BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

MISSION

It is our mission to deliver quality healthcare to the residents of and visitors to BigBearValley through the most effective use of available resources.

VISION

To be the premier provider of emergency medical and healthcare services in our BigBearValley.

BOARD OF DIRECTORS BUSINESS MEETING AGENDA
WEDNESDAY, FEBRUARY 09, 2022 @ 1:00 PM
CLOSED SESSION 1:00 PM HOSPITAL CONFERENCE ROOM
OPEN SESSION @ APPROXIMATELY 2:00 PM HOSPITAL CONFERENCE ROOM
41870 GARSTIN DRIVE, BIG BEAR LAKE, CA 92315

(Closed Session will be held upon adjournment of Open Session as noted below. Open Session will reconvene @ approximately 2:00 p.m. –Hospital Conference Room 41870 Garstin Drive, Big Bear Lake, CA 92315)

Copies of staff reports or other written documentation relating to each item of business referred to on this agenda are on file in the Chief Executive Officer's Office and are available for public inspection or purchase at 10 cents per page with advance written notice. In compliance with the Americans with Disabilities Act and Government Code Section 54954.2, if you need special assistance to participate in a District meeting or other services offered by the District, please contact Administration (909) 878-8214. Notification at least 48 hours prior to the meeting or time when services are needed will assist the District staff in assuring that reasonable arrangements can be made to provide accessibility to the meeting or service. **DOCUMENTS RELATED TO OPEN SESSION AGENDAS (SB 343)** -- Any public record, relating to an open session agenda item, that is distributed within 72 hours prior to the meeting is available for public inspection at the public counter located in the Administration Office, located at 41870 Garstin Drive, Big Bear Lake, CA 92315. For questions regarding any agenda item, contact Administration at (909) 878-8214.

OPEN SESSION

1. **CALL TO ORDER** **Peter Boss, President**

2. **PUBLIC FORUM FOR CLOSED SESSION**
   This is the opportunity for members of the public to address the Board on Closed Session items.
   (Government Code Section 54954.3, there will be a three (3) minute limit per speaker. Any report or data required at this time must be requested in writing, signed and turned in to Administration. Please state your name and city of residence.)

3. **ADJOURN TO CLOSED SESSION***

CLOSED SESSION

1. **CHIEF OF STAFF REPORT/QUALITY IMPROVEMENT: *Pursuant to Health & Safety Code Section 32155**
   (1) Chief of Staff Report

2. **CONFERENCE WITH LEGAL COUNSEL –LITIGATION: *Pursuant to Government Code Section 54956.9**
   (1) Three Case's

3. **HOSPITAL QUALITY/RISK/COMPLIANCE REPORTS: *Pursuant to Health & Safety Code Section 32155**
   (1) Risk / Compliance Management Report
   (2) QI Management Report

4. **REAL PROPERTY NEGOTIATIONS: *Government Code Section 54956.8 *Pursuant to Health and Safety Code Section 32106 and Civil Code Section 34266.1**
   (1) Property Acquisition/Lease/Tentative Improvement (Anticipated Disclosure 2/09/22)

5. **CONFERENCE WITH LABOR NEGOTIATORS: *Government Code Section 54957.6 Negotiator(s): Michael Sarrao, Esq., & Erin Wilson, HR Director**
   (1) Continuing Negotiations with Teamsters Local No. 1932

(2) Upcoming Negotiations with UNAC

6. TRADE SECRETS: *Pursuant to Health and Safety Code Section 32106, and Civil Code Section 3426.1

(1) Comtrix Healthcare Staffing Agreement (Anticipated Disclosure 02/09/22)
(2) Michael Chin, MD; Dba: Mission Surgical Clinic Service Agreement (Anticipated Disclosure 02/09/22)
(3) Michael Norman, DO; Medical Director Respiratory/EKG Department Service Agreement (Anticipated Disclosure 02/09/22)
(4) Prashanth Kumar, MD, Dba: High Desert Nephrology Medical Center Physician Clinic Service Agreement (Anticipated Disclosure 02/09/22)
(5) Third Party Payor Contract Negotiations (Anticipated Disclosure 02/09/22)

OPEN SESSION

1. CALL TO ORDER **Peter Boss, President**

2. ROLL CALL **Shelly Egerer, Executive Assistant**

3. FLAG SALUTE

4. ADOPTION OF AGENDA*

5. RESULTS OF CLOSED SESSION **Peter Boss, President**

6. PUBLIC FORUM FOR OPEN SESSION

This is the opportunity for persons to speak on items of interest to the public within subject matter jurisdiction of the District, but which are not on the agenda. Any person may, in addition to this public forum, address the Board regarding any item listed on the Board agenda at the time the item is being considered by the Board of Directors. *(Government Code Section 54954.3, there will be a three (3) minute limit per speaker. Any report or data required at this time must be requested in writing, signed and turned in to Administration. Please state your name and city of residence.)*

PUBLIC RESPONSE IS ENCOURAGED AFTER MOTION, SECOND AND PRIOR TO VOTE ON ANY ACTION ITEM

7. DIRECTORS' COMMENTS

8. INFORMATION REPORTS

A. Foundation Report **Marsha Oskey, Foundation President**

B. Auxiliary Report **Gail Dick, Auxiliary President**

9. CONSENT AGENDA*

Notice to the Public:

Background information has been provided to the Board on all matters listed under the Consent Agenda, and the items are considered to be routine by the Board. All items under the Consent Agenda are normally approved by one (1) motion. If discussion is requested by any Board Member on any item; that item will be removed from the Consent Agenda if separate action other than that as stated is required.

A. January 12, 2022 Business Board Meeting Minutes: Shelly Egerer, Executive Assistant
B. January 2022 Human Resource Report: Erin Wilson, Human Resource Director
C. January 2022 Plant and Maintenance Report: Michael Mursick, Plant & Maint. Manager
D. January 2022 Infection Control Report: Heather Loose, Infection Preventionist

E. Quality Improvement Plan and Program Summary 2021: Sheri Mursick, QI Director

F. Polices & Procedures (Summary Attached)

(1) Diagnostic Imaging
(2) Facilities & Maintenance Department
(3) Material's Management
(4) Information Technology
(5) Patient Financial Services
(6) Pharmacy
(7) Quality Improvement
(8) Risk Management
(9) Safety
(10) Urgent Care

G. Committee Meeting Minutes:

(1) January 04, 2022 Finance Committee Meeting Minutes

10. OLD BUSINESS*

A. Discussion and Potential Approval of BVCHD Board of Directors Board Stipend Modification/Frequency & Health Benefits

11. NEW BUSINESS*

A. Discussion and Potential Approval of the Following Service Agreements:

(1) Comtrix Healthcare Staffing Agreement
(2) Michael Chin, MD; Dba: Mission Surgical Clinic Service Agreement
(3) Michael Norman, DO; Medical Director Respiratory/EKG Department Service Agreement
(4) Prashanth Kumar, MD, Dba: High Desert Nephrology Medical Center Physician Clinic Service Agreement

B. Discussion and Potential Approval of 2021 Fiscal Year Audited Financial Report

12. ACTION ITEMS*

A. **Acceptance of QHR Health Report**

Woody White, QHR Health

(1) February 2022 QHR Health Report

B. **Acceptance of CNO Report**

Kerri Jex, Chief Nursing Officer

(1) January 2022 CNO Report

C. **Acceptance of the CEO Report**

Evan Rayner, Chief Executive Officer

(1) February 2022 CEO Report

D. **Acceptance of the Finance Report & CFO Report**

Garth Hamblin, Chief Financial Officer

(1) December 2021
(2) CFO Report

13. ADJOURNMENT*

*** Denotes Possible Action Items**

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
BUSINESS BOARD MEETING MINUTES
41870 GARSTIN DRIVE, BIG BEAR LAKE, CA 92315
JANUARY 12, 2022

PRESENT:	Peter Boss, MD, President	Steven Baker, Treasurer
	Jack Briner, 2nd Vice President	Evan Rayner, CEO
	Mark Kaliher, RN, Secretary	Shelly Egerer, Exec. Assistant
ABSENT:	Gail Dick, Auxiliary	Erin Wilson
	Marsha Oskey w/Foundation	Ellen Clarke, 1st Vice President
STAFF:	Kerri Jex Mary Norman	Sheri Mursick
OTHER:	Woody White w/ QHR	
COMMUNITY MEMBERS:	None	

OPEN SESSION

1. **CALL TO ORDER:**
   President Boss called the meeting to order at 1:00 p.m.

CLOSED SESSION

1. **PUBLIC FORUM FOR CLOSED SESSION:**
   President Boss opened the Hearing Section for Public Comment on Closed Session items at 1:00 p.m. Hearing no request to make public comment. President Boss closed Public Forum for Closed Session at 1:00 p.m.

2. **ADJOURNED TO CLOSED SESSION:**
   President Boss called for a motion to adjourn to Closed Session at 1:01 p.m. Motion by Board Member Baker to adjourn to Closed Session. Second by Board Member Kaliher to adjourn to Closed Session. President Boss called for a vote. A vote in favor of the motion was 4/0.
   - Board Member Briner - yes
   - President Boss - yes
   - Board Member Baker - yes
   - Board Member Kaliher - yes

RECONVENE TO OPEN SESSION

1. **CALL TO ORDER:**
   President Boss called the meeting to Open Session at 2:00 p.m.

2. **ROLL CALL:**
   Peter Boss, Steven Baker, Jack Briner, and Mark Kaliher were present. Also present was Evan Rayner, CEO, and Shelly Egerer, Executive Assistant. Absent was Ellen Clarke.

3. **FLAG SALUTE:**
Board Member Baker led flag salute and all present participated.

4. **ADOPTION OF AGENDA:**
President Boss called for a motion to adopt the January 12, 2022 Board Meeting Agenda as presented. Motion by Board Member Kaliher to adopt the January 12, 2022 Board Meeting Agenda as presented. Second by Board Member Baker to adopt the January 12, 2022 agenda as presented. President Boss called for a vote. A vote in favor of the motion was 4/0.
   - Board Member Briner - yes
   - President Boss - yes
   - Board Member Baker - yes
   - Board Member Kaliher - yes

5. **RESULTS OF CLOSED SESSION:**
President Boss reported that the following action was taken in Closed Session:
   - Chief of Staff Report:
     - Initial Appointment:
       - Ronald Gertsch, MD- Urgent Care
       - Mark Shafik, MD- Urgent Care
       - Victoria Morrison, DO- Urgent Care
       - Frank Paul, DO- Urgent Care
       - Andrew Ho, DO- Urgent Care
       - Tennille Allen, FNP- Urgent Care
       - Omeed Saghafi, MD- Emergency Medicine
       - Amy Jones, DO- OB/GYN

     - Re-Appointment:
       - Mauricio DeLaLama, MD- Renaissance Radiology
       - Vito Fodera, MD- Renaissance Radiology
       - Karin Fu, MD- Renaissance Radiology
       - Steven Kussman, MD- Renaissance Radiology
       - Farbod Nasseri, MD- Renaissance Radiology
       - Harun Ozer, MD- Renaissance Radiology
       - Lucas Payor, MD- Renaissance Radiology
       - Tanya Tivorsak, MD- Renaissance Radiology
       - Nhan Tran, MD- Renaissance Radiology
       - Douglas Rusnack, MD- Renaissance Radiology
       - Kevin Rice, MD- Renaissance Radiology
       - Jennifer Hill, MD- Renaissance Radiology
       - Olga Lyass, MD- Renaissance Radiology
       - Richard Yoo, MD- Renaissance Radiology
       - Mark Beller, MD- Renaissance Radiology
       - Dianna Chooljian, MD- Renaissance Radiology
       - Christopher Fagan, MD- Family Medicine
       - Steven Groke, MD- Emergency Medicine

- Risk Report/Compliance Report
  - Letter of rejection on claim # 21-001892

- QI Report

President Boss called for a vote. A vote in favor of the motion was 4/0.

- Board Member Briner - yes
- President Boss - yes
- Board Member Baker - yes
- Board Member Kaliher - yes

6. PUBLIC FORUM FOR OPEN SESSION:

President Boss opened the Hearing Section for Public Comment on Open Session items at 2:00 p.m. Hearing no request to make public comment, President Boss closed Public Forum for Open Session at 2:00 p.m.

7. DIRECTORS COMMENTS

- President Boss wished all a Happy New Year
- Board Member Kaliher thanked staff for listening to him at the Christmas party and appreciated everyone's support.

8. INFORMATION REPORTS

A. Foundation Report:

- Ms. Oskey was not present to provide a report

B. Auxiliary Report:

- Ms. Dick was not present to provide a report

9. CONSENT AGENDA:

A. December 08, 2021 Business Board Meeting Minutes: Shelly Egerer, Executive Assistant

B. December 2021 Human Resource Report: Erin Wilson; Human Resource Director

C. December 2021 Plant and Maintenance Report: Michael Mursick, Plant & Maint. Manager

D. December 2021 Infection Control Report: Heather Loose, Infection Preventionist

E. Policies & Procedures:

(1) Diagnostic Imaging
(2) Employee Health
(3) HIM
(4) Infection Control
(5) Laboratory
(6) Medical Staff
(7) Surgery

F. Committee Meeting Minutes:

(1) December 07, 2021 Finance Committee Meeting

President Boss called for a motion to approve the Consent Agenda as presented. Motion by Board Member Briner to approve the Consent Agenda as presented. Second by Board Member Baker to approve the Consent Agenda as presented. President Boss called for the vote. A vote in favor of the motion was 4/0.

- Board Member Briner - yes
- President Boss - yes
- Board Member Baker - yes
- Board Member Kaliher - yes

10. OLD BUSINESS*

- None

11. NEW BUSINESS*

A. Discussion and Potential Approval of the Following Service Agreements:
(1) Brent Beaird, MD BBUC Service Agreement

President Boss called for a motion to approve Brent Beaird; MD Service Agreement as presented. Motion by Board Member Baker to approve Brent Beaird, MD Service Agreement as presented. Second by Board Member Briner to Brent Beaird, MD Service Agreement as presented. President Boss called for the vote. A vote in favor of the motion was 4/0.

- Board Member Briner - yes
- President Boss - yes
- Board Member Baker - yes
- Board Member Kaliher - yes

B. Discussion and Potential Approval of BVCHD Board of Directors Board Stipend Modification/Frequency:

- Mr. Baker reported that an ordinance was in place in regard to a board stipend of 5% and feels this item should be retroactive to Jan. 1, 2019, do we have to offer it to all other board members; health insurance is also offered to the Board and two board members receive it; Mr. Baker feels that his monthly Medicare Insurance and any other Board Member should be reimbursed for their monthly premiums.
- Mr. Rayner reported at this time we cannot take action on this item; a 5% increase for the last three years would be $117.00 per meeting; also provided information on health insurance being offered by the district; Mr. Rayner is going to have legal counsel assist in this topic to include her opinion on retroactive pay.

President Boss called for a motion to table the Board of Directors Board Stipend Modification/Frequency until the February Meeting. Motion by Board Member Baker to table the Board of Directors Board Stipend Modification/Frequency until the February Meeting. Second by Board Member Briner to table the Board of Directors Board Stipend Modification/Frequency until the February Meeting. President Boss called for the vote. A vote in favor of the motion was 4/0.

- Board Member Briner - yes
- President Boss - yes
- Board Member Baker - yes
- Board Member Kaliher - yes

C. Discussion and Update on QHR Board Leadership Conference February 22 – February 24:

- Mr. Rayner reported that the conference is scheduled; Garth, Dr. Boss and Evan will be in attendance. A copy of the agenda has been provided.

President Boss reported no action required

D. Discussion and Potential Approval of Travel Expenses for BVCHD Board of Directors to Attend the QHR Board of Directors Conference not to exceed $1,700.00:

President Boss called for a motion to approve travel expenses of $1,700.00 for QHR Board of Directors Conference. Motion by Board Member Baker to approve travel expenses of $1,700.00 for QHR Board of Directors Conference. Second by Board Member Kaliher to approve travel expenses of $1,700.00 for QHR Board of Directors Conference. President Boss called for the vote. A vote in favor of the motion was 4/0.

- Board Member Briner - yes
- President Boss - yes
- Board Member Baker - yes
- Board Member Kaliher - yes

E. Discussion, Review and Update on BVCHD Strategic Plan:

- Mr. Rayner reported that the Board approved the plan over a year ago; this is a living document and needs to be addressed and request a special Board Meeting in March to review the Strategic Plan, meeting should take approximately an hour.

President Boss reported no action required

F. Discussion and Potential Approval of the Board of Directors Big Bear Urgent Care Inc. Board Meeting Schedule:

- Mr. Rayner recommended that the Board of Directors schedule a Special Board Meeting on a quarterly basis to review and approve any necessary items in regard to the Urgent Care. Mr. Rayner informed the Board that the UC Bylaws state at least quarterly meetings.

President Boss called for a motion to approve quarterly meetings for the Big Bear Urgent Care beginning in February 2022. Motion by Board Member Baker to approve quarterly meetings for the Big Bear Urgent Care beginning in February 2022. Second by Board Member Briner to approve quarterly meetings for the Big Bear Urgent Care beginning in February 2022. President Boss called for the vote. A vote in favor of the motion was 4/0.

- Board Member Briner - yes
- President Boss - yes
- Board Member Baker - yes
- Board Member Kaliher - yes

G. Discussion and Potential Approval of Resolution No. 22-467 Big Bear Urgent Care Inc. Company Credit Card:

- Mr. Rayner reported that the UC needs a credit card to keep the UC separated from the hospital and for business related services. At this time, we were denied due to no credit, but we have reapplied for the credit.
- Mr. Hamblin reported that we applied for a $5,000 credit limit; we may have to start at a lower limit and build our way up.

Motion by Board Member Kaliher Approval of Resolution No. 22-467 Big Bear Urgent Care Inc. Company Credit Card. Second by Board Member Briner Approval of Resolution No. 22-467 Big Bear Urgent Care Inc. Company Credit Card. President Boss called for the vote. A vote in favor of the motion was 4/0.

- Board Member Briner - yes
- President Boss - yes
- Board Member Baker - yes
- Board Member Kaliher - yes

12. ACTION ITEMS*

A. QHR Health Report:

(1) January 2022 QHR Health Report:

- Mr. White reported the following information:
  - Eight-page report and there are at least five pages of current information
    - Woody provided a briefing on the report
  - Board Self-Assessment is to be completed by QHR
  - 2nd Tuesday of the month there is a learning institute specifically for Board Members

President Boss motioned to approve the QHR Report as presented. Motion by Board Member Briner to approve the QHR Report as Presented. Second by Board Member Baker to approve the QHR Report as presented. President Boss called for the vote. A vote in favor of the motion was 4/0.

- Board Member Briner - yes
- President Boss - yes
- Board Member Baker - yes
- Board Member Kaliher - yes

B. Acceptance of CNO Report:

(1) December 2021

- Ms. Jex reported the following information:
  - Working towards getting staff the COVID booster
    - Staff who does not get the booster will be tested twice per week
    - Continue to provide vaccination clinics
  - We have one full time acute in the hiring process and two per diems
  - Extended offer to new coordinator for Medical Stabilization program
  - Physical Therapy is flexing volumes due to IEHP conversion
  - Our staff has done so fantastic the last two to three weeks; they have done an excellent job with all the obstacles they have been facing.

President Boss called for a motion to approve the CNO Report as presented. Motion by Board Member Baker to approve the CNO Report as presented. Second by Board Member Briner to approve the CNO Report as presented. President Boss called for the vote. A vote in favor of the motion was 4/0.

- Board Member Briner - yes
- President Boss - yes
- Board Member Baker - yes
- Board Member Kaliher – yes

C. Acceptance of CEO Report

(1) January 2022

- Mr. Rayner reported the following information:
  - State mandate on vaccination booster
    - February 1 is effective date
    - 100 employees have received the booster
  - Urgent Care is continuing to see patients
    - EMR is being utilized
    - Marketing and open house will be scheduled
  - Fawnskin property being utilized by travelers
    - $500.00 single room
    - $1,000 double unit
  - Clinical critical staff
    - RN's are hard to fine
    - Used staffing agreements to obtain nurses
    - Have had success in hiring CLS
  - COVID pay was reinstated until January 29 for specific departments
  - Orthopedic coverage began last weekend; Dr. Melvani will also see patients at the clinic beginning at the end of the month; saw approximately 10 patients per day
  - Looking into telemedicine and the different options we can use
  - CDPH is offering program flexibility under the circumstances due to COVID looking into a two bed ICU
    - Will need critical care RN
    - Financial analysis
  - New OB to begin in January
  - Dr. Chin will be returning to the clinic
  - MRI mobile services are being looked at
  - Began discussion with UC Riverside for affiliation purposes

President Boss motioned to approve the CEO Report as presented. Motion by Board Member Briner to approve the CEO Report as Presented. Second by Board Member Kaliher to approve the CEO Report as presented. President Boss called for the vote. A vote in favor of the motion was 4/0.

- Board Member Briner – yes
- President Boss - yes
- Board Member Baker - yes
- Board Member Kaliher - yes

D. Acceptance of the CFO Report:

(1) November 2021:

- Mr. Hamblin reported the following:
  - 433 days cash on hand
  - Expenses are 20% more than budget
  - Received $641,000 in CARES ACT funding
  - November was not a good month

- Board Member Baker requested the UC expenses/graphs/details be included in the finance report

(2) CFO Report:

- Mr. Hamblin provided the following:
  - CARES Act Funding:
    - Portal open to begin reporting
  - Urgent Care:
    - Continue to monitor expenses

President Boss called for a motion to approve the November 2021 Finance Report and CFO Report as presented. Motion by Board Member Briner to approve the November 2021 Finance Report and CFO Report as presented. Second by Board Member Baker to approve the November 2021 Finance Report as presented. President Boss called for the vote. A vote in favor was unanimously approved 4/0.

- Board Member Briner - yes
- President Boss - yes
- Board Member Baker - yes
- Board Member Kaliher - yes

13. ADJOURNMENT:

President Boss called for a motion to adjourn the meeting at 3:10 p.m. Motion by Board Member Briner to adjourn the meeting. Second by Board Member Baker to adjourn the meeting. President Boss called for the vote. A vote in favor of the motion was unanimously approved 4/0.

- Board Member Briner - yes
- President Boss - yes
- Board Member Baker - yes
- Board Member Kaliher - yes

Board Report
January 2021

Staffing	**Active:** 239 – FT: 165 PT: 10 PD: 64 **New Hires:** 6 **Terms:** 3 (3 Voluntary 0 Involuntary) **Open Positions:** 19
Employee Performance Evaluations	**DELINQUENT:** 30 days: 10 60 days: 5 90 days: 9 90+ days: 25 – (RT, ER, Accounting, Admitting, Maintenance, EVS, FHC, Mom and Dads)
Work Comp	**NEW CLAIMS: 0** **OPEN:** 9 Indemnity (Wage Replacement, attempts to make the employee financially whole) – 9 Future Medical Care – 0 Medical Only – 0
Employee Morale	Culture of Ownership team is working on updating BVCHD values Birthday Celebration January 18th
Beta HEART	Care for the Caregiver up and Running CPI (Workplace Violence) classes have resumed
Teamsters Negotiations	BVCHD continues negotiations for Radiology Technicians, Respiratory Therapists, Phlebotomists/Lab Assistants, ER Technicians, and Nursing Staffing Coordinator/Surgical Techs. PERB has confirmed majority vote with Admitting Clerks.

Bear Valley Community Healthcare District
Construction Projects 2021

Department / Project	Details	Vendor and all associated costs	Comments	Date Complete
Urgent Care- Patient Records	Planning the removal of excessive paitent record boxes from the facility	Facilities	In Progress	
EVS Storage Drywall Repair	Replace old damaged drywall	Facilities	In Progress	
Plumbing Repair SNF/ACute	Repair the bad plumbing under the showers in the SNF & Acute Departments	Pride Plumbing	In Progress	
Hospital/FHC	Electrical equipment modernization	Centrica	In Progress	
Hospital/Cardboard Stall	Build a new stall for the cardboard hoppers and bring the old trash bin to code.	Bear Valley Paving	Completed	
Hospital- OR Renovations	Replace wall coverings and flooring	TBD	In Progress	
Fawnskin Lodge	Install new handrails, install new door access, install alarm system	Facilities	In Progress	
RHC Storage Conversion	Framing, flooring, lighting etc..	Facilities	In Progress	

Bear Valley Community Healthcare District
Potential Equipment Requirements

Department / Project	Details	Vendor and all associated costs	Comments	Date Complete
Facilities- New Toolbox & Tool Set	Replace the old broken toolbox and replace the old handtool set	Northern Tools	Complete	
Hospital- Water treatment equipment	Our water treatment system is having issues that neeed to be adressed and replaced	Facilities/C.C.I	In Progress	

Infection Prevention Monthly Report

December 2021

TOPIC	UPDATE	ACTION/FOLLOW UP
1. Regulatory	▪ Continue to receive updates from APIC. Meetings are being conducted through Zoom. ▪ AFL (All Facility Letters) from CDPH have been reviewed. o 22-02 SNF Notice of Testing Supply Availability and Distribution 1. The state will provide covid antigen tests to facilitate testing of SNF visitors. ▪ NHSN o Continue NHSN surveillance reporting for hospital. ▪ No Hospital Acquired Infections to report. ▪ No surgical site infections. o Continue weekly reporting of vaccine status for SNF residents and staff.	` • AFLs reviewed and necessary actions initiated • Continue reporting as required.

	▪ Completion of CMR reports to Public Health per Title 17 and CDPH regulations o January – 230 positive COVID-19 reported o December – 66 positive COVID-19 reported	
2. Construction	▪ ICRAs issued: o None currently	▪ Work with Maintenance and contractors to ensure compliance.
3. QI	▪ Continue to work towards increased compliance with Hand Hygiene ▪ January 78% ▪ December 72%	• Continue monitoring hand hygiene compliance.
4. Outbreaks/ Surveillance	▪ January: 1 MRSA, 1 C-diff ▪ December: 2 -MRSA, 0-C diff	▪ Informational

5. Policy Updates	▪ No infection control policies this month.	▪ Clinical Policy and Procedure Committee to review and update Infection Prevention policies.
6. Safety/Product	▪ IP will be continuing to monitor environmental cleaning practices.	▪ Continue to monitor compliance with infection control practices.
7. Antibiotic Stewardship	▪ Pharmacist continues to monitor antibiotic usage. o Culture Follow-up o January: 6 patients needing follow-up, 1 changed Rx, 1.6 days to resolution o December: 6 patients needing follow up, 1 new Rx, less than 1 day to resolution	▪ Informational.
8. Education	▪ Infection Preventionist keeping up to date on latest COVID-19 and other infectious disease information. ▪ IP and EVS Supervisor to plan yearly competency and training for EVS staff. ▪ Heather Morse, PA-C from San Bernardino County came for a collaborative visit. She advised us on our COVID mitigation strategies for SNF.	▪ ICP to share information at appropriate committees.

9. Informational	▪ Immediate Use Steam Sterilization ▪ January – 0 surgeries, 0 IUSS ▪ December – 4 surgeries, 0 IUSS o Covid -19 Vaccine ▪ Booster shots required for vaccinated staff by March 1.	
Heather Loose, BSN, RN	*Infection Preventionist*	*Date: February 1, 2022*

Quality Improvement Plan and Program Summary 2021

Bear Valley Community Healthcare District (BVCHD) is committed to deliver the highest quality of care through the most efficient use of resources to patients, patient representatives, members of the community and visitors. The Quality Assurance Performance Improvement (QAPI) program is ongoing, comprehensive and deals with a full range of services offered by the facility. The scope of the program encompasses all systems of care and management practices including but not limited to patient/family feedback, staff input, provider engagement, business operations, individualized patient care plans, clinical care, regulatory compliance, and patient safety.

The purpose of QAPI in our organization is to take a proactive approach to continually improve the way we care for and engage with our patients, patient representatives, families and staff so we may support our mission to deliver the highest quality of care through the most effective use of resources to our patients. Employees shall participate in ongoing QAPI efforts which demonstrates the facility's commitment to providing high quality, compassionate care.

The organization uses Just Culture which is a system designed to balance the assessment of systems, processes and human behavior when errors occur. The goal as it pertains to Quality Improvement includes fostering and embedding a culture of accountability that is just and fair, supporting an open and safe reporting system in which everyone is encouraged to speak up without fear of reprisal and creating an environment of shared learning that focuses on safe system design to help employees make better behavioral choices and promote patient safety in a challenging healthcare environment.

The overall goal of the Quality Improvement Committee is to provide a process for continuous improvement through collaborative efforts between organizational levels. The Quality Committee is supported by the Risk/Quality Committee. The Committee integrates quality and risk management throughout the organization thereby providing a mechanism to identify opportunities for improvement through assessment, evaluation, recommendation, action and follow-up of occurrences, patient grievances and quality variances. The Risk/Quality Committee supports Root Cause Analysis (RCA) and Failure Mode and Effect Analysis (FMEA) methodologies. FMEA is a structured way used to identify and address potential problems, or failures and their resulting effects on the system or process before an adverse event occurs. An RCA is used once an issue has already occurred and is focused on uncovering the failure cause and effect chain that ultimately led to the root cause of failure. An action plan for improvement may be the result of either a FMEA or RCA.

Oversight of the Quality Improvement Program is performed by the Medical Executive Committee (MEC) and the Governing Board. The Medical Executive Committee is responsible for the ongoing quality of medical care and professional services provided by all individuals with clinical privileges; and 1) participates in organization-wide measurement, assessment and improvement activities, 2) has representation as Chair of the Quality Improvement Committee, 3) approves the Quality Improvement Plan, and 4) involves Medical Staff members in the assessment and improvement of clinical care, including Peer Review.

In conjunction with the Quality Improvement Committee, the Medical Executive Committee has oversight responsibility for Medical Staff-related Improvement activities. The Medical Executive Committee reviews utilization review, infection control, peer review, pharmacy and therapeutics, credentialing, risk management and safety activities impacting services.

The Governing Board is responsible to ensure the provision of optimal quality care and organization-wide performance within available resources. The authority to fulfill the goals of Quality Improvement function is delegated to the Medical Staff and the Administrative Team of BVCHD with the Governing Board's oversight.

The Quality Improvement Plan is evaluated to review the clinical and service activities BVCHD undertakes to improve outcomes. The evaluation is used to identify further actions and opportunities to improve the care and services BVCHD provides to the community.

The QI Committee consisting of the administrative team, workgroup champions and support staff meet on a monthly basis to discuss action plans and progress made in each area. Quarterly, the QI Committee, Physician Chair and Department Managers meet to review dashboards and departmental QI initiatives. Annually, the QI program is reviewed to identify accomplishments and areas for continued improvement.

In 2021 the QI Committee focused on the following programs: Patient Family Advisory Council (PFAC), BETA HEART, BETA Employee Safety and Wellness Initiative (ESWI), Culture of Ownership, Regulatory and SNF QAPI. Workgroups were developed for Sepsis, Medication Reconciliation, Pediatric Readiness/ED Labor & Delivery, Telehealth (clinic) and Emergency Medicine Collaborative. A "champion" was assigned to each of the work groups. The workgroups met on a regular basis to review performance data, identify areas in need of improvement and carry out and monitor improvement efforts. In addition to programs and workgroups, the QI Committee also is involved in DHCS programs such as PRIME and QIP.

Teams were developed to address specific target areas. Each team developed objectives and action plans.

- Patient Family Advisory Council (PFAC) -The council approaches opportunities to improve quality, safety and patient satisfaction. Patient and family advisors are valuable partners in efforts to reduce medical errors and improve the safety and quality of health care.

- BETA HEART -The BETA HEART program is a holistic approach to reduce patient harm. The overall goals of the program are to develop an empathic and clinically appropriate process that supports healing of both the patient and clinician after an

adverse event; ensure accountability for the development of reliable systems that support the provision of safe care; provide a mechanism for early, ethical resolution when harm occurs as a result of medical error or inappropriate care; and instill trust in all clinicians and patients.

- BETA Employee Safety and Wellness Initiative (ESWI)- The BETA Employee Safety and Wellness Program is focused on addressing areas through 8 different domains to improve organizational safety and minimize injuries. The eight domains include Ergonomics, Fleet Safety and Mobile Ergonomics, Manual Material Handling, Opioid & Polypharmacy Prescribing, Return to Work, Safe Patient Handling and Mobility, Slip, Trip and Fall Prevention, and Workplace Violence. The two domains the team is focusing on are Slip, Trip and Fall Prevention and Workplace Violence Prevention.
    - Slip, Trip and Fall Prevention familiarizes staff with common hazards as well as recognizing hidden hazards in different environments. This includes auditing for prevention and educating employees on their joint responsibility with leadership to avoid injuries in the workplace.
    - Workplace Violence Prevention is in alignment with the California Violence Prevention in Health Care Standards. This program will evaluate and revise the plan that includes risk assessments, reporting and recording requirements, training and hazard identification and correction if an effort to reduce violence exposure and associated injuries.

- Culture of Ownership - The goal is to transform people through the power of values and to transform organizations through the power of people. The Culture of Ownership team aims to accomplish this by developing and delivering resources to promote values-based life and leadership skills.

- Regulatory- The goal is to monitor and ensure compliance with regulatory updates to which the District is subject. CDPH All Facility Letters (AFLs), CMS updates, Interoperability requirements, NSHN and quality reporting mandates are monitored.

- SNF QAPI (Quality Assurance Performance Improvement) -The focus of this groups is to take a proactive approach to improving the quality of life, care, and services in the skilled nursing facility. The activities of QAPI involve members at all levels of the organization to identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions.

2021 QI Program Accomplishments:

TARGET AREA	ACCOMPLISHMENTS
Patient Family Advisory Council (PFAC)	• Recruited new members • Beginning stages of patient advocacy program • Discussions regarding community education • Participation in Community Health Needs Assessment

	• Continued "Daisy Award" Program • Department showcase • Review of effective marketing and community outreach programs
BETA HEART	• Completed opt-in agreement requirements • BETA HEART year 4 award • BETA HEART team members and champions for each domain continue to meet and work towards validation • Participated in BETA HEART workshops throughout year • Culture of Safety Domain: o Achieved validation o Completed SCORE Survey action plans that are reported regularly to QI Committee o Developed Culture of Safety Newsletter • Rapid Event Detection, Investigation and Determination Domain: o Validation achieved o Reviewed Risk Management policies o Emphasized importance of rapid event notification o Safety Assessment Code (SAC) matrix for variance reports • Communication and Transparency Domain: o Achieved validation o Maintained Communication Team and on-call schedule (using AOC schedule) • Care for the Caregiver o Identified program lead o Recruited peer supporters o Revised policy o Key staff attended train the trainer course o Training for peer supporters o Posted information on Intranet
BETA Employee Safety and Wellness Initiative	• Signed opt-in agreement • Reviewed program requirements for each domain. • Recruited staff for participation on workgroups • Continued CPI training • Revised Safety Management Plan • Identified program lead
Culture of Ownership	• Daily Pickle Pledge • Daily positive empowerment tools near timeclocks • Culture of Ownership embedded in New Hire Orientation • Continued morale building activities/employee events

	• Developed "Be the One" slogan • Worked on Mission, Vision and Values development

SNF Quality Assurance Performance Improvement (QAPI)	• Continued routine SNF QAPI meetings with frontline staff.
	• Participation in Project ECHO
	• Performance improvement plans (PIPs) identified and implemented.
	  o Infection prevention- COVID preparedness
	  o Monitoring residents on psychotropic medications
	• Successful CDPH/Infection Prevention surveys

Regulatory	• Review AFLs • Develop strategies to address regulatory changes • Review survey preparation tools • Attended CDPH virtual conference • Identify ways to improve compliance/improve metrics • Implemented QHi reporting

2021 QI Workgroup Accomplishments:

TARGET AREA	ACCOMPLISHMENTS
Sepsis	• Participation in HQIC focused work group • Completed annual staff training • BETA recognition • Improved metrics • Group will be dissolved in 2022 due to improved processes and compliance.

BETA Quest for Zero	• Completed Sepsis Training required for Tier I award
	• Achieved Tier II award:
	  o Sepsis Standards of Care
	  o PFAC
	• Participated in Emergency Department Sepsis Collaborative

Medication Reconciliation	• Continued multi-department team • Reviewed gap analysis/analyzed workflow • Performed chart audits • Engaged Clinical Managers in staff training and monitoring • Improved metrics • Work group was dissolved due to process improvements

Telehealth-clinics	• Performed gap analysis • Goals include improve patient satisfaction, increase compliance with telehealth consents and decrease no-show rates. • Developed telehealth specific appointment reminder calls using TAVOCA • Clinic staff call new telehealth patients 1-3 days prior to appointment to review process/answer questions • Revised consent process • Improved metrics • Group was dissolved due to process improvement
Pediatric Readiness/Labor and Delivery	• Implemented co-signatures for pediatric medications • Staff education-simulation lab/competency (labor and delivery) • Performed gap analysis for pediatric readiness/supplies/equipment • Developed and implemented fetal demise kits • Develop and implemented order sets
Emergency Medicine Collaborative	• Participation in BETA work group • Participation in HQIC workgroup • Identified influence that bias has on patient outcomes • Chart reviews • Staff education

District-Wide Accomplishments

District-wide	**ACCOMPLISHMENTS**

	• SCORE survey action plans
	• COVID mitigation-on-going
	  o COVID vaccine programs
	  o COVID confidence grant
	  o COVID screening
	  o Enhanced Telemedicine
	  o Staff testing
	  o CDPH/CMS surveys
	• BETA HEART award
	• BETA validation in Culture of Safety, Rapid Event Investigation and Communication domains
	• BETA Quest for Zero awards
	• Program development/implementation:
	  o Inpatient Medical Stabilization

	o Outpatient wound care- Restorix Health o Urgent care o Opioid Stewardship Program

2022 Plan

The Quality Improvement Plan consists of systematic and continuous actions that lead to measurable improvement in health care services. Indicators are developed to measure and monitor the performance of processes. Special attention is given to the development of indicators for those processes which are high risk, high volume, problem-prone, and/or offer opportunities for improvement. The goal of indicator development, data collection and analysis is to quantify the level of performance and stability of processes, to identify areas for performance improvement and to determine if performance improvement initiatives have met their goals.

Programs and workgroups will continue to be the backbone of the QI Program in 2022. Workgroups meet regularly to review performance data, identify areas in need of improvement, to carry out and monitor improvement efforts. An emphasis will be placed on identifying clear objectives and goals. The teams will use a variety of QI approaches and tools, including Action Plans, Performance Improvement Plans (PIPs), Plan Do Study Act (PDSA) cycles, workflow mapping, assessments, audit and feedback, benchmarking, and best practices research. Workgroups may be dissolved once the objectives/goals have been met. Additional workgroups may be implemented as needs are identified.

BVCHD has elected to enroll in year 5 of the BETA HEART program and year 1 of BETA Employee Wellness and Safety Initiative. Both programs focus on creating a culture of safety and promote culture change in the organization. Beta sets forth expectations for an organization-wide commitment that involves leadership and staff training, development of policies and procedures, evidence of performance improvement strategies and development of teams to carry out the functions of the programs. One goal is to maintain validation in the Culture of Safety and Communication and Transparency domains as well as achieve validation in Rapid Event Detection and Care for the Caregiver domains of the BETA HEART program. In addition, Inland Empire Health Plan has partnered with BETA and the Hospital Quality Institute (HQI) to implement HQI Cares. This program mimics BETA HEART initiatives. The District has elected to participate in both programs to improve patient safety, decrease insurance premiums and be eligible for incentive funds from IEHP.

Continued focused will be centered around staff and patient safety and improvement of overall quality throughout the District. This will be accomplished by participation in programs and engaging in monitoring and measuring key metrics identified thorough health plan participation, DHCS QIP program, CMS requirements for interoperability and participation with Quality Organizations such as HSAG/HQIC, QHi and HQI.

Challenges are inevitable in 2022 with the on-going public health emergency and evolving environment. As the District navigates through changes, it is important that staff morale, patient safety and quality care are maintained. In consideration of the Strategic Plan, Community Needs Assessment, Strategic Marketing Plan and cumulative patient feedback, the QI Committee and workgroups will strive to find solutions and opportunity for growth.

Results of quality improvement initiatives will be communicated as appropriate throughout the organization to share ideas, gain understanding of relevant processes, stimulate innovative improvement initiatives and promote collaboration. The staff is encouraged to participate by offering improvement suggestions formally or informally and through participation on teams. The findings, conclusions, recommendations, actions and results of interdepartmental or multi-disciplinary process improvement teams shall be reviewed at relevant hospital and departmental meetings.

Policies for Approval by BOD		
Department	**Title**	**Summary**
Diagnostic Imaging - Mammography	Basic Responsibility for Overall Quality of Screening Mammography – PI-MAM-1	Annual review. Formatted. Added "Lead Interpreting Physician" next to Dr. name. Removed at the end of line 1. "and is on site at least once a week".
Diagnostic Imaging - Mammography	Cleaning of Mammography Equipment – EC-MAM-3	Annual review. Formatted. Added policy statement.
Diagnostic Imaging - Mammography	Consumer Complaints - PI-MAM-6	Annual review. Formatted.
Diagnostic Imaging - Mammography	Continuing Education Requirements for Mammographers – PF-MAM-9	Annual review. Formatted.
Diagnostic Imaging - Mammography	Criteria for Screening and Diagnostic Mammography – PE-MAM-1	Annual review. Formatted. Added "and Diagnostic" to title. Incorporated Procedure for Diagnostic Mammography Exam policy into this policy. Revised to reflect current process.
Diagnostic Imaging - Mammography	Electrical Safety – EC-MAM-1	Annual review. Formatted.
Diagnostic Imaging - Mammography	Enhancing Quality Using the Inspection Program (EQUIP) Initiative	Annual review. Formatted.
Diagnostic Imaging - Mammography	Federal, State and Local Licensure Registration Requirements - HR-MAM-1	Annual review. Formatted.
Diagnostic Imaging - Mammography	Imaging the Dense Breast –TX-MAM-4	Annual review. Formatted.
Diagnostic Imaging - Mammography	Implant Mammography –TX-MAM-3	Annual review. Formatted. Added policy statement.
Diagnostic Imaging - Mammography	Lists of Duties & Assigned Personnel	Annual review. Formatted.
Diagnostic Imaging - Mammography	Mammographer Operator Requirements Including State of California Restrictions – HR-MAM-3	Annual review. Formatted. Revised title from Mammography Operator Requirements. Incorporated State of California Technologist Restrictions policy into this policy. Condensed original into section 2 and State portion is new section 1.
Diagnostic Imaging - Mammography	Mammographers Equipment Quality Assurance Program - PI-MAM-4	Annual review. Formatted.
Diagnostic Imaging - Mammography	Mammography Patient Education - PF-MAM-4	Annual review. Formatted. Revised policy statement. Incorporated Patient Education for the Technologist policy into this policy as section 13.
Diagnostic Imaging - Mammography	Requirements For Interpreting Physician – MS-MAM-1	Annual review. Formatted.
Diagnostic Imaging - Mammography	Responsibility for Monitoring & Review – PI-MAM-5	Annual review. Formatted. Revised policy statement.
Diagnostic Imaging - Mammography	Retention of Films & Reports – IM-MAM-2	Annual review. Formatted.
Diagnostic Imaging - Mammography	Technologist Role in Needle Localization – TX-MAM-7	Annual review. Formatted. Revised 1.1.2. and 1.4. Added policy statement. Removed 1.1.2.2.
Environmental Services	Daily Patient Room Cleaning	Annual review. Formatted. Added Policy Statement. Revised to reflect current process.
Facilities Department	Backflow Preventers	Annual review. Formatted. Updated policy statement. Revised to reflect current practice & compliance w/regulations. Included references.
Facilities Department	Electrical Extension Cords/Adapters	Annual review. Formatted. Updated policy statement. Revised to reflect current practice & compliance w/regulations. Added #2 NFPA 101 Life and Safety standards as well as the table in #6. Included references.
Facilities Department	HVAC Filters	Annual review. Formatted. Updated policy statement. Revised to reflect current practice & compliance w/regulations. Removed "Changing" from title as the policy addresses daily inspection as well as changing. Included references.
Information Technology	Patch Management	New policy. Replacing Media Sanitization policy.
Materials Management	Surplus Property	Annual review. Formatted. Changed title from Disposition of Assets, Property and Other Obsolete Items. Re-wrote to reflect current process.
Patient Financial Services	Advanced Beneficiary Notification (ABN)	Annual review. Formatted.
Patient Financial Services	Financial Aid/Charity Discount or Partial Charity Care Program	Annual review. Formatted. Changed title from Charity Care and Discount Payment (Partial Charity Care). Changed reference to AB1020. Corrected discrepancies in timelines and finance options. Updated FPL percentages. Replaced Director of Patient Financial Serv. to being Patient Financial Serv. as a whole. Removed link and added attachment of application.
Patient Financial Services	Food and Nutrition Services Department Deposit	Annual review. Formatted. Changed title from "Dietary Department Deposit". Revised wording in 1.
Pharmacy	Opioid Stewardship Program	New policy.
Pharmacy	Security of Medication Areas	Annual review. Formatted. Revised statement, 2 & 5.
Quality Improvement	Quality Improvement Plan-Facility Wide	Annual review. Formatted.
Risk Management	Abuse - Mandatory Reporting Requirements	Annual review. Formatted. Updated fax telephone numbers.
Risk Management	Adverse Event Response and Investigation	Annual review. Formatted.
Risk Management	Against Medical Advice	Annual review. Formatted.
Risk Management	Communication After a Harm Event	Annual review. Formatted.

Risk Management	Consents	Annual review. Formatted.
Risk Management	EMTALA Guidelines	Annual review. Formatted. Updated Compliance hotline and URL..
Risk Management	Identifying Patients	Annual review. No changes.
Risk Management	Loitering	Annual review. Formatted. Updated to reflect current process.
Risk Management	Medical Device-Related Incidents Reporting	Annual review. Formatted.
Risk Management	Patient Complaint and Grievance	Annual review. Formatted.
Risk Management	Photography, Videotaping and/or Audiotaping	Annual review. Formatted. Added 2.
Risk Management	Reportable Adverse Events	Formatted. The document was retired but needs to be created due to changes in law.
Risk Management	Risk Management Plan	Annual review. Formatted. Took "financial" out of policy statement.
Risk Management	Risk/Quality Committee	Annual review. Formatted. Revised Policy Statement to reflect part of BVCHD Risk Management Plan.
Risk Management	Root Cause Analysis (RCA)	Annual review. Formatted.
Risk Management	Service Animals	Annual review. Formatted.
Risk Management	Variance Report	Annual review. Formatted. Added SAC scoring by Risk Manager to each variance. Added new 10.2.
Safety	Security Management Plan	Annual review. Formatted. Removed "Program" from title. Revised to reflect current process.
Urgent Care	Diagnostic Imaging	New policy.
Urgent Care	District Wide Policies	New policy.
Urgent Care	Radiological Exposure Reduction Plan	New policy.
Urgent Care	Radiology Orders and Interpretation	New policy.
Urgent Care	Radiology Overread	New policy.

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS
FINANCE COMMITTEE MEETING MINUTES
41870 GARSTIN DR., BIG BEAR LAKE, CA 92315
JANUARY 04, 2022

MEMBERS PRESENT: Steven Baker, Treasurer; Jack Briner, 2nd Vice President; Garth Hamblin, CFO; Evan Rayner, CFO

STAFF: Kerri Jex; Kathy Breuer; Mary Norman

OTHER: Woody White w/QHR

COMMUNITY MEMBERS: None

ABSENT:

OPEN SESSION

1. **CALL TO ORDER:**
   Board Member Baker called the meeting to order at 1:00 p.m.

2. **ROLL CALL:**
   Steven Baker and Jack Briner were present. Also present were Evan Rayner, CEO, Garth Hamblin, CFO and Shelly Egerer, Executive Assistant.

3. **ADOPTION OF AGENDA:**
   Board Member Briner motioned to adopt the January 04, 2022 Finance Committee Meeting Agenda as presented. Second by Board Member Baker to adopt the January 04, 2022 Finance Committee Meeting Agenda as presented. Board Member Baker called for a vote. A vote in favor of the motion was unanimously approved.
   - Board Member Baker - yes
   - Board Member Briner- yes

CLOSED SESSION

1. **PUBLIC FORUM FOR CLOSED SESSION:**
   Board Member Baker opened the Hearing Section for Public Comment on Closed Session items at 1:00 p.m. Hearing no request to address the Finance Committee, Board Member Baker closed the Hearing Section at 1:00 p.m.

2. **ADJOURN TO CLOSED SESSION:**
   Board Member Baker motioned to adjourn to Closed Session at 1:00 p.m. Second by Board Member Briner to adjourn to Closed Session at 1:00 p.m. Board Member Baker called for a vote. A vote in favor of the motion was unanimously approved.
   - Board Member Baker - yes
   - Board Member Briner- yes

OPEN SESSION

1. **CALL TO ORDER:**
   Board Member Baker called the meeting to order at 1:30 p.m.

2. **RESULTS OF CLOSED SESSION:**
   Board Member Baker stated there was no reportable action from Closed Session.

3. **PUBLIC FORUM FOR OPEN SESSION:**
   Board Member Baker opened the Hearing Section for Public Comment on Open Session items at 1:30 p.m. Hearing no request to address the Finance Committee, Board Member Baker closed the Hearing Section at 1:30 p.m.

4. **DIRECTOR'S COMMENTS:**
   - None

5. **APPROVAL OF MINUTES:**
   A. December 07, 2021

   Board Member Briner motioned to approve the December 07, 2021 minutes as presented. Second by Board Member Baker to approve the December 07, 2021 minutes as presented. **Board Member Baker called for a vote**. **A vote in favor of the motion was unanimously approved.**
   - Board Member Baker - yes
   - Board Member Briner- yes

6. **OLD BUSINESS:**
   - None

7. **NEW BUSINESS***
   A. Discussion and Potential Recommendation to the Board of Directors Resolution No. 22-467 Urgent Care Inc. Credit Card
   - Mr. Hamblin reported that as we continue to move forward with the Urgent Care vendors are wanting credit card for certain fees or services. This card is assigned directly to the Urgent Care.
     - Lora Townsend and Sheri Mursick will have access to this credit card
     - $5,000 monthly credit limit

   Board Member Briner motioned to provide a positive recommendation to the Board of Directors for Resolution No. 22-467 as presented. Second by Board Member Baker to provide a positive recommendation to the Board of Directors for Resolution No. 22-467 as presented. Board Member Baker called for a vote. **A vote in favor of the motion was unanimously approved.**
   - Board Member Baker - yes
   - Board Member Briner- yes

8. **PRESENTATION AND REVIEW OF FINANCIAL STATEMENTS***
   A. November 2021 Finances:
   - Mr. Hamblin reported the following information:
     - ER over budget

- Swing days under budget
- Expenses continue to increase
  - 23.6% higher than budget
  - We continue to bring in travelers
- Net loss of $600,000 for the month
- 433 days cash on hand
  - UC and Fawnskin property purchase has decreased days cash on hand
- AR continues to be worked on
- Revenue under budget year to date

B. CFO Report:

- Mr. Hamblin reported the following:
  - **CARES Act funding:**
    - Submitted documents to portal
    - Looks like we will have this money as cash flow
  - **Urgent Care:**
    - Provided a list of expenses we have spent at this time
    - Cabinets are a large cost
  - Mr. Rayner reported that COVID is surging; staff is tired and working hard, supplies are short, and we have staff shortages.

Board Member Briner motioned to approve the November 2021 Finance Report and CFO Report as presented. Second by Board Member Baker to approve the November 2021 Finance Report and CFO Report as presented. Board Member Baker called for a vote. **A vote in favor of the motion was unanimously approved.**

- Board Member Baker - yes
- Board Member Briner- yes

9. ADJOURNMENT*

Board Member Baker motioned to adjourn the meeting at 1:48 p.m. Second by Board Member Briner to adjourn the meeting. Board Member Baker called for a vote. **A vote in favor of the motion was unanimously approved.**

- Board Member Baker - yes
- Board Member Briner- yes

Recommendation for Action

Date: January 27, 2022

To: Board of Directors

From: Evan Rayner, CEO

Re: Comtrix Healthcare Staffing Agreement

Michael Chin,MD, Dba: Mission Surgical Clinic Service Agreement

Parshanth Kumar, MD, Dba High Desert Nephrology Medical Associates Inc.

Michael Norman, DO, Respiratory/EKG Department Service Agreement

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Recommendation:

To approve Comtrix Healthcare, Michael Chin, MD, Parshanth Kumar, MD, and Michael Norman, DO Service Agreements as presented.

Discussion:

Comtrix Healthcare is an international staffing agreement for recruitment and permanent placement of clinical staff for Clinical Laboratory Scientists (CLS) 30-day termination notice without cause.

Michael Chin, MD. (General Surgeon) agreement is a renewal agreement for clinic physician services at the FHC\RHC with a two-year term, $65.00 per patient with a 90-day termination notice without cause.

Parshanth Kumar, MD (Nephrology) is a new service and physician agreement for clinic specialty physician services with a two-year term, $75.00 per patient(in person or telemedicine) and a 90-day termination notice without cause.

Michael Norman, DO (Internal Medicine) is a renewal agreement to provide Respiratory Therapy Director services, this is a two-year term, $1,500.00 monthly stipend and a 60-day termination notice without cause

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Contract Cover Sheet

Contract Name: Comtri Healthcare

Purpose of Contract: Temporaty Staffing

Contract # _____ **Effective Date:** _____ **Term:** _____ **Cost:** _____

Originating Department Name: _____ **Department Number:** _____

Department Manager **Signature:** _____ **Date:** _____

BAA: ☐ Yes ☐ No **W-9:** ☑ Yes ☐ No

Administrative Officer	**Signature:**	NA	**Date:** NA
HIPAA/Security Officer (Software/EHR Related)	**Signature:**	NA	**Date:** NA
HIPAA Privacy Officer (BAA applicable)	**Signature:**	NA	**Date:** NA
Legal Counsel	**Signature:**		**Date:**
Compliance Officer	**Signature:**	Mary Norman	**Date:** 1/20/22
Chief Financial Officer	**Signature:**		**Date:**
Chief Executive Officer	**Signature:**		**Date:**
Board of Directors When Applicable	**Signature**		**Date:**

1. **Final Signatures on Contract, BAA & W-9:** **Date:** _____
2. **Copy of BAA forwarded to HIPAA Privacy Officer** **Date:** _____
3. **Copy of Contract/BAA/W-9 forwarded to Department Manager:** **Date:** _____
4. **Copy of Contract/BAA/W-9 forwarded to Contractor (if applicable):** **Date:** _____
5. **Copy of Contract/BAA/W-9 scanned/emailed to Controller:** **Date:** _____

Contract Cover Sheet

CONFIDENTIAL NOTICE:

COMTRIX HEALTHCARE

PROFESSIONAL SERVICES
TEMPORARY STAFFING AGREEMENT

This Temporary Staffing Agreement (hereinafter "Agreement") is entered effective as of November 23, 2021, by and between Bear Valley Community Healthcare District, located at 41870 Garstin Drive, Big Bear Lake, California, 92315 (Client"), and Comtrix Healthcare located at 23099 Red Sunset Place, Aldie, VA, 20105(Agency").

WHEREAS, Client is in need of certain healthcare professionals such as Medical Technologists, for placement at its own or its client(s) sites; and Agency has the ability to fulfill Client's requirements by providing necessary staff as and when requested;

NOW THEREFORE, Client and Agency desire to provide a full statement of their respective rights and obligations in connection with their performance hereunder. In consideration of the above premises, the parties agree to enter into this Agreement on the following terms and conditions:

1. AGENCY RESPONSIBILITIES

1.1 Full Time Assignments. Agency shall provide the services of requested Healthcare Professionals to Client for temporary full-time assignments. If Client selects a Healthcare Professional provided by Agency, Client shall be obligated to use his/her services for a minimum of thirty-five (35) hours per week for the entire assignment term as required for maintaining a fulltime status, except as otherwise provided herein. In the event that Client accepts for placement, the Healthcare Professional, the parties shall complete Agency's Temporary Staffing Confirmation Sheet attached hereto as Exhibit A. The Exhibit is a sample of the form to be provided for each referred employee.

1.2 Qualified Agency Employees. Agency agrees to provide Client, competent personnel as requested by Client to meet client's supplemental staffing needs. The existence of the required work experience, licensure and/or professional certification, and results of a background/criminal record check shall be confirmed

by Agency at the time of Pre-assignment Screening. Agency shall provide only those personnel who meet the qualifications set forth in Section 2 of this Agreement. Client shall have the right to demand proof that any individual assigned to Client by Agency satisfies the criteria and accept/reject the assignment of any individual who it deems satisfies or fails to satisfy the criteria.

1.3 Credentials. The Agency Healthcare Professional shall be required to provide the following at the beginning of first shift worked at Client: (i) Valid photo identification card; (ii) professional license or certification, or when applicable, information which will enable Client to electronically confirm credentials, and (iii) CPR Certification Card.

1.4 Agency agrees that there is no minimum shift cancellation time, as long as full-time status is maintained.

1.5 Agency Contact. Agency will provide Client with the name of the individual dedicated to the Company for the coordination of services including resolution of billing discrepancies.

1.6 Responsibility for Client Services. To the extent required by law and regulations governing the operation of Client sites, Client or its representative retains professional and administrative responsibility for the services rendered by personnel provided hereunder. All applicable provisions of law relating to licensing and regulation of facilities and agencies shall be fully adhered to by all parties.

1.7 Agency Employer Responsibilities. Agency agrees to provide only those personnel that maintain employer-employee relationship with the Agency and continue to do so for the duration of the placement. Further:

i. Agency agrees to compensate all healthcare professionals provided herein in accordance with the requirements of applicable federal, state, and/or local statutes, ordinances, and/or regulations.

ii. Agency shall with respect to said personnel be responsible for withholding federal and state income taxes, pay federal social security taxes and maintain unemployment and worker's compensation insurance in an amount and under such terms as required by the applicable State Labor Code.

iii. Agency will allow Client to routinely audit the pay practices for all Healthcare Professionals during this agreement period in conjunction with all audits referred to in this agreement.

iv. Agency will indemnify and hold Client harmless from any and all liability arising from claims relating to the failure of Agency to properly make payments for salary and benefits, or to withhold taxes and obtain

insurance of any kind. This duty shall survive the termination of this Agreement.

1.8 Warranty. Agency warrants that services provided pursuant to this Agreement shall be performed:

i. in a timely, high quality and professional manner, using only qualified personnel;

ii. in conformance with generally acceptable industry standards;

in compliance with all applicable federal, state, local and foreign laws and regulations;

iii. otherwise in conformance with any standards identified by Client. Agency shall obtain at its own cost any and all necessary consents, licenses, approvals and permits required for its provision of services.

1.9 Confidentiality. Individuals providing services pursuant to this Agreement shall maintain the confidentiality of all information and medical records associated with patient care at Client's site as well as any quality assurance/peer review activities that they participate in or learn of regarding Client.

1.10 Ownership of Patient Care Records. Agency understands and agrees that all records associated with the provision of services pursuant to the terms of this Agreement are the sole property of Client.

1.11 Investigation of Complaint. Client agrees to cooperate with Agency's reasonable risk management and quality assurance activities. Should Client become aware of an incident or claim which may give rise to a claim under Agency's professional or general liability insurance policies, Client shall use reasonable efforts to notify Agency of the nature of the claim and report necessary information related to the claim, as permitted by applicable law. Agency has in place a formal Risk Management Protocol ("Protocol"), which details how incidents are reported, tracked and documented. The Protocol is available for review by Client upon request. Similarly, in the event that Agency becomes aware of an incident or claim relating to services provided by Agency personnel to Client, Agency shall notify Client of the nature of claim and report necessary information relating to the claim. The obligations of this Section shall survive the termination of this Agreement

2. PERSONNEL QUALIFICATIONS

Agency shall provide Client only those personnel who meet the requirements set forth herein, as well as any additional requirements of the applicable functional Client unit to which personnel will be assigned, including those set forth in the applicable job description for each position.

2.1 License. The Healthcare Professional must possess a current, valid license or certificate to practice in the state where he/she will be placed hereunder. In accordance with the standards of The Joint Commission (TJC), Agency shall verify an individual's reported qualifications by the original source or an approved agent of that source, at the time of hire and upon expiration of the credentials. Methods for conducting primary source verification of credentials include direct correspondence, documented telephone verification, or secure electronic verification from the original qualification source or reports from credentials verification organizations that meet The Joint Commission requirements.

2.2 Immigration Status and Full Cooperation. Agency warrants that Healthcare Professionals are authorized to work in the United States for the duration of his/her assignment to Client in accordance with Immigration Reform and Control Act (IRCA). Agency certifies that it has on file a validly completed Federal Form I-9 (Employment Eligibility Verification) and shall provide the proof of same upon request. Client agrees to cooperate to the greatest extent possible with Agency in obtaining or providing any required documentation or information sought by USCIS in support of any petitions filed for Healthcare Professionals placed hereunder.

2.3 Background Check. Agency shall complete criminal background checks on all its personnel upon hire by Agency, and upon subsequent rehire following termination for any reason. Prior to assigning any individual whose background check reveals a criminal history, including arrests, pending charges, and/or convictions, Agency shall provide a copy of the background check to Client, and obtain written acknowledgement and acceptance from Client of the results of background check. Agency shall notify Client of any new information which it becomes aware regarding the criminal background of any Agency personnel assigned to Client.

2.4 References/Experience. Agency shall provide Client only those personnel who have at least one year of experience in their area of professional specialty obtained within three years preceding the placement and for whom it has obtained and have on file at least two (2) acceptable professional references. Client may request copies and/or validation of the references at any time.

2.5 CPR Certification. Agency shall provide to Client only those personnel who have current cardiopulmonary resuscitation ("CPR") certification. Agency shall be solely responsible for monitoring CPR certification compliance. Copies of CPR certification shall be provided to Client upon request.

2.6 Health Screening. Agency shall provide to Client only those personnel for whom the Agency has required, upon hire, a general health screening performed by a licensed practitioner, the results of which have been satisfactory. Said health screening shall include: current PPD (TB test), HBV vaccine (unless declination signed), drug screen (nine panel), and rubella/rubella titers MMR inoculations.

Agency shall update the PPD test annually and shall update the drug screen anytime there has been a lapse of 12 months or longer since the worker has accepted an assignment from Agency. Agency shall ensure that any personnel provided to Client shall comply with all of Client's infection control policies and procedures including, without limitation, those related to the COVID-19 pandemic, and shall comply with any vaccination and testing mandates imposed by the federal or state government which are applicable to Client and healthcare workers at Client's facilities and/or any vaccination and testing mandates adopted by Client.

2.7 Compliance with Client's Policies and Procedures. Each Healthcare Professional assigned to Client by Agency shall comply with Client's policies, procedures, and rules and regulations in effect during the time of any assignment and as may be amended from time to time during any assignment.

3. COMPENSATION

3.1 Bill Rate. Agency's fee schedule for services is described in Exhibit A. The Exhibit A is a sample of the form to be provided for each referred employee. Agency will submit an invoice identifying the Healthcare Professional, dates of service, cost centers, total hours, and total dollars with signed timesheet.

3.2 Payment Terms. Invoices will be submitted weekly, and Client agrees to pay within 30 days of the receipt of the invoice. If Client does not pay in accordance with terms herein, it agrees to pay an additional late fee of 1.5% of the outstanding invoice per month, or the highest allowable amount by law.

3.3 Time slip. Agency agrees to have personnel leave one (1) signed time slip with the Client.

3.4 Call Backs/On-Call. On-Call is billed at $2 per hour. On-Call hours are not billed during call back time. Call-back is billed at time and a half. A one (1) hour minimum call back is guaranteed on first call only. An additional one (1) hour minimum will only apply if the Healthcare Professional has been signed out from the Client for a minimum of two (2) hours. Otherwise, the actual time worked will be billed at time and a half. Overtime aggregate applies only once regardless of eight (8), twelve (12) or forty (40) hour overtime rule.

4. NON-SOLICITATION

4.1 Client agrees not to hire or solicit for employment or other professional engagements, either directly or indirectly, any international healthcare professional provided by the Agency under this Agreement, during the initial three years of a Temp to Perm assignment. A green card petition will be submitted to the USCIS for each Medical Technologist that has completed 18 months of employment at Comtrix Healthcare. At the end of the third year of employment, the Client may retain the Medical Technologist on their payroll at no additional cost to Client. If a

green card is in process at the end of the third year, the Med Tech will continue to work under the contract and once the green card is approved, the Client may retain the Med Tech at no additional cost. The transfer is only subject to agreement between Client and Medical Technologist as it pertains to wages and benefits. On Exhibit A, there will be a start date identified for each Medical Technologist. The "end" date will be exactly three years from the "start" date identified for each Medical Technologist. (Note: the "end" date may be adjusted if the Medical Technologist takes leave for time in excess of the 80 hours granted for vacation per year; those extra leave hours will be added to the "end date"). Following the completion of three years as identified on Exhibit A, and receipt of the green card visa, the Medical Technologist can be transferred at no cost to the Client.

5. LEGISLATIVE LIMITATIONS

5.1 Regulatory Amendments. In the event (i) Medicaid, Medicare, any third-party or any federal, state or local legislative or regulatory authority adopts any law, rule, regulation, policy, procedure or interpretation thereof which establishes a material change in the method or any amount of reimbursement or payment for services under this Agreement, or (ii) any or all of such payers/authorities impose requirements which require a material change in the manner of either party's operations under this Agreement and/or the costs related thereto, then, upon the request of either party materially affected by any such change in circumstances, the parties shall enter into good faith negotiations for the purpose of establishing such amendments or modifications as may be appropriate in order to accommodate the new requirements and change of circumstances while preserving the original intent of this Agreement to the greatest extent possible. If, after thirty (30) days of such negotiations, the parties are unable to reach an agreement as to how or whether this Agreement shall continue, then either party may terminate this Agreement upon thirty (30) days prior written notice.

6. TERM AND TERMINATION

6.1 Term. This Agreement shall commence on the effective date as aforementioned and remain in effect for a term of thirty-six (36) months unless otherwise terminated as provided herein. At the end of the initial term, the Agreement shall automatically renew for additional thirty-six (36) months.

6.2 Termination without Cause. Either party may terminate this Agreement without cause upon thirty (30) days written notice to the other party.

6.3 Termination for Cause. Client may terminate this Agreement immediately in the event Agency or healthcare professional fails to perform services required hereunder in accordance with appropriate standards of quality or fails to comply with any of the terms and conditions of the Agreement, or the written policy and procedures of the Client. Agency may terminate the Agreement immediately for

Client's violation of payment terms outlined in Section 3.2 above or any other provision herein.

7. RELATIONSHIP OF PARTIES

7.1 Agency is performing services and duties required hereunder as an independent contractor and not as an employee, agency, partner of or joint venture with the Client. All personnel assigned to Client pursuant to this Agreement shall, for all purposes under this Agreement, be considered to maintain an employer-employee relationship with the Agency and remain under its managerial control. Agency assumes sole and exclusive responsibility for payment of wages to personnel for services performed hereunder and withholding of federal and state income taxes and payment of the federal social security taxes.

8. INSURANCE AND INDEMNIFICATION

8.1 Insurance Requirements. Agency shall maintain general liability and professional liability insurance for Agency, its agents and employees, in the minimum amount of one million dollars ($1,000,000) for each occurrence, three million dollars ($3,000,000) annual aggregate for each insurance. If the insurance required by this subsection is written on a "claims-made" basis, Agency shall obtain at its cost an extended reporting endorsement ("tail coverage") upon the expiration or termination of this Agreement.

8.2 Indemnification. Agency and Client agree to defend, indemnify and hold the other harmless from and against any and all liability, losses, damages, claims, or causes of action, and expenses connected therewith caused as a result of the performance of its employees or agents' duties hereunder; provided however that nothing herein shall be construed to require a party to indemnify the other for the negligent acts of the other or its employees to the extent allowed by law. This includes any claims made by employees provided by Agency concerning their compensation for work performed.

8.3 Workers' Compensation. Agency shall provide Client with documentation in a form satisfactory to Client, which establishes that Agency has in effect current Workers' Compensation insurance. Agency shall ensure that all its employees are covered under workers compensation insurance up to the limits established by law in the state where employees are assigned, or up to the industry standard, whichever is higher.

9. MISCELLANEOUS

9.1 **Notice. Any notice required or permitted by this Agreement shall be in** writing and deemed given at the time it is deposited in the United States Mail, postage prepaid, certified or registered mail, return receipt requested, addressed to the party to whom it is to be given as follows:

Client: BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT

41870 GARSTIN DRIVE, BIG BEAR LAKE, CALIFORNIA, 92315

Mailing: PO Box 1649
Big Bear Lake, C.a.92315

Agency: Comtrix Healthcare
23099 Red Sunset Place, Aldie, Virginia, 20105

Either party may change the address to which notices shall be by providing the other with a written notice of the new address.

9.2 Entire Agreement. This Agreement with attachments contains the entire agreement of the parties hereto and supersedes all prior contracts, and understanding whether written or otherwise between the parties relating to the subject matter hereof. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. In the event any provision of this Agreement is found to be legally invalid or unenforceable for any reason, all remaining provisions of the Agreement will remain in full force and effect.

9.3 Limitation of Liability. Other than for violations of Section 4 above, neither party will be liable to the other party for consequential, incidental, indirect or

special damages, including but not limited to lost profits, even if such party has been apprised of the likelihood of such damages occurring, for an amount greater than the value of the services provided under this agreement.

9.4 Open Records Requirements. In the event compensation payable hereunder shall exceed Ten Thousand ($10,000) per annum, Agency hereby agrees to make available to the Secretary of Health and Human Services ("HHS"), the Comptroller General of the Government Accounting Office ("GAO"), Company and Intermediary and their authorized representatives, all contracts, book, documents and records that are necessary to certify to the nature and extent of the costs hereunder for a period of four (4) years after the furnishing of services hereunder or six [6] years if the services are of the type reimbursable under Medicare + Choice or any other government healthcare program. In addition, Agency hereby agrees, if services are to be provided by subcontract make available to the HHS, and GAO Company and Intermediary or their authorized representative, all contracts, books, documents, and records that are necessary to certify the nature and extent of the costs hereunder, for a period of four (4) years after furnishing of services hereunder, within 14 days of request. Client may audit employee files to ensure compliance with requirements of Section 2 of this agreement with twenty-four (24) hours notice; however, the company reserves the right to conduct unannounced audits at any time.

9.5 Arbitration. The parties agree to resolve any and all claims or disputes arising out of or relating to this Agreement exclusively through final and binding arbitration, in accordance with the commercial arbitration rules of the American Arbitration Association. The location of the arbitration shall be exclusively in Niagara County, New York.

9.6 No Debarment. Agency represents and warrants to Client that Agency, its directors, officers, and employees, if any, (i) are not currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 USC § 1320a-7b(f) (the "Federal healthcare programs"); (ii) have not been convicted of a criminal offense related to the provision of healthcare items or services but have not yet been excluded, debarred, or otherwise declared ineligible to participate in the Federal healthcare programs, and (iii) are not under investigation or otherwise aware of any circumstances which may result in Agency being excluded from participation in the Federal healthcare programs. This shall be an ongoing representation and warranty during the term of this Agreement and Agency shall immediately notify Client of any change in the status of the representations and warranties set forth in this section. Any breach of this section shall give Client the right to terminate this Agreement immediately for cause.

9.7 No Inducement; Vendor Full Disclosure Statement. No cash, merchandise, equipment or other items of intrinsic value shall be offered by or on behalf of

Agency to Facilities and/or their employees, officers, or directors as an inducement to purchase from Agency.

9.8 Books and Records. During the Term of this Agreement and for four (4) years thereafter, Client shall have the right, during normal business hours and with reasonable advance notice, to review and photocopy Agency's books, documents and records that relate to this Agreement and pertain directly to the accounts of Client, the fees payable to Agency under this Agreement, the Services provided by Agency hereunder, and compliance by Agency with the obligations hereunder. The audit may be conducted by Client employees or by an external auditing firm selected by Client. The cost of audit, including the cost of the auditors and reasonable cost of copies of books, documents, and records shall be paid by the Client. Client shall have no obligation to pay the cost incurred by employees and agents of Agency in cooperating with Client in such audit. In the event the results of the audit indicate either an over or under payment by Client, appropriate payment shall be made by the party owing such amount to the other party.

9.9 Regulatory Requirements. The parties expressly agree that nothing contained in this Agreement shall require Agency or Agency's Representatives to refer or admit any patients to or order any goods or services from Client. Notwithstanding any unanticipated effect of any provision of this Agreement, neither party will knowingly or intentionally conduct itself in such a manner as to violate the prohibition against fraud and abuse in connection with Medicare and Medicaid programs (42 USC Section 1320a-7b).

The terms of this Agreement incorporate by reference the contract clauses contained in 41 CFR Section 60-1.4 (Executive Order 11246), 41 CFR Section 60-250-4 (Vietnam Era Veterans Readjustment Assistance Act), and 41 Section 60-741.5 (Rehabilitation Act).

Agency agrees to comply at all times with the regulations issued by the Department of Health and Human Services published at 42 CFR 1001, and which relate to Agency's obligations to report and disclose discounts, rebates and other price reductions to Company for services obtained under this Agreement. Where a discount or other reduction in price is applicable, the parties also intend to comply with requirements of 42 U.S.C. §1320a-7b(b)(3)(A) and the "safe harbor" regulations regarding discounts or other reductions in price set forth at 42 C.F.R. §1001.952(h).

9.10 Assignment. This Agreement shall be binding upon and inure to the benefit of Agency and Client and their successors and assigns.

9.11 HIPAA Requirements. Agency agrees to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d ("HIPAA") and any current and future regulations promulgated thereunder, including without limitation, the federal privacy regulations contained in 45 C.F.R.

Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45

9.12 C.F.R. Part 142 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162, all collectively referred to herein as "HIPAA Requirements". Agency agrees not to use or further disclose any Protected Health Information (as defined in 45 C.F.R. Section 164.501) or Individually Identifiable Health Information (as defined in 42 U.S.C. Section 1320d), other than as permitted by HIPAA Requirements and the terms of this Agreement. Agency will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services to the extent required for determining compliance with the Federal Privacy Regulations.

IN WITNESS WHEREOF, Client and Agency have duly executed this Agreement on the date first written above.

Comtrix Healthcare	**Bear Valley Community Healthcare District**
Signature:	Signature:
Title: Lakshmi Narra/ Contracts Manager	Title:
Date:	Date:
Fed ID:203712109	Fed ID: 33-0294751

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Contract Cover Sheet

Contract Name: Michael Chin, MD Dba: Mission Surgical Clinic

Purpose of Contract: Physician Clinic Service Agreement

Contract # _____ **Effective Date:** 3/13/22 **Term:** 2 year **Cost:** $65.00 per patien

Originating Department Name: _____ **Department Number:** _____

Department Manager **Signature:** _____ **Date:** _____

BAA: ☑ Yes ☐ No **W-9:** ☑ Yes ☐ No

need to sign new BAA

Administrative Officer	**Signature:**	NA	**Date:** NA
HIPAA/Security Officer (Software/EHR Related)	**Signature:**	NA	**Date:** NA
HIPAA Privacy Officer (BAA applicable)	**Signature:**	NA	**Date:** NA
Legal Counsel	**Signature:**	via email	**Date:** 1-2022
Compliance Officer	**Signature:**	Mary Norman	**Date:** 1-21-2022
Chief Financial Officer	**Signature:**		**Date:**
Chief Executive Officer	**Signature:**		**Date:**
Board of Directors When Applicable	**Signature**		**Date:**

attach sample timesheet

1. **Final Signatures on Contract, BAA & W-9:** **Date:** _____
2. **Copy of BAA forwarded to HIPAA Privacy Officer** **Date:** _____
3. **Copy of Contract/BAA/W-9 forwarded to Department Manager:** **Date:** _____
4. **Copy of Contract/BAA/W-9 forwarded to Contractor (if applicable):** **Date:** _____
5. **Copy of Contract/BAA/W-9 scanned/emailed to Controller:** **Date:** _____

Contract Cover Sheet

CONFIDENTIAL NOTICE:

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
PHYSICIAN AGREEMENT FOR SERVICES AT THE RURAL HEALTH CLINICS
WITH
MICHAEL CHIN, MD
DBA
MISSION SURGICAL CLINIC

THIS PHYSICIAN AGREEMENT ("Agreement") is made and entered into as of the 13th day of March 2022 by and between Bear Valley Community Healthcare District (a public entity), ("Hospital") and Michael Chin, M.D. ("Physician").

RECITALS

WHEREAS, Hospital, is the owner and operator of a general acute care hospital located in Big Bear Lake, California. Hospital has a federally approved hospital-based 95-210 Rural Health Clinic located at two sites known as the Family Health Center and the Rural Health Clinic ("the Clinic"), under which Hospital may contract with physicians and physician extenders to provide medical treatment to the Clinic's patients.

WHEREAS, Physician is licensed by the Medical Board of California to practice medicine, is certified by the American Board of Surgery and is qualified to perform physician services for the Hospital's Clinic patients.

WHEREAS, Hospital desires to retain the services of Physician to provide professional medical services, and Physician desires to so contract with Hospital to furnish those services.

NOW THEREFORE, in consideration of the mutual covenants, undertakings and promises contained herein, as well as other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, and intending to be legally bound hereby, the parties hereto agree as follows:

AGREEMENTS

SECTION I. RESPONSIBILITIES OF PHYSICIAN.

A. SERVICES. During the term of this Agreement, Physician agrees to the following:

1. Physician shall provide professional physician services at the Clinic on an as needed basis as agreed upon by Hospital and Physician.
2. Physician shall maintain medical records for all patients consistent with standard industry practices and shall provide such other record keeping and administrative services as may be reasonably requested by Hospital. All medical records remain the property of the Hospital.
3. Physician shall cooperate with any quality management and utilization management programs instituted by Hospital.

B. ACCESS TO BOOKS AND RECORDS. If the value or cost of Services rendered to Hospital pursuant to this Agreement is Ten Thousand Dollars ($10,000.00) or more over a twelve- month period, Physician agrees as follows:

1. Until the expiration of four (4) years after the furnishing of such Services, Physician shall, upon written request, make available to the Secretary of the Department of Health and Human Services (the "Secretary'), the Secretary's duly-authorized representative, the Comptroller General, or the Comptroller General's duly-authorized representative, such books, documents and records as may be necessary to certify the nature and extent of the cost of such Services; and

2. If any such Services are performed by way of subcontract with another organization and the value or cost of such subcontracted services is Ten Thousand Dollars ($10,000.00) or more over a twelve (12) month period, such subcontract shall contain, and Physician shall enforce, a clause to the same effect as subparagraph 1. immediately above.

The availability of Physician's books, documents, and records shall be subject at all times to all applicable legal requirements, including without limitation, such criteria and procedures for seeking and obtaining access that may be promulgated by the Secretary by regulation. The provisions of subparagraphs 1. and 2. of Section I.B. shall survive expiration or other termination of this Agreement, regardless of the cause of such termination.

C. Physician will not carry out any of the duties of the Agreement through a subcontract.

D. ETHICS. In performing services under this Agreement, Physician shall use his/her best and most diligent efforts and professional skills; perform professional supervisory services; render care to patients in accordance with and in a manner consistent with the high standards of medicine; conduct himself/herself in a manner consistent with the principles of medical ethics promulgated by the American Medical Association; and comply with the Hospital's rules and regulations.

E. In respect to Physician's performance of Physician's professional duties, the Hospital shall neither have nor exercise control or direction over the specific methods by which Physician performs Physician's professional clinical duties. The Hospital's sole interest shall be to ensure that such duties are rendered in a competent, efficient and satisfactory manner.

F. Physician recognizes that the professional reputation of the Hospital is a unique and valuable asset. Physician shall not make any negative, disparaging or unfavorable comments regarding the Hospital or any of its owners, officers and/or employees to any person, either during the term of this Agreement or following termination of this Agreement.

G. NOTIFICATION OF CERTAIN EVENTS. Physician shall notify Hospital in writing within three (3) business days after the occurrence of any one or more of the following events:

1. Physician's medical staff membership or clinical privileges at any hospital are denied, suspended, restricted, revoked or voluntarily relinquished;
2. Physician becomes the subject of any suit, action or other legal proceeding arising out of Physician's professional services;
3. Physician is required to pay damages or any other amount in any malpractice action by way of judgment or settlement;
4. Physician becomes the subject of any disciplinary proceeding or action before any state's medical board or similar agency responsible for professional standards or behavior;
5. Physician becomes incapacitated or disabled from practicing medicine;

6. Any act of nature or any other event occurs which has a material adverse effect on Physician's ability to perform the Services under this Agreement;
7. Physician changes the location of her offices;
8. Physician is charged with or convicted of a criminal offense; or
9. Physician is debarred, suspended, or otherwise excluded from any federal and/or state health care payment program by action of the Office of Inspector General of the Department of Health and Human Services or Medi-Cal Office, or by any equivalent or coordinating governmental agencies.

H. COORDINATION OF SERVICES. Physician shall cooperate with Hospital, through its Chief Executive Officer, in connection with providing the Services.

SECTION II. REPRESENTATIONS AND WARRANTIES

Physician represents and warrants to Hospital, upon execution and throughout the term of this Agreement as follows:

A. Physician is not bound by any agreement or arrangement which would preclude Physician from entering into, or from fully performing the services required under this Agreement;

B. Physician's license to practice medicine in the State of California or in any other jurisdiction has never been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or made subject to terms of probation or any other restriction;

C. Physician's medical staff privileges at any health care facility have never been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or restricted in any way;

D. Physician shall perform the services required hereunder in accordance with: (1) all applicable federal, state, and local laws, rules and regulations; (2) all applicable standards of care of relevant accrediting organizations; and (3) all applicable Bylaws, Rules and Regulations of Hospital and it's Medical Staff;

E. Physician has not in the past conducted and is not presently conducting Physician's medical practice in such a manner as to cause Physician to be suspended, excluded, barred or sanctioned under the Medicare or Medi-Cal Programs or any government licensing agency, and has never been convicted of an offense related to health care, or listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation;

F. Physician has, and shall maintain throughout the term of this Agreement, an unrestricted license to practice medicine in the State of California and staff membership privileges at Hospital;

G. Physician has disclosed and will at all times during the term of this Agreement promptly disclose to the Hospital: (1) the existence and basis of any legal, regulatory, professional or other proceeding against Physician instituted by any person, organization, governmental agency, health care facility, peer review organization, or professional society which involves any allegation of substandard care or professional misconduct raised against Physician; and (2) any allegation of substandard care or professional misconduct raised against Physician by any person, organization, governmental agency, health care facility, peer review organization or professional society.

H. Physician agrees to promptly disclose any change to the status of his license to practice medicine or any changes the status of any privileges Physician may have at any other health care facility;

I. Physician shall deliver to the Hospital promptly upon request copies of all certificates, registrations, certificates of insurance and other evidence of Physician's compliance with the foregoing as reasonably requested by the Hospital; and

J. Physician shall participate in all government and third-party payment or managed care programs in which Hospital/Clinic participates, render services to patients covered by such programs, and accept the payment amounts provided for under these programs as payment in full for services of Physician to Hospital/Clinic's patients. If Hospital/Clinic deems it advisable for Physician to contract with a payer with which Hospital/Clinic has a contract, Physician agrees in good faith to negotiate a contractual agreement equal to the reasonable prevailing reimbursement rates for physician's specialty within the geographic area of Hospital/Clinic.

SECTION III. INDEMNIFICATION OF LIABILITY.

Physician agrees to indemnify, defend and hold harmless Hospital and its governing board, officers, employees and agents from and against any and all liabilities, costs, penalties, fines, forfeitures, demands, claims, causes of action, suits, and costs and expenses related thereto (including reasonable attorney's fees) which any or all of them may thereafter suffer, incur, be responsible for or pay out as a result of bodily injuries (including death) to any person or damage to any property (public or private), alleged to be caused by or arising from: (1) the negligent or intentional acts, errors, or omissions of Physician; (2) any violations of federal, state, or local statutes or regulations arising out of or resulting from any negligent act, error or omission of Physician; (3) the use of any copyrighted materials or patented inventions by Physician; or (4) Physician's breach of its warranties or obligations under this Agreement. The rights and obligations created by this indemnification provision shall survive termination or expiration of this Agreement.

SECTION IV. INDEPENDENT CONTRACTOR.

In performing the services herein specified, Physician is acting as an independent contractor, and shall not be considered an employee of Hospital. In no event shall this Agreement be construed as establishing a partnership or joint venture or similar relationship between the parties hereto, and nothing herein contained shall be construed to authorize either party to act as agent for the other. Physician shall be liable for Physician's own debts, obligations, acts and omissions, including the payment of all withholding, social security and other taxes and benefits. As an independent contractor, Physician is responsible for filing such tax returns and paying such self-employment taxes as may be required by law or regulations.

SECTION V. COMPENSATION.

At the end of each month, Physician shall submit to the administration a completed time sheet of time spent in the Family Health Clinic seeing patients. Upon receipt of completed and signed provider time sheet for services rendered under this Agreement, Hospital shall pay Physician, as for sole compensation hereunder, on a fee per visit basis at $65.00 (Sixty-Five Dollars) per visit. "No charge/courtesy" visits are not eligible for provider payment. Hospital will provide Physician a list of patients seen per Hospital records that supports the payment made to Physician. All patient billings for Physician services remain the property of Hospital. Monthly payments to Physician shall be made on or before the 10th (tenth) day of the month, following the month in which services are rendered.

SECTION VI. COMPLIANCE.

A. Hospital is committed to compliance with all billing and claims submission, fraud and abuse laws and regulations. In contracting with Hospital, physician agrees to act in compliance with all laws and regulations. Hospital has completed a Compliance Program to assure compliance with laws and regulations. Physician is therefore expected to comply with the policies of the Hospital Compliance Program.

At a minimum, Physician is expected to:

1. Be aware of those procedures which affect the physician, and which are necessary to implement the Compliance Program, including the mandatory duty of Physician to report actual or possible violations of fraud and abuse laws and regulations; and
2. Understand and adhere to standards, especially those which relate to the Physician's functions for or on behalf of the District/Hospital.

B. Failure to follow the standards of Hospital's Compliance Programs (including the duty to report misconduct) may be considered to be a violation of the Physician's arrangement with the Hospital and may be grounds for action by Hospital, including termination of the relationship.

SECTION VII. TERM.

This Agreement is effective from March 13, 2022 to March 12, 2024; however, this Agreement is subject to early termination as provided in Section. VIII. below.

SECTION VIII. EARLY TERMINATION.

A. Hospital may terminate this Agreement immediately upon written notice to Physician based on the occurrence of any of the following events:

1. Physician's license to practice medicine is suspended, revoked, terminated, or otherwise restricted;
2. Physician's medical staff privileges at the Hospital, or any other healthcare facility, are in any way suspended, revoked, or otherwise restricted;
3. Medicare and/or Medi-Cal significantly changes the RHC program;
4. Hospital fails to maintain RHC status;
5. Physician Services Agreement is terminated or expires;
6. Physician's failure to comply with the standards of the Hospital's Compliance Program, to the extent that such failure results in material fine and or sanction from Medicare or Medi-Cal Program;
7. Physician fails to complete medical records in a timely fashion;
8. Physician fails to maintain the minimum professional liability insurance coverage;
9. Physician inefficiently manages patients and such inefficient management has not been cured after 30 days written notice from the Hospital;
10. Physician's inability to work with and relate to others, including, but not limited to patients and ancillary staff, in a respectful, cooperative and professional manner and such inability has not been cured after 30 days written notice from the Hospital;
11. Physician is unable to provide medical services under the terms of this Agreement due to a physical or mental disability;
12. Physician becomes impaired by the use of alcohol or the abuse of drugs;
13. Physician is convicted of any criminal offense, regardless of whether such action arose out of Physician's provision of professional services;

14. Physician commits any act of fraud as determined by reasonable discretion of the Board whether related to the Physician's provision of professional services or otherwise; or
15. A mutual written agreement terminating this Agreement is entered into between the Hospital and Physician.

B. Either party may terminate this Agreement for material breach; provided that the non-defaulting party shall give written notice of the claimed default, and the other party shall have 30 days to cure such performance, failing which, this Agreement may thereafter be immediately terminated by the non-defaulting party.

C. Either party may terminate this Agreement, without cause, by providing the other party ninety (90) days prior written notice.

D. EFFECT OF TERMINATION. In the event that this Agreement is terminated for any reason, Physician shall be entitled to receive only the amount of compensation earned prior to the date of termination.

E. TERMINATION WITHIN FIRST TWELVE (12) MONTHS. If this Agreement is terminated, with or without cause, during the first twelve (12) months of the term, the parties shall not enter any new agreement or arrangement during the remainder of such twelve (12) month period.

SECTION IX. CONFIDENTIALITY.

Physician shall not disclose to any third party, except where permitted or required by law or where such disclosure is expressly approved by the patient in writing, any patient or medical record information regarding Hospital patients (including Family Health Center patients), and Physician shall comply with all federal and state laws and regulations, and all rules, regulations, and policies of Hospital and its Medical Staff, regarding the confidentiality of such information from Hospital or Family Health Center patients receiving treatment of any kind, including treatment for alcohol and drug abuse. Physician is fully bound by the provisions of the federal regulations governing Confidentially of Alcohol and Drug Abuse Patient Records as codified at 42 C.F.R. Chapter 1, Part 2, enacted pursuant to 42 U.S.C. 290ee, and agrees to be separately bound by a Business Associate Agreement drafted pursuant to HIPAA as set forth in Public Law 104-191, as codified at 42 U.S.C. 1301 et. seq.

SECTION X. INSURANCE.

Physician shall maintain, at Physician's sole expense, a policy or policies of professional liability insurance as required by this Section. Such insurance shall provide coverage for Physician as the named insured, and such policy shall cover any acts of Physician's professional negligence which may have occurred during the relevant term and said policies of insurance shall be written with limits of liability of at least the minimum coverage required from time to time by the Medical Staff bylaws, but in any event no less than One Million Dollars ($1,000,000.00) per claim/Three Million Dollars ($3,000,000.00) annual aggregate for "claims made" insurance coverage. Physician will provide District with no less than 30 days advance written notice of any coverage changes or cancellation of the policy. The coverage required by this section shall be either on an occurrence basis or on a claim made basis. If the coverage is on a claims made basis, not less than 30 days prior to the termination of Physician's claims made coverage, Physician shall be obligated to provide evidence to District of continued coverage for claims which arise from Physician's services either by (1) evidence of continued effect of a claims made policy which provides coverage for all claims arising out of incidents occurring prior to the termination of such coverage, or (2) evidence of an extended reporting

period endorsement or "tail insurance" for all claims arising out of incidents occurring prior to termination of such coverage, and shall provide District with a certificate evidencing such tail or retroactive coverage.

The obligations set forth in this Section shall survive the termination of this Agreement.

SECTION XI. ASSIGNMENT.

Physician shall not assign, sell, or otherwise transfer his/her Agreement or any interest in it without written consent of Hospital.

SECTION XII. NOTICES.

The notice required by this Agreement shall be effective if mailed, one (1) business day after the day on which the notice was sent via overnight mail, addressed as follows:

Hospital: Evan Rayner, Chief Executive Officer
Bear Valley Community Healthcare District
P. O. Box 1649
Big Bear Lake, CA 92315

Physician: Michael S. Chin, MD
Dba: Mission Surgical Clinic
2575 Stewart St.
Riverside, CA 92503

SECTION XIII. PRE EXISTING AGREEMENT.

This Contract replaces and supersedes any and all prior arrangements or understandings by and between Hospital and Physician with regard to the subject matter hereof.

SECTION XIV. HOSPITAL NOT PRACTICING MEDICINE.

This Agreement shall in no way be construed to mean or suggest that Hospital is engaged in the practice of medicine.

SECTION XV. ENTIRE AGREEMENT.

This Agreement constitutes the entire Agreement, both written and oral, between the parties, and all prior or contemporaneous agreements respecting the subject matter hereof, whether written or oral, express or implied, are suppressed. This Agreement may be modified only by written agreement signed by both of the parties.

SECTION XVI. SEVERABILITY.

The non-enforceability, invalidity, or illegality of any provision to this Agreement shall not render the other provisions unenforceable, invalid or illegal.

SECTION XVII. GOVERNING LAW.

This Agreement shall be governed under the laws of the State of California. In the event of any dispute arising between the parties arising out of or related to this Agreement, the parties agree

that such dispute shall be settled by binding arbitration, pursuant to the rules of the American Arbitration Association, San Bernardino County.

SECTION XVIII. REFERRALS.

The parties acknowledge that none of the benefits granted Physician is conditioned on any requirement that Physician make referrals to, be in a position to make or influence referrals to, or otherwise generate business for Hospital. The parties further acknowledge that Physician is not restricted from establishing staff privileges at, referring any service to, or otherwise generating any business for any other facility of Physician's choosing.

SECTION XIX. ANTI-HARASSMENT/DISCRIMINATION/RETALIATION

The parties are prohibited from engaging in any discriminatory, harassing, or retaliatory conduct, and Physician agrees to fully comply with all applicable local, state and federal anti-discrimination and employment-related regulations and laws.

SECTION XX. HIPAA BUSINESS ASSOCIATE AGREEMENT.

The parties have concurrently with the execution of this Agreement, executed Exhibit A entitled HIPAA Business Associates Agreement, which Exhibit is attached hereto and incorporated herein by reference.

In Witness Whereof, the parties have executed this Agreement as of the first date written above.

Dated:_____ **By:**_____

Evan Rayner, CEO
Bear Valley Community Healthcare District
PO Box 1649
Big Bear Lake, CA 92315

Dated: _____ **By:** _____

Peter Boss, President, BOD
Bear Valley Community Healthcare District
P. O. Box 1649
Big Bear Lake, CA 92315

Dated: _____ **By:** _____

Michael Chin, MD
Dba: Mission Surgical Clinic
2575 Stewart St.
Riverside, CA 92503

Family Health Center

Provider Monthly Report

Provider Name: _____ Month:

Date	# Patients Scheduled	Cancelled	No Shows	Walk Ins	Total Pts. Seen			Total Hrs.Wrkd.
1					0			
2					0			
3					0			
4					0			
5					0			
6					0			
7					0			
8					0			
9					0			
10					0			
11					0			
12					0			
13					0			
14					0			
15					0			
16					0			
17					0			
18					0			
19					0			
20					0			
21					0			
22					0			
23					0			
24					0			
25					0			
26					0			
27					0			
28					0			
29					0			
30					0			
31					0			
Totals:	0	0	0	0	0	X	65	$ - 0

Provider Signature: _____ Date: _____

Manager Signature: _____ Date: _____

Administration Signature: _____ Date: _____

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
PHYSICIAN AGREEMENT FOR SERVICES AT THE RURAL HEALTH CLINICS
WITH
PRASHANTH KUMAR, MD
DBA
HIGH DESERT NEPHROLOGY MEDICAL ASSOCIATES INC.

THIS PHYSICIAN AGREEMENT ("Agreement") is made and entered into as of the 10th day of February 2022 by and between Bear Valley Community Healthcare District (a public entity), ("Hospital") and Prashanth Kumar, M.D. ("Physician").

RECITALS

WHEREAS, Hospital, is the owner and operator of a general acute care hospital located in Big Bear Lake, California. Hospital has a federally approved hospital-based 95-210 Rural Health Clinic located at two sites known as the Family Health Center and the Rural Health Clinic ("the Clinic"), under which Hospital may contract with physicians and physician extenders to provide medical treatment to the Clinic's patients.

WHEREAS, Physician is licensed by the Medical Board of California to practice medicine, is certified by the American Board of Surgery and is qualified to perform physician services for the Hospital's Clinic patients.

WHEREAS, Hospital desires to retain the services of Physician to provide professional medical services, and Physician desires to so contract with Hospital to furnish those services.

NOW THEREFORE, in consideration of the mutual covenants, undertakings and promises contained herein, as well as other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, and intending to be legally bound hereby, the parties hereto agree as follows:

AGREEMENTS

SECTION I. RESPONSIBILITIES OF PHYSICIAN.

A. SERVICES. During the term of this Agreement, Physician agrees to the following:

1. Physician shall provide professional physician services at the Clinic on an as needed basis as agreed upon by Hospital and Physician.
2. Physician shall maintain medical records for all patients consistent with standard industry practices and shall provide such other record keeping and administrative services as may be reasonably requested by Hospital. All medical records remain the property of the Hospital.
3. Physician shall cooperate with any quality management and utilization management programs instituted by Hospital.

B. ACCESS TO BOOKS AND RECORDS. If the value or cost of Services rendered to Hospital pursuant to this Agreement is Ten Thousand Dollars ($10,000.00) or more over a twelve- month period, Physician agrees as follows:

1. Until the expiration of four (4) years after the furnishing of such Services, Physician shall, upon written request, make available to the Secretary of the Department of Health and Human Services (the "Secretary'), the Secretary's duly-authorized representative, the Comptroller General, or the Comptroller General's duly-authorized representative, such books, documents and records as may be necessary to certify the nature and extent of the cost of such Services; and

2. If any such Services are performed by way of subcontract with another organization and the value or cost of such subcontracted services is Ten Thousand Dollars ($10,000.00) or more over a twelve (12) month period, such subcontract shall contain, and Physician shall enforce, a clause to the same effect as subparagraph 1. immediately above.

The availability of Physician's books, documents, and records shall be subject at all times to all applicable legal requirements, including without limitation, such criteria and procedures for seeking and obtaining access that may be promulgated by the Secretary by regulation. The provisions of subparagraphs 1. and 2. of Section I.B. shall survive expiration or other termination of this Agreement, regardless of the cause of such termination.

C. Physician will not carry out any of the duties of the Agreement through a subcontract.

D. ETHICS. In performing services under this Agreement, Physician shall use his/her best and most diligent efforts and professional skills; perform professional supervisory services; render care to patients in accordance with and in a manner consistent with the high standards of medicine; conduct himself/herself in a manner consistent with the principles of medical ethics promulgated by the American Medical Association; and comply with the Hospital's rules and regulations.

E. In respect to Physician's performance of Physician's professional duties, the Hospital shall neither have nor exercise control or direction over the specific methods by which Physician performs Physician's professional clinical duties. The Hospital's sole interest shall be to ensure that such duties are rendered in a competent, efficient and satisfactory manner.

F. Physician recognizes that the professional reputation of the Hospital is a unique and valuable asset. Physician shall not make any negative, disparaging or unfavorable comments regarding the Hospital or any of its owners, officers and/or employees to any person, either during the term of this Agreement or following termination of this Agreement.

G. NOTIFICATION OF CERTAIN EVENTS. Physician shall notify Hospital in writing within three (3) business days after the occurrence of any one or more of the following events:

1. Physician's medical staff membership or clinical privileges at any hospital are denied, suspended, restricted, revoked or voluntarily relinquished;
2. Physician becomes the subject of any suit, action or other legal proceeding arising out of Physician's professional services;
3. Physician is required to pay damages or any other amount in any malpractice action by way of judgment or settlement;
4. Physician becomes the subject of any disciplinary proceeding or action before any state's medical board or similar agency responsible for professional standards or behavior;
5. Physician becomes incapacitated or disabled from practicing medicine;

6. Any act of nature or any other event occurs which has a material adverse effect on Physician's ability to perform the Services under this Agreement;
7. Physician changes the location of her offices;
8. Physician is charged with or convicted of a criminal offense; or
9. Physician is debarred, suspended, or otherwise excluded from any federal and/or state health care payment program by action of the Office of Inspector General of the Department of Health and Human Services or Medi-Cal Office, or by any equivalent or coordinating governmental agencies.

H. COORDINATION OF SERVICES. Physician shall cooperate with Hospital, through its Chief Executive Officer, in connection with providing the Services.

SECTION II. REPRESENTATIONS AND WARRANTIES

Physician represents and warrants to Hospital, upon execution and throughout the term of this Agreement as follows:

A. Physician is not bound by any agreement or arrangement which would preclude Physician from entering into, or from fully performing the services required under this Agreement;

B. Physician's license to practice medicine in the State of California or in any other jurisdiction has never been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or made subject to terms of probation or any other restriction;

C. Physician's medical staff privileges at any health care facility have never been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or restricted in any way;

D. Physician shall perform the services required hereunder in accordance with: (1) all applicable federal, state, and local laws, rules and regulations; (2) all applicable standards of care of relevant accrediting organizations; and (3) all applicable Bylaws, Rules and Regulations of Hospital and it's Medical Staff;

E. Physician has not in the past conducted and is not presently conducting Physician's medical practice in such a manner as to cause Physician to be suspended, excluded, barred or sanctioned under the Medicare or Medi-Cal Programs or any government licensing agency, and has never been convicted of an offense related to health care, or listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation;

F. Physician has, and shall maintain throughout the term of this Agreement, an unrestricted license to practice medicine in the State of California and staff membership privileges at Hospital;

G. Physician has disclosed and will at all times during the term of this Agreement promptly disclose to the Hospital: (1) the existence and basis of any legal, regulatory, professional or other proceeding against Physician instituted by any person, organization, governmental agency, health care facility, peer review organization, or professional society which involves any allegation of substandard care or professional misconduct raised against Physician; and (2) any allegation of substandard care or professional misconduct raised against Physician by any person, organization, governmental agency, health care facility, peer review organization or professional society.

H. Physician agrees to promptly disclose any change to the status of his license to practice medicine or any changes the status of any privileges Physician may have at any other health care facility;

I. Physician shall deliver to the Hospital promptly upon request copies of all certificates, registrations, certificates of insurance and other evidence of Physician's compliance with the foregoing as reasonably requested by the Hospital; and

J. Physician shall participate in all government and third-party payment or managed care programs in which Hospital/Clinic participates, render services to patients covered by such programs, and accept the payment amounts provided for under these programs as payment in full for services of Physician to Hospital/Clinic's patients. If Hospital/Clinic deems it advisable for Physician to contract with a payer with which Hospital/Clinic has a contract, Physician agrees in good faith to negotiate a contractual agreement equal to the reasonable prevailing reimbursement rates for physician's specialty within the geographic area of Hospital/Clinic.

SECTION III. INDEMNIFICATION OF LIABILITY.

Physician agrees to indemnify, defend and hold harmless Hospital and its governing board, officers, employees and agents from and against any and all liabilities, costs, penalties, fines, forfeitures, demands, claims, causes of action, suits, and costs and expenses related thereto (including reasonable attorney's fees) which any or all of them may thereafter suffer, incur, be responsible for or pay out as a result of bodily injuries (including death) to any person or damage to any property (public or private), alleged to be caused by or arising from: (1) the negligent or intentional acts, errors, or omissions of Physician; (2) any violations of federal, state, or local statutes or regulations arising out of or resulting from any negligent act, error or omission of Physician; (3) the use of any copyrighted materials or patented inventions by Physician; or (4) Physician's breach of its warranties or obligations under this Agreement. The rights and obligations created by this indemnification provision shall survive termination or expiration of this Agreement.

SECTION IV. INDEPENDENT CONTRACTOR.

In performing the services herein specified, Physician is acting as an independent contractor, and shall not be considered an employee of Hospital. In no event shall this Agreement be construed as establishing a partnership or joint venture or similar relationship between the parties hereto, and nothing herein contained shall be construed to authorize either party to act as agent for the other. Physician shall be liable for Physician's own debts, obligations, acts and omissions, including the payment of all withholding, social security and other taxes and benefits. As an independent contractor, Physician is responsible for filing such tax returns and paying such self-employment taxes as may be required by law or regulations.

SECTION V. COMPENSATION.

At the end of each month, Physician shall submit to the administration a completed time sheet of time spent in the Family Health Clinic seeing patients. Upon receipt of completed and signed provider time sheet for services rendered under this Agreement, Hospital shall pay Physician, as for sole compensation hereunder, on a fee per visit basis at $75.00 (Seventy-Five Dollars) per visit or telemedicine encounter "No charge/courtesy" visits are not eligible for provider payment. Hospital will provide Physician a list of patients seen per Hospital records that supports the payment made to Physician. All patient billings for Physician services remain the property of Hospital. Monthly payments to Physician shall be made on or before the 10th (tenth) day of the month, following the month in which services are rendered.

SECTION VI. COMPLIANCE.

A. Hospital is committed to compliance with all billing and claims submission, fraud and abuse laws and regulations. In contracting with Hospital, physician agrees to act in compliance with all laws and regulations. Hospital has completed a Compliance Program to assure compliance with laws and regulations. Physician is therefore expected to comply with the policies of the Hospital Compliance Program.

At a minimum, Physician is expected to:

1. Be aware of those procedures which affect the physician, and which are necessary to implement the Compliance Program, including the mandatory duty of Physician to report actual or possible violations of fraud and abuse laws and regulations; and
2. Understand and adhere to standards, especially those which relate to the Physician's functions for or on behalf of the District/Hospital.

B. Failure to follow the standards of Hospital's Compliance Programs (including the duty to report misconduct) may be considered to be a violation of the Physician's arrangement with the Hospital and may be grounds for action by Hospital, including termination of the relationship.

SECTION VII. TERM.

This Agreement is effective from February 10, 2022 to February 09, 2024; however, this Agreement is subject to early termination as provided in Section. VIII. below.

SECTION VIII. EARLY TERMINATION.

A. Hospital may terminate this Agreement immediately upon written notice to Physician based on the occurrence of any of the following events:

1. Physician's license to practice medicine is suspended, revoked, terminated, or otherwise restricted;
2. Physician's medical staff privileges at the Hospital, or any other healthcare facility, are in any way suspended, revoked, or otherwise restricted;
3. Medicare and/or Medi-Cal significantly changes the RHC program;
4. Hospital fails to maintain RHC status;
5. Physician Services Agreement is terminated or expires;
6. Physician's failure to comply with the standards of the Hospital's Compliance Program, to the extent that such failure results in material fine and or sanction from Medicare or Medi-Cal Program;
7. Physician fails to complete medical records in a timely fashion;
8. Physician fails to maintain the minimum professional liability insurance coverage;
9. Physician inefficiently manages patients and such inefficient management has not been cured after 30 days written notice from the Hospital;
10. Physician's inability to work with and relate to others, including, but not limited to patients and ancillary staff, in a respectful, cooperative and professional manner and such inability has not been cured after 30 days written notice from the Hospital;
11. Physician is unable to provide medical services under the terms of this Agreement due to a physical or mental disability;
12. Physician becomes impaired by the use of alcohol or the abuse of drugs;
13. Physician is convicted of any criminal offense, regardless of whether such action arose out of Physician's provision of professional services;

14. Physician commits any act of fraud as determined by reasonable discretion of the Board whether related to the Physician's provision of professional services or otherwise; or
15. A mutual written agreement terminating this Agreement is entered into between the Hospital and Physician.

B. Either party may terminate this Agreement for material breach; provided that the non-defaulting party shall give written notice of the claimed default, and the other party shall have 30 days to cure such performance, failing which, this Agreement may thereafter be immediately terminated by the non-defaulting party.

C. Either party may terminate this Agreement, without cause, by providing the other party ninety (90) days prior written notice.

D. EFFECT OF TERMINATION. In the event that this Agreement is terminated for any reason, Physician shall be entitled to receive only the amount of compensation earned prior to the date of termination.

E. TERMINATION WITHIN FIRST TWELVE (12) MONTHS. If this Agreement is terminated, with or without cause, during the first twelve (12) months of the term, the parties shall not enter any new agreement or arrangement during the remainder of such twelve (12) month period.

SECTION IX. CONFIDENTIALITY.

Physician shall not disclose to any third party, except where permitted or required by law or where such disclosure is expressly approved by the patient in writing, any patient or medical record information regarding Hospital patients (including Family Health Center patients), and Physician shall comply with all federal and state laws and regulations, and all rules, regulations, and policies of Hospital and its Medical Staff, regarding the confidentiality of such information from Hospital or Family Health Center patients receiving treatment of any kind, including treatment for alcohol and drug abuse. Physician is fully bound by the provisions of the federal regulations governing Confidentially of Alcohol and Drug Abuse Patient Records as codified at 42 C.F.R. Chapter 1, Part 2, enacted pursuant to 42 U.S.C. 290ee, and agrees to be separately bound by a Business Associate Agreement drafted pursuant to HIPAA as set forth in Public Law 104-191, as codified at 42 U.S.C. 1301 et. seq.

SECTION X. INSURANCE.

Physician shall maintain, at Physician's sole expense, a policy or policies of professional liability insurance as required by this Section. Such insurance shall provide coverage for Physician as the named insured, and such policy shall cover any acts of Physician's professional negligence which may have occurred during the relevant term and said policies of insurance shall be written with limits of liability of at least the minimum coverage required from time to time by the Medical Staff bylaws, but in any event no less than One Million Dollars ($1,000,000.00) per claim/Three Million Dollars ($3,000,000.00) annual aggregate for "claims made" insurance coverage. Physician will provide District with no less than 30 days advance written notice of any coverage changes or cancellation of the policy. The coverage required by this section shall be either on an occurrence basis or on a claim made basis. If the coverage is on a claims made basis, not less than 30 days prior to the termination of Physician's claims made coverage, Physician shall be obligated to provide evidence to District of continued coverage for claims which arise from Physician's services either by (1) evidence of continued effect of a claims made policy which provides coverage for all claims arising out of incidents occurring prior to the termination of such coverage, or (2) evidence of an extended reporting

period endorsement or “tail insurance” for all claims arising out of incidents occurring prior to termination of such coverage, and shall provide District with a certificate evidencing such tail or retroactive coverage.

The obligations set forth in this Section shall survive the termination of this Agreement.

SECTION XI. ASSIGNMENT.

Physician shall not assign, sell, or otherwise transfer his/her Agreement or any interest in it without written consent of Hospital.

SECTION XII. NOTICES.

The notice required by this Agreement shall be effective if mailed, one (1) business day after the day on which the notice was sent via overnight mail, addressed as follows:

Hospital: Evan Rayner, Chief Executive Officer
Bear Valley Community Healthcare District
P. O. Box 1649
Big Bear Lake, CA 92315

Physician: Prashanth Kumar, MD
Dba: High Desert Nephrology Medical Associates Inc.
1183 Amethyst Road, Suite 100
Victorville, CA 92392

SECTION XIII. PRE EXISTING AGREEMENT.

This Contract replaces and supersedes any and all prior arrangements or understandings by and between Hospital and Physician with regard to the subject matter hereof.

SECTION XIV. HOSPITAL NOT PRACTICING MEDICINE.

This Agreement shall in no way be construed to mean or suggest that Hospital is engaged in the practice of medicine.

SECTION XV. ENTIRE AGREEMENT.

This Agreement constitutes the entire Agreement, both written and oral, between the parties, and all prior or contemporaneous agreements respecting the subject matter hereof, whether written or oral, express or implied, are suppressed. This Agreement may be modified only by written agreement signed by both of the parties.

SECTION XVI. SEVERABILITY.

The non-enforceability, invalidity, or illegality of any provision to this Agreement shall not render the other provisions unenforceable, invalid or illegal.

SECTION XVII. GOVERNING LAW.

This Agreement shall be governed under the laws of the State of California. In the event of any dispute arising between the parties arising out of or related to this Agreement, the parties agree

that such dispute shall be settled by binding arbitration, pursuant to the rules of the American Arbitration Association, San Bernardino County.

SECTION XVIII. REFERRALS.

The parties acknowledge that none of the benefits granted Physician is conditioned on any requirement that Physician make referrals to, be in a position to make or influence referrals to, or otherwise generate business for Hospital. The parties further acknowledge that Physician is not restricted from establishing staff privileges at, referring any service to, or otherwise generating any business for any other facility of Physician's choosing.

SECTION XIX. ANTI-HARASSMENT/DISCRIMINATION/RETALIATION

The parties are prohibited from engaging in any discriminatory, harassing, or retaliatory conduct, and Physician agrees to fully comply with all applicable local, state and federal anti-discrimination and employment-related regulations and laws.

SECTION XX. HIPAA BUSINESS ASSOCIATE AGREEMENT.

The parties have concurrently with the execution of this Agreement, executed Exhibit A entitled HIPAA Business Associates Agreement, which Exhibit is attached hereto and incorporated herein by reference.

In Witness Whereof, the parties have executed this Agreement as of the first date written above.

Dated:_____ **By:**_____

Evan Rayner, CEO
Bear Valley Community Healthcare District
PO Box 1649
Big Bear Lake, CA 92315

Dated: _____ **By:** _____

Peter Boss, President, BOD
Bear Valley Community Healthcare District
P. O. Box 1649
Big Bear Lake, CA 92315

Dated: _____ **By:** _____

Prashanth Kumar, MD
Dba: High Desert Nephrology Medical Associates Inc.
1183 Amethyst Road, Suite 100
Victorville, CA 92392

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Contract Cover Sheet

Contract Name: Michael Norman, DO

Purpose of Contract: Respiratory/EKG Department

Contract # _____ **Effective Date:** 2/11/22 **Term:** 2 year **Cost:** $1,500.00 Mnth

Originating Department Name: RT **Department Number:** _____

Department Manager **Signature:** _____ **Date:** _____

BAA: ☑ Yes ☐ No **W-9:** ☑ Yes ☐ No

Need new BAA signed

Administrative Officer	**Signature:**	NA	**Date:** NA
HIPAA/Security Officer (Software/EHR Related)	**Signature:**	NA	**Date:** NA
HIPAA Privacy Officer (BAA applicable)	**Signature:**	NA	**Date:** NA
Legal Counsel	**Signature:**	via email	**Date:** 1/18/22
Compliance Officer	**Signature:**	Mary Norman	**Date:** 1/21/2022
Chief Financial Officer	**Signature:**		**Date:**
Chief Executive Officer	**Signature:**		**Date:**
Board of Directors When Applicable	**Signature**		**Date:**

1. **Final Signatures on Contract, BAA & W-9:** **Date:** _____
2. **Copy of BAA forwarded to HIPAA Privacy Officer** **Date:** _____
3. **Copy of Contract/BAA/W-9 forwarded to Department Manager:** **Date:** _____
4. **Copy of Contract/BAA/W-9 forwarded to Contractor (if applicable):** **Date:** _____
5. **Copy of Contract/BAA/W-9 scanned/emailed to Controller:** **Date:** _____

Contract Cover Sheet

CONFIDENTIAL NOTICE:

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
MEDICAL DIRECTOR AGREEMENT
(RESPIRATORY/EKG DEPARTMENT)
WITH
MICHAEL NORMAN, D.O.

THIS MEDICAL DIRECTOR AGREEMENT ("Agreement") is made and entered into as of the 11th day of February 2022 by and between Bear Valley Community Healthcare District (a public entity), ("Hospital") and Michael Norman, D.O. ("Physician").

RECITALS

WHEREAS Hospital is the owner and operator of a general acute care hospital located in Big Bear Lake, California.

WHEREAS, Physician is licensed by the Osteopathic Medical Board of California to practice medicine, and is qualified to perform medical services for the Hospital.

WHEREAS, the District desires Physician to provide medical director services in the Hospital's Respiratory/EKG Department ("Department"); and Physician is willing and so desires to contract with Hospital to furnish said medical director services to the District and its patients.

NOW THEREFORE, in consideration of the mutual covenants, undertakings and promises contained herein, as well as other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, and intending to be legally bound hereby, the parties hereto agree as follows:

AGREEMENTS

SECTION I. RESPONSIBILITIES OF PHYSICIAN.

A. PHYSICIAN QUALIFICATIONS. Physician shall be duly licensed and qualified to practice medicine in California (and San Bernardino County), and shall be approved for membership and/or clinical privileges on Hospital's medical staff in accordance with the medical staff Bylaws, Rules and Regulations. Physician shall have overall responsibility for the Respiratory/EKG services. Physician shall satisfy such other requirements set forth in Section 8.3 of the medical staff Bylaws.

B. DUTIES AND OBLIGATIONS. During the term of this Agreement, Physician shall serve as Medical Director of the Respiratory/EKG Department and Physician shall be responsible for the medical direction of the Department and the performance of the other medical administrative services, including all of the duties customarily associated therewith, to the reasonable satisfaction of Hospital. Physician shall devote as much time to the discharge of the medical administrative responsibilities under this Agreement as is necessary to provide for the proper and adequate medical administrative management of the Department. Without limiting the foregoing, Physician's duties as Medical Director shall include, without limitation, the following:

1. Physician shall generally monitor the quality of patient care and professional performance rendered by members with clinical privileges in internal medicine;

2. Physician shall conduct investigations and submit reports and recommendations to the appropriate committees regarding the clinical privileges to be exercised within service by members or of applicants to the medical staff;

3. Physician shall be a member of the Medical Executive Committee, and give guidance on the overall medical policies of the medical staff and make specific recommendations, and suggestions regarding the service;

4. Physician shall perform such other duties commensurate with the office as may from time to time be reasonably requested by the chief of staff or the medical executive committee;

5. Physician shall provide clinical direction and guidelines for the clinical activities of physician, professional department personnel and non-physician personnel within the department, including, without limitation, those nurses and technicians that may serve in the Department;

6. Physician shall advise the Hospital as to the selection, replacement, condition, and repair of the supplies and medical equipment in the Department. Physician is not authorized to enter into any contract on behalf of the Hospital for the purchase, rental, or other acquisition of equipment or supplies;

7. Physician shall develop and/or review for the Hospital's approval, at least annually, the Department's professional policies, protocols, procedures, and standards;

8. Physician shall participate in the educational programs conducted by the Hospital and the medical staff necessary to insure the Department's and the Hospital's compliance with regulatory accreditation, with insurance requirements, and shall participate in such other educational programs within the Hospital as the Hospital may reasonably request;

9. Physician shall participate in the quality improvement programs conducted by the Hospital and the medical staff necessary to insure the Department's and the Hospital's compliance with regulatory, accreditation, and insurance requirements and shall participate in such other quality improvement programs within the Hospital as the Hospital may reasonably request;

10. Physician shall participate in the utilization review programs conducted by the Hospital and the medical staff necessary to insure the Department's and the Hospital's compliance with regulatory, accreditation and insurance requirements and shall participate in such other utilization review programs within the Hospital as the Hospital may reasonably request;

11. Physician shall participate in the risk management programs conducted by the Hospital and the medical staff necessary to insure the Department's and the Hospital's compliance with regulatory, accreditation, and insurance requirements and shall participate in such other risk management programs within the Hospital as the Hospital may reasonably request;

12. Physician shall actively participate in the marketing of the Hospital's and the Department's services to the public and physician community;

13. Physician shall, upon the Hospital's request, assist in the preparation of the annual and long-term operating and capital budgets for the Department;

14. Physician shall, upon request by the Hospital or the medical staff, report the status and functioning of the Department and report the nature of Physician's activities towards fulfilling its obligations under this Agreement and towards ensuring the competent and efficient provision of the Department's professional services to the various divisions and departments of the Hospital;

15. Physician shall establish the necessary guidelines for the timely implementation of orders for Department services through appropriate medical staff committees. Physician shall review and countersign an order of a nonmember of the medical staff prior to the implementation of that order in the Department; and,

16. Physician shall report on a quarterly basis to the Medical Executive Committee the overall status of the Department and perform such other administrative duties as the Hospital shall reasonably request. Physician shall attend a minimum of 75% of the medical staff meetings.

17. ETHICS. In performing services under this Agreement, Physician shall use his best and most diligent efforts and professional skills; perform professional supervisory services; render care to patients in accordance with and in a manner consistent with the high standards of medicine; conduct himself in a manner consistent with the principles of medical ethics promulgated by the American Osteopathic Association; and comply with the Hospital's rules and regulations.

18. In respect to Physician's performance of Physician's professional duties, the Hospital shall neither have nor exercise control or direction over the specific methods by which Physician performs Physician's professional clinical duties. The Hospital's sole interest shall be to ensure that such duties are rendered in a competent, efficient and satisfactory manner.

19. Physician recognizes that the professional reputation of the Hospital is a unique and valuable asset. Physician shall not make any negative, disparaging, or unfavorable comments regarding the Hospital or any of its owners, officers, employees to any person, either during the term of this Agreement or following termination of this Agreement.

20. NOTIFICATION OF CERTAIN EVENTS. Physician shall notify Hospital in writing within three (3) business days after the occurrence of any one or more of the following events:

a. Physician's medical staff membership or clinical privileges at any hospital are denied, suspended, restricted, revoked or voluntarily relinquished;
b. Physician becomes the subject of any suit, action or other legal proceeding arising out of Physician's professional services;
c. Physician is required to pay damages or any other amount in any malpractice action by way of judgment or settlement;
d. Physician becomes the subject of any disciplinary proceeding or action before any state's medical board or similar agency responsible for professional standards or behavior;
e. Physician becomes incapacitated or disabled from practicing medicine;
f. Any act of nature or any other event occurs which has a material adverse effect on Physician's ability to perform the Services under this Agreement;
g. Physician changes the location of his offices;
h. Physician is charged with or convicted of a criminal offense; or

i. Physician is debarred, suspended, or otherwise excluded from any federal and/or state health care payment program by action of the Office of Inspector General of the Department of Health and Human Services or Medi-Cal Office, or by any equivalent or coordinating governmental agencies.

C. COORDINATION OF SERVICES. The parties further acknowledge and agree that in addition to the duties and obligations set forth above, Physician shall have the following obligations as medical director:

1. Physician shall have overall responsibility for the Department's services. The parties acknowledge that Physician may be absent or not available from time to time for good reason (but subject to the prior written approval of Hospital), such as attendance at medical practice continuing education. During these periods of absence, Physician shall provide a substitute physician so long as (a) said substitute physician satisfies the same requirements and qualifications applicable to Physician under this Agreement, and (b) said substitute Physician assumes all of Physician's contractual, malpractice, and other liabilities related to the provision of services in the Department.

2. Physician shall be available in person or by electronic communication at all times.

3. Physician shall over-read electrocardiograms within seven (7) business days of obtaining the electrocardiogram.

4. Physician shall review and sign off on the arterial blood gas log daily.

5. Physician shall review and sign off on the arterial blood gas proficiency testing quarterly.

6. Physician shall review and sign off on the respiratory care practitioners arterial blood gas competencies annually.

7. Physician shall review and sign off on the pulmonary function testing within forty-eight (48) hours of spirometry testing.

8. Physician shall provide administrative direction and supervision to the Department manager.

9. Physician shall participate in quality improvement by reviewing electrocardiograms interpreted by emergency room physicians on a quarterly basis.

10. Physician shall provide on-site services in compliance with all applicable Medicare/Medi-Cal rules and regulations pertaining the Clinics to assure certification.

D. ACCESS TO BOOKS AND RECORDS. If the value or cost of Services rendered to Hospital pursuant to this Agreement is Ten Thousand Dollars ($10,000.00) or more over a twelve-month period, Physician agrees as follows:

1. Until the expiration of four (4) years after the furnishing of such Services, Physician shall, upon written request, make available to the Secretary of the Department of Health and Human Services (the "Secretary'), the Secretary's duly authorized representative, the Comptroller General, or the Comptroller General's duly-authorized representative, such books, documents and records as may be necessary to certify the nature and extent of the cost of such Services; and

2. If any such Services are performed by way of subcontract with another organization and the value or cost of such subcontracted services is Ten Thousand Dollars ($10,000.00) or more over a twelve-month period, such subcontract shall contain, and Physician shall enforce, a clause to the same effect as subparagraph 1. immediately above.

The availability of Physician's books, documents, and records shall be subject at all times to all applicable legal requirements, including without limitation, such criteria and procedures for seeking and obtaining access that may be promulgated by the Secretary by regulation. The provisions of subparagraphs 1. and 2. of Section D. shall survive expiration or other termination of this Agreement, regardless of the cause of such termination.

E. REPORTS AND RECORDS. Physician shall, in accordance with Hospital and medical staff policies, cause to be promptly prepared and filed with appropriate physicians, and the Hospital's medical records department, reports of all examinations, procedures, and other professional services performed by Physician and shall maintain an accurate and complete file within the Department, or other location approved by the Hospital, of all such reports and supporting documents. The ownership and right of control of all reports, records, and supporting documents prepared in connection with the Department belong to the Hospital; provided that Physician shall have access to such reports, records, and supporting documents as authorized by Hospital policies and the law of the State of California.

F. USE OF PREMISES. Physician shall neither use nor permit anyone employed, retained, or otherwise associated with Physician to use any part of the Department or Hospital for any purpose other than the performance of services under this Agreement.

SECTION II. REPRESENTATIONS AND WARRANTIES

Physician represents and warrants to Hospital, upon execution and throughout the term of this Agreement as follows:

A. Physician is not bound by any agreement or arrangement which would preclude Physician from entering into, or from fully performing the services required under this Agreement;

B. Physician's license to practice medicine in the State of California or in any other jurisdiction has never been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or made subject to terms of probation or any other restriction;

C. Physician's medical staff privileges at any health care facility have never been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or restricted in any way;

D. Physician shall perform the services required hereunder in accordance with: (1) all applicable federal, state, and local laws, rules and regulations; (2) all applicable standards of care of relevant accrediting organizations; and (3) all applicable Bylaws, Rules and Regulations of Hospital and it's Medical Staff;

E. Physician has not in the past conducted and is not presently conducting Physician's medical practice in such a manner as to cause Physician to be suspended, excluded, barred or sanctioned under the Medicare or MediCal Programs or any government licensing agency, and has never been convicted of an offense related to health care, or

listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation;

F. Physician has, and shall maintain throughout the term of this Agreement, an unrestricted license to practice medicine in the State of California and staff membership privileges at Hospital;

G. Physician has disclosed, and will at all times during the term of this Agreement promptly disclose, to the Hospital: (1) the existence and basis of any legal, regulatory, professional or other proceeding against Physician instituted by any person, organization, governmental agency, health care facility, peer review organization, or professional society which involves any allegation of substandard care or professional misconduct raised against Physician; and (2) any allegation of substandard care or professional misconduct raised against Physician by any person, organization, governmental agency, health care facility, peer review organization or professional society;

H. Physician agrees to promptly disclose any change to the status of his license to practice medicine or any changes the status of any privileges Physician may have at any other health care facility;

I. Physician shall deliver to the Hospital promptly upon request copies of all certificates, registrations, certificates of insurance and other evidence of Physician's compliance with the foregoing as reasonably requested by the Hospital; and,

J. Physician shall participate in all government and third-party payment or managed care programs in which Hospital/Clinic participates, render services to patients covered by such programs, and accept the payment amounts provided for under these programs as payment in full for services of Physician to Hospital/Clinic's patients. If Hospital/Clinic deems it advisable for Physician to contract with a payer with which Hospital/Clinic has a contract, Physician agrees in good faith to negotiate a contractual agreement equal to the reasonable prevailing reimbursement rates for internists/hospitalists within the geographic area of Hospital/Clinic.

SECTION III. INDEMNIFICATION OF LIABILITY.

Physician agrees to indemnify, defend and hold harmless Hospital and its governing board, officers, employees and agents from and against any and all liabilities, costs, penalties, fines, forfeitures, demands, claims, causes of action, suits, and costs and expenses related thereto (including reasonable attorney's fees) which any or all of them may thereafter suffer, incur, be responsible for or pay out as a result of bodily injuries (including death) to any person or damage to any property (public or private), alleged to be caused by or arising from: (1) the negligent or intentional acts, errors, or omissions of Physician; (2) any violations of federal, state, or local statutes or regulations arising out of or resulting from any negligent act, error or omission of Physician; (3) the use of any copyrighted materials or patented inventions by Physician; or (4) Physician's breach of its warranties or obligations under this Agreement. The rights and obligations created by this indemnification provision shall survive termination or expiration of this Agreement.

SECTION IV. INDEPENDENT CONTRACTOR.

In performing the services herein specified, Physician is acting as an independent contractor, and shall not be considered an employee of Hospital. In no event shall this Agreement be construed as establishing a partnership or joint venture or similar relationship between the parties hereto,

and nothing herein contained shall be construed to authorize either party to act as agent for the other. Physician shall be liable for Physician's own debts, obligations, acts and omissions, including the payment of all withholding, social security and other taxes and benefits. As an independent contractor, Physician is responsible for filing such tax returns and paying such self-employment taxes as may be required by law or regulations.

SECTION V. COMPENSATION.

At the end of each month, Physician shall submit to the Hospital administration a completed and signed Director Monthly Administrative Services Log in the form set forth in Exhibit "A" attached hereto and incorporated herein by reference. Upon receipt of a completed and signed log, Hospital shall pay Physician a monthly sum in the amount of $1,500.00 (One Thousand Five Dollars and No Cents) for services under this Agreement. Monthly payments to Physician shall be made on or before the 10th (tenth) day of the month, following the month in which services are rendered.

SECTION VI. COMPLIANCE.

A. Hospital is committed to compliance with all billing and claims submission, fraud and abuse laws and regulations. In contracting with Hospital, physician agrees to act in compliance with all laws and regulations. Hospital has completed a Compliance Program to assure compliance with laws and regulations. Physician is therefore expected to comply with the policies of the Hospital Compliance Program.

At a minimum, Physician is expected to:

1. Be aware of those procedures which affect the physician and which are necessary to implement the Compliance Program, including the mandatory duty of physician to report actual or possible violations of fraud and abuse laws and regulations; and
2. Understand and adhere to standards, especially those which relate to the physician's functions for or on behalf of the District/Hospital.

B. Failure to follow the standards of Hospital's Compliance Programs (including the duty to report misconduct) may be considered to be a violation of the Physician's arrangement with the Hospital and may be grounds for action by Hospital, including termination of the relationship.

SECTION VII. TERM.

This Agreement is effective from February 11, 2022 to February 10, 2024; however, this Agreement is subject to early termination as provided in Section. VIII. below.

SECTION VIII. EARLY TERMINATION.

A. Hospital may terminate this Agreement immediately upon written notice to Physician based on the occurrence of any of the following events:

1. Physician's license to practice medicine is suspended, revoked, terminated, or otherwise restricted;
2. Physician's medical staff privileges at the Hospital, or any other health care facility, are in any way suspended, revoked, or otherwise restricted;
3. Medicare and/or MediCal significantly changes the RHC program;
4. Hospital fails to maintain RHC status;
5. Physician Services Agreement is terminated or expires;

6. Physician's failure to comply with the standards of the Hospital's Compliance Program to the extent that such failure results in material fine and or sanction from Medicare or Medi-Cal Program;
7. Physician breaches any material term of this Agreement;
8. Physician fails to complete medical records in a timely fashion;
9. Physician fails to maintain the minimum professional liability insurance coverage;
10. Physician inefficiently manages patients and such inefficient management has not been cured after 30 days written notice from the Hospital;
11. Physician's inability to work with and relate to others, including, but not limited to patients and ancillary staff, in a respectful, cooperative and professional manner and such inability has not been cured after 30 days written notice from the Hospital;
12. Physician is unable to provide medical services under the terms of this Agreement due to a physical or mental disability;
13. Physician becomes impaired by the use of alcohol or the abuse of drugs;
14. Physician is convicted of any criminal offense, regardless of whether such action arose out of Physician's provision of professional services;
15. Physician commits any act of fraud as determined by reasonable discretion of the Board whether related to the Physician's provision of professional services or otherwise; or
16. A mutual written agreement terminating this Agreement is entered into between the Hospital and Physician.

B. Either party may terminate this Agreement for material breach; provided that the non-defaulting party shall give written notice of the claimed default, and the other party shall have 30 days to cure such performance, failing which, this Agreement may thereafter be immediately terminated by the non-defaulting party.

C. Either party may terminate this Agreement, without cause, by providing the other party sixty (60) days prior written notice.

D. EFFECT OF TERMINATION. In the event that this Agreement is terminated for any reason, Physician shall be entitled to receive only the amount of compensation earned prior to the date of termination.

E. TERMINATION WITHIN FIRST TWELVE (12) MONTHS. If this Agreement is terminated, with or without cause, during the first twelve (12) months of the term, the parties shall not enter any new agreement or arrangement during the remainder of such twelve (12) month period.

SECTION IX. CONFIDENTIALITY.

Physician shall not disclose to any third party, except where permitted or required by law or where such disclosure is expressly approved by the patient in writing, any patient or medical record information regarding Hospital patients (including Family Health Center patients), and Physician shall comply with all federal and state laws and regulations, and all rules, regulations, and policies of Hospital and its Medical Staff, regarding the confidentiality of such information from Hospital or Family Health Center patients receiving treatment of any kind, including treatment for alcohol and drug abuse. Physician is fully bound by the provisions of the federal regulations governing Confidentially of Alcohol and Drug Abuse Patient Records as codified at 42 C.F.R. Chapter 1, Part 2, enacted pursuant to 42 U.S.C. 290ee, and agrees to be separately bound by a Business Associate Agreement drafted pursuant to HIPAA as set forth in Public Law 104-191, as codified at 42 U.S.C. 1301 et. seq.

SECTION X. INSURANCE.

1. Hospital. District represents that Physician shall be covered under Hospital's Directors and Officers Liability Insurance against liability arising from Physician's performance of Director services within the course and scope of the directorship duties stated in this Agreement.

2. Professional Liability. Physician shall maintain, at Physician's sole expense, a policy or policies of professional liability insurance as required by this Section. Such insurance shall provide coverage for Physician as the named insured, and such policy shall cover any acts of Physician's professional negligence which may have occurred during the relevant term and said policies of insurance shall be written with limits of liability of at least the minimum coverage required from time to time by the Medical Staff bylaws, but in any event no less than One Million Dollars ($1,000,000.00) per claim/Three Million Dollars ($3,000,000.00) annual aggregate for "claims made" insurance coverage. Physician will provide District with no less than 30 days advance written notice of any coverage changes or cancellation of the policy. The coverage required by this section shall be either on an occurrence basis or on a claim made basis. If the coverage is on a claims made basis, not less than 30 days prior to the termination of Physician's claims made coverage, Physician shall be obligated to provide evidence to District of continued coverage for claims which arise from Physician's services either by (1) evidence of continued effect of a claims made policy which provides coverage for all claims arising out of incidents occurring prior to the termination of such coverage, or (2) evidence of an extended reporting period endorsement or "tail insurance" for all claims arising out of incidents occurring prior to termination of such coverage, and shall provide District with a certificate evidencing such tail or retroactive coverage.

The obligations set forth in this Section shall survive the termination of this Agreement.

SECTION XI. ASSIGNMENT.

Physician shall not assign, sell, or otherwise transfer his Agreement or any interest in it without written consent of Hospital.

SECTION XII. NOTICES.

The notice required by this Agreement shall be effective if mailed, postage prepaid, as follows:

Hospital: Evan Rayner, Chief Executive Officer
Bear Valley Community Healthcare District
P. O. Box 1649
Big Bear Lake, CA 92315

Physician: Michael Norman, D.O.
12814 Coby Court
Apple Valley, CA 92308

SECTION XIII. PRE EXISTING AGREEMENT.

This Agreement replaces and supersedes any and all prior arrangements or understandings by and between Hospital and Physician with regard to the subject matter hereof.

SECTION XIV. HOSPITAL NOT PRACTICING MEDICINE.

This Agreement shall in no way be construed to mean or suggest that Hospital is engaged in the practice of medicine.

SECTION XV. ENTIRE AGREEMENT.

This Agreement constitutes the entire Agreement, both written and oral, between the parties, and all prior or contemporaneous agreements respecting the subject matter hereof, whether written or oral, express or implied, are suppressed. This Agreement may be modified only by written agreement signed by both of the parties.

SECTION XVI. SEVERABILITY.

The non-enforceability, invalidity, or illegality of any provision to this Agreement shall not render the other provisions unenforceable, invalid or illegal.

SECTION XVII. GOVERNING LAW.

This Agreement shall be governed under the laws of the State of California. In the event of any dispute arising between the parties arising out of or related to this Agreement, the parties agree that such dispute shall be settled by binding arbitration, pursuant to the rules of the American Arbitration Association, San Bernardino County.

SECTION XVIII. REFERRALS.

The parties acknowledge that none of the benefits granted Physician is conditioned on any requirement that Physician make referrals to, be in a position to make or influence referrals to, or otherwise generate business for Hospital. The parties further acknowledge that Physician is not restricted from establishing staff privileges at, referring any service to, or otherwise generating any business for any other facility of Physician's choosing.

SECTION XIX. ANTI-HARASSMENT/DISCRIMINATION/RETALIATION

The parties are prohibited from engaging in any discriminatory, harassing, or retaliatory conduct, and Physician agrees to fully comply with all applicable local, state and federal anti-discrimination and employment-related regulations and laws.

SECTION XX. HIPAA BUSINESS ASSOCIATE AGREEMENT.

The parties have concurrently with the execution of this Agreement, executed Exhibit B entitled HIPAA Business Associates Agreement, which Exhibit is attached hereto and incorporated herein by reference.

In Witness Whereof, the parties have executed this Agreement as of the first date written above.

Dated:_____ **By:** _____

Evan Rayner, CEO
Bear Valley Community Healthcare District
P. O. Box 1649
Big Bear Lake, CA 92315

Dated: _____ **By:** _____

Peter Boss, Board President
Bear Valley Community Healthcare District
P. O. Box 1649
Big Bear Lake, CA 92315

Dated: _____ **By:** _____

Michael Norman, D.O.
12814 Coby Court
Apple Valley, CA 92308

EXHIBIT A

PHYSICIAN DEPARTMENT DIRECTOR MONTHLY ADMINISTRATION SERVICES LOG

Respiratory Therapy & EKG Medical Director
Michael Norman, DO

Month of: _____

Meeting Attendance:

- Medical Executive Committee Attendance _____ Present _____ Absent
- Quarterly Department Status Report to MED _____ Yes _____ No

EKG Interpretation of Month: _____

Department Supervision/Administration:

	Hours	Comments
➢ Department Clinical Direction/Personnel Supervision	_____	
➢ Department Quality Improvement Activity	_____	
➢ Department Utilization Review	_____	
➢ Presentation/Participation Continuing Education Activity	_____	
➢ Other (Department policy/procedure development, equipment needs evaluation, risk management)	_____	
TOTAL Department Supervision/Administration Hours	_____	

_____ _____
Signature Date

_____ _____
CEO Date

Bear Valley Community Healthcare District

June 30, 2021

Audit Presentation

JWT & Associates, LLP
Advisory Assurance Tax

Bear Valley Community Healthcare District
June 30, 2021

Financial Audit Results

> Received an unmodified opinion.

> There were no material weaknesses or significant deficiencies identified relating to the District's internal controls and there were no reportable findings.

> There were no audit adjustments. There were five LCEs as follows:
Late AP accruals $(398k)
Accrue IGT payments $1.7M
Workers' Comp audit adjustment $(63k)
Recognize PRF as income per portal reporting $3.3M
Cost Report adjustment $(3.0M)
Total impact on income was $1.5M increase

> There were no difficulties encountered with Management in performing our audit and we had no disputes or disagreements with management during the course of our audit.

> Significant accounting issues
> Hospital Fee Program Payments - IGT - $1M paid, $2.7M received, $1.7 net
> COVID-19 Supplemental Funding - $7.6M total, $2.7M PPP recognized, $3.3M PRF recognized $400k other recognized and $1.6M deferred/liability.

Bear Valley Community Healthcare District

Statement of Operations

	2021	2020	2019
Revenue:			
Net patient service revenue	26,865,766	26,813,843	28,820,063
Other operating revenue	4,562,891	4,478,336	2,113,456
District tax revenue	2,586,082	2,451,636	2,459,050
Other non-operating revenue	489,895	726,215	618,451
Total revenue	34,504,634	34,470,030	34,011,020
Expenses:			
Labor and benefits	15,842,495	14,592,109	14,019,751
Prof fees and purchased services	6,995,233	5,985,906	6,370,177
Supplies	2,274,933	1,928,906	1,686,895
Depreciation	1,176,528	1,050,652	966,722
IGT	1,036,253	1,504,841	1,485,984
All other	2,500,203	2,547,088	2,171,371
Total expenses	29,825,645	27,609,502	26,700,900
Net income (loss)	4,678,989	6,860,528	7,310,120
Net income margin	14%	20%	21%
Deductions from revenue %	49%	46%	46%
Labor and benefits as % of expenses	55%	56%	56%
Labor and benefits as % of net patient rev	59%	54%	49%
Supplies as % of net patient rev	8%	7%	6%

Bear Valley Community Healthcare District

Statement of Net Position

	2021	2020	Change
Assets:			
Cash and investments	40,479,963	37,923,810	2,556,153
Patient A/R net	3,173,391	2,318,898	854,493
Other receivables	248,508	140,340	108,168
Property and equipment	10,678,082	10,807,758	(129,676)
All other assets	976,157	636,226	339,931
Total assets	55,556,101	51,827,032	3,729,069
Liabilities:			
Accounts payable	1,485,394	1,106,889	378,505
Payroll and related accrual	862,992	905,115	(42,123)
Long-term debt	2,815,000	2,855,000	(40,000)
Settlements	5,063,441	3,397,468	1,665,973
Deferred revenue	1,607,677	4,519,952	(2,912,275)
Total liabilities	11,834,504	12,784,424	(949,920)
Net assets	43,721,597	39,042,608	4,678,989
Total liabilities and net assets	55,556,101	51,827,032	3,729,069
Current ratio	4.95	4.11	0.84
Debt service coverage	46.0	61.5	-15.5
Days cash on hand	537	554	-17
Days in A/R, net	43	32	11
Average pay period	46	39	7

Bear Valley Community Healthcare District

Comparisons and Benchmarks

	2020	2021	Peer Avg	Benchmark
Net income margin	20%	14%	15%	5%
Deductions from revenue %	46%	49%	52%	N/A
Labor and benefits as % of expenses	56%	55%	54%	55%
Labor and benefits as % of net patient rev	54%	59%	58%	60%
Supplies as % of net patient rev	7%	8%	9%	10%
Current ratio	4.11	4.95	5.61	1.50
Debt service coverage	61.5	46.0	15.4	1.50
Days cash on hand	554	537	136	90
Days in A/R	32	43	45	45
Average pay period	39	46	33	45

Report of Independent Auditors
and Financial Statements

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT

June 30, 2021 & 2020

JWT & Associates, LLP
Advisory Assurance Tax

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT

Audited Financial Statements

Table of Contents

JWT & Associates, LLP

Advisory Assurance Tax

1111 East Herndon, Suite 211, Fresno, California 93720
Voice: (559) 431-7708 Fax: (559) 431-7685

Report of Independent Auditors

The Board of Directors
Bear Valley Community Healthcare District
Big Bear Lake, California

Report on the Financial Statements

We have audited the accompanying financial statements of Bear Valley Community Healthcare District (the District) as of June 30, 2021 and 2020, which comprise the statements of net position as of June 30, 2021 and 2020, and the related statements of revenues, expenses and changes in net position, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with the accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America, the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States and in accordance with the State Controller's Minimum Audit Requirements for Special Districts. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the District at June 30, 2021 and 2020, and the results of its operations and its cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 3 through 14 be presented to supplement the financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic, or historical context We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated February 9, 2022, on our consideration of the District's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the District's internal control over financial reporting and compliance.

JWT & Associates, LLP

Fresno, California
February 9, 2022

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT

Management's Discussion and Analysis

June 30, 2021

The administration of the Bear Valley Community Healthcare District (the District) prepared the following Management Discussion and Analysis of the financial performance of the District for the fiscal year ended June 30, 2021 (FYE 2021) to accompany the financial statements prepared in accordance with the Governmental Accounting Standards Board Statement Numbers 34, 37 and 38. This discussion and the associated schedules are intended to provide an analysis, explanation, and historical basis of comparison for the reporting of financial results of the District for FYE 2021. The audited financial statements included herewith have been prepared and submitted with an unmodified opinion from the District's independent auditor.

Overview of the Bear Valley Community Healthcare District and its Financial Statements

This annual financial report consists of the audited financial statements included herewith and the associated notes to those statements that describe the District's combined financial position and results of operations for the FYE 2021. The audited financial statements of the District include the statement of net position, statement of revenues, expenses and changes in net position, and statement of cash flows.

- The statement of net position includes all of the District's assets and liabilities, using the accrual basis of accounting, as well as any indication as to which assets are intended for use to fund future capital asset expenditures or otherwise designated as to use by board of director policy.
- The Statement of Revenues, Expenses, and Changes in Net Position present the results of operating and non-operating activities during the fiscal year and the associated incomes.
- The Statement of Cash Flows reports the net cash provided by operating activities, as well as other sources and uses of cash from investing, non-capital financing activities, and capital and related financing activities.

Financial Highlights

				Change	
	2021	2020	2019	2021	2020
Current assets	$ 5,569,237	$ 6,932,236	$ 5,963,589	$ (1,362,999)	$ 968,647
Current liabilities	$ 9,059,504	$ 9,969,424	$ 5,477,074	$ (909,920)	$ 4,492,350
Investments	$ 39,135,702	$ 33,942,664	$ 25,298,992	$ 5,193,038	$ 8,643,672
Capital assets, net of depreciation	$ 10,678,081	$ 10,807,759	$ 8,644,372	$ (129,678)	$ 2,163,387
Long-term debt	$ 2,775,000	$ 2,815,000	$ 2,860,000	$ (40,000)	$ (45,000)
Total net position	$ 43,721,597	$ 39,042,608	$ 32,182,080	$ 4,678,989	$ 6,860,528
Excess of revenues over expenses	$ 5,715,242	$ 8,365,369	$ 8,796,104	$ (2,650,127)	$ (430,735)

CURRENT ASSETS

Current assets are cash or other assets that could reasonably be expected to be converted into cash in one year. Current assets decreased by $1,362,589 from last year. Net Patient Receivables increased by $854,493. Cash decreased by $2,636,884, but investments increased by $5,193,038. The table below also shows another significant increase in Investments.

Current Assets

				Change	
	2021	**2020**	**2019**	**2021**	**2020**
Current assets	**$ 5,569,237**	**$ 6,932,236**	**$ 5,963,589**	**$ (1,362,999)**	**$ 968,647**
Cash	1,344,262	3,981,146	2,406,940	(2,636,884)	1,574,207
Net patient receivables	3,173,391	2,318,898	2,885,934	854,493	(567,036)
Other Assets	219,802	140,340	127,266	79,462	13,074
Assets whose use is limited	-	-	-	-	-
Inventory	279,460	178,033	136,982	101,427	41,051
Prepaid expenses	552,322	313,818	406,467	238,504	(92,649)
Investments	$ 39,135,702	$ 33,942,664	$ 25,298,992	$ 5,193,038	$ 8,643,672

Cash and Investments

The District maintains sufficient cash balances to pay its short-term liabilities. Excess funds are invested with the Local Agency Investment Fund (LAIF) to ensure protection of amounts invested. LAIF is a voluntary fund created by statute in 1977 as an investment alternative for California's local governments and special districts.

During the year, our investments grew by $5,193,038 bringing the total to $39,135,702.

For the year ending June 30, 2021, the District's cash and investments increased by $2,556,154. Total days cash on hand decreased from 558 to 539. See audited financial statements for additional information. Days Cash on Hand remains strong.

Cash and Investments

				Change	
	2021	**2020**	**2019**	**2021**	**2020**
Cash and cash equivalents	$ 1,344,262	$ 3,981,146	$ 2,406,940	$ (2,636,884)	$ 1,574,206
Assets whose use is limited	$ 144,375	$ 144,375	$ 144,375	-	-
Investments	39,135,702	33,942,664	25,298,992	5,193,038	8,643,672
Total cash and investments	$ 40,624,339	$ 38,068,185	$ 27,850,307	$ 2,556,154	$ 10,217,878
Days cash on hand	539	558	421	-19	137

Net Patient Accounts Receivables

Net patient accounts receivables at June 30, 2021, as compared to June 30, 2020, were higher by $854,493. Management and staff continue to work with our Accounts Receivable Management company (outsourced Patient Financial Services / Billing functions) to reduce Accounts Receivable and Accounts Receivable Days.

				Change	
	2021	2020	2019	2021	2020
Net patient receivables	3,173,391	2,318,898	2,885,934	854,493	(567,036)

Inventory

Inventory increased by $101,427. This is due to increased costs and added supplies in response to the pandemic

				Change	
	2021	2020	2019	2021	2020
Inventory	$ 279,460	$ 178,033	$ 136,982	$ 101,427	$ 41,051

CAPITAL ASSETS

Capital assets are long term assets such as buildings, improvements, and equipment with a purchase cost of $5,000 or more and a useful life greater than one year. Items costing less than $5,000 are expensed as minor equipment.

Capital assets, net of accumulated depreciation, decreased $129,678 as of June 30, 2021, over the prior year balance.

Capital Assets

				Change	
	2021	2020	2019	2021	2020
Property and equipment	$ 27,480,692	$ 26,433,841	$ 23,219,802	$ 1,046,851	$ 3,214,039
Less: accumulated depreciation	(16,802,611)	(15,626,082)	(14,575,430)	(1,176,529)	(1,050,652)
	$ 10,678,081	$ 10,807,759	$ 8,644,372	$ (129,678)	$ 2,163,387

Property and equipment increased $1,046,851 during FYE 2021. We continue to closely monitor capital expenditures. Notable expenditures in FY 2021 included – expenditures in Surgery Department (sterilizers, scopes and processors, shoulder instrument set, and phaco equipment for cataract surgeries), Respiratory Department (EKG machines, program for fit testing N95 masks, and BIPAP machine), Physical Therapy (replace air handling / HVAC system and upgrade laser), Purchasing Department (new shelving system for store room), and Information Technology (refresh Nutanix servers).

CURRENT LIABILITIES

Current liabilities are short-term debts due in less than one year. At June 30, 2021, current liabilities decreased by $909,920. Unearned Income decreased with recognition of CARES Acts funding.

Current Liabilities

				Change	
	2021	2020	2019	2021	2020
Current Liabilities	**$ 9,059,504**	**$ 9,969,424**	**$ 5,477,074**	**$ (909,920)**	**$ 4,492,350**
Current portion of long term debt	40,000	40,000	35,000	-	5,000
Accounts payable	1,485,394	1,106,890	913,724	378,504	193,166
Unearned Income	1,607,677	4,519,952	-	(2,912,275)	4,519,952
Accrued compensation	862,992	905,115	758,370	(42,123)	146,745
Third-party payor settlements	5,063,441	3,397,468	3,769,980	1,665,973	(372,512)

Accounts Payable

Accounts payable increased by $378,504 with accruing expenses in stocking up on supplies related to preparing for ongoing impacts of the pandemic. Days in Accounts Payable increased from 39.1 to 46.4

Third party settlements

The estimate for third party settlements are higher by $1,665,973 at June 30, 2021, as compared to the prior year-end. During the year we recorded settlements from prior year Cost Reports.

Both the Medicare and Medi-Cal program administrative procedures preclude final determination of amounts due to/from the District until the cost reports are audited and settled. Administration is of the opinion that no significant adverse adjustment to the recorded settlement amounts will be required upon final settlement.

PATIENT REVENUE AND DEDUCTIONS FROM REVENUE

Under antitrust statues, hospitals are required to charge all patients the same price for a given level of service. Accordingly, the District charges all patients uniformly based on its established charge description master (CDM) pricing structure for the services rendered. In addition, all California hospitals are required to annually file an electronic version of their CDM, also known as the "charge master", with the Office of Statewide Health Planning (OSHPD). The district complies with the OSHPD filing requirement; therefore, an electronic version of the CDM is available from the OSHPD website. As of January 2020, we complied with the requirement to post Charge Master on our Website.

Gross patient revenue for FYE 2021 increased over the previous fiscal year by $3,508,158 or 7.0%. Inpatient Revenue saw a $1,487,764 increase with more than double the number of patient days compared to the previous year. Outpatient Revenue (which includes Emergency Department and Clinics) saw a 4.7% increase. Emergency Department visits were lower than the prior year, but acuity and therefore revenue was higher. Clinic visits were 11.8% lower.

				Change			
	2021	2020	2019	2021		2020	
Gross Patient Charges							
Inpatient	$ 2,813,268	$ 1,325,504	$ 1,818,132	$ 1,487,764	112.2%	$ (492,627)	-27.1%
Outpatient	48,483,914	46,300,075	49,011,430	2,183,840	4.7%	(2,711,356)	-5.5%
Skilled Nursing Facility	2,115,752	2,279,197	2,581,707	(163,445)	-7.2%	(302,510)	-11.7%
Total gross revenue	$ 53,412,934	$ 49,904,776	$ 53,411,269	$ 3,508,158	7.0%	$ (3,506,493)	-6.6%
Acute Inpatient Census Statistics							
Staffed beds 5							
Patient days	722	229	345	493	215.3%	(116)	-33.6%
Days in the year	365	366	365	(1)	-0.3%	1	0.3%
Average Daily Census	2.0	0.6	0.9	1.4	216.1%	(0.3)	-33.8%
Discharges	128	84	124	44	52.4%	(40)	-32.3%
Average Length of Stay	5.6	2.7	2.8	2.9	107.4%	(0.1)	-3.6%
Swing Inpatient Census Statistics							
Staffed beds 5							
Patient days	218	270	185	(52)	-19.3%	85	45.9%
Days in the year	365	366	365	(1)	-0.3%	1	0.3%
Average Daily Census	0.6	0.7	0.5	(0.1)	-19.0%	0.2	45.5%
Discharges	8	16	14	(8)	-50.0%	2	14.3%
Average Length of Stay	27.3	16.9	13.2	10.4	61.5%	3.7	28.0%
Skilled Nursing Facility Census Statistics							
Staffed beds 21							
Patient days	4,747	5,125	5,776	(378)	-7.4%	(651)	-11.3%
Average Daily Census	13.0	14.0	15.8	(1.0)	-7.1%	(1.8)	-11.5%
Discharges	11	26	13	(15)	-57.7%	13	100.0%
Emergency Department Visits	10,476	10,879	11,849	(403)	-3.7%	(970)	-8.2%
Clinic Visits	21,766	24,667	25,360	(2,901)	-11.8%	(693)	-2.7%

Deductions from Revenue

A contractual adjustment is the difference between gross charges and a contractually agreed-upon payment rate with third-party payors. Typically, third-party payors are 1) government programs such as Medicare and Medi-Cal; 2) Independent Practice Associations (IPA) such as Heritage Victor Valley Medical Group, which are often referred to as "gatekeeper physicians", and 3) other third-party payors or Preferred Provider Organizations (PPO) networks, which generally include insurance carriers such as Blue Cross, Blue Shield, Health Net, Aetna, etc.

Contractual adjustments are accrual-based on estimates derived from historical reimbursement experience using remittance advices by payor and by type of account (inpatient, outpatient, or clinic), adjusted for known exposures, such as payment denials, and are used to reduce the gross charges to the expected realizable value.

Contractual adjustments as a percentage of gross patient charges, excluding prior year third-party settlement adjustments, were 45.3% for FYE 2021 compared to 47.8% for FYE 2020.

FY 2014 was our first year as a Critical Access Hospital (CAH). We continue to review CAH status and impacts each year.

Additionally, deductions from revenue include other uncompensated care categories such as Charity Care, Administrative Adjustments, Patient Discounts (principally discounts offered to uninsured or private pay patients who do not qualify for financial assistance) and Employee Discounts. Effective January 1, 2007, the California State Assembly passed AB 774, which requires all hospitals in California to follow a specific state-mandated means testing process to determine if a patient qualifies for financial assistance. The charity care can range from a full write-off to a partial write-off of the patient's outstanding balance. Furthermore, OSHPD requires every hospital to file an electronic copy of its financial assistance policy. As of June 30, 2020, the District is in compliance with the financial assistance policy reporting requirement.

Total deductions from revenue, including the provision for bad debts, as a percent of gross patient revenue, was 48.9% for FYE 2021 versus 44.0% for FYE 2020.

	2021	2020	Change 2021
Deductions from Revenue			
Contractual adjustments	$ 24,174,850	$ 23,829,918	$ 344,932
Prior year contractual allowances	(1,270,368)	(4,048,687)	$ 2,778,319
Charity Care	238,369	190,034	$ 48,335
Administrative	113,820	127,530	$ (13,710)
Patient discount	180,914	183,000	$ (2,086)
Employee discount	116,899	55,643	$ 61,256
Bad Debts	2,577,364	1,619,494	$ 957,870
	$ 26,131,848	$ 21,956,932	
Deductions from Revenue as a percent of gross revenue			
Contractual adjustments	45.3%	47.8%	-2.5%
Prior year contractual allowances	-2.4%	-8.1%	5.7%
Charity Care	0.4%	0.4%	0.1%
Administrative	0.2%	0.3%	0.0%
Patient discount	0.3%	0.4%	0.0%
Employee discount	0.2%	0.1%	0.1%
Bad Debts	4.8%	3.2%	1.6%
Total	48.9%	44.0%	4.9%

Provision for Bad Debts / Allowance for Doubtful Accounts

The provision for bad debts or Allowance for Doubtful Accounts increased for FYE 2021, as compared to the previous fiscal year. As a percent of gross revenue, bad debts were 5.0% for the current fiscal in comparison to 3.2% for the prior year.

Allowance for Doubtful Accounts

	2021	2020	2019	Change 2021	Change 2020
Bad debt expense	$ 2,694,660	$ 1,619,494	$ 3,247,995	$ 1,075,166	$(1,628,501)
Bad debt expense as a percent of gross revenue	5.0%	3.2%	6.1%	1.8%	-2.8%

Net Patient Revenue

Net patient revenue is the difference between gross patient charges and revenue deductions. For FYE June 30, 2021, net patient services revenues decreased $666,756 or 2.4% lower than the previous fiscal year. Net patient revenue decreased due to decreases in volume in Outpatient (Emergency Room and Clinics revenues), and Skilled Nursing Facility.

Net Patient Revenue

	2021	2020	2019	Change 2021	Change 2020
Net patient service revenue	$ 27,281,086	$ 27,947,842	$ 28,820,063	$ (666,756)	$ (872,221)
				-2.4%	-3.0%

OPERATING EXPENSES

Total operating expenses in FYE 2021 were $28,700,153 as compared to $26,014,646 for FYE 2020, an increase of 10.3%.

Salaries, Wages, and Benefits (which comprised just over 55% of Total Operating Expenses) increased by 8.6%. We also saw an increase in Purchased Services with additional expenses related to the pandemic. Supply expense increased by 24.1% due to increases in cost and increased usage due to the pandemic.

	2021		2020		2019		Change 2021	Change 2020
Salaries and wages	$ 13,249,079	46.2%	$ 11,947,584	45.9%	$ 11,556,253	46.0%	$ 1,301,495	$ 391,331
Employee benefits	2,593,416	9.0%	2,644,525	10.2%	2,463,498	9.8%	(51,109)	181,027
Total salaries and benefits	15,842,495	55.2%	14,592,109	56.1%	14,019,751	55.8%	1,250,386	572,358
Professional fees	2,750,523	9.6%	2,081,288	8.0%	2,267,800	9.0%	669,235	(186,512)
Purchased services	4,244,710	14.8%	3,904,618	15.0%	4,102,377	16.3%	340,092	(197,759)
Supplies	2,274,933	7.9%	1,928,906	7.4%	1,686,895	6.7%	346,027	242,011
Repairs and maintenance	669,264	2.2%	719,957	2.7%	354,161	1.3%	(50,693)	365,796
Utilities	498,793	1.7%	526,889	2.0%	579,035	2.3%	(28,096)	(52,146)
Rentals and leases	353,969	1.2%	195,712	0.8%	136,381	0.5%	158,257	59,331
Depreciation and amortization	1,176,528	4.1%	1,050,652	4.0%	966,722	3.8%	125,876	83,930
Insurance	451,421	1.6%	381,178	1.5%	341,365	1.4%	70,243	39,813
Other operating expenses	437,517	1.5%	633,338	2.4%	669,198	2.7%	(195,821)	(35,860)
Total Operating Expenses	$ 28,700,153	100%	$ 26,014,646	100%	$ 25,123,685	100%	$ 2,685,507	$ 890,961
							10.3%	3.5%

Supply Costs

Supply costs as a percentage of gross revenue increased from 3.9% in FYE 2020 to 4.3% in FYE 2021. As previously noted Supply costs have increased with pricing and usage. Management continues to work with our group purchasing organization (GPO), HealthTrust Purchasing Group (HPG), to identify opportunities for supply cost reductions.

	2021	2020	2019	Change 2021	Change 2020
Supply costs	2,274,933	1,928,906	1,686,895	$ 346,027	$ 242,011
Supply costs as a percent of gross revenue	4.3%	3.9%	3.2%	0.4%	0.7%

FISCAL YEAR 2022 BUDGET AND ECONOMIC FACTORS

The District's Board of Directors approved the Budget for FYE ending June 30, 2022 (FY 2022) at a general board meeting. The financial plan for FYE 2022, compared to projected results during the budget process, included a increase in Gross Revenue due to volume projections (but no rate increase in charges) and an increase in Net Revenue. Operating Expense is budgeted to increase by 1.4%. The net result is a budgeted Surplus of $3,123,946.

Capital expenditure plans for FY 2022 include continuing to add and upgrade some surgery equipment, increase Respiratory Therapy equipment, building repairs and upgrades, and ongoing upgrades of computers and computer software.

Current and future favorable operations are helped by the continuation of a parcel tax assessed on property located in the Big Bear Valley area and an allocation of county tax revenue. During FYE 2021, the District received $2,586,082 in such tax revenue. The projected tax revenue for FYE 2022 is $2,450,000.

BUSINESS STRATEGIES

In May 2014, the District converted to Critical Access Hospital (CAH) status. Our Analysis after filing FYE 2019 Cost Report showed a favorable impact of $996,840 for the year from CAH status as compared to payments we would have received as a PPS (Prospective Payment System) Hospital. FY 2018 favorable impact was $1,094,823.

Revenue cycle management and cost containment strategies

Administration is continuing its efforts to improve the revenue cycle process by monitoring provider contract administration, accounts receivable through our Accounts Receivable Management agreement, and working with QHR Health (Management Company) consultants.

Also, administration will continue to work to monitor and lower operating expenses as possible to improve the net operating margin.

Status of Regulatory Requirements

- The District is in compliance with applicable state and federal regulations.
- The facility was reclassified as SPC-2 under HAZUS to comply with Senate Bill (SB) 1953.

Administration is working to meet the SB 1953 deadline under NPC-3 performance levels that requires healthcare institutions to be in compliance by the year 2030. Accordingly, the objective is to identify the full extent of equipment and non-structural items that must meet NPC-3 anchorage requirement. Once a plan is established develop a timetable to ensure compliance with NPC-3 performance level as quickly as possible. We continue to focus on operations to improve cash flow to have funds to pay toward such a costly undertaking.

- On January 1, 2007, Assembly Bill (AB) 774 Charity Care and Discount Payment law was effective. The District implemented and updated its charity and discount payment policy to conform to the requirements of AB 774. Additionally, in 2008 all acute care hospitals were required to file electronically their Charity Care and Discount Payment Policy with OSHPD. The District is in compliance with OSHPD policy.
- Administration reviewed the charge description master (CDM), updated it as necessary, and as required filed the electronic CDM with OSHPD.
- The State of California had proposed a reduction in the Distinct-Part Skilled Nursing Facility (DP/SNF) reimbursement rate to 90% of the 2008-2009 level in AB 97, with a caveat to apply this reduction retroactively with a "clawback" demand for repayment. The Department of Health Care Services (DHCS) did announce in August 2013 that rural DP/SNFs would be exempted from this rate reduction. The clawback provision was eliminated during FYE 2016.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Beginning in 2002, the District began an effort to comply with the Health Insurance Portability and Accountability Act (HIPAA) enacted by the federal government. Required steps to comply with provisions of the Act have been put into place within the periods specified therein. Upgrades to our patient information system have already been installed to meet the security requirements. The information system infrastructure will continue to be reviewed throughout the stages of HIPAA enforcement to ensure continued compliance. The employees of the District continue to be educated in the privacy requirements of the Act. Organizations are subject to significant fines and penalties if found not to be compliant with the provisions outlined in the regulations. Moreover, the state of California passed a law requiring additional state requirements regarding patient confidentiality. The District complies with the HIPAA and the new California law.

ELECTRONIC HEALTH RECORD (EHR)

In 2009, the American Recovery and Reinvestment Act (ARRA) was signed into law. The Health Information Technology Economic and Clinical Health (HITECH) Act is part of the ARRA. The HITECH Act created the Medicare and Medicaid (Medi-Cal in California) EHR incentive programs, which will provide incentive payments to eligible professionals and hospitals that adopt and demonstrate Meaningful Use (MU) of certified EHR technology. These incentives are considered to be of high strategic importance by virtually all healthcare organizations in the United States to further the federal government's goal of achieving health care reform and improvement of clinical outcomes for the population. The District implemented its electronic medical records system effective April 1, 2013 and attested that it has achieved MU as of October 2013. We continue to meet the requirements of MU.

ACCOUNTABLE CARE ACT (ACA)

The future of the ACA still seems to be uncertain. National election results and claims to revise or even repeal come on the heels of uncertainty of what will happen with the Healthcare Exchanges in light of likely high increase in premium cost and some carriers no longer being willing to offer coverage in certain locations. Congressional efforts to repeal or repair or replace the ACA have not been successful. Major healthcare reform could have a huge impact on California and Bear Valley Community Healthcare District.

Bear Valley Community Healthcare District

Statements of Net Position

June 30, 2021 and 2020

	2021	2020
Assets		
Current Assets		
Cash and cash equivalents	$ 40,479,963	$ 37,923,810
Patient accounts receivable, net of allownaces	3,173,391	2,318,898
Other receivables and physician advances	248,508	140,340
Assets whose use is limited	144,375	144,375
Supplies	279,460	178,033
Prepaid expenses and deposits	552,322	313,818
Total current assets	44,878,019	41,019,274
Capital assets, net of accumulated depreciation	10,678,082	10,807,758
Total assets	$ 55,556,101	$ 51,827,032
Liabilities and Net Position		
Current liabilities		
Current portion of long-term debt	$ 40,000	$ 40,000
Accounts payable and accrued expenses	1,485,394	1,106,889
Accrued payroll and related liabilities	862,992	905,115
Third-party payor settlements	5,063,441	3,397,468
Deferred revenue	1,607,677	4,519,952
Total current liabilities	9,059,504	9,969,424
Long-term debt, less current portion	2,775,000	2,815,000
Total liabilities	11,834,504	12,784,424
Net position		
Invested in capital assets, net of related debt	7,863,082	7,952,758
Unrestricted	35,858,515	31,089,850
Total net position	43,721,597	39,042,608
Total liabilities and net position	$ 55,556,101	$ 51,827,032

See accompanying notes to the financial statements

Bear Valley Community Healthcare District

Statements of Revenues, Expenses and Changes in Net position

For The Years Ended June 30, 2021 and 2020

	2021	2020
Operating revenues		
Net patient service revenue	$ 26,865,766	$ 26,813,843
Other operating revenue	4,562,891	4,478,336
Total operating revenues	31,428,657	31,292,179
Operating expenses		
Salaries & wages	13,249,079	11,947,584
Employee benefits	2,593,416	2,644,525
Professional Fees	2,750,523	2,081,288
Purchased services	4,244,710	3,904,618
Supplies	2,274,933	1,928,906
Repairs & maintenance	669,264	719,957
Utilities	498,793	526,889
Rentals and leases	353,969	195,712
Depreciation & amortization	1,176,528	1,050,652
Insurance	451,421	381,178
Other operating expenses	437,517	633,338
Total operating expenses	28,700,153	26,014,647
Operating income (loss)	2,728,504	5,277,532
Nonoperating revenues (expenses)		
District tax revenues	2,586,082	2,451,636
Capital grants and donations	279,951	176,652
Investment income	209,944	549,563
Interest expense	(89,239)	(90,014)
Total nonoperating revenues (expenses)	2,986,738	3,087,837
Excess of revenues (expenses)	5,715,242	8,365,369
Inter-governmental transfers	(1,036,253)	(1,504,841)
Increase in net position	4,678,989	6,860,528
Net position, beginning of the year	39,042,608	32,182,080
Net position, end of year	$ 43,721,597	$ 39,042,608

See accompanying notes to the financial statements

Bear Valley Community Healthcare District

Statements of Cash Flows

For The Years Ended June 30, 2021 and 2020

	2021	2020
Cash flows from operating activities		
Cash received from patients and third-party payers	$ 27,677,246	$ 27,467,255
Other receipts	1,542,448	9,035,250
Cash payments to suppliers and contractors	(11,642,556)	(10,144,685)
Cash payments to employees and benefit programs	(15,884,618)	(14,468,899)
Net cash provided by operating activities	1,692,520	11,888,921
Cash flows from non-capital and related financing activities		
District tax revenue	2,586,082	2,451,636
Net cash provided by non-capital and related financing activities	2,586,082	2,451,636
Cash flows from capital and related financing activities		
Purchase of property, plant & equipment	(1,046,852)	(3,214,038)
Capital grants and contributions	279,951	176,652
Payments of long-term debt	(40,000)	(40,000)
Interest paid on capital debt	(89,239)	(90,014)
Net cash used in capital and related financing activities	(896,140)	(3,167,400)
Cash flows from investing activities		
Inter-governmental transfers	(1,036,253)	(1,504,841)
Investment income	209,944	549,563
Net cash used in investing activities	(826,309)	(955,278)
Increase in cash and cash equivalents	2,556,153	10,217,879
Cash and cash equivalents at beginning of year	37,923,810	27,705,931
Cash and cash equivalents at end of year	$ 40,479,963	$ 37,923,810

See accompanying notes to the financial statements

Bear Valley Community Healthcare District

Statements of Cash Flows (continued)

For The Years Ended June 30, 2021 and 2020

	2021	2020
Reconciliation of operating income (loss) to net cash provided by operating activities		
Operating income	$ 2,728,504	$ 5,277,532
Adjustments to reconcile operating income to net cash provided by operating activities		
Depreciation	1,176,528	1,050,652
Changes in operating assets and liabilities		
Patient accounts receivable	(854,493)	567,036
Other receivables	(108,168)	36,962
Supplies	(101,427)	(41,051)
Prepaid expenses	(238,504)	91,176
Accounts payable and accrued expenses	378,505	177,076
Accrued payroll and related expenses	(42,123)	123,210
Deferred revenue	(2,912,275)	4,519,952
Third-party payor settlements	1,665,973	86,376
Net cash provided by operating activities	$ 1,692,520	$ 11,888,921

See accompanying notes to the financial statements

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES

Reporting Entity: Bear Valley Community Health Care District (the District) is a public entity organized under Local Hospital District Law as set forth in the Health and Safety Code of the State of California. The District operates a hospital, Bear Valley Community Hospital (the Hospital), for the community of Big Bear Lake and the surrounding area. The Hospital is a 30-bed facility that provides general acute and skilled nursing care. As a political subdivision of the State of California, the District is generally not subject to federal or state income taxes.

Basis of Preparation: The accounting policies and financial statements of the District generally conform with the recommendations of the audit and accounting guide, *Health Care Organizations*, published by the American Institute of Certified Public Accountants. The financial statements are presented in accordance with the pronouncements of the Governmental Accounting Standards Board (GASB). For purposes of presentation, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operational revenues and expenses.

The District uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. Based on GASB Statement Number 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, as amended, the District has elected to apply the provisions of all relevant pronouncements as the Financial Accounting Standards Board (FASB), including those issued after November 30, 1989, that do not conflict with or contradict GASB pronouncements.

Financial Statement Presentation: The District applies the provisions of GASB 34, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments* (Statement 34), as amended by GASB 37, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments: Omnibus*, and Statement 38, *Certain Financial Statement Note Disclosures*. Statement 34 established financial reporting standards for all state and local governments and related entities. Statement 34 primarily relates to presentation and disclosure requirements. The impact of this change was related to the format of the financial statements; the inclusion of management's discussion and analysis; and the preparation of the statement of cash flows on the direct method. The application of these accounting standards had no impact on the total net position.

Management's Discussion and Analysis: Statement 34 requires that financial statements be accompanied by a narrative introduction and analytical overview of the District's financial activities in the form of "management's discussion and analysis" (MD&A). This analysis is similar to the analysis provided in the annual reports of organizations in the private sector.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Use of Estimates: The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amount of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents and Investments: The District considers cash and cash equivalents to include certain investments in highly liquid debt instruments, when present, with an original maturity of a short-term nature or subject to withdrawal upon request. Exceptions are for those investments which are intended to be continuously invested. Investments in debt securities are reported at market value. Interest, dividends and both unrealized and realized gains and losses on investments are included as investment income in non-operating revenues when earned.

Patient Accounts Receivable: Patient accounts receivable consist of amounts owed by various governmental agencies, insurance companies and private patients. The District manages its receivables by regularly reviewing the accounts, inquiring with respective payors as to collectability and providing for allowances on their accounting records for estimated contractual adjustments and uncollectible accounts. Significant concentrations of patient accounts receivable are discussed further in the footnotes.

Supplies: Inventories are consistently reported from year to year at cost determined by average costs and replacement values which are not in excess of market. The District does not maintain levels of inventory values such as those under a first-in, first out or last-in, first out method.

Assets Limited as to Use: Assets limited as to use include amounts designated by the Board of Directors for replacement or purchases of capital assets and other specific purposes. Assets limited as to use consist of money market accounts on hand with banking institutions.

Capital Assets: Capital assets consist of property and equipment and are reported on the basis of cost, or in the case of donated items, on the basis of fair market value at the date of donation. Routine maintenance and repairs are charged to expense as incurred. Expenditures which increase values, change capacities, or extend useful lives are capitalized. Depreciation of property and equipment and amortization of property under capital leases are computed by the straight-line method for both financial reporting and cost reimbursement purposes over the estimated useful lives of the assets, which range from 10 to 30 years for buildings and improvements, and 3 to 10 years for equipment. The District periodically reviews its capital assets for value impairment. As of June 30, 2021, and 2020, the District has determined that no capital assets are impaired.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Compensated Absences: The employees of the District earn paid time off ("PTO") benefits at varying rates. The rate is determined based on their years of service. This PTO benefit can accumulate up to specified maximum levels. Employees may use their accumulated PTO for vacation, holidays and sick leave. Accumulated PTO benefits are paid to an employee upon either termination or retirement. Accrued PTO liabilities as of June 30, 2021, and 2020 are $592,293 and $628,015, respectively.

Risk Management: The District is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and medical malpractice. Commercial insurance coverage is purchased for claims arising from such matters.

Net Position: Net position (formally net assets) is presented in three categories. The first category is net position "invested in capital assets, net of related debt". This category of net position consists of capital assets (both restricted and unrestricted), net of accumulated depreciation and reduced by the outstanding principal balances of any debt borrowings that were attributable to the acquisition, construction, or improvement of those capital assets.

The second category is "restricted" net position. This category consists of externally designated constraints placed on assets by creditors (such as through debt covenants), grantors, contributors, law or regulations of other governments or government agencies, or law or constitutional provisions or enabling legislation.

The third category is "unrestricted" net position. This category consists of net assets that do not meet the definition or criteria of the previous two categories.

Net Patient Service Revenues: Net patient service revenues are reported in the period at the estimated net realized amounts from patients, third-party payors and others including estimated retroactive adjustments under reimbursement agreements with third-party programs. Normal estimation differences between final reimbursement and amounts accrued in previous years are reported as adjustments of current year's net patient service revenues.

Charity Care: The District accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies of the District. Essentially, these policies define charity services as those services for which no payment is anticipated. Because the District does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenues. Services provided are recorded as gross patient service revenues and then written off entirely as an adjustment to net patient service revenues.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

District Tax Revenues: The District receives financial support from property taxes. These funds are used to support operations. They are classified as non-operating revenue as the revenue is not directly linked to patient care. Property taxes are levied by the County on the Hospital's behalf during the year, and are intended to help finance the District's activities during the same year. Amounts are levied on the basis of the most current property values on record with the County. The County has established certain dates to levy, lien, mail bills, and receive payments from property owners during the year. Property taxes are considered delinquent on the day following each payment due date. The District received tax revenue totaling $2,586,082 and $2,451,636 for the years ended June 30, 2021 and 2020, respectively. Property tax revenues accounted for 7.5% and 7.1% of the District's total revenues for the years ended June 30, 2021 and 2020, respectively.

Grants and Contributions: From time to time, the District receives grants from various governmental agencies and private organizations. The District also receives contributions from related foundation and auxiliary organizations, as well as from individuals and other private organizations. Revenues from grants and contributions are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or capital acquisitions. These amounts, when recognized upon meeting all requirements, are reported as components of the statement of revenues, expenses and changes in net assets.

Operating Revenues and Expenses: The District's statement of revenues, expenses and changes in net position distinguishes between operating and non-operating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services, which is the District's principal activity. Operating expenses are all expenses incurred to provide health care services, other than financing costs. Non-operating revenues and expenses are those transactions not considered directly linked to providing health care services.

***Subsequent events*:** Subsequent events have been evaluated through the date of the Independent Auditor's Report, which is the date the financial statements were available to be issued.

Reclassifications: Certain financial statement amounts as presented in the prior year financial statements have been reclassified in these, the current year financial statements, in order to conform to the current year financial statement presentation.

NOTE 2 – CASH AND CASH EQUIVALENTS

As of June 30, 2021 and 2020, the District had deposits invested in various financial institutions in the form of cash and cash equivalents amounting to $40,621,738 and $38,065,585. All of these funds were held in deposits, which are collateralized in accordance with the California Government Code (CGC), except for $250,000 per account that is federally insured.

NOTE 2 – CASH AND CASH EQUIVALENTS (continued)

Under the provisions of the CGC, California banks and savings and loan associations are required to secure the District's deposits by pledging government securities as collateral. The market value of pledged securities must equal at least 110% of the District's deposits. California law also allows financial institutions to secure Hospital deposits by pledging first trust deed mortgage notes having a value of 150% of the District's total deposits. The pledged securities are held by the pledging financial institution's trust department in the name of the District.

Investments consist of U.S. Government securities and state and local agency funds invested in U. S. Government securities and are stated at quoted market values. Changes in market value between years are reflected as a component of investment income in the accompanying statement of revenues, expenses and changes in net assets.

NOTE 3 - NET PATIENT SERVICE REVENUES AND REIMBURSEMENT PROGRAMS

The District renders services to patients under contractual arrangements with the Medicare and Medi-Cal programs, health maintenance organizations (HMOs), preferred provider organizations (PPOs) and other insurance programs. Patient service revenues from these programs approximate 95% of gross patient service revenues.

The Medicare Program reimburses the District on a cost basis payment system for inpatient and outpatient hospital services. The cost-based reimbursement is determined based on filed Medicare cost reports. Skilled nursing services are reimbursed on a predetermined amount based on the Medicare rates for the services.

The District contracts to provide services to Medi-Cal, HMO and PPO inpatients on negotiated rates. Certain outpatient reimbursement is subject to a schedule of maximum allowable charges for Medi-Cal and to a percentage discount for HMOs and PPOs. The skilled nursing facility (SNF) is reimbursed by the Medi-Cal program on a prospective per diem basis subject to audit by the state. The results of the state audits are incorporated prospectively and are subject to appeal by the provider.

Both the Medicare and Medi-Cal program's administrative procedures preclude final determination of amounts due to the District for services to program patients until after patients' medical records are reviewed and cost reports are audited or otherwise reviewed by and settled with the respective administrative agencies. The Medicare and Medi-Cal cost reports are subject to audit and possible adjustment. Management is of the opinion that no significant adverse adjustment to the recorded settlement amounts will be required upon final settlement.

NOTE 3 - NET PATIENT SERVICE REVENUES AND REIMBURSEMENT PROGRAMS (continued)

Medicare and Medi-Cal revenue accounts for approximately 26% and 39% of the District's net patient revenues for the years ended June 30, 2021 and 2020, respectively. Laws and regulations governing the Medicare and Medi-Cal programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

NOTE 4 - INVESTMENTS

The District's investment balances, and average maturities were as follows at June 30, 2021 and 2020:

2021		Investment Maturities in Years		
	Fair Value	Less than 1	1 to 5	Over 5
Government investment funds	$ 39,135,702	$ 39,135,702	$ -	$ -
Total investments	$ 39,135,702	$ 39,135,702	$ -	$ -

2020		Investment Maturities in Years		
	Fair Value	Less than 1	1 to 5	Over 5
Government investment funds	$ 33,942,664	$ 33,942,664	$ -	$ -
Total investments	$ 33,942,664	$ 33,942,664	$ -	$ -

The District's investments are reported at fair value as previously discussed. The District's investment policy allows for various forms of investments generally set to mature within a few months to others over 15 years. The policy identifies certain provisions which address interest rate risk, credit risk and concentration of credit risk. Currently all investments have a maturity of less than one year.

Interest income, dividends, and both realized and unrealized gains and losses on investments are recorded as investment income. These amounts were $209,944 and $549,563 for the years ended June 30, 2021 and 2020, respectively. Total investment income includes both income from operating cash and cash equivalents and cash and cash equivalents related to assets limited as to use. Debt securities, when present, are recorded at market price or the fair market value as of the date of each balance sheet.

NOTE 4 – INVESTMENTS (continued)

Interest Rate Risk: Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment the greater the sensitivity of its fair value to changes in market interest rates. The District's exposure to interest rate risk is minimal as 100% of their investments have a maturity of less than one year. Information about the sensitivity of the fair values of the District's investments to market interest rate fluctuations is provided by the preceding schedules that shows the distribution of the District's investments by maturity.

Credit Risk: Credit risk is the risk that the issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of a rating by a nationally recognized statistical rating organization, such as Moody's Investor Service, Inc. The District's investments in such obligations are in government investment funds. The District believes that there is minimal credit risk with these obligations at this time.

Custodial Credit Risk: Custodial credit risk is the risk that, in the event of the failure of the counterparty (e.g. broker-dealer), the District will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The District's investments are generally held by banks or government agencies. The District believes that there is minimal custodial credit risk with their investments at this time. District management monitors the entities which hold the various investments to ensure they remain in good standing.

Concentration of Credit Risk: Concentration of credit risk is the risk of loss attributed to the magnitude of the District's investment in a single issuer. The District's investments are held as follows: governmental agencies 100%. The District believes that there is minimal custodial credit risk with their investments at this time. District management monitors the entities which hold the various investments to ensure they remain in good standing.

NOTE 5 - ASSETS LIMITED AS TO USE

Assets limited as to use as of June 30, 2021 were comprised of cash held in a Debt Service Reserve Fund as required by the terms of a sale and leaseback agreement entered into by the District in January 2016. Under the agreement the District was initially required to make annual payments into the Debt Service Reserve Fund equal to $1/10^{th}$ of the current annual lease payment. The District established this fund accordingly and at June 30, 2021 the balance totaled $144,375. See Note 9.

NOTE 6 - CONCENTRATION OF CREDIT RISK

The District grants credit without collateral to its patients and third-party payors. Patient accounts receivable from government agencies represent the only concentrated group of credit risk for the District and management does not believe that there is any credit risk associated with these governmental agencies. Contracted and other patient accounts receivable consist of various payors including individuals involved in diverse activities, subject to differing economic conditions and do not represent any concentrated credit risks to the District. Concentration of patient accounts receivable at June 30, 2021 and 2020 were as follows:

	2021	2020
Medicare	$ 905,651	$ 843,088
Medi-Cal and Medi-Cal pending	2,567,360	2,548,461
Other third party payors	3,040,192	2,842,165
Self pay and other	2,521,153	1,846,208
Gross patient accounts receivable	9,034,356	8,079,922
Less allowances for contractual adjustments and bad debts	(5,860,965)	(5,761,024)
Net patient accounts receivable	$ 3,173,391	$ 2,318,898

NOTE 7 - OTHER RECEIVABLES

Other receivables as of June 30, 2021 and 2020 were comprised of the following:

	2021	2020
Grants	$ 183,267	$ 69,401
Physician advance	9,722	18,333
District tax revenue	55,519	52,606
	$ 248,508	$ 140,340

NOTE 8 - CAPITAL ASSETS

Capital assets as of June 30, 2021 and 2020 were comprised of the following:

	Balance at June 30, 2020	Transfers & Additions	Transfers & Retirements	Balance at June 30, 2021
Land and land improvements	$ 3,061,292	$ -	$ -	$ 3,061,292
Buildings and improvements	10,157,771	36,951	-	10,194,722
Equipment	12,998,413	852,085	-	13,850,498
Construction-in-progress	216,365	184,821	(27,005)	374,181
Totals at historical cost	26,433,841	$ 1,073,857	$ (27,005)	27,480,693
Less accumulated depreciation	(15,626,083)	$ (1,176,528)	$ -	(16,802,611)
Capital assets, net	$ 10,807,758			$ 10,678,082

	Balance at June 30, 2019	Transfers & Additions	Transfers & Retirements	Balance at June 30, 2020
Land and land improvements	$ 570,615	$ 2,490,677	$ -	$ 3,061,292
Buildings and improvements	10,063,005	94,766	-	10,157,771
Equipment	12,365,729	632,684	-	12,998,413
Construction-in-progress	220,454	135,379	(139,468)	216,365
Totals at historical cost	23,219,803	$ 3,353,506	$ (139,468)	26,433,841
Less accumulated depreciation	(14,575,431)	$ (1,050,652)	$ -	(15,626,083)
Capital assets, net	$ 8,644,372			$ 10,807,758

NOTE 9 - DEBT BORROWINGS

Long-term debt at June 30, 2021 and 2020 consists of the following:

	2021	2020
Note payable to the Public Property Financing Corporation of California, original amount of $3,000,000, bearing interest at 3.125%, principal payable annually and interest payable biannually per schedule, maturing in December 2055, secured by property, building and improvements.	$ 2,815,000	$ 2,855,000
Total debt borrowings	2,815,000	2,855,000
Less current maturities	(40,000)	(40,000)
Debt borrowings, net of current maturities	$ 2,775,000	$ 2,815,000

Effective January 1, 2016, the District entered into a sale and leaseback agreement with the United States Department of Agriculture, acting through the Rural Housing Service and the Public Property Financing Corporation of California, for the Brenda Boss Family Resource Center. The Brenda Boss Family Resource Center is a building recently constructed by the District on the District's main hospital campus and was put into service during the fiscal year ended June 30, 2014. In accordance with GAAP, the sale and leaseback agreement will be treated as a financing transaction. The principal amount borrowed totaled $3,000,000, with an annual interest rate of 3.125%. Principal is payable annually on December 1st starting in 2016 and continuing through 2055 per a schedule with payments ranging in amounts from $35,000 to $140,000. Interest is payable biannually on June 1st and December 1st in an amount equal to the current outstanding principal balance multiplied by the annual interest rate of 3.125% and divided by two, for a six-month interest amount. There is no provision for a pre-payment penalty. The District must establish and maintain a Debt Service Reserve Fund throughout the term of the sale and leaseback agreement. The District is required to make annual payments into the Debt Service Reserve Fund equal to 1/10th of the current annual lease payment. The District established this fund and at June 30, 2021, the balance totals $144,375. Upon completion of the sale and leaseback agreement, ownership and title of the Brenda Boss Building will revert to the District with no encumbrances.

Future principal maturities for debt borrowings for the next five years are: $40,000 in 2022; $45,000 in 2023; $45,000 in 2024; $45,000 in 2025; $45,000 in 2026; and $2,595,000 thereafter.

NOTE 10 - RETIREMENT PLANS

The District has a defined contribution retirement plan covering substantially all of the District's employees. In a defined contribution retirement plan, benefits depend solely on amounts contributed to the plan plus investment earnings. The District contributes to the plan at a rate of two to four percent of eligible compensation, based on the length of the employee's service as defined by the plan. The District's contributions become fully vested after three years of continuous service. The District's pension expense for the plan was $165,809 and $182,716 during the years ended June 30, 2021 and 2020, respectively.

NOTE 11 – INCOME TAXES

The District is a political subdivision of the state of California organized under the Local Health Care District Law as set forth in the Health and Safety Code of the State of California. The Hospital has been determined to be exempt from income taxes under Local Health Care District Law. Accordingly, no provision for income taxes is included in the accompanying financial statements. The District is no longer subject to examination by federal or state authorities for years prior to June 30, 2016, nor has it been notified of any impending examination and no examinations are currently in process.

NOTE 12 - COMMITMENTS AND CONTINGENCIES

Construction-in-Progress: As of June 30, 2021, the District has $374,181 recorded as construction-in-progress which represents cost capitalized for various remodeling, major repair, and expansion projects on the District's premises. No interest was capitalized under FAS 62 during the years ended June 30, 2021 and 2020. Estimated costs to complete current obligated construction-in-progress projects as of June 30, 2021 are approximately $393,000. Costs are to be financed with District reserves and continued District operations.

Operating Leases: The District has operating leases for office space and various medical and office equipment. Rental expense under operating leases was $353,969 and $195,712 for the years ended June 30, 2021 and 2020, respectively. Future minimum lease payments for the succeeding years under operating leases with a remaining term in excess of one year as of June 30, 2021, are as follows: $92,586 in 2022; $68,856 in 2023; $68,856 in 2024; and $51,035 in 2025.

Litigation: The District may from time-to-time be involved in litigation and regulatory investigations which arise in the normal course of doing business. After consultation with legal counsel, management estimates that matters existing as of June 30, 2021, will be resolved without material adverse effect on the District's future financial position, results from operations or cash flows.

NOTE 12 - COMMITMENTS AND CONTINGENCIES (continued)

Workers Compensation Program: The District is a participant in the Association of California Hospital District's ALPHA Fund which administers a self-insured worker's compensation plan for participating hospital employees of its member hospitals. The District pays premiums to the ALPHA Fund which is adjusted annually. If participation in the ALPHA Fund is terminated by the District, the District would be liable for its share of any additional premiums necessary for final disposition of all claims and losses covered by the ALPHA Fund

Health Insurance Portability and Accountability Act: The Health Insurance Portability and Accountability Act (HIPAA) was enacted August 21, 1996, to ensure health insurance portability, reduce health care fraud and abuse, guarantee security and privacy of health information, and enforce standards for health information. Organizations are subject to significant fines and penalties if found not to be compliant with the provisions outlined in the regulations. Management continues to evaluate the impact of this legislation on its operations including future financial commitments that will be required.

Health Care Reform: The health care industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements and reimbursement for patient services, antitrust, anti-kickback and anti-referral by physicians, false claims prohibitions and, in the case of tax-exempt organizations, the requirement of tax exemption. In recent years, government activity has increased with respect to investigations and allegations concerning possible violations by health care providers of reimbursement, false claims, anti-kickback and anti-referral statutes and regulations, quality of care provided to patients, and handling of controlled substances. Violations of these laws and regulations could result in expulsion from government health care programs with the imposition of significant fines and penalties as well as significant repayments for patient services previously billed.

Laws and regulations concerning government programs, including Medicare, Medicaid and various other programs, are complex and subject to varying interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. As a result of nationwide investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements.

Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines and penalties and exclusion from related programs. The District expects that the level of review and audit to which it and other health care providers are subject will increase. There can be no assurance that regulatory authorities will not challenge the District's compliance with these regulations, and it is not possible to determine the effect (if any) such claims or penalties would have upon the District.

JWT & Associates, LLP

Advisory Assurance Tax

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Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With Government Auditing Standards

The Board of Directors
Bear Valley Community Healthcare District
Big Bear Lake, California

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the comptroller General of the United States, the financial statements of Bear Valley Community Healthcare District (the District), which comprise the statement of net position as of June 30, 2021, and the related statements of revenues, expenses and changes in net position, and cash flows for the year then ended, and the related notes to the financial statements and have issued our report thereon dated February 9, 2022.

Internal Control Over Financial Reporting

In planning and performing our audit, we considered the District's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the District's financial statements will not be prevented or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the District's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

JWT & Associates, LLP

February 9, 2022

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT

Schedule of Findings and Questioned Costs

For the Year Ended June 30, 2021

I. Summary of Auditor's Results

Type of auditor's report issued:	Unmodified	
Internal Control over financial reporting:		
Material weakness identified?	___yes	_X_no
Significant deficiency(ies) identified that are not considered to be material weaknesses?	___yes	_X_no
Noncompliance material to financial statements noted?	___yes	_X_no

II. Current Year Audit Findings and Questioned Costs

Financial Statement Findings

None reported

III. Prior Year Audit Findings and Questioned Costs

None reported

Thank you Bear Valley Family for our Partnership

	QHR Solution	Leader	Coverage	2021 - 2022	Comments
Key	**Focus Items This Month**	**Focus Items This Year**	**Completed This Year**	**Updated This Month**	
Coverage	**WIC - Within Contract**				

Return On Investment

		2020	2021
Direct QHR Business Partner Benefits		$ 307,272	$ 319,632
Indirect QHR Business Partner Benefits		$ 133,797	$ 147,252
		$ 441,069	$ 466,884
Professional Fees		$ 320,488	$ 320,488
Return On Investment-Dollars		**$ 120,581**	**$ 146,396**
Return On Investment-Percentage		**37.6%**	**45.7%**

	QHR Solution	Leader	Coverage	2021-2022	Comments
Strategy & Positioning	Ongoing Strategy Advisement	Strategy Team	WIC	Ongoing support for the Strategic and Business plans. Quarterly check-ups with the Board/Hospital.	Business Plan and Strategy review to be updated and presented to Board quarterly. QHR to be involved throughout the year.
	Construction and Design Project	David Anton	WIC	Initial discussions/meetings for the construction of new Hospital to meet CA codes.	Process to begin Q2 2022.
	Recruitment for new CEO	Region VP	WIC	Begin search for new CEO. John leaving at end of October 2021.	New CEO hired-Evan Rayner. Start date Nov 15th.
	Strategic Plan	Strategy Team	WIC	Process started in May 2020. Covid caused delays in finalization.	Plan completed, Board retreat in November 2020, adopted by Board in January 2021.

	QHR Solution	Leader	Coverage	2021-2022	Comments
Clinical & Compliance	Compliance/Risk Assessment	Compliance Team	WIC	Assessment of Hospital Compliance and Risk programs	Review to begin in Q3 2022.
	Community Health Needs Assessment	Strategy Team	WIC	Assessment of community needs and sentiment, hospital needs, provider needs.	Review to begin in Q3 2022.
	Medical Stabilization Program	Shelley Riser	Add-on	Ongoing support for Medical Stabilization program	Physician coverage being finalized. Operational issues being addressed by QHR with Administration.
	Urgent Care Transisiton/Start-up	Region Team	WIC	Transition begun Oct 1, 2021.	UCC transaction has been completed. Renovations completed. Provider staffing being addressed. Weekly calls were held to aid with start-up.
	Urgent Care Analysis/Proforma	Region Team	WIC	Project begun August 2019.	Analysis completed. Contracts reviewed. Purchase completed October 1, 2021.
Financial & Operations	Financial Ops Review (FOR)	Region Team	WIC	Information request to go out in February.	
	Contractual Accounting Review	David Perry	WIC	Information request to go out in February.	
	Monthly Operations Review	Region Team	WIC	Held Monthly on 2nd Monday	Monthly calls with BVCHD admin, QHR Region Team, Support Team
	Vantage Productivity Refresh/Modeling	Jennifer Stephens	WIC	Review/update staffing models, FTE's.	Review to begin in Q2 2022.
	Qrate Price Comparison	HFR Team	WIC	Project to compare BVCHD pricing to "like" Hospitals.	Project scheduled to start April 2022
	Comparative Data Analysis	Leslie Roney	WIC	Perfomed Monthly	Results are reported in rankings report distributed to hospital monthly. See graphs below.
	Managed Care Assessment and Contract Review	Wanda Wright	WIC	Project started March 2021	Negotiations with Heritage ongoing. Call held to coordinate efforts with Hospital's CA representative. Revised contract close.
	QPA/GPO Review	PLUS Team	WIC	Report issued annually	Annual report being completed by PLUS. Report to Board in Q1 2022. 2019-20 savings shown in table below.
	COVID-19 Supply Focus	PLUS Team	WIC	QHR PLUS Warehouse Operating	Three orders requested/completed FY to date.
	Price Transparency	CPSI	WIC	Project started October 2020	Finalized and implemented in January 2021.
	Cost Report Review	HFR Team	WIC	Review held Nov 2021	Review completed with no changes. Report submitted.

	QHR Solution	Leader	Coverage	2021-2022	Comments
Trustee Education	National Trustee Conference with Trustee Essentials	QLI	WIC	Q1 2022-Wigwam Resort Phoenix, AZ	Unfortunately the conference had to be cancelled. Regional conferences will be scheduled later in 2022.
	Board Self-Assessment	Region Team	WIC	Schedule Q1 2022	
	Governance Webinars	QLI	WIC	Second Tuesday each month	See monthly listing below.
	Regional Conferences	QLI	WIC	Three regional conferences held in 2021.	John and Connie attended the Boston conference.
Leadership Education & Development	CEO Evaluation	Region VP	WIC	Initial 90-day evaluation to be held in February.	
	QLI Webinars and Leadership Development	QLI	WIC	Monthly webinars held throughout the year.	
	HFR Regulatory Updates	HFR	WIC	Udates sent daily/monthly as dictates.	
	Director Leadership Series	QLI	Add-on	Board approved QHR onsite program in Feb 2021.	"Leading From the Middle" completed August 2021
	CFO Evaluation	Region VP	WIC	Annual evaluation to begin August 2021	Evaluation completed. Presented at Oct Board meeting.

QHR Region Team and Internal Consulting Hours		
	2020	2021 YTD
Region Team	340	428
Internal Consultants	286	285
Total:	**626**	**713**

Key Contract Items

Hospital

Annual Professional Fee = $320,488
Current Contract November 1, 2020 - October 31, 2026
Mutual 90-day window to terminate October 31, 2024
Original Contract Date: June 25, 2015

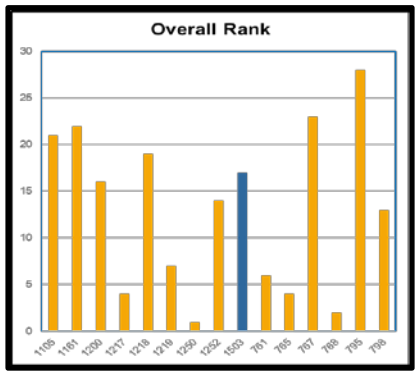
Medical Stabilization Unit

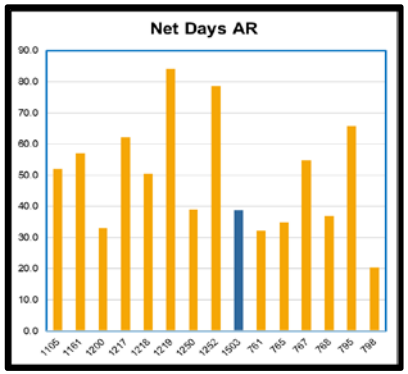
Annual Professional Fee = $183,600
Current Contract January 1, 2021 - December 31, 2025
Mutual 90-day window to terminate December 31, 2023
Original Contract Date: January 1, 2021

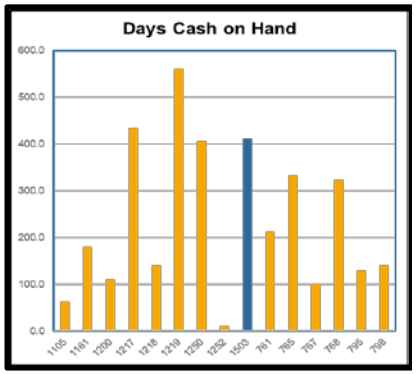
Estimated Annual Benefits & Savings Annual Totals		
QHR Business Partnership Benefits		
	2020	**2021**
HPG Discounts	$ 218,188	$ 225,951
HPS Rebates	$ 10,917	$ 9,211
GPO Group Savings	$ 6,922	$ 7,018
MD Buyline	$ 10,000	$ 10,000
Strategic Service Partner	$ 61,245	$ 67,452
Total:	**$ 307,272**	**$ 319,632**
Other QHR Business Partnership Benefits		
AHA Dues Discounts	$ 8,597	$ 4,605
J & J QPA Rebate	-	$ 47
Consulting (Region Team)	$ 68,000	$ 85,600
Consulting Engagements	$ 57,200	$ 57,000
Total:	**$ 133,797**	**$ 147,252**
Partnership Education Benefit		
Direct Employee Education	Trustee Quick Reference Guide	
QLI Monthly Education Offerings	Board Essesntial Workshop	
Regional Education Conferences	Monthly Trustee Education Webinars	
Board Specific Education Action Plan	Monthly/Daily Regulatory Updates	
National QHR Trustee Conference	HealthTrust University	
Other Benefits		
New Compliance Director Support	Cost Report Review and Analysis	
Urgent Care Assessment, Structure, Planning	QHR Best Practices	
Managed Care Payor Yield Assessment	Accounts Receivable Review and Analysis	
Contractual Allowance & Bad Debt Analysis	Strategic Plan and Quarterly Updates	
PLUS Supply Chain Support	CEO Recruitment	
Community Health Needs Assessment		

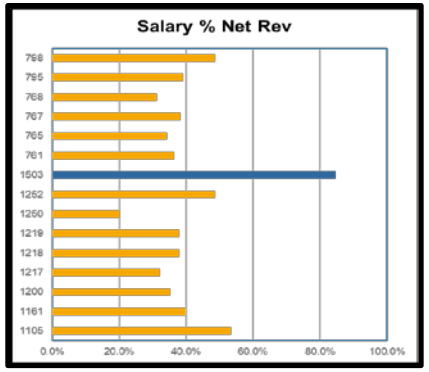
Bear Valley QHR QPA/Plus Summary									
Desc	**Spend**			**Savings $$s**			**QHR AF**		
	2019	**2020**	**Variance**	**2019**	**2020**	**Variance**	**2019**	**2020**	**Variance**
SSP	$2,440,068.00	$2,694,883.21	$254,815.21	$54,447.00	$61,244.91	$6,797.91	$8,976.00	$36,602.13	$27,626.13
HPG	$1,533,998.00	$2,280,772.29	$746,774.29	$136,988.00	$297,918.57	$160,930.57	$22,438.00	$10,291.70	-$12,146.30
Total:	**$3,974,066**	**$4,975,656**	**$1,001,590**	**$191,435**	**$359,163**	**$167,728**	**$31,414**	**$46,894**	**$15,480**
Notes:	SSP - Strategic Service Partners								
	HPG - Healthcare Purchasing Group - HPG savings do not include savings from capital equipment & services purchases. These saving are not indluded due to the complex & custom nature of those contracts.								
QPA Administrative Fees - A formal disclosure letter is sent out annually to the Board Chair and CEO (these AF are industry standard paid by Vendors to QHR QPA/PLUS).									

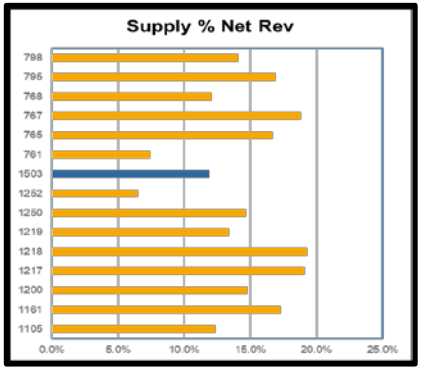
Critical Access Hospitals: Comparison Ranking Charts - November 2021 Data





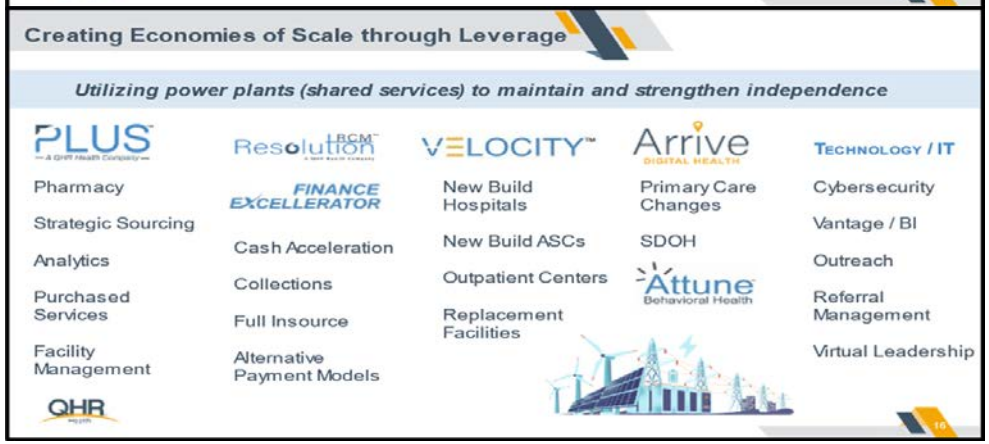






QHR Learning Institute (QLI) Education Information Section		
2022 Trustee Webinars - 2nd Tuesday @ 12 PM CST		**BVCHD Participants**
Jan 11	Cybersecurity 2022	
Feb 8	Outreach & Engagement	
Mar 8	TBD	
Check out all Webinars through the link below Be sure to add these dates to you calendar! Visit https://qhr.com/learning-institute/ **to register**		

QHR Health Vision and Share Services



QHR Health COVID-19 ASSISTANCE

- Developed a **COVID-19 Task Force** with Resources Website
  QHR Health COVID-19 Online Resource Center.
  Or https://qhrcovid19.com/
  - Taskforce providing support & guidance on:
    - Finance & Reimbursement
    - FEMA Assistance
    - Supply Chain & Pharmacy
    - Clinical Care & Survey Readiness
    - Includes Podcasts on key areas of focus

- Set up **PPE Warehouse & Distribution Program**
  - For QHR Health Hospital Families *only*
  - Actively working with Supply Chain Leaders at all Facilities
    - Assisting an average of 38 Hospital Families a week
    - Up and running since April 1, 2020
    - BVCHD received support 3 times (N95 Masks, Isolation Gowns, Nitrile Gloves)

- Published **QHR Health Post-COVID Operational Playbook Vols. 1 & 2**
  - Covers US Government's guidelines for reopening our Country's healthcare system complemented with QHR suggested best practices focused on:
    - Restart Readiness
    - Capacity & Utilization
    - Service Changes
    - Revenue Integrity & Reimbursement Due Diligence
    - Regulatory & Compliance
    - Communications & Strategy

- **Financial, Funding & Reimbursement Options Federal & State**
  - Monitoring, developing & recommending plans for all three phases of Government response for financial support (i.e.: Accelerated Payments, Grants, Loans, Future Cost Reporting)

- Established **Shared Service Centers**
  - COVID-19 Patient Triage
  - CARES Act / Federal & State Funding Options - Identification, Application & Tracking

QHR Regional Team		
Team Member & Position	**Phone**	**Email**
Regional Team		
Woody White, CPA - Senior Vice President	561.644.5391	wwhite@qhr.com
Leslie Roney - Regional Financial Analyst	615.400.7220	lroney@qhr.com
Support Team		
David Perry - VP Healthcare Finance & Reimbursement	615.371.4703	dperry@qhr.com
John Waltko - VP Regulatory & Financial Reporting	615.371.4678	jwaltko@qhr.com
Wanda Wright - AVP Managed Care	704.999.8890	wwright@qhr.com
Lisa Boston - AVP Compliance Consulting	225.337.3155	lboston@qhr.com
Jo Piland - Manager QHR Health Learning Institute	615.371.4842	jpiland@qhr.com
Sue Dorsey - Director SSP, QHR PLUS Services	615.427.3631	sdorsey@myplusnow.com
Peter Miessner - VP ResolutionRCM	281.415.8388	pmiessner@qhr.com
Ryan Nestrick - Senior Director Strategy	847.533.0759	rnestrick@qhr.com
Jonathan Boatwright - Manager SSP, QHR PLUS Services	615.371.4932	jboatwright@myplusnow.com
Scott Nation - VP ASC Services	423.653.6620	snation@qhr.com
Erika Sundrud - VP Care Transformation	617.838.2496	esundrud@qhr.com

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

CNO Monthly Report

TOPIC	UPDATE
1. Regulatory	▪ Program Flexibilities sent to CDPH for annual review process. ▪ Working on CMS/ CDPH Vaccine Mandates for Healthcare workers, including booster shots. ▪ No deficiencies were issued for SNF self-report visit.
2. Budget/Staffing	▪ We have been able to recruit 1 PD RN for acute ▪ One employment offer has been extended for 1 FT acute RN with ICU background ▪ One employment offer has been extended for 1 FR acute RN- New Graduate. She will require 6- 8 weeks of preceptorship. Our Education Coordinator has a new graduate education program ready. ▪ 5,000.00 referral bonus in place ▪ 10,000.00 signing bonus in place
3. Departmental Reports	
▪ Emergency Department	▪ Staffing is a concern as ICU holds have been decreasing nursing ratios/ combined with high volume ski days. ▪ Travelers have become difficult to recruit ▪ COVID volume and ski volume have been very high ▪ It has been difficult to transfer patients to higher level of care. ICU beds across California are over capacity.
▪ Acute	▪ Medical stabilization program has been on hold due to staffing difficulties. ▪ Hospitalists are ready to admit patients when COVID and staffing stabilize. ▪ Continuing weekly calls with QHR staff for MS implementation plan.
▪ Skilled Nursing	▪ New DON and ADON have assumed their new positions. ▪ SNF residents continue to be closely monitored for COVID.

	▪ SNF unit on high infection control precautions due to recent COVID activity. ▪ Currently no positive residents. ▪ Several vacant positions CNA/ LVN ▪ CNA school in Lucerne will start bringing students onto the SNF- we are hoping we may be able to hire a couple of those students post graduation.
▪ Surgical Services	▪ Cataract and Pain management cases are currently being performed. ▪ Working with Dr.Chin to resume general surgery.
▪ Case Management	▪ Case Management position has been filled.
▪ Respiratory Therapy	▪ Ventilators are updated for COVID capability. ▪ Updating RT policies. ▪ PFT services on hold. ▪ COVID volume affecting RT department
▪ Physical Therapy	▪ Volumes have been affected by IEHP contract ▪ Permanent PT has been recruited.
▪ Food and Nutritional Services	▪ Working with Culture of Ownership committee to host employee appreciation Holiday events ▪ Food vending machine for afterhours/ night staff has been delivered. Working with IT to get the machine ready for credit card processing. ▪ Volumes of sales continue to increase each month. ▪ Hosted employee appreciation lunch 1/27
4. Infection Prevention	▪ Planning, research and education regarding COVID-19 planning ▪ Reporting COVID cases to Public Health and CDPH L&C ▪ Completing mandatory reporting for COVID-19 for SNF and the District
5. Quality Improvement	▪ SCORE Survey mapping in process for 2022 survey ▪ Culture of Safety Newsletter is being developed. ▪ Care for the Caregiver program continues to be a BETA HEART focus. ▪ HRSA Grant Federal Financial Quarterly Report has been submitted. BVCHD has received 72,488 of 99,058. Remaining funding to be allocated towards IT projects and vaccine advertising.

6. Policy Updates	▪ New Policy developed for mandatory vaccine plan- updating to include mandatory booster shots.
7. Safety & Products	▪ Workplace Violence committee continues to make progress on BETA ESWI projects.
8. Education	▪ Several trainings taking place ▪ Working on RQI program implementation ▪ Working with maintenance to rain on new fire extinguisher process. ▪ Working closely with Acute nurses to implement Medical Stabilization program.
9. Information Items/Concerns	▪ Attending many calls related to COVID with HASC, CHA, CDPH. ▪ Closely monitoring COVID trends/ hospital bed utilization throughout the state. ▪ COVID volume affecting multiple departments in the hospital. Staffing resources are limited. Staff are doing an exceptional job at handling the stress and workload. ▪ Continuing to provide public vaccination clinics for initial and booster vaccines.
Respectfully Submitted by: *Kerri Jex, CNO*	*Date: January 28th, 2022*

2022 Surgery Report

Jan-22		
Physician	**# of Cases**	**Procedures**
Chin - MD		
Busch - Podiatrist		
Critel - CRNA	3	LESI
Tayani	1	Trigger Point Injection
Total	4	

Feb-22		
Physician	**# of Cases**	**Procedures**
Chin - MD		
Chin - MD		
Chin - MD		
Busch - Podiatrist		
Critel - CRNA		
Tayani		
Total	0	

Mar-22		
Physician	**# of Cases**	**Procedures**
Chin - MD		
Busch - Podiatrist		
Critel - CRNA		
Tayani		
Total	0	

Apr-22		
Physician	**# of Cases**	**Procedures**
Chin - MD		
Chin - MD		
Kondal - MD		
Busch - Podiatrist		
Critel - CRNA		
Tayani		
Total	0	

May-22		
Physician	**# of Cases**	**Procedures**
Chin - MD		
Chin - MD		
Busch - Podiatrist		
Critel - CRNA		
Critel - CRNA		
Tayani		
Total	0	

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

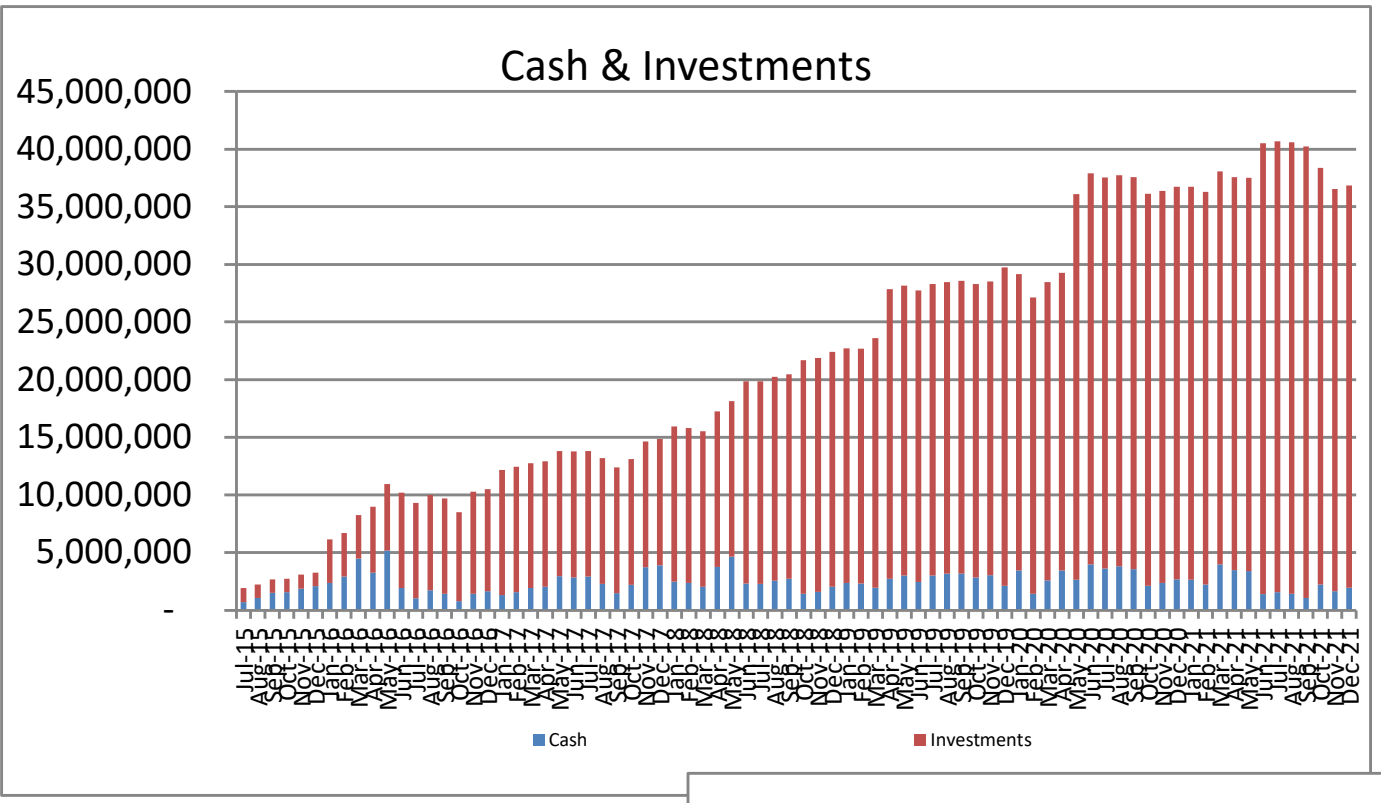
Finance Report

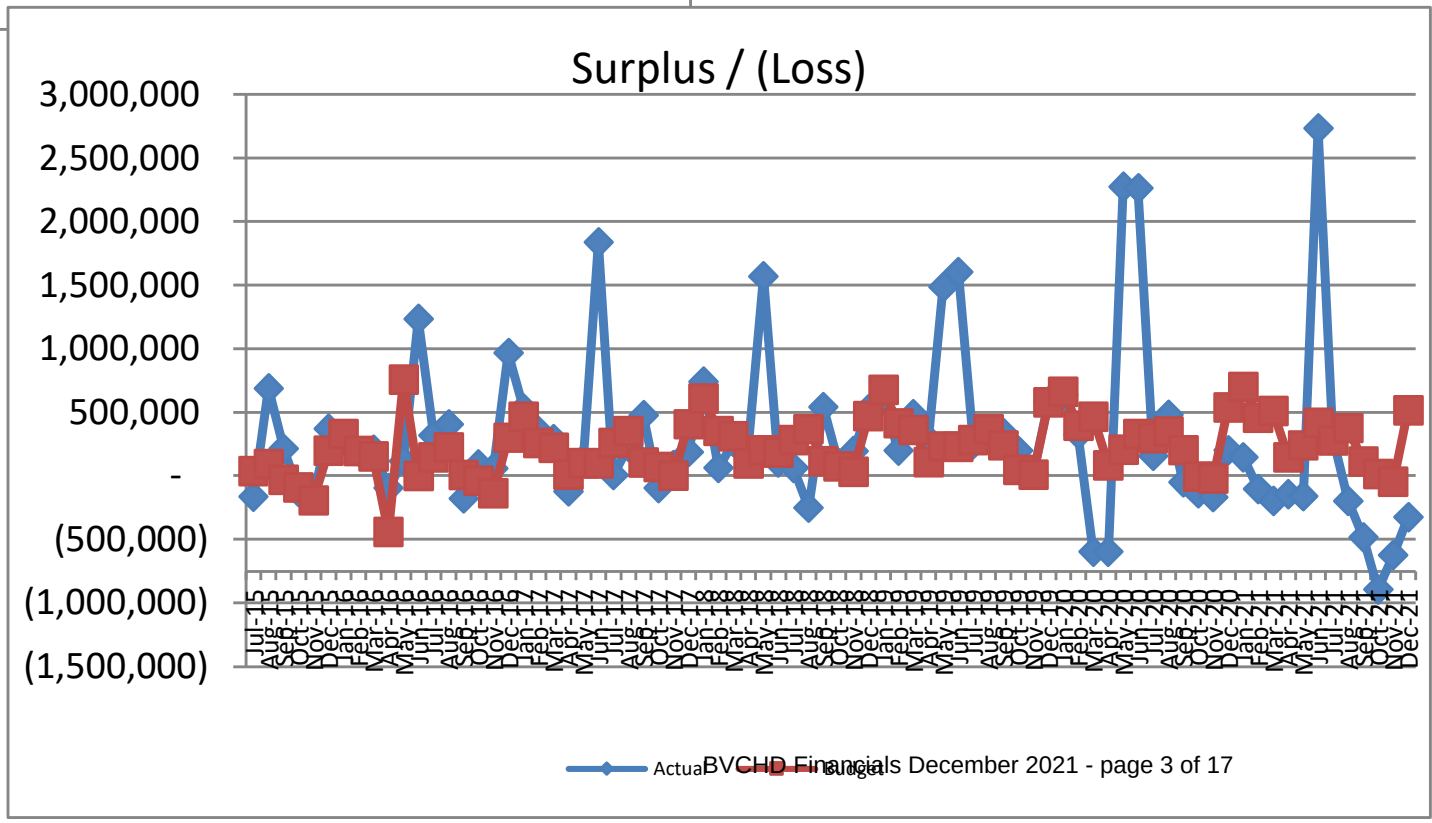
December 2021 Results

Summary for December 2021

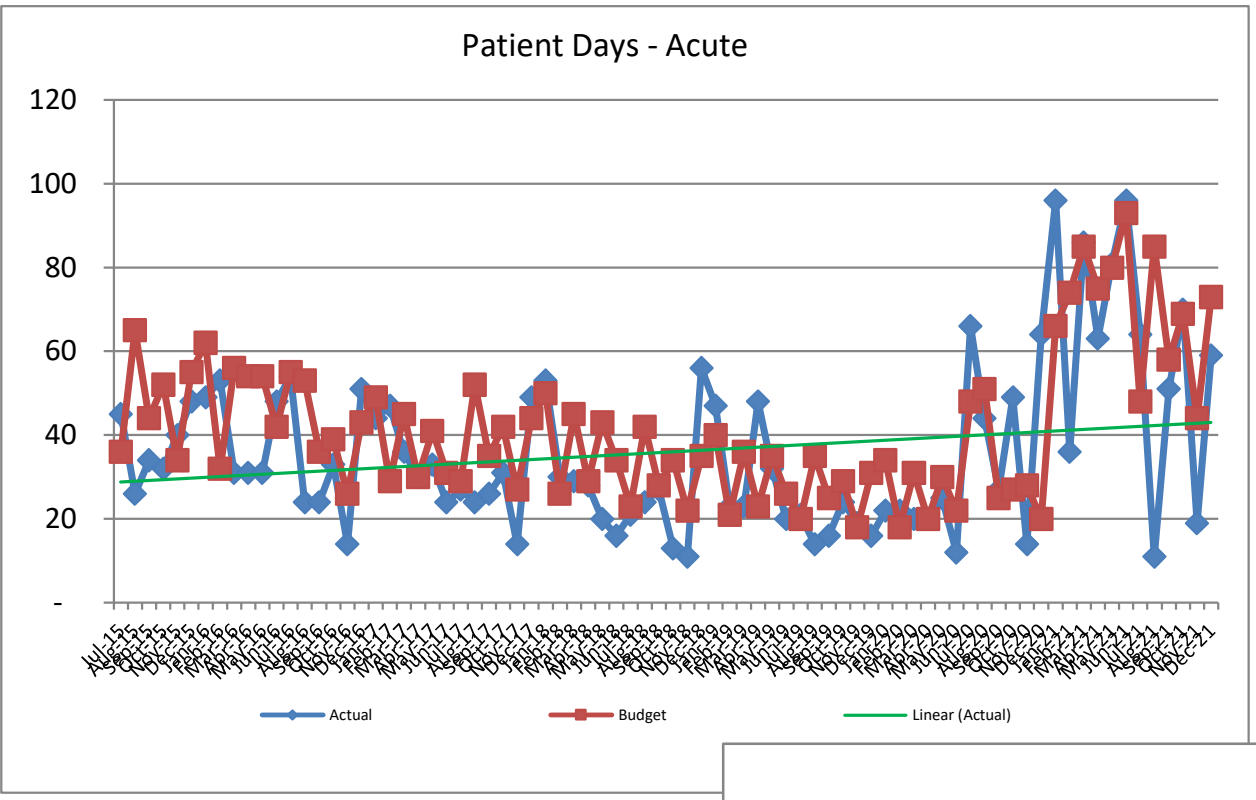
- Cash on hand $ 1,947,742
  Investments $ 34,930,232
- Days Cash on hand, including investments with LAIF – 438
- Loss of $326,796 was lower than budgeted surplus
- Total Patient Revenue was 6.5% lower than Budget for the month
- Net Patient Revenue was 13.4% lower than budget
- Total Expenses were 9.8% more than budget

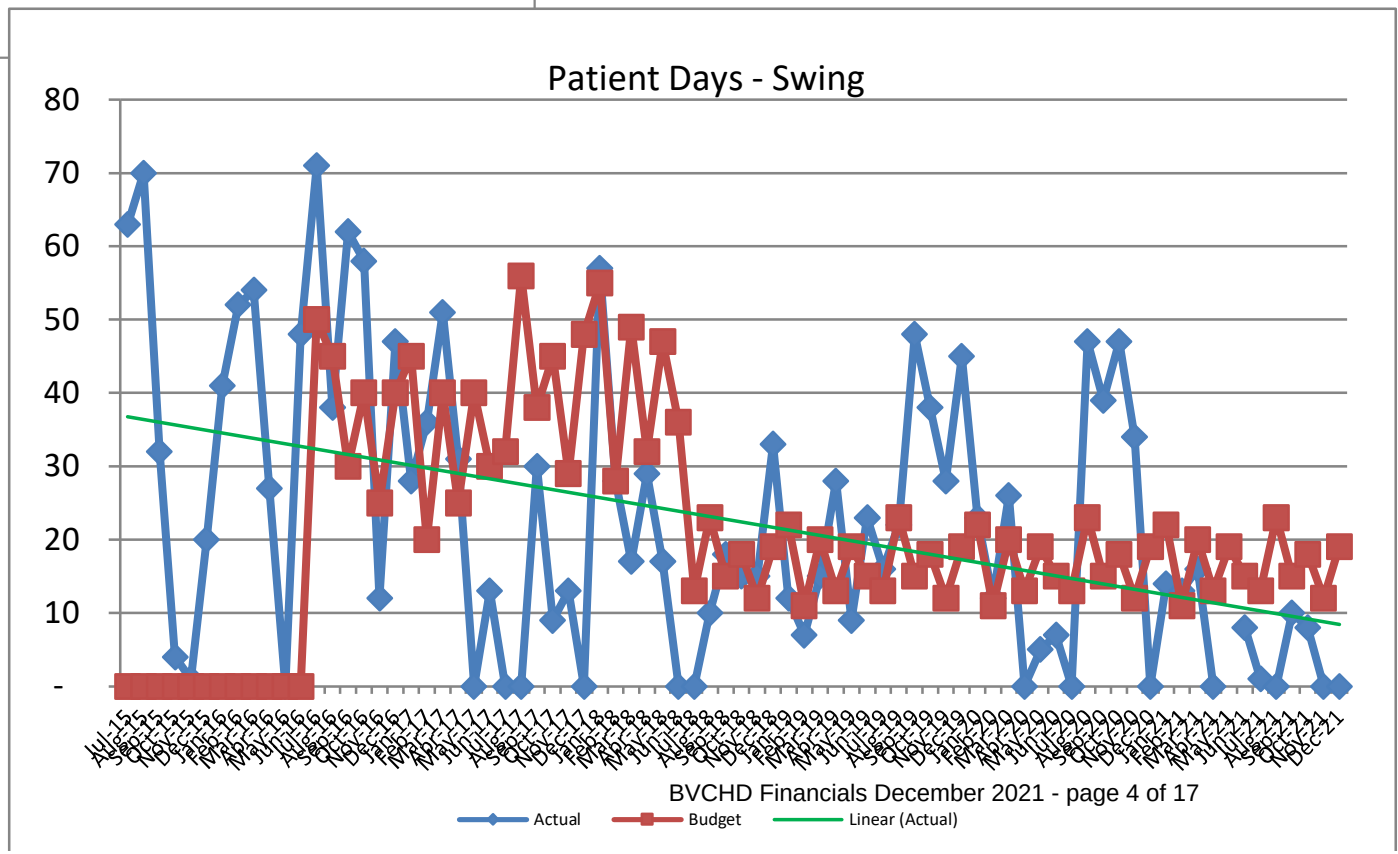
BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT



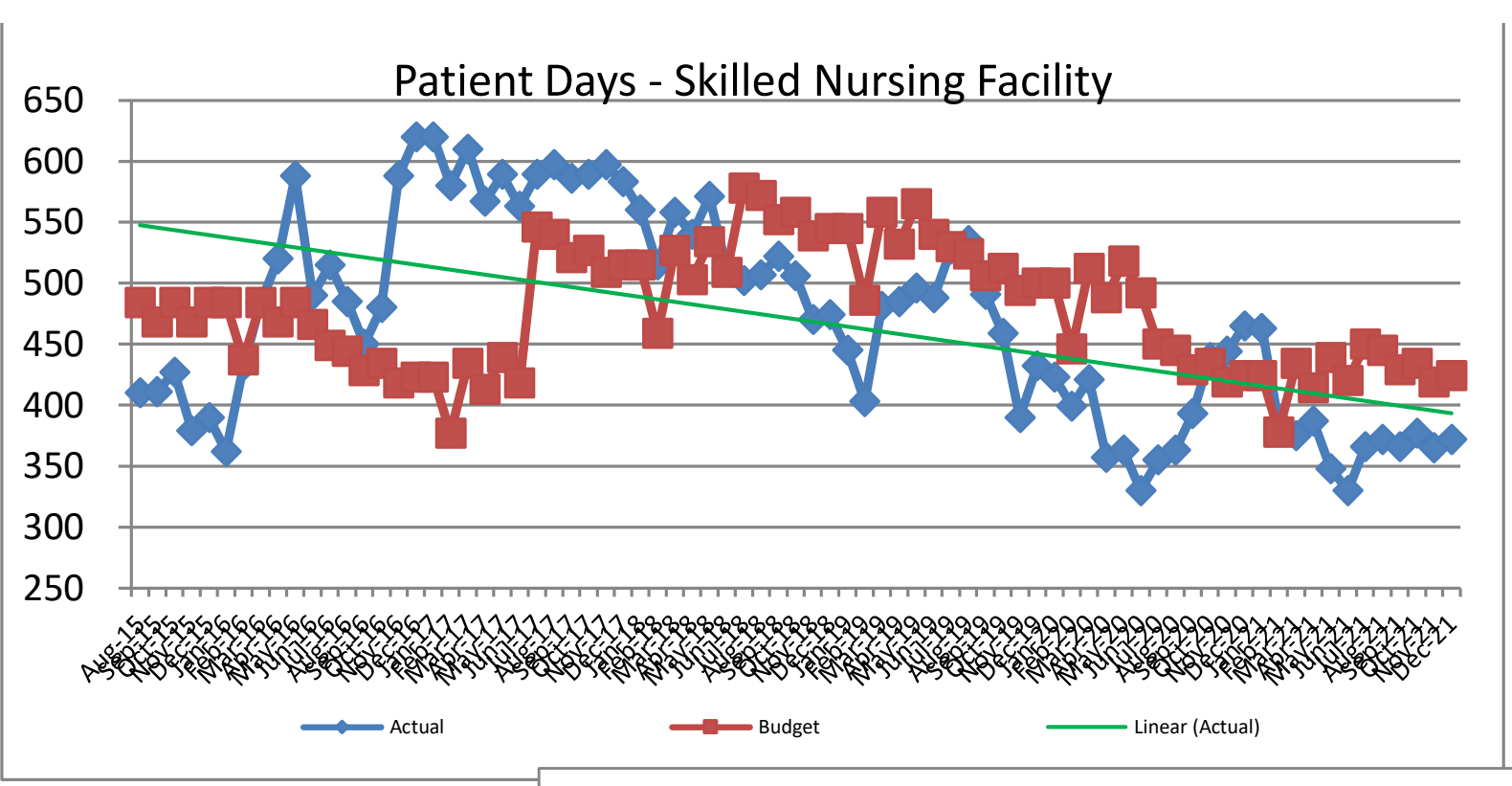


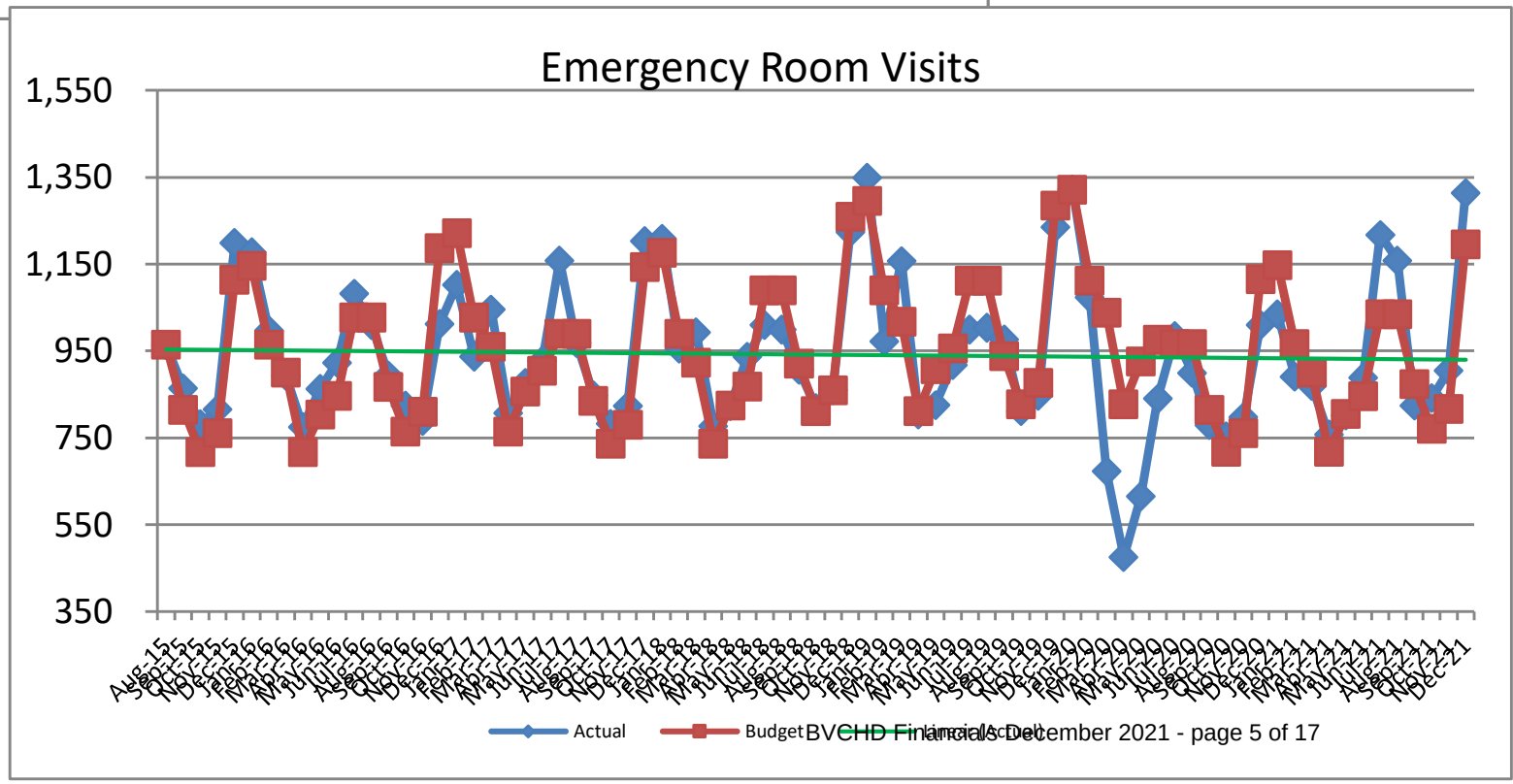
BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT





BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT





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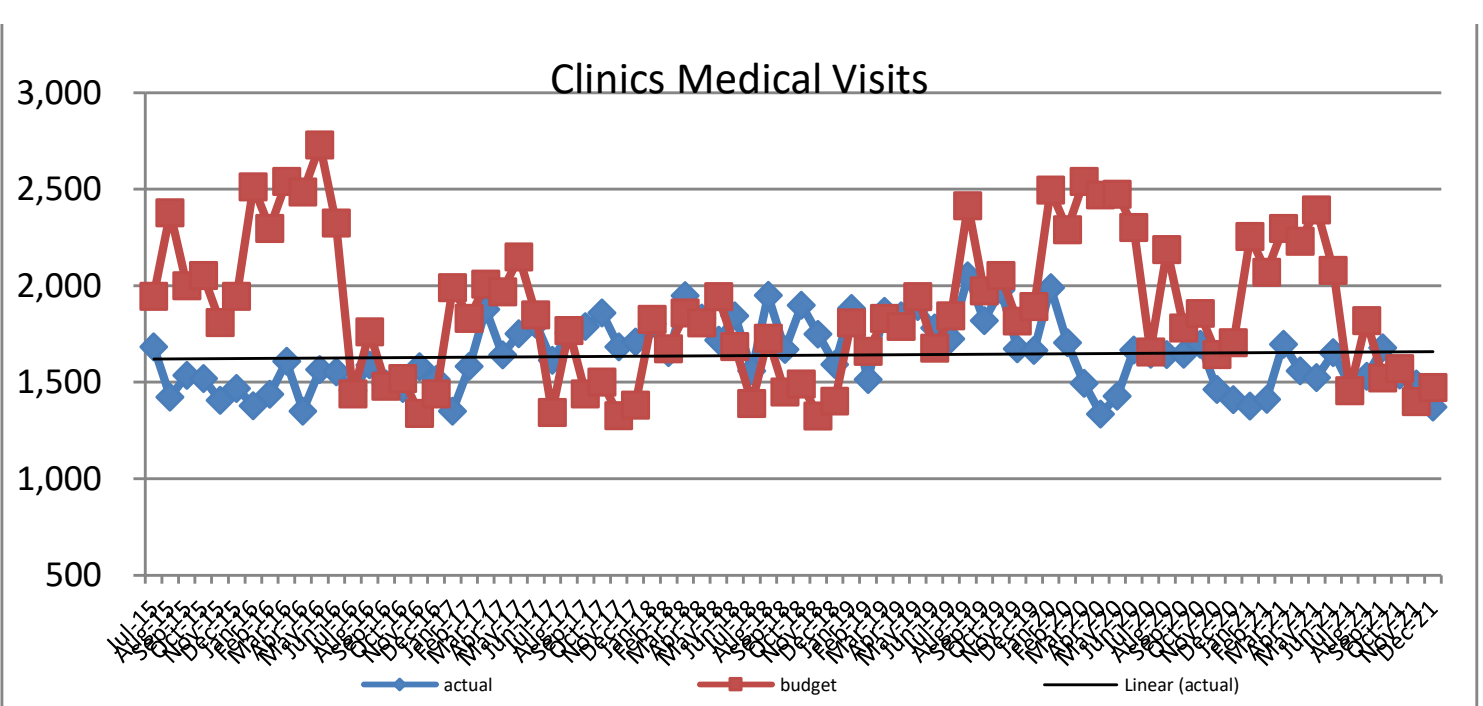

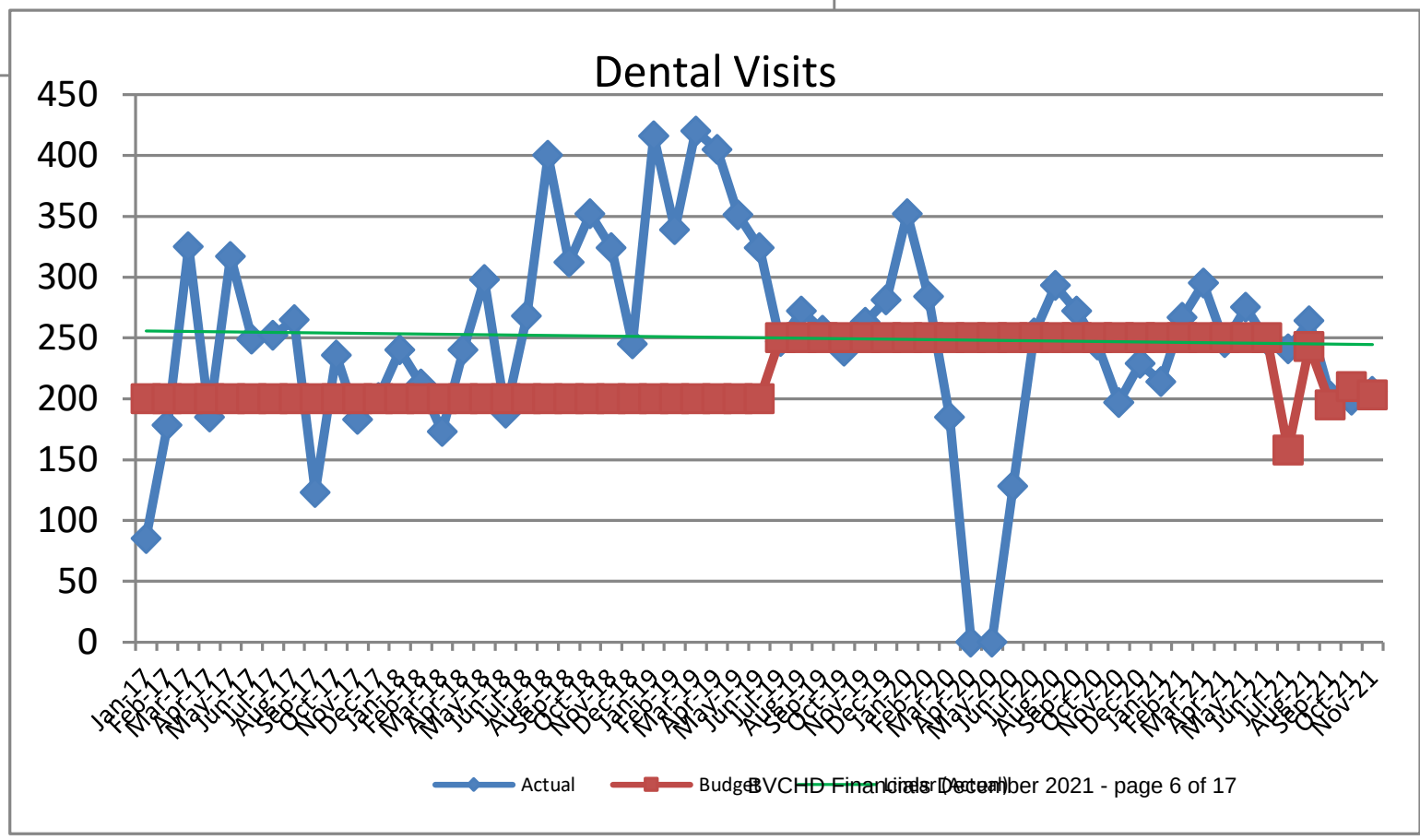

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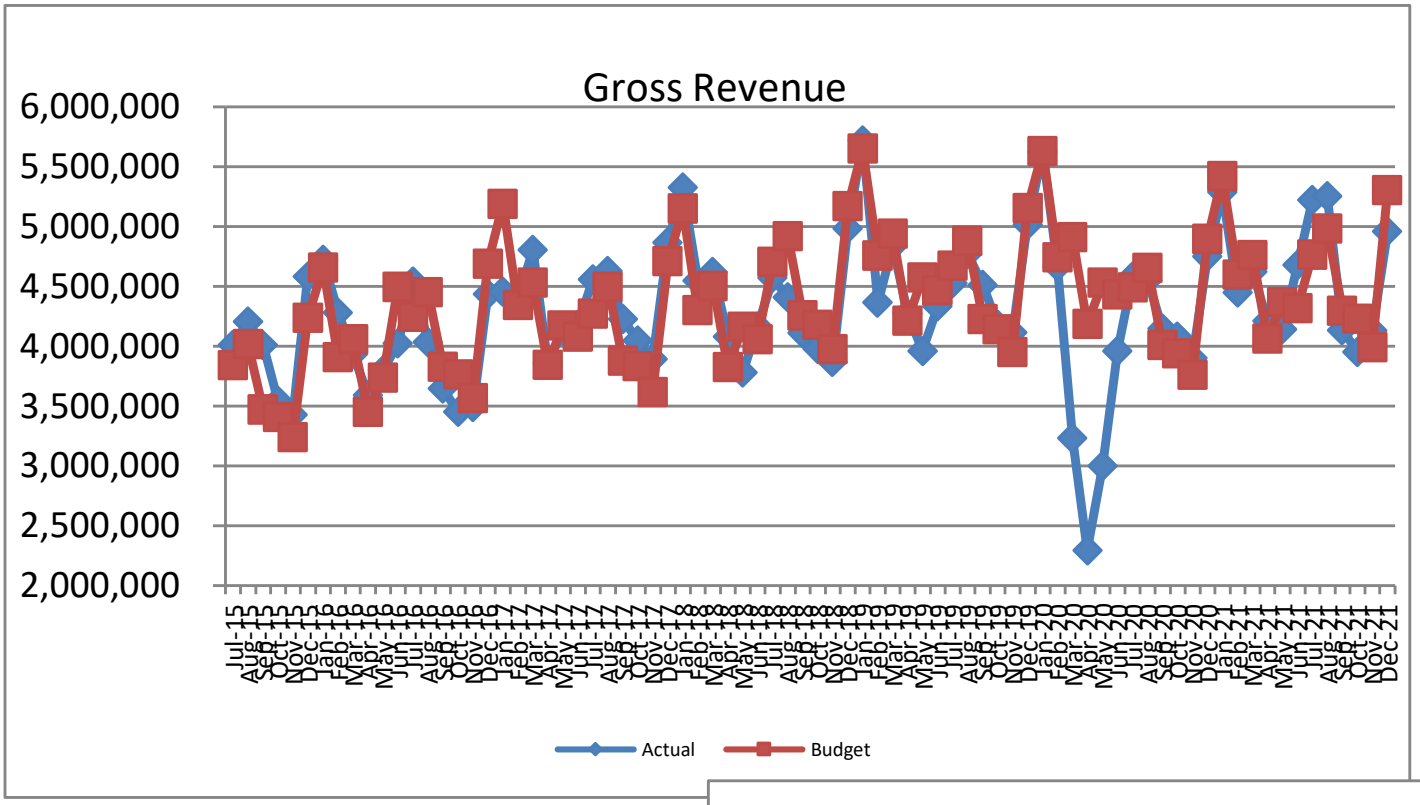

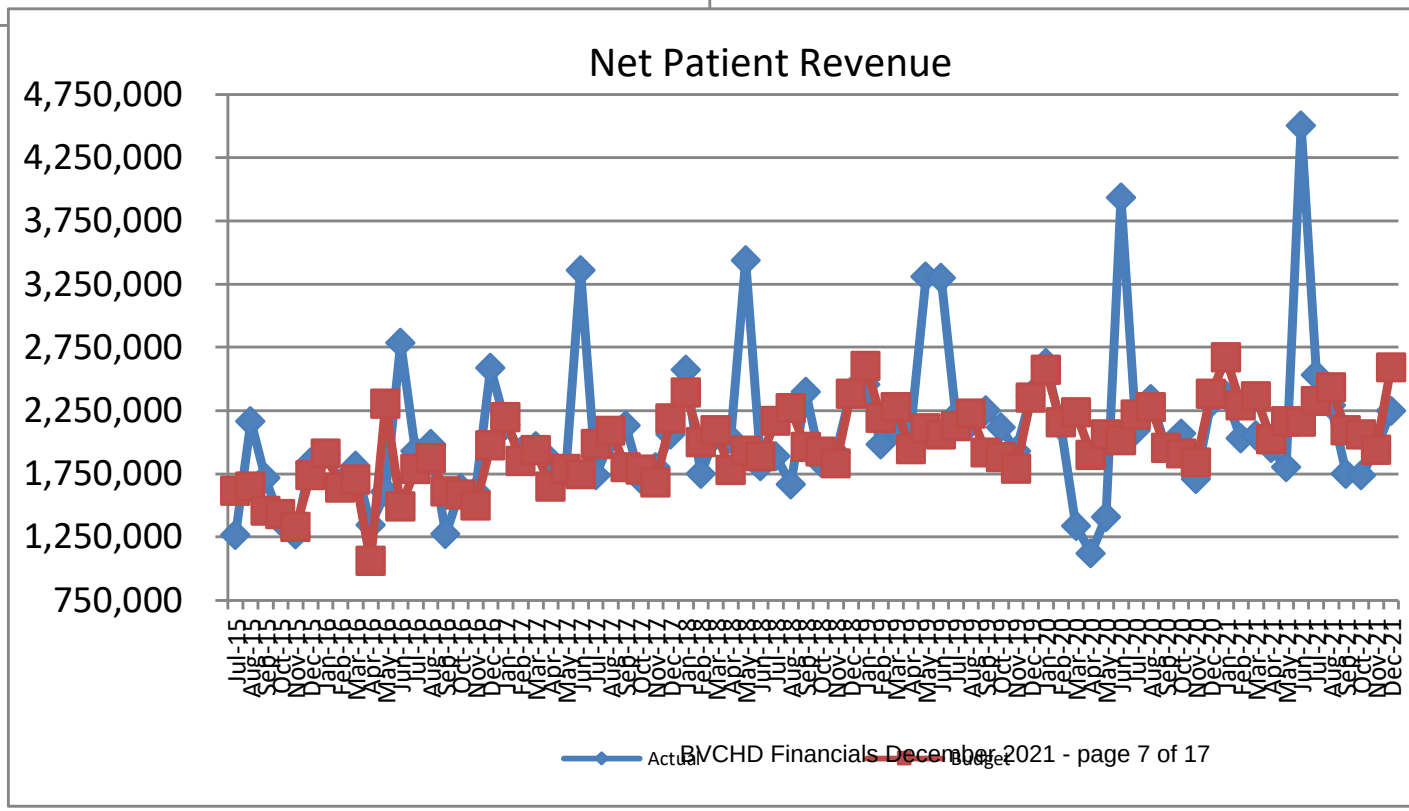

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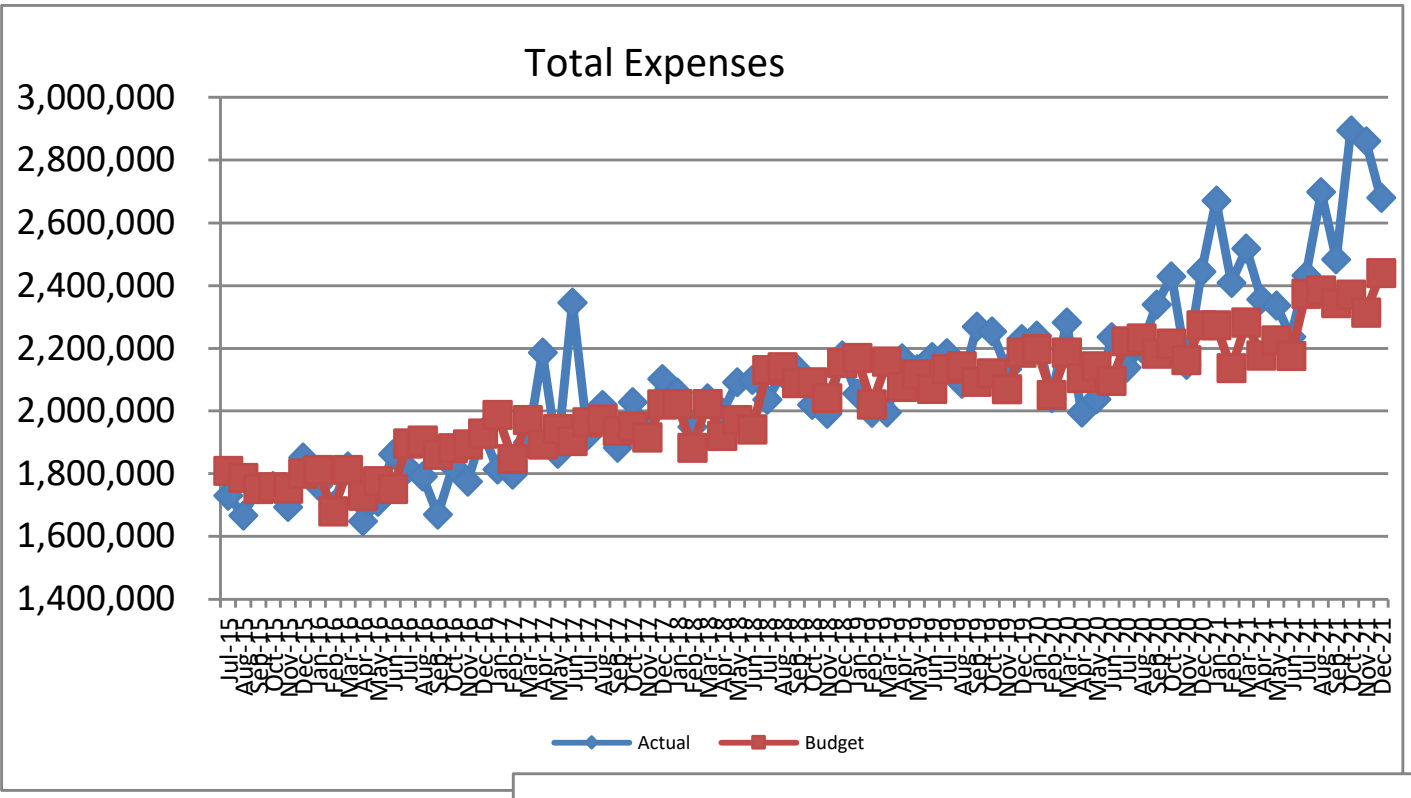

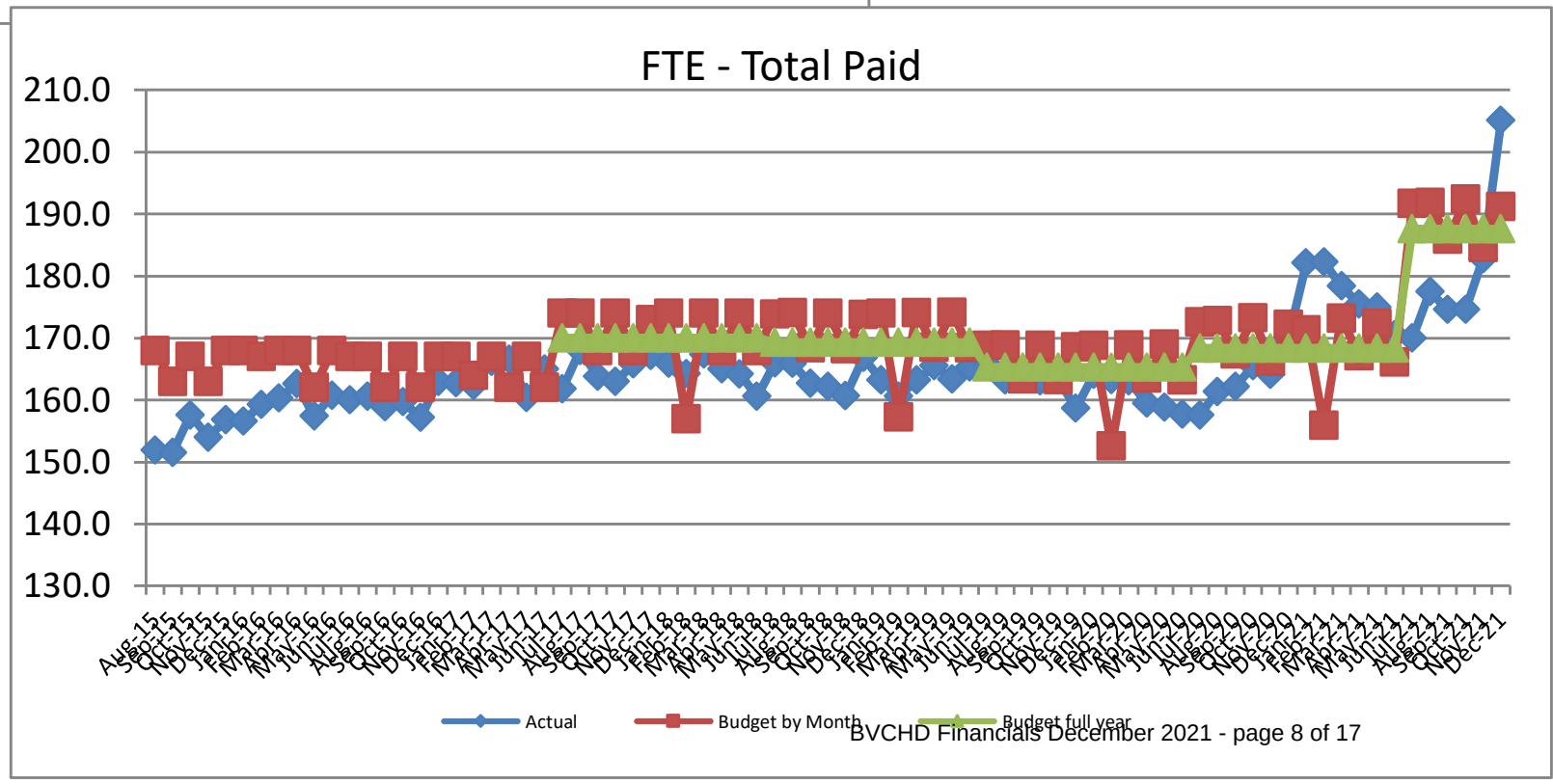

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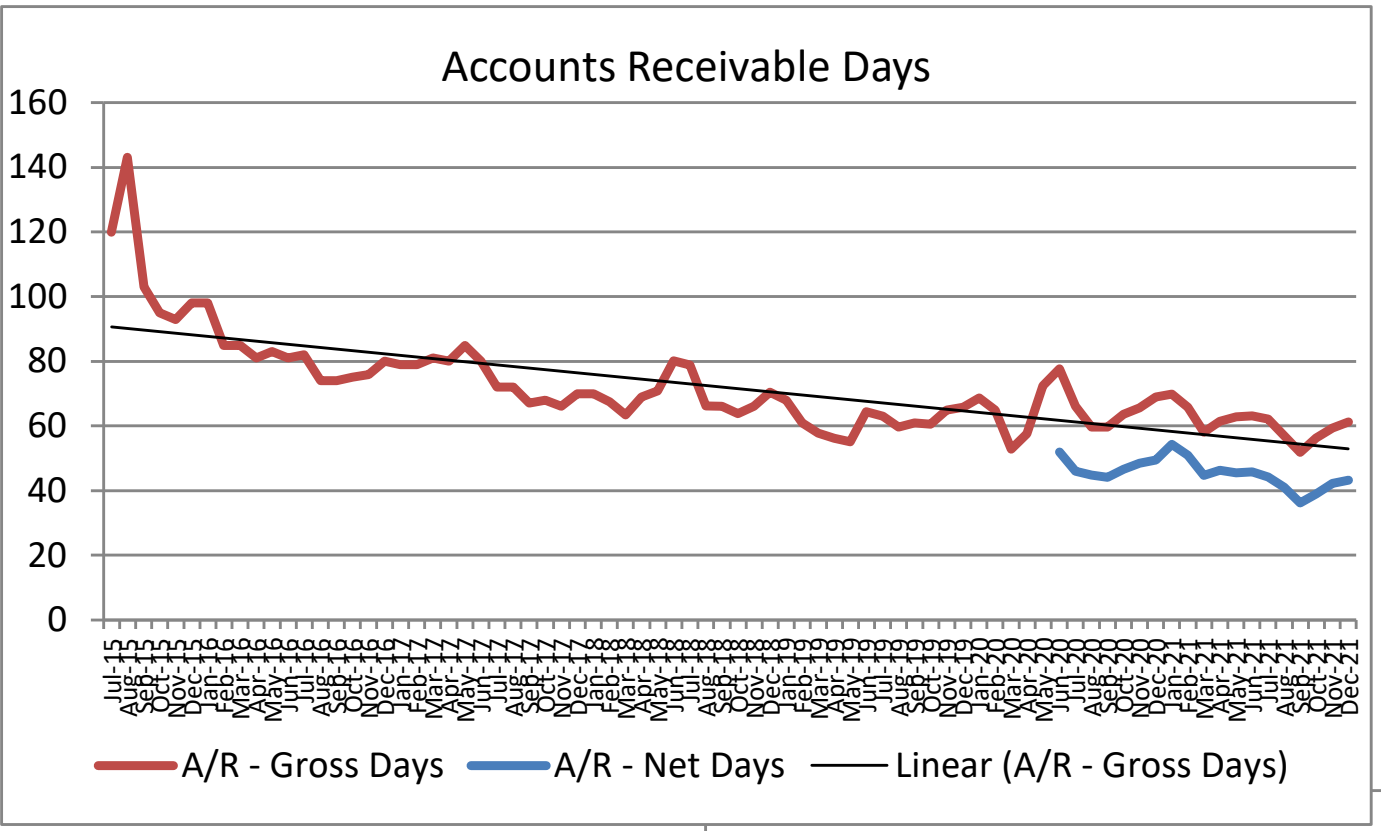

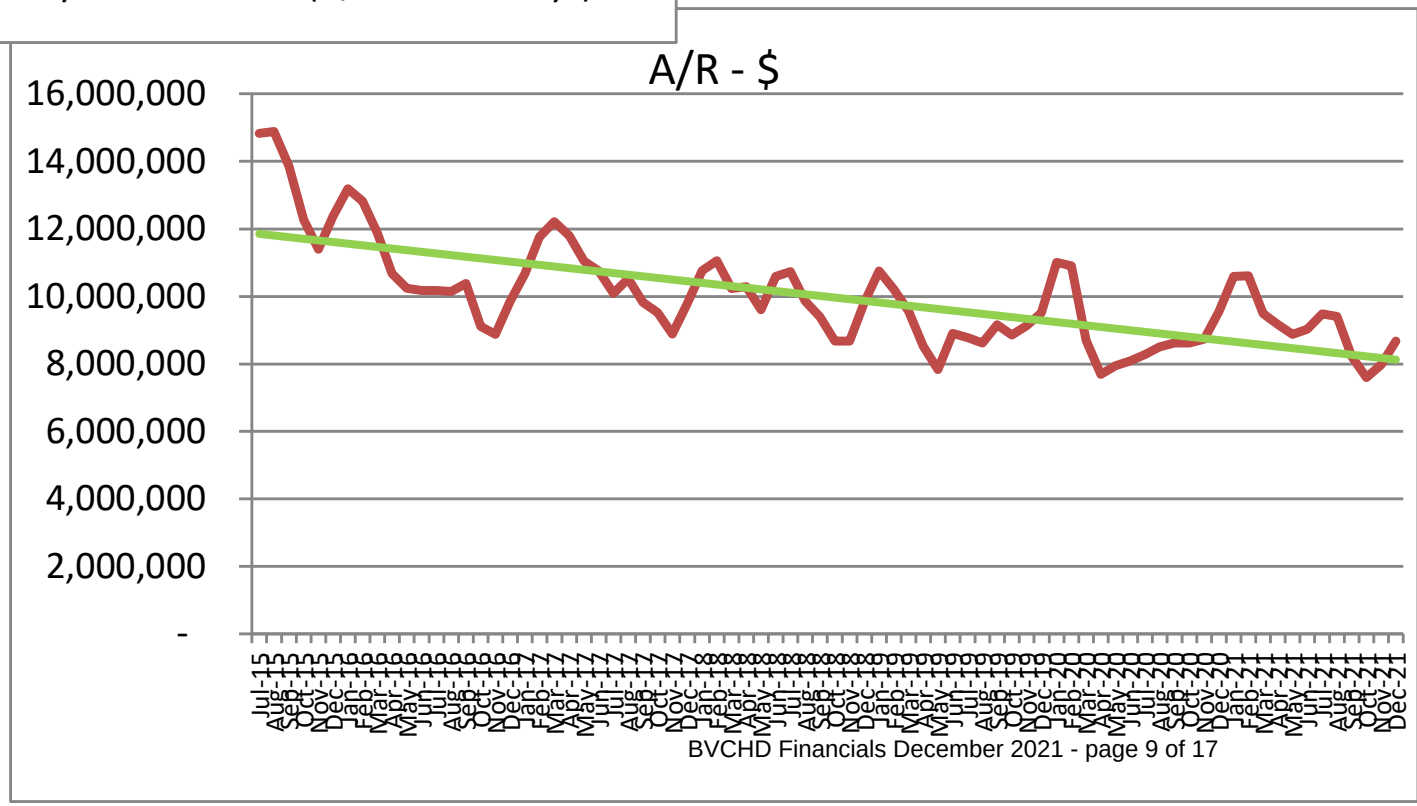

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT

December 2021 Financial Results

For the month . . .

Total Patient Revenue for December 2021 was $4,960,713 ($829,063 more than November 2021). This was 6.5% or $347,075 less than budget. Inpatient revenue was 19.0% less than budget for the month. Outpatient revenue was 33.2% lower than budget. Clinic revenue was 8.1% less than budget. ER revenue was 0.5% less than budget. Skilled Nursing Facility revenue was 8.4% more than budget.

Total Revenue deductions of $2,715,665 were right at budget for the month.

Total Operating Revenue was 17.6% lower than our budgeted amount for the month.

Total Expenses of $2,679,982 were 9.8% more than budget (but $181,204 lower than last month). We continue to see Salaries and Benefits over budget. Supplies expenses continue over budget. Purchased Services were more than budget. Insurance expense continues over budget in Property and D & O insurance.

Our Operating Cash and Investments total $36,877,974 as of the end of month. Total days cash on hand as of the end of December 2021 were 438.

Key Statistics

Acute patient days were 59 for the month, 19% under budget. We had no Swing Patient days for the month. Skilled Nursing Facility days of 372 were 12% under budget – our Average Daily Census was 12.0. ER Visits of 1,314 were 9.9% higher than budget. Clinics Medical visits were 6.9% less than budget. Dental visits were 202 for month.

FTE (Full Time Equivalents) for the month were 205.1.

Year-to-Date (through our first 3 months)

Total Patient Revenue – 0.3% more than budget
Total Revenue Deductions – 7.2% more than budget
Total Operating Revenue – 10.3% under budget
Total Expenses – 12.8% more than budget

Bear Valley Community Healthcare District

Financial Statements November 30, 2021

Financial Highlights—Hospital

STATEMENT OF OPERATIONS

		A	B	C	D	E	F	G	H	I	J
		Current Month					Year-to-Date				
		FY 20/21	FY 21/22		VARIANCE		FY 20/21	FY 21/22		VARIANCE	
		Actual	Actual	Budget	Amount	%	Actual	Actual	Budget	Amount	%
1	Total patient revenue	4,752,401	4,960,713	5,307,788	(347,075)	-6.5%	26,019,448	27,659,248	27,583,282	75,966	0.3%
2	Total revenue deductions	2,441,637	2,715,529	2,715,665	(136)	0.0%	13,545,319	15,154,770	14,141,654	1,013,116	7.2%
3	% Deductions	51%	55%	51%			52%	55%	51%		
4	Net Patient Revenue	2,310,763	2,245,184	2,592,123	(346,939)	-13.4%	12,474,129	12,504,478	13,441,628	(937,150)	-7.0%
5	% Net to Gross	49%	45%	49%			48%	45%	49%		
6	Other Revenue	67,363	(14,843)	114,878	(129,721)	-112.9%	357,077	174,685	688,658	(513,973)	-74.6%
7	Total Operating Revenue	2,378,127	2,230,342	2,707,001	(476,659)	-17.6%	12,831,207	12,679,163	14,130,286	(1,451,123)	-10.3%
8	Total Expenses	2,445,264	2,679,982	2,440,005	239,977	9.8%	13,700,884	16,051,413	14,228,726	1,822,687	12.8%
9	% Expenses	51%	54%	46%			53%	58%	52%		
10	Surplus (Loss) from Operations	(67,137)	(449,640)	266,996	(716,636)	268.4%	(869,678)	(3,372,250)	(98,440)	(3,273,810)	-3325.7%
11	% Operating margin	-1%	-9%	5%			-3%	-12%	0%		
12	Total Non-operating	269,352	122,844	248,254	(125,410)	-50.5%	1,350,555	1,150,705	1,337,524	(186,819)	-14.0%
13	Surplus/(Loss)	202,215	(326,796)	515,250	(842,046)	163.4%	480,877	(2,221,545)	1,239,084	(3,460,629)	279.3%
14	% Total margin	4%	-7%	10%			2%	-8%	4%		

BALANCE SHEET

		A	B	C	D	E
		December	December	November		
		FY 20/21	FY 21/22	FY 21/22	VARIANCE	
					Amount	%
15	Gross Accounts Receivables	9,554,472	8,680,600	7,969,758	710,842	8.9%
16	Net Accounts Receivables	2,985,923	2,576,732	2,312,866	263,866	11.4%
17	% Net AR to Gross AR	31%	30%	29%		
18	Days Gross AR	69.0	61.2	59.3	1.9	3.2%
19	Cash Collections	1,901,700	1,883,013	1,657,029	225,984	13.6%
20	Settlements/IGT Transactions	65,404	181,052	110,780	70,272	63.4%
	Stimulus Receipts	6,958	641,505	524,616	116,889	22.3%
21	Investments	34,068,528	34,930,232	34,909,533	20,699	0.1%
22	Cash on hand	2,691,025	1,947,742	1,616,814	330,928	20.5%
23	Total Cash & Invest	36,759,553	36,877,974	36,526,347	351,627	1.0%
24	Days Cash & Invest	514	438	433	5	1.1%
	Total Cash and Investments	36,759,553	36,877,974			
	Increase Current Year vs. Prior Year		118,421			

Bear Valley Community Healthcare District
Financial Statements November 30, 2021

Statement of Operations

		A	B	C	D	E	F	G	H	I	J
		Current Month					Year-to-Date				
		FY 20/21	FY 21/22		VARIANCE		FY 20/21	FY 21/22		VARIANCE	
		Actual	Actual	Budget	Amount	%	Actual	Actual	Budget	Amount	%
	Gross Patient Revenue										
1	Inpatient	186,971	170,795	210,846	(40,051)	-19.0%	1,163,387	800,687	1,116,927	(316,240)	-28.3%
2	Outpatient	972,010	561,835	840,863	(279,028)	-33.2%	4,660,446	4,490,602	4,948,792	(458,190)	-9.3%
3	Clinic Revenue	284,301	281,768	306,762	(24,994)	-8.1%	1,900,523	1,808,375	1,882,530	(74,155)	-3.9%
4	Emergency Room	3,102,541	3,737,527	3,756,752	(19,225)	-0.5%	17,200,120	19,359,001	18,492,065	866,936	4.7%
5	Skilled Nursing Facility	206,578	208,788	192,565	16,223	8.4%	1,094,972	1,200,583	1,142,968	57,615	5.0%
6	**Total patient revenue**	**4,752,401**	**4,960,713**	**5,307,788**	**(347,075)**	**-6.5%**	**26,019,448**	**27,659,248**	**27,583,282**	**75,966**	**0.3%**
	Revenue Deductions										
7	Contractual Allow	2,151,875	2,617,644	2,391,232	226,412	9.5%	12,454,819	14,244,857	12,455,656	1,789,201	14.4%
8	Contractual Allow PY	(150,000)	(150,000)	-	(150,000)	#DIV/0!	(1,183,402)	(868,294)	-	(868,294)	#DIV/0!
9	Charity Care	1,748	(1,094)	22,788	(23,882)	-104.8%	107,428	82,744	118,425	(35,681)	-30.1%
10	Administrative	5,530	3,086	5,946	(2,860)	-48.1%	19,326	106,054	30,901	75,153	243.2%
11	Policy Discount	15,336	21,404	18,302	3,102	16.9%	83,884	118,173	95,109	23,064	24.2%
12	Employee Discount	5,918	18,715	11,052	7,663	69.3%	35,778	93,947	57,434	36,513	63.6%
13	Bad Debts	334,477	143,638	266,345	(122,707)	-46.1%	1,532,238	896,950	1,384,129	(487,179)	-35.2%
14	Denials	109,385	62,136	-	62,136	#DIV/0!	495,248	480,341	-	480,341	#DIV/0!
15	**Total revenue deductions**	**2,441,637**	**2,715,529**	**2,715,665**	**(136)**	**0.0%**	**13,545,319**	**15,154,770**	**14,141,654**	**1,013,116**	**7.2%**
16	**Net Patient Revenue**	**2,310,763**	**2,245,184**	**2,592,123**	**(346,939)**	**-13.4%**	**12,474,129**	**12,504,478**	**13,441,628**	**(937,150)**	**-7.0%**
							-				
	gross revenue including Prior Year	40.2%	40.2%		40.2%		40.2%	447.4%	447.4%	0.0%	
	Contractual Allowances as a percent to gross revenue WO PY and Other CA	39.2%	39.2%		39.2%		39.2%	437.2%	437.2%	0.0%	
17	**Other Revenue**	67,363	(14,843)	114,878	(129,721)	-112.9%	357,077	174,685	688,658	(513,973)	-74.6%
18	**Total Operating Revenue**	**2,378,127**	**2,230,342**	**2,707,001**	**(476,659)**	**-17.6%**	**12,831,207**	**12,679,163**	**14,130,286**	**(1,451,123)**	**-10.3%**
	Expenses										
19	Salaries	1,020,963	1,149,239	1,021,507	127,732	12.5%	5,903,702	6,706,367	6,081,695	624,672	10.3%
20	Employee Benefits	350,869	316,185	403,288	(87,103)	-21.6%	1,935,067	1,959,345	2,322,029	(362,684)	-15.6%
21	Registry	6,696	62,342	-	62,342	#DIV/0!	105,873	821,563	-	821,563	#DIV/0!
22	Salaries and Benefits	**1,378,528**	**1,527,766**	**1,424,795**	**102,971**	7.2%	**7,944,642**	**9,487,274**	**8,403,724**	**1,083,550**	**12.9%**
23	Professional fees	178,669	159,273	190,830	(31,557)	-16.5%	988,489	961,993	1,019,478	(57,485)	-5.6%
24	Supplies	237,684	249,695	157,736	91,959	58.3%	976,338	1,220,776	883,908	336,868	38.1%
25	Utilities	34,994	40,309	37,178	3,131	8.4%	203,705	249,929	219,174	30,755	14.0%
26	Repairs and Maintenance	50,897	41,589	53,430	(11,841)	-22.2%	310,115	260,664	319,992	(59,328)	-18.5%
27	Purchased Services	349,372	436,034	325,554	110,480	33.9%	2,057,022	2,343,098	1,877,695	465,403	24.8%
28	Insurance	37,712	68,935	43,393	25,542	58.9%	222,932	473,284	260,644	212,640	81.6%
29	Depreciation	91,295	91,901	97,426	(5,525)	-5.7%	547,770	551,404	585,361	(33,957)	-5.8%
30	Rental and Leases	16,655	1,219	27,103	(25,884)	-95.5%	102,068	119,075	162,618	(43,543)	-26.8%
32	Dues and Subscriptions	5,231	8,748	6,599	2,149	32.6%	36,914	43,745	39,594	4,151	10.5%
33	Other Expense.	64,228	54,513	75,961	(21,448)	-28.2%	310,892	340,170	456,538	(116,368)	-25.5%
34	**Total Expenses**	**2,445,264**	**2,679,982**	**2,440,005**	**239,977**	**9.8%**	**13,700,884**	**16,051,413**	**14,228,726**	**1,822,687**	**12.8%**
35	**Surplus (Loss) from Operations**	**(67,137)**	**(449,640)**	**266,996**	**(716,636)**	**268.4%**	**(869,678)**	**(3,372,250)**	**(98,440)**	**(3,273,810)**	**-3325.7%**
36	**Non-Operating Income**										
37	Tax Revenue	204,167	204,175	204,167	8	0.0%	1,225,002	1,224,998	1,225,002	(4)	0.0%
38	Other non-operating	10,020	(95,495)	13,320	(108,815)	-816.9%	30,752	(77,296)	79,920	(157,216)	-196.7%
	Interest Income	55,390	21,426	38,100	(16,674)	-43.8%	131,990	47,048	76,600	(29,552)	-38.6%
	Interest Expense	(225)	(7,261)	(7,333)	72	-1.0%	(37,189)	(44,045)	(43,998)	(47)	0.1%
	IGT Expense	-	-	-	-	#DIV/0!	-	-	-	-	#DIV/0!
39	**Total Non-operating**	**269,352**	**122,844**	**248,254**	**(125,410)**	**-50.5%**	**1,350,555**	**1,150,705**	**1,337,524**	**(186,819)**	**-14.0%**
40	**Surplus/(Loss)**	**202,215**	**(326,796)**	**515,250**	**(842,046)**	**163.4%**	**480,877**	**(2,221,545)**	**1,239,084**	**(3,460,629)**	**279.3%**

Bear Valley Community Healthcare District
Financial Statements

Current Year Trending Statement of Operations

A Statement of Operations—CURRENT YEAR 2022

			1	2	3	4	5	6	7	8	9	10	11	12	
			July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	YTD
	Gross Patient Revenue														
1	Inpatient		205,183	68,218	158,880	137,136	60,476	170,795							800,687
2	Outpatient		711,151	1,107,243	748,528	714,979	646,865	561,835							4,490,602
3	Clinic		286,746	319,875	317,058	307,913	295,014	281,768							1,808,375
4	Emergency Room		3,855,619	3,551,235	2,705,755	2,582,787	2,926,079	3,737,527							19,359,001
5	Skilled Nursing Facility		162,677	208,828	205,420	211,653	203,217	208,788							1,200,583
6	**Total patient revenue**		**5,221,376**	**5,255,400**	**4,135,641**	**3,954,468**	**4,131,650**	**4,960,713**	-	-	-	-	-	-	**27,659,248**
	Revenue Deductions	C/A	0.50	0.50	0.51	0.55	0.50	0.53	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.52
7	Contractual Allow		2,633,241	2,641,433	2,123,304	2,161,012	2,068,222	2,617,644							14,244,857
8	Contractual Allow PY		-	(166,414)	(150,000)	(161,900)	(239,980)	(150,000)							(868,294)
9	Charity Care		13,835	10,821	29,173	3,011	26,998	(1,094)							82,744
10	Administrative		13,068	65,243	2,149	470	22,039	3,086							106,054
11	Policy Discount		11,886	25,978	22,294	21,686	14,924	21,404							118,173
12	Employee Discount		3,477	8,688	21,685	14,258	27,122	18,715							93,947
13	Bad Debts		(20,228)	286,419	213,959	94,463	178,698	143,638							896,950
14	Denials		36,893	90,512	122,409	85,491	82,900	62,136							480,341
15	**Total revenue deductions**		**2,692,172**	**2,962,680**	**2,384,974**	**2,218,491**	**2,180,924**	**2,715,529**	-	-	-	-	-	-	**15,154,770**
			0.52	0.56	0.58	0.56	0.53	0.55	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
16	**Net Patient Revenue**		**2,529,203**	**2,292,719**	**1,750,667**	**1,735,978**	**1,950,726**	**2,245,184**	-	-	-	-	-	-	**12,504,478**
	net / tot pat rev		48.4%	43.6%	42.3%	43.9%	47.2%	45.3%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	45.2%
17	**Other Revenue**		7,903	12,423	12,179	69,102	87,920	(14,843)							174,685
18	**Total Operating Revenue**		**2,537,106**	**2,305,142**	**1,762,847**	**1,805,080**	**2,038,646**	**2,230,342**	-	-	-	-	-	-	**12,679,163**
	Expenses														
19	Salaries		1,031,745	1,186,235	1,128,310	1,030,308	1,180,530	1,149,239							6,706,367
20	Employee Benefits		328,024	322,710	327,131	341,164	324,130	316,185							1,959,345
21	Registry		18,220	19,970	20,190	426,685	274,156	62,342							821,563
22	Salaries and Benefits		**1,377,989**	**1,528,915**	**1,475,631**	**1,798,157**	**1,778,816**	**1,527,766**	-	-	-	-	-	-	**9,487,274**
23	Professional fees		158,025	158,753	160,727	159,587	165,629	159,273							961,993
24	Supplies		161,829	250,136	164,872	187,956	206,287	249,695							1,220,776
25	Utilities		41,897	42,700	40,028	40,081	44,915	40,309							249,929
26	Repairs and Maintenance		45,118	36,613	40,799	56,470	40,075	41,589							260,664
27	Purchased Services		390,217	395,513	354,590	405,689	361,055	436,034							2,343,098
28	Insurance		94,188	90,303	77,166	71,409	71,283	68,935							473,284
29	Depreciation		91,901	91,901	91,901	91,901	91,901	91,901							551,404
30	Rental and Leases		17,852	32,492	20,979	21,417	25,116	1,219							119,075
32	Dues and Subscriptions		8,330	6,022	6,214	6,592	7,840	8,748							43,745
33	Other Expense.		45,482	64,915	51,030	55,961	68,269	54,513							340,170
34	**Total Expenses**		**2,432,828**	**2,698,263**	**2,483,936**	**2,895,219**	**2,861,186**	**2,679,982**	-	-	-	-	-	-	**16,051,413**
35	**Surplus (Loss) from Operations**		**104,279**	**(393,120)**	**(721,089)**	**(1,090,139)**	**(822,540)**	**(449,640)**	-	-	-	-	-	-	**(3,372,250)**
36	**Non-Operating Income**														
37	Tax Revenue		204,167	204,167	204,163	204,163	204,163	204,175							1,224,998
38	Other non-operating		20	120	17,719	120	220	(95,495)							(77,296)
	Interest Income		623	403	24,114	163	320	21,426							47,048
	Interest Expense		(7,507)	(7,594)	(7,504)	(7,177)	(7,002)	(7,261)							(44,045)
	IGT Expense														-
39	**Total Non-operating**		**197,304**	**197,095**	**238,492**	**197,269**	**197,701**	**122,844**	-	-	-	-	-	-	**1,150,705**
40	**Surplus/(Loss)**		**301,582**	**(196,025)**	**(482,597)**	**(892,871)**	**(624,839)**	**(326,796)**	-	-	-	-	-	-	**(2,221,545)**

Input Trend Stmt Ops

2021-2022 Actual BS

December Statements include 6/30/21 audit adjustments

BALANCE SHEET

	July	Aug	Sept	Oct	Nov	Dec	PY June
ASSETS:							
Current Assets							
Cash and Cash Equivalents (Includes CD's)	1,511,284	1,403,907	1,085,094	2,218,655	1,616,814	1,947,742	1,344,262
Gross Patient Accounts Receivable	9,485,223	9,407,701	8,231,530	7,586,726	7,968,263	8,676,578	9,034,356
Less: Reserves for Allowances & Bad Debt	6,448,695	6,374,389	5,757,999	5,320,373	5,655,397	6,099,846	5,860,965
Net Patient Accounts Receivable	3,036,527	3,033,312	2,473,531	2,266,353	2,312,866	2,576,732	3,173,391
Tax Revenue Receivable	2,450,000	2,450,000	2,450,000	2,450,000	1,948,524	977,044	55,519
Other Receivables	-3,899	4,389	-33,265	295,202	481,488	634,389	164,283
Inventories	278,346	277,571	273,934	274,099	282,701	269,874	279,460
Prepaid Expenses	780,163	813,857	766,194	727,526	665,682	660,627	552,322
Due From Third Party Payers	0	0					
Due From Affiliates/Related Organizations	0	0					
Other Current Assets	0	0					
Total Current Assets	8,052,421	7,983,036	7,015,487	8,231,835	7,308,075	7,066,408	5,569,237
Assets Whose Use is Limited							
Investments	39,135,702	39,135,702	39,159,533	36,159,533	34,909,533	34,930,232	39,135,702
Other Limited Use Assets	144,375	144,375	144,375	144,375	144,375	144,375	144,375
Total Limited Use Assets	39,280,077	39,280,077	39,303,908	36,303,908	35,053,908	35,074,607	39,280,077
Property, Plant, and Equipment							
Land and Land Improvements	3,061,292	3,061,292	3,061,292	3,061,292	3,071,192	3,071,192	3,061,292
Building and Building Improvements	10,194,722	10,194,722	10,194,722	10,194,722	10,533,054	10,533,054	10,194,722
Equipment	13,874,411	14,013,046	14,058,598	14,100,865	14,100,865	14,136,426	13,850,497
Construction In Progress	376,228	627,178	627,878	1,191,715	2,798,223	2,824,104	374,181
Capitalized Interest							
Gross Property, Plant, and Equipment	27,506,653	27,896,238	27,942,490	28,548,594	30,503,334	30,564,776	27,480,692
Less: Accumulated Depreciation	16,894,511	16,986,412	17,078,313	17,170,213	17,262,114	17,354,014	16,802,611
Net Property, Plant, and Equipment	10,612,142	10,909,826	10,864,178	11,378,381	13,241,220	13,210,762	10,678,081
TOTAL UNRESTRICTED ASSETS	57,944,639	58,172,939	57,183,572	55,914,124	55,603,204	55,351,777	55,527,395
Restricted Assets	0	0	0	0	0	0	0
TOTAL ASSETS	57,944,639	58,172,939	57,183,572	55,914,124	55,603,204	55,351,777	55,527,395

2021-2022 Actual BS

December Statements include 6/30/21 audit adjustments

BALANCE SHEET

	July	Aug	Sept	Oct	Nov	Dec	PY June
LIABILITIES:							
Current Liabilities							
Accounts Payable	1,142,730	1,297,913	830,678	1,295,173	1,276,619	843,265	1,477,884
Notes and Loans Payable							
Accrued Payroll	968,095	1,101,911	1,218,912	669,378	803,595	947,059	834,286
Patient Refunds Payable							
Due to Third Party Payers (Settlements)	6,734,792	7,066,883	7,107,149	7,012,564	7,407,980	8,054,137	6,671,118
Advances From Third Party Payers							
Current Portion of Def Rev - Txs,	2,245,833	2,041,666	1,837,503	1,633,340	1,429,177	1,225,002	0
Current Portion - LT Debt	40,000	40,000	40,000	40,000	40,000	40,000	40,000
Current Portion of AB915							
Other Current Liabilities (Accrued Interest & Accrued Other)	15,009	22,412	29,772	36,983	43,984	7,261	7,511
Total Current Liabilities	11,146,459	11,570,784	11,064,015	10,687,437	11,001,356	11,116,724	9,030,798
Long Term Debt							
USDA Loan	2,775,000	2,775,000	2,775,000	2,775,000	2,775,000	2,775,000	2,775,000
Leases Payable	0	0	0	0	0	0	0
Less: Current Portion Of Long Term Debt	0	0	0	0	0	0	0
Total Long Term Debt (Net of Current)	2,775,000	2,775,000	2,775,000	2,775,000	2,775,000	2,775,000	2,775,000
Other Long Term Liabilities							
Deferred Revenue	0	0	0	0	0	0	0
Other	0	0	0	0	0		
Total Other Long Term Liabilities	0	0	0	0	0	0	0
TOTAL LIABILITIES	13,921,459	14,345,784	13,839,015	13,462,437	13,776,356	13,891,724	11,805,798
Fund Balance							
Unrestricted Fund Balance	43,721,597	43,721,597	43,721,597	43,721,597	43,721,597	43,721,597	39,042,608
Temporarily Restricted Fund Balance	0	0				0	
Equity Transfer from FRHG	0	0				0	
Net Revenue/(Expenses)	301,582	105,557	-377,040	-1,269,910	-1,894,749	-2,221,545	4,678,990
TOTAL FUND BALANCE	44,023,180	43,827,155	43,344,558	42,451,687	41,826,848	41,500,052	43,721,596
TOTAL LIABILITIES & FUND BALANCE	57,944,639	58,172,939	57,183,572	55,914,124	55,603,204	55,391,777	55,527,395

Units of Service

For the period ending December 31, 2021

31							184					
Current Month						**Bear Valley Community Hospital**	**Year-To-Date**					
Nov-21		**Nov-20**	**Actual -Budget**		**Act.-Act.**		**Nov-21**		**Nov-20**	**Actual -Budget**		**Act.-Act.**
Actual	**Budget**	**Actual**	**Variance**	**Var %**	**Var %**		**Actual**	**Budget**	**Actual**	**Variance**	**Var %**	**Var %**
59	73	64	(14)	-19.2%	-7.8%	Med Surg Patient Days	274	377	264	(103)	-27.3%	3.8%
-	19	-	(19)	0.0%	#DIV/0!	Swing Patient Days	19	100	167	(81)	-81.0%	-88.6%
372	424	465	(52)	-12.3%	-20.0%	SNF Patient Days	2,218	2,601	2,459	(383)	-14.7%	-9.8%
431	**516**	**529**	**(85)**	**-16.5%**	**-18.5%**	**Total Patient Days**	**2,511**	**3,078**	**2,890**	**(567)**	**-18.4%**	**-13.1%**
12	13	11	(1)	-7.7%	9.1%	Acute Admissions	60	78	64	(18)	-23.1%	-6.3%
13	13	9	-	0.0%	44.4%	Acute Discharges	65	78	61	(13)	-16.7%	6.6%
4.5	5.6	7.1	#DIV/0!	#DIV/0!	-36.2%	Acute Average Length of Stay	4.2	4.8	4.3	7.9	163.9%	-2.6%
1.9	2.4	2.06	(0.45)	-19.2%	-7.8%	Acute Average Daily Census	1.5	2	1.4	(0.6)	-27.3%	3.8%
12.0	14.3	15.0	(2.3)	-16.0%	-20.0%	SNF/Swing Avg Daily Census	12.2	15	14.3	(2.5)	-17.2%	-14.8%
13.9	**16.6**	**17.1**	**(2.7)**	**-16.5%**	**-18.5%**	**Total Avg. Daily Census**	**13.6**	**17**	**15.7**	**(3.1)**	**-18.4%**	**-13.1%**
31%	**37%**	**38%**	**-6%**	**-16.5%**	**-18.5%**	**% Occupancy**	**30%**	**37%**	**35%**	-7%	**-18.4%**	**-13.1%**
10	10	7	-	0.0%	42.9%	Emergency Room Admitted	29	60	33	(31)	-51.7%	-12.1%
1,304	1,184	5,195	120	10.1%	-74.9%	Emergency Room Discharged	6,234	5,667	5,195	567	10.0%	20.0%
1,314	**1,196**	**5,202**	**118**	**9.9%**	**-74.7%**	**Emergency Room Total**	**6,263**	**5,728**	**5,228**	**535**	**9.3%**	**19.8%**
42	**39**	**168**	**4**	**9.9%**	**-74.7%**	**ER visits per calendar day**	**34**	**31**	**28**	**3**	**9.3%**	**19.8%**
83%	**77%**	**64%**	**#DIV/0!**	**#DIV/0!**	**31.0%**	**% Admits from ER**	**48%**	**77%**	**52%**	**58%**	**75.5%**	**-6.3%**
-	-	-	-	0.0%	#DIV/0!	Surgical Procedures I/P	-	-	1	-	#DIV/0!	-100.0%
4	17	4	(13)	-76.5%	0.0%	Surgical Procedures O/P	9	107	34	(98)	-91.6%	-73.5%
4	**17**	**4**	**(13)**	**-76.5%**	**0.0%**	**TOTAL Procedures**	**9**	**107**	**35**	**(98)**	**-91.6%**	**-74.3%**
415	**849**	**751**	**(434)**	**-51.1%**	**-44.7%**	**Surgical Minutes Total**	**2,842**	**5,040**	**4,018**	**(2,198)**	**-43.6%**	**-29.3%**

Units of Service

For the period ending December 31, 2021

Bear Valley Community Hospital

Current Month							Year-To-Date					
Nov-21		Nov-20	Actual -Budget		Act.-Act.		Nov-21		Nov-20	Actual -Budget		Act.-Act.
Actual	Budget	Actual	Variance	Var %	Var %		Actual	Budget	Actual	Variance	Var %	Var %
6,010	5,625	6,332	385	6.8%	-5.1%	Lab Procedures	37,783	36,075	35,910	1,708	4.7%	5.2%
964	903	801	61	6.8%	20.3%	X-Ray Procedures	4,425	4,447	4,258	(22)	-0.5%	3.9%
398	422	339	(24)	-5.7%	17.4%	C.T. Scan Procedures	2,160	1,972	1,977	188	9.5%	9.3%
123	154	173	(31)	-20.1%	-28.9%	Ultrasound Procedures	1,001	1,073	1,143	(72)	-6.7%	-12.4%
43	52	53	(9)	-17.3%	-18.9%	Mammography Procedures	280	257	274	23	8.9%	2.2%
300	295	215	5	1.7%	39.5%	EKG Procedures	1,792	1,694	1,492	98	5.8%	20.1%
106	122	120	(16)	-13.1%	-11.7%	Respiratory Procedures	706	531	445	175	33.0%	58.7%
1,480	1,054	1,341	426	40.4%	10.4%	Physical Therapy Procedures	11,374	8,296	8,536	3,078	37.1%	33.2%
1,372	1,474	1,409	(102)	-6.9%	-2.6%	Primary Care Clinic Visits	9,096	9,245	9,505	(149)	-1.6%	-4.3%
202	180	229	22	12.2%	-11.8%	Specialty Clinic Visits	1,314	1,189	1,489	125	10.5%	-11.8%
1,574	**1,654**	**1,638**	**(80)**	**-4.8%**	**-3.9%**	**Clinic**	**10,410**	**10,434**	**10,994**	**(24)**	**-0.2%**	**-5.3%**
61	**64**	**63**	**(3)**	**-4.8%**	**-3.9%**	**Clinic visits per work day**	**57**	**57**	**60**	**(0)**	**-0.2%**	**-5.3%**
10.0%	19.00%	14.50%	-9.00%	-47.37%	-31.03%	% Medicare Revenue	14.52%	19.00%	15.98%	-4.48%	-23.60%	-9.18%
34.00%	37.00%	34.00%	-3.00%	-8.11%	0.00%	% Medi-Cal Revenue	36.12%	37.00%	35.40%	-0.88%	-2.39%	2.02%
51.60%	39.00%	45.00%	12.60%	32.31%	14.67%	% Insurance Revenue	44.65%	39.00%	42.68%	5.65%	14.49%	4.61%
4.40%	5.00%	6.50%	-0.60%	-12.00%	-32.31%	% Self-Pay Revenue	4.72%	5.00%	5.93%	-0.28%	-5.67%	-20.51%
157.6	172.1	148.4	(14.5)	-8.4%	6.3%	Productive FTE's	155.62	170.5	144.2	(14.8)	-8.7%	7.9%
205.1	191.2	169.8	13.9	7.3%	20.8%	Total FTE's	188.13	189.6	163.4	(1.5)	-0.8%	15.1%

CFO REPORT for

February 2022 Finance Committee and Board

vaccine confidence HRSA grant

We received a $ 100,000 vaccine confidence HRSA grant. The money is being allocated to partial payment of the Employee Health Nurse's wages and benefits, indirect costs, IT equipment for vaccine clinics, marketing of vaccines, and the purchase of a car to conduct vaccine home visits and transportation of supplies to and from vaccine clinics.

American Rescue Plan (ARP) SHIP

These are trying times for our health care systems. Our working environment is changing again with the Omicron COVID-19 virus.

"The American Rescue Plan (ARP) COVID-19 Testing and Mitigation SHIP Funding program will provide increased COVID-19 testing to rural populations ensuring an equitable distribution across the country. Long-standing systemic health and social inequities have put some rural residents at increased risk of getting COVID-19 or having severe illness. This includes the 10 million rural residents who identify as Black, Hispanic, American Indian/Alaska Native (AI/AN),

Asian American/Pacific Islander (AA/PI), or mixed race. One in five rural residents belongs to one or more of these groups.

Targeted support is necessary for rural communities to overcome barriers towards achieving and maintaining high COVID-19 testing rates. From the provider perspective, these barriers include limited financial and personnel resources to support ongoing testing efforts. Providers have limited staff and physical resources and COVID-19 testing activities must be balanced against COVID-19 vaccinations and other health care services. From the patient perspective, these barriers include hesitancy and challenges with health care access."

The grant will disburse a grant amount of $258,376.

The graph below shows urgent care visits by month for 2021.