Alliant

Hospital All Risk Property Program (HARPP)

2018-2019 Pre-Renewal Package

Optional Coverage Checklist

Palm Drive Health Care District dba: Palm Drive Hospital

			No Change	Change As Shown	
Total Insured Value	$	21,287,732	☑	☐	
All-Risk "Basic" Deductible:	$	10,000	☑	☐	
Course of Construction Total Insured Value:	$	0	☑	☐	
Vehicle (Auto Physical Damage) Total Insured Value:	$	0	☑	☐	
Vehicles in Yard Total Insured Value:	$	0	☑	☐	
Vehicle (Auto Physical Damage) Deductible:		Not Covered	☑	☐	
Flood Insured Values:	$	0	☑	☐	
Flood Deductible – All other Zones:		Not Covered	☑	☐	
Flood Limit:		Not Covered	☑	☐	
Flood Zones A&V Values:	$	0	☑	☐	
Flood Deductible – Zones A & V:		Not Covered	☑	☐	
Flood Limit – Zones A & V:		Not Covered	☑	☐	

*Disclaimer: Flood zones were identified by using the various Flood determination systems and location addresses. Please feel free to review the data and provide any difference in writing as soon as possible as this may impact your coverage. The actual Flood zone will be determined at the time of loss and may impact coverage deductible(s) and limit(s).

			No Change	Change As Shown	
Earthquake Total Insured Value:	$	0	☑	☐	
Earthquake Deductible:		Not Covered	☑	☐	
Earthquake Limit:		Not Covered	☑	☐	
Boiler and Machinery Total Insured Value:	$	21,287,732	☑	☐	
Boiler and Machinery Deductible:	$	10,000	☑	☐	
Boiler and Machinery Limit:	$	100,000,000	☑	☐	
Stand Alone Terrorism Total Insured Value:	$	0	☑	☐	
Stand Alone Terrorism Deductible:		Not Covered	☑	☐	
Stand Alone Terrorism Limit:		Not Covered	☑	☐	

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Optional Coverage Checklist

Palm Drive Health Care District dba: Palm Drive Hospital

	No Change	Change As Shown
Please Provide Optional Quotes for:	**Yes**	**No**
Upgrade to Green Coverage - $5,000,000 per Occurrence per Declaration - AR deductible	☐	☑
Cyber Liability Coverage -	☑	☐
Cyber Enhancement Option (CEO) -	☐	☑
Pollution Liability Coverage -	☑	☐

Notes: ____

Insured Signature: ____

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Hospital All Risk Property Program (HARPP)

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Property Schedule Guidelines

Palm Drive Health Care District dba: Palm Drive Hospital

Please provide complete information on the attached property schedule. For your reference in updating this form, listed below are the definitions of each column heading

ADDRESS
Complete Address including City, State and Zip Codes.

OCCUPANCY
Indicate the square footage, name of location, and the number of floors.

CONSTRUCTION
Building "Class," Construction Type, Roof Type. The following is a list of available options for this field:

A	=	Non Combustible Steel Frame (Steel Frames protected with fire rated gunite)
B	=	All Reinforced Concrete (aka Poured in Place Concrete)
C	=	Masonry Construction with Wood Roof
C1	=	Masonry Construction with Non-Combustible Roof
C3	=	Concrete Block with Non-Combustible Roof
C4	=	Concrete Block with Combustible Roof
CB	=	Concrete Block with Wood Roof
D	=	All Combustible (Wood Frame including Modular Buildings)
E	=	Equipment (Contractor's Equipment)
FR	=	Fire Resistive
M	=	Mixed Non-Combustible/Combustible
S	=	All Steel (Including Metal Frame Construction)
U	=	Unknown
V	=	Vehicles

"AUTO SPKLR"
(Automatic Sprinkler System in a Building) - Indicate "YES" or "NO" and if yes, write in percent of the building which is sprinklered.

YEAR BUILT
In this column you would indicate the year of construction.

"YEAR APPRS"
Year Last Appraised - Indicate the year of your last appraisal at each location.

EARTHQUAKE
Indicate "YES" if you want to include Earthquake coverage for specified location(s); otherwise Indicate "NO". Note that Earthquake is an Optional Coverage available for additional premium.

HOSPITAL ALL RISK PROPERTY PROGRAM (HARPP)

2018-2019 PRE-RENEWAL PACKAGE

PROPERTY SCHEDULE GUIDELINES

PALM DRIVE HEALTH CARE DISTRICT DBA: PALM DRIVE HOSPITAL

FLOOD
Indicate "YES" if you want to include Flood coverage for specified location(s); otherwise Indicate "NO". Note that Flood is an Optional Coverage available for additional premium.

REAL PROPERTY
Value shown should represent Replacement Cost Valuation of buildings and structures. This is the cost to repair or replace the structure in the same manner (at the same location) as currently constructed. Building means real property, permanently installed equipment or fixtures, building service equipment and yard fixtures and tenants improvements if a permanent part of a leased building.

PERSONAL PROPERTY
Value shown should represent Replacement Cost Valuation on Personal Property, equipment, computer systems, etc. This is the cost to repair or replace property with material of like kind and quality. Personal property means furniture, fixture, equipment, tenant improvements, and property in your care while at your location.

BI/RENTS
Amount of annual Rental Income, Bond Revenue Payment (amount required in finance documents), and Business Interruption.

Definitions

COMPUTER EQUIPMENT
Data processing systems including equipment and component parts owned or leased by you and data processing media (software). If it is difficult to determine value per location, this equipment can be shown in one lump sum.

FINE ARTS
Works of Art whether located inside or outside of a building. Please state appraisal value regardless of location.

CONTRACTORS EQUIPMENT
Heavy-duty equipment not licensed for road use. Please state total replacement value regardless of location.

BOILER & MACHINERY COVERAGE
Coverage Description - The schedule of values will be used to rate the Boiler and Machinery policy premium. Items insured under Boiler and Machinery insurance can be divided into two basic categories:

A. Boilers and Pressure Vessels - Typical examples are: boilers of all types, fired water heaters, air tanks, steam chests, steam cookers, sterilizers, stills, refrigeration vessels and piping.

   "Accidents" or losses to these items normally involve fire areas: explosion, cracking, rapture, distortion and melting.

B. Machinery - This can be subdivided into mechanical and electrical equipment. Typical examples of mechanical equipment are compressors (air or refrigeration), pumps, blowers, turbines (steam, water, gas) and gears. Examples of electrical equipment are motors, generators, switchboards, and transformers.

"Accidents" or losses to these items normally involve burning out, short circuiting, melting, cracking, explosion and breaking.

Electronic Property Schedule

Electronic copies of the property schedule are available upon request in Microsoft Excel format. If you have received an electronic schedule, we encourage you to make your changes in the Excel document and send it back to us electronically, either by email or on a disk. We will then upload the changes into our system automatically. To increase the accuracy of this upload, please observe the following as you do your updates:

A. Please leave all columns where they are. Also, do not change the column headings. This will allow our upload process to tell which fields should be updated. You may add columns at the end of the sheet for your convenience in working with the document, and you may change the sort order of the individual locations.

B. If you would like to delete a location, please do not actually delete it from the spreadsheet. Add a column called "Add/Delete" at the end of the sheet, and write the word "Delete" in the cell for the appropriate locations. Similarly, if you would like to add a location, make a new row at the bottom of the sheet, and put the word "Add" in the "Add/Delete" column.

C. Please highlight any changes made for tracking purposes.

D. Below are the occupancy codes available in our system to help identify those noted as "Other". Although, "Other" is a valid occupancy type we would like to narrow it down for underwriting purposes. Please enter the new Code or Description under your Change column.

Code	New Description
	-UNKNOWN-
HANGARSTOR	AIRPORT HANGARS (STORAGE)
HANGART	AIRPORT HANGARS (T-HANGARS)
HANGARMNT	AIRPORT HANGERS (MAINTENANCE)
AIRPORTS	AIRPORT TERMINALS (PASSENGER)
ANIMALSHEL	ANIMAL SHELTERS (KENNELS)
APARTMENTS	APARTMENTS
ARENASFARM	ARENAS (FARM ARENAS)
ARENASOUT	ARENAS (INDOOR)
HOAUDITOR	AUDITORIUMS
VEHICLEMNT	AUTOMOTIVE SERVICE CENTERS
BANKS	BANKS (BRANCH)
BANQUETHAL	BANQUET HALLS
BARNS	BARNS - GENERAL PURPOSE (INCLUDING STALLS AND STABLES)
BARNSDAIRY	BARNS - SPECIAL PURPOSE (INCLUDING DAIRY)
BARS	BARS/TAVERNS

HOSPITAL ALL RISK PROPERTY PROGRAM (HARPP)

2018-2019 PRE-RENEWAL PACKAGE

PROPERTY SCHEDULE GUIDELINES

PALM DRIVE HEALTH CARE DISTRICT DBA: PALM DRIVE HOSPITAL

Code	New Description
BATHOUSES	BATH HOUSES
BOWLING	BOWLING CENTERS
BUSSES	BUSSES
BRIDGES	BRIDGES
CAFETERIA	CAFETERIAS
CARWASHAUT	CAR WASH (AUTOMATIC)
CARWASHDRV	CAR WASH (DRIVE-THRU)
CARWASHSLF	CAR WASH (SELF-SERVE)
CARPORTS	CARPORTS
CASINOS	CASINOS
CEMENTPLAN	CEMENT PLANTS
CHURCHES	CHURCH SANCTUARIES (CHAPELS)
CHURCHWSCH	CHURCHES WITH SUNDAY SCHOOLS
COGENPWR	CO. GEN/POWER GENERATION FACILITIES
COMMUNCH	COMMUNITY CENTERS/CLUB HOUSES
COMMUNREC	COMMUNITY RECREATION CENTERS
CONSTTRAIL	CONSTRUCTION TRAILERS
CONVSTORS	CONVENIENCE STORES
CONVENTION	CONVENTION CENTERS
COURTS	COURTS
CRANES	CRANES (BOOMS 50' OR LESS)
CRANESOV50	CRANES (BOOMS 50' OR MORE)
DAMSEARTH	DAMS - EARTHEN NON-POWER GENERATING
DAMSNONPOW	DAMS - NON POWER GENERATING (OTHER)
DAMSPOWER	DAMS - POWER GENERATING
DAYCARE	DAY CARE/CHILD CARE/HEAD START
EDP	EDP
THEATREAMP	ENTERTAINMENT - AMPITHEATERS
THEATRE	ENTERTAINMENT - THEATERS (CINEMA)
THEATRELIV	ENTERTAINMENT - THEATERS (LIVE-STAGE)
EQUIPMENT	EQUIPMENT
EQUIPLEASE	EQUIPMENT LEASED FROM OTHERS
EQUIPSHOPS	EQUIPMENT SHOPS (LIGHT COM'L)
FIELDHOUSE	FIELDHOUSES
FIELDSREC	FIELDS - RECREATIONAL
FINEARTS	FINE ARTS
FIRE	FIRE STATIONS (STAFFED)
FIREOL	FIRE STATIONS (VOLUNTEER)
FITNCENTEC	FITNESS CENTERS
GARAGE	GARAGES (MUNICIPAL SERVICE)
GARAGERES	GARAGES (RESIDENTIAL DETACHED)
GARAGES	GARAGES (SERVICE/REPAIR)
GASSTATMM	GAS STATION MINI MARTS

GASSTATION	GAS STATIONS

Code	New Description
GOLFCARTTO	GOLF CART STORAGE
GOLFCARTS	GOLF CARTS
GOLFCOURSE	GOLF COURSES
GRNHOUSCOM	GREENHOUSES (COMMERCIAL-INSTITUTIONAL)
HABITACOTT	HABITATIONAL - COTTAGES
HABITAMANF	HABITATIONAL - MANUFACTURED HOMES
HABITAMOBH	HABITATIONAL - MOBILE HOMES
HABITAMULF	HABITATIONAL - MULTIPLE FAMILY DWELLINGS
HABITASENI	HABITATIONAL - SENIOR HOMES
RESIDENT	HABITATIONAL - SINGLE FAMILY DWELLINGS
OUSESTSEWN	HABITATIONAL - TOWNHOUSES
HOTELS	HOTELS (FULL SERVICE)
INLANDMARS	INLAND MARINE - SCHEDULED
INLANDMARU	INLAND MARINE - UNSCHEDULED
LABS	LABORATORIES
LANDFILL	LANDFILLS
LAUNDROMAT	LAUNDROMATS
JAIL	LAW ENF - JAILS (CORRECTIONAL FACILITIES)
POLICEJAIL	LAW ENF - JAILS/POLICE STATIONS
POLICE	LAW ENF - POLICE STATIONS
PRISON	LAW ENF - PRISON & CORRECTIONAL FACILITIES
LIBRARY	LIBRARIES (PUBLIC)
LODGES	LODGES
MAINBUILB	MAINTENANCE BUILDINGS
MANUFMETAL	MANUFACTURING (HEAVY INDUSTRIAL)
MANUFNOMET	MANUFACTURING (LIGHT INDUSTRIAL)
HOZACCUTE	MEDICAL - ACCUTE CARE
HOZASSISTL	MEDICAL - ASSISTED LIVING (ELDERLY RESIDENCES)
HOZCANCERC	MEDICAL - CANCER CENTERS
HOZCHEM	MEDICAL - CHEMICAL DEPENDANCE
HOZURGENT	MEDICAL - CLINIC/DISPENSARIES (URGENT CARE HOSPITAL)
HOZDENIST	MEDICAL - DENTISTS
HOZDONATED	MEDICAL - DONATED PROPERTY (OTHER)
HOSPITAL	MEDICAL - HOSPITALS (GENERAL)

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HOZDIAGRAD	MEDICAL - HOSPITALS (OUTPATIENT/SURGICAL)
HOZMAINTEN	MEDICAL - MAINTENANCE BUILDINGS

Code	New Description
HOZMEDOFF	MEDICAL - MEDICAL OFFICE BUILDINGS
HOZMULUSE1	MEDICAL - MULTIPLE USE
HOZMULUSE2	MEDICAL - MULTIPLE USE 2
HOZOFFMOD	MEDICAL - OFFICE (MODULAR/RELOCATABLE)
HOZOUTPAT	MEDICAL - OUTPATIENT/COUNSELING
HOZPAINMGM	MEDICAL - PAIN MANAGEMENT
HOZRESEARC	MEDICAL - RESEARCH, CLINICAL/BENCH
HOZSKILLNU	MEDICAL - SKILLED NURSING FACILITY
HOZHERRAD	MEDICAL - THERAPEUDIC RADIOLOGY
MORTUARIES	MORTUARIES
MOTEL	MOTELS
MUSEUM	MUSEUMS
NURSINGHOM	NURSING HOMES (CONVALESCENT HOSPITALS)
OFFICE	OFFICE
GOVBLDGOTH	OFFICE (GOVERNMENT)
OFFICERELO	OFFICE (RELOCATABLE)
ORDPAYROLL	ORDINARY PAYROLL
OTHER	OTHER OCCUPANCY
PARKINGSTR	PARKING STRUCTURES (PARKADES)
PARKINGUND	PARKING STRUCTURES (UNDERGROUND)
PARKS	PARKS & RECREATION
PARKSHELTP	PARKS & RECREATION - SHELTERS AND PAVILIONS
PARKSSPORT	PARKS & RECREATION - SPORTS COMPLEX
PAVILION	PAVILIONS
PIERS	PIERS/WHARVES/DOCKS NOT ASSOCIATED WITH A PORT
PIPING-AG	PIPING - ABOVE GROUND
PIPING-BG	PIPING - BELOW GROUND
PIPING-OF	PIPING - OUTFALL
PORTS	PORTS - ASSOC. PROPERTY EXCLUDING PIERS, WHARVES, DOCKS
POSTNC	POST OFFICE (BRANCH)
POSTOFFBRA	POST OFFICE (MAIN)
POSTOFMAIN	PROPERTY IN THE OPEN
RECYCLE	RECYCLING FACILITIES
RENTALREIM	RENTAL REIMBURSEMENT

Hospital All Risk Property Program (HARPP)

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Property Schedule Guidelines

Palm Drive Health Care District dba: Palm Drive Hospital

RESTAURANT	RESTAURANTS
RESTROOM	RESTROOMS
RETAIL	RETAIL STORES
RETAILTIRE	RETAIL TIRE STORES
Code	**New Description**
SAWMILLNEW	SAW MILLS
SCHOOL	SCHOOLS - ADMIN/OFFICE BUILDINGS
STUDENTDIN	SCHOOLS - CAFETERIA/DINING
CLASSRMCOL	SCHOOLS - CLASSROOMS (COLLEGES/UNIVERSITIES)
CLASSROOMS	SCHOOLS - CLASSROOMS (GENERAL EDUCATION)
CLASSLAB	SCHOOLS - CLASSROOMS (LABORATORY)
CLASSRELO	SCHOOLS - CLASSROOMS (RELOCATABLE/MODULAR)
STUDENTHOU	SCHOOLS - DORMITORIES (INCLUDING COLLEGES/UNIVERSITIES)
GYMS	SCHOOLS - GYMNASIUMS
SCHOOLSPOR	SCHOOLS - SPORTS COMPLEX
UNIVERSITY	SCHOOLS (COLLEGES/UNIVERSITIES)
SCHOOLELEM	SCHOOLS (ELEMENTARY SCHOOLS)
SCHOOLHIGH	SCHOOLS (HIGH SCHOOLS)
SCHOOLMIDL	SCHOOLS (MIDDLE SCHOOLS)
SCHOOLSPEC	SCHOOLS (SPECIAL EDUCATION)
SCHOOLVOC	SCHOOLS (VOCATIONAL)
SHOPCTRCOM	SHOPPING CENTERS (COMMUNITY)
SHOPCTRNEI	SHOPPING CENTERS (NEIGHBORHOOD)
SHOPCTRREG	SHOPPING CENTERS (REGIONAL)
SHOWERBLDG	SHOWER ROOM BUILDINGS
TRAFSIGNLT	SIGNS, STREET LIGHTS, TRAFFIC SIGNALS, FENCING, ETC.
SNACKBARS	SNACK BARS/CONCESSION STANDS
SOLARPANEL	SOLAR PANELS
STADIUM	STADIUMS
STORBOATS	STORAGE (BOATS)
STORAGE	STORAGE FACILITIES - UNDER 20,000 FT2
STORAGCOLD	STORAGE FACILITIES (COLD STORAGE)
STORAGMODU	STORAGE SHED (MODULAR)
STORAGPREF	STORAGE SHED (PREFABRICATED)
SUPERMKTS	SUPERMARKETS/GROCERY STORES
SWIMPOOLS	SWIMMING POOLS
TENNISINDO	TENNIS CLUBS (INDOOR)
TOOLS	TOOLS
TOOLSHEDS	TOOLSHED BUILDINGS
TRANSFER	TRANSFER STATIONS

HOSPITAL ALL RISK PROPERTY PROGRAM (HARPP)

2018-2019 PRE-RENEWAL PACKAGE

PROPERTY SCHEDULE GUIDELINES

PALM DRIVE HEALTH CARE DISTRICT DBA: PALM DRIVE HOSPITAL

Code	New Description
TRANSDEPOT	TRANSPORTATION DEPOTS
TRANSSHLTR	TRANSPORTATION SHELTERS
TUNNELS	TUNNELS

Code	New Description
UNKNOWN	UNKNOWN OCCUPANCY
POWERPLANT	UTILITIES/POWER PLANTS
UTILITYLIT	UTILITY BUILDINGS (LIGHT COMMERCIAL)
VACANTBLDG	VACANT BULIDINGS
VACANTLAND	VACANT LAND
VEHICLES	VEHICLES
VISITCENTE	VISITOR CENTERS
WAREHOUSE	WAREHOUSES (DISTRIBUTION)
WAREHSSTOR	WAREHOUSES (STORAGE)
WASTWTRLFT	WASTERWATER/SEWER PUMP LIFT STATIONS & EQUIPMENT
WASTWTRTMT	WASTEWATER/SEWER TREATMENT PLANTS & EQUIPMENT
WATERTMT	WATER TREATMENT
WATERCRAFT	WATERCRAFT
WHARVES	WHARVES AND DOCKS

Alliant

ALLIANT PROPERTY INSURANCE PROGRAM (APIP)

2018-2019 PRE-RENEWAL PACKAGE

VEHICLE REPORTING FORM

PALM DRIVE HEALTH CARE DISTRICT DBA: PALM DRIVE HOSPITAL

Directions:

1) Write in number of owned vehicles in applicable row(s).
2) Determine if you want the valuation of a damaged covered vehicle to be on a Replacement Cost (RCV), or Actual Cash Value (ACV) basis. Select the appropriate box to indicate your choice.
3) Determine if you have average an ACV value or RCV value for your fleet by vehicle type. If so, replace the numbers in column 3 and 4 as appropriate with your own. If you do not, you may use the values listed below which are adjusted according to the Consumer Price Index (CPI) Inflation Rate.
4) Multiply number of vehicles by your selections in Column 2 against either the RCV or ACV values used in columns 3 and 4. You must select the same valuation for all vehicle types.
5) Totals to be entered in Column 5.
6) Sign and date page 2 of the Vehicle Reporting Form and return to your account representative.

VALUATION: **RCV** ☐ **ACV** ☐

1. Type of Vehicle	2. Number of Vehicles	3. Average Replacement Value	4. Average Actual Cash Value	5. Total Insurable Values
Private Passenger Cars		$26,524	$14,344	Ø
Light Trucks (1 ton or less)		$30,945	$16,737	
Heavy Trucks (over 1 ton)		$38,681	$20,918	↓
Police Cars		$50,945	$27,000	
Police Motorcycles		$25,000	$15,000	
Fire Pumper Trucks		$431,013	$233,095	
Fire Snorkel/Ladder Trucks		$884,129	$478,143	
Fire Brush Trucks		$265,239	$143,443	
Fire – High End Trucks		1,500.000	811,190	
School Buses – 30 Passenger		$165,774	$89,652	
School Buses – 60 Passenger		$359,178	$194,246	
Refuse/Trash Truck		$350,000	$225,000	
City Transit Buses		$661,050	$427,140	↓
List Other Vehicles or Mobile equipment below or attach separate spreadsheet				
				Ø
				↓

ALLIANT PROPERTY INSURANCE PROGRAM (APIP)

2018-2019 PRE-RENEWAL PACKAGE

VEHICLE REPORTING FORM

PALM DRIVE HEALTH CARE DISTRICT DBA: PALM DRIVE HOSPITAL

1. Type of Vehicle	2. Number of Vehicles	3. Average Replacement Value	4. Average Actual Cash Value	5. Total Insurable Values
				Ø

GRAND TOTAL: Ø

Disclaimer: These numbers are estimated values. Please do not replace values with these when you have documentation to support your values. These numbers are intended as a guideline when values are unknown and may be used as a starting basis for values.

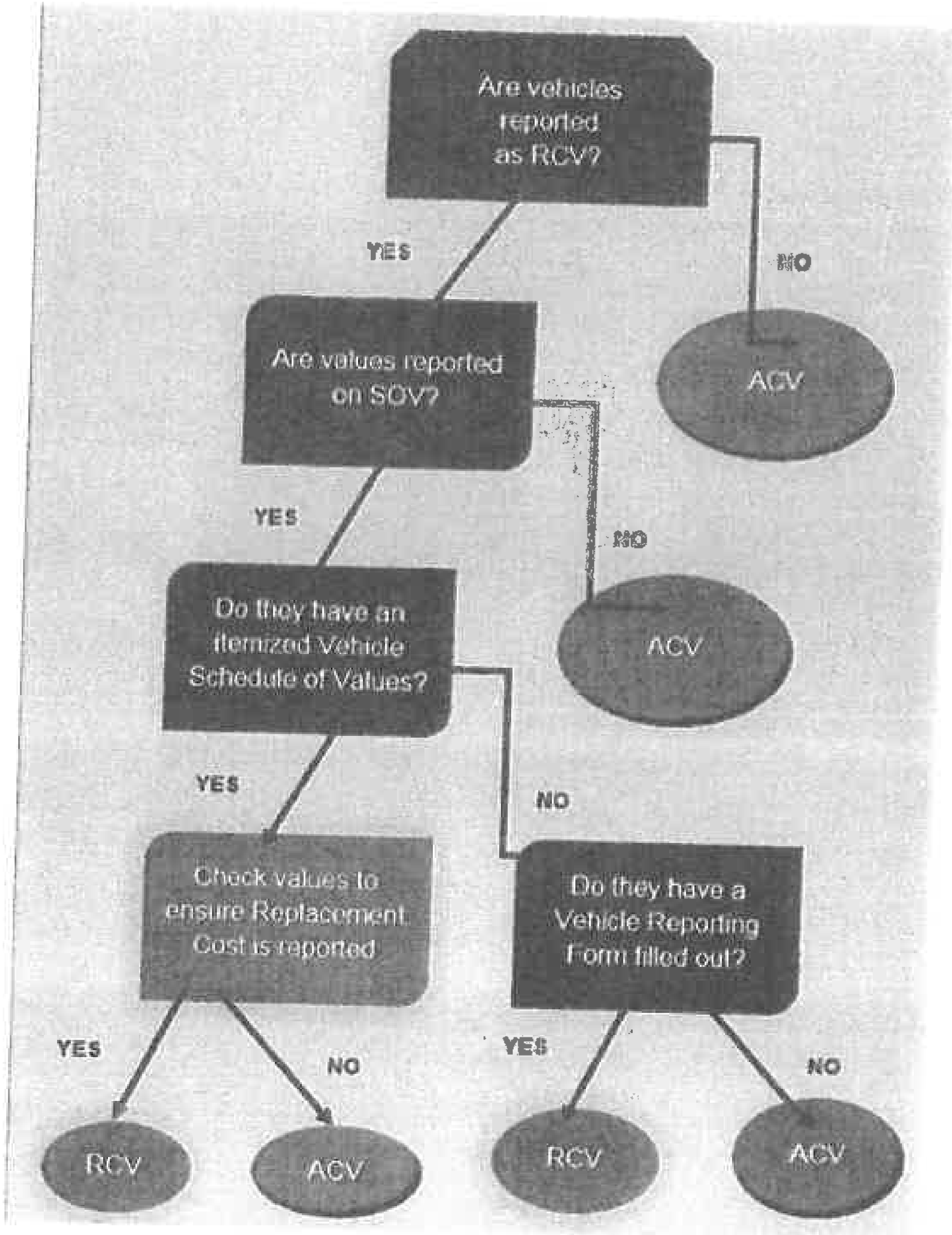
Please see page 3 for a diagram explaining how a loss valuation is determined in our program. Once reviewed your name and signature is required below.

ALANNA BROGAN
Print name

Signature

Date

ALLIANT PROPERTY INSURANCE PROGRAM (APIP)
2018-2019 PRE-RENEWAL PACKAGE
VEHICLE REPORTING FORM
PALM DRIVE HEALTH CARE DISTRICT DBA: PALM DRIVE HOSPITAL



BUSINESS INTERRUPTION
GROSS EARNINGS WORKSHEET

(THIS IS NOT A PART OF THE POLICY)

PLEASE COMPLETE FOR EACH BUILDING OR PROFIT CENTER

Name of Insured: Palm Drive Health Care District dba: Palm Drive Hospital

Location of Risk: 501 Petaluma Ave. Sebastopol, CA 95472

Date:________ Signature:____________ Title: Executive Director

Total number of beds at this location: 37

ALL ENTRIES TO BE ON AN ANNUAL BASIS COINCIDING WITH POLICY TERM

	Actual Values for Year Ended:	***Projected** Values for Next Year Ended:
Date:		
A. Total Annual Income from:		
1. In-patient & out-patient services	N/A	
2. Grants and research contracts		
3. School tuition, fees and other income		
4. Commissions or rents from leased departments		
5. Cafeteria		
6. Ambulance		
7. Other Income (excluding donations and contributions)		
B. Total Income (Items A.1 through A.7)		
C. Deduct only the NET cost of:		
1. Contractual adjustments, bad debts and free services		
2. Supplies consisting of material consumed directly in supplying the services of the Insured		
3. Merchandise sold		
4. Service(s) purchased from outsiders (not employees of the Insured) for resale which do not continue under contract		
5. Total deduction (Items C.1 through C.4)		
D. GROSS EARNINGS VALUES** (B minus C.5)		

We are only the owner of [illegible] building and equipment [illegible]

* Business Interruption losses are always adjusted from the time of the loss event forward. It is important that past known values are projected for the next policy year.

** Gross Earnings (Item D) includes all payroll expense. Complete the 2nd page to limit or exclude Ordinary Payroll. Otherwise, mark N/A on the 2nd page.

HOSPITAL
BUSINESS INTERRUPTION
GROSS EARNINGS WORKSHEET SUPPLEMENT

This page is for excluding or limiting Ordinary Payroll coverage; otherwise mark N/A

(THIS IS NOT A PART OF THE POLICY)

ALL ENTRIES TO BE ON AN ANNUAL BASIS COINCIDING WITH POLICY TERM

	Actual Values for Year Ended:	***Projected** Values for Next Year Ended:
Date:		
E. Start with **GROSS EARNINGS** (Item D)........	N/A	
F. Deduct: Payroll expense for Group II employees (Ordinary Payroll) including variable fringe benefits plus all taxes associated with Ordinary Payroll........		
G. Gross Earnings Value excluding Ordinary Payroll (E minus F)........		
H. Ordinary Payroll Amount of Insurance *** This is the Payroll Expense (F above) for Group II (Ordinary Payroll) for 90 or ( ) consecutive calendar days........		

N/A

NOTES: Group II employees include all employees except officers, executives, department managers, employees under contract and other important employees. Other important employees are those employees who are not officers, executives, department managers or employees under contract but whose continued employment would be required during the period of interruption.

* Business Interruption losses are always adjusted from the time of the loss event forward. It is important that past known values are projected for the next policy year.

***If Ordinary Payroll should be limited, please make sure to indicate the number of days you want covered.

COMPLETE BOTH PAGES OF THE WORKSHEET.
IF INCLUDING FULL ORDINARY PAYROLL, PLEASE MARK "N/A" ACROSS THE 2ND PAGE.

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HOSPITAL ALL RISK PROPERTY PROGRAM (HARPP)
2018-2019 PRE-RENEWAL PACKAGE
BOILER & MACHINERY CONTACT

Named Insured: HOSPITAL ALL RISK PROPERTY PROGRAM (HARPP)

PALM DRIVE HEALTH CARE DISTRICT DBA: PALM DRIVE HOSPITAL
501 PETALUMA AVE.
SEBASTOPOL CA 95472

CURRENT PLANT ENGINEER CONTACT:

Name: ~~Chuck Ferguson~~ STEVE DAY

Title: Manager

Telephone Number: ~~707-829-4077~~ 707-813-7246

Fax Number: 707-829-4141

Email Address: ~~chuck.ferguson@sonomawestmedicalcenter.com~~ STEVE.DAY@SONOMAMEDICALCENTER.COM

Location Address: 501 PETALUMA AVE, SEBASTOPOL. CA 95472.

Please fill in or Correct as Necessary

PREPARED BY
Alliant Insurance Services, Inc.
1301 Dove Street
Suite 200
Newport Beach, CA 92660 (949) 756-0271

HARPP PROPERTY SCHEDULE
PALM DRIVE HEALTH CARE DISTRICT
DBA: PALM DRIVE HOSPITAL

March 13, 2018

Includes B & M

Real Property Trend Factor: 3.66%
Personal Property Trend Factor: 2.33%

Loc #	2nd Id	Address, City, Zip	Occupancy	Construction	Auto Spklr	Year Built	Year Apprs	Zone	Real Prop	Pers Prop	BI / Rents	Year	Real Property	Personal Property	BI / Rents	Totals
1		PALM DRIVE HEALTH CARE HOSPITAL BUILDING 501 PETALUMA AVENUE SEBASTOPOL CA 95472 Stories: 1	48,423 SQ. FT. HOSPITAL BUILDING Pct. Sprnkl: 100	Class: A NON COMB STEEL FRAME	Yes	1999	2014	EQ: A3 Flood: X	No No	No No	No No	2017 2018	$20,286,590 $21,029,079	$0 $0	$0 $0	$20,286,590 $21,029,079
Lat: 38.398297		Lng. -122.821211														
5		DOCUMENT STORAGE 6789 WALKER ST. SEBASTOPOL CA 95472-4212 Stories: 1	2,000 SQ. FT.	Class: C MASONRY CONST/WOOD ROOF	No	1952	1999	EQ: A3 Flood: X	No No	No No	No No	2017 2018	$249,027 $258,141	$500 $512	$0 $0	$249,527 $258,653
Lat: 38.398626		Lng. -122.819460														

	Year	Real Property	Personal Property	BI / Rents	Totals
GRAND TOTALS:	2017	$20,535,617	$500	$0	$20,536,117
SPRINKLERED:	2017	$20,286,590	$0	$0	$20,286,590
UNSPRINKLERED:	2017	$249,027	$500	$0	$249,527
EARTHQUAKE:	2017	$0	$0	$0	$0
FLOOD:	2017	$0	$0	$0	$0

	Year	Real Property	Personal Property	BI / Rents	Totals
GRAND TOTALS:	2018	$21,287,220	$512	$0	$21,287,732
SPRINKLERED:	2018	$21,029,079	$0	$0	$21,029,079
UNSPRINKLERED:	2018	$258,141	$512	$0	$258,653
EARTHQUAKE:	2018	$0	$0	$0	$0
FLOOD:	2018	$0	$0	$0	$0

County.Frx

SIGNED / ACCEPTED BY: ______________________

DATE: ______________________

FOR DEPARTMENTAL USE ONLY	
District:	ELMS Facility Number:
Proposed name of facility/agency/clinic:	

APPLICANT INDIVIDUAL INFORMATION

This form is intended for any individual owning the applicant facility or for any individual involved (now or in the past) with any health or community care facility. **Refer to the INSTRUCTION SHEET to see who needs to complete this form.**

This HS 215A form needs to be completed as part of an application package plus it needs to be completed for disclosure purposes when changes are reported in officers, directors, purchase of stock, etc., as required by law, **even though no change in legal ownership is occurring.**

A. Identifying Information

Name

Date of Birth

Business address (number, street, apartment/suite number or letter if applicable)

City, State, & Zip

Title in relation to this facility

Have you applied for ANY license for a health facility or community care facility using any name other than your true full name? If yes, list all other names.

If an Administrator for proposed clinic, list hours that will be spent at the clinic each week. If an Administrator at more than one licensed clinic, list the name of **each clinic** and the number of hours spent in each licensed clinic per week.

B. Criminal Record

1. Have you ever been convicted of an offense that is still on your record, whether misdemeanor or felony? ◯ **Yes** ◯ **No**
2. Has there been a judgment against you for Medicare or Medicaid (Medi-Cal) fraud or by a health care professional/technical licensing entity? ◯ **Yes** ◯ **No**

If yes to questions 1 or 2 above, please explain and provide dates and conviction information (attach additional pages if necessary):

C. Professional Licenses/Certificates – This requirement is mandatory for Primary Care Clinics and optional for Health facilities.

TYPE	PERIOD HELD	ISSUING AGENCY

D. Employment/Business Summary (for last 10 years). Please list any additional experience that qualifies you to operate this type of facility. Begin with your most recent job. Attach additional pages if necessary.

	Name and address of employer	Job title
From:		
To:		
From:		
To:		
From:		
To:		
From:		
To:		

E. Facility, Agency, Clinic Involvement (in or out of California)

The questions below are for "individuals" and do not pertain to the facility that is applying for licensure.

1. **Have you ever been involved with a business entity that operated a health facility or community care facility?**
   ◯ **Yes** ◯ **No** **If YES, complete Section F (below) and the "Facility Information Sheet" (attached).**

2. Have you ever operated or managed (including management agreements) any of the following facility types?
   ◯ Yes ◯ No **If YES, complete Section F (below) and the "Facility Information Sheet" (attached).**

Adult Day Health Care Center	ICF/DD
Clinics	ICF/DD-H
COMMUNITY CARE FACILITY	ICF-DD-N
General Acute Care Hospital	Intermediate Care Facility
Health Facility	Pediatric Day Health & Respite Care
Home Health Agency	Residential Care Facility for the Elderly
Hospice	Skilled Nursing Facility
	Other

3. Have you ever held a **5 percent** or more beneficial ownership interest in any of the facility types above?
   ◯ Yes ◯ No **If YES, complete Section F (below) and the "Facility Information Sheet" (attached).**

F. Adverse Actions

Have you been affiliated with any facility, either past or present, that has been identified as having one or more of the following adverse actions? ◯ **Yes** ◯ **No** **If YES, check all applicable:**

◯ Had a final Medi-Cal decertification action taken ◯ Placed on probation ◯ Receiver appointed
◯ Resolved by settlement ◯ Revocation action filed ◯ Revoked (whether stayed or not) ◯ Suspension

If yes, please explain (including facility name and address). Attach additional pages if necessary:

I declare under penalty of perjury that the statements on this form and any accompanying attachments are correct to the best of my knowledge.

Signature: Date:

RELEASE OF INFORMATION STATEMENT

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicant's or applicant facility's ability to provide health services. The information is requested by the California Department of Public Health, Licensing and Certification, in accordance with the Health and Safety Code. Failure to provide the information as requested may result in nonissuance of a license or license revocation. The information is considered public information and will be made available to the public upon request. The information shall be included and maintained in the individual facility's public files located in Licensing and Certification district offices.

FACILITY INFORMATION SHEET

You are required to complete the following for each facility (including all facilities in all business entities) with which you have a current relationship or have had a past relationship (going back 3 years). Refer to the INSTRUCTION SHEET.

Facility name: ______ **Facility address (number, street, city):** ______ **State:** ______ **Zip code:** ______

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center ○ Clinic ○ COMMUNITY CARE FACILITY ○ General Acute Care Hospital ○ Health Facility ○ HHA ○ Hospice ○ ICF ○ ICF/DD ○ ICF/DD-H ○ ICF/DD-N ○ ICF ○ Residential Care for the Elderly ○ SNF ○ OTHER FACILITY TYPE (explain): ______	For EACH business entity, identify the name & EIN of the entity: ○ Corporation: ______ ○ Individual: ______ ○ LLC: ______ ○ Management Company: ______ ○ Partnership: ______ ○ OTHER Business Entity (explain): ______ Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain. ○ Yes ______ ○ No	○ Administrator of Clinic, SNF or ICF ○ Agent ○ Director ○ Licensee ○ Manager of "parent" organization ○ Managing employee of a HHA ○ Member ○ Officer of corporation ○ Owner ○ Partner ○ Sole Proprietorship ○ Stockholder – Ownership %: ______ ○ Trustee ○ OTHER Nature of Involvement (explain): ______ Dates of involvement: From: ______ To: ______

Facility name: ______ **Facility address (number, street, city):** ______ **State:** ______ **Zip code:** ______

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center ○ Clinic ○ COMMUNITY CARE FACILITY ○ General Acute Care Hospital ○ Health Facility ○ HHA ○ Hospice ○ ICF ○ ICF/DD ○ ICF/DD-H ○ ICF/DD-N ○ ICF ○ Residential Care for the Elderly ○ SNF ○ OTHER FACILITY TYPE (explain): ______	For EACH business entity, identify the name & EIN of the entity: ○ Corporation: ______ ○ Individual: ______ ○ LLC: ______ ○ Management Company: ______ ○ Partnership: ______ ○ OTHER Business Entity (explain): ______ Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain. ○ Yes ______ ○ No	○ Administrator of Clinic, SNF or ICF ○ Agent ○ Director ○ Licensee ○ Manager of "parent" organization ○ Managing employee of a HHA ○ Member ○ Officer of corporation ○ Owner ○ Partner ○ Sole Proprietorship ○ Stockholder – Ownership %: ______ ○ Trustee ○ OTHER Nature of Involvement (explain): ______ Dates of involvement: From: ______ To: ______

Facility name: ______ **Facility address (number, street, city):** ______ **State:** ______ **Zip code:** ______

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center ○ Clinic ○ COMMUNITY CARE FACILITY ○ General Acute Care Hospital ○ Health Facility ○ HHA ○ Hospice ○ ICF ○ ICF/DD ○ ICF/DD-H ○ ICF/DD-N ○ ICF ○ Residential Care for the Elderly ○ SNF ○ OTHER FACILITY TYPE (explain): ______	For EACH business entity, identify the name & EIN of the entity: ○ Corporation: ______ ○ Individual: ______ ○ LLC: ______ ○ Management Company: ______ ○ Partnership: ______ ○ OTHER Business Entity (explain): ______ Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain. ○ Yes ______ ○ No	○ Administrator of Clinic, SNF or ICF ○ Agent ○ Director ○ Licensee ○ Manager of "parent" organization ○ Managing employee of a HHA ○ Member ○ Officer of corporation ○ Owner ○ Partner ○ Sole Proprietorship ○ Stockholder – Ownership %: ______ ○ Trustee ○ OTHER Nature of Involvement (explain): ______ Dates of involvement: From: ______ To: ______

Facility name:	Facility address (number, street, city):	State:	Zip code:

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
◯ Adult Day Health Care Center ◯ Clinic ◯ COMMUNITY CARE FACILITY ◯ General Acute Care Hospital ◯ Health Facility ◯ HHA ◯ Hospice ◯ ICF ◯ ICF/DD ◯ ICF/DD-H ◯ ICF/DD-N ◯ ICF ◯ Residential Care for the Elderly ◯ SNF ◯ OTHER FACILITY TYPE (explain):	For EACH business entity, identify the name & EIN of the entity: ◯ Corporation: ◯ Individual: ◯ LLC: ◯ Management Company: ◯ Partnership: ◯ OTHER Business Entity (explain): Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain. ◯ Yes ◯ No	◯ Administrator of Clinic, SNF or ICF ◯ Agent ◯ Director ◯ Licensee ◯ Manager of "parent" organization ◯ Managing employee of a HHA ◯ Member ◯ Officer of corporation ◯ Owner ◯ Partner ◯ Sole Proprietorship ◯ Stockholder – Ownership %: ◯ Trustee ◯ OTHER Nature of Involvement (explain): Dates of involvement: From: To:

Facility name:	Facility address (number, street, city):	State:	Zip code:

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
◯ Adult Day Health Care Center ◯ Clinic ◯ COMMUNITY CARE FACILITY ◯ General Acute Care Hospital ◯ Health Facility ◯ HHA ◯ Hospice ◯ ICF ◯ ICF/DD ◯ ICF/DD-H ◯ ICF/DD-N ◯ ICF ◯ Residential Care for the Elderly ◯ SNF ◯ OTHER FACILITY TYPE (explain):	For EACH business entity, identify the name & EIN of the entity: ◯ Corporation: ◯ Individual: ◯ LLC: ◯ Management Company: ◯ Partnership: ◯ OTHER Business Entity (explain): Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain. ◯ Yes ◯ No	◯ Administrator of Clinic, SNF or ICF ◯ Agent ◯ Director ◯ Licensee ◯ Manager of "parent" organization ◯ Managing employee of a HHA ◯ Member ◯ Officer of corporation ◯ Owner ◯ Partner ◯ Sole Proprietorship ◯ Stockholder – Ownership %: ◯ Trustee ◯ OTHER Nature of Involvement (explain): Dates of involvement: From: To:

Facility name:	Facility address (number, street, city):	State:	Zip code:

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
◯ Adult Day Health Care Center ◯ Clinic ◯ COMMUNITY CARE FACILITY ◯ General Acute Care Hospital ◯ Health Facility ◯ HHA ◯ Hospice ◯ ICF ◯ ICF/DD ◯ ICF/DD-H ◯ ICF/DD-N ◯ ICF ◯ Residential Care for the Elderly ◯ SNF ◯ OTHER FACILITY TYPE (explain):	For EACH business entity, identify the name & EIN of the entity: ◯ Corporation: ◯ Individual: ◯ LLC: ◯ Management Company: ◯ Partnership: ◯ OTHER Business Entity (explain): Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain. ◯ Yes ◯ No	◯ Administrator of Clinic, SNF or ICF ◯ Agent ◯ Director ◯ Licensee ◯ Manager of "parent" organization ◯ Managing employee of a HHA ◯ Member ◯ Officer of corporation ◯ Owner ◯ Partner ◯ Sole Proprietorship ◯ Stockholder – Ownership %: ◯ Trustee ◯ OTHER Nature of Involvement (explain): Dates of involvement: From: To:

INSTRUCTIONS FOR HS 215A

The HS 215A must contain an original signature and date. The date of this form should be within the last three months.
This form is intended for the following:

1. Any individual owning an applicant facility;
2. Each agent, each partner, each director, each member, each managing employee of a HHA, each officer of a corporation;
3. Each agent, each partner, each director, each officer, each member or manager of a parent organization of licensee applicant;
4. Each manager, each member of a limited liability company;
5. Administrators;
6. Each person having a beneficial interest of 5 percent or more in the applicant corporation, applicant limited liability company, applicant partnership, applicant management company, applicant facility or private agency; and
7. Each officer and each director of the parent of the management company.

District office and ELMS Number	To be completed by the California Department of Public Health
Proposed name of facility/agency/clinic	Enter the name of your facility as it appears on your application (HS 200).

A. IDENTIFYING INFORMATION

Name	Please enter your full legal name.
Date of birth	Day/Month/Year
Business Address	Location of your business; number, street, apartment/suite number or letter if applicable.
City	City where business is located.
State	State where business is located.
Zip code	Zip code where business is located
Title in relation to this facility	Your title in relation to this facility.
If an Administrator for proposed clinic, list hours that will be spent at the clinic each week. If an Administrator at more than one licensed clinic, list the name of each clinic and the number of hours spent in each licensed clinic per week.	Please list hours spent at each clinic per week. If your title is not administrator, please list N/A.
Have you applied for any license for a health facility or community care facility regardless of your role or title using any name other than your true full name? If yes, list all other names.	Please answer yes or no. If yes, list any other names you have used if you have ever applied for a health facility or community care facility license.

B. CRIMINAL RECORD

Please check appropriate box. If you have checked 'yes', please provide dates and conviction information. If not applicable, please enter 'N/A'.

C. PROFESSIONAL LICENSES/CERTIFICATES

Type	Type of licenses or certificate that you hold.
Period held	Dates that you held your license.
Issuing Agency	Agency that issued you a license and/or certificate.

D. EMPLOYMENT/BUSINESS SUMMARY (FOR LAST10 YEARS). Please list any additional experience that qualifies you to operate this type of facility. If self employed, never worked or now retired, indicate the 'From' and 'To' dates. Begin with your most recent job. Attach additional pages if necessary.

Dates (From/To)	Dates that you were employed in position from the start to the end date.
Name and Address of Employer(s)	Name and street, city, state address of the employer.
Job Title	Title that you held within your company/place of employment.

E. FACILITY, AGENCY, CLINIC INVOLVEMENT (IN OR OUT OF CALIFORNIA)

Questions No. 1-3	Please check appropriate box(es). If you have checked yes, you must fill out the attached "Facility Information Sheet" and complete Section F.

F. ADVERSE ACTIONS

Please check appropriate box. If box is checked yes, please explain and include facility information.

FACILITY INFORMATION SHEET

Facility Name	Name of Facility that correlates to the checkboxes you have checked as 'yes' in Section E.
Facility address	Number and street address of the facility involved.
City	City where facility is located.
State	State where facility is located.
ZIP code	Zip code where facility is located.
Type of Facility	Check appropriate health facility.
"Type" of Business Entity	Check appropriate business entity and identify if this entity is a "parent" corporation to the applicant facility.
Individual "Nature" of Involvement	Check appropriate position held at that facility.