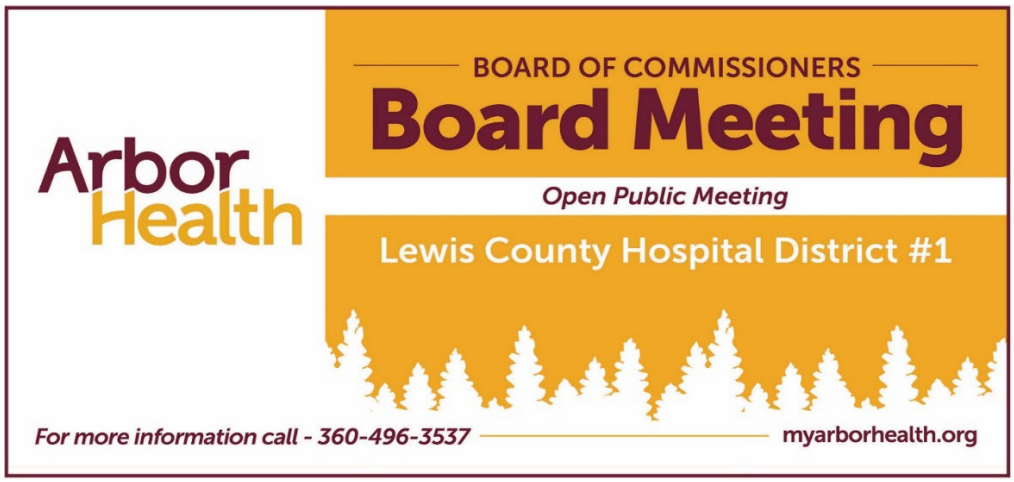
REGULAR BOARD MEETING PACKET



BOARD OF COMMISSIONERS

Board Chair –Tom Herrin, Secretary – Vacant,
Commissioner – Craig Coppock, Commissioner – Wes McMahan,
Commissioner-Van Anderson & Commissioner-Chris Schumaker

January 31, 2024 @ 3:30 PM
Conference Room 1 & 2 or Join Zoom Meeting:
https://myarborhealth.zoom.us/j/88957566693
Meeting ID: 889 5756 6693
One tap mobile:+12532158782,,88957566693#
Dial: +1 253 215 8782

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LEWIS COUNTY HOSPITAL DISTRICT NO. 1
REGULAR BOARD OF COMMISSIONERS' MEETING
January 31, 2024 at 3:30 p.m.
Conference Room 1 & 2 or via ZOOM
https://myarborhealth.zoom.us/j/88957566693
Meeting ID: 889 5756 6693
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Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide every patient the best care and every employee the best place to work.

AGENDA	PAGE	TIME
Call to Order **Roll Call** **Excused/Unexcused Absences** **Reading of the Mission & Vision Statement** **Approval or Amendment of Agenda** **Conflicts of Interest**		3:30 pm
Comments and Remarks • Commissioners • Audience		3:35 pm
Executive Session- *RCW 70.41.200 & RCW 42.30.110 (g)* • Medical Privileging-Chief of Staff Dr. Victoria Acosta & Medical Staff Coordinator Barb Goble • To discuss the performance of a public employee.	6	3:40 pm 3:45 pm
Department Spotlight • Patient Access	8	3:55 pm
Board Committee Reports • Hospital Foundation Report-Committee Chair-Board Chair Herrin/Foundation Manager Jessica Scogin	20	4:05 pm
• Finance Committee Report- Committee Chair-Commissioner McMahan	22	4:10 pm
Consent Agenda *(Action)* • Approval of Minutes: ○ *December 20, 2023, Finance Committee Meeting* ○ *December 20, 2023, Regular Board Meeting* ○ *January 24, 2024, Finance Committee Meeting*	 29 33 41	4:20 pm
• Warrants & EFTs in the amount of $2,843,226.26 dated December 2023	45	
• RES 24-01-Adopting the Flexible Spending Account Plan ○ *To adopt the flexible spending account portion of the employee benefit package; 3rd party administrator requires board resolution of plan.*	47	

• RES-24-02-Declaring to Surplus or Dispose of Personal Property o *To approve liquidation of items beyond their useful life.*	103	
Old Business • 2024 Organization & Officers of the Board of Commissioners o *To elect the Board Chair and Secretary, as well as finalize committee assignments.*	106	4:25 pm
New Business • Elected Official Salaries o *To increase the daily rate for commissioner pay for new and existing commissioners for Special Purpose District-Public Hospital Districts (RCW 70.44.050).*	108	4:35 pm
• RES-24-03-Approving the Capital Purchase of the Ultrasound Equipment *(Action)* o *To approve the purchase of the Siemens Sequoia & Redwood Ultrasound Equipment through a lease.*	116	4:40 pm
• Conflicts of Interest o *New commissioner requirement for Commissioners Anderson & Schumaker to sign electronically. The entire Board will join the organizational signing process in Q4 of 2024.*	155	4:50 pm
• Board Education/Development o *Kurt O'Brien (2-Sessions Remain)* o *AWPHD/WSHA Annual Conference in Chelan, WA* o *30 Minute Q & A Prior to Committee Meeting Discussion*	161	4:55 pm
Superintendent Report • Advocacy Day • 2023-2025 Strategic Plan (Quarterly Update) • Board Educational Article-CAH Finance Basics in the New Health Care Environment	165 167 171	5:05 pm
Meeting Summary & Evaluation		5:25 pm
Next Board Meeting Dates and Times • Regular Board Meeting-February 28, 2024 @ 3:30 PM (ZOOM & In Person) **Next Committee Meeting Dates and Times** • Compliance Committee Meeting-February 7, 2024 @ 12:00 PM (ZOOM) • QIO Committee Meeting-February 14, 2024 @ 7:00 AM (ZOOM) • Finance Committee Meeting-February 21, 2024 @ 12:00 PM (ZOOM)		
Adjournment		5:30 pm

EXECUTIVE SESSION

MEDICAL STAFF PRIVILEGING

The below providers are requesting appointment to the Arbor Health Medical Staff. All files have been reviewed for Quality Data, active state license, any malpractice claims, current liability insurance, peer references, all hospital affiliations, work history, National Practitioner Data Bank reports, sanctions reports, Department of Health complaints, Washington State Patrol background check and have been reviewed by the credentialing and medical executive committees including the starred items below. The credentialing and medical executive committees have recommended the following for approval.

INITIAL APPOINTMENTS-5

Radia Inc.

- Sandeep Shah, MD (Consulting Radiology Privileges)
- Joe Pastrano, MD (Consulting Radiology Privileges)
- Eric Hoover, MD (Consulting Radiology Privileges)

Providence Health & Services Privileging by Proxy

- Amin Rabiei, MD (Consulting Telehealth/Neurology Privileges)
- Meghana Srinivas Kinariwala, MD (Consulting Telehealth/Neurology Privileges)

REAPPOINTMENTS-3

Radia Inc.

- Lauren Fetty, MD (Consulting Radiology Privileges)

Providence Health & Services Privileging by Proxy

- Ravi Menon, MD (Consulting Telestroke/Neurology Privileges)
- Maria Recio, MD (Consulting Telestroke/Neurology Privileges)

✪-notates files with items to note.

DEPARTMENT SPOTLIGHT

Patient Access

Department Spotlight

Janice Cramer, CPCS

Patient Access Manager

Face of the Hospital

When entering Arbor Health Morton Hospital, the first faces you see are the smiling faces of the always helpful Patient Access Staff.

Patient Access includes:

- Front Desk Registration
- Emergency Department Registration
- Radiology scheduling
- Outpatient, Wound Care, Procedure, and Surgery Scheduling
- Authorizations for Outpatient, Wound Care, Procedures, Surgeries, Sleep Studies, Rehab and Inpatient/Observation.

Patient Access

Front Desk Registration

Front Registration Desk is staffed Monday-Friday 6:00am-5:30pm

- Check in patients for: Lab, Radiology, Respiratory Therapy, Wound Care, Outpatient Services, Surgery, Physical Therapy Evaluations and Occupational Therapy Evaluations.
- Responsible for creating observation, inpatient and swing bed encounter after reviewing orders placed by physicians
- Verify and accurately input insurance information including coordination of benefits and knowing benefit information.
- Collect payments and copays on any Arbor Health account.
- Reviews patient accounts when patients come in with billing questions.

Arbor Health

Patient Access

Emergency Department Registration

Emergency Department Registration Desk is staffed by Patient Access 7 days a week from 7:00am-10:00pm

- Quick Registers all patients who present to the Emergency Department for triage**.**
- Informs RN when they have a triage in a timely manner.
- Completes a full registration once triage is complete, this includes gathering demographic and insurance information. If the patient does not have insurance, they are given an application to apply for Medicaid and a Charity Care application.
- During times when there are no patients in the Emergency Department the staff works on reports to help reduce denials, insurance errors and a self pay report to send out application for Medicaid and Chartiy Care.

Patient Access

Radiology Scheduling

Radiology Scheduler is available Monday-Friday 7:00am-3:30pm

- Receives orders from Arbor Health Referral Coordinators when a patient needs to be schedule for: Cat Scans, Ultrasounds, Mammograms, Nuclear Medicine Scans and MRI's.
- Receives orders from outside Arbor Health providers.
- Reviews orders for accuracy and authorization
- Creates preregistration encounter, verifies insurance and calls patient to place on radiology schedule.
- Mammo's must be reviewed annually to call patients who are due for their screenings.

Patient Access

Authorization and Scheduling

Authorization and Scheduling Representative is available Monday-Friday 6:00am-2:30pm

- Receives orders from Arbor Health providers in the Referral Management module or from outside providers via fax.
- Reviews orders for accuracy and verifies insurance and if authorization is required.
- Once authorization is obtained, the patient is then called and placed on the schedule. Representative creates a preregistration encounter with all the insurance authorization information included.
- Reviews the daily census for patients who are admitted to the hospital, orders and patient status are reviewed for accuracy and notification is submitted when needed.

Patient Access
Challenges

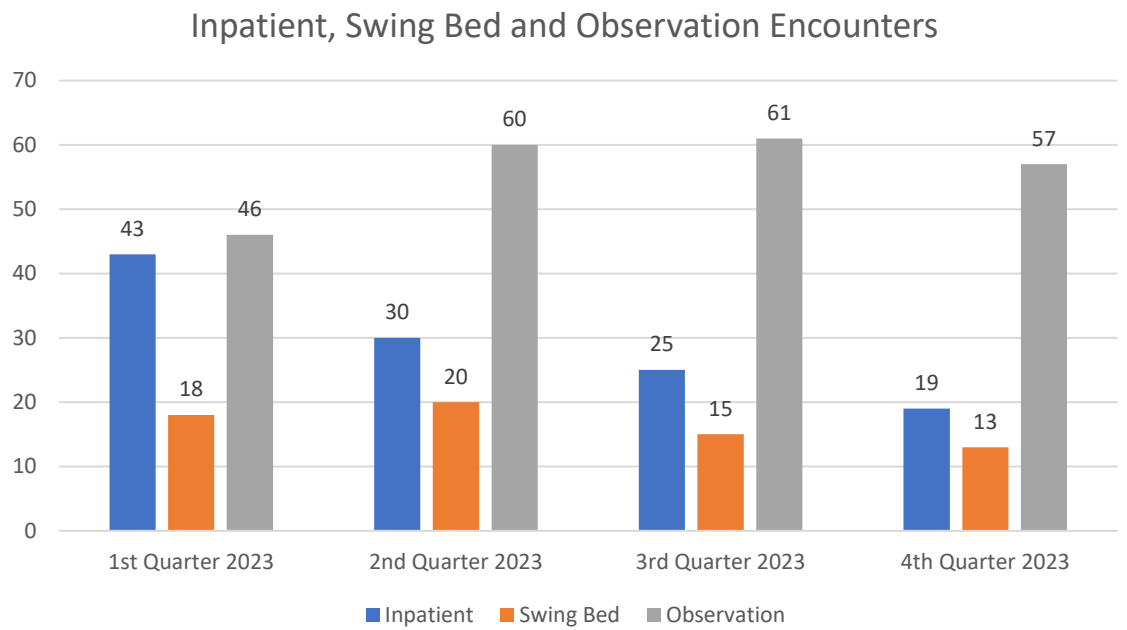
- Staffing: Under utilizing the full 10 FTE's it takes to meet the needs of the average number of encounters created in Arbor Health.
- Registration Denials: Billing sends encounters back to registration to fix errors for denials based on registration errors i.e., incorrect demographic information, incorrect insurance chosen, incorrect policy numbers or group numbers.
- Authorization Denials: Significant adjustments taken on hospital encounters due to missing, incomplete, invalid or expired authorizations. The average monthly amount of authorization denials for 2022 was $46,000. The average adjustment amount each month related to the denials is $13,325 which means 29% of all auth denials result in a write off.
- Payment & Copays: Not consistently collecting payments and copays at time of service.
- Incorrect Status for IP/Observation encounters: Orders being placed for observation or inpatient are not always correct which is difficult for registration to get it right at the start of the admission.
- New SOGI requirements: Collecting sexual orientation and gender identity information at the time of registration.
- IMMs: Not 100% compliant on obtaining IMM's (Important Message from Medicare) at admission and discharge of Medicare patients.

Patient Access
2023 Successes

- Staffing: Hired 2 Full Time and 2 Casual Part Time employees to fully staff the department.
- Registration Errors: Implemented monthly audits to improve knowledge and reduce registration errors.
- Authorization Denials: Tracking authorization denials monthly and reporting on PI (performance improvement) dashboard.
- Incorrect Status for IP/Observation encounters: Patient Access started attending IDT (interdisciplinary team) to help ensure patient status and all required forms are getting signed during a patients stay at the hospital.
- New SOGI requirements: Revamped the Patient Registration Forms to start collecting sexual orientation and gender identity information at the time of registration.
- IMMs: Tracking collection of IMM's at admission and discharge of Medicare patients to improve to 100% compliance.
- Started registering patients in the cubicles full time to allow more patient privacy.

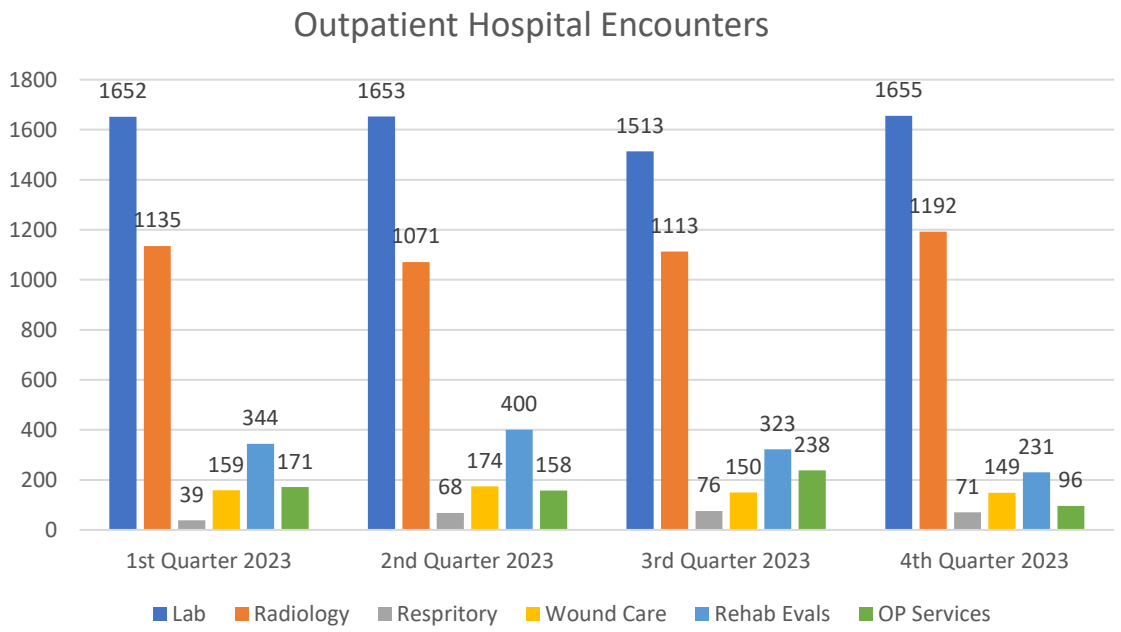
Hospital Admission Encounters for 2023

Total for 2023=407



Hospital Outpatient Encounters for 2023

Total for 2023=13,831



Payment and Copays Collected for 2023

$222,952.13

BOARD COMMITTEE REPORTS

Arbor Health | FOUNDATION

521 Adams Avenue, Morton, WA 98356 | 360-496-3749
Mailing Address: P.O. Box 1132, Morton, WA 98356

Arbor Health Foundation evening meeting
01-08-2024

1. **Call to order** 1210 by Marc Fisher

   OUR MISSION: To raise funds and provide services that will support the viability and long-term goals of the Lewis County Hospital District No. 1. This includes, but is not limited to, taking a leadership role in maintaining and improving community connections and confidence in all aspects of the hospital's health care system.

   Attendance, Lyn Bishop, Christine Brower, Martha Write, Gwen Turner, Marc Fisher, Kip Hendersen Tom Herron Jennine Walker Shannon Kelly Rob Mach, Louise, Kateline Forrest Lenee Langdon Ann Marie

   - **EXCUSED ABSENCES:** Bonnie Justice

2. **Approval of Treasurer's Report and November Minutes**

Motion to approve Minutes and Treasurers report by Louise Fischer second by Kip Henderson

3. **Administrators Report-** Robert Mach: Dr. Heinz accepted the offer and he'll be coming on board soon. January 30 is Healthcare Advocacy Day. WSHA, judge decided she didn't have jurisdiction to rule on the suit WSHA against the State for requiring a no geographical restriction for Charity Care. Signed the affiliation agreement with CC for nursing program. There have been some issues with the HVAC, to include a fire in one portion of the system. Looking at costs to fix/replace/repair – they are 30-40 years old now. Still working on getting orthopedic doctor on board, the issue is there isn't enough volume to warrant a full-time orthopedist.

4. **Executive Directors Report:**

   - Theme for this year is Peter Pan, pirate theme auction. Tinkerbelle Color Run
   - Reviewed the Annual Report
   - Family Resource Fair March 22, 10-12 Molina is sending basketballs. There will be free diapers. Vendors will have raffle items too. If you know of an organization that you think would be good to be part of this let Jessica know.
   - Sign up sheets going around to help other organizations with other local runs coming up.
     - What is Ladies Night? – This is a women's education night.

5. **Old Business:**

- Support Agreement with Hospital is still in process. We have to make some changes to the Article of Incorporation of the Foundation. Legal is working on that.

6. New Business:

- Budget will be presented next month
- Slate of Officers Marc Fisher President, Kateline Forrest Vice President, Bonnie Justice Treasurer, Gwen Turner Secretary.

7. Next Meeting: Feb 12

Good of the order please share.

Commissioner Tom Herron announced two new commissioners Chris Shoemaker and Van Anderson would be sworn into office on January 12th.

ARBOR HEALTH
EXECUTIVE SUMMARY
Fiscal Year Ending: 12/31/23

BALANCE SHEET

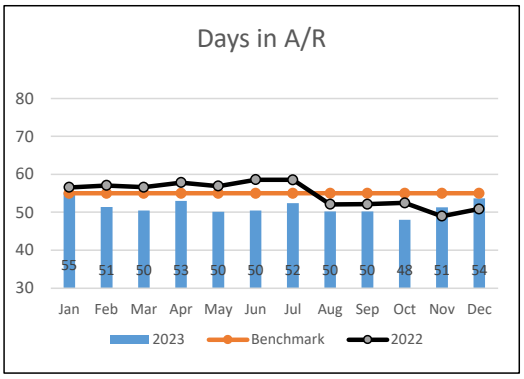
	YTD	Prior YTD
ASSETS	**12/31/2023**	**12/31/2022**
Current Assets	$9,207,497	$10,000,819
Assets Whose Use is Limited	$0	$0
Property, Plant & Equipment (Net)	$9,848,128	$10,472,799
Other Assets	$523,017	$848,578
Total Unrestricted Assets	**$19,578,642**	**$21,322,196**
Restricted Assets	$1,853,293	$1,711,559
Total Assets	**$21,431,935**	**$23,033,755**
LIABILITIES & NET ASSETS		
Current Liabilities	$3,904,005	$3,548,610
Long-Term Debt	$5,809,663	$6,249,856
Other Long-Term Liabilities	$0	$0
Total Liabilities	**$9,713,668**	**$9,798,466**
Net Assets	$11,718,267	$13,235,289
Total Liabilities and Net Assets	**$21,431,935**	**$23,033,755**

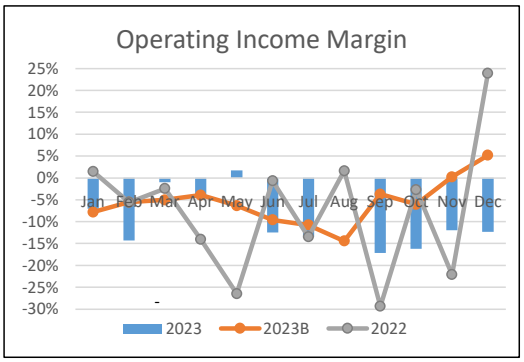
STATEMENT OF REVENUE AND EXPENSES - YTD

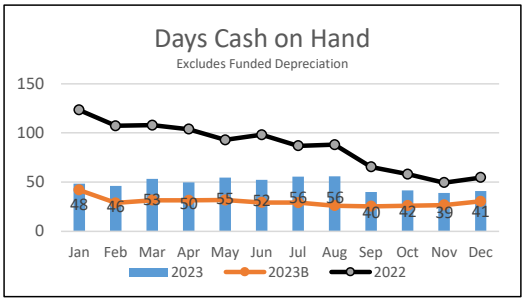
	12/31/2023		YEAR TO DATE	
	ACTUAL	**BUDGET**	**ACTUAL**	**BUDGET**
Gross Patient Revenues	$5,071,449	$5,145,992	$58,079,686	$60,411,834
Discounts and allowances	($2,031,043)	($1,623,631)	($21,322,189)	($22,407,032)
Bad Dbt & Char C Write-Offs	($275,367)	($63,700)	($1,649,205)	($851,525)
Net Patient Revenues	$2,765,039	$3,458,661	$35,108,292	$37,153,277
Other Operating Revenues	$124,749	$103,428	$982,269	$1,241,144
Total Operating Revenues	**$2,889,788**	**$3,562,089**	**$36,090,561**	**$38,394,421**
Salaries & Benefits	$2,246,581	$2,319,440	$26,874,977	$27,801,047
Purchased Serv	$389,915	$422,163	$4,285,533	$4,897,842
Supply Expenses	$255,471	$231,436	$2,969,982	$2,784,239
Other Operating Expenses	$201,080	$265,362	$2,996,505	$3,313,472
Depreciation & Interest Exp.	$153,697	$138,237	$1,880,492	$1,680,935
Total Expenses	**$3,246,744**	**$3,376,638**	**$39,007,489**	**$40,477,535**
NET OPERATING SURPLUS	($356,956)	$185,451	($2,916,928)	($2,083,114)
Non-Operating Revenue/(Exp)	$120,176	$77,949	$1,399,906	$935,384
TOTAL NET SURPLUS	**($236,780)**	**$263,400**	**($1,517,022)**	**($1,147,730)**

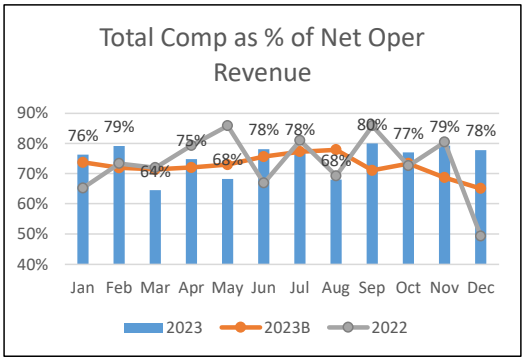
KEY STATISTICS

	12/31/2023		YEAR TO DATE	
	ACTUAL	**BUDGET**	**ACTUAL**	**BUDGET**
Total Inpatient Admits	14	16	119	191
Average Length of Stay	2.40	3.00	4.20	3.00
Total Emergency Room Visits	475	467	5,474	5,600
Outpatient Visits	1,126	1,226	14,471	16,349
Total Surgeries	34	50	474	410









Arbor Health

Cash Forecast

	Actual **January**	Actual **February**	Actual **March**	Actual **April**	Actual **May**	Actual **June**	Actual **July**	Actual **August**	Actual **September**	Actual **October**	Actual **November**	Actual **December**
Planned Cash Reserves												
Total Cash Balance	6,767,215	6,916,201	6,861,634	7,063,075	6,584,059	6,998,206	7,043,631	6,916,644	7,730,325	6,260,430	6,266,839	5,926,125
Operating Reserves	(1,711,559)	(1,719,773)	(1,728,952)	(1,738,547)	(1,746,846)	(1,756,068)	(1,764,576)	(1,772,855)	(1,781,150)	(1,789,272)	(1,797,753)	(1,853,293)
Commitments and Contingencies	-											
Cash, Net of Reserves	5,055,656	5,196,428	5,132,682	5,324,528	4,837,213	5,242,138	5,279,055	5,143,789	5,949,175	4,471,158	4,469,086	4,072,832
Cash Receipts												
Patient Receipts - Run Rate	2,973,519	2,701,154	3,403,324	2,455,154	3,141,600	2,908,195	2,928,378	3,141,864	2,731,523	3,247,402	2,358,446	2,855,827
Non Operating	75,955	299,264	98,949	114,734	99,837	113,299	117,253	97,626	98,112	85,008	88,899	120,176
Other Operating Receipts	56,739	142,326	65,070	72,802	114,258	95,642	(97,354)	148,545	96,102	90,315	78,384	124,748
Total Cash Receipts	3,106,213	3,142,744	3,567,343	2,642,690	3,355,695	3,117,136	2,948,277	3,388,035	2,925,737	3,422,725	2,525,729	3,100,751
Cash Disbursements												
Payroll and Benefits	2,212,316	2,001,921	2,743,985	1,899,223	1,920,312	1,890,252	1,841,187	2,129,478	2,740,854	2,050,487	1,724,894	1,881,709
A/P -	479,413	978,330	198,397	1,009,481	710,533	877,326	1,072,752	187,010	1,169,632	1,149,156	743,510	1,017,343
A/P - Employee Health Claims	194,046	192,108	286,026	166,147	171,597	253,075	126,504	231,128	448,884	156,758	369,050	112,803
Debt Coverage	24,901	24,952	69,706	46,855	47,917	47,358	34,821	26,738	36,262	59,915	28,989	43,839
Property, Plan, Equipment	46,551	-	67,788	-	91,189	3,700	-	-	-	-	-	-
Total Cash Disbursements	2,957,227	3,197,311	3,365,902	3,121,706	2,941,548	3,071,711	3,075,264	2,574,354	4,395,632	3,416,316	2,866,443	3,055,694
Net Change in Cash	**148,986**	**(54,567)**	**201,441**	**(479,016)**	**414,147**	**45,425**	**(126,987)**	**813,681**	**(1,469,895)**	**6,409**	**(340,714)**	**45,057**
Ending Cash Balance	**6,916,201**	**6,861,634**	**7,063,075**	**6,584,059**	**6,998,206**	**7,043,631**	**6,916,644**	**7,730,325**	**6,260,430**	**6,266,839**	**5,926,125**	**5,971,182**
Ending Cash Net Of Reserves	**5,204,642**	**5,141,861**	**5,334,123**	**4,845,512**	**5,251,360**	**5,287,563**	**5,152,068**	**5,957,470**	**4,479,280**	**4,477,567**	**4,128,372**	**4,117,889**

Lewis County Public Hospital District No. 1
Balance Sheet
December, 2023

	Current Month	Prior-Month	Prior-Year end	Incr/(Decr) From PrYr
Assets				
Current Assets:				
Cash	$ 4,117,889	4,128,302	5,055,656	(937,767)
Total Accounts Receivable	8,573,268	8,107,830	7,508,625	1,064,644
Reserve Allowances	(4,503,473)	(3,947,177)	(3,362,569)	(1,140,904)
Net Patient Accounts Receivable	4,069,795	4,160,653	4,146,056	(76,261)
Taxes Receivable	10,893	41,090	52,607	(41,714)
Estimated 3rd Party Receivables	263,159	263,159	(11,605)	274,764
Prepaid Expenses	435,037	343,756	324,031	111,006
Inventory	245,879	268,401	253,658	(7,780)
Funds in Trust	1,853,293	1,797,753	1,711,559	141,734
Other Current Assets	64,846	62,147	180,415	(115,569)
Total Current Assets	11,060,790	11,065,261	11,712,378	(651,587)
Property, Buildings and Equipment	35,226,814	35,035,722	34,963,861	262,953
Accumulated Depreciation	(25,378,687)	(25,280,210)	(24,491,062)	(887,625)
Net Property, Plant, & Equipment	9,848,128	9,755,512	10,472,799	(624,671)
Right-of-use assets	521,017	545,811	681,064	(160,047)
Other Assets	2,000	169,514	167,514	(165,514)
Total Assets	$ 21,431,935	21,536,098	23,033,755	(1,601,820)
Liabilities				
Current Liabilities:				
Accounts Payable	703,936	732,642	697,151	6,785
Accrued Payroll and Related Liabilities	1,200,971	944,412	1,312,233	(111,262)
Accrued Vacation	900,057	867,218	716,055	184,002
Third Party Cost Settlement	68,817	179,790	(69,226)	138,044
Interest Payable	160,367	133,628	0	160,367
Current Maturities - Debt	865,842	865,842	865,842	0
Other Payables	4,015	4,015	26,555	(22,540)
Current Liabilities	3,904,005	3,727,548	3,548,610	355,395
Total Notes Payable	782,904	808,412	1,086,048	(303,144)
Lease Liability	293,063	311,505	431,433	(138,370)
Net Bond Payable	4,733,695	4,733,585	4,732,375	1,321
Total Long Term Liabilities	5,809,663	5,853,503	6,249,856	(440,193)
Total Liabilities	9,713,668	9,581,050	9,798,466	(84,798)
General Fund Balance	13,235,289	13,235,289	13,235,289	0
Net Gain (Loss)	(1,517,022)	(1,280,242)	0	(1,517,022)
Fund Balance	11,718,268	11,955,048	13,235,289	(1,517,022)
Total Liabilities And Fund Balance	$ 21,431,935	21,536,098	23,033,755	(1,601,820)

All Morton General Hospital
Income Statement
December, 2023

Pr Yr MTD	% Var	MTD $ Var	MTD Budget	MTD Actual		YTD Actual	YTD Budget	YTD $ Var	YTD % Var	PY YR YTD
767,720	-31%	(318,072)	1,016,663	698,590	Total Hospital IP Revenues	8,042,273	12,161,942	(4,119,670)	-33.9	6,859,180
3,367,940	9%	309,558	3,558,299	3,867,857	Outpatient Revenues	43,800,888	41,422,451	2,378,437	5.7	39,063,039
462,303	-12%	(66,029)	571,031	505,002	Clinic Revenues	6,236,525	6,827,441	(590,915)	-8.7	5,232,787
4,597,962	-1%	(74,543)	5,145,992	5,071,449	**Total Gross Patient Revenues**	58,079,686	60,411,834	(2,332,147)	-3.9	51,155,005
(1,185,156)	-25%	407,411	(1,623,631)	(2,031,043)	Contractual Allowances	(21,322,189)	(22,407,032)	(1,084,843)	4.8	(16,580,040)
(114,348)	554%	(112,857)	(20,368)	(133,226)	Bad Debt	(922,831)	(242,545)	(680,285)	280.5	(490,237)
(117,959)	228%	(98,808)	(43,332)	(142,141)	Charity Care	(726,374)	(608,980)	(117,394)	19.3	(718,583)
(1,417,463)	37%	(619,077)	(1,687,332)	(2,306,409)	**Total Deductions From Revenue**	(22,971,394)	(23,258,557)	287,163	-1.2	(17,788,860)
3,180,499	**-20%**	**(693,620)**	**3,458,660**	**2,765,040**	**Net Patient Revenues**	**35,108,292**	**37,153,276**	**(2,044,984)**	**-5.5**	**33,366,146**
1,412,988	21%	21,319	103,429	124,748	Other Operating Revenue	982,269	1,241,145	(258,876)	-20.9	2,557,405
4,593,487	**-19%**	**(672,301)**	**3,562,089**	**2,889,788**	**Total Operating Revenue**	**36,090,561**	**38,394,421**	**(2,303,860)**	**-6.0**	**35,923,550**
					Operating Expenses					
1,980,774	-1%	(28,265)	1,925,288	1,953,553	Salaries	22,429,708	23,053,472	623,765	2.7	21,427,371
(69,081)	26%	101,124	394,152	293,028	Total Benefits	4,445,269	4,747,575	302,306	6.4	3,914,496
1,911,693	3%	72,859	2,319,440	2,246,581	Salaries And Benefits	26,874,977	27,801,047	926,070	3.3	25,341,867
156,081	65%	81,712	125,178	43,466	Professional Fees	1,451,059	1,640,308	189,249	11.5	1,648,430
349,184	-10%	(24,035)	231,436	255,471	Supplies	2,969,982	2,784,239	(185,743)	-6.7	2,771,740
121,054	8%	32,249	422,163	389,915	Total Purchased Services	4,285,533	4,897,842	612,309	12.5	4,177,454
82,998	12%	7,488	62,196	54,708	Utilities	503,986	562,930	58,944	10.5	593,257
36,659	-7%	(2,287)	30,695	32,981	Insurance Expense	370,404	368,338	(2,066)	-0.6	308,975
375,890	-13%	(14,132)	109,248	123,380	Depreciation and Amortization	1,496,218	1,333,070	(163,148)	-12.2	1,573,152
78,848	-5%	(1,328)	28,989	30,317	Interest Expense	384,274	347,865	(36,409)	-10.5	414,941
52,971	-48%	(22,633)	47,292	69,926	Other Expense	671,056	741,895	70,838	9.5	635,151
3,165,378	4%	129,894	3,376,638	3,246,744	**Total Operating Expenses**	39,007,489	40,477,535	1,470,046	3.6	37,464,968
1,428,110	-292%	(542,407)	185,451	(356,956)	**Income (Loss) From Operations**	(2,916,928)	(2,083,113)	(833,814)	40.0	(1,541,418)
331,686	-54%	(42,227)	77,949	120,176	Non-Operating Revenue/Expense	1,399,906	935,383	(464,523)	-49.7	1,957,693
1,759,795	**-190%**	**(500,180)**	**263,400**	**(236,780)**	**Net Gain (Loss)**	**(1,517,022)**	**(1,147,730)**	**(369,292)**	**32.2**	**416,275**

Lewis County Hospital District No. 1
Income Statement
December, 2023

CURRENT MONTH						YEAR TO DATE				
Pr Yr Month	% Var	$ Var	Budget	Actual		Actual	Budget	$ Var	% Var	Actual
767,720	-31%	(318,072)	1,016,663	698,590	Inpatient Revenue	8,042,273	12,161,942	(4,119,670)	-34%	6,859,180
3,367,940	9%	309,558	3,558,299	3,867,857	Outpatient Revenue	43,800,888	41,422,451	2,378,437	6%	39,063,039
462,303	-12%	(66,029)	571,031	505,002	Clinic Revenue	6,236,525	6,827,441	(590,915)	-9%	5,232,787
4,597,962	-1%	(74,543)	5,145,992	5,071,449	**Gross Patient Revenues**	**58,079,686**	60,411,834	(2,332,147)	-4%	51,155,005
1,361,273	-25%	(407,411)	1,623,631	2,031,043	Contractual Allowances	21,355,581	22,407,032	1,051,451	5%	16,741,201
117,959	-228%	(98,808)	43,332	142,141	Charity Care	726,374	608,980	(117,394)	-19%	718,583
114,348	-554%	(112,857)	20,368	133,226	Bad Debt	922,831	242,545	(680,285)	-280%	490,237
1,593,580	-37%	(619,077)	1,687,332	2,306,409	**Deductions from Revenue**	**23,004,786**	23,258,557	253,771	1%	17,950,021
3,004,382	**-20%**	**(693,620)**	**3,458,660**	**2,765,040**	**Net Patient Service Rev**	**35,074,900**	**37,153,276**	**(2,078,376)**	**-6%**	**33,204,985**
65.3%	18.9%	12.7%	67.2%	54.5%	**NPSR %**	60.4%	61.5%	1.1%	1.8%	64.9%
1,412,988	21%	21,319	103,429	124,748	Other Operating Revenue	982,269	1,241,145	(258,876)	-21%	2,557,405
4,417,370	**-19%**	**(672,301)**	**3,562,089**	**2,889,788**	**Net Operating Revenue**	**36,057,169**	**38,394,421**	**(2,337,252)**	**-6%**	**35,762,389**
					Operating Expenses					
1,980,774	-1%	(28,265)	1,925,288	1,953,553	Salaries & Wages	22,429,708	23,053,472	623,765	3%	21,427,371
(69,081)	26%	101,124	394,152	293,028	Benefits	4,445,269	4,747,575	302,306	6%	3,914,496
156,081	65%	81,712	125,178	43,466	Professional Fees	1,451,059	1,640,308	189,249	12%	1,648,430
349,184	-10%	(24,035)	231,436	255,471	Supplies	2,969,982	2,784,239	(185,743)	-7%	2,771,740
121,054	8%	32,249	422,163	389,915	Purchase Services	4,285,533	4,897,842	612,309	13%	4,177,454
82,998	12%	7,488	62,196	54,708	Utilities	503,986	562,930	58,944	10%	593,257
36,659	-7%	(2,287)	30,695	32,981	Insurance	370,404	368,338	(2,066)	-1%	308,975
52,971	-48%	(22,633)	47,292	69,926	Other Expenses	671,056	741,895	70,838	10%	635,151
2,710,639	4%	145,353	3,238,401	3,093,048	EBDITA Expenses	37,126,997	38,796,599	1,669,602	4%	35,476,875
1,706,731	-163%	(526,948)	323,688	(203,259)	**EBDITA**	(1,069,828)	(402,178)	(667,650)	166%	285,515
38.6%	177.4%	16.1%	9.1%	-7.0%	EBDITA %	-3.0%	-1.0%	1.9%	-183.3%	0.8%
					Capital Cost					
375,890	-13%	(14,132)	109,248	123,380	Depreciation	1,496,218	1,333,070	(163,148)	-12%	1,573,152
78,848	-5%	(1,328)	28,989	30,317	Interest Cost	384,274	347,865	(36,409)	-10%	414,941
3,165,378	4%	129,894	3,376,638	3,246,744	Operating Expenses	39,007,489	40,477,535	1,470,046	4%	37,464,968
1,251,993	-292%	(542,407)	185,451	(356,956)	**Operating Income / (Loss)**	(2,950,320)	(2,083,113)	(867,206)	42%	(1,702,579)
28.3%			5.2%	-12.4%	Operating Margin %	-8.2%	-5.4%			-4.8%
176,117	0%	0	0	0	**Mcare/Mcaid Pr Yr**	33,392	0	(33,392)	0%	161,161
					Non Operating Activity					
335,491	57%	46,537	81,737	128,274	Non-Op Revenue	1,459,372	980,841	478,531	49%	2,014,392
3,805	-114%	(4,309)	3,788	8,098	Non-Op Expenses	59,466	45,458	(14,008)	-31%	56,700
331,686	54%	42,227	77,949	120,176	Net Non Operating Activity	1,399,906	935,383	464,523	50%	1,957,693
1,759,795	-190%	(500,180)	263,400	(236,780)	**Net Income / (Loss)**	(1,517,022)	(1,147,730)	(369,292)	32%	416,275
39.8%			7.4%	-8.2%	Net Income Margin %	-4.2%	-3.0%			1.2%

Arbor Health
Cash Flow Statement
For the Month Ending December 2023

	MTD	YTD
Cash Flows from Operating Activites		
Net Income	(236,780)	(1,517,022)
Adjustments to reconcile net income to net cash provided by operating activities		
Decrease/(Increase) in Net Patient Accounts receivable	90,787	76,261
Decrease/(Increase) in Taxes receivable	30,197	41,714
Decrease/(Increase) in Est 3rd Party Receivable	0	(274,764)
Decrease/(Increase) in Prepaid expenses	(91,281)	(111,006)
Decrease/(Increase) in Inventories	22,522	7,779
Decrease in Other Current Assets	(2,699)	115,570
Increase/(Decrease) in Accrued payroll liabilities	289,398	72,740
Increase/(Decrease) in 3rd Party cost stlmt liabilities	(110,973)	138,043
Increase/(Decrease) in Accounts payable	(28,707)	(15,755)
Increase/(Decrease) in Interest payable	26,739	160,367
Depreciation expense	98,477	887,625
Net Cash Flow from Operations	87,680	(418,448)
Cash Flows from Investing Activities		
Cash paid for		
Purchases of Fixed assets	(191,092)	(262,954)
Right-of-use assets	192,308	325,562
Net Cash Flow from (used) in Investing Activities	1,216	62,608
Cash Flows from Financing Activities		
Cash paid for		
Additions to long-term debt	0	0
Principal payments of long-term liabilities	(25,397)	(301,823)
Lease liabilities	(18,442)	(138,370)
Net Cash Flow from (used) in Financing Activities	(43,839)	(440,193)
Net Increase (Decrease) in Cash	45,057	(796,033)
Cash at Beginning of Period	$ 5,926,126	$ 6,767,215
Cash at End of Period	$ 5,971,183	$ 5,971,182

CONSENT AGENDA

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Finance Committee Meeting
December 20, 2023, at 12:00 p.m.
Via Zoom

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide every patient the best care and every employee the best place to work.

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Call to Order Roll Call Excused/ Unexcused Absences Conflicts of Interest	Commissioner Coppock called the meeting to order via Zoom at 12:00 p.m. Commissioner(s) Present in Person or via Zoom: ☒ Craig Coppock, Commissioner ☒ Wes McMahan, Commissioner Committee Member(s) Present in Person or via Zoom: ☒ Shana Garcia, Executive Assistant ☒ Cheryl Cornwell, CFO ☒ Robert Mach, Superintendent ☒ Marc Fisher, Community Member ☒ Clint Scogin, Controller ☒ Sherry Sofich, Revenue Cycle Director ☒ Barbara van Duren, CNO/CQO ☒ Julie Taylor, Ancillary Services Director	Excused: None Unexcused Absences: None		
Approval or Amendment of Agenda		Commissioner McMahan made a motion to approve the agenda and Community Member Fisher seconded. The motion passed unanimously.		

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Conflicts of Interest	Commissioner Coppock asked the Committee to state any conflicts of interest with today's agenda.	None noted.		
Consent Agenda	Commissioner Coppock announced the following in consent agenda up for approval: 1. Review of Finance Minutes –November 22, 2023 2. Revenue Cycle 3. Board Oversight Activities	Commissioner McMahan made a motion to approve the consent agenda and Community Member Fisher seconded. The motion passed unanimously.		
Old Business • Financial Department Spotlight	Commissioner Coppock noted spotlights will resume in January 2024 to align with the Board meetings.			
• CFO Financial Review	CFO Cornwell shared the following highlights: 1. November was another tough month with volumes being lower than budget in both Swing bed and the ED. Surgery is the bright spot. a. The 96-hour rule continues to apply and is being discussed further at UR Committee. 2. Net Income MTD is showing a loss of ($264,106). With revenue trending behind budget, the continued denials from Medicare Advantage Plans which increases bad debt and is really a sign of the current state of the economy. 3. Cash decreased by 3 days and accounts receivable increased by 3 days. As a reminder, even though the purchases for the CT and MRI were approved, the leases have not been signed and have not been recognized to date. 4. Still no new news regarding the ERC credit. 5. Anticipating there may be a pick up on the cost report			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	given prior year experiences. The interim cost report was filed in third quarter given the auditor switch and the outcome was a receivable to the District. 6. YTD the District is still stronger than budget with plans to grow revenue in 2024. Improvements include adding FT ultrasound, signing a fulltime clinic provider, adding a nurse to the hospital staff plan to ensure we can admit patients.			
New Business • 340b Update	CFO Cornwell highlighted that a group was hired to audit the 340b program given the past year's performance. The findings showed it was not set up properly from the start with missing data but with the changes made we may be able to retro back to April 2023. To date, 340b is not making money but anticipating a shift in the next couple quarters to become positive. Highest utilization comes from the Chehalis Safeway and Walmart. Kirks Pharmacy stopped participating in 2022 and Coltons has never participated in 340b.			
• Long-term Debt Schedule	CFO Cornwell shared the long-term debt schedule for the District. In 2023, the leases are now included and not just recorded as a monthly expense.			
• Medicare & Medicaid Rate Adjustments	CFO Cornwell shared the hospital and RHC rates adjustments for Medicare and Medicaid. The District continues to utilize the cost reporting tool monthly which tends to be conservative at best.			
Meeting Summary & Evaluation	CFO Cornwell highlighted the decisions made and action items that need to be taken to the entire board for approval. Commissioner McMahan acknowledged the ongoing			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	healthcare issues and complimented the dedication of the staff on their problem solving and being solution based. Also, a great discussion on Artificial Intelligence and the potential future in healthcare.			
Adjournment	Commissioner Coppock adjourned the meeting at 12:44 pm.			

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
REGULAR BOARD OF COMMISSIONERS' MEETING
December 20, 2023, at 3:30 p.m.
Conference Room 1 & 2 and via ZOOM
https://myarborhealth.zoom.us/j/83730587850
Meeting ID: 837 3058 7850
One tap mobile: +12532050468,,83730587850#
Dial: +1 253 205 0468 US

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide every patient the best care and every employee the best place to work.

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Call to Order **Roll Call** **Unexcused/Excused Absences** **Reading the Mission & Vision Statements**	Board Chair Herrin called the meeting to order at 3:30 p.m. **Commissioners present:** ☒ Tom Herrin, Board Chair ☐ Kim Olive, Secretary ☒ Wes McMahan ☒ Craig Coppock ☒ Trish Frady **Others present:** ☒ Robert Mach, Superintendent ☒ Shana Garcia, Executive Assistant ☒ Barbara Van Duren, CNO/CQO ☒ Cheryl Cornwell, CFO ☒ Shannon Kelly, CHRO ☐ Julie Taylor, Ancillary Services Director ☐ Dr. Kevin McCurry, CMO ☐ Matthew Lindstrom, CFMO ☒ Spencer Hargett, Compliance Officer ☒ Barb Goble, Medical Staff Coordinator	Excused: Secretary Olive		

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	☒ Dr. Travis Podbilski, Chief of Staff ☒ Clint Scogin, Controller ☒ Julie Johnson, QMRC Manager ☒ Jessica Scogin, Foundation Manager ☒ Van Anderson, Community Member ☒ Diane Markham, Marketing and Communication Manager ☒ Chris Schumaker, Community Member Board Chair Herrin noted the chat function has been disabled and the meeting will not be recorded.			
Approval or Amendment of Agenda	Board Chair Herrin requested to amend the agenda by removing the Oath of Office due to illness. Commissioner McMahan proposed removing committee assignments until the Chair and Secretary are elected in January. Board Chair Herrin reiterated the importance of assigning the committee membership, as committees will resume prior to the regular board meeting and whoever is elected board chair can swap assignments at that time.	Commissioner Frady made a motion to approve the amended agenda. Commissioner Coppock seconded, and the motion passed unanimously.		
Conflicts of Interest	Board Chair Herrin asked the attendees to state any conflicts of interest with today's amended agenda.	None noted.		
Comments and Remarks	Commissioners: Commissioner Frady commended Dr. Podbilski on his recent appearance on New Day Northwest. Also, extended an awesome job to Diane Markham for setting up this opportunity. Lastly, a big thank you to all staff this past year while being on the Board again. Both Commissioners Coppock and McMahan thanked Commissioners Frady and Olive for assisting in the process for being both productive and moving the District forward. They welcomed Van Anderson and Chris			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	Schumaker to the Board, and were excited to see so much interest in the Board. Lastly, they commended Dr. Travis on sharing the message on extended-care rehab. Board Chair Herrin thanked Commissioner Frady for coming back and bringing us forward in 2023. Also, thanked Commissioner Olive and wished her the best. Lastly, echoed a welcome to Van and Chris, as well as looking forward to working with them both. Audience: Van Anderson inquired if Rehabilitation Services and other hospital services can have automated calls for appointments for all services to reduce no shows and potential fees.	Follow up with Rehabilitation Services Director on this topic.	Superintendent Mach	01.31.24
Executive Session- RCW 70.41.200	Board Chair Herrin announced going into executive session at 3:41 p.m. for ten minutes to discuss RCW 70.41.200-Medical Privileging and Quality Improvement Oversight Report. The Board returned to open session at 3:51 p.m. Board Chair Herrin noted no decisions were made in Executive Session. Reappointments: Arbor Health 1. Kevin McCurry, MD (Emergency Medicine Privileges) (Family Medicine Privileges) 2. Amy Nielsen, CRNA (Anesthesia Privileges) 3. Kevin Gurney, CRNA (Anesthesia Privileges) Radiology Consulting Privileges 4. Alice Josafat, MD (Radiology Consulting Privileges)	Commissioner Coppock made a motion to approve the Medical Privileging as presented, Commissioner Frady seconded. The motion passed unanimously.		

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	5. John McGowan, MD (Radiology Consulting Privileges) 6. Ross Ondersma, MD (Radiology Consulting Privileges) 7. Matthew Stein, MD (Radiology Consulting Privileges) Providence Health & Services (privileging by proxy) 8. James Jordan, MD (Telestroke/Neurology Consulting Privileges) 9. Mimi Lee, MD (Telestroke/Neurology Consulting Privileges) 10. James Wang, MD (Telestroke/Neurology Consulting Privileges) PeaceHealth 11. Helen Kim, MD (Pathology Consulting Privileges)			
Department Spotlight • Deferred	Board Chair Herrin noted the spotlight has been deferred to January to align with Finance Committee again.			
Board Committee Reports • Hospital Foundation Report	Foundation Manager Scogin shared the auction proceeds will be allocated to the Rapid Care Clinic, Foundation Giving Day was a success and employees were thankful again this year for the appreciation gift, holiday gift shop sale was a success, an Arbor Health Foundation Memorial Plaque will be coming soon. Commissioner McMahan inquired if someone wants to earmark a donation on a personal level for developing public relationship is this possible through the Foundation.	Follow up on earmarking donations through the Foundation.	Foundation Manager Scogin	01.31.24

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
• Finance Committee Report	Commissioner Coppock highlighted the November meeting noting the spotlight from EVS, an update on both the AH Retirement Fund, as well as the AH Self-Insured Health Insurance Plan, the Property Tax Levy Options and the continued challenges on volumes and revenues in 2023. Commissioner Coppock shared the November financials from today's meeting, and we continue monitor financial performance. The leaders in the District are reviewing and continually looking for opportunities to grow revenue.			
Consent Agenda	Board Chair Herrin announced the consent agenda items for consideration of approval: 1. Approval of Minutes a. November 13, 2023, Special Board Meeting b. November 15, 2023, Regular Board Meeting c. November 22, 2023, Finance Committee Meeting d. November 27, 2023, Special Board Meeting e. December 13, 2023, QIO Committee Meeting 2. Warrants & EFTs in the amount of $3,677,730.69 dated November 2023 3. 2024 Medical Staff Appointments	Commissioner McMahan made a motion to approve the Consent Agenda and Commissioner Coppock seconded. The motion passed unanimously. Minutes and Warrants will be sent for electronic signatures.	Executive Assistant Garcia	01.02.24
Old Business • Board Self Evaluation	Board Chair Herrin reviewed the results of the Board Self-Evaluation and highlighted the ones less than 4.8. A couple areas of broader discussion included board orientation, regularly reviews and evaluates the performance of the Superintendent and district partnerships. The Board agreed to	Update the annual calendar and policy/procedure to include the Superintendent Evaluation updates. Schedule quarterly updates with District	Board Chair Herrin & EA Garcia Superintendent Mach	01.31.24 01.31.24

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	the orientation outlined in the packet, as well as a mentorship/buddy system for the first year with monthly check ins by this person. The Board requested revising the Superintendent Evaluation process to move to Superintendent Mach's start date in June. This will allow the Superintendent to turn the prior years goals and results into the Board in April for the Board to meet in Executive Session in May to review with the Superintendent in Executive Session in June/July. Also, the Board wants at least quarterly updates on district partnerships with AWPHD, WSHA, Choice, TRC, ACO as either guest speakers or through Superintendent Report.	partnerships either in person or in the Superintendent's Report.		
New Business • 2024 Organization & Officers of the Board of Commissioners	Board Chair Herrin presented the following committee assignments and noted whoever is elected Board Chair can just swap spots.  2024 Organization & Officers of the Board of Commissioners Effective Date: January 1, 2024 Board Leadership / Board Representation Board Chair: TBD Board Secretary: TBD Committee / Administration Representation / Committee Chair / Board Representation Finance: Superintendent & CFO / Wes McMahan / Van Anderson QI Oversight: Superintendent & CNO/CQO / Craig Coppock / Van Anderson Governance: Superintendent / Board Chair / Secretary Plant Planning: Superintendent & CFO / Wes McMahan / Chris Schumaker Strategic Planning: Superintendent / Board of Commissioners Compliance Committee: Superintendent & Compliance Officer / Craig Coppock / Chris Schumaker Other Board Representation / Board Representation Foundation: Tom Herrin State Representation: Wes McMahan	Send calendar invites for committee meetings.	Executive Assistant Garcia	Post 01.31.24 Board Meeting
• Board Policy and Procedure Review	Board Chair Herrin presented the following policies/procedures for review and/or revision: 1. Code of Ethics-Marked a Revised and Approved with Recommended Edits. 2. Annual CEO/Superintendent Evaluation-Approve with Edits-Include new timeline, two months before annual review is due the Superintendent completes the evaluation, the Board meetings one month before	Commissioner McMahan made a motion to approve the two P & P's and revise two P & P's as noted and Commissioner Coppock seconded. The motion passed unanimously. Mark Board Spending Authority and Records Retention as	 Executive Assistant Garcia	 01.02.24

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	to complete the review and the review is given the month of hire. 3. Board Spending Authority-Marked as Reviewed. 4. Records Retention-Marked as Reviewed.	Reviewed in Lucidoc. Mark Code of Ethics and Annual CEO/Superintendent Evaluation as Revised in Lucidoc.		
• New Commissioner Orientation	Board Chair Herrin noted the upcoming orientation for the new commissioners tentatively scheduled for January 12th, 2024. Executive Assistant Garcia will finalize the date and coordinate the schedule. Superintendent Mach and Notary Jennifer Smith will work with Commissioners Anderson and Schumaker to administer the Oath of Office tentatively for December 29, 2023.	Schedule Oath of Office.	Superintendent Mach	12.29.23
Superintendent Report	Superintendent Mach highlighted the memo in the packet and added the following updates: 1. Dr. Hines has officially agreed to join our Medical Staff in 2024. 2. Collaborating with Centralia College. 3. Dr. Ford is retiring and actively working on his replacement. 4. In compliance with the latest Charity Care requirements. 5. Folling SB1893 as it is a bill proposing to change the scope of service for EMT's. 6. Continue to receive denials from Medicare Advantage which is over 50% of our business. 7. Penetration testing in progress, a report coming soon to the Board. CHRO Kelly shared as recruitment ends for 2023 13 positions were filled, 7 of which are hard to fill positions. In the process of			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	restarting the NAC programs. Marketing and Communication Manager Markham shared the great success on the New Day Northwest interview with Dr. Travis and also noted there are extended care rehab video brochures to share with patients too. CNO/CQO Van Duren shared the new hospital staffing plan is in process and will be submitted before the end of the year to DOH. The new model will include an additional RN to improve our ability to admit patients and provide better safe, quality patient care.			
Meeting Summary & Evaluation	Superintendent Mach highlighted the meeting which included decisions made and action items. Commissioner Frady noted a good final meeting. Commissioner Coppock noted a good meeting. Commissioner McMahan enjoyed the special reports and hopes Dr. Travis continues his career in medicine and not a future career in showbiz. Board Chair Herrin and Superintendent Mach thanked Commissioner Frady for her services and sad that Secretary Olive was unable to be here; however, she is where she needs to be with her family. Best wishes and welcome to Commissioners Anderson and Schumaker!			
Adjournment		Commissioner Coppock moved, and Commissioner Frady seconded to adjourn the meeting at 5:15 p.m. The motion passed unanimously.		

Respectfully submitted,

Kim Olive, Secretary Date

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Finance Committee Meeting
January 24, 2024, at 12:00 p.m.
Via Zoom

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide every patient the best care and every employee the best place to work.

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Call to Order Roll Call Excused/ Unexcused Absences Conflicts of Interest	Commissioner McMahan called the meeting to order via Zoom at 12:00 p.m. Commissioner(s) Present in Person or via Zoom: ☒ Wes McMahan, Commissioner ☒ Van Anderson, Commissioner Committee Member(s) Present in Person or via Zoom: ☒ Shana Garcia, Executive Assistant ☒ Cheryl Cornwell, CFO ☒ Robert Mach, Superintendent ☒ Marc Fisher, Community Member ☐ Clint Scogin, Controller ☒ Sherry Sofich, Revenue Cycle Director ☒ Barbara van Duren, CNO/CQO ☐ Julie Taylor, Ancillary Services Director ☒ Will Sullivan, Facility Engineering Manager ☒ Robert Houser, Imaging Manager	Excused: Julie Taylor (Lab) & Clint Scogin (PTO) Unexcused Absences: None		
Approval or Amendment of Agenda		Superintendent Mach made a motion to approve the agenda and Community Member		

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
		Fisher seconded. The motion passed unanimously.		
Conflicts of Interest	Commissioner McMahan asked the Committee to state any conflicts of interest with today's agenda.	None noted.		
Consent Agenda	Commissioner McMahan requested more information related to the Revenue Cycle Update regarding the Packwood Clinic. Revenue Cycle Director Sofich shared this remains a real concern that may need to be escalated to the WA Health Care Authority. The Rural Collaborative is assisting on a larger claim basis, as hospitals across the state are experiencing the same challenges. CFO Cornwell shared not only is the District small but resources and monies are limited to fight payers. Commissioner McMahan recommended taking a legislative route to the senators on these issues which Superintendent Mach agreed was on his list for next during advocacy day for hospitals. Commissioner McMahan announced the following in consent agenda up for approval: 1. Review of Finance Minutes –December 20, 2023 2. Revenue Cycle 3. Board Oversight Activities	Superintendent Mach made a motion to approve the consent agenda and Community Member Fisher seconded. The motion passed unanimously.		
Old Business • CFO Financial Review	CFO Cornwell included a 2023 Actual versus Budget Profit and Loss memo. The District is carefully reviewing monthly the financials, as the hospital is staffed to bring in more revenue so finding the services and patients to serve is next steps. CFO Cornwell clarified that bad debt is patients who cannot or will not pay their bills and we offer them charity care. The patient may or may not be interested or eligible, so they become self-pay and sent to collections. Again, the bad debt and charity care numbers are correct; however, the need			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	refining into the smaller buckets. This becomes a software issue related to Cerner and Multiveiw, which Controller Scogin in researching. Remember is was a tough year for patients and the economy affecting revenue and collections. CFO Cornwell is exploring to do a revenue cycle audit to ensure we are meeting the industry standards and gain a better understanding. CFO Cornwell included the quarterly service lines newest to the District. Packwood Clinic is operating at a loss which was expected. Rapid Care is well on its way, as well as Podiatry is a great success. Orthopedics is not on pace and we no longer have a doctor in this position, so room to grow this program.			
New Business • 501 (r) Discount Calculation	CFO Cornwell shared the 501 (r) calculation is required annual. This is to ensure patients are treated equal regardless of insurance status. This is included in the District's financial assistance policy.			
• Capital Review • Ultrasound Equipment • Replacement of HVAC	Imaging Manager Houser shared the current ultrasound equipment is from 2012 and approaching end of life. Industry standard is replacing every 5-7 years, conservatively 7-10 years, so the hospital is due not only for aging but for software and imaging quality issues. In order to not disrupt patient care or reads to stop happening due images, we are proposing to purchase two ultrasounds. The Arbor Health Foundation has received a grant and has approved to fund this equipment up to $70,000. The pricing is considerably strong, as we are essentially getting two for the price of one. The MRI was purchase through Siemens and they service our location. This will add revenue and capability. The department was just approved to hire another	The Finance Committee supported requesting the Board's approval of a resolution for Ultrasound Equipment at the Regular Board Meeting.	Executive Assistant Garcia	01.31.24

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	ultrasound tech to increase access for patients. CFO Cornwell is proposing to maintain cash, we should move forward with leasing the equipment as it should be positive cash flow. CNO/CQO Van Duren noted at least weekly we transfer patients due ultrasound access, so this could improve quality of care for patients to stay with Arbor Health. The Finance Committee supports the resolution and will recommend approval at the Board level in New Business. Facility Engineering Manager Sullivan highlighted that the District continues to replace HVAC units on campus. This time it includes Administration/Specialty Clinic and the Nurses Station Area. The HVAC units continue to age, and the facilities team is tracking to replace to hopefully manage costs along the way. The units costs were within Superintendent Mach's spending authority but want to keep the Finance Committee informed.			
• Surplus or Dispose of Personal Property	CFO Cornwell presented the list of assets for surplus. The Finance Committee supports the resolution and will recommend approval at the Board level in Consent Agenda.	The Finance Committee supported requesting the Board's approval of a resolution of the Surplus at the Regular Board Meeting.	Executive Assistant Garcia	01.31.24
Meeting Summary & Evaluation	CFO Cornwell highlighted the decisions made and action items that need to be taken to the entire board for approval. Commissioner McMahan appreciates the Finance Committees patience with the questions and values the work being done.			
Adjournment	Commissioner McMahan adjourned the meeting at 1:26 pm.			

WARRANT & EFT LISTING NO. 2023-12

RECORD OF CLAIMS ALLOWED BY THE BOARD OF LEWIS COUNTY COMMISSIONERS

The following vouchers have been audited, charged to the proper account, and are within the budget appropriation.

CERTIFICATION

I, the undersigned, do hereby certify, under penalty of perjury, that the materials have been furnished, as described herein, and that the claim is a just, due and unpaid obligation against LEWIS COUNTY HOSPITAL DISTRICT NO. 1 and that I am authorized to authenticate and certify said claim.

Signed:

Cheryl Cornwell, CFO

We, the undersigned Lewis County Hospital District No. 1 Commissioners, do hereby certify that the merchandise or services hereinafter specified has been received and that total Warrants and EFT's are approved for payment in the amount of

$2,843,226.26 this 31st day

of January 2024

Board Chair, Tom Herrin

Commissioner, Wes McMahan

Commissioner, Craig Coppock

Commissioner, Van Anderson

Commissioner, Chris Schumaker

SEE WARRANT & EFT REGISTER in the amount of $2,843,226.26 dated December 1, 2023 – December 31, 2023.

Dec-23
ARBOR HEALTH WARRANT REGISTER

Routine A/P Runs

Warrant No.	Date	Amount	Description
132386 - 132428	1-Dec-2023	51,768.81	CHECK RUN
132429 - 132464	1-Dec-2023	230,323.57	CHECK RUN
132465 - 132472	1-Dec-2023	79,187.52	CHECK RUN
132473 - 132513	8-Dec-2023	107,900.30	CHECK RUN
132514 - 132531	11-Dec-2023	205,657.71	CHECK RUN
132532 - 132593	15-Dec-2023	452,446.72	CHECK RUN
132594 - 132611	18-Dec-2023	789,468.79	CHECK RUN
132612	4-Dec-2023	40.70	CHECK RUN
132613	5-Dec-2023	227.17	CHECK RUN
132614	11-Dec-2023	1,000.00	CHECK RUN
132615	12-Dec-2023	207.30	CHECK RUN
132616 132635	19-Dec-2023	108,176.10	CHECK RUN
132636 - 132680	22-Dec-2023	187,788.90	CHECK RUN
132681 - 132690	26-Dec-2023	35,546.37	CHECK RUN
132691 - 132734	29-Dec-2023	186,335.70	CHECK RUN
132749	15-Dec-2023	22,425.59	CHECK RUN
132750	18-Dec-2023	3,706.31	CHECK RUN
132751	19-Dec-2023	97.35	CHECK RUN
132752	22-Dec-2023	660.20	CHECK RUN
132753 - 132755	26-Dec-2023	23,500.32	CHECK RUN
132756	28-Dec-2023	419.25	CHECK RUN
132757 - 132758	28-Dec-2023	663.79	CHECK RUN
Total - Check Runs		**$ 2,487,548.47**	

Error Corrections - in Check Register Order

Warrant No.	Date Voided	Amount	Description
132756	28-Dec-23	(419.25)	VOID CHECK
TOTAL - VOIDED CHECKS		**$ (419.25)**	

UMPQUA BANK CHECKS, EFT'S, LESS VOIDS	**$ 2,487,967.72**

Eft	Date	Amount	Description
4783	4-Dec-2023	759.12	TPSC
1214	7-Dec-2023	175,534.93	IRS
4784	11-Dec-2023	422.81	TPSC
4785	18-Dec-2023	1,758.06	TPSC
4786	22-Dec-2023	132.00	TPSC
4787	26-Dec-2023	1,988.07	TPSC
1215	22-Dec-2023	170,082.80	IRS
4788	19-Dec-2023	5,000.00	BBP ADMIN
TOTAL EFTS AT SECURITY STATE BANK		**$ 355,677.79**	

TOTAL CHECKS, EFT'S, &TRANSFERS	**$ 2,843,226.26**

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION ADOPTING THE
FLEXIBLE SPENDING ACCOUNT PLAN (FSA) RESOLUTION NO. 24-01

WHEREAS, the Lewis County Hospital District No. 1 owns and operates Arbor Health, a 25-bed Critical Access Hospital located in Morton, Washington, and;

WHEREAS, the Lewis County Hospital District No. 1 feel that this is worthy,

NOW, THEREFORE, BE IT RESOLVED by the Commissioners of Lewis County Hospital District No. 1 as follows:

The undersigned authorized representative of Arbor Health (the Employer) hereby certifies that the following resolution was duly adopted by the governing body of the Employer on January 31, 2024, and that such resolution has not been modified or rescinded as the date hereof:

RESOLVED, that the form of Welfare Benefit Plan, effective January 1, 2024, presented to this meeting (and a copy of which is attached hereto) is hereby approved and adopted, and that the proper agents of the Employer are hereby authorized and directed to execute and deliver to the Administrator of said Plan one or more counterparts of the Plan.

RESOLVED, that the Administrator shall be instructed to take such actions that the Administrator deems necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures for the provision of benefits under the Plan.

RESOLVED, that the proper agents of the Employer shall act as soon as possible to notify the employees of the Employer of the adoption of the Plan to deliver to each employee a copy of the Summary Plan Description of the Plan, which Summary Plan Description is attached hereto and is hereby approve.

The undersigned further certifies that attached hereto as Exhibits, are true copies of Arbor Health's Benefit Plan Document and Summary Plan Description approved and adopted at this meeting.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 31st day of January 2024, the following commissioners being present and voting in favor of this resolution.

_____
Tom Herrin, Board Chair

_____
Wes McMahan, Commissioner

_____
Van Anderson, Commissioner

_____
Craig Coppock, Commissioner

_____
Chris Schumaker, Commissioner

Arbor Health

Arbor Health
PO Box 1138
Morton, WA 98356

Arbor Health FSA Plan

Plan Document

Effective January 01, 2024

TABLE OF CONTENTS

Arbor Health

Arbor Health FSA Plan

INTRODUCTION

The company has adopted this Plan effective January 01, 2024. Its purpose is to provide benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to elect between cash compensation or certain nontaxable benefit options as they desire. The Plan shall be known as the Arbor Health FSA Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

I. ARTICLE - PLAN DEFINITIONS

01. **"Administrator"** means the Employer, unless another person or entity has been designated by the Employer pursuant to the Article titled: "Administration" to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including but not limited to the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

02. **"Benefit"** or **"Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in the Article titled: "Benefit Information".

03. **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefit Options as provided under the Article titled: "Benefit Information". Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

04. **"Code"** means the Internal Revenue Code of 1986, as amended or replaced from time to time.

05. **"Compensation"** means the amounts received as compensation by the Participant from the Employer during a Plan Year.

06. **"Dependent"** means any individual who qualifies as a dependent under an Insurance Contract for purposes of coverage under that Contract only or under Code Section 152 (as modified by Code Section 105(b)). Any child of a Plan Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Sec. 609 shall be considered a Dependent under this Plan.

    "Dependent" shall include any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under the Health Flexible Spending Account or as allowed by reason of the Affordable Care Act.

    For purposes of the Health Flexible Spending Account, a Participant's "Child" includes his or her natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

    The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

07. **"Effective Date"** means January 01, 2024.

08. **"Election Period"** means the period, established by the Administrator, immediately preceding the beginning of each Plan Year, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to the Article titled: "Participant Elections".

09. **"Eligible Employee"** means any Employee who has satisfied the provisions of the Section titled: "Eligibility".

    An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll

records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

An "Eligible Employee" shall exclude the following:

- Part-Time

10. **"Employee"** means any person who is currently or hereafter employed by the Employer.

    The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

11. **"Employer"** means Arbor Health and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer shall include any Participating, or Adopting Employer.

12. **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time to time.

13. **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit, or any self-funded arrangement providing any Benefit offered for health and welfare coverage to Eligible Employees of the Employer.

14. **"Insurance Premium Payment Plan"** means the plan of benefits contained in the "Benefit Options" section of this Plan, which provides for the payment of Premium Expenses.

15. **"Insurer"** means any insurance company that underwrites a Benefit or any self-funded arrangement under this Plan.

16. **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

17. **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to the Section titled: "Application to Participate" and has not for any reason become ineligible to participate further in the Plan.

18. **"Plan"** means the flexible benefits plan described in this instrument, including all amendments thereto.

19. **"Plan Year"** means the 12-month period beginning January 01 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

20. **"Premium Expenses"** or **"Premiums"** means the Participant's cost for the Benefits described in the Section titled: "Benefit Options".

21. **"Premium Expense Reimbursement Account"** means the account established for a Participant pursuant to this Plan to which part of his or her Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant shall be paid or reimbursed. If more than one type of insured Benefit is elected, sub-accounts shall be established for each type of insured Benefit.

22. **"Run-out Period"** means the set number of days after the plan year ends that allows you to submit claims for eligible expenses incurred during the Plan Year.

23. **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to the Section titled: "Salary Redirection". These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under the Article titled: "Participant Elections".

24. **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his or her Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

25. **"Spouse"** means "spouse" as defined in an Insurance Contract, then, for purposes of coverage under that Insurance Contract only, "spouse" shall have the meaning stated in the Insurance Contract. In all other cases, "spouse" shall have the meaning stated under applicable federal or state law.

II. ARTICLE - PARTICIPATION

01. **ELIGIBILITY**

An individual is eligible to participate in this Plan if the individual:

a. is an Eligible Employee as defined in the Article titled: "Definitions"
b. is working an average of 30 hours or more per week or at least 130 hours per month; and
c. is eligible for the group medical plan

02. **EFFECTIVE DATE OF PARTICIPATION**

An Eligible Employee shall become a Participant effective as of the entry date under the Employer's group medical plan.

03. **APPLICATION TO PARTICIPATE**

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his or her Benefit elections pursuant to the Section titled: "Change in Status".

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to the Section titled: "Effective Date of Participation".

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured Benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance, unless the Employee elects, during the Election Period, not to participate in the Plan.

04. **TERMINATION OF PARTICIPATION**

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

a. **Termination of employment.** The termination of Participant's employment, subject to the provisions of the Section titled: "Termination of Employment"

b. **Death.** The Participant's death, subject to the provisions of the Section titled: "Death" or

c. **Termination of the plan.** The termination of this Plan, subject to the provisions of the Section titled: "Termination".

05. **TERMINATION OF EMPLOYMENT**

If a Participant's employment with the Employer is terminated for any reason other than death, his or her participation in the Benefit Options provided under the Section titled: "Benefit Options" shall be governed in accordance with the following:

a. **Insurance Benefit.** With regard to Benefits which are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid.

b. **Dependent Care FSA.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment-related Dependent Care Expense reimbursements for expenses within 60 days after the date of termination, limited by the balance in the Participant's Dependent Care Flexible Spending Account as of the date of termination.

c. **Health FSA, COBRA applicability.** With regard to the Health Flexible Spending Account, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year for which contributions to the Health Flexible Spending Account have already been made. Thereafter, the health benefits under this Plan including the Health Flexible Spending Account, shall be applied and administered consistent with such further rights that a Participant and his or her Dependents may be entitled to pursuant to Code Section 4980B and the Section titled: "Continuation of Coverage" of the Plan.

06. **REINSTATEMENT OF A FORMER PARTICIPANT**

An Employee whose participation terminates and returns to an eligible status less than thirty days

later may re-enroll within thirty days of returning to an eligible status with a commencement date of the first of the month following the adjusted eligibility date. An Employee who re-enrolls in a Health Flexible Spending Account or Dependent Care Account after such time must re-enter the Plan and reinstate their original elections for that Plan Year with adjustments to the annual election amount as the Administrator deems necessary to prorate the annual election amount over the remainder of the Plan Year. Expenses incurred by the employee during the time that the employee was not a Participant will not be covered expenses unless COBRA was elected pursuant to the Article titled: "Continuation of Coverage (COBRA)".

Any Employee who terminates employment and is rehired into an eligible status after thirty days from the date of termination will be treated as a new enrollee under the Plan. If such Employee returns within the same Plan Year, prior contributions made to the Health Flexible Spending Account and/or the Dependent Care Account will be taken into consideration so as not to exceed Plan or IRS maximums.

07. **DEATH**

If a Participant dies, his or her participation in the Plan shall immediately cease. However, such Participant's spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to a particular specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Flexible Spending Account.

III. ARTICLE - CONTRIBUTIONS TO THE PLAN

01. **SALARY REDIRECTION**

Subject to the provisions of the section titled "Employer Contributions," benefits under the Plan shall be financed by Salary Redirections sufficient to support the benefits that a Participant has elected hereunder and to pay the Participant's Premium Expenses. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his or her pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participant's elections made under the Section titled: "Initial Elections".

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to the Section titled: "Initial Elections") and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under the Article titled: "Participant Elections" and are consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

02. **APPLICATION OF CONTRIBUTIONS**

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

03. **PERIODIC CONTRIBUTIONS**

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

04. **EMPLOYER CONTRIBUTIONS**

The Employer may provide non-elective contributions in the form of Employer Funding into the Health Flexible Spending Account and Dependent Care Spending Account to the extent as described in the Section Titled: "Limitation on Allocations". Such contributions may be prorated for Participants who begin participating in the middle of the Plan Year. Contributions or matching contributions made to the Health Flexible Spending Account and Dependent Care Spending Account generally do not count toward the annual contribution limit as described in the Section Titled: "Limitation on Allocations".

IV. ARTICLE - BENEFITS

01. **BENEFIT OPTIONS**

Each Participant may elect any one or more of the following optional Benefits:

- Health Flexible Spending Account
- Dependent Care Flexible Spending Account

In addition, each Participant shall have a sufficient portion of his or her Salary Redirections applied to the following Benefits unless the Participant elects not to receive such Benefits:

- Group Medical Plan
- Group Dental Plan
- Group Vision Plan
- Voluntary Benefit(s)

02. **HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT**

Each Participant may elect to participate in the Health Flexible Spending Account option, in which case the Article titled: "Health Flexible Spending Account" shall apply.

03. **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT**

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case the Article titled: "Dependent Care Flexible Spending Account" shall apply.

04. **HEALTH INSURANCE BENEFIT**

a. **Coverage for Participant and Dependents.** Each Participant may elect to be covered under a health Insurance Contract for the Participant, his or her Spouse, and his or her Dependents.

b. **Employer selects contracts.** The Employer may select suitable health Insurance Contracts for use in providing this health insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

05. **DENTAL INSURANCE BENEFIT**

a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.

b. **Employer selects contracts.** The Employer may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.

06. **VISION INSURANCE BENEFIT**

a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's vision Insurance Contract. In addition, the Participant may elect either individual or family coverage.

b. **Employer selects contracts.** The Employer may select suitable vision Insurance Contracts for use in providing this vision insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such vision Insurance Contract shall be determined therefrom, and such vision Insurance Contract shall be incorporated herein by reference.

07. **VOLUNTARY BENEFIT(S)**

a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under a Voluntary Benefit Contract.

b. **Employer selects contracts.** The Employer may select suitable voluntary benefit Contracts for use in providing this voluntary benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such voluntary benefit Contract shall be determined therefrom, and such voluntary benefit Contract shall be incorporated herein by reference.

08. **NONDISCRIMINATION REQUIREMENTS**

a. **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

b. **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

c. **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination is prohibited by Code Section 125, it may, but shall not be required to, reduce contributions or non-taxable Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his or her non-taxable Benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his or her non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

09. **NON-TAX DEPENDENT COVERAGE**

a. If (i) Employee Salary Redirections are made to fund Benefits under the Plan, and (ii) the Employer allows a Participant to elect to cover a Non-Tax Dependent through the Participant's coverage under group Medical, Dental or Vision benefit(s), a Participant who elects to participate in the Salary Redirection program may pay on a pre-tax basis through salary reduction contributions the Participant's portion of the premium cost of coverage under the Employer's Medical, Dental or Vision Benefits, provided that the full fair market value of such Medical, Dental or Vision coverage for any such Non-Tax Dependent shall be includible in the Participant's gross income as a taxable benefit in accordance with applicable federal income tax rules. For purposes of this Plan, the Participant electing coverage for Non-Tax Dependent(s) shall be treated as receiving, at the time that coverage is received, cash compensation equal to the full fair market value of such coverage and then as having purchased the coverage with after-tax employee contributions.

b. Notwithstanding the foregoing, no medical care or dependent care expenses incurred by or with respect to a Non-Tax Dependent of a Participant shall be eligible for reimbursement as eligible expenses under the Health Flexible Spending Account or Dependent Care Flexible Spending Account.

V. ARTICLE - PARTICIPANT ELECTIONS

01. **INITIAL ELECTIONS**

An Employee who meets the eligibility requirements of the Section titled: "Eligibility" on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his or her effective date of participation pursuant to the Section titled: "Effective Date of Participation".

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

02. **SUBSEQUENT ANNUAL ELECTIONS**

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form or electronically, as provided by the Administrator, which spending account Benefit options he wishes to participate in. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which immediately follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

a. A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

b. A Participant may terminate his or her participation in the Plan by notifying the Administrator in writing or by electronic notification, as determined by the Employer, during the Election Period that he does not want to participate in the Plan for the next Plan Year;

c. An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in the Section titled: "Change of Status".

03. **FAILURE TO ELECT**

With regard to Benefits available under the Plan for which no Premium Expenses apply, any Participant who fails to complete a new benefit election pursuant to the Section titled: "Subsequent Annual Elections" by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized or made for the subsequent Plan Year for such Benefits, subject to the provisions of the Section titled: "Change in Status" below.

With regard to Benefits available under the Plan for which Premium Expenses apply, any Participant who fails to complete a new benefit election pursuant to the Section titled: "Subsequent Annual Elections" by the end of the applicable Election Period shall be deemed to have made the same Benefit elections as are then in effect for the current Plan Year. The Participant shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit options.

04. **CHANGE IN STATUS**

a. **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict with any of the provisions of this Plan, then such rules and regulations shall control. See below in this Section for other situations in which changes in Benefit elections are permitted.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains eligibility for coverage under any other plan, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan is consistent with that change in status only if coverage for that individual becomes applicable or is increased under said other plan. Also, if the Participant, Spouse or Dependent loses eligibility for coverage under any other plan, then a Participant's election under the Plan to start or increase coverage for that individual under the Plan is consistent with that change in

status only if coverage for that individual ceases or is decreased under said other plan.

Regardless of the consistency requirement, if the individual, or the individual's Spouse or Dependent, becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

1. Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;

2. Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

3. Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

4. Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

5. Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and IRS Notice 2010-38, shall qualify as a change in status.

b. **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP), provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

c. **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) (collectively, an "order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) that requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

   1. The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

   2. The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan, and such coverage is actually provided.

d. **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or

Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

e. **Cost increase or decrease.** Notwithstanding subsection (a), if the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

   A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

f. **Loss of coverage.** Notwithstanding subsection (a), if the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

g. **Addition of a new benefit.** Notwithstanding subsection (a), if, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

h. **Loss of coverage under certain other plans.** Notwithstanding subsection (a), a Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

i. **Change of coverage due to change under certain other plans.** Notwithstanding subsection (a), a Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse, former Spouse's employer or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse, former Spouse's employer or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse, former Spouse's employer or Dependent's employer.

j. **Change in dependent care provider.** Notwithstanding subsection (a), a Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in a dependent care provider. The availability of dependent care services from a new dependent care provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

k. Notwithstanding subsection (a), a Participant may prospectively revoke his or her election of group health plan coverage if (i) the Participant changes from full-time employment (i.e., an average of 30 hours of service per week) to part-time employment (i.e., an average of less than 30 hours of service per week), even if the Participant continues to be eligible for coverage under the group health plan, and (ii) the Participant, and any related individuals whose coverage is also to be revoked, intend to enroll in another plan that provides minimum essential coverage and is effective no later than the first day of the second month after the month during which the revocation is effective.

l. **Health Flexible Spending Account cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits.

VI. ARTICLE - HEALTH FLEXIBLE SPENDING ACCOUNT

01. **ESTABLISHMENT OF BENEFIT**

This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of allowable Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Participant's Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly.

02. **DEFINITIONS**

For the purposes of this Article and the Plan, the terms below have the following meanings:

a. **"Health Flexible Spending Account"** means the account established for a Participant pursuant to this Plan to which part of his or her Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by the Participant, his or her Spouse and his or her Dependents may be reimbursed.

b. **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

1. one of the 5 highest paid officers;

2. a shareholder who owns (or is considered to own, applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

3. among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

c. **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his or her tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his or her Spouse or Dependent.

d. A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

e. The definitions of the Article titled: "Plan Definitions" are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

03. **FORFEITURES**

The amount in the Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to the Section titled: "Health Flexible Spending Account Claims" hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

04. **LIMITATION ON ALLOCATIONS**

Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount of salary redirections that may be allocated to the Health Flexible Spending Account by a Participant in any Plan Year is $3,200.00. The maximum limit may increase from year-to-year pursuant to Section 125(i)(2) of the Internal Revenue Code.

05. **NONDISCRIMINATION REQUIREMENTS**

a. **Intent to be nondiscriminatory.** It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

b. **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a

uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section and/or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

06. **COORDINATION WITH CAFETERIA PLAN**

All Participants under the Plan are eligible to receive Benefits under this Health Flexible Spending Account. Enrollment under the Cafeteria Plan shall constitute enrollment under this Health Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

07. **HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS**

a. **Expenses must be incurred during Plan Year.** All eligible Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year shall be reimbursed, subject to the Section titled: "Termination of Employment", even though the submission of such a claim occurs after his or her participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

b. **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his or her Spouse or Dependents.

c. **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time after incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

d. **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 60 days after the date of termination.

08. **DEBIT AND CREDIT CARDS**

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

a. **Card only for medical expenses.** Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

b. **Card issuance.** Such card shall be issued upon the Participant’s Effective Date of

Participation and reissued or remain in effect for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

c. **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in the Section titled: "Limitation on Allocations".

d. **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator.

e. **Card use.** The cards shall only be used for Medical Expense purchases as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, including, but not limited to, the following:

   1. Co-payments for doctor and other medical care;

   2. Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;

   3. Purchase of medical items such as eyeglasses, syringes, crutches, etc.

f. **Substantiation.** Such purchases by the cards shall be subject to confirmation by the Administrator, usually by requiring the Participant to submit a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation by the Administrator.

g. **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

   1. Repayment of the improper amount by the Participant;

   2. Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal and state law;

   3. Claims substitution or offset of future claims until the amount is repaid; and

   4. If subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

VII. ARTICLE - DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

01. **ESTABLISHMENT OF ACCOUNT**

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

02. **DEFINITIONS**

For the purposes of this Article and the Plan, the terms below shall have the following meaning:

a. **"Dependent Care Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which part of his or her Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

b. **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

c. **"Employment-Related Dependent Care Expenses"** means the amounts paid for those expenses of a Participant that, if paid by the Participant, would be considered employment related expenses under Code Section 21(b)(2). Generally, they include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period during which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for, the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

1. If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment Related Dependent Care Expenses only if incurred for a Qualifying Dependent (as defined in the "Definitions" Section of the Article titled: "Dependent Care Flexible Spending Account") who regularly spends at least eight (8) hours per day in the Participant's household;

2. If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than six (6) individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

3. Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid to or incurred by a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

d. **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account purposes,

1. a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;

2. a Dependent or Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

3. a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

e. The definitions of the Article titled: "Definitions" are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account.

03. **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

04. **INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the amount of Cafeteria Plan Benefit Dollars that he has elected to apply toward his or her Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

05. **DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of the Participant pursuant to the Section titled: "Dependent Care Flexible Spending Account Claims" hereof.

06. **ALLOWABLE DEPENDENT CARE REIMBURSEMENT**

Subject to limitations contained in the Section titled: "Limitation on Payments" below, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

07. **ANNUAL STATEMENT OF BENEFITS**

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under the Section titled: "Definitions" during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

08. **FORFEITURES**

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to the Section titled: "Dependent Care Flexible Spending Account Claims" hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

09. **LIMITATION ON PAYMENTS**

a. **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any tax year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000.00 (or cannot exceed $5,000 as provided under Code Section 129 or $2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

10. **NONDISCRIMINATION REQUIREMENTS**

a. **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination is prohibited under Code Section 129(d).

b. **25% test for shareholders.** It is the intent of this Dependent Care Flexible Spending Account that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of (i) the stock of, or (ii) the capital or profits interest in, the Employer.

c. **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination is prohibited by Code Section 129, it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

11. **COORDINATION WITH CAFETERIA PLAN**

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

12. **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS**

The Administrator shall direct the payment of all qualified Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

a. The Dependent or Dependents for whom the services were performed;

b. The nature of the services performed for the Dependent, the cost of which the Participant wishes reimbursement;

c. The relationship, if any, of the person performing the services to the Participant;

d. If the services are being performed by a child of the Participant, the age of the child;

e. A statement as to where the services were performed;

f. If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

g. If the services were being performed in a day care center, a statement:

    1. that the day care center complies with all applicable laws and regulations of the state of residence,

    2. that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

    3. of the amount of fee paid to the provider.

h. If the Participant is married, a statement containing the following:

    1. the Spouse's salary or wages, if he or she is employed, or

    2. if the Participant's Spouse is not employed, that

        i. he or she is incapacitated, or

        ii. he or she is a full-time student attending an educational institution, and the months of the year during which he or she attends such institution.

i. **Claims for reimbursement.** If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

VIII. ARTICLE - ERISA PROVISIONS

01. **CLAIM FOR BENEFITS**

a. **Insurance claims.** Any claim for Benefits underwritten by Insurance Contract(s) shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure.

b. **Health FSA claims.** If a Participant fails to submit a claim under the Health Flexible Spending Account within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement must be submitted within 60 days after the date of termination. Once a claim is submitted, the following timetable for claims and the rules below apply:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

1. The specific reason or reasons for the denial.
2. Reference to the specific Plan provisions on which the denial was based.
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under Section 502 of ERISA following a denial on review.
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
6. If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided with the denial free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When the Participant receives a denial, the Participant shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a decision on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

1. was relied upon in making the claim determination;
2. was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

4. constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

c. **Forfeitures.** Any balance remaining in the Participant's Dependent Care Flexible Spending Account or Health Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to the Section titled: "Forfeitures", whichever is applicable. Provided, any provision of the Plan to the contrary notwithstanding, where a Participant has properly appealed the denial of a claim and the appeal has not been finally resolved or the appeal has been finally resolved in favor of the Participant, no forfeiture shall take place as to any such balance in dispute. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited and returned to the Employer following a reasonable time after the date any such payment first became due.

02. **APPLICATION OF BENEFIT PLAN SURPLUS**

Any forfeited amounts credited to the benefit plan surplus may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

03. **NAMED FIDUCIARY**

The Administrator shall be the named fiduciary pursuant to ERISA Section 402 and shall be responsible for the management and control of the operation and administration of the Plan.

04. **GENERAL FIDUCIARY RESPONSIBILITIES**

The Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and

a. for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;

b. with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

c. in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

05. **NONASSIGNABILITY OF RIGHTS**

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so alienated or subjected shall not be recognized, except to such extent as may be required by law.

IX. ARTICLE - ADMINISTRATION

01. **PLAN ADMINISTRATION**

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person or persons, including, but not limited to, one or more Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. An Administrator may resign by delivering a written resignation to the Employer or may be removed by the Employer by delivery of written notice of removal, to take effect at a date specified therein, or upon delivery if no date is specified. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of ERISA, the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconciles any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

a. To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

b. To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

c. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

d. To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

e. To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

f. To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

g. To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such should be paid. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

h. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609; and

i. To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

02. **EXAMINATION OF RECORDS**

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer, for examination at reasonable times during normal business hours, such records as pertain to their interest under the Plan.

03. **PAYMENT OF EXPENSES**

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

04. **INSURANCE CONTROL CLAUSE**

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer or other benefit program that is self-insured whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

05. **INDEMNIFICATION OF ADMINISTRATOR**

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

X. ARTICLE - AMENDMENT OR TERMINATION OF PLAN

01. **AMENDMENT**

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state and local laws, statutes and regulations.

02. **TERMINATION**

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such accounts shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

XI. ARTICLE - MISCELLANEOUS

01. **PLAN INTERPRETATION**

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in the Section titled: "Severability".

02. **GENDER AND NUMBER**

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

03. **WRITTEN DOCUMENT**

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

04. **EXCLUSIVE BENEFIT**

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

05. **PARTICIPANT'S RIGHTS**

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

06. **ACTION BY THE EMPLOYER**

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by the Employer.

07. **EMPLOYER'S PROTECTIVE CLAUSES**

a. **Insurance purchase.** Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's Benefits shall be limited to the insurance premium(s), if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim.

b. **Validity of insurance contract.** The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance Contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

08. **NO GUARANTEE OF TAX CONSEQUENCES**

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

09. **INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS**

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant.

as regular cash compensation, plus the Participant's share of any Social Security tax and Medicare tax that would have been paid on such compensation, less any such additional income tax, Social Security tax, and Medicare tax actually paid by the Participant.

10. **FUNDING**

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

11. **GOVERNING LAW**

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event does the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of Washington.

12. **SEVERABILITY**

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

13. **CAPTIONS**

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

14. **CONTINUATION OF COVERAGE (COBRA)**

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

15. **FAMILY AND MEDICAL LEAVE ACT (FMLA)**

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

16. **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

17. **UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)**

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.

18. **COMPLIANCE WITH HIPAA PRIVACY STANDARDS**

a. **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

b. **Disclosure of PHI.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

c. **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term

"payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Genetic information will not be used or disclosed for underwriting purposes.

d. **PHI disclosed to certain workforce members.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

   1. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

   2. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:

      i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

      ii. appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

      iii. mitigation of any harm caused by the breach, to the extent practicable; and

      iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

e. **Certification.** The Employer must and hereby does provide certification to the Plan that it agrees to adopt all required provisions as mandated under HIPAA for all non-exempt group health plans, including the following:

   1. Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

   2. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

   3. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

   4. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

   5. Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

   6. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

   7. Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

   8. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

   9. If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

10. Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

19. **COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS**

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

a. **Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

b. **Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

c. **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in the Section titled: "Compliance with HIPAA Privacy Standards".

20. **MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712.

21. **GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

22. **WOMEN'S HEALTH AND CANCER RIGHTS ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

23. **NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

Execution Agreement

IN WITNESS WHEREOF, Arbor Health has caused its authorized officer to execute this Plan document as of _____, the same to be effective **January 01, 2024**, unless otherwise indicated herein.

Arbor Health

By: _____

Name: _____

Title: _____

Arbor Health

Arbor Health
PO Box 1138
Morton, WA 98356

Arbor Health FSA Plan

Summary Plan Description

Effective January 01, 2024

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Arbor Health

Arbor Health FSA Plan

INTRODUCTION

The Company’s Flexible Benefit Plan (“Plan”) has been established to allow Eligible Employees to pay for certain benefits on a pre-tax basis. There are specific benefits that you may elect, and they are outlined in this Summary Plan Description. You will also be informed about other important information concerning the Plan, such as the conditions you must satisfy before you can join and the laws that protect your rights.

Read this Summary Plan Description (“SPD”) carefully so that you understand the provisions of the Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the Plan document, which governs the operation of the Plan. The Plan document is written in much more technical language. Please note that if the non-technical language in this SPD and the legal language of the Plan document conflict, the Plan document will always govern the Plan. Also, if there is a conflict between any of the insurance contracts and either the Plan document or this Summary Plan Description, the insurance contracts will control the respective insurance policies. If you wish to receive a copy of the legal Plan document, please contact the Plan Administrator.

The Plan is subject to the Internal Revenue Code and other federal and state laws and regulations that may affect your rights under this plan. This SPD explains the current details of the Plan in order to comply with all applicable legal requirements. From time to time, the Plan may be revised due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. This Plan may be amended or terminated by the Company. If the Plan is ever amended or changed, the Company will notify you.

This SPD was designed to provide you with information regarding the Company Flexible Benefit Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other assigned person). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About our Plan."

I. ARTICLE - ELIGIBILITY

01. **How can I participate in the Plan?**

    Before you can become a Participant in the Plan, there are certain conditions that you must satisfy. First, you must be an active employee working 30 or more hours per week or 130 hours per month and meet the eligibility requirements.

    After that, you must enroll in the Plan on the "entry date" that has been established for all employees. The "entry date" is defined in Question 3 below. However, in certain limited situations, you may enroll in the Plan at other times as well. See the Article titled: "Contributions".

02. **What are the eligibility requirements for our Plan?**

    You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan and the other eligibility requirements established by your employer as defined in section 1.

03. **When can I enter the plan?**

    You can enter the Plan on the same day you can enter our group medical plan.

04. **How do I enroll in the Plan?**

    Before you can join the Plan, you must complete an enrollment form. The enrollment form will allow you to select which benefits you want to participate in under the Plan. This form will also authorize the Company to redirect some of your earnings in order to pay for the benefits you select.

    However, if you are already covered under any of the insured benefits, you will automatically participate in this Plan to the extent of your premiums unless you elect not to participate in this Plan. These benefits are listed in the Article titled: "Benefits".

II. ARTICLE - OPERATION

01. **How does this Plan operate?**

Before the start of each Plan Year, you will be able to elect to have some of your earnings contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your earnings that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses that you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under this Plan, you cannot claim a Federal income tax credit or deduction on your return. Participation in this plan is completely voluntary.

III. ARTICLE - CONTRIBUTIONS; ELECTIONS

01. **How much of my pay may the Employer redirect?**

Each year, we will automatically contribute on your behalf enough of your compensation to pay for the insurance coverage provided unless you elect not to receive any or all of such coverage. You may also elect to have us contribute on your behalf enough of your compensation to pay for any other benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year on a per payroll basis.

02. **What happens to contributions made to the Plan?**

Prior to the Plan start date each year, you must decide on the amount of pre-tax dollars you want to contribute to the Plan. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, those dollars will be used to pay those expenses as they arise during the Plan Year. In addition, you should also note that any previous benefit payments made from any Account under the Plan that are unclaimed (e.g., uncashed benefit checks) at the end of the Plan Year following the period of coverage in which the qualifying expense was incurred will be forfeited to the Employer.

For information regarding the administration of contributions in specific accounts under this Plan, please refer to the Article titled: "Benefits".

03. **When must I decide which accounts I want to use?**

You are required by Federal regulations to decide during the enrollment or election period (defined below) prior to the Plan Year start. You must decide which accounts you want and how much you want to contribute to each account.

If you are already covered by any of the insured benefits offered by this Plan, you will automatically become a Participant to the extent of the premiums for such insurance, unless you elect during the election period (defined below) not to participate in the Plan.

04. **When is the election period for our Plan?**

You will make your initial election on or before your entry date. (Please review the Article titled: "Eligibility" to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Company and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Company will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

05. **May I change my elections during the Plan Year?**

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections.

You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you certain other rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the

law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if the Company adds a new coverage option or eliminates an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse, former spouse or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

In addition, there are laws that give you rights to change group health coverage for you, your spouse, and/or your dependents (i) if you go from working 30 or more hours a week to working less than 30 hours a week and you intend to enroll in certain other health plans, or (ii) if you are eligible to enroll in and intend to enroll in certain Marketplace Qualified Health Plans. If you change coverage due to rights under these laws, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the administrator.

06. **May I make new elections in future Plan Years?**

Yes. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, the Company will assume you want your elections for insured benefits only to remain the same and you will not be considered a Participant for the non-insured benefit options under the Plan for the upcoming Plan Year.

IV. ARTICLE - BENEFITS

01. **What benefits are offered under the Plan?**

You may choose to receive your entire compensation or use a portion to pay for benefits under this plan.

02. **Health Flexible Spending Account**

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code and that are not covered by our insured medical plan, and to save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for out-of-pocket medical, dental and/or vision expenses incurred by you and your dependents.

Drug costs, including insulin, may be reimbursed. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

The most that you can contribute to your Health Flexible Spending Account for the Plan Year is $3,200.00. The maximum limit may increase from year-to-year pursuant to Section 125(i)(2) of the Internal Revenue Code.

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. The Company will also provide you with a debit card to use to pay for qualified medical expenses. The Administrator will provide you with further details about the debit card. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. As required by law, reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A “child” is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status for purposes of coverage changes.

Newborns' and Mothers' Health Protection Act: Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

03. **Dependent Care Flexible Spending Account**

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

The most that you can contribute to your Dependent Care Flexible Spending Account for the Plan Year is $5,000.00.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

a. A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;

b. An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and

c. An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying qualify under our Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) $5,000.00 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed annual earned income (a spouse who is a full time student or incapable of caring for himself/herself has a deemed monthly earned income of $250 for one dependent or $500 for two or more dependents).

Also, in order to be able to exclude from your income the reimbursements made to you from this account, you must provide on your tax form for the year the name, address, and in most cases, the taxpayer identification number of the service provider, as well as the amount of such expense. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Consult with your tax adviser for further information.

04. **Premium Expense Account**

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various group insurance programs the Company offers you. These premium expenses include:

- Health care premiums under our insured group medical plan
- Dental insurance premiums
- Vision insurance premiums
- Voluntary Benefit(s)

Under this Plan, the Company will allocate the pre-tax premium withholding to the accounts established under the Plan pursuant to the Participants' elections. Certain limits on the amount of coverage that can be paid through pre-tax premiums may apply.

The Company may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. The Company will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

V. ARTICLE - BENEFIT PAYMENTS

01. **When will I receive payments from my accounts?**

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Health Flexible Spending Account or Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

02. **What happens if I don't spend all Plan contributions during the Plan Year?**

If you have unused contributions in your account at the end of the current Plan Year, those monies will be forfeited to the Employer. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited.

For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year.

For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year.

Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

03. **Family and Medical Leave Act (FMLA)**

If you take a leave under the Family and Medical Leave Act, you may continue, revoke or change your existing elections for health insurance and the Health Flexible Spending Account. If your coverage for these benefits terminates, due to your revocation of the benefit to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect $1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference – for example, from $100 per month to $150 per month, etc. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect $1,200 for the year and are out on leave for 3 months, your amount will be reduced to $900. The expenses you incur during the time you are not in the Health Flexible Spending Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

04. **Uniformed Services Employment and Reemployment Rights Act (USERRA)**

If you are going into or returning from military service, you may have special rights to health care coverage through your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected, ask your Administrator for further details.

05. **What happens if my employment terminates?**

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

a. You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

b. You will still be able to request reimbursement for qualifying dependent care expenses up to 60 days after the date of termination from the balance remaining in your Dependent Care Account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after termination.

c. For health benefit coverage and Health Flexible Spending Account coverage on termination of employment, please see the Article entitled "Continuation Coverage Rights Under COBRA." Upon your termination of employment, your participation in the Health Flexible Spending Account will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit, within 60 days after the date of termination, claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made. Your further participation will be governed by "Continuation Coverage Rights Under COBRA."

06. **Will my Social Security benefits be affected?**

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as the Company contributions to Social Security on your behalf.

VI. ARTICLE - HIGHLY COMPENSATED AND KEY EMPLOYEES

01. **Do limitations apply to highly compensated employees?**

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or are highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VII. ARTICLE - PLAN ACCOUNTING

01. **Periodic Statements**

Periodically during the Plan Year, the Administrator will provide you with a statement of your account that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII. ARTICLE - GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

01. **General Plan Information**

Arbor Health FSA Plan is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The company has adopted this Plan effective January 01, 2024

Your Plan's records are maintained on a twelve-month period of time known as the Plan Year. The Plan Year begins on January 01 and ends on December 31.

02. **Employer Information**

Your Employer's name, address, and tax identification number are:

Arbor Health
Teresa Thorton
PO Box 1138
Morton, WA 98356
360-496-3706
tthornton@myarborhealth.org
FEIN: 91-1655613

03. **Plan Administrator Information**

The name and address of your Plan's Administrator are:

Arbor Health
PO Box 1138
Morton, WA 98356
360-496-3706
tthornton@myarborhealth.org

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

04. **Agent for Service of Legal Process**

Should it ever be necessary, you or your personal representative may serve legal process on the agent for service of legal process for the Plan. The Plan's Agent of Service is:

Arbor Health
PO Box 1138
Morton, WA 98356
360-496-3706
tthornton@myarborhealth.org

05. **Type of Administration**

The type of Administration is Employer Administration.

06. **Claims Submission**

Claims for expenses should be submitted to:

Arbor Health
PO Box 1138
Morton, WA 98356
360-496-3706
tthornton@myarborhealth.org

IX. ARTICLE - ADDITIONAL PLAN INFORMATION

01. **Your Rights Under ERISA**

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

a. examine, without charge, at the Plan Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor (also available at the Public Disclosure Room of the Employee Benefits Security Administration);

b. obtain copies of all documents that govern the operations of the Plan, and other Plan information, upon written request to the Administrator. The Administrator may charge a reasonable fee for copies;

c. continue health coverage for yourself, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage; and

d. review this summary plan description and the documents governing COBRA continuation rights under the Plan.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and the other Plan Participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), or if you need assistance in obtaining documents from the Administrator, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

02. **Claims Process**

It is recommended that you submit all reimbursement claims during the Plan Year. For information on how claims will be processed at the end of the Plan Year, please refer to the Article titled: "Benefit Payments".

Claims for insured benefits will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Administrator of our Plan. If

a dependent care claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit to the Administrator a written request for reconsideration of the denial.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

In the case of a claim for medical expenses under the Health Flexible Spending Account, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

a. The specific reason or reasons for the denial;

b. Reference to the specific Plan provisions on which the denial was based;

c. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

d. A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review;

e. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and

f. If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

a. was relied upon in making the claim determination;

b. was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

c. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

d. constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

03. **Qualified Medical Child Support Order**

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

X. ARTICLE - CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") beyond the time when coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. While the Plan itself is not a group health plan, it does provide health benefits. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health Flexible Spending Account.

01. **What is COBRA continuation coverage?**

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

02. **Who can become a Qualified Beneficiary?**

In general, a Qualified Beneficiary can be:

a. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

b. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

03. **What is a Qualifying Event?**

A Qualifying Event is any of the following if the Plan provides that the Plan participant will lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

a. The death of a covered Employee.

b. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

c. The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

d. A covered Employee's enrollment in any part of the Medicare program.

e. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

04. **What factors should be considered when determining to elect COBRA continuation coverage?**

You should take into account that a failure to continue your group health coverage will affect your rights under federal law. You should be aware that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

05. **What is the procedure for obtaining COBRA continuation coverage?**

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

06. **What is the election period and how long must it last?**

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

07. **Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?**

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

a. the end of employment or reduction of hours of employment,

b. death of the employee,

c. commencement of a proceeding in bankruptcy with respect to the Employer, or

d. entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES: Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Arbor Health

PO Box 1138
Morton, WA 98356

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

08. **Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?**

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

09. **Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?**

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

10. **When may a Qualified Beneficiary's COBRA continuation coverage be terminated?**

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

a. The last day of the applicable maximum coverage period.

b. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

c. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

d. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

e. The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

f. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

1. (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

2. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

11. **What are the maximum coverage periods for COBRA continuation coverage?**

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

a. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

b. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

1. 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

2. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

c. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

d. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

12. **Under what circumstances can the maximum coverage period be expanded?**

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be

sent to the Plan Administrator or its designee in accordance with the procedures above.

13. **How does a Qualified Beneficiary become entitled to a disability extension?**

    A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

14. **Does the Plan require payment for COBRA continuation coverage?**

    For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

15. **Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?**

    Yes. The Plan is also permitted to allow for payment at other intervals.

16. **What is Timely Payment for COBRA continuation coverage?**

    Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

    Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

    If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

17. **Are there other coverage options besides COBRA Continuation Coverage?**

    Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

18. **Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?**

    If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

19. **How is my participation in the Health Flexible Spending Account affected?**

    You can elect to continue your participation in the Health Flexible Spending Account for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Flexible Spending Account if you have elected to contribute more money than you have taken out in claims. For example, if you elected to contribute an annual amount of

$750 and, at the time you terminate employment, you have contributed $400 but only claimed $200, you may elect to continue coverage under the Health Flexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the $750. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

Attachment A

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose

This notice is intended to inform you of the privacy practices followed by your employer's Healthcare Flexible Spending Account Plan. It also explains the Federal privacy rights afforded to you and the members of your family as Plan Participants covered under a group health plan.

As a Plan sponsor your employer often needs access to health information in order to perform Plan Administrator functions. We want to assure the Plan Participants covered under our group health plan that we comply with Federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information to comply with the privacy practices outlined below.

Uses and Disclosures of Health Information

Healthcare Operations. We use and disclose health information about you in order to perform Plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand utilization and to make plan design changes that are intended to control health care costs.

Payment. We may also use or disclose identifiable health information about you without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a healthcare provider that provided treatment to you will provide us with your health information. We use that information to determine whether those services are eligible for payment under our group health plan.

Treatment. Although the law allows use and disclosure of your health information for purposes of treatment, as a Plan sponsor we generally do not need to disclose your information for treatment purposes. Your physician or healthcare provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and healthcare operations.

As permitted or required by law. We may also use or disclose your health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share health information during a corporate restructuring such as an merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures.

Right to Inspect and Copy. In most cases, you have a right to inspect and copy the health information we maintain about you. If you request copies, we will charge you $0.05 (5 cents) for each page. Your request to inspect or review your health information must be submitted in writing to the person listed below.

Right to an Accounting of Disclosures. You have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, healthcare operations, or pursuant to your written authorization.

Right to Amend. If you believe that information within our records is incorrect or missing, you have a right to request that we correct the incorrect or missing information.

Right to Request Restrictions. You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have a right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Legal Information

The Company is required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our current notice at any time. For more information about our

privacy practices, contact the person listed below:

Arbor Health
Teresa Thorton
PO Box 1138
Morton, WA 98356
360-496-3706
tthornton@myarborhealth.org

If you have any questions or complaints, please contact the Plan Administrator listed under the Article titled: "General Information About Our Plan".

Filing a Complaint

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services; Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit *www.hhs.gov/ocr* for further information.

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION DECLARING TO
SURPLUS OR DISPOSE OF PERSONAL
PROPERTY RESOLUTION NO. 24-02

WHEREAS, the Lewis County Hospital District No. 1 owns and operates Arbor Health, a 25-bed Critical Access Hospital located in Morton, Washington, and;

WHEREAS, the Lewis County Hospital District No. 1 feel that this is worthy,

NOW, THEREFORE, BE IT RESOLVED by the Commissioners of Lewis County Hospital District No. 1 as follows:

That the equipment and supplies listed on Exhibit A, attached hereto and by this reference incorporated herein, are hereby determined to be no longer required for hospital purposes. The Administrator is hereby authorized to surplus, dispose and/or trade in of said property upon such terms and conditions as are in the best interest of the District.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 31st day of January 2024, the following commissioners being present and voting in favor of this resolution.

_____
Tom Herrin, Board Chair

_____
Wes McMahan, Commissioner

_____
Van Anderson, Commissioner

_____
Craig Coppock, Commissioner

_____
Chris Schumaker, Commissioner

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Packwood Clinic
13051 US HWY 12
360-496-3777

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

To: Finance Committee
From: Tina Clevenger, Materials Management Supervisor
Date: January 18, 2024
Subject: Surplus or Dispose of Personal Property

Surplus or Dispose of Personal Property (RCW 43.19.1919)

EXHIBIT A

DATE	DESCRIPTION	DEPARTMENT	PROPERTY #	DISPOSITION	REASON
01/2024	CENTRIFUGE/INCUBATOR	LAB	1756	SURPLUS	OBSOLETE

OLD BUSINESS

2024 Organization & Officers of the Board of Commissioners
Effective Date: January 1, 2024

Board Leadership	Board Representation
Board Chair	TBD
Board Secretary	TBD

Committee	Administration Representation	Committee Chair	Board Representation
Finance	Superintendent & CFO	Wes McMahan	Van Anderson
QI Oversight	Superintendent & CNO/CQO	Craig Coppock	Van Anderson
Governance	Superintendent	Board Chair	Secretary
Plant Planning	Superintendent & CFO	Wes McMahan	Chris Schumaker
Strategic Planning	Superintendent	Board of Commissioners	
Compliance Committee	Superintendent & Compliance Officer	Craig Coppock	Chris Schumaker

Other Board Representation	Board Representation
Foundation	Tom Herrin
State Representation	Wes McMahan

NEW BUSINESS

Salary Increases Coming in 2024 for Many Special Purpose District Officials

December 18, 2023 by Cheryl Grant
Category: Compensation, Special Districts

As those of you knowledgeable in special purpose districts may be aware, elected commissioners, board members, supervisors, and directors of special purpose districts receive increases in compensation every five years as established by the Washington State Office of Financial Management (OFM).

OFM is required to calculate the new dollar threshold and transmit it to the Office of the Code Reviser for publication in the Washington State Register at least one month before the new dollar threshold is to take effect. In prior years, these increases became effective on July 1. As of 2024, these increases now take effect on January 1, with adjustments occurring every five years thereafter.

Background

OFM recently released the Notice of Dollar Threshold Adjustment for all special purpose districts (see WSR 23-23-158). As OFM states in the notice:

> The adjustment is to be based upon changes in the consumer price index for "wage earners and clerical workers, all items" compiled by the Bureau of Labor and Statistics, U.S. Department of Labor during that time period. The new dollar threshold shall be transmitted to the Office of the Code Reviser for publication in the Washington State Register at least one month before the new threshold takes effect. Over the five-year period from October 2018 to October 2023, the Consumer Price Index for Urban Wage Earners and Clerical Workers for the Seattle-Tacoma-Bellevue, WA area as reported by the Bureau of Labor Statistics, U.S. Department of Labor, increased by 26.16 percent.

Specific Guidance on Compensation

Below is a list of districts, presented alphabetically, with a description that includes:

- Applicable RCW;
- Compensation, both per diem and salary, if applicable (numerically only), and position(s) for which it is applicable;
- Annual cap, and;
- Notes as to whether the compensation amount is required (*shall*) or a maximum (*may*).

Regarding compensation, interpretation of the word "shall" by MRSC and the Washington State Auditor's Office has been and continues to be that the threshold is *mandatory*, meaning the new rates are effective January 1, and are to be paid regardless of whether or not the elected official is newly elected or serving an existing term.

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The word "may" is interpreted to mean "maximum." In these districts, officials may choose to take an increase in compensation up to the maximum threshold. They will, however, need to take action to establish what that new rate will be. Further, elected officials in the midst of a term may not receive a compensation increase until such time as they are re-elected. Current officials also must take action prior to the end of 2023 for newly elected officials of the district to receive the 2024 rate.

Here is the list of alphabetized special purpose districts.

- **Board of Drainage (RCW 85.06.380):** Payment of compensation for the board and members of the board *may* be at a rate up to $161 per day, with compensation for each commissioner not to exceed $15,456 per year.
- **Cemetery Districts (RCW 68.52.220):** Payment of compensation for each commissioner *may* be at a rate up to $161 per day, with compensation for each commissioner not to exceed $15,456 per year.
- **Diking Districts (RCW 85.05.410):** Payment of compensation for each commissioner *may* be at a rate up to $161 per day, with compensation for each commissioner not to exceed $15,456 per year.
- **Diking, Drainage, and Sewerage Improvement Districts (RCW 85.08.320):** Payment of compensation for each member of the board of supervisors *may* be at a rate up to $161 per day, with compensation for each commissioner not to exceed $15,456 per year.
- **Diking and Drainage Districts in two or more counties (RCW 85.24.080):** Payment of compensation for each member of the board *may* be at a rate up to $161 per day, with compensation for each member not to exceed $15,456 per year.
- **Fire Districts: (RCW 52.14.010):** Payment of compensation for each member of the board *shall* be at a rate of $161 per day, with compensation for each commissioner not to exceed $15,456 per year. Members serving in an ex-officio capacity on a board of fire commissioners *may not* receive compensation.
- **Flood Control Districts (RCW 86.09.283):** Payment of compensation for each member of the board of directors *may* be at a rate up to $161 per day, with compensation for each member not to exceed $15,456 per year.
- **Flood Control Zone Districts (RCW 86.15.055):** Payment of compensation for each member of the board of supervisors *may* be at a

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rate up to $161 per day, with compensation for each supervisor not to exceed $15,456 per year.

- **Irrigation Districts (RCW 87.03.460):** Payment of compensation for each district director *shall* be at a rate of $161 per day, with compensation for each director not to exceed $15,456 per year.
- **Metropolitan Park Districts (RCW 35.61.150):** Payment of compensation for each commissioner *may* be at a rate up to $161 per day, with compensation for each commissioner not to exceed $15,456 per year. However, for any metropolitan park district with facilities, including an aquarium, a wildlife park, and a zoo, and which is accredited by a nationally recognized accrediting agency, the annual compensation maximum amount per commissioner is $30,912.
- **Port Districts (RCW 53.12.260):** Payment of compensation for each commissioner *shall* be at a rate of $161 per day, with compensation for each commissioner not to exceed $15,456 per year, or $19,320 per year for districts with a gross operating income of $25 million or more in the preceding calendar year. Commissioners also receive a salary of $899 for districts with a gross operating income of $25 million or more in the preceding calendar year, or $360 for districts with a gross operating income of from $ 1 million to less than $25 million in the preceding calendar year.
- **Public Hospital Districts (RCW 70.44.050):** Payment of compensation for each commissioner *shall* be at a rate of $161 per day, with compensation for each commissioner not to exceed $15,456 per year.
- **Public Transportation Benefit Authorities (RCW 36.57A.050):** Payment of compensation for each regular member *may* be at a rate of $79 per day with an annual compensation limit of $5,925. The authority *may*, by resolution, increase the payment of per diem to $161 per day/regular member with an annual compensation limit of $12,075. The dollar threshold for the chair is $79 per day with an annual compensation limit of $7,900. The authority *may*, by resolution, increase the payment of per diem to $161 per day for the chair, with an annual compensation limit of $16,100. Members *may not* be compensated in any year for more than 75 days, except the chair who may be paid compensation for not more than 100 days. In any event, compensation *shall not* be paid to an elected official or employee of federal, state, or local government who is receiving regular full-time compensation from such government for attending meetings and performing prescribed duties of the authority.

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- **Public Utility Districts (RCW 54.12.080):** Payment of compensation for each commissioner *shall* be at a rate of $161 per day, with compensation for each commissioner not to exceed $22,540 per year. Monthly salaries *shall* be $3,238 per month for districts with a gross revenue of over $15 million in the preceding fiscal year, or $2,339 per month for districts with a gross revenue of from $2 million to $15 million or less in the preceding fiscal year, or $1,080 per month for other districts. Also, we're happy to announce that all PUDs in Washington can now use our Ask MRSC service to get free, personalized guidance on any legal, finance, or policy questions! This service is provided through a contract with the Washington Public Utility Districts Association (WPUDA).
- **Special Districts – Diking, Drainage, and Flood Control facilities and services (RCW 85.38.075):** Payment of compensation for each governing body member *may* be at a rate of $161 per day with an annual compensation limit of $15,456.
- **Water/Sewer Districts (RCW 57.12.010):** Payment of compensation for each board member *shall* be at a rate of $161 per day, with compensation for each board member not to exceed $15,456 per year.

Compensation and salary adoption procedures are not uniform throughout Washington's many types of special purpose districts. For information regarding a specific district, follow the link on the relevant RCW.

Resources

Questions about the above increases in compensation should be directed to Bob Baker, Senior Forecast Analyst with OFM.

MRSC is a private nonprofit organization serving local governments in Washington State. Eligible government agencies in Washington State may use our free, one-on-one Ask MRSC service to get answers to legal, policy, or financial questions.

About Cheryl Grant

Cheryl joined MRSC in August 2023 as a finance consultant. Born and raised in Washington State, Cheryl has many years of experience working in local government finance, particularly with small cities. Prior to ming to MRSC, Cheryl spent 13 years as the finance

director for the City of Chelan, as well as consulting on a variety of finance-related topics for small cities.

VIEW ALL POSTS BY CHERYL GRANT

Sample Documents

Budgets
Contracts/Agreements
Fee/Rate Schedules
Forms
Franchises
Job Descriptions
Ordinances/Resolutions
Other Documents
Policies/Procedures
RFP/RFQ/Bid Documents

Topics

Economic Development
Environment
Finance
Governance
Legal
Management
Parks and Recreation
Personnel
Planning
Public Safety
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PDF **RCW 70.44.050**

Commissioners—Compensation and expenses—Insurance—Resolutions by majority vote—Officers—Rules.

Each commissioner shall receive ninety dollars for each day or portion thereof spent in actual attendance at official meetings of the district commission, or in performance of other official services or duties on behalf of the district, to include meetings of the commission of his or her own district, or meetings attended by one or more commissioners of two or more districts called to consider business common to them, except that the total compensation paid to such commissioner during any one year shall not exceed eight thousand six hundred forty dollars. The commissioners may not be compensated for services performed of a ministerial or professional nature.

Any commissioner may waive all or any portion of his or her compensation payable under this section as to any month or months during his or her term of office, by a written waiver filed with the district as provided in this section. The waiver, to be effective, must be filed any time after the commissioner's election and prior to the date on which the compensation would otherwise be paid. The waiver shall specify the month or period of months for which it is made.

Any district providing group insurance for its employees, covering them, their immediate family, and dependents, may provide insurance for its commissioners with the same coverage. Each commissioner shall be reimbursed for reasonable expenses actually incurred in connection with such business and meetings, including his or her subsistence and lodging and travel while away from his or her place of residence. No resolution shall be adopted without a majority vote of the whole commission. The commission shall organize by election of its own members of a president and secretary, shall by resolution adopt rules governing the transaction of its business and shall adopt an official seal. All proceedings of the commission shall be by motion or resolution recorded in a book or books kept for such purpose, which shall be public records.

The dollar thresholds established in this section must be adjusted for inflation by the office of financial management every five years, beginning January 1, 2024, based upon changes in the consumer price index during that time period. "Consumer price index" means, for any calendar year, that year's annual average consumer price index, for Washington state, for wage earners and clerical workers, all items, compiled by the bureau of labor and statistics, United States department of labor. If the bureau of labor and statistics develops more than one consumer price index for areas within the state, the index covering the greatest number of people, covering areas exclusively within the boundaries of the state, and including all items shall be used for the adjustments for inflation in this section. The office of financial management must calculate the new dollar threshold and transmit it to the office of the code reviser for publication in the Washington State Register at least one month before the new dollar threshold is to take effect.

A person holding office as commissioner for two or more special purpose districts shall receive only that per diem compensation authorized for one of his or her commissioner positions as compensation for attending an official meeting or conducting official services or duties while representing more than one of his or her districts. However, such commissioner may receive additional per diem compensation if approved by resolution of all boards of the affected commissions.

[**2020 c 83 § 7**; **2008 c 31 § 2**; **2007 c 469 § 7**; **1998 c 121 § 7**; **1985 c 330 § 7**; **1982 c 84 § 14**; **1975 c 42 § 1**; **1965 c 157 § 1**; **1945 c 264 § 15**; Rem. Supp. 1945 § 6090-44.]

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING
THE CAPITAL PURCHASE OF
ULTRASOUND EQUIPMENT

RESOLUTION NO. 24-03

WHEREAS, the Lewis County Hospital District No. 1 owns and operates Arbor Health, a 25-bed Critical Access Hospital located in Morton, Washington, and;

WHEREAS, the Lewis County Hospital District No. 1 feel that this is worthy,

NOW, THEREFORE, BE IT RESOLVED by the Commissioners of Lewis County Hospital District No. 1 as follows:

Approving the purchase of the Ultrasound Equipment-Siemens-Sequoia & Redwood.

The new purchase cost totals $157,228 which will be a new 84-month lease.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 31st day of January 2024, the following commissioners being present and voting in favor of this resolution.

_____
Tom Herrin, Board Chair

_____
Wes McMahan, Commissioner

_____
Van Anderson, Commissioner

_____
Craig Coppock, Commissioner

_____
Chris Schumaker, Commissioner

EQUIPMENT ASSESSMENT REQUEST FORM

SECTION 1 - DEPARTMENT INFORMATION / ITEM REQUESTED

Department Name: Ultrasound/Diagnostic Imaging | Department#: 7143

Manager: Robert Houser | Phone #: 360 496 3527

General Description of Item: Siemens Acuson Sequoia/Redwood

Reason For Purchase (Choose all that apply)
- ☐ New
- ☑ Replacement
- ☑ End of Life
- ☑ Quality of Care
- ☐ Patient Satisfaction
- ☑ Increase Volume
- ☐ Other

Expected Life of New Equipment in Years: 7 Years

Notes about reason for request, effect on department's operations, effect on other departments, and impact of purchase on revenues or volumes :

Current Ultrasound unit S2000 (2012) is approaching end of life. According to industry experts ultrasound machines should be replaced every 5 to 7 years. Mainly due to advances in software improving image quality. Our cardiac reading group (Providence) has expressed concern over the quality of our images in the past year. We are also unable to use this machine for breast ultrasounds which prohibited our ability to re-introduce diagnostic mammograms. Received approval of 2023 and 2024 foundational grant of 70K Siemens pack includes 2 Ultrasound machines with breast probe +add probes not in use all probes usable on each machine

Do We Have Any Similar Equipment In The Organization / Which Department? ☐ Yes ☑ No

Can This Equipment Be Utilized By Other Departments? ☑ Yes ☐ No

This package is for 2 U/S machines possible for Emergency room /Clinic/inpatient use.

Were (3) Competitive Quotes Obtained? (Please Attach) ☐ Yes ☑ No - Detail below

Other quote obtained from Phillips. Received better pricing due to purchase of MRI purchase through Siemens

Suggested Vendor: Siemens | PREFERRED MODEL #: Sequoia/Redwood

Name/Contact Of Vendor: Lavanya Rajan lavanya.rajan@siemens-healthineers.com (206) 696-3047

Estimated Price $: $ 157,228.00

Source Of Estimated Price: Quote (attach) □ Other (Explain)

SECTION 2 – DEPARTMENT AND TECHNOLOGY IMPACT

Will this purchase interface with our computer system? ☑ Yes - Detail below ☐ No ☑ Unsure

Facilities Involvement	☐ Yes - Detail below	☑ No	☐ Unsure
Biomed Involvement	☑ Yes - Detail below	☐ No	☐ Unsure
Clinical Informatics Involvement	☐ Yes - Detail below	☐ No	☑ Unsure
Infection Control	☐ Yes - Detail below	☑ No	☐ Unsure
IT Involvement	☑ Yes - Detail below	☐ No	☑ Unsure

Explain and/or quantify any known involvement or expenses in these areas.

Standard BioMed testing. IT support to send and receive from PACS Awarded 70,000 in foundation money to apply

SECTION 3 - EQUIPMENT ASSESSMENT TEAM EVALUATION SUMMARY

Assessment Team Members:

PROS	
CONS	
CONSIDERATIONS	
RECOMMENDATIONS	
WARRANTY INFORMATION	

ADDITIONAL ACQUISITION/ PREP COST $

ADDITIONAL PREP/ TRAINING HOURS

COMMENTS	

Base Equipment Price - As Provided	$ 157,228.00	Ongoing/Monthly
Support And Maintenance Costs		$ 3,000.00
Additional Cost of Installation Support	$ -	
Total Additional Associated Cost	$ -	
Total Monthly Consumables Cost		
Depreciation		
TOTAL NON- RECURRING EXPENSE	$ 157,228.00	
TOTAL RECURRING EXPENSE	$ -	

****** FOR FINANCE DEPARTMENT USE ONLY ******

HOW ARE WE PAYING FOR THIS? Foundation approved GRANT money see Jessica Scogin 70 K

IS THIS BUDGETED ☐ Yes ☐ No

BUDGETED PURCHASE DATE ASAP

TYPE OF EQUIPMENT

☐ Building Improvement ☑ Fixed Equipment ☐ Building ☐ Capital Lease

☐ Major Moveable Equipment ☐ Other - Explain

****** APPROVALS ******

Chief Financial Officer _____ Date

Chief Executive Officer _____ Date

Board of Commissioner Chairperson _____
if > than $30,000 Date

SIEMENS Healthineers

Proposal # 1-YVC856

District / Sales Office

SIEMENS MEDICAL SOLUTIONS USA,INC.

,
Attn: Christie Stenzel
Email: christie.stenzel@siemens-healthineers.com

Sold To
LEWIS COUNTY HOSPITAL DISTRICT NO 1
521 ADAMS AVE
Morton, WA 98356

Bill To
LEWIS COUNTY HOSPITAL DISTRICT NO 1
521 ADAMS AVE
Morton, WA 98356

Payer
LEWIS COUNTY HOSPITAL DISTRICT NO 1
521 ADAMS AVE
Morton, WA 98356

Siemens Medical Solutions USA, Inc. is pleased to submit the following proposal for service and maintenance described herein at the stated prices and terms. Subject to your acceptance of the terms and conditions on the face and general terms and conditions Document hereof.

Item #	System Name	Functional Location	Service Agreement	Contract Duration	Warranty Period Price	Partial Year Price	Annual Price
1	ACUSON Redwood		Silver contract	Warranty + 5 Years	$0	$0	$8,500

Includes:
Parts and/or Labor to the extent shown in Exhibit A.
System Updates.
Access to Siemens Customer Care Center for technical telephone support (remote diagnostics, if available to the site and the equipment).

Excludes:
Parts defective due to "acts of God", abuse, misuse, neglect, thermal and shock. Specialty components, including, but not limited to: Glassware, Flat Detectors, Consumables, Transducers, MRI coils, SPECT and PET sources (unless purchased as an option). Non-Siemens components and accessories (such as VCR, injector, laser printer, MR surface coils, tables/table tops, chiller, UPS, etc.) unless specifically identified in Exhibit A.

Terms of payment: Net 30 days from invoice date. Past due payment is subject to 1.5% interest charge per month.

Customer's Acceptance

_____
(By) (Signature)

_____
Name and Title

Acceptance Date _____

Siemens Medical Solutions USA, Inc.

_____
(By) (Signature)

Christie Stenzel Service Account Exec
Name and Title

Customer P.O. # _____ (enter P.O. # for contract billing; if not provided, Siemens will invoice without P.O.)
_____ (Initial if P.O. is required but will be issued prior to warranty expiration)
Standing P.O. # _____ (for T&M charges outside of the contract)

This service agreement proposal is valid for 30 days. Agreement becomes effective upon customer signature and Siemens acceptance. Customer's acceptance acknowledges receipt and agreement to Terms and Conditions set forth on all pages of this proposal.

Exhibit A

Item #1:

Equipment:	**ACUSON Redwood**		
Equipment Location:	LEWIS COUNTY HOSPITAL DISTRICT NO 1		
Address:	521 ADAMS AVE, Morton, WA 98356		
Functional Location:	**Service Quote Nr:** 1-YV7PJQ Rev 0	**Equipment Quote Nr:** CPQ-929468	**Payment Frequency:** Monthly
Standard Warranty: Extended Warranty	**Warranty Start:** Upon Warranty Commencement	**Warranty End:** 1 Year Duration	**Warranty Price:** $0
Service Agreement: Silver contract	**Contract Start:** Upon Warranty Expiration	**Contract End:** 5 Year Duration	**Annual Price:** $8,500

(See Glossary pages for detailed description of items listed below.)

Coverage applies during the Warranty or Contract Period as indicated:	Warranty Period	Contract Period
Principal Coverage Period	08:00am - 05:00pm M-F	08:00am - 05:00pm M-F
Uptime Guarantee	99%	95%
Phone Response	30 min	60 min
On-Site Response	10 hours	16 hours
Parts Order Requirement	6pm	6pm
Parts Delivery	Next Day	Next Day
Smart Remote Services	✓	✓
Safety Checks	✓	✓
Quality Assurance	✓	✓
Travel	✓	✓
Updates	✓	✓
Technical Phone Support	✓	✓
Labor	✓	✓
General Spare Parts Coverage	✓	✓
Application Hotline Phone Support	✓	✓
No Consumable Coverage	✓	✓
Tier 1 Transducer Pooling	✓	✓
Planned Maintenance	✓	✓
teamplay Fleet Access	✓	✓
Warranty Transducer - WF	✓	N/A
Enhanced Virtual Learning Sub. - US	N/A	Qty 1
Transducer Tier 1 (WFD)	N/A	Qty 1

The Options or Alternatives listed below will be included in the warranty or contract as indicated, only if initialed:

Opt/ Alt	Option / Alternative	Add to Warranty Price	Add to Contract Annual Price	Initial
Opt	Consumable Coverage	$0	$315	

This pricing is only valid for new service contracts that are signed with the equipment purchase or prior to warranty commencement.

No further Options or Alternatives are included in the above listed equipment.

Glossary

Deliverables	Description
Application Hotline Phone Support	Siemens Customer Care Center Clinical Applications Phone Support is provided with this contract during modality specified hours, call 1-800-888-7436 with your questions and to receive direct access to a Clinical Education Specialist.
Consumable Coverage *(Optional)*	Siemens will supply at its own expense, consumables; such as but not limited to, batteries, leads, padding, storage media, cassettes, etc. Full list of consumables covered can be found on teamplay Fleet customer portal: fleet.siemens-healthineers.com Excludes parts defective due to "acts of God", abuse, misuse, neglect, thermal and shock. Excludes specialty components, including, but not limited to: Glassware, Flat Detectors, Transducers, MRI coils, SPECT and PET sources (unless purchased as an option). Excludes non-Siemens components and accessories (such as VCR, injector, laser printer, MR surface coils, tables/table tops, chiller, UPS, etc.) unless specifically identified in Exhibit A.
Enhanced Virtual Learning Sub. - US	This 12 month multi-modality subscription provides access for imaging professionals to receive additional educational content. This high-value content includes step-by-step performance-enhancing videos, a minimum of 6 one-hour on-demand webinars covering current clinical and industry topics, and access for up to 12 CEUs via your PEPconnect Virtual Wallet. The on-demand webinars are recorded and posted on a regular basis over the term of the subscription and are available for unlimited viewing once posted. Imaging professionals must be logged into PEPconnect (Siemens' online learning platform) to be eligible to receive the CEUs. PEPconnect provides access to all online and virtual training with a wide variety of product-specific, clinical and job-relevant courses. This educational offering must be completed 12 months from purchase date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
General Spare Parts Coverage	Includes replacement of standard spare parts. Excludes Consumables (batteries, leads, padding, storage media, cassettes, radioactive sources, etc.), Glassware; MR Surface and specialty coils (knee, head, etc.); MR MMA, cryocare and helium; high-Vacuum components including Magnetron, Klystron and Thyratron, Waveguide; shock wave components, Transducers, TEE's and Specialty Probes, Flat Panel Detectors, MMLC, Van System coverage, PACS related systems and non-Siemens parts such as VCR, injector, laser printer, tables/table tops, chiller etc.) unless specifically identified in Exhibit A. Excludes parts defective due to "acts of God", abuse, misuse, neglect, thermal and shock.
Labor	Unlimited coverage of on-site labor during the Principal Coverage Period indicated. Preferred labor rates for billable service outside of Principal Coverage Period (at current prevailing tiered rates).
No Consumable Coverage	Upon selection to not have consumable coverage, customer agrees to supply at his/her own expense consumables, such as but not limited to, batteries, leads, padding, storage media, cassettes, etc. Full list of consumables covered can be found on teamplay Fleet customer portal: fleet.siemens-healthineers.com.
On-Site Response	Siemens guarantees on-site CSE arrival within a specific time period (see Exhibit A) after a call for service has been placed with the UPTIME Service Center. This on-site response applies in system/room down situations only. (See Response Time Guarantee in General Terms and Conditions for additional information.)
Parts Delivery	Spare parts arrival for on-site repair of room-down/system-down is typically the Next Day following the time the parts order is submitted.
Parts Order Requirement	Parts order must be placed with Siemens by 6pm (Customer's local time) in order to receive Parts Delivery commitment as specified.
Phone Response	30-minute maximum phone response time by Siemens Customer Care Center personnel or service engineer to provide status of a service call during Principal Coverage Period.
Planned Maintenance	Preventive services carried out in accordance with the equipment's specific maintenance plan. This includes: tracking and scheduling of required maintenance tasks; exchange of wear and tear parts according to maintenance plan; care measures; adjustments to factory specifications; verification of specified performance and functionality; documentation and detailed protocol of system condition.
Principal Coverage Period	Hours defined in Exhibit A during which agreed-upon services are provided.
Quality Assurance	Quality Assurance tasks are performed to keep the system within the quality specifications as issued by the relevant Equipment's specifications. They consist of Tracking and scheduling of required quality assurance tasks Check of measuring and image quality parameters Verification of specified quality parameters Adjustments to factory quality specifications Documentation and detailed quality report of system condition
Safety Checks	Safety Checks are performed to insure compliance with all local and federal guidelines and regulations. This service consists of Tracking and scheduling of required tests Mechanical Safety Checks (e.g. mechanical movements etc.) Electrical Safety Checks (e.g. leakage currents, insulation etc.) Reporting of findings and results
Smart Remote Services	Smart Remote Services – the efficient and comprehensive infrastructure for medical equipment-related remote services – combines high-tech medical engineering with state-of-the-art information technology. Services, which formerly required on-site visits, are now available via data transfer. SRS enables both Core Services (which are included as part of our standard service agreements), as well as optional services (called Enhanced Productivity Services - EPS). A VPN connection is required.

Deliverables	Description
teamplay Fleet Access	teamplay Fleet portal provides most relevant equipment information, including contract duration and service level agreement across your entire institution and multiple locations. Access includes documents, online training courses provided by PEPconnect and smart connection to other teamplay applications across any of Siemens Healthineers imaging, laboratory and software solutions.
Technical Phone Support	Access to specialists at the Siemens Customer Care Center for fast diagnosis and technical support is available during Modality Staffed hours (MSH). Technical support resources will be available outside of Staffed Hours on an on-call basis during the On-Call Hours specified by modality for emergency calls only. Telephone response times for technical support cannot be guaranteed outside of Staffed Hours. All modality Staffed Hours are listed below (and can also be found on teamplay Fleet: fleet.siemens-healthineers.com) and are subject to change. Modality Staffed Hours (MSH) On-Call Hours (EST) On-Call Hours (EST) AT AX 7:00a - 7:00p M-F 24x7 outside MSH AT SU 8:00a - 6:00p M-F N/A AT ECS 8:00a - 6:00p M-F 6:00p - 12:00a M-F CT 7:00a - 12:00a M-F 7:00a – 5:00p Sat-Sun 24x7 outside MSH MI PET 7:00a – 10:00p M-F 7:00a – 3:00p Sat-Sun 6:30a –10:00p Holidays MI SPECT 7:00a - 10:00p M-F 8:00p - 12:00a M-F 7:00a – 5:00p Sat-Sun 6:00a –12:00a Holidays MI PCL 8:00a - 6:00p M-F N/A MR 6:30a - 10:00p M-F 7:00a – 5:00p Sat 24x7 outside MSH ULT 7:30a - 8:00p M-F 8:00a – 11:00p M-F 8:00a – 8:00p Sat-Sun XPRF 8:00a - 7:00p M-F 7:00a – 12:00a M-F 8:00a – 8:00p Sat-Sun XPWH, XPU, XPSU 8:00a – 5:30p M-F 5:30a – 12:00a M-F 8:00a – 8:00p Sat-Sun
Tier 1 Transducer Pooling	Annual Tier 1 Transducer allowances may be shared across all functional locations that provide for pooling of Tier 1 Transducers. Annual allowances may not be applied to any prior or subsequent contract year.
Transducer Tier 1 (WFD)	Covers replacement of Tier 1 Transducers up to the quantity specified per year (as shown on Exhibit A) for Wear, Failure or Damage. Damage examples include: damage to the Lens (e.g. gouges, tears, cuts, and cracks) and damage to the Cable Jacket (e.g. cuts, kinks). If this coverage is not purchased, Tier 1 Transducer replacements are chargeable and may cost up to approximately $12,000 each after any applicable exchange credit has been applied.
Travel	Includes travel time for Customer Service Engineer to and from Customer's site. Subject to change to reflect currently prevailing rates, if occurring outside of the Principal Coverage Period indicated.
Updates	Modifications or reliability enhancements to equipment includes two types: Mandatory (safety and performance-related update instructions) and Non-mandatory (reliability-related service instructions). Labor is included during the hours of PCP. Does not include enhancements to the operating systems or additional functionality.
Uptime Guarantee	Siemens guarantees that the Equipment will function at the minimum Uptime Performance level as specified on Exhibit A. System availability is calculated over a 12-month period, calculated over the Principal Coverage Period. Siemens Remote Services (SRS) connection via VPN broadband is required. (See Uptime Guarantee of General Terms and Conditions for further details.)
Warranty Transducer - WF	Covers unlimited replacement of Transducers for Wear or Failure (but not for Damage) during the warranty period.

Siemens Medical Solutions USA, Inc. General Terms and Conditions

1. Scope
For the term set forth on the first page hereof under the heading "Contract Duration", Siemens will provide (i) remedial maintenance service on the equipment described on the preceding pages hereof (the "Equipment") when requested by the Customer, as well as planned maintenance inspections, when scheduled, as further described in the Glossary section attached hereto, in order to keep the Equipment operating in accordance with the manufacturer's specifications, and (ii) any training courses and/or other educational offerings described in Exhibit A and the Glossary. Siemens will make every effort to respond to service calls at a mutually agreed upon arrival time consistent with the provisions cited in Section 2. In connection with the provision of Equipment maintenance services, Siemens may take photographs or other images of the Equipment or components thereof in order to expedite the completion of repairs, provided that any such photographs shall not include any patients, employees or agents of the Customer and further provided that such photographs and images will only be used in order for Siemens to carry out its duties and responsibilities hereunder.

In the event that (i) the term of this Agreement does not include the Equipment warranty period (as indicated on the first page hereof under the heading "Contract Duration"), or (ii) the term of this Agreement does not commence immediately upon the expiration of the Siemens warranty, or (iii) the Equipment was serviced prior to commencement of the term by anyone other than Siemens or an authorized Siemens dealer or service provider, or (iv) the Equipment was moved from its original location or is not connected to its original power supply (other than portable or mobile Equipment), then the Equipment is subject to inspection by Siemens to determine if it is in good operating condition prior to the commencement of services under this Agreement. Any inspection as well as any repairs or adjustments deemed necessary by Siemens during such inspection may be made at Siemens' per-call rates and terms then in effect and may include charges for parts, with all such repairs or adjustments to be completed prior to the commencement of service under this Agreement.

2. Principal Coverage Period (PCP)
Service and maintenance will be provided during the principal coverage period ("PCP") as defined on Exhibit A, excluding the following holidays: New Years Day, Memorial Day (observed), Independence Day, Labor Day, Thanksgiving Day, Christmas Day. If one of the foregoing holidays falls on a Saturday, then the holiday will be observed on the previous Friday, and if the holiday falls on a Sunday, the holiday will be observed on the following Monday. Unless an extended hours coverage option has been selected, labor and travel required outside the PCP will be charged at Siemens' per-call rates and terms then in effect.

3. Replacement Parts and Labor
Siemens will supply at its own expense, necessary parts and labor, except as indicated in the Glossary section, provided replacement of the parts and necessary labor is required because of normal wear and tear or otherwise deemed necessary by Siemens and further provided that the Siemens-manufactured parts are available from the factory. For all parts and labor excluded from coverage under this Agreement, Customer must purchase all necessary replacement parts and labor from Siemens under Siemens' Standard Terms and Conditions of Sale for Spare Parts and promptly return to Siemens all used, unused or defective parts. All Parts will be new, standard parts, or used, reworked or refurbished parts that comply with applicable performance and reliability specifications. Exchange parts removed from the Equipment shall become the property of Siemens unless such exchange parts constitute "hazardous wastes", "hazardous substances", "special wastes" or other similar materials, as such terms are defined by any federal, state or local laws, rules or regulations, in which case, at the option of Siemens, the exchange parts shall remain the property of the Customer and shall be disposed of by the Customer in strict compliance with all applicable laws, rules and regulations.

4. Planned Maintenance (PM)
Planned maintenance will be carried out according to the manufacturer's recommended schedule. Planned maintenance generally includes checking mechanical and electrical safety, lubrication, functional testing and adjusting for optimum performance as specified in the detailed planned maintenance work plan.

5. Software Maintenance
Whenever the Equipment covered by this Agreement utilizes Siemens' operating system software, Siemens will provide all maintenance and commercially available updates for such operating system software as part of this Agreement. Such updates will solely enhance previously purchased capacities of the Equipment. Operating system software upgrades that provide new features or capabilities or that require hardware changes will be offered to Customer when commercially available and at purchase prices established by Siemens. In addition, some upgrades may require applications training performed by Siemens' personnel that will be offered at Siemens' rates and terms then in effect. Siemens retains the sole right to determine whether an upgrade requires such training.

Nothing in this Agreement shall in any way grant to Customer any right to or license in any diagnostic service software utilized by Siemens in servicing the Equipment. Such service software is and remains the property of Siemens and is available to Customer pursuant to the terms and conditions of a separate diagnostic materials license agreement, which may require payment of a license fee. This service software shall be disabled by Siemens upon cancellation or termination of this Agreement.

6. Equipment; Location; Remote Access
The Equipment covered under this Agreement is limited to the Siemens furnished Equipment described on the face sheet(s). Customer is required to maintain the Equipment in accordance with the manufacturer's written specifications. The Equipment shall not be moved to another location unless Customer obtains the prior written consent of Siemens, except that Customer shall be entitled to move: portable Equipment (e.g., Ultrasound equipment so long as it remains inside the Customer's same facility to which it was originally delivered). Siemens Equipment that is housed in a mobile vehicle, van or trailer may be moved to other locations within the same facility, so long as the Customer informs Siemens of the location of the Equipment when Siemens is scheduled to provide on-site service. If Equipment is located in a trailer, van or other form of mobile vehicle, the Equipment may be moved from the Equipment Location identified on Exhibit A, provided, however, that Siemens shall not be required to service such Equipment, and the Response Time and Uptime Performance Guarantees (if any) or Availability Commitment (if applicable) shall not apply, if either (a) the Customer does not notify Siemens at least one (1) month in advance of the Equipment's mobile route, or (b) the Equipment is moved more than 25 miles from the original Equipment Location. If fixed Equipment is moved to any other location within the Customer's facility, then either (a) the Customer will engage Siemens to relocate the Equipment, at Siemens' then current rates and charges, or (b) if Siemens does not perform the services necessary to relocate the Equipment, then Siemens may suspend services with respect to such Equipment until Siemens performs an inspection of the Equipment, at the Customer's cost, to determine if any repairs are necessitated as a result of any such relocation (in which case the Customer shall be separately charged for such repairs, including parts and labor, at Siemens' rates and charges then in effect). Customer shall, at its expense, provide all proper and necessary labor and materials for plumbing service, carpentry work, electrical and conduit wiring, water supply, ventilation and other preparations required for such installation and connection services and all the permitting relating to the foregoing. All such labor and materials shall be completed by Customer and available prior to the time Siemens is scheduled to perform the services.

Siemens service personnel will be given full and safe access to the Equipment to perform inspections and service/maintenance on the Customer's premises, and will make specific appointments for such maintenance. If the Equipment is not made available at the appointed time, waiting time beyond a reasonable allowance will be charged at Siemens' per-call rates and terms then in effect.

Customer shall arrange for the Equipment to be cleaned and decontaminated after contact with blood or other potentially infectious material. However, Customer shall have no obligation to open closed Equipment to clean or decontaminate internal components.

Customer shall provide Siemens with both on-site and remote access to the Equipment. Customer shall provide on-site access at premises free of hazardous, concealed or dangerous conditions, including safe and unobstructed means of ingress and egress. The remote access shall be provided through the Customer network as is reasonably necessary for Siemens to provide services under this Agreement. Remote access will be established through a broadband internet based connection to either a Customer owned or Siemens provided secure end-point. The method of connection will be a Peer-to-Peer VPN IPsec tunnel (non-client based) or another technology specified by Siemens which provides a comparable level of protection, in either case with specific inbound and outbound port requirements.

In the event the Customer fails to provide or maintain the remote access connection for any Proactive Service Agreement (e.g., Pinnacle, Select, Essential, as identified in Exhibit A), or any Signature, Benchmark, or Balance Service Agreement with a volume-based deliverable as defined in Exhibit A, then Siemens shall have the option to terminate this Agreement. In addition, in accordance with the terms of Section 22 hereof, any Uptime Performance Guarantee or Availability Commitment (if applicable) shall be void if the remote access connection is not provided and available 24 hours per day, 7 days a week.

7. Agreement Term; Price; Payment Terms
This Agreement shall be in effect for the period stated on the first page of this Agreement.

For the basic services to be provided by Siemens under the terms of this Agreement, Siemens shall send invoices to the Customer and payments shall be made in advance based on the payment frequency shown in Exhibit A under "Payment Frequency".

Invoices for all amounts due under this Agreement shall be sent to the Customer by regular U.S. mail, postage prepaid, at the address set forth on the first page hereof under "Bill To".

After the first year of the term of the Equipment coverage period set forth in the Agreement, Siemens may increase the Annual Agreement Price no more than once every twelve (12) months based upon the percentage increase in the Consumer Price

Index for All Urban Consumers, U.S. City Average, All Items ("CPI"), as published by the United States Department of Labor, Bureau of Labor Statistics. The percentage increase in the CPI shall be measured over the period since the commencement of the Agreement (in the case of the first price increase) or since the effective date of the last price increase (in the case of any subsequent price increases). Siemens shall provide the Customer with no less than thirty (30) days written notice of any price increase.

All payments to be made by Customer under this Agreement are due net thirty (30) days from the invoice date. Past due payments shall bear interest at the rate of 1½% per month.

8. Causes for Exclusion/Separate Charges

This Agreement specifically excludes labor, parts and expenses necessary to repair Equipment:

• damaged by fire, accident, misuse, abuse, negligence, improper application or alteration or by a force majeure occurrence as described in Section 17 hereof, or by the Customer's failure to operate the Equipment in accordance with the manufacturer's instructions, including without limitation Customer's failure to maintain the recommended operating environment and line conditions or intentional delay in requesting service for Equipment;

• defective due to unauthorized attempts to repair, relocate, maintain, service, add to or modify the Equipment by the Customer or any third party or due to the attachment and/or use of non-Siemens supplied parts, equipment or software without Siemens' prior written approval (and if the Customer or a third party modifies the Equipment, then Siemens may remove such Equipment from coverage under this Agreement unless the Customer restores the Equipment to the manufacturer's published specifications);

• defective due to any repair or service of the Equipment by the Customer or any third party prior to the commencement of the term of this Agreement;

• due to Customer not providing full access to the Equipment, on a safe site free of hazardous, concealed or dangerous conditions;

• which failed due to causes from within non-Siemens supplied equipment, parts or software including, but not limited to, problems with the Customer's network;

• which is worn out and cannot be reasonably repaired due to the unavailability of spare parts from the original equipment manufacturer; or

• which is a transducer or probe and which is damaged or defective, or which failed, due to any of the foregoing causes or due to improper cleaning, disinfecting or TEE bite marks.

If Siemens is called upon to service or repair Equipment which falls under this Section 8, a separate invoice will be issued for labor, parts and expenses at Siemens' rates and terms then in effect.

This Agreement does not entitle the Customer to services related to information technology, patient and imaging workflow design and analysis, or problem diagnosis. Siemens' responsibility under this Agreement does not extend beyond the outbound or inbound sockets of the Equipment. In addition, changes, adjustments, additions or repairs required to or with respect to the Equipment resulting from issues, matters, items or concerns that are the responsibility of the Customer, such as changes related to Customer's network infrastructure, are not covered by this Agreement. This may include, but is not limited to, network IP address changes. Although the Equipment may have limited short term storage capacity, the storage of images, both patient and QA images, is the responsibility of the Customer.

If Siemens offers a Network Assistance option for the Equipment and the Customer purchases this option as indicated on Exhibit A, then Siemens shall assist the Customer in its efforts to identify the cause of any network or connectivity problems which may affect the operation of the Equipment; provided, however, that the price for this option does not include the cost of any repairs (labor, parts, etc.) to remedy such problems, which shall be the sole responsibility of the Customer. If the Customer does not purchase this option, or if this option is not offered by Siemens, then any assistance provided by Siemens to the Customer with respect to any network or connectivity issues shall require a P.O. from the Customer and shall be separately billed to the Customer at Siemens' then current rates and charges.

9. Default

Customer shall be in default under this Agreement upon: (i) a failure by Customer to make any payment due Siemens within ten (10) days of receipt of notice from Siemens that the payment was not made within the applicable payment period; (ii) a failure by Customer to perform any other obligation under this Agreement within thirty (30) days of receipt of notice from Siemens; (iii) a failure by Customer to grant Siemens access to the Equipment as set forth in Section 6 of this Agreement; (iv) a failure by Customer to notify Siemens the Equipment is in need of remedial maintenance or to permit Siemens to inspect, repair or adjust the Equipment as deemed necessary by Siemens (a) as set forth in Section 1 of this Agreement; or (b) at any time during the term of this Agreement in order to keep the Equipment operating in material compliance with the written specifications; (v) a failure by Customer to maintain the Equipment in accordance with the manufacturer's written specifications; (vi) a failure by Customer to purchase from Siemens all necessary replacement parts and labor that are excluded from coverage under this Agreement; (vii) a default by Customer or any affiliate of the Customer under any other obligation to or agreement with Siemens or Siemens Financial Services, Inc. or any assignee of the foregoing (including but not limited to, a promissory note, lease, rental agreement, license agreement or purchase contract); or (viii) the commencement of any insolvency, bankruptcy or similar proceedings by or against the Customer (including any assignment by Customer for the benefit of creditors). Upon the occurrence of any event of default hereunder, Siemens may, in addition to any and all other remedies available under law, elect to: (i) immediately cease providing services under this Agreement and any and all other agreements between the parties, or suspend any training courses or educational offerings provided under this Agreement, until the default is cured or corrected, (ii) terminate this Agreement, in which case Customer shall pay to Siemens (a) all amounts due under this Agreement through the effective date of termination, (b) as liquidated damages and not as a penalty, an amount equal to 25% of the remaining payments due under this Agreement from the date of termination through the scheduled expiration of the term of this Agreement, and (c) all costs and expenses of collection, including without limitation reasonable attorneys' fees and court costs incurred by Siemens as a result of the Customer's default, (iii) void any and all warranties for the Equipment that has been affected by the use of unauthorized replacement parts and/or Customer or third-party labor; and/or (iv) commence collection actions (including court actions) for all sums due under this Agreement. All rights and remedies available to Siemens hereunder, by law or equity, shall be cumulative and there shall be no obligation for Siemens to exercise a particular remedy.

In the event that Customer cures all defaults hereunder, then prior to resumption of the Equipment maintenance services under this Agreement, Siemens may inspect the Equipment to determine if it is in good operating condition. Such inspection shall be charged to the Customer at Siemens' per-call rates and terms then in effect. Any repairs or adjustments which Siemens determines are required due to (i) the use of any non-Siemens parts, (ii) the repair or service of the Equipment by the Customer or any third party during the suspension of services by Siemens, or (iii) any of the exclusions from coverage set forth in Section 8 of this Agreement, shall be charged to the Customer at Siemens' rates and terms then in effect and shall include charges for parts, with all such repairs or adjustments to be completed prior to the resumption of service under this Agreement.

10. Limitation of Liability

Siemens' entire liability and Customer's exclusive remedy for any direct damages incurred by the Customer from any cause whatsoever, and regardless of the form of action, whether liability in contract or in tort, arising under this Agreement or related hereto, shall not exceed, as applicable: (i) an amount equal to the Annual Agreement Price (in effect when the cause of action arose) for the specific item of Equipment under this Agreement that caused the damage or is the subject matter of, or is directly related to, the cause of action, or (ii) the amount paid by Customer to Siemens under this Agreement for the particular training course or educational offering that is the subject matter of the claim. The foregoing limitation of liability shall not apply to claims by Customer or third parties for bodily injury or damage to real property or tangible personal property (including damage to the Equipment covered by this Agreement) caused solely and directly by the gross negligence or willful misconduct of Siemens. In addition, Siemens shall have no liability hereunder to Customer to the extent that Customer's or any third party's acts or omissions contributed in any way to any loss it sustained or to the extent that the loss or damage is due to a force majeure occurrence as described in Section 17 hereof or any other cause beyond the reasonable control of Siemens.

THIS IS A SERVICE AGREEMENT. WITHOUT LIMITING THE LIMITATION OF LIABILITY SET FORTH IN THE PRECEDING PARAGRAPH, SIEMENS EXPRESSLY DISCLAIMS ALL WARRANTIES, EXPRESS OR IMPLIED, INCLUDING BUT NOT LIMITED TO, ANY IMPLIED WARRANTIES OF MERCHANTABILITY AND WARRANTIES OF FITNESS FOR A PARTICULAR PURPOSE. IN NO EVENT WILL SIEMENS BE LIABLE FOR ANY LOST PROFITS, LOST SAVINGS, LOST REVENUES, LOSS OF USE OR DOWNTIME (EXCEPT AS OTHERWISE PROVIDED HEREIN), LOST DATA, OR FOR ANY INDIRECT, INCIDENTAL, UNFORESEEN, SPECIAL, PUNITIVE OR CONSEQUENTIAL DAMAGES WHETHER BASED ON CONTRACT, TORT (INCLUDING NEGLIGENCE), STRICT LIABILITY OR ANY OTHER THEORY OR FORM OF ACTION, EVEN IF SIEMENS HAS BEEN ADVISED OF THE POSSIBILITY THEREOF, ARISING OUT OF OR IN CONNECTION WITH THIS AGREEMENT OR THE USE OR PERFORMANCE OF THE EQUIPMENT.

11. Notices

Except for the issuance of invoices as set forth in Section 7 hereof, all notices required to be provided hereunder shall be in writing and shall be sent by overnight delivery via a nationally recognized delivery service or by certified or registered mail, postage prepaid, to Siemens at the address set forth on the first page of this Agreement and to the Customer at the address set forth under "Bill To" on the first page of this Agreement. Notice given in compliance with this Section 11 shall be sufficient for all purposes under this Agreement, and such notice shall be effective when sent. Either party may change its notice address only if notification is sent in writing pursuant to this Section 11.

12. Governing Law; Waiver of Jury Trial

This Agreement shall be governed by the laws of the Commonwealth of PA. TO THE EXTENT NOT PROHIBITED BY LAW, THE PARTIES WAIVE ALL RIGHTS TO A JURY TRIAL IN ANY LITIGATION ARISING FROM OR RELATED IN ANY WAY TO THIS AGREEMENT OR THE TRANSACTION CONTEMPLATED HEREBY.

13. Government Access Clause
Until the expiration of four (4) years after the furnishing of any services under this Agreement, Siemens shall make available upon written request of the Secretary of the Department of Health and Human Services, the Comptroller General, or any of their duly authorized representatives, this Agreement and the books, documents and records of Siemens which are necessary to certify the nature and extent of costs incurred under this Agreement. If Siemens carries out any of the duties of this Agreement through a subcontract with a value of $10,000 or more over a 12 month period with a related organization, such subcontract shall include a clause to the effect that until the expiration of four (4) years after the furnishing of any services under the subcontract, the related organization shall make available upon written request of the Secretary of the Department of Health and Human Services, the Comptroller General, or any of their duly authorized representatives, the subcontract and the books, documents and records of the related organization that are necessary to certify the nature and extent of costs incurred under that subcontract.

This provision shall apply if and solely to the extent that Section 1861 (v) (1) (I) of the Social Security Act applies to this Agreement.

14. Damages, Costs, And Fees
In the event that any dispute or difference is brought arising from or relating to this Agreement or the breach, termination, or validity thereof, the prevailing party shall not be entitled to recover from the other party punitive damages. The prevailing party shall be entitled to recover from the other party all reasonable attorneys' fees and collection agency fees incurred, together with such other expenses, costs and disbursements as may be allowed by law.

15. Severability; Headings
No provision of this Agreement which may be deemed invalid, illegal or unenforceable will in any way invalidate any other portion or provision of this Agreement. Paragraph headings are for convenience only and will have no substantive effect.

16. Waiver
No failure, and no delay in exercising, on the part of any party, any right under this Agreement will operate as a waiver thereof, nor will any single or partial exercise of any right preclude the further exercise of any other right.

17. Force Majeure
Siemens will not be liable to Customer for any failure to fulfill its obligations under this Agreement due to causes beyond its reasonable control and without its fault or negligence including, but not limited to, governmental laws and regulations, acts of God or the public, war or other violence, civil commotion, blockades, embargoes, calamities, floods, fires, earthquakes, explosions, accidents, storms, strikes, lockouts, work stoppages, labor disputes, or unavailability of labor, raw materials, power or supplies. In addition, in the event of any determination pursuant to the provisions of a collective bargaining agreement between the Customer and any labor union representing any employees of the Customer preventing or hindering the performance of any of the obligations of Siemens under this Agreement, or determining that the performance of any such obligations violates provisions of that collective bargaining agreement, or in the event a trade union, or unions, representing any of the employees of the Customer otherwise prevents Siemens from performing any such obligations, then Siemens shall be excused from the performance of such obligations unless the Customer makes all required arrangements with the trade union, or unions, to permit Siemens to perform the work. The Customer shall pay any additional costs incurred by Siemens that are related to any labor dispute(s) that involve the Customer.

18. Confidentiality
Siemens and the Customer shall maintain the confidentiality of any information provided or disclosed to the other party, its employees or agents (a "receiving party") relating to the business, customers and/or patients of the disclosing party, including but not limited to know-how, technical data, processes, software, techniques, developments, inventions, research products and plans for future developments, proprietary matters of a business or technical nature, as well as this Agreement and its terms (including the pricing and other financial terms under which the Customer will be obtaining the services hereunder). Confidential Information shall also include all written materials (including correspondence, memoranda, manuals, training materials, notes and notebooks) and all computer software, models, mechanisms, devices, drawings or plans which may be disclosed or made available embodying Confidential Information. All Confidential Information shall be and remain the sole and exclusive property of the disclosing party. Each party shall use reasonable care to protect the confidentiality of the information disclosed, but no less than the degree of care it would use to protect its own confidential information, and shall only disclose the other party's confidential information to its employees and agents having a need to know this information. Confidential Information shall not include any information or data which (i) is or becomes public knowledge (through no fault of the receiving party or any of its employees or agents), (ii) is made available to the receiving party by an independent third party without any obligation of confidentiality, (iii) is already in the receiving party's possession at the time of receipt from the disclosing party (as such prior possession can be properly demonstrated by it), or (iv) is required by law to be disclosed, provided that the receiving party gives the disclosing party advance notice of the requirement for disclosure so that the disclosing party can take whatever action it deems necessary to protect the disclosure of its Confidential Information. In addition, this confidentiality provision shall not apply to any action brought by either party to enforce the terms of this Agreement against the other party.

Any unauthorized use, disclosure or misappropriation of any Confidential Information by the receiving party in violation the foregoing may result in irreparable and continuing damage to the disclosing party; in the event of such breach, the disclosing party shall be entitled to obtain immediate injunctive relief and any other relief or remedies to which it may be entitled. The receiving party waives any requirement that the disclosing party post a bond or other security in connection with any petition filed by the disclosing party for injunctive relief. In the event that a court of competent jurisdiction determines that the receiving party has breached this provision, then the receiving party shall reimburse the disclosing party for the costs of any court proceedings and all reasonable attorneys' fees.

19. End of Support Announcement
Notwithstanding anything to the contrary contained herein, in the event that Siemens makes a general announcement that it will no longer offer service agreements for an item of Equipment or components thereof, or provide a particular service agreement option or feature, whether due to the unavailability of spare parts or otherwise (an "EOS Announcement"), then upon no less than twelve (12) months prior written notice to the Customer, Siemens may remove any affected Equipment, components, options or features from coverage under this Agreement, with a corresponding adjustment of the Annual Agreement Price. In addition, at the end of this twelve (12) month period, the Customer may either remove the affected Equipment, components, options or features from coverage under this Agreement on or after the EOS date and with no less than thirty (30) days written notice; or request that Siemens provide service or parts on a time and materials basis only, at Siemens' rates and terms then in effect, for any Equipment, components, options or features subject to an EOS Announcement.

20. Removal of Equipment from Coverage
The Customer may remove Equipment from coverage under this Agreement at any time upon no less than thirty (30) days prior written notice to Siemens if the use of the Equipment is permanently discontinued and the Equipment is removed from service. There is no fee for this cancellation. Prorated credit will be issued for any advance payments made by the Customer for the period after the effective date of removal (based on the notice requirement). In addition, if the Customer sells or otherwise transfers any of the Equipment to a third party and the Equipment remains installed and in use at the same location, but such third party does not assume the obligations of the Customer under this Agreement or enter into a new service agreement with Siemens with a term at least equal to the unexpired term of this Agreement, then the Customer may terminate this Agreement with respect to such Equipment upon no less than thirty (30) days prior written notice to Siemens, in which case the Customer shall pay to Siemens (i) all amounts due under this Agreement through the effective date of termination (based on the notice requirement) and (ii) as liquidated damages and not as a penalty, an amount equal to 25% of the remaining payments due under this Agreement for such Equipment from the date of termination through the scheduled expiration of the term of this Agreement.

21. HIPAA
To the extent required by the provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and any regulations promulgated thereunder, Siemens does hereby assure Customer that it will appropriately safeguard Protected Health Information (as defined under HIPAA) made available to or obtained by Siemens pursuant to this Agreement or any Service Schedule ("PHI"). Without limiting the obligations of Siemens otherwise set forth in this Agreement or imposed by applicable law, Siemens agrees to comply with applicable requirements of law relating to PHI and with respect to any task or other activity Siemens performs on behalf of Customer. Specifically, Siemens shall:

(a) not use or disclose PHI other than as permitted or required by this Agreement or as required by law, and limit any use or disclosure of PHI to a limited data set or the minimum necessary to accomplish the intended purpose of such use or disclosure;

(b) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any electronic PHI that it creates, receives, maintains or transmits on behalf of the Customer, and comply, where applicable, with the HIPAA Security Rule with respect to such electronic PHI, and otherwise use appropriate safeguards to prevent use or disclosure of PHI, other than as provided for by this Agreement;

(c) report to Customer any use or disclosure of PHI not provided for by this Agreement, and report any security incident, of which Siemens becomes aware;

(d) in accordance with applicable HIPAA and HITECH requirements, ensure that any subcontractors or agents to whom Siemens provides PHI received from, or created or received by Siemens on behalf of, Customer agree to essentially the same restrictions and conditions that apply to Siemens with respect to PHI and implement reasonable and appropriate safeguards with respect to PHI;

(e) upon Customer's written request, make PHI available to the Customer as necessary for Customer to respond to individuals' requests for access to PHI about them, provided that the PHI in Siemens' possession constitutes a Designated Record Set and Siemens has been specifically engaged by Customer to so maintain and service such PHI on behalf of Customer;

(f) upon Customer's written request, make PHI available to Customer for amendment and incorporate any amendments to the PHI in accordance with applicable law, provided that the PHI in Siemens' possession constitutes a Designated Record Set and Siemens has been specifically engaged by Customer to so maintain and service such PHI on behalf of Customer;

(g) make available to Customer the information in its possession required to provide an accounting of disclosures of PHI as required by applicable law;

(h) mitigate, to the extent practicable, any harmful effect that is known to Siemens of a use or disclosure of PHI by Siemens in violation of the requirements of this Agreement or of law;

(i) provide notice of a breach of unsecured PHI to Customer without unreasonable delay, and in no case later than thirty (30) days after discovery of a breach. The notification shall include, to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed by Siemens to have been, accessed, acquired, used, or disclosed. Siemens shall provide Customer with any other available information that Customer is required to include in notification to the Individual under applicable law;

(j) make Siemens' internal practices, books, and records relating to the use and disclosure of PHI received from Customer available to the Secretary of the United States Health & Human Services for purposes of determining Customer's compliance with applicable law; and

(k) upon expiration or termination of this Agreement, return to Customer or destroy all PHI in its possession as a result of this Agreement and retain no copies of PHI, if it is feasible to do so. If return or destruction is not feasible, Siemens agrees to extend all protections contained in this Agreement to Siemens' use and/or disclosure of any retained PHI, and to limit further uses and/or disclosures to the purposes that make the return or destruction of the PHI infeasible.

Siemens may use and disclose PHI as necessary for Siemens to perform its obligations hereunder, and may (i) use the PHI for its proper management and administration and to carry out its legal responsibilities, (ii) disclose the PHI to a third party for Siemens' proper management and administration or to carry out Siemens' legal responsibilities, provided that the disclosures are required by law or Siemens obtains reasonable assurances from the third party regarding the confidential handling of such PHI as required under HIPAA and/or HITECH, and the third party agrees to notify Siemens of any instances in which the confidentiality of the information has been breached, (iii) provide data aggregation services related to the healthcare operations of Customer, and (iv) de-identify the PHI, and use such de-identified data, in accordance with the de-identification requirements under HIPAA.

Siemens agrees that it will negotiate in good faith an amendment to this Agreement if, and to the extent required by, the provisions of HIPAA and regulations promulgated thereunder, in order to assure that this Agreement is consistent therewith.

22. Uptime Performance Guarantee [DOES NOT APPLY TO EVERY SERVICE AGREEMENT]

For any Equipment that includes an Uptime Guarantee as specified in Exhibit A, Siemens guarantees that the Equipment will function at the minimum Uptime Performance (defined below) level set forth in Exhibit A (computed as described below).

"Uptime Performance" is defined as the capability of the Equipment to be utilized to treat or diagnose patients. The Equipment will be considered to be operational (i.e., it will not be considered to be "down"): (a) unless it cannot be utilized to treat or diagnose patients (room down); (b) if Siemens is prepared to perform maintenance services to make the Equipment operational but such service is refused by the Customer or is deferred by the Customer until a later time or date; (c) if the Equipment is not otherwise made available to Siemens' service engineers; (d) if the Equipment is down is due to, associated with, or caused by (i) misuse, negligence, or operator error, (ii) inadequate environmental conditions (not conforming with the environmental specifications provided by Siemens), including temperature and humidity, line power exceeding Siemens' requirements of voltage, frequency, impulses or transients, (iii) any of the exclusions set forth in Section 8 hereof, or (iv) acts of God or other force majeure events described in Section 17 hereof; or (e) during periods in which Siemens is performing scheduled or planned maintenance, changing high-vacuum components, and installing updates and/or upgrades. If the Equipment is not operational, then the Customer must immediately notify the Siemens Customer Care Center (24-hour Service Call Dispatch Center). Downtime will not commence until such notification is given to Siemens.

For purposes of calculating the Uptime Performance level percentage, such computation shall be made over the PCP, to include any extended coverage hours as indicated on Exhibit A. The Equipment's Uptime Performance shall be calculated to comply with the above guidelines on an annual basis. If the Equipment's Uptime Performance level is found to be less than the guaranteed percentage, as computed in accordance with the above guidelines, Siemens will extend the term of this Agreement by seven (7) calendar days (30 calendar days for Oncology Care Systems) for every percentage point (rounded to the nearest percent) below the guaranteed percentage. These days will be added at the end of the term of this Agreement. For example, if the guaranteed percentage is 97%, then 96% Uptime Performance would result in an extension of seven (7) calendar days and 95% Uptime Performance would result in an extension of fourteen (14) calendar days. The foregoing states Siemens' entire obligation and liability, and the Customer's sole remedy, for Siemens' failure to meet the Uptime Performance Guarantee.

In order for the Uptime Performance Guarantee to be effective, the Customer must place all calls for service through the Siemens Customer Care Center and must accept all Technical Assistance that is offered by Siemens, including, but not limited to, telephone support and remote diagnostics. For any period of time that the Customer does not seek and accept Technical Assistance from Siemens, then the Equipment shall be considered to be operational.

The Customer agrees to allow connection to Smart Remote Service diagnostic equipment, where available, for the Equipment covered by this Agreement. Smart Remote Service (SRS) is required for SRS-capable systems. The Uptime Performance Guarantee shall be void if the SRS connection is not provided and available 24 hours per day, 7 days a week.

23. Response Time Guarantee [DOES NOT APPLY TO EVERY SERVICE AGREEMENT]

Siemens guarantees that it shall meet any on-site response time as specified in Exhibit A for system "down" situations. Response time is measured from the time that the Customer notifies the Siemens Customer Care Center that a system is down. The response time only applies during the PCP, to include any extended coverage hours (if selected by the Customer), as indicated on Exhibit A. For example, a request for on-site service made at noon on a Monday (where the PCP is 8:00 a.m. through 5:00 p.m., Mondays through Fridays) will have a guaranteed arrival time of 4:00 p.m. on the same day for customers with a four (4) hour response time and a guaranteed arrival time of 11:00 a.m. on the next day for customers with an eight (8) hour response time guarantee. A request for on-site service made at 9:00 a.m. on a Saturday will have a guaranteed arrival time of noon on the next Monday for customers with a four (4) hour response time and 4:00 p.m. on that Monday for customers with an eight (8) hour response time guarantee. If a request for on-site service is made outside the PCP (to include extended coverage hours, if selected by the Customer), Siemens will use its best efforts to have a CSE on-site as soon as possible.

If Siemens responds to a request for on-site service during the PCP but its work to repair or service the Equipment continues after the expiration of the PCP (to include any extended coverage hours, if applicable), then any work outside the PCP will be billed to the Customer, unless any optional Continuous Effort coverage that is available for the Equipment has been purchased as part of this Agreement. Continuous Effort coverage ensures that in room/system down situations, work will continue past the contracted PCP (including any extended coverage hours, if applicable, and/or core modality specific hours, as defined in the Glossary, if applicable) at no additional charge until the system is repaired or 1:00 a.m., whichever comes first, as long as the CSE has been on-site for one hour or more before the end of the contracted PCP (including any extended coverage hours and/or core modality specific hours, if applicable).

The remedy provided by Siemens for its failure to meet the on-site response time guarantee is as follows: for each one (1) hour or portion thereof that Siemens fails to meet the on-site response time guarantee, the Customer will receive one (1) free hour of overtime after the PCP for that service event. The foregoing states Siemens' entire obligation and liability, and the Customer's sole remedy, for Siemens' failure to meet the Response Time Guarantee.

24. Tool and Test Access [DOES NOT APPLY TO EVERY SERVICE AGREEMENT]

Siemens agrees to rent to the Customer, certain tools and test equipment as determined by Siemens ("Tools") to enable Customer to service the Equipment during the Contract Duration on the terms set forth herein. Siemens shall provide Tools after verifying to its sole satisfaction that Customer's In-House Biomedical Engineers are properly trained on the Equipment and Tools.

Siemens shall notify Customer of the rental fee for the Tools at the time of the order. Customer will be charged the rental fee after shipment of the Tools to Customer. Customer agrees to pay full list price of Tools (less rental fees paid) if Customer fails to return the Tools as required herein.

Customer may use the Tools for up to two (2) weeks ("Rental Period") from the date of receipt of the Tools. Customer may, with Siemens' consent, extend the Rental Period for an additional rental fee. Customer must return the Tools within five (5) business days of the conclusion of the Rental Period ("Return Period"). If the Tools are not received by Siemens before the conclusion of the Return Period, Customer will be charged the then-current list price for the Tools. Customer may, at the conclusion of the Return Period, purchase the Tools at the then-current list price, subject to the Terms and Conditions of Sale for Spare Parts and Service. The delivery of the Tools to the Customer and return of the Tools to Siemens shall be completed by Siemens at its own expense.

Title to the Tools shall be and at all times remain with Siemens and Customer shall keep the same free and clear of any and all liens and claims. Customer (i) authorizes Siemens to execute in Customer's name and file (and Customer shall promptly execute, if requested by Siemens) and (ii) irrevocably appoints Siemens its agent and attorney-in-fact to execute in the name of Customer and file, with such authorities and at such locations as Siemens may deem appropriate, any Uniform Commercial Code financing statements evidencing Siemens' ownership of the Tools. Risk of loss shall pass to Customer upon delivery. Customer shall maintain at its expense adequate liability insurance with respect to its possession and use of the Tools and against all common risks (i.e., fire, flood, theft, Acts of God, etc.) for the full replacement value of the Tools. At the request of Siemens, Customer shall provide Siemens with an insurance certificate evidencing such insurance coverage.

Customer shall only use the Tools for their intended purpose, in the proper manner and with appropriate care, pursuant to any instructions, training and manuals provided to Customer by Siemens, Customer shall immediately report to Siemens or its designee any malfunction or defect, whatever the nature or cause.
Customer shall ensure that any necessary repair, modification or service to any Tool is carried out by Siemens or Siemens' designee. Siemens agrees to use its best efforts to repair the Tools as needed in a prompt and timely fashion, following a reported malfunction or defect. Customer shall not move the Tools from the

Customer's facilities identified on the front page of this Agreement. Customer shall return the Tools to Siemens in the same condition as when delivered to Customer (ordinary wear and tear excepted). Customer acknowledges the Tools constitute Confidential Information, and Customer will maintain the Tools in accordance with the Confidentiality provisions of this Agreement.

25. Centralized Depot Repair Procedures [DOES NOT APPLY TO EVERY SERVICE AGREEMENT]

For any Equipment that includes Centralized Depot Repair and Loaner Program as specified in Exhibit A, Siemens may provide the Customer a comparable system ("Loaned System") while Siemens attempts to repair the non-complying system. Purchaser's use of the Loaned System commences upon receipt of the Loaned System and continues until receipt of the repaired or replaced system (the "Loan Period"). The Loaned System must be returned to Siemens within two (2) business days of receiving the repaired or replaced system, and in accordance with the Siemens' written instructions. The Loaned System shall be returned in the same condition as when delivered, ordinary wear and tear excepted. Title to the Loaned System shall at all times remain with Siemens, but Customer will be responsible for equipment that is lost, stolen, or damaged during the Loan Period. Customer is also responsible for any personal injuries or property damages caused by the negligent acts or omissions of Customer, its officers, directors, employees or agents. Customer agrees to use the Loaned System in accordance with all instructions and manuals, and to immediately report to Siemens any malfunction or defect in the Loaned System. If the Loaned System is not returned to Siemens per requirements herein then Purchaser will be charged, and agrees to pay Siemens, a monthly rental fee of 3.5% of the fair market value of the Loaned System as determined by Siemens for each full month (or any portion thereof) until Siemens receives the Loaned System.

26. Non-Assignment

Customer may not assign this Agreement unless it obtains the prior written consent of Siemens, which consent shall not be unreasonably withheld or delayed. Siemens may not assign this Agreement unless it obtains the prior written consent of the Customer, which consent shall not be unreasonably withheld or delayed, except that Siemens may assign without Customer approval to any subsidiary or affiliated company or any of its authorized dealers.

27. Reimbursement for Training Courses and Educational Services Upon Early Termination; Cancellation

If this Agreement includes any training courses or other educational offerings and this Agreement is terminated or Equipment is removed from coverage as provided hereunder prior to the expiration of the term, then Siemens may bill the Customer for any balance due and owing with respect to those training courses or other educational offerings that have been completed by the Customer, and Customer agrees to pay the same.

Customer shall notify the Siemens training and education coordinator, in advance, of the cancellation, in whole or in part, of any training or other educational offering, or any request to reschedule the same. The cancellation or rescheduling of any training courses and other educational offerings may be subject to the payment of a cancellation fee. A copy of Siemens' cancellation policy is available upon request or can be found at:

https://usa.healthcare.siemens.com/education/personalized-education-by-solution/solution/imaging-and-therapy/cancellation-policy

28. Cost Reporting

Customer agrees that it must fully and accurately report prices paid under this Agreement, net of all discounts, as required by applicable law and contract, including without limitation 42 CFR §1001.952(h),in all applicable Medicare, Medicaid and state agency cost reports. Customer shall retain a copy of this Agreement and all other communications regarding this Agreement, together with the invoices for purchase and permit agents of the U.S. Department of Health and Human Services or any state agency access to such records upon request.

29. Execution; Counterparts

If the Customer is a corporation or partnership, the person signing this Agreement on its behalf certifies that such person is an officer or partner thereof, that his or her action was duly authorized by appropriate corporate or partnership action, that such action does not conflict with the corporate charter or bylaws or the partnership agreement, as the case may be, or any contractual provision binding on such corporation or partnership, and that no consent of any stockholders to his or her action is required.

This Agreement may be executed in two (2) or more counterparts, each of which shall constitute an original document but all of which together shall constitute one and the same agreement.

30. Entire Agreement

This Agreement, including all exhibits and addenda attached hereto, constitutes the entire agreement between the parties relating to the subject matter hereof, and supersedes all prior and contemporaneous oral or written representations or communications between the parties. This Agreement may not be modified or amended, except in writing executed by the appropriate designated officers of the parties hereto. Any variation in the terms and conditions contained in this Agreement (including, but not limited to, the inclusion of Customer's own terms and conditions in any purchase order or other document issued by Customer in response to and/or referencing Siemens' quotation for service or this Agreement) shall not be deemed to be a part of this Agreement and shall not be binding upon Siemens unless set forth in writing and executed by the appropriate designated officer of Siemens. Subject to the limitations expressed herein, this Agreement will be binding upon and inure to the benefit of the parties hereto, their successors, legal representatives, and permitted assigns. Notwithstanding anything to the contrary contained herein, the provisions of Sections 9, 10, 12, 13, 14, 15, 16, 18, 21 and 27 shall survive the expiration or termination of this Agreement.

SIEMENS Healthineers

Proposal # 1-YVC8EF

District / Sales Office

SIEMENS MEDICAL SOLUTIONS USA,INC.

,
Attn: Christie Stenzel
Email: christie.stenzel@siemens-healthineers.com

Sold To
LEWIS COUNTY HOSPITAL DISTRICT NO 1
521 ADAMS AVE
Morton, WA 98356

Bill To
LEWIS COUNTY HOSPITAL DISTRICT NO 1
521 ADAMS AVE
Morton, WA 98356

Payer
LEWIS COUNTY HOSPITAL DISTRICT NO 1
521 ADAMS AVE
Morton, WA 98356

Siemens Medical Solutions USA, Inc. is pleased to submit the following proposal for service and maintenance described herein at the stated prices and terms. Subject to your acceptance of the terms and conditions on the face and general terms and conditions Document hereof.

Item #	System Name	Functional Location	Service Agreement	Contract Duration	Warranty Period Price	Partial Year Price	Annual Price
1	ACUSON Sequoia ST		Silver contract	Warranty + 5 Years	$0	$0	$11,018

Includes:
Parts and/or Labor to the extent shown in Exhibit A.
System Updates.
Access to Siemens Customer Care Center for technical telephone support (remote diagnostics, if available to the site and the equipment).

Excludes:
Parts defective due to "acts of God", abuse, misuse, neglect, thermal and shock. Specialty components, including, but not limited to: Glassware, Flat Detectors, Consumables, Transducers, MRI coils, SPECT and PET sources (unless purchased as an option). Non-Siemens components and accessories (such as VCR, injector, laser printer, MR surface coils, tables/table tops, chiller, UPS, etc.) unless specifically identified in Exhibit A.

Terms of payment: Net 30 days from invoice date. Past due payment is subject to 1.5% interest charge per month.

Customer's Acceptance

_____
(By) (Signature)

_____
Name and Title

Acceptance Date _____

Siemens Medical Solutions USA, Inc.

_____
(By) (Signature)

Christie Stenzel Service Account Exec
Name and Title

Customer P.O. # _____ (enter P.O. # for contract billing; if not provided, Siemens will invoice without P.O.)
_____ (Initial if P.O. is required but will be issued prior to warranty expiration)
Standing P.O. # _____ (for T&M charges outside of the contract)

This service agreement proposal is valid for 30 days. Agreement becomes effective upon customer signature and Siemens acceptance. Customer's acceptance acknowledges receipt and agreement to Terms and Conditions set forth on all pages of this proposal.

Exhibit A

Item #1:

Equipment:	**ACUSON Sequoia ST**		
Equipment Location:	LEWIS COUNTY HOSPITAL DISTRICT NO 1		
Address:	521 ADAMS AVE, Morton, WA 98356		
Functional Location:	**Service Quote Nr:** 1-YVBTJS Rev 0	**Equipment Quote Nr:** CPQ-927821	**Payment Frequency:** Monthly
Standard Warranty: Extended Warranty	**Warranty Start:** Upon Warranty Commencement	**Warranty End:** 1 Year Duration	**Warranty Price:** $0
Service Agreement: Silver contract	**Contract Start:** Upon Warranty Expiration	**Contract End:** 5 Year Duration	**Annual Price:** $11,018

(See Glossary pages for detailed description of items listed below.)

Coverage applies during the Warranty or Contract Period as indicated:	Warranty Period	Contract Period
Principal Coverage Period	08:00am - 05:00pm M-F	08:00am - 05:00pm M-F
Uptime Guarantee	99%	95%
Phone Response	30 min	60 min
On-Site Response	10 hours	16 hours
Parts Order Requirement	6pm	6pm
Parts Delivery	Next Day	Next Day
Smart Remote Services	✓	✓
Safety Checks	✓	✓
Quality Assurance	✓	✓
Travel	✓	✓
Updates	✓	✓
Technical Phone Support	✓	✓
Labor	✓	✓
General Spare Parts Coverage	✓	✓
Application Hotline Phone Support	✓	✓
No Consumable Coverage	✓	✓
Tier 1 Transducer Pooling	✓	✓
Planned Maintenance	✓	✓
teamplay Fleet Access	✓	✓
No TechUp 18 (previously Evolve) Coverage	✓	N/A
Warranty Transducer - WF	✓	N/A
TechUp 18 (previously Evolve) (Min 3yr agreement post-warranty)	N/A	✓
Enhanced Virtual Learning Sub. - US	N/A	Qty 1
Transducer Tier 1 (WFD)	N/A	Qty 1

The Options or Alternatives listed below will be included in the warranty or contract as indicated, only if initialed:

Opt/ Alt	Option / Alternative	Add to Warranty Price	Add to Contract Annual Price	Initial
Opt	Consumable Coverage	$0	$315	

This pricing is only valid for new service contracts that are signed with the equipment purchase or prior to warranty commencement.

No further Options or Alternatives are included in the above listed equipment.

Glossary

Deliverables	Description
Application Hotline Phone Support	Siemens Customer Care Center Clinical Applications Phone Support is provided with this contract during modality specified hours, call 1-800-888-7436 with your questions and to receive direct access to a Clinical Education Specialist.
Consumable Coverage *(Optional)*	Siemens will supply at its own expense, consumables; such as but not limited to, batteries, leads, padding, storage media, cassettes, etc. Full list of consumables covered can be found on teamplay Fleet customer portal: fleet.siemens-healthineers.com Excludes parts defective due to “acts of God”, abuse, misuse, neglect, thermal and shock. Excludes specialty components, including, but not limited to: Glassware, Flat Detectors, Transducers, MRI coils, SPECT and PET sources (unless purchased as an option). Excludes non-Siemens components and accessories (such as VCR, injector, laser printer, MR surface coils, tables/table tops, chiller, UPS, etc.) unless specifically identified in Exhibit A.
Enhanced Virtual Learning Sub. - US	This 12 month multi-modality subscription provides access for imaging professionals to receive additional educational content. This high-value content includes step-by-step performance-enhancing videos, a minimum of 6 one-hour on-demand webinars covering current clinical and industry topics, and access for up to 12 CEUs via your PEPconnect Virtual Wallet. The on-demand webinars are recorded and posted on a regular basis over the term of the subscription and are available for unlimited viewing once posted. Imaging professionals must be logged into PEPconnect (Siemens’ online learning platform) to be eligible to receive the CEUs. PEPconnect provides access to all online and virtual training with a wide variety of product-specific, clinical and job-relevant courses. This educational offering must be completed 12 months from purchase date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
General Spare Parts Coverage	Includes replacement of standard spare parts. Excludes Consumables (batteries, leads, padding, storage media, cassettes, radioactive sources, etc.), Glassware; MR Surface and specialty coils (knee, head, etc.); MR MMA, cryocare and helium; high-Vacuum components including Magnetron, Klystron and Thyratron, Waveguide; shock wave components, Transducers, TEE’s and Specialty Probes, Flat Panel Detectors, MMLC, Van System coverage, PACS related systems and non-Siemens parts such as VCR, injector, laser printer, tables/table tops, chiller etc.) unless specifically identified in Exhibit A. Excludes parts defective due to “acts of God”, abuse, misuse, neglect, thermal and shock.
Labor	Unlimited coverage of on-site labor during the Principal Coverage Period indicated. Preferred labor rates for billable service outside of Principal Coverage Period (at current prevailing tiered rates).
No Consumable Coverage	Upon selection to not have consumable coverage, customer agrees to supply at his/her own expense consumables, such as but not limited to, batteries, leads, padding, storage media, cassettes, etc. Full list of consumables covered can be found on teamplay Fleet customer portal: fleet.siemens-healthineers.com.
No TechUp 18 (previously Evolve) Coverage	Operating system software or hardware upgrades are not included; Siemens is not obligated to provide software updates to down-level software versions. This could limit Siemens’ capabilities to mitigate system or component end of support and may result in hardware or software obsolescence. Alternative hardware and/or software may be purchased as an upgrade—if available—but will not be covered by the terms of this service agreement.
On-Site Response	Siemens guarantees on-site CSE arrival within a specific time period (see Exhibit A) after a call for service has been placed with the UPTIME Service Center. This on-site response applies in system/room down situations only. (See Response Time Guarantee in General Terms and Conditions for additional information.)
Parts Delivery	Spare parts arrival for on-site repair of room-down/system-down is typically the Next Day following the time the parts order is submitted.
Parts Order Requirement	Parts order must be placed with Siemens by 6pm (Customer's local time) in order to receive Parts Delivery commitment as specified.
Phone Response	30-minute maximum phone response time by Siemens Customer Care Center personnel or service engineer to provide status of a service call during Principal Coverage Period.
Planned Maintenance	Preventive services carried out in accordance with the equipment's specific maintenance plan. This includes: tracking and scheduling of required maintenance tasks; exchange of wear and tear parts according to maintenance plan; care measures; adjustments to factory specifications; verification of specified performance and functionality; documentation and detailed protocol of system condition.
Principal Coverage Period	Hours defined in Exhibit A during which agreed-upon services are provided.
Quality Assurance	Quality Assurance tasks are performed to keep the system within the quality specifications as issued by the relevant Equipment’s specifications. They consist of Tracking and scheduling of required quality assurance tasks Check of measuring and image quality parameters Verification of specified quality parameters Adjustments to factory quality specifications Documentation and detailed quality report of system condition

Deliverables	Description
Safety Checks	Safety Checks are performed to insure compliance with all local and federal guidelines and regulations. This service consists of Tracking and scheduling of required tests Mechanical Safety Checks (e.g. mechanical movements etc.) Electrical Safety Checks (e.g. leakage currents, insulation etc.) Reporting of findings and results
Smart Remote Services	Smart Remote Services – the efficient and comprehensive infrastructure for medical equipment-related remote services – combines high-tech medical engineering with state-of-the-art information technology. Services, which formerly required on-site visits, are now available via data transfer. SRS enables both Core Services (which are included as part of our standard service agreements), as well as optional services (called Enhanced Productivity Services - EPS). A VPN connection is required.
teamplay Fleet Access	teamplay Fleet portal provides most relevant equipment information, including contract duration and service level agreement across your entire institution and multiple locations. Access includes documents, online training courses provided by PEPconnect and smart connection to other teamplay applications across any of Siemens Healthineers imaging, laboratory and software solutions.
Technical Phone Support	Access to specialists at the Siemens Customer Care Center for fast diagnosis and technical support is available during Modality Staffed hours (MSH). Technical support resources will be available outside of Staffed Hours on an on-call basis during the On-Call Hours specified by modality for emergency calls only. Telephone response times for technical support cannot be guaranteed outside of Staffed Hours. All modality Staffed Hours are listed below (and can also be found on teamplay Fleet: fleet.siemens-healthineers.com) and are subject to change. Modality Staffed Hours (MSH) On-Call Hours (EST) On-Call Hours (EST) AT AX 7:00a - 7:00p M-F 24x7 outside MSH AT SU 8:00a - 6:00p M-F N/A AT ECS 8:00a - 6:00p M-F 6:00p - 12:00a M-F CT 7:00a - 12:00a M-F 7:00a – 5:00p Sat-Sun 24x7 outside MSH MI PET 7:00a – 10:00p M-F 7:00a – 3:00p Sat-Sun 6:30a –10:00p Holidays MI SPECT 7:00a - 10:00p M-F 8:00p - 12:00a M-F 7:00a – 5:00p Sat-Sun 6:00a –12:00a Holidays MI PCL 8:00a - 6:00p M-F N/A MR 6:30a - 10:00p M-F 7:00a – 5:00p Sat 24x7 outside MSH ULT 7:30a - 8:00p M-F 8:00a – 11:00p M-F 8:00a – 8:00p Sat-Sun XPRF 8:00a - 7:00p M-F 7:00a – 12:00a M-F 8:00a – 8:00p Sat-Sun XPWH, XPU, XPSU 8:00a – 5:30p M-F 5:30a – 12:00a M-F 8:00a – 8:00p Sat-Sun
TechUp 18 (previously Evolve) (Min 3yr agreement post-warranty)	Ultrasound TechUp 18 program provides eligible customers with feature enhancements to existing software licenses, new features from software base configuration and new features from Loyalty Plus license if available from the software chosen by Siemens Healthineers. TechUp 18 updates are software only and will be available at least once every 18 months.
Tier 1 Transducer Pooling	Annual Tier 1 Transducer allowances may be shared across all functional locations that provide for pooling of Tier 1 Transducers. Annual allowances may not be applied to any prior or subsequent contract year.
Transducer Tier 1 (WFD)	Covers replacement of Tier 1 Transducers up to the quantity specified per year (as shown on Exhibit A) for Wear, Failure or Damage. Damage examples include: damage to the Lens (e.g. gouges, tears, cuts, and cracks) and damage to the Cable Jacket (e.g. cuts, kinks). If this coverage is not purchased, Tier 1 Transducer replacements are chargeable and may cost up to approximately $12,000 each after any applicable exchange credit has been applied.
Travel	Includes travel time for Customer Service Engineer to and from Customer's site. Subject to change to reflect currently prevailing rates, if occurring outside of the Principal Coverage Period indicated.
Updates	Modifications or reliability enhancements to equipment includes two types: Mandatory (safety and performance-related update instructions) and Non-mandatory (reliability-related service instructions). Labor is included during the hours of PCP. Does not include enhancements to the operating systems or additional functionality.
Uptime Guarantee	Siemens guarantees that the Equipment will function at the minimum Uptime Performance level as specified on Exhibit A. System availability is calculated over a 12-month period, calculated over the Principal Coverage Period. Siemens Remote Services (SRS) connection via VPN broadband is required. (See Uptime Guarantee of General Terms and Conditions for further details.)
Warranty Transducer - WF	Covers unlimited replacement of Transducers for Wear or Failure (but not for Damage) during the warranty period.

Siemens Medical Solutions USA, Inc. General Terms and Conditions

1. Scope
For the term set forth on the first page hereof under the heading "Contract Duration", Siemens will provide (i) remedial maintenance service on the equipment described on the preceding pages hereof (the "Equipment") when requested by the Customer, as well as planned maintenance inspections, when scheduled, as further described in the Glossary section attached hereto, in order to keep the Equipment operating in accordance with the manufacturer's specifications, and (ii) any training courses and/or other educational offerings described in Exhibit A and the Glossary. Siemens will make every effort to respond to service calls at a mutually agreed upon arrival time consistent with the provisions cited in Section 2. In connection with the provision of Equipment maintenance services, Siemens may take photographs or other images of the Equipment or components thereof in order to expedite the completion of repairs, provided that any such photographs shall not include any patients, employees or agents of the Customer and further provided that such photographs and images will only be used in order for Siemens to carry out its duties and responsibilities hereunder.

In the event that (i) the term of this Agreement does not include the Equipment warranty period (as indicated on the first page hereof under the heading "Contract Duration"), or (ii) the term of this Agreement does not commence immediately upon the expiration of the Siemens warranty, or (iii) the Equipment was serviced prior to commencement of the term by anyone other than Siemens or an authorized Siemens dealer or service provider, or (iv) the Equipment was moved from its original location or is not connected to its original power supply (other than portable or mobile Equipment), then the Equipment is subject to inspection by Siemens to determine if it is in good operating condition prior to the commencement of services under this Agreement. Any inspection as well as any repairs or adjustments deemed necessary by Siemens during such inspection may be made at Siemens' per-call rates and terms then in effect and may include charges for parts, with all such repairs or adjustments to be completed prior to the commencement of service under this Agreement.

2. Principal Coverage Period (PCP)
Service and maintenance will be provided during the principal coverage period ("PCP") as defined on Exhibit A, excluding the following holidays: New Years Day, Memorial Day (observed), Independence Day, Labor Day, Thanksgiving Day, Christmas Day. If one of the foregoing holidays falls on a Saturday, then the holiday will be observed on the previous Friday, and if the holiday falls on a Sunday, the holiday will be observed on the following Monday. Unless an extended hours coverage option has been selected, labor and travel required outside the PCP will be charged at Siemens' per-call rates and terms then in effect.

3. Replacement Parts and Labor
Siemens will supply at its own expense, necessary parts and labor, except as indicated in the Glossary section, provided replacement of the parts and necessary labor is required because of normal wear and tear or otherwise deemed necessary by Siemens and further provided that the Siemens-manufactured parts are available from the factory. For all parts and labor excluded from coverage under this Agreement, Customer must purchase all necessary replacement parts and labor from Siemens under Siemens' Standard Terms and Conditions of Sale for Spare Parts and promptly return to Siemens all used, unused or defective parts. All Parts will be new, standard parts, or used, reworked or refurbished parts that comply with applicable performance and reliability specifications. Exchange parts removed from the Equipment shall become the property of Siemens unless such exchange parts constitute "hazardous wastes", "hazardous substances", "special wastes" or other similar materials, as such terms are defined by any federal, state or local laws, rules or regulations, in which case, at the option of Siemens, the exchange parts shall remain the property of the Customer and shall be disposed of by the Customer in strict compliance with all applicable laws, rules and regulations.

4. Planned Maintenance (PM)
Planned maintenance will be carried out according to the manufacturer's recommended schedule. Planned maintenance generally includes checking mechanical and electrical safety, lubrication, functional testing and adjusting for optimum performance as specified in the detailed planned maintenance work plan.

5. Software Maintenance
Whenever the Equipment covered by this Agreement utilizes Siemens' operating system software, Siemens will provide all maintenance and commercially available updates for such operating system software as part of this Agreement. Such updates will solely enhance previously purchased capacities of the Equipment. Operating system software upgrades that provide new features or capabilities or that require hardware changes will be offered to Customer when commercially available and at purchase prices established by Siemens. In addition, some upgrades may require applications training performed by Siemens' personnel that will be offered at Siemens' rates and terms then in effect. Siemens retains the sole right to determine whether an upgrade requires such training.

Nothing in this Agreement shall in any way grant to Customer any right to or license in any diagnostic service software utilized by Siemens in servicing the Equipment. Such service software is and remains the property of Siemens and is available to Customer pursuant to the terms and conditions of a separate diagnostic materials license agreement, which may require payment of a license fee. This service software shall be disabled by Siemens upon cancellation or termination of this Agreement.

6. Equipment; Location; Remote Access
The Equipment covered under this Agreement is limited to the Siemens furnished Equipment described on the face sheet(s). Customer is required to maintain the Equipment in accordance with the manufacturer's written specifications. The Equipment shall not be moved to another location unless Customer obtains the prior written consent of Siemens, except that Customer shall be entitled to move: portable Equipment (e.g., Ultrasound equipment so long as it remains inside the Customer's same facility to which it was originally delivered). Siemens Equipment that is housed in a mobile vehicle, van or trailer may be moved to other locations within the same facility, so long as the Customer informs Siemens of the location of the Equipment when Siemens is scheduled to provide on-site service. If Equipment is located in a trailer, van or other form of mobile vehicle, the Equipment may be moved from the Equipment Location identified on Exhibit A, provided, however, that Siemens shall not be required to service such Equipment, and the Response Time and Uptime Performance Guarantees (if any) or Availability Commitment (if applicable) shall not apply, if either (a) the Customer does not notify Siemens at least one (1) month in advance of the Equipment's mobile route, or (b) the Equipment is moved more than 25 miles from the original Equipment Location. If fixed Equipment is moved to any other location within the Customer's facility, then either (a) the Customer will engage Siemens to relocate the Equipment, at Siemens' then current rates and charges, or (b) if Siemens does not perform the services necessary to relocate the Equipment, then Siemens may suspend services with respect to such Equipment until Siemens performs an inspection of the Equipment, at the Customer's cost, to determine if any repairs are necessitated as a result of any such relocation (in which case the Customer shall be separately charged for such repairs, including parts and labor, at Siemens' rates and charges then in effect). Customer shall, at its expense, provide all proper and necessary labor and materials for plumbing service, carpentry work, electrical and conduit wiring, water supply, ventilation and other preparations required for such installation and connection services and all the permitting relating to the foregoing. All such labor and materials shall be completed by Customer and available prior to the time Siemens is scheduled to perform the services.

Siemens service personnel will be given full and safe access to the Equipment to perform inspections and service/maintenance on the Customer's premises, and will make specific appointments for such maintenance. If the Equipment is not made available at the appointed time, waiting time beyond a reasonable allowance will be charged at Siemens' per-call rates and terms then in effect.

Customer shall arrange for the Equipment to be cleaned and decontaminated after contact with blood or other potentially infectious material. However, Customer shall have no obligation to open closed Equipment to clean or decontaminate internal components.

Customer shall provide Siemens with both on-site and remote access to the Equipment. Customer shall provide on-site access at premises free of hazardous, concealed or dangerous conditions, including safe and unobstructed means of ingress and egress. The remote access shall be provided through the Customer network as is reasonably necessary for Siemens to provide services under this Agreement. Remote access will be established through a broadband internet based connection to either a Customer owned or Siemens provided secure end-point. The method of connection will be a Peer-to-Peer VPN IPsec tunnel (non-client based) or another technology specified by Siemens which provides a comparable level of protection, in either case with specific inbound and outbound port requirements.

In the event the Customer fails to provide or maintain the remote access connection for any Proactive Service Agreement (e.g., Pinnacle, Select, Essential, as identified in Exhibit A), or any Signature, Benchmark, or Balance Service Agreement with a volume-based deliverable as defined in Exhibit A, then Siemens shall have the option to terminate this Agreement. In addition, in accordance with the terms of Section 22 hereof, any Uptime Performance Guarantee or Availability Commitment (if applicable) shall be void if the remote access connection is not provided and available 24 hours per day, 7 days a week.

7. Agreement Term; Price; Payment Terms
This Agreement shall be in effect for the period stated on the first page of this Agreement.

For the basic services to be provided by Siemens under the terms of this Agreement, Siemens shall send invoices to the Customer and payments shall be made in advance based on the payment frequency shown in Exhibit A under "Payment Frequency".

Invoices for all amounts due under this Agreement shall be sent to the Customer by regular U.S. mail, postage prepaid, at the address set forth on the first page hereof under "Bill To".

After the first year of the term of the Equipment coverage period set forth in the Agreement, Siemens may increase the Annual Agreement Price no more than once every twelve (12) months based upon the percentage increase in the Consumer Price

Index for All Urban Consumers, U.S. City Average, All Items ("CPI"), as published by the United States Department of Labor, Bureau of Labor Statistics. The percentage increase in the CPI shall be measured over the period since the commencement of the Agreement (in the case of the first price increase) or since the effective date of the last price increase (in the case of any subsequent price increases). Siemens shall provide the Customer with no less than thirty (30) days written notice of any price increase.

All payments to be made by Customer under this Agreement are due net thirty (30) days from the invoice date. Past due payments shall bear interest at the rate of 1½% per month.

8. Causes for Exclusion/Separate Charges

This Agreement specifically excludes labor, parts and expenses necessary to repair Equipment:

• damaged by fire, accident, misuse, abuse, negligence, improper application or alteration or by a force majeure occurrence as described in Section 17 hereof, or by the Customer's failure to operate the Equipment in accordance with the manufacturer's instructions, including without limitation Customer's failure to maintain the recommended operating environment and line conditions or intentional delay in requesting service for Equipment;

• defective due to unauthorized attempts to repair, relocate, maintain, service, add to or modify the Equipment by the Customer or any third party or due to the attachment and/or use of non-Siemens supplied parts, equipment or software without Siemens' prior written approval (and if the Customer or a third party modifies the Equipment, then Siemens may remove such Equipment from coverage under this Agreement unless the Customer restores the Equipment to the manufacturer's published specifications);

• defective due to any repair or service of the Equipment by the Customer or any third party prior to the commencement of the term of this Agreement;

• due to Customer not providing full access to the Equipment, on a safe site free of hazardous, concealed or dangerous conditions;

• which failed due to causes from within non-Siemens supplied equipment, parts or software including, but not limited to, problems with the Customer's network;

• which is worn out and cannot be reasonably repaired due to the unavailability of spare parts from the original equipment manufacturer; or

• which is a transducer or probe and which is damaged or defective, or which failed, due to any of the foregoing causes or due to improper cleaning, disinfecting or TEE bite marks.

If Siemens is called upon to service or repair Equipment which falls under this Section 8, a separate invoice will be issued for labor, parts and expenses at Siemens' rates and terms then in effect.

This Agreement does not entitle the Customer to services related to information technology, patient and imaging workflow design and analysis, or problem diagnosis. Siemens' responsibility under this Agreement does not extend beyond the outbound or inbound sockets of the Equipment. In addition, changes, adjustments, additions or repairs required to or with respect to the Equipment resulting from issues, matters, items or concerns that are the responsibility of the Customer, such as changes related to Customer's network infrastructure, are not covered by this Agreement. This may include, but is not limited to, network IP address changes. Although the Equipment may have limited short term storage capacity, the storage of images, both patient and QA images, is the responsibility of the Customer.

If Siemens offers a Network Assistance option for the Equipment and the Customer purchases this option as indicated on Exhibit A, then Siemens shall assist the Customer in its efforts to identify the cause of any network or connectivity problems which may affect the operation of the Equipment; provided, however, that the price for this option does not include the cost of any repairs (labor, parts, etc.) to remedy such problems, which shall be the sole responsibility of the Customer. If the Customer does not purchase this option, or if this option is not offered by Siemens, then any assistance provided by Siemens to the Customer with respect to any network or connectivity issues shall require a P.O. from the Customer and shall be separately billed to the Customer at Siemens' then current rates and charges.

9. Default

Customer shall be in default under this Agreement upon: (i) a failure by Customer to make any payment due Siemens within ten (10) days of receipt of notice from Siemens that the payment was not made within the applicable payment period; (ii) a failure by Customer to perform any other obligation under this Agreement within thirty (30) days of receipt of notice from Siemens; (iii) a failure by Customer to grant Siemens access to the Equipment as set forth in Section 6 of this Agreement; (iv) a failure by Customer to notify Siemens the Equipment is in need of remedial maintenance or to permit Siemens to inspect, repair or adjust the Equipment as deemed necessary by Siemens (a) as set forth in Section 1 of this Agreement; or (b) at any time during the term of this Agreement in order to keep the Equipment operating in material compliance with the written specifications; (v) a failure by Customer to maintain the Equipment in accordance with the manufacturer's written specifications; (vi) a failure by Customer to purchase from Siemens all necessary replacement parts and labor that are excluded from coverage under this Agreement; (vii) a default by Customer or any affiliate of the Customer under any other obligation to or agreement with Siemens or Siemens Financial Services, Inc. or any assignee of the foregoing (including but not limited to, a promissory note, lease, rental agreement, license agreement or purchase contract); or (viii) the commencement of any insolvency, bankruptcy or similar proceedings by or against the Customer (including any assignment by Customer for the benefit of creditors). Upon the occurrence of any event of default hereunder, Siemens may, in addition to any and all other remedies available under law, elect to: (i) immediately cease providing services under this Agreement and any and all other agreements between the parties, or suspend any training courses or educational offerings provided under this Agreement, until the default is cured or corrected, (ii) terminate this Agreement, in which case Customer shall pay to Siemens (a) all amounts due under this Agreement through the effective date of termination, (b) as liquidated damages and not as a penalty, an amount equal to 25% of the remaining payments due under this Agreement from the date of termination through the scheduled expiration of the term of this Agreement, and (c) all costs and expenses of collection, including without limitation reasonable attorneys' fees and court costs incurred by Siemens as a result of the Customer's default, (iii) void any and all warranties for the Equipment that has been affected by the use of unauthorized replacement parts and/or Customer or third-party labor; and/or (iv) commence collection actions (including court actions) for all sums due under this Agreement. All rights and remedies available to Siemens hereunder, by law or equity, shall be cumulative and there shall be no obligation for Siemens to exercise a particular remedy.

In the event that Customer cures all defaults hereunder, then prior to resumption of the Equipment maintenance services under this Agreement, Siemens may inspect the Equipment to determine if it is in good operating condition. Such inspection shall be charged to the Customer at Siemens' per-call rates and terms then in effect. Any repairs or adjustments which Siemens determines are required due to (i) the use of any non-Siemens parts, (ii) the repair or service of the Equipment by the Customer or any third party during the suspension of services by Siemens, or (iii) any of the exclusions from coverage set forth in Section 8 of this Agreement, shall be charged to the Customer at Siemens' rates and terms then in effect and shall include charges for parts, with all such repairs or adjustments to be completed prior to the resumption of service under this Agreement.

10. Limitation of Liability

Siemens' entire liability and Customer's exclusive remedy for any direct damages incurred by the Customer from any cause whatsoever, and regardless of the form of action, whether liability in contract or in tort, arising under this Agreement or related hereto, shall not exceed, as applicable: (i) an amount equal to the Annual Agreement Price (in effect when the cause of action arose) for the specific item of Equipment under this Agreement that caused the damage or is the subject matter of, or is directly related to, the cause of action, or (ii) the amount paid by Customer to Siemens under this Agreement for the particular training course or educational offering that is the subject matter of the claim. The foregoing limitation of liability shall not apply to claims by Customer or third parties for bodily injury or damage to real property or tangible personal property (including damage to the Equipment covered by this Agreement) caused solely and directly by the gross negligence or willful misconduct of Siemens. In addition, Siemens shall have no liability hereunder to Customer to the extent that Customer's or any third party's acts or omissions contributed in any way to any loss it sustained or to the extent that the loss or damage is due to a force majeure occurrence as described in Section 17 hereof or any other cause beyond the reasonable control of Siemens.

THIS IS A SERVICE AGREEMENT. WITHOUT LIMITING THE LIMITATION OF LIABILITY SET FORTH IN THE PRECEDING PARAGRAPH, SIEMENS EXPRESSLY DISCLAIMS ALL WARRANTIES, EXPRESS OR IMPLIED, INCLUDING BUT NOT LIMITED TO, ANY IMPLIED WARRANTIES OF MERCHANTABILITY AND WARRANTIES OF FITNESS FOR A PARTICULAR PURPOSE. IN NO EVENT WILL SIEMENS BE LIABLE FOR ANY LOST PROFITS, LOST SAVINGS, LOST REVENUES, LOSS OF USE OR DOWNTIME (EXCEPT AS OTHERWISE PROVIDED HEREIN), LOST DATA, OR FOR ANY INDIRECT, INCIDENTAL, UNFORESEEN, SPECIAL, PUNITIVE OR CONSEQUENTIAL DAMAGES WHETHER BASED ON CONTRACT, TORT (INCLUDING NEGLIGENCE), STRICT LIABILITY OR ANY OTHER THEORY OR FORM OF ACTION, EVEN IF SIEMENS HAS BEEN ADVISED OF THE POSSIBILITY THEREOF, ARISING OUT OF OR IN CONNECTION WITH THIS AGREEMENT OR THE USE OR PERFORMANCE OF THE EQUIPMENT.

11. Notices

Except for the issuance of invoices as set forth in Section 7 hereof, all notices required to be provided hereunder shall be in writing and shall be sent by overnight delivery via a nationally recognized delivery service or by certified or registered mail, postage prepaid, to Siemens at the address set forth on the first page of this Agreement and to the Customer at the address set forth under "Bill To" on the first page of this Agreement. Notice given in compliance with this Section 11 shall be sufficient for all purposes under this Agreement, and such notice shall be effective when sent. Either party may change its notice address only if notification is sent in writing pursuant to this Section 11.

12. Governing Law; Waiver of Jury Trial

This Agreement shall be governed by the laws of the Commonwealth of PA. TO THE EXTENT NOT PROHIBITED BY LAW, THE PARTIES WAIVE ALL RIGHTS TO A JURY TRIAL IN ANY LITIGATION ARISING FROM OR RELATED IN ANY WAY TO THIS AGREEMENT OR THE TRANSACTION CONTEMPLATED HEREBY.

13. Government Access Clause
Until the expiration of four (4) years after the furnishing of any services under this Agreement, Siemens shall make available upon written request of the Secretary of the Department of Health and Human Services, the Comptroller General, or any of their duly authorized representatives, this Agreement and the books, documents and records of Siemens which are necessary to certify the nature and extent of costs incurred under this Agreement. If Siemens carries out any of the duties of this Agreement through a subcontract with a value of $10,000 or more over a 12 month period with a related organization, such subcontract shall include a clause to the effect that until the expiration of four (4) years after the furnishing of any services under the subcontract, the related organization shall make available upon written request of the Secretary of the Department of Health and Human Services, the Comptroller General, or any of their duly authorized representatives, the subcontract and the books, documents and records of the related organization that are necessary to certify the nature and extent of costs incurred under that subcontract.

This provision shall apply if and solely to the extent that Section 1861 (v) (1) (I) of the Social Security Act applies to this Agreement.

14. Damages, Costs, And Fees
In the event that any dispute or difference is brought arising from or relating to this Agreement or the breach, termination, or validity thereof, the prevailing party shall not be entitled to recover from the other party punitive damages. The prevailing party shall be entitled to recover from the other party all reasonable attorneys' fees and collection agency fees incurred, together with such other expenses, costs and disbursements as may be allowed by law.

15. Severability; Headings
No provision of this Agreement which may be deemed invalid, illegal or unenforceable will in any way invalidate any other portion or provision of this Agreement. Paragraph headings are for convenience only and will have no substantive effect.

16. Waiver
No failure, and no delay in exercising, on the part of any party, any right under this Agreement will operate as a waiver thereof, nor will any single or partial exercise of any right preclude the further exercise of any other right.

17. Force Majeure
Siemens will not be liable to Customer for any failure to fulfill its obligations under this Agreement due to causes beyond its reasonable control and without its fault or negligence including, but not limited to, governmental laws and regulations, acts of God or the public, war or other violence, civil commotion, blockades, embargoes, calamities, floods, fires, earthquakes, explosions, accidents, storms, strikes, lockouts, work stoppages, labor disputes, or unavailability of labor, raw materials, power or supplies. In addition, in the event of any determination pursuant to the provisions of a collective bargaining agreement between the Customer and any labor union representing any employees of the Customer preventing or hindering the performance of any of the obligations of Siemens under this Agreement, or determining that the performance of any such obligations violates provisions of that collective bargaining agreement, or in the event a trade union, or unions, representing any of the employees of the Customer otherwise prevents Siemens from performing any such obligations, then Siemens shall be excused from the performance of such obligations unless the Customer makes all required arrangements with the trade union, or unions, to permit Siemens to perform the work. The Customer shall pay any additional costs incurred by Siemens that are related to any labor dispute(s) that involve the Customer.

18. Confidentiality
Siemens and the Customer shall maintain the confidentiality of any information provided or disclosed to the other party, its employees or agents (a "receiving party") relating to the business, customers and/or patients of the disclosing party, including but not limited to know-how, technical data, processes, software, techniques, developments, inventions, research products and plans for future developments, proprietary matters of a business or technical nature, as well as this Agreement and its terms (including the pricing and other financial terms under which the Customer will be obtaining the services hereunder). Confidential Information shall also include all written materials (including correspondence, memoranda, manuals, training materials, notes and notebooks) and all computer software, models, mechanisms, devices, drawings or plans which may be disclosed or made available embodying Confidential Information. All Confidential Information shall be and remain the sole and exclusive property of the disclosing party. Each party shall use reasonable care to protect the confidentiality of the information disclosed, but no less than the degree of care it would use to protect its own confidential information, and shall only disclose the other party's confidential information to its employees and agents having a need to know this information. Confidential Information shall not include any information or data which (i) is or becomes public knowledge (through no fault of the receiving party or any of its employees or agents), (ii) is made available to the receiving party by an independent third party without any obligation of confidentiality, (iii) is already in the receiving party's possession at the time of receipt from the disclosing party (as such prior possession can be properly demonstrated by it), or (iv) is required by law to be disclosed, provided that the receiving party gives the disclosing party advance notice of the requirement for disclosure so that the disclosing party can take whatever action it deems necessary to protect the disclosure of its Confidential Information. In addition, this confidentiality provision shall not apply to any action brought by either party to enforce the terms of this Agreement against the other party.

Any unauthorized use, disclosure or misappropriation of any Confidential Information by the receiving party in violation the foregoing may result in irreparable and continuing damage to the disclosing party; in the event of such breach, the disclosing party shall be entitled to obtain immediate injunctive relief and any other relief or remedies to which it may be entitled. The receiving party waives any requirement that the disclosing party post a bond or other security in connection with any petition filed by the disclosing party for injunctive relief. In the event that a court of competent jurisdiction determines that the receiving party has breached this provision, then the receiving party shall reimburse the disclosing party for the costs of any court proceedings and all reasonable attorneys' fees.

19. End of Support Announcement
Notwithstanding anything to the contrary contained herein, in the event that Siemens makes a general announcement that it will no longer offer service agreements for an item of Equipment or components thereof, or provide a particular service agreement option or feature, whether due to the unavailability of spare parts or otherwise (an "EOS Announcement"), then upon no less than twelve (12) months prior written notice to the Customer, Siemens may remove any affected Equipment, components, options or features from coverage under this Agreement, with a corresponding adjustment of the Annual Agreement Price. In addition, at the end of this twelve (12) month period, the Customer may either remove the affected Equipment, components, options or features from coverage under this Agreement on or after the EOS date and with no less than thirty (30) days written notice; or request that Siemens provide service or parts on a time and materials basis only, at Siemens' rates and terms then in effect, for any Equipment, components, options or features subject to an EOS Announcement.

20. Removal of Equipment from Coverage
The Customer may remove Equipment from coverage under this Agreement at any time upon no less than thirty (30) days prior written notice to Siemens if the use of the Equipment is permanently discontinued and the Equipment is removed from service. There is no fee for this cancellation. Prorated credit will be issued for any advance payments made by the Customer for the period after the effective date of removal (based on the notice requirement). In addition, if the Customer sells or otherwise transfers any of the Equipment to a third party and the Equipment remains installed and in use at the same location, but such third party does not assume the obligations of the Customer under this Agreement or enter into a new service agreement with Siemens with a term at least equal to the unexpired term of this Agreement, then the Customer may terminate this Agreement with respect to such Equipment upon no less than thirty (30) days prior written notice to Siemens, in which case the Customer shall pay to Siemens (i) all amounts due under this Agreement through the effective date of termination (based on the notice requirement) and (ii) as liquidated damages and not as a penalty, an amount equal to 25% of the remaining payments due under this Agreement for such Equipment from the date of termination through the scheduled expiration of the term of this Agreement.

21. HIPAA
To the extent required by the provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and any regulations promulgated thereunder, Siemens does hereby assure Customer that it will appropriately safeguard Protected Health Information (as defined under HIPAA) made available to or obtained by Siemens pursuant to this Agreement or any Service Schedule ("PHI"). Without limiting the obligations of Siemens otherwise set forth in this Agreement or imposed by applicable law, Siemens agrees to comply with applicable requirements of law relating to PHI and with respect to any task or other activity Siemens performs on behalf of Customer. Specifically, Siemens shall:

(a) not use or disclose PHI other than as permitted or required by this Agreement or as required by law, and limit any use or disclosure of PHI to a limited data set or the minimum necessary to accomplish the intended purpose of such use or disclosure;

(b) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any electronic PHI that it creates, receives, maintains or transmits on behalf of the Customer, and comply, where applicable, with the HIPAA Security Rule with respect to such electronic PHI, and otherwise use appropriate safeguards to prevent use or disclosure of PHI, other than as provided for by this Agreement;

(c) report to Customer any use or disclosure of PHI not provided for by this Agreement, and report any security incident, of which Siemens becomes aware;

(d) in accordance with applicable HIPAA and HITECH requirements, ensure that any subcontractors or agents to whom Siemens provides PHI received from, or created or received by Siemens on behalf of, Customer agree to essentially the same restrictions and conditions that apply to Siemens with respect to PHI and implement reasonable and appropriate safeguards with respect to PHI;

(e) upon Customer's written request, make PHI available to the Customer as necessary for Customer to respond to individuals' requests for access to PHI about them, provided that the PHI in Siemens' possession constitutes a Designated Record Set and Siemens has been specifically engaged by Customer to so maintain and service such PHI on behalf of Customer;

(f) upon Customer's written request, make PHI available to Customer for amendment and incorporate any amendments to the PHI in accordance with applicable law, provided that the PHI in Siemens' possession constitutes a Designated Record Set and Siemens has been specifically engaged by Customer to so maintain and service such PHI on behalf of Customer;

(g) make available to Customer the information in its possession required to provide an accounting of disclosures of PHI as required by applicable law;

(h) mitigate, to the extent practicable, any harmful effect that is known to Siemens of a use or disclosure of PHI by Siemens in violation of the requirements of this Agreement or of law;

(i) provide notice of a breach of unsecured PHI to Customer without unreasonable delay, and in no case later than thirty (30) days after discovery of a breach. The notification shall include, to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed by Siemens to have been, accessed, acquired, used, or disclosed. Siemens shall provide Customer with any other available information that Customer is required to include in notification to the Individual under applicable law;

(j) make Siemens' internal practices, books, and records relating to the use and disclosure of PHI received from Customer available to the Secretary of the United States Health & Human Services for purposes of determining Customer's compliance with applicable law; and

(k) upon expiration or termination of this Agreement, return to Customer or destroy all PHI in its possession as a result of this Agreement and retain no copies of PHI, if it is feasible to do so. If return or destruction is not feasible, Siemens agrees to extend all protections contained in this Agreement to Siemens' use and/or disclosure of any retained PHI, and to limit further uses and/or disclosures to the purposes that make the return or destruction of the PHI infeasible.

Siemens may use and disclose PHI as necessary for Siemens to perform its obligations hereunder, and may (i) use the PHI for its proper management and administration and to carry out its legal responsibilities, (ii) disclose the PHI to a third party for Siemens' proper management and administration or to carry out Siemens' legal responsibilities, provided that the disclosures are required by law or Siemens obtains reasonable assurances from the third party regarding the confidential handling of such PHI as required under HIPAA and/or HITECH, and the third party agrees to notify Siemens of any instances in which the confidentiality of the information has been breached, (iii) provide data aggregation services related to the healthcare operations of Customer, and (iv) de-identify the PHI, and use such de-identified data, in accordance with the de-identification requirements under HIPAA.

Siemens agrees that it will negotiate in good faith an amendment to this Agreement if, and to the extent required by, the provisions of HIPAA and regulations promulgated thereunder, in order to assure that this Agreement is consistent therewith.

22. Uptime Performance Guarantee [DOES NOT APPLY TO EVERY SERVICE AGREEMENT]

For any Equipment that includes an Uptime Guarantee as specified in Exhibit A, Siemens guarantees that the Equipment will function at the minimum Uptime Performance (defined below) level set forth in Exhibit A (computed as described below).

"Uptime Performance" is defined as the capability of the Equipment to be utilized to treat or diagnose patients. The Equipment will be considered to be operational (i.e., it will not be considered to be "down"): (a) unless it cannot be utilized to treat or diagnose patients (room down); (b) if Siemens is prepared to perform maintenance services to make the Equipment operational but such service is refused by the Customer or is deferred by the Customer until a later time or date; (c) if the Equipment is not otherwise made available to Siemens' service engineers; (d) if the Equipment is down is due to, associated with, or caused by (i) misuse, negligence, or operator error, (ii) inadequate environmental conditions (not conforming with the environmental specifications provided by Siemens), including temperature and humidity, line power exceeding Siemens' requirements of voltage, frequency, impulses or transients, (iii) any of the exclusions set forth in Section 8 hereof, or (iv) acts of God or other force majeure events described in Section 17 hereof; or (e) during periods in which Siemens is performing scheduled or planned maintenance, changing high-vacuum components, and installing updates and/or upgrades. If the Equipment is not operational, then the Customer must immediately notify the Siemens Customer Care Center (24-hour Service Call Dispatch Center). Downtime will not commence until such notification is given to Siemens.

For purposes of calculating the Uptime Performance level percentage, such computation shall be made over the PCP, to include any extended coverage hours as indicated on Exhibit A. The Equipment's Uptime Performance shall be calculated to comply with the above guidelines on an annual basis. If the Equipment's Uptime Performance level is found to be less than the guaranteed percentage, as computed in accordance with the above guidelines, Siemens will extend the term of this Agreement by seven (7) calendar days (30 calendar days for Oncology Care Systems) for every percentage point (rounded to the nearest percent) below the guaranteed percentage. These days will be added at the end of the term of this Agreement. For example, if the guaranteed percentage is 97%, then 96% Uptime Performance would result in an extension of seven (7) calendar days and 95% Uptime Performance would result in an extension of fourteen (14) calendar days. The foregoing states Siemens' entire obligation and liability, and the Customer's sole remedy, for Siemens' failure to meet the Uptime Performance Guarantee.

In order for the Uptime Performance Guarantee to be effective, the Customer must place all calls for service through the Siemens Customer Care Center and must accept all Technical Assistance that is offered by Siemens, including, but not limited to, telephone support and remote diagnostics. For any period of time that the Customer does not seek and accept Technical Assistance from Siemens, then the Equipment shall be considered to be operational.

The Customer agrees to allow connection to Smart Remote Service diagnostic equipment, where available, for the Equipment covered by this Agreement. Smart Remote Service (SRS) is required for SRS-capable systems. The Uptime Performance Guarantee shall be void if the SRS connection is not provided and available 24 hours per day, 7 days a week.

23. Response Time Guarantee [DOES NOT APPLY TO EVERY SERVICE AGREEMENT]

Siemens guarantees that it shall meet any on-site response time as specified in Exhibit A for system "down" situations. Response time is measured from the time that the Customer notifies the Siemens Customer Care Center that a system is down. The response time only applies during the PCP, to include any extended coverage hours (if selected by the Customer), as indicated on Exhibit A. For example, a request for on-site service made at noon on a Monday (where the PCP is 8:00 a.m. through 5:00 p.m., Mondays through Fridays) will have a guaranteed arrival time of 4:00 p.m. on the same day for customers with a four (4) hour response time and a guaranteed arrival time of 11:00 a.m. on the next day for customers with an eight (8) hour response time guarantee. A request for on-site service made at 9:00 a.m. on a Saturday will have a guaranteed arrival time of noon on the next Monday for customers with a four (4) hour response time and 4:00 p.m. on that Monday for customers with an eight (8) hour response time guarantee. If a request for on-site service is made outside the PCP (to include extended coverage hours, if selected by the Customer), Siemens will use its best efforts to have a CSE on-site as soon as possible.

If Siemens responds to a request for on-site service during the PCP but its work to repair or service the Equipment continues after the expiration of the PCP (to include any extended coverage hours, if applicable), then any work outside the PCP will be billed to the Customer, unless any optional Continuous Effort coverage that is available for the Equipment has been purchased as part of this Agreement. Continuous Effort coverage ensures that in room/system down situations, work will continue past the contracted PCP (including any extended coverage hours, if applicable, and/or core modality specific hours, as defined in the Glossary, if applicable) at no additional charge until the system is repaired or 1:00 a.m., whichever comes first, as long as the CSE has been on-site for one hour or more before the end of the contracted PCP (including any extended coverage hours and/or core modality specific hours, if applicable).

The remedy provided by Siemens for its failure to meet the on-site response time guarantee is as follows: for each one (1) hour or portion thereof that Siemens fails to meet the on-site response time guarantee, the Customer will receive one (1) free hour of overtime after the PCP for that service event. The foregoing states Siemens' entire obligation and liability, and the Customer's sole remedy, for Siemens' failure to meet the Response Time Guarantee.

24. Tool and Test Access [DOES NOT APPLY TO EVERY SERVICE AGREEMENT]

Siemens agrees to rent to the Customer, certain tools and test equipment as determined by Siemens ("Tools") to enable Customer to service the Equipment during the Contract Duration on the terms set forth herein. Siemens shall provide Tools after verifying to its sole satisfaction that Customer's In-House Biomedical Engineers are properly trained on the Equipment and Tools.

Siemens shall notify Customer of the rental fee for the Tools at the time of the order. Customer will be charged the rental fee after shipment of the Tools to Customer. Customer agrees to pay full list price of Tools (less rental fees paid) if Customer fails to return the Tools as required herein.

Customer may use the Tools for up to two (2) weeks ("Rental Period") from the date of receipt of the Tools. Customer may, with Siemens' consent, extend the Rental Period for an additional rental fee. Customer must return the Tools within five (5) business days of the conclusion of the Rental Period ("Return Period"). If the Tools are not received by Siemens before the conclusion of the Return Period, Customer will be charged the then-current list price for the Tools. Customer may, at the conclusion of the Return Period, purchase the Tools at the then-current list price, subject to the Terms and Conditions of Sale for Spare Parts and Service. The delivery of the Tools to the Customer and return of the Tools to Siemens shall be completed by Siemens at its own expense.

Title to the Tools shall be and at all times remain with Siemens and Customer shall keep the same free and clear of any and all liens and claims. Customer (i) authorizes Siemens to execute in Customer's name and file (and Customer shall promptly execute, if requested by Siemens) and (ii) irrevocably appoints Siemens its agent and attorney-in-fact to execute in the name of Customer and file, with such authorities and at such locations as Siemens may deem appropriate, any Uniform Commercial Code financing statements evidencing Siemens' ownership of the Tools. Risk of loss shall pass to Customer upon delivery. Customer shall maintain at its expense adequate liability insurance with respect to its possession and use of the Tools and against all common risks (i.e., fire, flood, theft, Acts of God, etc.) for the full replacement value of the Tools. At the request of Siemens, Customer shall provide Siemens with an insurance certificate evidencing such insurance coverage.

Customer shall only use the Tools for their intended purpose, in the proper manner and with appropriate care, pursuant to any instructions, training and manuals provided to Customer by Siemens, Customer shall immediately report to Siemens or its designee any malfunction or defect, whatever the nature or cause.
Customer shall ensure that any necessary repair, modification or service to any Tool is carried out by Siemens or Siemens' designee. Siemens agrees to use its best efforts to repair the Tools as needed in a prompt and timely fashion, following a reported malfunction or defect. Customer shall not move the Tools from the

Customer's facilities identified on the front page of this Agreement. Customer shall return the Tools to Siemens in the same condition as when delivered to Customer (ordinary wear and tear excepted). Customer acknowledges the Tools constitute Confidential Information, and Customer will maintain the Tools in accordance with the Confidentiality provisions of this Agreement.

25. Centralized Depot Repair Procedures [DOES NOT APPLY TO EVERY SERVICE AGREEMENT]
For any Equipment that includes Centralized Depot Repair and Loaner Program as specified in Exhibit A, Siemens may provide the Customer a comparable system ("Loaned System") while Siemens attempts to repair the non-complying system. Purchaser's use of the Loaned System commences upon receipt of the Loaned System and continues until receipt of the repaired or replaced system (the "Loan Period"). The Loaned System must be returned to Siemens within two (2) business days of receiving the repaired or replaced system, and in accordance with the Siemens' written instructions. The Loaned System shall be returned in the same condition as when delivered, ordinary wear and tear excepted. Title to the Loaned System shall at all times remain with Siemens, but Customer will be responsible for equipment that is lost, stolen, or damaged during the Loan Period. Customer is also responsible for any personal injuries or property damages caused by the negligent acts or omissions of Customer, its officers, directors, employees or agents. Customer agrees to use the Loaned System in accordance with all instructions and manuals, and to immediately report to Siemens any malfunction or defect in the Loaned System. If the Loaned System is not returned to Siemens per requirements herein then Purchaser will be charged, and agrees to pay Siemens, a monthly rental fee of 3.5% of the fair market value of the Loaned System as determined by Siemens for each full month (or any portion thereof) until Siemens receives the Loaned System.

26. Non-Assignment
Customer may not assign this Agreement unless it obtains the prior written consent of Siemens, which consent shall not be unreasonably withheld or delayed. Siemens may not assign this Agreement unless it obtains the prior written consent of the Customer, which consent shall not be unreasonably withheld or delayed, except that Siemens may assign without Customer approval to any subsidiary or affiliated company or any of its authorized dealers.

27. Reimbursement for Training Courses and Educational Services Upon Early Termination; Cancellation
If this Agreement includes any training courses or other educational offerings and this Agreement is terminated or Equipment is removed from coverage as provided hereunder prior to the expiration of the term, then Siemens may bill the Customer for any balance due and owing with respect to those training courses or other educational offerings that have been completed by the Customer, and Customer agrees to pay the same.

Customer shall notify the Siemens training and education coordinator, in advance, of the cancellation, in whole or in part, of any training or other educational offering, or any request to reschedule the same. The cancellation or rescheduling of any training courses and other educational offerings may be subject to the payment of a cancellation fee. A copy of Siemens' cancellation policy is available upon request or can be found at:

https://usa.healthcare.siemens.com/education/personalized-education-by-solution/solution/imaging-and-therapy/cancellation-policy

28. Cost Reporting
Customer agrees that it must fully and accurately report prices paid under this Agreement, net of all discounts, as required by applicable law and contract, including without limitation 42 CFR §1001.952(h),in all applicable Medicare, Medicaid and state agency cost reports. Customer shall retain a copy of this Agreement and all other communications regarding this Agreement, together with the invoices for purchase and permit agents of the U.S. Department of Health and Human Services or any state agency access to such records upon request.

29. Execution; Counterparts
If the Customer is a corporation or partnership, the person signing this Agreement on its behalf certifies that such person is an officer or partner thereof, that his or her action was duly authorized by appropriate corporate or partnership action, that such action does not conflict with the corporate charter or bylaws or the partnership agreement, as the case may be, or any contractual provision binding on such corporation or partnership, and that no consent of any stockholders to his or her action is required.

This Agreement may be executed in two (2) or more counterparts, each of which shall constitute an original document but all of which together shall constitute one and the same agreement.

30. Entire Agreement
This Agreement, including all exhibits and addenda attached hereto, constitutes the entire agreement between the parties relating to the subject matter hereof, and supersedes all prior and contemporaneous oral or written representations or communications between the parties. This Agreement may not be modified or amended, except in writing executed by the appropriate designated officers of the parties hereto. Any variation in the terms and conditions contained in this Agreement (including, but not limited to, the inclusion of Customer's own terms and conditions in any purchase order or other document issued by Customer in response to and/or referencing Siemens' quotation for service or this Agreement) shall not be deemed to be a part of this Agreement and shall not be binding upon Siemens unless set forth in writing and executed by the appropriate designated officer of Siemens. Subject to the limitations expressed herein, this Agreement will be binding upon and inure to the benefit of the parties hereto, their successors, legal representatives, and permitted assigns. Notwithstanding anything to the contrary contained herein, the provisions of Sections 9, 10, 12, 13, 14, 15, 16, 18, 21 and 27 shall survive the expiration or termination of this Agreement.

PHILIPS

Sold to:
Morton General Hospital
521 Adams Ave
Morton, WA 98356-9323

Presented By
John Sandvick
Philips Healthcare a division of Philips North America LLC
414 Union Street
Nashville, Tennessee 37219
Phone: (206) 954-5255
Email: john.sandvick@philips.com

Quote #: Q-00152706
Customer #: 94040319
Quote Date: 02/09/23
Valid Until: 05/12/23

Morton General EPIQ Elite shared

Dear Valued Customer,

I am pleased to submit the attached proposal for your consideration. Philips Healthcare is transitioning to a new quoting system and you will notice that this quote looks different than the ones you are used to receiving from us.
I would like to point out a specific area of change to you. Promotions are applied to the line item price of individual items, instead of to the total net price as you are used to. As a result the line item prices appear lower than you might expect based on previous quotations. Please note that the list price of the system has not changed and promotion values are subject to availability.
I trust this meets your expectation, however should you have any queries or require further information or clarification, please do not hesitate to contact me using the details shown at the bottom of this letter.
Please note that all necessary initial applications training is included in the offer price. Further application training can be purchased separately by contacting our Customer Care Center.
Orders relating to this proposal should be sent to the address or fax number at the top of this document.

Thank you,
John Sandvick

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Table of Content

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1. Financial Overview

Line	Article No.	Description	Qty	List Price	Net Price
1	795234	EPIQ Elite Diagnostic Ultrasound System	1	$ 429,150.00	$ 191,862.50

Discount Amount: **$ -237,287.50**

	Total Price
Contract Discount	$ -180,062.50
Promotion Discount	$ -12,000.00
Additional Discount	$ -45,225.00
Total Net Price	**$ 191,862.50**

(Optional Items)

Line	Article No.	Description	Qty	Net Price
1	**795234**	**EPIQ Elite Diagnostic Ultrasound System**		
	NUSY162	(Opt) Dynamic HeartModel	*1*	*$ 20,571.30*
	NUSY147	(Opt) AutoStrain LV	*1*	*$ 6,914.10*
	FUS9204	(Opt) S9-2 Transducer	*1*	*$ 13,224.00*
	FUS9205	(Opt) S12-4 Transducer	*1*	*$ 9,661.50*

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2. Quote Summary

Line	Article No.	Description	Qty	Unit List Price	Contract Disc	Additional Discount	Net Price
1	**795234**	**EPIQ Elite Diagnostic Ultrasound System**					
1.1	NNAV417	EPIQ Elite Advanced G	1	$ 160,640.00	$ 69,075.20	$ 17,349.12	$ 74,215.68
1.2	NNAV459	Advanced Radiology High Frequency Transducer Bundle	1	$ 77,650.00	$ 33,389.50	$ 8,386.20	$ 35,874.30
1.3	989801291179	Maximizer Basic Package Per Year	2	$ 5,200.00	$ 0.00	$ 0.00	$ 10,400.00
1.4	NUSY040	Shared Service	1	$ 39,540.00	$ 17,002.20	$ 4,270.32	$ 18,267.48
1.5	NUSY100	xMATRIX xPlane and Live 3D SS	1	$ 37,280.00	$ 16,030.40	$ 4,026.24	$ 17,223.36
1.6	NUSY186	EPIQ ELITE CV Doppler and 2D Auto Measure	1	$ 5,050.00	$ 2,171.50	$ 545.40	$ 2,333.10
1.7	FUS9161	X5-1c transthoracic echo transducer	1	$ 48,020.00	$ 20,648.60	$ 5,186.16	$ 22,185.24
1.8	FUS9186	mC12-3 Transducer	1	$ 22,150.00	$ 9,524.50	$ 2,392.20	$ 10,233.30
1.9	FUS9193	L15-7io Transducer	1	$ 16,950.00	$ 7,288.50	$ 1,830.60	$ 7,830.90
1.10	FUS9210	D2CWC Transducer	1	$ 1,360.00	$ 584.80	$ 146.88	$ 628.32
1.11	NUSY292	ElastQ Imaging Curved	1	$ 10,110.00	$ 4,347.30	$ 1,091.88	$ 4,670.82
1.12	FUS7000	English Manual	1	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Promotion Discount:							$ -12,000.00
CONVERT THE COMPETITION TRADE IN GI							$ 191,862.50

	Total Price
Contract Discount	$ -180,062.50
Promotion Discount	$ -12,000.00
Additional Discount	$ -45,225.00
Total Net Price	**$ 191,862.50**

(Optional Items)

Line	Article No.	Description	Qty	Unit List Price	Contract Disc	Promo & Add'l Disc	Net Price
1	**795234**	**EPIQ Elite Diagnostic Ultrasound System**					
	NUSY162	(Opt) Dynamic HeartModel	*1*	*$ 36,090.00*	*$ 15,518.70*	*$ 0.00*	*$ 20,571.30*
	NUSY147	(Opt) AutoStrain LV	*1*	*$ 12,130.00*	*$ 5,215.90*	*$ 0.00*	*$ 6,914.10*
	FUS9204	(Opt) S9-2 Transducer	*1*	*$ 23,200.00*	*$ 9,976.00*	*$ 0.00*	*$ 13,224.00*
	FUS9205	(Opt) S12-4 Transducer	*1*	*$ 16,950.00*	*$ 7,288.50*	*$ 0.00*	*$ 9,661.50*

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3. Quote Overview

Line	Description	Qty	Included	Optional
1	**EPIQ Elite Diagnostic Ultrasound System**			
1.1	EPIQ Elite Advanced G	1	●	
1.2	Advanced Radiology High Frequency Transducer Bundle	1	●	
1.3	Maximizer Basic Package Per Year	2	●	
1.4	Shared Service	1	●	
1.5	xMATRIX xPlane and Live 3D SS	1	●	
1.6	EPIQ ELITE CV Doppler and 2D Auto Measure	1	●	
1.7	X5-1c transthoracic echo transducer	1	●	
1.8	mC12-3 Transducer	1	●	
1.9	L15-7io Transducer	1	●	
1.10	D2CWC Transducer	1	●	
1.11	ElastQ Imaging Curved	1	●	
1.12	English Manual	1	●	
	(Opt) Dynamic HeartModel	1		●
	(Opt) AutoStrain LV	1		●
	(Opt) S9-2 Transducer	1		●
	(Opt) S12-4 Transducer	1		●

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4. Quote Details

Line	Description	Qty
1	**EPIQ Elite Diagnostic Ultrasound System** **Article No. 795234**	1

Promotion Name	**Promotion description**
CONVERT THE COMPETITION TRADE IN GI	Philips Healthcare is pleased to offer a special promotion. Purchase (2) new Philips EPIQ Elite Ultrasound systems, and take advantage of an additional trade-in discount of $12,000 on each EPIQ Elite systems when trading in (2) Competitive Trades (GE E10/ E9 , Canon Aplio, or Siemens Sequoia,S3000/S2000 system. The discount will be taken off the Net purchase price of the new system, and is addition to the FMV of the trade-in system. The serial number, make and model of the trade-in system will be required to take advantage of this promotion and must be returned to Philips Healthcare upon delivery of the new EPIQ Elite system. The promotion may not be available to certain GPOs/SBGs, if overall discount exceeds pre-authorized limits.

EPIQ Elite Diagnostic Ultrasound System

EPIQ Elite Diagnostic Ultrasound System

- EPIQ Elite Diagnostic Ultrasound System

1.1	**EPIQ Elite Advanced G** **Article No. NNAV417**	1

EPIQ Elite advanced for general imaging is a premium diagnostic ultrasound system featuring an uncompromised level of clinical performance, design and intelligence to meet the challenges of today's most demanding practices.

- Proprietary nSIGHT Imaging architecture with GPU for elevated levels of tissue uniformity, frame rate and penetration.
- Supports PureWave family of transducers
- xMATRIX ready architecture for GI or SS applications
- Supports 3D/4D imaging modes across various clinical options
- XRES Pro next generation image processing, Variable XRES
- Supports MicroFlow Imaging option with MicroFlow HD across various transducers and applications
- Supports Needle Visualization enhancement (eL18-4 transducer)
- Supports CEUS clinical option
- Supports TrueVue Pro photorealistic 3D option
- Supports FlexVue curved MPR capability
- Supports TouchVue with MPR touch
- Supports Fusion and Navigation Interventional option
- Active Native data for post-processing of frozen image data and Cineloop image data
- Supports strain elastography, ElastPQ and ElastQ Imaging shear wave elastography clinical options across various applications and transducers
- AutoScan (real time iSCAN) automatically optimizes gain and TCG continuously
- SmartExam system-guided protocols

- Tablet-like user interface with gesture control
- Infinite articulation of control panel and monitor allows for perfect alignment whether sitting or standing
- Control panel adjustability with 720 degrees of freedom to scan ergonomically
- Enhanced mobility with battery backup options
- MaxVue High Definition Ultrasound with over a 1 million more pixels and 38% larger viewing area
- Standard 21-inch high definition LED display for easy viewing in virtually any environment
- Optional 24-inch HD MAX immersive display monitor for the ultimate ultrasound visualization
- 4 active transducer ports
- Supports Anatomically Intelligent Ultrasound (AIUS) options

-AI Breast

-Dynamic HeartModel

-AAA Model

-AutoRegistration for Fusion/Nav

-aBiometry Assist

-aReveal

- Windows 10 Operating System
- Defense in depth security support
- Multi-Modality Query Retrieve (Allows for the viewing of DICOM CT, Mammography, NM, MRI and ultrasound images –you can review these images while you are live imaging)
- NetLink/DICOM 3.0 provides network print and store, commit, modality worklist, DICOM Query and Retrieve, and structured reporting for adult and pediatric echo, vascular, and OB/GYN
- DICOM 3.0 Print and Store capability to internal drive or DVD/CD
- Integrated Wireless DICOM
- On-board workstation-class data management with thumbnail previews and storage of images, loops,
- Retrospective and prospective clip capture to internal drive or removable media and reports

MicroFlow Imaging

MicroFlow Imaging (MFI) enhances visualization of small and weak blood. Now includes MFI HD a sub mode that offers twice the sensitivity and resolution of MFI feature.

DVD Option

Integrated DVD/CD burning capability for storage of DICOM images or export in JPEG and .avi for PC compatibility.

SafeGuard

This is a standard computer administration tool used to prevent unauthorized programs (malware) from running on the ultrasound system.

Security Plus

Security Plus provides a Defense-in-depth strategy implementing security features designed to help healthcare facilities provide additional patient data privacy, and protection from unauthorized access via the ultrasound systems on hospital networks. New data security enhancements will make EPIQ and Affiniti compatible with data security on medical devices.

HD Max Display

24-inch HD MAX immersive display monitor for the ultimate ultrasound visualization

Extended Life Battery

Highly recommended for portable ultrasound studies. Doubles the time to be in transport mode when going mobile as compared to the Battery Standard Life. Allows system to be place in sleep mode and booted up in 20 seconds. Allows activation of the smart handle when not plugged in to central power.

Clinical Education

***2 days of Implementation Onsite Training (expires 90 days after install, provided Mon-Fri during normal business hours), Qty 2 Essential Education Membership 6 Month, Qty 3 One-Day Travel and Tuition. See travel disclaimer**

The Essential Education Membership includes: For one individual, One Online e-Learning Bundle (unlimited E-learning, access to average 30 education credits), Access to short “how to”videos, Quick reference guides on system usage, System update reference guide, and unlimited enrollment to all regularly scheduled virtual "CSS and Speaker-led" education with available seats (vary in length from 1 hr to full day). Virtual courses are purposefully designed trainings that allow participants the same quality education of an instructor-led classroom without the need or expense of traveling. Education Access expires six (6) months from term start date. 3rd party content is excluded form this membership.

1 Day tuition with Travel - this 1 day tuition may be used to attend any one (1) regularly scheduled "CSS and Speaker-led" course and includes the corresponding travel package. Due to travel and scheduling

requirements, a twenty-one (21) day notification of cancellation is required or training / education entitlements will be forfeited. Curriculum is subject to change without notice. Travel & Accommodations for one (1) registered attendee. Includes one (1) participant's airfare from a North American customer location to a Philips North America Ultrasound Clinical Education training location with modest lodging, ground transportation and meal expenses for up to 2 days. Breakfast/dinner are provided by the hotel and lunch/breaks are catered by Philips Healthcare. All other expenses will be the responsibility of the attendee (ie. Baggage fees, meals while traveling, transportation to and from customer's home airport). Details are provided during the scheduling process. Purchased Education expires one (1) year from equipment installation date or purchase date if sold separately.*Must be used consecutively with other offsite advanced customer training tuitions associated with the same system, if purchased with other options that include offsite advanced customer training; offsite advanced customer training will be limited to a maximum of 2 consecutive days. See travel disclaimer**

**TRAVEL Disclaimer: Travel & Accommodations for registered attendees. Each tuition includes one (1) participant's airfare from a North American customer location to a Philips North America Ultrasound Clinical Education training location with modest lodging, ground transportation and meal expenses for the course duration. Breakfast/dinner are provided by the hotel and lunch/breaks are catered by Philips Healthcare. All other expenses will be the responsibility of the attendee (ie. Baggage fees, meals while traveling, transportation to and from customer's home airport). Details are provided during the scheduling process. Note: 21 day Cancellation/Rescheduling policy is strictly enforced.

***Note: Philips Healthcare personnel are not responsible for actual patient contact or operation of equipment during education sessions except to demonstrate proper equipment operation. The training sessions should be attended by the appropriate healthcare professional as identified by the department director. Repeat training for staff non-attendance will not be accepted. Site must be patient-ready to meet training expectations.

1.2 **Advanced Radiology High Frequency Transducer Bundle** 1

Article No. NNAV459

C5-1 Transducer

PureWave curved array transducer with 5 to 1 MHz extended operating frequency range. C5-1 PureWave Curved Array for high performance OB/GYN, Fetal Echo, Abdominal and Interventional applications. Now, one transducer provides exceptional clinical performance for a wide range of patient types including obese and technically challenging patients.

C10-3v Transducer

PureWave Curved array transducer with 3 to 10 MHz operating frequency range, end fire sector, 11.5 radius at curvature, 130 degree field of view for endovaginal applications.

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L12-3 Ergo Transducer

L12-3 ERGO is an ergonomically designed Linear array transducer with 12 to 3 MHz extended operating frequency range for vascular applications. Also supports musculoskeletal, pediatric radiology, small parts applications.

eL18-4 EMT Transducer

Ultra-broadband 18-4 MHz PureWave Linear multi-row array transducer with fine elevation focusing. This transducer incorporates integrated EM (electro-magnetic) tracking coils for AI Breast and Fusion/Navigation compatibility. This transducers supports a broad range of high resolution applications including breast, small parts, vascular and musculoskeletal imaging. Also supports pediatric and specialty OB imaging. The eL18-4 transducer features exceptional imaging performance and supports advanced clinical tools such as full solution elastography, MicroFlow Imaging and precision biopsy

1.3 **Maximizer Basic Package Per Year** 2
Article No. 989801291179

Not combinable with RightFit Service Contract or Master Service Contract

Package includes Philips Technology Maximizer and a Clinical Education Flex Account

Philips Technology Maximizer: Philips Technology Maximizer entitles Customer to software upgrades during the agreement term (annual units selected) beginning at the completion of the standard warranty period. Software upgrades may be provided and will not be excluded during the initial warranty period. Includes core operating system software upgrades only, if and when available. Hardware updates are not included.

Clinical Education Flex Account: The clinical education flex account entitles Customer to $1,500 of clinical education and product training (“Training”) that Customer has selected from Philips’ course catalog(s) (“Course Catalog(s)”) during each year of coverage.

The Technology Maximizer Package is not cancelable and will remain in effect for the Maximizer agreement term.

1.4 **Shared Service** 1
Article No. NUSY040

Includes the following:
- Abdominal Clinical Option
- Gynecology Clinical Option
- Vascular Clinical Option
- Pediatric Radiology Clinical Option
- Small Parts Clinical Option
- Musculoskeletal Clinical Option
- Adult Cardiology Clinical Option (includes Adult ECG and LVO Contrast)
- Pediatric Cardiology Clinical Option (Includes Pediatric ECG leads)
- Obstetrical Clinical Option

- Fetal Echocardiography Clinical Option
- Urology Clinical Option
- TCD Clinical Option
- Interventional Clinical Option

1.5 **xMATRIX xPlane and Live 3D SS** 1
Article No. NUSY100

xMATRIX performance option that enables Live xPlane and Live 3D for shared service applications. This includes support for all xMATRIX transducers. This feature also includes 4D Imaging support capability for mechanical volume transducers.

Clinical Education

***1 day of Implementation Onsite Training (expires 90 days after install, provided Mon-Fri during normal business hours), Essential Education Membership 6 Month

The Essential Education Membership includes: For one individual, One Online e-Learning Bundle (unlimited E-learning, access to average 30 education credits), Access to short “how to”videos, Quick reference guides on system usage, System update reference guide, and unlimited enrollment to all regularly scheduled virtual "CSS and Speaker-led" education with available seats (vary in length from 1 hr to full day). Virtual courses are purposefully designed trainings that allow participants the same quality education of an instructor-led classroom without the need or expense of traveling. Education Access expires six (6) months from term start date. 3rd party content is excluded form this membership.

***Note: Philips Healthcare personnel are not responsible for actual patient contact or operation of equipment during education sessions except to demonstrate proper equipment operation. The training sessions should be attended by the appropriate healthcare professional as identified by the department director. Repeat training for staff non-attendance will not be accepted. Site must be patient-ready to meet training expectations.

1.6 **EPIQ ELITE CV Doppler and 2D Auto Measure** 1
Article No. NUSY186

EPIQ ELITE Auto Measure

CV Doppler and 2D Auto Measure

Auto Measure, powered by AI, will automatically measure Doppler waveforms for Mitral, Tricuspid, Aortic and Pulmonary valves, along with Auto 2D measure for length measurements, including LV, LVOT, Aortic Root and RV when using adult cardiac transthoracic transducers X5-1c, X5-1, S5-1 and S4-2. Auto Measure enables more efficient echo exams and robust and reproducible measurements.

- Auto Measure
- Auto Measure

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1.7	**X5-1c transthoracic echo transducer** **Article No. FUS9161** X5-1c transthoracic echo transducer Philips 3rd-generation xMATRIX sector array transthoracic transducer, now powered by the updated nSight Plus system architecture based on software image formation. 5 to 1 MHz extended operating frequency range for adult echo applications in 2D, Live xPlane and Live 3D modes. A unique curved nose fits within the rib spaces more easily. Using Philip's nSight Plus image formation technology, improved image quality can be seen on more patients. • Improved overall image quality • Improved performance when analyzing echo images with Qapps.	1
1.8	**mC12-3 Transducer** **Article No. FUS9186** mC12-3 PureWave micro convex transducer for pediatric and vascular applications.	1
1.9	**L15-7io Transducer** **Article No. FUS9193** Compact high resolution linear array transducer with 15 to 7 MHz extended operating frequency range for intraoperative vascular imaging. Also supports high-resolution superficial venous and arterial studies.	1
1.10	**D2CWC Transducer** **Article No. FUS9210** Non-imaging 2 MHz PW/CW Doppler transducer for cardiac applications.	1
1.11	**ElastQ Imaging Curved** **Article No. NUSY292** ElastQ Imaging (EQI) for curved array (C5-1) features a real-time, large region of interest (ROI) color coded quantitative assessment of tissue stiffness using shear wave elastography. ElastQ Imaging includes the ability to make retrospective measurements on stored images as well. Unique confidence map display utilizes intelligent analysis that adds additional assurance that user measurements are obtained on tissue areas with adequate shear wave propagation. EQI also includes ElastPQ shear wave point quantification technology support. **Clinical Education** A one Day Clinical University w/Travel & Accom Pkg course for one (expires 180 days after install). All offsite training includes travel, see travel disclaimer** **Travel packages included with education entitlements are available if needed, to cover the customer's airfare, transportation, hotel, and meals while attending a Philips program at one of our Philips corporate training centers. These packages are only provided if needed and are not intended to provide a dollar value to the customer to use towards alternative programs. Travel packages included with entitlements do not cover travel and accommodations to one of our premium education	1

symposiums. Customer will be required to purchase a premium travel package in order to attend. Philips reserves the right to deliver virtually or through live stream, any live in person courses that may be impacted due to facility shut down, inclement weather, natural disaster, speakers inability to travel, or any other situation that is outside Philips control. Note: 21 day Cancellation/Rescheduling policy is strictly enforced.

1.12 **English Manual** 1
Article No. FUS7000

Operation Manual

(Opt) **Dynamic HeartModel** 1
Article No. NUSY162

Dynamic HeartModel, powered by AIUS, is a fully automated Live 3D quantification tool that calculates both the volumes of the LV and LA simultaneously, as well as an LV EF and SV in under 30 seconds. It quantifies Live 3D volumes using the X5-1 transducer and is designed to provide faster, easier and more robust results than previously available, on the majority of your patients.

The Dynamic HeartModel App provides dynamics of the heart by showing moving contours for the left ventricle and left atrium which ensures higher diagnostic confidence. Dynamic HeartModelA.I. offers new measurements such as LV Mass, Cardiac Index, Complete LA volumes, and index using Body Surface Area for LA Max and LA Min volumes. This App allows the user to analyze multiple beats and average the results.

(Opt) **AutoStrain LV** 1
Article No. NUSY147

TOMTEC AutoStrain LV:
One button push fully automated global and segmental longitudinal strain measurement tool with 18 segments bull's eye display for left ventricle (LV). It supports images from cardiac sector transducers with or without ECG.

Clinical Education

*** If you purchase Cardiology 2DQ Pkg and/or AutoStrain LV you will receive a 1 Day 2D AST w/Travel & Accom (expires 180 days after install). All offsite training includes travel, see travel disclaimer**

**Travel packages included with education entitlements are available if needed, to cover the customer's airfare, transportation, hotel, and meals while attending a Philips program at one of our Philips corporate training centers. These packages are only provided if needed and are not intended to provide a dollar value to the customer to use towards alternative programs. Travel packages included with entitlements do not cover travel and accommodations to one of our premium education symposiums. Customer will be required to purchase a premium travel package in order to attend. Philips reserves the right to deliver virtually or through live stream, any live in person courses that may be impacted due to facility shut down, inclement weather, natural disaster, speakers inability to travel, or any other situation that is outside Philips control. Note: 21 day Cancellation/Rescheduling policy is strictly enforced.

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***Note: Philips Healthcare personnel are not responsible for actual patient contact or operation of equipment during education sessions except to demonstrate proper equipment operation. The training sessions should be attended by the appropriate healthcare professional as identified by the department director. Repeat training for staff non-attendance will not be accepted. Site must be patient-ready to meet training expectations.

(Opt) **S9-2 Transducer** 1
Article No. FUS9204

Phased array transducer with 9 to 2 MHz extended operating frequency range for pediatric and small adult cardiology applications. This transducer is has a 120° wide field of view.

(Opt) **S12-4 Transducer** 1
Article No. FUS9205

High frequency phased array transducer with 12 to 4 MHz extended operating frequency range for pediatric and neonatal cardiology and neonatal head applications. Also can be used with the adult echo clinical option, and for intraoperative applications.

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5. Local Sales Terms and Conditions

Line	Product Code	Contract Name	Contract No.	Billing Plan
1	795234 EPIQ Elite Diagnostic Ultrasound System	Providence Health System Distribution Operations Center	LSP0003300	0/100/0

Payment Terms US: Net 30 Days

INCO Terms: Carriage and Insurance Paid To Destination

This is a cash price quote, which includes ACH, check, and wire transfer. Any other form of payment will result in different price, which may be higher.

Billing Terms: Are as displayed under the Billing Plan table above. For each item, X/Y/Z milestones are defined as follows (unless an Agreement specifying alternative payment terms has been negotiated between the parties):

X is the percentage invoiced upon signed acceptance of quotation or upon receipt of Customer Purchase Order
Y is the percentage invoiced upon delivery of major components
Z is the percentage invoiced upon completion of installation or product available for first patient use, whichever occurs first.

If DEMO Equipment is included in this quotation it is sold under the Contact No. Contract Name/Contract Number ("Contract") of the products/solution included in this quotation.

All amounts in this quote are in USD

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6. Signature Page

Invoice to:
Morton General Hospital
521 Adams Ave
Morton, WA 98356-9323

	Total Price
Total Net Price	$ 191,862.50

Acceptance by Parties

Each Quotation solution is issued pursuant to and will reference a specific Contract Name/Contract Number ("Contract") representing an agreement containing discounts, fees and any specific terms and conditions which will apply to that single quoted solution. Any PO for the items herein will be accepted subject to the terms of that Contract. If no Contract is shown, Philips Terms and Conditions of Sale including applicable product warranty or Philips Terms of Service ("Philips Terms") located in the Philips Standard Terms and Conditions of the quotation shall solely apply to the quoted solution.

Each equipment system and/or service listed on purchase order/orders represents a separate and distinct financial transaction. We understand and agree that each transaction is to be individually billed and paid. This quotation contains confidential and proprietary information of Philips Healthcare and is intended for use only by the customer whose name appears on this quotation. It may not be disclosed to third parties without prior written consent of Philips Healthcare.

This quotation provides contract agreement discounts and does not reflect rebates that may be earned by Customer, under separate written rebate agreements, from cumulative volume purchases beyond the individual quantity being ordered under this quote. Customer is reminded that rebates constitute discounts under government laws which are reportable by Customers.

Price above do not include sales taxes

Tax Status: Taxable _____ Tax Exempt _____
If Exempt, please indicate the Exemption Certification Number: _____, and attach a copy of the certificate.

If you do not issue formal purchase orders indicate by initialing here: _____
Requested Delivery Date _____

Our facility does issue formal purchase orders, however, due to our business/system limitation, we cannot issue a formal purchase order until _____ days prior to warranty expiration. Initialed: _____

CUSTOMER SIGNATURE
by its authorized representative

Signature: _____
Print Name: _____
Title: _____
_____
_____
Date: _____

PHILIPS SIGNATURE
by its authorized representative

Signature: _____
Print Name: _____
Title: _____
_____
_____
Date: _____

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7. Warranty

ULTRASOUND (UL) SYSTEMS PRODUCT WARRANTY

This product warranty document is an addition to the Conditions of Sales set forth in the quotation. Unless specifically listed below, this warranty does not apply to replacement parts. The terms and conditions of the quotation are incorporated into this warranty document. The capitalized terms herein have the same meaning as set forth in the quotation.

1. Twelve (12) Month System Warranty

1.1 Philips warrants to Customer that the Philips' Ultrasound Systems (System) will perform in substantial compliance with its product specifications, in the documentation accompanying the System, for a period of twelve (12) months after completion of installation or availability for first patient use, whichever occurs first.

1.2 If your purchase includes a new Lumify Ultrasound Solution, then the above warranty extends to cover all standard transducers purchased as part of the solution, for a period of sixty (60) months from the date of shipment of the System to the Customer.

1.2.1 If your purchase includes a Diamond Select Lumify Ultrasound Solution the standard twelve (12) Month System Warranty applies.

1.3 If your purchase includes a Rugged Lumify System Bundle Solution, then the above warranty extends to the Lumify Transducer and the associated Rugged Tablet for a period of sixty (60) months from the date of shipment to the Customer.

1.4 In addition, if your purchase includes a Lumify System Bundle (including transducer (s), commercial off the shelf smart device and smart device sleeve), then the warranty extends to cover the included smart device for a period of twelve (12) months from the date shipment of the System to the Customer.

1.5 If your purchase includes a Sparq or CX50 Ultrasound Solution, then the above warranty extends to cover all standard transducers purchased with the System for a period of sixty (60) months after completion of installation or first patient use, whichever occurs first (not applicable in Canada).

1.6 If your purchase includes an Xperius Ultrasound Solution, then the above warranty extends for a period of Sixty (60) months from the date that is ten (10) calendar days after shipment of the System to the Customer.

1.7 If your purchase includes an InnoSight Ultrasound Solution, then the above warranty extends for a period of thirty-six (36) months from the date that is ten (10) calendar days after shipment of the System to the Customer.

2. Planned Maintenance

2.1 During the warranty period, Philips' service personnel will schedule planned maintenance visits in advance at a mutually agreeable time on weekdays, between 8:00am and 5:00pm, excluding Philips' observed holidays.

2.2 If your purchase includes a Lumify Ultrasound Solution, Lumify System Bundle, or Innosight solution, then planned maintenance is not required and any technical support is provided remotely.

2.3 If your purchase includes an Xperius Ultrasound Solution, then Planned Maintenance is not required.

3. System Options, Upgrades or Accessories

3.1 Any Philips' authorized options, upgrades, or accessories for the System which are delivered and/or installed on the System during the original term of the System warranty shall be subject to the same warranty terms contained in the first paragraph of this warranty, except that such warranty shall expire on the later of:

3.1.1 upon termination of the initial twelve (12) month warranty period for the System on which the option, upgrade or accessory is installed; or

3.1.2 after ninety (90) days for parts only from the date of installation.

3.2 If your purchase includes a Lumify Ultrasound Solution or Lumify System Bundle, accessories are covered for a period of twelve (12) months from the date of shipment of the System to the Customer.

3.3 System upgrades for a Lumify Ultrasound Solution or a Lumify System Bundle are only available in the form of software updates.

4. System Software and Software Updates

4.1 The software provided with the System will be the latest version of the standard software available for that System as of the ninetieth (90th) day prior to the date the System is delivered to Customer.

4.2 Updates to standard software for the System that do not require additional hardware or equipment modifications will be performed as a part of normal warranty service during the term of the warranty.

4.3 All software is and shall remain the sole property of Philips or its software suppliers.

4.4 Use of the software is subject to the terms of a separate software license agreement.

4.5 No license or other right is granted to Customer or to any other party to use the software except as set forth in the license agreements.

4.6 Any Philips' maintenance or service software and documentation provided with the System and/or located at Customer's premises is intended solely to assist Philips and its authorized agents to install and to test the System, to assist Philips and its authorized agents to maintain and to service the System under a separate support agreement with Customer, or to permit Customer to maintain and service the System.

4.7 Customer agrees to restrict the access to such software and documentation to Philips' employees, those of its authorized agents and its authorized employees of Customer only.

4.8 If your purchase includes a Lumify Ultrasound Solution, installation of software licenses and updates are not performed by Philips.

4.9 If your purchase includes a Lumify System Bundle, the Lumify Software Application will be pre-installed by the Philips' factory.

4.10 Software updates and upgrades for a Lumify System Bundle will be available via the GooglePlay store or Apple App store.

5. Warranty Limitations

5.1 Philips' sole obligations and Customer's exclusive remedy under any product warranty are limited, at Philips' option, to the repair or the replacement of the product or a portion thereof within thirty (30) days after receipt of written notice of such material breach from Customer (Product Warranty Cure Period) or, upon expiration of the Product Warranty Cure Period, to a refund of a portion of the purchase price paid by the Customer, upon Customer's request.

5.2 Any refund will be paid, to the Customer when the product is returned to Philips.

5.3 Warranty service outside of normal working hours (i.e. 8:00am - 5:00pm, through Friday, excluding Philips' observed holidays), will be subject to payment by Customer at Philips' standard service rates.

5.4 This warranty is subject to the following conditions: the product:

5.4.1 is to be installed by authorized Philips' representatives (or is to be installed in accordance with all Philips' installation instructions by personnel trained by Philips);

5.4.2 is to be operated exclusively by duly qualified personnel in a safe and reasonable manner in accordance with Philips' written instructions and for the purpose for which the products were intended; and

5.4.3 is to be maintained and in strict compliance with all recommended and scheduled maintenance instructions provided with the product and Customer is to notify Philips immediately if the product at any time fails to meet its printed product specifications.

5.5 Philips' obligations under any product warranty do not apply to any product defects resulting from improper or inadequate maintenance or calibration by the Customer or its agents; Customer or third party supplied interfaces, supplies, or software including without limitation loading of operating system patches to the Licensed Software and/or upgrades to anti-virus software running in connection with the Licensed Software without prior approval by Philips; use or operation of the product other than in accordance with Philips' applicable product specifications and written instructions; abuse, negligence, accident, loss, or damage in transit; improper site preparation; unauthorized maintenance or modifications to the product; or viruses or similar software interference resulting from connection of the product to a network.

5.6 Philips does not provide a warranty for any third party products furnished to Customer by Philips under the quotation; however, Philips shall use reasonable efforts to extend to Customer the third party warranty for the product.

5.7 The obligations of Philips described herein are Philips' only obligations and Customer's sole and exclusive remedy for a breach of a product warranty.

5.8 **Limitation of Remedies for Xperius or InnoSight:** Customer's remedy for damage to a Xperius or InnoSight Transducer or Tablet that affects its functionality and that is covered by the warranty (e.g., excluding damage resulting from abuse or misuse or cosmetic issues) is limited to repair or replacement of each the Xperius or InnoSight Transducer and Tablet not more than once in any twelve (12) month period.

5.9 **Limitation of Remedies for Sparq or CX50 Ultrasound Transducer(s):** Customer's remedy for damage to a standard transducer (excludes TEE and Specialty Transducers) ordered with the Sparq or CX50 that affects its functionality and that is covered by the warranty (e.g., excluding damage resulting from abuse or misuse, or cosmetic issues) is limited to repair or replacement of any standard transducer ordered with the Sparq or CX50 Solution not more than twice in any twelve (12) month period.

5.10 **Limitation of Remedies for Lumify Ultrasound Transducer(s) (including Rugged Lumify System Bundle Solution):** Customer's remedy for damage to a Lumify Transducer or Rugged Tablet that affects its functionality and that is covered by the warranty (e.g., excluding damage resulting from abuse or misuse or cosmetic issues) is limited to repair or replacement of each the Lumify Transducer and Rugged Tablet not more than once in any twelve (12) month period.

5.11 THE WARRANTIES SET FORTH HEREIN WITH RESPECT TO A PRODUCT (INCLUDING THE SOFTWARE PROVIDED WITH THE PRODUCT), ARE THE ONLY WARRANTIES MADE BY PHILIPS IN CONNECTION WITH THE PRODUCT; THE SOFTWARE, AND THE TRANSACTIONS CONTEMPLATED BY THE QUOTATION, AND ARE EXPRESSLY IN LIEU OF ANY OTHER WARRANTIES, WHETHER WRITTEN, ORAL, STATUTORY, EXPRESS OR IMPLIED, INCLUDING, WITHOUT LIMITATION, ANY WARRANTY OF NON-INFRINGEMENT, MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE.

5.12 Philips may use refurbished parts in the manufacture of the products, which are subject to the same quality control procedures and warranties as for new products.

6. Philips' Remote Services (PRS) also known as Philips' Remote Services Network (RSN)

6.1 Customer will (a) provide Philips with a secure location at Customer's premises to store one Philips' Remote Services Network router and provide full and free access to this router, (or a Customer-owned router acceptable to Philips) for connection to the equipment and to Customer's network; or (b) provide Philips with outbound internet access over SSL; at all times during the warranty period provide full and free access to the equipment and the Customer network for Philips' use in remote servicing of the product, remote assistance to personnel that operate the products, updating the products software, transmitting automated status notifications from the product and regular uploading of products data files (such as but not limited to error logs and utilization data for improvement of Philips' products and services and aggregation into services).

6.2 Customer's failure to provide such access will constitute Customer's waiver of the scheduled planned maintenance service and will void support or warranty coverage of product malfunctions until such time as planned maintenance service is completed or PRS/RSN access is provided.

6.3 Customer agrees to pay Philips at the prevailing demand service rates for all time spent by Philips' service personnel waiting for access to the products.

6.4 Warranty service for remote support only products like Lumify and InnoSight Ultrasound Solutions will be available only via phone between 8:00am - 5:00pm Eastern Standard Time (EST).

7. Transfer of System

7.1 In the event Customer transfers or relocates the System, all obligations under this warranty will terminate unless Customer receives the prior written consent of Philips for the transfer or relocation.

7.2 Upon any transfer or relocation, the System must be inspected and certified by Philips as being free from all defects in material, software and workmanship and as being in compliance with the product specifications.

7.3 Customer will compensate Philips for these services at the prevailing service rates in effect as of the date the inspection is performed.

7.4 Any System which is transported intact to pre-approved locations and is maintained as originally installed in mobile configurations will remain covered by this warranty.

7.5 For the Lumify Ultrasound Solution, this warranty is made only to the original purchaser of the Lumify Ultrasound Solution or, if the seller is an authorized Philips' distributor or sub-distributor, this warranty is made to the initial end user of the Lumify Ultrasound Solution.

7.6 In either case, any subsequent sale or transfer of the Lumify Ultrasound Solution will void the warranty.

DocID:	17988
Revision:	1
Status:	Official
Department:	Compliance
Manual(s):	

Policy & Procedure : Conflict of Interest

Policy:

It is the policy of Lewis County Hospital District No. 1 (LCHD No. 1) to avoid any actual or perceived conflicts of interest to ensure that the conflict of interest does not affect, or appear to affect patient safety, quality of care, research integrity or interfere with LCHD No. 1's responsibility to the community it serves. For example, any situation where a LCHD No. 1 employee or agent may benefit financially, whether directly or indirectly (e.g., through a family member) as a result of their position with LCHD No. 1 is a potential conflict of interest.

Purpose:

The purpose of this policy is to define a conflict of interest, define when a conflict may apply, and describe expectations for acknowledgement of the policy and individual disclosure.

Procedure:

1. All Employees & Agents- Review and Acknowledgement of Conflicts of Interest Policy and Procedure.

    a. All employees and agents are required to review and acknowledge this policy and procedure upon hire and annually thereafter.

    b. If an employee or agent believes a conflict of interest may exist, they are obligated to expediently report the suspected conflict of interest to their supervisor, unless the conflict of interest involves the employee's or agent's supervisor, in which case the suspected conflict should be reported to the supervisor's supervisor. Supervisors are obligated to report suspected conflicts of interest to the Compliance Officer.

2. Annual Disclosures.

    a. Individuals who serve as Board Commissioners, medical staff members, contracted professional staff, managers (department heads and above), directors of clinical departments, managers of clinical departments – and any other employee, or non-employed contractor acting in a managerial or clinical leadership capacity deemed by an administrative officer or chief of service to be in a position to influence decision-making for LCHD No. 1 shall:

        1. Disclose potential conflicts of interest by submitting a Conflict of Interest Disclosure Form ("Form") to the Compliance Officer upon hire or appointment and then annually thereafter.
        2. If during the year any new potential Conflicts of Interest arise, employees must report the potential Conflicts of Interest immediately (and prior to undertaking any activity that may raise a potential Conflict of Interest) as outlined directly above.

3. Confidentiality.

a. Disclosure information will be confidentially maintained. It may be shared in a confidential manner with the person to whom the employee or agent directly reports, the Compliance Officer, the Compliance Committee, the Board of Commissioners and as required by law.

4. Review and Resolution of Conflicts of Interests- Annual disclosure forms and reported conflicts of interests will be reviewed and resolved in the following manner:

a. For Board Members and the Chief Executive Officer, the Compliance Officer will review the completed form and follow-up as appropriate. When it is determined that a conflict of interest may exist, the Compliance Officer will discuss with the Compliance Committee and the Board of Commissioners and recommend any needed action to cure or manage the conflict.

b. For all other employees and agents, the Compliance Officer will review the completed forms along with the direct supervisor and follow-up as appropriate. The Compliance Officer may discuss with the Compliance Committee any needed action to cure or manage the conflict.

c. Determination and Course of Action:

1. If the Compliance Officer determines that a conflict of interest exists, they shall notify the individual in writing of the determination and the recommended course of action.

2. The individual shall respond in writing indicating how he/she complied with the determination.

3. Appeals

a. For Members of the Board of Commissioners and the Chief Executive Officer, any appeal will be made to the entire Board of Commissioners. For employees or agents who sit on the Compliance Committee or who directly report to the Chief Executive Officer, appeals may be made to the Compliance Committee and/or the Board of Commissioners. Appeals for all other applicable colleagues will be made to the Compliance Committee.

5. Records

a. Forms, in hard copy and electronic format, will be retained as required by LCHD No. 1 retention requirements.

b. The Compliance Officer will retain memoranda of all decisions relating to conflicts of interests, as required by LCHD No. 1 retention requirements.

6. Institutional Conflicts of Interest

a. Institutional conflicts of interest are conflicts involving LCHD No. 1 or an institutional component thereof, rather than an individual. Anyone who becomes aware of a potential institutional conflict of interest should refer the potential conflict to the Compliance Officer who with the Compliance Committee will review the potential conflict and either issue a recommendation or refer the matter to the CEO and the Board of Commissioners for a decision.

b. LCHD No. 1 conducts regular conflicts of interest reviews of its relationships with other health care providers, educational institutions, payors, and pharmaceutical, device and equipment manufacturers to determine whether conflicts exist and whether these relationships comply with applicable laws.

RESPONSIBLE PARTY:

1. This policy applies to Board Commissioners, employees, and agents of LCHD No. 1.

DEFINITIONS:

"Agents" means all persons and entities that have contracted with the District to provide health care related services, equipment or other goods or services. Agents do not include Volunteers.

“Board Members” means members of the Board of Commissioners of Lewis County Hospital District #1.

"Employee" means all District employees and temporary, per diem personnel, volunteers, students and others rendering paid or unpaid services to the District, including, but not limited to, Agents, Board Members, Medical Staff, and Officers.

“Conflict of Interest” means a situation in which financial, professional, or personal interests, including the interests of

Immediate Family Members, may compromise one's professional judgment or other obligations to the District. There is no minimum amount below which financial Conflicts of Interest do not need to be disclosed.

"Entity" means any for-profit or not-for-profit organization, including, but not limited to, any corporation, trust, foundation, association, company, sole proprietorship, partnership, firm, venture, vendor, or other form of organization.

"Equity" means any investment having a value greater than 1% of total worth or ($25) or having an unknown value (such as stock options).

"Immediate Family Member" means a spouse/domestic partner, parent, child, sibling, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild, aunts, uncles, nephews, nieces and spouse of a grandparent or grandchild.

"Significant Financial Interest" means anything of monetary value, including, but not limited to, salary or other payments for services (e.g., consulting fees or honoraria); equity interests (e.g., stocks, stock options or other ownership interests); and intellectual property rights (e.g., patents, copyrights and royalties from such rights). Significant Financial Interest does not include:

- Salary, royalties, or other remuneration from the District;
- Income from seminars, lectures, or teaching engagements sponsored by, or from service on advisory committees or review panels for, public or nonprofit entities;
- An equity interest that when aggregated for Employee and the Employee's spouse and dependent children, does not exceed $25 in value and does not represent more than a 1% ownership interest in any single entity; or
- Salary, royalties or other payments that when aggregated for the Employee and the Employee's spouse and dependent children are not expected to exceed $500 over the next twelve months.

REFERENCES:

- Anti-Kickback Statute; 42 USC §1320a-7b(b);

Document Owner:	Hargett, Spencer
Collaborators:	
Approvals	
- Committees:	(07/05/2022) Non-Clinical Policy Review Committee, (07/22/2022) Policy Oversight Committee, (08/31/2022) Board of Commissioners,
- Signers:	
Original Effective Date:	01/25/2019
Revision Date:	[01/25/2019 Rev. 0], [07/22/2022 Rev. 1]
Review Date:	
Attachments: (REFERENCED BY THIS DOCUMENT)	Annual Conflict of Interest Disclosure Form
Other Documents: (WHICH REFERENCE THIS DOCUMENT)	Outside Employment Annual Conflict of Interest Disclosure Form Compliance Plan

Annual Conflict of Interest Disclosure Form

Administrators, Managers, Medical Staff members, and Commissioners complete this form annually to identify and resolve possible conflicts of interest. A conflict of interest may exist when an employee, agent, or Board Commissioner is involved in any activity, or has a personal, familial, or financial interest, that may interfere in their performance or objectivity in performing their duties. (Where appropriate please check boxes yes or no and please use the additionally provided lined paper if needed.)

Name_____ **Position** _____ **Date:** _____

1. Are you or do you:
   1.1. Have a relationship with an entity that does business with LCHD#1:
   Yes ☐ No ☐
   1.2. Have you referred business from LCHD#1 to the organization(s): Yes ☐ No ☐
   1.3. Have you referred business from the organization to LCDH#1: Yes ☐ No ☐
   1.4. Provide products or services similar to LCHD#1 products or services: Yes ☐ No ☐
      1.4.1 If you checked "Yes" above:
         1.4.1.1. state the name and address or the organization(s):_____
         _____
         1.4.1.2. Your position(s):_____

2. Do you have a financial interest in any other entity that does business in any capacity with, or competes in any way with LCHD#1? Yes ☐ No ☐
   2.1 If you checked "Yes":
      2.1.1. State the name and address of the organization(s)_____
      2.1.2. What is your financial interest in the organization(s):_____
      2.1.3. Do you own more than one-tenth of one percent of the organization(s): yes ☐ No ☐
      2.1.4. Have you referred business from LCHD to the organization(s): yes ☐ No ☐
      2.1.5. Has the organization referred business to LCHD through you: yes ☐ No ☐

3. Do you have any relative(s) that:
   3.1. Are employed by LCHD#1: Yes ☐ No ☐
   3.2. Provide contracted services to LCHD#1: Yes ☐ No ☐
   3.3. Serve as a Board Commissioner for LCHD#1: Yes ☐ No ☐
   3.4. Has a financial interest in an entity doing business, in any capacity, LCHD#1: Yes ☐ No ☐
   3.5. Has a financial interest in an entity that provides products and services that competes with LCHD#1:
   Yes ☐ No ☐

   3.6. If you checked "Yes" to any of the above (3.1 through 3.5) state:
      3.6.1. The name(s) of the relative(s) and your relationship to such person:_____

_____

3.6.2. The name and address of the organization(s) with which associated:_____

_____

3.6.3. The relative(s) position(s) with the organization(s):_____

_____

3.6.4. The relatives(s) financial interest in the organization(s):_____

_____

3.6.5 Have you referred business to the organization(s): yes ☐ No ☐

3.6.6 Has the relative or family member referred business to LCHD#1: yes ☐ No ☐

4. Has any current or prospective vendor, supplier, or customer of LCHD#1, or any other entity that does or has sought to do business with LCHD#1 provided you or your family members with, or assumed on behalf of you or your family members behalf the cost of, goods or services of any kind whose value exceeds $25.00 as a gift or other prerequisite? Yes ☐ No ☐

4.1 If you checked "Yes" state:

4.1.1 The name of the person who provided you with, or assumed the cost of, such goods and/or services and the business entity with which such person is associated:_____

_____

4.1.2. The goods / services you received, their estimated value and when you received them:_____

_____

5. Are you or a family member involved in any public service or charitable organizations to which LCHD#1 contributes or whose actives may conflict with those or LCHD#1? Yes ☐ No ☐

5.1 If you check "Yes" state/describe the activity and/or relationship:_____

_____

6. In your capacity with LCHD#1, have you hired or retained, as an employee, an independent contractor or otherwise, or do you supervise, a family member or other relatives? Yes ☐ No ☐

6.1 If you checked "Yes":

6.1.1 The name of the family member(s) or other relative(s) and your relationship to such person(s):

_____

See next page:

Please place your name, position, and date on form. If you have no additional information, write "nothing to report" on the first blank line and cross through the rest of the lines.

Name_____ **Position** _____ **Date:** _____

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2024 AWPHD & WSHA Rural Hospital Leadership Conference

June 23 @ 3:00 pm - June 26 @ 12:00 pm

AWPHD & WSHA Rural Hospital Leadership Conference

- Sunday, June 23 – Wednesday, June 26
- Campbell's Resort | Chelan, WA
- Audience: Rural C-Suite Leaders, Hospital Board Members
- Registration to open in spring 2024

Lodging Information

To reserve a room within the Campbell's room block, please call Campbell's at 800-553-8225 and reference the group name: WA St Hospital Association and block number: 608134

When Campbell's rooms are sold out, you may contact them to be put on their waiting list in case of cancelations.

We have coordinated a room block with Grandview on the Lake which is 4-minutes away from Campbell's. To book within our room block, please contact Grandview at (509) 682-2582, ask for Latreece Fulton, and reference the Washington State Hospital Association room block.

DETAILS

Start:

June 23 @ 3:00 pm (2024-06-23)

End:

June 26 @ 12:00 pm (2024-06-26)

VENUE

Campbell's Resort on Lake Chelan

104 W Woodin Ave

Chelan, WA (Washington) 98816 United States + Google Map

Phone

(509) 682-2561

View Venue Website

Washington Hospital Services | Association of Washington Public Hospital Districts

Contact Us

Washington State Hospital Association
999 Third Avenue
Suite 1400
Seattle, WA 98104

Map / Directions (/about/getting-to-wsha-map-and-directions/)

206.281.7211 phone
206.283.6122 fax

info@wsha.org (mailto:info@wsha.org)

Staff List (/about/staff/)

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jane.doe@example.com

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SUPERINTENDENT REPORT

Arbor Health

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Packwood Clinic
13051 US HWY 12
360-496-3777

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

To: Board of Commissioner

From: Superintendent Mach

Date: 01.31.24

Re: January's Superintendent Report

- Dr. Hines returned his offer letter.
    - Working on getting his contract done.
- Advocacy day on January 30th at capital.
- Geographic restrictions on services still in limbo but as of this moment, no geographic restrictions allowed.
- working on review of all physician agreements and updating salary and quality metrics.
- I have been appointed to the WSHA Rural Hospital Committee Board
- Case manager meeting with Multicare to work on increasing Swing bed admissions.
    - Agreement signed to allow us to access system.
- Working on affiliation agreement with Tacoma Community Hospital for x-ray students and centralia for nursing students.
- Working on "Just Culture" training for managers and staff in 2024.
- Winter weather has caused havoc with heating units.
- Fire in OT room controlled extremely quickly.
- Damage in the Morton Clinic due to a failure of a sprinkler head.

  - Working on assessing costs and submitting to insurance.

- W2's available on 1/15/2024
- New Employees
  - Respiratory Therapy
  - IT
  - Facilities
- Crypto chart available for Radiology images and reports for patients

Financial Stability and Growth	Progress	Status	Estimated Completion
Develop 5 year capital plan	Progress being made. Meeting with department managers and shared with senior team		
Complete Facility master plan	Mathew met with company on 10/12, selected company to help with plans		
Establish 3 year IT plan	Jim frey working on plan		
Ensure compliance with federal interoperability requirements	Multi factor authitication, Self service pass word reset, strengthened cyber security policy		
Identify and Implement new expanded services to attract patients	Board approved purchase of MRI, install mid 2024. Chronic care management nurse hired and working		
Increase Swing Bed ADC by 1	Meeting with Providence health quarterly to discuss issues including swing bed, access granted to both Providence and Multicare HER		
Recruit Surgeon	No progress		*2024/2025*
Expand rapid care to 6 days	Currently recruiting for Mid level providers		
Implement Labor productivity	Scrapped plan, bad purchase.		

Workforce stabilization	Progress	Status	Estimated Completion
Reduce traveler/contracted staff usage by 50%	Working on recruiting new permanent positions, working on increasing visability on social media platforms. Hired X-ray and lab tech positions in December		
Become Employer of Choice in East Lewis County	Working on rolling out employalty book and ideas. Working on an onsite program for leadership training and culture. Just Culture training in 2024 for staff		
Partner with local high schools to promote healthcare careers	Participated in career days. Working on developing scholarship program		
Partner with colleges to provide alternative education paths for healthcare careers	Met with centralia college on Arbor health needs. Will have nursing students from centralia college and Xray students from tacoma.		
Establish discount programs for employees	Solv has discount program as part of new offering		
Establish an employee recruitment and retention committee to identify retention and engagement opportunities	Shannon working on this		
Develop a wage and benefit structure that is competitive with the local market and competition	Developing pay comensation policy		

Service and Quality	Progress	Status	Estimated Completion
Recruit psychiatrist	No progress		
Expand LICSW/Therapy services	moving PT LICWS to full time		
Develop regional partnerships with behavioral care facilities	Contracts signed with CHIS and Cascade		
Implement streamlined check-in/registration system for all patient encounters (Phreesia)	August - IT working with Phreesia to implement streamline check-in/registration		
Implement Medicare Coordination program	Staff hired and working on Care coordination		
Employ 2 measures for improved clinic access	Hired Dr. Ho, Dr. Hines signed offer letter		
Develop and implement 4 improvement strategies from patient experience surveys	Focus on allowing patient family members to be with the patient in ED, Improve pharmacy discharge pt medication education		
Achieve successful NIAHO reaccreditation and maintain acute stroke ready certification annually	Work on improving door to CT/Lab metrics		
Partner or develop a regional OP transportation service	Regional meeting held to discuss transportation issues in east lewis county		
Initiate and complete management review for initial ISO project	Medical Staff and Hospital Committee structures refined so that PI and projects now flow to Senior Leadership, QIO, and Medical Staff Leadership consistently.		
Complete 2 internal audits	Code red process, Access to new software, Lab resulting		
Receive ISO 9001 stage 2 certification			
Implement 2 new service lines for the community	MRI, Chronic care management		

Community relationships and partnerships	Progress	Status	Estimated Completion
Identify and partner with external groups to support youth based outreach	Contract signed with CIHS		
Implement school based school physicals	Completed		
Develop annual youth safety events for schools	No progress		
Partner with Lewis county early childhood education and other wellness groups to create ongoing connections with providers	No Progress		
Identify and align with external groups to support wellness focused outreach	Sep - meeting with veterans group to promote hospital and clinic and how we can work together to provide care. Contracted with 2 other organizations to provide space for behavioral health.		
Organize community education opportunities to enhance community awareness of Arbor health	Mossy Rock run, wellness week events		
Continue senior fitness program	Started in August		
Sponsor Packwood 5K, Mossyrock 5k, 5k color run, wellness week	Completed		
Include health literacy focus at community resource fairs	TED talks at wellness week		
Develop educational programs and partner with Molina on medical literacy	Working thru RHC with Molina on MCO		
Participate in annual Latino community event in Mossyrock	Diane markham working on plan		
Implement a diabetes education and outreach program	RN Hired in clinics		
Partner with area organizations to address district food insecurity and homelessness programs	Working with Blue Zone organization		
Implement a community cardiac and/or pulmonary disease program	No progress		

CAH Finance Basics in the New Health Care Environment

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EideBailly

CPAs & BUSINESS ADVISORS

Agenda

- Basics of CAH finances
- Importance in the present and future
- 10 financial indicators.

CAH Finance Basics

- CAH Reimbursement Methodology
- Impact on other programs
- Not all costs are allowed in calculation
- Some revenues are used to offset costs
- Costs are not reimbursed at the same level
- Cost + 1% ≠ Profit
- CAHs cannot spend their way to success
- The rules and interpretations are always changing
- CAHs often leave money on the table

CAH Reimbursement Methodology

- Medicare (and in some states Medicaid) reimburse CAH's based on allowable costs + 1%
  - Costs reported on Medicare Cost Report
    - Similar to a tax return
    - Filed within 5 months of year end
  - Interim payments
    - Based on historical costs as claims processed
  - Final settlement
    - Based on Medicare Cost Report

CAH Reimbursement Methodology

- Other payors
  - Fee schedules
  - Charges
  - Percentage of charges

Impact on other programs

- Cost reimbursement does not apply to all services offered by the Hospital
  - Cost based reimbursement extends to:
    - Inpatient and most outpatient hospital services
    - Swing bed
    - Rural Health Clinics

Impact on other programs

- Cost reimbursement does not apply to all services offered by the Hospital
  - Cost based reimbursement does not extend to:
    - Free-standing clinics
    - Psychiatric or Rehabilitation Units
    - Nursing home (some exceptions for Medicaid)
    - Home Health
    - Hospice
    - Ambulance (some exceptions)
    - Assisted Living

Not all costs are allowed in calculations

- Patient phone and television costs
- Advertising costs
- Physician professional costs (exception – RHC)
- Physician recruitment costs (exception – RHC)
- Lobbying
- Bad debts (except Medicare bad debts)

Some revenues are used to offset costs

- Interest income
- Medical record fees
- Rebates
- Miscellaneous revenues
- Grant revenues are usually not offset against cost

Costs are not reimbursed at the same level

- Medicare reimburses costs on a department by department basis
  - Reimbursement for an individual department is based on the Medicare utilization of that department
    - Days for room and board
    - Charges for ancillaries
  - Medicare reimburses a higher percentage of costs in departments with higher Medicare utilization

Costs are not reimbursed at the same level

- Typically higher
  - Inpatient/swing bed
  - Operating Room
  - Pharmacy
- Typically lower
  - Lab
  - Radiology
  - Emergency Room

Costs are not reimbursed at the same level

- Overall impact varies by provider
  - Different services
  - Different utilization patterns.

- Overall impact varies by state
  - Medicaid payment rules for CAH and nursing homes

Cost + 1% ≠ Profit

- As previously noted some costs are not allowed
  - Offsets are frequently 5-10% of total cost
  - 95% + 1% = 95.95% reimbursement

- Must be able to be profitable in other services provided to other payors

Cost + 1% ≠ Profit

- Providers with more non-CAH services tend to struggle more with profitability
  - Nursing Homes
  - Home Health
  - Hospice
  - Psychiatric and Rehabilitation Units

CAHs cannot spend their way to success

- Increasing allowable costs will increase revenues, but will it improve profitability?

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NO!

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- As costs go up, the increase in reimbursement is limited to the Medicare utilization of that department.
  - Medicare profitability is stable
  - Profitability of other payors goes down

CAHs cannot spend their way to success

- As costs go down, the decrease in reimbursement is limited to the Medicare utilization of that department.
  - Medicare profitability is stable
  - Profitability of other payors goes up

CAHs often leave money on the table

- Improper Medicare cost report filing
  - Overhead allocations
  - Revenue/expense mismatching

- Revenue Cycle Mismanagement
  - Proper Chargemaster updates
  - Pricing of services in chargemaster
  - Changes in billing regulations
  - Billing opportunities
  - Coding deficiencies

CAHs often leave money on the table

- Proper staff
  - Administrative
  - Revenue Cycle
  - Nursing
- Overstaffing

Finance Today

- Understanding the intricacies in reimbursement is important in providing opportunities to generate profitability.

Finance Tomorrow

- Managing of profitability with other payors will become more difficult as payors introduce new payment methodologies
  - ACOs to manage a population of patients
    - Medicare
    - Commercial
  - Reductions in reimbursement for products offered through Health Insurance Marketplaces

Finance Tomorrow

- Expect payment for quality of care
  - Commercial payors
  - Expected for Medicare and other cost based payors

Finance Tomorrow

- Tough choices ahead
  - Cannot be everything to everybody
  - Increased incentives to partner with others
    - Lower volume services
    - Lower compensated services

Tough Choices Require Solid Indicators

- Challenges in the future will require providers to increase their focus on indicators that highlight strengths and weaknesses

- 10 indicators have been identified for ongoing monitoring and management

Tough Choices Require Solid Indicators

- Net Days in Accounts Receivable
- Gross Days in Accounts Receivable
- Days Cash in Hand
- Total Margin
- Operating Margin
- Debt Service Coverage
- Salaries to Net Patient Revenue
- Medicare Inpatient Payor Mix
- Average Age of Plant
- Long Term Debt to Capitalization