NOTICE AND AVAILABILTY OF INFORMATION

ORCHARD HOSPITAL, a California not for profit corporation

IN CONNECTION WITH ITS

MANAGEMENT SERVICES AGREEMENT WITH

AMERICAN ADVANCED MANAGEMENT, INC., a Delaware corporation

PREPARED FOR THE OFFICE OF THE ATTORNEY GENERAL

CALIFORNIA DEPARTMENT OF JUSTICE

CHARITABLE TRUSTS DIVISION

Amended, November 5, 2024

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

DESCRIPTION OF THE TRANSACTION

This summarizes the transaction between the following parties: Orchard Hospital, a California not for profit corporation ("Licensee") and American Advanced Management, Inc., a Delaware corporation (the "New Operator"). Licensee is the licensed operator of a certain twenty-four (24)-bed critical access hospital located at 240 Spruce Street, Gridley, California and rural health primary care clinics located in Gridley and Oroville. (the "Facility").

New Operator commenced managing the Facility on behalf of Licensee as of July 1, 2023. New Operator is currently occupying the Facility pursuant to the terms of the Management Services Agreement executed on June 12, 2023.

Licensee appointed New Operator as its sole and exclusive manager of the Facility and New Operator accepted such appointment. The Agreement will terminate by its terms once a CHOW has been approved by the California State Attorney General's Office, if applicable, or by termination provisions set for in the Agreement.

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

EXHIBIT 1

A Complete copy of the Management Services Agreement dated June 12, 2023 with an effective date of July 1, 2023

MANAGEMENT SERVICES AGREEMENT

This MANAGEMENT SERVICES AGREEMENT (this "**Agreement**") is made and entered into as of July 1, 2023 (the "**Effective Date**"), by and between **Orchard Hospital,** a California not for profit corporation ("**Licensee**"), and **American Advanced Management, Inc.,** a Delaware corporation (the "**New Operator**").

RECITALS

A. WHEREAS, Licensee is the licensed operator of a certain twenty-four (24)-bed critical access hospital located at 240 Spruce Street, Gridley, California and rural health primary care clinics located in Gridley and Oroville. (the "**Facility**").

B. WHEREAS, Licensee desires for New Operator to commence managing the Facility on behalf of Licensee as of the Management Agreement Date, as defined below, and New Operator desires to so manage the Facility.

C. WHEREAS, effective upon the Management Agreement Date, as defined below, New Operator will occupy the Facility pursuant to the terms of this Management Agreement (the "**Agreement**") between New Operator, a California limited liability company.

D. WHEREAS, New Operator and Licensee have further agreed that New Operator will manage the Facility for Licensee from the Effective Date of this Agreement to the License Transition Date (as defined below). In conjunction therewith,

E. WHEREAS, in order to facilitate a transition of operational and financial responsibility from Licensee to New Operator in a manner which will ensure the continued operation of the Facility after the Effective Date in compliance with the Agreement and applicable law and in a manner which does not jeopardize the health and welfare of the patients of the Facility, Licensee and New Operator are desirous of documenting the terms and conditions on which New Operator will manage the Facility for Licensee as of the Effective Date and certain other terms and conditions relevant to the transition of operational and financial responsibility from Licensee to New Operator.

NOW, THEREFORE, in consideration of the foregoing premises and the mutual covenants of the parties set forth herein, it is hereby agreed as follows:

1. Definitions. For purposes hereof, the following terms shall have the following meanings:

1.1 "**Available Cash**" means the amount by which the total of the cash on hand in the Facility's bank accounts is in excess of the reasonable cash requirements and reserves of the Facility. The cash and reserve requirements shall include, but not be limited to, the amounts reasonably required for all taxes, insurance, debt service, and other expenses of the Company.

1.2 "**Change of Control**" shall have occurred: (i) upon the sale of all or substantially all of the assets of Licensee, (ii) following the merger, consolidation, or acquisition involving a Licensee following which the Licensee is not a surviving entity, or (iii) following the change in ownership of more than fifty percent (50%) of the voting rights controlling the Licensee or a change in the power to direct or cause the direction of management of the Licensee.

1.3 **"Days Cash on Hand" "DCOH"** is means the result of the following formula: Available Cash / (operating expenses – depreciation) / 365 days.

1.4 **"Management Agreement Date"** shall be July 1, 2023, provided the Conditions Precedent (as defined below) have been waived or satisfied in full.

1.5 **"Permits"** means a facility license for the Facility as a critical access hospital, and a Medicare and Medi-Cal certification as a critical access hospital.

1.6 **"Transition Date"** shall mean the date upon which the Attorney General of California and the California Department of Public Health (**"CDPH"**) issues the new Permit or approved Change of Ownership to New Operator for the Facility pursuant to Section 10 of this Agreement and the Provider Numbers have been issued or transferred to New Operator pursuant to the Tie-In.

2. Conditions Precedent. For purposes hereof, the **"Conditions Precedent"** to the transfer of operations shall be: (a) the execution and delivery of this Management Agreement, (b) the execution and delivery of the Business Associate Addendum (the **"BAA"**); (c) the execution of all documents required to be signed by Licensee in connection with New Operator's CHOW, including, but not limited to, the CMS 855A form and patient trust verification; (d) the execution of all documents required to be signed by Licensee in connection with the transactions contemplated by this Agreement; and (e) the satisfaction or waiver of any conditions precedent in any of the transaction documents.

3. Management of the Facility.

3.1 Commencing on the Management Agreement Date and ending on the Transition Date (this period being known as the **"Management Period"**), Licensee hereby appoints New Operator as its sole and exclusive manager of the Facility and New Operator accepts such appointment. Licensee shall cooperate with New Operator in all material respects to make the transition in management of the Facility to New Operator as smooth as possible. This Agreement shall terminate by its terms once a CHOW has been approved by the California State Attorney General's Office, if applicable, or by termination provisions set forth in this Agreement.

3.2 New Operator shall perform its duties under this Agreement in compliance with this Agreement.

3.3 New operator shall (a) supervise and direct the management of the Facility in a financially sound, cost-effective and efficient manner, and (b) establish and maintain programs to promote the most effective utilization of the Facility's services and maximize occupancy and gross revenues.

3.4 During the Management Period the New Operator shall give regular reports concerning the operations of the Facility to the Board Chairperson of the Licensee and shall ensure that the Facility remains in compliance in all material respects with all regulations promulgated by all Governmental agencies, including life safety requirements, staffing requirements, physical plant requirements and all other regulatory requirements applicable to licensed health care facilities. If at any point in time during the Management Period, any regulatory survey (complaint

or standard) performed by CDPH identifies any deficiencies with a scope and severity of "**NC1**" or greater, New Operator shall have the latter of : (a) thirty (30) days after receipt of such survey results to bring the Facility into substantial compliance; or (b) until such time as CDPH is able to send a regulatory surveyor to the Facility to conduct a first time re-survey to clear such deficiencies identified in such prior survey results; and if substantial compliance is not achieved and such deficiencies failed to be cured by New Operator within the foregoing time frame, then Licensee may take unilateral action to cure the defect at New Operator's expense. Such expenses charged to New Operator for Licensee's curing of any such deficiencies shall include a reasonable allocation for overhead costs incurred by Licensee and associated with curing such deficiencies. Notwithstanding the foregoing, if any conduct by New Operator during the Management Period jeopardizes Licensee's general acute care hospital license or Medicare or Medicaid certification for Licensee's hospital, in the reasonable discretion of Licensee, Licensee may either: take unilateral action to remedy the defect, with the costs to be reimbursed by New Operator (including indirect and administrative costs) or declare this to be a material breach and cause for termination of this Agreement.

3.5 New Operator shall arrange (utilizing Facility personnel as appropriate) and pay, at its sole cost and expense, for the provision of sound bookkeeping, accounting, and administrative functions, including, but not limited to, the following, as reasonably necessary for the efficient and proper operation of the Facility:

3.5.1 Preparation and maintenance of business records and financial and other reports;

3.5.2 Establishment and administration of adequate accounting procedures and controls;

3.5.3 Adequate internal fiscal controls through proper budgeting and accounting procedures

3.5.4 Financial and business planning;

3.5.5 Timely processing and payment of accounts payable; and

3.5.6 Billing, processing and collection of accounts receivable, including the billing and completion of any reports and forms that may be required by insurance companies, governmental agencies or other third-party payors; and in conformity with applicable law, Licensee and New Operator shall not discriminate against Medicare and Medi-Cal patients who request services at the Facility.

3.6 New Operator shall (a) diligently monitor and assure physical plant maintenance and housekeeping, and (b) comply with any and all codes, ordinances, rules, regulations and requirements of all federal, state and municipal authorities now in force, or which may hereafter be in force, pertaining to the Facility and its operations.

3.7 Investments aimed at improving both the external and internal aesthetics of the Facility shall be undertaken during the term of this Agreement. Notably, any investment shall be considered as a credit towards future lease payments or asset purchases, if applicable.

3.7.1 All investments made, or any cash shortfalls advanced to the Facility, shall be fully forgiven and will not be recoverable, irrespective of the value of such investments or advances, during the term of this Agreement.

3.7.2 Notwithstanding the above, should the Facility elect to terminate this Agreement without just cause, all aforementioned investments and advances shall be transmuted into a payable obligation.

3.7.3 In such circumstances set forth in Section 3.7.2, the payable obligation created by the Facility's investments and advances will be due and repayable within a period of 24 months from the effective date of the Agreement's termination.

3.8 New Operator shall work with Licensee on an external and internal marketing campaign to build and strengthen relationships following the execution of this Agreement.

3.9 Upon completion of change of ownership, New Operator agrees to make necessary improvements to existing structures or replace existing structures as required to ensure compliance with state seismic regulations.

3.10 New Operator agrees to utilize the name "Orchard Hospital" or "Biggs-Gridley Memorial Hospital" in its name and marketing materials.

3.11 During the term of this Agreement, New Operator shall maintain quality and well trained budgeted non-support (i.e., clinical) department staffing levels of at least 95% or higher to ensure the efficient and effective delivery of healthcare services, and to support the operational needs and strategic goals of Facility. This commitment to maintaining appropriate staffing levels shall be reviewed periodically and adjusted at the recommendation of the New Operator to align with the evolving needs of the organizations and the communities they serve. New Operator shall comply with all applicable legal requirements having to do with employees, including without limitation workers compensation, unemployment insurance, hours of labor, wages, working conditions, benefits, and taxes.

4. Billings, Collections and Accounts Receivable.

4.1 New Operator shall, on behalf of Licensee, bill patients and payors and use its commercially reasonable efforts to timely collect all cash revenue resulting from Facility operations during the Billing Period. Licensee agrees to cooperate with New Operator to make available such billing and accounting information and to provide such financial records for review as shall be necessary to accomplish the billing and collection of patient charges for services provided for in this Section 4.1 and to cooperate with New Operator in the completion of reports and claim forms as necessary to procure payments and reimbursement from governmental agencies, insurance carriers or other third-party payors. During the Billing Period, Licensee authorizes New Operator to do the following:

4.2 To bill patients in Licensee's name, on Licensee's behalf and under Licensee's Provider Numbers, specifically including without limitation, services provided to Medicare and Medi-Cal patients during the Billing Period, and the resulting revenue will be treated as revenue

of Licensee (subject to New Operator's right to direct the use of such funds as herein provided and subject to New Operator's right to the Management Fee pursuant to Section 7 hereof);

4.2.1 To collect accounts receivable resulting from such billing in Licensee's name and on Licensee's behalf;

4.2.2 To receive payments from insurance companies, prepayments from health care plans, and payments from all other third-party payors;

4.2.3 To take possession of and endorse in the name of Licensee any notices, checks, money orders, insurance payments and other instruments received in payment of the accounts receivable resulting from such billing and deposit them directly in New Operator's account; and, to initiate legal proceedings in accordance with policies reasonably approved by Licensee to collect any accounts or monies owed to the Facility or Licensee related to the Facility during the Management Period. In connection with New Operator's assumption of operational and financial responsibility for the Facility, Licensee shall provide to New Operator its Medi-Cal and Medicare Provider Numbers, Submitter I.D., National Provider Identifier ("**NPI**") and any other identifying numbers which New Operator may use to bill for services provided to patients (of any payor source) at the Facility (collectively, the "**Provider Numbers**"). Notwithstanding the foregoing, Licensee shall remain ultimately responsible for the daily operational decisions and the care delivered to the patients at the Facility during the Management Period and, accordingly, Licensee shall have the right to confer and consult with New Operator on any administrative, business or management matters concerning the operation of the Facility during the Management Period; provided, however, such ultimate responsibility shall not relieve New Operator from its obligations specified in this Section 4, all of which shall apply during the Management Period.

4.3 For purposes hereof, the "**Billing Period**" shall mean the period from the Management Agreement Date until the occurrence of both of: (a) in the case of Medicare, the date on which the Centers for Medicare and Medicaid Services ("CMS") issues a tie-in notice and the fiscal intermediary has completed the process of tying the Licensee's Medicare Provider Number to the New Operator's NPI number and tax identification number, and (b) in the case of Medi-Cal, the date on which a Medi-Cal provider agreement has been issued to the New Operator by the Medi-Cal Provider Certification Office and a Medi-Cal enrollment has been approved for the New Operator by the Medi-Cal Provider Enrollment Division (collectively, the "Tie-In"). The Tie-In is complete when the Provider Numbers have been assigned over and transferred to New Operator, allowing New Operator to bill directly for services provided at the Facility.

4.4 All cash revenue received during the Management Period related to operating revenues for services rendered by New Operator on and before the Effective Date shall be under the control of New Operator, rather than Licensee.

4.4.1 New Operator shall use the cash revenues which relate to the operation of the Facility during the Management Period, or if necessary, make available additional cash to pay for expenses incurred during the Management Period, including both expenses paid during such period and expenses which are due before or after the Management Period but which were incurred both prior and during the Management Period.

4.4.2 Further, in order to maintain sufficient working capital for operations, the Days Cash on Hand (DCOH) shall be evaluated by the parties on a monthly basis. If the DCOH falls below the minimum threshold of twenty-five (25) days (the "**Minimum Threshold**") at any point during a given month, New Operator will rectify the shortfall according to the procedures in this Section. Within seventy-two (72) hours of the DCOH falling below the Minimum Threshold, New Operator will wire transfer a sufficient amount of funds to the Facility, sufficient to restore the DCOH to a minimum balance equal to or exceeding thirty (30) Days Cash on Hand. This procedure shall be carried out in compliance with all applicable laws, including without limitation, all applicable wire transfer and banking regulations.

5. Net Cash Assets and Matching Contribution.

5.1 As of the Effective Date, Licensee shall reserve its current investment cash assets and designate such investment assets as "**Board Reserved Funds**." Subject to this Section 5, these funds shall be used at the sole discretion of the Licensee's Board of Directors ("**Board**").

5.2 At the Board's sole discretion and only following an approval of a license Change of Ownership, the Board may choose to disperse Board Reserved Funds to New Operator under the following conditions:

5.2.1 If the Board elects a disbursement of funds from the Board Reserved Fund to the New Operator, it will be contingent upon pre-approval and presented in written form.

5.2.2 This pre-approval requires a formal request by the New Operator detailing the proposed investment into the Facility. This request should outline the following: a comprehensive description of the intended investment, an estimated cost of the investment, the projected time frame for completion, and an assessment of the anticipated community benefits resulting from such an investment.

5.3 Subject to any amounts reserved under this Section 5, the total amount of funds released from the Board Reserved Fund to the New Operator under this provision shall not exceed the total amount of net cash assets held within the Board reserved Fund as of the Effective Date of this Agreement.

5.4 The specifics of how the funds are used for enhancement of the Facility or services shall be determined by the New Operator, provided that all such uses are in compliance with all applicable laws, rules, regulations and this Agreement, and provided further that all such uses contribute positively to the provision of healthcare services at the Facility.

5.5 The Orchard Hospital Foundation ("**Foundation**") may reserve its cash assets, and the board may, in its discretion, designate such assets, in whole or in part, to be used as Board Reserved Funds in accordance with this Section 5.

5.6 Any outstanding lines of credit shall be paid by New Operator.

5.7 Within sixty (60) days of the execution of this Agreement, the New Operator shall ensure that any credit holds imposed by any vendors associated with the Facility are duly lifted. Under no circumstances shall the duration of accounts payable exceed the days in accounts payable

as stipulated in the audited financial reports for the year ending June 30, 2023. Further, the New Operator shall maintain strict adherence to this accounts payable cycle to ensure the continued financial health and vendor relationships of the Facility.

5.8 Following the removal of any credit holds and the payment of outstanding accounts payable, the New Operator shall be responsible for managing accounts payable throughout the term of this Agreement.

6. Net Equity Balance and Management

6.1 Based on the audited financial statements for the year ending June 30, 2023, the net equity remaining on the hospital's balance sheet shall be accurately calculated and recorded. This remaining net equity, herein referred to as the "**Net Equity Balance**," shall be reserved by the New Operator.

6.2 The Net Equity Balance, as reserved by the New Operator, is intended to be made payable upon approval of a Change of Ownership as outlined in this Agreement. However, the payment destination shall not be to a standard recipient but instead directed towards a designated non-profit organization or a selection of the Board's choice. The specifics of this payment, including the chosen recipient organization or Board's choice, shall be determined at the time of approval of the Change of Ownership and be in accordance with all applicable laws and regulations.

6.2.1 Notwithstanding the aforementioned, the Net Equity Balance shall be subject to adjustments during the Management Period. Specifically, the Net Equity Balance shall be reduced by the value of each investment made into the Facility's physical plant, whether in the form of enhancements, additions or similar improvements.

6.2.2 These investments into the Facility's physical plant shall be accurately recorded and deducted from the Net Equity Balance, resulting in an adjusted Net Equity Balance.

6.2.3 All adjustments to the Net Equity Balance will be duly documented and communicated between the parties in a timely manner. This provision ensures clarity and transparency in the management and calculation of the Net Equity Balance, and its relation to the investments made to the Facility's physical plant.

7. Management Fee.

7.1 For its services under Sections 3, New Operator shall be entitled to a fee from Licensee (the "**Management Fee**") equal to twenty-thousand dollars and 00/100 ($20,000.00) per month plus the Facility's operating revenues less all operating expenses, including the rent and related expenses due under the terms of this Agreement, resulting from operation of the Facility during and prior to the Management Period, calculated in accordance with New Operator's standard bookkeeping practices.

7.2 If the Facility incurs losses during the Management Period, New Operator shall be responsible for such losses and shall indemnify, protect, defend and hold Licensee harmless from

all claims, demands, liability and losses related thereto, inclusive of any expense that relates to operation of the Facility prior to the Management Agreement Date.

7.3 New Operator has responsibility to pay for liabilities accrued during the Management Period and liabilities accrued prior to the Management Agreement Date, if applicable.

8. Medical Staff.

8.1 Orchard Hospital shall grant or deny privileges to its own Medical Staff to provide services at the discretion of the Board and the Orchard Hospital Medical Staff during the term of this Agreement.

9. Patient Quality.

9.1 New Operator shall maintain or exceed existing core clinical quality standards as defined by the Centers for Medicare & Medicaid Services (CMS).

10. Change of Ownership.

10.1 Within 60 days of Management Agreement Date, Licensee shall file with the California Department of Public Health and the California State Attorney General's Office an application to change the ownership of Facility to New Operator and transfer its Medicare and Medi-Cal provider agreements, solely to the extent permitted by law, and subject to all terms, conditions and obligations set forth herein.

10.2 New Operator shall diligently proceed with securing the Permits and shall, (a) from time to time, upon request of Licensee, advise Licensee of the status of New Operator's efforts to secure the Permits, and (b) promptly advise Licensee once the anticipated Transition Date is known to New Operator. New Operator shall be solely responsible for any and all costs associated with the CHOW process. Licensee agrees to execute all documentation required by CDPH or CMS in connection with its review and approval of New Operator's CHOW, including, but not limited to, completing portions of CMS Form 855A requiring information about Licensee and Licensee's signature to assign the Medicare provider agreement. Licensee further agrees to provide New Operator or New Operator's representatives with an attestation that the Facility does not retain patient trust funds.

10.3 Promptly upon receipt of a request therefore from Licensee, New Operator will provide Licensee with copies of its licensure applications and any further documents submitted by New Operator to CDPH in response to any requests from such governmental authority and with copies of its Permits.

10.4 Licensee shall otherwise cooperate with New Operator, to the extent reasonably necessary, in order to facilitate the issuance of the new Permits and shall not voluntarily surrender its Permits or Medicare or Medi-Cal provider agreements.

10.5 The parties recognize and agree that there are certain regulatory requirements for transitioning the ownership of the hospital to new operator. The parties agree that they will work

cooperatively to facilitate all regulatory approvals, but recognize there may be a point at which the necessary approvals may not be timely forthcoming or may be unreasonable. At that point, the parties agree to work cooperatively together to revise the transaction to accommodate any new regulatory requirements or timelines.

11. Cost Reports.

11.1 At the end of the Management Period, Licensee shall timely prepare and file with the appropriate Medicare and Medi-Cal agencies any final cost reports with respect to its operation of the Facility which are required to be filed by law under the terms of the Medicare and Medi-Cal programs. Within five (5) business days of request by New Operator, Licensee shall provide New Operator with copies of such cost reports, together with copies of any amendments thereto and correspondence related to such final cost reports. Licensee shall pay for any costs related to the preparation or filing of cost reports or Medi-Cal cost audits for any period prior to the Management Agreement Date and New Operator shall pay any costs related to the preparation or filing of costs reports or Medi-Cal cost audits for periods from and following the Management Agreement Date. In the event Licensee fails to timely file any cost report, New Operator shall have the right to do so in Licensee's name and at Licensee's expense.

12. Employees.

12.1 Licensee shall retain employees sufficient to provide safe and high-quality operations, at the direction of the New Operator's appointed chief executive officer.

12.2 During the Management Period, Licensee shall maintain the minimum staffing required by all regulations and Governmental agencies having jurisdiction over the Facility.

12.3 For the purposes of this provision, an "**Officer**" shall mean any person employed by the Facility in a senior management position, including, but not limited to, the Chief Financial Officer, Chief Operating Officer, Chief Nursing Officer, Chief Medical Officer, and Chief Clinic Administrator.

12.4 Subject to the terms and conditions set forth in this provision, the New Operator hereby guarantees that each Officer, as defined in Section 12.3, shall have continuous and uninterrupted employment for a minimum period of one hundred eighty (180) days from the commencement of their service as an Officer ("**Employment Guarantee Period**").

12.5 In the event that an Officer's employment is terminated by the New Operator without cause during the Employment Guarantee Period, the New Operator shall pay to the Officer, as compensation for such termination, an amount equal to the Officer's regular salary for the remaining portion of the Employment Guarantee Period, subject to the conditions set forth in this Section 12.

12.6 The Officer shall not be entitled to the termination compensation set forth in Section 12.5 if the Officer voluntarily resigns or retires from their position, or if the Officer's employment is terminated for cause, including, but not limited to, fraud, poor performance, embezzlement, gross misconduct, or violation of any applicable law or regulation or the New Operator's policies and procedures.

12.7 The termination compensation payable under Section 12.5 shall be paid in a lump sum within thirty (30) days after the date of termination or as otherwise required by applicable law.

12.8 The receipt of the termination compensation set forth in Section 12.5 shall be in lieu of any other severance, notice, or termination benefits that the Officer may be entitled to under any employment agreement, plan, policy, or statute, except as otherwise expressly provided by the New Operator and is conditioned upon signing a mutual release and hold harmless agreement thereby removing any rights to file a suit against the Facility or New Operator for any such termination either with or without cause.

13. Costs and Prorations.

13.1 In addition to any costs for which New Operator is responsible this Agreement, New Operator shall be solely responsible for all costs, fees and expenses incurred by it in connection with the transfer of operations of the Facility as contemplated hereunder, including, but not limited to, the cost of any training of the Facility's employees which it may elect to undertake with the approval of Licensee, which approval shall not be unreasonably withheld, conditioned or delayed, provided such training is conducted in a manner which does not disrupt the operation of the Facility prior to the Management Agreement Date, and the cost of any due diligence that it undertakes in furtherance of such transfer of operations, including, but not limited to, the costs of any examination or copying by New Operator or its agents of any books, records, patient files or other operational or fiscal information and data of any kind of Licensee or the Facility. In furtherance and not in limitation of the foregoing, in the event that in the process of any such employee training and/or due diligence examinations Licensee shall incur any out-of-pocket costs or expenses related to the use of its employees, equipment and/or the provision of any such information, New Operator shall, within seven (7) days after a written demand therefor accompanied by reasonably detailed supporting documentation, reimburse Licensee for all of such out-of-pocket costs and expenses.

14. Access to Records.

14.1 On the Management Agreement Date, Licensee shall deliver to New Operator, upon request, all records exclusively used in the operation of the Facility. Nothing herein shall be construed as precluding Licensee from removing from the Facility (a) the originals of the financial records that relate to its operations at the Facility, including all accounts payable and accounts receivable records; provided, however, Licensee shall leave copies of such records at the Facility in order to facilitate the provisions of this Agreement, (b) the originals of any proprietary materials related to its overall corporate operations, (c) the originals of all performance improvement data, (d) originals of employee records for all former employees not employed by New Operator, (e) copies of employee records, (f) copies of patient records for all former patients no longer residing at the Facility, (g) copies of records for all current patients residing at the facility, and (h) legacy records stored either on-site or off-site. The parties acknowledge that, with respect to records associated with current patients residing at the facility, Licensee will deliver to New Operator on the Management Agreement Date such paper records that will to allow New Operator to care for the patients in the short term until New Operator establishes its own electronic access to such records. Notwithstanding anything to the contrary in this Agreement, Licensee and New Operator

agree that all information, records and data collected or maintained regarding Facility patients shall be confidential. Licensee, New Operator, and their respective employees and agents shall maintain the confidentiality of all Facility patient information received in accordance with applicable California and federal laws, including the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91) ("**HIPAA**") the Health Information Technology for Economic and Clinical Health Act Public Law 111-005 ("HITECH") and the regulations issued in connection therewith. No employee or agent of Licensee or New Operator shall discuss, transmit or narrate in any manner any Facility patient information of a personal, medical or other nature except as a necessary part of providing services to the patient, effectuating a transfer of the Facility operations, or otherwise fulfilling its obligations under this Agreement or under law. New Operator acknowledges that it will become the custodian of records for all medical records of the Facility transferred to it pursuant to this Section 14.1 and shall timely respond to subpoenas and patient requests for access to medical records pursuant to HIPAA and HITECH. The obligations under this Section 14 shall survive the termination of this Agreement, whether by rescission or otherwise as amended and the regulations issued in connection therewith.

14.2 New Operator agrees to maintain such books, records and other materials comprising records of the Facility's operations, including, but not limited to, patient records, to the extent required by law, which relate to the period preceding the Management Agreement Date and which have been delivered to New Operator by Licensee in conjunction herewith. If upon the expiration of any legislatively mandated retention period for such books and records, New Operator decides to dispose of or destroy such books and records, New Operator shall, upon receipt of a written request from Licensee, allow Licensee a reasonable opportunity to remove such books and records, at Licensee's sole cost and expense, from the Facility.-

14.3 Upon request, New Operator shall provide Licensee with information relating to the Facility and New Operator that (a) may be required for Owner to prepare financial statements and to comply with applicable laws, (b) may be required for Licensee to prepare tax returns, or (c) other records that Licensee may reasonable request in connection with this Agreement and the Facility.

14.4 New Operator acknowledges and agrees that the books, records and other material described in this Section 14 are unique, that in the event of a breach by New Operator of its obligations under this Section 14, Licensee would suffer injury for which it would not be fully compensated with monetary damages and accordingly that in the event of a breach by New Operator of its obligations under this Section 14, Licensee shall be entitled to seek to enjoin a breach by New Operator of its obligations under this Section 14 and/or to specifically enforce the obligations of New Operator hereunder.

15. Proprietary Information and Materials.

15.1 New Operator acknowledges and agrees that any and all proprietary and confidential materials and information located at and used in connection with the operation of the Facility, which are not being transferred to New Operator pursuant to this Agreement, shall be and remain the property of Licensee, and accordingly, that Licensee shall remove all of such materials and information from the Facility on or immediately before the Management Agreement Date. Licensee's policies and procedures manuals are being transferred to New Operator.

16. Computer Software and Hardware.

Licensee shall transfer its accounts receivable data in electronic or paper form to New Operator on the Management Agreement Date. Licensee agrees to cooperate with New Operator in transferring such information and shall allow, to the extent such temporary arrangement is permissible under Licensee's vendor contracts, New Operator to use Licensee's computer systems and software that relate exclusively to the operation of the Facility for a period up to ninety (90) days after the Management Agreement Date for accounts receivable collections and patient care maintenance. New Operator shall bear the expense of interfacing computer software and hardware with existing infrastructure.

17. Indemnification.

17.1 Licensee hereby agrees to indemnify, protect, defend and hold harmless New Operator and its members, managers, directors, board of directors, officers, employees, agents, successors and assigns from and against any and all demands, claims, causes of action, fines, penalties, damages, losses, liabilities (including strict liability), judgments and expenses (including without limitation, reasonable attorneys' and other professionals' fees and court costs) (collectively, a "Loss") incurred in connection with or arising from the following: (a) a breach by Licensee of its obligations under this Agreement which is not cured within thirty (30) days after receipt of written notice from New Operator setting forth, in reasonable detail, the nature of such breach, (b) (i) any Operating Contract to which Licensee is a party that is not an Assigned Contract, and/or (ii) any Assigned Contract with respect to periods occurring prior to the Management Agreement Date, (c) the leasing, occupancy or operation of the Facility by Licensee prior to the Management Agreement Date, (d) any acts, omissions, elder abuse (as that term is defined in California Welfare and Institutions Code §15610) or negligence of Licensee or any person claiming under Licensee or the contractors, agents, employees, invitees or visitors of Licensee with respect to the Facility and its patients and patients prior to the Management Agreement Date, (e) any failure by Licensee to pay any liabilities in connection with the Facility attributable to periods prior to the Management Agreement Date, including, but not limited to, quality assurance fees or bed taxes, (f) any claim by any Governmental Entity, third-party payor, RAC audit, ZPIC audit, or any claim of recapture by CMS, the U.S. Office of Inspector General or any other Governmental Entity with respect to an alleged Medicare or Medi-Cal overpayment for periods relating prior to the Management Agreement Date, including without limitation, any COVID Payments and Advances received by Licensee, as well as other funds received by Licensee related to the Coronavirus Aid, Relief and Economic Security Act (the "CARES Act"), Paycheck Protection Program ("PPP"), CMS Accelerated and Advance Payments ("AAP") or any other state or federal stimulus funding related to the COVID-19 pandemic (collectively, the "Stimulus/Relief "), and/or (g) the designation of the Facility as a "Special Focus Facility" by CMS, as a result of any action, omission, circumstance or event that occurs prior to the Management Agreement Date.

17.2 New Operator hereby agrees to indemnify, protect, defend and hold harmless Licensee and its directors, officers, employees, agents, successors and assigns from and against any and all "Loss" or "Losses" incurred in connection with or arising from: (a) a breach by New Operator of its obligations under this Agreement which is not cured within thirty (30) days after receipt of written notice from Licensee setting forth in reasonable detail the nature of such breach; (b) the occupancy or operation of the Facility by New Operator from and after the Management

Agreement Date, (c) any acts, omissions, elder abuse (as that term is defined above) or negligence of New Operator or any person claiming under New Operator or the contractors, agents, employees, invitees or visitors of New Operator with respect to the Facility and its patients and patients from and after the Management Agreement Date, (d) the obligations and liabilities under any Assigned Contract with respect to periods occurring on and after the Management Agreement Date, (e) any employment claims made against Licensee for employment issues occurring after the Management Agreement Date, (f) any failure by New Operator to pay any liabilities in connection with the Facility attributable to period from and after the Management Agreement Date (including without limitation, reasonable attorneys' and other professionals' fees and court costs), (g) any failure by New Operator to pay any liabilities in connection with the Facility attributable to periods from and after the Management Agreement Date, including, but not limited to, bed taxes, and/or (h) any claim by any Governmental Entity, third -party payor, RAC audit, ZPIC audit, or any claim of recapture by CMS, the U.S. Office of Inspector General or any other Governmental Entity with respect to an alleged Medicare or Medi-Cal overpayment for periods relating from and after the Management Agreement Date.

18. Further Assurances. Each of the parties hereto agrees to execute and deliver any and all further agreements, documents or instruments reasonably necessary to effectuate this Agreement and the transactions referred to herein or contemplated hereby or reasonably requested by the other party to perfect or evidence their rights hereunder.

19. Notices. All notices to be given by either party to this Agreement to the other party hereto shall be in writing, and shall be (a) given in person, (b) deposited in the United States mail, certified or registered, postage prepaid, return receipt requested, or (c) sent by national overnight courier service with confirmed receipt, each addressed as follows:

If to New Operator:

If to Licensee: Orchard Hospital
Attn: Ed Becker, Board Chairperson
240 Spruce Street
Gridley, CA 95948
Facsimile: (530) 797-9027

Any such notice shall be deemed delivered when actually received or when delivery is first refused regardless of the method of delivery used. Any party to whom notices are to be sent pursuant to this Agreement may from time to time change its address for further communications thereunder by giving notice in the manner prescribed herein to all other parties hereto. Although either party shall have the right to change its address for notice purposes from time to time, any notice delivered pursuant to this Section 19 to the address set forth in this Section 19, or to such other address as may be hereafter specified in writing in accordance with this Section 19 shall be effective even if actual delivery cannot be made as a result of a change in the address of the recipient of such notice and the party delivering the notice has not received actual written notice in accordance with the provisions of this Section 19 of the current address to which notices are to be sent.

20. Payment of Expenses. Each party hereto shall bear its own legal, accounting and other expenses incurred in connection with the preparation and negotiation of this Agreement and the consummation of the transactions contemplated hereby, whether or not the transaction is consummated.

21. Representations and Warranties.

21.1 To the best of Licensee's knowledge, Licensee hereby represents and warrants to New Operator, as of the Management Agreement Date, that:

21.1.1 Licensee is a not for profit corporation duly organized, validly existing and in good standing under the laws of the State of California, and has all necessary power and authority to operate and carry on its business as it is now being conducted. Licensee has the power and authority to execute and deliver this Agreement to New Operator, and to perform its obligations under this Agreement, and to undertake the transactions contemplated hereby.

21.1.2 All Medicare and Medi-Cal provider agreements, certificates of need, if applicable, and all material certifications, governmental licenses, permits, regulatory agreements or other agreements and approvals, including certificates of operation, completion and occupancy, and state nursing facility licenses or other licenses required by any applicable health care authorities for the legal use, occupancy and operation of the Facility have been obtained by the Licensee, including approved provider status in any approved third-party payor program and remain in full force and effect.

21.1.3 The Facility is duly licensed as a twenty-four (24)-bed critical access hospital as required under the applicable laws of the State of California and there are no proceedings or actions pending or contemplated to reduce the number of licensed or certified beds of the Facility.

21.1.4 Licensee has not had any deficiencies on its most recent survey (standard or complaint) that would result in a denial of payment for new admissions with no opportunity to correct prior to termination, and the Facility has not been designated as a Special Focus Facility (as such term is defined by the Centers for Medicare and Medicaid Services Special Focus Facility Program).

21.1.5 The Facility is in substantial compliance with applicable federal and state laws governing or regulating the operation of skilled nursing facilities in California.

21.1.6 There are no pending actions, complaints, administrative or judicial proceedings pending against the Facility or Licensee relating to the Facility, or have otherwise been disclosed to New Operator.

21.1.7 The execution and delivery of this Agreement by Licensee does not violate any provision of any agreement or judicial order to which Licensee is a party or to which Licensee is subject.

21.1.8 All payroll taxes and employee wages for the period prior to the Management Agreement Date are or will be timely paid in full and current and all required tax

returns have been or will be timely filed with the applicable taxing authority and are or will be accurate in all material respects.

21.1.9 The execution, delivery and performance of this Agreement has been duly authorized by Licensee, and this Agreement constitutes the valid and binding obligation of Licensee, fully enforceable in accordance with its terms, except as enforceability may be restricted, limited or delayed by applicable bankruptcy or other laws affecting creditors' rights generally and except as enforceability may be subject to general principles of equity.

21.1.10Licensee's general acute care hospital license and Medicare and Medi-Cal certification that apply to the Facility (collectively, "**Licensee's Permits**") have been lawfully and validly issued and is in full force and effect and good standing. Licensee has no notice of any pending or, threatened, action with respect to the revocation, cancellation, rescission, suspension or limitation of, or refusal to renew of any of Licensee's Permits. Licensee has not been notified or presently has any reason to believe any of Licensee's Permits will not be renewed in the ordinary course of business upon its expiration.

21.1.11Neither the Licensee nor the Facility has any outstanding overpayments or refunds due to the Medicare or Medicaid programs for services delivered at the Facility, there are no pending RAC, ZPIC or other program integrity audits, or any amounts owed to the Medicare or Medicaid program that will not have been paid in full by the Management Agreement Date and neither Licensee nor the Facility owes, overpayments, refunds, any provider, bed or similar taxes or quality assurance fees or other payments to the Medicare or Medicaid programs, relating to any event or circumstance existing or occurring at any time prior to the Management Agreement Date.

21.1.12Licensee is in compliance with all federal anti-kickback statutes, the Stark law, the federal False Claims Act and any state law prohibiting kickbacks or certain referrals relating or applicable to Medicare or any other state or federal health care programs.

To the best of New Operator's knowledge, New Operator hereby represents and warrants to Licensee as of the Management Agreement Date, that:

New Operator is corporation duly organized, validly existing and in good standing under the laws of the State of California, and has all necessary power and authority to operate and carry on its business as it is now being conducted. New Operator has the power and authority to execute and deliver this Agreement to Licensee, and to perform its obligations under this Agreement, and to undertake the transactions contemplated hereby.

The execution and delivery of this Agreement by New Operator does not violate any provision of any agreement or judicial order to which New Operator is a party or to which New Operator is subject.

The execution, delivery and performance of this Agreement has been duly authorized by New Operator, and this Agreement constitutes the valid and binding obligation of New Operator, fully enforceable in accordance with its terms, except as enforceability may be restricted, limited or delayed by applicable bankruptcy or other laws affecting creditors' rights generally and except as enforceability may be subject to general principles of equity.

22. Termination. This Agreement shall terminate if any of the following happen prior to the Transition Date:

22.1 New Operator does not pursue with reasonable deliberate speed the Transition Date;

22.2 New Operator's Medicare or Medi-Cal applications filed in connection with implementation of the Transition Date are denied in finality without opportunity to appeal;

22.3 New Operator shall become unable to pay its debts when they are due or files for bankruptcy; or

22.3.1 In the event that the New Operator becomes insolvent, or files for bankruptcy, or chooses or is compelled to cancel, void, terminate, or otherwise conclude this Agreement, whether voluntarily or involuntarily, the Board of Directors of the Facility, or its designated delegate, shall have the exclusive and preemptive right, but not the obligation, to purchase the hospital license from the New Operator for a nominal consideration of One Dollar (USD 1.00), and any such expenses or monies owed by Facility to the New Operator, or perceived to be owed, shall be forgiven.

22.3.2 Notice of Insolvency or Bankruptcy: The New Operator shall promptly notify the Board of Directors or its designated delegate in writing of any occurrence of insolvency or filing for bankruptcy.

22.3.3 Exercise of Right of Refusal: Upon receipt of the notice in Section 22.3.2, the Board of Directors or its designated delegate shall have thirty (30) calendar days to exercise its right of first refusal by providing written notice to the New Operator of its intent to purchase the hospital license and begin proceedings to acquire the license through the California Department of Public Health and the California State Attorney General.

22.3.4 Transfer of License: If the Board of Directors or its designated delegate exercises its right of first refusal, the New Operator shall cooperate and take all necessary actions to effectuate the transfer of the hospital license to the Board of Directors or its designated delegate for the agreed-upon consideration of One Dollar (USD 1.00).

22.3.5 Non-exercise of Right of Refusal: If the Board of Directors or its designated delegate elects not to exercise its right of first refusal, or fails to provide the required notice within the specified time period, the right of first refusal shall be deemed to have been waived, and the New Operator shall be free to sell or otherwise transfer the hospital license in accordance with applicable laws and regulations, subject to any other rights or restrictions that may be set forth in the relevant agreements or governing documents.

22.4 If there is a material breach of this Agreement by New Operator, which remains uncured after thirty (30) days written notice from Licensee; or

22.5 New Operator is unable or unwilling to meet the terms set forth by the California State Attorney General for an acquisition or CHOW of hospital license.

23. Entire Agreement; Amendment; Waiver. This Agreement, together with the other agreements referred to herein, constitutes the entire understanding between the parties with respect to the subject matter hereof, superseding all negotiations, prior discussions and preliminary agreements. This Agreement may not be modified or amended except in writing signed by the parties hereto. No waiver of any term, provision or condition of this Agreement in any one (1) or more instances, shall be deemed to be or be construed as a further or continuing waiver of any such term, provision or condition of this Agreement. No failure to act shall be construed as a waiver of any term, provision, condition or rights granted hereunder.

24. Assignment.

24.1 Licensee may not assign its rights nor delegate its duties hereunder to anyone without the prior written consent of New Operator. New Operator may assign its rights and/or delegate its duties hereunder to any entity owned, managed, affiliated with or controlled directly or indirectly by New Operator ("**New Operator's Internal Assignment**"). Any other assignment or delegation by New Operator hereunder shall require the prior written consent of Licensee, which consent shall not be unreasonably withheld or delayed, except that any change or transfer of Facility license shall not be done so without the majority vote of the Facility's Board of Directors or delegated party.

25. Requirement to Maintain Insurance.

25.1 Throughout the duration of this Agreement, and until such time as the real assets of the Facility transfer to the New Operator, the New Operator shall be required to maintain an adequate level of insurance coverage for the real assets of the Facility.

25.2 The New Operator shall procure and maintain, at their own expense, a comprehensive insurance policy that provides coverage against potential risks, including but not limited to, property damage, theft, natural disaster, and liability issues.

25.3 The minimum level of insurance coverage shall be determined based on the appraised value of the real assets and any additional costs that may arise in case of an unforeseen incident or risk event. The specifics of this coverage, including the minimum levels of insurance, shall be agreed upon by both parties and outlined in an insurance policy.

25.4 The New Operator shall provide proof of this insurance coverage upon request and shall promptly notify all relevant parties of any changes to the insurance policy.

25.5 Failure to maintain the minimum level of insurance as agreed upon may be deemed a breach of this Agreement. In such an event, the Facility reserves the right to obtain an adequate insurance policy covering the real assets at the New Operator's expense

26. No Joint Venture; Third-Party Beneficiaries. Nothing contained herein shall be construed as forming a joint venture or partnership between the parties hereto with respect to the subject matter hereof. The parties hereto do not intend that any third party shall have any rights under this Agreement except as expressly provided.

27. Captions. The section headings contained herein are for convenience only and shall not be considered or referred to in resolving questions of interpretation.

28. Counterparts. This Agreement may be executed and delivered via facsimile and in one (1) or more counterparts and all such counterparts taken together shall constitute a single original agreement.

29. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of California, County of Butte, without regard to principles of conflicts of law.

30. Costs and Attorneys' Fees. In case a disagreement arises between the parties concerning the interpretation or implementation of the terms herein, Section 35, shall apply. Each party shall bear its own attorney costs and other expenses relating to such dispute..

31. Construction. Both parties acknowledge and agree that they have participated in the drafting and negotiation of this Agreement. Accordingly, in the event of a dispute between the parties hereto with respect to the interpretation or enforcement of the terms hereof no provision shall be construed so as to favor or disfavor either party hereto. All references to "applicable law" herein shall refer to laws, statutes, rules, regulations and judicial or administrative interpretations thereof.

32. Opening Mail. From and after the Management Agreement Date, New Operator shall be authorized to open mail addressed to Licensee received at the Facility. All mail received at the Facility relating to Licensee's operation of the Facility prior to the Management Agreement Date shall be promptly delivered to Licensee by New Operator at the address set forth in Section 18, with all such mail to be hand delivered or deposited in the United States mail, certified or registered, postage prepaid, return receipt requested within five (5) days of receipt.

33. Protected Health Information. The parties acknowledge that in performing its obligations under Sections 2 and 3 of this Agreement, New Operator will be a business associate of Licensee, as that term is defined in 45 C.F.R. Section 160.130. Accordingly, the parties adopt and incorporate by reference the provisions of the Business Associate Addendum attached to this Agreement as "**EXHIBIT A**."

34. Successors. Subject to the express provisions of this Agreements, the covenants and agreements contained in this Agreement bind and inure to the benefit of Licensee, New Operator, and their respective successors and assigns.

35. Severability. If any covenant, condition, provision, term or agreement of this Agreement is, to any extent, held invalid or unenforceable, the remaining portion thereof and all other covenants, conditions, provisions, terms and agreements of this Agreement will not be affected by such holding, and will remain valid and in force to the fullest extent permitted by law.

36. Time is of the Essence. Time is of the essence with respect to the performance of every provision of this Agreement in which time of performance is a factor.

37. Electronic Signatures. Signatures to this Agreement transmitted by electronic mail, facsimile or other electronic means shall be the equivalent of original signatures for all purposes.

38. Survivability. The Parties agree that, in the event of termination, expiration, or cancellation of this Agreement for any reason, certain provisions herein shall remain in effect. These provisions include, but are not limited to, representations, warranties, covenants, indemnification obligations, and any other obligations that are inherently intended to continue beyond termination, specifically Sections 17-40. These surviving provisions shall remain in effect for a minimum duration as required by any provisions set forth by the California State Attorney General or for a period of five (5) years, whichever is longer. The Parties recognize and agree that maintaining these provisions after the Agreement's termination is essential to safeguard their respective rights, obligations, and interests in accordance with this Agreement and applicable law.

39. PROVISION FOR ALTERNATIVE DISPUTE RESOLUTION (ADR) CONCLUDING WITH BINDING ARBITRATION AND WAIVER OF RIGHT TO TRIAL BY COURT OR JURY

39.1 THIS PROVISION OUTLINES THE AGREEMENT OF THE PARTIES TO RESOLVE ANY DISPUTES, CONTROVERSIES, OR CLAIMS ARISING OUT OF OR RELATING TO THIS AGREEMENT, OR THE BREACH, TERMINATION, OR VALIDITY THEREOF (COLLECTIVELY, "DISPUTES") THROUGH ALTERNATIVE DISPUTE RESOLUTION (ADR) METHODS, CONCLUDING WITH BINDING ARBITRATION, AS DESCRIBED HEREIN. THE PARTIES EXPRESSLY AGREE TO WAIVE THEIR RIGHTS TO A TRIAL BY COURT OR JURY, AND TO RESOLVE THEIR DISPUTES EXCLUSIVELY THROUGH THE ADR PROCESS DETAILED BELOW.

39.2 NEGOTIATION

39.2.1 THE PARTIES SHALL FIRST ATTEMPT TO RESOLVE ANY DISPUTE INFORMALLY THROUGH GOOD FAITH NEGOTIATION. EITHER PARTY MAY INITIATE SUCH NEGOTIATION BY PROVIDING WRITTEN NOTICE TO THE OTHER PARTY, DETAILING THE NATURE OF THE DISPUTE AND PROPOSING A RESOLUTION. THE PARTIES SHALL ENGAGE IN NEGOTIATION FOR A PERIOD OF THIRTY (30) DAYS FROM THE DATE OF RECEIPT OF THE WRITTEN NOTICE, UNLESS OTHERWISE AGREED UPON BY THE PARTIES IN WRITING.

39.3 MEDIATION

39.3.1 IF THE DISPUTE REMAINS UNRESOLVED FOLLOWING GOOD FAITH NEGOTIATION, THE PARTIES SHALL PROCEED TO MEDIATION. THE PARTIES SHALL MUTUALLY AGREE UPON A QUALIFIED, NEUTRAL MEDIATOR WITHIN FIFTEEN (15) DAYS OF THE CONCLUSION OF THE NEGOTIATION PERIOD. THE MEDIATION SHALL BE CONDUCTED IN ACCORDANCE WITH THE RULES OF A MUTUALLY AGREED-UPON MEDIATION SERVICE PROVIDER. THE PARTIES SHALL SHARE THE COST OF MEDIATION EQUALLY UNLESS OTHERWISE AGREED UPON IN WRITING. IF THE MEDIATION DOES NOT RESOLVE THE DISPUTE WITHIN THIRTY (30) DAYS OF THE MEDIATOR'S APPOINTMENT, OR WITHIN SUCH OTHER PERIOD

AS THE PARTIES MAY AGREE UPON IN WRITING, THE PARTIES SHALL PROCEED TO BINDING ARBITRATION.

39.4 BINDING ARBITRATION

39.4.1 ANY DISPUTE THAT REMAINS UNRESOLVED AFTER NEGOTIATION AND MEDIATION SHALL BE FINALLY AND EXCLUSIVELY SETTLED BY BINDING ARBITRATION. THE ARBITRATION SHALL BE ADMINISTERED BY A MUTUALLY AGREED-UPON ARBITRATION SERVICE PROVIDER, IN ACCORDANCE WITH ITS RULES AND PROCEDURES, AS AMENDED BY THIS PROVISION. THE ARBITRATION SHALL BE CONDUCTED BY A SINGLE ARBITRATOR, WHO SHALL BE SELECTED BY THE PARTIES OR, IF THE PARTIES CANNOT AGREE, BY THE ARBITRATION SERVICE PROVIDER IN ACCORDANCE WITH ITS RULES. THE ARBITRATOR'S AWARD SHALL BE FINAL, BINDING, AND NON-APPEALABLE, AND JUDGMENT ON THE AWARD MAY BE ENTERED IN ANY COURT HAVING JURISDICTION THEREOF.

39.5 WAIVER OF RIGHT TO TRIAL BY COURT OR JURY

39.5.1 BY AGREEING TO THIS PROVISION, THE PARTIES KNOWINGLY, VOLUNTARILY, AND INTENTIONALLY WAIVE THEIR RESPECTIVE RIGHTS TO A TRIAL BY COURT OR JURY FOR ANY DISPUTE ARISING OUT OF OR RELATED TO THIS AGREEMENT. THE PARTIES UNDERSTAND AND AGREE THAT ANY DISPUTE SHALL BE RESOLVED EXCLUSIVELY THROUGH THE ADR PROCESS DESCRIBED HEREIN, INCLUDING, IF NECESSARY, BINDING ARBITRATION. THIS WAIVER SHALL BE BINDING UPON AND INURE TO THE BENEFIT OF THE PARTIES, THEIR SUCCESSORS, AND ASSIGNS.

40. Confidentiality.

40.1 For the purposes of this Confidentiality Provision, "Confidential Information" shall mean the existence, terms, conditions, and subject matter of this Agreement, and any non-public information, whether written or oral, in any form, including but not limited to trade secrets, proprietary information, financial data, business plans, marketing strategies, customer lists, pricing information, research and development information, intellectual property, and any other information that either party considers to be confidential or proprietary, that is disclosed or made available by one party (the "**Disclosing Party**") to the other party (the "**Receiving Party**") in connection with this Agreement.

40.2 The Receiving Party agrees to:

40.2.1 Treat and maintain the Confidential Information, including the existence, terms, and conditions of this Agreement, as strictly confidential, and use the same degree of care to protect the Confidential Information as it uses to protect its own confidential information, but in no event less than a reasonable degree of care;

40.2.2 Not disclose, copy, reproduce, or distribute the Confidential Information, in whole or in part, to any third party without the prior written consent of the Disclosing Party, except as required by law, regulation, or court order, and subject to the notice requirement set forth below;

40.2.3 Restrict access to the Confidential Information to those employees, agents, or subcontractors of the Receiving Party who have a need to know such information for the performance of this Agreement, and who are bound by confidentiality obligations at least as protective as those set forth in this Confidentiality Provision;

40.2.4 Promptly notify the Disclosing Party in writing of any unauthorized use, disclosure, or breach of this Confidentiality Provision, and cooperate with the Disclosing Party in any effort to prevent or remedy such unauthorized use or disclosure; and

40.2.5 Upon termination or expiration of this Agreement, or at any time upon the Disclosing Party's written request, return or destroy all Confidential Information in the Receiving Party's possession, including any copies thereof, and certify in writing to the Disclosing Party that such return or destruction has been completed.

40.3 Exception.

40.3.1 The obligations of the Receiving Party set forth in this Confidentiality Provision shall not apply to any information that:

40.3.2 Was already known to the Receiving Party at the time of disclosure by the Disclosing Party, as evidenced by the Receiving Party's written records;

40.3.3 Is or becomes publicly available through no fault of the Receiving Party;

40.3.4 Is independently developed by the Receiving Party without reference to or use of the Disclosing Party's Confidential Information, as evidenced by the Receiving Party's written records;

40.3.5 Is rightfully obtained by the Receiving Party from a third party without restriction on disclosure and without breach of any obligation of confidentiality; or

40.3.6 Such a disclosure is required by law.

40.4 Duration

40.4.1 The obligations of the Receiving Party under this Confidentiality Provision shall survive the termination or expiration of this Agreement and continue for a period of five (5) years thereafter, unless a longer period is required by applicable law or by the nature of the specific Confidential Information.

40.5 Remedies

40.5.1 The Receiving Party acknowledges and agrees that any breach or threatened breach of this Confidentiality Provision may cause irreparable harm to the Disclosing Party for

which monetary damages may be inadequate, and that the Disclosing Party shall be entitled to seek injunctive or other equitable relief to enforce the terms of this Confidentiality Provision, in addition to any other remedies available at law or in equity.

[Signatures on following pages.]

IN WITNESS WHEREOF, the parties hereby execute this Management Services Agreement as of the day and year first set forth above.

LICENSEE:

ORCHARD HOSPITAL
a California not for profit corporation

By: [redacted]
Name: STEVE STARK
Title: CEO
June 12, 2023

NEW OPERATOR:
AMERICAN ADVANCED MANAGEMENT, INC.
a ~~California limited liability company~~ Delaware Corporation JS

By [redacted]
Name: Tammy Thompson
Title: CFO/VP of Finance

EXHIBIT A

BUSINESS ASSOCIATE ADDENDUM

ADDENDUM

This BUSINESS ASSOCIATE ADDENDUM ("**Addendum**") was entered into as of the 1st day of July 2023, ("**Commencement Date**"), by and between Orchard Hospital, a California not for profit corporation ("**Covered Entity**"), and American Advanced Management, Inc., a Delaware corporation ("**Business Associate**"). Covered Entity is referred to below as "**CE**." Business Associate is referred to below as "**BA**."

RECITALS

A. Covered Entity is the licensed operator of that certain critical access hospital located at 240 Spruce Street, Gridley, CA (the "**Facility**");

B. BA provides services to or on behalf of CE pursuant to the terms of that certain Management and Operations Transfer Agreement, dated as of July 1, 2023, by and between CE and BA (the "**Agreement**"), that may require CE to disclose the individually identifiable health information of some or all of its patients to BA or may require BA to create health information on behalf of CE, some of which may constitute Protected Health Information ("**PHI**") (defined below).

C. CE and BA intend to protect the privacy and provide for the security of PHI disclosed to BA pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("**HIPAA**"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("**HITECH Act**"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "**HIPAA Regulations**") and other applicable laws.

D. As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require CE to enter into a contract containing specific requirements with BA prior to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations ("**C.F.R.**") and contained in this Addendum.

NOW, THEREFORE, in consideration of the promises and mutual agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties, intending to be legally bound, agree as set forth below.

AGREEMENT

1. DEFINITIONS

1.1 **Breach** shall have the meaning given to such term under the HITECH Act [42 U.S.C. Section 17921].

1.2 **Business Associate** shall have the meaning given to such term under the Privacy Rule, the Security Rule, and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17938 and 45 C.F.R. Section 160.103.

1.3 **Covered Entity** shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Section 160.103.

1.4 **Data Aggregation** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

1.5 **Designated Record Set** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

1.6 **Electronic Protected Health Information** means Protected Health Information that is maintained in or transmitted by electronic media.

1.7 **Electronic Health Record** shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C. Section 17921.

1.8 **Health Care Operations** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

1.9 **Privacy Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

1.10 **Protected Health Information or PHI** means any information, whether oral or recorded in any form or medium: (a) that relates to the past, present or future physical or mental condition of an individual or the provision of health care to an individual; and (b) that identifies the individual or with respect to where there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501. Protected Health Information includes Electronic Protected Health Information [45 C.F.R. Sections 160.103, 164.501].

1.11 **Protected Information** shall mean PHI provided by CE to BA or created or received by BA on CE's behalf.

1.12 **Security Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

1.13 **Unsecured PHI** shall have the meaning given to such term under the HITECH Act and any guidance issued pursuant to such Act including, but not limited to, 42 U.S.C. Section 17932(h).

2. OBLIGATIONS OF BA

2.1 Permitted Uses. BA shall not use or disclose Protected Information except for the purpose of performing BA's obligations under the Agreement and as permitted under the

Agreement and this Addendum. Further, BA shall not use or disclose Protected Information in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so used by CE. However, BA may use or disclose Protected Information (a) for the proper management and administration of BA, (b) to carry out the legal responsibilities of BA, or (c) for Data Aggregation purposes for the Health Care Operations of CE [45 C.F.R. Sections 164.504(e)(2)(i), 164.504(e)(2)(ii)(A) and 164.504(e)(4)(i)].

2.2 Permitted Disclosures. If BA discloses Protected Information to a third party, BA must obtain, prior to making any such disclosure, (a) prior written approval from CE, (b) reasonable *written* assurances from such third party that such Protected Information will be held confidential as provided pursuant to this Addendum and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and (c) a *written* agreement from such third party to immediately notify BA of any breaches of confidentiality of the Protected Information, to the extent it has obtained knowledge of such breach [42 U.S.C. Section 17932; 45 C.F.R. Sections 164.504(e)(2)(i), 164.504(e)(2)(i)(B), 164.504(e)(2)(ii)(A) and 164.504(e)(4)(ii)].

2.3 Notice of Request for PHI. BA agrees to notify CE within two (2) business days of receipt of any request, subpoena or other legal process to obtain PHI or an accounting of PHI. CE, in its discretion, shall determine whether BA may disclose PHI pursuant to such request, subpoena or other legal process. BA agrees to cooperate fully with CE in any legal challenge initiated by CE in response to such request, subpoena or other legal process. The provisions of this section shall survive the termination of this Addendum.

2.4 Prohibited Uses and Disclosures. BA shall not use or disclose Protected Information for fundraising or marketing purposes. BA shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out-of-pocket in full for the health care item or service to which the PHI solely relates [42 U.S.C. Section 17935(a)]. BA shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of CE and as permitted by the HITECH Act, 42 U.S.C. Section 17935(d)(2); however, this prohibition shall not affect payment by CE to BA for services provided pursuant to the Agreement.

2.5 Appropriate Safeguards. BA shall implement appropriate safeguards as are necessary to prevent the use or disclosure of Protected Information otherwise than as permitted by the Agreement or this Addendum, including, but not limited to, administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Protected Information, in accordance with 45 C.F.R Section 164.308(b). BA shall comply with the policies and procedures and documentation requirements of the HIPAA Security Rule, including, but not limited to, 45 C.F.R. Section 164.316 [42 U.S.C. Section 17931].

2.6 Reporting of Improper Access, Use or Disclosure. BA shall report to CE in writing of any access, use or disclosure of Protected Information not permitted by the Agreement and Addendum, and any Breach of Unsecured PHI of which it becomes aware without unreasonable delay and in no case later than two (2) calendar days after discovery [42 U.S.C. Section 17921; 45 C.F.R. Section 164.504(e)(2)(ii)(C); 45 C.R.R. Section 164.308(b)].

2.7 BA's Agents. BA shall ensure that any agents, including subcontractors, to whom it provides Protected Information, agree in writing to the same restrictions and conditions that apply to BA with respect to such PHI. If BA creates, maintains, receives or transmits electronic PHI on behalf of CE, then BA shall implement the safeguards required Section 2.5 with respect to Electronic PHI [45 C.F.R. Section 164.504(e)(2)(ii)(D); 45 C.F.R. Section 164.308(b)]. BA shall implement and maintain sanctions against agents and subcontractors that violate such restrictions and conditions and shall promptly mitigate the effects of any such violation (see 45 C.F.R. Sections 164.530(f) and 164.530(e)(1)).

2.8 Access to Protected Information. BA shall make Protected Information maintained by BA or its agents or subcontractors available to CE for inspection and copying within ten (10) days of a request by CE to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.524 [45 C.F.R. Section 164.504(e)(2)(ii)(E)]. If BA maintains an Electronic Health Record, BA shall provide such information in electronic format to enable CE to fulfill its obligations under the HITECH Act, including, but not limited to, 42 U.S.C. Section 17935(e).

2.9 Amendment of PHI. Within ten (10) days of receipt of a request from CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, BA or its agents or subcontractors shall make such Protected Information available to CE for amendment and incorporate any such amendment to enable CE to fulfill its obligation under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.526. If any individual requests an amendment of Protected Information directly from BA or its agents or subcontractors, BA must notify CE in writing within five (5) days of the request. Any approval or denial of amendment of Protected Information maintained by BA or its agents or subcontractors shall be the responsibility of CE [45 C.F.R. Section 164.504(e)(2)(ii)(F)].

2.10 Accounting Rights. Within ten (10) calendar days of notice by CE of a request for an accounting for disclosures of Protected Information or upon any disclosure of Protected Information for which CE is required to account to an individual, BA and its agents or subcontractors shall make available to CE the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.528, and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17935(c), as determined by CE. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents or subcontractors for at least six (6) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that BA maintains an electronic health record and is subject to this requirement. At a minimum, the information collected and maintained shall include: (a) the date of disclosure; (b) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (c) a brief description of Protected Information disclosed; and (d) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. In the event that the request for an accounting is delivered directly to BA or its agents or subcontractors, BA shall within five (5) calendar days of a request forward it to CE in writing. It shall be CE's responsibility to prepare and deliver any such accounting requested. BA shall not disclose any Protected

Information except as set forth in Section 2.2 of this Addendum [45 C.F.R. Sections 164.504(e)(2)(ii)(G) and 165.528]. The provisions of this Section 2.10 shall survive the termination of this Agreement.

2.11 Governmental Access to Records. BA shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to CE and to the Secretary of the U.S. Department of Health and Human Services (the "**Secretary**") for purposes of determining BA's compliance with the Privacy Rule [45 C.F.R. Section 164.504(e)(2)(ii)(H)]. BA shall provide to CE a copy of any Protected Information that BA provides to the Secretary concurrently with providing such Protected Information to the Secretary.

2.12 Minimum Necessary. BA (and its agents or subcontractors) shall request, use and disclose only the minimum amount of Protected Information necessary to accomplish the purpose of the request, use or disclosure. [42 U.S.C. Section 17935(b); 45 C.F.R. Section 164.514(d)(3)]. BA understands and agrees that the definition of "**minimum necessary**" is in flux and shall keep itself informed of guidance issued by the Secretary with respect to what constitutes "minimum necessary."

2.13 Data Ownership. BA acknowledges that BA has no ownership rights with respect to the Protected Information.

2.14 BA's Insurance. BA shall maintain a sufficient amount of insurance to adequately address risks associated with BA's use and disclosure of Protected Information under this Addendum.

2.15 Notification of Breach. During the term of the Agreement, BA shall notify CE within twenty-four (24) hours of any suspected or actual breach of security, intrusion or unauthorized use or disclosure of PHI of which BA becomes aware and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. BA shall take (a) prompt corrective action to cure any such deficiencies and to mitigate any harmful effect of a use or disclosure of PHI and (b) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

2.16 Breach Pattern or Practice by CE. Pursuant to 42 U.S.C. Section 17934(b), if the BA knows of a pattern of activity or practice of the CE that constitutes a material breach or violation of the CE's obligations under the Agreement or Addendum or other arrangement, the BA must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the BA must terminate the Agreement or other arrangement if feasible, or if termination is not feasible, report the problem to the Secretary. BA shall provide written notice to CE of any pattern of activity or practice of the CE that BA believes constitutes a material breach or violation of the CE's obligations under the Agreement or Addendum or other arrangement within five (5) calendar days of discovery and shall meet with CE to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

2.17 Audits, Inspection and Enforcement. Within ten (10) calendar days of a written request by CE, BA and its agents or subcontractors shall allow CE to conduct a reasonable

inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of Protected Information pursuant to this Addendum for the purpose of determining whether BA has complied with this Addendum; *provided, however,* that (a) BA and CE shall mutually agree in advance upon the scope, timing and location of such an inspection, (b) CE shall protect the confidentiality of all confidential and proprietary information of BA to which CE has access during the course of such inspection; and (c) CE shall execute a nondisclosure agreement, upon terms mutually agreed upon by the parties, if requested by BA. The fact that CE inspects, or fails to inspect, or has the right to inspect, BA's facilities, systems, books, records, agreements, policies and procedures does not relieve BA of its responsibility to comply with this Addendum, nor does CE's (i) failure to detect or (ii) detection, but failure to notify BA or require BA's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of CE's enforcement rights under the Agreement or Addendum, BA shall notify CE within ten (10) calendar days of learning that BA has become the subject of an audit, compliance review or complaint investigation by the Office for Civil Rights.

2.18 Indemnification. BA hereby agrees to indemnify and hold CE and its employees and agents harmless from and against any and all loss, liability or damages, including reasonable attorneys' fees, arising out of or in any manner occasioned by a breach of any provision of this Addendum by BA or its employees or agents.

3. TERMINATION

3.1 Material Breach. A material breach by BA of any provision of this Addendum, as determined by CE in its good faith and reasonable discretion, shall constitute a material breach of the Agreement and shall provide grounds for immediate termination of the Agreement, any provision in the Agreement to the contrary notwithstanding [45 C.F.R. Section 164.504(e)(2)(iii)].

3.2 Judicial or Administrative Proceedings. CE may terminate the Agreement, effective immediately, if (a) BA is named as a defendant in a criminal proceeding for a violation of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws or (b) a finding or stipulation that the BA has violated any standard or requirement of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

3.3 Effect of Termination. Upon termination of the Agreement for any reason, BA shall, at the option of CE, return or destroy all Protected Information that BA or its agents or subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If return or destruction is not feasible, as determined by CE, BA shall continue to extend the protections of Section 2 of this Addendum to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible [45 C.F.R. Section 164.504(e)(ii)(2)(I)]. If CE elects destruction of the PHI, BA shall certify in writing to CE that such PHI has been destroyed.

4. MISCELLANEOUS

4.1 Notices. Any notice, demand or communication required, permitted or desired to be given hereunder shall be in writing and shall be delivered in accordance with the terms and provisions of Section 17 of this Agreement with CE as Licensee and BA as New Operator.

4.2 Limitation of Liability. Any limitations of liability as set forth in the Agreement shall not apply to damages related to a breach of the BA's privacy or security obligations under the Agreement or Addendum.

4.3 Disclaimer. CE makes no warranty or representation that compliance by BA with this Addendum, HIPAA, the HITECH Act, or the HIPAA Regulations will be adequate or satisfactory for BA's own purposes. BA is solely responsible for all decisions made by BA regarding the safeguarding of PHI.

4.4 Certification. To the extent that CE determines that an examination is necessary to comply with CE's legal obligations pursuant to HIPAA relating to certification of its security practices, CE or its authorized agents or contractors may, at CE's expense, examine BA's facilities, systems, procedures and records as may be necessary for such agents or contractors to certify to CE the extent to which BA's security safeguards comply with HIPAA, the HITECH Act, the HIPAA Regulations or this Addendum.

4.5 Amendment to Comply with Law. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of the Agreement or Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule and other applicable laws relating to the security or confidentiality of PHI. The parties understand and agree that CE must receive satisfactory written assurance from BA that BA will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule or other applicable laws. CE may terminate the Agreement upon thirty (30) calendar days' written notice in the event (a) BA does not promptly enter into negotiations to amend the Agreement or Addendum when requested by CE pursuant to the preceding sentence, or (b) BA does not enter into an amendment to the Agreement or Addendum providing assurances regarding the safeguarding of PHI that CE, in its reasonable and good faith discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

4.6 Assistance in Litigation or Administrative Proceedings. BA shall make itself, and any subcontractors, employees or agents assisting BA in the performance of its obligations under the Agreement or Addendum, available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its directors, officers or employees based upon a claimed violation of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule, or other laws relating to security and privacy, except where BA or its subcontractor, employee or agent is a named adverse party.

4.7 No Third-Party Beneficiaries. Nothing express or implied in the Agreement or Addendum is intended to confer, nor shall anything herein confer, upon any person other than CE, BA and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

4.8 Effect on Agreement. Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the Agreement shall remain in force and effect.

4.9 Interpretation. The provisions of this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provision in this Addendum. This Addendum and the Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule. The parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule.

4.10 No Third Party Beneficiary. The provisions and covenants set forth in this Addendum are expressly entered into only by and between Business Associate and Covered Entity, and are only for their benefit. Neither Business Associate nor Covered Entity intends to create or establish any third party beneficiary status or right (or the equivalent thereof) in any other third party and no such third party shall have any right to enforce or enjoy any benefit created or established by the provisions and covenants in this Exhibit.

4.11 Replaces and Supersedes Previous BA Addendums or Agreements. This Addendum replaces and supersedes any previous business associate addendums or agreements between the parties hereto.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS WHEREOF, the parties hereto have duly executed this Addendum as of the date set forth above.

BUSINESS ASSOCIATE:

AMERICAN ADVANCED MANAGEMENT, INC.,
a Delaware corporation

By: [redacted]
Name: Tammy Thompson
Title: CFO N-P Finance
Date: 6/12/2023

COVERED ENTITY:

ORCHARD HOSPITAL
a California not for profit corporation

By: [redacted]
Name: STEVE STARK
Title: CEO
Date: June 12, 2023

1863780v4

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

A statement of all of the reasons the board of directors believes that the proposed agreement or transaction is either necessary or desirable

Orchard Hospital's Board of Directors believes that the agreement between Orchard Hospital and American Advanced Management Inc., is necessary because during Covid-19 pandemic, Orchard Hospital faced rising costs while reimbursements remained largely unchanged. This resulted in a financial shortfall of over $200,000 each month. It quickly became evident that our resources would be exhausted, leaving us with no choice but to either reduce services or shut down entirely. Partnering with an organization to expand community services and secure the future of our hospital became essential.

Title 11, California Code of Regulations § 999.5(d)(2)

Fair Market Value

Title 11, California Code of Regulations § 999.5(d)(2)(A)

The estimated market value of all cash, property, stock, notes, assumption or forgiveness of debt, and any other thing of value that the applicant would receive for each health facility or facility that provides similar health care covered by the proposed agreement or transaction

As of June 30, 2023 the estimated market value of all cash, property, stock, notes, assumption or forgiveness of debt, and any other thing of value was $5,488,245

Title 11, California Code of Regulations § 999.5(d)(2)(B)

The estimated market value of each health facility, facility that provides similar health care or other asset to be sold or transferred by the applicant under the proposed agreement or transaction

As of June 30, 2023, the estimated market value of each health facility, facility that provides similar health care or other asset to be sold or transferred by Orchard Hospital was $2,826,970

Title 11, California Code of Regulations § 999.5(d)(2)(C)

A description of the methods used by the applicant to determine the market value of any assets involved in the proposed agreement or transaction. This description shall include a description of the efforts made by the applicant to sell or transfer each health facility or facility that provides similar health care that is the subject of the proposed agreement or transaction

As of June 30, 2023 the valuation for all net assets was based on the book value from Orchard Hospital's audited financial statements. The estimated value provided under 2(A) excludes $2,470,018 of board designated investments per the management services agreement dated July 1, 2023, between Orchard Hospital and American Advanced Management, Inc.

Efforts made by Orchard Hospital Board Members and Administration included meeting with local, larger systems to gauge interest in partnering with Orchard Hospital. They also reached out to the California Hospital Association to help find potential suiters that would like to support our small, rural hospital.

Orchard Hospital initiated efforts to change the control and governance of its facilities in 2022 by exploring a potential partnership with Adventist Health. The Orchard Hospital CEO reached out to Adventist Health's leadership, and both parties signed a non-disclosure agreement to facilitate further discussions. After several exchanges, a final meeting was held between Adventist Health's leadership and Orchard Hospital's Board Chairperson. However, Adventist Health ultimately decided that acquiring additional hospitals was not feasible at the time, and the discussions were concluded.

Following this, the Orchard Hospital CEO sought assistance from the California Hospital Association's Northern Council, reaching out to its regional vice-president to identify other potential partners. While an attempt was made to engage Sutter Health, they similarly showed no interest in partnering with Orchard Hospital. As the hospital's financial situation worsened and cash reserves depleted, the Board of Trustees took action by voting to enter into a managed service agreement with American Advanced Management, Inc., ensuring the necessary financial support to sustain operations.

Title 11, California Code of Regulations § 999.5(d)(2)(E)

Reports, analysis, Requests for Proposal, and any other documents that refer or relate to the valuation of any asset involved in the agreement or transaction.

Please see Orchard Hospital's Audited Financial Statements that are attached in Section 999.5(d)(11)(F) for fiscal year ending June 30, 2023

Title 11, California Code of Regulations § 999.5(d)(3)

Inurement and Self-Dealing

Title 11, California Code of Regulations § 999.5(d)(3)(A) & (B)

EXHIBIT 1

A copy of Orchard Hospital's Board of Directors Director and Officer Annual Conflict of Interest Statements from the following Board Members:

1. Ed Becker – Ed Becker leases a building to Orchard Hospital

2. Joe Cunha – Joe Cunha is an Edward Jones Financial Advisor, where Orchard Hospital holds investment and other financial accounts

3. Jatinder Kullar – Jatinder Kullar leases real property to Orchard Hospital

4. John Harris – John Harris is a former Board Member but was a current member when the MSA was executed. He is an attorney that had a law firm that occasionally provided legal work to Orchard Hospital

999.5(a)(1)

Orchard Hospital

Director and Officer Annual Conflict of Interest Statement

1. Name: ED BECKER Date: 9-26-22
2. Position:

   Are you a voting Director? ☒ Yes ☐ No

   Are you an Officer? ☒ Yes ☐ No

   If you are an Officer, which Officer position do you hold: CHAIR
3. I affirm the following:

   I have received a copy of Orchard Hospital Conflict of Interest Policy. EB (Initial)

   I have read and understand the policy. EB (Initial)

   I agree to comply with the policy. EB (Initial)

   I understand that Orchard Hospital is charitable and in order to maintain its federal tax exemption it must engage primarily in activities which accomplish one or more of tax exempt purposes. EB (Initial)
4. Disclosures:

   a. Do you have a financial interest (current or potential), including a compensation arrangement, as defined in the Conflict of Interest policy with Orchard Hospital? Yes No

      i. If yes, please describe it: I LEASE A BUILDING TO THE HOSPITAL

      ii. If yes, has the financial interest been disclosed, as provided in the Conflict of Interest policy with Orchard Hospital? ☐ Yes ☐ No

   b. In the past, have you had a financial interest, including a compensation arrangement, as defined in the Conflict of Interest policy with Orchard Hospital

      i. If yes, please describe it, including when (approximately): _____

      ii. If yes, has the financial interest been disclosed, as provided in the Conflict of [redacted] ☐ Yes ☐ No

[redacted]

Signature of Director

9-26-22

Date

Date of Review by Executive Committee: _____

Orchard Hospital

Director and Officer Annual Conflict of Interest Statement

1. Name: Joe Cunha Date: 9-27-22
2. Position:

   Are you a voting Director? ☒ Yes ☐ No

   Are you an Officer? ☐ Yes ☒ No

   If you are an Officer, which Officer position do you hold: _____.
3. I affirm the following:

   I have received a copy of Orchard Hospital Conflict of Interest Policy. JC (Initial)
   I have read and understand the policy. JC (Initial)

   I agree to comply with the policy. JC (Initial)

   I understand that Orchard Hospital is charitable and in order to maintain its federal tax exemption it must engage primarily in activities which accomplish one or more of tax exempt purposes. JC (Initial)
4. Disclosures:

   a. Do you have a financial interest (current or potential), including a compensation arrangement, as defined in the Conflict of Interest policy with Orchard Hospital? (Yes) No

      i. If yes, please describe it: Edward Jones Acct.

      ii. If yes, has the financial interest been disclosed, as provided in the Conflict of Interest policy with Orchard Hospital? ☒ Yes ☐ No

   b. In the past, have you had a financial interest, including a compensation arrangement, as defined in the Conflict of Interest policy with Orchard Hospital

      i. If yes, please describe it, including when (approximately): Existing Brokerage account.

      ii. If yes, has the financial interest been disclosed, as provided in the Conflict of Interest policy? ☒ Yes ☐ No

[redacted]
Signature of Director

9-27-22
Date

Date of Review by Executive Committee: _____

Orchard Hospital

Director and Officer Annual Conflict of Interest Statement

1. Name: Jatinder Kullar Date: 9/27/22
2. Position:

   Are you a voting Director? ☑ Yes ☐ No

   Are you an Officer? ☐ Yes ☑ No

   If you are an Officer, which Officer position do you hold: _____.
3. I affirm the following:

   I have received a copy of Orchard Hospital Conflict of Interest Policy. JK (Initial)
   I have read and understand the policy. JK (Initial)

   I agree to comply with the policy. JK (Initial)

   I understand that Orchard Hospital is charitable and in order to maintain its federal tax exemption it must engage primarily in activities which accomplish one or more of tax exempt purposes. JK (Initial)
4. Disclosures:

   a. Do you have a financial interest (current or potential), including a compensation arrangement, as defined in the Conflict of Interest policy with Orchard Hospital? (Yes) No

      i. If yes, please describe it: Lease RE to OH.

      ii. If yes, has the financial interest been disclosed, as provided in the Conflict of Interest policy with Orchard Hospital? ☑ Yes ☐ No

   b. In the past, have you had a financial interest, including a compensation arrangement, as defined in the Conflict of Interest policy with Orchard Hospital

      i. If yes, please describe it, including when (approximately):

      _____.

      ii. If yes, has the financial interest been disclosed, as provided in the Conflict of Interest policy? ☐ Yes ☐ No

[redacted]

Signature of Director

9/27/22

Date

Date of Review by Executive Committee: _____

Orchard Hospital

Director and Officer Annual Conflict of Interest Statement

1. Name: John T. Harris Date: 9/21/2022
2. Position:

   Are you a voting Director? ☒ Yes ☐ No

   Are you an Officer? ☐ Yes ☒ No

   If you are an Officer, which Officer position do you hold: _____.
3. I affirm the following:

   I have received a copy of Orchard Hospital Conflict of Interest Policy. ____. (Initial)

   I have read and understand the policy. ____(Initial)

   I agree to comply with the policy. ____(Initial)

   I understand that Orchard Hospital is charitable and in order to maintain its federal tax exemption it must engage primarily in activities which accomplish one or more of tax exempt purposes. ____(Initial)
4. Disclosures:

   a. Do you have a financial interest (current or potential), including a compensation arrangement, as defined in the Conflict of Interest policy with Orchard Hospital? Yes No

      i. If yes, please describe it: _____.

      ii. If yes, has the financial interest been disclosed, as provided in the Conflict of Interest policy with Orchard Hospital? ☐ Yes ☐ No

   b. In the past, have you had a financial interest, including a compensation arrangement, as defined in the Conflict of Interest policy with Orchard Hospital

      i. If yes, please describe it, including when (approximately): Our firm has done some work for hospital

      ii. If yes, has the financial interest been disclosed, as provided in the Conflict of Interest policy? ☒ Yes ☐ No

[redacted]
Signature of Director

9/21/2022
Date

Date of Review by Executive Committee: _____

Title 11, California Code of Regulations § 999.5(d)(3)(C)

A statement describing how the board of directors of the nonprofit corporations involved in the transaction are complying with the provisions of Health and Safety Code Sections 1260 and 1260.1

Orchard Hospital – No member of the board of directors of Orchard Hospital negotiated the terms and conditions of the agreement. Orchard Hospital's Management Team negotiated the agreement along with outside legal counsel that represented Orchard Hospital.

American Advanced Management – No member of the board of directors of American Advanced Management negotiated the terms and conditions of the agreement. American Advanced Management Team negotiated the agreement along with outside legal counsel that represented American Advanced Management.

Title 11, California Code of Regulations § 999.5(d)(4)(A)

The Applicant's Articles of Incorporation and all amendments thereto and current bylaws, any charitable trust restrictions, and any other information necessary to define the charitable trust purpose of the applicant's assets

Orchard Hospital does not hold charitable trust assets that would impact the Agreement.

Attached to this Section are the following Orchard Hospital documents:

1. **Exhibit 1** – a copy of the Articles of Incorporation
2. **Exhibit 2 -** a copy of the Hospital Bylaws
3. **Exhibit 3 -** a copy of the Hospital License

Attached to this Section are the following American Advanced Management documents:

1. **Exhibit 4** – a copy of the Statement of Information
2. **Exhibit 5** – a copy of the Bylaws
3. **Exhibit 6** – a copy of the Articles of Incorporation

Title 11, California Code of Regulations § 999.5(d)(4)(A)

The Applicant's Articles of Incorporation and all amendments thereto and current bylaws, any charitable trust restrictions, and any other information necessary to define the charitable trust purpose of the applicant's assets

EXHIBIT 1

AU7/0428

NCTO

0205130

Certificate of Amendment of Articles of Incorporation of
BIGGS-GRIDLEY MEMORIAL HOSPITAL

FILED
Secretary of State
State of California
MAY 22 2015
1 cc

The undersigned certify that:

1. They are the chairman and the secretary, respectively, of BIGGS-GRIDLEY MEMORIAL HOSPITAL, a California corporation.

2. Article I of the Articles of Incorporation of this corporation is amended to read as follows:

The name of said corporation shall be:
ORCHARD HOSPITAL.

3. The foregoing amendment of Articles of Incorporation has been duly approved by the board of directors.

4. The corporation has no members.

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this certificate are true and correct of our own knowledge.

Date: May 21, 2015

[redacted]
JOHN T. HARRIS, Chairman of the Board

[redacted]
CLARK REDFIELD, Secretary

I hereby certify that the foregoing transcript of 1 page(s) is a full, true and correct copy of the original record in the custody of the California Secretary of State's office.

MAY 26 2015

Date:

ALEX PADILLA, Secretary of State

A0691273

State of California
Secretary of State

I, DEBRA BOWEN, Secretary of State of the State of California, hereby certify:

That the attached transcript of 3 page(s) has been compared with the record on file in this office, of which it purports to be a copy, and that it is full, true and correct.

IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California this day of

MAY 13 2009

Debra Bowen

DEBRA BOWEN
Secretary of State

Sec/State Form CE-107 (REV 1/2007)

OSP 08 111441

A0691273

ENDORSED - FILED
In the office of the Secretary of State
of the State of California

APR 30 2009

CERTIFICATE OF AMENDMENT TO

ARTICLES OF INCORPORATION

OF

BIGGS-GRIDLEY MEMORIAL HOSPITAL

The undersigned certify that:

I. They are the Chairman of the Board and the Secretary of BIGGS-GRIDLEY MEMORIAL HOSPITAL, a California nonprofit public benefit corporation.

II. The Articles of Incorporation of the Corporation are hereby amended and restated in full to read as set forth in EXHIBIT A attached hereto and incorporated herein by this reference.

III. Said Amended and Restated Articles of Incorporation have been duly approved by the Board of Directors of this Corporation.

IV. Said Amended and Restated Articles of Incorporation have been duly approved by the required vote of the member of this Corporation.

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this Certificate are true and cor

Date: April 29, 2009
Gridley, California

Chair

Secretary

EXHIBIT A

AMENDED AND RESTATED ARTICLES OF INCORPORATION

BIGGS-GRIDLEY MEMORIAL HOSPITAL

I.

That the name of said corporation shall be:

BIGGS-GRIDLEY MEMORIAL HOSPITAL

II.

A. This Corporation is a nonprofit public benefit corporation and is not organized for the private gain of any person. It is organized under the Nonprofit Public Benefit Corporation Law for charitable purposes.

B. This Corporation elects to be governed by all of the provisions of the Nonprofit Corporation Law of 1980 not otherwise applicable to it under Part 5 of Division 2.

C. The primary purposes of this corporation are:

1. To establish, equip and maintain one or more nonprofit hospitals, medical centers, institutions or other places for the reception and care of the sick, injured and disabled, with permanent facilities that include inpatient beds and medical services; to provide diagnosis and treatment for patients; and to provide associated services, outpatient care and home care in furtherance of this corporation's charitable purposes;

2. To promote and carry on educational activities related to the care of the sick, injured and disabled, or to the promotion of health;

3. To promote and carry on educational activities related to the care of the sick, injured and disabled, or to the promotion of health; and

4. To promote or carry out such other activities as may be deemed advisable for the betterment of the general health of the community served.

D. The general purpose of this corporation is to have and exercise all rights and powers conferred on nonprofit public benefit corporations under the laws of the State of California.

III.

E. This corporation is organized and operated exclusively for charitable purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, and successor provisions thereto (the "Code").

F. Notwithstanding any other provision of these articles, the corporation shall not carry on any other activities not permitted to be carried on:

1. By a corporation exempt from federal income tax under Section 501(c)(3) of the Code; or

2. By a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

G. No substantial part of the activities of this corporation shall consist of carrying on propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate or intervene in any political campaign (including the publishing or distribution of statements) on behalf of any candidate for public office.

IV.

The property of this corporation is irrevocably dedicated to charitable purposes and no part of the net income or assets of this corporation shall ever inure to the benefit of any director, officer or member thereof or to the benefit of any private person. Upon the dissolution or winding up of the corporation, its assets remaining after payment or provision for payment of all debts and liabilities of this corporation shall be transferred exclusively to and shall become the property of such nonprofit funds, foundations or corporations as are designated by the Board of Directors of this corporation and which:

1. Are organized and operated exclusively for religious, charitable, hospital, scientific purposes, or charitable *and* educational purposes meeting the requirements for exemption by Section 214 of the Revenue and Taxation Code; and

2. Have established their tax-exempt status under Section 501(c)(3) of the Code.

V.

The principal office for the transaction of the business of this corporation shall be located in Butte County; the State of California.

Title 11, California Code of Regulations § 999.5(d)(4)(A)

The Applicant's Articles of Incorporation and all amendments thereto and current bylaws, any charitable trust restrictions, and any other information necessary to define the charitable trust purpose of the applicant's assets

EXHIBIT 2

ORCHARD HOSPITAL

AMENDED AND RESTATED BYLAWS

OF

ORCHARD HOSPITAL

A nonprofit public benefit corporation
organized under the laws of the State of California

March, 2018

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ARTICLE ONE

NAME, OFFICES, PURPOSE AND POWERS

Section 1.1 Name of Corporation

The name of this corporation shall be as listed in the Articles of Incorporation ("the Articles"), namely ORCHARD HOSPITAL ("the Corporation"), a nonprofit public benefit corporation organized under the laws of the State of California.

Section 1.2 Office.

The principal office for the transaction of the business of this Corporation shall be located in Gridley, Butte County, California and this Corporation may have other offices within the State of California, as the Board may determine from time to time.

Section 1.3 Purpose.

As more particularly described in its Articles, this Corporation is primarily formed to establish, equip and maintain one or more nonprofit hospitals and its ancillary facilities.

Section 1.4 Powers

Consistent with the Articles, this Corporation may engage in any activity which the Board of Directors determines to be in the best interest of the Corporation.

ARTICLE TWO

MEMBERSHIP

There shall be no corporate members of the Corporation. All rights which would otherwise vest under the California Corporations Code in the members of a nonprofit public benefit corporation shall vest in the Directors, as hereinafter defined.

ARTICLE THREE

BOARD OF DIRECTORS

Section 3.1 Number and Qualification of Directors

(a) The authorized number of directors on the Board of Directors (the "Board") shall be no less than five (5) and no more than thirteen (13) persons satisfying the qualifications set forth in Section 3.1(b) of these Bylaws, and at least one (1) of whom shall be an individual who is licensed to practice medicine in the State of California, but shall not be under contract or an employee of Orchard Hospital. The Chief Executive Officer, Board Chief Financial Officer (if an employee of this Corporation), the Chief of Staff, and the Chief Nursing Officer shall, in the discretion of the Board, be *ex officio,* nonvoting, participants in the meetings (but not a member) of the Board.

(b) Qualifications for nomination and election as a Director shall include the following:

(1) Commitment to the improvement and development of community health care;

(2) Experience in organizational and community activities;

(3) Willingness and ability to participate effectively in fulfilling Board's responsibilities; and

(4) Adequate time to serve and to attend Board meetings as required by these Bylaws.

Section 3.2 Nomination and Selection

The Governance Committee shall nominate Director Nominees to the Board, and the Board shall elect the Directors of this Corporation at its annual meeting or at any other time designated by the Board. The Governance Committee shall nominate Director Nominees for full terms and Directors to fill vacancies created by resignation, removal or death occurring during a term. The candidates receiving the highest number of votes shall be the elected directors.

Section 3.3 Nondiscrimination

Membership on the Board shall not be restricted on the basis of sex, race, religion, creed, color, or national origin, or on the basis of any other criteria not relevant to the needs of the Board in exercising responsible oversight of the affairs of the Corporation.

Section 3.4 Powers and Responsibilities

(a) Subject to the provisions of the Code; the powers of the Corporation shall be exercised, its property controlled, and its affairs conducted by or under the direction of the Board.

(b) The Board may delegate the management of this Corporation to any person or persons, or committee however composed, provided that the activities and affairs of this Corporation shall be managed and all corporate powers shall be exercised under the ultimate direction of the Board.

(c) The Board shall have the sole authority to exercise this Corporation's rights as a member or shareholder of each and every corporation or other entity of which this Corporation is a corporate member or shareholder. The Board may, by resolution, authorize one or more of this Corporation's Officers to exercise its vote on any matter that comes before the membership or the shareholders of any such corporation or entity.

(d) The powers and responsibilities of the Board and its members include, but are not limited to, the following:

(1) To act as fiduciaries to fulfill the purposes of the Corporation as set forth in its Articles;

(2) To establish and monitor the Corporation's quality assurance activities, including all aspects of patient care evaluation, in accordance with guidelines established by the Board or its designee;

(3) To establish and monitor an effective medical and hospital care performance improvement program

(4) To monitor and assure that the Corporation has an effective ethics and compliance program;

(5) To establish and monitor a program of continuing education to be made available to all members of the Board;

(6) To conduct orientation of newly elected Board members to Board functions and procedures;

(7) To conduct periodic review of the Board's performance, including director self-assessment.

(8) To assure that the Corporation's community benefit programs are meeting the needs of the community served by the Corporation within the resources available to do so;

(9) To review operations with management to ensure that services are necessary to the Corporation's mission and are affordable when compared to like services in the community;

(10) To review and approve an annual operating and capital budget in accordance with guidelines established by the Board or the Finance Committee;

(11) To develop strategic plans which are consistent with and fully support progress toward achieving objectives of the Corporation;

(12) To select the Chief Executive Officer;

(13) In collaboration with the Chief Executive Officer or his/her designee, to ensure leadership succession plans are in place for the Chief Executive Officer and for all positions reporting to the Chief Executive Officer and other positions identified as critical to the organization;

(14) To oversee and support the philanthropic activities of the Corporation and the Orchard Hospital Foundation;

(15) To be loyal to the organization, always furthering the interests of the organization in its pursuit of its mission, and complying with all laws, regulations and Board policies regarding conflicts of interest;

(16) To be diligent in the fulfillment of Board responsibilities, including attendance at and active participation in Board meetings, and participation in continuing education opportunities;

(17) To respect the confidentiality of the Board room and discussions and actions of the Corporation; and

(18) To support the decisions and policies of the Board.

Section 3.5 Standard of Conduct

Each Director of this Corporation shall perform his or her duties in good faith, in a manner the Director believes to be in the best interests of the Corporation, and including such reasonable inquiry as an ordinarily prudent person in a like position, would use under similar circumstances. In performing the duties of a Director, each Director shall be entitled to rely on information, opinions, reports or statements (including financial statements and other financial data) as they are prepared or presented by:

(a) One or more Officers or employees of this Corporation whom the Director believes to be reliable and competent in the matters presented;

(b) Counsel, independent accountants or other persons, as to matters which the Director believes to be within such person's professional or expert competence; and

(c) A committee of the Board, upon which the Director does not serve, as to matters within its designated authority, which committee the Director believes to merit confidence.

Section 3.6 Restriction on Interested Persons Acting as Directors

No more than forty-nine percent (49%) of the persons serving on the Board may be "interested persons." An "interested person" is:

(a) Any person compensated by the Corporation for services rendered to it within the previous twelve (12) months, whether as a full-time or part-time employee, independent contractor, or otherwise, excluding any reasonable compensation paid to a Director for his or her performance in such capacity; and

(b) Any brother, sister, ancestor, descendant, spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, or father-in-law of such person.

A violation of the provisions of this Section shall not affect the validity or enforceability of any transaction entered into by the Corporation.

Section 3.7 Conflict of Interest

The Board shall promulgate a Conflict of Interest Policy developed by the Board or its designee regarding conflicts of interest relating to its own members, employees of the Corporation and members of the Corporation's Medical Staff. The Conflict of Interest Policy shall be consistent with the standards of conduct set forth in Sections 5230 through 5239 of the California Corporations Code. The Conflict of Interest Policy shall ensure full disclosure of financial interests and transactions where conflict of interest is a possibility, and shall ensure the avoidance of potential conflict of interest in choosing new Board members. The Conflict of Interest Policy shall impose upon each Board member the responsibility to be alert to possible conflicts of interest of himself or herself or of other Board members, and shall require that each Director annually declare his/her absence of conflict of interest on a declaration form provided for that purpose and disqualify himself or herself from making a decision where he/she has a conflict of interest.

Section 3.8 Self-Dealing Transactions Involving Directors

Except as otherwise provided under applicable law and these Bylaws, whenever a Director has a material financial interest in any proposed transaction to which this Corporation is a party, the Director shall disclose the nature of the interest at the earliest opportunity before the Board discusses or acts on any part of the transaction. In such cases after the disclosure of his or her interest, the interested Director may participate in any discussion of the proposed transaction, but may not vote on the matter.

Section 3.9 Term

The term of office shall be three (3) years. Except as to any *ex officio* members. The terms shall be for three (3) years with approximately one-third (⅓) of the Board being elected annually.

(a) Emeritus - Upon nomination by a Director currently serving in good standing, a Board member may be considered for an Emeritus position.

(b) Emeritus members are non-voting, but are eligible to receive all Board information typically provided other Board members.

(c) The Board of Directors will consider observation and/or recommendation provided by Emeritus in the usual course of Board activity.

(d) Emeritus member will serve at their own discretion unless otherwise removed in accordance with these bylaws. Emeritus members could attend executive sessions at approval of the Board.

Section 3.10 Resignation

Any Director may resign at any time by giving written notice to the Chairperson or the Secretary of the Board, except in cases where such resignation would leave the Corporation without a duly elected Director in charge of its affairs as described in Section 5226 of the California Corporations Code. Under those circumstances, notice to the Attorney General is required upon resignation. Any Director's resignation, which may or may not be made contingent on formal acceptance, will take effect on the date of receipt or at any later time specified in the written notice. If the resignation is effective at a future time, a successor Director may be elected to take office when the resignation becomes effective in accordance with Section 3.2 of these Bylaws.

Section 3.11 Removal of Directors

A Director may be removed from office with or without cause by the affirmative vote of a majority of the votes entitled to be cast. The Board may declare vacant the office of a Director who fails to satisfy the attendance requirements set forth in Section 4.13 of these Bylaws. The Board, by a majority vote of the Directors who meet all of the required qualifications to be a director, may declare vacant the office of any Director who fails or ceases to meet any of the qualifications set forth in Section 3.1(b) of these Bylaws.

Section 3.12 Vacancies

A vacancy on the Board of Directors shall be deemed to exist on the occurrence of the death, resignation, or removal of any Director, an increase of the authorized number of Directors, or in the event that the Board has determined that a Director has not been an active member of the Board following the review described in Section 3.11 of these Bylaws. The Directors shall elect Directors to fill vacancies in accordance with Section 3.2 of these Bylaws.

Section 3.13 Additional Advisors

The Board or Chairperson may invite additional persons with expertise in a pertinent area to meet with and assist the Board. Such advisors shall not vote or be counted in determining the existence of a quorum and may be excluded from any executive session.

Section 3.14 Compensation and Expenses

(a) Directors shall receive a stipend of $100.00 per regularly scheduled monthly meeting and monthly executive round table meeting attended and shall be reimbursed for any expense reasonably incurred by Directors in connection with the performance of official duties.

(b) Directors and beneficiaries will not be required to pay a co-pay when presenting themselves to any location of the entity with their current insurance ($1500 max per family).

(c) Subject to the provisions of California law and these Bylaws relating to the approval of contracts and transactions in which a Director or Directors has direct or indirect material financial interest, the Board may contract with one or more Directors for services as an employee or independent contractor.

ARTICLE FOUR

MEETINGS OF DIRECTORS

Section 4.1 Place of Meetings

All meetings of the Board are held at the principal office of the Corporation or at such other place as the Chairperson or majority of the Board of Directors recommends.

Section 4.2 Meetings Electronically

Any meeting, regular or special, may be held by conference telephone or similar communication equipment, in accordance with California Corporations Code Section 5211(a)(6) so long as the Directors participating in the meeting can hear one another, and all such Directors shall be deemed to be present in person at such meeting.

Section 4.3 Annual Meeting

The annual meeting shall be held on the fourth (4^{th}) Tuesday in March, or if no date is set for the regular board meeting of March, and shall be held for the purpose of organization, election of Officers, and the transaction of such other business as may appropriately come before the Board.

Section 4.4 Regular Meetings

Regular meetings shall be held without call or notice on the fourth (4^{th}) Tuesday of each month at a time and place to be designated by the Board. In the event that any meeting day falls on a

holiday, the meeting shall be held at the same time on the next day thereafter that is not a holiday or at such time as may be designated by the Board.

Section 4.5 Special Meetings

Special meetings of the Board for any purpose may be called at any time by the Chairperson of the Board, Vice Chairperson, Secretary, or any three (3) or more Directors.

Section 4.6 Notice

Notice shall be provided consistent with the provisions of California Corporations Code Section 5211. Special meetings of the Board shall be held upon four (4) days' notice to each Director by first-class mail or 48 hours' notice to each Director delivered personally, by telephone, facsimile transmission, or by electronic mail. The attendance of a Director at any meeting shall constitute a waiver of notice of the meeting, except where a Director attends a meeting only for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened.

Section 4.7 Quorum

Except as hereinafter provided, a majority of the Directors in office shall constitute a quorum for the transaction of business (except to adjourn as provided in these Bylaws). Every act or decision done or made by a majority of the Directors present at a meeting duly held at which a quorum is present shall be regarded as the act of the Board.

A meeting at which a quorum is initially present may continue to transact business, notwithstanding a withdrawal of Directors, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as is required by the California Corporations Code, the Articles or these Bylaws.

Section 4.8 Voting

Each Director is entitled to one vote on any matter before the Board.

Section 4.9 Waiver of Notice

The transaction of any meeting of the Board, however called and noticed or wherever held, shall be valid as if taken at a meeting duly held after regular call and notice, if a quorum is present and, either before or after the meeting, each of the Directors not present signs a written waiver of notice, consent to holding the meeting, or an approval of the minutes. The waiver of notice or consent need not specify the purposes of the meeting. All waivers, consents, and approvals shall be filed with the corporate records or made a part of the minutes of the meeting. Notice of a meeting shall also be deemed given to any Director who attends the meeting without protesting before or at its commencement about the lack of adequate notice.

Section 4.10 Adjournment

A majority of the Directors present, whether or not constituting a quorum, may adjourn any meeting to another time and place.

Section 4.11 Notice of Adjournment

Notice of the time and place of holding an adjourned meeting need not be given unless the meeting is adjourned for more than forty-eight (48) hours, in which case notice of the time and place shall be given before the time of the adjourned meeting to the Directors who were not present at the time of adjournment.

Section 4.12 Action Without Meeting

An action required or permitted to be taken by the Board may be taken without a meeting if all of the Directors, individually or collectively, consent in writing or electronically to that action. Such action by written consent shall have the same force and effect as an unanimous vote of the Board. Such written consent or consents shall be filed with the Board's minutes.

Section 4.13 Attendance at Meetings

Directors are required to attend at least seventy- percent (75%), or a minimum of eight (8) regular and special meetings of the Board each year. Each Director must also attend seventy-five percent (75%) of all assigned committee meetings. If a Board member satisfies the foregoing attendance requirements but misses more than three (3) consecutive meetings, then the Board shall consider whether this constitutes grounds for removal, and if so, may remove the Director.

ARTICLE FIVE

OFFICERS

Section 5.1 Officers

The Officers of this Corporation shall be a Chairperson of the Board, a Vice Chairperson, a Secretary, a Board Chief Financial Officer, and such other Officers as the Board may elect or appoint. Any number of offices may be held by the same person, except that neither the Secretary nor the Chief Financial Officer may serve concurrently as the Chairperson of the Board.

Section 5.2 Election and Tenure

The Officers shall be elected by a majority vote of the Directors at the annual meeting of the Board of Directors for terms of one (3) year or until their successors are elected and qualified.

- 2018- Chair and Vice Chair elected to 3 year terms expiring in 2021.
- 2018- Secretary will serve 1 year term
- 2018-CFO- Serve 2 year term

- 2019- Nominate Secretary to serve 3 year term
- 2020- Nominate CFO to serve 3 year term
- 2021- Vice Chair will move to Chair where they will be nominated for another 3 year term
- 2021- Nominate new Vice Chair to serve 3 year term

Section 5.3 Resignation

Any Officer may resign at any time by giving written notice to the Chairperson or to the Secretary. Such resignation, which may or may not be made contingent on formal acceptance, shall take effect on the date of receipt or at any later time specified in it.

Section 5.4 Removal

Any elected or appointed Officer may be removed from office, with or without cause, by the majority vote of all the Directors.

Section 5.5 Vacancies

Any vacancies in any office because of death, resignation or removal, or any other cause, shall be filled by the Board to complete the unexpired term of office or until a successor is elected and qualified.

Section 5.6 Responsibilities of Officers

(a) Chairperson

The Chairperson of this Corporation presides at all meetings of the Board. The Chairperson may sign on behalf of this Corporation any documents or instruments which the Board has authorized to be executed, except where the signing and execution thereof is expressly delegated by the Board or these Bylaws to some other Officer or Agent. The Chairperson shall have such other powers and duties as may be prescribed by the Board or these Bylaws. The Chairperson shall recommend candidates to the Board for Board committees.

(b) Vice Chairperson

In the absence or disability of the Chairperson, the Vice Chairperson shall perform all the duties of the Chairperson, and when so acting shall have all the powers of, and be subject to all the restrictions upon, the Chairperson. In the event that the Vice Chairperson is not available to so act, the Chairperson shall designate another member of the Board to act as Chairperson in the Chairperson's absence. The Vice Chairperson shall have such other powers and perform such other duties from time to time as may be prescribed by the Board or the Chairperson.

(c) Secretary

The Secretary shall keep or cause to be kept at the principal office of this Corporation, a book of minutes of all meetings and actions of the Board and committees of the Board. Such records shall contain: the time and place of holding the meeting, whether the meeting was regular or special (and, if special, how authorized), the notice given, the names of those present at such meeting, and the proceedings of such meetings. It shall be the responsibility of the Secretary to give or cause to be given notice of all meetings of the Board required by these Bylaws. The Secretary shall keep the seal of this Corporation in safe custody. The Secretary shall also have such other powers and perform such other duties as may be prescribed by the Board or these Bylaws. In the absence or disability of the Secretary, the Vice Chair shall perform all the duties of the Secretary. Board Chief Financial Officer

The Board Chief Financial Officer shall keep or cause to be kept correct and accurate accounts of the properties and financial transactions of this Corporation. The Board Chief Financial Officer shall also perform all duties incident to the office, and such other duties as maybe assigned from time to time by the Board or the Chairperson. The Board Chief Financial Officer may delegate any of the Board Chief Financial Officer's duties to any duly elected or appointed Assistant Financial Officer. In the absence or disability of the Board Chief Financial Officer, the Vice Chair shall perform all the duties of the Board Chief Financial Officer.

ARTICLE SIX

COMMITTEES

Section 6.1 Board Committees

(a) Committees

(1) A majority of Directors then in office may establish and appoint Directors to one or more committees, each consisting of two or more Directors, as appropriate, to serve at the pleasure of the Board.

(2) A majority of the Directors then in office may establish committees comprised of both Directors and non-Directors, provided that such committees shall not exercise any authority of the Board and shall at all times be under the ultimate direction of the Board. Such committees shall be advisory in nature and may carry out functions of study or investigation and make reports and recommendations to the Board and implement Board actions.

(3) If a Board committee is established, the resolution creating it must designate:

1. The Directors who are to serve as the voting committee members;

2. The Chairperson of the committee;

3. Any limitations on the authority of the committee; and

4. The functions the committee shall discharge.

(b) Delegation of Powers

The Board may delegate any of its powers to a committee comprised solely of Board members. The Board may not delegate the following powers:

(1) Fill vacancies on the Board of Directors;

(2) Fix the compensation of the Directors for serving on the Board or any committee;

(3) Amend or repeal these Bylaws or adopt new bylaws;

(4) Amend or repeal any resolution of the Board which by its express terms is not able to be amended or repealed;

(5) Establish committees of the Board;

(6) Approve any self-dealing transaction as such transactions are defined under Section 5233 of the California Corporations Code, or a successor section, except as provided in such law.

(c) Term

Each committee member and committee Chairperson shall hold office until the next annual meeting of the Board of Directors or until an occurrence of one of the follow: (a) a successor is appointed, (b) a committee member ceases to be a Director, (c) resigns or (d) is removed from the committee. A committee member of a Board committee may be reappointed for successive terms.

(d) Resignation

Any committee member may resign at any time by giving written notice to the Chairperson of the committee. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or at any later time specified in it.

(e) Removal

Any committee member except an *ex officio* participant may be removed at any time by a resolution adopted by a majority of the Directors then in office. An *ex-officio* committee member shall cease to be such if he or she ceases to hold a designated position which is the basis of the *ex-officio* committee member's membership.

(f) Vacancies

A vacancy on any Board committee or any increase in the membership thereof may be filled for the unexpired portion of the term in the same manner in which the original appointment to such committee was made.

(g) Meetings and Actions of Committee

Meetings and actions of the committee shall be under the direction of the Board. Minutes shall be kept of each meeting of any committee and shall be filed with the corporate records. The Board of Directors may adopt rules for the government of any committee. A majority of the members of a committee shall constitute a quorum.

(h) Attendance

Committee members shall attend at least seventy-two percent (75%) of the meetings of all committees to which assignment is made. Failure to satisfy these requirements may be grounds for removal from the Board or the committees in accordance with Section 4.13 of these Bylaws.

(i) Creation and Combination of Committees and Reassignment of Functions

(1) The creation of Board committees is discretionary with the Board. The Board may determine that any one or more of such committees should not exist, or it may assign the functions of such committee to a new or existing committee of the Board, or to the board acting as a committee of the whole, or to an individual Officer or Agent of this Corporation.

(j) Additional Participants

At the discretion of the Board, the Chief Executive Officer may be an *ex officio*, non-voting participant in committee meetings including the Executive Committee meetings.

Section 6.2 Standing Board Committees

(a) Executive Committee

(1) Composition: The Executive Committee shall be composed of the Chairperson, the Vice-Chairperson, the Board Chief Financial Officer (if not an employee of the Corporation), the Secretary, and the Immediate Past Chairperson. The Chief Executive Officer shall be *ex officio* non-voting participants in the meetings (but not members) of the Executive Committee at the discretion of the Board Chairperson.

(2) Functions: The Executive Committee shall have the authority and responsibility to:

1. Exercise all power and authority and to perform all duties and responsibilities as may be delegated to it from time to time by the Board subject to any limitations imposed by the Board. The Board may from time to time delegate to the Executive Committee any and all powers and authority of the Board in the management of the business and affairs of this corporation, except as provided in Section 5212(a) of the California Corporations Code or any successor statute, provided, however, that the delegation of such authority shall not operate to relieve the Board or any individual director of any responsibility imposed upon them by law, by the Articles or by these Bylaws;

2. Act on behalf of this Corporation in emergency situations provided that the Executive Committee shall have no power without approval of the Board to authorize any expenditure or commit this corporation in excess of the sum of $25,000.00;

3. Prepare written minutes of all of its meetings which shall be furnished to the Board at or prior to the next Board meeting;

4. Perform such other functions as may be assigned to it by the Board.

(3) Chairperson: The Chairperson of this Corporation shall serve as the Chairperson of the Executive Committee.

(4) Meetings: Meetings of the Executive Committee shall be held on call of the Chairperson.

(b) Finance and Planning Committee

(1) Composition: The Finance and Planning Committee shall be composed of at least three (3) Directors.

(2) Roles and Responsibilities: The Finance and Planning Committee shall be advisory in nature and shall carry out the following roles and responsibilities:

1. Recommending policies that maintain and improve the financial health and integrity of the organization.

2. Reviewing and recommending a long-range financial plan for the organization.

3. Reviewing and recommending an annual operating budget and annual capital budget consistent with the long-range financial plan and financial policies.

4. Reviewing and recommending capital expenditures and unbudgeted operating expenditures that exceed management's spending authority.

5. Reviewing the financial aspects of major proposed transactions, new programs and services, as well as proposals to discontinue programs or services, and making action recommendations to the Board.

6. Monitoring the financial performance of the organization as a whole and its major subsidiary organizations or business lines against approved budgets, long-term trends, and industry benchmarks.

7. Requiring and monitoring corrective actions to bring the organization into compliance with its budget and other financial targets.

8. Participating in annual continuing education pertinent to Committee responsibilities.

9. Acquiring and maintaining a working knowledge of payer contracts.

10. The Committee shall keep minutes from each meeting.

11. The Committee charter shall be reviewed annually.

12. Investment Policy responsibilities:

a. Recommending to the Board independent investments and pension plans.
b. Approving the selection of independent investment advisers and managers;
c. Reviewing reports from the independent investment advisers and managers;
d. Reviewing and reporting to the Board annually on investment and benefit plan performance;
e. Reviewing investment reports to see how each category of investments performed versus benchmarks.

(3) The Board Chief Financial Officer shall serve as Chairperson

(4) Meetings: Meetings of the Finance and Planning Committee shall be held on call of the Chairperson thereof.

(c) Quality Committee

(1) Composition: The Quality Committee shall be composed of at least two (2) Directors and any additional members as designated by the Board including at least one physician and the Chief Executive Officer, Chief Financial Officer, Chief of Staff, and Chief Nursing Officer

(2) Roles and Responsibilities: The Quality Committee shall be advisory in nature and shall carry out the following roles and responsibilities:

1. Develop, evaluate, modify, and approve the Quality Improvement Plan.

2. Set priorities for ongoing measurement of important processes.

3. Evaluate the need to reprioritize improvement activities in response to unusual or urgent events identified through measurement and/or changes in the environment of care or community.

4. Receive and review reports regarding the effectiveness of organization-wide QI (Quality Improvement) activities.

5. Review new service proposals ensuring they are in alignment with the organization's mission, philosophy, and appropriate quality measures are established.

6. Analyze and compare data with external sources when available.

7. Review and act upon Opportunity/Process Referral forms.

8. Support quality improvement teams, acting upon their recommendations.

9. Convene multidisciplinary QI teams for specific improvement efforts, some of which may be triggered by the results of ongoing measurement and/or customer feedback.

10. Communicate relevant activities, as necessary, throughout the organization.

11. Review Customer Service Surveys, QI Teams, Risk Management, Hospital Committees, Resource Management reports and other executive level data/information impacting organization quality and safety.

12. Evaluate the effectiveness of the QI activities of the hospital departments and teams.

13. Integrate findings and outcomes of reviews conducted by Medical Staff.

14. Determine the education and training needs of the organization related to Quality Improvement.

15. Evaluate and validate corrective action has resulted in improvement.

16. Report to the Peer Review/Credentialing Committee and/or Board of Trustees.

17. Maintain a permanent record of council proceedings.

18. Annually review and assess the adequacy of this charter and make recommendations to the Board for improvement.

(3) Chairperson: The Director of Quality and Compliance is the Chairperson.

(4) Meetings: Meetings of the Quality Committee shall be held quarterly or on the call of the Chairperson thereof.

(d) Governance Committee

(1) Composition: The Governance Committee shall be composed of at least three Directors.

(2) Functions: The Governance Committee shall be advisory in nature and shall carry the following functions

1.Assist the board to fulfill its responsibility for ensuring high levels of governance performance.

2.Assist the board with director selection, retention and replacement

3.Formulate policy to evaluate board governance effectiveness, efficiency, creativity and adaptability.

4.Enhance board medical staff relations.

5.Develop leadership and governance training programs.

6.Annually review the corporation's bylaws.

7.Review committee structure and make recommendations for changes as may be needed.

8.Formulate Chief Executive Officer evaluation process.

(3) The Vice Chair of the Board shall serve as Chiarperson of this committee.

(e) Audit and Corporate Compliance

(1) Composition: The Audit and Corporate Compliance Committee shall be composed of at least three (3) Directors.

(2) Functions: The Audit and Corporate Compliance Committee ("Committee") will assist the Board in fulling its oversight responsibility relating to Financial (1) the integrity of the company's financial statements, (2) the independent auditor's qualifications and independence, (3) the performance of the company's internal audit function and independent auditors, (4) the accounting and financial reporting processes of the company and audits of the financial statements of the company, The Audit and Corporate Compliance Committee ("Committee") will assist the Board in fulling its oversight responsibility relating to Compliance (1) legal and regulatory compliance systems, and (2) the anti-fraud program. The Committee shall also assist the Board in establishing a corporate culture that encourages a commitment to compliance with law, (3) the company's compliance with legal and regulatory requirements.

(3) Roles and Responsibilities: The duties and responsibilities of the Corporate Audit and Compliance Committee shall be:

Financial:

1. To recommend to the Board the selection of an external auditor for this Corporation and its subsidiary corporations.
2. To review the terms of the auditor's engagement at least every three (3) years, review scope of audits to be made and approve in advance non-audit services, if any, to be provided by the auditor.
3. To oversee the performance of the audit; review the results of the audit (including any Management Letter); confer with the auditor to ensure that the affairs of the corporation are in order; to review the implementation of internal financial controls adopted through the audit process; and based theron to make recommendations to the Board concerning the financial operation of this Corporation and its subsidiary corporations.

Compliance:

1. To oversee all corporate compliance and internal audit efforts of the Corporation in such manner as the Committee deems fit, subject to Board approval and to monitor the Corporation's response to potentially questionable corporate practices.
2. To oversee the Corporation's compliance with applicable laws, regulations, and accreditation standards, including but not limited to: Medicare Conditions of Participation and the DNV.
3. To meet at least annually, without anyone from management of the Corporation present (i.e., President/Chief Executive Officer, Chief Financial Officer, and any other officer that the Committee deems in its sole discretion to be a representative of management), with the

Corporation's external auditor, internal auditor if one is designated, and Corporate Compliance Officer, respectively.

4. Provide direction and assistance to the Compliance Program as it relates to the Seven Compliance Elements:

5. Provide direction and assistance to the Compliance Program as it relates to the Eight Specific Areas of Concern:

6. Meetings: Meetings of the Audit and Corporate Compliance Committee shall be held quarterly or on the call of the Chairperson thereof.

7. The Chairman is appointed by the Chairperson of the Board.

Section 6.3 Non-Directors Serving on Board Committees

(a) Notwithstanding any other provision of these Bylaws, non-Directors may be appointed to serve on any Board committee except the Executive Committee, including but not limited to the Standing Board Committees, and may participate in the discussion of issues before a Board committee, but shall not be entitled to vote and shall not be counted in determining the existence of a quorum.

(b) Each non-Director serving on a Board committee shall agree that he or she has a fiduciary duty to this Corporation, including but not limited to the provisions of Sections 3.5, 3.7 and 3.8 of these Bylaws. Each non-Director shall also have a duty of confidentiality to this Corporation, and shall agree that he or she shall not disclose any information received as part of this appointment to persons other than the Directors unless the Board shall have consented in writing. Non-Directors serving on a Board committee shall sign such an agreement and a conflict of interest form prior to the first meeting of the Board committee to which they are appointed.

ARTICLE SEVEN

CHIEF EXECUTIVE OFFICER

Section 7.1 Chief Executive Officer

(a) Appointment

The Board shall select and appoint a qualified person to serve as the Chief Executive Officer of this Corporation and be its direct executive representative in the management of this Corporation. The Chief Executive Officer shall have the

necessary authority and be held responsible for the management of this Corporation in all its activities, subject only to the policies enacted by the Board or any committees or persons to which the Board has specifically delegated power for such action. The Chief Executive Officer shall, attend all meetings of the Board and Board committees as an *ex officio*, non-voting participant providing support to the Board and Board committees as necessary or requested by the Board. The Chief Executive Officer shall act as a duly authorized representative of the Board in all matters except those in which the Board has formally designated another person or group to act. The Chief Executive Officer shall serve at the pleasure of the Board.

(b) Authority, Duties and Requirements

The Chief Executive Officer shall, subject to the directions of the Board:

(1) Be responsible to review and report updated Policies and Procedures to the Board;

(2) Be responsible for implementing policies established and plans authorized by the Board for the operation of this Corporation, and for advising the Board on the formation of these policies and plans;

(3) Send periodic reports to the Board on the overall activities of this Corporation, as well as on appropriate federal, state and local developments that affect the operation of this Corporation;

(4) Provide the Board and Board committees with such staff and administrative support and personnel as they may reasonably require;

(5) Organize the administrative functions of this Corporation, delegate duties, and establish formal means of accountability;

(6) Supervise the business affairs of this Corporation to assure that funds are expended to the best possible advantage for community health care;

(7) Attend, personally or by designee, all meetings of the Board and Board committees;

(8) Perform any other duties within the express or implicit terms of these Bylaws that may be necessary for the best interests of this Corporation;

(9) Designate, in writing, other individuals by name or position who are, in order of succession, authorized to act for the Chief Executive Officer during any period of absence from this corporation; and

(10) Perform such other duties as the Board shall from time to time direct.

(11) Recommend to the Board strategic and long range plans to fulfill the requirements of the mission statement.

ARTICLE EIGHT

MEDICAL STAFF

Section 8.1 Organization

The Board shall cause to be created a Medical Staff organization to be known as the Orchard Hospital Medical Staff (the "Medical Staff"), which shall be a distinct part of the hospital corporation and whose membership shall be comprised of all physicians, osteopaths, dentists, podiatrists, and others who are privileged to attend patients in this hospital. Only a member of the Medical Staff with admitting privileges shall admit patients to the Orchard Hospital. Membership in the Medical Staff shall be a prerequisite to the exercise of clinical privileges in the hospital except as otherwise specifically provided in the Medical Staff bylaws.

Section 8.2 Medical Staff Bylaws, Rules and Regulations

The Medical Staff bylaws and rules and regulations shall create an administrative unit to discharge the functions and responsibilities assigned to the Medical Staff by the Board, and such bylaws, rules and regulations shall be consistent with Joint Commission standards and recommendations, applicable law, applicable hospital policy and the Articles and Bylaws of this Corporation. The Bylaws, rules and regulations shall

(a) State the purposes, functions and organization of the Medical Staff;

(b) Set forth the policies by which the Medical Staff exercises and accounts for its functions and responsibilities; and

(c) Define relationships, responsibilities, authority and methods of accountability for each Medical Staff official, department officer and committee.

The Medical Staff Bylaws will specifically assure that only a member of the Medical Staff with admitting privileges shall admit patients to Orchard Hospital.

The Medical Staff shall have the initial responsibility to formulate, adopt, periodically review and recommend to the Board Medical Staff bylaws and amendments thereto and rules and regulations which will be effective when approved by the Board of Directors, which approval shall not be unreasonably withheld. If said bylaws or amendments thereto or rules and regulations or amendments thereto are not adopted in accordance with the standards set forth in this Section or are not adopted in a reasonable, timely and responsible manner, and after notice from the Board to such effect, including a reasonable period of time for response, then the Hospital will not be in compliance with state law and applicable accreditation standards. To the extent necessary for Orchard Hospital to comply with state law and applicable accreditation standards, the Board may resort to its own initiative in formulating or amending Medical Staff

bylaws or rules and regulations. In such event, Medical Staff recommendations and views shall be duly considered by the Board during its deliberations and in its actions.

Section 8.3 Medical Executive Committee

The Medical Staff Bylaws shall provide for an Executive Committee that represents the Medical Staff has responsibility for the effectiveness of all medical activities of the Staff and acts for the Medical Staff. The Executive Committee is a mechanism for providing a formal relationship between the Medical Staff organization and the Chief Executive Officer of the hospital. The members of the Executive Committee shall be selected as described in the Medical Staff Bylaws.

Section 8.4 Medical Staff Membership and Clinical Privileges

(a) Action by the Board of Directors

The Board shall refer to the Medical Staff the responsibility and authority to investigate and evaluate all matters relating to Medical Staff membership status, clinical privileges and corrective action, and shall require that the Staff make recommendations to it thereon. Final action on all such matters shall be taken by the Board after giving great weight to the Staff recommendations forwarded to it pursuant to paragraph (b) of this Section, and in no event will the Board act in an arbitrary or capricious manner. Notwithstanding the foregoing, the Board shall act in any event if the Staff does not adopt and submit any such recommendation within the time periods required by the Medical Staff Bylaws. Such Board action without a Staff recommendation shall be based on the same kind of documented investigation and evaluation of current ability, judgment, and character as is required for Staff recommendation and shall be taken only after providing written notice to the peer review body.

(b) Medical Staff Recommendations

The Medical Staff bylaws shall contain provisions for Staff to adopt and forward to the Board specific written recommendations on all matters of Medical Staff membership status, clinical privileges and corrective action, and to support and document these recommendations in a manner that will allow the Board to take informed action.

(c) Criteria for Board of Directors Action

(d) In acting on matters of Medical Staff membership status, the Board of Directors shall consider the Staff's recommendations, this Corporation's and the community's needs, and such other criteria as they are set forth in the Medical Staff bylaws. In granting and defining the scope of clinical privileges to be exercised by each practitioner, the Board shall give great weight to the Staff's recommendations, the supporting information on which they are based, and such criteria as are set forth in the Medical Staff bylaws. No aspect of membership status nor specific clinical privileges shall be limited or denied to a practitioner on the bases of sex, race, creed, color or natural origin, or on the basis of any other criterion unrelated to good patient care at the hospital, or to professional ability and judgment, or to community needs. Any differences between the Medical Staff and the Board regarding recommendations concerning membership status, clinical privileges and corrective action shall be resolved by the Board and the Medical Staff, within a reasonable period of time as determined by the Board.
Terms and Conditions of Staff Membership and Clinical Privileges

The terms and conditions of membership status in the Medical Staff and of the exercise of clinical privileges shall be specified in the Medical Staff Bylaws. It shall be a condition of appointment to the Medical Staff of this hospital that a practitioner has malpractice insurance in amounts determined from time to time by the Board of Directors.

(e) Procedure

The procedure to be followed by the Medical Staff and the Board in acting on matters of membership status, clinical privileges and corrective action shall be specified in the Medical Staff Bylaws.

Section 8.5 Hearing and Appellate Reviews

The Board shall require that any action taken by the Executive Committee of the Medical staff or by the Board, the effect of which is to adversely affect a practitioner as described in the Medical Staff bylaws, be accomplished in accordance with a Board-approved fair hearing plan then in effect, which must be set forth in the Medical Staff bylaws. Such plans shall provide for procedures to assure fair treatment and afford an opportunity for the presentation of all pertinent information.

Section 8.6 Allied Health Professionals

The Board shall refer to the Medical Staff the responsibility and authority to investigate and evaluate all matters relating to allied health professional's status, clinical privileges and corrective action, and shall require that the Staff make recommendations to it thereon. Allied Health Professional is defined as medical staff that require privileges, but are not physicians. Final action on all such matters shall be taken by the Board after considering the Staff recommendations forwarded to it pursuant to paragraph (b) of Section 8.4, provided that the Board shall act in any event if the Staff does not adopt and submit any such recommendations

within the time periods required by the Medical Staff Bylaws. Such Board action without a Staff recommendation shall be based on the same kind of documented investigation and evaluation of current ability, judgment, and character as is required for Staff recommendation. Allied health practitioners shall consist of health professionals who are not members of the Medical Staff, but who desire to practice in some capacity within the hospital. Allied health practitioners shall not have rights to fair hearing and appeals except as may expressly be provided in the Medical Staff Bylaws.

Section 8.7 Contractual, Medico-Administrative and Special Staff Officers

Medico-Administrative officer means a practitioner, engaged by or otherwise contracting with the hospital on a full or part-time basis, whose duties include certain responsibilities which may be both administrative and clinical in nature. Clinical responsibilities are defined as those involving professional capability as a practitioner, such to require the exercise of clinical judgment with respect to patient care and include the supervision of professional activities of practitioners under his direction.

A practitioner engaged by the hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the hospital and to the terms of his or her contract, or other conditions of engagement, and need not be a member of the Medical Staff. Conversely, a Medico-Administrative officer must be a member of the Medical Staff. His or her clinical privileges must be delineated in accordance with the Medical Staff bylaws. His or her Medical Staff membership and clinical privileges shall not be dependent upon his or her continued occupation of that position, unless otherwise provided in an employment agreement, contract or other arrangement or Board process that complies with state law.

Section 8.8 Chief Executive Officer

The Chief Executive Officer, and any other person designated by the Board shall be privileged to attend all meetings of the Medical Staff and shall be given notice of such meetings or Board process that complies with state law.

ARTICLE NINE

QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT AND RISK MANAGEMENT PROGRAM

Section 9.1 Board Responsibility

The Board shall establish, maintain, support and exercise oversight of an ongoing quality assessment/performance improvement program that includes specific and effective review, evaluation and monitoring mechanisms to assess, preserve and improve the overall quality and efficiency of patient care in the hospital.

Section 9.2 Delegation to Administration

The Board delegates to the Administration and holds it accountable for

(a) Providing the administrative assistance reasonably necessary to support and facilitate the implementation and ongoing operation of the Corporation's quality assessment/improvement performance and risk management program;

(b) Implementing the quality assessment/improvement performance and risk management program relating to all hospital personnel, medical and non-medical. Analyzing information and acting upon problems involving technical, administrative and support services and hospital policy.

Section 9.3 Delegation to the Medical Staff

The Board delegates to the Medical Staff and holds it accountable for conducting specific activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the hospital which activities include:

(a) Systematic evaluation of practitioner performance against explicit, predetermined criteria;

(b) Ongoing monitoring of critical aspects of care, including antibiotic and drug usage, transfusion practices, tissue, infections, mortalities and so on, and monitoring of unexpected clinical occurrences;

(c) Review of utilization of the hospital's resources to provide for their proper and timely allocation to patients in need of them;

(d) Provision of continuing professional education, fashioned in part on the needs identified through the review, evaluation, and monitoring activities and on new state-of-the-art developments;

(e) Definition of clinical privileges which may be appropriately granted within the hospital and within each department or service, delineation of clinical privileges for members of the Medical Staff commensurate with individual credentials and demonstrated ability and judgment, and participation in assigning patient care responsibilities to other health care professionals consistent with individual qualification and demonstrated abilities;

(f) Management of clinical affairs, including enforcement of clinical policies and consultation requirements, initiation of disciplinary actions, surveillance over requirements for performance monitoring and for the exercise of newly-acquired clinical privileges, and like clinically oriented activities; and

(g) Such other measures as the Board may, after considering the advice of each of the Medical Staff, the professional services and the facility management, deem necessary for the preservation and improvement of the quality and efficiency of patient care.

Section 9.4 Documentation and Oversight

At least annually, the Board shall require, receive, consider and, as appropriate, act upon the findings and recommendations emanating from the activities required by Sections 9.2 and 9.3. All such findings and recommendations shall be in writing, signed by the persons responsible for conducting the activities and supported and accompanied by appropriate documentation and rationale upon which the Board can take informed action, as required or necessary and can exercise effective oversight of the quality assessment/performance improvement and risk management program.

Section 9.5 Professional Liability Insurance

The Board shall ensure that each practitioner granted clinical privileges in the Corporation's facilities shall maintain professional liability insurance in not less than the minimum amounts as from time to time may be determined by the Board, based upon the recommendation of the Executive Committee of the Medical Staff or as required by the Corporation's professional liability insurance carrier. The minimum amount of required coverage established pursuant to this provision shall not exceed the amount of professional liability insurance carried by the Corporation.

ARTICLE TEN

FISCAL YEAR

Section 10.1 Accounting Year

The accounting year of the corporation shall be established by resolution of the Board.

Section 10.2 Audit

At the end of the accounting year, the books of this Corporation shall be closed and audited by a certified public accountant selected by the Board. The financial report of the auditor shall be furnished to the Board of Directors.

Section 10.3 Annual Report

The audit referred to in Section 10.3 shall be included as a part of the annual report referred to in the California Non-profit Public Benefit Corporation Law. Such report shall contain the following information in reasonable detail:

(a) The assets and liabilities, including trust funds, of this Corporation as of the end of the fiscal year;

(b) The principle changes in assets and liabilities, including trust funds, during the fiscal year;

(c) The revenue or receipts of this Corporation, both unrestricted and restricted to particular purposes, for the fiscal year;

(d) The expenses of disbursements of this corporation, both general and restricted purposes, during the fiscal year;

(e) Any information required by California Corporations Code Section 6322; and

(f) All other information required by law.

ARTICLE ELEVEN

INDEMNIFICATION

Section 11.1 Indemnification of Directors, Officers, Employees, and Other Agents

(a) The Corporation shall, to the maximum extent permitted by the California Corporations Code, indemnify each of its Directors, Officers, employees, agents and others against expenses, judgments, fines, settlements and other amounts actually and reasonably incurred in connection with any proceeding arising by reason of the fact any such person is or was an agent of the Corporation.

The Board may authorize the purchase and maintenance by the Corporation of insurance on behalf of any agent of the Corporation against liability asserted against or incurred by the agent in such capacity or arising out of the agent's status as such whether or not the Corporation is empowered to indemnify the agent against such liability under the provisions of this Article.

For purposes of this Article, an "agent" of the Corporation includes any person who is or was a director, officer, employee or other agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise or was a director, officer or employee or agent of a corporation which was a predecessor corporation of the Corporation or of another enterprise at the request of such predecessor corporation.

(b) Determination of Agent's Good Faith Conduct

The agent seeking indemnification must be found by the Board (as evidenced by a majority vote of a quorum consisting of Directors who are not parties to the proceedings) to have acted in good faith, in a manner the agent believed to be in the best interests of this corporation, and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use in similar circumstances. The termination of any proceeding by judgment, order, settlement, conviction, or otherwise shall not, of itself, create a presumption that the person did not act in good faith. In the case of a criminal proceeding, the

person must have had no reasonable cause to believe that the conduct was unlawful. The Board's decision in this matter shall be final.

(c) Limitations

No indemnification or advance shall be made under this Section in any circumstances when it appears:

(1) The indemnification or advance would be inconsistent with a provision of the Articles, or an agreement in effect at the time of the accrual of the alleged cause of action asserted in the proceeding in which the expenses were incurred or other amounts were paid, which prohibits or otherwise limits indemnifications;

(2) The indemnification would be inconsistent with any condition expressly imposed by a court or other body in approving a settlement; or

(3) The indemnification is prohibited by law or regulation, or would jeopardize the exempt status of this or a supported or affiliated corporation.

(d) Contractual Rights of Non-Directors and Non-Officers

Nothing contained in this Section shall affect any right to indemnification to which persons other than Directors and Officers of either this Corporation or any supported or affiliate organization may be entitled by contract or otherwise.

Section 11.2 Bonding

All Officers and employees handling funds shall be properly bonded.

ARTICLE TWELVE

RECORDS, REPORTS AND INSPECTION RIGHTS

Section 12.1 Maintenance of Articles and Bylaws

The Corporation shall keep at its principal office the original or a copy of the Articles and of these Bylaws as amended to date.

Section 12.2 Maintenance of Other Corporation Records

The accounting books, records and minutes of proceedings of the Board and any committee(s) of the Board shall be kept at such place or places designated by the Board or, in the absence of such designation, at the principal executive office of the Corporation. The minutes shall be kept in written or typed form, and the accounting books and records shall be kept in wither written or typed form. All minutes, accounting books, records and any corporate records and documents

shall be kept and maintained in accordance with policies, procedures, or other directives that may be established by the Board.

Section 12.3 Inspection by Directors

Except as otherwise limited by law, every Director shall have the absolute right at any reasonable time to inspect all books, records, and documents of every kind and the physical properties of the Corporation. This inspection by a Director may be made in person or by an agent or attorney, and the right of inspection includes the right to copy and make extracts of documents.

ARTICLE THIRTEEN

EXECUTION OF DOCUMENTS

The following persons shall be authorized to execute any deeds, mortgages, bonds, contracts, or other instruments which the Board has authorized to be executed and for which this Corporation has authority to act:

A. Any Officer or other person duly authorized by resolution of the Board to execute documents; or

B. In the absence of express authorization by Board resolution, the Chairperson or the President, and any one of the Secretary, or the Chief Financial Officer (all subject to such limitations as may be imposed by resolution of the Board).

ARTICLE FOURTEEN

GENERAL PROVISIONS

Section 14.1 Auxiliaries and Related Groups

The Board may establish or support the establishment of one or more auxiliary groups, including a Foundation, and/or related organizations willing to support the objectives of the Corporation or work in complementary ways with the Corporation. The Board reserves the right, subject to any charitable trust law requirements to allocate any such funds as may be donated by such bodies to uses or objectives consistent with the purposes of this Corporation. Additionally, for liaison purposes only, a member of the Board shall be appointed to attend Executive Committee meetings of the Foundation, Auxiliary, and other related organizations, and from time to time, but not less than annually, the Board shall receive a report, for information purposes only from the Foundation, Auxiliary, and all other related organizations as to the operations of that organization.

Section 14.2 Amendments

These Bylaws may be replaced or amended or new Bylaws may be adopted by a majority vote of the Directors at any annual meeting or at any other meeting called for that purpose.

March, 2018

Section 14.3 Construction and Definitions

Unless the context requires otherwise, the general provisions, rules of construction, and definitions in the California nonprofit public benefit corporation law shall govern the construction of these Bylaws. Without limiting the generality of the above, the masculine gender includes the feminine and neuter, the singular numbers include the plural, the plural numbers include the singular, and the term "person" includes both corporations and natural persons. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

Section 14.4 Corporate Seal

The Board shall provide a suitable seal for this Corporation.

Section 14.5 Meeting Procedure

All meetings of the Board and of committees shall be conducted in accordance with the standing rules and procedures established by the Board, and to the extent such rules and procedures are not specifically established by the Board, Roberts Rules of Order, as revised from time to time, shall be controlling as to procedure.

Section 14.6 Leave of Absence

(a) Directors may be granted leaves of absence by the affirmative vote of a majority of the Board for a definitely-stated period of time.

(b) Requests for leaves of absence shall be made to the Chairperson of the Board and shall state the beginning and ending dates of the requested leave and the reasons for the leave.

(c) No later than ninety (90) calendar days prior to the conclusion of the leave of absence, the individual may request, in writing to the Chairperson of the Board, to be reinstated. The request shall summarize the activities undertaken during the leave of absence. The individual shall also provide such other information as may be requested by the Board at that time.

(d) In acting upon the request for reinstatement, the Board may consider the individual for the first available vacancy on the Board, but shall not be required to appoint or elect the individual to fill that vacancy.

OFFICER'S CERTIFICATE

THIS IS TO CERTIFY that:

The undersigned persons are the Chairperson of the Board and the Secretary of Orchard Hospital, a California nonprofit public benefit corporation; and

The foregoing Amended and Restated Bylaws of Orchard Hospital were duly adopted and approved by the Board of Directors of this Corporation on the 27th day of March, 2018.

ORCHARD HOSPITAL

By [redacted]
Chairperson of the Board

Date: March 27, 2018

By [redacted]
Secretary

Date: March 27, 2018

March, 2018

Title 11, California Code of Regulations § 999.5(d)(4)(A)

The Applicant's Articles of Incorporation and all amendments thereto and current bylaws, any charitable trust restrictions, and any other information necessary to define the charitable trust purpose of the applicant's assets

EXHIBIT 3

License: 230000007
Effective: 12/01/2023
Expires: 11/30/2024
Licensed Capacity: 24

State of California
Department of Public Health

In accordance with applicable provisions of the Health and Safety Code of California and its rules and regulations, the Department of Public Health hereby issues

this **License** *to*

Orchard Hospital

to operate and maintain the following **General Acute Care Hospital**

Orchard Hospital
240 Spruce St
Gridley, CA 95948-2216

Bed Classifications/Services/Stations
24 General Acute Care
4 Intensive Care
20 Unspecified General Acute Care

Other Approved Services
Mobile Unit - Computed Tomography (CT) Scan
Mobile Unit - Magnetic Resonance Imaging (MRI)
Occupational Therapy
Outpatient Services - PCC at Orchard Hospital Medical Specialty Center, 284 Spruce Street, Gridley
Outpatient Services - Primary Care at Orchard Hospital Medical Specialty Center Oroville, 2990 Oro Dam Blvd. E Suite A, Oroville
Outpatient Services - Psychiatry - Geriatric Psychiatric Program
Physical Therapy
Respiratory Care Services
Social Services
Speech Pathology and/or Audiology Service
Standby Emergency Medical Services

(Additional Information Listed on License Addendum)

Refer Complaints regarding these facilities to: The California Department of Public Health, Licensing and Certification, Chico District Office, 126 Mission Ranch Blvd, Chico, CA 95926, (530) 895-6711

POST IN A PROMINENT PLACE

State of California
Department of Public Health
License Addendum

License: 230000007
Effective: 12/01/2023
Expires: 11/30/2024
Licensed Capacity: 24

Orchard Hospital (Continued)
240 Spruce St
Gridley, CA 95948-2216

Approved Other Certifiable Parts

Rural Health Clinic
Orchard Hospital Medical Specialty Center Oroville
2990 Oro Dam Blvd E
Suite A
Oroville, CA 95966-5177

Rural Health Clinic
Orchard Hospital Medical Specialty Center
284 Spruce St
Gridley, CA 95948-2216

This **LICENSE** is not transferable and is granted solely upon the following conditions, limitations and comments:
24 hospital beds approved as swing beds.
Critical Access Hospital

TOMÁS J. ARAGÓN, MD, DrPH
Director and State Public Health Officer

Chris Fong for
Michelle Dunlap, Staff Service Manager II

Refer Complaints regarding these facilities to: The California Department of Public Health, Licensing and Certification, Chico District Office, 126 Mission Ranch Blvd, Chico, CA 95926, (530) 895-6711

POST IN A PROMINENT PLACE

Title 11, California Code of Regulations § 999.5(d)(4)(A)

The Applicant's Articles of Incorporation and all amendments thereto and current bylaws, any charitable trust restrictions, and any other information necessary to define the charitable trust purpose of the applicant's assets

EXHIBIT 4

BA20220998608

STATE OF CALIFORNIA
Office of the Secretary of State
STATEMENT OF INFORMATION
CORPORATION

California Secretary of State
1500 11th Street
Sacramento, California 95814
(916) 653-3516

For Office Use Only

-FILED-

File No.: BA20220998608

Date Filed: 10/18/2022

Entity Details

Corporation Name	AMERICAN ADVANCED MANAGEMENT, INC
Entity No.	4155461
Formed In	DELAWARE

Street Address of Principal Office of Corporation

Principal Address	300 DELAWARE AVENUE STE 210-A WILMINGTON, DE 19801

Mailing Address of Corporation

Mailing Address	PO BOX 4841 MODESTO, CA 95352
Attention	

Street Address of California Office of Corporation

Street Address of California Office	700 17TH STREET MODESTO, CA 95354

Officers

Officer Name	Officer Address	Position(s)
~~– GURPREET SINGH~~	~~4120 DALE ROAD, J8 140 MODESTO, CA 95356~~	~~Chief Executive Officer, Secretary~~
Tammy Thompson	700 17th Street Modesto, CA 95354	Chief Financial Officer
+ Gurpreet S Randhawa	4120 DALE ROAD, J8140 MODESTO, CA 95356	Chief Executive Officer, Secretary

Additional Officers

Officer Name	Officer Address	Position	Stated Position
None Entered			

Agent for Service of Process

Agent Name	Tammy Thompson
Agent Address	700 17TH STREET STE 205 MODESTO, CA 95354

Type of Business

Type of Business	HEALTHCARE MANAGEMENT

Email Notifications

Opt-in Email Notifications	No, I do NOT want to receive entity notifications via email. I prefer notifications by USPS mail.

Labor Judgment

No Officer or Director of this Corporation has an outstanding final judgment issued by the Division of Labor Standards Enforcement or a court of law, for which no appeal therefrom is pending, for the violation of any wage order or provision of the Labor Code.

Electronic Signature

☒ By signing, I affirm that the information herein is true and correct and that I am authorized by California law to sign.

G S Randhawa	*10/18/2022*
Signature	Date

Title 11, California Code of Regulations § 999.5(d)(4)(A)

The Applicant's Articles of Incorporation and all amendments thereto and current bylaws, any charitable trust restrictions, and any other information necessary to define the charitable trust purpose of the applicant's assets

EXHIBIT 5

ACTION BY WRITTEN CONSENT
OF THE SOLE INCORPORATOR
OF
American Advanced Management, Inc.,
a Delaware Corporation,
February 10, 2018

The undersigned, acting as the sole incorporator of American Advanced Management, Inc., a Delaware corporation (the "Corporation"), hereby approves and adopts the following resolutions by this written consent without a meeting (this "Written Consent") pursuant to Section 108 of the Delaware General Corporation Law, which shall be effective upon the commencement of the corporation's existence:

RESOLVED, that the bylaws regulating the conduct of the Corporation's business and affairs, in the form attached to this Written Consent, are hereby adopted as the bylaws of the Corporation ("Bylaws").

RESOLVED FURTHER, that the Secretary of the Corporation is hereby authorized and directed to execute a certificate of the adoption of the Bylaws, to insert the Bylaws as so certified and as may be amended from time to time, in the minute book of the Corporation and to see that a copy of the Bylaws, similarly certified, is kept at the principal executive office for the transaction of business of the Corporation, as required by law.

RESOLVED FURTHER, that each person named below is hereby elected to serve as a director of the Corporation until such time as his or her successor is duly elected and qualified:

Gurpreet Singh

RESOLVED FURTHER, that the officers of the Corporation, as elected by the Corporation's Board of Directors, are authorized and directed to insert a copy of this Written Consent in the minute book of the Corporation.

RESOLVED FURTHER, that the undersigned, the sole incorporator of the Corporation, hereby resigns as the incorporator of the Corporation, effective upon the commencement of the corporation's existence.

IN WITNESS WHEREOF, the undersigned executes this Written Consent as of the date set forth above.

[redacted]

By: Cheyenne Moseley, Assistant Secretary
LegalZoom.com, Inc., Sole Incorporator

EXHIBIT A
BYLAWS OF
American Advanced Management, Inc.

BYLAWS

OF

American Advanced Management, Inc., a Delaware Corporation

ARTICLE I

Stockholders

Section 1.1. **Annual Meetings.** An annual meeting of stockholders of American Advanced Management, Inc. (the "Corporation") shall be held for the election of directors on a date and at a time and place either within or without the state of Delaware fixed by resolution of the Board of Directors. Any other proper business may be transacted at the annual meeting.

Section 1.2. **Special Meetings.** Special meetings of the stockholders may be called at any time by the Board of Directors, the Chairman of the Board of Directors or the holders of shares entitled to cast not less than ten percent of the votes at the meeting, such meeting to be held on a date and at a time and place either within or without the state of Delaware as may be stated in the notice of the meeting. Business transacted at any special meeting of the stockholders shall be limited to the purposes stated in the notice.

Section 1.3. **Notice of Meetings.** Whenever stockholders are required or permitted to take any action at a meeting, a written notice of the meeting shall be given not less than ten nor more than sixty days before the date of the meeting to each stockholder entitled to vote thereat. If mailed, such notice shall be deemed to be given when deposited in the United States mail, postage prepaid, directed to the stockholder at such stockholder's address as it appears on the records of the Corporation. Such notice shall state the place, date and hour of the meeting, and in the case of a special meeting, the general purpose for which the meeting is called.

Section 1.4. **Adjournments.** Any meeting of stockholders may be adjourned from time to time, to reconvene at the same or some other place. Notice need not be given of any such adjourned meeting if the date, time and place thereof are announced at the meeting at which the adjournment is taken. At the adjourned meeting the Corporation may transact any business which might have been transacted at the original meeting. If the adjournment is for more than 30 days or if after the adjournment a new record date is fixed for the adjourned meeting, a notice of the adjourned meeting shall be given to each stockholder of record entitled to vote at the meeting.

Section 1.5. **Quorum.** At each meeting of stockholders, except where otherwise provided by law or the certificate of incorporation or these bylaws, the holders of a majority of the outstanding shares of stock entitled to vote, represented in person or by proxy, shall constitute a quorum at a meeting of the stockholders. In the absence of a quorum, any meeting of stockholders may be adjourned from time to time by the vote of a majority of the shares represented either in person or by proxy until a quorum is present or represented. Shares of its own capital stock belonging to the Corporation or to another Corporation where the majority of the voting power is held by the Corporation shall nether be entitled to vote nor counted for quorum purposes; provided, however, that the foregoing shall not limit the right of the Corporation to vote stock, including but not limited to its own stock, held by it in a fiduciary capacity.

Section 1.6. **Organization.** Meetings of stockholders shall be presided over by the Chairman of the Board of Directors, if any, or in the absence of the Chairman of the Board of Directors by the Vice Chairman of the Board of Directors, if any, or in the absence of the Vice Chairman of the Board of Directors by the President, or in the absence of the foregoing persons by a chairman designated by the Board of Directors, or in the absence of such designation by a chairman chosen at the meeting. The Secretary, or in the absence of the Secretary, an Assistant Secretary, shall act as secretary of the meeting, or in their absence the chairman of the meeting may appoint any person to act as secretary of the meeting.

Section 1.7. **Voting.** Unless otherwise provided in the certificate of incorporation, each stockholder entitled to vote at any meeting of stockholders shall be entitled to one vote for each share held by such stockholder which has voting power upon the matter in questions. Directors shall be elected by a plurality of the votes of the shares present in person or represented by proxy at the meeting and entitled to vote on the election of directors. In all other matters, unless otherwise provided by law or by the certificate of incorporation or these bylaws, the affirmative vote of the holders of a majority of the shares present in person or represented by proxy and entitled to vote on the subject matter at a meeting in which a quorum is present shall be the act of the stockholders. Where a separate vote by class or classes is required, the affirmative vote of the holders of a majority of the shares of such class or classes present in person or represented by proxy shall be the act of such class or classes, except as otherwise provided by law or by the certificate of incorporation or these bylaws.

Section 1.8. **Stockholder's Proxies.** Every person entitled to vote or to express consent or dissent to corporate action in writing without a meeting may authorize another person or persons to act by proxy with respect to such shares. No proxy shall be voted or acted on after three years from its date, unless the proxy provides for a longer period. Every proxy continues in full force and effect until revoked by the person executing it. Such revocation may be effected by a writing delivered to the Corporation stating that the proxy is revoked or by a subsequent proxy executed by the person executing the prior proxy and presented to the meeting, or as to any meeting by attendance at such meeting and voting in person by the person executing the proxy.

Section 1.9. **Fixing Date for Determination of Stockholders of Record.** In order that the Corporation may determine the stockholders entitled to notice of any meeting, the Board of Directors may fix a record date, which shall not be more than sixty nor less than ten days prior to the date of such meeting, nor shall the record date precede the date upon which the resolution fixing the record date is adopted by the Board of Directors. In order that the Corporation may determine the stockholders entitled to consent to corporate action without a meeting, the Board of Directors may fix a record date, which shall not precede, or be more than 10 days after, the date upon which the resolution fixing the record date is adopted by the Board of Directors. In order that the Corporation may determine the stockholders entitled to receive payment of any dividend or other distribution or allotment of any rights or of any other lawful action, the Board of Directors may fix a record date, which shall not be more than sixty days prior to such action.

If no record date is fixed: (1) the record date for determining stockholders entitled to notice of or to vote at a meeting of stockholders shall be at the close of business on the business day next preceding the day on which notice is given or, if notice is waived, at the close of business on the business day next preceding the day on which the meeting is held; (2) the record date for determining stockholders entitled to give consent to corporate action in writing without a meeting, when no prior action by the Board of Directors has been taken, shall be the day on which the first written consent is given; if prior action by the Board of Directors is required, then the record date shall be the close of business on the date the Board of Directors adopts the resolution taking such prior action, and (3) the record date for determining stockholders for any other purpose shall be at the close of business on the day on which the Board of Directors adopts the resolution relating thereto, unless the Board of Directors sets a new record date.

Section 1.10. **Consent of Stockholders in Lieu of Meeting.** Except as otherwise provided in the certificate of incorporation, any action which may be taken at any annual or special meeting of the stockholders may be taken without a meeting and without prior notice, if a consent in writing, setting forth the action so taken, shall be signed by the holders of outstanding shares having not less than the minimum number of votes that would be necessary to authorize or take such action at a meeting at which all shares entitled to vote thereon were present and voted, and shall be delivered to the Corporation. Every written consent shall bear the date of signature of each stockholder who signs the consent, and no written consent shall be effective unless, within 60 days of the earliest consent, written consents signed by a sufficient number of holders have been delivered to the Corporation.

Unless all stockholders entitled to vote consent in writing, prompt notice of any stockholder approval without a meeting shall be given to those stockholders who have not consented in writing and who, if the action had been taken at a meeting, would have been entitled to notice of the meeting if the record date for such meeting had been the date that sufficient consents were delivered to the Corporation.

ARTICLE II

Board of Directors

Section 2.1. **Powers; Number; Qualifications.** The business and affairs of the Corporation shall be managed by, and all corporate powers shall be exercised by or under, the direction of the Board of Directors, except as otherwise provided by laws or in the certificate of incorporation. The Board of Directors shall consist of one or more members, the number thereof to be determined from time to time by the Board of Directors.

Section 2.2. **Election; Term of Office; Resignation; Removal; Vacancies.** Each director shall hold office until a successor has been elected and qualified or until his or her earlier resignation or removal. Any director may resign effective upon giving written notice to the Chairman of the Board of Directors, the President or the Secretary of the Corporation. Such resignation shall take effect at the time specified therein, and unless otherwise specified therein no acceptance of such resignation shall be necessary to make it effective. Any or all of the directors may be removed, with or without cause if such removal is approved by a majority of the outstanding voting shares then entitled to vote on the election of directors. Unless otherwise provided in the certificate of incorporation or in these bylaws, vacancies and newly-created directorships resulting from any increase in the authorized number of directors may be filled by a majority of the directors then in office, although less than a quorum, or by the sole remaining director.

Section 2.3. **Regular Meetings.** Regular meetings of the Board of Directors may be held without notice at such places within or without the state of Delaware and at such times as the Board of Directors may from time to time determine, and if so determined notice thereof need not be given.

Section 2.4. **Special Meetings; Notice of Meetings; Waiver of Notice.** Special meetings of the Board of Directors may be held at any time or place within or without the state of Delaware whenever called by the Chairman of the Board of Directors, by the Vice Chairman of the Board of Directors, if any, or by any two directors. Reasonable notice shall be given by the person or persons calling the meeting unless a director signs a waiver of notice or a consent to holding the meeting or an approval of the minutes thereof, whether before or after the meeting, or who attends the meeting without protesting the lack of notice prior to the meeting or at its commencement.

Section 2.5. **Participation in Meetings by Conference Telephone Permitted.** Members of the Board of Directors, or any committee designated by the Board of Directors, may participate in a meeting of the Board of Directors or of such committee, as the case may be, through the use of conference telephone or similar communications equipment by means of which all members participating in such meeting can hear one another, and participation in a meeting pursuant to this Section shall constitute presence in person at such meeting.

Section 2.6. **Quorum; Adjournment; Vote Required for Action.** At all meetings of the Board of Directors a majority of the authorized number of directors shall constitute a quorum for the transaction of business. The vote of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors unless the certificate of incorporation or these bylaws shall require a vote of a greater number.

Section 2.7. **Organization.** Meetings of the Board of Directors shall be presided over by the Chairman of the Board of Directors, or in the absence of the Chairman of the Board of Directors by the Vice Chairman of the Board of Directors, if any, or in their absence by a chairman chosen at the meeting. The Secretary, or in the absence of the Secretary an Assistant Secretary, shall act as secretary of the meeting, but in the absence of the Secretary and any Assistant Secretary the chairman of the meeting may appoint any person to act as secretary of the meeting.

Section 2.8. **Action by Directors Without a Meeting.** Any action required or permitted to be taken by the Board of Directors, or any committee thereof, may be taken without a meeting if all members of the Board of Directors or of such committee, as the case may be, consent in writing to such action and such consent is filed with the minutes of the proceedings of the Board of Directors.

Section 2.9. **Compensation of Directors.** The Board of Directors shall have the authority to fix the compensation of directors for services in any capacity.

ARTICLE III

Committees

Section 3.1. **Committees of Directors.** The Board of Directors may designate one or more committees, each consisting of one or more directors. Any committee, to the extent provided in the resolution of the Board of Directors, shall have and may exercise all the powers and authority of the Board of Directors, except that no such committee shall have power or authority with respect to the following matters:

a) Approving or adopting, or recommending to the stockholders, any action or matter expressly required by Delaware Corporation Law to be submitted to the stockholders for approval; or

b) The amendment or repeal of the bylaws, or the adoption of new bylaws.

Section 3.2. **Committee Rules.** Unless the Board of Directors otherwise provides, each committee designated by the Board of Directors may adopt, amend and repeal rules for the conduct of its business. In the absence of a provision by the Board of Directors or a provision in the rules of such committee to the contrary, each committee shall conduct its business in the same manner as the Board of Directors conducts its business pursuant to Article II of these bylaws.

ARTICLE IV

Officers

Section 4.1. **Officers; Election.** As soon as practicable after the annual meeting of stockholders in each year, the Board of Directors shall elect a President and a Secretary, and if it so determines, elect from among its members a Chairman of the Board of Directors and a Vice Chairman of the Board of Directors. The Board of Directors may also elect one or more Vice Presidents, one or more Assistant Secretaries, and such other officers as the Board of Directors may deem desirable or appropriate and may give any of them such further designations or alternate titles, as it considers desirable.

Section 4.2. **Term of Office; Resignation; Removal; Vacancies.** Except as otherwise provided in the resolution of the Board of Directors electing any officer, each officer shall hold office until his or her successor is elected and qualified or until his or her earlier resignation or removal. Any officer may resign at any time upon written notice to the Board of Directors or to the Chairman of the Board of Directors or the Secretary of the Corporation. Such resignation shall take effect at the time specified therein, and unless otherwise specified therein no acceptance of such resignation shall be necessary to make it effective. The Board of Directors may remove any officer with or without cause at any time. Any such removal shall be without prejudice to the contractual rights of such officer, if any, with the Corporation, but the election of an officer shall not of itself create contractual rights. Any vacancy occurring in any office of the Corporation by death, resignation, removal or otherwise may be filled by the Board of Directors at any regular or special meeting.

Section 4.3. **Powers and Duties.** The officers of the Corporation shall have such powers and duties in the management of the Corporation as shall be stated in these bylaws or in a resolution of the Board of Directors which is not inconsistent with these bylaws and, to the extent not so stated, as generally pertain to their respective offices, subject to the control of the Board of Directors. The Secretary shall have the duty to record the proceedings of the meetings of the stockholders, the Board of Directors and any committees in a book to be kept for that purpose. The Board of Directors may require any officer, agent or employee to give security for the faithful performance of his or her duties.

ARTICLE V

Forms of Certificates; Loss and Transfer of Shares

Section 5.1. **Forms of Certificates.** Every holder of shares in the Corporation shall be entitled to have a certificate signed in the name of the Corporation by (1) the President, any Vice President, Chairman of the Board of Directors or Vice Chairman, and (2) by the Chief Financial Officer, Treasurer, Assistant Treasurer, Secretary or Assistant Secretary. Each certificate shall state the number of shares and the class or series of shares owned by such stockholder. If such certificate is manually signed by one officer or manually countersigned by a transfer agent or by a registrar, any other signature on the certificate may be a facsimile. In case any officer, transfer agent or registrar who has signed or whose facsimile signature has been placed upon a certificate shall have ceased to be such officer, transfer agent or registrar before such certificate is issued, it may be issued by the Corporation with the same effect as if such person were such officer, transfer agent or registrar at the date of issue.

If the Corporation is authorized to issue more than one class of stock or more than one series of any class, the powers, designations, preferences, relative or other special rights, qualifications, restrictions and limitations of each class or series shall be set forth in full or summarized on the face or back of the certificate representing such class or series of stock, provided that in lieu of the foregoing, there may be set forth on the back or face of the certificate a statement that the Corporation will furnish without charge to each stockholder who requests the powers, designations, preferences, relative or other special rights, qualifications, restrictions and limitations of such class or series.

Section 5.2. **Lost, Stolen or Destroyed Stock Certificates; Issuance of New Certificates.** The Corporation may issue a new share certificate or a new certificate for any other security in the place of any certificate theretofore issued by it, alleged to have been lost, stolen or destroyed, and the Corporation may require the owner of the lost, stolen or destroyed certificate, or such owner's legal representative, to give the Corporation a bond sufficient to indemnify it against any claim that may be made against it (including any expense or liability) on account of the alleged loss, theft or destruction of any such certificate or the issuance of such new certificate.

ARTICLE VI

Records

Section 6.1. **Records.** The Corporation shall keep a stock ledger, a list of stockholders and other books and records as may be required to run the Corporation. The Secretary shall have the duty to record the proceedings of the meetings of the stockholders, the Board of Directors and any committees in a book to be kept for that purpose.

Section 6.2. **Form of Records.** Any records maintained by the Corporation in the regular course of its business, including its stock ledger, books of account and minute books, may be kept on, or be in the form of, computer discs, magnetic tape, photographs, or any other information storage device, provided that the records so kept can be converted into clearly legible form within a reasonable time. The Corporation shall so convert any records so kept upon the request of any person entitled to inspect the same.

ARTICLE VII

Miscellaneous

Section 7.1. **Fiscal Year.** The fiscal year of the Corporation shall be determined by the Board of Directors.

Section 7.2. **Seal.** The Corporation may have a corporate seal which shall have the name of the Corporation inscribed thereon and shall be in such form as may be approved from time to time by the Board of Directors. The corporate seal may be used by causing it or a facsimile thereof to be impressed or affixed or in any other manner reproduced.

Section 7.3. **Waiver of Notice of Meetings of Stockholders, Directors and Committees.** Whenever notice is required to be given by law or under any provision of the certificate of incorporation or these bylaws, a written waiver thereof, signed by the person entitled to notice, whether before or after the time stated therein, shall be deemed equivalent of notice. Attendance of a person at a meeting shall constitute a waiver of notice of such meeting, except when the person attends a meeting for the express purpose of objecting, at the beginning of the meeting, to the transaction of any business because the meeting is not lawfully called or convened. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the stockholders, directors or members of a committee of directors need be specified in any written waiver of notice unless required in the certificate of incorporation or these bylaws.

Section 7.4. **Interested Directors; Quorum.** No contract or transaction between the Corporation and one or more of its directors or between the Corporation and any other Corporation, firm or association in which one or more of its directors are directors, or have a financial interest, shall be void or voidable solely for this reason, or solely because such director or directors are present at the meeting of the Board of Directors or committee thereof which authorizes, approves or ratifies the contract or transaction, or solely because his or her or their votes are counted for such purpose, if: (1) the material facts as to his or her relationship or interest and as to the contract or transaction are fully disclosed or are known to the Board of Directors or the committee, and the Board of Directors or committee authorizes, approves or ratifies the contract or transaction in good faith authorizes the contract or transaction by the affirmative votes of a majority of the disinterested directors, even though the disinterested directors be less than a quorum; or (2) the material facts as to his or her relationship or interest and as to the contract or transaction are fully disclosed or are known to the stockholders and such contract or transaction is specifically approved by the stockholders in good faith by vote of the stockholders; or (3) the contract or transaction is fair as to the Corporation as of the time it is authorized, approved or ratified, by the Board of Directors, a committee thereof or the stockholders. Common or interested directors may be counted in determining the presence of a quorum at a meeting of the Board of Directors or of a committee which authorizes the contract or transaction.

Section 7.5. **Indemnification**. The Corporation shall have the power to indemnify to the full extent permitted by law any person made or threatened to be made a party to any action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that such person or such person's testator or instate is or was a director, officer or employee of the Corporation serves or served at the request of the Corporation as a director, officer, employee or agent of another enterprise. Expenses, including attorneys' fees, incurred by any such person in defending against such action, suit or proceeding may be paid in advance of the final disposition of such action, suit or proceeding by the Corporation upon receipt by it of an undertaking of such person to repay such expenses if it shall be ultimately determined that such person is not entitled to be indemnified by the Corporation. For purposes of this Section, the term "Corporation" shall include any predecessor of the Corporation and any constituent Corporation absorbed by the Corporation in consolidation or merger; the term "other enterprise" shall include any corporation, partnership, joint venture, trust or employee benefit plan; service "at the request of the Corporation" shall include services as a director, officer or employee of the Corporation which imposes duties on, or involves services by, such director, officer or employee with respect to an employee benefit plan, its participants or beneficiaries; any excise taxes assessed on a person with respect to an employee benefit plan shall be deemed to be indemnifiable expenses; and action by a person with respect to an employee benefit plan which such person reasonable believes to be in the interest of the participants and beneficiaries of such plan shall be deemed to be action not opposed to the best interests of the Corporation.

Section 7.6. **Amendment of Bylaws**. These bylaws may be amended or repealed, and new bylaws adopted, by the Board of Directors. The stockholders entitled to vote, however, retain the right to adopt additional bylaws and may amend or repeal any bylaw whether or not adopted by them.

[Remainder Intentionally Left Blank.]

ADOPTION OF BYLAWS BY SOLE INCORPORATOR

OF

American Advanced Management, Inc.

The undersigned, as sole incorporator of American Advanced Management, Inc., a Delaware corporation (the "Corporation"), hereby adopts the attached bylaws as the bylaws of the Corporation.

Executed as of February 10, 2018.

[redacted]

By: Cheyenne Moseley, Assistant Secretary
LegalZoom.com, Inc., Sole Incorporator

CERTIFICATE BY SECRETARY OF ADOPTION OF BYLAWS BY SOLE INCORPORATOR

OF

American Advanced Management, Inc.

The undersigned, Gurpreet Singh, as Secretary of American Advanced Management, Inc., a Delaware corporation (the "Corporation"), hereby certifies the attached document is a true and complete copy of the bylaws of the Corporation and that such bylaws were duly adopted by the person appointed in the Certificate of Incorporation to act as the sole incorporator of the Corporation on the date set forth below.

IN WITNESS WHEREOF, the undersigned has executed this certificate as of February 10, 2018.

_____

Gurpreet Singh
Secretary

ACTION BY UNANIMOUS WRITTEN CONSENT IN LIEU OF ORGANIZATIONAL MEETING BY THE BOARD OF DIRECTORS OF

American Advanced Management, Inc.,
a Delaware Corporation

The undersigned, constituting all of the members of the board of directors (the "Board") of American Advanced Management, Inc., a Delaware corporation (the Corporation), in lieu of holding a meeting of the Board, hereby consent to the taking of the actions set forth herein, and the approval and adoption of the following resolutions by this unanimous written consent ("Written Consent") pursuant to Section 141 of the Delaware General Corporation Law and the Bylaws of the Corporation:

Certificate of Incorporation

RESOLVED, that the Certificate of Incorporation of the Corporation filed with the Delaware Secretary of State hereby is adopted, ratified and affirmed in all respects.

RESOLVED FURTHER, that the Secretary of the Corporation is authorized and directed to insert a certified copy of the Certificate of Incorporation in the Corporation's minute book.

Stock Issuance

RESOLVED, that the officers of the Corporation are hereby authorized to issue and sell shares of common stock of the Corporation, $0.001 par value (the "Shares"), which the Board hereby determines to be the fair market value of the Corporation's common stock as of the date hereof, to each person named below (the "Stockholder"), in the amounts specified opposite each name in exchange for cash or contributed property as follows:

Name of Stockholder	Number of Shares	Total Purchase Price($)
Gurpreet Singh	1,000	$100.00

RESOLVED FURTHER, that the Board hereby determines that the consideration to be received for the above-mentioned Shares is adequate for the Corporation's purposes, and that the sale and issuance of the Shares to each of the above-named persons shall be conditioned upon receipt by the Corporation of the purchase price of said Shares and final copies of all appropriate documentation required by Corporation.

RESOLVED FURTHER, that upon the issuance and sale in accordance with the foregoing resolutions, such Shares shall be validly issued, fully paid and non-assessable shares of common stock of the Corporation.

RESOLVED FURTHER, that the officers of the Corporation are hereby authorized and directed, for and on behalf of the Corporation, (i) to take all actions necessary to comply with applicable laws with respect to the sale and issuance of the Shares, (ii) to thereafter execute and deliver on behalf of the Corporation, pursuant to the authorization above, share certificates representing the Shares set forth above, and (iii) to take any such other action as they may deem necessary or appropriate to carry out the issuance of the Shares and intent of these resolutions.

Election of Officers

RESOLVED, that the following individuals are hereby elected to serve in the offices of the Corporation set forth opposite their names until their successors are duly elected and qualified, or their earlier death, resignation or removal:

President: Gurpreet Singh
Treasurer: Gurpreet Singh
Secretary: Gurpreet Singh

Corporate Records and Minute Book

RESOLVED, that the officers of the Corporation are hereby authorized and directed to procure all corporate books, books of account and stock books that may be required by the laws of Delaware or of any foreign jurisdiction in which the Corporation may do business or which may be necessary or appropriate in connection with the business of the Corporation.

RESOLVED FURTHER, that the officers of the Corporation are authorized and directed to maintain a minute book containing the Certificate of Incorporation, as filed with and certified by the office of the Delaware Secretary of State and as may be amended from time to time, its Bylaws and any amendments thereto, and the minutes of any and all meetings and actions of the Board, Board committees and the Corporation's stockholders, together with such other documents, including this Written Consent, as the Corporation, the Board or the Corporation's stockholders shall from time to time direct and to ensure that an up to date copy is also kept at the principal executive office of the Corporation (as designated below).

Corporate Seal

RESOLVED, that the Corporation shall have a corporate seal in the form of two concentric circles with the name of the Corporation between the two circles and the year of incorporation and "Delaware" within the inner circle.

Stocks Certificates

RESOLVED, that the form of Stocks certificate attached hereto has been presented to the Board for review and is hereby approved and adopted as the form Stocks certificate of the Corporation and the Secretary of the Corporation is directed to insert such form Stocks certificate in the minute book of the Corporation.

Ratification of Actions by Incorporator

RESOLVED, that the Action by Written Consent of the Sole Incorporator dated February 10, 2018 and all actions taken by the Corporation's sole incorporator, LegalZoom.com, Inc. and its agents, in connection with the formation of the Corporation are hereby in all respects approved, ratified and affirmed for and on behalf of the Corporation.

Annual Accounting Period

RESOLVED, that until otherwise determined by the Board the fiscal year of the Corporation shall end on December 31.

Principal Executive Office

RESOLVED, that the principal executive office of the Corporation shall initially be located at 700 17th Street, Modesto, California 95354.

Bank Accounts

RESOLVED, that the officers of the Corporation are hereby authorized and directed to establish, maintain and close one or more accounts in the name of the Corporation for the funds of the Corporation with any federally insured bank or similar depository; to cause to be deposited, from time to time, in such accounts, such funds of the Corporation as such officer deems necessary or advisable, and to designate, change or revoke the designation, from time to time, of the officer or officers or agent or agents of the Corporation authorized to make such deposits and to sign or countersign checks, drafts or other orders for the payment of money issued in the name of the Corporation against any funds deposited in any of such accounts; and to make such rules and regulations with respect to such accounts as such officers may deem necessary or advisable, and to complete, execute and deliver any documents as banks and similar financial institutions customarily require to establish any such account and to exercise the authority granted by this resolution including, but not limited to, customary signature card forms and form banking resolutions.

RESOLVED FURTHER, that all form resolutions required by any such depository, if any, are adopted in such form used by such depository by this Board, and that the Secretary is authorized to certify such resolutions as having been adopted by the Board and directed to insert a copy of any such form resolutions in the minute book of the Corporation.

RESOLVED FURTHER, that any such depository to which a certified copy of these resolutions has been delivered by the Secretary of the Corporation is entitled to rely upon such resolutions for all purposes until it shall have received written notice of the revocation or amendment of these resolutions, as adopted by the Board.

Qualification to do Business

RESOLVED, that the officers of the Corporation are hereby authorized and directed for and on behalf of the Corporation to take such action as they may deem necessary or advisable to effect the qualification of the Corporation to do business as a foreign corporation in each state that the officers may determine to be necessary or appropriate, or to withdraw from or terminate the Corporation's qualification to do business in any such state.

RESOLVED FURTHER, that any resolutions which in connection with the foregoing shall be certified by the Secretary of the Corporation as having been adopted by the Board pursuant to this Written Consent shall be deemed adopted pursuant to this Written Consent with the same force and effect as if presented to the Board and adopted thereby on the date of this Written Consent, and shall be included in the minute book of the Corporation.

Payment of Expenses

RESOLVED, that the officers of the Corporation are hereby authorized and directed to pay all expenses of the incorporation and organization of the Corporation, including reimbursing any person for such person's verifiable expenses therefor.

Agent for Service of Process in Delaware

RESOLVED, that United States Corporation Agents, Inc. shall be appointed the Corporation's agent for service of process in Delaware.

Subchapter S Election

RESOLVED, that the Corporation shall elect to be treated as a "small business corporation" for income tax purposes under Subchapter S of Chapter 1 of the Internal Revenue Code of 1986,and under the parallel provisions of the laws of the state of Delaware and that the officers of the Corporation are hereby authorized and directed to complete and file or cause to be filed an Election by a Small Business Corporation with the Internal Revenue Service pursuant to Section 1362(a) of the Internal Revenue Code and obtain the written consent of each stockholder of the Corporation to such Subchapter S election and file such consent at the same time as the Election by a Small Business Corporation, or within an extended period of time as may be granted by the Internal Revenue Service.

Authorization of Further Actions

RESOLVED, that the officers of the Corporation are, and each of them hereby is, authorized, empowered and directed, for and on behalf of the Corporation, to execute all documents and to take all further actions they may deem necessary, appropriate or advisable to effect the purposes of each of the foregoing resolutions.

RESOLVED, that any and all actions taken by any officer of the Corporation in connection with the matters contemplated by the foregoing resolutions are hereby approved, ratified and confirmed in all respects as fully as if such actions had been presented to the Board for approval prior to such actions being taken.

IN WITNESS WHEREOF, each of the undersigned, being all the directors of the Corporation, has executed this Written Consent as of the date set forth below.

Date: February 10, 2018

Directors:

_____

Gurpreet Singh

EXHIBIT B
FORM OF STOCK CERTIFICATE

Title 11, California Code of Regulations § 999.5(d)(4)(A)

The Applicant's Articles of Incorporation and all amendments thereto and current bylaws, any charitable trust restrictions, and any other information necessary to define the charitable trust purpose of the applicant's assets

EXHIBIT 6

State of Delaware
Secretary of State
Division of Corporations
Delivered 11:00 AM 02/07/2018
FILED 11:00 AM 02/07/2018
SR 20180795751 - File Number 6747830

CERTIFICATE OF INCORPORATION

OF

American Advanced Management, Inc.

FIRST. The name of the corporation is American Advanced Management, Inc.

SECOND. The corporation's registered office in the State of Delaware is located at 300 Delaware Avenue, Suite 210-A, Wilmington, DE 19801 in New Castle County. The name of its registered agent at such address is United States Corporation Agents, Inc.

THIRD. The purpose of the corporation is to engage in any lawful act or activity for which a corporation may be organized under the General Corporation Law of Delaware.

FOURTH. The corporation is authorized to issue one class of stock to be designated "Common Stock." The total number of shares which the corporation shall have the authority to issue is 1,000,000 shares of Common Stock, and the par value of each of such shares is $0.001.

FIFTH. The incorporator of the corporation is LegalZoom.com, Inc., and its mailing address is 101 N. Brand Blvd., 11th Floor, Glendale, CA 91203.

SIXTH. In furtherance and not in limitation of the powers conferred by statute, the Board of Directors of the corporation is expressly authorized to adopt, amend or repeal bylaws of the corporation.

SEVENTH. Elections of directors need not be by written ballot except and to the extent provided in the bylaws of the corporation.

EIGHTH. The personal liability of the directors of the corporation for monetary damages for breach of fiduciary duty as a director shall be eliminated to the fullest extent permitted by the General Corporation Law of Delaware. The corporation is authorized to indemnify, and advance expenses, to its officers, employees, other agents of the corporation and any other person to which the General Corporation Law of Delaware permits the corporation to provide indemnification to the fullest extent permitted by applicable law.

Any repeal or modification of this Section Eighth, by amendment of such section or by operation of law, shall not adversely affect any right or protection of a director, officer, employee or other agent of the corporation existing at the time of, or increase the liability of any such person with respect to any acts or omissions in their capacity as a director, officer, employee, or other agent of the corporation occurring prior to, such repeal or modification.

I, the undersigned, as the sole incorporator of the corporation, hereby declare and certify that this certificate of incorporation is my act and deed and that the facts stated in this Certificate of Incorporation are true.

Date: February 2, 2018

/s/ Cheyenne Moseley
LegalZoom.com, Inc., Incorporator
By: Cheyenne Moseley, Assistant Secretary

Title 11, California Code of Regulations § 999.5(d)(4)(B)

The Applicant's plan for use of the net proceeds after the close of the proposed transaction together with a statement explaining how the proposed plan is as consistent s possible with existing charitable purposes and complies with all applicable charitable trusts that govern use of applicant's assets. The plan must include any proposed amendments to the articles of incorporation or bylaws of the applicant or any entity related to the applicant that will control any of the proceeds from the proposed transfer

Orchard Hospital's plan for use of the net proceeds, if any, after close of the proposed transaction is to continue to fund projects that benefit the needs of the community that Orchard Hospital serves. One main project focuses on youth mental health needs as Orchard Hospital has acquired a BHCIP grant to build a 16-bed Youth Psychiatric Health Facility.

Title 11, California Code of Regulations § 999.5(d)(5)

Impacts on Health Care Services

Title 11, California Code of Regulations § 999.5(d)(5)(A)

Impacts on Health Care Services

EXHIBIT 1

Orchard Hospital's 2022 Community Health Needs Assessment

Orchard HOSPITAL

Community Health Needs Assessment 2022

Mission, Vision & Values

Our Mission

Our Mission is to Improve the Health and Well-being of our Community. Achieving this requires clear priorities, supportive leadership, and staff and community collaboration, which will be engrained in our HERO Values.

Our Vision

At Orchard Hospital, our Vision to ***Provide Quality Health Care Close to Home***, is consistent with the direction of the Orchard Hospital Board of Directors with three main goals in mind:

- Provide High-quality healthcare in the services we provide
- Promote healthy lifestyles with focus on obesity prevention and management, starting with our youth
- Implement key strategies important to our communities that allow us to achieve sustainable operating margins

Our Values

At Orchard Hospital, our governance and decision-making will always be based upon integrity, respect, innovative processes, ethical foundations, and continual self-improvement.

H - Honesty and Integrity

We will make decisions with honesty and integrity that will ensure Orchard Hospital's future.

E - Engaged and Empowered Staff

We will hire staff that are engaged and empowered to make a positive difference in the lives of our patients and each other.

R - Responsive

We will respond to the needs of our community by implementing programs that align with our Community Health Needs Assessment (CHNA).

O - Outcomes-Driven

We will be recognized for having excellent outcomes for the services we provide at Orchard Hospital.

Introduction

Orchard Hospital located in Gridley, California is a 501(c)(3) Critical Access

Hospital offering 24-hour emergency services, inpatient, outpatient, and rural health clinic services. Orchard Hospital is dedicated to always providing the finest personalized healthcare to North Valley communities by offering a wide range of integrated services, from prevention through treatment to wellness.

Orchard Hospital is the only acute care hospital in Gridley, as well as along the Highway 99 corridor between Sacramento and Chico, providing much-needed emergency care for travelers.

Orchard Hospital is certified for 24 general acute care beds (4 Monitored Beds and 20 Unspecified General Acute Care) and offers the following medical services.

Orchard Hospital Services
Cardiology
Social Services
Emergency Services
Inpatient/ Outpatient Surgery
Imaging Services
Respiratory Care
Cardiopulmonary
Laboratory
Physical Therapy
Senior Life Solutions
Clinic Services

Rural Health Clinic Services
Laboratory
Digital Radiology
DEXA Scanning
Digital Mammography
Ultrasound (General & Cardiac)
Physicals
Workers Comp
Industrial Medicine
Drug Screening
Psychotherapy
Physical Therapy
Internal Medicine

Purpose and Overview of the Community Health Needs Assessment

Under the Affordable Care Act, hospitals throughout the country are required to conduct a Community Health Needs Assessment (CHNA) every three years.

The primary purpose of conducting a CHNA is to objectively look at the current health needs of a community, as well as the existing resources available to address those needs, then prioritize the unmet health needs and create an action plan to address them in the coming years.

Using the community feedback and health data gathered, the resulting response and action plan will help shape programs over the next three years

Report Adoption, Availability and Comments

This CHNA report was adopted by the Orchard Hospital Board of Trustees on December 27, 2022.

This report is widely available to the public on the hospital's website, www.orchardhospital.com. Written comments on this report can be submitted to jbunn@orchardhospital.com

2019 CHNA Response

In 2019, Orchard Hospital partnered with Butte County Public Health and the three other hospitals in our county to conduct a Community Health Needs Assessment. The outcome was an action plan that committed the focus of our community outreach efforts on three main areas affecting the health of our community:

- Access to Care
- Mental health and Substance Use Disorders

- Chronic Disease and Conditions
- Adverse Childhood Experiences and Childhood Maltreatment

Orchard Hospital committed to identifying opportunities to collaborate with community partners throughout the region to break down barriers associated with these pressing health and social needs, as well as providing the education and other tools members of our community need to be proactive in their health and lifestyle choices.

Action Plan and Results from 2019 Community Health Needs Assessment:

Access to Care – Response to Need

Community Health Events

Orchard Hospital participated in community health events throughout the surrounding areas to ensure high-risk and underserved individuals had access to health care and health education:

- Town Hall Meeting at Gridley High School – The Town Hall meeting was in collaboration with Si Se Puede and the Nicotine Action Alliance coalition, Gridley High School, Butte County Public Health and Northern Valley Catholic Social Service. This event provided education on flavored tobacco, cessation resources, health screening resources for tobacco-related health issues, student-run town hall presentation.
- Sports Registration Night at Gridley High School – Orchard Hospital partnered with Gridley High School to provide free athletic physicals to high school students.
- Orchard Hospital Teddy Bear Clinic – The annual Teddy Bear clinic partners Orchard Hospital with Cal-Fire, Butte County Sheriff's Department, Gridley Police Department, and California Highway Patrol to educate and familiarize local children about emergency situations. The Teddy Bear clinic allows children to bring an "injured" stuffed animal to receive treatment from medical staff by starting at triage, radiology, X-ray and some cases visiting the surgical area designed just for the miniature teddy bear patient.

- Community Health Fair – Orchard Hospital partnered with the Gridley Lions Club to hold an annual Community Health Fair. This free event is offered to all ages and provides an opportunity to learn about many healthy lifestyle resources. A-1C testing for diabetes, blood glucose, blood pressure, free flu-vaccines, and free eye exams.
- Annual Flu & Covid Clinics – Orchard Hospital provides multiple Flu and Covid vaccine clinics annually throughout the community. Several clinics were in collaboration with Butte County Public Health and the local schools.
- Covid-19 Testing Clinics – Orchard Hospital provided ongoing Covid-19 testing for the community.

Mental Health and Substance Use – Response to Need

Orchard Hospital offered easy access at the hospital and clinic for safe disposal of medications and syringes.

Orchard Hospital implemented a program called Senior Life Solutions which provides assistance to individuals suffering from one or more of the following: crying, hopelessness, loneliness, restlessness, sadness, coping with loss, decreased energy, difficulty sleeping, low self-confidence and life transitions. We will continue to grow this program and offer another track.

Orchard Hospital will continue collaborating, partnering with and supporting other programs and organizations to extend our reach and impact in high needs areas, including, but not limited to:

- Butte County Behavioral Health
- Butte County Drug Abuse Prevention Task Force
- Butte County Tobacco Prevention Coalition
    - Smoking Cessation
- Orchard Hospital Senior Life Solutions
- Offering counseling for Mental Health

Chronic Disease and Conditions - Response to Need

Orchard Hospital recruited and retained a physician specializing in internal medicine and recruited and retained a Chiropractor. Orchard Hospital participated in the local annual Farmer's Market to promote healthy diet and educate the community on chronic conditions. Orchard Hospital implemented a patient portal that offers health records on Apple products like an iPhone, iPad, Apple Watch and iPod touch. With the health app, health records are available and easily assessable to patients.

Adverse Childhood Experiences and Child Maltreatment - Response to Need

Add the sports physical night in here to add mental health screening and at clinic. Personal Safety screening

Prioritization Process

Significant health needs were identified from secondary data using the size of the problem (relative portion of population afflicted by the problem) and the seriousness of the problem (impact at individual, family, and community levels). To determine size or seriousness of the problem, the health need indicators that were identified in the secondary data were measured against benchmark data; specifically, county rates, state rates and/or Healthy People objectives. Indicators related to the health needs that performed poorly against one or more of these benchmarks met this criterion to be considered a health need.

The list of significant health needs informed primary data collection. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets to address needs, and discover gaps in resources. Community focus groups and stakeholder interviews were used to gather input and prioritize the significant health needs.

Top priorities identified in partnership with our communities:

Significant needs were identified through a review of the secondary health data and validation through community stakeholder surveys. The significant needs identified are as follows:

- Access to Care
- Mental Health Issues
- Substance Use Disorders
- Chronic Diseases (Diabetes, Aging problems, Heart disease, Lung Disease, Stroke)
- Low crime/safe neighborhoods
- Adverse Childhood Experiences and Childhood Maltreatment
- Overweight & obesity

From 2023-2025, Orchard Hospital will address the following health needs through a commitment of community programs and resources.

Orchard Hospital's CHNA Oversight team:

Julie A. Bunn, Foundation, Grants and Community Outreach Coordinator

Stephanie Orozco, Marketing and Social Media Coordinator

Kami Duntsch, Chief Human Resource Officer

Kirsten Storne-Piazza, Chief Clinic Administrator

Service Area

Orchard Hospital is located at 240 Spruce St., Gridley, CA 95948. The service area includes five communities consisting of 5 ZIP Codes in Butte County.

Orchard Hospital Service Area	
Zip Code	**City**
95948	Gridley
95917	Biggs
95974	Richvale
95965	Oroville
95966	Oroville
95953	Live Oak

Community Profile

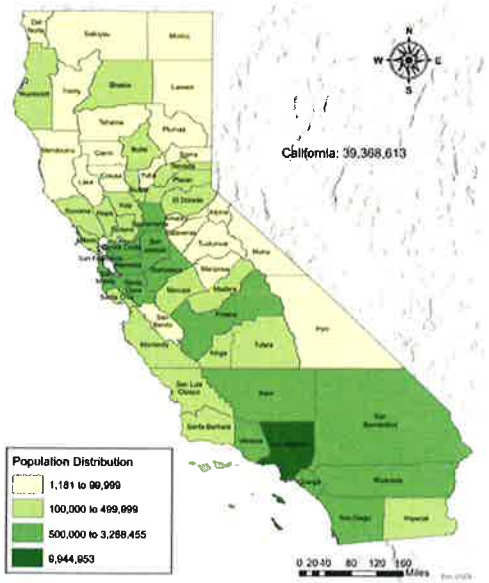

Figure 1: Population distribution

Source: State of California, Department of Finance, E-2, California County Population Estimates and Components of Change by Year, July 1, 2021.

Butte County is in the Northern portion of the Sacramento Valley Region of North Central California and encompasses approximately 1,677 square miles, of which 1,636.5 square miles are land and 41 square miles are water. According to the 2021 California Department of Finance County Population State and County Population Estimates, California's population is 39,368,613, and Butte County is ranked the 28th largest county with a population of 201,158 (see Figure 1).

Primary Data Collection

Orchard Hospital conducted a survey in order obtain an estimate of the prevalence of behaviors and conditions in Butte County.

The full report and summary table of risk factors data from the 2022 Survey can be found in the Appendix.

Secondary Data Collection

Orchard Hospital staff spoke with representatives from Public Health, law enforcement agencies, neighboring hospitals, and clinic systems in order to gather insight and feedback for the Community Health Needs Assessment.

Participants were asked to share their professional and personal thoughts and experiences regarding access to health care, obstacles and barriers to quality health care and ability to live healthy lives.

The results of this feedback are included in the Executive Summary and assisted in the development of the Action Plan.

2022 Executive Summary

The results of were reviewed for their degree of commonality. Secondary health metric data was made to align with health survey and qualitative focus group data, such that those health factors with the greatest alignment became evident. The health factors most substantially implicated that emerged through this process are:

- Access to Care
- Mental Health Issues
- Substance Use Disorders
- Chronic Diseases (Diabetes, Aging problems, Heart disease, Lung Disease, Stroke)

Access to Care: Access to health services is a leading health indicator (LHI) for the Healthy People 2020 (HP-2020) national health objectives. A person's ability to access health services profoundly affects their health and well-being. Having a usual Primary Care Provider (PCP) is associated with: greater patient trust in the provider; better patient-provider communication; increased likelihood that patients will receive appropriate care; and lower mortality from all causes[i]. Access to mental health and oral health care are also both important, as both mental health conditions and oral health correlate strongly with physical health and well-being.

Access to Care | Primary Care Shortage: The Health Resources & Services Administration (HRSA) has determined that there are Primary Care Shortage Areas, Dental Care Shortage Areas, and Mental Health Shortage Areas in Butte County. While only parts of the county meet Primary Care Shortage and Dental Care Shortage Area criteria, the entire county meets Mental Health Shortage Area criteria. Population to provider ratios also demonstrate that Butte County has fewer Primary Care Physicians and Dental Care Providers per capita than the state overall; however, Butte County does have more Non-Physician Primary Care Providers (e.g. Physician's Assistants, Nurse Practitioners) and Mental Health Care providers per population than the state overall.

Table – Access 1: Population to Provider Ratios: Butte County and California, 2017 & 2021.

	Butte County		California	
	2017	2021	2017	2021
Primary Care Physician	1,570:1	1,650:1	1,280:1	1,250:1
Dental Care	1,440:1	1,340:1	1,250:1	1,150:1
Mental Health Care	190:1	140:1	350:1	270:1
Uninsured	13%	8%	14%	8%
Mammography Screening	60%	40%	60%	36%

Source: 2017 and 2021 Area Health Resource Data File via County Health Rankings. Retrieved From: http://www.countyhealthrankings.org/california/buttecounty

Access to Care | Preventative Practices: Preventive health practices are those that prevent illnesses or diseases, such as screenings and immunizations, or patient counseling to prevent illness[i]. Examples include standard immunizations; and screenings for blood pressure, cancer, cholesterol, depression, obesity, and Type 2 diabetes[ii]. In recent years, several vaccine-preventable diseases once on the verge of eradication, such as measles, have reemerged in the United States, with outbreaks

occurring throughout California, including Butte County. Likewise, sexually transmitted infections (STIs) once thought to be declining or close to eradication, such as syphilis, have shown increasing rates nationally. Many STIs are treatable, but if undetected, may continue to be transmitted; and many more are preventable through education and patient counseling.

The percentage of students having all required immunizations for enrollment into Butte County schools is slightly below the percentage of students statewide (93% vs. 96%), with more conditional entrants – students with some but not all required immunizations – attending Butte County schools than California schools overall (3.1% vs. 1.7%). According to the BRFS, 47.8% of Butte County respondents over the age of 65 have not had a flu shot in the past 12 months; and 29% had not received the pneumococcal vaccine, which was also greater than the percentage statewide (23.2%). Likewise, 73.2% of Butte County respondents age 50 or older have not been vaccinated against shingles, which was slightly greater than the percentage of respondent's state and nationwide (68.9% and 71.4%, respectively).

Rates of STIs (chlamydia, gonorrhea, and syphilis) were lower in Butte County than the state, except for syphilis. According to the California Department of Public Health, STD Control Branch 2018 Surveillance Report, in Butte County, rates of primary and secondary syphilis increased by 35.6 cases per 100,000 persons. Chlamydia was 579.4 cases per 100,000 persons and gonorrhea was 186.1 cases per 100,000 persons.

Pertaining to preventative practices for adult smoking, adult obesity, physical inactivity, excessive alcohol drinking, alcohol-impaired deaths, and teen births were all up in Butte County from 2017 to 2021 except teen births and alcohol-impaired driving deaths.

Table – Access 2: Population to Provider Ratios: Butte County and California, 2017 & 2021.

	Butte County		California	
	2017	2021	2017	2021
Adult Smoking	15%	17%	12%	11%

Adult Obesity	26%	23%	30%	24%
Physical Inactivity	19%	17%	23%	18%
Excessive Alcohol Drinking	21%	18%	22%	18%
Alcahol-Impaired Deaths	35%	29%	32%	29%
Teen Births	24	29	16	17

Mental Health and Substance Use Disorders: Like access to care, mental health is a LHI for the HP-2020 objectives. Mental health and physical health are inextricably linked. Evidence has shown that mental health disorders—most often depression—are strongly associated with the risk, occurrence, management, progression, and outcome of serious chronic diseases and health conditions, including diabetes, hypertension, stroke, heart disease, and cancer[i]. Suicide is the tenth leading cause of death in the nation, and the national suicide rate increased by 19.5% between 2007 and 2016.

Mental Health and Substance Use Disorders | Suicide and Depressive Disorders: Suicide rates also tend to be higher in rural areas than in urban settings. Of significant concern, the suicide rate per capita in Butte County is elevated to nearly twice that of California overall (18.1 vs. 10.4 per 100,000 population); and likewise elevated above the HP-2020 objective (10.2). This is especially alarming when viewed in the context of Butte County's co-occurring elevated metrics for drug induced deaths and excessive alcohol use; as nationally drug induced and alcohol related deaths in combination with suicide, collectively referred to as deaths of despair, have resulted in decreasing life expectancy in the United States since 2015. Rates of depressive disorders, a strong risk factor for suicide, also appear to be elevated in Butte County. Twenty-seven percent of BRFS respondents in Butte County indicated having been diagnosed with a depressive disorder, compared to 17% statewide, and 20% nationwide. Focus groups also overwhelmingly felt mental health was a top community health priority in Butte County, with 69% of total focus group participants ranking mental health as a very important community health priority area. The finding that all of Butte County meets HRSA Mental

Health Professional Shortage Area criteria highlights a disparity between the populations need for mental health services and the current capacity of the county's healthcare delivery system to meet this demand.

Mental Health and Substance Use Disorders | Opioid Use and Excessive Drinking:
Substance use disorders are defined as both mental health disorders and chronic diseases. The American Society of Addiction Medicine defines addiction as "a primary, chronic disease of brain reward, motivation, memory and related circuitry". The development of substance use disorders are often preceded by substance misuse, such as taking an opioid medication other than how it was prescribed before meeting criteria for opioid use disorder, or escalating episodes of excessive alcohol consumption before meeting criteria for alcohol use disorder. Across focus groups, 50% of the 88 total participants indicated substance misuse and substance use disorders to be a top community health concern.

The ongoing opioid epidemic continues to be the leading driver of drug-induced deaths nationally. In Butte County, the age-adjusted drug-induced death rate continues to be significantly elevated compared to the statewide rate (30.2 vs. 12.2), with Butte County holding the 5th highest rate out of California's 58 counties. In 2017, mortality attributed exclusively to opioids (e.g. no other class of substances detected) in Butte County was 7.6 per 100,000 population compared with a statewide rate of 5.23; and the rate of hospitalizations for opioid overdose were the highest of all California counties, with 40.3 hospitalizations due to opioids other than heroin per 100,000 population compared to 7.75 statewide; and a rate of 9.95 hospitalizations due to heroin compared to 1.78 statewide. Also, of significant concern is that according to the California Healthy Kids Survey (CHKS), 21% percent of Butte County 11th grade students have used prescription drugs recreationally, compared with 16% of 11th grade students statewide.

Excessive alcohol consumption—which includes binge drinking (4 or more drinks for women and 5 or more drinks for men within about 2 hours); heavy drinking (8 or more drinks a week for women and 15 or more drinks a week for men); and any drinking by pregnant women or those under 21 years of age, is responsible for 88,000 deaths in the United States each year. These include 1 in 10 deaths among working age adults (age

20-64 years), and in 2010, the estimated economic cost to the United States of excessive drinking was $249 billion. Binge drinking accounts for over half of the deaths and three-fourths of the economic costs due to excessive drinking. The most recently available data from the CDPH Safe and Active Communities Branch demonstrates that in Butte County, rates of emergency department treatment, non-fatal hospital admissions, and deaths due to alcohol were all considerably higher than statewide rates (1011.1 vs. 763.8 per 100,000; 306.6 vs. 143.4; and 16.2 vs. 11.9, respectively). Likewise, 42.5% of adult CHIS respondents in Butte County reported binge drinking, relative to 34.7% statewide. This discrepancy was further supported by the results of the BRFS, with 22.1% of Butte County respondents reporting binge drinking compared with 17.6% of respondents statewide. A similarly concerning trend among adolescents was demonstrated by the CHKS, with 20% percent of Butte County 11th grade students reporting binge drinking, compared with 11% of 11th grade students statewide.

Chronic Disease and Conditions: Chronic diseases and conditions such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States, accounting for 7 out of 10 deaths annually. They are also leading drivers of the nation's $3.3 trillion in annual health care costs, with 90% of healthcare dollars spent in the United States attributed to the treatment of people with chronic physical and mental health conditions[ii]. In Butte County, like the nation and the state, many of the leading causes of death are chronic conditions including heart disease and stroke, cancers, Alzheimer's disease, chronic lower respiratory disease. chronic liver disease, and diabetes. While the mortality rate was only higher for Butte County than the statewide and national rates for some chronic diseases and conditions (cancer, Alzheimer's disease, chronic lower respiratory disease, and chronic liver disease), (See Table X1); all chronic conditions result in substantial portions of health care spending in Butte County. A 2015 study estimated that over 51% of the $1.4 Billion total annual healthcare expenditures in Butte County could be attributed to six chronic conditions (arthritis, asthma, cardiovascular disease, diabetes, cancer, and depression), while 42.% of total statewide healthcare expenditures could be attributed to these conditions (see Table X2). Forty-eight percent of total focus group participants in Butte County indicated chronic disease and conditions to be a significant community health concern, and 45.5% indicated

overweight/obesity, a predictive factor for many chronic diseases, to likewise be a top health concern. While most chronic conditions are of significant concern in Butte County, some emerged with greater emphasis including cancer, Alzheimer's disease, asthma, chronic lower respiratory disease, and chronic liver disease.

Chronic Disease and Conditions | Cancer: The age-adjusted death rate for cancer was significantly higher in Butte County than the statewide rate, with 162.2 and 140.2 deaths per 100,000 population, respectively. The five-year incidence rate for cancer from 2011 – 2015 was also elevated relative to the state rate at 452.4 and 395.2 cases per 100,000 population, respectively. These trends generally held for most forms of cancer, including lung, female breast, and colorectal cancers. The BRFS also indicated higher rates of cancer, with 8.4% of Butte County respondents reporting having ever been diagnosed with cancer (other than skin cancer), compared with 5.9% of survey respondents statewide.

Chronic Disease and Conditions | Alzheimer's Disease: The age-adjusted death rate for Alzheimer's disease was also significantly higher in Butte County than the statewide rate, with 51.1 and 34.2 deaths per 100,000 population, respectively.

Chronic Disease and Conditions | Asthma: In Butte County 9.7% of Medicare beneficiaries have been diagnosed with asthma, which is higher than the percentage of Medicare beneficiaries diagnosed statewide (7.5%). Results of the CHIS also demonstrate that slightly more adults in Butte County have been diagnosed with asthma than adults statewide (15.0% vs. 14.5%); while 18.3% of Butte County BRFS respondents indicated having ever been diagnosed with asthma, relative to 14.1% of statewide respondents; and 11.8% of Butte County respondents reported currently having asthma relative to 7.9% of statewide respondents.

Chronic Disease and Conditions | Chronic Lower Respiratory Disease: The age-adjusted death rate for chronic lower respiratory disease was significantly higher in Butte County than the statewide rate, with 45.8 and 32.1 deaths per 100,000 population, respectively. The BRFS also indicated higher rates of chronic obstructive pulmonary disease (COPD) – a type of chronic lower respiratory disease, with 7.1% of Butte County

respondents reporting having ever been diagnosed with COPD, compared with 4.5% of survey respondents statewide.

Chronic Disease and Conditions | Chronic Liver Disease: The age-adjusted death rate for chronic liver disease was significantly higher in Butte County than the statewide rate, with 18.4 and 12.2 deaths per 100,000 population, respectively.

Table X-2: Mortality Rates for Chronic Diseases and Conditions

Age-adjusted death per 100,000	Butte County	California	HP-2020	Rank out of 58 CA
All Causes	765.3	608.5	a	46
All Cancers	162.2	140.2	161.4	49
- Lung Cancer	37.7	28.9	45.5	49
- Female Breast Cancer	21.2	19.1	20.7	46
- Prostate Cancer	19.4	19.6	21.8	24
- Colorectal Cancer	15.7	12.8	14.5	54
Coronary Heart Disease	85.8	89.1	103.4	28
Alzheimer's Disease	51.1	34.2	a	55
Chronic Lower Respiratory Disease	45.8	32.1	a	42
Cerebrovascular Disease (Stroke)	39.3	35.3	34.8	39
Diabetes	18.9	20.7	b	26
Chronic Liver Disease & Cirrhosis	18.4	12.2	8.2	45

Adapted from: California Health Status Profiles, 2018. Available at: https://www.cdph.ca.gov/Programs/CHSI/Pages/County-Health-Status-Profi.aspx#pasteds

Table X-3: Healthcare costs with six chronic conditions

Healthcare costs	Total healthcare	Total cost of six chronic	Percent of total

	costs		conditions		healthcare costs due to six conditions	
Butte County	$1,372,360,000		$625,045,759		50.8%	
California	$232,390,177,528		$98,443,138,663		42.4%	
Percent of total healthcare costs	**Arthritis**	**Asthma**	**Cardiovascular disease**	**Diabetes**	**Cancer**	**Depression**
Butte County	7.78%	4.55%	19.99%	5.27%	7.95%	5.26%
California	6.16%	4.06%	16.13%	5.59%	6.01%	4.41%

Adapted from: Brown, P.M., et al. (2015). Economic Burden of Chronic Disease in California 2015. CA Department of Public Health. Sacramento, California:. http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1600

Chronic Disease and Conditions | Other Notable Chronic Condition: Butte County had a slightly higher age adjusted death rate than the statewide rate for stroke (39.3 vs. 35.3 per 100,000 population). Likewise, a slightly higher percentage of Butte County BRFS respondents (3.3%) reported having ever had a stroke than statewide respondents (2.2%). Approximately one-third (32.2%) of Butte County respondents also reported having high blood pressure, which was slightly higher than for statewide respondents (28.4%). A 2016 UCLA Center for Health Policy Research study estimated the percent of adults in Butte County that are pre-diabetic (43%) was slightly lower than the statewide estimate (46%), and a lower percentage Butte County CHIS respondent reported being diagnosed with diabetes than statewide respondents (7.4% vs. 9.3%). This discrepancy was also found in BRFS results (7.0% vs. 10.5%); however, a slightly higher percentage of CHIS respondents age 65 and over from Butte County were diagnosed with diabetes than the percent of respondents statewide (23.5% vs. 21.4%). Major risk factors for the development of chronic conditions and premature death include being overweight/obese and smoking tobacco products. While the percent of adult CHIS respondents that reported being overweight or obese was marginally lower in Butte County than statewide (60.3% vs. 61.5%), the percent of Butte County BRFS respondents that indicated having no physical activity in the past 30 days was higher than the percent of statewide respondents (28.5% vs. 20.0%); and significantly more Butte County respondents indicated being current smokers than statewide respondents (20.6%

vs.11.3%).

Conclusion and Action Plan

Once the health needs were prioritized by the Orchard Hospital Administration team and Board of trustees, the final step in the CHNA process was to develop an implementation strategy. The purpose of the implementation strategy is to develop a clear set of goals to respond to the priorities identified. This strategy will include a written plan that addresses each of the community health needs identified through the CHNA, describe how the hospital plans to meet the health needs, and identify health needs the hospital does not intend to meet and why.

The following implementation strategy components within each priority were addressed:

1. Objectives/Strategy
2. How
3. Programs/Resources to Commit
4. Impact of Programs/Resources on Health Need
5. Accountable Parties
6. Partnerships/Collaboration

The detailed implementation strategy for each priority can be found in Appendix 6. In summary, the following priorities were addressed through the implementation strategy:

- Access to Care
- Mental Health and Substance Use Disorders
- Chronic Disease and Conditions

The implementation strategy detail for each priority is located in Appendix ___ and provides supporting tactics, programs/resources, accountable parties, and potential partnerships/collaboration.

Supporting Documents

Community Engagement
Community Health Needs Assessment
Survey

Community Engagement- Survey

Orchard HOSPITAL

Please take a moment to complete the survey below. The purpose of this survey is to seek your input regarding community health problems in south Butte County. Orchard Hospital will use the results of this survey to identify and take action of community needs.

1. Where do you go for routine healthcare?
   - _____ Primary care physician
   - _____ Urgent Care
   - _____ ER
   - _____ Other
   - _____ None

2. Are there issues that prevent you from accessing healthcare?
   - _____ Language barriers
   - _____ Don't know how to find doctors
   - _____ No insurance
   - _____ Other barriers
   - _____ No barriers

3. In the following list, what do you think are the three most important factors for a "Healthy Community?"
   Check only three:
   - _____ Good place to raise children
   - _____ Low crime / safe neighborhoods
   - _____ Low level of child abuse
   - _____ Good schools
   - _____ Access to health care (e.g., family doctor)
   - _____ Parks and recreation
   - _____ Arts and cultural events
   - _____ Good jobs and healthy economy
   - _____ Strong family life
   - _____ Healthy behaviors and lifestyles
   - _____ Low death and disease rates
   - _____ Religious or spiritual values
   - _____ Other_____

4. In the following list, what do you think are the three most important "health problems" in our community? (Those problems which have the greatest impact on overall community health.)
   Check only three:
   - _____ Aging problems
   - _____ Cancer
   - _____ Child abuse / neglect
   - _____ Dental problems
   - _____ Diabetes
   - _____ Domestic Violence
   - _____ Firearm related injuries
   - _____ Motor vehicle crash injuries
   - _____ Respiratory / lung disease
   - _____ Suicide
   - _____ Heart disease and stroke
   - _____ High blood pressure
   - _____ HIV / AIDS
   - _____ Homicide
   - _____ Death
   - _____ Infectious Diseases (e.g., Hepatitis, TB, etc.)
   - _____ Mental health issues
   - _____ Rape / sexual assault
   - _____ Other _____

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5. In the following list, what do you think are the three most important "risky behaviors" in our community? (Those behaviors which have the greatest impact on overall community health.)
Check only three:

_____ Alcohol abuse
_____ Being overweight
_____ Dropping out of school
_____ Drug abuse
_____ Lack of exercise
_____ Poor eating habits
_____ Not getting "shots" to prevent disease
_____ Tobacco use
_____ Not using birth control
_____ Not using seat belts / child safety seats
_____ Unsafe sex
_____ Other_____

6. How would you rate our community as a "Healthy Community?"
___ Very unhealthy ___ Unhealthy ___ Somewhat healthy ___ Healthy ___ Very healthy

7. How would you rate your own personal health?
___ Very unhealthy ___ Unhealthy ___ Somewhat healthy ___ Healthy ___ Very healthy

8. Approximately how many hours per month do you volunteer your time to community service?
___ None ___ 1 - 5 hours ___ 6 - 10 hours ___ Over 10 hours

9. Zip code where you live: _____

10. Age:
_____ 25 or younger
_____ 26-39
_____ 40-54
_____ 55-64
_____ 65 or over

11. Sex: Male___ Female___ Non Binary___ Other:_____

12. Ethnic group you most identify with:
_____ African American / Black
_____ Asian / Pacific Islander
_____ Hispanic / Latino
_____ Native American
_____ White / Caucasian
_____ Other _____

13. Marital Status:
_____ Married / co-habitating
_____ Not married / Single

14. Education:
_____ Some high school
_____ High school diploma or GED
_____ College degree or higher
_____ Other_____

15. Household income
_____ Less than $25,000
_____ $25,000 to $49,999
_____ $50,000 to $74,999
_____ Over $75,000

16. How do you pay for your health care? **(check all that apply)**
_____ Pay cash (no insurance)
_____ Private Health insurance
_____ Medi-cal
_____ Other _____
_____ Medicare
_____ Veterans Administration
_____ Indian Health Services

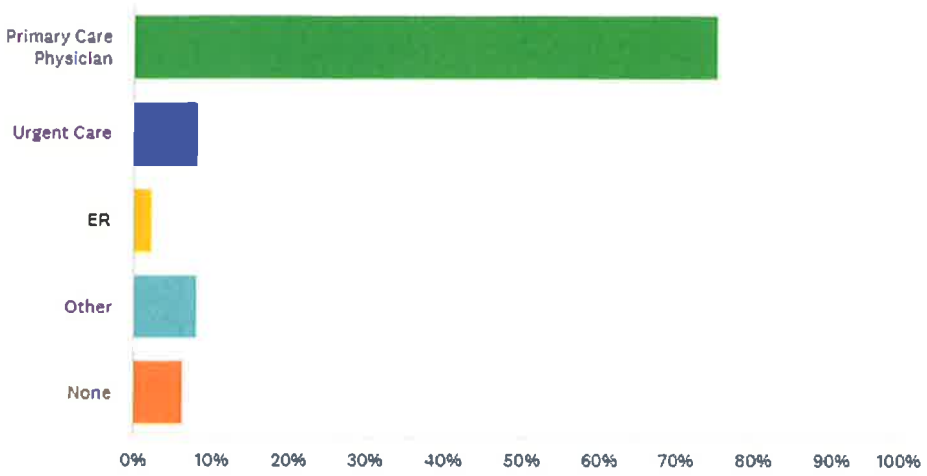
17. Where / how you got this survey: **(check one)**
_____ Church
_____ Community Meeting
_____ Grocery Store / Shopping Mall
_____ Mail
_____ Other _____
_____ Newspaper
_____ Newsletter
_____ Personal Contact
_____ Workplace

Supporting Documents

Community Health Needs Assessment
Survey Answers

Where do you go for routine healthcare?

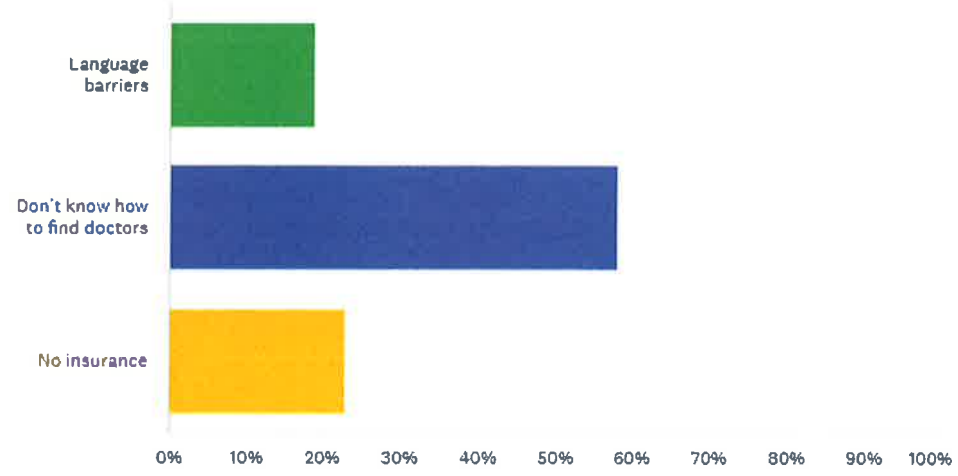
Answered: 288 Skipped: 2



Orchard Hospital Survey - Community Health Needs (0)

Are there issues that prevent you from accessing healthcare?

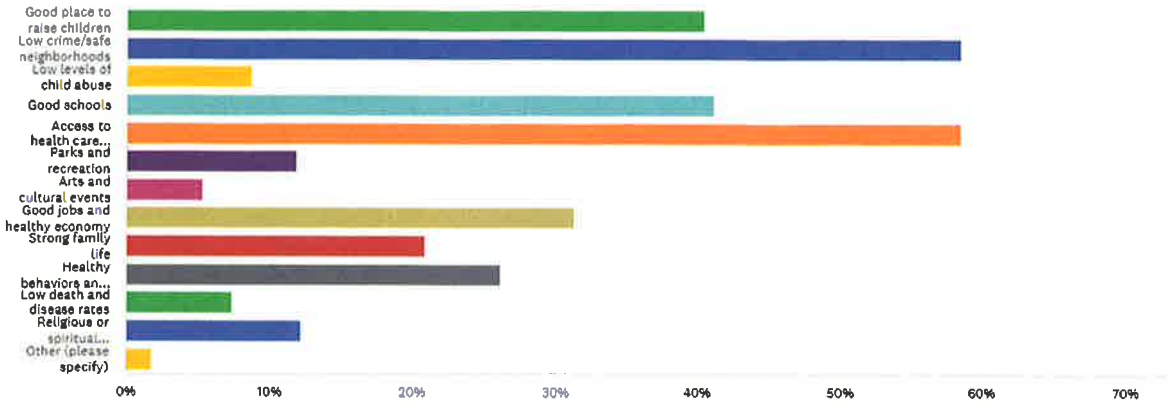
Answered: 74 Skipped: 216



Orchard Hospital Survey - Community Health Needs (0)

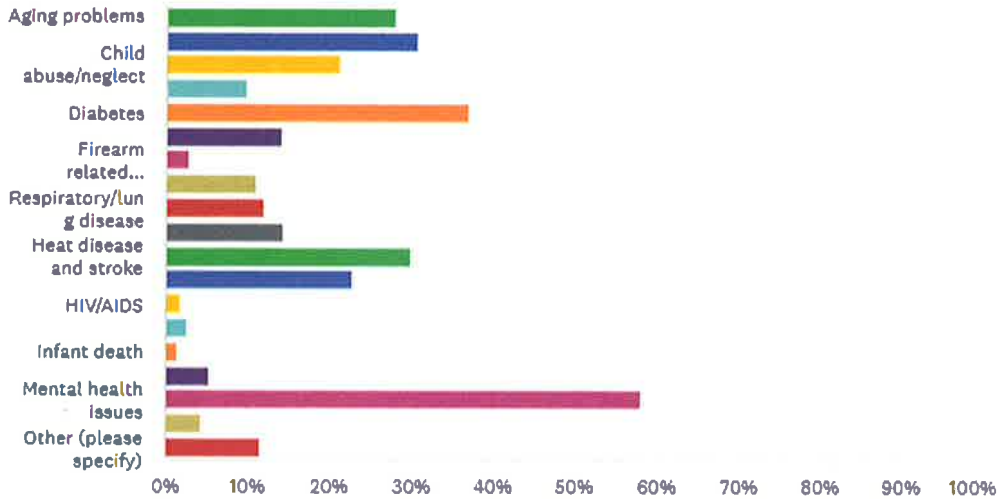
In the following list, what do you think are the three most important factors for a "Healthy Community?" (check only three)

Answered: 287 Skipped: 3



In the following list, what do you think are the three most important "...

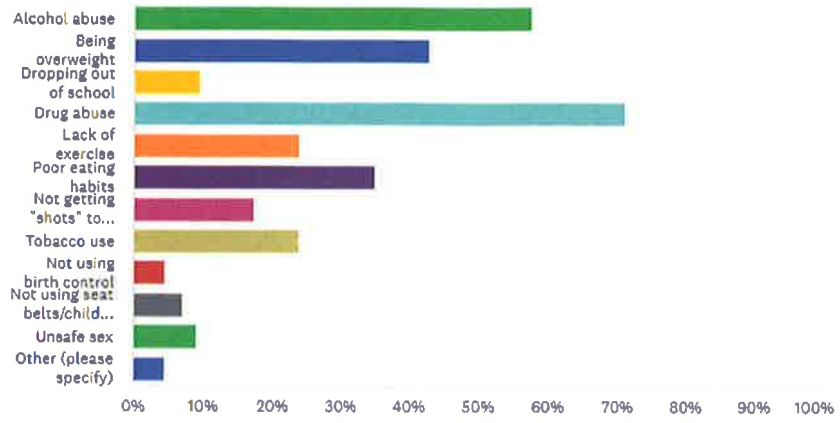
Answered: 284 Skipped: 6



Orchard Hospital Survey - Community Health Needs (0)

In the following list, what do you think are the three most important "...

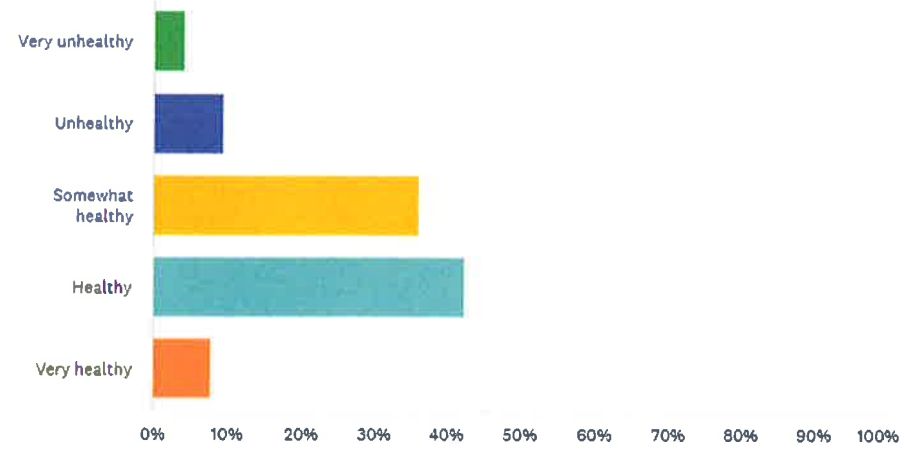
Answered: 266 Skipped: 24



Orchard Hospital Survey - Community Health Needs (0)

How would you rate your own personal health?

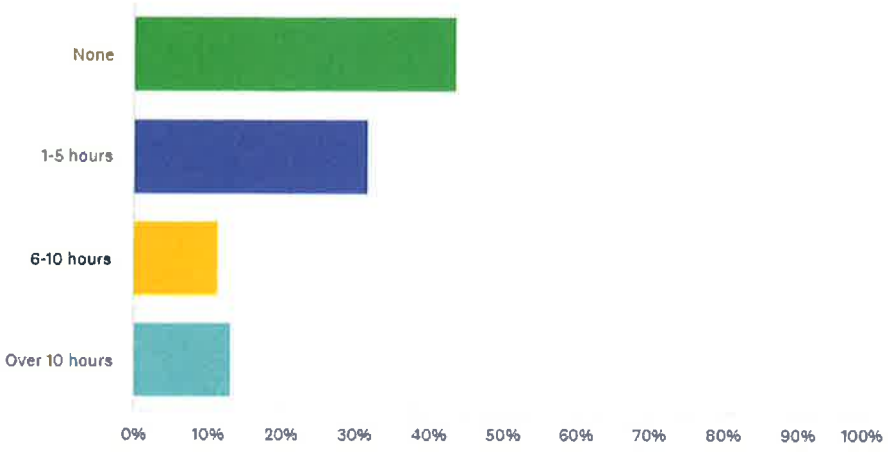
Answered: 266 Skipped: 24



Orchard Hospital Survey - Community Health Needs (0)

Approximately how many hours per month do you volunteer your tim...

Answered: 264 Skipped: 26



Orchard Hospital Survey - Community Health Needs (0)

What is the zip code where you live?

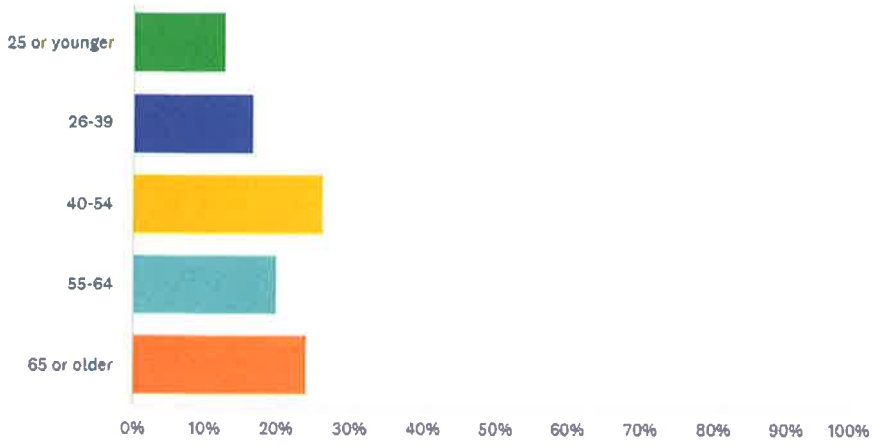
Answered: 250 Skipped: 40

95966
95948
95917
95966
95966
95965
95966
95966
95965
95965

Orchard Hospital Survey - Community Health Needs (0)

How old are you?

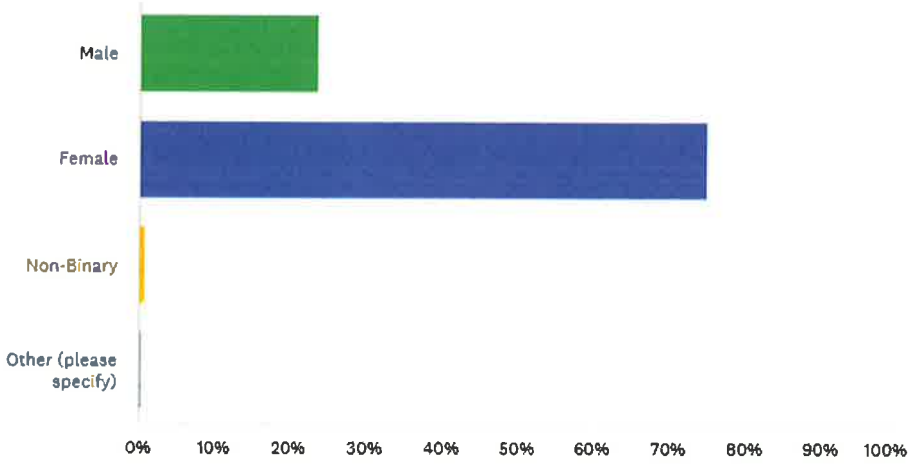
Answered: 265 Skipped: 25



Orchard Hospital Survey - Community Health Needs (0)

What is your gender?

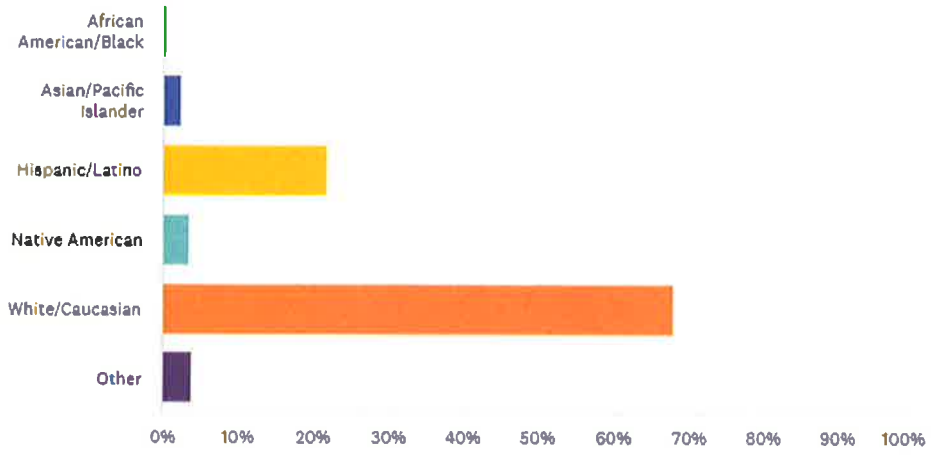
Answered: 232 Skipped: 58



Orchard Hospital Survey - Community Health Needs (0)

What ethnic group do you most identify with?

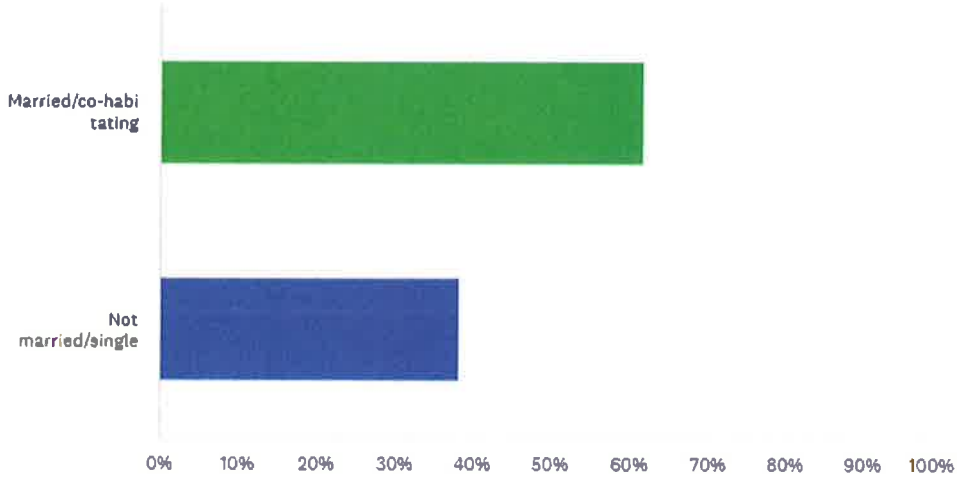
Answered: 253 Skipped: 37



Orchard Hospital Survey - Community Health Needs (0)

What is your marital status?

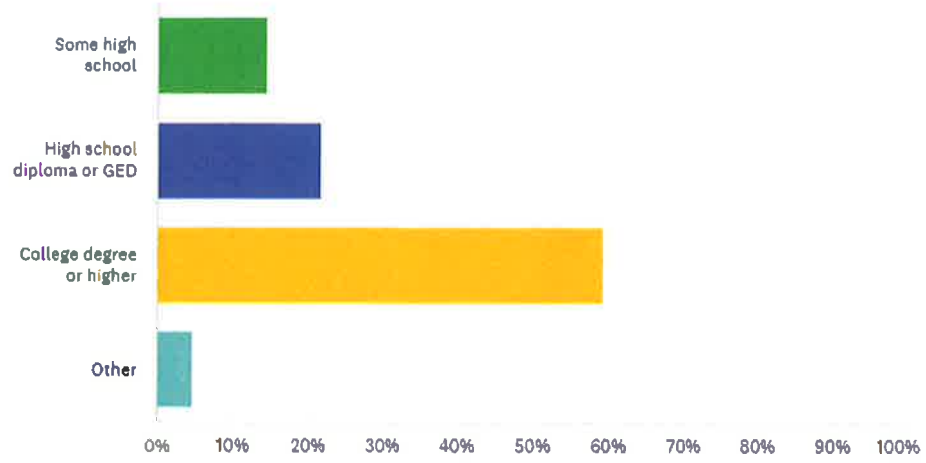
Answered: 259 Skipped: 31



Orchard Hospital Survey - Community Health Needs (0)

What is your highest level of completed education?

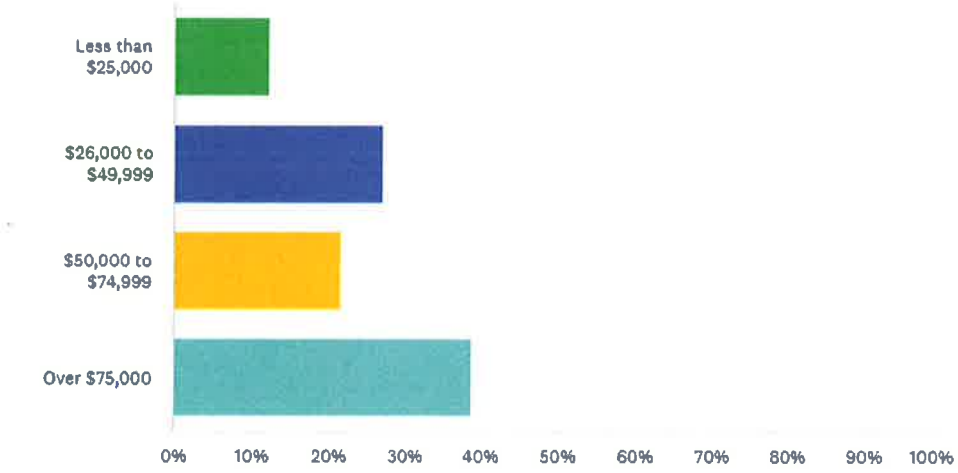
Answered: 231 Skipped: 59



Orchard Hospital Survey - Community Health Needs (0)

What is your annual household income?

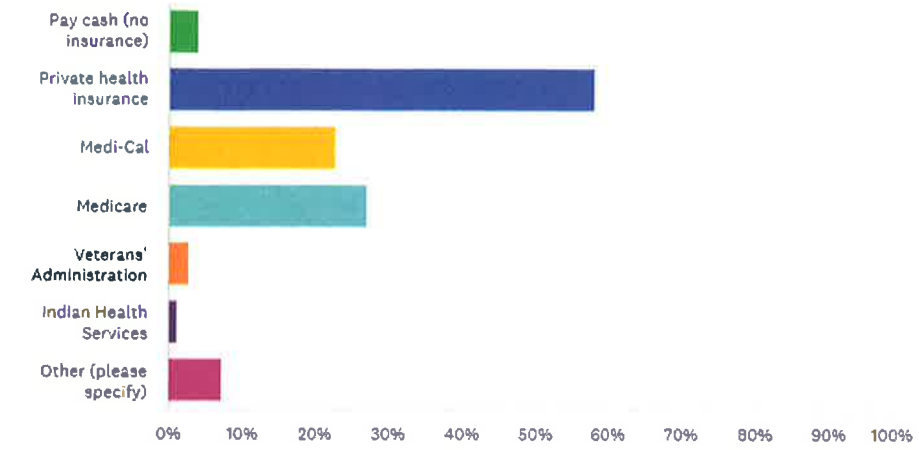
Answered: 254 Skipped: 36



Orchard Hospital Survey - Community Health Needs (0)

How do you pay for your healthcare? Check all that apply

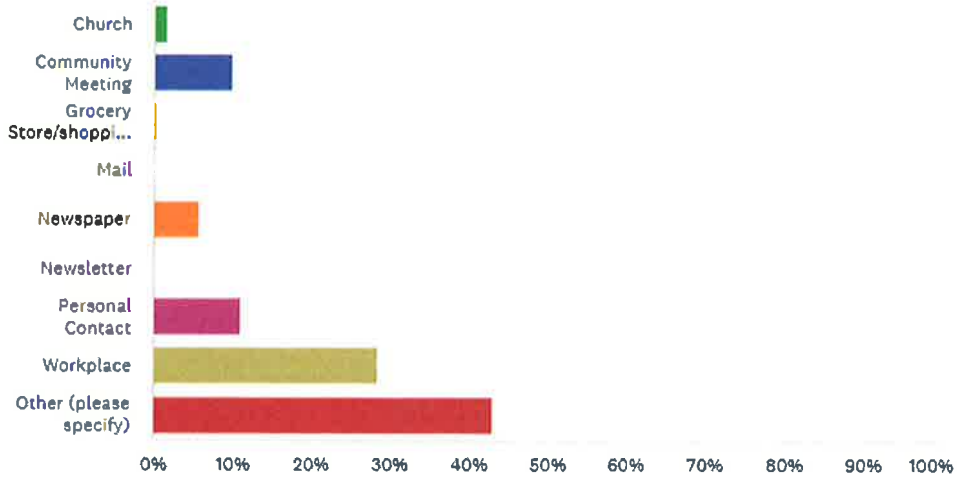
Answered: 251 Skipped: 39



Orchard Hospital Survey - Community Health Needs (0)

Where/how did you get this survey? Check one

Answered: 263 Skipped: 27



Orchard Hospital Survey - Community Health Needs (0)

Supporting Documents

Press Releases and Media Coverage

Orchard HOSPITAL

Growing Healthy Communities

Orchard Hospital Health Needs Survey

We need your help!

Results impact decisions that affect your health!

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OH.AAM000163

Appendix: 1

Implementation Plan
2022

Table of Contents:

Priority: Access to Health Care

Objective/Strategy

The lack of providers and not knowing how to find doctors in Butte County was the dominant theme reflected from responses to the survey. Improving access to healthcare was not just a matter of making it more affordable it is about the services and making them available in our area. Improving access to healthcare is the main focus of Orchard Hospital. Orchard Hospital will continue to offer Specialties and enhance our current service lines to help eliminate those needing to leave the area for healthcare.

How:

Improving access to healthcare services helps to ensure that patients have a usual and ongoing source of care (that is, a provider or facility where one regularly receives care). Patients with a usual source of care have better health outcomes, fewer disparities, and lower costs. We plan on improving this by:

- Improve access to healthcare by expanding care and services in Butte County.
    - Expand Services offered at the Gridley and Oroville Clinics
- Increase number of Providers at the Medical Specialty Centers
    - Hiring more providers with new specialty service lines
    - Providers that speak a second language
    - Increase number or Primary care providers (PCP)
        - Guiding patients to establish a PCP
- Timeliness:
    - Availability of appointments and care for illness or injury when it is needed
    - Time spent waiting in doctors' offices and emergency departments (EDs)
- Substance Use Navigator:
    - Offering Emergency Department and Inpatients access to Substance Use resources

- Free Flu and Covid-19 Vaccination clinics

- Collaborating with local health department to continue to offer Flu and Covid-19 Vaccinations

Priority: Mental Health and Substance Use Disorders

Objective/Strategy

Metal illness & Substance abuse ; including but not limited to alcohol, tobacco, illicit drugs and opioids, continue to rise toward the top of the pressing health needs facing Butte County residents. Orchard Hospital will continue to promote smoking cessation among young people and adults within our community in order to decrease the % of those who smoke or use smokeless tobacco. We will also continue to provide our community with a pain management provider, manage prescription pain medications, and provide mental health.

How

Upgrade website to include marketing of programs and services available throughout our community related to mental Health, Substance Use and the use of tobacco. Communicate services offered at Orchard Hospital through existing and new community marketing. Orchard Hospital employees will be encouraged to participate.

- Implement best-practices for managing prescription pain medications
- Implement Substance Use Navigator program in the Emergency Department
- Provide Continuing Medical Education (CME) for Butte County prescribing providers regarding prescription opioid misuse and abuse.
- Implement Orchard Hospital Adolescent Services Center
- Continue to offer Mental Health Services:
  - Senior Life Solutions
  - Family Licensed Therapist
  - Emergency Room offers Tele-Med Psychiatry

Priority: Chronic Diseases

Objective/Strategy

Enhance care for Chronic Diseases including, but not limited to obesity and diabetes

How

- Communicate service offered through local Service Clubs, Schools, Churches, and at Orchard Hospital through existing and new community marketing.
- Utilize the website and social media outlets to include marketing of programs and services available throughout our community for childhood obesity.
- Continue education through the Health Ambassador Program
  - GHS Nursing Pathway Students will be instructed on how to educate elementary students and junior high students on nutrition and fitness (play 60)
  - Orchard Hospital will be able to reaching children ages 9-18 in our service area
  - Educate on how to make healthy snacks and 60 min fitness activity.

Programs/Resources to Commit

Collaborate with local schools and partner with school nurses and the Center for Nutrition & Activity Promotion. Offer nutritional and fitness program to local schools utilizing the play 60 activities and help children and young adults learn how to move for 60 minutes.

Public Comment

In compliance with IRS regulations 501(r) for charitable hospitals, a hospital Community Health Needs Assessment (CHNA) and Implementation Strategy are to be made widely available to the public and public comment is to be solicited. The previous Community Health Needs Assessment and annual implementation strategies were made widely available to the public on the website www.OrchardHospital.com . To date, no comments have been received.

Title 11, California Code of Regulations § 999.5(d)(5)(A)

Impacts on Health Care Services

EXHIBIT 2

Orchard Hospital's 2019 Community Health Needs Assessment

2019
Community Health Needs Assessment

Orchard Hospital

2019

COMMUNITY

HEALTH

NEEDS ASSESSMENT

Orchard HOSPITAL

Growing Healthy Communities

OH.AAM000170

Table of Contents

Mission, Vision, and Values

Our Mission

Growing Healthy Communities

Our Vision

Orchard Hospital will be a Health Center of Excellence, nationally recognized for providing quality, compassionate, and personalized care that improves the health and well-being of our patients and their communities.

Our Values

At Orchard Hospital, our governance and decision making will always be based upon integrity, respect, innovative processes, ethical foundations, and continual self-improvement.

H - Honesty and Integrity

We will make decisions with honesty and integrity that will ensure Orchard Hospital's future.

E - Engaged and Empowered Staff

We will hire staff that are engaged and empowered to make a positive difference in the lives of our patients and each other.

R - Responsive

We will respond to the needs of our community by implementing programs that align with our Community Health Needs Assessment (CHNA).

O - Outcomes-Driven

We will be recognized for having excellent outcomes for the services we provide at Orchard Hospital.

Growing Healthy Communities

Introduction

Orchard Hospital located in Gridley, California is a 501(c)(3) Critical Access Hospital offering 24 hour emergency services, inpatient, outpatient and rural health clinic services. Orchard Hospital is dedicated to always providing the finest personalized healthcare to North Valley communities by offering a wide range of integrated services, from prevention through treatment to wellness.

Orchard Hospital is the only acute care hospital in Gridley, as well as along Highway 99 between Sacramento and Chico, providing needed emergency and inpatient services.

Orchard Hospital is certified for 24 general acute care beds (4 Monitored Beds and 20 Unspecified General Acute Care).

SERVICES AVAILABLE

- Acute/Skilled Inpatient Care
- Cardiology
- Cardiopulmonary
- Emergency Services
- Geriatric Clinic Services
- Inpatient/Outpatient GeneralSurgery
- Laboratory Services
- Long Term Care
- Occupational Therapy
- Physical Therapy
- Primary and Specialty Clinic Services
- Radiology Services
- Speech Language Pathology
- Social Services

Rural Health Clinic Services

- DEXA Scanning
- Digital Mammography
- Digital Radiology
- Drug Screening
- Industrial Medicine
- Internal Medicine
- Interventional
- Laboratory
- MRI
- Nephrology
- Pain Management
- Pathology
- Physicals
- Physical Therapy
- Podiatry
- Psychotherapy
- Ultrasound
- Workers Comp

OrchardHospital.com

@ORCHARDHOSPITAL

Orchard Hospital
240 Spruce Street
Gridley, CA 95948

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Purpose and Overview of the Community Health Needs Assessment

Under the Affordable Care Act, hospitals throughout the country are required to conduct a Community Health Needs Assessment (CHNA) every three years.

The primary purpose of conducting a CHNA is to objectively look at the current health needs of a community, as well as the existing resources available to address those needs, then prioritize the unmet health needs and create an action plan to address them in the coming years. In Butte County, this has been a comprehensive and collaborative project, bringing together Orchard Hospital, Enloe Medical Center, Adventist Health Feather River, and Butte County Public Health.

Using the community feedback and health data gathered, the resulting response and action plan will help shape programs over the next three years

Report Adoption, Availability, and Comments

This CHNA report was adopted by the Orchard Hospital Board of Directors on November 2019.

This report is widely available to the public on the hospital's web site, www.orchardhospital.com. Written comments on this report can be submitted to llittle@orchardhospital.com.

2016 CHNA Response

In 2016, Orchard Hospital partnered with Butte County Public Health and the three other hospitals in our county to conduct the Community Health Needs Assessment. The outcome was an action plan that focused our community outreach efforts on three main areas affecting community health:

- Social determinants of health
- Chronic diseases
    - Obesity
    - Diabetes
- Substance abuse and mental illness

Orchard Hospital is committed to identifying opportunities to collaborate with community partners throughout the region to break down barriers associated with these pressing health and social needs as well as providing the education and other tools members of our community need to be proactive in their health and lifestyle choices.

Action Plan and Results from the 2016 Community Health Needs Assessment:

Social Determinates of Health:

The Centers for Medicare and Medicaid Services promotes the concept of an accountable healthy community model for addressing social needs that can improve health outcomes and reduce costs. Orchard Hospital will continue fostering relationships throughout the community that support this model and promote connections between community members and essential services such as access to healthy foods, transportation, safe living environments, etc.

Response - Through community partnerships and outreach events such as Orchard Hospital's annual community health fair and other health education programs, we increased awareness and access to necessary support services. Programs and activities included:

- Orchard Hospital Health Ambassador Program
  - Educating youth on healthy eating options and fitness goals.
- Orchard Hospital Case Management
  - Offering support services for patients and family members during their inpatient status and following discharge.
- Center for Healthy Communities, CalFresh Outreach Program
  - Nutrition education and CalFresh
  - Referrals to food benefits for qualified individuals
- Help Central Inc./Butte 2-1-1
  - Community resource database and referral assistance
- California Health Care Options
  - Education and enrollment support for Medi-Cal benefits
- Passages
  - Education and enrollment support for Medicare benefits

Chronic Disease:

Butte County residents have a higher than average incidence of chronic conditions including adult/childhood obesity, chronic obstructive pulmonary disease (COPD, asthma), and depression. Addressing the unmet social needs and influencing the health of the community is one way in

which we can work to lower the incidence of these chronic conditions. There is also the expressed need for one-on-one, inpatient, outpatient, and community education to empower individuals to take charge of their health and move toward wellness.

Response- Throughout the last three years, Orchard Hospital has hosted community health education programs and provided opportunities for individuals to learn directly from health care professionals in the specialty areas linked to top identified health needs.

In addition to facilitating physician-community engagement opportunities through community events, Orchard Hospital was able to create a new program called Accessible Intervention Respiratory Education program (AIRE). This program was designed to assess and monitor disease, reduce risk factors, manage stable COPD, and manage exacerbations. We were able to teach our community members suffering from lung disease about living a healthier and active lifestyle with minimal exacerbations.

Orchard Hospital partnered with Gridley Unified School District to offer the Health Ambassador Program to help curb and prevent childhood obesity. Through weekly P.E. classes, Health Science Pathway students from Gridley High School mentored middle school and elementary-aged children about the importance of nutrition and fitness. The Health Ambassadors taught 15-20 minute nutritional lessons using MyPlate and provided a healthy snack along with a 25-minute fitness lesson from play 60.

Orchard Hospital will continue extending our reach and impact in high need areas through collaboration, partnerships, and support of programs including:

- Center for Healthy Communities
- Gridley Unified School District
- Diabetes Prevention Education
- Nutritional Counseling
- MyPlate Education
- AIRE Program
- Orchard Hospital Senior Life Solutions
- Psychotherapy

Substance Abuse & Mental Illness:

Mental illness and substance abuse; including alcohol, tobacco, illicit drugs, and prescription opioids, continue to rise toward the top of pressing health needs facing Butte County residents. In

our region, nearly one-third of youth and adults struggle with mood disorders, such as depression, and roughly 20% of youth and adults experience a form of substance use disorder.

Feedback from participants in the focus group discussions called for a community-wide focus on prescription overdose problems, easy access to safe disposal of medications, and a need to educate youth on the consequences of flavored tobacco, vaping, e-cigarettes, and nicotine. Orchard Hospital partnered with local programs, agencies, coalitions, and task-forces dedicated to addressing these needs.

Response: Orchard Hospital offers easy access for safe disposal of medications and syringes.

Orchard Hospital implemented best-practices for managing prescription pain medications by hiring an integrated pain management physician to help provide additional approaches to pain management. Orchard Hospital is also providing Continuing Medical Education (CME) for Butte County prescribing providers regarding prescription opioid misuse and abuse.

Orchard Hospital created a program called Senior Life Solutions. This program helps individuals suffering from depression, anxiety, loss/grief, trauma, life transition, and other mild to moderate forms of psychiatric issues. We will continue to grow this program to serve our geriatric patients better.

In the spirit of an accountable health community model, Orchard Hospital will continue collaborating, partnering with and supporting other programs and organizations to extend our reach and impact in high needs areas including:

- Butte County Behavioral Health
- Butte County Drug Abuse Prevention Task Force
- Butte County Tobacco Prevention Coalition
    - Smoking Cessation
- Orchard Hospital Pain Management Doctor
- Orchard Hospital Senior Life Solutions
- Psychotherapy

Representatives from these areas span health care, law enforcement, treatment providers, pharmacists, educators, advocates, and community members at large. Together, we provide educational opportunities and develop and promote policy changes to improve contributing factors such as density of retail alcohol and tobacco establishments, public smoking (including the use of vaping devices), and substance use among youth.

A Commitment to Our Community

Work on the 2019 Butte County Community Health Needs Assessment (CHNA) began in the Spring/Summer of 2018 with the convening of core partners who share a common service area: Butte County Public Health, Orchard Hospital, Enloe Medical Center, and Adventist Health Feather River Hospital. This collaborative effort has reduced redundancies and increased data collection efficiency. Of note, the most destructive wildfire in California's history, the Camp Fire, interrupted these collaborative CNHA efforts in the Fall of 2018 through the Spring of 2019; which dramatically affected Butte County across a myriad of health care delivery system factors and community health determinants. The full impact of natural disaster has had on the community's health will not be evident for some time, and the results of the current assessment do not adequately address them.

Prioritization Process

Significant health needs were identified from secondary data using the size of the problem (relative portion of population afflicted by the problem) and the seriousness of the problem (impact at individual, family, and community levels). To determine the size or severity of the problem, the health need indicators identified in the secondary data were measured against benchmark data from county rates, state rates and/or Healthy People 2020 objectives. Indicators related to the health needs that compared unfavorably against one or more of the benchmarks met the "health need" criteria.

The list of significant health needs informed primary data collection. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets to address needs, and discover gaps in resources. Community focus groups and stakeholder interviews were used to gather input and prioritize the significant health needs.

Top priorities identified in partnership with our communities:

Community stakeholders were asked to rank order the significant health needs according to the highest level of importance in the community.

- Access to Care
- Mental Health
- Substance Use Disorders
- Chronic Conditions
- Adverse Childhood Experiences and Childhood Maltreatment
- Dental health
- Overweight & obesity
- Transportation
- General Health

From 2020-2022, Orchard Hospital will address the following health needs through a commitment of community programs and resources.

Lead members of the collaborative team include:

Orchard Hospital | Lyndi Little Wallace, Director of, Physician Recruitment, Marketing & Community Outreach

Enloe Medical Center | Suzie Lawry-Hall, Community Outreach Coordinator

Adventist Health Feather River Hospital | Paul Sandman, Senior Community Integration Analyst Mission Integration

Butte County Public Health | Gene Azparren, Program Manager, Accreditation, and Sandy Henley, MS, MHPA, Public Health Epidemiologist

Service Area

Orchard Hospital is located at 240 Spruce St., Gridley, CA 95948. The service area includes four communities consisting of 5 ZIP Codes in Butte County.

Orchard Hospital Service Area

ZIP Code	Place
95948	Gridley
95917	Biggs
95974	Richvale
95965	Oroville
95966	Oroville

Community Profile

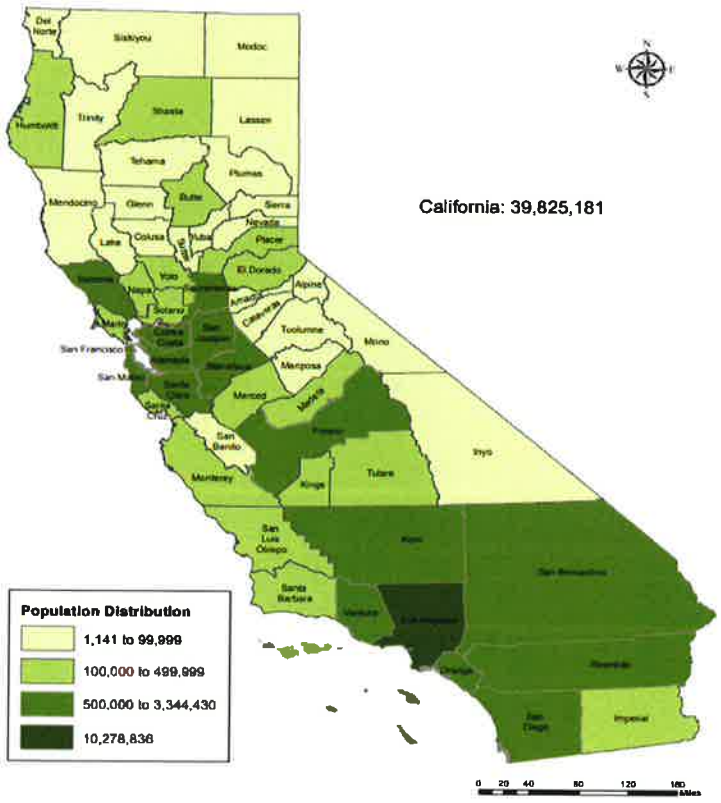

Figure 1: Population distribution

Source: State of California, Department of Finance, E-2. California County Population Estimates and Components of Change by Year, July 1, 2010-2018. Sacramento, California, December 2018

Butte County is in the northern portion of the Sacramento Valley Region of North Central California and encompasses approximately 1,677 square miles, of which 1,636.5 square miles are land, and 41 square miles are water. According to the 2018 California Department of Finance County Population State and County Population Estimates, California's population is 39,825,181, and Butte County is ranked the 27th largest county with a population of 227,837 (see Figure 1).

Population estimates for California have increased every year since 2010. Butte County estimates have also increased every year since 2010. California had an average estimated increase in population of 0.8% each year while Butte County's population estimates increased by an average of 0.4% each year (see Table 1).

Table 1: Population of Butte County and California, 2010-2013

	Butte County		California	
	Number	Percent	Number	Percent
2010	220,202	-	37,334,578	-
2011	220,636	0.20%	37,678,534	0.92%
2012	221,823	0.54%	38,045,271	0.97%
2013	222,541	0.32%	38,425,695	1.00%
2014	223,978	0.65%	38,756,940	0.86%
2015	224,533	0.25%	39,076,128	0.82%
2016	225,094	0.25%	39,328,337	0.65%
2017	226,661	0.70%	39,610,556	0.72%
2018	227,837	0.52%	39,825,181	0.54%

Source: State of California, Department of Finance, E-2. California County Population Estimates and Components of Change by Year — July 1, 2010–2018, December 2018

Age and Gender

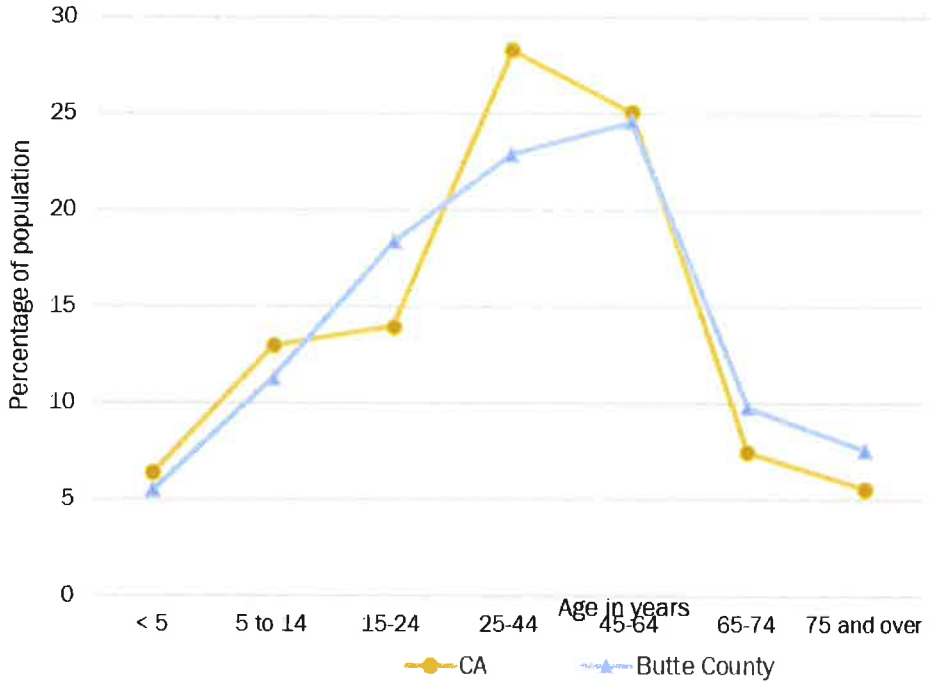

Figure 2: Population by age group: Butte County and. California, 2013-2017

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table S0101

The population of Butte County is slightly older than the population of California. The median age in Butte County is 36.9 years old compared to California, which is 36.1 years old1. Butte County has a higher percentage of individuals, ages 15 to 24 years old, and seniors, over the age of 65 years old, but a lower percentage of adults, ages 25 to 64 years old, when compared to California (see Figure-2).

The population increase has been steady in Butte County with an increase between 2015 and 2017 of 3,883 (1.7%) people. As predicted in a growing population, many age groups had increasing numbers. Exceptions included children under age 5, which remained unchanged in population; and decreases in the number of school-age children, between the ages of 5 and 9, young teens, between the ages 10 and 14, and teens and young adults, between the ages 15 and 24 (see Table 2).

[1] U.S. Census Bureau, 2013-217 American Community Survey 5-Year Estimates, Table S0101

Table 2: Age distribution in Butte County, 2015-2017					
	2015		2017		Trend, 2015-2017
	Number	Percent	Number	Percent	
Total population	225,411		229,294		↑
Under 5 years	12,172	5.4%	12,387	5.4%	↔
5 to 9 years	15,103	6.7%	14,888	6.5%	↓
10 to 14 years	11,045	4.9%	10,780	4.7%	↓
15 to 24	41,025	18.2%	40,138	17.5%	
25 to 64	106,394	47.2%	109,678	47.9%	
65 to 84	33,586	14.9%	35,887	15.6%	
85 and over	5,635	2.5%	5,536	2.6%	

Source: U.S. Census Bureau, 2015 and 2017 American Community Survey 1-Year Estimates. Table-S0101-age and sex

In 2017, the distribution of males to females in Butte County was similar to that of California (see Table 3). Although there are more females than males in Butte County, men (67%) outnumber women (64.7%) among working-age adults, ages 15 to 64 years old. For seniors, ages 70 and over, there is a greater percentage of females (13%) compared to males (10.1%).

Table 3: Gender distribution in Butte County, 2017				
	Butte County		California	
	Number	Percent	Number	Percent
Male	113,399	49.5%	19,650,051	49.7%
Female	115,895	50.5%	19,886,602	50.3%

Source: U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates. T-S0101 - age and sex

Race and Ethnicity

Based on the U.S. Census Bureau there are seven major race and ethnicity categories: African American/Black, American Indian/Alaska Native, Asian, Hispanic/Latino, Native Hawaiian/Pacific Islander, White, and other. In addition, an individual may identify as belonging to two or more races, and an individual who identifies as being Hispanic/Latino may identify as belonging to any race. These race and ethnicity categories are self-determined, meaning that individuals identify their own race or ethnicity in the census. *Race* refers to groups of people who have differences and similarities in biological traits deemed by society to be socially significant, addition, a lower percentage of Butte County residents spoke Spanish at home than residents of California (see Table 5).

Table 5: Language other than English spoken at home				
	Butte County		California	
Language at home, ages 5 to 17 years				
English only	85.6%	185,707	55.6%	20,596,574
Spanish	9.0%	19,495	28.9%	10,698,137
Other	5.4%	11,705	15.6%	5,781,517
Language at home, ages 18 years and over				
English only	88.3%	155,805	64.4%	16,526,703
Spanish	7.1%	12,465	21.3%	5,455,874
Other	4.6%	8,171	14.3%	3,667,878

Source: 2017 American Community Survey 1-Year Estimates. Table S1601

Most people over the age of 5 in Butte County spoke only English at home (85.7%). Of these English speakers, 15.2% were between the ages of 5 and 17, 65.1% were between the ages of 18 and 64, and 19.7% were age 65 or older (see *Table 6*).

Table 6: Characteristics of people by language spoken at home, Butte County, 2013-2017			
	Total	People who speak only English at home	People who speak a language other than English at home
Total population, 5 years and over	212,825	182,365 (85.7%)	30,460, (14.3%)
5 to 17 years	15.5%	15.2%	17.6%
18 to 64 years	66.2%	65.1%	72.3%
65 years and over	18.3%	19.7%	10.1%

Source: 2013-2017 American Community Survey 5-Year Estimates. Table - S1603

Disability Prevalence

According to the Centers for Disease Control and Prevention (CDC), the number of adults reporting a disability is expected to increase, along with the need for appropriate medical and public health services. People with disabilities face many barriers to good health. Studies show that individuals with disabilities are more likely than people without disabilities to report having poorer overall health, less access to adequate health care, limited access to health insurance, skipping medical care because of cost, and engaging in risky health behaviors including smoking and physical inactivity.

Independent living difficulty

The percent of the population with an independent living difficulty is based on the 2013-2017 American Community Survey question asked of persons ages 15 and older: "Because of a physical, mental, or emotional condition, does this person have difficulty doing errands alone such as visiting a doctor's office or shopping?" with response categories "yes" or "no."

Self-care difficulty

The percentage of the population with a self-care difficulty provides a narrower measure of the need for personal assistance services, similar to having difficulty in one or more activities of daily living (ADL). It is based on questions from the 2013-2017 American Community Survey questionnaire asked in a series to person's ages 5 years and older: "Because of a physical, mental, or emotional condition, does this person have serious difficulty concentrating, remembering, or making decisions? Does this person have serious difficulty walking or climbing stairs? Does this person have difficulty dressing or bathing?" with response categories "yes" or "no."

In Butte County, a higher percentage of adults, between the ages of 18 and 64, have disabilities than in the state (see Table 7).

Table 7: Disability prevalence, Butte County and California, 2013- 2017

	Ages 18-64			Ages 65 and over		
	With an independent living difficulty	With a self-care difficulty	Total persons	With an independent living difficulty	With a self-care difficulty	Total persons
Butte County	**5.8%**	**2.7%**	**139,388**	**16.1%**	**9.8%**	37,864
California	3.0%	1.6%	24,335,458	17.2%	9.9%	5,052,924

Source: 2013-2017 American Community Survey 5-Year Estimates. Table S1810

Household Characteristics

Like the state of California, the majority of households in Butte County are family households. Married-couple families make up slightly less than half of the county's households. The percentage of single-parent families in Butte County is lower than the statewide average and a notably greater percentage of Butte County residents live alone or in non-family households than the statewide average. Nearly 13% of Butte County households include adults, ages 65 and over (see *Table 8*).

Table 8: Household characteristics, 2013-2017

	Butte County	California
Total households	86,167	12,888,128
Family households (families)	59.8%	68.8%
Married-couple family	43.4%	49.5%
Male householder, no wife present, family	5.1%	5.9%
Female householder, no husband present, family	11.3%	13.3%
Non family household	40.2%	31.2%
Aged 65 years and over	12.8%	9.1%
Number of grandparents responsible for own grandchildren under 18 years	2,001 of 4,298 (46.6%)	270,310 of 1,149,466 (23.5%)
Grandparents responsible who are female	61.9 %	61.7%
Grandparents responsible who are married	73.6%	71.1%

Source: 2013-2017 American Community Survey 5-Year Estimates; Tables S1101; S1201; DPO2

Primary and Secondary Data Sources Were Gathered

Primary health survey sample data was collected in Spring/Summer 2019 from over 700 Butte County residents using the Behavioral Risk Factor Surveillance System (BRFSS) survey protocol and methodology. Results are hereafter referred to as the Behavioral Risk Factor Survey (BRFS) and treated as equivalent to state and national BRFSS results for comparisons. Qualitative focus group data with underrepresented groups and other hard to reach subpopulations were also conducted in the Spring and Summer of 2019. Quantitative secondary data was collected beginning in the Fall of 2018 from several sources including the Robert Wood Johnson Foundation (RWJF), California Health Interview Survey (CHIS), Office of Statewide Health Planning and Development (OSHPD), and the California Department of Public Health (CDPH).

Primary Data Collection

In 2019,the Butte County Public Health Department partnered with Orchard Hospital, Enloe Medical Center, and Adventist Health Feather River Hospital to retain the services of Issues & Answers Network, Inc. to administer the Butte County Behavioral Risk Factor Survey in order obtain an estimate of the prevalence of behaviors and conditions in Butte County. This survey also follows the CDC protocol for the BRFSS and uses the standardized core questionnaire and modules.

Respondents were drawn from a random sample of Butte County residents. The phone call campaign resulted in 711 completed interviews, 184 refusals, 2,359 non-working or disconnected numbers, 6,357 no answers, 1,849 numbers that were not private residences, 2,348 numbers and/or respondents with undetermined eligibility, 61 households and/or respondents with physical or mental impairment, 66 eligible respondents selected but not interviewed, 176 households and/or eligible respondents with language barriers, 946 households with telecommunication barriers and special technological circumstances, 537 households on a do-not-call list, 498 households that were out-of-sample, 149 fax or modem lines, 5,038 answering machines, 68 pagers, 28 landline numbers in the cell phone sample, and 126 interviews that were terminated/partial completes. The American Association for Public Opinion Research (AAPOR) response rate was 18.41%. The refusal rate was 1.48%.

All of the interviews were completed between April 17 and June 16, 2017, with each completed interview lasting, on average, approximately 35 minutes.

Moreover, considering the 2018 November Campfire, additional steps were taken to ensure that the temporarily relocated residents of Paradise (95965) and Magalia (95954) were included and adequately represented in the survey process. This was achieved via a series of screening questions asked of respondents (both landline and cell phone) who said they did not live in Butte County.

The collected BRFSS data were weighted to adjust for gender, age, and race using the 2010 Butte County Census population distributions.

The full report and summary table of risk factors data from the 2019 Butte County Risk Factors Survey can be found in the Appendix.

Secondary Data Collection

To gather valuable insights from community members to inform the Community Health Needs Assessment, Butte County Public Health (BCPH) contracted the firm Morrision and Company (Chico, California) to facilitate numerous community focus groups.

Representatives from Orchard Hospital, Enloe Medical Center, Adventist Health Feather River, and BCPH organized each focus group, collaborating with existing Butte County community organizations on several occasions to host focus groups in coordination with previously scheduled events or meetings. This leveraged the established relationships these groups have with the individuals they serve, facilitating active participation by community members. Focus groups were also held at various times throughout the day to best accommodate the schedules of participants. The focus groups ranged in size, with an average of 10 attendees per group.

In total, 12 focus groups reaching 114 participants were conducted, with participants representing a broad spectrum of the community. Participation was received from seniors, college students, individuals receiving mental health services, individuals participating in programs at both the African American Family and Cultural Center and the Hmong Cultural Center, high-school students, physicians, general community members, veterans, and individuals experiencing homelessness. Of those 114 participants, 88 completed a written survey utilized in data collection as displayed for the purposes of this reporting section. A series of questions were designed with input from representatives from Orchard Hospital, Enloe Medical Center, Adventist Health Feather River, and Butte County Public Health, as well as the Morrison facilitator. Participants were asked questions as a group and encouraged to share their own personal experiences or anecdotal experiences observed from friends and family in accessing health care and living healthy lives.

The full report and summary of data from the 2019 Butte County Focus Groups can be found in the Appendix: 3 Supporting Documents Community Engagement Focus Group Summary, Morrison Inc.

2019 Executive Summary

The results of all three-assessment methods were reviewed for their degree of commonality. Secondary health metric data was made to align with health survey and qualitative focus group data, such that those health factors with the greatest alignment became evident. The health factors most substantially implicated that emerged through this process are:

- Access to Care
- Mental Health and Substance Use Disorders
- Chronic Disease and Conditions
- Adverse Childhood Experiences and Childhood Maltreatment

***Access to Care*:** Access to health services is a leading health indicator (LHI) for the Healthy People 2020 (HP-2020) national health objectives. A person's ability to access health services profoundly affects their health and well-being. Having a usual primary care provider (PCP) is associated with: greater patient trust in the provider; better patient-provider communication; increased likelihood that patients will receive appropriate care; and lower mortality from all causesi. Access to mental health and oral health care are also important, as both mental health conditions and oral health correlate strongly with physical health and well-being.

Primary Care Shortage: The Health Resources & Services Administration (HRSA) has designated Butte County as provider "shortage areas" in primary care, dental care, and mental health. While only parts of the county meet primary care and dental care shortage area criteria, the entire county meets "Mental Health Shortage Area" criteria. Population to provider ratios also demonstrate that Butte County has fewer primary care physicians and dental care providers per capita than the statewide average; however, Butte County does have more non-physician primary care providers (e.g. physician's assistants and nurse practitioners) and mental health care providers per capita than the statewide average.

Table – Access 1: Population to Provider Ratios: Butte County and California, 2012 & 2016.

	Butte County			Statewide Average		
	2012	2016	Percent Change	2012	2016	Percent Change
Primary Care Physician	1497:1	1660:1	10.9%	1294:1	1270:1	-1.9%
Other Primary Care (Non Physician)	1241:1	1042:1	-16.0%	2406:1	1770:1	-26.4%
Dental Care	1461:1	1410:1	-3.5%	1291:1	1200:1	-7.0%
Mental Health Care	238:1	170:1	-28.6%	388:1	310:1	-20.1%

Source: 2012 and 2016 Area Health Resource Data File via County Health Rankings. Retrieved From: http://www.countyhealthrankings.org/app/california/2019/rankings/butte/county/outcomes/overall/snapshot

The BRFS indicated slightly more than one-third (34.1%) of Butte County adult respondents do not have a personal doctor or health care provider, which is substantially above California state and national averages (24.5% and 22.5%, respectively.) In addition, 14.5% of Butte County respondents reported not seeing a doctor because of the cost, while just 11.8% of respondents statewide cited cost as a barrier to seeking medical care. Focus group results revealed that access to care was ranked as the most important health topic across all groups, with 81% of the 88 total focus group participants ranking access to care as very important for community health in Butte County and 40.9% ranking transportation as a substantial barrier to care for county residents.

Preventative Practices: Preventive health practices are health services that prevent illnesses or diseases, such as screenings and immunizations, or patient counselling to prevent illnessii. Examples include standard immunizations; and screenings for blood pressure, cancer, cholesterol, depression, obesity, and Type 2 diabetesiii. In recent years, several preventable diseases once on the verge of eradication, such as measles, have reemerged in the United States, with outbreaks occurring throughout California, including Butte County. Likewise, sexually transmitted infections (STIs) once thought to be declining or close to eradication, such as syphilis, have shown increasing rates nationally. Many STIs are treatable, but if undetected, may continue to be transmitted; and many more are preventable through education and patient counseling.

The percentage of students having all required immunizations for enrollment into Butte County schools is slightly below the statewide percentage (93% vs. 96%). Likewise, conditional entrant enrollments – students with some but not all required immunizations – attending Butte County schools is higher than California schools overall (3.1% vs. 1.7%). According to the BRFS, 47.8% of Butte County respondents over the age of 65 have not had a flu shot in the past 12 months; and 29% had not received pneumococcal vaccine, which was also greater than the percentage statewide (23.2%). Likewise, 73.2% of Butte County respondents age 50 or older have not been vaccinated against shingles, which was slightly greater than the percentage of respondent's state and nationwide (68.9% and 71.4%, respectively).

Rates of STIs (chlamydia, gonorrhea, and syphilis) for both the county and the state have demonstrated a steadily increasing trend from 2013 to 2017. Especially concerning are the increasing rates of syphilis. In Butte County, rates increased from 0.9 cases per 100,000 residents in 2013 to 33.6 in 2017; and from 16.8 cases per 100,000 residents to 34.6 statewide during this time period. While rates of congenital syphilis showed an increasing but statistically unreliable trend in Butte County, the statewide rate increased from 11.7 to 58.2, indicating that the

statistically underpowered trend observed in Butte County is likely accurate. Also concerning, is that a slightly lower percentage (37.9%) of Butte County BRFS respondents reported ever having an HIV test than respondents statewide (40.8%).

Pertaining to preventative practices for excessive alcohol use, 17.0% of Butte County BRFS respondents reported being advised on harmful levels of drinking during a routine checkup with a healthcare provider, compared with 24.2% of respondents statewide; and 11.5% of Butte County respondents were advised to drink less compared with 12.5% of survey respondents statewide.

Mental Health and Substance Use Disorders: Mental health is a leading health indicator for the HP-2020 objectives. Mental health and physical health are inextricably linked. Evidence has shown that mental health disorders—most often depression—are strongly associated with the risk, occurrence, management, progression, and outcome of serious chronic diseases and health conditions including diabetes, hypertension, stroke, heart disease, and cancer[iv].

Suicide and Depressive Disorders: Suicide is the tenth leading cause of death in the nation, and the national suicide rate increased by 19.5% between 2007 and 2016. Suicide rates tend to be higher in rural areas than in urban settings. Of significant concern, the suicide rate per capita in Butte County is elevated to nearly twice that of California overall (18.1 vs. 10.4 per 100,000 population); and likewise elevated above the HP-2020 objective (10.2). This is especially alarming when viewed in the context of Butte County's co-occurring elevated metrics for drug induced deaths and excessive alcohol use; as nationally drug induced and alcohol related deaths in combination with suicide, collectively referred to as deaths of despair, have resulted in decreasing life expectancy in the United States since 2015. Rates of depressive disorders, a strong risk factor for suicide, also appear to be elevated in Butte County. Twenty-seven percent of BRFS respondents in Butte County indicated having been diagnosed with a depressive disorder, compared to 17% statewide, and 20% nationwide. Focus groups also overwhelmingly felt mental health was a top community health priority in Butte County, with 69% of total focus group participants ranking mental health as a very important community health priority area. The finding that all of Butte County meets HRSA Mental Health Professional Shortage Area criteria highlights a disparity between the populations need for mental health services and the current capacity of the county's healthcare delivery system to meet this demand.

Opioid Use and Excessive Drinking: Substance use disorders are defined as both mental health disorders and chronic diseases. The American Society of Addiction Medicine defines addiction as "a primary, chronic disease of brain reward, motivation, memory, and related circuitry." The development of substance use disorders are often preceded by substance misuse (taking an opioid medication other than how it was prescribed) or escalating episodes of excessive

alcohol consumption before meeting criteria for alcohol use disorder. Across focus groups, 50% of the 88 total participants indicated substance misuse and substance use disorders to be a top community health concern.

The ongoing opioid epidemic continues to be the leading driver of drug-induced deaths nationally. In Butte County, the age adjusted drug induced death rate continues to be significantly elevated compared to the statewide rate (30.2 vs. 12.2), with Butte County holding the 5th highest rate out of California's 58 counties. In 2017, mortality attributed exclusively to opioids (e.g. no other class of substances detected) in Butte County was 7.6 per 100,000 population compared with a statewide rate of 5.23; and the rate of hospitalizations for opioid overdose were the highest of all California counties, with 40.3 hospitalizations due to opioids other than heroin per 100,000 population compared to 7.75 statewide; and a rate of 9.95 hospitalizations due to heroin compared to 1.78 statewide. Also, of significant concern is that according to the California Healthy Kids Survey (CHKS), 21% percent of Butte County 11th-grade students have used prescription drugs recreationally, compared with 16% of 11th grade students statewide.

Excessive alcohol consumption—which includes binge drinking (4 or more drinks for women and 5 or more drinks for men within about 2 hours); heavy drinking (8 or more drinks a week for women and 15 or more drinks a week for men); and any drinking by pregnant women or those under 21 years of age, is responsible for 88,000 deaths in the United States each year. These include 1 in 10 deaths among working age adults (age 20-64 years), and in 2010, the estimated economic cost to the United States of excessive drinking was $249 billion. Binge drinking accounts for over half of the deaths and three-fourths of the economic costs due to excessive drinking. The most recently available data from the CDPH Safe and Active Communities Branch demonstrates that in Butte County, rates of emergency department treatment, non-fatal hospital admissions, and deaths due to alcohol were all considerably higher than statewide rates (1011.1 vs. 763.8 per 100,000; 306.6 vs. 143.4; and 16.2 vs. 11.9, respectively). Likewise, 42.5% of adult CHIS respondents in Butte County reported binge drinking, relative to 34.7% statewide. This discrepancy was further supported by the results of the BRFS, with 22.1% of Butte County respondents reporting binge drinking compared with 17.6% of respondents statewide. A similarly concerning trend among adolescents was demonstrated by the CHKS, with 20% percent of Butte County 11th grade students reporting binge drinking, compared with 11% of 11th grade students statewide.

Chronic Disease and Conditions: Accounting for 7 out of 10 deaths annually, chronic diseases and conditions such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. They are also leading drivers of the nation's $3.3 trillion in annual health care costs, with 90% of healthcare dollars in the United States spent on treatment of people with chronic physical and mental health conditionsv. In Butte County, like the nation and the state, the leading causes of death include many of the same chronic conditions, such as heart disease and stroke, cancers, Alzheimer's disease, chronic lower respiratory disease, chronic liver disease, and diabetes. While the mortality rate was

only higher for Butte County than the statewide and national rates for some chronic diseases and conditions (cancer, Alzheimer's disease, chronic lower respiratory disease, and chronic liver disease), (See Table X1); all chronic conditions comprise a substantial portion of health care spending in Butte County. A 2015 study estimated that over 51% of the $1.4 Billion total annual healthcare expenditures in Butte County could be attributed to six chronic conditions (arthritis, asthma, cardiovascular disease, diabetes, cancer, and depression), while 42.% of total statewide healthcare expenditures could be attributed to these conditions (see Table X2). Forty-eight percent of total focus group participants in Butte County indicated chronic disease and conditions to be a significant community health concern, and 45.5% indicated overweight/obesity, a predictive factor for many chronic diseases, to likewise be a top health concern. While most chronic conditions are of significant concern in Butte County, some emerged with greater emphasis including: cancer, Alzheimer's disease, asthma, chronic lower respiratory disease, and chronic liver disease.

Cancer: The age-adjusted death rate for cancer was significantly higher in Butte County than the statewide rate, with 162.2 and 140.2 deaths per 100,000 population, respectively. The five-year incidence rate for cancer from 2011 – 2015 was also elevated relative to the state rate at 452.4 and 395.2 cases per 100,000 population, respectively. These trends generally held for most forms of cancer, including lung, female breast, and colorectal cancers. The BRFS also indicated higher rates of cancer, with 8.4% of Butte County respondents reporting having ever been diagnosed with cancer (other than skin cancer), compared with 5.9% of survey respondents statewide.

Alzheimer's Disease: The age-adjusted death rate for Alzheimer's disease was also significantly higher in Butte County than the statewide rate, with 51.1 and 34.2 deaths per 100,000 population, respectively.

Asthma: In Butte County 9.7% of Medicare beneficiaries have been diagnosed with asthma, which is higher than the percentage of Medicare beneficiaries diagnosed statewide (7.5%). Results of the CHIS also demonstrate that slightly more adults in Butte County have been diagnosed with asthma than adults statewide (15.0% vs. 14.5%); while 18.3% of Butte County BRFS respondents indicated having ever been diagnosed with asthma, relative to 14.1% of statewide respondents; and 11.8% of Butte County respondents reported currently having asthma relative to 7.9% of statewide respondents.

Chronic Lower Respiratory Disease: The age-adjusted death rate for chronic lower respiratory disease was significantly higher in Butte County than the statewide rate, with 45.8 and 32.1 deaths per 100,000 population, respectively. The BRFS also indicated higher rates of chronic obstructive pulmonary disease (COPD) – a type of chronic lower respiratory disease, with 7.1% of Butte County respondents reporting having ever been diagnosed with COPD, compared with 4.5% of survey respondents statewide.

Chronic Liver Disease: The age-adjusted death rate for chronic liver disease was significantly higher in Butte County than the statewide rate, with 18.4 and 12.2 deaths per 100,000 population, respectively.

Table X-2: Mortality Rates for Chronic Diseases and Conditions:

Age Adjusted Death Rate per 100,000	Butte County	California	HP-2020	Rank out of 58 CA
All Causes	765.3	608.5	a	46
All Cancers	162.2	140.2	161.4	49
• (Lung Cancer)	(37.7)	(28.9)	(45.5)	(49)
• (Female Breast Cancer)	(21.2)	(19.1)	(20.7)	(46)
• (Prostate Cancer)	(19.4)	(19.6)	(21.8)	(24)
• (Colorectal Cancer)	(15.7)	(12.8)	(14.5)	(54)
Coronary Heart Disease	85.8	89.1	103.4	28
Alzheimer's Disease	51.1	34.2	a	55
Chronic Lower Respiratory Disease	45.8	32.1	a	42
Cerebrovascular Disease (Stroke)	39.3	35.3	34.8	39
Diabetes	18.9	20.7	b	26
Chronic Liver Disease and Cirrhosis	18.4	12.2	8.2	45

Adapted from: California Health Status Profiles, 2018. Available at: https://www.cdph.ca.gov/Programs/CHSI/Pages/County-Health-Status-Profi.aspx#pasteds

Table X-3: Healthcare Costs with Six Chronic Conditions:

Healthcare Costs	Total Healthcare Costs		Total Cost of Six Chronic Conditions		Percent of Total Health Care Costs Due to Six Conditions	
Butte County	$1,372,360,000		$625,045,759		50.8%	
California	$232,390,177,528		$98,443,138,663		42.4%	
Percent of Total Healthcare Costs	Arthritis	Asthma	Cardio-vascular disease	Diabetes	Cancer	Depression
Butte County	7.78%	4.55%	19.99%	5.27%	7.95%	5.26%
California	6.16%	4.06%	16.13%	5.59%	6.01%	4.41%

Adapted from: Brown, P.M., et al. (2015). Economic Burden of Chronic Disease in California 2015. California Department of Public Health. Sacramento, California. Available at: http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1600

Chronic Disease and Conditions | Other Notable Chronic Condition: Butte County had a slightly higher age adjusted death rate than the statewide rate for stroke (39.3 vs. 35.3 per 100,000 population). Likewise, a slightly higher percentage of Butte County BRFS respondents (3.3%) reported having ever had a stroke than statewide respondents (2.2%). Approximately one-third (32.2%) of Butte County respondents also reported having high blood pressure, which was slightly higher than for statewide respondents (28.4%). A 2016 UCLA Center for Health Policy Research study estimated the percent of adults in Butte County that are pre-diabetic (43%) was slightly lower than the statewide estimate (46%), and a lower percentage Butte County CHIS respondent reported being diagnosed with diabetes than statewide respondents (7.4% vs. 9.3%). This discrepancy was also found in BRFS results (7.0% vs. 10.5%); however, a slightly higher

percentage of CHIS respondents age 65 and over from Butte County were diagnosed with diabetes than the percent of respondents statewide (23.5% vs. 21.4%). Major risk factors for the development of chronic conditions and premature death include being overweight/obese and smoking tobacco products. While the percent of adult CHIS respondents that reported being overweight or obese was marginally lower in Butte County than statewide (60.3% vs. 61.5%), the percent of Butte County BRFS respondents that indicated having no physical activity in the past 30 days was higher than the percent of statewide respondents (28.5% vs. 20.0%); and significantly more Butte County respondents indicated being current smokers than statewide respondents (20.6% vs.11.3%).

Adverse Childhood Experiences and Childhood Maltreatment: Adverse childhood experiences (ACEs) are traumatic events in forms of neglect, abuse, or household challenges that occur during childhood and can negatively influence an individual's overall health and wellbeing throughout their lifespan. Early childhood adversity has been associated with increased likelihood of risky behaviors, chronic disease, poor quality of life, and decreased life expectancyvi. Research suggest that there is a dose response curve for ACEs and poor health, that is the likelihood of adverse health outcomes increases with the number of ACEs experienced; with individuals having experienced four or more ACEs being at substantially greater risk than individuals experiencing three or fewer ACEsvii. A top priority of the Surgeon General of California's Office is addressing social determinants that influence early childhood development and health. Within the states Let's Get Healthy California campaign, the Healthy Beginnings objectives focus on maternal and infant health; as well as child and adolescent physical, mental, and social health – for which ACEs rates are key health indicators.

Butte County has notably higher childhood maltreatment rates than California overall, including neglect and abuse allegations (74.0 vs. 54.3 per 1,000 children), substantiations (9.9 vs. 7.7) and entries into protective care (6.5 vs. 3.1)viii. A 2014 Center for Youth Wellness report found that from 2008 -2013, 76.5% Butte County residents reported having one or more ACEs; which was the highest rate of all California counties and significantly higher than for California overall (61.7%). In addition, nearly twice the percentage of Butte County residents as California residents reported having four or more ACEs (30.3% vs. 15.9%)ix. Similarly, results of the 2019 BRFS demonstrated that 77% of Butte County respondents had one or more ACEs, which was considerably higher than the most recent data for statewide respondents (65.5%). Further, Butte County respondents had higher rates than statewide respondents across all ACEs categories, with the most frequent being: substance use by a household member (37.8% vs. 26.1%); parental separation or divorce (37.3% vs. 26.7%); emotional or verbal abuse (35.2% vs. 34.9%,); household member with mental illness (28.4% vs. 15.0%,); and witnessing domestic violence (19.3% vs. 17.5%).

Conclusion and Action Plan

Once the health needs were prioritized by the Orchard Hospital Administration team and Board of trustees, the final step in the CHNA process was to develop an implementation strategy. The purpose of the implementation strategy is to develop a clear set of goals to respond to the priorities identified. This strategy will include a written plan that addresses each of the community health needs identified through the CHNA, describe how the hospital plans to meet the health needs, and identify health needs the hospital does not intend to meet and why.

The following implementation strategy components within each priority were addressed:

1. Objectives/Strategy
2. How
3. Programs/Resources to Commit
4. Impact of Programs/Resources on Health Need
5. Accountable Parties
6. Partnerships/Collaboration

The detailed implementation strategy for each priority can be found in Appendix 6. In summary the following priorities were addressed through the implementation strategy:

- Access to Care
- Mental Health and Substance Use Disorders
- Chronic Disease and Conditions
    - Obesity
    - Diabetes

The implementation strategy detail for each priority is located in Appendix 6 and provides supporting tactics, programs/resources, accountable parties, and potential partnerships/collaboration.

Appendix: 1

Supporting Documents

2019 Behavior Risk Factor Survey

2019 Behavioral Risk Factor Survey

Butte County, CA

Butte County Public Health

Orchard Hospital
Growing Healthy Communities

Enloe Medical Center

AdventistHealth Feather River

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Introduction

In 1990, *Healthy People 2000, National Health Promotion and Disease Prevention Objectives*, was released to the public. The document outlined the U.S. government's plan to improve the health of individuals, communities, and the nation. This plan was revised in 1999 (*Healthy People 2010,*) and, subsequently, in 2010 (*Healthy People 2020.*)

Healthy People 2020 documents 10-year health objectives organized into 4 over-arching goals and 42 Focus Areas (page 4.) These Focus Areas address factors such as behavior, biology, physical environment and social environment that interact to influence health. In addition to the Focus Areas, a smaller subset of 12 indicators called Leading Health Indicators (page 5) was developed. The LHIs reflect a life stage perspective, with the intent to draw attention to both individual and societal determinants that affect the public's health and contribute to health disparities from infancy through old age. This approach recognizes that specific risk factors and determinants of health vary across the life span. Health and disease result from the accumulation, over time, of the effects of risk factors and determinants. Therefore, intervening at specific points in the life course can help reduce risk factors and promote health.

How do behaviors fit into this framework? Behaviors are individual responses or reactions to internal stimuli and external conditions. It has been estimated that behavioral and environmental factors are responsible for approximately 70% of all premature deaths in the United States. Obtaining information surrounding behaviors that put one at risk for poor health is instrumental in developing policies and interventions.

This report explores the behaviors that put Butte County residents at risk for poor health. Leading Health Indicators are presented accompanied by their *Healthy People 2020* Objective/Focus Area.

Healthy People 2020 Goals & Focus Areas

Healthy People 2020 Goals

1. Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
2. Achieve health equity, eliminate disparities, and improve the health of all groups.
3. Create social and physical environments that promote good health for all.
4. Promote quality of life, healthy development, and healthy behaviors across all life stages.

Healthy People 2020 Focus Areas

1. Access to Health Services
2. Adolescent Health
3. Arthritis, Osteoporosis, and Chronic Back Conditions
4. Blood Disorders and Blood Safety
5. Cancer
6. Chronic Kidney Disease
7. Dementias, Including Alzheimer's Disease
8. Diabetes
9. Disability and Health
10. Early and Middle Childhood
11. Educational and Community-Based Programs
12. Environmental Health
13. Family Planning
14. Food Safety
15. Genomics
16. Global Health
17. Health Communication & Health Information Technology
18. Health-Related Quality of Life & Well-Being
19. Healthcare-Associated Infections
20. Hearing and Other Sensory or Communication Disorders
21. Heart Disease and Stroke
22. HIV
23. Immunization and Infectious Diseases
24. Injury and Violence Prevention
25. Lesbian, Gay, Bisexual and Transgender Health
26. Maternal, Infant, and Child Health
27. Medical Product Safety
28. Mental Health and Mental Disorders
29. Nutrition and Weight Status
30. Occupational Safety and Health
31. Older Adults
32. Oral Health
33. Physical Activity
34. Preparedness
35. Public Health Infrastructure
36. Respiratory Diseases
37. Sexually Transmitted Diseases
38. Sleep Health
39. Social Determinants of Health
40. Substance Abuse
41. Tobacco Use
42. Vision

Healthy People 2020 Leading Health Indicators

1. Access to Health Services
2. Clinical Preventive Services
3. Environmental Quality
4. Injury and Violence
5. Maternal, Infant, and Child Health
6. Mental Health
7. Nutrition, Physical Activity, and Obesity
8. Oral Health
9. Reproductive and Sexual Health
10. Social Determinants
11. Substance Abuse
12. Tobacco

Methodology

The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing, state-based telephone surveillance system supported by the Centers for Disease Control and Prevention (CDC.) Through a series of monthly telephone interviews, states uniformly collect data on the behaviors and conditions that place adults at risk for chronic diseases, injuries, and preventable infectious diseases that are the leading causes of illness and death in the United States. The annual California surveys follow the overall CDC telephone survey protocol for the BRFSS. California Behavioral Risk Factor Survey (BRFS) data is collected by the Public Health Survey Research program (PHSRP) of California State University, Sacramento.

In 2019, in order to obtain an estimate of the prevalence of these behaviors and conditions in Butte County, the Butte County Public Health Department partnered with Enloe Medical Center, Adventist Health Feather River Hospital and Orchard Hospital to retain the services of Issues & Answers Network, Inc. The Butte County Behavioral Risk Factor Survey also follows the CDC protocol for the BRFSS and uses the standardized core questionnaire and modules.

For the needs of the 2019 Butte County BRFSS, the interviews were administered via telephone (via landline and cell phone) to randomly selected adults from a sample of households in the County.

- ✓ The sample of landline telephone numbers was selected using a list-assisted, random-digit-dialed methodology with disproportionate stratification based on "listedness."
- ✓ The cell phone sample included the application of Cellular Working Identification Number Service, which identified inactive telephone numbers within the cellular RDD sample. In order to improve the efficiency of the sample further and reduce the number of out-of-scope calls, a zip code matching process was also used.

Moreover, in light of the 2018 November Campfire, additional steps were taken to ensure that the temporarily relocated residents of Paradise (95965) and Magalia (95954) were included and adequately represented in the survey process. This was achieved via a series of screening questions asked of respondents (both landline and cell phone) who said they did not live in Butte County. The questions were as follows:

S4.1 Do you now live or have you lived in Butte County, California?

1. Currently live in Butte
2. Previously lived in Butte (GO TO S4.2)
3. No – never lived in Butte (THANK AND TERMINATE)

S4.2 Did you move out of Butte County due to the recent fires?

1. Yes (GO TO S4.3)
2. No (THANK AND TERMINATE)

S4.3 Is this a permanent move or a temporary move?

1. Permanent (THANK AND TERMINATE)
2. Temporary

The collected BRFSS data were weighted to adjust for gender, age, and race using the 2010 Butte County Census population distributions.

Sample Results

All of the respondents who were included in the final sample were drawn from a random sample of Butte County residents. Among the calls that were attempted, there were 711 completed interviews, 184 refusals, 2,359 non-working or disconnected numbers, 6,357 no answers, 1,849 numbers that were not private residences, 2,348 numbers and/or respondents with undetermined eligibility, 61 households and/or respondents with physical or mental impairment, 66 eligible respondents selected but not interviewed, 176 households and/or eligible respondents with language barriers, 946 households with telecommunication barriers and special technological circumstances, 537 households on a do-not-call list, 498 households that were out-of-sample, 149 fax or modem lines, 5,038 answering machines, 68 pagers, 28 landline numbers in the cell phone sample, and 126 interviews that were terminated/partial completes. The American Association for Public Opinion Research (AAPOR) response rate was 18.41%. The refusal rate was 1.48%.

All of the interviews were completed between April 17 and June 16, 2017, with each completed interview lasting, on average, approximately 35 minutes.

Please note that, when available, comparisons to California and national results presented in this report are based on the 2017 California and U.S. Behavioral Risk Factor Surveys (the most recent surveys released to the public.)

In a few instances, for question topics due to be released at a later time (September 2017,) older state BRFSS data (years 2008-2016) were used for comparisons. These questions are marked with asterisks.

California BRFSS data is not available for the Intimate Partner Violence topic. National BRFSS data is not available for a handful of topics including Other Tobacco Use, Marijuana Use, and Intimate Partner Violence.

Analysis of Selected Risk Factors

Summary Table: At a Glance

Factor	Butte County	California
Perceived Health Status (fair/poor)	19.0%	17.6%*
Quality of Life: Poor physical health (14+ days)	16.0%	11.1%*
Quality of Life: Poor mental health (14+ days)	18.8%	10.6%*
Disability	20.9%	21.9%*
Health Care Access: No Health Care Coverage (age 18-64)	10.8%	12.7%*
Health Care Access: No Personal Health Care Provider	34.1%	24.5%*
Health Care Access: No Health Care Access Due to Cost	14.5%	11.8%*
Health Care Access: No Routine Checkup	30.5%	32.4%*
Chronic Health Conditions: Ever told had a heart attack	3.7%	3.1%*
Chronic Health Conditions: Ever told had angina or coronary artery disease	2.8%	2.8%*
Chronic Health Conditions: Ever told had a stroke	3.3%	2.2%*
Chronic Health Conditions: Ever told had asthma	18.3%	14.1%*
Chronic Health Conditions: Still have asthma	11.8%	7.9%*
Chronic Health Conditions: Ever told had COPD	7.1%	4.5%*
Chronic Health Conditions: Ever told you had some form of arthritis	24.1%	19.4%*
Chronic Health Conditions: Ever told had a depressive disorder	27.5%	17.3%*
Chronic Health Conditions: Ever told had kidney disease	3.0%	3.3%*
Chronic Health Conditions: Ever told had skin cancer	8.5%	5.9%*
Chronic Health Conditions: Ever told had any other types of cancer	8.4%	5.9%*
Cancer Survivorship: Survivors currently receiving cancer treatment	6.8%	12.9%**
Cancer Survivorship: Survivors who participated in clinical trial	2.1%	N/A**
Cancer Survivorship: Survivors who received a survivorship care plan	76.2%^^	47.6%**
Hypertension Awareness: Ever told had high blood pressure	32.2%	28.4%*
Cholesterol Awareness: Blood cholesterol not checked within last 5 years	10.8%	12.4%*
Cholesterol Awareness: Had blood cholesterol checked and told it was high	24.0%	30.8%*

**Note: Based on 2017 BRFSS of California Residents*
***Note: Based on 2009 BRFSS of California Residents*
^Items marked in red are below the statewide figures and may require the County's attention. Items marked in green indicate results above the statewide figures
^^Caution: Fewer than 30 respondents

Analysis of Selected Risk Factors – cont'd.

Summary Table: At a Glance

Factor	Butte County	California
Diabetes: Ever told had diabetes (excluding pregnancy-related)	7.0%	10.5%*
Tobacco Use: Current Smoker	20.6%	11.3%*
Other Tobacco Use: Have ever used chewing tobacco	28.1%	4.2%**
Other Tobacco Use: Current user of chewing tobacco	4.0%	0.6%**
Other Tobacco Use: Have ever used cigars/cigarillos	39.0%	15.2%**
Other Tobacco Use: Current user of cigars/cigarillos	4.9%	1.7%**
Other Tobacco Use: Have ever used tobacco pipe	14.8%	4.5%**
Other Tobacco Use: Current user of tobacco pipe	0.4%	0.2%**
Other Tobacco Use: Have ever used hookah water pipe	16.0%	6.3%**
Other Tobacco Use: Current user of hookah water pipe	0.0%	0.6%**
Marijuana Use: Smoked 1+ day within past 30 days	17.7%	10.5%***
Alcohol Consumption: Binge drinking	22.1%	17.6%*
Alcohol Consumption: Heavy drinking	4.2%	6.3%
Alcohol Screening & Brief Intervention: Did not discuss alcohol use with a health professional at last routine checkup	22.5%	22.1%****
Alcohol Screening & Brief Intervention: Advised about harmful drinking	17.0%	24.2%****
Alcohol Screening & Brief Intervention: Advised to reduce or quit drinking	11.5%	12.5%****
Fruit Consumption (<1 time/day)	41.9%	32.5%*
Vegetable Consumption (<1 time/day)	16.8%	21.4%*
Physical Activity: No activity during past month	28.5%	20.0%*
Seatbelt Use: Do not always use seatbelt	6.7%	2.2%*
Adult Immunization: No flu shot in past year (age 65+)	47.8%	40.7%*
Adult Immunization: Never had pneumococcal vaccination (age 65+)	29.0%	23.2%*
Adult Immunization: Never had shingles/zoster vaccination	73.2%	68.9%*
HIV/AIDS: Ever had an HIV test	37.9%	40.8%*

**Note: Based on 2017 BRFSS of California Residents*
***Note: Based on 2015 BRFSS of California Residents*
****Note: Based on 2016 BRFSS of California Residents*
*****Note: Based on 2014 BRFSS of California Residents*
^Items marked in red are below the statewide figures and may require the County's attention. Items marked in green indicate results above the statewide figures

Analysis of Selected Risk Factors – cont'd.

Summary Table: At a Glance

Factor	Butte County	California
Adverse Childhood Experience: Emotional/verbal abuse (more than once)	35.2%	34.9%*
Adverse Childhood Experience: Parental separation or divorce	37.3%	26.7%*
Adverse Childhood Experience: Substance abuse by household member	37.8%	26.1%*
Adverse Childhood Experience: Physical abuse (more than once)	21.0%	19.9%*
Adverse Childhood Experience: Witness to domestic violence (more than once)	19.3%	17.5%*
Adverse Childhood Experience: Household member with mental illness	28.4%	15.0%*
Adverse Childhood Experience: Sexual abuse (ever)	13.8%	11.4%*
Adverse Childhood Experience: Incarcerated household member	14.6%	6.6%*
Intimate Partner Violence: Threatened physical (past 12 months)	4.3%	N/A
Intimate Partner Violence: Completed physical (past 12 months)	3.8%	N/A
Intimate Partner Violence: Attempted control (past 12 months)	5.1%	N/A
Intimate Partner Violence: Unwanted sex (past 12 months)	0.6%	N/A

**Note: Based on combined 2008-2013 BRFSS of California Residents*
^Items marked in red are below the statewide figures and may require the County's attention. Items marked in green indicate results above the statewide figures

Perceived Health Status

Healthy People 2020 objective HRQOL/WB-1: Increase the proportion of adults who self-report good or better health

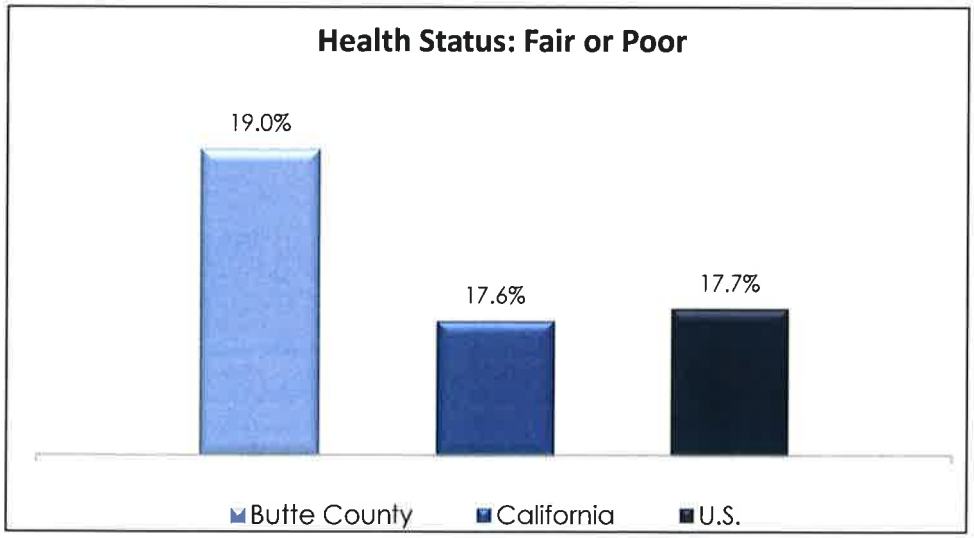
A primary goal of Healthy People 2020 is to help individuals improve their quality of life. General health status is a reliable self-rated assessment of one's perceived health, which may be influenced by all aspects of life, including behaviors, environmental factors, and community. Self-rated general health status is useful in determining unmet health needs, identifying disparities among subpopulations, and characterizing the burden of chronic diseases within a population. The prevalence of self-rated fair or poor health status has been found to be higher within older age groups, females, and minorities, and has also been associated with lower socioeconomic status in the presence or absence of disease.

At 19%, Butte County residents are slightly more likely than Californians and Americans as a whole to report fair or poor general health (17.6% and 17.7%, respectively.)

The self-reported rate of fair/poor health is highest among residents older than 45 years of age, with over one-fifth giving this response. Additionally, non-Hispanics (20.8%,) residents with less than a high school education (35.6%,) and those with less than $35,000 in an annual household income (roughly three in ten) are among the most likely to rate their health as fair or poor.

Percentage of respondents who said their health, in general, was fair or poor

Demographic Characteristics	General Health Fair or Poor
Total	19.0%
Age	
18-24	14.0%
25-34	12.3%
35-44	15.7%
45-54	20.4%
55-64	31.4%
65+	20.6%
Gender	
Male	19.7%
Female	18.4%
Race	
White	18.6%
Black**	17.2%
Hispanic	10.3%
Non-Hispanic	20.8%
Education	
< High School	35.6%
High School Grad	21.1%
Some College	19.3%
College Graduate	13.8%
Household Income	
<$20,000	32.0%
$20,000-$34,999	27.6%
$35,000-$$49,999**	10.8%
$50,000-$74,999	18.9%
$75,000 or more	10.1%



**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Quality of Life

Healthy People 2020 objective HRQOL/WB-1.1: Increase the proportion of adults who self-report good or better physical health

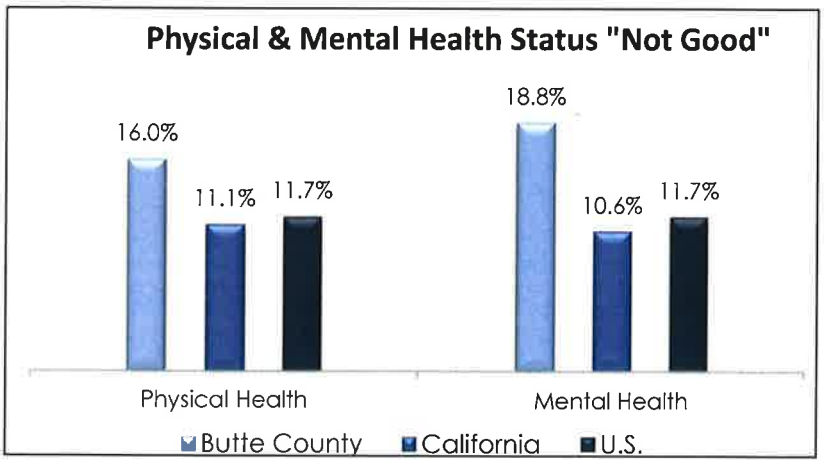
Healthy People 2020 objective HRQOL/WB-1.2: Increase the proportion of adults who self-report good or better mental health

Health-related quality of life reflects a personal sense of physical and mental health and the ability to react to factors in the physical and social environments. The key indicator used in this analysis is the number of days in the past month that residents experienced physical or mental health problems, and in particular, whether they had experienced problems for 14 or more days within that timeframe.

A total of 16% of Butte County residents report having 14 or more days of poor physical health, and 18.8% say the same about their mental health. Both quality of life metrics are notably above the state and U.S. figures.

Residents most likely to report poor physical health are those with less than high school education (40.6%,) those with income of under $35,000 per year (just under one-quarter), as well as those over the age of 55 (more than two in ten.)

In terms of poor mental health, its incidence is driven mostly by residents ages 25-54 (more than two in ten,) females (24.1%,) Black and Hispanic residents (22.2% and 25.1%, respectively,) those without a high school diploma (33.2%,) and respondents in the bottom income bracket (29.7%.)



Percentage of respondents with 14 or more days of poor physical or mental health

Demographic Characteristics	Physical Health Not Good	Mental Health Not Good
Total	16.0%	18.8%
Age		
18-24	3.8%	19.0%
25-34	18.5%	24.3%
35-44	14.0%	21.3%
45-54	15.3%	26.4%
55-64	25.9%	17.2%
65+	19.6%	8.3%
Gender		
Male	14.2%	13.4%
Female	17.7%	24.1%
Race		
White	14.9%	16.7%
Black**	17.2%	22.2%
Hispanic	18.9%	25.1%
Non-Hispanic	15.8%	18.1%
Education		
< High School	40.6%	33.2%
High School Grad	11.7%	16.7%
Some College	15.9%	19.7%
College Graduate	14.2%	16.1%
Household Income		
<$20,000	23.1%	29.7%
$20,000-$34,999	24.6%	11.8%
$35,000-$$49,999**	9.5%	11.9%
$50,000-$74,999	13.1%	10.3%
$75,000 or more	11.6%	14.3%

*Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents

Disability

Healthy People 2020 objective DH-13: Increase the proportion of adults with disabilities aged 18 years and older who participate in leisure, social, religious or community activities

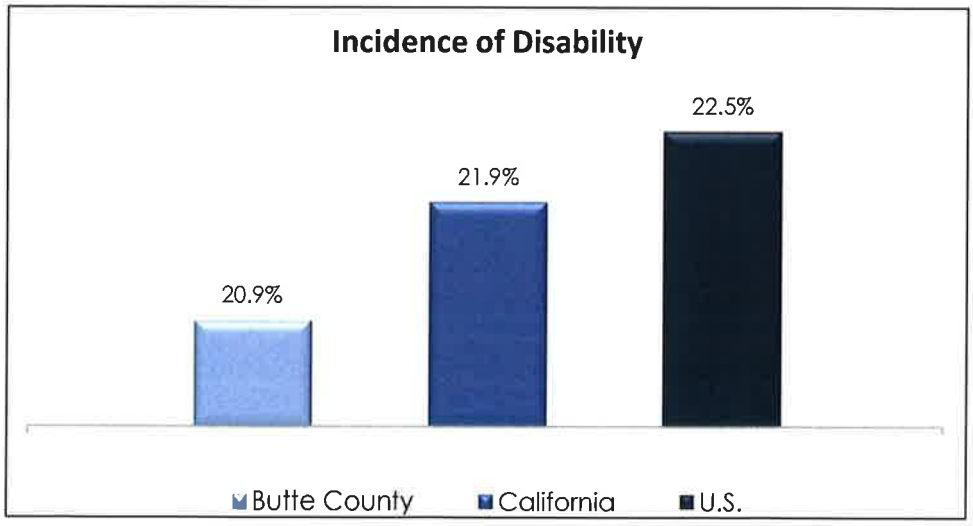
Healthy People 2020 objective DH-14: Increase the proportion of children and youth with disabilities who spend at least 80 percent of their time in regular education programs

Healthy People 2020 objective goal DH-16: Increase employment among people with disabilities

One of the Healthy People 2020 goals is to "promote the health and well-being of people with disabilities." There are many ways in which disability can be defined, ranging from experiencing difficulty in participating in certain activities (such as lifting and carrying objects, seeing, hearing, talking, walking or climbing stairs) to having more severe disabilities that require assistance in personal care needs (i.e. bathing) or routine care needs (i.e. housework). In this report, disability is defined as being limited in any activities because of physical, mental, or emotional problems.

Approximately one-fifth (20.9%) of the Butte County adult population lives with a disability, which is essentially consistent with the state- and nationwide results (21.9% and 22.5%, respectively.)

The prevalence of disability in Butte County is highest among African Americans (64.2%,) respondents in the lowest income bracket (36%,) and those with less than high school education (38.1%.) Moreover, residents over the age of 35 are more likely to report disability than their younger counterparts, with a peak among those age 55-64 (30.2%.)



Percentage of respondents limited in activities because of physical, mental or emotional problems

Demographic Characteristics	Disability
Total	20.9%
Age	
18-24	10.1%
25-34	19.1%
35-44	24.2%
45-54	21.2%
55-64	30.2%
65+	22.0%
Gender	
Male	22.7%
Female	19.8%
Race	
White	21.5%
Black**	64.2%
Hispanic	12.3%
Non-Hispanic	22.5%
Education	
< High School	38.1%
High School Grad	20.4%
Some College	19.2%
College Graduate	18.6%
Household Income	
<$20,000	36.0%
$20,000-$34,999	15.7%
$35,000-$$49,999**	18.9%
$50,000-$74,999	18.2%
$75,000 or more	14.6%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Health Care Access: No Health Care Coverage

Healthy People 2020 objective AHS-1.1: Increase the proportion of persons with medical insurance

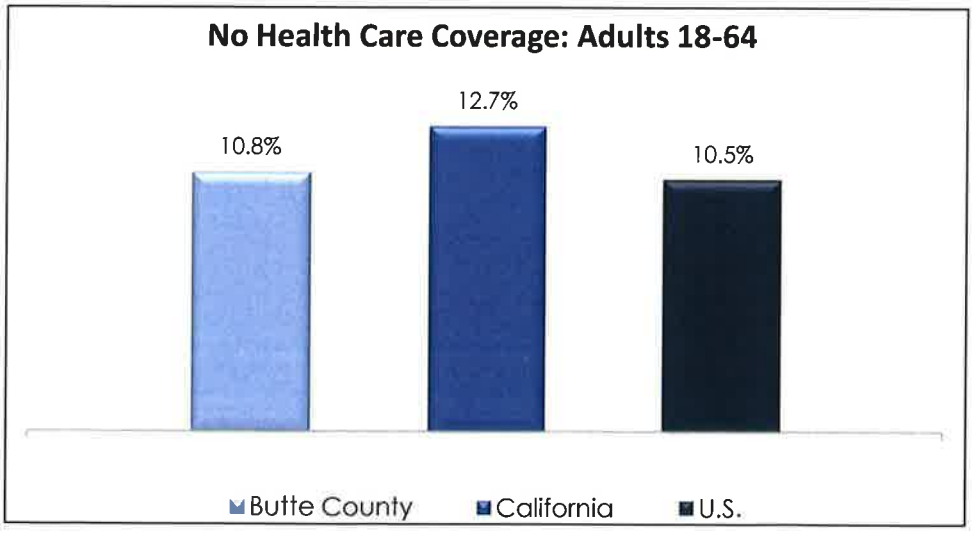
Health insurance coverage is an important determinant of access to health care. Uninsured individuals are substantially less likely to have a usual source of health care or a recent health care visit than their insured counterparts.[10] Utilization of preventive health care services, such as mammography, Pap tests, prostate exams, influenza vaccinations, and cholesterol tests, could reduce the prevalence and severity of diseases and chronic conditions in the United States. The Healthy People 2020 target for health care coverage is to have 100% insured by 2020.[11]

An estimated 10.8% of the Butte County residents between the ages of 18 and 64 have no health insurance coverage – a rate below the state figure (12.7%) and on par with the national score (10.5%.)

Access to health care is closely related to several socio-economic factors. Specifically, at 22.6%, the Hispanic segment of Butte County residents is substantially less likely to have coverage than their non-Hispanic counterparts. Male residents are somewhat more likely than females to have no coverage. Predictably, the likelihood to be insured is directly proportional to the income and educational attainment levels. Finally, age is closely associated with health care coverage, as younger individuals are more apt to report that they do not have health insurance coverage than those age 35+.

Percentage of respondents age 18-64 who have no health care insurance coverage

Demographic Characteristics	No Health Insurance
Total	10.8%
Age	
18-24	16.2%
25-34	15.5%
35-44	7.2%
45-54	8.6%
55-64	5.7%
Gender	
Male	13.6%
Female	8.2%
Race	
White	7.3%
Black**	9.4%
Hispanic	22.6%
Non-Hispanic	8.7%
Education	
< High School	18.4%
High School Grad	13.1%
Some College	12.7%
College Graduate	5.0%
Household Income	
<$20,000	18.6%
$20,000-$34,999	11.5%
$35,000-$$49,999**	15.6%
$50,000-$74,999	11.7%
$75,000 or more	1.4%



**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Health Care Access: Limited Health Care Coverage

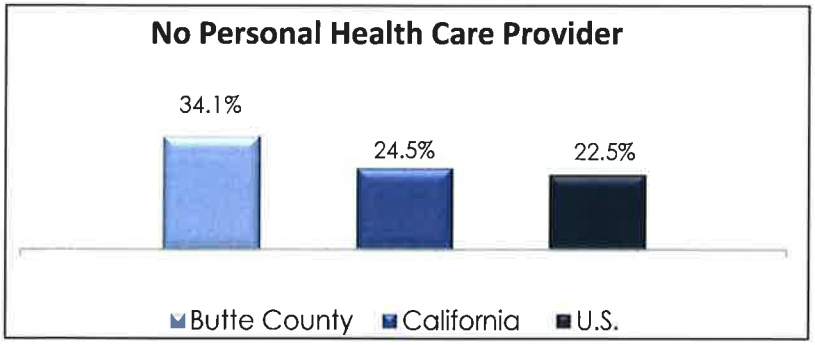
Healthy People 2020 objective AHS-3: Increase the proportion of persons with a usual primary care provider

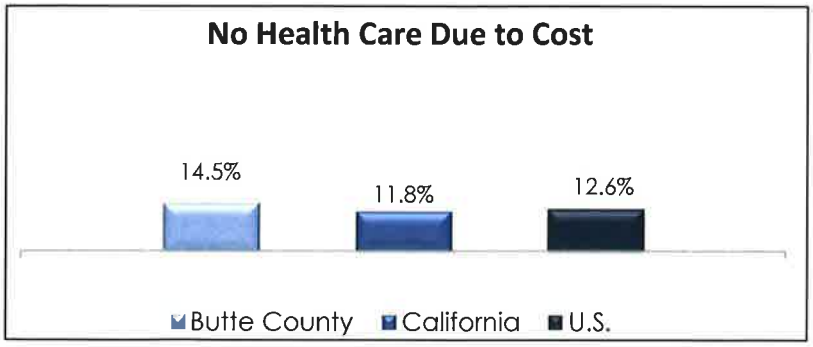
Healthy People 2020 objective AHS-6: Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines

Two additional indicators that address issues related to health care access include not having a personal doctor or health care provider and having had a time during the past 12 months when health care was needed but could not be obtained because of cost.

More than one-third (34.1%) of Butte County adults do not have a personal doctor or health care provider – a figure substantially above state- and nationwide rates (24.5% and 22.5%, respectively.) Moreover, 14.5% of Butte County residents could not see a doctor because of the cost.

As in the past, men are more likely than women to have no personal health care provider (38% vs. 30.2%.) Moreover, no access to a personal provider and cost barriers are cited more often among less educated and less affluent population segments. Hispanics are the most likely cohort to report having no personal health care provider. Finally, the likelihood of having a personal provider is lowest among those under the age of 35, and the likelihood of not being able to see a doctor due to cost is highest among those under the age of 24.





Percentage of respondents with no personal health care provider and percentage of respondents who reported an instance of not obtaining care due to cost

Demographic Characteristics	No Personal Health Care Provider	No Health Care Access Due to Cost
Total	34.1%	14.5%
Age		
18-24	51.7%	23.4%
25-34	52.9%	17.9%
35-44	33.0%	16.2%
45-54	32.6%	15.7%
55-64	17.9%	8.8%
65+	17.5%	6.5%
Gender		
Male	38.0%	15.0%
Female	30.2%	13.9%
Race		
White	31.9%	12.8%
Black**	34.3%	19.2%
Hispanic	46.2%	16.6%
Non-Hispanic	31.8%	14.3%
Education		
< High School	48.1%	28.9%
High School Grad	34.6%	12.0%
Some College	38.4%	18.0%
College Graduate	26.0%	9.4%
Household Income		
<$20,000	42.8%	18.4%
$20,000-$34,999	30.9%	26.9%
$35,000-$$49,999**	23.4%	7.6%
$50,000-$74,999	26.0%	14.8%
$75,000 or more	25.4%	7.6%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Health Care Access: No Routine Checkup

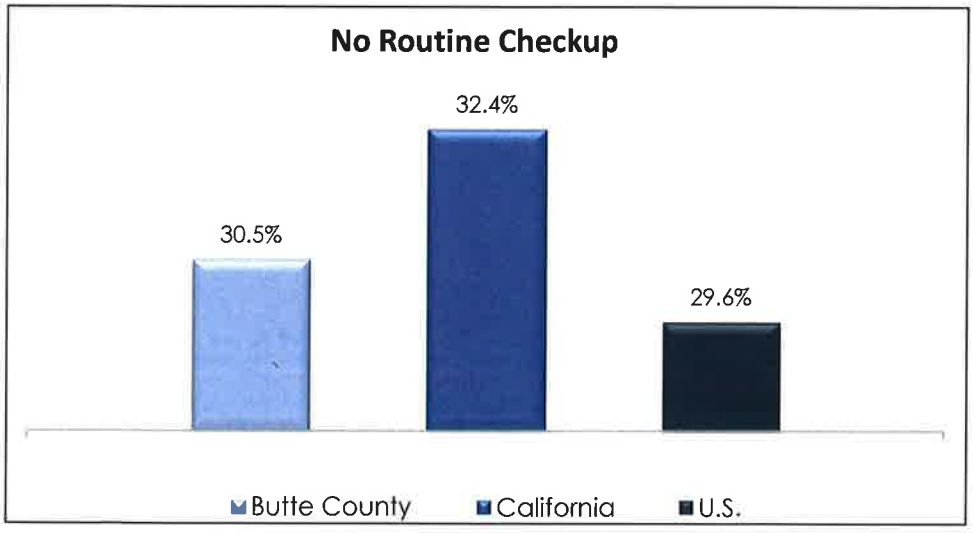
A yearly routine checkup with a health care professional provides an opportunity to raise awareness regarding adult preventive services, conduct individual risk assessments, promote informed decision-making, and potentially benefit from early detection.

Butte County residents are less likely than Californians overall to report not having a routine checkup within the past year (30.5% vs. 32.4%.) The figure observed in the County is consistent with the nationwide results (29.6%.)

A more in-depth analysis reveals that males are more likely to have had no checkup than females (35.3% vs. 25.9%)..Moreover, African Americans (54.3%) and Hispanic residents (55.3%) are more likely to report no checkup than their Caucasian counterparts (28.2%.) Finally, the likelihood of having an annual checkup increases proportionately to residents' age and income.

Percentage of respondents who had no routine checkup in the past year

Demographic Characteristics	No Routine Checkup
Total	30.5%
Age	
18-24	46.9%
25-34	48.1%
35-44	32.5%
45-54	26.2%
55-64	21.2%
65+	11.4%
Gender	
Male	35.3%
Female	25.9%
Race	
White	28.2%
Black**	54.3%
Hispanic	55.3%
Non-Hispanic	26.4%
Education	
< High School	37.5%
High School Grad	34.9%
Some College	30.8%
College Graduate	25.7%
Household Income	
<$20,000	40.3%
$20,000-$34,999	37.4%
$35,000-$$49,999**	35.4%
$50,000-$74,999	23.1%
$75,000 or more	20.0%



**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Chronic Health Conditions: Heart Attack

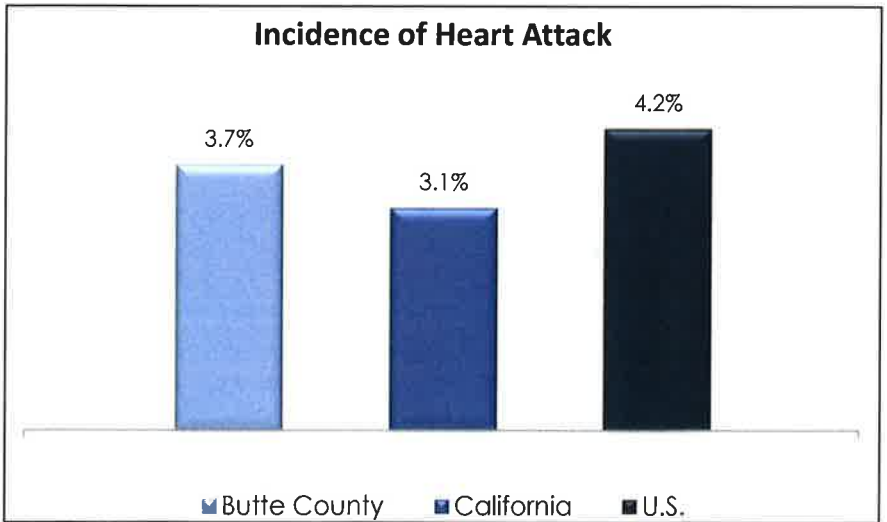
Healthy People 2020 objective HDS-1: Increase overall cardiovascular health in the U.S. population

Healthy People 2020 objective HDS-16: Increase the proportion of adults aged 20 years and older who are aware of the symptoms of and how to respond to a heart attack

In 2015, an estimated 114,023 deaths were attributable to heart attacks in the United States. An estimated 720,000 heart attacks and 335,000 recurrent heart attacks occur yearly among U.S. adults. The cost of heart attacks was $12.1 billion in 2013, which includes health care services, medication, and lost productivity.[33] Many risk factors for heart attack are the same as those for coronary artery disease, including high blood pressure, high cholesterol, smoking, family history of heart disease, obesity, physical inactivity, diabetes, and excessive alcohol consumption.[26]

A total of 3.7% of Butte County residents have ever been told that they had a heart attack. This result is only marginally higher than the California figure (3.1%) and on par with the national result (4.2%.)

Unsurprisingly, the prevalence of heart attacks is highest among residents age 55+.



Percentage of respondents who were told by a doctor that they had a heart attack

Demographic Characteristics	Ever Told You Had Heart Attack
Total	3.7%
Age	
18-24	1.9%
25-34	-
35-44	1.5%
45-54	3.2%
55-64	6.4%
65+	7.4%
Gender	
Male	4.0%
Female	3.4%
Race	
White	3.9%
Black**	8.6%
Hispanic	1.0%
Non-Hispanic	4.2%
Education	
< High School	2.1%
High School Grad	3.7%
Some College	2.6%
College Graduate	5.1%
Household Income	
<$20,000	4.8%
$20,000-$34,999	2.9%
$35,000-$$49,999**	7.0%
$50,000-$74,999	6.4%
$75,000 or more	1.9%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Chronic Health Conditions: Heart Disease

Healthy People 2020 objective HDS-1: Increase overall cardiovascular health in the U.S. population

Healthy People 2020 objective HDS-2: Reduce coronary heart disease deaths

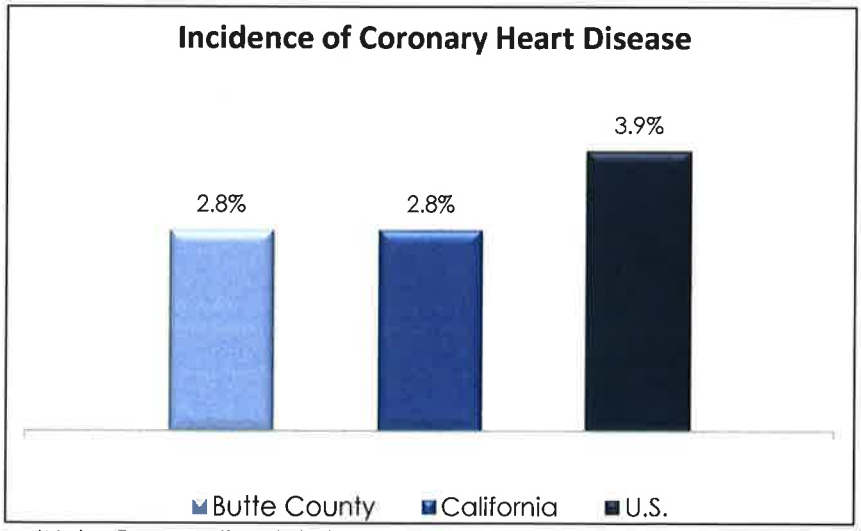
Heart disease and stroke are leading causes of death in the United States for both genders and across all ethnic groups. In 2017, in California, heart disease was the primary cause of death, claiming 62,797 lives.[12] Approximately 5.7 million people nationwide have heart failure, and about one-half of these individuals will die within five years of diagnosis. Cardiovascular disease costs the nation an estimated $31 billion annually.[13] Modifying cardiovascular disease risk factors offers the greatest potential for reducing death and disability.

Among Butte County adults, 2.8% have been told at some point that they had angina or coronary heart disease. This figure is on par with the current state data, and below the nationwide prevalence data.

Unsurprisingly, residents over the age of 65 report a significantly higher rate of heart disease than younger individuals.

Percentage of respondents who were told by a doctor that they had angina or coronary heart disease

Demographic Characteristics	Ever Told You Have Angina or Coronary Heart Disease
Total	2.8%
Age	
18-24	-
25-34	-
35-44	3.3%
45-54	-
55-64	2.5%
65+	10.0%
Gender	
Male	3.2%
Female	2.4%
Race	
White	2.9%
Black**	8.6%
Hispanic	0.5%
Non-Hispanic	3.2%
Education	
< High School	5.0%
High School Grad	3.2%
Some College	1.1%
College Graduate	3.7%
Household Income	
<$20,000	4.0%
$20,000-$34,999	-
$35,000-$$49,999**	8.8%
$50,000-$74,999	5.8%
$75,000 or more	1.1%



*Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents

Chronic Health Conditions: Stroke

Healthy People 2020 objective HDS-3: Reduce stroke deaths

Healthy People 2020 objective HDS-17: Increase the proportion of adults aged 20 years and older who are aware of the symptoms and how to respond to a stroke

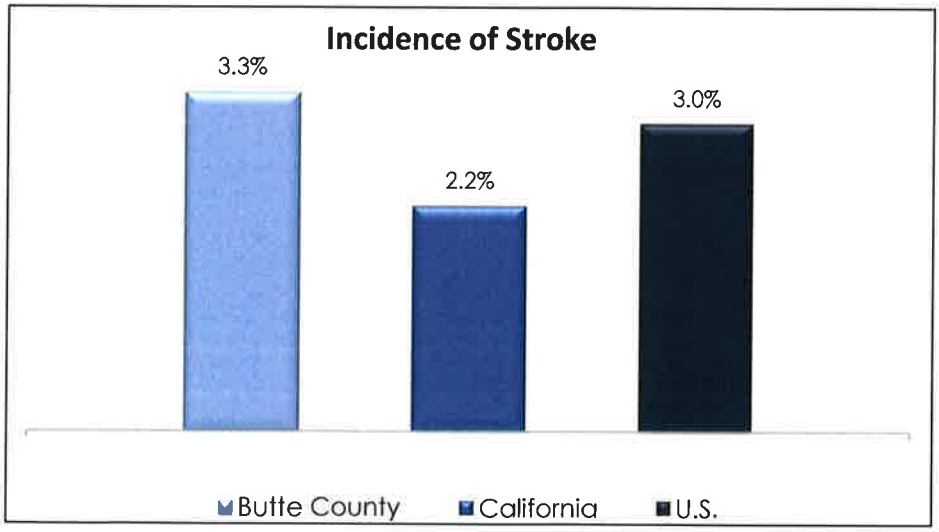
Stroke kills nearly 140,000 Americans each year – that's 1 of every 20 deaths. Stroke and Cardiovascular Heart Disease share many of the same risk factors. Although the health complications from stroke are severe, the risk of stroke can be greatly reduced by increasing physical activity, eating a balanced diet, avoiding drinking too much alcohol, and quitting smoking.[14]

The overall rate of stroke among Butte County adults is 3.3%. This figure is slightly above the state rate (2.2%,) but on par with the nationwide prevalence data (3.0%.)

Mirroring the patterns noted for other cardiovascular conditions, stroke is most common in the oldest age cohort (65+ years olds.)

Percentage of respondents who were told by a doctor that they had a stroke

Demographic Characteristics	Ever Told You Had a Stroke
Total	3.3%
Age	
18-24	-
25-34	-
35-44	3.3%
45-54	0.9%
55-64	3.0%
65+	11.6%
Gender	
Male	3.0%
Female	3.6%
Race	
White	3.7%
Black**	-
Hispanic	2.2%
Non-Hispanic	3.6%
Education	
< High School	3.1%
High School Grad	3.4%
Some College	3.3%
College Graduate	3.3%
Household Income	
<$20,000	5.7%
$20,000-$34,999	2.1%
$35,000-$$49,999**	5.2%
$50,000-$74,999	1.4%
$75,000 or more	2.2%



*Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents

Chronic Health Conditions: Asthma

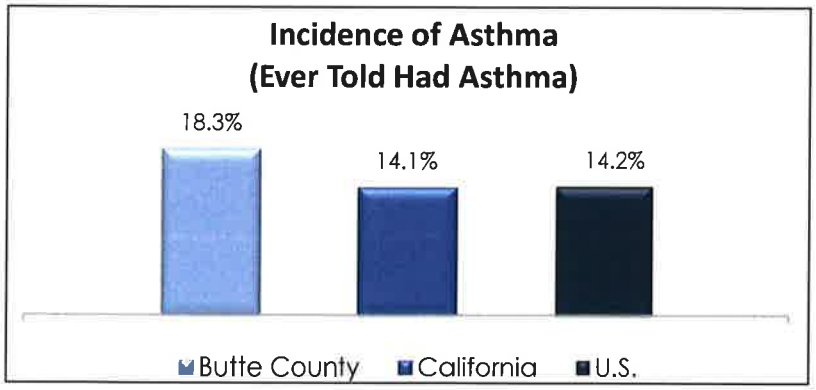
Healthy People 2020 objective RD-1: Reduce asthma deaths

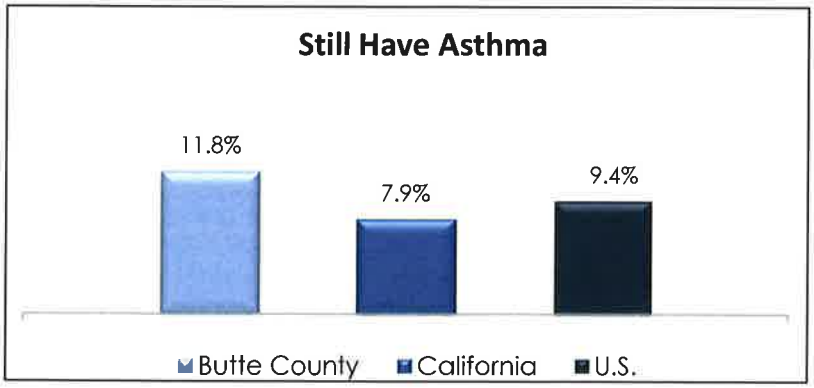
Healthy People 2020 objective RD-7: Increase the proportion of persons with current asthma who receive appropriate asthma care according to National Asthma Education and Prevention Program (NAEPP) guidelines

Asthma is a chronic inflammatory disorder of the lungs, and is characterized by wheezing, nighttime or early morning coughing, difficulty breathing, and chest tightness. Asthma attacks can be triggered by a variety of factors, such as pollution, tobacco smoke, dust mites, pets, mold, and/or respiratory infections. At present, over 25,000 Americans suffer from asthma. In 2016, the condition caused 188,968 hospitalizations, more than 1.8 million emergency department visits, and 9.8 million doctor visits.[15]

The incidence of self-reported asthma among Butte County adults is at 18.3%. This result is above the statewide and national rates (14.1% and 14.2%.) The prevalence of asthma peaks in the 25-34 age segment, as well as among females.

A total of 11.8% of Butte County residents currently have asthma – notably more than California and U.S.-wide figures (7.9% and 9.4%, respectively.) Residents most likely to still have asthma also include those ages 25-34, females, as well as those with lower income and education levels.





Percentage of respondents who have ever been told by a doctor that they had asthma, and percentage of respondents who still have asthma

Demographic Characteristics	Ever Told Have Asthma	Still Have Asthma
Total	18.3%	11.8%
Age		
18-24	17.5%	15.6%
25-34	31.7%	17.2%
35-44	19.5%	7.3%
45-54	18.2%	12.4%
55-64	14.6%	12.0%
65+	11.7%	6.8%
Gender		
Male	14.3%	10.5%
Female	22.2%	13.0%
Race		
White	17.1%	10.7%
Black**	16.0%	16.0%
Hispanic	22.5%	15.4%
Non-Hispanic	18.0%	11.4%
Education		
< High School	25.9%	12.1%
High School Grad	21.0%	17.0%
Some College	18.9%	11.4%
College Graduate	14.1%	8.2%
Household Income		
<$20,000	27.0%	19.9%
$20,000-$34,999	17.7%	15.9%
$35,000-$$49,999**	28.5%	13.6%
$50,000-$74,999	25.7%	13.2%
$75,000 or more	9.6%	7.3%

*Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents

Chronic Health Conditions: COPD, Emphysema or Bronchitis

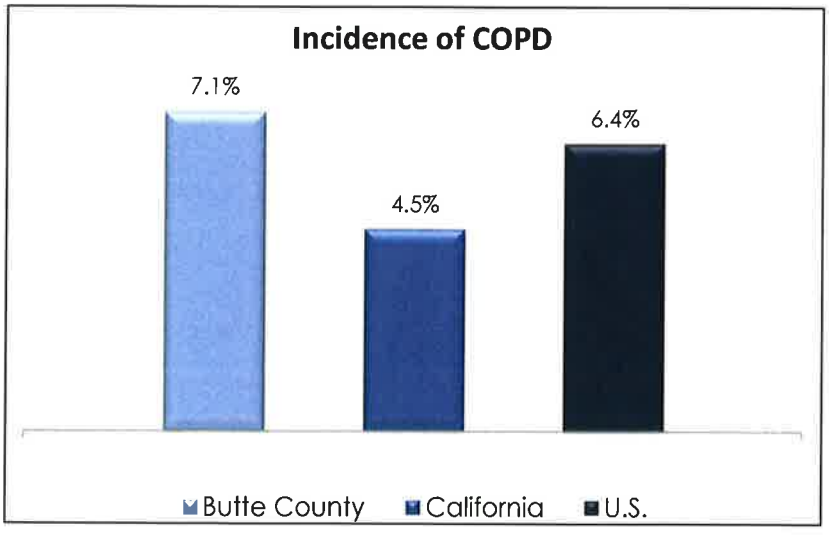
Healthy People 2020 objective RD-10: Reduce deaths from chronic obstructive pulmonary disease (COPD)

Healthy People 2020 objective RD-11: Reduce hospitalizations from chronic obstructive pulmonary disease (COPD)

People with chronic obstructive pulmonary disease (COPD) experience persistent breathing problems and low respiratory function. Three-quarters of COPD cases are linked to a history of smoking, with genetics and exposure to environmental irritants also contributing to the disease. A total of 16 million of Americans have been diagnosed with this condition, while 12 million more may have undiagnosed COPD. [26]

A total of 7.1% of Butte County residents has ever been told that they had COPD, emphysema, or chronic bronchitis. This figure is above the statewide data (4.5%), but only marginally higher than the national result (6.4%).

Like many other conditions, COPD is notably more prevalent among residents over the age of 55. It is also more frequent among non-Hispanic population of the County. Finally, residents with less than high school education, as well as those making under $50,000 per year, are more apt to report this diagnosis than their more educated and more affluent counterparts.



Percentage of respondents who were told by a doctor that they had COPD, emphysema or chronic bronchitis

Demographic Characteristics	Ever Told Had COPD, Emphysema or Chronic Bronchitis
Total	7.1%
Age	
18-24	-
25-34	4.2%
35-44	4.8%
45-54	4.6%
55-64	15.9%
65+	12.9%
Gender	
Male	6.4%
Female	7.9%
Race	
White	7.4%
Black**	17.2%
Hispanic	1.0%
Non-Hispanic	8.3%
Education	
< High School	13.7%
High School Grad	7.7%
Some College	7.8%
College Graduate	4.6%
Household Income	
<$20,000	13.3%
$20,000-$34,999	11.3%
$35,000-$$49,999**	12.2%
$50,000-$74,999	4.4%
$75,000 or more	4.2%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Chronic Health Conditions: Arthritis, Rheumatoid Arthritis, Gout, Lupus or Fibromyalgia

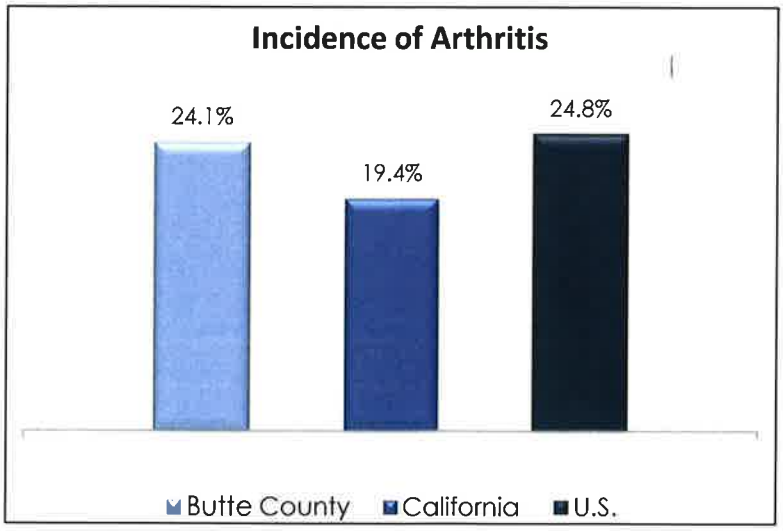
Healthy People 2020 objective AOCBC-1: Reduce the mean level of joint pain among adults with doctor-diagnosed arthritis

Healthy People 2020 objective AOCBC-7: Increase the proportion of adults with doctor-diagnosed arthritis who receive health care provider counseling

Over 54 million Americans have arthritis, a condition that can cause severe, chronic joint pain. Arthritis is a leading cause of disability, and over half of people living with this condition says it interferes with their daily activities.[26] Arthritis can take many forms such as rheumatoid arthritis (an autoimmune disease causing painful swelling,) gout (a form of inflammatory arthritis affecting one joint at a time) fibromyalgia (a condition causing abnormal pain perception processing)[39] or lupus (an autoimmune disease that can damage any part of the body.)[40]

Nearly one-quarter (24.1%) of Butte County residents have been diagnosed with some form of arthritis. This result is above the statewide figure (19.4%,) and on par with the national data (24.8%.)

The incidence of arthritis increases in proportion to residents' age. It is also more common among non-Hispanic respondents, and slightly more prevalent among females.



Percentage of respondents who were told by a doctor that they had some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia

Demographic Characteristics	Ever Told Had Arthritis, Rheumatoid Arthritis, Gout, Lupus or Fibromylagia
Total	24.1%
Age	
18-24	3.8%
25-34	3.3%
35-44	14.5%
45-54	21.8%
55-64	45.2%
65+	51.4%
Gender	
Male	21.1%
Female	27.0%
Race	
White	25.5%
Black**	37.3%
Hispanic	11.2%
Non-Hispanic	26.3%
Education	
< High School	25.5%
High School Grad	24.7%
Some College	23.1%
College Graduate	24.5%
Household Income	
<$20,000	31.9%
$20,000-$34,999	27.5%
$35,000-$$49,999**	26.8%
$50,000-$74,999	33.5%
$75,000 or more	23.9%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Chronic Health Conditions: Depressive Disorder

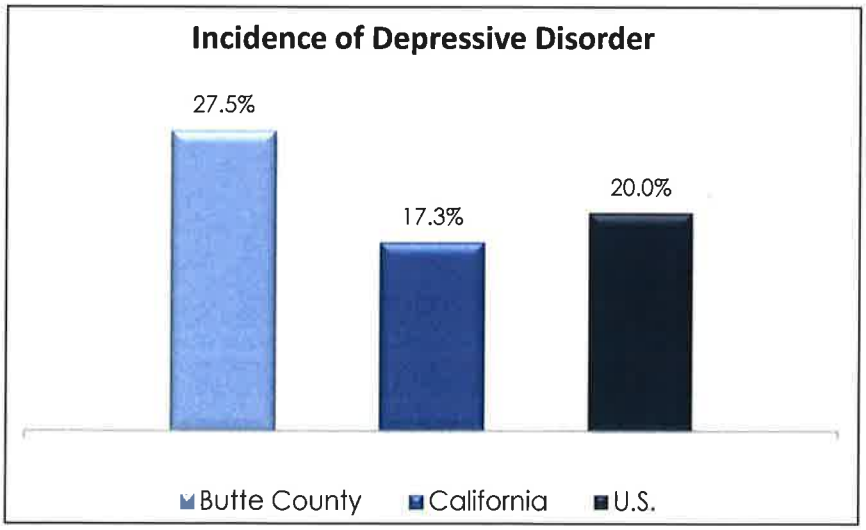
Healthy People 2020 objective MHMD-11: Increase depression screening by primary care workers

Healthy People 2020 objective MHMD-4: Reduce the proportion of persons who experience major depressive episodes (MDEs)

Depression is a common and treatable mental disorder characterized by changes in mood, and cognitive and physical symptoms over a period of time. It is the leading cause of disability in the U.S., associated with high societal costs and greater functional impairment than many other chronic diseases, including diabetes and arthritis.[41] The most commonly diagnosed form of depression is major depressive disorder. In 2015, approximately 16.1 million Americans had experienced at least one major depressive episode in the last year.[42]

Nearly three in ten residents of Butte County (27.5%) have ever been told that they had a depressive disorder (depression, major depression, dysthymia) or minor depression. This rate is considerably above the figure observed for California as a whole (17.3%,) as well as above the national data (20%.)

The likelihood of this diagnosis is inversely proportional to residents' age, with younger individuals being more likely to suffer from depression than their older counterparts. Moreover, females are more apt to be depressed than males. Finally, the lower income segments (and particularly those with less than $20,000 per year) are more likely to feel this way than their more affluent counterparts.



Percentage of respondents who were told by a doctor that they had a depressive disorder, or minor depression

Demographic Characteristics	Ever Told Had Depressive Disorder
Total	27.5%
Age	
18-24	30.2%
25-34	36.0%
35-44	35.3%
45-54	29.0%
55-64	27.1%
65+	13.2%
Gender	
Male	21.6%
Female	33.3%
Race	
White	27.0%
Black**	39.4%
Hispanic	35.7%
Non-Hispanic	26.7%
Education	
< High School	22.0%
High School Grad	29.1%
Some College	32.2%
College Graduate	22.9%
Household Income	
<$20,000	44.1%
$20,000-$34,999	25.4%
$35,000-$$49,999**	14.4%
$50,000-$74,999	19.4%
$75,000 or more	20.4%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Chronic Health Conditions: Kidney Disease

Healthy People 2020 objective CKD-1: Reduce the proportion of the U.S. population with chronic kidney disease

Healthy People 2020 objective CKD-7: Reduce the number of deaths among persons with chronic kidney disease

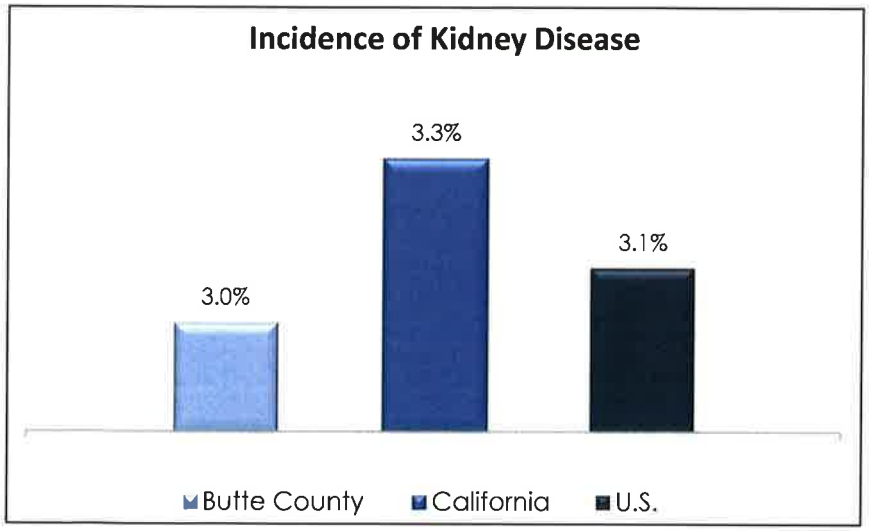
Chronic kidney disease (CKD) is a condition in which kidneys are damaged and cannot filter blood the way they should. In early stages, CKD may go undetected, and the only way to diagnose the condition is through specific blood and urine tests. Adults with diabetes, high blood pressure, heart disease, obesity, lupus, and a family history of CKD have a higher risk of developing the condition.[43] If untreated, the disease may progress to kidney failure – a condition currently affecting more than 661,000 Americans. Each year, kidney disease kills more people than breast and prostate cancer.[44] Eating more fruit and vegetables, staying physically active, and getting regular checkups are the best prevention methods.[43]

At 3%, the incidence of kidney disease in Butte County is on par with the statewide and nationwide rates (3.3% and 3.1%, respectively.)

Residents over the age of 65% are the highest risk of this condition.

Percentage of respondents who were told by a doctor that they had kidney disease

Demographic Characteristics	Ever Told Had Kidney Disease
Total	3.0%
Age	
18-24	-
25-34	-
35-44	-
45-54	3.0%
55-64	4.8%
65+	9.0%
Gender	
Male	3.1%
Female	3.0%
Race	
White	3.5%
Black**	-
Hispanic	-
Non-Hispanic	3.6%
Education	
< High School	2.7%
High School Grad	4.3%
Some College	2.9%
College Graduate	2.2%
Household Income	
<$20,000	2.8%
$20,000-$34,999	5.3%
$35,000-$$49,999**	3.6%
$50,000-$74,999	4.8%
$75,000 or more	3.8%



*Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents

Chronic Health Conditions: Skin Cancer

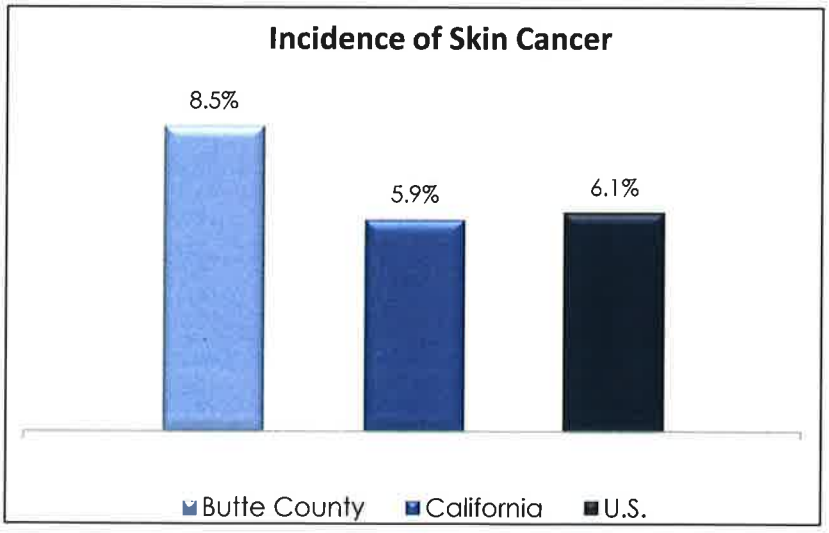
Healthy People 2020 objective C-8: Reduce the melanoma cancer death rate

Healthy People 2020 objective C-20: Increase the proportion of persons who participate in behaviors that reduce their exposure to harmful ultraviolet (UV) irradiation and avoid sunburn

In the U.S., more than 9,500 people are diagnosed with skin cancer every day. On an annual basis, that is more than all other cancers combined.[35] In 2016, the melanoma type of skin cancer was the 6th most common cancer as measured by new cases nationwide. In the same year, 9,535 melanoma cases were reported in California.[36] The annual cost of treating skin cancers in the U.S. is estimated at $8.1 billion.[35]

The overall rate of skin cancer among Butte County adults is 8.5%. This figure is above both the state rate (5.9%) and the national prevalence data (6.1%).

The incidence of skin cancer is directly proportional to residents' ages, with a peak in the 65+ age segment. White respondents are also notably more likely to report having skin cancer than their Hispanic counterparts.



Percentage of respondents who were told by a doctor that they had skin cancer

Demographic Characteristics	Ever Told You Had Skin Cancer
Total	8.5%
Age	
18-24	1.9%
25-34	1.5%
35-44	4.5%
45-54	5.1%
55-64	12.7%
65+	22.8%
Gender	
Male	7.5%
Female	9.5%
Race	
White	9.4%
Black**	14.6%
Hispanic	3.2%
Non-Hispanic	9.1%
Education	
< High School	5.3%
High School Grad	6.1%
Some College	9.6%
College Graduate	9.9%
Household Income	
<$20,000	6.3%
$20,000-$34,999	9.1%
$35,000-$$49,999**	17.5%
$50,000-$74,999	19.1%
$75,000 or more	7.4%

*Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents

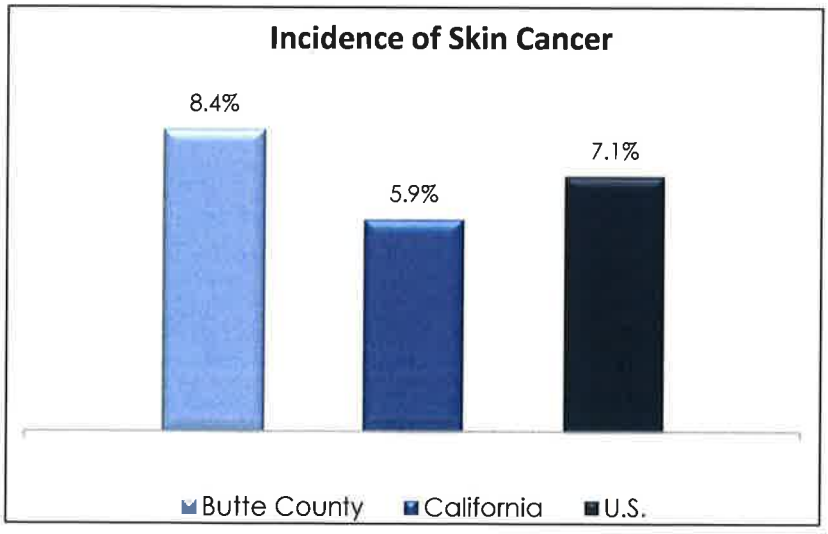
Chronic Health Conditions: Other Types of Cancer

Healthy People 2020 objective C-1: Reduce the overall cancer death rate

Cancer is the second-leading cause of death in the United States, behind heart disease. The most common cancers in the nation – breast, prostate, lungs and bronchus, and colorectal cancer – are responsible for the most deaths. Smoking is a factor in 32% of cancer deaths, and avoiding tobacco use is the best way to reduce that rate.[26] In 2017, in California, cancer was the cause of 59,516 deaths.[12] The cost of cancer care is expected to increase to nearly $158 billion by 2020.[37] The estimated cost of lost productivity from cancer mortality is $146.7 billion in 2020.[38]

The overall rate of cancer (other than skin cancer) among Butte County adults is 8.4%. This figure is higher than the state rate (5.9%) and somewhat above the national prevalence data (7.1%.)

Residents age 55+ are more likely than those younger to develop other types of cancer. Non-Hispanics are also slightly more likely to have been diagnosed with cancer than Hispanic respondents, and those in the bottom income and education brackets are somewhat more likely to have been told they had it than their more educated and more affluent counterparts.



Percentage of respondents who were told by a doctor that they had any other types of cancer

Demographic Characteristics	Ever Told Had Any Other Types of Cancer
Total	8.4%
Age	
18-24	3.5%
25-34	1.5%
35-44	8.4%
45-54	2.3%
55-64	11.9%
65+	20.4%
Gender	
Male	8.0%
Female	8.9%
Race	
White	8.3%
Black**	-
Hispanic	2.5%
Non-Hispanic	9.4%
Education	
< High School	20.4%
High School Grad	7.9%
Some College	7.2%
College Graduate	7.6%
Household Income	
<$20,000	11.0%
$20,000-$34,999	8.1%
$35,000-$$49,999**	9.1%
$50,000-$74,999	7.6%
$75,000 or more	9.3%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Cancer Survivorship: Treatment & Clinical Trial Participation

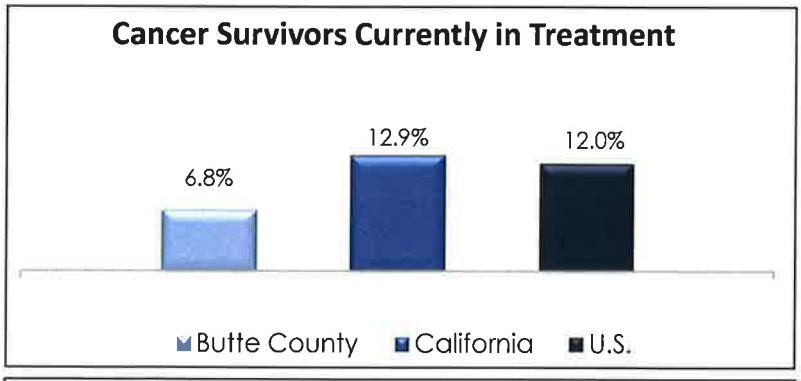
Healthy People 2020 objective C-1: Reduce the overall cancer death rate

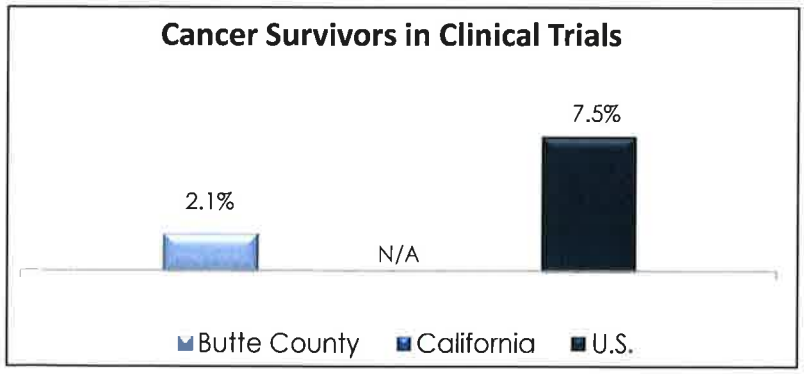
The term "cancer survivor" refers to any person with a history of cancer, from the time of the diagnosis through the remainder of their life. There are three phases of cancer survival: the time from diagnosis to the end of initial treatment, the transition from treatment to extended survival, and long-term survival.

Cancer treatments may include surgery, chemotherapy, radiation therapy, hormone therapy, immunotherapy, or stem cell/bone marrow transplant. Treatments may be used alone or in combination, depending on the kind and stage of cancer. Patients may also choose to join a clinical trial to help find out which treatments are safe and if they work well. In 2016, an estimated 15.5 million Americans survived cancer. Among them were 1.7 million Californians.[15]

A total of 6.8% of Butte County residents are cancer survivors who are currently in treatment. This is roughly half of the percentages estimated for the state and the U.S. as a whole (12.9% and 12.0%, respectively.)

Additionally, 2.1% of those who completed treatment participated in clinical trials. This is notably less than the 7.5% noted nationwide.





Percentage of respondents who are currently in treatment, and percentage of respondents who participated in clinical trial

Demographic Characteristics	Currently in Treatment	Participated in Clinical Trial
Total	6.8%	2.1%
Age		
18-24	-**	-**
25-34	-**	-**
35-44	-**	-**
45-54	-**	-**
55-64	12.1%**	-**
65+	8.4%	4.6%**
Gender		
Male**	10.6%	2.2%
Female	4.0%	2.0%
Race		
White	6.7%	2.4%%
Black**	-	-
Hispanic**	-	-
Non-Hispanic	7.5%	2.3%
Education		
< High School**	10.8%	-
High School Grad**	7.6%	2.0%
Some College**	5.4%	-
College Graduate**	6.6%	5.0%
Household Income		
<$20,000**	11.9%	2.5%
$20,000-$34,999**	16.4%	-
$35,000-$$49,999**	-	-
$50,000-$74,999**	4.6%	-
$75,000 or more**	5.5%	9.7%

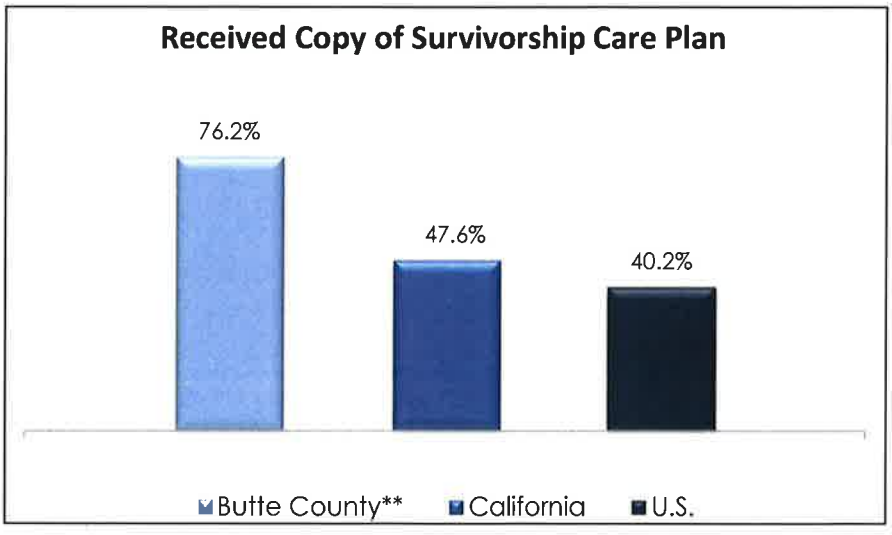
*Note: Comparative data is based on 2009 BRFSS of California Residents and 2009 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents

Cancer Survivorship: Survivorship Care Plan

Healthy People 2020 objective C-13: Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis

A survivorship care plan is a record of the survivor's cancer and treatment history, as well as any checkups or follow-up tests needed in the future. It may also list ideas for staying healthy. It is recommended that survivorship care plans address the chronic effects of cancer (pain, fatigue, depression/anxiety), as well as monitoring for and preventing late effects (osteoporosis, heart disease, second malignancies.) They should also explicitly identify the providers responsible for each aspect of ongoing care and provide information on resources available for psychosocial issues that may arise as a result of the prior cancer diagnosis.[32]

More than three-quarters of Butte County cancer survivors received a copy of their survivorship care plan. This percentage is observably above the state- and nationwide figures (47.6% and 40.2%;) however, this result needs to be treated with caution due to a very small sample size (n=14.)



Percentage of respondents who received copy of survivorship care plan

Demographic Characteristics	Received copy of survivorship care plan
Total**	76.2%
Age	
18-24**	-
25-34**	100%
35-44**	-
45-54**	100%
55-64**	80.0%
65+**	67.1%
Gender	
Male**	54.4%
Female**	87.8%
Race	
White**	75.5%
Black**	100.0%
Hispanic**	100.0%
Non-Hispanic**	75.5%
Education	
< High School**	-
High School Grad**	100.0%
Some College**	86.1%
College Graduate**	83.5%
Household Income	
<$20,000**	100.0%
$20,000-$34,999**	71.5%
$35,000-$$49,999**	72.5%
$50,000-$74,999**	66.5%
$75,000 or more**	100.0%

*Note: Comparative data is based on 2009 BRFSS of California Residents and 2009 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents

Hypertension Awareness

Healthy People 2020 objective HD S-5: Reduce the proportion of adults with hypertension

High blood pressure, also known as hypertension, is a major and modifiable risk factor for heart disease and stroke. In 2015, there were 427,631 deaths in the United States with any mention of high blood pressure, 78,862 of which were primarily attributable to high blood pressure. As of 2017, nearly half of Americans (45.6%) were estimated to have high blood pressure,[33] but because it often has no sign or symptoms, only 54% of adults with the condition have it under control.[34] High blood pressure is influenced by factors such as smoking, obesity, physical inactivity, poor diet, and excessive alcohol use.[26]

Approximately one-third of Butte County residents have ever been told by a doctor that they had high blood pressure. This is above the state figure (28.4%) and on par with the nationwide result (32.3%).

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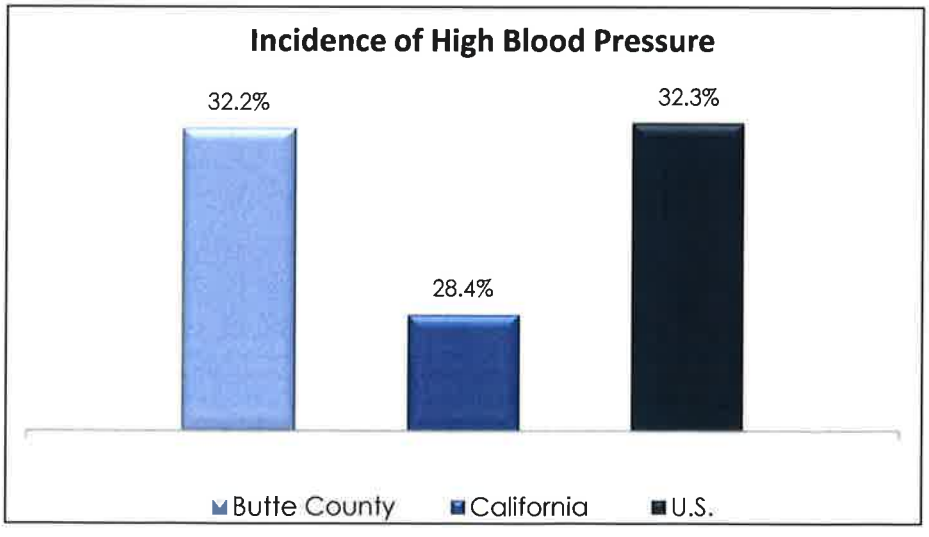
The incidence of high blood pressure increases proportionately to age and is most prevalent among African American residents.



Percentage of respondents who have ever been told by a doctor that they had high blood pressure

Demographic Characteristics	Ever Told Have High Blood Pressure
Total	32.2%
Age	
18-24	11.6%
25-34	14.8%
35-44	28.3%
45-54	32.2%
55-64	48.0%
65+	55.6%
Gender	
Male	30.6%
Female	33.8%
Race	
White	33.5%
Black**	46.9%
Hispanic	21.6%
Non-Hispanic	34.2%
Education	
< High School	32.7%
High School Grad	27.7%
Some College	31.8%
College Graduate	36.2%
Household Income	
<$20,000	38.0%
$20,000-$34,999	29.1%
$35,000-$$49,999**	34.8%
$50,000-$74,999	40.0%
$75,000 or more	36.8%

*Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents

Cholesterol Awareness

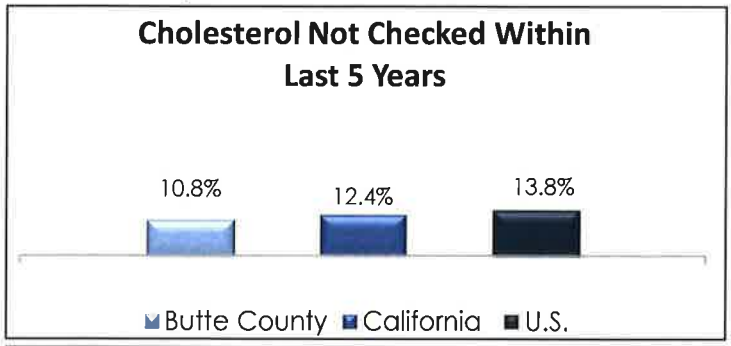
Healthy People 2020 objective HD S-6: Reduce the proportion of adults with who have had their blood cholesterol checked within the preceding 5 years

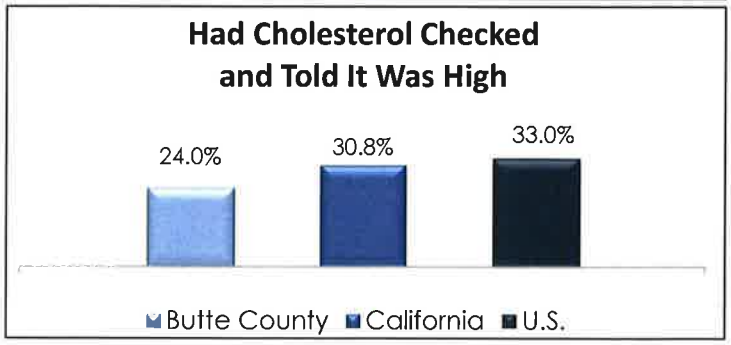
Healthy People 2020 objective HD S-7: Reduce the proportion of adults with high total blood cholesterol levels

High cholesterol is a major and modifiable risk factor for heart disease and stroke. The American Heart Association recommends adults aged 20+ have their cholesterol checked every 4-to-6 years. High cholesterol has no symptoms, but it can be detected with a simple blood test.[26] At present, an estimated 28.5 million Americans have high cholesterol levels.[33]

A total of 11% of Butte County residents have not had their blood cholesterol checked within the last 5 years. This result is below the figures noted for California as a whole (12.4%) and the U.S. (13.8%). Respondents most likely not to have their cholesterol checked include those with less than high school education and those with incomes below the $35,000 threshold.

Additionally, just under one-quarter (24%) had their blood cholesterol checked and have been told that it was high. Again, this is below the state- and nationwide figures (30.8% and 33%, respectively.) High cholesterol levels are most prevalent among non-Hispanics, and increase proportionately to residents' age.





Percentage of respondents who have had blood cholesterol checked within the last 5 years, and percentage of respondents told it was high

Demographic Characteristics	Cholesterol Not Checked Within Last 5 Years	Cholesterol Checked and Told It Was High
Total	10.8%	24.0%
Age		
18-24	10.2%	2.0%
25-34	25.9%	10.3%
35-44	11.1%	18.7%
45-54	4.2%	27.5%
55-64	10.0%	36.5%
65+	4.9%	42.2%
Gender		
Male	12.3%	24.5%
Female	9.1%	23.5%
Race		
White	10.5%	25.8%
Black**	8.6%	22.9%
Hispanic	13.8%	17.1%
Non-Hispanic	10.5%	25.0%
Education		
< High School	17.0%	24.9%
High School Grad	9.5%	22.3%
Some College	10.8%	19.0%
College Graduate	10.3%	29.7%
Household Income		
<$20,000	13.3%	26.2%
$20,000-$34,999	28.4%	26.5%
$35,000-$$49,999**	5.0%	35.3%
$50,000-$74,999	3.7%	29.3%
$75,000 or more	4.5%	27.6%

*Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents

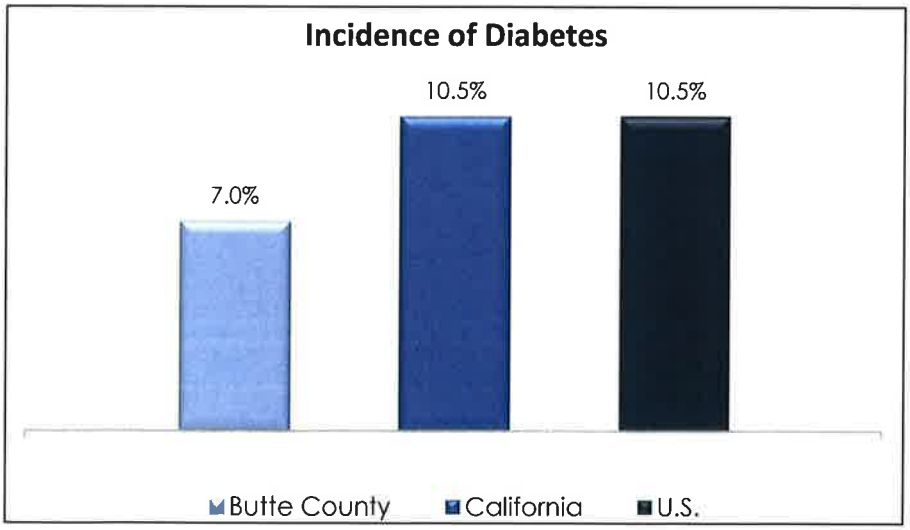
Diabetes

Healthy People 2020 objective D-1: Reduce the annual number of new cases of diagnosed diabetes in the population

Diabetes mellitus is a chronic disease characterized by high glucose levels, owing to insufficient production of insulin by the pancreas or to a reduction in the body's ability to use insulin. In the last 20 years, the number of adults diagnosed with diabetes has more than tripled as the US population has aged and become more overweight.[16] In California, diabetes was the seventh leading cause of death with 9,595 deaths in 2017.[17] Obesity, physical inactivity, being 45 years or older, and/or having a family history of diabetes are just a few of the known risk factors that are associated with the development of diabetes.[18]

At 7.0%, the incidence of diabetes among Butte County residents is considerably lower than the state- and nationwide rates (10.5% each.)

Incidence of diabetes increases substantially with the age of residents. It is also somewhat higher among individuals with less than high school education, and among those with lower income levels (up to $49,999 per year.)



Percentage of respondents who had ever been told by a doctor that they have diabetes (excluding gestational diabetes)

Demographic Characteristics	Ever Told You Have Diabetes
Total	7.0%
Age	
18-24	-
25-34	-
35-44	4.2%
45-54	7.1%
55-64	13.5%
65+	15.6%
Gender	
Male	6.9%
Female	7.1%
Race	
White	6.8%
Black**	13.2%
Hispanic	5.6%
Non-Hispanic	7.4%
Education	
< High School	14.2%
High School Grad	4.5%
Some College	6.6%
College Graduate	7.8%
Household Income	
<$20,000	7.3%
$20,000-$34,999	15.5%
$35,000-$$49,999**	11.9%
$50,000-$74,999	5.1%
$75,000 or more	4.6%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Tobacco Use

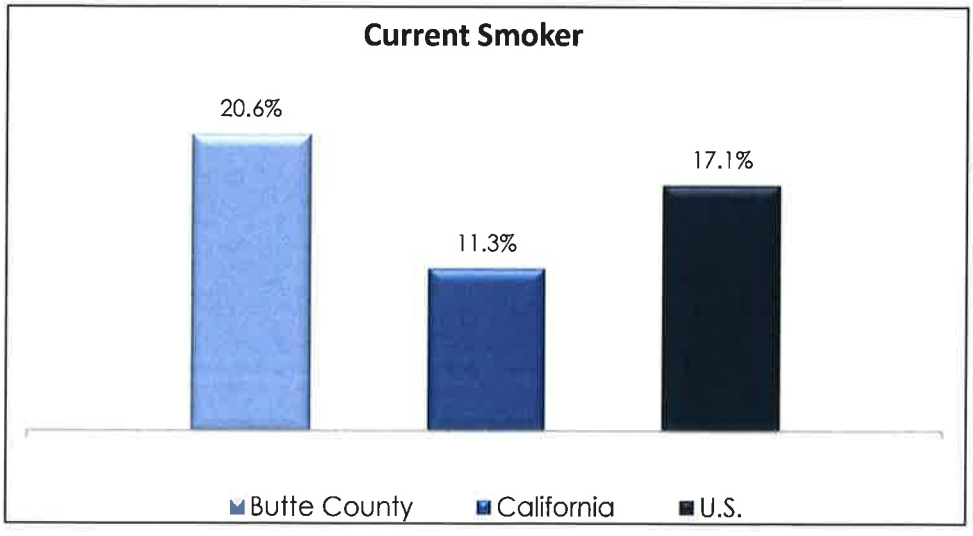
Healthy People 2020 objective TU-1: Reduce tobacco use by adults

Healthy People 2020 objective TU-14: Increase the proportion of smoke-free homes

Smoking contributes to the development of many kinds of chronic conditions, including cancers, respiratory diseases, diabetes, and cardiovascular diseases. It is "the leading cause of preventable death"[19] and "one of the biggest public health threats the world has ever faced, killing more than 8 million people a year."[20] It has been estimated that smoking costs the United States more than $170 billion in annual medical costs and another $156 billion in lost economic productivity,[21] as well as over 5 million years of potential life lost each year.[22] Current smoking status is defined as ever having smoked 100 cigarettes (five packs) and smoking cigarettes now, either every day or on some days.

Approximately one-fifth (20.6%) of Butte County residents are current smokers, based on the definition cited above. This figure is substantially above the state- and nationwide rates (11.3% and 17.1%).

Prevalence of smoking is least common among respondents under the age of 24 and over the age of 65, as well as college graduates. Females are also slightly less likely to be current smokers than males.



Percentage of respondents who are current smokers

Demographic Characteristics	Current Smoker
Total	20.6%
Age	
18-24	18.8%
25-34	25.9%
35-44	28.6%
45-54	22.7%
55-64	22.6%
65+	10.2%
Gender	
Male	23.1%
Female	18.2%
Race	
White	21.1%
Black**	37.3%
Hispanic	16.7%
Non-Hispanic	20.9%
Education	
< High School	30.6%
High School Grad	25.4%
Some College	23.6%
College Graduate	11.9%
Household Income	
<$20,000	28.1%
$20,000-$34,999	31.7%
$35,000-$$49,999**	5.3%
$50,000-$74,999	28.6%
$75,000 or more	8.7%

*Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents

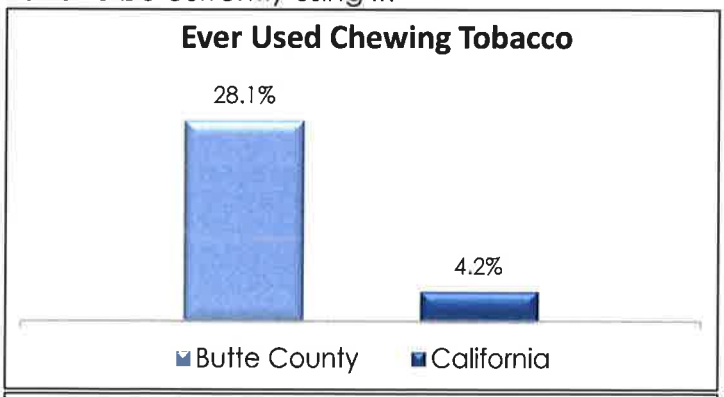
Other Tobacco Use: Chewing Tobacco

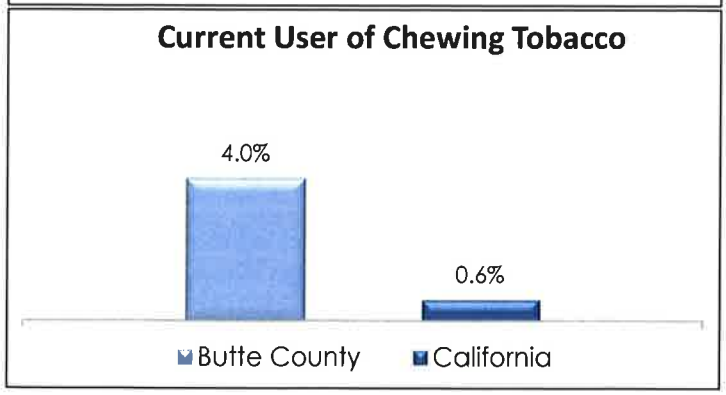
Healthy People 2020 objective TU-1.2: Reduce use of smokeless tobacco products by adults

Chewing tobacco and snuff are commonly used forms of tobacco in the United States in addition to cigarettes. Several oral health problems are associated with smokeless tobacco including receding gums, mouth sores and plaques, dental cavities and tooth abrasions.[22] Smokeless tobacco is a known cause of oral cancer and oral disease, and also may increase risk of pancreatic cancers, early delivery and stillbirth, heart disease and stroke.[22] Current user status is defined as having used chewing tobacco at least once during lifetime and using it on 1 or more day in the past 30 days.

Nearly three in ten residents of Butte County have ever used chewing tobacco, and a total of 4% are current users, as defined above. Both metrics are notably above statewide figures.

Males are notably more likely than females to have ever used chewing tobacco and to be current users. Likewise, residents in the top income bracket ($75+) are more likely than their less affluent counterparts to have ever tried it and to be currently using it.





Percentage of respondents who have ever used chewing tobacco, and percentage of respondents who are current users of chewing tobacco

Demographic Characteristics	Ever Used Chewing Tobacco	Current User of Chewing Tobacco
Total	28.1%	4.0%
Age		
18-24	18.2%	2.4%
25-34	35.0%	8.9%
35-44	42.0%	7.3%
45-54	42.7%	3.2%
55-64	26.9%	3.6%
65+	10.8%	0.8%
Gender		
Male	45.7%	7.1%
Female	10.8%	1.1%
Race		
White	30.7%	4.4%
Black**	41.8%	8.6%
Hispanic	25.0%	2.2%
Non-Hispanic	27.9%	4.4%
Education		
< High School	25.4%	9.7%
High School Grad	35.1%	5.5%
Some College	28.0%	2.0%
College Graduate	23.5%	3.8%
Household Income		
<$20,000	23.7%	3.6%
$20,000-$34,999	27.5%	1.5%
$35,000-$$49,999**	14.9%	4.1%
$50,000-$74,999	20.1%	2.8%
$75,000 or more	32.6%	6.5%

**Note: Comparative data is based on 2015 BRFSS of California Residents. National comparative data is not available in this category **Caution: Fewer than 30 respondents*

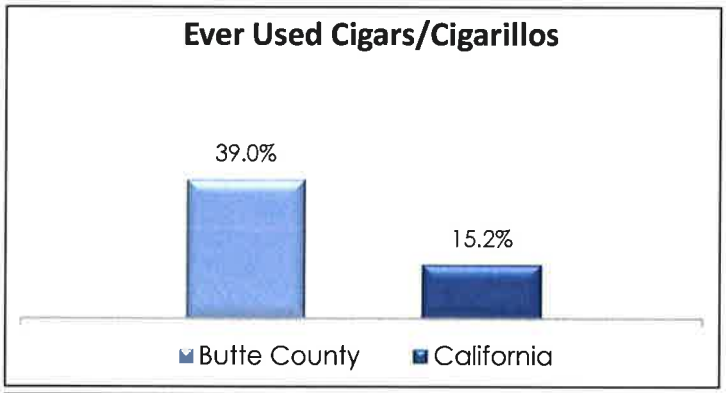
Other Tobacco Use: Cigars/Cigarillos

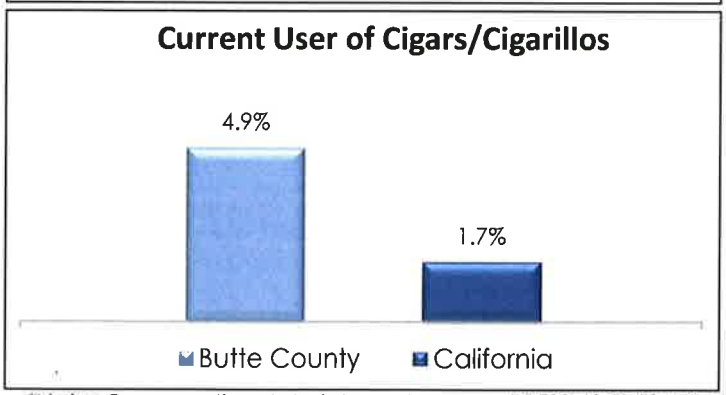
Healthy People 2020 objective TU-1.3: Reduce use of cigars, cigarillos, and little filtered cigars by adults

Healthy People 2020 objective TU-14: Increase the proportion of smoke-free homes

In the United States, cigarette consumption declined during 2000-2011. However, consumption of cigars more than doubled during the same period.[47] The three major types of cigars sold in the U.S. are large cigars, cigarillos and little cigars. All of them contain the same toxic and carcinogenic compounds found in cigarettes, and are associated with an increased risk for cancers of the lung, oesophagus, larynx, and oral cavity. They are also linked to gum disease and tooth loss, coronary heart disease, and lung diseases (such as emphysema and chronic bronchitis).[48] Current user status is defined as having used cigars/cigarillos at least once during lifetime and using them on 1 or more day in the past 30 days.

Approximately four in ten residents of Butte County have ever used cigars or cigarillos/little cigars, and a total of 4.9% are current users. Both metrics are notably above statewide figures. Males are more likely than females to have ever used and to be currently using cigars/cigarillos,





Percentage of respondents who have ever used cigars/cigarillos, and percentage of respondents who are current users of cigars/cigarillos

Demographic Characteristics	Ever Used Cigars/ Cigarillos	Current User of Cigars/ Cigarillos
Total	39.0%	4.9%
Age		
18-24	25.5%	5.9%
25-34	49.5%	8.1%
35-44	49.6%	8.2%
45-54	38.0%	3.3%
55-64	42.6%	4.5%
65+	34.1%	1.3%
Gender		
Male	54.2%	6.6%
Female	24.1%	3.3%
Race		
White	41.1%	4.5%
Black**	34.1%	-
Hispanic	39.2%	5.2%
Non-Hispanic	38.4%	4.9%
Education		
< High School	38.6%	9.7%
High School Grad	37.7%	6.7%
Some College	41.2%	4.5%
College Graduate	37.8%	3.0%
Household Income		
<$20,000	34.2%	6.7%
$20,000-$34,999	47.8%	5.2%
$35,000-$$49,999**	32.3%	2.1%
$50,000-$74,999	41.6%	10.8%
$75,000 or more	48.4%	0.6%

**Note: Comparative data is based on 2015 BRFSS of California Residents. National comparative data is not available in this category **Caution: Fewer than 30 respondents*

Other Tobacco Use: Tobacco Pipe

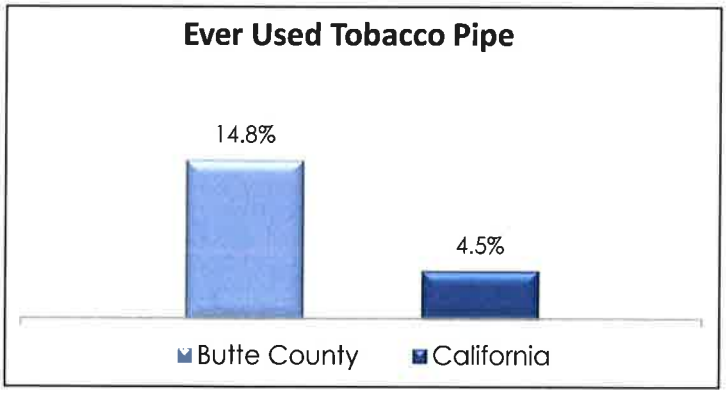
Healthy People 2020 objective TU-1: Reduce tobacco use by adults

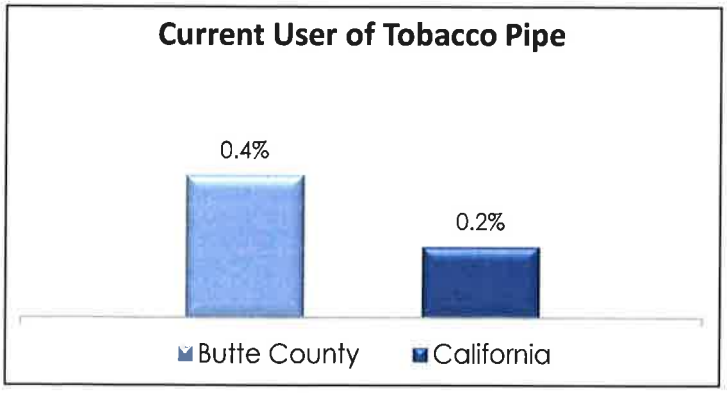
Healthy People 2020 objective TU-14: Increase the proportion of smoke-free homes

Pipe smoking consists of loose leaf tobacco that is fire-cured and burned in a traditional pipe with a bowl and a mouthpiece. Although pipe smoking has dwindled over the years, the proportion of respondents who have ever used it varies by state and ranges from 3% to 12%.[6] Like cigarettes, pipe tobacco contains toxic chemicals that increase the risk for some cancers. Current user status is defined as having used tobacco pipe at least once during lifetime and using it on 1 or more day in the past 30 days.

A total of 14.8% of Butte County residents have ever used a tobacco pipe – a figure much above the rate observed for California. The current use of tobacco pipes is marginal, at 0.4%; this result is consistent with the statewide result (0.2%.)

Males and white/non-Hispanic residents are most likely to have ever used, and to be currently using, tobacco pipe.





Percentage of respondents who have ever used tobacco pipe, and percentage of respondents who are current users of tobacco pipe

Demographic Characteristics	Ever Used Tobacco Pipe	Current User of Tobacco Pipe
Total	14.8%	0.4%
Age		
18-24	3.5%	-
25-34	10.8%	-
35-44	23.8%	3.3%
45-54	12.7%	-
55-64	14.7%	-
65+	24.2%	-
Gender		
Male	24.1%	0.5%
Female	5.7%	0.4%
Race		
White	15.9%	0.5%
Black**	5.3%	-
Hispanic	7.6%	-
Non-Hispanic	16.0%	0.5%
Education		
< High School	20.8%	-
High School Grad	15.4%	-
Some College	15.4%	0.7%
College Graduate	12.6%	0.6%
Household Income		
<$20,000	18.7%	-
$20,000-$34,999	16.1%	-
$35,000-$$49,999**	12.0%	-
$50,000-$74,999	22.6%	-
$75,000 or more	21.1%	1.1%

**Note: Comparative data is based on 2015 BRFSS of California Residents. National comparative data is not available in this category **Caution: Fewer than 30 respondents*

Other Tobacco Use: Hookah Water Pipe

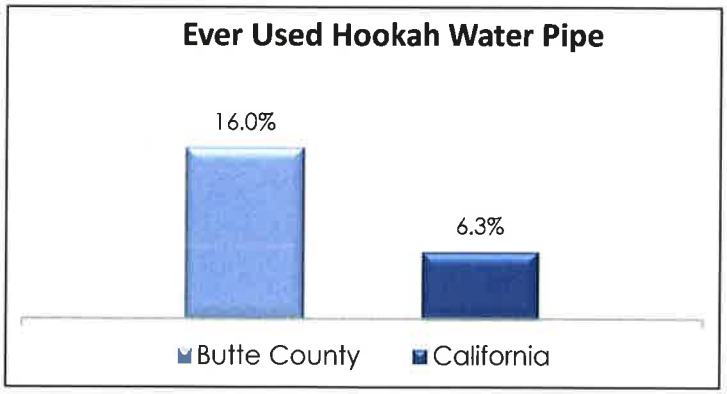
Healthy People 2020 objective TU-1: Reduce tobacco use by adults

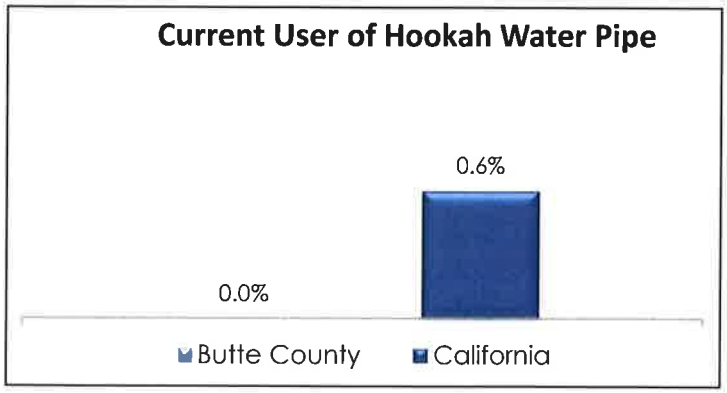
Healthy People 2020 objective TU-14: Increase the proportion of smoke-free homes

Hookahs are water pipes that are used to smoke specially made tobacco that comes in different flavors. Although many users think it is less harmful, hookah smoking has many of the same risks as cigarette smoking, including oral cancer, lung cancer, stomach cancer, cancer of the oesophagus, and reduced lung function.[49] Current user status is defined as having used hookah at least once during lifetime and using it on 1 or more day in the past 30 days.

A total of 16.0% of Butte County residents have ever used a hookah pipe – a figure much above the rate observed for California (6.3%.) However, there are no current users of hookah in the County – a result fairly consistent with the state figure of only 0.6%.

Residents age 25-44 are most likely to have ever tried hookah, and males are more likely to have done so than females. Additionally, Hispanic residents and those with some college-level work completed report having tried it more often than their counterparts.





Percentage of respondents who have ever used hookah water pipe, and percentage of respondents who are current users of hookah water pipe

Demographic Characteristics	Ever Used Hookah Water Pipe	Current User of Hookah Water Pipe
Total	16.0%	-
Age		
18-24	17.0%	-
25-34	37.4%	-
35-44	21.0%	-
45-54	6.9%	-
55-64	11.4%	-
65+	5.8%	-
Gender		
Male	20.5%	-
Female	11.6%	-
Race		
White	15.0%	-
Black**	4.6%	-
Hispanic	28.6%	-
Non-Hispanic	13.7%	-
Education		
< High School	8.4%	-
High School Grad	13.7%	-
Some College	20.0%	-
College Graduate	15.3%	-
Household Income		
<$20,000	11.0%	-
$20,000-$34,999	23.7%	-
$35,000-$$49,999**	13.1%	-
$50,000-$74,999	21.2%	-
$75,000 or more	23.0%	-

**Note: Comparative data is based on 2015 BRFSS of California Residents. National comparative data is not available in this category **Caution: Fewer than 30 respondents*

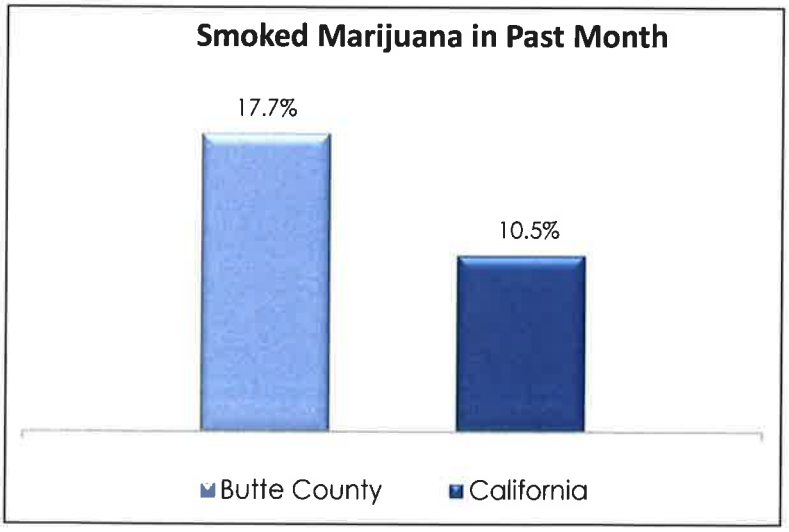
Marijuana Use

Healthy People 2020 objective SA-13: Reduce past-month use of illicit substances

While legalized in many states, marijuana is still considered an illicit substance in others. Its use is on the rise, with 37.6 million users in the U.S. in 2016.[50] Only from 2002 to 2014, the prevalence of past month marijuana use went up by 35% among persons age 12+, with the increases being greatest among adults age 55+.[51] Heavy or frequent marijuana use has a negative effect on attention, memory, and learning, and has been linked to depression and anxiety.[52] Smoked marijuana also includes many of the same substances found in tobacco smoke, which are harmful to the lungs and cardiovascular system, and could lead to increased risk of stroke and heart disease.[53]

A total of 17.7% of Butte County residents have smoked marijuana or hashish at least once within the past 30 days. This is notably above the figure noted for California as a state (10.5%.)

This result is driven mostly by respondents in the younger age categories (up to 44 years old,) males, and Caucasians. The likelihood to report having smoked marijuana in the past month is also inversely proportional to the education level.



Percentage of respondents who smoked marijuana/hashish 1+ day within past 30 days

Demographic Characteristics	Smoked Marijuana/Hashish 1+ Day Within Past 30 Days
Total	17.7%
Age	
18-24	22.6%
25-34	22.5%
35-44	24.6%
45-54	14.6%
55-64	17.0%
65+	8.1%
Gender	
Male	22.7%
Female	12.9%
Race	
White	18.5%
Black**	5.3%
Hispanic	15.9%
Non-Hispanic	17.8%
Education	
< High School	33.1%
High School Grad	27.4%
Some College	14.2%
College Graduate	10.7%
Household Income	
<$20,000	23.7%
$20,000-$34,999	15.1%
$35,000-$$49,999**	4.8%
$50,000-$74,999	21.1%
$75,000 or more	8.6%

*Note: Comparative data is based on 2016 BRFSS of California Residents. National comparative data is not available in this category **Caution: Fewer than 30 respondents

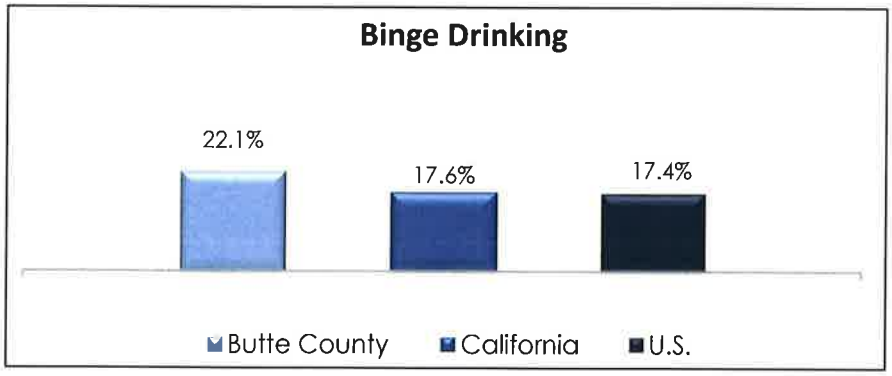
Alcohol Consumption

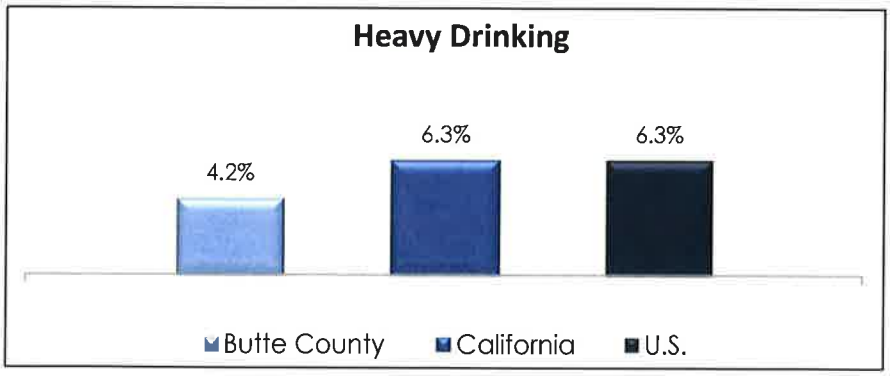
Healthy People 2020 objective SA-8.3: Reduce the proportion of persons engaging in binge drinking during the past 30 days – adults aged 18 years and older

Healthy People 2020 objective SA-15: Reduce the proportion of adults who drank excessively in the previous 30 days

Alcohol abuse has been associated with serious health problems such as cirrhosis of the liver, high blood pressure, stroke, and some types of cancer, and can increase the risk for motor vehicle accidents, injuries, violence, and suicide. In California, the percent of fatal motor vehicle crashes that involved any alcohol was 31% in 2017.[23] Binge drinking is defined as consuming five or more drinks per occasion (for men) or 4 or more drinks per occasion (for women) at least once in the past month, while heavy drinking is defined as consuming more than two alcoholic drinks per day (for men) or more than one drink per day (for women) in the past month.

At 4.2%, the rate of heavy drinking among Butte County residents is below state and nationwide levels (6.3% each.) At the same time, however, the rate of binge drinking (22.1%) exceeds the California and U.S. figures (17.6% and 17.4%, respectively). The highest rates of binge drinking are observed among respondents under the age of 54, as well as Caucasian males, and respondents without a college degree. Heavy drinking is driven by males.





**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Percentage of respondents reporting heavy drinking and percentage of respondents reporting binge drinking

Demographic Characteristics	Heavy Drinking	Binge Drinking
Total	4.2%	22.1%
Age		
18-24	5.3%	30.5%
25-34	1.5%	23.9%
35-44	3.1%	36.4%
45-54	2.3%	26.7%
55-64	6.4%	14.8%
65+	5.3%	5.5%
Gender		
Male	6.3%	31.2%
Female	2.1%	13.2%
Race		
White	4.6%	23.7%
Black**	-	5.3%
Hispanic	3.9%	21.3%
Non-Hispanic	4.2%	21.5%
Education		
< High School	0.9%	31.7%
High School Grad	5.6%	25.7%
Some College	4.4%	23.7%
College Graduate	3.6%	15.8%
Household Income		
<$20,000	5.7%	22.9%
$20,000-$34,999	1.0%	16.7%
$35,000-$$49,999**	5.3%	11.1%
$50,000-$74,999	3.1%	20.7%
$75,000 or more	4.0%	16.9%

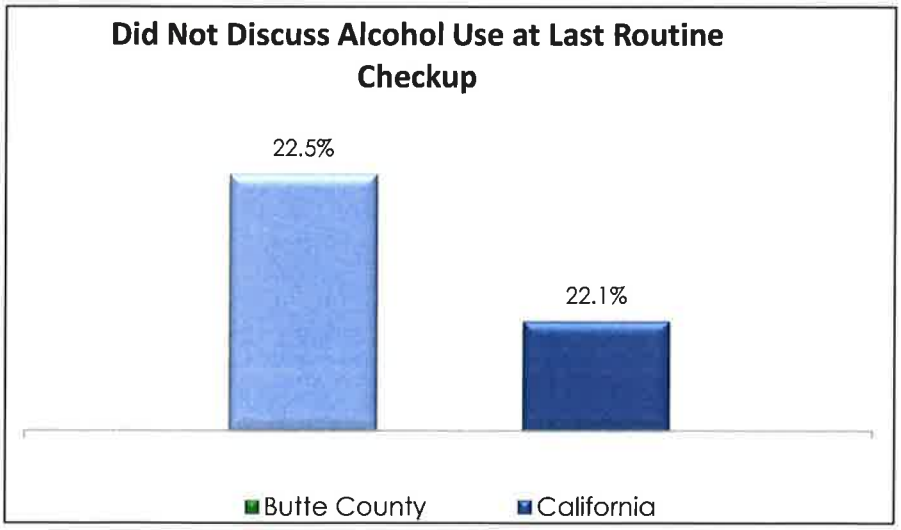
Alcohol Screening & Brief Intervention: Screened for Alcohol Consumption

Healthy People 2020 objective SA-8.3: Increase the proportion of persons who need alcohol abuse or dependence treatment and received specialty treatment for abuse or dependence in the past year

Risky alcohol use (heavy and binge drinking) contributes to a wide range of negative health and social consequences, including motor vehicle crashes, intimate partner violence, and fetal alcohol spectrum disorders. Over time, it can result in serious medical conditions, such as hypertension, gastritis, liver disease and various cancers. Alcohol Screening & Brief Intervention (ASBI) is a preventive service like hypertension or cholesterol screening that can occur as a part of a patient's wellness visit. ASBI involves a brief set of screening questions designed to identify patients' drinking patterns, a short conversation with those who are drinking too much, and referral to treatment, as appropriate.[56]

More than one-fifth (22.5%) of Butte County residents who had their routine checkup reports that they did not discuss alcohol use with their health care provider. This result is on par with California statistics (22.1%.)

Older respondents (65+ years of age), as well as those with lower levels of education (high school graduate or less) are most likely to say they were not screened for alcohol consumption.



Percentage of respondents not screened for alcohol consumption at last routine checkup

Demographic Characteristics	Not Screened for Alcohol Consumption
Total	22.5%
Age	
18-24	19.8%
25-34	29.5%
35-44	10.1%
45-54	15.2%
55-64	18.9%
65+	36.8%
Gender	
Male	21.5%
Female	23.4%
Race	
White	21.2%
Black**	33.9%
Hispanic	17.9%
Non-Hispanic	23.0%
Education	
< High School**	29.9%
High School Grad	30.6%
Some College	16.7%
College Graduate	21.2%
Household Income	
<$20,000	22.2%
$20,000-$34,999	20.8%
$35,000-$$49,999**	26.0%
$50,000-$74,999**	25.3%
$75,000 or more	16.8%

**Note: Comparative data is based on 2014 BRFSS of California Residents. National comparative data is not available in this category **Caution: Fewer than 30 respondents*

Alcohol Screening & Brief Intervention: Given Advise on Harmful Levels of Drinking

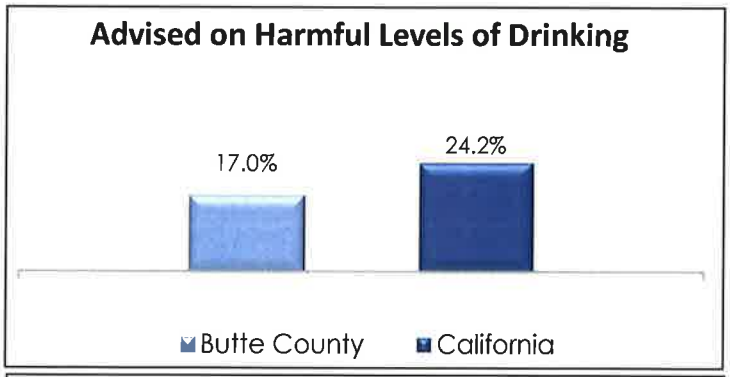
Healthy People 2020 objective SA-8.3: Increase the proportion of persons who need alcohol abuse or dependence treatment and received specialty treatment for abuse or dependence in the past year

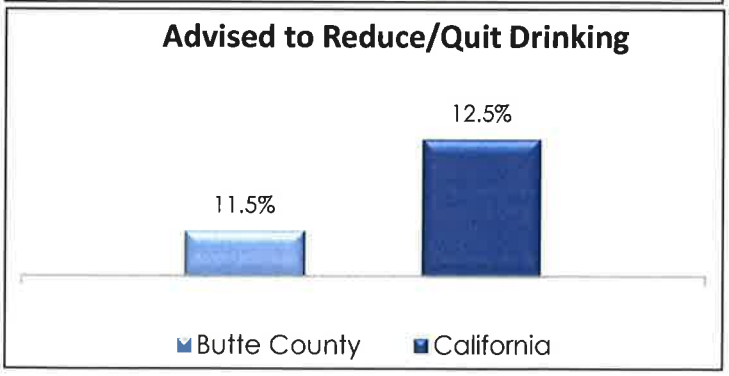
ASBI aims to increase a person's awareness of their alcohol use and motivate them to reduce risky drinking patterns and/or seek treatment. [57] *A review of studies shows a reduction in alcohol consumption from 13% to 34% among those who received brief intervention.* [58]

A total of 17.0% of Butte County residents say they were advised on harmful levels of drinking during their routine checkup, and 11.5% were advised to drink less. Both metrics are below the statewide results (24.2% and 12.5%, respectively.)

Older residents, i.e., those age 45+ are less likely to have discussed risky levels of drinking, as are females and those in the middle income categories ($20,000-$74,999.)

Among those asked about drinking, respondents most likely to receive advice on limiting alcohol consumption include individuals age 35-44, males, and those in the bottom and top income brackets (under $20,000 and over $75,000.)





Percentage of respondents who were offered advise on harmful levels of drinking, and percentage of respondents advised to drink less

Demographic Characteristics	Advised on Harmful Levels of Drinking	Advised to Reduce/Quit Drinking
Total	17.0%	11.5%
Age		
18-24	25.2%	10.9%
25-34	19.7%	14.0%
35-44	28.5%	18.9%
45-54	13.7%	10.9%
55-64	14.1%	6.2%
65+	7.8%	10.2%
Gender		
Male	24.4%	18.0%
Female	10.2%	5.3%
Race		
White	17.4%	10.9%
Black	31.7**	24.0%**
Hispanic	26.9%	12.7%**
Non-Hispanic	15.6%	11.5%
Education		
< High School	12.9%**	26.4%**
High School Grad	14.2%	6.4%
Some College	17.7%	9.5%
College Graduate	19.2%	14.0%
Household Income		
<$20,000	18.3%	19.5%
$20,000-$34,999	4.9%	3.8%**
$35,000-$$49,999	9.7%**	6.5%**
$50,000-$74,999	9.5%**	5.4%**
$75,000 or more	19.4%	16.6%

**Note: Comparative data is based on 2014 BRFSS of California Residents. National comparative data is not available in this category **Caution: Fewer than 30 respondents*

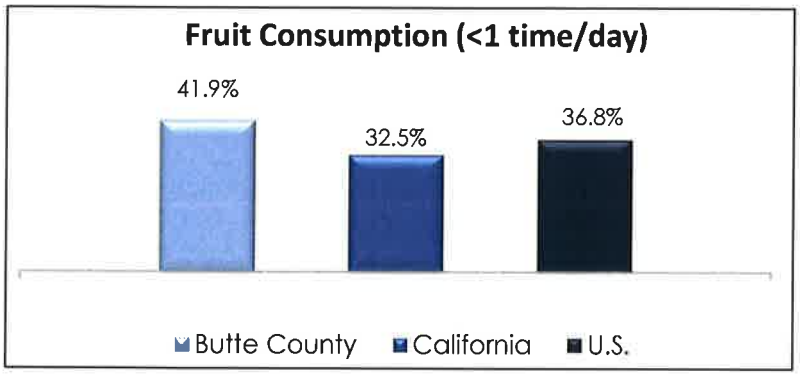
Fruit & Vegetable Consumption

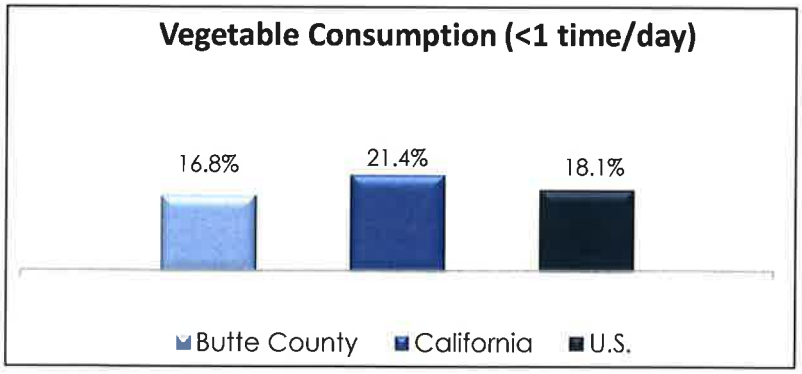
Healthy People 2020 objective NWS-14: Increase the contribution of fruits to the diets of the population aged 2 years and older

Healthy People 2020 objective NWS-15: Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older

Eating a diet rich in fruits and vegetables can help reduce the risk of developing many chronic diseases, including heart disease, diabetes, some cancers and obesity.[24] Fruits and vegetables are also major contributors of a number of nutrients (such as potassium, dietary fiber, magnesium, as well as vitamins A, C, and K) that are currently underconsumed in the United States.[25] National findings indicate that, on average, adults consume 1.4 fruits per day and 1.9 vegetables per day.[26] Currently, only 12.2% of adults meet their daily fruit recommendation (2 cups daily), and only 9.3% meet the vegetable recommendation (2.5 cups).[27]

More than four in ten Butte County residents (41.9%) consume fruit less than 1 time per day, and 16.8% consume vegetables less than 1 time per day. Limited fruit consumption exceeds the figures reported in state- and nationwide BRFS studies. However, limited vegetable consumption is lower than what was reported in Michigan and the U.S. in general. The lowest fruit and vegetable consumption is reported by males, respondents with less than high school diploma, and those with incomes under $20,000.





Percentage of respondents who reported limited fruit and vegetable consumption

Demographic Characteristics	Fruits (<1 time/day)	Vegetables (<1 time /day)
Total	41.9%	16.8%
Age		
18-24	52.1%	19.1%
25-34	37.5%	21.7%
35-44	52.1%	11.1%
45-54	45.3%	12.4%
55-64	39.7%	20.4%
65+	29.6%	16.3%
Gender		
Male	48.5%	18.6%
Female	35.6%	15.1%
Race		
White	41.2%	16.4%
Black**	15.5%	8.6%
Hispanic	42.9%	18.1%
Non-Hispanic	42.2%	16.2%
Education		
< High School	61.3%	35.6%
High School Grad	42.6%	14.3%
Some College	45.0%	16.5%
College Graduate	34.0%	15.3%
Household Income		
<$20,000	53.7%	27.0%
$20,000-$34,999	36.7%	19.6%
$35,000-$$49,999**	26.9%	16.3%
$50,000-$74,999	37.6%	18.2%
$75,000 or more	46.6%	14.2%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

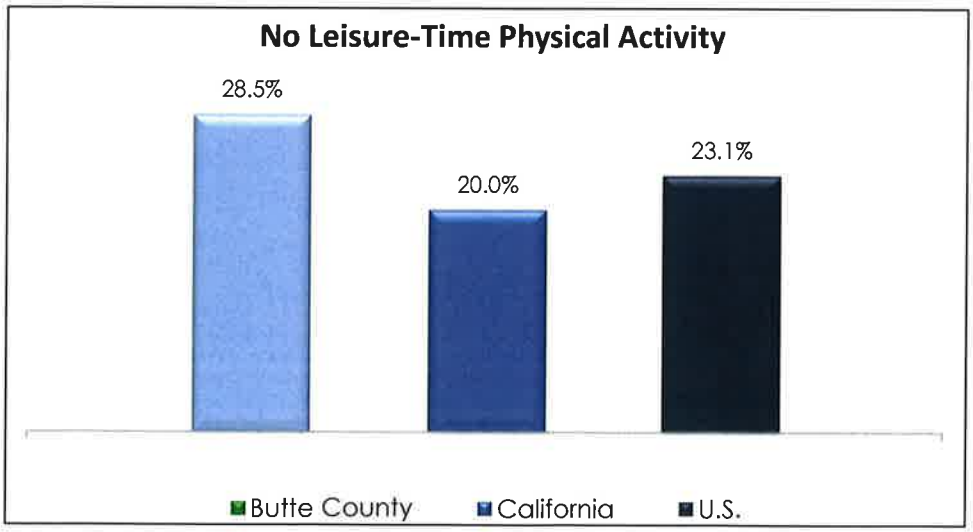
Physical Activity

Healthy People 2020 objective PA-1: Reduce the proportion of adults who engage in no leisure-time physical activity

Regular physical activity has been shown to reduce the risk of premature mortality and a number of chronic diseases, such as cancer, cardiovascular disease, and diabetes. Keeping physically active not only helps maintain a healthy body weight and normal muscle strength, bone mass, and joint function, but it can also relieve symptoms of anxiety and depression, and improve sleep.[28] The Healthy People target for no leisure-time physical activity is set at 32.6%.

The percentage of Butte County residents who report no leisure-time physical activity stands at 28.5%, which is above the state- and nationwide rates (20% and 23.1%, respectively). The prevalence of no leisure-time activity among Butte County adults is currently 4.1 points below the 2020 target of 32.6%, indicating that this Healthy People objective can be considered met.

Leisure-time physical activity is least prevalent among those age 25-34, as well as the oldest respondent segment (age 65+.) Moreover, the likelihood of engaging in physical activity increases in proportion to respondents' income, with those making less than $35,000 per year being most apt to report no activity.



Percentage of respondents who reported no leisure-time physical activity

Demographic Characteristics	No Physical Activity
Total	28.5%
Age	
18-24	26.3%
25-34	37.2%
35-44	20.5%
45-54	28.4%
55-64	28.2%
65+	30.9%
Gender	
Male	30.3%
Female	26.7%
Race	
White	27.9%
Black**	25.8%
Hispanic	31.8%
Non-Hispanic	27.6%
Education	
< High School	33.8%
High School Grad	28.6%
Some College	32.4%
College Graduate	23.5%
Household Income	
<$20,000	42.7%
$20,000-$34,999	44.5%
$35,000-$$49,999**	20.0%
$50,000-$74,999	19.9%
$75,000 or more	16.7%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Seatbelt Use

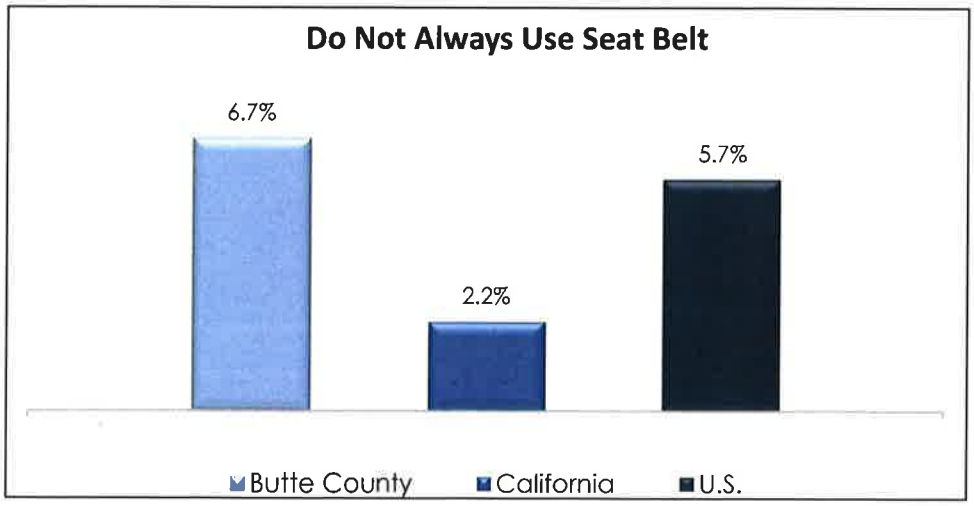
Healthy People 2020 objective IVP-13: Reduce motor vehicle crash-related deaths

Healthy People 2020 objective IVP-15: Increase use of safety belts

In 2017, 3,602 people died in automobile accidents in California, with an additional 14,188 people sustaining serious injuries. Among the fatalities, 600 passengers were unrestrained.[23] Seatbelt use has been proven to save lives and prevent injuries. It has been estimated that, among drivers and front seat passengers, seat belts reduce the risk of death by 45%, and cut the risk of serious injury by 50%.[30] With 97.8% reporting consistent seatbelt use, California is the healthies state on this metric.

A total of 6.7% of Butte County residents do not always use a seatbelt when driving or riding in a car. This is substantially above the California-wide rate (2.2%) and somewhat below the nationwide figure (5.7%.)

The youngest respondents (18-24 years of age,) as well as males and those with less than a college degree are more likely than their counterparts to say they do not always wear a seatbelt.



Percentage of respondents who do not always use seatbelts when driving/riding in the car

Demographic Characteristics	Do Not Always Use Seatbelt
Total	6.7%
Age	
18-24	12.7%
25-34	3.3%
35-44	7.3%
45-54	2.1%
55-64	6.7%
65+	7.4%
Gender	
Male	8.6%
Female	4.8%
Race	
White	6.5%
Black**	-
Hispanic	11.2%
Non-Hispanic	5.7%
Education	
< High School	6.3%
High School Grad	9.6%
Some College	7.5%
College Graduate	3.7%
Household Income	
<$20,000	3.9%
$20,000-$34,999	6.2%
$35,000-$$49,999**	2.1%
$50,000-$74,999	10.4%
$75,000 or more	5.7%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Adult Immunization: Flu and Pneumonia Shots

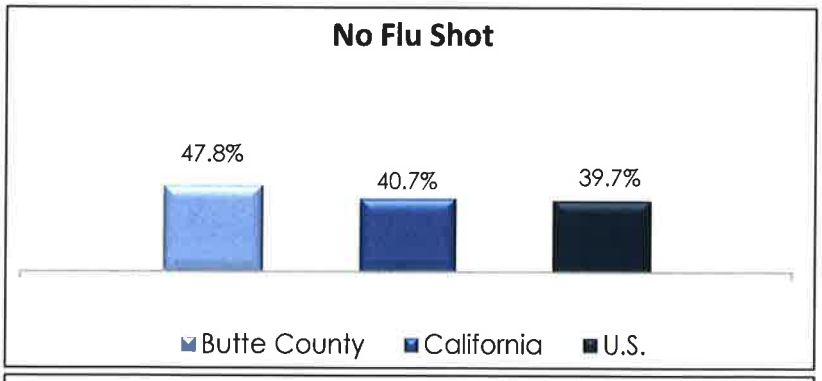
Healthy People 2020 objective IID-12.12: Increase the percentage of noninstitutionalized adults aged 18 years and older who are vaccinated annually against seasonal influenza

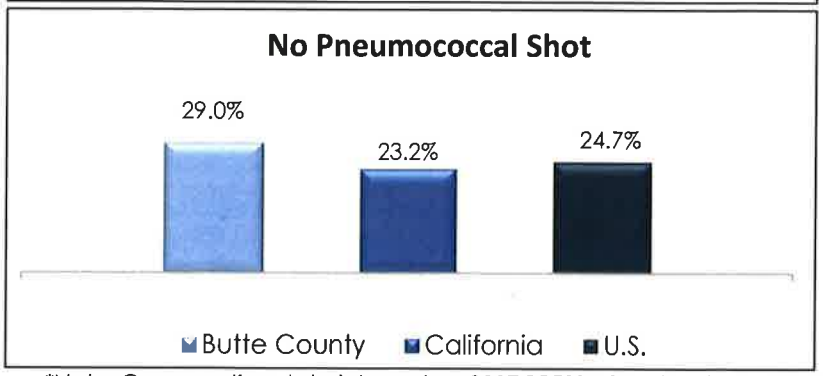
Healthy People 2020 objective IID-13.1: Increase the percentage of noninstitutionalized adults aged 65 years and older who are vaccinated against pneumococcal disease

Currently, the Advisory Committee on Immunization Practices recommends immunizing adults against 15 infectious diseases, including influenza and pneumonia. However, the adult coverage rates for these vaccines remain substantially below the target levels.[31] Influenza and pneumonia were the 8th leading cause of death in 2017 in California, attributing to over 6,300 deaths.[12] A Healthy People 2020 objective is to ensure that 70% of adults aged 18 years and older are vaccinated annually against influenza, and 90% of those aged 65+ have ever been vaccinated against pneumococcal disease.

Almost half (47.8%) of Butte County residents over the age of 65 have not had a flu shot in the past 12 months. Additionally, nearly three in ten Butte County residents (29%) have never been vaccinated against pneumonia.

Both results exceed the state and national figures.





Proportion of respondents age 65 years and older who have not had a flu shot in the past 12 months and who never had a pneumonia shot

Demographic Characteristics	No Flu Shot	Never Had Pneum. Shot
Total	47.8%	29.0%
Age		
65-74	52.0%	37.7%
75+	43.4%	20.0%
Gender		
Male	44.9%	31.7%
Female	50.4%	26.4%
Race		
White	47.9%	28.1%
Black**	46.3%	100.0%
Hispanic**	53.8%	30.7%
Non-Hispanic	47.1%	28.4%
Education		
< High School**	57.1%	40.4%
High School Grad**	41.7%	21.9%
Some College**	50.9%	31.5%
College Graduate	47.3%	28.9%
Household Income		
<$20,000**	39.9%	34.2%
$20,000-$34,999**	56.3%	18.8%
$35,000-$$49,999**	52.9%	23.2%
$50,000-$74,999**	53.8%	36.6%
$75,000 or more**	45.3%	27.5%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Adult Immunization: Shingles Vaccination

Healthy People 2020 objective IID-12.12: Increase the percentage of adults who are vaccinated against zoster (shingles)

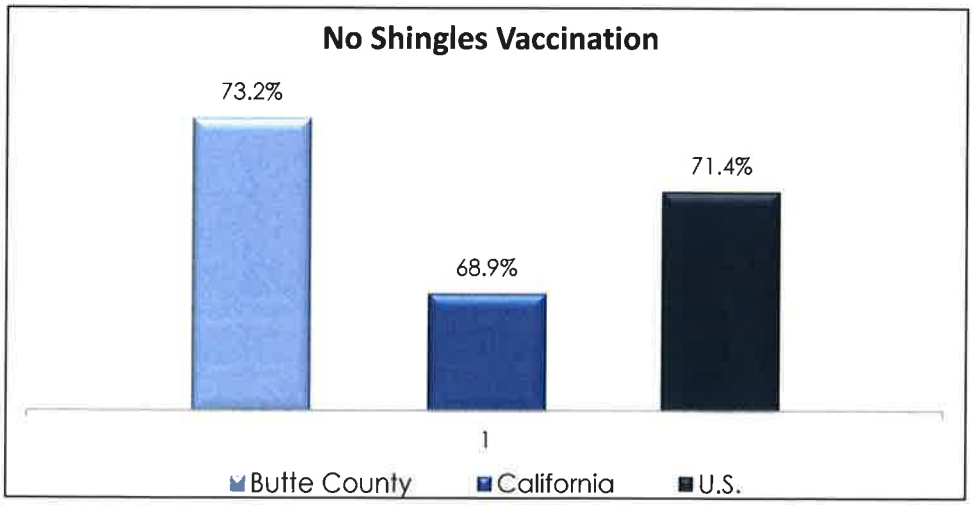
A total of 1 out of every 3 people in the United States will develop shingles during their liftetime. Shingles is a painful rash that usually develops on one side of the body, often the face or torso. The rash consists of blisters that typically scab over in 7-10 days and clears up within 2-4 weeks. For 1 in 10 people, however, the nerve pain, can last for months or even years after the rash goes away. This long-lasting pain is called postherpetic neuralgia (PHN,) and is the most common complication of shingles. Other serious complications may lead to blindness, pneumonia, hearing problems, brain inflammation, or even death. The risk of getting shingles, PHN, and other complications increases with age. Therefore, it is recommended that people 50 or older get vaccinated. [64]

More than seven in ten Butte County residents (73.2%) age 50 or older have not been vaccinated against shingles. This result is above the state- and nationwide figures (68.9% and 71,4%, respectively.)

The likelihood of having been vaccinated increases with age and peaks in the 70+ category. It is also directly proportional to residents' level of education. Finally, those in lower income categories (under $35,000) are somewhat less likely than their more affluent counterparts to have been vaccinated against shingles.

Percentage of respondents age 50+ who have ever had the shingles or zoster vaccine

Demographic Characteristics	Never Had Shingles Vaccination
Total	73.2%
Age	
50-59	90.1%
60-69	76.9%
70+	50.0%
Gender	
Male	74.8%
Female	71.9%
Race	
White	71.0%
Black**	100.0%
Hispanic**	78.4%
Non-Hispanic	72.7%
Education	
< High School**	83.7%
High School Grad	77.2%
Some College	74.8%
College Graduate	68.3%
Household Income	
<$20,000	79.2%
$20,000-$34,999	70.9%
$35,000-$$49,999**	64.0%
$50,000-$74,999	64.7%
$75,000 or more	66.8%



*Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents

HIV/AIDS

Healthy People 2020 objective HIV-1: Reduce new HIV diagnoses

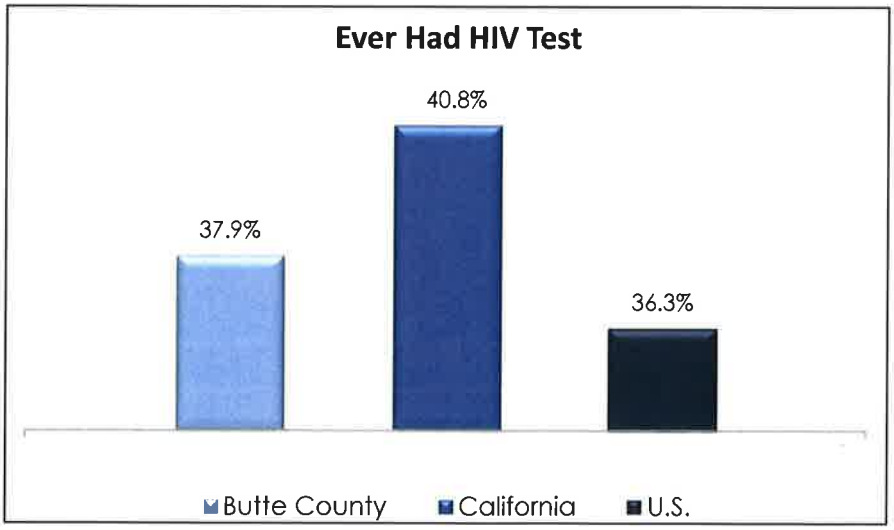
Healthy People 2020 objective HIV-14: Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months

Healthy People 2020 objective HIV-12: Reduce deaths from HIV infection

As of 2016, 132,405 people were living with diagnosed HIV infection in California.[32] Early awareness of the infection through HIV testing can prevent further spread of the disease, and an early start on antiretroviral therapy can increase the lifespan and quality of life among those who are living with HIV/AIDS.

A total of 37.9% of Butte County residents has ever been tested for HIV. This percentage is below the figure noted for California as a whole (40.8%,) but above the nationwide data (36.3%.)

A segment analysis reveals that the youngest and oldest respondents (age 18-24 and 65+) are least likely to indicate they have ever been tested. Additionally, those in the lowest income bracket (under $20,000) are most likely to report a prior HIV test, and females are slightly more likely to do so than males.



Percentage of respondents who have ever had an HIV test

Demographic Characteristics	Ever Tested for HIV
Total	37.9%
Age	
18-24	20.6%
25-34	49.2%
35-44	63.5%
45-54	46.4%
55-64	38.9%
65+	19.3%
Gender	
Male	34.0%
Female	41.8%
Race	
White	39.9%
Black**	52.6%
Hispanic	35.1%
Non-Hispanic	38.5%
Education	
< High School	42.5%
High School Grad	32.3%
Some College	40.1%
College Graduate	38.7%
Household Income	
<$20,000	43.6%
$20,000-$34,999	34.5%
$35,000-$$49,999**	30.4%
$50,000-$74,999	39.3%
$75,000 or more	26.0%

**Note: Comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories) **Caution: Fewer than 30 respondents*

Adverse Childhood Experience: Emotional/Verbal and Physical Abuse

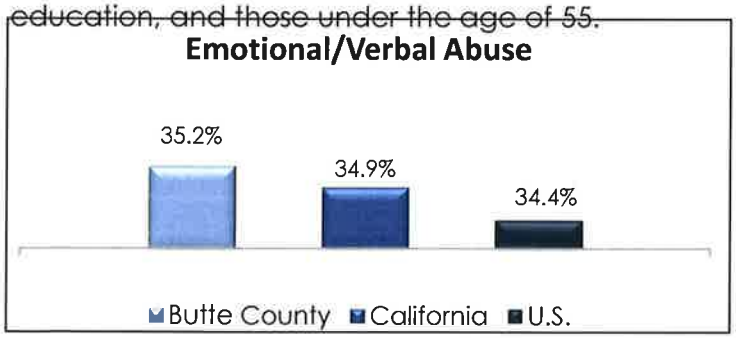
Healthy People 2020 objective EMC-2.2: Increase the proportion of parents who use positive communication with their child

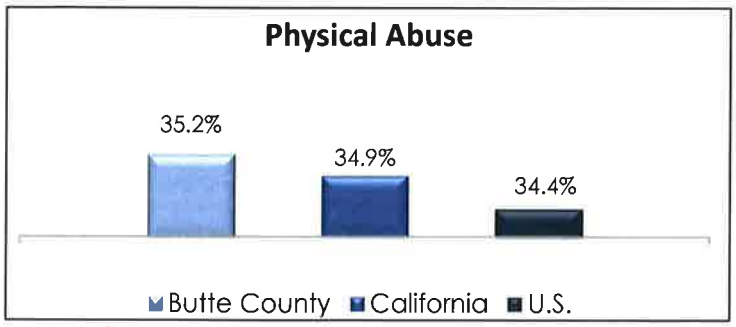
Healthy People 2020 objective IVP-38: Reduce nonfatal child mistreatment

Adverse Childhood Experiences (ACEs) is a term used to describe a range of traumatic experiences that may occur during a person's first 17 years of life, including child abuse, neglect, and other household dysfunctions. Over 60% of Californians report experiencing at least one ACE before age 18. Approximately one in four Californians reports having three or more ACEs.[61] At 35%, the most common ACE among California adults is emotional (or verbal) abuse.[62]

More than one-third (35.2%) of Butte County residents report having been emotionally and/or verbally abused by adults in their home before they were 18. This figure is on par with the statewide and nationwide data (34.9% and 34.4%, respectively.) Residents most likely to report emotional abuse are non-Hispanic and younger than 65+.

Additionally, just over one-fifth (21%) recalls physical abuse in their childhood – a result marginally above the California-wide rate, and higher than the national figure. This is attributable mostly to white residents with less than high school education, and those under the age of 55.





**Note: Comparative data is based on combined 2008-2013 BRFSS of California Residents and combined 2011-2014 BRFSS for 23 States (not all states include ACE questions) **Caution: Fewer than 30 respondents*

Percentage of respondents who were emotionally/verbally abused more than once, and percentage of respondents who were physically hurt by adults more than once (before age 18)

Demographic Characteristics	Emotional Abuse	Physical Abuse
Total	35.2%	21.0%
Age		
18-24	41.3%	27.0%
25-34	51.9%	22.9%
35-44	30.4%	22.2%
45-54	34.3%	23.2%
55-64	32.1%	19.5%
65+	23.2%	12.7%
Gender		
Male	34.4%	22.4%
Female	36.0%	19.7%
Race		
White	33.0%	17.5%
Black**	43.3%	15.8%
Hispanic	31.4%	25.6%
Non-Hispanic	36.2%	20.8%
Education		
< High School	44.1%	32.5%
High School Grad	34.7%	22.8%
Some College	36.3%	22.4%
College Graduate	32.8%	15.9%
Household Income		
<$20,000	39.5%	26.2%
$20,000-$34,999	25.1%	19.3%
$35,000-$$49,999**	30.8%	6.2%
$50,000-$74,999	45.8%	28.7%
$75,000 or more	33.6%	13.3%

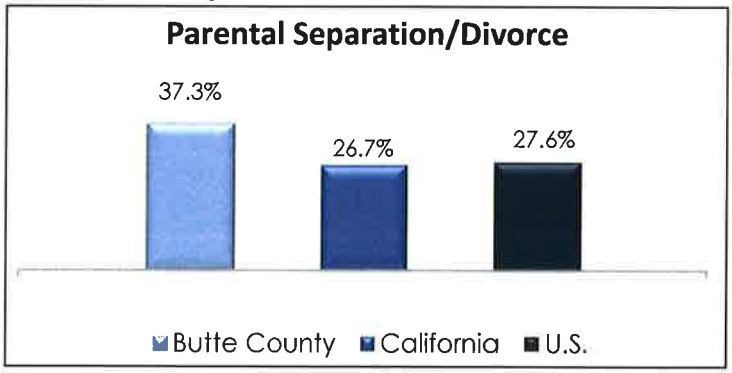
Adverse Childhood Experience: Separation/ Divorce and Incarcerated Household Member

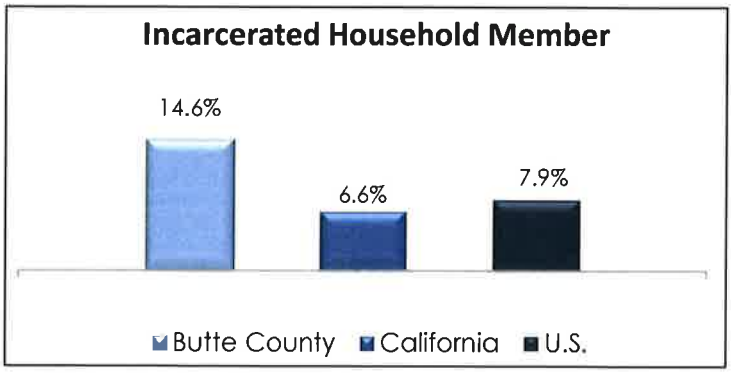
ACEs affect every community in California. Butte County is among California's counties with the highest number of ACEs; 77% of residents have 1 or more adverse childhood experiences. However, even in counties with the lowest prevalence of ACEs, 1 out of every 2 residents, or 50%, has at least one adverse experience in childhood. Parental separation or divorce is the second most prevalent ACE after emotional/verbal abuse, reported by 27% of adults.[62]

Almost four in ten Butte County residents (37.3%) have experienced parental separation or divorce before the age of 18. This is reported notably less often by residents age 65+, and those with at least some college education.

A total of 14.6% was growing up with a household member who served time in a prison, jail, or other corrections facility. This response is given mostly by residents under the age of 44, Hispanics, and those in lower education and income brackets.

Both ACEs are observably above the state- and nationwide figures.





Percentage of respondents whose parents separated/divorced, and percentage of respondents who lived with anyone who served time in prison/jail (before age 18)

Demographic Characteristics	Parental Separation/ Divorce	Incarcerated Household Member
Total	37.3%	14.6%
Age		
18-24	38.0%	23.0%
25-34	51.6%	31.9%
35-44	39.1%	18.4%
45-54	44.6%	7.4%
55-64	34.6%	6.6%
65+	21.2%	3.7%
Gender		
Male	35.7%	14.0%
Female	39.0%	15.1%
Race		
White	37.2%	13.3%
Black**	56.3%	13.9%
Hispanic	42.3%	26.6%
Non-Hispanic	36.6%	12.5%
Education		
< High School	54.0%	18.5%
High School Grad	41.1%	20.0%
Some College	39.9%	16.4%
College Graduate	28.6%	7.7%
Household Income		
<$20,000	39.8%	14.1%
$20,000-$34,999	40.3%	23.8%
$35,000-$$49,999**	27.7%	9.5%
$50,000-$74,999	37.7%	10.9%
$75,000 or more	29.3%	9.0%

**Note: Comparative data is based on combined 2008-2013 BRFSS of California Residents and combined 2011-2014 BRFSS for 23 states (not all states include ACE questions) **Caution: Fewer than 30 respondents*

Adverse Childhood Experience: Sexual Abuse and Witness to Domestic Violence

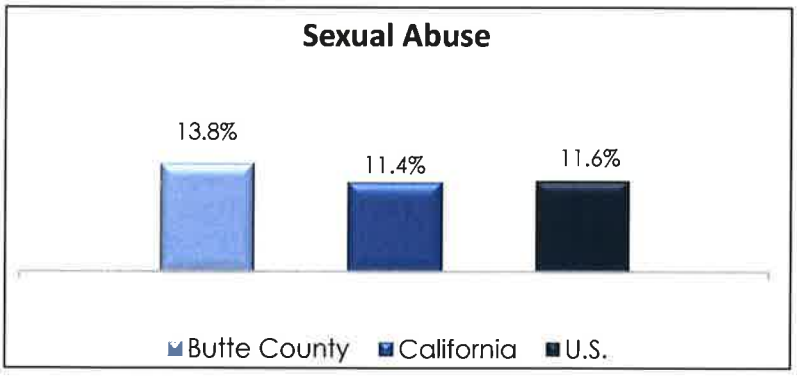
Healthy People 2020 objective IVP-40: Reduce sexual violence

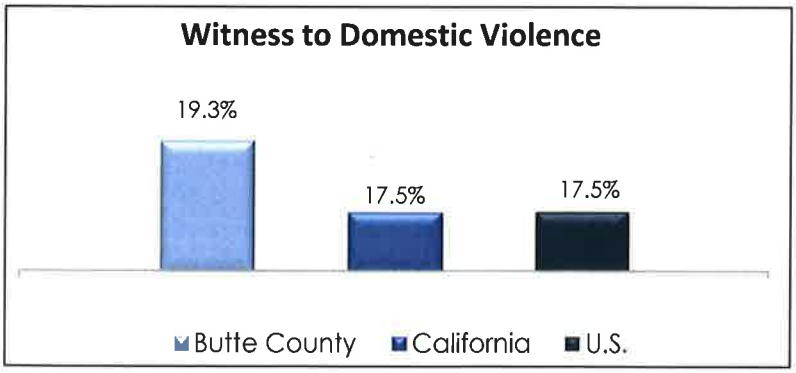
Healthy People 2020 objective IVP-42: Reduce children's exposure to violence

There is a strong relationship between exposure to ACEs and subsequent negative health behaviors and conditions later as adults, including smoking, unintended pregnancies, alcoholism, illicit drug use, binge drinking, depression, suicide attempts, COPD, asthma, obesity, stroke, heart disease, cancer, diabetes, kidney disease, and liver disease. [61, 62]

A total of 13.8% of Butte County residents have ever experienced sexual abuse as a child – a figure slightly above the state- and nationwide statistics (11.4% and 11.6%, respectively.) Females are notably more likely than males to report this ACE.

Witnessing domestic violence before the age of 18 is reported by nearly a fifth of residents (19.3%) – a result higher than the nationwide and California prevalence data (17.5% each.) The rates of this ACE are higher among residents with incomes of under $20,000, and are decreasing with respondents' age.





**Note: Comparative data is based on combined 2008-2013 BRFSS of California Residents and combined 2011-2014 BRFSS for 23 states (not all states include ACE questions) **Caution: Fewer than 30 respondents*

Percentage of respondents who reported having ever experienced sexual abuse, and percentage of respondents who witnessed domestic violence more than once (before age 18)

Demographic Characteristics	Sexual Abuse	Witness to Domestic Violence
Total	13.8%	19.3%
Age		
18-24	13.2%	30.6%
25-34	19.1%	25.8%
35-44	8.4%	19.7%
45-54	15.3%	16.6%
55-64	16.1%	16.0%
65+	11.3%	9.4%
Gender		
Male	7.5%	20.1%
Female	20.0%	18.6%
Race		
White	12.4%	15.8%
Black**	24.3%	38.8%
Hispanic	17.1%	19.1%
Non-Hispanic	13.4%	19.9%
Education		
< High School	13.6%	31.2%
High School Grad	17.0%	13.4%
Some College	13.1%	26.4%
College Graduate	12.1%	14.4%
Household Income		
<$20,000	16.6%	25.1%
$20,000-$34,999	14.9%	18.8%
$35,000-$$49,999**	9.6%	10.2%
$50,000-$74,999	20.0%	11.8%
$75,000 or more	8.7%	16.5%

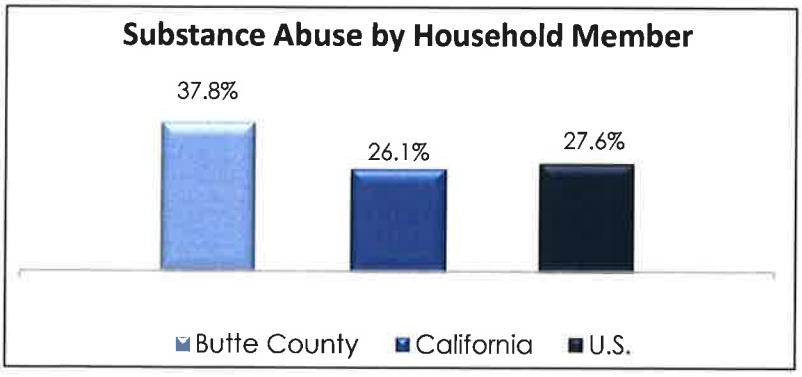
Adverse Childhood Experience: Substance Abuse and Household Member with Mental Illness

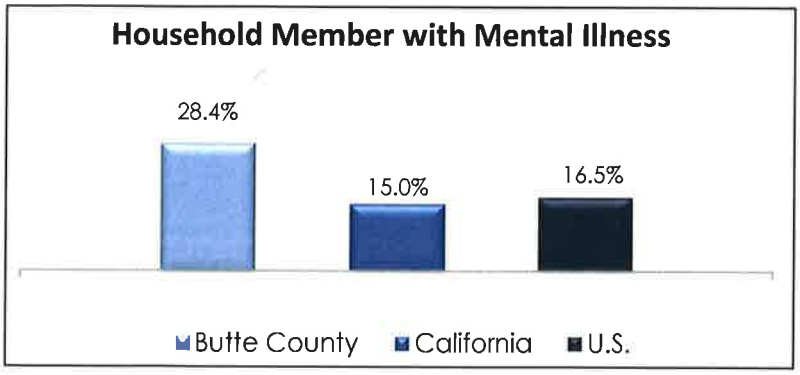
Substance abuse by a household member is the third most frequently reported ACE in California, as cited by 26% of adults. [61]

Nearly four in ten Butte County residents (37.8%) lived with a household member who had a substance abuse problem before they were 18 years old. This figure is attributable mostly to respondents who have high school education or less, and is least common among the oldest residents (65+.)

Close to three in ten (28.4%) lived with a household member who was depressed, mentally ill, or suicidal. The incidence of this adverse experience is lowest in the 65+ age category, and among males. It is also slightly more prevalent among those who completed high school or less.

Both ACEs are above the state- and nationwide levels.





**Note: Comparative data is based on combined 2008-2013 BRFSS of California Residents and combined 2011-2014 BRFSS for 23 states (not all states include ACE questions) **Caution: Fewer than 30 respondents*

Percentage of respondents who lived with anyone who was a problem drinker/alcoholic/drug user, and percentage of respondents who lived with anyone who was mentally ill (before age 18)

Demographic Characteristics	Substance Abuse	Household Member with Mental Illness
Total	37.8%	28.4%
Age		
18-24	38.7%	39.3%
25-34	53.3%	50.1%
35-44	45.9%	24.9%
45-54	40.4%	30.3%
55-64	31.2%	20.7%
65+	23.3%	9.5%
Gender		
Male	36.3%	21.9%
Female	39.2%	34.8%
Race		
White	36.7%	26.8%
Black**	42.8%	38.0%
Hispanic	36.9%	31.8%
Non-Hispanic	37.7%	27.9%
Education		
< High School	65.4%	35.1%
High School Grad	44.0%	33.7%
Some College	35.8%	27.5%
College Graduate	29.2%	23.9%
Household Income		
<$20,000	38.3%	31.9%
$20,000-$34,999	42.0%	31.9%
$35,000-$$49,999**	26.9%	19.9%
$50,000-$74,999	32.1%	27.7%
$75,000 or more	32.9%	22.0%

Intimate Partner Violence: Threatened and Completed Physical Violence

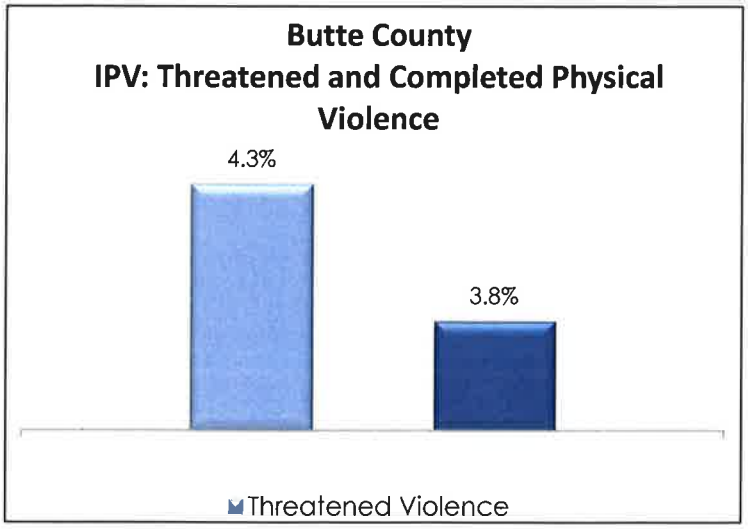
Healthy People 2020 objective IPV-39.1: Reduce physical violence by current or former intimate partners

Healthy People 2020 objective IPV-39.3: Reduce psychological abuse by current or former intimate partners

Intimate Partner Violence (IPV) is violence that occurs in a close relationship, including current or former spouses and dating partners. It includes physical violence, sexual violence, stalking, and psychological aggression. Data from CDC's National Intimate Partner and Sexual Violence Survey (NISVS) indicate that about 1 in 4 women and 1 in 10 men have experienced sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime. Additionally, over 43 million women and 38 million men experienced psychological aggression by an intimate partner. [32]

Within the past year, 4.3% of Butte County residents have been frightened for the safety of themselves, their family or friends because of the threats of their partner (or a former partner.) This result was driven by women and respondents who were high school graduates or less.

The completed physical violence rate is lower, with 3.8% reporting that their partner pushed, hit, slapped, kicked, choked, or physically hurt them in any way within the past 12 months. Again, the likelihood of being physically assaulted is higher among residents with lower educational attainment (high school graduate or less.)



Proportion of respondents frightened for safety of self/family/friends because of partner's threats, and proportion of respondents assaulted by partner (past 12 months)

Demographic Characteristics	Threatened Violence	Completed Violence
Total	4.3%	3.8%
Age		
18-24	6.8%	11.6%
25-34	-	-
35-44**	12.8%	6.4%
45-54	5.9%	4.0%
55-64	2.2%	1.1%
65+	-	-
Gender		
Male	1.0%	2.9%
Female	7.0%	4.5%
Race		
White	3.6%	3.0%
Black**	-	-
Hispanic**	16.2%	9.7%
Non-Hispanic	2.5%	3.0%
Education		
< High School**	14.7%	15.1%
High School Grad	6.6%	9.5%
Some College	0.9%	-
College Graduate	4.1%	0.6%
Household Income		
<$20,000	4.2%	2.7%
$20,000-$34,999**	4.6%	4.6%
$35,000-$$49,999**	-	-
$50,000-$74,999**	2.1%	-
$75,000 or more**	2.3%	2.3%

**Note: No comparative BRFSS data (California or national) is available for this category **Caution: Fewer than 30 respondents*

Intimate Partner Violence: Attempted Control and Unwanted Sex

Healthy People 2020 objective IPV-39.2: Reduce sexual violence by current or former intimate partners

Healthy People 2020 objective IPV-39.3: Reduce psychological abuse by current or former intimate partners

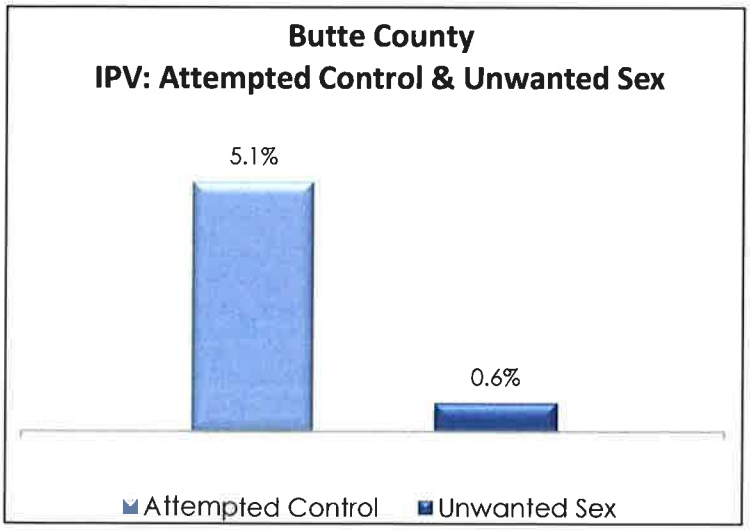
Intimate Partner Violence (IPV) has been shown to have serious health consequences for both women and men, including poor general health, depressive symptoms, substance abuse, and elevated rates of chronic diseases.[60]

A total of 5.1% of Butte County residents has/had a partner (or former partner) who tried to control most or all of their daily activities. This appears to be more prevalent among respondents who are high school graduates or less.

Only 0.6% of residents report having been forced into unwanted sexual activity within the past year after they told their partner (or former partner) that they did not want it.

Proportion of respondents whose partner tried to control their daily activities, and proportion of respondents sexually assaulted by partner (past 12 months)

Demographic Characteristics	Attempted Control	Unwanted Sex
Total	5.1%	0.6%
Age		
18-24	11.6%	-
25-34	3.7%	-
35-44**	10.0%	3.5%
45-54	4.0%	-
55-64	2.2%	-
65+	0.6%	0.5%
Gender		
Male	4.4%	-
Female	5.8%	1.1%
Race		
White	4.6%	0.7%
Black**	-	-
Hispanic**	13.4%	3.7%
Non-Hispanic	4.0%	0.1%
Education		
< High School**	5.8%	-
High School Grad	12.7%	-
Some College	1.8%	0.3%
College Graduate	1.5%	1.5%
Household Income		
<$20,000	5.0%	0.5%
$20,000-$34,999**	2.9%	-
$35,000-$$49,999**	-	-
$50,000-$74,999**	-	-
$75,000 or more**	1.3%	-



*Note: No comparative BRFSS data (California or national) is available for this category **Caution: Fewer than 30 respondents

Demographics

The following is a comparison of the demographic characteristics of the Butte County BRFSS respondents to those of the state and national BRFSS participants.

Demographic Characteristics	Butte County	California	U.S.
Age			
18-24	18.4%	12.6%	12.6%
25-34	15.2%	19.0%	17.0%
35-44	13.3%	17.3%	16.1%
45-54	16.5%	17.0%	16.4%
55-64	16.5%	15.8%	16.9%
65+	19.3%	18.3%	21.0%
Gender			
Male	49.5%	49.2%	48.7%
Female	50.5%	50.8%	51.3%
Race			
White	72.7%	40.7%	72.3%
Black	1.2%	5.4%	6.3%
Hispanic	13.8%	35.1%	8.3%
American Indian or Alaskan Native	4.3%	0.6%	1.0%
Asian	2.2%	15.3%	2.3%
Native Hawaiian or Other Pacific Islander	0.2%	0.2%	0.0%
Other race	1.2%	1.2%	0.0%
Multiracial, non-Hispanic	3.5%	1.5%	1.3%
Education			
< High School	7.0%	17.7%	11.5%
High School Grad	25.7%	21.9%	28.8%
Some Post High School / Some College	33.9%	31.8%	31.8%
College Graduate	33.2%	28.7%	26.0%

**Note: The comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories)*

***"Refused" and "Don't Know" responses not shown / percentages may not add up to 100%*

Demographics – cont'd.

Demographic Characteristics	Butte County	California	U.S.
Household Income			
<$15,000	14.3%	14.9%	9.1%
$15,000-$24,999	9.9%	13.2%	16.5%
$25,000-$34,999	6.0%	9.3%	10.5%
$35,000-$49,999	5.4%	10.8%	14.2%
$50,000 or more	25.2%	51.8%	49.0%
Employment Status			
Employed	44.9%	47.3%	49.2%
Self-employed	8.7%	10.4%	8.9%
No work < year	1.8%	3.3%	2.7%
No work > year	2.6%	2.8%	2.5%
Homemaker	3.8%	7.9%	5.6%
Student	8.6%	6.5%	5.4%
Retired	18.1%	16.2%	18.8%
Unable to work	10.2%	5.6%	6.5%
Marital Status			
Married	39.2%	49.5%	51.4%
Divorced	14.7%	9.2%	11.5%
Widowed	8.4%	5.8%	6.9%
Separated	1.2%	3.1%	2.2%
Never married	31.8%	26.0%	23.8%
Partnered	3.9%	6.4%	4.7%

**Note: The comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories)*

***"Refused" and "Don't Know" responses not shown / percentages may not add up to 100%*

Demographics – cont'd.

Demographic Characteristics	Butte County	California	U.S.
Number of Children Under 18 Years of Age in Household			
5+ children	1.2%	0.9%	1.0%
4 children	1.1%	1.9%	2.0%
3 children	3.7%	6.4%	5.5%
2 children	9.9%	13.7%	12.5%
1 child	12.8%	16.5%	14.5%
None	57.1%	60.6%	64.4%
Home Ownership			
Own	50.2%	57.0%	69.4%
Rent	37.0%	37.8%	24.7%
Other	10.5%	5.3%	5.9%
Veteran Status			
Served on Active Duty in the US Armed Forces	10.7%	8.2%	11.4%
Never served on Active Duty in the US Armed Forces	89.3%	91.8%	88.6%
Internet Use			
Used Internet in Past 30 Days	87.9%	85.1%	85.0%
Did Not Use Internet in Past 30 Days	11.6%	14.9%	15.0%

**Note: The comparative data is based on 2017 BRFSS of California Residents and 2017 Nationwide BRFSS (States, DC and Territories)*

***"Refused" and "Don't Know" responses not shown / percentages may not add up to 100%*

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Appendix: 2

Community Engagement
Focus Group Summary, Morrison Inc.

COMMUNITY ENGAGEMENT- FOCUS GROUPS

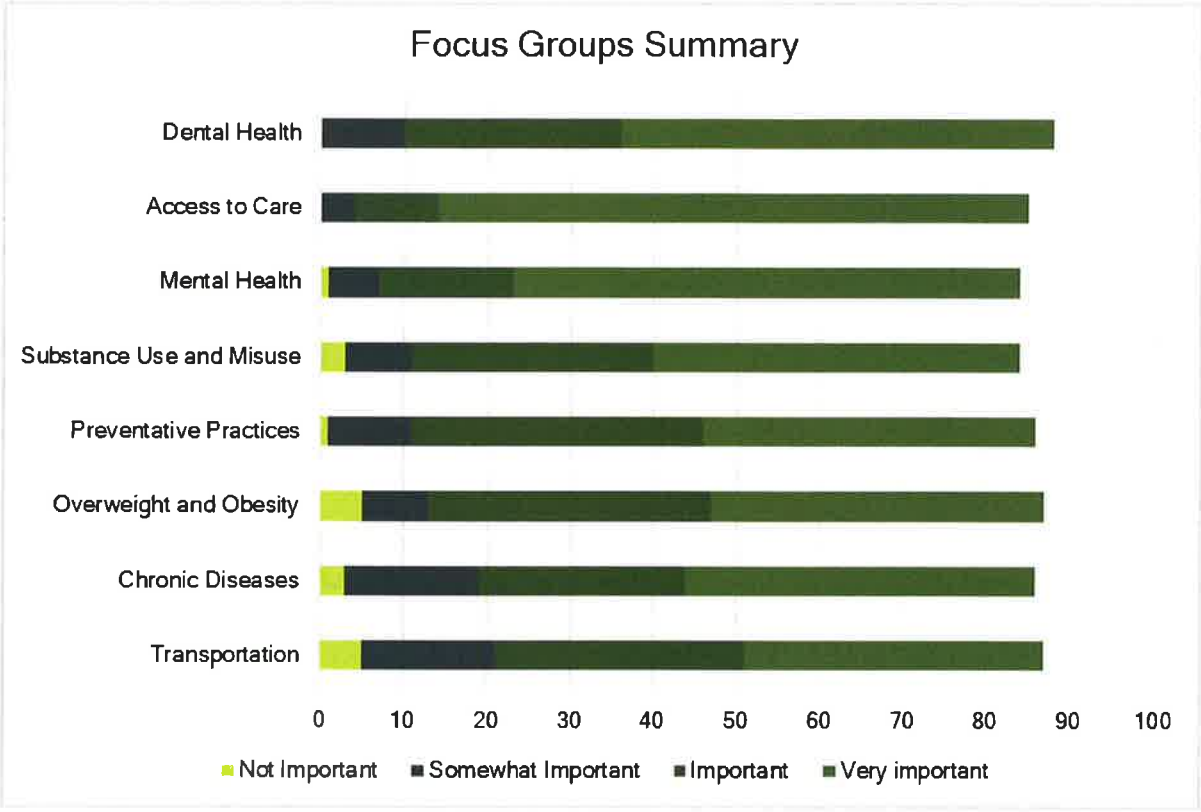
In an effort to gather valuable insights from community members to inform the Community Health Needs Assessment, Butte County Public Health contracted the firm Morrision and Company (Chico, California) to facilitate numerous community focus groups.

Representatives from Enloe Medical Center, Adventist Health Feather River, Orchard Hospital, and BCPH organized each focus group, collaborating with existing Butte County community organizations on several occasions to host focus groups in coordination with previously scheduled events or meetings. This leveraged the established relationships these groups have with the individuals they serve, facilitating active participation by community members. Focus groups were also held at various times throughout the day to best accommodate the schedules of participants. The focus groups ranged in size, with an average of 10 attendees per group.

In total, 12 focus groups reaching 114 participants were conducted, with participants representing a broad spectrum of the community. Participation was received from seniors, college students, individuals receiving mental health services, individuals participating in programs at both the African American Family and Cultural Center and the Hmong Cultural Center, high-school students, physicians, general community members, veterans, and individuals experiencing homelessness. Of those 114 participants, 88 completed a written survey utilized in data collection as displayed for the purposes of this reporting section. A series of questions were designed with input from representatives from Enloe Medical Center, Adventist Health Feather River, Orchard Hospital, and Butte County Public Health, as well as the Morrison facilitator. Participants were asked questions as a group and encouraged to share their own personal experiences or anecdotal experiences observed from friends and family in accessing health care and living healthy lives.

Featured below is a summarized collection of responses received across all focus groups that reference the existing successes and signs of health in Butte County communities, as well as issues that need to be addressed within those communities. These responses are oriented toward themes covered within the groups such as: dental health, access to healthcare, mental health, substance us and misuse, preventative practices, overweight and obesity, chronic diseases, and transportation. Quotations provided are from focus group members regarding the topics mentioned above.

FOCUS GROUPS SUMMARY



Total number of participants: 88

Ranked most important across all the focus groups:

1. Access to care – 81%
    - 71 out of 88 participants
2. Mental health – 69%
    - 61 out of 88 participants
3. Dental health – 59%
    - 52 out of 88 participants

DENTAL CARE

Identified Successes

Noted successes in Butte County communities included an annual free dental clinic offered by local providers, the availability of low cost services from various providers, a mobile dental unit, events and services specifically for veterans, classes available for dental education, and interventional programs for children. The theme supporting much of the participants' feedback when discussing success appears to be programs available over a wide variety of locations, wherein positive intervention might be implemented like dental education, referrals to practitioners, providing detailed information about how to access dental care, or providing on-scene, low-cost/no-cost dental care in a nontraditional location.

"THERE IS A FLOURIDE VARNISH PROGRAM, THEY PROVIDE PARENTAL AND CHILD TRAINING, AND DENTAL EDUCATION." -MEMBER OF THE BCPH CAMP FIRE RECOVERY GROUP

Issues to Address

Issues focused on by groups were largely a lack of available dental providers, and a lack of providers that accepted specific forms of coverage, whether that be Medi-Cal or certain types of private insurance. Parents either being uninformed about proper dental care for children or neglectful of their children's dental care needs was mentioned as an issue, as well as a lack of providers for young children under three with dental issues. Participants stated that some coverages incentivized pulling teeth rather than preventative dentals care, and often these extractions must be performed outside Butte County. It was mentioned that issues often need to be extreme in order to be prioritized to receive care from some programs. Areas for improvement mentioned by participants included expanded access to dental care through school clinics, availability for evening or weekend appointments, and more flexibility overall from providers, and a consideration that dental care might be considered healthcare.

"DENTAL CARE IS SUCH A CHALLENGE IN BUTTE COUNTY THAT I HAVE HAD TO SCHEDULE TEETH TO BE PULLED BEFORE PERFORMING UNRELATED SURGERIES, DUE TO THE RISK OF INFECTION FROM UNTREATED DENTAL ISSUES." -LOCAL MEDICAL PROVIDER

ACCESS TO CARE

Identified Successes

Programs and organizations providing a variety of medical screenings for residents who lacked coverage or income to pay for services were named as successful supports. Organizations providing case management services who were able to assist clients in completing applications for medical coverage, and refer clients and other community members to medical providers and specialty services were also discussed as successes. Programs, organizations, and providers that provided counseling and therapy for people who had experienced trauma and secondary trauma, as well as organizations that had pursued training to become trauma informed in their approach, were mentioned as successful. Multiple local hospice programs were mentioned as successful, as well as one emergency room and a rural health provider in a smaller community within the county. Programs providing community members with healthy food through subsidy or reduced cost, along with nutritional education, were cited as successes. Generally, the programs, organizations, and providers mentioned as successful by focus group participants appear to be focused on bridging gaps in coverage, getting important information revolving around care to community members, and focused on serving vulnerable and underrepresented groups in the community.

Issues to Address

When discussing access to care, participants mentioned that their insurances coverage often acted as a barrier to receiving the care that was most appropriate for their situation. It was brought up that certain providers being unwilling to take Medi-Cal patients limited availability of providers for a large subset of the populations. Ongoing issues regarding contract negotiations between major medical providers and major insurance providers in the area were cited as possibly having a huge impact on availability of care if an agreement could not be worked out. Some participants felt the eligibility window of five years after ending active duty for Veteran's Affairs insurance was too restrictive. Participants stated that some payment systems often incentivized treatment being withheld until the late state or high acuity levels of health issues, and that often symptoms were addressed rather than root causes when care was sought. Some participants felt that eligibility for Medi-Cal or other, low-cost insurance programs was too restrictive based on income levels. It was expressed that there was a significant equity gap between community members with good, private insurance coverage, and individuals who were on Medi-Cal.

"THERE'S A LOT OF TRIAL AND ERROR TO FIND A PROVIDER TO RECEIVE NEEDED SERVICES...YOU NEED TO INVEST A LOT OF PERSONAL TIME AND MONEY." - PARTICIPANT FROM THE IVERSEN CENTER

A lack of access to every type of medical provider, and especially to mental health providers was a key issue mentioned in discussions of access to care; community members were having to wait too long for appointments, and that waiting period was only extended when referred to specialists. The process of connecting to the appropriate care provider was considered very costly and time intensive by some participants. The lack of an

easily available resource to ascertain which providers were accepting new patients, which insurance providers accepted, and other common questions was noted as an obstacle for access to care. It was mentioned by multiple groups that there was not enough accessibility to providers on evenings and weekends, and that there was a lack of transparency in the process of providing care. Issues with reimbursements to doctors were brought up, with added detail that a restructuring of fee systems may often result in higher costs for patients. Lack of reliability in the local public transportation network, and the lack of on-demand services catered specifically for seniors were considered obstacles in physically traveling to locations to receive care.

MENTAL HEALTH

Identified Successes

Regarding mental health, organizations that focused on services for veterans, students, those pursuing treatment for substance use and misuse, and groups focusing on secondary trauma were all praised as being successful in assisting members of the community support mental health issues. A key development discussed was the expansion of telehealth services for providers to be available long-distance; this was cited as a success, and continued expansion could help alleviate the deficit in available mental health professionals in Butte County. Local churches and cultural centers for different ethnic communities were also cited as successful in engaging community members in ways that helped them with mental health issues. Community members cite success for a wide range of locales; from informal groups at cultural meeting spaces to clinical, government programs, an underlying theme of indiscriminate appreciation for mental health providers and spaces to process mental health issues was present throughout group discussions.

"I FEEL LIKE BEING DIAGNOSED AS A 51-50 IS THE ONLY WAY TO GET ADMITTED." - PARTICIPANT FROM THE JESUS CENTER

Issues to Address

A shortage of psychiatrists and counselors, often leading to long wait times for appointments, were a significant obstacle in receiving mental health care; there was a significant concern mentioned by participants that the additional trauma experienced in the community due to the Camp Fire would place even more strain on local mental health care providers. The process to receive care was considered long; a lack of clear resources for finding a counselor or therapist that provided services for the milder end of the spectrum of mental health issues was mentioned as an obstacle to receiving mental health care. A lack of providers willing to accept Medi-Cal, and the lack of affordable mental health services even for those with substantial private insurance plans was cited as a major issue by participants. A lack of programs focusing on service to vulnerable communities like recent immigrants and refugees was mentioned as an issue around mental health care. A lack of aftercare for patients that had received intensive psychiatric services was mentioned as a barrier to mental health care. A lack of knowledge or availability regarding quality services and programs for community members was a dominant them in discussing issues of mental health care for the groups. Some community members felt

"WE HAVE A FRAGMENTED MENTAL HEALTH & SOCIAL SERVICES DELIVERY SYSTEM." - MEMBER OF THE BCPH CAMP FIRE RECOVERY GROUP

that providers might be too reliant on medication as a form of mental health care. At least one participant felt that there was a prevalence of misdiagnosis of mental health issues that created issues for patients. Some participants felt that being placed on a 51/50 hold was the only way to quickly access mental health care

The stigma of being open about struggles with one's mental health was a common topic as an obstacle to mental health care in groups as well; participants felt that mental health issues were still viewed as weakness by a large portion of the community. A lack of demographic representativeness amongst providers was cited as an obstacle for some populations to connect with mental health providers. Some participants felt that some providers did not show respect for patients. Some participants stated that the idea that mental health care might be done as a preventative measure rather than a treatment of acute symptoms was still foreign to much of the community. Participants cited the fear of punishment should mental health services be accessed as a significant source of stigma within the community, particularly the fear that one might lose the ability to own firearms should they seek mental health care.

SUBSTANCE USE AND ABUSE

Identified Successes

"PHARMACY DRUG TAKEBACK PROGRAMS FOR UNUSED OR EXPIRED DRUGS ARE HELPFUL." -PARTICIPANT FROM THE CALIFORNIA HEALTH COLLECTIVE

Participants discussed outpatient treatment programs, residential treatment programs, twelve step organizations, programs that offered education and early intervention, and harm reduction programs, as well as the local Drug Court when asked about successful programs to prevent or treat drug, alcohol, and tobacco usage. Multiple harm reduction measures were mentioned; Nalaxone training, needle exchange, and pharmacy medicine collection bins. The noticeable trend in discussion about helpful programs was toward positive intervention meeting people struggling with substances in places that were familiar and comfortable for them, taking proactive measures for high risk populations to make them aware of treatment structures, and the fact that there are people available looking to address addiction with community members struggling with substance use, abuse, or addiction.

Issues to Address

Issues mentioned by participants that tied in to obstacles with treating and avoiding substance use and misuse included loneliness, the cycle of addiction, stigma for those struggling with addiction, a lack of education around addiction for community members, and an overemphasis on individual responsibility for finding appropriate treatment. The view of vaping as a healthy alternative to smoking rather than another harmful addiction was cited as an obstacle to healthy relationships to substances. Stigma around addiction and fear of being honest with healthcare professionals due to possible punishment was also mentioned. Members of the community using substances to self-medicate was mentioned, and a lack or dual-diagnosis programs available was also a concern for participants. Participants felt substances that might be abused were easy to access, and that drugs being marketed as glamorous were both issues that contributed to substance use and misuse. With the legalization of marijuana in California, the issue was raised that many parents grow marijuana in their home, and are either not educated or are willfully endangering their children due to constant exposure to marijuana when growing large amounts in confined spaces. Some participants did not feel that school officials were easy to connect regarding substance use and abuse issues for youth enrolled at school.

> "THE ADDICTION TREATMENT SYSTEM IS BROKEN; LACK OF FOCUS ON REUNIFICATION; THERE ARE BROKEN FAMILIES, BROKEN HOUSEHOLDS." - PARTICIPANT FROM THE IVERSEN CENTER

PREVENTATIVE PRACTICES – SCREENING, VACCINATIONS, INJURY PREVENTION

Identified Successes

Successful preventative outlets for preventative practices mentioned included low-cost/no-cost immunization and inoculation clinics, and other free health clinics provided by local and statewide healthcare providers. Outreach and education provided through social media was mentioned, along with classes available through educational providers, healthcare providers, churches, and other faith-based organizations. Businesses and organizations that provide exercise classes and resources for exercise, particularly to vulnerable groups, were cited. Early intervention programs that provided information, screening, and healthcare for infants and toddlers were considered a success by participants. Again, the focus for participants appears to be low-cost or no-cost providers for intervention and education, many of whom are not located in traditional healthcare locations. Culturally specific services, particularly for underrepresented groups, were mentioned.

Issues to Address

Cost of preventative practices was cited repeatedly as an issue. The impact of anti-vaccination discourse was cited as having an effect on community members' willing to be vaccinated and vaccinate their children. Lack of screening and education for adult asthma was brought up by a group. At least one participant felt there was too much information available on screenings and vaccinations, which caused a paralysis; they

would prefer a clear, efficient path to their preventative practices. A lack of information for community members was also mentioned multiple times. Distrust of scientific information and of government institutions was cited as an obstacle to preventative practices, as well as cultural barriers, including a reliance on traditional forms of medicine that may lack the same base of evidence as the preventative practices mentioned in the title of this subsection. Fear of discovering that they have some other health problem was a dissuading influence on community members seeking preventative care according to some participants. Residual effects of vaccinations were also mentioned as a dissuading influence by participants.

"[BASED ON VOLUME OF AVAILABLE INFORMATION] IT'S DIFFICULT TO UNDERSTAND AND MAKE AN INFORMED DECISION, SO INDIVIDUALS CHOOSE TO WAIT UNTIL SOMETHING BAD HAPPENS, RATHER THAN [SEEK OUT] PREVENTATIVE CARE." - PARTICIPANT FROM THE CALIFORNIA HEALTH COLLECTIVE

OVERWEIGHT AND OBESITY

Identified Successes

Community Successes in addressing being overweight or obese included education from a variety of sources and programs connecting the public with medical professionals in nontraditional locations. Many of the successes cited were opportunities to exercise for no cost outdoors, access to public areas of recreation for people of all ages, and communities that centered on forming a consistent social group to participate in those activities together. Likewise, community groups that provided healthy, communal meals on a regular basis were mentioned as a success. Government programs and food pantries that provided access to nutritious food for those that lacked resources to purchase or access such foods were also cited.

"MENTAL HEALTH ISSUES AND MEDICATION CAN IMPACT YOUR LEVEL OF PHYSICAL ACTIVITY." - PARTICIPANT FROM THE IVERSEN CENTER

Issues to Address

Prevalence and convenience of fast food was an issue brought up by participants. Current technology contributing to less physical activity by giving people many sedentary entertainment options at all times was mentioned in multiple groups. A lack of free time to pursue exercise was brought up repeatedly, as well as individual laziness and a lack of motivation to be healthy for some members of the community. A lack of healthy options for students at school, and open campuses that give the option of traveling to fast food restaurants to students were both brought up as issues contributing to children and youth being obese and overweight. A lack of public recreation programs and centers, whose programs are cited as a positive but were not considered to be widely enough available by participants. Private gyms and fitness clubs are not

affordable to many members of the community was a repeated sentiment in focus groups; the public pools are only available during the summer months rather than year-round, which could be a recreational outlet for families more often if that capability were changed. Budget cuts to physical education programs at schools were mentioned as contributing factors to being overweight or obese, as well as a lack of open access to school weight rooms, with preferences being given to school sports teams. Participants mentioned that Chico's bike paths are unsafe and should be made safer. Participants stated that Oroville was not very walkable, due to concerns over safety, and specifically the relatively large amount of dogs off the leash. It was expressed that many community members struggled to afford fresh, healthy food. It was mentioned multiple times that mental health issues made it difficult to pursue regular physical activity. At least one participant brought up that being physically active might be seen as a sign of privilege, and some community members might be afraid that their benefits would be stripped if they were seen to be exercising in public.

CHRONIC DISEASE - ASTHMA, DIABETES, HEART DISEASE, STROKE, LIVER DISEASE, ETC.

Identified Successes

Community organizations, recovery-based communities, and existing medical providers, especially government programs, were mentioned as successful in helping people prevent or care for chronic diseases. New technology like fitness bands were also mentioned.

Issues to Address

Lack of support for specific conditions, like epilepsy, Parkinson's, and Multiple Sclerosis, was mentioned as an issue. It was mentioned that resource classes for people with diabetes were poorly attended due to a bad location and a lack of availability. There is a lack of specialists in smaller communities, and a lack of pediatric specialists in the county according to participants. Long wait times were cited again as an issue for receiving care. Difficulties with the system for obtaining prescriptions if there are complications like a lost prescription. Side effects from multiple medications, and community members' concerns that side effects were causing more issues in their daily lives than the actual conditions they were treating were considered obstacles for chronic diseases. A lack of understanding about underlying causes for community members who have chronic diseases, and how factors like lifestyle choices may contribute was expressed as a concern by groups. The effect of the toxic air and water from local wildfires, especially the camp fire, and the resultant uptick in people with chronic conditions and the symptoms those with chronic disease will struggle with were mentioned as a concern by participants. Some participants felt that providers sometimes "pre-diagnose" based on race or ethnicity. Participants at the Hmong Cultural Center stated that a lack of family history knowledge regarding genetic possibilities for chronic health conditions is an issue specifically for Hmong community members.

TRANSPORTATION

Identified Successes

Programs offered to assist special populations with transport were cited as successful in getting people access to necessary transportation. Programs that provide bus passes at low cost or no cost were cited, with the B-Line local bus system being mentioned as a positive success, especially some of the newer routes. Calling the Butte County information line as a way to access transport was an example of success in increasing access to crucial, specialized transportation like getting a ride to medical appointments. The availability of services like Uber and Lyft were mentioned as a method that has increased on-demand access to transportation. Cabs, and cab driver's generosity were cited as successes in transportation access, as well as certain cultural organizations that provided a more expansive definition of essential transport, like rides to the grocery store, when contacted ahead of time to set up an appointment. Buses provided by local medical providers were mentioned as a key success for necessary transport to and from medical services, as well as emergency flightcare. The amount of bike paths and the accessibility they provide, particularly in Chico, was mentioned as a strength for providing transportation access.

Issues to Address

"[RIDESHARING APPLICATIONS] REQUIRE TECHNOLOGY AND A DEBIT OR CREDIT CARD."
- PARTICIPANT FROM THE IVERSEN CENTER

Participants listed a variety of issues for transportation in Butte County. One participant stated there are not enough paratransit services available in the county. Bus services to Paradise and Magalia are limited according to participants. The feeling that transport that specifically caters to elderly community members is not widely available enough was expressed multiple times in groups. The B Line bus system does not run on Sundays, and is not always frequent enough, resulting in long wait times and significant time devoted to travel even for small errands, and at least one participant felt the bus stops are too infrequent and far apart from one another. It was mentioned that there was a lack of trust in newer ridesharing applications, and that people seek a more low-cost, reliable way to get to a pharmacy or a grocery store on an individual basis. Participants mentioned that cars are expensive to own and maintain. Ridesharing applications require a certain level of technology that is not universally accessible, as well as a debit or credit card, which were issues of accessibility for participants. There were not enough accessible alternatives for people unable to obtain driver's license due to being differently abled according to participants. Driver's education programs are not widely available enough at public schools, and private programs can be costly, which affects the ability of young people to become properly licensed drivers.

Appendix: 3

Press Release

BUTTE COUNTY HEALTH NEEDS SURVEY

Your voice matters in improving the health and well-being of our community.

Calls Coming

Answer Your Phone!

Results impact decisions that affect your health.

Supported by Enloe Medical Center, Adventist Health, Orchard Hospital and Butte County Public Health. Visit ***www.enloe.org/chna*** for more information.

ENLOE MEDICAL CENTER

AdventistHealth

Orchard HOSPITAL

Butte County PUBLIC HEALTH

Appendix: 4

Form 990 Scheduled H Reference Chart

Form 990 (Schedule H) Reference Chart

Form 990 Question No.	Description	Reference Page in CHNA Document
	Fiscal Year End	June 30th
	State	CA
1	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8. If "Yes," indicate what the Needs Assessment describes (check all that apply):	Yes
A	A definition of the community served by the hospital facility	Pg 2
B	Demographics of the community	Pg 5
C	Existing health care facilities and resources within the community that are available to respond to the health needs of the community	Appendix 5
D	How data was obtained	Pg 2
E	The health needs of the community	Pg 12
F	Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Pg 12
G	The process for identifying and prioritizing community health needs and services to meet the community health needs	Pg 12 and Appendix 4
H	The process for consulting with persons representing the community's interests	Appendix 1 and 2
I	Information gaps that limit the hospital facility's ability to assess all of the community's health needs	Pg 4
J	Other (describe in Part VI)	Appendix 3: Survey
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 2013	2016
3	In conducting the most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	Yes

Form 990 (Schedule H) Reference Chart (continued)

Form 990 Question No.	Description	Reference Page in CHNA Document
4	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI.	Yes (See Part VI)
5	**Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):**	**Yes**
A	**Hospital facility's website**	**Yes**
B	**Available upon request from the hospital facility**	**Yes**
C	**Other (describe in Part VI)**	**See Part VI**
6	If the hospital facility addressed needs identified in its most recently conducted needs Assessment, indicate how (check all that apply):	Yes
A	Adoption of an implementation strategy to address the health needs of the hospital facility's community	Appendix 6
B	Execution of the implementation strategy	Appendix 6
C	Participation in the development of a community-wide community benefit plan	Appendix 6
D	Participation in the execution of a community-wide community benefit plan	Appendix 6
E	Inclusion of a community benefit section in operational plans	Appendix 6
F	Adoption of a budget for provision of services that address the needs identified in the Needs Assessment	N/A
G	Prioritization of health needs in its community	Appendix 6
H	Prioritization of services that the hospital facility will undertake to meet health needs in its community	Appendix 6
I	Other (describe in Part VI)	N/A
7	**Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs**	Yes

Other: Part VI

#4 – Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI.

Orchard Hospital worked collaboratively with the following hospitals and public health entity to complete the data gathering process for the Community Health Needs Assessment:

- Enloe Medical Center
- Feather River Hospital Adventist Health
- Butte County Department of Public Health

#5C – Did the hospital facility make its Needs Assessment widely available to the public? Other (describe in Part VI).

1. Notification to the public that the Orchard Hospital Community Health Needs Assessment was available for review and was placed in the local newspaper with the website link to access the report.
2. Notification to all of our employees has been made through a facility-wide mass email. Email included a link to the report on our website and an attachment (PDF) of the report.
3. Notification to our employees was also placed on our intranet along with a PDF of the report.

Appendix: 5

Implementation Plan 2019

Table of Contents:

Priority: Access to Health Care

Objective/Strategy

Improving access to healthcare is a major focus for Orchard Hospital, and lack of providers in Butte County was a dominant theme reflected across all focus groups. Improving access to healthcare is not just a matter of *affordability*, but also *availability* in our primary and secondary service areas. Orchard Hospital will continue to enhance our current service lines and expand specialty services in order to reduce the need to leave the area for healthcare.

How:

Improving access to healthcare services helps to ensure that patients have a medical home (a provider or facility where one regularly receives care). Patients with a medical home exhibit better health outcomes, fewer disparities, and lower costs. Orchard Hospital will:

- Increase access to healthcare by expanding care and services in Butte County
  - Medical Specialty Center-Oroville
  - Expand Services offered at the Oroville Clinic
- Offer transportation
  - Senior Life Solutions
  - FEMA Site
- Increase number of providers at the Medical Specialty Centers
  - Hire more providers with new specialty service lines
  - Recruit providers that speak a second language
  - Increase number of primary care providers (PCP)
  - Guiding patients to establish a PCP
- Timeliness of service:
  - Availability of appointments and care for illness or injury when needed
  - Time spent waiting in doctors' offices and emergency departments (EDs)
- Add Tele Psychiatry:
  - Offering emergency department and acute care patients access to mental health consultations via online conferencing and consultation
- Emergency department pediatric care:
  - Partnership with the University of California - Davis allows us to expand the pediatric care program to our community
- Long-term care
  - Skilled nursing facility
    - Keep patients close to home
  - Increase resident capacity
- Free influenza vaccination clinics
  - Collaborating with local health department

Priority: Access to Health Care

Programs/Resources to Commit

- Increase the number of providers
- Transportation- Uber, Lyft, Gridley Feather Flyer and taxi
- Medicare Seminars- long term care
- Increased Skilled Nursing Facility to 82 beds

Impact of Programs/Resources on Health Need

- Orchard Hospital Community Financial Assistance
- Butte County B-Line
- Gridley Feather Flyer
- Preventive Service
- Medicare Seminar

Accountable Parties

- Administrator of the Medical Specialty Center
- Director of Physician Recruitment, Marketing and Community Outreach
- Education/Infection Prevention
- Social Services
- Utilization Review and Discharge Planning
- Director of Senior Life Solutions
- Administration - Hovlid Community Care Center – DP/SNF

Partnerships/Collaboration

- Orchard Hospital will work with the City of Gridley, CSU Chico (dietary intern), Butte County Social Services (intern), Rural Health Nursing student, Gridley Feather Flyer Program, Butte County Department of Public Health, community outreach programs/service clubs and other local hospitals.

Priority: Mental Health and Substance Use Disorders

Objective/Strategy

Metal illness and substance abuse including alcohol, tobacco, illicit drugs, and opioids, continue to rise toward the top of the health needs for Butte County residents. Orchard Hospital will continue to promote smoking cessation among young people and adults within our community to decrease the percentage of those who smoke or use smokeless tobacco. We will also continue to provide our community with a pain management provider, manage prescription pain medications, and provide mental health referrals.

How

Upgrade website to include marketing of programs and services available throughout our community related to mental health, substance use, and the use of tobacco. Communicate services offered at Orchard Hospital through existing and new community marketing campaigns. Orchard Hospital employees will be encouraged to participate.

Implement best-practices for managing prescription pain medications

- Continue to offer Pain Management Provider
- Provide Continuing Medical Education (CME) for Butte County prescribing providers regarding prescription opioid misuse and abuse.
- Continue to offer Mental Health Services:
    - Senior Life Solution
    - Family Licensed Therapist
    - Emergency Room offers Tele-Med Psychiatry

Programs/Resources to Commit

Orchard Hospital is currently collaborating with the Butte County Department of Public Health and Butte County Drug Abuse Task Force to continue to implement the smoking cessation program. Work with the Local School Districts and the local Parks and Recreation Departments to roll- out programs to the youth. Promotion of this program will continue to be communicated to patients through staff and physicians. Work with our current human resource department and healthcare insurance to offer incentives to our employees for participating in smoking cessation. Orchard Hospital will also provide Accessible Intervention and Respiratory Education (AIRE program) for those that have lung disease.

Community Resources:

Substance Use and Misuse

- Alcoholics Anonymous
- Butte County Public Health Department
- Chico Rescue Mission
- Narcotics Anonymous
- No Butts
- Skyway House
- Smoke Free North State
- Tobacco Use Prevention Education
- Vet Center

Mental Health

- Orchard Hospital Senior Health Solutions
- African American Family & Cultural Center
- Butte County Behavioral Health
- Chico Veteran Center
- Hmong Cultural Center

Impact of Programs/Resources on Health Need

- Decline in percentage of those who smoke or use smokeless tobacco
- Additional education to front line staff.

Accountable Parties

- Administrator of the Medical Specialty Center
- Director of Physician Recruitment, Marketing and Community Outreach
- Education/Infection Prevention
- Social Services
- Utilization Review and Discharge Planning
- Director of Senior Life Solutions
- Administration - Hovlid Community Care Center – DP/SNF

Partnerships/Collaboration

Orchard Hospital will work with Butte County Department of Public Health and Partner with the Rural County Opioid Group.

Priority: Chronic Diseases: Obesity

Objective/Strategy

Enhance care for Childhood Obesity. Orchard Hospital will provide a weight loss management program at the Medical Specialty Center Oroville. Orchard Hospital will continue to offer educational information and to increase the outreach for the Health Ambassador Program.

How

- Weight Loss Management Program
  - Healthcare Provider will counsel Patient and refer patient to clinic Registered Dietician
- Orchard Hospital employees will be encouraged to participate.
- Communicate service offered through local Service Clubs, Schools, Churches, and at Orchard Hospital through existing and new community marketing.
- Utilize the website and social media outlets to include marketing of programs and services available throughout our community for childhood obesity.
- Health Ambassador Program
  - Gridley High School Nursing Pathway Students will be instructed on how to educate elementary students and junior high students on nutrition and fitness (play 60).
  - Orchard Hospital will be able to reach children ages 9-18 in our service area.
  - Educate on how to make healthy snacks and 60 min fitness activity.

Programs/Resources to Commit

Collaborate with local schools and partner with school nurses and the Center for Nutrition & Activity Promotion. Offer nutritional and fitness program to local schools utilizing the play 60 activities and help children and young adults learn how to move for 60 minutes.

Impact of Programs/Resources on Health Need

- See a marked improvement in the management of individual weight and nutrition. This will be proven by increased activity among children/teens as well as weight loss.

Accountable Parties

- Administrator of the Medical Specialty Center
- Marketing and Community Outreach
- Education/Infection Prevention
- Social Services
- Nutritional Services Utilization Review and Discharge Planning
- Director of Senior Life Solutions
- Administration

Partnerships/Collaboration

Butte County Public Health, Orchard Hospital Nutritional Services, Medical Specialty Center clinic, Partnership with CSU Chico for Dietary Intern, CSU Chico for Social Services Intern and Rural Health Nursing students, Local Service Clubs, and the Local School Districts.

Priority: Chronic Diseases: Diabetes

Objective/Strategy

Enhance care for Diabetes. Orchard Hospital will provide diabetes education to patients identified by providers at the Medical Specialty Center. A provider will refer a patient to diabetic counseling with the registered dietician as needed.

How

Upgrade website to include marketing of programs and services available throughout our community for diabetes. Patients will be referred when newly diagnosed with diabetes and receive lifestyle/self-care information.

Programs/Resources to Commit

Orchard Hospital Dietitian and o r Provider (MD or FNP) will meet with the patient and provide a diabetic counseling session.

Impact of Programs/Resources on Health Need

- See a marked improvement in the management of diabetes. This will be evidenced by lower blood sugar levels and weight loss when applicable.

Accountable Parties

- Administrator of the Medical Specialty Center
- Marketing and Community Outreach
- Education/Infection Prevention
- Social Services
- Registered Dietician in Nutritional Services
- Utilization Review and Discharge Planning
- Administration

Partnerships/Collaboration

Initially, this process will be in-house (utilizing the services of our Nutritional Services Department and the Medical Specialty Center Clinic). We will collaborate and partner with Butte County Public Health, other Hospitals, CSU Chico for Dietary Intern, Social Services Intern, and Rural Health Nursing students.

Appendix: 6

Public Comment

Public Comment

In compliance with IRS regulations 501(r) for charitable hospitals, a hospital Community Health Needs Assessment (CHNA) and Implementation Strategy are to be made widely available to the public and public comment is to be solicited. The previous Community Health Needs Assessment, and annual implementation strategies were made widely available to the public on the website www.OrchardHospital.com . To date, no comments have been received.

Appendix: 7

Works Cited

Works Cited:

[i] https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Access-to-Health-Services

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[iv] https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health

[v] https://www.cdc.gov/chronicdisease/about/index.htm

[vi] Centers for Disease Control and Prevention (April 2, 2019). About the CDC-Kaiser ACE Study |Violence Prevention|Injury Center|CDC. Retrieved from https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html

[vii] Center for Youth Wellness. Findings on Adverse Childhood Experiences in California. Retrieved from https://centerforyouthwellness.org/wp-content/themes/cyw/build/img/building-a-movement/hidden-crisis.pdf

[viii] Rodriguez, D., et al. (2016). Prevalence of adverse childhood experiences by county, California Behavioral Risk Factor Surveillance System 2008 - 2013. Public Health Institute, Survey Research Group

Title 11, California Code of Regulations § 999.5(d)(5)(B)

A description of all charity care provided in the last five years by each health facility or facility that provides similar health care that is the subject of the agreement or transaction.

Orchard Hospital – Charity care at Orchard Hospital consists of a Community Care Financial Assistance Program that serves patients who cannot otherwise afford health care.

1. Exhibit 1 – Orchard Hospital Community Care Assistance Policy
2. Exhibit 2 – Orchard Hospital Schedule of Charity Care Community Benefits for the past 5 years, ending June 30, 2023.

American Advanced Management – Charity care with AAM consists of a Financial Assistance Program for patients facing financial hardship.

1. Exhibit 3 – American Advanced Management Policy on Financial Assistance.

Title 11, California Code of Regulations § 999.5(d)(5)(B)

A description of all charity care provided in the last five years by each health facility or facility that provides similar health care that is the subject of the agreement or transaction.

EXHIBIT 1

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

x	All Orchard Hospital entities		Medical Specialty Center		
	Orchard Hospital		Medical Specialty Center (Oroville)		

COMMUNITY CARE FINANCIAL ASSISTANCE POLICY

POLICY:

Orchard Hospital realizes the need to provide service to patients who cannot otherwise afford health care. This policy is to provide financial assistance to patients who have health care needs and are uninsured, under-insured, ineligible for a government program, and are otherwise unable to pay for medically necessary care based on their individual needs.

A graduate schedule based on the annual HHS Poverty Guidelines, as well as assessment of the patient's monetary assets will be used to determine the qualifying income and asset levels of applicants. Guidelines are subject to change yearly based on the HHS Poverty Guidelines. Understanding this need, the hospital has chosen to fulfill their responsibility to the community by adopting the following Community Care Policy.

PROCEDURE:

1. Standard Eligibility Criteria for Participation in the Community Care Program:

a. A patient qualifies for Community Care if all of the following conditions are met:

The patient does not have private health insurance (including coverage offered through the California Health Benefit Exchange), Medicare, or Medi-Cal as determined and documented by the hospital.

The patient's injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital.

The patient's household income does not exceed 75% (see matrix) of the Federal Poverty Level; **and**

The patient's allowable monetary assets do not exceed $5,000.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

X	**All Orchard Hospital entities**		**Medical Specialty Center**		
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

1. In determining a patient's monetary assets, the hospital **shall not** consider:
   Retirement or deferred compensation plans qualified under the Internal Revenue Code.
   Non-qualified deferred compensation plans.
   The first ten thousand dollars ($10,000) of monetary assets, and fifty percent (50%) of the patient's monetary assets over the first ten thousand dollars ($10,000).

b. Family size to determine federal poverty level is defined as follows:
   The patient's legal spouse or domestic partner
   the patient's legal guardian or parent
   Children under 21 whether living at home or not Caretaker relatives.

2. Special Eligibility and Enrollment Exceptions:

a. High Medical Costs/Medically Indigent

A patient whose family income does not exceed 400% (see matrix) of the federal poverty and their annual out-of-pocket medical expenses for non-elective/medically necessary services with

Orchard Hospital and other health care providers exceed 10% of the patient's family gross income in the prior 12 months, would then be considered as "Medically Indigent" as defined by AB774.

1. For those who have been informally determined to be Medically Indigent or have incurred high medical costs will be offered the chance to complete a Community Care application by the Financial Counselor.

2. Supporting documentation to show what medical expenses have been paid in the prior 12 months is required to determine eligibility.

b. Homeless/Indigent Patients

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)					
x	All Orchard Hospital entities		Medical Specialty Center		
	Orchard Hospital		Medical Specialty Center (Oroville)		

Patients who are determined to be indigent/homeless by either clinical documentation or are unable to provide sufficient demographic information such as a mailing address, phone number, or residential address will/can be considered for Community Care.

1. No application will be required by a patient who has been determined to be indigent/homeless.

2. Only emergency/medically necessary services will be considered. Should a patient who presents for outpatient services, financial counseling will be done at the time of service.

c. Deceased No Estate

Upon receipt of confirmation that a patient is deceased and who has no estate, third party coverage, or spouse, will be automatically eligible for Community Care upon receipt of the following items.

1. Notification from county in which patient expired in.
2. Received copy of death certificate from patient family notifying OH of death and no estate exists.
3. Confirmation that patient does not have a living spouse who would be liable for outstanding/unpaid debt.
4. Confirmation from another facility of patients' expiration and that no estate or pending probate exist.
5. Upon notification from collections agency that collections accounts are being cancelled back due to deceased/no estate.
6. Knowledge that patient has expired based on clinical documentation for services provided by OH.

d. Administrative Community Care

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

X	All Orchard Hospital entities		Medical Specialty Center		
	Orchard Hospital		Medical Specialty Center (Oroville)		

In cases where medically necessary services are provided to a patient who has been screened by the financial counselor, and it has been determined that the patient is unable to complete the standard application process due to medical, social, or other documented circumstances, charges may be considered for Community Care on a case-by-case basis.

1. Account(s) should be written up for Community Care adjustment with all supporting documentation attached and be presented to the Manager of Business Office/Registration and Chief Financial Officer for approval.

3. Standard Enrollment Process:

An informal determination of Community Care eligibility will be determined by the Patient Financial Counselor and Credit/Collection Specialist, and the applicant may choose to fill out an application based on the recommendation of the Patient Financial Counselor and Credit/Collection Specialist; however, the recommendation of the Patient Financial Counselor and Credit/Collection Specialist is not required in choosing to fill out the Community Care Application.

Upon being submitted for consideration by the Patient Financial Counselor and Credit/Collection Specialist, all properly submitted applications will be reviewed and considered for implementation within 10 business days.

All application packets must be filled out completely and accurately with each of the following required documentation attached, to be considered:

Documentation of non-coverage from Medi-Cal for the service on the date performed; Documentation of household income, as provided by:

1. Current W-2 withholding form or Income Tax statement form from the previous year, **or**
2. Pay stubs from the previous three months

Documentation of monetary assets, to include:

1. Most current bank statement, and any additional information or statements on all monetary assets
    a. Statements on retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans **shall not** be included.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

X	All Orchard Hospital entities		Medical Specialty Center		
	Orchard Hospital		Medical Specialty Center (Oroville)		

2. Signed waiver or release from the patient or the patient's family, authorizing the hospital to obtain account information from financial and/or commercial institutions, or other entities that hold or maintain monetary assets, to verify their value.

Completed Medicare Secondary Payer (MSP) Questionnaire indicating the patient's injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance.

b. Any additional accounts with outstanding balances at time of application will be screened for Community Care eligibility using the same information collected above.

c. Verification of accuracy of application information, including contacting employers for verification of employment, will be made.

d. A letter of either approval or denial will be submitted to each applicant.

The approval letter will include a demand statement for the service in question with adjustments and a balance of zero dollars ($0) and contact information for any questions that may arise.

The denial letter will include reason for denial; indication of potential eligibility under the Discount Payment Program, Payment Plan Program, or other self-pay policy; and information and request to contact the Patient Financial Counselor and Credit/Collection Specialist as soon as possible.

e. Any additional services rendered up to a year after the submission date of an approved Community Care Application will additionally require updated documentation of non-coverage for the service on the date performed; and a completed MSP Questionnaire indicating the patient's injury is not a compensable injury.

f. Any disputes regarding a patient's eligibility to participate in the Community Care Program shall be directed to the Manager of Business Office/Registration and will be resolved within 10 business days.
If it is determined that the patient is ineligible to participate, the number of days spent on dispute resolution shall not be counted toward the minimum 150 days prior to reporting any amount to a credit reporting bureau.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

x	**All Orchard Hospital entities**		**Medical Specialty Center**		
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

4. Participant Accounts Maintenance:

A record for each Community Care applicant will be created, and will include the following items:

a. Patient information and application
b. A copy of every correspondence between Orchard Hospital and the participant
c. Detailed bills on all accounts to be included in the application.
d. Adjustment form with adjustments taken on accounts.
e. Any additional notations and pertinent information

5. Availability of the Community Care Policy:

a. Notice of the Community Care Policy shall be posted clearly posted in locations visible to the public, including but not limited to:

Emergency department
Billing office
Admissions office
Other outpatient locations

b. In the event of the hospital providing service to a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, the hospital shall provide a notice to the patient that includes, but is not limited to:

A statement of charges for services rendered by Orchard Hospital; and

A request that the patient inform Orchard Hospital if the patient has health insurance coverage, Medicare, Medi-Cal or other coverage, and if the patient does not, that the patient may be eligible for such coverage, and can obtain an application for such coverage from Orchard Hospital; and

A statement that indicates the patient may qualify for Community Care if they meet the eligibility criteria set forth in this policy; and

The name and telephone number of the Patient Financial Counselor and Credit/Collection Specialist from whom the patient may obtain information about the Community Care policy and other assistance policies, and about how to apply for that assistance.

REFERENCES:

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

X	All Orchard Hospital entities		Medical Specialty Center		
	Orchard Hospital		Medical Specialty Center (Oroville)		

The processes and procedures described above are designed to comply with CA SB 1276 (Chapter 758, Statutes of 2014), CA AB 774 (Statutes of 2006) and SB 350 (Chapter 347, Statutes of 2007).

Questions regarding SB 1276, AB 774 and SB 350 can be addressed by the Patient Financial Counselor or by California's Office of Statewide Health Planning and Development's website, at

http://www.oshpd.ca.gov/hid/products/hospitals/fairpricing/index.html.
http://aspe.hhs.gov/poverty/14poverty.shtml

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

x	All Orchard Hospital entities		Medical Specialty Center		
	Orchard Hospital		Medical Specialty Center (Oroville)		

2023 HHS POVERTY GUIDELINES – 75% FPL

Persons in Family or Household	75% US Poverty Level
1	$ 10,935
2	$ 14,720
3	$ 18,545
4	$ 22,500
5	$ 26,355
6	$ 30,210
7	$ 34,065
8	$ 37,920
For each additional person, add	$ 5,140

To determine community care eligibility according to income level:

Count the number of people in your family/household.

a. For persons 18 years of age and older, including spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not
b. For persons under 18 years of age, include parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

Calculate the household income (annual).

On the row corresponding to the number of persons in your family/household above, compare your household income to the amount in the column labeled "75% US Poverty Level."

If your household income is less than 75% US Poverty Level amount, your income supports your eligibility for Community Care.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

X	**All Orchard Hospital entities**		**Medical Specialty Center**		
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

To determine community care eligibility according to total monetary assets:

Calculate your total monetary assets (referred to as "ASSETS" in the equation below)

- Assets included in retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans **shall not** be included.

Insert total assets into the following equation:

- (ASSETS – 10,000)/2

If the remaining amount is less than $5,000, your total asset level supports your eligibility for Community Care.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

x	All Orchard Hospital entities		Medical Specialty Center		
	Orchard Hospital		Medical Specialty Center (Oroville)		

2023 HHS POVERTY GUIDELINES - 400% FPL

Household Size	400% US Poverty Level
1	$58,320
2	$78,880
3	$99,440
4	$120,000
5	$140,560
6	$161,120
7	$181,680
8	$202,240
9	$222,800
10	$243,360

To determine Medically Indigent eligibility according to income level:

Count the number of people in your family/household.

- For persons 18 years of age and older, include spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not
- For persons under 18 years of age, include parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

Calculate the household income (annual).

On the row corresponding to the number of persons in your family/household above, compare your household income to the amount in the column labeled "400% US Poverty Level."

If paid medical expenses for medically necessary services exceed 10% of household income in the prior 12 months, then additional expenses beyond that 10% incurred would then be considered eligible for community care.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

X	All Orchard Hospital entities		Medical Specialty Center		
	Orchard Hospital		Medical Specialty Center (Oroville)		

Note: Pursuant to AB 774 Sect. 127405(2), Orchard Hospital has established eligibility levels for financial assistance and community care at less than 350 percent of the federal poverty level as appropriate to maintain its financial and operational integrity.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

x	All Orchard Hospital entities		Medical Specialty Center		
	Orchard Hospital		Medical Specialty Center (Oroville)		

DISCOUNT PAYMENT POLICY

POLICY:

Orchard Hospital realizes the need to provide service to patients who cannot otherwise afford health care. This policy applies to all uninsured or underinsured patients who meet the guidelines of this policy and who agree to its terms. A sliding fee schedule based on the annual HHS Poverty Guidelines will be used to determine the qualifying income levels of applicants. Guidelines are subject to change yearly based on the HHS Poverty Guidelines. Understanding this need, the hospital has chosen to fulfill their responsibility to the community by adopting the following Discount Payment Policy.

PROCEDURE:

1. Enrollment Process

An informal determination of Discount Payment eligibility will be determined by the Patient Financial Counselor and Credit/Collection Specialist, and the applicant may choose to fill out an application based on the recommendation of the Patient Financial Counselor and Credit/Collection Specialist; however, the recommendation of the Patient Financial Counselor and Credit/Collection Specialist is not required in choosing to fill out the Discount Payment Application.

Upon being submitted for consideration by the Patient Financial Counselor and Credit/Collection Specialist, all properly submitted applications will be reviewed and considered for implementation within 10 business days.

All applications must be filled out completely and accurately with one of the following required documentations attached, to be considered:

- Current W-2 withholding form or Income Tax statement form from the previous year, **or**
- Pay stubs from the previous three months

Verification of accuracy of application information, including contacting employers for verification of employment, will be made.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

x	All Orchard Hospital entities		Medical Specialty Center		
	Orchard Hospital		Medical Specialty Center (Oroville)		

A letter of either approval or denial will be submitted to each applicant. The letter will contain: the percent discount; adjusted balance (if more than one account, each will be combined into one account for accounting and billing/statement purposes); and the required monthly payment due each month. Also included in the envelope will be a payment schedule and a discount card.

Updates will be conducted at the end of each calendar year for continued eligibility, or as needed with updated information/changes to guarantor accounts.

2. Discount Payment Account Billing Process, Terms and Settlement

All accounts will be billed out on a monthly basis.

Participants are requested to remain current on their outstanding balances. In order to remain current, participants must pay the balance due by the 15th of the following month. If unable to meet these requirements, prior arrangements must be made with the Business Office/Patient Financial Counselor and Credit/Collection Specialist.

If participant information changes, the participant shall submit changes to the Business Office/Patient Financial Counselor and Credit/Collection Specialist to update their applications or to complete/submit a new application.

If a participant does not pay within 15 days past due, without prior arrangements with the Business Office/Patient Financial Counselor and Credit/Collection Specialist, he/she will be removed from the program.

Upon removal from the program, a 6-month grace period will be enforced where all amounts will be due, and the patient will not be eligible for the program. Accounts on the program will have the discounted amount removed, original balance reinstated minus any payments, and prepared for collections. These accounts will not be considered a part of the new application once the participant is eligible for the program again.

A new application on new accounts may be submitted after the grace period for consideration.

Accounts that are removed from the program and that still contain a positive balance after the 6-month grace period will be forwarded to an outside collection agency who will, at their discretion and in accordance with rules and regulations put forth by California Assembly Bill 774, notify credit reporting bureaus. Under no circumstances will an account be reported to a credit reporting bureau under 150 days from the first bill date.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

X	All Orchard Hospital entities		Medical Specialty Center		Community Care Center
	Orchard Hospital		Medical Specialty Center (Oroville)		

3. Participant Accounts Maintenance

All accounts will be reviewed monthly for fee adjustments, monthly payments and co-payments. Notices will be sent to all accounts which are non-compliant.

Collections efforts may be pursued for accounts that violate the terms set herein.

In the folder for each application the following items are required:

- Patient information and application
- A copy of every correspondence between Orchard Hospital and the participant
- Detailed bills on all accounts to be included in the application.
- Adjustment form with adjustments taken on accounts
- Any additional notations and pertinent information

The processes and procedures described above are designed to comply with CA AB 774 (Statutes of 2006) and SB 350 (Chapter 347, Statutes of 2007). Questions regarding AB 774 and SB 350 can be addressed by the Patient Financial Counselor and Credit/Collection Specialist or by California's Office of Statewide Health Planning and Development's website, at http://www.oshpd.ca.gov/hid/products/hospitals/fairpricing/index.html.

REFERENCES:

Pursuant to AB 774 Sect. 127405(2), Orchard Hospital has established eligibility levels for financial assistance and community care at less than 400 percent of the federal poverty level as appropriate to maintain its financial and operational integrity. Mayers Memorial Hospital is a rural hospital as defined in Section 124840. http://aspe.hhs.gov/poverty/12poverty.shtml

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

x	All Orchard Hospital entities		Medical Specialty Center		
	Orchard Hospital		Medical Specialty Center (Oroville)		

2023 HHS POVERTY GUIDELINES

Household Size	100% US Poverty Level	150% US Poverty Level	200% US Poverty Level
	80% Discount	60% Discount	40% Discount
1	$14,580	$21,870	$29,160
2	$19,720	$29,580	$39,440
3	$24,860	$37,290	$49,720
4	$30,000	$45,000	$60,000
5	$35,140	$52,710	$70,280
6	$40,280	$60,420	$80,560
7	$45,420	$68,130	$90,840
8	$50,560	$75,840	$101,120
9	$55,700	$83,550	$111,400
10	$60,840	$91,260	$121,680

To determine discount eligibility:

Count the number of people in your family/household.

a. For persons 18 years of age and older, spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not

b. For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

x	All Orchard Hospital entities		Medical Specialty Center		Community Care Center
	Orchard Hospital		Medical Specialty Center (Oroville)		

Calculate the household income (annual).

Sliding across the row corresponding to the number of persons in your family/household above, stop in the first bucket that has an amount greater than the household income.

At the top of that column, the % discount is displayed.

REPAYMENT SCHEDULE

Total Patient Responsibility	Maximum Repayment Term	Minimum Monthly Payment
$50 or less	In Full	In Full
$51 - $100	2 Months	$40
$101- $300	3 Months	$55
$301- 4600	6 Months	$75
$601 - $1,000	9 Months	$100
$1,001- $3,000	12 Months	$150
$3,001- $6,000	15 Months	$250
$6,000 And over	18 Months	$350

To determine repayment schedule parameters:

Establish estimated or calculated total patient charges prior to discount.

a. The Patient Financial Counselor and Credit/Collection Specialist and/or Department Personnel can provide a list of anticipated charged services and supplies, summed to Total Charges

b. Per AB 774 Sect 127405(d), the Total Charges amount will be adjusted to mirror the amount of payment the hospital would receive as if it were providing the same services and supplies to Medicare.

Subject	Community Care Financial Assistance and Discount Payment Program
Department(s)	Business Office and Compliance
Reference #	4632

Scope of Policy (Identifies the entities that are covered under the policy)

x	All Orchard Hospital entities		Medical Specialty Center		Community Care Center
	Orchard Hospital		Medical Specialty Center (Oroville)		

Once the total liabilities reflect the amount payable by Medicare, the discount percentage established above will be applied. The resulting amount is "TOTAL PT RESPONSIBILITY" that can be inserted into the table above.

Determine which row applies to your "TOTAL PT LIABILITIES" amount by putting the amount in the appropriate range above.

Sliding to the right, the repayment of the discounted Total Patient Liabilities must be performed within the corresponding parameters.

Title 11, California Code of Regulations § 999.5(d)(5)(B)

A description of all charity care provided in the last five years by each health facility or facility that provides similar health care that is the subject of the agreement or transaction.

EXHIBIT 2

Orchard Hospital
Schedule of Charity Care and Community Benefits
For the past 5 years, ending on June 30

Description	FY 2023	FY 2022	FY 2021	FY 2020	FY 2019
Financial Assistance at Cost	$ 51,438	$ 55,599	$ 20,984	$ 47,352	$ 9,744
Community Benefits at Cost	$ 3,853	$ -	$ 7,899	$ 14,852	$ 10,033

Title 11, California Code of Regulations § 999.5(d)(5)(B)

A description of all charity care provided in the last five years by each health facility or facility that provides similar health care that is the subject of the agreement or transaction.

EXHIBIT 3

COLUSA MEDICAL CENTER

Finance Department (Acute)

POLICY NUMBER: 002	**APPLIES TO: All Financial Department**
POLICY TITLE: CHARITY CARE	**Page 1 OF 8**
EFFECTIVE DATE: 11/01/17	**REVISION: 01/01/2020, 8/10/2022**

POLICY ON FINANCIAL ASSISTANCE FOR COLUSA MEDICAL CENTER

PURPOSE

The purpose of this policy is to establish policies and procedures that align with our guidelines to provide Financial Assistance (Charity Care) for patients who are facing financial hardship. By consistently identifying, upholding accountability, along with recording and following up on patient's potential eligibility to receive charity care in compliance with all applicable laws, including the Hospital Fair Pricing Law and Section 501 (r) of the Internal Revenue Code, which was added by the 2010 Affordable Care Act which imposes specific requirements on tax exempt hospitals with respect to community benefit obligations.

POLICY

It is our policy to provide patients with understandable written information regarding Financial Assistance to provide income-based Financial Assistance (Charity Care) to qualified patients. Unless otherwise specified, this policy does not apply to physicians or other medical providers, including emergency room physicians, anesthesiologists, radiologists, hospitalists, pathologists, etc., whose services are not included in a hospital's bill. This policy does not create an obligation for the hospital to pay for such physicians' or other medical providers' services. In California, an emergency physician who provides emergency services in a hospital is required to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level. Colusa Medical Center provides, without discrimination, examination, medical screening and care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)) to individuals regardless of their eligibility under the Policy on Financial Assistance for Colusa Medical Center (Charity Care), within the capabilities and capacity of the facility. Colusa Medical Center will not engage in any actions that discourage individuals from seeking treatment for emergency medical conditions.

SCOPE

The Hospital Financial Assistance Program set forth in this policy is intended to comply with California' Hospital Fair Pricing Law requirements, as well as the IRS Requirements for non-profit hospitals set forth in I.R.C Section 501(r). This policy applies to Colusa Medical Center and all clinics that are associated with Colusa Medical Center.

DEFINITIONS

Charity Care: means full financial assistance such that the patient does not have any financial obligation for Medically Necessary Services.

Discounted Care: means financial assistance such that the patient is relieved of a portion of their financial obligation for Medically Necessary Services.

Complex/Specialized Services: means services that Colusa hospital determines are complex and specialized (e.g., transplants, experimental and investigational services) as well as certain elective services that are typically excluded from coverage under health plan coverage agreements (e.g., cosmetic procedures).

Federal Poverty Level (FPL): means the measure of income level published annually by the United States Department of Health and Human Services (HHS) and is used by hospitals for determining eligibility for Financial Assistance.

Financial Assistance: means to provide full charity care and high medical cost charity care.

High Medical Costs are defined as:

1. Annual out of pocket costs incurred by the individual at the hospital that exceeds 10% of the patient's family income in the prior 12 months.
2. Annual out of pocket expenses that exceed 10% of the patient's family income if the patient provides documentation of the patient's medical expenses paid by the patient or patient's family in the prior 12 months.

Hospital Services: "means all services that a hospital is licensed to provide, including emergency and other medically necessary care (excluding Complex/Specialized Services).

Insured Patient: means a patient who has a third-party source of payment for a portion of their medical expenses, but excludes patients who are covered by Medi-Cal/Medicaid.

Medically Necessary Services: shall be defined, for purposes of this policy as

- Emergency medical services that were provided
- Non-elective services provided in response to life-threating circumstances in a non-emergency room setting;
- Services that the hospital determines, in its discretion, qualify as medically necessary such as services for a condition which, if not promptly treated, would lead to an adverse change in the health status of the individual; and

- shall not include elective services

Patient Responsibility: means the amount that an Insured Patient is responsible to pay out-of-pocket after the patient's third-party coverage has determined the amount of the patient's benefits.

Primary Language of Hospital's Service Area: means a language used by the lesser of 1,000 people or 5% of the community served by the hospital based upon the most recent community health needs assessment performed by hospital.

Uninsured Patient: means a patient who has no third-party source of payment for any portion of their medical expenses, including without limitation, commercial or other insurance, government sponsored healthcare benefit programs, or third party liability, and includes a patient whose benefits under all potential sources of payment have been exhausted prior to an admission.

PROCEDURE

Colusa Medical Center makes a decision on the need of financial assistance by reviewing the particular services requested or received, insurance coverage or other sources of payment, a person's historical financial profile and current financial situation. This course of action allows for a fair and accurate method to provide assistance to patients who are experiencing financial difficulties. Partial and/or full financial assistance may be granted based on the criteria set forth in this policy.

Colusa Medical Center may determine eligibility for financial assistance before or after Medically Necessary Services are provided, as well as before or after discharge. All eligibility determinations related to emergency services shall be conducted in accordance with applicable EMTALA polices.

A. ELIGIBILITY

1. Eligibility Criteria: During the application process set forth in sections B and C below, hospitals shall apply the following eligibility criteria for Financial Assistance:

Financial Assistance Category	Patient Eligibility Criteria	Available Discount
FULL CHARITY CARE	Patient is an Uninsured Patient with a family income (as defined below) at or below 400% of the most recent FPL	Full write off of all charges for Hospital Services.
HIGH MEDICAL COST CHARITY CARE (for Insured Patients)	—. Patient is an Insured Patient with a family income (as defined below) at or below 400% of the most recent FPL; **and** —. Medical expenses for themselves or their family (incurred at the hospital or paid to other providers in the past twelve (12) months exceed 10% of the patient's family income.	A write off of the Patient Responsibility amount for Hospital Services.

2. Calculating Family Income: To determine a patient's eligibility for Financial Assistance, the hospital shall first calculate the patient's Family income, as follows:
a. Patient Family: The patient family shall be determined as follows:
i. Adult Patients: For patients over 18 years of age, the patient family includes their spouse, domestic partner, and dependent children less than 21 years of age, whether living at home or not.
ii. Minor Patients: For patients under 18 years of age, the patient family includes their parent{s}, caretaker relatives, and other children less than 21 years of age of the parent(s) or caretaker relatives.

b. Proof of Family Income: Patient shall only be required to provide recent pay stubs or tax returns as proof of income when submitting an application. Family Income is annual earnings of all members of the patient family from the prior 12

months or prior tax year as shown by the recent pay stubs or income tax returns, less payments made for alimony and child support. Income included in this calculation is every form of income, e.g., salaries and wages, retirement income, near cash government transfers like food stamps, and investment gains. Annual income may be determined by annualizing year-to-date family income. Colusa Medical Center may validate income by using external presumptive eligibility service providers, provided that such service only determines eligibility using only information permitted by this policy.

c. Calculating Family Income for Expired Patients: Expired patients, with no surviving spouse, may be deemed to have no income for purposes of calculation of family income. Documentation of income is not required for expired patients; however, documentation of estate assets may be required. The surviving spouse of an expired patient may apply for Financial Assistance

3. Calculating Family Income as a Percentage of FPL: After determining family income, hospital shall calculate the family income level in comparison to the FPL, expressed as a percentage of the FPL. For example, if the FPL for a family of three is $20,000, and a patient's family income is $60,000, the hospital shall calculate the patient's family income to be 300% of the FPL. Hospitals shall use this calculation during the application process to determine whether a patient meets the income criteria for Financial Assistance.

4. Special Circumstance – Benefits Exhausted During Inpatient Stay: When an Insured Patient's third-party coverage pays only a portion of the expected reimbursement for the patient's stay because the patient exhausted their benefits during the stay, the hospital should collect from the patient the balance of the expected reimbursement that would have been due from the third-party coverage if the benefits were not exhausted. A hospital shall not pursue from the patient any amount in excess of the amount that would have been due from the third-party coverage if the benefits were not exhausted, plus the patient's share of or co-insurance. A patient who exceeded their benefit cap during a stay is eligible to apply for Financial Assistance. If the patient is eligible for Financial Assistance, the hospital shall write off all charges for services that the hospital provided after the patient exceeded the benefit cap.

5. Medi-Cal/Medicaid Denied Patient Days and Non-covered Services: Medi-Cal/Medicaid patient are eligible for charity care write-offs related to denied charges and non-covered services. These Treatment Authorization Request (TAR) denial and any lack of payment for non-covered services provided to Medi-Cal/Medicaid patients are to be classified as charity, excluding share of cost identified in Section A.6b below.

6. **Financial Assistance Exclusions/Disqualification**: The following are circumstances in which Financial Assistance is not available under this policy:

a. **Uninsured Patient seeks Complex/Specialized Services**: Generally, Uninsured Patients who seek Complex/Specialized Services (e.g. transplants, experimental or investigational procedures), and seek to receive Financial Assistance for such services, must receive administrative approval from the individual responsible for finance at the Hospital (or designee) prior to the provision of such services in order to be eligible for Financial Assistance. Hospitals shall develop a process for patients to seek prior administrative approval for services that require such approval. Elective services that are normally exclusions from coverage under health plan coverage agreements (e.g., cosmetic procedures) are not eligible for Financial Assistance.

b. **Medi-Cal/Medicaid Patients with Share of Cost**: Medi-Cal/Medicaid patients who are responsible to pay share of cost are not eligible to apply for Financial Assistance to reduce the amount of share of cost owed. Hospitals shall seek to collect these amounts from the patients.

c. **Patient declines covered services**: An Insured Patient who elects to seek services that are not covered under the patient's benefit agreement (such as an HMO patient who seeks out-of-network services from Colusa Medical Center, or a patient refusal to transfer from Colusa Medical Center to an in-network facility) is not eligible for Financial Assistance

d. **Insured Patient does not cooperate with third-party payer:** An Insured Patient who is insured by a third-party payer that refuses to pay for services because the patient failed to provide information to the third-party payer necessary to determine the third-party payer's liability is not eligible for Financial Assistance.

e. **Payer pays patient directly:** If a patient receives payment for services directly from an indemnity, Medicare Supplement, or other payer, the patient is not eligible for Financial Assistance for the services.

f. **Information falsification**: Hospitals may refuse to award Financial Assistance to patients who falsify information regarding Family Income, household size or other information in their eligibility application.

g. **Third party recoveries**: If the patient receives a financial settlement or judgment from a third-party tort that caused the patient's injury, the patient must use the settlement or judgment amount to satisfy any patient account balances, and is not eligible for Financial Assistance.

h. **Professional (physician) Services:** Services of physicians such as anesthesiologists, radiologists, hospitalists, pathologists, etc. are not covered under this policy. Many physicians have charity care policies that allow patients to apply for free or discounted care. Patients should obtain information about a physician's charity care policy directly from their physician.

B. APPLICATION PROCESS

1. Each hospital shall make all reasonable efforts to obtain from the patient or their representative information about whether private or public health insurance may fully or partially cover the charges for care rendered by the hospital to a patient. A patient who indicates at any time the financial inability to pay a bill for Hospital Services shall be evaluated for Financial Assistance. In order to qualify as an Uninsured Patient, the patient or the patient's guarantor must verify that they are not aware of any right to insurance or government program benefits that would cover or discount the bill. All patients should be encouraged to investigate their potential eligibility for government program assistance if they have not already done so.

2. Patients may request assistance with completing the application for financial assistance in person at Colusa Medical Center, over the phone at (530) 619-0800, through the mail or via the Colusa Medical Center website www.colusamedcenter.org.

3. Patients who wish to apply for Financial Assistance shall use the standardized application form, the application for financial assistance (see **Attachment A)**.

4. Patients should mail applications for Financial Assistance to Colusa Medical Center 199 E. Webster St. Colusa, CA 95932 Attn: Charity Care Application.

5. Patients should complete the application for Financial Assistance as soon as possible after receiving Hospital Services. Failure to complete and return the application within two hundred and forty 240 days of the date the hospital first sent a post-discharge bill to the patient may result in the denial of Financial Assistance.

C. FINANCIAL ASSISTANCE DETERMINATION

1.The hospital will consider each applicant's application for Financial Assistance and grant Financial Assistance when the patient meets the eligibility criteria set forth in

section A.1 and has received (or will receive) Hospital Service(s) (see **Attachment B**).

2. Patients also may apply for governmental program assistance, which may be prudent if the particular patient requires ongoing services.

a. The hospital should assist patients in determining if they are eligible for any governmental or other assistance, or if a patient is eligible to enroll with plans in the California Health Benefit Exchange (i.e. Covered California). Many potential Financial Assistance Program patients are not aware they may be eligible for public health insurance programs or have not pursued application for such programs.

b. If a patient applies, or has a pending application, for another health coverage program at the same time that they apply for Financial Assistance, the application for coverage under another health coverage program shall not preclude the patient's eligibility for Financial Assistance.

3. Once a full charity care or high medical cost charity care determination has been made, a notification form (see **Attachment C**) will be sent to each applicant advising them of the hospital's decision.

4. Patients are presumed to be eligible for Financial Assistance for a period of one (1) year after the hospital issues the notification form to the patient. After one (1) year, patients must re-apply for Financial Assistance.
5. If the Financial Assistance determination creates a credit balance in favor of a patient, the refund of the credit balance shall include interest on the amount of the overpayment from the date of the patient's payment at the statutory rate (10% per annum) pursuant to Health and Safety Code section 127440, provided that hospitals are not required to refund a credit balance that is, together with interest, less than five dollars ($5).

D. DISPUTES

A patient may seek review of any decision by the hospital to deny Financial Assistance by notifying the individual responsible for finance at the hospital or designee, of the basis of the dispute and the desired relief within thirty (30) days of the patient receiving notice of the circumstances giving rise to the dispute. Patients may submit the dispute orally or in writing. The individual responsible for finance at the hospital or designee shall review the patient's dispute as soon as possible and inform the patient of any decision in writing.

E. ALTERNATIVE ELIGIBILITY DETERMINATION METHOD

In the event that eligibility cannot be determined upon the completion of the Financial Assistance Application, CMC may elect to make the eligibility determination via the use of alternative processes.

CMC understands that certain patients may be unable to complete a Financial Assistance Application, comply with requests for documentation, or are otherwise non-responsive to the application process. As a result, there may be circumstances under which a patient's qualification for financial assistance may be determined by CMC via an alternative process, including utilization of other sources of information to make an individual assessment of financial need. This information will enable CMC to make an informed decision on the financial need of patients utilizing the best estimated available in the absence of information provided directly to the patient.

CMC may utilize a third party to conduct an electronic review of patient information to assess financial need. This review utilizes a healthcare industry recognized electronic predictive model that is based on public record databases. The Predictive Model incorporates public record data to calculate socio-economic and financial capacity score that includes estimates for income, assets and liquidity. The Predictive Model is designed to assess each patient to the same standard Financial Assistance Application process.

The Predictive Model will be used by CMC prior to bad debt assignment and after all other eligibility and payment sources have been exhausted. This allows CMC to screen all patients for financial assistance prior to pursing any extraordinary collection actions. The data generated via the Predictive Model will constitute adequate documentation of financial need under this policy.

When the Predictive Model is used as the basis for a determination of eligibility, the highest discount of full free care, Charity Care, will be granted for eligible services for retrospective dates and services only. A determination of eligibility for Discounted Care will not be made via the Predictive Model method.

Patient accounts granted eligibility via the Predictive Model process will be reclassified under the financial assistance policy as Charity Care. They will not be sent to collection, will not be subject to further collection actions, will not be notified of their qualification and will not be included in the hospital's bad debt expense.

F. AVAILABILITY OF FINANCIAL ASSISTANCE INFORMATION

1. Languages: This policy shall be available in the Primary Language(s) of Hospital's Service Area. In addition, all notices/communications provided in this section shall be available in Primary Language(s) of Hospital's Service Area and in a manner consistent with all applicable federal and state laws and regulations.

2. Information Provided to Patients During the Provision of Hospital Services:

a. Preadmission or Registration: During preadmission or registration (or as soon thereafter as practicable) hospitals shall provide all patients with a copy of **Attachment D**, which includes a plain language summary of the Financial Assistance policy and also contains information regarding their right to request an estimate of their financial responsibility for services. Hospitals shall identify the department that patients can visit to receive information about, and assistance with applying for, Financial Assistance.

b. Financial Assistance Counselors: Patients who may be Uninsured Patients shall be assigned financial counselors, who shall visit with the patients in person at the hospital. Financial counselors shall give such patients a Financial Assistance application, as well as contact information for hospital personnel who can provide additional information about this Financial Assistance policy, and assist with the application process.

c. Emergency Services: In the case of emergency services, hospitals shall provide all patients a plain language summary of the Financial Assistance policy as soon as practicable after stabilization of the patient's emergency medical condition or upon discharge. In accordance to EMTALA, following the evaluation and stabilizing treatment (if necessary), non-emergent patients requesting financial assistance should complete a Financial Assistance Application, which should be reviewed by the Business Office and approved before additional services are provided.

An emergency physician, as defined in the Health and Safety Code section124750(c), who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to patients who are at or below the 350 percent of the federal poverty level and are uninsured patients or patients with High Medical Costs. This statement shall not be construed to impose any additional responsibilities upon the hospital. The emergency physicians are solely responsible for compliance with the provisions of Hospital Fair Pricing Law applicable to emergency physicians.

d. Applications Provided at Discharge: At the time of discharge, hospitals shall provide all patients with a copy of **Attachment D**, which includes a plain language summary of the Financial Assistance policy and all Uninsured Patients with applications for Medi-Cal/Medicaid and California Children's Services or any other potentially applicable government program.

3. Information Provided to Patients at Other Times:

a. Billing Statements: Hospitals shall bill patients in accordance with the Policy on Billing and Collections. A phone number for patients to call with questions about Financial Assistance, and the website address where patients can obtain additional information about Financial Assistance including the Financial Assistance Policy, a plain language summary of the policy, and the application for Financial Assistance. A summary of your legal rights is included on the patient's final billing statement.

b. Contact Information: Patients may call (530) 619-0800 to obtain additional information about Financial Assistance and assistance with the application process.

c. Upon Request: Hospitals shall provide patients with paper copies of the Financial Assistance Policy, the application for Financial Assistance, and the plain language summary of the Financial Assistance Policy upon request and without charge.

4. Publicity of Financial Assistance Information

a. Public Posting: As required by the Hospital Fair Pricing Law, hospitals shall post copies of the Financial Assistance Policy, the application for Financial Assistance, and the plain language summary of the Financial Assistance Policy in a prominent location in the emergency room, admissions area, and any other location in the hospital where there is a high volume of patient traffic, including, but not limited to the waiting rooms, billing offices, and

hospital outpatient service settings. These public notices shall include information about the right to request an estimate of financial responsibility for services. As required by the Hospital Fair Pricing Law, when the hospital bills a patient that has not provided evidence of third-party coverage, the bill shall include a statement of charges for services; a request that the patient inform the hospital if the patient has health insurance coverage; notice that if the patient does not have health insurance coverage, that the patient may be eligible for Medicare or Medi-Cal, coverage through the California Health Benefit Exchange or other state- or county-funded health coverage programs and indicate that the hospital will provide such applications and inform the patient how to obtain the applications for such programs; and information of the availability of the Financial Assistance Program, including a statement that if the patient meets certain low- income requirements ,that patient may qualify for the hospital's Financial Assistance Program. The notice shall include the name and phone number of a hospital employee or office from whom the patient may obtain more information. (H & S Code § § 127410(a) and 127420(b)(5)(B).)

In addition to the above notices, during the intake/admission process, patients shall be offered a plain language summary of this policy. CMC shall make proper copies available upon request form the Admissions Department and the Emergency Department, as well as other appropriate areas. CMC can offer to send the documents electronically and, upon approval of the patient, such electronic copies can serve to satisfy the provision of paper copies, including the provision of the plain language summary during intake or discharge. All of these actions are measures to widely publicize the policy within the community being served by the hospital in accordance with the Affordable Care Act. This policy and the Financial Application form shall be sent to the Office of Statewide Health and Planning and Development every two (2) years upon significant changes.

b. Website: The Financial Assistance Policy, application for Financial Assistance, and plain language summary shall be available in a prominent place on the Colusa Medical Centers www.colusamedcenter.org. Persons seeking information about Financial Assistance shall not be required to create an account or provide any personal information before receiving information about Financial Assistance.

c. Mail: Patients may request a copy of the Financial Assistance Policy, application for Financial Assistance and plain language summary be sent by mail, at no cost to the Patient.

e. Community Awareness: Colusa Medical Center will work with aligned organizations, physicians, community clinics and other health care providers to notify members of the community (especially those who are most likely to require Financial Assistance) about the availability of Financial Assistance.

G. MISCELLANEOUS

1. Recordkeeping: Records relating to Financial Assistance must be readily accessible. Hospitals must maintain information regarding the number of Uninsured

Patients who have received services from the hospital, the number of Financial Assistance applications completed, the number approved, the estimated dollar value of the benefits provided, the number of applications denied, and the reasons for denial. In addition, notes relating to a patient's approval or denial for Financial Assistance should be entered into the patient's account.

2. Payment Plans: Patients may be eligible for a payment plan. Payment plan shall be offered and negotiated per the Policy on Billing and Collections.

3. **Discounted Care Payments:** For Discounted Care, the hospital shall limit the expected payment for Medically Necessary Services it provides to a patient eligible for a discount under this policy to amount of payment the hospital would expect, in good faith, to receive, for providing services under Medicare. If the hospital provides a service for which there is no established payment by Medicare, the hospital shall establish an appropriate discounted charge for the service. The patients shall not be charged interest in accordance with the Hospital Far Pricing Law (H & S Code 127425(g).) The hospital and the patient may negotiate the terms of the payment plan. In the event the hospital and the patient cannot agree upon the terms of the payment plan, the payment shall not exceed 10% of the patient's family income for a month, excluding deductions for essential living expenses. The discounted care payment plan may be declared no longer operative after the patient's failure to make all consecutive payments due during the 90-day period. Before declaring the hospital extended payment plan no longer operative, the hospital, collection agency, or assignee shall make a reasonable attempt to contact the patient by telephone and, give notice in writing that the extended payment plan may be come inoperative, and of the opportunity to renegotiate the extended payment plan. The hospital or any representative thereof including a collection agency or assignee, shall not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or responsible party for nonpayment prior to the time the extended payment plan is declared no longer operative. The notice and telephone call to the patient described above may be made to the last known telephone number and address of the patient. If the patient fails to make all consecutive payments for 90 days and fails to renegotiate a payment plan, the patient/guarantor is obligated to make payments on his or her obligation to the hospital from the date the extended payment plan is declared no longer operative.

4. Billing and Collections: Hospitals may employ reasonable collection efforts to obtain payment from Patients. Information obtained during the application process for Financial Assistance may not be used in the collection process, either by the hospital or by any collection agency engaged by the hospital. General collection activities may include issuing patient statements, phone calls, and referral of statements have been sent to the patient or guarantor. Revenue cycle departments must develop procedures to ensure that patient questions and complaints about bills are researched and corrected where appropriate, with timely follow up with the patient. Hospital or collection agencies will not engage in any extraordinary collection actions

5. Amounts Generally Billed: In accordance with Internal Revenue Code Section1. 501(r)-5, Colusa Medical Center adopts the prospective Medicare method for amounts generally billed; however, patients who are eligible for Financial Assistance are not financially responsible for more than the amounts generally billed because eligible patients do not pay any amount.

6.Discretionary Discounts: Nothing contained herein shall prohibit the hospital from providing discretionary discounts (including free care) to patients that do not meet the requirements for Charity Care or Discounted Care as forth in this policy. The hospital may require such patients to complete the Financial Assistance Application. The discount shall be made from the hospital's undiscounted charges. The discount may differ for inpatient and outpatient services and, in general, the discount will usually be no greater than the hospital's current average commercial fee-for-service discounts with managed care payers. However, greater discounts may be provided upon approval of the CEO and CFO. Every effort shall be made to afford administrative discounts in a uniform manner.

7. Equal Opportunity: CMC is committed to upholding all applicable federal and state laws that preclude discrimination on the basis of race, sex, age, religion, national origin, marital status, sexual orientation, disabilities, military services, or any other classification protected by the federal, state, and local laws.

8. Confidentiality: CMC staff will uphold the confidentiality and individual dignity of each and every patient. CMC will meet all HIPAA requirements for handling personal health information.

ATTACHMENTS

Attachment A- Application for Financial Assistance
Attachment B-Financial Assistance Calculation Worksheet
Attachment C-Notification Form Colusa Medical Center Eligibility Determination for Charity Care
Attachment D-Important Billing Information for Patients, Plain Language
Attachment E-Notice of Rights

Title 11, California Code of Regulations § 999.5(d)(5)(C)

A description of all services provided by each health facility or facility that provides similar health care that is the subject of the agreement or transaction in the past five years to Medi-Cal patients, county indigent patients, and any other class of patients

Orchard Hospital Services
Cardiology
Social Services
Emergency Services
Inpatient/ Outpatient Surgery
Imaging Services
Respiratory Care
Cardiopulmonary
Laboratory
Physical Therapy
Senior Life Solutions
Clinic Services

Rural Health Clinic Services
Laboratory
Digital Radiology
DEXA Scanning
Digital Mammography
Ultrasound (General & Cardiac)
Physicals
Workers Comp
Industrial Medicine
Drug Screening
Psychotherapy
Physical Therapy
Internal Medicine

Title 11, California Code of Regulations § 999.5(d)(5)(D)

A description of any community benefit program provided by the health facility or facility that provides similar health care during the past five years with an annual cost of at least $10,000 and the annual cost of each program for the past five years

Orchard Hospital's Community benefit program is the Community Care Financial Assistance. This was included in Section 999.5(d)(5)(C). Please see that section for the pertinent information.

Title 11, California Code of Regulations § 999.5(d)(5)(E)

For each health facility or facility that provides similar health care that is the subject of the agreement or transaction, a description of current policies and procedures on staffing for patient care areas; employee input on health quality and staffing issues; and employee wages, salaries, benefits, working conditions and employment protections

Orchard Hospital's Policies and Procedures re: Staffing for Patient Care Areas and Employee Input on Health Quality and Staffing Issues are as follows:

Clinical Care Manual, Hospitalist and Nursing Process, Patient Sitter Guidelines, Nursing Acute Care and Acuity and Staffing, Nursing and Skills Procedure Manual, 340B Program, Hospital Policy Manual, General Administration, Quality Assessment and Performance Improvement, Patient Services, Nursing Assessment and Plan of Care, Nursing Form Intake and Output, Nursing Orient Comp Eval, Nursing Services, Admission, Discharge and Transfer of Patients, Safe Patient and Resident Handling.

Orchard Hospital's Policies and Procedures re: Employee Input on Health and Quality and Staffing Issues:
Quality Improvement Plan, Quality Internal Audit, Quality Document Control, Alternative work schedules, Attendance Standards, Employee Health Program, Employee Hotline, Employee Injury Protocol, Employee Handbook, Employee Suggestion Program, Hospital HERO Award, Ergonomics, Ethics Committee, Group Medical, Dental and Vision Insurances, Holidays, Introductory Period, New Hire Orientation, Paid Time Off, Paid Family Leave, Recruitment, Promotions and Transfers, Safety Workplace, Scheduling of Hours, Telecommuting

Title 11, California Code of Regulations § 999.5(d)(5)(F)

For each health facility or facility that provides similar health care that is the subject of the agreement or transaction, all existing documents setting forth any guarantees made by any entity that would be taking over operation or control of the health facility or facility that provides similar health care relating to employee job security

Orchard Hospital shall retain employees sufficient to provide safe and high-quality operations, at the direction of American Advanced Management's appointed chief executive officer. During the Management period, Orchard Hospital shall maintain the minimum staffing required by all regulations and Governmental agencies having jurisdiction over the Facility.

Title 11, California Code of Regulations § 999.5(d)(5)(G)

If the agreement or transaction will have any impact on reproductive health care services provided by any facility that is the subject of the agreement or transaction, or any impact on the availability or accessibility of reproductive health care services

Orchard Hospital and American Advanced Management do not anticipate that the Agreement will have any impact on reproductive healthcare services. The Management Services Agreement in no way limits or modifies current provisions of healthcare services. Orchard Hospital will continue to provide the same types and levels of reproductive services.

Title 11, California Code of Regulations § 999.5(d)(5)(H)

A Statement describing all effects that the proposed agreement or transaction may have on health care services provided by each facility proposed to be transferred including, but not limited to, any changes in the types or levels of medical services that may be provided at the health facility or facility that provides similar health care and a statement of how the proposed transaction may affect the availability and accessibility of health care in the affected communities

The Management Services Agreement between Orchard Hospital and American Advanced Management in no way limits or modifies their current provision of healthcare services. This Agreement is expected to have a positive impact that will benefit the communities Orchard Hospital serves. This Agreement will assist in improving quality and expand services.

Title 11, California Code of Regulations § 999.5(d)(5)(I)

A description and copy of all current contracts between applicant and the city in which the applicant is located and current contracts between the applicant and the county in which the applicant is located for each healthcare facility or facility that provides similar health care that are the subject of the agreement or transaction

Orchard Hospital does not have any contracts with any City or County entities.

Title 11, California Code of Regulations § 999.5(d)(5)(J)

A description of compliance with the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, as amended by the California Hospital Facilities Seismic Safety Act (Health & Saf. Code, § 129675-130070), for each health facility or facility that provides similar health care that is the subject of the agreement or transaction, including the certified Structural Performance Category of every building affected by the agreement or transaction and a copy of every final determination letter received from the Office of Statewide Health Planning and Development for every building affected by the agreement or transaction

Please see the following attachments that document compliance with the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983:

1. Exhibit 1 – A letter from HCAI dated 3/29/2024 – Record No. GACSIGN-2023-01688
2. Exhibit 2 – A letter from HCAI dated 3/29/2024 – Record No. GACSIGN-01701
3. Exhibit 3 – A letter from HCAI dated 3/29/2024 – Record No. GACSIGN-2023-01700
4. Exhibit 4 – A letter from HCAI dated 8/13/2024 – Record No. GACSIGN-202301700

Title 11, California Code of Regulations § 999.5(d)(5)(J)

A description of compliance with the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, as amended by the California Hospital Facilities Seismic Safety Act (Health & Saf. Code, § 129675-130070), for each health facility or facility that provides similar health care that is the subject of the agreement or transaction, including the certified Structural Performance Category of every building affected by the agreement or transaction and a copy of every final determination letter received from the Office of Statewide Health Planning and Development for every building affected by the agreement or transaction

EXHIBIT 1

Department of Health Care Access and Information

Office of Statewide Hospital Planning and Development
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
Phone: (916) 440-8300
Fax: (916) 274-0102
www.hcai.ca.gov/facilities/building-safety/

March 29, 2024

Steve Stark

240 Spruce st.
Gridley, CA 95948

Facility: Orchard Hospital - 10006
240 Spruce St
Gridley, CA 95948

Record #: GACSIGN-2023-01688

Hospital Signage Report

Your submission for AB 1882 signage for BLD-00090 at the above referenced facility is determined herein as Acceptance Pending Field Confirmation. Location of signage and sign graphics have been reviewed and the Office takes no exception based on the information provided pending a confirmation by the Compliance Officer. Please schedule a field visit with the Compliance Officer.

The Compliance Officer for your facility can be found at Facility Details Web Page.

If there are any questions, please contact me at 213-897-9773 or by email at Kamalpreet.Kalsi@hcai.ca.gov.

Kamalpreet Kalsi,
Senior Structural Engineer

cc: Facility Representative

Title 11, California Code of Regulations § 999.5(d)(5)(J)

A description of compliance with the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, as amended by the California Hospital Facilities Seismic Safety Act (Health & Saf. Code, § 129675-130070), for each health facility or facility that provides similar health care that is the subject of the agreement or transaction, including the certified Structural Performance Category of every building affected by the agreement or transaction and a copy of every final determination letter received from the Office of Statewide Health Planning and Development for every building affected by the agreement or transaction

EXHIBIT 2

Department of Health Care Access and Information

Office of Statewide Hospital Planning and Development
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
Phone: (916) 440-8300
Fax: (916) 274-0102
www.hcai.ca.gov/facilities/building-safety/

March 29, 2024

Steve Stark

240 Spruce st.
Gridley, CA 95948

Facility: Orchard Hospital - 10006
240 Spruce St
Gridley, CA 95948

Record #: GACSIGN-2023-01701

Hospital Signage Report

Your submission for AB 1882 signage for BLD-00094 at the above referenced facility is determined herein as Acceptance Pending Field Confirmation. Location of signage and sign graphics have been reviewed and the Office takes no exception based on the information provided pending a confirmation by the Compliance Officer. Please schedule a field visit with the Compliance Officer.

The Compliance Officer for your facility can be found at Facility Details Web Page.

If there are any questions, please contact me at 213-897-9773 or by email at Kamalpreet.Kalsi@hcai.ca.gov.

Kamalpreet Kalsi,
Senior Structural Engineer

cc: Facility Representative

Title 11, California Code of Regulations § 999.5(d)(5)(J)

A description of compliance with the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, as amended by the California Hospital Facilities Seismic Safety Act (Health & Saf. Code, § 129675-130070), for each health facility or facility that provides similar health care that is the subject of the agreement or transaction, including the certified Structural Performance Category of every building affected by the agreement or transaction and a copy of every final determination letter received from the Office of Statewide Health Planning and Development for every building affected by the agreement or transaction

EXHIBIT 3

Department of Health Care Access and Information

Office of Statewide Hospital Planning and Development
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
Phone: (916) 440-8300
Fax: (916) 274-0102
www.hcai.ca.gov/facilities/building-safety/

March 29, 2024

Steve Stark

240 Spruce st.
Gridley, CA 95948

Facility: Orchard Hospital - 10006
240 Spruce St
Gridley, CA 95948

Record #: GACSIGN-2023-01700

Hospital Signage Report

Your submission for AB 1882 signage for BLD-00100 at the above referenced facility is determined herein as Acceptance Pending Field Confirmation. Location of signage and sign graphics have been reviewed and the Office takes no exception based on the information provided pending a confirmation by the Compliance Officer. Please schedule a field visit with the Compliance Officer.

The Compliance Officer for your facility can be found at Facility Details Web Page.

If there are any questions, please contact me at 213-897-9773 or by email at Kamalpreet.Kalsi@hcai.ca.gov.

Kamalpreet Kalsi,
Senior Structural Engineer

cc: Facility Representative

Title 11, California Code of Regulations § 999.5(d)(5)(J)

A description of compliance with the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, as amended by the California Hospital Facilities Seismic Safety Act (Health & Saf. Code, § 129675-130070), for each health facility or facility that provides similar health care that is the subject of the agreement or transaction, including the certified Structural Performance Category of every building affected by the agreement or transaction and a copy of every final determination letter received from the Office of Statewide Health Planning and Development for every building affected by the agreement or transaction

EXHIBIT 4

Department of Health Care Access and Information

Office of Statewide Hospital Planning and Development
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
Phone: (916) 440-8300
Fax: (916) 274-0102
www.hcai.ca.gov/facilities/building-safety/

August 13, 2024

Steve Stark

240 Spruce st.
Gridley, CA 95948

Facility: Orchard Hospital - 10006
240 Spruce St
Gridley, CA 95948

Record #: GACSIGN-2023-01700

Hospital Signage Report

Your submission for AB 1882 signage for BLD-00100 at the above referenced facility is determined herein as Field Confirmed. Location of signage and sign graphics have been reviewed and the Office takes no exception based on the information provided and have been field confirmed.

If there are any questions, please contact me at 916-809-4341 or by email at Jamel.Martin@hcai.ca.gov.

Jamel Martin,
Compliance Officer

cc: Facility Representative

Title 11, California Code of Regulations § 999.5(d)(5)(K)

A description of each measure proposed by the applicant to mitigate or eliminate any potential adverse effect on the availability or accessibility of health care services to the affected community that may result from the agreement or transaction

The Management Services Agreement between Orchard Hospital and American Advanced Management is not expected to have an adverse effect on the availability or accessibility to healthcare services. This Agreement is expected to have a positive impact that will benefit the communities Orchard Hospital serves. This Agreement will assist in improving quality and expand services.

Title 11, California Code of Regulations § 999.5(d)(5)(L)

A list of the primary languages spoken at the health facility or facility that provides similar health care and the threshold languages for Medi-Cal beneficiaries, as determined by the State Department of Health Care Services for the county in which the health facility or facility that provides similar health care is located

Orchard Hospital is located in Gridley, Butte County, California. The primary languages spoken at the hospital are English, Spanish, and Punjabi. Orchard Hospital does utilize a Limited English Proficiency Interpreter/Translation Language Service.

Orchard Hospital LEP Policy is attached as Exhibit 1.

Title 11, California Code of Regulations § 999.5(d)(5)(L)

A list of the primary languages spoken at the health facility or facility that provides similar health care and the threshold languages for Medi-Cal beneficiaries, as determined by the State Department of Health Care Services for the county in which the health facility or facility that provides similar health care is located

EXHIBIT 1

Orchard HOSPITAL

Subject	Limited English Proficiency (LEP) Interpreter/Translation Language Services				
Department(s)	Housewide				
Reference #	1577				
Scope of Policy (Identifies the entities that are covered under the policy)					
X	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

Purpose:

To ensure that patients with limited English proficiency, or patients who are hearing impaired, are not denied access to basic health care services. To ensure compliance with State Health and Safety Code 1259.0, regarding hospital interpreter services.

Definitions:

For the purpose of this policy, "Limited English Proficiency" (LEP) applies to those individuals who demonstrate a limited ability, or inability, to speak, read, write or understand the English language at a level that permits the person to interact effectively with healthcare providers or social service agencies.

For the purpose of this policy, "Interpreter" means someone fluent in English and in the necessary second language, who can accurately speak, read and readily interpret the necessary second language, or a person who can accurately sign and read sign language. Interpreters must have the ability to translate the names of body parts and to describe competently symptoms and injuries in both languages.

For the purpose of this policy, "Language Barrier" applies to those individuals who are limited English speaking or non-English speaking.

For the purpose of this policy, "Communication Barrier" applies to those individuals who are deaf, and whose primary communication is sign language.

For the purposes of this policy, "Employee Language Interpreters" applies to those employees who have volunteered to act as interpreters and have been tested by an outside agency and found to be proficient in the interpretation abilities.

Statement of Policy:

Orchard Hospital will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of Orchard Hospital is to ensure meaningful communication with LEP patients/clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment forms, financial and insurance benefit forms, etc. All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/clients and their families will be informed of the availability of such assistance free of charge.

Subject	Limited English Proficiency (LEP) Interpreter/Translation Language Services				
Department(s)	Housewide				
Reference #	1577				
Scope of Policy (Identifies the entities that are covered under the policy)					
X	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

Language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the effective use of an interpreter.

Orchard Hospital will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of this policy and these procedures, as necessary.

Procedure:

1. IDENTIFYING LEP PERSONS AND THEIR LANGUAGE

Orchard Hospital will promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card (or "I speak cards," available online at www.lep.gov) or posters to determine the language. In addition, when records are kept of past interactions with patients, residents, or family members, the language used to communicate with the LEP person will be included as part of the record.

2. OBTAINING A QUALIFIED INTEPRETER

Human Resources department (530-846-9038) is responsible for:

(a) Maintaining an accurate and current list showing the name, language, phone number and hours of availability of bilingual staff;

(b) Contacting the appropriate bilingual staff member to interpret, in the event that an interpreter is needed, if an employee who speaks the needed language is available and is qualified to interpret;

(c) Obtaining an outside interpreter if a bilingual staff or staff interpreter is not available or does not speak the needed language:

Interpretive Services are available through:

If a patient has a need for a TDD phone, one may be obtained from the Acute Care Nursing Station. The phone number for California Relay Service is 800-735-2922 and is available 24 hours a day.

CYRACOM ACCOUNT INFORMATION - call 1-800-481-3289

Orchard Hospital Account Number 501022152

Subject	Limited English Proficiency (LEP) Interpreter/Translation Language Services
Department(s)	Housewide
Reference #	1577

Scope of Policy (Identifies the entities that are covered under the policy)

X	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

(Account should auto-populate their system based on our phone number but in case it doesn't please provide them the above account number and the appropriate pin number designated below)

Department PINS:

Emergency Department = 2323

Medical Specialty Center (Gridley) = 2756

Medical Specialty Center (Oroville) = 9699

Acute Care = 6030

Physical Therapy = 7259

Radiology = 4040

ASL Video Interpretation Login Information

Please navigate to https://video.cyracom.com/login

User Name = cyracom@orchardhospital.com

Password = OrchardHospital240

In order to initiate video interpretation, primarily ASL, you will need to go to https://video.cyracom.com/login.

Some LEP persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and **after** the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person's chart. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person.

Children and other clients/patients/residents will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

3. PROVIDING WRITTEN TRANSLATIONS

Subject	Limited English Proficiency (LEP) Interpreter/Translation Language Services				
Department(s)	Housewide				
Reference #	1577				
Scope of Policy (Identifies the entities that are covered under the policy)					
X	**All Orchard Hospital entities**		**Medical Specialty Center**		**Hovlid Community Care Center**
	Orchard Hospital		**Medical Specialty Center (Oroville)**		

(a) When translation of vital documents is needed, each unit in Orchard Hospital will submit documents for translation into frequently-encountered languages to Health Information Management department. Original documents being submitted for translation will be in final, approved form with updated and accurate legal and medical information.

(b) Facilities will provide translation of other written materials, if needed, as well as written notice of the availability of translation, free of charge, for LEP individuals.

(c) Orchard Hospital will set benchmarks for translation of vital documents into additional languages over time.

4. PROVIDING NOTICE TO LEP PERSONS

Orchard Hospital will inform LEP persons of the availability of language assistance, free of charge, by providing written notice in languages LEP persons will understand. At a minimum, notices and signs will be posted and provided in intake areas and other points of entry, including but not limited to registration, the emergency room, outpatient areas, etc. Notification will also be provided through one or more of the following: Orchard Hospital website, outreach documents, telephone voice mail menus, local newspapers, radio and television stations, and/or community-based organizations.

5. MONITORING LANGUAGE NEEDS AND IMPLEMENTATION

On an ongoing basis, Orchard Hospital will assess changes in demographics, types of services or other needs that may require reevaluation of this policy and its procedures. In addition, Orchard Hospital will regularly assess the efficacy of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback from patients and community organizations, etc.

References: DNV-NIAHO Critical Access Hospital Accreditation Program: Patient Rights: PR.3 Language and Communication- SR.1; California Code of Regulations: Title 22, Section 70721, 71521; Office for Civil Rights; Title VI: Civil Rights Act, 42 USC 2000d et. Seq.

Title 11, California Code of Regulations § 999.5(d)(7)

Other Public Interest Factors

Title 11, California Code of Regulations § 999.5(d)(5)(7)

Other information the applicant believes the Attorney General should consider in deciding whether the proposed agreement or transaction is in the public interest

Orchard Hospital and American Advanced Management believe any public interest factors are described in this Notice. It is believed that this agreement is in the best interest of the public, especially the communities Orchard Hospital serves. Please see Management Services Agreement for additional information.

Title 11, California Code of Regulations § 999.5(d)(5)(9)

List of the officers and directors of the transferee, the most recent audited financial statements for the transferee, the transferee's governance documents, such as the articles of incorporation and bylaws, and a description of the transferee's policies, procedures, and eligibility requirements for the provision of charity care

Orchard Hospital will maintain their current Board of Directors and follow their current Bylaws.

Orchard Hospital Board of Directors:

Clark Redfield, Chairperson
Dago Candelario, Vice Chair
Ben Taylor, Treasurer
Jatinder Kullar, Secretary
Ed Becker
Joe Cunha
Maggie Daugherty
Landon Little

American Advanced Management Board of Directors:

Gurpreet Singh Randhawa, CEO/Secretary
Tammy Thompson, CFO
Shamsher Bhullar

American Advanced Management Governing Documents and Charity Care information are listed in the previous sections.

American Advanced Management's Financials are attached as

Exhibit1

Title 11, California Code of Regulations § 999.5(d)(5)(9)

List of the officers and directors of the transferee, the most recent audited financial statements for the transferee, the transferee's governance documents, such as the articles of incorporation and bylaws, and a description of the transferee's policies, procedures, and eligibility requirements for the provision of charity care

EXHIBIT 1

Report of Independent Auditors and Consolidated Financial Statements

American Advanced Management, Inc. and Affiliates

December 31, 2023 and 2022

JWT & Associates, LLP
Advisory Assurance Tax

American Advanced Management, Inc. and Affiliates

Audited Consolidated Financial Statements

December 31, 2023 and 2022

JWT & Associates, LLP

A Certified Public Accountancy Limited Liability Partnership
1111 East Herndon Avenue Suite 211, Fresno, CA 93720
Voice (559) 431-7708 Fax (559) 431-7685

Report of Independent Auditors

To the Stockholders
American Advanced Management, Inc. and Affiliates
Modesto, California

Opinion

We have audited the accompanying financial statements of American Advanced Management, Inc. and Affiliates (the Company), a for-profit organization, which comprise the consolidated balance sheets as of December 31, 2023 and 2022, and the related consolidated statements of income, changes in stockholders' equity, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2023 and 2022, and the results of its operations, changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Company and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but it is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements, including omissions, are considered material is there is a substantial likelihood that, individually or in the aggregate, they would influence the judgement made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgement and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgement, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Emphasis of Matter

As discussed in Note 1, the Company adopted Accounting Standards Update ("ASU") ASU No. 2016-02, *Leases (Topic 842),* for the year ended December 31, 20, 2021. Our opinion is not modified with respect to this matter.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary consolidating information is presented for purposes of additional analysis rather than to present the financial position and results of operations and changes in net assets of the individual entities and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

JWT & Associates, LLP

Fresno, California
March 13, 2024

American Advanced Management, Inc. and Affiliates

Consolidated Balance Sheets

December 31, 2023 and 2022

	2023	2022
Assets		
Current Assets		
Cash and cash equivalents	$ 6,208,347	$ 6,862,615
Patient accounts receivable, net	136,376,675	97,973,273
Other receivables	35,074,539	4,907,871
Supplies	1,816,060	1,313,719
Prepaid expenses and other assets	2,408,737	2,847,376
Total current assets	181,884,358	113,904,854
Right-of-use assets	87,573,549	34,753,519
Property, plant and equipment, net	6,792,286	14,733,620
Total assets	$ 276,250,193	$ 163,391,993
Liabilities and Stockholder's Equity		
Current liabilities		
Bank overdraft	$ 1,242,406	$ 186,836
Current portion of operating lease liability	7,383,937	6,476,148
Current portion of notes payable	2,826,681	2,703,646
Accounts payable and accrued expenses	104,641,780	52,214,423
Accrued payroll and related liabilities	8,546,169	49,951,954
Total current liabilities	124,640,973	111,533,007
Operating lease liability, net of current portion	82,156,481	28,277,371
Notes payable, net of current portion	10,508,895	13,301,484
Total liabilities	217,306,349	153,111,862
Stockholder's equity	58,943,844	10,280,131
Total liabilities and stockholder's equity	$ 276,250,193	$ 163,391,993

See notes to the financial statements

American Advanced Management, Inc. and Affiliates

Consolidated Statements of Income

Years Ended December 31, 2023 and 2022

	2023	2022
Revenues		
Net patient service revenue	$ 237,165,772	$ 192,989,756
Other	17,260,649	7,499,889
Total revenues	254,426,421	200,489,645
Expenses		
Salaries and wages	84,259,544	84,909,390
Employee benefits	17,353,701	18,468,137
Professional fees	24,539,458	28,692,194
Purchased services	8,735,413	10,583,021
Supplies	17,937,778	15,874,482
Repairs and maintenance	3,010,089	2,803,540
Lease and rent	16,392,805	11,535,977
Depreciation and amortization	955,031	1,281,931
Insurance	2,576,301	4,028,943
Interest	7,409,270	2,358,938
Other	14,830,261	13,396,159
Total expenses	197,999,651	193,932,712
Net income	$ 56,426,770	$ 6,556,933

See notes to the financial statements

American Advanced Management, Inc. and Affiliates

Consolidated Statements of Stockholders' Equity

	Common Stock	Retained Earnings (Deficit)	Total
Balance, December 31, 2021	$ 15,000	$ 11,735,603	$ 11,750,603
Net income (loss)	-	6,556,933	6,556,933
Net equity transactions	-	(8,012,405)	(8,027,405)
Balance, December 31, 2022	$ 15,000	$ 10,280,131	$ 10,280,131
Net income (loss)	-	56,426,770	56,426,770
Net equity transactions	-	(7,763,057)	(7,763,057)
Balance, December 31, 2023	$ 15,000	$ 58,943,844	$ 58,943,844

See notes to the financial statements

American Advanced Management, Inc. and Affiliates

Consolidated Statements of Cash Flows

Years Ended December 31, 2023 and 2022

	2023	2022
Operating activities		
Net income	$ 56,426,770	$ 6,556,933
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	955,031	1,281,931
Changes in operating assets and liabilities:		
Patient accounts receivable, net	(38,403,402)	(11,310,537)
Other receivables	(30,166,668)	6,537,208
Supplies	(502,341)	252,079
Prepaid expenses and other assets	438,639	(2,245,851)
Accounts payable and accrued expenses	52,427,357	7,826,416
Accrued personnel costs	(41,405,785)	3,377,177
Net cash provided by operating activities	(230,399)	12,275,356
Investing activities		
Net change in right-of-use assets	(52,820,030)	6,988,914
Capital expenditures	(292,775)	(2,985,584)
Gain on disposal of capital assets	7,279,078	-
Net cash provided by (used in) investing activities	(45,833,727)	4,003,330
Financing activities		
New operating lease liability	63,504,903	-
Payments of operating lease liability	(8,718,004)	(6,988,914)
Principal payments of notes payable	(2,669,554)	(6,291,583)
Net stockholder's equity transactions	(7,763,057)	(8,027,405)
Net cash provided by (used in) financing activities	44,354,288	(21,307,902)
Net decrease in cash and cash equivalents	(1,709,838)	(5,029,216)
Cash and cash equivalents, beginning of year	6,675,779	11,704,995
Cash and cash equivalents, end of year	$ 4,965,941	$ 6,675,779
Supplemental disclosure of cash flow information		
Cash paid for interest	$ 7,399,036	$ 2,358,938

See notes to the financial statements

American Advanced Management, Inc. and Affiliates

Audited Consolidated Financial Statements

December 31, 2023 and 2022

Note 1 – Nature of Operations and Summary of Significant Accounting Policies

Organization – American Advanced Management, Inc. and affiliates (the Company) is a California corporation, formed in 2014, which provides healthcare related management services to several related entities. The Company also runs several other healthcare related businesses through its affiliates. Affiliates include Central Valley Specialty Hospital, Inc. a California corporation which runs a 96 bed long-term acute care facility located in Modesto, California, a 42-bed acute care hospital and 6-bed skilled nursing facility in Colusa, California, a 58-bed acute care hospital facility in Sebastopol, California, a 25-bed acute care hospital in Willows, California, a 24-bed acute care hospital and 99-bed skilled nursing facility in Coalinga, California, a home health and hospice care service, sub-acute services, rehabilitation services and healthcare facility and operations management services.

Basis of preparation – The accounting policies and consolidated financial statements of the Company generally conform to the recommendations of the audit and accounting guide, Health Care Organizations, published by the American Institute of Certified Public Accountants. The consolidated financial statements are presented in accordance with the pronouncements of the Financial Accounting Standards Board (FASB). For purposes of presentation, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operational revenues and expenses.

Principles of consolidation – The consolidated financial statements include the accounts of Central Valley Specialty Hospital, Inc., Sonoma Specialty Hospital, LLC, American Advanced Management, Inc., American Advanced Management Group, Inc., Riverbank Rehabilitation Center, LLC, Colusa Medical Center, LLC, Progressive Home Health and Hospice, LLC, Glenn Medical Center, LLC, Pacific Gardens Medical Center, LLC, American Advanced Physician Group, Inc. and Coalinga Medical Center, LLC. All material intercompany transactions and balances have been eliminated in the consolidation. The Company is the primary beneficiary of these entities, who qualify as variable interest entities (VIEs). The determination was based on the fact that the Company has a controlling financial interest in the entities.

Use of estimates - The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting year. Amounts subject to significant estimate include allowances for contractual and bad debts on patient accounts receivable, reserves for workers' compensation and medical malpractice claims, medical claims payable under capitation arrangements, and estimated third party cost report settlements. Actual results could differ from those estimates.

Cash and cash equivalents - Cash and cash equivalents include all deposits and investments in highly liquid debt instruments with a maturity of three months or less, excluding those amounts that are limited for use by contract or agreement.

Note 1 – Nature of Operations and Summary of Significant Accounting Policies (continued)

Patient accounts receivable – The Company reports patient accounts receivable for services rendered at net realizable amounts from third-party payers, patients and others. The Company provides an allowance for bad debts based upon a review of outstanding receivables, historical collection information and existing economic conditions. As a service to the patient, the Company bills third-party payers directly and bills the patient when the patient's liability is determined. Net patient accounts receivable are due in full when billed. Accounts are considered delinquent and subsequently written off as bad debts based on individual credit evaluation and specific circumstances of the account.

Allowance for doubtful accounts – Patient accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of patient accounts receivable, the Company analyzes its past history and identifies trends for each of its major payer sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts.

Management regularly reviews data about these major payer sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For patient accounts receivable associated with services provided to patients who have third-party coverage, the Company analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary.

For patient accounts receivable associated with self-pay patients and non-contracted insurance (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Company records a provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts. The allowance for doubtful accounts is approximately 5% at December 31, 2023 and 2022.

Supplies - The Company states supply inventories at cost, which does not exceed market value.

Fair value of financial instruments - The financial statements include financial instruments for which the fair market value may differ from amounts reflected on a historical basis. Financial instruments of the Company consist of cash deposits, accounts receivable, accounts payable and certain accrued liabilities. The Company's other financial instruments generally approximate fair market value based on the short-term nature of these instruments.

Property and equipment – Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method.

American Advanced Management, Inc. and Affiliates

Audited Consolidated Financial Statements

December 31, 2023 and 2022

Note 1 – Nature of Operations and Summary of Significant Accounting Policies (continued)

Impairment – Impairment of long-lived assets is recognized whenever events or changes in circumstances indicate that the carrying amount of the asset may not be recoverable. Measurement of the amount of impairment may be based on market values of similar assets or estimates of future discounted cash flows resulting from use and ultimate disposition of the assets.

Net patient service revenue – The Company has agreements with third-party payors that provide for payments to the Company at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursement costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined.

Charity care – The Company provides care to patients who meet certain criterion under its charity care policy. The Company provides medical care to patients regardless of their ability to pay. The evaluation of the necessity for medical treatment of any patient is based upon clinical judgment, irrespective of the financial status of the patient. Because the Company does not pursue collection of amounts determined to qualify as charity care, they are not included in net patient service revenue.

Income taxes – No provision for income taxes is included in these consolidated financial statements. Central Valley Specialty Hospital, Inc., American Advanced Management, Inc., American Advanced Management Group, Inc. and American Advanced Physician Group, Inc. have elected S Corporation status and corporate earnings and losses are taxable to the individual stockholders. In addition, the Company incurs a 1.5% state income tax.

Sonoma Specialty Hospital, LLC, Riverbank Rehabilitation Center, LLC, Colusa Medical Center, LLC, Progressive Home Health and Hospice, LLC, Glenn Medical Center, LLC, Pacific Gardens Medical Center, LLC and Coalinga Medical Center, LLC are Limited Liability Companies (LLCs). As such, these entities are not tax paying entities for federal income tax purposes, and thus no deferred income tax expense has been recorded in the consolidated financial statements. Instead, LLC members are taxed individually on their share of these entities' earnings. These entities pay an annual state franchise fee and a limited liability company fee based on gross revenue.

Income taxes are accounted for using an asset and liability approach that requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the consolidated financial statements and tax basis of assets and liabilities at the applicable enacted tax rates. A valuation allowance is provided when it is more likely than not that some portion or all of the deferred tax assets will not be realized.

Note 1 – Nature of Operations and Summary of Significant Accounting Policies (continued)

The Company recognizes the tax benefit from uncertain tax positions only if it is more likely than not that the tax positions will be sustained on examination by the tax authorities, based on the technical merits of the position. The tax benefit is measured based on the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement. At December 31, 2023, there were no uncertain tax positions.

Recently Adopted Accounting Pronouncement - In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)*, to increase transparency and comparability among organizations by recognizing lease assets and lease liabilities on the balance sheet and disclosing key information about leasing arrangements. The Company has adopted ASU 2016-02 for the year beginning January 1, 2021, using the modified retrospective approach. The adoption of ASU 2016-02 also implemented additional disclosure requirements.

Subsequent events - Subsequent events are events or transactions that occur after the balance sheet date but before financial statements are available to be issued. The Company recognizes in the consolidated financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the balance sheet, including the estimates inherent in the process of preparing the consolidated financial statements. The Company's consolidated financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the balance sheet but arose after the balance sheet date and before consolidated financial statements are available to be issued. The Company has evaluated subsequent events through the date of the Independent Auditor's Report, which is the date the consolidated financial statements were available to be issued.

Note 2 - Information Regarding Liquidity and Availability of Resources

The Company regularly monitors the availability of resources required to meet its operating needs and other contractual commitments, while striving to maximize the investment of its available funds. The Company various sources of liquidity at its disposal as itemized in the table presented below. For purposes of analyzing resources available to meet general expenditures over a 12-month period, the Company considers all expenditures related to its ongoing activities of providing health care services as well as the conduct of services undertaken to support those activities, to be general expenditures.

The Company strives to maintain liquid financial assets sufficient to cover at least 30 days of expenditures. The Company's policy is that excess cash on hand is invested in investment instruments with liquidity requirements to enable the Company usage of those assets within a short time period.

Note 2 - Information Regarding Liquidity and Availability of Resources (continued)

The following table reflects the Company's financial assets as of December 31, 2023 and 2022, reduced by amounts that are not available to meet general expenditures within one year of the statement of financial position date.

	2023	2022
Cash and cash equivalents	$ 6,208,347	$ 6,862,615
Patient accounts receivable, net of allowances	136,376,675	97,973,273
Other receivables	35,074,539	4,907,871
Total financial assets	177,659,561	109,743,759
Less reduction of financial assets not available for general expenses	-	-
Total financial assets available for one year of general expenses	$ 177,659,561	$ 109,743,759

In addition to financial assets available to meet general expenditures over the next 12-month period, the Company operates a balanced budget and anticipates collecting sufficient patient service revenue to cover general expenditures. Refer to the statement of cash flows which identifies the sources and uses of the Company's cash flow and shows positive cash generated by operations for the years ended December 31, 2023 and 2022.

Note 3 - Net Patient Service Revenue and Reimbursement Programs

The Company renders services to patients under contractual arrangements with Medicare and Medi-Cal programs, commercial insurance companies, health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Patient service revenues from these programs approximate 96% of gross patient service revenues.

The Medicare Program reimburses the Company on a prospective payment system for inpatient hospital services. The prospective rates are predetermined amounts based on the Medicare inpatient discharge diagnosis including capital. Other services are reimbursed on a program similar in nature to the inpatient services.

The Company contracts to provide services to Medi-Cal, HMO and PPO inpatients on negotiated rates. Certain outpatient reimbursement is subject to a schedule of maximum allowable charges for Medi-Cal and to a percentage discount for HMOs and PPOs. LTAC and other services are reimbursed by the Medi-Cal program on a prospective per diem basis subject to audit by the state. The results of the state audits are incorporated prospectively and are subject to appeal by the provider.

Note 3 - Net Patient Service Revenue and Reimbursement Programs (continued)

Both the Medicare and Medi-Cal program's administrative procedures preclude final determination of amounts due to the Company for services to program patients until after patients' medical records are reviewed and cost reports are audited or otherwise reviewed by and settled with the respective administrative agencies. The Medicare and Medi-Cal cost reports are subject to audit and possible adjustment. Management is of the opinion that no significant adverse adjustment to the recorded settlement amounts will be required upon final settlement.

Medicare and Medi-Cal revenue accounts for approximately 45% in 2023 and 2022 of the Hospital's net patient revenues for each year. Laws and regulations governing Medicare and Medi-Cal programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

Note 4 – Concentration of Credit Risk

Patient Account Receivable - The Company grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of gross patient accounts receivable from patients and third-party payors at December 31, 2023 and 2022 was as follows:

	2023	2022
Medicare	24%	26%
Medi-Cal	21%	19%
Insurance and other third-party payors	51%	50%
Private pay	4%	5%
Total	100%	100%

Bank balances – The Company maintains a substantial portion of its cash at two financial institutions. At December 31, 2023, the Company's cash accounts per bank records did not exceed federally insured limits. Management believes the credit risk related to these deposits is minimal.

Note 5 – Property, Plant & Equipment

The components and amounts which comprise property, plant and equipment as of December 31, 2023 and 2022 are as follows:

	2023	2022
Land and improvemants	$ 69,086	$ 69,086
Buildings and improvements	7,221,865	5,326,853
Equipment and vehicles	10,281,100	10,503,811
Construction in progress	1,993,250	4,059,147
Other	1,167,000	7,867,000
	20,732,301	27,825,897
Less: accumulated depreciation	(13,940,015)	(13,092,277)
	$ 6,792,286	$ 14,733,620

Note 6 – Pension Plan

The Company has a defined contribution pension plan covering substantially all employees. The Company's management annually determines the amount, if any, of the Company contributions to the pension plan. For the years ended December 31, 2023 and 2022, the Company made no contributions.

American Advanced Management, Inc. and Affiliates

Audited Consolidated Financial Statements

December 31, 2023 and 2022

Note 7 – Long-term Debt and Notes Payable

Long-term debt consisted of the following at December 31, 2023 and 2022:

	2023	2022
Note payable to a healthcare district, original amount of $1,200,000, non-interest bearing, no principal payments due till maturity in December 2029, at which time the loan is forgivable if certain terms and conditions are met, secured by certain assets and equipment.	$ 1,200,000	$ 1,200,000
Note payable to the U.S. Small Business Administration as part of the Economic Injury Disaster Loan Program, original amount of $750,000, bearing interest at 3.75%, monthly principal and interest payments of $3,655 deferred till August 2022, maturing in August 2052, unsecured.	744,152	750,000
Note payable to a bank, original amount of $16,133,231, bearing interest at 4.75%, principal and interest payable monthly in the amount of $257,697, maturing in August 2027, secured by certain assets and equipment.	10,569,202	13,066,242
Note payable to a healthcare company, original amount of $500,000, non-interest bearing, principal payments deferred indefinitely, unsecured.	500,000	500,000
Note payable to an individual, original amount of $1,000,000, non-interest bearing, principal payable monthly in the amount of $11,111, maturing in August 2026, secured by certain assets and equipment.	322,222	488,888
Total debt borrowings	13,335,576	16,005,130
Less current maturities	(2,826,681)	(2,703,646)
Debt borrowings, net of current maturities	$ 10,508,895	$ 13,301,484

Note 7 – Long-term Debt and Notes Payable (continued)

The future principal payments required under existing debt, by year, are as follows:

Years ended December 31,	
2024	$ 2,826,681
2025	4,158,494
2026	3,017,660
2027	2,234,616
2028	73,273
Thereafter	1,024,852
	$ 13,335,576

Note 8 - Leases

The Company leases certain office space under operating leases. Lease commencement occurs on the date the Company takes possession or control of the property. Original terms for facility-related leases are generally between three to five years. Some of the Company's leases also include rental escalation clauses and/or termination provisions. Renewal options and termination options are included in determining the lease payments when management determines the options are reasonably certain of exercise.

If readily determinable, the rate implicit in the lease is used to discount lease payments to present value: however, substantially all of the Company's leases do not provide a readily determinable implicit rate. When the implicit rate is not determinable, the Company's estimated incremental borrowing rate is utilized, determined on a collateralized basis, to discount lease payments based on information available at lease commencement.

The Company's leases typically require payment of common area maintenance and real estate taxes which represent the majority of variable lease costs. Certain lease agreements also provide for variable rental payments based on sales performance in excess of specified minimums, usage measures, or changes in the consumer price index. Variable rent payments based on future performance, usage, or changes in indices were not significant for any of the periods presented. Variable lease costs are excluded from the present value of lease obligations.

The Company's lease agreements do not contain any material restrictions, covenants, or any material residual value guarantees.

Note 8 – Leases (continued)

Lease related assets and liabilities as of December 31, 2023 and 2022, consist of the following:

	2023	2022
Assets		
Right-of-use assets	$ 87,573,549	$ 34,753,519
Liabilities		
Operating lease liability, current	$ 7,383,937	$ 6,476,148
Operating lease liability, less current portion	82,156,481	28,277,370
	$ 89,540,418	$ 34,753,518

Total operating lease expense for the years ended December 31, 2023 and 2022, was $16,392,805 and $11,535,977, respectively.

The future minimum rental payments required under operating lease obligations as of December 31, 2023, having initial or remaining non-cancelable lease terms in excess of one year are summarized as follows:

Years ended December 31,	
2024	$ 11,693,271
2025	11,324,528
2026	10,521,046
2027	10,424,400
Thereafter	78,176,900
	122,140,145
Less interest	(32,599,727)
Present value of lease liability	$ 89,540,418

The weighted-average remaining lease term and discount rate as of December 31, 2023, are as follows:

Weighted-average remaining lease term	
Operating leases (months)	183
Weighted-average discount rate	
Operating leases	5.0%

Note 9 - Commitments and Contingencies

Litigation – The Company is party to legal proceedings and claims, which arise during the ordinary course of business. In the opinion of management, the ultimate outcome of the claims and litigation will not have a material adverse effect on the Company's financial position.

The Company is subject to many complex federal, state, and local laws and regulations. Compliance with these laws and regulations is subject to government review and interpretation and unknown or unasserted regulatory actions. Government activity with respect to investigations and allegations regarding possible violations of these laws and regulations by health care providers, including those related to medical necessity, coding, and billing for services, and repayment of past patient service revenues. Management believes any actions that may result from investigations on non-compliance with laws and regulations will not have a material effect on the Company's futures financial position or results of operations.

Professional and general liability insurance – The Company is covered under a combination of claims-made (for professional liability) and occurrence-based (for commercial general liability) policies. Under these policies the Company is covered in the amount of $1,000,000 per incident and $3,000,000 in the aggregate.

Workers' compensation insurance – The Company is insured for workers' compensation claims. Claims are accrued under the workers' compensation plan as the incidents that give rise to them occur. Unpaid claim accruals are based on the estimated ultimate cost of settlement, including claim settlement expenses.

Note 10 – Sale of Assets and Discontinuance of Operations

During the year ended December 31, 2023, the Company sold assets and the operations of three entities that are included in the combined financial statements.

Riverbank Rehabilitation Center, LLC (Riverbank) sold a 99-bed skilled nursing facility known as Central Valley Post-Acute and the operations of the facility in May 2023. The Company is now winding down the administration and other required activities of the LLC, including collecting remaining patient accounts receivable and paying off liabilities. Riverbank recorded a gain of $5,439,997 on the sale which is reported in the combined statement of income as other operating revenue.

Progressive Home Health and Hospice, LLC (PHHH) sold assets and the operations of a home health and hospice operation in December 2021. The Company is now winding down the administration and other required activities of the LLC, including collecting remaining patient accounts receivable and paying off liabilities. PHHH recorded a gain of $1,200,000 on the sale which was reported in the combined statement of income as other operating revenue for year ended December 31, 2022.

Note 10 – Sale of Assets and Discontinuance of Operations (continued)

Pacific Gardens Medical Center, LLC (PGMC) sold a 153-bed acute care hospital and the operations of the facility in December 2023. The Company is now winding down the administration and other required activities of the LLC, including collecting remaining receivables and paying off liabilities. PGMC recorded a gain of $1,946,029 on the sale which is reported in the combined statement of income as other operating revenue.

999.5(a)(1)

American Advanced Management, Inc. and Affiliates

Balance Sheet Consolidation

December 31, 2023

	Central Valley Specialty Hospital	Sonoma Specialty Hospital	American Advanced Management	American Advanced Mgmt Group	Riverbank Rehabilitation Center	Colusa Medical Center	Progressive Home Health and Hospice	Glenn Medical Center	Pacific Gardens Medical Center	American Advanced Physician Group	Coalinga Medical Center	Consolidating Adjustments	Consolidated Total
Assets													
Current Assets													
Cash and cash equivalents	$ 1,291,881	$ -	$ 120,427	$ 22,823	$ 1,852,178	$ 115,842	$ -	$ 1,426,495	$ 225,294	$ 1,153,407	$ -	$ -	$ 6,208,347
Patient accounts receivable, net	20,162,100	21,153,237	-	-	5,999,674	30,690,748	12,692	12,564,560	-	1,111,105	44,682,559	-	136,376,675
Other receivables	368,810	17,046	19,136,598	1,514,023	900,000	-	-	4,068,062	9,070,000	-	-	-	35,074,539
Supplies	756,632	326,804	-	-	-	184,288	-	154,786	-	-	393,550	-	1,816,060
Prepaid expenses and other assets	472,806	82,755	840,417	69,587	78,281	357,199	2,022	92,948	-	6,454	406,268	-	2,408,737
Total current assets	23,052,229	21,579,842	20,097,442	1,606,433	8,830,133	31,348,077	14,714	18,306,851	9,295,294	2,270,966	45,482,377	-	181,884,358
Right-of-use assets	33,175,565	47,695,740	2,810,674	-		3,891,570	-	-	-	-	-	-	87,573,549
Property, plant and equipment, net	2,231,391	1,862,013	-	-	-	408,290	-	713,330	-	-	1,577,262	-	6,792,286
Total assets	$ 58,459,185	$ 71,137,595	$ 22,908,116	$ 1,606,433	$ 8,830,133	$ 35,647,937	$ 14,714	$ 19,020,181	$ 9,295,294	$ 2,270,966	$ 47,059,639	$ -	$ 276,250,193
Liabilities and Stockholder's Equity													
Current liabilities													
Bank overdraft	$ -	$ 977,961	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 264,445	$ -	$ 1,242,406
Current portion of operating lease liability	4,156,348	1,856,426	1,097,859	-	-	273,304	-	-	-	-	-	-	7,383,937
Current portion of notes payable	-	-	2,658,260	8,772	8,772	-	8,772	-	-	8,772	133,333	-	2,826,681
Accounts payable and accrued expenses	29,573,326	14,045,175	12,497,341	108,544	3,689,919	14,139,603	1,008,037	3,622,845	5,900,872	5,951,759	14,104,359	-	104,641,780
Accrued payroll and related liabilities	1,762,894	2,009,023	789,492	457,235	81,784	778,961	245,584	602,821	-	486,522	1,331,853	-	8,546,169
Intercompany due to (from)	(57,398,713)	10,246,924	(32,694,502)	(12,260,574)	5,347,643	20,544,292	1,142,139	23,254,230	12,691,932	(29,160,304)	58,286,933	-	-
Total current liabilities	(21,906,145)	29,135,509	(15,651,550)	(11,686,023)	9,128,118	35,736,160	2,404,532	27,479,896	18,592,804	(22,713,251)	74,120,923	-	124,640,973
Operating lease liability, net of portion	29,804,533	46,866,243	1,779,620	-	-	3,706,085	-	-	-	-	-	-	82,156,481
Notes payable, net of current portion	-	1,200,000	8,060,942	141,228	141,228	-	141,228	900,000	-	135,380	188,889	-	10,508,895
Total liabilities	7,898,388	77,201,752	(5,810,988)	(11,544,795)	9,269,346	39,442,245	2,545,760	27,979,896	18,592,804	(22,577,871)	74,309,812	-	217,306,349
Stockholder's equity (deficit)	50,560,797	(6,064,157)	28,719,104	13,151,228	(439,213)	(3,794,308)	(2,531,046)	(8,959,715)	(9,297,510)	24,848,837	(27,250,173)	-	58,943,844
Total liabilities and stockholder's equity	$ 58,459,185	$ 71,137,595	$ 22,908,116	$ 1,606,433	$ 8,830,133	$ 35,647,937	$ 14,714	$ 19,020,181	$ 9,295,294	$ 2,270,966	$ 47,059,639	$ -	$ 276,250,193

999.5(a)(1)

American Advanced Management, Inc. and Affiliates

Statement of Income Consolidation

Year Ended December 31, 2023

	Central Valley Specialty Hospital	Sonoma Specialty Hospital	American Advanced Management	American Advanced Mgmt Group	Riverbank Rehabilitation Center	Colusa Medical Center	Progressive Home Health and Hospice	Glenn Medical Center	Pacific Gardens Medical Center	American Advanced Physician Group	Coalinga Medical Center	Consolidating Adjustments	Consolidated Total
Operating revenues													
Net patient service revenue	$ 66,052,990	$ 42,680,255	$ -	$ -	$ 4,607,056	$ 32,053,685	$ -	$ 28,674,420	$ -	$ 22,313,673	$ 40,783,693	$ -	$ 237,165,772
Other	8,808,254	5,167,865	19,546,697	7,094,739	8,217,247	1,545,988	-	559,531	3,904,821	2,878	5,601,409	(43,188,780)	17,260,649
Total revenues	74,861,244	47,848,120	19,546,697	7,094,739	12,824,303	33,599,673	-	29,233,951	3,904,821	22,316,551	46,385,102	(43,188,780)	254,426,421
Operating expenses													
Salaries and wages	24,175,469	15,954,131	3,896,618	1,790,506	2,571,692	9,818,906	-	12,105,432	-	993,082	14,268,855	(1,315,147)	84,259,544
Employee benefits	2,957,547	2,733,152	1,338,579	202,034	279,345	5,864,360	-	2,407,188	-	85,827	1,485,669	-	17,353,701
Professional fees	3,417,481	3,109,253	2,944	-	384,047	5,230,532	-	8,837,060	167	10,437,255	10,253,946	(17,133,227)	24,539,458
Purchased services	6,877,258	4,945,446	11,104	-	261,307	3,379,213	-	5,404,219	-	2,103,060	6,800,118	(21,046,312)	8,735,413
Supplies	7,183,292	3,138,512	17,864	-	405,852	1,865,748	-	1,780,220	36,237	125,520	3,384,533	-	17,937,778
Repairs and maintenance	1,053,741	526,419	-	-	33,978	210,619	-	269,059	950	3,717	1,296,814	(385,208)	3,010,089
Lease and rent	4,901,740	2,234,880	2,405,678	-	456,161	484,437	-	410,598	880,076	-	4,872,531	(253,296)	16,392,805
Depreciation and amortization	89,146	155,031	-	-	7,574	466,572	-	47,584	-	-	189,124	-	955,031
Insurance	632,514	87,875	129,081	91,806	72,114	345,188	-	215,199	108,174	481,059	413,291	-	2,576,301
Interest	2,618,432	3,513,687	268,446	579	3,655	631,385	6,579	334,812	-	-	3,087,285	(3,055,590)	7,409,270
Other	2,647,848	1,429,644	349,532	16,278	931,702	1,829,471	-	4,091,415	32,885	11,931	3,489,555	-	14,830,261
Total expenses	56,554,468	37,828,030	8,419,846	2,101,203	5,407,427	30,126,431	6,579	35,902,786	1,058,489	14,241,451	49,541,721	(43,188,780)	197,999,651
Net income (loss)	$ 18,306,776	$ 10,020,090	$ 11,126,851	$ 4,993,536	$ 7,416,876	$ 3,473,242	$ (6,579)	$ (6,668,835)	$ 2,846,332	$ 8,075,100	$ (3,156,619)	$ -	$ 56,426,770

See notes to the financial statements

Title 11, California Code of Regulations § 999.5(d)(5)(10)

Written notice of any proposed agreement or transaction set forth in section 999.5(a)(1) shall include a description of the applicant's efforts to inform local governmental entities, professional staff and employees of the health facility or facility that provides similar health care and the general public of the proposed transaction. This description shall include any comments or reaction to this effort

Orchard Hospital and American Advanced Management made every effort to inform the communities they serve and key stakeholders of the agreement. This included local governmental agencies, professional staff and employees. There were press releases, e-mail communications, telephone calls, organizational announcements, staff meetings and many community events. The feedback was very positive and supportive.

1. Exhibit 1 – a copy of the Press Release, dated May 4, 2023
2. Exhibit 2 – a copy of the letter to CDPH, dated March 8, 2024

Title 11, California Code of Regulations § 999.5(d)(5)(10)

Written notice of any proposed agreement or transaction set forth in section 999.5(a)(1) shall include a description of the applicant's efforts to inform local governmental entities, professional staff and employees of the health facility or facility that provides similar health care and the general public of the proposed transaction. This description shall include any comments or reaction to this effort

EXHIBIT 1

FOR IMMEDIATE RELEASE

Orchard Hospital Enters Management Agreement with American Advanced Management Group

Gridley, CA – May 4, 2023

Orchard Hospital is pleased to announce that it will be entering into a management agreement with American Advanced Management Group (AAMG), effective July 1, 2023. This partnership aims to bolster the hospital's growth and expand its services to better serve Gridley and the surrounding communities.

AAMG, a well-regarded organization, has demonstrated a strong track record of assisting small hospitals to thrive by increasing patient volume, augmenting staff, and broadening the range of services offered. Through this management agreement, AAMG will oversee day-to-day operations at Orchard Hospital and work closely with the existing team to implement efficiencies and improvements that will benefit both the hospital and its patients.

As the partnership progresses, Orchard Hospital plans to submit a change of ownership request to the California Department of Public Health and the California State Attorney General. The Attorney General will establish conditions to ensure that AAMG possesses the financial capability and business acumen necessary to maintain and enhance the high-quality healthcare services provided by Orchard Hospital to Gridley and its surrounding communities.

"Steve Stark, CEO at Orchard Hospital, said, 'We are excited to embark on this new chapter with AAMG. Their expertise and resources will be invaluable in strengthening Orchard Hospital and ensuring our continued success. We are confident that this partnership will bring positive changes to our hospital and the community at large.'"

Orchard Hospital is committed to keeping the community informed throughout this transition process. The hospital will be organizing informational sessions for its staff and community to address any questions or concerns regarding the partnership with AAMG.

About Orchard Hospital:

Orchard Hospital is a leading healthcare provider in Gridley, CA, dedicated to offering exceptional care to its patients and serving the needs of the community. With a focus on innovation, compassion, and excellence, Orchard Hospital continually strives to improve its services and positively impact the lives of those it serves.

For more information, please contact:

Orchard Hospital
Administration
240 Spruce Street
Gridley, CA 95948
(530) 846-9021
pr@orchardhospital.com

Title 11, California Code of Regulations § 999.5(d)(5)(10)

Written notice of any proposed agreement or transaction set forth in section 999.5(a)(1) shall include a description of the applicant's efforts to inform local governmental entities, professional staff and employees of the health facility or facility that provides similar health care and the general public of the proposed transaction. This description shall include any comments or reaction to this effort

EXHIBIT 2

Orchard Hospital

Steve Stark
CEO
Orchard Hospital
240 Spruce Street
Gridley, CA 95948

March 8, 2024

Joanne Gilchrist
District Manager II, Chico District
126 Mission Ranch Blvd.
Chico, CA 95926

Dear Joanne,

I'm writing to update you on Orchard Hospital's situation. As you know, on July 1, 2023, we started working with American Advanced Management, Inc. (AAM) to eventually become an AAM hospital. We have a management services agreement in place where AAM provides financial support to OH in our time of need, but fundamentally, our hospital has not changed, but we want to get into the next steps where it will.

I'm still working for Orchard Hospital as their CEO, and our board is still in their fiduciary role, but we've reached a point where we're unsure if we need to start formal processes with the California Department of Public Health or the California State Attorney General's Office for this transition.

We've always appreciated your support and advice for our hospital. Could you guide us on what steps to take next? Your help would be very valuable to us.

As always, I appreciate any guidance you can provide or point me to.

Warm regards,

Steve Stark

Orchard Hospital
CEO

Title 11, California Code of Regulations § 999.5(d)(5)(11)

Any board minutes or other documents relating or referring to consideration by the board of directors of the applicant and any related entity, or any committee thereof of the agreement or transaction or of any other possible transaction involving any of the health facilities or facilities that provide similar health care that are the subject of agreement or transaction

Title 11, California Code of Regulations § 999.5(d)(5)(11)(A)

Any board minutes or other documents relating or referring to consideration by the board of directors of the applicant and any related entity, or any committee thereof of the agreement or transaction or of any other possible transaction involving any of the health facilities or facilities that provide similar health care that are the subject of agreement or transaction

1. Exhibit 1 – June, 2023 Orchard Hospital Board Meeting Minutes

2. Exhibit 2 – July, 2023 Orchard Hospital Board Meeting Minutes

Title 11, California Code of Regulations § 999.5(d)(5)(11)(A)

Any board minutes or other documents relating or referring to consideration by the board of directors of the applicant and any related entity, or any committee thereof of the agreement or transaction or of any other possible transaction involving any of the health facilities or facilities that provide similar health care that are the subject of agreement or transaction

EXHIBIT 1

Orchard Hospital
June 2023 - Monthly Board Meeting
June 27, 2023
12:00 pm-2:00 pm Pacific Time

I. **CALL TO ORDER** (12:00PM)

II. **CONSENT AGENDA All matters listed under the Consent Agenda are considered routine by the Board and will be enacted by majority vote. If discussion is desired, that item will be removed from the Consent Agenda and will be considered separately.**

A. April 2023 Meeting Minutes There was no May Board Meeting.

B. Policies and Procedures approved by Medical Staff with changes

C. Policies and Procedures approved by Medical Staff with only a date reviewed

III. **APPROVAL OF AGENDA Motion by John Harris, Second by Jatinder Kullar. Motion passed.**

IV. **ITEMS FOR CONSIDERATION**

A. **Board Finance Committee Summary**

1. Approval of Financial Report - April and May 2023 - Motion by Ben Taylor. Second by Jatinder Kullar. Motion passed.
2. Approval of FY2024 Budget - Motion by Ben Taylor. Second by Jatinder Kullar. Motion passed.

V. **Board Quality Committee Report**

A. Board Quality Meeting Scheduled for July 25, 2023! Please plan to attend beginning at 2:00PM.

VI. **Board Audit and Corporate Compliance Report**

VII. **Board Governance Committee Report**

A. Report from Board Governance Chairperson.

B. Approval of MOU with AAM - Motion by Clark Redfield. Second by Ben Taylor. Motion passed.

VIII. **Chief of Staff Report**

A. Approval of Medical Staff Credentials - Motion by Ben Taylor. Second by John Harris. Motion passed.

B. Approve adding the Medical Staff library fund as a sub account to Orchard Hospital - Motion by Ben Taylor. Second by Clark Redfield. Motion passed.

IX. **Executive Staff Reports**

A. Organizational Update - Steve Stark, CEO

B. Quality and Nursing Update - John Christopher, MSN, FNP-C

C. Medical Specialty Center/Marketing Update - Kirsten Storne-Piazza, CCA

D. Medical Staff Update - Natalie Ladine, MD, CMO

E. Operations Update - Kami Duntsch, COO

X. **Chairperson's Report**

A. Executive Session Determination

XI. **Adjournment**

Title 11, California Code of Regulations § 999.5(d)(5)(11)(A)

Any board minutes or other documents relating or referring to consideration by the board of directors of the applicant and any related entity, or any committee thereof of the agreement or transaction or of any other possible transaction involving any of the health facilities or facilities that provide similar health care that are the subject of agreement or transaction

EXHIBIT 2

Orchard Hospital
July 2023 - Monthly Board Meeting
July 25, 2023
12:00 pm-2:00 pm Pacific Time

I. **CALL TO ORDER** (12:00PM)

II. **CONSENT AGENDA All matters listed under the Consent Agenda are considered routine by the Board and will be enacted by majority vote. If discussion is desired, that item will be removed from the Consent Agenda and will be considered separately.**

A. June 2023 Meeting Minutes - Motion by Joe Cunha and seconded by John Harris. Motion passed.
B. Policies and Procedures approved by Medical Staff with changes
C. Policies and Procedures approved by Medical Staff with only a date reviewed

III. **APPROVAL OF AGENDA**

IV. **ITEMS FOR CONSIDERATION**

V. Resolution to Enter AAM agreement - Motion by Clark Redfield and seconded by John Harris. Motion passed as amended. Clark Redfield would like the wording to be changed to "has reviewed" instead of "performed".

VI. Financial Statistics – Financial Statistics will be posted to Govenda after the meeting today.

VII. **Board Quality Committee Report**

A. Board Quality Meeting has been cancelled. The Quality Committee will report at the Board Meeting in August.

VIII. **Board Audit and Corporate Compliance Report**

IX. **Chief of Staff Report**

A. Approval of Medical Staff Credentials - Motion by Clark Redfield and seconded by Joe Cunha. Motion passed.

X. **Executive Staff Reports**

A. Organizational Update - Steve Stark, CEO – Discussion regarding distressed hospital loan. We will apply for the loan. If we receive funding, we will need to approve the resolution. This may open more opportunities for the hospital as well as be ready to accept the funding if or when it is disbursed. Discussion regarding OHAS. Chris Roberts' last day with Orchard Hospital will be September 1, 2023.
B. Nursing Update - John Christopher, MSN, FNP-C – Discussion regarding Referrals from other hospital within AAM. Regionalization has brought a lot of opportunities to share services, which is also increasing our other resources including Radiology and other Outpatient Services.
C. Medical Specialty Center/Marketing Update - Kirsten Storne-Piazza, CCA - In absence of Kirsten Storne-Piazza, report presented by Steve Stark.
D. Medical Staff Update - Natalie Ladine, MD, CMO - In absence of Natalie Ladine, MD, report presented by Steve Stark – Discussion about Dr. Singh having privileges at Orchard Hospital because he will be assisting wherever he is needed.
E. Operations Update - Kami Duntsch, COO

XI. **Chairperson's Report**

A. Executive Session Determination

XII. **Adjournment**

Title 11, California Code of Regulations § 999.5(d)(5)(11)(B)

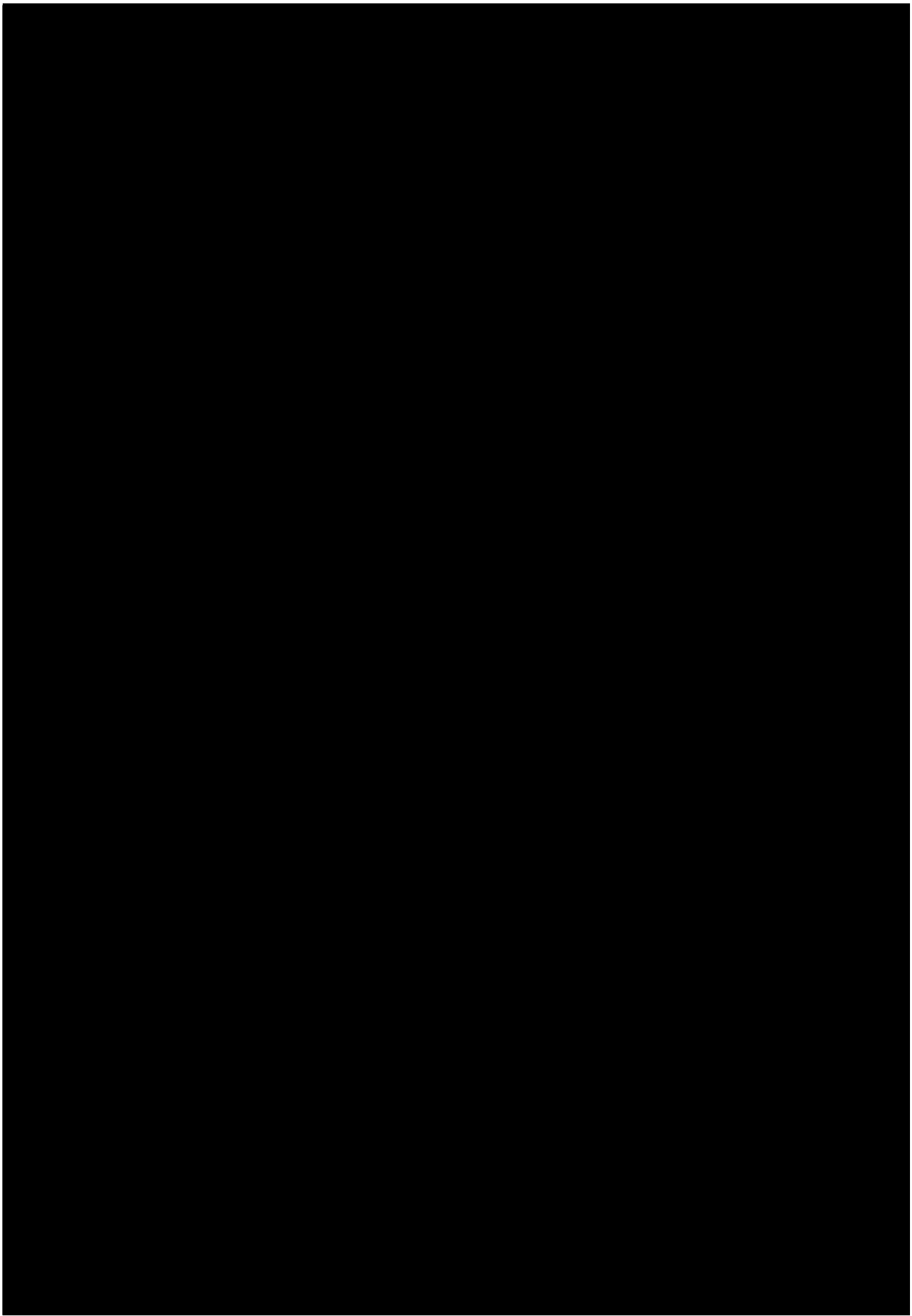
Copies of all documents relating or referring to the reasons why any potential transferee was excluded from further consideration as a potential transferee for any of the health facilities or facilities that provide similar health care that are the subject of the agreement or transaction

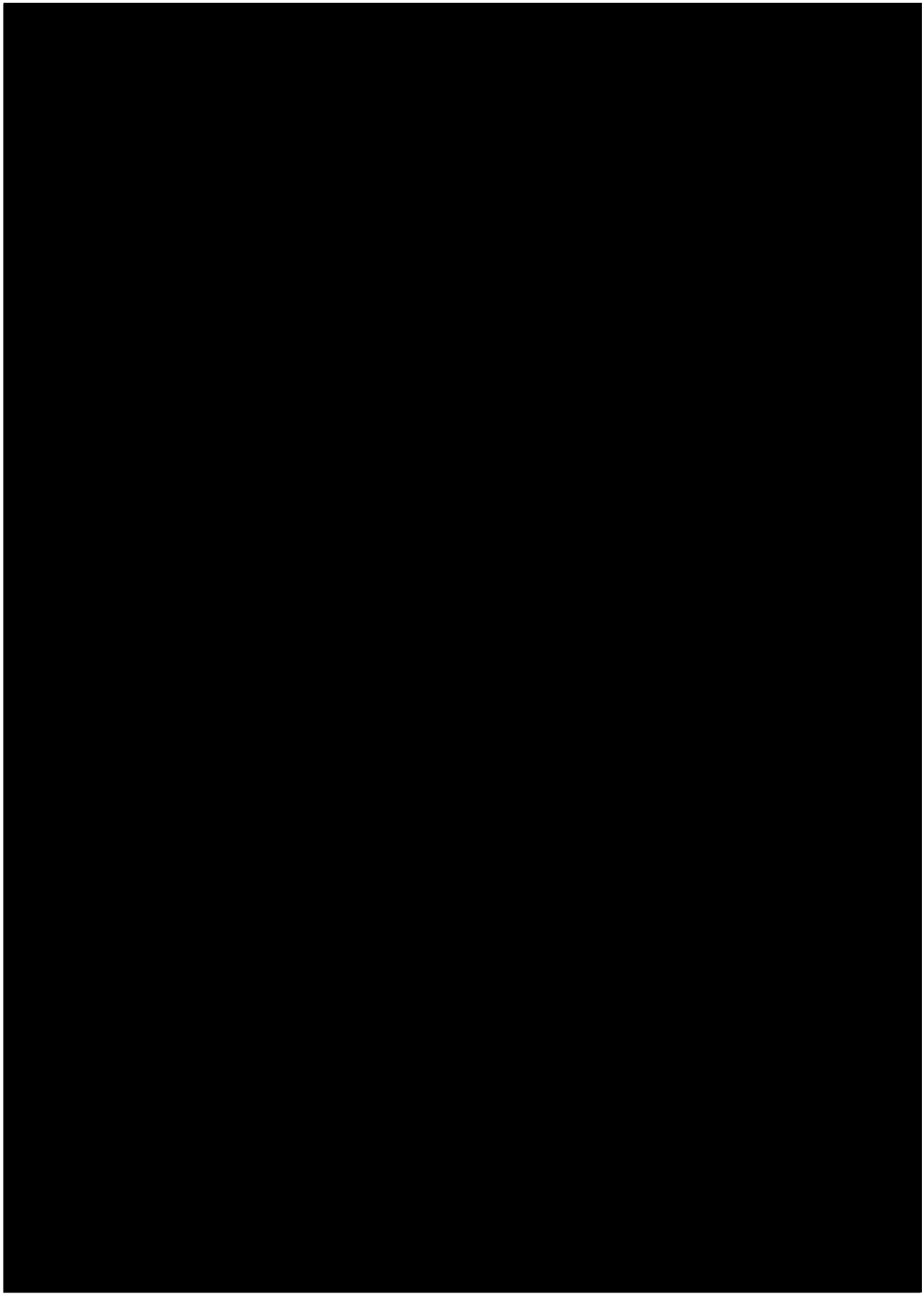
Exhibit 1 – Nondisclosure Agreement between Orchard Hospital and [redacted], dated 4/28/2022.

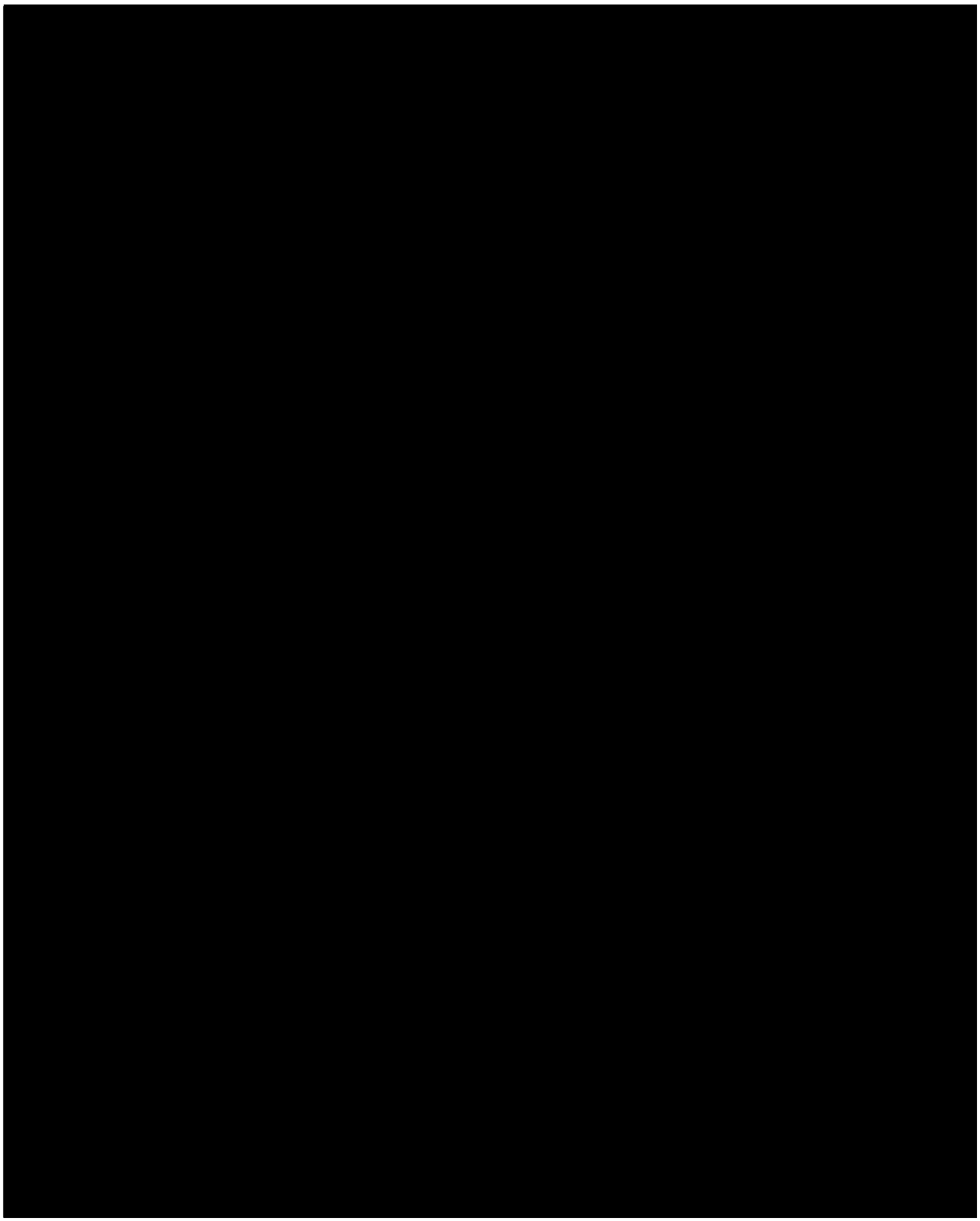
Title 11, California Code of Regulations § 999.5(d)(5)(11)(B)

Copies of all documents relating or referring to the reasons why any potential transferee was excluded from further consideration as a potential transferee for any of the health facilities or facilities that provide similar health care that are the subject of the agreement or transaction

EXHIBIT 1







Title 11, California Code of Regulations § 999.5(d)(5)(11)(F)

The applicant's prior two annual audited financial statements, the applicant's most current unaudited financial statement, business projection data and current capital asset valuation data

Exhibit 1 – Orchard Hospital's 2022 Audited Financials

Exhibit 2 – Orchard Hospital's 2023 Audited Financials

Title 11, California Code of Regulations § 999.5(d)(5)(11)(F)

The applicant's prior two annual audited financial statements, the applicant's most current unaudited financial statement, business projection data and current capital asset valuation data

EXHIBIT 1

Orchard Hospital and Affiliate

Gridley, California

Consolidated Financial Statements and Supplementary Information

Years Ended June 30, 2022 and 2021

WIPFLI

WIPFLI

Independent Auditor's Report

Board of Directors
Orchard Hospital and Affiliate
Gridley, California

Opinion

We have audited the accompanying consolidated financial statements of Orchard Hospital and Affiliate (the "Organization"), which comprise the consolidated balance sheets as of June 30, 2022 and 2021, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the accompanying consolidated financial statements referred to above present fairly, in all material respects, the financial position of Orchard Hospital and Affiliate as of June 30, 2022 and 2021, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United Sates of America ("GAAP").

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America ("GAAS"). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the consolidated financial statements section of our report. We are required to be independent of Orchard Hospital and Affiliate and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Emphasis of Matter

Substantial Doubt about the Organization's Ability to Continue as a Going Concern

The accompanying consolidated financial statements have been prepared assuming that the Organization will continue as a going concern. As discussed in Note 24 to the consolidated financial statements, the Organization has ongoing operating losses that raise substantial doubt about its ability to continue as a going concern. Management's evaluation of the events and conditions and management's plans regarding those matters are also described in Note 24. The consolidated financial statements do not include any adjustments that might result from the outcome of this uncertainty. Our opinion on the June 30, 2022, consolidated financial statements is not modified with respect to that matter.

Responsibilities of Management for the consolidated financial statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United Sates of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Orchard Hospital and Affiliate's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the consolidated financial statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not absolute assurance and, therefore, is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Orchard Hospital and Affiliate's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Orchard Hospital and Affiliate's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating balance sheets and consolidating statements of operations and changes in net assets are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Wipfli LLP

Wipfli LLP

Irvine, California
February 27, 2023

Orchard Hospital and Affiliate

Consolidated Balance Sheets

June 30, 2022 and 2021

Assets	2022	2021
Current assets:		
Cash and cash equivalents	$ 768,884	$ 2,488,130
Investments	5,371,483	5,410,905
Receivables:		
Patient accounts receivable - Net	2,687,000	3,304,204
California hospital fee program	3,611,966	4,920,942
Other	15,373	50,002
Due from third-party reimbursement programs	-	387,661
Inventories	445,253	456,504
Prepaid expenses and other	156,732	159,380
Total current assets	13,056,691	17,177,728
Assets limited as to use	131,176	132,759
Property and equipment - Net	3,645,472	2,965,072
TOTAL ASSETS	$ 16,833,339	$ 20,275,559

Orchard Hospital and Affiliate

Consolidated Balance Sheets (Continued)

June 30, 2022 and 2021

Liabilities and Net Assets	2022	2021
Current liabilities:		
Current maturities of notes payable	$ 26,387	$ 25,145
Current portion of capital lease obligations	340,291	261,229
Short-term loan payable	1,001,819	-
Due to third-party reimbursement programs:		
Other	260,438	-
Current portion of Medicare refundable advance	-	1,638,440
Accounts payable	1,993,845	2,279,313
Accrued payroll	531,324	524,409
Accrued vacation	598,292	578,801
Deferred revenue	9,500	9,500
Total current liabilities	4,761,896	5,316,837
Long-term liabilities:		
Notes payable, less current maturities	171,125	193,283
Capital lease obligations, less current portion	829,332	838,648
Due to third-party reimbursement programs - Medicare refundable advance - Less current portion	-	715,478
Other long-term liabilities	131,176	132,759
Total long-term liabilities	1,131,633	1,880,168
Total liabilities	5,893,529	7,197,005
Net assets:		
Without donor restrictions	10,712,886	12,787,857
With donor restrictions	226,924	290,697
Total net assets	10,939,810	13,078,554
TOTAL LIABILITIES AND NET ASSETS	$ 16,833,339	$ 20,275,559

See accompanying notes to consolidated financial statements.

Orchard Hospital and Affiliate

Consolidated Statements of Operations and Changes in Net Assets

Years Ended June 30, 2022 and 2021

	2022	2021
Revenue:		
Patient service revenue	$ 20,825,766	$ 26,075,271
Other revenue:		
Other operating revenue	467,612	759,704
COVID-19 HHS provider relief funds	2,291,266	3,872,341
Total revenue	23,584,644	30,707,316
Expenses:		
Salaries and wages	12,529,085	10,740,107
Employee benefits	2,159,251	3,734,424
Professional fees	5,049,500	5,697,917
Purchased services	1,793,856	2,175,029
Supplies	1,812,023	1,985,776
Utilities	561,446	657,359
Repairs and maintenance	465,182	287,111
Insurance	288,337	272,949
Rent and lease	326,295	316,233
Depreciation	562,620	527,920
Interest	94,803	74,270
Other	773,355	631,909
Total expenses	26,415,753	27,101,004
Income (loss) from operations	(2,831,109)	3,606,312
Other income (loss):		
Net investment income (loss)	(556,602)	369,149
Contributions	1,205,200	859,580
Rental income	223,990	132,535
Gain on debt forgiveness - PPP loan	-	3,009,374
Total other income	872,588	4,370,638
Excess (deficiency) of revenue over expenses	(1,958,521)	7,976,950

Orchard Hospital and Affiliate

Consolidated Statements of Operations and Changes in Net Assets

(Continued)

Years Ended June 30, 2022 and 2021

	2022	2021
Change in net assets with donor restrictions:		
Contributions	$ 4,530	$ 108,432
Net assets released from restrictions	(114,857)	(762,475)
Change in net assets with donor restrictions	(110,327)	(654,043)
Change in net asset, before discontinued operations	(2,068,848)	7,322,907
Change in net assets from discontinued operations	(69,896)	(603,433)
Change in net assets	(2,138,744)	6,719,474
Net assets at beginning of year	13,078,554	6,359,080
Net assets at end of year	$ 10,939,810	$ 13,078,554

See accompanying notes to consolidated financial statements.

Orchard Hospital and Affiliate

Consolidated Statements of Cash Flows

Years Ended June 30, 2022 and 2021

	2022	2021
Increase (decrease) in cash and cash equivalents:		
Cash flows from operating activities:		
Cash received from patients and third-party payors	$ 21,385,278	$ 30,148,131
Cash paid to suppliers and contractors	(11,492,837)	(15,180,365)
Cash paid to employees	(14,943,703)	(18,095,464)
Cash paid for interest	(94,803)	(74,270)
Cash received from grants and contributions	3,410,139	-
Other cash received	704,523	191,518
Net cash flows from operating activities	(1,031,403)	(3,010,450)
Cash flows from investing activities:		
Purchases of property and equipment	(865,105)	(294,781)
Net purchases of investments and assets limited as to use	(4,914,954)	(3,065,607)
Sales of investments and assets limited as to use	4,419,482	-
Net cash flows from investing activities	(1,360,577)	(3,360,388)
Cash flows from financing activities:		
Proceeds on issuance of long-term debt and loan payable	1,002,824	150,000
Principal payments on long-term debt	(21,921)	(756,995)
Principal payments on capital lease obligations	(308,169)	(219,918)
Net cash flows from financing activities	672,734	(826,913)
Net decrease in cash and cash equivalents	(1,719,246)	(7,197,751)
Cash and cash equivalents at beginning of year	2,488,130	9,685,881
Cash and cash equivalents at end of year	$ 768,884	$ 2,488,130

Orchard Hospital and Affiliate

Consolidated Statements of Cash Flows (Continued)

Years Ended June 30, 2022 and 2021

	2022	2021
Reconciliation of changes in net assets to net cash flows from operating activities:		
Change in net assets	$ (2,138,744)	$ 6,719,474
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation	562,620	527,920
Net unrealized loss (gain) on trading securities	534,892	(215,672)
Gain on forgiveness of debt - PPP loan	-	(3,009,374)
Gain on forgiveness of debt - Other	-	(39,629)
Loss on disposal of fixed assets	-	234,444
Changes in operating assets and liabilities:		
Patient accounts receivable	617,204	511,965
Other accounts receivable	1,343,605	(1,640,636)
Due from/to third-party reimbursement programs	648,099	(768,614)
Inventories	11,251	(6,089)
Prepaid expenses and other	2,648	43,220
Accounts payable	(285,466)	(1,086,351)
Electronic health records incentive payable	-	(570,162)
Accrued payroll	6,915	102,500
Accrued vacation	19,491	41,556
Due to third-party reimbursement programs - Medicare refundable advance	(2,353,918)	(368,747)
Deferred revenue	-	(3,486,255)
Total adjustments	1,107,341	(9,729,924)
Net cash flows from operating activities	$ (1,031,403)	$ (3,010,450)
Noncash investing and financing activities:		
Net equipment acquired under capital lease obligations	$ 377,915	$ 365,668
Forgiveness of debt - PPP loan	-	3,009,374
Forgiveness of debt - Other	-	39,629

See accompanying notes to consolidated financial statements.

Note 1: Organization

Orchard Hospital and Affiliate (collectively referred to as the "Organization") consists of the following entities:

- Orchard Hospital (the "Hospital") is a nonprofit, nonstock corporation that is licensed to operate a 24-bed critical access hospital (CAH). The Hospital provides comprehensive medical, surgical, emergency, outpatient, rural health clinic, and physician services to the residents of Gridley, California, and the surrounding area. The Hospital also operated Hovlid Community Care Center, an 82-bed nursing facility, as a department of the Hospital. In July 2021, the Organization entered into a management and operations transfer agreement to cease managing Hovlid Community Care Center and transfer operations to the new operator. This agreement effectively terminated the previous lease agreement and operations were transferred on July 31, 2021. See note 23 for discontinued operations disclosures.

- Orchard Hospital Foundation (the "Foundation") raises, receives, and administers funds in the form of gifts and bequests for the sole benefit of the Hospital.

Note 2: Summary of Significant Accounting Policies

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Hospital and the Foundation. All significant intercompany accounts and transactions have been eliminated in preparing the accompanying consolidated financial statements.

Financial Statement Presentation

The Organization follows accounting standards set by the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC). The ASC is the single source of authoritative accounting principles generally accepted in the United States of America (GAAP) to be applied to nongovernmental entities.

Use of Estimates in Preparation of Consolidated Financial Statements

The preparation of the accompanying consolidated financial statements in conformity with GAAP requires management to make certain estimates and assumptions that directly affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results may differ from these estimates.

Cash Equivalents

The Organization considers all highly liquid debt instruments with an original maturity of three months or less to be cash equivalents, excluding amounts held as short-term investments in the investment portfolio and amounts whose use is limited or restricted.

Note 2: Summary of Significant Accounting Policies (Continued)

Patient Accounts Receivable and Credit Policy

Patient accounts receivable are reported at the amount that reflects the consideration to which the Organization expects to be entitled in exchange for providing patient care services. Patient accounts receivable are recorded in the accompanying consolidated balance sheets net of contractual adjustments and implicit price concessions, which reflects management's estimate of the transaction price. The Organization estimates the transaction price based on negotiated contractual agreements, historical experience, and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions and is recorded through a reduction of gross revenue and a credit to patient accounts receivable. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change.

The Organization does not have a policy to charge interest on past due accounts.

California Hospital Fee Program

The state of California enacted legislation for a California Hospital Fee Program (the "Program") to fund certain Medi-Cal coverage expansions. The Program provides supplemental Medi-Cal payments to certain California hospitals. The Program is funded by a quality assurance fee paid by participating hospitals that is used to obtain matching federal funds for Medi-Cal with the proceeds redistributed as supplemental payments from either the California Department of Health Care Services, managed care plans, or a combination of both.

The Program covers the period of July 1, 2019, through December 31, 2022. The Organization recognized the net proceeds from this Program in patient service revenue in 2022 and 2021.

Inventory

Supplies are valued at the lower of cost, determined on the first-in, first-out method, or net realizable value.

Investments, Assets Limited as to Use, and Investment Income

Investments, including investments designated as assets limited as to use, are recorded at fair value in the accompanying consolidated balance sheets.

Assets limited as to use represent assets that are restricted under a deferred compensation 457 plan.

Investment income (including realized and unrealized gains and losses, interest, and dividends) is reported as nonoperating income unless the income is restricted by donor or law.

Note 2: Summary of Significant Accounting Policies (Continued)

Fair Value Measurements

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an ordinary transaction between market participants at the measurement date. A three-tier hierarchy prioritizes the inputs used in measuring fair value. These tiers include Level 1, defined as observable inputs such as quoted market prices in active markets; Level 2, defined as inputs other than quoted market prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore, requiring an entity to develop its own assumptions. The asset's or liability's fair value measurement within the hierarchy is based on the lowest level of any input that is significant to the fair value measurement.

Property, Equipment, and Depreciation

Property and equipment acquisitions are recorded at cost or, if donated, at fair value at the date of donation. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Property and equipment under capital leases are amortized on the straight-line method over the shorter period of the lease term or the estimated economic life. Such amortization is included with depreciation expense. Leasehold improvements are amortized over the shorter period of the estimated useful life or the remaining term of the lease. Estimated useful lives range from 8 to 25 years for land improvements, 5 to 40 years for buildings and improvements, and 3 to 25 years for equipment.

Interest costs incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets, net of any earnings on these funds. No interest costs were capitalized in 2022 and 2021.

Gifts of long-lived assets such as land, buildings, or equipment are reported as net assets without donor restrictions and excluded from deficiency of revenue over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used, and gifts of cash or other assets that must be used to acquire long-lived assets are reported as net assets with donor restrictions. Absent explicit donor stipulations regarding the length of time long-lived assets must be maintained, the Organization reports expirations of donor restrictions when the donated or acquired long-lived assets are placed into service.

Self-Funded Health Insurance

The Organization self-funds health benefits for eligible employees and their dependents. Health insurance expense is recorded on the accrual basis.

Note 2: Summary of Significant Accounting Policies (Continued)

Impairment

The Organization reviews its property and equipment and other assets periodically to determine potential impairment by comparing the carrying value with the estimated future net discounted cash flows expected to result from the use of the assets, including cash flows from disposition. Should the sum of the expected future net cash flows be less than the carrying value, the Organization would recognize an impairment loss at that time. No impairment loss was recognized in 2022 or 2021.

Net Assets

Net assets without donor restrictions are those not subject to donor-imposed stipulations and includes those expendable resources, which have been designated for special use by the Board of Directors. Net assets with donor restrictions are those whose use by the Organization has been limited by donors to a specific time period or purpose.

Excess (Deficiency) of Revenue Over Expenses

The accompanying consolidated statements of operations and changes in net assets include excess (deficiency) of revenue over expenses, which is considered the operating indicator. Changes in net assets without donor restrictions that are excluded from the operating indicator include contributions of long-lived assets, including assets acquired using contributions that by donor restriction were to be used for the purposes of acquiring such assets and net assets released from restrictions for capital additions.

Patient Service Revenue

Patient service revenue is reported at the amount that reflects the consideration to which the Organization expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Organization bills the patients and third-party payors several days after the services are performed and/or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

Note 2: Summary of Significant Accounting Policies (Continued)

Patient Service Revenue (Continued)

Performance obligations are determined based on the nature of the services provided. Revenue from performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. Generally, performance obligations satisfied over time relate to patients receiving hospital inpatient acute care services, nursing home post-acute care services, and hospice post-acute care services. For these services the Organization measures the performance obligation from admission to the point when there are no further services required for the patient, which is generally at the time of discharge. For outpatient services provided in our hospital, clinics, and nursing home, the performance obligation is satisfied as the patient simultaneously receives and consumes the benefits provided as the services are performed. In the case of these outpatient services, recognition of the obligation over time yields the same result as recognizing the obligation at a point in time. The Organization believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation.

Because the Organization's performance obligations relate to contracts with a duration of less than one year, the Organization has elected to apply the optional exemption and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to the performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

The Organization uses a portfolio approach to account for categories of patient contracts as a collective group rather than recognizing revenue on an individual contract basis. The Organization used the following factors to develop portfolios: major payor classes and type of service (that is, inpatient, outpatient, emergency, clinic) and geographical location. Using historical collection trends and other analysis, the Organization evaluated the accuracy of its estimate and determined that recognizing revenue by utilizing the portfolio approach approximates the revenue that would have been recognized if an individual contract approach had been used.

The nature, amount, timing, and uncertainty of revenue and cash flows are affected by several factors that the Organization considers in its recognition of revenue. Following are some of the factors considered:

- Payors (for example, Medicare, Medicaid, managed care or other insurance, patient) have different reimbursement/payment methodologies
- Length of the patient's service/episode of care
- Geography of the service location
- Organization's line of business that provided the service (for example, hospital, nursing home, etc.)

Note 2: Summary of Significant Accounting Policies (Continued)

Patient Service Revenue (Continued)

The Organization determines the transaction price, which involves significant estimates and judgment, based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Organization's policy, and implicit price concessions provided to patients. The Organization determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policy, and historical experience. The Organization determines its estimate of implicit price concessions based on its historical collection experience for each patient portfolio based on payor class and service type.

The Organization has agreements with third-party payors that typically provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors follows:

- **Hospital Medicare:** The Organization is designated as a CAH. As such, all inpatient, swing bed, and outpatient hospital services are paid based on a cost-reimbursement methodology, except for certain types of laboratory, radiology, and professional services provided to Medicare beneficiaries, which are reimbursed on prospectively determined fee schedules.

- **Hospital Medi-Cal:** Payments for inpatient services rendered to Medi-Cal patients are based on the State's diagnosis-related group system (DRG's). Under this methodology, services are paid at prospectively determined rates per discharge according to a patient classification system that is based on clinical, diagnostic, and other factors. Inpatient swing bed services rendered to Medi-Cal program beneficiaries are reimbursed at prospectively determined per diem rates.

- **Hospital - Other:** Payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations provide for payment using prospectively determined rates per discharge, discounts from established charges, prospectively determined daily rates, and fee schedules.

- **Clinic Services:** Certain physician and professional services rendered to Medicare and Medi-Cal beneficiaries qualify for reimbursement as Medicare-approved rural health clinic services. Substantially, all Medicare services are reimbursed based on a cost-reimbursement methodology. Medi-Cal is paid on a prospective rate per encounter basis for substantially all physician services, updated annually for inflation.

- **Nursing Home:** Reimbursement for residents under the Medicare Part A program is based on a prospectively based case mix system. Reimbursement for Medi-Cal residents is paid on a lower of cost or charge basis utilizing cost data from two years prior.

Note 2: Summary of Significant Accounting Policies (Continued)

Patient Service Revenue (Continued)

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. Because of investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties, and potential exclusion from the related programs. There can be no assurance that regulatory authorities will not challenge the Organization's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the Organization. The Centers for Medicare and Medicaid Services (CMS) uses recovery audit contractors (RACs) to search for potentially inaccurate Medicare payments that may have been made to health care providers and that were not detected through existing CMS program integrity efforts. Once the RAC identifies a claim it believes is inaccurate, the RAC makes a deduction from or addition to the provider's Medicare reimbursement in an amount estimated to equal the overpayment or underpayment. The Organization has not been notified by the RAC of any potential significant reimbursement adjustments. In addition, the contracts the Organization has with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor, and the Organization's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. Adjustments arising from a change in the transaction price were not significant in 2022 and 2021.

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Organization also provides services to uninsured patients and offers those uninsured patients a discount, either by policy or law, from standard charges. The Organization estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions.

Consistent with the Organization's mission, care is provided to patients regardless of their ability to pay. Therefore, the Organization has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Organization expects to collect based on its collection history with those patients. The Organization's policy is to provide a 40% discount from established charges to uninsured patients. This policy did not change in 2022 and 2021.

Note 2: Summary of Significant Accounting Policies (Continued)

Patient Service Revenue (Continued)

The promised amount of consideration from patients and third-party payors has not been adjusted for the effects of a significant financing component due to the Organization's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payor pays for that service will be one year or less. However, the Organization does, in certain instances, enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

All incremental customer contract acquisition costs are expensed as they are incurred as the amortization period of the asset that the Organization otherwise would have recognized is one year or less in duration.

For uninsured patients who do not qualify for charity care, the Organization recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the Organization's uninsured patients and residents will be unable or unwilling to pay for the services provided. Thus, the Organization includes price concessions related to uninsured patients in the period the services are provided.

Charity Care

The Organization provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because collection is not pursued on amounts determined to qualify as charity care, these amounts are not included in net patient service revenue, less implicit price concessions in the accompanying consolidated statements of operations and changes in net assets.

The estimated cost of providing care to patients under the Organization's charity care policy is calculated by multiplying the ratio of cost to gross charges by the gross uncompensated charity care charges. The costs to provide charity care under the charity care policy was approximately $74,200 and $22,200 for the years ended June 30, 2022 and 2021, respectively.

Grant Income

The Organization receives certain government grants for a variety of purposes. Revenue from grants is considered earned when the Organization incurs the related expenditures or otherwise meets the terms and conditions of the grant. Grant income is included with other operating income in the statements of operations and changes in net assets. Grants earned but not received are recorded in other receivables, and grants received but not yet earned are recorded as deferred revenue in the accompanying balance sheets.

Advertising Costs

Advertising costs are expensed as incurred.

Note 2: Summary of Significant Accounting Policies (Continued)

Contributions/Gifts

Unconditional promises to give cash and other assets to the Organization are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is deemed unconditional. The gifts are reported as with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the statements of operations and changes in net assets as net assets released from restrictions.

Income Taxes

Both the Hospital and the Foundation are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code (the "Code") and are exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. The Hospital and the Foundation are also exempt from state income taxes on related income.

Subsequent Events

Subsequent events have been evaluated through February 27, 2023, which is the date the consolidated financial statements were available to be issued.

New Accounting Pronouncements

In 2016, FASB issued Accounting Standards Update No. 2016-02, *Leases* (Topic 842). The objective of this ASU is to assist organizations in recognizing the right to the use of an asset and its related liability or obligation when there is a contract in place, which includes the right to control or direct the use of an identifiable asset. This ASU also includes provisions where the majority of leases that have lease terms greater than one year are to be recorded as capital leases on the balance sheet, whereas in the past, these leases have been recorded as either capital or operating leases. This ASU is effective for the Organization's year ending June 30, 2023, with early adoption permitted. The Organization is currently evaluating the impact this ASU will have on the Organization's financial statements and disclosures.

ASU No. 2016-13, *Measurement of Credit Losses on Financial Instruments*, will require the Organization to present financial assets measured at amortized cost (including trade receivables) at the net amount expected to be collected over their remaining contractual lives. Estimated credit losses will be based on relevant information about historical experience, current conditions, and reasonable and supportable forecasts that affect the collectability of the reported amounts. This ASU is effective for the Organization's year ending June 30, 2024. The Organization is currently evaluating the impact this ASU will have on the Organization's financial statements and disclosures.

Note 3: Patient Accounts Receivable

Patient accounts receivable consisted of the following at June 30:

	2022	2021
Patient accounts receivable	$ 11,778,271	$ 13,501,582
Less - Contractual adjustments and implicit price concessions	9,091,271	10,197,378
Patient accounts receivable - Net	$ 2,687,000	$ 3,304,204

Patient accounts receivable were $3,816,169 at July 1, 2020.

Note 4: Investments and Assets Limited as to Use

Investments

Investments consisted of the following at June 30:

	2022	2021
Money market funds	$ 80,175	$ 29,618
Common stocks	-	25,195
Mutual funds	5,291,308	5,356,092
Totals	$ 5,371,483	$ 5,410,905

Assets Limited as to Use

Assets limited as to use consisted of funds held by trustees under deferred compensation agreements in mutual funds totaling $131,176 and $132,759 at June 30, 2022 and 2021, respectively.

Investment Income (Loss)

Investment income (loss) was comprised of the following for the years ended June 30:

	2022	2021
Interest and dividend income	$ 200,341	$ 153,477
Unrealized gains and losses on trading securities	(756,943)	215,672
Total investment income (loss)	$ (556,602)	$ 369,149

Note 5: Fair Value Measurements

The following is a description of the valuation methodologies used for assets measured at fair value:

Money market funds are valued using a net asset value (NAV) of $1. Common stocks and mutual funds are valued at the daily closing price as reported by the fund. These funds are registered with the U.S. Securities and Exchange Commission and are required to publish their daily NAV and to transact at that price. These funds are deemed to be actively traded.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Organization believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following table sets forth by level, within the fair value hierarchy, the Organization's assets at fair value as of June 30:

2022	Level 1	Level 2	Level 3	Total Assets at Fair Value
Money market funds	$ 80,175	$ -	$ -	$ 80,175
Mutual funds	5,422,484	-	-	5,422,484
Totals	$ 5,502,659	$ -	$ -	$ 5,502,659
2021				
Money market funds	$ 29,618	$ -	$ -	$ 29,618
Common stocks	25,195	-	-	25,195
Mutual funds	5,488,851	-	-	5,488,851
Totals	$ 5,543,664	$ -	$ -	$ 5,543,664

Reconciliation of the hierarchy tables to the balance sheets follows:

	2022	2021
Investments	$ 5,371,483	$ 5,410,905
Assets limited as to use	131,176	132,759
Total assets in hierarchy tables	$ 5,502,659	$ 5,543,664

Note 6: Property and Equipment

Property and equipment consisted of the following at June 30:

	2022	2021
Land	$ 106,951	$ 106,951
Land improvements	178,980	178,980
Buildings and improvements	3,738,173	3,740,173
Equipment	8,554,945	8,061,664
Total property and equipment	12,579,049	12,087,768
Less - Accumulated depreciation	9,787,751	9,225,129
Net depreciated value	2,791,298	2,862,639
Construction in progress	854,174	102,433
Property and equipment - Net	$ 3,645,472	$ 2,965,072

Construction in progress relates to routine capital projects for renovating and updating the Organization's facilities and other projects.

Note 7: Due to Third-Party Reimbursement Programs - Medicare Refundable Advance

During 2020, as a result of the COVID-19 pandemic, CMS offered an accelerated and advance payment program, which gave healthcare providers the opportunity to receive an advance on future Medicare payments. The Organization received a non-interest-bearing Medicare Refundable Advance of $2,722,665 in 2020. Repayment of the Medicare Refundable Advance began 12 months after receipt of the advance, with recoupments capped at 25% of Medicare receipts during the 12th through 23rd months after the original advance, and 50% of Medicare receipts during the 24th through 29th month after the original advance. Interest will be charged on any remaining balance after the 29th month at an annual rate of 4.0%. The Hospital reported a Medicare Advance Payment liability totaling $0 and $2,353,918 at June 30, 2022 and June 30, 2021, respectively. The current and long-term portions are reported on the accompanying consolidated balance sheets as a refundable advance. The current portion of the refundable advance is management's estimate of the amount to be repaid within the next fiscal year.

Note 8: Short-term Loan Payable

The Organization holds investments with Edward Jones. A credit agreement was obtained allowing the Organization to borrow against its investments. The interest rate will vary depending on the assets held with Edward Jones and was 4.00% as of June 30, 2022. The amount available for borrowing is dependent upon the value of the investments. As of June 30, 2022 and 2021, the Organization had an amount available to be borrowed of $1,011,445 and $2,424,134 on the short-term note payable, respectively. The balance of the short-term loan was $1,001,819 and $0 as of June 30, 2022 and 2021, respectively.

Note 9: Long-Term Debt

Long-term debt consisted of the following at June 30:

	2022	2021
Note payable, dated April 14, 2014; annual payments of $24,658, including interest at 4%, due May 2024; secured by a medical office building.	$ 46,508	$ 68,428
Economic Injury Disaster Loan under the Small Business Administration, dated July 13, 2020; monthly payments of $641 beginning in July 2021, including interest at 2.75%, due June 2051; secured by all tangible and intangible personal property.	151,004	150,000
Total long-term debt	197,512	218,428
Less - Current maturities	(26,387)	(25,145)
Long-term portion	$ 171,125	$ 193,283

Scheduled payments of principal on long-term debt at June 30, 2022, including current maturities, are summarized as follows:

2023	$ 26,387
2024	27,394
2025	3,787
2026	3,892
2027	4,001
Thereafter	132,051
Total	$ 197,512

In March 2020, the Coronavirus Aid, Relief, and Economic Security Act created and funded the Small Business Administration (SBA) Paycheck Protection Program (PPP) to provide loans designated to help small businesses cover their near-term operating expenses and to provide an incentive to retain their employees during the COVID-19 crisis. The Organization applied for and was approved for a loan of $3,009,374 that was fully forgiven during the year ended June 30, 2021.

Note 10: Leases

The Organization leases medical and office equipment and office space from unrelated organizations under operating lease agreements. Total rent expense was $329,192 and $348,385 in 2022 and 2021, respectively.

Future minimum lease payments, by year and in the aggregate, under noncancelable lease agreements are as follows:

	Capital Leases	Operating Leases
2023	$ 395,202	$ 96,515
2024	319,277	27,278
2025	267,147	-
2026	167,390	-
2027	72,591	-
Thereafter	79,128	-
Total minimum lease payments	1,300,735	$ 123,793
Less - Amounts representing interest	(131,112)	
Present value of net minimum lease payments	1,169,623	
Less - Current portion	340,291	
Long-term obligation under capital lease	$ 829,332	

The cost and accumulated depreciation of the equipment under capital leases is as follows at June 30:

	2022	2021
Equipment	$ 2,334,116	$ 1,940,299
Less - Accumulated depreciation	1,055,612	778,139
Totals	$ 1,278,504	$ 1,162,160

Note 11: Net Assets With Donor Restrictions

Net assets with donor restrictions are restricted for the following purposes or periods as of June 30:

	2022	2021
Subject to expenditure for specified purpose:		
Champions campaign (ER equipment)	$ 201,403	$ 169,029
Mammography	10,253	5,723
Other	15,268	1,087
Purchase of real property	-	20,000
Direct relief grant	-	70,052
NVCF grant	-	4,562
CA Health Foundation	-	3,819
State of CA Ship Grant	-	15,271
North Valley Community Foundation	-	1,154
Total net assets with donor restrictions	$ 226,924	$ 290,697

Net assets were released from donor restrictions by incurring expenses satisfying the restricted purposes specified by donors of $114,857 and $762,475 during the years ended June 30, 2022 and 2021, respectively.

Note 12: Patient Service Revenue

Patient service revenue consisted of the following for the years ended June 30:

	2022	2021
Gross patient service revenue:		
Hospital	$ 71,688,093	$ 62,358,577
Swing bed	3,019,357	3,040,485
Clinic	4,977,249	5,126,007
Total gross patient service revenue	79,684,699	70,525,069
Less - Contractual allowances, discounts, and implicit price concessions	58,858,933	44,449,798
Patient service revenue	$ 20,825,766	$ 26,075,271

Note 12: Patient Service Revenue (Continued)

Patient service revenue consisted of the following for the years ended June 30:

	2022	2021
Medicare	$ 9,123,776	$ 7,583,540
Medi-Cal	3,636,088	8,783,492
Other third-party payors	6,426,994	3,831,920
Patients	26,734	793,051
California hospital fee program payment	1,505,248	4,849,509
California disproportionate share payment	106,926	233,759
Patient service revenue	$ 20,825,766	$ 26,075,271

For the years ended June 30, 2022 and 2021, $339,153 and $4,698,256, respectively, was recognized as revenue for services from discontinued operations and is included in change in net assets from discontinued operations in the accompanying consolidated statements of operations and changes in net assets as well as in Note 23.

Note 13: COVID-19 Relief Funds and Grant Revenue

During 2022 and 2021, the Hospital received $2,291,266 and $376,586, respectively, in grant funding from the U.S. Department of Health and Human Services (HHS) Provider Relief Fund and American Rescue Plan (ARP) Rural Payments. Based on the terms and conditions of the grants, the Hospital earns the grants by incurring healthcare-related expenses attributable to COVID-19 that another source has not reimbursed and is not obligated to reimburse, or by incurring lost revenues, defined as a negative change in year-over-year net patient care revenue. During 2022 and 2021, the Hospital recognized $2,291,266 and $3,872,341, respectively, in grant revenue related to these programs, which reflects management's estimate of the amount of the grant earned, including consideration for uncertainties related to reporting guidance. There was no deferred revenue related to these programs at June 30, 2022 and 2021.

Note 14: Retirement Plan

The Organization maintains a contributory defined contribution retirement plan covering substantially all of its employees. The Organization makes a matching contribution of up to 4% of compensation for eligible participants. Total expense related to this plan for the years ended June 30, 2022 and 2021, was $309,227 and $339,176, respectively. Of that expense, $3,253 and $27,433 are from discontinued operations for the years ended June 30, 2022 and 2021, respectively.

Note 15: Malpractice Insurance

The Organization's professional liability insurance for claim losses of less than $5,000,000 per claim and $15,000,000 per year covers professional liability claims reported during a policy year ("claims made" coverage). The professional liability insurance policy is renewable annually and has been renewed by the insurance carrier for the period extending to May 1, 2023. Under a claims-made policy, the risk for claims and incidents not asserted within the policy period remains with the Organization. Although there exists the possibility of claims arising from services provided to patients through June 30, 2022, which had not been asserted, the Organization is unable to determine the ultimate cost, if any, of such possible claims; accordingly, no provision has been made for them.

Note 16: Self-Funded Health Insurance

The Organization has a self-funded health plan that provides benefits to employees. Costs are expensed as incurred. Health expenses are based on claims paid, reinsurance premiums, administrative fees, and unpaid claims at year-end. The Organization buys reinsurance to cover catastrophic individual claims over $50,000. Self-funded health expenses for the years ended June 30, 2022 and 2021, were $538,235 and $2,174,053, respectively. The Organization recorded a liability for self funded health claims outstanding of $280,000 and $330,000 at June 30, 2022 and 2021. Of that expense, $19,428 and $254,011 are from discontinued operations for the years ended June 30, 2022 and 2021, respectively.

Note 17: Functional Expenses

The Organization provides general health care services to residents within its geographic location. Expenses related to providing these services for the year ended June 30, 2022, is as follows:

	Health Care Services	General and Administrative	Fund-Raising	Total
Salaries and wages	$ 8,282,166	$ 4,172,991	$ 73,928	$ 12,529,085
Employee benefits	1,467,482	666,417	25,352	2,159,251
Professional fees and purchased services	5,141,835	1,701,520	-	6,843,355
Supplies	1,575,216	236,496	311	1,812,023
Utilities	444,905	116,541	-	561,446
Other	833,197	931,672	88,300	1,853,169
Depreciation	285,670	275,383	1,568	562,621
Interest	25,352	69,451	-	94,803
Totals	$ 18,055,823	$ 8,170,471	$ 189,459	$ 26,415,753

Note 17: Functional Expenses (Continued)

Expenses related to providing these services for the year ended June 30, 2021, is as follows:

	Health Care Services	General and Administrative	Fund-Raising	Total
Salaries and wages	$ 6,715,432	$ 3,956,994	$ 67,681	$ 10,740,107
Employee benefits	1,782,146	1,943,823	8,455	3,734,424
Professional fees and purchased services	5,548,764	2,324,182	-	7,872,946
Supplies	1,481,711	504,065	-	1,985,776
Utilities	533,775	120,421	3,163	657,359
Other	554,848	884,177	69,177	1,508,202
Depreciation	266,247	261,673	-	527,920
Interest	32,539	41,731	-	74,270
Totals	$ 16,915,462	$ 10,037,066	$ 148,476	$ 27,101,004

For the years ended June 30, 2022 and 2021, $409,047 and $5,301,690, respectively, was recognized as expense for services from discontinued operations and is included in change in net assets from discontinued operations in the accompanying consolidated statements of operations and changes in net assets as well as in Note 23.

The consolidated financial statements report certain categories of expenses that are attributable to one or more supporting functions of the Organization. Those expenses include depreciation, interest, salaries and wages, and employee benefits. Depreciation and interest is allocated based on a square footage basis. Salaries and wages and employee benefits are allocated based on estimates of time and effort.

Note 18: Rental Income

The Organization leases certain premises to a third party under a lease agreement that has been extended through June 30, 2023. The lease agreement requires minimum monthly payments of $19,755. Future minimum rental payments to be received under the non-cancelable lease are $237,060 for the year ended June 30, 2023.

Total rental income was $223,990 and $132,535 for the years ended June 30, 2022 and 2021, respectively, and is included in other income in the accompanying consolidated statements of operations and changes in net assets.

Note 19: Deferred Compensation

The Hospital sponsors a deferred compensation plan under Section 457(b) of the Code. The plan is intended primarily for certain employees to defer compensation until retirement. Investments in mutual funds designated for deferred compensation under this plan are recorded in the accompanying consolidated balance sheets as assets limited as to use and the accrued liabilities are recorded as other long-term liabilities.

Note 20: Liquidity

As part of the Organization's liquidity management, it invests cash in excess of daily requirements in a variety of investment vehicles. These funds, included in investments, are considered available for operational or capital needs. As of June 30, 2022 and 2021, financial assets and liquidity resources available within one year for general expenditure, such as operating expenses, scheduled debt service payments, and capital items were as follows:

	2022	2021
Financial assets:		
Cash and cash equivalents	$ 768,884	$ 2,488,130
Investments	5,371,483	5,410,905
Patient accounts receivable, net	2,687,000	3,304,204
Other accounts receivable	3,627,339	4,970,944
Due from third-party reimbursement programs	-	387,661
Total financial assets	12,454,706	16,561,844
Liquidity resources -		
Short-term loan available	1,011,445	2,424,134
Less restrictions -		
Net assets with donor restrictions	(226,924)	(290,697)
Total financial assets and liquidity resources available for general expenditure within one year	$ 13,239,227	$ 18,695,281

Note 21: Concentration of Credit Risk

Financial instruments that subject the Organization to possible credit risk consist principally of accounts receivable, cash deposits in excess of insured limits, and investments that are uninsured.

The mix of Organization receivables from patients and third-party payors is as follows at June 30:

	2022	2021
Medicare	24 %	21 %
Medi-Cal	29	36
Other third-party payors	29	25
Patients	18	18
Totals	100 %	100 %

The Organization maintains depository relationships with area financial institutions that are FDIC-insured institutions. Depository accounts at these institutions are insured by the FDIC up to $250,000. At June 30, 2022, the Organization's deposits exceeded FDIC-insured limits by approximately $564,000. In addition, other investments held by financial institutions are uninsured.

Note 22: Reclassifications

Certain reclassifications have been made to the 2021 financial statements to conform to the 2022 classifications. Total assets, total liabilities, total net assets, and the total change in net assets was not affected.

Note 23: Discontinued Operations

Effective July 31, 2021, the Organization transfered the management and operations of the skilled nursing facility.

The assets, liabilities, net assets, revenues, and expenses pertaining to discontinued operations were determined based on actual or estimated amounts, if actual was not readily determinable.

The allocation method for breaking out discontinued operations from continuing operations for the years ended June 30, 2022 and 2021 when actual amounts were not readily determinable was as follows:

- Square footage of the skilled nursing facility compared to the whole property
- Headcount of the skilled nursing employees compared to total headcount
- Skilled nursing revenue compared to total patient revenue

Assets, liabilities, and net assets of the discontinued operation were as follows as of June 30, 2022 and 2021. These balances are presented with continuing operations in the consolidated balance sheets.

Years Ended June 30,	2022	2021
Current assets:		
Patient accounts receivable - Net	$ -	$ 1,120,400
Inventories	-	11,182
Total assets	$ -	$ 1,131,582
Current liabilities:		
Checks in excess of cash	$ -	$ 393,439
Accounts payable	-	414,247
Accrued payroll	-	130,143
Accrued vacation	-	123,857
Total liabilities	-	1,061,686
Net assets of discontinued operations	-	69,896
Total liabilities and net assets	$ -	$ 1,131,582

Note 23: Discontinued Operations (Continued)

Below is the breakout of revenue and expenses related to the operation of the skilled nursing facility for the years ended June 30, 2022 and 2021. The revenue and expenses related to the skilled nursing facility have been excluded from revenues and expenses from continuing operations on the consolidated statements of operations and changes in net assets for the years ended June 30, 2022 and 2020. The change in net assets from discontinued operations is presented as one line on the consolidated statements of operations and changes in net assets for the respective years.

Years Ended June 30,	2022	2021
Revenue:		
Patient service revenue	$ 339,153	$ 4,698,256
Expenses:		
Salaries and wages	261,422	3,399,198
Employee benefits	20,351	365,791
Professional fees	70,006	767,025
Purchased services	26,066	240,412
Supplies	14,934	268,354
Utilities	4,047	61,575
Repairs and maintenance	1,863	35,293
Insurance	2,242	27,506
Rent and lease	2,897	32,152
Other	5,221	104,384
Total expenses	409,049	5,301,690
Change in net assets from discontinued operations	$ (69,896)	$ (603,434)

For the years ended June 30, 2022 and 2021, cash flows from discontinued operations consisted of the change in operating assets and liabilities. There were no cash flows from investing or financing activities.

Note 24: Going Concern Contingency

As indicated in the accompanying financial statements, the Organization showed a decrease in net assets before discontinued operations of $2,068,848 during the year ended June 30, 2022. In addition, the Organization has continued to suffer large monthly losses from operations. Those factors create an uncertainty about the Organization's ability to continue as a going concern.

Management of the Organization has developed and is beginning implementation of its plan to improve operations through a reduction in expenses, renegotiation of payor contracts, and improvement of the census. The ability of the Organization to continue as a going concern is dependent on the plan's success. The consolidated financial statements do not include any adjustments that might be necessary if the Organization is unable to continue as a going concern.

Note 25: Risk and Uncertainties

On March 11, 2020, the World Health Organization (WHO) recognized COVID-19 as a global pandemic, prompting many national, regional, and local governments to implement preventative or protective measures, such as travel and business restrictions, temporary store closures, and wide-sweeping quarantines and stay-at-home orders. As a result, COVID-19 and the related restrictive measures have had a significant adverse impact upon many sectors of the economy, including the healthcare industry. The extent of the impact of COVID-19 on the Organization's financial condition will depend on certain developments, including the duration and spread of the outbreak, impact on the Organization's patients, employees, and vendors, all of which are uncertain and cannot be predicted. At this point, the extent to which COVID-19 may impact the Organization's financial condition is uncertain.

Supplementary Information

Orchard Hospital and Affiliate

Consolidating Balance Sheets

June 30, 2022 (With Comparative Totals for June 30, 2021)

Assets	Orchard Hospital	Orchard Hospital Foundation	Eliminations	2022	2021
Current assets:					
Cash and cash equivalents	$ 735,552	$ 33,332	$ -	$ 768,884	$ 2,488,130
Investments	3,954,090	1,417,393	-	5,371,483	5,410,905
Receivables:					
Patient accounts receivable - Net	2,687,000	-	-	2,687,000	3,304,204
California hospital fee program	3,611,966	-	-	3,611,966	4,920,942
Other	15,373	-	-	15,373	50,002
Due from third-party reimbursement programs	-	-	-	-	387,661
Inventories	445,253	-	-	445,253	456,504
Prepaid expenses and other	156,732	-	-	156,732	159,380
Total current assets	11,605,966	1,450,725	-	13,056,691	17,177,728
Assets limited as to use	131,176	-	-	131,176	132,759
Property and equipment - Net	3,645,472	-	-	3,645,472	2,965,072
TOTAL ASSETS	$ 15,382,614	$ 1,450,725	$ -	$ 16,833,339	$ 20,275,559

Orchard Hospital and Affiliate

Consolidating Balance Sheets (Continued)

June 30, 2022 (With Comparative Totals for June 30, 2021)

Liabilities and Net Assets	Orchard Hospital	Orchard Hospital Foundation	Eliminations	2022	2021
Current liabilities:					
Current maturities of notes payable	$ 26,387	$ -	$ -	$ 26,387	$ 25,145
Current portion of capital lease obligations	340,291	-	-	340,291	261,229
Short-term loan payable	1,001,819	-	-	1,001,819	-
Due to third-party reimbursement programs:					
Other	260,438	-	-	260,438	-
Current portion of Medicare refundable advance	-	-	-	-	1,638,440
Accounts payable	1,949,531	44,314	-	1,993,845	2,279,313
Accrued payroll	531,324	-	-	531,324	524,409
Accrued vacation	598,292	-	-	598,292	578,801
Deferred revenue	9,500	-	-	9,500	9,500
Total current liabilities	4,717,582	44,314	-	4,761,896	5,316,837
Long-term liabilities:					
Notes payable, less current maturities	171,125	-	-	171,125	193,283
Capital lease obligations, less current portion	829,332	-	-	829,332	838,648
Due to third-party reimbursement programs - Medicare refundable advance - Less current portion	-	-	-	-	715,478
Other long-term liabilities	131,176	-	-	131,176	132,759
Total long-term liabilities	1,131,633	-	-	1,131,633	1,880,168
Total liabilities	5,849,215	44,314	-	5,893,529	7,197,005
Net assets:					
Without donor restrictions	9,533,399	1,179,487	-	10,712,886	12,787,857
With donor restrictions	-	226,924	-	226,924	290,697
Total net assets	9,533,399	1,406,411	-	10,939,810	13,078,554
TOTAL LIABILITIES AND NET ASSETS	$ 15,382,614	$ 1,450,725	$ -	$ 16,833,339	$ 20,275,559

See Independent Auditor's Report.

Orchard Hospital and Affiliate

Consolidating Statement of Operations and Changes in Net Assets

Year Ended June 30, 2022 (With Comparative Totals for June 30, 2021)

	Orchard Hospital	Orchard Hospital Foundation	Eliminations	2022	2021
Revenue:					
Patient service revenue	$ 20,825,766	$ -	$ -	$ 20,825,766	$ 26,075,271
Other revenue:					
Other operating revenue	467,612	-	-	467,612	759,704
COVID-19 HHS provider relief funds	2,291,266	-	-	2,291,266	3,872,341
Total revenue	23,584,644	-	-	23,584,644	30,707,316
Expenses:					
Salaries and wages	12,529,085	-	-	12,529,085	10,740,107
Employee benefits	2,159,251	-	-	2,159,251	3,734,424
Professional fees	5,049,500	-	-	5,049,500	5,697,917
Purchased services	1,793,856	-	-	1,793,856	2,175,029
Supplies	1,812,023	-	-	1,812,023	1,985,776
Utilities	561,446	-	-	561,446	657,359
Repairs and maintenance	465,182	-	-	465,182	287,111
Insurance	288,337	-	-	288,337	272,949
Rent and lease	326,295	-	-	326,295	316,233
Depreciation	562,620	-	-	562,620	527,920
Interest	94,803	-	-	94,803	74,270
Other	709,210	88,145	(24,000)	773,355	631,909
Total expenses	26,351,608	88,145	(24,000)	26,415,753	27,101,004
Income (loss) from operations	(2,766,964)	(88,145)	24,000	(2,831,109)	3,606,312
Other income (loss):					
Investment income (loss)	(392,847)	(163,755)	-	(556,602)	369,149
Contributions	161,427	1,067,773	(24,000)	1,205,200	859,580
Rental income	223,990	-	-	223,990	132,535
Gain on debt forgiveness - PPP loan	-	-	-	-	3,009,374
Total other income (loss)	(7,430)	904,018	(24,000)	872,588	4,370,638
Excess (deficiency) of revenue over expenses	(2,774,394)	815,873	-	(1,958,521)	7,976,950

Orchard Hospital and Affiliate

Consolidating Statement of Operations and Changes in Net Assets

(Continued)

Year Ended June 30, 2022 (With Comparative Totals for June 30, 2021)

	Orchard Hospital	Orchard Hospital Foundation	Eliminations	2022	2021
Change in net assets with donor restrictions:					
Contributions	$ -	$ 4,530	$ -	$ 4,530	$ 108,432
Net assets released from restrictions	(114,857)	-	-	(114,857)	(762,475)
Change in net assets with donor restrictions	(114,857)	4,530	-	(110,327)	(654,043)
Change in net assets, before discontinued operations	(2,889,251)	820,403	-	(2,068,848)	7,322,907
Change in net assets from discontinued operations	(69,896)	-	-	(69,896)	(603,433)
Change in net assets	(2,959,147)	820,403	-	(2,138,744)	6,719,474
Net assets at beginning of year	12,492,546	586,008	-	13,078,554	6,359,080
Net assets at end of year	$ 9,533,399	$ 1,406,411	$ -	$ 10,939,810	$ 13,078,554

See Independent Auditor's Report.

Title 11, California Code of Regulations § 999.5(d)(5)(11)(F)

The applicant's prior two annual audited financial statements, the applicant's most current unaudited financial statement, business projection data and current capital asset valuation data

EXHIBIT 2

Orchard Hospital and Affiliate

Gridley, California

Consolidated Financial Statements and Supplementary Information

Years Ended June 30, 2023 and 2022

WIPFLI

WIPFLI

Independent Auditor's Report

Board of Directors
Orchard Hospital and Affiliate
Gridley, California

Report on the Audit of the consolidated financial statements

Opinion

We have audited the accompanying consolidated financial statements of Orchard Hospital and Affiliate (the "Organization"), which comprise the consolidated balance sheets as of June 30, 2023 and 2022, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the accompanying consolidated financial statements referred to above present fairly, in all material respects, the financial position of Orchard Hospital and Affiliate as of June 30, 2023 and 2022, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America ("GAAP").

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America ("GAAS") and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Consolidated Financial Statements section of our report. The consolidated financial statements as of and for the year ended June 30, 2022 were not audited in accordance with *Goverment Auditing Standards*. We are required to be independent of Orchard Hospital and Affiliate and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Substantial Doubt about the Organization's Ability to Continue as a Going Concern

The accompanying consolidated financial statements have been prepared assuming that the Organization will continue as a going concern. As discussed in Note 22 to the consolidated financial statements, the Organization has ongoing operating losses that raise substantial doubt about its ability to continue as a going concern. Management's evaluation of the events and conditions and management's plans regarding those matters are also described in Note 22. The consolidated financial statements do not include any adjustments that might result from the outcome of this uncertainty. Our opinion is not modified with respect to that matter.

Responsibilities of Management for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with GAAP, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Orchard Hospital and Affiliate's ability to continue as a going concern for one year after the date the consolidated financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Consolidated Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not absolute assurance and, therefore, is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards,* we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Orchard Hospital and Affiliate's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Orchard Hospital and Affiliate's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Supplementary Information

Our audit was conducted for the purpose of forming opinions on the consolidated financial statements as a whole. The consolidating balance sheets and consolidating statements of operations and changes in net assets and the accompanying schedule of expenditures of federal awards, as required by Title 2 U.S. *Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated May 24, 2024 on our consideration of the Orchard Hospital and Affiliate's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of Orchard Hospital and Affiliate's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Organization's internal control over financial reporting and compliance.

Wipfli LLP

Wipfli LLP

Irvine, California
May 24, 2024

Orchard Hospital and Affiliate

Consolidated Balance Sheets

June 30, 2023 and 2022

Assets	2023	2022
Current assets:		
Cash	$ 1,039,316	$ 768,884
Investments	3,871,558	5,371,483
Receivables:		
Patient accounts receivable - Net	3,116,536	2,687,000
California hospital fee program	5,303,011	3,611,966
Other	90,302	15,373
Inventories	444,006	445,253
Prepaid expenses and other	129,813	156,732
Total current assets	13,994,542	13,056,691
Assets limited as to use	171,899	131,176
Right-of-use lease asset - Operating leases	960,724	-
Property and equipment - Net	3,247,785	3,645,472
TOTAL ASSETS	$ 18,374,950	$ 16,833,339

Orchard Hospital and Affiliate

Consolidated Balance Sheets (Continued)

June 30, 2023 and 2022

Liabilities and Net Assets	2023	2022
Current liabilities:		
Current maturities of notes payable	$ 27,394	$ 26,387
Current portion of finance lease liabilities	289,136	340,291
Current portion of operating lease liabilities	210,999	-
Short-term loan payable	1,235,292	1,001,819
Due to third-party reimbursement programs	446,786	260,438
Accounts payable	3,874,102	1,993,845
Accrued payroll	703,047	531,324
Accrued vacation	546,161	598,292
Deferred revenue	63,011	9,500
Total current liabilities	7,395,928	4,761,896
Long-term liabilities:		
Notes payable, less current maturities	140,046	171,125
Finance lease liabilities, less current portion	544,820	829,332
Operating lease liabilities, less current portion	749,725	-
Other long-term liabilities	171,899	131,176
Total long-term liabilities	1,606,490	1,131,633
Total liabilities	9,002,418	5,893,529
Net assets:		
Without donor restrictions	9,145,608	10,712,886
With donor restrictions	226,924	226,924
Total net assets	9,372,532	10,939,810
TOTAL LIABILITIES AND NET ASSETS	$ 18,374,950	$ 16,833,339

See accompanying notes to consolidated financial statements.

Orchard Hospital and Affiliate

Consolidated Statements of Operations and Changes in Net Assets

Years Ended June 30, 2023 and 2022

	2023	2022
Revenue:		
Patient service revenue	$ 26,735,314	$ 20,825,766
Other revenue:		
Other operating revenue	410,718	134,212
340B pharmacy revenue	189,360	333,400
COVID-19 HHS provider relief funds	-	2,291,266
Grant income	331,406	-
Total revenue	27,666,798	23,584,644
Expenses:		
Salaries and wages	13,752,177	12,529,085
Employee benefits	3,751,130	2,159,251
Professional fees	4,858,155	5,049,500
Purchased services	2,437,579	1,793,856
Supplies	1,757,962	1,812,023
Utilities	653,511	561,446
Repairs and maintenance	580,436	465,182
Insurance	371,026	288,337
Rent and lease	295,279	326,295
Depreciation	557,784	562,620
Interest	189,213	94,803
Other	550,785	773,355
Total expenses	29,755,037	26,415,753
Loss from operations	(2,088,239)	(2,831,109)
Other income (loss):		
Net investment income (loss)	188,759	(556,602)
Contributions	116,543	1,205,200
Rental income	239,880	223,990
Other non-operating expenses	(24,221)	-
Total other income	520,961	872,588
Deficiency of revenue over expenses	$ (1,567,278)	$ (1,958,521)

Orchard Hospital and Affiliate

Consolidated Statements of Operations and Changes in Net Assets

(Continued)

Years Ended June 30, 2023 and 2022

	2023	2022
Change in net assets with donor restrictions:		
Contributions	$ -	$ 4,530
Net assets released from restrictions	-	(114,857)
Change in net assets with donor restrictions	-	(110,327)
Change in net asset, before discontinued operations	(1,567,278)	(2,068,848)
Change in net assets from discontinued operations	-	(69,896)
Change in net assets	(1,567,278)	(2,138,744)
Net assets at beginning of year	10,939,810	13,078,554
Net assets at end of year	$ 9,372,532	$ 10,939,810

See accompanying notes to consolidated financial statements.

Orchard Hospital and Affiliate

Consolidated Statements of Cash Flows

Years Ended June 30, 2023 and 2022

	2023	2022
Increase (decrease) in cash:		
Cash flows from operating activities:		
Cash received from patients and third-party payors	$ 24,801,088	$ 21,385,278
Cash paid to suppliers and contractors	(9,703,817)	(11,492,837)
Cash paid to employees	(17,383,715)	(14,943,703)
Cash paid for interest	(189,213)	(94,803)
Cash received from grants and contributions	531,228	3,410,139
Other cash received	1,024,460	926,572
Net cash flows from operating activities	(919,969)	(809,354)
Cash flows from investing activities:		
Purchases of property and equipment	(160,097)	(865,105)
Net purchases of investments and assets limited as to use	(1,401,540)	(4,914,954)
Sales of investments and assets limited as to use	2,884,304	4,197,433
Net cash flows from investing activities	1,322,667	(1,582,626)
Cash flows from financing activities:		
Proceeds on issuance of long-term debt and loan payable	1,750,000	1,002,824
Principal payments on long-term debt	(1,546,599)	(21,921)
Principal payments on finance lease liabilities	(335,667)	(308,169)
Net cash flows from financing activities	(132,266)	672,734
Change in cash	270,432	(1,719,246)
Cash at beginning of year	768,884	2,488,130
Cash at end of year	$ 1,039,316	$ 768,884

Orchard Hospital and Affiliate

Consolidated Statements of Cash Flows (Continued)

Years Ended June 30, 2023 and 2022

	2023	2022
Reconciliation of changes in net assets to net cash flows from operating activities:		
Change in net assets	$ (1,567,278)	$ (2,138,744)
Adjustments to reconcile change in net assets to net cash flows from operating activities:		
Depreciation	557,784	562,620
Net unrealized loss on trading securities	17,161	756,943
Changes in operating assets and liabilities:		
Patient accounts receivable	(429,536)	617,204
Other accounts receivable	(1,765,974)	1,343,605
Due from/to third-party reimbursement programs	186,348	648,099
Inventories	1,247	11,251
Prepaid expenses and other	26,919	2,648
Accounts payable	1,880,257	(285,466)
Accrued payroll	171,723	6,915
Accrued vacation	(52,131)	19,491
Due to third-party reimbursement programs - Medicare refundable advance	-	(2,353,918)
Deferred revenue	53,511	-
Total adjustments	647,309	1,329,392
Net cash flows from operating activities	$ (919,969)	$ (809,352)
Noncash investing and financing activities:		
Net equipment acquired under finance lease liabilities	$ -	$ 377,915

See accompanying notes to consolidated financial statements.

Note 1: Organization

Orchard Hospital and Affiliate (collectively referred to as the "Organization") consists of the following entities:

- Orchard Hospital (the "Hospital") is a nonprofit, nonstock corporation that is licensed to operate a 24-bed critical access hospital (CAH). The Hospital provides comprehensive medical, surgical, emergency, outpatient, rural health clinic, and physician services to the residents of Gridley, California, and the surrounding area. The Hospital also operated Hovlid Community Care Center, an 82-bed nursing facility, as a department of the Hospital. In July 2021, the Organization entered into a management and operations transfer agreement to cease managing Hovlid Community Care Center and transfer operations to the new operator. This agreement effectively terminated the previous lease agreement and operations were transferred on July 31, 2021. See note 18 for discontinued operations disclosures.

- Orchard Hospital Foundation (the "Foundation") raises, receives, and administers funds in the form of gifts and bequests for the sole benefit of the Hospital.

Note 2: Summary of Significant Accounting Policies

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Hospital and the Foundation. All significant intercompany accounts and transactions have been eliminated in preparing the accompanying consolidated financial statements.

Financial Statement Presentation

The Organization follows accounting standards set by the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC). The ASC is the single source of authoritative accounting principles generally accepted in the United States of America (GAAP) to be applied to nongovernmental entities.

Use of Estimates in Preparation of Consolidated Financial Statements

The preparation of the accompanying consolidated financial statements in conformity with GAAP requires management to make certain estimates and assumptions that directly affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results may differ from these estimates.

Note 2: Summary of Significant Accounting Policies (Continued)

Patient Accounts Receivable and Credit Policy

Patient accounts receivable are reported at the amount that reflects the consideration to which the Organization expects to be entitled in exchange for providing patient care services. Patient accounts receivable are recorded in the accompanying consolidated balance sheets net of contractual adjustments and implicit price concessions, which reflects management's estimate of the transaction price. The Organization estimates the transaction price based on negotiated contractual agreements, historical experience, and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions and is recorded through a reduction of gross revenue and a credit to patient accounts receivable. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change.

The Organization does not have a policy to charge interest on past due accounts.

California Hospital Fee Program

The state of California enacted legislation for a California Hospital Fee Program (the "Program") to fund certain Medi-Cal coverage expansions. The Program provides supplemental Medi-Cal payments to certain California hospitals. The Program is funded by a quality assurance fee paid by participating hospitals that is used to obtain matching federal funds for Medi-Cal with the proceeds redistributed as supplemental payments from either the California Department of Health Care Services, managed care plans, or a combination of both.

The Program covers the period of July 1, 2019, through December 31, 2024. The Organization recognized the net proceeds from this Program in patient service revenue in 2023 and 2022.

Inventory

Supplies are valued at the lower of cost, determined on the first-in, first-out method, or net realizable value.

Investments, Assets Limited as to Use, and Investment Income

Investments, including investments designated as assets limited as to use, are recorded at fair value in the accompanying consolidated balance sheets.

Assets limited as to use represent assets that are restricted under a deferred compensation 457 plan.

Investment income (including realized and unrealized gains and losses, interest, and dividends) is reported as nonoperating income unless the income is restricted by donor or law.

Note 2: Summary of Significant Accounting Policies (Continued)

Fair Value Measurements

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an ordinary transaction between market participants at the measurement date. A three-tier hierarchy prioritizes the inputs used in measuring fair value. These tiers include Level 1, defined as observable inputs such as quoted market prices in active markets; Level 2, defined as inputs other than quoted market prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore, requiring an entity to develop its own assumptions. The asset's or liability's fair value measurement within the hierarchy is based on the lowest level of any input that is significant to the fair value measurement.

Property, Equipment, and Depreciation

Property and equipment acquisitions are recorded at cost or, if donated, at fair value at the date of donation. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Property and equipment under finance leases are amortized on the straight-line method over the shorter period of the lease term or the estimated economic life. Such amortization is included with depreciation expense. Leasehold improvements are amortized over the shorter period of the estimated useful life or the remaining term of the lease. Estimated useful lives range from 8 to 25 years for land improvements, 5 to 40 years for buildings and improvements, and 3 to 25 years for equipment.

Gifts of long-lived assets such as land, buildings, or equipment are reported as net assets without donor restrictions and excluded from deficiency of revenue over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used, and gifts of cash or other assets that must be used to acquire long-lived assets are reported as net assets with donor restrictions. Absent explicit donor stipulations regarding the length of time long-lived assets must be maintained, the Organization reports expirations of donor restrictions when the donated or acquired long-lived assets are placed into service.

Leases

The Organization is a lessee in multiple noncancelable operating and financing leases. If the contract provides the Organization the right to substantially all the economic benefits and the right to direct the use of the identified asset, it is considered to be or contain a lease. Right-of-use (ROU) assets and lease liabilities are recognized at the lease commencement date based on the present value of the future lease payments over the expected lease term. The ROU asset is also adjusted for any lease prepayments made, lease incentives received, and initial direct costs incurred.

The lease liability is initially and subsequently recognized based on the present value of its future lease payments. Variable payments are included in the future lease payments when those variable payments depend on an index or a rate. Increases (decreases) to variable lease payments due to subsequent changes in an index or rate are recorded as variable lease expense (income) in the future period in which they are incurred.

Note 2: Summary of Significant Accounting Policies (Continued)

Leases (Continued)

The Organization has elected to use a risk-free rate for a term similar to the underlying lease as the discount rate if the implicit rate in the lease contract is not readily determinable.

The ROU asset for operating leases is subsequently measured throughout the lease term at the amount of the remeasured lease liability (i.e., present value of the remaining lease payments), plus unamortized initial direct costs, plus (minus) any prepaid (accrued) lease payments, less the unamortized balance of lease incentives received, and any impairment recognized. The ROU asset for finance leases is amortized on a straight-line basis over the lease term. For operating leases with lease payments that fluctuate over the lease term, the total lease costs are recognized on a straight-line basis over the lease term.

For all underlying classes of assets, the Organization has elected to not recognize ROU assets and lease liabilities for short-term leases that have a lease term of 12 months or less at lease commencement and do not include an option to purchase the underlying asset that the Organization is reasonably certain to exercise. Leases containing termination clauses in which either party may terminate the lease without cause and the notice period is less than 12 months are deemed short-term leases with lease costs included in short-term lease expense. The Organization recognizes short-term lease cost on a straight-line basis over the lease term.

The Organization made an ccounting policy election to separate lease and non-lease components to determine the lease payment.

Self-Funded Health Insurance

The Organization self-funds health benefits for eligible employees and their dependents. Health insurance expense is recorded on the accrual basis.

Impairment

The Organization reviews its property and equipment and other assets periodically to determine potential impairment by comparing the carrying value with the estimated future net discounted cash flows expected to result from the use of the assets, including cash flows from disposition. Should the sum of the expected future net cash flows be less than the carrying value, the Organization would recognize an impairment loss at that time. No impairment loss was recognized in 2023 or 2022.

Net Assets

Net assets without donor restrictions are those not subject to donor-imposed stipulations and includes those expendable resources, which have been designated for special use by the Board of Directors. Net assets with donor restrictions are those whose use by the Organization has been limited by donors to a specific time period or purpose.

Note 2: Summary of Significant Accounting Policies (Continued)

Excess (Deficiency) of Revenue Over Expenses

The accompanying consolidated statements of operations and changes in net assets include excess (deficiency) of revenue over expenses, which is considered the operating indicator. Changes in net assets without donor restrictions that are excluded from the operating indicator include contributions of long-lived assets, including assets acquired using contributions that by donor restriction were to be used for the purposes of acquiring such assets and net assets released from restrictions for capital additions.

Patient Service Revenue

Patient service revenue is reported at the amount that reflects the consideration to which the Organization expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Organization bills the patients and third-party payors several days after the services are performed and/or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided. Revenue from performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. Generally, performance obligations satisfied over time relate to patients receiving hospital inpatient acute care services, nursing home post-acute care services, and hospice post-acute care services. For these services the Organization measures the performance obligation from admission to the point when there are no further services required for the patient, which is generally at the time of discharge. For outpatient services provided in our hospital, clinics, and nursing home, the performance obligation is satisfied as the patient simultaneously receives and consumes the benefits provided as the services are performed. In the case of these outpatient services, recognition of the obligation over time yields the same result as recognizing the obligation at a point in time. The Organization believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation.

Because the Organization's performance obligations relate to contracts with a duration of less than one year, the Organization has elected to apply the optional exemption and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to the performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

Note 2: Summary of Significant Accounting Policies (Continued)

Patient Service Revenue (Continued)

The Organization uses a portfolio approach to account for categories of patient contracts as a collective group rather than recognizing revenue on an individual contract basis. The Organization used the following factors to develop portfolios: major payor classes and type of service (that is, inpatient, outpatient, emergency, clinic) and geographical location. Using historical collection trends and other analysis, the Organization evaluated the accuracy of its estimate and determined that recognizing revenue by utilizing the portfolio approach approximates the revenue that would have been recognized if an individual contract approach had been used.

The nature, amount, timing, and uncertainty of revenue and cash flows are affected by several factors that the Organization considers in its recognition of revenue. Following are some of the factors considered:

- Payors (for example, Medicare, Medi-Cal, managed care or other insurance, patient) have different reimbursement/payment methodologies
- Length of the patient's service/episode of care
- Geography of the service location
- Organization's line of business that provided the service (for example, hospital, nursing home, etc.)

The Organization determines the transaction price, which involves significant estimates and judgment, based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Organization's policy, and implicit price concessions provided to patients. The Organization determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policy, and historical experience. The Organization determines its estimate of implicit price concessions based on its historical collection experience for each patient portfolio based on payor class and service type.

The Organization has agreements with third-party payors that typically provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors follows:

- **Hospital Medicare:** The Organization is designated as a CAH. As such, all inpatient, swing bed, and outpatient hospital services are paid based on a cost-reimbursement methodology, except for certain types of laboratory, radiology, and professional services provided to Medicare beneficiaries, which are reimbursed on prospectively determined fee schedules.

- **Hospital Medi-Cal:** Payments for inpatient services rendered to Medi-Cal patients are based on the State's diagnosis-related group system (DRG's). Under this methodology, services are paid at prospectively determined rates per discharge according to a patient classification system that is based on clinical, diagnostic, and other factors. Inpatient swing bed services rendered to Medi-Cal program beneficiaries are reimbursed at prospectively determined per diem rates.

Note 2: Summary of Significant Accounting Policies (Continued)

Patient Service Revenue (Continued)

- **Hospital - Other:** Payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations provide for payment using prospectively determined rates per discharge, discounts from established charges, prospectively determined daily rates, and fee schedules.

- **Clinic Services:** Certain physician and professional services rendered to Medicare and Medi-Cal beneficiaries qualify for reimbursement as Medicare-approved rural health clinic services. Substantially, all Medicare services are reimbursed based on a cost-reimbursement methodology. Medi-Cal is paid on a prospective rate per encounter basis for substantially all physician services, updated annually for inflation.

- **Nursing Home:** Reimbursement for residents under the Medicare Part A program is based on a prospectively based case mix system. Reimbursement for Medi-Cal residents is paid on a lower of cost or charge basis utilizing cost data from two years prior.

Laws and regulations concerning government programs, including Medicare and Medi-Cal, are complex and subject to varying interpretation. Because of investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties, and potential exclusion from the related programs. There can be no assurance that regulatory authorities will not challenge the Organization's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the Organization. The Centers for Medicare and Medicaid Services (CMS) uses recovery audit contractors (RACs) to search for potentially inaccurate Medicare payments that may have been made to health care providers and that were not detected through existing CMS program integrity efforts. Once the RAC identifies a claim it believes is inaccurate, the RAC makes a deduction from or addition to the provider's Medicare reimbursement in an amount estimated to equal the overpayment or underpayment. The Organization has not been notified by the RAC of any potential significant reimbursement adjustments. In addition, the contracts the Organization has with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor, and the Organization's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. Adjustments arising from a change in the transaction price were not significant in 2023 and 2022.

Note 2: Summary of Significant Accounting Policies (Continued)

Patient Service Revenue (Continued)

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Organization also provides services to uninsured patients and offers those uninsured patients a discount, either by policy or law, from standard charges. The Organization estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions.

Consistent with the Organization's mission, care is provided to patients regardless of their ability to pay. Therefore, the Organization has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Organization expects to collect based on its collection history with those patients. The Organization's policy is to provide a 40% discount from established charges to uninsured patients. This policy did not change in 2023 and 2022.

The promised amount of consideration from patients and third-party payors has not been adjusted for the effects of a significant financing component due to the Organization's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payor pays for that service will be one year or less. However, the Organization does, in certain instances, enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

All incremental customer contract acquisition costs are expensed as they are incurred as the amortization period of the asset that the Organization otherwise would have recognized is one year or less in duration.

For uninsured patients who do not qualify for charity care, the Organization recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the Organization's uninsured patients and residents will be unable or unwilling to pay for the services provided. Thus, the Organization includes price concessions related to uninsured patients in the period the services are provided.

Charity Care

The Organization provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because collection is not pursued on amounts determined to qualify as charity care, these amounts are not included in net patient service revenue, less implicit price concessions in the accompanying consolidated statements of operations and changes in net assets.

Note 2: Summary of Significant Accounting Policies (Continued)

Charity Care (Continued)

The estimated cost of providing care to patients under the Organization's charity care policy is calculated by multiplying the ratio of cost to gross charges by the gross uncompensated charity care charges. The costs to provide charity care under the charity care policy was approximately $52,800 and $74,200 for the years ended June 30, 2023 and 2022, respectively.

Grant Income

The Organization receives certain government grants for a variety of purposes. Revenue from grants is considered earned when the Organization incurs the related expenditures or otherwise meets the terms and conditions of the grant. Grant income is included with other operating income in the statements of operations and changes in net assets. Grants earned but not received are recorded in other receivables, and grants received but not yet earned are recorded as deferred revenue in the accompanying balance sheets.

Advertising Costs

Advertising costs are expensed as incurred.

Contributions/Gifts

Unconditional promises to give cash and other assets to the Organization are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is deemed unconditional. The gifts are reported as with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the statements of operations and changes in net assets as net assets released from restrictions.

Functional Allocation of Expenses

The consolidated financial statements report certain categories of expenses that are attributable to one or more supporting functions of the Organization. Those expenses include depreciation, interest, salaries and wages, and employee benefits. Depreciation and interest is allocated based on a square footage basis. Salaries and wages and employee benefits are allocated based on estimates of time and effort.

Income Taxes

Both the Hospital and the Foundation are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code (the "Code") and are exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. The Hospital and the Foundation are also exempt from state income taxes on related income.

Note 2: Summary of Significant Accounting Policies (Continued)

Accounting Pronouncement Adopted

In February 2016, FASB issued Accounting Standards Update (ASU) No. 2016-02, *Leases* (Topic 842). ASU No. 2016-02 is intended to improve financial reporting of leasing transactions by requiring organizations that lease assets to recognize assets and liabilities for the rights and obligations created by leases on the balance sheet. This accounting update also requires additional disclosures surrounding the amount, timing, and uncertainty of cash flows arising from leases. The Organization adopted this guidance for the year ended June 30, 2023 with modified retrospective application to July 1, 2022 through a cumulative-effect adjustment. The Organization has elected the package of practical expedients permitted in ASC Topic 842. Accordingly, the Organization accounted for its existing operating leases as operating leases and capital leases as finance leases under the new guidance, without reassessing (a) whether the contracts contain a lease under ASC Topic 842, (b) whether the classification of the leases would be different in accordance with ASC Topic 842, or (c) whether any unamortized initial direct costs before transition adjustments would have met the definition of initial direct costs in ASC Topic 842 at lease commencement. Similarly, the Organization did not reassess service contracts evaluated for lease treatment under ASC 840 for embedded leases under ASC 842.

As a result of the adoption of the new lease accounting guidance, the Organization recognized the following ROU assets and lease liabilities as of July 1, 2022:

ROU asset - Operating leases	$ 1,186,448
ROU asset - Finance leases	$ 1,278,504
Lease liabilities - Operating leases	$ 1,186,448
Lease liabilities - Finance leases	$ 1,169,624

Future Accounting Pronouncements

ASU No. 2016-13, *Measurement of Credit Losses on Financial Instruments*, will require the Organization to present financial assets measured at amortized cost (including trade receivables) at the net amount expected to be collected over their remaining contractual lives. Estimated credit losses will be based on relevant information about historical experience, current conditions, and reasonable and supportable forecasts that affect the collectability of the reported amounts. This ASU is effective for the Organization's year ending June 30, 2024. The Organization is currently evaluating the impact this ASU will have on the Organization's financial statements and disclosures.

Subsequent Events

Subsequent events have been evaluated through May 24, 2024, which is the date the consolidated financial statements were available to be issued.

Effective July 1, 2023, the Organization entered into a management services agreement with American Advanced Management, Inc. (AAM). In accordance with the agreement, AAM will manage the Organization from July 1, 2023 through the date upon which the change of ownership is approved.

Note 3: Patient Accounts Receivable

Patient accounts receivable consisted of the following at June 30:

	2023	2022
Patient accounts receivable	$ 13,117,536	$ 11,778,271
Less - Contractual adjustments and implicit price concessions	10,001,000	9,091,271
Patient accounts receivable - Net	$ 3,116,536	$ 2,687,000

Patient accounts receivable were $3,304,204 at July 1, 2021.

Note 4: Investments and Assets Limited as to Use

Investments

Investments consisted of the following at June 30:

	2023	2022
Money market funds	$ 11,357	$ 80,175
Mutual funds	3,860,201	5,291,308
Totals	$ 3,871,558	$ 5,371,483

Assets Limited as to Use

Assets limited as to use consisted of funds held by trustees under deferred compensation agreements in mutual funds totaling $171,899 and $131,176 at June 30, 2023 and 2022, respectively.

Investment Income (Loss)

Investment income (loss) was comprised of the following for the years ended June 30:

	2023	2022
Interest and dividend income	$ 205,920	$ 200,341
Unrealized losses on trading securities	(17,161)	(756,943)
Total investment income (loss)	$ 188,759	$ (556,602)

Note 5: Fair Value Measurements

The following is a description of the valuation methodologies used for assets measured at fair value:

Money market funds are valued using a net asset value (NAV) of $1. Mutual funds are valued at the daily closing price as reported by the fund. These funds are registered with the U.S. Securities and Exchange Commission and are required to publish their daily NAV and to transact at that price. These funds are deemed to be actively traded.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Organization believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following table sets forth by level, within the fair value hierarchy, the Organization's assets at fair value as of June 30:

2023	Level 1	Level 2	Level 3	Total Assets at Fair Value
Money market funds	$ 11,357	$ -	$ -	$ 11,357
Mutual funds	4,032,100	-	-	4,032,100
Totals	$ 4,043,457	$ -	$ -	$ 4,043,457
2022				
Money market funds	$ 80,175	$ -	$ -	$ 80,175
Mutual funds	5,422,484	-	-	5,422,484
Totals	$ 5,502,659	$ -	$ -	$ 5,502,659

Reconciliation of the hierarchy tables to the balance sheets follows:

	2023	2022
Investments	$ 3,871,558	$ 5,371,483
Assets limited as to use	171,899	131,176
Total assets in hierarchy tables	$ 4,043,457	$ 5,502,659

Note 6: Property and Equipment

Property and equipment consisted of the following at June 30:

	2023	2022
Land	$ 106,951	$ 106,951
Land improvements	178,980	178,980
Buildings and improvements	4,534,792	3,738,173
Equipment	8,691,731	8,554,945
Total property and equipment	13,512,454	12,579,049
Less - Accumulated depreciation	10,345,535	9,787,751
Net depreciated value	3,166,919	2,791,298
Construction in progress	80,866	854,174
Property and equipment - Net	$ 3,247,785	$ 3,645,472

Construction in progress relates to routine capital projects for renovating and updating the Organization's facilities and other projects.

Note 7: Leases

The Organization leases equipment and building space. The majority of leases entered into include one or more options to renew. The exercise of lease renewal options is at the Organization's sole discretion. Renewal option periods are included in the measurement of the ROU asset and lease liability when the exercise is reasonably certain to occur.

The renewal options have been recognized in the respective right-of-use asset and liability. All other renewal options have not been recognized as the Company does not intend to exercise those options.

The depreciable life of assets and leasehold improvements are limited by the expected lease term, unless there is a transfer of title or purchase option reasonably certain of exercise.

The Organization's lease agreements do not contain any material residual value guarantees or material restrictive covenants. Payments due under the lease contracts include fixed payments plus, for many of the Organization's leases, variable payments. These variable lease payments are not included in lease payments used to determine the lease liability and are recognized as variable costs when incurred.

Note 7: Leases (Continued)

Components of lease expense were as follows for the year ended June 30, 2023:

Lease cost		
Finance lease cost:		
Interest	$	39,732
Amortization of right-of-use asset		159,598
Operating lease cost		225,725
Short-term lease cost		69,554
Total lease cost	$	494,609

Supplemental cash flow information related to leases is as follows for the year ended June 30, 2023:

Other information		
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from finance leases	$	39,732
Operating cash flows from operating leases	$	225,725
Financing cash flows from finance leases	$	335,667
Right-of-use assets obtained in exchange for new operating lease liabilities	$	1,186,448

Supplemental information information for the year ended June 30, 2023 is as follows:

Weighted-average remaining lease term - Finance leases (in years)	2.24
Weighted-average remaining lease term - Operating leases (in years)	4.33
Weighted-average discount rate - Finance leases	6.28 %
Weighted-average discount rate - Operating leases	4.11 %

Note 7: Leases (Continued)

Maturities of lease liabilities are as follows as of June 30, 2023:

	Operating Leases	Finance Leases
2024	$ 216,164	$ 323,902
2025	213,253	267,147
2026	214,361	158,773
2027	215,514	67,721
2028	216,713	36,000
Thereafter	-	48,000
Total lease payments	1,076,005	901,543
Less imputed interest	(115,281)	(67,587)
Totals	$ 960,724	$ 833,956

Right-of-use assets acquired under finance lease obligations are included in property and equipment.

Note 8: Short-term Loan Payable

The Organization holds investments with Edward Jones. A credit agreement was obtained allowing the Organization to borrow against its investments. The interest rate will vary depending on the assets held with Edward Jones and was 7.50% and 4.00% as of June 30, 2023 and 2022, respectively. The amount available for borrowing is dependent upon the value of the investments. Interest only payments are due monthly with no expiration date. As of June 30, 2023 and 2022, the Organization had an amount available to be borrowed of $164,393 and $1,011,445 on the short-term note payable, respectively. The balance of the short-term loan was $1,235,292 and $1,001,819 as of June 30, 2023 and 2022, respectively.

Note 9: Long-Term Debt

Long-term debt consisted of the following at June 30:

	2023	2022
Note payable, dated April 14, 2014; annual payments of $24,658, including interest at 4%, due May 2024; secured by a medical office building.	$ 23,710	$ 46,508
Economic Injury Disaster Loan under the Small Business Administration, dated July 13, 2020; monthly payments of $641 beginning in July 2021, including interest at 2.75%, due June 2051; secured by all tangible and intangible personal property.	143,730	151,004
Total long-term debt	167,440	197,512
Less - Current maturities	(27,394)	(26,387)
Long-term portion	$ 140,046	$ 171,125

Scheduled payments of principal on long-term debt at June 30, 2023, including current maturities, are summarized as follows:

2024	$ 27,394
2025	3,787
2026	3,892
2027	4,001
2028	4,112
Thereafter	124,254
Total	$ 167,440

Note 10: Net Assets With Donor Restrictions

Net assets with donor restrictions are restricted for the following purposes or periods as of June 30:

	2023	2022
Subject to expenditure for specified purpose:		
Champions campaign (ER equipment)	$ 201,403	$ 201,403
Mammography	10,253	10,253
Other	15,268	15,268
Total net assets with donor restrictions	$ 226,924	$ 226,924

Net assets were released from donor restrictions by incurring expenses satisfying the restricted purposes specified by donors totaling $114,857 during the year ended June 30, 2022. There were no assets released from donor restrictions during the year ended June 30, 2023.

Note 11: Patient Service Revenue

Patient service revenue consisted of the following for the years ended June 30:

	2023	2022
Gross patient service revenue:		
Hospital	$ 82,652,335	$ 71,688,093
Swing bed	4,948,843	3,019,357
Clinic	4,602,177	4,977,249
Total gross patient service revenue	92,203,355	79,684,699
Less - Contractual allowances, discounts, and implicit price concessions	65,468,041	58,858,933
Patient service revenue	$ 26,735,314	$ 20,825,766

Note 11: Patient Service Revenue (Continued)

Patient service revenue consisted of the following for the years ended June 30:

	2023		2022	
Medicare	$ 12,948,391	48 %	$ 9,123,776	44 %
Medi-Cal	1,599,866	6	3,636,088	17
Other third-party payors	7,661,895	29	6,426,994	31
Patients	363,790	1	26,734	-
California hospital fee program payment	3,942,396	15	1,505,248	7
California disproportionate share payment	218,976	1	106,926	1
Patient service revenue	$ 26,735,314	100 %	$ 20,825,766	100 %

For the year ended June 30, 2022, a total of $339,153 was recognized as revenue for services from discontinued operations and is included in change in net assets from discontinued operations in the accompanying consolidated statements of operations and changes in net assets as well as in Note 18.

Note 12: COVID-19 Relief Funds and Grant Revenue

During 2022, the Hospital received $2,291,266 in grant funding from the U.S. Department of Health and Human Services (HHS) Provider Relief Fund and American Rescue Plan (ARP) Rural Payments. Based on the terms and conditions of the grant, the Hospital earns the grant by incurring healthcare-related expenses attributable to COVID-19 that another source has not reimbursed and is not obligated to reimburse, or by incurring lost revenues, defined as a negative change in year-over-year net patient care revenue. During 2022, the Hospital recognized $2,291,266 in grant revenue related to this program, which reflects management's estimate of the amount of the grant earned, including consideration for uncertainties related to reporting guidance.

Note 13: Retirement Plan

The Organization maintains a contributory defined contribution retirement plan covering substantially all of its employees. Employer matching contributions to the plan were frozen effective February 1, 2023. The Organization reinstated matching contributions of up to 4% of compensation for eligible participants effective January 1, 2024. For fiscal year ended June 30, 2022, the employer matching contributions were up to 5% of compensation for eligible participants. Total expense related to this plan for the years ended June 30, 2023 and 2022, was $314,023 and $309,227, respectively.

Note 14: Malpractice Insurance

The Organization's professional liability insurance for claim losses of less than $5,000,000 per claim and $15,000,000 per year covers professional liability claims reported during a policy year ("claims made" coverage). The professional liability insurance policy is renewable annually and has been renewed by the insurance carrier for the period extending to May 1, 2025. Under a claims-made policy, the risk for claims and incidents not asserted within the policy period remains with the Organization. Although there exists the possibility of claims arising from services provided to patients through June 30, 2023, which had not been asserted, the Organization is unable to determine the ultimate cost, if any, of such possible claims; accordingly, no provision has been made for them.

Note 15: Self-Funded Health Insurance

The Organization has a self-funded health plan that provides benefits to employees. Costs are expensed as incurred. Health expenses are based on claims paid, reinsurance premiums, administrative fees, and unpaid claims at year-end. The Organization buys reinsurance to cover catastrophic individual claims over $50,000. Self-funded health expenses for the years ended June 30, 2023 and 2022, were $1,668,067 and $538,235, respectively. The Organization recorded a liability for self funded health claims incurred but not reported of $291,625 and $280,000 at June 30, 2023 and 2022.

Note 16: Functional Expenses

The Organization provides general health care services to residents within its geographic location. Expenses related to providing these services for the year ended June 30, 2023, are as follows:

	Health Care Services	General and Administrative	Fund-Raising	Total
Salaries and wages	$ 9,584,515	$ 4,130,834	$ 36,828	$ 13,752,177
Employee benefits	2,099,342	1,636,709	15,079	3,751,130
Professional fees and purchased services	5,585,338	1,710,396	-	7,295,734
Supplies	1,498,501	259,401	60	1,757,962
Utilities	513,045	140,466	-	653,511
Other	898,944	886,266	-	1,785,210
Depreciation	387,485	170,299	-	557,784
Interest	54,620	134,593	-	189,213
Totals	$ 20,621,790	$ 9,068,964	$ 51,967	$ 29,742,721

Note 16: Functional Expenses (Continued)

Expenses related to providing these services for the year ended June 30, 2022, are as follows:

	Health Care Services	General and Administrative	Fund-Raising	Total
Salaries and wages	$ 8,282,166	$ 4,172,991	$ 73,928	$ 12,529,085
Employee benefits	1,467,482	666,417	25,352	2,159,251
Professional fees and purchased services	5,141,835	1,701,521	-	6,843,356
Supplies	1,575,216	236,496	311	1,812,023
Utilities	444,905	116,541	-	561,446
Other	833,197	931,672	88,300	1,853,169
Depreciation	285,670	275,382	1,568	562,620
Interest	25,352	69,451	-	94,803
Totals	$ 18,055,823	$ 8,170,471	$ 189,459	$ 26,415,753

For the year ended June 30, 2022, $409,049 was recognized as expense for services from discontinued operations and is included in change in net assets from discontinued operations in the accompanying consolidated statements of operations and changes in net assets as well as in Note 18.

Note 17: Deferred Compensation

The Hospital sponsors a deferred compensation plan under Section 457(b) of the Code. The plan is intended primarily for certain employees to defer compensation until retirement. Investments in mutual funds designated for deferred compensation under this plan are recorded in the accompanying consolidated balance sheets as assets limited as to use and the accrued liabilities are recorded as other long-term liabilities.

In October 2023, the plan was terminated and all assets were distributed to the participants.

Note 18: Discontinued Operations

Effective July 31, 2021, the Organization transferred the management and operations of the skilled nursing facility.

The assets, liabilities, net assets, revenues, and expenses pertaining to discontinued operations were determined based on actual or estimated amounts, if actual was not readily determinable.

The allocation method for breaking out discontinued operations from continuing operations for the year ended June 30, 2022 when actual amounts were not readily determinable was as follows:

- Square footage of the skilled nursing facility compared to the whole property
- Headcount of the skilled nursing employees compared to total headcount
- Skilled nursing revenue compared to total patient revenue

There were no assets, liabilities, or net assets from discontinued operations as of June 30, 2023 and 2022.

The revenue and expenses related to the skilled nursing facility have been excluded from revenues and expenses from continuing operations on the consolidated statement of operations and changes in net assets for the year ended June 30, 2022. There were no revenues or expenses related to discontinued operations for the year ended June 30, 2023. The change in net assets from discontinued operations is presented as one line on the consolidated statement of operations and changes in net assets for the year ended June 30, 2022. The breakout of revenue and expenses related to the operation of the skilled nursing facility for the year ended June 30, 2022 is as follows:

Revenue:		
Patient service revenue	$	339,153
Expenses:		
Salaries and wages		261,422
Employee benefits		20,351
Professional fees		70,006
Purchased services		26,066
Supplies		14,934
Utilities		4,047
Repairs and maintenance		1,863
Insurance		2,242
Rent and lease		2,897
Other		5,221
Total expenses		409,049
Change in net assets from discontinued operations	$	(69,896)

For the year ended June 30, 2022, cash flows from discontinued operations consisted of the change in operating assets and liabilities. There were no cash flows from investing or financing activities.

Note 19: Liquidity

As part of the Organization's liquidity management, it invests cash in excess of daily requirements in a variety of investment vehicles. These funds, included in investments, are considered available for operational or capital needs. As of June 30, 2023 and 2022, financial assets and liquidity resources available within one year for general expenditure, such as operating expenses, scheduled debt service payments, and capital items were as follows:

	2023	2022
Financial assets:		
Cash	$ 1,039,316	$ 768,884
Investments	3,871,558	5,371,483
Patient accounts receivable, net	3,116,536	2,687,000
Other accounts receivable	5,393,313	3,627,339
Total financial assets	13,420,723	12,454,706
Liquidity resources -		
Short-term loan available	164,393	1,011,445
Less restrictions -		
Net assets with donor restrictions	(226,924)	(226,924)
Total financial assets and liquidity resources available for general expenditure within one year	$ 13,358,192	$ 13,239,227

Note 20: Concentration of Credit Risk

Financial instruments that subject the Organization to possible credit risk consist principally of accounts receivable, cash deposits in excess of insured limits, and investments that are uninsured.

The mix of Organization receivables from patients and third-party payors is as follows at June 30:

	2023	2022
Medicare	27 %	24 %
Medi-Cal	27	29
Other third-party payors	28	29
Patients	18	18
Totals	100 %	100 %

Note 20: Concentration of Credit Risk (Continued)

The Organization maintains depository relationships with area financial institutions that are FDIC-insured institutions. Depository accounts at these institutions are insured by the FDIC up to $250,000. At June 30, 2023, the Organization's deposits exceeded FDIC-insured limits by approximately $1,200,000. In addition, investments held by financial institutions are uninsured.

Note 21: Reclassifications

Certain reclassifications have been made to the 2022 financial statements to conform to the 2023 classifications. Total assets, total liabilities, total net assets, and the total change in net assets were not affected.

Note 22: Going Concern Contingency

As indicated in the accompanying financial statements, the Organization showed a decrease in net assets of $1,567,278 during the year ended June 30, 2023. In addition, the Organization has continued to suffer large monthly losses from operations throughout the first half of the year ending June 30, 2024. Those factors create an uncertainty about the Organization's ability to continue as a going concern.

Management of the Organization has implemented its plan to improve operations through a reduction in expenses, renegotiation of payor contracts, and improvement of the census. The ability of the Organization to continue as a going concern is dependent on the plan's success. The consolidated financial statements do not include any adjustments that might be necessary if the Organization is unable to continue as a going concern.

Supplementary Information

Orchard Hospital and Affiliate

Consolidating Balance Sheets

June 30, 2023 (With Comparative Totals for June 30, 2022)

Assets	Orchard Hospital	Orchard Hospital Foundation	Eliminations	2023	2022
Current assets:					
Cash	$ 1,025,513	$ 13,803	$ -	$ 1,039,316	$ 768,884
Investments	2,470,018	1,401,540	-	3,871,558	5,371,483
Receivables:					
Patient accounts receivable - Net	3,116,536	-	-	3,116,536	2,687,000
California hospital fee program	5,303,011	-	-	5,303,011	3,611,966
Other	90,302	-	-	90,302	15,373
Inventories	444,006	-	-	444,006	445,253
Prepaid expenses and other	127,158	2,655	-	129,813	156,732
Total current assets	12,576,544	1,417,998	-	13,994,542	13,056,691
Assets limited as to use	171,899	-	-	171,899	131,176
Right-of-use asset - Operating leases	960,724	-	-	960,724	-
Property and equipment - Net	3,247,785	-	-	3,247,785	3,645,472
TOTAL ASSETS	$ 16,956,952	$ 1,417,998	$ -	$ 18,374,950	$ 16,833,339

Orchard Hospital and Affiliate

Consolidating Balance Sheets (Continued)

June 30, 2023 (With Comparative Totals for June 30, 2022)

Liabilities and Net Assets	Orchard Hospital	Orchard Hospital Foundation	Eliminations	2023	2022
Current liabilities:					
Current maturities of notes payable	$ 27,394	$ -	$ -	$ 27,394	$ 26,387
Current portion of finance lease liabilities	289,136	-	-	289,136	340,291
Current portion of operating lease liabilities	210,999	-	-	210,999	-
Short-term loan payable	1,235,292	-	-	1,235,292	1,001,819
Due to third-party reimbursement programs	446,786	-	-	446,786	260,438
Accounts payable	3,870,373	3,729	-	3,874,102	1,993,845
Accrued payroll	703,047	-	-	703,047	531,324
Accrued vacation	546,161	-	-	546,161	598,292
Deferred revenue	63,011	-	-	63,011	9,500
Total current liabilities	7,392,199	3,729	-	7,395,928	4,761,896
Long-term liabilities:					
Notes payable, less current maturities	140,046	-	-	140,046	171,125
Finance lease liabilities, less current portion	544,820	-	-	544,820	829,332
Operating lease liabilities, less current portion	749,725	-	-	749,725	-
Other long-term liabilities	171,899	-	-	171,899	131,176
Total long-term liabilities	1,606,490	-	-	1,606,490	1,131,633
Total liabilities	8,998,689	3,729	-	9,002,418	5,893,529
Net assets:					
Without donor restrictions	7,958,263	1,187,345	-	9,145,608	10,712,886
With donor restrictions	-	226,924	-	226,924	226,924
Total net assets	7,958,263	1,414,269	-	9,372,532	10,939,810
TOTAL LIABILITIES AND NET ASSETS	$ 16,956,952	$ 1,417,998	$ -	$ 18,374,950	$ 16,833,339

See Independent Auditor's Report.

Orchard Hospital and Affiliate

Consolidating Statements of Operations and Changes in Net Assets

Year Ended June 30, 2023 (With Comparative Totals for June 30, 2022)

	Orchard Hospital	Orchard Hospital Foundation	Eliminations	2023	2022
Revenue:					
Patient service revenue	$ 26,735,314	$ -	$ -	$ 26,735,314	$ 20,825,766
Other revenue:					
Other operating revenue	410,718	-	-	410,718	134,212
340B pharmacy revenue	189,360	-	-	189,360	333,400
COVID-19 HHS provider relief funds	-	-	-	-	2,291,266
Grant income	331,406	-	-	331,406	-
Total revenue	27,666,798	-	-	27,666,798	23,584,644
Expenses:					
Salaries and wages	13,752,177	-	-	13,752,177	12,529,085
Employee benefits	3,751,130	-	-	3,751,130	2,159,251
Professional fees	4,858,155	-	-	4,858,155	5,049,500
Purchased services	2,437,579	-	-	2,437,579	1,793,856
Supplies	1,757,962	-	-	1,757,962	1,812,023
Utilities	653,511	-	-	653,511	561,446
Repairs and maintenance	580,436	-	-	580,436	465,182
Insurance	371,026	-	-	371,026	288,337
Rent and lease	295,279	-	-	295,279	326,295
Depreciation	557,784	-	-	557,784	562,620
Interest	189,213	-	-	189,213	94,803
Other	550,785	-	-	550,785	773,355
Total expenses	29,755,037	-	-	29,755,037	26,415,753
Loss from operations	(2,088,239)	-	-	(2,088,239)	(2,831,109)
Other income (loss):					
Investment income (loss)	144,518	44,241	-	188,759	(556,602)
Contributions	128,705	71,117	(83,279)	116,543	1,205,200
Rental income	239,880	-	-	239,880	223,990
Other expenses	-	(107,500)	83,279	(24,221)	-
Total other income	513,103	7,858	-	520,961	872,588
Excess (deficiency) of revenue over expenses	$ (1,575,136)	$ 7,858	$ -	$ (1,567,278)	$ (1,958,521)

Orchard Hospital and Affiliate

Consolidating Statements of Operations and Changes in Net Assets

(Continued)

Year Ended June 30, 2023 (With Comparative Totals for June 30, 2022)

	Orchard Hospital	Orchard Hospital Foundation	Eliminations	2023	2022
Change in net assets with donor restrictions:					
Contributions	$ -	$ -	$ -	$ -	$ 4,530
Net assets released from restrictions	-	-	-	-	(114,857)
Change in net assets with donor restrictions	-	-	-	-	(110,327)
Change in net assets, before discontinued operations	(1,575,136)	7,858	-	(1,567,278)	(2,068,848)
Change in net assets from discontinued operations	-	-	-	-	(69,896)
Change in net assets	(1,575,136)	7,858	-	(1,567,278)	(2,138,744)
Net assets at beginning of year	9,533,399	1,406,411	-	10,939,810	13,078,554
Net assets at end of year	$ 7,958,263	$ 1,414,269	$ -	$ 9,372,532	$ 10,939,810

See Independent Auditor's Report.

Orchard Hospital and Affiliate

Schedule of Expenditures of Federal Awards

Year Ended June 30, 2023

Federal Grantor/Program Title	Contract Number	Entity Passed Through	Federal Assistance Listing Number	Federal Expenditures
U.S. Department of Health and Human Services:				
Rural Hospital Research Centers	N/A	HCAI	93.155	$ 258,376
COVID 19 - Provider Relief Fund and American Rescue Plan (ARP) Rural Distribution	N/A	Direct	93.498	2,291,266
Small Rural Hospital Improvement Grant Program	N/A	HCAI	93.301	11,855
Total U.S. Department of Health and Human Services				2,561,497
Total expenditures of federal awards				$ 2,561,497

See Notes to Schedule of Expenditures of Federal Awards.
See Independent Auditor's Report.

Orchard Hospital and Affiliate

Notes to Schedule of Expenditures of Federal Awards

Year Ended June 30, 2023

Note 1: General

The accompanying schedule of expenditures of federal awards (the "Schedule") includes the federal grant activity of Orchard Hospital and Affiliate under programs of the federal governments for the year ended June 30, 2023. The information in this schedule is presented in accordance with requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* ("Uniform Guidance"). Because the schedule presents only a selected portion of the operations of Orchard Hospital and Affiliate, it is not intended to and does not present the financial position, changes in net assets ,or cash flows of Orchard Hospital and Affiliate.

Note 2: Basis of Accounting

With the exception of expenditures related to the Provider Relief Fund (PRF) and American Rescue Plan (ARP) Rural Distribution, expenditures on the Schedule are reported on the accrual basis of accounting and are recognized following the cost principles contained in the Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement. The PRF and ARP are not subject to cost principles requirements contained in the Uniform Guidance. Expenditures reported on the Schedule for PRF and ARP are based on the PRF and ARP period of availability, terms and conditions of the program, and amounts reported in the PRF and ARP portal for the reporting period 5, due September 30, 2023.

Note 3: Indirect Cost Rate

Orchard Hospital and Affiliate has elected not to use the 10-percent de minimis indirect cost rate allowed under the Uniform Guidance.

Note 4: Sub-Recipients

Orchard Hospital and Affiliate does not have any sub-recipients of federal awards.

WIPFLI

Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

Board of Directors
Orchard Hospital and Affiliate
Gridley, California

We have audited, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, the consolidated financial statements of Orchard Hospital and Affiliate, which comprise the consolidated balance sheet as of June 30, 2023, and the related consolidated statements of operations and changes in net assets, and cash flows for the year then ended and the related notes to the consolidated financial statements, and have issued our report thereon dated May 24, 2024.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the consolidated financial statements, we considered Orchard Hospital and Affiliate's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of Orchard Hospital and Affiliate's internal control. Accordingly, we do not express an opinion on the effectiveness of Orchard Hospital and Affiliate's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies in internal control, such that there is a reasonable possibility that a material misstatement of Orchard Hospital and Affiliate's consolidated financial statements will not be prevented or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses or significant deficiencies may exist that were not identified.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether Orchard Hospital and Affiliate's consolidated financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the consolidated financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of Orchard Hospital and Affiliate's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Orchard Hospital and Affiliate's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Wipfli LLP

Wipfli LLP

Irvine, California
May 24, 2024

WIPFLI

Independent Auditor's Report on Compliance for Each Major Federal Program and on Internal Control Over Compliance Required by the Uniform Guidance

Board of Directors
Orchard Hospital and Affiliate
Gridley, California

Report on Compliance for the Major Federal Program

Opinion on the Major Federal Program

We have audited Orchard Hospital and Affiliate's compliance with the types of compliance requirements identified as subject to audit in the OMB *Compliance Supplement* that could have a direct and material effect on its major federal program for the year ended June 30, 2023. Orchard Hospital and Affiliate's major federal program is identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

In our opinion, Orchard Hospital and Affiliate complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on its major federal program for the year ended June 30, 2023.

Basis for Opinion on the Major Federal Program

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America (GAAS); the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*); and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Our responsibilities under those standards and the Uniform Guidance are further described in the Auditor's Responsibilities for the Audit of Compliance section of our report.

We are required to be independent of Orchard Hospital and Affiliate and to meet our other ethical responsibilities, in accordance with relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion on compliance for the major federal program. Our audit does not provide a legal determination of Orchard Hospital and Affiliate's compliance with the compliance requirements referred to above.

Responsibilities of Management for Compliance

Management is responsible for compliance with the requirements referred to above and for the design, implementation, and maintenance of effective internal control over compliance with the requirements of laws, statutes, regulations, rules and provisions of contracts or grant agreements applicable to Orchard Hospital and Affiliate's federal program.

Auditor's Responsibilities for the Audit of Compliance

Our objectives are to obtain reasonable assurance about whether material noncompliance with the compliance requirements referred to above occurred, whether due to fraud or error, and express an opinion on Orchard Hospital and Affiliate's compliance based on our audit. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance will always detect material noncompliance when it exists. The risk of not detecting material noncompliance resulting from fraud is higher than for that resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Noncompliance with the compliance requirements referred to above is considered material, if there is a substantial likelihood that, individually or in the aggregate, it would influence the judgment made by a reasonable user of the report on compliance about Orchard Hospital and Affiliate's compliance with the requirements of the major federal program as a whole.

In performing an audit in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material noncompliance, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding Orchard Hospital and Affiliate's compliance with the compliance requirements referred to above and performing such other procedures as we considered necessary in the circumstances.
- Obtain an understanding of Orchard Hospital and Affiliate's internal control over compliance relevant to the audit in order to design audit procedures that are appropriate in the circumstances and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of Orchard Hospital and Affiliate's internal control over compliance. Accordingly, no such opinion is expressed.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and any significant deficiencies and material weaknesses in internal control over compliance that we identified during the audit.

Other Matters

The results of our auditing procedures disclosed an instance of noncompliance, which is required to be reported in accordance with Uniform Guidance and which is described in the accompanying schedule of findings and questioned costs as item 2023-001. Our opinion on the major federal program is not modified with respect to this matter.

Government Auditing Standards requires the auditor to perform limited procedures on the Organization's response to the noncompliance finding identified in our audit described in the accompanying schedule of findings and questioned costs. The Organization's response was not subjected to the other auditing procedures applied in the audit of compliance and, accordingly, we express no opinion on the response.

Report on Internal Control Over Compliance

Our consideration of internal control over compliance was for the limited purpose described in the Auditor's Responsibilities for the Audit of Compliance section above and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies in internal control over compliance and therefore, material weaknesses or significant deficiencies may exist that were not identified. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, as discussed below, we did identify a certain deficiency in internal control over compliance that we consider to be a significant deficiency.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance. We consider the deficiency in internal control over compliance described in the accompanying schedule of findings and questioned costs as item 2023-001 to be a significant deficiency.

Our audit was not designed for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, no such opinion is expressed.

Government Auditing Standards requires the auditor to perform limited procedures on Orchard Hospital and Affiliate's response to the internal control over compliance finding identified in our audit described in the accompanying schedule of findings and questioned costs. The Orchard Hospital and Affiliate's response was not subjected to the other auditing procedures applied in the audit of compliance and, accordingly, we express no opinion on the response.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Wipfli LLP

Wipfli LLP

Irvine, California
May 24, 2024

Orchard Hospital and Affiliate
Schedule of Findings and Questioned Costs
Year Ended June 30, 2023

Section I - Summary of Auditor's Results

Financial Statements

Type of auditor's report issued	Unmodified
Internal control over financial reporting:	
Material weakness(es) identified?	___ yes _x_ no
Significant deficiency(ies) identified?	___ yes _x_ no
Noncompliance material to financial statements noted?	___ yes _x_ no

Federal Awards

Internal control over major programs:	
Material weakness(es) identified?	___ yes _x_ no
Significant deficiency(ies) identified?	_x_ yes ___ no
Type of auditor's report issued on compliance for major programs	Unmodified
Any audit findings disclosed that are required to be reported in accordance with the Uniform Guidance [2 CFR 200.516(a)]?	_x_ yes ___ no

Identification of major federal programs:

Federal Assistance Listing Number	Name of Federal Program or Cluster
93.498	Provider Relief Fund and American Rescue Plan (ARP) Rural Distribution

Dollar threshold used to distinguish between Type A and Type B programs:	$750,000
Auditee qualified as low-risk auditee?	No

Section II - Financial Statement Findings

None

Section III – Federal Award Findings and Questioned Costs

Finding 2023-001
Program Name: Provider Relief Fund and American Rescue Plan (ARP) Rural Distribution
Federal Assistance Listing Number: 93.498
Federal Agency: U.S. Department of Health and Human Services
Questioned Costs: N/A
Type of Finding: Significant Deficiency
Compliance Requirement: Reporting

Condition:	The Organization did not meet its financial reporting obligations under the grant during the year. The Organization was unable to complete the FYE 2023 audit timely and therefore were unable to file their Data Collection Form (SF-SAC) by the due date of March 31, 2024.
Criteria:	The Organization is required to file the Data Collection Form within 30 days after receipt of audit or 9 months after year end, whichever comes first.
Cause:	The Data Collection form was not filed within the required time period due to a delay in preparations for the audit.
Questioned Costs:	None
Effect:	The Organization was not in compliance with federal regulations.
Recommendation:	We recommend audit preparations are completed on a timely basis to ensure that the reporting deadline is met.
View of Responsible Officials:	Management acknowledges there were significant capacity issues caused by turnover within the organization which delayed the audit. Management will complete the Data Collection Form upon issuance of the audit.