

Regular Board Packet

October 1, 2026

Meeting Board Packet

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Oak Valley Hospital District

OUR MISSION

“We Focus on Personalized Quality Health Care and Wellness for Those We Serve”

OUR VISION

“Oak Valley Hospital District Will Continue as an Independent Locally Controlled and Governed Special District Hospital. To Accomplish This We Will Adhere to the Following Guidelines:
Being Fiscally Responsible in Our Decision Making Process
Maintain and Expand Services that Best Reflect Our Needs and Resources Available
Promote Positive Change in the Health Status of Employees and Area Residents.”

OUR VALUES

“Accountability; Being Responsible for Actions Taken and Not Taken
Integrity; Doing the Right Thing for the Right Reason
Respect; Valuing All People at All Times”

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## **REGULAR MEETING OF THE BOARD OF DIRECTORS OF OAK VALLEY HOSPITAL DISTRICT**

**October 1, 2026, 5:30 p.m.  
350 S. Oak Ave. Oakdale, CA 95361  
REDWOOD ROOM**

| <u>Time</u> | <u>Action</u> | <u>Item</u>                                                |
|-------------|---------------|------------------------------------------------------------|
| 5:30 p.m.   | Action        | <b>MEETING CALLED TO ORDER</b><br>Dan Cummins, Chairperson |

## **PUBLIC COMMENT**

In compliance with the California Brown Act the District Board of Directors welcomes comments from the public.

This is the opportunity for members of the public to directly address the District Board of Directors on any item of interest to the public under the jurisdiction of the District including items on this agenda.

Persons wishing to make a presentation to the Board of Directors shall observe the following procedure:

1. A written request to the Board on the form provided at the meeting (optional)
2. Oral presentations are limited to three (3) minutes.
3. Members of the public will be afforded the opportunity to speak at the beginning of the public meeting during the general Public Comment section of the agenda on any item under the jurisdiction of the District as well as during the consideration of an individual item on the agenda for that public meeting, however the three-minute limit described in item 2, above, will be applied to an individual's cumulative comments during the meeting.

The proceedings of the Board are recorded and are part of the public record.

Materials related to an item on this Agenda, submitted to the Oak Valley Hospital District after distribution of the agenda packet, are available for public inspection in the Secretary's Office at 350 S. Oak Ave., Oakdale, CA during normal business hours.

Information/Action     **CONSENT CALENDAR ITEMS**

Items 1-2 comprise the consent agenda, unless there is discussion by a member of the audience or Board Members, they may be approved in one motion.

**1. Oakdale Nursing and Rehabilitation Center Report**

Will Pringle, V.P., Oakdale Nursing and Rehabilitation Center

**2. Approval of Minutes –**

- September 3, 2026 – Regular Meeting

Action                    **MEDICAL STAFF REPORT** –Matthew Tilstra, M.D., Chief of Staff

**The Medical Executive Committee requests the District Board’s approval of the following items forwarded from the September 18, 2026, meeting.**

**Committee Meeting Reports**

A. The Medical Executive Committee Minutes – (September 15, 2026) **Approval**  
Matthew Tilstra, MD, Chief of Staff

B. Interdisciplinary Practice Committee Meeting (IDPC) – (September 1, 2026) **Approval**  
Chaitanya Mahida, MD, Chairperson

C. Credentials Committee Meeting – (September 1, 2026) **Approval**  
Chaitanya Mahida, MD, Chairperson

D. The Department of Medicine Committee Report – (September 8, 2026) **Approval**  
Lee Horwitz, MD, Chairperson

E. The Quality Council Minutes – (Cancelled Mtg 08/13/2026; Next 10/08/2026) **Standing**  
Lee Horwitz, MD, Chairperson

F. The Department of Surgery Committee Minutes – (Next Mtg 10/13/2026) **Discussion**  
Andrew Huber, MD, Dept of Surgery Chairperson

o Update - Bariatric Center of Excellence has been earned.

**Other**

G. Forms - None

H. Policies **Approval**

1. Case Management Manual
  - a. Medicare – An Important Message About Your Rights – Manual Change **Page 1-13**
2. Clinical Manual
  - a. Accu-Check Inform II Fingerstick Glucose **Page 14-20**
  - b. Safe injection practices → Recommend Retire **Page 21-22**
3. Emergency Department Manual
  - a. Febrile Neonates and Infants **Page 23-24**
  - b. Ordering of Pediatric X-Rays and Foreign Body Ingestion **Page 25-27**
  - c. Triage **Page 28-40**
4. Infection Control Manual
  - a. Covid Vaccination Declination Requirements → Recommend Retire **Page 41-46**
  - b. Discontinue Isolation in patients with covid 19 **Page 47-51**
  - c. Environmental Culturing → Recommend Retire **Page 52-51**
  - d. Environmental Surveillance → Recommend Retire **Page 54**
  - e. Ice Machines Maintenance and Cleaning **Page 55-57**
  - f. Influenza and Pneumococcal Vaccinations for Hospital Patients **Page 58-59**
  - g. Influx of Infectious Patients **Page 60-63**
  - h. Reportable Diseases **Page 64-65**
  - i. Respiratory Hygiene Program – Visitors & Patients → Recommend Retire **Page 66-67**
  - j. Scabies – Prevention and Control **Page 68-75**

**FINANCE COMMITTEE – Sara Shipman, Chairperson**

- Chang Ahn, Chief Financial Officer

- Action
1. Financial Reports for August 2026 – Chang Ahn, Chief Financial Officer
    - Approval of August 2026 Financial Statements

**CHAIRPERSON REPORT**

- Dan Cummins, Chairperson

- Information
1. Chairperson Comments

- Action
2. Formation of an Ad Hoc Committee for the President and Chief Executive Officer Performance and Compensation Review

**CHIEF EXECUTIVE OFFICER REPORT**

- Matt Heyn, President and Chief Executive Officer

- Information
1. Chief Executive Officer Report
    - a. John C. Fremont Update
    - b. Physician Recruitment Updates

- Action
2. Consideration and Approval of Call Light System Replacement/Upgrade Not to Exceed \$145,000. – Will Pringle, VP LTC

- Action  
**Resolution 2026-07**
3. Consideration and Approval of Resolution Authorizing the Execution and Delivery of Documents Related to the Issuance, Sale, and Delivery of Oak Valley Hospital District Health Facility Revenue Bonds, Series 2026.

**ADJOURN TO CLOSED SESSION**

- Action
1. **Approval of Closed Session Minutes –**
- September 3, 2026 - Regular Meeting

**(See attached Agenda for Closed Session)**

**RECONVENE TO OPEN SESSION**

Information **REPORT OF CLOSED SESSION**

Action **ADJOURNMENT**

**The next Regular meeting of the Board of Directors is scheduled on November 5, 2026 at 5:30 p.m.**

Posted on: September 28, 2026

By: Sheryl Perry, Clerk of the Board

**OAK VALLEY HOSPITAL DISTRICT  
BOARD OF DIRECTORS  
AGENDA FOR CLOSED SESSION**

Pursuant to California Government Code Section 54954.2 and 54954.5, the board agenda may describe closed session agenda items as provided below. No legislative body or elected official shall be in violation of Section 54954.2 or 54956 if the closed session items are described in substantial compliance with Section 54954.5 of the Government Code.

**Regular Meeting of the Board of Directors of the Oak Valley Hospital District  
October 1, 2026 5:30 p.m.  
350 S Oak Ave., Oakdale, CA 95361  
Redwood Room**

**CLOSED SESSION AGENDA ITEMS**

**Hearings/Reports**

(Government Code §37624.3 & Health and Safety Code §§1461, 32155)

- **Medical Staff Report – Matthew Tilstra, M.D.**  
(Government Code §37624.3 & Health and Safety Code §§1461, 32155)
- **Chief Executive Officer Report – Matt Heyn, President & CEO**  
**REPORT INVOLVING TRADE SECRET**  
**Health & Safety Code § 32106**  
Discussion will concern: No program, service or facility.  
**Estimated Date of Public Disclosure: Unknown**

In observance of the Americans with Disabilities Act, please notify us at 209-848-4102 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

## October 2026 ONRC Board Report

ONRC recorded an average daily census of 88 patients per day in our prior month of operations. We experienced a drop in census this month and the drop was seen in the LTC settings.

From a regulatory standpoint, ONRC had no unannounced complaint surveys. That said, we did receive the results of our most recent self-report and we were found to be deficiency free. Finally, we remain in our annual survey window, and this month marks a 6-month delay. According to the Modesto Bee, the State is slow due to the government shutdowns in the year and are now focused on facilities requiring a resurvey, a result of a failed survey and those with serious complaints.

Regarding the physical plant, we continue to invest in the facility with furniture replacement and room improvements, TCU gym improvements and public restroom renovations.

Finally, we are thrilled to have been recognized by both Senator Marie Alvarado Gill & Congressman Tom Mc Clintock this month when we were proudly awarded certificates of recognition from their respective offices. ONRC will celebrate this on 10/2/2026 with an employee BBQ.

This concludes our ONRC monthly board report.



# *Certificate of Special Congressional Recognition*

*Presented to*  
**Oakdale Nursing and Rehabilitation Center**  
*in recognition of*

*Receiving Best Long-Term Care Honors by U.S. News and World Report  
Congratulations and thank you for your commitment to care and the  
community.*

*September 11, 2026*

TOM MCCLINTOCK  
MEMBER OF CONGRESS  
5TH DISTRICT, CALIFORNIA



CERTIFICATE OF RECOGNITION

*Oakdale Nursing & Rehabilitation Center*  
*In Recognition of*  
*Being Named A U.S. News & World Report Best*  
*Nursing Home*

*On behalf of the California State Senate, I am pleased to recognize Oakdale Nursing and Rehabilitation Center upon being named among the Best Nursing Homes by U.S. News & World Report and earning High Performing ratings in both Short-Term Rehabilitation and Long-Term Care. This distinguished national recognition reflects your team's exceptional dedication to providing quality care and service to residents and their families. Congratulations on this outstanding achievement and your continued service to the Oakdale community.*

*Congratulations!*

*Presented on this Day, September 14th, 2026*

A handwritten signature in black ink, appearing to read 'Marie Alvarado-Gil', written over a horizontal line.

Senator Marie Alvarado-Gil  
FOURTH DISTRICT, CALIFORNIA STATE SENATE

**REGULAR MEETING OF THE BOARD OF DIRECTORS  
OF OAK VALLEY HOSPITAL DISTRICT  
OPEN SESSION  
September 3, 2026 5:30 p.m.  
350 S. Oak Ave, Oakdale, CA 95361  
Redwood Room**

**Board**

Dan Cummins, Chairperson  
Danielle Sanders, Vice Chairperson  
Billie Scott, Secretary  
Sara Shipman, Director  
Ann Bairos, Director

**Staff**

Matt Heyn, President and C.E.O.  
David Rodrigues, Sr. VP/COO  
David Neal, Sr. VP/CNO  
Chang Ahn, VP/CFO  
Will Pringle, V.P., Oakdale Nursing & Rehab

**CALLED TO ORDER**

The District Board of Directors Meeting was called to order by Dan Cummins, Board Chairperson, at 5:32 p.m.

**PUBLIC COMMENT**

Members of the public were in attendance. The Public Comment statement was read.

**CONSENT CALENDAR**

The following items, 1-2, will be acted on by one action, with discussion, unless a director or other person requests that an item be considered separately. In the event of such a request, the item will be addressed, considered, and acted upon separately.

1. Oakdale Nursing and Rehabilitation Center Report  
Will Pringle, V.P., Oakdale Nursing and Rehabilitation Center
2. Approval of Minutes –
  - August 5, 2026 – Special Meeting

Director Shipman made the motion to approve the Consent Calendar items. Vice Chair Sanders made the second. No public input.

Cummins – Aye  
Sanders – Aye  
Scott – Aye  
Shipman – Aye  
Bairos – Aye

**MOTION CARRIED**

**MEDICAL STAFF REPORT – Matthew Tilstra, M.D., Chief of Staff**

The Medical Executive Committee requests the District Board's approval of the following items forwarded from the August 18, 2026, meeting.

**Committee Reports**

A. The Medical Executive Committee Minutes – August 18, 2026

Discussion

Matthew Tilstra, MD, Chief of Staff

B. Interdisciplinary Practice Committee Meeting (IDPC) – August 4, 2026

Approval

Chaitanya Mahida, MD, Chairperson

C. Credentials Committee Meeting – August 4, 2026

Approval

Chaitanya Mahida, MD, Chairperson

D. The Department of Medicine Committee Report – Next Meeting September 8, 2026

Standing

Lee Horwitz, MD, Chairperson

E. The Quality Council Minutes – August 13, 2026 Meeting Cancelled; Next Meeting October 8, 2026

Standing

Lee Horwitz, MD, Chairperson

F. The Department of Surgery Committee Minutes – Next Meeting August 13, 2026

Discussion

Andrew Huber, MD, Department of Surgery Chairperson

Other

G. Forms & Policies – None

Director Shipman made the motion to approve the Medical Staff Report. Director Bairos made the second. No public input.

Cummins – Aye

Sanders – Aye

Scott – Aye

Shipman – Aye

Bairos – Aye

**MOTION CARRIED**

**Financial Report for July 2026 – Matthew Heyn, Chief Executive Officer**

Mr. Heyn reported that July gross patient revenue reached \$44.9 million, the District's second-highest month following June's \$47.6 million. The District reported an operating profit of approximately \$1.05 million before new hospital expenses, operating income of approximately \$715,000 after depreciation and interest, and net income of approximately \$1.02 million. The EBIDA margin was 10.3%. Days of cash on hand decreased from approximately 64 to 46 days, while Gross Accounts Receivable days improved from 50 to 49.

Mr. Heyn also reported that, to ensure compliance with GAAP, Intergovernmental Transfers (IGTs) should be recorded as non-operating transfers rather than operating expenses. The report noted that \$1.24 million in IGT expenses recorded in July contributed to the decrease in days of cash on hand.

Secretary Scott made the motion to approve the July 2026 Financial Report. Director Shipman made the second. No public input.

Cummins – Aye  
Sanders – Aye  
Scott – Aye  
Shipman – Aye  
Bairos – Aye

**MOTION CARRIED**

**Chairperson Report – Dan Cummins**

Chair Cummins expressed appreciation for the District’s continued financial and operational improvements, highlighting Accounts Receivable days remaining below 50 and growth in clinic volume. He also discussed the impact of increased operating and personnel costs as the District continues to grow and expressed support for the developing relationship with John C. Fremont Healthcare District.

Chair Cummins was appointed to the Finance Committee. Vice Chair Sanders made a motion to concur with the appointment. Director Bairos seconded the motion. No public input.

Cummins – Aye  
Sanders – Aye  
Scott – Aye  
Shipman – Aye  
Bairos – Aye

**MOTION CARRIED**

The Board approved reinstating the December Regular Board Meeting for December 2, 2026, at 5:30 p.m. Director Shipman made the motion. Secretary Scott seconded the motion. No public input.

Cummins – Aye  
Sanders – Aye  
Scott – Aye  
Shipman – Aye  
Bairos – Aye

**MOTION CARRIED**

**Chief Executive Officer Report - Matthew Heyn**

**District Growth and Capital Investment**

Mr. Heyn reported that the District recently exceeded 700 employees and invested approximately \$4.5 million in capital during the prior fiscal year, reflecting continued growth and reinvestment in personnel, capital, and infrastructure. He also noted that the Oak Valley Center for Health Improvement signage

and video board are operational and provided an update on upcoming community programming at the facility.

#### **John C. Fremont Healthcare District Partnership**

Mr. Heyn provided an update on the District's developing partnership with John C. Fremont Healthcare District. Representatives from John C. Fremont attended the meeting, and Mr. Heyn reported that Oak Valley had completed and forwarded a draft definitive agreement for review. He stated that the organizations have already begun collaborating, including work related to CalRHT grant opportunities, and expressed continued support for strengthening the partnership.

#### **LAFCO Annexation Update**

Board Counsel Matthew Toney provided an update on the LAFCO annexation process for the proposed expansion of District boundaries into the Riverbank area. The process will include defining the territory and legal description, preparing a plan of services and required environmental documentation, completing financial analysis, and submitting an application to LAFCO following Board review and approval. The anticipated timeline is approximately six to seven months, depending on the LAFCO review process. The Board also discussed property tax considerations associated with annexation and potential future discussions with Stanislaus County regarding allocation of ad valorem property tax revenue.

#### **Bariatric Accreditation**

Mr. Neal reported on the recent Bariatric Accreditation survey, stating that the survey was highly successful and that accreditation is anticipated within approximately 60 days. The survey included a comprehensive review of the program and facility, including surgical and inpatient care, staff, equipment, and processes. The District requested expedited final approval to help accommodate bariatric patients requiring care at an accredited Center of Excellence.

#### **Quality Report**

Mr. Heyn presented a Quality Report highlighting continued growth in inpatient admissions and surgical volumes, strong employee satisfaction and engagement results, physician recruitment, patient experience measures, and clinical quality performance. Employee satisfaction reached 96.1% and employee engagement reached 86.3%. The District also reported 96% EMS stroke compliance and continued to maintain zero surgical site infections despite increased surgical volume. Primary Stroke designation is the District's next planned accreditation, with a Joint Commission survey anticipated after October 25.

#### **CalRHT Funding Update**

Mr. Rodrigues provided an update on CalRHT funding applications. The District applied for available grant opportunities supporting the John C. Fremont partnership, the Center for Health Improvement, workforce development and recruitment, and HR modernization. Oak Valley and John C. Fremont submitted a joint workforce recruitment application to support recruitment and retention of healthcare professionals in rural communities.

**Consideration and Adoption of Resolution No. 2026-05 Authorizing the Issuance of Revenue Bonds**

The Board received an overview of the proposed revenue bond financing to generate approximately \$18 million for District capital projects. The financing would be secured by operating revenues, with final approval anticipated at the October 1, 2026 Board meeting.

Vice Chair Sanders made a motion to adopt Resolution No. 2026-05. Director Shipman seconded the motion. No public input.

Roll Call by Sheryl Perry, Clerk of the Board:

Chairperson Cummins – Aye

Vice Chairperson Sanders – Aye

Secretary Scott – Aye

Director Shipman – Aye

Director Bairos – Aye

**MOTION CARRIED**

**Consideration and Adoption of Ordinance No. 2026-01 Approving a Formal Agreement for the Sale of Oak Valley Hospital District Health Facility Revenue Bonds, Series 2026**

Mr. Heyn explained that the Ordinance continues the revenue bond process and authorizes the District to move forward with the proposed bond sale, with final terms and figures to return to the Board for approval in October.

Director Shipman made a motion to adopt Ordinance No. 2026-01. Secretary Scott seconded the motion. No public input.

Roll Call by Sheryl Perry, Clerk of the Board:

Chairperson Cummins – Aye

Vice Chairperson Sanders – Aye

Secretary Scott – Aye

Director Shipman – Aye

Director Bairos – Aye

**MOTION CARRIED**

**Consideration and Adoption of Resolution No. 2026-06 Seeking Approval of a Healthcare Expansion Loan Program (HELP II) Loan**

Mr. Heyn reported that the District is eligible to seek up to \$2 million through the California Health Facilities Financing Authority to provide additional flexibility for previously funded capital purchases and strengthen the District's cash position if needed. The loan was described as a financial safety net with favorable financing terms.

Director Shipman made a motion to adopt Resolution No. 2026-06. Secretary Scott seconded the motion. No public input.

Roll Call by Sheryl Perry, Clerk of the Board:

Chairperson Cummins – Aye

Vice Chairperson Sanders – Aye

Secretary Scott – Aye

Director Shipman – Aye

Director Bairos – Aye

**MOTION CARRIED**

**ADJOURNMENT TO CLOSED SESSION**

Vice Chair Sanders made the motion to adjourn to Closed Session. Director Shipman made the second. No public input.

Cummins – Aye

Sanders – Aye

Scott – Aye

Shipman – Aye

Bairos – Aye

**MOTION CARRIED**

The Oak Valley Hospital District meeting was adjourned to Closed Session at 7:19 p.m.

**RECONVENE TO OPEN SESSION**

**ANNOUNCEMENT OF CLOSED SESSION**

- Approval of Closed Session August 5, 2026 Special Meeting Minutes
- Approval of Medical Staff Credentials Report

**ADJOURNMENT**

Vice Chair Sanders made the motion to adjourn the Board of Directors meeting. Director Shipman made the second. No public input.

Cummins – Aye

Sanders – Aye

Scott – Aye

Shipman – Aye

Bairos – Aye

**MOTION CARRIED**

The Board of Directors meeting was adjourned at 7:33 p.m.

Recorder: Sheryl Perry, Clerk of the Board.

APPROVED: \_\_\_\_\_ DATE: \_\_\_\_\_  
Billie Scott, Secretary

## **OAK VALLEY HOSPITAL DISTRICT**

### **RESOLUTION NO. 2026-07**

#### **RESOLUTION APPROVING THE FORM AND AUTHORIZING THE EXECUTION AND DELIVERY OF A SEVENTH SUPPLEMENTAL INDENTURE OF TRUST, A PRELIMINARY OFFICIAL STATEMENT, A CONTINUING DISCLOSURE CERTIFICATE AND A BOND PURCHASE AGREEMENT IN CONNECTION WITH THE ISSUANCE, SALE AND DELIVERY OF OAK VALLEY HOSPITAL DISTRICT HEALTH FACILITY REVENUE BONDS, SERIES 2026, AND APPROVING CERTAIN OTHER ACTIONS**

RESOLVED, by the Board of Directors (the “Board”) of the Oak Valley Hospital District (the “District”), as follows:

WHEREAS, the District has entered into that certain Indenture of Trust, dated as of November 1, 2004 (the “Original Indenture”), by and between the District and U.S. Bank Trust Company, National Association, as successor to U.S. Bank National Association, as trustee, and has supplemented and amended the Original Indenture from time to time in connection with the issuance of revenue bonds (as so amended and supplemented, the “Indenture”) pursuant to the Local Health Care District Law (Health and Safety Code Section 32000, *et seq.*), in particular Chapter 5 (commencing with Section 32315 thereof);

WHEREAS, initially capitalized terms used herein without definition have the meaning set forth in the Indenture;

WHEREAS, the District has issued its \$11,550,000 Oak Valley Hospital District (Stanislaus County, California) Health Facility Revenue Bonds, Series 2020A (the “2020A Bonds”), for the purpose of refunding its \$8,775,000 Oak Valley Hospital District (Stanislaus County, California) Health Facility Revenue Bonds, Series 2010B (Federally Taxable-Direct Payment Build America Bonds) and financing the remodeling, expansion, improvement and equipping of health facilities owned and operated by the District;

WHEREAS, the 2020A Bonds were issued pursuant to the Original Indenture as amended and supplemented by the Third Supplemental Indenture;

WHEREAS, the District has also issued its \$7,000,000 Oak Valley Hospital District (Stanislaus County, California) Health Facility Revenue Bonds, Series 2020B (the “2020B Bonds”) for the purpose of refunding its \$8,820,000 Oak Valley Hospital District (Stanislaus County, California) Health Facility Revenue Bonds, Series 2010A (Tax Exempt);

WHEREAS, the 2020B Bonds were issued pursuant to the Original Indenture as amended and supplemented by the Fourth Supplemental Indenture;

WHEREAS, the District has also issued its \$11,067,000 Oak Valley Hospital District (Stanislaus County, California) Health Facility Refunding Revenue Bonds, Series 2021 (the “2021 Bonds”), for the purpose of refunding its \$14,049,000 Oak Valley Hospital District (Stanislaus

County, California) Health Facility Refunding Revenue Bonds, Series 2015A and its \$1,548,000 Oak Valley Hospital District (Stanislaus County, California) Health Facility Revenue Bonds, Series 2015B;

WHEREAS, the 2021 Bonds were issued pursuant to the Original Indenture as amended and supplemented by the Fifth Supplemental Indenture;

WHEREAS, the District has also issued its \$10,000,000 Oak Valley Hospital District (Stanislaus County, California) Health Facility Refunding Revenue Bonds, Series 2024 (Federally Taxable) (the “2024 Bonds”) for the purpose of refinancing three loans made by the California Health Facilities Financing Authority to the District to provide working capital to the District and financing the remodeling, expansion, improvement and equipping of health facilities owned and operated by the District;

WHEREAS, the 2024 Bonds were issued pursuant to the Original Indenture as amended and supplemented by the Sixth Supplemental Indenture;

WHEREAS, the District has determined to issue its Oak Valley Hospital District (Stanislaus County, California) Health Facility Revenue Bonds, Series 2026 (the “2026 Bonds”), on a parity as to payment and security with the 2020A Bonds, the 2020B Bonds, the 2021 Bonds and the 2024 Bonds, to (i) finance the remodeling, expansion, improvement and equipping of health facilities owned and operated by the District (the “2026 Project”), (ii) fund a debt service reserve fund, (iii) finance capitalized interest on the 2026 Bonds, and (iv) pay costs of issuing the 2026 Bonds;

WHEREAS, the District has determined to take all necessary action to accomplish the issuance, sale and delivery of the 2026 Bonds; and

WHEREAS, pursuant to section 5852.1 of the Government Code, which became effective on January 1, 2018 by the enactment of Senate Bill 450, certain information relating to the 2026 Bonds is set forth in Appendix A attached to this Resolution, and such information is hereby disclosed and made public;

NOW, THEREFORE, it is hereby ORDERED and DETERMINED, as follows:

Section 1        The financing of the 2026 Project is hereby authorized and approved.

Section 2        A seventh supplemental indenture of trust, by and between the District and the U.S. Bank Trust Company, National Association, as a successor trustee to U.S. Bank National Association (the “Trustee”), amending and supplementing the Indenture (the “Seventh Supplemental Indenture”) in the form presented to this meeting, is hereby approved.

The Chairperson, the Vice Chairperson, the President & Chief Executive Officer or the Vice President & Chief Financial Officer, or the designee thereof, are each hereby authorized and directed, for and in the name of the District, to execute and deliver the Seventh Supplemental Indenture, with such changes, additions and deletions therein as the officer executing the same may approve, such approval to be conclusively evidenced by the execution and delivery of the Seventh Supplemental Indenture. The date, maturity dates, interest rates, interest payment dates, denominations, forms, registration privileges, place or places of payment, terms of redemption and other terms of the 2026 Bonds shall be as provided in the Seventh Supplemental Indenture as finally executed.

Section 3 A preliminary official statement relating to the offering and sale of the 2026 Bonds, in the form presented at this meeting (the “Preliminary Official Statement”), and the distribution thereof, is hereby authorized and approved. The Chairperson, the Vice Chairperson, the President & Chief Executive Officer or the Vice President & Chief Financial Officer, or the designee thereof, are each hereby authorized to cause the Preliminary Official Statement to be brought into the form of a final official statement (the “Final Official Statement”), to be dated the date of sale of the 2026 Bonds, and to execute and deliver the Final Official Statement, and any amendment or supplement thereto, for and on behalf of the District, with such changes therein as such officer may require or approve, such approval to be conclusively evidenced by execution and delivery thereof. The Chairperson, the Vice Chairperson, the President & Chief Executive Officer or the Vice President & Chief Financial Officer, or the designee thereof, are each hereby authorized to execute a statement that the information contained in the Final Official Statement, and any supplement or amendment thereto (which shall be deemed an original part thereof for the purpose of such statement) were, at the time of sale of the 2026 Bonds, and are at the date of delivery of the 2026 Bonds, true and correct in all material respects and that the Final Official Statement did not, on the date of sale of the 2026 Bonds, and does not, as of the date of delivery of the 2026 Bonds, contain any untrue statement of a material fact or omit to state material facts required to be stated where necessary to make any statement made therein not misleading in light of the circumstances under which it was made.

Section 4 A continuing disclosure certificate, in the form presented to this meeting (the “Continuing Disclosure Certificate”), is hereby approved. The Chairperson, the Vice Chairperson, the President & Chief Executive Officer or the Vice President & Chief Financial Officer, or the designee thereof, are each hereby authorized and directed, for and in the name of the District, to execute and deliver the Continuing Disclosure Certificate with such changes, additions and deletions therein as the officer executing the same may approve, such approval to be conclusively evidenced by the execution and delivery of the Continuing Disclosure Certificate.

Section 5 A bond purchase agreement by and between the District and Hilltop Securities Inc. as an underwriter (the “Underwriter”), for the purchase of the 2026 Bonds, in the form presented to this meeting (the “2026 Bond Purchase Agreement”), is hereby approved. The Chairperson, the Vice Chairperson, the President & Chief Executive Officer or the Vice President & Chief Financial Officer, or the designee thereof, are each hereby authorized and directed for and in the name of the District, to execute and deliver the 2026 Bond Purchase Agreement, with such changes, additions and deletions therein as the officer executing the same may approve, such approval to be conclusively evidenced by the execution and delivery of the 2026 Bond Purchase Agreement, so long as the principal amount of the 2026 Bonds to finance the 2026 Project does not exceed \$23,000,000 and the Underwriter’s discount for purchase of the 2026 Bonds does not exceed 0.70% of the principal amount of the 2026 Bonds (not including any original issue discount which does not constitute compensation to the Underwriter).

Section 6 The 2026 Bonds shall be executed by the manual or facsimile signature of the Chairperson, the Vice Chairperson, the President & Chief Executive Officer or the Vice President & Chief Financial Officer, or the designee thereof, and attested by the manual or facsimile signature of the Secretary or Assistant Secretary of the Board, in the form set forth in and otherwise in accordance with the Seventh Supplemental Indenture.

Section 7       The 2026 Bonds, when so executed, shall be delivered to the Trustee for authentication by the Trustee. The Trustee is hereby requested and directed to authenticate the 2026 Bonds by executing the Trustee's Certificate of Authentication appearing thereon and to deliver the 2026 Bonds, when duly executed and authenticated, to the order of the Underwriter in accordance with written instructions of the District. Said instructions shall provide for the delivery of the 2026 Bonds to the order of the Underwriter upon payment of the purchase price therefor.

Section 8       The Chairperson, the Vice Chairperson, the President & Chief Executive Officer or the Vice President & Chief Financial Officer, or the designee thereof, are each hereby authorized and directed, for and in the name of the District, to execute and deliver any other documents as may be deemed necessary or appropriate to issue the 2026 Bonds, such approval to be conclusively evidenced by the execution and delivery of such documents.

Section 9       The Secretary or the Assistant Secretary of the Board are each hereby authorized and directed to attest the signature of the Chairperson, the Vice Chairperson, the President & Chief Executive Officer or the Vice President & Chief Financial Officer, or the designee thereof, as may be required in connection with the execution and delivery of the Seventh Supplemental Indenture, the 2026 Bond Purchase Agreement, the Final Official Statement and the 2026 Bonds in accordance with this resolution.

Section 10       This resolution shall take effect immediately upon its passage.

\* \* \* \* \*

PASSED AND ADOPTED this 1st day of October, 2026, by the following vote:

AYES:

NOES:

ABSENT:

ABSTAINING:

By: \_\_\_\_\_  
Chairperson, Board of Directors  
Oak Valley Hospital District

I hereby certify that the foregoing resolution was duly adopted at a meeting of the Board of Directors of the Oak Valley Hospital District held on the 1st day of October, 2026.

By: \_\_\_\_\_  
Secretary, Board of Directors  
Oak Valley Hospital District

## APPENDIX A

### GOVERNMENT CODE SECTION 5852.1 DISCLOSURE

The following information consists of estimates that have been provided by the District's municipal advisor which has been represented to have been provided in good faith:

- (A) True Interest Cost of the 2026 Bonds: 6.44%
- (B) Finance Charges (Costs of Issuance): \$363,919.89
- (C) Debt Service Reserve Fund: \$1,635,887.50
- (D) Net Proceeds to be Received for the 2026 Bonds \$18,000,000.00
- (E) Total Payment Amount through Maturity: \$47,357,250.00

The foregoing estimates constitute good faith estimates only.

The principal amount of the 2026 Bonds, the true interest cost of the 2026 Bonds, the finance charges thereof, the amount of proceeds received therefrom and total payment amount with respect thereto may differ from such good faith estimates due to (a) the actual date of the sale of the 2026 Bonds being different than the date assumed for purposes of such estimates, (b) the actual principal amount of 2026 Bonds sold being different from the estimated amount used for purposes of such estimates, (c) the actual amortization of the 2026 Bonds being different than the amortization assumed for purposes of such estimates, (d) the actual market interest rates at the time of sale of the 2026 Bonds being different than those estimated for purposes of such estimates, (e) other market conditions, or (f) alterations in the District's financing plan, or a combination of such factors. The actual date of sale of the 2026 Bonds and the actual principal amount of 2026 Bonds sold will be determined by the District based on the timing of the need for proceeds of the 2026 Bonds and other factors. The actual interest rates with respect to the 2026 Bonds will depend on market interest rates at the time of sale thereof. The actual amortization of the 2026 Bonds will also depend, in part, on market interest rates at the time of sale thereof. Market interest rates are affected by economic and other factors beyond the control of the District.

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SEVENTH SUPPLEMENTAL INDENTURE OF TRUST

by and between the

OAK VALLEY HOSPITAL DISTRICT

and

U.S. BANK TRUST COMPANY, NATIONAL ASSOCIATION, as Trustee

Dated as of November 1, 2026

---

Relating to

\$ \_\_\_\_\_

Oak Valley Hospital District  
(Stanislaus County, California)  
Health Facility Revenue Bonds, Series 2026

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## SEVENTH SUPPLEMENTAL INDENTURE OF TRUST

This SEVENTH SUPPLEMENTAL INDENTURE OF TRUST, is dated as of November 1, 2026 (the “Seventh Supplemental Indenture”), by and between OAK VALLEY HOSPITAL DISTRICT (the “District”), a local health care district organized and existing under the constitution and laws of the State of California (the “State”), and U.S. BANK TRUST COMPANY, NATIONAL ASSOCIATION, a national banking association organized and existing under the laws of the United States of America, with a corporate trust office in San Francisco, California, being qualified to accept and administer the trusts hereby created (as successor to U.S. Bank National Association), as trustee (the “Trustee”), amending and supplementing that certain Indenture of Trust, dated as of November 1, 2004, by and between the District and the Trustee (the “Original Indenture”), as amended and supplemented by that certain First Supplemental Indenture, dated as of February 1, 2010, by and between the District and the Trustee (the “First Supplemental Indenture”), as further amended and supplemented by that certain Second Supplemental Indenture, dated as of April 1, 2015, by and between the District and the Trustee (the “Second Supplemental Indenture”), as further amended and supplemented by that certain Third Supplemental Indenture, dated as of August 1, 2020, by and between the District and the Trustee (the “Third Supplemental Indenture”), as further amended and supplemented by that certain Fourth Supplemental Indenture, dated as of August 1, 2020, by and between the District and the Trustee (the “Fourth Supplemental Indenture”), as further amended and supplemented by that certain Fifth Supplemental Indenture, dated as of November 1, 2021 and amended as of March 1, 2022, by and between the District and the Trustee (together, the “Fifth Supplemental Indenture”) and as further amended and supplemented by that certain Sixth Supplemental Indenture, dated as of January 1, 2024 by and between the District and the Trustee (the “Sixth Supplemental Indenture” and, with the Original Indenture, the First Supplemental Indenture, the Second Supplemental Indenture, the Third Supplemental Indenture, the Fourth Supplemental Indenture, the Fifth Supplemental Indenture, the Sixth Supplemental Indenture, and the Seventh Supplemental Indenture, the “Indenture”);

### WITNESSETH:

WHEREAS, the District has issued its \$11,550,000 Oak Valley Hospital District (Stanislaus County, California) Health Facility Revenue Bonds, Series 2020A (the “2020A Bonds”), for the purpose of refunding the 2010B Bonds (defined in the First Supplemental Indenture) and financing the remodeling, expansion, improvement and equipping of health facilities owned and operated by the District;

WHEREAS, the 2020A Bonds were issued pursuant to the Original Indenture as amended and supplemented, and as further amended and supplemented by the Third Supplemental Indenture;

WHEREAS, the District has also issued its \$7,000,000 Oak Valley Hospital District (Stanislaus County, California) Health Facility Revenue Bonds, Series 2020B (the “2020B Bonds” and, with the 2020A Bonds, the “2020 Bonds”), for the purpose of refunding the 2010A Bonds (defined in the First Supplemental Indenture);

WHEREAS, the 2020B Bonds were issued pursuant to the Original Indenture as amended and supplemented, and as further amended and supplemented by the Fourth Supplemental Indenture;

WHEREAS, the District has also issued its \$11,067,000 Oak Valley Hospital District (Stanislaus County, California) Health Facility Refunding Revenue Bonds, Series 2021 (the “2021 Bonds”), for the purpose of refunding the 2015 Bonds (defined in the Second Supplemental Indenture);

WHEREAS, the 2021 Bonds were issued pursuant to the Original Indenture as amended and supplemented, and as further amended and supplemented by the Fifth Supplemental Indenture;

WHEREAS, the District has also issued its \$10,000,000 Oak Valley Hospital District (Stanislaus County, California) Health Facility Refunding Revenue Bonds, Series 2024 (Federally Taxable) (the “2024 Bonds”) for the purpose of refinancing three loans made by the California Health Facilities Financing Authority to the District to provide working capital to the District and financing the remodeling, expansion, improvement and equipping of health facilities owned and operated by the District;

WHEREAS, the 2024 Bonds were issued pursuant to the Original Indenture as amended and supplemented, and as further amended and supplemented by the Sixth Supplemental Indenture;

WHEREAS, the District has determined to issue its Oak Valley Hospital District (Stanislaus County, California) Health Facility Revenue Bonds, Series 2026 (the “2026 Bonds”), on a parity as to payment and security with the 2020 Bonds, the 2021 Bonds and the 2024 Bonds, to (i) finance the remodeling, expansion, improvement and equipping of health facilities owned and operated by the District (the “2026 Project”), (ii) fund a debt service reserve fund, (iii) finance capitalized interest on the 2026 Bonds, and (iv) pay costs of issuing the 2026 Bonds;

WHEREAS, the Local Health Care District Law, constituting Division 23 of the California Health and Safety Code, specifically Chapter 5 (commencing with Section 32315 thereof), authorizes the District to issue the 2026 Bonds for the purpose of financing the 2026 Project;

WHEREAS, in order to provide for the authentication and delivery of the 2026 Bonds, to establish and declare the terms and conditions upon which the 2026 Bonds are to be issued and secured and to secure the payment of the principal thereof and of the interest and premium, if any, thereon, the Board of Directors of the District (the “Board”) has authorized the execution and delivery of this Seventh Supplemental Indenture; and

WHEREAS, the Board has determined that all acts and proceedings required by law necessary to make the 2026 Bonds, when executed by the District, authenticated and delivered by the Trustee and duly issued, the valid, binding and legal special obligations of the District, and to constitute this Seventh Supplemental Indenture a valid and binding agreement for the uses and purposes herein set forth, in accordance with its terms, have been done and taken; and the execution and delivery of this Seventh Supplemental Indenture have been in all respects duly authorized;

NOW, THEREFORE, THIS SEVENTH SUPPLEMENTAL INDENTURE WITNESSETH, that in order to secure the payment of the principal of and interest and premium (if any) on all 2026 Bonds at any time issued and Outstanding under the Indenture, according to their tenor, and to secure the performance and observance of all the covenants and conditions therein and herein set forth, and to declare the terms and conditions upon and subject to which the 2026 Bonds are to be issued and received, and in consideration of the premises and of the mutual covenants herein contained and of the purchase and acceptance of the 2026 Bonds by the Owner, and for other valuable consideration, the

receipt of which is hereby acknowledged, the District does hereby covenant and agree with the Trustee, for the benefit of the respective Owners from time to time of the 2026 Bonds, as follows:

## ARTICLE I

### DEFINITIONS; AUTHORIZATION AND PURPOSE OF BONDS; EQUAL SECURITY

**Section 1.01 Definitions.** All terms which are defined in Section 1.01 of the Indenture shall have the same meanings in this Seventh Supplemental Indenture as such terms are given in said Section 1.01 of the Indenture. Unless the context otherwise requires, the additional terms defined in this Section 1.01 or in the preambles hereof shall for all purposes of this Seventh Supplemental Indenture and of the 2026 Bonds and of any certificate, opinion, request or other documents herein mentioned have the meanings specified in the recitals and in this Section 1.01.

*“Authorized Denomination”* means \$5,000 or any integral multiple thereof.

*“Business Day”* means (a) any day that is not a Saturday, Sunday or legal holiday on which banking institutions in the State or in any state in which the corporate trust office of the Trustee is located are closed, or (b) a day on which the New York Stock Exchange is closed.

*“Closing Date”* means \_\_\_\_\_, 2026, the date upon which the 2026 Bonds are delivered in exchange for the amount representing the purchase price of the 2026 Bonds.

*“Code”* means the Internal Revenue Code of 1986 as in effect on the Closing Date or (except as otherwise referenced in the Indenture or this Seventh Supplemental Indenture) as it may be amended to apply to obligations issued on the Closing Date, together with applicable temporary and final regulations promulgated under the Code.

*“Fair Market Value”* means the price at which a willing buyer would purchase the investment from a willing seller in a bona fide, arm’s length transaction (determined as of the date the contract to purchase or sell the investment becomes binding) if the investment is traded on an established securities market (within the meaning of section 1273 of the Code) and, otherwise, the term “Fair Market Value” means the acquisition price in a bona fide arm’s length transaction (as referenced above) if (i) the investment is a certificate of deposit that is acquired in accordance with applicable regulations under the Code, (ii) the investment is an agreement with specifically negotiated withdrawal or reinvestment provisions and a specifically negotiated interest rate (for example, a guaranteed investment contract, a forward supply contract or other investment agreement) that is acquired in accordance with applicable regulations under the Code, (iii) the investment is a United States Treasury Security--State and Local Government Series that is acquired in accordance with applicable regulations of the United States Bureau of Public Debt, or (iv) the investment is the Local Agency Investment Fund of the State.

*“Interest Payment Date”* means, with respect to the 2026 Bonds, May 1 and November 1 in each year, beginning May 1, 2027, and continuing so long as any 2026 Bonds remain Outstanding.

*“Local Health Care District Law”* means Division 23 (commencing with section 32000) of the California Health and Safety Code.

*“Owners”* means the registered owners of the 2026 Bonds.

“*Trustee*” means U.S. Bank Trust Company, National Association, or another trustee, which must be a banking association, banking corporation or trust company acting in the capacity of trustee under this Seventh Supplemental Indenture.

“*2026 Bonds*” means the bonds authorized by Article II hereof.

“*2026 Bond Reserve Account*” means the account by that name established and held by the Trustee pursuant to Section 3.04.

“*2026 Bond Reserve Account Requirement*” means, on any date of computation, an amount equal to the least of maximum annual debt service payments on the 2026 Bonds, 125% of average annual debt service payments on the 2026 Bonds and 10% of the principal amount of the 2026 Bonds, which amount shall be \$ \_\_\_\_\_ on the Closing Date.

“*2026 Capitalized Interest Account*” means the fund by that name established in accordance with Section 3.05 hereof.

“*2026 Costs of Issuance Account*” means the account by that name established and held by the Trustee pursuant to Section 3.02.

“*2026 Project*” means the financing of the purchase, construction, acquisition, improvement, renovation and equipping of health facilities owned or leased and operated by the District.

“*2026 Project Account*” means the account by that name established and held by the Trustee pursuant to Section 3.03.

**Section 1.02 Rules of Construction.** All references in this Seventh Supplemental Indenture to “Articles,” “Sections,” and other subdivisions are to the corresponding Articles, Sections or subdivisions of this Seventh Supplemental Indenture; and the words “herein,” “hereof,” “hereunder,” and other words of similar import refer to this Seventh Supplemental Indenture as a whole and not to any particular Article, Section or subdivision hereof.

Words of the masculine gender shall be deemed and construed to include correlative words of the feminine and neuter genders. Unless the context shall otherwise indicate, words importing the singular number shall include the plural number and vice versa, and words importing persons shall include corporations and associations, including public bodies, as well as natural persons.

**Section 1.03 Authorization and Purpose of 2026 Bonds.** The District has reviewed all proceedings heretofore taken relative to the authorization of the 2026 Bonds and has found, as a result of such review, and hereby finds and determines that all things, conditions, and acts required by law to exist, happen and/or be performed precedent to and in the issuance of the 2026 Bonds do exist, have happened and have been performed in due time, form and manner as required by law, and the District is now authorized, as an exercise of the municipal affairs and powers of the District under the constitution and laws of the State and pursuant to the Local Health Care District Law and each and every other requirement of law, to issue the 2026 Bonds in the manner and form provided in this Seventh Supplemental Indenture to finance the 2026 Project. Accordingly, the District hereby authorizes the issuance of the 2026 Bonds pursuant to the Law, the Indenture and this Seventh Supplemental Indenture.

**Section 1.04 Representations, Warranties and Covenants.** The representations and warranties of the District contained in Section 8.01 of the Original Indenture are true and correct in all material respects as of the date hereof. The District hereby confirms and agrees to the covenants set forth in the Indenture.

## **ARTICLE II**

### **ISSUANCE OF 2026 Bonds**

#### **Section 2.01 Issuance of the 2026 Bonds; Terms of the 2026 Bonds.**

(a) Issuance of the 2026 Bonds. The 2026 Bonds, authorized to be issued by the District under and subject to the Local Health Care District Law, the Indenture including this Seventh Supplemental Indenture, shall be designated the “Oak Valley Hospital District (Stanislaus County, California) Health Facility Revenue Bonds, Series 2026” and shall be issued in the original aggregate principal amount of \_\_\_\_\_ (\$\_\_\_\_\_).

(b) Terms of the 2026 Bonds. The 2026 Bonds shall be registered initially in the name of “Cede & Co.,” as nominee of The Depository Trust Company as the initial Securities Depository and shall be evidenced by one Bond for each maturity of the 2026 Bonds in the principal amount of the respective maturities of the 2026 Bonds. Registered ownership of the 2026 Bonds, or any portion thereof, may not thereafter be transferred except as set forth herein.

The 2026 Bonds shall be issued as fully registered bonds in denominations of \$5,000 or any integral multiple thereof. The 2026 Bonds shall be dated as of the Closing Date and interest thereon shall be payable semiannually on each Interest Payment Date. The 2026 Bonds shall mature on the following dates in the following amounts and shall bear interest at the following rates per annum:

| <i>Maturity<br/>(November 1)</i> | <i>Principal<br/>Amount</i> | <i>Interest<br/>Rate</i> |
|----------------------------------|-----------------------------|--------------------------|
|                                  | \$                          | %                        |

The principal or sinking fund installments of, and redemption premium, if any, of the 2026 Bonds shall be payable in lawful money of the United States of America at the Principal Corporate Trust Office. Payment of the interest on any Bond shall be made to the person whose name appears on the bond registration books of the Trustee as the Owner thereof as of the Record Date for each Interest Payment Date, such interest to be paid by check or draft mailed on each Interest Payment Date to the Owner at his or her address as it appears on such registration books; provided that such interest shall be paid by wire transfer to any Owner of at least \$1,000,000 in aggregate principal amount of Bonds if the Owner makes a written request of the Trustee prior to the Record Date for an Interest Payment Date specifying the account address in the United States which written request will remain in effect until rescinded in writing by the Owner.

The 2026 Bonds shall be numbered consecutively, beginning with number R-1, and shall bear interest from the Closing Date. Interest shall be calculated on the basis of a three hundred sixty (360) day year of twelve thirty (30) day months.

Any such interest not so punctually paid or duly provided for shall forthwith cease to be payable to the Owners on such Record Date and shall be paid to the person in whose name the 2026 Bond is registered at the close of business on a Special Record Date for the payment of such defaulted interest to be fixed by the Trustee, notice of which shall be given to the Owners by first class mail not less than ten (10) days prior to such Special Record Date.

## **Section 2.02 Redemption of the 2026 Bonds.**

(a) Optional Redemption. The 2026 Bonds maturing on or before November 1, 20\_\_, are not subject to redemption prior to their respective stated maturities. The 2026 Bonds

maturing on or after November 1, 20\_\_, are subject to redemption prior to their respective stated maturities, at the option of the District, in whole or in part on any date by such maturities as are selected by the District (or if the District fails to designate such maturities, in inverse order of maturity) and by lot within a maturity, on or after November 1, 20\_\_, at a redemption price equal to the principal amount of 2026 Bonds called for redemption, together with interest accrued thereon to the date fixed for redemption, without premium.

(b) Sinking Fund Redemption. The 2026 Bonds maturing on November 1, 20\_\_ (the “2026 Term Bonds”) are subject to mandatory redemption, in part by lot, from Sinking Account payments set forth in the following schedule on November 1, 20\_\_, and November 1, 20\_\_, at a redemption price equal to the principal amount thereof to be redeemed (without premium), together with interest accrued thereon to the date fixed for redemption; *provided, however*, that if some but not all of the 2026 Term Bonds have been redeemed pursuant to subsection (a) above, the total amount of Sinking Account payments to be made subsequent to such redemption shall be reduced in an amount equal to the principal amount of the 2026 Term Bonds so redeemed by reducing each such future Sinking Account payment on a pro rata basis (as nearly as practicable) in integral multiples of \$5,000, as shall be designated pursuant to written notice filed by the District with the Trustee.

| <i><b>Sinking Account<br/>Redemption Date<br/>(November 1)</b></i> | <i><b>Principal Amount<br/>to be Redeemed</b></i> |
|--------------------------------------------------------------------|---------------------------------------------------|
|                                                                    | \$                                                |

†

---

† Maturity

(c) Partial Redemption; Selection. All or a portion of any 2026 Bond may be redeemed, by lot but only in a principal amount equal to an Authorized Denomination. In the event that less than all of the 2026 Bonds outstanding are to be redeemed, the Trustee shall select the 2026 Bonds to be redeemed in such order of redemption as shall be selected by the District. Upon surrender of any 2026 Bond for redemption in part, the Trustee shall authenticate and deliver to the Owner thereof, at the expense of the District, a new 2026 Bond or 2026 Bonds of Authorized Denominations of the same type and maturity and in an aggregate principal amount equal to the unredeemed portion of the 2026 Bond so surrendered.

(d) Notice of Redemption. Notice of any such redemption shall be given by the Trustee on behalf and at the expense of the District by mailing a copy of a redemption notice by first class mail at least twenty (20) days and not more than sixty (60) days prior to the date fixed for redemption to each Owner of the 2026 Bond or 2026 Bonds to be redeemed at the address shown on the Registration Books; *provided, however*, that neither the failure to receive such notice nor any defect in any notice shall affect the sufficiency of the proceedings for the redemption of the 2026 Bonds.

All notices of redemption shall be dated and shall state: (i) the redemption date, (ii) the redemption price, (iii) if less than all Outstanding 2026 Bonds are to be redeemed, the identification

(and, in the case of partial redemption, the respective principal amounts) of the 2026 Bonds to be redeemed, (iv) that on the redemption date the redemption price will become due and payable with respect to each such 2026 Bond or portion thereof called for redemption, and that interest with respect thereto shall cease to accrue from and after said date, (v) the place where such 2026 Bonds are to be surrendered for payment of the redemption price, and (vi) in the case of a redemption pursuant to Section 2.02(a), that such notice of redemption is revocable by written notice to be provided in the same manner as notice of redemption had been provided.

Notice of redemption having been given as aforesaid, the 2026 Bonds or portions of 2026 Bonds so to be redeemed shall, on the redemption date, become due and payable at the redemption price therein specified, and from and after such date (unless the District shall default in the payment of the redemption price) interest with respect to such 2026 Bonds or portions of 2026 Bonds shall cease to accrue and be payable. Upon surrender of such 2026 Bonds for redemption in accordance with said notice, such 2026 Bonds shall be paid by the Trustee at the redemption price. Installments of interest due on or prior to the redemption date shall be payable as herein provided for payment of interest. Upon surrender for any partial redemption of any 2026 Bond, there shall be prepared for the Owner a new 2026 Bond or 2026 Bonds of the same maturity in the amount of the unpaid principal. All 2026 Bonds which have been redeemed shall be canceled by the Trustee, shall not be reissued and shall be destroyed pursuant to Section 12.04 of the Original Indenture.

In addition to the foregoing notice to the Owners, notice shall also be given by the Trustee at least thirty (30) days before the redemption date, by telecopy, registered, certified or overnight mail or by such other acceptable means, to all Securities Depositories and to an Information Service which shall state the information set forth above, but no defect in said notice nor any failure to give all or any portion of such further notice shall in any manner defeat the effectiveness of a call for redemption if notice thereof is given the Owners as described above.

The Trustee shall have no responsibility for a defect in the CUSIP number that appears on any 2026 Bond or in the redemption notice. The redemption notice may provide that the CUSIP numbers have been assigned by an independent service and are included in the notice solely for the convenience of Owners and that the Trustee and the District shall not be liable in any way for inaccuracies in said numbers.

**Section 2.03 Book-Entry System.** Notwithstanding any provision of this Seventh Supplemental Indenture to the contrary:

(a) The 2026 Bonds shall be initially issued registered in the name of “Cede & Co.,” as nominee of The Depository Trust Company, and shall be evidenced by one certificate in a denomination corresponding to the total principal of the 2026 Bonds. Registered ownership of such 2026 Bonds, or any portions thereof, may not thereafter be transferred except:

(i) to any successor of The Depository Trust Company or its nominee, or of any substitute depository designated pursuant to paragraph (ii) of this subsection (a) (“substitute depository”); provided that any successor of The Depository Trust Company or substitute depository shall be qualified under any applicable laws to provide the service proposed to be provided by it;

(ii) to any substitute depository designated in a written request of the District, upon (A) the resignation of The Depository Trust Company or its successor (or any substitute depository or its successor) from its functions as depository or (B) a determination by the District that

The Depository Trust Company or its successor is no longer able to carry out its functions as depository; provided that any such substitute depository shall be qualified under any applicable laws to provide the services proposed to be provided by it; or

(iii) to any person as provided below, upon (A) the resignation of The Depository Trust Company or its successor (or any substitute depository or its successor) from its functions as depository or (B) a determination by the District that The Depository Trust Company or its successor is no longer able to carry out its functions as depository; provided that no substitute depository which is not objected to by the District and the Trustee can be obtained.

(b) In the case of any transfer pursuant to paragraph (i) or paragraph (ii) of subsection (a) of this Section 2.03, upon receipt of all Outstanding 2026 Bonds by the Trustee, together with a written request of an Authorized Representative of the District to the Trustee, a single new 2026 Bond shall be issued, authenticated and delivered for each maturity of such 2026 Bond then outstanding, registered in the name of such successor or such substitute depository or their nominees, as the case may be, all as specified in such written request of an Authorized Representative of the District. In the case of any transfer pursuant to paragraph (iii) of subsection (a) of this Section 2.03, upon receipt of all Outstanding 2026 Bonds by the Trustee together with a written request of an Authorized Representative of the District, new 2026 Bonds shall be issued, authenticated and delivered in such denominations and registered in the names of such persons as are requested in a written request of the District provided the Trustee shall not be required to deliver such new 2026 Bonds within a period less than sixty (60) days from the date of receipt of such a written request of an Authorized Representative of the District.

(c) In the case of partial redemption or an advance refunding of any 2026 Bonds evidencing all of the principal maturing in a particular year, The Depository Trust Company shall, at the District's expense, deliver the 2026 Bonds to the Trustee for cancellation and re-registration to reflect the amounts of such reduction in principal.

(d) The District and the Trustee shall be entitled to treat the person in whose name any 2026 Bond is registered as the absolute Owner thereof for all purposes of this Seventh Supplemental Indenture and any applicable laws, notwithstanding any notice to the contrary received by the Trustee or the District; and the District and the Trustee shall have no responsibility for transmitting payments to, communication with, notifying or otherwise dealing with any beneficial owners of the 2026 Bonds. Neither the District nor the Trustee will have any responsibility or obligations, legal or otherwise, to the beneficial owners or to any other party including The Depository Trust Company or its successor (or substitute depository or its successor), except for the registered owner of any 2026 Bond.

(e) So long as all outstanding 2026 Bonds are registered in the name of Cede & Co. or its registered assign, the District and the Trustee shall reasonably cooperate with Cede & Co., as sole registered Owner, or its registered assign in effecting payment of the principal and redemption premium, if any, and interest due with respect to the 2026 Bonds by arranging for payment in such manner that funds for such payments are properly identified and are made immediately available on the date they are due. So long as all Outstanding 2026 Bonds are registered in the name of Cede & Co. or its registered assigns (hereinafter, for purposes of this paragraph (f), the "Owner"):

(i) All notices and payments addressed to the Owners shall contain the 2026 Bonds' CUSIP number.

(ii) Notices to the Owner shall be forwarded in the manner set forth in the form of blanket issuer letter of representations (prepared by The Depository Trust Company) executed by the District and received and accepted by The Depository Trust Company.

### ARTICLE III

#### APPLICATION OF PROCEEDS

**Section 3.01 Application of Proceeds of Sale of 2026 Bonds and Other Moneys.** Upon the receipt of payment for the 2026 Bonds on the Closing Date, the Trustee shall apply the proceeds of sale thereof of \$\_\_\_\_\_ (being the principal amount of the 2026 Bonds of \$\_\_\_\_\_, plus a net original issue premium of \$\_\_\_\_\_, less an underwriters' discount of \$\_\_\_\_\_) as follows:

(i) The Trustee shall deposit in the 2026 Costs of Issuance Account the amount of \$\_\_\_\_\_, which represents the amount necessary for the payment of the Costs of Issuance of the 2026 Bonds;

(ii) The Trustee shall deposit in the 2026 Project Account the amount of \$\_\_\_\_\_;

(iii) The Trustee shall deposit in the 2026 Bond Reserve Account the amount of \$\_\_\_\_\_, being equal to the 2026 Bond Reserve Requirement; and

(iv) The Trustee shall deposit \$\_\_\_\_\_ in the 2026 Capitalized Interest Account.

(b) The Trustee may, in its discretion, establish a temporary fund or account to facilitate the foregoing deposit and transfer.

#### **Section 3.02 2026 Costs of Issuance Account.**

(a) There is hereby created a separate account within the Costs of Issuance Fund to be known as the "2026 Costs of Issuance Account," to be held in trust by the Trustee. The Trustee shall disburse moneys in the 2026 Costs of Issuance Account for the purpose of paying or reimbursing the payment of the Costs of Issuance of the 2026 Bonds in accordance with the provisions of the Indenture. The moneys in the 2026 Costs of Issuance Account shall be used and withdrawn by the Trustee to pay the Costs of Issuance of the 2026 Bonds.

(b) Any amounts remaining in the 2026 Costs of Issuance Account on the date three months after the Closing Date, or such earlier date as the District shall determine all Costs of Issuance of the 2026 Bonds have been paid, shall be transferred by the Trustee to the Interest Account and applied to the purposes thereof and the 2026 Costs of Issuance Account shall be closed.

**Section 3.03 2026 Project Account.** There is hereby created a separate account within the Project Fund to be known as the "2026 Project Account," to be held in trust by the Trustee. The Trustee shall disburse moneys in the 2026 Project Account for the purpose of paying or reimbursing the payment of the costs of the 2026 Project, in accordance with the provisions of the Indenture. At such time as the Trustee receives a direction of the District to the effect that amounts, if any, then on deposit in the 2026 Project Account are no longer needed for purposes of such account, any remaining amount in such account shall be

transferred by the Trustee to the Interest Account to be used for the purposes of the Interest Account and the 2026 Project Account shall be closed.

**Section 3.04 2026 Bond Reserve Account.** There is hereby created a separate account within the Revenue Fund to be known as the “2026 Bond Reserve Account,” to be held in trust by the Trustee. If, on any Interest Payment Date, the moneys available in the Interest Account and/or the Principal Account do not equal the amount of the principal and interest with respect to the 2026 Bonds then coming due and payable, the Trustee shall apply the moneys available in the 2026 Bond Reserve Account to make delinquent amounts by transferring the amount necessary for this purpose to the Interest Account and/or the Principal Account.

**Section 3.05 2026 Capitalized Interest Account.** The Trustee shall establish and maintain a separate account within the Revenue Fund to be known as the “2026 Capitalized Interest Account.” On the second Business Day immediately preceding each Interest Payment Date as set forth in the following table, the Trustee shall transfer from the 2026 Capitalized Interest Account to the Interest Account, the following amounts. All amounts remaining in the 2026 Capitalized Interest Account after \_\_\_\_\_, 20\_\_, if any, shall be transferred to the Interest Account.

| <i>Date</i> | <i>Amount</i> |
|-------------|---------------|
|             | \$            |

**Section 3.06 Satisfaction of Requirements of Additional Bonds.** The District hereby certifies that all provisions of Sections 3.05, 3.06 and 6.05 of the Indenture relating to the issuance of Additional Bonds have been satisfied such that the 2026 Bonds are payable from Revenues and secured by the pledge made under the Indenture equally and ratably with the Outstanding 2020 Bonds, 2021 Bonds and 2024 Bonds.

**Section 3.07 Validity of Bonds.**

(a) The Board has reviewed all proceedings heretofore taken relative to the authorization of the 2026 Bonds and has found, as a result of such review, and hereby finds and determines that all acts, conditions and things required by law to exist, happen or be performed precedent to and in the issuance of the 2026 Bonds do exist, have happened and have been performed in due time, form and manner as required by law, and the Board is now authorized, pursuant to each and every requirement of the Law to issue the 2026 Bonds in the form and manner provided in this Seventh Supplemental Indenture and the 2026 Bonds shall be entitled to the benefit, protection and security of the provisions of the Indenture. From and after the issuance of the 2026 Bonds the findings and determinations of the Board respecting the 2026 Bonds shall be conclusive evidence of the existence of the facts so found and determined in any action or proceeding in any court in which the validity of the 2026 Bonds is at issue, and no bona fide purchaser of any of the 2026 Bonds shall be required to see to the existence of any fact or to the performance of any condition or to the taking of any proceeding required prior to such issuance or to the application of the proceeds of sale of the 2026 Bonds. The recital contained in the 2026 Bonds that the same are issued pursuant to the Law and

the Indenture shall be conclusive evidence of their validity and of the regularity of the issuance and all 2026 Bonds shall be incontestable from and after their issuance. The 2026 Bonds shall be deemed to be issued, within the meaning of the Indenture, whenever the definitive 2026 Bonds (or any temporary 2026 Bonds exchangeable therefor) have been delivered to the Owner thereof and the proceeds of sale thereof received.

## **ARTICLE IV**

### **REVENUES; FUNDS AND ACCOUNTS**

**Section 4.01 Pledge of Revenues, Revenue Fund.** The District has heretofore transferred, placed a charge upon, assigned and set over to the Trustee, for the benefit of the Owner, that portion of the Revenues which is necessary to pay the principal or Redemption Price of and interest on the Bonds (including the 2026 Bonds) in any year, together with all moneys on deposit in the Revenue Fund, to the punctual payment of the principal or Redemption Price of and interest on the Bonds (including the 2026 Bonds).

**Section 4.02 Administration of Funds and Accounts.** All funds and accounts created pursuant to the Indenture shall continue to be administered by the Trustee in the manner provided by the Indenture and this Seventh Supplemental Indenture as if there were a single issue of Bonds concurrently sold and delivered.

**Section 4.03 Application of 2026 Sinking Fund Account.**

(a) The Trustee shall establish and maintain a separate account within the Principal Account, such account to be designated “2026 Sinking Fund Account.”

(b) All amounts in the 2026 Sinking Fund Account shall be used and withdrawn by the Trustee solely to purchase or redeem or pay at maturity the 2026 Bonds as provided herein and in the Indenture.

(c) Subject to the terms and conditions set forth in the Indenture and in this Section 4.03, the 2026 Bonds shall be redeemed (or paid at maturity, as the case may be) by application of sinking fund installments in the amounts and upon the dates set forth in Section 2.02(b) hereof.

**Section 4.04 Fees, Charges and Expenses of Trustee.** The Trustee shall be entitled to payment and reimbursement for reasonable fees for its services rendered hereunder and all advances, if any, including interest on all such advances at its, or one of its affiliates’, prime rate then in effect, reasonable external counsel fees (including expenses), the reasonable allocated cost of internal legal services (to the extent such services are not redundant of services performed by external counsel) and all reasonable disbursements of internal counsel, and other expenses reasonably and necessarily made or incurred by the Trustee in connection with such services and, in the Event of Default, the Trustee shall have a first and prior lien on the funds held hereunder to secure the same; *provided, however*, that in no event shall the Trustee have a lien on premiums, if any, paid in connection with an optional redemption of 2026 Bonds or of any moneys held for the benefit of an Owner. The Trustee’s compensation shall not be limited by any provision of law in regard to the compensation of a trustee of an express trust. The Trustee’s rights hereunder shall survive its resignation or removal and final payment of the 2026 Bonds.

#### **Section 4.05 Investments.**

(a) All moneys in any of the funds or accounts established with the Trustee pursuant to this Seventh Supplemental Indenture shall be invested by the Trustee solely in Permitted Investments, as directed pursuant to the Request of the District filed with the Trustee at least two (2) Business Days in advance of the making of such investments. In the absence of any such directions from the District, the Trustee shall hold such moneys uninvested. Obligations purchased as an investment of moneys in any fund shall be deemed to be part of such fund or account. All interest or gain derived from the investment of amounts in any of the funds or accounts established hereunder shall be deposited in the fund or account from which such investment was made. The Trustee may act as principal or agent in the acquisition of any investment. The Trustee shall incur no liability for losses arising from any investments made pursuant to this Section 4.05. The District acknowledges that to the extent regulations of the Comptroller of the Currency or other applicable regulatory entity grant the District the right to receive brokerage confirmations of security transactions as they occur, at no additional cost, the District specifically waives receipt of such confirmations to the extent permitted by law. The Trustee will furnish the District with monthly account statements as provided herein which include detail for all investment transactions made by the Trustee hereunder. The Trustee may conclusively rely on the investment instructions of the District as to the suitability and legality of the directed investments.

(b) For investment purposes, the Trustee may commingle the funds and accounts established hereunder but shall account for each separately.

**Section 4.06 Acquisition; Valuation and Disposition of Investments.** Except as otherwise provided in the next sentence, all investments of amounts deposited in any fund or account created by or pursuant to this Indenture, or otherwise containing gross proceeds of the 2026 Bonds (within the meaning of section 148 of the Code) shall be acquired, disposed of, and valued (as of the date that valuation is required by this Indenture of the Code) by the District at Fair Market Value. Investments in funds or accounts (or portions thereof) that are subject to a yield restriction under applicable provisions of the Code shall be valued by the District at their present value (within the meaning of section 148 of the Code). The Trustee has no duty in connection with the determination of Fair Market Value.

### **ARTICLE V**

#### **COVENANTS**

**Section 5.01 Tax Covenants.** Notwithstanding any other provision of the Indenture, absent an opinion of nationally-recognized bond counsel that the exclusion from gross income of interest with respect to the 2026 Bonds will not be adversely affected for federal income tax purposes, the District covenants to comply with all applicable requirements of the Code necessary to preserve such exclusion from gross income with respect to the 2026 Bonds and specifically covenants, without limiting the generality of the foregoing, as follows:

(a) Private Activity Bond Limitation. The District shall assure that the proceeds of the 2026 Bonds are not so used as to cause the 2026 Bonds to satisfy the private business tests of section 141(b) of the Code.

(b) Private Loan Financing Limitation. The District shall assure that the proceeds of the 2026 Bonds are not so used as to cause the 2026 Bonds to satisfy the private loan financing test of section 141(c) of the Code.

(c) Federal Guarantee Prohibition. The District shall not take any action or permit or suffer any action to be taken if the result of the same would be to cause any of the 2026 Bonds to be “federally guaranteed” within the meaning of section 149(b) of the Code.

(d) Rebate Requirement. The District shall take any and all actions necessary to assure compliance with section 148(f) of the Code, relating to the rebate of excess investment earnings, if any, to the federal government.

(e) No Arbitrage. The District shall not take, or permit or suffer to be taken by the Trustee or otherwise, any action with respect to the proceeds of the 2026 Bonds which, if such action had been reasonably expected to have been taken, or had been deliberately and intentionally taken, on the Closing Date would have caused the 2026 Bonds, to be “arbitrage bonds” within the meaning of section 148 of the Code.

(f) Information Reporting. The District shall take or cause to be taken all necessary actions to comply with the informational reporting requirements of Section 149(e) of the Code necessary to preserve the exclusion with respect to the 2026 Bonds pursuant to Section 103(a) of the Code.

(g) Hedge Bonds. The District will make no use of the proceeds of the 2026 Bonds or any other amounts of property, regardless of the source, and will not take any action or permit or suffer any action to be taken if the result of the same would be to cause the 2026 Bonds to be considered “hedge bonds” within the meaning of Section 149(g) of the Code unless the District takes all necessary actions to assure compliance with the requirements of Section 149(g) of the Code to maintain the exclusion from gross income for federal income tax purposes with respect to the 2026 Bonds.

(h) Maintenance of Tax-Exemption. The District shall take all actions necessary to assure the exclusion of interest on the 2026 Bonds from the gross income of the Owners to the same extent as such interest is permitted to be excluded from gross income under the Code as in effect on the Closing Date.

(i) Tax Certificate Compliance. The District will not take any action or permit or suffer any action to be taken inconsistent with the expectations stated in any Tax Certificate executed with respect to the 2026 Bonds and will comply with the covenants and requirements stated therein and incorporated by reference therein.

**Section 5.02 Confirmation of Indenture.** Except as otherwise provided herein, all covenants made in Article VI of the Indenture are hereby confirmed as applicable to the 2026 Bonds under this Seventh Supplemental Indenture.

**Section 5.03 Continuing Disclosure.** The District shall undertake the continuing disclosure requirements promulgated under S.E.C. Rule 15c2-12, as it may from time to time hereafter be amended or supplemented. Notwithstanding any other provision of this Seventh Supplemental Indenture, failure of the District to comply with the requirements of S.E.C. Rule 15c2-12, as it may

from time to time hereafter be amended or supplemented, shall not be considered an Event of Default hereunder.

## ARTICLE VI

### MISCELLANEOUS

**Section 6.01 Notices.** All written notices to be given under this Seventh Supplemental Indenture shall be given by mail or personal delivery to the party entitled thereto at its address set forth below, or at such address as the party may provide to the other party in writing from time to time. All notices, certificates or other communications hereunder shall be sufficiently given and shall be deemed to have been received upon actual receipt.

|                     |                                                                                                                                          |
|---------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| If to the District: | Oak Valley Hospital District<br>350 South Oak Avenue<br>Oakdale, CA 95361<br>Attention: Chief Executive Officer<br>Phone: (209) 848-4102 |
|---------------------|------------------------------------------------------------------------------------------------------------------------------------------|

|                    |                                                                                                                                                                             |
|--------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If to the Trustee: | U.S. Bank Trust Company, National Association<br>One California Street, Suite 1000<br>San Francisco, CA 94111<br>Attention: Global Corporate Trust<br>Phone: (415) 677-3622 |
|--------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Section 6.02 Execution in Several Counterparts.** This Seventh Supplemental Indenture may be executed in any number of counterparts and each of such counterparts shall for all purposes be deemed to be an original; and all such counterparts, or as many of them as the District and the Trustee shall preserve undestroyed, shall together constitute but one and the same instrument.

**Section 6.03 Force Majeure.** From the effective date of this Seventh Supplemental Indenture, the Trustee, or any successor in interest, shall not be considered in breach of or in default in its obligations with respect to any obligations created hereunder or progress in respect thereto, in the event of delay) in the performance of such obligations due to unforeseeable causes beyond its control and without its fault or negligence, including, but not limited to, acts of God, or of the public enemy or terrorists, acts of a government, acts of the other party, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, earthquakes, explosion, mob violence, riot, inability to procure or general sabotage or rationing of labor, equipment, facilities, sources of energy, material or supplies in the open market, litigation or arbitration involving a party or others relating to zoning or other governmental action or inaction pertaining to the project, malicious mischief, condemnation, and unusually severe weather or delays of suppliers or subcontractors due to such causes or any similar event and/or occurrences beyond the control of the Trustee.

**Section 6.04 Electronic Communications.** The Trustee shall have the right to accept and act upon instructions, including funds transfer instructions (“Instructions”) given pursuant to this Indenture and delivered using Electronic Means. “Electronic Means” shall mean the following communications methods: e-mail, facsimile transmission, secure electronic transmission containing applicable authorization codes, passwords and/or authentication keys issued by the Trustee, or another method or system specified by the Trustee as available for use in connection with its services

hereunder; provided, however, that the District shall provide to the Trustee an incumbency certificate listing officers with the authority to provide such Instructions (“Authorized Officers”) and containing specimen signatures of such Authorized Officers, which incumbency certificate shall be amended by the District whenever a person is to be added or deleted from the listing. If the District elects to give the Trustee Instructions using Electronic Means and the Trustee in its discretion elects to act upon such Instructions, the Trustee’s reasonable understanding of such Instructions shall be deemed controlling. The District understands and agrees that the Trustee cannot determine the identity of the actual sender of such Instructions and that the Trustee shall conclusively presume that directions that purport to have been sent by an Authorized Officer listed on the incumbency certificate provided to the Trustee have been sent by such Authorized Officer. The District shall be responsible for ensuring that only Authorized Officers transmit such Instructions to the Trustee and that the District and all Authorized Officers are solely responsible to safeguard the use and confidentiality of applicable user and authorization codes, passwords and/or authentication keys upon receipt by the District. The Trustee shall not be liable for any losses, costs or expenses arising directly or indirectly from the Trustee’s reliance upon and compliance with such Instructions notwithstanding such directions conflict or are inconsistent with a subsequent written instruction. The District agrees: (i) to assume all risks arising out of the use of Electronic Means to submit Instructions to the Trustee, including without limitation the risk of the Trustee acting on unauthorized Instructions, and the risk of interception and misuse by third parties; (ii) that it is fully informed of the protections and risks associated with the various methods of transmitting Instructions to the Trustee and that there may be more secure methods of transmitting Instructions than the method(s) selected by the District; (iii) that the security procedures (if any) to be followed in connection with its transmission of Instructions provide to it a commercially reasonable degree of protection in light of its particular needs and circumstances; and (iv) to notify the Trustee immediately upon learning of any compromise or unauthorized use of the security procedures.

**Section 6.05 Transfer of 2026 Bonds Outside of the Book-Entry System.** Prior to any transfer of the 2026 Bonds outside the book-entry system (including, but not limited to, the initial transfer outside the book-entry system), the transferor shall provide or cause to be provided to the Trustee all information necessary to allow the Trustee to comply with any applicable tax reporting obligations, including without limitation any cost basis reporting obligations under section 6045 of the Code. The Trustee shall conclusively rely on the information provided to it and shall have no responsibility to verify or ensure the accuracy of such information.

**Section 6.06 Governing Law.** This Seventh Supplemental Indenture shall be governed by the laws of the State of California.

IN WITNESS WHEREOF, OAK VALLEY HOSPITAL DISTRICT has caused this Seventh Supplemental Indenture to be signed in its name by its President & Chief Executive Officer, and U.S. BANK TRUST COMPANY, NATIONAL ASSOCIATION, as Trustee, in token of its acceptance of the trusts created hereunder, has caused this Seventh Supplemental Indenture to be signed in its corporate name by its authorized officers, all as of the day and year first above written.

OAK VALLEY HOSPITAL DISTRICT

By: \_\_\_\_\_  
Matthew Heyn  
President & Chief Executive Officer

U.S. BANK TRUST COMPANY,  
NATIONAL ASSOCIATION, as Trustee

By: \_\_\_\_\_  
David Jason  
Vice President, Client Manager

## EXHIBIT A

### FORM OF 2026 Bond

STATE OF CALIFORNIA  
STANISLAUS COUNTY

#### OAK VALLEY HOSPITAL DISTRICT Health Facility Revenue Bond, Series 2026

| <i>Interest Rate</i> | <i>Maturity Date</i> | <i>Dated Date</i> | <i>CUSIP Number</i> |
|----------------------|----------------------|-------------------|---------------------|
| _____ %              | November 1, _____    | _____, 2026       | ____ 671808 _____   |

REGISTERED OWNER: CEDE & CO.

PRINCIPAL AMOUNT: \_\_\_\_\_ DOLLARS

The OAK VALLEY HOSPITAL DISTRICT, a local health care district, duly organized and existing under the laws of the State of California (herein called the “District”), for value received, hereby promises to pay (but only out of the Revenues and other moneys and securities hereinafter referred to) to the Registered Owner identified above or registered assigns (the “Registered Owner”), on the Maturity Date stated above (subject to any right of prior redemption hereinafter mentioned), the Principal Amount stated above, in lawful money of the United States of America; and to pay interest thereon in like lawful money from the Interest Payment Date (as herein defined) next preceding the date of authentication of this Bond (unless this Bond is authenticated on or before April 15, 2027, in which event it shall bear interest from the Dated Date stated above) until payment of such principal sum shall be discharged as provided in the Indenture hereinafter mentioned, at the Interest Rate per annum stated above, payable semiannually on each May 1 and November 1, commencing May 1, 2027 (each, an “Interest Payment Date”). The principal (or redemption price) hereof is payable at the Principal Corporate Trust Office (as such term is defined in the hereinafter defined Indenture) of U.S. Bank Trust Company, National Association (together with any successor trustee under the indenture, the “Trustee”). Interest hereon is payable by check of the Trustee mailed by first class mail on each Interest Payment Date to the Registered Owner as of the fifteenth (15th) day of the month preceding each Interest Payment Date (except as otherwise provided in the Indenture with respect to defaulted interest) at the address shown on the registration books maintained by the Trustee; *provided however*, that payment of interest will be made by wire transfer in immediately available funds to an account in the United States of America to any Registered Owner of 2026 Bonds (hereinafter defined) in the aggregate principal amount of \$1,000,000 or more who shall furnish written wire instructions to the Trustee before the fifteenth day of the month preceding the applicable Interest Payment Date. Interest on the 2026 Bonds shall be calculated on the basis of a 360-day year comprised of twelve 30-day months.

This Bond is one of a duly authorized issue of bonds of the District designated as “Oak Valley Hospital District (Stanislaus County, California) Health Facility Revenue Bonds” (herein called the “Bonds”), unlimited in aggregate principal amount, except as otherwise provided in the Indenture hereinafter mentioned, which issue consists or may consist of one or more series of varying dates, maturities, interest rates, redemption and other provisions, all issued pursuant to the provisions of Division 23 (commencing with section 32000) of the California Health and Safety Code (herein called the “Law”), specifically Chapter 5 (commencing with Section 32315 thereof), and pursuant to an

indenture, dated as of November 1, 2004 (the “Original Indenture”), between the District and the Trustee, as amended and supplemented by a first supplemental indenture, dated as of February 1, 2010, by and between the District and the Trustee (the “First Supplemental Indenture”), as further amended and supplemented by a second supplemental indenture, dated as of April 1, 2015, by and between the District and the Trustee (the “Second Supplemental Indenture”), as further amended and supplemented by a third supplemental indenture, dated as of August 1, 2020, by and between the District and the Trustee (the “Third Supplemental Indenture”), as further amended and supplemented by a fourth supplemental indenture, dated as of August 1, 2020, by and between the District and the Trustee (the “Fourth Supplemental Indenture”), as further amended and supplemented by a fifth supplemental indenture, dated as of November 1, 2021 and amended as of March 1, 2022, by and between the District and the Trustee (together, the “Fifth Supplemental Indenture”), as further amended and supplemented by a sixth supplemental indenture, dated as of January 1, 2024 by and between the District and the Trustee (the “Sixth Supplemental Indenture”) and as further amended and supplemented by a seventh supplemental indenture, dated as of November 1, 2026 by and between the District and the Trustee (the “Seventh Supplemental Indenture” and together with the Original Indenture, First Supplemental Indenture, Second Supplemental Indenture, Third Supplemental Indenture, Fourth Supplemental Indenture, Fifth Supplemental Indenture, and the Sixth Supplemental Indenture, the “Indenture”).

This Bond is also one of a duly authorized series of Bonds designated “Oak Valley Hospital District (Stanislaus County, California) Health Facility Revenue Bonds, Series 2026 (herein called the “2026 Bonds”), in the aggregate principal amount of \_\_\_\_\_ (\$ \_\_\_\_\_), issued to (a) finance the remodeling, expansion, improvement and equipping of health facilities owned and operated by the District, (b) fund a debt service reserve fund, (c) finance capitalized interest, and (d) pay the costs of issuance of the 2026 Bonds.

Reference is hereby made to the Indenture (a copy of which is on file at the Principal Corporate Trust Office of the Trustee) and all indentures supplemental thereto and to the Law for a description of the rights thereunder of the registered owners of the 2026 Bonds, of the nature and extent of the security, of the rights, duties and immunities of the Trustee and of the rights and obligations of the District thereunder, to all the provisions of which Indenture the registered owner of this Bond, by acceptance hereof, assents and agrees.

The 2026 Bonds maturing on and after November 1, 20\_\_, are subject to redemption prior to their maturity date, at the option of the District, in whole or in part on any date, on or after November 1, 20\_\_, at a redemption price equal to the principal amount of 2026 Bonds called for redemption, together with interest accrued thereon to the date fixed for redemption, without premium.

The 2026 Bonds maturing on November 1, 20\_\_ (the “2026 Term Bonds”) are subject to mandatory redemption, in part by lot, from Sinking Account payments set forth in the following schedule on November 1, 20\_\_, and November 1, 20\_\_, at a redemption price equal to the principal amount thereof to be redeemed (without premium), together with interest accrued thereon to the date fixed for redemption; *provided, however*, that if some but not all of the 2026 Term Bonds have been optionally redeemed, the total amount of Sinking Account payments to be made subsequent to such redemption shall be reduced in an amount equal to the principal amount of the 2026 Term Bonds so redeemed by reducing each such future Sinking Account payment on a pro rata basis (as nearly as practicable) in integral multiples of \$5,000, as shall be designated pursuant to written notice filed by the District with the Trustee.

***Sinking Account  
Redemption Date  
(November 1)***

***Principal Amount  
to be Redeemed***

\$

†

---

† Maturity

If an Event of Default (as that term is defined in the Indenture) shall occur, the principal of all 2026 Bonds may be declared due and payable upon the conditions, in the manner and with the effect provided in the Indenture. The Indenture provides that in certain events such declaration and its consequences may be rescinded by the registered owners of not less than a majority in aggregate principal amount of the 2026 Bonds then outstanding, or by the Trustee.

The Bond is transferable by the registered owner hereof, in person or by his attorney duly authorized in writing, at the office of the Trustee but only in the manner, subject to the limitations and upon payment of the charges, if any, provided in the Indenture, and upon surrender and cancellation of this Bond. Upon such transfer a new 2026 Bond or 2026 Bonds, of authorized denomination or denominations, of the same series and maturity for the same aggregate principal amount, will be issued to the transferee in exchange herefor.

The District and the Trustee may treat the registered owner hereof as the absolute owner hereof for all purposes, and the District and the Trustee shall not be affected by any notice to the contrary.

The 2026 Bonds are issuable as fully registered bonds in "Authorized Denominations." The term Authorized Denominations means \$5,000 or any integral multiple of \$5,000 in excess thereof. Subject to the limitations provided in the Indenture, 2026 Bonds may be exchanged, at said corporate trust office of the Trustee, for a like aggregate principal amount of 2026 Bonds of other authorized denominations of the same maturity.

The Indenture and the rights and obligations of the District and of the registered owners of the 2026 Bonds and of the Trustee may be modified or amended from time to time and at any time in the manner, to the extent, and upon the terms provided in the Indenture; provided that no such modification or amendment shall (i) extend the fixed maturity of this Bond, or reduce the amount of principal hereof, or extend the time of payment or reduce the amount of any Mandatory Sinking Account Payment provided for in the Indenture for the payment of this maturity of 2026 Bonds, or reduce the rate of interest thereon, or extend the time of payment of interest hereon, or reduce any premium payable upon the redemption hereof, without the consent of the registered owner hereof, or (ii) reduce the percentage of 2026 Bonds the consent of the registered owners of which is required to effect any such modification or amendment, or permit the creation of any lien on the Revenues and other assets pledged as security for the 2026 Bonds prior to or on a parity with the lien created by the Indenture, or deprive the registered owners of the 2026 Bonds of the lien created by the Indenture on such Revenues and other assets (except as expressly provided in the Indenture), without the consent of the registered owners of all 2026 Bonds then outstanding, all as more fully set forth in the Indenture.

The 2026 Bonds and the interest thereon are payable from Revenues (as that term is defined in the Indenture) and are secured by a pledge and assignment of said Revenues and of amounts held in the funds and accounts established pursuant to the Indenture (except any amounts held in the Rebate

Fund, as such term is defined in the Indenture), subject only to the provisions of the Indenture permitting the application thereof for the purposes and on the terms and conditions set forth in the Indenture.

The 2026 Bonds are limited obligations of the District and are not a lien or charge upon the funds or property of the District, except to the extent of the aforementioned pledge and assignment. NEITHER THE FAITH AND CREDIT NOR THE TAXING POWER OF THE DISTRICT IS PLEDGED TO THE PAYMENT OF THE PRINCIPAL OF, PREMIUM, IF ANY, OR INTEREST ON THE 2026 BONDS.

Unless this Bond is presented by an authorized representative of The Depository Trust Company, a New York corporation ("DTC"), to the District or its agent for registration of transfer, exchange, or payment, and any 2026 Bond issued is registered in the name of Cede & Co. or in such other name as is requested by an authorized representative of DTC (and any payment is made to Cede & Co. or to such other entity as is requested by an authorized representative of DTC), ANY TRANSFER, PLEDGE, OR OTHER USE HEREOF FOR VALUE OR OTHERWISE BY OR TO ANY PERSON IS WRONGFUL inasmuch as the Registered Owner hereof, Cede & Co., has an interest herein.

It is hereby certified and recited that any and all conditions, things and acts required to exist, to have happened and to have been performed precedent to and in the issuance of this Bond do exist, have happened and have been performed in due time, form and manner as required by the Law and by the Constitution and laws of the State of California, and that the amount of this Bond, together with all other indebtedness of the District, does not exceed any limit prescribed by the Law, or by the Constitution and laws of the State of California, and is not in excess of the amount of 2026 Bonds permitted to be issued under the Indenture.

This Bond shall not be entitled to any benefit under the Indenture, or become valid or obligatory for any purpose, until the certificate of authentication and registration hereon endorsed shall have been signed by the Trustee.

IN WITNESS HEREOF, the Oak Valley Hospital District has caused this Bond to be executed in its name and on its behalf by the facsimile signature of its Chairperson and attested by the facsimile signature of its Secretary, all as of the dated date identified above.

OAK VALLEY HOSPITAL DISTRICT

By: \_\_\_\_\_  
Chairperson

Attest:

\_\_\_\_\_  
Secretary

## FORM OF TRUSTEE'S CERTIFICATE OF AUTHENTICATION

This is one of the 2026 Bonds described in the within-mentioned Indenture and registered on the registration books of the Trustee.

Dated:

U.S. BANK TRUST COMPANY, NATIONAL  
ASSOCIATION, as Trustee

By: \_\_\_\_\_  
Authorized Signatory

## FORM OF ASSIGNMENT

For value received the undersigned hereby sells, assigns and transfers unto

---

---

---

(Name, Address and Tax Identification or Social Security Number of Assignee)

the within-registered 2026 Bond and hereby irrevocably constitute(s) and appoints(s)

---

attorney, to transfer the same on the 2026 Bond register of the Trustee with full power of substitution in the premises.

Dated: \_\_\_\_\_

Signature:

---

Note: The signature(s) on this Assignment must correspond with the name(s) as written on the face of the within Bond in every particular without alteration or enlargement or any change whatsoever.

Signature Guaranteed:

---

Note: Signature(s) must be guaranteed by a financial institution that is a member of the Securities Transfer Agents Medallion Program ("STAMP"), the Stock Exchanges Medallion Program ("SEMP") or the New York Stock Exchange, Inc. Medallions Securities Program ("MSP") or an "eligible guarantor."

NEW ISSUE - BOOK ENTRY ONLY

S&P Rating: “\_\_\_”  
(See “RATING” herein)

*In the opinion of Stradling Yocca Carlson & Rauth LLP, Newport Beach, California (“Bond Counsel”), under existing statutes, regulations, rulings and judicial decisions, and assuming the accuracy of certain representations and compliance with certain covenants and requirements described herein, interest (and original issue discount) on the 2026 Bonds is excluded from gross income for federal income tax purposes and is not an item of tax preference for purposes of calculating the federal alternative minimum tax imposed on individuals. In the further opinion of Bond Counsel, interest (and original issue discount) on the 2026 Bonds is exempt from State of California personal income tax. See “TAX MATTERS” with respect to tax consequences relating to the 2026 Bonds, including with respect to the alternative minimum tax imposed on certain large corporations.*



Oak Valley Hospital District

\$ \_\_\_\_\_ \*

## OAK VALLEY HOSPITAL DISTRICT (STANISLAUS COUNTY, CALIFORNIA) HEALTH FACILITY REVENUE BONDS, SERIES 2026

**Dated: Date of Delivery****Due: November 1, as shown on the inside cover page**

The Oak Valley Hospital District (Stanislaus County, California) Health Facility Revenue Bonds, Series 2026 (the “2026 Bonds”), will be issued in the form of fully registered bonds, without coupons, in the name of Cede & Co., as nominee of The Depository Trust Company (“DTC”), New York, New York. DTC will act as securities depository for the 2026 Bonds. Purchases will be made in book-entry form through DTC participants only in the principal amount of \$5,000 or any integral multiple thereof. Except as described herein, purchasers will not receive physical certificates representing the 2026 Bonds purchased but will receive a credit balance on the books of the nominees of such beneficial owners. As long as DTC or its nominee is the registered owner of the 2026 Bonds, payment of principal of and interest on the 2026 Bonds will be made directly by U.S. Bank Trust Company, National Association, San Francisco, California, as trustee (the “Trustee”), to DTC or its nominee. Disbursement of such payments to DTC participants is the responsibility of DTC, and disbursement of such payments to beneficial owners is the responsibility of the DTC participants. See “BOOK-ENTRY SYSTEM.” Interest on the 2026 Bonds is payable on each May 1 and November 1, commencing May 1, 2027.

The 2026 Bonds will be subject to optional, special and mandatory redemption as described under “THE 2026 BONDS - Redemption” herein.

The 2026 Bonds will constitute limited obligations of Oak Valley Hospital District (the “District”), will be secured under the provisions of the Indenture, dated as of November 1, 2004, as previously amended and supplemented, and as further amended and supplemented by the Seventh Supplemental Indenture of Trust, dated as of November 1, 2026 (collectively, the “Indenture”), all between the District and the Trustee, and will be equally and ratably payable from Revenues (as that term is defined in the Indenture) and certain funds held under the Indenture. The 2026 Bonds will be on a parity as to payment and security with Parity Debt (as defined in the Indenture), including certain outstanding bonds of the District. See Appendix C – “SUMMARY OF THE INDENTURE - Definitions of Certain Terms.”

The 2026 Bonds are being issued by the District to (a) finance the remodeling, expansion, improvement and equipping of health facilities owned and operated by the District, (b) fund a bond reserve account, (c) finance capitalized interest on the 2026 Bonds, and (d) pay certain costs and expenses relating to the issuance and sale of the 2026 Bonds. See “THE PROJECT” and “FINANCING PLAN” herein.

THE 2026 BONDS ARE THE LIMITED OBLIGATIONS OF THE DISTRICT PAYABLE SOLELY FROM THE REVENUES IN ACCORDANCE WITH THE INDENTURE. THE TAX REVENUES OF THE DISTRICT ARE NOT PLEDGED TO THE PAYMENT OF THE PRINCIPAL OF OR INTEREST ON THE 2026 BONDS. THE 2026 BONDS ARE NOT A DEBT OF THE STATE OF CALIFORNIA, AND THE STATE OF CALIFORNIA IS NOT LIABLE FOR THE PAYMENT THEREOF.

The purchase of the 2026 Bonds involves various investment risks described throughout this Official Statement, including those described under “BONDHOLDERS’ RISKS” herein.

*This cover page contains certain information for quick reference only. It is not a summary of this issue. Investors must read the entire Official Statement to obtain information essential to the making of an informed investment decision.*

The 2026 Bonds are offered when, as and if issued by the District and received by the Underwriter, subject to prior sale and to the approval of validity by Stradling Yocca Carlson & Rauth LLP, Bond Counsel, and the approval of certain matters for the District by its counsel, McDougal Boehmer Foley Lyon Mitchell & Erickson, a professional corporation, as special counsel, and Pierson Ferdinand LLP, as disclosure counsel. Fieldman, Rolapp & Associates, Inc. has served as municipal advisor to the District in connection with the issuance of the 2026 Bonds. Certain legal matters will be passed upon for the Underwriter by Jones Hall LLP. It is expected that the 2026 Bonds in definitive form will be available for delivery through the facilities of DTC on or about November \_\_, 2026.



Dated: \_\_\_\_\_, 2026

\* Preliminary; subject to change.

\$ \_\_\_\_\_\*

**OAK VALLEY HOSPITAL DISTRICT  
(STANISLAUS COUNTY, CALIFORNIA)  
HEALTH FACILITY REVENUE BONDS,  
SERIES 2026**

**MATURITY SCHEDULE\***

**Serial Bonds\***

| <u>Maturity Date</u><br><u>(November 1)*</u> | <u>Principal</u><br><u>Amount*</u> | <u>Interest</u><br><u>Rate</u> | <u>Price</u> | <u>Yield</u> | <u>CUSIP<sup>†</sup></u><br><u>Number</u> |
|----------------------------------------------|------------------------------------|--------------------------------|--------------|--------------|-------------------------------------------|
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |
| 20__                                         | \$ _____                           | _____ %                        | _____ %      | _____ %      | _____                                     |

**Term Bonds\***

\$ \_\_\_\_\_\* \_\_\_\_\_ % Term Bonds due November 1, 20\_\_\*;  
Price: \_\_\_\_\_ %; Yield: \_\_\_\_\_ %; CUSIP<sup>†</sup> Number: \_\_\_\_\_

\$ \_\_\_\_\_\* \_\_\_\_\_ % Term Bonds due November 1, 20\_\_\*;  
Price: \_\_\_\_\_ %; Yield: \_\_\_\_\_ %; CUSIP<sup>†</sup> Number: \_\_\_\_\_

\* Preliminary; subject to change.

† CUSIP Numbers have been assigned to this issue by CUSIP Global Services managed on behalf of the American Bankers Association by FactSet Research Systems Inc. and are included solely for the convenience of the Bondholders. None of the District, the Trustee or the Underwriter shall be responsible for the selection or correctness of the CUSIP numbers set forth above.

**OAK VALLEY HOSPITAL DISTRICT**

350 S Oak Avenue  
Oakdale, California 95361

Board of Directors

Dan Cummins, Chairperson  
Danielle Sanders, Vice Chairperson  
Billie Scott, Secretary  
Ann Bairos, Director  
Sara Shipman, Finance Chairperson

Administration Team

Matthew Heyn, President and Chief Executive Officer  
Chang Ahn, Vice President and Chief Financial Officer  
David Rodrigues, Chief Operating Officer  
David Neal, Chief Nursing Officer  
Ali Sadeghi, MD, Chief Medical Officer

Special Counsel

McDougal Boehmer Foley Lyon Mitchell & Erickson, a professional corporation  
La Mesa, California

Municipal Advisor

Fieldman, Rolapp & Associates, Inc.  
Irvine, California

**SPECIAL SERVICES**

Bond Counsel

Stradling Yocca Carlson & Rauth LLP  
Newport Beach, California

Disclosure Counsel

Pierson Ferdinand LLP

Trustee

U.S. Bank Trust Company, National Association  
San Francisco, California

Trustee's Counsel

Dorsey & Whitney LLP  
New York, New York

Underwriter

Hilltop Securities Inc.  
Solana Beach, California

Underwriter's Counsel

Jones Hall LLP  
San Mateo, California

## GENERAL INFORMATION ABOUT THIS OFFICIAL STATEMENT

*THIS PRELIMINARY OFFICIAL STATEMENT HAS BEEN “DEEMED FINAL” AS OF ITS DATE BY THE DISTRICT PURSUANT TO RULE 15c2-12 OF THE SECURITIES AND EXCHANGE COMMISSION. THE DISTRICT HAS UNDERTAKEN TO PROVIDE CONTINUING DISCLOSURE ON CERTAIN MATTERS, INCLUDING ANNUAL FINANCIAL INFORMATION AND SPECIFIC ENUMERATED EVENTS, AS MORE FULLY DESCRIBED UNDER “CONTINUING DISCLOSURE UNDERTAKING” HEREIN.*

**Continuing Disclosure.** The District has undertaken to provide continuing disclosure on certain matters, including annual financial information and specific enumerated events, as more fully described under “**CONTINUING DISCLOSURE UNDERTAKING**.”

**Use of Official Statement.** This Official Statement is submitted in connection with the sale of the 2026 Bonds referred to herein and may not be reproduced or used, in whole or in part, for any other purpose. This Official Statement is not to be construed as a contract with the purchasers of the 2026 Bonds.

**Estimates and Forecasts.** When used in this Official Statement and in any continuing disclosure by the District, in any press release and in any oral statement made with the approval of an authorized officer of the District, the words or phrases “will likely result,” “are expected to,” “will continue,” “is anticipated,” “estimate,” “project,” “forecast,” “expect,” “intend” and similar expressions identify “forward looking statements” within the meaning of the Private Securities Litigation Reform Act of 1995. Such statements are subject to risks and uncertainties that could cause actual results to differ materially from those contemplated in such forward-looking statements. Any forecast is subject to such uncertainties. Inevitably, some assumptions used to develop the forecasts will not be realized and unanticipated events and circumstances may occur. Therefore, there are likely to be differences between forecasts and actual results, and those differences may be material. The information and expressions of opinion herein are subject to change without notice, and neither the delivery of this Official Statement nor any sale made hereunder shall, under any circumstances, give rise to any implication that there has been no change in the affairs of the District since the date hereof.

**Involvement of the Underwriter.** The Underwriter has reviewed the information in this Official Statement in accordance with, and as a part of, their responsibilities to investors under the federal securities laws as applied to the facts and circumstances of this transaction, but the Underwriter does not guarantee the accuracy or completeness of such information.

**Offer and Sale of Bonds.** The Underwriter may offer and sell the 2026 Bonds to certain dealers and others at prices lower than the public offering prices set forth on the cover page hereof and said public offering prices may be changed from time to time by the Underwriter.

**Limit of Offering.** No dealer, broker, salesperson or other person has been authorized by the District to give any information or to make any representations in connection with the offer or sale of the 2026 Bonds other than those contained herein and if given or made, such other information or representation must not be relied upon as having been authorized by the District or the Municipal Advisor. This Official Statement does not constitute an offer to sell or the solicitation of an offer to buy nor shall there be any sale of the 2026 Bonds by a person in any jurisdiction in which it is unlawful for such person to make such an offer, solicitation or sale.

**Website References.** References to website addresses presented in this Official Statement are for informational purposes only and may be in the form of a hyperlink solely for the reader’s convenience. Unless specified otherwise, such websites and the information or links contained therein are not incorporated into, and are not part of, this Official Statement.

**THE 2026 BONDS HAVE NOT BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933, AS AMENDED, IN RELIANCE UPON AN EXCEPTION FROM THE REGISTRATION REQUIREMENTS CONTAINED IN SUCH ACT. THE 2026 BONDS HAVE NOT BEEN REGISTERED OR QUALIFIED UNDER THE SECURITIES LAWS OF ANY STATE. THESE SECURITIES HAVE NOT BEEN RECOMMENDED BY A FEDERAL OR STATE SECURITIES COMMISSION OR REGULATORY AUTHORITY. FURTHERMORE, THE FOREGOING AUTHORITIES HAVE NOT CONFIRMED THE ACCURACY OR DETERMINED THE ADEQUACY OF THIS DOCUMENT. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE.**

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## PRELIMINARY OFFICIAL STATEMENT

relating to

\$ \_\_\_\_\_ \*

**OAK VALLEY HOSPITAL DISTRICT  
(STANISLAUS COUNTY, CALIFORNIA)  
HEALTH FACILITY REVENUE BONDS,  
SERIES 2026**

### INTRODUCTORY STATEMENT

This Official Statement is furnished in connection with the offering of \$ \_\_\_\_\_ \* aggregate principal amount of Health Facility Revenue Bonds, Series 2026 (the “**2026 Bonds**”) of the Oak Valley Hospital District (the “**District**”). All capitalized terms used in this Official Statement and not otherwise defined herein have the same meanings as in that certain Indenture, dated as of November 1, 2004, as previously amended and supplemented, and as further amended and supplemented by the Seventh Supplemental Indenture of Trust, dated as of November 1, 2026 (collectively, the “**Indenture**”), by and between the District and U.S. Bank Trust Company, National Association, as trustee (the “**Trustee**”). See **Appendix C – “Summary of the Indenture - Definitions of Certain Terms.”**

**Use of Bond Proceeds.** Proceeds from the sale of the 2026 Bonds will be used by the District to (a) finance the remodeling, expansion, improvement and equipping of health facilities owned and operated by the District (the “**Project**”), (b) fund a bond reserve account, (c) finance capitalized interest on the 2026 Bonds, and (d) pay certain costs of issuance related to the 2026 Bonds. See “**ESTIMATED SOURCES AND USES OF FUNDS**” and “**THE PROJECT**” herein.

**The 2026 Bonds; Security for the 2026 Bonds.** The 2026 Bonds will be issued pursuant to and secured by the Indenture. The principal of the 2026 Bonds and the interest thereon will be payable solely from Revenues and secured by a pledge of Revenues of the District and of amounts held in the funds and accounts established pursuant to the Indenture, subject only to the provisions of the Indenture permitting the application thereof for the purposes and on the terms and conditions set forth in the Indenture. Under the Indenture, the District is required to deposit all of its Revenues (other than interest and other investment income) into the Gross Revenue Fund established under the Indenture as soon as practicable upon receipt and transfer monthly to the Trustee an amount sufficient to pay the principal of and interest on the 2026 Bonds and outstanding Parity Debt when due, and any other Parity Debt issued pursuant to and as defined in the Indenture as the same become due and payable.

As of the date hereof and prior to the issuance of the 2026 Bonds, the District has the following outstanding bonds which were issued pursuant to the terms of the Indenture as then in effect and are Parity Debt and payable on a parity with the 2026 Bonds:

(a) Health Facility Revenue Bonds, Series 2020A (the “**2020A Bonds**”), originally issued in the aggregate principal amount of \$11,550,000 and, following the November 1, 2026 principal payment, will be outstanding in the aggregate principal amount of \$10,735,000;

(b) Health Facility Revenue Bonds, Series 2020B (the “**2020B Bonds**”), originally issued in the aggregate principal amount of \$7,000,000 and, following the November 1, 2026 principal payment, will be outstanding in the aggregate principal amount of \$4,951,248.13;

(c) Health Facility Refunding Revenue Bonds, Series 2021 (the “**2021 Bonds**”), originally issued in the aggregate principal amount of \$11,067,000 and, following the November 1, 2026 principal payment, will be outstanding in the aggregate principal amount of \$6,936,200; and

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\* Preliminary; subject to change.

(d) Health Facility Refunding Revenue Bonds, Series 2024 (the “**2024 Bonds**”), originally issued in the aggregate principal amount of \$10,000,000 and, following the November 1, 2026 principal payment, will be outstanding in the aggregate principal amount of \$6,275,000.

Upon issuance of the 2026 Bonds, Parity Debt of the District will consist of the 2020A Bonds, the 2020B Bonds, the 2021 Bonds, the 2024 Bonds and the 2026 Bonds. See “**SECURITY FOR THE 2026 BONDS – Pledge Under the Indenture; Revenues of the District; Gross Revenue Fund**” and “**– Additional Bonds; Parity Debt; Senior Security Interest**” and **Appendix C – “SUMMARY OF THE INDENTURE.”**

Pursuant to the Indenture, the District has covenanted and agreed to fix, charge and collect, or cause to be fixed, charged and collected, such rates, fees and charges for the use of, and for services furnished or to be furnished at, the District’s hospital (the “**Hospital**”) and other health care facilities located in Oakdale, California and nearby communities (collectively, the “**Health Facilities**”), which, together with all other receipts and revenues of the District and any other funds available therefor, are reasonably projected in each Fiscal Year so that the Long-Term Debt Service Coverage Ratio for such Fiscal Year is not less than 1.50x. The District also covenants to maintain an actual Long-Term Debt Service Coverage Ratio of not less than 1.25x (or 1.10x as long as the District has 75 or more Days Cash on Hand, excluding amounts on deposit in the Bond Reserve Account) for each Fiscal Year. The District has covenanted in the Indenture to maintain as of the end of each Fiscal Year at least 50 Days Cash on Hand. For a discussion of action, if any, required of the District if the Long-Term Debt Service Coverage Ratio falls below the required level and a summary of other covenants of the District, see **Appendix C – “SUMMARY OF THE INDENTURE.”** See also “**SECURITY FOR THE 2026 BONDS – Debt Service Coverage.**”

**THE 2026 BONDS ARE LIMITED OBLIGATIONS OF THE DISTRICT AND ARE NOT A LIEN OR CHARGE UPON THE FUNDS OR PROPERTY OF THE DISTRICT, EXCEPT TO THE EXTENT OF THE PLEDGE AND ASSIGNMENT OF THE REVENUES AND OF AMOUNTS HELD IN THE FUNDS AND ACCOUNTS ESTABLISHED PURSUANT TO THE INDENTURE. THE FULL FAITH AND CREDIT OF THE DISTRICT IS NOT PLEDGED TO THE PAYMENT OF THE PRINCIPAL OF OR INTEREST ON THE 2026 BONDS. THE 2026 BONDS ARE NOT A DEBT OF THE STATE OF CALIFORNIA OR STANISLAUS COUNTY OR OTHER POLITICAL SUBDIVISION THEREOF, AND NEITHER THE STATE OF CALIFORNIA NOR ANY POLITICAL SUBDIVISION THEREOF (OTHER THAN THE DISTRICT TO THE EXTENT PROVIDED IN THE INDENTURE), IS LIABLE FOR THE PAYMENT THEREOF.**

***Additional Indebtedness; Senior Security Interest.*** The District may incur Indebtedness other than the 2026 Bonds that may be secured on a parity with the District’s obligations under the Indenture, including Additional Bonds, as long as such other Indebtedness is incurred for the purposes authorized by and subject to the conditions provided in the Indenture. Any Parity Debt incurred by the District would be equally and ratably secured by the pledge of Revenues. See **Appendix C – “Summary of the Indenture - Definitions of Certain Terms”** for a description of Parity Debt. Subject to certain limitations, the District is also permitted to enter into Short Term Indebtedness secured by the District’s accounts receivable. Such a security interest would have priority as to that collateral over the District’s pledge of Revenues to secure payment of Parity Debt. See “**SECURITY FOR THE 2026 BONDS – Additional Bonds; Parity Debt; Senior Security Interest**” and **Appendix C – “SUMMARY OF THE INDENTURE – Limitation on Additional Indebtedness”** herein.

***Bondholders’ Risks.*** There are risks associated with the purchase of the 2026 Bonds discussed throughout this Official Statement, including the discussion in “**BONDHOLDERS’ RISKS**” herein.

***Legal Professionals Involved in the Offering.*** Stradling Yocca Carlson & Rauth LLP serves as Bond Counsel to the District. McDougal Boehmer Foley Lyon Mitchell & Erickson, a professional corporation, serves as the District’s special counsel. Pierson Ferdinand LLP serves as the District’s disclosure counsel. Certain legal matters will be passed upon for the Underwriter by Jones Hall LLP. Each of these law firms has acted as counsel to the Underwriter in the past and may do so in the future.

**Continuing Disclosure.** The District will undertake, pursuant to the Indenture and a Continuing Disclosure Certificate, to provide certain quarterly and annual financial information and notices of the occurrence of certain events. See “**CONTINUING DISCLOSURE UNDERTAKING**” herein.

**General.** The descriptions and summaries of various documents herein set forth do not purport to be comprehensive or definitive, and reference is made to each document for the complete details of its terms and conditions. All statements herein are qualified in their entirety by reference to such documents. See “**SUMMARY OF THE INDENTURE - Definitions of Certain Terms**” in **Appendix C** hereto for definitions of certain words and terms used but not otherwise defined herein.

## THE 2026 BONDS

### General Information

The 2026 Bonds, when issued, will be registered in the name of Cede & Co., as nominee of The Depository Trust Company, New York, New York (“**DTC**”). DTC will act as securities depository of the 2026 Bonds, and all payments due with respect to the 2026 Bonds will be made to DTC or its nominee. Individual purchases will be made only in book-entry form. See **Appendix F – “BOOK ENTRY SYSTEM”** herein. The 2026 Bonds will be dated the date that they are delivered and bear interest (computed on the basis of a 360-day year of twelve 30-day months) from that date, payable on May 1 and November 1 of each year, commencing May 1, 2027 (each an “**Interest Payment Date**”). The 2026 Bonds will mature, subject to the redemption provisions described herein, in the amounts and on the dates and will bear interest at the rates per annum set forth on the inside cover page of this Official Statement. The 2026 Bonds will be issued only as fully registered bonds without coupons, initially in book-entry form, and ownership interests in the 2026 Bonds will be in denominations of \$5,000 or any integral multiple thereof.

The principal or redemption price of the 2026 Bonds is payable upon presentation and surrender thereof at the principal corporate trust office of the Trustee in San Francisco, California. Interest on the 2026 Bonds is payable by check or draft mailed on each Interest Payment Date to the person whose name appears in the registration books maintained by the Trustee as the registered holder thereof at the close of business on the fifteenth day of the month preceding each Interest Payment Date (the “**Record Date**”), except as provided in the Indenture with respect to defaulted interest. Interest on the 2026 Bonds will be paid by wire transfer of immediately available funds to any registered holder of at least \$1,000,000 in aggregate principal amount of Bonds, at its option, according to a request received by the Trustee for such purpose on or before the close of business on the respective Record Date.

### Redemption

**Optional Redemption.** The 2026 Bonds maturing on or before November 1, 20\_\_, are not subject to redemption prior to their respective stated maturities. The 2026 Bonds maturing on or after November 1, 20\_\_, are subject to redemption prior to their respective stated maturities, at the option of the District, in whole or in part on any date by such maturities as are selected by the District (or if the District fails to designate such maturities, in inverse order of maturity) and by lot within a maturity, on or after November 1, 20\_\_, at a redemption price equal to the principal amount of 2026 Bonds called for redemption, together with interest accrued thereon to the date fixed for redemption, without premium.

**Mandatory Sinking Fund Redemption.** The 2026 Bonds maturing on November 1, 20\_\_ (the “**2026 Term Bonds**”) are subject to mandatory redemption, in part by lot, from Sinking Account payments set forth in the following schedule on November 1, 20\_\_, and November 1, 20\_\_, at a redemption price equal to the principal amount thereof to be redeemed (without premium), together with interest accrued thereon to the date fixed for redemption; provided, however, that if some but not all of the 2026 Term Bonds have been redeemed pursuant to optional redemption, as described above, the total amount of Sinking Account payments to be made subsequent to such redemption shall be reduced in an amount equal to the principal amount of the 2026 Term Bonds so redeemed by reducing each such future Sinking Account payment on a pro rata basis (as nearly as practicable) in integral multiples of \$5,000, as shall be designated pursuant to written notice filed by the District with the Trustee.

| <b>Sinking Account<br/>Redemption Date<br/>(November 1)</b> | <b>Principal Amount<br/>to be Redeemed</b> |
|-------------------------------------------------------------|--------------------------------------------|
| 20__                                                        | \$ _____                                   |
| 20__ <sup>+</sup>                                           | _____                                      |
| <hr/>                                                       |                                            |
| + Maturity                                                  |                                            |

**Partial Redemption; Selection.** All or a portion of any 2026 Bond may be redeemed, by lot but only in a principal amount equal to an Authorized Denomination. In the event that less than all of the 2026 Bonds outstanding are to be redeemed, the Trustee shall select the 2026 Bonds to be redeemed in such order of redemption as shall be selected by the District. Upon surrender of any 2026 Bond for redemption in part, the Trustee shall authenticate and deliver to the Owner thereof, at the expense of the District, a new 2026 Bond or 2026 Bonds of Authorized Denominations of the same type and maturity and in an aggregate principal amount equal to the unredeemed portion of the 2026 Bond so surrendered.

**Notice of Redemption.** Notice of any such redemption shall be given by the Trustee on behalf and at the expense of the District by mailing a copy of a redemption notice by first class mail at least twenty (20) days and not more than sixty (60) days prior to the date fixed for redemption to each Owner of the 2026 Bond or 2026 Bonds to be redeemed at the address shown on the Registration Books; provided, however, that neither the failure to receive such notice nor any defect in any notice shall affect the sufficiency of the proceedings for the redemption of the 2026 Bonds.

All notices of redemption shall be dated and shall state: (i) the redemption date, (ii) the redemption price, (iii) if less than all Outstanding 2026 Bonds are to be redeemed, the identification (and, in the case of partial redemption, the respective principal amounts) of the 2026 Bonds to be redeemed, (iv) that on the redemption date the redemption price will become due and payable with respect to each such 2026 Bond or portion thereof called for redemption, and that interest with respect thereto shall cease to accrue from and after said date, (v) the place where such 2026 Bonds are to be surrendered for payment of the redemption price, and (vi) in the case of an optional redemption, that such notice of redemption is revocable by written notice to be provided in the same manner as notice of redemption had been provided.

Notice of redemption having been given as aforesaid, the 2026 Bonds or portions of 2026 Bonds so to be redeemed shall, on the redemption date, become due and payable at the redemption price therein specified, and from and after such date (unless the District shall default in the payment of the redemption price) interest with respect to such 2026 Bonds or portions of 2026 Bonds shall cease to accrue and be payable. Upon surrender of such 2026 Bonds for redemption in accordance with said notice, such 2026 Bonds shall be paid by the Trustee at the redemption price. Installments of interest due on or prior to the redemption date shall be payable as herein provided for payment of interest. Upon surrender for any partial redemption of any 2026 Bond, there shall be prepared for the Owner a new 2026 Bond or 2026 Bonds of the same maturity in the amount of the unpaid principal.

**As long as the book-entry system is in effect with respect to the 2026 Bonds, all notices of redemption will be mailed to DTC (or its nominee), as the holder of the 2026 Bonds. See Appendix F – “BOOK-ENTRY SYSTEM.”**

## **Registration, Transfer and Exchange**

The Trustee will keep, or cause to be kept, sufficient books for the registration and transfer of the 2026 Bonds, which will at all times be open to inspection by the District. In the event that the book-entry system is discontinued, any Bond may, in accordance with its terms, be transferred upon the registration books by the person in whose name it is registered, in person or by such person's duly authorized attorney, upon surrender of such 2026 Bond for cancellation, accompanied by delivery of a written instrument of transfer, duly executed in a form approved by the Trustee. Whenever any Bonds are surrendered for transfer, the District is required to execute and the Trustee to authenticate and deliver new Bonds of the same maturity and interest rate for a like aggregate principal amount. In the event that the book-entry system is discontinued, Bonds may be exchanged at the principal corporate trust office of the Trustee in San Francisco, California, for a like aggregate principal amount of Bonds of other authorized denominations of the same maturity and interest rate. The Trustee will require the Bondholder requesting such transfer or exchange to pay any tax or other governmental charge required to be paid with respect to such transfer or exchange.

No transfer or exchange of Bonds will be required to be made (a) after such 2026 Bonds have been selected for redemption as provided in the Indenture and (b) between any Record Date and the next succeeding Interest Payment Date.

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## ANNUAL DEBT SERVICE REQUIREMENTS

The following table sets forth for the debt service payable with respect to the 2026 Bonds for each year ending November 1 and the annual debt service on outstanding Parity Debt (consisting of the 2020A Bonds, the 2020B Bonds, the 2021 Bonds and the 2024 Bonds).

| <b>Year Ending<br/>(November 1)</b> | <b>2026 Bonds</b>       |                        |                                      | <b>Outstanding<br/>Parity<br/>Debt<sup>(1)</sup></b> | <b>Total<br/>Debt Service</b> |
|-------------------------------------|-------------------------|------------------------|--------------------------------------|------------------------------------------------------|-------------------------------|
|                                     | <b><u>Principal</u></b> | <b><u>Interest</u></b> | <b><u>Total<br/>Debt Service</u></b> |                                                      |                               |
| 2027                                |                         |                        |                                      |                                                      |                               |
| 2028                                |                         |                        |                                      |                                                      |                               |
| 2029                                |                         |                        |                                      |                                                      |                               |
| 2030                                |                         |                        |                                      |                                                      |                               |
| 2031                                |                         |                        |                                      |                                                      |                               |
| 2032                                |                         |                        |                                      |                                                      |                               |
| 2033                                |                         |                        |                                      |                                                      |                               |
| 2034                                |                         |                        |                                      |                                                      |                               |
| 2035                                |                         |                        |                                      |                                                      |                               |
| 2036                                |                         |                        |                                      |                                                      |                               |
| 2037                                |                         |                        |                                      |                                                      |                               |
| 2038                                |                         |                        |                                      |                                                      |                               |
| 2039                                |                         |                        |                                      |                                                      |                               |
| 2040                                |                         |                        |                                      |                                                      |                               |
| 2041                                |                         |                        |                                      |                                                      |                               |
| 2042                                |                         |                        |                                      |                                                      |                               |
| 2043                                |                         |                        |                                      |                                                      |                               |
| 2044                                |                         |                        |                                      |                                                      |                               |
| 2045                                |                         |                        |                                      |                                                      |                               |
| 2046                                |                         |                        |                                      |                                                      |                               |
| 2047                                |                         |                        |                                      |                                                      |                               |
| 2048                                |                         |                        |                                      |                                                      |                               |
| 2049                                |                         |                        |                                      |                                                      |                               |
| 2050                                |                         |                        |                                      |                                                      |                               |
| 2051                                |                         |                        |                                      |                                                      |                               |
| 2052                                |                         |                        |                                      |                                                      |                               |
| 2053                                |                         |                        |                                      |                                                      |                               |
| 2054                                |                         |                        |                                      |                                                      |                               |
| 2055                                |                         |                        |                                      |                                                      |                               |
| 2056                                |                         |                        |                                      |                                                      |                               |
| 2057                                |                         |                        |                                      |                                                      |                               |
| Total                               |                         |                        |                                      |                                                      |                               |

<sup>(1)</sup> Includes scheduled debt service (including any applicable mandatory sinking fund payments) on the District's 2020A Bonds, 2020B Bonds, 2021 Bonds and 2024 Bonds.

## ESTIMATED SOURCES AND USES OF FUNDS

Proceeds to be received from the sale of the 2026 Bonds will be applied as estimated in the following table:

### Sources of Funds:

|                                 |                 |
|---------------------------------|-----------------|
| Par Amount of 2026 Bonds        | \$ _____        |
| Plus Net Original Issue Premium | _____           |
| Total Sources                   | <u>\$ _____</u> |

### Uses of Funds:

|                                                     |                 |
|-----------------------------------------------------|-----------------|
| Deposit to Project Fund <sup>(1)</sup>              | \$ _____        |
| Deposit to Bond Reserve Account <sup>(2)</sup>      | _____           |
| Deposit to Capitalized Interest Fund <sup>(3)</sup> | _____           |
| Deposit to Costs of Issuance Fund <sup>(4)</sup>    | _____           |
| Total Uses                                          | <u>\$ _____</u> |

- (1) See “**THE PROJECT**” herein. The District expects to disburse approximately \$\_\_\_\_\_ of the funds deposited into the Project Fund to reimburse itself for previously paid costs related to the Project.
- (2) Equal to the Bond Reserve Account requirement.
- (3) Capitalized interest on the 2026 Bonds to and including November 1, 2027.
- (4) Includes Underwriter’s discount, legal, municipal advisory, printing, rating agency, Trustee and other miscellaneous fees and costs associated with issuance of the 2026 Bonds.

## THE PROJECT

The District will utilize funds deposited into the Project Fund to fund all or a portion of the costs related to the following projects (collectively, the “**Project**”):

(a) **TCU to Med-Surg Conversion.** The District plans to pay for the cost of converting its existing 11-bed Transitional Care Unit (“**TCU**”), a skilled nursing and rehabilitation unit that provides short-term, post-acute care to patients, into medical-surgical beds to provide additional inpatient capacity. This project cost is approximately \$900,000 and was completed in August 2026.

(b) **New Purchasing Building.** The District plans to provide additional and improved space for the procurement, storage, and distribution of supplies, pharmaceuticals, and equipment. The building will be constructed adjacent to the Hospital and is expected to be completed in October 2027 and cost approximately \$750,000. The project is currently in the design phase.

(c) **Completion of Operating Room #4 as an Interventional Radiology Space.** The District plans to complete the build-out of operating room #4, a currently shelled space, into a space for interventional cardiology and interventional radiology space. The District plans to complete this project by April 2027 at a cost of approximately \$1.9 million.

(d) **Kitchen & Dining Build-out.** The District plans to remodel and upgrade the Hospital’s existing cafeteria. This project is expected to be completed by May 2028 at a cost of approximately \$2 million.

(e) **Medical Office and Clinic Build-out.** The District plans to build out a portion of the second floor of the Hospital into medical office building space to provide a space for in-house physician services that are currently provided in a rented offsite location. The District plans to begin construction in January 2027 following approval by the California Department of Healthcare Access and Information and complete the build-out by June 2028 at a cost of approximately \$5 million.

(f) **Center for Health Improvement.** In 2026, the District previously purchased a former Rite-Aid Pharmacy building located one block north of the Hospital. The District plans to convert this building into a Center for Health Improvement that will include space for an outpatient pharmacy, urgent care services, and a wellness center to be used by the District, along with conference rooms and space available for lease to third parties. The District expects to complete this project by April 2028 at a cost of approximately \$4 million.

(g) **New CT Suite.** As part of the District's plan to add a stroke services program, a new CT Machine will be acquired and CT Suite will be constructed. This will provide additional overall capacity for CT services and also provide a second CT machine that will be needed for the stroke program, to ensure that the hospital can provide CT services at all times, even if one machine is temporarily taken off line for servicing. The suite and equipment are estimated to cost \$3.45 million.

## SECURITY FOR THE 2026 BONDS

### Pledge Under the Indenture; Revenues of the District; Gross Revenue Fund

Subject to, and for the purposes and on the terms and conditions set forth in the Indenture, there are pledged to secure the payment of the principal of, and interest on, the 2026 Bonds issued under the Indenture in accordance with their terms, all amounts (including proceeds of the sale of the 2026 Bonds) held in any fund or account established pursuant to the Indenture (except the Rebate Fund). The Revenues of the District are also pledged to the Trustee to secure payment of principal of and interest on the 2026 Bonds. See **Appendix C – "SUMMARY OF THE INDENTURE – Definitions of Certain Terms"** for a description of what constitutes "**Revenues**" of the District.

The District agrees that, so long as any Bonds remain outstanding under the Indenture, all of the Revenues of the District shall be deposited as soon as practicable upon receipt in a fund designated as the "**District Gross Revenue Fund**," which the District shall establish and maintain at such banking or financial institution or institutions located in the State of California as the District shall designate for such purpose (herein called the "**Depository Bank(s)**"). Subject only to the provisions of the Indenture permitting the application thereof for the purposes and on the terms and conditions set forth therein, the District pledges and, to the extent permitted by law, grants a security interest to the Trustee in the Gross Revenue Fund to secure the payment of the principal of and interest on the 2026 Bonds, the 2020A Bonds, 2020B Bonds, the 2021 Bonds and the 2024 Bonds, and any Additional Bonds and other Indebtedness issued under the Indenture as Parity Debt.

Pursuant to California Government Code section 5451 the District's pledge of Revenues to secure payment of the 2026 Bonds constitutes a lien on the Revenues that immediately attaches and is enforceable against the District and its creditors without notice or filing or the taking of physical delivery of the Revenues. The bond documentation for this transaction does not provide for a deposit account control agreement with respect to the Revenues. See "**BONDHOLDERS' RISKS – General-Security Interest Limitations**" herein.

### Debt Service Coverage

The District covenants and agrees in the Indenture to fix, charge and collect, or cause to be fixed, charged and collected, such rates, fees and charges for the use of and for the services furnished or to be furnished at the Health Facilities which, together with all other receipts and revenues of the District and any other funds available therefor, are reasonably projected in each Fiscal Year to cause the Long-Term Debt Service Coverage Ratio at the end of each such Fiscal Year to be not less than 1.50. If the District's actual Debt Service Coverage Ratio falls below 1.25 (or 1.10 so long as the District has 75 or more Days Cash on Hand, excluding amounts on deposit in the Bond Reserve Account), the District must take action to remediate the situation. For a discussion of what action may be required of the District if the Long-Term Debt Service Coverage Ratio falls below its required level, see **Appendix C – "SUMMARY OF THE INDENTURE – The Indenture – Covenants of the District."**

## Bond Reserve Account

A Bond Reserve Account has been established for the 2026 Bonds and will be funded in an amount equal to the Bond Reserve Account Requirement (\$\_\_\_\_\_). Amounts in the Bond Reserve Account will be used and withdrawn by the Trustee solely for the purpose of making up any deficiency in the Interest Account or Principal Account. The District is required to replenish the Bond Reserve Account in equal monthly installments within one year of any withdrawal. See **Appendix C – “SUMMARY OF THE INDENTURE – Definitions of Certain Terms.”**

## Additional Bonds; Parity Debt; Senior Security Interest

The District may authorize the issuance of an additional series of Bonds upon the terms and conditions provided in the Indenture (“**Additional Bonds**”). The District may also incur other Parity Debt subject to the provisions of the Indenture. The District is permitted, subject to certain restrictions, to incur other forms of Indebtedness. See **Appendix C – “SUMMARY OF THE INDENTURE – The Indenture – Covenants of the District.”**

Following the issuance of the 2026 Bonds, the District will have Outstanding the following series of Bonds under the terms of the Indenture, which Bonds constitute Parity Debt under the terms of the Indenture:

|             | June 30, 2026<br><u>Principal Outstanding</u> | November 1, 2026<br><u>Principal Payment</u> | Principal Outstanding<br>following issuance of<br><u>the 2026 Bonds</u> |
|-------------|-----------------------------------------------|----------------------------------------------|-------------------------------------------------------------------------|
| 2020A Bonds | \$ 11,005,000.00                              | \$ 270,000.00                                | \$ 10,735,000.00                                                        |
| 2020B Bonds | 5,288,881.76                                  | 337,633.63                                   | 4,951,248.13                                                            |
| 2021 Bonds  | 7,698,760.00                                  | 762,560.00                                   | 6,936,200.00                                                            |
| 2024 Bonds  | 7,600,000.00                                  | 1,325,000.00                                 | 6,275,000.00                                                            |
| 2026 Bonds  | 0.00                                          | 0.00                                         | 0.00                                                                    |
| Total       | <u>\$ 31,592,641.76</u>                       |                                              | <u>\$ 22,905,508.13</u>                                                 |

\* Preliminary; subject to change.

Under the terms of the Indenture, the District may incur Short-Term Indebtedness secured by the District’s accounts receivable. Such a security interest would have priority as to that collateral over the pledge of Revenues of the District pursuant to the Indenture.

## Limited Obligations

**THE 2026 BONDS ARE LIMITED OBLIGATIONS OF THE DISTRICT AND ARE NOT A LIEN OR CHARGE UPON THE FUNDS OR PROPERTY OF THE DISTRICT, EXCEPT TO THE EXTENT OF THE PLEDGE AND ASSIGNMENT OF THE REVENUES AND OF AMOUNTS HELD IN THE FUNDS AND ACCOUNTS ESTABLISHED PURSUANT TO THE INDENTURE. THE FULL FAITH AND CREDIT OF THE DISTRICT IS NOT PLEDGED TO THE PAYMENT OF THE PRINCIPAL OF OR INTEREST ON THE 2026 BONDS. THE 2026 BONDS ARE NOT A DEBT OF THE STATE OF CALIFORNIA OR ANY POLITICAL SUBDIVISION THEREOF, AND NEITHER THE STATE OF CALIFORNIA NOR ANY POLITICAL SUBDIVISION THEREOF (OTHER THAN THE DISTRICT TO THE EXTENT PROVIDED IN THE INDENTURE) IS LIABLE FOR THE PAYMENT THEREOF.**

## THE DISTRICT

The District was formed in 1968 and is a political subdivision of the State of California. The geographic area that comprises the District encompasses approximately 327 square miles in the northeastern portion of Stanislaus County and primarily services residents within the cities of Oakdale and Waterford. The District serves

\* Preliminary; subject to change.

areas beyond its boundaries including the City of Riverbank, which is in its sphere of influence, and the City of Escalon, which is in San Joaquin County.

The District operates the Oak Valley Hospital, Oak Valley Community Health Center, Oak Valley Medical Plaza, Waterford Community Health Center, Escalon Community Health Center, and Riverbank Community Health Center (collectively referred to herein as the “**Health Facilities**”).

See **Appendix A – “INFORMATION CONCERNING OAK VALLEY HOSPITAL DISTRICT”** hereto for additional general information about the District and its Health Facilities.

## **BONDHOLDERS’ RISKS**

*The purchase of the 2026 Bonds involves certain investment risks that are discussed throughout this Official Statement. Accordingly, each prospective purchaser of the 2026 Bonds should make an independent evaluation of all of the information presented in this Official Statement in order to make an informed investment decision. This section on BONDHOLDERS’ RISKS focuses primarily on the general risks associated with an investment in the 2026 Bonds and the general risks of hospital and health care operations. APPENDIX A describes the health care operations and financial results of the District more specifically. These discussions should be read together.*

**This following discussion of risk factors is not, and is not intended to be, exhaustive or an attempt to prioritize such risks.**

### **General**

The 2026 Bonds are limited obligations of the District, payable solely from and secured by Revenues and amounts on deposit in funds and accounts held under the Indenture. No representation or assurance can be made that Revenues will be realized by the District in amounts sufficient to pay principal of and interest on the 2026 Bonds.

The District is subject to a wide variety of federal and state regulatory actions and legislative and policy changes by those governmental and private agencies that administer Medicare, California’s Medicaid program (known as “**Medi-Cal**”) and other payors and is subject to actions by, among others, the National Labor Relations Board, The Joint Commission, the Centers for Medicare & Medicaid Services (“**CMS**”) of the U.S. Department of Health and Human Services (“**DHHS**”), the Attorney General of the State, and other federal, state and local government agencies. The future financial condition of the District could be adversely affected by, among other things, changes in the method and amount of payments to the District by governmental and nongovernmental payors, the financial viability of these payors, increased competition from other health care entities, the costs associated with responding to governmental inquiries and investigations, demand for health care, other forms of care or treatment, changes in the methods by which employers purchase health care for employees, capability of management, changes in the structure of how health care is delivered and paid for (e.g., accountable care organizations, value-based purchasing, bundled payments, and other health reform payment mechanisms, including a “single-payor” system), future changes in the economy, demographic changes, availability of physicians, nurses and other health care professionals, and malpractice claims and other litigation. These factors and others may adversely affect payment by the District under the Indenture and, consequently, on the 2026 Bonds.

### **Significant Risk Areas Summarized**

Certain of the primary risks associated with the operations of the District are briefly summarized in general terms below and are explained in greater detail in subsequent sections. The occurrence of one or more of these risks could have a material adverse effect on the financial condition and results of operations of the District, and in turn the ability of the District to make payments required under the Indenture.

**Federal Health Care Reform.** The federal health care reform legislation enacted in March 2010, the Patient Protection and Affordable Care Act (“**ACA**”), contains extensive provisions that have taken effect. This legislation addresses almost all aspects of health care organization and provider operations, health care delivery and

reimbursement. As noted below under the caption “**OBBBA Recent Tax and Spending Federal Law and Other Present Federal Funding Action,**” the One Big Beautiful Bill Act (“OBBBA”) contains certain provisions that would impact the ACA, Medicaid and other health care related federal programs and funding. These changes have resulted and will continue to result in changes to health care organizations and provider reimbursement methods, utilization changes, patient eligibility, enrollment and coverage, increased government enforcement and the necessity for health care organizations and providers to assess, and potentially alter, their business strategy and practices, among other consequences.

**California Health Care Reform.** The State of California actively reforms and revises its health care related laws.

Medi-Cal reforms under California Advancing and Innovating Medi-Cal (“**CalAIM**”), a framework that encompasses a broad-based delivery system, program, and payment reform across the Medi-Cal program, include expanded Community Supports, such as housing navigation, medically tailored meals, and transitional rent, with Transitional Rent becoming mandatory in 2026. DHCS has rolled out Closed-Loop Referral requirements under Enhanced Care Management to improve follow-through on social supports. AB 688, the “Telehealth for All Act of 2025,” mandates a biennial public report analyzing telehealth usage in Medi-Cal and disparities, guiding future policy with equity data. Additional data reporting requirements take substantial time and effort to implement and perfect, which could affect operations.

Together, these reforms seek to enhance care access, accountability, social needs integration, and telehealth quality. However, implementation challenges such as administrative complexity, audit requirements, and potential coverage reductions for undocumented enrollees may impact the operations of the District and access for Medi-Cal beneficiaries.

**Reliance on Payments from Government.** Health care providers and health care systems rely to a high degree on revenues from Medicare and Medi-Cal. Medicare and Medi-Cal are the commonly used names for reimbursement or payment programs governed by certain provisions of the federal Social Security Act. Implementation of the ACA, changes under the OBBBA, and any future changes in the law and regulations governing these governmental programs, as well as in payment policy and timing, create uncertainty and could have a material adverse impact on payments from Medicare and Medi-Cal. Such State and federal programs are a significant source of revenues to many health care districts. With health care spending reported to be increasing faster than the rate of general inflation, Congress and/or CMS may take action in the future to decrease or restrain Medicare and Medi-Cal outlays for health care providers, including the District. This could have a material adverse impact on the District. Because Medi-Cal is partially funded by the State, any adverse effects on the current fiscal condition of the State may result in lower funding levels and/or payment delays.

**Rate Pressure from Insurers and Purchasers.** Certain health care markets, including many communities in California, are strongly impacted by large health insurers and, in some cases, by major purchasers of health services. In those areas, health insurers may have significant influence over the rates, utilization and competition of hospitals and other health care providers. Rate pressure imposed by health insurers or other major purchasers, including managed care payors, may have a material adverse impact on health care providers, particularly if major purchasers put increasing pressure on payors to restrain rate increases. Mergers and other consolidation activities by health insurers could also materially adversely affect the ability of hospitals and other health care providers to negotiate favorable rates. Business failures by health insurers also could have a material adverse impact on contracted hospitals and other health care providers in the form of payment shortfalls or delays, and/or continuing obligations to care for managed care patients without receiving payment. In addition, disputes with non-contracted payors may result in an inability to collect billed charges from these payors.

**Capital Needs vs. Capital Capacity.** Hospital and other health care operations are capital intensive. Regulation, technology and expectations of physicians and patients require constant and often significant capital investment. In California, seismic safety standards mandated by the State may require that many hospital facilities be substantially modified, replaced or closed. Nearly all hospitals in California are affected. Estimated construction costs are substantial and actual costs of compliance may exceed estimates. Total capital needs may exceed capital capacity. Additionally, the technology needs of hospitals also present significant capital needs, including acquisition

and implementation of electronic health record (“EHR”) technology. Furthermore, capital capacity of hospitals and health systems may be reduced as a result of any credit market dislocations.

**Construction Risks.** Construction projects are subject to a variety of risks, including but not limited to delays in issuance of required building permits or other necessary approvals or permits, including environmental approvals, strikes, shortages of materials and labor, and adverse weather conditions. Such events could delay occupancy. Cost overruns may occur due to change orders, delays in the construction schedule, scarcity of building materials and labor and other factors. Cost overruns could cause the costs of any project to exceed available funds.

**New Programs and Services Risks.** Health care providers from time to time establish and provide new programs and services to meet present and emerging patient and community needs. Those new programs and services present risks, both financial and operational. The costs of establishing a new program or offering a new service may be substantial and the future revenues to be derived therefrom may be uncertain and may not result at levels or by dates budgeted or anticipated by management in its preliminary determinations regarding the feasibility thereof.

**Government Fraud Enforcement.** Fraud in government-funded health care programs is a significant concern of federal and state regulatory agencies overseeing health care programs and is one of the federal government’s prime law enforcement priorities. The federal government and, to a lesser degree, state governments impose a wide variety of extraordinarily complex and technical requirements intended to prevent over-utilization based on economic inducements, misallocation of expenses, overcharging and other forms of fraud in the Medicare and Medicaid programs, as well as other state and federally-funded health care programs. This body of regulation impacts a broad spectrum of hospital and other health care provider commercial activity, including billing, accounting, recordkeeping, medical staff oversight, physician contracting and recruiting, cost allocation, clinical trials, discounts and other functions and transactions.

Violations and alleged violations may be deliberate, but also frequently occur in circumstances where management is unaware of the conduct in question, as a result of mistake, or where the individual participants do not know that their conduct is in violation of law. Violations may occur and be prosecuted in circumstances that do not have the traditional elements of fraud, and enforcement actions may extend to conduct that occurred in the past. Violations carry significant sanctions. Both federal and state governments periodically conduct widespread investigations covering categories of services or certain accounting or billing practices.

The government and/or private “whistleblowers” often pursue aggressive investigative and enforcement actions. The government has a wide array of civil, criminal and monetary penalties, including withholding essential hospital and other health care provider payments from the Medicare or Medicaid programs, or exclusion from those programs. Aggressive investigation tactics, negative publicity and threatened penalties can be, and often are, used to force settlements, payment of fines and prospective restrictions that may have a materially adverse impact on hospital and other health care provider operations, financial condition, results of operations and reputation. Multi-million dollar fines and settlements are common. These risks are generally uninsured. Government enforcement and private whistleblower suits may increase in the hospital and health care sector. Many large hospital and other health care provider systems are likely to be adversely impacted.

**Personnel Shortage.** From time to time, shortages of physicians and nursing and other technical personnel occur, which may affect hospitals and health care systems. The COVID-19 pandemic exacerbated personnel shortages in health care. As reimbursement amounts are reduced to health care facilities and organizations that employ or contract with physicians, nurses and other health care professionals, pressure to control and possibly reduce wage and benefit costs may further strain the supply of those professionals. In California, regulation of nurse staff ratios can intensify the potential shortage of nursing personnel. In addition, shortages of other professional and technical staff such as pharmacists, therapists, laboratory technicians, billing coders and others may occur or worsen. A new influx of patients with insurance coverage, as a result of any health care reform initiatives, may exacerbate personnel shortage issues. Hospital operations, patient and physician satisfaction, financial condition and future growth could be negatively affected by physician and nursing and other technical personnel shortages, resulting in material adverse effect to hospitals and health care systems.

**Technical and Clinical Developments.** New clinical techniques and technology, as well as new pharmaceutical and genetic developments and products, may alter the course of medical diagnosis and treatment in ways that are currently unanticipated, and that may dramatically change medical and hospital care. These developments could result in higher costs, reductions in patient populations, lower utilization of hospital service and/or new sources of competition for hospitals.

**Costs and Restrictions from Governmental Regulation.** Nearly every aspect of hospital operation and health care delivery is regulated, in some cases by multiple governmental agencies. The level and complexity of regulation and compliance audits appear to be increasing, imposing greater operational limitations, higher staffing and training requirements, enforcement and liability risks, and significant and sometimes unanticipated costs.

**Proliferation of Competition.** Hospitals increasingly face competition from specialty providers of care and ambulatory care facilities. Such competition may cause hospitals to lose essential inpatient or outpatient market share. Competition may be focused on services or payor classifications where hospitals realize their highest margins, thus negatively affecting programs that are economically important to hospitals. Specialty hospitals may treat only profitable classifications of patients, leaving full-service hospitals with higher acuity and/or lower paying patient populations. These new sources of competition may have a material adverse impact on hospitals, particularly where principal physician admitters may curtail their use of a hospital service in favor of a competitor's facilities.

**Increasing Consumer Choice.** Hospitals and other health care providers face increased pressure to be transparent and provide information about cost and quality of services, which may lead to a loss of business as consumers and others make choices about where to receive health care services based upon published information.

**Labor Costs and Disruption.** The delivery of health care services is labor intensive. Labor costs, including salary, benefits and other liabilities associated with the workforce, have significant effects on hospital and health care provider operations and financial condition. Hospital and health care employees are increasingly organized in collective bargaining units and may be involved in work actions of various kinds, including work stoppages and strikes. Overall costs of the hospital workforce are high, and turnover is high. Pressure to recruit, train and retain qualified employees is expected to accelerate. These factors may materially increase hospital costs of operation. At the same time, health care organizations will be under increasing pressure to reduce the cost of delivering care to patients, including the cost of salary and benefits, in order to compete in a transparent price market. These factors may materially increase hospital costs of operation. Workforce disruption may negatively affect hospital revenues and reputation.

**Reliance on Medicare.** Inpatient hospitals rely to a high degree on payment from the federal Medicare program. Recent, as well as future, changes in the underlying law and regulations, as well as in payment policy and timing, create uncertainty and could have a material adverse impact on hospitals' payment stream from Medicare. With health care and hospital spending reported to be increasing faster than the rate of general inflation, Congress and/or CMS may take action in the future to decrease or restrain Medicare outlays for hospitals.

**State Medicaid Program.** Medi-Cal, California's Medicaid program, and other state health care programs are an important payor source for many hospitals and other health care providers and are likely to become a proportionately larger source of revenue as federal health care reform is implemented, expanding Medicaid coverage, in those states that choose to expand Medicaid, to significant numbers of uninsured Americans. These programs often pay hospitals and physicians at levels that may be below the actual cost of the care provided. As Medi-Cal and other State health care programs are partially funded by the State, the financial condition of the State may result in lower funding levels and/or payment delays in the future.

**General Economic Conditions; Bad Debt, Indigent Care and Investment Performance.** Hospitals and health care providers are economically influenced by the environment in which they operate. Any national, regional or local economic difficulties may constrain corporate and personal spending, limit the availability of credit and increase the national debt and federal and certain state government deficits. To the extent that unemployment rates are high, employers reduce their workforces and their budgets for employee health care coverage, or private and public insurers seek to reduce payments to health care providers or curb utilization of health care services, health care providers may experience decreases in insured patient volume, decreases in demands for services and

reductions in payments for services. In addition, to the extent that state, county or city governments are unable to provide a safety net of medical services, pressure is applied to local hospitals and health care providers to increase free care. Economic downturns and lower funding of federal Medicare and state Medicaid and other state health care programs may increase the number of patients who are unable to pay for some or all of their medical and hospital services. These conditions may give rise to increases in health care providers' uncollectible accounts, or "bad debt," uninsured discount and charity care and, consequently, to reductions in operating income. Declines in investment portfolio values may reduce or eliminate non-operating revenues. Investment losses (even if unrealized) may trigger debt covenant violations and may jeopardize hospitals' economic security. Losses in pension and other postretirement benefit funds may result in increased funding requirements for hospitals and health systems. Potential failure of lenders, insurers or vendors may negatively impact the results of operations and the overall financial condition of health care providers. Philanthropic support may also decrease or be delayed. These factors may have a material adverse impact on hospitals and health care providers.

***Pension and Benefit Funds.*** As large employers, hospitals may incur significant expenses to fund pension and benefit plans for employees and former employees, and to fund required workers' compensation benefits. Plans are often underfunded, or may become underfunded, and funding obligations in some cases may be erratic or unanticipated and may require significant commitments of available cash needed for other purposes.

***Medical Liability Litigation and Insurance.*** Medical liability litigation is subject to public policy determinations and legal and procedural rules that may be altered from time to time, with the result that the frequency and cost of such litigation, and resultant liabilities, may increase in the future. Hospitals may be affected by negative financial and liability impacts on physicians. Costs of insurance, including self-insurance, may increase dramatically.

***Facility Damage.*** Hospitals are highly dependent on the condition and functionality of their physical facilities. Damage from earthquakes, floods, fires, other natural causes, deliberate acts of destruction, or various facilities system failures may have a material adverse impact on hospital operations and financial condition.

***State Licensure and Regulation of Skilled Nursing Facilities.*** The operations of the District's skilled nursing facility is subject to numerous licensing, certification, accreditation, and other governmental requirements that are administered by a variety of federal and state governmental agencies as well as by self-regulatory associations and commercial medical insurance reimbursement programs. These include, but are not limited to, requirements relating to Medicare and Medicaid participation, accrediting organizations, state licensing agencies and private payors. Renewal and continuance of certain of these licenses, certifications, accreditations, and approvals are based upon inspections, surveys, audits, investigations or other review, some of which may require or include affirmative action or response by the District. An adverse determination could result in a loss, fine or reduction in the District's scope of licensure or certification, could adversely affect the District's ability to undertake certain expenditures, or could reduce the payment received or require the repayment of the amounts previously remitted. A pandemic or similar public health emergency may result in increased governmental inspection and survey activity or enhanced penalties. Management currently anticipates no difficulty in renewing or continuing the District's current licenses, accreditations, and certifications. It is impossible, however, to predict the effect of future regulation of the skilled nursing facility on the operations or financial condition of the District.

## **Federal Budget Cuts**

The Budget Control Act of 2011 set in place a capped 2% reduction in Medicare spending, among other reductions, which took effect in March 2013, resulting in Medicare payment reductions of up to 2% per fiscal year with a uniform percentage reduction across all Medicare programs. Subsequent legislation has extended this sequestration through fiscal year 2033. For fiscal year 2032, the payment reduction is 2.0% for the full fiscal year. For fiscal year 2033, the payment reduction is 2.0% for the first 5 months and 0% for the last 7 months. The CARES Act, as amended, temporarily suspended or limited the application of this sequestration from May 1, 2020 through June 30, 2022, with a return to the full 2% Medicare payment reduction thereafter.

Congress has not taken action to eliminate some or all of the reductions, but it is possible that Congress will take action to eliminate some or all of the reductions in the future and any Congressional action could be made

retroactive in order to eliminate some or all of the cuts even to the extent they were imposed. However, there is no certainty that Congress will take any action. Ultimately, these reductions or alternatives could have a disproportionate impact on hospital providers and could have a material adverse effect on the financial condition of the District.

### **Federal Funding Authorization and Priorities**

On March 15, 2025, President Trump signed the Full-Year Continuing Appropriations and Extension Act, which provided fiscal 2025 appropriations to Federal agencies through September 30, 2025, for continuing projects and activities of the federal government, along with certain disaster relief appropriations and economic assistance to farmers, and extended several expiring authorities. Due to the failure by Congress to enact appropriation legislation by October 1, 2025, the federal government experienced a 43-day partial shutdown from October 1, 2025 to November 12, 2025, during which time, certain “nonessential” government workers were furloughed and payments related to certain federal programs were not processed. On November 12, 2025, Congress enacted and the President signed a continuing resolution to provide current funding levels for most of the federal government through January 31, 2026, along with full year appropriation bills to fund the Departments of Agriculture and Veterans Affairs, as well as legislative operations, through September 30, 2026. On February 3, 2026, the President signed the Consolidated Appropriations Act, 2026, which, along with a short-term continuing resolution that provided funding for the Department of Homeland Security through February 13, 2026, ending a partial government shutdown that began on January 31, 2026. With the exception of the Department of Homeland Security, the federal government has appropriation funding authorization through the end of the current federal fiscal year that ends on September 30, 2026. Funding for the Department of Homeland Security expired on February 13, 2026, resulting in a partial shutdown of that Department that will last until additional Congressional action and Presidential approval for full funding is obtained. Ongoing funding of the federal government beyond the current authorizations will require additional Congressional action and Presidential approval.

Federal policies can shift dramatically from one administration to another. From time to time, such changes can result in substantial shifts in the level of federal funding for various policy priorities, leading to unpredictability in future federal funding. The evolving priorities and policies of the new executive administration may have a significant effect on the health care industry. As described above, proposed legislative and ongoing executive actions could lead to reduced federal funds otherwise available to health care providers, an increase in uninsured patients, and financial strain on health care providers, particularly those serving low-income populations. Federal funding decreases may occur in the near future or long-term and the impact any changes may have upon the District are unpredictable. If and to the extent Medicare, Medicaid, and/or other federal funding is reduced or ended, such action could have a material adverse effect upon the financial condition of the District, which is highly dependent on federal funding through reimbursement and grants.

### **OBBBA Recent Tax and Spending Federal Law and Other Present Federal Funding Action**

U.S. federal tax law and spending legislation titled the One Big Beautiful Bill Act (“OBBBA”) was passed by the U.S. Congress and signed into law by the U.S. President on July 4, 2025. OBBBA has widespread purposes and impacts, including extension of certain tax provisions of the Tax Cuts and Jobs Act, and certain proposed budget reconciliation spending offset provisions including, among others, changes to health program laws (Medicaid, Medicare, CHIP, ACA and others and their eligibility and funding), education laws, immigration laws, and food and nutrition program laws.

Because OBBBA was recently signed into law and its full impact cannot be ascertained, the District and other health sector participants continue evaluating its changes to existing law, especially provisions related to Medicaid (e.g., eligibility limits, community engagement/work requirements, enrollment changes, state provider tax restrictions, and funding cuts), Medicare, the ACA (e.g., marketplace changes) and immigration law. Many OBBBA provisions appear designed to eliminate or severely restrict eligibility of, and substantially reduce funding for, certain immigrant/noncitizen populations’ participation, benefits and services previously available under government health programs, including programs utilized by the District to provide health care to its patients. As another example, Medi-Cal (California’s Medicaid program), from which the District receives a portion of its funding, relies significantly on state provider taxes for funding and OBBBA’s limitations and reductions in such

taxes could cause Medi-Cal to further limit eligibility or limit or eliminate benefits or reduce provider payment rates to offset such funding reductions.

Immigrant coverage restrictions for Medi-Cal Expansion populations could also have a significant effect on the operations of the District. Under OBBBA only lawful permanent residents, some Cuban and Haitian nationals, and people residing in the U.S. under the Compact of Free Association (COFA) are eligible for Medicaid, CHIP, and ACA tax credits. Refugees, people granted asylum, and survivors of domestic violence and trafficking are other categories of non-citizens who are currently eligible for coverage but who will lose coverage under OBBBA. Other effects of OBBBA include Retroactive Coverage Restrictions that decrease retroactive Medicaid coverage from 3 months to 2 months for traditional beneficiaries and decreases retroactive Medicaid coverage from 3 months to 1 month for “expansion” populations. New Medicaid work requirements will also require 80 work or community service hours per month or enrollment in employment assistance or half-time enrollment in an educational program for Medicaid expansion beneficiaries who are between 19 and 65 years old. Regarding Medicare, while direct benefit reductions are limited, the bill delays implementation of Medicare Savings Programs (which help low-income beneficiaries pay premiums and cost-sharing) until 2035 and excludes certain immigrant populations, threatening access. A small 2.5% physician payment increase for 2026 provides temporary relief, but long-term uncertainty remains.

Until further analysis is made, the District is exercising caution in assessing its initial response to the impacts of OBBBA and other recent legislation. Initially, however, management of the District recognizes that provisions of OBBBA are likely to have significant potential to materially and adversely impact the health care sector generally, and the District and its operations, federal and state funding, financial condition, and patient care and services, particularly having the likelihood of limiting program and funding eligibility and services available for certain immigration/noncitizen status populations. The District is not yet able to fully predict such direct impacts or to quantify the financial magnitude to the District in the future, and believes that the current volume of demand for services by insured patients could absorb any losses that would otherwise occur, but investors considering purchasing the 2026 Bonds should carefully consider such risks of possible impacts and evaluate other publicly available information regarding OBBBA when making their decisions of whether to invest in the 2026 Bonds.

In addition to OBBBA, recent executive branch activity and orders have caused freezes and funding cuts to programs, grants and other federal funding awards, some of which have or could result in reduced availability of federal funding for the District. For example, Title X of the PHSA which provides federal funding for family planning services has recently been subject to funding freezes. Although to date such funding freezes and funding cuts have not directly impacted the District, no assurance can be given that other or similar actions and funding freezes will not occur in the future and such actions may adversely impact the District. Additionally, on July 10, 2025 the U.S. Department of Health and Human Services released a notice with a significant policy shift impacting eligibility for several federal programs, including the Health Center Program, by including such programs in the definition of “Federal public benefit” as used in Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (“**PRWORA**”), thereby making services subject to the PRWORA eligibility restrictions further limiting or precluding eligibility for services of individuals with certain immigration statuses. As with the OBBBA eligibility restrictions described above, the District is not yet able to fully predict the possible impacts of such policy shift.

### **Debt Limit Increase**

The federal government has through legislation created a debt “ceiling” or limit on the amount of debt that may be issued by the United States Treasury. In the past several years, political disputes have arisen within the federal government over whether to authorize further increases in the federal debt ceiling. Any failure by Congress to increase the federal debt limit may impact the federal government’s ability to incur additional debt, pay its existing debt instruments and to satisfy its obligations relating to the Medicare and Medicaid programs.

Management of the District is unable to determine at this time what impact any future failure to increase the federal debt limit may have on the operations and financial condition of the District, although such impact may be material. Additionally, the market price or marketability of the 2026 Bonds in the secondary market may be materially adversely impacted by any failure to increase the federal debt limit.

## Patient Service Revenues

***The Medicare Program.*** Medicare is the federal health insurance system under which health care providers are paid for health care services. Under Part A of the Medicare program, hospitals receive payments for services provided to eligible senior and disabled persons or those who qualify under the End Stage Renal Disease Program. Medicare is administered by CMS, which delegates to the states the process for certifying hospitals to which CMS will make payment. In order to achieve and maintain Medicare certification, hospitals must meet CMS's "Conditions of Participation" on an ongoing basis, as determined by the hospital's state survey agency and/or CMS, and comply with the standards of The Joint Commission or other CMS-approved accrediting organization. The requirements for Medicare certification are subject to change and, therefore, it may be necessary for hospitals to effect changes from time to time in their facilities, equipment, personnel, billing, policies and services to ensure continued compliance. The District is certified to participate in the Medicare program.

As the population ages, more people will become eligible for the Medicare program. Current projections indicate that demographic changes and continuation of current cost trends will exert significant and negative forces on the overall federal budget. Part A of the Medicare program reimburses hospitals based on a fixed schedule of rates based on categories of treatments or conditions. These rates change over time and there is no assurance that these rates will cover the actual costs of providing services to Medicare patients. The ACA institutes multiple mechanisms for reducing the rate of increase in the costs of the Medicare program, including the following:

***Value-Based Purchasing Program.*** Medicare inpatient payments to hospitals are determined, in part, based on a program under which value-based incentive payments are made in a fiscal year to hospitals that meet certain performance standards during that fiscal year. The program is funded through the reduction of hospital inpatient care payments. Hospitals that perform poorly under the value-based purchasing program will receive reduced Medicare inpatient hospital payments. This reduction may be offset by incentive payments for hospitals that meet or exceed quality standards. In each federal fiscal year, the total amount collected from these reductions will be pooled and used to fund payments to reward hospitals that meet certain quality performance standards established by DHHS.

***Market Basket Reductions.*** Generally, Medicare payment rates to hospitals are adjusted annually based on a "market basket" of estimated cost increases. In recent years, market basket adjustments for inpatient hospital care have averaged approximately 2% to 4% annually. The ACA provides for "market basket" adjustments based on overall national economic productivity statistics calculated by the Bureau of Labor Statistics. The market basket updates, and the productivity adjustments, may not reflect the increased cost of providing hospital services and, therefore, have had, and will continue to have, a disproportionately negative effect upon those providers that are relatively more dependent upon Medicare than other providers. The combination of reduced market basket updates and the imposition of the productivity adjustments may result in reductions in Medicare payment per discharge on a year-to-year basis. The reductions in market basket updates and the productivity adjustments will have a disproportionately negative effect upon those providers that are relatively more dependent upon Medicare than other providers.

***Market Productivity Adjustments.*** In federal fiscal year 2012 and thereafter, the ACA provides for "market basket" adjustments based on overall national economic productivity statistics calculated by the Bureau of Labor Statistics. This adjustment is currently anticipated to result in an approximately 0.3% additional reduction to the annual "market basket" update.

***Hospital-Acquired Conditions Penalty.*** Medicare inpatient payments to hospitals that are in the top quartile nationally for frequency of certain HACs identified by CMS are reduced by 1% of what would otherwise be payable to each hospital for the applicable federal fiscal year.

***Readmission Rate Penalty.*** Medicare inpatient payments to those hospitals with excess readmissions compared to the national average for specified conditions/procedures (*i.e.*, acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, coronary artery bypass graft, and total hip arthroplasty/total knee arthroplasty) are reduced based on the dollar value of that hospital's

percentage of excess preventable Medicare readmissions within 30 days of discharge for such medical conditions. Hospital performance is assessed separately for each measure. The current maximum penalty is 3%. It is expected that CMS will continue to expand and refine the patient conditions that can lead to readmission payment adjustments.

**Medicare/Medicaid DSH Payments.** The ACA provided that, beginning in federal fiscal year 2014, hospitals receiving supplemental disproportionate share hospital (“**DSH**”) payments from Medicare (i.e., those hospitals that care for a disproportionate share of low-income Medicare beneficiaries) would see their DSH payments reduced significantly. This reduction potentially would be offset by new, additional payments based on the volume of uninsured and uncompensated care provided by each such hospital, and is anticipated to be offset by a higher proportion of covered patients, if all other provisions of the ACA go into effect. Commencing in federal fiscal year 2024, and through 2028, a state’s Medicaid DSH allotment from federal funds will be reduced. Such reductions have been delayed several times, most recently under the Consolidated Appropriations Act, 2021. During the reduction period, state Medicaid DSH allotments from federal funds will be reduced by \$8 billion annually. Reductions are imposed on states based on percentage of uninsured individuals, Medicaid utilization, and uncompensated care. See also “– **Disproportionate Share Payments**” below.

**Medicare Advantage.** Hospitals also receive payments from health plans under the Medicare Advantage program. Medicare Advantage is the managed option for Medicare beneficiaries. Federal policymakers have been attentive to the cost of the Medicare Advantage program, relative to traditional fee-for-service Medicare, and fluctuations in Medicare Advantage payments by the federal government are common, which may result in increased premiums or out-of-pocket costs to Medicare beneficiaries enrolled in Medicare Advantage plans. Those beneficiaries may terminate their participation in those plans and opt for the traditional Medicare fee-for-service program. The reduction in payments to Medicare Advantage programs may also lead to decreased payments to providers by managed care companies operating Medicare Advantage programs, depending on the contractual arrangement between the Medicare Advantage program and the provider. All or any of these outcomes could have a disproportionately negative effect upon those providers with relatively high dependence on Medicare Advantage program revenues.

See **APPENDIX A – “INFORMATION CONCERNING THE DISTRICT – THE HEALTH FACILITIES – Source of Patient Service Revenues”** for the percentage of the District’s gross patient service revenues received from Medicare.

**Hospital Inpatient Reimbursement.** Hospitals generally are paid for inpatient services rendered to Medicare beneficiaries under the inpatient prospective payment system (“**IPPS**”). Under the IPPS, for each covered hospitalization, Medicare pays a predetermined base operating payment and a separate predetermined base payment for capital-related costs. Hospitals are generally paid for inpatient services provided to Medicare beneficiaries based on established categories of treatments or conditions, each known as a diagnosis related group (“**DRG**”). Each DRG has its own predetermined rate, which, in the case of the service component, is based upon the national average costs to care for patients for the specific DRG, adjusted for geographic wage differences and, in the case of the capital component, at a per-case federal rate, adjusted for limited hospital-specific characteristics. The actual cost of care, including capital costs, may be more or less than the DRG rate. DRG rates are subject to adjustment by CMS, including reductions mandated by the ACA and the BCA, and are further subject to federal budget considerations. There is no guarantee that DRG rates, as they change from time to time, will cover actual costs of providing services to Medicare patients. For information regarding the impact of the ACA on payments to hospitals for inpatient services, see “– **The Medicare Program**” and “– Market Basket Reductions” above.

**Medicare Bad Debt Reimbursement.** Under Medicare, the costs attributable to the deductible and coinsurance amounts which remain unpaid by the Medicare beneficiary can be added to the Medicare share of allowable costs as cost reports are filed. Hospitals generally receive interim pass-through payments during the cost report year which were determined by the Medicare Administrative Contractor (“**MAC**”) from the prior cost report filing. Bad debts must meet the following criteria to be allowable:

- the debt must be related to covered services and derived from deductible and coinsurance amounts;
- the provider must be able to establish that reasonable collection efforts were made;
- the debt was actually uncollectible when claimed as worthless; and
- sound business judgment established that there was no likelihood of recovery at any time in the future.

The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be uncollectible. In some cases, an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period. In these cases, the recoveries must be used to reduce the cost of beneficiary services for the period in which the collection is made. In determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs is reduced by 35%. Amounts incurred by a hospital as reimbursement for bad debts are subject to audit and recoupment by the MAC. Bad debt reimbursement has been a focus of MAC audit/recoupment efforts in the past.

**Hospital Outpatient Reimbursement.** Hospitals are generally paid for outpatient services provided to Medicare beneficiaries based on established categories of treatments or conditions, each known as ambulatory payment classification (“APC”). The actual cost of care, including capital costs, may be more or less than the Medicare reimbursements. Generally, Medicare payment rates to hospitals for outpatient hospital services are adjusted annually based on estimated cost increases and other factors, including productivity and budget neutrality adjustments. These adjustments are typically positive, and often range from 0.5% to 2.5%. However, occasionally, because of statutory formulas and other legislative and administrative actions, these adjustments can be negative, and Medicare payments to hospitals can be reduced as a result. Moreover, Congress often takes action to specify payment update reductions, which can have the effect of constraining or reducing hospital payments. There is no guarantee that APC rates, as they change from time to time, will cover actual costs of providing services to Medicare patients.

**Price Transparency.** On January 1, 2021, the CMS Price Transparency Rule (the “**Price Transparency Rule**”) went into effect, requiring hospitals to publish gross charges, discounted cash prices, payor-specific negotiated charges, and minimum and maximum negotiated charges for all items and services provided by the hospital. Hospitals are also required to publish a consumer-friendly list of standard charges for at least 300 shoppable services – generally, non-emergency services that patients can schedule in advance. Failure to comply with these requirements may result in daily monetary penalties to the hospital. Initially, the penalty for noncompliance by a hospital was a maximum of \$109,500 annually. However, the Biden administration, in response to widespread noncompliance with the Price Transparency Rule, finalized a rule change in 2022 that increased the maximum penalty for hospitals with over 550 beds to \$2,007,500, and for hospitals with a range of 31 beds through 549 beds, a civil monetary penalty of \$10 per bed per day, with the total maximum penalty being just under \$2 million. The Price Transparency Rule could result in further legislative or regulatory action to restrain hospital rates or charges. Additionally, the availability of competitively sensitive rate information among hospitals, insurers, and employer sponsors of group health plans could lead to market distortions and possible anti-competitive effects that could affect hospital rates and revenue. The publication of hospital standard charges, including negotiated charges, could also result in changes to patient choice that may negatively affect the District. Accordingly, compliance with the Price Transparency Rule could have a material adverse effect upon the future financial condition and operations of the District.

The “No Surprises Act” was passed as part of the omnibus bill on December 27, 2020, to address costly bills patients may receive after unknowingly receiving out-of-network care. The No Surprises Act requires that health plans hold patients harmless from surprise bills, requiring individuals to pay only the in-network cost-sharing amount for out-of-network emergency care, ancillary services provided at in-network facilities by out-of-network providers, and out-of-network care provided at in-network facilities without a patient’s informed consent. The law provides for a 30-day negotiation period for providers and payers to settle out-of-network claims. If no agreement is reached after this period, either party may opt for a binding independent dispute resolution process. In addition,

the No Surprises Act includes transparency requirements for health plans to communicate in-network and out-of-network deductibles, as well as out-of-pocket caps. The statute also includes language requiring health plans to have publicly available, online, and up-to-date directories for their in-network providers and to offer a price comparison tool for consumers.

To the extent the provisions of the ACA produce the intended result, an increase in utilization of health care services by those who are currently avoiding or rationing their health care can be expected. Bad debt expenses may be reduced because reimbursement for otherwise uncompensated care will be received; however, the net impact of such an increase in utilization of health care services is difficult to predict, due to the rates of reimbursement under the Medicaid and Medicare programs, which could be further reduced. Associated with increased utilization will be increased variable and fixed costs of providing health care services, which may or may not be offset by increased revenues, and a risk of physician shortages, especially in specialties necessary to provide critical intervention or chronic disease management (*e.g.*, primary care).

**Off-Campus Provider-Based Departments.** Beginning January 1, 2017, under provisions of the Bipartisan Budget Act of 2015, and regulations proposed by CMS, most new off-campus hospital outpatient departments (“**HOPDs**”) and services that first billed Medicare as a hospital service on or after November 2, 2015, are no longer eligible for payment under the OPPTS for non-emergency services. A hospital outpatient department is considered to be “off-campus” if it is located more than 250 yards from a main provider hospital or a remote location of a hospital. Instead, non-emergency services performed at these facilities will be paid under the Medicare Physician Fee Schedule (“**PFS**”) at a set of PFS payment rates that are specific to hospitals. Effective January 1, 2018, these hospital specific PFS rates are based on 40% of the comparable OPPTS rate. Beginning January 1, 2019, CMS began applying the PFS equivalent pay rate for certain evaluation and management services when provided at an off-campus HOPD that is paid under the OPPTS, including at those HOPDs grandfathered under Bipartisan Budget Act of 2015, stepping down from 70% of OPPTS rates in 2019 and 40% of OPPTS rates in 2020 and thereafter.

**Medicare Physician Payment.** In April 2015, the Medicare and CHIP Reauthorization Act (“**MACRA**”) established the Quality Payment Program (“**QPP**”), which repealed the sustainable growth rate methodology for updates to the Medicare PFS, changed the way that Medicare rewards clinicians for services, streamlined existing quality and value programs, and provided for bonus payments to physicians and other clinicians for participating in certain payment models. The QPP provides incentive payments to eligible clinicians participating in Medicare Part B through two tracks: the Merit-based Incentive Payment System (“**MIPS**”) and Advanced Alternative Payment Models (“**Advanced APMs**”). In calculating physician payment adjustments, MIPS streamlines existing quality and value programs, accounting for physician performance under the meaningful use of electronic health records incentive program, the value-based modifier, and physician quality reporting system. Payments to physicians participating in APMs similarly account for performance under such programs. Beginning January 1, 2026, and effective January 1 of each subsequent calendar year, physician payments will be increased 0.75% for physicians who adequately participate in APMs, and 0.25% for those in MIPS. 2017 was the first MIPS performance period and 2019 was the first year Part B payment adjustments were applied for eligible clinicians. The outcomes of these programs, including the likelihood of being revised or expanded or their effect on health care organization revenues or financial performance cannot be predicted, and it remains unclear what effect this legislation will have on the District. For example, these programs may encourage more physicians to retire or not accept Medicare (or only accept Medicare Advantage). Alternatively, or in addition to other externalities of the implementation of these programs, increased focus and performance scoring on resource use may affect utilization of health care resources across the District. Furthermore, implementation of a quality payment system will likely require regular reporting to CMS and greater internal resources to monitor performance and prevent payment reductions.

**Other Medicare Service Payments.** Medicare payments for skilled nursing services, psychiatric services, inpatient rehabilitation services, general outpatient services and home health services are based on regulatory formulas or pre-determined rates. There is no guarantee that these rates, as they may change from time to time, will be adequate to cover the actual cost of providing these services to Medicare patients.

**Reimbursement of Hospital Capital Costs.** Hospital capital costs apportioned to Medicare patient use (including depreciation and interest) are paid by Medicare on the basis of a standard federal rate (based upon average national costs of capital), subject to limited adjustments specific to the hospital. There can be no assurance

that future capital-related payments will be sufficient to cover the actual capital-related costs of the Facilities applicable to Medicare patient stays or will provide flexibility for hospitals to meet changing capital needs.

**Recovery Audit Contractor Program.** CMS implemented a Recovery Audit Contractor (“**RAC**”) program on a nationwide basis pursuant to which CMS contracts with private contractors to conduct pre-and post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program. The ACA expanded the RAC program’s scope to include managed Medicare plans and Medicaid claims. CMS also employs Medicaid Integrity Contractors to perform post-payment audits of Medicaid claims and identify overpayments. These programs tend to result in retroactively reduced payment and higher administration costs to hospitals. See “**Regulatory Environment – Medicare and Medicaid Audits**” below.

**Medicaid Program.** Medicaid is a program of medical assistance, funded jointly by the federal government and the states, for certain needy individuals and their dependents. Under Medicaid, the federal government provides limited funding to states that have medical assistance programs that meet federal standards. The ACA provides significantly enhanced federal funding for states to expand their Medicaid program to virtually all non-elderly, non-disabled adults with incomes up to 133% of the federal poverty level. Further attempts to balance or reduce the federal budget, along with balanced-budget requirements in the State, will likely negatively impact Medicaid funding. Payments made to health care providers under the Medicaid program are also subject to change as a result of federal or state legislative and administrative actions, including changes in the methods for calculating payments, the amount of payments that will be made for covered services, the eligibility requirements for Medicaid coverage, and the types of services that will be covered under the program. Such changes have occurred in the past and may be expected to occur in the future, particularly in response to federal and state budgetary constraints and increased fiscal pressure on the Medicaid program in periods of high unemployment. Under the Social Security Act, CMS has granted, and may grant in the future, additional Section 1115 demonstration waivers providing for work and community engagement requirements as a condition of eligibility for certain Medicaid-eligible individuals. It is anticipated this will lead to reductions in coverage, and likely increases in uncompensated care, in states where these demonstration waivers are granted. Reduction in coverage of persons under Medicaid, by changes in the poverty level threshold required for eligibility or otherwise, to eliminate groups of currently eligible California residents, could increase the number of uninsured persons treated by health care providers and increase the risk of unreimbursed expenses.

**Medi-Cal Program.** Medi-Cal is the California Medicaid program. The State has traditionally lagged behind other states in the amounts it pays to providers. The Medi-Cal program operates under two primary care delivery models: Fee-For-Service (“**FFS**”) Medi-Cal and Medi-Cal Managed Care. In the FFS Medi-Cal model, health care providers are reimbursed through a Medi-Cal Fiscal Intermediary. In the Medi-Cal Managed Care model, the California Department of Health Care Services (“**DHCS**”) contracts with health insurance organizations to provide services to groups of Medi-Cal eligible persons in specific counties. Benefits paid under the Medi-Cal Managed Care plan vary by contract, and any non-covered managed care services are paid through the FFS Medi-Cal delivery model. Specialty Medi-Cal programs such as Mental Health, Developmental Services and Personal Care Services are administered through other state departments. In 2022, approximately 13 million Medi-Cal beneficiaries received coverage from managed care plans or traditional fee-for-service programs. During the COVID-19 public health emergency, the California DHCS delayed the processing of Medi-Cal annual redeterminations and delayed discontinuances and negative actions for Medi-Cal and other state and county healthcare programs. DHCS has resumed redeterminations, which may cause some of our patients to lose their coverage.

At this time, a significant amount of legislation regarding Medi-Cal has been proposed and management is unable to determine the impact that such legislation may have on the financial condition of the District.

See **APPENDIX A – “INFORMATION CONCERNING THE DISTRICT – THE HEALTH FACILITIES – Source of Patient Service Revenues”** for the percentage of the District’s gross patient service revenues received from Medi-Cal.

**California Hospital Provider Fee Program.** In 2009, the State legislature enacted the Medi-Cal Hospital Provider Rate Stabilization Act and the Quality Assurance Fee Act, which imposed a “quality assurance fee” on

California's general acute care hospitals, as a condition for participation in the Medi-Cal program, except for public hospitals and certain exempt hospitals. The Medi-Cal Hospital Provider Rate Stabilization Act and the Quality Assurance Fee Act governs supplemental payments made to providers from the fund established to accumulate the quality assurance fees and matching federal funds. The quality assurance fee ("**QAF**") is an assessment on hospitals to raise funds for provider payments. The proceeds are used to earn federal matching funds for Medi-Cal, and to increase Medi-Cal payments to hospitals. Under this program, some California hospitals receive more funding in increased Medi-Cal reimbursement than the quality assurance fees paid, while other California hospitals receive less money in Medi-Cal payments than the fees paid. The California Medi-Cal Hospital Reimbursement Initiative, or Proposition 52, which passed in November 2016, extended the hospital fee program indefinitely and put projections in place to prevent diversion of funds from the program. CMS issued formal approval of the 2019–21 Hospital Fee Program in February 2020 retroactive to July 1, 2019 and effective through December 31, 2021. On September 29, 2022, CMS approved a new 12-month extension of the Hospital Fee Program effective January 1, 2022. Delays in State or CMS approval could have adverse effects on the financial condition of the District. Because it operates a "public hospital," the District is exempt from making payments under the Provider Fee program.

***Disproportionate Share Payments.*** The federal Medicare and the State Medi-Cal programs each provide additional payment for hospitals that serve a disproportionate share of certain low-income patients. The District currently qualifies as a disproportionate share hospital under the Medi-Cal program. The ACA substantially reduces Medicare and Medicaid payments to disproportionate share hospitals. See also "*– Medicare/Medicaid DSH Payments*" above.

***Health Plans and Managed Care.*** Most private health insurance coverage is provided by various types of "managed care" plans, including health maintenance organizations ("**HMOs**") and preferred provider organizations ("**PPOs**") that generally use discounts and other economic incentives to reduce or limit the cost and utilization of health care services. Medicare and Medicaid also purchase hospital care using managed care options. Payments to hospitals from managed care plans typically are lower than those received from traditional indemnity or commercial insurers.

In California, managed care plans have replaced indemnity insurance as the primary source of non-governmental payment for hospital services, and hospitals must be capable of attracting and maintaining managed care business, often on a regional basis. Regional coverage and aggressive pricing may be required. However, it is also essential that contracting hospitals be able to provide the contracted services without significant operating losses, which may require multiple forms of cost containment.

Many HMOs and PPOs currently pay providers on a negotiated fee-for-service basis, on a fixed rate per day of care or on a fixed-rate per hospital stay, which, in each case, usually is discounted from the usual and customary charges for the care provided. As a result, the discounts offered to HMOs and PPOs may result in payment to a provider that is less than its actual cost. Additionally, the volume of patients directed to a provider may vary significantly from projections, and/or changes in the utilization may be dramatic and unexpected, thus jeopardizing the provider's ability to manage this component of revenue and cost.

Some HMOs employ a "capitation" payment method under which hospitals are paid a predetermined periodic rate for each enrollee in the HMO who is "assigned" or otherwise directed to receive care at a particular hospital. The hospital may assume financial risk for the cost and scope of institutional care given. If payment is insufficient to meet the hospital's actual costs of care, or if utilization by such enrollees materially exceeds projections, the financial condition of the hospital could erode rapidly and significantly. In addition to this standard managed care risk sharing approach, private health insurance companies are increasingly adopting various additional risk sharing/cost containing measures, sometimes similar to those introduced by government payors. Providers may expect health care cost containment and its associated risk sharing to continue to increase in the coming years among all payors.

Often, HMO contracts are enforceable for a stated term, regardless of hospital losses and may require hospitals to care for enrollees for a certain time period, regardless of whether the HMO is able to pay the hospital. Hospitals from time to time have disputes with HMOs, PPOs and other managed care payors concerning payment and contract interpretation issues. Such disputes may result in mediation, arbitration or litigation.

Failure to maintain contracts could have the effect of reducing a hospital's market share and net patient services revenues. Conversely, participation may result in lower net income if participating hospitals are unable to adequately contain their costs. In part to reduce costs, health plans are increasingly implementing, and offering to purchasing employers, tiered provider networks, which involve classification of a plan's network providers into different tiers based on care quality and cost. With tiered benefit designs, plan enrollees are generally encouraged, through incentives or reductions in copayments or deductibles, to seek care from providers in the top tier. Classification of a hospital in a non-preferred or lower tier by a significant payor may result in a material loss of volume. The new demands of dominant health plans and other shifts in the managed care industry may also reduce patient volume and revenue. Thus, managed care poses one of the most significant business risks (and opportunities) that health care organizations face.

In addition to tiered provider networks, managed care plans have implemented narrow provider networks in which only a select group of providers participate as in-network providers. Managed care plans often look at quality performance and cost in selecting providers to participate in their narrow networks. A provider's exclusion from a narrow network may result in a material loss of volume. Managed care plans may offer lower reimbursement for providers in their narrow network(s) in exchange for additional volume expected from being one of a select group of network providers. This reimbursement may be insufficient to cover a network provider's cost in providing the services. The new demands of dominant health plans and other shifts in the managed care industry may also reduce patient volume and revenue. Thus, managed care poses one of the most significant business risks (and opportunities) that health care organizations face.

In addition, the current trend of consolidation in the health care industry is likely to increase the leverage of commercial insurers when negotiating rates with health care providers. Large health insurers that assume dominant positions in local markets threaten to increase health insurer concentration, reduce competition and decrease choice. If the District were to terminate its agreement with any of the major managed care payors or reject terms proposed by such payors, it could have a significant material adverse impact on the financial condition of the District.

With implementation of the ACA, substantial numbers of individuals chose health insurance under the health insurance exchanges, increasing the number of individuals covered in the individual market. Individuals choosing their own coverage may be highly price sensitive, which could increase the number of enrollees in plans with narrow provider networks, increasing the use of capitation, and making price negotiations with HMO and other insurance plans more difficult.

See **APPENDIX A – "INFORMATION CONCERNING THE DISTRICT – THE HEALTH FACILITIES – Source of Patient Service Revenues"** for the percentage of the District's gross patient service revenues received from managed care, insurance and other payments.

***Negative Rankings Based on Clinical Outcomes, Cost, Quality, Patient Satisfaction and Other Performance Measures.*** Health plans, Medicare, Medicaid, employers, trade groups and other purchasers of health services, private standard-setting organizations and accrediting agencies increasingly are using statistical and other measures in efforts to characterize, publicize, compare, rank and change the quality, safety and cost of health care services provided by hospitals and health care providers. The ACA shifted payments from paying for volume to paying for value, based on various health outcome measures. Published rankings such as "score cards," "pay for performance" and other financial and non-financial incentive programs are being introduced to affect the reputation and revenue of hospitals, the members of their medical staffs and other providers and to influence the behavior of consumers and providers. Currently prevalent are measures of quality based on clinical outcomes of patient care, reduction in costs, patient satisfaction and investment in health information technology. Measures of performance that are set by others and that characterize a hospital or a health care provider negatively may adversely affect its reputation and financial condition.

***340B Drug Pricing Program.*** Hospitals that participate in the prescription drug discount program established under Section 340B of the federal Public Health Service Act (the "**340B Program**") are able to purchase certain outpatient prescription drugs for their patients at a reduced cost. The rules and regulations applicable to participation in the 340B Program are technical, complex, numerous and may not fully be understood or implemented by billing or reporting personnel. Failure to comply with the 340B Program requirements or rules

could result in exclusion from the 340B Program thus significantly increasing costs for drugs as well as creating a repayment obligation, which in either case could have a material adverse effect on the operations or financial condition of the District. The 340B Program has been a topic of controversy and litigation among pharmaceutical companies, participating health providers, state governments and others. Judicial rulings may in the future limit or adversely impact the program.

## **Regulatory Environment**

**“Fraud” and “False Claims”.** Health care “fraud and abuse” laws at the federal and state levels broadly regulate providers of services to government program beneficiaries and the methods and requirements for submitting claims for services rendered. Hospitals and others can be penalized for a wide variety of conduct, including submitting claims for services that are not provided, billing in a manner that does not comply with government requirements or including inaccurate billing information, billing for services deemed to be medically unnecessary, or billings accompanied by certain proscribed inducements to utilize or refrain from utilizing a service or product.

Federal and state governments have a broad range of criminal, civil and administrative sanctions available to penalize and remediate health care fraud, including the exclusion of a hospital from participation in the Medicare/Medicaid programs, civil monetary penalties, and suspension of Medicare/Medicaid payments. Fraud and abuse cases may be prosecuted by one or more government entities and private individuals, and more than one of the available sanctions may be, and often are, imposed for each violation. The ACA authorizes the Secretary of DHHS to exclude a provider’s participation in Medicare and Medicaid, as well as suspend payments to a provider pending an investigation or prosecution of a credible allegation of fraud against the provider.

The Health Insurance Portability and Accountability Act of 1996 (“**HIPAA**”) added additional criminal sanctions for health care fraud and applies to all health care benefit programs, whether public or private. HIPAA also provides for punishment of a health care provider for knowingly and willfully embezzling, stealing, converting or intentionally misapplying any money, funds, or other assets of a health care benefit program. A health care provider convicted of health care fraud could be subject to mandatory exclusion from Medicare.

Laws governing fraud and abuse may apply to a hospital and to nearly all individuals and entities with which a hospital does business. Fraud investigations, settlements, prosecutions and related publicity can have a material adverse effect on hospitals. See “**Enforcement Activity**” below. Major elements of these often highly technical laws and regulations are generally summarized below.

**False Claims Act.** The federal False Claims Act (the “**FCA**”) makes it illegal to knowingly submit or present a false, fictitious or fraudulent claim for payment or approval for which the federal government provides, or reimburses at least some portion of, the requested money or property. A person may be charged with knowledge of the falsity of a claim based not only on actual knowledge but also based on deliberate ignorance or reckless disregard of the relevant facts. The FCA has become one of the federal government’s primary weapons against health care fraud. Due to the broad range of conduct covered by the statute, FCA investigations and cases have become common in the health care field and may cover a range of activity from submission of intentionally inflated billings, to highly technical billing infractions, to allegations of inadequate care. Penalties under the FCA are severe and may include damages equal to three times the amount of the alleged false claims, as well as substantial civil monetary penalties. As a result, violation or alleged violation of the FCA frequently results in settlements that require multi-million dollar payments and costly corporate integrity agreements. In June 2016, the DOJ issued a rule that more than doubled civil monetary penalties under the FCA, which are subsequently adjusted for inflation on an annual basis. The penalty range significantly increases the potential financial exposure resulting from an FCA violation. As a result, violation or alleged violations of the FCA frequently result in settlements involving multi-million dollar payments and compliance agreements.

The FCA also permits individuals to initiate civil actions on behalf of the government in lawsuits called “*qui tam*” actions. *Qui tam* plaintiffs, or “whistleblowers,” can share in the damages recovered by the government. FCA violations or alleged violations could lead to settlements, fines, exclusion or reputation damage that could have a material adverse impact on hospitals and other health care providers. In June 2016, the U.S. Supreme Court announced its decision in *Universal Health Services, Inc. v. United States ex. Rel. Escobar*, No. 15–7 (U.S. June 16,

2016). Prior to *Escobar*, lower courts had split on the issue of whether the FCA extended to so-called “implied certification” of compliance with laws, and whether such compliance was limited to express conditions of payment or extended to conditions of participation. The Supreme Court affirmed the theory of “implied certification” and rejected the distinction between conditions of payment and conditions of participation for these purposes, ruling that the relevant inquiry is whether the alleged noncompliance, if known to the government, would have in fact been material to the government’s determination as to whether to pay the claim. There is considerable uncertainty as to the application of the *Escobar* holding and lower courts remain split in their interpretation but depending on how it is interpreted by the lower courts, it could result in an expanded scope of potential FCA liability for noncompliance with applicable laws, regulations and sub-regulatory guidance. It is anticipated that these questions will again reach the U.S. Supreme Court.

Under the ACA, the FCA has been expanded to include overpayments that are identified by a health care provider and not timely reported or refunded to the applicable federal health care program, even if the claims relating to the overpayment were initially submitted without any knowledge that they were false. The 2016 Medicare Overpayments Final Rule, which took effect on March 14, 2016 (the “**Final Rule**”), requires that providers report and return identified overpayments by the later of 60 days after identification, or the date the corresponding cost report is due, if applicable. If the overpayment is not reported and returned as described, it becomes an “obligation” under the FCA. This expansion of the FCA exposes hospitals and other health care providers to liability under the FCA for a considerably broader range of claims than in the past. CMS clarified that the 60-day timeframe for report and return begins when either reasonable diligence is completed (including determination of the overpayment amount) or on the day the person received credible information of a potential overpayment (if the person failed to conduct reasonable diligence and the person in fact received an overpayment). Failure to report and return overpayments as described herein may result in false claims liability. That same Final Rule also established a six-year lookback period, meaning that providers have the obligation to evaluate potential overpayments dating back six years from the point of discovery. In December 2022, CMS proposed to change the standard for identification and instead would require the report and return of an overpayment if a provider or supplier has actual knowledge of the existence of an overpayment or acts in reckless disregard or deliberate ignorance of an overpayment. While CMS has not finalized this policy, whether CMS will ultimately implement the December 2022 revisions to the Final Rule as proposed cannot be predicted, nor can any potential impact on the District.

**Anti-Kickback Law.** The federal “Anti-Kickback Law” is a statute with both civil and criminal liability, that prohibits anyone from soliciting, receiving, offering or paying any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, in return for referral of a patient (or to induce a referral) for or the ordering or recommending of the purchase (or lease) of any item or service that is paid by any federal or state health care program. This prohibition has been broadly applied by the courts. The Anti-Kickback Law potentially applies to many common health care transactions between persons and entities with which a hospital does business, including hospital-physician joint ventures, medical director arrangements, physician recruitments, physician office leases and other transactions with persons or entities in a position to provide federal health care program business to hospitals. The ACA amended the Anti-Kickback Law to provide explicitly that a claim that includes items or services resulting from a violation of the Anti-Kickback Law constitutes a false or fraudulent claim for purposes of the FCA. Another amendment provides that an Anti-Kickback Law violation may be established without showing that an individual knew of the statute’s proscriptions or acted with specific intent to violate the Anti-Kickback Law, but only that the conduct was generally wrongful.

Violations or alleged violations of the Anti-Kickback Law may result in settlements that require multi-million dollar payments and onerous corporate integrity agreements. The Anti-Kickback Law can be prosecuted either criminally or civilly. A criminal violation may be prosecuted as a felony, subject to significant fines for each act (which may be each item or each bill sent to a federal program), imprisonment and/or exclusion from the Medicare and Medicaid programs, any of which would have a significant detrimental effect on the financial stability of most hospitals. Civil monetary penalties and administrative sanctions for violating the Anti-Kickback Statute include substantial fines per kickback plus monetary penalties up to three times the amount of damages sustained by government, jail terms, and exclusion from participation in the federal health care programs. Increasingly, the federal government and *qui tam* relators are prosecuting violations of the Anti-Kickback Statute under the FCA, based on the argument that claims resulting from an illegal kickback arrangement are also false claims for FCA purposes.

***Stark Referral Law.*** The federal “Stark Law” prohibits the referral by a physician of Medicare and Medicaid patients for certain designated health services (including inpatient and outpatient hospital services, clinical laboratory services, and radiation therapy services, radiology and certain other imaging services) to entities with which the referring physician has a financial relationship unless that relationship fits within a Stark exception. It also prohibits a hospital furnishing the designated services from billing Medicare, or any other payor or individual for services performed pursuant to a prohibited referral. The government does not need to prove that the entity knew that the referral was prohibited to establish a Stark Law violation. If certain substantive and technical requirements of an applicable exception are not satisfied, many ordinary business practices and economically desirable arrangements between hospitals and physicians, which constitute “financial relationships” within the meaning of the Stark Law, result in the prohibition on referrals and billing. While failure to comply with the safe harbors under the Anti-Kickback Statute does not necessarily result in violation of the statute, an arrangement must comply with every requirement of a Stark Law exception or the arrangement is in violation of the Stark Law. Most providers of the designated health services with physician relationships have exposure to liability under the Stark Law.

Medicare may deny payment for all services performed based on a prohibited referral and a hospital that has billed for prohibited services may be obligated to refund the amounts collected from the Medicare program or to make a self-disclosure to CMS under its Self-Referral Disclosure Protocol (“**SRDP**”). For example, if an office lease between a hospital and a large group of heart surgeons is found to violate Stark, the hospital could be obligated to repay CMS for the payments received from Medicare for all of the heart surgeries performed by all of the physicians of the group for the duration of the lease; a potentially significant amount. As a result, even relatively minor technical violations of the law may trigger substantial refund obligations. If Stark Law violations were knowing, the government may also seek civil monetary penalties, and in some cases, a hospital may be excluded from the Medicare and Medicaid programs. In addition, violations of the Stark Law increasingly are being prosecuted under the FCA, triggering the FCA penalties discussed above. Potential repayments to CMS, settlements, fines or exclusion for a Stark Law violation or alleged violation could have a material adverse impact on a hospital.

CMS has established the voluntary SRDP program under which hospitals and other health care providers or suppliers may report potential Stark Law violations and seek a reduction in potential refund obligations. The limited publicly available information with respect to the SRDP suggests that most voluntary self-disclosure submissions remain under consideration by CMS for an extended period of time, and therefore it is difficult to determine at this time how CMS would react to any specific voluntary self-disclosure or whether submitting such a disclosure would provide significant monetary relief to hospitals that discover inadvertent Stark Law violations. The District may make self-disclosures pursuant to this program as appropriate and may make other disclosures from time to time. Any submission pursuant to the SRDP program does not waive or limit the ability of the Office of Inspector General or the Department of Justice (“**DOJ**”) to seek or prosecute violations of the Anti-Kickback Statute or impose civil monetary penalties.

***State “Fraud” and “False Claims” Laws.*** Hospital and health care providers in California are also subject to a variety of State laws related to false claims (similar to the FCA or that are generally applicable false claims laws), anti-kickback (similar to the federal Anti-Kickback Law or that are generally applicable anti-kickback or fraud laws), and physician referral (similar to the Stark Law). These prohibitions, while similar in public policy and scope to the federal laws, have not in all instances been regularly enforced to date. However, in the future they could pose the possibility of material adverse impact for the same reasons as the federal statutes. See discussion under the subheadings “– ***False Claims Act,***” “– ***Anti-Kickback Law***” and “– ***Stark Referral Law***” above.

California also has a false claims law that applies to fraudulent claims presented to an insurance company, and that goes beyond the scope of the FCA and California’s directly analogous statute, both of which are limited to fraudulent claims for which the federal government is required to pay or reimburse a portion or all of the claim. Under the California law, codified in Section 1871.7 of the California Insurance Code, a person who submits a fraudulent claim to an insurance company, is subject to civil fines ranging from \$5,000 to \$10,000 per fraudulent claim, plus an additional assessment of no more than three times the amount of each claim, and may be subject to criminal penalties under the California Penal Code as well. Similar to FCA, actions under this Insurance Code section may be initiated by private parties.

**Medicare and Medicaid Audits.** Hospitals that participate in the Medicare and Medicaid programs are subject from time to time to audits and other investigations relating to various aspects of their operations and billing practices, as well as to retroactive audit adjustments with respect to reimbursements claimed under these programs. Medicare and Medicaid regulations also provide for withholding reimbursement payments in certain circumstances. New billing rules and reporting requirements for which there is no clear guidance from CMS or state Medicaid agencies could result in claims submissions being considered inaccurate. The penalties for violations may include an obligation to refund money to the Medicare or Medicaid program, payment of criminal or civil fines and, for serious or repeated violations, exclusion from participation in federal health programs. The ACA requires states to institute a RAC program for Medicaid, similar to that conducted for Medicare, in order to search for and recoup improper payments made to Medicare and Medicaid in prior years. The RACs will be private contractors, paid a contingency fee from any recovery of overpayments. Although required to identify both overpayments and underpayments, RACs have in practice collected significantly more in overpayments from providers in proportion to the underpayments to providers.

**HIPAA and Other Privacy Requirements.** HIPAA, along with privacy rules under federal and various state statutes, addresses the confidentiality of individuals' personal information. For example, HIPAA prohibits the disclosure of certain broadly defined protected health information unless expressly permitted by regulation or authorized by the patient. HIPAA's confidentiality provisions extend not only to patient medical records, but also to a wide variety of individually identifiable health care clinical and financial information. These patient privacy requirements often impose communication, operational, and accounting obligations that add costs and create potentially unanticipated sources of liability.

There are also other federal or state privacy laws that may have more restrictive privacy requirements than HIPAA. For example, the regulations under 42 C.F.R. Part 2 provide a heightened level of privacy of records associated with the provision of substance abuse counseling and treatment by covered alcohol and substance abuse treatment programs. These rules are significantly more restrictive than the privacy provisions set forth in HIPAA. States may also adopt privacy laws that are more restrictive than HIPAA, but not less restrictive. For example, California broadened its data security breach notification laws to cover compromised medical and health insurance information. California also enacted laws that provide greater protection for certain sensitive health information, such as mental health records. Together, all these laws and regulations create communication, operational, and accounting obligations that add costs and create potentially unanticipated sources of liability for the District.

**The HITECH Act.** Provisions in the Health Information Technology for Economic and Clinical Health Act (the "**HITECH Act**"), enacted in 2009 as part of the economic stimulus legislation, increased the maximum civil monetary penalties for violations of HIPAA and grant enforcement authority of HIPAA to state attorneys general. The HITECH Act also (i) extended the reach of HIPAA beyond "covered entities," (ii) imposed a breach notification requirement on HIPAA covered entities, (iii) limited certain uses and disclosures of individually identifiable health information; (iv) increased individuals' rights with respect to protected health information ("**PHI**"); (v) restricted covered entities' marketing communications; and (vi) increased enforcement of, and penalties for, violations of privacy and security of individually identifiable health information.

The breach notification obligations, in particular, may expose covered entities such as hospitals to heightened liability. Under the HITECH Act, in the event of a breach of PHI, covered entities are required to notify affected individuals within 60 days, the federal government at least annually, and in some cases, the media. If more than 500 residents of a state or jurisdiction are affected by the breach, the covered entity must notify prominent media outlets servicing the state or jurisdiction. If 500 or more individuals are affected in total, the covered entity must notify the federal government within 60 days of discovery, and the federal government will post a description of the breach, identifying the covered entity on its website. These breach notification obligations increase the risk of government enforcement as well as class action lawsuits, especially if large numbers of individuals are affected by a breach.

The Office for Civil Rights ("**OCR**") is the administrative office that is tasked with enforcing HIPAA, and is also beginning to perform periodic audits of health care providers and group health plans to ensure that required policies under HIPAA (as amended by the HITECH Act) are in place. OCR is also working to establish a methodology under which an individual who is harmed by an offense punishable under HIPAA may be able to

recover a percentage of the civil monetary penalty or settlement collected with respect to the offense. These enforcement actions may significantly increase the number of HIPAA–related complaints from individuals, as well as increase penalty and settlement amounts.

OCR has stated that it has transitioned from education of new HITECH requirements to enforcement in its implementation of the law. Recent settlements of HIPAA violations and civil monetary penalties have reached millions of dollars. Any violation of HIPAA, regardless of intent or scope, may result in penalties or settlement amounts that are material to a covered entity health care provider or health plan.

***Security Breaches and Unauthorized Releases of Personal Information.*** State and local authorities are increasingly focused on the importance of protecting the confidentiality of individuals’ personal information, including patient health information. Many states, including California, have enacted laws requiring businesses to notify individuals of security breaches that result in the unauthorized release of personal information. In some states, notification requirements may be triggered even where information has not been used or disclosed but rather has been inappropriately accessed. For example, in California, businesses and state agencies are required to notify any California resident whose unencrypted personal information has been acquired, or reasonably believed to have been acquired, by an unauthorized person. In some states, notification requirements may be triggered even where information has not been used or disclosed but rather has been inappropriately accessed. California’s Confidentiality of Medical Information Act requires health care providers and others to keep medical information private and secure and, subject to certain exceptions, prohibits disclosure of such medical information without a patient’s consent. Pursuant to that statute, violations may result in significant fines and penalties including punitive damages and “nominal” damages, even in the absence of actual damages. State consumer protection laws may also provide the basis for legal action for privacy and security breaches and frequently, unlike HIPAA, authorize a private right of action. In particular, the public nature of security breaches exposes health organizations to increased risk of individual or class action lawsuits from patients or other affected persons, in addition to government enforcement.

In 2018, California passed the California Consumer Privacy Act (“**CCPA**”), which took effect on January 1, 2020. The law provides new rights regarding the collection and use of personal information. The law applies to all entities with data on over 50,000 consumers, with over \$25 million in annual gross revenue, or that derive 50% or more of their revenue from the sale of consumers’ personal information. The CCPA applies to the District under the second of these tests. The CCPA implements significant new requirements, including additional notice requirements, increased disclosure to consumers, the right for consumers to opt–out of data sharing, the right to be forgotten, and provides for damages in data breach cases to \$750 per consumer per incident. Enforcement of the CCPA began July 1, 2020.

State consumer protection laws may also provide the basis for legal action for privacy and security breaches and frequently, unlike HIPAA, authorize a private right of action. In particular, as discussed in “– ***The HITECH Act***” above, the public nature of security incidents exposes health organizations to increased risk of individual or class action lawsuits from patients or other affected persons, in addition to government enforcement. Failure to comply with restrictions on patient privacy or to maintain robust information security safeguards, including taking steps to ensure that contractors who have access to sensitive patient information maintain the confidentiality of such information, could consequently damage a hospital’s reputation and materially adversely affect business operations.

***Business Associates.*** Under existing HIPAA regulations, covered entities must include certain required provisions in their contractual relationships with organizations that perform functions on their behalf which involve use or disclosure of protected health information. These organizations are called business associates, and prior to the HITECH Act, business associates had been indirectly regulated by HIPAA through those contractual obligations. The HITECH Act, including the final rules promulgated thereunder, provide that all the HIPAA security administrative, physical, and technical safeguards, as well as security policies, procedures and documentation requirements now apply directly to all business associates. In addition, the HITECH Act makes certain privacy provisions directly applicable to business associates. These changes are significant because business associates will now be directly regulated by DHHS for those requirements, and as a result, will be subject to penalties imposed by DHHS and/or state attorneys general. Likewise, to the extent a business associate is deemed to be an agent of the covered entity under the federal common law, the covered entity will be liable for the breaches of the business

associate. Covered entities have had to review and amend their business associate agreements in recent years in order to comply with these changing rules, which can be costly and administratively burdensome.

**Civil Monetary Penalties Law.** The federal Civil Monetary Penalties Law (“**CMPL**”) provides for administrative sanctions against health care providers for a broad range of billing and other abuses. For example, penalties may be imposed for the knowing presentation of claims that are (i) incorrectly coded for payment; (ii) for services that are known to be medically unnecessary; (iii) for services furnished by an excluded party; or (iv) otherwise false. A hospital or health care provider that participates in arrangements known as “gainsharing” by paying a physician to limit or reduce services to Medicare fee-for-service beneficiaries also could be subject to CMPL penalties. Further, a hospital or health care provider that provides benefits to Medicare or Medicaid beneficiaries that such provider knows or should know are likely to induce the beneficiaries to choose the provider for their care could also be subject to CMPL penalties.

Civil monetary penalties may also be assessed for (a) knowingly making or using a false record or statement material to a false or fraudulent claim for payment; (b) failing to grant timely access for audits; and (c) failing to report and return a known overpayment within statutory time limits. The ACA also amended the CMPL to establish various new grounds for exclusion and civil monetary penalties, as well as increased penalty thresholds for existing civil monetary penalties.

Health care providers may be found liable under the CMPL even when they did not have actual knowledge of the impropriety of their action. Knowingly undertaking the action is sufficient. Ignorance of the Medicare regulations is no defense. The imposition of civil money penalties on a health care provider could have a material adverse impact on the provider’s financial condition.

**Exclusions from Medicare or Medicaid Participation.** The government may exclude a hospital from Medicare/Medicaid program participation if it is convicted of a criminal offense relating to the delivery of any item or service reimbursed under Medicare or a state health care program, any criminal offense relating to patient neglect or abuse in connection with the delivery of health care, fraud against any federal, state or locally financed health care program or an offense relating to the illegal manufacture, distribution, prescription, or dispensing of a controlled substance. The government also may exclude individuals or entities under certain other circumstances, such as an unrelated conviction of fraud, or other financial misconduct relating either to the delivery of health care in general or to participation in a federal, state or local government program. Exclusion from the Medicare/Medicaid program means that a hospital would be decertified from program participation and no program payments can be made. Any hospital exclusion could be a materially adverse event. In addition, exclusion of hospital employees under Medicare or Medicaid may be another source of potential liability for hospitals or health systems based on services provided by those excluded employees.

**Administrative Enforcement.** Administrative regulations may require less proof of a violation than do criminal laws, and, thus, health care providers may have a higher risk of imposition of monetary penalties as a result of administrative enforcement actions.

**Compliance with Conditions of Participation.** CMS, in its role of monitoring participating providers’ compliance with conditions of participation in the Medicare program, may determine that a provider is not in compliance with its conditions of participation. In that event, a notice of termination of participation may be issued or other sanctions, such as suspension or executing potentially burdensome corrective action plans, potentially could be imposed. If a corrective action plan is not accepted by CMS, or if the corrective action plan is not successfully implemented, the provider’s Medicare provider agreement could be terminated. Other sanctions could potentially be imposed, including, in limited instances, monetary penalties.

**EMTALA.** The Emergency Medical Treatment and Labor Act (“**EMTALA**”) is a federal civil statute that requires Medicare-participating hospitals with an emergency department to conduct a medical screening examination to determine the presence or absence of an emergency medical condition and to provide treatment sufficient to stabilize such patient’s emergency medical condition or active labor prior to discharging or transferring the patient, notwithstanding an individual’s ability to pay. A hospital may not delay the provision of a medical screening examination in order to inquire about the patient’s ability to pay or method of payment. A hospital that

violates EMTALA is subject to civil penalties per offense and termination of its Medicare provider agreement. In addition, the hospital may be liable for any claim by an individual who has suffered harm as a result of a violation and may be liable to the receiving hospital for financial losses suffered as a result of a transfer in violation of EMTALA. See the discussion under the subheading “– **False Claims Act**,” above.

Over the last few years, the federal government has increased its enforcement of EMTALA. Failure to comply with the law can result in exclusion from the Medicare and/or Medicaid programs, as well as civil and criminal penalties. Substantial failure to meet its responsibilities under EMTALA, as applicable, could materially adversely affect the financial condition of the District. Outpatient facilities that are included as part of a hospital by virtue of a provider-based status designation are required to adhere to EMTALA’s requirements, regardless of whether they are located on or away from the hospital’s main campus.

**Licensing, Surveys, Investigations and Audits.** Hospitals are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. These include, but are not limited to, requirements of state licensing agencies and The Joint Commission. Renewal and continuation of certain of these licenses, certifications and accreditations are based on inspections or other reviews generally conducted in the normal course of business of health facilities. Loss of, or limitations imposed on, hospital licenses or accreditations could reduce hospital utilization or revenues, or a hospital’s ability to operate all or a portion of its facilities or to bill various third party payors. Certain states, including California, can levy penalties against hospitals that experience certain significant patient care events, including those that are classified as posing “immediate jeopardy” to patient health and safety.

**Environmental Laws and Regulations.** Hospitals are subject to a wide variety of federal, state and local environmental and occupational health and safety laws and regulations. These include but are not limited to: air and water quality control requirements; waste management requirements; specific regulatory requirements applicable to asbestos and radioactive substances; requirements for providing notice to employees and members of the public about hazardous materials handled by or located at the hospital; and requirements for training employees in the proper handling and management of hazardous materials and wastes.

Hospitals may be subject to requirements related to investigating and remedying hazardous substances located on their property, including such substances that may have migrated off the property. Typical hospital operations include the handling, use, storage, transportation, disposal and discharge of hazardous, infectious, toxic, radioactive, flammable and other hazardous materials, wastes, pollutants and contaminants. As such, hospital operations are particularly susceptible to the practical, financial and legal risks associated with environmental laws and regulations. Such risks may result in damage to individuals, property or the environment; may interrupt operations and increase their cost; may result in legal liability, damages, injunctions or fines; and may result in investigations, administrative proceedings, civil litigation, criminal prosecution, penalties or other governmental agency actions; and may not be covered by insurance.

**Enforcement Activity.** Enforcement activity of federal and state authorities against health care providers has increased, and enforcement authorities have adopted aggressive approaches. In the current regulatory climate, it is anticipated that many hospitals and physician groups will be subject to an audit, investigation, or other enforcement action regarding the health care fraud and physician anti-referral laws mentioned above.

Enforcement authorities are often in a position to compel settlements by providers charged with or being investigated for false claims violations by withholding or threatening to withhold Medicare, Medicaid and similar payments or to recover higher damages, assessments or penalties by instituting criminal action. In addition, the cost of defending such an action, the time and management attention consumed, and the facts of a case may dictate settlement. Therefore, regardless of the merits of a particular case, a hospital could experience materially adverse settlement costs, as well as materially adverse costs associated with implementation of any settlement agreement. Prolonged and publicized investigations could be damaging to the reputation and business of a hospital, regardless of outcome.

Certain acts or transactions may result in violation or alleged violation of a number of the federal health care fraud laws described above, and therefore penalties or settlement amounts often are compounded. Generally,

these risks are not covered by insurance. Enforcement actions may involve multiple hospitals or other facilities in a health system, as the government often extends enforcement actions regarding health care fraud to other entities in the same organization. Therefore, Medicare fraud related risks identified as being materially adverse as to a hospital could have materially adverse consequences for a health system taken as a whole.

**Antitrust.** Antitrust liability may arise in a wide variety of circumstances, including medical staff privilege disputes, payor contracting, physician relations, joint ventures, merger, affiliation and acquisition activities, certain pricing or salary setting activities, as well as other areas of activity. Consolidation transactions among health care providers is an area in which investigation and enforcement activity by federal and state antitrust agencies is particularly frequent and vigorous. The application of the federal and state antitrust laws to health care is evolving as the industry adapts to accountability for the cost and quality of care, and therefore not always clear. Currently, the most common areas of potential liability are joint action among providers with respect to payor contracting and medical staff credentialing disputes, and hospital mergers and acquisitions. The health care industry is expected to experience increased pressure from the Federal Trade Commission (“FTC”) after President Biden signed an executive order on July 9, 2021, aimed at encouraging economic competition. The executive order targets health care as one of the sectors that will receive increased FTC enforcement and scrutiny. A primary point of concern is consolidation among hospitals. The executive order calls on the Attorney General and the chair of the FTC to review and consider revising the current horizontal and vertical merger guidelines. Additionally, it reiterates that the FTC and DOJ are allowed to challenge prior mergers that are already consummated. This remains an evolving issue.

Violation of the antitrust laws could result in criminal and/or civil enforcement proceedings by federal and state agencies, as well as actions by private litigants. In certain actions, private litigants may be entitled to treble damages, and in others, governmental entities may be able to assess substantial monetary fines. Investigations and proceedings arising from the application of federal and state antitrust laws can require the dedication of substantial resources by affected providers and can delay or impede proposed transactions even if ultimately it is determined that no violation of applicable law would occur as a result of the proposed transaction.

## **Business Relationships and Other Business Matters**

**Integrated Delivery Systems.** Hospitals and health care systems often own, control or have affiliations with physician groups and independent practice associations. Generally, the sponsoring health facility or health system is the primary capital and funding source for such alliances and may have an ongoing financial commitment to provide growth capital and support operating deficits. As separate operating units, integrated physician practices and medical foundations sometimes operate at a loss and require subsidy or other support from the related hospital or health system. In addition, integrated delivery systems present business challenges and risks. Inability to attract or retain participating physicians may negatively affect managed care, contracting and utilization. The technological and administrative infrastructure necessary both to develop and operate integrated delivery systems and to implement new payment arrangements in response to changes in Medicare and other payor reimbursement is costly. Hospitals may not achieve savings sufficient to offset the substantial costs of creating and maintaining this infrastructure.

These types of alliances are generally designed to respond to trends in the delivery of medicine to better integrate hospital and physician care, to increase physician availability to the community and/or to enhance the managed care capability of the affiliated hospitals and physicians. However, these goals may not be achieved, and an unsuccessful alliance may be costly and counterproductive to all the above-stated goals.

These types of alliances have become increasingly important to the success of hospitals in the future as a result of changes to the health care delivery and reimbursement systems that are intended to restrain the rate of increases of health care costs, encourage coordinated care, promote collective provider accountability and improve clinical outcomes. The ACA authorizes several alternative payment programs for Medicare that promote, reward or necessitate integration among hospitals, physicians and other providers.

Whether these programs will achieve their objectives and be expanded or mandated as conditions of Medicare participation cannot be predicted. However, Congress and CMS have clearly emphasized continuing the trend away from the fee-for-service reimbursement model, which began in the 1980s with the introduction of the prospective payment system for inpatient care, and toward episode-based or value-based payment models that

reward use of evidence-based protocols, quality and satisfaction in patient outcomes, efficiency in using resources, and the ability to measure and report clinical performance. CMS continues to focus on moving the health care system towards the goal of paying for value. This shift is likely to favor integrated delivery systems, which may be better able than stand-alone providers to realize efficiencies, coordinate services across the continuum of patient care, track performance and monitor and control patient outcomes. Changes to the reimbursement methods and payment requirements of Medicare, which is the dominant purchaser of medical services, are likely to prompt equivalent changes in the commercial sector, because commercial payors frequently follow Medicare's lead in adopting payment policies.

While payment trends may stimulate the growth of integrated delivery systems, these systems carry with them the potential for legal or regulatory risks. Many of the risks discussed in “– **Regulatory Environment**” above, may be heightened in an integrated delivery system. The foregoing laws were not designed to accommodate coordinated action among hospitals, physicians and other health care providers to set standards, reduce costs and share savings, among other things. The ability of hospitals or health systems to conduct integrated physician operations may be altered or eliminated in the future by legal or regulatory interpretation or changes, or by health care fraud enforcement. In addition, participating physicians may seek to maintain their independence for a variety of reasons, thus putting the hospital or health system's investment at risk, and potentially reducing its managed care leverage and/or overall utilization. In October 2011, CMS, the Federal Trade Commission and the DOJ jointly issued guidance regarding waivers and safe harbors to enable providers to participate in the Medicare Shared Savings Program (“**MSSP**”) (see “**Accountable Care Organizations**” below). Although CMS issued the MSSP final rule in June 2015, there can be no assurance that such guidance issued will sufficiently clarify the scope of permissible activities in all cases. On February 3, 2023, DOJ withdrew its October 2011 guidance on antitrust enforcement, stating that it was overly permissive on certain subjects, including information sharing. State law prohibitions, such as the bar on the corporate practice of medicine, or state law requirements, such as insurance laws regarding licensure and minimum financial reserve holdings of risk-bearing organizations, may also introduce complexity, risk and additional costs in organizing and operating integrated delivery systems. In affiliating with for-profit entities, tax-exempt hospitals and health systems also face the risk that the IRS will determine that compensation practices or business arrangements result in private benefit or private use or generate unrelated business income for the hospitals and health systems.

Health care providers, responding to health care reform and other industry pressures, have increasingly moved toward integrated delivery systems, managing the health of populations of individuals, patient-centered medical homes, bundled payments, and capitated insurance plans. These trends will require new competencies, including the appropriate mix of physician specialties, new administrative skills, close and aligned relationships between physicians and hospitals, insurance risk management, and new relationships between patients and providers. Providers may be unsuccessful in assembling successful integrated networks, fail to achieve savings sufficient to offset the substantial costs of creating and maintaining the necessary capabilities to support such developments, or otherwise could incur losses or damage reputations from assuming increased risk. Some health care organizations that traditionally operated hospitals may, directly or in partnership, take on actual insurance risk, market various health coverage products, and access patients by way of unknown channels. Such new endeavors could adversely affect the financial and operating condition or reputation of an organization.

**Bundled Payment Programs.** The ACA established a Medicare bundled payment pilot program, under which Medicare makes a single payment for an episode of care, such as heart bypass surgery, covering some combination of hospital, physician and post-hospital care for the episode. As previously discussed, bundled payment models establish a budgeted payment to cover the entire cost of an episode of care (*e.g.*, a hip or knee replacement). Examples of Bundled Payments for Care Improvement (“**BPCI**”) models include, among others, BPCI Initiative models 2, 3 and 4 (which ended September 30, 2018); BPCI Advanced; Comprehensive Care for Joint Replacement; and the Oncology Care Model. Population health models incentivize providers to maintain or improve quality while reducing cost through shared savings or shared loss arrangements. Population health models usually involve a form of capitated payment, which is a per patient payment for the cost of care over a set period of time. While bundled payments offer opportunities to provide better coordinated care and to save costs, they also entail financial risk if the episode is not well managed.

**Accountable Care Organizations.** The ACA established a Medicare Shared Savings Program that seeks to promote accountability and coordination of care through the creation of Accountable Care Organizations (“ACOs”). The MSSP allows hospitals, physicians and other health care providers to form ACOs and work together to invest in infrastructure and redesign integrated delivery processes to achieve high quality and efficient delivery of services. ACOs that achieve quality performance standards will be eligible to share in a portion of the amounts saved by the Medicare program. DHHS has significant discretion to determine key elements of the program, including what steps providers must take to be considered an ACO, how to decide if Medicare program savings have occurred, and what portion of such savings will be paid to ACOs.

To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. The ACO and MSSP final rules were published in November 2011 and June 2015; however, the regulations are complex and it remains unclear whether the qualification requirements will be a formidable barrier to entry for many providers. It is possible that hospital participants in ACOs will have to marshal large upfront financial investments to form unique and untested ACO structures, which may or may not succeed in gaining qualification. For those ACOs that do qualify, it is not clear if the savings will be adequate to recoup the initial investment. In addition, although the regulation provides for waivers of certain federal laws, there may remain regulatory risks for participating hospitals, as well as financial and operational risks. The applicable regulating bodies have published guidance for ACOs to follow in order to comply with the law, but the published guidance is complex.

In particular, because the federal ACO regulations do not preempt state law, California providers participating as a federal ACO must be organized and operated in compliance with California’s existing statutes and regulations. Numerous organizations have formed ACOs and been selected by CMS to participate in the MSSP. CMS is also developing and implementing more advanced ACO payment models, such as the Next Generation ACO Model, which require ACOs to assume greater risk for attributed beneficiaries. On December 21, 2018, CMS published a final rule that, in general, requires ACO participants to take on additional risk associated with participation in the MSSP. It remains unclear to what extent providers will pursue federal ACO status or whether the required investment would be warranted by increased payment. Nevertheless, it is anticipated that private insurers may seek to establish similar incentives for providers, while requiring less infrastructural and organizational change.

Providers participating in MSSP and other ACO payment models developed by CMS may not be able to recoup their initial investments and may suffer further losses if they are not able to meet quality targets and sufficiently control the cost of care for their attributed beneficiaries. In addition, it is anticipated that private insurers may seek to establish similar incentives for providers, while requiring change in infrastructure and organization. The potential impacts of these initiatives and the regulation for ACOs are currently unknown to the District, but introduce greater risk and complexity to health care finance and operations.

**Hospital Pricing.** Inflation in hospital prices may evoke action by legislatures, payors or consumers. It is possible that legislative action at the state or national level may be taken with regard to the pricing of health care services. California law requires hospitals to implement written policies for charity care and discounted care, which must offer reduced rates to low-to-moderate income patients. Hospitals are required to submit these policies to the State for posting on a publicly accessible State website. California law also requires annual submission of hospital charges for posting on a publicly accessible State website.

**Hospital Medical Staff.** The primary relationship between a hospital and physicians who practice in it is through the hospital’s organized medical staff. Medical staff bylaws, rules and policies establish the criteria and procedures by which a physician may have his or her privileges or membership curtailed, denied or revoked. Physicians who are denied medical staff membership or certain clinical privileges or who have such membership or privileges curtailed or revoked often file legal actions against hospitals and medical staffs. Such actions may include a wide variety of claims, some of which could result in substantial uninsured damages to a hospital. In addition, failure of the hospital governing body to adequately oversee the conduct of its medical staff may result in hospital liability to third parties.

**Physician Supply.** Sufficient community-based physician supply is important to hospitals and other health care facilities. CMS annually reviews overall physician reimbursement formulas for Medicare and Medicaid. Changes to physician compensation under these programs could lead to physicians ceasing to accept Medicare and/or Medicaid patients. Regional differences in reimbursement by commercial and governmental payors, along with variations in the costs of living, may cause physicians to avoid locating their practices in communities with low reimbursement or high living costs. Hospitals and health systems may be required to invest additional resources in recruiting and retaining physicians, or may be compelled to affiliate with, and provide support to, physicians in order to continue serving the growing population base and maintain market share. The physician-to-population ratio in certain parts of the State is below the national average, and the shortage of physicians could become a significant issue for hospitals and health care systems in the State.

**Competition Among Health Care Providers.** Increased competition from a wide variety of sources, including specialty hospitals, other hospitals and health care systems, HMOs, inpatient and outpatient health care facilities, long-term care and skilled nursing services facilities, clinics, physicians and others, may adversely affect the utilization and/or revenues of hospitals. Existing and potential competitors may not be subject to various restrictions applicable to hospitals, and competition, in the future, may arise from new sources not currently anticipated or prevalent. The strong market position of Kaiser Permanente, a closed managed care system in California, with health facilities nearby in the cities of Modesto and Manteca, presents additional challenges.

Freestanding ambulatory surgery centers may attract away significant commercial outpatient services traditionally performed at hospitals. Commercial outpatient surgery services, currently among the most profitable services for hospitals, may be lost to competitors who can provide these services in an alternative, less costly setting. Full-service hospitals rely upon the revenues generated from commercial outpatient services to fund other less profitable services, and the decline of such business may result in the significant reduction of profitable income. Competing ambulatory surgery centers, more likely for-profit businesses, may not accept indigent patients or low paying programs and would leave these populations to receive services in the full-service hospital setting. Consequently, hospitals are vulnerable to competition from ambulatory surgery centers.

Additionally, scientific and technological advances, new procedures, drugs and appliances, preventive medicine and outpatient health care delivery may reduce utilization and revenues of the hospitals in the future or otherwise lead the way to new avenues of competition. In some cases, hospital investment in facilities and equipment for capital-intensive services may be lost as a result of rapid changes in diagnosis, treatment or clinical practice brought about by new technology or new pharmacology.

**Action by Purchasers of Hospital Services and Consumers.** Major purchasers of hospital services could take action to restrain hospital charges or charge increases. As a result of increased public scrutiny, it is also possible that the pricing strategies of hospitals may be perceived negatively by consumers, and hospitals may be forced to reduce fees for their services. Decreased utilization could result, and hospitals' revenues may be negatively impacted. In addition, consumers and groups on behalf of consumers are increasing pressure for hospitals and other health care providers to be transparent and provide information about cost and quality of services that may affect future consumer choices about where to receive health care services.

**Employer Status.** Hospitals are major employers with mixed technical and nontechnical workforces. Labor costs, including salary, benefits and other liabilities associated with a workforce, have significant impacts on hospital operations and financial condition. Developments affecting hospitals as major employers include: (i) imposing higher minimum or living wages; (ii) enhancing occupational health and safety standards; (iii) imposing joint employer status on employers using contract, staffing agency or other temporary labor; and (iv) penalizing employers of undocumented immigrants. Legislation or regulation on any of the above or related topics could have a material adverse impact on the District.

**Labor Relations and Collective Bargaining.** Many hospitals are large employers with a wide diversity of employees. Increasingly, employees of hospitals are becoming unionized, and many hospitals have collective bargaining agreements with one or more labor organizations. Employees subject to collective bargaining agreements may include essential nursing and technical personnel, as well as food service, maintenance and other trade personnel. Renegotiation of such agreements upon expiration or negotiation of a first agreement following a union

organization may result in significant cost increases to hospitals. Employee strikes or other adverse labor actions may have an adverse impact on operations, revenue and hospital reputation. Certain employees of the District are currently covered by a collective bargaining agreements. See **APPENDIX A – “INFORMATION CONCERNING THE DISTRICT– EMPLOYEES AND MEDICAL STAFF MATTERS – Employees.”**

***Class Actions.*** Hospitals and health systems have long been subject to a wide variety of litigation risks, including liability for care outcomes, employer liability, property and premises liability, and peer review litigation with physicians, among others. In recent years, consumer class action litigation has emerged as a potentially significant source of litigation liability for nonprofit hospitals and health systems. These class action suits have most recently focused on hospital billing and collections practices, and they may be used for a variety of currently unanticipated causes of action. Since the subject matter of class action suits may involve uninsured risks, and since such actions often involve alleged large classes of plaintiffs, they may have material adverse consequences on nonprofit hospitals and health systems in the future.

***Wage and Hour Class Actions and Litigation.*** Federal law and many states, including notably California, impose standards related to worker classification, eligibility and payment for overtime, liability for providing rest periods and similar requirements. Large employers with complex workforces, such as hospitals, are susceptible to actual and alleged violations of these standards. In recent years there has been a proliferation of lawsuits over these “wage and hour” issues, often in the form of large class actions. For large employers, such as hospitals and health systems, such class actions can involve multi-million dollar claims, judgments and settlements. A major class action decided or settled adversely to the District could have a material adverse impact on its financial conditions and results of operations.

***Health Care Worker Classification.*** Health care providers, like all businesses, are required to withhold income taxes from amounts paid to employees. If the employer fails to withhold the tax, the employer becomes liable for payment of the tax imposed on the employee. On the other hand, businesses are not required to withhold federal taxes from amounts paid to a worker classified as an independent contractor. The IRS has established criteria for determining whether a worker is an employee or an independent contractor for tax purposes. If the IRS were to reclassify a significant number of hospital independent contractors (e.g., physician medical directors) as employees, back taxes and penalties could be material.

***Staffing.*** From time to time, the health care industry has suffered from a scarcity of nursing personnel, respiratory therapists, pharmacists and other trained health care and information system technicians. In addition, aging medical staffs and difficulties recruiting individuals to the medical professions are predicted to result in shortages. A significant factor underlying this trend includes a decrease in the number of persons entering such professions. This is expected to intensify in the future, aggravating the general shortage and increasing the likelihood of specific shortages. Competition for employees, coupled with increased recruiting and retention costs will increase operating costs, possibly significantly, and growth may be constrained. As reimbursement amounts are reduced to health care organizations that employ or contract with physicians, nurses and other health care professionals, pressure to control and possibly reduce wage and benefit costs may further strain the supply of those professionals. This trend could have a material adverse impact on the financial conditions and results of operations of certain health care providers, including the District.

***Professional Liability Claims and General Liability Insurance.*** In recent years, the number of professional and general liability suits and the dollar amounts of damage recoveries have increased in health care nationwide, resulting in substantial increases in malpractice insurance premiums, higher deductibles and generally less coverage. Professional liability and other actions alleging wrongful conduct and seeking punitive damages are often filed against health care providers. Insurance does not provide coverage for judgments of punitive damages; however, punitive damages cannot be assessed against public agencies in California, such as the District.

CMS does not reimburse hospitals for medical costs arising from certain “never events,” which include specific preventable medical errors. Certain private insurers and HMOs followed suit. The occurrence of “never events” is more likely to be publicized and may negatively impact a hospital’s reputation, thereby reducing future utilization and potentially increasing the possibility of liability claims.

Litigation also arises from the corporate and business activities of hospitals, from a hospital's status as an employer or as a result of medical staff or provider network peer review or the denial of medical staff or provider network privileges. As with professional liability, many of these risks are covered by insurance, but some are not. For example, some antitrust claims or business disputes are not covered by insurance or other sources and may, in whole or in part, be a liability of the hospital or other health care provider if determined or settled adversely.

There is no assurance that hospitals will be able to maintain coverage amounts currently in place in the future, that the coverage will be sufficient to cover malpractice judgments rendered against a hospital or that such coverage will be available at a reasonable cost in the future.

**Information Systems.** The ability to adequately price and bill health care services and to accurately report financial results depends on the integrity of the data stored within information systems, as well as the operability of such systems. Information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards. There can be no assurance that efforts to upgrade and expand information systems capabilities, protect and enhance these systems, and develop new systems to keep pace with continuing changes in information processing technology will be successful or that additional systems issues will not arise in the future.

Electronic medical records (“**EMR**”) systems, and enterprise resource planning (“**ERP**”) systems are also increasingly being used in clinical operations. The reliance on information technology for these purposes imposes ongoing additional requirements on physicians and other workforce members to be adept in using and managing electronic systems. It also increases risks related to patient information privacy. See “**Regulatory Environment – HIPAA and Other Privacy Requirements,**” “– **The HITECH Act,**” and “– **Security Breaches and Unauthorized Release of Personal Information**” above. Technology malfunctions or failure to understand and use information systems properly could result in the dissemination of, or reliance on, inaccurate information, as well as in disputes with patients, physicians and other health care professionals.

Health information systems may also be subject to different or higher standards or greater regulation than other information technology or the paper-based systems previously used by health care providers, which may increase the cost, complexity and risks of operations. All of these risks may have adverse consequences on health care providers.

Future government regulation and adherence to technological advances could result in an increased need of the District to implement new technology. Such implementation could be costly and is subject to cost overruns and delays in application, which could negatively affect the financial condition of the District.

**Cybersecurity Risks.** Health care providers are highly dependent upon integrated electronic medical record and other information technology systems to deliver high quality, coordinated and cost-effective health care. These systems necessarily hold large quantities of highly sensitive patient health information or other sensitive information that is highly valued on the black market for such information. As a result, the electronic systems and networks of health care providers are considered likely targets for cyberattacks and other potential breaches of their systems.

Information technology systems are also vulnerable to random attacks, computer viruses, and physical or electronic break-ins. In addition to regulatory fines and penalties, the health care entities subject to the breaches may be liable for the costs of remediating the breaches, damages to individuals (or classes) whose information has been breached, reputational damage and business loss, and damage to the information technology infrastructure. The District has taken, and continues to take, measures to protect its information technology system against such cyberattacks and other events and issues that could result in breaches, but there can be no assurance that the District will not experience a significant breach. If such a breach occurs, the financial consequences of such a breach could have a material adverse impact on the District. The District maintains insurance related to certain cyber-security risks.

**Physician Financial Relationships.** In addition to the physician integration relationships referred to above, hospitals and health systems frequently have various additional business and financial relationships with physicians

and physician groups. These are in addition to hospital physician contracts for individual services performed by physicians in hospitals. They potentially include: joint ventures to provide a variety of outpatient services; recruiting arrangements with individual physicians and/or physician groups; loans to physicians; medical office leases; equipment leases from or to physicians; and various forms of physician practice support or assistance. These and other financial relationships with physicians (including hospital physician contracts for individual services) may involve financial and legal compliance risks for the hospitals and health systems involved. From a compliance standpoint, these types of financial relationships may raise federal and state “anti-kickback” and federal “Stark Law” issues (see “**Regulatory Environment**” above), tax exemption issues, as well as other legal and regulatory risks, and these could have a material adverse impact on hospitals.

## **Tax Matters**

The Code imposes a number of requirements that must be satisfied for interest (and original issue discount) on state and local obligations, such as the 2026 Bonds, to be excludable from gross income for federal income tax purposes. The District has covenanted that it will comply with such requirements. Future failure by the District to comply with the requirements stated in the Code and related regulations and rulings may result in the treatment of interest (and original issue discount) on the 2026 Bonds as taxable, retroactively to the date of issuance. The District has covenanted in the Indenture that it will at all times do and perform all acts permitted by law and the Indenture which are necessary or desirable in order to assure that interest (and original issue discount) paid on the 2026 Bonds will be excluded from gross income for federal income tax purposes.

The District believes that the 2026 Bonds properly comply with the tax laws. In addition, Bond Counsel to the District will render an opinion with respect to the tax-exempt status of the 2026 Bonds, as described under the caption “**TAX MATTERS**.” No ruling with respect to the 2026 Bonds has been or will be sought from the IRS, however, and the opinions of counsel are not binding on the IRS or the courts. There can be no assurance that an examination of the 2026 Bonds will not adversely affect the 2026 Bonds or the market value of the 2026 Bonds, nor that future legislative action might limit or remove the tax-exempt status of interest (and original issue discount) on the 2026 Bonds. See “**TAX MATTERS**” herein.

Future legislative proposals, if enacted, regulations, rulings or court decisions may cause interest (and original issue discount) on the 2026 Bonds to be subject, directly or indirectly, to federal income taxation or to State or local income taxation, or may otherwise prevent beneficial owners from realizing the full current benefit of the tax status of such interest (and original issue discount). See “**TAX MATTERS**” herein.

Legislation or regulatory actions and future proposals, whether or not enacted, may also affect the economic value of the federal or state tax exemption or the market value of the 2026 Bonds.

## **Bankruptcy**

Under Chapter 9 of the Federal Bankruptcy Code (Title 11, United States Code) (the “**Bankruptcy Code**”), no involuntary petitions for bankruptcy relief are permitted. However, California health care districts may petition for bankruptcy relief under Chapter 9 of the Bankruptcy Code. If the District were a debtor in bankruptcy, the parties may be prohibited from taking any action to collect any amount from the District or to enforce any obligation of the District, without the bankruptcy court’s permission. This prohibition may also prevent the Trustee from making payments to the Holders of the 2026 Bonds from funds in the Trustee’s possession. There may be other possible effects of a bankruptcy of the District that could result in delays or reductions in payments on the 2026 Bonds, which could have an adverse effect on the liquidity and value of the 2026 Bonds.

## **Other Risk Factors**

***Wildfires, Earthquakes, Other Weather Events and Climate Change.*** In several recent years, portions of California have experienced wildfires that have burned thousands of acres and destroyed thousands of homes and structures resulting in evacuations, temporary or permanent business closures, rolling power outages, severe traffic problems, among other disruptions. Some of the District’s facilities could be affected by wildfire issues, including interruption of service to patients for a temporary period. It is not possible for the District to make any

representation regarding the extent to which wildfires and related issues, including power outages, could cause reduced usage of their facilities or the extent to which wildfires may damage or even destroy such facilities. The District carries fire insurance for its facilities and also conducts annual fire drills, disaster drills and annual fire extinguisher training at all sites. The main effect on the District during weather events and natural disasters are from site closures caused by unsafe driving conditions and also power outages.

The Stanislaus County area experiences dozens of earthquakes each year, of varying magnitude and with differing amounts of property damage. Although most earthquakes do not result in significant property damage, significantly damaging and destructive earthquakes have occurred in the area in the past and should one of those be proximate to one or more of the District's facilities, a material and sustained interruption in the District's services could be expected, whether from severe ground shaking or liquefaction. The District does carry earthquake insurance covering its facilities, including business income interruption coverage; however, no guarantees can be made that such coverage will be available or sufficient through the term the 2026 Bonds are outstanding.

California law requires each acute care hospital in the State to evaluate and upgrade its patient care facilities to meet stated seismic standards by 2008 or, in certain cases, by 2030; ultimate deadlines depend on each acute care hospital building's structural performance category.

Other weather events in the District's area, such as severe storms with high winds and precipitation, flooding, droughts, etc., including those created by or exacerbated by climate change, could adversely impact the District's operations. Such events could result in a material and sustained interruption in the District's services at certain of its facilities and could have a material adverse effect on the finances and operations of the District.

***Financial Crises, Economic Downturns and Disruptions and General Economic Factors.*** International, U.S. domestic and state and local economic conditions are often volatile and unpredictable. Occurrences of financial crises or other national or global economic downturns or disruptions, may have negative repercussions, including a scarcity of credit, lack of confidence in the financial sector, extreme volatility in the financial markets, reduced business activity, increased inflation, increased consumer bankruptcies and increased business failures and bankruptcies. Financial crises and economic downturns and disruptions could result from, among other causes, underlying national and international market conditions (e.g., 2008 financial crisis), public health crises (e.g., economic impact of pandemic), natural disasters (e.g., flooding or wildfire destruction economic impacts), legislative and political policy changes (e.g., economic reactions to tariff policies, international trade wars, and proposed legislation), economic policy decisions (e.g., federal reserve rate cuts or increases), terrorism acts and threats, military wars and conflicts, or other causes. The weakening of the economy could have a negative impact upon the District and could impair the District's ability to pay the principal of, and interest on, the 2026 Bonds.

The financial condition of the District may also be threatened by particular pressures, including risks of: increased inflation; increased pressure on the federal government to decrease Medicare funding, on the federal and state governments to decrease Medicaid funding and on employers to reduce health care coverage and increase deductibles; increased unemployment, uncompensated care and bad debt; and decrease in return on investments.

These and other risks may adversely affect the District and jeopardize their ability to generate revenues or have sufficient resources and to make payments under the Indenture when due. There can be no assurance that any turmoil in the financial and bond markets will not negatively impact the marketability of the 2026 Bonds in the secondary market. Investors should remain vigilant of financial crisis risks when making investment decisions.

***Ratings.*** There is no assurance that the ratings assigned to the 2026 Bonds will not be lowered or withdrawn at any time, the effect of which could adversely affect the market price for and marketability of the 2026 Bonds. See the information herein under the heading "**RATING.**"

***Marketability of the 2026 Bonds.*** There is no assurance as to the liquidity of markets that may develop for the 2026 Bonds, the ability of beneficial owners to sell the 2026 Bonds or the price at which beneficial owners would be able to sell the 2026 Bonds. Neither the Underwriter nor any other financial institution is obligated to make a market in the 2026 Bonds, and any financial institution that does so may discontinue its market-making activities at any time without notice. Any market for the 2026 Bonds may be subject to disruption which could

adversely affect the prices at which beneficial owners may sell the 2026 Bonds. The 2026 Bonds may trade at a discount from their original purchase prices depending upon interest rates, the market for obligations similar to the 2026 Bonds, the financial condition of the District and other factors.

***Incurrence of Future Indebtedness.*** Pursuant to the Indenture, the District is permitted under certain conditions to incur additional indebtedness, including debt that is on a parity with the 2026 Bonds with respect to certain security therefor. See “**SECURITY FOR THE 2026 BONDS – Additional Bonds; Parity Debt; Senior Security Interest**” herein.

***Amendments to Indenture.*** Certain amendments to the Indenture may be made without consent of the Holders of the Outstanding Bonds or with the consent of the Holders of a majority of the aggregate principal amount of the Outstanding Bonds. See **Appendix C – “FORM OF THE INDENTURE.”**

***Other Future Risks.*** In the future, the following factors, among others, may adversely affect the operations of health care providers, including the District, or the market value of health care revenue bonds, including the 2026 Bonds, to an extent that cannot be determined at this time.

- Adoption of legislation that would establish a national or statewide single-pay or health program or that would establish national, statewide or otherwise regulated rates applicable to hospitals and other health care providers.
- Reduced demand for the services of the District that might result from decreases in population or loss of market share to competitors.
- Increased unemployment or other adverse economic conditions in the service area of the District, which would increase the proportion of patients who are unable to pay fully for the cost of their care.
- Bankruptcy of an indemnity/commercial insurer, managed care plan or other payor.
- Efforts by insurers and governmental agencies to limit the cost of hospital services, to reduce the number of beds and to reduce the utilization of hospital facilities by such means as preventive medicine, improved occupational health and safety and outpatient care, or comparable regulations or attempts by third-party payors to control or restrict the operations of certain health care facilities.
- New clinical techniques and technology as well as new pharmaceutical and genetic developments and products, may alter the course of medical diagnosis and treatment in ways that are currently unanticipated and that may dramatically change medical and hospital care. These could result in higher health care costs, lower utilization of hospital services and/or new sources of competition for hospitals.
- Regulatory actions which might limit the ability of the District to undertake capital improvements at its facilities or to develop new institutional health services.
- The occurrence of a natural or man-made disaster (including wildfires and severe storms), that could damage the Facilities, interrupt utility service to the facilities, result in an abnormally high demand for health care services or otherwise impair the District’s operations and the generation of revenues from the facilities.
- Pandemics and public health emergencies like the COVID-19 pandemic could occur at any time in the future and could have far reaching societal and economic consequences that could materially adversely affect the operations of the District and the finances of the District.
- Limitations on the availability of, and increased compensation necessary to secure and retain, nursing, technical and other professional personnel.

- Cost and availability of any insurance, such as professional liability, fire, automobile and general comprehensive liability coverages, which health care facilities of a similar size and type generally carry.

## TAX MATTERS

In the opinion of Stradling Yocca Carlson & Rauth LLP, Newport Beach, California (“**Bond Counsel**”), under existing statutes, regulations, rulings and judicial decisions, and assuming the accuracy of certain representations and compliance with certain covenants and requirements described herein, interest (and original issue discount) on the 2026 Bonds is excluded from gross income for federal income tax purposes and is not an item of tax preference for purposes of calculating the federal alternative minimum tax imposed on individuals. However, it should be noted that, with respect to applicable corporations as defined in Section 59(k) of the Internal Revenue Code of 1986, as amended (the “**Code**”), generally certain corporations with more than \$1,000,000,000 of average annual adjusted financial statement income, interest (and original issue discount) with respect to the 2026 Bonds might be taken into account in determining adjusted financial statement income for purposes of computing the alternative minimum tax imposed by Section 55 of the Code on such corporations. In the further opinion of Bond Counsel, interest (and original issue discount) on the 2026 Bonds is exempt from State of California personal income tax.

The difference between the issue price of a 2026 Bond (the first price at which a substantial amount of the 2026 Bonds of the same maturity is to be sold to the public) and the stated redemption price at maturity with respect to such 2026 Bond constitutes original issue discount. Original issue discount accrues under a constant yield method, and original issue discount will accrue to a Bond Owner before receipt of cash attributable to such excludable income. The amount of original issue discount deemed received by the Bond Owner will increase the Bond Owner’s basis in the 2026 Bond. In the opinion of Bond Counsel, the amount of original issue discount that accrues to the owner of a 2026 Bond is excluded from the gross income of such owner for federal income tax purposes, is not an item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations, and is exempt from State of California personal income tax.

Bond Counsel’s opinion as to the exclusion from gross income of interest (and original issue discount) on the 2026 Bonds is based upon certain representations of fact and certifications made by the District and others and is subject to the condition that the District complies with all requirements of the Code, that must be satisfied subsequent to the issuance of the 2026 Bonds to assure that interest (and original issue discount) on the 2026 Bonds will not become includable in gross income for federal income tax purposes. Failure to comply with such requirements of the Code might cause the interest (and original issue discount) on the 2026 Bonds to be included in gross income for federal income tax purposes retroactive to the date of issuance of the 2026 Bonds. The District has covenanted to comply with all such requirements.

The amount by which a Bond Owner’s original basis for determining loss on sale or exchange in the applicable 2026 Bond (generally, the purchase price) exceeds the amount payable on maturity (or on an earlier call date) constitutes amortizable Bond premium, which must be amortized under Section 171 of the Code; such amortizable Bond premium reduces the Bond Owner’s basis in the applicable 2026 Bond (and the amount of tax exempt interest received), and is not deductible for federal income tax purposes. The basis reduction as a result of the amortization of Bond premium may result in a Bond Owner realizing a taxable gain when a 2026 Bond is sold by the Owner for an amount equal to or less (under certain circumstances) than the original cost of the 2026 Bond to the Owner. Purchasers of the 2026 Bonds should consult their own tax advisors as to the treatment, computation and collateral consequences of amortizable Bond premium.

The Internal Revenue Service (the “**IRS**”) has initiated an expanded program for the auditing of tax exempt bond issues, including both random and targeted audits. It is possible that the 2026 Bonds will be selected for audit by the IRS. It is also possible that the market value of the 2026 Bonds might be affected as a result of such an audit of the 2026 Bonds (or by an audit of other similar bonds). No assurance can be given that in the course of an audit, as a result of an audit, or otherwise, Congress or the IRS might not change the Code (or interpretation thereof) subsequent to the issuance of the 2026 Bonds to the extent that it adversely affects the exclusion from gross income of interest (and original issue discount) on the 2026 Bonds or their market value.

SUBSEQUENT TO THE ISSUANCE OF THE 2026 BONDS THERE MIGHT BE FEDERAL, STATE OR LOCAL STATUTORY CHANGES (OR JUDICIAL OR REGULATORY CHANGES TO OR INTERPRETATIONS OF FEDERAL, STATE OR LOCAL LAW) THAT AFFECT THE FEDERAL, STATE OR LOCAL TAX TREATMENT OF THE 2026 BONDS, INCLUDING THE IMPOSITION OF ADDITIONAL FEDERAL INCOME OR STATE TAXES ON OWNERS OF TAX-EXEMPT STATE OR LOCAL OBLIGATIONS, SUCH AS THE 2026 BONDS. THESE CHANGES COULD ADVERSELY AFFECT THE MARKET VALUE OR LIQUIDITY OF THE 2026 BONDS. NO ASSURANCE CAN BE GIVEN THAT SUBSEQUENT TO THE ISSUANCE OF THE 2026 BONDS STATUTORY CHANGES WILL NOT BE INTRODUCED OR ENACTED OR JUDICIAL OR REGULATORY INTERPRETATIONS WILL NOT OCCUR HAVING THE EFFECTS DESCRIBED ABOVE. BEFORE PURCHASING ANY OF THE 2026 BONDS, ALL POTENTIAL PURCHASERS SHOULD CONSULT THEIR TAX ADVISORS REGARDING POSSIBLE STATUTORY CHANGES OR JUDICIAL OR REGULATORY CHANGES OR INTERPRETATIONS, AND THEIR COLLATERAL TAX CONSEQUENCES RELATING TO THE 2026 BONDS.

Bond Counsel's opinions may be affected by actions taken (or not taken) or events occurring (or not occurring) after the date of issuance of the 2026 Bonds. Bond Counsel has not undertaken to determine, or to inform any person, whether any such actions or events are taken or do occur. The Indenture and the Tax Certificate relating to the 2026 Bonds permit certain actions to be taken or to be omitted if a favorable opinion of Bond Counsel is provided with respect thereto. Bond Counsel expresses no opinion as to the exclusion from gross income of interest (and original issue discount) on the 2026 Bonds for federal income tax purposes with respect to any 2026 Bond if any such action is taken or omitted based upon the advice of counsel other than Stradling Yocca Carlson & Rauth LLP.

Although Bond Counsel has rendered an opinion that interest (and original issue discount) on the 2026 Bonds is excluded from gross income for federal income tax purposes provided that the District continues to comply with certain requirements of the Code, the ownership of the 2026 Bonds and the accrual or receipt of interest (and original issue discount) with respect to the 2026 Bonds may otherwise affect the tax liability of certain persons. Bond Counsel expresses no opinion regarding any such tax consequences. Accordingly, before purchasing any of the 2026 Bonds, all potential purchasers should consult their tax advisors with respect to collateral tax consequences relating to the 2026 Bonds.

Should interest on the 2026 Bonds (including any original issue discount) become includable in gross income for federal income tax purposes, the 2026 Bonds are not subject to early redemption and will remain outstanding until maturity or until redeemed in accordance with the Indenture.

The complete text of the final opinion that Bond Counsel expects to deliver upon the issuance of the 2026 Bonds is set forth in **Appendix D – "Form of Final Opinion of Bond Counsel."**

## **LITIGATION**

There is no material litigation pending against the District and, to the knowledge of its officers, there is no controversy or litigation threatened that in any way questions or affects the validity of the 2026 Bonds or any proceedings or transactions relating to their issuance, sale, and delivery or the pledge or application of any moneys or security provided for the payment of the 2026 Bonds.

## **APPROVAL OF LEGALITY**

The validity of the 2026 Bonds and certain legal matters is subject to the approving opinion of Stradling Yocca Carlson & Rauth LLP, Bond Counsel. A complete copy of the proposed form of Bond Counsel opinion is contained in **Appendix D** hereto.

Other legal matters will be passed upon for the District by McDougal Boehmer Foley Lyon Mitchell & Erickson, a professional corporation, as special counsel to the District and by Pierson Ferdinand LLP, as the District's disclosure counsel. Certain legal matters will be passed upon for the Underwriter by Jones Hall LLP.

## RATING

S&P Global Ratings (“**S&P**”) has assigned the rating of “\_\_\_\_\_” (\_\_\_\_\_ outlook) to the 2026 Bonds. Any explanation of the significance of any such rating may be obtained only from S&P.

The District has furnished the rating agency with certain information and materials relating to the 2026 Bonds and the District that have not been included in this Official Statement. Generally, rating agencies base their ratings on the information and materials so furnished and on investigations, studies and assumptions made by the rating agencies. There is no assurance that a particular rating will be maintained for any given period of time or that it will not be lowered or withdrawn entirely if, in the judgment of the rating agency originally establishing such rating, circumstances so warrant. The Underwriter has not undertaken any responsibility to bring to the attention of the holders of the 2026 Bonds any proposed revision or withdrawal of the ratings of the 2026 Bonds or to oppose any such proposed revision or withdrawal. Pursuant to the Continuing Disclosure Certificate, the District is required to bring to the attention of the holders of the 2026 Bonds any revision or withdrawal of the ratings of the 2026 Bonds but has not undertaken any responsibility to oppose any such revision or withdrawal. See “**CONTINUING DISCLOSURE UNDERTAKING**” and **Appendix E – “FORM OF CONTINUING DISCLOSURE CERTIFICATE.”**

## FINANCIAL STATEMENTS

The audited financial statements of the District for the fiscal years ended June 30, 2025 and 2024, are included in **Appendix B** to this Official Statement.

The financial statements of the District as of and for the fiscal years ended June 30, 2025 and 2024, included herein as **Appendix B**, have been audited by Forvis Mazars, LLP, independent auditors, as stated in its report appearing herein. The District has not requested and Forvis Mazars, LLP has not provided consent for inclusion of its audit report in this Official Statement; however, Forvis Mazars, LLP has acknowledged that they are aware the above-referenced audit report will be included in this Official Statement. Forvis Mazars, LLP has not been engaged to perform, and has not performed, since the date of its report included herein, any procedures on the financial statements addressed in that report. Further, Forvis Mazars, LLP has not participated in any way in the preparation or review of this Official Statement.

Certain financial information for the fiscal year ended June 30, 2026 is provided in **Appendix A – “INFORMATION CONCERNING OAK VALLEY HOSPITAL DISTRICT”** and is derived from the unaudited financial statements of the District prepared by District management, but includes all adjustments that District management considers necessary for a fair presentation under generally accepted accounting principles; however, the final audit procedures may result in the reclassification or restatement of certain items from the unaudited financial information included herein.

## UNDERWRITING

The 2026 Bonds are being purchased by Hilltop Securities, Inc. (the “**Underwriter**”) at a purchase price of \$\_\_\_\_\_, which is the par amount of the 2026 Bonds of \$\_\_\_\_\_ less an Underwriter’s discount of \$\_\_\_\_\_, and [•plus•][•less•] a [•net•] original issue [•premium•][•discount•] of \$\_\_\_\_\_. The Bond Purchase Contract for the 2026 Bonds provides that the Underwriter will purchase all of the 2026 Bonds, if any are purchased, and contains the agreement of the District to indemnify the Underwriter against certain liabilities to the extent permitted by law. The obligation of the Underwriter to make such purchase is subject to certain terms and conditions set forth in the Bond Purchase Contract.

The Underwriter and its affiliates is a full service financial institution engaged in various activities, which may include securities trading, commercial and investment banking, municipal advisory, investment management, principal investment, hedging, financing and brokerage services. The Underwriter and certain of its affiliates may have, from time to time, performed, and may in the future perform, various investment banking services for the District, for which they may have received or will receive customary fees and expenses. In the ordinary course of its various business activities, the Underwriter and its affiliates may make or hold a broad array of investments and

actively trade debt and equity securities (or related derivative securities) and financial instruments (including bank loans and/or credit default swaps) for its own account and for the accounts of their customers and may at any time hold long and short positions in such securities and instruments. Such investment and securities activities may involve securities and instruments of the District.

The Underwriter may offer and sell the 2026 Bonds to certain dealers and others at prices or yields different from the prices or yields stated on the cover page of this Official Statement. The offering prices or yields may be changed from time to time without notice by the Underwriter.

### CONTINUING DISCLOSURE UNDERTAKING

The District has covenanted for the benefit of holders and beneficial owners of the 2026 Bonds to provide certain financial information and operating data relating to the District by not later than nine months following the end of the District's fiscal year commencing with the report for the fiscal year ending June 30, 2026 (the "**Annual Report**"), and to provide notices of the occurrence of certain enumerated events. The Annual Report will be filed by or on behalf of the District with the Municipal Securities Rulemaking Board (the "**MSRB**"). The notices of material events will also be filed by or on behalf of the District with the MSRB. The specific nature of the information to be contained in the Annual Report and the notices of material events is set forth in **Appendix E - "FORM OF CONTINUING DISCLOSURE CERTIFICATE."** These covenants have been made in order to assist the Underwriter in complying with Securities and Exchange Commission Rule 15c2-12(b)(5). The District has also covenanted to provide quarterly, unaudited financial information not later than 60 days following the end of each fiscal quarter commencing with the report for the fiscal quarter ending December 31, 2026.

Within the last five years, the District has not failed to timely comply with its prior continuing disclosure obligations under Rule 15c2-12(b)(5) in any material respect.

Failure by the District to comply with the provisions of the Continuing Disclosure Certificate will not constitute an event of default under the Indenture and holders and beneficial owners of the 2026 Bonds are limited to the remedies described in **Appendix E - "FORM OF CONTINUING DISCLOSURE CERTIFICATE."** Any failure by the District to comply with the provisions of the Continuing Disclosure Certificate is required to be reported in accordance with Rule 15c2-12 and is required to be considered by any broker, dealer or municipal securities dealer before recommending the purchase or sale of the 2026 Bonds in the secondary market. Consequently, any such failure may adversely affect the transferability and liquidity of the 2026 Bonds and their market price.

### MUNICIPAL ADVISOR

The District has retained Fieldman, Rolapp & Associates, Inc. ("**Fieldman**"), Irvine, California, a municipal advisory firm registered with the U.S. Securities and Exchange Commission and the Municipal Securities Rulemaking Board, as municipal advisor in connection with the issuance of the 2026 Bonds. Although Fieldman has assisted in the preparation of this Official Statement, Fieldman was not and is not obligated to undertake, and has not undertaken to make, an independent verification and assumes no responsibility for the accuracy, completeness or fairness of the information contained in this Official Statement.

## **MISCELLANEOUS**

The foregoing and subsequent summaries or descriptions of the 2026 Bonds and the Indenture, and all references to other materials not purporting to be quoted in full are only brief outlines of some of the provisions thereof and do not purport to summarize or describe all of the provisions thereof, and reference is made to said documents for full and complete statements of their provisions. Copies in reasonable quantity of the Indenture may be obtained during the offering period upon request directed to the Underwriter and thereafter upon request directed to the principal corporate trust office of the Trustee.

Any statements in this Official Statement involving matters of opinion, whether or not expressly so stated, are intended as such and not as representations of fact. This Official Statement is not to be construed as a contract or agreement between the District and the purchasers or Owners of any of the 2026 Bonds.

The District has approved this Official Statement and has authorized its execution and delivery.

### **OAK VALLEY HOSPITAL DISTRICT**

By: \_\_\_\_\_  
Chief Executive Officer

**APPENDIX A**  
**INFORMATION CONCERNING OAK VALLEY HOSPITAL DISTRICT**

*The information contained in this Appendix A  
has been obtained from Oak Valley Hospital District and  
other sources identified herein and deemed to be reliable by the District*

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## APPENDIX A

### INFORMATION CONCERNING OAK VALLEY HOSPITAL DISTRICT

#### INTRODUCTION

Oak Valley Hospital District (the “**District**”), a local health care district formed in 1968, is a political subdivision of the State of California organized pursuant to the State’s Local Health Care District Law (formerly the Local Hospital District Law) as set forth in the State’s Health and Safety Code. The geographic area that composes the District, which includes the voting residents who elect the District’s Board of Directors and passed the District’s general obligation bond measure, encompasses approximately 327 square miles in the northeastern portion of Stanislaus County and includes the city of Oakdale, portions of the cities of Modesto, Riverbank and Waterford, as well as the neighboring unincorporated areas of Valley Home and Knights Ferry. The 2026 estimated population of the cities of Oakdale, Riverbank, and Waterford and Stanislaus County was approximately 23,489, 26,594, 9,261 and 557,159, respectively. The permanent resident population of the District is approximately 42,000 and the population of the District’s service area is approximately 88,000.

The District operates Oak Valley Hospital, the Oak Valley Care Center, the Waterford Clinic, the Escalon Clinic, the Oakdale Clinic and the Riverbank Clinic (collectively referred to herein as the “**Health Facilities**”). The District leases the Oak Valley Care Center and three of its four community health centers but owns all remaining buildings that comprise the Health Facilities.

#### THE HOSPITAL AND HEALTH FACILITIES

Oak Valley Hospital (the “**Hospital**”) commenced operations in 1973 with significant expansions completed in 1992, 1995, 2000 and 2011. The Hospital is a general acute care hospital licensed for 40 acute care beds. The Hospital is located in Oakdale, California, approximately 14 miles east of Modesto, California, and approximately 80 miles southeast of Sacramento, California, near the intersection of State Highways 108 and 120. The Hospital is situated on a 12-acre campus and consists of a one-story, 42,629 square foot building and a new adjacent, two-story, approximately 123,000 square foot building. The first floor of the new building contains a 12-bay emergency room, two surgery suites, five post-anesthesia beds, two endoscopy



procedure rooms, seven out-patient surgical prep and recovery rooms, radiology, laboratory, materials management, and nutritional services. The second floor of the new building is shelled out to allow for the future addition of up to fifty-eight acute care beds. The new Hospital building has been constructed within seven feet of the existing building with corridors connecting the two structures. The Hospital provides a full range of primary and secondary acute care services, skilled nursing and comprehensive emergency, outpatient and ambulatory care services. The existing hospital facility meets California’s earthquake requirements through 2030.

To meet the needs of the residents of its service area, the District has gradually expanded its services over time. The District’s primary health facility, the Hospital, was originally constructed as a 32-bed general acute care facility. Since its opening, additions to the Hospital and the expansion into other facilities and services have included the following:

1992 – Emergency Department expansion of the Hospital;

- 1995 – Expansion of patient rooms and added 11 skilled nursing beds to the Hospital;
- 2000 – Family Centered Maternity Care – six-bed labor, delivery, recovery and postpartum conversion; and
- 2011 – Two-story expansion to the Hospital (described above).

In addition to the Hospital, the District operates the following hospital-based facilities:

**Oak Valley Care Center.** The District leased the Oak Valley Care Center in 1991 and operates this facility as a 104-bed licensed skilled nursing facility, located immediately adjacent to the Hospital campus. The Oak Valley Care Center is designated as a distinct part skilled nursing facility by the State of California, affording the District a higher rate of reimbursement than similar freestanding skilled nursing facilities for services provided based upon an allowable cost not to exceed formula. The District purchased a thirteen percent ownership in the Oak Valley Care Center facility in 2006. The Oak Valley Care Center lease is on a month-to-month basis.



**Waterford Clinic.** The Waterford Clinic (also referred to as Waterford Community Health Center) (a Public Law (“PL”) 95-210 rural health clinic) is located in the City of Waterford and was opened in 2014. This 2,700-square-foot leased facility is located approximately 11 miles from the Hospital in a community retail complex in the city of Waterford. The center is licensed as a Rural Health Clinic by the State Department of Public Health.



**Escalon Clinic.** The Escalon Clinic (also referred to as Escalon Community Health Center) (a PL 95-210 rural health clinic) is located in the City of Escalon and was opened in 2004. This 2,885-square-foot leased facility is located approximately 10 miles from the Hospital in a leased medical/professional office complex. It is licensed as a Rural Health Clinic by the State Department of Public Health.



**Oakdale Clinic.** The Oakdale Clinic (also referred to as Oak Valley Community Health Center) (a PL 95-210 rural health clinic) is located adjacent to the Hospital and is operated in a leased 9,612-square-foot building. This clinic facility commenced operation in 1997 and is also licensed as a Rural Health Clinic by the State Department of Public Health.



**Riverbank Clinic.** The Riverbank Clinic (also referred to as Riverbank Community Health Center) (a PL 95-210 rural health clinic) is located in the City of Riverbank and began operations in 1996. This 3,012-square-foot clinic facility is located approximately 6 miles from the Hospital in a leased medical/professional office complex. It is also licensed as a Rural Health Clinic by the State Department of Public Health.



The District also provides ambulance services located in the Cities of Oakdale, Riverbank and Waterford.

## BOARD OF DIRECTORS

The Board of Directors of the District (the “**Board**”), consists of five members elected to four-year terms by voters who reside within the confines of the District’s boundaries. No election is required if a candidate for election to the Board is unopposed. Members of the Board must be registered voters residing within the District and, beginning with elections held on or after November 2, 2026, elections will be conducted based on election zones within the District, with voters in each zone elected a director residing within that zone.

The current members of the Board, their offices, principal occupations and the dates on which their terms expire are shown in the following table. Each of the current members of the Board are residents of separate election zones and will not be required to resign in connection with the change to zone-based election in the District. to be confirmed.

| <u>Name</u>      | <u>Position</u>     | <u>Principal Occupation</u>     | <u>Term Expires</u> |
|------------------|---------------------|---------------------------------|---------------------|
| Dan Cummins      | Chairperson         | Fire Captain (Retired)          | 2026                |
| Danielle Sanders | Vice Chairperson    | Realtor                         | 2028                |
| Billie Scott     | Secretary           | Hearing Healthcare Professional | 2028                |
| Ann Bairos       | Director            | Healthcare Professional         | 2028                |
| Sara Shipman     | Finance Chairperson | Realtor                         | 2028                |

## SENIOR MANAGEMENT

The day-to-day operations and management planning for the Health Facilities are handled by the following key administrative officers:

***Matthew Heyn, President and Chief Executive Officer.*** Mr. Heyn has served as the President and Chief Executive Officer of the Health Facilities since August of 2023. Prior to joining the District Mr. Heyn served as the President and Chief Executive Officer of Delta Health in Delta, Colorado from April of 2020 through March of 2023. During his tenure there Mr. Heyn led the 50-bed, acute care hospital with 11 clinics through the pandemic and improved the operating margin by 8% with a multi-year strategic plan that included expanding operations, voter approved tax measures and partnering with other providers and overhauling systems to improve performance. Positions prior to this included Chief Executive Officer at Advent Health Ottawa in Kansas and Pawnee Valley Community Hospital in Larned, Kansas, and Chief Financial Officer at Central Kansas Medical Center in Great Bend, Kansas and Rangely District Hospital in Colorado.

Mr. Heyn has been in the healthcare industry for 19 years in leadership positions including Chief Financial Officer and Chief Executive Officer. He received his Bachelor of Science degree from the University of Texas at San Antonio, and his Master of Healthcare Administration degree from Trinity University, San Antonio, Texas. He is a member of the American College of Healthcare Executives and was a speaker at the 2022 National Rural Health Association Annual Conference.

***Chang Ahn, Chief Financial Officer.*** Mr. Ahn has served the District since June of 2017. He assumed the duties of Assistant Chief Financial Officer in July of 2025 and was appointed as Chief Financial Officer in 2026. Prior to becoming the Assistant Chief Financial Officer, Mr. Ahn served as the Director of Finance for two years and served as the Controller for six years. Prior to that and, since his professional career began in 2007, he has worked his way up progressively from Accountant to Controller at other hospital facilities in California and Texas. Mr. Ahn received his Bachelor of Science degree in Accounting from the University of Texas at Dallas and his Master of Business Administration Finance degree from the University of North Texas.

***David Rodrigues, Vice President, Chief Operating Officer.*** Mr. Rodrigues has served the District since June of 1998 and assumed the duties of Vice President and Chief Operating Officer in November of 2012. Prior to taking this position Mr. Rodrigues served as the Vice President of Administrative Services, and the Director of Clinics and Business Development. He began his career with the District as the Information System Manager from 1998 to 2008. Mr. Rodrigues received his Bachelor of Science degree in Computer Information Systems and his Master of Business Administration from California State University, Stanislaus.

***David Neal, Chief Nursing Officer.*** Mr. Neal has held the position of Vice President of Nursing since July of 2024. Before that he was an interim Chief Nurse Executive of Sutter Coast Hospital in Crescent City, California and Chief Executive at Mad River Hospital in Arcata, California from February 2019 through December 2024. Mr. Neal began his nursing career in 1984 and has gained experience in all aspects of nursing specialties over his tenure. Mr. Neal received his Bachelor of Science degree in Nursing from the Oregon Health Sciences University and his master's in healthcare management from the California Coast University. He has held his Inpatient Obstetric Nursing Certification since 1990, is a current American Heart Healthcare Provider and is a California Licensed Registered Nurse.

***Will Pringle, Vice President, Long Term Care.*** Mr. Pringle has been the Vice President of Long Term Care Services since 2022. He has had over 14 years in the skilled nursing and assisted living facility industry, generally serving in the roles of director and administrator for such facilities. Mr. Pringle received a bachelor's degree from Gonzaga University in Spokane, Washington and his master's degree in Gerontology Administration from the University of Southern California.

## EMPLOYEES AND MEDICAL STAFF MATTERS

### Employees

As of June 30, 2026, the District had 666 employees, representing approximately 445.7 full-time equivalent (“FTE”) employees. The following table sets forth the total number of provider FTEs as of the indicated dates:

| <u>Date</u>   | <u>Total Employees</u> | <u>Approximately<br/>FTE Employees</u> |
|---------------|------------------------|----------------------------------------|
| June 30, 2022 | 464                    | 377.9                                  |
| June 30, 2023 | 479                    | 379.4                                  |
| June 30, 2024 | 496                    | 394.8                                  |
| June 30, 2025 | 550                    | 391.4                                  |
| June 30, 2026 | 666                    | 445.7                                  |

Source: District records

The District has two employee bargaining unit agreements. One with the National Association of Government Employees who represent all ambulance personnel (approximately 57 employees) that expires in November 2028, and one with United Steelworkers who represent clinic staff across the Hospital and Nursing Home (approximately 474 employees) that expires in January 2027.

### Medical Staff

The following table sets forth the indicated information regarding the District’s total medical staff as of the indicated dates:

| <u>Date</u>   | <u>Total<br/>Medical Staff</u> | <u>Active &amp;<br/>Provisional<br/>Medical Staff</u> | <u>% of Active<br/>Medical Staff<br/>Board<br/>Certified</u> | <u>Admission %<br/>from Top 10<br/>Admitting<br/>Physicians</u> | <u>Highest<br/>Admission %<br/>from Single<br/>Physician</u> | <u>Average Age<br/>of Top 10<br/>Admitting<br/>Physicians</u> |
|---------------|--------------------------------|-------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------------|
| June 30, 2022 | 150                            | 53                                                    | 72%                                                          | 96%                                                             | 29%                                                          | 49                                                            |
| June 30, 2023 | 171                            | 39                                                    | 75%                                                          | 97%                                                             | 34%                                                          | 49                                                            |
| June 30, 2024 | 137                            | 35                                                    | 83%                                                          | 95%                                                             | 37%                                                          | 50                                                            |
| June 30, 2025 | 157                            | 101                                                   | 87%                                                          | 92%                                                             | 25%                                                          | 52                                                            |
| June 30, 2026 | 162                            | 106                                                   | 88%                                                          | 74%                                                             | 16%                                                          | 47                                                            |

Source: District records

### Employees’ Retirement Plan

The District’s employees’ retirement plan (the “**Retirement Plan**”) is a defined contribution pension plan established to provide retirement benefits for District employees. Employees are eligible to enter the plan upon employment and are 50% vested when they enter and retirement benefits fully vest after six years of service. The annual contribution made by the District is equal to approximately 7.5% of eligible employee salaries for the first year of employment and 15.9% of eligible employee salaries thereafter. As of June 30, 2025 and 2026, the District contributed total pension costs of \$4,361,000 (audited) and \$\_\_\_\_\_ (unaudited), respectively.

Additional employee benefits include programs under which health care, life insurance, disability insurance, vision care and dental care are provided, as well as retirement programs.

## RELATED ENTITIES AND AFFILIATIONS

The District plans for and evaluates potential affiliations as part of its overall strategic planning process where there are strategic or operational benefits to be realized.

The District has established an affiliation with Modesto Junior College in Modesto, California, to provide clinical training degrees for respiratory care, certified nursing assistants, and medical assistants and to assist students enrolled in the College's nursing program. The District has also established an affiliation with California State University, Stanislaus in Turlock, California, to provide clinical training for nurse practitioners in the program. This program assists the District in maintaining a full complement of qualified medical staff for the Health Facilities.

The Oak Valley District Foundation and Auxiliary (the "**Foundation**") has been established as a department within the District to solicit contributions on behalf of the Hospital. The Foundation's funds are distributed to the District as determined by the Foundation's Board of Trustees.

## SERVICE AREA AND COMPETITION

District management considers its primary service area to include a four-zip code area in northeastern Stanislaus County and southeastern San Joaquin County, encompassing the Cities of Oakdale, Waterford, Riverbank and Escalon. This primary service area accounted for a majority of the Hospital's inpatient discharges for the fiscal year ended June 30, 2026, and includes a significant area outside of the District's geographic boundary. Management estimates that most of the remaining acute care services are provided by Kaiser Hospital, Memorial Medical Center and Doctors Medical Center; all located approximately 12 to 15 miles from the Hospital in Modesto, California. Kaiser Hospital is a member of Kaiser Permanente Health System. Memorial Medical Center is a member of the Sutter Health System and Doctors Medical Center is a member of the Tenet Health System.

For the calendar year 2025, the Hospital maintained a 7% market share for its primary service area based upon acute care discharges reported to the Office of Statewide Health Planning and Development.

**Competing Facilities.** In April of 2024, Kaiser Permanente broke ground on a new 105,000 square foot medical office building in Modesto on the campus of its Modesto Medical Center, which is located approximately 11 miles west, south-west of the Hospital. The facility includes primary and specialty care and office space for 74 physicians and was completed in February 2026.

In 2024, Sutter Health announced plans to construct a new \$380 million, 165,000 square foot cancer center in Modesto at the Memorial Medical Center campus, which is located approximately 9 miles southwest of the Hospital. The new four-story facility is slated for completion in 2029 and will include cancer care on the first two floors, an ambulatory center on the third floor and outpatient services on the fourth floor. The project is planned to accommodate significant growth that is projected for the Central Valley.

In September of 2024, the Stanislaus Surgical Hospital, a 23-bed hospital in Modesto operated by Sutter Health suspended its operations due to the loss of its provider agreement for serving Medicare and Medi-Cal patients. Prior to its closure, the hospital provided radiology, surgeries and preventative screenings to over 1,800 patients a month. The hospital had been in operation since 1985.

## SERVICES

The District provides a range of acute care, long-term care, outpatient and ancillary services at the Health Facilities, including pediatric, medical surgical, orthopedic, laboratory, diagnostic imaging, respiratory therapy, urgent care, emergency services, primary care, skilled nursing services, and women's health among others.

Diagnostic imaging services with real time image transfer throughout their system include computed tomography (CT), digital mammography, cystoscopy, magnetic resonance imaging (MRI), cardiac (Echo) ultrasonography and x-ray radiology.

Surgical services include general, orthopedic, gastroenterology, ophthalmologic, otolaryngologic, plastic, podiatry, thoracic, and urologic and in 2024, was expanded to include a broader range of surgery services including bariatric surgery. The expanded services are provided through a partnership with Central California Surgery Center whose surgical team operates at the Hospital.

The District’s orthopedic unit includes board certified orthopedic surgeons offering advanced robotic-assisted orthopedic surgery, using technology that offers high precision partial and full knee and hip replacement which enables patients to recover quickly, reduce their pain and restore movement to improve their quality of life.

The District re-opened its intensive care unit in 2025 following a temporarily closure in 2024 due to fiscal constraints that faced many rural hospitals at the time including declining reimbursements, staffing shortages and rising costs.

The District established a cooperative arrangement with Sound Physicians in June of 2025 to bring Board Certified physicians to its emergency room services.

The District operates four community health centers in Escalon, Oakdale, Riverbank and Waterford. These facilities offer primary care as well as unscheduled walk-in services. Services include virtual primary care and behavioral health visits, routine checkups, immunizations, regular screenings, disease management, Medicare wellness exams and sports physicals.

### ACCREDITATIONS, MEMBERSHIPS AND DESIGNATIONS

The Hospital has been accredited since it was opened in 1968 and the Oak Valley Care Center has been accredited since the District began operations in 1991. The Hospital’s and Oak Valley Care Center’s most recent three-year accreditations from The Joint Commission will expire around July of 2028. In addition to The Joint Commission accreditations of the Hospital and Oak Valley Care Center, the District’s laboratory services have been separately accredited by The Joint Commission through approximately October of 2026. Lab accreditation status to be confirmed prior to posting POS.

The Hospital is an eligible provider under Medicare, Medi-Cal, Blue Cross and other commercial insurance programs and holds memberships in the California Hospital Association, the District Hospital Leadership Forum, and the Healthcare Compliance Association. The Hospital is designated as a Small Rural Hospital and as a Disproportionate Share Hospital for Medicare and Medi-Cal purposes. It is also located within a Rural Designated Area, is designated as a Health Professional Shortage Area as well as a Medically Underserved Area.

### BED COMPLEMENT

The Health Facilities have a combined licensed capacity of 144 beds. The licensed bed count for the Health Facilities, classified by service type and by facility, is as follows:

|                                     | <i>Licensed Beds</i>           |                                   |              |
|-------------------------------------|--------------------------------|-----------------------------------|--------------|
|                                     | <i>Oak Valley<br/>Hospital</i> | <i>Oak Valley<br/>Care Center</i> | <i>Total</i> |
| Medical Surgical                    | 35                             | 0                                 | 35           |
| Intensive Care                      | <u>5</u>                       | <u>0</u>                          | <u>5</u>     |
| Total Acute Care                    | 40                             | 0                                 | 40           |
| Skilled Nursing Care <sup>(1)</sup> | <u>0</u>                       | <u>104</u>                        | <u>104</u>   |
| Total Licensed Beds                 | <u>40</u>                      | <u>104</u>                        | <u>144</u>   |

<sup>(1)</sup> The skilled nursing beds are designated by the State of California as distinct part beds, which designation currently provides a significantly higher rate of reimbursement to the District than other skilled nursing facilities not receiving such designation.

Source: District records and State of California Department of Public Health license.

## FINANCIAL INFORMATION

### In General

The following summaries of the statements of revenues, expenses and changes in net assets of the District are qualified by reference to and should be read in conjunction with the District's audited financial statements, including the notes thereto included as **Appendix B** herein, and "**Management's Discussion and Analysis of Recent Financial Performance**," herein. The accounting policies of the District conform to those recommended by the audit and accounting guide, Health Care Organization, published by the American Institute of Certified Public Accountants and the financial statements summarized below were prepared in accordance with the pronouncements of the Governmental Accounting Standards Board ("**GASB**"). The statements of revenues, expenses and changes in net assets of the District for the four fiscal years ended June 30, 2022 through 2025, are derived from the District's audited financial statements.

The summaries of statements of revenues, expenses and changes in net assets for the fiscal year ending June 30, 2026, and the two-month periods ended August 31, 2025 and 2026, have been obtained from unaudited financial statements of the District. These financial statements have been prepared in accordance with generally accepted accounting principles ("**GAAP**") on a basis consistent with the accounting policies reflected in the audited financial statements of the District presented below. They do not, however, include all of the information required by GAAP for complete financial statements. In the opinion of District management, the unaudited financial statements reflect all significant adjustments (which are of a normal, recurring nature) necessary for a fair presentation of the results for the interim periods presented. Operating results for the interim periods presented are not necessarily indicative of the results that may be expected for any other interim period or for the fiscal year as a whole.

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## Statements of Revenues, Expenses and Changes in Net Assets

| (000's omitted)                         | Fiscal Year Ending June 30, |                   |                   |                                  |                     | Two-Month Period<br>Ending August 31, |                     |
|-----------------------------------------|-----------------------------|-------------------|-------------------|----------------------------------|---------------------|---------------------------------------|---------------------|
|                                         | 2022<br>(audited)           | 2023<br>(audited) | 2024<br>(audited) | 2025 <sup>(1)</sup><br>(audited) | 2026<br>(unaudited) | 2025<br>(unaudited)                   | 2026<br>(unaudited) |
| Operating Revenues:                     |                             |                   |                   |                                  |                     |                                       |                     |
| Net Patient Service Revenue             | \$ 71,091                   | \$ 72,384         | \$ 77,134         | \$ 89,863                        | \$ 124,598          | \$ 14,875                             | \$ 26,438           |
| Other Operating Revenue                 | 6,726                       | 13,184            | 12,949            | 1,054                            | 1,886               | 1,992                                 | 114                 |
| Total Operating Revenue                 | 77,817                      | 85,568            | 90,184            | 90,917                           | 126,484             | 16,867                                | 26,553              |
| Operating Expenses:                     |                             |                   |                   |                                  |                     |                                       |                     |
| Salaries & Benefits                     | 38,685                      | 43,374            | 45,638            | 45,111                           | 57,147              | 8,722                                 | 12,088              |
| Professional Fees & Purchased Services  | 17,067                      | 17,711            | 16,069            | 15,229                           | 22,474              | 2,840                                 | 4,633               |
| Supplies and Other                      | 11,019                      | 11,174            | 11,950            | 13,700                           | 32,367              | 2,784                                 | 7,171               |
| Rent & Lease                            | 1,979                       | 2,128             | 2,182             | —                                | —                   | —                                     | —                   |
| Inter-governmental transfer expense     | —                           | —                 | —                 | 10,236                           | —                   | —                                     | —                   |
| Depreciation & Amortization             | 5,782                       | 5,484             | 4,716             | 6,053                            | 5,077               | 803                                   | 928                 |
| Total Operating Expenses                | 74,531                      | 79,871            | 80,556            | 90,329                           | 117,065             | 15,149                                | 24,822              |
| Operating Income (Loss)                 | 3,286                       | 5,697             | 9,628             | 588                              | 9,419               | 1,718                                 | 1,731               |
| Non-operating Revenues (Expenses):      |                             |                   |                   |                                  |                     |                                       |                     |
| District Tax Revenue                    | 2,327                       | 2,384             | 2,450             | 2,672                            | 2,574               | 429                                   | 478                 |
| Investment Income                       | 71                          | 430               | 693               | 945                              | 861                 | 195                                   | 106                 |
| Interest Expense                        | (2,496)                     | (2,433)           | (2,710)           | (2,674)                          | (2,448)             | (423)                                 | (394)               |
| Other Non-Operating Income (Expenses)   | (1)                         | 0                 | 0                 | 0                                | 0                   | 0                                     | 0                   |
| Total Non-operating Revenues (Expenses) | (99)                        | 380               | 433               | 943                              | 987                 | 201                                   | 190                 |
| Excess of Revenues Over Expenses        | 3,187                       | 6,077             | 10,061            | 1,531                            | 10,406              | 1,919                                 | 1,921               |
| Inter-Governmental Transfers            | (3,993)                     | (6,700)           | (9,536)           | —                                | —                   | —                                     | —                   |
| Capital Grants and Contributions        | 0                           | 0                 | 10                | 296                              | —                   | —                                     | —                   |
| Increase (Decrease) in Net Assets       | (806)                       | (623)             | 535               | 1,827                            | 10,406              | 1,919                                 | 1,921               |
| Adjustment Applicable to Prior Year     | —                           | —                 | —                 | (586) <sup>(2)</sup>             | —                   | —                                     | —                   |
| Beginning Net Assets                    | 38,050                      | 37,244            | 36,621            | 37,156                           | 38,397              | 38,397                                | 48,803              |
| Ending Net Assets                       | \$ 37,244                   | \$ 36,621         | \$ 37,156         | \$ 38,397                        | \$ 48,803           | \$ 40,316                             | \$ 50,724           |

<sup>(1)</sup> The District changed auditors beginning with the audit for the fiscal year ended June 30, 2025, and, in connection therewith, certain expense and other categories were adjusted.

<sup>(2)</sup> See Note 1 to the audited financial statements attached as **Appendix B** hereto.

Source: Information for fiscal years ending June 30, 2022, 2023, 2024, and 2025 has been derived from the District's audited financial statements and data for the fiscal year ending on June 30, 2026, and the two-month periods ending August 31, 2025 and 2026, have been derived from the District's unaudited financial records. Note: Sums may not add due to rounding.

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## Unrestricted Funds and Days Cash on Hand

The following table provides the total unrestricted funds and days cash on hand for the District as of June 30, 2022, 2023, 2024, 2025 and 2026. Marketable securities are carried at market value.

| (000's Omitted)                       | As of June 30            |                          |                          |                          |                            |
|---------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------------------|
|                                       | <u>2022</u><br>(audited) | <u>2023</u><br>(audited) | <u>2024</u><br>(audited) | <u>2025</u><br>(audited) | <u>2026</u><br>(unaudited) |
| Cash and Cash Equivalents             | \$23,897                 | \$23,120                 | \$24,800                 | \$26,625                 | \$19,977                   |
| Board Designated Use                  | <u>184</u>               | <u>192</u>               | <u>193</u>               | =                        | =                          |
| Total Unrestricted Funds              | \$24,081                 | \$23,312                 | \$24,993                 | \$26,625                 | \$19,977                   |
| Average Daily Expenses <sup>(1)</sup> | <u>188</u>               | <u>204</u>               | <u>208</u>               | <u>231</u>               | <u>307</u>                 |
| Days Cash on Hand                     | <u>128</u>               | <u>114</u>               | <u>120</u>               | <u>115</u>               | <u>65</u>                  |

<sup>(1)</sup> The District changed its method of accounting for Intergovernmental Transfer Payments in fiscal year ending June 30, 2025 and began including it in operating expenses at that time, resulting in an impact on the daily cash and days cash on hand calculation.

Source: Audited financial statements of the District for the fiscal years ending June 30, 2022 through 2025 and unaudited financial statements for the fiscal year ending June 30, 2026. Note: Days cash on hand in this table does not include interest on debt service which was included in the calculation of days cash on hand in the summary section of the audited financial statements. Note: Sums may not add due to rounding.

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## Health Facilities Utilization

Selected utilization statistics for the Health Facilities for each of the five fiscal years ended June 30, 2022 through 2026, and the two-month periods ending August 31, 2025 and 2026 are detailed in the table below.

|                                                           | Fiscal Year Ending June 30, |             |             |             |             | Two-Month Periods Ended August 31, |             |
|-----------------------------------------------------------|-----------------------------|-------------|-------------|-------------|-------------|------------------------------------|-------------|
|                                                           | <u>2022</u>                 | <u>2023</u> | <u>2024</u> | <u>2025</u> | <u>2026</u> | <u>2025</u>                        | <u>2026</u> |
| <b><u>Acute Medical Surgical Care:</u></b> <sup>(1)</sup> |                             |             |             |             |             |                                    |             |
| Available Beds                                            | 29                          | 29          | 24          | 24          | 40          | 24                                 | 40          |
| Inpatient admissions                                      | 624                         | 597         | 538         | 539         | 1,318       | 68                                 | 138         |
| Observation admissions                                    | 220                         | 265         | 267         | 377         | 785         | 51                                 | 95          |
| Patient Days                                              | 3,075                       | 2,727       | 1,979       | 1,867       | 4,426       | 225                                | 405         |
| Percent Occupancy                                         | 29%                         | 26%         | 23%         | 21%         | 30%         | 25%                                | 45%         |
| Ambulance Runs                                            | 7,005                       | 6,819       | 7,014       | 6,930       | 7,494       | 1,268                              | 1,335       |
| Emergency Visits                                          | 19,413                      | 21,226      | 20,423      | 21,234      | 20,253      | 3,470                              | 3,490       |
| Clinic Visits                                             | 51,832                      | 53,913      | 54,146      | 49,287      | 45,436      | 8,234                              | 8,805       |
| Total Surgeries (includes endoscopy)                      | 766                         | 712         | 773         | 939         | 1,567       | 94                                 | 207         |
| - Inpatient Surgeries                                     | 115                         | 99          | 101         | 194         | 384         | 72                                 | 71          |
| - Outpatient Surgeries                                    | 137                         | 119         | 86          | 128         | 506         | 22                                 | 74          |
| Total Outpatient Visits                                   | 106,068                     | 104,949     | 105,715     | 98,967      | 98,014      | 16,388                             | 18,232      |
| <b><u>Skilled Nursing Care:</u></b>                       |                             |             |             |             |             |                                    |             |
| Available Beds                                            | 115                         | 115         | 115         | 115         | 104         | 115                                | 104         |
| Admissions                                                | 76                          | 156         | 169         | 138         | 168         | 40                                 | 21          |
| Facility Days                                             | 25,471                      | 25,654      | 31,157      | 33,544      | 34,557      | 5,930                              | 5,549       |
| Percent Occupancy                                         | 61%                         | 61%         | 74%         | 80%         | 91%         | 83%                                | 85%         |
| <b><u>Combined:</u></b>                                   |                             |             |             |             |             |                                    |             |
| Available Beds                                            | 144                         | 144         | 139         | 139         | 144         | 139                                | 144         |
| Patient Days                                              | 28,546                      | 28,381      | 33,136      | 35,411      | 38,983      | 6,394                              | 6,579       |
| Percent Occupancy                                         | 54%                         | 54%         | 65%         | 70%         | 74%         | 70%                                | 74%         |

<sup>(1)</sup> Includes adult medical and surgical services, pediatrics, and intermediate care nursery; excludes newborns based on number of available beds.

Source: District records and annual continuing disclosure reports.

## Sources of Patient Service Revenue

The District receives payment for services from commercial insurers and other private payors, the federal government under the Medicare program, the federal government and the State under the Medi-Cal program and directly from patients. The following table shows an apportionment of the District's gross revenues from various sources for the five fiscal years ended June 30, 2022 through 2026.

|                                   | <u>2022</u>   | <u>2023</u>   | <u>2024</u>   | <u>2025</u>   | <u>2026</u>   |
|-----------------------------------|---------------|---------------|---------------|---------------|---------------|
| Medicare (including Medicare HMO) | 28.1%         | 27.9%         | 25.2%         | 25.4%         | 47.1%         |
| Medi-Cal (including Medi-Cal HMO) | 51.8%         | 53.7%         | 53.6%         | 52.1%         | 31.5%         |
| Private Pay, Commercial & Other   | 16.6%         | 15.3%         | 16.9%         | 17.5%         | 20.0%         |
| HMO/PPO                           |               |               |               |               |               |
| County & Charity Programs         | <u>3.6%</u>   | <u>3.1%</u>   | <u>4.3%</u>   | <u>5.0%</u>   | <u>1.4%</u>   |
| Total                             | <u>100.0%</u> | <u>100.0%</u> | <u>100.0%</u> | <u>100.0%</u> | <u>100.0%</u> |

Source: District records.

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. These payment arrangements include:

*Medicare.* Certain inpatient acute care services are paid at prospectively determined rates per discharge based on clinical, diagnostic, and other factors. Physician services are paid based upon established fee schedules. Outpatient services are paid using prospectively determined rates. The District is reimbursed for certain services at tentative rates with final settlement determined after submission of annual cost reports by the District and audits thereof by the Medicare administrative contractor.

*Medi-Cal.* Reimbursements for Medi-Cal services are generally paid at prospectively determined rates per discharge (APR-DRG). These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Outpatient services are reimbursed based upon a fee schedule per procedure, test, or service.

*Other.* Payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations provide for payment using prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

See the discussion under the caption “**BONDHOLDERS’ RISKS – Patient Service Revenues**” in the front part of this Official Statement for additional information on risks associated with each revenue sources.

#### **Other Indebtedness**

**General Obligation Bonds.** The District was successful, on August 31, 2004, in securing approval of registered voters residing within the District of a \$37,000,000 general obligation bond issue (the “**General Obligation Bonds**”). The District’s bond measure (Measure H) received 77.8% voter approval of all residents who voted. The General Obligation Bonds are secured by a pledge of *ad valorem* taxes on all taxable property located within the District and are not secured by, nor repaid from, revenues of the District. The District issued all \$37,000,000 in authorized General Obligation Bonds on June 8, 2005, which bonds were refunded in full with the proceeds of the District’s 2014 General Obligation Refunding Bonds issued in the original aggregate principal amount of \$32,690,000, which were subsequently refunded in full with the proceeds of the District’s 2025 General Obligation Refunding Bonds issued in the original aggregate principal amount of \$21,145,000 and currently outstanding in the aggregate principal amount of \$19,635,000 (the “**2025 General Obligation Bonds**”).

#### **Other Debt.**

**Mortgage Loan.** The District has an outstanding mortgage loan that was incurred to provide for the Oakdale Clinic located at 1420 West H Street in Oakdale. This loan matures in May 2042, with principal payable annually and interest at 3.95% through May 2032. Beginning June 2032, interest accrues at the five-year U.S. Treasury rate plus 2.25% payable monthly. The note is secured by a deed of trust on the clinic property.

**Line of Credit.** The District maintains a revolving line of credit with Oak Valley Community Bank with a \$3,000,000 limit, which is unsecured. The District made a draw on the line of credit in September of 2026 in the full amount and plans to repay the Line of Credit in January of 2027. The Line of credit has a current maturity date of February 15, 2027.

## Capitalization

The District's actual and pro forma capitalization as of June 30, 2026, excluding the General Obligation Bonds payable from *ad valorem* taxes, and as adjusted as if the 2026 Bonds had been outstanding as of that date, is as follows:

|                                                            | As of June 30, 2026 |                   |
|------------------------------------------------------------|---------------------|-------------------|
|                                                            | <u>Actual</u>       | <u>Pro Forma*</u> |
| 2020A Bonds                                                | \$ 11,005,000       | \$ 11,005,000     |
| 2020B Bonds                                                | 5,228,882           | 5,228,882         |
| 2021 Bonds                                                 | 7,698,760           | 7,698,760         |
| 2024 Bonds                                                 | 7,600,000           | 7,600,000         |
| 2026 Bonds                                                 | —                   | —                 |
| Notes Payable and Capital Leases                           | <u>1,615,620</u>    | <u>1,615,620</u>  |
| Total Long-Term Debt                                       | \$ 33,148,262       | \$ —              |
| Less: Current Maturities of Long-Term Indebtedness         | <u>( )</u>          | <u>( )</u>        |
| Net Long-Term Debt                                         | \$ —                | \$ —              |
| Total Net Assets (unrestricted)                            | <u>48,579,766</u>   | <u>48,579,766</u> |
| Total Capitalization                                       | <u>\$ —</u>         | <u>\$ —</u>       |
| Net Long-Term Debt as a Percentage of Total Capitalization | ___%                | ___%              |

\* Preliminary; subject to change.

Source: Actual information as of June 30, 2026 has been derived from the District's unaudited financial statements. The above information excludes the District's general obligation bonds issued in 2014 because they are secured by property taxes, not revenues of the District.

## Historical and Pro Forma Debt Service Coverage

The following table sets forth for each of the five fiscal years ended June 30, 2022 through 2026, the total funds available to pay the District's debt service and the extent to which such revenues (a) covered actual debt service requirements on all long-term indebtedness of the District during those periods and (b) would have covered, on a proforma basis, the maximum aggregate annual debt service requirements on the 2026 Bonds and on other long-term indebtedness for the periods indicated.

|                                                                                            | Fiscal Year Ended June 30, |                  |                  |                  |                  |
|--------------------------------------------------------------------------------------------|----------------------------|------------------|------------------|------------------|------------------|
| (000's Omitted)                                                                            | 2022                       | 2023             | 2024             | 2025             | 2026             |
| Increase in Net Assets                                                                     | \$ (806,102)               | \$ (623,321)     | \$ 524,767       | \$ 1,827,391     | \$ 10,406,000    |
| Less: District Tax Revenues                                                                | (2,326,800)                | (2,383,550)      | (2,449,800)      | (2,672,305)      | (2,574,000)      |
| Add: Depreciation and Amortization                                                         | 5,781,681                  | 5,484,396        | 4,716,342        | 6,053,364        | 5,077,000        |
| Interest Expense                                                                           | <u>2,496,478</u>           | <u>2,433,451</u> | <u>2,709,641</u> | <u>2,674,189</u> | <u>2,448,000</u> |
| Funds Available to Meet Debt Service                                                       | \$ 5,145,357               | \$ 4,810,396     | \$ 5,500,350     | \$ 7,882,639     | \$ 15,357,000    |
| Actual Debt Service for the District                                                       | \$ 1,271,651               | \$ 2,270,395     | \$ 2,438,389     | \$ 4,075,045     | \$ 4,074,990     |
| Historical Debt Service Coverage Ratio                                                     | 4.05x                      | 2.12x            | 2.26x            | 1.93x            | 3.77x            |
| Pro Forma Maximum Annual Debt Service on the Revenue Bonds and all Outstanding Parity Debt | \$ —                       | \$ —             | \$ —             | \$ —             | \$ —             |
| Pro Forma Maximum Annual Debt Service Coverage Ratio                                       | ___x                       | ___x             | ___x             | ___x             | ___x             |

Source: Information for the fiscal years ended June 30, 2022 through 2025 has been derived from the District's audited financial statements. Information for the fiscal year ended June 30, 2026 has been derived from the District's internal unaudited records. Proforma maximum annual debt service for the

2026 Bonds for all periods has been provided by the Underwriter. Debt service above excludes debt service relating to the General Obligation Bonds and excludes tax revenues collected by the County for the purpose of repaying debt service on the General Obligation Bonds.

<sup>(1)</sup> Proforma Maximum Annual Debt Service for the 2026 Bonds for the eleven-month periods ended May 31, 2019, and May 31, 2020, is equal to the maximum annual debt service payments applicable to the fiscal years in which those financial periods occur multiplied by 91.7% (reflecting 11 of the 12 months). Excludes debt service on the General Obligation Bonds.

## Management's Discussion and Analysis of Recent Financial Performance

**[•to be inserted in a subsequent draft •]**

## OTHER INFORMATION

### Public and Professional Liability Insurance

**Insurance.** The District has secured insurance through Beta Healthcare Group as a member of the BETA Risk Management Authority (BETARMA), a pooled self-insurance program insuring the District for healthcare liability, directors, officers and trustees liability, professional liability. The BETARMA is a California Joint Powers Authority formed to pool self-insured claims and losses among public entities and nonprofit organizations providing healthcare services as authorized by California Government Code Sections 990.4(a), 990.8(c) and 6257, and subject to the provisions of Section 991.2 BETARMA is not subject to regulation as an insurer.

The District's current public and professional liability coverage contract is in continuous effect until canceled. The District's coverage with BETA Healthcare Group is on a claims made basis.

BETARMA is funded by monthly contributions paid by districts and counties participating in BETA Healthcare Group. The contributions are used to fund a reserve for expected losses to be paid by BETA Healthcare Group on a pooled, self-insured basis. The amount of the monthly contribution to be paid by a participant is based on independent actuarial computations taking into account factors such as, among others, total number of beds, outpatient and inpatient visits, surgeries, deductible and loss experience of the participant. The reserve for claims and claims expenses has been determined using the developed loss and loss expense method.

The District carries commercial insurance policies covering property, earthquake, cyber, pollution and fiduciary liability.

The District currently has two pending malpractice liability claims for compensatory damages. The District carries insurance which covers the pending claims. Certain claims, suits and complaints arising in the ordinary course of business have been filed or are pending against the District. In the opinion of management and its insurance defense legal counsel, such claims, if disposed of unfavorably, would not have a material adverse effect on the financial position of the District.

### Service Area Economy

The Health Facilities are located in and serve the Cities of Oakdale, Waterford, Riverbank, Escalon, and the surrounding unincorporated areas. The Cities of Oakdale, Riverbank and Waterford are located in the north-east quadrant of Stanislaus County, the State of California's 16<sup>th</sup> most populous county as of January 1, 2026. The City of Escalon is located in the southeast corner of San Joaquin County, the State of California's 14<sup>th</sup> most populous county as of January, 2026.

From 2010 to 2026, the Cities of Oakdale, Riverbank and Waterford grew by 13.61%, 17.27% and 9.52% respectively. In 2010, the City of Oakdale was the fifth largest city in Stanislaus County with a population of 20,675. However, as of 2025, the resident population of the City of Oakdale is estimated to have grown 13.61% to 23,489. Combined these cities make up approximately 10.6% of the population of Stanislaus County. The largest cities located within Stanislaus County, as of 2026, are the Cities of Modesto and Turlock with populations of 220,048 and 72,592, respectively. Stanislaus County covers approximately 1,494 square miles in the north-central portion of

California. From 2010 to 2026, the resident population of Stanislaus County is estimated to have grown 8.30% to 557,159.

The 2010 United States census showed the population of the cities in the District's primary service area to be a combined total of 58,941. During the past 16 years the estimated population of these cities has increased to 66,648, an approximately 13.08% increase, while the population of the State of California has increased just 6.28% over the same period. As estimated by the State Department of Finance for the cities within the District's service area and comparison figures for the Counties and State are as follows:

|                     | <u>2010</u>  | <u>2015</u>  | <u>2020</u>  | <u>2026</u>  | <u>2010-2026<br/>% Change</u> |
|---------------------|--------------|--------------|--------------|--------------|-------------------------------|
| City of Escalon     | 7,132        | 7,378        | 7,444        | 7,304        | 2.41%                         |
| City of Oakdale     | 20,675       | 21,760       | 23,171       | 23,489       | 13.61%                        |
| City of Riverbank   | 22,678       | 23,522       | 24,810       | 26,594       | 17.27%                        |
| City of Waterford   | <u>8,456</u> | <u>8,777</u> | <u>9,099</u> | <u>9,261</u> | <u>9.52%</u>                  |
| All Four Cities     | 58,941       | 61,437       | 64,524       | 66,648       | 13.08%                        |
| San Joaquin County  | 685,306      | 724,185      | 779,233      | 820,125      | 19.67%                        |
| Stanislaus County   | 514,453      | 532,534      | 552,878      | 557,159      | 8.30%                         |
| State of California | 37,253,956   | 38,810,306   | 39,535,623   | 39,592,962   | 6.28%                         |

Source: California State Department of Finance. The 2010 and 2020 figures are reported as of April 1. The 2015 and 2026 estimated figures are reported as of January 1.

The Hospital's service area, which extends beyond the District boundaries, incorporates a good portion of Stanislaus County. Although Stanislaus County's economy is developing rapidly in the manufacturing, commercial and service sectors, the presence of a strong and diverse agriculture backbone remains.

Due primarily to the seasonality of many of the major employers in this area and the agriculture basis of the economy, Stanislaus County's unemployment percentages are above the State of California's average. As indicated above, this is in large part attributed to the area's reliance on agriculture and farming related enterprises that dominate the area served by the Health Facilities. The August 2026 unadjusted labor market data are divided into the following sectors:

|                   | <u>City of<br/>Oakdale</u> | <u>City of<br/>Escalon</u> | <u>City of<br/>Riverbank</u> | <u>City of<br/>Waterford</u> | <u>Stanislaus<br/>County</u> | <u>State of<br/>California</u> |
|-------------------|----------------------------|----------------------------|------------------------------|------------------------------|------------------------------|--------------------------------|
| Employment        | 10,100                     | 3,000                      | 10,300                       | 3,900                        | 235,500                      | 18,446,700                     |
| Unemployment      | 1,000                      | 200                        | 900                          | 300                          | 17,700                       | 1,044,300                      |
| Unemployment Rate | 9.0%                       | 5.0%                       | 7.9%                         | 6.9%                         | 7.0%                         | 5.4%                           |

Source: State Employment Development Department, Preliminary August of 2026 employment and unemployment numbers are rounded as reflected in the reports provided in the source documentation.

**APPENDIX B**

**AUDITED FINANCIAL STATEMENTS OF THE DISTRICT  
AS OF AND FOR THE FISCAL YEARS ENDED JUNE 30, 2025 AND 2024**

**APPENDIX C**  
**SUMMARY OF THE INDENTURE**

**APPENDIX D**

**FORM OF FINAL OPINION OF BOND COUNSEL**

**APPENDIX E**

**FORM OF CONTINUING DISCLOSURE CERTIFICATE**

## APPENDIX F

### BOOK-ENTRY SYSTEM

*The information in this section concerning DTC and DTC's book-entry only system has been obtained from sources that the District believes to be reliable, but the District takes no responsibility for the completeness or accuracy thereof. The following description of the procedures and record keeping with respect to beneficial ownership interests in the 2026 Bonds, payment of principal, premium, if any, accreted value and interest on the 2026 Bonds to DTC Participants or Beneficial Owners, confirmation and transfers of beneficial ownership interests in the 2026 Bonds and other related transactions by and between DTC, the DTC Participants and the Beneficial Owners is based solely on information provided by DTC to the District which the District believes to be reliable, but the District and the Underwriter do not and cannot make any independent representations concerning these matters and do not take responsibility for the accuracy or completeness thereof. Neither the DTC, Direct Participants, Indirect Participants nor the Beneficial Owners should rely on the foregoing information with respect to such matters, but should instead confirm the same with DTC or the DTC Participants, as the case may be.*

The Depository Trust Company ("DTC"), New York, New York, will act as securities depository for the 2026 Bonds. The 2026 Bonds will be issued as fully-registered securities registered in the name of Cede & Co. (DTC's partnership nominee) or such other name as may be requested by an authorized representative of DTC. One fully-registered bond will be issued for each annual maturity of the 2026 Bonds, each in the aggregate principal amount of such maturity, and will be deposited through the facilities of DTC.

DTC, the world's largest securities depository, is a limited-purpose trust company organized under the New York Banking Law, a "banking organization" within the meaning of the New York Banking Law, a member of the Federal Reserve System, a "clearing corporation" within the meaning of the New York Uniform Commercial Code, and a "clearing agency" registered pursuant to the provisions of Section 17A of the Securities Exchange Act of 1934. DTC holds and provides asset servicing for over 3.6 million issues of U.S. and non-U.S. equity issues, corporate and municipal debt issues, and money market instruments (from over 100 countries) that DTC's participants ("Direct Participants") deposit with DTC. DTC also facilitates the post trade settlement among Direct Participants of sales and other securities transactions in deposited securities, through electronic computerized book-entry transfers and pledges between Direct Participants' accounts. This eliminates the need for physical movement of securities certificates. Direct Participants include both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, clearing corporations, and certain other organizations. DTC is a wholly-owned subsidiary of The Depository Trust & Clearing Corporation ("DTCC"). DTCC is the holding company for DTC, National Securities Clearing Corporation and Fixed Income Clearing Corporation, all of which are registered clearing agencies. DTCC is owned by the users of its regulated subsidiaries. Access to the DTC system is also available to others such as both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, and clearing corporations that clear through or maintain a custodial relationship with a Direct Participant, either directly or indirectly ("Indirect Participants"). DTC has a Standard & Poor's rating of "AA+." The DTC Rules applicable to its Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at [www.dtcc.com](http://www.dtcc.com).

Purchases of 2026 Bonds under the DTC system must be made by or through Direct Participants, which will receive a credit for the 2026 Bonds on DTC's records. The ownership interest of each actual purchaser of each 2026 Bond ("Beneficial Owner") is in turn to be recorded on the Direct and Indirect Participants' records. Beneficial Owners will not receive written confirmation from DTC of their purchase. Beneficial Owners are, however, expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct or Indirect Participant through which the Beneficial Owner entered into the transaction. Transfers of ownership interests in the 2026 Bonds are to be accomplished by entries made on the books of Direct and Indirect Participants acting on behalf of Beneficial Owners. Beneficial Owners will not receive 2026 Bonds representing their ownership interests in Bonds, except in the event that use of the book-entry system for the 2026 Bonds is discontinued.

To facilitate subsequent transfers, all 2026 Bonds deposited by Direct Participants with DTC are registered in the name of DTC's partnership nominee, Cede & Co., or such other name as may be requested by an authorized representative of DTC. The deposit of 2026 Bonds with DTC and their registration in the name of Cede & Co. or such other DTC nominee do not affect any change in beneficial ownership. DTC has no knowledge of the actual Beneficial Owners of the 2026 Bonds; DTC's records reflect only the identity of the Direct Participants to whose accounts such 2026 Bonds are credited, which may or may not be the Beneficial Owners. The Direct and Indirect Participants will remain responsible for keeping account of their holdings on behalf of their customers.

Conveyance of notices and other communications by DTC to Direct Participants, by Direct Participants to Indirect Participants, and by Direct Participants and Indirect Participants to Beneficial Owners will be governed by arrangements among them, subject to any statutory or regulatory requirements as may be in effect from time to time. Beneficial Owners of 2026 Bonds may wish to take certain steps to augment the transmission to them of notices of significant events with respect to the 2026 Bonds, such as prepayments, tenders, defaults, and proposed amendments to the 2026 Bond documents. For example, Beneficial Owners of 2026 Bonds may wish to ascertain that the nominee holding the 2026 Bonds for their benefit has agreed to obtain and transmit notices to Beneficial Owners. In the alternative, Beneficial Owners may wish to provide their names and addresses to the registrar and request that copies of notices be provided directly to them.

Redemption notices shall be sent to DTC. If less than all of the 2026 Bonds within a maturity are being prepaid, DTC's practice is to determine by lot the amount of the interest of each Direct Participant in such maturity to be redeemed.

Neither DTC nor Cede & Co. (nor any other DTC nominee) will consent or vote with respect to 2026 Bonds unless authorized by a Direct Participant in accordance with DTC's MMI Procedures. Under its usual procedures, DTC mails an Omnibus Proxy to the District as soon as possible after the record date. The Omnibus Proxy assigns Cede & Co.'s consenting or voting rights to those Direct Participants to whose accounts 2026 Bonds are credited on the record date (identified in a listing attached to the Omnibus Proxy).

Redemption proceeds, distributions, and dividend payments on the 2026 Bonds will be made to Cede & Co., or such other nominee as may be requested by an authorized representative of DTC. DTC's practice is to credit Direct Participants' accounts upon DTC's receipt of funds and corresponding detail information from the District or the Trustee, on payable date in accordance with their respective holdings shown on DTC's records. Payments by Participants to Beneficial Owners will be governed by standing instructions and customary practices, as is the case with securities held for the accounts of customers in bearer form or registered in "street name," and will be the responsibility of such Participant and not of DTC, the Trustee, or the District, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of redemption proceeds, distributions, and dividend payments to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the District or the Trustee, disbursement of such payments to Direct Participants will be the responsibility of DTC, and disbursement of such payments to the Beneficial Owners will be the responsibility of Direct and Indirect Participants.

A Bond Owner shall give notice to elect to have its 2026 Bonds purchased or tendered, through its Participant, to the Trustee, and shall effect delivery of such 2026 Bonds by causing the Direct Participant to transfer the Participant's interest in the 2026 Bonds, on DTC's records, to the Trustee. The requirement for physical delivery of 2026 Bonds in connection with an optional tender or a mandatory purchase will be deemed satisfied when the ownership rights in the 2026 Bonds are transferred by Direct Participants on DTC's records and followed by a book-entry credit of tendered 2026 Bonds to the Trustee's DTC account.

DTC may discontinue providing its services as depository with respect to the 2026 Bonds at any time by giving reasonable notice to the District or the Trustee. Under such circumstances, in the event that a successor depository is not obtained, physical certificates are required to be printed and delivered.

The District may decide to discontinue use of the system of book-entry only transfers through DTC (or a successor securities depository). In that event, Bonds will be printed and delivered to DTC.

THE TRUSTEE, AS LONG AS A BOOK-ENTRY ONLY SYSTEM IS USED FOR THE 2026 BONDS, WILL SEND ANY NOTICE OF REDEMPTION OR OTHER NOTICES TO OWNERS ONLY TO DTC. ANY FAILURE OF DTC TO ADVISE ANY DTC PARTICIPANT, OR OF ANY DTC PARTICIPANT TO NOTIFY ANY BENEFICIAL OWNER, OF ANY NOTICE AND ITS CONTENT OR EFFECT WILL NOT AFFECT THE VALIDITY OF SUFFICIENCY OF THE PROCEEDINGS RELATING TO THE REDEMPTION OF THE 2026 BONDS CALLED FOR REDEMPTION OR OF ANY OTHER ACTION PREMISED ON SUCH NOTICE.

## CONTINUING DISCLOSURE CERTIFICATE

This **CONTINUING DISCLOSURE CERTIFICATE** (this “**Disclosure Certificate**”) is executed and delivered by the **OAK VALLEY HOSPITAL DISTRICT**, a California local health care district and political subdivision of the State of California (the “**District**”) in connection with the issuance of \$\_\_\_\_\_ Oak Valley Hospital District (Stanislaus County, California) Health Facility Revenue Bonds, Series 2026 (the “**Bonds**”). The Bonds are being issued pursuant to that certain Indenture, dated as of November 1, 2004 (the “**Original Indenture**”), as previously amended and supplemented, and as amended and supplemented pursuant to a Seventh Supplemental Indenture of Trust, dated as of November 1, 2026 (the Original Indenture, as amended and supplemented, the “**Indenture**”), by and between the District and U.S. Bank Trust Company, National Association, as trustee (the “**Trustee**”). Pursuant to the Indenture, the District covenants and agrees as follows:

**Section 1. Definitions.** In addition to the definitions set forth in the Indenture, which apply to any capitalized term used in this Disclosure Certificate unless otherwise defined, the following capitalized terms shall have the following meanings:

“**Annual Report**” shall mean any Annual Report provided by the District pursuant to, and as described in, **Sections 3** and **4** of this Disclosure Certificate.

“**Annual Report Date**” means March 31.

“**Beneficial Owner**” shall mean any person which (a) has the power, directly or indirectly, to vote or consent with respect to, or to dispose of ownership of, any Bonds (including persons holding Bonds through nominees, depositories or other intermediaries), or (b) is treated as the owner of any Bonds for federal income tax purposes.

“**Dissemination Agent**” shall mean D.K. Goulding Financial Services, LLC, or any successor Dissemination Agent designated in writing by the District and which has filed with the District a written acceptance of such designation. In the absence of such a designation, the District shall act as the Dissemination Agent.

“**EMMA**” or “**Electronic Municipal Market Access**” means the centralized on-line repository for documents filed with the MSRB, such as official statements and disclosure information relating to municipal bonds, notes and other securities as issued by state and local governments.

“**Fiscal Year**” means any twelve-month period beginning on July 1 in any year and extending to the next succeeding June 30, both dates inclusive, or any other twelve-month period selected and designated by the District as its official fiscal year period under a Certificate of the District filed with the Trustee.

“**MSRB**” means the Municipal Securities Rulemaking Board, which has been designated by the Securities and Exchange Commission as the sole repository of disclosure information for purposes of the Rule, or any other repository of

disclosure information which may be designated by the Securities and Exchange Commission as such for purposes of the Rule in the future.

**“Official Statement”** means the final official statement executed by the District in connection with the issuance of the Bonds.

**“Participating Underwriter”** shall mean any of the original underwriters of the Bonds required to comply with the Rule in connection with offering of the Bonds.

**“Quarterly Report”** shall mean any Quarterly Report provided by the District pursuant to, and as described in, **Sections 3** and **4** of this Disclosure Certificate.

**“Quarterly Report Date”** means each February 15, May 15, August 15, and November 15.

**“Rule”** shall mean Rule 15c2-12(b)(5) adopted by the Securities and Exchange Commission under the Securities Exchange Act of 1934, as the same may be amended from time to time.

**“Significant Events”** means any of the events listed in **Section 5(a)** of this Disclosure Certificate.

**Section 2. Purpose of the Disclosure Certificate.** This Disclosure Certificate is being executed and delivered by the District for the benefit of the holders and beneficial owners of the Bonds and in order to assist the Participating Underwriter in complying with Securities and Exchange Commission Rule 15c2-12(b)(5).

### **Section 3. Provision of Annual Reports; Quarterly Reports.**

(a) Delivery of Annual Report. The District shall, or shall cause the Dissemination Agent to, not later than the Annual Report Date, commencing March 31, 2027, with the report for the Fiscal Year ending June 30, 2026 provide to the MSRB, in an electronic format as prescribed by the MSRB, an Annual Report that is consistent with the requirements of **Section 4(a)** of this Disclosure Certificate. Not later than fifteen (15) Business Days prior to the Annual Report Date, the District shall provide the Annual Report to the Dissemination Agent (if other than the District). If by fifteen (15) Business Days prior to the Annual Report Date the Dissemination Agent (if other than the District) has not received a copy of the Annual Report, the Dissemination Agent shall contact the District to determine if the District is in compliance with the previous sentence. The Annual Report may be submitted as a single document or as separate documents comprising a package and may include by reference other information as provided in **Section 4(a)** of this Disclosure Certificate; provided that the audited financial statements of the District may be submitted separately from the balance of the Annual Report, and later than the Annual Report Date, if not available by that date. If the District's Fiscal Year changes, it shall give notice of such change in the same manner as for a Significant Event under **Section 5(b)**. The District shall provide a written certification with each Annual Report furnished to the Dissemination Agent to the effect that such Annual Report constitutes the Annual Report required to be furnished by the District hereunder.

(b) Delivery of Quarterly Reports. In addition to the filing of an Annual Report, as described above, the District shall, or shall cause the Dissemination Agent to, not later than the Quarterly Report Date, commencing February 15, 2027, provide to the MSRB, in an electronic format as prescribed by the MSRB, a Quarterly Report that is consistent with the requirements of **Section 4(b)** of this Disclosure Certificate. Not later than ten (10) Business Days prior to the Quarterly Report Date, the District shall provide the Quarterly Report to the Dissemination Agent (if other than the District). If by ten (10) Business Days prior to the Quarterly Report Date the Dissemination Agent (if other than the District) has not received a copy of the Quarterly Report, the Dissemination Agent shall contact the District to determine if the District is in compliance with the previous sentence. The Quarterly Report may be submitted as a single document or as separate documents comprising a package and may include by reference other information as provided in **Section 4(b)** of this Disclosure Certificate. The District shall provide a written certification with each Quarterly Report furnished to the Dissemination Agent to the effect that such Quarterly Report constitutes the Quarterly Report required to be furnished by the District hereunder.

(c) Change of Fiscal Year. If the District's Fiscal Year changes, it shall give notice of such change in the same manner as for a Significant Event under **Section 5(d)**, which notice shall include updates to the dates set forth in the definitions of Annual Report Date and Quarterly Report Date, which updated dates shall reflect the same period following the end of the District's then current Fiscal Year and each applicable fiscal quarter as contained in this Disclosure Certificate based on the District's Fiscal Year end on the date hereof.

(d) Report of Non-Compliance. If the District is unable to provide an Annual Report by the date required in subsection (a) or a Quarterly Report by the date required in subsection (b) of this **Section 3**, the Dissemination Agent shall send a notice to EMMA in substantially the form attached as **Exhibit A**.

(e) Annual Compliance Certification. The Dissemination Agent shall, if the Dissemination Agent is other than the District, file a report with the District certifying that the Annual Report and the Quarterly Reports have been provided pursuant to this Disclosure Certificate, stating the date it was provided.

#### **Section 4. Content of Annual Reports and Quarterly Reports.**

(a) Annual Report. The Annual Report shall contain or incorporate by reference the following:

(i) Audited financial statements of the District for the preceding Fiscal Year. If the District's audited financial statements are not available by the time the Annual Report is required to be filed pursuant to **Section 3(a)**, the Annual Report shall contain unaudited financial statements in a format similar to the financial statements contained in the final Official Statement, and the audited financial statements shall be filed in the same manner as the Annual Report when they become available.

(ii) To the extent not included in the audited financial statement of the District, the Annual Report shall also include operating data with respect to the District for the preceding Fiscal Year, substantially similar to that provided in the tables under the following captions in the Official Statement:

(A) EMPLOYEES AND MEDICAL STAFF MEMBERS - Employees;

(B) EMPLOYEES AND MEDICAL STAFF MEMBERS - Medical Staff;

(C) FINANCIAL INFORMATION - Health Facilities Utilization;

(D) FINANCIAL INFORMATION - Sources of Patient Services Revenue;

(E) FINANCIAL INFORMATION - Historical and Pro Forma Debt Service Coverage Ratio (historical information only); and

(F) FINANCIAL INFORMATION - Unrestricted Funds and Days Cash on Hand.

(iii) Any or all of the items listed above may be included by specific reference to other documents, including official statements of debt issues of the District or related public entities, which are available to the public on the MSRB's Internet web site or filed with the Securities and Exchange Commission. The District shall clearly identify each such other document so included by reference.

If the document included by reference is a final official statement, it must be available from EMMA.

(iv) In addition to any of the information expressly required to be provided under paragraph (ii) of this **Section 4(a)**, the District shall provide such further information, if any, as may be necessary to make the specifically required statements, in light of the circumstances under which they are made, not misleading.

(b) Quarterly Report. The Quarterly Report shall contain or incorporate by reference the following:

(i) Unaudited quarterly balance sheet; and

(ii) Unaudited quarterly statement of revenues and expenditures.

## **Section 5. Reporting of Significant Events.**

(a) The District shall give, or cause to be given, notice of the occurrence of any of the following Significant Events with respect to the Bonds:

(i) Principal and interest payment delinquencies;

(ii) Non-payment related defaults, if material;

- (iii)    Unscheduled draws on debt service reserves reflecting financial difficulties;
- (iv)    Unscheduled draws on credit enhancements reflecting financial difficulties;
- (v)     Substitution of credit or liquidity providers, or their failure to perform;
- (vi)    Adverse tax opinions, the issuance by the Internal Revenue Service of proposed or final determinations of taxability, Notices of Proposed Issue (IRS Form 5701-TEB) or other material notices or determinations with respect to the tax status of the security, or other material events affecting the tax status of the security;
- (vii)   Modifications to rights of security holders, if material;
- (viii)   Bond calls, if material, and tender offers;
- (ix)    Defeasances;
- (x)     Release, substitution, or sale of property securing repayment of the securities, if material;
- (xi)    Rating changes;
- (xii)   Bankruptcy, insolvency, receivership or similar event of the District or other obligated person;
- (xiii)   The consummation of a merger, consolidation, or acquisition involving the District or an obligated person, or the sale of all or substantially all of the assets of the District or an obligated person (other than in the ordinary course of business), the entry into a definitive agreement to undertake such an action, or the termination of a definitive agreement relating to any such actions, other than pursuant to its terms, if material; or
- (xiv)   Appointment of a successor or additional trustee or the change of name of a trustee, if material;
- (xv)    The incurrence of a financial obligation of the District, if material, or agreement to covenants, events of default, remedies, priority rights, or other similar terms of a financial obligation of the District, any of which affect security holders, if material; or
- (xvi)   A default, event of acceleration, termination event, modification of terms, or other similar events under the terms of a financial obligation of the District, any of which reflect financial difficulties.

(b) Whenever the District obtains knowledge of the occurrence of a Significant Event, the District shall, or shall cause the Dissemination Agent (if not the District) to, file a notice of such occurrence with the MSRB, in an electronic format as prescribed by the MSRB, in a timely manner not in excess of 10 business days after the occurrence of the Significant Event. Notwithstanding the foregoing,

notice of Significant Events described in subsection (a)(viii) above need not be given under this subsection any earlier than the notice (if any) of the underlying event is given to holders of affected Bonds under the Indenture.

(c) The District acknowledges that the events described in subparagraphs (a)(ii), (a)(vii), (a)(viii) (if the event is a bond call), (a)(x), (a)(xiii), (a)(xiv) and (a)(xv) of this **Section 5** contain the qualifier “if material.” The District shall cause a notice to be filed as set forth in paragraph (b) above with respect to any such event only to the extent that the District determines the event’s occurrence is material for purposes of U.S. federal securities law. The District intends that the words used in paragraphs (xv) and (xvi) and the definition of “financial obligation” to have the meanings ascribed thereto in the Rule.

(d) For purposes of this Disclosure Certificate, any event described in paragraph (a)(xii) above is considered to occur when any of the following occur: the appointment of a receiver, fiscal agent, or similar officer for the District in a proceeding under the United States Bankruptcy Code or in any other proceeding under state or federal law in which a court or governmental authority has assumed jurisdiction over substantially all of the assets or business of the District, or if such jurisdiction has been assumed by leaving the existing governing body and officials or officers in possession but subject to the supervision and orders of a court or governmental authority, or the entry of an order confirming a plan of reorganization, arrangement, or liquidation by a court or governmental authority having supervision or jurisdiction over substantially all of the assets or business of the District.

**Section 6. Identifying Information for Filings with EMMA.** All documents provided to EMMA under this Disclosure Certificate shall be accompanied by identifying information as prescribed by the MSRB.

**Section 7. Termination of Reporting Obligation.** The District’s obligations under this Disclosure Certificate shall terminate upon the defeasance, prior redemption or payment in full of all of the Bonds. If such termination occurs prior to the final maturity of the Bonds, the District shall give notice of such termination in the same manner as for a Significant Event under **Section 5**.

#### **Section 8. Dissemination Agent.**

(a) Appointment of Dissemination Agent. The District may, from time to time, appoint or engage a dissemination agent to succeed the Dissemination Agent, which may be the District itself, to assist it in carrying out its obligations under this Disclosure Certificate, and may discharge any such agent, with or without appointing a successor Dissemination Agent. If the Dissemination Agent is not the District, the Dissemination Agent shall not be responsible in any manner for the content of any notice or report prepared by the District pursuant to this Disclosure Certificate.

(b) Compensation of Dissemination Agent. The Dissemination Agent shall be paid compensation by the District for its services provided hereunder in accordance with its schedule of fees as agreed to between the Dissemination Agent and the District from time to time and all expenses, legal fees and advances made or incurred by the Dissemination Agent in the performance of its duties hereunder. The Dissemination Agent shall not be deemed to be acting in any fiduciary capacity

for the District, Holders or Beneficial Owners, or any other party. The Dissemination Agent may rely and shall be protected in acting or refraining from acting upon any direction from the District or an opinion of a nationally recognized bond counsel. The Dissemination Agent may at any time resign by giving written notice of such resignation to the District.

**Section 9. Amendment or Waiver.** Notwithstanding any other provision of this Disclosure Certificate, the District may amend this Disclosure Certificate, and any provision of this Disclosure Certificate may be waived, provided that the following conditions are satisfied:

(a) if the amendment or waiver relates to the provisions of **Sections 3(a), 4 or 5(a)**, it may only be made in connection with a change in circumstances that arises from a change in legal requirements, change in law, or change in the identity, nature, or status of an obligated person with respect to the Bonds, or type of business conducted;

(b) the undertakings herein, as proposed to be amended or waived, would, in the opinion of nationally recognized bond counsel, have complied with the requirements of the Rule at the time of the primary offering of the Bonds, after taking into account any amendments or interpretations of the Rule, as well as any change in circumstances; and

(c) the proposed amendment or waiver either (i) is approved by holders of the Bonds in the manner provided in the Indenture for amendments to the Indenture with the consent of holders, or (ii) does not, in the opinion of nationally recognized bond counsel, materially impair the interests of the holders or beneficial owners of the Bonds.

If the annual financial information or operating data to be provided in the Annual Report is amended pursuant to the provisions hereof, the first annual financial information filed pursuant hereto containing the amended operating data or financial information shall explain, in narrative form, the reasons for the amendment and the impact of the change in the type of operating data or financial information being provided.

If an amendment is made to the undertaking specifying the accounting principles to be followed in preparing financial statements, the annual financial information for the year in which the change is made shall present a comparison between the financial statements or information prepared on the basis of the new accounting principles and those prepared on the basis of the former accounting principles. The comparison shall include a qualitative discussion of the differences in the accounting principles and the impact of the change in the accounting principles on the presentation of the financial information, in order to provide information to investors to enable them to evaluate the ability of the District to meet its obligations. To the extent reasonably feasible, the comparison shall be quantitative.

The Dissemination Agent shall not be obligated to enter into any amendment increasing or affecting its duties or obligations hereunder.

A notice of any amendment made pursuant to this **Section 9** shall be filed in the same manner as for a Significant Event under **Section 5(b)**.

**Section 10. Additional Information.** Nothing in this Disclosure Certificate shall be deemed to prevent the District from disseminating any other information, using the means of dissemination set forth in this Disclosure Certificate or any other means of communication, or including any other information in any Annual Report or notice of occurrence of a Significant Event, in addition to that which is required by this Disclosure Certificate. If the District chooses to include any information in any Annual Report or notice of occurrence of a Significant Event in addition to that which is specifically required by this Disclosure Certificate, the District shall have no obligation under this Disclosure Certificate to update such information or include it in any future Annual Report or notice of occurrence of a Significant Event.

**Section 11. Default.** If the District fails to comply with any provision of this Disclosure Certificate, the Participating Underwriter or any holder or beneficial owner of the Bonds may take such actions as may be necessary and appropriate, including seeking mandate or specific performance by court order, to cause the District to comply with its obligations under this Disclosure Certificate. A default under this Disclosure Certificate shall not be deemed an Event of Default under the Indenture, and the sole remedy under this Disclosure Certificate in the event of any failure of the District to comply with this Disclosure Certificate shall be an action to compel performance.

**Section 12. Duties, Immunities and Liabilities of Dissemination Agent.** The Dissemination Agent shall have only such duties as are specifically set forth in this Disclosure Certificate, and the District agrees to indemnify and save the Dissemination Agent, its officers, directors, employees and agents, harmless against any loss, expense and liabilities which they may incur arising out of or in the exercise or performance of its powers and duties hereunder, including the costs and expenses (including attorneys' fees) of defending against any claim of liability, but excluding liabilities due to the Dissemination Agent's negligence or willful misconduct. The Dissemination Agent shall have no duty or obligation to review any information provided to it by the District hereunder and shall not be deemed to be acting in any fiduciary capacity for the District, the Bond holders or any other party. The obligations of the District under this **Section 12** shall survive resignation or removal of the Dissemination Agent and payment of the Bonds.

**Section 13. Beneficiaries.** This Disclosure Certificate shall inure solely to the benefit of the District, the Dissemination Agent, the Participating Underwriter and the holders and beneficial owners from time to time of the Bonds and shall create no rights in any other person or entity.

*(Remainder of this page intentionally left blank – signature page on following page)*

**Section 14. Counterparts.** This Disclosure Certificate may be executed in several counterparts, each of which shall be regarded as an original, and all of which shall constitute one and the same instrument.

**Date:** November \_\_, 2026

**OAK VALLEY HOSPITAL DISTRICT**

By: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

**ACKNOWLEDGED:**

**D.K. GOULDING FINANCIAL  
SERVICES, LLC**, as Dissemination  
Agent

By: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

*(Continuing Disclosure Certificate Signature Page)*

**EXHIBIT A**

**NOTICE TO EMMA OF FAILURE TO FILE REPORT**

**Name of Issuer:** Oak Valley Hospital District

**Name of Issue:** Oak Valley Hospital District (Stanislaus County, California)  
Health Facility Revenue Bonds, Series 2026

**Issue Date:** November \_\_, 2026

**NOTICE IS HEREBY GIVEN** that the Oak Valley Hospital District has not provided: (*check applicable box*)

☐ the Annual Report for the fiscal year ended \_\_\_\_\_

☐ the Quarterly Report for the fiscal quarter ended \_\_\_\_\_

with respect to the above-named Bonds as required by the Continuing Disclosure Certificate dated the Issue Date, furnished by the District in connection with the Issue. The District anticipates that such report will be filed by \_\_\_\_\_.

Dated: \_\_\_\_\_

\_\_\_\_\_, as  
Dissemination Agent

By:

\_\_\_\_\_  
Name:

\_\_\_\_\_  
Title:

**DISTRICT BOARD REPORT**  
**MEDICAL STAFF OPEN SESSION AGENDA**  
**October 1, 2026**

**Memo:** October 1, 2026  
**To:** Members of the District Board  
**From:** Medical Executive Committee  
**Re:** Approval items to be reviewed in open session

The Medical Executive Committee requests the District Board's approval of the following items forwarded from the September 18, 2026, meeting.

**Committee Meeting Reports**

- |                                                                                                                                                                                                                                    |                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| A. The Medical Executive Committee Minutes – (September 15, 2026)<br>Matthew Tilstra, MD, Chief of Staff                                                                                                                           | <b>Approval</b>   |
| B. Interdisciplinary Practice Committee Meeting (IDPC) – (September 1, 2026)<br>Chaitanya Mahida, MD, Chairperson                                                                                                                  | <b>Approval</b>   |
| C. Credentials Committee Meeting – (September 1, 2026)<br>Chaitanya Mahida, MD, Chairperson                                                                                                                                        | <b>Approval</b>   |
| D. The Department of Medicine Committee Report – (September 8, 2026)<br>Lee Horwitz, MD, Chairperson                                                                                                                               | <b>Approval</b>   |
| E. The Quality Council Minutes – (Cancelled Mtg 08/13/2026; Next 10/08/2026)<br>Lee Horwitz, MD, Chairperson                                                                                                                       | <b>Standing</b>   |
| F. The Department of Surgery Committee Minutes – (Next Mtg 10/13/2026)<br>Andrew Huber, MD, Dept of Surgery Chairperson <ul style="list-style-type: none"><li>o Update - Bariatric Center of Excellence has been earned.</li></ul> | <b>Discussion</b> |

**Other**

- |                                                                                |                   |
|--------------------------------------------------------------------------------|-------------------|
| G. Forms - None                                                                | <b>None</b>       |
| H. Policies                                                                    | <b>Approval</b>   |
| 1. Case Management Manual                                                      |                   |
| a. Medicare – An Important Message About Your Rights – <b>Manual Change</b>    | <b>Page 1-13</b>  |
| 2. Clinical Manual                                                             |                   |
| a. Accu-Check Inform II Fingerstick Glucose                                    | <b>Page 14-20</b> |
| b. Safe injection practices → <b>Recommend Retire</b>                          | <b>Page 21-22</b> |
| 3. Emergency Department Manual                                                 |                   |
| a. Febrile Neonates and Infants                                                | <b>Page 23-24</b> |
| b. Ordering of Pediatric X-Rays and Foreign Body Ingestion                     | <b>Page 25-27</b> |
| c. Triage                                                                      | <b>Page 28-40</b> |
| 4. Infection Control Manual                                                    |                   |
| a. Covid Vaccination Declination Requirements → <b>Recommend Retire</b>        | <b>Page 41-46</b> |
| b. Discontinue Isolation in patients with covid 19                             | <b>Page 47-51</b> |
| c. Environmental Culturing → <b>Recommend Retire</b>                           | <b>Page 52-51</b> |
| d. Environmental Surveillance → <b>Recommend Retire</b>                        | <b>Page 54</b>    |
| e. Ice Machines Maintenance and Cleaning                                       | <b>Page 55-57</b> |
| f. Influenza and Pneumococcal Vaccinations for Hospital Patients               | <b>Page 58-59</b> |
| g. Influx of Infectious Patients                                               | <b>Page 60-63</b> |
| h. Reportable Diseases                                                         | <b>Page 64-65</b> |
| i. Respiratory Hygiene Program – Visitors & Patients → <b>Recommend Retire</b> | <b>Page 66-67</b> |
| j. Scabies – Prevention and Control                                            | <b>Page 68-75</b> |

# OAK VALLEY HOSPITAL DISTRICT

## ~~Administrative~~ Case Management Manual

|                                                                                                                                                       |                     |                                   |                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------|---------------------------------------------|
| <b>Policy/Procedure:</b><br><br><b>Medicare - An Important Message About Your Rights</b><br><i>(Notification of Hospital Discharge Appeal Rights)</i> |                     |                                   |                                             |
| <b>Effective Date:</b> 12/2007                                                                                                                        |                     | <b>Page 1 of 3 (+Attachments)</b> |                                             |
| Areas Affected: All Divisions and Departments of the Hospital District                                                                                |                     |                                   |                                             |
| Composed by: Unknown                                                                                                                                  |                     |                                   |                                             |
| <input type="checkbox"/> Reviewed <input checked="" type="checkbox"/> Revised by: Admitting Manager                                                   |                     |                                   |                                             |
| <b>Dept / Committee Approval:</b>                                                                                                                     | <b>Dept/Title:</b>  | <b>Date</b>                       | <b>Approved</b>                             |
| Policy, Procedures, Forms Comm.                                                                                                                       | VP of Nursing       |                                   |                                             |
| Department of Medicine                                                                                                                                | Medical Staff Coord |                                   |                                             |
| Medical Executive Committee                                                                                                                           | Medical Staff Coord |                                   |                                             |
| District Board                                                                                                                                        | Board Liaison       |                                   |                                             |
| <b>Revised:</b> 04/2018; 12/31/2021                                                                                                                   |                     | <b>Reviewed:</b> 03/2011          | <b>Next Review Date:</b> <del>09/2025</del> |

### POLICY

Oak Valley Hospital District must issue the Important Message for Medicare (IM) within two (2) days of admission and must obtain the signature of the patient or his/her representative. Hospitals must also deliver a follow-up copy of this signed notice to each patient not more than two (2) days before the day of discharge. Follow-up notice is not required if delivery of the initial IM falls within two (2) calendar days of discharge, if the patient is being transferred from one inpatient hospital setting to another inpatient hospital setting, or when a patient exhausts Part A hospital days. Hospitals must retain a copy of the signed notice.

### PURPOSE

To comply with the Centers for Medicare and Medicaid Services (CMS) regulatory requirement that hospitals notify Medicare beneficiaries who are hospital inpatients about their hospital discharge rights.

### PROCEDURE

#### Initial Notice

Hospital Registration Staff must provide the IM at or near admission but no later than two (2) calendar days from the day of admission or at preadmission, but not more than seven (7) calendar days before admission and obtain the signature and signature date and time of the patient or representative to indicate receipt of notice. The original ~~/or a copy~~ is given to the patient with an ~~original~~ /copy retained by the hospital.

### Follow-up Notice

The follow-up IM must also be provided to the patient as soon as possible prior to discharge, but no more than two (2) days before. When a discharge seems likely in one-two (1-2) days, the follow-up notice should be given to the patient, so the patient has ample time to review and act on it. If the follow up notice is delivered on the day of discharge, the patient must be given at least four (4) hours prior to discharge to consider their rights. The facility must document delivery of the notice within the discharge documentation in order to demonstrate compliance with this requirement. If the hospital delivers the follow-up notice, and the beneficiary status subsequently changes, so that the discharge is beyond the two-day timeframe, hospitals must deliver another copy of the signed notice again within two (2) calendar days of the new planned discharge date.

### Patient Refusal to Sign

If the patient refuses to sign the notice, the hospital should note the refusal and date of refusal on the form and this will be considered the date of notice.

### Notice Delivery to Patient Representatives

When a patient is unable to understand the notice, the hospital may have the patient's representative receive and sign the notice in accordance with state or other applicable law. If the hospital is unable to personally deliver a notice to a representative, then the hospital should telephone the representative to advise him or her of the patient's rights as a hospital patient, including the right to appeal a discharge decision. The delivery of the initial IM or follow up IM notice should be in person. If the representative is not available for in person delivery, the notice may be made by telephone, but not by voicemail, with documentation of a copy of the notice mailed or faxed within the same day. If the hospital is unable to reach the representative by telephone, the notice may be sent by certified mail/return receipt. The date of signature or refusal becomes the date of notification.

### Medical Record Documentation

Oak Valley Hospital District will place a copy of the initial notice in the patient's medical record. The hospital must document timely delivery of the follow-up copy of the IM in the patient records, when applicable. The hospital will sign and date ~~use the "Additional Information" section of~~ the IM to document delivery of the follow-up copy. The hospital should also document any attempted contact with patient representatives, including telephone calls, messages and subsequent certified mail.

### Copies

- IM form: three(3) copies: 1) signed original for patient on admission; 2) follow-up copy to be given to patient within 48 hours prior to discharge and/or upon discharge; 3) hospital copy. Additional copies may be needed if the patient requests a review as Commerce Health ~~Livanta~~, the Quality Improvement Organization (QIO) will require a copy.
- Detailed Notice: two (2) copies: 1) original notice for patient; 2) hospital copy. Additional copies may be needed if the patient requests a review, as the QIO will require a copy.

Prior to the patient signing and dating the notice, the hospital must ensure the patient comprehends the contents of the notice.

Notices should not be delivered in an emergency medical situation.

### **Expedited Reviews**

A patient has a right to request a review of the discharge decision, by asking for an expedited review by the QIO when the hospital (acting directly or through its utilization review committee), with physician concurrence, determines that inpatient care is no longer necessary.

The process is as follows:

1. The patient submits a request for review to the QIO no later than midnight of the day of discharge that has been ordered by the physician. The request may be in writing or by telephone and must be before the patient leaves the hospital. If the request is not in this timeframe, and the patient remains in the hospital, he or she may request a review at any time, but will be held responsible for the charges incurred after the date of discharge ordered. If the QIO rules in favor of the patient, the hospital will refund the patient any funds collected.
2. When the patient requests a review prior to midnight the day of discharge, the patient is not financially responsible for inpatient hospital services (except coinsurance and deductibles) furnished before noon the day after the patient receives notification of the determination from the QIO.
  - a. If the QIO does not agree with the patient, the liability for continued services begins at noon of the day after the QIO notifies the patient.
  - b. If the QIO does agree with the patient, the patient is not financially responsible for continued care, until the hospital once again determines that the patient no longer requires inpatient care, secures the concurrence of the physician responsible for the patient or the QIO and notifies the patient with a follow-up copy of the IM letter.

### **RELATED FORMS**

[FORM0439 – Medicare An Important Message about your Rights](#)

[FORM0439S - Medicare An Important Message about your Rights](#)

### **REFERENCES**

1. [Centers for Medicare & Medicaid Services; FFS & MA IM/DND \(2026, March 17\).](#)  
[Retrieved from FFS & MA IM/DND | CMS](#)

~~;~~  
~~{Insert contact information here}~~

### ~~Important Message from Medicare~~

~~Patient name: \_\_\_\_\_ Patient number: \_\_\_\_\_~~  
~~\_\_\_\_\_~~

#### ~~Your Rights as a Hospital Inpatient:~~

- ~~• You can receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.~~
- ~~• You can be involved in any decisions about your hospital stay.~~
- ~~• You can report any concerns you have about the quality of care you receive to your QIO at: {insert QIO name and toll-free number of QIO} The QIO is the independent reviewer authorized by Medicare to review the decision to discharge you.~~
- ~~• You can work with the hospital to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.~~
- ~~• You can speak with your doctor or other hospital staff if you have concerns about being discharged.~~

#### ~~Your Right to Appeal Your Hospital Discharge:~~

- ~~• You have the right to an immediate, independent medical review (appeal) of the decision to discharge you from the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).~~
- ~~• If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.~~
- ~~• If you choose to appeal, you and the reviewer will each receive a copy of a detailed explanation about why your covered hospital stay should not continue. You will receive this detailed notice only after you request an appeal.~~
- ~~• If the QIO finds that you are not ready to be discharged from the hospital, Medicare will continue to cover your hospital services.~~
- ~~• If the QIO agrees services should no longer be covered after the discharge date, neither Medicare nor your Medicare health plan will pay for your hospital stay after noon of the day after the QIO notifies you of its decision. If you stop services no later than that time, you will avoid financial liability.~~
- ~~• If you do not appeal, you may have to pay for any services you receive after your discharge date.~~

~~See page 2 of this notice for more information.~~

~~How to Ask For an Appeal of your Hospital Discharge~~

- ~~• You must make your request to the QIO listed above.~~
- ~~• Your request for an appeal should be made as soon as possible, but no later than your planned discharge date and before you leave the hospital.~~
- ~~• The QIO will notify you of its decision as soon as possible, generally no later than 1 day after it receives all necessary information.~~
- ~~• Call the QIO listed on Page 1 to appeal, or if you have questions.~~

~~If You Miss The Deadline to Request An Appeal, You May Have Other Appeal Rights:~~

- ~~• If you have Original Medicare: Call the QIO listed on Page 1.~~
- ~~• If you belong to a Medicare health plan: Call your plan at {insert plan name and toll-free number of plan}~~

~~For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048. CMS does not discriminate in its programs and activities. To request this publication in an alternate format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.~~

~~Additional Information (Optional):~~

~~Please sign below to indicate you received and understood this notice.~~

~~I have been notified of my rights as a hospital inpatient and that I may appeal my discharge by contacting my QIO.~~

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date / Time

~~According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1019. The time required to complete this~~

information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail

~~Form CMS 10065-IM (Exp. 12/31/2022)~~

~~OMB approval 0938-1019~~

~~{Ingresar informaci6n de contacto aqui}~~

~~Un mensaje importante de Medicare~~

~~Nombre del paciente:~~

~~Numero del paciente:~~

~~Sus derechos como paciente hospitalizado:~~

- ~~• Usted puede recibir los servicios que son cubiertos por Medicare. Estes incluyen los servicios hospitalarios que sean necesarios por razones medicas y los servicios que podria necesitar luego de ser dado de alta, siempre y cuando los servicios sean ordenados por su medico. Usted tiene derecho a enterarse de estos servicios, quien los pagara, y donde podra obtenerlos.~~
- ~~• Usted puede participar en toda decision relativa a su hospitalizacion.~~
- ~~• Usted puede informar sus preocupaciones relativas a la calidad de la atencion que recibe a su QIO en: {ingresar nombre y numero de telefono gratuito de la QIO} La QIO es el reviser independiente que Medicare autoriza para revisar la decision de darle de alta.~~
- ~~• Usted puede trabajar con el hospital para prepararse para la alta de manera segura y organizar los servicios que podria necesitar luego de salir del hospital. Cuando usted ya no necesita atencion hospitalaria como paciente internado, su medico o el personal del hospital le informara de la fecha prevista para su alta.~~
- ~~• Usted puede hablar con su medico u otro personal del hospital si tiene inquietudes sobre su alta.~~

~~Su derecho de apelar el alta del hospital:~~

- ~~• Usted tiene derecho a una revision (apelacion) medica independiente e inmediata de la decision de darle de alta. Si usted la hace, no tendra que pagar por los servicios que recibe durante la apelacion (salvo los cargos como copagos y deducibles)~~
- ~~• Si decide apelar, el reviser independiente le pedira su opinion. El reviser ademas examinara sus expedientes medicos y/u~~

~~otra informacion relevante. Listed no tendra que preparar nada por escrito, pero tiene derecho a hacerlo si desea.~~

~~• Si decide apelar, usted y el reviser recibiran una copia de la explicacion detallada indicando los motives por los cuales la cobertura de la hospitalizacion no deberia continuar. Listed recibira este aviso detallado solamente despues de solicitar~~

la apelación.

- Si la QIO determina que usted no está en condiciones para ser dado de alta, Medicare seguirá cubriendo los servicios hospitalarios.
- Si la QIO está de acuerdo en que los servicios no deberían ser cubiertos más allá de la fecha del alta, ni Medicare ni su plan de salud de Medicare pagará por su hospitalización después del mediodía del día en que la QIO le notifica de su decisión. Si usted pone fin a los servicios antes de dicho momento, evitara la responsabilidad económica.
- Si usted no apela, podría tener que pagar por los servicios que reciba más allá de la fecha del alta.

**Vea la página 2 de este aviso para más información.** Como solicitar una apelación del alta del hospital

- Usted deberá presentar su solicitud a la QIO indicada arriba.
- Deberá hacer su solicitud de apelación lo antes posible, pero en la fecha prevista para el alta y antes de salir del hospital, a más tardar.
- La QIO le notificará de su decisión lo antes posible; por lo general, será un máximo de 1 día después de haber recibido toda la información necesaria.
- Llame a la QIO indicada en la Página 1 para apelar o si tiene preguntas.

---

Si usted pierde la fecha límite para solicitar la apelación, es posible que tenga otros derechos de apelación:

- Si usted tiene Medicare Original: Llame a la QIO indicada en la Página 1.
  - Si tiene un plan de salud de Medicare: Llame a su plan al (ingrese el nombre y número de teléfono gratuito del plan).
- Para más información, llame al 1-800-MEDICARE (1-800-633-4227), o para TTY: 1-877-486-2048. CMS no discrimina en sus programas y actividades. Para solicitar esta publicación en formato alternativo, llame al: 1-800-MEDICARE o envíe un mensaje de correo electrónico:**

**AltFormatRequest@cms.hhs.gov**

---

**Información adicional (Opcional):**

---

Firme abajo para indicar que usted ha recibido y entendido este

~~Se me notificó de mis derechos como paciente hospitalizado y que podre comunicarme con mi QIO para apelar el alta.~~

~~Firma \_\_\_\_\_ del \_\_\_\_\_ paciente \_\_\_\_\_ o \_\_\_\_\_ representante  
Fecha/Tiempo \_\_\_\_\_~~

~~De acuerdo con la Ley para la Reducción de Trámites de 1995, ninguna persona será obligada a responder a una recopilación de información a menos que se exhiba un número de control válido de la OMB. El número de control válido de la OMB para esta recopilación de información es 0938-1019. El tiempo necesario para completar esta recopilación de información es de aproximadamente 15 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar fuentes de datos existentes, reunir los datos necesarios, y completar y revisar la recopilación de información. Si tiene preguntas sobre la precisión de los tiempos estimados o sugerencias para mejorar este formulario, escriba a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.~~

~~Formulario CMS 10065-IM (Exp. 12/31/2022)  
Aprobación de OMB 0938-1019~~

**Insert contact information here}**

**Detailed \_\_\_\_\_ Notice \_\_\_\_\_ of \_\_\_\_\_ Discharge**

**Date:** \_\_\_\_\_

**Patient name:** \_\_\_\_\_ **Patient number:** \_\_\_\_\_

~~This notice gives a detailed explanation of why your hospital or Medicare health plan has determined Medicare coverage for your hospital stay should end. This notice is not the decision on your appeal. The decision on your appeal will come from your Quality Improvement Organization (QIO).~~

~~We have reviewed your case and decided that Medicare coverage of your hospital stay should end.~~

• ~~The facts used to make this decision:~~

● \_\_\_\_\_

● ~~Detailed explanation of why your hospital stay is no longer covered, and the specific Medicare coverage rules and policy used to make this decision:~~

● ~~Plan policy, provision, or rationale used in making the decision (health plans only):~~

~~If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at:~~

~~{insert hospital/Medicare health plan name and toll-free telephone number}~~

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1019. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

~~{Ingresar información de contacto aquí}~~

~~Aviso detallado del alta~~

~~Fecha: \_\_\_\_\_~~

~~Nombre del paciente: \_\_\_\_\_ Número del paciente: \_\_\_\_\_~~

~~Este aviso provee una explicación detallada de los motivos por los cuales su hospital o plan de salud de Medicare ha determinado que se debería finalizar la cobertura de Medicare de su hospitalización. Este aviso no es la decisión sobre su apelación. La decisión sobre su apelación vendrá de su Organización para el Mejoramiento de Calidad (QIO, por sus siglas en inglés).~~

~~Hemos revisado su caso y decidido que se debería finalizar la cobertura de Medicare de su hospitalización.~~

~~• Los hechos que se utilizaron para tomar esta decisión:~~

~~• Una explicación detallada de los motivos por los cuales su hospitalización ya no será cubierto, y las normas y políticas específicas de Medicare que se utilizaron para tomar esta decisión:~~

~~• La política, disposición, o razón que se utilizó para tomar la decisión (solamente para planes de salud):~~

~~Si usted desea recibir una copia de las políticas o guías de cobertura que se utilizaron para tomar esta decisión, o una copia de los documentos que se enviaron a la QIO, llámenos al:~~

~~{ingresar el nombre y número de teléfono gratuito del hospital/plan de salud de Medicare}~~

~~De acuerdo con la Ley para la Reducción de Trámites de 1995, ninguna persona será obligada a responder a una recopilación de información a menos que se exhiba un número de control válido de la OMB. El número de control válido de la OMB para esta recopilación de información es el 0938-0692. El tiempo necesario para completar esta recopilación de información es de aproximadamente 15 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar fuentes de datos existentes, reunir los datos necesarios, y completar y revisar la recopilación de información. Si tiene preguntas sobre la precisión de los tiempos estimados o sugerencias para mejorar este formulario, escriba a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.~~

~~Formulario CMS-10066-DND (Exp. 12/31/2022)~~  
~~OMB 0938-101~~

~~Aprobación de~~

# OAK VALLEY HOSPITAL DISTRICT

## Clinical Manual

|                                                                                               |                           |                                  |                   |
|-----------------------------------------------------------------------------------------------|---------------------------|----------------------------------|-------------------|
| <b>Policy/Procedure:</b> <span style="float: right;"><i>**Bi-Annual Review</i></span>         |                           |                                  |                   |
| <b>ACCU-CHECK INFORM II FINGERSTICK GLUCOSE</b>                                               |                           |                                  |                   |
| <i>Also indexed as: Fingerstick Glucose Test; Glucose Test - Fingerstick</i>                  |                           |                                  |                   |
| <b>Effective Date:</b> 11/5/2013                                                              | <b>Page 1 of 7</b>        |                                  |                   |
| Areas Affected: Outpatient Clinics and Clinical Areas of Hospital                             |                           |                                  |                   |
| Composed by: Lab                                                                              |                           |                                  |                   |
| <input checked="" type="checkbox"/> Reviewed <input type="checkbox"/> Revised by: Lab Manager |                           |                                  |                   |
| <b>Dept / Committee Approval:</b>                                                             | <b>Dept/Title:</b>        | <b>Date</b>                      | <b>Approved</b>   |
| Laboratory                                                                                    | Medical Director          | <a href="#">08/02/2026</a>       | <a href="#">X</a> |
| Policy, Procedures, Forms Comm.                                                               | VP of Nursing             | <a href="#">09/02/2026</a>       | <a href="#">X</a> |
| Department of Medicine                                                                        | Medical Staff Coordinator | <a href="#">09/08/2026</a>       |                   |
| Medical Executive Committee                                                                   | Medical Staff Coordinator |                                  |                   |
| District Board                                                                                | Board Liaison             |                                  |                   |
|                                                                                               |                           |                                  |                   |
| <b>Revised:</b> 12/14; 5/16; 4/21;12/25                                                       | <b>Reviewed:</b>          | <b>Next Review Date:</b> 12/2027 |                   |

### PRINCIPLE

The ACCU-CHECK Inform II system quantitatively measures glucose in whole blood. The enzyme on the test strip, a mutant variant of quinoprotein glucose dehydrogenase from *Acinetobacter calcoaceticus*, recombinant in *E. coli*, converts the glucose in the blood sample to gluconolactone. This reaction creates a harmless electrical DC current that the meter interprets for a glucose result. The sample and environmental conditions are also evaluated using a small AC signal. A small drop of blood is applied to a Roche Accu-Check Inform Strip while it is in the Accu-Check meter and results are displayed in 5 seconds.

The system is calibrated with venous blood containing various glucose concentrations and is calibrated to deliver plasma-like results. The reference values are obtained using a validated test method. This test method is referenced to the hexokinase method and is traceable to an NIST standard. The system is not for use in diagnosis or screening of diabetes mellitus, nor for testing neonatal cord blood samples. The Accu-Check Inform II glucose monitoring system is intended for *in vitro* diagnostic use in the professional healthcare setting.

### SPECIMEN

#### Patient Preparation

Assure correct patient identification by using two patient identifiers – name and date of birth.

Capillary blood can be obtained from puncturing the fingertip or heel using the Unistick® 2 or similar lancing device. Tenderfoot® and Quickheel® lancet devices are not recommended. The puncture site should be cleaned and thoroughly dried before obtaining the blood sample.

## Type

Fresh whole blood – Capillary, venous, arterial, and neonatal blood may be used. Venous and capillary blood may differ in glucose concentration by as much as 70 mg/dL, depending on the time of blood collection after food intake.<sup>1</sup> Shock, administration of vasoactive agents, and other factors affecting the peripheral circulation may also cause discrepancies between venous and capillary glucose results.<sup>2,3</sup> Do not use serum or plasma samples. Blood samples in anticoagulants and preservatives (heparins and EDTA) may be used. Do not use preservatives that contain fluoride (gray top tubes).

## CAPILLARY BLOOD COLLECTION

Capillary blood collection for whole blood glucose should be a fingerstick specimen for all patients over 1 year of age.

*Note: Care should be taken with children under 1 year of age because the tissue depth is minimal and the risk to bone and underlying structures is high.*

*Heel sticks, from the lateral or medial plantar surfaces of the heel, should be the specimen of choice for infants.*

Guidelines - Collection for patients over 1 year of age:

- Site should always be the middle or ring finger. The puncture should be on the palm up surface of the distal segment (fingertip). The puncture should be made on the side of the fingertip where tissue depth is deeper and away from nerve endings.
- The patient should have their hand hanging downward, lower than their heart.
- Massage the puncture site to increase blood flow
- The site should be cleaned with isopropyl alcohol and allowed to dry.
- Puncture the site (heel or finger) with a sterile, single use, safety lancet.
- Wipe away the first drop of blood with sterile gauze. Touch the next drop of blood to the end of the glucose meter strip. The strip will fill by capillary action.
- After collection, wipe the site with a cotton ball and have the patient pinch the cotton ball with another finger or apply a band-aid.

## EQUIPMENT AND MATERIALS

- Accu-Check meter and operator's guide
- Lancing device, or equivalent (if obtaining a capillary sample)
- Accu-Check Test Strip
- Accu-Check High and Low Glucose Control Solutions
- Alcohol prep pads
- Cotton ball or gauze

## REAGENT STORAGE REQUIREMENTS

- Date all reagents and controls when opened.
- Store test strips tightly capped in their original bottle in a cool, dry place below

30°C. Keep away from heat and direct sunlight. Do not refrigerate or freeze. Discard any unused portion 3 months (90 days) after opening. Do not use after the expiration date printed on the bottle label.

- Store control and linearity solutions below 30°C. Do not refrigerate or freeze. Discard any unused portion 3 months after opening. Do not use after the expiration date printed on the vial label.

## QUALITY CONTROL

1. Accu-Check Low & High Glucose Control Solutions should be used to check the Accu-Check brand blood glucose monitoring system performance:
  - As required by your institution quality control policy or local regulatory requirements - Oak Valley requires both levels of control be run once every 24 hours. Meters are set to lock out use on patients if the controls have not been run in the last 24 hours.
  - If a patient test has been repeated and blood glucose results are still lower or higher than expected.
  - When troubleshooting the system
  - If you drop the meter
  - If the lid has been left open on the strips.
2. Valid results depend on the correct test strip lot number being used. Results that fall within the range when testing in the meter's QC Test Mode are indicated by PASSED on the meter display. Results that are not within the range are indicated by FAILED. If control solution test results fall outside the expected range, the system is not functioning properly. Repeat the test. DO NOT use the system to test patient glucose levels until the control solutions results fall within the expected range.
3. Results that fall outside the expected range may indicate:
  - procedural error
  - old or contaminated glucose control solution
  - incorrect lot number or code number entered in the meter
  - test strip deterioration
  - meter malfunction
  - control solution outside the 15° - 30°C functional temperature range
  - The testing range of the meter is 10 – 600 mg/dL
4. The [Lab](#) Medical Director will designate a coordinator to oversee training and monitor meter QC. The Medical Director will also designate trainers from each area to assess the competency of users. The competency of the trainers is evaluated annually by the coordinator. Competency for the glucose meters will be established during initial orientation and annually thereafter. After the initial "Competency Assessment Checklist" has been completed, competency will be established yearly by monitoring the users QC results, completing the annual written test, by direct observation and with the use of blind specimens. The coordinator will monitor user training and competency periodically. Correct user ID is necessary to monitor compliance and competency. User IDs will be assigned by the coordinator. Each user will have their own individual ID number (#). Sharing user ID's is prohibited.
5. The Accu-Check meters are set to lock out users when the controls have not been run in 24 hours. Both levels of control must be run every 24 hours or as needed to troubleshoot the instrument. The meter shows when the next QC is due.

## PROCEDURE – QUALITY CONTROL

1. Turn on the meter
2. Check the battery status to ensure adequate power.
3. Enter your operator ID and touch the check mark.
4. Select *Control Test* from the Main Menu.
5. Touch the control level you wish to run.
6. Scan the control lot number.
7. Insert the test strip into the test strip holder. Firmly push the strip until it comes to a complete stop.
8. Gently shake the control solution vial. Apply one drop of control to the front edge of the test strip. The sample will fill the yellow sample chamber by capillary actions. **Do not apply sample to the top of the test strip.** Once sufficient sample has been detected, the measurement begins. An hourglass icon indicates that the measurement is in progress.
9. The result appears in approximately 5 seconds.
  - Control Solution test results should fall within the expected ranges and will be shown as *PASS* or *FAIL*.
  - If control solution test results fall outside the expected control range, repeat the QC test, check the lot numbers and expiration dates for controls strip.
10. Remove the test strip and dispose of it according to your institution's policies and procedures.

## PROCEDURE – PATIENT TEST

1. Turn on the meter
2. Check the battery status to ensure adequate power, remember to return meter to dock for charging.
3. Enter your operator ID and touch the check marker.
4. Select *Patient Test* from the Main Menu.
5. Scan the patient's ID from their band or manually enter the Medical Record Number without the leading "0". [Confirm patient identity by using two \(2\) identifiers. Example: name and date of birth.](#)
6. Select the test strip lot number from the list displayed or scan the bottle.
7. Insert the test strip into the test strip holder.
8. Apply blood to the front edge of the test strip. The sample will fill the yellow sample chamber by capillary actions. **Do not apply sample to the top of the test strip.** Once sufficient sample has been detected, the measurement begins. An hourglass icon indicates that the measurement is in progress.

9. The result appears in approximately 5 seconds.
  - Press the check mark to continue testing.
  - Or, press Enter Note and choose one to three comments that correspond to the patient's current situation. Press OK
10. Remove the test strip and dispose of it according to your institution's policies and procedures.

## REPORTING RESULTS

### Reference Ranges

Blood glucose levels for people without diabetes <sup>4</sup> are as follows:

| <u>Time</u>   | <u>Range</u>   |
|---------------|----------------|
| Before Meals: | 75 – 110 mg/dL |

|                               |                            |
|-------------------------------|----------------------------|
| Expected values for neonates: | 30 – 60 mg/dL <sup>5</sup> |
|-------------------------------|----------------------------|

Test results below 60 mg/dL (3.3 mmol/L)<sup>6</sup> indicate low blood glucose (hypoglycemia)  
Test results above 240 mg/dL (13.3 mmol/L)<sup>7</sup> indicate high blood glucose (hyperglycemia)

### Procedure for Abnormal Results

1. Refer to the alert value reporting procedure for alert value ranges. If the glucose result does not match the patient's clinical condition, nursing is responsible for ordering a blood draw to confirm the glucose results with the lab.
2. Alert Value glucose is less than 640 mg/dL or greater than 400 mg/dL. - [Notify physician.](#)
3. Values greater than 400 or less than 640 should be [repeated and verified by lab draw if they don't meet the clinical criteria.](#) ~~verified by a lab draw.~~

### Reporting Format

Results are reported in milligrams per deciliter (mg/dL) and must be entered in the chart.

## PROCEDURE NOTES

1. For *in vitro* diagnostic use.
2. Use Accu-Check Test Strips with Accu-Check brand blood glucose meters only.
3. Use test strips before the expiration date printed on the test strip bottle label or within 90 days of opening whichever comes first.
4. Abnormal values should be confirmed by clinical laboratory methods.
5. If the patient is experiencing symptoms which are not consistent with blood glucose results obtained and you have followed the test procedure as described in this procedure, follow your institution's policies for treating the symptoms and confirm the blood glucose results with the laboratory test.

## LIMITATIONS OF THE PROCEDURE

1. Use only fresh whole blood. Do not use serum or plasma. Cord blood samples cannot be used.
2. The measuring range of the meter is 10-600 mg/dL.
3. Extremes in hematocrit can affect test results. Extremely high (above 65%) and low (below 10%) hematocrits (non-neonatal samples) can cause false results.<sup>8</sup> At low hematocrits test results can, on average, be higher than those obtained with reference methods; while at high hematocrits test results can, on average, be lower than reference methods.
4. Blood glucose results obtained with Accu-Check Test Strip may be affected if excessive water loss or dehydration occurs.<sup>9,10</sup> Severe dehydration can lead to many serious medical complications. One complication which is of particular importance in diabetes management is a hyperglycemic-hyperosmolar state, with or without ketosis, which may be life-threatening if left untreated.
5. Do not use blood collection tubes containing fluoride. Sodium fluoride interferes with test result.
6. Ascorbic acid at concentrations up to 3 mg/dL has not significant effect on results.
7. Lipemic samples (triglycerides) in excess of 1800 mg/dL may produce elevated results.
8. Altitudes up to 10,000 ft do not affect results obtained with Accu-Check Glucose Monitoring Systems.
9. When inserting the test strip, be sure to firmly push the strip until it comes to a complete stop.
10. Blood concentrations of galactose greater than 15 mg/dL will cause overestimation of glucose results.

### Additional Precautions for Neonatal Testing

- All abnormal neonatal values should be confirmed by a clinical laboratory test method. All neonates exhibiting hypoglycemic symptoms, regardless of blood glucose monitoring results, should have their glucose tested by a clinical laboratory method.
- Use caution when interpreting neonatal blood glucose results which are less than 50 mg/dL.

## CLEANING THE METERS

1. Every glucose meter must be wiped down with Oak Valley Hospital District (OVHD) approved disinfectant wipes after every patient. Follow the manufacturer's instructions on the wipe packaging, ensuring that the device remains wet for the duration of the manufacturer's "contact time". Follow disinfection by wiping the meter with clean gauze to remove any residue. In addition, the entire meter and case must be cleaned and disinfected once daily.
2. In cases of suspected or confirmed C. Difficile infection use the OVHD approved bleach-based wipes, following manufacturer's instructions on the packaging and ensuring adequate "contact time". Follow disinfection by wiping meter with clean gauze to remove any residue. Refer to the Oak Valley Hospital Infection Control manual for information regarding isolation policies and procedures.

## REFERENCES

1. National Committee for Clinical Laboratory Standards (NCCLS). *Clinical Laboratory Technical Procedures Manuals – Current Edition (GP2-A2)*. Villanova, PA: National Committee for Clinical Laboratory Standards, 2025
2. Wichman NWR, et al. *Practical Diabetes*, 1986;3(2): 100.
3. Coehn FE. et al *Diabetes Care*. 1986;9:320-322
4. Accu-Check Inform II Operator's Manual
5. California Department of Public Health "Capillary Blood Specimen Collection" 2019
6. Medical Laboratory Observer " Best Practices in Capillary Blood Collection" Jan 2021

## RECOMMEND RETIRE

# OAK VALLEY HOSPITAL DISTRICT Clinical Manual

|                                                                        |                           |                                  |                 |
|------------------------------------------------------------------------|---------------------------|----------------------------------|-----------------|
| <b>Policy/Procedure:</b>                                               |                           |                                  |                 |
| <b>SAFE INJECTION PRACTICES</b>                                        |                           |                                  |                 |
| <b>Effective Date:</b> 12/4/2017                                       |                           | <b>Page</b> 1 <b>of</b> 2        |                 |
| Areas Affected: All Clinical Departments of the Hospital District      |                           |                                  |                 |
| Composed by: Infection Preventionist                                   |                           |                                  |                 |
| <input type="checkbox"/> Reviewed <input type="checkbox"/> Revised by: |                           |                                  |                 |
| <b>Dept / Committee Approval:</b>                                      | <b>Dept/Title:</b>        | <b>Date</b>                      | <b>Approved</b> |
| Policy, Procedures, Forms Comm.                                        | VP of Nursing             |                                  |                 |
| Department of Medicine                                                 | Medical Staff Coordinator |                                  |                 |
| Medical Executive Committee                                            | Medical Staff Coordinator |                                  |                 |
| District Board                                                         | Board Liaison             |                                  |                 |
|                                                                        |                           |                                  |                 |
| <b>Revised:</b> 6/23                                                   | <b>Reviewed:</b> 6/23     | <b>Next Review Date:</b> 07/2026 |                 |

### POLICY

All members of the healthcare team will comply with current Centers for Disease Control and Preventions (CDC) recommendations for safe injection practices.

### PURPOSE

Safe injection practices help prevent the transmission of bloodborne infections from patient to patient.

### PROCEDURE

The following procedures apply to the use of needles, cannulas that replace needles, and intravenous delivery systems.

1. Perform hand hygiene before accessing supplies, handling vials and IV solutions, and preparing or administering medications.
2. Use aseptic technique in all aspects of parenteral medication preparation, administration, medication vial use, and injection.
3. Store, access, and prepare medications and supplies in a clean area on a clean surface.
4. Needles, cannula and syringes are sterile, single-use items. They should never be reused for another patient nor to access a medication or solution that might be used for a subsequent patient.

5. Do not administer medications from a syringe to multi-dose patients, even if the needle or cannula on the syringe is changed.
6. Use fluid infusion and administration sets (i.e., intravenous bags, tubing and connectors) for one patient only and dispose appropriately after use. Once it has been used to enter or connect to a patient's intravenous infusion bag or administration set, consider a syringe or needle/cannula contaminated.
7. Use single-dose vials for parenteral medications whenever possible.
8. Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use.
9. Disinfect the rubber stopper of medication vials, the neck of the glass ampuls, catheter hubs, needleless connectors, and injection ports before accessing by following the approved disinfectant practices.
10. Do not keep multi-dose vials in the immediate patient treatment area. Store multi-dose vials in accordance with the manufacturer's recommendations. Discard multi-dose vials if sterility is compromised or questionable.
11. Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients.
12. Do not transport medication filled syringes/needles in pockets or clothing.

## REFERENCES

~~To access the CDC's complete 2007 Guideline for Isolation Precautions: preventing Transmission of Infectious Agents in Healthcare Settings, which includes recommendations on safe infection practices, see the CDC website at: <http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf>~~

1. [The Association for Professionals in Infection Control and Epidemiology \(APIC\). Safe Injection, Infusion, and Medication Vial Practices in Health Care \(2016\).](#)
2. [Centers for Disease Control and prevention \(CDC\). Safe Injection Practices to Prevent Transmission of Infections to Patients. \(2024, April 12\).](#)
3. [Centers for Disease Control and Prevention \(CDC\). Safe Injection Practices Coalition; Injection Safety Checklist. \(2012, March 12\).](#)

# OAK VALLEY HOSPITAL DISTRICT

## Emergency Department Manual

|                                                                        |                           |                          |                 |
|------------------------------------------------------------------------|---------------------------|--------------------------|-----------------|
| Procedure:                                                             |                           |                          |                 |
| <b>Febrile Neonates and Infants</b>                                    |                           |                          |                 |
| <b>Effective Date:</b> New Policy                                      |                           | <b>Page 1 of 2</b>       |                 |
| Areas Affected: Emergency Department                                   |                           |                          |                 |
| Composed by: ED Manager                                                |                           |                          |                 |
| <input type="checkbox"/> Reviewed <input type="checkbox"/> Revised by: |                           |                          |                 |
| <b>Dept / Committee Approval:</b>                                      | <b>Dept/Title:</b>        | <b>Date</b>              | <b>Approved</b> |
| Policy, Procedures, Forms Comm.                                        | VP of Nursing             |                          |                 |
| Department of Medicine                                                 | Medical Staff Coordinator |                          |                 |
| Medical Executive Committee                                            | Medical Staff Coordinator |                          |                 |
| District Board                                                         | Board Liaison             |                          |                 |
|                                                                        |                           |                          |                 |
| <b>Revised:</b>                                                        | <b>Reviewed:</b>          | <b>Next Review Date:</b> |                 |

### POLICY

This policy outlines the standardized approach for the emergency evaluation and management of febrile infants 60 days of age or younger presenting with a rectal temperature  $\geq 38^{\circ}\text{C}$  ( $100.4^{\circ}\text{F}$ ) or a reliable history of fever to ensure timely recognition of serious bacterial infection, sepsis, and meningitis.

### PURPOSE

To provide evidence-based guidelines for the identification, evaluation, monitoring, and initial treatment of febrile infants presenting to the Emergency Department.

### SCOPE

This policy applies to all Emergency Department physicians, registered nurses, and clinical support staff involved in the assessment and treatment of infants 60 days of age or younger with suspected serious bacterial infection.

### SUPPORTIVE DATA

1. Infants  $\leq 60$  days old with a rectal temperature  $\geq 38^{\circ}\text{C}$  ( $100.4^{\circ}\text{F}$ ) or a reliable history of fever require prompt evaluation due to increased risk of invasive bacterial infection.
2. Inclusion Criteria:
  - Age  $\leq 60$  days
  - Rectal temperature  $\geq 38^{\circ}\text{C}$  ( $100.4^{\circ}\text{F}$ ) or reliable history of fever
  - Exclusion Criteria:
  - Immunocompromised infant
  - Imperforate anus preventing rectal temperature assessment

### EQUIPMENT

- Cardiac monitor and pulse oximeter
- Pediatric scale
- IV supplies and blood culture equipment

- Urinary catheterization kit, lumbar puncture tray
- 0.9% Normal Saline and 0.22-micron inline filter

## PROCEDURE

1. Notify the Emergency Physician and Charge Nurse immediately.
  - Obtain vital signs, weight in kilograms, cardiac and pulse oximetry monitoring.
  - Obtain catheterized urinalysis and urine culture.
  - Establish IV access and obtain CBC, CMP, CRP, Procalcitonin, blood culture.
2. Monitoring:
  - Assess for poor perfusion, respiratory distress, lethargy, dehydration, cyanosis, delayed capillary refill, mottling, or weak pulses.
  - Obtain point-of-care glucose if lethargic.
  - Reassess every 30 minutes until physician evaluation and stabilization.
3. Treatment:
  - Administer antipyretics per hospital policy.
  - Administer Normal Saline 20 mL/kg when clinically indicated.
  - Reassess perfusion and lung sounds after fluid bolus.
  - Prepare for lumbar puncture if ordered.
  - Administer IV antibiotics after cultures; goal within 60 minutes for suspected sepsis/meningitis.
4. Physician Notification:
  - Delayed IV access (>15 minutes)
    - Inability to obtain cultures
  - Blood glucose <70 mg/dL
  - Clinical deterioration, dehydration, feeding intolerance, parental refusal
  - Desired glucose drop: 100 mg/dL per hour; maintain glucose 200–300 mg/dL once controlled
  - DO NOT GIVE IV INSULIN BOLUS due to risk of cardiac arrest in children
  - Infuse insulin into the same IV line as maintenance fluids

\*REMINDER: Administer cultures before antibiotics whenever possible without delaying treatment.\*

## DOCUMENTATION

1. The following will be documented in the Electronic Health Record by nursing staff:
  - Initial assessment, vital signs, weight
  - Laboratory specimens and results
  - IV fluids, medications, and reassessments
  - Physician notifications
  - Patient response and family education

## REFERENCES

1. Pantell RH, et al. Pediatrics. 2021.
2. Downes KJ, et al. Journal of Clinical Microbiology. 2020.
3. Stocker M, et al. Clinical Infectious Diseases. 2021.
4. Valley Children's Healthcare. Febrile Infants Standardized Procedure. Revised January 2024.

# OAK VALLEY HOSPITAL DISTRICT

## Emergency Department Manual

|                                                                        |                           |                          |                   |
|------------------------------------------------------------------------|---------------------------|--------------------------|-------------------|
| <b>Procedure:</b>                                                      |                           |                          |                   |
| <b>Ordering of Pediatric X-Rays and Foreign Body Ingestion, ED</b>     |                           |                          |                   |
| Effective Date: <a href="#">New Policy</a>                             |                           | Page 1 of                |                   |
| Areas Affected: Emergency Department                                   |                           |                          |                   |
| Composed by: Emergency Department Manager                              |                           |                          |                   |
| <input type="checkbox"/> Reviewed <input type="checkbox"/> Revised by: |                           |                          |                   |
| Dept / Committee Approval:                                             | Dept/Title:               | Date                     | Approved          |
| Policy, Procedures, Forms Comm.                                        | VP of Nursing             | <a href="#">08/02/26</a> | <a href="#">X</a> |
| Department of Medicine                                                 | Medical Staff Coordinator |                          |                   |
| Medical Executive Committee                                            | Medical Staff Coordinator |                          |                   |
| District Board                                                         | Board Liaison             |                          |                   |
| Revised:                                                               | Reviewed:                 | Next Review Date:        |                   |

### POLICY

Registered nurses in the Emergency Department may initiate specified radiographic examinations before physician evaluation when pediatric patients meet the criteria in this policy. This process is intended to expedite care while maintaining patient safety, appropriate physician notification, and required documentation.

### PURPOSE

To establish a standardized process for nurse-initiated x-ray ordering for selected and suspected ingested foreign-body presentations in the Emergency Department, including suspected button-battery ingestion.

### SCOPE

This policy applies to Emergency Department registered nurses, physicians, advanced practice providers, radiology personnel, and clinical support staff involved in the evaluation and treatment of pediatric patients who meet the criteria below.

### SUPPORTIVE DATA

1. Eligible patient presentations include:
  - Known or suspected ingestion of a radiopaque foreign body without respiratory distress or airway obstruction.
  - Known or suspected button-battery ingestion. These cases require immediate physician notification and urgent imaging.
2. Contraindications to independent nurse-initiated imaging include:
  - Respiratory distress, airway obstruction, stridor, cyanosis, or suspected aspiration.
  - Hemodynamic instability, altered mental status, active major bleeding, or any condition requiring immediate physician evaluation.
3. Qualified nurses must hold a current California registered nurse license, practice within the California Nurse Practice Act.

## **EQUIPMENT**

- Electronic Health Record order-entry access
- Personal protective equipment
- Radiology transport equipment as clinically indicated

## **PROCEDURE**

### **1. Initial Assessment**

- Obtain and document the history of possible ingestion, including time of event, object involved, symptoms, and relevant medical history.
- Assess airway, breathing, circulation, pain, neurovascular status, level of consciousness, and vital signs.
- Determine pregnancy status when clinically appropriate before radiographic imaging.
- Keep patients with suspected foreign-body or battery ingestion NPO unless otherwise directed by the physician.

### **2. Suspected Foreign-Body or Button-Battery Ingestion**

- Immediately notify the Emergency Department physician of any known or suspected button-battery ingestion.
- Contact Poison Control for pediatric possible or confirmed battery ingestion and document the case number and recommendations.
- If there is no respiratory distress or airway obstruction, order the facility-approved foreign-body series from nose/neck through rectum, or the equivalent chest and abdominal imaging protocol. (Pediatric foreign-body series includes: AP neck, chest, and abdomen, plus lateral neck/chest.)
- Do not delay physician evaluation, specialty consultation, transfer, or removal planning while awaiting imaging when battery ingestion is strongly suspected.
- If respiratory distress, drooling, dysphagia, stridor, cyanosis, or airway obstruction is present, do not send the patient unaccompanied to radiology; initiate emergency stabilization and obtain immediate physician assistance.

### **3. Physician Notification**

Notify the Emergency Department physician immediately for any of the following:

- Severe or rapidly increasing pain
- Difficulty breathing or swallowing, drooling, stridor, cyanosis, or vomiting
- Change in behavior, mental status, or level of consciousness
- Abnormal or deteriorating vital signs
- Suspected abuse or neglect
- Foreign body visualized in the esophagus
- Known or suspected button-battery ingestion
- Active bleeding
- Pregnancy or suspected pregnancy when imaging is contemplated

### **4. Patient and Family Education**

- Explain that imaging has been ordered and that radiology staff will coordinate the examination and transport.
- For ingestion cases, instruct the patient or caregiver to maintain NPO status until the physician changes the order.
- Instruct the patient or caregiver to immediately report breathing difficulty, color change, increased pain, vomiting, change in behavior, or any worsening symptom.

## DOCUMENTATION

1. Document all assessments, interventions, patient responses, and education in the Electronic Health Record.
2. Record the imaging order under the approved Emergency Department standardized procedure or protocol and route it for the required physician co-signature.
3. Document the ordering and authorizing physician according to current hospital order-entry requirements.
4. For suspected battery ingestion, document physician notification, Poison Control contact, case number, recommendations, imaging results, consultations, and transfer or disposition actions.

## REFERENCES

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2. Gautier, J., Verdan, M., Rochette, E., Lambert, C., Caron, N., & Merlin, E. (2022). Triage nurse-initiated x-ray radiography in minor trauma. *International Journal for Quality in Health Care*, 34(4), 1-7.
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# OAK VALLEY HOSPITAL DISTRICT

## Emergency Department

|                                                                                                                                   |                                                |
|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| <b>POLICY/PROCEDURE:</b><br><br><b>Triage</b>                                                                                     |                                                |
| <b>EFFECTIVE DATE:</b> 01/1998                                                                                                    | <b>PAGE</b> 1 <b>OF</b> 8                      |
| <b>AREAS AFFECTED:</b><br>Emergency Department                                                                                    | <b>REVISIONS:</b> 04/04                        |
|                                                                                                                                   | <b>REVIEW DATE:</b> 01/00; 01/02; 01/10; 05/13 |
|                                                                                                                                   | <b>NEXT REVIEW DATE:</b> 05/16                 |
| <b>Services Required to Review for Revisions:</b> Emergency Department Medical Director; Standards Committee; MEC; Governing Body |                                                |

### **GUIDELINES FOR EMERGENCY DEPARTMENT TRIAGE AND NURSING FLOW SHEET**

#### **PURPOSE**

Direct Emergency Department staff in accurate documentation.

#### **NATURE**

This is a permanent patient record. The patient admitting registration card is used for addressographing the upper right corner for identification purposes. This flow sheet is used on all Emergency Department patients. Documentation is to be made with black ink. Both sides of the form are to be utilized for patient record.

#### **PATIENT POPULATION**

The Emergency Department Flow Sheet is to be utilized on all ED patients except rechecks, injection and procedure only, or suture removal.

#### **RESPONSIBLE PERSONS**

The Emergency Department nurse is responsible for initiating, and completing the Emergency Department Flow Sheet. The Emergency Department assistants also document the ED Flow Sheet. It is, however, the Registered Nurse's responsibility to make sure that documentation is appropriate and complete.

## DETAILED INSTRUCTIONS

1. Time patient arrived in ED registration area
2. 

|           |               |
|-----------|---------------|
| Level I   | Resuscitation |
| Level II  | Emergent      |
| Level III | Urgent        |
| Level IV  | Less Urgent   |
| Level V   | Non-Urgent    |
3. Date – (Month/Day/Year)
4. Time triage was started
5. Time patient enters the ED treatment area
6. Visual acuity for patients who present eye, vision problems
7. How patient arrived in Emergency Department
8. 

|                                |
|--------------------------------|
| Triage Intervention            |
| Interpreter Information        |
| Family/friends in waiting room |

## TRIAGE PROTOCOL

### PURPOSE

To ensure an effective method to separate those patients who require immediate medical attention from those patients who have non-urgent problems, to ensure prompt evaluation of all patients entering the Emergency Department.

### LEVEL

Dependent (\*Requires no physician order)

### SUPPORTIVE DATA

Assess, nursing diagnosis, planning, implementation and evaluation of patient's health status.

1. Assessment
  - a. Collection of objective and subjective information
  - b. This assessment provides enough data to determine patient acuity and any immediate physiological, psychosocial or educational needs.
  - c. The assessment phase leads the nurse to first categorize patients based on the triage acuity criteria, second to identify nursing diagnoses when possible.

2. Planning

The triage nurse may be responsible for planning nursing interventions and medical or diagnostic procedures (based on protocols) that can be initiated at the triage area. (See attached – Standing Orders for Emergency Department Patients). In the event the RN is unable to do triage, the

Emergency Medical Technician will gather pertinent information and relay information to the Registered Nurse who will make triage decision.

3. Implementation

The triage nurse is responsible for assigning patients to an appropriate treatment area and caregiver until the patient is triaged by the RN and deemed to have a non-threatening condition. The Registration Clerk is not to obtain or request any financial information or demographic information.

4. Evaluation

Reassessment of patients should occur based on predetermined criteria for each triage acuity category.

## **TRIAGE ACUITY CATEGORY**

### **Resuscitation – Level I (Is patient dying?)**

Examples:

- Cardiac arrest
- Intubated
- Unresponsive

### **Emergent – Level II (Can patient wait?)**

Examples:

- Trauma Alert
- Medical Alert
- AMI Alert
- Stroke Alert
- Overdose
- Possible Cardiac Chest Pain
- Severe Pain >7/10
- Needle Stick in a Healthcare Worker

### **Urgent – Level III (Stable, requires moderate to extensive workup.)**

Examples:

- Pain Scale <7/10
- Nausea and vomiting
- Headache with history of same
- Complicated laceration
- 1<sup>st</sup> trimester with bleeding, saturating <1pad/hr
- Any patient requiring IV, lab or radiological services

### **Less urgent – Level IV (Stable, requires minor workup.)**

Examples:

- Simple Laceration
- Strains, Sprains

- Fever responsive to Tylenol
- Abscess
- URI with productive green sputum
- Cellulitis (if facial consider Level II or III)
- Simple Fracture with Pain

### **Non-urgent – Level V (Stable)**

#### Examples:

- Suture Removal
- Cold Symptoms
- Prescription Refill
- Earache
- Requesting Pregnancy Test
- UTI (no fever)
- Poison Oak, Ivy
- Minor Bites (human, animal, insect – Skin NOT broken)
- Paronychia

## **CLINIC**

Those patients whose condition is not life threatening and the clinic will accept.

### Non-Emergency Complaints:

Allergy or hay fever

Anxiety

Back pain-non-trauma, new onset or chronic recurrent (able to walk without assistance)

Constipation

Chronic obstructive pulmonary disease (minor complaint, non-labored breathing)

Cough without hemoptysis or respiratory impairment

Dental problems

Depression (non-suicidal)

Diarrhea, normal vital signs

Dizziness, chronic

Drug or alcohol detoxification

Dysuria, female

Eye, milky, burning without signs of infection, no foreign bodies

Ear pain

Nausea and vomiting normal vital signs

Neck pain (no history of trauma)

Penile discharge or dysuria (male)

Pharyngitis, symptoms of

Physical examination requests

Pregnancy testing

Prescription refills

Pruritus without rash

Rash, localized

Rectal pain or itching, minor bleeding

Sexual disease exposure

Sinusitis, chronic

Skin infection – minor (sores)

Skin lumps, bumps, or growths

Sleep disorders

Sunburn without blisters – localized

Suture removal

Trauma – minor acute (within 48 hours)

|                                                                   |                                                                                                    |
|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| Foot problems (blisters or ingrown toenails, plantar warts, pain) | Trauma – recently treated elsewhere and discharged (pain, contusion, abrasions)                    |
| Fracture, recently treated and splinted in another ED             | Urinary tract infection symptoms (except patients with diabetes, congestive heart failure, cancer) |
| Hematuria, chronic recurrent                                      |                                                                                                    |
| Hepatitis, exposure or symptoms of                                | Vaginal bleeding – minor (one pad in past six hours)                                               |
| HIV test request                                                  | Vaginal discharge                                                                                  |
| Immunizations and gamma-globulin requests                         | Varicose veins                                                                                     |
| Joint pain                                                        | Weakness – appears well                                                                            |
| Lice or scabies (suspected)                                       | Work release or disability form completion                                                         |
| Mouth blisters                                                    | Wound checks                                                                                       |
| Muscle aches                                                      |                                                                                                    |

## REFERENCE

Triage Meeting the Challenge, Emergency Nurses Association  
Emergency Nursing Principals and Practice, Susan Sheehy

## TRIAGE PROCEDURE

### PURPOSE

To provide registration and emergency personnel guidelines to ensure that all Emergency Department patients receive appropriate care in a timely manner. The triage area shall be an area or room next to the Emergency Department with direct access to the Emergency Department. The area shall have privacy for an initial assessment and vital signs.

### LEVEL

Interdependent

### SUPPORTIVE DATA

Patients presenting to the Emergency Department will be treated in order of medical priority as defined in Triage Protocol.

### EQUIPMENT

|                            |                        |              |
|----------------------------|------------------------|--------------|
| Triage Room                | Scale (Adult and Peds) | Face Shields |
| Triage Sheet               | Gloves                 | Kleenex      |
| Thermometer                | Emesis Basis           | Diapers      |
| B/P Machine                | 4 X 4                  | Tape         |
| Otoscope                   | Band-Aids              | Ice Packs    |
| Ophthalmoscope             | K-Y Jelly              | Linen        |
| O <sub>2</sub> Sat Monitor | Chux                   |              |

## CONTENT

1. Patient will be clocked in by ER admitting staff and brought back to triage room for triage.
2. Document Triage time. Obtain initial vital signs, including the temperature, pulse, respirations, and B/P, allergies and current medication.
3. Record a brief assessment as related to the Triage and Nursing Flow Sheet (See Addendum A).  
Key Point: A nurse will respond and the patient will be assessed prior to registration information being obtained, walk-in time noted. Formulating information regarding triage acuity.
4. Registered Nurse given data on patient if not seen by RN to decide patient category.  
Key Point: Formulating information regarding triage acuity.
5. Triage nurse will take emergent patients immediately to ER treatment area.  
Key Point: Assist with prioritization regarding chief complaint.
6. If the patient is non-emergent, the triage nurse will direct the patient to the registration area, after the initial assessment has been completed. The admitting information will then be obtained and the patient will be directed to the ED waiting room until called into the treatment area.  
Key Point: Registered Nurse must triage the patient with information gathered by self or assistant. Triage nurse will inform the registration clerk and the admitting information will be obtained in ER treatment area. Triage nurse directs patient to ED registration clerk. The medical record and triage sheet will be hand carried to the ED treatment area by ED registration clerk. ED staff will obtain the further process.
7. Triaged patients are then called into treatment area; the nurse will note the time. The patient is brought back into treatment area.  
Key Point: To ensure that patients are seen in a timely manner.
8. During the triage process, certain diagnostic and treatment protocols will be followed (See Diagnostic and Treatment Protocol).  
Key Point: To assist with timeliness of diagnosis and treatment of patient.

## TRIAGE DIAGNOSTIC AND TREATMENT PROTOCOL

### PURPOSE

Certain diagnostic procedures and/or treatments can be initiated without delay to improve the promptness and efficiency of the Emergency Department.

### SUPPORTIVE DATA

These orders are intended as guidelines. They are in no way a substitute for clinical assessment and should not delay requesting the immediate attention of the Emergency Department doctor when appropriate. The medication orders are to be implemented only after standard triage procedures have been completed. Orders in parentheses are optional, depending on the clinical situation. If there is any uncertainty, the physician should be consulted.

## CONTENT

1. Chest Pain – Rule out cardiac origin
  - Monitor
  - Check O<sub>2</sub> saturation, then flow O<sub>2</sub> by nasal canula
  - EKG, (then nitroglycerin 0.4 mg sl x 1, hold for SBP <90)
  - IV – NS to keep open
  - Lab work – CBC, (Chem 20), Myoglobin, Troponin, PT, PTT, magnesium, and drug levels as indicated.
  - Portable Chest X-Ray
2. Chest Pain – Minor trauma, no apparent distress, or associated with upper respiratory infection, with stable vital signs.
  - O<sub>2</sub> Saturation
  - (Chest X-Ray)
3. Shortness of Breath
  - O<sub>2</sub> saturation (Stat ABG for saturation >90%), then O<sub>2</sub> to keep saturation >90%
  - Monitor
  - Atrovent/Proventil nebulizers, unit dose for wheezing and respiratory distress
  - Lab Work – (CBC, Chem 20, drug levels as appropriate)
  - Portable chest X-Ray for moderate to severe respiratory distress
  - IV – NS TKO rate, for severe respiratory distress
  - Respiratory therapist and respiratory kit available for severe respiratory distress
4. Trauma – High risk, in distress, or unstable vital signs
  - O<sub>2</sub>, O<sub>2</sub> saturation, monitor
  - Two large-bore IV's, 18 g. or larger, one normal saline, one lactated ringers
  - Surgeon alert
  - Foley catheter for severe abdominal or pelvic trauma
  - (Ng tube, aspirate for meme, lavage prn, for abdominal or chest trauma)
  - (Chest tube and/or paracentesis trays as indicated)
  - (X-rays – C-Spine, chest, and long bones as indicated)
  - (Lab Work – CBC, blood type, Chem 20, amylase, UA, drug levels, pt, ptt, ABG's as indicated)
  - EKG for blunt sternal trauma
  - DT 0.5cc IM as indicated
5. Known or Suspected Overdose
  - O<sub>2</sub>, O<sub>2</sub> saturation, monitor
  - IV – Normal saline
  - Luvacuator tube, confirm placement, gastric lavage, one liter sterile water or until clear
  - EKG for history of cardiac disease or polycyclic antidepressant ingestion
  - Lab Work – CBC, UA, and tox screen, Chem 20, Aspirin and Tylenol levels
6. Burn Patients
  - Cooling measures
  - DT 0.5cc IM as indicated
  - IV, lactated ringers, for severe pain or unstable vital signs
  - Morphine sulfate as ordered for pain

7. Abdominal Pain

- Orthostatic Vital Signs when indicated
- Lab work and X-ray (CBC, Chem 20, amylase, UA, drug levels, KUB/UR)
- For fertile women with diffuse or lower abdominal pain, draw HCG and place in pelvic room if available.
- IV normal saline, 250cc bolus for dehydration

8. Flank Pain – Rule out Kidney Stone

- UA, CBC, Chem 20, KUB
- IVP consent if UA positive for Hematuria and no history of kidney stones
- IV normal saline at 150cc/hr., if as #2 above
- (Morphine Sulfate, as ordered for pain)

For Dr. Edward Chock – H&H, Chem7, U/A, Uric Acid, and Calcium

9. Vaginal Bleeding – Greater than normal menstruation

- Orthostatic vital signs
- IV normal saline, for unstable or orthostasis, or for severe pain
- Lab Work – CBC, HCG, UA, tube for blood type if needed
- Prepare patient for pelvic exam

10. Fever >101

- Tylenol 15mg/kg PO/PR up to 1000mg
- Cooling measures
- Lab work and X-ray in adults or toxic looking children – CHC, Blood Culture x1 (x2 for adults), UA (wee bag, straight cath Foley prn), (Chem 20, chest X-ray, O<sub>2</sub> saturation)

11. Lacerations

- DT 0.5cc IM if indicated
- Clean and prepare wound, shave hair
- Suture tray
- Wound culture if infection
- (X-ray if indicated for r/o fracture or foreign body)
- Wound dressing

12. Amputation

- DT 0.5cc IM as indicated
- X-ray affected part
- Place amputated part in plastic bag and place bag in container with ice
- IV – Normal saline if unstable vital signs or in severe pain
- Rectal aspirin, 650mg, CBC and NPO in candidates for re-implantation
- Wound preparation

13. Fracture and/or Dislocation

- Elevate, ice affected part as indicated
- X-ray affected part
- (IV – Normal saline for planned reduction)
- Sling/splint as indicated

14. Eye Pain – Foreign body sensation

- Instill ophthane
- Visual acuity

# OAK VALLEY HOSPITAL DISTRICT

## Emergency Department Manual

|                                                                                                 |                    |                                  |                 |
|-------------------------------------------------------------------------------------------------|--------------------|----------------------------------|-----------------|
| <b>Policy/Procedure:</b> <div style="text-align: center; margin-top: 10px;"><b>TRIAGE</b></div> |                    |                                  |                 |
| <b>Effective Date:</b> 01/1/1998                                                                |                    | <b>Page</b> 1 <b>of</b> 5        |                 |
| Areas Affected: All Divisions and Departments of the Hospital District                          |                    |                                  |                 |
| Composed by: Disaster Coordinator                                                               |                    |                                  |                 |
| <input checked="" type="checkbox"/> Reviewed <input type="checkbox"/> Revised by: ED Manager    |                    |                                  |                 |
| <b>Dept / Committee Approval:</b>                                                               | <b>Dept/Title:</b> | <b>Date</b>                      | <b>Approved</b> |
| Policy, Procedures, Forms Comm.                                                                 | VP of Nursing      | 09/02/2026                       |                 |
| Dept. of Medicine                                                                               | VP of Nursing      |                                  |                 |
| MEC                                                                                             | VP of Nursing      |                                  |                 |
| District Board                                                                                  | Board Liaison      |                                  |                 |
|                                                                                                 |                    |                                  |                 |
| <b>Revised:</b>                                                                                 | <b>Reviewed:</b>   | <b>Next Review Date:</b> 02/2029 |                 |

### PROCEDURE

This policy establishes the standardized process for Emergency Department triage, rapid identification of time-sensitive emergencies, assignment of Emergency Severity Index (ESI) acuity, reassessment, and initiation of approved nurse-driven protocols. It is designed to align Emergency Department practice with current standards while Oak Valley Hospital District works toward Primary Stroke Center certification and Level III Trauma Center designation, and to support development of the systems, documentation, response processes, and performance expectations necessary to achieve and maintain those goals. Emergency Medical Treatment and Labor Act (EMTALA) requirements remain applicable at all times.

### PURPOSE

To ensure an effective method to separate those patients who require immediate medical attention from those patients who have non-urgent problems, to ensure prompt evaluation of all patients entering the Emergency Department.

Triage will rapidly identify life- or limb-threatening conditions, prioritize patients according to clinical acuity rather than order of arrival, activate stroke, trauma, sepsis, cardiac, and other emergency pathways without avoidable delay, and provide a documented process for ongoing reassessment while patients await a treatment space.

### SCOPE

This policy applies to all patients presenting to the Emergency Department and to all ED clinical and registration personnel involved in the initial reception, triage, reassessment, and placement of patients. Triage does not replace the medical screening examination (MSE). Registration, insurance verification, or financial questions shall not delay triage, the MSE, stabilizing treatment, or activation of a time-sensitive emergency pathway.

Certification/Designation Readiness: Because Primary Stroke Center certification and Level III Trauma Center designation are organizational goals currently in process, this policy establishes practice expectations intended to move the Emergency Department toward those standards. It does not represent that Oak Valley Hospital District is currently certified or designated at those levels. Staff will follow the hospital's current approved capabilities, policies, medical staff privileges, transfer agreements, and activation criteria while readiness work continues.

## **PATIENT POPULATION**

The Emergency Department triage process applies to all persons who present to the ED requesting examination or treatment, including walk-in, ambulance, law-enforcement, interfacility, and unscheduled presentations. Limited encounters such as scheduled injections, procedure-only visits, or wound/suture checks remain subject to an appropriate screening process when a medical condition is presented or suspected.

## **RESPONSIBLE PERSONS**

A Registered Nurse (RN) trained and competent in the hospital-approved ESI process is responsible for the final triage acuity assignment. Other qualified staff may obtain preliminary information, vital signs, or assist with workflow within their scope of practice; however, information suggesting an emergency condition must be immediately communicated to the RN and emergency physician/advanced practice provider. The RN remains responsible for ensuring triage and reassessment documentation is complete and clinically appropriate.

## **SUPPORTIVE DATA**

1. Triage is a rapid clinical evaluation used to determine patient acuity and the order and/or location in which the patient should be evaluated and treated.
2. Oak Valley Hospital District will use the Emergency Severity Index (ESI), a validated five-level ED triage system, as the standard acuity framework.
3. Triage is dynamic. Acuity may be increased at any time based on new information, abnormal vital signs, deterioration, high-risk features, or nursing judgment.
4. Acuity assignment does not constitute the EMTALA medical screening examination and must not delay immediate stabilizing interventions.
5. Time-sensitive emergency pathways (including stroke and trauma) take priority over completion of routine triage documentation.

## **EQUIPMENT**

- Automated and manual blood pressure equipment with appropriately sized adult and pediatric cuffs
- Thermometer
- Pulse oximeter
- Cardiac monitor/defibrillator with pacing capability immediately available
- 12-lead ECG capability
- Adult and pediatric scales
- Point-of-care glucose testing
- Oxygen, suction, and airway/resuscitation equipment
- Personal protective equipment and isolation supplies
- Age-appropriate pain scales and neurologic screening tools
- Wheelchair/stretchers and fall-prevention equipment

## **TRIAGE PROCEDURE**

1. Upon arrival, the patient will receive an immediate visual/rapid assessment for airway, breathing, circulation, major hemorrhage, altered mental status, severe distress, or other obvious instability. Patients requiring resuscitation will be moved directly to a treatment/resuscitation area and the emergency response initiated.
2. The arrival time and mode of arrival will be documented. Triage and clinical assessment will occur before completion of nonessential registration or financial processes when delay could affect care.
3. The triage RN will obtain and document the chief complaint in the patient's own words when feasible, focused history, allergies, current medications when relevant, pain assessment, pertinent vital signs, and focused physical/neurologic findings sufficient to determine acuity.
4. Vital signs should include temperature, heart rate, respiratory rate, blood pressure, and oxygen saturation when clinically appropriate. Weight will be obtained when needed for medication dosing or clinical decision-making. Point-of-care glucose will be obtained promptly for altered mental status, suspected stroke, seizure, diabetic emergency, or when clinically indicated.

5. The RN will assign an ESI level using the current ENA ESI algorithm, considering immediate life-saving intervention needs, high-risk situation, severe pain/distress, mental-status abnormality, expected resources, and danger-zone vital signs.
6. The RN will determine the appropriate care location and initiate approved standing orders/protocols when indicated. Standing orders are adjuncts to clinical assessment and shall never delay physician/APP evaluation of an unstable or high-risk patient.
7. Any patient whose condition worsens, who develops new symptoms, or who triggers concern by staff or family will be immediately reassessed and, when indicated, assigned a higher acuity level and moved to a monitored treatment area.

## TRIAGE ACUITY CATEGORY

**ESI Level 1 - Resuscitation:** Patient requires an immediate life-saving intervention. Examples include cardiac or respiratory arrest, severe respiratory failure requiring immediate airway intervention, profound shock, unresponsiveness with threatened airway, or uncontrolled major hemorrhage.

**ESI Level 2 - Emergent/High Risk:** Patient is high risk, confused/lethargic/disoriented, in severe pain or distress, or could rapidly deteriorate. Examples include acute stroke symptoms, trauma activation criteria, suspected acute coronary syndrome with concerning features, severe sepsis/septic shock, major overdose/toxic exposure, ectopic pregnancy concern, active significant GI hemorrhage, or suicidal/homicidal patient with immediate safety risk.

**ESI Level 3 - Urgent:** Stable patient expected to require two or more ED resources who does not meet Level 1 or 2 criteria. Danger-zone vital signs and age-specific risk must prompt consideration of up-triage.

**ESI Level 4 - Less Urgent:** Stable patient expected to require one ED resource.

**ESI Level 5 - Non-Urgent:** Stable patient expected to require no ED resources beyond history and examination. *Examples are illustrative only. The ESI algorithm, clinical presentation, age, comorbidities, and RN judgment determine the final acuity level.*

## HIGH-RISK / TIME-SENSITIVE TRIAGE PATHWAYS

### 1. Suspected Acute Stroke / Primary Stroke Center Certification Goal:

- Any new focal neurologic deficit, acute speech/language disturbance, facial weakness, unilateral weakness/numbness, vision loss, severe unexplained ataxia, or other presentation concerning for acute stroke will receive immediate assessment of last-known-well/time of symptom discovery and rapid stroke screening.
- Activate the hospital Stroke Alert process immediately when criteria are met. Do not delay activation for full triage, registration, laboratory results, or placement of a routine IV.
- Obtain point-of-care glucose promptly and communicate anticoagulant/antiplatelet use, recent surgery/bleeding, baseline functional status, seizure at onset, and blood pressure to the stroke team.
- Rapid noncontrast brain imaging and vascular imaging will proceed according to the hospital stroke protocol and in a manner consistent with current Primary Stroke Center standards as Oak Valley Hospital District works toward certification. Patients potentially eligible for thrombectomy or other higher-level neurovascular care will undergo rapid consultation and transfer processes without avoidable delay.
- Patients with suspected stroke should be treated as time-sensitive even when symptom onset is uncertain or outside the traditional thrombolytic window because advanced imaging and endovascular treatment eligibility may extend beyond 4.5 hours in selected patients.

### 2. Trauma / Level III Trauma Center Designation Goal:

- Patients meeting hospital trauma activation criteria based on physiology, anatomic injury, mechanism, special considerations, or clinical judgment will have the appropriate trauma activation initiated immediately.

- Unstable trauma patients and those with major hemorrhage, airway compromise, severe traumatic brain injury, penetrating torso injury, or other immediately life-threatening injury will bypass routine triage documentation and proceed directly to the resuscitation area.
- Apply hemorrhage control immediately when indicated, including direct pressure/tourniquet use per protocol. Maintain spinal motion restriction selectively when clinically indicated rather than applying routine immobilization to all trauma patients.
- Early notification of the emergency physician, trauma surgeon/team, radiology, laboratory/blood bank, operating room, and transfer resources will occur according to the trauma activation level and hospital trauma plan.
- For patients whose needs exceed Oak Valley Hospital District's current capabilities or the anticipated scope of a Level III Trauma Center, stabilization and transfer to a higher-level trauma center will be initiated promptly in accordance with the trauma transfer policy. This process supports safe current practice while the hospital works toward Level III Trauma Center designation.

### **3. Suspected Sepsis/Septic Shock:**

- Patients with suspected infection plus signs of organ dysfunction, hypotension, altered mental status, respiratory distress, poor perfusion, or other concerning findings will be escalated for immediate provider evaluation and sepsis screening.
- When sepsis criteria are met, activate the hospital sepsis pathway and initiate protocolized diagnostic and treatment measures without delaying care for completion of routine triage tasks.

### **4. Chest Pain / Suspected Acute Coronary Syndrome:**

- Patients with concerning chest discomfort or ischemic equivalents will receive rapid provider notification and a 12-lead ECG as soon as possible, with a goal of acquisition within 10 minutes of arrival when acute coronary syndrome is suspected.
- Patients with hemodynamic instability, active ischemic ECG changes, malignant dysrhythmia, or ongoing severe symptoms will be placed in a monitored treatment area immediately.

### **5. Behavioral Health / Safety Risk:**

- Patients with suicidal ideation, homicidal ideation, severe agitation, psychosis, intoxication, elopement risk, or violence risk will receive immediate safety assessment, removal of hazards, and placement in the safest clinically appropriate environment.
- Medical causes of behavioral change or altered mental status must be considered; psychiatric presentation does not exclude a medical emergency.

## **WAITING ROOM REASSESSMENT**

- Patients awaiting placement remain under the care of the ED and require ongoing observation and reassessment based on acuity, presenting complaint, vital-sign abnormalities, age, comorbidities, treatment already initiated, and change in condition.
- ESI Level 1 patients will not remain in the waiting room. ESI Level 2 patients should be placed in a treatment/monitored area as rapidly as possible and should not remain in an unmonitored waiting environment when high-risk features persist.
- For patients who remain in the waiting room, repeat vital signs and focused reassessment will be performed at clinically appropriate intervals and whenever there is a reported or observed change. A fixed time interval does not replace clinical judgment.
- Any deterioration requires immediate escalation, repeat ESI assignment when appropriate, provider notification, and movement to a higher-acuity area.
- Analgesia, fever control, immobilization/splinting, ice/elevation, oral rehydration, or other approved measures may be initiated under hospital standing orders when appropriate.

## **TRIAGE DIAGNOSTIC AND TREATMENT PROTOCOL**

Certain diagnostic procedures and/or treatments can be initiated without delay to improve the promptness and efficiency of the Emergency Department.

Nurse-initiated diagnostic testing and treatment will be performed only under current, separately approved ED standing orders or protocols. These protocols are not a substitute for clinical assessment and must not delay immediate physician/APP evaluation, resuscitation, stroke/trauma activation, or transfer. Because diagnostic and treatment standards change over time, specific medication doses and test panels should be maintained in the applicable standing-order sets rather than embedded in this triage policy.

## DOCUMENTATION

1. Arrival date/time and mode of arrival.
2. Triage start time and, when applicable, time moved to the treatment area.
3. Chief complaint, focused history, pertinent assessment findings, allergies, medications when clinically relevant, and pain score.
4. Initial vital signs and repeat vital signs/reassessments as clinically indicated.
5. ESI level and any subsequent change in acuity, including the reason for escalation.
6. Stroke, trauma, sepsis, cardiac, behavioral health, or other pathway activation times when applicable.
7. Interventions and standing orders initiated at triage, patient response, and communication with the provider/team.
8. Interpreter use, communication needs, fall/safety risk, isolation needs, and other special precautions.
9. If a patient leaves before completion of the MSE or treatment, document the circumstances and actions taken according to the LWBS/elopement policy.

## QUALITY / COMPETENCY

- RNs performing triage will complete initial education and competency validation in the hospital-approved ESI process and receive periodic reassessment/education.
- Triage accuracy, under-triage/over-triage, time-sensitive pathway activation, waiting-room deterioration events, left-without-being-seen trends, and relevant stroke/trauma metrics will be reviewed through departmental and hospital performance-improvement processes.
- Stroke and trauma triage processes will be reviewed in coordination with the developing Stroke Program, Trauma Program, ED Medical Director, and nursing leadership to identify gaps, monitor readiness, and support progression toward Primary Stroke Center certification and Level III Trauma Center designation.

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# RECOMMEND RETIRE

## OAK VALLEY HOSPITAL DISTRICT Infection Control Manual

|                                                                                                                               |                     |                                  |                 |
|-------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------|-----------------|
| <b>Policy/Procedure:</b><br><b>COVID VACCINATION / DECLINATION REQUIREMENTS</b><br>Mandatory Vaccination / Declination Policy |                     |                                  |                 |
| <b>Effective Date:</b>                                                                                                        |                     | Page 1 of 6 - Attachments        |                 |
| Areas Affected: All Divisions and Departments of the Hospital District                                                        |                     |                                  |                 |
| Composed by: Infection Preventionist                                                                                          |                     |                                  |                 |
| <input type="checkbox"/> Reviewed <input type="checkbox"/> Revised by: Infection Preventionist                                |                     |                                  |                 |
| <b>Dept / Committee Approval:</b>                                                                                             | <b>Dept/Title:</b>  | <b>Date</b>                      | <b>Approved</b> |
| Policy, Procedures, Forms Comm.                                                                                               | Medical Staff Coord |                                  |                 |
| Department of Medicine                                                                                                        | Medical Staff Coord |                                  |                 |
| Medical Executive Committee                                                                                                   | Medical Staff Coord |                                  |                 |
| P&T / Infection Control Committee                                                                                             | Medical Staff Coord |                                  |                 |
| District Board                                                                                                                | Board Liaison       |                                  |                 |
| <b>Revised: NEW</b>                                                                                                           | <b>Reviewed:</b>    | <b>Next Review Date:</b> 10/2025 |                 |

### Policy

Oak Valley Hospital District (OVHD) utilizes the CDC (Centers for Disease Control), CDPH (California Department of Public Health), and OSHA (Occupational Safety and Health Administration) guidelines to prevent the risk of transmission of COVID-19 (SARS-CoV-2). This Mandatory COVID-19 Vaccination Policy applies to all employees, physicians and contracted staff, of Oak Valley Hospital District (OVHD) except those who exclusively work remotely.

### Purpose

Vaccination is a vital tool to reduce the presence and severity of COVID-19 cases in the workplace, in communities. Oak Valley Hospital District has adopted this policy on mandatory vaccination to safeguard the health of our employee, physicians and contracted workers from the hazard of COVID-19.

### Scope

This Mandatory COVID-19 Vaccination Policy applies to all employees, physicians and contracted staff, of Oak Valley Hospital District (OVHD) except for employees and/or contracted employees that work remotely.

All employees, physicians and contracted workers covered by this policy are required to be fully vaccinated, including a booster vaccine, as a term and condition of employment at OVHD. Employees, physicians and contracted workers are considered fully vaccinated two weeks after completing primary vaccination series and a booster vaccine. All are required to report their vaccination status and to provide proof of vaccination. Employees, physicians and contracted workers must provide truthful and accurate information about their COVID-19 vaccination

status. Employees not in compliance with this policy will be subject to discipline, up to and including termination.

Employees, physicians and contracted workers may request an exception from this mandatory vaccination policy if the vaccine is medically contraindicated for them or medical necessity requires a delay in vaccination or a religious exemption is being requested. Requests for exceptions and reasonable accommodations must be initiated by HR (Human Resources). All such requests will be handled in accordance with applicable laws and regulations and OVHD applicable policies and procedure. See Healthcare Worker Exemption below.

### **Procedure**

All OVHD employees, physicians and contracted workers must be fully vaccinated no later than March 1, 2022.

To be fully vaccinated an employee must:

- Obtain either 2 dose series of Moderna, Pfizer-BioNTech or Novavax.
  - Obtain one single dose of Johnson and Johnson vaccine.
  - Obtained any other completed series of an approved Covid-19 vaccine
  - Obtain a booster vaccine according to the approved Covid-19 vaccine schedule.
- 
- Employees, physicians and contracted workers will be considered fully vaccinated two weeks after receiving the number of doses of a COVID-19 vaccine plus a booster.
  - An employee, physician or contracted worker will be considered partially vaccinated if they have received only one dose of a two dose vaccine.

### **Vaccination Status and Acceptable Forms of Proof of Vaccination**

All vaccinated employees, physicians and contracted workers are required to provide proof of COVID-19 vaccination, regardless of where they received vaccination. Proof of vaccination status can be submitted to HR.

Acceptable proof of vaccination status is:

1. COVID-19 Vaccination record Card (issued by the Department of Health and Human services Centers for Disease control & Prevention or WHO Yellow Card) which includes name of person vaccinated, type of vaccine provided, and date last dose administered);  
OR
2. A photo of a Vaccination Record Card as a separate document; OR
3. A photo of the client's Vaccination Record Card stored on a phone or electronic device;  
or
4. Documentation of COVID-19 vaccination from a health care provider; OR
5. Digital record that includes a QR code that when scanned by a SMART health Card reader displays to the reader client name, date of birth, vaccine dates and vaccine type.

Proof of vaccination generally should include the employee's name, the type of vaccine administered, the date(s) of administration, and the name of the healthcare professional(s) or

clinic site(s) that administered the vaccine. In some cases, state immunization records may not include one or more of these data fields, such as clinic site; in those circumstances OVHD will still accept the state immunization record as acceptable proof of vaccination.

All employees, physicians and contracted workers must inform HR of their vaccination status. The following table outlines the California Immunization Requirements for Covered Workers.

| <b>California Immunization Requirements for Covered Workers</b>                                                  |                       |                                                           |                                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>COVID-19 Vaccine</b>                                                                                          | <b>Primary Series</b> | <b>When to get the vaccine booster dose</b>               | <b>Which vaccine booster dose to receive</b>                                                                                                       |
| Moderna, Pfizer-BioNTech or Novavax                                                                              | 1st and 2nd doses     | Booster dose 6 months after 2nd dose                      | Any of the COVID-19 vaccines authorized in the United States may be used for the booster dose, but either Moderna or Pfizer-BioNTech is preferred. |
| Johnson and Johnson [J&J]/Janssen                                                                                | 1st dose              | Booster dose 2 months after 1st dose                      | Any of the COVID-19 vaccines authorized in the United States may be used for the booster dose, but either Moderna or Pfizer-BioNTech is preferred. |
| World Health Organization (WHO) emergency use listing COVID-19 vaccine                                           | All recommended doses | Booster dose 6 months after getting all recommended doses | Single booster dose of Pfizer-BioNTech COVID-19 vaccine                                                                                            |
| A mix and match series composed of any combination of FDA-approved, FDA-authorized, or WHO-EUL COVID-19 vaccines | All recommended doses | Booster dose 6 months after getting all recommended doses | Single booster dose of Pfizer-BioNTech COVID-19 vaccine                                                                                            |

- Those workers currently eligible for booster doses per the Table above must receive their booster dose by no later than March 1, 2022.
- Workers who provide proof of COVID-19 infection after completion of their primary series may defer booster administration for up to 90 days from date of first positive test or clinical diagnosis, which in some situations, may extend the booster dose requirement beyond March 1st.

- Workers not yet eligible for boosters must comply no later than 15 days after the recommended timeframe above for receiving the booster dose.
- Workers with a deferral due to a proven COVID-19 infection must be in compliance no later than 15 days after the expiration of their deferral.

### **Diagnostic screening testing of Unvaccinated Exempt or Booster Eligible Individuals.**

If an employee, physician or contracted worker covered by this policy is not fully vaccinated (e.g., if they are granted an exception from the mandatory vaccination requirement because the vaccine is contraindicated for them), the employee will be required to comply with this policy for testing.

- HCW who are unvaccinated exempt or booster-eligible:
  - who have not yet received their booster must undergo **at least weekly** SARS-CoV-2 diagnostic screening testing
  - who have not yet received their booster that work no more than one shift per week must undergo **weekly** SARS-CoV-2 diagnostic screening testing, and the testing should occur within 48 hours before their shift
  - Who have not yet received their booster that work less often than weekly must undergo SARS-CoV-2 diagnostic screening testing, and the testing should occur within 48 hours before **each shift**.
  - who have not yet received their booster that do not work in areas where care is provided to patients, or to which patients do not have access for any purpose, must undergo **weekly** SARS-CoV-2 diagnostic screening testing.
- HCW, physicians and contracted workers who work in:
  - Clinics will be testing once weekly
  - Acute Care Hospital will test twice weekly
  - Oakdale nursing and Rehab (ONRC) will test twice weekly.
  - Oak Valley Ambulance will test twice weekly.
  - All other departments that do not have patient care will test once weekly.
- HCW, physicians and contracted workers with signs or symptoms consistent with COVID-19 should be tested immediately, **regardless of their vaccination status**. Health facilities should not delay testing of symptomatic individuals until scheduled diagnostic screening testing. HCP with a prior positive viral test who develop new symptoms consistent with COVID-19 should be tested if it is more than three months after the date of onset of the prior infection; if symptoms develop during the three months after the date of initial symptom onset, if an alternative etiology cannot be identified, then retesting can be considered in consultation with infectious disease or infection control experts.

Health care facilities can provide antigen testing or polymerase chain reaction (PCR) testing, or may choose to use antigen or PCR tests provided by the health care facility to satisfy this requirement. Any PCR (molecular) or antigen test used must either have Emergency Use Authorization by the U.S. Food and Drug Administration or be operating per the Laboratory Developed Test requirements by the U.S. Centers for Medicare and Medicaid Services.

All must observe all other infection control requirements, including masking, and are not exempted from the testing requirement, even if they have a medical contraindication to vaccination, since they are still potentially able to spread the illness. Previous history of COVID-19 from which the individual recovered **more than 90 days earlier or a previous positive antibody test for COVID-19 does not waive this requirement.**

Testing is not a substitute for other COVID-19 prevention measures, such as vaccination, mask wearing, physical distancing, improved ventilation, hand hygiene, and cleaning and disinfection.

### **Tracking Workplace Diagnostic Screening Testing**

OVHD will have a plan in place for tracking test results, conducting workplace contact tracing and testing as guided by their local health department, and reporting results to public health departments and CalRedi.

### **Personal Protective Equipment and Masking for Unvaccinated HCW**

In addition to respirators required under Title 8 of the California Code of Regulations, **facilities must provide respirators to all unvaccinated or workers who work in indoor work settings where (1) care is provided to patients or residents, or (2) to which patients or residents have access for any purpose.** Workers are strongly encouraged to wear respirators in all such settings. The facility must provide the respirators at no cost, and workers must be instructed how to properly wear the respirator and how to perform a seal check according to the manufacturer's instructions, if this has not already occurred.

### **Healthcare Worker, physicians, and contracted workers Exemption**

Healthcare workers may be exempt from the vaccination requirements only upon providing the employer a written declination statement, signed by the healthcare worker stating either:

- The worker is declining vaccination based on religious beliefs; or
- The worker is excused from receiving any COVID-19 vaccine due to Qualifying Medical Reasons.

To be eligible for a Qualified Medical Reasons exemption, the healthcare worker must also provide their employer with a written statement signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician stating that the individual qualifies for the exemption (but the statement should not describe the underlying medical condition or disability) and indicating the probable duration of the worker's inability to receive the vaccine (or if the duration is unknown or permanent, so indicate). The employer may

request documentation of a medical exemption or a religious exemption in accordance with federal and state antidiscrimination law.

If the employer deems a worker to have met the requirements of an exemption, the unvaccinated exempt worker must meet the following requirements when entering or working in such facility or home:

- Test for COVID-19 with either molecular (e.g. PCR) or antigen test that either has Emergency Use Authorization by the U.S. Food and Drug Administration or be operating per the Laboratory Developed Test requirements by the U.S. Centers for Medicare and Medicaid Services.
  - Testing must occur twice weekly for unvaccinated exempt workers in acute health care and long-term care settings, and testing must occur once weekly for workers in direct care settings and other health care settings.
  - HCP that provides care to patients in outpatient clinics that are not in the main hospital are not workers in the acute health care setting; for these unvaccinated exempt workers, testing must occur weekly.
  - Unvaccinated exempt workers who work no more than one shift per week must undergo SARS-CoV-2 diagnostic screening testing within 48 hours of each shift. Unvaccinated exempt workers who work less frequently than weekly must undergo SARS-CoV-2 diagnostic screening testing within 48 hours of each shift.
- Wear a surgical mask or higher-level respirator approved by the National Institute of Occupational Safety and Health (NIOSH), such as an N95 filtering facepiece respirator, at all times while in the facility or in the home providing care.

For healthcare workers who test positive, hospitals should follow AFL 21-08.7, "Guidance on Quarantine for Health Care Personnel (HCP) Exposed to SARS-CoV-2." Twice weekly or weekly testing is not necessary during quarantine.

## References

*OSHA's Emergency temporary Standard on Vaccination and Testing (29 CFR 1910.501), **AFL 21-08.7***

*OSHA Emergency Temporary Standard (ETS) (Title 8, sections 3205-3205.4)*

*Aerosol transmissible disease (ADT) standard: Title 8 of the California Code of Regulations section 5199.*

*State Public Health Office Order of February 22, 2022; CDPH AFL 21-30.3; AFL 21-29.3; AFL 21-34.4; 21-27.3 and AFL 21-28.3.*

## Related Forms - HR Forms

- 1- Declination – Medical Exemption
- 2- Declination - Religious Exemption

# OAK VALLEY HOSPITAL DISTRICT

## Infection Control Manual

|                                                                                                                      |                           |                                 |                 |
|----------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------------------|-----------------|
| <b>Policy/Procedure:</b>                                                                                             |                           |                                 |                 |
| <b>Discontinuing Isolation in Patients with COVID-19</b>                                                             |                           |                                 |                 |
| <b>Effective Date:</b> 4/1/21                                                                                        |                           | <b>Page</b> 1 of                |                 |
| Areas Affected: All Divisions and Departments of the Hospital District                                               |                           |                                 |                 |
| Composed by: Unknown                                                                                                 |                           |                                 |                 |
| <input checked="" type="checkbox"/> Reviewed <input checked="" type="checkbox"/> Revised by: Infection Preventionist |                           |                                 |                 |
| <b>Dept / Committee Approval:</b>                                                                                    | <b>Dept/Title:</b>        | <b>Date</b>                     | <b>Approved</b> |
| Policy, Procedures, Forms Comm.                                                                                      | VP of Nursing             | 8/5/026                         |                 |
| EOC Committee                                                                                                        | Chief Engineer            |                                 |                 |
| P&T & Infection Control                                                                                              | Medical Staff Coordinator |                                 |                 |
| Department of Medicine                                                                                               | Medical Staff Coordinator |                                 |                 |
| Medical Executive Committee                                                                                          | Medical Staff Coordinator |                                 |                 |
| District Board                                                                                                       | Board Liaison             |                                 |                 |
|                                                                                                                      |                           |                                 |                 |
| <b>Revised:</b> 6/23                                                                                                 | <b>Reviewed:</b> 6/23     | <b>Next Review Date:</b> 6/2026 |                 |

### POLICY

Oak Valley Hospital District (OVHD) utilizes the CDC (Centers for Disease Control) guidelines to prevent the risk of transmission of COVID-19 (SARS-CoV-2)

### PURPOSE

To determine when Transmission-Based Precautions could be discontinued for patients with SARS-CoV2 infection and are influenced by severity of symptoms and presence of immunocompromising conditions.

### DEFINITIONS

**Healthcare Personnel (HCP):** HCP refers to all paid and unpaid persons serving in healthcare settings who. Have the potential for direct or indirect exposures to patients or infectious materials. HCP include, but not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, dental healthcare personnel, students, trainees, contractual staff not employed by the facility, and those not directly involved in patient care such as clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing and volunteers.

**Immunocompromised:** Moderate to severely immunocompromising conditions include, but might not be limited to, chronic lymphocytic leukemia, non-Hodgkin lymphoma, leukemia,

receipt of solid-organ transplant, immunosuppressive therapy, active treatment of tumor or hematologic malignancies, active treatment of high-dose corticosteroids, and cancer chemotherapeutic agents. Further conditions are defined in the [Interim Clinical Considerations for Use of COVID-19 Vaccines](#).

- Other factors, such as end-stage renal disease, may pose a lower degree of immunocompromise. However, people in this category should still consider continuing to use of source control while in a healthcare facility.
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

**Mild Illness:** Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

**Moderate Illness:** Individuals who have evidence of lower respiratory disease, by clinical assessment or imaging, and a saturation of oxygen (SpO<sub>2</sub>) ≥94% on room air at sea level.

**Severe Illness:** Individuals who have respiratory frequency >30 breaths per minute, SpO<sub>2</sub> <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO<sub>2</sub>/FiO<sub>2</sub>) <300 mmHg, or lung infiltrates >50%.

**Critical Illness:** Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

In pediatric patients, radiographic abnormalities are common and, for the most part, should not be used as the sole criteria to define COVID-19 illness category. Normal values for respiratory rate also vary with age in children; thus, hypoxia should be the primary criterion to define severe illness, especially in younger children.

**Fever:** For the purpose of this guidance, fever is defined as subjective fever (feeling feverish) or a measured temperature of 100.0°F (37.8°C) or higher. Note that fever may be intermittent or may not be present in some people, such as those who are elderly, immunocompromised, or taking certain fever-reducing medications (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs]).

## PROCEDURE

### 1. Patients with *Mild to Moderate illness* and not moderately to severely immunocompromised:

- a) Isolate for at least 10 days since onset of symptoms which is counted as day zero **AND**
- b) 24 hours passed since last fever without use of fever-reducing medications **AND**
- c) Significant improvement of symptoms (e.g., cough, shortness of breath, O<sub>2</sub> need)
- d) If continued significant symptoms or O<sub>2</sub> requirements, continue isolation to 20 days, *although*.

- e) If patient significantly improves after 10 days, as noted in b and c, can consider retesting (see criteria below)

## **2. Patients with *Severe to Critical illness* and not moderate to severely immunocompromised:**

- a) Isolate at least 20 days since onset of symptoms which is counted as day zero **AND**
- b) 24 hours passed since last fever without use of fever-reducing medications **AND**
- c) Significant improvement of symptoms (e.g., cough, shortness of breath, O2 need)
- d) If patient significantly improves after 10 days, as noted in b and c, can consider retesting (see criteria below)

## **3. Patients who are *asymptomatic* and not moderate to severely immunocompromised:**

- a) Isolate for at least 10 days after the first positive test (day 0 being the date of specimen collection)

### **Criteria for the test-based strategy (retesting):**

#### **1. Patients who are *symptomatic*:**

- a. Consultation with an infectious disease doctor is *strongly recommended*~~recommended~~.
- b. Resolution of fever without the use of fever-reducing medications **AND**
- c. Significant improvement of symptoms (e.g., cough, shortness of breath, need of O2) **AND**
- d. Results are *negative* from at least two consecutive respiratory specimens collected 48 hours apart tested using an antigen test or a single *negative* using a NAAT (molecular) test.

#### **2. Patients who are *asymptomatic*:**

- a. Consultation with an infectious disease doctor is *strongly recommended*~~recommended~~.
- b. Results are *negative* from at least two consecutive respiratory specimens collected 48 hours apart tested using an antigen test or a single *negative* using a NAAT (molecular) test.

### **If discontinuation of isolation criteria is *not* met:**

1. Patient should continue isolation in an Airborne Infection Isolation Room (AIIR). If AIIR is not available then in a single-person room with the door closed, if available.
- ~~1.~~2. Patients **MUST** be in an AIIR if aerosol-generating procedures such as nebulizer treatments, continuous positive airway pressure (CPAP), bilevel positive airway pressure (BiPAP) are being administered.
- ~~2.~~3. If cohorting, place with patients with same respiratory pathogen.
- ~~3.~~4. Dedicated medical equipment should be used, if available.
- ~~4.~~5. If non-dedicated, non-disposable medical equipment is used, it should be cleaned and disinfected according to the manufacturer's instructions before use on another patient.
- ~~5.~~6. Limit transport or movement of patients outside of the room unless deemed medically necessary.

## Personal Protective Equipment (PPE)

1. HCP should continue to practice the use of an alcohol-based hand rub or wash with soap and water before entering and exiting the patient room and before and after patient contact.
2. HCP should continue to adhere to the donning and doffing of N95 mask, gown, gloves, and face shield when entering and exiting the patient room.
3. Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing, and training in accordance with the Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard (29 CFR 1910.134)

## REFERENCES

1. [The California Department of State Hospitals. \(2025, August 14\). \*COVID-19 Transmission-Based Precautions and Testing\*. Retrieved June 27, 2026, from TransmissionBasedPrecautionsandTesting\\_8.14.25](#)
2. [Central for Disease Control and Prevention. \(2025, February 7\). \*Infection Control: Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions\*. Retrieved on July 18, 2026, from Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions | Infection Control | CDC](#)
3. [Central for Disease Control and Prevention. \(2022, September 27\). \*Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic\*. Retrieved March 28, 2023, from \[https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC\\\_AA\\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Fdisposition-hospitalized-patients.html\]\(https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC\_AA\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Fdisposition-hospitalized-patients.html\)](#)
4. [Central for Disease Control and Prevention. \(2023, March 16\). \*Intern Clinic Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States\*. Retrieved March 28, 2023, from \[Clinical Guidance for COVID-19 Vaccination | CDC\]\(#\)](#)

## RELATED POLICIES:

Aerosol Transmissible Disease Exposure Control Plan  
Isolation Precaution, Transmission-Based  
Respiratory Protection Program  
Standard [\(Universal\) Precautions](#)  
Precautions Personal Protective Equipment

## Pandemic Influenza and Novel Virus Preparedness Plan

# RECOMMEND RETIRE

## OAK VALLEY HOSPITAL DISTRICT Infection Control Manual

|                                                                         |                     |                                   |                                 |
|-------------------------------------------------------------------------|---------------------|-----------------------------------|---------------------------------|
| <b>Policy/Procedure:</b><br><br><b>Environmental Culturing</b>          |                     |                                   |                                 |
| <b>Effective Date:</b> 03/1989                                          |                     | <b>Page</b> 1 <b>of</b>           |                                 |
| Areas Affected: All Divisions and Departments of the Hospital District  |                     |                                   |                                 |
| Composed by: Unknown                                                    |                     |                                   |                                 |
| X Reviewed <input type="checkbox"/> Revised by: Infection Preventionist |                     |                                   |                                 |
| <b>Dept / Committee Approval:</b>                                       | <b>Dept/Title:</b>  | <b>Date</b>                       | <b>Approved</b>                 |
| Policy, Procedures, Forms Comm.                                         | VP of Nursing       |                                   |                                 |
| EOC Committee                                                           | Chief Engineer      |                                   |                                 |
| P&T / Infection Control Committee                                       | Medical Staff Coord |                                   |                                 |
| Department of Medicine                                                  | Medical Staff Coord |                                   |                                 |
| Medical Executive Committee                                             | Medical Staff Coord |                                   |                                 |
| District Board                                                          | Board Liaison       |                                   |                                 |
| <b>Revised:</b> 10/20, 03/23,                                           |                     | <b>Reviewed:</b> 04/2017, 03/2023 | <b>Next Review Date:</b> 6/2026 |

### POLICY

At Oak Valley Hospital District (OVHD) routine microbiological surveillance on an inanimate hospital environment is limited to steam and ethylene oxide sterilizers. Routine culturing of environmental surfaces, air, or water are not performed, unless approved by the Infection Preventionist.

### INDICATIONS

The following events could be an exception, and culturing would be done at the discretion of the Infection Preventionist.

1. Outbreak investigation.
2. Suspected environmental transmission.
3. Water management / Legionella investigation.
4. Construction or renovation concerns.
5. Verification after remediation.
6. Regulatory or manufacturer-required testing.
7. Personal education and training.
8. Testing effectiveness of a new or modified cleaning procedure.

### NON-INDICATIONS

Routine cultures of floors, walls, furniture, work stations, or patient rooms solely to evaluate cleanliness are not performed.

### PROCEDURE

1. Coordinate with the Infection Preventionist to develop a sampling plan identifying organism of concern, sites, methods, and laboratory.
2. Collect specimens.
3. Review results with the Infection Preventionist.
4. Initiate corrective action plan, if indicated.
5. Repeat sampling only when clinically justified.

a.

## REFERENCES

1. Brown, Michael PhD, et al. "Microbiology Basics." APIC, 2 Oct. 2014, retrieved March 27, 2023, from [https://text.apic.org/toc/microbiology-and-risk-factors-for-transmission/microbiology-basics#book\\_section\\_531](https://text.apic.org/toc/microbiology-and-risk-factors-for-transmission/microbiology-basics#book_section_531)
2. Center for Disease Control and Prevention (CDC). Part II. Recommendations for Environmental Infection Control in Health-Care Facilities: *Guidelines for Environmental Infection Control in Health-Care Facilities (2003). F. Environmental Sampling. (2017, February). Retrieved July 18, 2026, from [Part II. Recommendations for Environmental Infection Control in Health-Care Facilities | Infection Control | CDC](#)*
3. Center for Disease Control and Prevention (CDC). Guidelines for Environmental Infection Control in Health-Care Facilities; Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC) (2003). (2017, February). Retrieved July 18, 2026; from [Guidelines for Environmental Infection Control in Health-Care Facilities](#)
4. Mehtar, MBBS, FRCPath, FCPATH, MD, S, et al. (2018, March). Guide to Infection Control in the Healthcare Setting: Patient Areas and Environmental Cleaning. International Society for Infectious Disease. Retrieved March 27, 2023, from <https://isid.org/guide/infectionprevention/patientareas/>

## RECOMMEND RETIRE

# OAK VALLEY HOSPITAL DISTRICT

## Infection Control Manual

|                                                                                                           |                     |                        |                          |
|-----------------------------------------------------------------------------------------------------------|---------------------|------------------------|--------------------------|
| <b>Policy/Procedure:</b>                                                                                  |                     |                        |                          |
| <b>Environmental Surveillance</b>                                                                         |                     |                        |                          |
| <b>Effective Date:</b> Unknown                                                                            |                     | <b>Page 1 of 1</b>     |                          |
| Areas Affected: All Divisions and Departments of the Hospital District                                    |                     |                        |                          |
| Composed by: Unknown                                                                                      |                     |                        |                          |
| <input type="checkbox"/> Reviewed <input checked="" type="checkbox"/> Revised by: Infection Preventionist |                     |                        |                          |
| <b>Dept / Committee Approval:</b>                                                                         | <b>Dept/Title:</b>  | <b>Date</b>            | <b>Approved</b>          |
| Policy, Procedures, Forms Comm.                                                                           | Medical Staff Coord |                        |                          |
| EOC                                                                                                       | Engineer            |                        |                          |
| P&T / Infection Control Committee                                                                         | Medical Staff Coord |                        |                          |
| Department of Medicine                                                                                    | Medical Staff Coord |                        |                          |
| Medical Executive Committee                                                                               | Medical Staff Coord |                        |                          |
| District Board                                                                                            | Board Liaison       |                        |                          |
| <b>Revised:</b> 07/27/16, 06/23                                                                           |                     | <b>Reviewed:</b> 06/23 | <b>Next Review Date:</b> |

### POLICY

The Safety Officer, the Manager of Environmental Services (EVS) and the Infection Preventionist will ensure that an ongoing hospital wide program to collect and evaluate information about environmental deficiencies, hazards, and unsafe practices covers each patient care department or service at least semi-annually and non-patient care departments annually.

Reports from Environmental Surveillance Surveys shall be forwarded to the next Environment of Care/Safety Committee Meeting following the survey date. Quarterly reports from Security Services and Engineering Department/Service will be obtained regarding incidents in their departments.

There will be documented surveys of all areas of the facility. Patient care areas will be surveyed semi-annually (at six-month intervals) and will be reported back to the Environment of Care/Safety Committee with a summary report of findings and the current status of improvement projects.

### REFERENCES

The Joint Commission, 2016

1. Association for Professional in Infection Control and Epidemiology (APIC). APIC Text. Surveillance (2024, January 17).

# OAK VALLEY HOSPITAL DISTRICT

## Infection Control Manual

|                                                                                                                                     |                     |                           |                                 |
|-------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------|---------------------------------|
| <b>Policy/Procedure:</b><br><div style="text-align: center; margin-top: 10px;"><b>Ice Machines - Maintenance and Cleaning</b></div> |                     |                           |                                 |
| <b>Effective Date:</b> 07/2008                                                                                                      |                     | <b>Page</b> 1 <b>of</b> 3 |                                 |
| Areas Affected: All Divisions and Departments of the Hospital District                                                              |                     |                           |                                 |
| Composed by: Unknown                                                                                                                |                     |                           |                                 |
| <input type="checkbox"/> Reviewed <input checked="" type="checkbox"/> Revised by: Infection Preventionist                           |                     |                           |                                 |
| <b>Dept / Committee Approval:</b>                                                                                                   | <b>Dept/Title:</b>  | <b>Date</b>               | <b>Approved</b>                 |
| Policy, Procedures, Forms Comm.                                                                                                     | Medical Staff Coord |                           |                                 |
| EOC                                                                                                                                 | Chief Engineer      |                           |                                 |
| P&T / Infection Control Committee                                                                                                   | Medical Staff Coord |                           |                                 |
| Department of Medicine                                                                                                              | Medical Staff Coord |                           |                                 |
| Medical Executive Committee                                                                                                         | Medical Staff Coord |                           |                                 |
| District Board                                                                                                                      | Board Liaison       |                           |                                 |
| <b>Revised:</b> 716; 8/19, 6/23                                                                                                     |                     | <b>Reviewed:</b> 6/23     | <b>Next Review Date:</b> 6/2026 |

### POLICY

Oak Valley Hospital District (OVHD) will ensure the proper maintenance and cleaning of ice machines.

### PURPOSE

1. To provide guidelines on the maintenance and cleaning of ice machines.
2. To prevent infections associated with air, water, and other environmental elements.

### SUPPORTIVE DATA

1. Microorganisms may be present in ice, and ice-making machines. The two (2) main sources of microorganisms are from the water in which it is made and the transfer of organisms from hands.
2. Ice from contaminated ice machines has been associated with patient colonization, blood stream infections, pulmonary and gastrointestinal illnesses, and pseudo infections.
3. Ice and ice making machines may be contaminated via improper storage or handling of ice by patients and/or staff.
4. Manufacturers' instructions for both the proper method of cleaning and/or maintenance should be followed. In the event that instructions and suitable disinfectants are not available for this process, then the procedure listed should be followed.
5. Self dispensing ice machines are used for any ice intended for consumption by patients, residents, employees, and visitors.

## PROCEDURE

### I. Daily Cleaning and Disinfection

#### -Performed by Environmental Services Department Personnel

##### A. Ice Machines

1. Clean external surfaces of ice machines with a hospital grade disinfectant.
2. Remove and drain any removable grills or trays.
3. Clean the grills or trays with water and detergent.
4. Monitor for scale or hard water build up and remove any buildup.

### II. Monthly Descaling

1. Apply descaler directly to calcium buildup with brush, cloth or sponge.
2. Leave descaler on for 2 minutes.
3. Rinse with cold water.
4. If calcium remains after step 3, repeat steps 1-3 again, until calcium is removed.

### III. Quarterly Cleaning, Disinfection and Maintenance

#### - Performed by properly trained Engineering Department personnel

##### A. Ice Machines

1. Disconnect unit from power supply.
2. Remove and discard ice.
3. Allow unit to warm to room temperature.
4. Disassemble removable parts of machine that make contact with water to make ice.
5. Thoroughly clean machine and parts with water and detergent.
6. Dry external surfaces of removable parts before reassembling.
7. Check for any needed repair.
8. Replace feeder lines, as appropriate (e.g., when damaged, old, or difficult to clean).
9. Ensure presence of an air space in tubing leading from water inlet into water distribution system of machine.
10. Inspect for rodent or insect infestations under the unit and treat, as needed.
11. Check door gaskets (open compartment models) for evidence of leakage or dripping into the storage chest.

12. Clean the ice machines per manufactures instructions.

13. Allow all surfaces of equipment to dry before returning to service.

#### IV. Environmental Sampling of Ice Machines and Carts

##### A. Annually

1. Engineering department will take a microbiological culture from the inside surface of ice machines on annual basis.
2. Send culture to an outside laboratory to test for coliform bacteria and Escherichia coli (E. coli).
3. Results of culture will be sent to Engineering department and Infection Control Department; if test results are positive, machine will be re-cleaned and retested.
4. Infection Control will begin outbreak investigation if positive results.
5. Results will be reported to the Infection Control Committee.

#### REFERENCES

1. Center for Disease Control and Prevention (2003). Guidelines for Environmental Infection Control in Health-Care Facilities. Environmental Infection Control Guidelines. Retrieved ~~March 14, 2023~~ June 19, 2026, from Part II. Recommendations for Environmental Infection Control in Health-Care Facilities | Infection Control | CDC ~~<https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html>~~

# OAK VALLEY HOSPITAL DISTRICT

## Infection Control Manual

### Policy/Procedure:

### Influenza and Pneumococcal Vaccinations for Hospital Patients

*Also indexed as Influenza Vaccine Program; Flu Vaccine Program; Pneumonia Vaccine Program*

**Effective Date:** 11/2004

**Page 1 of 2**

Areas Affected: All Divisions and Departments of the Hospital District

Composed by: Unknown

☐ Reviewed ☐ Revised by: Infection Preventionist

| Dept / Committee Approval:        | Dept/Title:         | Date                       | Approved          |
|-----------------------------------|---------------------|----------------------------|-------------------|
| Policy, Procedures, Forms Comm.   | Medical Staff Coord | <a href="#">08/05/2026</a> | <a href="#">X</a> |
| EOC Committee                     | Chief Engineer      | <a href="#">08/08/2026</a> | <a href="#">X</a> |
| P&T / Infection Control Committee | Medical Staff Coord | <a href="#">08/12/2026</a> | <a href="#">X</a> |
| Department of Medicine            | Medical Staff Coord | <a href="#">09/08/2026</a> |                   |
| Medical Executive Committee       | Medical Staff Coord |                            |                   |
| District Board                    | Board Liaison       |                            |                   |

**Revised:** 01/2019, 6/23

**Reviewed:** 05/2010, 6/23

**Next Review Date:** ~~7/2026~~

### POLICY

Oak Valley Hospital District (OVHD) vaccinates in-patients who meet the screening criteria.

### PURPOSE

To reduce morbidity and mortality from influenza and pneumococcal disease by vaccinating patients who meet the screening criteria.

### PROCEDURE

#### A. INFLUENZA VACCINE

1. All patients six (6) months of age and older will be screened upon admission for any contraindications or precautions to receive the recommended influenza vaccine, during the months of October 1<sup>st</sup> through March 31<sup>st</sup> or as determined by the local health department.
2. The Influenza vaccination order (Form0118B) will be reviewed and completed by the nurse. If the patient meets criteria and consents to receive the vaccination, the vaccine will be ordered and administered prior to the patient being discharged.

#### B. PNEUMOCOCCAL VACCINE

1. All patients 19-~~64~~-years [and older](#) of age will be screened upon admission for any contraindication or precautions to receive the recommended pneumococcal vaccine.
2. The Pneumococcal vaccination order (Form0118A) will be reviewed and completed by the nurse. If the patient meets criteria and consents to receive the vaccination the vaccine will be ordered and administered prior to the patient being discharged.

#### C. PATIENT EDUCATION

1. Prior to administering the vaccine, the nurse will provide education and a copy of the most current Vaccine Information Statement (VIS) from the Centers for Disease Control (CDC) to the patient (or their parent/legal representative). For non-English speaking patients, the Video Interpreter or Language Line will be used to provide education and a copy of the VIS in their native language, if available and preferred.

#### D. CONTRAINDICATIONS AND PRECAUTIONS

1. [Refer to the Immunize.org website: http://www.immunize.org/catg.d/p3072.pdf](http://www.immunize.org/catg.d/p3072.pdf)

#### REFERENCES

1. Centers for Disease Control and Prevention. (~~2022, October 18~~ [2024, July 25](#)). Vaccine Recommendations and Guidelines of the ACIP; Contraindications and Precautions. Retrieved from: <https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html>
2. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices – United States, ~~2022-2023~~ [2025-26](#) Influenza Season. MMWR Recomm Rep ~~2022;71 (No. RR-1):1-28~~; [2025; 74:500-507](#). Retrieved from: <http://dx.doi.org/10.15585/mmwr.mm7432a2>  
~~<https://www.cdc.gov/mmwr/volumes/71/rr/rr7101a1.htm>~~
3. Center for Disease Control and Prevention. (~~2023, May 12~~ [2025, May 25](#)). Vaccine Information Statements (VISs). Retrieved from: <https://www.cdc.gov/vaccines/hcp/vis/current-vis.html>
4. ~~Specifications Manual for Joint Commission National Quality Measures (v2020A1v2024B). (2019, September 13).~~ [2024, February 2](#)) Measure Information Form. Retrieved from: [Influenza Vaccination Status \(v2024B\)](#)  
~~<https://manual.jointcommission.org/releases/TJC2020A1/MIF0332.html>~~
5. ~~4. Center for Disease Control Prevention. (2023, February 9). Vaccines & Preventable Diseases: Pneumococcal Vaccination. Retrieved from https://www.cdc.gov/vaccines/vpd/pneumo/index.html~~  
Centers for Disease Control Prevention. (2024, December 11). [Pneumococcal Vaccine Recommendations](#). Retrieved from: [PneumoRecs VaxAdvisor](#)

#### RELATED FORMS

Form0118A Pneumococcal Vaccination Order  
Form0118B Influenza Vaccination Order  
Interpreters and Translation Services Policy

# OAK VALLEY HOSPITAL DISTRICT

## Infection Control Manual

|                                                                                                           |                       |                                            |                 |
|-----------------------------------------------------------------------------------------------------------|-----------------------|--------------------------------------------|-----------------|
| <b>Policy/Procedure:</b><br><br><b>Influx of Infectious Patients</b>                                      |                       |                                            |                 |
| <b>Effective Date:</b> 03/2006                                                                            |                       | <b>Page</b> 1 <b>of</b> 3                  |                 |
| Areas Affected: All Divisions and Departments of the Hospital District                                    |                       |                                            |                 |
| Composed by: Unknown                                                                                      |                       |                                            |                 |
| <input type="checkbox"/> Reviewed <input checked="" type="checkbox"/> Revised by: Infection Preventionist |                       |                                            |                 |
| <b>Dept / Committee Approval:</b>                                                                         | <b>Dept/Title:</b>    | <b>Date</b>                                | <b>Approved</b> |
| Policy, Procedures, Forms Comm.                                                                           | Medical Staff Coord   |                                            |                 |
| P&T / Infection Control Committee                                                                         | Medical Staff Coord   |                                            |                 |
| EOC Committee                                                                                             | Safety Officer        |                                            |                 |
| Department of Medicine                                                                                    | Medical Staff Coord   |                                            |                 |
| Medical Executive Committee                                                                               | Medical Staff Coord   |                                            |                 |
| District Board                                                                                            | Board Liaison         |                                            |                 |
|                                                                                                           |                       |                                            |                 |
| <b>Revised:</b> 07/2016, 6/23                                                                             | <b>Reviewed:</b> 6/23 | <b>Next Review Date:</b> <del>6/2026</del> |                 |

### POLICY

In the event of an influx of infectious patients requiring admission to an isolation room Oak Valley Hospital District (OVHD) will have an organized plan will be implemented to care for the patients.

### PURPOSE

To ensure the safety of patients, personnel and visitors in the event of an unusual increase in patients presenting with infectious conditions

### DEFINITIONS

Influx- admission of patients that is beyond the ability of the staff and/or facilities to provide care within normal hospital operations.

### PROCEDURE

The hospital keeps abreast of potential infectious diseases that might be occurring in the community, the country or worldwide that might affect the community. Various mechanisms are used:

1. The Infection Control Practitioner (ICP) is a member of APIC, a national, professional organization that emails its members notices of potential infection control problems including infectious disease.
2. The ICP receives updates and alerts from the Department of Health Services that are reviewed with the Infection Control Committee and are shared with the Emergency Department.
3. There is a Hospital Bioterrorism Response Guide policy.

4. The hospital partners with the Stanislaus Medical Response System
5. The hospital participates with the Emergency Medical Services Authority (EMSA) of California.
6. Through professional meetings, literature review and website search the ICP keeps abreast of Infectious Disease alerts/concerns worldwide.
7. The ICP, Laboratory Department, Emergency Department and local health care providers report disease to the local health department as mandated by specific laws and regulations of governing the control of communicable disease.
8. The hospital conducts drills using the Hospital Emergency Incident Command System (HICS).

## IDENTIFICATION

Triggers that identify a potential influx:

1. Hospital is alerted by state or local health departments of potential increase in admissions of infectious patients requiring isolation.
2. The Emergency Department ([ED](#)) becomes aware of increase of patients with infectious disease.
3. The ICP or administrator on call become aware of an influx of patients with infectious diseases.

Once any of the above takes place, the Chief of Staff, the Chairman of the Infection Control Committee, the Vice President of Quality Services, the ICP, ~~Vice President of Nursing~~[Chief Nursing Officer](#), and the Administrator on ~~Call~~[call](#) will meet to discuss the situation.

- ~~Vice President of Nursing~~[Chief Nursing Officer](#) will determine the current bed and staff availability.

If proper bed availability or staffing is a concern, then:

1. The Administrator will decide if Hospital Emergency Incident Command System needs to be activated.
2. Identify patients who are ready for discharge.
3. Contact Case Management and/or the Hospitalist to identify patients who may be discharged.

## ROOM ASSIGNMENTS

1. Patient requiring Airborne Isolation will be admitted to Negative Pressure Rooms:
  - Rooms: ~~202, 206, 302, 2, 6, 16, and~~ ICU #2
  - ED: 7 – 12, sick room in ED lobby, Post Anesthesia Care Unit (PACU), [Ambulatory Treatment Center \(ATC\)](#).
2. Engineering Manager will determine the number of portable High Efficiency Particulate Arrestance filtered negative pressure machines available for use.

3. Materials Management will increase number of N-95 respirators and other appropriate Personal Protective Equipment for areas receiving patients.
4. Contact and Droplet Isolation can be instituted in any room.
5. Patients may be cohorted as needed if approved by Infection Control.

## ONGOING EVALUATION

The chairman of the Infection Control Committee and/or the chairman of the Quality Council Committee, The Chief of Staff, ICP, Vice President Quality and Risk Management Services, and ~~Vice President of Nursing~~ Chief Nursing Officer will meet regularly to assess the situation.

1. Frequency of the meetings will be determined by the seriousness of the situation.
2. Will determine if admissions of another patient need to be suspended.
3. Will determine if elective procedures including surgery needs to be cancelled.
4. Will determine if visiting needs to be suspended.
5. Will have ongoing communication with the local health department.
6. Will determine when the Influx Contingency Plan is no longer needed.

## COMMUNICATION

In the event of the activation of this plan the hospital will maintain ongoing communication with the staff, the physicians and the local health department:

1. Alert managers of the situation and maintain communication as the situation changes.
2. Post alerts on the nursing units.
3. Infectious Disease physicians and ICP will visit the unit to assess situation and offer assistance.
4. Communication to the community will be given by the Chief of Operations or designee.

## COMMUNITY RESOURCES

1. Maintain communication with the local health department via phone, email, and/or Fax.
2. Activate the Emergency Medical Services Authority of California, if necessary, through Stanislaus County Emergency Medical Services Authority.

## REPORTING REQUIREMENTS

The Infection Control Department shall notify appropriate agencies of reportable diseases consistent with California Department of Public Health (CDPH), Stanislaus County Public Health, and Center of Disease Control and Prevention CDC) requirements and/or recommendations.

## **EDUCATION AND TRAINING**

All staff shall receive initial orientation on infection prevention practices, annual competency validation, and personal protective equipment donning and doffing education.

## **REFERENCES**

1. Centers of Disease Control and Prevention (CDC). Pandemic Flu: Healthcare System Preparedness and Response (2024, April 11).
2. U.S. Department of Health & Human Services. ASPR TRACIE; Topic Collection: Crisis Standards of Care Considerations (2024, October).

# OAK VALLEY HOSPITAL DISTRICT

## Infection Control Manual

|                                                                        |                       |                                 |                   |
|------------------------------------------------------------------------|-----------------------|---------------------------------|-------------------|
| <b>Policy/Procedure:</b>                                               |                       |                                 |                   |
| <b>Reportable Diseases</b>                                             |                       |                                 |                   |
| <b>Effective Date:</b> 01/1998                                         |                       | <b>Page 1 of</b>                |                   |
| Areas Affected: All Divisions and Departments of the Hospital District |                       |                                 |                   |
| Composed by: Unknown                                                   |                       |                                 |                   |
| X Reviewed X Revised by: Infection Preventionist                       |                       |                                 |                   |
| <b>Dept / Committee Approval:</b>                                      | <b>Dept/Title:</b>    | <b>Date</b>                     | <b>Approved</b>   |
| Policy, Procedures, Forms Comm.                                        | Medical Staff Coord   | <a href="#">08/05/2026</a>      | <a href="#">X</a> |
| EOC Committee                                                          | Chief Engineer        | <a href="#">08/05/2026</a>      | <a href="#">X</a> |
| P&T / Infection Control Committee                                      | Medical Staff Coord   | <a href="#">08/12/2026</a>      | <a href="#">X</a> |
| Department of Medicine                                                 | Medical Staff Coord   | <a href="#">09/08/2026</a>      |                   |
| Medical Executive Committee                                            | Medical Staff Coord   |                                 |                   |
| District Board                                                         | Board Liaison         |                                 |                   |
|                                                                        |                       |                                 |                   |
| <b>Revised:</b> 04/2018; 08/2019, 6/23                                 | <b>Reviewed:</b> 6/23 | <b>Next Review Date:</b> 6/2026 |                   |

### POLICY

Oak Valley Hospital District (OVHD) adheres to the regulatory requirements of disease reporting.

### PURPOSE

To outline diseases that are required to ~~be reported~~[report](#) to the County Health Department

### SCOPE~~DEFINITIONS~~

**Health Care Provider**- [legally defined as any individual, professional person, medical group, facility, or institution licensed, certified, or authorized by the state to deliver or furnish health care services in the ordinary course of business or practice.](#) ~~means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, a dentist and Emergency Medical Services (EMS) and Clinical Laboratory Scientist (CLS).~~

### PROCEDURE

#### A. Reporting to the Local Health Authority

1. It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed in Title 17, California Code of Regulations, Reportable Diseases and Conditions to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
2. The administrator of each health facility, ~~clinic~~[clinic](#), or other setting where more than one health care provider may know of a case, a suspected case, or an outbreak of disease within the facility shall

establish and be responsible for administrative procedures to assure that reports are made to the local officer.

B. Communicable Disease List and Control Forms

1. Reportable diseases and conditions list can be found on the following website: SCHSA-Title-17-Rev-07-31-25.pdf
2. All forms to report mandated diseases or conditions can be found on the following website: Communicable Disease Control Forms

C.

B.D. Urgency Reporting Requirements

To Report by Phone: Business hours (209) 558-5678

To Report by FAX: (209) 558-7531 After business hours (209) 664-6032

To Report by Mail: Stanislaus County HSA Public Health division, Attn: Morbidity, 917 Oakdale Road, Modesto, CA 95350.

To Report Electronically: CalREDIE

C.E. AIDS/HIV Reporting Only by Health Care Providers

1. Human Immunodeficiency Virus (HIV) infection is reportable by phone, traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Reporting form (CDPH 8641A) and for pediatric form (CDPH 8641P)
2. **DO NOT FAX** -- Phone call or mail (traceable or courier service only – double envelope marked confidential) to:

Stanislaus County HSA  
Public Health Division  
Division, Attn: Morbidity  
917 Oakdale Road  
Modesto, CA 95350  
Phone: (209) 558-4714

D.F. Reportable Non-Communicable Diseases and Conditions

1. Pesticide-related illness or injury (known or suspected cases)
2. Disorders characterized by lapses of consciousness
3. Animal bites

**REFERENCE**

1. Title 17, California Code of Regulations, Reportable Diseases & Conditions, ~~February 1, 2018.~~ July 31, 2025. Retrieved from: SCHSA-Title-17-Rev-07-31-25.pdf
2. ~~“Communicable Disease Control Program (CD).” Stanislaus County Health Services Agency, 2023. 3.~~
3. Stanislaus County Health Services Agency, Communicable Disease (CD) Prevention Program. Retrieved from: Communicable Disease Control Program (CD) - HSA - Stanislaus County

## RECOMMEND RETIRE

# OAK VALLEY HOSPITAL DISTRICT

## Infection Control Manual

|                                                                                                                                            |                                |                                 |                 |
|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------|-----------------|
| <b>Policy/Procedures:</b><br><b>Respiratory Hygiene Program - Visitors &amp; Patients</b>                                                  |                                |                                 |                 |
| <b>Effective Date:</b> 01/2004                                                                                                             |                                | <b>Page 1 of 2</b>              |                 |
| Areas Affected: All Divisions and Departments of the Hospital District                                                                     |                                |                                 |                 |
| Composed by: Unknown                                                                                                                       |                                |                                 |                 |
| <input checked="" type="checkbox"/> <del>Reviewed</del> <input checked="" type="checkbox"/> <del>Revised</del> by: Infection Preventionist |                                |                                 |                 |
| <b>Dept / Committee Approval:</b>                                                                                                          | <b>Dept/Title:</b>             | <b>Date</b>                     | <b>Approved</b> |
| Policies, Procedures & Forms Committee                                                                                                     | Medical Staff Coordinator      |                                 |                 |
| EOC Committee                                                                                                                              | Chief Engineer                 |                                 |                 |
| P&T/Infection Control Committee                                                                                                            | Medical Staff Coordinator      |                                 |                 |
| Department of Medicine                                                                                                                     | Medical Staff Coordinator      |                                 |                 |
| Medical Executive Committee                                                                                                                | Medical Staff Coordinator      |                                 |                 |
| District Board                                                                                                                             | Board Liaison                  |                                 |                 |
| <b>Revised:</b> 08/03/2017; 10/01/2020, 6/23                                                                                               | <b>Reviewed:</b> 03/2014, 6/23 | <b>Next Review Date:</b> 7/2026 |                 |

### POLICY

Oak Valley Hospital District (OVHD) will provide information to the public, which addresses ways to reduce transmission of seasonal infections to patients and staff.

### PURPOSE

To outline guidelines for patients and visitors to follow which will reduce the transmission of respiratory infections/virus

### PROCEDURE

1. Patients and visitors entering the facility will be educated about the importance of the respiratory hygiene program. This is accomplished by posting signs in appropriate languages (English and Spanish) at all entrances used by patients/visitors who enter hospitals, emergency departments or outpatient clinics. In addition to signs, OVHD will:
  - Provide surgical masks to all patients/visitors with symptoms of a respiratory illness (cough or fever) with instructions on proper use and disposal.
  - Place a box of surgical masks as close to the entries as possible.
  - Instruct patients to cover their nose and mouth with a tissue when they cough or sneeze or use the inside of your elbow.
  - Provide ~~for~~ a no-touch waste receptacles for used masks and tissue disposal.
  - Provide a readily accessible waterless hand hygiene product and instruct patients to decontaminate their hands after contact with respiratory secretions and before contact with a healthcare worker, family member and registration personnel.
  - Educate patients/visitors on proper hand washing with soap and water for at least 20 seconds.

Whenever possible, separate patients with respiratory illness from other patients. Separation must be at least 6 feet (about 2 arms' length) from other people.

2. In times of community saturation with respiratory illnesses, ongoing communication with the county health department will occur, and will ~~guide further action~~[provide further guidance](#).

## REFERENCES

1. State of California - Health and Human Services Agency, Department of Health Services
  2. ~~<https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html>~~
  3. Centers for Disease Control and Prevention. Infection Control: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007).
  4. Centers for Disease Control and Prevention Influenza; Respiratory Hygiene/Cough Etiquette in Healthcare Settings [\(2012\)](#).
  5. [Centers for Disease Control and Prevention \(CDC\). Preventing Transmission of Viral Respiratory Pathogens in Healthcare Settings. \(2025, May 21\)](#)
- ~~5.~~

# OAK VALLEY HOSPITAL DISTRICT

## Infection Control Manual

|                                                                                                                      |                             |                                 |                 |
|----------------------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------|-----------------|
| <b>Policy/Procedure:</b>                                                                                             |                             |                                 |                 |
| <b>Scabies - Prevention and Control</b>                                                                              |                             |                                 |                 |
| <b>Effective Date:</b> 8/2001                                                                                        |                             | <b>Page</b> 1 <b>of</b> 7       |                 |
| Areas Affected: All Divisions and Departments of the Hospital District                                               |                             |                                 |                 |
| Composed by: Unknown                                                                                                 |                             |                                 |                 |
| <input checked="" type="checkbox"/> Reviewed <input checked="" type="checkbox"/> Revised by: Infection Preventionist |                             |                                 |                 |
| <b>Dept / Committee Approval:</b>                                                                                    | <b>Dept/Title:</b>          | <b>Date</b>                     | <b>Approved</b> |
| Policy, Procedures, Forms Comm.                                                                                      | Medical Staff Coord         |                                 |                 |
| EOC                                                                                                                  | Engineering Manager         |                                 |                 |
| P&T / Infection Control Committee                                                                                    | Medical Staff Coord         |                                 |                 |
| Department of Medicine                                                                                               | Medical Staff Coord         |                                 |                 |
| Medical Executive Committee                                                                                          | Medical Staff Coord         |                                 |                 |
| District Board                                                                                                       | Board Liaison               |                                 |                 |
|                                                                                                                      |                             |                                 |                 |
| <b>Revised:</b> 2/14; 10/17; 7/18                                                                                    | <b>Reviewed:</b> 1/04; 6/21 | <b>Next Review Date:</b> 6/2024 |                 |

### POLICY

Oak Valley Hospital District (OVHD) is committed to following the current Center for Disease Control recommendations for prevention and control of scabies.

### PURPOSE

To decrease the incidence of scabies and prevent the spread of mites from person-to-person.

### SCOPE

Interdependent, registered nurse, Licensed Vocational Nurse, Nurse Practitioner, Physician's Assistant, and lab personnel that have completed their competency. Requires a physician's order.

### SUPPORTIVE DATA

#### Transmission

Scabies infestations are generally categorized as typical, ~~atypical~~ atypical, or crusted/keratotic (Norwegian). Persons with typical scabies generally have fewer than 50 live mites on their skin at any given time. Therefore, typical scabies is difficult to transmit from patient-to healthcare worker unless there is prolonged, unprotected skin-to-skin contact between the infested patient and the non-infested healthcare worker.

In contrast, persons with atypical or crusted scabies harbor hundreds to millions of mites in multiple skin burrows or in layers of crusted skin lesions. Healthcare workers who have unprotected skin-to-skin contact with any patient with atypical or crusted scabies will commonly develop scabies following exposure. Additionally, any exposure to contaminated bedding such as sheets or blankets, pillows clothing, lotions, and creams, walking belts or upholstered furniture in close proximity to a patient with atypical or crusted scabies case may also be a source of transmission.

It may take as long as 2 – 6 weeks following exposure before symptoms of scabies infestation are apparent. If the healthcare worker has previously been infested, symptoms tend to develop much sooner, even within several days following exposure. During the incubation period the newly infested healthcare worker could be a source of transmission of typical scabies to other persons (patients, employees, visitors, volunteers, and family members).— The probability of transmission increases over time and until the infested healthcare worker is identified and treated.

### Incubation Period

- In a person who has never had scabies: 4-8 weeks
- In a person previously infected: 1-4 days after exposure

### Signs and Symptoms

- A pimple-like (papular) rash are the primary sign of scabies. Intense itching (pruritus), especially at night, is the primary symptom.
- Itchy lines (linear burrows) and bumps (papules) on the fingers, wrists, arms, legs, belt area, and inflamed bumps on male genitalia and female breasts.
- Severe itch, often worse at night.

### Complications

- Secondary bacterial infections can occur when scratching breaks open the skin. The bacterial infections are usually caused by group A streptococci and/or Staphylococcus aureus.
- People with suppressed immune systems, may develop crusted (Norwegian) scabies. This severe infection can cause dry, scaly areas on the skin that can spread easily and cause secondary infections.

## **Institutional Outbreak Control Measures**

**Multiple cases of non-crusted scabies** (/parasites/scabies/healthy professional/multiple.html) should consist of heightened surveillance for early detection of new cases, proper use of infection control measures when handling patients (e.g. avoidance of direct skin-to-skin contact, hand washing, etc.), confirmation of the diagnosis of scabies, early and complete treatment and follow-up cases, and prophylactic treatment of staff, other patients, and household members who had prolonged skin-to-skin contact with suspected and confirmed cases. Skin-to-skin contact with scabies patients should be avoided for at least 8 hours after treatment. In addition, an institution-side information program should be implemented to instruct all management, medical, nursing, and support staff about scabies, the scabies mite, and how scabies is and is not spread. Epidemiologic and clinical data should be reviewed to determine the extent of the outbreak and risk factors for spreading.

**One or more cases of crusted scabies** (/parasites/scabies/~~health~~—~~professionals~~health professionals/crusted.html) should involve rapid and aggressive detection, diagnosis, infection control, and treatment measures because this or of scabies is so highly transmissible. Unrecognized crusted scabies often is the source of institutional outbreaks of scabies. Infection control personnel and dermatologists should be involved as soon as scabies is suspected in an institution.— An institution-wide information program should be implemented to instruct all management, medical, nursing, and support staff about scabies, the scabies mite, and how scabies is and is not spread.

Until successfully treated, patients with crusted scabies should be isolated from other patients who do not have crusted scabies. Assigning a cohort of caretakers to care only for patients with crusted scabies can reduce the potential for further transmission. Direct skin-to skin contact between a patient with crusted scabies and his/her caretakers and visitors should be eliminated by following strict contact precautions, including the use of protective garments such as gowns, gloves, and shoe covers. The patient's room should be cleaned thoroughly. Bedding and clothing used by a person with scabies should be machine-laundered using the hot water and hot dryer cycles.

All staff, volunteers, and visitors who may have been exposed to a patient with crusted scabies, or to clothing, bedding or furniture used by such a patient, should be identified and treated. Treatment should be strongly considered even in equivocal circumstances because of the complexity of controlling an institutional outbreak and the low risk associated with treatment. ~~—~~ All suspected and confirmed cases, as well as all potentially exposed patients, staff, visitors, and family members should be treated at the same time to prevent re-exposure. Remember that symptoms of scabies can take weeks to appear the first time a person is infested; however, the person can spread scabies during this asymptomatic period.

**Persons with crusted scabies generally require treatment at least twice, a week apart. Topical treatment with Permethrin or oral treatment with Ivermectin has been used successfully, although Ivermectin currently is not FDA-approved for treatment of scabies.**

Long-term surveillance of scabies is imperative to eradicate scabies from an institution. All new patients and staff should be screened and treated for skin conditions, suggestive of possible scabies. The local health department and neighboring institutions should be notified of the outbreak and of any patients who may have been transferred to or of staff who may have worked in other institutions.

1. Identify and ensure treatment of all patients, staff, and visitors who may have been exposed to a patient with crusted scabies or to clothing, bedding, furniture, or other items (fomites) used by such a patient.
2. **Strongly consider treatment even in equivocal circumstances because controlling an outbreak involving crusted scabies can be difficult and risk associated with treatment is relatively low.**
3. Treat patients, staff, and household members at the same time to prevent re-exposure and continued transmission.
4. Staff generally can return to work the day after receiving a dose of treatment with Permethrin or Ivermectin; however, symptomatic staff who provide hands-on care to any patient may need to use disposable gloves for several days after treatment until sure they are no longer infested.

### **Environmental Disinfection**

*Establish appropriate procedures for environmental disinfection.*

1. Ensure bedding and clothing used by a person with crusted scabies is collected and transported in a plastic bag and emptied directly into washer to avoid contaminating other surfaces and items; machine wash and dry all items using the hot water and high heat cycles (temperatures in excess of 50°C or 122°F for 10 minutes will kill mites and eggs); ensure laundry personnel use protective garments and gloves when handling contaminated items.

2. Attempt to ensure that all persons who received treatment have the clothing and bedding they used anytime during the three (3) days before treatment machine-washed and dried using the hot water and high heat cycles.
3. Clean the room of patients with crusted scabies regularly to remove contaminating skin crusts and scales that can contain mites.
4. Thoroughly clean and vacuum the room when a patient with crusted scabies leaves the facility or moves to a new room.

## PROCEDURE

### Prevention

Assess the skin, hair and nail beds of all new admissions and symptomatic patients as soon as possible. Pruritus, rashes, and skin lesions should be documented and brought to the attention of the physician. If the skin lesion is suspicious of scabies, the physician may order diagnostic procedures such as skin scrapings and order prophylactic and therapeutic scabies treatment for exposed persons.

Refer to ~~Clinical~~ Laboratory Manual policy and procedure Scabies - Scraping Procedure.

### Identification of Contact Symptomatic Cases

As soon as a case of scabies is identified a contact identification list will be developed. The list will contain the names of every person who may have had direct physical contact with the case suspected of scabies. If more than one symptomatic case is identified, a separate contact list for each case will be required. Initially, the contact identification list will be limited to the nursing unit where the suspect or confirmed case is located.

See Form0937 Scabies Contact Information.

### Reporting Outbreaks

Outbreaks will be reported to the Public Health Department and to the California Department of Health Services, Licensing and Certification District Office. Two (2) or more confirmed cases or one (1) confirmed case and at least two (2) suspect cases occurring among patients, healthcare workers, visitors, or volunteers during a two (2) week period will be considered an outbreak for reporting purposes.

### Control Procedure for Typical Infestation

1. Place symptomatic patient on Contact Isolation precautions in their assigned room. Restrict patient to his/her room for the duration of the first treatment period. Following bathing, to remove the first application of scabicide, discontinue isolation precautions. Isolation precautions are not necessary for prophylactic treatment (e.g., follow-up treatments or treatment of asymptomatic contacts).
2. Notify the attending physician to obtain orders for any diagnostic procedures and/or treatment.
3. Wear cloth or disposable long sleeve gowns and gloves when applying the scabicide and for all direct patient contacts during the defined treatment period. Gowns may be reused by the same healthcare worker during the entire treatment period and then discarded.
4. Wear gown and gloves when applying the scabicide and for all direct patient contacts during the defined treatment period. The cuff of the glove must cover the wrist of the gown. Gown and gloves must be discarded immediately following the completion of any task involving skin contact during the defined treatment period.

5. Instruct visitors to wear long-sleeved gown and gloves until after the scabicide has been washed off.
6. Wash hands, wrists and lower arms following removal of gowns and gloves with soap and water.
7. Bathe or shower the patient(s) prior to applying scabicide if the patient has not been bathed within the previous 24 hours. Wash hair, clip and clean finger and toe nails.
8. Apply the scabicide from the hairline and ears to the soles of the feet. Use a soft brush, such as a toothbrush, and apply scabicide under the finger and toenails. Reapply the scabicide immediately after hand washing or cleansing of the perineal-rectal area following incontinence and other areas of the body that have become moist. If the patient perspires heavily, the scabicide may have to be reapplied to the back, buttocks, and the backs of the legs several times during the treatment period.
9. Place all washable personal clothes worn by the patient during the preceding week into a plastic bag, seal and send home with the family members to wash and dry or if have capacity to wash and dry, the facility will wash and dry all items. Instruct family members/staff to wash clothes in hot water using laundry detergent and dry in a hot dryer for at least 20 minutes.
10. Change all bed linens including blankets and bedspreads following the initial application of scabicide. Remove all used towels, wash clothes and bedclothes worn by the patient. Place these items in a plastic bag and send to the laundry for processing.
11. Instruct laundry personnel not to sort personal clothes, sheets, towels, or bedspreads and to wash and dry these items separately from other laundry.
12. Place non-washable items i.e., plush stuffed animals in a plastic bag and seal for 7 – 10 days.
13. Change bed linens, towels, and clothing after the scabicide has been washed off.
14. Disinfect mattress, pillow covers, bedside equipment, and floors after scabicide has been washed off.
15. Disinfect multiple use equipment such as blood pressure cuffs, gait belts, etc.
16. Discard any topical creams, ointments or lotions used in symptomatic cases.

### **Control of Atypical Infestation**

1. Place patient diagnosed with atypical scabies on Contact Isolation precautions in a private room or cohort with other scabies positive patients. Maintain Contact precautions until the patient is asymptomatic.
2. Place symptomatic contacts on Contact Isolation precautions in their assigned rooms. Restrict contact(s) to their room for the duration of the treatment period (8 – 12 hours – symptomatic contacts will be considered to have typical scabies. Following bathing, to remove the scabicide, precautions can be discontinued. Isolation precautions are not necessary for prophylactic treatment (e.g., follow-up treatments or treatment of asymptomatic contacts).
3. Remove upholstered furniture from the room and cover with plastic for 7 – 10 days.

4. Follow the same procedure for application of scabicide and removal of clothing, bed linens, etc.
5. Perform hand hygiene after providing care to patient.

### Control of Crusted or Keratotic Scabies

1. Place patient on Contact Isolation precautions in a private room or cohort with other scabies positive patients until asymptomatic. This may take from 7 – 30 days or longer, depending on the severity of the infestations.
2. Perform follow-up skin scrapings when the condition of the skin is noticeably improved, e.g., the crusted lesions have begun to resolve, and signs and symptoms associated with scabies have improved.
3. Bath or shower and shampoo the patient 12 hours after applying the scabicide to remove the scabicide.

### Treatment of Symptomatic Cases

The current recommended treatment to scabies is 5% Permethrin cream (Elimite). When applied to the skin as directed, it is approximately 90% effective after one application. Two applications may be required, and it is often recommended to ~~assure~~ensure complete eradication. The cream has a low rate of reported side effects, which consist of burning, stinging, or itching immediately following the application.

1. Treat case(s) and their contacts during a defined 24 – 48 hour treatment period. Symptomatic cases should be treated during the first 24-hour treatment period. Asymptomatic contacts can be treated during the second 24-hour treatment period.
2. Re-apply Permethrin to areas of the body, which have become moist following application. If a second application of Permethrin is necessary, it can be applied ~~up to 3~~ 7 days after removal of first application. Bathe or shower and shampoo the patient 12 hours after applying the second application. If symptoms of scabies persist, a third and fourth application of Permethrin may be required.
3. Bathe or shower and shampoo the patient 12 hours after applying the scabicide to remove the scabicide.

### Treatment for Control of Crusted or Keratotic Scabies

Both oral and topical agents should be used.

#### 1. Permethrin cream 5%

1. ~~1.~~ Bathe ~~person~~the person in lukewarm water for 10 minutes and apply Permethrin: cream to the skin from the neck down, covering all areas including folds and creases.
2. Give Ivermectin 200 mcg/kg ~~orally, oral tablet,~~ on an empty stomach with water:
  - Ivermectin is an oral anti-parasitic agent; it is not FDA approved for this use, but evidence suggests that it is safe and effective for the treatment of scabies.
  - Oral Ivermectin should be considered for patients who have failed treatment with, or who cannot tolerate, FDA approved topical medication.
  - For crusted scabies, Ivermectin should be administered together with a topical agent.
  - ~~Ivermectin should be taken in (3) three doses' days 1, 2, and 8, (5) five doses' days 1, 2, 8, 9 and 15, or (7) seven doses' days 1, 2, 8, 9, 15, 22 and 29 depending on the severity of infection.~~

[Ivermectin guidelines can be discussed with the pharmacist or follow CDC guidelines: Clinical Care of Scabies | Parasites - Scabies | CDC.](#)

3. Reapply Permethrin [cream](#) 12 hours following the first application and leave on for 12 hours.
4. Bathe in lukewarm water to remove Permethrin [cream](#).
5. Observe and assess for improvement for at least four (4) weeks.
6. Two or more treatments, each a week apart, may be necessary to eliminate all mites, particularly crusted scabies.

### **Treatment of Healthcare Workers, Visitors and Volunteer Contacts**

1. Treat symptomatic healthcare workers during the same treatment period as the symptomatic patients are treated.
2. Allow healthcare workers to return to work following a single application (12 hours) of Permethrin. Follow-up treatments are not necessary unless re-exposure occurs, or symptoms persist. The following information may be useful in determining who needs to be treated.
  - a. Contact where a symptomatic case has not been substantiated, no treatment is required. However, approval of one (1) application of scabicide should be granted if requested.
  - b. If contact with a symptomatic case is minimal, if duties include delivering dietary trays, newspapers, books, etc.; treatment is not necessary. However, approval of one (1) application of scabicide should be granted if requested.
  - c. If contact with a symptomatic person is substantial such as bed making, physical assessment or turning, the asymptomatic and symptomatic person should be treated with one (1) application of Permethrin. Family members, roommates and sexual partners of symptomatic cases should also be treated at the same time. Re-treatment may be necessary if symptoms persist following the first treatment.
  - d. Symptomatic healthcare workers, visitors, volunteers should follow the instructions for washing clothes and decontamination of the home environment as outlined in the Prevention of Transmission section.

### **Post Treatment Assessment**

1. Assess signs and symptoms of treatment daily until symptoms are resolved. The intensity of pruritus and rash should gradually resolve over a 7 – 14 day period; consider treatment failure if signs and symptoms persist or intensify or, if new lesions are identified within 7 – 14 days (unless Ivermectin is used).
2. Obtain an order and apply 1% hydrocortisone cream, Triamcinolone cream (0.1% to 0.025%) to the most intense areas of pruritus and a lubricating agent or emollient to the areas of the skin less affected. Steroid creams, however, should not be applied until the scabicide has been removed. Antihistamines may also be effective in relieving some of the symptoms.

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#### RELATED POLICIES/FORMS

1. ~~Clinical~~ [Laboratory](#) Manual Policy & Procedure *Scabies - Scraping Procedure*
2. Form0937 Scabies Contact Information