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Attorney General

State of California
DEPARTMENT OF JUSTICE



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December 17, 2021

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Sent via email

RE: Proposed Change in Control and Governance of St. Mary Medical Center

Dear Mr. Miller and Mr. Owens:

Pursuant to Corporations Code section 5920 et seq., the Attorney General hereby conditionally consents to the proposed change in control and governance of St. Mary Medical Center, part of Providence St. Joseph Health, a Nonprofit Health System, through an Affiliation Agreement with Kaiser Foundation Hospitals, a California Nonprofit Public Benefit Corporation, and their investments in St. Mary Medical Center, LLC, a California limited liability LLC.

Corporations Code section 5923 and California Code of Regulations, title 11, section 999.5, subdivision (f) set forth factors that the Attorney General shall consider in determining whether to consent to a proposed transaction between nonprofit corporations or entities. The Attorney General has considered such factors and consents to the proposed transaction subject to the attached conditions that are incorporated by reference herein.

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Please also find enclosed a copy of the expert's supplemental report.

Sincerely,

A handwritten signature in cursive script that reads "Lily Weaver". The signature is written in black ink and is underlined with a single horizontal stroke.

LILY WEAVER
Deputy Attorney General

For ROB BONTA
Attorney General

LGW: Enclosures as stated.

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SUMMARY LISTS OF CONDITIONS

Condition I: Identifies the entities that are legally bound by the conditions.

Condition II: Identifies the transaction documents and requires notice of any changes. Establishes Attorney General review process for modification or rescission of transaction document terms. Requires notice of physician services agreements involving competing Kaiser and Providence medical groups.

Condition III: Requires 60 days' notice of any transfer or change in governance/control.

Condition IV: Requires a 24-hour emergency room with specific services at the New Hospital for up to six years and that, in the interim, the parties maintain the existing emergency room at the current hospital for up to 10 years.

Condition V: Requires specific services at the New Hospital for up to six years, and that, in the interim, the parties maintain existing services at the current hospital for up to 10 years. Requires equal access to hospital beds regardless of the payor.

Condition VI: Finds and declares that certain outpatient clinics and the Bright Futures Mobile Van program are an important resource for the High Desert region and encourages continued collaboration with these programs.

Condition VII: Requires a study on reuse of the current hospital site within three years and the consideration of certain alternatives, such as selling the hospital and operating a freestanding emergency room or mental health facility.

Condition VIII: Requires continued participation in Medi-Cal and Medicare at the New Hospital for up to six years and that, in the interim, the parties maintain participation in Medi-Cal and Medicare at the current hospital for up to 10 years. Requires maintaining Medi-Cal Managed Care and county contracts.

Condition IX: Requires at least \$4.7 million in annual charity care at the New Hospital for up to six years and that, in the interim, the parties maintain annual charity care at the current hospital for up to 10 years. Requires the maintenance of a charity care policy no less favorable than the current policy.

Condition X: Requires certain steps to inform patients and their representatives of the Financial Assistance Policy, such as posting the policy within the hospital and online.

Condition XI: Requires at least \$25 million in community benefit programs at the New Hospital for up to six years, and that, in the interim, the parties maintain community benefit programs at the current hospital for up to 10 years. Requires \$750,000 annually to the St. Joseph Health Community Partnership Fund for the next five years.

Condition XII: Requires maintenance of existing contracts with state and local governments at the New Hospital for six years and that, in the interim, the parties maintain these contracts at the current hospital for up to 10 years.

Condition XIII: Requires a community board for the duration of Condition XI and consultation with the community board prior to making any non-emergency changes to services or community benefit programs.

Condition XIV: Requires maintaining privileges for current medical staff in good standing.

Condition XV: Prohibits discrimination on the basis of protected personal characteristics.

Condition XVI: Requires adoption, posting, and maintenance of policies to ensure equal access to healthcare without discrimination on the basis of sex, gender, gender identity, and gender expression at the New Hospital and the current hospital.

Condition XVII: Requires that Kaiser ensure Kaiser patients full and equal access to services without discrimination at the New Hospital and the current hospital. Requires a study plan to evaluate specific alternatives, such as building a separate facility under Kaiser's sole control and obtaining admitting privileges at another local hospital. Requires reporting.

Condition XVIII: Requires a study plan to address employee retention and morale issues and other working condition issues at the current hospital.

Condition XIX: Requires Behavioral Health Quality Improvement Program (BH-QIP) plan with measurable outcomes to address mental and behavioral health challenges in the community. Requires reporting.

Condition XX: Requires a feasibility study for opening a trauma center at the New Hospital.

Condition XXI: Ensures separation of Kaiser and Providence as separate businesses by prohibiting requiring Kaiser's supermajority approval under certain circumstances, including approval of third party payor contracts. Prohibits most-favored-nation clauses in Kaiser's Medi-Cal and Medicare contracts. Caps profit sharing by Kaiser to 20 percent and prohibits Kaiser from guaranteeing SMMC's profit margin.

Condition XXII: Imposes certain requirements on Kaiser's reimbursement contract with SMMC such as capping their commercial price discount. Disputes related to SMMC bed availability related to third party payor contracts are subject to arbitration. Delays self-funded Kaiser payor discount.

Condition XXIII: Allows the Attorney General to appoint an independent monitor for compliance with Conditions XXIV, XXV, XXVI, XXVII, the competitive impact conditions, for six years at the New Hospital and for up to 10 years at the existing hospital in the interim, with the possibility of continuing for five additional years. Describes the monitor's powers and duties, including reporting obligations. Prohibits retaliation.

Condition XXIV: Imposes price increase caps on SMMC's commercial payor contracts, and price caps for managed Medicare and Medi-Cal contracts. Caps out-of-network reimbursement for emergency and essential services.

Condition XXV: Prohibits Providence from engaging in “all-or-nothing” contracting or requiring a payer to enter an exclusive contract or agree to “anti-tiering” or “anti-steering” contract terms.

Condition XXVI: Ensures independent negotiation of payor contracts for the duration of any Agreement listed in Condition II.

Condition: XXVII: Requires that Providence, SMMC, and Heritage on the one hand continue to run as separate businesses from Kaiser and SCPMG on the other hand for the duration of any Agreement listed in Condition II. Prohibits sharing of certain employees and managers and sharing of certain competitively sensitive information.

Condition: XXVIII: Requires that Providence, Heritage, and SMMC on the one hand and Kaiser and SCPMG on the other hand shall maintain their respective existing transactional, reporting, and information systems and prevent the sharing of certain competitively sensitive information.

Condition XXIX: Requires an annual report on compliance with the conditions for their duration.

Condition XXX: Requires information to be provided to this office during monitoring.

Condition XXXI: The Attorney General reserves the right to enforce conditions and to recover attorneys’ fees and costs.

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Attorney General’s Conditions to Proposed Change in Control and Governance of St. Mary Medical Center, Part of Providence St. Joseph Health, a Nonprofit Health System, Through an Affiliation Agreement with Kaiser Foundation Hospitals, a California Nonprofit Public Benefit Corporation, and Their Investments in St. Mary Medical Center, LLC, a California Limited Liability LLC.

I.

These Conditions shall be legally binding on the following entities: St. Mary Medical Center,(SMMC),¹ a California nonprofit public benefit corporation; Covenant Health Network (Covenant), a California nonprofit public benefit corporation that is a member of SMMC; Providence St. Joseph Health (Providence), a Washington nonprofit corporation that is the ultimate parent company of SMMC; St. Mary Medical Center, LLC (SMMC LLC), a California limited liability company; Kaiser Foundation Health Plan, a California nonprofit public benefit corporation and Kaiser Foundation Hospitals, a California nonprofit public benefit corporation (collectively, Kaiser); Southern California Permanente Medical Group (SCPMG), a California general partnership; any other subsidiary, parent, general partner, limited partner, member, affiliate, successor, successor in interest, assignee, or person or entity serving in a similar capacity of SMMC, Covenant, Providence, SMMC LLC, SCPMG, or Kaiser; any entity succeeding thereto as a result of consolidation, affiliation, merger, or acquisition of all or substantially all of the real property or operating assets of SMMC or the real property on which SMMC is located; any entity succeeding thereto as a result of consolidation, affiliation, merger, or acquisition of all or substantially all of the real property or operating assets of the New Hospital² or the real property on which the New Hospital is located; any and all current and future owners, lessees, licensees, or operators of SMMC or the New Hospital; and any and all

¹ Throughout this document, the term “SMMC” shall include the 213 bed general acute care hospital located at 18300 Highway 18, Apple Valley, CA 92307 and any other clinics, laboratories, units, services, or beds included on the license issued to “St. Mary Medical Center” by the California Department of Public Health, effective December 22, 2020, unless otherwise indicated. The Contribution Agreement states that the business and operations of SMMC have been transferred to SMMC LLC. Further the Operating Agreement indicates that SMMC LLC will operate both the existing Hospital in Apple Valley, California and a general acute care successor to SMMC to be constructed in Victorville, California. Unless otherwise specified in a Condition, “SMMC” refers to both hospital operations.

² Throughout this document, the term “New Hospital” shall include the general acute care hospital successor to SMMC that will be operated by SMMC LLC. It is understood that the New Hospital will have at least 260 beds and be built on land described in Schedule 1.1(a) to the Contribution Agreement by and between SMMC, SMMC LLC, and their respective parent companies dated May 7, 2021.

current and future lessees and owners of the real property on which SMMC or the New Hospital is located.

To the extent necessary and proper to administer the following Conditions, these Conditions shall also be binding on Providence Medical Foundation (Heritage), a California nonprofit public benefit corporation that provides physician services to Providence; St. Joseph Health System (St. Joseph), a California nonprofit public benefit corporation that is a member of SMMC; and any other subsidiary, parent, general partner, limited partner, member, affiliate, successor, successor in interest, assignee, or person or entity serving in a similar capacity of Heritage, St. Joseph, any entity succeeding thereto as a result of consolidation, affiliation, merger, or acquisition of all or substantially all of the real property or operating assets of the respective entities or the real property on which the respective entities are located, any and all current and future owners, lessees, licensees, or operators of the respective entities, and any and all current and future lessees and owners of the real property on which the respective entities are located.

II.

The transaction approved by the Attorney General consists of the Affiliation Agreement, the Contribution Agreement, the Operating Agreement, the Care Model Agreement, the Management Services Agreement, two License Agreements, and the Health Care Services Agreements by and between SMMC, SMMC LLC, Kaiser, SCPMG and their respective parent companies noticed May 7, 2021, and any and all amendments, agreements, or documents referenced in or attached as an exhibit or schedule to any of the foregoing agreements (collectively, the Affiliation Agreement).

All of the entities listed in Condition I shall obtain all approvals required to fulfil the terms of the Affiliation Agreement including, but not limited to, any exhibits or schedules to the Affiliation Agreement, and shall notify the Attorney General in writing of the approval and of any modifications or rescissions. Such notifications shall be provided at least ninety (90) days after the entity listed in the Condition obtains approval. Within ninety (90) days of receiving notice, the Attorney General will decide whether the proposed modification or rescission will affect the factors set forth in Corporations Code section 5923 and require the amendment of these Conditions. Upon receiving the Attorney General's determination, the entities listed in Conditions I shall, as applicable, request an amendment of these Conditions pursuant to title 11, section 999.5, subdivision (h) of the California Code of Regulations.

Upon failing to obtain any approval required to fulfill the terms of the Affiliation Agreement, the entities listed in Condition I shall notify the Attorney General in writing. Such notifications shall be provided at least ninety (90) days after the entity listed in Condition I determines that it has failed to obtain approval.

All of the entities listed in Condition I shall fulfill the terms of the Affiliation Agreement, including any exhibits or schedules to the Affiliation Agreement, and shall notify the Attorney

General in writing of any proposed modification or rescission of any of the terms of the Affiliation Agreement. Such notifications shall be provided at least sixty (60) days prior to the effective date of the proposed modification or rescission. Within ninety (90) days of receiving notice, the Attorney General will decide whether the proposed modification or rescission will affect the factors set forth in Corporations Code section 5923 and require the amendment of these Conditions. Upon receiving the Attorney General's determination, the entities listed in Condition I shall, as applicable, request an amendment of these Conditions pursuant to title 11, section 999.5, subdivision (h) of the California Code of Regulations.

All of the entities listed in Condition I shall notify the Attorney General in writing of any proposed modification or rescission of any of the terms of the Affiliation Agreement that relate to any provision of physician services by SCPMG or Heritage outside of the provision of general acute care services performed at SMMC or the New Hospital. Such notifications shall be provided at least sixty (60) days prior to the effective date of the proposed modification or rescission. Within ninety (90) days of receiving notice, the Attorney General will decide whether the proposed modification or rescission will affect the factors set forth in Corporations Code section 5923 and require the amendment of these Conditions. Upon receiving the Attorney General's determination, the entities listed in Condition I shall, as applicable, request an amendment of these Conditions pursuant to title 11, section 999.5, subdivision (h) of the California Code of Regulations.

III.

For the greater of ten (10) years from the Closing Date of the Affiliation Agreement while the existing Hospital continues to operate or six (6) years from the commencement of operations at the New Hospital, the entities listed in Condition I shall be required to provide written notice to the Attorney General sixty (60) days prior to entering into any agreement or transaction to do any of the following:

- a) Sell, transfer, lease, exchange, option, convey, manage, or otherwise dispose of SMMC or SMMC LLC; or
- b) Transfer control, responsibility, management, or governance of SMMC or SMMC LLC. The substitution or addition of a new corporate member or members of SMMC or SMMC LLC that transfers the control of, responsibility for, or governance of SMMC or SMMC LLC shall be deemed a transfer for purposes of this Condition. The substitution or addition of one or more members of the governing bodies of SMMC or SMMC LLC, or any arrangement, written or oral, that would transfer voting control of the members of the governing bodies of SMMC or SMMC LLC, shall also be deemed a transfer for purposes of this Condition.

In no event shall the duration of this Condition last longer than fifteen (15) years in total from the Closing Date of the Affiliation Agreement.

IV.

For the greater of ten (10) years from the Closing Date of the Affiliation Agreement while the existing Hospital continues to operate or six (6) years from the commencement of operations at the New Hospital, the entities listed in Condition I shall operate and maintain SMMC and the New Hospital, as applicable, as a licensed general acute care hospital (as defined in California Health and Safety Code section 1250) and shall maintain and provide 24-hour emergency and trauma medical services at no less than current³ licensure, designations and certification with the same types and/or levels of services, including the following:

- a) Forty-four (44) Emergency Treatment Stations;
- b) Designation as an Emergency Department Approved for Pediatrics (EDAP);
- c) Designation as a Paramedic Base Station; and
- d) Certification as an Advanced Primary Stroke Center.

In no event shall the duration of this Condition last longer than fifteen (15) years in total from the Closing Date of the Affiliation Agreement.

V.

For the greater of ten (10) years from the Closing Date of the Affiliation Agreement while the existing Hospital continues to operate or six (6) years from the commencement of operations at the New Hospital, the entities listed in Condition I shall maintain and provide the following healthcare services at current licensure and designation at SMMC and the New Hospital, as applicable, with the current types and/or levels of services:

- a) Pediatric services;
- b) Cardiology services, including two (2) cardiac catheterization labs and the designation as a STEMI Receiving Center;
- c) Critical care services, including a minimum of twenty (20) intensive care beds;
- d) Obstetric services, including a minimum of sixteen (16) obstetrics beds;
- e) Neonatal intensive care services, including designation as a Level IIIB Neonatal Intensive Care Unit with a minimum of eight (8) neonatal intensive care beds;

³ The term “current” or “currently” throughout this document means as of January 19, 2021.

- f) California Children’s Services (CCS) certification⁴ to allow the facility to keep CCS-eligible neonatal intensive care patients at the hospital, thereby allowing these patients and their families to stay and receive care without being transferred outside the service area;
- g) Diabetes care services;
- h) Imaging and radiology services;
- i) Laboratory services;
- j) Rehabilitation services;
- k) Surgical services;
- l) Wound care services; and
- m) Women’s health services, including full reproductive health services, and mammography services.

In no event shall the duration of this Condition last longer than fifteen (15) years in total from the Closing Date of the Affiliation Agreement.

Notwithstanding Condition II or any “set aside” and to ensure equal access to healthcare without discrimination, beds at SMMC and the New Hospital shall be made available to patients without respect to their payor and on a first-come-first-served basis. The Attorney General may extend this first-come-first-served provision for five (5) additional years in his, her, or their sole discretion, but under no event shall the total duration of this provision last longer than fifteen (15) years in total from the Closing Date of the Affiliation Agreement.

VI.

The Attorney General finds and declares that the following programs are an important resource for the High Desert region⁵:

- a) The SMMC Community Health Center located at 18077 Outer Highway 18, Suite 100, in Apple Valley, CA;

⁴ It is understood that SMMC’s CCS certification number is currently 7.13.102.

⁵ It is understood that SMMC transferred these programs and facilities to St. Jude Neighborhood Health Centers, a California nonprofit public benefit corporation that operates as a federally qualified health center, on August 24, 2020.

- b) The SMMC Community Health Center Hesperia Clinic located at 17071 Main Street in Hesperia, CA;
- c) The SMMC Health Beginnings Adelanto Clinic located at 11424 Chamberlain Way, Suite 9, in Adelanto, CA; and
- d) The Bright Futures Mobile Van Program.

The Attorney General encourages the entities listed in Condition I to collaborate with these programs to ensure continued access to healthcare throughout the High Desert region.

VII.

Within three (3) years of the Closing Date of the Affiliation Agreement, SMMC, SMMC LLC, Covenant, and Providence, as applicable, shall complete a comprehensive plan for the reuse of the existing SMMC site and facilities in Apple Valley once the New Hospital is operational and admitting patients. The plan shall include consideration of the following alternatives:

- a) Operating or retaining a third-party to operate a freestanding emergency department at the current SMMC site in Apple Valley for at least ten (10) years from the time that the New Hospital becomes operational and begins admitting patients;
- b) Operating or retaining a third-party to operate a freestanding mental health facility at the current SMMC site in Apple Valley for at least ten (10) years from the time that the New Hospital becomes operational and begins admitting patients;
- c) Selling the current SMMC site and facilities in Apple Valley to a buyer capable of continuing to operate it as a licensed general acute care hospital for at least ten (10) years from the time that the New Hospital becomes operational and begins admitting patients without deterioration in quality of care; and
- d) Any other feasible alternatives that the entities listed in Condition I see fit to consider.

The plan shall be submitted to the Attorney General in writing within three (3) years of the Closing Date of the Affiliation Agreement. The Attorney General will make the plan available for public review and written comment for thirty (30) days. After considering the plan, any comments received, and any response submitted by any of the entities listed in Condition I, the Attorney General will decide within one hundred and eighty (180) days of the close of the comment period whether to consent to, give conditional consent to, or not consent to the plan. In making a decision, the Attorney General will consider community need, community support, and financial viability. Complying with and implementing the plan shall become a requirement of this Condition upon the plan's approval or conditional approval by the Attorney General.

VIII.

For the greater of ten (10) years from the Closing Date of the Affiliation Agreement while the existing Hospital continues to operate or six (6) years from the commencement of operations at the New Hospital, the entities listed in Condition I shall⁶:

- a) Be certified to participate in the Medi-Cal program at SMMC and the New Hospital, as applicable;
- b) Maintain Medi-Cal Managed Care and county contracts in effect as of May 7, 2021, the Notice Date of the Affiliation Agreement, to provide the same types and/or levels of emergency and non-emergency services at SMMC and the New Hospital, as applicable, to Medi-Cal beneficiaries (both county and Medi-Cal Managed Care) as required in these Conditions, on the same terms and conditions as other similarly situated hospitals offering substantially the same services, without any loss, interruption of service or diminution in quality, or gap in contracted hospital coverage, unless the contract is terminated by either party for cause or not extended or renewed by a Medi-Cal Managed Care Plan or county on its own initiative without cause;
- c) Maintaining Medi-Cal Managed Care or county contracts includes the renewal of such contracts for ten (10) years from the Closing Date of the Affiliation Agreement on the same terms and conditions as the Medi-Cal Managed Care plan or county's prior contract that may have expired, lapsed, or been terminated since May 7, 2021, the Notice Date of the Affiliation Agreement, unless the contract was terminated by a Medi-Cal Managed Care Plan or county on its own initiative without cause; and
- d) Be certified to participate in the Medicare program by maintaining a Medicare Provider Number to provide the same types and/or levels of emergency and non-emergency services at SMMC and the New Hospital, as applicable, to Medicare beneficiaries (both Traditional Medicare and Medicare Managed Care) as required in these Conditions.

In no event shall the duration of this Condition last longer than fifteen (15) years in total from the Closing Date of the Affiliation Agreement.

IX.

For the greater of ten (10) years from the Closing Date of the Affiliation Agreement while the existing Hospital continues to operate or six (6) years from the commencement of operations at

⁶ This obligation applies to SMMC, SMMC LLC, Covenant, and Providence, as applicable, with respect to the existing Hospital and to all the entities listed in Condition I with respect to the New Hospital.

the New Hospital, the entities listed in Condition I⁷ shall provide an annual amount of Charity Care (as defined below) at SMMC and the New Hospital, as applicable, equal to or greater than \$4.7 million (the Minimum Charity Care Amount) as adjusted under the methodology described below.⁸

For purposes hereof, the term “charity care” shall mean the amount of charity care costs (not charges) incurred by SMMC and the New Hospital, as applicable, in connection with the operation and provision of services at SMMC and the New Hospital, as applicable. The definition and methodology for calculating “charity care” and the methodology for calculating “costs” shall be the same as that used by the California Department of Health Care Access and Information (HCAI) for annual hospital reporting purposes.⁹

SMMC and SMMC LLC shall use and maintain a charity care policy that is no less favorable than SMMC’s Financial Assistance Policy (attached as Exhibit 1) and in compliance with California and Federal law.

For the second year and each subsequent year, the Minimum Charity Care Amount shall increase yearly by 4.049 percent.¹⁰

If the actual amount of charity care provided at SMMC or the New Hospital, as applicable, for any year is less than the Minimum Charity Care Amount (as adjusted pursuant to the above-referenced Consumer Price Index) required for such year, SMMC or SMMC LLC, as applicable,

⁷ This obligation applies to SMMC, SMMC LLC, Covenant, and Providence, as applicable, with respect to the existing Hospital and to all the entities listed in Condition I with respect to the New Hospital.

⁸ It is understood that this figure is consistent with the historic level of charity care provided by SMMC as calculated based on the average hospital charity care expenditure during 2017, 2018, and 2019, the most recent three (3) years prior to the Closing Date for which data are available and determined in accordance with HCAI standards.

⁹ HCAI defines charity care by contrasting charity care and bad debt. According to HCAI, “the determination of what is classified as ... charity care can be made by establishing whether or not the patient has the ability to pay. The patient’s accounts receivable must be written off as bad debt if the patient has the ability but is unwilling to pay off the account.” OSHPD [now HCAI], Accounting and Reporting Manual for California Long-Term Care Facilities § 1064 (1992), <https://oshpd.ca.gov/wp-content/uploads/2020/10/Chpt1000-1.pdf>.

¹⁰ It is understood that this percentage corresponds to the three-year rolling average of the yearly change in the Annual Percent increase in the 12 Months Percent Change: Medical Care Consumer Price Index for Riverside-San Bernardino-Ontario CA Base Period: December 2017=100 (as published by U.S. Bureau of Labor Statistics) between 2018 and 2020.

shall pay an amount equal to the deficiency to one or more tax-exempt entities that provide direct healthcare services to residents in the service area including and surrounding Adelanto, Apple Valley, Helendale, Hesperia, Lucerne Valley, Oro Grande, Phelan, Pinon Hills and Victorville, including the 92307, 92345, 92308, 92395, 92392, 92301, 92394, 92356, 92368, 92342, 92344, 92340, 92393, 92371, 92372, and 92328 ZIP codes. Such payment(s) shall be made within six (6) months following the end of such year.

In no event shall the duration of this Condition last longer than fifteen (15) years in total from the Closing Date of the Affiliation Agreement.

X.

Within ninety (90) days from the Closing Date of the Affiliation Agreement and for at least the duration of Condition IX, SMMC and SMMC LLC shall take the following steps to ensure that patients at SMMC and the New Hospital, respectively, are informed about SMMC and SMMC LLC's Financial Assistance Policy (Financial Assistance Policy):

- a) A copy of the Financial Assistance Policy and the plain language summary of the Financial Assistance Policy shall be posted in a prominent location in the admissions area and any other location in SMMC and the New Hospital, as applicable, where there is a high volume of patient traffic, including waiting rooms, billing offices, and outpatient service settings;
- b) A copy of the Financial Assistance Policy, the Financial Assistance Application Form, and the plain language summary of the Charity Care and Cash Price Policies shall be posted in a prominent place on SMMC's and the New Hospital's website, as applicable;
- c) If requested by a patient, a copy of the Financial Assistance Policy, Financial Assistance Application Form, and the plain language summary shall be sent by mail at no cost to the patient;
- d) As necessary and at least on an annual basis, SMMC and SMMC LLC, as applicable, will place an advertisement regarding the availability of financial assistance at SMMC and the New Hospital in a newspaper of general circulation in the communities served by SMMC and the New Hospital, or issue a Press Release to widely publicize the availability of the Financial Assistance Policy to the communities served by SMMC and the New Hospital;
- e) On no less than an annual basis, SMMC and SMMC LLC, as applicable, will work with affiliated organizations, physicians, community clinics, other health care providers, houses of worship, and other community-based organizations to notify members of the community (especially those who are most likely to require financial assistance) about the availability of financial assistance at SMMC and the New Hospital, as applicable; and
- f) No later than sixty (60) days after the Closing Date of the Affiliation Agreement, SMMC and SMMC LLC shall train all staff who interact with patients and their families concerning payment of services to make patients and their families aware of and informed about the availability of

financial assistance at SMMC and the New Hospital, as applicable. SMMC and SMMC LLC shall also provide this training on an annual basis to staff who interact with patients and their families.

XI.

For the greater of ten (10) years from the Closing Date of the Affiliation Agreement while the existing Hospital continues to operate or six (6) years from the commencement of operations at the New Hospital, the entities listed in Condition I¹¹ shall provide an annual amount of Community Benefit Services at SMMC and the New Hospital, as applicable, equal to or greater than \$25,227,158 (the Minimum Community Benefit Services Amount) exclusive of any funds from grants, as adjusted under the methodology described below.

For the second year and each subsequent year, the Minimum Community Benefit Amount shall increase yearly by 4.049 percent.¹²

If the actual amount of community benefit services provided at SMMC or the New Hospital, as applicable, for any year is less than the Minimum Community Benefit Services Amount (as adjusted pursuant to the above-referenced Consumer Price Index) required for such year, SMMC or SMMC LLC, as applicable, shall pay an amount equal to the deficiency to one or more tax exempt entities that provide community benefit services for residents in the service area including and surrounding Adelanto, Apple Valley, Helendale, Hesperia, Lucerne Valley, Oro Grande, Phelan, Pinon Hills and Victorville, including the 92307, 92345, 92308, 92395, 92392, 92301, 92394, 92356, 92368, 92342, 92344, 92340, 92393, 92371, 92372, and 92328 ZIP codes. Such payment(s) shall be made within six (6) months following the end of such year.

In no event shall the duration of this Condition last longer than fifteen (15) years in total from the Closing Date of the Affiliation Agreement.

¹¹ This obligation applies to SMMC, SMMC LLC, Covenant, and Providence, as applicable, with respect to the existing Hospital and to all the entities listed in Condition I with respect to the New Hospital.

¹² It is understood that this percentage corresponds to the three-year rolling average of the yearly change in the Annual Percent increase in the 12 Months Percent Change: Medical Care Consumer Price Index for Riverside-San Bernardino-Ontario CA Base Period: December 2017=100 (as published by U.S. Bureau of Labor Statistics) between 2018 and 2020.

For the next five (5) years from the Closing Date of the Affiliation Agreement, the entities listed in Condition I shall allocate \$750,000 annually¹³ to the St. Joseph Health Community Partnership Fund to support low income and underserved populations in SMMC's and the New Hospital's primary and secondary service areas.

XII.

For the greater of ten (10) years from the Closing Date of the Affiliation Agreement while the existing Hospital continues to operate or six (6) years from the commencement of operations at the New Hospital, the entities listed in Condition I¹⁴ shall maintain all contracts, including any superseding, successor, or replacement contracts, and any amendments and exhibits thereto, with local governments or their subdivisions, departments, or agencies for services at SMMC or the New Hospital, as applicable, unless otherwise terminated by the local government or the State, as applicable, including the following:

- a) 340B Drug Pricing Program Memorandum of Understanding, dated March 27, 2018, between Providence, SMMC and the Town of Apple Valley;
- b) Clinical Training Affiliation Agreement (without School Instructor on Hospital Premises), dated July 24, 2019, between SMMC and Apple Valley Unified School District;
- c) Affiliation Agreement (without School Instructor on Hospital Premises), dated July 1, 2018, between SMMC and Apple Valley Unified School District;
- d) Memorandum of Understanding, dated March 4, 2014, between SMMC and Inland Counties Emergency Medical Agency;
- e) Contract No. 20.527, dated July 1, 2020, between SMMC and Inland Counties Emergency Medical Agency;
- f) Contract No. 20.541, dated July 1, 2020, between SMMC and Inland Counties Emergency Medical Agency;
- g) Agreement for Consultant Services, dated October 1, 2019, between SMMC and Oro Grande Elementary School District;

¹³ It is understood that this amount represents the average annual contribution from SMMC to the fund from 2018 to 2021.

¹⁴ This obligation applies to SMMC, SMMC LLC, Covenant, and Providence, as applicable, with respect to the existing Hospital and to all the entities listed in Condition I with respect to the New Hospital.

- h) Contract No. 19-268, dated April 30, 2019, between SMMC and the County of San Bernardino;
- i) Memorandum of Understanding, dated June 3, 2019, between SMMC and the County of San Bernardino;
- j) Contract No. 17-763, dated September 26, 2017, between SMMC and the County of San Bernardino Department of Behavioral Health;
- k) Contract No. 18-105, dated March 13, 2018, between SMMC and the County of San Bernardino on behalf of Arrowhead Regional Medical Center; and
- l) Letter re: San Bernardino County Probation Department's Payment Policy and Procedures for Medical Treatment for Juveniles, dated June 28, 2004, by the County of San Bernardino to SMMC.

In no event shall the duration of this Condition last longer than fifteen (15) years in total from the Closing Date of the Affiliation Agreement.

XIII.

For the duration of Condition XI, entities listed in Condition I shall maintain a community board at SMMC and the New Hospital, as applicable, including physicians and community representatives. The entities listed in Condition I shall consult with the community board at least sixty (60) days prior to making any non-emergency changes to services or community benefit programs at SMMC and the New Hospital. The community board may comment on all reports submitted to the Attorney General regarding compliance with these Conditions and such comments shall be included in the written report provided to the Attorney General pursuant to Condition XXIX.

XIV.

SMMC shall maintain privileges for current medical staff at SMMC and the New Hospital who are in good standing as of the Closing Date of the Affiliation Agreement. Further, the closing of the Affiliation Agreement shall not change the medical staff officers, committee chairs, or independence of the medical staff, and such persons shall remain in good standing for the remainder of their tenure as medical staff officers or committee chairs at SMMC and the New Hospital. This condition is not intended to preclude medical staff leadership changes as warranted for operational flexibility in accordance with the medical staff bylaws in effect on the Closing Date.

XV.

The entities listed in Condition I shall prohibit discrimination at SMMC and the New Hospital on the basis of any protected personal characteristic identified in state and federal civil rights laws, including section 51 of the California Civil Code and title 42, section 18116 of the United States Code. Categories of protected personal characteristics include:

- a) Gender, including sex, gender, gender identity, and gender expression;
- b) Intimate relationships, including sexual orientation and marital status;
- c) Ethnicity, including race, color, ancestry, national origin, citizenship, primary language, and immigration status;
- d) Religion;
- e) Age; and
- f) Disability, including disability, protected medical condition, and protected genetic information.

XVI.

Within one (1) year of the Closing Date of the Affiliation Agreement, the entities listed in Condition I¹⁵ shall adopt policies for SMMC and the New Hospital to ensure equal access to healthcare without discrimination on the basis of sex, gender, gender identity, and gender expression. SMMC and SMMC LLC shall prominently post these policies on their website and shall train all staff who interact with patients and their families on compliance with the policies on an annual basis.

XVII.

Kaiser shall ensure full and equal access to healthcare for all Kaiser patients in the High Desert region without discrimination by Kaiser physicians, employees, and contractors at SMMC and the New Hospital. This obligation includes the prevention of discrimination on the basis of any protected personal characteristic listed in Condition XV and the elimination of maternal mortality, maternal morbidity, and other health disparities on the basis of any protected personal characteristic listed in Condition XV.

¹⁵ This obligation applies to SMMC, SMMC LLC, Covenant, and Providence, as applicable, with respect to the existing Hospital and to all the entities listed in Condition I with respect to the New Hospital.

Within one (1) year of the Closing Date of the Affiliation Agreement, Kaiser shall prepare a plan to ensure full and equal access to healthcare for all Kaiser patients in the High Desert region without discrimination by Kaiser physicians, employees, and contractors at SMMC and the New Hospital. The plan shall be submitted to the Attorney General in writing and accompanied by a comprehensive study of all feasible alternatives, including but not limited to the following:

a) Constructing or designating a separate facility under Kaiser's sole control at or in close proximity to the New Hospital to enable Kaiser physicians, employees, and contractors to: (i) make clinical decisions consistent with the standard of care and their independent professional judgment, respecting the needs and wishes of each individual patient; (ii) inform patients of all of their healthcare options; (iii) prescribe any interventions that are medically necessary and appropriate; (iv) transfer or refer patients to other facilities whenever they determine it is in the patient's interests; and (v) provide any item or service they deem in their professional judgment to be necessary and appropriate in the event of an emergency, without restriction, and without seeking approval from any non-provider, including any items or services where referral or transfer to another facility would, in their sole professional judgment, risk material deterioration to the patient's condition;

b) Obtaining admitting privileges at a nearby non-Kaiser hospital for Kaiser physicians, employees, or contractors to: (i) make clinical decisions consistent with the standard of care and their independent professional judgment, respecting the needs and wishes of each individual patient; (ii) inform patients of all of their healthcare options; (iii) prescribe any interventions that are medically necessary and appropriate; (iv) transfer or refer patients to other facilities whenever they determine it is in the patient's interests; and (v) provide any item or service they deem in their professional judgment to be necessary and appropriate in the event of an emergency, without restriction, and without seeking approval from any non-provider, including any items or services where referral or transfer to another facility would, in their sole professional judgment, risk material deterioration to the patient's condition;

c) Directing affected patients to another Kaiser hospital to receive the medically indicated prevention, diagnosis, and treatment without unreasonable delay and establishing a standard and process for compensating affected patients for any resulting harm relating to the transfer; and

d) Developing a mechanism to proactively inform Kaiser patients of any limitations on services provided at SMMC and the New Hospital that might otherwise be offered if the patient were at a strictly Kaiser facility and to further inform them of any alternative options.

The Attorney General will make the proposed plan available for public review and written comment for thirty (30) days. After considering the plan, any comments received, and any response submitted by any of the entities listed in Condition I, the Attorney General will decide within one hundred and eighty (180) days of the close of the comment period whether to consent to, give conditional consent to, or not consent to the plan. In making a decision, the Attorney

General will consider community need, community support, and financial viability. Complying with and implementing the plan shall become a requirement of this Condition upon the plan's approval or conditional approval by the Attorney General.

Within one (1) year of the Closing Date of the Affiliation Agreement, Kaiser shall develop and implement a process for receiving and resolving complaints from Kaiser physicians, employees, and contractors if they believe that their professional judgment or freedom to counsel patients, prescribe medication or services, refer or transfer them to Kaiser or other alternative locations for care, or provide emergency items and services, including any necessary items and services to any patient for whom referral or transfer to another facility would risk material deterioration to the patient's condition, is being impeded in any way at SMMC or the New Hospital.

Within one (1) year of the Closing Date of the Affiliation Agreement, Kaiser shall also establish a formal process for Kaiser patients receiving care at SMMC and the New Hospital to share concerns or complaints regarding access to comprehensive healthcare services or discrimination in the provision of such services, including any concerns raised about perceived impediments to accessing comprehensive reproductive healthcare, gender affirming services, or end-of-life care.

Kaiser shall provide a written description of both processes described in the two prior paragraphs to the Attorney General within one (1) year of the Closing Date of the Affiliation Agreement. Kaiser shall provide a written report of any complaints received under either process in the previous year and their resolution in the annual reports to the Attorney General described below in Condition XXIX.

XVIII.

Within one (1) year of the Closing Date of the Affiliation Agreement, SMMC and Providence shall complete a plan to address employee retention and morale issues and other working condition issues at SMMC and submit the plan to the Attorney General in writing. As part of this process, SMMC and Providence shall convene and solicit input from an advisory committee of nursing staff, including at least one nurse from each department or specialty, and such other advisory committees as SMMC and Providence see fit.¹⁶

The Attorney General will make the proposed plan available to SMMC staff and their labor organizations for confidential review and written comment for thirty (30) days. Copies of any labor organization comments received will be provided to SMMC and Providence. After considering the report, any comments received, and any response submitted by any of the entities listed in Condition I, the Attorney General will decide within one hundred and eighty (180) days of the close of the comment period whether to consent to, give conditional consent to, or not

¹⁶ It is understood that employee participation in an advisory committee shall constitute protected concerted activity under section 157 of title 29 of the United States Code.

consent to the plan. Complying with and implementing the plan shall become a requirement of this Condition upon the plan's approval or conditional approval by the Attorney General.

Retaliation or threats of retaliation based on any entity, or individual having provided information in conjunction with Condition XVIII to the Attorney General or to a court is prohibited.

XIX.

Within three (3) years of the Closing Date of the Affiliation Agreement, the entities listed in Condition I shall complete, implement, and deliver to the Attorney General a Behavioral Health Quality Improvement Program (BH-QIP) plan with measurable outcomes to address mental and behavioral health challenges in the community. The Attorney General will make the proposed plan available for public review and written comment for thirty (30) days. After considering the report, any comments received, and any response submitted by any of the entities listed in Condition I, the Attorney General will decide within one hundred and eighty (180) days of the close of the comment period whether to consent to, give conditional consent to, or not consent to the plan. In making a decision, the Attorney General will consider community need, community support, and financial viability. Complying with and implementing the plan shall become a requirement of this Condition upon the plan's approval or conditional approval by the Attorney General.

For the duration of Condition XXIX, the entities listed in Condition I shall include an annual report on progress toward those goals in annual reports filed pursuant to Condition XXIX.

XX.

Within three (3) year of the Closing Date of the Affiliation Agreement, the entities listed in Condition I shall complete a comprehensive study of the feasibility of opening a trauma center at the New Hospital and present their findings to the Attorney General in a public report. The Attorney General will make the report available for public review and written comment for thirty (30) days. After considering the report, any comments received, and any response submitted by any of the entities listed in Condition I, the Attorney General will decide within one hundred and eighty (180) days of the close of the comment period whether to consent to, give conditional consent to, or not consent to the study's findings. In making a decision, the Attorney General will consider community need, community support, and financial viability. Complying with and implementing the study's findings shall become a requirement of this Condition upon approval or conditional approval by the Attorney General.

XXI.

Any of the entities listed in Condition I shall not, directly or indirectly:¹⁷

Require Kaiser's consent, supermajority approval, or any other form of input from Kaiser to agree to approve or authorize any strategic plan for SMMC, except to the extent the approval or authorization concerns SMMC's right of first refusal to participate in a competing business in the High Desert Region to provide general acute care hospital services or the strategic plan for the care and treatment of Kaiser patients at SMMC;¹⁸

Require Kaiser's consent, supermajority approval, or any other form of input from Kaiser to approve or authorize any annual marketing plans for SMMC, except to the extent the approval or authorization concerns SMMC's participation in a Commercial or Government-Sponsored Product offered by Kaiser;

¹⁷ None of the entities listed in Condition I, including Kaiser, may use this Condition to vitiate any of the other Conditions, including, but not limited to, Conditions XXII, XXIII, XXIV, XXV, XXVI, XXVII, XXVIII.

¹⁸ The following definitions apply throughout these Conditions:

a) "Payor" means a company that provides health insurance policies or makes hospital networks accessible for residents in San Bernardino County. The term "payor" also includes, but is not limited to, self-funded or self-insured employers and managed behavioral health management organizations that do the foregoing, as well as independent physician associations (IPAs), who in turn provide capitated services, under a limited or restricted Knox-Keane license from the Department of Managed Health Care to any payor who sells any commercial, Medicare, and Medi-Cal health plans of any kind or makes any networks available to self-funded or self-insured employers, union trusts, or state and local government entities.

b) "Commercial or Government-Sponsored Product" means a commercial or government sponsored product (e.g., Medicare Advantage plans, Medi-Cal Managed Care plans, or county mental health plans) offered by a payor.

c) "High Desert Region" means the service area including and surrounding Adelanto, Apple Valley, Helendale, Hesperia, Lucerne Valley, Oro Grande, Phelan, Pinon Hills and Victorville, including the 92307, 92345, 92308, 92395, 92392, 92301, 92394, 92356, 92368, 92342, 92344, 92340, 92393, 92371, 92372, and 92328 ZIP codes.

Require Kaiser's consent, supermajority approval, or any other form of input from Kaiser to approve an annual operating budget for SMMC until the commencement of operations at the New Hospital, and at the New Hospital, only to the extent the approval or authorization concerns the operating budget necessary for the care and treatment of Kaiser patients at SMMC;

Require Kaiser's consent, supermajority approval, or any other form of input from Kaiser to approve or authorize any unbudgeted capital or operating expenditures by SMMC until the commencement of operations at the New Hospital, and at the New Hospital, only to the extent the approval or authorization concerns expenditures necessary for the care and treatment of Kaiser patients at SMMC;

Require Kaiser's consent, supermajority approval, or any other form of input from Kaiser to approve or authorize unbudgeted incurrence, assumption, or guarantee of any indebtedness or other borrowings by SMMC until the commencement of operations at the New Hospital, and at the New Hospital, only to the extent the approval or authorization concerns unbudgeted incurrence, indebtedness, or borrowing necessary for the care and treatment of Kaiser patients at SMMC;

Require Kaiser's consent, supermajority approval, or any other form of input from Kaiser to establish reserves for SMMC until the commencement of operations at the New Hospital, and at the New Hospital, only to the extent the approval or authorizations concerns reserves necessary for the care and treatment of Kaiser patients at SMMC;

Require Kaiser's consent, supermajority approval, or any other form of input from Kaiser to approve or authorize any agreements between SMMC and a payor;

Require that Kaiser's Medicare and Medi-Cal prices for general acute care hospital services that are being performed at SMMC depend on the prices paid by any other payor for services, or that any applicable discounts be tied in any way to SMMC's operating revenue, expenses, or profit margin;

Require that any self-funded or self-insured payors, whom have a contract with Kaiser for administrative or management services, receive any discount tied in any way to SMMC's operating revenue, expenses, or profit margin.

Kaiser shall not, directly or indirectly:

Obtain more than 20 percent of the net income, earnings, cash distributions, or otherwise share in more than 20 percent of the revenue generated by SMMC;

Guarantee the difference between SMMC's operating revenue and operating expenses through a decrease in its payor discount(s), direct transfers of cash, or any other transfers of value.

For the avoidance of all doubt, those provisions of this Condition relating to profit-sharing do not require a reduction in Kaiser's ownership interest as provided for in the Affiliation Agreement.

In the event that the parties need to request any new exceptions to the prohibitions in Condition XXI on the requirement of Kaiser's consent, supermajority approval, or any other form of agreement from Kaiser on matters before the SMMC Board of Managers, Kaiser and SMMC shall file a petition with the independent monitor appointed pursuant to Condition XXII requesting a report and recommendation as to such a new exception, with a copy of that petition to be filed with the Attorney General. In considering the petition, the independent monitor shall consider the following: the parties' claimed need for any such exception, whether the exception is reasonably necessary for the operation of the SMMC Board of Managers or for Kaiser members on the Board to fulfill their fiduciary duties, whether the exception is narrowly tailored to achieve that need, and whether there is evidence of any negative effects of the new exception, including, but not limited to, improper sharing of competitively sensitive or confidential information or the exercise of control by Kaiser over aspects of business with which it competes with SMMC. In its sole discretion, the Attorney General may present evidence of any negative effects of the new exception to the independent monitor. The independent monitor shall commence an investigation upon receipt of the petition and within no more than one hundred twenty (120) days of receiving the petition, the independent monitor must issue a report and recommendation as to whether the petition should be granted, conditionally granted, or denied. The Attorney General shall review the report and recommendation and make a final decision on the petition within no more than sixty (60) days of the receipt of the independent monitor's report and recommendation on the petition.

XXII.

Any of the entities listed in Condition I may agree:

That Kaiser's commercial prices for general acute care hospital services that are being performed at SMMC may receive a discount as described in Exhibit 3.1 of its Health Care Services Agreement that is dated May 7, 2021 and Exhibit 3 and Section 2.a.v of Exhibit 3.1 of its Health Care Services Agreement that will go into effect the later of the commencement of operations at the New Hospital or the Agreement's date of approval by the California Department of Managed Health Care, provided, however, that the rate of discount may not be tied in any way to SMMC's operating revenue, expenses, or profit margin and that the rate of discount shall not exceed [REDACTED] percent of the weighted average of SMMC's commercial prices (excluding Kaiser Commercial Sponsored Products).¹⁹

¹⁹ The following definitions apply throughout these Conditions:

That self-funded or self-insured payors, whom have a contract with Kaiser for administrative or management services, may benefit from the commercial prices discount as described in the paragraph above, provided however, that this benefit shall not begin to run until six (6) years from the Closing Date of the Affiliation Agreement.

That an independent third party review, test, and confirm commercial prices for services provided at SMMC, except that under no circumstances may the independent third party share non-public information concerning payors with Kaiser or otherwise violate Conditions XXVI, XXVII, and XXVIII.

That if Contract Terms in a Managed Care Contract between SMMC and a payor are reasonably likely to lead to material reductions in capacity or access for Kaiser's patients at SMMC or if Kaiser disputes the amount of its commercial prices discount and its implementation, Kaiser may submit any dispute as to those Contract Terms and its discount as follows:

To the dispute resolution mechanism described in Exhibit 9.1 to the Affiliation Agreement, except that the Attorney General may participate in the selection of an arbitrator and the arbitration process, the existing Managed Care Contract(s) between a payor and SMMC shall

a) "Contract Terms" means the conditions under which a SMMC is willing to enter into a Managed Care Contract with a payor, including price and reimbursement terms, terms under which SMMC will participate as a network provider (including a provider in a tiered network), terms relating to utilization review, information or data disclosure and sharing, and terms relating to quality of care.

b) "Managed Care Contracts" means contracts and agreements for all healthcare services (e.g., inpatient, outpatient, physician, and laboratory services, etc.) provided by any or all individual components of SMMC to any payor, including but not limited to rates, definitions, terms, conditions, policies, and pricing methodologies (e.g., per diem, discount rate, or case rate, etc.) who sell any commercial, Medicare, and Medi-Cal healthcare plans of any kind or make any networks available to self-insured employers, union trusts, and/or state and local government entities. This term includes contracts and agreements negotiated with any independent physician associations, who in turn provide capitated services, under a limited or restricted Knox-Keane license from the Department of Managed Health Care, to any payor who sells any commercial, Medicare, and Medi-Cal healthcare plans of any kind or makes any networks available to self-insured employers, union trusts, and/or state and local government entities.

c) "Weighted average" refers to the average of commercial prices for general acute care hospital services performed at SMMC for the non-Kaiser commercial payors that generate 80 percent of net patient revenue at SMMC weighted by each payor's percentage share of net patient revenue.

continue as described below, and that none of the entities that participate in the dispute resolution mechanism shall under any circumstances share non-public information concerning payors with Kaiser or otherwise violate Conditions XXVI, XXVII, and XXVIII; or

To a single arbitrator at JAMS, experienced in managed care contracting negotiating, who shall conduct binding arbitration in accordance with the commercial arbitration rules of JAMS, or if not available at JAMS, at the American Arbitration Association (AAA) in accordance with the commercial arbitration rules of AAA, who shall conduct the arbitration in San Bernardino County at a location mutually agreed to by SMMC and Kaiser or virtually as may either be agreed to by SMMC and Kaiser, or as may be required by federal, state, or San Bernardino County executive orders, federal, state, or San Bernardino County laws, or federal, state, or San Bernardino County regulations or orders of any kind, in order to determine fair and reasonable Contract Terms that are reasonably unlikely to lead to material reductions in capacity or access for Kaiser's patients at SMMC.

The arbitrator shall be mutually agreed on by SMMC and Kaiser. In the event of a dispute over the arbitrator that cannot be reasonably resolved, the Attorney General's Office shall select the arbitrator from a list of two arbitrators each provided separately by SMMC and by Kaiser.

The arbitrator and any other entity that participates in the arbitration shall under no circumstances share non-public information concerning payors with Kaiser or otherwise violate Conditions XXVI, XXVII, and XXVIII.

The arbitration shall be conducted as Final Offer Arbitration, unless SMMC and Kaiser, agree to an alternate manner of arbitration.²⁰

The costs of the arbitration (other than attorneys' fees, which shall be borne by the party that incurs them) shall be borne by the loser of Final Offer Arbitration. If the parties settle the matter prior to the issuance of the final decision by the arbitrator, the arbitrator shall assess costs, unless the parties agree as to the allocation of costs.

The existing Managed Care Contract between a payor and SMMC, shall continue past the termination date in all respects, including as to those Contract Terms in arbitration, until the arbitration concludes with a decision as to those prices and terms. Other Contract Terms already

²⁰ Throughout Condition XXII, "Final Offer Arbitration" means a manner of arbitration whereby each party in a disputed matter submits its best and final offer to an arbitrator who is then required to choose what they believe is the best offer (sometimes referred to as "baseball arbitration").

negotiated between the parties with a resolution shall not be reopened after the arbitration has concluded as to those Contract Terms submitted to the arbitrator.

The Attorney General's Office shall have a right in its discretion to provide a submission to the arbitrator stating its views as to the matter under arbitration.

The first-come first-served condition concerning the non-discrimination between patients treated at SMMC shall continue in effect regardless of whether any disputed issue over whether the Contract Terms may lead to a reduction in capacity or access at SMMC is being arbitrated in accordance with this Condition.

XXIII.

The Attorney General shall have the power to appoint and will promptly appoint an independent monitor to monitor and evaluate compliance with Conditions XXIV, XXV, XXVI, XXVII, and XXVIII for the greater of ten (10) years from the Closing Date of the Affiliation Agreement while the existing Hospital continues to operate or six (6) years from the commencement of operations at the New Hospital.

To be qualified to serve as an independent monitor, a candidate must disclose to the Attorney General any potential conflict of interest, be experienced with hospital operations and managed care contracting in general, if not also knowledgeable as to hospital operations and managed care contracting in California. SMMC and Kaiser will disclose candidates they propose to serve as the independent monitor to the Attorney General and the Attorney General will disclose candidates it proposes to serve as the independent monitor to SMMC and Kaiser.

a) The Attorney General and SMMC and Kaiser shall consider diversity, equity, and inclusion in proposing candidates to serve as the independent monitor. The Attorney General will give due consideration to any candidates proposed by SMMC, and Kaiser and SMMC will give due consideration to any candidates proposed by the Attorney General.

b) Any interviews of any candidates will be jointly conducted by SMMC, Kaiser, and the Attorney General.

c) Not later than thirty (30) days after the Attorney General's selection of the independent monitor, SMMC and Kaiser shall execute an agreement that, subject to the prior approval of the Attorney General, confers on the independent monitor those rights, powers, and authorities necessary to permit the independent monitor to perform his/her duties and responsibilities described below.

d) SMMC and Kaiser may require the independent monitor and each of the independent monitor's staff and experts to sign a customary confidentiality agreement; provided however, that such agreement shall not restrict the independent monitor from providing any information

to the Attorney General.

The monitor shall have the power to conduct and provide ongoing oversight and surveillance of SMMC and Kaiser's compliance with Conditions XXIV, XXV, XXVI, XXVII, and XXVIII. The monitor shall have all powers necessary to monitor compliance with Conditions XXIV, XXV, XXVI, XXVII, and XXVIII, including the power to:

- a) Take complaints from payors, competitors of SMMC and Kaiser, employees of SMMC, Providence, and Heritage, employees of Kaiser and SCPMG, or from the Attorney General (with reasonable notice to be provided thereafter to all parties);
- b) Inspect records and compel disclosure of confidential documents subject to any demonstrated legally recognized privilege and appropriate confidentiality protections;
- c) Interview staff, patients, visitors, contractors, and other interested persons (if SMMC, Kaiser, Heritage, or SCPMG employees, then at the employee's election subject to reasonable prior notice and the opportunity for SMMC, Kaiser, Heritage, or SCPMG to have counsel present);
- d) Hire staff and experts; and
- e) Make recommendations concerning enforcement to the Attorney General.

Providence, SMMC, Heritage, Kaiser, or SCPMG shall cooperate with the monitor in the performance of the monitor's work and shall take no action to interfere with or impede the monitor's ability to monitor compliance with Conditions XXIV, XXV, XXVI, XXVII, and XXVIII.

SMMC and Kaiser shall provide annual reports to the monitor of SMMC and Kaiser's efforts to comply with Conditions XXIV, XXV, XXVI, XXVII, and XXVIII. Within a reasonable time from the date the monitor receives these reports, the monitor will be obligated to report in writing to the Attorney General as to any and all concerns as set out in these annual reports regarding Providence, SMMC, Heritage, Kaiser, or SCPMG's performance of their respective obligations under Conditions XXIV, XXV, XXVI, XXVII, and XXVIII.

SMMC and Kaiser will be solely responsible for the expenses of the monitor, including staff and experts of the monitor, in performing the services described in this condition.

The Attorney General may extend the above monitor condition for five (5) additional years as to Conditions XXIV, XXV, XXVI, XXVII, or XXVIII in his, her, or their sole discretion, but in no event shall the conditions last longer than fifteen (15) years in total from the Closing Date of the Affiliation Agreement.

Retaliation or threats of retaliation based on any payor, entity, or individual having provided information in conjunction with Conditions XXIV, XXV, XXVI, XXVII, or XXVIII to the Attorney General, the monitor, or to a court is prohibited.

XXIV.

From the greater of ten (10) years from the Closing Date of the Affiliation Agreement while the existing Hospital continues to operate or five (5) years from the commencement of operations at the New Hospital, the maximum that Providence and SMMC may charge a payor for any Commercial or Government-Sponsored Product for general acute care hospital services that are being performed at SMMC will be governed by the applicable payment provisions in the Contract Terms that are in effect between SMMC and that payor as of May 7, 2021, the Notice Date of the Affiliation Agreement, subject to any renewal Contract Terms that are negotiated in compliance with Conditions XXIV and XXV, so long as such annual price increase shall not exceed the 12 Months Percent Change: Consumer Price Index for Medical Care for Riverside-San Bernardino-Ontario CA Base Period: December 2017=100 (as published by U.S. Bureau of Labor Statistics) per year for commercial, Medicare, and Medi-Cal prices.

From the greater of ten (10) years from the Closing Date of the Affiliation Agreement while the existing Hospital continues to operate or five (5) years from the commencement of operations at the New Hospital, the maximum that Providence and SMMC may charge a payor for any Government-Sponsored Product for general acute care hospital services that are being performed at SMMC shall not exceed: one hundred twenty-five percent of the applicable Medicare DRG classifications (with no additional amounts related to indirect and direct medical education costs) including, as applicable, Wage Index Geographic Classification changes, for Medicare prices; and one hundred and ten percent of the State of California's inpatient and outpatient fee-for-service Medi-Cal fee schedule rates for Medi-Cal prices.

From the greater of ten (10) years from the Closing Date of the Affiliation Agreement while the existing Hospital continues to operate or five (5) years from the commencement of operations at the New Hospital, Providence and SMMC shall not enter into any amendment to any agreement with a payor that would violate this Condition; if this Condition is renewed, Providence and SMMC shall not enter into any amendment to any agreement with a payor that would violate this Condition for five (5) additional years from the Renewal Date.

From the greater of ten (10) years from the Closing Date of the Affiliation Agreement while the existing Hospital continues to operate or six (6) years from the commencement of operations at the New Hospital, if SMMC was not contracted with a payor, as of May 7, 2021, the Notice Date of the Affiliation Agreement, or if SMMC should subsequently go out of network with a payor with whom it was contracted as of that date, SMMC will be subject to reimbursement from that payor for Emergency Services²¹ and Neonatal Intensive Care Unit Services at a rate no higher

²¹ For Conditions XXIV and XXV "Emergency Services" means items and services needed to screen, treat, and stabilize a patient with an emergency medical condition.

than two hundred and seventy-five percent of the applicable Medicare DRG classifications (with no additional amounts related to indirect and direct medical education costs), including, as applicable, Wage Index Geographic Classification charges for Medicare prices.

The Attorney General may extend this Condition for five (5) additional years in his, her, or their sole discretion, but under no event shall the conditions last longer than fifteen (15) years in total from the Closing Date of the Affiliation Agreement.

XXV.

From the greater of ten (10) years from the Closing Date of the Affiliation Agreement while the existing Hospital continues to operate or six (6) years from the commencement of operations at the New Hospital, unless a payor voluntarily requests otherwise, Providence and SMMC will not expressly or implicitly condition the participation of, or impose any Contract Terms concerning, a Providence Controlled Facility,²² including prices or any other conditions, on the participation of, or any Contract Terms concerning, one or more other Controlled Facilities, with any payor.

This prohibition on conditioning of participation or Contract Terms across Controlled Facilities includes:

Engaging a payor in “all-or-nothing” contracting for facility services by expressly or impliedly requiring the payor to contract with all Controlled Facilities and not permitting the payor to contract with individual Controlled Facilities, including by conditioning the participation, pricing, or Contract Terms of a Controlled Facility in a Commercial or Government-Sponsored Product on any of the following:

- a) Participation or Contract Terms of another Controlled Facility in the same or any other Commercial or Government-Sponsored Product offered by the Payor;
- b) Pricing of another Controlled Facility in the same or any other Commercial or Government-Sponsored Product offered by the payor; and
- c) Status of a Controlled Facility (including the decision on whether to include or exclude) in the payor’s center of excellence program (or other program designed to differentiate facilities based on their quality of care, their cost, or other consideration), or the exclusion of any third party’s facility in the payor’s center of excellence program (or other similar program).

²² The following definition applies throughout condition XXV: “Controlled Facility” means any facility that is controlled by Providence during the greater of ten (10) years from the Closing Date of the Affiliation Agreement while the existing Hospital continues to operate or six (6) years from the commencement of operations at the new Hospital; and in the event that this Condition is extended, any facility that is controlled by Providence during the renewal period.

Explicitly or implicitly penalizing a payor for contracting with individual Controlled Facilities. This includes setting significantly higher than existing contract prices or out-of-network fees for any or all of Providence facilities should the payor choose to contract with less than all (or a group) of Providence facilities. If a Controlled Facility other than SMMC is not contracted with a payor, such Controlled Facility will be subject to reimbursement from that payor as determined under California Code of Regulations, tit. 28, § 1300.71, subd. (a)(3)(B), as adjusted for a comparison of the Controlled Facilities with other comparable facilities.

Interfering with or otherwise engaging in any action, direct or indirect, to prevent a payor from contracting with any other hospital, provider, or facility or to prevent the introduction or promotion of narrow, tiered, or steering commercial or Government-Sponsored Products or value-based benefit designs for commercial or Government-Sponsored Products (i.e. benefit designs that attempt to reward providers for affordability and/or quality), including reference pricing.

The Attorney General may extend this Condition for three (3) additional years. In choosing whether to extend this Condition for another three (3) years, the Attorney General shall consider whether Providence or SMMC has been found to have committed a material violation of this Condition within the preceding ten (10) years, but under no event shall the conditions last longer than fifteen (15) years in total from the Closing Date of the Affiliation Agreement.

For the greater of ten (10) years from the Closing Date of the Affiliation Agreement or six (6) years from the commencement of operations at the New Hospital, Providence and SMMC will not enter into any amendment to any agreement with a payor that would violate this Condition, but under no event shall the conditions last longer than fifteen (15) years in total from the Closing Date of the Affiliation Agreement.

XXVI.

For the duration of any Agreement(s) listed in Condition II, SMMC and Providence shall negotiate all commercial, Medicare, and Medi-Cal Managed Care Contracts, including contracts for Covered California, with any payor or Future Payor, separately and independently from Kaiser, SCPMG, and Kaiser members on the SMMC Board of Managers.²³

²³ For Conditions XXVI and XXVIII, “Future Payor” shall include any new company that provides or intends to provide healthcare insurance policies, capitated networks for inclusion in healthcare insurance policies, or makes networks accessible for San Bernardino County residents and wishes to negotiate a Managed Care Contract directly with SMMC. Once a Future Payor enters into a Managed Care Contract with SMMC, that Future Payor shall become a payor for purposes of these conditions.

SMMC and Providence shall continue to maintain a team of negotiators for Managed Care Contracts for payors and Future Payors that will not overlap with, and otherwise shall be kept separate from Kaiser, SCPMG, and Kaiser members on the SMMC Board of Managers.

SMMC's team of negotiators shall be known as the SMMC Negotiating Team for purposes of the conditions governing separate negotiations and firewalls for SMMC.

The SMMC Negotiating Team shall be exclusively responsible for negotiating Managed Care Contracts for SMMC and shall not report in any manner to Kaiser, SCPMG, and Kaiser members on the SMMC Board of Managers.

Managed Care Contracts involving SMMC shall only be administered by Providence and SMMC and any information involved in Contract Administration shall not be shared with Kaiser, SCPMG, or Kaiser members on the SMMC Board of Managers,²⁴ except insofar that Kaiser, SCPMG, or members on the SMMC Board of Managers may receive such information that involves only aggregated costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead.

For the avoidance of all doubt, under no circumstances may Kaiser, SCPMG, or Kaiser members on the SMMC Board of Managers receive information aggregated at the individual payor level nor any information that is more granular.

XXVII.

For the duration of any Agreement(s) listed in Condition II, all the entities listed in Condition I shall ensure that Providence, SMMC, and Heritage on the one hand continue to run as a separate businesses from Kaiser and SCPMG on the other hand, except as allowed in this Condition, and that as part of running Providence-related entities separately from Kaiser and SCPMG, that the

²⁴ For Condition XXVI, "Contract Administration" means the act or acts associated with compliance and implementation of final contract terms, such as payment monitoring, communication of payor medical and administrative policies, utilization management, liaison to the business office, annual updates, and organizing Managed Care Contract-related budget information.

non-public information and data²⁵ of SMMC, Providence, and Heritage on the one hand and Kaiser and SCPMG on the other hand, is not inappropriately used or accessed.²⁶

After the proposed transaction closes, other than the exceptions described in this Condition, there shall be no integration or sharing of Providence, SMMC, and Heritage employees, processes, transactional and reporting information technology systems, or any non-public information and data with Kaiser and SCPMG.

After the transaction closes, other than the exceptions described in this Condition, there shall be no integration or sharing of Kaiser and SCPMG employees, processes, transactional and reporting information technology systems, or any non-public information with Providence, SMMC, and Heritage.

Providence, SMMC, and Heritage on the one hand and Kaiser and SCPMG on the other hand, shall not share any information systems except for an electronic healthcare record system for the treatment of patients at SMMC.

To the extent necessary to exercise SMMC's right of first refusal to participate in a competing business to provide general acute care hospital services in the High Desert Region, Providence, SMMC, Heritage, Kaiser, and SCPMG may disclose non-public information concerning strategic projects and partnerships under consideration that are located in the High Desert Region.

To the extent data of SMMC is required for financial reporting or other entity-wide purposes by Kaiser and SCPMG, all such data shall be aggregated to the broadest extent possible consistent with proper accounting practices (e.g., not payor or health-plan specific) before being reported to Kaiser and SCPMG.

To the extent necessary to plan for expansions or reductions in the provision of general acute care hospital services at SMMC, Providence, Heritage, Kaiser, and SCPMG may share non-

²⁵ For Conditions XXVII and XXVIII, "non-public information" includes, but is not limited to, non-public financial information and data, non-public information and data about strategic projects and partnerships under consideration, and all other confidential, proprietary, commercially sensitive information and data of any of the entities listed in Condition I, or that any of the entities may access or receive from payors or other organizations.

²⁶ This Condition also applies to contractors of SMMC, Providence, and Heritage that have access to any confidential or proprietary information and data of Providence, SMMC, and Heritage; and vice-versa for Kaiser and SCPMG contractors that have access to any confidential or proprietary information and data of Kaiser and SCPMG.

public information concerning summary level financial, administrative, and operational reporting information, and nothing more granular.

Providence, Heritage, and SMMC on the one hand and Kaiser and SCPMG on the other hand, shall not share employees or managers except for the Board of Managers of SMMC after the proposed transaction closes.

To the extent that an employee of Providence, SMMC, and Heritage seeks to transfer to Kaiser and SCPMG, or vice versa, such transferring employees will sign a specific attestation, offer letter, or similar document agreeing not to disclose any non-public information and data from their prior role.

XXVIII.

Providence, Heritage, and SMMC on the one hand and Kaiser and SCPMG on the other hand shall maintain their respective existing transactional, reporting, and information systems, including access controls, host-based intrusion detection, and data management requirements, and related operational processes used to support their respective businesses shall continue to be maintained separately and shall prevent unauthorized access to non-public information, including payor and patient information and data, of each entity. Specifically:

- a) Providence, Heritage, and SMMC will maintain control and oversight of their transactional and reporting systems, servers, data repositories, and any other information technology systems, which shall be maintained separate and apart from transactional and reporting systems, servers, data repositories, and information technology systems of Kaiser and SCPMG.
- b) Kaiser and SCPMG will maintain control and oversight of their transactional and reporting systems, servers, data repositories, and any other information technology systems, which shall be maintained separate and apart from transactional and reporting systems, servers, data repositories, and information technology systems of Providence, Heritage, and SMMC.
- c) Providence, Heritage, and SMMC will ensure these systems shall continue to store and process data in a manner that supports segregation, to ensure that Kaiser and SCPMG personnel cannot access proprietary information and data of Providence, Heritage, and SMMC, including commercially sensitive data of any kind and any confidential information and data about Providence, Heritage, and SMMC payors and patients.
- d) Kaiser and SCPMG will ensure these systems shall continue to store and process data in a manner that supports segregation, to ensure that Providence, Heritage, and SMMC personnel cannot access proprietary information and data of Kaiser and SCPMG, including commercially sensitive data of any kind and any confidential information and data about Kaiser customers and patients.

e) No system connections between Providence, Heritage, and SMMC systems on the one hand and Kaiser and SCPMG systems on the other hand, inflows of data between Providence, Heritage, and SMMC on the one hand and Kaiser and SCPMG on the other hand, and access from Kaiser and SCPMG systems to Providence, Heritage, and SMMC systems, or vice-versa, shall be permitted except insofar as the Electronic Medical Records systems of Kaiser, and SMMC need to be connected for the treatment of Kaiser patients.

f) Providence, Heritage, and SMMC shall maintain or implement role-based access to ensure that its data and systems cannot be accessed by personnel of Kaiser and SCPMG, except insofar as Electronic Medical Records systems of SMMC need to be accessed for the treatment of Kaiser patients. Providence, Heritage, and SMMC shall use the most current technological safeguards and standards to prevent unauthorized access to its informational technology systems and data.

g) Kaiser and SCPMG shall maintain or implement role-based access to ensure that its data and systems cannot be accessed by personnel of Providence, Heritage, and SMMC. Kaiser and SCPMG shall use the most current technological safeguards and standards to prevent unauthorized access to its informational technology systems and data.

h) Providence, Heritage, and SMMC shall maintain or establish a Contract Management System for the SMMC Negotiating Team that is segregated or clearly partitioned from the Contract Management System for Kaiser and SCPMG to ensure the confidentiality of Managed Care Contracting Information.²⁷

Providence, SMMC, and Heritage on the one hand and Kaiser and SCPMG on the other hand shall provide training and education programs for each of their employees regarding the treatment of non-public information:

a) Such training and educational programs shall happen on an annual basis except for newly hired employees, who shall be required to go through such training or educational programs as

²⁷ For Condition XXVIII, “Managed Care Contracting Information” means information concerning the negotiation, execution, provisions, and enforcement of Managed Care Contracts, or negotiations with a specific payor or Future Payor for healthcare services of any kind and in any form, including but not limited to documents, materials, data, and knowledge of such; provided, however, that “Managed Care Contracting Information” shall not include (i) information that is in the public domain or falls in the public domain through no violation of these conditions or breach any confidentiality or non-disclosure agreement or provision with respect to such information by Providence, SMMC, Heritage, Kaiser, and SCPMG; (ii) information that becomes known to SMMC or Kaiser through a third party that discloses this information legitimately; (iii) information that is required by law to be publicly disclosed; or (iv) aggregated information concerning the financial condition of SMMC.

immediately is feasible upon starting work. Each employee shall be required to attest to their completion of these trainings.

b) The entities shall annually provide such attestations from an authorized officer at SMMC and an authorized officer at Kaiser to the independent monitor and to the Attorney General's Office stating that the attestations required by this Condition have been signed and are being complied with by all relevant employees.

Providence, SMMC, and Heritage on the one hand and Kaiser and SCMPG on the other hand shall maintain compliance programs, including appropriate disciplinary measures, the appointment of an internal compliance officer, and reporting system for potential breaches, in order to prevent the exchange and misuse of non-public information. Records of potential breaches shall be turned over to the independent monitor and to the Attorney General's Office upon demand.

The independent monitor shall be afforded a reasonable opportunity to review and report on any modifications in user-based security that may affect the obligations of this Condition before those modifications are implemented. The independent monitor shall also be afforded a reasonable opportunity to review and report on any access list of individual employees who have access to non-public information of SMMC, including those employees involved in training or who have investigative functions, prior to finalization of the list.

XXIX.

For ten (10) years from the Closing Date of the Affiliation Agreement, or until the New Hospital is operational and admitting patients and six (6) years thereafter, SMMC and SMMC LLC shall submit to the Attorney General, no later than six (6) months after the conclusion of each year, a report describing in detail compliance with each Condition set forth herein. The first report shall be due no later than six (6) months after the Closing Date. The Chair(s) of the Board of Directors of SMMC and SMMC LLC and the Chief Executive Officers of SMMC and SMMC LLC shall each certify that the report is true, accurate, and complete and provide documentation of the review and approval of the report by these Boards of Directors. This Condition shall extend automatically for a proportional time period should the Attorney General exercise discretion to extend any of the other Conditions as provided herein.

XXX.

At the request of the Attorney General, all of the entities listed in Condition I shall provide such information as is reasonably necessary for the Attorney General to monitor compliance with these Conditions and the terms of the transaction as set forth herein. The Attorney General will, at the request of an entity listed in Condition I and to the extent provided by law, keep confidential any information so produced to the extent that such information is a trade secret or is

privileged under state or federal law, or if the private interest in maintaining confidentiality clearly outweighs the public interest in disclosure.

XXXI.

Once the Affiliation Agreement is closed, all of the entities listed in Condition I are deemed to have explicitly and implicitly consented to the applicability and compliance with each and every Condition and to have waived any right to seek judicial relief with respect to each and every Condition.

The Attorney General reserves the right to enforce each and every Condition set forth herein to the fullest extent provided by law. In addition to any legal remedies the Attorney General may have, the Attorney General shall be entitled to specific performance, injunctive relief, and such other equitable remedies as a court may deem appropriate for breach of any of these Conditions.

Pursuant to Government Code section 12598, the Attorney General shall also be entitled to recover its attorney fees and costs incurred in remedying each and every violation.

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Exhibit 1

EXHIBIT A

FINANCIAL ASSISTANCE PLAN AND EMERGENCY CARE POLICY

Purpose:

The purpose of this policy is to set forth Providence Health & Services (PH&S)'s Financial Assistance and Emergency Medical Care policies, which are designed to promote access to medically necessary care for those without the ability to pay, and to offer a discount from billed charges for individuals who are able to pay for only a portion of the costs of their care. These programs apply solely with respect to emergency and other medically necessary healthcare services provided by PH&S. This policy and the financial assistance programs described herein constitute the official Financial Assistance Policy ("FAP") and Emergency Medical Care Policy for each hospital that is owned, leased or operated by PH&S within the state of California.

Policy:

PH&S is an affiliate of Providence Health & Services (PH&S), which is a Catholic healthcare organization guided by a commitment to its Mission and Core Values, designed to reveal God's love for all, especially the poor and vulnerable, through compassionate service. It is both the philosophy and practice of each PH&S ministry that medically necessary healthcare services are available to community members and those in emergent medical need, without delay, regardless of their ability to pay. For purposes of this policy, "financial assistance" includes charity care and other financial assistance programs offered by PH&S.

1. PH&S will comply with federal and state laws and regulations relating to emergency medical services and charity care. The hospital will provide, without discrimination, care for emergency medical conditions regardless of whether an individual is eligible for financial assistance. The hospital will not engage in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care.
2. PH&S will provide charity care to qualifying patients with no other primary payment sources to relieve them of all or some of their financial obligation for medically necessary PH&S healthcare services.
3. In alignment with PH&S's Core Values, PH&S will provide charity care to qualifying patients in a respectful, compassionate, fair, consistent, effective and efficient manner.
4. PH&S will not discriminate on the basis of age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law when making charity care determinations.
5. In extenuating circumstances, PH&S may at its discretion approve financial assistance outside of the scope of this policy. Uncollectible/presumptive charity is approved due to but not limited to the following: social diagnosis, homelessness, bankruptcy, deceased with no estate, history of non-patient/guarantors inability to pay and why collection agency assignment would not result in resolution of the account.
6. This policy is to be interpreted and implemented so as to be in full compliance with California Assembly Bill 774, codified at Health and Safety Code Section 127400 *et. seq.*, effective January 1, 2007, as revised by California State Senate Bill 350, effective January 1, 2008, Assembly Bill 1503 effective January 1, 2011 and SB 1276 effective 01/01/2015. All collection agencies working on behalf of PH&S shall comply with Health and Safety Code Section 127400 *et. seq.* as amended and applicable PH&S policies regarding collection agencies.

Definitions:

7. **“Charity Care”** refers to full financial assistance to qualifying patients, to relieve them of their financial obligation in whole for medically necessary or eligible elective health care services (full charity).
8. **“Discount Payment”** refers to partial financial assistance to qualifying patients, to relieve them of their financial obligation in part for medically necessary or eligible elective health care services (partial charity).
9. **Gross charges** are the total charges at the facility’s full established rates for the provision of patient care services before deductions from revenue are applied. Gross charges are never billed to patients who qualify for partial charity or Private Pay Discounts.
10. **Private Pay Discount** is a discount provided to patients who do not qualify for financial assistance and who do not have a third party payor or whose insurance does not cover the service provided or who have exhausted their benefits.
11. **Emergency Physician** means a physician and surgeon licensed pursuant to Chapter 2 (commencing with Section 2000) of the Business and Professions Code who is credentialed by a hospital and either employed or contracted by the hospital to provide emergency medical services in the emergency department of the hospital, except that an “emergency physician” shall not include a physician specialist who is called into the emergency department of a hospital or who is on staff or has privileges at the hospital outside of the emergency department. Emergency room physicians who provide emergency medical services to patients at PH&S are required by California law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350% of the federal poverty level.
12. **Providers Subject to PH&S’s FAP:** All physicians and other providers rendering care to PH&S patients during a hospital stay are subject to these policies unless specifically identified otherwise. Attachment A indicates where patients may obtain the list(s) pertaining to all Providers who render care in the PH&S hospital departments, and whether or not they are subject to the PH&S Financial Assistance Policy. This list can be accessed online at www.providence.org, and is also available in paper form by request through the Financial Counselor at PH&S.
13. **Services Eligible Under the Policy:** This Financial Assistance and Emergency Care Policy applies to all services provided to eligible patients receiving emergency or medically necessary care or eligible elective care, including self-pay patients and co-payment liabilities required by third party payors, including Medicare and Medi-Cal cost-sharing amounts, in which it is determined that the patient is financially unable to pay. Medically necessary health care includes:
 - a. Emergency services in the emergency department.
 - b. Services for a condition that, if not promptly treated, would lead to an adverse change in the patient’s health status.
 - c. Non-elective services provided in response to life-threatening circumstances outside of the emergency department (direct admissions).
 - d. Medically necessary services provided to Medicaid beneficiaries that are non-covered services.
 - e. Any other medically necessary services determined on a case-by-case basis by PH&S.
14. **Eligible Elective Health Care includes:**
 - a. Patients and their physicians may seek charitable services for elective, deferrable care. Elective care becomes eligible for charitable and discount services only when all of the following requirements are met:
 - i. A member of the medical staff of a PH&S facility must submit the charitable services request;
 - ii. The patient is already a patient of the requesting physician and the care is needed for good continuity of care; aesthetic procedures are not eligible for charitable services;
 - iii. The physician will provide services at the same discount rate as determined by the hospital per charity guidelines of this policy, up to and including free care;
 - iv. The patient lives within our services area (as determined by PH&S); and
 - v. The patient completes a Financial Assistance Application and receives approval in writing from PH&S prior to receiving the elective care.
15. **Eligibility for Charity** shall be determined by an inability to pay defined in this policy based on one or more of the following criteria:

- a. **Presumptive Charity** – Individual assessment determines that Financial Assistance Application is not required because:
 - i. Patient is without a residence address (e.g. homeless);
 - ii. Services deemed eligible under this policy but not covered by a third party payor were rendered to a patient who is enrolled in some form of Medicaid (Medi-Cal for California residents) or State Indigency Program (e.g. receiving services outside of Restricted Medi-Cal coverage) or services were denied Medi-Cal treatment authorization, as financial qualification for these programs includes having no more than marginal assets and a Medi-Cal defined share of cost as the maximum ability to pay; and/or
 - iii. Patient's inability to pay is identified via an outside collection agency income/asset search. Should the agency determine that a lawsuit will not be pursued, the account will be placed in an inactive status, where a monthly PH&S review will determine further action, including possible charity acceptance and cancellation from the agency and removal of credit reporting.
 - iv. Patient's inability to pay is identified by Regional Business Office staff through an income/asset search using a third party entity.

- b. **Charity** – Individual assessment of inability to pay requires:
 - i. Completion of a Financial Assistance Application for the Mary Potter Program for Human Dignity for all facilities in the PHSSC Region;
 - ii. Validation that a patient's gross income is less than three times (300%) the Federal Poverty Guidelines (FPG) applicable at the time the patient has applied for financial assistance. A patient with this income level will be deemed eligible for 100% charity care; and/or
 - iii. Validation that a patient's gross income is between 100% and 350% of the FPG applicable at the time the patient has applied for financial assistance and that their individual financial situation (high medical costs, etc.) makes them eligible for possible discount payment (partial charity care) or 100% charity care. Facility may consider income and monetary assets of the patient in assessing the patient's individual financial situation. Monetary assets, however, shall not include retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. Further, the first ten thousand dollars (\$10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars (\$10,000) be counted in determining eligibility. Information obtained about income and monetary assets, however, shall not be used for collections activities.
 - iv. Patients with gross income at or below 350% of FPG will never owe more than 100% of the amount of payment the hospital would expect, in good faith, to receive for providing services from Medicare, Medi-Cal, the Healthy Families Program, or another government-sponsored program of health benefits in which the hospital where treatment was received participates, whichever is greater. This amount shall be verified at least annually. If the hospital where treatment was received provides a service for which there is no established payment by Medicare or any other government-sponsored program of health benefits in which the hospital participates, the hospital shall establish and appropriate discounted payment. A patient with a gross income exceeding 350% of FPG will owe no more than the applicable private pay inpatient or outpatient discounted reimbursement rate, or stated co-pay amount, whichever is less. In addition, uninsured and insured patients with gross incomes at or below 350% of FPG who incur total medical expenses in excess of ten percent (10%) of gross annual income during the prior 12 months will receive 100% charity benefit. Eligible costs for charity write off shall include only the patient liability amounts after insurance is billed and insurance liability amounts collected.

Note: Gross charges never apply to patients who qualify for partial charity or private pay discounts. Once gross charges are adjusted to the appropriate Medicare or private pay rate, the patient liability will not change even if eventually referred to a collection agency.

16. Basis for Calculating Amounts Charged to Patients Eligible for Financial Assistance

- a. Categories of available discounts and limitations on charges under this policy include
 - i. **100 Percent Discount/Free Care:** Any patient or guarantor whose gross family income, adjusted for family size, is at or below 300% of the current federal poverty level ("FPL") is eligible for a 100 percent discount off of total hospital charges for emergency or medically necessary care, to the extent that the patient or guarantor is not eligible for other private or public health coverage sponsorship.
 - ii. **Discounts Off Charges at 75 Percent :** The PH&S sliding fee scale set forth in Attachment B will be used to determine the amount of financial assistance to be provided in the form of a discount of 75 percent for patients or guarantors with incomes between 301% and 350% of the current federal

poverty level after all funding possibilities available to the patient or guarantor have been exhausted or denied and personal financial resources and assets have been reviewed for possible funding to pay for billed charges. Financial assistance may be offered to patients or guarantors with family income in excess of 350% of the federal poverty level when circumstances indicate severe financial hardship or personal loss.

- iii. **Limitation on Charges for all Patients Eligible for Financial Assistance:** Limitation on Charges for all Patients Eligible for Financial Assistance: No patient or guarantor eligible for any of the above-noted discounts will be personally responsible for more than the “Amounts Generally Billed” (AGB) percentage of gross charges, as defined in Treasury Regulation Section 1.501(r)-1(b)(2), by the applicable PH&S hospital for the emergency or other medically necessary services received. PH&S determines AGB by multiplying the hospital’s gross charges for any emergency or medically necessary care by a fixed percentage which is based on claims allowed under Medicare. Information sheets detailing the AGB percentages used by each PH&S Hospital, and how they are calculated, can be obtained by visiting the following website: www.providence.org or by calling: **1-866-747-2455** to request a paper copy. In addition, the maximum amount that may be collected in a 12 month period¹ for emergency or medically necessary health care services to patients eligible for financial assistance is 20 percent of the patient’s gross family income, and is subject to the patient’s continued eligibility under this policy.

17. Charity Care is not:

- a. **Bad Debt:** A bad debt results from a patients unwillingness to pay or from a failure to qualify for financial assistance that would otherwise prove an inability to pay;
- b. **Contractual adjustment:** The difference between the retail charges for services and the amount allowed by a governmental or contracted managed care payor for covered services that is written off; or
- c. **Other Adjustments:**
 - i. **Service Recovery Adjustments** are completed when the patient identifies a less than optimal patient care experience;
 - ii. **Risk Management Adjustments:** where a potential risk liability situation is identified and Providence Risk Management has elected to absorb the cost of care and not have the patient billed;
 - iii. **Payor Denials:** where the facility was unable to obtain payment due to untimely billing percontractual terms; or retroactive denial of service by a managed care payor where appeal is not successful.

18. **Reasonable Payment Plan:** a default plan required by SB 1276 for patients qualifying for partial charity when a negotiated plan cannot be reached.SB 1276 defines the plan as monthly payments that are not more than 10% of a patient’s family income for a month, excluding deductions for essential living expenses.

- a. **“Essential Living Expenses”** means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs. Installment payments, laundry and cleaning, and other extraordinary expenses. Emergency Department physicians and their assignees may rely upon the hospital’s determination of income and expenses in establishing a reasonable payment plan.

Evaluation Process:

Patients or guarantors may apply for financial assistance under this Policy by any of the following means: (1) advising PH&S’s patient financial services staff at or prior to the time of discharge that assistance is requested, and submitting an application form and any documentation if requested by PH&S; (2) downloading an application form from PH&S’ website, at www.providence.org, and submitting the form together with any required documentation; (3) requesting an application form by telephone, by calling: **1-866-747-2455**, and submitting the form; or (4) any other methods specified in PH&S’s Billing and Collections Policy. PH&S will display signage and information about its financial assistance policy at appropriate access areas. Including but not limited to the emergency department and admission areas.

A person seeking charity care will be given a preliminary screening and if this screening does not disqualify him/her for charity care, an application will be provided with instructions on how to apply. As part of this screening process PH&S will review whether the guarantor has exhausted or is not eligible for any third-party payment sources. Where the guarantor’s

¹ The 12 month period to which the maximum amount applies shall begin on the first date, after the effective date of this policy, an eligible patient receives health care services that are determined to be eligible (e.g. medically necessary services).

identification as an indigent person is obvious to PH&S a prima-facie determination of eligibility may be made and in these cases PH&S may not require an application or supporting documentation.

A guarantor who may be eligible to apply for charity care after the initial screening will have until fourteen (14) days after the application is made or two hundred forty (240) days after the date the first post-discharge bill was sent to the patient, whichever is later, to provide sufficient documentation to PH&S to support a charity determination. Based upon documentation provided with the charity application, PH&S will determine if additional information is required, or whether a charity determination can be made. The failure of a guarantor to reasonably complete appropriate application procedures within the time periods specified above shall be sufficient grounds for PH&S to initiate collection efforts.

An initial determination of sponsorship status and potential eligibility for charity care will be completed as closely as possible to the date of service.

PH&S will notify the guarantor of a final determination in writing within ten (10) business days of receiving the necessary documentation.

The guarantor may appeal the determination of ineligibility for charity care by providing relevant additional documentation to PH&S within thirty (30) days of receipt of the notice of denial. All appeals will be reviewed and if the determination on appeal affirms the denial, written notification will be sent to the guarantor and the Department of Health in accordance with state law. The final appeal process will conclude within thirty (30) days of the receipt of a denial by the applicant. Other methods of qualifications for Financial Assistance may fall under the following:

- The legal statute of collection limitations has expired;
- The guarantor has deceased and there is no estate or probate;
- The guarantor has filed bankruptcy;
- The guarantor has provided financial records that qualify him/her for financial assistance; and/or
- Financial records indicate the guarantor's income will never improve to be able to pay the debt, for example with guarantors on lifetime fixed incomes.

Billing and Collections: Any unpaid balances owed by patients or guarantors after application of available discounts, if any, may be referred to collections in accordance with PH&S's uniform billing and collections policies. For information on PH&S' billing and collections practices for amounts owed by patients or guarantors, please see PH&S's Billing and Collections Policy, which is available free of charge at each PH&S hospital's registration desk, at: www.providence.org; or which can be sent to you if you call: **1-866-747-2455**.

Attachment A to Financial Assistance Plan and Emergency Care Policy

Hospital-Based Providers Not Subject to PH&S's Financial Assistance Policy and Associated Discounts

A list is available of all Providers who render care in the PH&S Hospital, and whether or not they are subject to the PH&S Financial Assistance Policy. This list can be accessed online at www.providence.org, or is available in paper form by request through the Financial Counselor at the Hospital. If a Provider is not subject to the Financial Assistance Policy then that Provider will bill patients separately for any professional services that that Provider provides during a patient's hospital stay, based on the Provider's own applicable financial assistance guidelines, if any.

Attachment B to Financial Assistance Plan and Emergency Care Policy

PH&S CA Charity Care Percentage Sliding Fee Scale

For guarantors with income and assets above 300% of the FPL household income and assets are considered in determining the applicability of the sliding fee scale.

Assets considered for evaluation; IRA's, 403b, 401k are exempt under this policy, unless the patient is actively drawing from them. For all other assets, the first \$10,000 is exempt.

Income and assets as a percentage of Federal Poverty Guideline Level	Percent of discount (write-off) from original charges	Balance billed to guarantor
100-300%	100%	0%
301-350%	75%	25%