		174,657,481	196,662,021	188,768,600	165,388,430	158,155,342	50.5%	56.4%	55.5%	52.9%	44.7%
		174,657,481	196,662,021	188,768,600	165,388,430	158,155,342	50.5%	56.4%	55.5%	52.9%	44.7%
Occupancy Costs											
Maintenance, Rent, and Utilities		16,830,358	15,826,822	17,216,569	14,918,073	17,376,575	4.9%	4.5%	5.1%	4.8%	4.9%
		16,830,358	15,826,822	17,216,569	14,918,073	17,376,575	4.9%	4.5%	5.1%	4.8%	4.9%
Drugs and Medical Supplies											
Drugs and Medical Supplies		75,874,286	80,801,391	76,985,637	73,883,951	79,907,522	21.9%	23.2%	22.6%	23.6%	22.6%
		75,874,286	80,801,391	76,985,637	73,883,951	79,907,522	21.9%	23.2%	22.6%	23.6%	22.6%
Other Medical Costs											
Professional Fees		29,193,516	29,015,336	40,632,121	36,645,127	38,720,630	8.4%	8.3%	11.9%	11.7%	10.9%
		29,193,516	29,015,336	40,632,121	36,645,127	38,720,630	8.4%	8.3%	11.9%	11.7%	10.9%
General and Administrative											
Purchased Services		17,787,757	16,668,071	16,101,726	13,918,476	15,141,546	5.1%	4.8%	4.7%	4.4%	4.3%
Other Operating Expenses		19,285,149	20,258,464	17,793,198	15,410,851	19,873,111	5.6%	5.8%	5.2%	4.9%	5.6%
		37,072,906	36,926,535	33,894,924	29,329,327	35,014,657	10.7%	10.6%	10.0%	9.4%	9.9%
Total Operating Expenses		333,628,547	359,232,105	357,497,851	320,164,908	329,174,726	96.5%	103.0%	105.1%	102.4%	93.1%
Growth		*n/a*	*7.7%*	*(0.5%)*	*(10.4%)*	*2.8%*					
EBITDA		**12,053,258**	**(10,402,538)**	**(17,471,811)**	**(7,365,772)**	**24,453,651**	**3.5%**	**(3.0%)**	**(5.1%)**	**(2.4%)**	**6.9%**
Growth		*n/a*	*(nmf)*	*(nmf)*	*nmf*	*nmf*					

Tri-City Medical Center

Historical Operations Analysis | Income Statement

Income Statement	Footnotes	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	Common Size Income Statement FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Depreciation and Amortization Expense		10,447,087	10,735,355	15,048,194	13,822,305	13,480,216	3.0%	3.1%	4.4%	4.4%	3.8%
Net Interest Expense		3,541,287	3,888,214	5,592,453	4,469,152	3,048,843	1.0%	1.1%	1.6%	1.4%	0.9%
Earnings Before Non-Operating Items		(1,935,116)	(25,026,107)	(38,112,458)	(25,657,229)	7,924,592	(0.6%)	(7.2%)	(11.2%)	(8.2%)	2.2%
Non-Operating Income (Expense)	4	8,019,278	1,121,047	6,340,800	702,260	3,986,063	2.3%	0.3%	1.9%	0.2%	1.1%
Earnings Before Income Taxes		6,084,162	(23,905,060)	(31,771,658)	(24,954,969)	11,910,655	1.8%	(6.9%)	(9.3%)	(8.0%)	3.4%
Federal and State Income Tax Expense		-	-	-	-	-	-	-	-	-	-
Earnings After Income Taxes		$6,084,162	($23,905,060)	($31,771,658)	($24,954,969)	$11,910,655	1.8%	(6.9%)	(9.3%)	(8.0%)	3.4%
Growth		*n/a*	*(nmf)*	*(nmf)*	*nmf*	*nmf*					

Notes and Sources

Sources: We have utilized audited financials provided by Hospital management for the time periods presented.

FY = Fiscal Year ended June 30.

(1) The fluctuation in hospital revenue between FY 2023 and FY 2025 reflects several operational factors. In FY 2024, a cyber attack temporarily disrupted operations and negatively affected revenue. In addition, the discontinuation of the Mother Baby service line midway through FY 2023 and its complete phase out by FY 2024 further contributed to the decline observed over the historical period.

(2) Per the Audited financial notes, Premium Revenue is received via monthly capitation payments. This program was suspended during FY 2025.

(3) The District receives annual property tax support from San Diego County to fund operations. Taxes are levied each fiscal year based on property values assessed as of January 1 preceding the levy year.

(4) Per the Audited financial notes, non-operating revenues and expenses include activities that have the characteristics of nonexchange transactions, such as appropriations, gifts, government levies and subsidies, interest, and other expenses related to issuing and servicing debt. Non-operating revenues also include revenues earned outside the clinical operations of the hospital and their associated costs.

Utilization Statistics	*Footnotes*	FY 2022	FY 2023	FY 2024	FY 2025	*Growth Rates* FY 2023	FY 2024	FY 2025
Discharges	*2*	10,549	8,571	7,874	8,889	*(18.8%)*	*(8.1%)*	*12.9%*
Average Length of Stay ("ALOS")		5.64	5.25	5.37	5.10	*(6.9%)*	*2.2%*	*(5.0%)*
Patient Days		59,492	45,006	42,268	45,309	*(24.3%)*	*(6.1%)*	*7.2%*
Outpatient Visits		134,763	128,382	149,311	167,510	*(4.7%)*	*16.3%*	*12.2%*
Outpatient Equivalency Factor		1.82	1.87	1.92	1.78	*2.6%*	*2.6%*	*(7.1%)*
Adjusted Discharges		19,220	16,015	15,095	15,835	*(16.7%)*	*(5.7%)*	*4.9%*
Adjusted Patient Days		108,390	84,094	81,032	80,716	*(22.4%)*	*(3.6%)*	*(0.4%)*
Census Data								
Beds	*3*	397	397	397	397	-	-	-
Beds in Service		175	175	175	175			
Average Daily Census ("ADC")		163	123	116	124	*(24.3%)*	*(6.1%)*	*7.2%*
Occupancy		*93.1%*	*70.5%*	*66.2%*	*70.9%*	*(24.3%)*	*(6.1%)*	*7.2%*

Notes and Sources

(1) Sources: The above information was sourced through production reports provided by Hospital management.

(2) In FY 2024, discharge volume declined due to the closing of the Mother Baby Unit and the Cyber attack discussed on the previous page (See footnote 1).

(3) Of the 397 available beds, Hospital management estimates that 140 beds are staffed and operational. An additional 35 beds are useable, but are on a suspended license status.

						Growth Rates		
Reimbursement Ratios	*Footnotes*	FY 2022	FY 2023	FY 2024	FY 2025	FY 2023	FY 2024	FY 2025
Gross Inpatient Revenue	*2*	$725,936,550	$633,291,375	$629,432,093	$918,124,427	*(12.8%)*	*(0.6%)*	*45.9%*
Gross Outpatient Revenue	*2*	596,666,984	550,020,449	577,256,291	717,475,883	*(7.8%)*	*5.0%*	*24.3%*
Gross Revenue	*3*	**1,322,603,534**	**1,183,311,824**	**1,206,688,384**	**1,635,600,310**	***(10.5%)***	***2.0%***	***35.5%***
Net Inpatient Revenue	*2*	189,475,361	175,365,936	153,170,224	174,013,325	*(7.4%)*	*(12.7%)*	*13.6%*
Net Outpatient Revenue	*2*	130,963,852	135,883,916	126,241,403	158,429,304	*3.8%*	*(7.1%)*	*25.5%*
Net Revenue	*3*	**$320,439,213**	**$311,249,852**	**$279,411,627**	**$332,442,629**	***(2.9%)***	***(10.2%)***	***19.0%***
Gross Inpatient Revenue per Discharge	*2*	68,816	73,888	79,938	103,288	*7.4%*	*8.2%*	*29.2%*
Gross Inpatient Revenue per Patient Day	*2*	12,202	14,071	14,891	20,264	*15.3%*	*5.8%*	*36.1%*
Gross Outpatient Revenue per Outpatient Visit	*2*	4,428	4,284	3,866	4,283	*(3.2%)*	*(9.8%)*	*10.8%*
Net Inpatient Revenue per Discharge		17,961	20,460	19,453	19,576	*13.9%*	*(4.9%)*	*0.6%*
Net Inpatient Revenue per Patient Day		3,185	3,897	3,624	3,841	*22.3%*	*(7.0%)*	*6.0%*
Net Outpatient Revenue per Outpatient Visit	*2*	972	1,058	845	946	*8.9%*	*(20.1%)*	*11.9%*
Net Patient Service Revenue per Adjusted Patient Day	*2*	2,956	3,701	3,448	4,119	*25.2%*	*(6.8%)*	*19.4%*
Other Key Statistics								
Emergency Room Visits		50,218	50,237	47,229	44,409	*0.0%*	*(6.0%)*	*(6.0%)*
Total Emergency Room Visits		**50,218**	**50,237**	**47,229**	**44,409**	***0.0%***	***(6.0%)***	***(6.0%)***
Inpatient Surgery Cases		2,207	1,854	1,818	1,926	*(16.0%)*	*(1.9%)*	*5.9%*
Outpatient Surgery Cases		4,059	3,354	3,257	3,445	*(17.4%)*	*(2.9%)*	*5.8%*
Total Surgeries		**6,266**	**5,208**	**5,075**	**5,371**	***(16.9%)***	***(2.6%)***	***5.8%***

Notes and Sources

(1) Sources: The above information was sourced through production reports provided by Hospital management.

(2) Please note, this data as presented above is representative of the production data provided by Management. A weighted average has been applied to reconcile the provided production data to the Net-Fee-for-Service on the Income Statement. As such, metrics like Adjusted Patient Days, OP Equivalency Factor, and Adjusted Discharges differ from figures provided in the production data because they are calculated based on revenue from the income statement.

(3) The increase in Gross and Net Revenue in FY 2025 is due to a pricing increase of 10% implemented by the hospital.

Inpatient Payor Statistics	*Gross Charges*				*Collections*			
IP Payors - Historical Analysis	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
Commercial / Managed Care	85,848,748	68,760,138	70,753,661	76,961,104	28,331,491	22,519,948	22,784,317	15,956,087
Medicare / Managed Medicare	380,756,542	371,142,202	352,169,122	539,519,159	78,711,387	74,373,056	77,612,133	91,076,752
Medicaid	182,264,683	130,762,683	123,717,383	181,767,103	28,519,180	18,626,819	36,223,726	27,512,101
Self Pay	5,582,278	4,617,235	4,159,312	8,715,327	181,169	304,015	(2,455,413)	(2,876,740)
Other	58,618,133	45,429,816	71,601,935	105,910,940	15,302,294	12,581,702	17,893,724	19,141,402
Worker Compensation	3,923,133	3,615,188	3,534,864	3,597,246	968,301	775,847	599,033	856,473
Tricare / CHAMPUS	8,943,033	8,964,113	3,495,816	1,653,548	1,958,698	1,903,359	614,637	(309,467)
Total	**725,936,550**	**633,291,375**	**629,432,093**	**918,124,427**	**153,972,518**	**131,084,746**	**153,272,157**	**151,356,608**

	Gross Charges				*Collections*			
IP Payors - Percent of Total	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
Commercial / Managed Care	11.8%	10.9%	11.2%	8.4%	18.4%	17.2%	14.9%	10.5%
Medicare / Managed Medicare	52.5%	58.6%	56.0%	58.8%	51.1%	56.7%	50.6%	60.2%
Medicaid	25.1%	20.6%	19.7%	19.8%	18.5%	14.2%	23.6%	18.2%
Self Pay	0.8%	0.7%	0.7%	0.9%	0.1%	0.2%	(1.6%)	(1.9%)
Other	8.1%	7.2%	11.4%	11.5%	9.9%	9.6%	11.7%	12.6%
Worker Compensation	0.5%	0.6%	0.6%	0.4%	0.6%	0.6%	0.4%	0.6%
Tricare / CHAMPUS	1.2%	1.4%	0.6%	0.2%	1.3%	1.5%	0.4%	(0.2%)
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Notes and Sources

(1) Sources: We have utilized unaudited production and operating reports provided by Hospital management for the time periods presented.

(2) Please note, this data as presented above is representative of the production data provided by Management. A weighted average has been applied to reconcile the provided production data to the Net-Fee-for-Service on the Income Statement.

(3) Medicaid collections have been adjusted to a normalized level due to a classification issue in the source data.

Outpatient Payor Statistics	*Gross Charges*				*Collections*			
OP Payors - Historical Analysis	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
Commercial / Managed Care	147,172,972	133,679,701	133,824,135	156,268,838	42,999,840	39,729,421	48,363,534	54,222,708
Medicare / Managed Medicare	256,710,204	238,810,343	260,297,134	319,324,854	41,038,533	41,075,939	59,993,554	63,725,890
Medicaid	134,911,505	128,697,430	129,121,517	167,699,246	13,075,569	12,622,095	9,669,446	8,116,346
Self Pay	15,578,461	12,899,969	12,079,939	14,775,319	982,316	697,331	(2,244,792)	778,537
Other	28,047,974	23,942,687	26,977,742	41,256,423	5,680,150	5,203,649	6,820,908	6,651,011
Worker Compensation	6,471,601	5,619,907	7,050,622	8,469,120	1,277,609	1,100,647	1,806,585	2,261,400
Tricare / CHAMPUS	7,774,267	6,370,412	7,905,201	9,682,083	1,370,554	1,143,145	1,916,181	2,045,750
Total	**596,666,984**	**550,020,449**	**577,256,291**	**717,475,883**	**106,424,571**	**101,572,227**	**126,325,416**	**137,801,642**

	Gross Charges				*Collections*			
OP Payors - Percent of Total	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
Commercial / Managed Care	24.7%	24.3%	23.2%	21.8%	40.4%	39.1%	38.3%	39.3%
Medicare / Managed Medicare	43.0%	43.4%	45.1%	44.5%	38.6%	40.4%	47.5%	46.2%
Medicaid	22.6%	23.4%	22.4%	23.4%	12.3%	12.4%	7.7%	5.9%
Self Pay	2.6%	2.3%	2.1%	2.1%	0.9%	0.7%	(1.8%)	0.6%
Other	4.7%	4.4%	4.7%	5.8%	5.3%	5.1%	5.4%	4.8%
Worker Compensation	1.1%	1.0%	1.2%	1.2%	1.2%	1.1%	1.4%	1.6%
Tricare / CHAMPUS	1.3%	1.2%	1.4%	1.3%	1.3%	1.1%	1.5%	1.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Notes and Sources

(1) Sources: We have utilized unaudited production and operating reports provided by Hospital management for the time periods presented.

(2) Please note, this data as presented above is representative of the production data provided by Management. A weighted average has been applied to reconcile the provided production data to the Net-Fee-for-Service on the Income Statement.

(3) Medicaid collections have been adjusted to a normalized level due to a classification issue in the source data.

Tri-City Medical Center

Historical Operations Analysis | Budget Comparison

Budget Comparison	Footnotes	Historical FY 2025	Budget FY 2026	Difference Numeric	Difference Percent	Commentary
Discharges		8,889	8,981	92	1.0%	
Outpatient Visits		167,510	169,185	1,675	1.0%	*No OP Visits were provided in budget, VMG has assumed 1.0% growth*
Net Operating Revenue						
Gross Revenue		$1,635,600,310	$1,680,070,859	$44,470,549	2.7%	
Adjustments and Refunds		(1,303,157,681)	(1,366,770,859)	(63,613,178)	4.9%	
Net Patient Service Revenue		**332,442,629**	**313,300,000**	**(19,142,629)**	**(5.8%)**	
Premium Revenue		2,980,718	-	(2,980,718)	(100.0%)	
Supplemental Funding	2	-	40,000,000	40,000,000	-	*See footnote (2)*
Other Revenue		2,276,656	1,867,000	(409,656)	(18.0%)	
District Tax Revenue		15,928,374	15,488,000	(440,374)	(2.8%)	
Total Net Operating Revenue		**353,628,377**	**370,655,000**	**17,026,623**	**4.8%**	
Operating Expenses						
Employee Salaries and Wages						
Salaries and Wages		158,155,342	179,349,000	21,193,658	13.4%	
		158,155,342	179,349,000	21,193,658	13.4%	
Occupancy Costs						
Maintenance, Rent, and Utilities		17,376,575	16,385,000	(991,575)	(5.7%)	*Major Repairs in FY 2025 are not expected to continue in FY 2026.*
		17,376,575	16,385,000	(991,575)	(5.7%)	
Drugs and Medical Supplies						
Drugs and Medical Supplies		79,907,522	83,629,000	3,721,478	4.7%	*Management expects a 5.0% - 6.0% YoY increase in Drugs and Medical Supplies expense going forward.*
		79,907,522	83,629,000	3,721,478	4.7%	
Other Medical Costs						
Professional Fees		38,720,630	41,813,000	3,092,370	8.0%	
		38,720,630	41,813,000	3,092,370	8.0%	
General and Administrative						
Purchased Services		15,141,546	17,156,000	2,014,454	13.3%	
Other Operating Expenses		19,873,111	15,694,000	(4,179,111)	(21.0%)	
		35,014,657	32,850,000	(2,164,657)	(6.2%)	
Total Operating Expenses		329,174,726	354,026,000	24,851,274	7.5%	
EBITDA		**$24,453,651**	**$16,629,000**	**($7,824,651)**	**(32.0%)**	

Notes and Sources

(1) Budget figures per the source file 1c -TCHD Operating & Capital Budgets-FY2026.pdf.

(2) Hospital management indicated that approximately $40 million in supplemental funding will be recognized and boost Hospital collections. As a result, this amount has been incorporated as a positive adjustment to the Net Patient Service Revenue line items proportionally for both Inpatient and Outpatient Revenue in Year 1.

Final Report

Tri-City Medical Center

Income Approach

Attorney-Client Privileged Communication

Income Statement	Footnotes	FY 2025	Adjustments	NBY	Common Size FY 2025	Common Size NBY
Net Operating Revenue						
Gross Revenue		$1,635,600,310	-	$1,635,600,310	462.5%	462.5%
Adjustments and Refunds		(1,303,157,681)	-	(1,303,157,681)	(368.5%)	(368.5%)
Total Net Patient Service Revenue		332,442,629	-	332,442,629	94.0%	94.0%
Premium Revenue		2,980,718	-	2,980,718	0.8%	0.8%
Other Revenue		2,276,656	-	2,276,656	0.6%	0.6%
District Tax Revenue		15,928,374	-	15,928,374	4.5%	4.5%
Total Net Operating Revenue		**353,628,377**	**-**	**353,628,377**	**100.0%**	**100.0%**
Operating Expenses						
Employee Salaries and Wages						
Salaries and Wages	*1*	158,155,342	(33,623,577)	124,531,765	44.7%	35.2%
		158,155,342	(33,623,577)	124,531,765	44.7%	35.2%
Employee Benefits						
Employee Benefits	*1*	-	33,623,577	33,623,577	-	9.5%
		-	33,623,577	33,623,577	-	9.5%
Occupancy Costs						
Maintenance, Rent, and Utilities		17,376,575	-	17,376,575	4.9%	4.9%
		17,376,575	-	17,376,575	4.9%	4.9%
Drugs and Medical Supplies						
Drugs and Medical Supplies		79,907,522	-	79,907,522	22.6%	22.6%
		79,907,522	-	79,907,522	22.6%	22.6%
Other Medical Costs						
Professional Fees		38,720,630	-	38,720,630	10.9%	10.9%
		38,720,630	-	38,720,630	10.9%	10.9%
General and Administrative						
Purchased Services		15,141,546	-	15,141,546	4.3%	4.3%
Other Operating Expenses		19,873,111	-	19,873,111	5.6%	5.6%
		35,014,657	-	35,014,657	9.9%	9.9%
Total Operating Expenses		329,174,726	-	329,174,726	93.1%	93.1%

Tri-City Medical Center

Income Approach | Development of the Normalized Base Year

Income Statement	Footnotes	FY 2025	Adjustments	NBY	Common Size FY 2025	Common Size NBY
EBITDA		$24,453,651	-	$24,453,651	6.9%	6.9%
Depreciation and Amortization Expense		13,480,216	-	13,480,216	3.8%	3.8%
Net Interest Expense	*2*	3,048,843	(3,048,843)	-	0.9%	-
Earnings Before Non-Operating Items		7,924,592	3,048,843	10,973,435	2.2%	3.1%
Non-Operating Income (Expense)	*3*	3,986,063	(3,986,063)	-	1.1%	-
Earnings Before Income Taxes		11,910,655	7,034,906	10,973,435	3.4%	3.1%
Federal and State Income Tax Expense	*4*	-	3,070,762	3,070,762	-	0.9%
Earnings After Income Taxes		$11,910,655	$3,964,144	$7,902,673	3.4%	2.2%

Notes and Sources

The Normalized Base Year ("NBY") is based on the FY 2025 income statement. Nonrecurring and nonoperational items are adjusted out of the FY 2025 income statement to give a clearer, more accurate picture of the Hospital's operations from which to project the income statement in Year 1. Please refer to the following page for details related to each adjustment.

1. Employe benefits was reallocated from Employee Salaries, Wages, and Benefits using 27.0% of Salaries and Wages, as per Hospital management.

2. Net Interest Expense has been eliminated to derive debt-free operations.

3. Non-Operating Income (Expense) has been eliminated to project only recurring patient-service revenues.

4. Our analysis has applied a blended federal and state income tax rate of 27.98% to the earnings before taxes. Discount rates used in the valuation are market based and derived in part from the publicly traded comparable companies. These companies are for profit; thus, the market-based discount rate is an after-tax discount rate. Therefore, NBY earnings of the Hospital are tax affected using a blended federal and state tax rate to match the expected future cash flows with the level of cash flow stream being discounted.

Guideline Public Company Net Working Capital Metrics	FY - 2	FY - 1	FYE	TTM
Cash-Free Net Working Capital (As a Percent of Revenues)				
1. Community Health Systems, Inc.	7.8%	9.4%	8.3%	8.2%
2. HCA Healthcare, Inc.	5.8%	6.2%	6.0%	5.1%
3. Tenet Healthcare Corporation	5.2%	7.3%	3.1%	2.3%
4. Universal Health Services, Inc.	5.0%	6.1%	3.8%	3.9%
5. Ardent Health, Inc.	3.7%	4.3%	6.3%	7.5%
Median	**5.2%**	**6.2%**	**6.0%**	**5.1%**
Mean	**5.5%**	**6.7%**	**5.5%**	**5.4%**
Tri-City Medical Center	**1.2%**	**(6.0%)**	**(7.6%)**	**1.9%**

Net Working Capital Excess / (Deficit) Calculation

FYE 2025 Total Net Operating Revenue	$353,628,377
Times: Normalized Level of Cash-Free Net Working Capital as a Percentage of Revenue	5.4%
Normalized Cash-Free Net Working Capital	$19,208,912
Reported Cash-Free Net Working Capital	($13,683,497)
Less: Normalized Net Working Capital	(19,208,912)
Net Working Capital Excess / (Deficit)	**($32,892,409)**

Notes and Sources

(1) Source(s): S&P's Capital IQ as of June 30, 2025. Historical financials are "Latest" (i.e., information is retrieved from the most recent period, including press releases). Estimates are consolidated (i.e., includes the parent company and all subsidiaries). Source financials retrieved are as of the company's period end date. Where applicable, the historical spot exchange rate on the period end date is applied to foreign currency types across all historical periods. Unless otherwise noted, data is presented in USD ($), in thousands.

Tri-City Medical Center

Income Approach | Revenue Assumptions

						Projection Period					
Total Net Operating Revenue	FY 2022	FY 2023	FY 2024	FY 2025	NBY	Year 1	Year 2	Year 3	Year 4	Year 5	Key Assumptions
Inpatient											
Volume											
Estimated Discharges per Year	10,549	8,571	7,874	8,889	8,889	8,978	9,157	9,341	9,527	9,718	*Year 1 per management, then*
Growth	*n/a*	*(18.8%)*	*(8.1%)*	*12.9%*	-	*1.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0% year-over-year growth*
Average Length of Stay ("ALOS")	5.64	5.25	5.37	5.10	5.10	5.10	5.10	5.10	5.10	5.10	
Patient Days	59,492	45,006	42,268	45,309	45,309	45,762	46,677	47,611	48,563	49,534	
Growth	*n/a*	*(24.3%)*	*(6.1%)*	*7.2%*	-	*1.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	
Average Daily Census ("ADC")	163.0	123.3	115.8	124.1	124.1	125.4	127.9	130.4	133.0	135.7	
Beds in Service	175	175	175	175	175	175	175	175	175	175	*Per Hospital management*
Occupancy	93.1%	70.5%	66.2%	70.9%	70.9%	71.6%	73.1%	74.5%	76.0%	77.5%	
Revenue											
Estimated Gross Revenue per Discharge	$68,816	$73,888	$79,938	$103,288	$103,288	$104,976	$107,076	$109,217	$111,402	$113,630	*Year 1 per management, then*
Growth	*n/a*	*7.4%*	*8.2%*	*29.2%*	-	*1.6%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0% year-over-year growth*
Less: Adjustments and Refunds	($50,854)	($53,427)	($60,485)	($83,711)	($83,711)	($84,378)	($86,065)	($87,787)	($89,542)	($91,333)	*See footnote (1)*
As a Percent of Gross Revenue	*(73.9%)*	*(72.3%)*	*(75.7%)*	*(81.0%)*	*(81.0%)*	*(80.4%)*	*(80.4%)*	*(80.4%)*	*(80.4%)*	*(80.4%)*	
Estimated Net Patient Service Revenue per Discharge	$17,961	$20,460	$19,453	$19,576	$19,576	$20,598	$21,010	$21,431	$21,859	$22,296	*Year 1 per management, then*
Growth	*n/a*	*13.9%*	*(4.9%)*	*0.6%*	-	*5.2%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0% year-over-year growth*
Inpatient Gross Revenue	$725,936,550	$633,291,375	$629,432,093	$918,124,427	$918,124,427	$942,466,357	$980,541,998	$1,020,155,895	$1,061,370,193	$1,104,249,548	
Less: Estimated Inpatient Contractual Adjustments	(536,461,189)	(457,925,440)	(476,261,869)	(744,111,101)	(744,111,101)	(757,535,477)	(788,139,911)	(819,980,763)	(853,107,986)	(887,573,548)	
Inpatient Net Patient Service Revenue	**$189,475,361**	**$175,365,936**	**$153,170,224**	**$174,013,325**	**$174,013,325**	**$184,930,880**	**$192,402,087**	**$200,175,132**	**$208,262,207**	**$216,676,000**	
Growth		*(7.4%)*	*(12.7%)*	*13.6%*	-	*6.3%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	
Outpatient											
Volume											
Estimated Outpatient Visits ("OP Visits") per Year	134,763	128,382	149,311	167,510	167,510	169,185	172,569	176,020	179,541	183,131	*Year 1 per management, then*
Growth	*n/a*	*(4.7%)*	*16.3%*	*12.2%*	-	*1.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0% year-over-year growth*
Revenue											
Estimated Gross Revenue per OP Visit	$4,428	$4,284	$3,866	$4,283	$4,283	$4,360	$4,447	$4,536	$4,627	$4,719	
Growth	*n/a*	*(3.2%)*	*(9.8%)*	*10.8%*	-	*1.8%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0% year-over-year growth*
Less: Adjustments and Refunds	($3,456)	($3,226)	($3,021)	($3,337)	($3,337)	($3,365)	($3,432)	($3,501)	($3,571)	($3,642)	*See footnote (1)*
As a Percent of Gross Revenue	*(78.1%)*	*(75.3%)*	*(78.1%)*	*(77.9%)*	*(77.9%)*	*(77.2%)*	*(77.2%)*	*(77.2%)*	*(77.2%)*	*(77.2%)*	
Estimated Net Patient Service Revenue per OP Visit	$972	$1,058	$845	$946	$946	$995	$1,015	$1,035	$1,056	$1,077	*Year 1 per management, then*
Growth	*n/a*	*8.9%*	*(20.1%)*	*11.9%*	-	*5.2%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0% year-over-year growth*
Outpatient Gross Revenue	$596,666,984	$550,020,449	$577,256,291	$717,475,883	$717,475,883	$737,604,502	$767,403,724	$798,406,834	$830,662,470	$864,221,234	
Less: Estimated Outpatient Contractual Adjustments	(465,703,132)	(414,136,533)	(451,014,888)	(559,046,579)	(559,046,579)	(569,235,382)	(592,232,491)	(616,158,684)	(641,051,495)	(666,949,975)	
Outpatient Net Patient Service Revenue	**$130,963,852**	**$135,883,916**	**$126,241,403**	**$158,429,304**	**$158,429,304**	**$168,369,120**	**$175,171,233**	**$182,248,151**	**$189,610,976**	**$197,271,259**	
Growth	*n/a*	*3.8%*	*(7.1%)*	*25.5%*	-	*6.3%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	

Tri-City Medical Center

Income Approach | Revenue Assumptions

Total Net Operating Revenue	FY 2022	FY 2023	FY 2024	FY 2025	NBY	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5	Key Assumptions
Total Net Operating Revenue											
Gross Patient Service Revenue											
Gross Inpatient Revenue	$725,936,550	$633,291,375	$629,432,093	$918,124,427	$918,124,427	$942,466,357	$980,541,998	$1,020,155,895	$1,061,370,193	$1,104,249,548	
Gross Outpatient Revenue	596,666,984	550,020,449	577,256,291	717,475,883	717,475,883	737,604,502	767,403,724	798,406,834	830,662,470	864,221,234	
Gross Patient Service Revenue	$1,322,603,534	$1,183,311,824	$1,206,688,384	$1,635,600,310	$1,635,600,310	$1,680,070,859	$1,747,945,722	$1,818,562,729	$1,892,032,663	$1,968,470,783	
Growth	*n/a*	*(10.5%)*	*2.0%*	*35.5%*	-	*2.7%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	
Adjustments and Refunds	(1,002,164,321)	(872,061,972)	(927,276,757)	(1,303,157,681)	(1,303,157,681)	(1,326,770,859)	(1,380,372,402)	(1,436,139,447)	(1,494,159,480)	(1,554,523,523)	
Net Patient Service Revenue											
Net Inpatient Revenue	189,475,361	175,365,936	153,170,224	174,013,325	174,013,325	184,930,880	192,402,087	200,175,132	208,262,207	216,676,000	
Net Outpatient Revenue	130,963,852	135,883,916	126,241,403	158,429,304	158,429,304	168,369,120	175,171,233	182,248,151	189,610,976	197,271,259	
Net Patient Service Revenue	$320,439,213	$311,249,852	$279,411,627	$332,442,629	$332,442,629	$353,300,000	$367,573,320	$382,423,282	$397,873,183	$413,947,259	
Growth	*n/a*	*(2.9%)*	*(10.2%)*	*19.0%*	-	*6.3%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	
Premium Revenue	12,193,638	11,267,183	12,235,986	2,980,718	2,980,718	-	-	-	-	-	*n/a*
Other Revenue	3,133,638	3,198,627	5,898,725	2,276,656	2,276,656	1,867,000	1,867,000	1,867,000	1,867,000	1,867,000	*Year 1 per management, then no growth*
District Tax Revenue	13,063,078	14,310,378	15,252,798	15,928,374	15,928,374	16,246,941	16,571,880	16,903,318	17,241,384	17,586,212	*2.0% growth, per management*
Total Net Operating Revenue	$348,829,567	$340,026,040	$312,799,136	$353,628,377	$353,628,377	$371,413,941	$386,012,200	$401,193,600	$416,981,567	$433,400,471	
Growth	*n/a*	*(2.5%)*	*(8.0%)*	*13.1%*	-	*5.0%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	
Key Revenue Statistics											
Outpatient Equivalency Factor	1.82	1.87	1.92	1.78	1.78	1.78	1.78	1.78	1.78	1.78	
Adjusted Discharges	19,220	16,015	15,095	15,835	15,835	16,004	16,324	16,651	16,984	17,324	
Growth	*n/a*	*(16.7%)*	*(5.7%)*	*4.9%*	-	*1.1%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	
Adjusted Patient Days	108,390	84,094	81,032	80,716	80,716	81,577	83,209	84,873	86,570	88,302	
Growth	*n/a*	*(22.4%)*	*(3.6%)*	*(0.4%)*	-	*1.1%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	

Notes and Sources

(1) Hospital management indicated that approximately $40 million in supplemental funding will be recognized and boost Hospital collections. As a result, this amount has been incorporated as a positive adjustment to the Net Patient Service Revenue line items proportionally for both Inpatient and Outpatient Revenue in Year 1.

Tri-City Medical Center

Income Approach | Operating Expense Assumptions

Operating Expenses	FY 2022	FY 2023	FY 2024	FY 2025	NBY	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5	Key Assumptions
Employee Salaries and Wages											
Total Employed FTEs	1,578	1,466	1,388	1,346	1,346	1,355	1,372	1,390	1,408	1,427	*Admin, Leadership, and Maintenance/Security Staff kept flat*
Growth	*n/a*	*(7.1%)*	*(5.4%)*	*(3.1%)*	-	*0.7%*	*1.3%*	*1.3%*	*1.3%*	*1.3%*	*Adj. with Total Adj. Patient Days*
Paid Hours	3,282,198	3,050,112	2,886,790	2,798,640	2,798,640	2,817,785	2,854,069	2,891,078	2,928,828	2,967,332	
Paid Hours per Adjusted Patient Day	30	36	36	35	35	35	34	34	34	34	
Growth	*n/a*	*(7.1%)*	*(5.4%)*	*(3.1%)*	-	*0.7%*	*1.3%*	*1.3%*	*1.3%*	*1.3%*	
Adjusted Patient Days	108,390	84,094	81,032	80,716	80,716	81,577	83,209	84,873	86,570	88,302	
FTEs per Adjusted Occupied Bed	5.3	6.4	6.3	6.1	6.1	6.1	6.0	6.0	5.9	5.9	
Growth	*n/a*	*19.8%*	*(1.8%)*	*(2.7%)*	-	*(0.4%)*	*(0.7%)*	*(0.7%)*	*(0.7%)*	*(0.7%)*	
Average Salary per Full-Time Equivalent	124,629	128,729	119,166	117,544	92,554	104,244	107,455	110,765	114,176	117,691	
Growth	*n/a*	*3.3%*	*(7.4%)*	*(1.4%)*	*(21.3%)*	*12.6%*	*3.1%*	*3.1%*	*3.1%*	*3.1%*	*Year 1 per management, increase with inflation thereafter*
Total Salaries and Wages	$196,662,021	$188,768,600	$165,388,430	$158,155,342	$124,531,765	$141,219,685	$147,444,481	$153,956,624	$160,769,824	$167,898,463	
Growth	*n/a*	*(4.0%)*	*(12.4%)*	*(4.4%)*	*(21.3%)*	*13.4%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*	
Employee Benefits											
Employee Benefits					$33,623,577	$38,129,315	$39,810,010	$41,568,288	$43,407,853	$45,332,585	*Remains at 27.0% of Salaries and Wages*
As a Percent of Salaries and Wages					*27.0%*	*27.0%*	*27.0%*	*27.0%*	*27.0%*	*27.0%*	
Total Employee Benefits					$33,623,577	$38,129,315	$39,810,010	$41,568,288	$43,407,853	$45,332,585	
Growth					*n/a*	*13.4%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*	
Drugs and Medical Supplies											
Drugs and Medical Supplies											
Adjusted Patient Days	108,390	84,094	81,032	80,716	80,716	81,577	83,209	84,873	86,570	88,302	
Drugs and Medical Supplies per Adj. Patient Day	$745.47	$915.47	$911.78	$989.98	$989.98	$1,025.15	$1,055.91	$1,087.59	$1,120.21	$1,153.82	*Year 1 per Budget then Inflation*
Growth	*n/a*	*22.8%*	*(0.4%)*	*8.6%*	-	*3.6%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	
Total Drugs and Medical Supplies	$80,801,391	$76,985,637	$73,883,951	$79,907,522	$79,907,522	$83,629,000	$87,860,627	$92,306,375	$96,977,078	$101,884,118	
Total Drugs and Medical Supplies	$80,801,391	$76,985,637	$73,883,951	$79,907,522	$79,907,522	$83,629,000	$87,860,627	$92,306,375	$96,977,078	$101,884,118	
Growth	*n/a*	*(4.7%)*	*(4.0%)*	*8.2%*	-	*4.7%*	*5.1%*	*5.1%*	*5.1%*	*5.1%*	
Operating Expenses											
Employee Salaries and Wages											
Salaries and Wages	$196,662,021	$188,768,600	$165,388,430	$158,155,342	$124,531,765	$141,219,685	$147,444,481	$153,956,624	$160,769,824	$167,898,463	*See Employee Salaries and Wages Assumptions*
Employee Benefits											
Employee Benefits					33,623,577	38,129,315	39,810,010	41,568,288	43,407,853	45,332,585	*See Employee Benefits Assumptions*
Occupancy Costs											
Maintenance, Rent, and Utilities	15,826,822	17,216,569	14,918,073	17,376,575	17,376,575	16,385,000	16,876,550	17,382,847	17,904,332	18,441,462	*Year 1 per Budget, then Increase with Inflation*
Drugs and Medical Supplies											
Drugs and Medical Supplies	80,801,391	76,985,637	73,883,951	79,907,522	79,907,522	83,629,000	87,860,627	92,306,375	96,977,078	101,884,118	*See Drugs and Medical Supplies Assumptions*
Other Medical Costs											
Professional Fees	29,015,336	40,632,121	36,645,127	38,720,630	38,720,630	41,813,000	43,067,390	44,359,412	45,690,194	47,060,900	*Year 1 per Budget, then Increase with Inflation*
General and Administrative											
Purchased Services	16,668,071	16,101,726	13,918,476	15,141,546	15,141,546	17,156,000	17,670,680	18,200,800	18,746,824	19,309,229	*Year 1 per Budget, then Increase with Inflation*
Other Operating Expenses	20,258,464	17,793,198	15,410,851	19,873,111	19,873,111	15,694,000	16,164,820	16,649,765	17,149,258	17,663,735	*Year 1 per Budget, then Increase with Inflation*
Total Operating Expenses	$359,232,105	$357,497,851	$320,164,908	$329,174,726	$329,174,726	$354,026,000	$368,894,558	$384,424,110	$400,645,363	$417,590,492	
Growth	*n/a*	*(0.5%)*	*(10.4%)*	*2.8%*	-	*7.5%*	*4.2%*	*4.2%*	*4.2%*	*4.2%*	
Total Operating Expenses per Adj. Patient Day	$3,314	$4,251	$3,951	$4,078	$4,078	$4,340	$4,433	$4,529	$4,628	$4,729	
Growth	*n/a*	*28.3%*	*(7.1%)*	*3.2%*	-	*6.4%*	*2.2%*	*2.2%*	*2.2%*	*2.2%*	

Discounted Cash Flow Analysis Assumptions	
• Discount Rate	12.5%
• Normalized Net Working Capital	$19,208,912
• Normalized Net Working Capital as a Percent of Total Net Operating Revenue	5.4%
• Terminal Growth Rate	3.0%
• Blended Federal and State (CA) Corporate Income Tax Rate	28.0%

Depreciation Assumptions	
• Net Initial Depreciable Basis of Furniture, Fixtures, Equipment and Leasehold Improvements	$14,609,420
• Estimated Useful Life of Initial Furniture, Fixtures, Equipment and Leasehold Improvements	7.0
• Net Initial Depreciable Basis of Real Estate	$46,030,000
• Estimated Useful Life of Initial Real Estate	17.0
• Estimated Useful Life of Projected Furniture, Fixtures, Equipment and Leasehold Improvement Expenditures	7.0
• Estimated Useful Life of Projected Real Estate Expenditures	39.0

Projected Capital Expenditures and Depreciation Expense	Year 1	Year 2	Year 3	Year 4	Year 5	Terminal Year
Total Net Operating Revenue	*$371,413,942*	*$386,012,200*	*$401,193,600*	*$416,981,567*	*$433,400,471*	*$446,402,485*
Capital Expenditures and Improvements						
Furniture, Fixtures, Equipment and Leasehold Improvements	$6,550,000	$4,400,290	$4,573,348	$4,753,321	$4,940,485	$5,088,700
Real Estate	6,700,000	3,319,954	3,450,524	3,586,311	3,727,524	3,839,350
Total Capital Expenditures	**$13,250,000**	**$7,720,244**	**$8,023,872**	**$8,339,631**	**$8,668,009**	**$8,928,050**
As a Percent of Total Net Operating Revenue	*3.6%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Depreciation Schedule						
Depreciation of Initial Net Fixed Assets	$8,561,707	$4,166,874	$4,166,874	$4,166,874	$4,166,874	
Calculated Depreciation of Capital Expenditures	2,383,396	2,109,983	1,836,194	2,544,443	3,295,456	8,928,050
Total Depreciation	**$10,945,104**	**$6,276,857**	**$6,003,067**	**$6,711,316**	**$7,462,330**	**$8,928,050**

Notes and Sources

(1) Projected depreciation and amortization expense was based on the Tax Cuts and Jobs Act ("TCJA") signed into law on December 22, 2017. The depreciation was modeled assuming a hypothetical control transaction using an asset deal structure. VMG assumed a hypothetical buyer would take full advantage of this new law; therefore, depreciation expense includes the application of Section 179 and Section 168(k) (Bonus Depreciation) to the initial depreciable basis of qualifying assets. Straight-line depreciation was applied to the remaining depreciable basis of assets after considering any applicable deductions.

(2) Year 1 capital expenditures are projected per the FY 2026 Capital Budget provided by Hospital management. Year 2 through Terminal Year capital expenditures are estimated at 2.0% of Total Net Operating Revenue.

Tri-City Medical Center

Income Approach | Cash Flow Projections

						Projection Period					
Cash Flow Projections	FY 2022	FY 2023	FY 2024	FY 2025	NBY	Year 1	Year 2	Year 3	Year 4	Year 5	Terminal Year
Net Operating Revenue											
Gross Revenue	$1,322,603,534	$1,183,311,824	$1,206,688,384	$1,635,600,310	$1,635,600,310	$1,680,070,859	$1,747,945,722	$1,818,562,729	$1,892,032,663	$1,968,470,783	
Adjustments and Refunds	(1,002,164,321)	(872,061,972)	(927,276,757)	(1,303,157,681)	(1,303,157,681)	(1,326,770,859)	(1,380,372,402)	(1,436,139,447)	(1,494,159,480)	(1,554,523,523)	
Net Patient Service Revenue	**320,439,213**	**311,249,852**	**279,411,627**	**332,442,629**	**332,442,629**	**353,300,000**	**367,573,320**	**382,423,282**	**397,873,183**	**413,947,259**	
Growth	*n/a*	*(2.9%)*	*(10.2%)*	*19.0%*	*-*	*6.3%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	
Premium Revenue	12,193,638	11,267,183	12,235,986	2,980,718	2,980,718	-	-	-	-	-	
Other Revenue	3,133,638	3,198,627	5,898,725	2,276,656	2,276,656	1,867,000	1,867,000	1,867,000	1,867,000	1,867,000	
District Tax Revenue	13,063,078	14,310,378	15,252,798	15,928,374	15,928,374	16,246,941	16,571,880	16,903,318	17,241,384	17,586,212	
Total Net Operating Revenue	**348,829,567**	**340,026,040**	**312,799,136**	**353,628,377**	**353,628,377**	**371,413,942**	**386,012,200**	**401,193,600**	**416,981,567**	**433,400,471**	**446,402,485**
Growth	*n/a*	*(2.5%)*	*(8.0%)*	*13.1%*	*(0.0%)*	*5.0%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.0%*
Operating Expenses											
Employee Salaries and Wages	196,662,021	188,768,600	165,388,430	158,155,342	124,531,765	141,219,685	147,444,481	153,956,624	160,769,824	167,898,463	
Employee Benefits	-	-	-	-	33,623,577	38,129,315	39,810,010	41,568,288	43,407,853	45,332,585	
Occupancy Costs	15,826,822	17,216,569	14,918,073	17,376,575	17,376,575	16,385,000	16,876,550	17,382,847	17,904,332	18,441,462	
Drugs and Medical Supplies	80,801,391	76,985,637	73,883,951	79,907,522	79,907,522	83,629,000	87,860,627	92,306,375	96,977,078	101,884,118	
Other Medical Costs	29,015,336	40,632,121	36,645,127	38,720,630	38,720,630	41,813,000	43,067,390	44,359,412	45,690,194	47,060,900	
General and Administrative	36,926,535	33,894,924	29,329,327	35,014,657	35,014,657	32,850,000	33,835,500	34,850,565	35,896,082	36,972,964	
Total Operating Expenses	359,232,105	357,497,851	320,164,908	329,174,726	329,174,726	354,026,000	368,894,558	384,424,110	400,645,363	417,590,492	
Growth	*n/a*	*(0.5%)*	*(10.4%)*	*2.8%*	*-*	*7.5%*	*4.2%*	*4.2%*	*4.2%*	*4.2%*	
EBITDA	**(10,402,538)**	**(17,471,811)**	**(7,365,772)**	**24,453,651**	**24,453,651**	**17,387,942**	**17,117,642**	**16,769,490**	**16,336,204**	**15,809,979**	**16,284,279**
Growth	*n/a*	*(nmf)*	*nmf*	*nmf*	*(0.0%)*	*(28.9%)*	*(1.6%)*	*(2.0%)*	*(2.6%)*	*(3.2%)*	*3.0%*
Depreciation and Amortization Expense	10,735,355	15,048,194	13,822,305	13,480,216	13,480,216	10,945,104	6,276,857	6,003,067	6,711,316	7,462,330	8,928,050
Net Interest Expense	3,888,214	5,592,453	4,469,152	3,048,843	-	-	-	-	-	-	-
Earnings Before Non-Operating Items	**(25,026,107)**	**(38,112,458)**	**(25,657,229)**	**7,924,592**	**10,973,435**	**6,442,838**	**10,840,786**	**10,766,422**	**9,624,888**	**8,347,649**	**7,356,229**
Non-Operating Income (Expense)	1,121,047	6,340,800	702,260	3,986,063	-	-	-	-	-	-	-
Earnings Before Income Taxes	**(23,905,060)**	**(31,771,658)**	**(24,954,969)**	**11,910,655**	**10,973,435**	**6,442,838**	**10,840,786**	**10,766,422**	**9,624,888**	**8,347,649**	**7,356,229**
Federal and State Income Tax Expense	-	-	-	-	3,070,762	1,802,938	3,033,642	3,012,833	2,693,390	2,335,973	2,058,538
Earnings After Income Taxes	($23,905,060)	($31,771,658)	($24,954,969)	$11,910,655	$7,902,673	$4,639,900	$7,807,144	$7,753,590	$6,931,498	$6,011,676	$5,297,691

Tri-City Medical Center

Income Approach | Cash Flow Projections

						Projection Period					
Cash Flow Projections	FY 2022	FY 2023	FY 2024	FY 2025	NBY	Year 1	Year 2	Year 3	Year 4	Year 5	Terminal Year
Common Size Basis											
Net Operating Revenue											
Gross Revenue	379.2%	348.0%	385.8%	462.5%	462.5%	452.3%	452.8%	453.3%	453.7%	454.2%	
Adjustments and Refunds	(287.3%)	(256.5%)	(296.4%)	(368.5%)	(368.5%)	(357.2%)	(357.6%)	(358.0%)	(358.3%)	(358.7%)	
Net Patient Service Revenue	**91.9%**	**91.5%**	**89.3%**	**94.0%**	**94.0%**	**95.1%**	**95.2%**	**95.3%**	**95.4%**	**95.5%**	
Premium Revenue	3.5%	3.3%	3.9%	0.8%	0.8%	-	-	-	-	-	
Other Revenue	0.9%	0.9%	1.9%	0.6%	0.6%	0.5%	0.5%	0.5%	0.4%	0.4%	
District Tax Revenue	3.7%	4.2%	4.9%	4.5%	4.5%	4.4%	4.3%	4.2%	4.1%	4.1%	
Total Net Operating Revenue	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Operating Expenses											
Employee Salaries and Wages	56.4%	55.5%	52.9%	44.7%	35.2%	38.0%	38.2%	38.4%	38.6%	38.7%	
Employee Benefits	-	-	-	-	9.5%	10.3%	10.3%	10.4%	10.4%	10.5%	
Occupancy Costs	4.5%	5.1%	4.8%	4.9%	4.9%	4.4%	4.4%	4.3%	4.3%	4.3%	
Drugs and Medical Supplies	23.2%	22.6%	23.6%	22.6%	22.6%	22.5%	22.8%	23.0%	23.3%	23.5%	
Other Medical Costs	8.3%	11.9%	11.7%	10.9%	10.9%	11.3%	11.2%	11.1%	11.0%	10.9%	
General and Administrative	10.6%	10.0%	9.4%	9.9%	9.9%	8.8%	8.8%	8.7%	8.6%	8.5%	
Total Operating Expenses	103.0%	105.1%	102.4%	93.1%	93.1%	95.3%	95.6%	95.8%	96.1%	96.4%	
EBITDA	**(3.0%)**	**(5.1%)**	**(2.4%)**	**6.9%**	**6.9%**	**4.7%**	**4.4%**	**4.2%**	**3.9%**	**3.6%**	**3.6%**
Depreciation and Amortization Expense	3.1%	4.4%	4.4%	3.8%	3.8%	2.9%	1.6%	1.5%	1.6%	1.7%	2.0%
Net Interest Expense	1.1%	1.6%	1.4%	0.9%	-	-	-	-	-	-	-
Earnings Before Non-Operating Items	**(7.2%)**	**(11.2%)**	**(8.2%)**	**2.2%**	**3.1%**	**1.7%**	**2.8%**	**2.7%**	**2.3%**	**1.9%**	**1.6%**
Non-Operating Income (Expense)	0.3%	1.9%	0.2%	1.1%	-	-	-	-	-	-	-
Earnings Before Income Taxes	**(6.9%)**	**(9.3%)**	**(8.0%)**	**3.4%**	**3.1%**	**1.7%**	**2.8%**	**2.7%**	**2.3%**	**1.9%**	**1.6%**
Federal and State Income Tax Expense	-	-	-	-	0.9%	0.5%	0.8%	0.8%	0.6%	0.5%	0.5%
Earnings After Income Taxes	(6.9%)	(9.3%)	(8.0%)	3.4%	2.2%	1.2%	2.0%	1.9%	1.7%	1.4%	1.2%

Tri-City Medical Center

Income Approach | Discounted Cash Flow Multi-Period Method

Discounted Cash Flow Multi-Period Method	Year 1	Year 2	Year 3	Year 4	Year 5	Terminal Year	Key Assumptions
EBITDA	$17,387,942	$17,117,642	$16,769,490	$16,336,204	$15,809,979	$16,284,279	
Depreciation and Amortization Expense	10,945,104	6,276,857	6,003,067	6,711,316	7,462,330	8,928,050	
Earnings Before Income Taxes	6,442,838	10,840,786	10,766,422	9,624,888	8,347,649	7,356,229	
Federal and State Income Tax Expense	1,802,938	3,033,642	3,012,833	2,693,390	2,335,973	2,058,538	*28.0% Blended Federal and State (California) Tax Rate*
Earnings After Income Taxes	4,639,900	7,807,144	7,753,590	6,931,498	6,011,676	5,297,691	
(+) Depreciation and Amortization Expense	10,945,104	6,276,857	6,003,067	6,711,316	7,462,330	8,928,050	
(−) Required Annual Capital Expenditures	(13,250,000)	(7,720,244)	(8,023,872)	(8,339,631)	(8,668,009)	(8,928,050)	
(−) Incremental Working Capital Requirements	(966,103)	(792,970)	(824,646)	(857,594)	(891,866)	(706,263)	*5.4% of Total Net Operating Revenues*
Net Discretionary Cash Flow	1,368,901	5,570,786	4,908,139	4,445,589	3,914,131	4,591,428	
						48,330,826	*3.0% Estimated Long-Term Growth Rate*
Present Value Period *(Mid-Year Convention)*	0.50	1.50	2.50	3.50	4.50	4.50	
Present Value Factor	0.9428	0.8381	0.7449	0.6622	0.5886	0.5886	*12.5% Estimated Weighted Average Cost of Capital*
Discounted Net Discretionary Cash Flows	**$1,290,612**	**$4,668,611**	**$3,656,247**	**$2,943,713**	**$2,303,822**	**$28,447,091**	
Sum of the Present Value of the Years One through Five Projected Cash Flows					$14,863,006	34.3%	
Present Value of the Terminal Year					28,447,091	65.7%	
Fair Market Value Indication					$43,310,097	100.0%	

Final Report

Tri-City Medical Center

Cost of Capital

Attorney-Client Privileged Communication

Tri-City Medical Center

Cost of Capital | Capital Asset Pricing Model

Capital Asset Pricing Model		Key Assumptions
Cost of Equity (K_e)		*= (R_m x B_i) + R_s + R_u + R_f*
Equity Risk Premium (R_m)	6.26%	*Supply Side Long-Term Equity Risk Premium, per Kroll's Cost of Capital Navigator: U.S. Cost of Capital Module, as of Dec. 31, 2024*
(×) Subject Company Re-Levered Beta (B_i)	0.9227	*Please refer to the Beta Calculation (page 51)*
Adjusted Market Risk Premium	5.78%	
(+) Size Premium (R_s)	4.47%	*Premium for the 10th Decile, per Kroll's CRSP Deciles Size Study, Cost of Capital Navigator: U.S. Cost of Capital Module, as of Dec. 31, 2024*
(+) Specific Company Risk Premium (R_u)	1.50%	*Risk associated with the operations of the specific entity or the "unsystematic" risk of the specific entity*
Total Estimated Equity Risk Premium	11.75%	
(+) Risk-Free Rate of Return (R_F)	4.79%	*United States Treasury Constant Maturity, 20 Year, per S&P's Capital IQ as of Jun. 30, 2025*
Total Cost of Equity (K_e)	16.54%	
(×) Equity as a Percent of Total Capital (W_e)	67.95%	*= 1 − [Selected Debt Weighting]*
Pro-Rata Cost of Equity	**11.24%**	
Cost of Debt		
Pre-Tax Cost of Debt (K_d)	6.13%	*Moody's Seasoned Corporate Bond Yield, Percent, Daily, Not Seasonally Adjusted, Rating Baa, as of Jul. 8, 2025*
(×) Tax Rate (t)	27.98%	*= Blended federal (21.0%) and state of California (8.8%) corporate income tax rate, per rates effective Jan. 1, 2025*
After-Tax Cost of Debt	4.41%	*= Pre-Tax Cost of Debt × (1 − Tax Rate)*
(×) Debt as a Percent of Total Capital (W_d)	32.05%	*The selected debt weighting is based on the median Debt / TIC of the guideline companies*
Pro-Rata Cost of Debt	**1.41%**	
Weighted Average Cost of Capital		*= (K_e × W_e) + [K_d × (1 − t) × W_d]*
Pro-Rata Cost of Equity	11.24%	
(+) Pro-Rata Cost of Debt	1.41%	
Weighted Average Cost of Capital *(Unrounded)*	**12.65%**	
Selected Weighted Average Cost of Capital *(Rounded)*	12.50%	

Company Name	Credit Rating [2]	Market Cap.	Total Debt [3]	Minority Interest	Debt / TIC [3]	Debt / Equity	Tax Rate [4]	Levered Beta [5]	Unlevered Beta [6]
1. Community Health Systems, Inc.	CCC+	$454,744	$10,863,000	$533,000	Excluded	Excluded	Excluded	Excluded	Excluded
2. HCA Healthcare, Inc.	BBB-	92,163,861	44,483,000	3,156,000	31.8%	46.7%	21.1%	0.9273	0.6777
3. Tenet Healthcare Corporation	BB-	16,347,760	13,175,000	4,553,000	38.7%	63.0%	20.6%	1.3785	0.9185
4. Universal Health Services, Inc.	BB+	11,673,377	4,582,897	115,034	28.0%	38.9%	23.4%	0.9082	0.6998
5. Ardent Health, Inc.	B+	1,953,976	1,117,829	391,789	32.3%	47.7%	28.0%	0.3920	0.2919
Statistical Analysis									
Median					32.0%	47.2%	22.2%	0.9178	0.6888
Mean					32.7%	49.1%	23.3%	0.9015	0.6470

Relevered Beta Calculation ***Key Assumptions***

Public Comparable Unlevered Beta	Median of the Guideline Public Company Unlevered Betas	0.6888
Debt / TIC	The selected debt weighting is based on the median Debt / TIC of the guideline companies	32.0%
÷ Equity / TIC	*= 1 − [Selected Debt Weighting]*	68.0%
= Debt / Equity		47.2%
Blended Federal and State (CA) Corporate Income Tax Rate	*= Blended federal (21.0%) and state of California (8.8%) corporate income tax rate, per rates effective Jan. 1, 2025*	28.0%
Relevered Beta	*Notes and Sources (7)*	0.9227

Notes and Sources

(1) Source(s): S&P's Capital IQ as of June 30, 2025. Historical financials are "Latest" (i.e., information is retrieved from the most recent period, including press releases). Estimates are consolidated (i.e., includes the parent company and all subsidiaries). Source financials retrieved are as of the company's period end date. Where applicable, the historical spot exchange rate on the period end date is applied to foreign currency types across all historical periods. Unless otherwise noted, data is presented in USD ($), in thousands.

(2) Reflects S&P Global Issuer Credit Ratings, Local Currency, Long-Term.

(3) The Debt / TIC ratio was sourced from S&P's Capital IQ, and represents the median of the public companies' debt structure. Please note, the debt figures exclude lease liabilities.

(4) A 5 Year effective tax rate was calculated to match the beta calculation period and adjust for single-period inconsistencies.

(5) The 5 Year Levered Beta was sourced from S&P's Capital IQ, and was computed by taking the slope of a weekly regression line of the percent change of the stock relative to the percentage price change in the S&P 500.

(6) Unlevered Beta = Levered Beta / { 1 + [(Debt ÷ Equity) × (1 − T)] }

(7) Relevered Beta = Unlevered Beta × { 1 + [(Debt ÷ Equity) × (1 − T)] }

Final Report

Tri-City Medical Center

Cost Approach

Attorney-Client Privileged Communication

Build-Up Approach	Jun. 30, 2025	*Adjustments*	Estimated Value	Stated as a Percent of BEV: Jun. 30, 2025	Stated as a Percent of BEV: Estimated Value	Key Assumptions
Current Assets						
Cash and Equivalents	$1,968,834	($1,968,834)	-	1.7%	-	*Excluded from Net Working Capital*
Short-Term Investments	20,447,027	(20,447,027)	-	17.3%	-	*Excluded from Net Working Capital*
Restricted Cash and Investments	298,000	(298,000)	-	0.3%	-	*Excluded from Net Working Capital*
Patient Accounts Receivable	51,351,904	-	51,351,904	43.6%	37.0%	*Estimated value based on the Jun. 30, 2025 balance sheet*
Other Receivables	4,143,216	-	4,143,216	3.5%	3.0%	*Estimated value based on the Jun. 30, 2025 balance sheet*
Supplies Inventory	7,477,168	-	7,477,168	6.3%	5.4%	*Estimated value based on the Jun. 30, 2025 balance sheet*
Prepaid Expenses and Other Assets	4,441,844	-	4,441,844	3.8%	3.2%	*Estimated value based on the Jun. 30, 2025 balance sheet*
Estimated Third-Party Payor Settlements	702,640	-	702,640	0.6%	0.5%	*Estimated value based on the Jun. 30, 2025 balance sheet*
	90,830,633	(22,713,861)	68,116,772	77.0%	49.1%	
Current Liabilities						
Line of Credit	8,678,515	(8,678,515)	-	7.4%	-	*Excluded from Net Working Capital*
Accounts Payable and Accrued Liabilities	61,234,982	-	61,234,982	51.9%	44.1%	*Estimated value based on the Jun. 30, 2025 balance sheet*
Accrued Payroll and Related Expenses	20,181,488	-	20,181,488	17.1%	14.5%	*Estimated value based on the Jun. 30, 2025 balance sheet*
Current Maturities of Long-Term Debt	3,388,687	(3,388,687)	-	2.9%	-	*Excluded from Net Working Capital*
Other Current Liabilities	383,799	-	383,799	0.3%	0.3%	*Estimated value based on the Jun. 30, 2025 balance sheet*
ROU Lease and SBITA Liabilities, Current	6,811,736	(6,811,736)	-	5.8%	-	*Excluded from Net Working Capital*
	100,679,207	(18,878,938)	81,800,269	85.4%	59.0%	
Estimated Normalized Net Working Capital	(9,848,574)	(3,834,923)	(13,683,497)	(8.4%)	(9.9%)	*= Current Assets - Current Liabilities*
Adjustment to Reflect a Normalized Level of Working Capital			*32,892,409*	-	*23.7%*	
Estimated Normalized Net Working Capital	(9,848,574)	29,057,486	19,208,912	(8.4%)	13.8%	*Estimated at 5.4% of Total Net Operating Revenue*
Fixed Assets						
Land and Land Improvements	24,686,017	(24,686,017)	-	20.9%	-	*Considered in VMG's FMV Analysis of the Fixed Assets & Real Estate*
Buildings and Improvements	214,323,603	(214,323,603)	-	181.8%	-	*Considered in VMG's FMV Analysis of the Fixed Assets & Real Estate*
Equipment	193,613,907	(193,613,907)	-	164.2%	-	*Considered in VMG's FMV Analysis of the Fixed Assets & Real Estate*
Construction in Progress	23,942,762	(23,942,762)	-	20.3%	-	*Considered in VMG's FMV Analysis of the Fixed Assets & Real Estate*
Accumulated Depreciation	(360,939,707)	360,939,707	-	(306.1%)	-	*Considered in VMG's FMV Analysis of the Fixed Assets & Real Estate*
Right-of-Use ("ROU") Lease and SBITA, Net	32,129,110	(32,129,110)	-	27.2%	-	*Removed; ROU*
VMG Real Estate FMV	-	104,900,000	104,900,000	-	75.6%	*Based on VMG's FMV Analysis of the Real Estate (Page 41)*
VMG Personal Property FMV	-	14,609,420	14,609,420	-	10.5%	*Based on VMG's FMV Analysis of the Personal Property (Page 42)*
	127,755,692	(8,246,272)	119,509,420	108.4%	86.2%	
Fair Market Value Indication	$117,907,118	$20,811,214	$138,718,332	100.0%	100.0%	

Tri-City Medical Center

Cost Approach | Real Estate FMV

Subject	Address	City	State	Cost Approach	Remaining Useful Life of Land Improvements (Years)	Remaining Useful Life of Building Improvements (Years)	Excess Land	Land Value	Land Improvements	Building Improvements	Final Indicated Value
Pre-Seismic Retrofit Costs											
Appraised Real Estate Value											
Tri-City Medical Campus	4002 Vista Way	Oceanside	California	$161,300,000	10	10	-	$48,150,000	$8,340,000	$104,850,000	$161,340,000
Carlsbad Medical Offices	6250 & 6260 El Camino Real	Carlsbad	California	50,000,000	10	40	-	10,720,000	1,270,000	38,010,000	50,000,000
Total Appraised Real Estate Value				**$211,300,000**			**-**	**$58,870,000**	**$9,610,000**	**$142,860,000**	**$211,340,000**
Total Pre-Seismic Retrofit Value											**$211,340,000**
Post-Seismic Retrofit Cost Projections											
Appraised Real Estate Value											
Tri-City Medical Campus	4002 Vista Way	Oceanside	California	$54,900,000	10	40	-	$48,150,000	w/building	$6,750,000	$54,900,000
Carlsbad Medical Offices	6250 & 6260 El Camino Real	Carlsbad	California	50,000,000	10	40	-	10,720,000	1,270,000	38,010,000	50,000,000
Total Appraised Real Estate Value				**$104,900,000**			**-**	**$58,870,000**	**$1,270,000**	**$44,760,000**	**$104,900,000**
Total Post-Seismic Retrofit Value											**$104,900,000**

Notes and Sources

(1) Fair Market Value Analysis of the Real Estate Property prepared by VMG's Real Estate division.

Asset Classification	*Footnotes*	Acquisition Cost (1)	Net Book Value (1)	Estimated Fair Market Value (2)	Estimated Orderly Liquidation Value (3)
Land	*4*	$24,655,219	$17,396,176	-	-
Buildings	*4*	208,029,369	46,607,598	-	-
Leasehold Improvements		10,000,604	2,499,136	2,472,400	-
Total Real Property		**$242,685,193**	**$66,502,909**	**$2,472,400**	**-**
Medical Equipment		$75,009,616	$15,266,911	$18,105,380	$14,139,690
Vehicles		396,811	-	93,200	3,740
Computer Equipment		6,524,748	596,310	787,750	130,350
Software		26,726,195	447,893	1,952,510	-
Communications Equipment		1,443,370	14,583	207,150	11,310
Office Furniture		3,494,650	189,742	745,480	66,770
Office Equipment		3,071,999	777,076	949,780	177,180
Other Equipment		2,751,588	123,562	673,150	80,380
Total Personal Property		**$119,418,977**	**$17,416,077**	**$23,514,400**	**$14,609,420**
Construction in Progress	*5*	$12,976,611	$12,976,611	$12,976,611	-
Excluded	*6*	68,660,157	10,053	-	-
Total Adjustments		**$81,636,769**	**$12,986,665**	**$12,976,611**	**-**
Total Tangible Assets		$443,740,939	$96,905,651	$38,963,411	$14,609,420

Notes and Sources

Fair Market Value Analysis of the Tangible Personal Property prepared by VMG's Capital Asset Valuation division, as of June 30, 2025.

(1) Information provided in the Hospital's Fixed Asset Record, as of May 31, 2025.

(2) Fair Market Value premise represents an opinion of price at which the subject assets would change hands between a willing buyer and willing seller, neither under any compulsion to buy or sell and both having reasonable knowledge of relevant facts, as of a specific date.

(3) Estimated Orderly Liquidation Value represents an opinion of price that would be realized from a liquidation sale, given reasonable time to find a buyer, with the seller compelled to sell on a as-is, where-is basis, typically within a 6 to 9-month period.

(4) Real Property excluded from the Personal Property Fair Market Value analysis.

(5) Construction in Progress provided in the Hospital's consolidated financial statements, as of June 30, 2025.

(6) Excluded category primarily consist of fixed asset disposals and retirements.

Final Report

Tri-City Medical Center

Market Approach

Attorney-Client Privileged Communication

Tri-City Medical Center

Market Approach | Guideline Public Company Method

Financial Performance	Ticker	Revenue			EBITDA (Including Equity from Affiliates)		
		TTM	FY + 1	FY + 2	TTM	FY + 1	FY + 2
1. Community Health Systems, Inc.	CYH	$12,647,000	$12,374,774	$12,785,823	$1,266,000	$1,514,280	$1,569,331
2. HCA Healthcare, Inc.	HCA	72,698,000	74,732,140	78,496,591	14,561,000	14,833,525	15,512,436
3. Tenet Healthcare Corporation	THC	20,683,000	20,916,373	21,947,120	4,590,000	4,156,677	4,362,950
4. Universal Health Services, Inc.	UHS	16,460,285	17,130,147	18,081,639	2,412,658	2,460,214	2,583,641
5. Ardent Health, Inc.	ARDT	6,198,620	6,329,740	6,680,445	582,458	596,111	640,414

Valuation Multiples	Ticker	Revenue			EBITDA (Including Equity from Affiliates)		
		TTM	FY + 1	FY + 2	TTM	FY + 1	FY + 2
1. Community Health Systems, Inc.	CYH	0.94x	0.96x	0.93x	9.36x	7.83x	7.55x
2. HCA Healthcare, Inc.	HCA	1.92x	1.87x	1.78x	9.60x	9.42x	9.01x
3. Tenet Healthcare Corporation	THC	1.65x	1.63x	1.55x	7.42x	8.20x	7.81x
4. Universal Health Services, Inc.	UHS	0.99x	0.96x	0.91x	6.79x	6.65x	6.34x
5. Ardent Health, Inc.	ARDT	0.56x	0.55x	0.52x	5.95x	5.81x	5.41x
Statistical Analysis							
Median		0.99x	0.96x	0.93x	7.42x	7.83x	7.55x
Mean		1.21x	1.19x	1.14x	7.82x	7.58x	7.22x

Notes and Sources

(1) Source(s): S&P's Capital IQ as of June 30, 2025. Historical financials are "Latest" (i.e., information is retrieved from the most recent period, including press releases). Estimates are consolidated (i.e., includes the parent company and all subsidiaries). Source financials retrieved are as of the company's period end date. Where applicable, the historical spot exchange rate on the period end date is applied to foreign currency types across all historical periods. Unless otherwise noted, data is presented in USD ($), in thousands.

(2) Total Invested Capital ("TIC") is defined as Market Value of Equity plus Interest-bearing Debt.

(3) Please note, the Total Debt figures presented reflect Total Debt (Excluding Lease Liabilities).

Key Trends by Company	Ticker	FY - 2	FY - 1	FYE	TTM	FY + 1	FY + 2	FY + 3
Revenue Growth								
1. Community Health Systems, Inc.	CYH	(1.3%)	2.3%	1.2%	0.1%	(2.2%)	3.3%	4.0%
2. HCA Healthcare, Inc.	HCA	2.5%	7.9%	8.7%	3.0%	2.8%	5.0%	5.2%
3. Tenet Healthcare Corporation	THC	(1.6%)	7.2%	0.6%	0.1%	1.1%	4.9%	5.3%
4. Universal Health Services, Inc.	UHS	6.0%	6.6%	10.8%	4.0%	4.1%	5.6%	5.0%
5. Ardent Health, Inc.	ARDT	5.3%	5.5%	10.3%	3.9%	2.1%	5.5%	5.3%
Median of the Guideline Companies:		**2.5%**	**6.6%**	**8.7%**	**3.0%**	**2.1%**	**5.0%**	**5.2%**
EBITDA (Including Equity from Affiliates, Excluding Operating Lease Adjustment) Growth								
1. Community Health Systems, Inc.	CYH	(31.8%)	10.2%	(3.4%)	0.6%	19.6%	3.6%	1.7%
2. HCA Healthcare, Inc.	HCA	(4.6%)	5.4%	9.1%	4.9%	1.9%	4.6%	5.6%
3. Tenet Healthcare Corporation	THC	(2.6%)	9.9%	10.4%	6.8%	(9.4%)	5.0%	6.1%
4. Universal Health Services, Inc.	UHS	(15.0%)	6.1%	30.2%	6.2%	2.0%	5.0%	6.3%
5. Ardent Health, Inc.	ARDT	(23.2%)	5.4%	54.8%	5.5%	2.3%	7.4%	7.4%
Median of the Guideline Companies:		**(15.0%)**	**6.1%**	**10.4%**	**5.5%**	**2.0%**	**5.0%**	**6.1%**
Capital Expenditures (As a Percent of Revenues)								
1. Community Health Systems, Inc.	CYH	3.4%	3.7%	2.8%	2.8%	n/a	n/a	n/a
2. HCA Healthcare, Inc.	HCA	7.3%	7.3%	6.9%	6.4%	n/a	n/a	n/a
3. Tenet Healthcare Corporation	THC	4.0%	3.7%	4.5%	4.4%	n/a	n/a	n/a
4. Universal Health Services, Inc.	UHS	5.5%	5.2%	6.0%	6.1%	n/a	n/a	n/a
5. Ardent Health, Inc.	ARDT	2.9%	2.5%	3.1%	3.1%	n/a	n/a	n/a
Median of the Guideline Companies:		**4.0%**	**3.7%**	**4.5%**	**4.4%**	**n/a**	**n/a**	**n/a**
Capital Structure (Debt to Total Invested Capital)								
1. Community Health Systems, Inc.	CYH	90.7%	92.2%	92.0%	91.7%	n/a	n/a	n/a
2. HCA Healthcare, Inc.	HCA	35.1%	34.5%	35.2%	31.8%	n/a	n/a	n/a
3. Tenet Healthcare Corporation	THC	63.3%	56.4%	44.6%	38.7%	n/a	n/a	n/a
4. Universal Health Services, Inc.	UHS	32.2%	32.0%	27.4%	28.0%	n/a	n/a	n/a
5. Ardent Health, Inc.	ARDT	n/a	n/a	27.9%	32.3%	n/a	n/a	n/a
Median of the Guideline Companies:		**49.2%**	**45.5%**	**35.2%**	**32.3%**	**n/a**	**n/a**	**n/a**

Notes and Sources

(1) Source(s): S&P's Capital IQ as of June 30, 2025. Historical financials are "Latest" (i.e., information is retrieved from the most recent period, including press releases). Estimates are consolidated (i.e., includes the parent company and all subsidiaries). Source financials retrieved are as of the company's period end date. Where applicable, the historical spot exchange rate on the period end date is applied to foreign currency types across all historical periods. Unless otherwise noted, data is presented in USD ($), in thousands.

(2) Please note, the Debt figures presented above exclude lease liabilities.

CYH	Community Health Systems, Inc. owns, leases, and operates general acute care hospitals in the United States. The company offers general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric, and rehabilitation services, as well as skilled nursing and home care services. It also provides outpatient services at primary care practices, urgent care centers, free-standing emergency departments, ambulatory surgery centers, imaging and diagnostic centers, and direct-to-consumer virtual health visits. The company was founded in 1985 and is headquartered in Franklin, Tennessee.
HCA	HCA Healthcare, Inc., through its subsidiaries, owns and operates hospitals and related healthcare entities in the United States. It operates general and acute care hospitals that offers medical and surgical services, including inpatient care, intensive care, cardiac care, diagnostic, and emergency services; and outpatient services, such as outpatient surgery, laboratory, radiology, respiratory therapy, cardiology, and physical therapy. The company also operates outpatient health care facilities consisting of freestanding ambulatory surgery centers, freestanding emergency care facilities, urgent care facilities, walk-in clinics, diagnostic and imaging centers, rehabilitation and physical therapy centers, radiation and oncology therapy centers, physician practices, and various other facilities. In addition, it operates behavioral hospitals, which provide therapeutic programs comprising child, adolescent and adult psychiatric care, adolescent and adult alcohol, drug abuse treatment, and counseling services. The company was formerly known as HCA Holdings, Inc. HCA Healthcare, Inc. was founded in 1968 and is headquartered in Nashville, Tennessee.
THC	Tenet Healthcare Corporation operates as a diversified healthcare services company in the United States. The company operates through two segments: Hospital Operations and Services, and Ambulatory Care. Its general hospitals offer acute care services, operating and recovery rooms, radiology and respiratory therapy services, clinical laboratories, and pharmacies. The company also provides intensive and critical care, and/or coronary care units; cardiovascular, digestive disease, neurosciences, musculoskeletal, and obstetrics services; outpatient services, including physical therapy; tertiary care services, such as cardiothoracic surgery, complex spinal surgery, neonatal intensive care, and neurosurgery services; pediatric quaternary care services in heart, liver, and kidney transplants; and limb salvaging vascular procedure, acute level 1 trauma, intravascular stroke care, minimally invasive cardiac valve replacement, imaging technology, surgical robotic, and telemedicine access services. In addition, it offers a range of procedures and services, such as orthopedics, total joint replacement, and spinal and other musculoskeletal procedures; gastroenterology; pain management; otolaryngology; ophthalmology; and urology. It operates hospitals, ambulatory surgery centers, urgent care centers, imaging centers, surgical hospitals, off-campus emergency departments, and micro-hospitals. Tenet Healthcare Corporation was founded in 1967 and is headquartered in Dallas, Texas.
UHS	Universal Health Services, Inc., through its subsidiaries, owns and operates acute care hospitals, and outpatient and behavioral health care facilities. It operates through Acute Care Hospital Services and Behavioral Health Care Services segments. The company's hospitals offer general and specialty surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic and coronary care, pediatric, pharmacy, and/or behavioral health services. It also provides commercial health insurance services; and various management services, including central purchasing, information services, finance and control systems, facilities planning, physician recruitment, administrative personnel management, marketing, and public relations services. The company was founded in 1978 and is headquartered in King of Prussia, Pennsylvania.
ARDT	Ardent Health, Inc. owns and operates a network of hospitals and clinics that provides a range of healthcare services in the United States. The company offers general and specialty services, including internal medicine, general surgery, cardiology, oncology, orthopedics, women's services, neurology, urology, and emergency services within inpatient and ambulatory care settings. It also operates a network of ambulatory facilities and telehealth services, including primary care and specialty care clinics, ambulatory surgery centers, urgent care centers, free-standing emergency departments, and diagnostic imaging centers. It operates acute care hospitals, including rehabilitation hospitals and surgical hospitals. Ardent Health, Inc. was formerly known as Ardent Health Partners, Inc. and changed its name to Ardent Health, Inc. in June 2025. The company was founded in 2001 and is based in Brentwood, Tennessee. Ardent Health, Inc. is a subsidiary of EGI-AM Investments, L.L.C.

Notes and Sources

(1) Source(s): S&P's Capital IQ as of June 30, 2025. Historical financials are "Latest" (i.e., information is retrieved from the most recent period, including press releases). Estimates are consolidated (i.e., includes the parent company and all subsidiaries). Source financials retrieved are as of the company's period end date. Where applicable, the historical spot exchange rate on the period end date is applied to foreign currency types across all historical periods. Unless otherwise noted, data is presented in USD ($), in thousands.

Tri-City Medical Center

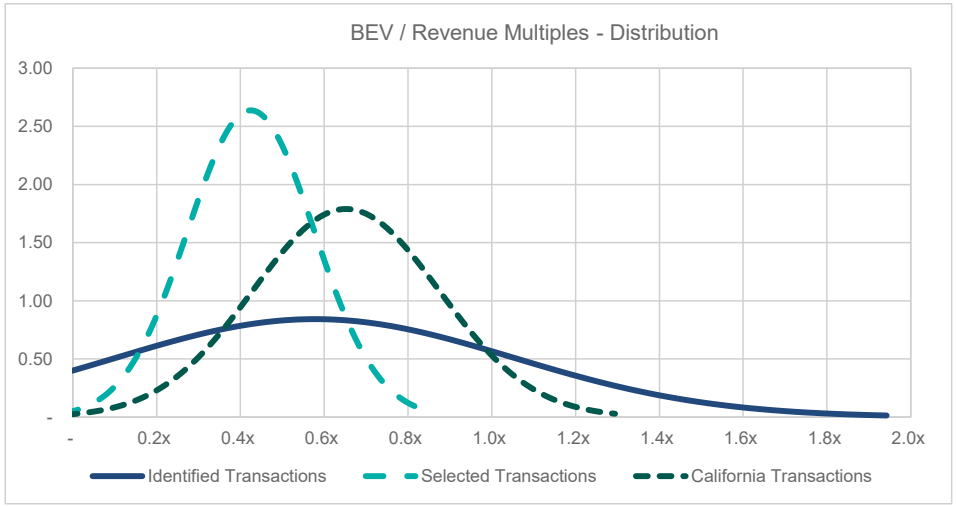
Market Approach | Summary of Merger and Acquisition Multiples

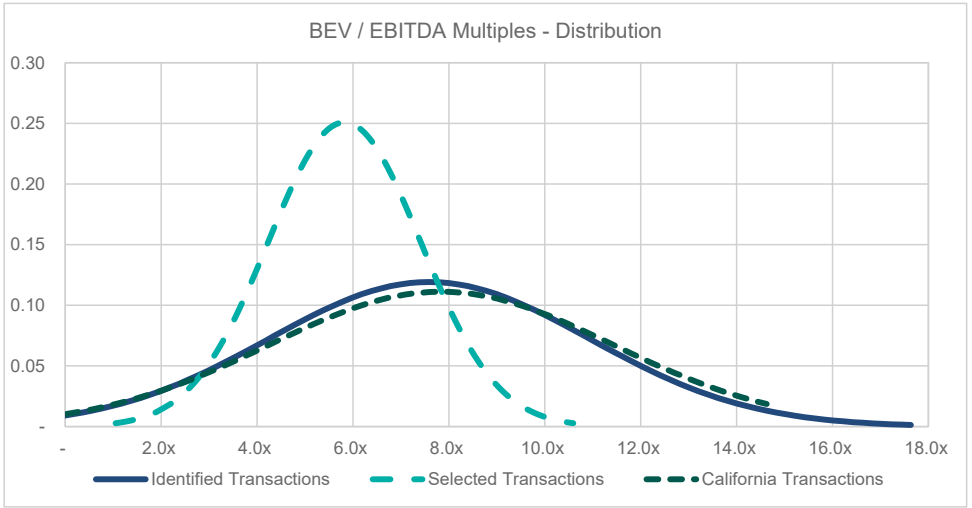
Identified Transactions	BEV / Revenue	BEV / EBITDA
Number of Observations	287	148
Minimum	0.04x	1.92x
25th Percentile	0.27x	5.29x
50th Percentile	0.46x	7.1x
75th Percentile	0.79x	9.06x
Maximum	4.35x	20.49x
Standard Deviation	0.47x	3.3x

Selected Transactions	BEV / Revenue	BEV / EBITDA
Number of Observations	52	25
Minimum	0.20x	3.22x
25th Percentile	**0.31x**	**4.28x**
50th Percentile	**0.40x**	**5.59x**
75th Percentile	**0.55x**	**7.08x**
Maximum	0.80x	9.38x
Standard Deviation	0.15x	1.59x

California Transactions	BEV / Revenue	BEV / EBITDA
Number of Observations	20	8
Minimum	0.09x	3.14x
25th Percentile	0.28x	4.62x
50th Percentile	0.58x	6.7x
75th Percentile	0.96x	12.40x
Maximum	1.75x	14.47x
Standard Deviation	0.22x	3.6x

The below graphs display the normal distribution of the BEV / Revenue multiples. The X-Axis displays the 99.7% confidence interval (non-negative multiples within three standard deviations of the mean) of the multiples. The Y-Axis displays the probability density of the distribution (probability per multiple). The probability density function, unlike probability, can have a value larger than 1.0 (the integral - or area under the curve - will always have a value equal to one).





Notes and Sources

(1) Identified Transactions were sourced from DealStats, Scope Research, Capital IQ, and proprietary information. These data sets include transactions that occurred between January 1, 2015 and June 30, 2025.

(2) The "Selected Transactions" represent a subset of the "Identified Transactions", and were selected as those involving targets most closely aligned to the facts and circumstances surrounding the Hospital.

Measure of Performance	Selected Multiples			Hospital Results	Indicated Value			Weight	Conclusion
	25th %tile	*50th %tile*	*75th %tile*		*Low*	*Midpoint*	*High*		*Midpoint*
BEV / NBY Total Net Operating Revenue	0.31x	0.40x	0.55x	$353,628,377	$110,508,868	$141,451,351	$192,727,465	100.0%	$141,451,351
BEV / Year 1 Total Net Operating Revenue	0.31x	0.40x	0.55x	371,413,942	116,066,857	148,565,577	202,420,598	-	-
Fair Market Value Indication(s)									$141,451,351

Notes and Sources

(1) Identified Transactions were sourced from DealStats, Scope Research, Capital IQ, and proprietary information. These data sets include transactions that occurred between January 1, 2015 and June 30, 2025.

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Tri-City Medical Center

Qualifications and Certification

Attorney-Client Privileged Communication

Statement of Limiting Conditions

The Conclusion(s) of Value in this report are qualified as follows:

- Reliance on Data Provided by Client: The facts described in this Summary Report were provided by management or obtained from independent third parties including the Hospital's accountants, published sources, and commercial databases. VMG accepted this information without verification, and assume this information is materially true and correct.
- Going Concern Value: The Conclusion(s) of Value assumes competent management in the context of a going concern value.
- Client Compliance with Laws: Certain matters are outside the purview of VMG's expertise. As a result, the Conclusion(s) of Value assume (1) the Hospital complies fully with all federal, state, and local laws and ordinances; (2) funding for pensions and healthcare liabilities, if any, is adequate; and (3) there are no undisclosed factors that might render the Hospital materially more or less valuable. Any statements in this Summary Report about the above issues are based on management representations. Client is responsible for any differences and any impact on the Conclusion(s) of Value.
- Client of Record and No Third-Party Reliance: This Summary Report is intended only for the use of the addressee and only for the purpose described. All other uses of this Summary Report are unauthorized and prohibited. The Summary Report may not be distributed, either in whole or part, to any third party, and more possession of the Summary Report does not convey a right of reliance. This Summary Report is not investment, legal, or tax advice.
- No Assurance of Forecasts: VMG has not examined the historical, interim, or prospective financial statements according to generally accepted auditing standards, and so expresses no opinion thereon in this Summary Report. Actual operating results may vary materially from those described.
- Valuation Engagement Methods: Any estimates of future performance in this Summary Report or associated exhibits relate to specific Valuation Engagement methods. These methods match performance scenarios with their associated risk rates to quantify the Valuation Engagement parameters. Using the future performance scenarios or discount rate separately, or outside the Valuation Engagement context, is unauthorized and prohibited.
- Value Synergies: Synergies and cost savings, if any, incorporated into the projections were believed to be realizable by any hypothetical and willing market participant. VMG excluded buyer-specific synergies from the analysis to be consistent with the definition of FMV.
- The fee for this assignment is provided only for the preparation of this Summary Report for the specific Valuation Date. All other services including (1) updates to the Conclusion(s) of Value for any other date; (2) preparation and testimony in court or before governmental agencies; or (3) meetings about the Summary Report after its delivery will be provided at additional cost for fees and expenses.

Experience

Clinton Flume is a managing director at VMG Health in the Dallas office. Over his 17-year tenure, his focus has been on developing client relationships and providing valuation, transaction advisory, and operational consulting services in the healthcare services industry. He has significant experience with the physician practice, post-acute, cancer centers, ambulatory surgery centers, and diagnostic imaging segments. Mr. Flume also has experience valuing intangible assets such as brand/trade name, certificate of needs (CON) and non-compete agreements. Mr. Flume's clients include academic medical centers and teaching hospitals, for-profit and not-for-profit health systems, ancillary services providers, development companies across several healthcare industry sub-specialties, and other publicly owned and privately held healthcare entities.

Mr. Flume is also a contributing author in The Healthcare Executive's Simple Guide to FMV published in 2017 in conjunction with the ABA Health Law section. Mr. Flume's contributing chapters include professional physician practices and inpatient rehabilitation facilities.

Mr. Flume leads VMG's Physician Practice affinity group and is a member of AHLA's behavioral health task force. In 2020, Mr. Flume contributed to industry trends and transaction content to American Health Law Association (ASC & Behavioral Health), American Bar Association Health Law (Behavioral Health) and the Ambulatory Surgery Center Association (ASC).

Clinton Flume, CVA

Managing Director

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More About Me

Mr. Flume received a Bachelor of Arts in Communication from the Texas Christian University and a Master's in Business Administration from the Mays Business School at Texas A&M University. He has achieved the Certified Valuation Analyst (CVA) designation with the National Association of Certified Valuators and Analyst (NACVA) and is a member of the American Health Lawyers Association.

Areas of Expertise

- Business Valuation
- Brand Valuation
- Transaction Advisory
- Intellectual Property
- Financial Planning & Analysis

Appraiser's Certification

I certify that, to the best of my knowledge and belief:

- The statements of fact contained in this Summary Report are true and correct.
- The Summary Report analysis, opinions, and Conclusion(s) of Value are limited by the reported assumptions and limiting conditions and represent my personal, impartial, and unbiased professional analysis, opinions, and conclusions.
- I have no present or prospective interest in the assets that are the subject of this Summary Report and no personal interest with respect to the parties involved.
- I have no bias with respect to the assets that are the subject of this Summary Report or to the parties involved with this assignment.
- My engagement in this assignment was not contingent on developing or reporting predetermined results.
- My compensation for completing this assignment is not contingent on the development or reporting of a predetermined value or direction in value that favors the cause of the Client, the amount of the value opinion, the attainment of a stipulated result, or the occurrence of a subsequent event directly related to the intended use of this Valuation Engagement.
- I have performed no services, as an appraiser or in any other capacity, regarding the property that is the subject of this Summary Report other than prior services that have been fully disclosed to the Client.
- My analyses, opinions, and conclusions were developed, and this Summary Report has been prepared, in conformity with the Uniform Standards of Professional Appraisal.
- No persons other than the undersigned or those acknowledged in this Summary Report prepared analysis, values, and Conclusion(s) of Value set forth in this Summary Report.
- This Summary Report was completed in accordance with the National Association of Certified Valuation Analysts Professional Standards.

Certifying Appraiser: Clinton Flume, CVA

Other Contributing Appraisers: Lance Whitty and Joshua Miner

Final Report

Tri-City Medical Center

Appendix

Attorney-Client Privileged Communication

Tri-City Medical Center

Appendix | Sources of Information

VMG has relied on information provided directly from the Hospital's management as well as information obtained from independent data sources. The following list summarizes the information VMG has relied upon in forming our opinion:

Information provided by the Hospital:
• Audited historical balance sheets as of Jun. 30, 2022, Jun. 30, 2023, Jun. 30, 2024, and Jun. 30, 2025
• Audited historical income statements for FY 2021, FY 2022, FY 2023, FY 2024, and FY 2025
• Unaudited operating reports for FY 2021, FY 2022, FY 2023, FY 2024, and FY 2025
• Unaudited payor mix reports for FY 2021, FY 2022, FY 2023, FY 2024, and FY 2025
• Current staffing roster
• Governing legal documents
• Depreciation schedule
• Management interviews

VMG has relied on information provided directly from the Hospital's management as well as information obtained from independent data sources. The following list summarizes the information VMG has relied upon in forming our opinion:

Other information sources including, but not limited to, these:

- U.S. Census Bureau
- Centers for Medicare & Medicaid Services
- U.S. Bureau of Labor Statistics
- U.S. Bureau of Economic Analyses
- Federal Reserve Statistical Releases
- Office of Management and Budget
- Congressional Budget Office
- Federal Reserve Bank of Philadelphia, Survey of Professional Forecasters
- Public company SEC filings
- Federal Register
- Irving Levin Associates database
- *DealStats*
- *Mergerstat Review*
- *ScopeResearch*
- *The Market Approach to Valuing Businesses, 2nd Edition* by Shannon P. Pratt
- *Cost of Capital: Estimation and Applications, 2nd Edition* by Shannon P. Pratt
- *Valuing a Business, 5th Edition* by Shannon P. Pratt with Alina V. Niculita
- S&P's Capital IQ
- 2025 State Corporate Income Tax Rates: https://taxfoundation.org/data/all/state/state-corporate-income-tax-rates-brackets/
- 2025 Section 179 Thresholds: https://www.irs.gov/pub/irs-drop/rp-24-40.pdf
- Proprietary internal database of acute care hospital transactions

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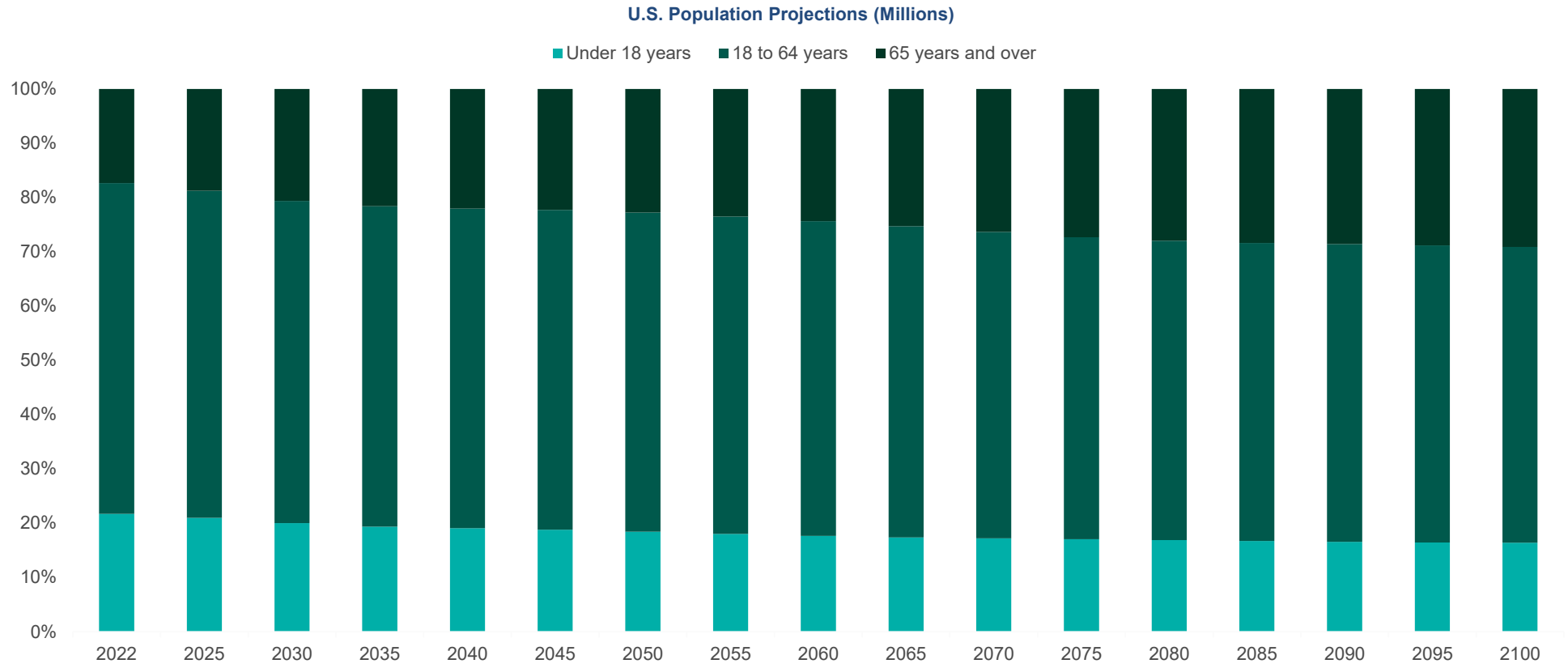
Tri-City Medical Center

Market Overview

Attorney-Client Privileged Communication

Presented in the chart below is a summary of the United States' historical and projected population by age category from 2022 to 2100 provided by the U.S. Census Bureau. As of 2022, there were approximately 57.8 million Americans (17.3% of the total population) 65 years of age or older. In addition, there are approximately 82.5 million Americans (24.8% of the total population) between the ages of 45 and 64 who will become eligible for Medicare over the next 15 to 20 years. Based on projections published by the U.S. Census Bureau, the total percentage of the United States' population over the age of 65 is projected to increase from 17.3% in 2022 to 29.1% in 2100. The aging of the United States' population is projected to drive increased demand for a variety of healthcare services. However, the projected increase in the number of Medicare beneficiaries and the historical increases in spending per beneficiary is forcing policy makers to re-evaluate how Medicare pays for healthcare services.



Notes and Sources

(1) Source(s): Table 2. Projected Population by Age Group and Sex for the United States, Main Series: 2022-2100. U.S. Census Bureau, Population Division. Released November 2023. https://www.census.gov/data/tables/2023/demo/popproj/2023-summary-tables.html

The Hospital is located in Oceanside, California, which is located in San Diego County and, more broadly, the San Diego-Chula Vista-Carlsbad, CA Metropolitan Statistical Area ("MSA"). Population estimates provided by the United States Census Bureau indicate the population of San Diego County increased at a compound annual growth rate ("CAGR") of 0.4% from approximately 3,103,000 residents in 2010 to approximately 3,299,000 residents in 2024. Notably, the growth of the population of San Diego County was consistent with the CAGR for the broader San Diego-Chula Vista-Carlsbad, CA MSA of 0.4%, and above the CAGR for the overall state of 0.4% over the same time period. Most recently, the population of San Diego County, California grew 0.4% from 2023 to 2024.

Population Estimates	2000	2005	2010	2015	2020	2021	2022	2023	2024
San Diego County, California	2,827,366	2,938,375	3,103,260	3,280,825	3,301,182	3,274,244	3,283,755	3,285,890	3,298,799
Year-Over-Year Growth		*0.3%*	*1.4%*	*1.0%*	*(0.9%)*	*(0.8%)*	*0.3%*	*0.1%*	*0.4%*
CAGR Since 2000		*0.8%*	*0.9%*	*1.0%*	*0.8%*	*0.7%*	*0.7%*	*0.7%*	*0.6%*
CAGR Since 2010				*1.1%*	*0.6%*	*0.5%*	*0.5%*	*0.4%*	*0.4%*
CAGR Since 2020						*(0.8%)*	*(0.3%)*	*(0.2%)*	*(0.0%)*
San Diego-Chula Vista-Carlsbad, CA	n/a	n/a	3,103,260	3,280,825	3,301,182	3,274,244	3,283,755	3,285,890	3,298,799
Year-Over-Year Growth		*n/a*	*n/a*	*1.0%*	*(0.9%)*	*(0.8%)*	*0.3%*	*0.1%*	*0.4%*
CAGR Since 2000		*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*
CAGR Since 2010				*1.1%*	*0.6%*	*0.5%*	*0.5%*	*0.4%*	*0.4%*
CAGR Since 2020						*(0.8%)*	*(0.3%)*	*(0.2%)*	*(0.0%)*
California	33,994,571	35,795,255	37,319,550	38,904,296	39,521,958	39,142,565	39,142,414	39,198,693	39,431,263
Year-Over-Year Growth		*0.7%*	*1.0%*	*0.8%*	*0.2%*	*(1.0%)*	*(0.0%)*	*0.1%*	*0.6%*
CAGR Since 2000		*1.0%*	*0.9%*	*0.9%*	*0.8%*	*0.7%*	*0.6%*	*0.6%*	*0.6%*
CAGR Since 2010				*0.8%*	*0.6%*	*0.4%*	*0.4%*	*0.4%*	*0.4%*
CAGR Since 2020						*(1.0%)*	*(0.5%)*	*(0.3%)*	*(0.1%)*
United States	282,171,957	295,753,151	309,327,143	320,738,994	331,577,720	332,099,760	334,017,321	336,806,231	340,110,988
Year-Over-Year Growth		*0.9%*	*0.8%*	*0.7%*	*1.0%*	*0.2%*	*0.6%*	*0.8%*	*1.0%*
CAGR Since 2000		*0.9%*	*0.9%*	*0.9%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*
CAGR Since 2010				*0.7%*	*0.7%*	*0.6%*	*0.6%*	*0.7%*	*0.7%*
CAGR Since 2020						*0.2%*	*0.4%*	*0.5%*	*0.6%*

Notes and Sources

(1) Source(s): United States Census Bureau.

Approximately 15.9% of the population of San Diego County, California is over the age of 65, lower than the United States population distribution for the same age category of approximately 17.7%, according to 2023 estimates. Notably, the 65+ population within San Diego County, California has increased at a compound annual growth rate ("CAGR") of approximately 2.6% from 2010 to 2023.

Population by Age	2010	2015	2020	2021	2022	2023
San Diego County, California						
Population						
Age 19 and Under	820,720	819,999	795,401	777,095	775,323	766,491
Age 20 to 34	745,081	804,482	765,456	752,979	749,232	740,296
Age 35 to 64	1,184,099	1,231,828	1,253,700	1,251,231	1,246,443	1,242,902
Age 65+	353,360	424,516	480,741	493,127	506,178	520,284
Population Distribution						
Age 19 and Under	26.4%	25.0%	24.1%	23.7%	23.7%	23.4%
Age 20 to 34	24.0%	24.5%	23.2%	23.0%	22.9%	22.6%
Age 35 to 64	38.2%	37.5%	38.0%	38.2%	38.0%	38.0%
Age 65+	11.4%	12.9%	14.6%	15.1%	15.4%	15.9%
National						
Population						
Age 19 and Under	83,184,292	82,120,410	82,873,432	82,201,873	81,903,660	81,573,961
Age 20 to 34	62,914,600	66,762,737	67,150,133	67,062,720	67,183,890	67,353,688
Age 35 to 64	122,750,002	124,199,977	127,050,807	126,899,638	126,713,677	126,738,885
Age 65+	40,478,249	47,655,870	54,452,561	55,884,746	57,470,184	59,248,361
Population Distribution						
Age 19 and Under	26.9%	25.6%	25.0%	24.8%	24.6%	24.4%
Age 20 to 34	20.3%	20.8%	20.3%	20.2%	20.2%	20.1%
Age 35 to 64	39.7%	38.7%	38.3%	38.2%	38.0%	37.8%
Age 65+	13.1%	14.9%	16.4%	16.8%	17.2%	17.7%

2023 San Diego County, California Population Distribution

2023 National Population Distribution

Notes and Sources

(1) Source(s): United States Census Bureau.

As previously mentioned, the Hospital is located in Oceanside, California, which is located in San Diego County and, more broadly, the San Diego-Chula Vista-Carlsbad, CA Metropolitan Statistical Area ("MSA"). Medicare enrollment estimates provided by the Centers for Medicare & Medicaid Services ("CMS") indicate Medicare enrollment in San Diego County increased at a compound annual growth rate ("CAGR") of 2.8% from approximately 440,000 enrollees in 2013 to approximately 595,000 enrollees in 2024. The growth in Medicare enrollment has been driven by growth in Medicare Advantage; Medicare Advantage enrollment exceeded Original Medicare in San Diego County for the first time in 2021. Notably, the growth of the Medicare population of San Diego County was above the CAGR for the overall state of 2.5% over the same time period. Most recently, Medicare enrollment within San Diego County grew 2.5% from 2023 to 2024.

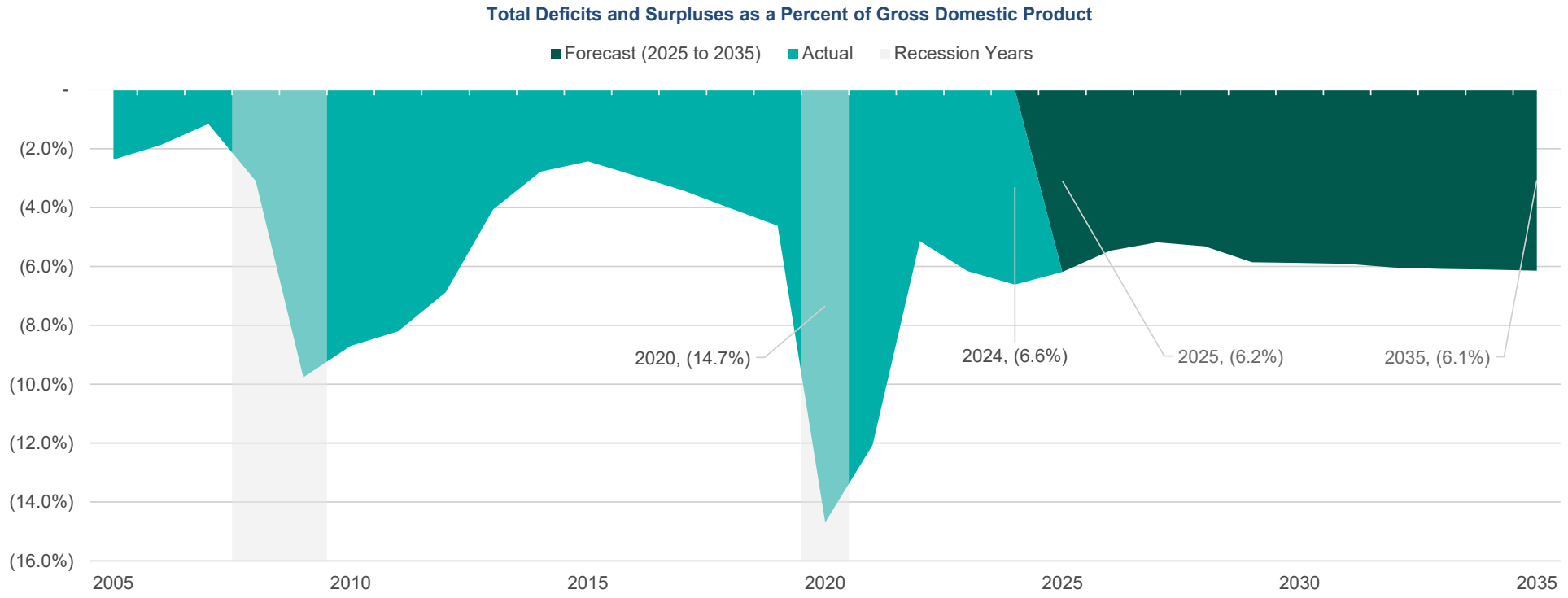
Medicare Enrollment	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
San Diego County, California												
• Original Medicare	259,131	258,575	257,229	264,024	268,029	271,994	275,027	274,523	270,680	270,440	270,739	279,859
• Medicare Advantage	181,261	198,216	215,275	223,217	233,449	245,019	256,857	270,276	284,511	296,889	309,836	314,944
• **Total Medicare Enrollment**	**440,392**	**456,790**	**472,504**	**487,241**	**501,477**	**517,013**	**531,884**	**544,799**	**555,191**	**567,329**	**580,574**	**594,803**
Year-Over-Year Growth		*3.7%*	*3.4%*	*3.1%*	*2.9%*	*3.1%*	*2.9%*	*2.4%*	*1.9%*	*2.2%*	*2.3%*	*2.5%*
CAGR Since 2013		*3.7%*	*3.6%*	*3.4%*	*3.3%*	*3.3%*	*3.2%*	*3.1%*	*2.9%*	*2.9%*	*2.8%*	*2.8%*
California												
• Original Medicare	3,318,396	3,346,928	3,370,508	3,420,954	3,473,379	3,511,605	3,528,546	3,503,899	3,436,742	3,416,586	3,401,066	3,408,449
• Medicare Advantage	1,981,781	2,134,664	2,283,388	2,393,321	2,492,111	2,612,490	2,748,620	2,907,207	3,062,462	3,208,461	3,373,285	3,518,886
• **Total Medicare Enrollment**	**5,300,177**	**5,481,592**	**5,653,896**	**5,814,275**	**5,965,489**	**6,124,095**	**6,277,166**	**6,411,106**	**6,499,203**	**6,625,047**	**6,774,351**	**6,927,335**
Year-Over-Year Growth		*3.4%*	*3.1%*	*2.8%*	*2.6%*	*2.7%*	*2.5%*	*2.1%*	*1.4%*	*1.9%*	*2.3%*	*2.3%*
CAGR Since 2013		*3.4%*	*3.3%*	*3.1%*	*3.0%*	*2.9%*	*2.9%*	*2.8%*	*2.6%*	*2.5%*	*2.5%*	*2.5%*
National												
• Original Medicare	37,613,096	37,790,373	38,025,274	38,610,384	38,667,830	38,665,082	38,577,012	37,776,345	36,356,380	35,270,914	34,367,703	33,824,358
• Medicare Advantage	14,812,563	16,222,665	17,470,948	18,370,800	19,789,414	21,324,800	22,937,498	25,063,922	27,536,246	29,829,632	32,142,166	34,084,407
• **Total Medicare Enrollment**	**52,425,659**	**54,013,038**	**55,496,222**	**56,981,183**	**58,457,244**	**59,989,883**	**61,514,510**	**62,840,267**	**63,892,626**	**65,100,546**	**66,509,869**	**67,908,765**
Year-Over-Year Growth		*0.5%*	*0.6%*	*1.5%*	*0.1%*	*(0.0%)*	*(0.2%)*	*(2.1%)*	*(3.8%)*	*(3.0%)*	*(2.6%)*	*(1.6%)*
CAGR Since 2013		*3.0%*	*2.9%*	*2.8%*	*2.8%*	*2.7%*	*2.7%*	*2.6%*	*2.5%*	*2.4%*	*2.4%*	*2.4%*

Notes and Sources

(1) Source(s): Medicare Monthly Enrollment data published by the Centers for Medicare & Medicaid Services. https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment

Economic Analysis

The federal budget deficit has long been an area of concern for lawmakers. According to estimates from the Congressional Budget Office ("CBO") released in February of 2024, the deficit was approximately 6.6% of gross domestic product ("GDP") in 2024. Since the Great Depression, the federal deficit has exceeded 6.0% of GDP only during and shortly after World War II, after the 2008 financial crisis (2009 through 2012), and the early years of the coronavirus pandemic (2020 and 2021). The deficit is projected to decrease to 6.2% of GDP in 2025, and continue to decrease to 5.3% of GDP in 2028. Beginning in 2029, the deficit is projected to continually increase, reaching 6.1% in 2035.



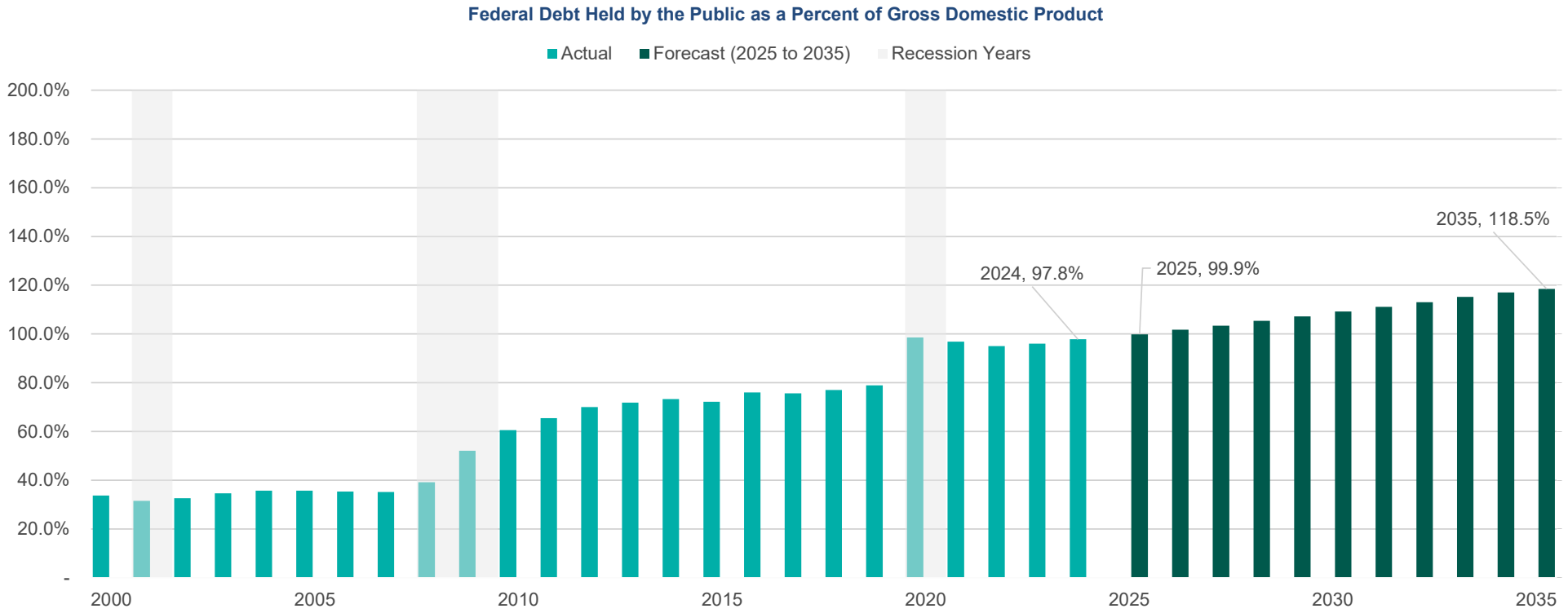
Notes and Sources

(1) Source(s): Figure 4. Total Deficit, Net Interest Outlays, and Primary Deficit. The Budget and Economic Outlook: 2025 to 2035, published January 17, 2025 by the Congressional Budget Office. https://www.cbo.gov/publication/60870

(2) Source(s): Federal Reserve Bank of St. Louis, National Bureau of Economic Research ("NBER")-Based Recession Indicators for the United States from the Period following the Peak through the Trough ("USREC"). FRED, Federal Reserve Bank of St. Louis. Data retrieved February 1, 2025. https://fred.stlouisfed.org/series/USREC

Economic Analysis

According to estimates from the CBO released in January of 2025, as a result of the aforementioned projected deficit, federal debt held by the public as a percent of GDP is projected to increase from 101.7% in 2026 to 118.5% in 2035, the highest level ever recorded.



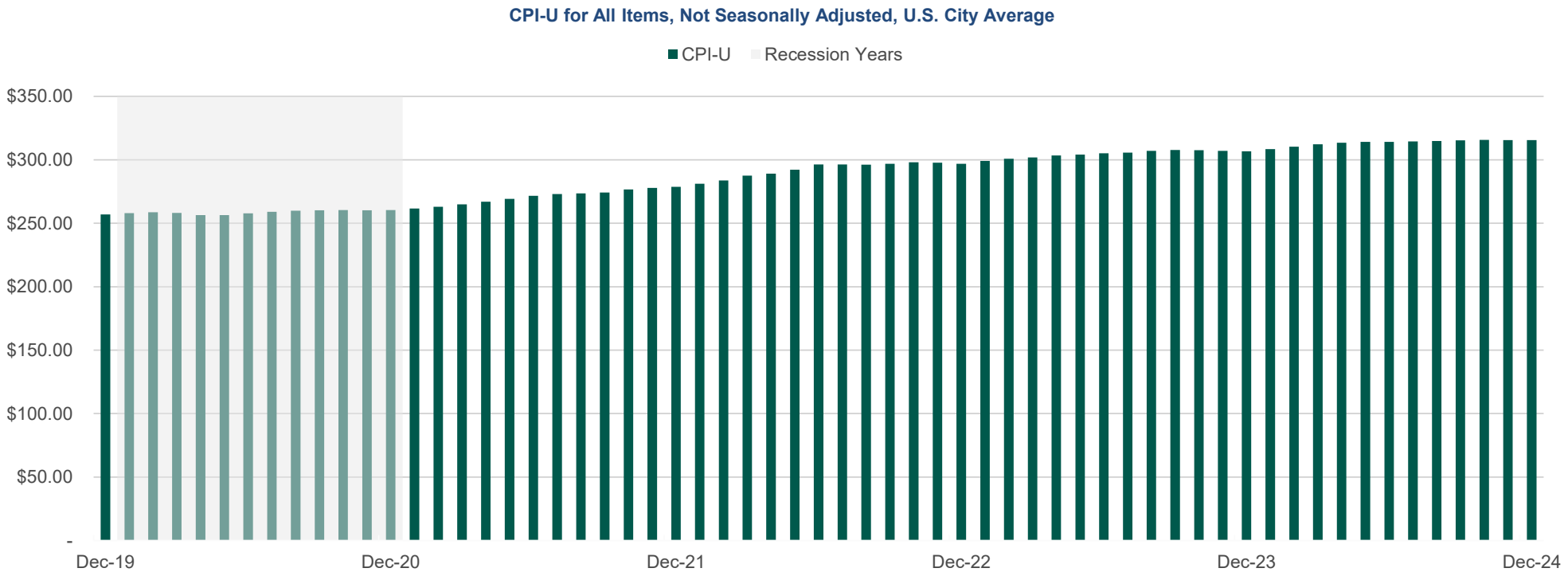
Notes and Sources

(1) Source(s): Figure 6. Federal Debt Held by the Public as a Percentage of GDP. The Budget and Economic Outlook: 2025 to 2035, published January 17, 2025 by the Congressional Budget Office. https://www.cbo.gov/publication/60870

(2) Source(s): Federal Reserve Bank of St. Louis, National Bureau of Economic Research ("NBER")-Based Recession Indicators for the United States from the Period following the Peak through the Trough ("USREC"). FRED, Federal Reserve Bank of St. Louis. Data retrieved February 1, 2025. https://fred.stlouisfed.org/series/USREC

Economic Analysis

Presented in the chart below is the consumer price index for all urban consumers in the United States ("CPI-U"), not seasonally adjusted, from December 2019 to December 2024. The CPI-U measures the average change in price for a market basket of goods and services over time for urban consumers. The percentage change in the CPI-U is commonly used to measure the general inflation in the price of goods and services for urban consumers. According to the U.S. Bureau of Labor Statistics ("BLS"), from December 2019 to December 2024, CPI-U increased at a compound annual growth rate ("CAGR") of approximately 4.2%. More recently, CPI-U increased approximately 2.9% from December 2023 to December 2024.



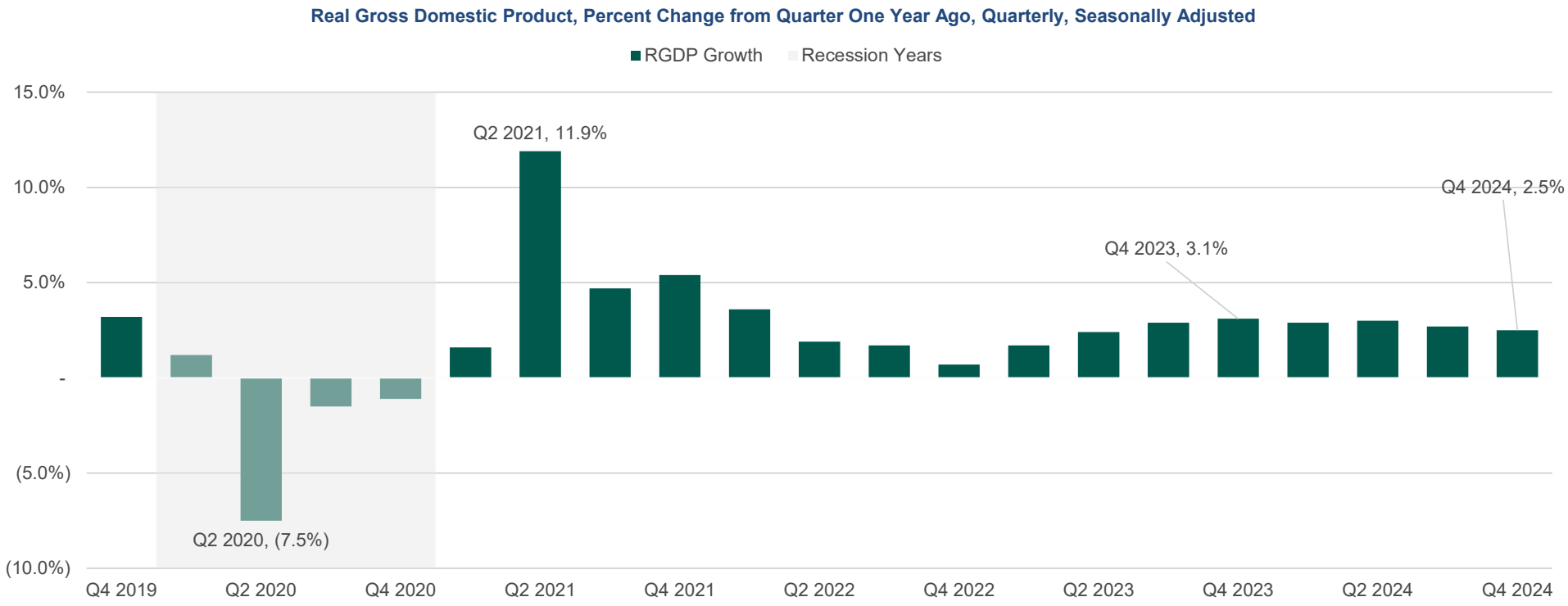
Notes and Sources

(1) Source(s): Consumer Price Index for All Urban Consumers ("CPI-U"), Not Seasonally Adjusted. All Items, U.S. City Average. U.S. Bureau of Labor Statistics. Data retrieved February 1, 2025. https://www.bls.gov/cpi/tables/supplemental-files/home.htm

(2) Source(s): Federal Reserve Bank of St. Louis, National Bureau of Economic Research ("NBER")-Based Recession Indicators for the United States from the Period following the Peak through the Trough ("USREC"). FRED, Federal Reserve Bank of St. Louis. Data retrieved February 1, 2025. https://fred.stlouisfed.org/series/USREC

Economic Analysis

Gross domestic product ("GDP") is a measure of the value of the goods and services produced by the nation's economy less the value of the goods and services used up in production. GDP is also equal to the sum of personal consumption expenditures, gross private domestic investment, net exports of goods and services, and government consumption expenditures and gross investment. Real values are inflation-adjusted estimates (i.e., estimates that exclude the effects of price changes). According to the Bureau of Economic Analysis ("BEA"), annual real GDP growth over the last 5 years (Q4 2019 to Q4 2024), measured as the percent change from the quarter one year ago, has ranged from a low of (7.5%) in Q2 2020 to a high of 11.9% in Q2 2021. Most recently, Q4 2024 real GDP growth was reported to be 2.5% over Q4 2023, a decline from the previous quarter's (Q3 2024) real GDP growth of 2.7%.



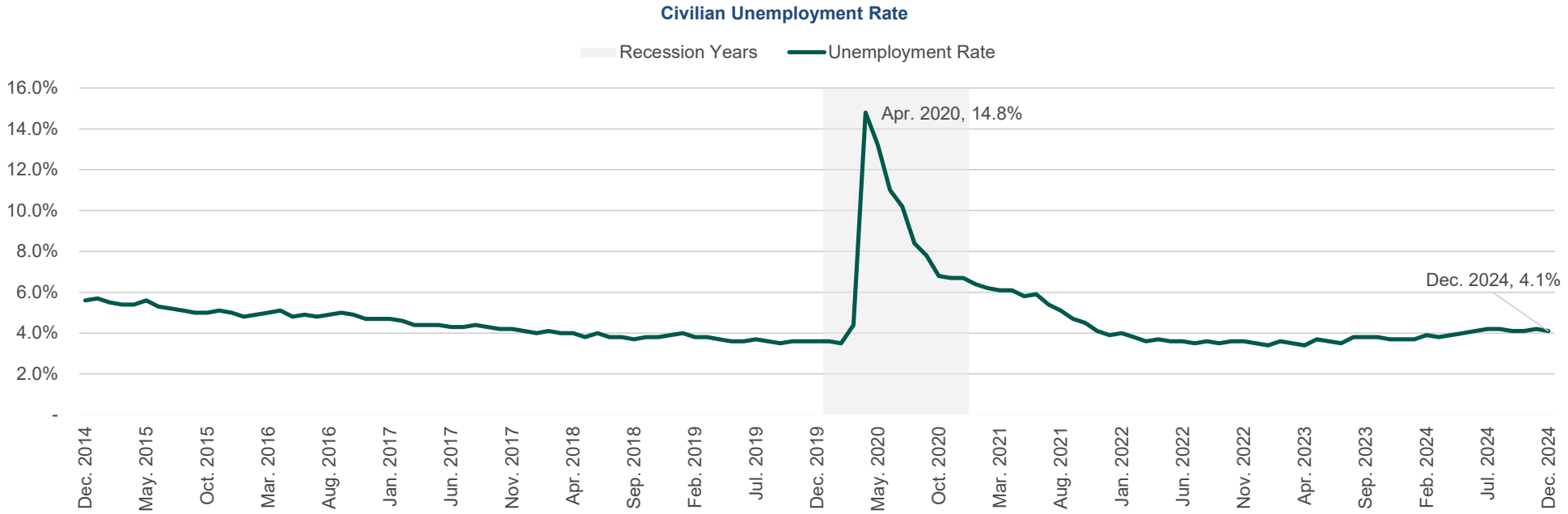
Notes and Sources

(1) Source(s): U.S. Bureau of Economic Analysis, Real Gross Domestic Product, Federal Reserve Bank of St. Louis. Data retrieved February 1, 2025.

(2) Source(s): Federal Reserve Bank of St. Louis, National Bureau of Economic Research ("NBER")-Based Recession Indicators for the United States from the Period following the Peak through the Trough ("USREC"). FRED, Federal Reserve Bank of St. Louis. Data retrieved February 1, 2025. https://fred.stlouisfed.org/series/USREC

Economic Analysis

The unemployment rate represents the number of unemployed people as a percentage of the labor force (the labor force is the sum of the employed and unemployed). According to the U.S. Bureau of Labor Statistics ("BLS"), the unemployment rate over the last 10 years (December 2014 to December 2024) has ranged from a low of 3.4% in January 2023 and April 2023 to a high of 14.8% in April 2020. Most recently, the unemployment rate was reported to be 4.1% as of December 2024, a decline from the previous month's unemployment rate of 4.2%.



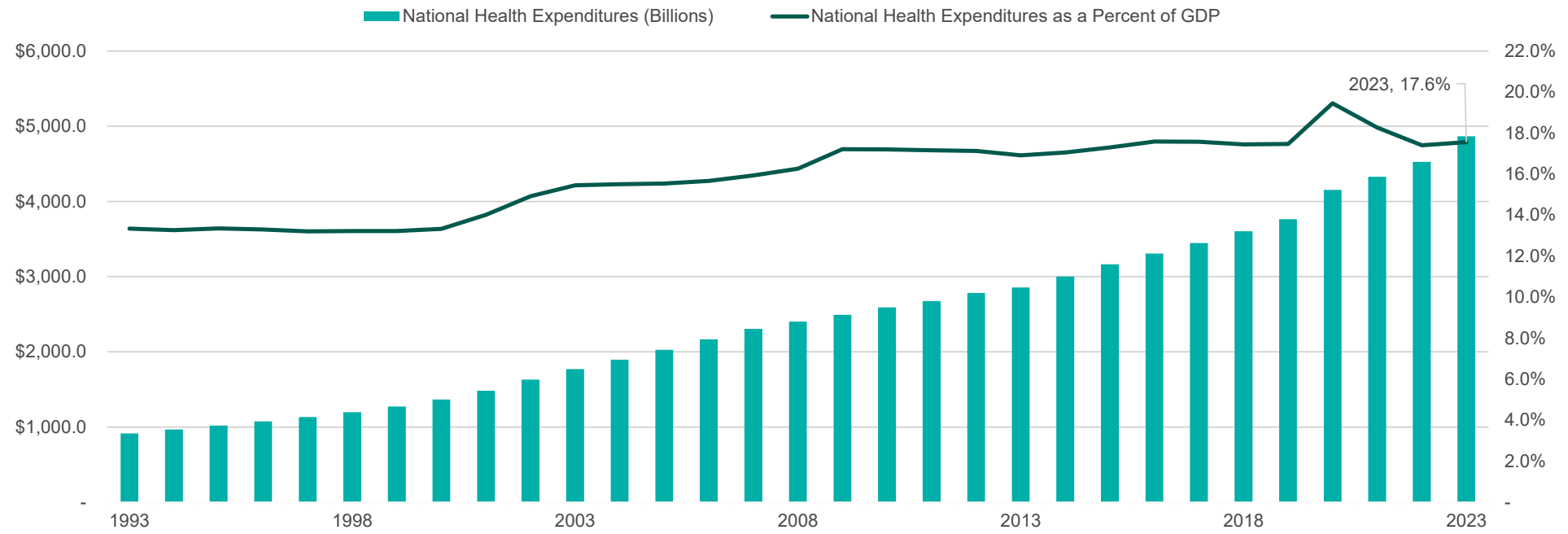
Notes and Sources

(1) Source(s): Civilian Unemployment Rate, Seasonally Adjusted. U.S. Bureau of Labor Statistics. Data retrieved February 1, 2025. https://www.bls.gov/charts/employment-situation/civilian-unemployment-rate.htm

(2) Source(s): Federal Reserve Bank of St. Louis, National Bureau of Economic Research ("NBER")-Based Recession Indicators for the United States from the Period following the Peak through the Trough ("USREC"). FRED, Federal Reserve Bank of St. Louis. Data retrieved February 1, 2025. https://fred.stlouisfed.org/series/USREC

United States Healthcare System

According to the Centers for Medicare & Medicaid Services ("CMS"), total national healthcare expenditures over the last 30 years have grown at a compound annual growth rate of 5.7% from approximately $914.9 billion in 1993 to approximately $4,866.5 billion in 2023. Most recently, total national health expenditures grew 7.5% from approximately $4,525.8 billion in 2022 to approximately $4,866.5 billion in 2023. Healthcare spending as a percent of gross domestic product ("GDP") over the last 30 years has increased from a low of 13.2% in 1997 to a high of 19.5% in 2020. More recently, healthcare spending was approximately 17.6% of GDP in 2023, an increase of approximatley 0.9% from 2022 healthcare spending as a percent of GDP of approximately 17.4%.



Notes and Sources

(1) Source(s): Table 1. National Health Expenditures; Aggregate and per Capita Amounts, Annual Percent Change, and Percent Distribution. Calendar Years 1960 to 2023. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

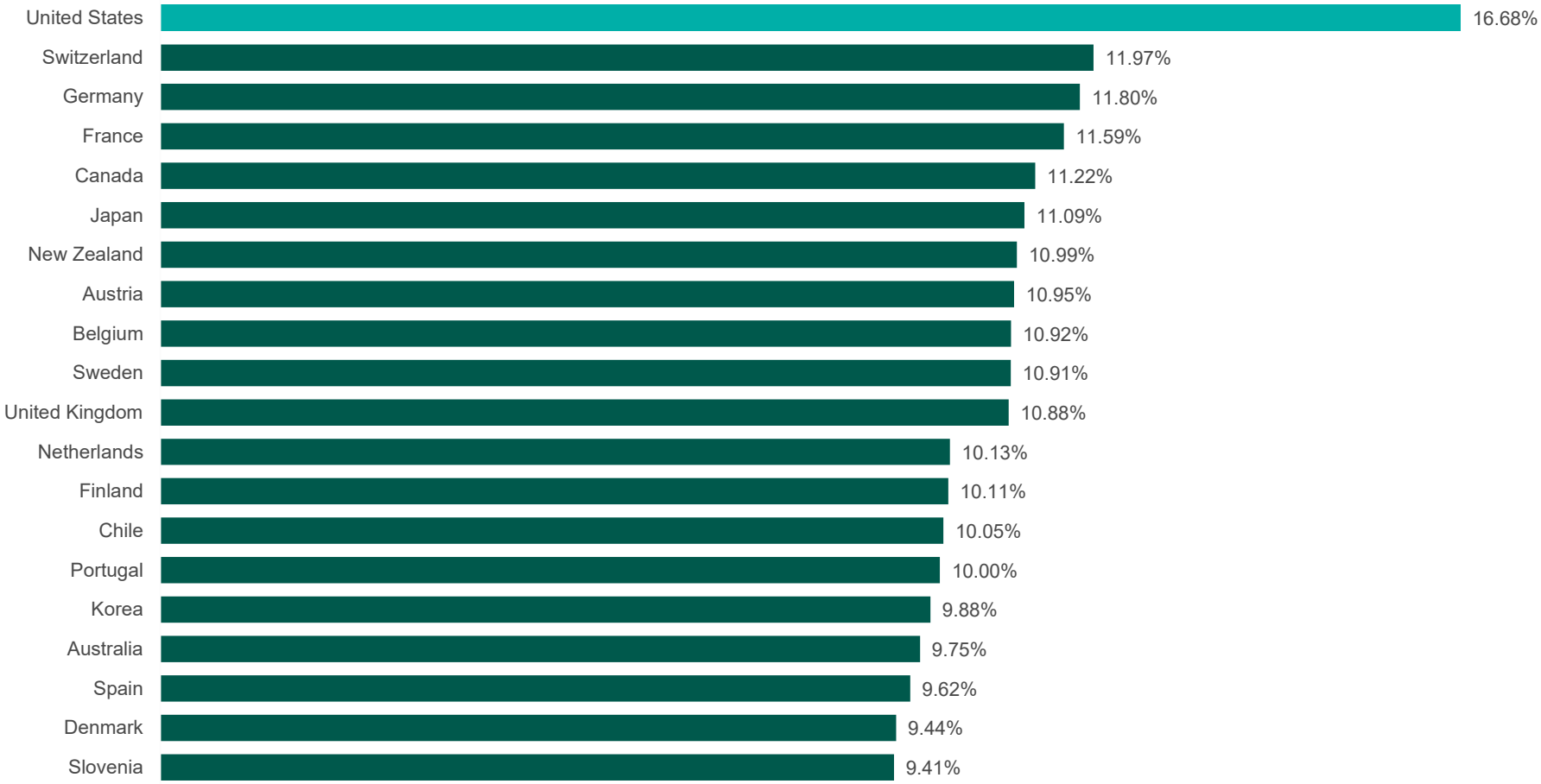
(2) Source(s): National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2023. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

(3) Source(s): Federal Reserve Bank of St. Louis, National Bureau of Economic Research ("NBER")-Based Recession Indicators for the United States from the Period following the Peak through the Trough ("USREC"). FRED, Federal Reserve Bank of St. Louis. Data retrieved February 1, 2025. https://fred.stlouisfed.org/series/USREC

United States Healthcare System

According to the Organisation for Economic Co-Operation and Development ("OECD"), the United States spends more on healthcare, both per capita, and as a share of GDP, than any other country in the world. The chart below presents the top twenty OECD countries in terms of annual health spending as a percent of GDP in 2023.

Annual Health Expenditure and Financing as a Percent of Gross Domestic Product, 2023



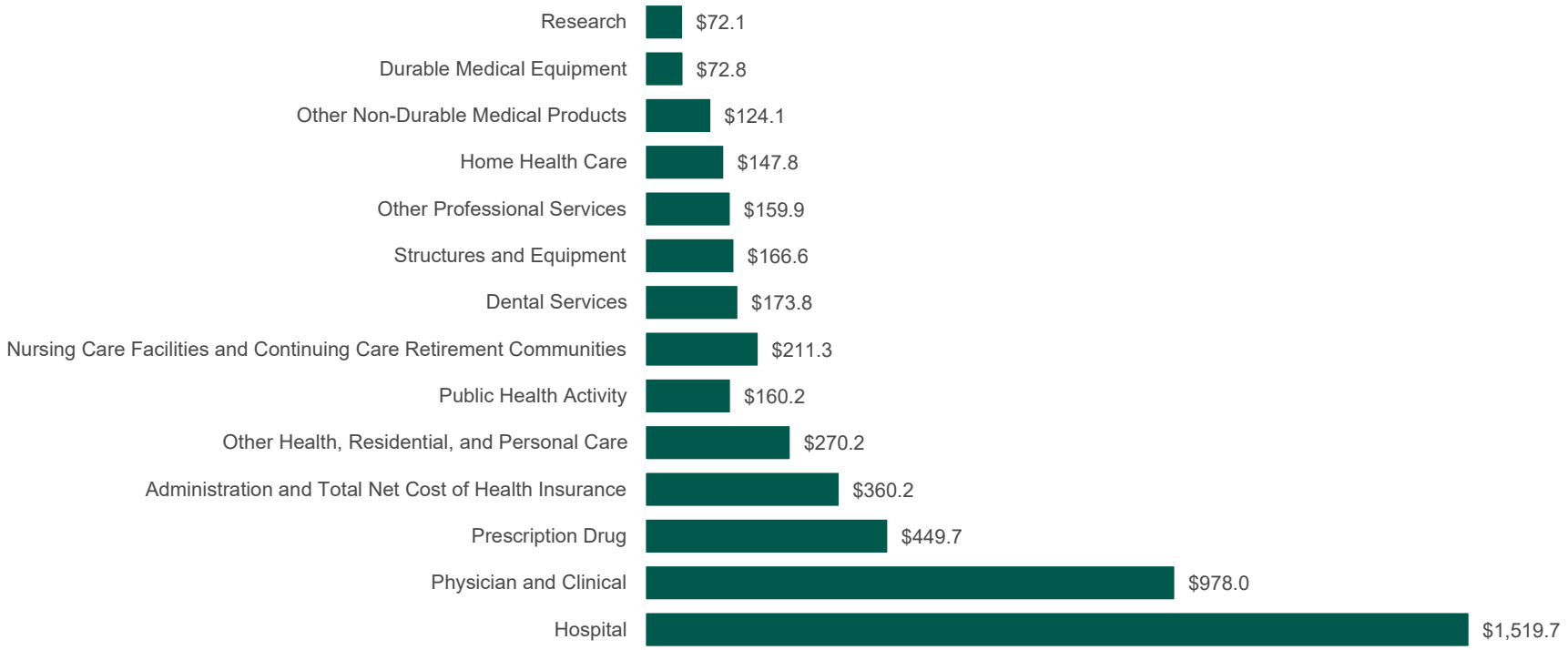
Notes and Sources

(1) Source(s): Organisation for Economic Co-Operation and Development. Data retrieved February 3, 2025. https://stats.oecd.org/Index.aspx?DataSetCode=SHA#

United States Healthcare System

From 2022 to 2023 total national health expenditures increased 7.5% from approximately $4,526 billion in 2022 to approximately $4,866 billion in 2023. In 2023 Hospital and Physician and Clinical were the largest spending categories, accounting for approximately $2,498 billion, or 51.3%, of total health expenditures. From 2013 to 2023 overall healthcare spending increased at a compound annual growth rate of approximately 5.5%. Over this time frame, Other Professional Services and Public Health Activity experienced the largest growth in spending, at compound annual growth rates of approximately 7.4% and 7.0%, respectively, from 2013 to 2023.

National Health Expenditures by Category, 2023 (Billions)



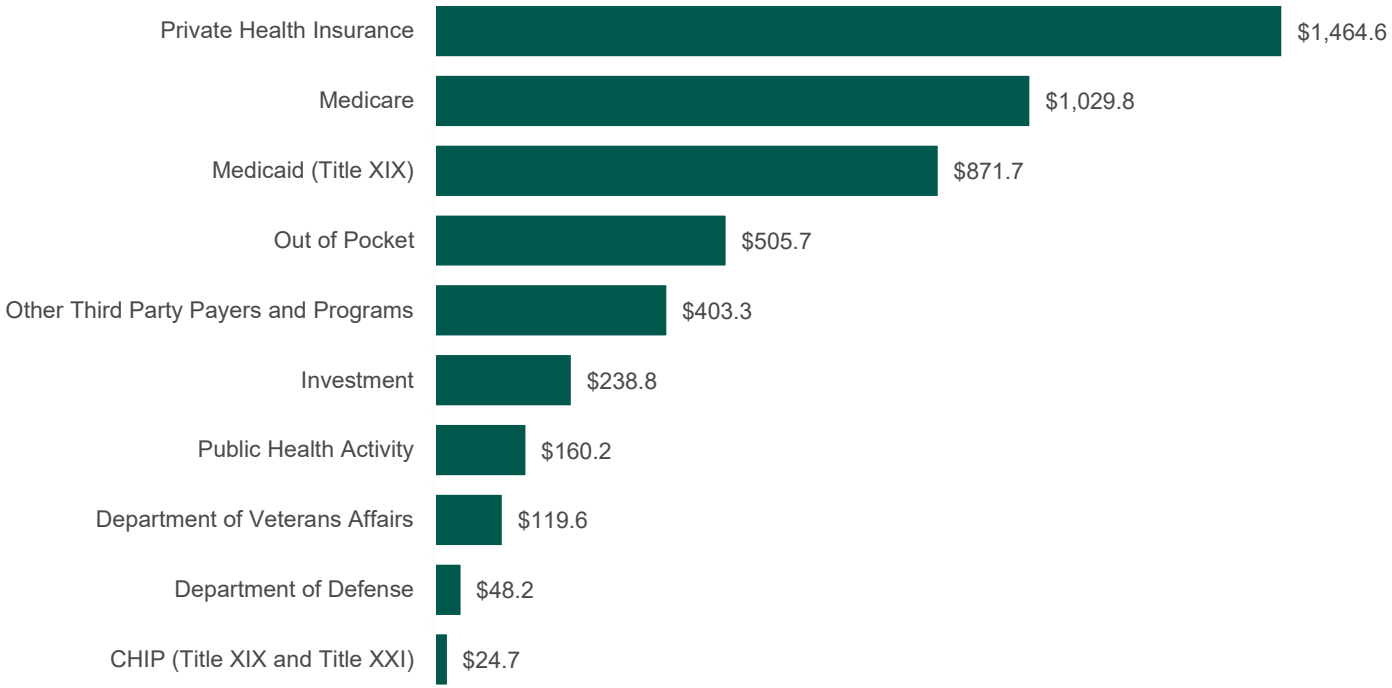
Notes and Sources

(1) Source(s): National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2023. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

United States Healthcare System

Multiple private and public sources combine to finance healthcare expenditures in the United States. Overall public sources of funding (CHIP (Title XIX and Title XXI), Department of Defense, Department of Veterans Affairs, Public Health Activity, Investment, Medicaid (Title XIX), Medicare) accounted for approximately 51.2% of national health expenditures during 2023.

National Health Expenditures by Payor, 2023 (Billions)



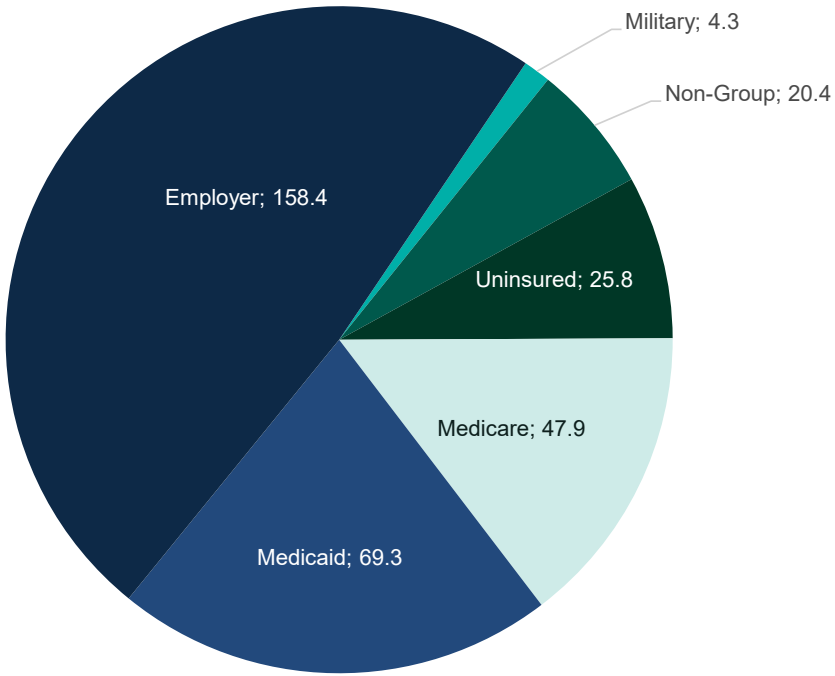
Notes and Sources

(1) Source(s): National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2023. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

United States Healthcare System

Most Americans under the age of 65 have health coverage through a private insurance provider. According to the Kaiser Family Foundation ("KFF"), during 2023 approximately 48.6% of Americans had Employer-based private insurance, while approximately 6.2% obtained private insurance through the individual plan market. The largest government payors, Medicaid and Medicare, covered approximately 21.2% and 14.7% of Americans, respectively, in 2023.

Health Insurance Coverage of the Total Population, 2023 (Millions)



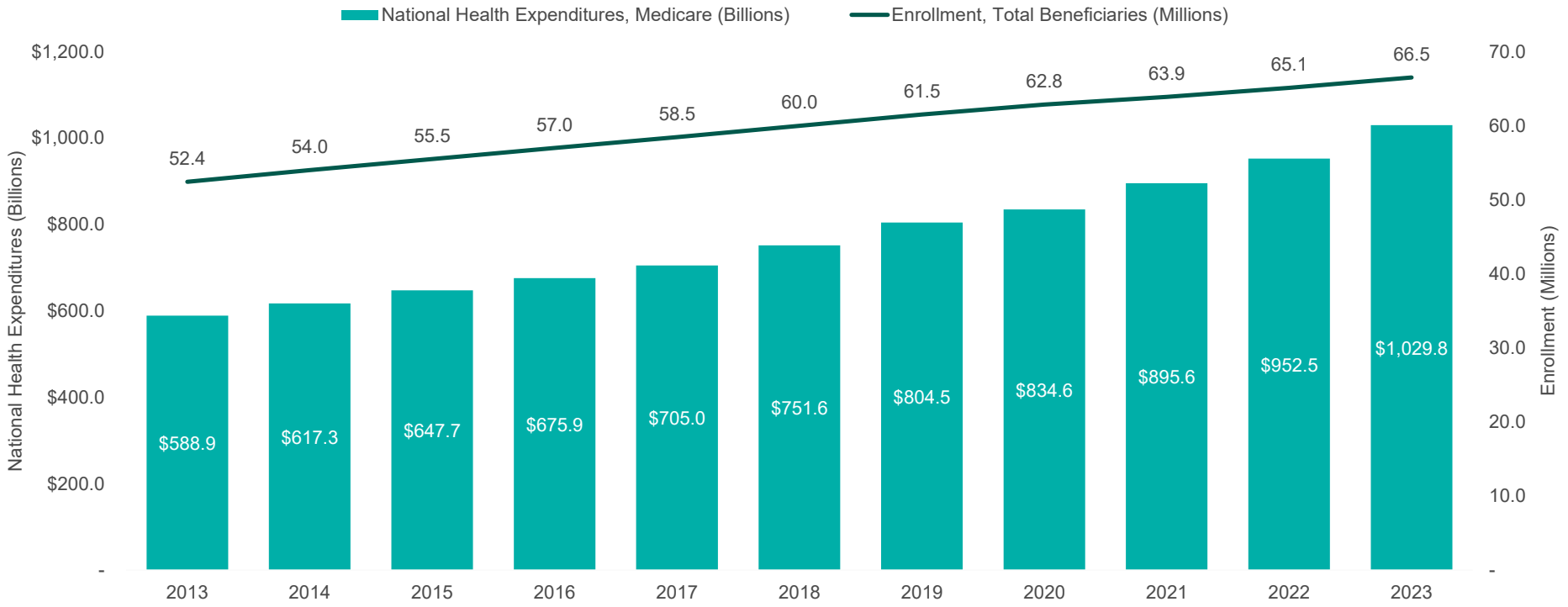
Notes and Sources

(1) Source(s): Kaiser Family Foundation ("KFF") estimates based on the 2008-2023 American Community Survey, 1-Year Estimates. Data retrieved February 3, 2025. https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

(2) The count of people with Medicare excludes those who report having both Medicare and Medicaid coverage, also known as dual eligibles. If these individuals were instead categorized as having Medicare, the total number of people with Medicare would increase.

United States Healthcare System

As of September 2024, Medicare provides federal health insurance for approximately 68.0 million beneficiaries who are elderly, disabled, have end-stage renal disease, or amyotrophic lateral sclerosis (also known as Lou Gehrig's disease). Individuals become eligible for Medicare when they reach the age of 65; certain disabled individuals also become eligible for Medicare 24 months after they become eligible for benefits under the Social Security Disability Insurance Program. Since 2013, Medicare spending has grown approximately 5.7% compounded annually from approximately $588.9 billion in 2013 to approximately $1,029.8 billion in 2023. More recently, total Medicare spending increased 8.1% from approximately $952.5 billion in 2022 to approximately $1,029.8 billion in 2023.



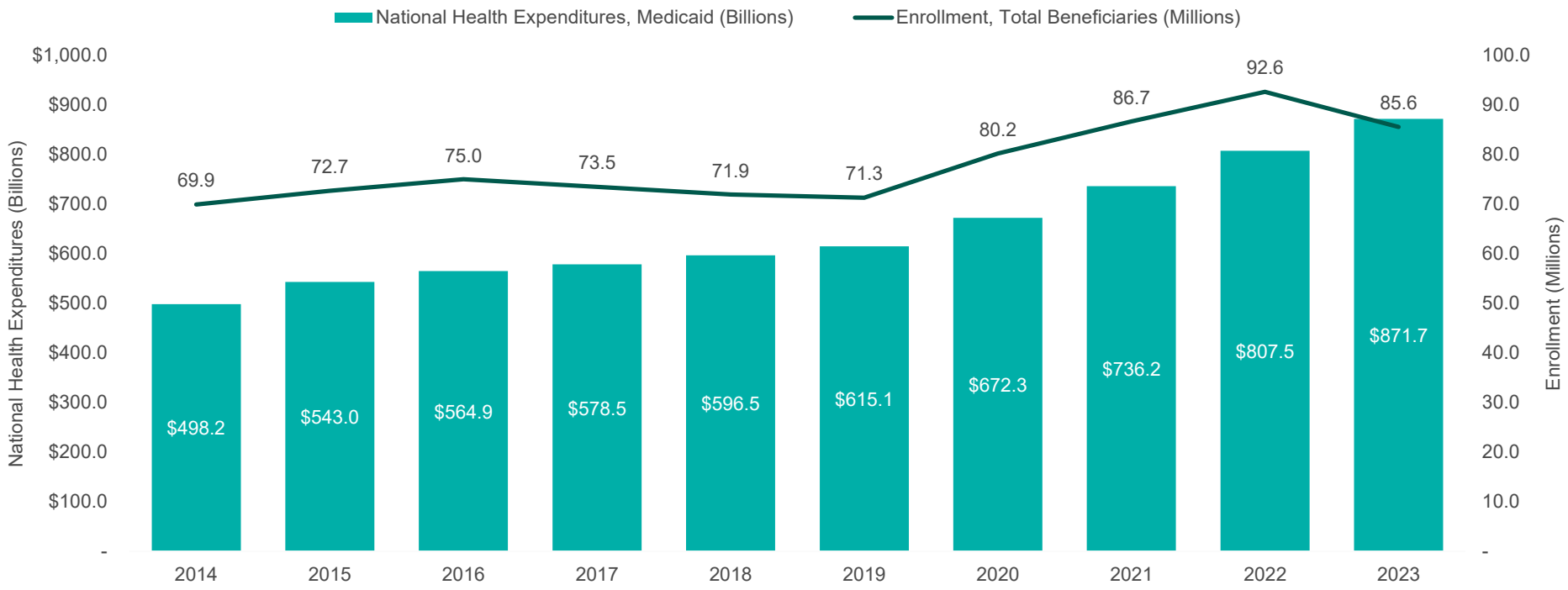
Notes and Sources

(1) Source(s): National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2023. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

(2) Source(s): Medicare Monthly Enrollment, Centers for Medicare & Medicaid Services. Data retrieved February 3, 2025. https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment

United States Healthcare System

Medicaid is a joint federal-state program that pays for healthcare services for a variety of low-income individuals. The Medicaid program, created in 1965 by the same legislation that created Medicare, replaced an earlier program of federal grants given to states to provide medical care to low-income residents. As of October 2024, approximately 79.3 million people were enrolled in the Medicaid program. It should be noted that certain individuals, often referred to as dual-eligible, are covered by both Medicaid and Medicare. Since 2014, Medicaid spending has grown 6.4% compounded annually from approximately $498.2 billion in 2014 to approximately $871.7 billion in 2023.



Notes and Sources

(1) Source(s): National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2023. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

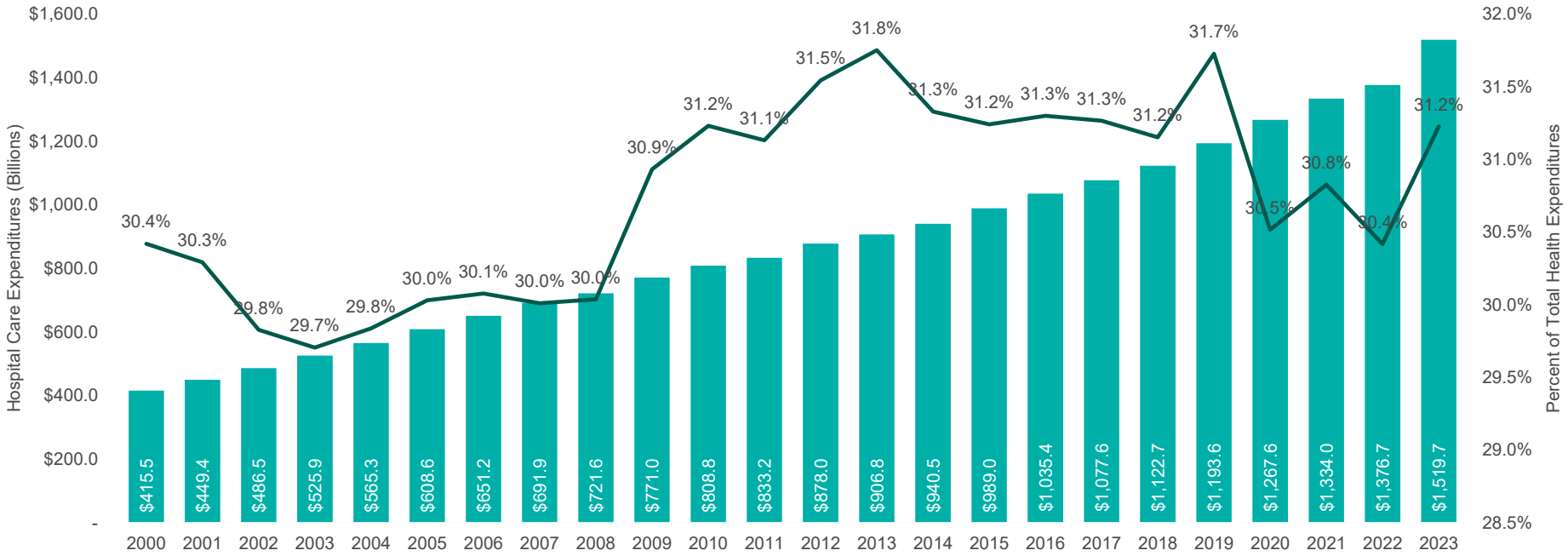
(2) Source(s): "Total Monthly Medicaid & CHIP Enrollment and Pre-ACA Enrollment." Kaiser Family Foundation. Data retrieved February 4, 2025. https://www.kff.org/affordable-care-act/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Analysis of Total Hospital Spending

The National Health Expenditure Accounts ("NHEA") are the official estimates of total health care spending in the United States reported by the Centers for Medicare & Medicaid Services ("CMS"). Dating back to 1960, the NHEA measures annual U.S. expenditures for health care goods and services, public health activities, government administration, the net cost of health insurance, and investment related to health care. The data is presented by type of service, including hospital care, which covers all services provided by hospitals to patients and has accounted for the largest percentage of total health expenditures compared to all other categories since 1960. Hospital care services include room and board, ancillary charges, services of resident physicians, inpatient pharmacy, hospital-based nursing home and home health care, and any other services billed by hospitals in the United States. The value of hospital services is measured by total net revenue, which equals gross patient revenues (charges) less contractual adjustments, bad debts, and charity care. It also includes government tax appropriations as well as non-patient and non-operating revenues.

According to the latest NHEA reports, total expenditures for hospital services were $1,519.7 billion, or approximately 31.2% of total health expenditures during 2023. Total hospital spending has increased at a compound annual growth rate ("CAGR") of approximately 5.8% from $415.5 billion in 2000 to $1,519.7 billion in 2023. The growth in hospital spending has accounted for a significant portion of growth in total national healthcare expenditures in recent years, most recently increasing 10.4% from $1,376.7 billion in 2022 to $1,519.7 billion in 2023.

Expenditures from Hospital Care Services from 2000 through 2023

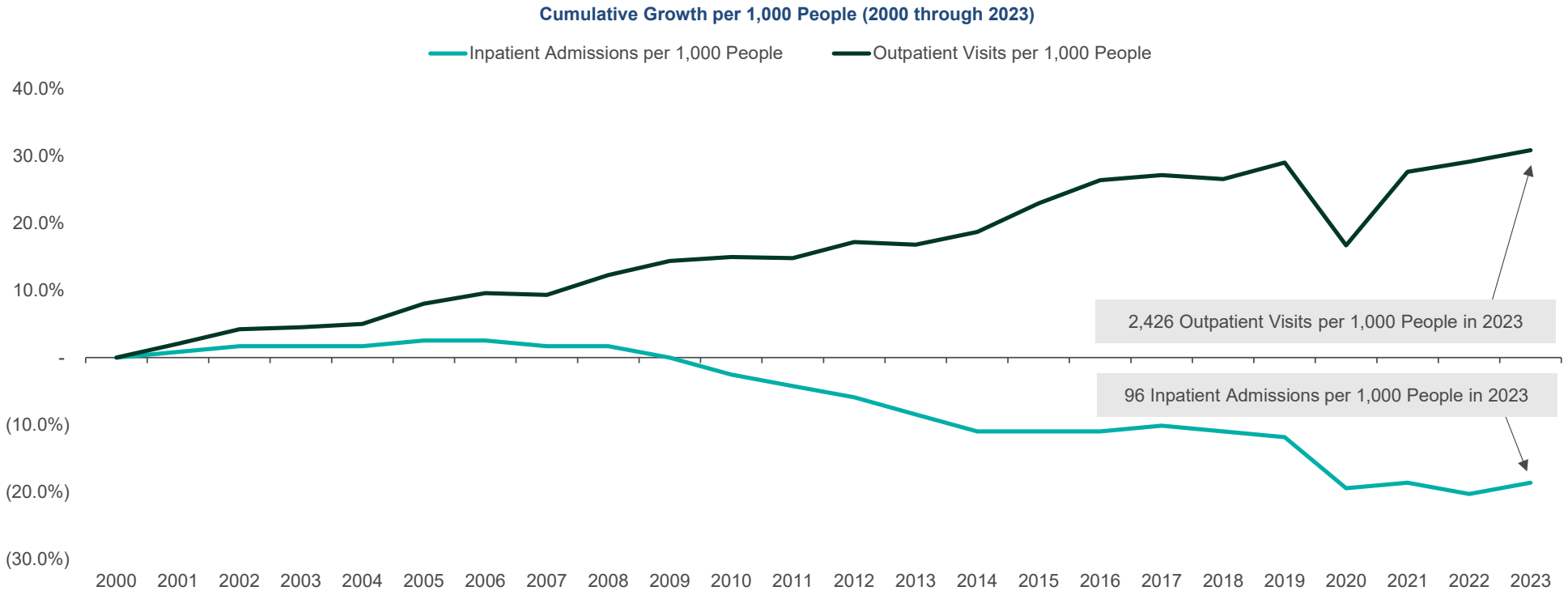


Notes and Sources

(1) Source(s): National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2023. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

Analysis of Utilization Trends

As mentioned previously, acute care hospitals provide a variety of inpatient and outpatient services. Presented in the chart below is the cumulative growth in inpatient admissions and outpatient visits per 1,000 people from 2000 to 2023 based on an analysis of community hospitals (excluding hospitals in U.S. territories), published by KFF. From 2000 to 2023, the number of inpatient admissions per 1,000 people has decreased 18.6% cumulatively, while the total number of outpatient visits per 1,000 individuals has increased 30.9% cumulatively. These volume trends are the result of an increased migration of services from the inpatient setting to the outpatient setting due to technological advances and pressure from payors and patients to reduce costs.

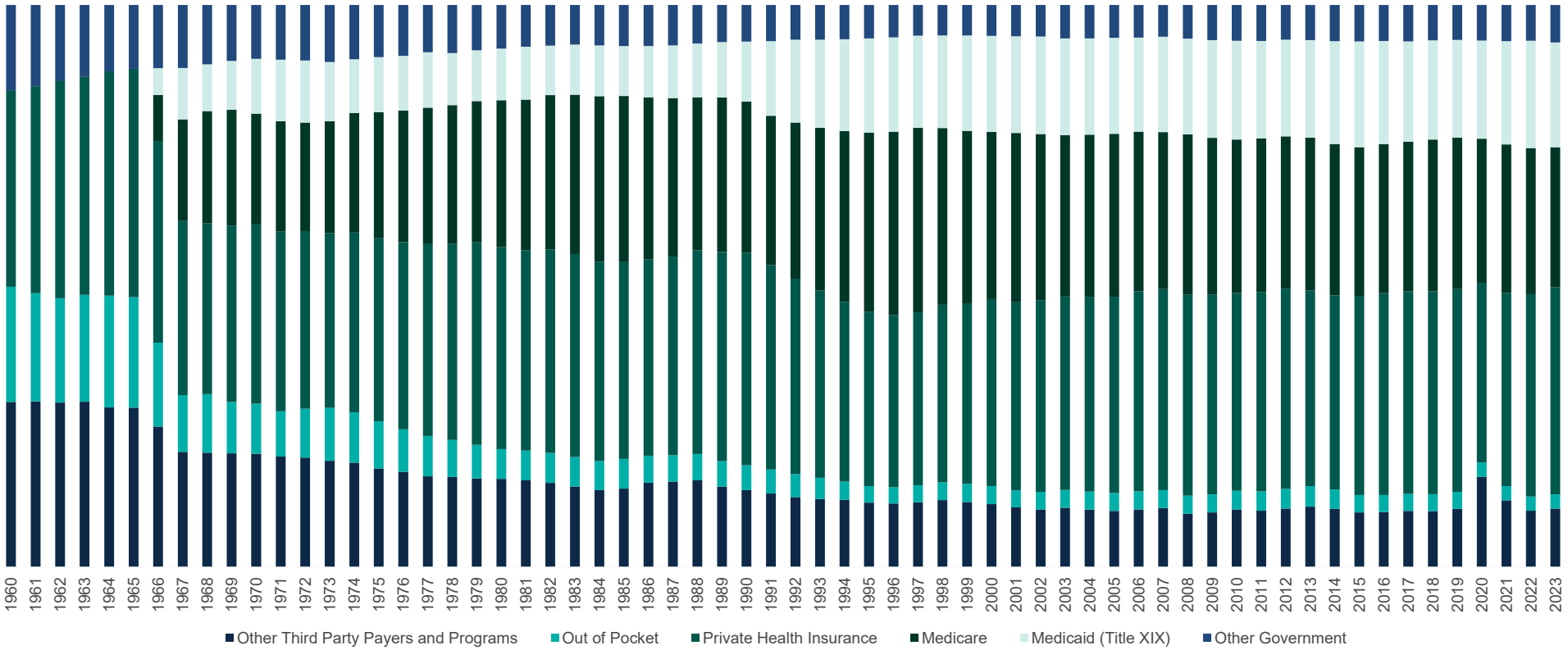


Notes and Sources

(1) Source(s): "Key Facts About Hospitals" by Zachary Levinson, Scott Hulver, Jamie Godwin, and Tricia Neuman. KFF, February 19, 2025. https://www.kff.org/key-facts-about-hospitals/?entry=overview-introduction

Analysis of Hospital Payor Mix

Presented in the chart below illustrates the relative allocation of total hospital spending by payor from 1960 to 2023 according to the latest NHEA reports published by CMS. In 2023 hospital spending was primarily from Private Health Insurance, which accounted for 36.8% of total hospital spending. Payment rates from private health insurers are negotiated with the individual payors and typically are paid a predetermined rate per diagnosis, per-diem, discount of charges, or other contractual arrangements. The next two largest payors in 2023 were Medicare and Medicaid (Title XIX), which accounted for 24.9% and 18.6% of total hospital spending, respectively.



Notes and Sources

(1) Source(s): National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2023. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

Healthcare Legislative Overview

The Patient Protection and Affordable Care Act ("PPACA") and the Health Care and Education Reconciliation Act, signed into law on March 23, 2010, have significantly changed the way that healthcare services in the United States are covered, delivered, and reimbursed. The overall goal of this comprehensive legislation is to extend health coverage to millions of uninsured legal U.S. residents through a combination of private sector health insurance reforms and public program expansion. In order to fund the expansion of insurance coverage, PPACA contains measures designed to promote quality and cost efficiency in health care delivery in order to generate budgetary savings for the Medicare and Medicaid programs. The statutes and regulations of the PPACA have been the subject of various administrative appeals and lawsuits; however, some of the key provisions of the legislation include:

- **Individual Mandate:** The legislation originally contained an "Individual Mandate" which requires most Americans to maintain "minimum essential" health insurance coverage. Those that did not comply with the mandate were required to make a "shared responsibility payment" to the federal government in the form of a tax penalty. It should be noted that the Tax Cuts and Jobs Act passed by Congress in December 2017 eliminated the Individual Mandate penalty effective as of January 1, 2019.

- **Health Exchanges:** To assist individuals who are not exempt from the individual mandate and who do not receive health insurance through an employer or government program in obtaining insurance coverage, PPACA established health exchanges. Health exchanges are government regulated organizations which provide competitive markets for buying health insurance for individuals and small employers. Certain states have established their own health exchanges while other states have chosen to utilize the federal government's health insurance exchange. Individuals who purchase a plan through the exchange may be eligible for a premium credit or cost sharing subsidy.

- **Employer Mandate:** The employer mandate provision of PPACA requires the imposition of penalties on employers with over 50 employees that do not offer affordable health insurance to employees working 30 or more hours per week. In February of 2014, the implementation of the employer mandate was delayed until January 1, 2016 for companies with 50 to 100 employees. For companies with more than 100 employees, the percentage of full-time workers required to be covered was reduced to 70.0% in 2014 and 2015. In 2016 and subsequent years, employers with over 100 employees must offer health coverage to 95.0% of employees. Affordable health insurance is defined as premiums of no more than 9.5% of an employee's income and the employer must pay 60.0% of the actuarial value of a worker's coverage. Companies that fail to comply with the employer mandate can face fines of up to $2,000 for each employee not covered.

- **Medicaid Expansion:** The PPACA extended eligibility under Medicaid to almost all individuals under the age of 65 with incomes up to 138.0% of the Federal Poverty Limit ("FPL") beginning in 2014. Under the PPACA, the federal government paid 100.0% of the cost of Medicaid expansion in 2014 through 2016. Federal funding was reduced to 90.0% over the course of a four year period from 2017 through 2020 and remains at 90.0% in 2021 onward. Historically, the income levels for Medicaid eligibility were determined by the state and were typically around 106.0% of the FPL. Initially, PPACA required all states to expand Medicaid coverage or face possible reductions in existing funding for the Medicaid programs. However, the constitutionality of this mandate was challenged in September of 2011 in the court case of the National Federation of Independent Businesses vs. Sebelius (Secretary of the Department of HHS). The Supreme Court ruled that Congress had no authority to require the states to expand their respective Medicaid programs. Congress may offer grants to the individual states for expanding Medicaid coverage but existing Medicaid funding cannot be threatened. As a result of the ruling, the individual states were given the choice to expand Medicaid coverage.

Healthcare Legislative Overview

PPACA also contains a number of provisions designed to improve the quality and efficiency of medical care provided to Medicare and Medicaid beneficiaries. These provisions include the prohibition of Medicare or Medicaid funds from paying for the treatment of Hospital-Acquired Conditions ("HACs"), reductions in reimbursement for hospitals with excessive readmissions, creation of the Medicare value-based purchasing program, and the creation of the Center for Medicare & Medicaid Innovation to further explore potential hospital payment bundles. PPACA also establishes a number of additional health insurance reforms including:

- Establishes a minimum medical loss ratio of 85.0% for large group plans and 80% for small group plans.
- Health insurers may not establish lifetime or annual limits on the dollar value of benefits.
- May not rescind coverage of any enrollee except in instances of fraud.
- Health insurers must reimburse hospitals for emergency services provided to enrollees without the need for prior authorization and without regard to whether or not there is an existing contract with the provider.
- Extends dependent coverage until the age of 26.

Healthcare Legislative Overview

The PPACA also contains a number of provisions designed to reduce Medicare and Medicaid program spending. These provisions include negative productivity adjustments to the annual inflation updates for the Medicare fee schedules and reductions to the Medicare and Medicaid Disproportionate Share Hospital Payments ("DSH"). Beginning in 2010, CMS has made negative productivity adjustments to the annual market basket updates for Medicare's IPPS, OPPS, LTACH PPS, and IRF PPS fee schedules. Below is a summary of the proposed changes to the Medicare and Medicaid DSH programs:

- **Medicare DSH Payments:** In addition to payments made under the inpatient prospective payment system for services provided directly to beneficiaries, Medicare makes payments to hospitals which treat a disproportionately high share of low-income patients. Prior to October 31, 2013, Medicare DSH payments were made based on statistical information defined by CMS and calculated as a percentage add-on to the MS-DRG payments. The PPACA revised the DSH adjustment effective for discharges occurring on or after October 31, 2013. Under the revised methodology, hospitals will receive 25.0% of the amount they previously would have received under the pre-PPACA formula. This portion is referred to as the "Empirically Justified Payment".

  Hospitals that qualify for the Empirically Justified Payment are also eligible to receive additional payments for uncompensated care, referred to as the "UC DSH Payment". The UC DSH payment comprises the remaining 75.0% of the total DSH payments that would have been paid under the historical formula. Each eligible hospital will receive a UC DSH payment based on its share of uninsured low income days (which is the sum of the Medicaid days and Medicare SSI days). The total UC DSH payments are calculated at 75.0% of DSH payments that would have been made under previous methodology and is reduced annually by the percentage change in uninsured individuals under the age of 65.

- **Medicaid DSH Payments:** CMS makes Medicaid DSH payments to states who then determine the methodology for distributing the payments to the individual hospitals. Federal law requires that state Medicaid programs make DSH payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. In the fiscal year 2016, Medicaid DSH payments totaled approximately $19.1 billion. The PPACA called for reductions in Medicaid DSH payments beginning in 2014. However, the decision not to expand Medicaid coverage by certain states resulted in several delays in the Medicaid DSH cuts. The Bipartisan Budget Act of 2018 pushed back Medicaid DSH payment reductions to FY 2020, when Medicaid DSH payments were scheduled to be reduced by $4.0 billion increasing to $8.0 billion annually from FY 2020 to FY 2025. More recently, the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") eliminated the proposed $4.0 billion in Medicaid DSH payment reductions in 2020. In addition, the CARES Act reduces the proposed DSH cuts in 2021 by an additional $4.0 billion and the Consolidated Appropriations Act in 2021 delayed implementation of reductions until FY 2024 when reductions of $8.0 billion will resume annually through FY 2027.

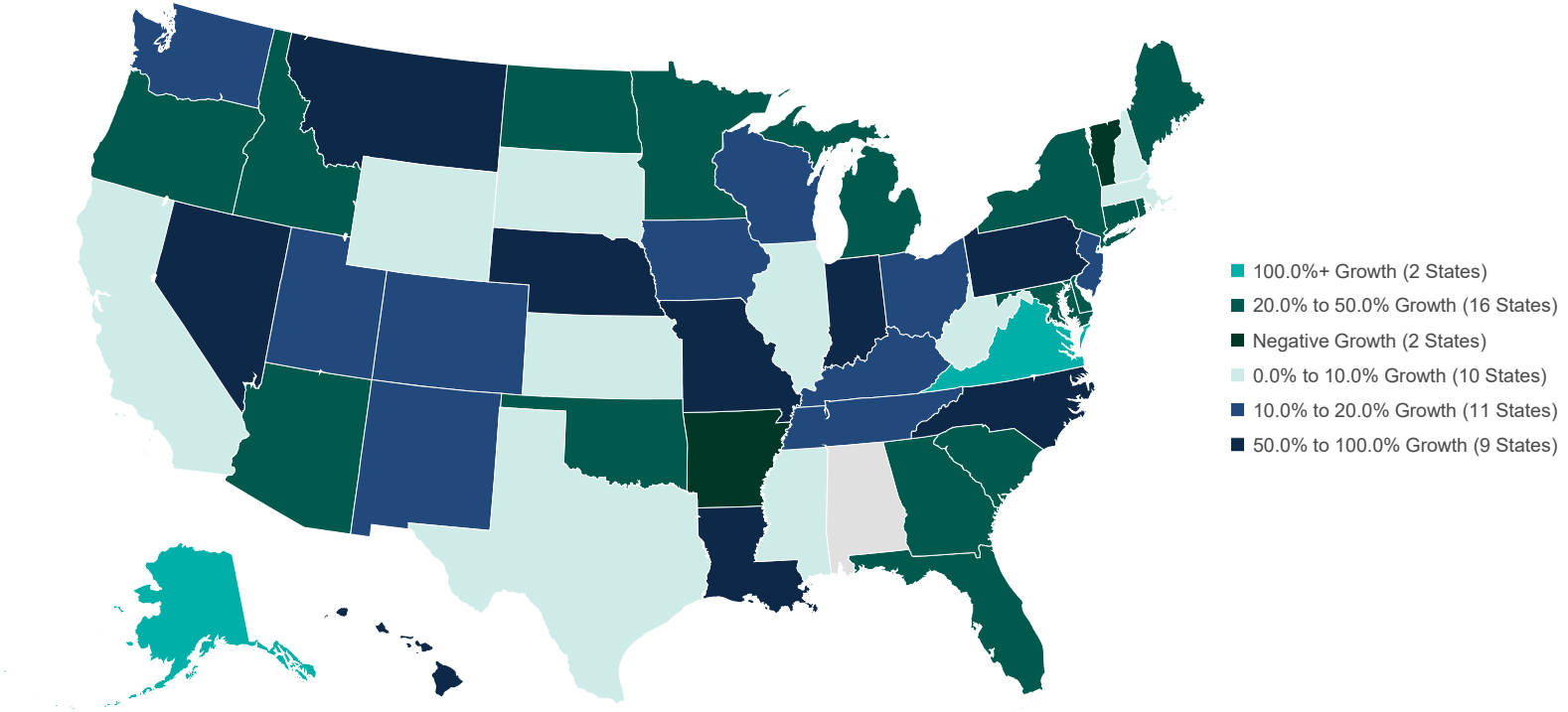
Notes and Sources

(1) Source(s): MedPAC and Medicaid & CHIP Payment and Access Commission

Medicaid Enrollment Trends by State

As previously mentioned, the PPACA required all states to expand Medicaid coverage or face possible reductions in existing funding for the Medicaid programs. However, the constitutionality of this mandate was challenged in September of 2011 in the court case of the National Federation of Independent Businesses vs. Sebelius (Secretary of the Department of HHS). The Supreme Court ruled that Congress had no authority to require the states to expand their respective Medicaid programs. Congress may offer grants to the individual states for expanding Medicaid coverage but existing Medicaid funding cannot be threatened. As a result of the ruling, the individual states were given the choice to expand Medicaid coverage. The chart below illustrates which states have elected to expand Medicaid and the resulting increase in enrollment from December 2014 to December 2023.

Medicaid Enrollment Growth from December 2014 to December 2023



Notes and Sources

(1) Source(s): Medicaid Enrollment Data Collected through MBES. Accessed August 18, 2025. https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/medicaid-enrollment-data-collected-through-mbes

(2) Source(s): "Status of State Medicaid Expansion Decisions" KFF. May 9, 2025. https://www.kff.org/status-of-state-medicaid-expansion-decisions/

Medicare Payment Overview

Medicare payments for inpatient services are made per the Inpatient Prospective Payment System, known as (“IPPS”). Under the IPPS, hospitals are paid a pre-determined amount for each hospital discharge based on the patient’s diagnosis, called a Diagnosis Related Group (”DRG”). DRG payments are based on national averages and not on specific hospitals costs, but DRG payments are adjusted by a predetermined geographic adjustment factor assigned to the hospital’s locale. DRG rates are adjusted by an update factor each federal fiscal year, which begins October 1st annually. The index used to adjust the DRG rates is referred to as the market basket index. This index gives consideration to the inflation experienced by hospitals in purchasing its required goods and services.

The majority of hospital outpatient services furnished to patients are paid by Medicare through the Outpatient Prospective Payment System (“OPPS”). These outpatient services are classified into Ambulatory Payment Classifications (“APCs”). A patient may be assigned into a single or multiple APCs depending on the service ordered during the patient encounter. Medicare pays a set price for each group, regardless of the actual costs incurred in providing care. Medicare sets the payment rate for each APC based on historical median cost data and adjusts the payment for geographic location. Similar to the payments based on DRGs, APC payments are updated each federal fiscal year based on the market basket index. The following services are paid based on other fee schedules established by Medicare: physical, occupational and speech therapy; durable medical equipment; diagnostic laboratory services; and services at freestanding surgical centers and diagnostic facilities.

CMS adopted a final rule on August 22, 2007 that established Medicare Severity DRGs (“MS-DRGs”). The rule’s goal was to refine the DRG weighting system to fully capture differences in severity of illness among patients, replacing 538 DRGs with 745 MS-DRGs. The switch to the MS-DRG system was intended to be budget neutral in that total Medicare payments to hospitals should not increase or decrease solely due to changes in documentation and coding practices. In order to ensure that improvements in coding and documentation do not lead to an increase in aggregate payments without a corresponding growth in patient severity, CMS will initiate a negative coding adjustment every fiscal year.

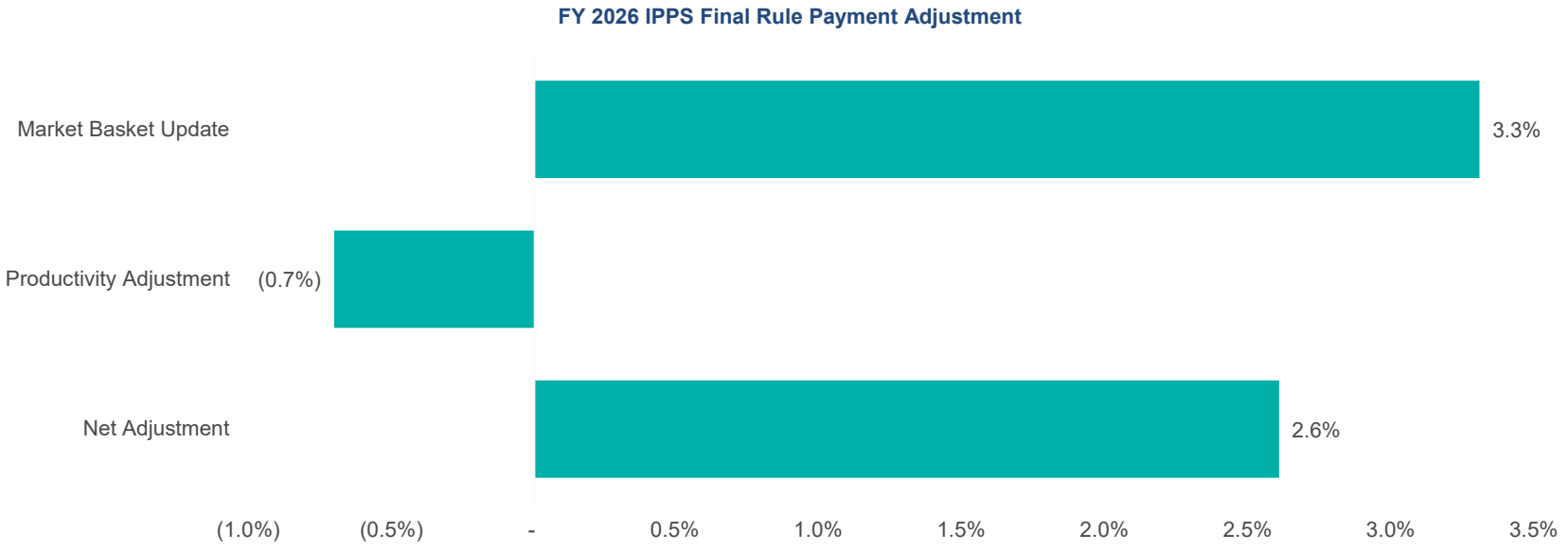
Notes and Sources

(1) *Hospital Acute Inpatient Services Payment System. Payment Basics, MedPAC, Revised October 2024. https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_hospital_FINAL_SEC.pdf*

(2) *Outpatient Hospital Services Payment System. Payment Basics, MedPAC, Revised October 2024. https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_OPD_FINAL_SEC.pdf*

FY 2026 IPPS Final Rule Payment Adjustment

On July 31, 2025, the Centers for Medicare & Medicaid Services ("CMS") issued the final rule that updates Medicare payment policies and rates for inpatient and long-term care hospitals under the Medicare Hospital Inpatient Prospective Payment System ("IPPS") and Long-Term Care Hospital Prospective Payment System ("LTCH PPS") final rule for fiscal year ("FY") 2026. The increase in IPPS operating payment rates for general acute care hospitals that successfully participate in the Hospital Inpatient Quality Reporting ("IQR") program and are meaningful electronic health record ("EHR") users under the Medicare Promoting Interoperability Program is 2.6%. This reflects a projected FY 2026 hospital market basket percentage increase of 3.3%, reduced by a 0.7 percentage point productivity adjustment.



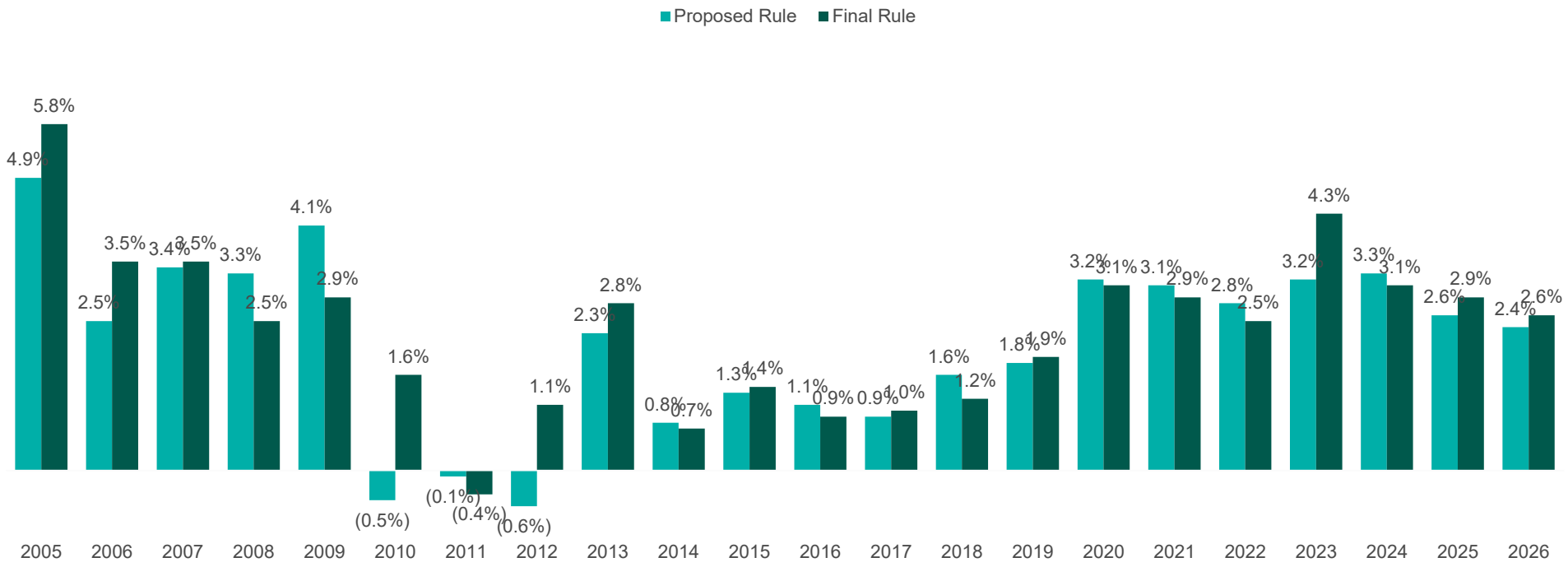
Notes and Sources

(1) Source(s): "FY 2026 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule - CMS-1833-F." Centers for Medicare & Medicaid Services Fact Sheet. July 31, 2025. https://www.cms.gov/newsroom/fact-sheets/fy-2026-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospital-prospective-0

Historical IPPS Reimbursement

Presented in the chart below are the net proposed and final IPPS payment increases from 2005 through 2026. From 2005 through 2010, the average final rule payment increase averaged 3.3%, however, from 2010 through 2026, the final rule payment increase has averaged 2.4%. In more recent years, the relatively modest increases in the annual updates is primarily due to the productivity adjustment mandated by the PPACA and the documentation and coding adjustment mandated by the American Taxpayer Relief Act. It should be noted that payment increases presented below do not reflect any DSH or outlier payment adjustments.

Proposed and Final Rule for IPPS Payment Rate Changes by Fiscal Year

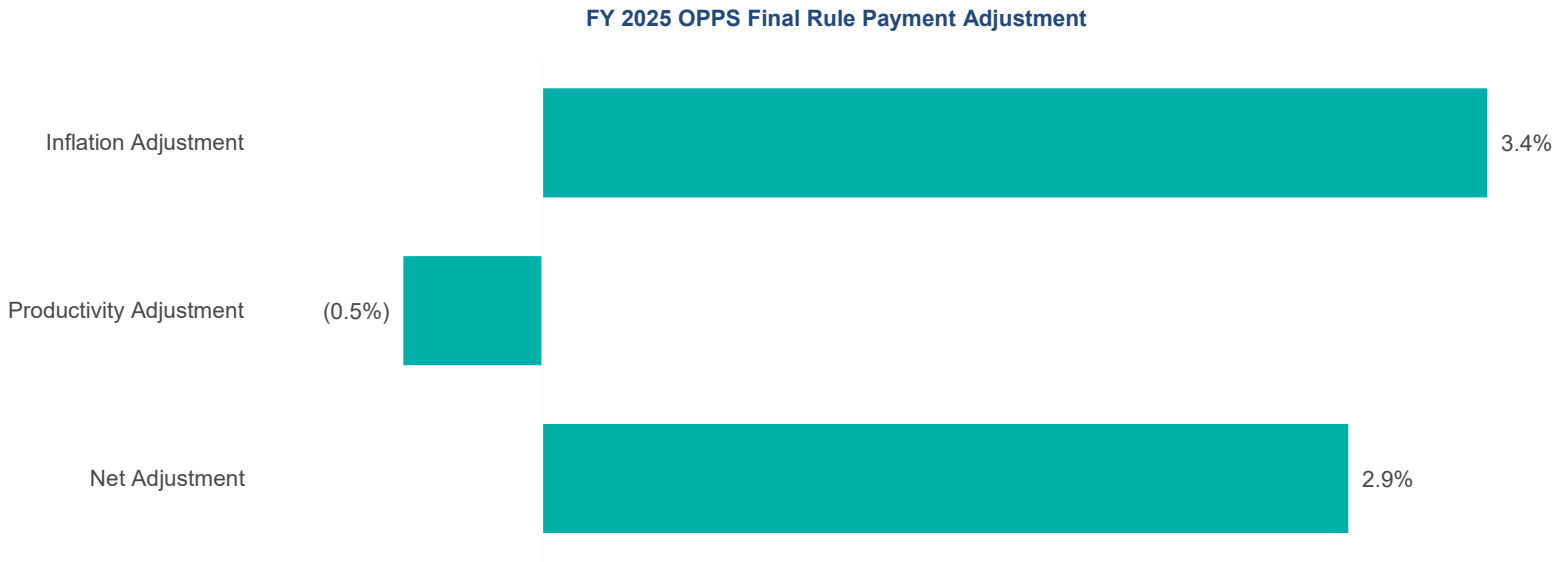


Notes and Sources

(1) Source(s): CMS Proposed and Final Rule Factsheets

FY 2025 OPPS Final Rule Payment Adjustment

On November 1, 2024, CMS issued Medicare payment rates for hospital outpatient and ambulatory surgical center ("ASC") services for calendar year ("CY") 2025. The Hospital Outpatient Prospective Payment System ("OPPS") is published annually. The CY 2025 rule includes policies that align with several key goals of the Biden-Harris Administration, including responding to the maternal health crisis, addressing health disparities, expanding access to behavioral health care, improving transparency in the health system, and promoting safe, effective, and patient-centered care. These payment policies affect approximately 3,500 hospitals and approximately 6,100 ASCs. The CY 2025 rule updates the OPPS payment rates to 2.9% for hospitals that meet applicable quality reporting requirements, which includes a projected hospital market basket percentage increase of 3.4% and negative 0.5 percentage point productivity adjustment.



Notes and Sources

(1) "CY 2025 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS 1809-FC)." Centers for Medicare & Medicaid Services Fact Sheet, November 1, 2024. https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0

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AFFILIATION AGREEMENT

BY AND AMONG

TRI-CITY HEALTHCARE DISTRICT

SHARP HEALTHCARE

AND

TRI-CITY MEDICAL CENTER CORPORATION

DATED: December 12, 2025

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AFFILIATION AGREEMENT

THIS AFFILIATION AGREEMENT ("Agreement"), is made and entered into as of December 12, 2025 ("Agreement Date"), by and among **SHARP HEALTHCARE**, a California nonprofit public benefit corporation ("SHARP"), **TRI-CITY MEDICAL CENTER CORPORATION**, a California nonprofit public benefit corporation ("STCMC") (collectively, SHARP and STCMC are referred to herein as the "SHARP Parties"), and **TRI-CITY HEALTHCARE DISTRICT** (the "DISTRICT"), a political subdivision of the State of California, organized and existing pursuant to the Div. 23 of the California Health & Safety Code (the "Local Hospital District Law"). SHARP, STCMC and the DISTRICT may each be individually referred to herein as a "Party" and collectively as the "Parties."

RECITALS:

WHEREAS, SHARP is the parent of a nonprofit multi-hospital health care system that operates, among other health care-related assets, four acute-care hospitals, four specialty hospitals, three affiliated medical groups and a licensed healthcare service plan in and around San Diego County, California.

WHEREAS, the DISTRICT owns and operates Tri-City Medical Center ("TCMC"), a general acute care hospital located in Oceanside, California licensed to operate 386 beds, and that is a provider of ambulatory clinical and related services at various office locations in support of TCMC.

WHEREAS, the boards of directors of SHARP, STCMC and the DISTRICT deem the affiliation of the DISTRICT and TCMC with SHARP and STCMC, on the terms and subject to the conditions set forth in this Agreement (the "Affiliation") to be desirable and in the best interest of their respective communities, and each has approved the Parties' entering into this Agreement.

WHEREAS, the Affiliation shall be conducted and structured in a manner consistent with any and all applicable requirements of Sections 32121 and 32126 of the California Health and Safety Code, including, without limitation, requirements related to the lease of TCMC-related property (including real property, furniture, fixtures and equipment used in the operation of TCMC) for a period not to exceed thirty (30) years, certain requirements related to the use of assets to be transferred to STCMC for the benefit of the communities served by the DISTRICT, satisfaction of public meeting requirements by the DISTRICT, the DISTRICT's obtaining a timely valuation of assets to be transferred to STCMC, and any other required review processes and approvals.

WHEREAS, the Affiliation is intended to accomplish the following objectives:

A. Enhance the provision of high quality, efficient and affordable health care services to the communities served by the DISTRICT and the SHARP Parties;

B. Continue the SHARP Parties' mission to provide comprehensive healthcare services that support the health and medical needs of the general public residing in the communities served by the SHARP Parties and the DISTRICT;

C. Deepen the SHARP Parties', the DISTRICT's and TCMC's collective ability to achieve performance excellence goals and enhance each other's skills, competencies and capabilities; and

D. Continue the Parties' respective tax-exempt and public missions to improve the health and wellbeing of their local communities.

WHEREAS, the Parties wish to enter into and effectuate the Affiliation to accomplish the foregoing purposes as further described in this Agreement.

AGREEMENT

NOW, THEREFORE, in consideration of the premises and of the respective representations, warranties, covenants and agreements contained in this Agreement, and for good and other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties to this Agreement agree as follows:

ARTICLE 1
DEFINITIONS

1.1 Definitions. The following terms have the definitions set forth below or ascribed thereto in the section of this Agreement identified below:

1.1.1 "Affiliate" means any corporation, partnership, limited liability company, sole proprietorship or other person or entity that, directly or indirectly through one or more intermediaries controls, is controlled by, or is under common control with, the person or entity specified.

1.1.2 "Affiliation" has the meaning set forth in the preamble to this Agreement.

1.1.3 "Affiliation Agreements" has the meaning set forth in Section 4.2.

1.1.4 "Agreement" have the meaning set forth in the preamble to this Agreement.

1.1.5 "Agreement Date" has the meaning set forth in the preamble to this Agreement.

1.1.6 "Amended Foundation Articles" has the meaning set forth in Section 2.1.4.1.

1.1.7 "Amended Foundation Bylaws" has the meaning set forth in Section 2.1.4.1.

1.1.8 "Amended Foundation Governance Documents" has the meaning set forth in Section 2.1.4.1.

1.1.9 "Amended STCMC Articles" has the meaning set forth in Section 2.1.5.1.

1.1.10 "Amended STCMC Bylaws" has the meaning set forth in Section 2.1.5.1.

1.1.11 "Amended STCMC Governance Documents" has the meaning set forth in Section 2.1.5.1.

1.1.12 "Assumed Contracts" has the meaning set forth in Article I of the Transfer Agreement.

1.1.13 "Assumed Leases" has the meaning set forth in Article I of the Transfer Agreement.

1.1.14 "Assumed Liabilities" has the meaning set forth in Article I of the Transfer Agreement.

1.1.15 "Benefit Plans" has the meaning set forth in Section 5.17.

1.1.16 "Business" means TCMC and all its related healthcare services, facilities, assets, and operations conducted at or in connection with TCMC, including, but not limited to, inpatient, outpatient, emergency, diagnostic, therapeutic, and ambulatory clinical services.

1.1.17 "Carlsbad Lease" has the meaning set forth in Section 2.1.1.

1.1.18 "Claim" has the meaning set forth in Section 12.3.

1.1.19 "Claim Notice" has the meaning set forth in Section 12.3.

1.1.20 "Closing" has the meaning set forth in Section 3.1.

1.1.21 "Closing Date" has the meaning set forth in Section 3.1.

1.1.22 "CMIR" means a Cost Market Impact Review, as defined in Section 127507.2 of the California Health and Safety Code, as amended.

1.1.23 "Confidentiality Agreement" has the meaning set forth in Section 10.1.

1.1.24 "Core Services" has the meaning set forth in Section 14.9 of the Hospital Lease.

1.1.25 "Cure Period" has the meaning set forth in Section 7.5.

1.1.26 "Disclosure Schedules" means the disclosure schedules delivered by DISTRICT to the SHARP Parties concurrently with the execution and delivery of this Agreement.

1.1.27 "Dispute" has the meaning set forth in Section 13.1.

1.1.28 "Dispute Notice" has the meaning set forth in Section 13.1.

1.1.29 "DISTRICT" has the meaning set forth in the preamble to this Agreement.

1.1.30 "DISTRICT Board" has the meaning set forth in Section 2.1.5.2.

1.1.31 "DISTRICT Financial Statements" has the meaning set forth in Section 5.3.

1.1.32 "DISTRICT Indemnitees" has the meaning set forth in Section 12.2.

1.1.33 "DISTRICT's Knowledge" means, after due inquiry, the actual current knowledge of the DISTRICT'S Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, and Compliance Officer as of the Agreement Date and/or the Closing Date, as applicable; and also, after due inquiry, the actual current knowledge of Susan Bond as of the Agreement Date.

1.1.34 "Effective Time" has the meaning set forth in Section 3.1.

1.1.35 "Eligible Employees" has the meaning set forth in Section 6.2.3.1.

1.1.36 "Encumbrance" means mean any mortgage, pledge, assessment, security interest, lease, sublease, lien, adverse claim, levy, right of way, easement, covenant, charge or other encumbrance of any kind, or any conditional sale contract, title retention contract, or other contract to give or to refrain from giving any of the foregoing.

1.1.37 "Epic System" has the meaning set forth in Section 9.5.3.

1.1.38 "Estoppel Certificate" has the meaning set forth in Section 6.2.1.

1.1.39 "Excluded Assets" has the meaning set forth in Article I of the Transfer Agreement.

1.1.40 "Excluded Contracts" has the meaning set forth in Article I of the Transfer Agreement.

1.1.41 "Excluded Liabilities" has the meaning set forth in Article I of the Transfer Agreement.

1.1.42 "Existing Landlord" has the meaning set forth in Section 6.2.1.

1.1.43 "Extraordinary Expenses" has the meaning set forth in Section **Error! Reference source not found.**.

1.1.44 "GAAP" shall mean the generally accepted accounting principles of the United States of America in effect from time to time, consistently applied.

1.1.45 "GO Bonds Property Tax Revenues" has the meaning set forth in Section 9.11.

1.1.46 "GO Bonds" has the meaning set forth in Section 9.6.

1.1.47 "Government Programs" has the meaning set forth in Section 5.8.4.

1.1.48 "Governmental Authority" means any U.S. federal, state, or local government or any court of competent jurisdiction, administrative agency or commission or other governmental authority or instrumentality, or any party contracted by any of the foregoing to administer, oversee, or provide services in relation to any Government Program.

1.1.49 "Healthcare Laws" means Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395hhh (the Medicare statute), including specifically, the Ethics in Patient Referrals Act, as amended (the Stark Law), 42 U.S.C. § 1395nn; Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v (the Medicaid statute); the Federal Health Care Program Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b); the False Claims Act, 31 U.S.C. §§ 3729-3733 (as amended); the Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-3812; the Anti-Kickback Act of 1986, 41 U.S.C. §§ 8701 - 8707; the Civil Monetary Penalties Law, 42 U.S.C. §§ 1320a-7a and 1320a-7b; the Exclusion Laws, 42 U.S.C. § 1320a-7; HIPAA; the HITECH Act; all legal requirements relating to the provision of, or billing or payment for, health care items or services, or relating to health care information; all applicable implementing regulations, rules, ordinances, judgments, and orders; and any Laws related to licensing, certificate of need, regulatory and reimbursement, corporate practice of medicine, and physician fee splitting.

1.1.50 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§ 1320d-1329d-8 and the rules and regulations promulgated thereunder.

1.1.51 "Hired Employees" has the meaning set forth in Section 6.2.3.1.

1.1.52 "Hitech Act" means the Health Information Technology for Economic and Clinical Health Act, 42 U.S.C. §§ 3000 et seq. and the rules and regulations promulgated thereunder.

1.1.53 "Hospital Lease" has the meaning set forth in Section 2.1.1.

1.1.54 "Insurance" has the meaning set forth in Section 5.14.

1.1.55 "Intellectual Property" has the meaning set forth in Section 5.18.1.

1.1.56 "JV Company" and "JV Companies" have the meaning set forth in Section 5.1.

1.1.57 "Laws" means statutes, laws, ordinances, regulations, rules, codes, orders, judgments, decrees, Permits, zoning requirements and other requirements of any Governmental Authority.

1.1.58 "Leased Premises" means the real property (including any improvements located thereon) that is the subject of the Leases.

1.1.59 "Leases" has the meaning set forth in Section 2.1.1.

1.1.60 "Local Hospital District Law" has the meaning set forth in the preamble to this Agreement.

1.1.61 "Losses" has the meaning set forth in Section 12.1.

1.1.62 "Material Adverse Effect" has the meaning set forth in Section 5.23.

1.1.63 "Material Contract" has the meaning set forth in Section 5.15.

1.1.64 "Medical Staff Bylaws" has the meaning set forth in Section 5.7.

1.1.65 "National Priorities List" has the meaning set forth in Section 5.13

1.1.66 "Non-GO Bonds Tax Revenues" has the meaning set forth in Section 9.11.

1.1.67 "Negotiation Period" has the meaning set forth in Section 13.2.

1.1.68 "Net Income (Loss) from Operations Margin" has the meaning set forth in Section 9.11.1.

1.1.69 "Oceanside Lease" has the meaning set forth in Section 2.1.1.

1.1.70 "OHCA" means the California Office of Health Care Affordability.

1.1.71 "Parties" and "Party" have the meaning set forth in the preamble to this Agreement.

1.1.72 "Permit" and "Permits" have the meaning set forth in Section 5.6.2.

1.1.73 "Permitted Encumbrance" means (a) any liens for taxes or other assessments not yet due and payable; (b) any zoning, building codes, and other land use Laws and directives affecting the Properties; (c) any statutory liens in favor of carriers, warehousemen, mechanics and materialmen, to secure claims for labor, materials or supplies or any carriers', warehousemen's, mechanics', landlords', materialmen's, repairmen's or similar Encumbrances arising out of work performed, services provided or materials delivered; (d) any matters shown by the Title Policies to which the SHARP Parties' do not object or which are waived (or deemed waived) or insured over by the SHARP Parties' under this Agreement; (e) any Encumbrance with respect to any mortgage, deed of trust, indenture or other instrument for or relating to DISTRICT indebtedness or the borrowing of money described in the Financial Statements or otherwise on the Disclosure Schedules; and (f) any Encumbrance under any Assumed Contract that is made available to the SHARP Parties by the DISTRICT.

1.1.74 "Private Programs" has the meaning set forth in Section 5.8.4.

1.1.75 "Properties" has the meaning set forth in Section 5.13.

1.1.76 "Property Tax Revenues" has the meaning set forth in Section 9.11.

1.1.77 "PTO" has the meaning set forth in Section 6.2.3.5.

1.1.78 "Qualified Health System" has the meaning set forth in Section 9.3.2.6.

1.1.79 "Settlement Proposal" has the meaning set forth in Section 13.3.

1.1.80 "SHARP" has the meaning set forth in the preamble to this Agreement.

1.1.81 "SHARP Financial Statements" has the meaning set forth in Section 4.3.

1.1.82 "SHARP Indemnitees" has the meaning set forth in Section 12.1.

1.1.83 "SHARP Parties" has the meaning set forth in the preamble to this Agreement.

1.1.84 "STCMC" has the meaning set forth in the preamble to this Agreement.

1.1.85 "STCMC Board" has the meaning set forth in Section 2.1.5.2.

1.1.86 "SHARP Parties' Knowledge" means the actual current knowledge of SHARP's and STCMC's Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, and Chief Legal Officer as of the Agreement Date and/or the Closing Date, as applicable.

1.1.87 "TCMC" has the meaning set forth in the recitals to this Agreement.

1.1.88 "TCMC Foundation" means the Tri-City Hospital Foundation, a California nonprofit public benefit corporation.

1.1.89 "TCMC Leased Premises" has the meaning set forth in Section 2.1.1.

1.1.90 "TCMC Medical Staff" has the meaning set forth in Section 9.7.1.

1.1.91 "Title Company" shall mean Chicago Title Insurance Company or another title insurance company reasonably approved by the SHARP Parties.

1.1.92 "Title Policies" has the meaning set forth in Section 7.14.

1.1.93 "Transfer Agreement" has the meaning set forth in Section 2.1.2.

1.1.94 "Transfer Documents" has the meaning set forth in Section 4.2.

1.1.95 "Transferring Assets" has the meaning set forth in Article I of the Transfer Agreement.

1.1.96 "Valuation Date" has the meaning set forth in Section 6.4.10.

1.1.97 "VP" has the meaning set forth in Section 6.2.3.5.

1.1.98 "WARN Events" has the meaning set forth in Section 6.2.3.9.

Capitalized terms used in Transfer Documents and not otherwise defined herein shall have the meanings ascribed to them in such Transfer Documents.

ARTICLE 2
STRUCTURE

2.1 The Affiliation. Subject to the satisfaction or waiver of the conditions set forth in Article 7 and Article 8 of this Agreement, on the Closing Date, the following shall occur and the Affiliation shall become effective as of the Effective Time:

2.1.1 The DISTRICT shall lease the "TCMC Leased Premises" (as defined by the Hospital Lease) to STCMC pursuant to a Lease Agreement in the form of Exhibit 2.1.1-A attached hereto (the "Hospital Lease"); the DISTRICT shall lease the Carlsbad Leased Premises (as defined by the Carlsbad Lease) to STCMC pursuant to a Lease Agreement in the form of Exhibit 2.1.1-B attached hereto (the "Carlsbad Lease"); and the DISTRICT shall lease the Oceanside Leased Premises (as defined in the Oceanside Lease) to STCMC pursuant to a Lease Agreement in the form of Exhibit 2.1.1.-C attached hereto (the "Oceanside Lease", and collectively with the Carlsbad Lease, and the Hospital Lease, the "Leases").

2.1.2 The DISTRICT shall transfer and convey the Transferring Assets to STCMC, including the rights and obligations of the DISTRICT under the Assumed Contracts pursuant to a Transfer Agreement in the form of Exhibit 2.1.2 (the "Transfer Agreement"). The Transferring Assets shall not include, and the Transfer Agreement shall not result in the transfer to the SHARP Parties of, the Excluded Assets.

2.1.3 Assumed Liabilities; Excluded Liabilities. Effective as of the Effective Time, subject to and in accordance with the terms and conditions of the Transfer Agreement, STCMC shall assume, and shall perform and discharge any obligations when due or sooner with respect to, the Assumed Liabilities but shall not assume or have any obligations with respect to the Excluded Liabilities.

2.1.4 TCMC Foundation Governance Documents.

2.1.4.1 The DISTRICT shall cause the Articles of Incorporation of the TCMC Foundation to be amended, in a form of Exhibit 2.1.4-A (the "Amended Foundation Articles"), and shall cause the bylaws of the TCMC Foundation to be amended, in a form of Exhibit 2.1.3-B (the "Amended Foundation Bylaws", and with the Amended Foundation Articles, the "Amended Foundation Governance Documents"), such that STCMC shall become the sole member of the TCMC Foundation as of the Effective Time.

2.1.4.2 After the Effective Time, the TCMC Foundation shall continue as a tax-exempt organization operating for the benefit and in support of STCMC's charitable mission.

2.1.5 STCMC Governance Documents.

2.1.5.1 The SHARP Parties shall cause the Articles of Incorporation of the STCMC to be amended, in a form of Exhibit 2.1.5-A (the "Amended STCMC Articles"), and shall cause Bylaws of the STCMC to be amended, in a form of Exhibit 2.1.5-B (the "Amended STCMC Bylaws", and with the Amended STCMC Articles, the "Amended STCMC Governance Documents").

2.1.5.2 The Amended STCMC Governance Documents shall provide (a) that the STCMC board of directors (the "STCMC Board") be made up of fifteen (15) directors; b) the DISTRICT shall have the right to designate up to up to five (5) voters residing within the DISTRICT's geographic boundaries to serve on the STCMC Board, which designations shall be subject to the approval of SHARP as STCMC's sole member, which shall not be unreasonably withheld; (c) the DISTRICT shall not have the right to designate, select or appoint any members serving on the DISTRICT's board of directors (the "DISTRICT Board") to the STCMC Board either before or after the Effective Time; (d) the DISTRICT may recommend up to three (3) members of the DISTRICT Board to the nominating committee of the STCMC Board for consideration, which will review the recommendations along with and in the same manner as all other candidates being considered for election and appointment to the STCMC Board; (e) all members of the STCMC Board shall be elected and appointed by SHARP other than *ex officio* directors and the DISTRICT's designees approved by SHARP; (f) at no time shall (i) more than three (3) members of the DISTRICT Board serve concurrently as members of the STCMC Board, and (ii) more than a total of five (5) members of the STCMC Board be comprised of the DISTRICT's designees approved by SHARP and members of the DISTRICT Board; and (g) DISTRICT Board members serving as members of the STCMC Board shall receive no compensation for serving as Directors of STCMC.

2.2 Taking of Necessary Action; Further Action. Each Party shall take all lawful actions as may be reasonably necessary or appropriate to effect the transactions contemplated by this Agreement. If at any time after the Effective Time any further action is reasonably necessary or required to effectuate the Affiliation and carry out the purposes of the Affiliation Agreements, the Parties shall, subject to the applicable corporate authority of their respective organizations, take all such lawful and necessary actions.

ARTICLE 3

CLOSING; CLOSING DELIVERABLES

3.1 Closing. Subject to the terms and conditions of this Agreement, the consummation of the Affiliation (the "Closing"), shall take place remotely (or in person if agreed to by the Parties) via the exchange of executed documents and other deliverables on (or as soon as practicable before) the last day of the calendar month during which the public vote approving the Affiliation Agreements and the transactions contemplated herein is certified, subject to the satisfaction or waiver of the conditions to the Closing set forth in Article 7 and Article 8 below. The date on which the Closing actually occurs is herein referred to as the ("Closing Date"). The Closing shall be deemed to be effective at 12:00:01 a.m. on the day immediately following the Closing Date (the "Effective Time"). The Parties shall use commercially reasonable efforts to fulfill and satisfy the various conditions and obligations under this Agreement on or prior to the Closing Date.

3.2 Certain Closing Deliverables. At Closing, the DISTRICT and the SHARP Parties shall execute and deliver, as applicable:

3.2.1 The Leases together with all other agreements, documents or instruments contemplated therein;

3.2.2 The Transfer Agreement together with all other agreements, documents or instruments contemplated therein;

3.2.3 The Amended Foundation Governance Documents, including the Amended Foundation Articles filed with and certified by the California Secretary of State and the Amended Foundation Bylaws certified by the TCMC Foundation's Secretary or Assistant Secretary;

3.2.4 The Amended STCMC Governance Documents, including the Amended STCMC Articles filed with and certified by the California Secretary of State and the Amended STCMC Bylaws certified by the TCMC Foundation's Secretary or Assistant Secretary; and

3.2.5 All other agreements, documents or instruments required of the Parties by any other provision of this Agreement, or as reasonably requested to be produced to consummate the transactions contemplated by this Agreement.

ARTICLE 4

REPRESENTATIONS AND WARRANTIES OF THE SHARP PARTIES

SHARP and STCMC make the following representations and warranties with respect to their respective organizations and acknowledge that such representations and warranties shall be relied upon by the DISTRICT for the purposes of this Agreement and the other Affiliation Agreements, as applicable to such other Affiliation Agreements.

4.1 Organization. SHARP and STCMC each are a nonprofit corporation duly organized and validly existing in good standing under the laws of the State of California, with the power and authority necessary or required by any and all applicable Laws to conduct the health care and other businesses as presently conducted by their respective entities. SHARP and STCMC have provided to the DISTRICT true, valid, and complete copies of each of SHARP's and STCMC's articles of incorporation and bylaws as of the Agreement Date. Neither SHARP nor STCMC is in default under its articles of incorporation or bylaws, the effect of which might adversely affect its right to operate its business as presently conducted, and there are no pending or, to the SHARP Parties' Knowledge, threatened proceedings or actions intending to (a) limit or impair any of SHARP's or STCMC's powers, rights and privileges in a manner that would prevent or impede the SHARP Parties' performance hereunder, or (b) dissolve or liquidate SHARP or STCMC.

4.2 Authorization; Noncontravention; Consents. The SHARP Parties have the power and requisite authority to enter into the Leases and the Transfer Agreement (collectively, the "Transfer Documents"), this Agreement (collectively, with the Transfer Documents, the "Affiliation Agreements"), and to carry out their respective obligations under each of the Affiliation Agreements, as applicable. The SHARP Parties have respectively taken all required corporate action to authorize, approve and enter into the Affiliation Agreements and to carry out their respective obligations thereunder, as applicable. The Affiliation Agreements shall be legally valid and binding upon the SHARP Parties as of their execution by the applicable Parties on the Agreement Date or Closing Date, as applicable. The Affiliation Agreements shall be enforceable against the applicable SHARP Parties in accordance with their respective terms, except as limited

by applicable bankruptcy, insolvency, reorganization, moratorium or other Laws of general application affecting enforcement of creditors' rights, and as limited by general principles of equity that restrict the availability of equitable remedies. Except as required by the Affiliation Agreements, no other proceeding or action on the part of the SHARP Parties is necessary to authorize the execution and delivery of, and performance under, the Affiliation Agreements. The execution and delivery of the Affiliation Agreements by the SHARP Parties, as applicable, together with the consummation of the transactions contemplated thereby, do not and shall not (i) conflict with any provision of the Articles of Incorporation or Bylaws of SHARP or STCMC, or (ii) conflict with, violate or constitute a default under, or result in the creation or imposition of any lien, charge, encumbrance or claim of any nature whatsoever upon any properties or assets of SHARP or STCMC pursuant to any provision of any indenture, mortgage, deed of trust, lien, lease, agreement, instrument, order, arbitration award, judgment or decree to which any of them is a party or to which any of their properties or assets are bound or any applicable Law, ordinance, regulation, decree or order of any Governmental Authority. Except as set forth in Disclosure Schedule 4.2, no authorization, consent, order or approval of, or filing or qualification with, any Governmental Authority is necessary for the consummation by SHARP or STCMC of the transactions contemplated by this Agreement.

4.3 Financial Statements. SHARP has furnished DISTRICT with true and complete copies of (a) its unaudited consolidated quarterly financial statement(s) for fiscal quarter(s) ended as of December 31, 2024; March 31, 2025; June 30, 2025; and September 30, 2025, (b) its audited consolidated financial statement for the fiscal year ended as of September 30, 2024 together with the related Report of Independent Auditor prepared by Ernst & Young, independent certified public accountants, and (c) prior to the Closing Date, SHARP shall have furnished the DISTRICT with true and complete copies of its audited consolidated financial statement for the fiscal year ended as of September 30, 2025 together with the related Report of Independent Auditor prepared by Ernst & Young, independent certified public accountants (collectively referred to as the "SHARP Financial Statements"). To the SHARP Parties' Knowledge, except as set forth on Disclosure Schedule 4.3, the SHARP Financial Statements have, and shall have, been prepared in accordance with GAAP throughout the periods covered by the SHARP Financial Statements, are consistent with SHARP's accounting records, and fairly present in all material respects the consolidated financial position of SHARP at their respective dates and the results of its consolidated operations and cash flows for the respective periods then ended. To the SHARP Parties' Knowledge, except as set forth on Disclosure Schedule 4.3, SHARP has no material liability or obligation, fixed or contingent, that is not reflected or reserved against in the SHARP Financial Statements or otherwise set forth in the notes thereto, other than liabilities incurred in the ordinary course of business after September 30, 2024, which in the aggregate do not have a Material Adverse Effect on the financial condition, business, or results of operations of the SHARP Parties on a consolidated basis.

4.4 Tax Status. SHARP is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code and Section 23701d of the Revenue and Taxation Code of the State of California and has received determination letters or acknowledgment letters, as applicable, as to its tax-exempt status from the Internal Revenue Service and the Franchise Tax Board of the State of California, which have not been revoked, rescinded or modified. STCMC has been organized and operated in a manner consistent with exemption from taxation under Section 501(c)(3) of the Internal Revenue Code and Section 23701d of the Revenue and Taxation Code of the State of

California, and, prior to the Closing Date, shall have submitted all necessary forms, documents, and other information to receive determination letters or acknowledgment letters, as applicable, as to its tax-exempt status from the Internal Revenue Service and the Franchise Tax Board of the State of California. To the SHARP Parties' Knowledge, there are no facts or circumstances concerning the current operations or structure of their respective organizations which would be reasonably expected to result in their current or anticipated, as applicable, tax-exempt status being rescinded, revoked, or challenged.

4.5 Litigation. Except as set forth on Disclosure Schedule 4.5, there is no action, suit or proceeding pending or, to the SHARP Parties' Knowledge, threatened against or affecting the SHARP Parties, at Law or in equity, or before any Governmental Authority, which either singularly or in the aggregate would, if adversely determined, be reasonably expected to result in any Material Adverse Effect in the financial condition, properties, business, results of operations, or prospects of the SHARP Parties, and there is no judgment, decree, order, writ, or injunction of any court or Governmental Authority against or affecting the SHARP Parties, which, either singularly or in the aggregate, had or would reasonably be expected to have any Material Adverse Effect on the financial condition, properties, business, results of operations, or prospects of the SHARP Parties.

4.6 Brokers or Finders. No person, broker or finder is entitled to any brokerage or finder's fee, other commission, fee or similar compensation in connection with the transactions contemplated by this Agreement based on any contract or arrangement made by or on behalf of either or both of the SHARP Parties.

ARTICLE 5

REPRESENTATIONS AND WARRANTIES OF THE DISTRICT

The DISTRICT makes the following representations and warranties with respect to itself and, in addition, each of the DISTRICT's representations and warranties is also made, to the extent applicable, with respect to TCMC, the Business and the assets to be transferred as Transferring Assets or leased to STCMC as part of the Affiliation. The DISTRICT acknowledges that such representations and warranties shall be relied upon by the SHARP Parties for the purposes of this Agreement and the other Affiliation Agreements, as applicable to such other Affiliation Agreements.

5.1 Organization. The DISTRICT is a local hospital district, duly organized, existing and in good standing under the Constitution and Laws of the State of California, and has the full legal right, power and authority to own or lease its properties and to conduct the Business as presently being conducted by the DISTRICT and TCMC. Except as disclosed on Disclosure Schedule 5.1, the DISTRICT has no subsidiaries and is not a partner in any partnership, limited liability company, or other similar entity. Further, and except as disclosed on Disclosure Schedule 5.1, the DISTRICT is not a party to any joint venture (each such disclosed joint venture is referred to as a "JV Company" and collectively, as the "JV Companies"). Disclosure Schedule 5.1 lists all JV Companies and Affiliates of the DISTRICT and describes the equity securities, if any, of each such entity, the number of shares or other ownership interests of each class authorized, the number of shares or other ownership interests outstanding, and the number of shares or other ownership

interests owned directly or indirectly by the DISTRICT, or the percentage of equity or other ownership interests so owned, as applicable. Disclosure Schedule 5.1 also identifies whether each such entity is tax-exempt or taxable.

5.2 Authorization; Noncontravention; Consents. The DISTRICT has the power and requisite authority to enter into the Affiliation Agreements, and to carry out its obligations under such Affiliation Agreements. The DISTRICT has provided full and complete copies of its bylaws and any other controlling governance documents to the SHARP Parties. The DISTRICT has taken all required corporate action to authorize, approve and enter into the Affiliation Agreements and to carry out its obligations thereunder, as applicable. The Affiliation Agreements shall be legally valid and binding upon the DISTRICT as of their execution by the applicable Parties on the Agreement Date or Closing Date, as applicable. The Affiliation Agreements shall be enforceable against the DISTRICT in accordance with their respective terms except as limited by applicable bankruptcy, insolvency, reorganization, moratorium or other Laws of general application affecting enforcement of creditors' rights, and as limited by general principles of equity that restrict the availability of equitable remedies. Except as required by the Affiliation Agreements, no other proceeding or action on the part of the DISTRICT is necessary to authorize the DISTRICT's execution, delivery and performance under the Affiliation Agreements. The execution and delivery of the Affiliation Agreements and the consummation of the transactions contemplated thereby, do not and will not (a) conflict with the Local Hospital District Law or any provision of the bylaws or other governance documents of the DISTRICT, or (b) conflict with, violate or constitute a default under, or result in the creation or imposition of any lien, charge, encumbrance or claim of any nature whatsoever upon any properties or assets of the DISTRICT pursuant to, any provision of any indenture, mortgage, deed of trust, lien, lease, agreement, instrument, order, arbitration award, judgment or decree to which the DISTRICT is a party or to which the DISTRICT or any of its properties or assets are bound or any applicable Law, ordinance, regulation, decree or order of any Governmental Authority. Except as set forth on Disclosure Schedule 5.2, no authorization, consent, order or approval of, or filing or qualification with any Governmental Authority is necessary for the consummation by the DISTRICT of the transactions contemplated by the Affiliation Agreements.

5.3 Financial Statements. The DISTRICT has furnished SHARP with true and complete copies of (a) its unaudited quarterly financial statement(s) for the fiscal quarter(s) ended as of December 31, 2024, March 31, 2025, and June 30, 2025, and (b) its audited financial statements for the fiscal years ended as of June 30, 2025, 2024 and 2023 together with the related Report of Independent Auditor prepared by Baker Tilly U.S. LLP, independent certified public accountants (collectively the "DISTRICT Financial Statements"). To the DISTRICT's Knowledge, except as set forth on Disclosure Schedule 5.3, the DISTRICT Financial Statements have been prepared in accordance with the accounting principles and methods required by the Governmental Accounting Standards Board applied on a consistent basis throughout the periods covered by the DISTRICT Financial Statements, are consistent with DISTRICT's accounting records, and fairly present in all material respects the financial position of the DISTRICT (including TCMC) at their respective dates and the results of its operations, its cash flows and changes in its financial position (including TCMC for these purposes) for the respective periods then ended. To the DISTRICT's Knowledge, except as set forth on Disclosure Schedule 5.3, neither the DISTRICT nor TCMC has any material liability or obligation, fixed or contingent, that is not reflected or reserved against on the balance sheets included in the DISTRICT Financial

Statements or otherwise set forth in the notes thereto, other than liabilities incurred in the ordinary course of business after June 30, 2025, which in the aggregate do not have a Material Adverse Effect on the financial condition, properties, Business, or results of operations or prospects of the DISTRICT or TCMC.

5.4 Tax Status. The DISTRICT's revenue from its current operations is exempt from all federal, state, county and local income and franchise taxes. To the DISTRICT's Knowledge, there are no facts or circumstances concerning the current operations or structure of the DISTRICT or TCMC that would be reasonably expected to result in the exemptions described in the immediately preceding sentence being rescinded, revoked, or challenged.

5.5 Litigation; Losses; Investigation. Except as set forth on Disclosure Schedule 5.5, there is no pending or, to the DISTRICT's Knowledge, threatened claim, action, suit, investigation or proceeding before any court, arbitrator, mediator or Governmental Authority against or affecting the DISTRICT, TCMC, or the Leased Premises which either singularly or in the aggregate would, if adversely determined, result in any Material Adverse Effect in the financial condition, properties, Business, results of operations or prospects of the DISTRICT or TCMC, or the use or development of the Leased Premises, and there is no judgment, decree, order, writ, or injunction of any court or Governmental Authority against or affecting the DISTRICT or TCMC, or the Leased Premises, which either singularly or in the aggregate, has had or would reasonably be expected to have any Material Adverse Effect in the financial condition, properties, Business, results of operations or prospects of the DISTRICT or TCMC, or the use or development of the Leased Premises.

5.6 Compliance with Applicable Law; Permits.

5.6.1 Subject to Section 5.8 below, the DISTRICT and TCMC each have complied in all material respects with all Laws that are applicable to or effect the Business or, to the DISTRICT's Knowledge, any owned or leased property of the DISTRICT and TCMC, and there are no currently pending or, to the DISTRICT's Knowledge, threatened investigations, probes or claims by any Governmental Authority against the DISTRICT, TCMC or the Leased Premises alleging or investigating a possible violation of any such Law that would be reasonably expected to have an Material Adverse Effect on the DISTRICT or TCMC, their operations, or the Permitted Use (as defined in each of the Leases), or the DISTRICT's ability to perform its obligations under this Agreement.

5.6.2 The DISTRICT has made available to the SHARP Parties each permit, license, certification and other approval that is held by the DISTRICT and/or TCMC (each, a "Permit" and together, the "Permits"). Each Permit is valid and in full force and effect. To the DISTRICT's Knowledge, neither the DISTRICT nor TCMC has received any written notice or other communication from any Governmental Authority or any other person acting on behalf of any Governmental Authority, of (i) any actual, alleged (and reasonably credible), possible, or potential violation of or failure to comply with any term or requirement of any Permit where such violation or failure to comply would be materially adverse to the DISTRICT or TCMC's Business; or (ii) any actual, proposed, possible or potential revocation, withdrawal, suspension, cancellation, termination of, or modification to any such Permit; and all applications required to have been filed for the renewal of such Permits have been duly filed on a timely basis with the appropriate

Governmental Authorities. All other filings required to have been made with respect to such Permits have been duly made on a timely basis with the appropriate Governmental Authorities. The Permits held by the DISTRICT and/or TCMC constitute all of the Permits necessary for the DISTRICT and TCMC to lawfully conduct and operate its Business in the manner they currently conduct and operate such Business (except where failure to hold or maintain such Permit would not be reasonably expected to have a Material Adverse Effect with respect to such Business).

5.7 Medical Staff. The DISTRICT has made available to SHARP a correct and complete copy of the bylaws, rules and regulations of the TCMC Medical Staff (as defined herein) that are currently in effect ("Medical Staff Bylaws"). With regard to the TCMC Medical Staff, except as set forth on Disclosure Schedule 5.7, there are no pending or, to the DISTRICT's Knowledge, threatened peer review proceedings, appeals or other disputes with applicants, staff members or health professional affiliates (including, without, limitation, allied health professionals and advanced practice providers). At all times in the past six (6) years, the DISTRICT and TCMC have maintained a process for reviewing the credentials of the members of the TCMC Medical Staff, and none of the California Department of Public Health, Medi-Cal, the Centers for Medicare & Medicaid Services or the Joint Commission have cited the DISTRICT or TCMC with any deficiencies in TCMC's credentialing process or its Medical Staff Bylaws. To the DISTRICT's Knowledge, in the past six (6) years, the DISTRICT and/or TCMC, as applicable, have made all required reports to the Medical Board of California and the National Practitioner Data Bank.

5.8 Healthcare Laws. Except as set forth on Disclosure Schedule 5.8:

5.8.1 To the DISTRICT's Knowledge, the DISTRICT is, and has been at all times for each of the past six (6) years, in material compliance with each Healthcare Law that is or was applicable to it and the Business conducted by the DISTRICT and TCMC, except where any noncompliance with Healthcare Laws has been limited to minor violations involving aggregate amounts less than Twenty Five Thousand Dollars ($25,000), and that (i) do not involve fraud, willful misconduct, or gross negligence, (ii) have not resulted in, or are currently the subject of, any investigations or non-routine audits, that have or are expected to result in any material fines, penalties, or adverse actions against the DISTRICT, TCMC or any officer or director thereof. In addition, to the DISTRICT's Knowledge, no event has occurred within the last six (6) years that would reasonably be expected to give rise to any material obligation on the part of the DISTRICT or TCMC to undertake, or to bear all or any portion of the cost of, any remedial action of any nature with respect to violation of any Healthcare Laws, including, without limitation, events relating to the making of any contribution, gift, bribe, rebate, payoff, influence payment, kickback, or other payment to any person, private or public, regardless of form, whether in money, property, or services in violation of any federal or state anti-bribery or anti-kickback Law or other legal requirement. Within the last six (6) years, neither the DISTRICT nor TCMC has received any written notice or other communication from any Governmental Authority of (i) any actual, alleged and reasonably credible material violation of, or material failure to comply with, any Healthcare Laws, or (ii) any actual, alleged and reasonably credible obligation on the part of the DISTRICT or TCMC to undertake, or to bear all or any portion of the cost of, any material remedial action with respect to any actual or alleged violation of Healthcare Laws of any nature.

5.8.2 Neither the DISTRICT, TCMC nor any or any of their officers, directors or other representatives is subject to the terms of any corporate integrity agreements or programs,

corrective action plans or compliance plans with a Governmental Authority that have not been fully implemented or satisfied, and the DISTRICT has disclosed its or TCMC's participation in any such programs or plans during the past six (6) years to the SHARP Parties, whether or not implemented or satisfied.

5.8.3 To the DISTRICT's Knowledge, neither the DISTRICT nor TCMC has engaged in any activities that are prohibited under the Federal Controlled Substances Act, 21 U.S.C. §§ 801 et seq., the Federal Food, Drug and Cosmetic Act, 21 U.S.C. §§ 301 et seq., or the regulations promulgated pursuant to such statutes or any related state or local statutes or regulations concerning the dispensing and sale of controlled substances.

5.8.4 The DISTRICT and/or TCMC, as applicable, has timely filed all applicable reports, returns and filings, including filing information data (e.g., annual Medicare cost reports) with all applicable federal, local and state authorities and regulatory agencies as are required by federal, state or local Laws in accordance with any federal or state healthcare programs (including as defined in 42 U.S.C. Section 1320a-7b(f)), and including, without limitation, the Medicare, Medicaid/Medi-Cal, or Tricare programs, and contractual arrangements with local authorities related to behavioral health, penal or other services (collectively, "Government Programs") in which it participates, the private third-party payor programs with which it is contracted ("Private Programs"), and all requirements of applicable fiscal intermediaries and contractors. To the DISTRICT's Knowledge, all such reports submitted by the DISTRICT or TCMC to Government Programs and Private Programs were complete and accurate in all material respects when filed and have been prepared in material compliance with all applicable Healthcare Laws governing reimbursement and payment of claims. The DISTRICT and TCMC have paid or caused to be paid in the ordinary course of business all material known and undisputed refunds, overpayments or adjustments that were or have become due to any Government Program or Private Program. Neither the DISTRICT nor TCMC (i) has any material pending appeals, adjustments, disputes, contested positions, challenges, litigation, or audits pending by or before a Governmental Authority or a Private Program with respect to submitted claims or cost reports, except for such appeals or individual claim denials that occur in the ordinary course of business; and (ii) within the last three (3) years, has been audited, surveyed or otherwise examined in connection with any Government Program or any Private Program other than audits, surveys or reviews that occur in the ordinary course of business. Neither the DISTRICT nor TCMC has received any notice of denial of payment, recoupment, or overpayment from any Government Program or Private Program, other than in the ordinary course of business.

5.8.5 Except as set forth on Schedule 5.8.5, all contracts with any Government Program or Private Program were entered into by the DISTRICT in the ordinary course of business. The DISTRICT is in material compliance with each of its respective contracts with any Government Program or Private Program, including any applicable requirements to provide quality assurance services, clinical service management, utilization review, outcomes monitoring, patient satisfaction, or complaint/grievance, credentialing and re-credentialing programs. To the DISTRICT's Knowledge, the DISTRICT has charged and billed in all material respects in accordance with the terms of its respective contracts with any Government Programs or Private Programs, including, where applicable, billing and collection of all deductibles and co-payments in all material respects. To the DISTRICT's Knowledge, (i) all claims that have been filed by it or TCMC were for services actually rendered, were properly coded, and were filed in compliance

with all Government Program and Private Program requirements, including those regarding physician certification and recertification for services, and (ii) there are no pending or threatened claims related to the DISTRICT's or TCMC's performance (or non-performance) under such Government Programs or Private Programs. To the DISTRICT's Knowledge, the Government Programs and Private Programs with which it or TCMC participate and have performed all material obligations under, and are not in default of, any such programs or related agreements.

5.8.6 Neither (a) any member of the DISTRICT Board or any other TCMC governing body, (b) any officer, or any physician or other enrolled provider who is a current employee or former employee (either before or during the course of such former employee's employment) of the DISTRICT or TCMC, (c) to the DISTRICT's Knowledge (which for the purpose of this Section 5.8.6(c) only, will include the Director of Medical Staff of the DISTRICT), any member of TCMC's Medical Staff (including physicians, allied health professionals and advanced practice practitioners), nor, (d) to the DISTRICT's Knowledge, any other affiliated provider group, clinical or ambulatory operation, person or entity working in support of TCMC or the DISTRICT, or any third party vendor or independent contractor who furnishes services or supplies to the DISTRICT or TCMC that may be reimbursed in whole or in part under any Government Program, is, or was at the time of providing such services or supplies, excluded, suspended or debarred from participation or is or was otherwise ineligible to participate in any Government Program, or, to the DISTRICT's Knowledge, has been convicted of or charged with any violation of any Law related to any Government Program that is reasonably likely to serve as the basis for any such exclusion, suspension, debarment or other ineligibility.

5.9 Government Settlements/Reporting Agreements; Investigations; Compliance Program. Except as set forth on Disclosure Schedule 5.9, neither the DISTRICT nor TCMC (i) is a party to a corporate integrity agreement, deferred prosecution agreement, probationary agreement, settlement agreement or any other similar agreement with any Governmental Authority, (ii) has no reporting obligations pursuant to any agreement entered into with any Governmental Authority with respect to any agreement of the type describe in subsection (i) above, (iii) to the DISTRICT's Knowledge, are not currently and have not in the last six (6) years been the subject of any Government Program-related investigation conducted by any Governmental Authority, and (iv) to the DISTRICT's Knowledge, are not currently and have not in the last six (6) years been a defendant in any qui tam / False Claims Act litigation. The DISTRICT has provided to the SHARP Parties a copy of all of its correspondence within the past three (3) years with the Office of Inspector General of the Department of Health and Human Services, including all independent review organization reports, annual reports, reportable events and overpayments.

5.10 HIPAA and HITECH Act; Data Security. The DISTRICT and TCMC have (i) adopted and adhered, in all material respects, to such policies and procedures, and entered into such business associate agreements with business associates, as required with respect to the use and disclosure of Protected Health Information (as defined by HIPAA), (ii) completed audits, reviews, analyses, and assessments of all areas of its Business and operations subject to HIPAA as are required for the DISTRICT and TCMC to be in compliance with HIPAA and/or the HITECH Act, (iii) except as set forth on Disclosure Schedule 5.10, not had any material HIPAA breach (as such term is defined in HIPAA) occur with respect to any unsecured Protected Health Information maintained by or for the DISTRICT or TCMC that is subject to the notification requirements of 45 C.F.R. Part 164, Subpart D, (iv) has timely notified, and/or filed reports with, all Governmental

Authorities with respect to any breaches, potential breaches, violations of, or other reportable matters, pursuant to HIPAA, the HITCEH Act or applicable California Law related to Protected Health Information, patient, customer and/or other data; and (v) except as set forth on Disclosure Schedule 5.10, no information security or privacy breach event (under HIPAA, the HITECH Act or any California Law) has occurred in the past six (6) years that would require notification under HIPAA, the HITECH Act or any California Law. Neither the DISTRICT nor TCMC transmits or stores any personally identifiable information outside of the United States and, to the DISTRICT's Knowledge, does not have in effect any contract with any third party vendor under which the third party vendor transmits or stores any personally identifiable information of the DISTRICT or TCMC outside of the United States in violation of applicable Law. To the DISTRICT's Knowledge, each of the DISTRICT's and TCMC's practices concerning collection, use, analysis, retention, storage, protection, security, transfer, disclosure and disposal of personal information are and have been in compliance in all material respects with any written policies and procedures applicable to the DISTRICT and TCMC relating to the collection, processing, or disclosure of personally identifiable information, including, without limitation, all website and mobile application privacy policies and internal information security procedures. To the DISTRICT's Knowledge, the DISTRICT and TCMC have posted to their website(s) and each of its online sites and services, a terms of use or service and a privacy policy that complies in all material respects with Laws and accurately reflects the DISTRICT's and TCMC's practices concerning the collection, use, and disclosure of personal information by the site or service.

5.11 No Default. Except as set forth on Disclosure Schedule 5.11, the DISTRICT is not in material default or violation, and no event has occurred that with notice or lapse of time or both would become a material default or violation of any term, condition or provision of (i) the Local Hospital District Law, (ii) the DISTRICT's bylaws or (iii) any mortgage, deed of trust, indenture, contract, agreement, lease or other instrument to which the DISTRICT is a party or by which it or any of its respective properties or assets may be bound, except for defaults and violations that either singularly or in the aggregate do not and would not reasonably be expected to have a Material Adverse Effect on the financial condition, properties, Business, results of operations or prospects of the DISTRICT or TCMC.

5.12 Marketable Title. Except as specifically set forth in the Transfer Agreement and except for any Permitted Encumbrance, the DISTRICT has good and marketable title to the Transferring Assets, and the DISTRICT has, or will have immediately prior to the Effective Time, title to all of the Transferring Assets, free and clear of all Encumbrances. Except as specifically permitted by the Transfer Agreement and except for any Permitted Encumbrance, the DISTRICT has not entered into any contract, commitment or arrangement that would cause any of the Transferring Assets to be subject to any Encumbrance that will exist or come into existence on or after the Effective Time. The DISTRICT has, and shall have immediately prior to the Effective Time, full power and authority to sell, assign, transfer, and deliver the Transferring Assets to STCMC, and such transfer will vest in STCMC good and marketable title to the Transferring Assets, free and clear of all liens and encumbrances, subject only to those permitted by the Transfer Agreement and the Permitted Encumbrances.

5.13 Environmental Matters. Except as disclosed on Disclosure Schedule 5.13, (a) during the past ten (10) years, the District has operated TCMC and the Business in accordance with applicable environmental Laws; and (b) there are no third party claims and/or regulatory

actions asserted, assessed, pending or, to the DISTRICT's Knowledge, threatened against the DISTRICT, the Leased Premises, or any real property now owned or leased or previously owned or leased in the past six (6) years by the DISTRICT, whether for use in the Business of the DISTRICT or TCMC or otherwise (collectively, "Properties"), arising out of or due to: (i) the release on, under or from any of its Properties of any hazardous substances in violation of any environmental Law; (ii) any contamination of any of its Properties, including, without limitation, the presence of any hazardous substance located on or under any of its Properties in violation of any environmental Law; (iii) any violation of any federal or state environmental Laws with respect to any of its Properties; (iv) any injury to human health and safety or to the environment by reason of the present condition of, or present activities on or under any of its Properties; or (v) the generation, manufacture, storage, treatment, handling, transportation, of any hazardous substance on any of its Properties in violation of any environmental Law. To the DISTRICT's Knowledge, during the DISTRICT's period of ownership up through the Effective Date, none of the Properties is listed in the federal Environmental Protection Agency's National Priorities List of Hazardous Waste Sites (the "National Priorities List") or any other comparable list maintained by any Governmental Authority. To the DISTRICT's Knowledge, no part of the Properties were ever used, nor are they now being used: (a) as a landfill, dump or other disposal, storage, transfer or handling area for hazardous substances, except in the ordinary course of hospital or clinic or related healthcare operations; or (b) as a gasoline service station or a facility for selling, dispensing, storing, transferring or handling petroleum and/or petroleum products, except in the ordinary course of hospital or clinic or related health care operations. Except as disclosed on Disclosure Schedule 5.13, to the DISTRICT's Knowledge there are no underground storage tanks, urea-formaldehyde materials, asbestos, asbestos containing materials, polychlorinated biphenyls or nuclear fuels or wastes, located on or under any of its Properties.

5.14 Insurance. The DISTRICT has continually maintained insurance policies and bonds insuring the DISTRICT against losses relating to the DISTRICT's and TCMC's past and present operations and activities, all real and personal property owned or leased by the DISTRICT, and any acts or omissions by its and TCMC's directors, officers and employees, including without limitation, comprehensive general liability insurance, real and personal property hazard and casualty insurance, automobile liability insurance, professional liability insurance, workers' compensation insurance, employers liability insurance, employment practices liability insurance, and cyber insurance (collectively, "Insurance"). To the DISTRICT's Knowledge, no application filed for the Insurance contains any material misstatement of fact or fails to state any material fact that may adversely affect the coverage provided. To the DISTRICT's Knowledge, the DISTRICT has properly and adequately notified all insurance carriers of any and all claims known to the DISTRICT with respect to the employees, operations, properties and third party claims of the DISTRICT and TCMC, has complied with all other material requirements and conditions of the Insurance, has not received any notice of denial of coverage or notice of limitation of coverage or other similar notifications from the carriers of the Insurance with respect to any claims tendered for coverage by the DISTRICT or TCMC, and has not received any notice of cancellation or nonrenewal of any Insurance prior to or as of the Effective Time.

5.15 Material Contracts. Except as set forth on Disclosure Schedule 5.15, the DISTRICT is not a party to or bound by, nor are TCMC or any of the DISTRICT's or TCMC-related properties subject to, any of the following contracts (each, a "Material Contract"):

5.15.1 Contract for the employment of any officer, employee or consultant or contract with a former officer, employee or consultant pursuant to which the DISTRICT may be required to make annual payments that exceed Two Hundred and Fifty Thousand Dollars ($250,000);

5.15.2 Mortgage, deed of trust, indenture, note or installment obligation, or other instrument for or relating to the borrowing of money by the DISTRICT pursuant to which the DISTRICT may be required to make annual payments that exceed Two Hundred and Fifty Thousand Dollars ($250,000);

5.15.3 Guarantee of any obligation for borrowing or otherwise by the DISTRICT, excluding endorsements made for collection in the ordinary course of business, where the obligation guaranteed exceeds Five Hundred Thousand Dollars ($500,000);

5.15.4 Agreement or arrangement for (i) the sale or lease of any of the DISTRICT's or TCMC's assets or portions of its Business having a fair market value in excess of One Million Dollars ($1,000,000) other than in the ordinary course of its business, or (ii) the grant of any preferential rights to purchase or lease any of such assets or portions of its Business having a fair market value in excess of One Million Dollars ($1,000,000), or (iii) the DISTRICT or TCMC is required or obligated to make annual payments in excess of Two Hundred and Fifty Thousand Dollars ($250,000) in connection with or with respect to any partnership, joint venture, limited liability company, or other similar agreement or arrangement;

5.15.5 Contracts pursuant to which the DISTRICT or TCMC is or may be obligated to make payments, contingent or otherwise, in excess of Five Hundred Thousand Dollars ($500,000) and arising out of the prior acquisition of real or personal property or of all or part of the stock or ownership interests, business or assets of any other persons or entities;

5.15.6 Lease of real property or personal property of any kind or nature (including any capital leases) or similar arrangement (a) where the DISTRICT or TCMC is the lessor or (b) for the use by DISTRICT or TCMC of personal property pursuant to which the DISTRICT or TCMC may be required to make annual payments that exceed Two Hundred and Fifty Thousand Dollars ($250,000); or

5.15.7 Any other written contract, agreement or other instrument that is material to the Business of the DISTRICT or TCMC.

The DISTRICT has provided full and complete copies of all Material Contracts to the SHARP Parties. To the DISTRICT's Knowledge, the Material Contracts are valid, legally binding and enforceable as to the DISTRICT and as to the other parties thereto in accordance with their respective terms, except as limited by applicable bankruptcy, insolvency, reorganization, moratorium or other Laws of general application affecting enforcement of creditors' rights, and as limited by general principles of equity that restrict the availability of equitable remedies. Except as described on Disclosure Schedule 5.15, to the DISTRICT's Knowledge, the DISTRICT and each other party thereto has performed all obligations required to be performed by it and is not in default under or in breach of, or in receipt of any notice or claim of default or breach under, any Material Contract. Except as described on Disclosure Schedule 5.15, to the DISTRICT's

Knowledge, there has not occurred any event that, with the lapse of time or the giving of notice or both, would constitute a default by the DISTRICT or by any of the other parties to such Material Contracts. Except as described on Disclosure Schedule 5.15, the DISTRICT has not received written notice that any party to any Material Contract intends to cancel, terminate, or not renew any such Material Contract.

5.16 Labor Relations. Except as set forth on Disclosure Schedule 5.16:

5.16.1 The DISTRICT has paid or made provision for the payment for all salaries and wages accrued through the date of this Agreement and has complied in all material respects with all applicable Laws relating to the employment of labor, including those relating to wages, hours, collective bargaining, discrimination, harassment, retaliation, occupational safety and health, and immigration and the payment and withholding of all employment and other taxes, and has withheld and paid to the appropriate Governmental Authority, or is holding for payment not yet due to such Governmental Authority, all amounts required by Law or agreement to be withheld from the wages or salaries of its employees.

5.16.2 There are no pending or, to the DISTRICT's Knowledge, threatened labor strikes, work stoppages, slowdowns, picketing, lockouts, union organizing campaigns, or other labor disputes involving the DISTRICT's employees or any employees whose services support TCMC.

5.16.3 The DISTRICT is not a party to, nor bound by, any collective bargaining agreement or similar labor agreement.

5.16.4 No labor union or other employee representative is currently certified or recognized as the exclusive bargaining representative of any of the DISTRICT's employees (or any employees whose services support TCMC).

5.16.5 No petition has been filed or proceedings instituted by or on behalf of any labor organization seeking recognition of a bargaining unit.

5.16.6 There are no pending or, to DISTRICT's Knowledge, threatened claims, charges, grievances, complaints, audits, litigation, or investigations against the DISTRICT by any employee, former employee, labor organization, or Governmental Authority relating to employment practices, including, but not limited to, alleged wage and hour violations, wrongful termination, disability, racial, gender or other forms of discrimination, harassment, or retaliation, including, without limitation, actions initiated under the California Private Attorney General Act and similar actions.

5.16.7 The DISTRICT has not taken any action in the past three (3) years that would trigger notice obligations under the federal Worker Adjustment and Retraining Notification Act (WARN) or under any similar state Law.

5.16.8 To the DISTRICT's Knowledge, the DISTRICT has properly classified all individuals who perform services for the DISTRICT and TCMC as employees or independent

contractors in accordance with applicable Laws and has no liability arising from any misclassification.

5.17 Benefit Plans. All employee benefit plans currently sponsored or maintained by DISTRICT (the "Benefit Plans") are listed on Disclosure Schedule 5.17. The DISTRICT does not, as of the Effective Date, and will not, as of the Closing Date, sponsor or maintain retirement benefit plans subject to ERISA. To DISTRICT's Knowledge, the DISTRICT is in material compliance with the terms of, and applicable Law with respect to, such Benefit Plans, and has sponsored and maintained its Benefit Plans in material compliance with such terms and applicable Law, including without limitation, with respect to the making of contributions and reporting obligations. The DISTRICT has not withdrawn from any benefit plans with any material outstanding liability that has not been settled or paid. There are no pending or, to the DISTRICT's Knowledge, threatened claims (other than routine claims for benefits) or audits involving any Benefit Plan. The DISTRICT is not aware of any facts that would reasonably be expected to result in DISTRICT liability under applicable Law with respect to the Benefit Plans.

5.18 Intellectual Property.

5.18.1 Disclosure Schedule 5.18.1(a) sets forth a true, correct and complete list of all patents and patent applications, registered trademarks and applications to register any trademarks, registered copyrights and applications for registration of copyrights, domain names and social media accounts, and material unregistered trademarks, in each case, owned by the DISTRICT or TCMC and used or held for use in its Business as presently conducted (the "Intellectual Property"). The DISTRICT also has made available to SHARP a complete list of (i) all software, other than any widely-available, commercial off-the-shelf software (including the identity of the owner of all such software and of the developer or provider from whom such software was obtained), and (ii) material contracts that cover Intellectual Property owned by a third party that is used or held for use in the Business of the DISTRICT or TCMC. Disclosure Schedule 5.18.1(b) to this Agreement sets forth a correct and complete listing of all contracts that cover Intellectual Property owned by the DISTRICT that is licensed to any person or entity.

5.18.2 Except as set forth on Disclosure Schedule 5.18.2 to this Agreement, all Intellectual Property that the DISTRICT has used or held for use during the prior three (3) years, or, is currently using, or is holding for use, in the conduct of its or TCMC's Business is exclusively owned by the DISTRICT free and of any encumbrance or has been licensed to the DISTRICT by a third party under a valid and enforceable contract. The DISTRICT has complied in all material respects with all internet domain name registration and other clear requirements of internet domain administration authorities concerning all domain names that are DISTRICT Intellectual Property and operated all websites associated with such domain names in accordance with all applicable Laws in all material respects. The DISTRICT owns, has sufficient rights to display or make available all content, data, and other information displayed or made available, as applicable, on all websites associated with any domain name included in DISTRICT Intellectual Property.

5.18.3 To the DISTRICT's Knowledge, all DISTRICT owned Intellectual Property is subsisting, valid, enforceable and in full force and effect. To the DISTRICT's Knowledge, there are no royalties, fees, honoraria or other payments payable by the DISTRICT to any person or entity by reason of the ownership, development, modification, use, license, sublicense, sale,

distribution or other disposition of DISTRICT owned Intellectual Property, other than, if applicable, salaries and sales commissions paid to employees and sales agents, and customary license fees charged by third party licensors in the ordinary course of business. The DISTRICT has the exclusive, unrestricted right to sue for past, present, and future infringement of such Intellectual Property that is owned by the DISTRICT.

5.18.4 During the prior three (3) years, neither the DISTRICT nor TCMC has received any written claim that the conduct of its Business or the DISTRICT's Intellectual Property (or use of it), as applicable, has infringed upon, misappropriated or violated, or is infringing, misappropriating or violating, any Intellectual Property of any other person or entity. Further, to the DISTRICT's Knowledge, no third party has infringed, misappropriated or otherwise violated or is infringing, misappropriating or otherwise violating any Intellectual Property owned by the DISTRICT or TCMC, and no such claim is pending or, to the DISTRICT's Knowledge, threatened against any person or entity by the DISTRICT.

5.19 Brokers or Finders. Except as set forth on Disclosure Schedule 5.19, no person, broker or finder is entitled to any brokerage or finder's fee, other commission, fee or similar compensation in connection with the transactions contemplated by this Agreement based on any contract or arrangement made by or on behalf of the DISTRICT or TCMC.

5.20 Hospital Survey. TCMC was most recently surveyed by the Joint Commission in April 2025 and received accreditation for a three-year period that expires in April 2028. TCMC's Joint Commission accreditation is valid and in full force and effect and is not impaired in any manner. In addition, the California Department of Public Health last surveyed TCMC in January 2020 and the hospital license, as well as all other licenses or approvals issued with respect to TCMC by the California Department of Public Health, are in good standing, or, in the event a statement of deficiencies was issued with respect to such license(s), all such deficiencies have been corrected and accepted by the California Department of Public Health.

5.21 Budgets and Master Plan.

5.21.1 The DISTRICT has made available to the SHARP Parties the DISTRICT's capital and operating budgets for the current fiscal year with reasonable detail, including, without limitation, details regarding equipment, capital improvements, and other operational budget-related matters and anticipated expenditures developed and maintained by the DISTRICT and relating to TCMC.

5.21.2 The DISTRICT has delivered to the SHARP Parties the DISTRICT's full and complete copies of the DISTRICT's most current (i.e., most recently adopted and approved) master plan for the development of TCMC, its campus and other adjoining properties owned by the DISTRICT and to be leased to STCMC.

5.22 JV Companies. To the DISTRICT's Knowledge, each JV Company (i) is and has operated (since the earlier of its formation or the past six (6) years) in material compliance with all applicable Laws, including, without limitation, all corporate, tax, and environmental Laws, Healthcare Laws, and all regulatory requirements; (ii) has been duly organized and is validly existing under the laws of its jurisdiction of formation; (iii) is not in material breach of, or default

under, any of its governing documents or material contracts; (iv) is in good standing with any and all Government Programs with which it contracts or otherwise participates and has not been terminated or excluded from, or threatened with termination or exclusion from any such Government Programs or from any Private Programs, and (v) is not subject to, or the target of, any pending or threatened claims, litigation, investigations, or proceedings that would reasonably be expected to have a Material Adverse Effect on such JV Company or its business.

5.23 Material Adverse Effect. To the DISTRICT's Knowledge, since June 30, 2025, there are not any circumstances creating or that would be reasonably expected to create any Material Adverse Effect on or with respect to the DISTRICT or the Business. As used in this Agreement, "Material Adverse Effect" means any event, circumstance, change, occurrence or development, that, individually or in the aggregate with other events, circumstances, changes, occurrences or developments, has had, or is reasonably likely to have, a materially negative impact or adverse effect on (i) the DISTRICT's ability to consummate the transactions contemplated by the Affiliation Agreements or perform its obligations under the Affiliation Agreements, or (ii) the the DISTRICT or the Business, each taken as whole, including with respect to operations, Properties, prospects, assets, results, liabilities or condition (financial or otherwise), other than to the extent resulting from events, circumstances, changes, occurrences or developments (a) relating to the United States and world economy in general or the health care industry (including the regulatory environment and decisions related thereto) in which the DISTRICT or TCMC operate in general, (b) affecting or relating to tax rates or the implementation of new taxes, capital or financial markets generally, or (c) arising as a result of enactment or implementation of any new Law or accounting rule, including the enactment or implementation of any change in payment or reimbursement from Government Programs.

5.24 Real Estate.

5.24.1 Easements & CC&Rs. To DISTRICT's Knowledge, except as set forth on Disclosure Schedule 5.24.1, no unrecorded easement, restriction, covenant, condition or similar agreement to which DISTRICT is a party exists which would have Materially Adversely Effect on SHARP Parties' Permitted Use of the Leased Premises.

5.24.2 Leases. To DISTRICT's Knowledge, except as set forth in the Assumed Leases made available to the SHARP Parties, there are no leases, licenses or other agreements, oral or written, with respect to the use and occupancy of the Leased Premises.

ARTICLE 6

PRE-CLOSING COVENANTS

6.1 Covenants related to Compliance with District Law. The SHARP Parties and the DISTRICT covenant and agree as follows:

6.1.1 Public Meetings. The DISTRICT, prior to the Agreement Date, complied with Section 32121(p)(2)(A)(i) of the California Health & Safety Code by holding at least five (5) properly noticed open and public meetings in accordance with the Ralph M. Brown Act to discuss the Affiliation Agreements and the transactions contemplated thereby.

6.1.2 Ballot Measure. The DISTRICT shall, prior to the Closing Date, by resolution, submit a measure to the voters of the DISTRICT proposing approval of the transactions, leases and transfers contemplated by the Affiliation Agreements in accordance with Section 32121(p)(2)(D) of the California Health & Safety Code.

6.1.3 Approval of STCMC Board Members. The SHARP Parties grant to the DISTRICT the right to approve, and as of the Closing Date the DISTRICT shall have approved, all initial members of the STCMC Board in accordance with Section 3212l(p)(2)(A)(ii) of the California Health & Safety Code.

6.2 SHARP Party Covenants. The SHARP Parties covenant that from the Agreement Date until the Effective Time they are bound by the obligations stated in this Section 6.2, except as specifically permitted by this Agreement or otherwise consented to in writing by the DISTRICT.

6.2.1 Consents of Third Parties. The SHARP Parties shall use commercially reasonable efforts to obtain third party consents required under the Assumed Contracts to effectuate assignments of such Assumed Contracts to STCMC as of the Effective Time. The DISTRICT shall use all commercially reasonable efforts to cooperate with the SHARP Parties (including, without limitation, promptly responding to and forwarding communications related to such consents and communicating with the SHARP Parties' representatives) and to help facilitate the SHARP Parties' obtaining such consents and facilitating such assignments prior to Closing. Promptly following the execution of this Agreement, the DISTRICT shall introduce SHARP to each landlord who leases the DISTRICT real property pursuant to an Assumed Lease (each, an "Existing Landlord") via email for the purpose of obtaining its written consent to the assignment of such Assumed Lease and allowing the SHARP Parties to conduct diligence with respect to the applicable Assumed Lease. Additionally, the DISTRICT shall reasonably cooperate with the SHARP Parties in requesting a commercially reasonable estoppel certificate from each Existing Landlord as to each Assumed Lease (each, an "Estoppel Certificate"). Notwithstanding the foregoing, the SHARP Parties shall not be obligated to (i) pay any fee or other consideration to any third party to obtain consent with respect to such Assumed Contract, (ii) agree to any material modification of the terms of any Assumed Contract, or (iii) initiate or participate in any litigation or arbitration to obtain such consent. If any required consent is not obtained prior to Closing, the DISTRICT shall, at the SHARP Parties' request and expense, use commercially reasonable efforts to facilitate the SHARP Parties receiving continued benefit under such Assumed Contract through alternative arrangements (including subcontracting, sublicensing, or other means), until such consent is obtained or the contract is terminated. In addition, the SHARP Parties shall use commercially reasonable efforts to facilitate the issuance and receipt of any and all Governmental Authority approvals required for the consummation of the transactions contemplated hereby.

6.2.2 Satisfaction of Conditions. The SHARP Parties shall use their commercially reasonable efforts to cause the conditions precedent to the consummation of the transactions contemplated by this Agreement to be satisfied.

6.2.3 Employment and Labor Relations.

6.2.3.1 STCMC shall offer employment to all employees in good standing employed by the DISTRICT with respect to the Business as of the Effective Time except for (i) employees scheduled for employment termination or retirement as of or prior to the Effective Time, (ii) employees who resign as employees of the DISTRICT as of or prior to the Effective Time, and (iii) any employees terminated by the DISTRICT in the ordinary course of business as of or prior to the Effective Time ("Eligible Employees"). STCMC's offers of employment to such Eligible Employees shall be subject to each such Eligible Employee's timely completion of employment applications, satisfaction of employment on-boarding processes and requirements with respect to background checks, excluded provider checks, and other standard processes and procedures for employees of SHARP and its Affiliates, and the acceptance of employment. All Eligible Employees who are offered employment pursuant to, and who satisfy the requirements of this Section 6.2.3.1, shall be hired by STCMC as of the later of the Effective Date or the date of such Employee's acceptance of such employment, and shall be hereinafter referred to herein as "Hired Employees." The SHARP Parties shall be solely responsible for determining whether any Eligible Employee meet the SHARP Parties' onboarding requirements.

6.2.3.2 The DISTRICT shall cooperate with the SHARP Parties and shall release all information to the SHARP Parties concerning DISTRICT's employment of any Eligible Employee who applies for employment with STCMC, including, but not limited to, information regarding qualifications, work history with DISTRICT, relevant licensure or certification, immunization or required health status, background and Government Program exclusion checks, verification of employment eligibility, and execution of standard employment documentation, immigration status, pending discipline or corrective action, or unusual limitations on the scope of clinical privileges for any Eligible Employee who is a health professional, subject to the receipt by the SHARP Parties of the written consent obtained by DISTRICT from an Eligible Employee to the release of information when required under applicable Laws.

6.2.3.3 Compensation offered to Hired Employees not covered by collective bargaining agreements by STCMC shall be in accordance with the DISTRICT's compensation rates and corresponding pay scales existing for such Hired Employees as of the Closing Date, subject to compliance with the healthcare minimum wage legal requirements. No later than two years after the Effective Time, Hired Employees who remain employed by STCMC and are not covered by collective bargaining agreements will transition to compensation rates and corresponding pay scales comparable to the compensation rates and corresponding pay scales of employees of other SHARP Affiliates in similar positions (based on their respective job descriptions) and years of experience.

6.2.3.4 STCMC will calculate and grant Hired Employees with years of service credit for seniority and employee benefits purposes based on the number of years of services assigned by the DISTRICT for each such Hired Employee as of the Closing Date, as defined by the DISTRICT's policies/procedures and years of service calculations then-in effect.

6.2.3.5 As of the Effective Time, STCMC's policies/procedures will provide that Hired Employees other than those Hired Employees in the position of a Vice President ("VP") and above may accrue paid-time-off ("PTO") hours up to a maximum level of 450 hours. The Parties acknowledge that the DISTRICT's current policies/procedures allow employees to accrue PTO hours at a maximum hour level higher than 450 hours. As of the Effective Time or,

if later, an employee's date of hire, Hired Employees (other than those Hired Employees with positions of Vice Presidents and above) will roll over, and STCMC will recognize, any accrued, unused PTO hours while employed by the DISTRICT up to a maximum of 450 PTO hours. The value of any Hired Employee's accrued PTO hours in excess of 450 hours will be paid out to such Hired Employees by the DISTRICT on the Closing Date. As part of the Eligible Employees' on-boarding process, Eligible Employees will be requested to provide written consent for the rollover of their PTO hours to STCMC. On the Closing Date, the value of all accrued PTO hours of those Hired Employees who hold positions of Vice President or above will be paid by the DISTRICT to such Hired Employees and such Hired Employees will become subject to the then existing PTO policy for the employees of SHARP's Affiliates, including STCMC, holding positions of Vice President and above.

6.2.3.6 As of their date of hire, the Hired Employees will rollover, and STCMC shall recognize and grant the Hired Employees with, the Extended Leave Bank and/or Annual Leave Bank hours consistent with such hours accumulated by each such Hired Employee as of the Closing Date in accordance with the DISTRICT's policies and procedures.

6.2.3.7 As of the Effective Time, STCMC will (a) recognize the DISTRICT's then-existing labor unions representing the bargaining units of those Eligible Employees who will be offered employment by STCMC, (b) bargain in good faith with the labor unions concerning the terms and conditions of employment under the applicable collective bargaining agreements covering such Eligible Employees, and, (c) subject to the good faith bargaining described in subpart (b) herein, pay wages to the represented Hired Employees covered by the collective bargaining agreements at the wage rates and pay scales contained in such collective bargaining agreements.

6.2.3.8 DISTRICT will terminate the employment of all Eligible Employees immediately prior to the Effective Time. DISTRICT shall be responsible for any obligations to or in respect of the Eligible Employees and Hired Employees arising from their employment or termination of employment by DISTRICT as required by this Section 6.2.3 and under applicable Laws, including with respect to required payments for accrued benefits, including accrued paid time off in accordance with Section 6.2.3.5. Except as expressly set forth in this Section 6.2.3, the SHARP Parties shall not be responsible for, and shall not be obligated to pay, any obligation, liability, promise or payment of any kind due from the DISTRICT to or on behalf of any Eligible Employee or Hired Employee. Nothing in this Agreement shall be construed to obligate the SHARP Parties to assume or accept assignment of any personal employment contract or any other agreement arising from or relating to employment of an Eligible Employee by the DISTRICT.

6.2.3.9 The termination of the Eligible Employees as of or prior to the Effective Time may be construed as a "plant closing" or "mass layoff," or may result in any Eligible Employee retained or employed by the DISTRICT suffering an "employment loss," as those terms are defined in WARN or a "mass layoff," "termination," "relocation" or "separation from a position", as those terms are defined by the Cal-WARN Act (collectively the "WARN Events"), and may require notices of such WARN Events to be given to the Eligible Employees and as otherwise required by applicable Laws. If determined to be required, DISTRICT shall issue all notices required by WARN or the Cal-WARN Act not less than sixty (60) days prior to the

Closing Date. If determined that notices are required, DISTRICT shall make any payments that may be required under WARN or the Cal-WARN Act as a result of the failure to provide such notices at least sixty (60) days in advance of a WARN Event.

6.2.3.10 The SHARP Parties shall not make any offer or promise of employment or other compensation to any DISTRICT public official or employee involved in the making of this Agreement prior to the Effective Time and shall have no obligation to employ or otherwise compensate any DISTRICT public official or employee involved in the making of this Agreement either before or after the Effective Time.

6.2.3.11 Nothing in this Agreement shall be construed to create any obligation on the part of the SHARP Parties to continue the employment of any Hired Employee for any specific period following the Effective Time, and the employment of all Hired Employees shall be "at will" unless otherwise required by applicable Law or agreed in writing. Following the Effective Time, the SHARP Parties, in their sole discretion, shall determine the number, classifications, job qualifications, and all terms and conditions of employment of the employees staffing TCMC and the Business transferred to the SHARP Parties following the Effective Time. Nothing in this Agreement shall be construed to preclude the SHARP Parties from determining the conditions under which it may operate TCMC, the Business or manage the employees at TCMC in connection with the Business.

6.3 Benefit Plan Transition.

6.3.1 STCMC will use commercially reasonable efforts to assume the DISTRICT's contracts for the DISTRICT's health/medical, dental, vision and other similar employee benefit programs in place as of the Closing Date with the then current providers thereof. To the extent such contracts are assumed by STCMC, as of the Effective Time or, if later, the date of hire, Hired Employees will receive employee benefits and coverage under such employee benefit programs pursuant to such assumed contracts. Employees who remain employed with Sharp by STCMC will transition Sharp's employee benefit programs (e.g., health/medical, dental, vision, etc.) as soon as reasonably possible after the Effective Time but no later than January 1, 2028.

6.3.2 The DISTRICT shall take any and all actions necessary and required to "freeze" it's then existing employee retirement plans (i.e., the NSRP, MPP and Section 457(b) plan) as of the Closing Date, which the Parties acknowledge are non-ERISA "government" plans that may only be sponsored by governmental entities. As soon as reasonably possible, but not more than six (6) months after the Closing Date, STCMC will offer one or more qualified retirement plans in which the Hired Employees will be eligible to participate.

6.3.3 The DISTRICT shall cooperate with the SHARP Parties to facilitate the transition of employee benefit plans, including providing all employee data, plan documentation, and historical benefit information as necessary to facilitate and effectuate the obligations and objectives of this Section 6.3. SHARP shall not assume any liability for benefits accrued under any DISTRICT benefit program, plan, policy or procedure, except as expressly provided in this Agreement.

6.4 DISTRICT Covenants. The DISTRICT covenants that, from the date of this Agreement until the Effective Time it is bound by the obligations stated in this Section 6.4, except as specifically permitted by this Agreement or otherwise consented to in writing by the SHARP Parties.

6.4.1 Access to Properties and Information. The DISTRICT shall grant, and SHARP and its officers, employees, counsel, accountants, contactors, agents and other representatives shall have access during normal business hours and upon reasonable prior notice to all properties, books, accounts, records, contracts, and documents of or relating to the DISTRICT and the Business. The DISTRICT shall furnish or cause to be furnished to the SHARP Parties and their representatives all data and information concerning the Business, finances, and properties of the DISTRICT, TCMC, the Transferring Assets and the JV Companies that may reasonably be requested.

6.4.2 Conduct of Business in Normal Course. The DISTRICT shall use commercially reasonable efforts to continue the Business in the ordinary course of business, except for those operations outside of the ordinary course of business previously approved by the SHARP Parties in writing, if any. The DISTRICT shall use commercially reasonable efforts to preserve intact the DISTRICT's and TCMC's present Business organization, keep available the services of the DISTRICT's and TCMC's present directors, officers and employees, and preserve the DISTRICT's and TCMC's relationship with patients, physicians, third-party payors and health plans, suppliers, customers and others having business dealings with them to the end that DISTRICT's and TCMC's goodwill and going Business shall be unimpaired and materially unchanged as of the Closing Date. The DISTRICT shall not make or institute any unusual or novel methods of patient care, purchase, sale, lease, management, accounting, or operation that will vary materially from those methods used by the DISTRICT as of the Agreement Date unless otherwise required to do so by applicable Laws. The DISTRICT shall use commercially reasonable efforts to continue to comply with, pay and satisfy its obligations with respect to its debts, accounts payable, contractual and other obligations in the ordinary course.

6.4.3 Prompt Notice. The DISTRICT shall give prompt notice to the SHARP Parties of the occurrence or non-occurrence of any event, act or omission or the discovery of any information that would be likely to cause any representation or warranty contained in this Agreement, the DISTRICT's Financial Statements, or any attached Disclosure Schedules, schedules or exhibits hereto, to be materially untrue or materially inaccurate when made, or at any other time on or before the Closing Date, and any material failure of the DISTRICT to comply with or satisfy any covenant, or condition of the Affiliation Agreements.

6.4.4 Maintenance of Insurance. The DISTRICT shall continue to maintain all of its existing insurance, and shall not eliminate or reduce such existing insurance coverage without the prior written consent of the SHARP Parties.

6.4.5 Consents of Third Parties. The DISTRICT shall use its commercially reasonable efforts to satisfy those obligations related to obtaining third party consents and facilitating the assignments of Assumed Contracts as set forth in Section 6.2.1. The DISTRICT shall use commercially reasonable efforts to cooperate with the SHARP Parties in obtaining any

required third party and Governmental Authority approvals or authorizations in connection with the Affiliation.

6.4.6 Satisfaction of Conditions. The DISTRICT shall take all steps reasonably necessary to cause the conditions precedent to the consummation of the transactions contemplated by this Agreement to be satisfied.

6.4.7 Delivery of Financials. Commencing as of the Agreement Date and prior to the Closing, and not less than on a monthly basis (following the closing of the accounting for each such month), the DISTRICT shall provide the SHARP Parties with updated unaudited monthly financial statements certified by the DISTRICT's Chief Financial Officer, including a comparison of the DISTRICT's and the Business' actual financial performance against the DISTRICT's last quarterly financial statements, against the DISTRICT's budget for the then current fiscal year, and against the monthly, if available, or quarterly period in the DISTRICT's then most recent audited financial statements. In addition, if prepared and available prior to the Closing Date, the DISTRICT shall provide the SHARP Parties with a copy of its audited financial statements for any fiscal year ending prior to the Closing.

6.4.8 Pre-Closing Transition and Integration Planning. Prior to the Closing, the Parties shall cooperate in good faith, and the DISTRICT shall use its commercially reasonable best efforts to assist the SHARP Parties, with respect to the transition and integration of the TCMC-related Business as of and after the Effective Time, including cooperation with respect to operational continuity, employee onboarding, systems integration, patient care coordination, and post-Closing budgeting. Notwithstanding the foregoing, all such cooperation shall be conducted in a manner that complies with all applicable Laws including antitrust and competition Laws.

6.4.9 Phone System Transition. Prior to the Closing, the DISTRICT shall use commercially reasonable efforts to upgrade the telephone system used by TCMC and with respect to its Business to a modern, cloud-based or VoIP-enabled system, that meets current industry standards for reliability, scalability, and security. The upgraded telephone system shall include replacement of outdated hardware, installation of necessary software, and configuration of call routing, voicemail, and conferencing features. The SHARP Parties shall, to the extent permissible by Law, be consulted and shall have the right to provide advice and recommendations regarding the upgraded system.

6.4.10 Valuations. The District has obtained a valuation of fair market value of the Transferring Assets as of June 30, 2025 (the "Valuation Date") in accordance with Section 32121(p)(2)(A)(vi) of the California Health & Safety Code.

6.4.11 DISTRICT Negative Covenants. The DISTRICT shall not undertake, enter into an arrangement resulting in, or permit with respect to itself or the Business any of the following acts or events from the Agreement Date until the Effective Time without the prior written consent of the SHARP Parties:

6.4.11.1 Any amendment or modification of its bylaws, the Medical Staff Bylaws, or other governance documents, except as required by applicable Law;

6.4.11.2 Any increase in salaries, bonuses, incentive compensation payable or to become payable by the DISTRICT or TCMC to any director, officer or employee, other than in the ordinary course of business or as required under any collective bargaining agreement to which the DISTRICT is a party;

6.4.11.3 Any increase in benefits provided or payable to any officer or employee under any bonus, employee benefit plan, pension, retirement or similar deferred compensation plan or other contract or commitment, other than in the ordinary course of business or as required under any collective bargaining agreement to which the DISTRICT is a party;

6.4.11.4 Any new contract, commitment, or transaction not in the ordinary course of business requiring total payments by the DISTRICT in excess of Two Hundred and Fifty Thousand Dollars ($250,000) and not terminable by DISTRCT without cause or penalty upon less than ninety (90) days' prior notice;

6.4.11.5 The sale, transfer, lease, mortgage, pledge, or other disposal or encumbrance of any material Transferring Assets, except in the ordinary course of business.

6.4.11.6 Any borrowings which in the aggregate exceeds Five Million Dollars ($5,000,000).

6.4.11.7 Any unbudgeted capital expenditure or expenditures in excess of One Million Dollars ($1,000,000) in the aggregate, except as required by applicable Law;

6.4.11.8 Any lease of capital equipment or property under which the annual lease payment is in excess of Two Hundred and Fifty Thousand Dollars ($250,000);

6.4.11.9 Any commencement, termination or substantial modification of any significant clinical program or service;

6.4.11.10 Any action that ultimately requires an application under California Code of Regulations, Title 22, §70105, which mandates prior approval under California Code of Regulations, Title 22, §70301, or a special permit under California Code of Regulations, Title 22, §70351.

6.4.11.11 Failure to timely pay and discharge all or any portion of federal, state, county, local and foreign taxes for which it is liable, including, without limitation, failing to withhold and/or pay over, as applicable, any wages, income and/or employment taxes required to be withheld from, or paid to, employees in accordance with applicable Law.

6.4.11.12 Cancel any debt or claims or waive any right with an aggregate value in excess of Fifty Thousand Dollars ($50,000), except in the ordinary course of business.

6.4.11.13 Incur or permit to be entered against the DISTRICT or TCMC any default judgment or permit any unsatisfied judgment to remain unsatisfied.

6.4.11.14 Settle or enter into an agreement to resolve any litigation, dispute, claim or matter having an aggregate value exceeding One Million Dollars ($1,000,000) and that is in-excess-of, or not otherwise covered by, insurance.

ARTICLE 7

CONDITIONS TO OBLIGATIONS OF SHARP

The obligation of the SHARP Parties to consummate the Affiliation is subject to the fulfillment of each of the following conditions, any or all of which may be waived either in whole or in part by the SHARP Parties to the extent permitted by applicable Law:

7.1 Transfer Documents. The DISTRICT shall have executed and delivered each of the Transfer Documents to the SHARP Parties.

7.2 Amended Foundation Articles. DISTRICT shall have delivered a certified copy of the Amended Foundation Articles filed with the California Secretary of State to the SHARP Parties.

7.3 Amended Foundation Bylaws. DISTRICT shall have delivered an executed, adopted, and approved copy of the Amended Foundation Bylaws certified by the Foundation's Secretary, to the SHARP Parties.

7.4 District Voter Approval. The DISTRICT's voters shall have approved a ballot measure authorizing the transfers contemplated by the Affiliation Agreements, as applicable, in accordance with Section 3212l(p)(2)(D) of the California Health & Safety Code.

7.5 No Material Pre-Closing Disclosures. Between the date of this Agreement and the Effective Time, the DISTRICT shall not have disclosed, and the SHARP Parties shall not have otherwise become aware of, any liability that: (a) was required to be disclosed on the Disclosure Schedules and was not disclosed on the Disclosure Schedules delivered as of the Agreement Date; (b) relates to liabilities or potential liabilities as a result of the DISTRICT's or TCMC's alleged or potential violation of Laws, including, without limitation, Healthcare Laws; (c) would reasonably be expected to result in any exclusion from Government Programs or a liability, penalty, loss or adverse effect on the DISTRICT's or TCMC's Business in excess of Twenty Five Million Dollars ($25,000,000) in the aggregate; and (d) is not cured or resolved to the SHARP Parties' reasonable satisfaction during the Cure Period described this Section 7.5. If the DISTRICT discloses, or if the SHARP Parties discover, a liability described in the immediately preceding sentence, the SHARP Parties shall deliver a written notice reasonably describing such liability to the DISTRICT and requesting that the DISTRICT cure such liability within thirty (30) days of the SHARP Parties' delivery of such notice (the "Cure Period"). If any such disclosure or liability is not cured within the Cure Period, the SHARP Parties shall have the right, in their sole discretion, to (i) terminate this Agreement without liability, or (ii) delay the Closing for a reasonable period to further assess and address the impact of such disclosure or liability.

7.6 Certified Copies of the DISTRICT Board Resolutions. The DISTRICT shall furnish SHARP with (i) copies of resolutions duly adopted by the DISTRICT Board approving the

execution and delivery of the Affiliation Agreements, the members of the initial STCMC Board, and all other necessary or proper actions to enable the DISTRICT to comply with the terms of the Affiliation Agreements and applicable Laws, and (ii) copies of resolutions duly adopted by the board of directors of the TCMC Foundation approving and adopting the Amended Foundation Governance Documents. Each such set of resolutions shall be certified by the Secretary or Assistant Secretary of the DISTRICT or the TCMC Foundation, as applicable.

7.7 Representations; Warranties. The representations and warranties of the DISTRICT contained in this Agreement (as modified by any pre-Closing disclosures in accordance with Section 7.4 hereof) shall be true and correct in all material respects as of the Agreement Date and immediately prior to the Effective Time, except for representations and warranties specifically relating to a time or times other than the Agreement Date, which shall be true and correct in all material respects at such time or times, and except for changes permitted by this Agreement, with the same force and effect as if made prior to the Effective Time.

7.8 Agreements; Covenants. The DISTRICT shall have performed and satisfied in all material respects all covenants and conditions required by this Agreement to be performed or satisfied by the DISTRICT at or prior to the Closing.

7.9 Certification of Financials. The DISTRICT shall have delivered to the SHARP Parties a certificate dated as of the Closing Date, and signed by the Chief Financial Officer of the DISTRICT, certifying that nothing has come to such officer's attention which would give such officer reason to believe that the unaudited financial statements delivered under this Agreement by the DISTRICT to the SHARP Parties have not been prepared substantially in accordance with the accounting principles and methods required by the Governmental Accounting Standards Board applied on a consistent basis, subject to usual and customary year-end adjustments.

7.10 Licenses, Authorizations and Consents of Agencies. STCMC shall have acquired, or the SHARP Parties shall have received reasonable assurance, from Governmental Authorities that they will receive in a timely manner those licenses and permits identified on Exhibit 7.10.

7.11 Material Consents. The consents listed on Exhibit 7.11 shall have been obtained.

7.12 Litigation. On the Closing Date, there shall be no effective injunction, writ or preliminary restraining order or other order of any nature issued by a Governmental Authority directing that any of the transactions provided for in the Affiliation Agreements not be consummated as provided therein, and immediately prior to the Effective Time no proceeding or lawsuit shall have been commenced or be pending or threatened by any Governmental Authority or any other person with respect to the transactions contemplated by the Affiliation Agreements, that the SHARP Parties, in good faith and with the advice of counsel, believe would prevent or materially delay the consummation of the Affiliation Agreements.

7.13 Legislation. No Law shall have been proposed, promulgated, enacted, entered, enforced or deemed applicable to the transactions contemplated by the Affiliation Agreements, by any Governmental Authority which the SHARP Parties, in good faith and with the advice of counsel, believe: (a) prohibits, restricts, delays or makes unlawful the consummation of the

transactions contemplated by the Affiliation Agreements, the satisfaction of any of the conditions to the consummation of such transactions, or otherwise impairs the material, contemplated economic benefits to any Party of such transactions; (b) requires the divestiture by any Party or any of their respective Affiliates of all or any portion of their businesses, assets or properties or imposes any limitation on the ability of any of them to conduct their businesses and own such assets and properties; (c) imposes any limitations on the ability of the DISTRICT or the SHARP Parties to exercise effectively all rights of membership, ownership, and control of their businesses and operations; or (d) otherwise adversely affects the Parties.

7.14 Real Estate Title. Title Company shall have committed to the SHARP Parties' reasonable satisfaction to issue ALTA owner's title insurance policies to STCMC subject to the Permitted Encumbrances in a form and in amount reasonably satisfactory to the SHARP Parties (the "Title Policies"), dated as of the Effective Time, insuring the leasehold title of STCMC to each of the Leased Premises, provided Sharp or STCMC has timely provided the Title Company with all of the required documentation and information necessary for Title Company to issue the Title Policies, it being acknowledged by the SHARP Parties that this Section 7.14 shall be deemed satisfied if Title Company's failure to irrevocably commit to issue the Title Policies is the result of Sharp's or STCMC's or any of their employee's or agent's direct or indirect acts or omissions, including, without limitation, Sharp's or STCMC's failure to obtain a new survey if such survey is required by Title Company. For purposes of clarity, the presence of any Permitted Encumbrance on any Title Policies shall not be grounds for STCMC to claim this Section 7.14 is not satisfied.

7.15 OHCA. OHCA shall have either (a) issued a written determination that it will not conduct a CMIR with respect to the transactions contemplated in this Agreement, as described in Section 97440(a) of Title 22 of the California Code of Regulations or (b) if OHCA elects to conduct a CMIR with respect to the transactions contemplated in this Agreement, OHCA shall have issued a final report of findings, as described in Section 97442(d) of Title 22 of the California Code of Regulations, and the sixty (60) day period from the date of the issuance of the final report of findings has lapsed.

7.16 Certain Payments. The DISTRICT shall have, to the SHARP Parties' reasonable satisfaction, made those payments set forth on Exhibit 7.16 or pursuant to a written agreement of the Parties.

ARTICLE 8

CONDITIONS TO OBLIGATIONS OF THE DISTRICT

The obligations of the DISTRICT to consummate the Affiliation are subject to the fulfillment of each of the following conditions, any or all of which may be waived either in whole or in part by the DISTRICT to the extent permitted by applicable Law:

8.1 Transfer Documents. STCMC shall have executed and delivered each of the Transfer Documents to the DISTRICT.

8.2 Amended STCMC Articles. The SHARP Parties shall have delivered a certified copy of the Amended STCMC Articles filed with the California Secretary of State to the DISTRICT.

8.3 Amended STCMC Bylaws. The SHARP Parties shall have delivered an adopted, approved copy of the Amended STCMC Bylaws to the DISTRICT, certified by the Secretary or Assistant Secretary of STCMC.

8.4 Amended SHARP Bylaws. SHARP shall have delivered an adopted, approved and certified copy of the amended Bylaws of SHARP to the DISTRICT that reflects the addition of a provision for the STCMC Board to designate a STCMC Board Member to serve on the SHARP board of directors following the Effective Time, certified by the Secretary or Assistant Secretary of SHARP.

8.6 District Voter Approval. The DISTRICT's voters shall have approved a ballot measure authorizing the transfers contemplated by the Affiliation Agreements, as applicable, in accordance with Section 3212l(p)(2)(D) of the California Health & Safety Code.

8.7 Election of Directors and Officers of STCMC . SHARP shall have elected the members of the STCMC Board who shall serve as of the Effective Time, subject to the approval of the DISTRICT in accordance with Section 6.1.3; and, in addition, the STCMC Board shall have appointed the persons who shall serve as the as officers of STCMC as of the Effective Time.

8.9 Certified Copies of SHARP and STCMC Resolutions. At the Closing, the SHARP Parties shall furnish the DISTRICT with copies of:

8.9.1 Resolutions duly adopted by the SHARP board of directors and the STCMC Board authorizing and approving the execution and delivery of the Affiliation Agreements, and all other necessary or proper corporate action to enable the SHARP Parties to comply with the terms of the Affiliation Agreements;

8.9.2 Resolutions duly adopted by SHARP amending the bylaws of SHARP as set forth in Section 8.4; and

8.9.3 Resolutions duly adopted by STCMC Board, and approved by SHARP as its sole member, amending STCMC's Articles of Incorporation as set forth in Section 8.2 and adopting the Amended STCMC's Bylaws as set forth in Section 8.3.

Each such set of resolutions shall be certified by the Secretary or Assistant Secretary of SHARP or STCMC, as the case may be.

8.10 Representations; Warranties. The representations and warranties of the SHARP Parties contained in this Agreement shall be true and correct in all material respects as of the Agreement Date and immediately prior to the Effective Time, except for representations and warranties specifically relating to a time or times other than the Agreement Date, which shall be true and correct in all material respects at such time or times, and except for changes permitted by this Agreement, with the same force and effect as if made prior to the Effective Time.

8.11 Agreements; Covenants. The SHARP Parties shall have performed and satisfied in all material respects all covenants and conditions required by this Agreement to be performed or satisfied to be performed by the SHARP Parties at or prior to the Closing.

8.12 Licenses, Authorizations and Consents of Governmental and Regulatory Authorities. The DISTRICT shall have determined, to its reasonable satisfaction, that STCMC has procured, or will be able to procure, all licenses and permits identified in Exhibit 7.10 as of the Effective Time or within a reasonable period after the Effective Time.

8.13 Material Consents. The consents listed on Exhibit 8.13 shall have been obtained.

8.14 Litigation. On the Closing Date, there shall be no effective injunction, writ or preliminary restraining order or other order of any nature issued by a Governmental Authority directing that any of the transactions provided for in the Affiliation Agreements not be consummated as provided therein, and immediately prior to the Effective Time no proceeding or lawsuit shall have been commenced or be pending or threatened by any Governmental Authority or any other person with respect to the transactions contemplated by the Affiliation Agreements, that the DISTRICT, in good faith and with the advice of counsel, believes would prevent or materially delay the consummation of the Affiliation Agreements.

8.15 Legislation. No Law shall have been proposed, promulgated, enacted, entered, enforced or deemed applicable to the transactions contemplated by the Affiliation Agreements, by any Governmental Authority which the DISTRICT, in good faith and with the advice of counsel, believes: (a) prohibits, restricts, delays or makes unlawful the consummation of the transactions contemplated by the Affiliation Agreements, the satisfaction of any of the conditions to the consummation of such transactions, or otherwise impairs the material, contemplated economic benefits to any Party of such transactions; (b) requires the divestiture by any Party or any of their respective Affiliates of all or any portion of their businesses, assets or properties or imposes any limitation on the ability of any of them to conduct their businesses and own such assets and properties; (c) imposes any limitations on the ability of the DISTRICT or the SHARP Parties to exercise effectively all rights of membership, ownership, and control of their businesses and operations; or (d) otherwise adversely affects the Parties.

8.16 OHCA. OHCA shall have either (a) issued a written determination that it will not conduct a CMIR with respect to the transactions contemplated in this Agreement, as described in Section 97440(a) of Title 22 of the California Code of Regulations or (b) if OHCA elects to conduct a CMIR with respect to the transactions contemplated in this Agreement, OHCA shall have issued a final report of findings, as described in Section 97442(d) of Title 22 of the California Code of Regulations, and the sixty (60) day period from the date of the issuance of the final report of findings has lapsed.

ARTICLE 9

POST-CLOSING COVENANTS

9.1 Compliance with District Law.

9.1.1 Operation of District Health Care Facilities. The SHARP Parties shall operate and maintain DISTRICT's health care facilities and its assets for the benefit of the communities served by DISTRICT in accordance with Section 32121(p)(2)(A)(iv) of the California Health & Safety Code.

9.1.2 Use of Funds. The SHARP Parties shall use any funds received from DISTRICT at the outset of this Agreement or any time thereafter during the term of this Agreement only to (i) reduce DISTRICT indebtedness, (ii) support the hospital and health care operations of TCMC and its associated Business, (iii) acquire needed equipment for the DISTRICT's health care facilities leased by STCMC, (iv) operate, maintain and make needed capital improvements to DISTRICT's health care facilities leased by STCMC, (v) provide supplemental health care services or facilities for the communities served by the DISTRICT, or (vi) conduct other activities that would further a valid public purpose if undertaken directly by the DISTRICT in accordance with Section 32121(p)(2)(A)(v) of the California Health & Safety Code.

9.2 Amendment of STCMC's Articles of Incorporation and Bylaws. During the term of the Hospital Lease and any extension or renewal thereof, SHARP shall not, as the sole member of STCMC, permit or cause STCMC, without the prior written consent of the DISTRICT, to amend the following provisions of the Amended STCMC Governance Documents, or adopt or amend other provisions of the Amended STCMC Governance Documents that have an adverse impact on the DISTRICT's rights under such provisions, without the prior written consent of the DISTRICT, which DISTRICT may grant, withhold, or condition in its sole discretion: [_____].

9.3 Transfer of TCMC or Transferring Assets.

9.3.1 Without the DISTRICT's prior written consent, which, subject to Section **Error! Reference source not found.** below, DISTRICT may grant, withhold, or condition in its sole discretion, the SHARP Parties shall not (a) transfer or assign all or a substantial portion of TCMC, the Business, the Transferring Assets or other assets owned or maintained by STCMC post-Closing, to any person or entity; (b) (i) transfer any membership interest in STCMC to any person or entity, if permitted by Law or the Amended STCMC Governance Documents, as amended from time to time, (ii) issue any new membership interest in STCMC, or (iii) amend STCMC's Amended STCMC Governance Documents, as amended from time to time, in a manner that effectuates the transfer or issuance of membership interests in STCMC to any other person or entity; (c) grant to any person or entity the right to appoint two or more of the directors serving on STCMC's board of directors; or (d) enter into any management agreement, joint operating agreement, or any similar agreement or arrangement to provide any person or entity the right to operate or manage all or a substantial portion of the Business.

9.3.2 Notwithstanding anything to the contrary in this Section 9.3, the prior written consent of the DISTRICT shall not be required for:

9.3.2.1 Any lease, license, transfer or assignment, management agreement, joint operating agreement, or any similar agreement or arrangement between or among one or more of the SHARP Parties and a SHARP Party Affiliate with respect to the use, operation or management of TCMC, the Business, or the Transferring Assets (or any replacements thereof)

or other assets owned or maintained by STCMC post-Closing and used in connection with the Business (including, without limitation, facilities, used or held by the Sharp Parties for the operation of ambulatory or outpatient clinic facilities or services (including those clinic facilities and assets operated by the District prior to the Closing Date under Health & Safety Code Section 1206(b))), provided that such assets remain subject to return to the DISTRICT upon the expiration or earlier termination of the Hospital Lease under Section 8.4.1 or Section 8.6.2(b) of the Hospital Lease or Article VII of the Transfer Agreement and remain subject to the methodology (including with respect to the consolidated accounting) related to the return of such assets in accordance with Section 7.2 of the Transfer Agreement;

9.3.2.2 Any agreement or arrangement, including, without limitation, a management agreement, joint operating agreement, or any similar agreement, providing any person or entity (other than a SHARP Party Affiliate) with the right to operate or manage a clinical program or service line of TCMC or the Business, provided that any Transferring Assets (or any replacements thereof) or other assets owned or maintained by STCMC post-Closing and used in connection with TCMC, the Business and such service line remain subject to return to the DISTRICT upon the expiration or earlier termination of the Hospital Lease under Section 8.4.1 or Section 8.6.2(b) of the Hospital Lease or Article VII of the Transfer Agreement and remain subject to the methodology (including with respect to the consolidated accounting) related to the return of such assets in accordance with Section 7.2 of the Transfer Agreement;

9.3.2.3 Any merger or consolidation of SHARP with any Qualified Health System, or any issuance by SHARP of its membership interest to any Qualified Health System or to any parent holding company established by SHARP and any Qualified Health System for purposes of the affiliation of SHARP and such Qualified Health System, provided that such Qualified Health System agrees in writing to be bound by the terms and conditions of the Affiliation Agreements, including, without limitation, obligations thereunder related to Assumed Liabilities, and STCMC continues to be, or an Affiliate of such Qualified Health System agrees in writing to be, bound by the terms and conditions of the Hospital Lease and the Transfer Agreement;

9.3.2.4 Any transfer or assignment of all or substantially all of the assets owned or held by SHARP, including all of the other SHARP-affiliated hospitals and/or the membership interests in the entities operating such hospitals, to any Qualified Health System, provided that such Qualified Health System and/or one of its Affiliates agrees to be bound by the terms and conditions of the Affiliation Agreements, including, without limitation, obligations thereunder related to Assumed Liabilities;

9.3.2.5 Any lease, license, sublease or other similar agreement or arrangement permitted under Section 14.2.3 of the Hospital Lease, the Carlsbad Lease, or the Oceanside Lease; or

9.3.2.6 Any sale or other disposition of assets not required for the operation of all or a substantial portion of the Business to any person or entity in the ordinary course of business.

As used herein, a "Qualified Health System" means a health system whose business includes the ownership, operation and/or management of general acute care hospitals that (a) operates as a

nonprofit corporation organized and operated exclusively for tax-exempt purposes under Section 501(c)(3) of the Internal Revenue Code, and (b) is not a private nonprofit organization owned or controlled by a religious creed, church, or sectarian denomination.

9.4 SHARP Board. Within ninety (90) days after the Effective Time, and on a continuing basis thereafter during the term of the Lease in accordance with the Bylaws of SHARP and the Affiliation Agreements, as amended, the STCMC Board shall designate one of its members to serve on the SHARP board of directors.

9.5 Capital Investment.

9.5.1 During the five (5) year period after the Effective Time, SHARP, STCMC or their Affiliates will expend at least Fifty Million Dollars ($50,000,000) for general plant and facility maintenance and repair, routine capital expenditures, and other capital expenditures reasonably required for the preservation and enhancement of TCMC's ongoing hospital and health care operations, including upgrades and replacements of TCMC's information technology, communications, cybersecurity and other systems infrastructure.

9.5.2 During the five (5) year period after the Effective Time, SHARP, STCMC or their Affiliates will expend at least Fifty Million Dollars ($50,000,000) for strategic investments related to the Business, including, without limitation, for support of the development and growth of North San Diego County-related ambulatory or clinical facilities and services, physician recruitment, retention and alignment, initiatives that benefit and support the growth and expansion or enhancement of the Business or its service lines, and the implementation of a North San Diego County strategic development plan.

9.5.3 SHARP has adopted the Epic Electronic Health Record System and enterprise technical infrastructure ("Epic System") for all sites of care in the SHARP system, including all acute care and ambulatory sites. In this regard, (i) within the six (6) year period after the Effective Time, the SHARP Parties will cause TCMC and its related health care facilities and operations to be fully integrated into SHARP's Epic System on a basis that is generally consistent with the way SHARP deploys the Epic System to its hospitals, clinics and outpatient sites as of the Effective Time, (ii) such implementation is anticipated to result in significant improvements to patient quality, safety, and coordination of care for the hospital and health care services in connection with the Business, (iii) the implementation schedule for such integration and implementation shall be mutually agreed upon by the Parties after the Effective Time, and (iv) the SHARP Parties shall be responsible for Epic System-related capital and operating costs and expenses associated with the integration and implementation of the Epic System.

9.5.4 Following the Closing, SHARP shall commit sufficient capital and make the improvements to achieve seismic compliance as required by applicable Law for the maintenance of a minimum of 175 licensed hospital beds at TCMC through either (a) retrofitting TCMC's existing hospital facilities (which the Parties acknowledge shall not be conditioned on whether the Parties are able to obtain voter approval for a general obligation (GO) bond ballot measure in accordance with Section 9.6 below); or (b) replacing all or a portion of TCMC's hospital facilities (which the Parties acknowledge shall be conditioned upon receipt of funds from the issuance of

tax-exempt bonds following the approval by the voters residing in the DISTRICT of a GO bond ballot measure in accordance with Section 9.6).

9.6 GO Bond Commitments. The Parties shall use commercially reasonable efforts and cooperate in good faith to pursue the issuance of General Obligation Bonds ("GO Bonds") to finance TCMC-related seismic needs and compliance objectives and certain other to-be-determined capital commitments within the initial three (3) years after the Effective Time. Each Party shall take all necessary and reasonable actions, including, without limitation, preparing and submitting required documentation, engaging legal, financial and other advisors, and participating in public hearings or elections, as applicable under California Law, to facilitate the approval by the voters residing in the DISTRICT of a ballot measure authorizing the GO Bonds and, following such approval, the issuance of such GO Bonds. The Parties acknowledge that the issuance of GO Bonds requires voter approval pursuant to Article XIII A of the California Constitution and applicable provisions of the California Government Code. Accordingly, the Parties shall jointly develop a timeline and strategy for obtaining such approval, including public outreach and coordination with relevant Governmental Authorities. The successful issuance or receipt of any such GO Bonds shall not be a requirement for compliance with Section 9.5.4(a) above or give rise to termination rights under the Leases or the Transfer Agreement. The Parties shall cooperate and meet according to a mutually agreed-upon schedule to facilitate their obligations in this Section 9.6 and to plan for, strategize and facilitate the issuance of GO Bonds.

9.7 Medical Staff Matters.

9.7.1 Following the Effective Time, STCMC shall maintain TCMC's independent medical staff ("TCMC Medical Staff"), whose membership shall, subject to the SHARP Parties' applicable policies and procedures, initially be comprised of all physicians and advanced practice providers who have privileges at TCMC immediately prior to the Effective Time.

9.7.2 The TCMC Medical Staff's Chief of Staff and other officers, Medical Executive Committee, committee chairs and other medical staff leaders immediately prior to the Effective Time shall continue to serve in such capacities for the remainder of their tenure, subject to removal and replacement in accordance with the TCMC Medical Staff Bylaws.

9.7.3 The TCMC Medical Staff Bylaws immediately prior to the Effective Time shall be adopted and approved by the STCMC Board as the TCMC Medical Staff Bylaws as of the Effective Time, subject to such amendments as may be necessary and effective as of the Effective Time for the STCMC Board to be recognized as the "governing body" for purposes thereof. After the Effective Time, the Medical Staff Bylaws may be modified in accordance with the applicable provisions of such Medical Staff Bylaws and without approval of the DISTRICT. Relatedly, the Hospital Lease will require that STCMC conform to, and abide by, California Health & Safety Code Section 32128.

9.8 Maintenance of Certain Clinical Services. From and after the Effective Time, STCMC will (a) maintain and operate TCMC as a separately licensed general acute care hospital with a minimum of 175 licensed acute care beds; (b) ensure that TCMC maintains and provides basic emergency department services (as such term is defined in Section 70411 of Title 22 of the California Code of Regulations), as well as all other services required by California Law for TCMC

to be licensed as a general acute care hospital (as set forth in Section 70001 *et seq.* of Title 22 of the California Code of Regulations); and (c) use commercially reasonable efforts to reestablish and maintain a perinatal unit (as defined in Section 70545 of Title 22 of the California Code of Regulations) and an intensive care newborn nursery services unit (as defined in Section 70481 of Title 22 of the California Code of Regulations).

9.9 Community Benefit Commitments. After the Effective Time, STCMC shall operate TCMC in furtherance of the DISTRICT's responsibility to deliver high-quality health care services to all residents within the DISTRICT's geographic boundaries regardless of insurance status, income or demographics. Without limiting the generality of the foregoing, STCMC shall, from and after the Effective Time:

9.9.1 Cause TCMC to participate in the Medicare and Medi-Cal programs and provide services to Medicare and Medi-Cal beneficiaries in a non-discriminatory manner; and

9.9.2 Adopt SHARP's financial assistance/charity care policy for use and application at TCMC, which will provide access to free or discounted care at a level reasonably consistent with TCMC's current charity care policy in effect immediately prior to the Effective Time.

9.10 DISTRICT Board Role Post-Closing. The DISTRICT Board shall, from and after the Effective Time, retain responsibility for the general operations of the DISTRICT that are unrelated to the governance, management, administration or operation of the Business and the Transferring Assets, including:

9.10.1 Facilitating community health partnerships;

9.10.2 Coordinating with the County Registrar in connection with the conduct of the DISTRICT's elections;

9.10.3 Receiving property tax revenue allocated to the DISTRICT, subject to Section 9.11;

9.10.4 Promoting community wellness and conducting health improvement initiatives, including working collaboratively with the SHARP Parties to develop initiatives to improve the health of the communities served by the DISTRICT and the SHARP Parties;

9.10.5 Subject to Section 9.6, facilitating GO Bond measures as may be mutually agreed upon by the DISTRICT and the SHARP Parties to support the renovation and/or replacement of TCMC facilities, including providing reasonable community oversight on the expenditure of GO Bond funds as agreed upon by the Parties; and

9.10.6 Such other activities as are consistent with the role and function of the DISTRICT and that are not in violation or inconsistent with the Affiliation Agreements. The DISTRICT agrees a SHARP-designated representative (which representative shall be subject to the reasonable approval of DISTRICT) shall be entitled to participate in the DISTRICT's process for evaluating and commenting upon grant requests received by the DISTRICT.

9.11 Property Tax Revenue Commitments. The Parties' intent is that, to the maximum extent possible, the proceeds of general or special property taxes levied on behalf of, and received by, the DISTRICT under applicable Law during the term of the Hospital Lease ("Property Tax Revenues") shall be used and applied to support STCMC's operations and maintenance of TCMC and the Business in accordance with the Affiliation Agreements for the benefit of the communities served by the DISTRICT. From and after the Effective Time, the DISTRICT shall continue to receive the Property Tax Revenues. In this regard, the DISTRICT shall not retain any portion of the Property Tax Revenues attributable to and pledged and/or used for the payment of debt service with respect to any GO Bonds (the "GO Bonds Property Tax Revenues"). However, subject to the terms and conditions of this Agreement, the DISTRICT shall be entitled to retain a portion of the Property Tax Revenues that does not constitute GO Bonds Property Tax Revenues (the "Non-GO Bonds Tax Revenues") for the operations and maintenance of the DISTRICT, and shall transfer and remit to or for the benefit of STCMC the entire remaining portion of such Non-GO Bonds Tax Revenues, as follows:

9.11.1 Commencing as of the Effective Time, the DISTRICT shall be entitled to retain for its use up to twelve thirteen and one-half percent (13.5%) of the Non-GO Bonds Tax Revenues actually received by the DISTRICT, and shall transfer and remit to or for the benefit of STCMC (or to such public agencies (e.g., the California Department of Health Care Services) as may be reasonably requested by STCMC from time to time, provided that the DISTRICT shall not unreasonably withhold, condition, or delay its actions related to such requests) a minimum of eighty-six and one half percent eight (86.5%) of the Non-GO Bonds Tax Revenues actually received by the DISTRICT. Thereafter, and except as set forth in Section 9.11.2 below, for each fiscal year of the DISTRICT commencing as of July 1, 2028 and continuing on the first date of each subsequent fiscal year during the term of the Affiliation Agreements, the allocation of Non-GO Bonds Tax Revenues actually received by the DISTRICT and either retained by the DISTRICT or transferred and remitted to or for the benefit of STCMC during such fiscal year of the DISTRICT shall be based on STCMC's Net Income (Loss) from Operations Margin (as defined below) for STCMC's immediately preceding fiscal year. As soon as reasonably possible following the end of each of STCMC's fiscal years and SHARP's preparation and issuance of its annual audited consolidated financial statements in connection therewith (other than the fiscal year ending September 30, 2026), STCMC shall prepare and deliver an accounting to the DISTRICT of STCMC's Net Income (Loss) from Operations Margin for such fiscal year. For this purpose and tied to SHARP's annual audited consolidated financial statement for such fiscal year, "Net Income (Loss) from Operations Margin" shall mean the margin percentage by which STCMC's total operating revenues exceeds its total operating expenses inclusive of depreciation and interest for such fiscal year, as determined in accordance with GAAP.

9.11.2 On the first to occur of (i) the initial fiscal year after the Effective Time (other than the fiscal year ending September 30, 2026) when STCMC's Net Income (Loss) from Operations Margin is breakeven (i.e., total operating expenses are equal to or less than total operating revenues) or better as reported in STCMC's accounting delivered to the DISTRICT pursuant to Section 9.11.1 above, or (ii) the fiscal year when GO Bonds are first issued for the purposes specified in Section 9.6 above, as of the first day of the DISTRICT's immediately succeeding fiscal year thereafter, DISTRICT shall be entitled to retain for its use up to fifteen percent (15%) of the Non-GO Bonds Tax Revenues actually received by the DISTRICT during such fiscal year, and shall transfer and remit to or for the benefit of STCMC (or to such public

agencies (e.g., the California Department of Health Care Services) as may be reasonably requested by STCMC from time to time, provided that the DISTRICT shall not unreasonably withhold, condition, or delay its actions related to such requests) a minimum of eighty-five percent (85%) of the Non-GO Bonds Tax Revenues actually received by the DISTRICT (the "Initial Allocation Adjustment").

9.11.3 Following the Initial Allocation Adjustment and the allocation of Non-GO Bonds Tax Revenues for the DISTRICT's succeeding fiscal year in accordance therewith, based on the amount of the Net Income (Loss) from Operations Margin as of the end of each of STCMC's fiscal years, as of the first day of the DISTRICT's immediately succeeding fiscal year and continuing thereafter during the remainder of such fiscal year, the Non-GO Bonds Tax Revenues actually received by the DISTRICT during such fiscal year shall be allocated between the DISTRICT and STCMC in the following manner:

(i) In the event STCMC's Net Income (Loss) from Operations Margin for any fiscal year is negative (i.e., as a result of a net loss from operations) or less than two percent (2%), the allocation of the Non-GO Bonds Tax Revenues as of the first day of the DISTRICT's immediately succeeding fiscal year and continuing during the remainder of such fiscal year shall be fifteen percent (15%) of the Non-GO Bonds Tax Revenues to the DISTRICT, and eighty-five (85%) of the Non-GO Bonds Tax Revenues to or for the benefit of STCMC (or to such public agencies (e.g., the California Department of Health Care Services) as may be reasonably requested by STCMC from time to time, provided that the DISTRICT shall not unreasonably withhold, condition, or delay its actions related to such requests).

(ii) In the event STCMC's Net Income (Loss) from Operations Margin for a fiscal year is two percent (2%) or greater, as of the first day of the DISTRICT's immediately succeeding fiscal year and continuing thereafter during the remainder of such fiscal year, the Non-GO Bonds Tax Revenues actually received by the DISTRICT during such fiscal year shall be allocated between the DISTRICT and STCMC in accordance with the following schedule:

STCMC Net Income (Loss) from Operations Margin	**Non-GO Bonds Tax Revenues Retained by TCHD**	**Non-GO Bonds Tax Revenues Remitted to STCMC**
2.00% to 2.99%	16%	84%
3.00% to 3.99%	18%	82%
4.00% to 4.99%	20%	80%
5.00% to 5.99%	22%	78%
6.00% to 6.99%	24%	76%
7.00% and above	26%	74%

9.11.4 The schedule for STCMC's preparation of the accounting of its Net Income (Loss) from Operations Margin following the end of each fiscal year for purposes of this Section 9.11 and the application of such accounting to the change, if any, in the DISTRICT's and

STCMC's percentage allocable share of the Non-GO Bonds Tax Revenues during the immediately succeeding fiscal year is illustrated as follows:

STCMC's Fiscal Year End	**TCHD's Fiscal Year for Taxes Reallocation**
9/30/27	7/01/28 to 6/30/29
9/30/28	7/01/29 to 6/30/30
9/30/29	7/01/30 to 6/30/31
9/30/30	7/01/31 to 6/30/32
9/30/31	7/01/32 to 6/30/33

9.11.5 After the Effective Time, the DISTRICT may, in its reasonable discretion, remit to STCMC additional Non-GO Bonds Tax Revenues to support TCMC and the Business. STCMC shall use any Non-GO Bonds Tax Revenues transferred and remitted to or for the benefit of STCMC pursuant to this Section 9.11 solely and exclusively for the operations and maintenance of TCMC and the Business for the benefit of the communities served by the DISTRICT.

9.11.6 If the DISTRICT (a) incurs or is reasonably expected to incur unanticipated, extraordinary costs and expenses directly related to its performance of the Affiliation Agreements that are not otherwise assumed by STCMC or related to the DISTRICT's operations, programs, initiatives and other activities after the Effective Time as described in Section 9.10 above (other than any GO Bond measures), such as those extraordinary costs and expenses of the DISTRICT related to the pursuit and issuance of the GO Bonds pursuant to Section 9.6 above (including the preparation and submission of a ballot measure seeking approval of the voters residing in the DISTRICT for the issuance of the GO Bonds) (the "Extraordinary Expenses"), and (b) does not have sufficient funds then held in reserve or from its allocation of Non-GO Bonds Tax Revenues pursuant to this Section 9.11 to satisfy such Extraordinary Expenses, the DISTRICT may give written notice thereof to the SHARP Parties requesting their consent to a temporary, time limited reallocation of additional Non-GO Bonds Tax Revenues to the DISTRICT to satisfy such Extraordinary Expenses. The DISTRICT's written request shall specify (i) the nature, purposes and relationship of the Extraordinary Expenses to the DISTRICT's performance of the Affiliation Agreements, (ii) the then outstanding balances of funds held by the DISTRICT in its reserve account and/or in any other accounts maintained by the DISTRICT to support the operations, programs and initiatives of the DISTRICT after the Effective Time, (iii) a reasonably detailed accounting of the amounts of Non-GO Bonds Tax Revenues expected to be received by the DISTRICT over the twelve (12) month period following its written request, and (iv) a reasonably detailed accounting of the actual Extraordinary Expenses already incurred and/or reasonably expected to be incurred by the DISTRICT. Following receipt of the DISTRICT's notice, the SHARP Parties may request to meet and confer with the DISTRICT to discuss and obtain additional information regarding the request. The SHARP Parties shall not unreasonably withhold or delay their consent to the DISTRICT's request. If the SHARP Parties consent to such limited reallocation request, the DISTRICT may retain additional Non-GO Bonds Tax Revenues consistent with such request beyond the agreed upon percentage allocation set forth in this Section 9.11 until the DISTRICT has replenished its funds used to pay the Extraordinary Expenses or has paid all of the Extraordinary Expenses with the additional Non-GO Bonds Tax Revenues. The DISTRICT shall give written notice to the SHARP Parties as soon as reasonably possible after it

has paid or satisfied all of such Extraordinary Expenses, which shall include an accounting of the actual Extraordinary Expenses it paid or satisfied. Immediately after the DISTRICT has completed payment or satisfaction of such Extraordinary Expenses, the percentage allocations of Non-GO Bonds Tax Revenues between the Parties shall either (a) revert to the percentage allocations in effect immediately preceding the application of the limited reallocation described herein, or (b) if the percentage allocations of Non-GO Bonds Tax Revenues would have changed as a result of the application of Section 9.11.1 above, the new percentage allocations that would then be in effect for such fiscal year of the DISTRICT shall apply to STCMC and the DISTRICT.

9.12 TCMC Foundation. The TCMC Foundation, with STCMC as its sole member after the Effective Time, shall remain a separate, supporting entity of TCMC, and all assets and funds of the TCMC Foundation from and after the Effective Time shall be utilized by the TCMC Foundation to support TCMC's operations and other healthcare, medical and community benefit activities, consistent with the purposes of the TCMC Foundation, as reasonably determined by the TCMC Foundation Board of Directors from time to time. The TCMC Foundation shall be an integrated part of, and have access to, the foundation management, fundraising, support and other services available from the Sharp HealthCare Foundation, which assists and furthers the charitable activities of the fundraising foundations associated with SHARP and its Affiliates. In connection with the expiration or earlier termination of the Hospital Lease, and in the absence of any extension or renewal thereof, the DISTRICT shall propose amendments to the TCMC Foundation's governance documents that provide for STCMC, upon such expiration or earlier termination, cease being the sole member of the TCMC Foundation, and for such other changes as may be reasonably necessary when STCMC will no longer be the lessee and operator of TCMC and to ensure that TCMC's charitable assets will continued to be used in support of and for benefit of TCMC. Such proposed amendments shall be reasonably accepted and approved by STCMC effective as of the expiration or earlier termination of the Hospital Lease.

9.13 Post-Closing TCMC Branding. After the Effective Time, the SHARP Parties shall initially operate TCMC under the name "Sharp Tri-City Medical Center." After the Effective Time, if the SHARP Parties determine that it is in the best interest of TCMC or its related Business to change the name of TCMC, they shall work collaboratively with the DISTRICT with respect to any such revised name and related branding strategy and obtain the prior written consent of DISTRICT prior to implementing such revised name and related branding strategy.

9.14 Post-Closing Covenant Review Meetings. After the Effective Time, representatives of the Parties shall meet on a biannual basis (or more frequently as mutually agreed upon by the Parties) to review and discuss the status of each Party's performance under the post-Closing covenants set forth in this Article 9 together with any other matters agreed upon by the Parties related to the use and operations of the Business, the Transferring Assets, and other matters related thereto. Such meetings shall be public if required by Law. During such meetings, SHARP and the DISTRICT will provide, as applicable, information regarding their respective activities with respect to their post-Closing obligations, including, without limitation, as related to the GO Bonds process, capital commitments, their respective post-Closing activities, STCMC's operations under the Leases, financial and clinical performance of the Business (including with respect to the Core Services), and other mutually-agreed-upon post-Closing matters.

9.15 Post-Closing Transition; Integration Planning. After the Effective Time, the Parties shall use commercially reasonable efforts and cooperate in good faith with the SHARP Parties and their representatives with respect to the planning and implementation of the transition and integration of TCMC and its related Business to the SHARP Parties. Such cooperation may include joint planning regarding operational continuity, employee onboarding, systems integration, patient care coordination, and other matters identified by the Parties. Notwithstanding the foregoing, all such cooperation shall be conducted in a manner that complies with all applicable Laws, including federal and state antitrust and competition Laws.

9.16 Post-Closing Insurance Commitments.

9.16.1 Following the Effective Time, the DISTRICT shall maintain, or cause to be maintained, all insurance policies covering pre-Closing operations of the DISTRICT's or TCMC's Business, including but not limited to general liability, professional liability, directors and officers liability, and cyber liability insurance, for a period of not less than seven (7) years from the Effective Time, to the extent such policies provide coverage for claims arising from acts or omissions occurring prior to the Closing. In the event such policies are claims-made policies, the DISTRICT shall, at its sole cost and expense, purchase extended reporting period endorsements ("tail coverage") providing coverage for such claims for a period of not less than seven (7) years following the Effective Time.

9.16.2 The DISTRICT shall provide the SHARP Parties with evidence of such tail coverage within thirty (30) days following the Effective Time. The DISTRICT shall not cancel or materially amend such policies in a manner that adversely affects the SHARP Parties' rights under this Section without the prior written consent of the SHARP Parties.

ARTICLE 10

CONFIDENTIAL INFORMATION; PUBLIC ANNOUNCEMENTS

10.1 Confidentiality. The Mutual Confidentiality and Non-Disclosure Agreement, dated April 10, 2025, between SHARP and the DISTRICT ("Confidentiality Agreement") remains in full force and effect, and in addition, shall keep confidential, in accordance with the provisions of the Confidentiality Agreement and the Affiliation Agreements, the terms and conditions of, and all proprietary and confidential information provided pursuant to, the Affiliation Agreements. In addition to the foregoing, the information, documents and instruments delivered to each Party by the other Parties or agents thereof in connection with the negotiation, consummation and performance of the Affiliation Agreements or in compliance with the terms, conditions and covenants thereof (including, without limitation financial and operational reports and information related to the Business and shared by the SHARP Parties with the DISTRICT after the Effective Time) that are not otherwise public or made public by the agreement of the Parties, are of a confidential and proprietary nature. Both prior to and following the Effective Time, the Parties shall, and shall cause their representatives and Affiliates to, maintain the confidentiality of all such confidential information, documents or instruments delivered to it by the other Parties or the Affiliates or agents thereof and shall not disclose such confidential information, documents and instruments to any third parties other than its representatives assisting in the transactions contemplated by the Affiliation Agreements or as may be required by applicable Laws and, for a

period of two (2) years immediately following the Effective Time, shall only use such information for purposes of the transactions contemplated by the Affiliation Agreements; provided, however, that after the Effective Time, the SHARP Parties shall have the right to use and disclose any confidential information with respect to TCMC and the Business assumed by the SHARP Parties pursuant to the Affiliation Agreements in the ordinary course of business and to the extent permitted by applicable Law. If the transactions contemplated by the Affiliation Agreements are not consummated, each Party shall return or destroy all such confidential information, documents and instruments and all copies thereof in its possession to the Party providing them upon the written request of the other Party. The terms and conditions of this Agreement and all other Affiliation Agreements shall remain confidential, and the Parties shall not disclose the Affiliation Agreements, or any part thereof, to any third party other than its representatives assisting in the transactions contemplated by the Affiliation Agreements or as may be required by applicable Laws. Any breach of this Section 10.1 or of the Confidentiality Agreement by a Party would result in irreparable harm to the other Parties and therefore the Parties shall be entitled to seek an injunction to prohibit any such breach or anticipated breach, without the necessity of posting a bond in addition to other legal and equitable remedies. In the event of any inconsistency or conflict between this Section 10.1 and the provisions of the Confidentiality Agreement, this Section 10.1 shall prevail to the extent of the inconsistency or conflict.

10.2 Public Announcements. No Party shall release, publish or otherwise make available to the public in any manner whatsoever any information or announcement regarding the transactions herein contemplated without the prior written consent of the other Parties after consultation with their respective counsel (which consent shall not be unreasonably withheld conditioned or delayed), except for information and filings (a) reasonably necessary to be directed to Governmental Authorities to fully and lawfully effect the transactions herein contemplated; or (b) required under Law, in which case, the Party issuing such information or announcement shall provide written notice and a copy of such required information disclosure or announcement to the other Parties not less than two (2) business days prior to the date of such disclosure or announcement and shall reasonably consider the views and/or input of the other Parties with respect to such disclosure or announcement in good faith prior to its release.

ARTICLE 11

TERMINATION OF AFFILIATION

11.1 Failure to Close by Specified Date. This Agreement may be terminated, and the Affiliation may be abandoned by action of either of the board of directors of the DISTRICT or SHARP, if the Affiliation shall have not be effective on or before December 31, 2026, or such later date as shall have been approved by the boards of directors of the DISTRICT and the SHARP Parties.

11.2 Pre-Closing Termination. This Agreement may also be terminated prior to the Effective Time:

11.2.1 By the DISTRICT if it discovers with respect to the SHARP Parties (a) any material breach of the representations or warranties of the SHARP Parties in Article 4 of this Agreement; (b) any such representations or warranties of the SHARP Parties in Article 4 of this

Agreement shall not be correct or accurate in all material respects at and as of the Closing Date with the same effect as if made at such time; or (c) the SHARP Parties shall have failed to comply in any material respect with any of the terms, covenants, conditions or agreements contained in this Agreement to be complied with or performed by the SHARP Parties on or prior to the Closing Date; and, in any such case, such breach or failure to comply is not cured or resolved to the DISTRICT's reasonable satisfaction within thirty (30) days following written notice from the DISTRICT to the SHARP Parties describing such breach or failure to comply in reasonable detail (or within such longer cure period as may be agreed upon by the Parties).

11.2.2 By the SHARP Parties if they discover with respect to the DISTRICT (a) any material breach of the representations or warranties of the DISTRICT in Article 5 of this Agreement (as modified by any pre-Closing disclosures in accordance with Section 7.4 hereof); (b) any such representations or warranties of the DISTRICT in Article 5 of this Agreement (as modified by any pre-Closing disclosures in accordance with Section 7.4 hereof) shall not be correct or accurate in all material respects at and as of the Closing Date with the same effect as if made at such time; or (c) the DISTRICT shall have failed to comply in any material respect with any of the terms, covenants, conditions or agreements contained in this Agreement to be complied with or performed by the DISTRICT on or prior to the Closing Date; and, in any such case, such breach or failure to comply is not cured or resolved to the SHARP Parties' reasonable satisfaction within thirty (30) days following written notice from the SHARP Parties describing such breach or failure to comply in reasonable detail (or within such longer cure period as may be agreed upon by the Parties).

11.2.3 By the DISTRICT if it discovers with respect to the SHARP Parties, or by the SHARP Parties if they discover with respect to the DISTRICT, that there has been any Material Adverse Effect in the financial condition, properties, Business, results of operations or prospects of any of the other Party or Parties, or any event shall have occurred that is likely to result in any such change, and such Material Adverse Effect is not cured or resolved to the terminating Party's or Parties' reasonable satisfaction within thirty (30) days following written notice from the discovering Party describing such Material Adverse Effect in reasonable detail (or within such longer cure period as may be agreed upon by the Parties).

11.2.4 By the SHARP Parties if the DISTRICT discloses, or the SHARP Parties become aware of, a material pre-Closing disclosure that results in the SHARP Parties having a termination right in accordance with Section 7.4 above

11.3 Post-Closing Termination. This Agreement shall automatically and immediately terminate upon the expiration or the termination of the Hospital Lease for any reason.

11.4 Effect of Termination. Upon termination pursuant to this Section, this Agreement shall be null and void, and neither Party shall have any further obligation or liability hereunder, except as otherwise expressly provided in this Agreement.

ARTICLE 12

INDEMNIFICATION

12.1 Indemnification by the DISTRICT. The DISTRICT shall, from and after the Effective Time, protect, indemnify, defend, and hold harmless SHARP and STCMC (which, for purposes of this Section 12.1 shall include directors, officers, employees, agents, representatives, successors and assigns of SHARP, STCMC and their respective Affiliates) (collectively, the "SHARP Indemnitees") harmless, and upon SHARP's request defend, the SHARP Indemnitees, from and against any and all claims, actions, suits, demands, judgments, penalties, liabilities, damages, costs, expenses and losses of any kind whatsoever (including, without limitation, reasonable attorneys' fees and costs) (collectively, "Losses") resulting from, arising out of or relating to (a) fraud or intentional misrepresentation by DISTRICT's Chief Executive Officer, Chief Operation Officer, Chief Financial Officer, its directors, officers or employees as of or prior to the Effective Time related to any of the DISTRICT's representations or warranties under Article 5; (b) any breach by the DISTRICT of any covenant or agreement set forth in any of the Affiliation Agreements; or (c) any Excluded Liability.

12.2 Indemnification by SHARP. SHARP shall, from and after the Effective Time, protect, indemnify, defend, and hold harmless the DISTRICT (which, for purposes of this Section 12.2 shall include not only the DISTRICT but also its directors, officers, employees, agents, representatives, successors and assigns) (collectively, the "DISTRICT Indemnitees") harmless, and, upon the DISTRICT's request defend, the DISTRICT from and against any and all Losses of any kind whatsoever resulting from, arising out of or relating to (a) any fraud or intentional misrepresentation by the SHARP Parties' Chief Executive Officer, Chief Operation Officer, Chief Financial Officer, Chief Legal Officer, its directors, officers or employees as of or prior to the Effective Time related to any SHARP Party representations or warranties under Article 4; (b) any breach by the SHARP Parties of any covenant or agreement set forth in this Agreement; (c) any Assumed Liability; and (d) any action or omission of the SHARP Parties related to the operation or activities of the Business and its other health care facilities and services from and after the Effective Time.

12.3 Notice of Third-Party Claims and Control of Defense. The indemnified Party shall cooperate in all reasonable respects with the indemnifying Party and such attorneys in the investigation, trial and defense of any lawsuit or action and any appeal arising therefrom; provided, however, that the indemnified Party may, at its own cost, participate in the investigation, trial and defense of such lawsuit or action and any appeal arising therefrom. The Parties shall cooperate with each other in any notifications to insurers. If a claim for Damages (a "Claim") is to be made for indemnification under this Agreement, the Party claiming such indemnification shall give written notice (a "Claim Notice") to the indemnifying Party as soon as practicable after the Party entitled to indemnification becomes aware of any fact, condition or event which may give rise to Losses for which indemnification may be sought. If any lawsuit or enforcement action is filed against any Party entitled to the benefit of indemnity under this Agreement, written notice shall be given to the indemnifying Party as promptly as practicable (and in any event within fifteen (15) calendar days after the service of the citation or summons). The failure of any indemnified Party to give timely notice shall not affect rights to indemnification, except to the extent that the indemnifying Party demonstrates actual damage caused by such failure. In the event of a lawsuit

or action against the DISTRICT for which the DISTRICT has delivered a Claim Notice to SHARP, if SHARP acknowledges in writing to the DISTRICT that SHARP shall be obligated under the terms of its indemnity in connection with such lawsuit or action, then SHARP, shall be entitled, if it so elects: (i) to take control of the defense and investigation of such lawsuit or action, (ii) to employ and engage attorneys of its own choice to handle and defend the same, at SHARP's cost, risk and expense unless the named parties to such action or proceeding include both SHARP and the DISTRICT and the DISTRICT has been advised in writing by counsel that there may be one or more legal defenses available to the DISTRICT that are different from or additional to those available to SHARP, and (iii) to compromise or settle such claim, which compromise or settlement shall be made only with the written consent of the DISTRICT, such consent not to be unreasonably withheld. In the event SHARP assumes the defense of the claim, the SHARP will keep the DISTRICT reasonably informed of the progress of any such defense, compromise or settlement. SHARP shall be liable for any settlement of any action effected pursuant to and in accordance with this Section and for any final judgment (subject to any right of appeal), and SHARP agrees to indemnify and hold harmless the DISTRICT from and against any Damages by reason of such settlement or judgment. SHARP shall not settle any claim in a manner that imposes any non-monetary obligation on the DISTRICT without the DISTRICT's prior written consent (which shall not be unreasonably withheld, conditioned, or delayed).

ARTICLE 13

DISPUTE RESOLUTION

13.1 Dispute Resolution. The Parties shall attempt to resolve through negotiation any controversy, dispute or claim arising out of or relating to this Agreement, or the breach thereof (each, a "Dispute"). Either Party may initiate negotiations by delivering written notice to the other Party specifying in reasonable detail the subject of the Dispute (the "Dispute Notice"). The Parties shall negotiate in good faith, which shall include a meet-and-confer between the principals of each Party, during the thirty (30) days after the delivery of any such Dispute Notice.

13.2 Mediation. If the Dispute is not resolved by the date that is ninety (90) days following the last meet-and-confer of the principals of each Party (the "Negotiation Period"), then it may be submitted, at the option of either Party, to mediation. If a Party elects to submit a Dispute to mediation, it shall notify the other Party or Parties of such election and the Parties shall use good faith efforts to select a mediator in accordance with this Section 13.2. A single disinterested third-party mediator shall be selected by mutual agreement of the Parties. If the Parties are unable to mutually select a mediator with fifteen (15) days, then a mediator shall be selected by Judicial Arbitration and Mediation Services with its then-current rules and procedures for mediation (or some other mutually-agreed-upon mediator). Such rules of the mediation may be modified by the Parties to the mediation by mutual agreement at the time of the mediation. The mediator shall be bound by the terms of this Agreement. Each Party shall pay one-half the cost of mediation including the mediator's fees. The timeframe for mediation shall be as soon as practicable in accordance with mediator's calendar and the reasonable availability of the Parties,

13.3 Settlement; Failure to Settle. If the Parties are unable to resolve such Dispute through the mediation, the mediator shall issue in writing a settlement proposal regarding the Dispute (the "Settlement Proposal"). The Settlement Proposal shall be non-binding, but upon

mutual written agreement among the Parties, the Settlement Proposal rendered by the mediator may be mutually accepted as binding.. In the event that any Party does not accept any such Settlement Proposal, any Party may bring an action in the Superior Court in the State of California, County of San Diego to resolve such Dispute (any such action shall be subject to the requirements and limitations of Section 14.3).

ARTICLE 14
MISCELLANEOUS

14.1 Amendment and Modification; Waiver. This Agreement, the Disclosure Schedules and the Exhibits may only be amended, modified or supplemented by an agreement in writing signed by each Party hereto. No waiver by any Party of any of the provisions of this Agreement, the Disclosure Schedules or the Exhibits shall be effective unless explicitly set forth in writing and signed by the Party so waiving. No waiver by any Party shall operate or be construed as a waiver in respect of any failure, breach or default not expressly identified by such written waiver, whether of a similar or different character, and whether occurring before or after that waiver. No failure to exercise, or delay in exercising, any right, remedy, power or privilege arising from this Agreement shall operate or be construed as a waiver thereof; nor shall any single or partial exercise of any right, remedy, power or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege.

14.2 Attorneys' Fees. In the event that any claim or contest regarding this Agreement is brought by one Party to this Agreement against the other Party, the losing Party (as determined by the applicable judge, arbitrator or person acting as the trier-of-fact) to such claim shall pay all costs and reasonable attorneys' fees incurred by the other Party or Parties as a result of such claim or contest, together with interest on any amount recovered (other than attorneys' fees) from the date judgment is entered at the maximum rate permitted by applicable Law.

14.3 Governing Law; Waiver of Jury Trial.

14.3.1 This Agreement (including the Disclosure Schedules and the Exhibits), and any action arising or relating to this Agreement, shall be governed by and construed in accordance with the internal laws of the State of California, applicable to agreements executed and performed entirely within the State of California, without giving effect to any choice or conflict of law provision or rule (whether of the State of California or any other jurisdiction) that would cause the application of Laws of any jurisdiction other than those of the State of California.

14.3.2 EACH PARTY ACKNOWLEDGES AND AGREES THAT ANY CONTROVERSY WHICH MAY ARISE UNDER THIS AGREEMENT OR THE OTHER TRANSFER DOCUMENTS IS LIKELY TO INVOLVE COMPLICATED AND DIFFICULT ISSUES AND, THEREFORE, EACH SUCH PARTY IRREVOCABLY AND UNCONDITIONALLY WAIVES ANY RIGHT IT MAY HAVE TO A TRIAL BY JURY IN RESPECT OF ANY LEGAL ACTION ARISING OUT OF OR RELATING TO THE AFFILIATION AGREEMENTS OR THE TRANSACTIONS CONTEMPLATED BY THE AFFILIATION AGREEMENTS. EACH PARTY TO THIS AGREEMENT CERTIFIES AND ACKNOWLEDGES THAT (i) NO REPRESENTATIVE OF ANY OTHER PARTY HAS REPRESENTED, EXPRESSLY OR OTHERWISE, THAT SUCH OTHER PARTY WOULD

NOT SEEK TO ENFORCE THE FOREGOING WAIVER IN THE EVENT OF A LEGAL ACTION, (ii) SUCH PARTY HAS CONSIDERED THE IMPLICATIONS OF THIS WAIVER, (iii) SUCH PARTY MAKES THIS WAIVER VOLUNTARILY, AND (iv) SUCH PARTY HAS BEEN INDUCED TO ENTER INTO THIS AGREEMENT BY, AMONG OTHER THINGS, THE MUTUAL WAIVERS AND CERTIFICATIONS IN THIS SECTION 14.3.

14.4 Specific Performance. Without intending to limit the remedies available to the Parties hereunder, irreparable damage would occur if any provision of this Agreement is not performed in accordance with the terms hereof, for which damages, even if available, will not be an adequate remedy. Accordingly, a Party shall be entitled to an injunction, specific performance and other equitable relief to prevent breaches of this Agreement and to enforce specifically the terms hereof against the other Party or Parties, without, in any such case, the requirement to post any bond or other undertaking, in addition to any other remedy to which such Party is entitled to at law or in equity. Each Party agrees not to oppose the granting of such injunctive or other equitable relief on the basis that monetary damages are an adequate remedy.

14.5 Counterparts. This Agreement and any amendments hereto may be executed and delivered in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, e-mail or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Agreement.

14.6 Interpretation. For purposes of this Agreement, (a) the words "include," "includes" and "including", unless otherwise specified, shall be deemed to be followed by the words "without limitation" whether or not such words are actually stated; (b) the word "or" is not exclusive; (c) the words "herein," "hereof," "hereby," "hereto", "hereunder" and derivative or similar words refer to this Agreement as a whole, including the Disclosure Schedules and Exhibits hereto; (d) words in the singular shall be held to include the plural and vice versa, and words of one gender shall be held to include the other gender as the context requires; (e) references to "dollars" or "$" shall mean United States dollars; (f) references to "written" or "in writing" include in electronic form; (g) provisions shall apply, when appropriate, to successive events and transactions; (h) a reference to any person or entity includes such person's or entity's successors and permitted assigns; (i) any reference to days means calendar days unless business days are expressly specified; (j) when calculating the period of time before which, within which or following which any act is to be done or step taken pursuant to this Agreement, the date that is the reference date in calculating such period shall be excluded, and if the last day of such period is not a business day, the period shall end on the next succeeding business day; and (k) all references to "close of business" on any given day shall be deemed to refer to 11:59 p.m. Pacific Time on such date. Unless the context otherwise requires, references herein: (i) to Articles, Sections, Disclosure Schedules and Exhibits mean the Articles and Sections of, and Disclosure Schedules and Exhibits attached to, this Agreement; (ii) to an agreement, instrument or other document means such agreement, instrument or other document as amended, supplemented and modified from time to time to the extent permitted by the provisions thereof; and (iii) to a statute or regulation or statutory or regulatory provisions means such statute as amended from time to time and includes any successor legislation thereto and any regulations promulgated thereunder. This Agreement shall be construed without regard to any presumption or rule requiring construction or interpretation against the Party drafting an instrument or causing any instrument to be drafted. The Schedules

(including the Disclosure Schedules) and Exhibits referred to herein shall be construed with, and as an integral part of, this Agreement to the same extent as if they were set forth verbatim herein.

14.7 Headings. The headings in this Agreement are for reference only and shall not affect the interpretation of this Agreement.

14.8 Severability. If any term or provision (or any portion thereof) of this Agreement, or the application of any such term or provision (or any portion thereof) to any person or circumstance, is invalid, illegal or unenforceable in any jurisdiction, such invalidity, illegality or unenforceability shall not affect any other term or provision of this Agreement or invalidate or render unenforceable such term or provision in any other jurisdiction, and this Agreement shall be reformed, construed and enforced in such jurisdiction as if such invalid, illegal or unenforceable term or provisions or any portion hereof had never been contained herein. Upon such determination that any term or other provision is invalid, illegal or unenforceable, the Parties shall negotiate in good faith to modify this Agreement so as to affect the original intent of the Parties as closely as possible in a mutually acceptable manner in order that the Affiliation be consummated as originally contemplated to the greatest extent possible.

14.9 Entire Agreement. This Agreement (including the Disclosure Schedules and the Exhibits) and the Transfer Documents constitute the sole and entire agreement of the Parties to this Agreement with respect to the subject matter contained herein and therein, and supersede all prior and contemporaneous understandings and agreements, both written and oral, with respect to such subject matter. In the event of any inconsistency between the statements in the body of this Agreement and those in the other Transfer Documents, the Exhibits and Disclosure Schedules (other than an exception expressly set forth as such in the Disclosure Schedules), the statements in the body of this Agreement will control.

14.10 Successors and Assigns. This Agreement and all of the provisions hereof shall be binding upon and shall inure to the benefit of the Parties and their respective successors and permitted assigns. No Party may assign (directly or indirectly, whether by operation of law or otherwise) its rights, interests or obligations hereunder without the prior written consent of the other Party hereto (except that the SHARP Parties may assign this Agreement to a successor pursuant to a permissible transaction in accordance with Section 9.3).

14.11 No Third-Party Beneficiaries. This Agreement is for the sole benefit of the Parties and its respective successors and permitted assigns and nothing herein, express or implied, is intended to or shall confer upon any other person or entity any legal or equitable right, claim, benefit or remedy of any nature whatsoever under or by reason of this Agreement.

14.12 Continued Existence of District. DISTRICT does not intend by the transfer of assets pursuant to this Agreement to dissolve DISTRICT, de facto, or otherwise, and DISTRICT intends to maintain its existence as a local health care district organized under the Local Hospital District Law. DISTRICT shall continue to exercise all of its rights and powers under the Local Hospital District Law and does not hereby grant or delegate any such rights or powers to the SHARP Parties in any manner. Except as set forth in the Amended STCMC Bylaws, this Agreement does not vest in DISTRICT or any other person or entity any right to control or govern the activities or operations of the SHARP Parties.

14.13 Notices. All notices, requests, demands or other communications required or permitted to be given under this Agreement shall be in writing and shall be delivered to the Party to whom notice is to be given either (i) by personal delivery (in which case such notice shall be deemed given on the date of delivery); (ii) by reliable next business day courier services (e.g., Federal Express, UPS or other similar service) (in which case such notice shall be deemed given on the business day following the date of deposit with the courier service); (iii) by email transmission as long as a copy of the notice is also sent on the same date by another means permitted under this Section (in which case such notice shall be deemed given on the date the email is transmitted); or (iv) by United States mail, first class, postage prepaid, registered or certified, return receipt requested (in which case such notice shall be deemed given on the third (3rd) day following the date of mailing), and in each instance properly addressed as follows:

To DISTRICT: Tri-City Health Care District
Attn: President and Chief Executive Officer
4002 Vista Way
Oceanside, CA 92056
Email: GMa@tcmc.com

With a copy to: Jeffrey G. Scott
Attn.: Law Offices of Jeffrey G. Scott
16935 W Bernardo Dr Ste 170
San Diego, CA 92127
Email: jeff@jeffscottlaw.com

To SHARP Parties: Sharp HealthCare
President and Chief Executive Officer
8695 Spectrum Center Boulevard
San Diego, CA 92123
Email: Chris.Howard@sharp.com

With a copy to: Sharp HealthCare
Attn.: Senior Vice President and Chief Legal Officer
8695 Spectrum Center Boulevard
San Diego, CA 92123
Email: LegalDept@sharp.com

And a copy to: Paul Carr-Rollitt
Manatt, Phelps & Phillips, LLP
2049 Century Park East
Suite 1700
Los Angeles, CA 90067
Email: pcarr-rollitt@manatt.com

A Party may change its addresses for purposes of this Section by giving written notice to the other Party in any manner specified in this Section.

14.14 Costs. The Parties shall each pay their respective costs for professional and other services rendered with respect to the transactions contemplated by the Affiliation Agreements.

14.15 Survival of Provisions. All of the provisions set forth in Article 1 (Definitions), Article 9 (Post-Closing Covenants), Article 10 (Confidentiality), Article 12 (Indemnification), and Article 13 (Dispute Resolution), and Article 14 (Miscellaneous) shall remain in full force and effect after the Closing of the Affiliation transaction, the consummation of this Agreement and shall survive the Closing and consummation. The provisions of this Agreement that by their nature are intended to survive termination or expiration of this Agreement shall so survive the termination of this Agreement, including but not limited to Article 10, Article 12, Article 13, and Article 14.

[Signature Page Follows]

IN WITNESS WHEREOF, the DISTRICT and the SHARP Parties cause this Agreement to be executed as of the Agreement Date.

SHARP HEALTHCARE

By:_____

Its: _____

TRI-CITY MEDICAL CENTER CORPORATION

By:_____

Its: _____

TRI-CITY HEALTHCARE DISTRICT

By:_____

Its: _____

TRANSFER AGREEMENT

BETWEEN

TRI-CITY HEALTHCARE DISTRICT

AND

TRI-CITY MEDICAL CENTER CORPORATION

DATED: _____, 2026

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TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (the "Transfer Agreement") is made and entered into as of _____, 2026 ("Agreement Date"), by and between **TRI-CITY MEDICAL CENTER CORPORATION**, a California nonprofit public benefit corporation ("STCMC") and **TRI-CITY HEALTHCARE DISTRICT**, a political subdivision of the State of California, organized and existing pursuant to the Local Hospital District Law (Div. 23 of the Health & Safety Code) (the "DISTRICT"). STCMC and the DISTRICT may each be individually referred to herein as a "Party" and collectively as the "Parties."

RECITALS:

WHEREAS, the DISTRICT owns and operates Tri-City Medical Center ("TCMC" or the "Hospital"), a general acute care hospital licensed to operate 386 beds located in Oceanside, California, and is a provider of ambulatory clinical and related services at various office locations in support of TCMC.

WHEREAS, STCMC's sole member is Sharp Healthcare, a California nonprofit public benefit corporation ("SHARP", and collectively with STCMC, the "SHARP Parties"), that is the parent of a nonprofit multi-hospital health care system operating, among other health care-related assets, four acute-care hospitals, three specialty hospitals, three affiliated medical groups and one health services plan in and around San Diego County, California.

WHEREAS, the board of directors of the DISTRICT ("DISTRICT Board") has determined that it will best serve the interests of the DISTRICT and the communities served by the DISTRICT to lease substantially all of the real property related to the Hospital campus and its operations ("Hospital Campus Real Property"), and certain real property owned by the DISTRICT that is not part of the Hospital's campus (collectively, the "Non-Hospital Campus Real Property") to STCMC for a term of thirty (30) years pursuant to one or more Lease Agreements entered into by the DISTRICT and STCMC as of the date of this Transfer Agreement (such leases related to the Hospital Campus Real Property and the Non-Hospital Campus Real Property of STCMC are collectively referred to herein as the "Leases"), in accordance with Health & Safety Code Section 32126.

WHEREAS, the Leases have been entered into in accordance with, and to promote the DISTRICT's and STCMC's objectives as set forth in, the Affiliation Agreement between the DISTRICT, SHARP and STCMC, dated [December 12], 2025, to which this Transfer Agreement is attached as an exhibit (the "Affiliation Agreement").

WHEREAS, it is in the best interests of the DISTRICT and the communities served by the DISTRICT to transfer the assets described in this Transfer Agreement to STCMC such that STCMC may operate TCMC and all its related healthcare services, facilities, assets, and operations conducted at or in connection with the Hospital, including, but not limited to, inpatient, outpatient, emergency, diagnostic. therapeutic, and ambulatory clinical services (collectively, the "Business") during the term of the Leases and maintain the assets for the benefit of the communities served by the DISTRICT in accordance with Law, including Health & Safety Code Section 32121(p)(2), and, in connection therewith, the DISTRICT Board has approved this Transfer Agreement.

WHEREAS, pursuant to Health & Safety Code Section 32121(p)(2) and 32126, and after consideration of public review and comment, DISTRICT has determined that execution and delivery of the Leases, the Affiliation Agreement and this Transfer Agreement is intended to:

A. Enhance the provision of high quality, efficient and affordable health care services to the communities served by the DISTRICT and the SHARP Parties;

B. Continue the SHARP Parties' mission to provide comprehensive healthcare services that support the health and medical needs of the general public residing in the communities served by the SHARP Parties and the DISTRICT;

C. Deepen the SHARP Parties', the DISTRICT's and TCMC's collective ability to achieve performance excellence goals and enhance each other's skills, competencies and capabilities; and

D. Continue the Parties' respective tax-exempt and public missions to improve the health and wellbeing of their local communities.

AGREEMENT:

NOW, THEREFORE, in consideration of the premises and the respective representations, warranties, covenants and agreements contained in this Transfer Agreement, and for good and other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties to this Transfer Agreement agree as follows:

ARTICLE I

DEFINITIONS

1.1 Definitions. Capitalized terms used in this Transfer Agreement and not otherwise defined herein shall have the meanings ascribed to them in the Affiliation Agreement. The following terms have the definitions set forth below or ascribed thereto in the section of this Transfer Agreement identified below:

1.1.1 "Accounting Records" has the meaning set forth in Section **Error! Reference source not found.**.

1.1.2 "Accounts Receivable" has the meaning set forth in Section **2.1.7.**

1.1.4 "Affiliate" means any corporation, partnership, limited liability company, sole proprietorship or other person or entity that directly or indirectly through one or more intermediaries controls, is controlled by or is under common control with, the person or entity specified.

1.1.5 "Affiliation Agreement" has the meaning set forth in the Recitals.

1.1.6 "Agency Settlements" shall mean rights to settlements and retroactive adjustments, if any, whether arising under a cost report of the DISTRICT or otherwise, for cost reporting periods ending on or prior to the Closing Date, whether open or closed, arising from or against the United States government under the terms of any Government Program, including, without limitation, the Disproportionate Share Replacement Payments program.

1.1.7 "Agreement Date" has the meaning set forth in the preamble.

1.1.8 "Annual Audited Financials" has the meaning set forth in Section **Error! Reference source not found.**.

1.1.9 "Assignment" has the meaning set forth in Section 4.2.

1.1.10 "Assumed Contract Rights" has the meaning set forth in Section 4.1.

1.1.11 "Assumed Contracts" has the meaning set forth in Section 2.1.3.

1.1.12 "Assumed Leases" has the meaning set forth in Section 2.1.2.

1.1.13 "Assumed Liabilities" has the meaning set forth in Section 3.1.

1.1.14 "Business" has the meaning set forth in the Recitals.

1.1.15 "Cumulative Annual Statement of Cash Flows" has the meaning set forth in Section **Error! Reference source not found.**.

1.1.16 "DISTRICT" has the meaning set forth in the preamble.

1.1.17 "DISTRICT Board" has the meaning set forth in the Recitals.

1.1.18 "Excluded Assets" has the meaning set forth in Section 2.3.

1.1.19 "Excluded Contracts" has the meaning set forth in 2.3.4.

1.1.20 **"**Excluded Liabilities" has the meaning set forth in Section 3.2.

1.1.21 "Final DISTRICT Payable" has the meaning set forth in Section **Error! Reference source not found.**.

1.1.22 "Final SHARP Receivable" has the meaning set forth in Section **Error! Reference source not found.**.

1.1.23 "Financial Reporting Documents" has the meaning set forth in Section **Error! Reference source not found.**.

1.1.24 "Hired Employees" has the meaning set forth in Section 6.2.3.1 of the Affiliation Agreement.

1.1.25 "Hospital" has the meaning set forth in the Recitals.

1.1.26 "Hospital Campus Real Property" has the meaning set forth in the Recitals.

1.1.27 "Intangible Property" has the meaning set forth in Section 2.1.12.

1.1.28 "Inventory" has the meaning set forth in Section 2.1.4.

1.1.29 "Lease Termination Date" means with respect to a Lease, the date as of which such Lease is terminated or expires on its terms.

1.1.30 "Leases" has the meaning set forth in the Recitals.

1.1.31 "Medical Records" has the meaning set forth in Section 2.1.11.

1.1.32 "Nonassignable Contracts" has the meaning set forth in Section 4.2.

1.1.33 "Non-Hospital Campus Real Property" has the meaning set forth in the Recitals.

1.1.34 "Objection Notice" has the meaning set forth in Section **Error! Reference source not found.**.

1.1.35 "Party" and "Parties" has the meaning set forth in the preamble.

1.1.36 "Permits" has the meaning set forth in Section 5.6.2 of the Affiliation Agreement.

1.1.37 "Personal Property" has the meaning set forth in Section 2.1.1.

1.1.38 "Promissory Note" has the meaning set forth in Section 7.2.8.

1.1.39 "Post-Lease Transferring Assets" has the meaning set forth in Section 7.1.

1.1.40 "Post-Valuation Assets" has the meaning set forth in Section 2.1.1(b).

1.1.41 "Prepaids" has the meaning set forth in Section 2.1.5.

1.1.42 "Prime Rate" has the meaning set forth in Section **Error! Reference source not found.**.

1.1.43 "Review Period" has the meaning set forth in Section **Error! Reference source not found.**.

1.1.44 "SHARP" has the meaning set forth in the Recitals.

1.1.45 "SHARP Advances" has the meaning set forth in Section **Error! Reference source not found.**.

1.1.46 "SHARP Parties" has the meaning set forth in the Recitals.

1.1.47 "Statement of Cash Flows" has the meaning set forth in Section **Error! Reference source not found.**.

1.1.48 "STCMC" has the meaning set forth in the preamble.

1.1.49 "STCMC Opening Balance Sheet" has the meaning set forth in Section **Error! Reference source not found.**.

1.1.50 "STCMC Payable" has the meaning set forth in Section **Error! Reference source not found.**.

1.1.51 "STCMC Receivable" has the meaning set forth in Section **Error! Reference source not found.**.

1.1.52 "Supplies" means any and all provisions, materials, goods and similar items used in the operation of the Business whether or not clinical in nature, including provisions, materials, goods and products related to pharmaceutical, surgical, administrative, food service, janitorial, facility maintenance, office and shop operations and other clinical and administrative services.

1.1.53 "TCMC" has the meaning set forth in the Recitals.

1.1.54 "TCMC Leased Premises" has the meaning set forth in Section 2.1 of the Affiliation Agreement.

1.1.55 "Termination Accounting" has the meaning set forth in Section **Error! Reference source not found.**.

1.1.56 "Termination Date" has the meaning set forth in Section **Error! Reference source not found.**.

1.1.57 "Transfer Agreement" has the meaning set forth in the preamble.

1.1.58 "Transferred Bank Accounts" has the meaning set forth in Section 2.1.6.

1.1.59 "Transferring Assets" has the meaning set forth in Section 2.1.

ARTICLE II

TRANSFER OF ASSETS

2.1 Transferring Assets. Upon the terms and subject to the conditions contained in this Transfer Agreement, and not including assets that constitute or are among the Excluded Assets, as of the Closing, the DISTRICT sells, conveys, transfers, assigns and delivers to STCMC, and STCMC acquires from the DISTRICT, all right, title and interest of the DISTRICT in and to all properties, assets and rights of any kind or nature, whether tangible or intangible, real, personal or mixed, owned, leased or held by the DISTRICT that constitute, are used in connection with, or are otherwise related to TCMC and the Business, as such assets exist on the Closing Date, including

the following items to the extent used or held for use in the operations of TCMC and the Business, but not including any of the Excluded Assets (collectively, the "Transferring Assets"):

2.1.1 Personal Property. All tangible personal property of every kind and nature owned by the DISTRICT that is physically located within the TCMC Leased Premises or any other location in which the Business is conducted or such personal property is used or held for use in connection with TCMC and the Business as of the Closing Date (collectively, the "Personal Property"), including, without limitation, the following:

(a) All tangible personal property of any kind and nature in connection with TCMC and the Business identified and scheduled on Schedule 2.1.1(a) as part of and pursuant to the fair market value appraisal process conducted pursuant to the valuation as of the Closing Date conducted in accordance with the Affiliation Agreement;

(b) All tangible personal property of any kind and nature in connection with TCMC and the Business that is acquired by the DISTRICT from and after the Valuation Date (the "Post-Valuation Assets"); and

(c) All other furniture, fixtures, machinery, vehicles, medical and other equipment, owned or licensed computer systems (including, without limitation, electronic medical records systems hardware) and applications, spare parts, and tools of any kind and nature, whether or not capitalized at the time of their purchase, and whether or not recorded on the books of the DISTRICT, that are physically located within the TCMC Leased Premises or any location in which the Business is conducted, used, or held for use.

2.1.2 Assumed Leases. All of the DISTRICT's right, title and interest in and to any and all real property or personal property leases and subleases to which the DISTRICT is a party and that are related to the Business, including those leases set forth on Schedule 2.1.2 (the "Assumed Leases").

2.1.3 Assumed Contracts. Any and all contracts to which the DISTRICT is a party and that are related to the Business, including those contracts set forth in Schedule 2.1.3, and including, without limitation, licenses (including shrinkwrap licenses and electronic medical record system and software related licenses) to which the DISTRICT is a party and which are assignable (all such contracts, together with the Assumed Leases, collectively, the "Assumed Contracts").

2.1.4 Inventory. All of the DISTRICT's inventory of Supplies, raw materials, parts, merchandise, drugs, and other disposables and consumables of any kind and nature (collectively, the "Inventory") located at the TCMC Leased Premises or any location in which the Business is conducted and used in connection with TCMC and the Business on the Closing Date.

2.1.5 Prepaids. All of the DISTRICT's advance payments, prepayments, prepaid rentals, prepaid expenses and deposits (including any prepaid deposits for Inventory and any deposits or other prepayments pursuant to any Assumed Contract) made by or on behalf of the DISTRICT in the ordinary course of business for goods and services, including those set forth on Schedule 2.1.5 (the "Prepaids").

2.1.6 Bank Accounts; Cash. As of the Closing Date, the DISTRICT shall assign and transfer to STCMC all rights, title, and interest in and to the bank accounts listed on Schedule 2.1.6 (the "Transferred Bank Accounts"), including all cash balances therein. The DISTRICT shall take all actions reasonably required or requested by STCMC to evidence and confirm such assignment, including providing written instructions to the relevant financial institutions and executing any required documentation.

2.1.7 Accounts Receivable. All accounts, notes, interest and other receivables of the DISTRICT of any kind and nature and all accounts receivable of the DISTRICT that have either (a) arisen and been billed but not collected prior to the Effective Time, or (b) have arisen but not been billed or collected prior to the Effective Time, in connection with TCMC and the Business, including: accounts, notes or other amounts receivable from any third-party, and all claims, rights, interests and proceeds related thereto; cost report settlements that relate to any period before the Effective Time; and any account receivable arising from Agency Settlements even if such adjustments occur after the Effective Time, for items and/or services provided by the DISTRICT prior to the Effective Time while owner of the Transferring Assets, whether payable by professional service providers, private pay patients, private insurance, third-party payors, Government Programs, or any other source (collectively, the "Accounts Receivable"), and all agreements, notes, statements, records, correspondence, work papers and other documents relating to the Accounts Receivable, the DISTRICT's cost reports or Agency Settlements.

2.1.8 Claims. All claims, causes of action, rights of recovery and rights of setoff and recoupment of any kind and nature (including rights to insurance proceeds and rights under and pursuant to all warranties, representations, and guarantees made by suppliers of services, products, materials, or equipment, or components thereof) that arise out of or inure to the benefit of the DISTRICT with respect to the Transferring Asset.

2.1.9 Warranties and Guarantees. All warranties and guarantees of third parties relating to Transferring Assets or the Business.

2.1.10 Books and Records. All books and records, except those books and records described in Section 2.3.3.

2.1.11 Medical Records. Originals, or where not available, copies, in a usable and accessible form and format, of all medical records, patient files, and other written accounts of the medical history of the TCMC's patients maintained in connection with TCMC and the Business (including electronic medical records in usable and accessible format through licensed access to TCMC's and the Business' electronic medical record systems), to the extent transferable by Law ("Medical Records").

2.1.12 Intangible Property. All of the DISTRICT's intangible property (the "Intangible Property") of any kind and nature used in connection with TCMC and the Business, including the following:

(a) All Permits, approvals or other permissions of any Governmental Authority with respect to the operation of TCMC, the Business or the Transferring Assets, to the extent assignable or transferable, owned, utilized, licensed, or issued to the DISTRICT relating to

the ownership, development and business or operation of TCMC, the Business or the Transferring Assets (including any pending permits, approvals or permissions related to TCMC, the Business or the Transferring Assets);

(b) All rights to intellectual property, including trademarks, trade names and trade secrets, of the DISTRICT related to the Business, licenses and sublicenses granted and obtained with respect thereto (including, without limitation, electronic medical record system-related licenses), copies of tangible embodiments thereof in whatever form or medium, all rights to sue and recover damages for infringement occurring on or after the Closing Date, misappropriation or breach thereof, rights to protection of interests therein under the Laws of all jurisdictions, and the goodwill associated therewith;

(c) All goodwill associated with the Business;

(d) All Business-related phone numbers, advertising and all sales and promotional literature, samples, and catalogs used in the marketing of TCMC and the Business.

2.1.13 JV Company Interests. Subject to the terms and conditions of this Transfer Agreement, the Affiliation Agreement, and in accordance with the applicable JV Company governance documentation, all of the DISTRICT's right, title, and interest in and to the JV Companies interests listed in Schedule 2.1.13. Such transfers shall be effected in compliance with all applicable provisions governing transfers, consents, and approvals as set forth in the applicable JV Company governance documentation.

2.1.14 Other Transferring Assets. To the extent not included in any of the foregoing, all other assets owned by the DISTRICT and used in connection with TCMC and the Business as of the Closing Date, but excluding the Excluded Assets.

2.2 Use of Transferring Assets. STCMC shall use, operate and maintain the Transferring Assets in accordance with California Health & Safety Code Section 32121(p)(2) for the benefit of the present and future health care needs of the communities served by the DISTRICT. Notwithstanding anything to the contrary in the immediately preceding sentence and subject to Article 9 of the Affiliation Agreement, STCMC shall have the right, power and authority to sell, or otherwise dispose of or abandon any or all of the Transferring Assets during the term of the Leases and until the Hospital Lease Termination Date without the consent or approval of the District.

2.3 Excluded Assets. Notwithstanding any other provision of this Transfer Agreement, the Transferring Assets shall not include the following assets, which shall be retained by the DISTRICT (collectively, the "Excluded Assets"):

2.3.1 Fee title to the DISTRICT's real property, including, without limitation, the underlying real property that constitutes Hospital Campus Real Property and the Non-Hospital Campus Real Property;

2.3.2 The bank account(s) listed on Schedule 2.3.2 and an amount of cash as described on Schedule 2.3.2, which shall be retained by the DISTRICT from its pre-Closing funds

for use by the DISTRICT to support the operations, programs and initiatives of the DISTRICT after the Effective Time;

2.3.3 Proprietary DISTRICT records, including (i) minute books and records relating to the ownership, governance, and internal affairs of the DISTRICT; (ii) DISTRICT financial records not related to the Transferring Assets or the business of TCMC; and (iii) privileged communications or documents, including attorney-client communications and work product, that are not related to the Transferring Assets or TCMC's business;

2.3.4 The contracts described on Schedule 2.3.4 (the "Excluded Contracts");

2.3.5 The proceeds of general or special property taxes levied on behalf of the DISTRICT, whether collected or not, provided that any DISTRICT retention of such taxes shall be in accordance with Section 9.11 of the Affiliation Agreement;

2.3.6 The rights that accrue or will accrue to DISTRICT under this Transfer Agreement, the Affiliation Agreement, or the Leases; and

2.3.7 Such other assets and items as may be mutually agreed upon by the Parties and described on Schedule 2.3.7.

ARTICLE III

ASSUMPTION OF LIABILITIES

3.1 Assumption of Liabilities. Effective as of the Effective Time, subject to and in accordance with the terms and conditions of this Transfer Agreement, STCMC assumes, and shall perform and discharge when due or sooner, any and all liabilities and obligations of the DISTRICT, except to the extent that such liabilities constitute Excluded Liabilities (collectively, the "Assumed Liabilities"), including:

3.1.1 Liabilities Related to Assumed Contracts. All liabilities and obligations of the DISTRICT under any Assumed Contract, including with respect to any unpaid amounts that accrued or became due and payable on or prior to the Closing Date or any failure to perform, improper performance, breach of warranty, or other breach, default, or violation of the terms thereof occurring on or prior to the Effective Time, except where such liabilities, obligations or amounts are special, punitive or consequential damages or are otherwise owed as a result of the DISTRICT's or its Affiliates' fraud or intentional misrepresentation or improper acts.

3.1.2 Post-Closing Liabilities. All obligations and liabilities relating to or arising out of STCMC's operations and/or ownership of the Transferring Assets or TCMC's Business or operations on or after the Effective Time.

3.1.3 Accounts Payable. All accounts payable of the DISTRICT that are outstanding as of the Closing Date and do not relate to any Excluded Assets or Excluded Liabilities.

3.1.4 DISTRICT Debt and Capital Lease Obligations. The obligations related to the DISTRICT's debt and capital lease obligations existing immediately prior to the Effective Time, including, without limitation, obligations under the debt arrangements listed on Schedule 3.1.4.

3.1.5 Employees. All obligations and liabilities related to the SHARP Parties' employment of the Hired Employees as of or after the Effective Time, as applicable.

3.1.6 Other Claims. Any other known or unknown debts, obligations or liabilities of the DISTRICT related to the Business or the Transferring Assets that arise out of or relate to incidents, actions or omissions of the DISTRICT or the DISTRICT's directors, officers, employees, contractors, agents or representatives occurring prior to the Effective Time, to the extent permitted by law, but excluding the Excluded Liabilities.

3.2 Excluded Liabilities. Notwithstanding any other provision of this Transfer Agreement, STCMC does not and shall not assume, or otherwise be responsible for, DISTRICT's liabilities and obligations related to (a) any obligations of DISTRICT to fund compensation and benefits payable to members or former members of the DISTRICT Board from and after the Closing Date, (b) any obligations or liabilities of DISTRICT under Excluded Contracts, (c) any obligations or liabilities incurred by District from its activities and operations after the Effective Time, (d) any liabilities of the DISTRICT under this Transfer Agreement, the Affiliation Agreement, or the Leases, (e) any and all liabilities related to claims covered by insurance maintained by the DISTRICT prior to the Closing Date or otherwise in accordance with the Affiliation Agreement; and (f) any liabilities that are Excluded Liabilities as defined under the Affiliation Agreement (collectively, the "Excluded Liabilities").

ARTICLE IV

ASSIGNMENT OF CONTRACTS AND RIGHTS

4.1 General Assignment. Except as set forth in Schedule 4.1 and except for the items listed in Subsections of this Article IV, the DISTRICT hereby assigns, transfers and coveys to STCMC, and STCMC hereby accepts such assignment of, all of the DISTRICT's right, title and interest in and to all of the leases (including the right to collect rents under the leases in which the DISTRICT is the lessor), contracts, partnerships, promissory notes, evidences of indebtedness, deeds of trust, mortgages, indentures, purchase orders, copyrights, service marks, trademarks, trade names, licenses, royalty rights, deposits, and rights and claims to refunds and adjustments of any kind and nature whatsoever that are among or that arise from or under the Assumed Contracts (collectively, "Assumed Contract Rights").

4.2 Nonassignability. Notwithstanding anything to the contrary in this Transfer Agreement, to the extent that any of the Assumed Contract Rights are not capable of being validly assigned, transferred, or conveyed without the consent or waiver of the issuer thereof, the other party thereto, any Governmental Authority or other person, or such assignment, transfer, or conveyance (collectively, "Assignment") or attempted Assignment would constitute a breach thereof or a violation of Law, this Transfer Agreement shall not constitute an Assignment thereof and the DISTRICT shall not be obligated to assign to STCMC any such Assumed Contract Rights

or other interest or right hereunder (collectively, "Nonassignable Contracts") without the Parties first having obtained all such necessary consents and waivers.

4.3 Obtaining Consents. STCMC shall use commercially reasonable efforts to obtain third party consents required under the Nonassignable Contracts to effectuate assignment of such Nonassignable Contracts to STCMC as of the Effective Time. The DISTRICT shall use all commercially reasonable efforts to cooperate with the STCMC (including, without limitation, promptly responding to and forwarding communications related to such consents and communicating with STCMC's representatives) and to help facilitate STCMC obtaining such consents and facilitating such assignment prior to Closing. Notwithstanding the foregoing, STCMC shall not be obligated to (i) pay any fee or other consideration to any third party to obtain consent with respect to such Nonassignable Contract, (ii) agree to any material modification of the terms of any Nonassignable Contract, or (iii) initiate or participate in any litigation or arbitration to obtain such consent.

4.4 If Waivers or Consents Cannot be Obtained. To the extent that the consents and waivers relating to Nonassignable Contracts are not obtained, the DISTRICT and STCMC shall during the term of the Leases (but, as to any particular Nonassignable Contract, not longer than the current term thereof), use commercially reasonable efforts to (a) provide STCMC with the benefits of any Nonassignable Contract, if and to the extent that it otherwise would constitute a Transferring Asset or Assumed Contract Right, (b) cooperate to reach a reasonable and lawful arrangement designed to provide such benefits to STCMC during the Term of the Leases, and (c) enforce, at the request of STCMC and using legal counsel selected by STCMC, any rights of the DISTRICT under any such Nonassignable Contract against such issuer or the other party or parties thereto (including the right to elect or terminate any of the foregoing in accordance with the terms thereof upon the advice of STCMC); provided, however, that all reasonable costs and expenses of the DISTRICT incurred with respect to any of the actions contemplated under clauses (a), (b), or (c) of this Section 4.4 shall be paid or reimbursed by STCMC to the DISTRICT.

ARTICLE V

REPRESENTATIONS AND WARRANTIES OF DISTRICT

5.1 The DISTRICT makes the representations and warranties set forth in Sections 5.1 (Organization), 5.2 (Authorization; Noncontravention; Consents), 5.12 (Marketable Title), 5.14 (Insurance), and 5.15 (Material Contracts) of the Affiliation Agreement with respect to itself, the Business and the Transferring Assets, which representations and warranties are incorporated by reference herein and constitute an integral part hereof. The DISTRICT acknowledges that such representations and warranties shall be relied upon by STCMC for the purposes of this Agreement. This Article V shall not, in any way limit, modify any of the DISTRICT's representations and warranties under the Affiliation Agreement or Leases, and shall not act as a waiver of any rights the SHARP Parties may have based on such representations and warranties under those agreements.

ARTICLE VI

ACTIONS TO EFFECTUATE POSSESSION

6.1 From and after the Closing Date and the transfer of the Transferring Assets to STCMC in accordance with this Transfer Agreement, the DISTRICT, through its officers, agents and employees, and at STCMC's cost and expense, shall take any and all commercially reasonable actions to cause STCMC to take into full possession and enjoyment of the Transferring Assets.

6.2 From and after the Closing Date, the DISTRICT shall execute, acknowledge, and deliver any further deeds, assignments, conveyances, and other assurances, documents, and instruments of transfer reasonably required by STCMC and shall take any and all other actions consistent with the terms of this Transfer Agreement that may be reasonably requested of the DISTRICT for the purpose of assigning, transferring, granting, conveying, and conferring to STCMC, or reducing to possession, any or all of the Transferring Assets and the Assumed Contract Rights to STCMC. If requested by STCMC, the DISTRICT shall prosecute or otherwise enforce in its own name the benefits that are transferred to STCMC by this Transfer Agreement and that require prosecution or enforcement in the DISTRICT's name. Any prosecution or enforcement of claims, rights, or benefits under this Article shall be solely at STCMC's cost and expense, and using legal counsel selected by STCMC, unless the prosecution or enforcement is necessary due to a breach of this Transfer Agreement by the DISTRICT.

ARTICLE VII

SURRENDER OF TRANSFERRING ASSETS

7.1 Transfer of Assets and Assumed Liabilities to DISTRICT Upon Termination of Hospital Lease. On the expiration or earlier termination of the term of the Hospital Lease, STCMC shall surrender to the DISTRICT any then-remaining Transferring Assets and any other tangible or intangible assets in STCMC's possession and that, prior to the termination or expiration of such Hospital Lease, were intended for use with respect to the operation of TCMC and the Business (collectively, the "Post-Lease Transferring Assets,") in "as-is" condition and "where is" location, including, without limitation, cash and related accounts, Personal Property, contracts to which STCMC is then a party and which are for the benefit of TCMC or the Business, Permits and approvals related to the operation of TCMC and the Business (to the extent assignable by Law), Medical Records, Accounts Receivable related to TCMC and the Business, intellectual property, as well as all other then-owned assets accumulated by STCMC during the term of the Hospital Lease and that arose out of or from, or relate to the operation of the Transferring Assets (but excluding assets owned or controlled by SHARP or SHARP's non-STCMC Affiliates and that are, at the time of such termination or expiration, not used with respect to TCMC or the Business as then operated by STCMC). In addition, on the expiration or earlier termination of the Hospital Lease (as amended or extended), the DISTRICT shall assume the short term and long-term liabilities related to TCMC and the Business, including accounts payable, contractual obligations related to contracts among the Post-Lease Transferring Assets, and all other liabilities related to the operation of TCMC and the Business after such expiration or earlier termination of the Hospital Lease including, without limitation, any remaining obligations with respect to the debts listed on Schedule 3.1.4. To the extent SHARP or SHARP's non-STCMC Affiliates provide services with

respect to the Business immediately prior to the expiration or termination of the Hospital Lease through contracts (e.g., system-wide management services), DISTRICT may elect to continue to receive such services. Upon the Parties engaging in discussions regarding the termination, extension or expiration of the Hospital Lease, the Parties shall also discuss the potential need for any such services. As applicable, SHARP Affiliates shall only be obligated to provide to DISTRICT such services, if permissible by Law (including, without limitation antitrust and anticompetition Laws), for a period of post-termination up to six (6) months following the termination or expiration of the Hospital Lease for compensation equal to the fair market value of such services when provided to independent non-SHARP system third-parties.

7.2 Reconciliation of SHARP Advances at Hospital Lease Termination. After the Effective Time and from time to time during the term of the Hospital Lease, as needed when STCMC does not have sufficient funds (i.e., cash and cash equivalents) readily available, SHARP will advance funds to STCMC for the hospital and healthcare operations, maintenance, improvements, capital investments and related expenditures of TCMC and the Business, including, without limitation, those capital investments described in Section 9.5 of the Affiliation Agreement (the "SHARP Advances"). Subject to Section 7.2.3 below, consistent with STCMC's obligation in Section 14.10 of the Hospital Lease to prepare and maintain proper accounting books and records in accordance with GAAP (the "Accounting Records"), STCMC shall account to the DISTRICT for the SHARP Advances as follows:

7.2.1 Not more than one hundred twenty (120) days after the Effective Time, the SHARP Parties, with the assistance and review of their outside certified public accountants (i.e., Ernst & Young), shall prepare an opening Balance Sheet for STCMC taking into account all of the transactions involving the leases, transfers and assignments of substantially all of the DISTRICT's assets to, and the assumption of substantially all of the DISTRICT's liabilities by, STCMC in accordance with the terms and conditions of the Affiliation Agreements (the "STCMC Opening Balance Sheet"). For this purpose, the STCMC Opening Balance Sheet shall be prepared in accordance with GAAP, including, without limitation, the application of purchase accounting, which requires that the DISTRICT's assets and liabilities transferred by STCMC pursuant to the Affiliation Agreement be adjusted to their fair values as of the Effective Time, and Accounting Standards Codification (ASC) 820 to the extent applicable. The SHARP Parties shall deliver a copy of the Opening Balance Sheet to the DISTRICT following the preparation thereof.

7.2.2 Subject to Section 7.2.4 below, not more than sixty (60) days following the end of the first calendar month after delivery of the STCMC Opening Balance Sheet to the DISTRICT and following the end of each subsequent calendar month during the term of the Hospital Lease or as otherwise set forth in Section 7.2.4 below, based on its unaudited Accounting Records for such calendar month, STCMC shall prepare and deliver to the DISTRICT: (a) a Balance Sheet (Statement of Financial Position), Statement of Operations, and Statement of Changes in Net Assets for STCMC as of the end of such calendar month, which shall generally be consistent with the forms attached hereto as Schedule 7.2.2(a) (the "Financial Reporting Documents"), (b) a Statement of Cash Flows generally consistent with the form attached hereto as Schedule 7.2.2(b) (a "Statement of Cash Flows") accounting for (i) the changes in the balance of cash and cash equivalents as of the beginning and end of each such calendar month and for the applicable fiscal year to date, and (ii) the cumulative net SHARP Advances due to SHARP or cumulative net receivable due from SHARP (i.e., the intercompany payable or receivable between

SHARP and STCMC) for the fiscal year to date based on the cumulative financial activities of STCMC as of the end of such calendar month, and (c) copies of such other books, records, or reports related to the financial performance of STCMC as may be reasonably requested by the DISTRICT from time to time. Such Statement of Cash Flows shall include, without limitation, and for example, increases in STCMC's intercompany payable resulting from additional SHARP Advances made to STCMC, reductions in STCMC's intercompany payable due to STCMC's cash flow from operations or any funds transfers from STCMC to SHARP (the "STCMC Payable"), or STCMC's intercompany receivable if STCMC's funds transferred or released to SHARP exceed prior SHARP Advances (the "STCMC Receivable"). For avoidance of doubt, the methodologies and calculations used to determine and develop the Accounting Records, shall include, without limitation, and take into account: (x) SHARP's payment of any and all SHARP Party Losses for which the DISTRICT has indemnification obligations in accordance with Article 12 of the Affiliation Agreement, as and to the extent not otherwise satisfied by the DISTRICT in accordance with Article 12 of the Affiliation Agreement; and (y) SHARP's payment of any and all SHARP Party Losses arising from acts, omissions, or occurrences resulting in or constituting a Landlord Default under Section 8.6.1 of the Hospital Lease. For purposes of determining the amount of any STCMC Payable or STCMC Receivable, and the Cumulative Annual Statements of Cash Flows (as defined below), SHARP shall allocate all costs for the centralized back office and other system services of SHARP or its Affiliates (e.g., IT, revenue cycle) and any revenues for the services of SHARP or its Affiliates that are not specifically allocated to an Affiliate of Sharp (the "Allocated Costs and Revenues") in a fair manner consistent with the allocation methodology applied to such costs and revenues for the hospital Affiliates of SHARP.

7.2.3 SHARP will prepare, have audited, and will issue and release to the DISTRICT its audited consolidated financial statements not more than one hundred twenty (120) days following the end of each fiscal year of the SHARP Parties during the term of the Affiliation Agreements ("Annual Audited Financials"). STCMC shall prepare and deliver to the DISTRICT, based on applicable Annual Audited Financials: (a) a copy of SHARP's Annual Audited Financials for such year, (b) the Financial Reporting Documents for STCMC as of the fiscal year end, (b) a Statement of Cash Flows as of the fiscal year end, and (c) a cumulative Annual Statement of Cash Flows detailing the Statement of Cash Flows prepared for each fiscal year (or portions thereof) to date over the term of the Hospital Lease reflecting, among other things, the cumulative STCMC Payable due to SHARP from STCMC or cumulative STCMC Receivable due from SHARP to STCMC based on STCMC's audited annual financial results over the term of the Hospital Lease (the "Cumulative Annual Statements of Cash Flows").

7.2.4 During the period for the preparation of the Annual Audited Financials and Cumulative Annual Statements of Cash Flows pursuant to Section 7.2.3 above, STCMC shall continue to prepare and deliver the monthly Financial Reporting Documents and Statement of Cash Flows for each calendar month pursuant to Section 7.2.2 above. Within sixty (60) days following the last day of the calendar month when the Annual Audited Financials are issued and delivered to the DISTRICT, STCMC shall prepare and deliver amended Financial Reporting Documents and Statements of Cash Flows, if needed, to the DISTRICT for the calendar months immediately following the end of the applicable fiscal year (e.g., October, November, December, etc.) and prior to the issuance and release of the Annual Audited Financials for such fiscal year to reflect adjustments, if any, to any previously issued monthly Financial Reporting Documents and

Statements of Cash Flows arising from the audited financial information contained in the Annual Audited Financials.

7.2.5 At least semi-annually (or more frequently as mutually agreed upon by the Parties), as a part of its regular financial reports, STCMC shall report to its Board of Directors Finance and Business Development Committee (as described in the Amended STCMC Bylaws) on the then outstanding STCMC Payable due to SHARP or outstanding STCMC Receivable due from SHARP based on the financial performance of STCMC. Further, at the biannual meeting of the Parties' representatives pursuant to Section 9.14 of the Affiliation Agreement (or more frequently as mutually agreed upon by the Parties), as a part of the report on the financial performance of STCMC, the SHARP Parties shall report to the DISTRICT on the then outstanding cumulative STCMC Payable due to SHARP or then outstanding cumulative STCMC Receivable due from SHARP based on the financial performance of STCMC.

7.2.6 Not more than sixty (60) days following the expiration or earlier termination of the Hospital Lease (the "Termination Date") and the concurrent surrender of all Post-Lease Transferring Assets (including the STCMC Receivable if any to, and assumption of all current and long-term liabilities of STCMC (including the STCMC Payable, if any) by, the DISTRICT pursuant to Article VII of the Transfer Agreement, the SHARP Parties shall prepare in good faith based on the Accounting Records and deliver to the DISTRICT: (a) the final Financial Reporting Documents for STCMC as of the Termination Date, (b) a final Statement of Cash Flows as of the Termination Date, (c) a final Cumulative Annual Statements of Cash Flows detailing the Statement of Cash Flows prepared for each fiscal year (or portions thereof) through the Termination Date, including the then outstanding cumulative STCMC Payable owing by the DISTRICT to Sharp (based on its assumption of such liability from STCMC) or then outstanding cumulative SHARP Receivable due from SHARP to the DISTRICT (based on its acceptance of such asset from STCMC) (the "Termination Accounting"). The DISTRICT shall have sixty (60) days after its receipt of the Termination Accounting (the "Review Period") to review the Termination Accounting. During the Review Period, the SHARP Parties shall provide the DISTRICT and its representatives with reasonable access during normal business hours to the books, records and personnel of the SHARP Parties as reasonably requested by the DISTRICT to evaluate the Termination Accounting. If the DISTRICT agrees with all items listed in the Termination Accounting, it shall become the final Termination Accounting and be paid in the manner described in Section 7.2.8 below. If the DISTRICT disagrees with any items in the Termination Accounting, the DISTRICT shall deliver a written notice of disagreement (the "Objection Notice") to the SHARP Parties before the end of the Review Period, specifying in reasonable detail the disputed items and the basis therefore.

7.2.7 If the DISTRICT delivers a timely Objection Notice, the DISTRICT and SHARP Parties shall meet and confer in good faith over a period of at least thirty (30) days to seek to resolve the disputed items. If they cannot resolve all disputed items within such period, then, notwithstanding Article 13 of the Affiliation Agreement, the DISTRICT and SHARP Parties shall jointly engage a nationally recognized independent accounting firm (the "Independent Accountant") to review the Termination Accounting only for the purpose of resolving any disputed items between the Parties. The Independent Accountant (a) shall act as an expert and not an arbitrator, (b) shall base its determination solely on (i) its examination of the Accounting Records, the materials delivered monthly and annually by STCMC to the DISTRICT pursuant to Section

7.2.2 and 7.2.3 above and additional information requested pursuant to Section 7.2.6(c) above, (ii) a confirmation that the SHARP Costs and Revenues are allocated in accordance with Section 7.2.2, and (iii) the written submissions of the Parties (with each Party having concurrent access and an opportunity to respond to such submissions), (c) may request and receive additional information and workpapers from either Party on a non-*ex parte* basis, and (d) shall be instructed to complete its review process as soon as practicable following its engagement and to render a written determination within thirty (30) days. The Independent Accountant's determination shall be final, conclusive and binding on the Parties, in the absence of fraud or manifest error. Fees and expenses of the Independent Accountant shall be borne equally by the SHARP Parties, on the one hand, and the DISTRICT, on the other hand. As soon as reasonably possible after the Independent Accountant issues its written determination, the SHARP Parties shall prepare and deliver a final Termination Accounting based on and consistent with such written determination, including, without limitation, to the final amount of the outstanding STCMC Payable owing by the DISTRICT to SHARP (the "Final DISTRICT Payable") or the final amount of the outstanding SHARP Receivable due from SHARP to the DISTRICT (the "Final SHARP Receivable").

7.2.8 If the final Termination Accounting, whether as a result of no disputed items to the Termination Accounting or the written determination of the Independent Accountant, reflects a Final SHARP Receivable, the SHARP Parties shall pay the amount owing to the DISTRICT not more than ninety (90) days following the SHARP Parties' receipt of such final Termination Accounting. If the final Termination Accounting reflects a Final DISTRICT Payable owing to SHARP, the Parties shall execute and deliver a promissory note and amortization schedule (the "Promissory Note") reasonably approved by the Parties that provides for the DISTRICT to (a) pay the Final DISTRICT Payable to SHARP with interest thereon at the Prime Rate (defined below) in arrears over either (i) ten (10) equal installments payments of principal and interest made on an annual basis over a period of ten (10) years, if the Final DISTRICT Payable owing to SHARP equals or exceeds Two Hundred Million Dollars ($ 200,000,000) or (ii) five (5) equal installments payments of principal and interest made on an annual basis over a period of five (5) years, if the Final DISTRICT Payable owing to SHARP is less than Two Hundred Million Dollars ($ 200,000,000), in each case beginning on the date that is six (6) months following the effective date of such Promissory Note and continuing each twelve (12) months thereafter until paid in full and (b) pledge in writing to SHARP in a form reasonably acceptable to the Parties a first-priority lien interest in all revenues from the DISTRICT's operation of TCMC and the Business as security for the payment of the Promissory Note, each subject to bankruptcy, insolvency, reorganization, arrangement, moratorium, fraudulent conveyance, and other laws affecting creditors' rights, to the application of equitable principles and to the exercise of judicial discretion. The Promissory Note shall be prepayable by the DISTRICT, without any penalty or additional cost to the DISTRICT. As used herein, "Prime Rate" shall mean the highest prime rate (or base rate) of interest reported in the "Money Rates" column or section of The Wall Street Journal published on the second business day of each month as having been the rate in effect for corporate loans at large United States money center commercial banks (whether or not such rate has actually been charged by any such bank) as of the first business day of such month for which such rate is published. The Prime Rate as provided in this Section 7.2.8 shall be adjusted each month and shall be effective for the entire calendar month. If The Wall Street Journal ceases publication of the Prime Rate, the "Prime Rate" shall mean the prime rate (or base rate) of interest announced by JPMorgan Chase & Co., New York, New York or its successors (whether or not such rate has actually been charged by such bank). If such bank discontinues the practice of

announcing the Prime Rate, the "Prime Rate" shall mean the highest rate of interest charged by such bank on short term (not greater than 5 years), unsecured loans to its most creditworthy large corporate borrowers.

7.3 [Obligated Group-Related Liabilities/Withdrawal. If at the time of the transfer of the Post-Lease Transferring Assets and liabilities in accordance with this Article VII, the Post-Lease Transferring Assets are among assets subject to SHARP's obligated group and master indenture liabilities, the DISTRICT shall take any and all actions necessary for it to assume all liability for such obligated-group liabilities upon such transfer [*discuss mechanics related to anticipated/required obligated group withdrawal actions*]

7.4 DISTRICT's Assumption of Liabilities Related to Contracts Among the Post-Lease Transferring Assets. The DISTRICT shall assume and satisfy all obligations under any contracts assumed by the DISTRICT that are among the Post-Lease Transferring Assets, including with respect to any unpaid amounts that accrued or became due and payable on or prior to the DISTRICT's assumption of such contracts, or any failure to perform, improper performance, breach of warranty, or other breach, default, or violation of the terms thereof occurring on or prior to the DISTRICT's assumption of such contracts, except where such liabilities, obligations or amounts are special, punitive or consequential damages or are otherwise owed as a result of SHARP Parties' or their Affiliates' fraud or intentional misrepresentation or improper acts.

7.5 Obtaining Consents. With Respect to Contracts Among the Post-Lease Transferring Assets. DISTRICT shall use commercially reasonable efforts to obtain any required third-party consents required under contracts assumed by the DISTRICT that are among the Post-Lease Transferring Assets in order to effectuate assignment of such contracts to the DISTRICT. STCMC shall use all commercially reasonable efforts to cooperate with the DISTRICT (including, without limitation, promptly responding to and forwarding communications related to such consents and communicating with DISTRICT representatives) and to help facilitate the DISTRICT obtaining such consents and facilitating such assignments. Notwithstanding the foregoing, the DISTRICT shall not be obligated to (i) pay any fee or other consideration to any third party to obtain consent with respect to such contracts, (ii) agree to any material modification of the terms of any contracts, or (iii) initiate or participate in any litigation or arbitration to obtain such consent.

ARTICLE VIII

INDEMNIFICATION

8.1 The indemnification obligations set forth in Article 12 of the Affiliation Agreement shall apply to this Agreement and hereby incorporated by reference into this Transfer Agreement.

ARTICLE IX

DISPUTE RESOLUTION

9.1 Dispute Resolution. The dispute resolution-related obligations set forth in Article 13 of the Affiliation Agreement shall apply to this Agreement are hereby incorporated by reference into this Transfer Agreement.

ARTICLE X

MISCELLANEOUS

10.1 Amendment and Modification; Waiver. This Transfer Agreement and the Schedules and exhibits hereto may only be amended, modified or supplemented by an agreement in writing signed by each Party hereto. No waiver by any Party of any of the provisions of this Transfer Agreement or the Schedules or exhibits hereto shall be effective unless explicitly set forth in writing and signed by the Party so waiving. No waiver by any Party shall operate or be construed as a waiver in respect of any failure, breach or default not expressly identified by such written waiver, whether of a similar or different character, and whether occurring before or after that waiver. No failure to exercise, or delay in exercising, any right, remedy, power or privilege arising from this Transfer Agreement shall operate or be construed as a waiver thereof; nor shall any single or partial exercise of any right, remedy, power or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege.

10.2 Attorneys' Fees. In the event that any claim or contest regarding this Transfer Agreement is brought by one Party to this Transfer Agreement against the other Party, the losing Party (as determined by the applicable judge, arbitrator or person acting as the trier-of-fact) to such claim shall pay all costs and reasonable attorneys' fees incurred by the other Party or Parties as a result of such claim or contest, together with interest on any amount recovered (other than attorneys' fees) from the date judgment is entered at the maximum rate permitted by applicable Law.

10.3 Governing Law; Waiver of Jury Trial.

10.3.1 This Transfer Agreement (including the Schedules), and any action arising or relating to this Transfer Agreement, shall be governed by and construed in accordance with the internal laws of the State of California, applicable to agreements executed and performed entirely within the State of California, without giving effect to any choice or conflict of law provision or rule (whether of the State of California or any other jurisdiction) that would cause the application of Laws of any jurisdiction other than those of the State of California.

10.3.2 EACH PARTY ACKNOWLEDGES AND AGREES THAT ANY CONTROVERSY WHICH MAY ARISE UNDER THIS TRANSFER AGREEMENT OR THE OTHER AFFILIATION AGREEMENTS IS LIKELY TO INVOLVE COMPLICATED AND DIFFICULT ISSUES AND, THEREFORE, EACH SUCH PARTY IRREVOCABLY AND UNCONDITIONALLY WAIVES ANY RIGHT IT MAY HAVE TO A TRIAL BY JURY IN RESPECT OF ANY LEGAL ACTION ARISING OUT OF OR RELATING TO THIS TRANSFER AGREEMENT, THE OTHER TRANSACTION DOCUMENTS OR THE TRANSACTION OR THEREBY. EACH PARTY TO THIS TRANSFER AGREEMENT CERTIFIES AND ACKNOWLEDGES THAT (i) NO REPRESENTATIVE OF ANY OTHER PARTY HAS REPRESENTED, EXPRESSLY OR OTHERWISE, THAT SUCH OTHER PARTY WOULD NOT SEEK TO ENFORCE THE FOREGOING WAIVER IN THE EVENT OF A LEGAL ACTION, (ii) SUCH PARTY HAS CONSIDERED THE IMPLICATIONS OF THIS WAIVER, (iii) SUCH PARTY MAKES THIS WAIVER VOLUNTARILY, AND (iv) SUCH PARTY HAS BEEN INDUCED TO ENTER INTO THIS TRANSFER AGREEMENT

BY, AMONG OTHER THINGS, THE MUTUAL WAIVERS AND CERTIFICATIONS IN THIS SECTION 10.3.

10.4 Specific Performance. Without intending to limit the remedies available to the Parties hereunder, irreparable damage would occur if any provision of this Transfer Agreement is not performed in accordance with the terms hereof, for which damages, even if available, will not be an adequate remedy. Accordingly, the Parties shall be entitled to an injunction, specific performance and other equitable relief to prevent breaches of this Transfer Agreement and to enforce specifically the terms hereof, without, in any such case, the requirement to post any bond or other undertaking, in addition to any other remedy to which they are entitled at law or in equity. Each Party agrees not to oppose the granting of such injunctive relief on the basis that monetary damages are an adequate remedy.

10.5 Counterparts. This Transfer Agreement and any amendments hereto may be executed and delivered in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Transfer Agreement delivered by facsimile, e-mail or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Transfer Agreement.

10.6 Interpretation. For purposes of this Transfer Agreement, (a) the words "include," "includes" and "including", unless otherwise specified, shall be deemed to be followed by the words "without limitation" whether or not such words are actually stated; (b) the word "or" is not exclusive; (c) the words "herein," "hereof," "hereby," "hereto", "hereunder" and derivative or similar words refer to this Transfer Agreement as a whole, including the Schedules hereto; (d) words in the singular shall be held to include the plural and vice versa, and words of one gender shall be held to include the other gender as the context requires; (e) references to "dollars" or "$" shall mean United States dollars; (f) references to "written" or "in writing" include in electronic form; (g) provisions shall apply, when appropriate, to successive events and transactions; (h) a reference to any person includes such person's successors and permitted assigns; (i) any reference to days means calendar days unless business days are expressly specified; (j) when calculating the period of time before which, within which or following which any act is to be done or step taken pursuant to this Transfer Agreement, the date that is the reference date in calculating such period shall be excluded, and if the last day of such period is not a business day, the period shall end on the next succeeding business day; and (k) all references to "close of business" on any given day shall be deemed to refer to 11:59 p.m. Pacific Time on such date. Unless the context otherwise requires, references herein: (i) to Articles, Sections, Schedules and exhibits mean the Articles and Sections of, Schedules and exhibits attached to this Transfer Agreement; (ii) to an agreement, instrument or other document means such agreement, instrument or other document as amended, supplemented and modified from time to time to the extent permitted by the provisions thereof and (iii) to a statute or regulation or statutory or regulatory provisions means such statute as amended from time to time and includes any successor legislation thereto and any regulations promulgated thereunder. This Transfer Agreement shall be construed without regard to any presumption or rule requiring construction or interpretation against the Party drafting an instrument or causing any instrument to be drafted. The Schedules and exhibits referred to herein shall be construed with, and as an integral part of, this Transfer Agreement to the same extent as if they were set forth verbatim herein.

10.7 Headings. The headings in this Transfer Agreement are for reference only and shall not affect the interpretation of this Transfer Agreement.

10.8 Severability. If any term or provision (or any portion thereof) of this Transfer Agreement, or the application of any such term or provision (or any portion thereof) to any person or circumstance, is invalid, illegal or unenforceable in any jurisdiction, such invalidity, illegality or unenforceability shall not affect any other term or provision of this Transfer Agreement or invalidate or render unenforceable such term or provision in any other jurisdiction, and this Transfer Agreement shall be reformed, construed and enforced in such jurisdiction as if such invalid, illegal or unenforceable term or provisions or any portion hereof had never been contained herein. Upon such determination that any term or other provision is invalid, illegal or unenforceable, the Parties shall negotiate in good faith to modify this Transfer Agreement so as to affect the original intent of the Parties as closely as possible in a mutually acceptable manner in order that the Affiliation be consummated as originally contemplated to the greatest extent possible.

10.9 Entire Agreement. This Transfer Agreement (including the Schedules), the Leases and Affiliation Agreement constitute the sole and entire agreement of the Parties to this Transfer Agreement with respect to the subject matter contained herein and therein, and supersede all prior and contemporaneous understandings and agreements, both written and oral, with respect to such subject matter. In the event of any inconsistency between the statements in the body of this Transfer Agreement and those in the Leases and Affiliation Agreement, the Schedules, exhibits and Disclosure Schedules (other than an exception expressly set forth as such in the Disclosure Schedules), the statements in the body of the Affiliation Agreement will control.

10.10 Successors and Assigns. This Transfer Agreement and all of the provisions hereof shall be binding upon and inure to the benefit of the Parties and their respective successors and permitted assigns. No Party may assign (directly or indirectly, whether by operation of law or otherwise) its rights, interests or obligations hereunder without the prior written consent of the other Party hereto (except that the SHARP Parties may assign this Transfer Agreement to a successor pursuant to a permissible transaction (e.g. system sale) in accordance with Section 9.3 of the Affiliation Agreement).

10.11 No Third-Party Beneficiaries. This Transfer Agreement is for the sole benefit of the Parties and its respective successors and permitted assigns and nothing herein, express or implied, is intended to or shall confer upon any other person or entity any legal or equitable right, claim, benefit or remedy of any nature whatsoever under or by reason of this Transfer Agreement.

10.12 Continued Existence of DISTRICT. DISTRICT does not intend by the transfer of assets pursuant to this Transfer Agreement to dissolve DISTRICT, de facto, or otherwise, and DISTRICT intends to maintain its existence as a local health care district organized under the Local Hospital District Law. DISTRICT shall continue to exercise all of its rights and powers under the Local Hospital District Law and does not hereby grant or delegate any such rights or powers. This Agreement does not vest in DISTRICT or any other person or entity any right to control or govern the activities or operations of the SHARP Parties.

10.13 Notices. All notices, requests, demands or other communications required or permitted to be given under this Transfer Agreement shall be in writing and shall be delivered to the Party to whom notice is to be given either (i) by personal delivery (in which case such notice shall be deemed given on the date of delivery); (ii) by reliable next business day courier services (e.g., Federal Express, UPS or other similar service) (in which case such notice shall be deemed given on the business day following the date of deposit with the courier service); (iii) by email transmission as long as a copy of the notice is also sent on the same date by another means permitted under this Section (in which case such notice shall be deemed given on the date the email is transmitted); or (iv) by United States mail, first class, postage prepaid, registered or certified, return receipt requested (in which case such notice shall be deemed given on the third (3rd) day following the date of mailing), and in each instance properly addressed as follows:

To DISTRICT: _____
_____
_____
_____

Email: _____

With a copy to: _____
Attn.: _____
_____
_____
Email: _____

To STCMC: Sharp HealthCare
President and Chief Executive Officer
8695 Spectrum Center Boulevard
San Diego, CA 92123
Email: Chris.Howard@sharp.com

With a copy to: Sharp HealthCare
Attn.: Senior Vice President and General Counsel
8695 Spectrum Center Boulevard
San Diego, CA 92123
Email: LegalDept@sharp.com

And a copy to: Paul Carr-Rollitt
Manatt, Phelps & Phillips, LLP
2049 Century Park East
Suite 1700
Los Angeles, CA 90067
Email: pcarr-rollitt@manatt.com

A Party may change its addresses for purposes of this Section by giving written notice to the other Party in any manner specified in this Section.

10.14 Costs. The Parties shall each pay their respective costs for professional and other services rendered with respect to the transactions contemplated by this Transfer Agreement.

10.15 Survival of Provisions. All of the provisions set forth in Section 4.3, Section 4.4, Section **Error! Reference source not found.**, Article VI, Article VII, Article VIII, Article IX, Article X shall remain in full force and effect after the closing of the Affiliation transaction and the consummation of the Affiliation Agreement and Section **Error! Reference source not found.**, Article VI, Article VII, Article VIII, Article IX, Article X shall survive the Closing and the termination of the Leases.

[Signature Page Follow]

IN WITNESS WHEREOF, the DISTRICT and the STCMC cause this Transfer Agreement to be executed as of the Agreement Date.

TRI-CITY MEDICAL CENTER CORPORATION

By:_____

Its: _____

TRI-CITY HEALTHCARE DISTRICT

By:_____

Its: _____

Schedule 3.1.4[1]

(a) The then outstanding balance of the HUD insured loan with Lument (HUD Insured Loan);

(b) The then outstanding balance of the loan under the California Distressed Hospital Loan Program (DHLP) (to the extent all or a portion is or will not be forgiven) (DHLP Loan);

(c) The then outstanding balance, if any, of the line of credit established by TCHD pursuant to the Credit and Security Agreement, as amended, with Mid Cap, LLC (Line of Credit); and

(d) [Description of DISTRICT Financial Statement liabilities]

1 **Note to Draft**: Formal descriptions/debt amounts to be added.

LEASE AGREEMENT

(MEDICAL OFFICES)

BETWEEN

TRI-CITY HEALTHCARE DISTRICT

AND

TRI-CITY MEDICAL CENTER CORPORATION

DATED: _____, 2026

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LEASE AGREEMENT

(Medical Office Building)
[INSERT ADDRESS]

This Lease Agreement ("Lease"), entered into as of_____ __, 2026 (the "Effective Date"), by and between TRI-CITY HEALTHCARE DISTRICT, a political subdivision of the State of California organized and existing pursuant to the Local Hospital District Law (Div. 23 of the Health & Safety Code) (the "Landlord"), and TRI-CITY MEDICAL CENTER CORPORATION, a California nonprofit public benefit corporation (the "Tenant"), is made with reference to the below facts. Each of Tenant and Landlord is referred to herein individually as a "Party" and together, as the "Parties". Initially capitalized terms not otherwise defined herein have the meaning given in the Affiliation Agreement (as defined herein).

RECITALS

A. Landlord is the owner of that certain real property more particularly described on Schedule 1.1 attached hereto, which real property is improved with [a medical office building located at _____/ a medical office condominium located at_____].

B. Tenant's sole member is Sharp HealthCare, a California nonprofit public benefit corporation ("Sharp HealthCare"). Sharp HealthCare is the parent corporation of a nonprofit multi-hospital healthcare system operating, among other healthcare-related assets, four acute-care hospitals, three specialty hospitals, three affiliated medical groups and one health services plan in and around the San Diego County, California area.

C. Landlord and Tenant have previously entered into that certain Affiliation Agreement ("Affiliation Agreement") dated as of [December 12], 2025, pursuant to which Landlord and Tenant have agreed to certain terms regarding the transfer of operations of and assets used in connection with the Hospital, including the medical office property constituting the Leased Premises (as defined herein) to Tenant in addition to such other matters as more specifically set forth therein

D. Concurrently herewith, pursuant to the Affiliation Agreement, Landlord and Tenant are entering into that certain Asset Transfer Agreement (the "Transfer Agreement") and that certain lease of certain hospital facilities located at 4002 Vista Way, Oceanside, CA 92056 and 4010 Vista Way, Oceanside, CA 92056 (the "Hospital Lease").

E. The Board of Directors of Landlord determined that it would best serve the interests of Landlord and the communities served by Landlord to lease the Leased Premises to Tenant for a term of thirty (30) years.

F. Pursuant to Health & Safety Code Section 32121 and Section 32126 and after consideration of public review and comment, Landlord has determined that execution of this

Lease will promote the following objectives:

i. Enhance the provision of high quality, efficient and affordable health care services to the communities served by Landlord and the SHARP Parties (as defined in the Affiliation Agreement);

ii. Continue the SHARP Parties' mission to provide comprehensive healthcare services that support the health and medical needs of the general public residing in the communities served by the SHARP Parties and the Landlord;

iii. Deepen the SHARP Parties', the Landlord's and TCMC's collective ability to achieve performance excellence goals and enhance each other's skills, competencies and capabilities; and

iv. Continue the Parties' respective tax-exempt and public missions to improve the health and wellbeing of their local communities.

G. The Parties acknowledge and agree that the conditions to Closing (as defined in the Affiliation Agreement) set forth in Articles 7 and 8 of the Affiliation Agreement have been satisfied or waived by the Parties including, but not limited to, receipt of all consents and approvals required in connection with this Lease.

AGREEMENT

NOW, THEREFORE, in consideration of the premises and the respective representations, warranties, covenants and agreements contained in this Lease, the Parties to this Lease hereby agree as follows:

ARTICLE 1
PREMISES AND TERM

1.1 Lease. Landlord hereby leases to Tenant, and Tenant hereby hires from Landlord, on the terms and conditions set forth in this Lease, the real property described in Schedule 1.1 attached hereto and incorporated herein by this reference, together with all buildings, appurtenances, improvements and fixtures located thereon, subject to any existing encumbrances, easements, conditions, covenants, and restrictions, rights of way, and other matters of record, matters as may be disclosed by inspection or survey, and subject to the provisions herein contained. Such property described under this Section 1.1 is referred to herein, collectively, as the "Leased Premises".

1.2 Term. Subject to any extension of the Lease pursuant to Section 15.14 hereof, the term of this Lease shall be for thirty (30) years, commencing on the Effective Date.

ARTICLE 2
RENT AND OTHER PAYMENTS

2.1 Rent. Commencing on the Effective Date, through the last day of the term, Tenant shall pay, without notice or demand, to Landlord base rent in the amount of One Dollar and 00/100 ($1.00) per each month of the term. Such base rent has been paid by Tenant in advance of the Effective Date in a single installment of Three Hundred and Sixty Dollars ($360.00) and Landlord acknowledges the receipt of such pre-payment of base rent.

2.2 Taxes and Assessments. Tenant shall timely pay all real and personal property taxes, general and special assessments, and other charges of every description levied on or assessed against the Leased Premises, improvements or personal property located on or in the Leased Premises, the leasehold estate or any subleasehold estate, to the full extent of installments falling due during the term of this Lease, whether belonging to or chargeable against Landlord or Tenant. During the term Tenant agrees that it will also separately timely pay any municipal, county, state, or federal income or franchise taxes chargeable against Tenant (as opposed to the Leased Premises). The foregoing shall not relieve any third party from any liability it may have for the payment of taxes relating to any part of the Leased Premises, such as any real property taxes levied or assessed against or attributable to a Sublease (as defined below) of any portion of the Leased Premises, nor shall Landlord be relieved from liability of payment of the same pursuant to any Sublease of the Leased Premises in which Landlord is subtenant thereunder. Notwithstanding the foregoing or anything to the contrary herein, Landlord acknowledges that Tenant intends to apply for and seek an exemption from the payment of real property taxes for the Leased Premises pursuant to Section 214 of the California Revenue and Taxation Code and Landlord shall use commercially reasonable efforts to cooperate with Tenant in connection with the same. It is the Parties' intention that this Lease should not create a possessory interest in the Leased Premises that shall be subject to real property taxation.

2.3 Right to Contest Taxes. Tenant may contest the legal validity or amount of any taxes, assessments, or charges for which Tenant is responsible under this Lease, and may institute such proceedings as Tenant considers necessary in connection with such contest. If Tenant contests any such tax, assessment, or charge, Tenant may withhold or defer payment of the same or pay the same under protest and such act shall not constitute a default under this Lease, provided that Tenant indemnifies and holds Landlord harmless from any damages arising out of the proceedings or contest in accordance with Section 15.3 hereof. Landlord appoints Tenant as Landlord's attorney-in-fact for the purpose of making all payments to any taxing authorities and for the purpose of contesting any taxes, assessments, or charges and shall cooperate with Tenant in connection therewith at all times that no Event of Default of Tenant beyond any applicable cure period exists hereunder. In the event Tenant contests the existence, amount of, or validity of such payment in accordance with Section 2.3 and Tenant is unsuccessful in its pursuit of the same, Tenant shall be solely responsible for any late penalties and fees associated with the same.

2.4 Landlord's Right to Pay Taxes. In the event an Event of Default remains uncured after applicable notice and cure periods, Landlord shall have the right, but not the obligation, to pay any real property taxes or assessments levied on the Leased Premises, provided that Landlord reasonably believes that failure to pay such taxes would create a substantial risk that all

or any part of the Leased Premises would be taken or sold by the taxing authority. Prior to payment of such taxes Landlord shall provide Tenant written notice of Landlord's intent to pay such amount, which notice will describe in reasonable detail the tax and the amount Landlord intends to pay and provide Tenant a reasonable period (no less than thirty (30) days) to pay or contest the same before Landlord makes such payment. If Landlord pays any taxes pursuant to this Section, Tenant shall reimburse Landlord for the amount of taxes so paid and any penalties or costs associated with such payment to the extent (a) Tenant does not contest the validity of such payment or (b) if Tenant does contest the validity of such payment, that the final and unappealable judgment of a trier of fact determines the contested taxes were properly assessed.

2.5 Utilities. Tenant shall, during the term of this Lease, or any renewal or extension thereof, pay, or cause to be paid, directly to the utility company or applicable governmental agency for all utilities used upon the Leased Premises, including without limitation, water, gas, heat, light, power, telephone and/or telecommunications or internet service, refuse collection and removal, and all other services supplied to the Leased Premises.

ARTICLE 3
USE, MAINTENANCE AND IMPROVEMENTS

3.1 Limitations on Use. During the term of this Lease, the Leased Premises are leased to Tenant for the purpose of Tenant operating and maintaining the Leased Premises as medical offices, which may include inpatient and outpatient health care services (including, without limiting the generality of the foregoing, rehabilitation, skilled nursing, subacute, psychiatric, primary care, home health, hospice, substance abuse, chemical dependency, or other specialty services, diagnostic centers, outpatient service centers, clinics, gymnasium, ambulatory surgery centers and all management, ancillary and administrative services associated therewith or with managed care providers of such services) (collectively, the "Permitted Use"), and for no other uses. Without limiting the foregoing, Tenant shall at all times operate and maintain the Leased Premises in accordance with the terms and conditions of the Affiliation Agreement and for the benefit of the communities served by the Landlord.

3.2 Compliance with Laws; Covenants, Conditions and Restrictions.

3.2.1 Tenant shall use the Leased Premises in material compliance with all applicable Laws. Tenant shall use the Leased Premises in compliance with all CC&Rs (defined below) existing as of the Effective Date and all amendments to any CC&Rs and all new encumbrances first entered into and recorded against the Leased Premises after the Effective Date and consented to by Tenant in accordance with this Section 3.2, and any MSP (as defined herein) applicable to the Leased Premises. In no event shall Landlord cause to be recorded or permit any third party (other than Tenant) to record against the Leased Premises any (i) lien, deed of trust, encumbrance, easement, covenant, condition and/or restriction (collectively "CC&Rs") nor (ii) amendment, termination or rescission to any CC&Rs without first obtaining the prior written consent of Tenant thereto, which consent shall not be unreasonably withheld, conditioned or delayed, provided, in the event any of the foregoing would diminish Tenant's rights or increase Tenant's obligations under this Lease or adversely affect any subtenant of Tenant in the Leased Premises, or would conflict with any Tenant financing, Tenant may withhold its consent to the same in Tenant's sole and absolute discretion; provided, however, in

no event shall Tenant have the right to lien the fee estate without Landlord's prior written consent, which may be withheld in Landlord's sole discretion.

3.2.2 Landlord shall perform all obligations of Landlord under any CC&Rs (to the extent not assumed by Tenant hereunder or under the Affiliation Agreement), provided if such CCR's contain any provision requiring payment of assessments levied against the Leased Premises, Tenant shall pay such assessments. Landlord hereby assigns to Tenant, to the extent permitted in any CC&R's, Landlord's voting rights under any applicable CCR's. If such rights are not assignable, Landlord shall vote as directed by Tenant, so long as voting as directed will not cause Landlord to incur liability to any third party and Tenant's voting selection is provided to Landlord at least two (2) business days prior to the vote.

3.2.3 Tenant, at its sole cost and expense, shall have the right to contest the applicability, validity, interpretation, construction or noncompliance of or with any applicable Laws or CC&R now or hereafter in force and relating to Tenant or the Leased Premises, and in the event Tenant elects to exercise such right, Tenant shall diligently and expeditiously prosecute the appropriate proceeding, contest, or appeal. Landlord shall not be required to join in any proceeding or contest brought by Tenant unless the provisions of any Law or such CCR's require that the proceeding, contest, or appeal be brought by or in the name of Landlord or any owner of the Leased Premises. In that case, Landlord shall have the right, but not the obligation, to join in the proceeding, contest, or appeal or to permit the same to be brought in Landlord's name as long as Landlord is not required to bear any cost or expense. If Tenant, within a reasonable time after any such final, non-appealable determination of the proceeding, contest, or appeal, as applicable, complies with the final, non-appealable determination resulting therefrom, the noncompliance of Tenant during the interim period shall not be deemed a default under this Lease.

3.3 Waste; Quiet Enjoyment. Tenant shall not commit or suffer to be committed any waste upon the Leased Premises. Landlord covenants and agrees that Tenant shall peacefully hold and enjoy the Leased Premises during the term hereof or any extension or renewal hereof, without interference or hindrance from Landlord or any person or persons holding or claiming under Landlord in any manner whatsoever. Landlord shall not exercise its power of eminent domain, to the extent any such power exists under this Lease and/or applicable Laws, in any manner which would interfere with Tenant's operation of the Leased Premises.

3.4 Maintenance and Operation of Leased Premises. Tenant shall, at its sole cost and expense, operate and maintain the Leased Premises (including, but not limited to, all engines, boilers, pumps, machinery, apparatus, fixtures, fittings, and equipment of any kind in or that shall be placed in any building or structure now or hereafter at any time constituting part of the Leased Premises) in the same condition and repair as of the Effective Date in accordance with applicable Laws (and the CCRs, if applicable), and in a manner consistent with any approved MSP pursuant to the Hospital Lease that is applicable to the Leased Premises and otherwise at no less than the level of similar medical office facilities owned by Sharp HealthCare or other similar owners of medical office facilities affiliated similar to the size, geographic region of the Leased Premises and in a similar community setting (the "Operating Standard"). Landlord shall not have any responsibility to maintain the Leased Premises or replace any fixture, equipment or other improvement located on the Leased Premises. Tenant hereby waives all right to make repairs at the expense of Landlord and to deduct the cost thereof from any payments due to Landlord under

this Lease. All rights under California Civil Code Sections 1932(1), 1941, and 1942 or any law in replacement thereof, are hereby waived and released.

3.5 Alterations, Additions, and Improvements. Tenant may make any alterations, additions, or improvements to the Leased Premises without the consent of Landlord provided that (i) alterations, additions, or improvements are made in compliance with all applicable Laws, and (ii) the same are consistent with the Permitted Use, the Operating Standard, and any applicable MSP. Landlord shall, at Tenant's sole cost and expense, reasonably cooperate with Tenant in connection with Tenant's (or any of Tenant's subtenants') performance any such alterations, addition and/or improvements, including, without limitation, in the preparation and submission of any documents, permit applications and/or entitlements, the execution and recordation of any easements and development agreements relating to the same. Title to all alterations, additions or improvements to the Leased Premises which are not owned by any subtenant of Tenant pursuant to any Sublease shall revert automatically to Landlord upon termination of this Lease in accordance with the Transfer Agreement.

ARTICLE 4
INSURANCE

4.1 Insurance Required. During the term of this Lease, Tenant shall, at Tenant's sole cost and expense, procure and maintain at all times in force and in effect, the following types of insurance:

4.1.1 Insurance against loss or damage by fire, lightning, vandalism, malicious mischief, and all other risks covered by an "all risk" insurance agreement then in use in the State of California, covering the Leased Premises in an amount equal to the "full replacement value" of the Leased Premises. As used in this Lease, the term "full replacement value" is the cost of replacing all improvements included in the Leased Premises with improvements of substantially like kind, quality, and capacity without deduction for depreciation, which shall be reviewed by Tenant at least every five (5) years and within a reasonable time following any major capital improvements or additions made by Tenant to the Leased Premises.

4.1.2 Boiler and machinery insurance providing coverage on pressure vessels, auxiliary piping, pumps and compressors, refrigeration systems, HVAC systems, transformers, and miscellaneous electrical apparatus constituting part of the Leased Premises in reasonable and customary amounts, as determined by Tenant in its sole, but good faith discretion.

4.1.3 Comprehensive general liability insurance, including automobile liability, in reasonable and customary amounts as determined by Tenant in its sole, but good faith discretion, for death, injury, or damage to property.

4.1.4 If Tenant shall provide any medical services at the Leased Premises, or during any time the Leased Premises shall be leased by the same entity that is the tenant under the Hospital Lease, professional liability and malpractice insurance in reasonable and customary amounts as determined by Tenant in its sole, but good faith discretion.

4.1.5 All employees' compensation insurance on Lessee's employees required by worker's compensation laws and regulations of the State of California.

4.1.6 Such other insurance as Tenant determines in its sole, but good faith discretion, is customarily procured and maintained in connection with the lease and operation of medical office buildings and/or offices and related facilities of similar size, geographic location and character to the Leased Premises.

4.2 Insurance Review. If pursuant to the Hospital Lease Landlord's Board of Directors requires that the insurance coverage of the tenant under the Hospital Lease be reviewed by an independent insurance consultant, such review may include a review of the insurance required by Tenant under this Lease and Tenant shall follow any recommendations of such consultant if the recommendations are commercially reasonable and consistent with the Operating Standard. Nothing contained herein shall be construed to require any review of any insurance held by any subtenant of Tenant nor to require any subtenant of Tenant in the Leased Premises to change or adjust any insurance held by such subtenant.

4.3 Alternative Insurance Plans. In lieu of maintaining the insurance coverage required by Section 4.1, Tenant shall have the right to adopt such alternative risk management programs as Tenant's Board of Directors determines to be reasonable and which shall not have a material adverse effect on reimbursement from third party payors (an "Alternative Insurance Plan"), including, without limitation, to self-insure in whole or in part individually or in connection with other institutions, to participate in programs of captive insurance, to participate with other health care institutions in mutual or other cooperative insurance or risk management programs, to participate in state or federal insurance programs, to take advantage of state or federal laws now or hereafter in existence limiting medical malpractice liability, or to establish or participate in other alternative risk management programs. In the event Tenant elects to participate in such Alternative Insurance Plan, Tenant shall provide written notice thereof to Landlord and, upon the written request of Landlord's Board of Directors (but no more than once per calendar year unless an Event of Default exists under this Lease beyond all applicable notice and cure periods), Tenant shall have such Alternative Insurance Plan reviewed by an independent actuary who will provide a copy of such report thereof to the Landlord. Any Alternative Insurance Plan will provide for actuarially sound reserves. In the event the Tenant shall terminate such Alternative Insurance Plan and obtain commercial insurance in lieu of the same, such policy and/or policies shall thereafter be maintained in accordance with the terms of this Lease.

4.4 Insurers; Policy Forms and Loss Payees. Each insurance policy required to be maintained by Tenant hereunder (excluding any Alternative Insurance Plan) shall be carried by stock, reciprocal, or mutual insurance companies that are financially responsible and capable of fulfilling the requirements of such policies. All such policies (except liability policies) shall name the Landlord and the Tenant as insured parties, beneficiaries, or loss payees as their interests may appear. Landlord and its Board of Directors shall be named as additional insureds on all liability insurance policies. Each policy shall be in such form and contain such provisions as are generally considered standard for the type of insurance involved and shall contain a provision to the effect that the insurer shall not cancel or substantially modify the policy provision without first giving at least thirty (30) days' written notice thereof to the Landlord and to the Tenant. In lieu of separate policies, Tenant may maintain blanket policies that cover any one or more risks required to be insured against so long as the minimum coverages required herein, if any, are met. Tenant shall file annually with the Landlord a certificate of insurance for

each such policy, or in lieu of such certificate, a certificate signed by an officer of Tenant setting forth the policies of insurance maintained pursuant to this Lease, the names of the insurers and insured parties, the amounts of such insurance and applicable deductibles, the risks covered thereby, and the expiration dates thereof.

4.5 Disposition of Insurance Proceeds. The proceeds of any insurance required to be maintained under this Article 4 shall be made available to Tenant for payment of costs and expenses of repair (including any amounts payable by Tenant to any subtenant for or in connection with such repair). Any unused portion of any insurance proceeds over the amount required to complete any repair required under this Lease and/or cover any costs shall be retained by Tenant. Each of the Parties hereto agrees to sign any and all documents reasonably approved by the non-requesting Party and reasonably required by the other Party or the insurance company or companies that may be necessary for use in connection with the settlement of any loss under the appropriate insurance policies, provided that such documents are factually accurate and in no manner prejudicial to the interest of such Party.

4.6 Waiver of Subrogation. Landlord and Tenant hereby release and relieve one another, and waive their entire right of recovery against the other, for loss or damage arising out of or incident to the perils insured against under this Article 4 which perils occur in, on, or about the Leased Premises to the extent insurance coverage is actually maintained or required to be maintained under this Lease by such waiving Party. Prior to obtaining any policies of insurance, Landlord and Tenant shall give notice to the insurance carrier or carriers that the foregoing mutual waiver of subrogation is contained in this Lease and each insurer issuing such insurance shall expressly acknowledge and consent to the foregoing waiver and shall expressly waive any right of subrogation on the part of the insurer against Landlord or Tenant, as the case may be, in accordance with the terms hereof.

ARTICLE 5
ACCEPTANCE AND SURRENDER OF LEASED PREMISES

5.1 Acceptance of Premises. On the Effective Date, Tenant accepts the Leased Premises in "as-is" condition.

5.2 Termination of Lease. This Lease shall automatically and immediately terminate upon the expiration or the termination of the Hospital Lease for any reason.

5.3 Surrender of Premises; Transfer of Assets. On the last day of the term or sooner termination of this Lease, Tenant shall surrender to Landlord the Leased Premises (including all fixtures and alterations made thereto) in its then "as-is" condition; provided, however, the foregoing surrender condition does not absolve Tenant of any maintenance and repair obligations set forth in this Lease with respect to the Leased Premises. Landlord shall not be liable for any payment for any capital improvements or repairs made by Tenant to the Leased Premises except as otherwise provided in the Transfer Agreement. As further described in the Transfer Agreement, five (5) years prior to the expiration of the term of this Lease (or any earlier date requested by either Party), the Parties shall meet and confer to discuss the potential acquisition of the Leased Premises by Tenant, renewal and/or extension of the term of this Lease, or any other

alternative arrangements that may be available under applicable Laws which would provide for Tenant's continued operation and occupation of the Leased Premises.

5.4 Survival. This Article 5 shall survive the expiration or earlier termination of this Lease.

ARTICLE 6
DESTRUCTION DURING TERM OF LEASE

6.1 Restoration of Leased Premises. If during the term of this Lease, the Leased Premises shall be partially or totally destroyed, whether or not from a risk covered by insurance, Tenant shall promptly and expeditiously make the repairs necessary to restore the Leased Premises to a condition for occupancy or use comparable to the condition thereof before such destruction (the "Restoration Work"); provided, however, if such Restoration Work requires substantial repairs to the Leased Premises which costs in excess of a commercially reasonable amount (after considering all insurance proceeds to be received or would be received if such insurance was carried by Tenant under this Lease) in Tenant's reasonable discretion, then Tenant may elect, by delivery of written notice to Landlord within ninety (90) days following such destruction, to terminate this Lease. Tenant's failure to deliver such termination notice within the aforementioned ninety (90)-day period shall be deemed Tenant's election not to terminate this Lease pursuant to this Section 6.1. If Tenant elects (or is deemed to have elected) not to terminate this Lease pursuant to the preceding sentence this Lease shall not terminate, and Tenant shall promptly and expeditiously perform such Restoration Work pursuant to plans and specifications prepared by Tenant and reasonably approved by Landlord. Notwithstanding the foregoing, if Tenant elects to terminate this Lease, Tenant shall assign to Landlord (or to any party designated by Landlord) any Subleases for the Leased Premises (to the extent the same have not been terminated) and all insurance proceeds payable to Tenant under Article 4 of this Lease and thereafter neither Landlord nor Tenant shall have any further liability hereunder, excluding those provisions which are expressly intended to survive the termination or expiration of this Lease. All Restoration Work made to the Leased Premises by Tenant pursuant to this Section 6.1 shall be deemed a part of the Leased Premises and shall, at the end of the term, belong solely to Landlord, and Tenant shall not have any right to reimbursement or refund from Landlord for such Restoration Work upon the termination or expiration of this Lease except as provided in the Transfer Agreement. Notwithstanding anything to the contrary herein, subject to Tenant's obligations under Section 3.2 hereof, the Restoration Work required of Tenant hereunder shall not be deemed to include any alterations, additions and/or improvements to the Leased Premises made solely at the election of Tenant or any subtenant of Tenant during the term of this Lease.

6.2 No Abatement of Payments; Insurance Proceeds. Tenant shall not be entitled to any abatement or reduction in rent due under this Lease while such repairs are being made. If the Leased Premises are to be repaired in accordance with this Lease, Tenant hereby waives the provisions contained in California Civil Code Sections 1932(2) and 1933(4) or any laws replacing or modifying such provisions. Except as set forth above in Section 6.1, Tenant shall be entitled to all insurance proceeds payable pursuant to any coverage maintained by Tenant (including Tenant's business interruption coverage). Each of the Parties hereto shall sign any and all commercially reasonable documents reasonably required by the other Party or the insurance

company or companies that may be necessary for use in connection with the settlement of any loss under the appropriate insurance policies, provided that such documents are factually accurate and in no manner prejudicial to the interest of such Party.

6.3 End of Term. Notwithstanding anything to the contrary herein, Tenant shall have the right to terminate this Lease if, during the last two (2) years of the term, the Leased Premises is partially or totally destroyed, whether or not from a risk covered by insurance and whether or not the Restoration Work is commercially feasible, by delivering written notice of such election to Landlord, whereupon neither Landlord nor Tenant shall have any further liability hereunder, excluding those provisions which are expressly intended to survive the termination or expiration of this Lease.

ARTICLE 7
CONDEMNATION

7.1 Taking. In the event that the Leased Premises or any portion thereof are taken by eminent domain, or by inverse condemnation, or for any public or quasi-public use under any statute, the rights of the Parties with respect to term, the rent and the award shall be as the Parties then agree to be just and equitable under all the circumstances, regardless of any technical rule of law, considering the rights of any subtenants, any leasehold, fee, or mortgage, the economics of operating any remaining portion of the Leased Premises and improvements, the cost of restoration, and the balance of the term remaining, among other relevant considerations. If Landlord and Tenant do not agree within sixty (60) days after the amount of the award is finally determined, the undecided questions shall be decided pursuant to Section 15.9 of this Lease. The foregoing notwithstanding, the disposition of any such award shall be governed by the provisions of any indenture, loan agreement, deed of trust, or similar document relating to any obligation of Tenant outstanding as of the date of the receipt of such award. Upon service on either Party hereto of any legal process in connection with any condemnation proceedings, the Party so served shall promptly give notice thereof to the other Party hereto. This Section 7.1 shall survive the expiration or earlier termination of this Lease.

ARTICLE 8
DEFAULT

8.1 Tenant Events of Default. Each of the following events (each, an "Event of Default") shall be a default by Tenant and a breach of this Lease if not cured within the period set forth in Section 8.3 hereof:

8.1.1 Abandonment, vacation, or surrender of the Leased Premises or of the leasehold estate by Tenant prior to the expiration or earlier termination of this Lease;

8.1.2 Tenant's failure or refusal to pay when due any amounts due or payable under this Lease to be paid by Tenant;

8.1.3 Tenant's failure to perform or observe any other covenant or condition of this Lease to be performed or observed by Tenant.

8.1.4 The subjection of any right or interest of Tenant to attachment, execution, or other levy, or to seizure under legal process, if not released (by bond or otherwise) within thirty (30) days.

8.1.5 The appointment of a receiver to take possession of the Leased Premises or improvements, or of Tenant's interest in the leasehold estate, or of Tenant's operations on the Leased Premises for any reason.

8.1.6 Tenant shall commence a voluntary case or other proceeding under the laws of any jurisdiction seeking liquidation, reorganization, or other relief with respect to itself or its debts under any bankruptcy, insolvency, or other similar law, or seeking the appointment of a trustee, self-trusteeship, receiver, custodian, or other similar official of it or any substantial part of its property; or shall consent to any such relief or to the appointment of, or taking possession by any such official in an involuntary case or other proceeding commenced against it; or shall make an assignment for the benefit of creditors.

8.1.7 An involuntary case or other proceeding shall be commenced under the laws of any jurisdiction against Tenant seeking liquidation, reorganization, or other relief with respect to it or its debts under any bankruptcy, insolvency, or other similar law now or hereafter in effect, or seeking the appointment of a trustee, receiver, custodian, or other similar official of it or any substantial part of its property, and such involuntary case or other proceeding shall remain undismissed and unstayed for a period of thirty (30) days or a trustee, receiver, custodian or other official shall be appointed in such involuntary case.

8.1.8 So long as the provisions of Sections 8.1.4, 8.1.5 and 8.1.6 authorizing termination of the Lease upon bankruptcy of Tenant are unenforceable under bankruptcy law, then the following provisions shall apply:

(a) In the event that Tenant files a petition for relief under any chapter of the Bankruptcy Code, and Tenant's trustee or Tenant, as debtor-in-possession, has failed to perform all of Tenant's obligations under this Lease within the time periods required for such performance, no election by Tenant's trustee or Tenant, as debtor-in-possession, to assume this Lease shall be effective unless each of the following conditions has been satisfied:

(1) Tenant's trustee or Tenant, as debtor-in-possession, has cured all defaults under this Lease, or has provided Landlord with adequate assurance (as defined below) that it will cure all Events of Default susceptible of being cured by the payment of money within sixty (60) days from the date of such assumption and that it will cure all other defaults under this Lease which are susceptible of being cured by the performance of any act promptly after the date of such assumption.

(2) Tenant's trustee or Tenant, as debtor-in-possession, has compensated, or has provided Landlord with adequate assurance that within sixty (60) days from the date of such assumption it will compensate, Landlord, or provide adequate assurance that Landlord will be compensated, for any actual pecuniary loss payable to Landlord in accordance with the provisions of this Lease and incurred by Landlord arising from the Event of Default of Tenant, Tenant's trustee, or Tenant, as debtor-in-possession, as debtor-in-possession.

(3) Tenant's trustee or Tenant, as debtor-in-possession, has provided Landlord with adequate assurance of the future performance of each of the obligations under this Lease of Tenant, Tenant's trustee or Tenant, as debtor-in-possession, and, if Tenant's trustee or Tenant, as debtor-in-possession, has provided such assurance, Tenant's trustee or Tenant, as debtor-in-possession, to the reasonable determination of Landlord that all the terms and provisions of this Lease shall have been complied with. The obligations imposed upon Tenant's trustee or Tenant, as debtor-in-possession, by this paragraph shall continue with respect to Tenant or any assignee of this Lease after the completion of bankruptcy proceedings.

(b) In the event that this Lease is assumed and not assigned in accordance with Section 8.1.8(a), and thereafter Tenant files a subsequent petition for reorganization or adjustment of debts under Chapter 11 or such other applicable section of the Bankruptcy Code, Landlord may, at its option, terminate this Lease and all rights of Tenant hereunder by giving Tenant notice of its election to so terminate within thirty (30) days after the occurrence of either of such events.

(c) If Tenant's trustee or Tenant, as debtor-in-possession, has assumed this Lease pursuant to the terms and provisions of Section 8.1.8(a) for the purpose of assigning (or elects to assign) this Lease, this Lease may be so assigned only if the proposed assignee has provided adequate assurance of future performance of all of the terms, covenants, and conditions of this Lease and of any agreements collateral to this Lease to be performed by Tenant. Landlord shall be entitled to receive all cash proceeds of such assignment to the extent of amounts due or payable by Tenant to Landlord hereunder. As used herein "adequate" assurance of future performance" shall mean that no less than that each of the following conditions has been satisfied:

(1) The proposed assignee has furnished Landlord with either (i) a current financial statement audited by a Certified Public Accountant indicating a net worth and working capital in amounts which Landlord reasonably determines to be sufficient to assure the future performance by such assignee of Tenant's obligations under this Lease or (ii) a guaranty or guaranties, in form and substance satisfactory to Landlord, from one or more persons with a net worth equal to or in excess of One Hundred Million Dollars ($100,000,000) ("Initial Net Worth Amount"), which amount is not more than the net worth of Tenant as of the Effective Date. The minimum net worth amount described in the preceding sentence shall be subject to adjustment at the commencement of the second year of the term of this Lease and each year thereafter (the "Adjustment Date") as follows:

The base for computing the adjustment is the Consumer Price Index (all items) for the San Diego-Chula Vista-Carlsbad Area, published by the United States Department of Labor, Bureau of Labor Statistics ("Index"), which is in effect on the date of the commencement of the term ("Beginning Index"). The Index published most immediately preceding the adjustment date in question ("Extension Index") is to be used in determining the amount of the adjustment. If the Extension Index is increased over the Beginning Index, the minimum net worth amount for the following year until the next net worth adjustment shall be determined by multiplying the minimum net worth amount set forth above by a fraction, the numerator of which is the Extension Index and the denominator of which is the Beginning Index. In no case shall the minimum net worth amount be less than the Initial Net Worth Amount. If the Index is changed

so that the base year differs from that in effect when the term commences, the Index shall be converted in accordance with the conversion factor published by the United States Department of Labor, Bureau of Labor Statistics. If the Index is discontinued or revised during the term, such other government index or computation with which it is replaced shall be used in order to obtain substantially the same economic effect as intended by the Parties.

(2) Landlord has obtained all consents or waivers from others required under any loan agreement, bond indenture, and financial arrangement or other agreement by which Landlord is bound in order to permit Landlord to consent to such assignment.

(3) The proposed assignment shall not release or impair any guaranty of the obligations of Tenant (including the proposed assignee) under this Lease.

(4) In the opinion of nationally recognized bond counsel, the proposed assignment shall not adversely affect the tax-exempt status of any bonds issued by or for the benefit of Landlord or Tenant or for the benefit of any obligated group of which Tenant is a member (if any).

8.1.9 It is understood and agreed that all covenants and agreements of Tenant contained in this Lease are conditions and Tenant's failure to observe or perform any of the same shall constitute a default by Tenant. If any such default by Tenant continues uncured following notice of default as required by this Lease for the applicable period set forth in Section 8.3, Landlord may, at any time thereafter, elect to terminate this Lease.

8.1.10 Tenant's material default in the performance or observance of any of the terms and provisions of the Transfer Agreement or Tenant's or Sharp HealthCare's material default in the performance or observance of any of the terms and provisions of the other Affiliation Agreements shall constitute a default under the terms of this Lease. If any such default by Tenant or Sharp HealthCare under the Affiliation Agreements continues uncured following notice of default as required by this Lease for the applicable period set forth in Section 8.3, Landlord may, at any time thereafter until such default is cured, elect to terminate this Lease.

8.1.11 [A Change of Control of Sharp Healthcare, other than to a Qualified Health System, in accordance with Section 9.3.2.3 or Section 9.3.2.4 of the Affiliation Agreement. For purposes of this Section 8.1.11, a "Change of Control" shall mean and include (a) a transfer or assignment of all or a substantial portion of Sharp Healthcare's assets or businesses to any person or entity, (b)(i) a transfer of a majority of the membership interests in Sharp Healthcare to any person or entity, (ii) the issuance of any new controlling membership interest in Sharp Healthcare, or (iii) the amendment of Sharp Healthcare's articles of incorporation or bylaws, as amended from time to time, in a manner that effectuates the transfer or issuance of membership interests in Sharp Healthcare to any other person or entity; (c) a grant to any person or entity the right to appoint a majority of the directors serving on Sharp Healthcare's board of directors; or (d) entering into any management agreement, joint operating agreement, or any similar agreement or arrangement to provide any person or entity the right to operate or manage all or a substantial portion of Sharp Healthcare or its assets or businesses.]

8.2 Notice and Right to Cure. As a condition to pursuing any remedy for an alleged default of Tenant, Landlord shall first deliver written notice of such default to Tenant, Sharp HealthCare and to any trustee under any indenture, provided any such trustee has given Landlord written notice of its desire to receive any notices of default. Each notice of default shall specify in detail the alleged Event of Default.

8.3 Tenant's Right to Cure. If the alleged default is nonpayment of taxes or other sums to be paid by Tenant as provided in Article 2 or elsewhere in this Lease, Tenant shall have thirty (30) days after notice is given to cure the default. For the cure of any other default, Tenant shall promptly and diligently after notice commence curing the default and shall have a reasonable period of time, in light of the circumstances, to complete the cure. Any trustee entitled to receive a notice of default pursuant to Section 8.2 shall be entitled, directly or through a third party appointed by such trustee, to cure any Event of Default hereunder, and Landlord shall accept such performance as if made by Tenant, provided such cure is completed within the time period specified in this Section 8.3.

8.4 Remedies. If any Event of Default by Tenant hereunder continues uncured following notice of default as required by this Lease for the period applicable to the default under Section 8.3 above, Landlord has the following remedies, in addition to the rights and remedies provided by law or equity, all of which Landlord may resort cumulatively or in the alternative, except as otherwise stated below:

8.4.1 (a) Landlord may at its election terminate this Lease by giving Tenant notice of termination. On the giving of notice, all Tenant's rights in the Leased Premises and improvements shall terminate. Promptly after notice of termination, Tenant shall assign to Landlord, without warranty or indemnity, any Sublease of the Leased Premises and surrender and vacate the Leased Premises and all improvements as provided in the Transfer Agreement.

(b) Termination under this subsection 8.4.1 shall not relieve Tenant from the obligation to pay any other sums then due to Landlord or from any claim for damages by Landlord previously accrued or thereafter accruing against Tenant. The election of the remedy provided in this subsection 8.4.1 shall prohibit Landlord from exercising any of its other rights or remedies under this Section 8.4.

(c) The right of termination contained in this Section 8.4.1. may be exercised only if prior to the termination becoming effective, Landlord shall have assumed in writing all of Tenant's liabilities pursuant to the Transfer Agreement and otherwise complied with all obligations of Landlord under the Transfer Agreement.

(d) If required by applicable Law, Landlord shall use reasonable efforts to mitigate any damages incurred by Landlord as a result of Tenant's default hereunder. In determining the amount of loss which Landlord suffers by reason of termination of this Lease, allowance shall be made for the expense of repossession and any necessary repairs, but not for any remodeling undertaken by Landlord following repossession nor any brokerage commissions or fees paid for releasing the Leased Premises.

8.5 Landlord's Right to Cure Default. In the event Tenant shall fail to pay and discharge or cause to be paid and discharged, when due and payable, any tax, assessment, or other charge upon or in connection with the Leased Premises, or any lien or claim for labor or material employed or used in, or any claim for damage arising out of, the construction, the repair, or restoration, replacement, and maintenance, and use of the Leased Premises, or any judgment on any contested lien or claim thereof, or any insurance premium or expense in connection with the Leased Premises, or any claim, charge or demand which Tenant has agreed to pay or cause to be paid under the covenants and conditions of this Lease, and if Tenant, after written notice from Landlord so to do as set forth in Section 8.3 shall fail to pay and discharge the same, then Landlord may, at its option, pay any such tax, assessment, insurance expenses, lien, claim, charge, or demand, or settle or discharge any action therefor, or judgment thereon. All costs, expenses, or other sums incurred or paid by Landlord in connection with any of the foregoing shall be paid by Tenant to Landlord together with interest thereon equal to the Prime Rate. Any default in such payment shall constitute a breach of the covenants and conditions of this Lease. All amounts owing by Tenant hereunder shall constitute additional rent. As used herein, "Prime Rate" shall mean the highest prime rate (or base rate) reported in the "Money Rates" column or section of The Wall Street Journal published on the second business day of each month as having been the rate in effect for corporate loans at large United States money center commercial banks (whether or not such rate has actually been charged by any such bank) as of the first business day of such month for which such rate is published. The Prime Rate shall be adjusted monthly and shall be effective for the entire calendar month. If The Wall Street Journal ceases publication of the Prime Rate, the "Prime Rate" shall mean the prime rate (or base rate) announced by JPMorgan Chase & Co., New York, New York or its successors (whether or not such rate has actually been charged by such bank). If such bank discontinues the practice of announcing the Prime Rate, the "Prime Rate" shall mean the highest rate charged by such bank on short term, unsecured loans to its most creditworthy large corporate borrowers.

8.6 Landlord Default.

8.6.1 The following shall be a default of Landlord hereunder ("Landlord Default"):

(a) Landlord's breach of any representation or default in the performance of any covenant, provision, warranty, condition or agreement herein if the same is not cured (a) in the case of any failure by Landlord to pay any sum required to be paid to Tenant hereunder or to any third party, within thirty (30) days after notice thereof from Tenant, or (b) in the case of any breach of any other default, such period expressly specified elsewhere in this Lease for a particular Landlord default, or where not specified, (i) within thirty (30) days after receipt by Landlord of written notice thereof from Tenant, or (ii) if the default of Landlord is of a type which is not reasonably possible to cure within thirty (30) days, then provided Landlord has commenced to cure said default within said thirty (30) day period and thereafter diligently prosecutes the curing of said default to completion, a reasonable period for such cure;

(b) For a period of five (5) years after the Effective Date, Tenant, as a result of a material violation of applicable Laws or contractual obligation arising from any acts or omissions of the Landlord or its directors, officers, employees or agents prior to the Effective Date which (i) is in connection with the Leased Premises and (ii) incurs Losses exceeding One

Hundred Million Dollars ($100,000,000) in the aggregate, but excluding any Losses related to matters disclosed in the Disclosure Schedules delivered by the Landlord (as modified by any pre-Closing disclosures in accordance with Section 7.4 of the Affiliation Agreement);

(c) Fraud or intentional misrepresentation by Landlord's Chief Executive Officer, Chief Operation Officer or Chief Financial Officer as of or prior to the Effective Date related to any of the representations or warranties of Landlord in Article 5 of the Affiliation Agreement (as modified by any pre-Closing disclosures in accordance with Section 7.4 of the Affiliation Agreement) to the extent such representation or warranty (i) is related to the Leased Premises and (ii) results in Losses to Tenant exceeding Fifty Million Dollars ($50,000,000) in the aggregate; or

(d) Landlord's default after the expiration of any applicable cure periods under the Hospital Lease.

8.6.2 Remedies. Following any Landlord Default, Tenant has the following remedies, in addition to the rights and remedies provided in the Affiliation Agreements or by law or equity, all of which Tenant may resort cumulatively or in the alternative, except as otherwise stated below:

(a) Tenant may (i) pay or perform any obligations of Landlord under this Agreement or (ii) seek injunctive relief and/or specific performance of any obligations of Landlord under this Agreement. In the event Tenant elects to cure Landlord's default pursuant to clause (i) above, Landlord shall pay to Tenant all amounts expended in the pursuit of such cure, with interest at the Prime Rate, from the date of Tenant's payment to the date of reimbursement. The reimbursement obligations described in this Section 8.6 shall survive the expiration or earlier termination of this Lease.

8.7 Waiver of Default. No waiver by Landlord or Tenant of any violation or breach of any of the terms, provisions, and covenants herein contained shall be deemed or construed to constitute a waiver of any other or later violation or breach of the same or any other of the terms, provision, and covenants of this Lease. Forbearance by Landlord or Tenant in enforcement of one or more of the remedies herein provided upon an Event of Default shall not be deemed or construed to constitute a waiver of such Event of Default. The acceptance of any payments hereunder by either Party following the occurrence of any default, whether or not known to such Party, shall not be deemed a waiver of any such default, except only a default in the payment of the amount so accepted.

ARTICLE 9
SURRENDER, HOLDING OVER

9.1 Surrender of Lease. The voluntary or other surrender of the Lease by Tenant, or a mutual cancellation or rescission thereof, shall not create a merger and shall operate as an assignment to Landlord of all existing and valid Subleases, subtenancies, or contracts relating to the use or operation of the Leased Premises as and to the extent described in the Transfer Agreement.

9.2 Holding Over. If Tenant shall, with the knowledge and consent of Landlord, continue to remain in possession of the Leased Premises after the expiration of the term of this Lease or any renewal or extension hereof, such holding over shall be on a month-to-month basis and shall not constitute a reletting or releasing on the Leased Premises. Such tenancy from month-to-month shall be on the same terms established for the last year of the term of this Lease and upon the same terms and conditions herein specified and shall continue to be such until thirty (30) calendar days after Tenant shall have given to Landlord, or Landlord shall have given to Tenant, a written notice of termination of such monthly tenancy. Nothing contained herein shall be construed as a consent by Landlord to the occupancy or possession of the Leased Premises by Tenant after the expiration of the term hereof.

ARTICLE 10
RIGHT OF FIRST REFUSAL

10.1 Right of First Refusal. In the event Landlord, at any time during the term of this Lease, including any renewal or extension hereof, desires to sell, assign, or in any manner transfer all or any portion of Landlord's interest in the Leased Premises, Landlord shall give to Tenant written notice of its intention to sell, assign, or transfer such interest, which notice shall name a bona fide proposed purchaser, assignee, or transferee, the interest to be sold, assigned, or transferred, the purchase price, and the other material terms ("Offer Notice"). Tenant shall then have an option to purchase such interest for the price and on the terms set forth in the Offer Notice. If Tenant elects to exercise such option, Tenant shall send written notice of such election ("Acceptance Notice") to Landlord in the manner specified under Section 15.10 within ninety (90) days after receipt of the Offer Notice. Tenant's failure to send such Acceptance Notice within such ninety (90)-day period ("Acceptance Period") shall be deemed Tenant's rejection of the Offer Notice and except as set forth below in this Section 10.1, this Section 10.1 shall be of no further force or effect thereafter. Such Acceptance Notice shall be accompanied by an opinion of nationally recognized bond counsel that the proposed sale, assignment, or transfer shall not affect the tax-exempt status of any indebtedness of Tenant outstanding at the time of such proposed transfer. Upon Tenant's exercise of such option during the Acceptance Period, Landlord and Tenant shall cause such sale, assignment, or transfer to be consummated within a reasonable time and shall execute and deliver all necessary documents. In the event Tenant fails to timely send an Acceptance Notice during the Acceptance Period, Landlord may sell, assign, or transfer no less than all of the interest that is the subject of the Offer Notice to the person and for the price and on the same terms specified in the Offer Notice. However, Tenant's right of first refusal shall continue in existence and Landlord shall then be obligated to give a new Offer Notice (i) if Landlord fails to consummate the sale contemplated by the Offer Notice upon the terms set forth in the Offer Notice within eighteen (18) months following the Acceptance Period; or (ii) if at any time the purchase price set forth in the declined Offer Notice is reduced to an amount that is 95% of the original purchase price presented in the declined Offer Notice.

ARTICLE 11
PRIORITY, ESTOPPELS AND EASEMENTS

11.1 Priority. Except for encumbrances existing on the Effective Date and the easements, covenants, conditions, and restrictions created in accordance with Section 11.3, if

any, the leasehold estate created hereby is and shall be prior and superior to any deed of trust, mortgage, or security lien ("Lien") hereafter placed upon the Leased Premises by Landlord.

11.2 Estoppel Certificate. Each Party, within ten (10) business days after notice from the other party, shall execute and deliver to the other party in recordable form, a certificate stating that this Lease is unmodified and in full force and effect, or in full force and effect as modified, and stating the modifications. The certificate also shall state the amount of payments due under this Lease, the dates to which such amounts have been paid in advance, the amount of any security deposit and the nature and extent of any then-existing default or breach of this Lease by the party requesting the certificate. Failure to deliver the certificate within such ten (10) business day period shall be conclusive upon the Party failing to deliver the certificate for the benefit of the Party requesting the certificate and any successor to the Party requesting the certificate, that this Lease is in full force and effect and has not been modified and no default or breach exists, except as may be represented by the Party requesting the certificate. If a Party fails to deliver the certificate within such ten (10)-business day period, the Party failing to deliver the certificate irrevocably constitutes and appoints the other Party as its special attorney- in-fact to execute and deliver the certificate to any third party. Any third party shall be entitled to conclusively rely upon any certificate delivered in accordance with this Section 11.2.

11.3 Easement, Restrictions. Landlord shall execute whatever documents Tenant reasonably requests to impose upon the Leased Premises such easements, covenants, conditions, and restrictions for parking, ingress, egress and utilities as are reasonably required by Tenant in connection with the orderly operation and development of the Leased Premises; provided that Landlord shall not be required to execute any such document which would have a material adverse effect upon the use of the Leased Premises as provided for in Section 3.

ARTICLE 12
REPRESENTATIONS AND WARRANTIES OF LANDLORD

Landlord hereby makes for the benefit of Tenant the representations and warranties made by Landlord in Sections 5.1, 5.2, 5.3, 5.4, 5.6, 5.13, 5.14, 5.23 and 5.25 of the Affiliation Agreement.

ARTICLE 13
REPRESENTATIONS AND WARRANTIES OF TENANT

Tenant hereby makes for the benefit of Landlord the representations and warranties made by Tenant in ARTICLE 4 of the Affiliation Agreement.

ARTICLE 14
ADDITIONAL COVENANTS OF TENANT

14.1 Assignment or Subletting.

14.1.1 Tenant shall have the right to transfer or assign this Lease to any party consented to by Landlord pursuant to Section 9.3.1 of the Affiliation Agreement.

14.1.2 Tenant shall also have the right to assign this Lease or sublease all or any portion of the Leased Premises in connection with a transfer or assignment permitted under Section 9.3.2 of the Affiliation Agreement.

14.1.3 Tenant shall also have the right to sublease, license and/or permit the occupancy of any portion of the Leased Premises to any third party provided any sublease is consistent with the Permitted Use and the Operating Standard. Any sublease, license or other occupancy arrangement between Tenant and any third party for the use by such third party of all or any portion of the Leased Premises is a "Sublease".

(a) Without limiting the foregoing, as of the Closing of the transactions contemplated in the Affiliation Agreement, any existing leases affecting the Leased Premises shall be deemed to be Subleases under this Lease effective upon the assumption thereof by Tenant.

(b) No default under any Sublease shall constitute a default under this Lease so long as Tenant is operating the Leased Premises in accordance with the Operating Standard. Tenant will have the exclusive right to enforce the terms and provisions of any Subleases and/or to enter into new Subleases, terminate any existing Subleases and/or approve any amendments to any such Subleases. Landlord will reasonably cooperate with Tenant to enforce any Subleases.

14.2 Tenant's written request, Landlord shall execute a commercially reasonable recognition agreement (the "Recognition Agreement") in favor of any third party to any Sublease (a "Subtenant") which provides that in the event this Lease is terminated, Landlord shall, effective as of such termination, assume Tenant's interest in such Subtenant's Sublease, recognize the Subtenant's right to continue to occupy the premises that Subtenant leases pursuant to its Sublease, and not disturb such Subtenant's possession of its premises due to such termination of the Lease (provided that the Subtenant is not in default under the Sublease beyond applicable notice and cure periods).

14.3 Master Site Plan. To the extent that the Leased Premises is included in any Hospital Master Site Plan ("MSP") prepared by Tenant pursuant to the Hospital Lease, Tenant shall operate the Leased Premises in accordance with any provisions of the MSP that shall apply to the Leased Premises from time to time.

14.4 Entry. Landlord shall appoint a Facilities Committee to periodically conduct an inspection of the Leased Premises, provided such periodic inspection shall occur no more frequently than twice per calendar year. Tenant shall reasonably cooperate with Landlord in facilitating these inspections and, following such inspection, Landlord's Facilities Committee shall provide a report to Tenant of items it reasonably determines are in need of maintenance and/or repair, if any. In the event Landlord reasonably determines the items identified in such report have not been satisfactorily maintained or repaired, Landlord shall provide written notice thereof (together with reasonable supporting documentation for the same) to Tenant ("Maintenance Request Notice"), which Maintenance Request Notice shall describe the corrective action Landlord desires to be performed. Landlord and Tenant shall reasonably cooperate in connection with the repair of any items identified in a Maintenance Request Notice

or to include the same in the next MSP. For any item set forth in a Maintenance Request Notice which is not then included in an MSP, if Landlord determines that such item has not been satisfactorily corrected within a reasonable time frame following receipt of such Maintenance Request Notice, Landlord shall have the option to invoke the dispute resolution process set forth in Section 15.5.2.

14.5 Accounting Records and Financial Statements. Tenant covenants and agrees at all times to keep, or cause to be kept, proper accounting records prepared in accordance with generally accepted accounting principles, in which complete and accurate entries shall be made of all transactions of or in relation to the business, properties and operations of the Tenant, including, without limitation, operations of the Leased Premises. Tenant further covenants and agrees to have prepared within one hundred sixty (160) days after the end of each fiscal year, complete financial statements for such fiscal year together with the report and opinion of a Certified Public Accountant stating that Sharp HealthCare's consolidated financial statements have been prepared in accordance with generally accepted accounting principles and that such accountant's examination of the financial statements was performed in accordance with generally accepted auditing standards. The consolidated schedules regarding Tenant contained in Sharp HealthCare's consolidated audited financial statements shall satisfy Tenant's foregoing obligation regarding the preparation of financial statements. The accounting records and financial statement and audit report (to the extent applicable to Tenant), and insurance policies shall be available for inspection no more than once per quarter of each calendar year (unless there has occurred an Event of Default of Tenant under this Lease beyond all applicable notice and cure periods) by the Landlord at the offices of Tenant upon reasonably prior written notice during regular business hours.

14.6 Performance Criteria. During the term of this Lease, Tenant shall use best efforts to pay its obligations to its creditors in accordance with the terms of any such agreement relating to the same. Notwithstanding the foregoing, Tenant may contest any such obligations or withhold or defer payment of any such obligations if Tenant, in the exercise of its reasonable business judgment, chooses to do so. Any such contesting, withholding, or deferral shall not constitute a default under this Lease.

ARTICLE 15
MISCELLANEOUS

15.1 Waiver of Conditions. The conditions to each of the Parties' obligations to consummate this Lease are for the sole benefit of such Party and may be waived by such Party in whole or in part to the extent permitted by applicable Laws.

15.2 Waiver of Consequential Damages. Notwithstanding anything in this Lease to the contrary, neither Party shall be liable to the other for consequential, incidental, punitive, exemplary, special or indirect damages (including without limitation, lost profits, loss of income, loss of business, loss of goodwill, lost opportunity, reputational damage, interest on monies), whether arising in tort, contract, under any statute, under any indemnity provision or otherwise, and each Party hereby waives any claims against the other related thereto. The Parties intend that the limitations under this Section imposed on remedies and the measure of damages be without regard to the cause(s) related thereto, including, without limitation, the negligence or strict

liability of any Party, whether such negligence be sole, joint or concurrent, or active or passive. The terms of this Section shall survive the expiration or earlier termination of this Lease.

15.3 Indemnification. The indemnification provisions of the Affiliation Agreement shall apply in connection with this Lease.

15.4 Attorney's Fees. In the event that any claim or contest regarding this Lease is brought by one Party to this Lease against another Party or Parties, the Party or Parties against whose favor such claim or contest is resolved shall pay all costs and reasonable attorneys' fees incurred by the other Party or Parties as a result of such claim or contest (including attorneys' fees and costs incurred in collecting any judgment), together with interest on any amount recovered (other than attorneys' fees) from the date judgment is entered at the maximum amount permitted by applicable Laws.

15.5 Governing Law; Waiver of Jury Trial.

15.5.1 This Lease (including the Schedules and Exhibits attached hereto), and any action arising or relating to this Lease, shall be governed by and construed in accordance with the internal laws of the State of California, applicable to agreements executed and performed entirely within the State of California, without giving effect to any choice or conflict of law provision or rule (whether of the State of California or any other jurisdiction) that would cause the application of Laws of any jurisdiction other than those of the State of California.

15.5.2 EACH PARTY ACKNOWLEDGES AND AGREES THAT ANY CONTROVERSY WHICH MAY ARISE UNDER THIS LEASE OR THE OTHER TRANSACTION DOCUMENTS IS LIKELY TO INVOLVE COMPLICATED AND DIFFICULT ISSUES AND, THEREFORE, EACH PARTY IRREVOCABLY AND UNCONDITIONALLY WAIVES ANY RIGHT IT MAY HAVE TO A TRIAL BY JURY IN RESPECT OF ANY LEGAL ACTION ARISING OUT OF OR RELATING TO THIS LEASE, THE OTHER TRANSACTION DOCUMENTS OR THE TRANSACTION OR THEREBY. EACH PARTY TO THIS LEASE CERTIFIES AND ACKNOWLEDGES THAT (i) NO REPRESENTATIVE OF ANY OTHER PARTY HAS REPRESENTED, EXPRESSLY OR OTHERWISE, THAT SUCH OTHER PARTY WOULD NOT SEEK TO ENFORCE THE FOREGOING WAIVER IN THE EVENT OF A LEGAL ACTION, (ii) SUCH PARTY HAS CONSIDERED THE IMPLICATIONS OF THIS WAIVER, (iii) SUCH PARTY MAKES THIS WAIVER VOLUNTARILY, AND (iv) SUCH PARTY HAS BEEN INDUCED TO ENTER INTO THIS LEASE BY, AMONG OTHER THINGS, THE MUTUAL WAIVERS AND CERTIFICATIONS IN THIS SECTION 15.5.

15.6 Severability. If any term or provision (or any portion thereof) of this Lease, or the application of any such term or provision (or any portion thereof) to any person or circumstance, is invalid, illegal or unenforceable in the State of California, such invalidity, illegality or unenforceability shall not affect any other term or provision of this Lease or invalidate or render unenforceable such term or provision, and this Lease shall be reformed, construed and enforced as if such invalid, illegal or unenforceable term or provisions or any portion hereof had never been contained herein. Upon such determination that any term or other provision is invalid, illegal or unenforceable, the Parties shall use commercially reasonable efforts to modify this

Lease so as to affect the original intent of the Parties as closely as possible in a mutually acceptable manner.

15.7 Interpretation. For purposes of this Lease, (a) the words "include," "includes" and "including", unless otherwise specified, shall be deemed to be followed by the words "without limitation" whether or not such words are actually stated; (b) the word "or" is not exclusive; (c) the words "herein," "hereof," "hereby," "hereto", "hereunder" and derivative or similar words refer to this Lease as a whole, including the Schedules and Exhibits hereto; (d) words in the singular shall be held to include the plural and vice versa, and words of one gender shall be held to include the other gender as the context requires; (e) references to "dollars" or "$" shall mean United States dollars; (f) references to "written" or "in writing" include in electronic form; (g) provisions shall apply, when appropriate, to successive events and transactions; (h) a reference to any Person includes such Person's successors and permitted assigns; (i) any reference to days means calendar days unless business days are expressly specified; (j) when calculating the period of time before which, within which or following which any act is to be done or step taken pursuant to this Lease, the date that is the reference date in calculating such period shall be excluded, and if the last day of such period is not a business day, the period shall end on the next succeeding business day; and (k) all references to "close of business" on any given day shall be deemed to refer to 11:59 p.m. Pacific Time on such date. Unless the context otherwise requires, references herein: (i) to Articles, Sections, Schedules and Exhibits mean the Articles and Sections of, and Schedules and Exhibits attached to, this Lease; (ii) to an agreement, instrument or other document means such agreement, instrument or other document as amended, supplemented and modified from time to time to the extent permitted by the provisions thereof and (iii) to a statute or regulation or statutory or regulatory provisions means such statute as amended from time to time and includes any successor legislation thereto and any regulations promulgated thereunder. This Lease shall be construed without regard to any presumption or rule requiring construction or interpretation against the Party drafting an instrument or causing any instrument to be drafted. The Schedules and Exhibits referred to herein shall be construed with, and as an integral part of, this Lease to the same extent as if they were set forth verbatim herein.

15.8 Headings. The headings in this Lease are for reference only and shall not affect the interpretation of this Lease.

15.9 Dispute Resolution. The Parties shall attempt to resolve through negotiation any controversy, dispute or claim arising out of or relating to this Lease, or the breach thereof (each, a "Dispute"). Either Party may initiate negotiations by delivering written notice to the other Party specifying the subject of the dispute (the "Dispute Notice"). The Parties shall negotiate in good faith, which shall include a meet-and-confer between the principals of each Party.

15.9.1 Mediation. If the Dispute is not resolved by the date that is thirty (30) days the following the meeting of the principals of each Party, then it may be submitted, at the option of Landlord or Tenant, to mediation. The mediation shall occur within thirty (30) days after the expiration of the Negotiation Period, or as soon thereafter as is reasonably practicable. A single disinterested third-party mediator shall be selected by mutual agreement of the Parties. If the Parties are unable to mutually select a mediator with fifteen (15) days, then a mediator shall be selected by JAMS/Endispute ("JAMS") with its then current Rules of Practice and

Procedure. The rules of the mediation shall be the Rules of Practice and Procedure of JAMS as may be modified by the Parties to the mediation by mutual agreement at the time of the mediation. The mediator shall be bound by the terms of this Lease. Each Party shall pay one-half the cost of mediation including the mediator's fees. Attorneys' fees shall be awarded separately as provided in this Lease.

15.9.2 If the Parties are unable to resolve such Dispute during the mediation, the mediator shall issue in writing a settlement proposal regarding the Dispute (the "Settlement Proposal"). The Settlement Proposal shall be non-binding, but upon mutual written agreement between Landlord and Tenant, the Settlement Proposal rendered by the mediator(s) may be mutually accepted as binding and, in such event, shall be entered in any court having jurisdiction thereof. In the event that either Landlord or Tenant does not accept any such Settlement Proposal, either Party may bring an action in a court of competent jurisdiction to resolve such Dispute.

15.10 Notices. All notices, requests, demands or other communications required or permitted to be given under this Lease shall be in writing and shall be delivered to the Party to whom notice is to be given either (i) by personal delivery (in which case such notice shall be deemed given on the date of delivery); (ii) by reliable next business day courier services (e.g., Federal Express, UPS or other similar service) (in which case such notice shall be deemed given on the business day following the date of deposit with the courier service); (iii) by email transmission as long as a copy of the notice is also sent on the same date by another means permitted under this Section (in which case such notice shall be deemed given on the date the email is transmitted); or (iv) by United States mail, first class, postage prepaid, registered or certified, return receipt requested (in which case such notice shall be deemed given on the third (3rd) day following the date of mailing), and in each instance properly addressed as follows:

To Landlord: _____
_____
_____
_____

Email: _____

With a copy to: _____
Attn.: _____
_____
_____

Email: _____

To Tenant : Sharp HealthCare
President and Chief Executive Officer
8695 Spectrum Center Boulevard
San Diego, CA 92123
Email: mailto:Chris.Howard@sharp.com

With a copy to: Sharp HealthCare
Attn.: Senior Vice President and General Counsel
8695 Spectrum Center Boulevard
San Diego, CA 92123
Email: LegalDept@sharp.com

And a copy to: Paul Carr-Rollitt
Manatt, Phelps & Phillips, LLP
2049 Century Park East
Suite 1700
Los Angeles, CA 90067
Email: pcarr-rollitt@manatt.com

A Party may change its addresses for purposes of this Section by giving written notice to the other Party in any manner specified in this Section.

15.11 Definitions. Any capitalized terms not otherwise defined herein shall have the definitions contained in the Affiliation Agreement. The term "Indenture" shall mean any indenture or master indenture, or any supplement thereto or similar instrument designed to substitute a new obligation or existing obligation under an indenture, or any loan agreement, or similar agreement, or any other debt instrument of any kind whatsoever, executed by Tenant during the term of the Lease in connection with the incurrence by Tenant of any indebtedness secured by the TCMC's revenues.

15.12 Memorandum of Lease. Landlord and Tenant shall execute, acknowledge, and record a memorandum of this Lease, the form of which is attached hereto as Schedule 15.13.

15.13 Counterparts. This Lease and any amendments hereto may be executed and delivered in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Lease delivered by facsimile, e-mail or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Lease.

15.14 Extension of Lease. If pursuant to the Hospital Lease Landlord and Tenant determine that it is in the best interests of Landlord and Tenant to extend the term hereof, Landlord and Tenant shall negotiate in good faith such extensions of the Lease as may be permissible by law and necessary or appropriate, from time to time, to achieve the mutual goals of Landlord and Tenant with respect to the operation of TCMC.

15.15 [Intentionally Omitted].

15.16 Confidentiality. Throughout the term of this Lease, Landlord and Tenant (the "Disclosing Party") shall not disclose any of the terms, covenants, conditions or agreements set forth in this Lease or any amendments hereto, nor provide such correspondence, this Lease, any amendments hereto or any copies of the same, nor any other information (oral, written or

electronic) which is communicated by or on behalf of Tenant or by or on behalf of Landlord relating or pertaining to Landlord, Tenant, Tenant's proposed occupancy of the Leased Premises, any financial information, or Tenant's or Landlord's business (collectively, "Confidential Information"), to any person or entity, or the press or any news media, without Landlord's or Tenant's, as applicable (the "Non-Disclosing Party"), written consent (except as provided herein) or except as ordered by a court with appropriate authority provided the Disclosing Party seeks available protective orders. Notwithstanding the foregoing, Landlord may disclose the terms of this Lease to those of its partners, members, owners, employees, representatives, property managers, vendors, brokers, consultants, architects, contractors, subcontractors, materialmen, attorneys, accountants, current or potential mortgagees, lenders or purchasers of the Leased Premises who have a reasonable need for such Confidential Information and who agree to be bound by the terms of this Section, and Tenant may disclose the terms of this Lease to those of its partners, members, owners, employees, representatives, property managers, vendors, brokers, consultants, architects, contractors, subcontractors, materialmen, attorneys, accountants, current or potential lenders, assignees or subtenants who agree to be so bound. In addition, and notwithstanding the foregoing, Landlord and Tenant may disclose architectural plans, specifications, site plans and drawings and such other information as is required in applications to the government bodies having jurisdiction (federal, state and local) over entitlements for the Leased Premises and any other necessary permits and approvals.

15.17 Intellectual Property; Trademarks. Landlord shall not have the right to use Tenant's, Sharp Health Care's, Sharp HealthCare Obligated Group's nor any Affiliate's (as defined below) trade names, trademarks, or logos (collectively, "Tenant's Trademarks"), nor shall the Tenant's Trademarks be used by Landlord in advertising or in photographs of the Leased Premises nor in any other manner without Tenant's prior written consent, in its sole and absolute discretion. As used herein, "Affiliate" and "Affiliates" shall mean any entity which controls, is controlled by or is under common control with Tenant, Sharp Health Care and/or Share HealthCare Obligated Group.

15.18 Consent. Wherever in this Lease Landlord or Tenant is required to give its consent or approval, such approval or consent must be in writing and where no standard of review is specified, such consent or approval shall not be unreasonably withheld, conditioned or delayed. Neither Party shall be deemed to have waived any right hereunder unless such waiver shall have been writing signed by an individual with authority to bind the waiving Party.

15.19 Entire Agreement. THIS LEASE AND THE TRANSACTION DOCUMENTS (AND THE EXHIBITS AND ANY ADDENDUM OR SCHEDULES ATTACHED TO THE LEASE AND THE TRANSACTION DOCUMENTS) CONSTITUTE THE ENTIRE AGREEMENT BETWEEN THE PARTIES HERETO WITH REGARD TO TENANT'S OCCUPANCY OR USE OF THE LEASED PREMISES, AND NO PRIOR AGREEMENT OR UNDERSTANDING PERTAINING TO ANY SUCH MATTER SHALL BE EFFECTIVE FOR ANY PURPOSE. NO PROVISION OF THIS LEASE MAY BE AMENDED OR SUPPLEMENTED EXCEPT BY AN AGREEMENT IN WRITING SIGNED BY THE PARTIES HERETO OR THEIR SUCCESSOR IN INTEREST. THE PARTIES AGREE THAT ANY DELETION OF LANGUAGE FROM THIS LEASE PRIOR TO ITS MUTUAL EXECUTION BY LANDLORD AND TENANT SHALL NOT BE CONSTRUED TO HAVE ANY PARTICULAR MEANING OR TO RAISE ANY PRESUMPTION, CANON OF

CONSTRUCTION OR IMPLICATION INCLUDING, WITHOUT LIMITATION, ANY IMPLICATION THAT THE PARTIES INTENDED THEREBY TO STATE THE CONVERSE, OBVERSE OR OPPOSITE OF THE DELETED LANGUAGE.

IN WITNESS WHEREOF, Landlord and Tenant cause this Lease Agreement to be executed as of the date first written above.

TRI-CITY HEALTHCARE DISTRICT ("Landlord")

By: _____

TRI-CITY MEDICAL CENTER CORPORATION ("Tenant")

By: _____

LEASE AGREEMENT

SCHEDULE 1.1

Real Property

The real property leased by Landlord to Tenant is described in **"Exhibit A"** attached hereto.

Exhibit "A"

LEGAL DESCRIPTION OF LEASED PREMISES

(To be attached prior to execution)

RESOLUTION NO. 829

RESOLUTION OF THE BOARD OF DIRECTORS OF THE TRI-CITY HEALTHCARE DISTRICT APPROVING THE AFFILIATION, TRANSFER AND LEASE AGREEMENTS BETWEEN THE TRI-CITY HEALTHCARE DISTRCT, SHARP HEALTHCARE, AND THE TRI-CITY MEDICAL CENTER CORPORATION DATED DECEMBER 11, 2025

WHEREAS, the Tri-City Healthcare District ("**District**") Board of Directors has determined that the best interests of the communities served by the District and the long-term viability of Tri-City Medical Center ("**Hospital**") would be enhanced and strengthened by the affiliation of the Hospital with Sharp Healthcare, a California nonprofit public benefit corporation ("**Sharp**"), and Tri-City Medical Center Corporation, a California nonprofit public benefit corporation, an affiliate of Sharp ("**TCMCC**"); and

WHEREAS, the Board of Directors of the District has engaged in extensive due diligence and negotiations with Sharp, and the terms and conditions of the Affiliation, Transfer and Lease Agreements with Sharp ("**Transfer Documents**") were discussed and public testimony was taken at six (6) duly noticed public meetings held on October 30, 2025, November 6, 2025, November 7, 2025, November 12, 2025, November 13, 2025 and December 11, 2025, concerning the affiliation with Sharp and TCMC, and

WHEREAS, based on its review of the Transfer Documents and the public testimony, it is the intent of the District Board of Directors to approve and authorize the Transfer Documents at a duly noticed public meeting held on this day of December 11, 2025, and, by virtue thereof and subject to District voter approval as required by California Health and Safety Code 32121(p)(2)(C), the transfer of more than 50% of the District's assets relating to the operation of Hospital and the District's other health care facilities to a nonprofit corporation for the benefit of the communities served by the District, in the absence of adequate consideration; and

WHEREAS, California Health & Safety Code Section 32121(p)(2)(A)(ii) provides that, the transfer of more than 50% of a District's assets requires that the District shall approve all of the initial board members of the nonprofit corporation and any subsequent board members as may be specified in the Transfer Documents; and

WHEREAS, California Health & Safety Code Section 32121(p)(2)(A)(iii) provides that all assets transferred to the nonprofit corporation, and all assets accumulated by the corporation during the term of the transfer and shall be transferred back to the District upon termination of the transfer, including any extension of the transfer, as as specified in the Transfer Documents; and

WHEREAS, California Health & Safety Code Section 32121(p)(2)(A)(iv) commits the nonprofit to operate and maintain the District's health care facilities and its assets for the benefit of the communities served by the District, as specified in the Transfer Documents; and

WHEREAS, California Health & Safety Code Section 32121(p)(2)(A)(v) requires, and the Transfer Documents specify, that any funds received from the District at the outset of the agreement or any time thereafter during the term of the Transfer Documents be used only to reduce district indebtedness, to acquire needed equipment for the District health care facilities, to operate, maintain, and make need capital improvements to the District's health care facilities, to provide supplemental health care services or facilities for the communities served by the District, or to conduct other activities that would further a valid public purpose if undertaken by the District; and

WHEREAS, California Health & Safety Code Section 32121(p)(2)(A)(vi) provides that the Transfer Documents include the appraised fair market value, from an independent consultant with expertise in the methods of appraisal and valuation and in accordance with applicable governmental and industry standards for appraisal and valuation, of any assets transferred pursuant to the Transfer Documents; and

WHEREAS, the District Board of Directors has retained the firm of VMG Health to provide an appraised fair market value analysis, which valuation has been presented to and is intended to be approved by the District Board of Directors at a public meeting held on this December 11, 2025.

NOW, THEREFORE, THE BOARD OF DIRECTORS OF THE TRI-CITY HEALTHCARE DISTRICT HEREBY FINDS, DETERMINES, RESOLVES, AND ORDERS AS FOLLOWS:

Section 1. Recitals. The Board of Directors finds the above recitals are true and correct in all material respects.

Section 2. Approval of Affiliation. The Board of Directors hereby approves the Transfer Documents between the District, Sharp and TCMCC, dated December 12, 2025, in accordance with Health & Safety Code Section 32121(p)(2), subject to approval of the voters of the District in accordance with Health & Safety Code Section 32121(p)(2)(C).

Section 3. Execution and Delivery. The President of the Board of Directors, or such other officer of the Board of Directors delegated in writing by the President, is hereby authorized and directed to execute and deliver the Transfer Documents and any other agreements, documents or instruments related thereto, on behalf of the District.

Section 4. Additional Authorizations. The District Chief Executive Officer and Board Counsel are hereby authorized and directed to perform such additional acts as necessary to effect and secure the purposes of this resolution, including making minor and non-substantive revisions to the Affiliation Documents prior to execution, as appropriate. The District Board also hereby ratifies and approves the actions and work of the staff and employees in conducting the due diligence required by this transaction. The District Board Counsel is further authorized and directed to take any additional actions deemed necessary and appropriate to validate the actions of the Board in approving the Transfer Documents including the filing of a validation action in accordance be State law.

PASSED AND ADOPTED at a Regular meeting of the Board of Directors of District Healthcare District on December 11, 2025, by the following vote:

AYES:_____
NOES:_____
ABSENT:_____
ABSTAIN:_____

_____
Tracy Younger, Chairperson
Board of Directors

ATTEST:

_____
Adela I Sanchez, Secretary
Board of Directors

STATE OF CALIFORNIA)
)
COUNTY OF SAN DIEGO)

I, ADELA I. SANCHEZ, Secretary of the District Healthcare District, DO HEREBY CERTIFY that the foregoing is a true copy of Resolution No. 829, adopted by the Board of Directors of the Tri-City Healthcare District at a Regular meeting of the Board of Directors held on December 11, 2025, which Resolution is a part of the official records of the Tri-City Healthcare District.

Dated: _____, 2025

_____
ADELA I. SANCHEZ

RESOLUTION NO. 830

RESOLUTION OF THE BOARD OF DIRECTORS OF THE TRI-CITY HEALTHCARE DISTRICT TO APPROVE THE TITLE VI PROGRAM AND POLICIES INCLUDING A LANGUAGE AND ASSISTANCE PLAN AND PUBLIC PARTICIPATION PLAN

WHEREAS, pursuant to Title VI of the Civil Rights Act of 1964, 42 U.S.C. §2000d et seq. (the Act) and 49 CFR Part 21, the U.S. Department of Transportation and the Federal Transit Administration (FTA) prohibit discrimination on the basis of race, color or national origin; and

WHEREAS, as a subrecipient of federal funds, Tri-City Medical Center is required to comply with the requirements of the Act and applicable implementing regulations; and

WHEREAS, pursuant to FTA Circular 4702.1B, Tri-City Medical Center is required to submit its Title VI Program to its governing entity for approval; and

WHEREAS, the Tri-City Medical Center Board of Directors have considered and determined to approve the organization's Title VI Program," including a Language Assistance Plan and Public Participation Plan;

NOW, THEREFORE, THE BOARD OF DIRECTORS OF THE TRI-CITY HEALTHCARE DISTRICT HEREBY FINDS, DETERMINES, RESOLVES, AND ORDERS AS FOLLOWS:

Section I. The foregoing recitals are true and correct.

ADOPTED, PASSED AND APPROVED this 11th day of December, 2025, at a regular meeting of the Board of Directors, at which a quorum was present and acting throughout, at Oceanside, California, by the following vote:

AYES:

NOES:

ABSTAIN/ABSENT:

By:_____
Chairperson, Board of Directors

ATTEST:

By:_____
Secretary, Board of Directors

Tri-City Medical Center

Title VI Program

November 18, 2025

Tri-City Medical Center

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Tri-City Medical Center

Title VI Notice and Discrimination Complaint Procedures

Tri-City Medical Center's Patient Transportation Express operates its programs and services without regard to race, color and national origin in accordance with Title VI of the Civil Rights Act. Any person who believes she or he has been aggrieved by any unlawful discriminatory practice under Title VI may file a complaint in English or in Spanish.

If information is needed in another format and or language, please contact the Office of Compliance and Privacy at (760) 940-3117 or at ComplianceDept@tcmc.com.

1. Applicability. The following complaint procedures apply to all persons who believe that they have been subject to discrimination by Tri-City Medical Center (Tri-City) related to its transportation services.

2. Preliminary Review Process. The following process must be completed prior to filing a Formal Complaint with FACT's Grantor.

> Informal Resolution - Prior to submitting a formal complaint, the complaining party must contact Director of Outpatient Behavioral Health for ADA, Title VI, or other discrimination complaints for assistance in resolving the matter informally as soon as is practical, generally within 15 calendar days of the time from when the subject of the complaint occurred, or the complaining party became aware of Tri-City's alleged non-compliance with state or federal non-discrimination laws. Complaints must be filed within 180 days of an alleged incident.
>
> Complaints can be sent to the Office of Compliance and Privacy at (760) 940-3117 or to the address 4002 Vista Way, Oceanside, CA, 92056.
>
> Tri-City will notify the grantor of the complaint within 72 hours of receiving the complaint, and record the complaint and steps taken toward resolution. Tri-City is responsible for informing the complaining party about Tri-City's complaint procedure, including the opportunity to file a formal complaint with the grantor and/or the Federal Transit Administration (FTA) as described below.
>
> Report of Results to Grantor and Complaining Party – Tri-City will email or mail the grantor and the complaining party the results of the informal resolution process within 30 calendar days of receiving the complaint. If the complaining party is not satisfied with Tri-City's disposition of the matter, the complaining party may file a formal complaint with the Grantor. For reference, SANDAG's procedure is described below.

3. Formal Complaint

If the procedure for Preliminary Review and informal resolution by Tri-City does not yield a

successful resolution, then the complaining party may file a formal, written complaint with SANDAG in the manner described below. SANDAG materials can be made available in alternative languages. To make a request, call (619) 699-1900. Los materiales de SANDAG están disponibles en otros idiomas. Para hacer una solicitud, llame al (619) 699-1900.

> Formal complaints must be filed within 10 calendar days from the date the complaining party receives notice of the end of the preliminary review process Complaints must be in writing and must include an attached copy of any correspondence concerning the complaint with Tri-City.

Complaints must be filed with the Compliance Officer at 1011 Union St, Suite 400, San Diego, CA 92101; Fax number (619) 699-1995; TTY (619) 699-1904.

Investigation – The Compliance Officer or their designee will initiate an investigation, which may include interviewing, consulting with, and/or requesting a written response to the issues raised in the complaint from any individual the Compliance Officer believes to have relevant information, Tri-City staff, and members of the public. The Compliance Officer may also hold an informal hearing at their discretion.

Representation - The complaining party and any party against whom the complaint is directed has the right to have a representative.

Findings and Notification - The Compliance Officer will prepare and provide the complaining party and all other parties involved a final report containing a summary of the investigation, written findings, and a proposed disposition. This report will be provided to the complaining party and Tri-City within 45 calendar days of the filing of the formal complaint.

Final Disposition - The disposition proposed by the Compliance Officer will be put into effect promptly. The complaining party or any party against whom the complaint or the proposed disposition is directed may appeal. The appeal to the Chief Executive Officer (as set forth below) will not suspend the implementation of the disposition proposed by the Compliance Officer, except in those circumstances where the SANDAG Chief Executive Officer decides that good cause exists, making the suspension of implementation appropriate.

4. Appeal

Within 10 calendar days of the issuance of the final report, the complaining party may appeal to the SANDAG Chief Executive Officer.

A complaining party may appeal by filing a written request for review by the SANDAG Chief Executive Officer.

The written request for review must specify the particular substantive and/or procedural basis for the appeal, and must be made on grounds other than general dissatisfaction with the

proposed disposition. Furthermore, the appeal must be directed only to issues raised in the formal complaint as filed or to procedural errors in the conduct of the complaint procedure itself, and not to new issues.

The review by the Chief Executive Officer or their designee normally will be limited to the following considerations: Were the proper facts and criteria brought to bear on the decision? Were improper or extraneous facts or criteria brought to bear on the decision that substantially affected the decision to the detriment of the complaining party? Were there any procedural irregularities that substantially affected the outcome of the matter to the detriment of the complaining party? Given proper facts, criteria, and procedure, was the decision one that a person in the position of the decision-maker might reasonably have made?

A copy of the Chief Executive Officer's written decision will be expected within 30 calendar days of the filing of the appeal and shall be sent to all parties involved and, if appropriate, to persons whose authority will be needed to carry out the disposition. The deadline may be extended by the Chief Executive Officer for good cause. The decision of the Chief Executive Officer or their designee on the appeal will be SANDAG's final decision.

2. File with the FTA - Any person who believes themselves or any specific class of persons to be subjected to discrimination prohibited by ADA or Title VI may also file a written complaint with the FTA. A complaint should be filed no later than 180 days after the date of the alleged discrimination unless the time for filing is extended by FTA. Title VI and ADA complaints regarding federally funded programs at FACT, can be sent to the following address:

Federal Transit Administration Office of Civil Rights
Attention: Complaint Team
East Building, 5th Floor - TCR
1200 New Jersey Ave., SE
Washington, DC 20590

Title VI Notice Public Posting
Tri-City Medical Center ensures that Title VI notice and complaint forms are accessible to the public. These materials are available on the Tri-City Medical Center website at https://www.tricitymed.org/titleVI-notice/. Title VI complaint forms are also posted in all transportation vehicles. Title VI notices can be accessed online, via printed forms, or requested by email or phone.

Tri-City Medical Center

Language Assistance Plan

Factor 1: The number or proportion of persons with LEP eligible to be served or likely to be served by Tri-City Medical Center's transportation program
(Source: Census Data accessed on 11/19/2025)

Primary Languages and People with LEP in Tri-City medical Center Service Area			
Primary Language	# of People with LEP in Service Area	% of People with the LEP in Service Area	% of Total Population in Service Area
Spanish	35,447	81.27	8.79
Chinese, Mandarin, Cantonese	2,028	4.65	.05
Other Asian Pacific Island Language	1,825	4.18	.04
Tagalog	1,773	4.07	.04
Vietnamese	1,558	3.57	.03
Other Indo-European Language	983	2.25	.02
Total	43,614	99.99	8.97

Factor 2: The frequency with which individuals with LEP come into contact with the program

In 2024, Tri-City Medical Center leadership established a diverse, multiracial, and interdisciplinary committee focused on health equity and improving community health outcomes. Committee members include physicians, nurses, social workers, and data analysts. During the last six months of 2024, Tri-City Medial Center has provided 72,401 minutes of language interpretation services—demonstrating its ongoing commitment to diversity, equity, and inclusion by addressing patients' communication needs at a fundamental level.

Tri-City Medical Center

2024 Summary of Preferred Languages [source: Health Care Access and Information (HCAI) Hospital Equity Measures Report]

Table 1. Summary of preferred languages reported by patients.

Languages	Number of patients who report preferring language	Total number of patients	Percentage of total patients who report preferring language (%)
English Language	47083	52513	89.7
Spanish Language	4977	52513	9.5
Asian Pacific Islander Languages	119	52513	0.2
Middle Eastern Languages	36	52513	0.1
American Sign Language	suppressed	52513	suppressed
Other Languages	suppressed	52513	suppressed

Factor 3: The nature and importance of the program to people's lives

Tri-City Medical Center recognizes that social determinants of health, such as language barriers and transportation challenges, significantly impact access to healthcare services. To address these needs and ensure equitable care, we have implemented the following measures:

- Language Assistance Services: We provide interpretation and translation services to patients with Limited English Proficiency (LEP) to ensure clear communication and informed decision-making.
- Transportation Support: Resources and assistance are available to help patients overcome transportation barriers that may prevent timely access to care.
- Staff Training and Awareness: All staff members receive annual training focused on identifying and addressing social needs that affect healthcare access. This training reinforces the importance of connecting patients to appropriate support services.
- Proactive Assessment: Staff are trained to assess social needs during patient interactions and link individuals to available resources, ensuring that no patient is left without the support necessary for quality care.

Through these efforts, Tri-City Medical Center demonstrates its commitment to Title VI compliance and to fostering an inclusive, patient-centered environment.

Factor 4: The resources available for LEP engagement and the costs of that engagement

Tri-City Medical Center adheres to its Interpretation and Translation Policies, providing language services to individuals who are:

- Sensory impaired (blind or deaf),
- Communicatively impaired (expressive or receptive language deficits),
- Patients with Limited English proficiency (LEP).

During the patient registration process, staff inform patients about the Language Assistance Plan. Tri-City staff offer translation in all languages, including Spanish, Chinese (Mandarin and Cantonese), Tagalog, Vietnamese, Arabic, Farsi, European languages, and others. This information is also displayed in multiple languages throughout all units. All staff receive initial and annual training on assessing patient language and interpretation needs, and on delivering timely and appropriate language assistance. Services include telephone translation, and computer-based translation for individuals who are hearing or visually impaired. (Refer to the second Appendix for posted materials.)

All Tri-City Medical Center staff also complete annual training in cultural competence and cultural humility. These computer-based trainings cover:

- Implicit bias,
- Health equity,
- Age-appropriate care,
- Communication across the lifespan,
- Needs of transgender, gender-diverse, and intersex individuals.

Tri-City Medical Center staff screen all patients for LEP and offers various translation services, including audio and video interpretation. The organization is committed to workforce diversity and actively recruits and retains a diverse staff. To enhance workforce availability, Tri-City Medical Center partnered with an agency that supplies foreign-educated registered nurses. To improve cultural responsiveness, staff use multiple platforms to deliver evidence-based educational materials in patients' native languages, ensuring accessibility and cultural relevance.

All language assistance services are provided at no cost to patients. Each year, Tri-City Medical Center allocates a dedicated budget to support these services, which includes:

- **Interpretation and Translation Services:** Ensuring patients with Limited English Proficiency (LEP) have meaningful access to care.
- **Staff Training:** Annual training for all staff on language access protocols and cultural competency.
- **Technology Resources:** Investment in interpretation platforms and translation tools to enhance service delivery.

- **Multilingual Communications:** Posting notices and vital information in multiple languages to inform patients of available LEP services.

This commitment reflects our responsibility under Title VI to eliminate language barriers and promote equitable access to healthcare.

Language Access Plan Application

Tri-City Medical Center applies its Language Access Plan (LAP) by ensuring that all patients with Limited English Proficiency (LEP) receive meaningful access to healthcare services. Based on our analysis of community demographics and patient encounters, we identified Spanish as the primary LEP language in our service area. This determination follows the Safe Harbor guidance under Title VI, which requires translation of vital documents when a language group constitutes 5% or 1,000 individuals of the eligible population.

Safe Harbor Languages

- **Spanish**: Tri-City meets the Safe Harbor threshold for Spanish-speaking individuals.
- Other languages: While Spanish is the only language meeting the threshold, interpretation services are available for all other languages for LEP patients.

Threshold Compliance for Vital Documents

To comply with Title VI and Safe Harbor requirements:

- **Translated Vital Documents**: All essential consent forms, educational handouts, and patient rights documents are translated into Spanish.
- **Multilingual Notices**: Notices informing patients of their right to free language assistance are posted in English and Spanish throughout the facility and on our website.
- **On-Demand Interpretation**: Professional interpreters (in-person, telephonic, and video) are available for any language, ensuring immediate access for patients who do not speak English or Spanish.
- **Transportation Materials**: Flyers and schedules related to transportation services are provided in Spanish.

How the LAP Is Applied

The LAP guides staff training, resource allocation, and patient communication protocols. Staff are trained to:

- Identify LEP patients during registration.
- Offer language assistance proactively.
- Document language needs in the patient record to ensure continuity of care.

Our goal is to eliminate language barriers and guarantee that every patient receives clear, understandable information about their care, regardless of language.

Evaluating, Monitoring, and Updating the LAP

Tri-City Medical Center is committed to maintaining an effective Language Access Plan (LAP) that ensures meaningful access for individuals with Limited English Proficiency (LEP). To achieve this, we implement the following measures:

- **Regular Updates:** Interpretation and translation services are reviewed and updated every three years to ensure accuracy, relevance, and compliance with federal and state requirements.
- **Complaint Resolution:** Any complaints regarding language access or barriers to communication are addressed promptly and documented in accordance with Title VI guidelines.
- **Public Information:** Title VI program details and complaint procedures are posted in every vehicle and facility to ensure visibility and accessibility for all community members.
- **Continuous Monitoring:** We track usage of interpretation and translation services at least annually, evaluate community language needs, and adjust resources accordingly.
- **Community Feedback:** Input from patients, families, and community stakeholders is actively sought to identify gaps and improve language access services. The patient experience evaluation at **Tri-city Medical Center** is based on the HCAHPS Patient Survey which is administered to a random sample of adult inpatients after they have been discharged. The survey is based on a national, standardized survey of 32 questions and includes patient perspectives on care and patient rating items in several key topics, including communication with staff and physicians. Additionally, we round on patients daily, to check on their experience, and address any patient issues or complaints.
- **Staff Training:** Employees receive ongoing training on language assistance protocols, cultural competency, and Title VI compliance to ensure consistent and equitable service delivery.

These steps help us maintain a responsive and inclusive LAP that meets the evolving needs of our diverse community.

Tri-City Medical Center

Public Participation Plan

Tri-City Medical Center is committed to transparency and community engagement as part of its obligations under Title VI. We provide multiple avenues for public participation to ensure inclusion and equitable access:

Board Meetings

- Board meetings are announced in advance on the Tri-City Medical Center website.
- Meetings are open to all community members, and participation is encouraged.
- Any member of the public may request accommodations, including disability access or language assistance, to ensure meaningful participation.

Community Outreach

- Tri-City actively engages with communities of color and individuals with Limited English Proficiency (LEP) through targeted outreach efforts.
- Outreach activities include in-person outreach events to inform the public about available services and opportunities for input. Flyers are provided in English and Spanish.

Equity Plan

- Tri-City Medical Center maintains a publicly posted Equity Plan, which outlines strategies for:
    - Improving health equity.
    - Addressing racial disparities.
    - Meeting the needs of LEP patients.
    - Expanding access to healthcare services.

Transportation Services Outreach

- The Patient Transportation Department participates in monthly department leadership meetings and provides reminders to various departments about transportation services.
- Information about transportation services is shared with community members and provided in English and Spanish.

Representation of People of Color on Planning and Advisory Bodies

Tri-City Medical Center serves a richly diverse community in North San Diego County. Our commitment to representation is reflected in the composition of our Board of Directors, which mirrors the demographics of the community we serve. Additionally, our Equity Committee includes a diverse group of individuals from various departments and cultural backgrounds.

Tri-City Medical Center

Minority Representation on the Board of Directors

Tri-City Medical Center Board of Directors Racial Breakdown

Race	Percentage
Middle Eastern	14%
Hispanic	29%
Black	14%
White	42%

To enhance cultural responsiveness, Tri-City staff utilize multiple platforms to provide evidence-based printed education for patients in their native languages, ensuring materials are accessible and culturally relevant. TCHD partners with various community organizations that serve underserved communities. This includes Vista Community Clinic, North County Health Services, and other community-based programs. Within the past year, TCHD leadership developed a diverse, multiracial, and interdisciplinary committee to address health equity and improve health outcomes for the community TCHD serves. This committee includes physicians, nurses, social workers, and data analysts.

In 2026, TCHD plans to include community members in our health equity committee. This expanded committee will enhance community engagement and ensure lived experiences inform our strategies. The committee members analyze health data by social determinants of health and identify goals to address disparities. For example, this past year, committee members have been working on improving diabetic care for Hispanic/Latinx patients by enhancing bilingual education and strengthening partnerships with community organizations.

Past Transit-Related Title VI Investigations or Complaints

Tri-City Medical Center has not had any Transit-Related Title VI Investigations or Complaints as of November 2025.

Tri-City Medical Center

Notice of Non-Discrimination

If information is needed in another language, contact the compliance department at ComplianceDept@tcmc.com, (760) 940-3117.

Tri-City Medical Center operates its programs without regard to race, color, and national origin in accordance with Title VI of the Civil Rights Act of 1964. Tri-City Medical Center also prohibits discrimination against individuals with disabilities in accordance with the Americans with Disabilities Act of 1990. Persons who believe they have been subjected to discrimination or have been denied access to services or accommodations required by law, have the right to file a complaint. For more information on the Tri-City Medical Center's civil rights program, and the obligations and procedures to file a complaint, contact (760) 940-3117; email ComplianceDept@tcmc.com; or visit its administrative office at 4002 Vista Way, Oceanside, CA 92056. For more information, visit TriCitymed.org.

Tri-City Medical Center

Aviso de No Discriminación

Si se necesita información en otro idioma, comuníquese con oficina decumplimiento, (760) 940-3117 o ComplianceDept@tcmc.com.

Tri-City Medical Center opera sus programas independientemente de la raza, color y nacionalidad en virtud del Título VI de la Ley de Derechos Civiles de 1964. Tri-City Medical Center también prohíbe la discriminación contra personas con discapacidades en virtud de la Ley para Estadounidenses con Discapacidades de 1990. Las personas que crean haber estado sujetas a discriminación o a las que se les ha denegado acceso a servicios o facilidades exigidas por ley, tienen el derecho de presentar una queja. Para obtener más información sobre el programa de derechos civiles de Tri-City Medical Center, así como sobre las obligaciones y procedimientos para presentar una queja, comuníquese al (760) 940-3117; correo electrónico ComplianceDept@tcmc.com; o visite la oficina administrativa en 4002 Vista Way, Oceanside, CA 92056. Para obtener más información, visite Tricitymed.org.

Tri-City Medical Center

Language Translation Service Posting

Throughout the Tri-City Medical Center departments (including off site clinics), the Tri-City Medical Center translation services are posted in multiple languages.

Availability of Language Assistance Services and Auxiliary Aids and Services (§ 92.11)

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-725-8382 (TTY: 1-800-855-3000) or speak to your provider."

Spanish Español	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855.725.8382 (TTY: 1-800-855-3000) o hable con su proveedor.
Việt **(Vietnamese)**	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-222-8262 (Người khuyết tật: 1-800-735-2929) hoặc trao đổi với người cung cấp dịch vụ của bạn."
中文 **(Chinese)**	**注意：如果您**说[**中文**]，**我**们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-855-222-8262 **文本**电话：1-800-735.2929）**或咨**询您的服务提供商。"
Tagalog / **Filipino**	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-222-8262 (TTY: 1-800-735.2929) o makipag-usap sa iyong provider.

Tri-City Medical Center

فارسي (Farsi)	توجه: اگر [وارد کردن زبان] صحبت میکنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمکها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالبهای قابل دسترس، بهطور رایگان موجود میباشند. با شماره 1-855-725-8382 (تلهتایپ: 1-800-855-3000-) تماس بگیرید یا با ارائهدهنده خود صحبت کنید.
العربية (Arabic)	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-855-725-8382 (1-800-855-3000) أو تحدث إلى مقدم الخدمة".
한국어 (Korean)	주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-855-222-8262 (TTY: 1-800-725-2929) 번으로 전화하거나 서비스 제공업체에 문의하십시오."
РУССКИЙ (Russian)	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-725-8382 (TTY: 1-800-855-3000) или обратитесь к своему поставщику услу
Français (French)	Modèle d'avis de disponibilité des services d'assistance linguistique et des aides et services auxiliaires (§ 92.11) ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-725-8382 (TTY : 1-800-855-3000) ou parlez à votre fournisseur. »
हिंदी (Hindi)	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-725-8382 (TTY: 1-800-855-3000) पर कॉल करें या अपने प्रदाता से बात करें।"

Tri-City Medical Center

Italiano (Italian)	Esempio di avviso di disponibilità di servizi di assistenza linguistica e di ausili e servizi ausiliari (§ 92.11) ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-855-725-8382 (tty: 1-800-855-3000) o parla con il tuo fornitore.
ՀԱՅԵՐԵՆ (Armenian)	ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, Դուք կարող եք օգտվել լեզվական աջակցության անվճար ծառայություններից: Մատչելի ձևաչափերով տեղեկատվություն տրամադրելու համապատասխան օժանդակ միջոցներն ու ծառայությունները նույնպես տրամադրվում են անվճար: Զանգահարեք 1-855-725-8382 հեռախոսահամարով (TTY՝ 1-800-855-3000) կամ խոսեք Ձեր մատակարարի հետ:
日本語 (Japanese)	注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-855-725-8382（TTY：1-800-855-3000）までお電話ください。または、ご利用の事業者にご相談ください。
POLSKI (Polish)	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-855-725-8382 (TTY: 1-800-855-3000) lub porozmawiaj ze swoim dostawcą"

Content created by Office of Civil Rights (OCR). Last reviewed 9/6/2024

Tri-City Medical Center

Complaint Form in English

Instructions: If you believe Tr-City Medical Center has engaged in discrimination against one or more persons relating to its transportation services or programs, please fill out this form completely, in black ink or typewritten form. Sign and return to the "Return To" address below. Alternative means of filing complaints will be made available for persons with disabilities upon request

Name _____

Date _____

Address _____

City _____ State _____ Zip Code _____

Telephone (include area code) _____

Best Time to Reach You _____

Were you discriminated against because of: ☐Race ☐National Origin ☐Color ☐Other

_____

Date of alleged incident _____

Is this an ADA complaint? ☐ Yes ☐ No

Describe as clearly as possible what happened and how you were discriminated against. Indicate who was involved. Be sure to include names and contact information of any witnesses. If you marked "Other" above, include the category upon which you believe the discrimination was based (medical condition, sex, veteran status, etc.):

(Please use the back of the form if more space is needed or attach additional pages.)

_____

_____

_____

_____

_____

Have you filed this complaint with any other federal, State, or local agencies? ☐ Yes ☐ No

If yes, please list agency/agencies and contact information below:

Tri-City Medical Center

Agency _____ Contact Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Agency _____ Contact Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Please sign below. You may attach any written materials or other information that you think is relevant to your complaint.

_____

Signature Signature Date

Please complete and return this form to:

The Office of Compliance and Privacy
Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056
ComplianceDept@tcmc.com

Alternatively, the Title VI Complaint Form may be filed in writing with SANDAG at the following address:

Title VI Coordinator
SANDAG
1011 Union Street, Suite 400,
San Diego, CA 92101
Telephone: 619-699-1900; Fax: 619-699-1995; TTY 619-699-1904

Tri-City Medical Center

Formulario de queja in Español

Instrucciones: Si considera que Tri-City Medical Center ha discriminado a una o más personas en relación con sus servicios o programas de transporte, complete este formulario con tinta negra o escrito a máquina. Firme y envíelo a la dirección de devolución que se indica abajo. Se pondrán a disposición medios alternativos para presentar denuncias a las personas con discapacidad que lo soliciten.

Nombre _____

Fecha _____

Dirección: _____

Ciudad: _____ Estado: _____ Código postal: _____

Teléfono (incluya código de área) _____

Mejor horario para comunicarnos con usted _____

Fue discriminado por motivos de: ☐Raza ☐Nacionalidad ☐Color ☐Otros

_____

Fecha del presunto incidente _____

¿Se trata de una denuncia en virtud de la ADA (Ley para Estadounidenses con Discapacidades)?
☐ Sí ☐ No

Describa lo más claro posible lo que sucedió y cómo fue discriminado. Indique quiénes estuvieron involucrados. Asegúrese de incluir los nombres e información de contacto de cualquier testigo. Si marcó la opción "Otros" arriba, incluya la categoría en la que cree que se basó la discriminación (condición médica, sexo, condición de veterano, etc.):

(Use el reverso del formulario si necesita más espacio o adjunte páginas adicionales).

_____

_____

_____

_____

_____

¿Ha presentado este reclamo ante alguna otra agencia federal, estatal o local? ☐ Sí ☐ No

En caso afirmativo, enumere las agencias y la información de contacto a continuación:

Tri-City Medical Center

Agencia _____ Nombre de contacto _____

Dirección: _____

Ciudad: _____ Estado: _____ Código postal: _____

Teléfono _____

Agencia _____ Nombre de contacto _____

Dirección: _____

Ciudad: _____ Estado: _____ Código postal: _____

Teléfono: _____

Firme a continuación. Puede adjuntar cualquier material escrito u otra información que considere relevante para su reclamo.

_____

Firma Fecha

Tri-City Medical Center

Complete y envíe este formulario a:

The Office of Compliance and Privacy
Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056
ComplianceDept@tcmc.com

De manera alternativa, el Formulario de reclamo del Título VI se puede presentar por escrito ante SANDAG en la siguiente dirección:

Title VI Coordinator
SANDAG
1011 Union Street, Suite 400,
San Diego, CA 92101
Teléfono: 619-699-1900; Fax: (619) 699-1995; TTY 619-699-1904

Tri-City Medical Center

TRI-CITY HEALTHCARE DISTRICT BOARD OF DIRECTORS
DATE OF MEETING: December 11, 2025
Office Lease Agreement Proposal – 902 Sycamore, Ste. 203, Vista, CA

Type of Agreement		Medical Directors		Panel		Other: Lease Renewal
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Landlord Name: Sycamore Ave II, LLC ("Landlord")

Premises: 902 Sycamore, Suite 203, Vista, CA 92081 (2,912 rentable sq.ft.)

Term of Agreement: 2/1/26 – 5/31/2031 (64 Months) beginning upon completion of tenant improvements estimated February 1, 2026

Within Fair Market Value: Yes (FMV was determined by Lease Comparables)

Rental Rate:	**Monthly Expense**
Rental Rate of $3.00 per sq. ft. full service gross NNN Expenses - $.88 per sq. ft. 4 – Months Free Rent	Year 1 - $12,580
Total 64 Month Term Expense Amount Not to Exceed:	**$ 749,719**

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:		Yes	NA	No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item: (Revenue)	X	Yes		No

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer

Motion:

I move that TCHD Board of Directors authorize the Office Lease Agreement with Sycamore Ave II, LLC for a 64-month term beginning approximately February 1, 2026 ending May 31, 2031. This proposal remains within the current fair market value for a monthly expense of $12,580, for a maximum total expense for the 64-month term of $749,719.

Tri-City Medical Center

TRI-CITY HEALTHCARE DISTRICT BOARD OF DIRECTORS
December 11, 2025
PROPOSAL FOR: Wellness Complex MOB Timeshare Lease

Type of Agreement		Medical Directors		Panel		Other:
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor Name: Tri-City Cardiology and Arrhythmia Services, Inc.
Area of Service: Wellness Center Medical Office Building - Timeshare Suite (6260 El Camino Real, Suite 105, Carlsbad, CA 92009)
Term of Lease: February 1, 2026 through January 31, 2027
Maximum Totals:

Usage	Monthly Rent	Annual Term Rental Income
4 Half Days (1 Day/week)	**$2,100**	**$25,200**
8 Half Days (2 Days/week)	**$4,200**	**$50,400**
12 Half Days (3 days/week)	**$6,300**	**$75,600**
16 Half Days (4 days/week)	**$8,400**	**$100,800**
20 Half Days (Full Use)	**$10,400**	**$126,000**

Additional Information:

- The timeshare suite totals 2,717 SF, with 40% allocated space (1,087 SF) for physician use.
- Included equipment: Echocardiogram machine ($112,000 value) and EKG machine ($4,000 value).
- Included personnel: 1 Front Office employee and 1 Medical Assistant during scheduled blocks.
- Scheduling format: Half-day increments (AM: 8:00–12:00; PM: 1:00–5:00).

A Fair Market Value (FMV) analysis was performed, confirming the defensible rate of $525 per half-day, consistent with industry standards and compliant with Stark Law, Anti-Kickback Statute, and California self-referral laws.

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer

I move that the Tri-City Healthcare District Board of Directors authorize a Medical Office Building Timeshare Lease Agreement with Tri-City Cardiology and Arrhythmia Services, Inc., at the FMV rental rate of $525 per half-day for the allocated 1,087 square feet of medical office space, including furnishings, echocardiogram and EKG equipment, and shared staffing, with the option to extend upon Board approval.

Tri-City Medical Center

TRI-CITY HEALTHCARE DISTRICT BOARD OF DIRECTORS
December 11, 2025
PROPOSAL FOR: Wellness Complex MOB Timeshare Lease

Type of Agreement		Medical Directors		Panel		Other:
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor Name: Abinav Sharma, M.D. Inc.
Area of Service: Wellness Center Medical Office Building - Timeshare Suite (6260 El Camino Real, Suite 105, Carlsbad, CA 92009)
Term of Lease: February 1, 2026 through January 31, 2027
Maximum Totals:

Usage	Monthly Rent	Annual Term Rental Income
4 Half Days (1 Day/week)	**$2,100**	**$25,200**
8 Half Days (2 Days/week)	**$4,200**	**$50,400**
12 Half Days (3 days/week)	**$6,300**	**$75,600**
16 Half Days (4 days/week)	**$8,400**	**$100,800**
20 Half Days (Full Use)	**$10,400**	**$126,000**

Additional Information:

- The timeshare suite totals 2,717 SF, with 40% allocated space (1,087 SF) for physician use.
- Included equipment: Echocardiogram machine ($112,000 value) and EKG machine ($4,000 value).
- Included personnel: 1 Front Office employee and 1 Medical Assistant during scheduled blocks.
- Scheduling format: Half-day increments (AM: 8:00–12:00; PM: 1:00–5:00).

A Fair Market Value (FMV) analysis was performed, confirming the defensible rate of $525 per half-day, consistent with industry standards and compliant with Stark Law, Anti-Kickback Statute, and California self-referral laws.

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer

I move that the Tri-City Healthcare District Board of Directors authorize a Medical Office Building Timeshare Lease Agreement with Abinav Sharma, Inc., at the FMV rental rate of $525 per half-day for the allocated 1,087 square feet of medical office space, including furnishings, echocardiogram and EKG equipment, and shared staffing, with the option to extend upon Board approval.

TCHD BOARD OF DIRECTORS
MEETING SCHEDULE
CALENDAR YEAR 2026

Regular Board of Directors Meetings – Open Session to begin at 3:30 p.m.
Closed Session (when necessary) to begin at approximately 1:30 p.m.
(depending on agenda items).

- January 29, 2026 (Last Thursday)
- February 26, 2026 (Last Thursday)
- March 26, 2026 (Last Thursday)
- April 30, 2026 (Last Thursday)
- May 28, 2026 (Last Thursday)
- June 25, 2026 (Last Thursday)
- July 2026 (DARK)
- August 27, 2026 (Last Thursday)
- September 24, 2026 (Last Thursday)
- October 2026 (DARK due to November election)
- November 12, 2026 (2nd Thursday following November election)
- December 10, 2026

Special Board Meetings – Special Board Meetings will be scheduled periodically throughout the year for Strategic Planning, Budget Consideration, etc. We will provide as much notice as possible.

Proposed: 12.11.25

Tri-City Medical Center Administration Attn: Teri Donnellan
4002 Vista Way
Oceanside, CA 92056

Dear TCMC Administration,

The Tri-City Hospital Auxiliary is excited to announce that the Scholarship committee is looking forward to another stellar year of donations and the ability to award many scholarships. Our last Scholarship night was an enriching experience for all, including Auxiliary volunteers, Donors, Recipients and Presenters. Eighty-six scholarships were presented that evening!

The Auxiliary Scholarship Committee is gratified that we can offer the scholarships this spring for students enrolled for the 2026-2027 academic year. I know the schools and students we serve are very thankful. It is our hope that this year's celebration will be as fulfilling as last year's, as well as, the opportunity for donors and recipients to meet each other.

We appreciate your past support of the Scholarship Fund. Believe me, it is so rewarding for the recipient to connect a face and background of the person who is giving them the opportunity to pursue further education to fulfill a lifetime goal. I would guess it is equally rewarding for you to get a more detailed background of what these worthy recipients have experienced in their trek toward serving in their chosen field.

We hope that recognizing the benefit of scholarships to the recipients as well as the rewarding feeling of helping earnest students in their pursuit of further training, you will continue your support of the Scholarship Program this year. We look forward to our annual Scholarship Awards Night April 14, 2026 (tentative) I will contact you with more information in the hope you will be available to attend.

Enclosed in this packet is the donation form with a return envelope. We hope to hear back from you soon.

Thank you for your generosity in the past.

Most gratefully yours,

Nancy E. Russian
Chair, Donor Program Committee
Tri-City Hospital Auxiliary Scholarship Awards

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT
November 12, 2025

Attachment A

Initial Appointments

Any items of concern will be "red" flagged in this report. Verification of education, training, experience, current competence, health status, current licensure, liability coverage, claims history and the National Practitioner Data Bank, the following practitioners are recommended for a 2-year appointment with delineated clinical privileges, to the Provisional Staff or Allied Health Professional Staff with customary monitoring.

Medical Staff:

Practitioner Name	Specialty	Staff Status	Initial Appointment Term	Comments
CAINE, Samuel DPM	Podiatry	Provisional	12/11/2025 - 12/11/2027	
de JESUS, Joseph MD	Teleradiology	Provisional	12/11/2025 - 12/11/2027	Settlement 3/2016 $500,000 failure to diagnose lung cancer
JANSEN, Jeremiah MD	Teleradiology	Provisional	12/11/2025 - 12/11/2027	Pending Claim 11/2024
PHAM, Kevin DO	Internal Medicine	Provisional	12/11/2025 - 12/11/2027	
SULLIVAN, Kevin DO	Emergency Medicine	Provisional	12/11/2025 - 12/11/2027	

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 2 of 3
November 12, 2025

Modification of Staff Status

The following practitioners have requested privilege status change as noted below.
Effective, **December 11, 2025.**

Practitioner Name	Department/Specialty	Change in Staff Status
CURRY, Jason MD	PM&R	Provider changing status from Refer and Follow to Active Affiliate

Addition/Deletion of Privilege(s)

The following practitioners have requested addition/deletion of privilege(s) as noted below. Effective **December 11, 2025.**

Practitioner Name	Department/Specialty	Change in Privilege/s
CURRY, Jason., MD	Physical Medicine & Rehab	Addition: H&P, Consultation & Implantables

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
November 12, 2025

Proctoring Recommendations

The following providers have successfully completed their initial FPPE (Focused Professional Practice Evaluation) and are being recommended for release of their proctoring requirements for the privilege(s) as noted below.

Practitioner Name	Department/Specialty	Privilege(s)
SIOW, Matthew MD	Orthopedic Surgery	• Admit, Consult (include tele), and Perform H&Ps (include tele) • Basic Ortho Privileges • Extremity Fractures Bundle • Extremity Dislocation Bundle
McKnight, Braden MD	Orthopedic Surgery	• Admit, Consultation w/telemedicine, H&P • Basic Ortho Privileges • Extremity-Fractures • Extremity-Dislocation • Spine • Spinal Arthrodesis • Fracture Treatment of the Spine • Cervical Fracture Treatment

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
NOVEMBER 12, 2025

Attachment B

Reappointments:

Any items of concern will be "red" flagged in this report. The following practitioners were presented to members of the Credentials Committee for consideration for reappointment to the Medical Staff or Allied Health Professional Staff, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance. Reappointment is for 2-years unless otherwise noted below.

Medical Staff

Department of Medicine:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
BARVALIA, Mihir M, .MD	Interventional Cardiology	Active	12/11/2025-12/11/2027	Peripheral Vascular Interventional Procedures Privileges added.
BRION, Paul H., MD	Rheumatology	Refer and Follow	12/11/2025-12/11/2027	Change of status from Active to Refer and Follow due to lack of activity.
HEIFETZ, Susan D., MD	Internal Medicine	Refer and Follow	12/11/2025-12/11/2027	
SHEREV, Dimitri A., MD	Interventional Cardiology	Active	12/11/2025-12/11/2027	
NAGHI, Jesse	Interventional Cardiology	Active	12/11/2025-12/11/2027	
PEREIRA, Isabel J., MD	Wound Care	Refer and Follow	12/11/2025-12/11/2027	Change of status from Active to Refer and Follow due to lack of activity.

Department of Surgery:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
BROOKS, Jeffrey R., DPM	Podiatric Surgery	Active	12/11/2025-12/11/2027	
BRAY, Robert S., MD	Neurosurgery	Refer and Follow	12/11/2025-12/11/2027	Change of status from Provisional to Refer and Follow due to lack of activity.
GUERENA, Michael P., MD	Urology	Active	12/11/2025-12/11/2027	

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
NOVEMBER 12, 2025

Attachment B

Department of Radiology:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
THALKEN, Gregory L. MD	Teleradiology	Active Affiliate	12/11/2025-12/11/2027	
COHEN, David J. MD	Teleradiology	Active Affiliate	12/11/2025-12/11/2027	Change of status from Provisional to Active Affiliate.
HUR, Jane L. MD	Teleradiology	Active Affiliate	12/11/2025-12/11/2027	Change of status from Provisional to Active Affiliate.

Department of Emergency Medicine:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
BONOMO, Rica MD	Emergency Medicine	Active	12/11/2025-12/11/2027	
SHUEN, Jessica A. MD	Emergency Medicine	Active	12/11/2025-12/11/2027	Claims (open) 9/27/2024 # PHY24635191

Department of Pediatrics:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
MILLER, Donald T. MD	Pediatrics	Refer & follow	12/11/2025-12/11/2027	Change of status from Active to Refer and Follow due to lack of activity.

Department of Anesthesiology:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
CHAYA, Nina MD	Anesthesiology	Refer & follow	12/11/2025-12/11/2027	Claims (open) 03/19/2025
GUPTA, Anuj MD	Pain Medicine	Refer & follow	12/11/2025-12/11/2027	

Resignations *Medical Staff*:

Practitioner Name	Department/Specialty	Reason for Resignation
CANSECO, Edilberto PA	Emergency Medicine	Resignation documentation received. Effective 9/17/2025
GONZALEZ, Nathan CRNA	Anesthesiology	Resignation documentation received. Effective 6/30/2025
ALASANTRO, Lori H. PhD	Neurology	Resignation letter received. Effective 10/28/2025
KAUP, Allison R. PhD	Neurology	Resignation letter received. Effective 10/28/2025
ROSEN, Jay W. PhD	Neurology	Resignation letter received. Effective 10/28/2025
KHAN, Gulam Ashfaq H MD	Teleradiology	Resignation letter received. Effective 10/25/2025

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
NOVEMBER 12, 2025

Attachment B

MBOC (Medical Board of California): No new information at this time

NPDB (National Practitioner Data Bank): No new information at this time

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

General & Vascular Surgery - (Revised 12/25)

Provider Name:

	Privilege

SITES:
All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.
Privileges annotated with (F) may be performed at either TCMC or 3925 Waring Road, Suite C, Oceanside CA 92056.

___ Admit Patients

___ Consultation, including via telemedicine (F)

___ Perform Medical History & Physical Examination, including via telemedicine (F)

___ **BASIC GENERAL SURGERY PRIVILEGES**

By selecting this privilege, you are requesting the Basic General Surgery privileges (open or laparoscopic) listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Basic General Surgery Privilege Criteria:
Initial:

- Board certification, or in the first 36 months of Board eligibility and actively pursuing certification by the American Board of Surgery, or demonstrate comparable ability, training or experience.

- One hundred (100) general surgery procedures, reflective of the scope of privileges requested, during the previous twenty-four (24) months or demonstrate successful completion of an ACGME/AOA-accredited residency or clinical fellowship within the previous (24) months.

Proctoring: Six (6) cases
Reappointment: Thirty (30) cases from this category within the previous twenty-four (24) months

Anal canal biopsy (F)

Anoscopy (F)

Arterial catheterization for monitoring

Basic advancement flaps: rotational and myocutaneous (excluding TRAM and micro-vascular)

Biopsy / excision skin & soft tissue lesions (F)

Central venous catheter placement

Chemical destruction of anal warts (F)

Cricothyroidotomy

Debridement of wound, soft tissue infection

Excision of neuroma, neurofibroma, neurilemoma

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

General & Vascular Surgery - (Revised 12/25)

Provider Name:

	Privilege
	Excision of skin, soft tissue neoplasm
	I&D abscess (F)
	Minor laceration repair
	Neurorrhaphy - Suture of Nerve
	Paracentesis
	Panniculectomy
	Parathyroidectomy
	Radical neck dissection, modified
	Right heart catheterization for monitoring
	Rigid proctoscopy (F)
	Rubber band ligation of internal hemorrhoids (F)
	Sentinel lymph node biopsy
	Sigmoidoscopy, includes rigid or flexible
	Thoracentesis
	Thyroidectomy
	Tracheostomy
	Tube thoracostomy
	Abdomen and Perineum Surgery:
	Abdominal perineal resection
	Abdominal wall repair, inguinal or femoral hernia
	Adrenalectomy
	Anal sphincterotomy
	Anti-reflux procedures
	Appendectomy
	Cholecystectomy

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

General & Vascular Surgery - (Revised 12/25)

Provider Name: _____

	Privilege
	Choledochoenteric anastomosis
	Colostomy, closure
	Colostomy, creation
	Common bile duct exploration, transcystic
	Diagnostic laparoscopy with or without biopsy
	Drainage of anorectal abscess
	Drainage of intra-abdominal abscess
	Drainage of Pseudocyst
	Enterolysis
	Esophageal diverticulectomy
	Esophagogastrectomy
	Exploratory Laparotomy
	Fasciotomy
	Gastrectomy, partial or total
	Hemorrhoidectomy
	Hernia, abdominal wall, to include: femoral, inguinal, incisional, lumbar, spigelian, ventral
	Hernia, repair of diaphragmatic or hiatal
	Ileostomy creation or closure
	Intestine resection (small or large intestine)
___	Intra-Peritoneal Catheter Placement
	Liver biopsy
	Lymphadenectomy
	Lysis of adhesions
	Pilonidal cystectomy
	Repair of anorectal fistula

Provider Name:

	Privilege

Repair of rectal prolapse

Splenectomy

Ulcer surgery (Omental patch, V&A, V&O, V&GJ, HSV, etc)

Vagus Transection, for peptic ulcer disease

Breast Surgery:

Axillary dissection

Biopsy, incisional or excisional

Breast abscess, drainage of

Intraoperative needle localization

Intraoperative ultrasound

Mastectomy, partial

Mastectomy, total

Mastopexy

Urogenital Surgery:

Bladder repair - incidental

Hydrocelectomy - incidental

Hysterectomy - incidental

Nephrectomy - incidental

Orchiectomy - incidental

Partial cystectomy - incidental

Salpingo-oophorectomy - incidental or in an acute abdominal emergency

Ureteral repair - incidental

Skin grafting

___ **BASIC PERIPHERAL VASCULAR SURGERY PRIVILEGES**

By selecting this privilege, you are requesting the Basic Peripheral Vascular Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Provider Name:

	Privilege

Basic Peripheral Vascular Surgery Criteria:
Initial: Board certification by the American Board of Surgery, or in the first 36 months of Board eligibility, or can demonstrate comparable ability, training and experience. Ten (10) cases within the previous twenty-four (24) months.
Proctoring: One (1) case from this category
Reappointment: Five (5) cases from this category within the previous twenty-four (24) months

Amputation, digital

Amputation, foot

Amputation, knee, above

Amputation, knee, below

Ligation of perforating veins (open or minimally invasive using laser or ablation using radiofrequency)

Operations for venous ulceration/split thickness skin grafting (STSG)

Sympathectomy - (Including vascular ischemia)

Vein ligation or stripping of varicose veins/phlebectomy

Portal Decompression

Mesocaval shunt

Portocaval shunt

Splenorenal shunt

ADVANCED GENERAL SURGERY PRIVILEGES:

___ **Advanced Breast Surgery**

By selecting this privilege, you are requesting the Advanced Breast Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Advanced Breast Surgery Criteria:
Initial:

- Basic General Surgery privileges which effectively covers the need for board certification.
- For Oncoplastic Repair privileges: Documentation of ten (10) CME credits relating to oncoplastic repair within the previous twenty-four (24) months, OR current oncoplastic repair privileges at another institution, OR completion of a Breast fellowship, OR ten (10) cases performed during residency training or within the previous twenty-four (24) months.

Proctoring: Three (3) cases from this category (Successful completion of proctoring for Advanced Breast privileges satisfies proctoring requirement for Basic Breast Privileges)
Reappointment: Ten (10) cases from this category within the previous twenty-four (24) months

Provider Name:

	Privilege

Oncoplastic repair

___ **Advanced Laparoscopic Surgery**

By selecting this privilege, you are requesting the Advanced Laparoscopic Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Advanced Laparoscopic Surgery Criteria:
Initial: Basic General Surgery privileges which effectively covers the need for board certification. Forty (40) advanced general and abdominal procedures during the previous twenty-four (24) months.
Proctoring: Three (3) cases from this category (Successful completion of proctoring for Advanced Laparoscopy privileges satisfies proctoring requirement for Basic General Surgery Privileges)
Reappointment: Ten (10) cases from this category within the previous twenty-four (24) months

Adrenalectomy

Antireflux/fundoplication procedures (e.g. laparoscopic Nissen/Toupet)

Cholecystoenteric anastamosis

Choledochoenteric anastamosis

Colostomy closure

Esophageal procedures

Gastric resection

Hepatic resection

Hernia repair, diaphragmatic or hiatal

Intestine resection (small or large intestine)

Splenectomy

Ulcer surgery (Omental patch, V&A, V&O, V&GJ, HSV, etc)

___ **Advanced Abdominal Surgery:**

By selecting this privilege, you are requesting the Peripheral Vascular Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Advanced Abdominal Surgery Criteria:
Initial:
1. Basic General Surgery privileges which effectively covers the need for board certification.
2. Two (2) advanced abdominal procedures during the previous twenty-four (24) months.
Proctoring: One (1) case from this category
Reappointment: Two (2) cases from this category per two-year reappointment

Provider Name:

	Privilege

Esophagectomy, including thoracoabdominal approach

Hepatic lobectomy, open

Hepaticoenterostomy

Pancreatic procedures, open or laparoscopic

___ **ADVANCED PERIPHERAL VASCULAR SURGERY**

By selecting this privilege, you are requesting the Peripheral Vascular Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Advanced Peripheral Vascular Surgery Privileges Criteria:
Initial:

- Basic General Peripheral Vascular Surgery privileges which effectively covers the need for board certification.
- Forty (40) vascular cases within the previous twenty-four (24) months (With application, submit list of major procedures done in two (2) years preceding application. Include indications, results, morbidity and mortality data and operative reports.)
- *If only Retroperitoneal exposure for spine vertebral body procedures privilege is requested, documentation of five (5) cases within the previous twenty-four (24) months and documentation of current privileges in vascular or trauma surgery at a
  healthcare facility. All other privileges in the category must be crossed out.

Proctoring: Five (5) cases from this category or * If only Retroperitoneal exposure for spine vertebral body procedures privilege is requested, two (2) cases (Successful completion of proctoring requirement for Advanced Peripheral Vascular Surgery satisfies proctoring requirement for Basic Peripheral Vascular Surgery)
Reappointment: Twenty (20) vascular cases from this category within the previous twenty-four (24) months or *If only Retroperitoneal exposure for spine vertebral body procedures granted, five (5) cases and documentation of current privileges in vascular or trauma surgery at a healthcare facility. All other privileges in the category must be crossed out.

Aortic, aorto-iliac, aorto-femoral bypass

Axillary-femoral bypass

Bypass of upper extremity vessel

Carotid - Subclavian bypass

Celiac/superior mesenteric axis endarterectomy, repair or bypass

Embolectomy or thrombectomy

Endarterectomy, carotid

Endarterectomy or bypass, vertebral

Provider Name:

	Privilege
	Endarterectomy, repair or bypass, renal artery
	Exploration, repair, thrombectomy, or embolectomy of abdominal aorta, iliac, femoral or infrageniculate artery
	Femoral to femoral bypass
	Femoral to infrageniculate bypass
	Femoral to popliteal bypass
	Repair of aortic arch branches
	Repair of iliac, femoral, popliteal, or mesenteric aneurysm
	Repair of infra or suprarenal aortic aneurysm
	Repair of upper extremity vessel
	Retroperitoneal exposure for spine vertebral body procedures, includes incidental vascular procedures*
	Upper and lower extremity deep or superficial vein procedures
	Upper or lower extremity fistula, autogenous or artificial placement of central venous catheter placement
	PERIPHERAL VASCULAR INTERVENTIONAL PROCEDURES (Refer to Medical Staff Policy # 8710-504 for Initial, Proctoring, and Reappointment Criteria)
___	Peripheral Angiography Privileges – *By selecting this privilege, you are requesting the core privileges listed immediately below. If you do **not** want any of the core privileges below, **strikethrough and initial the privilege(s)** you do **not** want.*
	Carotid
	Extremity
	Thoracic
	Pulmomary
	Visceral/Renal
___	Peripheral Intervention - *By selecting this privilege, you are requesting the core privileges listed immediately below. If you do **not** want any of the core privileges below, **strikethrough and initial the privilege(s)** you do **not** want.*
	Angioplasty
	Atherectomy
	Drug Infusion
	Stent graft

Provider Name:

	Privilege

Stent placement

Thrombolysis

___ Venography and Venous Intervention - *By selecting this privilege, you are requesting the core privileges listed immediately below. If you do **not** want any of the core privileges below, **strikethrough and initial the privilege(s)** you do **not** want.*

IVC filter

Stent

Tissue plasminogen activator (tPA)

Venous Sampling

Venous Thrombolysis

SPECIAL PRIVILEGES:

___ **BARIATRIC SURGERY**

By selecting this privilege, you are requesting the Bariatric Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Bariatric Surgery Criteria:
Initial:

- Completion of General Surgery residency program.
- Privileges to perform Basic and Advanced Abdominal surgery and advanced laparoscopy.
- Completion of a Bariatric and Metabolic Surgery fellowship, or Minimally Invasive fellowship with documentation of rotation in Bariatrics and the performance of a minimum of five (5) cases within the previous twenty-four (24) months, or case logs documenting the performance of a minimum of fifteen (15) bariatric cases within the previous twenty-four (24) months.
- Documentation to indicate malpractice coverage includes bariatric surgery.

Proctoring: Three (3) cases Bariatric and Three (3) Bariatric EGD Cases
Reappointment: Fifteen (15) cases within the previous twenty-four (24) months

Roux en Y gastric bypass

Sleeve gastrectomy

Adjustable gastric banding

Revisional metabolic and bariatric surgery

Biliopancreatic diversion, with or without duodenal switch

Bariatric Endoscopy

Provider Name:

	Privilege

Upper endoscopy (EGD) – intraoperative/as integral part of operation (i.e., Heller myotomy, gastric bypass), or as preoperative evaluation or as follow-up for specific operative procedures
Initial: Completion of an ACGME-accredited training program in General Surgery or Colon and Rectal Surgery within the previous twenty-four (24) months. If training was completed greater than twenty-four (24) months ago, documentation of a refresher training course in upper endoscopy or documentation of fifty (50) cases within the previous twenty-four (24) months is required.
Proctoring: Two (2) cases if training was completed within the previous twenty-four (24) months prior to granting of privileges or if training was completed more than twenty-four months prior to granting privileges and documentation of fifty (50) cases was provided; Five (5) cases if training was completed greater than twenty-four (24) months prior to granting of privileges and documentation of refresher course was provided. Proctoring for this privilege should include proctoring supplied for the Bariatric EGD privilege and/or proctored cases supplied for Transoral Esophagogastric Fundoplication (TIF).
Reappointment: Seven (7) cases within the previous twenty-four (24) months

___ Upper endoscopy (EGD) – intraoperative/as integral part of operation (i.e., Heller myotomy, gastric bypass), or as preoperative evaluation or as follow-up for specific operative procedures

Colonoscopy Criteria:
Initial: Completion of ACGME-accredited training program in General Surgery or Colon and Rectal Surgery within the previous twenty-four (24) months. If training was completed greater than twenty-four (24) months ago, documentation of fifty (50) cases within the previous twenty-four (24) months is required.
Proctoring: Two (2) cases
Reappointment: Five (5) cases within the previous twenty-four (24) months

___ Colonoscopy

Endovenous Ablative Therapy Criteria:
Initial: Documentation of completion of product-sponsored training, which included the performance/interpretation of twenty (20) endovenous ablative therapy procedures.
Proctoring: Three (3) cases
Reappointment: Five (5) cases within the previous twenty-four (24) months

___ Endovenous Ablative Therapy

___ Endovascular Repair of Aortic Aneurysms (Refer to Credentialing Policy, Standards for Endovascular Repair of Aortic Aneurysms #8710-503 for Initial, Proctoring, and Reappointment criteria)

KTP Laser Criteria:
Initial: Documentation of completion of training for specific energy source(s) to be used. Or, if training completed greater than two years prior to privilege request, submit case logs from previous 24 months identifying specific energy source used.
Proctoring: Two (2) cases
Reappointment: Two (2) cases within the previous twenty-four (24) months

___ KTP Laser

___ Moderate Sedation - Refer to Medical Staff policy 8710-517

___ Fluoroscopy in accordance with hospital policy (Refer to Medical Staff Policy 528 and 528A)

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

General & Vascular Surgery - (Revised 12/25)

Provider Name:

	Privilege

Robotic Surgery Bundle (da Vinci) (Refer to Credentialing Policy, Robotic Assisted Surgery #8710-563 for Initial, Proctoring, and Reappointment criteria)

By selecting this privilege, you are requesting the core privileges listed immediately below. If you do not want any of the core privileges below, strikethrough and initial the privilege(s) you do not want.

___ Xi Robotic Privileges
Initial Criteria: Must meet initial and reappointment for Core Robotic assisted privileges and provide certificate of training for Xi Robotic from Intuitive prior to case
Proctoring: Must meet proctoring criteria for Da Vinci Robotic Surgery

___ Assist in Xi Robotic
Initial Criteria: Must meet initial and reappointment for Core Robotic assisted privileges and provide certificate of training for Xi Robotic from Intuitive prior to case
Proctoring: Must meet proctoring criteria for Assisting in Da Vinci Robotic Surgery

Transoral Esophagogastric Fundoplication (TIF) Criteria:
Initial:
1. Completion of ACGME accredited residency program and possess board certification or board eligibility in Surgery; and
2. Documentation of completion of product-sponsored training course, or have performed at least five (5) TIF procedures in the previous twelve (12) months.
Proctoring: Three (3) cases
Reappointment: Six (6) cases within the previous twenty-four (24) months

___ Transoral Esophagogastric Fundoplication (TIF)

Placement of Vagal Nerve Stimulator Criteria:
Initial:
1. Basic General Surgery privileges which effectively covers the need for board certification.
2. Documentation of performing five (5) vagal nerve stimulator cases in the previous twenty-four (24) months or successful completion of VNS Therapy System Surgeon Training Program.
Proctoring: Two (2) cases
Reappointment: Five (5) cases within the previous twenty-four (24) months

___ Placement of vagal nerve stimulator

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

General & Vascular Surgery - (Revised 12/25)

Provider Name:

	Privilege

_____

Division/Department Signature (By Signing this form I agree with the granting of these privileges indicated above.)

_____

Date

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
December 3, 2025

Members Present	Director Tracy Younger, Director Adela Sanchez, Dr. Mohammad Jamshidi-Nezhad, Dr. Robert Lee
Non-Voting Members Present:	Dr. Gene Ma, Jeremy Raimo, COO, Donald Dawkins, CNE, Roger Cortez, CCO, Anh Nguyen, CFO, Mark Albright, CIO
Others Present:	Eva England, VP Ancillary Services, Chuck Sawyers, Manager, Supply Chain, Jennifer Paroly, President Foundation, Julie Abraham, Director Pharmacy, Miava Sullivan, FOP Coordinator, Jane Dunmeyer
Members Absent:	Director Nina Chaya, Susan Bond, General Counsel

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Tracy Younger called the meeting to order at 3:03 pm.		Chair
2. Approval of Agenda		**MOTION** **It was moved by Dr. Jamshidi-Nezhad, seconded by Director Sanchez, and it was unanimously approved, with Director Chaya absent, to accept the agenda of December 3, 2025.**	Chair
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Younger read the paragraph regarding comments from members of the public.	No comments	Chair
4. Ratification of minutes of September 24, 2025	Minutes were ratified.	Minutes were ratified. **MOTION** **It was moved by Director Younger, seconded by Dr. Jamshidi-Nezhad, and it was unanimously passed, with Director Chaya absent, that the**	Chair

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		minutes of September 24, 2025, are to be approved without any requested modifications.	
5. Old Business	None		
6. New Business	None		
7. Consideration of Consent Calendar:		**MOTION** **It was moved Director Sanchez and seconded by Dr. Jamshidi-Nezhad and unanimously passed with Director Chaya absent, to approve the Consent Calendar** **Members:** **AYES: Younger, Sanchez, Jamshidi-Nezhad, Lee** **NOES: None** **ABSTAIN: None** **ABSENT: Chaya**	Chair
a) Physician Recruitment Agreement • Dr. Elsie Ross		**Approved via Consent Calendar**	Jeremy Raimo
b) Medical Directorship Agreement – Diabetic Services Program • Jamil Alkhaddo, M.D.		**Approved via Consent Calendar**	Jeremy Raimo
c) Physician Assistant Specialist of California, Inc. (PASCAL) – Services Agreement • Physician Assistant Specialist of California, Inc.		**Approved via Consent Calendar**	Eva England

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
d) Physician Agreement for CVHI Operations Committee • Mohammad Jamshidi-Nezhad, D.O.		**Approved via Consent Calendar**	Eva England
e) Medical Directorship Agreement – Infection Prevention & Control and Antimicrobial Stewardship Program • Richard Smith, M.D.		**Approved via Consent Calendar**	Dr. Gene Ma
f) Group Purchasing Program Agreement Renewal • Vizient, Inc.		**Approved via Consent Calendar**	Chuck Sawyers
g) Linen and Laundry Services Agreement • CORE / Crothall Laundry Services		**Approved via Consent Calendar**	Jeremy Raimo
h) Renewal of Abstraction Agreement with Direct Difference, Inc. • Direct Difference, Inc.		**Approved via Consent Calendar**	Eva England
i) Addendum to Master Services Agreement – Iodine Software, LLC Add-on Module (AwareUM) • Iodine Software, LLC		**Approved via Consent Calendar**	Mark Albright
j) Office Lease Agreement Proposal • 161 Thunder MOB, LLC		**Approved via Consent Calendar**	Jeremy Raimo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
8. Financials	Anh Nguyen presented the financials ending October 31, 2025 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 114,235 Operating Expense $ 120,461 EBITDA $ 9,425 EROE $ 3,539 **TCMC – Key Indicators** **Fiscal Year to Date** Avg. Daily Census 119.5 Adjusted Patient Days 26,977 Avg Acute Length of Stay 4.89 Surgery Cases 1,717 ED Visits 16,324 **TCHD – Financial Summary** **Current Month** Operating Revenue $ 30,686 Operating Expense $ 31,533 EBITDA $ 2,847 EROE $ 1,260 **Graphs:** • TCHD-EBITDA and EROE • TCMC-Average Daily Census, Total Hospital - Excluding Newborns • TCMC-Acute Average Length of Stay • TCMC-Paid Full Time Equivalents-13 Month Trend		Anh Nguyen
a. Dashboard	No discussion	Information Only	Anh Nguyen
9. Construction Update	No discussion	Information Only	Benito Oporto

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
10. Comments by Committee Members	None	None	Chair
11. Date of next meeting	January 21, 2026		Chair
12. Adjournment	Meeting adjourned 3:37 p.m.	It was moved by Dr. Sanchez and seconded by Dr. Jamshidi-Nezhad and unanimously passed with Director Chaya absent, to adjourn the meeting at 3:37 p.m.	Chair

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 3, 2025
PHYSICIAN RECRUITMENT AGREEMENT

Type of Agreement		Medical Directors		Panel	X	Other: Physician Recruitment
Status of Agreement	X	New Agreement		Renewal: New Rates		Renewal: Same Rates

Physician Name: Elsie Ross, M.D., MSc, FAHA

Areas of Service: Vascular Surgery

Key Terms of Agreement:

Effective Date: January 1, 2026, or the first of the month following the date Dr. Ross becomes a credentialed member in good standing of the Tri-City Healthcare District Medical Staff.

Community Need: TCHD Physician Needs Assessment shows significant community need for Vascular Surgery

Service Area: Area defined by the lowest number of contiguous zip codes from which the hospital draws at least 75% of its inpatients

Terms of the Engagement:	Proposal Costs:
Sign-on Advance	$20,000
Monthly Income Guarantee, NTE	$41,667 per month ($500,000/year x 2 yrs.; 3-year forgiveness period)
Total Amount of Request:	**$1,020,000**

Requirements:

Business Pro Forma: Must submit a 24-month business pro forma for TCHD approval relating to the addition of this physician to the medical practice.

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer

Motion:

I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors approve this expenditure, not to exceed $1,020,000, to facilitate the addition of Elsie Ross, M.D., MSc, FAHA, a Vascular Surgery physician to practice medicine in the communities served by the District. This will be accomplished through an independent physician recruitment agreement (not to exceed a two-year income guarantee with a three-year forgiveness period) between Tri-City Healthcare District, and Elsie Ross, M.D., MSc, FAHA.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 3, 2025
MEDICAL DIRECTORSHIP AGREEMENT – DIABETIC SERVICES PROGRAM

Type of Agreement	X	Medical Directors		Panel		Other:
Status of Agreement		New Agreement		Renewal – New Rates	X	Renewal – Same Rates

Physician's Name: Jamil Alkhaddo, M.D.

Area of Service: Diabetic Services Program

Term of Agreement: Beginning, February 1, 2026 through January 31, 2027

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: Yes

Rate/Hour	Hours Per Month	Hours Per Year	Monthly Cost	Annual Cost
$150	16	192	$2,400	**$28,800**

Description of Services/Supplies:

- Medical Direction of Diabetes Program
- Develops, implements and monitors Diabetic planning to ensure patient care quality and regulatory compliance.
- As a requirement for Joint Commission for accreditation, the program must have physician oversight through a Medical Director

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize a renewal medical directorship agreement with Jamil Alkhaddo, M.D. for the Diabetes Program for a term of 12 months, beginning, February 1, 2026 through January 31, 2027 for a total term cost not to exceed $28,800.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 3, 2025
PHYSICIAN ASSISTANT SPECIALISTS OF CALIFORNIA, INC. (PASCAL) SERVICES AGREEMENT

Type of Agreement		Medical Director		Panel	X	Other: Physician Assistant Svcs.
Status of Agreement		New Agreement	X	Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Physician Assistant Specialist California, Inc. (PASCAL)

Area of Service: Surgery

Term of Agreement: 24 months, Beginning, December 1, 2025 – Ending, November 30, 2027

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$20,833	$250,000	**$500,000**

Description of Services/Supplies:

- Physician Assistant surgical scrub support for open heart patients, pursuant to Title 22

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	x	Yes		No

Person responsible for oversight of agreement: Eva England, Sr. Director-Ancillary Services

Motion:
I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Physician Assistant Specialist California, Inc. (PASCAL) for Physician Assistant surgical scrub support for a term of 24 months, beginning, December 1, 2025 and ending, November 30, 2027, for an annual cost of $250,000 and a total term cost not to exceed $500,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 3, 2025
PHYSICIAN AGREEMENT FOR CVHI-OPERATIONS COMMITTEE

Type of Agreement		Medical Directors		Panel	X	Other: Operations Committee-CVHI
Status of Agreement		New Agreement		Renewal – New Rates	X	Renewal – Same Rates

Physician's Name: Mohammad Jamshidi-Nezhad, D.O.

Area of Service: Cardiovascular Health Institute – Operations Committee

Term of Agreement: 12 months, Beginning, November 1, 2025– Ending, October 31, 2026

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	12 Month (Term) Cost
$210	2	24	$420	$5,040

Position Responsibilities:

- Physician shall serve as an Operations Committee Member and shall be responsible for the services as outlined in the previously approved Co-Management Agreement for the Institute

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Eva England, Sr. Director-Ancillary Services

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Dr. Mohammad Jamshidi-Nezhad, as Cardiovascular Health Institute – Operations Committee member for a term of 12 months, beginning, November 1, 2025 and ending, October 31, 2026, not to exceed 2 hours per month at an hourly rate of $210 for an annual and total term cost of $5,040.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 3, 2025
MEDICAL DIRECTORSHIP AGREEMENT - INFECTION PREVENTION & CONTROL (IPC) AND ANTIMICROBIAL STEWARDSHIP PROGRAM (ASP)

Type of Agreement	X	Medical Directors		Panel		Other:
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Physician's Name: Richard Smith, M.D.

Area of Service: Infection Prevention & Control, and Antimicrobial Stewardship Program

Term of Agreement: 36 months, Beginning December 1, 2025- Ending November 30, 2028

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Rate/Hour	Hours per Month Not to Exceed	Hours per Year Not to Exceed	Monthly Cost Not to Exceed	Annual Cost Not to Exceed	36 Month Term Cost Not to Exceed
$176	30	360	$5,280	$63,360	**$190,080**

Description of Services/Supplies:

- Provide infectious disease clinical consultation as requested by medical staff
- Develop, implement and evaluate an infection control plan to mitigate inappropriate prescribing of antibiotics based on evidence-based, best practices in the contemporary practice of infectious disease
- Assure quality of preventative measures and risk aversion
- Establish and evaluate policies and procedures for medical and nursing care, including new treatment modalities, drug information and management protocols
- Recommend, develop and implement new services related to infection control and prevention
- Identify equipment and supply needs, and coordinate standardization of instrumentation/equipment for patient care as it relates to infection prevention
- Co-lead Infection Control meetings and attend other Hospital and Medical Staff meetings in order to accomplish the duties of this role

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Gene Ma, M.D., Chief Executive Officer

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Dr. Richard Smith as the Medical Director for Infection Prevention & Control and Antimicrobial Stewardship Program for a term of 36 months, beginning December 1, 2025 and ending November 30, 2028, at an hourly rate of $176, for an annual cost not to exceed $63,360, and a total term cost not to exceed $190,080.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 3, 2025
GROUP PURCHASING PROGRAM AGREEMENT RENEWAL

Type of Agreement		Medical Directors		Panel		Other:
Status of Agreement		New Agreement		Renewal – New Rates	X	Renewal – Same Rates

Vendor's Name: Vizient, Inc.

Area of Service: Supply Chain

Term of Agreement: 36 months, Beginning January 1, 2026 – Ending, December 31, 2028

Maximum Totals:

Term	Total Spend Requirement
36 months	**$81,621,000**

Description of Services/Supplies:

- Vizient provides supply and service contracts for the entire facility.
- All contracts have been competitively bid.
- TCMC has had excellent service with Vizient for over 10 years.
- Our fees and rebates are based on actual contract usage. On average TCMC's fees are 1.25% of our spend, while our rebates on average is 3% of our spend.
    - Average annual rebate to TCMC is $250,000
- Vizient has confirmed that Sharp Healthcare is part of the Vizient Group Purchasing program. When our affiliation is certified and finalized, we will be transferred over to Sharp's Vizient agreement and contracts.

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Chuck Sawyers, Manager-Supply Chain Management / Anh Nguyen, Chief Financial Officer

Motion:

I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors approve a 36-month renewal of the agreement with Vizient, Inc. for Group Purchasing contracts which includes supply purchases and service contracts, to begin on January 1, 2026 and ends on December 31, 2028, for a total term not to exceed cost of $81,621,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
MEETING DATE: December 3, 2025
LINEN AND LAUNDRY SERVICES AGREEMENT

Type of Agreement		Medical Directors		Panel		Other:
Status of Agreement		New Agreement	X	Renewal – New Rates		Renewal – Same Rates

Vendor's Name: CORE / Crothall Laundry Services

Area of Service: Environmental Services (EVS)

Term of Agreement: 36 months, Beginning, January 1, 2026 – Ending, December 31, 2028

Maximum Totals:

Term	Annual Cost	Total Term Cost
3 Years	$840,000	**$2,520,000**

Description of Services/Supplies:

- Provide laundry services for all TCMC linen, scrubs, towels, etc.
- TCMC has had excellent service with Crothall for 10+ years
- This cost is based upon our Group Purchasing Organization contract and terms that were competitively bid

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:		Yes	N/A	No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Hope Chaney, Manager-Environmental Services & Chuck Sawyers, Manager-Supply Chain Management / Jeremy Raimo, Chief Operating Officer

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors approve a 36-month renewal agreement with CORE Laundry Services for TCHD's linen and laundry services with a historical annual spend of $840,000 a year and total spend of $2,520,000 with the term to begin on January 1, 2026 and end on December 31, 2028.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 3, 2025
RENEWAL OF ABSTRACTION AGREEMENT WITH DIRECT DIFFERENCE, INC.

Type of Agreement		Medical Director		Panel		Other:
Status of Agreement		New Agreement		Renewal – New Rates	X	Renewal – Same Rates

Vendor's Name: Direct Difference, Inc.

Area of Service: Cardiology/Quality

Term of Agreement: 24 months, Beginning, November 6, 2025 – Ending, November 5, 2027

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$14,583.33	$175,000	$350,000

Description of Services/Supplies:

- Perform medical record abstractions to review and abstract TCMC's charts and/or records for the purpose of reporting data to the Centers for Medicare and Medicaid services, The Joint Commission, and data registry
- Abstraction of STEMI, CAD, TAVR, Watchman Cases
- Abstraction of CABG cases for CCORP and STS (mandatory abstraction for the State)
- Abstraction of sepsis and quality data for Leap

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Eva England, Vice President-Ancillary Services

Motion:
I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Direct Difference, Inc. to perform abstraction services for cardiology/quality services for a term of 24 months, beginning, November 6, 2025 and ending, November 5, 2027 for an annual cost of $175,000 and a total term cost of $350,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 3, 2025
Iodine Software, LLC - Add-on Module (AwareUM)

Type of Agreement		Medical Directors		Panel	X	Other: Software Support
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Iodine Software, LLC

Area of Service: Utilization Management and Revenue Cycle

Term of Agreement: 36 months, Beginning January 1, 2026 – Ending December 31, 2028

Year	Annual Cost
1	$222,800
2	$367,080
3	$385,434
Total Term Cost	**$975,314**

- Year 1 total annual cost = $222,800. It reflects a 50% discounted 1st year subscription fee of $174,800 and a 20% discounted implementation fee of $48,000
- Year 2 annual cost = $367,080
- Year 3 annual cost = $385,434
- Years 2 and 3 have a 5% CPI escalator included.
- Total cost of the 3-year term = $975,314, (estimated 3 yr. return = $23,582,350)

Description of Services/Supplies:
AwareUM is an additional Iodine clinical document integrity (CDI) module and an addendum to the Iodine master service agreement (MSA). Using Iodine's artificial intelligence (AI), it automatically reviews all inpatient/observation accounts daily for appropriate status to include Inpatient Only Procedures, predicts geometric mean length of stay (GMLOS) to manage length of stay (LOS), prioritizes utilization review (UR) case lists, ensues medical necessity is met. Making timely status conversions, managing medical necessity, maximizing reimbursement, and decreasing denial rate yields an estimated incremental annual impact of $8,575,400.

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:		Yes	N/A	No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Mark Albright, Chief Information Officer

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the addendum with Iodine Software, LLC for a subscription and artificial intelligence (AI) services for a term of 36 months beginning January 1, 2026 and ending December 31, 2028, for a total term cost of $975,314.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 3, 2025
Office Lease Agreement Proposal – 161 Thunder Dr. MOB, LLC

Type of Agreement		Medical Directors		Panel		Other: Lease Renewal
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Landlord Name: 161 Thunder MOB, LLC ("Landlord")

Premises: 161 Thunder Dr., Vista, CA 92083 (8,647 rentable sq.ft.)

Term of Agreement: 7/1/26 – 1/31/37 (127 Months) beginning upon completion of tenant improvements estimated July 1, 2026

Within Fair Market Value: Yes (FMV was determined by Lease Comparables)

Rental Rate:	**Monthly Expense**
Full Service Gross Rental Rate of $3.14 per square foot	Year 1 - $27,151
Total 127 Month Term Expense Amount Not to Exceed:	**$4,595,140**

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:		Yes	NA	No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item: (Revenue)	X	Yes		No

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer / Sarah Jayyousi, Director OP Behavioral Health

Motion:

I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the Office Lease Agreement with 161 Thunder MOB, LLC for a 127-month term beginning approximately July 1, 2026 ending January 31, 2037. This proposal remains within the current fair market value full service gross rental rate of $3.14 per square foot for a monthly expense of $27,151, for a maximum total expense for the 127-month term of $4,595,140.

ADMINISTRATION CONSENT AGENDA
December 1, 2025

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Black Box Warnings, Drugs with Policy	3 year review, practice change	Forward to BOD for Approval
2. Bronchoscopy Nursing Procedure	3 year review, practice change	Forward to BOD for Approval
3. Communicating with Physician / Allied Health Professional Using the Process SBAR Policy	3 year review, practice change	Forward to BOD for Approval
4. Consent for Minors Policy	3 year review, practice change	Forward to BOD for Approval
5. Defibrillator Checks	3 year review, practice change	Forward to BOD for Approval
6. Discharge from Outpatient Post-Anesthesia Service Standardized Procedure	3 year review, practice change	Forward to BOD for Approval
7. Disposal of Chemotherapy Waste Procedure	3 year review	Forward to BOD for Approval
8. Documentation in the Medical Record Policy	3 year review, practice change	Forward to BOD for Approval
9. Enteral Feeding Preparation, Storage, Distribution, and Administration Policy	3 year review, practice change	Forward to BOD for Approval
10. Epilepsy Monitored Unit (EMU) Procedure	RETIRE	Forward to BOD for Approval
11. Food and Nutrition Relationships with Other Departments Policy	3 year review, practice change	Forward to BOD for Approval
12. Holds, Evaluation and Treatment of Involuntary Patients Policy	3 year review, practice change	Forward to BOD for Approval
13. Incentive Spirometer (IS) Instruct and Monitoring Procedure	3 year review, practice change	Forward to BOD for Approval
14. Infusion Pumps, Intravenous Therapy Policy	3 year review, practice change	Forward to BOD for Approval
15. Meals, Patients - Times, Menus, Substitutions, & Nourishments Policy	3 year review, practice change	Forward to BOD for Approval
16. Medical Examiner Notification Policy	3 year review, practice change	Forward to BOD for Approval
17. Medical Record, Making Corrections to Documentation Procedure	3 year review, practice change	Forward to BOD for Approval
18. Minors Attempting to Leave Without a Parent-Domestic Partner-Legal Guardian Policy	3 year review, practice change	Forward to BOD for Approval
19. Nutrition Education of Patients Policy	3 year revieW	Forward to BOD for Approval
20. Patient Food Refrigerators/ Freezers Procedure	3 year review	Forward to BOD for Approval
21. Patient Leave of Absence, Temporary Policy	3 year review, practice change	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
December 1, 2025

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
22. Physician / Allied Health Professionals (AHP) Orders for Outpatient Services	3 year review	Forward to BOD for Approval
23. Pre-Operative Education Medication Instructions to Surgical Patients Standardized Procedure	2 year review, practice change	Forward to BOD for Approval
24. Privacy Code Policy	3 year review, practice change	Forward to BOD for Approval
25. Private Duty Staff, Patient Acquired Policy	3 year review, practice change	Forward to BOD for Approval
26. Referrals to Social Services for Patients Identified to be of High Risk Policy	3 year review, practice change	Forward to BOD for Approval
27. Reporting Suspected Child Abuse/Neglect	3 year review, practice change	Forward to BOD for Approval
28. Reporting Suspected Dependent Adult/Elder Abuse/Neglect	3 year review	Forward to BOD for Approval
29. Staffing, Registry-Traveler Usage Policy	3 year review, practice change	Forward to BOD for Approval
30. Swallowing, Food and Nutrition Considerations for Patients with Oro-pharyngeal Dysphagia Policy	3 year review, practice change	Forward to BOD for Approval
31. Team NICU Response Plan	RETIRE	Forward to BOD for Approval
32. Vaccination Administration	3 year review, practice change	Forward to BOD for Approval
Administrative District Operations 200s		
1. Clinical Product Review/New Products 297	3 year review, practice change	Forward to BOD for Approval
2. Legal Documents 294	3 year review, practice change	Forward to BOD for Approval
3. Mandatory Reporting Requirements 236	3 year review, practice change	Forward to BOD for Approval
4. Parking Program 261	3 year review, practice change	Forward to BOD for Approval
5. Quality Assessment Performance Improvement (QAPI) Plan	1 year review, practice change	Forward to BOD for Approval
Administrative 300s Patient Care		
1. Medicare Change of Status Notice	NEW	Forward to BOD for Approval
Administrative 400s Human Resources		
1. Employment of Relatives - 406	3 year review, practice change	Forward to BOD for Approval
2. Performance Evaluations - 426	Practice change	Forward to BOD for Approval
3. Reduction in Work Force - 448	3 year review, practice change	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
December 1, 2025

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
Administrative 500s Compliance		
1. Advanced Beneficiary Notification 503	3 year review, practice change	Forward to BOD for Approval
2. EMTALA Emergency Medical Screening 506	1 year review	Forward to BOD for Approval
Administrative 600s Information Technology		
1. Incident Response Policy	NEW	Forward to BOD for Approval
Cardiac Cath Lab		
1. Angiojet Procedure	3 year review, practice change	Forward to BOD for Approval
2. D-Stat Flowable Procedure	Practice change	Forward to BOD for Approval
3. Manual Aspiration Extraction of Coronary Thrombus Procedure	3 year review, practice change	Forward to BOD for Approval
4. Right Heart Catheterization and Prep of a Pulmonary Artery Catheter Procedure	3 year review, practice change	Forward to BOD for Approval
5. Scheduling Cardiac Catheterization Cases Policy	3 year review, practice change	Forward to BOD for Approval
Food & Nutrition		
1. Clinical Nutrition Dietitian Staffing Policy	3 year review, practice change	Forward to BOD for Approval
2. Food Allergens Policy	3 year review, practice change	Forward to BOD for Approval
3. Food Safety and Department Cleaning Policy	3 year review	Forward to BOD for Approval
4. Food Service Employee Health-Work Restrictions for Personnel with Infectious Disease Policy	3 year review	Forward to BOD for Approval
5. Identification of Patients Not Receiving Oral Intake Policy	3 year review, practice change	Forward to BOD for Approval
6. Nutritional Care and Assessment for Infants Admitted to NICU Policy	RETIRE	Forward to BOD for Approval
7. Protocols for Nutrition Care	3 year review, practice change	Forward to BOD for Approval
Infection Control		
1. Aerosol Transmissible Diseases and Tuberculosis Control Plan	1 year review, practice change	Forward to BOD for Approval
2. Bloodborne Pathogen Exposure Control Plan	1 year review, practice change	Forward to BOD for Approval
Laboratory General		

ADMINISTRATION CONSENT AGENDA
December 1, 2025

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
1. QSE.06 Laboratory Information Management Quality System Essentials	2 year review	Forward to BOD for Approval
2. QSE.07 Laboratory Document and Records Quality System Essentials	2 year review	Forward to BOD for Approval
3. QSE.11 Laboratory Customer Service Quality System Essentials	2 year review	Forward to BOD for Approval
Laboratory Point of Care		
1. Point of Care Quality Assurance Policy	2 year review, practice change	Forward to BOD for Approval
Outpatient Behavioral Health		
1. Abbreviations	3 year review	Forward to BOD for Approval
2. Admission and Eligibility Criteria	3 year review	Forward to BOD for Approval
3. Admission Assessment	3 year review	Forward to BOD for Approval
4. Age Appropriate Care	3 year review	Forward to BOD for Approval
5. Clinical Assessment	3 year review	Forward to BOD for Approval
6. Contraband	3 year review	Forward to BOD for Approval
7. Co-treatment of Patients Policy	3 year review	Forward to BOD for Approval
8. Daily Progress Notes	3 year review	Forward to BOD for Approval
9. Discharge Planning & Discharge	3 year review	Forward to BOD for Approval
10. Laboratory Services	3 year review	Forward to BOD for Approval
11. Medical Emergencies	3 year review	Forward to BOD for Approval
12. Organizational Structure	3 year review	Forward to BOD for Approval
13. Physician Admission Order	3 year review	Forward to BOD for Approval
14. Psychiatric Evaluation for Higher Level of Care	3 year review, practice change	Forward to BOD for Approval
15. Referral and Admission Screening	3 year review	Forward to BOD for Approval
16. Role of the Therapist	3 year review	Forward to BOD for Approval
17. Scope of Services	3 year review	Forward to BOD

ADMINISTRATION CONSENT AGENDA
December 1, 2025

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
		for Approval
18. Smoke Free Environment	3 year review	Forward to BOD for Approval
19. Standards for Clinical and Professional Practice	3 year review	Forward to BOD for Approval
20. Substance Abuse	3 year review	Forward to BOD for Approval
21. Suicide Assessment	3 year review	Forward to BOD for Approval
22. Treatment Planning	3 year review	Forward to BOD for Approval
Rehabilitation		
1. Behavior Management/ Supervision Technique	3 year review, practice change	Forward to BOD for Approval
2. Job Site Assessment 609	3 year review, practice change	Forward to BOD for Approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: **10/08** **SUBJECT:** **Black Box Warnings, Drugs With**

REVISION DATE: **12/09, 5/13, 07/17, 04/22**

Department Approval:	**~~11/21~~09/24**
Clinical Policies & Procedures Committee Approval:	**~~12/21~~05/25**
Nursing Leadership Approval:	**~~01/22~~05/25**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~02/22~~09/25**
Medical Executive Committee Approval:	**~~03/22~~10/25**
Administration Approval:	**~~04/22~~12/25**
Professional Affairs Committee:	**n/a**
Board of Directors Approval:	**04/22**

A. **PURPOSE:**

1. Tri-City Healthcare District (TCHD), as part of their selection process for admission of a medication to the formulary, will determine if the medication contains a Food and Drug Administration (FDA) "Black Box Warning" and determine the appropriate action and/or limitation required for the use of the drug within the organization.

B. **DEFINITIONS:**

1. Black Box Warnings are specific product summaries of potential safety precautions and warnings of serious adverse reactions**,** including potentially life-threatening effects. These warnings and information are required by the FDA. Black Box Warnings can be found in the package insert. The FDA can require a pharmaceutical company to label a prescription medication with a Black Box Warning, the strongest warning the FDA can require.

C. **POLICY:**

1. The Pharmacy Department will develop guidelines and protocols that are approved by the Pharmacy & Therapeutics (P&T) Committee to ensure medications are controlled and distributed properly.
2. TCHD will develop a system for medications with Black Box Warnings**,** including but not limited to the following:
   a. Checklist or written guidelines for use
   b. Pre-printed orders/electronic orders
   c. Dose limitations
   d. Packaging adjustments (warning labels, special packaging)
   e. A system of double checks in prescribing, dispensing and administration processes
3. All adverse events associated with **Black** Box ~~w~~**W**arning medications will be reported separately to the P&T Committee. The P&T Committee will review, trend and take appropriate action to minimize any future adverse events with Black Box Warning medications.

D. **PROCEDURE:**

1. Identification
   a. Medications approved for use in the hospital will be ~~annually~~ reviewed **annually** for Black Box Warnings.
   b. TCHD shall maintain a list of the medications with Black Box Warnings that are most pertinent to the hospital patient population.

c. Computer systems will alert the physician/pharmacist at the time of order entry if a drug contains a Black Box Warning with special precautions.
d. Labeling of dispensed products will notify the end user of **Black** Box ~~w~~**W**arnings with special precautions.

2. Guidelines, Protocols and Limitations
   a. From a list of formulary drugs with Black Box Warnings, the P&T Committee will establish a subset of high-~~-~~priority drugs for focused attention. Analysis will be based on the severity risk level of the Black Box Warning, adverse reactions history and frequency of utilization.
   b. The P&T Committee will assess the need to develop actions, guidelines or protocols for appropriate use of these medications. These guidelines and/or protocols will address appropriate actions to be considered by physicians, nurses and pharmacists in each medication management sub process. Actions may include:
      i. Prescribing
         1) Maximum/Minimum dosing range
         2) Evidence-~~-~~based justification for use of the medication
         3) Preprinted or special physician order forms or electronic orders
            a) Dose limitations
            b) Dosing orders written with dosing criteria/calculations (example: mg/m^2) in addition to final dose
         4) Written and/or approved by designated medical staff members competent in the use of the medication
         5) Appropriate monitoring orders
            a) Laboratory test**s**
            b) Vital signs
      ii. Dispensing
         1) Warning label identifying “Black Box warning alert” in dispensing area
         2) Drug/drug interaction review
         3) Pharmacist documented intervention with prescribing physician to confirm order and/or clinical discussion
         4) Auxiliary labeling
         ~~5) Special packaging~~
         ~~6) Special transport procedures~~
      iii. Administration
         1) Warnings appropriate during administration of the drug
         2) Education of administering personnel regarding detection and monitoring of an adverse event
      iv. Monitoring
         1) Monitoring parameters
         2) Reporting mechanisms for adverse events
         3) Specific action to be taken if an adverse event occurs
      v. Education
         1) Information on any new Black Box Warnings and action needed is updated in the computer, Pyxis systems and taken before the P&T committee to approve specific actions, guidelines**,** or protocols.
      vi. Non-formulary Drugs with Black Box Warnings
         1) TCHD policy for non-formulary requests will be followed.
         2) All orders for non-formulary medications will be reviewed for Black Box warnings.
      vii. Patient’s Own Medications
         1) See Patient Care Services Policy: Medications Brought In By the Patient
         2) As part of the review process all drugs will be reviewed for Black Box warnings.

viii. Non-formulary Samples
1) Sample medications will not be permitted.
2) TCHD Sample Policy will be followed.

3. Nursing shall review any additional interventions per alert to Black Box Warning drugs via Pyxis and/or the Cerner eMAR prior to administration. Additional information may be obtained~~,~~ but is not limited to~~,~~ the following:
   a. Cerner reference text
   b. Micromedex
   c. TCHD Drug Formulary
   d. Pharmacist

E. **RELATED DOCUMENTS:**
1. Black Box Warning List
2. Patient Care Services Policy: Medications Brought In By the Patient

F. **REFERENCES:**
1. The Joint Commission Standard MM.01.01.03; MM.02.01.01
2. Healthcare Facilities Accreditation Program (HFAP) 25.01.19; 25.01.11
3. Centers for Medicare and Medicaid Services CMS Interpretation Guidelines CoP §482.25(a)(1)
4. Hospital Formulary System Policy

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**BRONCHOSCOPY NURSING**
Purpose:	To identify the roles and responsibilities of the primary, procedural, and recovery Registered Nurse (RN) when caring for patients requiring a bronchoscopy.
Supportive Data:	Bronchoscopy is a diagnostic or therapeutic procedure used to examine the tracheobronchial tree through a lighted tube, aspirate of bronchial secretions, remove foreign bodies, and obtain biopsy specimens. Bronchoscopy may be an emergent or elective procedure.
Equipment:	Personal Protective Equipment Cardiac Monitor Transport Monitor (if applicable) End-tidal Carbon Dioxide Monitor with Tubing Oxygen Devices with Tubing Vital Sign Machine with Pulse Oximeter Infusion Pump Crash Cart with Defibrillator or Automated External Defibrillator (AED) Suction Device and Suction Tubing Yankauer

A. **DEFINITIONS:**

1. Diagnostic Bronchoscopy: Performed to diagnose and assess pulmonary status through visualization and obtaining specimens via biopsies, brushings or washings.
   a. Diagnostic bronchoscopies must be performed in a negative airflow room (143, 243, 387, 443, 487, or the Bronchoscopy Suite) exceptions include:
      i. Patient is intubated ~~and~~ on a ventilator
      ii. Patient is in a private room with a High-efficiency particulate **air**~~arrestance~~ (HEPA) filtration system.
2. Therapeutic Bronchoscopy: Performed to remove retained secretions. Must be performed in a private room or Bronchoscopy Suite.
   a. A negative airflow room is not required, but must be performed in a private room.
3. Primary Nurse: Registered Nurse (RN) assigned primary care of a patient and responsible for preparing the patient for bronchoscopy as outlined in the Patient Care Services: Universal Protocol Procedure.
4. Procedural RN: RN qualified to implement PCS **Procedure**: **Procedural** Sedation~~/Analgesia Used During Therapeutic or Diagnostic Procedure~~.
5. Assisting Personnel: Staff assisting a physician during bronchoscopy procedure. Examples include:
   a. ~~Inpatient:~~ Respiratory Care Practitioner (RCP)
   b. ~~Outpatient:~~ Endoscopy/Surgical staff
6. Recovery RN: RN responsible for recovering patient post procedure.
7. Procedural Assessment: Pre-procedure, intra-procedure, immediate-post procedure assessment requirements performed by procedural and recovery RNs**.**

B. **POLICY:**

1. For inpatient bronchoscopy, the ordering physician will contact the Lead RCP to schedule.
   a. The Lead RCP will facilitate arrangements for the bronchoscopy, see Inpatient Bronchoscopy Process
2. For outpatient bronchoscopy, the ordering physician will schedule the procedure with Surgery scheduling.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership	Division of Pulmonary	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
09/12, 05/17, 05/21**, 07/23, 04/25**	10/12, 07/17, 02/22**, 05/25**	10/12, 07/17, 03/22**, 08/25**	06/18, 03/22	n/a	01/12, 06/18, 04/22**, 11/25**	05/22**, 12/25**	02/13, 07/18, n/a	02/13, 07/18, 05/22

a. The physician will coordinate outpatient fluoro-bronchs with Radiology and Endoscopy or Surgery.

b. Bronchoscopies requiring C arm/Fluoroscopy are coordinated between the Imaging Departments.

~~1. The primary RN is responsible for notifying their unit Manager or charge RN of the pending scheduled bronchoscopy as soon as possible.~~

~~2. The Acute Care Services (ACS) and Progressive Care Unit (PCU) charge RN is responsible for contacting the Telemetry charge RN as soon as possible, when informed by the primary RN or bronchoscopy orders are obtained.~~

~~a. The Telemetry charge RN will assign the role of procedural RN to a Telemetry RN designee.~~

~~b. When Telemetry RNs are not available to assist with inpatient bronchoscopies, the Intensive Care Unit (ICU) Manager or charge RN will be notified.~~

~~c. Telemetry staff RNs will notify the Telemetry RN designee when orders are received for a bronchoscopy. The Telemetry RN designee will notify the Telemetry charge RN.~~

~~3. The Telemetry charge RN will notify the Post Anesthesia Care Unit (PACU) charge RN to make arrangements for ACS and PCU patients to be recovered in the PACU by a PACU RN.~~

~~a. Telemetry patients will be returned to their assigned room to be recovered by the Telemetry procedural RN.~~

~~b. Outpatient bronchoscopies are recovered in PACU by PACU staff.~~

~~4. The inpatient procedural RN will:~~

~~a. Contact the PACU RN prior to the start of the procedure to provide an estimation of the completion time of the bronchoscopy.~~

~~b. Contact the PACU RN at the end of the procedure, prior to transport to provide hand-off for ACS and PCU patients.~~

~~5. All inpatient ACS and PCU patients will be recovered in PACU by PACU staff.~~

~~a. When PACU cannot assist with the recovery of ACS or PCU patients, the Telemetry procedural RN will recover the patient in their assigned inpatient room.~~

~~6.~~**3. Patients** ~~The Telemetry Procedural RN~~ may not **be** recover**ed** ~~patients at any time~~ in the Bronchoscopy Suite.

~~C.~~ **~~SCHEDULING:~~**

~~1. Inpatient:~~

~~a. The ordering physician will contact the Lead RCP to schedule the bronchoscopy procedure.~~

~~b. The primary RN will:~~

~~i. Ensure the order for bronchoscopy is entered in the Electronic Health Record (EHR).~~

~~ii. Contact the **Clinical Leader / AS**charge RN as soon as possible, to allow sufficient time for the **Procedure** Telemetry charge RN to initiate post-procedure recovery arrangements**.** for ACS and PCU patients.~~

~~2. Outpatient:~~

~~a. The ordering physician will schedule the procedure with Surgery scheduling.~~

~~b. The physician will coordinate outpatient fluoro-bronchs with Radiology and Endoscopy or Surgery.~~

~~c. Bronchoscopies requiring C arm/Fluoroscopy are coordinated between the Imaging Departments.~~

~~D.~~**C. PRIMARY RN RESPONSIBILITIES:**

1. Pre-Procedure:
   a. The primary RN is responsible for completing the Pre-Procedure verification process per the Patient Care Services: Universal Protocol Procedure.
   b. Primary Nurse shall:

i. Ensure the order for bronchoscopy is entered in the electronic health record (EHR),

~~i.~~**ii.** Ensure patient has a patent intravenous (IV) access and the ordered IV solution is infusi**ng**~~on~~ via an infusion pump.

~~ii.~~**iii.** Ensure an end-tidal carbon dioxide (ETCO2) module and oxygen tank is available for transport

~~iii.~~**iv.** Telemetry units **(emergency situations)**: if bronchoscopy will be performed in a patient room, ensure the following equipment is also available:

~~a)~~**1)** Electronic vital sign machine

~~b)~~**2)** Suction equipment

~~c)~~**3)** Crash cart readily available

~~d)~~**4)** Bedside cardiac monitor

c. Ensure pre-procedure medications are ordered and listed on the Medication Administration Record (MAR).

d. Administer pre-procedure medications as ordered prior to the arrival of the procedural RN.

i. On-call medications will be administered by the procedural RN.

e. Complete the Pre-procedure Checklist.

f. Provide hand-off communication to the procedural RN.

~~g.~~**2.** Prepare the patient for transport, if the bronchoscopy is to be performed in the Bronchoscopy/**Endoscopy** Suite.

i. Coordinate with the procedural RN to arrange transport of the patient.

ii. Transport patient via bed with oxygen, if applicable.

~~h.~~**b.** Document ~~the Nursing Handoff/~~**patient disposition**~~Transport Communication~~ in **EHR**~~Cerner~~.

~~2.~~**3.** Post-procedure primary RN responsibilities:

a. Receive hand-off report from the ~~PACU or Telemetry p~~**P**rocedural RN.

b. Assess the patient per orders. A focus assessment may include, but is not limited to the following:

i. Level of consciousness

ii. Breath sounds

iii. Vital signs (blood pressure, heart rate, respiratory rate, oxygen saturation continue) to monitoring as ordered

1) Telemetry patients – monitor cardiac rate and rhythm

c. Maintain Nothing by Mouth (NPO) status until patient is fully awake and advanced diet is ordered.

d. Implement falls prevention per Patient Care Services: Fall Risk Procedure ~~and Unit Specific Fall Precautions Procedure.~~

e. Monitor patient for increased mucus production, shortness of breath, difficulty swallowing, decreases or increases in heart rate (HR) and arrhythmias on cardiac monitoring units.

i. Anticipate minimal bleeding if brushings or biopsies were obtained.

f. Document the patient's arrival to the unit, assessment findings, and vital signs in the medical record.

g. Notify the procedure physician if the patient complains of shortness of breath, an increase in bloody mucus, and/or new onset arrhythmias.

~~E.~~**D. PROCEDURAL RN RESPONSIBILITIES**

1. Perform immediate pre-procedure, intra-procedure, and post-procedure task and assessments as outlined in Patient Care Services: **Procedural** Sedation~~/Analgesia Used During Therapeutic or Diagnostic Procedures~~.
2. Document immediate pre-procedure, intra procedure, and post-procedure task and assessments in the medical record.
3. Inpatient recovery and transport process:

a. Contact a**ppropriate transport personnel** ~~Patient Mobility Technician (PMT)~~ to assist with transporting the patient.
b. Provide hand-off report to **Recovery RN**~~PACU for ACS and PCU patients~~.
   i. If a bed is not available in PACU, transport the patient to their assigned inpatient room.
   ii. Recovery monitoring of the patient will be provided by the procedural RN, until a bed is available in PACU or until patient returns to their pre-sedation Aldrete level.
~~c. Telemetry patients will be transported to their assigned inpatient room and recovered by the procedural RN.~~
   ~~i.~~**iii.** ~~Provide hand-off communication to the primary RN when patient maintains their pre-sedation RASS level~~.

4. Post-procedure monitoring requirements:
   a. Monitor patient's outcomes per the Patient Care Services **Procedure**: **Procedural** Sedation~~/Analgesia Used During Therapeutic or Diagnostic Procedures~~ and as follows:
      i. Increase in bloody secretions
      ii. Hypoxia
      iii. New onset cardiac arrhythmias
      iv. Bronchospasm
      v. Hypotension
      vi. Signs of respiratory distress
      vii. Vomiting or complaint of nausea
      viii. Difficulty maintaining pre-sedation level of consciousness
   b. Maintain NPO status as ordered.
   c. Obtain chest x-ray per order.
5. Outpatients:
   a. Discharge patient as outlined in the Patient Care Services **Procedure: Procedural**: Sedation~~/Analgesia Used During Therapeutic or Diagnostic Procedures: Post Procedure Care, Documentation, and Discharge~~

~~F.~~E. RELATED DOCUMENT(S):

1. Patient Care Services Procedure: Fall Risk Procedure and Score Tool
2. Patient Care Services Procedure: **Procedural** Sedation~~/Analgesia Used During Therapeutic or Diagnostic~~
3. Patient Care Services Procedure: Universal Protocol
~~3.~~**4. Inpatient Bronchoscopy Process ~~Map~~**

~~G.~~F. REFERENCE(S):

1. Urden, L.D., Stacy, K.M., & Lough, M.E. (20**22**~~21~~17). Critical care nursing: Diagnosis and management. (~~8~~**9**th ed). Elsevier. St. Louis: MO

Scheduled Inpatient Bronchoscopy Process

- Physician Orders Inpatient Bronchoscopy (excluding ICU)
- Ordering MD calls OR Scheduler at 5400 to schedule

- OR Scheduler schedules Bronch with the ordering MD
- Or Scheduler uses below escalation for RN assistance:
  - Endo RN
  - RRT RN
- Once Bronch is scheduled with the available RN, OR Scheduler to notify RCP lead at 760 802-1974
- Lead RCP contacts:
  - Patients primary care nurse with the date and time of the Bronch
  - Admin Supervisor – adds procedure to the AS Report

- Procedure will be performed in the Bronch Suite
  - RN in the algorithm will assist with the procedure
- Post Procedure – the patient will be recovered in the PACU

- PACU RN will give report to primary RN prior to transport back to patient's room

Reference Policy: Bronchoscopy Nursing
Bronchoscopy Respiratory Care Practitioner

Revised JB 6.2.25

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**10/06**	**SUBJECT:**	**Communicating with Physicians/Allied Health Professionals (AHP) Using the SBAR Process**
REVISION DATE:	**07/09, 09/12, 03/16, 08/19, 12/22**		

Patient Care Services Content Expert Approval:	**~~05/22~~10/25**
Clinical Policies & Procedures Committee Approval:	**~~06/22~~10/25**
Nursing Leadership Approval:	**~~07/22~~11/25**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~09/22~~11/25**
Administration Approval:	**~~12/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/22**

A. **POLICY:**

1. The SBAR (Situation Background Assessment Recommendation) process shall be utilized to communicate with physicians/AHP, the Rapid Response Team, and Code Team members regarding patient status or a critical situation.

B. **PROCEDURE:**

1. Prior to calling the physician/AHP, follow these suggestions:
   a. Assess patient
   b. Discuss situation with resources (i.e. Nurse Leader or designee, resource nurse, rapid response nurse)
   c. Review the chart for appropriate physician/AHP
   d. **Confirm**~~Know~~ the admitting diagnosis and date of admission
   e. Read the most recent progress notes and review **nursing documentation**~~charting~~ from ~~the nurse who worked~~ the prior shift
   f. Have available when speaking with physician/AHP:
      i. **Open** Patient's ~~chart~~ **EMR record when conversing with MD**
      ii. List of current medications, allergies, intravenous (IV) fluids
      iii. Most recent vital signs
      iv. Most recent lab results
      v. Code status
2. When calling the physician/AHP, follow the SBAR process:
   a. (S) Situation: What is the situation you are calling about?
      i. Identify self, unit, patient, and room number~~.~~
      ii. Briefly state the problem, when it began, and how severe~~.~~
   b. (B) Background: Pertinent background information related to the situation may include the following:
      i. The admitting diagnosis and date of admission
      ii. List of current medications, allergies, IV fluids
      iii. Most recent vital signs
      iv. Lab results: provide the date and time test was completed and results of previous tests for comparison
      v. Other clinical information

vi. Code Status
vii. Relevant past medical history

c. (A) Assessment: Pertinent physical assessment findings
d. (R) Recommendation: What is the nurse's recommendation? Examples may be:
i. Change in level of care
ii. Come to see the patient at this time
iii. Talk to the patient or family about code status
iv. Any diagnostic tests needed
v. A change in treatment order

3. Document the change in patient's condition and physician/AHP notification in the medical record.

C. **RELATED DOCUMENT(S):**

1. SBAR Report to Physician

SBAR Report to Physician

SBAR report to physician about a critical situation (Ask physician "Are you familiar with this patient?")

S	**Situation** **I am calling about <**patient name and location**>** **The patient's code status is <**code statu**s>** **The problem I am calling about is < state what you are calling about>** (I am afraid the patient is going to arrest) **I have just assessed the patient personally:** **Vital signs are: Blood pressure ___/___, Pulse ___, Respiration ___ and temperature ___** **I am concerned about the:** Systolic blood pressure because it is less than 90 mm/Hg or greater than 200 mm/Hg Heart rate because it is less than 50 or greater than 130 beats per minute Respiratory rate because it is less than 8 or greater than 28 breaths per minute or threatened airway Oxygen saturation level is less than 92% despite oxygen therapy at _____liters via NC or _____ Temperature because it is less than 35.5 or greater than 40 degrees Celsius **Urine output** is less than 50 mL in 4 hours **Acute significant bleed**, new, repeated or prolonged seizures **Level of consciousness**, sudden unexplained agitation and confusion **Change in skin tone** (pale, dusky, gray, or blue) **Failure to respond** to treatment for an acute problem/symptom **The patient must be stabilized or a decision to transfer to a higher level of care must be made within 30 minutes.**
B	**Background** **The patient's mental status is:** Alert and oriented to person place and time. Confused and cooperative or non-cooperative. Agitated or combative Lethargic but conversant and able to swallow. Stuporous and not talking clearly and possibly not able to swallow. Comatose. Eyes closed. Not responding to stimulation. **The skin is:** Warm and dry Pale Mottled Diaphoretic Extremities are cold/warm **The patient is not or is on oxygen.** The patient has been on ____(l/min) or (%) oxygen for ____minutes (hours) The oximeter is reading ____% The oximeter does not detect a good pulse and is giving erratic readings.
A	**Assessment** **This is what I think the problem is** <state what you think is the problem> The problem seems to be **cardiac infection neurologic respiratory** _____ I am not sure what the problem is but the patient is deteriorating. **The patient seems to be unstable and may get worse, we need to do something.**
R	**Recommendation** **I suggest or Request that you** <say what you would like to see done> Transfer the patient to critical care Come to see the patient at this time Talk to the patient or family about code status Ask the on-call family practice resident to see the patient now **Are any test needed:** Do you need any test like: CXR, ABG, ECG, CBC, Labs {i.e. CBC, C7, C12, Magnesium CPK, Trop Other test? _____ **If a change in treatment is ordered then ask:** How often do you want vital signs? How long do you expect this problem will last? If the patient does not get better when would you want us to call again? Are there any new medication orders?

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: **11/94** **SUBJECT:** **Consent for Minors**

REVISION DATE~~(S)~~: **09/95, 11/96, 10/97, 07/99, 06/03, 01/06, 06/09, 06/11, 05/16, 12/19**

Patient Care Services Content Expert Approval:	**~~07/19~~10/25**
Clinical Policies & Procedures Committee Approval:	**~~08/19~~10/25**
Nurse Executive Committee Approval:	**~~09/19~~11/25**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~10/19~~11/25**
Administration Approval:	**~~11/19~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/19**

A. **PURPOSE:**

1. To establish guidelines to obtain a valid consent from all minor patients prior to a therapeutic, diagnostic, or invasive procedure based on California law and guidelines set forth in California Hospital Association (CHA) Consent Manual.

B. **DEFINITION(S):**

1. Minor is a person younger than eighteen (18) years of age.
2. Authorized individual is a parent, legal guardian or other person with the authority to consent to medical treatment for the minor.
~~2.~~

C. **POLICY:**

1. By statutory definition, a person under the age of eighteen (18) is unable to consent to medical treatment except as otherwise allowed by law.
2. Consent for Minors by Parents or Third Parties:
   a. When a minor needs medical treatment, health care providers must look to patient's authorized individual, unless it is a life threatening emergency or the minor is authorized to consent on his/her own behalf.
   b. The following may be authorized individuals to consent on behalf of the minor as set forth below:
      i. Parents. Either parent may generally consent to treatment for a minor unless there is documentation such as a court order showing the parent does not have that right. If the status of someone claiming to be a child's parent is unclear, the birth certificate or custody order may be used to determine who may legally provide consent.
      ii. Stepparents or Registered Domestic Partners of a Minor's Parent. A stepparent of a minor or registered domestic partner of a minor's parent, who has not legally adopted a minor, does not have the authority to consent to treatment on the minor's behalf without written authorization from the natural parent or guardian or a valid Caregiver's Authorization Affidavit.
      iii. Minor's Guardian. A guardian may consent to medical treatment for the minor as authorized by the court and the type of treatment. A copy of the official certified letters of guardianship should be obtained and reviewed to determine the scope of the guardian's legal authority to consent to medical treatment and that, if any,

of the parents.

iv. Other Third Parties. A nonparent adult relative with whom a minor is living may authorize medical and dental care for a minor by completing and signing a "Caregiver's Authorization Affidavit." It should be noted that this authority is not as extensive as a parent's authority. In specified circumstances, a third party (not the minor and not the parent/guardian) may consent to medical treatment on behalf of a minor. In these ~~circumstances~~**circumstances,** please consult the Risk ~~Manager~~/Legal Department and/or Administrative Supervisor on duty.

c. Documentation: When third parties, other than a parent, consent for treatment of a minor, official documentation showing the authority of the third party must be placed in the medical record. If questions arise concerning with documentation, a form or court order is sufficient, contact the Legal Department.

3. Minors with Legal Capacity to Consent to their Own Medical Treatment:

a. Certain minors may consent to medical or surgical care on their own behalf without parental consent if they have the legal capacity to do so. "Capacity" means that the person has the ability to understand the nature and consequences of a decision and to make and communicate a decision, including, in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives.

b. Minors legally authorized to consent to his/her own care include the following:

i. Emancipated Minors. An emancipated minor who has received a court order of emancipation and who holds a Department of Motor Vehicles identification card indicating that the minor is emancipated may consent to his/her own medical, dental or psychiatric care without parental consent, knowledge, or liability. A copy of the identification card shall be placed in the patient's permanent medical record. Parenthood is not an emancipating event.

ii. Self-sufficient minors. When a minor of 15 years of age or older is living separate and apart from his/her parent(s) or legal guardian, whether with or without consent or acquiescence of his/her parent(s) or legal guardian, and manages his/her own financial affairs, regardless of the source of income, the minor is capable of giving valid consent for medical or dental care without parental consent, knowledge or financial liability. The duration of the separate residence is irrelevant. The minor should affirm that these conditions are met and complete the CHA's "Self-Sufficient Minor Information Form." The form shall be placed in the medical record.

iii. Active Duty with the U**nited Stated (U.**~~.~~S.**)** Armed Forces. Minors serving on active duty with any branch of the U.S. armed forces may consent to medical, dental, or psychiatric care without parental consent, knowledge, or liability. A copy of the patient's active duty military identification cares shall be placed in the medical record.

iv. Married or Previously Married Minors. A minor who has entered into a valid marriage, whether or not such marriage was terminated, is emancipated and may consent to medical, dental or psychiatric care without parental consent, knowledge, or liability. A copy of the patient's marriage certificate shall be placed in the medical record.

v. Other Circumstances. A minor may have limited ability to consent to care under certain circumstances, including pregnancy or contraceptive care, communicable reportable diseases, rape victims, victims of sexual assault, outpatient mental health treatment or residential shelter services, drug- or alcohol- related problems, blood donations, or anatomical gifts. In these circumstances please refer to the CHA Consent Manual and/or consult the Risk ~~Manager~~/Legal Department and/or Administrative Supervisor on duty.

4. Telephone consent:

a. Telephone consent may be obtained only if the person having the legal ability to consent for the patient is not otherwise available. Steps shall be taken to verify the person is in person is the patient's legal representative, i.e.~~,~~ confirming patient's date of birth and

other identifying information.

b. Physician Responsibility. ~~-~~The physician should follow standard protocol for obtaining consent for the medical treatment and provide the patient's legal representative with the information the physician would disclose if the person were present.

c. TCHD Responsibility. Where the physician states he or she has obtained telephonic consent to treat the patient, hospital personnel should verify that the patient's legal representative and physician have discussed the patient's condition and the recommended treatment and that the patient's legal representative has given consent. The telephone conversation between the patient's legal representative and a TCHD staff member should be witnessed by a second TCHD staff member. ~~-~~The patient's legal representative should be informed that two TCHD staff members are on the phone. Telephonic consent should be documented on the Telephone Consent Form and placed in the patient's medical record.

5. Refusal of Treatment:
   a. The person who has legal authority to consent for the treatment of a minor also has the legal authority to refuse treatment.
      i. If the minor is legally authorized to consent to treatment, the minor also has the legal authority to refuse the treatment. (The minor must also have the capacity to make healthcare decisions.)
6. For further clarification regarding situations involving minor's authority to consent, contact Risk ~~Management~~/Legal Department and/or refer to the current CHA Consent Manual.

D. **FORM(S):**

1. 8740-1046 Telephone Consent Form - Sample
2. Authorization for Third Party to Consent to Treatment of Minor Lacking Capacity to Consent - Sample
3. Caregiver's Authorization Affidavit - Sample

E. **RELATED DOCUMENT(S):**

1. Consent Requirements for Medical Treatment of Minors
~~Self-Sufficient Minor Information~~
2. **California Hospital Association. (2024, March) Consent Requirements for Medical Treatment of Minors reference.**

F. **REFERENCE(S):**

1. California Hospital Association (20~~18~~**23**). *California Hospital Consent Manual*. Sacramento, CA: California Hospital Association**. (2023).**~~,~~ Chapter 4. **Who May Consent for Minor Patients**
2. California Family Code §~~§~~ 297.5, 6922, 7002, 7050(e)(1), 7120
~~2.~~**3. California Code, Family Code - FAM Division 11 – Minors Part 1 – Age of Majority §6500**

SAMPLE

Name of Patient: _____

Name of person called: _____

Relationship (Circle one): **Parent** **Legal guardian** **Legal representative**

Date: _____ Time called: _____ Phone number: _____

Name of person making call (please print): _____

Witness (please print): _____

STATEMENT

I, _____ the parent/legal guardian/legal representative
(name)

of _____ give my permission to Tri-City Medical Center, and Doctor
(Patient's name)

_____ to render/perform treatment/surgery _____
(physician/surgeon)

_____ on
(state procedure for which consent is requested)

the basis of informed consent received from Doctor _____.

I understand it is necessary for me to confirm this verbal consent by fax to Tri-City Medical Center and will do so immediately.

I also agree to the Condition of Admissions form that has been reviewed with me.

Comments: _____

_____ _____
(Signature of Person Making Call/1st Witness) Date / Time

_____ _____
(Signature of 2nd Witness) Date / Time

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

8720-1046
(Rev. 2/10)

TELEPHONE CONSENT FORM

Affix Patient Label

SAMPLE

**AUTHORIZATION FOR THIRD PARTY TO CONSENT
TO TREATMENT OF MINOR LACKING CAPACITY TO CONSENT
(Form 2)**

(I)(We), the undersigned, parent(s) person having legal custody/legal guardianship of (name of minor) _____, a minor, do hereby authorize (name of agent)_____as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of the physician or at the hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a physician, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

This authorization is given pursuant to the provisions of Family Code section 6910.

(I)(We) hereby authorize any hospital, which has provided treatment to the above-named minor pursuant to the provisions of Family Code section 6910 to surrender physical custody of such minor to (my)(our) above- named agent(s) upon the completion of treatment. This authorization is given pursuant to Health and Safety Code section 1283.

These authorizations shall remain effective until [month and day]_____, 20____, unless sooner revoked in writing delivered to the agent(s) noted above.

Date:_____

Signature:_____

[Parent/legal guardian/person having legal custody] (circle relationship)

Signature:_____

[parent]

Medically Relevant Information	
Minor's birth date	
Allergies to drugs or food	
Conditions for which minor is currently being treated	
Current medications	
Restrictions on activity	
Primary care physician (name and telephone number)	
Insurance company	
Mother's name, address and telephone numbers	Home Work Other
Father's name, address and telephone numbers	Home Work Other

Treatment of Minor Lacking Capacity to Consent	**Patient Identification Label**
Tri-City Medical Center 4002 Vista Way, Oceanside, California 92056 (760) 724-8411	

SAMPLE

CAREGIVER'S AUTHORIZATION AFFIDAVIT (Form 1)

Use of this affidavit is authorized by Part 1.5 (commencing with section 6550) of Division 11 of the California Family Code.

INSTRUCTIONS: Completion of items 1-4, inclusive and the signing of the affidavit is sufficient to authorize enrollment of a minor in school and authorize school-related medical care. School related medical care means medical care that is required by state or local governmental authority as a condition for school enrollment, including immunizations, physical exams and medical exams conducted in school.

Completion of items 5-8 inclusive is additionally required to authorize any other medical care. Please print clearly

- I am requesting enrollment of the minor in school and to authorize school-related medical care. Completion of items 1 – 4 only is required.
- I am requesting to authorize medical care not school-related. Completion of items 1 – 8 is required.

The minor named below lives in my home and I am 18 years of age or older.

1. Name of minor:_____
2. Minors birth date:_____
3. My name: (adult giving authorization)_____
4. My home address:_____
5. I am a grandparent, aunt, uncle, or other qualified relative of the minor (see back of this form for a definition of "qualified relative").
6. Check one or both (for example, if one parent was advised and the other cannot be located):
   - I have advised the parent(s) or other person(s) having legal custody of the minor of my intent to authorize medical care, and have received no objection.
   - I am unable to contact the parent(s) or other person(s) having legal custody of the minor at this time, to notify them of my intended authorization.
7. My date of birth:_____
8. My California driver's license or ID card number:_____

Warning: DO NOT SIGN THIS FORM IF ANY OF THE STATEMENTS ABOVE ARE INCORRECT, OR

Consent Requirements for MEDICAL TREATMENT OF MINORS

IF MINOR IS:	*Is parental consent required?*	*Are parents responsible for costs? †*	*Is minor's consent sufficient?*	*May M.D. inform parents of treatment without minor's consent?*
Unmarried, no special circumstances	Yes	Yes	No	Yes
Unmarried, emergency care and parents not available [Business and Professions Code § 2397]	No	Yes	Yes, if capable	Yes
Currently or previously married or in a domestic partnership [Family Code § 7002]	No	No	Yes	No
Emancipated (declaration by court, identification card from DMV) [Family Code §§ 7002, 7050, 7140]	No	Probably Not[1]	Yes	No
Self-sufficient (15 or older, not living at home, manages own financial affairs) [Family Code § 6922]	No	No	Yes	[1]
Not married, care related to prevention or treatment of pregnancy, except sterilization [Family Code § 6925]	No	No	Yes	No
Not married, seeking abortion [Family Code § 6925]	No	No	Yes	No
Not married, pregnant, care not related to prevention or treatment of pregnancy and no other special circumstances	Yes	Yes	No	Yes
On active duty with Armed Forces [Family Code § 7002]	No	No	Yes	No
12 or older, care related to diagnosis or treatment of a communicable reportable disease or to prevention of an STD [Family Code § 6926]	No	No	Yes	No
12 or older, care for rape[1] [Family Code § 6927]	No	No	Yes	Yes, usually[1]
Care for sexual assault or intimate partner violence[1] [Family Code §§ 6928 and 6930]	No	No	Yes	Yes, usually[1]
12 or older, care for alcohol or drug abuse[1] [Family Code § 6929]	No[2]	Only if parents are participating in counseling	Yes	Yes, usually[1]
12 or older, care for mental health treatment, outpatient only[1] [Family Code § 6924; Health and Safety Code § 124260]	No	Only if parents are participating in counseling	Yes	Yes, usually[1]
17 or older, blood donation only [Health and Safety Code § 1607.5]	No	No	Yes	Probably not

[1] Special requirements or exceptions may apply. See *Chapter 4* of the *Consent Manual*.

[2] Special requirements apply for a minor's participation in replacement narcotic therapy (such as methadone, LAAM or buprenorphine products) [Family Code § 6929(e) and 6929.1]

Note: Notwithstanding the above information, a psychotherapist may not disclose mental health information to a parent who has lost physical custody of a child in a juvenile court dependency hearing unless the parent has obtained a court order granting access to the information.

† Reference: Welfare and Institutions Code § 14010

Minors are defined as all persons under 18 years of age.

83/24

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Tri-City Medical Center	Patient Care Services
PROCEDURE:	**DEFIBRILLATOR CHECKS**
Purpose:	To ensure proper functioning of the defibrillator to ensure patient safety.
Supportive Data:	A defibrillator is a life support equipment used for the purpose of sustaining life, and whose failure to perform its primary function will lead to patient death in the absence of immediate intervention.
Equipment:	Zoll Defibrillator R Series® Plus
Supplies:	Two OneStep multifunction electrodes (Adult and Pediatric) 6 - ECG lead packages 2 - Gel pads (for external paddles, if present) 2 - ECG paper pads Three lead ECG cable The following supplies apply to select models • SpO_2 cable • SpO_2 probe • $ETC0_2$ cable • Disposable $ETCO_2$ Adapter • Non-invasive Blood Pressure (NIBP) Cable • Blood Pressure Cuff
Issue Date:	04/19

A. **POLICY:**

1. Defibrillator daily visual checks shall be performed once a day.
2. Defibrillator manual testing shall be performed once a week. If the defibrillator is configured Off, manual testing will be performed daily.
3. All units will check defibrillator once a day while unit is open.
4. The defibrillator must be plugged into a working outlet when not in use.
5. Defibrillators that will be stored longer than 90 days, remove the battery pack.
6. Check the device date and time once each month and document on the Crash Cart or Defibrillator checklist.

B. **DEFINITION(S)**:

1. Automatic Testing – System testing performed at pre-configured intervals**.**
2. Manual Testing – System testing perform by a healthcare provider or designee once a week to check the following; defibrillator testing, pacer testing and recorder checks**.**
3. Code-Readiness Testing – A system self-test performed whenever the unit is turned on, periodically during operation, whenever manual testing is initiated and automatically at pre-configured intervals.

C. **PROCEDURE:**

1. Daily Visual Checks
   a. Defibrillator is plugged into a working outlet, (red power outlet, if available)
   b. Gray power cord is connected to the black pigtail located in the back of the defibrillator
   c. Green "√" present in upper right-hand corner analog display window
   d. If Red "X" present, attempt to correct with a manual 30J (joules) test
   e. If Red "X" persists, contact Biomedical Engineering (Biomed) immediately for further evaluation
   f. AC light and battery light are steady green

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
12/18, 09/22**, 09/25**	01/19, 10/22**, 10/25**	01/19, 11/22**, 11/25**	n/a	n/a	n/a	04/19, 12/22**, 12/25**	n/a	04/19, 12/22

i. Green battery light = battery fully charged
ii. Amber battery light = battery is charging
iii. Flashing Amber/Green battery light = ensure battery is fully inserted into the battery well
1) If not inserted, fully insert battery and observe for steady Amber or Green battery light
2) If fully inserted, call Biomed for further evaluation

g. OneStep Pad **or equivalent** is plugged into the Electro-Therapy Cable.
i. Ensure a spare OneStep Pad set **or equivalent** is available

h. Defibrillator and emergency cart have required supplies**.**
i. Check expiration dates on all supplies, discard expired supplies and replace
ii. Check the following defibrillator checks:
1) Condition
a) Unit clean, no spills, clear of objects on top, case intact
2) Hands-free Therapy Electrodes
a) 1 set preconnected
b) 1 spare set
3) Paddles, if present
a) Verify adult paddles are installed and are pushed all the way into their holders
b) Paddles are clean, not pitted
c) Release from housing easily
4) Inspect cables for cracks, broken wires, connectors and ensure the following are present:
a) ECG electrode cable, connector
b) Defibrillator paddle cables
c) OneStep cable, connector
5) Batteries / External Power Supply
a) A fully charged battery in unit
b) Unit plugged into an outlet
6) Disposable Supplies – check expiration dates, discard expired supplies and replace with supplies that are not expired.

2. Weekly Checks
a. Manual Defibrillator Testing (Checks)
i. Ensure device is in Manual Mode and device is plugged into an outlet
ii. Connect unopened OneStep electrodes to the OneStep cable or connect to the OneStep or Multifunction (MFC) cable
iii. Turn to MONITOR, listen for four (4) beep tone. The message MONITOR message on display.
iv. ECG size X 1 (one)
v. “PADDLES” OR “PADS” as lead selected
~~vi. Paddles~~
~~1) See Defibrillator Testing with Paddles~~

b. Defibrillator Testing Using Hand-Free Therapy
i. Ensure device is connected to power outlet.
ii. Turn the defibrillator off for at least 10 seconds.
iii. Turn the Mode Selector to ON
iv. Press the Manual Mode softkey.
v. The unit emits a four-beep tone indicating successful completion of the power-on self-test. The ECG source is PADS and ECG size is X1. “DEFIB 120J Sel,” and DEFIB PAD SHORT appear on the display. The ECG trace appears as a solid line while the OneStep cable is connected to either the Test Port or OneStep electrodes.
vi. Press the ENERGY SELECT buttons to set the energy to 30 joules

vii. Press the CHARGE button on the front panel
viii. When the charge-ready tone sounds, press the ENERGY SELECT buttons to set the energy to 20 joules. The defibrillator will disarm itself
ix. Press the ENERGY SELECT buttons to reset the energy to 30 joules.
1) Note: For testing, the unit discharges the defibrillator only if the energy is set to 30 joules.
x. Press the CHARGE button on the front panel
xi. When the Ready tone sounds, press the SHOCK button on the front panel until the shock is delivered.
1) The unit displays the message 30J TEST OK and prints a stripchart indicating 30J TEST OK and the delivered energy.
2) If TEST FAILED appears, contact Clinical Engineering (Biomed) or ZOLL Technical Service Department immediately.
xii. Signing, dating and retaining the recorder output is not required.

c. PACER Testing
i. Ensure the device is connected to a power outlet
ii. Press the Manual Mode softkey
1) If the CONFIRM MANUAL MODE message displays, press the CONFIRM softkey to enter the Manual mode of operation.
iii. Turn the Mode Selector to PACER
iv. Turn the PACER RATE control to 150 pulse per minute (PPM).
v. Press RECORDER button
1) On the stripchart verify that pacing stimulus, markers occur approximately every centimeter (10 small divisions or two [2] large divisions
vi. Press and hold 4:1 button.
1) Frequency of the pacing stimulus markers decrease, occurring approximately every 4 centimeters (40 small divisions or 8 large divisions).
vii. Turn PACER OUTPUT control to 0 mA and ensure that there is no CHECK PADS or POOR PAD CONTACT message.
viii. Disconnect the OneStep Cable from the test port or OneStep electrodes, and slowly turn the PACER OUTPUT control to 16 mA or more. The messages CHECK PADS or POOR PAD CONTACT appear alternately. The pace alarm sounds, and Clear Pace Alarm softkey flashes.
ix. Reconnect OneStep cable and press the *Clear Pace Alarm* softkey. The messages CHECK PADS and POOR PAD CONTACT disappear, and the alarm tone stops.

d. Recorder Check
i. Turn the Mode Selector to ON.
ii. Press the Manual Mode softkey.
1) If the *COFIRM MANUAL MODE* message displays, press the *CONFIRM* softkey to enter the Manual mode of operation
iii. Select the ECG lead.
iv. Check the printer for an adequate supply of paper, then press the *RECORDER* button.
v. Press and hold the *SIZE* button for at least 2 seconds.
1) A calibration pulse of 1mV appears on the display while the button is held. The amplitude of the calibration pulse is independent of the SIZE setting
vi. Inspect the recorder waveform for uniformity and darkness**.**
vii. Inspect for uniformity of annotated characters and completeness of words.
viii. Check the printer speed by verifying that the resulting waveform is:
1) 2.5 mm ±0.5 mm wide
2) 10 mm ±1.0 mm high
ix. Signing, dating, and retaining the recorder output is not required.

D. **ONCE A MONTH TESTING:**

1. Setting Defibrillator Time and Date
    a. Turn the Mode Selector to ON
        i. If the CONFIRM Manual Mode message displays, press the *Confirm* softkey to enter the Manual mode of operations
    b. Press the *Manual Mode* softkey
    c. Press the Options softkey
    d. Press *More*
    e. Press *Set Clock*
        i. The month field will be highlighted
    f. Press the *Inc Value* or Dec Value softkeys to select the appropriate month
    g. Press the Next Field softkey to set the selected month, and move the highlight to the next field (day)
    h. Repeat steps 5 and 6 to set the correct day, year, hours, and selected month and minute values.
        i. Note: The last field does not automatically scroll (wrap) to the beginning. You must press the *Prev Field* softkey to enter the values for the previous field.
        ii. If you need to make corrections, press the *Prev Field* softkey to move the highlight to the field previously entered.
    i. Press the *Enter* and *Return* softkey to set all values and return to normal monitoring mode.

E. **DOCUMENTATION:**

1. Document defibrillator checks on the Crash Cart Checklist **and Stand Alone Defibrillator Checklist if applicable**.
2. All checks will be validated by the signature (no initials) of the licensed staff completing the checks.

F. **FORM(S):**

1. Tri-City Medical Center Adult Crash Cart Checklist
2. Tri-City Medical Center Stand Alone Defibrillator Checklist
3. ZOLL R Series Plus R Series BLS Operators' Guide: Chapter 13 Maintenance

G. **RELATED DOCUMENT(S):**

1. PCS Emergency Cart (Crash Cart), Cardiopulmonary Arrest
2. ~~Defibrillator Testing with Paddles~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: DISCHARGE FROM OUTPATIENT POST–ANESTHESIA SERVICE

I. **POLICY:**

A. Function: To provide a timely and appropriate discharge of the stable patient from the Post Anesthesia Care Unit (PACU).

B. Circumstances:

1. Setting: PACU
2. Supervision: None required
3. Physicians Orders: The physician orders must clearly reflect a Registered Nurse (RN) may discharge a patient when discharge criteria have been met. Anesthesia is required to complete a post anesthesia evaluation note of the patient within 48 hours, but prior to discharge.
4. Patient Contraindications: The anesthesiologist is to be notified of any patient who does not meet discharge criteria within four hours of admission post procedure, and/or of any patient who has airway complications, hemodynamic instability, surgical complications, or fails to respond to treatment/interventions.

II. **PROCEDURE:**

A. A patient will be ready for discharge as determined by the following criteria:

1. Airway:
   a. Patent airway and protective airway reflexes are intact
   b. Patient is able to cough and deep breathe
2. Ventilation/Oxygenation:
   a. Respiratory rate greater than or equal to 10 per minute/adult
   b. SpO2 greater than (>) 94% (or return to baseline) on room air (or on baseline home oxygen)
3. Cardiovascular:
   a. Blood pressure, heart rate, cardiac rhythm within patient's acceptable baseline parameters
      i. Blood pressure within plus or minus (±) 20 mmHg of patient's baseline
   b. Stable, no significant changes for at least 30 minutes
4. Thermoregulation:
   a. Temperature greater than or equal to (≥) 36°C (96.8°F)
   b. Patient describes feeling of acceptable warmth
5. General Condition:
   a. Awake, alert and oriented
   b. Follows commands per baseline
   c. Adequate intake and output.
      i. Voiding as indicated by procedure and patient condition
      ii. Oral intake as indicated by procedure and patient condition
   d. Pain level meets target pain level or is appropriate for procedure
   e. Vomiting controlled and/or acceptable level of nausea.
6. Ambulation
   a. Motor function/mobility- baseline or consistent with procedure
   b. Demonstrates understanding of assistive devices as appropriate

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Department of Anesthesiology	Pharmacy & Therapeutics Committee	Inter disciplinary Committee	Medical Executive Committee	Admin	Professional Affairs Committee	Board of Directors
02/99, **0**4/00, 02/09, 02/11, 07/13, **0**4/15, 03/18**, 08/23**	02/11, **0**7/13, 08/15, 06/18, 12/18**, 09/23**	03/11, 07/13, 09/15, 07/18, 12/18**, 10/23**	01/16, 01/19**, 09/24**	09/15, 03/19**, 02/25**	04/11, 09/13, 07/16, 04/19**, 04/25**	6/11,10/13, 09/16, 07/19**, 10/25**	08/19**, 12/25**	10/16, n/a	06/11, 10/13, 11/16, 08/19

7. Post-procedural/operative bleeding controlled or acceptable with procedure
    a. Dressing/surgical site is clean, dry and intact or has mild to moderate drainage with no marked increase
    b. Patent tubes, catheters and drains
8. For spinal or epidural block, patient has complete resolution of block
    a. No evidence of bleeding at puncture site
9. For regional anesthesia, protection of patient's extremity
10. Psychosocial issues identified and addressed
    a. Patient is calm
    b. Emotional status is under control
11. Provision made for safe transport home with responsible person present.
12. Discharge from PACU with a Aldrete score of 10 (or baseline) or per physician written orders**.**
13. Last set of vital signs, pain assessment and Aldrete Score documented immediately before discharge.

III. **PROCESS:**

A. Discharge:
1. When the patient meets the above criteria, initiate standardized procedure as appropriate.
2. Prepare patient or responsible party by reviewing patient education.
    a. Patient care provider verbalizes understanding of all discharge instructions.
    b. Written discharge instructions will be signed by the accompanying responsible adult and a copy provided upon discharge.
    c. Questions by patient/responsible adult invited and answered.
3. New prescriptions will be scanned to pharmacy and a copy will be kept in the chart.
4. Outpatients post sedation or anesthesia are required to be discharged in the company of a responsible person and have a pre-arranged ride home. See PCS Policy: Outpatient Post Anesthesia/ Procedure Discharge/ Transportation Guidelines.
~~5. Follow-up~~
    ~~a. A post-op phone call shall be made within 2 business days of surgery/procedure by a PACU RN~~
        ~~i. Two attempts will be made to contact the patient~~

IV. **DOCUMENTATION:**

A. Document the following in the electronic health record (EHR):
1. Vital signs
2. Pain assessment
3. Aldrete score
4. Intake and Output
5. Dermatome level (if applicable)
6. Surgical site assessment
7. Presence of nausea/vomiting
8. Additional elements of assessment as indicated by procedure and anesthesia/sedation type
9. PACU Expected Outcomes
10. For patients who have had moderate sedation without anesthesia care, document sedation outcomes~~.~~
11. PACU Departure

B. Document patient education
C. Document all medications given in the eMAR

V. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**

A. Current unencumbered California RN license**.**

B. Current Advanced Cardiac Life Support (ACLS) certification**.**
C. Initial Evaluation: During orientation period to include a nursing competency check-off list on discharge criteria.
D. Ongoing Evaluation: Annually.

VI. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This standardized procedure was developed through collaboration with nursing, medicine, and administration.
B. Review: Every two (2) years.

VII. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All RNs who have successfully completed requirements as outlined above are authorized to direct and perform Discharge from Outpatient Post-Anesthesia Nursing Service Standardized Procedure.

VIII. REFERENCE(S):

A. American Society of Perianesthesia Nurses. (2016). *Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements 2017- 2018.* Cherry Hill, NJ: American Society of Perianesthesia Nurses.
B. Schick, L., & Windle, P. E. (Eds.). (2016). *PeriAnesthesia Nursing Core Curriculum: Preprocedure, Phase I and Phase II PACU Nursing* (3rd ed.). St. Louis, MO: Elsevier.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**DISPOSAL OF CHEMOTHERAPY WASTE**
Purpose:	To outline the nursing responsibility and management of proper disposal of chemotherapy waste
Supportive Data:	Oncology Nursing Society's Chemotherapy and Biotherapy Guidelines and Recommendations for Practice 4th Edition 2014
Equipment:	Chemotherapy Safe Personal Protective equipment Puncture –proof container labeled "chemotherapy" container or RCRA container Gloves specified for use with chemotherapy agents Large yellow bag marked "Chemotherapy waste" Gown specified for use with Chemotherapy Agents

A. **PROCEDURE:**

1. Place puncture-proof trace or bulk chemotherapy container and large yellow chemotherapy waste plastic bags marked "Chemotherapy Waste" in patient's room upon initiating chemotherapy treatment.
   a. If a chemo drug waste contains more than 3% of the residual drug, it is referred to as "bulk chemo waste" and must be disposed in a black Resource Conservation and Recovery Act (RCRA) container.
   b. If a chemo drug waste contains 3% or less of the residual drug, it is referred to as "trace chemo waste" and can be disposed in a yellow chemotherapy waste container.
2. Always use chemotherapy safe personal protective equipment when handling chemotherapy waste.
3. Place any disposable cytoxic contaminated materials into a yellow chemotherapy waste plastic bag. Use puncture proof chemotherapy waste containers for sharps, breakable items, and items that are saturated with chemotherapy or chemotherapy contaminated body fluids.
4. Place contaminated Intravenous (IV) tubing, IV bags, and all non-sharp materials in the large yellow plastic bag marked "Chemotherapy Waste" after striking out any patient information on the label or tubing with a black permanent marker.
5. Tie off large yellow chemotherapy waste bag carefully gathering top portion of bag with one hand and slowly pull downward on gathered portion until internal air in bag resists further pulling down. Place yellow chemotherapy waste bag in puncture proof container labeled "Chemotherapy Waste."
6. -Place puncture-proof trace or bulk chemotherapy container in the chemo waste room when no longer in use or container is 2/3 full.
   a. For inpatient areas without a chemo waste room, contact Environmental Services (EVS) for removal.
7. Completely close the lid on the chemotherapy puncture proof waste containers when they are 2/3 full or if a potential risk is perceived. Document on top of the puncture proof container "full" with the date before placing it in the chemo waste room or contacting EVS for removal.
8. Notify environmental services when chemotherapy puncture-proof waste containers are full. Chemotherapy containers must be removed from the chemo waste room within 24 hours.
   a. Outpatient Infusion Center staff shall notify currently contracted waste management provider to pick-up chemotherapy waste containers.

B. **REFERENCES:**

1. American Society of Health-System Pharmacists. ASHP guidelines on handling hazardous drugs. Am J Health-Syst Pharm. 2018; 75:1996- 2031, https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/MedicalWaste.aspx - accessed 05.03.2023.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership	Division of Oncology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/03; 11/11, 05/16, 05/23, **10/24**	12/11, 08/15, 06/16, 05/23, **05/25**	09/15, 07/16, 06/23, **08/25**	07/16, 03/17, 03/19, 10/23	06/16, 07/23, **09/25**	01/12, 10/15, 05/19, 10/23, **10/25**	06/19, 12/23, **12/25**	02/12, 11/15, n/a	02/12, 12/15, 06/19, 12/23

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: **12/01**

SUBJECT: **Documentation in the Medical Record**

REVISION DATE: **06/03, 12/03, 02/04, 08/04, 01/05, 02/07, 07/10, 08/12, 09/16, 01/18, 12/21**

Patient Care Services Content Expert Approval:	**~~07/21~~04/25**
Clinical Policies & Procedures Committee Approval:	**~~10/21~~10/25**
Nursing Leadership Approval:	**~~11/21~~11/25**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/21~~11/25**
Administration Approval:	**~~11/21~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/21**

A. **PURPOSE:**

1. To maintain documented information for each patient that is accurate, timely, legible, readily accessible, and is performed by authorized personnel.
2. To ensure the medical record contains sufficient information to identify the patient, support the diagnosis, plan of care, continuity of care justify treatment and document the course and outcome of treatment.

B. **DEFINITION(S):**

1. Activity View: A set of clinical data elements related to a specific activity that may include required documentation elements.
2. Annotation: Ability to add a comment to documentation.
3. Authentication: Review process of documentation completed by a student or other caregiver requiring review by a licensed staff or instructor.
4. Carry forward functionality: fields which bring forward the last charted data.
5. Clinical Range Bar: Indicates the date range of displayed information.
6. CPOE: Computerized Provider Order Entry.
7. Duplicate Results: Allows clinician in Iview to copy and paste data to a different time column for review and signing.
8. Edit Fields: The ability to modify or delete documented fields.
9. EHR: Electronic Health Record.
10. Encounter: Each patient visit/admission is assigned a Financial (FIN)/encounter number.
11. Erasing fields: To delete or “unchart” information placed in a current field currently or from a carry forward function.
12. Iview: An interactive view for clinical documentation that allows direct charting.
13. MAR: Medication Administration Record.
14. Care Compass: An interactive screen available to the nursing staff to view and perform patient care tasks by selecting icons, which launch a form or screen for completion of the task.
15. PowerForm: Electronic forms with one or many sections. Each section provides data entry options for documenting assessments, procedures, and other patient care events.
16. Task List: An electronic list of tasks or reminders within a specified time frame that may be attached to a form or activity.

C. **POLICY:**

1. Documentation is the primary communication medium. Each practitioner is responsible for accurate documentation of care provided. All entries manual or computerized are permanent.
2. Documentation will be complete and reflect patient specific care, support the medical diagnosis, course of treatment, and Plan of Care.
3. Documentation shall be efficient with minimal to no duplication of charting.
4. Documented patient information must be readily accessible to all providers rendering care.
    a. For management of patient's medications information includes:
        i. Age
        ii. Sex
        iii. Diagnosis
        iv. Sensitivities
        v. Current medications
        vi. Height and weight
        vii. Pregnancy and lactation information (as applicable)
        viii. Lab results
5. Documentation in the Medical Record shall include key components such as:
    a. The patient's initial admission information, transfer information, and discharge summary, with a full and accurate description of the patient's condition and responses at the time.
    b. Any change in the patient's condition.
    c. A record of communication with physicians, patient or family.
    d. Upon discharge, clear documentation of understanding of all discharge education and instructions to patient/responsible party.
    e. When an unexpected event occurs, complete the following:
        i. Document the facts of occurrence in the Medical Record and complete an incident report/quality review report.
        ii. Do not document or reference that an incident report/quality review report has been completed in the medical record (See Administrative Policy: Disclosure of Unanticipated Adverse Outcomes to Patients/Families 8610-275).
6. Documentation in the patient's record shall be complete, factual, accurate, and legible.
    a. When charting on paper, do not pre-date or back date patient information. (See Late Entry into the Medical Record).
        i. In the manual record, document on the next available space.
        ii. Do not skip lines
7. Tri-City Healthcare District (TCHD) care providers shall document in the electronic health record (EHR) when online documentation forms/screens/IView bands are available.
    a. Exceptions to the practices are areas using paper flow sheets or other hard chart forms. Refer to unit specific policies and procedures.
    b. Powerforms shall be accessed from the task **list** or Care Compass when available. If not available on the task list or via Care Compass, access the forms from AdHoc. Some of the Powerform titles may vary slightly to indicate a patient or area specific document.
    c. All access and documentation in EHR shall be reflected by the user identification.
    d. Each user must define/update an encounter relationship to access a patient's chart.
        i. Some positions are assigned a default relationship.
    e. Users are required to use only their log-on to document in the patient's record.
8. Documentation shall be timed and dated to reflect the actual time events occurred.
    a. It is recommended that all shift assessments, reassessments, as the occasion arises (PRN) assessments, and/or care provided be documented after completion of the care in a timely manner.
    b. When it is not possible to document shift assessments, reassessments, PRN assessments and/or care provided due to unforeseen circumstances such as urgent or emergent situations, changes in assignment or increased patient acuity document the patient care and assessment as soon as reasonably able to do so.

c. Activity Views in IView will be used to help guide required data documentation for key assessments and reassessments.
d. Reasonable and timely manner may be defined as within four (4) hours after completion of assessments or care provided.
e. Discharge documentation must be completed within four hours of discharging the inpatient.

9. Documentation in the patient record shall not include:
   a. Issues affecting credibility, including inconsistency in documentation, contradiction or blaming of other practitioners.
   b. Issues affecting professionalism, including intentional documentation of inadequate care, unprofessional verbal communications among practitioner, judgment or emotional statements about patients or their families, or "sloppy" charting practices in the manual chart (squeezing in an entry where there is not adequate space~~,~~**)** or charting in advance of an intervention or treatment~~)~~.
   c. Issues which imply information or events are being hidden (i.e., obliterating a chart entry [in the manual chart), or failure to document an untoward event, such as a fall or change in vital signs.
   d. Duplication of results in IView.
10. Late entry into the Medical Record (See: Patient Care Services Procedure: Medical Record, Making Corrections in Documentation).
   a. When a pertinent entry is missed or not written/entered into the electronic health record (EHR) in a timely manner, a late entry shall be documented in the Medical Record.
11. If an entry is made for another practitioner (by proxy), the entry must include the original practitioner's name and reason for proxy entry.
   a. Name of person making revision, date and time of entry and practitioner's (proxy's) unique log-on will be tracked by the system.
12. Refer to departmental specific documentation procedures for unit or departmental documentation requirements.
13. Refer to Patient Care Services Policy: Cerner Downtime for specific downtime documentation requirements.
14. Authenticating documentation is a process for authenticating the person, identified by name and relationship (discipline), who is responsible for ordering, providing or evaluating a clinical service rendered to a patient.
   a. The TCHD health care provider shall authenticate information entered into a ~~powernote~~ Powerform, IView or clinical note by students.
15. The following are authorized to document in the Medical Record according to job description/responsibilities, including but not limited to :
   a. Advanced Care Technician (ACT)
   b. Audiologist
   c. Behavioral Health Liaison (BHL)**/Psychiatric Liaison (PL)**
   d. Case Managers
   e. Certified Nurse Midwife (CNM)
   f. Chaplain
   g. Clinical Informaticist
   h. Clinical Nurse Specialist (CNS)
   i. Dentist
   j. Department Specific Technologist (i.e., Cath Lab, Cardiology, Radiology, etc.)
   k. Dietician
   l. Doctor of Osteopathic Medicine (DO)
   m. Dosimetrist
   n. Technician
   o. Interpreter
   p. Lactation Consultant
   q. Licensed Vocational Nurse (LVN)

r. Marriage Family Therapist (MFT)
s. Marriage Family Therapist Intern
t. Medical Assistant
u. Doctor of Medicine (MD)
v. Medical Physicist
w. Mental Health Worker (MHW)
x. Monitor Technicians (MT) per unit specific policy
y. Neurophysiologist
z. Nursing Instructor
aa. Nurse Practitioner (NP)
bb. Nursing Assistant (NA)/Certified Nursing Assistants (CNA)/Student Nurse Technician
cc. Organ Procurement Representative
dd. Orthopedic Assistant
ee. Ophthalmologist
ff. Pharmacist
gg. Physical/Occupational/Speech/Recreational Therapist (PT/OT/ST/RT)
hh. Physician's Assistant (PA)
ii. Podiatrist
jj. Psychologist
kk. Respiratory Care Practitioner (RCP)
ll. Registered Nurse (RN)
mm. Research Coordinator (credentialed by TCHD Medical Staff)
nn. Resident Physician
oo. Social Worker
pp. Student in approved clinical rotation.
qq. Transcriptionist
~~rr. Transporter~~
~~ss.~~**rr.** Unit Secretary
~~tt.~~**ss.** Contracted services that have completed the process as outlined in the Administrative Policy: Non-TCHD Workers' Orientation and Identification Badge Process 8610-451.

D. **RELATED DOCUMENT(S):**

1. Administrative Policy: Disclosure of Unanticipated Adverse Outcomes to Patients/Families 8610-275
2. Administrative Policy: Non-TCHD Worker's Orientation and Identification Badge Process, Non-Employees 8610-451
3. Patient Care Service: Cerner Downtime Policy
4. Patient Care Services: Medical Record Making Corrections to Documentation Procedure

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: **2/94**

SUBJECT: **Enteral Feeding and Nourishment Preparation, Storage, Distribution, and Administration**

REVISION DATE: **04/00; 10/02, 06/03, 07/05, 08/07, 05/10, 05/13, 03/17, 05/20**

Patient Care Services Content Expert Approval:	**~~03/20~~09/25**
Clinical Policies & Procedures Committee Approval:	**~~04/20~~10/25**
Nursing Leadership Approval:	**~~05/20~~11/25**
Medical Staff Department/Division Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**n/a**
Administration Approval:	**~~05/20~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/20**

A. **PURPOSE:**

1. To assure proper preparation, storage, distribution, and administration of enteral feedings.

B. **POLICY:**

1. Food & Nutrition Services is responsible for enteral feedings and nourishment storage and delivery to nursing units.
   ~~a. For NICU see Women and Newborn Services NICU: Formula, Preparation and Storage of~~
2. Nursing shall administer enteral feedings and deliver nourishments to patients.
3. Enteral formulas utilized shall be prepared and packaged by various medical nutritional companies and shall be available in cans/cartons or closed system liter bottles.
4. Homemade~~, blenderized~~ formulas **are not permitted**~~shall not be processed~~ at Tri-City Medical Center.
5. Canned/bottled or closed enteral formulas shall be stored in the **designated**~~nursing pantry~~ area~~s~~ upon delivery to the unit.
   ~~a. Unused, opened cans or liters of formula shall be stored in a refrigerator and labeled with a 24 hour expiration date and time.~~
   b. Unopened cans of formula shall be stored and discarded on manufacturer's expiration date.
6. Food & Nutrition Service workers shall process and gather product for delivery to nursing station via food carts after receiving a tube feeding or nourishment order via the electronic health record.
7. Closed feeding system hang times shall be according to the labeled manufacturer's recommendation. Nursing must document the date and time the container is opened on the container. New tubing is required with each new container.
   a. Label feeding system tubing with *change day sticker* indicating date tubing is to be changed using numerical day and month.
8. Formula used in an open system should be changed every eight hours for adult patients ~~every four hours for neonates~~, the tubing and the bag shall be flushed thoroughly with tap water; any existing formula shall be discarded and new formula should be added.

a. Nursing instructions for open system bags- open system bags and tubing should be changed every 24 hours. Label the open system bag with date and time formula is first placed in the bag. Label feeding system tubing with change day sticker indicating date tubing is to be changed using numerical day and month.

C. **RELATED DOCUMENT(S):**

1. ~~Women and Newborn Services NICU: Formula, Preparation and Storage of~~

D. **REFERENCES:**

1. ASPEN Guidelines

Tri-City Medical Center	Patient Care Services	**RETIRE – no longer performed**

PROCEDURE:	**EPILEPSY MONITORED UNIT (EMU)**
Purpose:	To outline the EMU's responsibility when caring for a patient admitted to the EMU.
Supportive Data:	Neurologist Preference /VA EMU
Equipment:	EMU video screen, EMU alarm, EMU seizure alarm call button, seizure pads

A. **DEFINITION(S):**

1. ~~Epilepsy- at least 2 discrete seizures which occur 24 hours apart, one seizure with greater than (>) 60% chance of having another seizure.~~
2. ~~Epileptic seizures- abnormal electrical discharges.~~
3. ~~Non-epileptic spells- normal brain activity (i.e., pseudoseizures~~ **pseudoseizures,** ~~or other behavior/movement disorder).~~
4. ~~Partial Seizures-~~
   a. ~~Simple Partial Seizure- Awareness preserved, symptoms depend on origin of seizure, twitching of face, jerking of arm or leg, and or emotions, fear, déjà vu, panic.~~
   b. ~~Complex Partial Seizure- Most difficult to control with treatment, impairment of consciousness, may have an "aura", typically last less than 3 minutes, may appear awake but are unaware, does not respond appropriately, repetitive behavior (chewing, picking, lip-smacking), postictal fatigue or aggression and are sometimes amnestic for these events.~~
5. ~~Generalized Seizures- (Primary or Secondary)- Often proceeded~~ **preceded** ~~by a cry, tonic-clonic, sudden falling to the ground, typical convulsive movements, eyes usually rolled back during convulsion.~~
6. ~~Seizure Types:~~
   a. ~~Absence- sudden onset of staring~~
   b. ~~Myoclonic- brief muscle contractions~~
   c. ~~Clonic- rhythmic muscle contractions~~
   d. ~~Tonic- sudden stiffening~~
   e. ~~Atonic- sudden loss of muscle tone causing drop attacks~~
7. ~~Video-Electroencephalography (VEEG)- Video/Audio/EEG continuous monitoring- Allows seizures to occur naturally in a safe and controlled environment, helps physician understand seizure type, where it is coming from~~**physicians understand seizure type, where it is coming from,** ~~and how it spreads, and if in fact it is epileptic or not. This is also used for a surgical workup.~~

B. ~~**POLICY:**~~

1. ~~EMU Assistant Nurse Manager (ANM), EMU secretaries, and Monitor Technician will check the EMU alarm system every shift for adequate audibility.~~
2. ~~All staff members on the EMU will promptly respond to~~ **the** ~~alarm.~~

C. ~~**ADMISSION:**~~

1. ~~Patient Admission and Preparation:~~
   a. ~~Admitting~~ **The admitting** ~~or EEG technologist will notify the EMU ANM/ relief charge nurse of the patient's pending admission.~~
   b. ~~The admitting physician or Allied Health Professional (AHP) provides orders (such as EMU power plan).~~
   c. ~~Patients shall check in at registration upon arrival.~~
      i. ~~After checking in, registration will send~~ **After checking in, registration will send the** ~~patient to the EEG lab.~~
      ii. ~~EEG tech will begin the preparation for~~**The EEG technician will begin preparing** ~~the EMU unit.~~

Department Review	Clinical Policies and Procedures	Nurse Executive Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
04/17, **09/25**	07/17, **10/25**	07/17, **11/25**	**n/a**	08/17, **11/25**	10/17, **12/25**	10/17

d. EEG Techs will complete the following:
i. Have patient sign consent
ii. Routine EEG with activation procedures
iii. HV-Hyperventilate if ordered
iv. PS-Photic Stimulation if ordered

2. Patient will then be transferred to the EMU.
3. The primary nurse shall:
a. Initiate the EMU Power plan orders on **the** patient when they arrive to the unit.
i. Automated External Defibrillator (AEDs) may be lowered on admission and throughout hospital stay.
ii. Sleep deprived, 2AM-6AM only if ordered.
b. Notify **the** Monitor Technician (MT) of the patient's admission.
c. Ensure the following:
i. Padded bed rails/chair arms
ii. Call light and alarm button in reach
iii. Suction and Oxygen connected and ready
iv. Peripheral IV for emergency medication, as ordered
v. EMU laminated instructional guidelines, nursing checklist and Pocket Guide will be placed above the patients **patient's** bed
vi. Camera will be on **the** patient at all times (except in the Bathroom)
1) View **The view** of **the** Camera should include the patient's entire body
vii. EEG electrodes are effectively glued
viii. Games, radios, computers, etc., are permitted, but must be battery operated to reduce EEG artifact
d. Ensure the patient is accompanied by a companion/sitter (family, friend, or hospital-appointed) upon admission and is educated on the following:
i. How to push the button during an event
ii. Identifying signs and symptoms of seizures
iii. Notifying nursing staff if **they** need to leave the bedside
iv. Accompanying **the** patient during ambulation and toileting at all times
e. Verify with MT, **CNM,** EMU ANM, and/or EMU secretary **that** the cameras, monitor volume, and EEG button to ensure all equipment is working properly**are functioning properly to ensure all equipment is working**.

D. **ONGOING MONITORING:**
1. Primary Nurse Responsibilities:
a. Complete the "Epilepsy Monitoring Unit Checklist" at **the** bedside at the beginning of every shift.
b. Educate patient/sitter**the patient/sitter,** or companion on all safety measures and document the education in the electronic health record (EHR).
c. Complete the initial and postictal assessment on the EMU patient
d. Document a detailed description of all seizure episodes in the EHR.
e. Attempt to remain in the EMU room with the patient when documenting, if possible, to monitor for seizure activity and offer support.
2. Monitor Technician Responsibilities:
a. Ensure patient is visible on **the patient is visible on the** monitor during monitoring.
b. Monitor the video screen for **the** patient having any of the following visible seizure activity(s):
i. Twitching body movements (extremities, face, and/or eyes)
ii. Jerking body movements
iii. Stiffening of **the** body or extremities
iv. Staring
v. Sudden falling to **the** floor
c. If any of the above are observed, the monitor tech will sound the alarm and contact the nurse's station to notify the nursing staff.

3. EMU ANM/ relief charge responsibilities:
    a. Respond to all EMU alarms on the unit to ensure patient safety, and video recording is running
    b. Ensure there is adequate staffing to cover the EMU (patient/nurse ratio 4:1 with sitter or patient support person)
    c. Assign a primary nurse and a backup buddy nurse for the entire shift for the EMU patient
    d. Check the EMU video and alarm every shift to ensure volume of alarm, alarm functionality and video system is **the volume of the alarm, alarm functionality, and video system are** working properly **correctly**.
    e. Assign staff members to these patients that **who** have met the training requirements to be considered competent to care for EMU patients.
4. Backup Buddy Nurse:
    a. Respond to the EMU alarm and perform the initial assessment and safety measures for the EMU patient if the primary nurse is not available.

E. **WHEN PATIENT IS HAVING A SEIZURE:**

1. RN, **CNM** ANM or Advanced Care Technician (ACT) shall push **the** alarm button at **the** patient's bedside if **the** patient or companion did not activate **it**.
2. Primary RN, Backup Buddy nurse and/or ANM need to promptly respond to **, and/or CNM need to promptly respond to the** alarm.
3. ANM **CNM**, relief charge or secretary **needs to check the camera when the** need to check camera when alarm is activated. Patient's entire body needs to be in view of **The patient's entire body needs to be in view of the** camera.
4. Turn on lights in room and close curtain for optimal video recording.
5. Make sure **the** patient is safe.
6. Move bedside table away from **the bedside table away from the** patient.
7. Uncover bedding or covers from patient so all extremities are in view of **the patient so all extremities are in view of the** camera.
8. Turn off any background noise (TV, radio, etc.).
9. Stay clear of the camera (patient should be in total view).
10. If **the** patient experiences generalized tonic-clonic seizure, initiate emergency precautions:
    a. Goal: patient safety and supportive therapy
    b. Stay calm, stay with the patient, and call for help
    c. Activate the rapid response team for standby
    d. Clear bed, uncover patient, on camera
    e. Turn patient to side (to avoid aspiration)
    f. Utilize suction apparatus as necessary to clear **the** airway
    g. Apply O2 via **a** simple face mask
    h. Administer lorazepam (Ativan) 1mg IV Push per physician order
    i. Notify **the** neurologist on-call if:
        i. Prolonged seizure greater than (>) 5 minutes or recurrent/cluster seizures
    j. Postictally assess for fatigue/somnolent, wandering, **and** aggression
11. Patient Assessment:
    a. During the episode, perform seizure assessment and verbally describe findings in a loud, clear voice for the video, repeating what the patient says if they cannot speak clearly:
        i. Level of consciousness
        ii. Orientation
        iii. Body movements
            1) Rhythmic action of face or limbs, progression of movements
            2) Is one side more involved
        iv. How are pupils oriented?
            1) Staring, deviation, left, right, etc.
        v. Is **the** patient able to speak?
            1) Lips smacking , drooling, chewing, vocalization

vi. Is **the** patient fidgety, picking, searching?
vii. Ask **the** patient to remember a word, **for** example "pink"
viii. Ask **the** patient to squeeze fingers and point to **the** ceiling
ix. If very brief seizure or subjective sensation, ask patient**a very brief seizure or subjective sensation, ask the patient's** companion to describe it. Patient saying "I just had a seizure' is not sufficient.

12. After Seizure Assessment (Postictal):
    a. Neurological Checks:
        i. Check for drift – have **the** patient hold palms up
        ii. Tapping – have **the** patient tap fingers on **the** left and right hand
        iii. Facial droop – have **the** patient smile
        iv. Counting - have **the** patient count from 1-10
        v. Movement – have **the** patient move his/her hands, legs**,** and wiggle toes
        vi. Fear, agitation**,** or mood changes. Patient may attempt to disrobe, get out of bed**,** or "flee"
    b. Language:
        i. Comprehension – hold up two fingers on your right hand
        ii. Repetition – have **the** patient repeat the phrase, "I sat in the front of the room"
        iii. Naming – Show an object such as a pen and ask the patient "what**, "What** is this?"
        iv. Orientation- What is your name? Where are you? What is the name of this place?
        v. Recall – what word did I tell you to remember?

F. **DOCUMENTATION:**
1. Document patient and companion/sitter education in the EHR.
2. Document seizure assessment findings in the EHR.

G. **REFERENCE(S):**
1. VA Epilepsy Center of excellence **Excellence** web link:http://www.epilepsy.va.gov/nursing/
2. Epilepsy **F**foundation: http://www.epilepsy.com/
3. National Association of Epilepsy Centers: http://www.naec-epilepsy.org/

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: **05/78**

SUBJECT: **Food and Nutrition Relationships with other Departments**

REVISION DATE: **04/00, 06/03, 07/05, 07/07, 03/10, 04/13, 04/17, 08/20**

Patient Care Services Content Expert Approval:	**~~02/20~~09/25**
Clinical Policies and Procedures Committee Approval:	**~~05/20~~10/25**
Nursing Leadership Approval:	**~~06/20~~11/25**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~07/20~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **POLICY:**

1. Food and Nutrition Services is organized, staffed and integrated with other units and departments of the hospital in a manner designed to assure the provision of optimal nutritional care and quality food service. The department maintains operating relationships with most of the medical care and administrative activities of the hospital. Close relationships are maintained with the medical staff on special dietetic needs of patients; with nursing services on provisions of regular and modified diets and between meal nourishments; and with administration on management matters.

B. **NURSING SERVICE:**

1. Food and Nutrition personnel are responsible for:
   a. Preparation and delivery of all trays to patient units, including the provision of nourishment supplies.
   b. Return of soiled trays and dishes to the kitchen on food carts. Check soiled utility room for soiled trays / dishes, put on food carts, and bring back to kitchen.
   c. Dietitians screen and assess nutritional status of patients to provide optimal nutritional care or instruction regarding special dietary needs.
   d. Upon receiving a physician's order, or as deemed appropriate, dietitian instructs patients in maintenance of modified diets at home, prior to discharge if needed and appropriate.
   e. Attempt to visit patients daily to pick up or assist with completion of selective menu for the next day. Both nursing and food service personnel may help the patients with menu selections.
   f. Preparation and delivery of mid-morning, mid-afternoon, and evening nourishments to nursing stations.
   g. Storage and delivery of enteral feedings.
   h. Preparation and delivery of nutritionally sound meals under approved standards of sanitation.
   i. The clinical dietician will ~~assess nutritional~~**assess nutritional** status, and develop nutritional care plans with appropriate interventions.
   j. Educate food and nutrition staff on department related regulatory and food safety procedures and expectations.
   k. ~~Communicate patient~~**Communicate patient** nutritional needs and concerns with nursing.

2. Nursing personnel are responsible for:
    a. Obtaining a physician's order for each patient's diet.
    b. Transmitting diet orders to Food and Nutrition Services.
    c. Assisting patients with choices on selective menus as needed.
    d. Preparing patients to receive trays.
    e. Passing trays to patients upon arrival of food carts under direction of Primary Registered Nurse.
    f. Ensuring two patient identifiers are used when delivering trays and nourishments.
    g. Feeding patients who need assistance.
    h. Serving special interval nourishments (for example snacks).
    i. Obtaining height and weight and recording in patient's chart.
    j. Complet**ing** ~~e~~ Braden Scale Score and initiat**ing** ~~e~~ nutrition consult for patients at high risk for skin breakdown.
    k. Notifying the Food and Nutrition Services Dietitian if a patient is not eating well.
    l. **Requesting** ~~Transmitting~~ guest tray ~~orders~~.
        ~~l.~~ **i. Guest trays are limited to one per day**
    m. Collecting finished food trays and placing on food cart if still on floor, or storing in dirty utility room.
        i. Remove protected health information **(PHI)** from tray.
    n. Completion of patient history related to nutrition risk factors (generating nutrition consults if any risks are identified**).** ~~.~~)

C. **BUSINESS OFFICE:**
1. Food and Nutrition personnel are responsible for:
    a. Submitting a cafeteria cash report.
    b. Submitting statistical data for the department**.**
2. Business Office personnel are responsible for:
    a. Initiating receipts for cafeteria cash received.

D. **INFORMATION TECHNOLOGY:**
1. Food and Nutrition personnel are responsible for entering physicians' cafeteria charges into the computer at the end of each month.
2. Information Technology personnel are responsible for:
    a. Consulting with Food and Nutrition when initiating new dietary data processing procedures.
    b. Providing the system for receiving patient discharges, admissions, and room changes.
    c. Assisting Food and Nutrition in the use of the computer system.
    d. Providing support for Cerner.

E. **EMPLOYEE HEALTH:**
1. The Employee Health Nurse and/or the Emergency Room handle all Food and Nutrition Services employee accidents, pre-employment physicals, and annual physical reviews.

F. **ENVIRONMENTAL SERVICES:**
1. Food and Nutrition personnel are responsible for:
    a. Returning soiled mop heads to the laundry.
2. Environmental Services personnel are responsible for:
    a. Providing clean mop heads for use in Food and Nutrition Services.
    b. Cleaning Food and Nutrition offices and carpeted and tiled areas of cafeteria.
    c. Provides hand soap, sanitizer, and paper towels.

G. **FACILITIES MANAGEMENT:**
1. Food and Nutrition personnel are responsible for:
    a. Initiating work requests for repair of equipment.
    a. Reporting hazardous working conditions.

2. Facilities personnel are responsible for:
    b. Preventive maintenance and repair on all required Food and Nutrition equipment unless under contract with an outside agency.
    c. Keeping records of preventative maintenance in Facilities Management.
    d. Keeping files on maintenance of Food and Nutrition equipment.

H. **EDUCATION:**
1. Education provides in-service education for Food and Nutrition personnel for hospital orientation and other areas as needed and/or requested.

I. **AUXILIARY:**
1. Food and Nutrition Services provides refreshments for Auxiliary meetings.
2. Food and Nutrition Services provides supplies for Auxiliary functions.

J. **PHARMACY:**
1. Pharmacy personnel are responsible for:
    a. Conferring with **Registered Dietician (**RD**)**s regarding drug-nutrient interactions.
    b. Conferring with RDs regarding best means to achieve nutritional needs via TPN for those patients receiving **total parental nutrition (**TPN**)**.
2. Dietitians are responsible for:
    a. Conferring with Pharmacists regarding potential drug -- nutrient interactions.
    b. Conferring with Pharmacists on patients receiving TPN to optimize nutrition support via TPN.

K. **ALL TRI-CITY HEALTHCARE DISTRICT (TCHD) DEPARTMENTS:**
1. Food and Nutrition Services provides room set-ups and catering upon request for meetings/events for departments, Board of Directors, and the TCHD in general.
    a. Coordination is completed by contacting the ~~Event Coordinator, the~~ Catering/Cafeteria Supervisor**/designee**~~, and/or the Operations Manager of Food & Nutrition~~.
2. Individual departments may request catering with approval from the department director/manager.
3. Individual departments/cost centers are charged for internal catering.
    a. Departments may authorize payment via an external source (i.e. a vendor).

L. **REFERENCE(S):**
1. Title 22

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: **11/07**

SUBJECT: **Holds, Evaluation and Treatment of Involuntary Patients**

REVISION DATE: **12/08, 05/11, 01/18, 8/20**

Department Approval:	**~~03/20~~02/25**
Clinical Policies & Procedures Committee Approval:	**~~03/20~~05/25**
Nursing Leadership Approval:	**~~04/20~~08/25**
Division of Psychiatry Approval:	**~~05/20~~11/25**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~06/20~~11/25**
Administration Approval:	**~~07/20~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

~~A.~~ **PURPOSE:**

A.

1. To **provide legal clarity and** ensure individuals presenting to the Emergency Department (ED) or admitted to a medical floor at Tri-City Healthcare District (TCHD), a non-Lanterman-Petris Short (LPS) designated facility, with symptoms that place them at high risk for danger to themselves or others or who meet criteria for being considered gravely disabled are evaluated and treated in accordance with the procedural requirements set forth in the Lanterman-Petris-Short (LPS) Act, Welfare and Institutions Code (WIC), **sections 5150, 5150.05 and 5256.4, California Health and Safety (H&S) Code section 1799.111, and the San Diego County Board of Supervisors' Resolution No. 19-145.**

~~1. section 5150, California Assembly Bill No. 1424 (AB 1424), California Health and Safety (H&S) Code section 1799.111, and the San Diego County Board of Supervisors' Resolution No. 05-232.~~

2. To ensure patient rights are respected while on involuntary ~~holds~~**detentions**.

~~3. To clarify the legal process along with each staff member's legal responsibilities for WIC 5150s, and patients eligible for a 24-hour hold under H&S 1799.111 at a non-LPS designated facility, such as TCHD.~~

3. To ensure that TCHD complies with WIC 5256.4 (AB-2275 effective January 1, 2023) by notifying the Patient Advocacy Program at the conclusion of a WIC § 5150 detainment and conduct due process hearings.

B. **SCOPE AND APPLICABILITY:**

1. This policy applies to all patients evaluated and treated on an involuntary basis for an emotional or behavioral disorder in the Emergency Department (ED) ~~as well as~~**or any** inpatient **department**.

C. **DEFINITION(S):**

1. Lanterman-Petris-Short (LPS) Act (**WIC 5000-5556**~~WIC 51000 et seq.~~): This act establishes procedural requirements under which persons found to be dangerous to themselves or others or are gravely disabled due to a mental disorder which, may be involuntarily detained for specified periods for evaluation and treatment.
   a. Prolonged holds cannot be used at non-LPS facilities regarding additional hold, thus do not apply to TCHD (WIC 5152, 5250, 5260, 5270, 5300).

~~b. In certain instances, LPS designation guidelines require that the LPS designated facility first conduct a WIC 5151 assessment to determine whether or not the involuntary detention is appropriate and inpatient admission is required. This requires the involvement of a professional with admitting privileges at the LPS designated facility. Because TCHD is a non-LPS facility, this is not applicable to TCHD.~~

~~c.~~**b.** 5150 ~~hold~~ **detention** or 72-hour ~~hold~~**detention**: A~~n initial~~ 72-hour ~~hold~~ **detention** for evaluation and treatment~~ that applies only in the Emergency Department (WIC 5150).~~**. The involuntary detention begins from the time the person was first detained. This process is intended only as a temporary, limited detention until transport to a designated LPS facility can be arranged for individuals who present a danger to themselves or others, or are gravely disabled, as a result of a mental health disorder. An individual who is inpatient and meets criteria, can be placed on a 5150 by an ED physician who is certified by San Diego County.**

~~d. This is a "hold and transport" to a designated LPS facility and is for the temporary, involuntary psychiatric commitment of individuals who present a danger to themselves or others due to signs of mental illness.~~

~~2. 1799.111 hold or 24-hour hold: A 24-hour hold for evaluation and treatment, while admitted to the hospital (H&S 1799.111).~~

~~a. The law provides for a 24-hour **1799 medical hold**, placed by a physician, in which a patient who comes to the emergency room for **medical** treatment and is then discovered also to have a psychiatric problem that requires attention. If necessary, a **1799 hold** can be converted into a 5150 **hold.**~~

~~3.~~**2.** Gravely Disabled ~~(defines how one can be placed on a hold):~~

a. **A condition in which a person, as a result of a mental health disorder, a severe substance use disorder, or a co-occurring mental health disorder and a severe substance use disorder, is unable to provide for their basic personal needs for food, clothing, shelter, personal safety, or necessary medical care.** ~~A condition in which a person, due to mental disorder or, in some cases, chronic alcoholism, is unable to provide for his/her basic personal needs for food, clothing, or shelter.~~ (WIC 5008(h)(1);~~ H&S 1799.111(a)(1)~~).

b. ~~A person, as a result of a mental disorder, is in danger of serious physical harm resulting from failure to provide for his or her essential human needs of health or safety.~~**Effective January 1, 2025, the definition of grave disability will expand to include the following: A condition in which a person, as a result of a mental health disorder, a co-occurring mental health disorder and a severe substance use disorder, or a severe substance use disorder alone, is unable to provide for their basic needs for food, clothing, shelter, personal safety, or necessary medical care. WIC § 5008(h)(1)(A)**

i. "Personal safety" means the ability of one to survive safely in the community without involuntary detention or treatment pursuant to this part. WIC § 5008(p)

~~b.~~**ii. "Necessary medical care" means care that a licensed health care practitioner, while operating within the scope of their practice, determines to be necessary to prevent serious deterioration of an existing physical medical condition which, if left untreated, is likely to result in serious bodily injury as defined in Section 15610.67. (WIC § 5008(q))**

c. ~~Mental retardation, by itself, does not constitute a grave disability~~**The term "gravely disabled" does not include persons with intellectual disabilities by reason of that disability alone.**

~~4.~~**3.** Probable Cause~~ (defines when one can be placed on a hold)~~: To constitute probable cause to detain a person pursuant to section 5150, a state of facts must be known to the law enforcement officer (or other authorized person) that would lead a person of ordinary care and prudence to believe, or to entertain a strong suspicion, that the person detained is mentally disordered and is a danger to ~~himself or herself~~**themselves** or is gravely disabled. In justifying

the particular intrusion, the person initiating the hold must be able to point to specific and articulable facts which, taken together with rational inferences from those facts, reasonably warrant ~~his or her~~**their** belief or suspicion. (*See People v. Triplett* (1983) 144 Cal. App.3d 287-288).

a. When determining if probable cause exists to detain a person all available relevant information about the historical course of the person's mental disorder shall be considered if it has reasonable bearing on the determination (~~HS 1799.111,~~ WIC 5150, AB 1424). This information must be documented in the medical record.

i. The evidence does not have to be personally observed by the evaluator and may be observations reported to the evaluator by a reliable witness, which includes family members and/or significant others.

ii. See "~~Detention of Patient with Psychiatric Emergency In a Nondesignated Health Facility~~**Application for Assessment, evaluation, and Crisis Intervention or Placement for Evaluation and Treatment**" form

4. Writ of ~~Habeous~~ **Habeas** Corpus: A legal proceeding during which the individual being detained may challenge the grounds of their involuntary ~~hold~~**detention**. This may occur ~~when the 5150 or 1799.111 hold expires.~~ **at any time the individual is detained.**

5. **Due Process: A certification review hearing shall be held within 7 days of the date the person was initially detained pursuant to Section 5150 when being detained at a non-LPS facility (since they cannot be certified for intensive treatment).**

6. Medical Emergency: Medical condition manifesting as acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in either placing the health of an individual (or with respect to a pregnant woman, the health of her unborn child) in serious jeopardy; serious impairment of bodily functions; **or serious dysfunction of any bodily functions placing the individual at risk of damage or loss unless immediate medical care is received** ~~or serious dysfunction of any bodily organ or part~~42 California Code of Regulations CFR Section 489.24(b).

D. **POLICY: 72-HOUR DETENTION (WIC 5150)**

~~1. Persons detained under WIC 5150 and/or H&S 1799.111 retain their legal rights regarding consent for medical treatment.~~

~~a. A person does not give up the right to control his or her medical treatment simply because he or she has been diagnosed with a mental disorder.~~

~~i. Capacity to consent to medical treatment is a separate issue and must be assessed by the treating physician with all mental health patients before proceeding with medical treatment.~~

~~ii. Emergency treatment exception: Treatment of a medical emergency may be provided without consent if the provider reasonably believes that a medical procedure should be undertaken immediately, and that there is insufficient time to obtain the consent of the patient or of a patient authorized to consent on behalf of the patient.~~

~~1) A medical emergency exists when:~~

~~a) Immediate services are required for alleviation of severe pain; or~~

~~b) Immediate diagnosis and treatment of unforeseeable medical conditions are required, is such conditions would lead to serious disability or death if not immediately treated.~~

~~iii. See Patient Care Services Policy: Consent for Operative or Other Procedures and Patient Care Services Policy: Consent for Minors.~~

1. ~~72-HOUR HOLD (WIC 5150):~~**Persons detained under WIC 5150 retain their legal rights regarding consent for medical treatment.**

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1) A medical emergency exists when:

a) Immediate services are required for alleviation of severe pain; or

b) Immediate diagnosis and treatment of unforeseeable medical conditions are required, if such conditions would lead to serious disability or death if not immediately treated.

~~iv.~~**iii. See Patient Care Services Policy: Consent for Operative or Other Procedures and Patient Care Services Policy: Consent for Minors.**

2. Individuals who may initiate a 72-hour ~~hold~~ **detention as authorized by The Board of Supervisors of the County of San Diego in Resolution No. 19-145** include:

a. Peace Officers

~~i. Peace Officers/ Psychiatric Emergency Response Team (PERT) should only bring 5150 hold to ED if there is a medical emergency or a life threatening condition.~~

b. Members of the **County-contracted Psychiatric Emergency Response Team (**~~-~~PERT**)**

c. Emergency Room (ED) Physicians who are credentialed by or under contract to serve in the emergency room of a licensed general acute care hospital, specifically at TCHD

i. Only ED Physicians who meet the following criteria are authorized to place a detention:

1) Be appropriately licensed within their discipline in the State of California and act only within the scope of their practice, and

2) Must successfully complete training and testing approved by the Local Mental Health Director or Designee related to Welfare & Institutions Code, Section 5150 detention process

~~ii.~~ **TCHD ED Physicians, if certified as described above, may place a 72-hour detention on patients on the medical units (see procedure below)**

ii.

~~b. ED Physicians who are authorized to admit a person to the facility and who have been designated/certified by the Board of Supervisors of the County of San Diego, Resolution No. 05-232, and WIC section 5150, specifically at TCHD, a non LPS facility.~~

~~i. To be authorized, the ED Physician must complete the San Diego County training, pass the test with at least 85%, and be certified by the County.~~

~~ii. All TCHD ED Physicians must obtain this certification in order to place a 5150 hold.~~

~~1) The Board of Supervisors of San Diego authorizes only those ED physicians to place a hold who meet the following criteria:~~

~~a) The professional person will be appropriately licensed within his/her discipline in the State of CA and act only within the scope of his/her practice, and~~

~~b) The individual will have successfully completed training and testing approved by the Local Mental health Director or Local Mental Health Director Designee related to the WIC sections 5150 and 5585.50 detention process.~~

~~iii. Only ED physicians may place a 5150 in the ED in acute care hospitals with non-LPS hospitals.~~

iii. Note: Psyche Liaisons (PL) **do not** have the authority to initiate a 5150 hold. PL's may, however, evaluate a patient and make recommendations to the ED Physician.

d. Persons who are members of the Behavioral Health Services approved mobile behavioral health crisis intervention response teams

e. A complete list of individuals who can initiate 72-hour detentions pursuant to 5150 and 5585.50 can be found in the San Diego County Board of Supervisors' Resolution No 19-145.

3. A 5150 detention should only be placed if the patient does not wish to remain on a voluntary basis and requires transfer to an LPS facility.

a. If an ED physician examines patient and determines patient is voluntary there is no need to renew 5150 or place on a 5150 while in the ED

4. Suicidal Patients that are not medically stable should be evaluated for the appropriateness of 5150 advisement and detention. If the patient is not alert, comatose, etc. it is not necessary to place a 5150 detention since the patient is not danger to themselves or others. ED physicians should use their own discretion. A 5150 detention can be initiated once the patient begins wakening and articulates a request to leave. WIC 5150 is intended as a tool to temporarily detain an individual who is experiencing a mental health crisis and is deemed to a danger to oneself, others or is gravely disabled.

5. Special Considerations for 5150 patients brought in by law enforcement agencies:

a. If a law enforcement officer initiates a 5150 and brings the patient to a non-LPS facility, TCHD, for medical evaluation and remains with the patient until they are medically cleared for transport to an LPS facility, the 5150 remains intact for transport.

i. Once medically cleared, the law enforcement officer is required to transport the patient to an LPS facility to complete the 5150 process.

b. If the law enforcement officer who initiated the 5150 does not remain with the patient, the hold is terminated and no longer in effect.

i. The ED Physician may place a new 5150 detention, if in the physician's opinion, the patient meets criteria.

ii. The time of the 72-hour detention initiated by the ED physician begins at the time of the first 5150 detention placed by law enforcement.

E. **PROCEDURE:**

~~i. An ED Physician should only place the patient on 5150 hold if the patient must be transferred to LPS facility.~~

~~1) If an ED physician examines patient and determines patient is voluntary vs involuntary, no need for to renew 5150 or place on a 5150 while in the ED.~~

~~2. Designated personnel initiating a 72-hour evaluation (5150) are required to complete a written application which states the following:~~

~~a. Circumstance under which the individual's condition was called to his/her attention~~

~~b. Probable cause to believe the person is, due to mental disorder, a danger to self or others or is gravely disabled.~~

~~3. The written application must be completed for individuals brought to the ED as well as for those patients already being treated in the ED. The application must include the circumstances under which the patient's condition was called to the attention of the law enforcement officer or authorized professional person; and that there is probable cause to believe that the patient is, as a result of mental disorder, a danger to others, or to themself, or gravely disabled.~~

~~4. Specific Considerations for 5150 patients brought in by law enforcement agencies:~~

1. Placing a 5150 Detention

a. Clinical staff shall facilitate an evaluation by the PL as soon as possible and when possible prior to giving medications that may be sedating or restrict the patient's ability to participate in a mental status evaluation.

b. If deemed appropriate and the ED physician places a 5150 a written application must be completed
- **i. Designated personnel initiating a 72-hour detention (5150) are required to complete a written application which states the following:**
  - **1) Circumstance under which the individual's condition was called to their attention**
  - **2) Probable cause to believe the person is, due to mental disorder, a danger to self or others or is gravely disabled.**
- **ii. The application must be completed for both individuals brought to the ED on a 5150 as well as for patients already being treated in the ED or on the medical units.**

c. Clinical Staff or the PL shall provide the patient with the California Department of Health Care Services Handbook: Rights for Individuals in Mental Health Facilities found at https://www.dhcs.ca.gov/services/Documents/DHCS_Handbook_English.pdf

d. The Primary RN will notify the Security Department and Administrative Supervisor of the 5150 detention.

e. For patients identified as a high risk for elopement, the clinical staff shall:
- **i. Place the patient in a secure room that facilitates close observation by a Sitter (refer to Patient Care Services: Sitter Policy).**
- **ii. Psychiatric patients retain all of their rights including the right to wear their own clothing & retain their personal possessions, including toiletries.**
  - **1) If the facility has good cause to not allow these items it must be documented in the patient's chart and items can be removed for a limited duration.**
    - **a) Any items taken from the individual must be inventoried and securely stored with the Security Department.**
      - **(i) Ensure all items are returned to the patient on discharge or transferred with the individual to their next facility.**
- **iii. In the ED, place the wandering bracelet on the patient's wrist after activation.**
- **iv. Perform an initial assessment of the patient and implement necessary interventions to ensure the patient's immediate safety and the safety of the environment.**
- **v. Communicate the patient's status to the Charge Nurse (or designee), Physician & Security.**

f. Clinical Staff will:
- **i. Maintain ongoing communication with the PL regarding the plan for treatment.**
- **ii. Monitor the patient at regular intervals, as clinically indicated to provide safe and effective nursing care.**
- **iii. For suicidal patients, the sitter must continuously monitor and document monitoring per Patient Care Services Policy: Assessing and Managing Patients at Risk for Suicide.**
- **iv. Ensure the patient's rights are respected including:**
  - **1) The right to access the services of the Patient Advocacy Program.**
  - **2) The right to be free from restraint or seclusion and to be treated in the least restrictive environment unless the presenting behavior constitutes an imminent threat to the safety of the patient or others in the immediate environment.**
  - **3) The right to be treated with dignity and respect.**
- **v. Complete all necessary documentation in accordance with TCHD policy, including documentation associated with the use of restraints or seclusion.**

2. Special Considerations for placing a 5150 Detention on the Medical Units (Inpatients)

a. If the treating physician, psychiatrist, or Hospitalist believes a 5150 may be warranted on a patient they should contact the PL for evaluation.
i. In the event there is no PL in house the physician will need to contact the ED physician directly for evaluation.
b. If the PL determines the patient meets criteria for a 5150 they will contact the ED physician for further evaluation and subsequent placement of a 72-hour detention as appropriate.
c. The PL will complete the necessary documentation and written application to place the patient on a 5150.

3. The 72-hour detention may be discontinued at TCHD by the following individuals as dictated by TCHD's policy, custom and practice:
a. ED Physicians
b. PLs who have been certified by the County of San Diego under the direction and oversight of the ED physician.
c. On Call Psychiatrists

4. Due Process
a. WIC 5256.4 (AB-2275 effective January 1, 2023) stipulates that a due process hearing is required whenever individuals have been detained pursuant to WIC 5150 (for more than 72 hours and up to 7 days) at facilities where initiating a 5250 (14-day detention) is not possible.
b. The PL shall arrange for a Due Process Hearing to be scheduled before the 72-hour detention is up. The patient may be held for an additional four (4) days if waiting for the Due Process Hearing to take place.
i. For any patient detained on a 72-hour hold, the certification review hearing must be held within 7 days of the date the patient was initially detained and the patient must be notified of their specified rights as it pertains to the Due Process Hearing.
ii. If the 5150 expires prior to placement at an LPS facility, TCHD can only continue to detain a patient with symptoms related to danger to self, danger to others or grave disability (as defined above) if due process has been initiated.
c. The PL will notify Patient Advocacy via telephone and/or fax the 5150 form prior to the expiration of the 72 hours to initiate Due Process.
~~a.~~**d. A hearing will be scheduled by the court by or on the 7th day of detention.**
i. For further information or guidance, please refer to the Patient Advocacy Program's Quick Reference Guide for Non-LPS Designated Facilities found at https://www.jfssd.org/wp-content/uploads/2024/03/AB-2275-Due-Process-Hearings-in-Non-Designated-Locations.pdf.
ii. The patient has a right to a Writ of Habeas Corpus paperwork, including education materials. If the patient wishes to request a Writ of Habeas Corpus, the PL shall assist in completing the request and fax it to the Office of the Public Defender. The form can be found here: https://www.jfssd.org/wp-content/uploads/2023/07/Notice-of-Request-for-Writ.pdf.
iii. If the patient declines to seek a writ, PL will ask patient to sign a declination form and document in the medical record. If patient refuses to sign the declination, PL will note the refusal on the form and in the medical record.
iv. The PL will continue to make efforts to obtain placement at an LPS facility and document all efforts in the medical record.
v. TCHD (usually the PL) shall notify Patient Advocacy if the individual becomes voluntary, discharged, or transferred.
e. If the Hearing Officer determines there is Probable Cause to detain, there is no legal right to hold the patient, however, in order to protect the patient if the

treating providers believe the patient must still be held, TCHD may continue to detain the patient.

i. A hearing pursuant to WIC 5256.4 is for the benefit and protection of the patient's civil rights. It does not grant TCHD further authority. Any continued involuntary detention should be at an LPS designated facility that can provide the intensive treatment pursuant to WIC § 5250. As a result, after the hearing, the patient should be transferred to an LPS designated facility or discharged unless they decide to remain on a voluntary basis.

ii. During this time TCHD must continue to document all efforts to transfer the patient to an LPS facility, including conversations with outside facilities (who they spoke to about transfer) and dates & times of efforts made.

iii. PL must continue to document any symptoms the patient exhibits regarding the patient's danger to self or others.

~~b. WIC sections 5150.1 and 5150.2 restrict mental health professionals from interfering with law enforcement officers who may be transporting a person to TCHD for assessment to a LPS-designated facility for assessment. However, when law enforcement brings an individual on a 5150 hold to a non-LPS facility and leaves the patient in the ED, such as TCHD, the 5150 transport is not complete and the hold is terminated.~~

~~c. The law enforcement officer who initiated the 5150 is encouraged to remain with the patient until he or she is medically cleared for transport to a LPS facility and thus the 5150 hold stays intact for transport.~~

~~i. Once medically cleared, the law enforcement officer is required to transport the patient to a LPS Facility to complete the 5150 process.~~

~~d. If the law enforcement officer leaves the patient at TCHD, the hold is no longer in effect.~~

~~i. The ED Physician may then place a new 5150 hold if, in the physician's opinion, the patient meets the criteria. However, the time of the 72-hour hold initiated by the ED physician begins at the time of the first law enforcement hold.(time must be credited with new 5150 hold), i.e. if law enforcement placed the patient on a 5150 hold at midnight and transfers the patient to the ED at 5:00 am and leaves, then the ED Physician must credit 5 hours to the new 72 hour hold.~~

~~5. A 5150 gives the issuing party the authority to only detain and transport the patient until a 5151 has been completed. A 5150 may be released under the following two circumstances:~~

~~a. The 5150 issuing party obtains further information that the patient does not meet criteria and discontinues the 5150.~~

~~i. For instance, if the patient is a voluntary admission and wants help, because the person is voluntary, this does not require a 5150, or if the patient is not a danger to self or others and is not gravely disabled, or the person does not meet the criteria for a 5150 hold.~~

~~ii. The admitting non-designated LPS facility ED physician determines the patient is not a 5150, with same criteria immediately above.~~

~~b. The 5150 issuing party is a law enforcement officer or PERT member, and he or she presents the patient to a non-LPS Facility ED and does not remain with the patient until the patient is medically cleared for transport (the 5150 is by operation of law is terminated or void).~~

~~6. A 5150 remains in effect:~~

~~a. If the issuing outside agent places the 5150, remains with the patient in the ED until the patient is medically cleared for transport to a LPS facility, that 5150 remains in effect for purposes of detention and transport to a LPS facility.~~

i. For example, if a law enforcement officer brings a patient to TCHD on a 5150, who has cut their wrists wanting to harm self and the officer stays with the patient until they are sutured and medically safe/stable, then the patient can be transported and discharged with that officer to another LPS facility and the 5150 remains in effect.

b. 5150 holds can only be used in the ED. If a patient is transferred to a medical floor of a non-LPS facility, the hold is invalid.

7. Individuals who may remove a 72-hour hold at a TCHD (a Non-LPS Facility) include:
   a. The LPS Act and WIC are silent on who may remove a 5150 hold at non-LPS facility.
   b. TCHD's policy, custom and practice authorizes the below licensed professionals to remove 5150 holds:
      i. ED Physicians
      ii. PLs under the direction of the ED Physician and who have been certified by the County of San Diego. ED physicians should monitor PL's removal.
      iii. On call Psychiatrists
8. If the 72-hour (5150) hold expires before the PL and/or ED Physician finds placement for the patient at a LPS facility, TCHD can continue to hold the patient if the PL and/or ED Physician provide the patient with information regarding requesting a Writ of Habeas Corpus (because the patient will continue to be on a hold). The following is required:
   a. Proper Documentation of the following is required:
      i. The patient received Writ of Habeas Corus paperwork, including education materials.
      ii. The hospital staff, treating physician, or appropriately licensed mental health professional have made and documented repeated unsuccessful efforts to find appropriate mental health treatment for the person.
         1) Efforts to find placement at a LPS facility must begin when the treating physician has determined the time at which the patient will be medically stable for transfer.
         2) The efforts to find placement at LPS facility must not begin after the time when the patient becomes medically stable for transfer.
   b. If the patient chooses to seek a writ, PL will help patient complete the form and fax to the Office of the Public Defender.
   c. If patient declines to seek a writ, PL will ask patient to sign declination form and document the medical record.
      i. If patient refuses to sign the declination, PL will note the refusal in the medical record.
   d. PL will continue to make efforts to obtain placement at LPS facility and document all efforts in the medical record.
   e. If the patient admitted to the ED is suicidal and not medically stable, it should be determined whether the patient is alert enough for 5150 hold. If the patient is comatose, etc., it is not necessary for 5150 hold since the patient is not a danger to themselves since they are not alert. ED physicians should use their own discretion. An ED physician can later place a 5150 hold when the patient begins wakening.

F. **24-HOUR HOLD (H&S 1799.111):**

1. Under California Health and Safety Code section 1799.111 non-LPS Facilities may use Health and Safety Code section 1799.111 to hold a patient up to 24-hours for the purposes of transferring to a LPS Facility, when, in the opinion of the treating physician, licensed professional staff (PL) or a clinical psychologist with medical staff privileges, the person cannot be safely released from the hospital because, as a result of a mental disorder, the patient presents a danger to himself or herself, or others, or is gravely disabled (as defined above).
2. If a patient is on a 5150 hold and is transferred from the ED to the floor, the 5150 hold is void.

3. The 24-hour hold should be used only when admitted to the medical floor and may be initiated by licensed professional staff of TCHD (i.e., PLs), or any physician and/or surgeon at TCHD.
    a. The code does not mandate the need for a certification or authorization to hold an individual like a 5150 for physicians, rather the code provides immunity when a patient must be held for reasons of safety in a non-LPS facility until transfer to a LPS facility for appropriate care that can be arranged.
4. Section 1799.111 hold may be initiated if the following criterion are met:
    a. The patient cannot be safely released from the hospital because, in the opinion of the licensed professional staff, physician or surgeon, the patient, as a result of a mental disorder, presents a danger to themselves, or others, or is gravely disabled (as defined above).
        i. There must be probable cause for the detention, as defined above.
    b. The licensed professional staff, physician or surgeon, has made and documented repeated unsuccessful efforts to find appropriate mental health treatment for the person. (this must be conducted at time of patient admission to the floor).
        i. Telephone calls or other contacts shall commence at the earliest possible time when the treating physician has determined the time at which the person will be medically stable for transfer, and documented in the medical record.
        ii. The efforts to find placement at a LPS facility shall not be delayed until the time when the patient becomes medically stable for transfer. Rather, they should begin as soon as possible and should be documented once the hold is in place. (H&S 1799.111((a)(2)(B)).
            1) In other words, to be protected by the immunity in Section 1799.111, the efforts to find placement at a LPS Facility must begin before the patient is medically stable.
5. The licensed professional staff, physician or surgeon initiating the 24-hour hold shall complete the "Detention of Patient with Psychiatric Emergency in a Non-designated Health Facility" form, which states the following:
    a. How the individual's condition was called to the attention of the licensed professional staff, physician or surgeon;
    b. Probable cause to believe the person is, due to mental disorder, a danger to self or others or is gravely disabled; and
    c. Licensed professional staff, physician or surgeon, have made, and documented, repeated unsuccessful efforts to find appropriate mental health treatment for the person.
    d. Complete Form, and place into medical records.
6. Section 1799.111 24-hour detention starts when the patient is medically stable for transfer.
7. If the 24-hour hold expires and the patient still poses a threat to themselves or others, or is gravely disabled, and placement at a LPS Facility has not been secured despite documented efforts, medical staff must inform the patient of the following:
    a. The continued need to hold the patient;
    b. That the 24-hour hold is expiring;
    c. That efforts have been made and continue to be made to find placement at LPS Facility, and
    d. PL and/or physician MUST advise the patient of their right to request a writ hearing.
        i. Provide the patient the "Notice of Request for Writ of Habeas Corpus" form and education materials.
        ii. If the patient would like to request a Writ of Habeas Corpus:
            1) PL or other healthcare provider shall assist the patient to complete the Notice of Request for Writ of Habeas Corpus form.
            2) PL or other healthcare provider will fax the completed form to the Office of the Public Defender.
            3) A copy of the completed form shall be maintained in the medical record.
            4) If the patient declines to request a writ, the PL or other healthcare provider shall document the declination in the medical record.

~~5) PL or other healthcare provider shall present a declination form to the patient to sign and memorialize his/her decision not to request a writ.~~
~~6) If patient refuses to sign the declination form, PL or other healthcare provider shall notate the refusal in the medical record.~~

~~8. The hold, with proper documentation, continues until placement of patient at LPS facility.~~

~~G.~~ **~~PROCEDURE FOR ED:~~**

~~1. ED Clinical staff shall~~
~~a. Notify the Security Department when an individual is admitted to the ED pursuant to the initiation of a 5150.~~
~~b. For patients identified as a high risk for elopement, the clinical staff shall:~~
~~c. Place the patient in a secure room that facilitates close observation by Patient Safety Technician. Refer to Patient Care Services: Sitter Policy.~~
~~i. Assist the patient with removing his/her clothing including all undergarments, shoes and socks, and place the patient in a hospital gown.~~
~~1) Secure all the patient's personal belongings in a locked cabinet and out of reach of the patient.~~
~~ii. Place the wandering bracelet on the patient's wrist after activation.~~
~~iii. Perform an initial assessment of the patient and implement necessary interventions to ensure the patient's immediate safety and the safety of the environment.~~
~~iv. Communicate the patient's status to the Charge RN, Physician, and Security.~~
~~d. Facilitate an evaluation by the PL as soon as possible and whenever possible before the patient has been given medications that may be sedating or restrict his/her ability to participate in a mental status evaluation.~~
~~e. Maintain ongoing communication with the PL regarding the plan for treatment.~~
~~f. Monitor the patient at regular intervals, as clinically indicated to provide safe and effective nursing care.~~
~~g. If patient is suicidal, Patient Safety Technician must continuously monitor and document monitoring per Patient Care Services Policy: Assessing and Managing Patients at Risk for Suicide.~~
~~h. Ensure that the patient's rights are respected including:~~
~~i. The right to be free from restraint or seclusion and to be treated in the least restrictive environment unless the presenting behavior constitutes an imminent threat to the safety of the patient or others in the immediate environment~~
~~ii. The right to be treated with dignity and respect.~~
~~i. Complete all necessary documentation in accordance with TCHD policy, including documentation associated with the use of restraint or seclusion.~~

~~H.~~**F. FORM(S):**

1. Declination Form
~~2. Detention of Patient with Psychiatric Emergency in a Non-designated Health Facility (1799.111) CHA Form 12-12~~
~~3.~~**2.** Notice of Request for Writ of Habeas Corpus
~~4.~~**3.** Application for Assessment, Evaluation and Crisis Intervention or Placement for Evaluation and Treatment (WIC 5150)

~~I.~~**G. RELATED DOCUMENT(S):**

1. Administrative Patient Care Policy: Advisement of Legal Status 24-Hour Hold/72-Hour Hold
2. Patient Care Services Policy: Assessing and Managing Patients at Risk for Suicide
3. Patient Care Services Policy: Consent for Minors
4. Patient Care Services Policy: Consent for Operative or Other Procedures
5. Patient Care Services: Sitter Policy

~~J.~~H. REFERENCE(S):

1. **Detention of Mentally Disordered Persons for Evaluation and Treatment, CA Welfare and Institution Code § 5150**
2. **Welfare and Institutions Code § 5256.4**
3. **Lanterman–Petris–Short Act, CA Welfare and Institution Code § 5000**
4. **Welfare and Institutions Code § 5003**
5. **California Hospital Association (CHA) Consent Manual.**
6. **San Diego County Board of Supervisors' Resolution No. 19-145**
7. **Patient Advocacy Program Quick Reference Guide for Non-LPS Designated Facilities**
8. **California Department of Health Care Services, Rights for Individuals in Mental Health Facilities**
9. **Board of Supervisor Resolution (2019)**
10. **Assembly Bill 2275**

~~1. Detention of Mentally Disordered Persons for Evaluation and Treatment, CA Welfare and Institution Code § 5150 (1969)~~
~~2. Lanterman–Petris–Short Act, CA Welfare and Institution Code § 5000 (1967)~~
~~3. CA Health and Safety Code § 1799.111~~
~~4. California Hospital Association (CHA). (2019) Consent Manual.~~
~~5. San Diego County Board of Supervisors' Resolution No. 05-232~~
~~6. California Assembly Bill 1424~~

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**INCENTIVE SPIROMETER (IS) INSTRUCT AND MONITORING**
Purpose:	To identify the Respiratory Care Practitioner (RCP) and Registered Nurse (RN) roles for providing instructions and monitoring patients requiring an IS.

A. **DEFINITION:**

1. Incentive Spirometer (IS) – a device used to encourage and assist patients at risk for pneumonia, post-operative pulmonary complications, and patients with declining pulmonary status to breathe deeply to achieve normal vital capacity. The device provides a visual feedback to patients about the depth of their breaths.

B. **POLICY:**

1. A physicians order is required for an IS.
2. Patients at risk for postoperative pulmonary complications (i.e., patients undergoing surgical procedures involving abdomen or thorax and patients with conditions predisposing to development of atelectasis, including immobility and abdominal binders) should have an order for an IS. Examples include but are not limited to the following:
    a. Abdominal Surgery
    b. Thoracic Surgery
    c. Prolonged bed rest
    d. Post-operative patients with Chronic Obstructive Pulmonary Disease (COPD)
    e. Presence of a thoracic or abdominal binder
    f. Restrictive lung defeat associated with a dysfunctional diaphragm or involving respiratory musculature
    g. Patients with an inspiratory capacity of less than (<) 2.5 liters
    h. Patients with neuromuscular disease
    i. Patients with pain level interfering with their ability to take deep breaths
3. RCPs and RNs will work collaborative**ly** to ensure patients are provided instructions for the use of an IS.
    a. RCPs will provide the initial education and two follow-up treatments with education.
        i. If RCP is unavailable to provide initial education, the primary RN assigned to the patient is responsible for ensuring education is provided.
    b. RCPs and RNs will use the teach-back method to assess the patient's understanding of the instructions provided.
4. RCPs and RNs will review Online Skills: Incentive Spirometry Procedure **for additional information as needed**.

C. **PROCEDURE:**

1. RCP Role:
    a. Identify patient's predicted volume based on gender, age, and height.
    b. Mark the predicted volume with a permanent marker on the IS to inform the patient and RNs.
        i. Approximate the patient's predicted value using clinical judgment when the patient's age and height are not within the predicted values chart.
    c. Inform patient the mark represents the goal they should achieve
    d. Instruct patient to cough to expectorate phlegm.
        i. Ensure patients with surgical incisions splint using a pillow.
    e. Provide hand-off to the RN after the initial education and the two subsequent treatments are completed.
    f. Document in the Electronic Health Record (EHR)

Patient Care Content Expert Review	Clinical Policies & Procedures	Nursing Leadership	Division of Pulmonary	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
03/18, 10/21, **02/25**	9/14, 04/18, 11/21, **05/25**	10/14, 04/18, 12/21, **08/25**	05/15, 06/18, 03/22, **11/25**	n/a	06/15, 06/18, 04/22	05/22, **12/25**	08/15, 07/18, n/a	8/15, 07/18, 05/22

i. Patient's responses to the treatments
ii. Patient's ability to participate with their therapy
iii. Hand-off provided

2. RN Role:
   a. Obtain hand-off from RCP
   b. Ensure education is provided if task not completed by RCP
   ~~c. Review Online Skills Incentive Spirometry Procedure for the following:~~
      ~~i. Indications and contraindications~~
      ~~ii. Expected and unexpected outcomes~~
      ~~iii. Education topics~~
      ~~iv. Patient instructions for use of the IS~~
   ~~d.~~**c.** Encourage patient to use IS at least 5-10 times every hour while awake or as ordered.
   ~~e.~~**d.** Assess patient's understanding of the instructions for using an IS using teach-back
   ~~f.~~**e.** Document the use of IS each shift as appropriate
      i. Education provided to patient
      ii. Patient's response to using the IS
         1) Volumes achieved
         2) Frequency of use
      iii. Patient's ability to participate
3. Hand-off Process:
   a. RCP and RN hand-off shall consist of the following:
      i. Patient's response to therapy
      ii. Predicted volume
      iii. Actual volume
      iv. Additional information appropriate to patient

D. **REFERENCE(S):**

~~1. Agency of Healthcare Research and Quality (AHRQ). (nd). National guideline clearinghouse: Incentive spirometry, 2011. Retrieved from http://www.guideline.gov/content.aspx?id=34793~~

~~2.~~**1.** American Association for Respiratory Care (AARC). (2011). Clinical practice guidelines, incentive spirometry: 2011. *56(10):* 1600-4

~~3.~~**2.** Elsevier Inc. (**2025**~~2006-2014~~). **Elsevier**~~Mosby's~~ skills: Incentive spirometry. Retrieved from Tri-City Medical Center (TCMC) Intranet.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES
POLICY

ISSUE DATE: **06/05**

SUBJECT: **Infusion Pumps, Intravenous (IV) Therapy**

REVISION DATE: **04/07, 03/11, 07/15, 04/18**

Department Approval:	**~~10/20~~08/24**
Clinical Policies & Procedures Committee Approval:	**~~12/20~~05/25**
Nursing Leadership Approval:	**~~08/21~~08/25**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~09/21~~09/25**
Medical Executive Committee Approval:	**~~01/22~~10/25**
Administration Approval:	**~~02/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/22**

A. **PURPOSE:**

1. To establish standards at Tri-City Healthcare District (TCHD) for the management of intravenous (IV) administration sets, solutions, and medications in order to decrease the incidence of infections, complications, and errors.

B. **DEFINITION(S):**

1. Back flushing – A means to prime a secondary administration set in order to flush the secondary set of residual medication and/or to flush secondary tubing between the deliveries of incompatible medications.
2. Channel – The module attached to the programming module for the delivery of IV fluids or medications.
3. Channel Labels – Provides a hospital defined list of labels, which can be displayed in the channel message display allowing the user to identify the channel with the solution being infused (i.e., blood or chemotherapy), or the catheter location (i.e., pulmonary artery or intraperitoneal).
4. Drug Library – A drug dataset defines a list of up to 1500 drugs and concentrations appropriate for each Profile™. Programming via the drug dataset automates programming steps, including the drug name, drug amount and diluent volume, and represents established best practice Guardrails™ limit checking.
5. Epidural – Analgesia infusion delivered via the epidural space.
6. Flush solution – A solution used to provide a flush between or at the end of IV medications. The flush solution shall be compatible with the medications delivered.
7. Guardrails™ – The programming software within the Alaris Medley infusion system designed to help prevent programming errors by:
   a. Providing an advisory prompt if an out-of-limit entry is made at the time the device is programmed to infuse medications defined in the drug library
   b. Comparing user programming with the hospital-defined best practice guidelines
   c. Customizing device configurable settings to meet the need of the selected patient population
8. Intrathecal – Analgesia infusion delivered through the intrathecal space.
9. Point of Care (POC)/Programming Module – The module of the Alaris Medley medication safety system that contains the drug library and pump configurations. This module controls all of the solutions and medications delivered through the pumping modules. The programming module

cannot deliver any medication without a pumping module. Each programming module has the ability to control four pumping modules.

10. Priming Volume – The amount of fluid used to clear the administration set of air. The amount of priming volume varies by administration set. The amount of priming volume can be found on the administration set package.
11. Profile™ – Represents a specific patient population. Each profile contains drugs and instrument configurations that are appropriate for that patient population.

C. **INTRAVENOUS (IV) INFUSIONS:**

1. All solutions and medications administered via an IV route shall be administered using an IV infusion device except in the following situations:
   a. IV push administration.
   b. Surgery, under the direct supervision of an anesthesiologist.
   c. Emergent situations, under the direct supervision of the Registered Nurse (RN).
   d. Identified research studies when the research RN is present to monitor the infusion.
   e. High census, if there is a shortage of infusion pumps; plain solutions (without additives) at rates less than or equal to 75 mL/hour may be infused without an infusion pump.
2. Staff must utilize both the appropriate Profile™ with Guardrails™ features and the channel labels when programming the Alaris infusion system to enhance the safe delivery of IV medications and solutions **appropriate to level of care**.
   a. Intensive Care Unit (ICU)/Emergency Department (ED)/Operating Room (OR) shall be used by ICU, Post Anesthesia Care Unit (PACU), Cardiac Catheterization Lab, Interventional Radiology, and ED, Surgery.
   b. IMC/Telemetry shall be used by Telemetry and Progressive Care Unit.
   c. Acute Care shall be used by 1North, Acute Rehab, 2Pavilion, ~~3Pavilion,~~ 4Pavilion, and the **Progressive Care**~~Forensic~~ Unit.
   d. Neonatal Intensive Care Unit (NICU) shall be used by ~~NICU and~~ ED.
   e. Peds shall be used for pediatric patients **in the ED**.
   ~~f. WCS shall be used by Labor and Delivery and Mother Baby.~~
   ~~g.~~ **f.** Oncology
3. Profiles and Channel Labels shall be checked by the licensed nurse at the beginning of each shift.
4. Profiles ™ shall be checked and changed as needed when a patient is transferred to another patient care unit. The receiving unit RN shall be responsible to check and change the patient profile.
5. Channel labels shall be utilized for medications and/or solutions that are not a part of the drug data set.

D. **PRIMING AND FLUSHING:**

1. The priming volume shall be subtracted from the volume to be infused in order to ensure the medication and/or solution is infused over the prescribed rate as appropriate in NICU and Pediatrics **profiles**.
2. To clear residual medication volume from the IV administration set, the back flushing technique shall be utilized. Approximately 20 mL of medication shall be flushed back into the empty bag or bottle. The flush solution is then infused at the same rate as the original rate of the medication.

E. **SMART SITE PORTS:**

1. Smart Site injection sites on the IV tubing are accessed only with a luer lock syringe.
   a. Note: Using a needle or blunt tip syringe will damage the valve and result in leaking. The valve may be secured by attaching a Smart Site valve cap.

F. **CARE AND CLEANING:**

1. One POC and channel shall be left in the patient's room at discharge and cleaned by Environmental Services (EVS). Extra POCs and channels shall be stored in a designated area on the unit or in the Sterile Processing Department (SPD).

a. The tubing and IV bag shall be removed and discarded by the unit's RN prior to EVS cleaning pump.
b. EVS shall not clean pump if tubing and/or IV bag have not been removed.
c. EVS shall attempt to locate the Nursing Leader//designee and request the tubing and IV bag be removed. If the Nursing Leader/designee cannot be located, or the tubing/IV bag is not removed in a timely manner, cleaning the pump shall be nursing's responsibility.

2. Cleaned infusion pumps shall be covered with a plastic bag.
3. Cleaning needs of the Infusion Pump during patient care shall be the responsibility of the RN caring for the patient.
   a. They shall be wiped down with a hospital approved disinfectant weekly and when visibly soiled. (Refer to Infection Control Policy: Cleaning and Disinfection - IC 9).
   b. To avoid damage to the connectivity points never spray cleaning solutions directly onto the pump.
   c. Spray cleaning solution onto a cloth and wipe the pump with the moistened cloth.
4. Greater than 70% alcohol solutions are damaging to equipment surface, and shall not be used.
5. Infusion pumps shall be kept plugged into an electrical outlet at all times.
   a. Cleaned infusion pumps not in use shall be stored in the patient's room or designated storage area.
   b. SPD shall make rounds (Monday-Friday) to maintain a minimum supply in SPD.
      i. Exception: Progressive Care Unit, Emergency Department.

G. **RELATED DOCUMENTS**

1. Infection Control Policy: Cleaning and Disinfection IC 9

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: **5/78**

SUBJECT: **Meals, Patients – Times, Menus, Substitutions and Nourishments**

REVISION DATE: **04/00, 06/03, 08/05; 05/08; 02/11 06/15, 04/17, 08/20**

Patient Care Services Content Expert:	**~~05/20~~10/25**
Clinical Policies and Procedures Approval:	**~~06/20~~10/25**
Nursing Leadership Approval:	**~~07/20~~11/25**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~08/20~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **PATIENT MEALS:**

1. The Food and Nutrition Services Department provides three (3) patient meals daily and offers between-meal nourishments three (3) times daily. No more than 14 hours shall elapse between the serving of the dinner meal and the breakfast meal of the following day.
   a. Patient tray line shall operate according to the following schedule:
      i. Breakfast: 7:00 AM – 8:30 AM
      ii. Lunch: 11:00 AM – 12:30 PM
      iii. Dinner: 4:45 PM – 6:30 PM
      iv. (All finish times are approximate)
   b. Patient trays shall be loaded on food carts and delivered to the nursing units in a predetermined sequence.
2. Meal service shall be provided for patients who are not served meals during normal meal service time.
   a. Delayed trays are ordered via the computer system.
      i. Nursing or designee must call the diet office for all late tray meal requests.
      ii. All delayed tray requests shall be filled with a minimum of delay.
      iii. Food and Nutrition personnel will prepare ~~the~~ tray as listed on the diet slip.
      iv. All food items shall be covered.
      v. Normal tray line delivery systems shall be used to ensure maximum temperature retention.
   b. Early breakfast trays are available upon request.
   c. Standard late breakfast trays are served from 8:30 AM until 9:00 AM. Late trays shall be delivered on the half-hour.
      i. From 10 AM to 10:30 AM, Continental-type breakfast may be served.
   d. Standard late lunch trays are served from 12:30 PM until 2:30 PM.
      i. From 2:30 PM until 4:00 PM, soup, sandwich, dessert, and beverage lunch shall be served.
   e. Standard late dinner trays are served from 6:00 PM until 7:00 PM.
      i. From 7:00 PM until ~~1:30 AM, grilled items and~~**8 PM,** cold sandwiches~~,~~ - appropriate to the patient's diet, can be obtained ~~in the cafeteria.~~**by calling X 7235 (Supervisor office).**
   f. Late trays served shall comply with the patient's diet order.
   g. Floor stocks are used for non-emergency after-hours.

B. **MENUS:**

1. **Menu Pre-Adjustment:**
   a. The proper menu, based on the most restrictive diet order, is selected.
      i. Exceptions include: newly admitted patients, patients who are NPO, patients on liquid diets, severely restricted diets, and those patients opting to not select a menu.
   b. Additional diets, restrictions, name and room number are documented on the most restrictive menu.
   c. The diet manual and/or menu correction guide is referenced to assure accuracy.
   d. Fluid restrictions are noted on the menu **see Fluid Restriction Guidelines**~~. Food and Nutrition provide half of the total fluid restriction per 24 hours. s~~

Fluid Restriction:	Food & Nutrition Service
800 ml	Do not provide any fluids on tray, unless specified by MD, RD or Nursing.
1000 ml	BF- 120 mL; Lunch – 120 mL; Dinner – 120 mL (640 mL Nursing, 360 mL Kitchen)
1200 ml	BF- 120 mL; Lunch – 120 mL; Dinner – 120 mL (840 mL Nursing, 360 mL Kitchen)
1500 ml	BF- 120 mL; Lunch – 120 mL; Dinner – 120 mL (1140 mL Nursing, 360 mL Kitchen)
1800 ml	BF- 240 mL; Lunch – 240 mL; Dinner – 240 mL (1080 mL Nursing, 720 mL Kitchen)

2. **Menu Distribution:**
   a. Most patients receive selective menus from which to make their meal choices.
   b. The next day's menu is delivered to the patient by a Food Service Partner or designee.
   c. Newly admitted patients receive a selective menu within two (2) meals of receipt of the diet order. House menus are provided for patients not selecting a menu.
   d. Patients willing but unable to fill out the menu by themselves shall receive assistance from family members, Nursing or Food & Nutrition personnel.

3. **Menu Substitutions:**
   a. Menu substitutions are offered to patients who cannot make adequate choices from the printed menu.
   b. A minimum of a two-hour notice is required for staff to request a substitution item. If nursing is unable to provide this notice, every effort within reason will be made to accommodate the patient's nutritional needs.
   c. Substitutions are offered from the substitution list when the patient asks for other foods due to reasons as stated above.
   d. Production area is alerted by diet clerk if "write-ins" are done on the day food substitutions are to be served.
   ~~e. The hospital cafeteria menu is made available to patients who request additional selections. If these selected items are contraindicated on prescribed diet, a verbal approval is required by a Dietitian or Nurse.~~
   ~~f.~~**e.** Patients may refuse foods served; alternate choices that will meet nutritional needs are provided. Nursing may substitute foods from available floor stock items or contact Food & Nutrition ~~for an alternate tray~~**Services for alternative food items**.

4. **Menu Collection**:
   a. The Food Service Partner creates a list of patient menus that need to be collected
   b. Upon entering a patient's room, the Food Service Partner conducts proper hand hygiene, identifies self, and uses two patient identifiers before obtaining menu selections.
   c. Assistance is offered to patients who are unable to fill out their menus.
   d. If the menu is not ready at the time of collection, help may be offered in filling out the menu. Otherwise, these menus are collected at the next appropriate time.
      i. If the patient is unavailable, the Food Service Partner will return at a later time to complete the menu**.**
   e. The patient is notified when food choices are contraindicated with the diet order.
   f. Each menu is screened and corrected by a Food Service Partner or designee to ensure that the contents of the menu is in accordance with the diet prescription and is marked in a legible manner.

g. The menu is in three parts: Breakfast, Lunch, and Dinner. Each part should have the patient's name, room number, and diet order.

h. The evening Food Service Partner creates production and tally sheets based off menu selections received.

5. **Nourishments** or "between meal feedings" shall be recommended and provided to meet the patients' nutritional requirements per Food and Nutrition Procedure: Supplemental Feedings and Nourishments, Ordering, and Review.

C. **RELATED DOCUMENT(S):**

1. Fluid Restriction Guidelines

2. Food and Nutrition Procedure: Supplemental Feedings and Nourishments, Ordering~~,~~ and Review

3. Food and Nutrition Procedure: Tray Identification, Assembly, Request and Audit *

~~1.~~**4. Food and Nutrition Procedure: Fluid** Restriction - **24 hr – Guidelines**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/64

SUBJECT: Medical Examiner Notification

REVISION DATE: 06/64, 09/91, 07/97, 09/00, 04/02, 06/03, 08/05, 06/06, 08/08, 01/11, 06/11, 02/15, 10/17, 12/22

Patient Care Services Content Expert Approval:	**~~09/22~~09/25**
Clinical Policies & Procedures Committee Approval:	**~~10/22~~10/25**
Nursing Leadership Approval:	**11/25**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/22~~11/25**
Administration Approval:	**~~12/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/22**

A. **PURPOSE:**

1. To identify cases that must be reported to the Medical Examiner pursuant to California Health and Safety Code (Section 102850) as well as to Government Code, State of California (Section 27491).

B. **POLICY:**

1. In accordance with California State Law, Tri-City Medical Center (TCMC) must notify the Medical Examiner (858-694-2895) regarding all patients whose death meets the following criteria:
   a. It shall be the duty of the coroner to inquire into and determine the circumstances, manner, and cause of all violent, sudden, or unusual deaths; unattended deaths; deaths where the deceased has not been attended by either a physician or a registered nurse, who is a member of a hospice care interdisciplinary team, as defined by subdivision (g) of Section 1746 of the Health and Safety Code in the 20 days before death.
   b. Acute Alcoholism
   c. Aspiration
   d. Cutting
   e. Deaths known or suspected as resulting in whole or in part from or related to accident or injury either old or recent.
   f. Death in whole or in part occasioned by criminal means; deaths associated with a known or alleged rape; deaths in prison or while under sentence; deaths known or suspected as due to contagious disease and constituting a public hazard; deaths from occupational diseases or occupational hazard.
   g. Deaths of patients in state hospitals serving the mentally disordered and operated by the State Department of State Hospitals.
   h. Deaths of patients in state hospitals serving the developmentally disabled and operated by the State Department of Developmental Services.
   i. Deaths under circumstances that afford a reasonable ground to suspect that the death was caused by the criminal act of another.
   j. Deaths reported by physicians or other persons having knowledge of death for inquiry by coroner.
   k. Drowning

l. Drug Addiction
m. Exposure
n. Fire
o. Gun shot
p. Hanging
q. Homicide: known or suspected
r. Stabbing
s. Starvation
t. Strangulation
u. Suicide: including suicide where the deceased has a history of being victimized by domestic ––violence, or accidental poisoning. Known or suspected**.**
v. Suspected cause of death is sudden infant death syndrome
~~v.~~**w. Justice involved individuals**
~~w.~~**x.** ~~Acute alcoholism, Drug addiction, Aspiration~~
~~x.~~**y.** ~~Communicable Disease~~
~~y.~~**z.** ~~Death in whole or in part by criminal means, in prison or while under sentence~~
~~z.~~**aa.** ~~Deaths due to old or recent injuries or accidents~~
~~aa.~~**bb.** ~~Deaths without underlying etiologic cause~~
~~bb.~~**cc.** ~~Drowning, Fire, Gunshot, Stabbing, Strangulation, cutting~~
~~cc.~~**dd.** ~~Known or suspected homicide suicide or accidental poisoning, hanging~~
~~dd.~~**ee.** ~~Operating room or postoperative deaths~~
~~ee.~~**ff.** ~~Subdural and subarachnoid hemorrhages~~
~~ff.~~**gg.** ~~Sudden Deaths~~
~~gg.~~**hh.** ~~Sudden infant death syndrome~~
~~hh.~~**ii.** ~~Unidentified person~~
~~ii.~~**jj.** ~~Unusual Deaths~~
~~jj.~~**kk.** ~~Violent deaths~~

2. An investigator from the Medical Examiner's Office will review the decedent's demographic information, medical history, and circumstances surrounding the death to determine whether to accept the case for an investigation or issue a waive number.
   a. Waive numbers will be documented in the following format: WV## - #####
   b. Case number: year-xxxxx
3. Note: Death involving the above criteria must be reported even if a physician is willing to sign the death certificate. The State requires all death certificates to record both an actual and underlying cause of death.

C. **REFERENCE(S):**

1. ~~County of San Diego (2016) Deaths Reportable to the Medical Examiner's Office [Facsimile to Tri-City Medical Center]. San Diego, CA.~~
2. **GOVERNMENT CODE - GOV**
3. **TITLE 3. GOVERNMENT OF COUNTIES [23000 - 33205]**

(Title 3 added by Stats. 1947, Ch. 424.)

4. **DIVISION 2. OFFICERS [24000 - 28085]** ***(Division 2 added by Stats. 1947, Ch. 424.)*** **PART 3. OTHER OFFICERS [26500 - 27773]** ***(Part 3 added by Stats. 1947, Ch. 424.)***
5. CHAPTER 10. Coroner [27460 - 27530] *(Chapter 10 added by Stats. 1947, Ch. 424.)***27491.** *(Amended by Stats. 2024, Ch. 654, Sec. 3. (SB 989) Effective January 1, 2025.)*

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**MEDICAL RECORD, MAKING CORRECTIONS TO DOCUMENTATION**
Purpose:	To maintain documented information for each patient that is accurate, timely, and legible.

A. **CORRECTIONS IN THE PAPER CHART:**

1. Corrections due to practitioner documentation error shall be lined through with a single line and "Error" written above the line and the practitioner's initials. The corrected entry shall be dated, timed, and verified with full signature and title.
2. Clarification of orders or corrected orders due to circumstances such as unacceptable abbreviations or inappropriate medication dosages shall be rewritten with "clarification of above order" documented with practitioner's full name and title.

B. **INCORRECT CHART OR INCORRECT ENCOUNTER:**

1. When errors are found in the electronic medical record, the practitioner is notified to correct the documentation.
2. If the practitioner who made the error is not available, the Clinical Manager, Administrative Supervisor or Director is notified to correct the chart.
3. The documentation made in error is uncharted (in-error notation). The reason for the error is then entered into the comment field. The information is then re-charted on the correct patient or encounter electronically.
4. Lab and Radiology Orders entered on wrong encounters/patients/physicians' order:
   a. A new order must be entered on the correct patient or encounter.
   b. Once the new order is placed and completed, the report from the wrong encounter or patient shall be placed with the new order.
   c. Charges associated with incorrect lab and radiology orders shall be credited.
   d. After the new order has been corrected, the report is in place, and charges have been reconciled, the incorrect order shall be cancelled.
   e. Order entry errors are tracked electronically in Cerner.
   f. In the event a laboratory order entry error takes place and is not discovered same day, the error will appear on the Exception Report and will be reconciled by the Laboratory Billing Coordinator.

C. **COMBINED MEDICAL RECORD NUMBERS:**

1. This is required when a patient has been assigned more than one medical record number (MRN). The Medical Records/Health Information department researches and resolves the duplicate MRN resulting in combining the losing MRN into the winning MRN. Both the Cerner system and the hard copy record are corrected to reflect the winning MRN. (The losing MRN is displayed in parenthesis.)
   a. The Imaging department will merge Picture Archive and Communication Systems (PACS) images to the winning MRN.

D. **REMOVING OR MOVING INCORRECT ENCOUNTERS:**

1. This is required when an encounter is added to the incorrect patient. The encounter needs to be moved from the incorrect patient to the correct patient's MRN.
   a. The Emergency Department (ED) registration area initiates the on-call move encounter process.
2. Allergy and diagnosis information is verified on both encounters and transferred to the correct patient manually. When necessary, the additional step of combining encounters is completed.

E. **COMBINING ENCOUNTERS:**

Department Review	Clinical Policies & Procedures	Nursing Leadership	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
08/12, 06/21, **10/25**	10/12, 10/21, **10/25**	10/12, 11/21, **11/25**	n/a	n/a	11/12, 11/21, **11/25**	11/21, **12/25**	01/13, n/a	01/13, 12/21

1. This is required when two encounters have been created for the same episode of care. It is necessary to combine these into a single encounter.
2. Designated individuals (Registration and Medical Records/Health Information) combine the losing encounter into the winning encounter (the losing encounter is displayed in parenthesis).
3. Documentation in Cerner combines when the encounters are merged.
4. Individual departments are responsible for reconciling their orders and charges for combined encounters.

F. **CLINICAL NOTES:**

1. When documented in error or if additional information must be added, the clinician modifies the note, adds any corrections or changes in the addendum and enters the reason for the error.
2. If the note was made on the wrong patient or encounter, documentation is completed in the correct chart by entering the correct date and time of service.
3. The reason for the late entry shall be indicated.
4. ~~Medical Records must be notified to error out any transcribed Clinical Note documents.~~

G. **PHYSICIAN CLINICAL NOTE:**

1. These are notes entered by the physician directly into Cerner.
2. If the document has been attached to the incorrect patient the physician is to contact Medical Records/Health Information department for the document to be moved to the correct encounter.

~~H. **POWERNOTE:**~~

~~1. Corrections due to practitioner documentation error in the computerized chart shall be completed by adding an addendum to the bottom of the Powernote. This addendum is added by modifying the note.~~
~~2. NOTE: Until the Powernote is signed; changes made by the physician are not considered corrections. The saved, unsigned report is not seen by anyone except the physician or scribe.~~
~~3. If the signed note was made on the wrong patient or encounter, Medical Records or the Physician will notify Information Technology (IT) to move the Powernote to the correct patient/encounter.~~
~~4. The IT Analyst will complete the documentation move to the correct patient/encounter and note the correction reason.~~

~~I.~~**H. POWERCHART:**

1. Corrections due to practitioner documentation error or late entry of additional information shall be marked “modified” to reflect the correction. Any modification to a form is tracked in the form history. The reason for the modification shall be noted in the comment field.
2. If a form was charted in error or charted on the wrong patient, the entire form shall be “Uncharted” with the reason given in the comment field. The information shall be re-charted on the correct patient/encounter. The system will red line through the form and list the form “In Error.”

~~J.~~**I. PHARMACY:**

1. Medication orders entered on the wrong patient or wrong encounter shall be voided and re-entered on the correct patient or encounter.
2. Any charges associated with any of the above medication order entry errors shall be credited and charged to the correct patient/encounter using the pharmacy charge/credit application.

~~K.~~**J. SURGERY:**

1. Changes to the Operative Record shall be made as needed to maintain accuracy.
2. Existing entry shall be modified to make changes or additions to record.
3. Reason for change shall be noted in General Comments Section (i.e., “Corrected or Updated or Late or Revised Entry”).

4. Beneath the words Corrected or Updated or Late or Revised Entry, the required change/modification/or new data entry shall be made.
5. The record shall be modified/saved (as indicated) and the record shall be re-finalized to add new data.

~~L.~~K. MEDICAL RECORDS/HEALTH INFORMATION:

1. Scanned Documents
   a. ~~Operations~~ **Health Information** Man**a**ger confirms document is posted to the incorrect patient or incorrect location within Clinical Notes.
      i. Document copied and posted to the correct encounter and/or folder
      ii. Scanned document In Errored with documented reason
   ~~b. Transcribed Documents:~~
      ~~i. Transcription Supervisor shall receive submissions from incorrect dictation in Powerchart forms, physicians, and other Cerner users.~~
      ~~ii. Information is verified via:~~
      ~~iii. Master Patient Index (MPI) research~~
      ~~iv. Dictation notes from Physician/Physician Assistant (PA)/Resident~~
      ~~v. Listening to dictation~~
      ~~vi. Notations on incorrect dictation form~~
   ~~c.~~**b.** Upon verification of an incorrect encounter, staff will search in Powerchart for the encounter with incorrect documentation. The document shall be selected and changed to "in error" under the clinical notes tab. The document shall be marked "in error document" and a comment may be added.
   ~~d. Tracking document shall be updated with required information.~~

~~M.~~L. IMAGING SERVICES/RADNET—DIAGNOSTIC REPORTS:

1. Once the diagnostic report is finalized or signed by the radiologist, any changes shall result in the report being amended.
2. Amended Cerner reports are modified via the **dictation** ~~transcription~~ application. When a finalized report is opened from this application, the report shall automatically assume an amended status.
3. ~~Once the change has been made to the original report, it shall be placed in the radiologist queue. After the radiologist signs the report, an updated version will be electronically filed in Cerner. When this report is opened for review within Cerner, the amended portion of the report shall appear at the top, with the original report appearing at the bottom. The report shall also have a header entry of "Addendum" at the beginning of the report.~~ **Radiologist will sign off addendum report. An updated report will be exported into Cerner. When the report is open for view in Cerner the addendum report will be at the top with the heading of Addendum.**
4. When printed, amended reports shall also contain a header that indicates the report has an addendum.
5. Once finalized, any amended reports will auto fax, if applicable.
6. Information regarding date of ~~transcription and~~ verification, and names of ~~transcribers and~~ physicians involved in the completion of the report shall be included in the **signature line of the** report.
7. Audit trails shall exist with information regarding order, completion and verification of report.

~~N.~~M. CLINICAL LABORATORY:

1. Replacing the incorrect result with a correct result:
   a. In Accession Result Entry (ARE), click on Mode at the top of the screen, select Correction. The mode is indicated in the title bar, and the Perform and Verify buttons are replaced with a correct button.
   b. In the Accession box, enter the accession number for which you want to correct a result.
   c. Place the cursor on the result you want to correct.

d. Right click and select “Convert Result” and change to the proper result type, such as Numeric.
e. Enter the verified value and any other required documentation as a comment. Refer to the procedure for “Verification and Communication of Critical Values”.
f. Click on CORRECT to verify the result.

2. The technologist who corrects the reports is responsible for notifying the Department Supervisor as soon as possible by sending an e-mail with the following information:
   a. Accession number corrected
   b. An explanation of what happened, i.e. why the error occurred.
3. If the incorrect results are due to the wrong specimen, wrong sample labeled or wrong patient drawn, the results must be replaced with the result of ERROR since the incorrect result cannot be removed from Powerchart.
   a. ~~Credit the incorrect result(s) using Charge Viewer.~~ **Fill out the Credit Charges Form.**
   b. Enter ARE:
      i. Change the Mode to Correction**.**
      ii. Enter the appropriate test site.
      iii. Enter the accession number.
      iv. For the each result to be corrected change the result type to FREETEXT then enter the text ERROR. Continue to enter ERROR for all the test results for the accession number. On the first corrected test enter an Order Comment that explains the reason for the correction.
      v. Examples of Order Comments:
         1) Wrong patient drawn
         2) Sample incorrectly labeled
         3) Contaminated Specimen
      vi. **Click on CORRECT to verify the result.** ~~The remaining results must have the entry of ERROR without additional as long as the first tests result contained the comment. One of the results must have the reason comment attached. When complete, review the entries prior to correcting. All original results should have been replaced by the result ERROR. The first result should also have a reason commitment attached.~~

~~O. **FETALINK:**~~

~~1. Modifications and Deletions of Annotations must be made prior to Finalizing a Fetalink Episode.~~
~~2. To modify an annotation, complete the following steps.~~
   ~~a. While viewing the waveform from a single patient view, double-click on a previous documented annotation.~~
   ~~b. The annotation dialog displays. Either manually type in the new annotation or select one or multiple options from the Quick chart options.~~
   ~~c. A “Revision History” tab is accessible within the “Annotations” dialog box that allows clinicians to see every edit that has been charted to an annotation. The “Revision History” tab dates and time stamps these changes as well as associated the clinician’s user name to each annotation that has posted.~~
~~3. Deleting annotations made in errors, unselect the annotation options charged in error or delete the free text annotation and replace with free text “”In Error, Reason for uncharting.”~~
~~4. Incorrect Patient Association~~
   ~~a. After a period of time, whether that period of time is 5 minutes or 5 hours, the user notices the incorrect patient was selected, the user should note the Incorrect Patient Name, the device name, the room name and the approximate time of the episode and report it to their Nurse Leader/Charge Nurse.~~
   ~~b. The Nurse Leader/Charge Nurse will utilize the Fetalink Management Tool to remove the incorrect Fetalink Episode from the patient’s record.~~
   ~~c. After the user has noted or reported the information above, finalize the episode by selecting Finalize and Disassociate in the Single Patient View.~~

~~d. Once the Finalize and Disassociation process has been completed, the user must then retroactively associate the correct patient to the correct/current device.~~

~~P.~~N. ~~-~~BEDSIDE MEDICAL DEVICE INTEGRATION (BMDI):

1. Modifications and Deletions of BMDI data can be made at any time during the Nurses shift.
2. To Modify BMDI data, complete the following steps:
   a. If the data has not been signed, clear the incorrect data by placing the cursor into the cell and click on the backspace key.
   b. Once data is cleared, enter the correct data into the field. Verify information is correct and sign documentation.
3. Deleting incorrect data already signed, complete the following steps:
   a. Right click into each cell, select either unchart or modify
   b. Provide a reason
   c. Enter correct data into cell
   d. Validate and sign documentation
4. Incorrect Patient Association to device
   a. After a period of time, whether that period of time is 5 minutes or 5 hours, the user notices the incorrect patient was selected, the user should note the Incorrect patient name, the device name and disassociate the patient from all devices, and report it to their Nurse Leader/Charge Nurse.
   b. Reassociate the patient to the correct devices:
      i. Click on the BMDI ICON
      ii. Select the appropriate device and click Associate
      iii. Click Close

~~Q.~~O. POWER CHART ECG:

1. Power chart ECG changes via the computer**.**
   a. The cardiologist will read unconfirmed ECG's and either note OK or note the appropriate changes on the unconfirmed EC**G**~~B~~.
   b. Once the ECB is complete, the EC**G**~~B~~ technician will place the correct EKG in the MD computer box.
   c. The cardiologist will interpret the EC**G**~~B~~ typing their own interpretation in the interpretation section.
2. Power chart ECG changes via the mobile cart**.**
   a. Turn machine on
   b. Turn know to directory and locate patient
   c. Locate patient name and select at top of screen
   d. Make changes to the current EC**G**~~B~~ and press OK when done

~~R.~~P. LATE ENTRY INTO THE MEDICAL RECORD:

1. When a pertinent entry was missed or not written in a timely manner, a late entry shall be used to record the information in the medical record.
2. If discovered before the end of the shift, the practitioner may make this entry without consulting a manager or director.
3. If the chart is still open, but the shift has ended and the staff member has since left the facility and returned, a Manager or Director shall be notified and any entry made shall be labeled "late entry~~.~~"**.**
4. If the medical record has been closed (four hours or greater after discharged) and a late entry is required, the Nurse Leader shall work with the employee required to make the late entry. (Tasks and orders are not accessible after discharge for completion. A Clinical Note must be used to document any corrections or additional information~~.~~)**.**
5. Corrections to scanned documents must be completed in the Medical Records/Health Information department where a printed copy can be amended and labeled as a Late Entry. This

document will then be scanned into the medical records as a new entry (previous entry remains).

6. Under any of the above situations the following guidelines shall be followed when making a late entry in the medical record:
    a. The practitioner directly responsible for the care/information being documented shall make the entry whenever possible.
    b. The new entry shall be identified as a “late entry” in the Clinical Note.
    c. The current date and time the entry is actually being made shall be noted. No attempt shall be made to make the entry look as if it were entered on the previous date or time.
    d. When correcting an omission, validate the source of the additional information as much as possible (for example, where the information to write the late entry was obtained)
    e. The late entry shall be documented as soon as possible.
    f. There is no time limit for writing a late entry, however, the sooner the entry is made, the more reliable the information becomes.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: **08/05**

SUBJECT: **Minors Attempting to Leave Without a Parent/ Legal Guardian**

REVISION DATE: **07/08, 05/11, 02/18, 12/21**

Department Approval:	**~~08/21~~10/25**
Clinical Policies & Procedures Committee Approval:	**~~08/21~~10/25**
Nursing Leadership Approval:	**~~10/21~~11/25**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/21~~11/25**
Administration Approval:	**~~11/21~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/21**

A. **PURPOSE:**

1. **To provide** ~~D~~**d**irection for healthcare providers at Tri-City Healthcare District (TCHD) when minors are leaving without being accompanied by a parent or legal guardian.

B. **DEFINITION(S):**

1. Minor: a person younger than eighteen (18) years of age, in the state of California [Family Code Section 6500].
2. Authorized individual: A parent, legal guardian or other person with the authority to consent to medical treatment for a ~~minor .~~**minor.**

C. **POLICY:**

1. A minor shall be discharged to an authorized individual.
2. If a minor is attempting to leave TCHD without an authorized adult present and the physician or Allied Health Professional (AHP) deems it is not in the best interest of the minor to be discharged, the following actions must be taken:
   a. Verbal discussion of the risks of a premature discharge.
   b. Clear instructions to remain on the unit/department.
   c. Notification of hospital security and law enforcement. If the minor becomes combative, appropriate actions to detain the minor shall ensue, keeping patient and staff safety at the forefront.
3. If a minor is attempting to leave the facility without an adult present and the physician or AHP releases the minor, the authorized adult shall be contacted to pick up the minor.
4. If the authorized adult is not available to pick-up the minor in a reasonable period of time, consult with the Risk**/Legal Department** ~~Manager~~ to determine if the minor can be released to one that is authorized by the parent or legal guardian.

D. **RELATED DOCUMENT(S):**

1. Patient Care Services: Consent for Minors Policy

E. **REFERENCE(S):**

1. **California Hospital Association (**CHA**)** Consent Manual (202**4**~~0~~), Chapter 4**, Who May Consent for Minor Patients**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: **10/96** **SUBJECT:** **Nutrition Education of Patients**

REVISION DATE: **6/03, 1/04, 05/11, 05/17, 05/20**

Patient Care Services Content Expert Approval:	**~~03/20~~07/25**
Clinical Policies and Procedures Approval:	**~~05/20~~10/25**
Nursing Leadership Approval:	**~~06/20~~11/25**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~06/20~~11/25**
Administration Approval:	**~~07/20~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **POLICY:**

1. Registered Dietitian (RD) shall educate patients, family, and/or significant others, as appropriate, regarding prescribed diet and means by which nutritional goals can be met.
2. RD shall determine the need for patient education based upon nutritional assessment and assessment of patients' knowledge of prescribed diet.
3. The patient's educational needs shall be assessed for language, cognitive, and emotional barriers. Readiness to learn shall be assessed and available support networks are determined.
4. The patient/family/significant other shall be educated regarding diet so as to improve dietary compliance or nutritional needs as needed. Appropriate tools are utilized to enhance patient understanding of education. Both verbal and written tools are utilized; copies of written materials are provided for use at home as appropriate.
5. Patients are educated at a time when they are ready to learn.
6. Questions are asked of patient to solicit assessment of patient understanding. Diet history may be obtained. The patient is encouraged to develop a plan for implementing necessary changes in diet/nutrition.
7. Documentation of any educational activity is completed in the patient's medical record.
8. Follow up teaching is accomplished throughout the patient's stay as needed. The RD phone number is given for patient to contact RD with questions as needed after discharge.
9. The Registered Nurse (RN) is responsible for the initial functional assessment during the admission process, as well as reinforcing education provided by the dietitian as needed and upon discharge.
10. The RN shall also initiate the appropriate plan of care and per the Patient Care Services Policy; Interdisciplinary Plan of Care (IPOC).

B. **RELATED DOCUMENT(S):**

1. Patient Care Services Policy: Interdisciplinary Plan of Care (IPOC).

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**PATIENT FOOD REFRIGERATORS/FREEZERS**
Purpose:	To ensure patient care refrigerators for food are monitored, defrosted, and cleaned.

A. **PROCEDURE:**

1. All patient food refrigerators shall be cleaned/defrosted as needed.
   a. Food and Nutrition is responsible for cleaning and/or notifying engineering of defrost for the refrigerators/freezers routinely stocked by food and nutrition personnel.
   b. Nursing is responsible for cleaning and/or notifying engineering of defrost for refrigerators not routinely stocked by Food and Nutrition Services**.**
   c. Engineering is responsible for defrosting the refrigerator/freezer units.
2. Temperature ranges for patient food storage:
   a. Refrigerators 32 to 41.5 degrees Fahrenheit (ºF).
   b. Freezers minus (-) 20 to 2 degrees Fahrenheit (ºF).
3. All refrigerators/freezers are recommended to have a ~~back up~~**backup** thermometer in case the electronic surveillance system malfunctions.
4. The electronic surveillance system monitors patient refrigerator/freezer temperatures 24 hours a day, seven (7) days a week.
5. The electronic surveillance system will send an initial notification email to the Food and Nutrition Supervisors from 0500 to 2100 and to Engineering from 2100 to 0500 if the temperature is out of range.
6. If the temperature falls outside the correct range, Nursing/Food and Nutrition personnel/Supervisor/Engineering shall:
   a. Check the freezer compartment for over icing. If the freezer requires defrosting, place a work order to Engineering to follow up immediately.
   b. If the freezer is not the problem, Nursing/Food and Nutrition personnel/Engineering will adjust the thermostat, and/or implement appropriate action plan. Nursing/Food and Nutrition personnel /Engineering will monitor results within two (2) hours.
7. If the temperature is not corrected within two (2) hours after adjusting the thermostat or any other corrective actions, a work order will be placed to Engineering.
   a. The electronic surveillance system will send a notification email to the Food and Nutrition Director if the temperature is out of range for 4 ~~hours..~~**hours.**
   b. Food and Nutrition Supervisors will evaluate the need to relocate food items until temperature is corrected.
   c. Corrective actions shall be documented in the electronic surveillance system.
8. If the electronic surveillance system fails the temperature will be monitored manually.
   a. Food and nutrition personnel are responsible for documenting the temperatures one time per day for the refrigerators/freezers they routinely stock.
   b. Nursing is responsible for documenting the temperatures for refrigerators/freezers not routinely stocked by Food and Nutrition.
   c. Corrective actions shall be documented on the temperature log.

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursing Leadership	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
04/00, 06/03, 07/07, 11/10, 10/17, 06/18, 10/21**, 07/25**	11/10, 11/17, 08/18, 11/21, 06/22**, 10/25**	11/10, 12/17, 09/18, 12/21, 07/22**, 11/25**	n/a	n/a	n/a	10/18, 01/22, 08/22**, 12/25**	01/11, 01/18, n/a	01/11, 01/18, 11/18, 01/22, 08/22

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: **08/01** **SUBJECT:** **Patient Leave of Absence, Temporary e.g., Temporary Absence Release**

REVISION DATE~~(S)~~: 12/01, 06/02, 6/03, 8/05, 9/07, 03/11, 08/15, 04/19

Patient Care Services Content Expert:	**~~01/19~~08/25**
Clinical Policies & Procedures Committee Approval:	**~~02/19~~10/25**
Nurse Executive Committee Approval:	**~~03/19~~11/25**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~03/19~~11/25**
Administration Approval:	**~~04/19~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/19**

A. **PURPOSE:**

1. To identify the interventions to implement for patients to be temporarily absent from the hospital for medical reasons ~~or personal reasons~~.

~~1. It may be necessary for a patient to be temporarily absent from the hospital for medical reasons.~~

B. DEFINITION(S):

1. Medical reasons: patient requires treatment at another health facility.
~~Personal reasons: personal reasons include but are not limited to the following; attend psychiatric or rehabilitation outing, funeral, or for their own convenience.~~

~~B.~~**C. POLICY:**

1. All temporary absences **must be authorized and ordered by a physician.** ~~require a physician order.~~

2. Patient must understand the following:
- **a. They are not discharged from the hospital, but instead is temporarily "on leave"**
- **b. Will not be permitted to remain away from the hospital overnight without being discharged**
- **c. If the duration of the absence is unexpectedly extended, the hospital must be notified immediately and the patient will be discharged.**

3. Written consent must be signed by the patient or their legal representative for temporary absence from the hospital.

Temporary Leave Type	Consent Form
~~**Patient's Convenience**~~	~~**Temporary Absence Release**~~
~~**Patient' Participation in a Patient Outing**~~	~~**Consent for Participating in Patient Outing**~~
Medical Treatment at Another Facility	**Consent to Transfer for Medical Treatment**

~~It must be understood by the patient that he/she is not discharged from the hospital~~**~~3.~~**

~~1.~~**4.** The day on which the patient began a leave of absence is treated as a day of discharge, and is not counted as an inpatient day unless the patient returns to the facility by midnight of the same day.

~~C.~~D. PROCEDURE:

1. During the course of the stay, it is the physician's responsibility to provide written documentation in the order or progress notes regarding:
   a. Stability of patient for transfer in the case of absence for medical **treatment**~~procedures~~
2. Prior to transfer for medical **treatment**~~procedures~~:
   a. The patient or patient representative will sign "Consent for Transfer for Medical Treatment"**.**
   b. The transferring unit shall schedule the procedure with the appropriate department(s) at the receiving location or hospital (i.e., C**omputerized Axial Tomography (C**T scan**)**, echocardiogram).
   c. The physician shall designate mode of transport (i.e., ambulance) and level of transport (i.e.**.** Basic Life Support or Critical Care Transport Ambulance).
      i. Oncology patients being transported for Radiation Therapy can only be transported via ambulance~~.~~
         1) For **J**~~j~~ustice **I**~~i~~nvolved patients, custody staff **must**~~will~~ accompany **the** patient~~.~~
   d. The transferring unit shall make transportation arrangements**.**~~.~~
   e. The primary nurse will ~~attempt to~~ provide hand off to the receiving facility**, prior to transport. In the event, the receiving facility staff are not available prior to transport to accept hand-off, document in the medical record the attempts to notify the receiving ~~hospital~~facility.** ~~.~~
   f. Copies of pertinent components of the medical record shall accompany the patient.
3. ~~Receiving facility~~**Return to Tri-City Medical Center (TCMC)**
   ~~a. The receiving medical facility shall obtain an additional informed consent from the patient or patient representative when appropriate.~~
   ~~b. The receiving physician/staff shall be responsible for continuing medical care.~~
   ~~c. Following completion of the testing/procedure(s), the receiving medical facility shall arrange for appropriate return transportation of the patient and components of the medical record.~~
   ~~d. The physician sending the patient back to TCMC shall document the patient's condition prior to departure.~~
   ~~e.~~**a.** ~~Consent for the return trip is not necessary unless a change in mode of transportation is indicated.~~**Following the completion of the testing/procedure(s) the patient shall be transported back to TCMC.**

E. FORM(S):

~~D.~~**1. California Hospital Association 2024 Samples:**

a. Consent to Transfer for Medical Treatment - Sample

~~**Consent for Participating in Patient Outing - Sample**~~

~~1. **Temporary Absence Release - Sample**~~

FORM 9-3

Consent to Transfer for Medical Treatment

Patient's Name: _____

My attending physician is Dr. *(physician name)* _____.

My physician has recommended that I should be transferred to *(name of receiving facility)* _____ _____ where the following procedure(s) will be performed *(name of procedure)* _____ _____ by or under the supervision of Dr. *(name of receiving physician)* _____ . I have separately given my consent for the performance of this procedure(s).

Upon my consent, arrangements will be made to transfer me from this hospital to the facility named above. Before I give consent, I have the right to be informed of any risks or complications which may result from the transfer.

My physician has recommended the following method of transportation *(specify method of transportation)* _____ and, except in those cases in which an employee of the hospital accompanies me during the transfer, the hospital does not assume any responsibility for my care during the transfer or during my absence from the hospital.

Temporary Absence Release for Transfer to Another Facility

Having given my permission to the attending physician(s) and obtained his/her permission to be absent from the hospital for the performance of a medical procedure(s) at *(name of receiving facility)* _____ from *(time)* _____, *(date)* _____ to *(approximately) (time)* _____, *(date)* _____, I assume all responsibility for myself during the temporary absence. I hereby release *(name of transferring hospital)* _____, its employees and all attending physician(s) from all responsibility during my absence and for my condition as a result.

My signature below constitutes my acknowledgment (1) that I have read and agree to the foregoing; (2) that the plans for my transfer and the procedure(s) to be performed following the transfer have been adequately explained to me by my physician; (3) that I have received all of the information I desire concerning such plans and procedure(s); and (4) that I consent to the transfer to the facility named above for the performance of the medical procedure.

The physicians involved in your care are not employees or agents of the hospital. They are independent medical practitioners.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

©CALIFORNIA HOSPITAL ASSOCIATION

FORM 9-11

Consent for Participation in Patient Outing

Hospital Name: _____

Patient Name: _____

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Signature

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©CALIFORNIA HOSPITAL ASSOCIATION

FORM 9-10

Temporary Absence Release

Patient Name: _____

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Date: M / PM

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RETIRE

©CALIFORNIA HOSPITAL ASSOCIATION

SAMPLE

FORM 9-3

CONSENT TO TRANSFER FOR MEDICAL TREATMENT

Patient's Name: _____

Your/The patient's attending physician is Dr. *(physician name)* _____ _____. The physician who will perform the procedure(s) described below is Dr. *(physician name)* _____. The facility at which the procedure(s) will be performed is *(facility name)* _____ _____.

Your/the patient's physician has recommended that you/the patient should be transferred to *(name of receiving facility)* _____ where the following procedure(s) will be performed *(name of procedure)* _____ _____ by or under the supervision of Dr. *(name of receiving physician)* _____ and you have separately given your consent for the performance of this procedure(s).

Upon your consent, arrangements will be made to transfer you/the patient from this hospital to the facility named above. Before you give consent, you have the right to be informed of any risks or complications which may result from transferring you/the patient.

Your/the patient's physician has recommended that the method of transportation which will be used to transfer you/the patient will be *(specify method of transportation)* _____ _____ and, except in those cases in which an employee of the hospital accompanies a patient during the transfer, the hospital does not assume any responsibility for your/the patient's care during the transfer or during your/the patient's absence from the hospital.

TEMPORARY ABSENCE RELEASE FOR TRANSFER TO ANOTHER FACILITY

Having given my permission to the attending physician(s) and obtained his/her permission to be absent from the hospital for the performance of a medical procedure(s) at *(name of receiving facility)* _____ _____ from *(time)* _____, *(date)* _____ _____ to *(approximately) (time)* _____, *(date)* _____, I assume all responsibility for myself, or *(name of patient)* _____, who is my *(relationship)* _____ during the temporary absence and I hereby release *(name of transferring hospital)* _____ _____, its employees and the attending physician(s) from all responsibility during this absence and for my/the patient's condition as a result thereof.

(over)

SAMPLE

Form 9-3 Consent to Transfer for Medical Treatment

My signature below constitutes my acknowledgment that (1) I have read and agree to the foregoing; (2) that the plans for my/the patient's transfer and the procedure(s) to be performed following the transfer have been adequately explained to me by my/the patient's physician; (3) that I have received all of the information I desire concerning such plans and procedure(s); and (4) that I consent to my/the patient's transfer to the facility named above for the performance of the medical procedure.

The physicians involved in your care are not employees or agents of the hospital. They are independent medical practitioners.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 05/19

SUBJECT: Physician/Allied Health Professional (AHP) Orders – Outpatient Services

REVISION DATE: 04/22

Patient Care Services Content Expert Approval:	**~~11/21~~04/25**
Clinical Policies & Procedures Committee Approval:	**~~12/21~~05/25**
Nursing Leadership Approval:	**~~01/22~~08/25**
Pharmacy & Therapeutics Committee Approval:	**~~02/22~~09/25**
Medical Executive Committee Approval:	**~~03/22~~10/25**
Administration Approval:	**~~04/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/22**

A. **PURPOSE:**

1. To ensure outpatient orders and requisitions are written in accordance with Tri-City Healthcare District (TCHD)/Center for Medicare and Medicaid Services (CMS) guidelines.

B. **POLICY:**

1. TCHD Medical Staff or AHP credentialed by the Medical Staff Office may order outpatient treatment and diagnostic studies that are within their scope of practice and as permitted by applicable state law.
   a. AHP may not order chemotherapy.
   b. For Rehabilitation Services patients, the ordering physician must have an established relationship with the patient and be available to sign the plan of care at least every 10 visits or thirty (30) days, whichever comes first.
   c. Only physicians/AHP granted Wound Care & Hyperbaric Medicine Medical Staff privileges may provide orders for patients being seen at the Wound Care Center.
2. Non-Physician members and Non-Members of TCHD medical staff may only order diagnostic, imaging, therapeutics, laboratory tests, and rehabilitation services within their scope of practice for outpatient services per Patient Care Services Policy: Physician/ Allied Health Professionals (AHP) Inpatient Orders.
3. A valid order must be received prior to performing any outpatient procedure, test or service.
   a. Verbal orders are not accepted.
   b. Telephone orders:
      i. Are acceptable in STAT situations when the physician/Allied Health Professional (AHP) may not be in the office or is otherwise unavailable to send a copy of the order to initiate/modify any outpatient service.
      ii. Telephone orders shall be entered directly into the electronic health record (EHR). When it is not possible to enter a telephone order, document the order immediately on the Physician's Order sheet and ensure it is signed, dated and timed by the individual who received the order.
         1) The complete order(s) shall be clearly read back to the physician/AHP directly from the primary source.
            a) Orders entered directly into the EHR shall be entered using the correct Communication Type.
            b) If orders written on the Physician's Order sheet, the Read Back box shall be check-marked (✓) to document orders were read

back.

2) Orders must be signed within 48 hours for medication orders and fourteen (14) days post discharge for all other orders.
   a) Outpatient Behavioral Health Services medication orders written on Friday may be signed on the next business day (Monday).
   b) Arrangements must be made by the scheduling department as to when the written order will be received or when the physician/AHP will be available to authenticate the order.
3) Telephone orders for antineoplastic agents are not permitted.
   a) Exceptions: See Patient Care Services: Chemotherapy Prescribing, Processing, and Preparation Policy.

c. Faxed or original signed orders are acceptable provided all required elements are present and may be submitted in any of the following formats:
   i. Prescription Forms
   ii. Referral Forms (can be payer specific)
   iii. Order Sheets
   iv. Outpatient Scheduling Forms
   v. Office Letterhead
   vi. Office history and physical or progress notes including clear indication that an order is contained within
   vii. TCHD approved pre-printed order forms
d. Medication orders must be submitted on an approved TCHD order sheet or pre-printed order form.
e. A physician/AHP order is not required for provision of services that are provided to the community at large or for direct access testing.
   i. Examples: Wellness Health Fair, Cardiac Scoring, Screening mammogram
   ii. Patients requesting screening mammograms
   iii. Cardiac Phase 3 patients
   iv. Pulmonary Phase 3 patients

4. It is the responsibility of Registration or the ancillary departments scheduling the service to ensure all elements are present. These include:
   a. Patient Name
   b. Date of birth
   c. Validate physician license or AHP number
   d. Ordering physician/AHP signature (written or electronic)
      i. Orders signed by office personnel and stamped orders will not be accepted.
   e. Date and time of physician signature
   f. Service to be provided
   g. Reason for service/Medical necessity (i.e. diagnosis or condition)
      i. Orders to “Rule out _____” are not sufficient
      ii. A narrative description of medical necessity is preferable over ICD codes. However, if a code is provided and it is deemed to be a valid ICD code, it will be used in the absence of a narrative description.
   h. Orders must be activated within ninety (90) days of the date of the signed/authenticated order.
5. Invalid orders are to be brought to the attention of the ordering practitioner who will have an opportunity to clarify/complete the order to meet requirements.
6. Upon confirmation of a compliant order the department follows through with the Scheduling of the patient for services requested in the order and/or Registration of the patient for the walk-in service.
   a. Orders for outpatient invasive procedures and infusion therapies will be accepted based on additional patient care needs with consideration of the patient’s clinical condition and whether a licensed physician/AHP can assume responsibility for follow up treatment resulting from the order.

7. Orders will be valid for a period of ninety (90) days from date reflected on the outpatient order unless otherwise indicated.
    a. Outpatient Behavioral Health Services orders are valid for up to twelve (12) months.
    b. Outpatient medication orders (including but not limited to chemotherapy and infusion therapies) are valid for twelve (12) months.
    c. Cancer surveillance treatment orders are valid up to six (6) months.
    d. In-Custody patients:
        i. California Department of Corrections/Rehabilitation (CDCR) orders are valid for twelve (12) months
        ii. San Diego Sheriff Department (SDSD) orders are valid up to six (6) months
    e. For recurring accounts there is no specific date in which the order will expire. If there is a change in the patient's condition which warrants a change in treatment, a new physician/AHP order is required.
8. Patterns of non-compliant orders will be tracked and reported to department leadership for follow-up.

C. **RELATED DOCUMENT(S):**

1. Patient Care Services Policy: Chemotherapy, Prescribing, Processing, and Preparation
2. Patient Care Services Policy: Physician/ Allied Health Professionals (AHP) Inpatient Orders

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: PRE-OPERATIVE MEDICATION INSTRUCTIONS TO SURGICAL PATIENTS

I. **POLICY:**

A. Patients are to be provided instructions during the Pre-Operative Education appointment regarding their prescription medication management, as applicable, before surgery.

1. This education may occur through an appointment in-person or via telephone.
2. **Physician supervision: None required**

II. **PROCEDURE:**

A. The Registered Nurse (RN) in the Pre-Operative Education Department shall instruct patients to:

1. Stop ~~phentermine seven (7) days prior to surgery.~~**Glucagon-like peptid 1 (GLP-1) receptor agonist medications one dose prior to surgery. (i.e., Ozempic, Victoza, Byetta, Trulicity, Rybelsus, etc.) Example: Ozempic 0.5 mg SQ weekly, stop one week prior to surgery, Rybelsus 7 mg Daily, stop day prior to surgery.** **(1)**
2. Stop angiotensin converting enzyme (ACE) inhibitors and angiotensin II receptor blocker (ARB) agents twenty-four (24) hours prior to surgery.
3. Consult with their surgeon, primary care physician and/or cardiologist for medications that can affect bleeding (e.g., anticoagulants, platelet inhibitors, herbal medications) for discontinuation guidelines.
4. Take all of their morning medications prior to surgery, except the following:
   a. Insulin
   b. Oral hypoglycemic agents

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**

A. Initial training: Orientation
B. Ongoing: Annually

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

A. This procedure has been developed by Surgical Services, with approval from Nursing Leadership and the Operating Room (OR) Committee.

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

A. RN's in the **Outpatient Service Center (**Pre-Operative Education Department**)**.

VI. **REFERENCE(S):**

A. American Society of Anesthesiologists Consensus-Based Guidance on Preoperative Management of Patients (Adults and Children) on Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists | American Society of Anesthesiologists (ASA) (asahq.org).

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership	Operating Room Committee	Pharmacy & Therapeutics Committee	Inter-disciplinary Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
10/12, 07/13, 09/17~~,~~, 03/18~~,~~, 09/20**, 01/24**, 06/24	10/12, 07/13, 09/15, 08/18, 08/21**, 02/24**	10/12, 07/13, 09/15, 09/18, 10/21, **03/24**, 09/24	12/15, 07/18, 09/20**, 05/24,12/24**	11/12, 07/13, 09/15, 11/21**, 02/25**	01/13, 02/14, 01/16, 01/19, 01/22**, 04/25**	02/13, 02/14, 01/16, 02/19, 04/22**, 11/25**	03/19, 05/22**, 12/25**	02/16, n/a	02/13, 02/14, 02/16, 03/19, 05/22

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: **01/05** **SUBJECT:** **Privacy Code**

REVISION DATE: **08/07, 07/10, 11/10, 01/16, 02/18**

Department Approval:	**~~04/22~~10/25**
Clinical Policies & Procedures Committee Approval:	**~~06/22~~10/25**
Nursing Leadership Approval:	**~~07/22~~11/25**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~08/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/22**

A. **DEFINITION(S)**:
1. Privacy Code: ~~a~~**A** code or word selected by the patient or durable power of attorney that contains a minimum of four (4) characters.
2. Permitted Disclosure: **M**~~m~~eans the information can be, but is not required to be, shared without individual authorization.

B. **PURPOSE:**
1. A privacy code is used by staff to identify patient designee who may receive healthcare information when an individual is requesting protected health information (PHI) via the telephone or in person.
   a. Exclusions:
      ~~i. Women and Newborn Services for infant security and privacy considerations. For infant security and safety see department specific:~~
         ~~1) Patient Care Services Procedure: Identification of Newborn~~
         ~~2) Women and Newborn Services Policy: Infant Safety and Security~~
         ~~3) Women and Newborn Services NICU Policy: Visitation in the NICU~~
      ~~ii.~~**i.** Outpatient Behavioral Health Services patients - for privacy information for behavioral health patients see:
         1) Administrative Policy Rights to Request Privacy Protection for Protected Health Information
         2) Behavioral Health Policy: Confidentiality
         3) Behavioral Health Policy: Release of Information
      ~~iii.~~**ii.** Justice Involved Patients

C. **POLICY:**
1. The patient or durable power of attorney **(DPOA)** shall select a privacy code upon each admission to Tri-City Healthcare District (TCHD) as inpatient, observation status patient or surgical patient.
~~1.~~**2.** ~~The p~~**P**atient**s** shall be asked to update their privacy information for each new admission; this can be new information or remain the same from a previous admission.
   a. In the Emergency Department / Outpatient Areas:
      i. When the patient or **DPOA**~~durable power of attorney~~ presents to the department, staff will obtain verbal consent **from the patient or the DPOA** to discuss care / condition with person accompanying patient.

ii. When receiving telephone requests **for** PHI, staff will obtain verbal consent from the patient to discuss care / condition with person requesting information via the telephone.
1) Document name of person **the** ~~given~~ PHI **was provided to** in electronic health record.

~~2. If the patient is unable to select a privacy code because of the patient's incapacity or emergency circumstance, disclosure may be made if the staff, in the exercise of professional judgement, determines the disclosure is in the best interest of the patient and discloses only the PHI directly relevant to the person's involvement with the patient's health care, or needed for notification purposes~~
~~a. A reasonable effort shall be made to have the patient or durable power of attorney select a privacy code during the hospital stay as soon as the patient is able to communicate.~~

3. The Registered Nurse **(RN)** completing the admission process for inpatient, observation status or surgery patients shall ensure the privacy code information has been addressed **and the privacy code is documented in the medical record.** ~~.~~
a. Privacy Code Selection Process**:**
i. Once a privacy code is selected, document the following in the medical record ~~.~~**:**
1) The privacy code
2) Privacy Code Designee's name and relationship to patient
a) A maximum of four (4) privacy code designees may be listed
ii. ~~The patient shall be instructed to provide the privacy code to the designated family members/caregivers involved in their care~~**1/20**. The code authorizes those family members/caregivers to receive information directly relevant to the person's involvement with the patient's health care or needed for notification purposes.
b. Declination Process**:**
i. If the patient or **DPOA**~~durable power of attorney~~ declines to select a privacy code, document the declination in the medical record.
ii. **Inform t**~~T~~he patient or **DPOA that:**~~durable power of attorney will be educated:~~
1) No information related to their care will be given family or caregivers, either in person or via the telephone.
2) The **patient or the DPOA**~~y~~ will be responsible for updating family or caregivers regarding their care/condition.
c. Unable to Obtain a Privacy Code Process:
i. If the patient is unable to select a privacy code because of the patient's incapacity or emergency circumstance, disclosure may be made if the staff, in the exercise of professional judgement, determines the disclosure is in the best interest of the patient and discloses only the PHI directly relevant to the person's involvement with the patient's health care, or needed for notification purposes**.**
1) A reasonable effort shall be made to have the patient or **DPOA**~~durable power of attorney~~ select a privacy code during the hospital stay as soon as the patient is able to communicate
ii. Document in medical record "Unable to Obtain".

4. When the staff receives a request for information on a patient, the staff shall ask who is calling, their relationship to the patient, and the privacy code.
a. Once the privacy code is verified, the staff may give the designated family member / caregiver the minimum information necessary regarding the plan of care for the patient.

D. **RELATED DOCUMENT(S):**
1. Administrative Policy: Rights to Request Privacy Protection for Protected Health Information
~~2. Behavioral Health Policy: Confidentiality~~
~~3. Behavioral Health Policy: Release of Information~~
2. Patient Care Services Procedure: Identification of Newborn
3. California Code of Regulation (CCR). Title 22 Part 1101 Privacy Act of 1975

4. **CCR Title 22 §70707. Patients' Rights**
~~5. Women and Newborn Services NICU Policy: Visitation in the NICU~~
~~6. Women and Newborn Services Policy: Infant Safety and Security~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**10/01**	**SUBJECT:**	**Private Duty Staff, Patient Acquired**
REVISION DATE:	**03/03, 06/03, 05/05, 07/06, 08/08, 03/09, 08/11, 01/15, 10/19, 12/22**		

Patient Care Services Content Expert Approval:	**~~09/22~~09/25**
Clinical Policies & Procedures Committee Approval:	**~~10/22~~10/25**
Nursing Leadership Approval:	**~~11/22~~11/25**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~12/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/22**

A. **POLICY:**

1. Tri-City Medical Center (TCMC) allows the use of private duty nursing staff, except in the Intensive Care Unit (ICU) ~~and Neonatal Intensive Care (NICU),~~ to provide nursing care by an outside agency. The hospital remains ultimately responsible for the patient's care and welfare. The TCMC Registered Nurse (RN) is in charge of the patient and determines the care to be provided by and the supervision required by the private duty nurse.
2. Nursing staff shall notify the ~~primary care~~ **attending** physician/AHP of family's request for private duty staff.
3. Arrangements for all private duty nursing staff are made by the patient's family, patient, or attending physician/Allied Health Professional (AHP).
4. The hospital **may** ~~assists~~**assist** families by providing outside private duty agency names and telephone numbers. Payment is made directly by the patient/family to the private duty nurse or through the outside agency. TCMC nursing staff are not eligible for private duty nursing while the patient is in TCMC.
5. The hospital reserves the right to notify the outside agency when a nurse fails to meet the standards required of them.
6. The hospital assumes no responsibility in the collection of the fee. Agency payroll time slips may be signed by the shift supervisor/designee and given to the family/significant other, if a signature is required.
7. ~~Private duty nursing staff shall sign in at the Staffing Resource Office~~. Private duty staff must check in with the Administrative Supervisor prior to starting and at the completion of his/her shift.
8. Private duty staff members are only allowed to participate in patient's basic care needs.
   a. If a family/patient enlists licensed (RN/LVN) private duty personnel, he/she may not perform such tasks as dressing changes, indwelling urinary catheter insertion or removal, blood glucose monitoring, intravenous and medication administration, any insertion or removal on an indwelling tube or drain, or any other nursing duties that require proof of competency.
9. Private duty nurses will have no access to the patient's medical record.
10. Basic report will be given from the TCMC nursing staff to the private duty staff on ADL's for the patient based on the physician/AHP orders and the private duty staff must adhere to those orders.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: **03/85**

SUBJECT: **Referrals to Social Services for Patients Identified to be High Risk**

REVISION DATE: **05/91, 06/94, 09/99, 06/03, 01/04, 02/07, 05/10, 09/11, 12/17, 03/21**

Patient Care Services Content Expert Approval:	**~~08/20~~06/25**
Clinical Policies & Procedures Committee Approval:	**~~10/20~~10/25**
Nursing Leadership Approval:	**11/25**
Medical Staff Department or Division:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/21~~11/25**
Administration Approval:	**~~03/21~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/21**

A. **PURPOSE:**

1. Hospitalization represents a crisis to most patients. Social and emotional problems may be present at the time of admission and can complicate a patient's hospital stay, particularly if the patient is in a high-risk category. High-risk patients need to be identified and referred to the Social Service Department as early in the hospital stay as possible.

B. **DEFINITION(S):**

1. High-risk screening criteria:
   - a. Recent victim of violence/abuse /neglect
   - b. Suspected abuse or neglect
   - c. Demonstrating poor coping with illness/hospitalization
   - d. Demonstrating inadequate support systems
   - e. New cancer diagnosis, progressive cancer**,** or new diagnosis of other life-altering illness
   - f. Terminal illness diagnosis
   - g. Family conflict issues presenting a barrier to safe and appropriate discharge~~.~~
   - h. Current or recent substance abuse
   - i. Positive toxicology screen
   - j. Repeated Emergency Department visits
   - k. Intent to leave Against Medical Advice (AMA)
   - l. Homeless
   - m. Fourteen (14) to twenty (20) year old ~~adolescent~~**adolescents**
   - n. Pregnant/ near term and no prenatal care (including teen mothers)
   - o. Failure to thrive (infant)
   - ~~p. Neonatal Intensive Care Unit (NICU) admit~~
   - ~~q. Prospective adoption, foster placement~~
   - ~~r. Surrogacy~~
   - ~~s.~~**p.** Fetal demise
   - ~~t.~~**q.** Developmental disability or cognitive impairment**,** including dementia or suspected dementia**,** and not connected with appropriate community resources
   - ~~u.~~**r.** Any patient with a hospital Length of Stay (LOS) greater than seven days
   - ~~v.~~**s.** Patients readmitted to the hospital within thirty (30) days
2. Notify~~ Assistant Nurse Manager (ANM),~~ **the ~~Clinical~~ Nurse Leader~~Manager, (CNM)~~/designee**/Registered Nurse (RN) to arrange for psychiatric consultation if:

a. Recent suicide attempt
b. Suspected psychiatric disorder/behavior problem
c. Suspected psychiatric/behavior disorder (i.e., depressed, suicidal, acting out, etc.)
d. Cognitive/behavioral issue, including dementia or suspected dementia, presenting a barrier to safe and appropriate discharge

C. **POLICY:**

1. High-risk patients are identified in the following ways:
   a. Upon admission, through **the** use of the Admission Assessment-Patient History.
   b. During interdisciplinary case review rounds or treatment team conferences held on all units, where general high-risk indicators are identified and discussed.
   c. By a health care professional, physician, hospital personnel, community agency, or by patient, family, or friend.
   d. Through case finding by the Social Worker within their particular areas of responsibility and scope of practice.
2. High-risk Social Service referral screens help ~~to identify those patients needing priority services~~ **identify patients who need priority services as determined** by social work staff.
3. If high-risk psychosocial factors are identified, a referral is made by nursing to Social Services by placing an order for a Social Service referral in the electronic health record.
4. Social Workers will make every effort to complete Social Services assessments within twenty-four (24) business hours of receiving the referral.

D. **RELATED DOCUMENT(S):**

1. Patient Care Services: Referral to Social Services for Biopsychosocial Assessment

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY MANUAL
PATIENT CARE

ISSUE DATE:	**05/86**	**SUBJECT:**	**Reporting Suspected Child Abuse/Neglect**
REVISION DATE:	**08/94, 02/96, 01/97, 07/99, 04/02, 06/03, 12/05, 04/09, 06/11, 07/17, 12/21**	**POLICY NUMBER:**	**8610-308**

Department Approval:	**~~08/21~~10/25**
Clinical Policies and Procedures Approval:	**~~08/21~~10/25**
Nursing Leadership Approval:	**~~10/21~~11/25**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/21~~11/25**
Administration Approval:	**~~11/21~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/21**

A. **PURPOSE:**

1. To provide guidelines for the management and reporting of suspected child abuse and neglect cases.

B. **DEFINITIONS:**

1. Child – Person under the age of 18.
2. Mandated Reporter - Professionals or individuals listed under Penal Code required to report by law. Such persons include, but are not limited to, health care providers such as physicians, surgeons, psychiatrists, psychologists, dentists, residents, interns, or licensed nurses.
3. Abuse or neglect – Intentional maltreatment of an individual that may cause injury, either physical or psychological. The following are various types of abuse:
   a. Mental Abuse – includes humiliation, harassment, and threats of punishment or deprivation.
   b. Physical Abuse – includes hitting, slapping, ~~pinching ,kicking~~**pinching, kicking** or mistreatment. Also includes controlling behavior through unlawful corporal punishment.
   c. Sexual Abuse – means sexual assault and sexual exploitation.
   d. Emotional Damage – when a child is suffering serious emotional damage or is at a substantial risk of suffering serious emotional damage, evidenced by states of being or behavior, including but not limited to, severe anxiety, depression, withdrawal or untoward aggressive behavior toward self or others, regressive behavior or new speech disorders.
   e. Neglect – the negligent treatment or maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person {Penal Code 11165.2}.
      i. General Neglect - the negligent failure of a person having the care or custody of a child to provide adequate food,) clothing, shelter, medical care or supervision where no physical injury to the child has occurred.
      ii. Severe Neglect - the negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed non organic failure to thrive. It also means those situations of neglect where the person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that the child's person or

health is endangered. This includes intentional failure to provide adequate food, clothing, shelter and / or medical care.

f. Willful cruelty or unjustifiable punishment - A situation where a person willfully harms or injures a child or causes or permits a child to suffer or inflicts unjustifiable physical pain or mental suffering upon the child or permits a child to be placed in a situation where the child's person or health is endangered.

g. Unlawful corporal punishment or injury - a situation where a person willfully inflicts upon a child cruel or inhuman corporal punishment or injury resulting in a traumatic condition.

h. Reasonable Suspicion ~~– for purposes of this article,~~ "reasonable suspicion" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect.

~~h.~~**i.** "Reasonable suspicion" does not require certainty that child abuse or neglect has occurred nor does it require a specific medical indication of child abuse or neglect; any "reasonable suspicion" is sufficient. For purposes of this article, the pregnancy of a minor does not, in and of itself, constitute a basis for a reasonable suspicion of sexual abuse.

~~i.~~**ii.** Child abuse does not include a mutual affray between minors or an injury caused by a peace officer's reasonable and necessary force used while acting within the course and scope of the officer's employment as a peace officer. Affray is not defined in the law, but the dictionary defines it is a fight, quarrel or brawl.

C. **POLICY:**

1. California Penal Code §11166 mandated reporters who "has knowledge of or observes a child in his/her professional capacity or within the scope of his/her employment whom he/she knows or reasonably suspects~~,~~ has been the victim of child abuse or neglect, to report such suspected instances to the designated agency.

~~1.~~**2.** The initial report must be made immediately, or as soon as practically possible, by telephone and followed up with a written report within thirty-six (36) hours that is transmitted by facsimile (FAX) or electronically. A mandated reporter may report suspected emotional damage under Section 11166.05 of the California Penal Code.

~~2.~~**3.** The following criteria may indicate a need for further assessment. Criteria may include the following:

a. Injuries inconsistent with what the patient reports to have happened (i.e., burns, welts, bites and scratches).
b. Unusual patterns of injury (i.e., hairbrush, rope or belt marks).
c. Poor hygiene, malnourishment.
d. Fear of parent or caregiver, being withdrawn or tearful.
e. Inappropriate responses to questions about a safe environment or being threatened at home.
f. Home or institution in which child resides is unsuitable for the child because of abuse or neglect.

~~3.~~**4.** This law relates to any person under the age of 18 years whose home is an unfit place for him/her, by reason of neglect, cruelty, depravity or emotional abuse by parent, guardian or other person in whose custody or care he/she resides.

5. If a minor seeks treatment for pregnancy, an abortion, sexually transmitted disease or birth control assistance, a report is not indicated unless there is evidence or reasonable suspicion to believe that a sexual assault, sexual abuse, or other abuse or neglect has occurred.

~~4.~~**a.** ~~(~~Pregnancy in a mentally or physically impaired or mentally compromised child does raise a reasonable suspicion of child abuse~~)~~.

~~5.~~**6.** If voluntary sexual activity exists between minors who are of disparate ages and one of the minors is under 14 years of age, or~~,~~ one party is a minor and the other is over age 21, or~~,~~ any

relationship in which it appears that a minor is being manipulated or exploited**,** a report of child abuse is required.

~~6.~~**7.** All cases of child abuse suspected and actual must be reported by any mandated reporter as follows:
   a. Notify the Child Abuse Hotline by telephone (1-858-560-2191 or 1-800-344-6000**).**
   b. Prepare and send a written report (SS 8572: Suspected Child Abuse Report) within 36 hours of receiving the information concerning the incident e.g., contacting the Hotline
   c. Fax the completed SS 8372 or written report to the Hotline.
   d. Forward SS 8572 to the hospital Social Services Department**.**

~~7.~~**8.** Use a FAX Report: Monday - Friday, 0800 to 1700 only. (Do <u>not</u> send an SS 8572 if the FAX Report has been sent).

~~8.~~**9.** Upon reporting suspected child abuse, the county caseworker or child protective worker will instruct the hospital whether or not to place a 48 hour "hold" on said child. The court hold is usually placed as a means of providing protective custody and ensuring that the child will be given proper medical treatment. The "hold" shall be released within 48 hours, excluding non-judicial days, after the minor has been taken into custody, unless within said period of time a petition is filed with the Juvenile Court for a detention hearing. If a petition is filed with Juvenile Court, the child shall remain in custody until which time the "detention hearing" has transpired. At that time, the physician or District will act in accordance with court orders from said hearing.

~~9.~~**10.** The mandated reporter involved in evaluation, collection of facts and information, and reporting has the responsibility of ensuring such information is documented in writing in the medical chart in a comprehensive manner.

~~10.~~**11.** A mandated reporter shall inform the legal guardian of said "suspected" abused child of what actions have taken place, why they transpired, and what position the hospital must take in such situations as prescribed by law.

~~11.~~**12.** The Social Services Department at the hospital has the primary responsibility for coordinating, tracking the reporting of suspected cases of abuse/neglect to the appropriate agency as well as notification of the TCHD Compliance Officer. This applies whether seen in the Emergency Department or admitted to the Medical Center.

~~12.~~**13.** TCMC Social Services Department will be notified of all cases of suspected child abuse / neglect by one of the following methods:
   a. Making a Social Services referral through the computer.
   b. By telephone to the Social Services department or page to a specific Social Worker.
   c. By completing an SS 8572 Child Abuse Reporting Form and forwarding it to the hospital Social Services Office.
   d. By completing a Child Protective Service fax form and forwarding it to the hospital Social Services office.

~~13.~~**14.** The Clinical Social Worker shall serve as the communication link between the District and outside agencies regarding compliance with stated child abuse statutes and the regulations and procedures of the San Diego County Health and Human Services Agency, Children Services.

~~14.~~**15.** In the event that a child is to be discharged from the hospital while deemed in the custody of the Juvenile Court, the Clinical Social Worker or designee will coordinate such discharge by requiring proper identification from the person to whom the child is being discharged; and will request that court documentation of detention and custody be provided or mailed to the District as soon as possible.

~~15.~~**16.** Copies of all completed Child Protective Service fax forms and Child Abuse Reporting Forms (SS 8572) will be filed in the Social Services Department at the hospital.

~~16.~~**17.** Any problematic cases are reported to the Director/Manager of Social Services and Director of Legal Services/Risk Management for additional review.

~~17.~~**18.** Penal Code Section 11172 provides that no mandated reporter shall incur any civil or criminal liability as a result of making a report authorized by the law.

~~18.~~**19.** When two or more mandated reporters have knowledge, or reasonably suspect, a reporting incident, they can agree that a single report can be made. This can be coordinated through the Social Services Department.

~~19.~~**20.** Any person who is not a mandated reporter who knows, or reasonably suspects, that a child has

been the victim of abuse, may report that abuse. Such report may be coordinated through the Social Services Department.

D. **REFERENCES:**

1. California Hospital Association. (2024~~0~~). *California Hospital: Consent Manual*. CHA Publications: Sacramento.
2. California Penal Codes 11164-11174.3 of The Child Abuse and Neglect Reporting Act.

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: **05/86**

SUBJECT: **Reporting Suspected Dependent Adult / Elder Abuse/Neglect / Exploitation**

REVISION DATE: **06/91, 09/94, 02/96, 01/97, 07/99, 10/00, 06/03, 12/05, 04/09, 06/11, 07/17, 12/21, 06/22**

POLICY NUMBER: **8610-309**

Department Approval:	**~~03/22~~10/25**
Clinical Policies and Procedures Committee Approval:	**04~~/22~~10/25**
Nursing Leadership Approval:	**~~05/22~~11/25**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~05/22~~11/25**
Administration Approval:	**~~06/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**06/22**

A. **PURPOSE:**

1. To provide guidelines for the management and reporting of suspected abuse/neglect of elders and dependent adults.

B. **DEFINITIONS:**

1. Abandonment:
   a. Desertion or willful forsaking of an elder or dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody.
2. Abuse:
   a. Means physical abuse, neglect, financial abuse, abandonment, isolation, abduction, non-beneficial restraint, or other treatment resulting in harm, pain or mental suffering or deprivation by a care custodian of goods and ~~services that~~**services that** are necessary to avoid physical harm or mental suffering.
3. Dependent Adult:
   a. Anyone between the ages of 18 and 59 years who has physical or mental limitations or age-diminished physical or mental abilities which restrict that person's ability to carry out normal activities or to protect his/her rights including (but not limited to) persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. This definition also includes any one between the ages of 18 and 59 who is admitted as an inpatient in an acute care hospital or other 24-hour health facility.
4. Elder:
   a. Any person 60 years of age or older.
5. Endangered Adult:
   a. Means a dependent or elder adult who is at immediate risk of serious injury or death, due to suspected abuse or neglect and who demonstrates the inability to take action to protect himself or herself from the consequences of remaining in that situation or condition
6. Financial Abuse:
   a. Theft, misuse of funds or property, extortion, duress, fraud.

7. Exploitation:
   a. Taking advantage of another for one's own advantage or benefit. An unjust or improper advantage or use of another person or their property for one's own profit or advantage (i.e., using a victim's financial means for another's gain).
8. Imminent Danger:
   a. Substantial probability that elder or dependent adult is in imminent or immediate risk of death or serious physical harm, through either his/her own action or inaction or as a result of the action or inaction of any other person.
9. Isolation:
   a. Acts to intentionally preventing an individual from receiving mail, email, telephone calls or visitors.
   b. Telling a caller or prospective visitor that an elder or dependent adult is not present, when:
      i. False
      ii. Contrary to the express wishes of the elder or dependent adult, whether he or she is competent or not; and
      iii. Made for the purpose of preventing the elder or dependent adult from having contact with family, friends or concerned persons
   c. False imprisonment.
   d. Physical Restraint of an elder or dependent adult for the purpose of preventing him or her from meeting with visitors**.**
10. Mandated Reporter:
   a. Professionals or individuals listed under Penal Code required to report by law. Such persons include, but are not limited to, health care providers such as physicians, surgeons, psychiatrists, psychologists, social workers, dentists, residents, interns, or licensed nurses.
11. Mental Suffering:
   a. Fear, agitation, confusion, severe depression or other forms of serious emotional distress brought about by threats, harassment, or other forms of intimidating behavior.
   b. False or misleading statements made with malicious intent to agitate, confuse, frighten or cause severe depression or serious emotional distress of the elder or dependent adult**.**
12. Neglect:
   a. Failure to provide food, clothing, shelter, or health care for an individual under one's care when the means to do so are available.
   b. Neglect includes:
      i. Failure to assist in personal hygiene, or in provision of food, clothing or shelter
      ii. Failure to provide medical care for physical and mental health needs (excludes the elder or dependent adult who voluntarily relies on treatment by spiritual means vs. medical treatment, when no other indicators of abuse exist)
      iii. Failure to protect from health and safety hazards
      iv. Failure to prevent malnutrition or dehydration
   c. If a person cannot provide the above for oneself due to poor cognition functioning, mental limitation, substance abuse, or chronic poor health, this also constitutes neglect**.**
13. Physical Abuse: means any/all of the following:
   a. Hitting, kicking, burning, and dragging, over or under medicating. Battery
   b. Assault with a deadly weapon or force likely to cause great bodily harm
   c. Unreasonable physical constraint, or prolonged or continual deprivation of food or water
   d. Use of physical or chemical restraint, or psychotropic medication under the following conditions
      i. For punishment
      ii. For a period significantly beyond that for which the restraint or medication is authorized by a physician's licensed in California who is providing medical care to the elder or dependent adult at the time the instructions are given

iii. For any purpose not authorized by the physician

14. Self-Neglect:
    a. Failure to provide food, clothing, shelter or healthcare for oneself.
    b. Self-harming behavior including, but not limited to, suicide attempt.
15. Sexual Abuse:
    a. Unwanted sexual contact, sexual exploitation, forced viewing of pornography
    b. Sexual assault which means any of the following:
        i. Sexual battery
        ii. Rape
        iii. Rape in concert
        iv. Spousal rape
        v. Incest
        vi. Sodomy
        vii. Oral copulation
        viii. Sexual penetration
        ix. Lewd or lascivious act

C. **POLICY:**

1. Sections 15600, et seq., of the California Welfare and Institutions Code requires that a mandated reporter who, in his/her professional capacity, or within the scope of his/her employment that has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he/she has experienced behavior, including the act or omission, constituting acts described above, shall report to an adult protective services agency or local law enforcement agency by telephone immediately or as soon as practicably possible, and by written report within two (2) days.
2. The following may indicate a need for further assessment:
    a. Injuries inconsistent with what the patient reports to have happened (i.e., burns, welts, bites and scratches)
    b. Unusual patterns of injury (i.e., hairbrush, rope or belt marks)
    c. Poor hygiene, malnourishment
    d. Fear of parent or caregiver, being withdrawn or tearful
    e. Improper responses to questions such as, “Is anyone misusing your money, food, housing or not allowing you to obtain health care?”
    f. Inappropriate responses to questions about a safe environment or being threatened at home
3. The code also permits the reporting of suspected intimidation, cruel punishment, or other treatment that endangers an elder or dependent adults’ emotional wellbeing.
4. Instances do not have to be reported if a physician, registered nurse, or psychotherapist are unaware of independent evidence of incidents described in 1 above, and the patient has been diagnosed with a mental illness or dementia and mandated reporter does not believe abuse occurred.
5. Abuse of an elder or dependent adult is a criminal act.
6. Welfare and Institutions Code Section 15634 provides that no mandated reporter shall incur any civil or criminal liability as a result of making a report authorized by the law.
7. Any person who knowingly fails to report an instance of elder or dependent adult abuse is guilty of a misdemeanor.
8. The mandated reporter will complete an assessment and report the findings to the attending physician. If abuse is suspected, the mandated reporter will make a telephone report to the appropriate agency immediately or as soon as practically possible.
    a. If the alleged abuse occurred in a long-term care facility (Skilled Nursing Facility or Board & Care), the report must be made to the local ombudsman (1-800-640-4661; fax 858-694-2568) or the local law enforcement agency where the incident occurred.
    b. If the alleged abuse occurred anywhere else, the report must be made to the County

Aging and Independence Services (AIS) at 800-510-2020.

c. The mandated reporter will notify by phone, the adult abuse hotline (AIS) at 800-510-2020, or the ombudsman's office 1-800-640-4661 and will complete the elder abuse reporting form SOC 341.

9. The mandated reporter making the telephone report must complete a written report and mail it to the appropriate agency within two (2) days of making the telephone report.
10. All completed SOC 341 forms need to be forwarded to the hospital Social Services Department for mailing and filing. Copies of all completed "Suspected Dependent Adult/Elder Abuse" forms (SOC 341) will be filed and maintained in the Social Services Department at TCHD.
11. The Social Services Department at TCHD has the primary responsibility for coordinating, tracking the reporting of suspected cases of abuse/neglect to the appropriate agency, as well as notification of TCHD Compliance Officer. This applies whether seen in the Emergency Department, or admitted to the Medical Center.
12. Social Services Department will be notified of all cases of suspected elder abuse/neglect by one of the following methods:
    a. Making a Social Service referral through the computer. Making a Social Service referral does not satisfy the Mandated Reporter's Duty to Report as stated in C.8 of this policy.
    b. By telephone to the Social Services department or page to a specific Social Worker.
    c. By completing an SOC 341 Elder Abuse Reporting Form and forwarding it to the hospital Social Services Office.
13. Detention of Endangered Adults - Welfare and Institutions Code Section 15703.05 allows a physician treating an adult, if he/she determines that adult is endangered, to delay the release until:
    a. A local law enforcement agency takes custody of the patient
    b. The responding agency determines the adult is not an endangered adult
    c. The responding agency takes other appropriate action to ensure the safety of the endangered adult (This law applies whether or not medical treatment is required)
14. If the patient was a victim of abuse, neglect or domestic violence (except child abuse or neglect), the patient must be promptly informed that a report has been or will be made unless:
    a. The health care provider believes, in the exercise of professional judgement, that the informing the patient would place him or her at risk of serious harm, or
    b. The health care provider would be informing a personal representative , and the provider reasonably believes the personal representative is responsible for the abuse, neglect or other injury and that informing the personal representative would not be in the best interests of the patient
    c. Verbal notification is sufficient. A report must be made even if the patient objects. The health care provider may suggest that the victim go to a protected environment due to the risk of retaliation after the report is made.
15. When appropriate, the Clinical Social Worker shall inform the patient and/or family of what actions have taken place, why they transpired, and what position the District must take in such situations as prescribed by law.
16. The Clinical Social Worker shall serve as liaison between the District and all outside agencies, in compliance with Elder/Dependent Adult Abuse statutes and the regulations and procedures of San Diego County Department of Social Services.
17. The Clinical Social Worker may continue to provide case management including discharge planning to a safe environment.
18. Any problematic cases are reported to the Director/Manager of Social Services and of Risk Management for additional review.
19. When two or more mandated reporters have knowledge or reasonably suspect a reportable incident, they can agree that a single report can be made. This can be coordinated through the Social Services Department.
20. Any person who is not a mandated reporter who knows, or reasonably suspects, that an elder or dependent adult has been the victim of abuse, may report that abuse. Such reports may be coordinated through the Social Services Department.

D. **REFERENCE(S):**

1. Adult Protective Services (SRS).
2. California Hospital Association. (2020~~3~~**4**). *California Hospital: Consent Manual*. CHA Publications: Sacramento.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 10/01 **SUBJECT: Staffing, Registry/Traveler Usage**

REVISION DATE: 03/02, 06/03, 12/03, 05/05, 05/08, 03/11, 05/14, 06/14, 08/18, 08/22

Patient Care Services Content Expert Approval:	**~~03/22~~09/25**
Clinical Policies & Procedures Committee Approval:	**~~06/22~~10/25**
Nursing Leadership Approval:	**~~07/22~~11/25**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~08/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/22**

A. **POLICY:**

1. Registry shall only be approved if the following criteria have been met:
   a. Department Leader have exhausted all available staffing resources including Per Diem, extra shifts at regular pay, overtime, and on-call staff to cover shortage.
   b. Once the above have been evaluated, Registry coverage shall be considered.
      i. Overtime for registry may only be approved by the Clinical Administrator on call.
   c. Only Registry approved for use at Tri-City Healthcare District (TCHD) shall be contacted.
   d. A current, signed letter of competence (LOC) must be on file before the registry person may work.
   e. Registry shall be evaluated and approved on a shift-by-shift basis, after staffing needs are determined.
   f. Registry staff that has been scheduled to work shall be cancelled at least two-hours before their scheduled shift if, after reassessment of staffing requirements, it is determined that they are not needed.
   g. If it is determined during the Registry assigned shift that other available resources can meet staffing needs, the remainder of the shift shall be cancelled.
      i. The registry is paid a minimum of 2 hours once confirmed to work.
2. Registry personnel are utilized at TCHD on an as needed basis.
   a. They shall follow the policies and procedures of TCHD.
   b. A TCHD staff RN shall be available on the unit as a resource.
   c. A Registry nurse may be cancelled for unsatisfactory work performance or inappropriate conduct while on duty.
   d. The agency is responsible for Registry discipline.
   e. The following shall be maintained ~~in the Staffing Resource Center:~~ **with Nursing ~~a~~Administration:**
      i. Letter of competence
      ii. Evaluations
      iii. Signed Cerner Access form
   f. All Registry personnel shall receive evaluations from the assigned unit at the end of the first ~~three~~ shift~~s~~ worked, for each new specialty area worked, and quarterly. Copies of each evaluation shall be forwarded to the appropriate Registry and a copy shall be maintained in ~~Staffing Resource.~~ **Nursing aAdministration.**

i. Registry personnel who receive poor evaluations require counseling by their Agency and improved performance. Failure to improve performance shall result in a Do Not Return (DNR) status for the specific unit or the Medical Center.

3. Traveler contracts shall be utilized at TCHD as needed.
   a. Traveler contracts and extensions must be approved by position control.
   b. They shall follow the policies and procedures of TCHD.
   c. A TCHD staff RN shall be available on the unit as a resource.
   d. Travelers shall be built into the regular unit schedule via the Staffing and Scheduling system.
      i. Overtime for travelers may only be approved by the CNE based on individual contract.
   e. A traveler RN contract may be cancelled for unsatisfactory work performance or inappropriate conduct while on duty.
   f. The Department Leader/designee is responsible for discipline while the traveler is on assignment. All issues shall also be forwarded to the agency.
   g. All items as outlined in the traveler contract shall be maintained in the designated department.
   h. All travelers shall receive evaluations from the assigned unit(s) at the end of the contract.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**07/93**	**SUBJECT:**	**Swallowing, Food and Nutrition Considerations for Patients with Oro-Pharyngeal Dysphagia**
REVISION DATE:	**06/03, 08/05, 07/07, 05/10, 05/13 01/17, 04/19, 12/22**		

Patient Care Services Content Expert Approval:	**~~08/22~~08/25**
Clinical Policies & Procedures Committee Approval:	**~~09/22~~10/25**
Nursing Leadership Approval:	**~~10/22~~11/25**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~10/22~~11/25**
Administration Approval:	**~~12/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/22**

A. **POLICY:**

1. An order for **nectar thick, honey thick, pudding thick,** ~~thick liquids, thickened liquids,~~ or no thin liquids shall be interpreted by Food and Nutrition Services staff as meals with no thin liquids until further clarification or orders are received from physician.
    a. When an order for no thin liquids is received, meals sent to the patient shall be without thin liquids. Thin liquids are defined as: water, coffee, tea, iced tea, milk, all fruit juices, and broth, broth-based soups, soft drinks, Boost, hot chocolate, ice cream, jello and milkshakes.
    b. Thickened milk and thickened juices are available and may be added to the menu.
    c. Thick liquids shall be offered, including nectar thick liquids, honey thick liquids and pudding thick liquids as determined by speech pathology recommendations **or physician determination**.
    d. Foods of mixed consistencies where one consistency is thin liquid (i.e. fruit cocktail, dry cereal with milk, vegetable soup, and pineapple chunks) shall not be included unless otherwise ordered by the physician.
    e. In cases when speech therapy is involved in the patient's care, the speech pathologist may assess the patient's tolerance of liquids and may consult with the dietician, as appropriate.
        i. Recommendations for changes to diet will be made to the physician.
    f. The dietitian shall assess the patient's status per routine assessment and evaluation. The dietitian shall update the diet order in the electronic health record as appropriate.

Tri-City Medical Center
Oceanside, California

RETIRE – due to the suspension of Women and Children's Services

PATIENT CARE SERVICES

ISSUE DATE: 12/22

SUBJECT: Team NICU Response Plan

REVISION DATE: 12/22

Patient Care Services Content Expert Approval:	~~06/22~~10/25
Clinical Policies & Procedures Committee Approval:	~~07/22~~10/25
Nursing Leadership Approval:	~~10/22~~11/25
Perinatal Collaborative Practice Approval:	~~09/22~~ n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/22~~11/25
Administration Approval:	~~12/22~~12/25
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/22

~~A. **PURPOSE:**~~

~~1. To identify the members of the neonatal resuscitation team and circumstances under which the team will be called to attend to deliveries and emergencies in Women and Newborn Units.~~

~~B. **DEFINITION(S):**~~

~~1. Team Neonatal Intensive Care Unit (NICU):~~

~~a. A neonatal resuscitation team with a designated leader that attends high-risk deliveries.~~

~~b. Team members will be competent in the current guidelines of the Neonatal Resuscitation Program (NRP).~~

~~c. Team members will consist of a neonatologist, a respiratory therapist (RCP/RRT), and a NICU Registered Nurse (RN).~~

~~i. A neonatologist and at least one other qualified team member will be present when perinatal risk factors are present.~~

~~ii. At least one member of the team will be skilled in intubation.~~

~~iii. Additional personnel may be included depending on the neonatal condition.~~

~~C. **POLICY:**~~

~~1. The team will be immediately available at all times to perform a complete neonatal resuscitation.~~

~~2. The team will be activated when there are perinatal high-risk factors. Risks may include but are not limited to:~~

~~a. Anticipated delivery of less than 36 weeks gestation or ≥ 42 weeks gestation~~

~~b. Fetal heart rate patterns suggesting hypoxia (Category III and some Category II patterns)~~

~~c. Placental abnormalities (e.g. placenta previa, vasa previa, abruption)~~

~~d. Fetal anomalies, if it is suspected that resuscitative measures may be needed (e.g. pulmonary hypoplasia, diaphragmatic hernia)~~

~~e. Multiple gestations~~

~~f. Emergency cesarean delivery or general anesthesia~~

~~g. Operative vaginal delivery (e.g. vacuum assist, forceps)~~

~~h. Prolapse of the umbilical cord~~

~~i. Suspected hydrops~~

~~j. Macrosomic fetus and/or potential for shoulder dystocia~~

~~3. A Team NICU alert is not a "code". It is to be used whenever the neonatal team is needed.~~

~~4. Team NICU is used exclusively in the Women and Newborn Services (WNS) environment.~~

~~a. Labor & Delivery (L&D) unit: The Obstetrician (OB), Certified Nurse Midwife (CNM), Anesthesiologist or L&D RN may initiate a Team NICU at any delivery.~~

b. Postpartum unit: In the event of a neonatal emergency, any staff member may initiate a Team NICU.
c. For neonatal/newborn (≤ 30 days of life) emergencies outside of WNS, a Code CALEB (overhead announcement) will be activated and the neonatal team will respond (see Code CALEB Policy).

D. **PROCEDURE:**
1. Team NICU response is triggered by dialing 66 and activating a "Team NICU".
   a. The caller will request a Team NICU and provide the location and reason for request.
   b. If it is an emergency, can be indicated by adding "911" or "STAT"
   c. Hospital Private Branch Exchange (PBX) will text message to Team NICU cell phones.
      i. Text message will appear with location.
         1) e.g. "Team NICU L&D RM 7"
         2) e.g. "Team NICU OR 1 STAT"
2. Resuscitation supplies will be readily available prior to team's arrival.
3. L&D personnel will communicate the following information to the team.
   a. NRP 8th Edition "Four pre-birth questions"
      i. Gestational age
      ii. Amniotic fluid color.
      iii. Additional risk factors.
      iv. Umbilical cord management plan
   b. Any other pertinent maternal/neonate medical history.

E. **DOCUMENATION:**
1. Neonatologist will document according to protocols.

F. **RELATED DOCUMENT(S):**
1. Women and Newborn Services Policy: Neonatal Delivery Room Attendance
2. Patient Care Service Policy: Code Caleb Response Plan

G. **REFERENCE(S):**
1. Beauman, S. S., & Bowles, S. (Eds.). (2019). Policies, procedures, and competencies for neonatal nursing care (6th ed.), Code Blue Chicago, IL: National Association of Neonatal Nurses.
2. Chang C., Perlman P., 2019. Anticipation and preparation for delivery room emergencies. Seminars in Fetal and Neonatal Medicine, 24(6). doi.org/10.1016/j.siny.2019.101031.
3. Sawyer T, Lee H. C., Aziz K., 2018. Anticipation and preparation for every delivery room resuscitation. *Seminars in Fetal and Neonatal Medicine*, 23(5), doi.org/10.1016/j.siny.2018.06.004.
4. Weiner, G.M. (Ed). (2021). *Textbook of neonatal resuscitation (8th ed.)*. American Academy of Pediatrics.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: **04/03** **SUBJECT:** **Vaccination Administration**

REVISION DATE: **06/03, 09/05, 08/08, 04/11, 12/14, 07/17, 04/22**

Department Approval:	**~~10/21~~10/24**
Clinical Policies & Procedures Committee Approval:	**~~11/21~~05/25**
Nursing Leadership Approval:	**~~11/21~~08/25**
Pharmacy and Therapeutics Approval:	**~~02/22~~09/25**
Medical Executive Committee Approval:	**~~03/22~~10/25**
Administration Approval:	**~~04/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/22**

A. **PURPOSE:**

1. National Childhood Vaccine Injury Act (NCVIA) [42 U.S.C. Sections 300aa-14 and 300aa-26, 42 C.F.R. Section 100.3] requires health care providers **to** provide Vaccine Information Statement (VIS) to a patient (or the patient's legal representative) before administering specific vaccines. The patient or the patient's legal representative must be given this information to keep and in appropriate cases, the written material is supplemented with visual presentations, oral explanations, or videotape**.**
   a. VIS are required for the following under the NCVIA
      i. Diphtheria, tetanus and pertussis containing vaccines (DTaP, DT, Td, and Tdap)
      ii. *Haemophilus influenzae* type b (Hib)
      iii. Hepatitis A
      iv. Hepatitis B
      v. Human Papillomavirus (HPV)
      vi. Influenza (both Inactivated and Live, Intranasal vaccines)
      vii. Measles-Mumps-Rubella (MMR)
      viii. Measles-Mumps-Rubella-Varicella (MMRV)
      ix. Meningococcal
      x. Novel Viral Vaccines e.g., COVID - 19
      xi. Conjugate (PCV13)
      xii. Polio
      xiii. Rotavirus
      xiv. Varicella
   b. The Centers for Disease Control and Prevention (CDC) encourages healthcare providers to provide a VIS when administering the following vaccines:
      i. Adenoviruses
      ii. Anthrax
      iii. Cholera
      iv. COVID-19
      ~~iii.~~**v. Dengue**
      vi. Japanese Encephalitis (Ixiaro)
      ~~iv.~~**vii. Mpox**
      ~~v.~~**viii.** Pneumococcal **Conjugate**~~Polysaccharide~~
      ix. Rabies
      ~~vi.~~**x. Respiratory Syncytial Virus (RSV)**

xi. Shingles
~~vii.~~**xii. Tick-borne Encephalitis (TBE)**
~~viii.~~**xiii.** Typhoid
~~ix.~~**xiv.** Yellow Fever

2. Each health care provider who administers a vaccine is required to document the following information in the patient's medical record (this includes an electronic medical record, or in a permanent log):
   a. Administration date
   b. Injection site
   c. Vaccine manufacturer and lot number of the vaccine, expiration date of vaccine
   d. Name and title of the healthcare provider administering the vaccine
   e. Address of the location (site) where the vaccine is administered~~,~~
   f. Publication date of the VIS given to the patient or legal representative and the date the VIS was given **(found on the back at the right bottom corner of the form)**~~.~~

B. **POLICY:**

1. Federal and California state laws do not require special informed consent prior to vaccination.
2. Not all vaccines are covered by the National Childhood Vaccine Injury Act, but at Tri-City Healthcare District (TCHD), appropriate VIS will be given and reviewed prior to any vaccination. The most current copies of VIS are available at http://www.cdc.gov/vaccines/ or www.immunize.org as well as on the hospital intranet on the home page under patient education.
3. If the patient has a medical record, the information is charted there. If the patient is seen and an individual chart is not constructed (i.e. flu-shot clinic) the above information is recorded in a log. Stickers or a stamp can be used to prompt the health care provider to record required information (see example below).

Vaccine	Date of Admin.	Manufacturer	Lot #	VIS Edition Date	Date VIS Given
Name/Title of Health Care Provider Administering					

4. Any adverse occurrence from administration of a vaccination must be reported. Refer to Patient Care Services: Vaccine, Reporting Adverse Events Policy and Administrative Policy: 236 Mandatory Reporting Requirements.

C. **RELATED DOCUMENT(S):**

1. Centers for Disease and Prevention (CDC). ~~2019, May 7~~**2024**~~).~~. Document the vaccinations(s). https://www.cdc.gov/vaccines/hcp/vis/about/facts-vis.html~~#law~~ **(Reviewed 2024, Oct. 28)** Centers for Disease and Prevention (CDC). **2024**~~2019~~. Facts about **VISs**~~viss~~. Retrieved from https://www.cdc.gov/vaccines/hcp/vis/about/facts-vis.html~~#law~~. **(Reviewed 2024, Oct. 28)**
2. Administrative Policy: 236 Mandatory Reporting Requirements
3. Patient Care Services: Vaccine, Reporting Adverse Events Policy

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY
DISTRICT OPERATIONS

ISSUE DATE: 02/15

SUBJECT: Clinical Product Review/ New Products

REVISION DATE: 02/15, 01/22

POLICY NUMBER: 297

Administrative Policies and Procedures Content Expert:	**~~03/21~~10/25**
Administrative Policies and Procedures Approval:	**~~08/21~~10/25**
Administration Approval:	**~~01/22~~12/25**
Finance, Operations and Planning	**n/a**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/22**

A. **PURPOSE:**

1. Establishes the requirements and process for the assessment and procurement of all new products used for or in support of patient care activities.
2. Process delineates oversight accountability, assessment and review procedures and plan for implementation of all products prior to purchase or use.

B. **SCOPE OF THE PROCEDURE:**

1. Proper adoption of new products for patient care services is considered a key principle in the support of safe patient care. The requirements established in this policy and associated procedures must be followed by all Tri-City Healthcare District (TCHD) personnel and physicians for the consideration of any new product or service, not currently in use at TCHD.

C. **DEFINITION(S):**

1. CVAT**:** Clinical Value Analysis Team. This multi-disciplinary team ~~consists of managers, educators, and frontline staff~~ from clinical departments and **leadership** ~~areas to~~ provide**s** oversight and expertise for best practice in the selection and acquisition of supplies and equipment. Utilizing a team approach along with physicians, subject matter experts, administrators and frontline users the committee functions to:
   a. Conducts clinical, infection, financial, bio-med, educational, and patient safety review of new products and equipment.
   b. Ensures supplies, equipment and new technologies meet/exceed TCHD standards as they relate to regulatory or biomedical engineering requirements.
   c. Reviews existing supplies and equipment to identify potential opportunities for standardization and or cost savings.
2. Suppliers: A person who provides sales or sales support of products or services to TCHD. Examples of suppliers include but are not limited to representatives of equipment, supply, or medical materials.
3. Vendors: A person who provides contracted services to departments or patients at TCHD. Examples of vendors include but are not limited to registry and supplemental staff, equipment repair, or educational training staff.
4. Physicians: Medical Staff practicing at TCHD may be independent contractors/non-employees or under contract to provide services for the Health District. The group includes: Doctor of Medicine/Doctor of Osteopathic Medicine/Doctor of Dental Science/Doctor of Dental Medicine/Doctor of Optometry/Nurse Practitioner/Physician Assistant.

5. Patient Care Services: All departments that provide patient service or care, to include but not limited to: all patient care areas, physical therapy, dietary, environmental services, linen, security, facilities, clinical services, bio-med, sterile processing.
6. Supply Chain Management**:** Serves as the coordinator of the CVAT review process and will be the functional experts for defining and determining what is considered a new product here at TCHD~~.~~

D. **PROCEDURE:**

1. Product Adoption Process: All personnel requesting a product for use in patient care services are expected to ~~follow the Product Adoption Process.~~ **follow the CVAT process.**
2. Department Director/Managers Responsibilities**:** Review and determine if the new product/equipment fits their department needs and the strategic plan or needs of the organization.
3. Departments requesting a new clinical product or device complete the Request for Clinical Product Review form found on the TCHD intranet.
4. The completed form will be sent to Supply Chain Management for analysis.
    a. If this is a non-physician preference item, the process will continue to CVAT.
    b. If this is a physician preference item, the request will be forwarded to the appropriate service line administrator and the Medical Staff Manager/Director.
5. Physician Use Items: Supply Chain Management will notify The Medical Staff Manager/Director of the date/time of the CVAT Meeting in which the new product/device will be reviewed. The Medical Staff Manager/Director will receive an invitation to attend that CVAT Meeting and facilitate evaluation of physician competency and privileging prior to utilization of equipment.
6. Supply Chain Management will contact requestor with results of analysis and/or provide at the next CVAT meeting occurrence.
    a. Requestor attending CVAT meeting will complete the Request for Clinical product Review Checklist prior to attending meeting and will bring that checklist to the meeting.
    b. Requestor must attend the CVAT meeting for product consideration.
        i. If unable to attend CVAT meeting, a knowledgeable substitute may attend or the request may be postponed until the following month.
7. Request will be presented at the CVAT meeting. CVAT may approve or deny the request.
    a. If request is denied, additional information can be investigated by the requesting department and resubmitted at a later date.
    b. If request is approved, the determination will be made at that time if a product trial is necessary or if the item may be put into immediate use.
8. If no trial is needed, the Education Department will determine if product training is required. Supply Chain Management will begin the product procurement process and implementation.
9. If a trial is needed, the Education Department will be contacted to initiate staff training and product use through interaction with Supply Chain Management, the vendor, and/or supplier.
    a. Results of the trial will be presented at a subsequent CVAT meeting for approval or denial.
        i. If denied, the requesting department can obtain additional information for resubmission at a later date.
        ii. If approved, Supply Chain Management will begin the product procurement process and rollout. Education will work with the vendor and/or supplier for a complete education plan upon product implementation.
10. ~~Adoption~~ Process Exemption**:** Products and Services exempt from the **CVAT** ~~new product adoption~~ process must meet Biomedical Engineering, Supply Chain Management contractual agreements, and end-user educational requirements prior to use and must meet the criteria for exemption below:
    a. The new item add request is for a bill only or a charge number request
    b. Equipment replacements due to loss or repair issues
    c. Substitutions due to manufacturer backorder (department leaders responsible for final approval, education and use)

d. Loaner units that are borrowed via an equipment manufacturer, supplier, or another hospital. This is usually introduced due to clinical needs because their unit is broken.

11. Urgent requests: In circumstances of an urgent situation, which is defined as a request needing to be reviewed within less than 72 hours before use or a physician has an urgent situation that requires the use of an unapproved product; the department must contact Supply Chain Management.

E. **FORM(S):**

1. Request for Clinical Product Review ~~Form -~~ Sample

~~1.~~**2. Request for Clinical Product Review CHECKLIST - Sample**

~~Request for Clinical Product Review Form – Sample~~

Tri-City Medical Center

Request for Clinical Product Review

The purpose of this form is to request review and evaluation of a new or alternate product. Please complete this form and submit to Supply Chain Management. All requests will be reviewed by the Clinical Value Analysis Team.

Date of Request: _____

Requestor: _____ Product Name: _____

Department: _____ Sales Rep Contact Name: _____

Extension: _____ Sales Rep Contact #: _____

Vendor: _____ Manufacturer Rep: _____

Manufacturer: _____

Reason for Request:

❑ Regulatory Requirement ❑ Patient Safety ❑ Improves Quality / Outcomes

❑ Improve Efficiency ❑ Cost Savings ❑ Other: _____

Product description and function: _____

_____

Please explain the improvements noted above (attach literature, if appropriate): _____

_____

Indicate anticipated usage per month: _____

Indicate areas to use this product:

❑ Acute Care Services ❑ Critical Care Services ❑ WCS ❑ Ancillary Services

❑ Emergency Services ❑ Surgical Services ❑ Other: _____

Will this product replace a currently used product? ❑ Yes ❑ No

Current Product: _____ Manufacturer: _____ Manufacturer Item No.: _____

To be completed by Supply Chain Management

Current Product: _____ MMIS Item No: _____

Cost $ _____ Packaging: _____ Monthly Usage: _____ GPO Contract: _____

Proposed Product: _____

Cost $ _____ Packaging: _____ Monthly Usage: _____ GPO Contract: _____

ECRI Cost Range: _____

8402-8030 (11/13)

Tri-City Medical Center

Request for Clinical Product Review - CHECKLIST

The purpose of this form is to request review and evaluation of a new or alternate product. Please complete this form and submit to Supply Chain Management. All requests will be reviewed by the Clinical Value Analysis Team.

PRODUCT NAME: _____

REQUESTOR: _____ EXT: _____

DEPARTMENT: _____

In order to facilitate this request for the Clinical Value Analysis Committee, the items below need to be reviewed and approved by the appropriate department

Has the product been assessed/reviewed by:

- ❑ GAP Analysis performed for tubing misconnection
- ❑ Infection Control
- ❑ IT (computer/software related)
- ❑ Risk/Patient Safety
- ❑ Engineering (room modification/air handling)
- ❑ SPD

Is this new product disposable or reusable? _____

Does the new product require any additional consumable to utilize it? _____

If yes, provide product information: _____

Will this product require educational training? _____

What resources will the vendor provide for product education and final implementation? _____

_____

FOR ALL REQUESTS SUBMITTED FOR CLINICAL VALUE ANALYSIS PLEASE ATTACH BROCHURE, PRODUCT RESEARCH AND ANY EVIDENCE BASES ARTICLES / WHITE PAPERS

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: 08/11 **SUBJECT:** Legal Documents

REVISION DATE~~(S)~~: 10/14, 10/15, 08/18 **POLICY NUMBER:** 8610-294

~~Department Approval~~**Administrative Content Expert Approval:**	~~07/18~~10/25
Administrative Policies & Procedures Committee Approval:	~~08/18~~10/25
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~08/18~~12/25
Professional Affairs/Finance & Operations Committee Approval:	n/a
Board of Directors Approval:	08/18

A. PURPOSE:

1. This policy enables Tri-City Healthcare District (TCHD) to comply with procedural deadlines for responding to legal documents, by ensuring TCHD is sufficiently informed of legal proceedings against it. This policy identifies the proper protocols for service of legal documents for TCHD and its employees.
2. Employees who improperly handle, including damaging or discarding original packaging of said legal documents, could disadvantage TCHD in legal proceedings and may be subject to discipline for violating this policy.
3. Except as provided herein, TCHD employees or volunteers must not accept legal documents on behalf of TCHD or any TCHD employee, physician, or independent contractor.
4. All inquiries regarding this policy shall be directed to TCHD's Legal Department.
5. All envelopes must be saved with the document.

B. SUMMONS, COMPLAINTS, GARNISHMENTS AND SUBPOENAS:

1. Definitions:
   a. Summons – a legal document that notifies an individual or entity that a lawsuit has commenced and the individual or entity must respond.
   b. Complaint – a legal document that sets forth the claims in a lawsuit and relief sought.
   c. Garnishment – an order issued by a court declaring that money or property (usually wages) be seized to pay a debt.
   d. Subpoena – an order issued by a court or attorney for the production of records, documents, or tangible things, or for the appearance of a person at a deposition or in court and/or trial.
   e. Deposition – a proceeding in which an individual provides out of-court testimony under oath.
   f. Human Resources- Subpoena of employment records.
   g. Service – the process of delivering legal documents.
   h. Process Server – an individual who serves legal documents upon a person or entity.
2. Accepting Service of Summons, Complaints, Garnishments and Subpoenas:
   a. Process Servers seeking to serve legal documents will be directed first to Security who will **contact** ~~escort Process Server to a TCHD's Risk Management Department or~~ **the** Legal Department Designee for acceptance of Service. Designees include:
      1. Legal Department receives all subpoenas
      2. **Legal Department** ~~Risk Management~~ ~~Department~~ receives all Complaints, Government Claims, and Notice of Intent. ~~If Risk Management is not available, will forward to the Legal Department~~

b. Once Security is present, TCHD Legal Department Designee shall accept any Subpoena from a Process Server on behalf of TCHD including Subpoenas directed to Persons Most Knowledgeable or Persons Most Qualified at TCHD.
   1. Legal Department Designee will forward Subpoenas for medical records and patient bills to the Medical Records Department.
   2. Legal Department Designee will forward Subpoenas for employee records to Human Resources.
   3. Legal Department Designee will forward Garnishments and Subpoenas for payroll documents to the Payroll Department.
   4. Legal Department Designee will forward Subpoenas for Human Resources.
   5. All departments will report back to Legal Department once they have complied with the subpoena.

c. Legal Department Designee and Security staff shall not accept any Summons, Complaint, Garnishment or Subpoena on behalf of the Medical Staff, including Medical Board Subpoenas for credentialing. Documents to be served on physicians or Allied Health Professionals (AHP) that is not a TCHD employee.

d. Legal Department Designee or Security staff shall not accept any Summons, Complaint, Garnishment or Subpoena on behalf of the Tri-City Hospital Foundation.

e. Legal Department and staff, and Risk Management, shall not accept any Summons, Complaint, Subpoena, or Government Claims mailed an Independent Contractor.

f. All mail or subpoena with Attention to: The Board of Directors or Tri-City Healthcare District shall be directed to CEO Executive Assistant. If she/he is not available, direct to Legal Department.

g. Under no circumstances are Process Servers allowed onto patient care floors or into patient care areas for the purpose of serving Legal Documents.

h. In keeping with other TCHD privacy policies, TCHD employees must not provide information about other employees, physicians/AHP or independent contractors to Process Servers. This includes information about the employees', physicians'/AHP's, or independent contractors' shifts, department of employment, home address, home, cellular or office telephone number, or TCHD email address.

i. A Process Server who attempts service of a Summons, Complaint, Garnishment or Subpoena against an employee, physician/AHP, or independent contractor, or a Subpoena that requires the appearance of a physician/AHP, or independent contractor, shall be informed of TCHD's policy against the acceptance of such documents, asked to leave the premises, and escorted from the premises by Security if he or she refuses to leave voluntarily. If necessary contact the local Police Department.

C. GOVERNMENT CLAIM(S):

1. After the Legal Department determines whether a valid claim was brought against a public entity and whether the claim is within the specified time requirements, a claim must be presented to the public entity according to California Government Code section 915, either by delivering it to or mailing it to the: clerk, secretary, or governing body. (The secretary is defined as the Secretary of the Board of Directors).
2. A mailed claim is considered to be presented and received at the time and date the claim is deposited in the mail.
   a. Any other TCHD employee who receives a claim for money or damages that is not a Summons, Complaint, Garnishment or Subpoena, shall be directed to the Legal Department.
3. As provided in Board Policy 14-026, only the office of the Chief Executive Officer (CEO) may accept requests for public records**.** A Public Record Request Form shall be provided to those who wish to submit a public record request. The requestor must submit Public Record Request **~~(PRA)~~** Form to the CEO. See Board Policy No. 14-026**. The Legal Department handles all Public Record Request in accordance with the Public Records Acts (PRA~~s~~).**

D. FORM(S):

1. Public Record Request Form

E. RELATED DOCUMENT(S):

1. Board of Directors Policy #14-026 – Request For Inspection of Public Records Policy
2. Medical Records Policy: Release of Information Pursuant to a Subpoena

F. REFERENCE(S):

1. California Government Code Section 915, California *Government Code* section 915(a), California *Government Code* section 915.2(a)

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: **07/91** **SUBJECT:** **Mandatory Reporting Requirements**

REVISION DATE: **12/91, 11/94, 02/95, 03/96, 04/97, 07/99, 06/02, 05/03, 07/09, 06/11, 03/15, 09/17** **POLICY NUMBER:** **8610-236**

Department Approval:	**~~05/21~~10/25**
Administrative Policies & Procedures Committee Approval:	**~~08/21~~10/25**
Organizational Compliance Committee Approval:	**~~10/22~~ n/a**
Administration Approval:	**~~11/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**11/22**

A. **PURPOSE:**

1. To objectively and systematically monitor and evaluate quality and appropriateness of patient care, pursue opportunities to improve patient care, assure patient safety and resolve identified quality/risk issues on an ongoing basis.
2. To identify and prevent injury, actual or potential, harm to a patient**, workforce member,** or visitor of Tri-City Health Care District (TCHD).
~~2.~~**3.** **To** ~~Incident reporting~~ enhance~~s~~ the quality of patient care and reduces healthcare and medical liability **by implementing processes for reporting patient safety incidents that are preventable**.
~~3.~~**4.** This policy~~/procedure~~ consists of the following areas for reporting including but not limited to**:** (see the **Never Events Reporting Guide Reference)**.~~Reporting Grid and the National Quality Forum List of Serious Reportable Events – 2011 for additional reporting areas):~~
   a. Adverse Events
   b. Sentinel Events
   c. Serious Reportable Events
   d. Unusual Occurrences ~~(Title 22)~~
~~4.~~**5.** For Violence Against Hospital Personnel – see Administrative Policy: **Workplace Violence 463**~~Assault and Battery Reporting Process - 241~~.

B. **DEFINITION(S):**

1. Adverse Events **or Series of Adverse Events**: A patient safety event that result**ed** ~~s~~ in harm to a patient**. An adverse event may or may not result from an error. Examples may include** ~~including~~ surgical events, product or device events, patient protection events, care management events, environmental events, and criminal events**, events that caused the death or serious disability of a patient, personnel, or visitor.** ~~.~~
2. Root Cause Analysis - ~~is a~~**A** process for identifying basic or causal factor(s) underlying variation in performance, including the occurrence or possible occurrence of a sentinel event.
3. Sentinel Events: **A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of the duration of harm, permanent harm ~~(regardless of~~ or severity of harm). Sentinel events are subcategory of adverse events** Sentinel events are events that signal the need for immediate investigation and response. ~~A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm~~. Sentinel events are a subcategory of adverse events.

4. Serious Reportable Events (SREs): ~~a~~**A** set or compilation of serious, largely preventable, and harmful clinical events, designed to help the healthcare field assess, measure, and report performance in providing safe care. SREs are developed by the National Quality Forum.~~.~~
5. Unusual Occurrences ~~(Title 22):~~ Any occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence with threatens the welfare, safety or health of patients, personnel or visitors.
6. Violence Against Hospital Personnel: ~~a~~**A**cts of assault or battery against on-duty hospital personnel.

C. **POLICY:**

1. It is the District's policy to investigate any sentinel event, unusual occurrence, adverse event, or serious reportable even from an interdisciplinary perspective and take action to reduce the risk of recurrence.
   a. Each sentinel event, adverse event, and serious reportable events will be reviewed to determine if a more intensively assessment review is required through the use of the Root Cause Analysis (RCA) process.
   b. Every effort will be made to include the physicians and staff involved in the incident in the RCA process.
   c. A report of each RCA shall be communicated to the Quality Assurance~~/~~ Performance Improvement (QA~~/~~PI) and Patient Safety Committee ~~(/PS)~~ of the Medical Staff, for periodic reporting to the Board of Directors.
   d. RCAs shall not be reported to any external agency or organization, except upon specific, written advice of legal counsel. The investigation and reporting process, including development of the RCA, is intended to remain within the bounds of Attorney-Client and Attorney Work Product privileges.

D. **REPORTING TIMEFRAMES:**

1. The first person to identify an incident will notify his/her supervisor as soon as it is safe to do so.
   a. The supervisor must assure that the incident is reported to ~~the Risk~~**the Risk** Management Department, Chief Nurse Executive (CNE) ~~/ Chief of Patient Care Services (CPCS)~~, and ~~-~~Regulatory Compliance.
   b. The CNE ~~/CPCS~~ will **ensure**~~assure~~ that the **incident**~~event~~ is**:**
      ~~a.~~**i.** ~~then r~~**R**eported to the Chief Executive Officer (CEO) prior to reporting to regulatory agencies**, if time permits per regulations.**~~.~~
      ~~2.~~**ii.** The patient's primary and/or involved physician(s) is notified.
2. Based on the **event and regulatory requirements,** ~~incident, a decision will be made to report to the~~ **the** appropriate regulatory agency within the required timeframe.
~~3.~~

E. **COMMUNICATION:**

1. Reported incident**s**~~s~~ are communicated to the appropriate medical staff Quality Review committees and the Board of Directors.
2. Incidents may be reported in an expedited manner by Administration via verbal or electronic methods.

F. ATTACHMENT(S):

~~F.~~**1. Never Events – Reporting Guide Reference**
~~1. Reporting Grid~~

G. **RELATED DOCUMENT(S):**

1. Administrative Policy: **Workplace Violence 463**~~Assault and Battery Reporting Process 241~~

H. **REFERENCE(S):**

1. National Quality Forum. (202~~0~~**5**). Serious reportable events. Retrieved from http://www.qualityforum.org/topics/sres/serious_reportable_events.aspx
2. California Health and Safety Code **Section 1279.1 Reportable events~~s~~. Retrieved from California Health and Safety Code section 1279.1 (2025)**~~https://codes.findlaw.com/ca/health-and-safety-code/ unu~~
3. California **Code of Regulations (CCR). Title 22**
   a. **§70736. Sterilization Reporting Requirements**
   b. **§70970. Applicability e.g., to report events**
   c. **§70972. Adverse Event Reporting Requirements**
   d. **§70974. Adverse Events – Policies and Procedures**
   e. **§72541 Unusual Occurrences**

~~3. Title 22; §72541 Unusual Occurrences,~~
~~4. CA Health & Safety Code §§ 1279.1, 1279.2, 1279.3, and 1280.4~~

~~5.~~**4.** California Code of Evidence Section 1157
~~6.~~**5.** California Hospital Association Consent Manual
~~7.~~**6.** California Title 17 Code of Regulation $2500~~-~~ - Reporting to the Local Health Authority
~~8. Title 22, Section 70736~~

Never Events Reporting Guide

Tri-City Medical Center

Never Events

What are Never Events? Patient Safety incidents that are preventable and so serious they should never happen.

Surgical or Invasive Procedural Events

- Surgery or other invasive procedure performed on
  - The wrong site
  - The wrong patient
- Wrong surgical or other invasive procedure performed on a patient
- Unintended retention a foreign object in a patient after surgery or invasive procedure
- Death during or up to 24 hours after induction of anesthesia after surgery on a normal, healthy patient

Product or Device Events

- Patient death or serious injury associated with the:
  - Use of contaminated drugs, devices, or biologics
  - Use or function of a device in patient care for functions other than as intended by manufacturer
  - Intravascular air embolism
  - Administration of blood or blood products incompatibilities, hemolytic reactions

Patient Protection Events

- Discharge or release of a patient of any age, who is unable to make decisions, to an authorized person
- Patient death or serious injury associated with patient elopement (disappearance)
- Patient suicide, attempted suicide, or self-harm that results in serious injury

Potential Criminal Events

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
- Abduction of a patient of any age
- Sexual abuse/assault on a patient or staff member within or on healthcare grounds
- Death or serious injury of a patient or staff member resulting from a physical assault
- *Verbal violence

Environmental Events

- Patient or staff death or serious disability associated with
  - An electric shock during patient care
  - A burn incurred from any source
- Patient death or serious injury with the use of physical restraints or bedrails
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances
- Fire, flame, unanticipated smoke, heat, or flashes cause by equipment during patient care

Radiologic Events

- Death or serious injury of a patient or staff associated with metallic objects brought into the MRI area (i.e., prohibited zone)
- Delivery of radiotherapy to the wrong patient, wrong body region, unintended procedure or radiotherapy dose >25% above planned

Care Management Events

- Patient death or serious injury associated with
  - A medication error
  - Unsafe administration of blood products
  - A fall resulting in:
    - Fracture, surgery, casting, or traction
    - Blood transfusion
    - Neurological consult/management
    - Death or permanent harm
  - Spinal manipulative therapy performed at the health facility
  - Maternal death or serious injury associated with labor or delivery in a low pregnancy
- Death or serious injury of a neonate associated with labor or delivery in a low risk pregnancy
- Laboratory
  - The irretrievable loss of an irreplaceable biological specimen
  - Failure to follow up or communicate laboratory, pathology, or radiology test results
- Stage 3, stage 4, and unstageable pressure ulcers acquired after admission
- Artificial insemination with the wrong donor sperm or wrong egg

"Never Events" listed within this document are reportable to the California Department of Public Health per California Code, Health & Safety Code (HSC) §1279.1 & Title 22 (Exceptions = *)

5/2021, Update 3/2022, 10/2024, 8/2025

Reporting Grid

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Adverse Drug Reaction (ADR)	ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting	Attending Physician/Investigational Drug Pharmacists/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial/Clinical Research Coordinator	Clinical Trial Site/Principal Investigator of Clinical Trial, Sub Investigator of Clinical Trial/Clinical Research Coordinator	All ADRs must be documented in the research participants medical and research record.	Policy: Clinical Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010
Adverse Event (AE)	ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting	Attending Physician/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial/Clinical Research Coordinator	Clinical Trial Site/Principal Investigator of Clinical Trial, Sub Investigator of Clinical Trial/Clinical Research Coordinator	Aes are to be captured in the case report forms and as part of the medical records. There are no special reporting requirements for AEs at TCMC.	Policy: Clinical Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010
Animal Bites		Emergency Department, Business Office	Humane Society	Phone Call	Emergency Dept.
Assault & Battery to On-Duty Health Care Personnel	A.B. #508 CA Penal Code # 240,242	Security Department	Local Law Enforcement Professional & Regulatory Services (P&RS), Employee Health, Dept. of Health	Phone Call within 72 hours of occurrence. Employee Injury Report	Admin. Policy #241
Assault Victims Domestic Violence	CA Penal Code 11160/11161 CCR Title 11, Section 920	Emergency Department, Business Office Registrars, Social Service Department, Nursing Staff, Security, Risk Management	Local Law Enforcement	Phone police immediately and written report - 2 working days	Admin. Policy #310
Cancer/Reportable Neoplasms	Title 17, California Code of Regulations, Section 2593	Oncology Data Registrar	California Department of Public Health (CDPH) Cancer Prevention Section	Within six months of diagnosis	Oncology Registry/CNE
Certification of Birth	Health and Safety Code Section 10101	Birth Certificate Clerk Medical Records Department	San Diego County Registrar	Within 10 days of birth	Medical Records Dept.

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
(Suspected) Child Abuse	Penal Code: 11164-11174.3	Social Service Department Health Practitioner, Child Care Custodian	Child Protective Services or Local Law Enforcement	Immediately by Phone And Within 36 Hours in Writing	Admin. Policy #308 Social Service Dept. #308
Chromosomal Defects in Fetus or Infant	Title 17 CCR 6532	Lab performing the analysis or physician making diagnosis	CDPH	Within 30 days of diagnosis using form provided by CDPH	Women's & Children's Services
(Illegal) Drug Use - non employee	CA Penal Code, Section 11-160	Security Dept.	Oceanside Police	Telephone and written report	Admin. Policy #236
(Suspected) Elder and Dependent Adult Abuse	Penal Code: Section 368 Welfare & Institution Code #15600--15637	Social Service Department Health Practitioner, Care Custodian	Occurring in a LTC Facility report to Long Term Care Ombudsman or Local Law Enforcement; All others to County Adult Protective Services	Telephone Report-Immediately Written Report-Within 2 Working Days	Admin. Policy #309 Social Service Dept. #309
Infectious Diseases (Reportable *) (See Reporting Responsibility Table)	Title 17, Chapter 4, CCR 2500 Health & Safety Code 3125	Nursing Staff Emergency Department, Infection Control Practitioner, Laboratory - Microbiology & Chemistry	Infection Control Practitioner Public Health Department	Phone immediately to Public Health depending on disease. Fax information to Public Health using PM 110.	Infection Control #110
Lapses in Consciousness/Seizures	Health & Safety Code 3125 Section 410 Title 17, CCR 2500	Physician	Local Health Officer who reports to DMV	Fax information to Public Health using PM 110.	Physician Protocol
Mental Health holds beyond 24 hours (ED) (Unusual Occurrence)	Title 22 Section 70737, 71535	Health Care Practitioner Administration Manager Emergency Department	CDPH	Phone after 24 hour mark followed by letter to CDPH	Emergency Dept., Mental Health Unit
Missing Patient		Security Department	Local Law Enforcement Agencies	Telephone immediately within reasonable time frame (given situation)	Admin. Policy #305
Multiple bee stings (Unusual occurrence)	Title 22 CCR 70737	Emergency Department Nursing Staff	County of San Diego, CDPH	Phone call immediately to CDPH written report	Admin. Policy #228
Needle stick Injury/BS Exposure	Fed and Cal OSHA Rec. Blood borne Path.	Supervisor	Employee Health or ED	Immediate Supervisor Investigative Report. Employee Health uses separate injury log for needle sticks.	Employee Health Services/ Infection Control

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Neural Tube Defects in a Fetus	Title 17, California Code of Regulations, Section 6531	Medical Records Department	CDPH Alpha-Feto Protein Screening Program	Within 30 days of initial diagnosis	Women's & Children's Services
Newborn Abandonment: Voluntary surrender (abandonment of newborns up to 72 hours old)	SB 1368	Health Care Practitioner	Child Protective Services	As soon as possible; no later than 48 hours	Admin. Policy #380
Newborn Screening Test refusal (PKU)		Women's & Children's Services Representative	CDPH Genetic Disease Branch	Prior to infant discharge Fill out form #NBS-PR	Women's & Services
Occupational Injuries/Illnesses	Labor Code 3209.3 CCR Title 8 S - 14003	Physician	Employer & Employees Insurer	Written Report within 5 working days	Physician Protocol Employee Health Services
Outbreaks or undue prevalence of infectious or parasitic disorder	Title 17, Chapter 4 CCR 2502	Any healthcare provider (physicians, PA, RN, nurse midwife, or Infection Control Practitioner)	Local Health Officer	Phone, fax or mail information to Public Health using the CMR form found in the IC Manual.	Infection Control #IC.12
Patient Death	Title 22 72549 HSC 10250	Health Care Practitioner; Physician	Medical Examiner CDPH at a time and manner as requested, Pt. Reps – TCMC	Phone immediately Complete form 8720-37	PCS Policy IV.Z, PCS Procedure
Patient death due to unusual circumstances, i.e. suicide	Title 22 Section 70737, 71535	Health Care Practitioner Administration	Local law enforcement officer, medical examiner and CDPH. CMS and regional CDPH	Local law enforcement contacted prior to medical examiner. CDPH as soon as practical confirmed in writing. Incident report on file by facility for 1 year.	Admin Policy #228 PCS Policy IV.Z, PCS Procedure
Patient death while patient in seclusion or restraint for behavior management	42 CFR Section 482.13(f)(f) Reporting is required whether or not R/S was the cause of death Title 22, CCR Section 70737(a) Section 71535	Director of Regulatory Compliance	Centers for Medicare and Medicaid Services (CMS) CDPH	As soon as aware. By telephone: (415) 744-3726 or fax (415) 744-2692	Admin Policy #228 PCS Policy IV.Z, PCS Procedure

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Patient death while in medical surgical restraint	Title 22, CCR, Section 70737(a) Section 71535	Director of Regulatory Compliance	CDPH	As soon as reasonably practical, by phone: (800) 824-0613 Followed by letter: 7575 Metropolitan Drive Suite 104 San Diego, CA 92108	PCS Policy IV.Q
Patient Injury/Death due to Device Malfunction	Safe Medical Device Act 21 CFR 803	Health Practitioner Director of Risk Management	MFR Serious Injury FDA&MFR-Death or FDA if MFR is unknown	Within 24 hours via form FDA3500A and phone 301-796-6670. E-mail: MDRPOLICY@FDA.HHS.GOV Annual Summary of Medical Device Related Death and Serious Injury Report to FDA on Form FDA 3419 by January 1st of each year as described in 803.33	Admin. Policy #201
Patient Transfer Violation	(COBRA) Health and Safety Code 1317 through 1317.99 Title 42 U.S.C. Section 139 dd	Director of Regulatory Compliance	CDPH HCFA	7 days 72 hours	Admin. Policies 228, 506; PCS Policy VI.D
Pesticide Poisoning	Title 8 CCR 14003	Emergency Department Health Care Practitioner	Emergency Department Mgr. Local Health Officer Co. Dept. of Agric. Deputy Agricultural Commissioner	Phone call within 24 hours	Emergency Dept.
PKU Specimen not obtained		Unit Representative where infant was a patient	California Department of Public Health Genetic Disease Branch	When patient transferred, expires Fill out form # (BS - No - 90)	Women's & Children's Services
Rhesus Hemolytic (RH) Disease – Newborn	Title 17 CCR Section 6510 Title 22 CCR 70737	Health Care Practitioner	CDPH - Women's & Children's Services Office physician who made diagnosis	Use reporting form "A case report of RH Disease of Newborn"	Women's & Children's Services
Reye Syndrome	HSC Section 304.5	Attending Physician	CDPH	Within 7 days of diagnosis using reporting form "CBC Reye Syndrome..."	Physician Protocol

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Serious Adverse Event (SAE) as related to Clinical Research	ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting	Attending Physician/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial	Clinical Trial Site/Principal Investigator/Sub Investigator/Clinical Research Coordinator	Report Immediately to Attending Physician and Clinical Trial Site personnel. All SAEs must be documented in the research participants medical and research record.	**Policy: Clinical** Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010
Threat to kill	Tarasoff	Psychotherapist/Health Care Practitioner	Intended victim and local law enforcement	Immediately by telephone	Behavioral Health Unit, Social Service Dept.
Unusual occurrences that threaten the welfare of the patient, staff or visitors (i.e., allegation of staff sexual misconduct)	Title 22 Section 70737, 71535	Health Care Practitioner Administration Director of Regulatory Compliance	CDPH Local law enforcement as appropriate	As soon as reasonably practical - confirmed in writing Occurrence on file by facility for 1 year	Admin. Policy #228
Adverse effect of a vaccine	National Childhood Vaccine Injury Act	Health Care Provider	VAERS Hotline 800-822-7967	After administration by telephone	Infection Control

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATION

ISSUE DATE: **06/94** **SUBJECT:** **Parking Program**

REVISION DATE: **09/02, 03/03, 07/04, 12/05, 04/08 09/10, 08/14, 06/17, 06/20, 11/20** **POLICY NUMBER:** **~~8610-~~261**

Administrative Content Expert Approval:	**~~07/23~~09/24**
Administrative Policies & Procedures Committee Approval:	**~~10/23~~06/25**
Environmental Health and Safety Committee Approval:	**~~01/24~~11/25**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~02/24~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/24**

A. **PURPOSE:**

1. To provide adequate parking for patients and visitors by defining Tri-City Healthcare District's (TCHD) parking program.

B. **POLICY:**

1. All TCHD Board Members, Medical staff, Executives, Directors and authorized administrative staff may park in the Medical Staff parking area.
2. Employees shall park in designated employee parking areas (Refer to Tri-City Healthcare District Parking Map).
   a. Employees or others who use a b**icycle**~~ike~~ as their mode of transportation shall park and secure bi**cycles**~~kes~~ in the designated bi**cycle**~~ke~~ parking areas.
   b. Volunteers may park either in reserved volunteer parking areas or in employee parking areas.
3. Construction personnel shall receive parking instructions from the Engineering Department during their orientation.
4. Non-compliance with parking standards results in the issuance of a Security Department Parking Violation.
   a. The department manager shall be notified if an employee receives a ~~second~~ parking violation. ~~**The**~~ Corrective action ~~follows Administrative Policy, Coaching and Counseling for Performance Improvement.~~**is outlined on the ~~attached~~Parking Violations Enforcement Guidelines.**
5. The designated speed limit on campus is 15 MPH unless posted otherwise.

C. **RELATED DOCUMENT(S):**

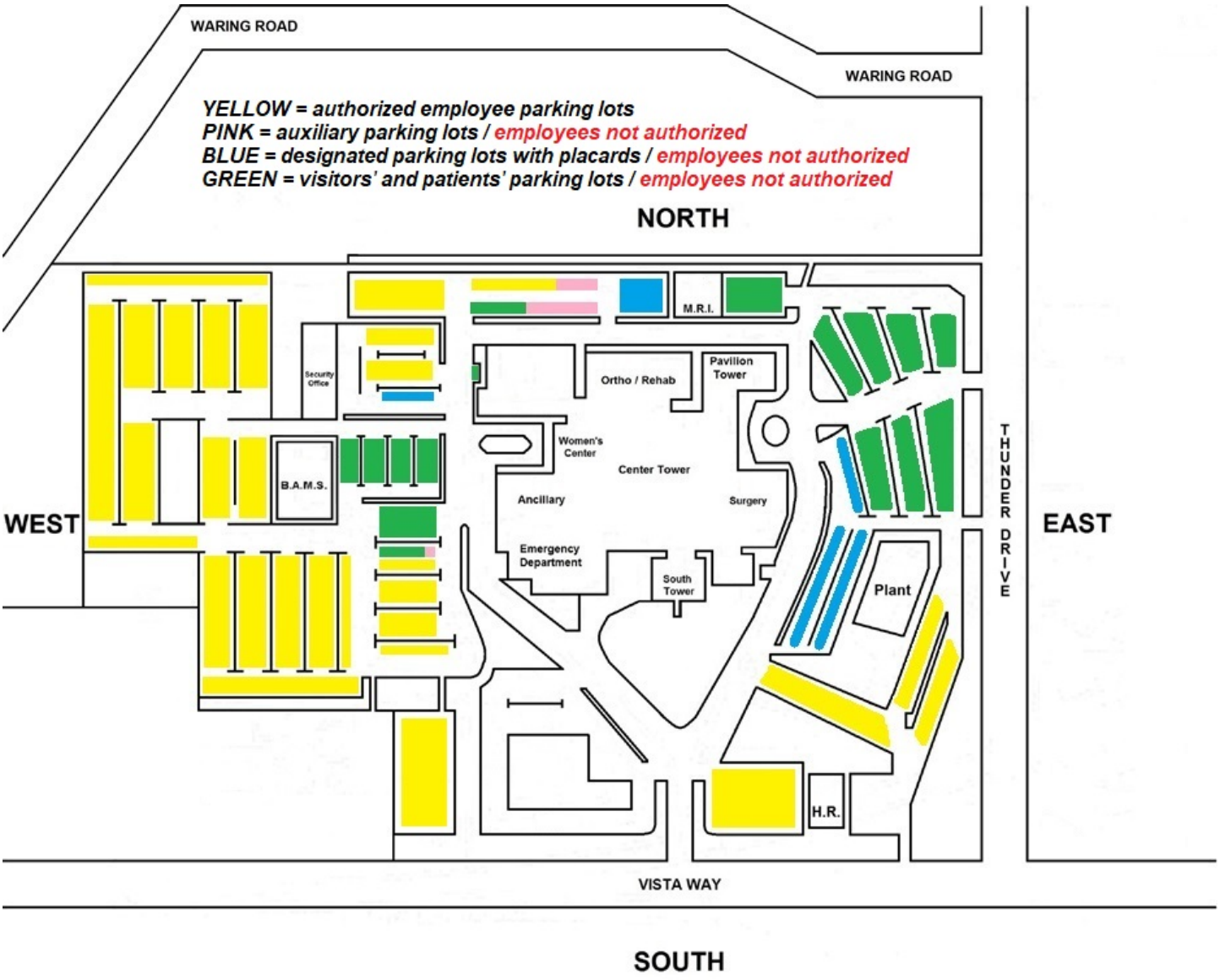
1. Tri-City Healthcare District Parking Map
2. **Parking Violations Enforcement Guidelines**

PARKING VIOLATIONS – ENFORCEMENT GUIDELINES

Parking violations will be tracked using a 12 consecutive month period.

Number of Parking Violations	Action
1	1st Employee Notification
2	2nd Employee Notification
3	Employee's Manager/Supervisor will be notified
4 or greater	HR Intervention

Parking Map


WARING ROAD
WARING ROAD
YELLOW = authorized employee parking lots
PINK = auxiliary parking lots / employees not authorized
BLUE = designated parking lots with placards / employees not authorized
GREEN = visitors' and patients' parking lots / employees not authorized
NORTH
M.R.I.
Security Office
Ortho / Rehab
Pavilion Tower
Women's Center
Center Tower
B.A.M.S.
Ancillary
Surgery
WEST
EAST
THUNDER DRIVE
Emergency Department
South Tower
Plant
H.R.
VISTA WAY
SOUTH

Tri-City Medical Center

Quality Assessment
Performance Improvement (QAPI) Plan
~~2023 &~~ 2024 & 2025

A. **INTRODUCTION:**

1. Tri-City Medical Center (TCMC) is a community owned and operated California District Hospital. TCMC is a full service, acute-care hospital and includes an Inpatient Rehab, Home Health Services, Outpatient Behavioral Health, Inpatient & Outpatient Physical/ Occupational/ Speech/ Wound Therapy Services, Orthopedic and Primary Care Clinics. TCMC embraces a culture of excellence, safety and continuous improvement. Governance, leadership, frontline staff and the organized medical staff work together to promote a culture of safety and reliability. The goal is to have a culture characterized by teamwork with open discussion about quality and safety with a particular focus on systems and processes, supported by robust data and benchmarking.

B. **MISSION:**

1. Mission: To advance the health and wellness of the community we serve.
2. Vision: Be recognized as a healthcare system of choice in our community.

C. **VALUES**

1. The needs of our patients come first.
   a. Quality
   b. Caring
   c. Innovation
   d. Safety
   e. Integrity
   f. Stewardship

D. **CULTURE OF SAFETY**

1. A patient safety culture can be defined as the shared values, beliefs, norms, and procedures related to patient safety among members of an organization, unit or team. Patient safety is an organization-wide, integrated and coordinated approach designed to avoid injuries to patients from the care that is intended to help them. Safety is a priority and a property of systems and processes.
~~1.~~**2.** ~~TCMC~~**Tri-City Medical Center** is committed to the periodic assessment of the culture of safety within the hospital district using evidence-based perception surveys to evaluate the culture and the effectiveness of interventions to strengthen the culture of safety over time.
~~2.~~**3.** Priorities are identified and categorized based on the Institute of Medicine (IOM) Six Aims of Healthcare:
   a. Safe: The organization supports the Just Culture Model as a framework for event investigation and response to events
   b. Timely: (e.g. reducing wait times and delays, timely test results)
   c. Effective: (e.g. reducing preventable mortality, sepsis management, stroke care)

Administrative Content Expert	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
03/23, 12/23	06/23, 01/24, 10/25	08/23, 02/24, 12/25	n/a	08/23, 02/24

d. Efficient: (e.g. timely data analytics, clinical documentation improvement)
e. Equitable: (e.g. reducing variation in our care, cultural diversity strategy)
f. Patient Centered: (e.g. Patient Rights and values guide all clinical decisions)

E. HOSPITAL ORGANIZATION:

1. Scope of the Plan
   a. The scope of the plan includes all patient-care services in all settings provided by staff, or through contracted services, and encompasses those departments and services that support patient care. This plan is designed to measure key processes and outcomes in order to understand and ensure the reliability of systems and processes, to prioritize improvement of systems or processes.
2. Roles and Responsibilities:
   a. The Board of Directors (BOD)
      i. The BOD oversees the accountability of the Medical Staff for the overall quality of patient care. Through the Quality Assurance/Performance Improvement (QA/PI) Committee, the BOD oversees the implementation and continuous evaluation of an organization wide, data-driven, QAPI program. BOD responsibilities include overseeing the implementation of a QA/PI Plan that sets clear expectations for:
         1) Quality of Care
         2) Patient Safety
         3) Resource Allocation for measuring, assessing and evaluating organizational performance
         4) Eliminating harm to patients caused, in part, by complex processes and communication challenges
         5) Ensuring safe, timely, effective, efficient, equitable and patient-centered care
      ii. The BOD oversees the QA/PI program through regular reports that filter up through the Medical Quality Peer Review (MQPR) Committee. The BOD acts as appropriate based on the recommendations from the above-mentioned committees as well as the Executive Team to ensure high quality patient care. The BOD ensures that Performance Improvement projects are appropriately prioritized and effectively implemented, as determined by Administration in collaboration with the BOD. The BOD also ensures that the QAPI activities are aligned with the organization's Mission, Vision and Strategic Goals.
      iii. Reports shall be presented to the BOD on a schedule. Based on the findings outlined within the quality reports, the BOD shall act to improve quality of care. Variations within the reporting schedule are permissible as long as the BOD maintains oversight of all these functions.
3. Medical Staff
   a. The TCMC Medical Staff, as outlined within the Medical Staff Bylaws, shall remain accountable for the overall quality of patient care. As such, the Medical Staff shall receive reports from the various Medical Staff committees accountable for monitoring ongoing care processes.

~~2.~~ **4.** Executive Team

a. TCMC's Executive Team consists of the Chief Executive Officer (CEO), ~~The Chief Operations Officer (COO), the Chief Medical Officer (CMO), the~~ **General Counsel,** Chief Financial Officer (CFO), ~~and the~~ Chief Nurse Executive (CNE~~).~~**), Chief Operating Officer (COO), Chief Strategic Officer, Chief Informatics Officer (CIO), Chief Compliance Officer.** The team actively oversees all QAPI activity within the organization. **The CNE oversees the Quality Department.** The Executive Team is ~~proactively~~**pro-actively** assessing the effect of upcoming healthcare reform and positioning the organization for success within a continuously changing operating environment.

~~4.~~**5.** Quality Assurance/Performance Improvement Committee

a. The Quality Assurance/Performance Improvement (QA/PI) Committee, as outlined within its scope of service maintains an active role in the evaluation of quality measures through regularly scheduled meetings.

b. The following committees will be integrated into the hospital-wide QAPI program for oversight of quality initiatives which includes health outcomes, patient safety, and quality of care:

i. Infection Control Committee

1) The Infection Control Committee is a medical staff committee which selects initiatives, monitors and evaluates the Infection Control Program, and reports to the Medical Executive Committee, Medical Quality Peer Review Committee and Quality Assurance/Performance Improvement Committee. The Infection Control Committee is a multidisciplinary committee that shall approve, establish, and oversee the program for surveillance, prevention, and control of infections in order to improve the quality of care provided.

ii. Pharmacy and Therapeutics

1) The Pharmacy and Therapeutics (P&T) Committee is a medical staff committee accountable for the safety and quality of medication and therapy as it relates to pharmaceuticals. The committee discusses the hospital formulary and antimicrobial stewardship among other issues.

a) The Medication Safety Committee also reports to P&T, which is multidisciplinary. Issues discussed at this level may be referred directly to the MEC, as well as going to the QA/PI Committee for discussion before advancing to the BOD.

iii. Patient Safety

1) TCMC maintains an active Patient Safety Program in accordance with TCMC's service standard "Safety". TCMC's Regulatory & Accreditation Manager oversees integration and coordination of patient safety activities, which supports and promotes the mission, vision and values of TCMC. ~~Please refer to the Risk and Patient Safety Plans for additional detail.~~

~~i.~~ Please refer to the Risk and Patient Safety Plans for additional detail.

~~Perioperative Surgical Home (PSH) Committee~~

~~1) The program establishes an interdisciplinary team to collaborate in the care of patients undergoing colorectal surgery. The committee works to provide a consistent high quality, safe approach to our PSH program across the continuum.~~

~~B.~~F. PERFORMANCE IMPROVEMENT MODEL:

1. FOCUS PDCA:

a. "PDCA process involves planning for change or improvement constantly, and prioritizing

~~a.~~ and reprioritizing your improvement efforts based on carefully defined measurements and whether or not the problem involves high-risk, high-volume, or problem-prone processes, and if it dovetails with the goals of the organization" (Dulgacz, Retifo, & Greenwood, 2004).

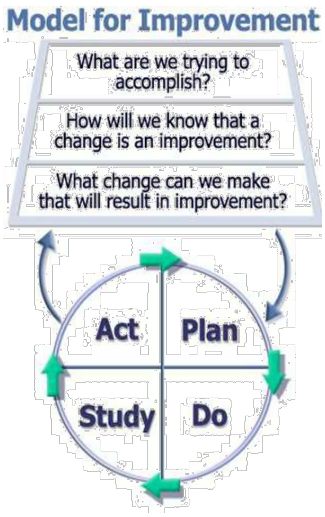
i. F= Find a process to improve

~~ii.~~**i.** O= Organize a team that knows the process

~~iii.~~**ii.** C = Clarify current knowledge of the process

~~iv.~~**iii.** U= Understand causes of process variation

~~v.~~**iv.** S= Select the process improvement



~~c.~~**b.** Plan: During this stage, TCMC analyzes and examines services in order to anticipate improvements. This includes collection of data and analysis of the process. The outcome of the "Plan" phase is a list of objectives used to move forward with improvement. Objectives include; appropriate indicators, best practices, and identifying a baseline to measure against. The recommended format for the PDCA cycle is the Institute for Healthcare Improvement (IHI) template. IHI uses the Model for Improvement as the framework to guide improvement work. The Model for Improvement, * developed by Associates in Process Improvement, is a simple, yet powerful tool for accelerating improvement.

~~d.~~**c.** Do: In the DO phase, TCMC develops a measure, including the numerator, denominator, sample size and sample population. Also included is how and from what source that data will be gathered. Finally, it identifies the method and frequency of data interpretation and reporting chain (QA/PI, and other committees).

~~e.~~**d.** Check: After gathering data, TCMC analyzes the information and measures the effectiveness of the improvements. This review includes whether data collected was reliable and whether the variation in the studied process is stable. At this point benchmarks and threshold can be reset and any studies modified to better identify any special cause variances. All measures should be analyzed against the baseline data. This stage looks at what improvements were implemented and if they were effective. If the measure needs refinement, the DO phase is revisited at this point.

~~f.~~**e.** Act: The ACT phase is where a refined and perfected process showing a desired outcome is then implemented on a broader scale throughout the organization. In this way success on one unit can beget similar success within the organization. The Act phase circles back to the Plan stage for new implementation, thus ensuring continuous process improvement.

~~5.~~**2.** TCMC employs a variety of professional resources for benchmarking and identifying best practices including the National Database of Nursing Quality Indicators (NDNQI), the Collaborative Alliance for Nursing Outcomes (CALNOC), Center for Medicare and Medicaid Services (CMS) Value Based Purchasing data, The Joint Commission (TJC)/CMS Core Measure rates, Center for Disease Control (CDC), National Quality Forum (NQF), Agency for Healthcare Research and Quality (AHRQ), Collaborative Healthcare Patient Safety Organization (CHPSO), the Institute for Healthcare Improvement (IHI), the National Healthcare Safety Network (NHSN), the National Association for Healthcare Quality (NAHQ), California Maternal Child Quality Collaborative (CMQCC), California Perinatal Quality Care Collaborative (CPQCC), Health Services Advisory Group Quality Improvement Organization (HSAG QIO), Health Services Advisory Group Improvement Innovation Network (HSAG-HIIN), and other evidence-based sources.

~~F.~~G. PRIORITIZATION AND PLANNING:

1. The Medical Center's Quality Department and Patient Safety Program facilitates an annual quality planning process which is transparent and inclusive to encourage a broad discussion across the medical center regarding quality improvement achievements, priorities for improvement in service, cost and outcomes. The process will be informed by a proactive risk assessment and review which includes the evaluation of:
   a. Performance on key quality outcomes, safety and process metrics compared to national benchmarks
   b. Patient and Family member feedback
   c. Pay for Performance metrics
   d. Regulatory requirements
   e. Event reporting, including near misses
   f. Results of survey data, including the Culture of Safety Survey and Leapfrog
   g. New legislative mandates

2. The Board of Trustees, Senior Leadership and Medical Staff Leadership working through the organization's standing committees shall establish priorities for performance improvement collaboratively. Criteria for prioritization are based on high-volume, high-risk, problem-prone, patient experience and cost-related issues. In addition, data collected from performance improvement and risk-reduction activities shall be considered in establishing priorities.
3. Established goals and priorities for improvement will be identified in the annually updated Quality and Patient Safety Plans which will be approved by the Quality Assurance/Performance Improvement Committee and BOD.

~~G.~~H. DEPLOYMENT:

1. The Medical Center charters multidisciplinary teams comprised of members with knowledge of the process to be improved.

~~H.~~I. PERFORMANCE MEASUREMENT AND MONITORING:

1. Measurement is conducted to establish the reliability of a process, to identify opportunities for improvement and to statistically evaluate clinical and organizational performance. Evaluation of clinical and organizational processes and outcomes is achieved through the development and ongoing monitoring of indicators based on aspects of performance, key organizational functions, identified dimensions of performance, and "best-practice" models or benchmarking. TCMC uses criteria to define its own performance measures including:
   a. The measure can identify the events it was intended to identify
   b. The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable. The measure has defined data elements and allowable values
   c. The measure can detect changes in performance over time
   d. The measure allows for comparison over time within the Medical Center or between the Medical Center and other entities
   e. The data intended for collection are available
   f. Results can be reported in a way that is useful to the organization and other interested stakeholders

~~I.~~J. ERROR PREVENTION, RISK IDENTIFICATION, AND MITIGATION:

1. Event Reporting, Trending and Analysis
   a. TCMC utilizes data from a variety of sources to identify areas of risk and to focus error reduction initiatives. The areas monitored include:
   b. Hospital Trends: Event reports and generic trends are routinely analyzed by the Risk Management Department to identify harm or "near misses" or patterns of care that result in less-than-optimum outcomes.
   c. Patient Surveys: TCMC utilizes questions related to the patients' perception of their care and safety during their hospitalization. This information is analyzed and considered in developing risk-reduction strategies.
   d. Employees: Employees are encouraged to use the Chain of Command, Escalation process to report safety concerns to their supervisors, Senior Leadership and through the online reporting system (Patient Safety Tracker). TCMC supports a non-punitive reporting environment.
   e. Safety Committee Reports: The Safety Officer provides the Medical Board with an update regarding safety issues as presented and discussed at the Safety Committee. All issues that require additional review are referred to the appropriate Leadership.
2. Proactive Risk Assessment
   a. TCMC consistently seeks to reduce the risk of sentinel events and other medical/healthcare system harm occurrences by conducting its own proactive risk assessments, including but not limited to Failure Mode Effects Analysis (FMEA) and Hazard Vulnerabilities Assessment of selected, existing systems and processes. The

Medical Center utilizes external agency reports, internal event reports, Leapfrog Survey, and any other recommendations related to patient safety. The purpose of the assessment is to identify a set of hazards, estimate how likely they are to occur, pick the most likely outcome, and prioritize improvement opportunities. TCMC closely monitors its compliance with TJC's National Patient Safety Goals. This proactive approach is undertaken so that processes, functions and services can be designed or redesigned to prevent harm to patients.

b. On an ongoing basis, the ~~Chief Medical Officer and Director of~~ Quality ~~involve~~**Leadership involves**, as appropriate, members of the medical staff, senior leadership, hospital managers and hospital staff in risk analysis of major medical services/processes. Risk Management and Quality Department and Patient Safety Program manager collect error-reduction data from benchmark healthcare organizations and other industries. This information includes, but is not limited to, the following:
   i. The Joint Commission Sentinel Event Alerts
   ii. Institute for Safe Medication Practices (ISMP)
   iii. Medication Safety Alerts
   iv. Emergency Care Research Institute (ECRI) Bulletins
   v. CDC Bulletins
   vi. CMS Hospital Compare Website

3. Utilizing the above data, as well as other internal and external metrics, the Director of Quality, in collaboration with Risk Management, makes recommendations to the Chief Medical Officer and the Quality Assurance/Performance Improvement Committee regarding priority aspects of care processes that are known to be high-risk or problem-prone. Collaboratively these individuals determine priorities for error reduction efforts and charter Teams/Committees to perform process redesign and improvements.

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: **NEW**

SUBJECT: **Medicare Change of Status Notice (MCSN)**

REVISION DATE:

POLICY NUMBER: 8560-

Administrative Expert Approval:	**10/25**
Administrative Policies & Procedures Committee Approval:	**10/25**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**12/25**
Professional Affairs:	**n/a**
Board of Directors Approval:	

A. **DEFINITION(S):**

1. **Medicare Change of Status Notice (MCSN):** A standardized CMS notice required to be provided to Medicare Fee-for-Service (FFS) beneficiaries when their hospital admission status changes from inpatient to outpatient with observation services during the same hospital stay. The MCSN informs beneficiaries of their right to request an expedited determination (appeal) and the potential financial and coverage implications of the change.
2. **Eligible Beneficiary:** A patient with Original Medicare (not Medicare Advantage) who was admitted as an inpatient and subsequently reclassified to outpatient observation status; and either did not have Part B at the time of status change or had Part B coverage and remained an inpatient for three (3) or more consecutive calendar days prior to reclassification.
3. **Expedited Determination:** A process through which an eligible beneficiary may request that a Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO) review the hospital's change of status decision within a short timeframe.
4. **Retrospective Appeal:** A process allowing beneficiaries, under the 2025 CMS rule, to appeal status changes dating back to January 1, 2009, where prior appeal rights were not afforded.

B. **POLICY:**

1. It is the policy of Tri-City Medical Center (TCMC) to comply with the Centers for Medicare & Medicaid Services (CMS) requirements effective February 14, 2025, as established under CMS-4204-F regarding the Medicare Change of Status Notice (MCSN).
2. TCMC shall ensure that all eligible Medicare FFS beneficiaries are identified when their status changes from inpatient to outpatient observation.
3. The MCSN is delivered timely, explained clearly, and documented appropriately in the patient's medical record.
4. Beneficiaries are provided their appeal rights in accordance with CMS instructions.
5. Staff involved in utilization review, case management, patient access, and discharge planning receive education and training on the MCSN process.
6. MCSN delivery shall occur no later than four (4) hours prior to discharge.
7. Copies of all delivered or refused MCSNs shall be retained in the medical record per record retention policy.

C. **PROCEDURE:**

1. The Utilization Review (UR) or Case Management Department monitors all inpatient cases for potential reclassification.

2. When a change from inpatient to outpatient observation is recommended, UR staff confirm if the patient meets MCSN eligibility criteria.
3. ~~UR or Case Management~~**Access Management** staff shall generate, explain, and deliver the MCSN to the patient or representative, ensuring understanding and signature.
4. If the patient refuses to sign, staff document 'refused to sign' with date/time noted.
5. MCSN must be provided as soon as feasible after status change and no later than four (4) hours before discharge.
6. A signed or annotated MCSN is filed in the patient's electronic **health**~~medical~~ record (EHR) and the delivery details are documented.
7. If an expedited appeal is requested **through BFCC-QIO by the patient**, **case management** staff will ~~contact the BFCC-QIO and~~ submit necessary records no later than noon of the next calendar day.
    a. Access Management Leadership will conduct periodic audits of MCSN delivery and documentation to ensure accuracy and timeliness.

D. **FORM(S):**

1. Medicare Change of Status Notice (MCSN) – CMS Standardized Form (effective 02/14/2025)

E. **RELATED DOCUMENT(S):**

1. **Patient Care Management Policy:** Utilization Review ~~Policy~~
2. Medicare Outpatient Observation Notice (MOON) Policy
3. **Patient Care Services Policy:** Patient Rights and Responsibilities ~~Policy~~
4. **Administrative Policy:** Record Retention ~~Policy~~

F. **EXTERNAL LINK(S):**

1. CMS MM13846 – Medicare Change of Status Notice Instructions (2025): https://www.cms.gov/files/document/mm13846-medicare-change-status-notice-instructions.pdf
2. Federal Register – Appeal Rights for Certain Changes in Patient Status (CMS-4204-F): https://www.federalregister.gov/documents/2024/10/15/2024-23195/medicare-program-appeal-rights-for-certain-changes-in-patient-status
3. BFCC-QIO Contact Information by State (CMS.gov): https://www.cms.gov/medicare/appeals-and-grievances/bfcc-qio-areas

G. **REFERENCE(S):**

1. CMS Final Rule: Medicare Program; Appeal Rights for Certain Changes in Patient Status (CMS-4204-F), effective February 14, 2025
2. CMS Manual System, Pub. 100-06, Medicare Financial Management Manual.
3. CMS Change Request (CR) 13846.
4. 42 CFR §405.1205 – Expedited Determinations.
5. ACP Advisors: Medicare Change of Status Notice and Appeal Process (January 2025).

Tri-City Medical Center

Medicare

Patient name: _____
Patient number: _____
Hospital name: **Tri-City Medical Center**_____
Hospital address: 4002 Vista Way Oceanside CA 92056

_____

Medicare Change of Status Notice

Important! You're getting this notice because your hospital changed your status from "hospital inpatient" to "hospital outpatient receiving observation services."

The box marked below shows what applies to you:

☐ While you're still in the hospital, your hospital stay will now be billed to Medicare Part B instead of Part A.

Your hospital bill may be lower or higher than the Part A inpatient deductible. Your hospital can give you more information about billing.

After you leave the hospital, Medicare will not pay if you go to a skilled nursing facility.

☐ While you're still in the hospital, the hospital may charge you the full cost of your outpatient hospital stay because you don't have Medicare Part B.

After you leave the hospital, Medicare will not pay if you go to a skilled nursing facility.

You Can Appeal

- You can appeal your status change to a Quality Improvement Organization right away. Quality Improvement Organizations are independent of Medicare.
- If you decide to appeal, your Quality Improvement Organization will look at your records and give you its decision about 2 days after you ask for an appeal.
- Call your Quality Improvement Organization to appeal at:
  Commence Health (877) 588-1123 (formerly Livanta QIO)
- You should ask for an appeal as soon as possible and before you leave the hospital.
- After you leave the hospital, you still have appeal rights. Call your Quality Improvement Organization.

Tri-City Medical Center

What Happens After I Appeal?

- You'll get the appeal decision from the Quality Improvement Organization about 2 days after you appeal, even if you leave the hospital.
- If you decide to stay in the hospital beyond your planned discharge date you may be responsible for payment of services you get during the appeal process.
- If your appeal is favorable to you, Medicare may cover your skilled facility nursing stay after you leave the hospital.

Questions?

- If you think you may want to appeal and want more information about the appeals process, call your Quality Improvement Organization at:
- Commence Health (877) 588-1123 (formerly Livanta QIO)
- For more information about your Medicare coverage, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Additional Information (Optional):

Signature of patient or representative	Date

Sign below to show you received and understood this notice.

Medicare

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call
1-877-486-2048.

Paid for by the Department of Health & Human Services.

Form CMS 10868 • Exp. 11/30/2027 • OMB approval 0938-1467

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
HUMAN RESOURCES

ISSUE DATE: **07/80** **SUBJECT: Employment of Relatives**

REVISION DATE(S): **03/92, 11/94, 10/97, 11/00, 03/03, 07/05, 08/12, 08/15, 04/19** **POLICY NUMBER: 8610-406**

Administrative ~~Human Resources~~ Content Expert Approval:	**~~03/19~~08/25**
Administrative Policies & Procedures Committee Approval:	**~~03/19~~10/25**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~04/19~~10/25**
Professional Affairs Approval:	**n/a**
Board of Directors Approval:	**04/19**

A. **PURPOSE:**

1. To **establish**~~define~~ guidelines for **the** employment of ~~related~~ individuals who **are related and** may be employed **simultaneously** by ~~the~~**Tri-City Healthcare** District **(TCHD)** ~~at the same time~~.

B. **DEFINITION(S):**

1. Relative or Related: ~~a spouse, parent, brother, sister, legal guardian, child, stepchild, aunt, uncle, niece, nephew, first cousin, grandparent, grandchild, mother-, father-, brother- or sister-in-laws, or any person involved in a legally binding relationship or guardianship with the employee, and/or residing in the home of the employee.~~**employee's spouse, child (including adoption child, minor ward of employee guardian, foster-child, step-child or grandchild), mother, father, mother-in-law, father-in-law, individual who serves as the legal guardian for either the employee the spouse, or the domestic partner of the employee, brother, sister, step-mother, step-father, brother-in-law, sister-in-law, daughter-in-law, son-in-law, grandparents, and California State registered domestic partners and domestic partner who is a bona fide spousal equivalent either of the employee, the spouse or the domestic partner of the employee.**
2. Supervisor, Supervision, Supervisory Role: individuals holding the following positions: Member of the Board of Directors, Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Nurse Executive (CNE), Vice President, Director, Manager, Supervisor, or Lead.
3. Official: is defined as the CEO and a member of the Board of Directors.
4. Grandfather Clause: A grandfather clause allows the current status of something pre-existing to remain unchanged, despite a change in policy which applies in the future.

C. **POLICY:**

1. Tri-City Healthcare District (TCHD) will accept and consider applications for employment from relatives. The applicant must identify any individual who is a ~~close~~ relative already employed by TCHD at the time **they**~~he/she~~ appl**y**~~ies~~ for employment.
2. An individual is precluded from employment with TCHD when an official has an economic interest in an individual's personal finances and those of the individual's relative. A governmental decision will have an effect on this economic interest if the decision will result in the personal expenses, income assets, or liabilities of the official or the individual's relative increasing or decreasing.
3. Applicants who are relatives of a TCHD employee will not be eligible for employment with

TCHD in a situation where potential problems of supervision, safety, security or morale exist including conflicts, claims of partiality in treatment at work, and personal conflicts from outside of the work environment that can be carried over into working relationships.

4. The relative cannot work within the chain of command/responsibility of the current TCHD employee at any level.
5. The relative cannot have direct influence over a relative's pay, financial data or exert influence on decisions concerning the status of employment, promotion, or compensation.
6. When a relationship exists between two employees that could present an actual or potential conflict of interest, TCHD may take appropriate action which may include reassignment, changing shifts, transfers or if necessary, possible termination.
7. Two relatives may not work in the same department or work unit, regardless of the supervisory status of either employee, or the lack of supervisory status between them.
    a. Float needs and/or patient care may supersede the above.
    b. Grandfather Clause: Employees who may be deemed related but who were employed with TCHD prior to August 1, 2012, will be grandfathered such that relatives may work in the same work unit or department, so long as a supervisory relationship does not exist between the employees. This grandfather clause will remain in effect until the employee changes status in job title, unit or department, or employment status.
8. TCHD has the right to reassign an employee and limit the working relationship between the relatives, in the event that any relationship interferes with the running of a department/care unit.

D. **REFERENCE(S):**

1. Regulations of the Fair Political Practices Commission, Title 2, Division 6, California Code of Regulations~~, section 180703.5~~.

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE
HUMAN RESOURCES

ISSUE DATE: **07/88** **SUBJECT:** **Performance Evaluations**

REVISION DATE: **10/12, 12/15, 01/23** **POLICY NUMBER: 8610-426**

Administrative Content ~~Human Resources Department~~Expert Approval: **~~09/22~~8/25**
Administrative Policies & Procedures Committee Approval: **~~09/22~~10/25**
Administration Approval: **~~01/23~~12/25**
~~Human Resources Committee Approval:~~ **~~n/a~~**
Professional Affairs Committee Approval: **n/a**
Board of Directors Approval: **01/23**

A. **PURPOSE:**

1. To ensure that all Tri-City Healthcare District (TCHD) employees receive a periodic performance evaluation.

B. **POLICY:**

1. All managers must have ongoing communication with the employee to discuss performance relative to specific responsibilities and manager's expectations.
2. The evaluation tool consists of pre-determined standards against which the employee's performance is measured.
3. Department Managers will complete a **periodic** ~~n annual~~ performance evaluation for ~~all~~ employees~~., any exceptions to be approved by CEO or designee.~~
4. Employee is responsible for acknowledging receipt of performance evaluation
5. Strict adherence to this policy is a management and employee performance expectation. Noncompliance will be addressed in accordance with Administrative Human Resources Policy: Coaching and Counseling for Work Performance - 424.
6. To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.

C. **RELATED DOCUMENT(S):**

1. Administrative Human Resources Policy: Coaching and Counseling for Work Performance 424

Tri-City Medical Center
Oceanside, California

Administrative ~~Policy~~
Human Resources

ISSUE DATE: **05/83**

SUBJECT: Reduction in Work Force

REVISION DATE: **08/96, 01/97, 02/98, 08/00, 06/03 10/05, 12/08. 08/09, 05/11, 11/14 08/20**

POLICY NUMBER: 8610-448

Administrative Content Expert~~Human Resources Department~~ Approval: **~~02/20~~8/25**
Administrative Policies & Procedures Committee Approval: **~~03/20~~10/25**
Medical Executive Committee Approval: **n/a**
Administration Approval: **~~08/20~~12/25**
Professional Affairs Committee Approval: **n/a**
Board of Directors Approval: **08/20**

A. PURPOSE:

1. It is the purpose of this policy to allow a **Reduction in Force (**RIF**)** to proceed while limiting disruption to TCHD operations and adverse effects upon **Tri-City Healthcare District (**TCHD**)** employees. A principal goal of any RIF will be to retain those personnel necessary to meet the operating needs of TCHD and its patients. All other considerations are subject to, and limited by, this overriding goal.

~~A.~~B. POLICY:~~INTRODUCTION:~~

1. ~~Tri-City Healthcare District (~~TCHD~~)~~ reserves the unrestricted right to engage in a ~~Reduction in Force (~~RIF~~)~~. No TCHD employee, representative or agent has the authority to limit this right, and any attempt to do so shall be null and void.
2. The Chief Executive Officer (CEO) has the ability to implement a RIF at~~-~~ their sole discretion, at any time, and in any manner, that ~~-~~they deem in the best interests of TCHD. This policy may be amended, revised or completely restated at any time before, after or during any particular RIF. The adoption and/or implementation of this policy does not create and shall not be deemed to confer upon any employee any right to continued employment, or to transfer or rehire following a RIF.
3. This policy shall not supersede any agreement between TCHD and the exclusive representative of any bargaining unit of TCHD employees and shall not abrogate the rights of any such employees under the Meyers-Milias-Brown Act and the Worker Adjustment and Retraining Notification Act (WARN Act), if applicable.

~~B.~~A. ~~PURPOSE:~~

~~2.~~1. ~~It is the purpose of this policy to allow a RIF to proceed while limiting disruption to TCHD operations and adverse effects upon TCHD employees. A principal goal of any RIF will be to retain those personnel necessary to meet the operating needs of TCHD and its patients. All other considerations are subject to, and limited by, this overriding goal.~~

C. PROCESS:

1. A RIF may be implemented district-wide, by department, by work group, by job classification or by some other criterion identified by the CEO or designee. Once the scope of the RIF has been determined, the Head of Human Resources (HR) or designee will work with each affected department to identify positions that may be eliminated as part of the RIF. In identifying these positions, the Head of HR and department supervisors may consider the specific experience, training, and competencies of the incumbents in those positions. By way of example, they may

consider whether an incumbent has the ability to perform duties that would allow the position they occupy to be restructured and to avoid elimination under the RIF.

2. Subject to the second sentence of C.1., above, after identifying the positions to be eliminated, the Head of HR and the affected supervisors will identify the individuals to be laid off as part of the RIF. Selection of such individuals shall be at TCHD's sole and absolute discretion, based upon the operating needs of TCHD and the needs of its patients, provided, however, individuals may not be identified by lay off based on their race, national origin, gender, disability, or other characteristic protected under state or federal law, or in retaliation for any protected activity.
3. Notification of the individuals selected to be laid off as part of the RIF shall be provided in compliance with applicable state and federal laws.
~~3.~~**4. To the extent that any applicable collective bargaining agreement, consistent with applicable law, conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement shall prevail.**

D. **TRANSFER/REHIRE:**

1. Employees who are selected for layoff may apply to transfer to any open position at TCHD for which they are qualified.
2. Employees who have been laid off may be considered for re-hire as long as they are otherwise in good standing and possess the qualifications of the position for which they are applying. It is an employee's responsibility to inquire and apply for any job openings.
3. Employees who are rehired in the first six **(6)** months following a RIF shall maintain their prior seniority date. Reinstatement of benefits will begin the 1st of the month following the date of re-hire.
4. TCHD will cease payments of any outstanding severance amounts payable under Administrative Policy: Severance Plan 454 for any employee rehired following a RIF and subsequent to first day of return to work.
5. The Head of HR, in consultation with the department head, shall have discretion and authority to approve if any employee is eligible for a transfer or for re-hire into a position not previously held by the employee.

E. **RELATED DOCUMENT(S):**

1. Administrative Policy: 432 Employee Transfers
2. Administrative Policy: 454 Severance Plan

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE COMPLIANCE

ISSUE DATE: 02/99 **SUBJECT:** Advanced Beneficiary Notice

REVISION DATE: 11/02, 12/02, 12/03, 10/05, 11/08 02/11, 10/13, 09/17 **POLICY NUMBER:** 8610-503

Administrative Content Expert Approval:	**~~011/21~~10/25**
Administrative Policies & Procedures Committee Approval:	**~~12/21~~10/25**
Organization Compliance Committee Approval:	**~~10/22~~ n/a**
Administration Approval:	**~~11/22~~10/25**
Audit, Compliance and Ethics Committee Approval:	**n/a**
Board of Directors Approval:	**11/22**

A. **PURPOSE:**

1. To insure an Advance Beneficiary Notice (ABN) is obtained from Medicare beneficiaries when Tri-City Healthcare District (TCHD) wishes to bill for outpatient tests and services that may not be covered by CMS.
2. TCHD will conduct patient care and all other business operations in a legal and ethical manner. Employees are expected to observe federal, state and local laws. TCHD will not tolerate fraud, waste and/or abuse in any manner, and employees are expected to adhere to all guidelines and regulations governing Medicare and other Federal and State funded healthcare programs.

B. **OVERVIEW:**

1. Effective departments include: Admitting Services (Scheduling and Registration), Compliance, Case Management, Medical Staff, Physician Office Staff, Laboratory, Patient Accounts, Ancillary Departments.
2. Advance Beneficiary Notice (ABN): An ABN is a written **or electronic** notice given to a Medicare Beneficiary before Part B services are furnished when TCHD believes that Medicare will not pay for some or all of the services on the basis that they are not reasonable and necessary (i.e ~~.,~~ under §1862(a)(1) of the Act) and TCHD wishes to bill the patient for the provided services. The ABN gives the beneficiary an idea of why TCHD is predicting the Medicare denial. The information in the ABN will assist the beneficiary in making an informed decision whether or not to receive the service and be financially responsible for the payment.
3. If TCHD expects payment for the services to be denied by Medicare, TCHD employees will advise the beneficiary before services are furnished ~~that, in our opinion~~**that, per CMS** ~~,~~ ~~the~~**validation. The** beneficiary will be personally and fully responsible for the payment.
4. "Personally, and fully responsible for payment": This means that the beneficiary will be liable to make payment "out-of-pocket," through other insurance coverage (e.g., employer group health plan coverage), or through Medicaid or other federal or non-federal payment source. TCHD must issue notices each time, and as soon as, ~~we~~ **TCHD** believe**s the** Medicare payment will be denied due to a medical necessity reason.
4.**5.** TCHD is not required to give ABN's to beneficiaries for items or tests that are statutorily excluded from Medicare payment, such as oral medications or routine screening tests, which fall under the routine physical exclusion (i.e., under §1862(a)(7) of the act.) If TCHD does not provide a proper ABN in situations where one is required, TCHD will be held liable for the loss of payment if Medicare denies the claim.

a. Notation: An ABN must be obtained for initial standing orders (for extended course of treatment) that contain tests that may be covered. However, it is not necessary to obtain a new ABN each time the test is performed in accordance with the standing order.
b. Routine use of the ABN is prohibited. There must be a specific reason to believe Medicare will determine that the test ordered may not be considered reasonable and necessary.

~~5.~~**6.** An ABN must be obtained when one or more of the following circumstances exist when TCHD wishes to bill the patient for the provided services:
a. The test for a routine exam or screening not covered by Medicare.
b. The test in for investigative or research use only.
c. The diagnosis provided may not or does not meet medical necessity requirements.
d. No diagnosis provided.
e. The test may only be paid for a limited number of times within a specified time period and this visit may exceed that limit.
f. The test has not been approved by the Food and Drug Administration.
g. For those services which Medicare excludes from coverage under Part A or Part B (e.g., tests associated with routine checkups, glasses, hearing aids, routine foot care, personal comfort items, etc.) an ABN may be obtained noting the appropriate reason of non-coverage.
h. Patients must be notified well enough in advance of receiving a medical service so the patient can make a rational, informed decision.

~~6.~~**7.** The ABN will clearly identify the following:
a. Description of service(s) that may be denied, including procedure name, price, and CPT **(Current Procedural Terminology)**/HCPC **(Healthcare Common Procedure Coding System)** code if available
b. Reason why the service may be denied
c. Patient's name
d. Patient's Medicare number
e. Patient's or guarantor's signature and date
~~f. Witness signature and date~~

~~C. **DEMAND BILL:**~~

~~1. A claim must always be sent for an initial determination on the basis of the likelihood of denial of payment for a service as "not reasonable and necessary" under Medicare standards. Enter an occurrence code 32 on the UB-04 in one of the fields numbered 32 through 35. It is the occurrence code that indicates that an ABN has been issued. A condition code of 20 must be entered in one of the fields numbered 24 through 30 to indicate TCHD felt the services would probably be non-covered or denied by Medicare.~~

~~D.~~**C. PROCEDURE:**

1. Employees entering the computerized order for outpatient tests and performing registration must review the physician's diagnosis, when processing every outpatient Medicare ~~order.~~**order.**
2. If the patient presents with a completed ABN from the physician's office, proceed with performing the ordered tests. A copy of the ABN must be made and kept with the patient's ~~order~~ **order.**
3. If the patient presents with no ABN and the diagnosis provided does not meet Medical Necessity Guidelines for the test(s) being ordered, registration staff must complete an ABN~~.~~
4. Instruct the patient on the purpose of the form and ask patient or guardian to sign one of two options: 1) agree to pay for service(s), which may be denied, and therefore obtain the service(s), or (2) deny responsibility and do not obtain the service(s). If the patient or guardian wishes to discuss the situation with their physician or a nurse, the registration employee will either contact the physician or a nurse in a timely manner to discuss the situation so the beneficiary may make an informed ~~decision.~~**decision.**

5. **In** the case in which the Beneficiary demands the service(s) and refuses to pay or sign the ABN form, then a second employee witness should sign the ABN form and a note should be made that the beneficiary refused to sign. In this case the services may be provided and if Medicare payment is denied, the beneficiary will be responsible for payment.
6. ~~-~~If the patient denies payment responsibilities and declines the test(s), then perform only those tests that meet the Medical Necessity Guidelines. It is the patient's responsibility to inform the ordering physician that services were not performed. If the patient agrees to pay for the service(s) then perform all tests ordered.
7. The signed ABN form should be distributed as follows:~~ give the back~~ **A** copy **is to be** ~~-to the~~**given to the** patient~~, retain the middle copy at physician's office or registration office~~ **and Access Management Representative is to scan the ABN into the Cerner Imaging system for record keeping.**~~, and file the original copy with the physician's order.~~

~~E.~~D. REFERENCE(S):

1. Medicare Carrier's Manual 7300.5, Part III (HCFA Publication 14-3) 3730
2. CMS 10123-NOMNC (Approved 12/31/2011) OMB approval 0938-0953

~~F.~~E. ATTACHMENT(S):

1. Advanced Beneficiary Notice English– Sample
2. Advanced Beneficiary Notice Spanish- Sample

TCHD Advanced Beneficiary Notice English- Sample

(A) Notifier:
(B) Patient Name: (C) Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED
- Read this n
- Ask us any
- Choose an

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Replace with current version

G. OPTIONS:

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☐ **OPTION 3.** I do
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H. Additional Infor

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

Affix Patient Label

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

8560-1021
(Rev. 12/11)

ADVANCE BENEFICIARY NOTICE
OF NON COVERAGE

A. Notifier:
B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D._____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D._____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the D._____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

TCHD Advanced Beneficiary Notice Spanish - Sample

R. Notificado:
B. Nombre del paciente: **C. Número de identificación:**

Aviso anticipado al beneficiario de no cobertura (ABN)

NOTA: Si Medicare no paga por D. _____ a continuación, es posible que tenga que pagar.
Medicare no paga todo, ni siquiera algunos cuidados que usted o su proveedor de atención médica tienen buenas razones para pensar que necesita. Es posible que Medicare no pague lo que se indica en **D.**_____ a continuación.

D.	E. Razón por la que Medicare no puede pagar:	F. Costo estimado

LO QUE NECESITA HACER AHORA:

- Lea este aviso para que pueda tomar una decisión informada sobre su cuidado.
- Háganos cualquier pregunta que pueda tener después de terminar de leer.
- Elija una opción a continuación sobre si desea recibir la **D.** _____mencionada anteriormente.

Nota: Si elige la opción 1 o 2, podemos ayudarle a utilizar cualquier otro seguro que tenga, pero Medicare no puede exigirnos que lo hagamos.

G. OPCIONES: Marque solo una casilla. No podemos elegir una casilla por usted.

☐ **OPCIÓN 1.** Deseo la **D.** _____ mencionada anteriormente. Puede solicitar que se le pague ahora, pero también deseo que se le facture a Medicare por una decisión oficial sobre el pago, que se me envía en un Resumen de Medicare (MSN). Entiendo que si Medicare no paga, soy responsable del pago, pero puedo apelar a Medicare siguiendo las instrucciones del MSN. Si Medicare paga, usted reembolsará cualquier pago que le haya hecho, menos copagos o deducibles.

☐ **OPCIÓN 2.** Deseo la **D.** _____ mencionada anteriormente, pero no facture a Medicare. Puede solicitar que se le pague ahora ya que soy responsable del pago. No puedo apelar si no se factura a Medicare.

☐ **OPCIÓN 3.** No deseo la **D.** _____mencionada anteriormente. Entiendo que con esta elección **no** soy responsable del pago y no puedo apelar para ver si Medicare pagaría.

H. Información adicional:

Este aviso da nuestra opinión, no es una decisión oficial de Medicare. Si tiene otras preguntas sobre este aviso o la facturación de Medicare, llame al **1-800-MEDICARE** (1-800-633-4227/ **TTY:** 1-877-486-2048).
Firmar a continuación significa que ha recibido y comprende este aviso. Puede solicitar recibir una copia.

I. Firma:	J. Fecha:

Tiene derecho a obtener información de Medicare en un formato accesible, como letra grande, braille o audio. También tiene derecho a presentar una queja si siente que ha sido discriminado. Visite Medicare.gov/about-us/accessibility-nondiscrimination-notice.

De acuerdo con la Ley de Reducción de Trámites de 1995, ninguna persona está obligada a responder a una recopilación de información a menos que muestre un número de control OMB válido. El número de control OMB válido para esta recopilación de información es 0938-0566. El tiempo requerido para completar esta recopilación de información se estima en un promedio de 7 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar recursos de datos existentes, recopilar los datos necesarios y completar y revisar la recopilación de información. Si tiene comentarios sobre la precisión de la estimación de tiempo o sugerencias para mejorar este formulario, escriba a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

A. Notificante:
B. Nombre del paciente: **C. Número de identificación:**

Notificación previa de NO-cobertura al beneficiario (ABN)

NOTA: Si Medicare no paga D._____ a continuación, usted deberá pagar.
Medicare no paga todo, incluso ciertos servicios que, según usted o su médico, están justificados.
Prevemos que Medicare no pagará D. _____ a continuación.

D.	E. Razón por la que no está cubierto por Medicare:	F. Costo estimado:

Lo que usted necesita hac

- Lea la presente not… e la atención que recibe
- Háganos toda preg…
- Escoja una opción… o anteriormente.

Nota: Si escog… al vez tenga, pe…

Replace with current version

G. Opciones: Sírvase recuadr…

❑ **OPCIÓN 1.** Quiero D. _… o también deseo que se cobre… la cual se me enviará en el Resum… sable por el pago, pero **puedo ap**… se me reembolsarán los pagos qu…

❑ **OPCIÓN 2.** Quiero D. _… licare. Puede solicitar que se le pa… **No tengo derecho a apela**…

❑ **OPCIÓN 3.** No quiero D… pción no soy responsable por el …

H. Información adicional:

En esta notificación se da a conocer nuestra opinión, no la de Medicare. Si tiene otras preguntas sobre la presente notificación o el cobro a Medicare, llame al **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).
Al firmar abajo usted indica que ha recibido y comprende la presente notificación. También se le entrega una copia.

I. Firma:	J. Fecha:

De conformidad con la Ley de reducción de los trámites burocráticos de 1995, nadie estará obligado a responder en todo pedido para recabar información a menos que se identifique con un número de control OMB válido. El número de control OMB válido para esta recolección de información es 0938-0566. El tiempo necesario para completar esta solicitud de información se calcula, en promedio, 7 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar en fuentes de datos existentes, recabar los datos necesarios y llenar y revisar los datos recogidos. Si tiene comentarios sobre la precisión del cálculo del tiempo o sugerencias para mejorar el presente formulario, sírvase escribir a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

Affix Patient Label

9560-1022
(Rev. 12/11)

ADVANCE BENEFICIARY NOTICE OF NON COVERAGE (SPANISH)

A. Notifier:
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

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Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE COMPLIANCE

ISSUE DATE: **05/00**

SUBJECT: **EMTALA: Emergency Medical Screening**

REVISION DATE: **06/03, 01/06, 08/09, 02/11, 04/17 09/20, 02/24**

POLICY NUMBER: **8610-506**

Administrative Content Expert Approval:	**~~10/23~~10/25**
Administrative Policies & Procedures Committee Approval:	**~~10/23~~10/25**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~02/24~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/24**

A. **PURPOSE:**

1. To ensure compliance with the Federal requirements contained in the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA waiver allows hospitals to direct or relocate individuals which would normally be prohibited under EMTALA of individuals with unstable emergency medical conditions if necessitated by the circumstances of the declared emergency. Centers for Medicare and Medicaid Services (CMS) will provide notice of the waiver.

B. **DEFINITION(S):**

1. Basic information obtained may include:
   a. Patient's full name
   b. Patient's date of birth
   c. Social Security number
   d. Family physician
   e. Insurance plan information, if applicable
2. Individual who presents with an emergency medical condition: An individual who presents with an emergency medical condition anywhere on Tri-City Healthcare District (TCHD) campus, even if the individual presents at a location other than the Emergency Department (ED). TCHD's campus includes ambulatory services departments located on or adjacent to the campus, as well as the medical center parking lots.
3. Emergency Medical Condition:
   a. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in either placing the health of an individual (or with respect to a pregnant woman, the health of her unborn child) in serious jeopardy; serious impairment of bodily functions; or serious dysfunction of any bodily organ or part; or
   b. With respect to a pregnant woman who is having contractions, there is adequate time to affect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or her unborn child.
4. Medical Screening Exam (MSE):
   a. The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether an emergency medical condition does or does not exist.
   b. MSE requires an evaluation by a qualified medical provider, within the capability of the hospital's ED, to determine whether an emergency medical condition exists, or if the person is in labor.
5. Stabilization:

a. Stabilization includes the provision of such medical treatment for the condition, necessary to assure within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or that the woman has delivered the child and placenta.
b. Stabilization may include either stabilization for discharge or stabilization for transfer.

6. Triage*:*
   a. Determines the order in which patients will be seen.
   b. Triage does not qualify as an appropriate MSE.

C. **POLICY:**

1. Collection of financial information in the ED must be performed in accordance with this policy.
2. Hospitals may not delay in providing a MSE or necessary stabilizing treatment by inquiring about an individual's ability to pay for care.
   a. Individuals who have an emergency medical condition must be offered, and if desired, receive a MSE regardless of answers the individual may give to questions asked during the registration process.
   b. A hospital may not delay screening or treatment to an individual while information is verified.
   c. Hospitals may continue to follow reasonable registration processes for individuals presenting with an emergency medical condition.
      i. Reasonable registration processes may include requesting information about insurance as long as these procedures do not delay screening or treatment.
3. Each patient seeking treatment in the ED is entitled to an emergency MSE. When collecting financial information in the ED setting, the following guidelines must be followed:
   a. A MSE and necessary stabilization may not be refused by TCHD for any reason, even if a managed care plan refuses to authorize treatment or pay for services the MSE must be completed despite ability to pay.
   b. A MSE for an ED patient may not be delayed in order to:
      i. Inquire about an individual's ability to pay
      ii. Inform the patient that he/she must pay a co-pay or deductible if they choose to be treated
      iii. Perform insurance verification and authorization
      iv. Inform the patient that his/her care will be free or at a lower cost if another facility is used
   c. The MSE must be the same for all individuals presenting to the ED with the same condition, regardless of financial status or payment source.
4. The registrar or Triage Registered Nurse (RN) must refrain from making any comments that the patient might interpret to mean that services might not be provided based on ability to pay. For example, the registrar must not say, "We don't accept XYZ insurance here."
5. The registrar shall not request co-pays, deductibles, or past due balances from the patient until the MSE and necessary stabilization have occurred.
6. If a patient expresses the intent to leave the ED, the patient shall be encouraged to remain in the ED until the MSE and necessary stabilization are completed. If a patient leaves TCHD as a result of questions asked prior to receiving the MSE, it may be interpreted that the there was a suggestion that the patient leave the ED. This occurrence must be documented by the Triage RN.
7. If a patient presents to the ED with a life-threatening emergent condition (i.e., patient arrives via ambulance in cardiac arrest) the MSE and necessary stabilization will begin immediately. The registrar may obtain the basic information from a source other than the patient (i.e., next of kin). Otherwise, financial information shall be obtained after the patient has received a MSE and necessary stabilizing treatment. Financial information may be discussed with the patient only after stabilization.
8. In case of an emergent situation or active labor identified after the MSE, stabilization and treatment will begin immediately. The registrar may obtain the basic information as well as insurance verification, provided that the necessary stabilization and treatment are not delayed.

9. If the MSE determines that the patient does not have an emergency medical condition, or the patient is not in active labor, the patient shall be informed of his/her treatment options. The registrar may obtain the basic information, as well as insurance verification. After the MSE is completed, and once the physician has made the determination that an emergency medical condition does not exist, the patient may be informed of his/her potential financial responsibility.
10. The registration process may be initiated as long as the process does not cause a delay in the provision of a MSE and necessary stabilization for an emergency medical condition. Basic identifying information may be gathered and entered into Cerner to allow for processing of tests in the order entry system.
11. If patient's information is already present in Cerner, the registrar will verify the existing information.
12. An Advance Beneficiary Notification Notice (ABN) shall not be obtained when rendering emergency medical treatment.
13. Signage indicating payment is due at time of service, or indicating that the patient's insurance may not pay for the service may not be placed in the ED lobby or treatment area.
14. Registration/ patient access management personnel must educate all registration staff responsible for registering, billing, and maintaining patient records.
15. The Registration supervisor shall observe registrars to ensure compliance.

D. **REFERENCES:**

1. Social Security Act, Section 1867, 42 U.S.C. 1395dd, Examination and Treatment for Emergency Conditions and Women in Labor.
2. Social Security Act, Section 1867, 42 U.S.C. 1395cc, Emergency Medical Treatment and Active Labor Act.
3. State Operations Manual Appendix V Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases §489.24, Special Responsibilities of Medicare Hospitals in Emergency Cases.
4. Code of Federal Regulations Title 42 (Updated 10/2/2023). §489.53 Termination of CMS;
5. Current California Hospital Association (CHA) Consent Manual. (2021). Chapter 12 Discharge Planning, Patient Transfers and Related Issues. –: or
6. EMTALA Answer Book 2020, Author Mark M. Moy

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
INFORMATION TECHNOLOGY

ISSUE DATE: **NEW** **SUBJECT: Incident Response Policy**

REVISION DATE: **POLICY NUMBER: NEW**

Administrative Content Expert Approval: **10/25**
Administrative Policies & Procedures Committee Approval: **10/25**
Administration Approval: **11/25**
Professional Affairs Committee Approval: **n/a**
Board of Directors Approval:

A. **PURPOSE:**

1. The purpose of the Incident Response policy is to establish how Tri-City **Healthcare District (TCDH)**~~Medical Center~~ manages detecting, responding, documenting, reporting, and handling cybersecurity incidents affecting ~~Tri-City Medical Center~~**TCHD** information systems and data.

B. **SCOPE AND APPLICABILITY:**

1. Policies and procedures apply to all **TCDH**~~Tri-City Medical Center~~ data, information systems, activities, and assets owned, leased, controlled, or used by **TCDH**~~Tri-City Medical Center~~, its agents, contractors, or other business partners on behalf of **TCDH**~~Tri-City Medical Center~~. Additionally, they apply to all **TCDH**~~Tri-City Medical Center~~ workforce members, contractors, and sub-contractors supporting Tri-City Medical Center operations. Some standards may only apply to persons with a specific job function (e.g., System Administrator); otherwise, all personnel supporting **TCDH**~~Tri-City Medical Center~~ operations are to adhere to applicable standards.

C. **POLICY OVERVIEW:**

1. This policy is disseminated to **Information Technology (**IT**)**, Legal, Compliance and Administration~~,~~**. ~~t~~T**he assigned **IT** Security Officer is responsible for managing the development, documentation, and dissemination of this policy and its related procedures. This policy and its related procedures are reviewed and updated on an annual basis, or when a security event occurs that requires the policy to be updated, such as a security incident.

D. **POLICY**

1. ~~Tri-City Medical Center~~**TCHD** implements and maintains a cybersecurity incident handling and response capability that can detect, analyze, contain, and recover from incidents. ~~Tri-City Medical Center~~**TCHD**'s executive leadership and cybersecurity team maintain situational awareness of incidents to support mission and business operations and protect ~~Tri-City Medical Center~~**TCHD**'s reputation.

E. **INCIDENT REPORTING**

1. **TCDH**~~Tri-City Medical Center~~ implements and governs processes and documentation to facilitate an organization-wide response capability for security and privacy-related incidents. Suspected security incidents may also be reported, including the receipt of suspicious email communications that can potentially contain malicious code. The types of security incidents reported, the content and timeliness of the reports, and the designated reporting authorities reflect applicable laws, Executive Orders, directives, regulations, and policies.

F. **INCIDENT HANDLING**

1. Tri-City Medical Center implements an incident handling capability for security incidents that includes preparation, detection and analysis, containment, eradication, and recovery. Incident-related information can be obtained from a variety of sources, including audit monitoring, physical access monitoring, network monitoring, user or administrator reports, and reported supply chain events. An effective incident-handling capability includes coordination among many organizational entities (e.g., mission or business owners, system owners, authorizing officials, human resources offices, physical security offices, personnel security offices, legal departments, etc.). Additionally, Tri-City Medical Center coordinates incident handling policies with contingency planning policies.
2. Suspected security incidents include the receipt of suspicious emails that may contain malware. Suspected supply chain incidents include the insertion of counterfeit hardware or malicious code into ~~Tri-City Medical Center~~**TCHD** information systems or system components. An incident that involves personally identifiable information (PII) or protected health information (PHI) is considered a breach. A breach results in unauthorized disclosure, loss of control, unauthorized acquisition, or a compromise of PII or PHI. All workforce members are required to report suspected security incidents to the IT department for review as soon as possible. IT will review the matter and take appropriate actions.
3. ~~Tri-City Medical Center~~**TCHD** employs automated mechanisms to assist in the tracking of security incidents and the collection and analysis of incident information. Tracking and documenting system security incidents includes maintaining records about each incident, the status of the incident, and other pertinent information necessary for forensics, evaluating incident details, trends, and handling. Incident information can be obtained from a variety of sources including incident reports, incident response teams, audit monitoring, network monitoring, physical access monitoring, and user/administrator reports.
4. Lessons learned from incident handling activities are incorporated into incident response procedures, training, and testing/exercises. Changes from lessons learned are implemented accordingly.

G. **INCIDENT RESPONSE PLAN**

1. ~~Tri-City Medical Center~~**TCHD** develops and implements a coordinated approach to incident response. Organizational missions, business functions, strategies, goals, and objectives for incident response help determine the structure of incident response capabilities. As part of a comprehensive incident response capability, ~~Tri-City Medical Center~~**TCHD** considers the coordination and sharing of information with external organizations, including, for example, external service providers and organizations involved in the supply chain for organizational systems. ~~Tri-City Medical Center~~**TCHD**'s incident response plan includes:
   a. A roadmap for implementing the incident response capability.
   b. The structure of the incident response capability.
   c. The unique requirements of the ~~Tri-City Medical Center~~**TCHD**, which relate to business, size, and functions.
   d. Reportable incidents.
   e. Metrics for measuring the incident response capability within the ~~Tri-City Medical Center~~**TCHD**.
   f. The resources and management support needed to effectively maintain and mature an incident response capability.
2. The incident response plan is distributed to designated personnel and teams, and is reviewed and updated, at a minimum, annually. Any changes to the incident response plan are communicated to defined teams and personnel. The incident response plan is protected from unauthorized disclosure and modification.

H. **INCIDENT RESPONSE TESTING**

1. ~~Tri-City Medical Center~~**TCHD** tests their incident response capability every annually using security tools and partner support to determine the incident response effectiveness and document the results. Incident response testing is coordinated with other organizations that are incorporated

in the incident response plan (e.g., Business Continuity Plans, Contingency Plans, Disaster Recovery Plans, Continuity of Operations Plans).

I. INCIDENT RESPONSE TRAINING

1. ~~Tri-City Medical Center~~**TCHD** provides incident response training to users with an incident response role or responsibility and provides updates when required by information system changes. Incident response training incorporates simulated events to facilitate practicing effective response by personnel. Automated mechanisms are employed for a more realistic incident response training environment.

J. PUBLIC RELATIONS & REPUTATION REPAIR

1. ~~Tri-City Medical Center~~**TCHD** manages public relations associated with incidents and employs appropriate actions to prevent further reputational damage and develops plans to repair any damage to reputation. ~~Tri-City Medical Center~~**TCHD** has a strategy in place for addressing incidents that have been brought to the attention of the public, have cast ~~Tri-City Medical Center~~**TCHD** in a negative light, or have affected ~~Tri-City Medical Center~~**TCHD**'s business partners or customers. Taking proactive steps to repair ~~Tri-City Medical Center~~**TCHD**'s reputation is essential to reestablishing the trust and confidence of business partners and customers.

K. EXCEPTIONS

1. ~~Tri-City Medical Center~~**TCHD** business needs, local situations, laws, and regulations may occasionally call for an exception to this policy or any other ~~Tri-City Medical Center~~**TCHD** policy. If an exception is needed, ~~Tri-City Medical Center~~**TCHD** management will determine an acceptable alternative approach.

L. ENFORCEMENT

1. Any violation of this policy or any other ~~Tri-City Medical Center~~**TCHD** policy or procedure may result in disciplinary action, up to and including termination of employment. ~~Tri-City Medical Center~~**TCHD** reserves the right to notify the appropriate law enforcement authorities of any unlawful activity and to cooperate in any investigation of such activity. ~~Tri-City Medical Center~~**TCHD** does not consider conduct in violation of this policy to be within an employee's or contractor's course and scope of work.
2. Any employee or contractor who is requested to undertake an activity that he or she believes is in violation of this policy must provide a written or verbal complaint to his or her manager or any other manager of ~~Tri-City Medical Center~~**TCHD** as soon as possible.
3. The disciplinary process should also be used as a deterrent to prevent employees and contractors from violating organizational security policies and procedures, and any other security breaches.

M. REFERENCES

1. HIPAA Security Rule: *164.308(a)(6)*
2. National Institute of Standards and Technology (NIST) Special Publications (SP): NIST CSF: ID.GV-1, ID.GV-3, PR.IP-8, PR.IP-9, DE.AE-2, DE.AE-3, DE.AE-4, DE.AE-5,RS.AN-, RS.AN-4, RS.AN-5, RS.CO-1, RS.CO-2, RS.CO-3, RS.CO-4, RS.CO-5, RS.IM-1, RS.IM-2, RS.MI-1, RS.MI-2, RS.MI-3, RS.RP-1, RC.CO-1, RC.CO-2, RC.CO-3, RC.IM-1, RC.IM-2, RC-RP.1

Tri-City Medical Center	Cardiac Catheterization Lab
PROCEDURE:	**ANGIOJET**
Purpose:	To assist physician with insertion of **A**~~a~~ngiojet catheter via femoral artery using a uniform set-up for invasive procedures in the cardiac catheterization laboratory
Supportive Data:	Angiojet unit guidelines for set-up from Boston Scientific
Equipment:	Angiojet motor drive unit AngioJet spiroflex Thrombectomy Set 1-Heparinized saline (2 units/ ml), 500 ml bag Temporary pacing cable Temporary pacer generator.
Issue Date:	02/05

A. **POLICY**

1. All cardiac catheterization laboratory (CCL) staff will be knowledgeable and comply with the procedure set forth for **A**~~a~~ngiojet insertion and use.~~.~~
2. Upon arrival to the CCL, the patient is prepped for a left heart catheterization. Angiojet is considered after visualization of coronary arteries, Physician's preference.
3. Possibly will need to place a temporary pacemaker, physician's preference, if so **a**~~A~~ 6 French sheath is inserted in the femoral vein for placement of a temporary pacemaker.
4. Temporary pacemaker lead is ~~inserted,follow~~**inserted, follow** cardiologist preferences for temporary pacer settings, must be set before **A**~~a~~ngiojet use. ***Note: Angiojet will cause dysrhythmias.**

B. **PROCEDURE:**

1. Hand off sterile Angiojet Spiroflex Monorail thrombectomy set to scrub person**.**
   a. Sterile person hands off the pump set circulating person, keeping the catheter on the sterile f**ield**~~iled~~.
   b. Scrub person to inspect the catheter to ensure that no damage is present**.**
2. Motor Drive Unit**:**~~:~~
   a. Turn drive unit on, power button is located at the top of the machine (power), the console drawer will open.
   b. Hang a 500 ml heparinized saline bag, per Physician order, onto the hook located on the left/right side of the console, the scrub person will hand off pump set back, spike the heparinized saline bag with the spike tubing.
   c. Insert the pump into the console, ensure that the waste bag tubing aligns in the roller pump, then push the button to close the console, grey button located just above the doors
   d. Place the foot pedal nearest the physician.
   e. Remove the mandrel form the catheter by pulling on the wire loop visible at the tip of the catheter and prime the catheter by completely submerging the tip in heparinized saline and pressing the foot pedal, continuing priming until the time display reaches zero seconds.
   f. Confirm system set-up is successfully completed by removing foot form foot pedal. Status panel displays ready and green icon is illuminated.
   g. Attach a syringe filled with saline to the flushing tool and insert the top of the catheter into the tool. Depress the syringe until saline exits the proximal end of the guidewire.
      i. A flushing tool is included in the package for the purpose of flushing the guidewire lumen**.**
   h. Wipe the catheter shaft to activate the hydrophilic coating.

C. **REFERENCE(S):**

Cardiac Catheterization Lab Review/Revise	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
05/05: 06/05, , 03/09, 05/20	06/21**, 05/25**	07/21**, 09/25**	09/21**, 10/25**	10/21**, 12/25**	n/a	08/11, 10/21

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1. Angiojet (2015). *Thrombectomy System and Set-up.* Boston Scientific Corporation.

Tri-City Medical Center	Cardiac Catheterization Lab
PROCEDURE:	**D STAT (FLOWABLE)**
Purpose:	For local management and control of bleeding from vascular access sites.
Supportive Data:	Vascular Solutions D-Stat Flowable Hemostat
Equipment:	D-Stat Flowable Hemostat package
Issue Date:	05/05

A. **PROCEDURE:**

1. It is indicated for use under the direction of a healthcare professional for the local management and control of bleeding from vascular access sites, percutaneous catheters and tubes, and prepectoral pockets.
2. Contraindicated in persons with known sensitivity to bovine-derived materials.
3. Preparation:
   a. Remove caps from thrombin and diluent vials to expose the rubber stoppers.
   b. Using the 10 ml mixing syringe and non-coring vial access device, withdraw all diluent from the diluent vial and transfer it into the thrombin vial.
   c. Gently rotate the vial to reconstitute. DO NOT SHAKE.
   d. When the thrombin is completely dissolved, withdraw the thrombin from the vial again using the mixing syringe and vial access device. Remove the vial access device from the mixing syringe.
   e. Attach the collagen syringe with attached mixing luer to the mixing syringe.
   f. Vigorously push the thrombin into the collagen syringe.
4. Application:
   a. Disconnect the mixing syringe containing the D-Stat and attach the desired applicator tip. Physician will apply D-Stat according to recommendation treatment.
      i. Scrub person may apply topical D-Stat per Physician order.
   b. Follow manufacturer's guidelines for application and use.

Cardiac Catheterization Lab Review/Revise	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
05/05; 08/09, 05/20, 05/25	06/21, 05/25	07/21, 09/25	09/21, 10/25	10/21, 12/25	n/a	08/11, 10/21

Tri-City Medical Center	Cardiac Catheterization Lab
PROCEDURE:	**MANUAL ASPIRATION/EXTRACTION OF CORONARY THROMBUS**
Purpose:	Manual aspiration of soft coronary thrombus
Supportive Data:	Vendor-specific Catheter guidelines for set-up
Equipment:	Aspiration catheter Sterile cath table with interventional equipment
Issue Date:	05/05

A. **PROCEDURE**

1. Scrub Tech will:
   a. Receive sterile kit, inspect for damage**.**
   b. Transfer the dispenser coil with ~~the extraction~~**the extraction** catheter into the sterile field**.**
   c. Remove the extraction catheter from the dispenser coil and remove the packaging mandrel from the guidewire lumen**.**
   d. Draw up 5 mL of heparinized saline into the 30 ml syringe**.**
   e. Connect the syringe to the stopcock and extension line and connect the attached extension line to the catheter.
   f. Flush the entire connection to remove all air from the catheter, extension line, stopcock and syringe.
   g. Turn the stopcock to the "OFF" position**.**
      i. With the Stopcock in the "Off" position, pull back the plunger on the 30 ml syringe.
      ii. Twist the plunger to lock the syringe in the vacuum position.
      iii. PRECAUTION: check to make sure are fittings are secure so that air i**s**~~n~~ not introduced into the extension line or syringe during extraction**.**
2. Removal of the aspiration catheter:
   a. After completing the extraction process, turn the stopcock to the "Off" position and remove the catheter or attach second syringe and repeat extraction.
   ~~b.~~

B. **REFERENCE(S):**

1. Vascular Solutions, Inc. (2017). *Pronto LP Extraction Catheter.* Minneapolis, Minnesota: Vascular Solutions, Inc.

Cardiac Catheterization Lab Review/Revise	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
05/05; 05/09, 02/20, **02/25**	06/21**, 05/25**	07/21**, 09/25**	09/21**, 10/25**	10/21**, 12/25**	n/a	10/21

Tri-City Medical Center	Cardiac Catheterization Lab
PROCEDURE:	**RIGHT HEART CATHETERIZATION AND PREP OF A PULMONARY ARTERY CATHETER**
Purpose:	To insure uniform setup
Supportive Data:	None
Equipment	Sterile cardiac cath tray ~~-~~Pulmonary artery catheter; Sheath 8 Fr; Two port manifold ~~-~~Angioplasty pack **V**~~-v~~ented contrast spike Transducer; 3-3 ml Heparinized syringes Pressure line ~~-~~Sterile gloves; Stopcock
Issue Date:	05/88

A. **PROCEDURE**

1. Table will be cleaned with disinfecting solution, **a**~~A~~llow table to dry for manufacturer's recommended time.
2. Angio pack will be opened in a sterile fashion.
3. Sterile supplies will be added.
4. ~~-~~Pulmonary artery catheter will be flushed with Heparinized solution and a stopcock will be placed on the proximal injectate per physician order**.**
5. 1.5 ml of air will be injected into the balloon port with a 3 ml syringe to make sure the balloon is intact.
6. Connect the stopcock to the transducer.
7. Connect pressure line to the transducer and to the port closest to the catheter port on the manifold.
8. Connect the solution spike to the other port on the manifold.
9. Attach the bag of Heparin solution to the solution spike per physician order.
10. Flush the lines and transducer until free of air.
11. Open the transducer to air and to balance the amplifier.
12. Connect the manifold to the distal infusion port on ~~the pulmonary~~**the pulmonary** artery catheter and flush the lumen.
13. **Precautions:**
    a. Make sure the syringes are Heparinized properly. Check for balloon patency.

Cardiac Catheterization Lab Review/Revise	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
06/97; 10/00; 04/03; 06/05; 08/09, 09/12, 05/20**, 02/25**	06/21**, 05/25**	07/21**, 09/25**	09/21**, 10/25**	10/21**, 12/25**	n/a	05/88, 10/21

Tri-City Medical Center
Oceanside, California

CARDIAC CATHETERIZATION LABORATORY

ISSUE DATE: 05/22 **SUBJECT: Scheduling Cardiac Catheterization Cases Policy**

REVISION DATE:

Cardiac Cath Lab Approval: **~~04/22~~02/25**
Division of Cardiology ~~Division Department~~ Approval: **~~04/22~~08/25**
Pharmacy &Therapeutics Committee Approval: **n/a**
Medical Executive Committee Approval: **10/25~~04/22~~**
Administration Approval: **~~05/22~~12/25**
Professional Affairs Committee Approval: **n/a**
Board of Directors Approval: **05/22**

A. **PURPOSE:**
1. To provide scheduling guidelines for Cardiac Procedures (Heart angiogram, Device Implants, Electrophysiology, Structural Heart, transesophageal echocardiogram (TEE), and elective Cardioversion) with and without an anesthesia provider.

B. **DEFINITIONS:**
1. Add-On Cases: Additions to the Cardiac Cath lab (CCL) schedule after the "final schedule" has been published. The "final schedule" is published by 2:00pm for the next day.
2. Elective Case: Procedure can be scheduled at the time best suited for the Cardiologist and the patient.
3. Urgent Case: Cardiac Procedure is needed within 4-6 hours of presentation. Urgent procedures are placed in an available time on the CCL schedule.
4. Emergent Case: Cardiac intervention is needed within one hour of presentation and may require that another scheduled or add-on case is bumped.
5. ON Call: Cardiac Cath lab team 1 RN, 1 RT and 2 other members CVT, RN OR RT – Call begins 1530-0700 weekdays and 24/7 weekends**.**
6. First Case Start: 0730 Patient in room**.**
7. STEMI: ST Elevation Myocardial infarction**.**
8. Normal business hours: 0700-1530**.**

C. **SCHEDULING ELECTIVE CASES:**
1. All elective outpatient cardiac procedures will be scheduled through the Cardiology scheduling office.
2. Inpatient elective procedures are only scheduled by the ordering Cardiologist thru the CCL charge RN on duty.
3. There are 2 rooms in the Tri-City Medical Center (TCMC) CCL suite which are utilized as follows:
   a. Room 1 can accommodate all Cardiac Procedures except for Electrophysiology
   b. Room 2 can accommodate all Cardiac Procedures
4. Procedural expected times in the CCL during normal business hours~~.~~ (times may fluctuate based on staffing, CCL volume and CCL acuity)**.**
   a. Heart cath blocked for 60 min
   b. Heart cath with intervention 90 min
   c. Electrophysiology without Ablations 90 min
   d. Electrophysiology with Ablations 180 min
   e. Device Implant 90 min
   f. TEE's 45 min

g. Cardioversion ~~30~~**45** min
h. Structural heart 180 min
i. Turn-around time 30 min with Anesthesia 60 min
j. Break and lunches staff 60 min

5. The process for scheduling an elective case is as follows:
   a. The Cardiologist's office calls the TCMC Cardiology Scheduling department to reserve a case time (Hours of Operation 0730-1600 Mon-Fri)**.**
   b. The Cardiologist's office completes a written "TCMC Cardiology Services form" (reservation sheet) and written orders. Forms to be faxed to the TCMC Cardiology department fax server (Fax # 760-940-4040).
      i. Documents to be Faxed:
         1) Orders
         2) Reservation form
         3) H&P (Valid within 30 days of procedure) if Available
   c. Upon receiving the written booking forms, the TCMC Cardiology Scheduler will schedule the case and obtain a financial account number (FIN#)**.**
   d. Cases are reserved in the CCL suites based on (C.3. and C.4) expected times and the order in which they are received.
      i. Case 1 and 2 expected start time 7:30 Unless an anesthesiology case is scheduled, which then case 2 is an 9:00 approximate Start**.**
      ii. Case 3 and 4 expected start time 9:00 Unless an anesthesiology case is scheduled then case 2 start 9:00, case 3 start 10:30 and case 4 at 12:30**.**
   e. The cardiology scheduler will notify the office that the reservation is booked and will provide the following information:
      i. Date of Procedure
      ii. Case number
   f. The Cardiologist's will enter electronic orders or fax written orders to the TCMC Cardiology Scheduling department fax server prior to finalizing the appointment.
6. Elective cases are performed during normal business hours.
   a. Last elective case scheduled time is 1400**.**
7. Patient Requirements:
   a. Cardiology patients must be at least 18 years of age at the time of Cardiology, except in the case of emergency.
   b. Any requested patients who is under 18 years of age accepted under the care of the cardiologist must also be reviewed/approved prior to scheduling by the Chief of Anesthesia or designee.
8. The Cardiologist must have the appropriate privileges granted to be allowed to schedule a procedure.
   a. Current privilege lists are maintained through the E-PRIV system, accessible through TCMC Intranet.
   b. If the physician's privilege status is still not clear, the Medical Staff Office is contacted for clarification. The Administrative Supervisor may be contacted for assistance outside of Medical Staff Office hours.
   c. It is the responsibility of the Cardiologist to acquire an assistant or proctor as necessary for designated procedures.

D. **START TIMES**:

1. All first case start times will be at 0730 unless limited by Anesthesia availability**.**
   a. All Physicians should arrive no later than 30 minutes prior to scheduled Anesthesia cases**.**
      i. Anesthesia start time is patient in room time
         1) Example: 11:15 start, requires Cardiologist to arrive at 10:45am**.**
      ii. The Start time of elective or add-on case requested for after the first case or later cannot be guaranteed. In those instances refer to (C.3 a).of this protocol for suggested time slots and proposed times. The cardiologist

preferred start time will be noted, and the cardiologist will be given on ~~hour's notice~~**hours' notice** of expected start time. If the cardiologist cannot start at the expected time, the next cardiologist will be offered that time.

2. Cases are scheduled on a consecutive, first-come first-served basis based on (3.a.) of this protocol.
3. Start time of first cases are tracked and reported to the Cardiology Division committee monthly.
   a. Three (3) or more late starts for the first case will lose first case Start for 30 days**.**
4. All cases must follow the Patient Care Service Universal protocol Procedure**.**
   a. 0730 cases, the patient must be ready for transfer to the CCL Suite by 0715, if all elements of the pre-procedure verification are not available, the next scheduled case may replace the delayed case.
   b. Possible Delays include, but are not limited to:
      i. NO H&P
      ii. NO Orders
      iii. NO Consent
      iv. Physician not available (not on site)
5. If physician leaves the CCL area prior to patient entering the room**.**
   a. The charge RN or charge RN on duty will communicate directly with the ordering physician via text or phone when patient is ready for procedure.
   b. Physician is to respond to the charge RN or charge RN on duty after hours within 10 minutes.
   c. Patient will be removed from the CCL room if physician does not arrive within 15 minutes (with anesthesia) or 30 minutes without anesthesia of initial notification, that patient is ready.

E. **PRE-OPERATIVE SCHEDULING CALLS:**
1. Patients are called the day before their appointment and provided instructions on the following:
   a. Time of arrival
   b. Location of registration
   c. Medication management

F. **SCHEDULING ADD-ON URGENT OR EMERGENCY PROCEDURES:**
1. STEMI procedures will bump any scheduled case for the first available room**.**
2. Urgent and Emergent cases may be performed at any time.
   a. If the Urgent or Emergent procedure must bump the current scheduled procedure then the physician adding the urgent/emergent case must communicate the bump to the affected physician.
      i. Examples of Urgent or Emergent include:
         1) Persistent chest pain presumed to be due to coronary insufficiency but not meeting criteria for STEMI
         2) Recurrent chest pain despite medical therapy for coronary insufficiency
         3) symptomatic bradycardia or heart block requiring temporary pacing
         4) A patient who clinical condition is such that they require urgent or emergent access to the cath lab at the discretion of the attending cardiologist
         5) List is not inclusive
   b. If the attending cardiologist and the cardiologist being bumped disagree the medical director of the cath lab may be requested to discuss the case**.**
3. Urgent and Emergent cases shall be scheduled through the PBX Operator or by calling the Charge RN on Duty.~~,~~
4. Required information when scheduling an add-on case includes:
   a. Patient name, date of birth, age, and medical record number
   b. Order entered into Cerner (excludes outpatient)

c. Patient phone number, Social Security number, and insurance information (excludes in- house patients) and authorization number when needed.
d. Patient current location in the hospital (Excludes out-patients)
e. NPO status
f. Pre-Op diagnosis and Procedure to be performed
g. Physical needs/mobility limitations
h. Relevant cardiac/medical history
i. Time of Cardiologist availability
j. Vendor information if applicable

5. Same day outpatient elective and inpatient elective add on procedures will be added to the end of the day.

G. **SCHEDULING ELECTIVE OUTPATIENT ADD ON CASES**:

1. Add-on cases are started in order of scheduling, providing the Cardiologist is available and the patient is ready for the procedure.
2. If the first scheduled add-on case cannot be performed in the first available time, the next case's Cardiologist will be contacted and offered to start at the available time. Upon availability of the next time to start an add-on case, the Cardiologist for the first case will again be contacted and offered the time.
   a. The first available time is 0730. If a physician requests a specific time, e.g., 0900 to start a case, and another physician is available to start at 0730, the physician requesting the 0900 start time will be contacted to move up to 0730, or will start after the preceding case is finished.
   b. An open cath lab will not be held more than 30 min to accommodate a requested start time.
3. Requests may be approved on an individual basis by the Cardiovascular Service Line**.** Director/designee and/or the Invasive Medical Director.

H. **WEEKEND/HOLIDAY CASES**:

1. For Saturday and Sunday 24/7, 1 room is available for On Call Urgent and Emergent cases. No elective procedures are scheduled on weekends or after hours.
2. Memorial Day, Labor Day, July 4th, Thanksgiving, Christmas, New Year's Day and Presidents Day have 1 room available for On Call Urgent and Emergent cases. No elective procedures are scheduled on these holidays.

I. **CANCELING CASES/DELAYS:**

1. Outpatient**:**
   a. To cancel an outpatient case contact the cardiology scheduler**.**
   b. If a patient cancels his/her procedure upon the Pre-operative call, the RN Making the call will notify the cardiology scheduler and the cardiologist.
   c. The cardiology scheduler will notify the MD's Office of the reason and work with the MD's office to reschedule the outpatient**.**
   d. Under no circumstance will an RN cancel a case without an order from the physician
2. Inpatient**:**
   a. MD to notify the CCL charge RN of the cancelled case immediately upon notification**.**
3. Cardiologist will notify the CCL they will be late for their scheduled start time and must provide an expected time of arrival. Delays of more than 30 minutes, or delays that will impact another Cardiologist's schedule will cause the ~~delayed Cardiologist~~**delayed Cardiologist** to be bumped back to the next available start time.
4. A Cardiologist who is not in CCL 15 minutes past the scheduled time of Procedure and/or are unable to be contacted will be bumped back to the next available start time once they either arrive at the hospital or contact the CCL.

J. **STRUCTURAL HEART CASES:**

1. Structural Heart cases may be performed Monday through Friday during normal business**.**

2. All Cases must be worked up in a multi-disciplinary fashion per CMS guidelines and the national standard of care.
3. Structural Heart cases are scheduled in the same manner as Cardiac procedures.
4. Cardiologist performing the procedure is responsible for ensuring availability of the physicians, vendors and staff prior to scheduling.
5. Elective Structural Heart cases are not to be scheduled on holidays or weekends.
6. Cardiac Anesthesia is preferred for structural heart cases.

Tri-City Medical Center
Oceanside, California

FOOD AND NUTRITION SERVICES
CLINICAL NUTRITION

ISSUE DATE: **04/06** **SUBJECT:** **Clinical Nutrition Dietitian Staffing**

REVISION DATE: **10/11, 03/18, 05/22**

Department Approval:	**~~07/22~~09/25**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~09/22~~11/25**
Administration Approval:	**~~11/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**11/22**

A. **DEFINITIONS**:
1. Clinical Dietitian/Clinical Staffing refers to a Registered ~~Dietician (RD~~**Dietitian Nutritionist (RDN**) who has completed department specific competencies.

B. **POLICY:**
1. Clinical dietitians are scheduled **daily** to assure continuity and consistency of nutrition care provided to patients.
~~2. Clinical dietitians are scheduled daily to assure consistency of care to patients.~~
2. A ~~dietitian~~**RDN is scheduled 7 days a week.**
3. **A RDN** is scheduled for weekend coverage.
4. A ~~dietitian~~**RDN** is scheduled for holiday coverage.
5. Staffing of clinical dietitians is adjusted to patient census and workload

C. **EMERGENCY OPERATION CLINICAL NUTRITION STAFFING**
1. **Phase 1 (Conventional Capacity)**
   a. In-patient - Clinical staffing at least 80% with dietitians working regularly scheduled hours.
      i. Follow facility nutrition assessment policy and identify opportunities for potential adjustments.
   b. Outpatients
      i. If facility remains open to outpatients, continue business as usual
      ii. Implement tele-health nutrition MNT options
2. **Phase 2 (Decreased Capacity)** Clinical staffing at 51-79% ~~-~~and/ or volume of patients with nutrition concerns is elevated.
   a. Inpatients
      i. Follow facility nutrition assessment policy and adjust assessment and reassessment time frames to prioritize severe nutrition risk patients including and limited to:
         1) Ventilated patients
         2) Patients on new nutrition support
         3) Malnutrition/Pressure Injuries Stage III & IV/ BMI < 18
         4) In the event that all severe nutritionally at risk patients are addressed, Dietitian will prioritize additional patients per clinical judgement.
   ~~ii.~~**b.** Outpatients
      ~~1) Closed~~
      i. If facility remains open to outpatients, continue business as usual

ii. Implement tele-health nutrition MNT options

3. **Phase 3 (Crisis Capacity)** Clinical staffing at 50% or less and/ or volume of patients with nutrition concerns is elevated.
   a. Inpatients
      i. Follow facility nutrition assessment policy and adjust assessment and reassessment time frames to prioritize severe nutrition risk patients including and limited to:
         1) New ventilated patients
         2) Patients on new enteral feeding
         3) New TPN, if consulted by consulted Pharmacy
         4) Consultation ordered that meet criteria for severe malnutrition
         5) Pressure Injuries Stage III & IV
      ii. Documentation will be completed in an abbreviated form
      iii. Reassessments will be completed per clinical judgement or if consulted through the EMR.
      iv. In the event that all severe nutritionally at risk patients are addressed, Dietitian will prioritize additional patients per clinical judgement.
   b. Outpatients
      i. Closed

Tri-City Medical Center
Oceanside, California

Food and Nutrition Services

ISSUE DATE: 4/06 **SUBJECT: Food Allergens**

REVISION DATE(S): 11/08; 10/10; 10/11, 02/12

Food & Nutrition Department Approval:	**~~02/17~~10/25**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~09/19~~11/25**
Administration Approval:	**~~10/19~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**10/19**

A. **POLICY:**

1. Food allergies of patients are reported via electronic health record (EHR) through the "allergy" section. Information may be obtained during the initial admission assessment, through communication by the patient to the Food & Nutrition staff, and/or at any time during the admission.
   a. Food allergy information is documented in the EHR. This information is automatically transmitted to Food & Nutrition Services as part of the diet order.
   b. Foods that the patient is allergic to and/or foods containing an allergen are omitted from the patient's diet and meals served.
   c. 90% of food allergies can be attributed to one or more of the following: milk, egg, fish (bass, flounder, or cod), crustacean shellfish (i.e. crab, lobster, or shrimp), tree nuts (i.e. almonds, pecans, walnuts), wheat, peanuts, and soybeans.

B. **PROCEDURE:**

1. For each diet order for each patient, food allergies are identified via diet sheets and individual diet orders.
2. These allergies are documented on the patient ~~cardex~~**Kardex**
3. The allergies are also put onto the menu heading via sticker printouts or manually.
4. The menu is stamped with "ALLERGY"
5. Any foods on the menu that contain the allergies **noted in EMR** are crossed off the menu. These foods are identified by:
   a. Reading ingredient lists of premade/packaged foods
   b. Reviewing the recipes
6. When the menu is retrieved from the patient, it is rechecked to verify selected foods do not contain allergens and that the menu is stamped with "ALLERGY".
7. ~~When the tray reaches the end of trayline, the checker will read the allergies and verify foods are safe.~~
7. **During tray line the checker physically inspects the tray to ensure that all food items match the order and comply with the diet requirements. They must verify that no prohibited items have been mistakenly placed on the tray.**

C. **REFERENCE:**

1. ~~2013~~**2022** FDA Food Code

Tri-City Medical Center
Oceanside, California

FOOD AND NUTRITION SERVICES

ISSUE DATE: **02/00**

SUBJECT: **Food Safety and Department Cleaning Policy**

REVISION DATE: **02/12, 02/13**

Department Approval:	**06/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**06/22**

A. **POLICY:**

1. All new employees must complete department specific orientation and follow all regulatory and food safety guidelines:

B. **PROCEDURE:**

1. Department Specific Orientation is conducted with the employee after attending Tri-City Medical Center New Employee Orientation Management conducts annual in-services for department safety.
2. Employees are scheduled to complete required computer based learning modules within the first 30 days of hire.
3. Department employees are expected to follow hospital wide dress and appearance per Administrative Policy: Dress and Appearance Philosophy 415. In addition, the following list of requirements must be met by each employee on a daily basis.
   a. Employees are responsible for reporting any health problem that might be contagious in nature. This includes respiratory tract infection, boils, infected burns, or sores. The employee is referred to the Employee Health Nurse for evaluation and clearance for work.
   b. Hair must be completely covered with a hairnet or hat.
      i. Hats/head covering must be worn by those individuals with short hair.
   c. Beards, mustaches, and sideburns are allowed if they are neatly trimmed. When beards are longer than ¼" appropriate covering is required
   d. Food & Nutrition services employees are provided with shirts and/or Chef Coats as part of the uniform. Employees may wear a clean white or black washable sweater in colder weather. Pants must be black, tan or khaki. No jeans or yoga pants are permitted
   e. Closed toe, slip resistant shoes and stockings are required.
   f. Aprons will be provided and must be promptly changed when soiled. Aprons should never be worn outside of kitchen
   g. Jewelry is limited to the following:
      i. Small pierced earrings, (no loops or dangling earrings allowed).
      ii. Necklaces that are a chain or have a small ornament attached must be tucked in under uniform
      iii. Only simple wedding bands may be worn by employees in food production. No other rings, bracelets, or watches may be worn.
   h. Employees must prevent miscellaneous items from falling into food by not carrying items in shirt pockets, behind the ears, stuck in the hair, etc.
   i. Smoking is prohibited in all areas of the hospital.
   j. Employees are not allowed to chew gum while on duty.

4. Personal protective equipment (PPE) is provided by the department. Examples include pot holders, safety goggles, rubber gloves, heat protective gloves.
5. Cutting Boards
    a. All cutting boards will be constructed of a non-porous material, which may be thoroughly cleaned and sanitized. Sufficient cutting boards will be maintained in each production area to ensure adequate food handling procedures.
6. Can opener
    a. Blades are inspected for cleanliness and maintenance daily.
    b. Receiving Clerk replaces blade monthly or as needed
    c. Can opener base is removed, cleaned, and sanitized monthly
7. Operation of safety locks in the Kitchen Refrigerators and Freezers.
    a. Vegetable and produce walk-in: Turn handle to right of door counter-clockwise as far as it will go, push door open.
    b. Freezer in kitchen: Press white knob on door and push door open as normal.
    c. Freezer in dry goods store room,:Turn lock on door, Push door open. Door is very difficult to open when door first closes.
    d. Milk and meat walk-ins (light switch located just to right of door, inside: Press white knob on door and push door open as normal.
8. Department Cleanliness and Equipment Maintenance
    a. Regular cleaning assignments are assigned to all positions to assure maintenance of cleanliness of the kitchen and cafeteria.
        i. This includes all refrigerators and freezers within the department.
        ii. Refrigerator shelves are cleaned weekly.
    b. Staff are required to initial cleaning schedule when daily cleaning is completed. If unable to complete, Supervisor must be notified. A Supervisor or designee is required to validate completion for compliance. Task sequences for various positions also outline specific assigned duties for maintenance of kitchen and cafeteria cleanliness.
    c. All surfaces used for food preparation are cleaned with an approved disinfectant after each meal period.
    d. Chipped or cracked china or glassware is discarded.
    e. Sanitation buckets are filled with appropriate concentration of disinfectant and changed every 4 hours or when dirty.
    f. Floors in the kitchen and cafeteria are cleaned daily or as needed. . Floors are power washed or buffed by EVS staff monthly as available.
    g. Floor mats are cleaned daily
    h. EVS is responsible for cleaning used mop heads
    i. Rags, aprons, and linen are cleaned by a third party.
    j. Patient food carts and other food carts are cleaned as part of scheduled cleaning assignments.
    k. Lighting, ventilation, and humidity is controlled to prevent the growth of bacteria/microorganisms.
    l. All preventive and corrective maintenance on equipment is to be documented by Engineering.
        i. Preventative Maintenance on the hoods and ice machines are conducted bi-annually or as needed.
9. Food- Borne Illness Outbreak
    a. In the event of a food-borne illness outbreak, the department will:
        i. Save suspected foods (if able) for culturing by the Public Health.
        ii. Document departmental conditions at the time of preparation of suspect foods, if possible.
        iii. Notify Infection Control/Employee Health of any reports of gastrointestinal complaints and suspected time interval.
        iv. Implement and supervise control measures to prevent further occurrence of the illness

C. **RELATED DOCUMENT(S):**

1. Administrative Policy: Dress and Appearance Philosophy 415
2. Infection Control Policy: Hand Hygiene

Tri-City Medical Center
Oceanside, California

FOOD AND NUTRITION SERVICES

ISSUE DATE: **04/06** **SUBJECT:** **Food Service Employee Health- Work Restriction for Personnel with Infectious Diseases**

REVISION DATE: **11/08, 10/10, 10/11, 02/12, 12/19, 01/23**

Food and Nutrition Services Content Expert Approval: **~~05/22~~07/25**
Infection Control Committee Approval: **~~11/22~~07/25**
Pharmacy &Therapeutics Committee Approval: **n/a**
Medical Executive Committee Approval: **n/a**
Administration Approval: **~~01/23~~12/25**
Professional Affairs Committee Approval: **n/a**
Board of Directors Approval: **01/23**

A. **PURPOSE:**

1. There are a wide range of communicable diseases and infections that can be transmitted by an infected food employee. Employees must be aware of the symptoms, illnesses, or conditions that must be reported to the supervisor and to Employee Health. In order to prevent the spread of infection to patients or other personnel, the department and District may require that food service employees with particular symptoms and/or illnesses be excluded from work or have work restrictions.
2. In addition to the restrictions for personnel with infectious diseases as outlined in Employee Health Policy: Work Restrictions for Personnel with Infectious Diseases, food service employees are also potentially subject to additional restrictions and/or exclusions as outlined in the following charts. Staff with symptoms, diagnoses, and/or exposures as outlined below is required to report information to the F&N supervisor who will refer the employee to the Employee Health nurse.

Food service employee shall report any listed symptoms to the F&N supervisor

Symptom	**Exclusion/ Restriction**	**Duration/Criteria for Return to Work**	**Regulatory Approval (RA) Required to return to work?**
Vomiting	Exclude from work	Asymptomatic for at least 24 hours *or* provides medical documentation. *Exceptions:* Diagnosis of Norovirus, Shigella spp., E. Coli 0157:h7 or other EHEC, HAV, or typhoid fever.	No if not diagnosed with exception.
Diarrhea (≥ 3 loose or watery stool in a 24 hours period)	Exclude from work	Asymptomatic for at least 24 hours *or* provides medical documentation. *Exceptions:* Diagnosis of Norovirus, Shigella spp., E. Coli 0157:h7 or other EHEC, HAV, or typhoid fever.	No if not diagnosed with exception.
Jaundice	Exclude from work if onset occurred within last 7 days.	When approval is obtained from regulatory approval and jaundice has been for more than 7 calendar	Yes

		days *or* provides medical documentation.	
Sore throat with fever	Exclude from work	When medical documentation is provided stating on antibiotics for *Streptococcus pyogenes* for more than 24 hours *or* has at least one negative throat culture *or* is determined by a health practitioner to be free of a *Streptococcus pyogenes* infection.	No
Infected wound or pustular boil	Restrict by covering wound, cut or boil with an impermeable cover and single use glove (if hand, finger, or wrist) and/or a dry, durable, tight fitting bandage if wound is elsewhere on body.	When infected wound or boil is properly covered (See exception for *Staphylococcus aureus* lesions in policy IC14)	No

Summary of Requirements for Diagnosed, Symptomatic *or* Diagnosed but with resolved symptoms Food Service Employees

Diagnosis	**Exclusion**	**Duration/Criteria for Return to Work**	**Regulatory Approval (RA) Required for Return to Work?**
Hepatitis A virus	Exclude from work if within 14 days of any symptom or within 7 days of jaundice	Approval from RA and employee has been jaundiced for more than 7 days *or* an anicteric employee has had symptoms for more than 14 days *or* medical documentation is provided stating employee is free of Hepatitis A.	Yes
Typhoid Fever	Exclude from work	Approval from RA and medical documentation is provided stating employee is free of a S. Typhi infection.	Yes
E. coli 0157:H7 or other EHEC/STEC	Exclude from work based on vomiting or diarrhea symptoms	Approval from RA and medically cleared *or* more than 7 days have passed since employee became asymptomatic or was diagnosed.	Yes
Norovirus	Exclude from work based upon vomiting or diarrhea symptoms	Approval from RA and medically cleared *or* more than 48 hours have passed since employee became asymptomatic or was diagnosed.	Yes

Shigella spp.	Exclude from work based upon vomiting or diarrhea symptoms	Approval from RA and medically cleared *or* more than 7 days have passed since employee became asymptomatic or was diagnosed.	Yes

Summary of Requirements for food service employees with History of Exposure and Absent Symptoms or Diagnosis

3. Reinforce and assure compliance with good hygienic practices, symptom reporting requirements and no bare hand contact with ready to eat foods with all food service employees who report a listed exposure.

Pathogen Diagnosis	**Exclusion/ Restriction**	**Duration/Criteria for Return to Work**	**Regulatory Approval (RA) Required for Return to Work?**
Typhoid fever	Restrict	14 days since last exposure or >14 days since household contact became asymptomatic	No
Shigella spp.	Restrict	> 3 days since last exposure or > 3 days since household contact became asymptomatic	No
Norovirus	Restrict	>48 hours since last exposure or >48 hours since household contact became asymptomatic	No
E. coli 0157:H7 or other EHEC/STEC	Restrict	> 3 days since last exposure or >3 days since household contact became asymptomatic	No
Hepatitis A virus	Restrict	Employee is immune from HAV infection due to a prior HAV illness, vaccination against HAV, or IgG administration *or* >30 days have passed since last exposure or since household contact became jaundiced *or* employee uses no bare hand contact with ready to eat foods until > 30 days after potential exposure.	No

B. **RELATED DOCUMENT(S):**

1. Employee Health Policy – Work Restrictions for Personnel with Infectious Diseases

C. **REFERENCE(S):**

1. US Dept. of Health & Human Services, Public Health Service, FDA: Food Code 2017.

Tri-City Medical Center
Oceanside, California

Food and Nutrition Services

ISSUE DATE: 3/88

SUBJECT: ~~Identification of~~ Patients Not Receiving Oral Intake~~

REVISION DATE~~(S)~~: 8/05, 10/11, 2/12, 9/25

Food & Nutrition Department Approval:	**~~02/17~~10/25**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~09/19~~11/25**
Administration Approval:	**~~10/19~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**10/19**

A. **PURPOSE:**

1. ~~To identify~~ **Identify** patients who are NPO and at risk for nutritional depletion in order to assure adequate nutritional care for these patients.

B. **POLICY:**

1. Patients who are NPO and/or on an enteral tube feeding**/parenteral feed** will be monitored by ~~the clinical nutrition staff.~~**a Registered Dietitian Nutritionist (RDN)**
   a. All patients are screened for nutrition risk by the ~~registered dietitian~~**RDN** (exception~~:~~ ~~patients on~~ BHU~~, OB patients, and NICU patients). BHU, OB, and NICU patients~~**),** who have **been** identified ~~nutrition risk as per screening by nursing are assessed~~ for nutrition risk ~~by the registered dietitian~~**per Nurse screening**.
   b. Patients who are NPO, receiving enteral feedings, and/or receiving TPN will be monitored per policy.

Tri-City Medical Center
Oceanside, California

RETIRE – Women and Newborn Services Suspended

FOOD AND NUTRITION SERVICES
CLINICAL NUTRITION

ISSUE DATE: 09/07

SUBJECT: Nutritional Care & Assessment for Infants Admitted to NICU

REVISION DATE: 11/07, 07/08, 11/08, 10/10, 10/11 02/12, 08/19

Food and Nutrition Services Department Approval:	**~~05/22~~09/25**
Perinatal Collaborative Practice Approval:	**08/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~09/22~~10/25**
Administration Approval:	**~~11/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**11/22**

~~A. **DEFINITIONS:**~~

~~1. Malnourished or Nutritionally at Risk:~~
- ~~a. Acute weight loss of greater than 10% of body weight~~
- ~~b. Weight below 3rd percentile on growth chart~~
- ~~c. Decreased percentile scores of height and/or weight~~
- ~~d. Low birth weight or prematurity~~
- ~~e. Inadequate provision or tolerance of nutrients~~
- ~~f. Chronic lung disease/bronchopulmonary dysplasia~~
- ~~g. Congenital heart disease~~
- ~~h. Necrotizing enterocolitis (NEC)~~
- ~~i. Short bowel syndrome~~
- ~~j. Small for gestational age (SGA)~~
- ~~k. Intrauterine growth retardation (IUGR)~~
- ~~l. Rickets of prematurity~~
- ~~m. Cholestasis~~
- ~~n. Failure to thrive~~
- ~~o. Inadequate weight gain (</= 20 gm) after day of life 14~~
- ~~p. Inappropriate or inadequate weight gain x 4 days after day of life 14~~

~~B. **POLICY:**~~

~~1. Function: A systematic method for the CCS-paneled Clinical Registered Dietitian to collaborate with the physician in the assessment of nutrition status of patients, the education of patients regarding nutritional therapies, and the provision of appropriate medical nutrition therapy given the patient's medical diagnosis and assessed nutritional requirements.~~

~~2. Setting: All patients admitted to or being treated at Tri City Medical Center's Neonatal Intensive Care Unit~~

~~3. Supervision: None required~~

~~4. Consults for Neonatal Dietitian are automatically generated from the EMR upon admission.~~

~~5. The CCS-paneled Clinical Registered Dietitian (RD) will complete a Neonatal Nutrition Assessment for nutritional risk within 48-72 hours of hospital admission., per CCS guidelines. This assessment to include age of patient, disease states, nutrition history, medical history, medical therapies/treatments, laboratory values, and recommendations for enteral and parenteral nutrition support, addition of~~

supplements, and education of patients/families regarding appropriate nutrition intervention for a particular disease state

C. **PROCEDURE:**

1. The CCS-paneled Clinical Registered Dietitian (RD) will complete a Neonatal Nutrition Assessment within 48-72 hours of hospital admission.
2. The Clinical Registered Dietitian will document on the Neonatal nutrition assessment form.
3. Assessments will be based on information provided by admission assessment, review of history and physical, physician notes, other disciplines' notes, and interview with parents, nursing, or other members of health care team:
4. within the electronic medical record
5. The Clinical Registered Dietitian will complete the assessment upon admission and monitor the following:
   a. Nutrition order (TPN versus gavage feedings versus nipple feedings versus breastfeeding)
   b. Diagnosis
   c. Chronological age and/or gestational age
   d. Weight and weight for height percentile or weight for age/weight for height percentile
   e. length,
   f. Head circumference, and head circumference percentile
   g. Macronutrient and micronutrient requirements
   h. Food allergies
   i. Birth weight - if available
   j. History of weight changes
   k. Potential drug nutrient interactions
   l. Laboratory and biochemical values pertinent to nutrition assessment
   m. Psychosocial, physiological, social and or environmental issues
   n. Clinical assessment changes
   o. Feeding concerns
   p. Weight change percentile (postnatal growth for the premature infant should mimic in utero fetal growth rates - ~1.5% (15g/kg) increase per day.
   q. Estimation of calories are based on the neonate's age, weight, disease state, and nutrition status
   r. Grams of protein per day
   s. Fluid requirements
   t. Z- Score
6. Psychosocial, physiological, social, and or environmental issues
7. A nutrition care plan will be developed and individualized based on assessment and will meet specific needs of patient. Goals will be individually determined with delineation of methods of achievement of goals and time frames. Goals will be documented in the Electronic Medical Record (EMR).

Energy, Protein, Fluid Requirements of the Pre-term Infant			
	Protein g/kg/d	Kcal/Kg/d	Water ml/kg/d
Enteral Preterm fed	2.5 – 4	105-130	120-200*
Preterm fed parenterally	3-4	90-120	140-160*

*Dependent upon clinical condition (i.e. less with PDA or BPD)

8. The Clinical Registered Dietitian will confer with Neonatologist, RN, and/or Pharmacist regarding pertinent factors affecting nutrition status (i.e. medication, I&O, intake, etc.).
9. The Clinical Dietitian will provide follow-up for patients every (7) days dependent on nutritional risk status and document on the Neonatal Nutrition Assessment form.
    a. Follow-up assessments may be scheduled for less than (7) days if warranted by a change in nutritional status and/or medical condition.
10. The Clinical Registered Dietitian will provide nutrition counseling and education explaining rationale to parent(s) as ordered by Physician, as requested by nursing, or family, or as deemed appropriate by RD.
    a. Documentation of education is completed in the physician progress notes.
    b. Education may include, but is not limited to, formula preparation, appropriate recommendations related to infant feedings and formulas. Referrals for outpatient medical nutrition therapy will be generated as appropriate, i.e. specialty formulas, feeding issues, growth concerns.

D. **REFERENCE(S):**

1. "The Science and Practice of Nutrition Support: A Case based Core Curriculum," ed. Gottschlich, MM, 2001.
2. Tsang, RC. "Nutrition of the Preterm Infant: Scientific Basis and Practical Guidelines" Cinicinnati, OH: 2005.
3.**1.** Koletzko, B., R. Vavay. "Nutritional Care of Preterm Infant". Frieburg Im Breisagua: Kerger. S, 2014.

Tri-City Medical Center
Oceanside, California

FOOD AND NUTRITION SERVICES

ISSUE DATE: 05/09 **SUBJECT: Nutrition Care Protocols**

REVISION DATE~~(S)~~: ~~02/12~~; 03/13, 9/25

Department Approval:	**02/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~11/19~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval Date(s):	**12/19**

A. **POLICY:**

1. Protocols address the role of the registered dietitian in the assessment of nutritional status of patients, nutritional intervention and delivery of medical nutrition, the development of an individualized nutrition care plan, and provision of education to patients.
   a. Protocols are developed utilizing standards set by the Business and Professional Standards for dietitians (Section 2585-2586.8) per the state of California. Protocols are approved by the medical staff.
   b. Protocols are developed to guide the nutritional care of all patients, including neonates, pediatrics, adolescents, adults and geriatrics.
      i. Nutrition Assessment and **Reassessment – Adult Patients (≥ ~~Care Adult Geriatric Patients~~18 yrs old)**
      ~~ii.~~ Nutrition Care and Assessment for Infants, Pediatrics, & Adolescents
      ~~iii.~~**ii.** ~~Nutritional Care and Assessment for Infants Admitted to NICU~~
   c. Guideline: Enteral Nutrition**, Enteral Formula Substitute and Total Parenteral Nutrition (TPN)** ~~Protocol~~
   d. Any nutrition interventions or medical nutrition therapies that are not addressed in the above protocols require a signed order by a Licensed Independent Practitioner.

B. **RELATED DOCUMENT(S):**

1. Food and Nutrition Policy: **Nutrition Assessment and Reassessment – Adult Patients (≥ 18 yrs old)** ~~Nutrition Assessment and Care for Adult Geriatric Patients~~
2. Food and Nutrition Policy: Nutrition Care and Assessment for Infants, Pediatrics, & Adolescents
3. ~~Food and Nutrition Policy: Nutritional Care and Assessment for Infants Admitted to NICU~~

Tri-City Healthcare District
Oceanside, California

INFECTION CONTROL

ISSUE DATE:	**09/95**	**SUBJECT:**	**Aerosol Transmissible Diseases and Tuberculosis Control Plan**
REVISION DATE:	**09/01, 09/02, 10/03, 10/06, 10/08, 07/09, 10/09, 07/11, 08/14, 01/16, 01/17, 02/18, 09/18, 08/19, 09/20, 02/23, ~~01/25~~, 05/24**		

Infection Control Department Approval:	**~~01/24~~07/25**
Infection Control Committee Approval:	**~~03/24~~07/25**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**10/25**
Administration Approval:	**~~05/24~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/24**

A. **TUBERCULOSIS AND AEROSOL TRANSMISSIBLE EXPOSURE CONTROL PLAN INTRODUCTION:**

1. Legal mandates and regulatory agencies such as California Code of Regulation Title 8, Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control and Prevention (CDC) have set the standards for the implementation of an Aerosol Transmissible Diseases (ATD) including Tuberculosis Exposure Control Plan.

B. **PURPOSE AND POLICY:**

1. It is the policy of Tri-City Healthcare District (TCHD) to provide care to patients with ATDs with a minimum risk of transmission to others**, as well as providing oversight to Employee Health practices among all Healthcare Workers (HCW), which include the Medical Staff (i.e. physicians and advanced practice providers [APPs])**~~.~~ The Infection Control Committee will provide assistance in ensuring compliance with the policy. The plan includes:

a. Source Control Procedures including cough etiquette / respiratory hygiene.
b. Implementation of an effective triage system and early identification of suspects and active cases
c. Engineering control measures
d. Respiratory protection programs
e. Education**,** ~~and~~ training ~~of employees~~**employees and new employee requirements regarding TB screening and fit testing**
f. Evaluation and treatment of HCW's exposed to ATDs
g. Protection of patients, HCW's and visitors from exposure to ATDs. These include:
    i. Pathogens requiring Airborne Precautions;
    See Type and Duration of Precautions - Disease Specific (formerly Short Sheet)
    ii. Diseases requiring Droplet Precautions;
    See Type and Duration of Precautions - Disease Specific (formerly Short Sheet)
    iii. Ebola disease: Requires special considerations: Please see Infection Control Ebola Plan policy for management of a patient with suspected or confirmed Ebola. *Requires a negative pressure room.

C. **SCOPE:**

1. The Tuberculosis Control and Aerosol Transmissible Diseases Plan applies to all inpatient and outpatient services

D. **RESPONSIBILITY:**

1. The Tuberculosis Control and Aerosol Transmissible Disease Program will require the

participation of the following personnel:

a. The Infection Control Officer and the Infection Preventionist are responsible for overseeing the plan. This includes, but is not limited to implementation of the plan for the facility; development of policies and procedures to support the implementation of the plan; reporting of suspected and diagnosed cases of ATDs and Tuberculosis as defined in under CA title 22 to the Infection Control Committee and county department of health. It is also the responsibility of the Infection Preventionist to evaluate the risk assessment at least annually.

b. **The** Infection Preventionist~~s are~~ **is** responsible for conducting investigation of non-employee (e.g. visitors, patients, vendors, etc.) exposures to ATDs and TB. Exposed will be notified via phone call and certified letter as soon as exposure and contact tracing is confirmed. Exposed non-employees are responsible of following up with their PCP's, their nearest community health service center or an SDPH Tuberculosis clinic, for screening, testing and evaluation of TB disease risk.

c. The Environment of Care Officer is responsible for implementation and maintenance of current standards to meet the requirements of the California Code of Regulation Title 8, Title 24 and the guidelines from the Centers for Disease Control and Prevention.

d. Employee Health Services**, with infection prevention oversight,** is responsible for employee TB ~~skin testing and interpretations~~**screening upon hire and maintaining annual screening documentation thereafter;** ; conducting investigation regarding employee exposure to ATDs and TB; maintaining employee TB ~~skin test~~ conversion data; reporting employee conversion and diagnosed cases to the Infection Control and Safety committees annually; and ~~managing and counseling~~**directing HCW** staff who have active ATDs **in follow up procedures**. Employee Health is responsible for ~~collaborating~~ developing and implementing policies and procedures related to the respiratory protection program. Employee Health is also responsible for screening, testing, and provision of immunizations as indicated and seasonal influenza vaccination administration and declination statement documentation.

e. Department Directors and Managers are responsible for implementation of the TB and ATD Control Plan in their respective areas, providing educational training to all employees before exposure to a source case; maintaining documentation of personnel training**, notification and follow up assurance of employees in their unit who have had a validated exposure~~.~~, maintaining timely communication with EHS for follow up post exposure, as directed by EHS and the IP dept.** ~~.~~

f. Administrative Supervisor is responsible for patient placement in a negative pressure room.

g. Case Management reports to the County TB Control for suspected and confirmed TB cases, during the weekdays, weekends and holidays.

h. The Director of Education is responsible for including TB and ATD control plan in orientation of new employees and annual OSHA required training related to ATDs.

i. The Manager of Environmental Services**, with infection prevention oversight,** is responsible for developing, implementing and monitoring procedures for cleaning rooms occupied by a patient with ATDs.

j. The Facilities Manager is responsible for monitoring and verifying air pressures daily on Airborne Infection Isolation Rooms (AIIR), when in use, and reporting of air changes and air pressures to the Infection Control and Safety committees annually. **In addition, the Facilities Manager is responsible for maintaining and cleaning of portable HEPA recirculators and providing portable HEPA recirculators to units as needed.**

k. The Manager of Pulmonary Services is responsible for training, implementing and monitoring respiratory staffs' adherence to the ATD and TB Control plan including protection for high-hazard procedures.

~~l. The Facilities Manager is responsible for maintaining and cleaning of portable HEPA recirculators and providing portable HEPA recirculators to units as needed.~~

~~m.~~**l.** Microbiology Supervisor is responsible for the notification to the local health authority according to California and Federal regulations of ATDs and TB.

~~n.~~**m.** The Employees are responsible for early identification of suspects and active cases of ATDs and TB; early implementation of Airborne Precautions; knowledge of Tuberculosis and ATD control plan; compliance with all protective practices; attendance of New Employee Orientation

Program and annual OSHA required education; **complying with exposure follow up in a timely manner once notified by their director/manager,** and reporting noncompliance and unusual occurrences using a quality review report.

~~o.~~**n.** The Physicians play an important part in TB and ATD Control by maintaining a high index of clinical suspicion.

i. Physicians should place all HIV positive patients with infiltrates in Airborne Precautions until three sputum concentrated smears are negative for AFB or until a diagnosis other than tuberculosis is clearly established.

ii. Place all new admits with a history of fever, weight loss and cough or pneumonia greater than 2-3 weeks in Airborne Precautions if no clear etiologic agent is identified.

iii. Treat all highly suspected tuberculosis cases with anti-tuberculosis medications pending sputum results.

iv. Consider ATD in patients with temperature greater than 100 degrees F and cough. ATD may also be considered in the presence of rash with fever.

v. Implement control measures when ATD is suspected.

E. AVAILABILITY OF THE PLAN:

1. The Tuberculosis and ATD Control Plan will be available via the Intranet in the Infection Control Manual for all staff.~~.~~ OSHA required education will be conducted at the new employee orientation program and all other ~~employees~~ **employees** are required to complete an annual review. The written plan will be reviewed and updated annually and as indicated by regulations.

F. FUNDAMENTALS OF TUBERCULOSIS INFECTION CONTROL:

1. Some segments of the U.S. population have a higher risk for TB because they are more likely to have been exposed or because their infection is more likely to progress to active TB after infection. TB is carried in the air after being generated when persons with pulmonary or laryngeal TB sneeze, cough, speak or sing. These particles are carried on air currents and stay afloat for a long time. Infection occurs when a person inhales the germs into their lungs. Usually within 2-10 weeks after infection, the immune response limits further multiplication and spread but some bacteria can remain dormant for years (latent infection). People with normal immune systems have a 5-10% lifetime risk of the latent infection progressing to active disease. Factors that influence infection include the concentration (number) of the bacteria in the air and duration of exposure. Exposure in a relatively small space with inadequate ventilation can increase the risk of infection. Persons who are immunocompromised are more likely to become infected and to also develop active disease. The transmission, epidemiology and pathogenesis of TB were all considered in our plan. An effective program requires early identification, isolation and effective treatment of persons who have active disease.

a. The most effective control measure is to ensure rapid identification, isolation, diagnostic evaluation and treatment of persons likely to have TB.

b. The next level of effective control is the use of engineering controls (i.e. airflow, dilution, filtration and exhaust of air)

c. The final and least effective control is the use of respiratory protection.

G. TUBERCULOSIS RISK ASSESSMENT:

1. Risks assessment will be performed annually **and as needed** by the Infection Preventionist and reviewed by the Infection Control and Environment of Care Committees. The purpose of this assessment is to evaluate the risk of transmission of Tuberculosis so that appropriate interventions can be developed. The assessment will include:

a. Community TB profile from public health department data

b. Number of infectious TB patients treated in outpatient and inpatient areas.

c. Drug susceptibility patterns of TB patients

d. Analysis of staff ~~PPD~~ **QuantiFERON Gold** test results by area

e. Review medical records for appropriate precautions, timing of specimens, duration of precautions and timely communication with public health.

f. Observation of practice and review of engineering controls.

2. Considerations for determining the hospital's risk classification will be based on the following:

VERY LOW RISK	There are no TB patients admitted to the facility during the preceding year
LOW RISK	The employee ~~PPD~~ **QuantiFERON Gold TB** conversion rate in an area is not higher than in areas with increased occupation exposure to Tuberculosis Fewer than 6 patients were admitted to area during the preceding year There is no evidence of person-to-person transmission No clusters of staff ~~PPD~~ **QuantiFERON Gold TB** conversion
INTERMEDIATE RISK	Same as Low Risk with the addition of six or more TB patients admitted to the area during the preceding year.
HIGH RISK	**QuantiFERON Gold TB** ~~PPD~~ conversion rate is higher in areas without occupational exposure to Tuberculosis. Clusters of staff **QuantiFERON Gold TB** ~~PPD~~ conversion. Evidence of person-to-person transmission. More than 6 patients admitted to an area.

3. Early identification of suspected and active TB patients can initiate prompt treatment and prevent transmission of the disease. This is the most effective method for controlling the spread of tuberculosis, an Administrative Control. A suspected case of TB is defined as:

a. A patient with unexplained cough, cough with bloody sputum, and/or a cough lasting longer than 3 weeks

b. A patient with unexplained fever, night sweats, weight loss and anorexia

c. Readmission of patients recently diagnosed with Tuberculosis

4. A high index of suspicion for Tuberculosis should be maintained for the following

a. Patients requiring high-risk procedures such as aerosolized pentamidine and sputum induction for Acid Fast Bacilli (AFB)

b. Patients who belong to a group with a higher prevalence of TB infection: medically under-served, foreign born from a developing country, homeless, current or past justice involved, alcoholic, injecting drug-user, elderly, or extended contact with an active TB case.

c. Patients who belong to a group with a higher risk to progress from latent TB to active disease: immunocompromised (HIV, organ transplant, or on high dose steroids), silicosis, status post gastrectomy or jejuno-ileal bypass surgery, >10% below body weight, chronic renal failure, diabetes mellitus, infected within past two years, or child >5 years old.

5. In outpatient areas where patients with undiagnosed Tuberculosis may be present, precautions must be taken to minimize the risk of transmission.

a. Instruct patients to cover their mouths with a handkerchief or tissue, and give them a surgical mask to wear. Tissues and masks must be readily available in the waiting areas.

b. Questionnaires will be utilized in all outpatient areas and Emergency Department to assist in the early identification of suspected cases.

c. Patients with symptoms suggestive of Tuberculosis will be removed from the common area and placed in a designated waiting area.

d. Patients unable to wear a mask can be placed outside with appropriate supervision until an appropriate room is available.

6. For departments in main hospital building without a built-in negative pressure room, staff can obtain a HEPA filter (recirculator) from the Engineering department to enhance circulation in the exam or treatment room. Contact Engineering for placement assistance. Please note: The patient must be placed in an AIIR room within 5 hours of identification.

a. Staff wear N95 particulate respirators and visitors wear surgical masks when entering this area.

b. If the patient is suspected or known to have infectious TB, the room must remain vacant per **Section M: Room Shut Down Time**. The door is to remain closed and the filter running.

c. Personnel may enter the area but must continue to wear respiratory protection until the time has

lapsed.

7. For off-site areas, the patient will be asked to wear a surgical mask while inside the building.
8. Any possibility of TB as a diagnosis should be communicated by telephone to other departments, prior to transporting the patient to those areas.
9. Patients seen in the ED with confirmed or suspected pulmonary TB are **instructed to wear a surgical** mask~~ed~~ and placed in C-26, a negative pressure room. Staff must wear an N95 respirator **or PAPR** when entering the room.

a. These patients might require hospitalization to control the spread of infection. Patients confirmed or suspected with pulmonary TB, will ~~be masked~~**wear a surgical mask when**~~if~~ transporting throughout the facility.

H. **MANAGEMENT OF HOSPITALIZED PATIENTS WHO MAY HAVE ACTIVE TB:**

1. Staff who are the first points of contact should ask questions that will facilitate identification of patients with signs and symptoms suggestive of TB. See the Admission Assessment Patient History form>TB Screening form>to assess for TB risk factors and symptoms.
2. Upon identification of a patient with active or suspected Tuberculosis, the nurse must place the patient in an AIIR (i.e. negative pressure room: C-26, 143, 243, 287, 387, 443, 487, ~~Maternal Child room 200, 201and~~ Progressive Care Unit (PCU) Rooms 301, 312 and 32**6**~~6~~,) **and** ~~T~~**t**he door must be closed~~.~~. Post the Airborne Precautions sign outside the room.
3. If a negative pressure room is not available, **notify the** Administrative Supervisor of the need for an Airborne Precautions room. Contact Engineering for a HEPA filter for the current room, until a negative pressure room is available. Keep the door closed and post the Airborne Precautions sign. Staff wear N95 particulate respirators **or PAPRs** and visitors wear surgical masks when entering this room. Please note: The patient must be placed in an AIIR room within 5 hours of identification.
4. Cohorting TB patients:

a. Patients with TB must not be placed together in the same room unless they have culture-confirmed TB, have drug susceptibility test available on current specimens obtained during the present hospitalization, have identical drug susceptibility patterns on these specimens and are on effective therapy.

5. Reporting:

a. The Unit Secretary notifies Engineering (by placing a worker order) that an Airborne Precautions room is in use for tuberculosis.
b. On weekends and holidays, the Case Manager will notify the County Public Health TB Control by calling phone number (619) 540-0194. Go to http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB-216TBSuspectCaseReport.pdf for a copy of the report.
c. Laboratory Results: Hospitals and staff are required by law to report TB to protect the public. This must be done within one day of identification of the case or suspected case.
d. The Microbiology department will notify the nursing unit and the Infection Preventionist of a positive AFB smear or culture results. A fax report of all positive AFB smears and cultures are sent to Public Health TB Control.
e. ~~The Infection Preventionist (x 5696) or designee~~**Case management, in collaboration with the Infection Preventionist,** is responsible for reporting to public health **weekdays, weekends and holidays**. County Public Health TB program nurses are available 8:00am to 5:00pm, 7 days a week and all holidays at (619) 540-0194. TB Control does not have personnel available between the hours of 5:00 pm and 8:00 am. Persons with routine questions about TB exposure should call (619) 692-8610 after 8:00am on the following day.
f. To report a case of TB after 5:00pm ~~-~~do one of the following:
    i. Call pager (619) 540-0194 after 8:00 am the following day to report directly to TB Control RN if they feel there is urgency about reporting; or
    ii. Leave a message on the TB Control RN voice mail (619) 692-8610 and their call will be returned on the next working week day. Message should include patient's name, date of birth, facility name, reporter's name and phone number, and contact person at facility who will be available for more patient information.

g. Persons requesting Discharge Approval should:
    i. Contact TB Control RN between 8:00am and 5:00pm
h. Physicians from emergency rooms requesting recommendations regarding patients they suspect may be infectious after 5:00pm, should do the following:
    i. If patient is homeless or from congregate setting (SNF, school dormitory, etc.) and has clinical picture consistent with TB, ~~we~~**it is** recommend to admit and rule out infectiousness.
    ii. If patient has a home and is otherwise medically stable (not in need of admission) patient can be sent home, obtain one sputum for AFB smear and culture prior to release, start on medication if indicated. Direct caller to contact TB Control RN on phone number (619) 692-8610 after 8:00am on the following day.
i. Persons calling about patients who are leaving against medical advice (AMA):
    i. Have facility get as much locating information as possible on patient (including address/phone of relatives or friends)
    ii. Call **TB** intake RN between 8:00am and 5:00pm; after hours call 8:00am the next day**.**

6. Staff (fit-tested and approved for use) will wear an N95 respirator when entering the patient's room. See the Respiratory Protection Program under the Employee Health & Wellness Policy Manual.
7. Pediatric patients with suspected or confirmed TB must be evaluated for potential TB according to the same criteria, as adults. Parents and other visitors of pediatric patients must be evaluated for TB as soon as possible. Until they are evaluated, they must wear surgical masks when in areas of the facility outside of the child's room.
8. Diagnostic and treatment procedures must be performed in the Airborne Precautions rooms to prevent transporting to other areas of the facility. If the procedure cannot be done in the isolation room, the patient must wear a surgical mask during transport. Procedures should be scheduled at times when they can be performed rapidly and when the areas are less crowded.
9. Limit the number of persons entering an isolation room to a minimum. All visitors (except staff who have been fit-tested for an N95 respiratory) wear a surgical mask when entering an Airborne Precautions room.
10. Facilities will verify airflow rates and negative pressures at the time the negative pressure room is established. Negative pressures will be verified daily and a log maintained by Facilities department.
11. Cough-inducing procedures will not be performed on patients who have or may have active Tuberculosis unless the procedures are absolutely necessary and can be performed with appropriate precautions.

a. The patient is in an Airborne Precautions room.
b. The portable air filtration system has been set-up in a regular room.

12. Staff must wear respiratory protection (N95 respiratory or Powered Air Purifying Respirator-PAPR) when present in rooms or enclosures in which cough-inducing procedures are being performed on patients who are being ruled out for Tuberculosis. See High Hazard Procedures.
13. After completion of the cough-inducing procedures, patients who may have infectious Tuberculosis will remain in the Airborne Precautions room until the coughing subsides. (If transport is necessary, patient will be provided with a surgical mask to wear.) Outpatients will wear surgical masks until they are outside of the hospital.
14. Before the Pulmonary Function Testing room is used again, after the booth has been in use, the HEPA filter is kept on and the door to the room closed for 1.5 hours. Staff entering the room before the 1.5 hours are over will wear an N95 respirator. See High Hazard Procedures.
15. Bronchoscopy considerations

a. The bronchoscopy room for all inpatient and outpatient procedures will be a negative pressure room. The air filtration system will remain in use whenever performed on a suspect TB patient. Respiratory protection must be worn. An N95 Respirator or Powered Air Purifying Respirator-PAPR must be worn by staff performing a Bronchoscopy on a suspect TB patient. The patient waiting for bronchoscopy will be provided a surgical mask and escorted to a non-communal

waiting room.

I. **ADDITIONAL CONSIDERATIONS FOR SELECTED AREAS:**

1. Surgery/Peri-Anesthesia Nursing Services

a. Postpone non-urgent or elective procedures on suspected/confirmed TB patients until the patient is no longer infectious.

b. If procedures must be performed, they should be done in OR rooms with door closed and traffic at a minimum.

c. Procedures should be done when other patients are not present in the operating suite e.g., end of day) and when minimum number of personnel are present. This applies to pulmonary and non-pulmonary surgical sites.

d. Utilize the portable HEPA unit in the operating room during intubation and extubation. Turn off the HEPA unit during the procedure.

e. For patients with known or suspected airborne infectious diseases staff must wear a N95 Respirator or Positive Air Purifying Respirator (PAPR). Order PAPRs from ~~SPD (xt 7728)~~**Materials Distribution (ext. 3331).**

i. PAPRs cannot be used near the sterile field, wear N95 mask in place of PAPR.

f. For additional information see Surgery Protocol for Active/Rule Out Tuberculosis (TB).

g. Airborne Precautions are maintained in the Post Anesthesia Care Unit. Post-operative patients are placed in a private recovery room with a portable HEPA unit.

~~2. Home Health Services~~

~~a. Staff entering the home of a patient with confirmed or suspected TB or ATD should wear appropriate respiratory protection.~~

~~b. The patient should be taught to cover mouth and nose with a tissue when coughing or sneezing.~~

~~c. Educate patient regarding importance of taking medication (and administering directly observed therapy).~~

~~d. Immunocompromised persons or young children living in home with TB patient should be temporarily relocated until patient is no longer infectious.~~

~~e. Cough-inducing procedures should be performed on patients with infectious tuberculosis only if absolutely necessary. If their performance is required a well-ventilated area away from other household members should be used (for example, go outside or open a window). Staff will wear respiratory protection during the procedure~~

~~f. Specific processes and procedures pertaining to ATDs in the home are found in the Home Health Care policy manual.~~

J. **DIAGNOSTIC EVALUATION:**

1. Diagnostic evaluation should include the following:

a. Medical history and evaluation - The probability of TB is greater among patients who have positive **(or history of)** ~~PPD~~ **QuantiFERON Gold** test results or a history of positive PPD results, who have previously had TB**,** ~~or~~ who have been exposed to someone with TB, or who belong to a group at high risk for TB.

~~b. Mantoux skin test (PPD skin test) – is placed by the specially trained staff and read at 48- 72 hours after injection. Results are to be documented in the Medical Record.~~

~~c.~~**b.** QuantiFERON-TB Gold (QFT-G) test **(and PCR when indicated)** ~~can~~ **is**~~be~~ ~~used~~ **ordered** ~~in any situation a Mantoux PPD skin test~~ **to assist in the diagnostic evaluation.** ~~is indicated~~. A positive ~~result has the same significance as a positive PPD skin test, and neither a positive PPD nor a positive~~ QFT-G by itself **does not** warrant~~s~~ Airborne Precautions **to be initiated**.

~~d.~~**c.** Chest radiograph - radiographic abnormalities that strongly suggest active TB include upper lobe infiltrates, particularly if ~~the cavitations~~**cavitation's** are seen, and patchy or nodular infiltrates in the apical or sub apical posterior upper lobes or the superior segment of the lower lobe. The MD may include the words "cavitary lesion", "granuloma disease" or "suspected tuberculosis" in the results.

~~e.~~**d.** Microscopic examination and culture of sputum or other appropriate specimen. Three sputum specimens should be collected 8–24 hours apart, and at least one should be an early morning specimen, induced, or bronchoalveolar lavage (BAL). Although direct AFB smears are available

in house, concentrated smears performed by our reference laboratory are preferred and are included with orders for a TB culture. Since neither a direct nor a concentrated smear has sufficient sensitivity to exclude a diagnosis of tuberculosis, cultures must also be ordered.

~~f.~~**e.** Initiating Treatment: Patients who have confirmed active TB or who are considered highly likely to have active TB should be started promptly on appropriate treatment in accordance with the current guidelines.

~~g.~~**f.** Drug susceptibility should be performed on all initial isolates from patients with TB.

~~h.~~**g.** Contact Infection Prevention at Ext. 5696 for the latest recommendations.

K. **AIRBORNE PRECAUTIONS:**

1. Airborne Precautions can be discontinued as soon as the diagnosis of TB has been ruled out, when another diagnosis is confirmed, or when the patient is no longer infectious.

a. Airborne Precautions can be discontinued:

i. In a patient with active tuberculosis when the patient is on effective therapy, improving clinically, and has had three consecutive negative concentrate sputum AFB smears

ii. In a patient with suspect tuberculosis as soon as the diagnosis of TB has been excluded by three negative AFB sputum smears taken 8-24 hours apart with at least one from an early morning specimen, induced specimen, or BAL or when another diagnosis is confirmed

2. Continued isolation throughout the hospitalization should be considered for patients who have multi-drug resistant tuberculosis (MDR-TB) because of the tendency for treatment failure or relapse.

L. **DISCHARGE:**

1. Before leaving the hospital, TB patients must be approved for discharge by the Public Health Department. A discharge plan must include all of the following prior to approval from the TB Control Officer. TB Control can be contacted at: 619-692-8610 or 619-540-0194.

a. Patients in the Progressive Care Unit (PCU): Specific notification(s) must be obtained prior to discharging justice involved patients:

i. The Department of Health TB Control to the specific county in which the justice involved patient is residing.

ii. The Public Health Department of the prison.

b. For all other inpatient units:

i. Three consecutive negative sputum smears from concentrate or approved living arrangements so that TB isolation can be maintained. For example, the accepting facility has an airborne precautions room available or the house and household contacts have been evaluated and cleared by the TB County public health nurse.

ii. A confirmed outpatient appointment (date/time/place) with a provider (name and phone number) who will manage the patient's care until cured.

iii. Sufficient medication to take until the outpatient appointment. Contact Pharmacy for assistance with take-home medications.

iv. Placement into case management (e.g. DOT) or outreach programs of the public health department.

v. The charge nurse, patients nurse or Case Manager, will notify the Public Health TB Control Department at (619) 692-8610 prior to the anticipated discharge and obtain approval.

vi. Public Health requires at least two days prior to discharge to review the case. On weekends and holidays, obtain approval from the on-call TB County public health nurse at cell phone number (619) 540-0194

2. Cleaning of the room after a known or suspected TB patient is moved or discharged:

a. If the suspected or confirmed TB patient was NOT in a negative pressure and HEPA filtered room:

i. Post the Airborne Precautions sign and keep the door closed.

ii. Call Engineering for a HEPA filter. To enter the room staff must wear an appropriate respirator (i.e. N95 or PAPR). Plug in the filter, turn it on and close the door. Post a sign that specifies the appropriate time period from the table below. Staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator until the time period has elapsed. After the time period has ended, discontinue Airborne Precautions and return the HEPA filter to Engineering.

M. **ROOM SHUT DOWN TIME:**

1. Keep the Airborne Precautions sign posted
2. Leave the HEPA filter running with door closed for specified time. Post a sign that specifies this time period.

a. AIIR Negative Pressure Room

AIIR/Negative Pressure Rooms	Length of Time AIIR Negative Pressure Room is Closed
ED-C26, 143, 243, 443, 287, 387, 487~~, NICU~~	30 min
Bronchoscopy, 200, 201	1 hour
PCU 301, 312, 326	2 hours

b. Non-Negative Pressure room

Location in Non-Negative Pressure Rooms	Length of Time Non-Negative Pressure Room is Closed
Surgery	30 min
1N/S, ~~MCH,~~ Pavillion, East/West Tower, Radiology/MRI/CT, ED	1 hour
PCU 3N/S	2 hours

3. Staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator **or PAPR** until the time period has elapsed.
4. After the time period has ended, discontinue Airborne Precautions.
5. If the patient is no longer infectious or TB has been ruled out: No special precautions needed. The door may be immediately opened and the room cleaned as usual.

~~N. ANNUAL TUBERCULOSIS SCREENING:~~

~~1. Auxiliary and Employees: See the Employee Health & Wellness Policy Manual: TB Surveillance and Respiratory Protection policies.~~

~~2. Physicians: the Medical Staff Office sends an annual screening survey to each physician on staff. PPD testing for physicians is required and available in Work Partners. It is highly recommended that all active medical staff be fit-tested upon hire and annually.~~

~~O.~~**N. AEROSOL TRANSMISSIBLE DISEASE CONTROL EXPOSURE DETERMINATION:**

1. A list of all job classifications in which employees have occupational exposure is available in the Employee Health & Wellness Policy Manual: Respiratory Protection Program (see Appendix C).

~~P.~~**O. ISOLATION PRECAUTIONS:**

1. Standard Precautions and Transmission based precautions including cough etiquette, Airborne Precautions, Droplet Precautions and Contact Precautions are outlined in the Infection Control Manual: Standard and Transmission based Precautions (IC.5), Type and Duration of Precautions for Selected Infections and Conditions (IC.5.1); Pregnant staff (IC.5.2).

~~Q.~~**P. HIGH HAZARD PROCEDURES:**

1. High hazard procedures include but not limited to
a. Intubation and Extubation
b. Sputum Induction
c. Endotracheal & Tracheostomy Tube Care
d. Bronchoscopy
e. Pulmonary Function Tests
f. Aerosolized administration of pentamidine or other medication
g. Autopsy
2. For patients with known or suspected Droplet infectious diseases staff must wear an N95 respirator **or PAPR**.
3. For patients with known or suspected airborne infectious diseases staff must wear a N95 Respirator or Positive Air Purifying Respirator (PAPR) except in an operating room or procedure room during an invasive procedure where there is a sterile field wear a N95 mask.
a. Contact Materials **Distribution (ext 3331)** for PAPRs supplies
4. Although Cal OSHA requires PAPRs for high hazard procedures on suspect/confirmed airborne disease patients, CDPH does allow the use of N95 Respirators instead of PAPRs if it interferes with the successful performance of the task or the procedure is performed with the patient in a ventilated enclosure.

~~R.~~Q. SOURCE CONTROLS AND ENGINEERING CONTROLS IN SPECIFIC HOSPITAL AREAS:

1. Throughout the facility cough etiquette is used in waiting areas. Signs with instructions are posted in these areas in Spanish and English. Patients are provided tissues and are asked to wear surgical masks to prevent droplets from disseminating into the environment. Alcohol hand hygiene solutions are made available for patient use. Bilingual signs are posted in waiting areas instructing patients to “Cover your cough.”
2. Emergency Department
a. Engineering Controls during a surge of patients with ATD is addressed in the TCHD Infection Control Policy IC15.0 Influx of Infectious Patients: *Epidemic Influenza or other respiratory transmitted disease*.
b. At the point of triage, ED staff shall screen and identify patients with symptoms of ATD and implement source control by placing a surgical mask on the patient and asking the patient to keep the mask on during their visit. If the patient cannot tolerate a surgical mask, tissues shall be provided and patients shall be instructed to cover their cough.
c. Staff wears PAPRs or N95 Respirator during high hazard procedures (listed above) for disease spread by the airborne route.
d. N95 respirators or PAPRs are used during patient contact for diseases spread by airborne route.
e. Surgical masks are used during patient contact for diseases spread by the droplet route. N95 mask is used by staff during high hazard procedures for disease spread by the droplet route.
f. Patients with diseases known to be transmitted by the airborne route, including novel viral infections, will be prioritized for AIIR C-26.
g. When room C-26 is not available a private room is used.
h. When there are no private rooms available, patients are asked to keep their **surgical** mask in place and use tissues to prevent droplet aerosolization.
i. Patients may be cohorted in designated rooms or bays when indicated.
j. Patients suspected of having ATDs are provided with disposable nebulizer units with expiratory filters or multi-dose inhalers as clinically indicated.
k. There are no special environmental cleaning recommendations for TB or r/o TB patients.
l. Rooms shall be cleaned between patients using the hospital approved disinfectant.
m. When used for a patient with ATD, room C-26 shall remain empty with Airborne Precautions sign posted and door closed for 30 minutes prior to being used by another patient.
3. Nursing Units
a. Patients who are admitted with airborne transmissible diseases are admitted to AIIRs on nursing units.
b. Airborne Precautions are initiated and followed in accordance with CDC recommendations for

Transmission Based Precautions.

c. Doors are kept closed.

d. Patients in Droplet precautions do not need AIIRs for routine care. However, high hazard and cough inducing procedures performed as part of the clinical care of patients in both Airborne and Droplet Precautions will be done in AIIR. See ~~chart~~ **section P** above for selection on type of respirator.

e. AIIRs shall remain empty with Airborne Precautions sign posted and door closed for designated time when a patient with airborne transmissible disease has occupied the room. (See Room Shut Down Time-)

4. Pulmonary Services

a. Bronchoscopy for patients in Airborne or Droplet Precautions will be performed in an AIIR.

b. N95 respirators or PAPRs are used during Bronchoscopy.

c. In areas where AIIR is not available, aerosolized medications are administered using disposable nebulizer units with expiratory filters or multi-dose inhalers as clinically indicated.

d. Aerosolized medications may be administered using traditional routes while the patient is in an AIIR. The staff should wear an N95 or PAPR during this treatment (see High Hazard Procedures).

e. Bronchoscopy suite will remain closed for the designated time when procedure is performed on a patient with known or suspected ATD.

f. Expiratory filters are used for intubated patients with known or suspected ATD during transport.

5. Laboratory Services

a. Methods of implementation for ATD exposure control in are found in the Laboratory Medicine Biosafety Plan.

b. For respiratory protection in Laboratory Services: See Employee Health & Wellness Policy: Respiratory Protection Program Policy

6. Facilities Management Staff

a. Facilities Management staff will wear N-95 respirators when entering an AIIR housing patient(s) with known or suspected ATD.

b. N95 respirators are required when repairing, replacing, or maintaining air systems or equipment that may contain or generate aerosolized pathogens.

7. Personal Protective Equipment

a. The respiratory protection program policy (Employee Health and Wellness Manual) describes requirements of PPE used for ATD protection in accordance with 29CFR1910.134 and CCR Title 8, section 5144.

b. Respiratory Protection including**,** N95 respirators or PAPRs**,** is required in any hospital location in the following circumstances:

    i. Entering an Airborne Precaution Room that is occupied or has been recently occupied (refer to Section M: Room Shutdown Time) by a patient with suspected or known Airborne transmitted ATD.

    ii. Attending high hazard procedure

c. Respirator Shortages

    i. In the event of reported shortages of N95 respirators**,** the following is recommended (notification received from supplier but still able to meet historic usage):

        1) TCHD will maintain a cache of N95 respirators in accordance with the disaster plan.

        2) Materials Distribution staff will perform in-house inventory to determine available stock and develop a timeline for inventory depletion.

        3) According to available stock, N95 respirators will be prioritized for distribution to areas where high hazard procedures are performed.

        4) Re-use of N95 respirators is acceptable for known or suspected Tuberculosis patients over a 12 hour shift unless the respirator is contaminated (e.g. visibly soiled) or the integrity of the respirator is disrupted (e.g. torn, cracked nose piece).

        5) Reuse of N95 respirators is acceptable during the care of patients with

other ATD's under the following circumstances:
a) A protective face shield (no surgical mask) is donned over the respirator to protect the respirator from contamination of ATD.
b) The respirator integrity remains intact
c) During the care of intubated and ventilated patients (closed circuit suction systems).

ii. In severe respirator shortages (less than 30 days of stock available in house, when supplier cannot meet the demand or can only supply an alternative N95) the following steps may be considered:
1) Prioritize available N95 for high hazard procedures.
2) Provide surgical grade masks for employees who are not provided a respirator due to the implementation of prioritized respirator use.
3) Contact Local Public Health Officer for possible acquisition of N95 respirators from local or state stockpiles.
4) Alternate manufacturer's respirators may be used in cases of tuberculosis and other airborne illnesses. Fit testing will be waived in a declared state of emergency.
5) Except during high hazard procedures, surgical masks may be used for H1N1 influenza.
6) PAPRs may be used.
7) The Infection Control Officer, Infection Preventionist, and the Safety Officer will determine if Internal Disaster Code Orange is warranted based on patient surge, physical and staffing resources.
8) When there is no option for providing N95 respirators, surgical masks will be provided to the employee.

iii. Positive Air Purifying Respirators (PAPRs)
1) PAPRs used for bronchoscopy are maintained in Respiratory Care Department.
2) **Materials Distribution (ext. 3331)**~~SPD~~ stores and maintains all other PAPRs.
3) Units are cleaned; disinfected using a hospital approved disinfectant and tested after each use.
4) Disposable hoods are used.

8. Admissions and transfers of patients with known or suspected airborne transmissible ATD:
a. Airborne transmissible ATD suspect cases shall be identified, and the individuals shall be given disposable tissues, hand hygiene materials and the patient will be masked until an AIIR is available. Transfer to an AIIR shall be facilitated within five (5) hours of identification.
b. If an AIIR is not available, patients shall be transferred to a facility with AIIR availability.
c. If the physician determines that transfer to another facility AIIR would be detrimental to the patient's condition the patient need not be transferred. In this case, employees will use N95 respirators when entering the room or area housing the individual. The patient's condition will be reassessed every 24 hours to determine if transfer is safe and the determination shall be documented.
9. Influenza Season
a. From November 1 to March 31, all employees, volunteers, contract workers or others covered under the ATD standard must wear a standard surgical mask while on duty ~~-~~as directed by the facility. This requirement does not apply to anyone who has received the current influenza vaccine as recommended by the County of San Diego Public Health and Centers for Disease Control and Prevention.
b. The enforcement dates are subject to change based on the recommendations of the hospital's Infection Control Committee.
c. Non-compliance with this requirement is subject to discipline as outlined in the hospital's Human Resources policy.

R. INITIAL TB TEST OF NEW ~~-~~HEALTHCARE WORKER~~EMPLOYEE~~:

1. **All new Health-care workers, including those with a history of BCG Vaccination, who cannot provide documentation of a negative TB skin test or QuantiFERON Gold within the past year will need to complete one as part of the initial screening. ~~upon completing other new employee requirements~~.**

~~10. Students may present the 2 step TB skin test or QuantiFERON Gold~~

~~11.~~**2. New Health-care workers with a previously documented positive QuantiFERON test are required to provide evidence of a negative chest x-ray and complete the review questionnaire annually.**

a. Note: Pursuant to §4.5-1 of the Medical Staff Bylaws, all medical staff are required to complete initial screening. Failure to comply with this requirement will result in the initial application being deemed incomplete.

S. ROUTINE SCREENING:

~~12.~~**1. TB Screening is a mandatory requirement and all Tri-City Healthcare District (TCHD) HCW will receive a QuantiFERON Gold TB test every 4 years, per the current community standard.**

a. Students may present a negative initial 2 step TB skin test from anytime, with PPD step 1 being within 7-365 days of PPD step 2, or a negative initial QuantiFERON Gold/T-Spot.

~~a.~~b. Annually thereafter, students must submit a negative annual 1-step PPD or QuantiFERON Gold/T-Spot. ~~Students may~~

~~13.~~**2. The review questionnaire will be completed by all HCW, regardless of a documented history of positive TB Skin Test or QuantiFERON or history of BCG Vaccination, on an annual basis. Failure to meet this requirement will be subject to disciplinary action up to and including termination. Remote TCHD HCW ~~employee~~ may be exempt from the required TB testing if the ~~employee~~HCW only works from home.**

a. Note: Pursuant to §6.3-5 of the Medical Staff Bylaws, all current medical staff are required to undergo annual screening (exemption is applied as noted above). Failure to comply with this requirement will result in limited suspension of clinical privileges.

~~S.~~**T. MANAGEMENT OF HEALTHCARE WORKER ~~EMPLOYEES~~ WITH A POSITIVE ~~T~~TB SKIN TEST~~ST~~ OR QUANTIFERON GOLD:**

1. **If TB Skin Test or QuantiFERON Gold test results are newly positive, and there is not a documented negative chest x-ray, the HCW will refer to EHS for guidance for follow up medical evaluation for TB preventive therapy.**

a. **Additional chest x-rays are not required for a HCW with a documented history of latent TB (positive TB Skin Test or QuantiFERON Gold) and a negative chest x-ray unless they develop symptoms of active TB.**

2. **Investigate reason for the conversion and follow up as indicated.**

~~T.~~**U. CONTACT INVESTIGATION:**

1. Once an exposure has been validated by Infection Control, Employee Health Services will send managers/directors notification of potential staff exposure. Managers/directors are responsible for immediate notification of employees who might have had contact with the patient. Infection Control will notify the Med Staff ~~o~~Office so they may notify applicable Med Staff. QuantiFERON- Gold TB test is drawn at least 3 weeks post exposure, and again 8-10 weeks post exposure date, if the initial post exposure QuantiFERON Gold test is negative.

~~U.~~**V. RECORD KEEPING:**

1. **Employee Health Services will document all Tuberculosis Skin Tests (TST) & QuantiFERON Gold TB test results, including the name of the HCW~~employee~~, the date of the test, and the result of the test. Any/all records received on a physician or APP of the medical staff will be forwarded to the Medical Staff Office.**

2. Contact or exposure documentation shall include the name of the ~~employee or~~ HCW

exposed, the date and location of the incidents, and all follow up evaluation and treatment.

~~V.~~W. MANAGEMENT OF EMPLOYEES WITH EVIDENCE OF ACTIVE TUBERCULOSIS:

1. **Employees who exhibit symptoms of Tuberculosis, i.e. fever, night sweats, hemoptysis, malaise, etc., or are diagnosed with active Tuberculosis, will not be allowed to work until medical treatment and counseling is completed.** \
   a. **If an employee has active Tuberculosis or suspected active Tuberculosis, Employee Health Services will immediately notify the Infection Preventionist and Public Health within one day of diagnosis or suspicion under Title 17, California Code of Regulations, Section 2500.**

~~W.~~X. MEDICAL SERVICES:

1. **Select** ~~V~~**v**accin~~ations~~**es** are offered to employees free of charge (Employee Health and Wellness Manual: Immunization Policy).
2. Medical Services shall be provided to **all** HC**W**~~P~~ who have occupational exposure to ATDs.
3. Medical Services may include vaccinations, tests, examinations, evaluations, determinations, procedures and follow-up.
4. Medical Services shall be conducted in accordance with EHS policies.

~~X.~~Y. TRAINING:

1. Training is provided during the New Employee Orientation Process and annually through computer~~-~~-based education modules.
2. Opportunity is provided for questions to be answered by an infection control professional.
3. Respirator Fit testing

a. Medical screening and training is performed in accordance with Employee Health and Wellness Manual: Respiratory Protection Program.

~~Y.~~Z. REVIEW SCHEDULE:

1. The ATD plan will be reviewed annually by the Infection Control Committee.
2. ~~Employees will assess the effectiveness of the program in their respective areas annually during the Annual Work Survey and deficiencies will be corrected~~

~~Z.~~AA. RELATED DOCUMENT(S):

1. Active/Rule Out Tuberculosis (TB) Surgery Protocol
2. Criteria for Infectiousness and Placement in High Risk Setting Table (PCU Unit Only)
3. Employee Health and Wellness Policy: Immunization
4. Employee Health and Wellness Policy: Respiratory Protection
5. Infection Control Policy: Infection Prevention Risk Assessment
6. Infection Control Policy: Epidemiologic Investigation of a Suspected Outbreak
7. Infection Control Policy: Standard and Transmission-Based Precautions
8. Type and Duration of Precautions - Disease Specific
9. Infection Control Policy: Ebola Plan

~~AA.~~BB. REFERENCE(S):

1. Centers for Disease Control & Prevention, Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis In Health Care Settings, 2005. MMWR 2005; 54 (No RR-17). **(Reviewed 02/05/2025)** .
2. Centers for Disease Control & Prevention, Guideline for Environmental Infection Control in Health Care Facilities, 2003 (last updated 02/15/2017)
3. Centers for Disease Control & Prevention H1N1 guidance, Seasonal Influenza and vaccine Guidance https://www.cdc.gov/flu/professionals/index.htm, ~~Accessed 2/14/19~~**(Updated 09/17/2024)**
4. California Department of Public Health, Occupational Health Branch. (2015, August). Respirator Selection Guide for Aerosol Transmissible Disease.

https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/CDPH%20Document%20Library/HCResp-ATD-RespSelectGuide.pdf **(Accessed 02/03/2025)**

5. CDPH Ebola Virus Disease for Healthcare Professionals **(Updated 05/10/2024)** https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/EbolaHealthProfessionals.aspx
6. ~~Respiratory Hygiene/Cough Etiquette in Healthcare Settings www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm~~
7. CDPH: Cal-OSHA Aerosol Transmissible Diseases Standard, Title 8 CCR Section 5199 ~~August~~ **March 24, 2021**~~5, 2009~~ https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/Pages/ATDStd.aspx

~~8. CDC: Tuberculin Skin Testing for TB dated May 11, 2016. https://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm~~

~~9.~~**8.** Cadena, J. (2014) Tuberculosis and other Mycobacteria. In P. Grota (Ed.), *APIC Text* ***Online*** ~~*of Infection Control and Epidemiology* -~~***64***th *Ed.*, ~~95~~**96**:1-20**9**.

~~10.~~**9.** Hospital Respiratory Protection Program Toolkit: U.S. Dept of Labor/CDC/OSHA/NIOSH. **(Up**~~D~~**d**ated ~~-~~**April 2022)**~~May 2015~~. https://www.osha.gov/Publications/OSHA3767.pdf

~~11.~~**10.** ~~CDPH/CTCA: California AdultTuberculosis Risk Assessment: September 2018 https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf~~ **Preventing TB in your clinical Setting: A Practical Guidebook https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Preventing-TB-in-Your-Clinical-Setting_A-Practical-Guidebook-nonADA.pdf#search=TB%20risk%20assessment%20and%20fact%20sheet**

~~12.~~**11.** CDPH Respirator Toolkit August 2015 (CDC, OSHA, NIOSH May 2015) page 16 https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/CDPH%20Document%20Library/HCResp-CARPPGuide.pdf **(Reviewed 02/03/2025)**

~~13.~~**12.** Guidelines for the Assessment of Tuberculosis Patient Infectiousness and Placement into High and Lower Risk Settings (ctca.org) **(Reviewed 02/03/2025)**

~~14.~~**13.** TB-454eTBServicesBrochure.pdf (sandiegocounty.gov) **(Reviewed 02/03/2025)**

14. Tuberculosis Control and Refugee Health Program (sandiegocounty.gov) **(Reviewed 02/03/2025)**

15. https://www.quantiferon.com/us/wp-content/uploads/sites/13/2017/10/PROM-11178-001_1107769_BRO-QFT-TB-Gold-Plus-FAQ-HCPs-0717-US.pdf

~~15.~~**16. The Joint Commission Standard Infection Prevention and Control (IC) standards, IC.4.10 (2024, July)**

Tri-City Health Care District
Oceanside, California

AIRBORNE PRECAUTIONS

Surgery Protocol

ADMINISTRATIVE CONTROLS	ENVIRONMENTAL CONTROLS	RESPIRATORY PROTECTION
• Postpone non-urgent procedures on suspected/confirmed TB patients until known to be non-infectious. • If necessary to proceed, schedule procedure as last case of the day, at low traffic times, whenever possible. • Case may be performed in any OR, but it is preferred there be no ongoing cases in the adjacent OR's. WHEN THE CASE IS SCHEDULED NOTIFY: • Infection Control- (x5696) • POH (x5452) • PACU (x7264) • Engineering (x7148) of date/time of procedure to set up HEPA filters in OR and PACU • Anesthesia Charge to assure anesthesiologist has been fit tested and knows N95 size • Notify pathology lab if TB specimens will be sent to lab. *DAY BEFORE PROCEDURE, IF POSSIBLE:* Assign staff and assure fit testing is completed and individuals know their N95 mask size. DAY OF SURGERY: • Obtain 3 Airborne Precaution Signs • Obtain five PAPR Units or N95 • Prior to transporting the patient to the OR, send OR RN to the patient's unit to pre-op patient and complete handoff report.	PRE-OP: • Admit patient directly to the OR from the floor/unit. Do not stop in POH. **OR:** • Place portable HEPA unit in OR, positioned near the patient's head with ventilation outflow in the direction of the door. • Utilize the portable HEPA unit in the OR during intubation and extubation. Turn the unit OFF during the procedure. • Keep OR doors closed, minimize traffic in/out of room and in surrounding areas. • A "runner" should be positioned outside the OR to minimize door openings during the procedure. • Display Airborne Precautions signs on all doors to OR. • Close all doors after leaving the OR and keep room vacant with HEPA filter running for **ONE (1) HOUR** after patient leaves room, then perform normal room turnover. • Remove HEPA unit and return to proper location. **POST-OP:** • Place portable HEPA unit in PACU cubicle, with ventilation outflow in the direction of the door. • Post Airborne Precautions signs on cubicle door. • Place patient in cubicle post-op and keep cubicle door closed. • Close cubicle door after patient leaves and keep room vacant with HEPA filter running for **ONE (1) HOUR,** then perform normal room turnover. • Remove HEPA unit and return to proper location.	PATIENT: • Provide surgical mask for patient during transport. • Intubated patients: Anesthesiologist to place expiratory filter (from Anesthesia Workroom) on the ambu bag (at PEEP valve) during transport. HEALTH CARE PROVIDERS: • N95 Respirator or Powered Air Purifying Respirator (PAPR) required during intubation and extubation for the anesthesiologist and anyone assisting anesthesia at the head of the table. • *PAPR's are not to be used near the sterile field.* • Once the patient is intubated, all staff should wear N95 mask until the procedure is complete. • Fit testing for N95 mask must be completed each year. Healthcare providers who fail fit testing may not be scheduled in a sterile procedure with Airborne Precautions.

Tri-City Health Care District
Oceanside, California

AIRBORNE PRECAUTIONS
Surgery Protocol

LATENT VS. ACTIVE TUBERCULOSIS

LATENT TB Infection (LTBI)	ACTIVE TB Infection
Persons with latent TB infection are not infectious and cannot spread TB infection to others	Persons with active TB disease are considered infectious and may spread TB bacteria to others.
• Usually has a skin test or blood test result indicating TB infection • Has a normal chest x-ray and a negative sputum test (Acid Fast Bacilli (AFB) smears x3 OR Nucleic acid amplification test (NAAT) negative x2 OR AFB smear positive and NAAT negative x2) • Has TB bacteria in his/her body that are alive, but inactive • Does not feel sick • Cannot spread TB bacteria to others • Has had, undergoing or needs treatment for latent TB infection to prevent TB disease (≥14 daily doses of appropriate treatment for TB, preferably by directly observed therapy (DOT), taken and tolerated AND Clinical improvement.)	• Usually has a skin test or blood test result indicating TB infection • May have an abnormal chest x-ray, or positive sputum smear or culture (Acid Fast Bacilli (AFB) smears x3 OR Nucleic acid amplification test (NAAT) negative x2 OR AFB smear positive and NAAT negative x2) • Has active TB bacteria in his/her body • Usually feels sick and may have symptoms such as coughing, fever, and weight loss • May spread TB bacteria to others • Needs treatment to treat TB disease (≥14 daily doses of appropriate treatment for TB, preferably by directly observed therapy (DOT), taken and tolerated AND Clinical improvement.)

TB treatment can take 4, 6, or 9 months or more depending on the regimen. Healthcare providers can choose the appropriate TB treatment regimen based on drug-susceptibility results, coexisting medical conditions and potential for drug-drug interactions. TB treatment regimens include:

- 4-month Rifapentine-moxifloxacin TB Treatment Regimen
  - high-dose daily rifapentine (RPT) with
  - Moxifloxacin (MOX),
  - Isoniazid (INH), and
  - Pyrazinamide (PZA)
- 6- or 9-month RIPE TB Treatment Regimen
  - Rifampin (RIF),
  - Isoniazid (INH),
  - Pyrazinamide (PZA), and
  - Ethambutol (EMB)

Sources:

CDPH/CTCA (2005). Guidelines for the assessment of tuberculosis patient infectiousness and placement in high and low risk settings. California Department of Public Health and California Tuberculosis Controllers Association. (Reviewed 01/09/2025)

Fact Sheets | General | Latent TB Infection vs. TB Disease | TB | CDC. (n.d.). https://www.cdc.gov/tb/publications/factsheets/general/ltbiandactivetb.htm (Reviewed 01/09/2025)

Tuberculosis (TB) - treatment for TB disease. (2025, January 9). Centers for Disease Control and Prevention. https://www.cdc.gov/tb/topic/treatment/tbdisease.htm

Tri-City Health Care District
Oceanside, California

Criteria for Infectiousness and Placement In High Risk Setting Table (PCU Unit Only)

CATEGORY	LAB CRITERIA	TREATMENT CRITERIA
TB suspect • Not on treatment for suspect active TB	1. AFB smear negative x 3 **OR** 2. NAAT negative x 2 **OR** 3. AFB smear positive **AND** NAAT negative x 2 (ideally done on the same specimens)	• No minimum number of days of TB treatment required
TB suspected or known • AFB smear negative **OR** NAAT negative x 2 (without smear results) **OR** AFB smear negative **AND** NAAT positive • No MDR TB risk factors	1. AFB smear negative x 3 2. Obtain direct genetic test, if available and not already done, for rifampin resistance	• ≥5 daily doses of appropriate TB treatment taken and tolerated **AND** • Clinical improvement
TB suspected or known • AFB smear positive **AND** NAAT positive **OR** NAAT positive (without smear results) • No MDR TB risk factors	1. AFB smear negative x 3 2. Obtain direct genetic test, if available and not already done, for rifampin resistance	• ≥14 daily doses of appropriate treatment for TB, preferably by directly observed therapy (DOT), taken and tolerated **AND** • Clinical improvement.
TB case or suspect on treatment for TB • At increased risk for MDR-TB	1. Obtain direct genetic test, if available and not already done, for Rifampin resistance **OR** 2. If direct genetic test unavailable, while phenotypic DST for rifampin is pending, either criteria for patients with known MDR TB or criteria for patients not at increased risk of MDR TB may be applied, at the discretion of the local TB controller	• ≥14 daily doses of appropriate treatment for TB, preferably by directly observed therapy (DOT), taken and tolerated **AND** • Clinical improvement
Known MDR-TB case	1. AFB smear negative x 3 **AND** 2. At least 2 consecutive negative sputum cultures without a subsequent positive culture **OR** If subsequent AFB smear positive after 3 negative AFB smears, a clinical assessment has been performed and determined to most likely not represent viable M. tb	• ≥14 daily doses of appropriate treatment for TB, preferably by directly observed therapy (DOT), taken and tolerated **AND** • Clinical improvement

~~Reference: CDPH/CTCA (2017). Guidelines for the assessment of tuberculosis patient infectiousness and placement in high and low risk settings. California Department of Public Health and California Tuberculosis Controllers Association. (Reviewed 6/5/25)~~

Tri-City Health Care District
Oceanside, California

Criteria for Infectiousness and Placement In High Risk Setting Table (PCU Unit Only)

Patient has signs and symptoms or chest x-ray compatible with TB

AND

Unstable housing or resident in a group setting

OR

Acutely ill or needing invasive diagnostic or therapeutic procedure

Admit to ~~Medicine~~ **Inpatient** and place on

Airborne Precautions

AND

Stable, non-group housing

AND

Not acutely ill or needing invasive diagnostic or therapeutic procedure

Discharge the patient with a written plan for outpatient care & surgical masks to wear
AND
Instruct the patient to remain on home isolation[1] until infectiousness is ruled out
AND
Alert the TB Control Program ASAP, but no longer than 24 hours.

San Diego County TB Control is available 7 days a week from 0800 to 1700 at (619) 692-8610

Weekends, holidays, and after hours the on-call RN can be reached at (619) 540-0194
Messages left will be returned within the day. Messages should include patient's name, date of birth, facility name, reporter's name and phone number, and contact person at facility who will be available for more patient information.

Notify TCMC Infection Control @ rlmoore@tcmc.com

[1]Home isolation: Stay alone in a separate room with the door closed, as much as possible. Keep a window slightly open at all times. When alone in this room, you do not need to wear a mask. Please be sure to sleep and eat while alone in this room. Persons entering this room need to wear a mask. If you leave the room, you need to wear a mask. For example, when you use a shared bathroom or go to the doctor's office wear a mask.

Reference: *Guidelines for the Assessment of Tuberculosis Patient Infectiousness and Placement into High and Lower Risk Settings*. (2017). https://ctca.org/wp-content/uploads/2018/11/InfectiousnessOctober2017.pdf

~~[1]Home isolation: Stay alone in a separate room with the door closed, as much as possible. Keep a window~~

Criteria for Infectiousness and Placement In High Risk Setting Table (PCU Unit Only)

~~slightly open at all times. When alone in this room, you do not need to wear a mask. Please be sure to sleep and eat while alone in this room. Persons entering this room need to wear a mask. If you leave the room, you need to wear a mask. For example, when you use a shared bathroom or go to the doctor's office wear a mask.~~

~~TB Control in San Diego County is available 7 days a week from 0800 to 1700 only. Weekdays call TB Control at (619) 692-8610 and on Weekends and holidays call cell phone number (619) 540-0194 OR Leave a message on the Tuberculosis RN voice mail (619) 692-8610 and your call will be returned on the next working week day. Messages should include patient's name, date of birth, facility name, reporter's name and phone number, and contact person at facility who will be available for more patient information. Also leave a message at TCHD Infection Control: call ext. 5696~~

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Appendix B. Tuberculosis (TB) Risk Assessment Worksheet CY2025~~21~~

Scoring √ or Y = Yes	X or N = No	NA = Not Applicable

1. Incidence of TB – CY2024~~0~~ DATA

What is the incidence of TB in your community (county or region served by the health-care setting), and how does it compare with the state and national average? What is the incidence of TB in your facility and specific settings and how do those rates compare? (Incidence is the number of TB cases in your community the previous year. A rate of TB cases per 100,000 persons should be obtained for comparison.)* This information can be obtained from the state or local health department.	Community rate: **7.4~~5.7~~** State rate: **5.4~~4.73~~** National rate: **2.~~92~~** Facility rate: **~~5.8~~8.8 (4 cases/ ~~3/52054 pt days~~45,289pt days X~~*~~ 100,000)**
Are patients with suspected or confirmed TB disease encountered in your setting (inpatient and outpatient)?	**Yes** No
If yes, how many patients with suspected and confirmed TB disease are treated in your health-care setting in 1 year (inpatient and outpatient)? Review laboratory data, infection-control records, and databases containing discharge diagnoses.	<table><tr><th></th><th>Suspect</th><th>Confirmed</th></tr><tr><td>1 yr ago (2024~~0~~)</td><td>**11~~25~~**</td><td>**~~43~~**</td></tr><tr><td>2 yrs ago (2023~~19~~)</td><td>**18~~20~~**</td><td>**~~412~~**</td></tr><tr><td>5 yrs ago (2020~~16~~)</td><td>**27~~21~~**</td><td>**~~87~~**</td></tr></table>
If no, does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease?	**Yes** No
Currently, does your health-care setting have a cluster of persons with confirmed TB disease that might be a result of ongoing transmission of *Mycobacterium tuberculosis* within your setting (inpatient and outpatient)?	Yes **No**

2. Risk Classification

Inpatient settings	
How many inpatient beds are in your inpatient setting?	**32~~887~~ beds**
How many patients with TB disease are encountered in the inpatient setting in 1 year? Review laboratory data, infection-control records, and databases containing discharge diagnoses.	Previous year (2024~~0~~):~~3~~ **4** 5 years ago (2020~~16~~): **~~87~~**
Depending on the number of beds and TB patients encountered in 1 year, what is the risk classification for your inpatient setting? (See Appendix C.)	**o Low risk** o Medium risk o Potential ongoing transmission
Does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease?	**Yes** No

3. Screening of HCWs for *M. tuberculosis* Infection

Does the health-care setting have a TB screening program for HCWs?	**Yes** No
If yes, which HCWs are included in the TB screening program? (Check all that apply.) √o **Physicians** √o **Mid-level practitioners (nurse practitioners [NP]— and physician's assistants [PA])** √o **Nurses** √o **Administrators** √o **Laboratory workers** √o **Respiratory therapists** √o **Physical therapists**	√o **Janitorial staff** √o **Maintenance or engineering staff** √o **Transportation staff** √o **Dietary staff** √o **Receptionists** √o **Trainees and students** √o Construction or renovation workers √o **Volunteers** o Others_____

√o **Contract staff**	
Is baseline skin testing performed with two-step TST for HCWs?	**Yes** No
Is baseline testing performed with QFT or other BAMT for HCWs?	**Yes** No
How frequently are HCWs tested for *M. tuberculosis* infection?	**Upon hire, Every 4 Years (community standard), Post Exposure follow up~~Annually~~**
Are the *M. tuberculosis* infection test records maintained for HCWs?	**Yes** No
Where are the *M. tuberculosis* infection test records for HCWs maintained? Who maintains the records?	**Test records are maintained by Employee Health**
If the setting has a serial TB screening program for HCWs to test for *M. tuberculosis* infection, what are the conversion rates for the previous years? † 1 year ago (2024~~0~~) **~~1~~0** 2 years ago (20~~1~~**923**) **2** ~~0~~ 3 years ago (20~~1~~**22**~~8~~) ~~**0**~~**1** 4 years ago (20**21**~~17~~) ~~**0**~~**1** 5 years ago (20**20**~~16~~) ~~**1**~~**1**	
Has the test conversion rate for *M. tuberculosis* infection been increasing or decreasing, or has it remained the same over the previous 5 years? (check one)	~~o~~ Increasing ~~o~~ Decreasing ~~x~~ No change

4. TB Infection-Control Program

Does the health-care setting have a written TB infection-control plan?	**Yes** No
Who is responsible for the infection-control program?	**Tri-City Medical Center Infection Prevention**
When was the TB infection-control plan last reviewed or updated?	**06~~5~~/2024~~0~~**
Does the written infection-control plan need to be updated based on the timing of the previous update (i.e., >1 year, changing TB epidemiology of the community or setting, the occurrence of a TB outbreak, change in state or local TB policy, or other factors related to a change in risk for transmission of *M. tuberculosis*)?	**Yes** No
Does the health-care setting have an infection-control committee (or another committee with infection control responsibilities)?	**Yes** No

If yes, which groups are represented on the infection-control committee? (Check all that apply.)

o **Physicians**	o **Laboratory personnel**
o **Health and safety staff**	o **Nurses**
o Administrator	o **Epidemiologists**
o **Engineers**	o Risk assessment
o **Pharmacists**	o Others (specify)_____
o **Quality control (QC)**	

5. Implementation of TB Infection-Control Plan Based on Review by Infection-Control Committee

Has a person been designated to be responsible for implementing an infection-control plan in your health-care setting? If yes, list the name**(s)**: ~~**HilaryMetcalf**~~ **Rabecka Moore**	**Yes** No

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Based on a review of the medical records, what is the average number of days for the following: • Presentation of patient until collection of specimen ~~N/A~~ **1-2** • Specimen collection until receipt by laboratory **1-2** • Receipt of specimen by laboratory until smear results are provided to health-care provider **2-4** • Diagnosis until initiation of standard anti-tuberculosis treatment **2-4** • Receipt of specimen by laboratory until culture results are provided to health-care provider **30** • Receipt of specimen by laboratory until drug-susceptibility results are provided to health-care provider **30** • Receipt of drug-susceptibility results until adjustment of anti-tuberculosis treatment, if indicated • Admission of patient to hospital until placement in airborne infection isolation (AII) **1-2**

Through what means (e.g., review of TST or BAMT conversion rates, patient medical records, and time analysis) are lapses in infection control recognized?	Conversion rates, employee exposures
What mechanisms are in place to correct lapses in infection control?	Exposure control plan
Based on measurement in routine QC exercises, is the infection-control plan being properly implemented?	Yes No
Is ongoing training and education regarding TB infection-control practices provided for HCWs?	Yes No

6. Laboratory Processing of TB-Related Specimens, Tests, and Results Based on Laboratory Review

Which of the following tests are either conducted in-house at your health-care setting's laboratory or sent out to a reference laboratory?	In-house	Sent out
Acid-fast bacilli (AFB) smears	~~x~~	**x**
Culture using liquid media (e.g., Bactec and MB-BacT)		**x**
Culture using solid media		**x**
Drug-susceptibility testing		**x**
Nucleic acid amplification (NAA) testing		**x**

What is the usual transport time for specimens to reach the laboratory for the following tests?

AFB smears **24-48 hours**
Culture using liquid media (e.g., Bactec, MB-BacT) ~~22~~ **24-48 hours**
Culture using solid media **24-48 hours**
Drug-susceptibility testing **24-48 hours**
~~Other (specify)~~ ~~24-48 hours~~
NAA testing **24-48 hours**

Does the laboratory at your health-care setting or the reference laboratory used by your health-care setting report AFB smear results for all patients within 24 hours of receipt of specimen? What is the procedure for weekends?	**Yes** No **S** ~~same procedure~~, 7 days a week

7. Environmental Controls

Which environmental controls are in place in your health-care setting? (Check all that apply and describe)

Environmental control	Description
✓ o AII rooms	~~32~~ 1
rooms	

✓ o Local exhaust ventilation (enclosing devices and exterior ~~devices)~~ **devices)**

✓ o General ventilation (e.g., single-pass system, recirculation system.)

✓ Air-cleaning methods (e.g., high-efficiency particulate air [HEPA] ~~filtration and ultraviolet germicidal irradiation [UVGI]))~~ ~~Both~~

What are the actual air changes per hour (ACH) and **are** design **requirements met** for various rooms in the setting?

ROOM	ACH	DESIGN Requirement met
ED-C26	18	Yes
143	21	Yes
200	17	Yes
201	13	Yes
243	19	Yes
287	17	Yes
301	29	Yes
312	17	Yes
326	19	Yes
387	17	Yes
443	23	Yes
487	13	Yes
NICU	16	Yes

~~Room ACH Design~~
~~not measured~~

Which of the following local exterior or enclosing devices such as exhaust ventilation devices are used in your health-care setting? (Check all that apply)

✓ Laboratory hoods
o Booths for sputum induction
✓ Tents or hoods for enclosing patient or procedure

What general ventilation systems are used in your health-care setting? (Check all that apply)

✓ Single-pass system —-South Tower
o Variable air volume (VAV)
✓ Constant air volume (CAV) -- -All
✓ Recirculation system —- ~~pavilion~~**pavillon** and center towers
o Other_____

What air-cleaning methods are used in your health-care setting? (Check all that apply)

HEPA filtration ✓ Fixed room-air recirculation systems – AIIR and surgery ✓ Portable room-air recirculation systems ~~UVGI~~ ~~o Duct irradiation~~ ~~o Upper-air irradiation~~ ~~✓ Portable room-air cleaners~~	
How many AII rooms are in the health-care setting? **1**~~3~~**2**	
What ventilation methods are used for AII rooms? (Check all that apply) Primary (general ventilation): ✓ Single-pass heating, ventilating, and air conditioning (HVAC) **o Recirculating HVAC systems** Secondary (methods to increase equivalent ACH): **o Fixed room recirculating units** ~~✓~~ HEPA filtration ~~✓ UVGI~~ ✓ ~~o Other (specify) _____~~	
Does your health-care setting employ, have access to, or collaborate with an environmental engineer (e.g., professional engineer) or other professional with appropriate expertise (e.g., certified industrial hygienist) for consultation on design specifications, installation, maintenance, and evaluation of environmental controls?	**Yes** No Annual certification
Are environmental controls regularly checked and maintained with results recorded in maintenance logs?	**Yes** No
Are AII rooms checked daily for negative pressure when in use?	**Yes** No
Is the directional airflow in AII rooms checked daily when in use with smoke tubes or visual checks?	**Yes** No
Are these results readily available? Kept in control plant	**Yes** No
What procedures are in place if the AII room pressure is not negative?	~~No procedure.~~ **Facility engineers to assess first, Outside certification company notified. Relocation of patient to working AII room, assess staff for potential exposures.**
Do AII rooms meet the recommended pressure differential of 0.01-inch water column negative to surrounding structures?	**Yes** No

8. Respiratory-Protection Program

Does your health-care setting have a written respiratory-protection program?	**Yes** No
Which HCWs are included in the respiratory protection program? (Check all that apply) ✓ Physicians ✓ Mid-level practitioners (NPs and PAs) ✓ Nurses ✓ Administrators ✓ Laboratory personnel ✓ Contract staff ✓ Construction or renovation staff ✓ Service personnel	✓ Janitorial staff ✓ Maintenance or engineering staff ✓ Transportation staff ✓ Dietary staff Students o Others (specify)_____ _____ _____ _____ _____
Are respirators used in this setting for HCWs working with TB patients? If yes, include manufacturer, model, and specific application (e.g., ABC model 1234 for bronchoscopy and DEF model 5678 for routine contact with infectious TB patients). Manufacturer Model Specific application	

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3M 1870+~~9205+~~ Routine contact, Aerosol inducing procedures	
Is annual respiratory-protection training for HCWs performed by a person with advanced training in respiratory protection?	**Yes** No
Does your health-care setting provide initial fit testing for HCWs? If yes, when is it conducted? upon hire	**Yes** No
Does your health-care setting provide periodic fit testing for HCWs? If yes, when and how frequently is it conducted? A~~a~~nnually	**Yes** No
What method of fit testing is used? Describe. **Qualitative fit testing is required and provided annually for all staff.**	
Is qualitative fit testing used?	**Yes** No
Is quantitative fit testing used?	Yes **No**

9. Reassessment of TB risk

How frequently is the TB risk assessment conducted or updated in the health-care setting?	**Annually, as needed**
When was the last TB risk assessment conducted?	**06/2024~~0~~**
What problems were identified during the previous TB risk assessment? 1) ~~**No problems identified. TCMC risk classification is low**~~**Increase in community cases of active TB infection, increase in TB hospitalizations.** 2) 3)	
What actions were taken to address the problems identified during the previous TB risk **assessment?** ~~assessment?~~ 1) **Increased/reinforced TB education for staff** 2)	
Did the risk classification need to be revised as a result of the last TB risk assessment?	Yes **No**

* If the population served by the health-care facility is not representative of the community in which the facility is located, an alternate comparison population might be appropriate.

† Test conversion rate is calculated by dividing the number of conversions among HCWs by the number of HCWs who were tested and had prior negative results during a certain period (see Supplement, Surveillance and Detection of *M. tuberculosis* infections in Health-Care Settings).

Tri-City Healthcare District
Oceanside, California

INFECTION CONTROL

ISSUE DATE:	**09/01**	**SUBJECT:**	**Bloodborne Pathogen Exposure Control Plan**
REVISION DATE:	**09/02, 09/03, 09/04, 09/05, 10/06, 10/07, 10/08, 10/09, 10/10, 10/12, 10/15, 08/16, 10/17, 08/18, 12/19, 12/20, 02/23**		

Infection Control Department Approval:	**~~11/22~~07/25**
Infection Control Committee Approval:	**~~12/22~~07/25**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/23~~10/25**
Administration Approval:	**~~02/23~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/23**

A. **INTRODUCTION:**

1. Legal mandates and regulatory agencies such as the California code of Regulation Title 8, Occupational Safety and Health Administration and the Centers of Disease Control and Prevention have set standards and published guidelines for the implementation of the Bloodborne Pathogen Exposure Control Plan.

B. **DEFINITION(S):**

1. ~~Workforce Member~~**Workforce member**: Employees, Medical Staff and Allied Health Professionals (AHP), volunteers, trainees, Business Visitors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.

C. **PURPOSE:**

1. The purpose of the Bloodborne Pathogens Exposure Control Plan is to reduce occupational exposure and transmission of Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), Human Immunodeficiency Virus (HIV) and other bloodborne pathogens. The second purpose is to satisfy the Occupational Safety and Health Administration (OSHA) regulations (29 CFR 1910.1030). Our plan outlines the steps we take to protect healthcare workers from the health hazards associated with bloodborne pathogens and to provide appropriate treatment and counseling after an exposure.

D. **SCOPE:**

1. This plan applies to all inpatient and outpatient services of Tri-City Healthcare District (TCHD).

E. **AVAILABILITY TO HEALTHCARE WORKERS:**

1. To help them with their efforts, our facility's Bloodborne Exposure Control Plan is available to healthcare workers at any time. The policy can be accessed in the Infection Control Manual located on the Intranet. Information is presented in orientation and during annual reviews.

F. **PROGRAM ADMINISTRATION:**

1. Employee Health Services (EHS) with the Infection Preventionist will review and update the Exposure Control Plan at least annually and whenever necessary to include new or modified

tasks and procedures. Employee Health Services is responsible for the implementation, maintenance, and administration of the Injury Prevention Program.

2. The Management/Leadership Team will ensure each employee for their area/unit of responsibility is provided information and training on the potential for exposure to bloodborne pathogens.
   a. Registry and contract staff are oriented to the hospital's exposure control plan prior to working.
   b. Training records are maintained for three years and available for examination and copying to our employees, as well as OSHA representatives. The records contain the following information, dates of all training sessions, contents/summary of the training sessions, and names and qualifications of the instructors as well as the names and job titles of employees attending.
3. The Management/Leadership Team is responsible for compliance in their respective areas. They work directly with the Safety/Environment of Care (EOC) Officer**,** the Infection Control Department, Employee Health and our employees to ensure that proper exposure control procedures are followed.
   a. The Management/Leadership Team will support activities that encourage the active involvement of employees in education and safety programs. The Management/Leadership Team will oversee employees so that initial training and annual review of bloodborne pathogens are completed prior to annual job evaluations.
   b. The Management/Leadership Team will review quality review reports (RL Solutions) their employees complete to document any needlestick occurrence.
      i. The Management/Leadership Team will counsel employees who do not use safe practices, PPE, and/or safety devices.
4. Materials Management and Environmental Services will provide all necessary personal protective equipment (PPE), engineering controls (e.g., sharps containers and sharps safety devices), labels, and red bags as required by the standard.
5. The ~~Product Steering~~**Clinical Value Analysis** Committee has been identified as the multi-disciplinary group with primary responsibility for introducing sharps safety products to TCHD. The committee will provide guidance in product selection, seeking to provide cost-effective safety devices.
   a. Review and selection Sharps Safety Products will follow established routes and include input from non-managerial employees responsible for direct patient care who are potentially exposed to contaminated sharps and injury. See ~~Products Steering~~ **Clinical Values analysis** Committee Product Evaluation and User Product Evaluation.
   b. Product Selection will follow a hierarchy of risk (i.e. high-risk procedures and devices targeted first). The committee will act on recommendations from Environmental Health and Safety or Infection Control Committees related to health care injuries and need for alternative product.
   c. All products will be judged by specific criteria and selection will be guided by user recommendations.
6. ~~Workforce Members~~**Workforce members** who are determined to have occupational exposure to blood and other potentially infectious materials (OPIM) must comply with the procedures and work practices deemed appropriate. They are actively involved in reviewing and updating the exposure control plan with respect to the procedures performed in the course of their work.
   a. If a~~n employee~~ **Workforce member** exposure occurs:
      i. Employees are to notify their Director/Manager/Supervisor of any exposure immediately.
      ii. Director/Manager/Supervisor will refer employee for follow to:
         1) Employee Health during business hours.
         2) Emergency Room after hour and weekends.
            a) Employee to notify Employee Health within 24 hours of exposure.
   b. If a ~~Workforce~~ **Workforce member** ~~Member~~ other than an employee exposure occurs:
      i. ~~Workforce~~ **Workforce member** ~~Members~~ must notify

Director/Manager/Supervisor of the area of any exposure immediately.

ii. Director/Manager/Supervisor will refer ~~Workforce~~ **Workforce member** ~~member~~ to the Emergency Room for follow up.

iii. The ~~Workforce~~ **Workforce member** ~~Member~~ is to notify their employer/agency or workers compensation as appropriate.

~~c. They participate in updating the bloodborne pathogen standard with respect to the procedures performed in their work area or department. "Safer Work Practices" (Safer Work Survey).~~

c. Our employees are expected to complete initial bloodborne pathogens training and annual review.

7. Employees will participate in the trial and selection of new safety devices.
   a. Safety rounds are conducted on an annual or as needed (for patient care units or departments) schedule.
   b. Information ~~from the annual "Safer Work Survey"~~ is compiled by the Safety/Environment of Care (EOC) Officer or designee and reports the results to the Environmental Health and Safety Committee (EHSC), the Infection Control Committee, and ~~Products~~ **Clinical Values analysis** ~~Standards~~ Committee.
   c. Risk, Legal and Regulatory Services forwards information from Incident and Quality Review Reports (RL reports) to the Safety/EOC Officer, Infection Preventionist and or Materials Management as appropriate.
   d. The information will be used to update the Exposure Control Plan with respect to:
      i. Areas where engineering controls are currently employed.
      ii. Areas where engineering controls can be updated.
      iii. Areas currently not employing engineering controls, but where engineering controls could be beneficial.
8. Employee Health and Infection Control will be responsible for ensuring that all medical actions required are performed and that appropriate employee health and OSHA records are maintained. See the Employee Health Services policy "Occupational Exposure to Blood/Body Fluid Secretions."
   a. Hepatitis B vaccination series is available at no cost and employees are encouraged to be vaccinated. See the Employee Health Policy "Hepatitis B Vaccine Immunization Protocol."
   b. Exposure incidents are evaluated to determine if the case meets OSHA's Record keeping Requirements (29 CFR 1904). The maintenance of the OSHA log is an Employee Health responsibility.
   c. Medical records are maintained for each employee with occupational exposure in accordance with 29 CFR 1910.20, "Access to Employee Exposure and Medical Records." These confidential records are kept in Employee Health for at least the duration of employment plus 30 years and are provided upon request of the employee or to anyone having written consent of the employee within 15 working days.
   d. Recommendations are made to the Materials Management- when a need for a safety device or alternative product is detected.
   e. Recommendations are made to service or department managers when issues related to unsafe work practices are identified. Referrals are made to appropriate Medical Staff Chairpersons.
   f. Employee Health will present sharps Injury data specific to TCHD at the Infection Control Committee meeting ~~annually~~ **quarterly** (i.e. safety devices, work practice changes or engineering).

G. **EXPOSURE DETERMINATION:**

1. The State of California (Cal/OSHA) requires employers to perform an exposure determination concerning which ~~Workforce Members~~ **Workforce member** may incur occupational exposure to blood or other potentially infectious materials (OPIM). The exposure determination is made without regard to the use of personal protective equipment (i.e., ~~Workforce~~ **Workforce member**

~~Members~~ are considered to be exposed even if they wear personal protective equipment).

2. See Potential Blood Exposure by Job Category for a list of the job classifications in our facility where all or some ~~Workforce~~ **Workforce member** ~~Members~~ handle human blood and OPIM, which may result in possible exposure to bloodborne pathogens.
3. Since not all of the ~~Workforce~~ **Workforce member** ~~Members~~ in these categories would be expected to incur exposure to blood OPIM, examples of tasks/procedures that would cause these Workforce Members to have occupational exposure are listed in Potential Blood Exposure by Job Category.

H. **ENGINEERING CONTROLS:**

1. One of the key aspects to our Exposure Control Plan is the use of Engineering Controls to eliminate or minimize ~~Workforce~~ **Workforce member** ~~Member~~ exposure to bloodborne pathogens. On December 17, 1998 the Cal/OSHA Standards Board adopted emergency regulation revisions to Title 8, Section 5193 to meet mandates of Assembly Bill 1208. On January 2001, Federal OSHA was instructed to add sharps safety to national requirements. The major purpose of the revisions is to increase protection from sharps injuries by supplying ~~Workforce~~ **Workforce member** ~~Members~~ with engineered sharps safety devices.
   a. If available, needleless systems are required for withdrawal of body fluids after the initial venous or arterial access is established administration of medications or fluids, and other procedures with potential for exposure to a contaminated needle.
   b. If needleless systems are not used then needles with engineered sharps injury protection are required for withdrawal of body fluids, accessing a vein or artery, administration of medication or fluids, and other procedures with potential for exposure to blood or OPIM.
   c. Other sharp devices with potential for contamination with blood or body fluids (e.g. scalpels, lancets, broken capillary tubes, and drills) are also required to have engineered sharps protection.
   d. TCHD is exempt from implementation if at least one the following is applicable.
      i. The device is not available in the marketplace.
      ii. A licensed healthcare professional directly involved in a patient's care determines that the use of the engineering control will jeopardize patient care or safety.
      iii. An objective product evaluation has been completed indicating that the device is not more effective in reducing sharps injuries than the device currently used by TCHD;
      iv. There is a lack of sufficient information to determine whether a new device on the market will effectively reduce the chances of a sharps injury and an objective product evaluation is being conducted.
   e. Contaminated needles and other contaminated sharps are not sheared or broken. They are not bent, recapped, or removed unless it can be demonstrated that there is no feasible alternative. Recapping or needle removal is accomplished using a mechanical device or a one-handed technique.
   f. Containers for contaminated sharps are easily accessible to personnel and located as close as is feasible to the area where sharps are used or can be reasonably anticipated to be found.
      i. Contaminated reusable sharps are placed in appropriate containers immediately, or as soon as possible, after use.
      ii. Sharps containers have the following characteristics: rigid, puncture-resistant, portable, if it is necessary to ensure easy access by user, color-coded and labeled with a biohazard warning label, and leak-proof on the sides and bottom. These containers lock when closed and do not reopen easily**.**
      iii. The sharps containers for single use items are disposable and are not opened, emptied, or manually cleaned. In the event of a special circumstance when it would be necessary to access the container, it would be reprocessed or decontaminated.

iv. The containers are maintained upright throughout use and are replaced as needed when ¾ full. ~~A contract service is responsible for replacing containers as needed.~~**Environmental services is notified through a workorder via the intranet when replacement is needed.**

g. In addition to the engineering controls identified on these lists, the following engineering controls are used throughout our facility.
   i. Hand washing facilities and waterless hand cleansers are readily accessible to ~~Workforce~~ **Workforce member** ~~Members~~ with potential for exposure.
   ii. Specimen containers are leak-proof. No special label/color coding is required for intra-facility specimens as Standard Precautions are utilized in the handling of all specimens and containers are recognizable as containing specimens.
   iii. Secondary containers are used if the specimen could puncture primary container or outside contamination.

I. WORK PRACTICE CONTROLS:

1. In addition to engineering controls, our facility uses a number of Work Practice Controls to help eliminate or minimize ~~Workforce~~ **Workforce member** ~~Member~~ exposure to bloodborne pathogens.
   a. ~~Workforce~~ **Workforce member** ~~Members~~ follow Standard Precautions with every patient. As a result, we treat all human blood and the following other potentially infectious materials (OPIM) as if they are known to be infectious for HBV, Hepatitis C Virus (HCV), HIV, and other bloodborne pathogens:
      i. Semen
      ii. Vaginal Secretions
      iii. Peritoneal fluid
      iv. Tissue and Organs
      v. Amniotic fluid
      vi. Synovial fluid
      vii. Pleural fluid
      viii. Saliva with visible blood
      ix. Pericardial fluid
      x. Cerebrospinal fluid
   b. Eating, drinking, smoking, applying cosmetics or lip balm and handling contact lenses is prohibited in work areas where there is potential for exposure to bloodborne pathogens.
      i. Food and drink are not kept in refrigerators, freezers, on countertops or in other storage areas where blood or other potentially infectious materials are present.
      ii. For example, eating and drinking is not allowed at nurses stations, in patient rooms, on patient bedside tables, or other places where patients, specimens, or dirty instruments/devices might have touched.
   c. Mouth pipetting/suctioning of blood or other infectious materials is prohibited.
   d. All procedures involving blood or other infectious materials are performed to minimize splashing, spraying or other actions generating droplets of these materials.
   e. Equipment, which becomes contaminated, is cleaned with a hospital-approved disinfectant as soon as possible.
      i. If shipping of equipment for repairs is required, the device will be cleaned or an appropriate biohazard-warning label is attached to any contaminated equipment, identifying the contaminated portions.
      ii. Information regarding the contamination is conveyed to all affected ~~Workforce~~ **Workforce member** ~~Members~~, the equipment manufacturer, and the equipment service representative.

J. PERSONAL PROTECTIVE EQUIPMENT (PPE):

1. PPE is the ~~Workforce~~ **Workforce member** ~~Member's~~ 'last line of defense' against bloodborne pathogens. Because of this, our facility provides (at no cost to our ~~Workforce~~ **Workforce**

member~~Members~~) the Personal Protective Equipment that they need to protect themselves against such exposure. See Standard Precautions-Personal Protective Equipment Table for tasks/PPE suggested. This equipment includes, but is not limited to:

a. Gloves
b. Fluid resistant gowns
c. Glove liners
d. Laboratory coats
e. Face shield
f. Resuscitation bags
g. Masks
h. Hoods
i. Safety glasses/goggles
j. Shoe covers
k. Mouthpieces
l. Pocket masks

2. Personal Protective Equipment is stocked on supply carts, Pyxis dispensing stations, or available from Materials Management.
   a. Reusable PPE is cleaned, laundered, or decontaminated as needed. The hospital provides laundry services for laboratory coats designated as PPE.
   b. Single-use PPE (or equipment that cannot, for whatever reason, be decontaminated) is disposed in the regular waste container. Only items saturated and/or dripping with blood are disposed of in 'red-bag' trash.
3. Protective clothing (such as gowns and aprons) is worn whenever potential exposure to the body is anticipated. See Standard Precautions-Personal Protective Equipment Table.
   a. Any garments penetrated by blood or other infectious materials are removed immediately or as soon as feasible and all personal protective equipment is removed prior to leaving a work area.
   b. Surgical caps/hoods and/or shoe covers/boots are used in any instances where gross contamination is anticipated (such as autopsies, deliveries, and orthopedic surgery).
4. Gloves are worn as outlined in Standard Precautions and Standard Precautions-Personal Protective Equipment Table.
   a. Hypoallergenic gloves, glove liners, and similar alternatives are readily available to Workforce Members who are allergic to the gloves our facility normally uses.
   b. Utility gloves are decontaminated for reuse. If they are cracked, peeling, torn or exhibit other signs of deterioration they are discarded.
5. Masks and eye protection (such as goggles, face shields, etc.) are used whenever splashes or sprays may generate droplets of infectious materials. See Standard and Transmission Based Precautions and Standard Precautions-Personal Protective Equipment Table.

K. **ENVIRONMENTAL SERVICES:**

1. Environmental Services plays an important role in maintaining our facility in a clean and sanitary condition and is an important part of our Bloodborne Pathogens Compliance Program.
2. The Supervisor of Environmental Services is responsible for setting up our cleaning and decontamination schedule and making sure it is carried out within our facility.
3. To facilitate this, we have set up a written schedule for cleaning and decontamination of the various areas of the facility. See the Environmental Services Unit Specific Standards.
   a. All ~~Workforce~~ **Workforce member** ~~Members~~ are responsible for maintaining a clean work area, equipment, and have hospital-approved disinfectants readily available to use on small spills. Environmental Services is called for assistance as needed with larger spills or special cleaning.
   b. All equipment and surfaces are cleaned and decontaminated after contact with blood or other potentially infectious materials. Patient care equipment and devices are cleaned between patients and after the completion of medical procedures. Work surfaces that may have been contaminated are cleaned at the end of the work shift.

c. All pails, bins, cans and other receptacles intended for use are routinely inspected, cleaned and decontaminated as soon as possible if visibly contaminated.
d. Potentially contaminated broken glassware is picked up using mechanical means (such as dustpan and brush, tongs, forceps, etc.). Only broken glass is placed in a Sharps Container.

4. All regulated waste is safely handled by staff according to TCHD policies and procedures. Disposal of all regulated waste is in accordance with California, State, and local regulations. See the Environment of Care Manual Section 6: Hazard Material Management: Waste Management Policy.
   a. See TCMC Waste Disposal Guidelines.
5. Environmental Services is responsible for the collection and handling of our facility's contaminated waste until our outside contractors pick it up for off-site processing. Environmental services aides should hold the bags away from their bodies when removing waste. During removal, use heavy gloves to protect their hands from possible sharps injury, and do not push down on trash in garbage containers.
6. Regulated waste is placed in containers that are closable, constructed to contain all contents, and prevent leakage. They are labeled or color-coded and closed prior to removal to prevent spillage or protrusion of contents during handling.
7. All used linen is presumed contaminated and placed in appropriate containers labeled 'soiled linen'. All linen is handled as little as possible and is not sorted or rinsed where it is used. Plastic bags are used to contain potential contaminants and these soiled linen bags are transported in secondary containers to prevent leakage.
   a. Workforce Members who contact contaminated linen wear appropriate protective equipment (gloves and gowns if soiling of clothes is possible).
   b. Plastic soiled linen bags can be taken into a patient’s room to contain used linen. These bags are then placed in the hamper or directly in the soiled linen room.
   c. Linen hampers lined with the plastic bags can also be used. When hampers are ¾ full, nursing staff will remove the bag, tie it off, and take it to the soiled linen room.
   d. Environmental Services is responsible for the collection and handling of our facility's contaminated waste until pick-up by our outside contractors for off-site processing.

L. **FORM(S)**:
1. Potential Blood Exposure by Job Category
2. Products Steering Committee Product Evaluation
3. Safer Work Survey
4. Standard Precautions – Personal Protective Equipment
5. User Product Evaluation

M. **RELATED DOCUMENT(S):**
1. Employee Health and Wellness Policy: Injury and Illness Prevention Program
2. Employee Health and Wellness Policy: Occupational Exposure to Blood/Body Fluid Secretions
3. Environment of Care Policy: Hazardous Material and Waste Management and Communication Plan
4. Environment of Care Manual: Waste Management
5. Infection Control Procedure: Hand Hygiene
6. Infection Control Policy: Standard and Transmission Based Precautions
7. TCMC Waste Disposal Guidelines

N. **REFERENCE(S):**
1. California Code of Regulations, Title 8, Section 5193. Bloodborne Pathogens. (n.d.). Www.dir.ca.gov. https://www.dir.ca.gov/title8/5193.html

~~1. Cal OSHA BBP Standard §5193. Bloodborne Pathogens, Subchapter 7. General Industry Safety Orders Group 16. Control of Hazardous Substances Article 109. Hazardous Substances and Processes 1998. https://www.dir.ca.gov/title8/5193.html~~ (accessed ~~10/13/2020~~**02/12/2025**)

2. Medical Waste Management Act, California Health and Safety Code, Sections 117600 – 118360 California Medical Waste Management Program Information Copy — January 2017**.** https://www.cdph.ca.gov/Programs/CEH/DRSEM/CDPH%20Document%20Library/EMB/Medica~~l~~lWaste/MedicalWasteManagementAct.pdf (accessed ~~10/13/2020~~**02/20/2025**)

3. Grota, P. (Ed.). (**2022**~~2014~~) APIC Text of Infection Control and Epidemiology (**6**~~4~~th ed). Washington ~~-~~DC: Association for Professionals in Infection control and Epidemiology, Inc. Waste Management Chapter 11**5**3

4. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf

5. (accessed 10/13/2020)

~~5.~~**6. Grota, P. (Ed.). (2022) APIC Text of Infection Control and Epidemiology (6th ed). Washington DC: Association for Professionals in Infection control and Epidemiology, Inc. Occupational Exposure to Bloodborne Pathogens Chapter 103.**

Tri-City Health Care District
Oceanside, California

POTENTIAL BLOOD EXPOSURE BY JOB CATEGORY

'ALL' EMPLOYEES	'SOME' EMPLOYEES (TASKS PERFORMED WITH RISK)
Administrative Coordinator Advanced Care Technician	Case Managers/ Clinical Social Worker (during patient interviews or family conferences)
Biomedical Tech Mechanic I & II	Chaplain (during patient or family ministrations)
Cardiac Rehabilitation Coordinator	Food Service Worker (during tray delivery, pick-up, or cleaning)
Certified Nursing Assistant	Clinical Dietician
EEG Tech and EEG coordinator	Security Officer
EKG Tech	
Environmental Service Aide and Supervisor	
Emergency Medical Technician	
Employee Health Nurse Occupational Health Nurses & Manager	
Infection Control Specialist	
Laboratory Assistant/Phlebotomist Operations Manager Clinical Laboratory Scientist Histology Lab Tech	
Licensed Vocational Nurse	
Lift Team	
Nurse Practitioner Physicians Assistant	
Occupational Therapist and Rehab Aid	
OR Tech/Sterile Processing Tech/Perioperative Aide/Surgical Instrument Aide	
Perfusionist	
Phlebotomist	
Physical Therapist	
Physicians	
Pulmonary Services Operations Manager	
Radiology Operations Manager & Tech	
Registered Nurse	
Rehabilitation Services Manager	
Respiratory Care Practitioner I, II & III	
Security Officer	
Wound Care Nurses	

Tri-City Health Care District
Oceanside, California

~~Products Steering Committee~~ Product Evaluation

1. Manufacturer of Product _____
2. Name of Product _____
3. Distributed by _____ Sales Rep _____
4. Description of Use _____
5. Will this device replace a high-risk device (hollow-core, blood-filled, or capable of deep injury)? ☐ Yes ☐ No
6. Product would be used? ☐ House-wide ☐ Lab ☐ OR ☐ Specialty Unit _____
7. What items would this replace? _____
8. Cost _____ Standard item cost _____
9. Has TCHD rejected the device in the past? ☐ Yes ☐ No _____
10. Does the device have a passive safety mechanism? ☐ Yes ☐ No
11. Can the safety mechanism be activated with one hand? ☐ Yes ☐ No
12. Can the user tell when the safety mechanism has been activated? ☐ Yes ☐ No
13. Are minimal changes in technique and use required? ☐ Yes ☐ No
14. Is this product dependent on other products or items? ☐ Yes ☐ No
    Identify: _____
15. Is the device compatible with products currently in use? ☐ Yes ☐ No
16. Does the system/device require a minimal number of parts? ☐ Yes ☐ No
17. Is the product available in typical size ranges? ☐ Yes ☐ No
18. Is the product on contract ☐ Yes ☐ No
19. Product rep available for 24hrs/day in-service? ☐ Yes ☐ No
20. Does the manufacturer supply free trial products? ☐ Yes ☐ No
21. Does the manufacturer have adequate supply capability? ☐ Yes ☐ No

APPROPRIATE FOR TRIALS ☐ **REJECTED** ☐

COMMENTS _____

Tri-City Health Care District
Oceanside, California

SAFER WORK SURVEY

The Centers for Disease Control and Prevention (CDC) estimates that between 100,000 and 1,000,000 sharps injuries occur each year. Various studies have estimated the risk of developing occupationally acquired bloodborne pathogen infections: HCV (3% - 10%), HBV (2% - 40%), and HIV (0.3%) following sharps exposure. The risk of transmission increases if a device visibly contaminated with blood causes the percutaneous injury, is used to puncture the vascular system, or causes deep injury.

1. Safety Devices

Do you have suggestions for sharp devices with built in protection that would make your job safer?
Comments: _____

2. Safe Work Practices

Do you have suggestions for adoption of safer user actions? (Examples: neutral or safe zone for sharps, second layer of gloves, and avoid handling dirty trays)
Comments: _____

3. Personal Protective Equipment

Do you have suggestions for use of personal protective equipment? (Examples: double gloving, heavy leather gloves for trash handling, effective eye and face protection)
Comments: _____

Tri-City Healthcare District
Oceanside, California

Standard Precautions
Personal Protective Equipment Table

	Exposed Body Parts						Contamination of Clothing								
R = Required	Hands			Face			Soiling			Saturation			Dripping		
~~**A = Available**~~ **O = Optional (if splash risk)** **N/A = Not Applicable**	Gloves			Face Shield or Mask & Goggles			Cloth Gown			Water-proof Gown			Shoe Covers		
	R	~~A~~**O**	N/A	R	**O**~~A~~	N/A	R	~~A~~**O**	N/A	R	~~A~~**O**	N/A	R	~~A~~**O**	N/A
REMOVING, OPENING AND MANIPULATING OR ASSISTING WITH THE REMOVAL OF HOLLOW CORE BLOOD OR BODY FLUID FILLED TUBES, NEEDLES OR CATHETERS															
• Abdominal paracentesis catheter • ~~Angiograph catheter~~**Angiograph catheter** • Bronchoscope (as above & to clean) • Central venous catheter • Chest tube/vent • Endoscope (as above & to clean) • ~~Intravascular catheters~~ • Thoracentesis • ~~Urine catheter~~	*			*				*			*			*	
• **Intravascular catheters (i.e., IV's PICCs)**	*				*			*			*				*
• **Urine catheter**	*				*			*			*				*
ASSISTING WITH PROCEDURES															
Angiography	*			*					*	*				*	
Bone marrow asp/bx	*			*	*			*	*	*	*				*
Bronchoscopy	*			**N95**				*	*	*	*				*
Bronchoscopy (R/O TB)	*			**PAPR**				*	*	*	*				*
Central venous catheter insertion	*			*	*			*	*	*	*				*
Chest tube/vent placement	*			*	*			*	*	*	*				*
Childbirth	*			*					*	*				*	
Endoscopy	*			*			*	*		*	*				*
Intubation	*			*				*		*	*				*
L.P. (holding R/O meningitis)	*			*				*		*	*				*
Morgue Release	*					*		*	*		*			*	*
Proctosigmodoscopy	*				*			*			*				*
Suture or stapling (within 3 ft. of wound)	*			**				*		*	*			*	
Assisting with Surgery	*													*	
Thoracentesis assist~~.~~	*			*	*			*		*	*				*
SPECIMEN COLLECTION															
ABG	*				*			**			*				*
Blood glucose test	*				*	*		**			*	*			*
Clean catch urine specimen	*				*			**			*	*			*
Dipstick urine test	*				*			**			*	*			*
Gastric occult. blood test	*			*				**			*				*
Nose/throat (R/O infection)	*			*				**			*				*
Sputum for AFB or TB culture	*			**N95**				**			*	*			*
Stool	*				*			**			*				*
Stool occult blood test	*				*			**			*				*

Tri-City Healthcare District
Oceanside, California

	Exposed Body Parts						Contamination of Clothing								
R = Required	Hands			Face			Soiling			Saturation			Dripping		
~~**A = Available**~~ **O = Optional (if splash risk)** **N/A = Not Applicable**	Gloves			Face Shield or Mask & Goggles			Cloth Gown			Water-proof Gown			Shoe Covers		
	R	~~A~~**O**	N/A	R	~~O~~**A**	N/A	R	~~A~~**O**	N/A	R	~~A~~**O**	N/A	R	~~A~~**O**	N/A
Urine	*				*			*			*				*
Urine specific gravity	*				*			*			*				*
Vaginal or urethral	*				*			*			*				*
Venipuncture for blood	*				*			*			*				*
Wound or wound drainage	*				*			*			*				*
SPECIMEN PROCESSING	*			per S.O			Lab coat								
CLINICAL TASKS															
Ambu bag: usage	*			*				*			*				*
Bladder irrigation	*			*				*			*				*
Blood or blood products administration	*				*			*			*				*
Blood warmer	*				*			*			*				*
Cleaning used instruments	*			*				*			*				*
Urine catheter: insert	*				*			*			*				*
Colostomy irrigation	*			*				*			*				*
Condom catheter application	*				*			*			*				*
Contact lense care	*				*				*			*			*
Dressing change	*				*			*			*				*
Emerson pump: use	*				*			*			*				*
Endoscope / Bronchoscopy cleaning	*			*			*		*	*	*				*
Enema administration	*			*				*			*				*
Enteral feeding tube (insert or manipulate)	*			*				*			*				*
Fecal disimpaction	*			*				*			*				*
Fecal or gastric occult blood test	*				*			*			*				*
Foley cath insertion	*				*			*			*				*
Gastric lavage	*			*					*	*					*
Hemovac drains-manipulate, empty / DC	*			*				*			*				*
Injections	*				*				*			*			*
Intravenous catheter insertion	*				*			*				*			*
J-P drain care	*				*			*			*				*
Nasogastric tube insertion and DC	*			*				*			*				*
Neonatal suck evaluations (latex-free)	*				*			*				*			*
1st. Newborn bath	*			*				*			*				*
Normal Saline or Heparin lock irrigation	*				*			*				*			*
O2 therapy w/ mucus membrane touch	*				*				*			*			*
Open suctioning of airway or airway tube	*			*				*			*				*
Oral care	*			*				*				*			*
Oral/nasal airway insertion or DC	*			*				*			*				*
Pleur-evac care	*				*			*			*				*
Postural drainage	*				*			*			*				*
Rectal tube insertion	*				*			*			*				*
Resp. Tx, cough inducing	*			*				*				*			*
Restraint placement		*			*			*				*			*
Seizing patient		*			*			*				*			*
Sputum Induction for AFB	*			N95				*				*			*

	Exposed Body Parts						Contamination of Clothing								
R = Required	Hands			Face			Soiling			Saturation			Dripping		
~~**A = Available**~~ **O = Optional (if splash risk)** **N/A = Not Applicable**	Gloves			Face Shield or Mask & Goggles			Cloth Gown			Water-proof Gown			Shoe Covers		
	R	~~A~~**O**	N/A	R	**O**~~A~~	N/A	R	~~A~~**O**	N/A	R	~~A~~**O**	N/A	R	~~A~~**O**	N/A
Sputum Induction for AFB R/O tuberculosis	*			**PAPR**				*				*			*
Total parenteral nutrition administration	*				*			*				*			*
Urine bag emptying	*			*				*				*			*
Vital signs and Weighing patients		*			*			*				*			*
Wound care (without irrigation)	*				*			*			*				*
Wound irrigation Pulsevac Tx	*			*				*			*				*

Tri-City Health Care District
Oceanside, California

User Product Evaluation

Name_____ Date_____

Dept/Unit_____

How would you rate this product compared to other similar products you have used?

CRITERIA	BETTER	SAME	WORSE
Easy to open package			
Ease of assembly			
Ease of use			
Comfortable feel for user			
Length of time required for use			
Activation of safety feature			
Safety feature can't be defeated			
Has minimum failure rate and functions as intended			
Good for use with different patients			
Safe for healthcare workers			
Safe for patients			
Patients complaints			
Doctors complaints			
Easy to dispose			
Compatible with other products			
Will reduce the risk of injury			
Reasonable number of parts			
Available in the sizes you need			

How many times did you use the product?_____

Would you recommend purchasing this device? ☐ Yes ☐ No

Is there another safety device you would rather use? ☐ Yes ☐ No

Specify:_____

Comments? _____

Tri-City Medical Center
Oceanside, California

LABORATORY
GENERAL/QUALITY MANAGEMENT

ISSUE DATE: 11/99

SUBJECT: Laboratory Information Management
Quality System Essentials

REVISION DATE(S): 05/07, 11/07, 05/08, 05/09, 05/10, 05/11, 05/12, 05/13, 05/14, 05/15, 07/16, 06/18, 06/19, 03/21, 05/24, 10/25

Department Approval:	**10/25**
Laboratory Medical Director Approval:	**10/25**
Medical Executive Committee Approval:	**11/25**
Administrative Approval:	**12/25**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **DEFINITION(S):**

1. **Access Control**: The use of authentication, authorization, and role-based privileges to manage who can view, enter, modify, or approve data within laboratory information systems. Access controls ensure that only authorized personnel perform information management functions appropriate to their roles.
2. **Audit Trail**: An electronic or manual log that records user activities, data changes, and system events related to laboratory information. Audit trails are used to verify compliance, identify unauthorized changes, and support traceability and accountability.
3. **Auto-verification**: A rules-based process within the LIS or middleware that automatically reviews, accepts, and releases laboratory test results without manual intervention by a technologist. Auto-verification is configured based on defined criteria such as quality control status, instrument flags, delta checks, and result ranges. The process improves efficiency, reduces turnaround time, and ensures standardization, while maintaining the ability to manually review exceptions.
4. **Confidentiality**: The obligation to protect patient-identifiable laboratory information from unauthorized access, disclosure, or misuse, in accordance with HIPAA, state laws, and institutional policies. Confidentiality applies to both electronic and paper records.
5. **Data Integrity**: The assurance that laboratory data are accurate, complete, consistent, and maintained in their original form throughout the record life cycle. Data integrity aligns with ALCOA principles: Attributable, Legible, Contemporaneous, Original, and Accurate.
6. **Downtime**: A period during which the Laboratory Information System (LIS), middleware, or other electronic systems are unavailable or non-functional due to planned maintenance, system failure, or unexpected disruptions. During downtime, laboratory operations may rely on manual processes for test ordering, result entry, and reporting. Downtime procedures must ensure data integrity, continuity of care, and proper documentation for reconciliation once systems are restored.
7. **Electronic Health Record (EHR)**: A digital system used across clinical settings to collect, store, and share patient health information. The EHR may interface with the LIS to allow for the seamless transmission of laboratory orders and results between providers and the laboratory.
8. **Laboratory Information Management**: The processes, technologies, and systems used to collect, store, manage, analyze, transmit, and retrieve laboratory data, including patient test orders and results, quality records, and supporting documentation across manual and electronic systems.

9. **Laboratory Information System (LIS)**: A software-based system used to manage laboratory workflows, including test ordering, specimen tracking, result entry, quality control, and reporting. The LIS may be interfaced with other systems such as analyzers, middleware, or the EHR.
10. **Middleware**: An intermediary software application that connects analyzers and other laboratory instruments to the LIS or EHR. Middleware enables rule-based decision-making, reflex testing, auto-verification, and result formatting.
11. **Quality Assurance (QA)**: Focuses on the entire laboratory testing process rather than just the equipment. QA encompasses a set of systematic activities and processes aimed at providing confidence that the laboratory consistently produces accurate and reliable results. QA components can include establishing standard operating procedures (SOPs), conducting proficiency testing, training and certifying laboratory personnel and ensuring compliance with regulatory requirements.
12. **Quality Management System (QMS)**: A QMS is a set of policies, processes, procedures, and resources designed to ensure high quality in an organization's services.
13. **Quality System Essentials (QSE)**: QSEs represent the fundamental components necessary to ensure the accuracy, reliability, and integrity of laboratory testing processes within the QMS. These essentials encompass aspects such as leadership commitment to quality, adherence to regulatory standards, continuous improvement initiatives, and employee training and competency assessments.
14. **Specimen Tracking**: The process of documenting and monitoring specimen movement, status, and location from collection to final disposition. Specimen tracking supports chain of custody, minimizes loss or misidentification, and enhances turnaround time management.
15. **Test System**: The process that includes pre-analytic, analytic, and post-analytic steps used to produce a test result or set of results. A test system may be manual, automated, multi-channel or single-use and can include reagents, components, equipment and/or instruments required to produce results. A test system may encompass multiple identical analyzers or devices. Different test systems may be used for the same analyte.

B. **POLICY:**

1. Laboratory Information Management: This QSE describes the laboratory's information management controls around confidentiality, privacy, security and accessibility of information stored on both paper and electronic record keeping systems, including storage and retrieval of information.
2. Laboratory Information System Overview:
    a. The Laboratory Information System Overview describes the components and processes of the LIS. This includes the steps to take in case of LIS malfunction, how to grant privileges to users and the applications that make up the LIS.
3. Computer Facility and Equipment
    a. The laboratory maintains all computer facilities and equipment in a clean, well-organized, and properly ventilated environment with appropriate temperature and humidity controls to ensure reliable operation and data integrity.
4. Fire Safety
    a. Fire-fighting equipment suitable for electronic and information-technology environments is available in all areas with computer equipment and maintained in accordance with facility safety protocols.
5. Power Protection
    a. The laboratory ensures that all computer systems are protected from power interruptions and electrical surges using uninterruptible power supplies (UPS) and other safeguards appropriate to the system's criticality.
6. Access Control and Security
    a. The laboratory enforces written policies defining user access privileges, methods for obtaining access, and procedures for maintaining security.
    b. Access credentials are deactivated promptly when personnel leave employment.

c. Security measures include password complexity standards, periodic password changes, monitoring of failed log-on attempts, and automatic lockout after multiple unsuccessful attempts.
d. The laboratory follows Network Security, Password Security, and all other applicable hospital network policies.

7. User Access Levels
   a. LIS access is controlled according to role; no user is granted access to LIS applications beyond the scope of their position. A general login with minimal necessary access is used on communal workstations (such as workstations in the clinical lab). This prevents sharing personal passwords and accessing applications through another user's account.
      i. Refer to the LIS User Authorization Privilege Guide.
8. Network Security
   a. Network security measures are maintained to protect the confidentiality and integrity of patient and client data transmitted over internal and public networks.
   b. The laboratory follows Network Access, Internet Access, Network Security and all other applicable hospital network policies.
9. Software Testing and Approval
   a. All software programs and applications are tested for proper function prior to initial implementation and after any modification or upgrade.
   b. The Laboratory Director or designee reviews and approves each new or modified program before use.
   c. Testing includes verification of reference intervals, critical values, calculation rules, and operational algorithms for both locally installed and remotely hosted systems.
10. Software and Spreadsheet Validation:
    a. The LIS Coordinator works with the relevant section supervisor(s) to validate software and spreadsheets.
11. Customized Software Documentation
    a. All customized or modified software is fully documented to describe its purpose, functionality, and interaction with other systems.
    b. Documentation includes records identifying individuals who created or modified the program and is maintained to support troubleshooting, maintenance, and future updates.
12. Software Installation Control
    a. Installation of software on computers used by the laboratory is controlled and restricted to authorized information-technology personnel or designated system administrators.
13. Calculation Verification
    a. Calculations using patient results to produce derived or reported values are reviewed every two years, or whenever a system change occurs that may affect the calculation logic or accuracy.
    b. See the Calculation Verification for the General Laboratory Job Aid for more information.
14. Result Verification
    a. All manual and automated result entries are reviewed and verified by authorized personnel prior to final acceptance and reporting.
    b. Verification includes checks for accuracy, reportable range compliance, and critical result thresholds.
    c. Verification procedures generate an auditable record of the reviewer and date/time of approval.
    d. See the Autoverification Job Aid and the Instrument and Method Validation and Verification Job Aid.
15. Data Entry Audit Trail
    a. The LIS maintains an audit trail identifying all individuals who enter, verify, or modify patient data or control files.
    b. Audit records allow traceability for each test, even when multiple personnel contribute to testing or data entry, including autoverified results.
    c. For point-of-care testing, both the operator and data-entry personnel are uniquely identified.

16. Specimen Quality Comments
    a. The LIS provides functionality to include comments regarding specimen quality that may affect analytic accuracy (e.g., hemolyzed or lipemic specimens).
17. Policy and Procedure Review
    a. The Laboratory Director or designee reviews and approves all new LIS-related policies and procedures, as well as any significant revisions, before implementation.
18. Training and Competency
    a. Records of training for all LIS users are maintained and include initial training, retraining after system modifications, and training for new system installations. Competency is verified according to the laboratory's training and competency assessment policies
19. Downtime Instructions
    a. Written instructions are available for responding to LIS malfunctions or outages, including contact information for the Computer System Manager or other responsible personnel. All staff are trained in the Laboratory Information System (LIS) Downtime Job Aid to ensure timely and accurate reporting of results during system downtime or recovery.
20. Downtime Continuity and Section Procedures
    a. The laboratory ensures continuous patient testing and reporting during scheduled or unscheduled LIS downtime.
    b. Each department maintains a section-specific downtime procedure to address its operational requirements.
        i. Cytology LIS Downtime
        ii. Downtime Coagulation Procedure
        iii. Downtime Procedures for Urinalysis
        iv. Hematology Laboratory Information System (LIS) Downtime
        v. Histology LIS Downtime Job Aid
        vi. Microbiology LIS Downtime
        vii. Phlebotomy Downtime
        viii. PYXIS Scan Assist System Downtime
        ix. Transfusion Medicine LIS Downtime Compatibility Testing and Dispensing
    c. Prompt documentation and reconciliation of results are performed upon system recovery.
        i. In addition, the LIS Coordinator will complete the Laboratory PathNet Downtime Checklist to verify the integrity of the system post-downtime.
        ii. The completed form is included in the Annual Review of the Laboratory QM Plan.
21. Confidentiality Agreements
    a. The lab follows the hospital Confidentiality policy. All employees sign a confidentiality agreement during orientation.
    b. Confidentiality is reviewed on an annual basis as part of the hospital-wide education requirement.
22. Electronic Transmission of PHI, including Results
    a. All electronically interfaced results between TCMC Lab and reference laboratories are encrypted and comply with the Health Insurance Portability and Accountability Act (HIPAA) and General Data Protection Regulation (GDPR).
23. LIS Maintenance and Updates
    a. Updates and maintenance to the LIS are performed by the associated vendor(s).
24. LIS Help Desk Coverage
    a. The LIS Coordinator is available during business hours to provide technical support to the lab.
25. Monitoring and Electronic Data Integrity
    a. Performed by Cybersecurity.
26. Requests for Information
    a. A forensics information request must be completed to track and authorize the release of information from the LIS.
27. Requests for Changes to Patient Records
    a. Medical records management is responsible for processing all requests for changes to patient records.

28. Retrieval and Back-Up of Data
    a. Oracle Cerner provides coverage for data back-up and retrieval.
29. LIS User Manual
    a. Lab personnel are trained to use the LIS during initial training and competency assessment. Section-specific LIS training is also required for lab personnel who work in that section. Job Aids are available for general LIS tasks, with specific data entry and correction instructions integrated into the overall procedure steps.

C. **FORM(S):**

1. Laboratory PathNet Downtime Checklist

D. **RELATED DOCUMENT(S):**

1. Laboratory Information System Overview
2. Confidentiality
3. LIS User Authorization Privilege Guide
4. Autoverification
5. Calculation Verification for General Laboratory
6. Instrument and Method Verification and Validation
7. Downtime:
    a. Laboratory Information System (LIS) Downtime Job Aid
    b. Cytology LIS Downtime
    c. Downtime Coagulation Procedure
    d. Downtime Procedures for Urinalysis
    e. Hematology Laboratory Information System (LIS) Downtime
    f. Histology LIS Downtime Job Aid
    g. Microbiology LIS Downtime
    h. Phlebotomy Downtime
    i. PYXIS Scan Assist System Downtime
    j. Transfusion Medicine LIS Downtime Compatibility Testing and Dispensing

E. **REFERENCES:**

1. College of American Pathologists. (2024). *Laboratory General Checklist*. CAP Accreditation Program.
2. Clinical and Laboratory Standards Institute (CLSI). A Quality Management System Model for Laboratory Services. 5th ed. CLSI guideline QMS01. Clinical and Laboratory Standards Institute, Wayne, PA; 2019.

Tri-City Medical Center
Oceanside, California

LABORATORY
GENERAL/QUALITY MANAGEMENT

ISSUE DATE: **NEW**

SUBJECT: Laboratory Documents and Records Quality System Essentials

REVISION DATE(S):

Department Approval:	**10/25**
Laboratory Medical Director Approval:	**10/25**
Medical Executive Committee Approval:	**11/25**
Administrative Approval:	**12/25**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **DEFINITION(S):**

1. Accreditation: The determination by the College of American Pathologists (CAP) that a laboratory has met the standards required for accreditation.
2. Accreditation Checklist: A series of requirements used to evaluate whether the laboratory complies with CAP standards.
3. Archiving: The process of securely storing inactive or retired documents and records, either electronically or physically, for reference and regulatory compliance.
4. CAP (College of American Pathologists): the accrediting body for this laboratory.
5. CLIA (Clinical Laboratory Improvement Amendments of 1988): federal regulations governing laboratory testing.
6. Controlled Document: Any official laboratory policy, procedure, or job aid that is approved, reviewed on a regular schedule, and maintained in the document control system.
7. Document Control System: The official electronic platform used to create, approve, review, store, and archive laboratory documents. It ensures only the current version of a document is in use.
8. Document Retention: The required period of time a document or record must be kept, based on CAP standards, CHA guidelines, and state/federal law.
9. Job Aid: A quick-reference tool (e.g., checklist, flowchart, instruction sheet) designed to assist staff in performing tasks consistently and correctly.
10. PHI (Protected Health Information): Any information that can be used to identify a patient and relates to their health status, medical care, or payment for medical care.
11. Policy: A guiding principle or rule that defines what should or should not be done in the laboratory.
12. Procedure: A specified set of steps describing how an activity or process is performed.
13. Record: Any written, printed, or electronic information that provides evidence of laboratory activities, processes, or results. Records include (but are not limited to) patient test results, quality control logs, and equipment maintenance logs.
14. Record Disposal: The secure destruction of records after their required retention period has passed, following the same procedures as Protected Health Information (PHI) waste.
15. Record Retention Schedule: The defined period during which laboratory records are kept, determined by the most stringent applicable requirement (CAP, CHA, state, or federal law).
16. Retired Document: A controlled laboratory document that is no longer active but must be archived for reference and compliance purposes.
17. Standard Operating Procedure (SOP) or Procedure: A controlled document describing in detail how to perform a laboratory process or activity in compliance with regulatory standards.

B. **POLICY:**

1. This Quality Service Essential (QSE) describes the laboratory's policies, process and procedures for document control and records management, from creation through destruction, including retention requirements, document destruction policies.
2. Document Creation, Editing, Review and Approval:
    a. Controlled Laboratory Documents (Policy, Procedure, Job Aid)
        i. Lab policies, procedures, and job aids are created to guide and support all lab processes. These documents are approved by the Lab Director prior to implementation and reviewed biennially throughout the life of the process.
            1) Refer to the Laboratory Document Development and Maintenance Job Aid.
        ii. Documents subject to review (controlled lab documents) are edited with the track changes function active.
            1) Even if a document is not subject to an approval process (forms and certain supporting documents are approved in association with the controlled lab document they accompany), previous iterations of the document are stored in the document control system for posterity.
            2) Refer to the Laboratory Track Changes Quick Guide.
        iii. All documents are reviewed on a biennial basis, as required by the College of American Pathologists (CAP), the laboratory's accrediting body.
            1) Forms and supporting documents are not uploaded to the document control system without being linked to a controlled lab document.
            2) Controlled lab documents are always subject to formal review.
        iv. The approval process is regulated by the document control system. Documents are moved automatically through the approval process following approval at each level.
            1) Documents are not available to general users until they have gone through Final Approval.
        v. Refer to Laboratory Policy and Procedure Document Control for more details.
    b. Review of Content and Format of Patient Reports:
        i. The Laboratory Director annually reviews and approves the content and format of laboratory patients reports, via printed or computer screen images, to ensure that they effectively communicate patient test results and that they meet the needs of the medical staff. Review guidelines are as follows:
            1) Review and approval of tests at the time of implementation of a new report.
            2) Review at the time of a major information system change.
            3) Annual review of a sampling of test results.
        ii. The following report formats are reviewed using both printed and end user screen images:
            1) Gen Lab
            2) Microbiology
            3) Blood Bank
            4) Anatomic Pathology
        iii. In addition, a selection of cases (preferably with an extended length of stay to increase the number of results reported) are also reviewed in printed and screen view format. This includes results in both Order result Viewer (flowsheet mode) and Powerchart (Lab Results tab).
        iv. The printed reports and screen image captures will be reviewed by the Laboratory Director and the review documented on the Laboratory Report Content and Format Review form.
        v. Any changes to the report format must be made through the Information Technology Department using the Change Control form.
        vi. Patient reports are retained indefinitely in the electronic patient record.
3. Record Retention and Disposal:
    a. Laboratory records are retained for the required period of time.

b. Retention time is determined through a combination of CAP requirements, California Hospital Association (CHA) recommendations, and state and local law.
c. Retention time always follows the most stringent recommendation.
    i. Refer to the Laboratory Record Retention Job Aid for more information.
d. Records eligible for disposal after the retention period are destroyed similarly to PHI (Protected health Information) Waste as described in the Laboratory Waste Management Job Aid.

4. Document Management:
    a. The Laboratory Accreditation Support Specialist works in tandem with the Education Department and the online document control system to manage documents. This includes:
        i. Monitoring queues to ensure that controlled lab documents are approved within the proper timeframe.
        ii. Keeping all documents uniform and enforcing document templates.
        iii. Updating, or making available to update, documents in the document control system when an off-cycle review is required.
        iv. Removing documents from the Lab Shared drive to prevent multiple version of documents from entering circulation.
        v. Notifying Technical Specialists when section documents have reached final approval.
5. Document Control:
    a. All lab policies, procedures, job aids, supporting documents, and forms are retained in the online document control system.
        i. The document control system is the default location to find these documents.
        ii. The current version of the document in the document control system is the only version allowed in circulation.
    b. Procedures and Job Aids that are frequently referenced as part of lab workflow can be kept in “bench manuals” for easy access. Documents in Bench Manuals must be identical to the documents in the online document control system.
    c. Document versions predating the online document control system are retained as described in the Laboratory Record Retention Job Aid.
    d. Document versions post-online document control system are retained in the system and stored indefinitely.
    e. Documents that are currently under review may be kept on the Lab Shared drive for the duration of the review.
6. Archiving:
    a. Controlled lab documents that are retired are retained per the CAP requirements.
    b. Retired lab documents that pre-date the online document control system are filed in a locked cabinet to prevent them from entering circulation. After the retention period has passed, these documents are placed in offsite storage.
    c. Controlled lab documents that are retired in the online document control system are archived indefinitely in the system. While not accessible to normal users, technical specialists and other lab leaders have the option to review these documents at any time. Note that these documents cannot be accessed for editing unless they are reinstated to active status.
7. Standard Operating Procedure (SOP) Management:
    a. A cornerstone of SOP Management includes reviewing and updating controlled lab documents to match current standards found in the CAP checklists, in state and federal law, and through other regulatory bodies. Updating a controlled lab document includes referencing the appropriate regulatory sources and integrating any changes in regulations.
        i. Lab documents that undergo significant changes to the way a task is performed or how a policy is enacted trigger a document review and competency assessment for all affected end users.
    b. The primary source for information on operating and maintaining instruments is the instrument manual. The manufacturer’s instructions (along with training) are a vital

component of equipment SOPs. They ensure appropriate instrument usage and accurate patient results.

i. Note that although instrument manuals are considered a primary source, a controlled lab document is still created detailing instrument operation, calibration, maintenance, and other day-to-day processes.

8. Lab Document Templates:
   a. Document templates are designed by the Education Department in collaboration with Lab Leadership to ensure that the resulting documents adequately address the needs of end users in the lab while supporting regulatory requirements. Additionally, these templates must comply with CAP content requirements.
   b. The Laboratory Accreditation Support Specialist maintains lab templates and ensures that all lab documents are formatting accordingly.
   c. Unique forms and supporting documents are designed by the Laboratory Accreditation Support Specialist with the expectation that they will match official templates in look and feel.

C. FORMS

1. Laboratory Report Content and Format Review

D. RELATED DOCUMENT(S):

1. Laboratory Document Development and Maintenance Job Aid
2. Laboratory Track Changes Quick Guide
3. Laboratory Policy and Procedure Document Control
4. Laboratory Record Retention Job Aid
5. Laboratory Waste Management Job Aid

E. REFERENCES:

1. College of American Pathologists. (2024). *All Common Checklist*. CAP Accreditation Program.
2. Clinical and Laboratory Standards Institute (CLSI). Developing and Managing Laboratory Documents. 7th ed. CLSI guideline QMS02. Clinical and Laboratory Standards Institute, Wayne, PA; 2019.
3. California Association of Hospital and Health Systems. Guide to Record Retention. 2018.
4. California's Business and Professions Code (BPC) section 1209.

Tri-City Medical Center
Oceanside, California

LABORATORY
GENERAL/QUALITY MANAGEMENT

ISSUE DATE: 11/99

SUBJECT: Laboratory Customer Service Quality System Essentials

REVISION DATE(S): 05/07, 11/07, 05/08, 05/09, 05/10, 05/11, 05/12, 05/13, 05/14, 05/15, 07/16, 06/18, 06/19, 03/21, 05/24, 10/25

Department Approval:	**10/25**
Laboratory Medical Director Approval:	**10/25**
Medical Executive Committee Approval:	**11/25**
Administrative Approval:	**12/25**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **DEFINITION(S):**

1. Client: Any individual or organization that requests, receives, or uses laboratory services, including patients, clinicians, nurses, public health professionals, or the community.
2. Commitment to Customer Satisfaction: The shared responsibility of all laboratory staff to understand and meet customer needs, supported by leadership and integrated into the quality system.
3. Community: The population or environment affected by laboratory operations; includes safety, waste management, and infection control considerations.
4. Continual Improvement: An ongoing effort to enhance laboratory processes and customer satisfaction through systematic review of indicators, complaints, and feedback.
5. Customer Satisfaction Program: The structured process used by the laboratory to assess, monitor, and improve customer satisfaction through surveys, indicators, complaint review, and corrective actions.
6. Direct-To-Consumer (DTC) Testing: clinical laboratory testing that an individual may request and receive without an order from an authorized healthcare provider, as permitted under the California Business and Professions Code (BPC) and the Clinical Laboratory Improvement Amendments (CLIA). Licensed clinical laboratories may perform only those tests that are classified as CLIA-waived and specifically authorized by California law for performance at the consumer's request. Results may be released directly to the individual when testing is performed on that individual's own specimen. The intent of DTC testing is to promote consumer access to certain low-risk health screenings while maintaining safeguards for quality, interpretation, and follow-up. The following tests may be performed at a consumer's request without a prescription or provider order: pregnancy test, blood glucose level, cholesterol, occult blood, HIV, and any other test for which an over-the-counter (OTC) test kit is available to the public.
7. Internal Audit: A systematic evaluation of laboratory operations to ensure compliance with procedures and identify issues affecting customer satisfaction.
8. Press Ganey: An external vendor that administers standardized patient and customer satisfaction surveys used by Tri-City Medical Center to evaluate the quality of services and identify areas for improvement.
9. Quality Indicator: A measurable element of laboratory practice used to assess performance related to customer satisfaction, such as TAT, complaint rates, or lost reports.
10. Rounding: A proactive process where laboratory leaders or designees meet with internal customers (nursing units, clinics, physicians) to collect real-time feedback.
11. Service Failure: Any instance where the laboratory fails to meet established service expectations or customer requirements, including delays, errors, or poor communication.

12. Service Recovery: The process of responding to a service failure or complaint to resolve the issue, restore trust, and prevent recurrence.
13. SUCCESS Standards: The core behavioral expectations guiding all laboratory and hospital interactions: Service, Unity, Confidentiality, Communication, Excellence, Safety, and Satisfaction.

B. **POLICY:**

1. The Laboratory Customer Service Plan ensures the needs of patients, physicians, and the community are identified, met, and monitored through the Quality Management Plan (QM Plan). Customer service is an integral part of the quality management system, and meeting customer needs is a primary goal of the laboratory. Everyone in the laboratory is responsible for quality and, therefore, for customer service.
2. The laboratory serves a diverse customer base including patients, healthcare providers, and the surrounding community. Each client group has distinct expectations that guide service delivery and quality improvement activities. Laboratory Clients fall into three categories, and each client has specific expectations of the lab.
    a. Patients:
        i. The laboratory is committed to providing exemplary patient service through a combination of practices including scripting standards, respect for patient privacy, and Quiet at Night initiatives to support restful patient recovery.
        ii. Patient Satisfaction encapsulates interaction with laboratory phlebotomists and lab assistants, post-venipuncture wound care, and review of the Post-Discharge Follow Up Survey.
            1) Refer to the Venipuncture for Specimen Collection by Phlebotomists Job Aid and the Lab Assistant and Phlebotomy Direct Observation Evaluation form for additional information.
    b. Physicians and other patient care providers:
        i. The laboratory maintains an up-to-date test menu and current specimen collection and transportation guidelines to support Patient Care Services. Downtime requirements are clearly stated and downtime requisition forms are readily available. Laboratory personnel are available to answer questions 24 hours a day.
        ii. The laboratory ensures timely, accurate, and clinically useful results by maintaining clear communication channels with healthcare providers, promptly addressing inquiries, and collaborating to resolve specimen or reporting issues that may impact patient care.
    c. Community and public health:
        i. The laboratory supports public health and community well-being by complying with all reporting requirements for communicable diseases and other reportable conditions, providing timely and accurate data to Infection Control and the San Diego County Public Health Department.
3. Customer Service Process Improvement
    a. The laboratory continuously assesses and improves customer satisfaction as part of the Laboratory Quality Management (QM) Plan.
    b. Customer feedback, complaints, and quality indicators are used to measure performance against service standards and identify opportunities for improvement.
    c. Customer feedback is analyzed and trended to detect patterns, drive corrective and preventive actions, and ensure service improvements are effective.
    d. Customer complaints are documented, investigated, and resolved in accordance with the Event Reporting Policy.
    e. Findings and improvement actions are reviewed at least annually.
4. Direct to Consumer (DTC) Testing:
    a. Tri-City Medical Center Laboratory does not currently offer DTC Testing. In the event DTC Testing is offered:
        i. The laboratory shall verify continued authorization to perform DTC testing every two years by indicating testing on the Annual Test Volumes form.

ii. Upon patient request, the laboratory shall forward the test result to a licensed healthcare practitioner designated by the patient. The practitioner's name and contact information may be documented on the requisition.
iii. The test report shall include:
1) Test result and reference range
2) Interpretive comments and limitations, as applicable
3) Language that is readily understood by a layperson
4) Name and contact information for a designated licensed healthcare practitioner at Tri-City Medical Center (e.g., pathologist) available for patient inquiries regarding test results.
iv. Critical values identified during DTC testing shall be managed in accordance with the Critical Tests and Critical Results Reporting procedure.

5. Administrative Customer Service
a. Refer to the Disclosure of Protected Health Information policy.
b. Refer to the Faxing of Protected Health Information (Medical Records) policy when transmitting results.
c. Laboratory personnel do not release test results directly to patients, except for authorized Direct-to-Consumer (DTC) tests. Patients requesting results are directed to contact their ordering provider or Medical Records.

6. Legal Requests
a. The laboratory works collaboratively with Legal Services and Medical Records on all legal requests involving laboratory specimens and reports, in accordance with the Legal Documents policy.
b. For requests involving slides, tissue blocks, or pathology materials and reports, follow the Pathology Legal Requests Job Aid.
c. Specimen preservation requests are managed by the laboratory to ensure proper handling, storage, and documentation in accordance with institutional policy and applicable regulations.

C. **PROCEDURE:**

1. Handle Specimen Preservation Requests
a. Verify the request by reviewing the documentation received (e.g., letter or email) and confirming that it originates from an authorized source such as Legal Services, Medical Records, or an external legal entity (commonly Zenith Insurance for workers' compensation claims).
b. Determine whether the requested specimens are available by checking the specimen log, pathology database, or storage location.
c. Set aside any identified specimens and label them clearly as "Preserve—Legal Hold." Maintain original labeling and integrity; do not alter or test specimens once a preservation request has been issued.
d. Notify the Legal Department of the request if they are not already aware, and confirm whether Medical Records has received corresponding documentation.
e. Document the outcome of the search, including whether specimens were located, where they are stored, and the date Legal was notified.
f. Retain preserved specimens under secure, controlled storage until Legal Services provides written authorization to release, transfer, or discard them.
g. Await direction from the Legal Department. Legal will notify the requesting agency whether specimens are available and instruct the agency to obtain a subpoena before release.
h. Coordinate specimen pickup once Legal Services has received the subpoena. Schedule pickups with the requesting agency between Monday and Friday, 9:00 a.m.–5:00 p.m., ensuring proper identification and documentation at the time of transfer.
i. Maintain records of the subpoena, chain of custody, and specimen release in accordance with institutional policy and regulatory requirements.

2. Customer Service Process Improvement
    a. Collect and Assess Customer Feedback
        i. Monitor customer satisfaction using the following tools:
            1) Press Ganey or other patient satisfaction surveys and interviews
            2) Patient Rounding
            3) RL Event Reporting
        ii. Design survey tools, as needed, to ensure neutrality, accessibility, and clarity, incorporating both closed- and open-ended questions.
        iii. Compile and analyze data to identify trends, measure performance against service standards, and detect opportunities for improvement.
        iv. Document findings, actions, and outcomes on the Annual Quality Management Review Form or as needed in RL and emails to the Quality, Risk, and/or Legal departments.
        v. Forward completed feedback forms to the Assistant Laboratory Director for review and distribution to Section Supervisors for follow-up.
    b. Address Complaints as needed.
        i. Document customer complaints in the Event Reporting System immediately upon receipt.
        ii. Acknowledge the concern to the complainant in a timely and professional manner.
        iii. Investigate the complaint and perform root-cause analysis when appropriate.
        iv. Implement corrective actions to resolve the issue and verify effectiveness through follow-up.
        v. Trend complaint data to identify recurring or systemic issues.
    c. Implement Service Improvements
        i. Identify opportunities for improvement through the analysis of feedback, complaint trends, and quality indicators.
        ii. Initiate corrective and preventive actions.
        iii. Integrate validated process changes into standard operating procedures and staff training materials.
        iv. Evaluate the effectiveness of improvement activities during the Annual Review of the Laboratory Quality Management Plan.

D. **FORM(S):**
1. Annual Review of the Laboratory Quality Management Plan

E. **RELATED DOCUMENT(S):**
1. Venipuncture for Specimen Collection by Phlebotomists Job Aid
2. Lab Assistant and Phlebotomy Direct Observation Evaluation
3. Laboratory Scope of Service
4. Blood and Tissue Service Agreement Policy
5. Event Reporting
6. Critical Tests and Critical Results Reporting
7. Disclosure of Protect Health Information
8. Faxing of Protected Health Information (Medical Records)
9. Legal Documents
10. Pathology legal Requests Job Aid

F. **REFERENCES:**
1. College of American Pathologists. (2024). *Laboratory General Checklist*. CAP Accreditation Program.
2. Clinical and Laboratory Standards Institute. (2019, June). *A Quality Management System Model for Laboratory Services (5th ed.)* (CLSI Guideline QMS01). Wayne, PA: CLSI.
3. Jhai, Q., & Siegal, G. P. (2017). *Quality management in anatomic pathology*. CAP Press.
4. AABB (American Association of Blood Banks). (2023). Technical manual (21st Edition).

Tri-City Medical Center
Oceanside, California

LABORATORY
POINT OF CARE ~~/ INTERNAL QM PROCEDURES~~

ISSUE DATE: **07/92** **SUBJECT:** **POINT OF CARE QUALITY ASSURANCE POLICY**

REVISION DATE(S): 02/10, 01/11, 06/11, 03/12, 06/12, 09/12, 08/16, 11/17, 09/19, 05/20, 08/22

Department Approval:	**10/21, 03/25**
Laboratory Medical Director Approval:	**01/22**
Medical Executive Committee Approval:	**10/25**
Administrative Approval:	**~~08/22~~12/25**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **DEFINITION(S):**

1. Point of Care Testing **(POCT): Tests designed to be used at or near the site where the patient is located, that do not require permanent dedicated space, and that are performed outside the physical facilities of the clinical laboratories. Examples include kits and instruments that are hand carried or otherwise transported to the vicinity of the patient for immediate testing at the site (eg, capillary blood glucose) or analytic instruments that are temporarily brought to a patient care location (eg, operating room, intensive care unit).** ~~Analysis performed outside the facility defined as the laboratory and by personnel other than those of the laboratory but within the institution~~
2. Calibration: The set of operations that establish, under specified conditions, the relationship between reagent system/ instrument response and the corresponding concentration/ activity values of an analyte. Calibration procedures are typically specified by a method manufacturer, but may also be established by the laboratory.
3. Calibration Verification: The process of confirming that the current calibration settings remain valid for a method.
4. Analytical Measurement Range (AMR): The range of analyte values that a method can directly measure on the specimen without any dilution, concentration, or other pretreatment not part of the usual assay process.
5. ~~5.~~ Provider Performed Testing **(PPT): T**~~is t~~esting that is performed directly by a physician or midlevel practitioner in conjunction with the physical examination or treatment of a patient.

~~6.~~**5.**

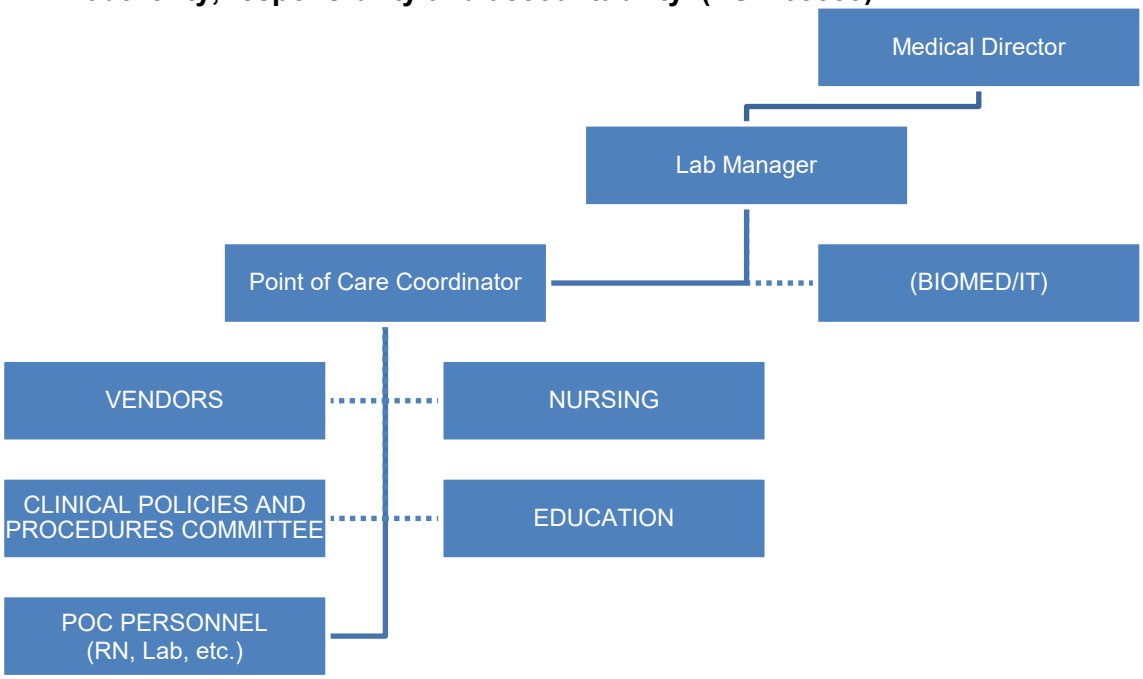
B. **POLICY:**

1. **Purpose:**
   a. To establish a program at TCMC which ensures appropriate and reliable laboratory results for patients tested under point of care (waived testing, bedside testing, decentralized testing) conditions. This program encompasses quality management, quality control, and competency testing as outlined by **Clinical Laboratory**

~~Effective Date~~	~~Department Review~~	~~Department Revision~~	~~Laboratory Medical Director~~	~~Medical Executive Committee~~	~~Administration~~
~~07/92~~	~~02/10, 01/1, 03/12, 10/21~~	~~02/10, 01/11, 06//11, 03/12, 06/12, 09/12, 08/16, 11/1712/19, 10/21~~	~~04/18, 12/19, 01/22~~	~~05/18, 01/20, 02/22~~	~~09/19, 05/20, 08/22~~

Improvement Amendments (CLIA**)**, **the Joint Commission (**JC**)**, and **the College of American Pathologists (**CAP**)**.

2. Tri-City Medical Center will provide accurate and reliable point of care laboratory results in accordance with regulatory requirements ~~of Clinical Laboratory Improvement Amendments (CLIA) 88, and the accreditation standards of the Joint Commission (JC) and the College of American Pathologists (CAP)~~.
3. Results **from POCT** are used for definitive or screening diagnostic or therapeutic purposes and are recorded in the patient's medical record.
   a. Tests that are performed solely for research or teaching purposes and are not recorded in the patient record are not subject to this policy.
4. Organizati**onal Chart**~~on~~:
   a. **The POCT program has a written organizational system/chart defining levels of authority, responsibility and accountability. (POC.03550)**



5. Program Responsibilities **(POC.03550)**:
   a. The **Laboratory Medical Director assumes** overall responsibility ~~of~~ **for** Point of Care Testing ~~is that of the Laboratory Medical Director~~. A licensed Clinical Laboratory Scientist, designated by the Laboratory Medical Director, supervises the program.
   b. Medical Director
      i. Assume overall responsibility of the Point of Care Program
      ii. Review and Approve testing procedures before implementation
      iii. Sign off original procedures and major changes
      iv. Review Proficiency Testing (PT) surveys with unacceptable performance evaluation
   c. Lab Manager
      i. Supervise the Point of Care Program as designated by the Medical Director
   d. Point of Care Coordinator
      i. Assume day-to-day responsibilities of the Point of Care Program
      ii. Regulatory:
         1) Ensure program is operating within guidelines established by accrediting agencies
         2) Maintain all records as defined in the CAP inspection checklist for POC testing (QC, Performance, Maintenance, Verification, Proficiency Testing)
         3) Maintain participation in an approved Proficiency Testing **(PT)** program
         4) Review completed PT surveys

5) Conduct PT sessions, review results, carry out and document corrective action
6) Maintain a current list of personnel who are authorized to perform waived and nonwaived testing
7) Staff training and Competency Assessments **at required intervals: —** Initial, 6-month, Annual and where applicable depending on CLIA test complexity

iii. Testing:
1) Develop testing and quality control procedures

iv. Quality Control (QC):
1) Provide paper QC logs to nursing units if not interfaced
2) Review and document review of QC monthly (logs and interfaced tests). Review interfaced tests QC by exception failures that are flagged as failed QC. Follow up with QC repeats, and add a corrective action review comment when control results exceed defined acceptable limits if necessary, and accept. In the event of QC failure, instruments lock and prompt the operator to repeat QC level to “PASS” before a patient’s sample can be analyzed
3) Verify new lots of assayed controls and develop tolerance limits for unassayed controls

v. Reagents:
1) Perform new reagent lots and shipments confirmation of acceptability as applicable **(refer to the Point of Care Quality Assurance** Quick Reference~~); refer to Part B of this procedure.~~
2) Maintain adequate inventory of supplies

vi. Support:
1) Provide routine troubleshooting help
2) Contact Manufacturer Technical Support
3) Provide after-hours/ weekend support and troubleshooting through trained lab personnel
4) Periodically meet with nursing representatives to review all aspects of the program

vii. Review:
1) Review ~~of~~ all **POC** procedures every 2 years
2) Monthly review of all QC
3) Periodic review of all Calibration Verifications, Method Comparisons, Instrument Validations, etc.
4) Provide weekly to monthly surveillance of all point-of-care tests

viii. Instrumentation:
1) Perform initial instrument performance verifications in accordance with regulatory guidelines
2) Perform routine and non-routine maintenance of instrumentation and documentation
3) Provide troubleshooting, storage, and replacement of instruments
4) Identify new testing opportunities and instrument updates

ix. Vendor:
1) Assist in implementing/ validating new tests and instrumentation
2) Assist in staff training and provided technical assistance as required

x. Biomedical Engineering:
1) Verify safety and operation of the hardware when necessary
2) Act as an interface between the hospital and manufacturer for service related items when necessary
3) Provide technical support

xi. Information Technology:

1) Provide necessary service for technical side of instrumentation: networking, interfaces, connectivity, etc.
2) Liaison with **the** ~~Cerner—~~Hospital Information System
3) Manage ~~RapidCOMM and RALS~~ middleware

xii. Clinical Policies and Procedures Committee:
1) Develop testing and quality control procedures
2) Review shared procedures at least every ~~-~~two years, or more frequently when required by regulatory agencies

xiii. Education (Hospital-wide and Departmental):
1) Complete staff training and Competency ~~Assessments – Initial, 6-month, Annual and where applicable depending on CLIA test complexity~~
2) Provide periodic clinical in-service updates
3) Maintain a current list of personnel who are authorized to perform testing
4) Periodically meet with laboratory representatives to review all aspects of the program

xiv. Nursing Management:
1) Complete staff training and Competency Assessments~~ – Initial, 6-month, Annual and where applicable depending on CLIA test complexity;~~ for unit-specific testing
2) Maintain Inventory of some supplies
3) Provide input for testing procedures
4) Oversee clinical practices
5) Maintain a current list of personnel who are authorized to perform testing
6) Periodically meet with laboratory representatives to review all aspects of the program

xv. POC Personnel:
1) Perform required competencies: Initial, 6-month, Annual and where applicable depending on CLIA test complexity
2) Perform routine QC
3) Review QC before Patient Testing
4) Perform Proficiency Testing when assigned
5) Perform Specimen Collection and testing
6) Record results in patient record/chart

6. New Method Implementation:
   a. Requests for new Point of Care testing will be evaluated with Laboratory Management and Laboratory Director before implementation. ~~[Refer to 'New Method Implementation' Policy].~~
   b. Considerations for new testing include the need for comparability with central laboratory testing, efficacy, operational device and kit fail safes, management and oversight requirements, operator performance standards, economic indicators, and patient outcome data.
   c. **Refer to the Point of Care (POC) New Test Method Request and Implementation Policy.**
7. Document Control:
   a. Document control is used to:
      i. Track all current procedures and associated forms
      ii. Ensure review occurs on schedule
      iii. Ensure all forms in use are the most current version
      iv. Document Control is maintained by the hospital MCN program.
      v. After a procedure/ test method retires, documents are retained for 3 years (California law)
   b. **Refer to Policy and Procedure Document Control**
8. Error Detection:

a. **The laboratory has processes to detect and correct significant clerical and analytical errors, and unusual or unexpected test results, in a timely manner. (POC.03700)**.

~~a.~~**b.** It is the responsibility of the nurse or heath care professional (most often the testing personnel) to correlate test results to patient clinical symptoms.

i. When results and symptoms do not correlate, or when a result is questionable, testing personnel are to first repeat testing on the original methodology to rule out any collection, sampling, or testing errors.

ii. If results are still questionable, if the result is outside the reportable range of the instrument, or any time at nurse or physician discretion, a sample can be sent to the lab for confirmation.

~~b.~~**c.** **Problem Resolution: The laboratory has a system to promptly resolve problems and/or difficulties with point-of-care methods/devices/test systems for all shifts in which point-of-care testing is available. (POC.03800)**.

i. When a nurse or physician reports a complaint or concern over test results or instrument performance, the **Point of Care Coordinator (**POCC**)** will investigate accordingly. The usual course of action includes, but is not limited to:

1) Review of instrument maintenance, performance, calibrations, and QC,
2) Repeat testing of the original sample if available, and to
3) Perform a 5-sample correlation to the lab instrument where applicable
4) All findings are documented

ii. Sources of Error include:

1) User error in performing the test (e.g. sample application, timing of reading)
2) User error in interpreting test results (e.g. inattention to control results, color discrimination problems, incorrect assumptions of what a positive or negative result looks like)
3) Sample problems (e.g. contamination, aged sample, inappropriate sample type, inappropriate collection device)
4) Interfering substances (e.g. skin cleansers, IV solutions, medications)
5) Patient's clinical conditions that might impact the test result (e.g. anemia, hypoxemia)
6) Reagent and/or device storage conditions (e.g. heat, humidity, sun exposure, expired)
7) Instrument problems (e.g. contaminated, dirty, out-of-control, improper programming).

iii. Errors are tracked ~~on the Laboratory Error Management Log (Correction Report)~~**through RL Solutions. Refer to the Event Reporting (396) policy.**~~.~~

9. Proficiency Testing~~-~~:

~~a. Clinical and Laboratory Standards Institute (CLSI) defines PT as the determination of lab testing performance by means of inter-laboratory comparisons, in which a PT program periodically sends multiple specimens to members of a group of laboratories for analysis and/or identification; the program then compares each laboratory's results with those of other labs in the group and/or with an assigned value.~~

~~b. Alternate Assessment is the determination of lab testing performance by means other than PT. This may include split sample analysis with a reference laboratory or in-house method, clinical validation by chart review, or other means. Record and review using the "Alternate Proficiency Testing" form for test analytes : Heparin Dose Response, Heparin Protamine Titration assay on the HMS PLUS instrument.~~

~~c.~~**a.** The POC program will participate in group PT when available, and will perform an alternate assessment for analytes and procedures for which PT is not available.

~~d.~~ **Refer to the** Proficiency **Testing procedure.** ~~samples will not be referred to other labs. Communication between labs regarding PT samples is prohibited until after the submission date for the survey has passed.~~

~~e. PT samples are assigned to units that perform testing and are rotated among testing personnel. When possible, PT samples are treated like and tested in the same manner as patient samples.~~

~~f.~~**b.** ~~Upon completion, all PT results (graded, un-graded, or alternate) are reviewed for acceptability. All unacceptable results are investigated. Trends or biases suggesting a problem are also investigated. Applicable remedial action is taken until testing is again acceptable. Nursing units and testing personnel are actively involved in this process.~~

10. Specimen Handling **and Test Performance**:
    a. The POC program follows manufacturer instructions for all test systems. **(POC.03810)**
    ~~b. The procedures and policies for patient identification and preparation, specimen collection, specimen identification, preservation, processing and accurate result reporting are contained in the Patient Care Services Procedure Manual, the textbook Clinical Nursing Skills and Techniques (Perry and Potter), the Clinical Laboratory Policies and Procedures, and the Hospital Administrative Policies and Procedures~~**Refer to the Point of Care Quality Assurance** Quick Reference~~.~~**.** ~~The intent of the P&P is to ensure optimum patient specimen integrity and maximum test quality in order to produce clinically useful data.~~
    ~~c.~~**b.**
11. Result Reporting **(POC.04400, POC.04700)**:
    a. Testing personnel are responsible for charting test results. Results must be reported with the reference range for the test or method, and must indicate test operator; these functions are built into ~~Cerner~~**the Laboratory Information System**.
    b. Reference intervals are determined either during initial validation of POC instrumentation or rolled over from Laboratory-based testing.
        i. In the Electronic Medical Record, reference intervals can be found by right clicking on the test result.
        ii. ~~Procedures also list reference and critical ranges.~~ It is not necessary to include reference intervals when test results are reported as part of the treatment protocol that includes clinical actions, which are based on test results.
    c. Critical limits for POC tests are the same as for General Lab.
    d. Refer to the Critical Tests and Critical Values Reporting procedure.
12. Temperature Monitoring:
    i. The analyzers and storage areas of POC reagents are monitored with a continuous temperature monitoring system. The system is checked daily for functionality. Alerts and deviations are responded to as soon as possible upon notification.
    ii. If the temperature monitoring system is down, temperatures are monitored manually.
    iii. Refer to the Laboratory Temperature and Environmental Monitoring procedure.

~~12.~~**13.** Reagents:
    ~~a. Temperature Monitoring:~~
        ~~The analyzers and storage areas of POC reagents are monitored with a continuous temperature monitoring system. The system is checked daily for functionality. Alerts and deviations are responded to as soon as possible upon notification.~~
        ~~i. **If the temperature monitoring system is down, temperatures are monitored manually.**~~
    ~~b.~~**a.** Waived:
        i. TCMC'S Point of Care Program ~~is to follow~~**follows** Manufacturer's instructions for handling and storing reagents. Refer to ~~individual testing procedures~~**the Point of Care Quality Assurance** Quick Reference.
    ~~c.~~**b.** Non-Waived:
        i. All reagents are stored and used according to manufacturer instructions.

ii. All reagent containers are labeled with pertinent information and used within the expiration date.

iii. Reagents are checked for acceptability before use or concurrently being place in service, most often by running two levels of liquid quality control.

1) Historical data is acceptable to use as a comparison to the old lot of reagent if the same lot of QC is used. ~~Refer to individual testing procedures and to Part B of this procedure.~~

~~1)~~

~~2)~~**c.** Refer to the Reagent Storage, Handling, Labeling and Lot Confirmation procedure.

~~13.~~**14.** Instruments and Equipment:

a. The Laboratory Medical Director approves all instruments before ~~being used for~~**use in** patient testing.

i. Methods validated after June 15, 2009 must have an approval statement signed by the Laboratory Medical Director. ~~[See 'Method Validation-Director Approval' form].~~

ii. **Refer to the Instrument and Method Validation and Verification procedure.**

b. All instruments perform their own function check upon powering on or before each patient test. Instruments will not display results if internal function checks fail.

c. Any additional routine or corrective maintenance is recorded on the respective maintenance log.

i. Refer to the ~~individual procedures for tests that require routine user maintenance~~**Point of Care Quality Assurance** Quick Reference.

ii. Instrument maintenance logs are reviewed on a monthly basis.

~~14.~~**15.** Test Method Validation:

a. Test Method Validation includes method comparison study, precision study, analytic sensitivity, interferences, AMR and director approval, as applicable.

b. For unmodified FDA-cleared or approved tests, data may be used from manufacturers' information or published reports, but the lab must verify data on accuracy, precision, and reportable range.

c. Not all method performance specifications apply to qualitative tests. For qualitative tests, the laboratory will establish/verify the method performance specifications that are applicable and clinically relevant, as determined by the medical director.

d. Records of test method validation will be retained while the method is in use and for at least three years after discontinuation.

~~e.~~ **Refer to the Instrument and Method Validation and Verification procedure**. ~~Critical value policy: see Patient Care Services Procedure: Critical Results and Critical Tests – Diagnostic Testing.~~

~~f.~~**e.**

~~15.~~**16.** Personnel **(POC.06800)**:

~~a. Testing personnel consist of Registered Nurses (RN), Licensed Vocational Nurses (LVN), Perfusionists, Respiratory Therapists (RT), CardioVascular (CV) techs, Anesthesia techs, Medical Assistants (MA), Clinical Laboratory Scientists (CLS), and Lab Assistants that have documented training and competency in the area(s) of testing.~~ ~~[JJK1]~~

~~b.~~**a.** POC testing personnel are allowed to perform the testing listed in their job description in accordance with regulatory requirements~~.~~ **(GEN.78250 and BPC 1206.5)**

~~c.~~**b. Individuals responsible for competency assessments have the education and experience to evaluate the complexity of the testing being assessed. (POC.06920, GEN.55510)**

i. **In California, competency of waived testing personnel must be assessed by an individual meeting all waived laboratory supervisor qualifications. These qualifications are:**

1) Has a Bachelor's degree

2) Is a licensed health care professional

3) Has one year of experience in clinical laboratory testing in those tests supervised AND

~~1)~~**4) Has competency in the tests supervised**

ii. The competency of moderate complexity testing personnel must be assessed by an individual meeting technical consultant requirements.

~~ii.~~**iii. Refer to the table in the CAP General Laboratory Checklist, GEN.~~78250, **Personnel Qualifications and Licensure for additional information.**

~~d.~~**c.** Refer ~~also to the POC Testing: Competency Checklist.~~**to the POC Competency Assignments by Job Description table.**

~~16.~~**17.** Competency Assessment **(POC.06850, POC.06875)**:

~~a. Competency is assessed for all POC users who perform waived testing upon hire and annually at Skills Lab. **(POC.06915)**~~

~~b. Competency is assessed for all POC users who perform moderate-complexity testing upon hire, semi-annually the first year of testing, and annually thereafter. **(POC.06915)**~~

~~c. Competency must be assessed for each test system personnel use.~~

~~d. **The competency of personnel performing nonwaived testing is assessed using all six CLIA elements (as applicable) on each test system. (POC.06910)**~~

~~e. **If testing personnel fail to demonstrate satisfactory performance on the competency assessment, the laboratory follows a plan of corrective action to retrain and reassess competency.** (POC.06925)~~

~~f. Documentation is maintained through the annual unit-specific and job-specific orientation checklist, competency section, unit-based competency records, skills lab records, and Point of Care Competency checklists and sheets.~~

~~g.~~**a.** Refer to the Laboratory Competency Assessment Procedure **and the Point of Care Testing Competency Assessment Procedure.**

~~17.~~**18.** Quality Control:

a. **POCT Controls:**

i. An acceptable control range is verified for each lot of control material. **(POC.07456).**

ii. **If controls are used, they are tested in the same way by the same personnel as patient samples. (POC.07512)**.

1) **If control materials are not commercially available, alternative control procedures will be performed and recorded to both detect immediate errors and to monitor test system performance over time. (POC.07520)**.

iii. **Refer to** the **Point of Care Quality Assurance** Quick Reference ~~**See the POC New QC Lot Verification Form.**~~

b. Waived (**POC.07037)**:

i. Quality Control is performed according to Manufacturer recommendations.

ii. Results are documented electronically by the instrument or on a paper log.

iii. When controls are outside acceptable limits, corrective action ~~should be~~**is** taken and documented in the instrument or on the log. Results must be acceptable before reporting patient results. **(POC.07124)**

iv. Refer to ~~each testing procedure and to Part B of this procedure~~**the Point of Care Quality Assurance** Quick Reference.

c. Non-Waived:

i. Controls are run and documented each day of patient testing by personnel who routinely perform patient testing. **(POC.07300)**.

ii. QC results are reviewed daily by testing personnel and monthly by the POCC.

iii. Failed Controls must be documented along with any corrective action. Controls must be verified for acceptability before reporting patient results. **(POC.07484)**

iv. Refer to ~~each testing procedure and to Part B of this procedure~~the Point of Care Quality Assurance Quick Reference.

~~18.~~**19.** Individualized Quality Control Plan (IQCP):

a. The lab has identified the list of tests needing an Individualized Quality Control Plan.

b. ~~Refer to the Point of Care IQCP binder for all completed and approved CAP forms that include individualized eligibility determination form, risk assessment, IQCP plan summary, quality assessment and monitoring~~**Refer to the Individualized Quality Control Plan Policy**.

~~19.~~**20.** Method Comparison:

a. Method Comparisons are performed at least every 6 months between all non-waived instruments that perform a given analyte.
b. If the main lab also performs testing on a given analyte, it is used as a reference for the POC instruments.
c. If the main lab does not perform testing, POC instruments are compared against each other.
d. If available and practical, fresh human samples are used for this purpose. If not available, QC data may be used as a correlation.
e. **Refer to the Point of Care Method and Instrument Comparison procedure.**

~~20.~~**21.** Calibration:

a. Waived:
   i. Follow manufacturer instructions for Calibration, Calibration Verification, and related functions when applicable to method and instrumentation.
b. Non-Waived:
   i. If applicable, perform calibration according to manufacturer recommendations and instructions.
      1) Refer to the **Point of Care Quality Assurance** Quick Reference ~~each procedure for more detail~~.
   ii. Calibration Verification is performed every 6 months. When Calibration Verification fails, calibration will be adjusted.
   iii. If calibration cannot be adjusted by the user, maintenance and troubleshooting steps will be taken until Calibration Verification is acceptable.
   iv. The AMR is defined by the manufacturer and validated every 6 months at the same time, and often with the same material as Calibration Verification.

~~21.~~**22.** Safety:

a. All POC users are required to follow all Hospital safety procedures at all times. Refer to Policies and Procedures of Infection Control, Health and Safety, and Patient Care Services.
b. Ensure Patient safety:
   i. Adhere to the Patient Identification Policy.
   ii. Correlate patient results to clinical history.
   iii. Report critical results to the physician ~~per Patient Care Services Procedure: Critical Results and Critical Tests – Diagnostic Procedures~~**per Critical Results of Tests and Diagnostic Procedures and Critical Tests and Critical Results Reporting**.
c. **Instruments and reagents are handled in accordance with the manufacture's safety recommendations.**~~Maintain instruments and reagents.~~
d. All Point of Care testing should be performed with standard precautions to prevent biohazard exposure.
   i. **Point of Care r**~~R~~eagents and test components are not considered to be chemically hazardous.
   ~~ii. Hospital and Lab protocols are to be followed in the event of a spill or exposure.~~ **~~Refer to the Laboratory Spills procedure.~~**

~~22.~~**23.** Provider Performed Testing:

a. Refer to the **Provider Performed Fecal and Gastric Occult Blood Testing procedure**~~POC Provider Performed Testing policy for more details~~.

~~Refer to the POC Test Menu/ Overview Form for current list of tests performed as PPT at TCMC.~~

C. **RELATED DOCUMENT(S):**

1. **Point of Care (POC) New Test Method Request and Implementation Policy**
2. **Policy and Procedure Document Control**

3. **Proficiency Testing**
4. Point of Care Quality Assurance Quick Reference
5. **Critical Tests and Critical Values Reporting**
6. Critical Results of Tests and Diagnostic Procedures
7. Reagent Storage, Handling, Labeling and Lot Confirmation
8. Instrument and Method Validation and Verification
9. **POC Competency Assignments by Job Description**
10. Individualized Quality Control Plan Policy
11. Point of Care Method and Instrument Comparison
~~12. **Laboratory Spills**~~
12. Provider Performed Fecal and Gastric Occult Blood Testing
13. Laboratory Temperature and Environmental Monitoring
14. Identification, Patient Policy
15. Laboratory Competency Assessment Procedure
16. Point of Care Testing Competency Assessment Procedure
~~13.~~**17. Policies and Procedures of Infection Control, Health and Safety, and Patient Care Services**

D. **REFERENCES:**

1. College of American Pathologists (CAP)**. *Point of Care Testing Checklist*. (2023). Northwood, IL.**~~, CAP Accreditation Program, Point of Care Testing, 9/17/2019~~
2. Joint Commission, JC Survey Activity Guide, 2/6/2017
3. CLIA 88, update 2012

~~A. **TABLE OF CONTENTS:**~~

~~1. INTRODUCTION~~
~~2. NEW METHOD IMPLEMENTATION~~
~~3. DOCUMENT CONTROL:~~
~~4. ERROR DETECTION~~
~~5. PROFICIENCY TESTING~~
~~6. PROCEDURES~~
~~7. SPECIMEN HANDLING~~
~~8. RESULT REPORTING~~
~~9. REAGENTS~~
~~10. INSTRUMENTS AND EQUIPMENT~~
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~~Tri-City Medical Center~~	~~**Laboratory Point of Care**~~
~~**PROCEDURE**:~~	~~**POINT OF CARE QUALITY ASSURANCE PLAN (PART A: POLICIES)**~~
~~Purpose:~~	

Supportive Data:	Part A of this procedure covers an overview of the Point of Care program. Test specific information can be found in Part B of this procedure and in each individual test procedure.

B. **PROCEDURES:**

1. The Medical Director reviews and approves testing procedures prior to implementation. All procedures will also be reviewed within a reasonable period of time by the new director upon a change in directorship. Testing Procedures are kept up to date and accurate. Procedures are based on manufacturer instructions and recommendations, and on CLSI guidelines. A lab designee reviews all procedures at least every two years. Procedures are retained for three years after retirement. Procedures are located on the TCMC Intranet. Procedure knowledge is taught upon hire at general and department specific orientations. Changes to procedures are reviewed through the monthly "Quest for Quality" newsletter and annually through Skills Lab.
2. When applicable, procedures will include the following information:

CAP: All Common Checklist 09.17.2019	**JC: WT.01.01.01**
Principle and Clinical Significance	Clinical usage and limitations of test methodology
Requirements for Patient Preparation	
Specimen Collection, labeling, storage, preservation, transportation, processing, and referral	Specimen type, collection, and identification, and required labeling Specimen preservation, if applicable
Criteria for specimen acceptability and rejection	
	Storage conditions for test components
Step by step performance of the procedure (including test calculations and interpretation of results)	Test performance Need for confirmatory testing and result follow-up recommendations
Preparation of controls, reagents, or other materials used in testing.	Storage conditions for test components Reagent use, including not using a reagent after its expiration date
Calibration and Calibration verification	Instrument maintenance and function checks
Analytic Measurement range, if applicable	
Control Procedures	Quality control (frequency and type) and remedial action
Corrective action when calibration or controls fail to meet criteria for acceptability	
Limitations in test methodology, including interfering substances	
Reference intervals	
Critical Results	
Pertinent literature references	
System for entering results into patient record	Result reporting, including not reporting individual patient results unless QC is acceptable
Course of action to take if system becomes inoperable	Equipment performance evaluation

3. Testing Procedures are available to all staff on the Tri-City MCN link located on the Intranet

4. In the event of a system-computer down-time, hard copies of the procedures may be accessed in the Laboratory. Point of care procedures are located in the Point of Care Quality Management Manual I and or in the individual test manuals.

C. **METHOD PERFORMANCE SPECIFICATIONS:**

1. Note: Does not apply to Waived tests.
2. Intermittent Testing—A test is 'out of production' when either Patient testing is not offered or PT is suspended. When a test is put back into production:
   a. PT or alternative assessment is performed within 30 days prior to restarting patient testing.
   b. Method performance specifications are verified, as applicable, within 20 days prior to restarting patient testing.
   c. Competency is assessed within 12 months prior to restarting patient testing.
3. Each will be verified or established as applicable. Specific procedures will be determined by the manufacturer or by the Medical Director or designee if the manufacturer offers no recommendations. These completed records must be available to clients and the inspection team upon request.
   a. Analytic Accuracy—by comparing result to a definitive or reference method or by comparing results to an established comparative method. Use of reference materials or other materials with known concentrations is suggested in establishing or verifying accuracy.
   b. Analytic Precision—by repeat measurement of samples at varying concentrations or activities within-run and between-run over a period of time.
   c. Analytic Sensitivity—the lower detection limit
   d. Analytic Interferences
   e. Reportable Range—The AMR (analytical measurement range) is the range that can be directly measured without dilution or concentration while meeting the accuracy and precision requirements.
   f. Reference Intervals—'Normal' Values. Literature or Manufacturer's package insert information may be appropriate. The reference interval should be evaluated upon introduction of a new analyte, upon a change of methodology, or upon a change in patient population.

4. Test Sites (different from the main Laboratory) that are under the POC Program oversight:

ED	NSY	CARD
ACCU	NICU	WK PTNS
IMC	PACU	Cath Lab
2P	REHAB	BHU
3P	RAD	Forensic
4P	HHC	Pulmonary Rehab
Labor/Delivery	WCC	Infusion,OP
Post-Partum	Surgery	Pre-OP Hold
Wellness Center	Primary Care Clinic	Ortho
Tele	SPRA	

REFERENCE(S):

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT:** Abbreviations

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 05/06, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~08/20~~01/25**
Division of Psychiatry Approval:	**~~03/22~~05/25**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE:**
1. To define the list of abbreviations applicable to Outpatient Behavioral Health.

B. **POLICY:**
1. When documenting in the patient medical record, clinical staff may use the following Program and the hospital approved abbreviations.

C. **PROCEDURE:**
1. Who may perform/responsible**:** Clinical Staff.

D. **RELATED DOCUMENT(S):**
1. Outpatient Behavioral Health Abbreviation List
2. The Joint Commission's Official "Do Not Use" List

E. **EXTERNAL LINK(S):**
1. Neil-Davis Medical Abbreviation - MedAbbrev.com

Outpatient Behavioral Health Abbreviation List

Approved List

Abbreviation	Word(s)
ψ	Psychiatric
- with a circle	Negative
+ with a circle	Positive
B & C	Board and Care
BHOS	Behavioral Health Outpatient Services
CC	Clinical Coordinator
CLC	Community Liaison Coordinator
Clt	Client
CM	Clinical Manager
DR	Dual Recovery
EFR	Early Full Remission
EPR	Early Partial Remission
F with a circle around it	Father
ITP	Initial Treatment Plan
M with a circle around it	Mother
MFT or MFTI	Marriage and Family Therapist (Intern)
PI	Paranoid Ideation
RI	Resulting In
RCF	Residential Care Facility
SFR	Sustained Full Remission
SPR	Sustained Partial Remission
Th	Therapist
TPR	Treatment Plan Review

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Admission and Eligibility Criteria**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/06, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~08/20~~01/25**
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Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE:**

1. Define the clinical criteria which determine eligibility for admission to the Behavioral Health Outpatient Services.

B. **POLICY:**

1. Persons may be admitted to the Behavioral Health Outpatient Services if they meet specific clinical criteria related to diagnosis, type of impairment and severity of impairment. The specific criteria are listed below. Generally, the criteria require the presence of a serious mental illness, significant functional impairment and a course of illness which, absent the proposed treatment, would likely result in psychiatric hospitalization.
2. Exclusion criteria generally relate to conditions in which the level of clinical risk warrants inpatient hospitalization, situations in which treatment could be reasonably provided at a less intensive level of care or there is an unstable non-psychiatric medical condition which cannot be appropriately managed in an outpatient setting.

C. **PRIMARY DIAGNOSTIC CATEGORIES:**

1. Serious Mental Illness-Diagnostic Criteria:
   a. Schizophrenia and Other Psychotic Disorders
   b. Anxiety Disorders
   c. Mood Disorders
   d. Somatoform Disorders
   e. Eating Disorders
   f. Personality Disorders
   g. Other Diagnostic Categories that significantly impair functioning and are authorized for treatment at IOP level of care.

D. **ADMISSION ELIGIBILITY CRITERIA:**

1. Current exacerbation of psychiatric symptoms
2. Functional impairment resulting in difficulty performing ADL's
3. Treatment at lower level of care has been unsuccessful
4. Severity of the current symptoms is such that success resulting from a lower level of care is doubtful
5. Reasonable expectation that symptoms, behaviors and functional levels can be stabilized or improved
6. Risk to self, others, or property is present but is such that patient can be managed with the structure and support of the program
7. Despite the degree of impairment present, patient has sufficient intact functioning to benefit from an active treatment program (e.g. any cognitive deficit or other diagnosis indicating organicity

will not preclude the patient from successful treatment.)

8. Recently discharged from an inpatient psychiatric hospitalization and requires this level of care to assist in reintegration into the community
9. Patient is capable of regularly attending program per treatment planning schedule

E. **CONTINUED STAY ELIGIBILITY:**

1. Persistence psychiatric symptomatology
2. Persistence of impairment in social, familial, residential, or vocational functioning.
3. Psychiatric symptoms continue to negatively impact ADL's
4. Continues to be reasonable expectation that patient will improve or be stabilized within a reasonable time frame
5. Improvement in this context is measured by comparing the effect of continuing treatment versus discontinuing it; where there is reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further or require hospitalization, this criterion would be met.
6. Patient is attending and participating in program and showing a capacity to benefit.

F. **EXCLUSIONARY CRITERIA:**

1. Deterioration in functioning represents a situational crisis, unrelated to the psychiatric condition
2. Patient is actively and seriously suicidal
3. Patient is actively and seriously homicidal or poses a threat of harm to others.
4. Patient is medically unstable
5. Patient has antisocial personality disorder or strong antisocial personality traits
6. Patient unable to follow ground rules (e.g. verbally/physically abusive to others)
7. Symptoms are transient and self-limiting
8. Patient requires inpatient level of care due to severity of psychiatric conditions
9. Current symptoms and impairment can be adequately managed at lower level of care
10. No reasonable expectation that condition can be stabilized or improved
11. Multiple absenteeism (from groups or program) and/or non-participation in program interfere with patient's ability to benefit from program
12. Substance abuse interferes with ability to benefit from Program
13. Program physicians unwilling to treat patient due to treatment non-adherence

G. **DISCHARGE CRITERIA:**

1. Symptoms/Impairments have decreased to a level indicating patient no longer requires treatment for their illness
2. Symptoms/impairments have been stabilized or patient is back to baseline
3. Patient is in need of or ready for a more intensive or less restrictive level of care
4. Patient is not able to benefit from the program
5. There is no reasonable expectation for improvement
6. Patient has achieved their established program goals and would not benefit from additional treatment goals
7. Patient is a danger to self or others and cannot be effectively or safely managed within the program needing a higher level of care
8. Patient does not have the capacity to benefit from program
9. Patient is not participating and/or not attending per treatment plan
10. Patient has achieved maximum benefit from this level of care
11. Patient presents a threat (physical or verbal) to the safety of the milieu

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Admission Assessment**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~08/20~~01/25**
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Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE**

1. To identify the guidelines for the Psychiatric Admission Assessment.

B. **PROCEDURE**

1. Who may perform/responsible: Attending Psychiatrist
2. The Psychiatric Admission Assessment must be completed by the attending physician within five program days (seven calendar days) from date of admission to the Intensive Outpatient Program and within 24 hours of admission to the Partial Hospitalization Program.
3. The assessment should include the following:
   a. Chief complaint/reason for the referral: information referencing recent hospitalization
   b. History of present illness
   c. Current mental status
   d. Current Diagnosis, Axes I through V
   e. Assessment and plan of treatment including medications
4. The physician, therapist and patient collaborate to help aid in the development a thorough Master Treatment Plan
5. The physician may have the following information available to aid in the completion of the Psychiatric Admission Assessment:
   a. Community Liaison Coordinator (CLC) Referral and Screening Report/Biopsychosocial assessment.
   b. Attempts will be made to obtain collateral including prior Program admission, treatment, and discharge information; last psychiatric inpatient hospital admission notes, history and physical, discharge summaries, medication sheet, and relevant treatment notes current psychosocial summary, face sheet, etc.
   c. The CLC or Registered Nurse (RN) provides a brief presentation of the patient to the treatment team prior to admission.
6. Prior level of functioning and recent acute change in mental status should be documented in the assessment in order to demonstrate current need for OPBHS. It is important that the physician be specific with regard to treatment plan recommendations so that physician driven treatment is evidenced.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Age Appropriate Care**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 09/17

Department Approval:	**~~08/20~~01/25**
Division of Psychiatry Approval:	**~~03/22~~05/25**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE:**

1. To provide guidelines to meet the age specific care needs of the patient and educate their caregiver and/or family.

B. **POLICY:**

1. Outpatient Behavioral Health Services (OPBHS) serves adults eighteen (18) and older. Efforts must be made to individualize the program to meet the specific needs of individuals and address age-related issues. Older adults may attend specialized groups to address issues related to their specific age group, such as aging and grief and loss issues. Likewise, young adults may be scheduled for groups with individuals of similar age to address issues that may arise for their age group, such as academic or job-related concerns. All employees shall demonstrate the skills and knowledge required to provide care appropriate to the age of the patients served. Caregiver/family shall be involved in treatment to meet the age specific needs of the patient.

C. **PROCEDURE:**

1. Who may perform/responsible: OPBHS staff.
    a. Educational information including the principles of growth and development will be provided during orientation.
    b. The knowledge and skills necessary for providing age specific care will be reviewed annually.
    c. Knowledge, skill base, and ability to provide care appropriate to the age of the patient will be evaluated during orientation and at each annual performance review.
    d. Employees will include family/caregiver, as appropriate, in meeting age specific needs of the patient.
    e. Treatment approaches will be modified to meet the age specific physiological, psychological, educational and social needs of the patient.
    f. Medications will be prescribed in age appropriate medication dosages; therapeutic ranges can be obtained from the pharmacy and laboratory department as needed.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Clinical Assessment**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~08/20~~01/25**
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Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE:**

1. To identify the core assessments that must be completed for all patients entering the program and to identify optional special assessments which are completed, as necessary, by physician's/Allied Health Professional's (AHP) order.

B. **POLICY:**

1. All patients admitted to the program will routinely have an Admission Psychiatric Assessment, and a Biopsychosocial Assessment, which includes a Nursing Assessment and psychosocial assessment.

C. **PROCEDURES:**

1. Who may perform/responsible: Physicians, Therapy, and Nursing Staff
2. Intensive Outpatient Program Services:
   a. All core assessments will be completed by appropriately licensed and qualified personnel using Tri-City Healthcare District (TCHD) approved electronic medical records or downtime forms.
   b. The Psychosocial and Nursing Assessments are routine and part of the core assessments and must be completed on all patients. Assessments will include findings and treatment recommendations, which will take into consideration patient strengths.
   c. All patients will be assessed for substance abuse.
   d. All new patients will undergo a suicide risk assessment at intake and as needed during their treatment.
   e. A general health statement by the attending psychiatrist or patient's medical doctor must be made on admission. If the patient has been hospitalized within the last 30 days for any reason, an effort must be made to obtain a copy of the H & P and any other pertinent data.
   f. Self-administered screenings, such as PHQ-9, GAD-7, PCL 5, or BPRS are utilized for diagnostic purposes as clinically appropriate and help inform treatment when administered monthly.
   g. If qualified personnel are not available on staff, then arrangements will be made for the special assessments to be completed by appropriately qualified independent practitioners. An example is when neuropsychological testing is ordered by the treating physician.

D. **BIOPSYCHOSOCIAL ASSESSMENT AND ADMIT NOTE: OVERVIEW:**

1. Part A Nursing Assessment:
   a. Part A of the Biopsychosocial Assessment is the Nursing Assessment and it is completed within 24 hours of admission by the Program Registered Nurse (RN). It should speak to medical necessity for admission and provide information to be considered in the development of the Initial and the Master Treatment Plan. In addition, it should address medical concerns and medical diagnoses.
   b. Part A of the Biopsychosocial Assessment shall contain patient identification and diagnosis and the following:
      i. Measurements and Vitals
      ii. Allergies and Sensitivities
      iii. Current Medications and Compliance
      iv. Nutritional Screening and History
      v. Functional Assessment
      vi. Sensory/Communication assessment
      vii. Surgical history
      viii. Medical Problems/History and Falls Risk Assessment
      ix. Contagious Diseases/exposure
      x. Pain Screening
      xi. Suicide Risk Screening
      xii. Fall Risk Assessment: If fall risk is indicated, then Fall Risk goals will be initiated along with treatment interventions
2. Part B: Psychosocial Assessment
   a. Part B of the Biopsychosocial Assessment is the Psychosocial Assessment and can be used as a rapport building opportunity between the Therapist and the patient. It is recommended, however, that it be conducted after the patient has had a few days to acclimate to the program but within one week of admission. It is also preferable that some rapport building occur between the Therapist and the patient prior to the assessment as the level of trust and the level of self-disclosure may be greater.
   b. This assessment should also be used as a springboard for exploring with the patient specific treatment plan problems and goals. This discussion should provide the patient with a thorough understanding of how a treatment plan is developed and revised and the role of the patient as an active participant in the treatment planning process. It may be useful during this discussion to share with the patient the impressions and recommendations of team members based on other assessments (e.g., the Psychiatric Admission Assessment; Part A of the Biopsychosocial Assessment) as you and the patient begin exploring potential treatment plan problems and goal areas. In doing so, the patient can perhaps better understand the connection between the assessment process and the treatment plan. Include in this discussion how the identified strengths of the patient will be incorporated into the treatment plan and reinforce patient active participation in the process.
   c. Part B of the Biopsychosocial shall contain the following:
      i. Source of information
      ii. Family relationships and current living arrangements
      iii. Brief psychiatric history
      iv. Developmental and family of origin history
      v. Ethnicity and Sexuality
      vi. Spirituality
      vii. Substance Use History
      viii. Adult social history
      ix. Education / Learning ability
      x. Employment / Vocational data
      xi. Legal history
      xii. Financial resources / Community support needs
      xiii. Military Service history

xiv. Risk factors / Violent behavior / Abuse history
xv. Additional observations and/or Special needs

3. An admission note should also be included in the chart. This provides an introduction of the patient to the various team members in the narrative form. It should emphasize the reason for referral, recent change in mental status, and symptomatology. All of these supports medical necessity for admission and help paint a clear picture for why the patient is being admitted to the program.

E. ADMISSION NOTE OUTLINE:

1. Admission to include:
   a. Admission Note is completed on day of admission
   b. Demographics (age, race, sex, who accompanied)
   c. Brief rationale for present admission to the program: Include observable psychiatric symptomatology and functional impairment.
   d. Remarkable observations of mood, affect, behavior
   e. Suicidal / homicidal / assaultive ideation or gestures upon presentation
   f. Patient Orientation to therapeutic milieu, schedule, staff, and Program (per Outpatient Behavioral Health: Orientation of New Patients Policy).

F. RELATED DOCUMENT(S):

1. Outpatient Behavioral Health Policy: Orientation of New Patients

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Contraband**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~08/20~~01/25**
Division of Psychiatry Approval:	**~~03/22~~05/25**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:`	**05/22**

A. **PURPOSE:**

1. To maintain patient and staff safety within Outpatient Behavioral Health Services (OPBHS).

B. **POLICY:**

1. Contraband items are not allowed in program. Contraband is defined as items that can be injurious to self or others. Contraband includes weapons or potential weapons, illegal drugs and alcohol. Medications that are not needed during program hours are also considered contraband.

C. **PROCEDURE:**

1. Who may perform/responsible: OPBHS staff
2. Contraband brought to the OPBHS will be removed from patient access and stored in a secure area. These items may be returned at the end of the day and the patient escorted out of the building. Contraband will be returned only if the Program Administrator feels that possession of the contraband item will not pose a threat to the patient or others. Items that are illegal to possess, such as illegal drugs and firearms, will be securely stored until their appropriate disposition is determined. The Operations Manager will notify the Director of Behavioral Health/CNE.
3. Patients who bring contraband to the OPBHS will be given one warning not to bring the item(s) back. Repeated violations of the contraband policy will result in suspension from the Program until the patient meets with his/her Therapist and the Operations Manager. At that time, the patient's noncompliance will be discussed as a treatment issue. A treatment contract will be written and the patient may be rescheduled if he/she agrees to stop bringing contraband to OPBHS.
4. Continued violations of the contraband policy may result in the patient's discharge from OPBHS.
5. If the patient refuses to relinquish the contraband, he/she shall be told to leave the premises and the attending physician shall be notified.
6. The incident should be documented in RL Solutions, and as applicable, in the patient's record along with the action taken.

D. **RELATED DOCUMENT(S):**

1. Security Policy: Seized Evidence or Contraband 231

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: **08/96** **SUBJECT:** **Co-treatment of Patients**

REVISION DATE: **05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 03/16, 06/19, 03/23**

Outpatient Behavioral Health Services Department Approval:	**~~03/22~~11/25**
Division of Psychiatry Approval:	**~~01/23~~11/25**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**02/23**
Administration Approval:	**~~03/23~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/23**

A. **PURPOSE:**

1. To provide guidelines on provision of physician Co-Treatment of patients by attending psychiatrists.

B. **POLICY:**

1. Co-treatment by attending psychiatrists will be facilitated if a patient has a primary psychiatrist in the community who will continue to manage medications while patient is attending the program. The Program physician will oversee treatment of the patient in Behavioral Health Outpatient program and will collaborate with the community physician with regard to medications, and post Program follow up. Co-treatment will be directed and certified as medically necessary by the attending program psychiatrist.

C. **PROCEDURE:**

1. Who May Perform/Responsible**:** Psychiatrists
   a. Patients will be admitted and followed by an attending Program psychiatrist. The Program psychiatrist will complete the admission order, and psychiatric evaluation. Monthly progress notes will be completed by the psychiatrist and/or Allied Health Professional (AHP) and will indicate medical necessity and patient's progress toward treatment goals.
   b. The Program psychiatrist and AHP will be encouraged to communicate regularly with the community psychiatrist to update him/her on the patient's progress and any medication issues.
   c. The Program psychiatrist will direct all treatment planning. The co-treating physicians are informed regarding any patient concerns and treatment progress.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Daily Progress Notes**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~08/20~~01/25**
Division of Psychiatry Approval:	**~~03/22~~05/25**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE**

1. To provide guidelines for the documentation of patient progress in the Outpatient Behavioral Health Services (OPBHS) Program.

B. **POLICY**

1. The Program is required to document progress for each intervention provided. The treatment plan problems can be identified within each note. Each intervention should be identified in terms of the focus, modality and the format and the facilitator / therapist name and credentials. Specific goals for each intervention, as well as symptoms, behaviors and/or responses should be documented.
2. Individual Therapy, a Family Session, and Crisis Intervention should also be documented as it occurs. Specific treatment, outcomes, and goals of the session should be documented in narrative form as an Interdisciplinary Progress Note.

C. **PROCEDURE**

1. Who may perform/responsible: Clinical Staff and Physicians
2. Per Service Notes:
   a. The note must clearly show how the various groups the patient is attending are focused on treating his/her specific psychiatric problems. The documentation must illustrate how the treatment relates to the problems stated in the treatment plan, what kind of improvement is shown and what still needs to be improved. Progress notes must reflect active treatment.
   b. When documenting, refer to observable symptomatology, staff interventions and response/progress noted.
   c. Physicians should document patient progress toward treatment goals, need for continued treatment and discharge readiness.
3. Charting Basics:
   a. Individual and group therapy session notes should be entered in the electronic medical record system.
   b. In case of downtime, use downtime forms and use black ink.
   c. Date and sign all documentation.
   d. Write legibly.
   e. Clinical staff must document daily on groups attended and patient progress/participation in the groups.
   f. Special notes (i.e., nursing notes, non-billable and collateral contacts) are identified as such.

g. Documentation needs to be descriptive, not interpretative. When documenting, include observed behaviors and patient statements.
h. Document all treatment rendered to the patient and the patient's response. Any quotations used are to be brief and relevant to the patient's problems.
i. Make chronological entries of the patient's clinical course - late entries must be identified as such.
j. All entries in the medical record are completed by the writer.
k. On paper forms, errors must be indicated by using one line through the incorrect documentation, write "error" over the line, and initial the error. Never use white-out.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Discharge Planning and Discharge**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~08/20~~01/25**
Division of Psychiatry Approval:	**~~03/22~~05/25**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE**

1. To define the discharge process as an integral part of treatment.

B. **POLICY**

1. Discharge planning will be an organized, coordinated process, with interdisciplinary treatment team, patient, physician and family/significant other input. The process identifies the patient's needs before and after discharge, delineates plans to meet these needs and engages the patient and family members in the process of plan implementation. Discharge planning will begin on admission.
2. Discharge criteria are tied to the long-term goals and will be established during the development of the Master Treatment Plan (MTP). At each treatment plan Update, the discharge criteria will be reviewed and modified as necessary, depending upon the rate of progress (or lack of progress) in treatment. A rationale for each change will be documented.
3. If a patient does not respond favorably to the Program or does not seem to be benefiting from the prescribed course of treatment, the issue is taken to the treatment team meeting to determine appropriateness of the treatment and identify possible changes in treatment plan or possible alternative referrals. However, lack of progress in treatment does not automatically imply the necessity for discharge. Treatment goals need to be re-evaluated and every effort must be put forth to insure that identified problems and target dates are appropriate and reasonable, prior to considering discharge.
4. Circumstances warranting discharge may include:
    a. Attainment of treatment goals, including a significant reduction in symptoms and functional impairment.
    b. Continued abusive and/or aggressive behaviors after clinical/behavioral interventions fail.
    c. Repeated substance abuse, after treatment interventions have been tried, to a point that substance abuse substantially interferes with the team's ability to address the primary Axis I diagnosis and patient does not appear to work towards harm reduction or abstinence as a goal.
    d. Repeated non-compliance with treatment or program rules.
    e. Discharge to inpatient due to:
        i. Suicide attempt or imminent risk of suicide;
        ii. Serious injury;
        iii. Accidental injury;
        iv. Acute exacerbation of symptoms;
        v. Danger to others.
5. Patient refusal to continue in treatment.

a. When a patient declines to continue in treatment, follow-up efforts will be made by the Therapist;

6. The patient will be discussed at the treatment team meeting and interventions planned in an effort to re-engage patient;
   a. Patients may be administratively discharged if they do not attend the Program on a regular basis and do not respond to repeated attempts to re-engage; and Program physician may discharge the patient due to lack of follow through with treatment recommendations.
7. All anticipated discharges from the Program will be discussed with the physician and significant others involved in the patient's care, before a discharge decision is made.
8. Individual and group sessions will be utilized to assist patients in achieving and maintaining treatment goals and planning for a smooth transition from the Program.

C. **PROCEDURE:**

1. Who may perform/responsible: Clinical Staff
2. Patient progress toward goals and appropriateness for discharge will be discussed in treatment team meetings and the discharge plan will also be reviewed at the treatment team meeting.
3. A plan of transition will be developed, which includes contacting the appropriate referral agency, establishing a time-line for discharge from the program, actively involving the patient in the planning and a subsequent decrease in treatment days.
4. The plan of transition will be developed to limit the potential for separation related stress and/or increased symptomatology. The plan will be discussed with, and agreed upon by the patient.
5. When the transition is complete, with the approval of the treating psychiatrist, patient, and the treatment team, the patient will be discharged from the Program.
6. When discharging a patient:
   a. Complete the discharge checklist on the day of discharge
   b. Complete the Discharge/Aftercare plan, to include the discharge medications, discharge instructions, and follow up care. In the case of an unanticipated discharge, mail the patient a copy of this Aftercare plan.
   c. The primary care physician is also sent the aftercare plan/discharge summary with written consent by the patient.
   d. Audit the chart and check for:
      i. All downtime and paper forms labeled/identified with name of patient, date of admission, attending physician and Medical Record number;
      ii. All progress notes completed, dated and signed;
      iii. All orders noted and signed;
   e. The complete discharge summary must be written within 3 days by the therapist.
7. The medical record may be retained on site for up to seven days.
8. The chart will then be sent to Medical Records to be scanned.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Laboratory Services**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~08/20~~01/25**
Division of Psychiatry Approval:	**~~03/22~~05/25**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE:**
1. To provide laboratory services for patients attending the Outpatient Behavioral Health Services (OPBHS).

B. **POLICY:**
1. OPBHS provides patients access to Tri-City Healthcare District (TCHD) laboratory services as ordered by the attending physician/Allied Health Professional (AHP) or medical consultant.

C. **PROCEDURES:**
1. Who may perform/responsible: Registered Nurse (RN) and Laboratory Staff
2. The RN notes the physician/AHP order for laboratory services and coordinates completion of lab services with the patient.
3. The RN refers to the physician/AHP order and hospital lab for any special provisions or preparations (i.e. fasting; hold a.m. prescription) and instructs patients prior to lab work.
4. Same gender identity staff should supervise collection from patients of specimens for drug and alcohol urine screenings.
5. The RN is responsible for correctly labeling the urine specimen and arranging for safe transport to the laboratory.
6. All staff handling urine specimen are to utilize Infection Control: Standard and Transmission-Based Precautions.
7. In the event of a critical lab value, the physician/AHP is notified immediately.

D. **RELATED DOCUMENT(S):**
1. Infection Control Policy: Standard and Transmission-Based Precautions

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Medical Emergencies**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~08/20~~01/25**
Division of Psychiatry Approval:	**~~03/22~~05/25**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE:**
1. To define appropriate methods of handling emergency medical situations.

B. **POLICY:**
1. Medical emergencies are managed by Outpatient Behavioral Health Services (OPBHS) Registered Nurse (RN). All clinical staff assisting in medical emergencies are required to maintain current Basic Life Support (BLS) Certification.

C. **PROCEDURE:**
1. Who may perform/responsible: Nursing Staff
2. For minor injuries (i.e., superficial cuts and bruises), the patient will be evaluated by the RN on duty. First aid treatment is provided by the RN. The patient is referred to his/her primary care physician for follow-up, as necessary.
3. For acute medical conditions requiring immediate attention, the RN will arrange for the most appropriate type of transportation for the patient, to the nearest Emergency Department.
4. In cases of severe suicide attempts or medical emergency, the RN will initiate lifesaving procedures, and have a staff member immediately dial 911.
5. Any first aid or other medical services provided to the patient must be documented by the RN in the patient's medical record.

D. **RELATED DOCUMENT(S):**
1. Outpatient Infusion Center Policy: Medical Emergencies

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Organizational Structure**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~08/20~~01/25**
Division of Psychiatry Approval:	**~~03/22~~05/25**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE:**

1. To define lines of responsibility for clinical supervision and administrative supervision.

B. **POLICY:**

1. Outpatient Behavioral Health Services (OPBHS) staff operates using the guidelines of the organizational structure, and obtain both clinical and administrative supervision.

C. **PROCEDURES:**

1. Who may perform/responsible: Tri-City Healthcare District (TCHD) Administrative Staff, Medical Directors, Operations Manager and Director of Behavioral Health or designee.
2. Clinical Supervision:
   a. All patients must be admitted by a psychiatrist who has the responsibility for supervising and periodically evaluating all treatment services provided to the patient under his/her care. The attending physician/Allied Health Professional (AHP) must also provide supervision and direction to any therapist involved in the client's treatment. The OPBHS Medical Director(s) has responsibility for overseeing and ensuring the quality of care provided to the patients. The Medical Director(s) reports administratively to the Operations Manager. The Medical Director(s) reports in all matters of a clinical nature to the TCHD Psychiatric Committee.
3. Administrative Supervision:
   a. The Operations Manager provides administrative supervision of all OPBHS staff and has administrative responsibility for all aspects of the OPBHS. The Operations Manager reports to the Director of Behavioral Health or CNE.
4. Site Management:
   a. Administrative and financial operation of the OPBHS is the responsibility of TCHD. The Operations Manager has responsibility for day to day operation of the site including staff recruitment, supervision, clinical services, nursing services, environmental maintenance, quality improvement and utilization of reviewed activities. Also included is monitoring of staff and physician documentation compliance and monitoring of compliance to all TCHD rules, policies and procedures.
   b. The Medical Director(s) has responsibility for overseeing the quality of medical care provided at the OPBHSs. The Medical Director(s) must be a Board Certified or Board Eligible Psychiatrist and be a member in good standing of the TCHD medical staff and a member of the appropriate TCHD medical committee. The Medical Director(s) attends weekly treatment planning meetings, clinical problem solving meetings and is available to the Operations Manager and staff to consult on cases, physician issues and clinical programming. The Operations Manager and Registered Nurses (RNs) provide initial

orientation and training of all Medical Director(s). The training includes:
   i. responsibilities and duties of the Medical Director(s);
   ii. documentation requirements;
   iii. policies and procedures; and
   iv. clinical program guidelines.

5. Quality Improvement and Utilization Review:
   a. The Operations Manager has responsibility for monitoring and reporting Quality Improvement issues to TCHD Director of Behavioral Health, CNE, and other medical staff committees. This includes an analysis of trends and a plan of correction when needed. Reports provide statistical analysis and trending of results across programs and recommend changes in programming, policies and procedures based upon an analysis of the results.
6. Personnel:
   a. Clinical and administrative personnel at OPBHS are TCHD employees. All employees must satisfy the personnel requirements set forth by TCHD (which may include) a pre-employment physical. The operations Manager or designee provides an orientation for all new employees. Staff development is provided on a regular basis to all staff. The Operations Manager is responsible for overseeing compliance with:
      i. TCHD policies;
      ii. The Joint Commission, Medicare, or appropriate standards, and staff development requirements (i.e., TCHD orientation, Basic Life Support, Crisis Prevention Intervention, etc.);
      iii. state and federal employee regulations; and
      iv. periodic and annual performance evaluations.
7. Community Development and Liaison (CLC):
   a. The CLC is responsible for screening each potential patient to determine clinical appropriateness for admission. The CLC also has responsibility for establishing and maintaining relationships with community agencies, residential care facilities, public and private mental health providers, advocacy groups and others involved in the treatment of the mental health patients in the community. The maintenance of these relationships is critical in providing a continuum of care for patients with psychiatric disabilities. Additionally, the CLC is responsible for developing community education programs for both professionals and non-professionals involved with patients.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Physician Admission Order**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~08/20~~01/25**
Division of Psychiatry Approval:	**~~03/22~~05/25**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE:**
1. To clarify what is necessary for admission to Outpatient Behavioral Health Services (OPBHS).

B. **POLICY:**
1. Admission to the OPBHS must be upon the order of a program physician.

C. **PROCEDURE:**
1. Who may perform/responsible: Tri-City Healthcare District (TCHD) credentialed physicians.
2. A Physician Admission Order must be received on the day the patient is admitted to the OPBHS.
3. The patient may be admitted with a telephone order but must be seen by the physician within seven days of admission to Intensive Outpatient and within 24 hours of admission to Partial Hospitalization Program.
4. Group therapy, individual and family therapy must be ordered by a program physician.
5. On admission, the physician orders the duration of treatment, based on medical need.
6. Admission to OPBHS requires a general health statement by the admitting physician, indicating medical stability.

D. **REFERENCE(S):**
1. Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L34616)

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE:	**08/96**	**SUBJECT:**	**Psychiatric Evaluation for Higher Level of Care**
REVISION DATE:	**05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 09/17, 05/20, 03/23**		

Department Approval:	**~~11/21~~11/25**
Division of Psychiatry Approval:	**~~01/23~~11/25**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**02/23**
Administration Approval:	**~~03/23~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/23**

A. **PURPOSE:**

1. To define appropriate methods for admitting a patient to an inpatient psychiatric unit.

B. **POLICY:**

1. When a patient is in need of inpatient treatment, the program staff and attending physician will arrange the admission.

C. **PROCEDURE:**

1. Who may perform/responsible: Clinical and Nursing Staff
   a. The treatment team, to include the Clinical Coordinator, Operations Manager and Registered Nurse (RN) whenever possible, meets to triage the patient and determine the need for inpatient admission or crisis stabilization unit (CSU) referral.
   b. The clinical staff contacts the attending psychiatrist to inform him/her of the current situation and the staff's assessment of the patient and recommendations for evaluation or inpatient treatment.
   c. If the attending psychiatrist concurs that a higher level of care is necessary, the clinical staff contacts the ~~psychiatric liaison to conduct~~**receiving facility for** handoff communication.
   d. If the patient refuses hospitalization or psychiatric evaluation in the Emergency Department (ED) or CSU, the attending program psychiatrist makes a determination as to whether the Sheriff/PERT should be contacted to evaluate for involuntary hold.
   e. The staff will be responsible for arranging for transport of the patient and obtaining consents from the patient/conservator, as needed. Depending on level of risk, a patient may be transported by Tri-City Medical Center van or accompanied by Staff on the van if they are voluntarily agreeing to be evaluated for hospitalization. Patients who are high risk, danger to self or others should be transported via ambulance or the Sheriff. The staff will contact the local Sheriff/PERT to assist with involuntary hold 5150 evaluation. OPBHS Staff may not place patients on involuntary hold and must utilize local law enforcement for involuntary detention evaluation.
   f. Staff will use the Situation, Background, Assessment, Recommendation (SBAR) process to conduct hand off communication with the intake coordinator, psychiatric liaison, shift Supervisor, MD, police department, or ambulance.
   g. The program staff will notify the patient’s family or significant others of the transfer, in accordance with the patient’s wishes. If appropriate, the patient’s insurance reviewer is contacted and informed regarding the inpatient admission.

h. Patient information/records will be sent at the time of transfer. These records will include diagnosis, pertinent financial/administrative information, current medical findings, current medications and a brief summary of the reason for the referral. Program nurse and clinical staff will ensure accuracy of medication reconciliation and hand off communication.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Referral and Admission Screening**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/06, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~08/20~~01/25**
Division of Psychiatry Approval:	**~~03/22~~05/25**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE:**

1. Define the referral and admission screening process.

B. **POLICY:**

1. Referrals for outpatient services are accepted from professional sources, through self-referral, from family members or from residential care providers. It is the responsibility of the Community Liaison Coordinator (CLC) (or his/her designated backup) to determine eligibility for service. All individuals that are in need of service should be evaluated as quickly as possible.
2. Whenever it is determined that a person, who is referred, is not eligible for services, it is the responsibility of the CLC to assure that an appropriate referral for alternative service(s) is made.
3. All persons accepted into the Program must meet admission criteria (see Outpatient Behavioral Health: Admission & Eligibility Criteria Policy).

C. **PROCEDURE:**

1. Who may perform/responsible: CLC or designee
2. At the point of initial referral contact, the CLC makes an initial determination of eligibility and legal status (if on conservatorship, the CLC obtains the conservator's consent to treat by the first day of admission to program). The CLC, along with the prospective patient, establishes a suitable time and location for admission screening. Screening may take place in an inpatient setting, at the patient's home, the program site, or other convenient location.
3. If the patient is referred by a non-psychiatrist, the CLC, after obtaining a release of information, contacts the psychiatrist currently working with the patient to determine if he/she agrees with the recommendation for treatment. The CLC inquiries about whether the community psychiatrist will continue to follow patient during treatment or if a program psychiatrist will follow the patient.
4. The CLC conducts a screening and completes the "Referral and Screening Report" or biopsychosocial to establish eligibility and appropriateness for admission, to identify any special issues or concerns and to gather all essential background information. The CLC obtains the "Authorization for Release of Information" which can be used to obtain copies of clinical records from previous treatment providers.
5. The CLC will meet with the Operations Manager, Clinical Coordinator, RN or designees to triage the potential admissions or to coordinate the admission process for any new patients.
6. The clinical staff will be briefed on all new admissions in the daily morning meeting. Briefing should include the patient's history and presenting problems.
7. The CLC will contact referral sources and the patient to advise them of specific admission activities, day and time. The CLC is responsible for assuring that arrangements for physician coverage have been finalized.

D. **CLC REFERRAL AND SCREENING REPORT/BIOPSYCHOSOCIAL: OVERVIEW:**

1. This report is used by the CLC for the purpose of evaluating clinical eligibility for admission to the Program. It is an important component to the admission process and rationale for treatment should be thoroughly completed. The medical director and attending physicians should use this report as part of their orientation to any potential admission prior to completion of the Psychiatric Admission Assessment. The final decision whether to admit the patient to program is the psychiatrist's.
2. The report should support medical necessity for this level of intensity of treatment by documented evidence which identifies: recent inpatient hospitalizations; failed efforts to ameliorate symptoms through outpatient services/lower level of care; recent change in acuity of psychiatric symptomatology; a description of decrease in functioning level; and, evidence that the individual meets the diagnostic inclusion criteria and criteria related to type and severity of impairment.
3. The CLC contacts the insurance company to obtain authorization for treatment and documents this in the authorization for treatment form.

E. **FORM(S):**

1. Authorization for Release of Information
2. Referral and Screening Report/BIOPSYCHOSOCIAL ASSESSMENT

F. **RELATED DOCUMENT(S):**

1. Outpatient Behavioral Health Policy: Admission & Eligibility Criteria

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Role of the Therapist**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~08/20~~01/25**
Division of Psychiatry Approval:	**~~03/22~~05/25**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE:**

1. To delineate the responsibilities of the Therapist in the Outpatient Behavioral Health Services (OPBHS).

B. **POLICY:**

1. A therapist is defined as a qualified mental health clinician authorized by the state to provide services, such as a psychologist, licensed clinical social worker, marriage family therapist, licensed professional clinical counselor, or license eligible therapists with California Board of Behavioral health registration.
2. On admission, all patients are assigned a Therapist. The Therapist acts as the primary OPBHS treatment coordinator for the patient, coordinating all treatment services provided to the patient, under the direction of the attending physician.

C. **PROCEDURE:**

1. Who may perform/responsible: Clinical staff
2. Responsibilities of the Therapist:
    a. Care Coordination:
        i. Develops therapeutic relationship with individual patients in caseload. Schedules regular 1:1 interaction to review patient goals and progress;
        ii. For each patient in caseload, the therapist has regular documented contacts with others involved in the patients care (i.e., physician, family members, residential care providers, case managers, conservators, etc.). Acts as liaison, as necessary, for information regarding treatment issues, changes in treatment plan, discharge plan, etc. These contacts may be both by phone and in person;
        iii. Monitors patient attendance at treatment program, following up in a timely manner when attendance problems develop;
        iv. Gathers information, initiates and implements behavioral contracts as needed;
        v. Assists in obtaining insurance authorizations and counseling patient on funding issues, as needed;
        vi. Coordinates with attending physician all treatment plan changes, reviews patient progress and discharge plan; and
        vii. Maintains patient satisfaction with the treatment program.
    b. Treatment and Documentation:
        i. Facilitates group treatment modalities within scope of practice, as assigned by the Operations Manager, using approved curriculum and standard group facilitation techniques.
        ii. Conducts initial assessment of new patients within caseload and develops the

treatment plan with patient and team collaboration. Develops master treatment plans in a timely manner as prescribed by OPBHS policies and procedures, using data from all assessments and with approval from treatment team.

iii. Reviews and updates treatment plans for patients within caseload, as defined in the OPBHS policies and procedures.

iv. Utilizes treatment planning meetings to review problems, progress and discharge plans for all patients on caseload.

v. Documents progress on a daily basis for all patients in groups facilitated by a Therapist. Progress notes are accurate; refer to problems identified on the treatment plan, and address group focus and patient response as related to treatment goals. All documentation must be legible.

vi. Documents each incident or unusual occurrence at the time it happens.

vii. Monitors medical records, for all patients within caseload, to insure completeness and accuracy. Notifies Operations Manager of any deficiencies and develops a plan of correction.

viii. Completes discharge summaries for all patients on caseload as prescribed by OPBHS policies and procedures.

c. Other Duties:

i. Participates in public relations and educational activities as assigned by the Operations Manager.

ii. Assists in the evaluation of patients referred for admission to OPBHS, as requested by Operations Manager.

D. **REFERENCE(S):**

1. Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Scope of Services**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/13, 08/17

Department Approval:	**~~08/20~~01/25**
Division of Psychiatry Approval:	**~~03/22~~05/25**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE:**

1. To define the specific plan and staff qualifications necessary for providing treatment in the intensive outpatient program (IOP) and partial hospitalization Program (PHP).
   a. **Intensive Outpatient Treatment (IOP):** This level of care that provides treatment for individuals with psychiatric illness who need structured treatment but at a lower intensity than Inpatient Behavioral Health Treatment. Patients typically receive 12-19 services per week (combination of group and individual therapy).
   b. **Partial Hospitalization Program (PHP):** This level of care is designed for individuals with psychiatric illnesses who need structured treatment at a lower intensity than inpatient behavioral health, but is more intensive than IOP. Patients typically receive 20 or more services per week.
   c. **Hospital Outpatient Services (HOPS):** This level of care is the least intensive hospital outpatient service and is for patients requiring 12 or less services per week. It is a step down from IOP but more intensive than outpatient community care.

B. **POLICY:**

1. In providing treatment in the Intensive Outpatient Treatment and partial hospitalization programs, the goal of the Behavioral Health Outpatient Services is to provide psychiatric treatment to individuals with psychiatric illness as defined in the current DSM of the American Psychiatric Association, in a less restrictive setting than an inpatient unit. The benefits of this type of care include: lessening the disruption of social, family and community ties; encouraging the patient to test new skills in a more natural environment than a hospital setting; providing a treatment milieu that fosters independence and self-reliance; soliciting feedback from the home environment thereby involving the patient's family or care providers in the treatment process and providing cost-saving benefits through a shortening of the inpatient stay or preventing the need for full hospitalization.

C. **SERVICES OFFERED:**

1. The Program philosophy of care is based on the belief that individuals with psychiatric symptoms can achieve recovery, maintain stability, and reach their maximum rehabilitation potential through the provision of quality, goal oriented treatment. Outpatient Behavioral Health Services (OPBHS) provides a highly structured treatment environment that is predicated on personal responsibility, individual dignity and respect for self-determination. Individuals served in OPBHS attend groups and individual sessions based on an individualized assessment of their needs. Each patient is encouraged to participate with the staff and physician in planning their treatment, setting realistic, obtainable goals and assessing their progress in the Program.
2. The OPBHS utilizes a blend of evidence-based psychosocial rehabilitation and the medical

model of treatment to help individuals achieve recovery. The Program is continually evaluated, utilizing feedback from physicians, staff, and patients; and evidenced-based information. The Program is responsive to the needs of the patients and the community standard of practice.

3. A highly trained and motivated staff is the key to maintaining a quality clinical Program. Staff development is promoted through a comprehensive orientation Program, ongoing in-service education and continuing educational opportunities. The philosophy revolves around the patient, his/her unique needs and assisting the patient to cope more effectively with psychiatric symptoms and life stressors. Assessment of a person's needs is based on past history and present level of functioning. Every area is assessed including physical, psychological, social, cultural, spiritual and environmental, so that a treatment plan is designed specific to each patient's needs. Through individual and group experiences in the OPBHS, progress will be assessed and the treatment interventions modified, as needed, to accomplish the goals defined by the patient and the treatment team. The OPBHS are designed to provide a series of successful experiences, allowing the patient to utilize skills learned, that result in enhanced symptom management and personal empowerment.

D. **CLINICAL PROGRAM:**

1. The clinical Program is based on the principles of recovery, crisis stabilization, psychiatric rehabilitation and relapse prevention. Programming includes group psychotherapy and individual psychotherapy, focusing on recovery, life management skill building, symptom management, functional skills development, relapse prevention and developing/utilizing a community-based support system. Dual Recovery groups are also provided for patients with Co-Occurring Mental Health and Substance Use Disorders. Specialized groups such as Dialectical Behavior Therapy, Cognitive Behavioral Therapy, Acceptance and Commitment Therapy are utilized to help with recovery and skills building.

E. **POPULATION SERVED:**

1. The OPBHS treats persons from the age of 18 and up who have a DSM psychiatric disorder with a primary diagnosis of Schizophrenia, or other psychotic disorders, Anxiety Disorders, Mood Disorders, Post Traumatic Stress Disorder, Somatoform Disorders, Eating Disorders, Personality Disorders, and other Diagnostic Categories that significantly impact functioning.

F. **ACCESSING SERVICES:**

1. A person may enter the OPBHS in several ways:
2. Referral by a discharge planner as a follow-up to inpatient treatment/Crisis Stabilization Unit;
3. Self-referral in coordination with a treating physician/Allied Health Professional (AHP) (If the patient is not currently in treatment with a psychiatrist, one will be assigned from the medical staff);
4. Community referral from a family member, board and care manager, conservator, social worker, or therapist.
5. Physician referral (The primary psychiatrist is encouraged to follow the patient while in treatment and a co-treatment option may be available).

G. **HOURS OF OPERATION:**

1. The OPBHS will provide three to four hours of clinical programming a day, Monday through Friday, except major holidays. Patients in IOP usually receive no more than nineteen (19) units of service per week. HOPS level of care typically has a maximum of 12 services. Patients in the PHP can receive more services, four per day, five days per week. Some exceptions can be granted for brief periods if the level of symptoms increase, and the insurance care manager approves.

H. **SCREENING:**

1. When an individual is referred for treatment in the OPBHS, an appointment is set for an initial screening. This is performed by the Community Liaison Coordinator (CLC), but may be done by another health care professional on the staff. The purpose of the initial screening is to determine

if the patient meets the clinical admission criteria for OPBHS (Admission & Eligibility Criteria policy). If the results of the initial screening indicate that the patient is not appropriate for this level of care, the referral source is contacted and an appropriate referral is made.

I. **ASSESSMENT AND EVALUATION:**

1. Upon admission to the OPBHS, an initial psychiatric assessment, nursing assessment, psychosocial assessment, suicide risk assessment, and if indicated, a substance abuse assessment will be completed. When a person is evaluated for treatment, the following information is obtained:
   a. Past psychiatric history;
   b. Current psychiatric/medical diagnosis and any medications being prescribed;
   c. Current symptoms;
   d. Risk for suicide;
   e. Risk for Falls;
   f. Substance abuse history;
   g. Identification of patient's strengths; and
   h. Any special considerations.

J. **METHOD OF SERVICE DELIVERY:**

1. Clinical needs, once identified, will be addressed in group and on an individual basis. Structured psycho-educational and process groups will utilize appropriate materials to enhance learning and address specific issues related to symptom management and functional living skills. The focus is on recovery, medication management, symptom management, community-living skills, reduction of suicide risk, crisis management, managing relationships, personal care management, substance abuse recovery and other topics as needed.

K. **THERAPEUTIC PROGRAM:**

1. All services provided are appropriate for the treatment of the patient's identified problems. OPBHS will assist in the improvement of the patient's functional level and reduce the risk for exacerbation of symptoms, relapse on substances and hospitalization. Programming is individualized so that patients may initially attend two to five days per week as needed in HOPS, IOP or PHP. As the patient improves, it is anticipated that they will move to a lower level of care. For example, patients may drop from a higher level of care, such as IOP to a lower level of care, such as HOPS. This will assist in maintaining stability and preventing psychiatric relapse.

L. **TREATMENT PLANNING AND REVIEW OF GOALS AND OBJECTIVES:**

1. The treatment planning process involves the establishment of a Master Treatment Plan within seven days of admission to the OPBHS. This individualized treatment plan is written based on the patient's identified symptoms, goals, and wishes, and in collaboration with the patient. The plan is written by the Therapist assigned to the patient, and is initiated under the direction of the admitting psychiatrist. An initial treatment plan may be initiated by the therapist the first day of treatment, but within seven days of treatment, a Master Treatment Plan (MTP) is completed by the Treatment Team, under the direction of the attending physician and/or Medical Director. After the completion of the MTP, the next treatment plan review will occur monthly for IOP or bi-weekly for PHP. The plan is also reviewed if the patient goes into crisis, or if their condition changes, so that treatment provided in the Program accommodates newly identified needs.

M. **DISCHARGE PROCESS:**

1. The patient's discharge needs are identified on admission to the OPBHS. As the patient's needs become more defined, programming and discharge planning for the patient will be modified to meet those needs. As part of the discharge planning process, the Therapist will follow-up with the referral source and those in the community providing support, as well as the patient, to assure a smooth transition back into the community and/or a transition to a lower level of care.

N. **ORGANIZATIONAL RELATIONSHIPS:**

1. The OPBHS staff is accountable to the Operations Manager. Each interdisciplinary treatment team member has input into the Program planning process. Staff meetings are held bi-monthly or as necessary to address problems as they relate to patient care.
2. The Operations Manager/designee has the authority to make operational decisions on a day to day basis. The Operations Manager is supervised by the Director of Behavioral Health or Chief Nurse Executive (CNE).

O. **EMERGENCY SERVICES:**

1. If a crisis or emergency psychiatric situation should occur at the site, immediate contact will be made by staff to de-escalate the situation. If attempts by staff at verbal de-escalation fail, emergency procedures will be initiated (see Psychiatric Emergencies). If a medical emergency occurs, it will be evaluated by the Registered Nurse (RN) and 911 will be called, if necessary (see Outpatient Behavioral Health: Medical Emergencies Policy).

P. **AFTERCARE AND POST-DISCHARGE:**

1. Post discharge planning may be provided by the patient's Therapist in an effort to provide continuity of care. The Clinical Coordinator and CLC will maintain and make available to staff, a current list of community resources

Q. **STAFFING QUALIFICATIONS AND PATTERNS:**

1. The OPBHS will provide clinical services delivered by qualified health care professionals to adequately assess and address the identified clinical needs of patients. These services are augmented by administrative and support staff necessary to maintaining a comprehensive and responsive treatment program. Professional staff meets all federal and state requirements for licensing, registration or certification. Clinical staffs providing services are Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (MFT), Licensed Professional Clinical Counselors (LPCC), Psychologists, and Associate MSWs, Associate MFTs and Associate LPCs who are supervised on site by licensed practitioners. There will be availability of professional nursing services to meet the needs of those patients requiring such services. Nursing services are provided by Registered Nurses who provide, supervise and evaluate nursing care.
2. Each therapist working a forty (40) hour week will be responsible for managing an average total of fifteen patient cases (on their caseload) and facilitating ten groups per week.
3. When appropriate qualified professional staff members are not available on a full time basis, arrangements are made to obtain these services on a per diem or part time basis.

R. **RELATED DOCUMENT(S):**

1. Outpatient Behavioral Health Policy: Medical Emergencies
2. Outpatient Behavioral Health Policy: Psychiatric Emergencies

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Smoke Free Environment**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~08/20~~01/25**
Division of Psychiatry Approval:	**~~03/22~~05/25**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE:**
1. To establish a smoke free environment.

B. **POLICY:**
1. It is the responsibility of the Outpatient Behavioral Health Services (OPBHS) to establish and maintain an optimally healthy and safe environment for its patients, employees, medical staff and visitors. Therefore, smoking is prohibited in all areas within the OPBHS.

C. **PROCEDURE:**
1. Who may perform/responsible: OPBHS staff and patients
2. Tri-City Medical Center (TCMC) is a non-smoking facility.
3. All employees are expected to respect and assist in enforcing this policy. Failure to maintain a smoke free environment is a violation of various local and state ordinances.
4. Outside area of OPBHS is not a TCMC property and patients may choose to smoke outside the building.
5. Patients are encouraged to not smoke in the front of the building.
6. Staff will provide patients with information and referrals for smoking cessation.

D. **RELATED DOCUMENT(S):**
1. Administrative Policy: 205 Smoke-Free Environment

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Standards for Clinical and Professional Practice**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~08/20~~01/25**
Division of Psychiatry Approval:	**~~03/22~~05/25**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE:**

1. To provide mandatory standards for Clinical and Professional Practice in Outpatient Behavioral Health Services (OPBHS).

B. **POLICY:**

1. All staff members must act in a professional and appropriate manner at all times at the OPBHS and must treat patients of the OPBHS, as well as each other, with respect and consideration. Accordingly, there are specific, clinically accepted and approved operating standards and principles that all staff members must follow, including, but not limited to, the following specific areas:
2. Community Outings and Diversional/Enrichment Activities:
   a. Certain diversional and enrichment activities can assist patients in developing tools to better understand and identify the natural support and opportunities available in the community after discharge from the OPBHS. However, community outings and diversional or enrichment activities are not a billable service and must not be billed for. Most times, outings are properly classed as enrichment or a diversional activity. Recognizing that at times it may be sensible and clinically appropriate, however enrichment or diversional activities must not be billed.
3. Token Economies, “Bonus" Stores, and Attendance Awards:
   a. Token economies and bonus stores, whether run by staff or patients, as a rule, are not allowed. Only under particular patient circumstances and based upon an individual patient’s treatment plan (and appropriate physician order), might it be approved. Further, any incentive that is likely to influence or induce an individual to receive services, or to continue to receive services, is strictly prohibited. There shall be no attendance awards such as, certificates or award ceremonies, which “reward” a patient for perfect attendance.
4. Recording of Services Provided:
   a. Groups are to be scheduled for a minimum of forty-five (50) minutes. To be credited for having provided a group therapy service to a patient, that patient must have participated in the group for a reasonable amount of time. The service is considered billable only if the patient has participated based on level of symptomatology. These sessions must begin and end on time. There must be absolute integrity and accuracy in the recording of such services.
5. Group Size:
   a. Staffing standards allow for reasonably sized therapy groups. A range of between eight (8) and ten (10) patients per group is optimal for the type of group work being conducted.
6. Use of Stigmatizing Language/Gestures:

a. It is clear that language not only reflects the nature of thinking, but it also shapes the quality of thinking and actions. It is with conviction that an OPBHS culture is created in which the language staff use is congruent with the view that consumers of OPBHS services are whole, adult people. Program is designed to be recovery oriented, strength-based, and focus on instilling hope.
b. Accordingly, it is inappropriate for any staff member to use stigmatizing, or otherwise offensive, language or gestures in the treatment of patients at the OPBHS.

7. Professional Boundaries:
   a. All staff members are required to maintain professional boundaries with patients at all times. It is in the best interest of the patient for staff members to avoid a personal relationship of any kind with patients or any family members or significant others of a current patient who participated in the patient's treatment. No staff member shall socialize or fraternize, by phone, social media, in-person or otherwise, at any time with any patients of the OPBHS, or any family member or significant others of patients who participated in the patient's treatment.
   b. If there's an existing relationship between a staff member and a patient/family member prior to the patient beginning treatment, the staff member must maintain professional boundaries and not engage in any discussions regarding the patient outside of the OPBHS. In addition, the staff member must convey to the treatment team the nature of the existing relationship so that adequate precautions are taken to protect patient's confidentiality.

C. **PROCEDURE:**

1. Who may perform/responsible: OPBHS Staff
2. All clinical and administrative staff members must abide by the above standards in the planning or provision of services or in the operation of the OPBHS. Any practice that conflicts with the above standards is prohibited and could result in disciplinary action, up to and including, termination.
3. If an individual case arises where a patient's physician/Allied Health Professional (AHP) and treatment team believe a patient would clinically benefit from a particular incentive or specific behavioral contract (which appears to be contradictory to the above), the Operations Manager must obtain approval from the Director of Behavioral Health or the Chief Nursing Officer.
4. Any staff member who becomes aware of a suspected compliance issue with respect to the above standards and requirements must report it immediately to his/her Supervisor, or Tri-City Healthcare District (TCHD) Values Line.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: **08/96** **SUBJECT: Substance Abuse**

REVISION DATE: **05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17**

Department Approval:	**~~08/20~~01/25**
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Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval	**n/a**
Board of Directors Approval:	**05/22**

A. **POLICY:**

1. Patients with comorbid substance abuse problems or dual diagnosis may be treated in Outpatient Behavioral Health Services (OPBHS) if they agree to adhere to OPBHS guidelines and if they agree to accept treatment for their substance use problem.
2. Patients are not permitted to attend OPBHS under the influence of alcohol, marijuana or illicit drugs or to bring those substances to OPBHS. Substance abuse is also defined as "misuse of prescribed medications".
    a. An individual under influence can include individuals that use alcohol, marijuana, illicit drugs or misuse prescribed medications the day they are in the program or the night before.
    b. Behaviors that may indicate an individual is under the influence include, someone behaving differently than usual, erratic, with an altered state of consciousness, unpredictable behavior, agitation, excessive sedation, slurred speech, dilated eyes, impaired gait, etc.
3. If the patient's substance use problem becomes so severe that it endangers the patient's safety, interferes with psychiatric treatment, or prevents the patient from benefiting from treatment, a referral to a higher level of care or a substance abuse program may be made.

B. **PROCEDURE:**

1. Who may perform/responsible: OPBHS Clinical and Nursing Staff
2. If substance abuse is detected by OPBHS staff during OPBHS time, the patient will be dismissed for the day. The patient's physician/Allied Health Professional (AHP) will be immediately notified.
3. If the patient may be medically endangered by his substance abuse, the physician/AHP will be notified before the patient is dismissed in order to determine the best approach to take and to assess the need for immediate medical treatment.
4. With collaboration with physicians/Allied Health Professionals, OPBHS staff will determine a safe plan to transport the individual home and to ensure that the individual does not drive under the influence.
5. At the time of dismissal, the patient will be reminded that he/she must meet with the Therapist or treatment team before he/she may continue in the OPBHS. If the patient does not call back within 24 hours, the Therapist will contact the patient to schedule the meeting. The meeting will include consideration of the patient's possible need for substance abuse treatment, within or independent of the OPBHS.
6. If the individual continues in treatment, a contract for continuing participation in the Dual Diagnosis component of the program may be developed. The contract may address various issues, such as substance abuse abstinence, participation in dual diagnosis groups, 12-step meeting attendance, avoidance of high risk places or things, etc.

7. Repeated violations of OPBHS rules concerning substance abuse may result in the patient's discharge from the OPBHS.
8. The incident is documented in the patient's record along with a description of the action taken.
9. Patients are referred to a higher level of care or substance use treatment if they are determined to meet one or more exclusionary criteria, which include:
    a. Lack of interest in being clean or sober and refusal to reduce substance use
    b. Daily excessive drinking or signs of withdrawal and increased tolerance
    c. More than one occasion of coming to OPBHS under the influence
    d. Multiple relapses and refusal to take steps to improve chance of success
    e. Inability to reduce use
    f. Multiple episodes of dishonesty regarding use
    g. High risk of suicide, violence, medical issues, homicide, or severe exacerbation of symptoms associated with use.
    h. Extent of prescription use leads to high risk of self harm
    i. Refusal to communicate with other prescribing physicians/AHPs, or primary care physician (PCP), or family/caregivers combined with severe risk of self harm
    j. Continued use of multiple pharmacies, Emergency Departments (EDs), and physicians/AHPs and refusal to change this high risk behavior
    k. Poses a risk to milieu by influencing other patient to use substances
    l. The team, including the physician, determines that patient has a current primary issue with substance use and can benefit from substance use treatment.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Suicide Assessment**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 09/17

Department Approval:	**~~08/20~~01/25**
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Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE:**

1. To define the course of action necessary when a patient expresses suicidal ideation.

B. **POLICY:**

1. Acutely suicidal patients are not appropriate for Outpatient Behavioral Health Services (OPBHS) and need to be evaluated for inpatient treatment. If a patient is admitted for inpatient care, OPBHS staff will follow the patient's progress and assist in assessing the patient's readiness to return to OPBHS. Patients reporting suicidal ideation will be assessed for level of risk and appropriate interventions will be conducted accordingly.

C. **PROCEDURE:**

1. Who may perform/responsible: OPBHS Clinical Staff.
2. All new patients will undergo an evidence-based suicide risk assessment, such as the Columbia-Suicide Severity Rating Scale (C-SSRS). The assessment is completed at intake by the Clinical staff.
3. If a patient is assessed to be at high risk for suicide, then the staff notifies the physician/Allied Health Professional (AHP) in order to evaluate appropriate level of care needed for the patient.
4. If physician/AHP determines that the patient can safely remain in OPBHS, staff will provide the patient with information on how to access emergency crisis services and will develop a safety plan.
5. The therapist will establish a treatment goal specifically addressing safety for those patients that score moderate to high on the suicide assessment.
6. If, during the course of treatment, the OPBHS staff member becomes aware of a patient's suicidal intentions or actions, he/she becomes responsible for initiating a course of action. That person, or designee, must take necessary precautions to ensure patient’s safety.
7. Assessment will be immediately initiated to determine the risk of the suicidal intent or action.
   a. Some of the factors to consider are: whether the patient has a specific plan to make an attempt, whether the patient is now experiencing circumstances that would enhance the likelihood of the attempt, etc.
8. The staff member who discovers the situation will inform the physician, Clinical Coordinator, and the Operations Manager.
9. An action plan is initiated based on the assessment of acuity.
   a. If a suicide attempt has already been made, the patient is to be transferred immediately to Tri-City Healthcare District’s (TCHD) emergency room by ambulance. A staff member will be designated to notify the patient's physician/AHP and family member or significant other.
   b. If a suicide attempt has not been made, but the threat is considered to be imminent, the

patient's physician/AHP is to be contacted immediately to give direction concerning the patient's disposition. If the patient's attending physician/AHP is not available, the Medical Director will be contacted.

c. Patients that are identified at risk will be closely monitored until they are transported safely for inpatient treatment.

d. Patients that are on close watch will be asked to voluntary give staff their belongings in case they possess any contraband items and to protect their safety.

e. If the threat of suicide is determined not to be imminent, the treatment team will be notified to heighten awareness to possible future suicidal risk and also to plan further treatment interventions. A written safety plan will be developed by the patient and the therapist to help identify warning signs, coping strategies, and emergency resources. If appropriate, the patient's family/support system/Board and Care Manager should be contacted to monitor for safety.

10. Document in the patient's medical record the patient's statements and actions, the assessment process, the disposition of the patient and staff interventions. The patient's Therapist will discuss all verbalizations of suicidal ideation with the patient's attending psychiatrist and the treatment team in order to develop appropriate treatment interventions.

11. The OPBHS staff will contact the Crisis Stabilization Unit/Emergency room, should the patient need a higher level of care to insure continuity of care and to conduct hand-off communication.

D. **RELATED DOCUMENT(S):**

1. Outpatient Behavioral Health: Psychiatric Emergencies

E. **REFERENCES:**

1. The Columbia Suicide Severity Rating Scale (C-SSRS) Supporting Evidence (2023). Retrieved from: The Columbia Suicide Severity Rating Scale (C-SSRS)

2. The Joint Commission National Patient Safety Goals (2025)

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Treatment Planning**

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/06, 06/10, 04/13, 08/17

Department Approval:	**~~08/20~~01/25**
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Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/22~~11/25**
Administration Approval:	**~~05/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **PURPOSE:**

1. To establish the requirements for inter-disciplinary treatment and develop appropriate plan for treatment.

B. **POLICY:**

1. A patient's treatment in the Outpatient Behavioral Health Services (OPBHS) will be guided by a written, individualized, inter-disciplinary, physician approved plan of treatment that abides by all regulatory guidelines. Pursuant to written clinical assessments (see Outpatient Behavioral Health: Clinical Assessment Policy), a master treatment plan (MTP) will be established within seven days of admission. This MTP is reviewed and, as clinically indicated, revised during the course of the patient's participation in OPBHS. It will be developed around medically authorized short-term and long-term treatment goals. These goals will be aimed at enabling the patient to recover and function appropriately at a less intensive level of care in the shortest amount of time possible and will reflect individualized discharge criteria. There is a high value placed upon patient participation in treatment planning and, accordingly, the MTP that is established will reflect a blend of both clinical judgment and patient preference. Psychiatric Diagnoses will be listed on the MTP in accordance with Medicare guidelines. Treatment Plan Reviews will be completed each calendar month thereafter and will incorporate feedback and recommendations provided during treatment planning and review meetings. Partial hospitalization patients will have treatment reviews every two weeks.
2. While the content of the treatment plan is ultimately a medical/clinical responsibility, it is the responsibility of the Operations Manager/designee to manage the treatment planning process and to assure that an up-to-date treatment plan is established and maintained for every patient in the OPBHS throughout the course of his/her treatment.

C. **PROCEDURE:**

1. Who may perform/responsible: OPBHS Clinical Staff
2. The assigned Therapist and the patient meet to begin developing the treatment plan. On the first day of treatment, the problem title is identified by the patient and the therapist. Within the first week of admission, a more comprehensive Master Treatment Plan (MTP) will be developed with input from the clinical team, including the physician, during the treatment team process. The MTP includes:
    a. At least one individual problem title and goal plan that reflects the psychiatric diagnosis, medical necessity for this level of treatment, a list of patient strengths, discharge criteria, and the recommendations of the physician. If the patient also has a diagnosis related to substance use, a second problem title and goal plan may be completed as well.

b. Each individual problem title and goal plan should include a minimum of one short-term goal that directly correlates with the problem title and diagnosis.
c. If the patient carries a medical/physical diagnosis that is treated by an outside physician and has the potential for being addressed in OPBHS (i.e. diabetes), a separate problem title may be opened and indicated as “active” or “monitored”. This determination should be a collaborative effort between clinical and nursing staff.

3. The MTP is presented in treatment team for approval by the seventh calendar day following admission to OPBHS. Patients in the Dual Recovery Treatment Track will have two active problems with at least one goal for each problem. Patient preferences are considered when developing treatment goals. The patient must always be involved in the treatment planning process.
   a. The MTP is developed based on information obtained from a variety of sources. These include past history; current assessments or screenings conducted by the Community Liaison Coordinator, physician/Allied Health Professional (AHP), nurse, and therapist; and information provided by the patient and caregivers. Consistent with the “physician driven treatment” model, the patient’s diagnosis is determined by the physician/AHP and the treatment plan must be approved by the physician/AHP.
4. Treatment interventions should be completed and include the number of days per week they will be attending; any changes in the interventions and frequency of treatment must be ordered by the physician/AHP.
5. All core clinical assessments and any other assessments ordered on admission will be completed before MTP presentation, within seven calendar days of admission. However if the patient does not attend prior to treatment team presentation, or is too anxious to complete the assessment, staff must make an effort to complete all assessments as soon as possible. The Therapist meets with the patient to conduct assessments, explain the treatment planning process and to determine his/her/their preferences concerning possible short and long-term goals and treatment interventions. Discharge planning and discharge criteria will also be discussed as part of the assessment process.
6. An MTP meeting is conducted by the Operations Manager, Clinical Coordinator, or designee, no later than the 7th calendar day following admission for patients in the OPBHS. Staff who have completed assessments will either be present at the meeting or will have submitted written recommendations to the designated Therapist. The Therapist leads an oral case presentation to summarize the reasons for referral to the OPBHS, present a concise clinical formulation and to identify/recommend problems, goals and treatment interventions. The presentation is based on:
   a. The initial CLC Referral and Screening Report;
   b. The physician’s admission orders;
   c. All core and special clinical assessments (Physician Admission Assessment, Nursing Assessment, Fall Risk Assessment Biopsychosocial Assessment, Substance Abuse Assessment, Suicide Risk Assessment and clinical screening questionnaires, such as the PHQ-9, PCL-5, BPRS and GAD-7);
   d. The patient’s stated treatment preferences;
   e. Problem Title and Short Term Goals that are measurable, specific and descriptive of the patient’s behavior and what they will do.
   f. Clinical impressions of the patient's initial response to treatment; and
   g. Other available clinical history/collateral information
7. The presentation of the patient is to include:
   a. Physical description;
   b. Diagnosis;
   c. Strengths
   d. Brief history of psychiatric illness;
   e. Current medications;
   f. Previous psychiatric hospitalizations (total number and most current);
   g. Specifically what triggered this admission, including any psychosocial stressors;
   h. Summary of recommendations from clinical assessments; and

i. Problem title and goals.
j. The treatment team is responsible for finalizing a MTP for each patient. The MTP is to be completed by the therapist and is reviewed in treatment team and approved by the OPBHS psychiatrist.

8. Patients' active participation in treatment planning is vital. The Therapist meets with the patient to review the MTP and obtain the patient's approval.
9. Routinely, at the prescribed treatment plan review intervals, the Therapist meets with the patient to assess his/her perspective on treatment progress and to review goal status, making goal and treatment modifications as necessary.
10. A review of each patient's treatment plan is conducted monthly for intensive outpatient and bi-weekly for partial hospitalization patients (depending on FI guidelines) at which time the Therapist once again leads a case presentation. This presentation will be preceded by the Therapist's review of all progress notes since the last MTP meeting. The purpose of the presentation is to summarize progress and to determine the need for any changes to identified problems, goals, treatment interventions or discharge criteria.
11. The Therapist completes any agreed upon treatment plan revisions with patient input and obtains approval from the patient and the treatment team.
12. To promote successful completion of treatment goals and positive outcomes, the patient's primary therapist will maintain contacts with patient's family members and outside providers as warranted. In addition, the therapist or the OPBHS Service Coordinator may assist patient with coordinating any outside services needed.

D. **RELATED DOCUMENT(S):**

1. CLC Referral and Screening Report
2. Outpatient Behavioral Health Policy: Clinical Assessment

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	**11/09**	**SUBJECT:**	**Behavior Management/Supervision Technique**
REVISION DATE:	**03/10, 03/12, 05/12, 01/18**		

Rehabilitation Department Approval:	**~~08/22~~08/25**
Department of Medicine Approval:	**~~08/22~~11/25**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**09/22**
Administration Approval:	**~~11/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**11/22**

A. **POLICY:**

1. All potentially violent and/or suspicious behavior will be dealt with immediately to prevent any harm to patients and staff.

B. **PROCEDURE:**

1. Responsibility/who may perform:
   a. The individuals responsible for performing behavior management/supervision during **patient care:**~~transport to the Rehabilitation Gym are the following:~~
      i. Physical Therapists and Physical Therapy Assistants who have active licenses to practice in the State of California.
      ii. Occupational Therapists and Occupational Therapist Assistants who have active licenses to practice in the State of California.
      iii. Speech Language Pathologists who have active licenses to practice in the State of California.
      iv. Assistants will be directly supervised by a therapist within the respective discipline.
   b. ~~To maintain safety during patient transport to/from~~ **If a patient becomes violent or suspicious behavior is observed in the** Rehabilitation Services Gym area, move the patient to another area or remove the other patients from the area and call for staff assistance ~~when violent or suspicious behavior is observed~~.
   c. Should an event occur, the staff member will gather all information regarding behavior and assess the patient's mental status.
   d. Implement the most appropriate response, which may be a time-out or verbal de-escalation techniques.
   e. Physical restraint is not used as a clinical intervention. If a patient becomes violent, a "Dr. Strong" code must be called immediately by dialing 66 in the hospital. If the patient becomes violent at an offsite location, 911 should be called immediately.
   f. The **Manager**~~Director~~ or designee will meet with all staff involved to process the incident. The team will discuss the effectiveness of actions taken and ways to improve future responses to similar occurrences.
   g. Submit required documentation when necessary and forward to the Risk Management Department.
   h. Document the incident and staff response in the patient's medical record.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE: **07/91** **SUBJECT:** **Job Site Assessment**

REVISION DATE: **11/94, 01/06, 01/09**
REVIEW DATE: **05/00, 01/03, 04/12, 02/18**

Department Approval:	**08/22**
Department of Medicine Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~11/22~~12/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**11/22**

A. **POLICY:**

1. Provide Tri-City employees and outside companies with a Job Site Assessment upon request and written agreement with Tri-City Medical Center**.**

B. **PROCEDURE:**

1. For Tri-City Medical Center (TCMC) employee work-related injuries, employee health will refer the employee to Concentra for evaluation and treatment. Once doctor recommends ergonomic evaluation, a referral request will be submitted by Concentra to the WC carrier for authorization. Once authorized, the referral will be forwarded to **Employee Health** ~~the Rehab Director or Manager~~ via email **or referral request** ~~(if internal) or electronic/paper referral (if external).~~
2. For TCMC employee non work-related injuries, but need for ergo assessment, employee **will need a referral from their primary physician for evaluation and treatment.** ~~will talk to their supervisor and their supervisor will submit a request for an ergonomic evaluation through Employee Health~~. **The request/paper referral for an ergonomic evaluation is submitted through and approved by Employee Health. The Department Manager may request ergonomic assessment for their department.** There will be no charges for in-house, non-injury related ergonomic assessments.
3. A physical or occupational therapist will be designated to provide the evaluation, and ~~they~~ will **coordinate directly** ~~work out a time~~ with the employee to schedule the evaluation. The onsite evaluation will include a thorough assessment of the workstation. The evaluation will focus on specified workstation setup relative to tasks, positions, repetitive motions, lifting, and proper body mechanics. A video camera may be used for assessment of findings and interpretation of data.
4. A written report of findings will be completed upon conclusion of the analysis. Included in the report will be recommendations regarding workstation design, tools, equipment modification, and education**al strategies** ~~programs~~ to help increase worker safety and efficiency.
5. A copy of all reports, and **pictures,** ~~videotapes~~ if applicable, will be maintained in the **Employee Health records.**~~Rehabilitation Services area~~. One copy of each final report will be **emailed** ~~forwarded~~ to **Employee Health, the employee's manager, and the Purchasing Department.** ~~the appointed designee for placement in the company master file or saved on the network shared drive.~~

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

October 30, 2025 – 1:30 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 1:30 p.m. on October 30, 2025.

The following Directors constituting a quorum of the Board of Directors were present:

Director Sheila Brown
Director Nina Chaya, M.D.
Director George W. Coulter
Director Rocky J. Chavez
Director Gigi S. Gleason
Director Tracy M. Younger

Absent: Director Adela I. Sanchez

Also present were:

Gene Ma, M.D., Chief Executive Officer
Anh Nguyen, Chief Financial Officer
Mohamad Jamshidi-Nezhad, D.O., Chief of Staff
Robert Lee, M.D., Chief of Staff Elect
Susan Bond, General Counsel
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. Chairperson Younger called the meeting to order at 1:30 p.m. with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Gleason and seconded by Director Sanchez to approve the agenda as presented. The motion passed (6-0-0-1) with Director Sanchez absent.

3. Oral Announcement of Items to be discussed during Closed Session

   Chairperson Younger made an oral announcement of the items listed on the October 30, 2025 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Reports Involving Trade Secrets, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees and one matter of Potential Litigation

4. Motion to go into Closed Session

   It was moved by Director Coulter and seconded by Director Gleason to go into Closed Session at 1:35 p.m. The motion passed (6-0-0-1) with Director Sanchez absent.

5. At 3:05 p.m., the Board returned to Open Session with attendance as previously noted.

6. Report from Board Counsel on any action taken in Closed Session.

Board Counsel Scott reported he would give a report regarding any action taken in Closed Session at the beginning of today's open session.

7. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 3:05 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Adela I. Sanchez
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS

October 30, 2025 – 3:30 o'clock p.m.

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at 3:30 p.m. on October 2, 2025.

The following Directors constituting a quorum of the Board of Directors were present:

Director Sheila Brown
Director Rocky J. Chavez
Director Nina Chaya, M.D.
Director George W. Coulter
Director Gigi Gleason
Director Tracy M. Younger

Absent: Director Adela I. Sanchez

Also present were:

Dr. Gene Ma, Chief Executive Officer
Jeremy Raimo, Chief Operating Officer
Donald Dawkins, Chief Nurse Executive
Anh Nguyen, Chief Financial Officer
Mark Albright, Chief Information Officer
Roger Cortez, Chief Compliance Officer
Jennifer Paroly, Foundation President
Mohamad Jamshidi-Nezhad, DO, Chief of Staff
Susan Bond, General Counsel
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. Board Chairperson Younger called the meeting to order at 3:30 p.m. with attendance as listed above.

2. Report from Closed Session

   Board Counsel Jeff Scott reported the Board in Closed Session discussed proposed new programs and services and took no action.

   The Board also discussed one Potential Litigation matter and took no action.

   Finally, the Board heard a report on a Quality Assurance matter and took no action.

3. Pledge of Allegiance

   Director Chavez led the Pledge of Allegiance.

4. Approval of Agenda

It was moved by Director Chavez and seconded by Director Brown to approve the agenda as presented. The motion passed (6-0-0-1) with Director Sanchez absent.

5. Public Comments – Announcement

Chairperson Younger read the Public Comments section listed on the October 30, 2025 Regular Board of Directors Meeting Agenda.

6. September, 2025 Financial Statements – Anh Nguyen, Chief Financial Officer

Anh Nguyen, Chief Financial Officer reported on the FYTD financials as follows (Dollars in Thousands):

Current month financials as follows (Dollars in Thousands):

- Net Operating Revenue – $27,240
- Operating Expense – $30,457
- EBITDA – $3,503
- EROE – $2,065

Fiscal YTD financials as follows (Dollars in Thousands):

- Net Operating Revenue - $83,550
- Operating Expense - $88,928
- Total Non-Operating Revenue (Expenses) - $7,657
- EROE - $2,279
- EBITDA - $6,578

Fiscal YTD Key Indicators as follows:

- Average Daily Census – 120.4
- Average Acute Length of Stay (ALOS) – 5.01
- Adjusted Patient Days – 20,123
- Surgery Cases –1,297
- ED Visits – 12,206

Anh also presented graphs including EBITDA and EROE, Average Daily Census, Average Length of Stay and Paid Full Time Equivalents per Adjusted Occupied Bed (13 Month Trend).

9. New Business –

a) Consideration to approve the Design Bid Proposal from CPM Project Management, LLC in collaboration with the District for the Underground Storage Tank (UST) Replacement Project in an amount not to exceed $2,198,167 and further approve additional costs (regulatory directives and necessary field changes) of $644,000 for a total project cost of $2,842,167.

Jeremy Raimo, Chief Operations Officer outlined a proposal to remove two single-wall underground storage tanks to meet the state's double-wall requirement. The plan calls for installing two above-ground tanks that will provide four days of

backup power, ensuring compliance with Joint Commission standards for a top-rated hospital.

It was moved by Director Chavez to approve the Design Bid Proposal from CPM Project Management, LLC in collaboration with the District for the Underground Storage Tank (UST) Replacement Project in an amount not to exceed $1,198,167, and further approve additional costs (regulatory directives and necessary field changes) of $644,000 for a total project cost of $2,842,167. Director Brown seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Brown Chavez, Chaya, Coulter, Gleason and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Sanchez**

b) Consideration to approve an agreement with Renew Medical Group for Comprehensive Anesthesia Services for a term of 24 months, beginning December 9, 2025 and ending December 8, 2027, for an annual cost of $3,224,688 and a total term cost of $6,449,476.

Dr. Ma, CEO stated that the new anesthesia services contract is effectively cost neutral but switches to a different contractor to better support the hospital's goal of creating a cost-plus model to manage rising market costs.

It was moved by Director Brown to approve an agreement with Renew Medical Group for Comprehensive Anesthesia Services for a term of 24 months, beginning December 9, 2025 and ending December 8, 2027, for an annual cost of $3,224,688 and a total term cost of $6,449,478. Director Gleason seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Brown Chavez, Chaya, Coulter, Gleason and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Sanchez**

a) Consideration to approve 2026 Employee Benefits.

Harjit Randhawa, VP/Human Resources reported that all employee benefits for 2026 will remain the same as 2025, with no changes to contributions or coverage. The only update is a shift in the medical provider network. Beginning January 2026, Tri-City Healthcare District will move from UnitedHealthcare to Sharp Health Plan for both HMO and PPO options, reflecting continued collaboration with Sharp Healthcare.

It was moved by Director Chaya to approve the 2026 Employee Benefits. Director Gleason seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Brown Chavez, Chaya, Coulter, Gleason and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Sanchez**

10. Old Business – None

11. Chief of Staff –

Consideration of October 2025 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on October 27, 2025.

Dr. Mohamad Jamshidi-Nezhad, Chief of Staff presented the October 2025 Credentialing Actions and Reappointments involving the Medical Staff and Allied Health Professionals.

It was moved by Director Brown to approve the October 2025 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on October 27, 2025. Director Coulter seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Brown Chavez, Chaya, Coulter, Gleason and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Sanchez**

12. Consideration of Consent Calendar

It was moved by Director Gleason to approve the Consent Agenda as presented. Director Coulter seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Brown, Chavez, Chaya, Coulter, Gleason and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Sanchez**

13. Discussion of items pulled from Consent Calendar

There were no items pulled from the Consent Calendar.

14. Comments by Members of the Public

There were no comments by members of the public.

15. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 3:45 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Adela Sanchez
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

October 30, 2025 – 4:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 4:00 p.m. on October 30, 2025.

The following Directors constituting a quorum of the Board of Directors were present:

Director Sheila Brown
Director Nina Chaya, M.D.
Director George W. Coulter
Director Rocky J. Chavez
Director Adela I. Sanchez
Director Gigi S. Gleason
Director Tracy M. Younger

Also present were:

Gene Ma, M.D., Chief Executive Officer
Jeff Scott, Board Counsel
Chris Howard, Chief Executive Officer, Sharp Healthcare
Brett McClain, Chief Operating Officer, Sharp Healthcare
Scott Evans, Chief Strategy Officer, Sharp Healthcare
Teri Donnellan, Executive Assistant

1. Chairperson Younger called the meeting to order at 4:00 p.m. with attendance as listed above.

2. Roll Call/Pledge of Allegiance

   Director Chavez led the Pledge of Allegiance.

3. Approval of the Agenda

   It was moved by Director Sanchez and seconded by Director Chavez to approve the agenda as presented. The motion passed unanimously (7-0).

4. Public Comments – Announcement

   Chairperson Younger read the Public Comments section listed on the October 30, 2025 Special Board of Directors Meeting Agenda.

5. Community Forum to the Affiliation Agreement, Transfer Agreement and Hospital Lease between Tri-City Healthcare District and Sharp Healthcare

   A Community Forum was held at Tri-City Medical Center in which presentations were given by Dr. Gene Ma, Tri-City Healthcare District CEO, Chris Howard, Sharp Healthcare CEO, Jeff Scott, Board Counsel and related to the Affiliation Agreement, Transfer Agreement and Lease Agreement.

   At the conclusion of the presentations, the meeting was opened for public comments.

6. Public Input and Comments

The Board heard comments from residents of Oceanside, Carlsbad and Vista, primarily in support of the partnership.

7. Board Discussion

The Board expressed its sincere appreciation to Chris Howard and the Sharp team, as well as to Dr. Ma and Board Counsel Jeff Scott, for their informative and thoughtful presentations. Board members also conveyed their gratitude for the strong community turnout and encouraged the public to continue engaging neighbors and friends in support of the coming together of two great institutions.

Additional Community Forums are scheduled for the following dates:

- November 6, 2025 – Oceanside Library
- November 7, 2025 - Vista Civic Center
- November 12, 2025 - Carlsbad Senior Center
- November 13, 2025 - Tri-City Medical Center

7. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 5:30 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Adela I. Sanchez
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

November 6, 2025 – 5:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 5:00 p.m. on November 6, 2025.

The following Directors constituting a quorum of the Board of Directors were present:

Director Sheila Brown
Director Nina Chaya, M.D.
Director George W. Coulter
Director Rocky J. Chavez
Director Adela I. Sanchez
Director Gigi S. Gleason
Director Tracy M. Younger

Also present were:

Gene Ma, M.D., Chief Executive Officer
Jeff Scott, Board Counsel
Chris Howard, Chief Executive Officer, Sharp Healthcare
Brett McClain, Chief Operating Officer, Sharp Healthcare
Rita Essaian, Chief People Officer, Sharp Healthcare
Teri Donnellan, Executive Assistant

1. Chairperson Younger called the meeting to order at 5:00 p.m. with attendance as listed above.

2. Roll Call/Pledge of Allegiance

   Director Chavez led the Pledge of Allegiance.

3. Approval of the Agenda

   It was moved by Director Gleason and seconded by Director Brown to approve the agenda as presented. The motion passed unanimously (7-0).

4. Public Comments – Announcement

   Chairperson Younger read the Public Comments section listed on the November 6, 2025 Special Board of Directors Meeting Agenda.

5. Community Forum to the Affiliation Agreement, Transfer Agreement and Hospital Lease between Tri-City Healthcare District and Sharp Healthcare

   A Community Forum was held at the Oceanside Library in which presentations were given by Dr. Gene Ma, Tri-City Healthcare District CEO, Chris Howard, Sharp Healthcare CEO, Jeff Scott, Board Counsel and Rita Essaian, Chief People Officer, Sharp Healthcare related to the Affiliation Agreement, Transfer Agreement and Lease Agreement.

At the conclusion of the presentations, the meeting was opened for public comments.

6. Public Input and Comments

The Board heard comments from residents of Oceanside, Carlsbad and Vista, primarily in support of the partnership.

7. Board Discussion

The Board expressed its sincere appreciation to Chris Howard and the Sharp team, as well as to Dr. Ma and Board Counsel Jeff Scott, for their informative and thoughtful presentations. Board members also conveyed their gratitude for the strong community turnout and encouraged the public to continue engaging neighbors and friends in support of the coming together of two great institutions.

Additional Community Forums are scheduled for the following dates:

- November 7, 2025 - Vista Civic Center
- November 12, 2025 - Carlsbad Senior Center
- November 13, 2025 - Tri-City Medical Center

8. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 6:30 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Adela I. Sanchez
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

November 7, 2025 – 5:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 5:00 p.m. on November 7, 2025.

The following Directors constituting a quorum of the Board of Directors were present:

Director Sheila Brown
Director Nina Chaya, M.D.
Director George W. Coulter
Director Rocky J. Chavez
Director Adela I. Sanchez
Director Gigi S. Gleason
Director Tracy M. Younger

Also present were:

Gene Ma, M.D., Chief Executive Officer
Jeff Scott, Board Counsel
Chris Howard, Chief Executive Officer, Sharp Healthcare
Brett McClain, Chief Operating Officer, Sharp Healthcare
Rita Essaian, Chief People Officer, Sharp Healthcare
Teri Donnellan, Executive Assistant

1. Chairperson Younger called the meeting to order at 5:00 p.m. with attendance as listed above.

2. Roll Call/Pledge of Allegiance

   Director Chavez led the Pledge of Allegiance.

3. Approval of the Agenda

   It was moved by Director Chavez and seconded by Director Brown to approve the agenda as presented. The motion passed unanimously (7-0).

4. Public Comments – Announcement

   Chairperson Younger read the Public Comments section listed on the November 7, 2025 Special Board of Directors Meeting Agenda.

5. Community Forum to the Affiliation Agreement, Transfer Agreement and Hospital Lease between Tri-City Healthcare District and Sharp Healthcare

   A Community Forum was held at the Vista Civic Center in which presentations were given by Dr. Gene Ma, Tri-City Healthcare District CEO, Chris Howard, Sharp Healthcare CEO, Jeff Scott, Board Counsel and Rita Essaian, Chief People Officer, Sharp Healthcare related to the Affiliation Agreement, Transfer Agreement and Lease Agreement.

At the conclusion of the presentations, the meeting was opened for public comments.

6. Public Input and Comments

The Board heard comments from residents of Oceanside, Carlsbad and Vista, primarily in support of the partnership.

7. Board Discussion

The Board expressed its sincere appreciation to Chris Howard and the Sharp team, as well as to Dr. Ma and Board Counsel Jeff Scott, for their informative and thoughtful presentations. Board members also conveyed their gratitude for the strong community turnout and encouraged the public to continue engaging neighbors and friends in support of the coming together of two great institutions.

Additional Community Forums are scheduled for the following:

- November 12, 2025 – Carlsbad Senior Center
- November 13, 2025 - Tri-City Medical Center

8. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 6:20 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Adela I. Sanchez
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS
November 12, 2025 – 5:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 5:00 p.m. on November 12, 2025.

The following Directors constituting a quorum of the Board of Directors were present:

Director Nina Chaya, M.D.
Director George W. Coulter
Director Rocky J. Chavez
Director Adela I. Sanchez
Director Gigi S. Gleason
Director Tracy M. Younger

Absent was Director Sheila Brown

Also present were:

Gene Ma, M.D., Chief Executive Officer
Jeff Scott, Board Counsel
Scott Evans, Chief Strategy Officer, Sharp Healthcare
Brett McClain, Chief Operating Officer, Sharp Healthcare
Rita Essaian, Chief People Officer, Sharp Healthcare
Teri Donnellan, Executive Assistant

1. Chairperson Younger called the meeting to order at 5:00 p.m. with attendance as listed above.

2. Roll Call/Pledge of Allegiance

   Director Chavez led the Pledge of Allegiance.

3. Approval of the Agenda

   It was moved by Director Sanchez and seconded by Director Chavez to approve the agenda as presented. The motion passed (6-0-0-1) with Director Brown absent.

4. Public Comments – Announcement

   Chairperson Younger read the Public Comments section listed on the November 12, 2025 Special Board of Directors Meeting Agenda.

5. Community Forum to the Affiliation Agreement, Transfer Agreement and Hospital Lease between Tri-City Healthcare District and Sharp Healthcare

   A Community Forum was held at the Carlsbad Senior Center in which presentations were given by Dr. Gene Ma, Tri-City Healthcare District CEO, Scott Evans, Chief Strategy Officer for Sharp Healthcare, Jeff Scott, Board Counsel and Rita Essaian, Chief People Officer for Sharp Healthcare related to the Affiliation Agreement, Transfer Agreement and Lease Agreement.

At the conclusion of the presentations, the meeting was opened for public comments.

6. Public Input and Comments

The Board heard comments from residents of Oceanside, Carlsbad and Vista, all in support of the partnership.

7. Board Discussion

The Board expressed its sincere appreciation to Scott Evans and the Sharp team, as well as to Dr. Ma and Board Counsel Jeff Scott, for their informative and thoughtful presentations. Board members also conveyed their gratitude for the strong community turnout and encouraged the public to continue engaging neighbors and friends in support of the coming together of two great institutions.

The final Community Forum will be held November 13, 2025 at Tri-City Medical Center.

8. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 6:35 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Adela I. Sanchez
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS
November 13, 2025 – 5:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 5:00 p.m. on November 13, 2025.

The following Directors constituting a quorum of the Board of Directors were present:

Director George W. Coulter
Director Adela I. Sanchez
Director Gigi S. Gleason
Director Tracy M. Younger

Absent was Director Sheila Brown, Director Rocky Chavez and Director Nina Chaya

Also present were:

Gene Ma, M.D., Chief Executive Officer
Jeff Scott, Board Counsel
Scott Evans, Chief Strategy Officer, Sharp Healthcare
Brett McClain, Chief Operating Officer, Sharp Healthcare
Rita Essalein, Chief People Officer, Sharp Healthcare
Teri Donnellan, Executive Assistant

1. Chairperson Younger called the meeting to order at 5:00 p.m. with attendance as listed above.

2. Roll Call/Pledge of Allegiance

   Chairperson Younger led the Pledge of Allegiance.

3. Approval of the Agenda

   It was moved by Director Gleason and seconded by Director Coulter to approve the agenda as presented. The motion passed (4-0-0-3) with Directors Brown, Chavez and Chaya absent.

4. Public Comments – Announcement

   Chairperson Younger read the Public Comments section listed on the November 13, 2025 Special Board of Directors Meeting Agenda.

5. Community Forum to the Affiliation Agreement, Transfer Agreement and Hospital Lease between Tri-City Healthcare District and Sharp Healthcare.

   A Community Forum was held at the Tri-City Medical Center in which presentations were given by Dr. Gene Ma, Tri-City Healthcare District CEO, Scott Evans, Chief Strategy Officer for Sharp Healthcare, Jeff Scott, Board Counsel and Rita Essaian, Chief People Officer for Sharp Healthcare related to the Affiliation Agreement, Transfer Agreement and Lease Agreement.

   At the conclusion of the presentations, the meeting was opened for public comments.

6. Public Input and Comments

The Board heard comments from residents of Oceanside, Carlsbad and Vista, all in support of the partnership.

7. Board Discussion

The Board expressed its sincere appreciation to Scott Evans and the Sharp team, as well as to Dr. Ma and Board Counsel Jeff Scott, for their informative and thoughtful presentations. Board members also conveyed their gratitude for the strong community turnout during each of the Community Forums encouraged the public to continue engaging neighbors and friends in support of the coming together of two great institutions

8. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 6:20 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Adela I. Sanchez
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

December 3, 2025 – 4:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 4:00 p.m. on December 3, 2025.

The following Directors constituting a quorum of the Board of Directors were present:

Director Sheila Brown
Director Nina Chaya, M.D.
Director George W. Coulter
Director Rocky J. Chavez
Director Gigi S. Gleason
Director Adela I. Sanchez
Director Tracy M. Younger

Also present were:

Gene Ma, M.D., Chief Executive Officer
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. Chairperson Younger called the meeting to order at 4:00 p.m. with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Chavez and seconded by Director Sanchez to approve the agenda as presented. The motion passed unanimously (7-0).

3. Oral Announcement of Items to be discussed during Closed Session

   Chairperson Younger made an oral announcement of the items listed on the December 3, 2025 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Reports Involving Trade Secrets and Public Employee Evaluation: CEO.

4. Motion to go into Closed Session

   It was moved by Director Coulter and seconded by Director Gleason to go into Closed Session at 4:05 p.m. The motion passed unanimously (7-0).

5. At 5:55 p.m., the Board returned to Open Session with attendance as previously noted.

6. Report from Board Counsel on any action taken in Closed Session.

   Board Counsel Scott reported that the Board met in Closed Session and discussed reports regarding Trade Secrets pursuant to Health & Safety Code Section 32106 and took no action.

The Board also discussed the Public Employee Evaluation of the CEO pursuant to Government Code Section 54957(b)(4) for the evaluation of the Chief Executive Officer. The Board voted 4-3 with Directors Gleason, Sanchez, and Brown in opposition to direct Board Counsel to bring back an Amendment to the CEO's Employment Agreement which provides for a 10% increase in his base salary retroactive to July 15, 2025.

7. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 6:15 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Adela I. Sanchez
Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending October 31, 2025

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	(a)	56,415.02	07/01/17	06/30/27	**OSNC - Carlsbad** 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011	7095
Cardiff Investments LLC 2729 Ocean St Carlsbad, CA 92008 V#83204	Approx 10,218	$2.58	(a)	44,563.91	07/01/17	08/31/26	**OSNC - Oceanside** 3905 Waring Road Oceanside, CA 92056	7095
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.70	(a)	20,594.69	07/01/20	06/30/30	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA 92081	7090
SoCAL Heart Property LLC 1958 Via Centre Drive Vista, Ca 92081 **V#84195**	Approx 4,995	$2.50	(a)	23,026.37	10/01/22	06/30/27	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081	7095
BELLA TIERRA INVESTMENTS, LLC 841 Prudential Dr, Suite 200 Jacksonville, FL 32207 V#84264	Approx 2,460	$2.21	(a)	8,511.41	04/01/23	03/31/26	**La Costa Urology** 3907 Waring Road, Suite 4 Oceanside, CA 92056	7082
Mission Camino LLC 4350 La Jolla Village Drive San Diego, CA 92122 V#83757	Appox 4,508	$1.75	(a)	16,914.69	05/14/21	10/31/31	**Seaside Medical Group** 115 N EL Camino Real, Suite A Oceanside, CA 92058	7094
Nextmed III Owner LLC 6125 Paseo Del Norte, Suite 210 Carlsbad, CA 92011 V#83774	Approx 4,553	$4.00	(a)	25,808.13	09/01/21	08/31/33	**PCP Clinic Cairsbad** 6185 Paseo Del Norte, Suite 100 Carlsbad, CA 92011	7090
500 W Vista Way, LLC & HFT Melrose P O Box 2522 La Jolla, CA 92038 V#81028	Approx 7,374	$1.67	(a)	14,055.70	07/01/21	06/30/26	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083	7320
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	Approx 7,000	$4.12	(a)	34,420.00	10/01/22	09/30/29	**North County Oncology Medical Clinic** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
SCRIPPSVIEW MEDICAL ASSOCIATES P O Box 234296 Encinitas, CA 234296 V#83589	Approx 3,864	$3.45	(a)	15,786.75	06/01/21	05/31/26	**OSNC Encinitas Medical Center** 351 Santa Fe Drive, Suite 351 Encinitas, CA 92023	7095
BELLA TIERRA INVESTMENTS, LLC 841 Prudential Dr, Suite 200 Jacksonville, FL 32207 V#84264	Approx 3,262	$2.21	(a)	11,556.77	05/01/23	04/30/26	**Pulmonary Specialists of NC** 3907 Waring Road, Suite 2 Oceanside, CA 92056	7088
Total				**271,653.44**				

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending October 2025

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8610	HOTEL	93025 EXP	370.71	83370	ROCKY JOHN CHAVEZ
8620	ACHD	536	850.00	5212	ACHD
8620	ACHD	537	850.00	5212	ACHD
8560	WORKPLACE CONF	100125 EXP	369.20	83668	HOGAN TANIA
8560	WORKPLACE CONF	100125 EXP	181.36	83668	HOGAN TANIA
8740	ASTR CE COURSE	102325 EDU	125.00	82343	TRACEY, MIKE
8740	MSN	100925 EDU	200.00	79284	FRENCH, JENESSA
8756	CPHQ CERT	100925 EXP	519.00	82852	KRUSSEL, SHIRLEY

**This report shows reimbursements to employees and Board members in the Education & Travel expense category in excess of $100.00.
**Detailed backup is available from the Finance department upon request.