BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

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 12, 2020 @ 1:00 p.m. – 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 3:00 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. **HOSPITAL QUALITY/RISK/COMPLIANCE REPORTS: *Pursuant to Health & Safety Code Section 32155**
   (1) Risk / Compliance Management Report
   (2) QI Management Report

3. **REAL PROPERTY NEGOTIATIONS: *Government Code Section 54956.8/TRADE SECRETS: *Pursuant to Health and Safety Code Section 32106 and Civil Code Section 34266.1**
   (1) Property Acquisition/Lease/Tentative Improvement (Anticipated Disclosure 02/12/2020)

4. **TRADE SECRETS: Pursuant to Health and Safety Code Section 32106, and Civil Code Section 3426.1**
   (1) Michael Norman D.O. Respiratory Therapy Director Service Agreement
   (Anticipated Disclosure 02/12/2020)

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 **Holly Elmer, 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. December 11, 2019 Business Board Meeting Minutes: Shelly Egerer, Executive Assistant
B. January 21, 2020 Special Business Board Meeting Minutes: Shelly Egerer, Executive Assistant
C. January 2020 Planning & Facilities Report: Michael Mursick, Plant Director
D. Q4 2019 Fire Life Safety Report: Michael Mursick, Plant Director
E. January 2020 Human Resource Report: Erin Wilson, Human Resource Director
F. January 2020 Infection Prevention Report: Heather Loose, Infection Preventionist
G. Policies & Procedures (Summary Attached)
  (1) Pharmacy Department
  (2) Emergency Preparedness
  (3) Plant Maintenance Department
  (4) Health Information Management
H. Committee Meeting Minutes
  (1) December 09, 2019 Finance Committee Meeting Minutes

10. OLD BUSINESS*

- None

11. NEW BUSINESS*

A. Discussion and Potential Approval of the Following Agreement:
  (1) Michael Norman D.O. Respiratory Therapy Director Service Agreement

12. ACTION ITEMS*

A. <u>Acceptance of QHR Report</u>

Ron Vigus, QHR

(1) February 2020 QHR Report

B. <u>Acceptance of CNO Report</u>

Kerri Jex, Chief Nursing Officer

(1) January 2020 CNO Report

C. <u>Acceptance of the CEO Report</u>

John Friel, Chief Executive Officer

(1) January 2020 CEO Report

(2) BVCHD Organizational Chart

(3) 2020 Board & Committee Meeting Calendar

D. <u>Acceptance of the Finance Report & CFO Report</u>

Garth Hamblin, Chief Financial Officer

(1) December 2019

(2) February 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
December 11, 2019

PRESENT:	Peter Boss, MD, President	Donna Nicely, Treasurer
	Gail McCarthy, 1st Vice President	John Friel, CEO
	Steven Baker, 2nd Vice President	Shelly Egerer, Exec. Administration
	Perri Melnick, Secretary	
ABSENT:	Holly Elmer, Foundation	
STAFF:	Garth Hamblin	Steven Knapik, DO	Erin Wilson
	Sheri Mursick	Kerri Jex	Mary Norman
OTHER:	Gail Dick, Auxiliary	Jerrald Tucker, JWT	Michelle French
	Donna Pappas, Foundation	Josh Steeber, SmartWatt	
COMMUNITY MEMBERS:			

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 at1:00 p.m. Hearing no request to make public comment. President Boss closed Public Forum for Closed Session at 1:01 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 Nicely to adjourn to Closed Session. Second by Board Member Baker to adjourn to Closed Session. President Boss called for a vote. A vote in favor of the motion was 5/0.
   - Board Member Melnick- yes
   - Board Member Nicely- yes
   - President Boss - yes
   - Board Member McCarthy - yes
   - Board Member Baker - yes

RECONVENE TO OPEN SESSION

1. **CALL TO ORDER:**
   President Boss called the meeting to Open Session at 3:00 p.m.

2. **ROLL CALL:**
   Peter Boss, Perri Melnick, Donna Nicely, Gail McCarthy and Steven Baker were present. Also, present was John Friel, CEO and Shelly Egerer, Executive Assistant.

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

4. **ADOPTION OF AGENDA:**
   President Boss called for a motion to adopt the December 11, 2019 agenda as presented. Motion by Board Member Nicely to adopt the December 11, 2019 agenda as presented. Second by Board Member Melnick to adopt the December 11, 2019 agenda as presented. President Boss called for a vote. A vote in favor of the motion was 5/0.
   - Board Member Melnick- yes
   - Board Member Nicely- yes
   - President Boss - yes
   - Board Member McCarthy - yes
   - Board Member Baker – yes

5. **RESULTS OF CLOSED SESSION:**
   President Boss reported that the following action was taken in Closed Session:

   The following reports were approved:
   - Chief of Staff Report;

   - Request for Initial Appointment:
     - Michael Chin, MD
     - Damian D'Auria, DDS

   - Request for Reappointment:
     - Brian Park, MD
     - Amanda Holden, MD
     - Christopher Fagan, MD

   - Request for Additional Privileges
     - Bohdan Olesnicky, MD

   - Voluntary Resignation
     - Jennifer Nowotney, RDH
     - Roxana Mendoza, RDH
     - Vanessa Montano, RDH

   - Risk Report/Compliance Report

- QI Report

President Boss called for a vote. A vote in favor of the motion was 5/0.

- Board Member Melnick- yes
- Board Member Nicely- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker - yes

6. PUBLIC FORUM FOR OPEN SESSION:

President Boss opened the Hearing Section for Public Comment on Open Session items at 3:00 p.m. Hearing no request to make public comment. President Boss closed Public Forum for Closed Session at 3:00 p.m.

7. DIRECTORS COMMENTS

- Board Member Melnick wished a very Merry Christmas & Happy New Year to all and thanked the full Board for welcoming her.
- President Boss reported that they received many thank you notes regarding the bonus and is pleased to know that employees are grateful.
- The full Board of Directors wished staff a Merry Christmas.

8. INFORMATION REPORTS:

A. Foundation Report:

- Ms. Pappas reported the following information:
  - Will be presenting a gift at the BVCHD holiday party
    - Humanitarian of the Year Award $4,139
    - Pasquale Esposito Concert approximately $32,000
    - Tree of Lights $13,582

B. Auxiliary Report:

- Ms. Dick reported the following:
  - Five new members
  - 12,527 hours volunteered for the year
  - New Board Members:
    - Gail Dick, President: Sandy Washbaugh, Vice President, Barbara Nadow, Treasurer and Sandy Groon, Secretary

9. CONSENT AGENDA:

A. November 13, 2019 Business Board Meeting Minutes: Shelly Egerer, Executive Assistant
B. November 2019 Planning & Facilities Report: Michael Mursick, Plant Director
C. November 2019 Human Resource Report: Erin Wilson, Human Resource Director
D. November 2019 Infection Prevention Report: Heather Loose, Infection Preventionist
E. Policies & Procedures (Summary Attached)
(1) Risk Management
(2) Infection Control
(3) Anesthesia
(4) Laboratory

F. Committee Meeting Minutes
(1) June 05, 2019 Planning & Facilities Committee Meeting
(2) October 01, 2019 Special Finance Committee Meeting

President Boss called for a motion to approve the Consent Agenda as presented. Motion by Board Member McCarthy to approve the Consent Agenda as presented. Second by Board Member Melnick to approve the Consent Agenda as presented. President Boss called for the vote. A vote in favor of the motion was 5/0.

- Board Member Melnick- yes
- Board Member Nicely- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker - yes

10. OLD BUSINESS:

- None

11. NEW BUSINESS*

A. Discussion and Potential Approval of the Following Service Agreements:
(1) Steven Knapik, D.O. Chief of Staff Service Agreement

President Boss called for a motion to approve Steven Knapik, DO Chief of Staff Service Agreement with the typo on page one needs to have two-year term and a 60-day written notice by either party added to the agreement. Motion by Board Member Melnick to approve Steven Knapik, DO Chief of Staff Service Agreement with the typo on page one needs to have two-year term and a 60-day written notice by either party added to the agreement. Second by Board Member Baker to approve Steven Knapik, DO Chief of Staff Service Agreement with the typo on page one needs to have two-year term and a 60-day written notice by either party added to the agreement. President Boss called for the vote. A vote in favor of the motion was 5/0.

- Board Member Melnick- yes
- Board Member Nicely- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker - yes

B. Discussion and Potential Approval of Fiscal Year 2019 Audited Financial Statement:

- Mr. Tucker provided the following information:
  - Received an unmodified opinion
  - No material weakness
  - No audit adjustments
  - No difficulties encountered with staff
  - One late entry for worker's comp audit
  - Three-year trend
  - Volumes and collections have driven main numbers
  - Hospital made $7 million for 2019
  - Revenue cycle management is handled well

- AR is 37 days
- Cash and investment approximately $27 million
- Cash on hand is 419 days

President Boss called for a motion to approve Fiscal Year 2019 Audited Financial Statement as presented. Motion by Board Member Nicely to approve Fiscal Year 2019 Audited Financial Statement presented. Second by Board Member Bakerto Fiscal Year 2019 Audited Financial Statement. President Boss called for the vote. A vote in favor of the motion was 5/0.

- Board Member Melnick- yes
- Board Member Nicely- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker - yes

C. Discussion and PotentialApproval of Fiscal Year 2019 Cost Report:

- Mr. Hamblin reported the following information:
  - Amount due to BVCHD $186,000
  - David Perry w/QHR reviews the report prior to being presented to the Board of Directors

President Boss called for a motion to approve Fiscal Year 2019 Cost Report as presented. Motion by Board Member Nicely to approve Fiscal Year 2019 Cost Report as presented. Second by Board Member McCarthyto approve Fiscal Year 2019 Cost Report as presented. President Boss called for the vote. A vote in favor of the motion was 5/0.

- Board Member Melnick- yes
- Board Member Nicely- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker - yes

D. Discussion and Potential Approval of Resolution No. 19-459 SmartWatt To Conduct An Investment Grade Audit At No Cost To BVCHD:

- Mr. Friel provided an introduction and informed the Board that the Planning & Facilities Committee received the presentation and approved providing the information to the Board of Directors.

- Josh Steeber reported the following:
  - Eight-year-old company
  - Certified by Department of Energy
  - Guaranteed results
  - Government Section Code 4217
  - Step one is to listen & learn
  - Step 2 envision and planning
  - Step 3 implement and sustain
  - Six energy measures throughout the campus
  - Transformers replacement
  - Renewable energy
  - Savings of $205,000 per year

- Goal is to bring best value
- Always have greater savings than cost
- We are the general contractor, we deal with OSHPD this if full turn-key
- 7% a year in energy savings
- Next step would be to approve the resolution, investment grade audit
- Team would be on site to complete a room by room assessment
- Would take approximately 3 to 4 months to complete assessment

Board Member Nicely excused herself at 4:00 pm

President Boss called for a motion to approve Resolution No. 19-459 SmartWatt To Conduct An Investment Grade Audit At No Cost To BVCHD with changes to line two and three. Motion by Board Member Melnick to approve Resolution No. 19-459 SmartWatt To Conduct An Investment Grade Audit At No Cost To BVCHD with changes to line two and three. Second by Board Member Baker to approve Resolution No. 19-459 SmartWatt To Conduct An Investment Grade Audit At No Cost To BVCHD with changes to line two and three. President Boss called for the vote. A vote in favor of the motion was 4/0.

- Board Member Melnick- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker - yes

12. ACTION ITEMS*

A. QHR Report:

(1) December2019 QHR Report:

- Mr. Friel reported Ron would not be in attendance and asked if there were any questions on Mr. Vigus report

President Boss called for a motion to approve the QHR Report as presented. Motion by Board Member Baker to approve the QHR Report as presented. Second by Board Member Melnick 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 Melnick- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker - yes

B. CNO Report:

(1) November 2019 CNO Report:

- Ms. Jex reported the following:
  - CDPH completed the annual survey received 2567; POC was submitted
  - Continue building relationship with ski patrol at the mountains, Orthopedic training was completed with their staff

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 Melnickto approve the CNO Report as presented. President Boss called for the vote. A vote in favor of the motion was 4/0.

- Board Member Melnick- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker - yes

C. Acceptance of the CEO Report:

(1) November 2019 CEO Report:

- Mr. Friel reported the following information:
  - UCR OB/GYN meeting was cancelled and will be rescheduled
  - We are working with legal counsel on Dr. Kondal's agreements that require Board approval. At this time, we want to inform the Board that Administration extended her current agreements with a holdover agreement that legal counsel drafted, and Dr. Boss signed off on the documents.
  - Christmas Party Saturday December 14 at the Convention Center

(2) Grant Writer:

- Ms. French
  - Works with various departments
  - Grant process of identifying needs
  - Meeting with Foundation needs to be scheduled in order to apply for grants through a 501C3

President Boss called for a motion to approve the CEO Report as presented. Motion by Board Member Baker to approve the CEO Report as presented. Second by Board Member McCarthy to approve the CEO Report as presented. President Boss called for the vote. A vote in favor was unanimously approved 4/0.

- Board Member Melnick- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker - yes

D. Acceptance of the Finance Report:

(1) October 2019 Financials:

- Mr. Hamblin reported the following information:
  - Days cash on hand 417
  - Financial results are well

(2) CFO Report:

- Mr. Hamblin reported the following:
  - Continue to work closely on AR
  - FTE running under budget
  - IT security results are good
  - Cyber insurance is still being looked at for coverage; we continue evaluating program and policies.

President Boss called for a motion to approve the October 2019 Finance Report and the CFO Report as presented. Motion by Board Member McCarthy to approve the October 2019 Finance Report and the CFO Report as presented. Second by Board Member Melnick to approve the October 2019 Finance Report and the CFO Report as presented. President Boss called for the vote. A vote in favor was unanimously approved 4/0.

- Board Member Melnick- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker - yes

E. **Discussion and Potential Approval of Bear Valley Community Healthcare District Election of Officers**:

(1) President

Board Member McCarthy motioned for Dr. Boss to remain as Board President. **Second by Board Member Melnick for Dr. Boss to remain as Board President**. **President Boss called for the vote. A vote in favor was unanimously approved 4/0.**

- Board Member Melnick- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker – yes

(2) 1st Vice President

President Boss motioned Board Member McCarthy to remain as 1st Vice President. Second by Board Member Melnick for Board Member McCarthy to remain as 1st Vice President. **President Boss called for the vote. A vote in favor was unanimously approved 4/0.**

- Board Member Melnick- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker – yes

(3) 2nd Vice President

Board Member McCarthy motioned for Board Member Baker to remain as 2nd Vice President. Second by President Boss for Board Member Baker to remain as 2nd Vice President. President Boss called for the vote. A vote in favor was unanimously approved 4/0.

- Board Member Melnick- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker – yes

(4) Secretary

President Boss motioned for Board Member Nicely as Board Secretary. Second by Board Member Melnick for Board Member Nicely as Board Secretary. President Boss called for the vote. A vote in favor was unanimously approved 4/0.

- Board Member Melnick- yes

- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker - yes

(5) Treasurer

President Boss motioned for Board Member Melnick as Board Treasurer. Second by Board Member Baker for Board Member Melnick as Board Treasurer. President Boss called for the vote. A vote in favor was unanimously approved 4/0.

- Board Member Melnick- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker - yes

F. Discussion and Potential Approval of Bear Valley Community Healthcare District **Committee Members:**

(1) Planning & Facilities Committee Meeting

Board Member McCarthy motioned for Board Member Baker and President Boss for Planning & Facilities Committee. Second by Board Member Melnick for Board Member Baker and President Boss for Planning & Facilities Committee. **President Boss called for the vote. A vote in favor was unanimously approved 4/0.**

- Board Member Melnick- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker - yes

(2) Finance Committee Meeting (Treasurer and Committee Member)

President Boss motioned Board Member Baker as a committee member and Board Member Melnick was Treasurer so she would be chair of the committee. Second by Board Member McCarthy motioned Board Member Baker as a committee member and Board Member Melnick was Treasurer so she would be chair of the committee. **President Boss called for the vote. A vote in favor was unanimously approved 4/0.**

- Board Member Melnick- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker - yes

(3) Human Resource Committee Meeting

President Boss motioned for Board Member McCarthy and Board Member Nicely to be the HR Committee Members. Second by Board Member Baker for Board Member McCarthy and Board Member Nicely to be the HR Committee Members. President Boss called for the vote. A vote in favor was unanimously approved 4/0.

- Board Member Melnick- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker - yes

13. ADJOURNMENT:

President Boss called for a motion to adjourn the meeting at 4:32 p.m. Motion by Board Member McCarthy 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 Melnick- yes
- President Boss - yes
- Board Member McCarthy - yes
- Board Member Baker - yes

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
SPECIAL BUSINESS BOARD MEETING MINUTES
41870 Garstin Drive, Big Bear Lake, Ca. 92315
January 21, 2020

PRESENT:	Peter Boss, President		John Friel, CEO
	Gail McCarthy, 1st Vice President		Shelly Egerer, Exec. Assistant
	Perri Melnick, Treasurer		
ABSENT:	Steve Baker, 2nd Vice President		Donna Nicely, Secretary
STAFF:	Kerri Jex	Michael Mursick	Garth Hamblin, via phone
OTHER:	Mike Sarrao, Legal Counsel		Tyler Wood, Real estate Agent
COMMUNITY MEMBERS:	None		

OPEN SESSION

1. **CALL TO ORDER:**
   President Boss called the meeting to order at 10:00 a.m.

2. **ROLLCALL:**
   Peter Boss, Gail McCarthy, and Perri Melnick, were present. Also present was John Friel, CEO and Shelly Egerer, Executive Assistant. Absent was Donna Nicely and Steven Baker.

3. **FLAG SALUTE:**
   Board Member McCarthy led the flag salute all present participated.

4. **ADOPTION OF AGENDA:**
   President Boss called for a motion to adopt the agenda as presented. Motion by Board Member Melnick to adopt the agenda as presented. Second by Board Member McCarthy to adopt the agenda as presented. President Boss called for the vote. A vote in favor of the motion was 3/0.
   - Board Member Melnick - yes
   - President Boss - yes
   - Board Member McCarthy - yes

CLOSED SESSION

5. **PUBLIC FORUM FOR CLOSSED SESSION:**
   President Boss opened the Hearing Section for Public Comment on Closed Session items at 10:00 a.m. Hearing no request to make public comment, President Boss closed Public Forum for Closed Session at 10:01 a.m.

6. **ADJOURNED TO CLOSED SESSION:**
   President Boss called for a motion to adjourn to Closed Session at 10:01 a.m. Motion by Board Member Melnick to adjourn to Closed Session. Second by Board Member McCarthy to adjourn to Closed Session. President Boss called for a vote. A vote in favor of the motion was 3/0.
   - Board Member Melnick- yes
   - President Boss - yes
   - Board Member McCarthy - yes

RECONVENE TO OPEN SESSION

1. **CALL TO ORDER:**
   President Boss opened the Hearing Section for Public Comment on Open Session items at 10:30 a.m. Hearing no request to make public comment, President Boss closed Public Forum for Open Session at 10:31 a.m.

2. **RESULTS OF CLOSED SESSION:**
   President Boss reported the following action was taken in Closed Session: The Board of Directors unanimously approved the CEO to proceed with the purchase of 10 acres on Sandalwood at $1.9 million and the cost of standard closing/escrow cost.

   President Boss called for a vote. A vote in favor of the motion was 3/0.
   - Board Member Melnick - yes
   - President Boss - yes
   - Board Member McCarthy - yes

3. **PUBLIC FORUM FOR OPEN SESSION**
   President Boss opened the Hearing Section for Public Comment on Open Session items at 10:33 a.m. Hearing no request to make public comment, President Boss closed Public Forum for Open Session at 10:33 a.m.

4. **DIRECTORS COMMENTS:**
   - None

5. **OLD BUSINESS:**
   - None

6. **NEW BUSINESS:**
   - None

7. **ADJOURNMENT**
   President Boss called for a motion to adjourn the meeting at 10:35 a.m. Motion by Board Member McCarthy to adjourn. Second by Board Member Melnick to adjourn. President Boss called for the vote. A vote in favor of the motion was unanimously approved 3/0.
   - Board Member Melnick- yes
   - President Boss - yes
   - Board Member McCarthy - yes

Bear Valley Community Healthcare District
Construction Projects 2019

Department / Project	Details	Vendor and all associated costs	Comments	Date Complete
Respiratory Therapy	Painted, installed curtains	Engineering	Completed	
Pyxis Replacement	Pyxis equipment is in place and seismic anchors will be installed soon.	Facilities	Nearly complete, waiting for Pyxis to send last mount that was not recivied during original delivery.	
SNF TV Project	Facilities is installing the necessary cabiling	Facilities	Completed	
Respritory Therapy	Flooring and cabinets	Facilities/Warren Const.	In Progress	
OR- Remodel & Electrical Repairs	Replace flooring, repair walls & replace LIM's	N/A	In Progress, prepared paperwork with legal and waiting for a response	
CT	CT Auto Opener disable device installation	Ludeke Electric	In Progress	

Bear Valley Community Healthcare District
Potential Equipment Requirements

Department / Project	Details	Vendor and all associated costs	Comments	Date Complete
Facilities- New Work Truck	Purchase a new truck for the department. Our current truck has numerous issues and it is time for a replacement	Victorville Motors, Mark Christopher Chevrolet, Redlands Ford	Completed	
Facilities- Pipe Threader	A new piece of equipment for making pipe for repairs	Northern Tool	New Budget item	
Facilities- Articulating Lift	A new piece of equipment for reaching unsafe places to do repairs	US Rentals	New Capital Budget item	

Bear Valley Community Healthcare District
Repairs Maintenance

Department / Project	Details	Vendor and all associated costs	Comments	Date Complete
Dietary	Replaced the old exhaust fan the imploded.	Engineering	Completed	
OR	Repaired hot/cold water issues on the sterilizer	Engineering	Completed	
Plant	Bioler contol valve is failing	California Boiler	In Progress	
RHC/Plumbing	Added new locking handles to the Lab and Dental door	Engineering	Completed	

Fire Life Safety Report

DATE OF REPORT: 12/10/19 for Q4 2019 Prepared by: Michael Mursick

MONITORED PROCESSES:

- Insure **monthly** maintenance log sheets are completed
- Insure fire drills are carried out once per quarter per shift as per NFPA 101, and District policy.
- Insure **quarterly** fire alarm system inspection was performed. (Simplex Grinnell)

SUMMARY OF FINDINGS:

Above listed processes above were carried out at required intervals. (**Log sheets or reports attached**)

- Above listed logs and drills (monthly & annual) were completed and carried out.
- Duct Detectors on the fire alarm system for the Hospital were failing and needed replaced. Those repairs are completed.
- Fire Sprinkler Heads were identified for replacement on our last quarter inspection. Those repairs have been completed.

ACTION (S) TAKEN:

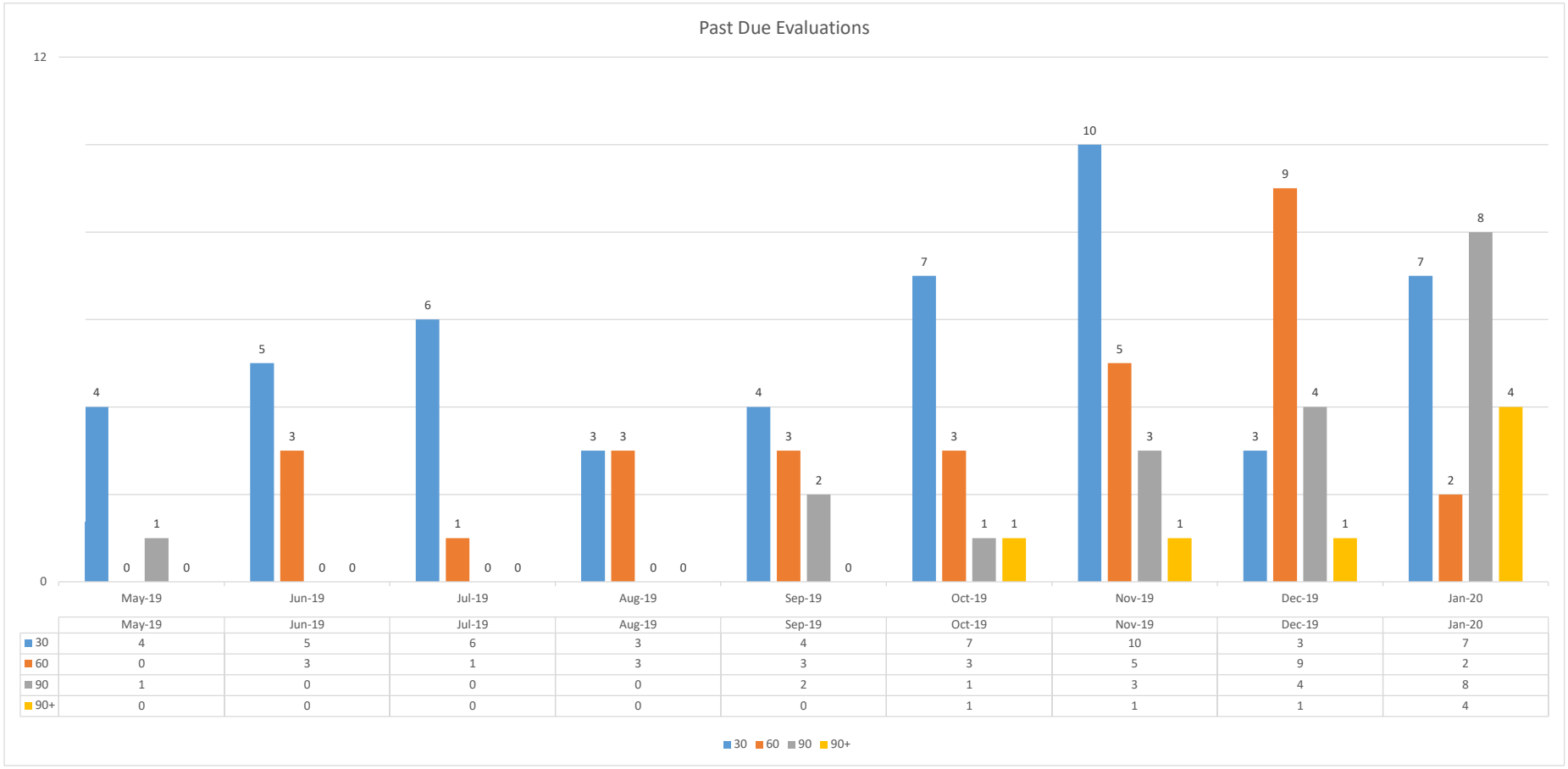
Not necessary at this time.

HR Committee/Board Report December/January 2019/2020

Staffing	**Active:** 220 – FT: 144 PT: 12 PD: 64 **New Hires:** 4 **Terms:** 4 (3 Voluntary 1 Involuntary) **Open Positions:** 10
Employee Performance Evaluations	**DELINQUENT: See attachment** 30 days: 3 60 days: 9 90 days: 4 90+ days: 1 **See Attachment**
Work Comp	**NEW CLAIMS: 0** **OPEN:** 3 Indemnity (Wage Replacement, attempts to make the employee financially whole) - 4 Future Medical Care – 1 Medical Only – 1
Employee File Audit	**FILE AUDIT:** Two files missing signed job description

January 2020

Staffing	**Active:** 219 – FT: 145 PT: 12 PD: 62 **New Hires:** 2 **Terms:** 3 (2 Voluntary 0 Involuntary) **Open Positions:** 13
Employee Performance Evaluations	**DELINQUENT: See attachment** 30 days: 7 60 days: 2 90 days: 8 90+ days: 4 **See Attachment**
Work Comp	**NEW CLAIMS: 2** **OPEN:** 5 Indemnity (Wage Replacement, attempts to make the employee financially whole) - 4 Future Medical Care – 0 Medical Only – 1
Employee File Audit	**FILE AUDIT:** One license expired, employee taken off schedule



	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
30	4	5	6	3	4	7	10	3	7
60	0	3	1	3	3	3	5	9	2
90	1	0	0	0	2	1	3	4	8
90+	0	0	0	0	0	1	1	1	4

Infection Prevention Monthly Report

January 2020

TOPIC	UPDATE	ACTION/FOLLOW UP
1. Regulatory	▪ Continue to receive updates from APIC. ▪ AFL (All Facility Letters) from CDPH have been reviewed. • AFL 20-09 with multiple updates regarding Novel Coronavirus from Wuhan, China – provides guidance for clinical providers, preparation/readiness information for hospitals and infection preventionists. • Our hospital is prepared in the event we receive a patient suspected of having the novel corona virus. We have isolation procedures in order, signage, and are screening all patients for recent travel to China or contact with those who have travelled. ▪ Continue NHSN surveillance reporting. • No Hospital Acquired Infections to report. ▪ Completion of CMR reports to Public Health per Title 17 and CDPH regulations. • November – No reportable illnesses • December – No reportable illnesses • January – No reportable illnesses	▪ Review ICP regulations. ▪ AFL to be reviewed at Infection Control Committee and Regulatory committee. ▪ Continue Monthly Reporting Plan submissions.
2. Construction	▪ One outstanding ICRA Permit for installing new mounts	▪ Work with

	and TVs in the SNF. ▪ As part of the recent Life Safety Survey it's noted that an "above ceiling" permit is required any time there is work being done above ceiling. IP to investigate details.	Maintenance and contractors to ensure compliance.
3. QI	▪ Continue to work towards increased compliance with Hand Hygiene o 71% for November o 72% in December o Final percentage for year 2019 is 77%	• Continue monitoring hand hygiene compliance.
4. Outbreaks/ Surveillance	▪ November – 1 MRSA in ER, 1 C-diff in ER patient ▪ December – 1 MRSA (B-Lactamase) in ER patient, no c-diff ▪ 1 MRSA (B-Lactamase) in ER patient, no C-diff.	▪ Informational
5. Policy Updates	• None this past month	▪ Clinical Policy and Procedure Committee to review and update Infection Prevention policies.
6. Safety/Product	• Continue working with EVS to obtain competencies and improve compliance with OR Cleaning through checklists and surveillance.	▪ Continue to monitor compliance with infection control practices.
7. Antibiotic Stewardship	▪ Pharmacist continues to monitor antibiotic usage.	▪ Informational.
8. Education	▪ ICP continues to attend the APIC meetings in Ontario when possible.	▪ ICP to share information at appropriate committees.

9. Informational	Statistics on Immediate Use Steam Sterilization will now be included with the monthly surgery stats and reported to P&T Committee monthly. ▪ November – 0 IUSS used out of 11 cases ▪ December – 0 IUSS used/ 15 cases ▪ January – 0 IUSS/4 cases Culture Follow-Up ▪ IP oversees culture follow-up process carried out by clinical managers. ▪ Statistics are presented at P&T monthly. Official Flu Season • There has been high flu activity in San Bernardino County with 46 deaths in California, 7 of them in S.B. County. ▪ Mostly influenza B is what's going around • A new law started Jan 1, 2020, requiring certain hospitals to provide IV drug users with clean needles/syringes. Although our hospital is not required, we discussed setting up something similar since we are involved with a program for opioid addiction.	▪ Informational
Heather Loose, BSN, RN Infection Preventionist		*Date: February 3, 2020*

Department	Title	Summary
Pharmacy	340B Inventory Management	Annual review. Formatted.
Pharmacy	340B Non-Compliance Material Breach	Annual review. Formatted.
Pharmacy	340B Policy Statement	Annual review. Formatted.
Pharmacy	340B Program - Roles and Responsibilities	Annual review. Formatted.
Pharmacy	Adult Intravenous Vancomycin Dosing and Monitoring Guidelines	Annual review. Formatted.
Pharmacy	Adverse Drug Reaction Report	Annual review. Formatted.
Pharmacy	After Hours Banana Bag Preparation	Annual review. Formatted.
Pharmacy	After Hours Pharmacy Service	Annual review. Formatted.
Pharmacy	Anesthetic Cart Medications	Annual review. Formatted.
Pharmacy	Antimicrobial Stewardship	Annual review. Formatted.
Pharmacy	Automated Dispensing Cabinets (Pyxis MedStation system)	Annual review. Formatted.
Pharmacy	Bedside Medication- Patient Self- Administration	Annual review. Formatted.
Pharmacy	Board of Pharmacy Notification Required	Annual review. Formatted.
Pharmacy	Controlled Substances	Annual review. Formatted. Policy name changed from "Controlled Drugs".
Pharmacy	Controlled Substance - Inventory Reconciliation Report	Annual review. Formatted. Changed policy name from "Inventory Reconciliation Report of Controlled Substances".
Pharmacy	Controlled Substance - Pharmacy Drug Storage	Annual review. Formatted. Policy name changed from "Pharmacy Controlled Drug Storage".
Pharmacy	Controlled Substance - Purchasing Procedure	Annual review. Formatted. Changed policy name from "Controlled Substances Purchasing Procedure".
Pharmacy	Controlled Substance - Theft or Loss	Annual review. Formatted. Revised to reflect current process. Changed policy name from "Theft or Loss of Controlled Substance".
Pharmacy	Crushing of Solid Dose Medication	Annual review. Formatted.
Pharmacy	CURES Policy	Annual review. Formatted.
Pharmacy	Delivery and Check-In of Refilled Cycle Meds for the SNF	Annual review. Formatted.
Pharmacy	Destruction of Medication	Annual review. Formatted.
Pharmacy	Director of Pharmacy	Annual review. Formatted.
Pharmacy	Distinct Part SNF Pharmacist Monthly Medication Review (MMR)	Annual review. Revised verbiage. Formatted. Changed policy name from "Distinct Part SNF Pharmacist Medication Regime Review".
Pharmacy	Drug Recall and Withdrawal	Annual review. Formatted.
Pharmacy	Drug Shortage	Annual review. Formatted.
Pharmacy	Drug Storage Temperatures	Annual review. Formatted.
Pharmacy	Drug Use Evaluation	Annual review. Formatted.
Pharmacy	Emergency Dispensing of Medications (4 Packs), in the E.D., For Patients to Take Home	Annual review. Formatted. Policy name changed from "Emergency Dispensing of Medications (4 Packs), in the E.D., For Patients to Take Home".
Pharmacy	Expiration Dates for Partially Used Multi Dose Vials (MDV) of Biologicals and Medications	Annual review. Formatted.
Pharmacy	Fentanyl Patch Safety	Annual review. Formatted.
Pharmacy	First Dose Review	Annual review. Formatted.
Pharmacy	Flushing Heparin Lock Ports in Anticoagulated Patients	Annual review. Formatted.
Pharmacy	Generic Drug Dispensing	Annual review. Formatted.
Pharmacy	Hyperalimination	Annual review. Formatted.

Pharmacy	Impaired Pharmacy Personnel	Annual review. Formatted.
Pharmacy	Infection Control in the Pharmacy	Annual review. Formatted.
Pharmacy	Injectable Cancer Chemotherapy Agents	Annual review. Formatted.
Pharmacy	Investigational Drug Use	Annual review. Formatted.
Pharmacy	Medical Staff Formulary Policy and Procedure	Annual review. Formatted.
Pharmacy	Medication Brought to the Facility by a Patient, Resident, or Family Member	Annual review. Formatted.
Pharmacy	Medication Error Reduction Program (MERP)	Annual review. Formatted. Attached last page of document to policy "Medications, High Risk (High Alert)".
Pharmacy	Medication Reconciliation	Annual review. Formatted.
Pharmacy	Medication Stop Order	Annual review. Formatted. Revised to reflect 2019 SNF Survey POC.
Pharmacy	Medications, High Risk (High Alert)	Annual review. Formatted. Revised verbiage to reflect current process. Added #9. Removed chart from last page.
Pharmacy	Minimal Risk Medications	Archived until process in place.
Pharmacy	Ordering Privileges	Annual review. Formatted.
Pharmacy	Pharmacy & Patient Care Area Medication Inspections	Annual review. Formatted.
Pharmacy	Pharmacy and Therapeutic Function of the Medical Staff Executive Committee	Annual review. Formatted.
Pharmacy	Pharmacy Safety Manual	Annual review. Formatted. Revised policy statement. Revised #3.
Pharmacy	Pharmacy Security	Annual review. Formatted.
Pharmacy	PRN Medications	Annual review. Formatted. Revised policy to reflect current process.
Pharmacy	Procurement of Pharmaceuticals	Annual review. Formatted.
Pharmacy	Pyxis User Access	Annual review. Formatted. Revised to reflect current process.
Pharmacy	Quality Assurance Program	Annual review. Formatted.
Pharmacy	Recommended Procedures for Compounding Intravenous Admixtures by Nursing Person	Annual review. Formatted. Revised policy to include definitions of compounding vs. admixing.
Pharmacy	Reference Materials	Annual review. Formatted. Revised to reflect current process. Changed policy name from "Reference Material".
Pharmacy	Repackaging of Pharmaceuticals	Annual review. Formatted.
Pharmacy	SNF Orders Requiring Laboratory Tests at Specified Frequencies	Annual review. Formatted. Revised to reflect current process. Changed policy name from "Required Orders with Specified Frequency as Assessment-Laboratory Test".
Pharmacy	Retention of Pharmacy Records	Annual review. Formatted. Revised to reflect current process.
Pharmacy	Safe Preparation of Compounded Sterile Products	Annual review. Formatted. Revised to reflect current process.
Pharmacy	Scope of Service-Pharmacy	Annual review. Formatted.
Pharmacy	Sound Alike, Look Alike Medications	Annual review. Formatted. Revised to reflect current process.
Pharmacy	Standard Schedule for Administration of Medications	Annual review. Formatted.
Pharmacy	Medication Stop Orders - Skilled Nursing Facility	Annual review. Formatted. Revised to reflect 2019 SNF Survey POC. Changed policy name from "Stop Orders Policy for the Skilled Nursing Facility". Colin feedback: 1) CPOE - how do we expect to happen, nurses or MD as well. 2) Implications of chronoc conditions and what it means. 3) Clarity on what is a psychotropic med.
Pharmacy	Storage Requirements for Skilled Nursing Facility Meds	Annual review. Formatted. Revised to reflect current process.

Pharmacy	Temperature Monitoring of Refrigerated Drugs and Pharmacy Work Space	Annual review. Formatted.
Emergency Preparedness	EMP Addendum Evacuation	Annual review. Revised verbiage to reflect the 2019 Life and Safety Survey POC.
Emergency Preparedness	EMP Addendum, Contacts, External	Annual review. Revised verbiage to reflect the 2019 Life and Safety Survey POC.
Emergency Preparedness	EMP Addendum Hospital Incident Command System	Annual review. Revised verbiage to reflect the 2019 Life and Safety Survey POC. Changed policy name from "Use of HICS Forms".
Plant Maintenance	Loss of Electrical Power	Annual review. Revised verbiage to reflect the 2019 Life and Safety Survey POC.
Plant Maintenance	Fire/Life Safety Management Plan	Annual review. Revised verbiage to reflect the 2019 Life and Safety Survey POC.
Health Information Management	Abbreviations in Medical Documentation	Annual review. Formatted. Revised to reflect current process.
Health Information Management	Accounting of Disclosures	Annual review. Formatted. Revised to reflect current process.
Health Information Management	Amendment To Protected Health Information (PHI)	Annual review. Formatted. Revised to reflect current process.
Health Information Management	De-Identification of PHI	Annual review. Formatted. Revised to reflect current process.
Health Information Management	Incidental Disclosures	Annual review. Formatted. Revised to reflect current process.
Health Information Management	Minimum Necessary	Annual review. Formatted. Revised to reflect current process.

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS
SPECIAL FINANCE COMMITTEE MEETING MINUTES
41870 Garstin Drive, Big Bear Lake, CA 92315
December 09, 2019

MEMBERS PRESENT:	Donna Nicely, Treasurer Peter Boss, M.D., President John Friel, CEO	Garth Hamblin, CFO Shelly Egerer, Exec. Asst.
STAFF:	Kerri Jex	Mary Norman
COMMUNITY MEMBERS:	None	
ABSENT:	None	

OPEN SESSION

1. **CALL TO ORDER:**
   Board Member Nicely called the meeting to order at 2:00 p.m.

2. **ROLL CALL:**
   Donna Nicely and Peter Boss, M.D. were present. Also present were John Friel, CEO, Garth Hamblin, CFO and Shelly Egerer, Executive Assistant.

3. **ADOPTION OF AGENDA:**
   Board Member Nicely motioned to adopt the December 09, 2019 Finance Committee Meeting Agenda as presented. Second by President Boss to adopt the December 09, 2019 Finance Committee Meeting Agenda as presented. Board Member Nicely called for a vote. **A vote in favor of the motion was unanimously approved.**
   - Board Member Nicely- yes
   - President Boss- yes

CLOSED SESSION

1. **PUBLIC FORUM FOR CLOSED SESSION:**
   Board Member Nicely opened the Hearing Section for Public Comment on Closed Session items at 2:00 p.m. Hearing no request to address the Finance Committee, Board Member Nicely closed the Hearing Section at 2:00 p.m.

2. **ADJOURN TO CLOSED SESSION:**
   Board Member Nicely motioned to adjourn to Closed Session at 2:01 p.m. Second by President Boss to adjourn to Closed Session at 2:01 p.m. Board Member Nicely called for a vote. **A vote in favor of the motion was unanimously approved.**
   - Board Member Nicely- yes
   - President Boss- yes

OPEN SESSION

1. **CALL TO ORDER:**
   Board Member Nicely called the meeting to order at 2:30 p.m.

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

3. **PUBLIC FORUM FOR OPEN SESSION:**
   Board Member Nicely opened the Hearing Section for Public Comment on Open Session items at 2:30 p.m. Hearing no request to address the Finance Committee, Board Member Nicely closed the Hearing Section at 2:30 p.m.

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

5. **APPROVAL OF MINUTES:**
   A. October 01, 2019

   Board Member Nicely motioned to approve October 01, 2019 minutes as presented. Second by President Boss to approve the October 01, 2019 minutes as presented. Board Member Nicely called for a vote. A vote in favor of the motion was unanimously approved.
   - Board Member Nicely- yes
   - President Boss- yes

6. **OLD BUSINESS:**
   - None

7. **NEW BUSINESS***

   A. Discussion and Potential Recommendation to the Board of Directors of the Fiscal Year 2019 Audited Financial Report:
   - Mr. Hamblin reported the following information:
     - Draft Audited Financial Statement will be presented by Jerrald Tucker w/JWT at the December Business Board Meeting
     - Audited financial statement stays in draft form until the Board of Directors approve the document
     - Net accounts receivable went down which caused current assets to decrease
     - TruBridge continues to monitor our unqualified opinion

   Board Member Nicely motioned to recommend to the Board of Directors the Fiscal Year 2019 Audited Financial Statement. Second by President Boss to recommend to the Board of Directors the Fiscal Year 2019 Audited Financial Statement. Board Member Nicely called for a vote. A vote in favor of the motion was unanimously approved.
   - Board Member Nicely- yes
   - President Boss- yes

   B. Discussion and Potential Recommendation to the Board of Directors of the Fiscal Year 2019 Medicare Cost Report:
   - Mr. Hamblin reported that information from the Audited Financial Statement is used to complete the Annual Medicare Cost Report.

- Receivable from $186, 000 from Medicare

Board Member Nicely motioned to recommend to the Board of Directors the Fiscal Year 2019 Medicare Cost Report. Second by President Boss to recommend to the Board of Directors the Fiscal Year 2019 Medicare Cost Report. Board Member Nicely called for a vote. **A vote in favor of the motion was unanimously approved.**

- Board Member Nicely- yes
- President Boss - yes

8. PRESENTATION AND REVIEW OF FINACIAL STATEMENTS*

A. October 2019 Finances:

- Mr. Hamblin reported the following information:
  - $2.8 million days cash on hand
  - Surplus of $197,151
  - Total patient revenue was over by 0.8%
  - Expenses are over due to the gas line leak
  - YTD operations are over budget
  - SNF census is 14
  - Surplus of $1,120,549 is $185,539 more than budget, and $664,162 more than the first four months of last year
  - Clinic and dental visits have decreased in patient visits
    - COH has been going through some staff transitions
    - No shows at the clinic

- Ms. Jex reported that staff continues to try to get more patients and that the DON and CNO will be visiting hospitals in our area to inform of services we offer and try to bring the census up. Mailers are to be sent to the senior community, potential to have an open house and lunch at the senior center.

B. CFO Report:

- Mr. Hamblin reported the following information:
  - Continue to work closely with TruBridge; would like to be under 60 days

  - FTE Report:
    - Overall, we have 16 out of 30 departments that are under budget
    - Made changes through attrition
      - HIM department is staffed with lower FTE
      - Acute is full staff (when we are low census we staff accordingly)
      - SNF when we have 13 patients is when we flex
      - Positions are being looked at with staffing and if there is a way to reduce staff
      - ER staffing will be looked at; house supervisors are included in the SNF and ER
      - Laboratory is staffed appropriately; is open 24 hours a day seven days a week
      - EVS and Admitting are being reviewed
      - HR will decrease, one HR employee resigned
      - Dietary department received a resignation and will only hire as a .5 in lieu of a full-time position
        Dietary manager is due to begin December 23

- IT Strategic Plan Update
  - Continuing to view plan and moving forward
  - Highly successful in areas of improvement
  - HIPAA work group has been formed and meets

- IT Cyber Security Insurance
  - Continue to evaluate cyber insurance
  - Premiums are quite high and looking for appropriate insurance and cost
  - At this time, we do not have Cyber Insurance

- Policy & Procedure Department Update
  - IT, Purchasing, HIM, Accounting, Patient Accounting, Patient Access
    - IT policies are being developed and under review
    - Admitting policies are under review
    - HIM policies will be reviewed by the Policy & Procedure Committee

Board Member Nicely motioned to approve the October 2019 Finance Report and CFO Report as presented. Second by Board Member Boss to approve the October 2019 Finance Report and CFO Report as presented. Board Member Nicely called for a vote. A vote in favor of the motion was unanimously approved.

- Board Member Nicely- yes
- President Boss- yes

9. ADJOURNMENT*

Board Member Nicely motioned to adjourn the meeting at 3:25 p.m. Second by President Boss to adjourn the meeting. Board Member Nicely called for a vote. A vote in favor of the motion was unanimously approved.

- Board Member Nicely- yes
- President Boss- yes

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Contract Cover Sheet

Contract Name: Michael Norman, D.O.

Purpose of Contract: RT Director

Contract # / Effective Date / Term/ Cost: 2/1/20 to 1/31/2022

Originating Dept. Name / Number: RT

Department Manager **Signature:** [signature] **Date:** 1/22/20

BAA: __Yes __No **W-9:** __Yes __No

Administrative Officer	**Signature:**	Kerri Fox	**Date:** 1/22/2020
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:** 1:30 2020
Compliance Officer	**Signature:**	Mary Norman	**Date:** 1/22/20
Chief Financial Officer	**Signature:**	via email	**Date:** 1/22/20
Chief Executive Officer	**Signature:**	John Hess	**Date:** 1/24/2020
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:

Updated 07/2019

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 1ST day of February 2020 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 physician satisfies the same requirements and qualifications applicable to Physician under this Agreement, and (b) said 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 spirmetry 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 1, 2020 to January 31, 2022; 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 further shall maintain "continuous coverage," as defined by this Section for the entire relevant term. The relevant term shall commence with the date of this Agreement and shall continue through the term of this Agreement, as well as any extensions or renewals thereof, and for a period thereafter of no less than three (3) years. In order to maintain continuous coverage for the entire relevant term Physician shall, if it changes insurers for any reason, take the necessary actions required in order to provide continuous coverage by either obtaining "tail" insurance from the preceding carriers, or "nose" insurance from the subsequent carriers. In order to satisfy the requirements of this Section, the "tail" insurance must be of either an unlimited type or of the type which would extend the discovery period beyond the last effective day of the last contract between the parties for a period of three (3) years. In order to satisfy the requirements of this Section for "nose" insurance, the retroactive effective date for such insurance must be at least the first date of the relevant term noted above. Physician shall provide proof of current insurance and, in the event of modification, termination, expiration, non-renewal or cancellation of any of the aforesaid policies of insurance, Physician shall give Hospital written notice thereof within thirty (30) business days of Physician's receipt of such notification from any of its insurers. In the event Physician fails to procure, maintain or pay for said insurance as required herein, Hospital shall have the right, but not the obligation to obtain such insurance. In that event, Physician shall reimburse Hospital for the cost thereof, and failure to repay the same upon demand by Hospital shall constitute a material breach hereunder.

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: John P. Friel 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:** _____

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

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

Board Report

February 2020

Managed Care Contract Review

The review has been completed and reviewed with management.

Community Health Needs Assessment

The report has been sent to management.

Compliance Risk Assessment

Based on discussion with the hospital's Compliance Officer, this project will be completed by the Compliance Officer with support from QHR Compliance Team.

Upcoming Education Events – February

Webinars (all times Central):

Board Leadership Webinar
Tue. February 11, 2020 | 12:00 pm-1:00 pm CST

Compliance Officer Hot Topics: Policy & Procedure Essentials
Thursday, February 13, 2020 | 10:30 am.-11:30 a.m. CST

Medicare Designated Provider Based Clinics & Departments – 2-Part Webinar Series
Wednesday-Thursday, February 19-20, 2020 | 2:00 pm-3:00 pm CST

Upcoming Projects

- Cost Report Review
- Contractual Accounts and Bad Debt Review
- Compliance Risk Assessment
- Strategic Planning

Completed Projects

- Community Health Needs Assessment
- Managed Care Contract Review

CNO Monthly Report

TOPIC	UPDATE
1. Regulatory	▪ CDPH on site for SNF Life Safety Survey. POC was submitted to CDPH and accepted. ▪ Monitoring for POC compliance has been implemented.
2. Budget/Staffing	▪ Overtime and call offs are assessed each shift. ▪ Flexing of staff is done daily as warranted by census. ▪ Departments working on capital requests for FY21.
3. Departmental Reports	
▪ Emergency Department	▪ Telepsych implementation in process. ▪ Starting planning for BETA Quest for Zero tier 1 and 2 projects. ▪ 1 FT RN retired
▪ Acute	▪ Medication reconciliation workgroup meeting regularly to revise med reconciliation process. ▪ Working with Clinical Informatics to ensure CPOE compliance.
▪ Skilled Nursing	▪ Candlelight dinner was held for residents and families. ▪ Multiple inquiries and tours resulting from marketing plan. ▪ SNF Quarterly QAPI meeting was held, variances, POC and PI projects were discussed. ▪ Working with clinical informatics to implement CPOE.
▪ Surgical Services	▪ Orthopedic procedures are being done weekly. ▪ Ophthalmic procedures are being done monthly. ▪ General surgery procedures will resume in March. ▪ OR staff is working on central sterile certifications. ▪ Working with Plant Maintenance on renovation planning. ▪ New Ultrasound has been purchased- Auxiliary donated funds. ▪ Working on purchase of GI scopes. ▪ General surgeon in process of training for TIF procedure.

▪ Case Management	▪ DON and Eligibility Worker are working on referrals for SNF residents and Swing patients. ▪ Attended HSAG readmissions workgroup. ▪ Providing education for staff regarding MOON form process.
▪ Respiratory Therapy	▪ Department being prepared for echocardiogram machine to be placed. ▪ Inservice on baby warmer completed 1/30/2020. ▪ Working on purchase of new PAPRs.
▪ Physical Therapy	▪ PT staffing according to volume changes.
▪ Food and Nutritional Services	▪ RD attended resident council. ▪ 2 PD positions are in the hiring process. ▪ Working on implementing new QI measures. ▪ Completing training with QHR Foodbuy program. ▪ Completing training through CAHF online resources.
4. Infection Prevention	▪ Official flu shot season started 11/1/19. Employees were given flu shots, those that declined will be masking until at least 4/1/19. ▪ Conducting planning and education regarding Coronavirus.
5. Quality Improvement	▪ Patient and Family Advisory Committee met 12/9/19. ▪ HEART guide team met to review quarterly progress. Care for the Caregiver and Rapid Event Investigation will be the focus for this policy year. ▪ Preparing mapping for SCORE survey administration. ▪ Opioid Stewardship – workgroup in place to work on ED Bridge program, and Inland Empire Safe Opioid Prescribing ED guidelines.
6. Policy Updates	▪ Policies reviewed weekly by Policy and Procedure committee.
7. Safety & Products	▪ Workplace Violence training is being provided to all BVCHD staff. ▪ Emergency Preparedness committee updated several policies related to SNF life safety survey. ▪ Emergency Preparedness coordinator attended HPP meeting at ICEMA. ▪
8. Education	▪ BLS Classes scheduled monthly, ACLS & PALS scheduled quarterly ▪ 1st Quarter Clinical Skills Day was held.

9. Information Items/Concerns	▪ Working on CAH 2020 annual report. ▪ Annual Culture of Safety Newsletter in development. ▪ Preparing for annual SCORE survey administration. ▪ Attended CHA Rural Hospital QI workshop.
Respectfully Submitted by: *Kerri Jex, CNO* *Date: January 31st, 2019*	

2019 Surgery Report

Oct-19		
Physician	**# of Cases**	**Procedures**
Pautz - DO	1	Repair Non-Union Clavicle
Pautz - DO	1	Excision Olecranon Bursa Right Elbow
Pautz - DO	1	Interpositional Arthroplasty Thumb
Kondal - MD	1	Excision Lipoma
Kondal - MD	1	Excision Ganglion Cyst
Tayani	4	Cataracts
Joson	1	Cataracts
Total	10	
Nov-19		
Physician	**# of Cases**	**Procedures**
Pautz - DO	1	Repair Non-Union Radial Neck, Removal Of Hardware
Pautz - DO	1	Removal Suture Knots Shoulder
Pautz - DO	1	Fluoroscopy Guided Hip Injection
Pautz - DO	1	Excision Mass Wrist
Critel - CRNA	2	LESI
Kondal - MD	1	Incisional Hernia Repair, Removal Of Mesh
Kondal - MD	1	Excision Lipoma
Joson	5	Cataracts
Total	13	
Dec-19		
Physician	**# of Cases**	**Procedures**
Pautz - DO	3	Arthroscopy
Pautz - DO	1	Removal Hardware Leg, Bone Marrow Aspiration/Injection
Pautz - DO	2	Fluoroscopy Guided Steroid Injection Hip
Pautz - DO	1	Removal Hardware Wrist, Repair Tendons Wrist
Pautz - DO	1	Removal Hardware Tibia
Pautz - DO	1	Excision Ganglion Cyst Foot
Critel - CRNA	2	LESI
Tayani	6	Cataracts
Total	17	

Annual Total 170

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

CHIEF EXECUTIVE OFFICER REPORT

January 2020

CEO Information:

A meeting with University California of Riverside Medical Center has been rescheduled to discuss our business relationship offering Ob/GYN services at our Family Health Center.

CDPH was on site to complete the annual SNF licensing Survey and the annual Fire Safety Survey. Booth Plan of Corrections submitted were accepted.

The Foundation raised approximately $75,000 and the Auxiliary raised approximately $23,000 to purchase new equipment for the hospital for the Surgery Department, Emergency Room, HAMAT equipment and an ultrasound machine.

We are continuing to work out the final contract details for the echocardiogram services. We anticipate taking the agreement to the March Board Meeting.

Staff has begun developing plans for the UCC opening in late Spring.

Culture of Ownership Committee is preparing for Joe Tye to provide three-day training. The committee has been interacting with all staff, passing out the Florence Prescription books and promoting the survey and placing promotional posters and questions of the day. The committee continues to receive positive feedback from staff.

The Mom & Dad Project received a grant from First 5 Riverside through DHCS to purchase a mobile dental unit and provided dental services to all schools and preschools in the valley. The grant was for approximately $110,000, the van was purchased for $60,000 and the remaining funds will be used to upgrade the van.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555468	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAR VALLEY COMMUNITY HOSPITAL	41870 GARSTIN RD BIG BEAR LAKE, CA 92315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a recertification survey from November 17, 2019 through November 21, 2019. Representing the Department of Public Health were the following surveyors: 40171 37427 Resident Census: 13 Sampled Residents: 9 Unsampled Residents: 4	F000		
F758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) 483.45(e) Psychotropic Drugs. 483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- 483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F758	Corrective Action for Identified Residents Seroquel 25mg PO PRN Q6 for resident #5 was discontinued on 11/19/2019. Identifying other residents with the potential to be affected and corrective action. Audit was done on all residents. There were no other residents identified who were on PRN psychotropic medications. System/Measures to Prevent Reoccurrence Pharmacist entered automatic stop date for PRN Seroquel at 14 days in the computer to ensure all orders for PRN Seroquel will be stopped at 14 days. Stop Date Policy updated to include the 14 day stop date for all PRN psychotropic medications unless specified in the physicians order.	12/14/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

CEO 12-17-19 — Electronically Signed — 12/11/2019

Any Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of the survey whether or not a correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555468	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F758	Continued From page 1 483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; 483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and 483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in 483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. 483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a prescription for an antipsychotic medication (a class of medication primarily used to manage psychosis, including delusions, hallucinations, or disordered thought) was limited for PRN (as needed) to 14 days, for one of nine sampled residents (Resident 5). This failure had the potential for Resident 5 to continue to receive a PRN antipsychotic	F758	Licensed nurses in serviced 11/22-12/14 regarding policy revision. Monitoring All PRN psychotropic medications will be reviewed weekly at Interdisciplinary Care Plan Meeting (IDCP) with the physician to discuss further indication and use of PRN psychotropic medications. Person responsible: Director of nursing	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

John Lee
CEO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555468	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAR VALLEY COMMUNITY HOSPITAL	41870 GARSTIN RD BIG BEAR LAKE, CA 92315

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F758	Continued From page 2 medication without being reassessed by the physician for the appropriateness of the continued use, which could lead to unnecessary side effects. Findings: During a review of Resident 5's medical record, diagnoses list with admission dated November 1, 2016, indicated the resident had the following diagnoses: Alzheimer's disease (a type of dementia that causes problems with memory, thinking and behavior,) and anxiety disorder. During a review of Resident 5's medical record and concurrent interview with the Director of Nursing (DON) on November 20, 2019 at 2:26 PM, the DON confirmed a physician order dated October 13, 2019, indicated Resident 5 was prescribed the anti-psychotic medication Seroquel (medication is used to treat certain mental/mood conditions) 25 mg (milligram-a unit of measurement) PO (by mouth) Q (every) 6 hours PRN (as needed) for agitation or hallucinations. The DON stated she was aware the limit for prescription antipsychotic medication was 14 days, and stated the medication was discontinued the day before, on November 19, 2019. During a review of Resident 5's medical record, Physician Orders dated October 27, 2019, indicated Seroquel 50 mg tab PO (by mouth) QD (daily) at 1600 (4PM) for psychosis (separate order from the PRN order noted above). During a review of Resident 5's medical record, the Medication Record dated November 1-21, 2019, indicated an order for Seroquel 25 mg, PRN Q6H (every six hours) oral, with start date October 15, 2019 and stop date November 19, 2019.	F758		

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	555468	A. BUILDING _____ B. WING _____	11/21/2019

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F758	Continued From page 3 During an interview on November 20, 2019 at 2:33 PM, the facility pharmacist (Pharm. D.) acknowledged the limit for antipsychotic medications is 14 days and Resident 5 should not have had a PRN prescription for the anti-psychotic medication, Seroquel, beyond the 14-day period. Review of the facility's policy and procedure titled "Antipsychotic Medications in the SNF," dated December 17, 2018, indicated: "...1. Antipsychotic medications must be prescribed at the lowest possible dosage for the shortest period of time...6. The Pharmacist will monitor the use of antipsychotic medications to assure that the medications are not used in excessive dose or for excessive duration on a quarterly or PRN basis."	F758		
F842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) 483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. 483.70(i) Medical records. 483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F842	Corrective Action for Identified Residents Resident #10 order for Ativan 0.5mg PO PRN QH6 was discontinued on 11/5/19. Identifying other residents with the potential to be affected and corrective action. Audit was completed for all residents was completed by the DON on 11/22/19. No other residents were identified to need clarification of verbal orders based on physician List of Auto stop records. System/Measures to Prevent Reoccurrence All licensed nurses were in-serviced by DON from 11/22-12/14/19 regarding Policy for telephone orders transcriptions. A	12/14/19

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F842	Continued From page 4 (iv) Systematically organized 483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. 483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. 483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. 483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F842	multidisciplinary work group was formed to evaluate our current process. Monitoring DON will monitor audits and data will be reported to the QI Committee, SNF QAPI Committee and up through the governing body for six months at which time the indicator will be evaluated for continuation, modification or deletion.	

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John Lee
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F842	Continued From page 5 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under 483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the medical record for one of nine sampled residents (Resident 10) was complete and accurate when a physician's order for Ativan was not documented in the resident's clinical record. This failure resulted in the facility having incomplete medical record documentation for Resident 10. Findings During an observation on November 17, 2019, at 10:56 AM, Resident 10 was seen sitting at a table in the activities room, with three other residents. The residents were playing a dice game with race horses. During a review of Resident 10's physician's orders, an order dated October 17, 2019, indicated "Ativan [medication commonly used to treat anxiety] 0.5 milligrams [mg - unit of measure] PO [administered by mouth] Q6 [every 6 hours] PRN [as needed] muscle pain/restlessness x2 weeks [for 2 weeks]." During an interview and concurrent record review, with the pharmacist (Pharm D), on November 21, 2019, at 10:59 AM, the Pharm D	F842		

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F842	Continued From page 6 provided a report titled "[Name of facility] Physician List of Auto Stops" (a report which lists which medications are scheduled to be automatically discontinued), dated October 31, 2019. The report indicated "[Resident 10's name] ...Ativan 0.5 mg PO PRN Q6H." The report was dated October 31, 2019, and signed by an LVN who wrote "T.O.R.B [telephone order received by] [Name of facility physician] cont [continue] with meds as ordered." The Pharm D stated the report is printed before every stop order and nursing staff is supposed to call the doctor to get instruction on whether to continue the medication or not. The Pharm D further stated the nurses are then supposed to include the doctor's orders in the resident's chart. The Pharm D further clarified the copy he provided was from his office. A review of Resident 10's clinical record indicated there was no documented evidence of a physician's telephone order for the continuation of the Ativan medication. During an interview and concurrent record review with Licensed Vocational Nurse 1 (LVN 1), on November 21, 2019, at 11:12 AM, LVN 1 reviewed the clinical record for Resident 10 and stated the nurse who received the telephone order from the physician should have written the instructions to continue the medication in the residents' chart as a physician's order but the LVN did not. During an interview and concurrent with the Director of Nursing (DON), on November 21, 2019, at 11:15 AM, the DON reviewed the clinical record for Resident 10, and the report titled "Physician List of Auto Stops" dated October 31, 2019. The DON stated the nurse who took the telephone order should have	F842		

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John Lund
C.E.O

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F842	Continued From page 7 written a proper order and included it in Resident 10's chart. The facility policy and procedure titled "Health Information Management" dated April 18, 2016, indicated "Policy: It is the responsibility of the attending Physician and other care providers caring for the patient at [name of facility] to prepare a complete health record." The facility policy and procedure titled "Telephone and Verbal Orders" undated, indicated "Procedure: ...2. Medication orders shall include the name of the drug, dosage, frequency of administration, route of administration, and a reason for the medication, date, time and name of the prescriber and shall be written on a physician's order form ..."	F842		

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John Lund
CEO

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E000	Initial Comments The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. Representing the California Department of Public Health: 41278 The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census = 14	E000		
E007 SS=D	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at 483.73(a)(3):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E007	BVCHD has updated the Emergency Management Plan to include an addendum specific to the organization of the Hospital Incident Command System, including succession planning. The following language has been added to the Plan: Hospital Incident Command System (HICS) will be utilized for organization of the Hospital Command Center (HCC), succession planning, and documentation purposes during emergency situations or drills. The initial Incident Commander positions and structure shall be organized according to availability of qualified personnel, taking into account the nature of the incident. During normal business hours the Incident Commander shall be assumed or appointed by the CEO or AOC. After business hours the Incident Commander shall be assumed or	12/16/19

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Electronically Signed | 01/02/2020

^ ny Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide ?cient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of the survey whether or not a n of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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E007	Continued From page 1 (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain their emergency preparedness program. This was evidenced by the failure to address succession planning. This had the potential for the facility to be unprepared in the event of an emergency. This affected 14 of 14 residents. Findings: During document review and interview with the Director of Facilities, Chief Director of Nursing (CDON), and Director of Nursing (DON) on 12/13/19, the surveyor requested documentation on the facility's succession plan. At 2 p.m., the facility's emergency preparedness program failed to address succession planning during an emergency At 4:20 p.m., the CEO, CFO, CDON, DON, Director of Facilities, Risk and Compliance staff, Environmental Services Supervisor, and HR Analyst acknowledged the above finding during the exit conference.	E007	appointed by the charge nurse in consultation with the AOC. BVCHD shall refer to the most current Organizational Chart to determine succession planning for Incident Command roles. BVCHD SNF staff were in-serviced by the Director of Staff Development on changes to the EMP from 12/13/19-12/16/19. All changes made to the EMP have been reflected in the Emergency Preparedness Training annual curriculum. The EMP will continue to be reviewed on an annual basis. Monitoring: The updated Emergency Management Plan Hospital Incident Command System Addendum and completed in-service will be reported to the Safety Committee and up through the Governing Body. Emergency Preparedness Program shall be reviewed by the Disaster Committee up through Safety Committee and Governing Board annually. Person Responsible: Disaster Coordinators and Director of Nursing	

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E023 E023 SS=D	Continued From page 2 Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at 403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain their emergency	E023 E023	BVCHD has updated the Emergency Management Plan Evacuation Addendum to include written verbiage that specifies current practice. The following language has been added to the plan: In order to protect confidentiality of patient information, all medical records shall be contained in a sealed nontransparent envelope with the patients name delineated on the outside of the envelope. BVCHD SNF staff were in-serviced by the Director of Staff Development on changes to the EMP from 12/13/19-12/16/19. All changes made to the EMP have been reflected in the Emergency Preparedness Training annual curriculum. The EMP will continue to be reviewed on an annual basis. Monitoring: The updated Emergency Management Plan Evacuation Addendum and completed in-service will be reported to the Safety Committee and up through the Governing Body. Emergency Preparedness Program shall be reviewed by the Disaster Committee up through Safety Committee and Governing Board annually. Person Responsible: Disaster Coordinators and Director of Nursing	12/16/19

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E023	Continued From page 3 preparedness program. This was evidenced by the failure to include policies and procedures addressing a system for medical documentation that preserves resident confidentiality. This had the potential for resident information to be released in the event of an emergency. This affected 14 of 14 residents. Findings: During document review and interview with the Director of Facilities, Chief Director of Nursing (CDON), and Director of Nursing (DON) on 12/13/19, the surveyor requested documentation on the facility's policies and procedures for medical documentation and confidentiality. At 2:29 p.m., the facility's emergency preparedness program failed to include policies and procedures for a system of medical documentation to preserve confidentiality of resident medical information during an emergency. The DON verbalized that their process includes use of sealed manila envelopes. At 4:20 p.m., the CEO, CFO, CDON, DON, Director of Facilities, Risk and Compliance staff, Environmental Services Supervisor, and HR Analyst acknowledged the above finding during the exit conference.	E023		
E030 SS=D	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the	E030	BVCHD has updated the EMP Addendum Contacts External to include contact information for contracted vendors providing services. BVCHD SNF staff were in-serviced by the Director of Staff Development on changes to the EMP from 12/13/19-12/16/19. All changes made to the EMP have been	12/16/19

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E030	Continued From page 4 following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at 482.15(c) and CAHs at 485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at 403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at 416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E030	reflected in the Emergency Preparedness Training annual curriculum. The EMP will continue to be reviewed on an annual basis. Monitoring: The updated Emergency Management Plan Addendum Contacts External and completed in-service will be reported to the Safety Committee and up through the Governing Body. Emergency Preparedness Program shall be reviewed by the Disaster Committee up through Safety Committee and Governing Board annually. Person Responsible: Disaster Coordinators and Director of Nursing	

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E030	Continued From page 5 (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at 418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at 484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at 486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on document review and interview, the	E030		

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E030	Continued From page 6 facility failed to maintain their communication plan. This was evidenced by the failure to include contact information for all contracted vendors. This had the potential for the facility to be unprepared in the event of an emergency. This affected 14 of 14 residents. Findings: During document review and interview with the Director of Facilities, Chief Director of Nursing (CDON), and Director of Nursing (DON) on 12/13/19, the surveyor requested documentation on the facility's contact information for vendors providing services. At 2:30 p.m., the facility's emergency preparedness program failed to include contact information for all contracted vendors providing services. At 4:20 p.m., the CEO, CFO, CDON, DON, Director of Facilities, Risk and Compliance staff, Environmental Services Supervisor, and HR Analyst acknowledged the above finding during the exit conference.	E030		
E031 SS=D	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff.	E031	BVCHD has updated the EMP Addendum Contacts External to include contact information for the following: FEMA, Cal-OES and the State Long Term Care Ombudsman Office. BVCHD SNF staff were in-serviced by the Director of Staff Development on changes to the EMP from 12/13/19-12/16/19. All changes made to the EMP have been reflected in the Emergency Preparedness Training annual curriculum. The EMP will continue to be reviewed on an annual basis.	12/16/19

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	555468	A. BUILDING _____ B. WING _____	12/13/2019

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E031	Continued From page 7 (ii) Other sources of assistance. *[For LTC Facilities at 483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at 483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain their emergency preparedness program. This was evidenced by the failure to include contact information for their Federal and State emergency preparedness officials, and the Office of the State Long-Term Care Ombudsman. This had the potential for the facility to be unprepared in the event of an emergency. This affected 14 of 14 residents. Findings: During document review and interview with the Director of Facilities, Chief Director of Nursing (CDON), and Director of Nursing (DON) on 12/13/19, the surveyor requested documentation	E031	Monitoring: The updated Emergency Management Plan Addendum Contacts External and completed in-service will be reported to the Safety Committee and up through the Governing Body. Emergency Preparedness Program shall be reviewed by the Disaster Committee up through Safety Committee and Governing Board annually. Person Responsible: Disaster Coordinators and Director of Nursing	

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E031	Continued From page 8 on the facility's contact information for emergency officials. At 2:37 p.m., the facility's emergency preparedness program failed to include contact information for their Federal (FEMA) and State (Cal-OES) emergency preparedness officials, and the contact for the Office of the State Long-Term Care Ombudsman. At 4:20 p.m., the CEO, CFO, CDON, DON, Director of Facilities, Risk and Compliance staff, Environmental Services Supervisor, and HR Analyst acknowledged the above finding during the exit conference.	E031		
E041 SS=D	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. 483.73(e), 485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. 482.15(e)(1), 483.73(e)(1), 485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA	E041	BVCHD has updated the Loss of Electrical Power Policy to include the amount of emergency generator fuel stored at the facility and the amount of time emergency systems are expected to remain operational utilizing generator power. The Loss of Electrical Power Policy will continue to be reviewed on an annual basis. Monitoring: The updated Loss of Electrical Power Policy will be reported to the Safety Committee and up through the Governing Body. Person Responsible: Director of Facilities	12/16/19

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E041	Continued From page 9 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), 483.73(e)(2), 485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), 483.73(e)(3), 485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at 482.15(h), LTC at 483.73(g), and CAHs 485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.	E041		

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E041	Continued From page 10 (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain documentation on their emergency power supply system in their emergency preparedness program. This was evidenced by the failure to identify the amount of emergency generator fuel stored at the facility and the amount of time it can keep emergency systems operational. This had the potential for the facility to be unprepared in the event of an emergency. This affect 14 of 14 residents.	E041		

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E041	Continued From page 11 Findings: During document review and interview with the Director of Facilities, Chief Director of Nursing (CDON), and Director of Nursing (DON) on 12/13/19, the surveyor requested documentation on the facility's emergency generator. At 2:49 p.m., the facility's emergency preparedness program failed to include the amount of generator fuel stored onsite at the facility and the amount of time that fuel can keep emergency power systems operational during an emergency. At 4:20 p.m., the CEO, CFO, CDON, DON, Director of Facilities, Risk and Compliance staff, Environmental Services Supervisor, and HR Analyst acknowledged the above finding during the exit conference.	E041		

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K000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 6/26/1991 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 41278 The facility is not in substantial compliance with 42 CFR 483.90 for Long Term Care Facilities. Census = 14	K000		
K161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type	K161	The identified penetrations were immediately addressed by the Plant Maintenance Staff. The ceiling and wall penetration in the upstairs mezzanine which had approximately three-inch penetrations with pipe and conduit were repaired with equal materials to those that exist in the mezzanine along with approved fire caulking. The penetrations next to the fire alarm control panel that were identified were also repaired with equal materials to	12/27/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	01/02/2020

^ ny Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide ficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of the survey whether or not a an of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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K161	Continued From page 1 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their building construction. This was evidenced by a ceiling and walls that had open penetrations that were not fire sealed. This had the potential for smoke and/or fire to pass through the ceiling and/or wall to other	K161	those that exist in the mezzanine along with approved fire caulking. Date Completed 12/13/19 Inspect for penetrations was added to the Mezzanine checklist that is performed daily. Date Completed 12/13/19 Just in time training was completed with Plant Maintenance and Information Technology staff regarding fire and smoke penetrations. Date Completed 12/16/19 Reviewed and revised Fire and Smoke Barrier Penetrations policy. Date Completed 12/27/19 Monitoring: Just in time training and the revised policy Fire and Smoke Barrier Penetrations will be reported to the Safety Committee and up through the Governing Board. Completed checklist shall be reported to the Safety Committee and up through the Governing Board for six months at which time it will be evaluated for continuation, modification or deletion. Person Responsible: Director of Facilities	

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K161	Continued From page 2 parts of the building. This affected one of one smoke compartments. NFPA 101 - Life Safety Code, 2012 Edition 8.5.6 Penetrations. 8.5.6.2 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. Findings: During a tour of the facility with the Director of Facilities on 12/13/19, the surveyor observed the building construction. 1. At 10 a.m., the ceiling and wall in the upstairs mezzanine room each had an approximately three inch penetration with pipe and conduit running through it with no fire sealant. 2. At 10:10 a.m., the wall in the upstairs mezzanine room by the fire alarm control panel had three open penetrations with pipe and cabling running through them and measuring approximately two inches, two inches, and one inch. The ceiling above the fire alarm control panel had an approximately two inch penetration with pipe running through it. The penetrations were not sealed to prevent spread of fire or smoke. At 4:20 p.m., the CEO, CFO, CDON, DON, Director of Facilities, Risk and Compliance staff, Environmental Services Supervisor, and HR	K161		

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K161	Continued From page 3 Analyst acknowledged the above findings during the exit conference.	K161		
K291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on document review, interview, and observation, the facility failed to maintain their battery powered emergency lighting units. This was evidenced by the failure to complete the testing requirements for the battery powered emergency light located by the generator. This resulted in failure of the emergency light to operate properly when tested. This affected one of one smoke compartments. NFPA 101 - Life Safety Code, 2012 Edition 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)* The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered.	K291	The battery powered emergency lighting unit located in the emergency generator room batteries were replaced immediately. Date Completed: 12/13/19 The emergency lighting unit was added to the monthly Fire Exit Sign/Smoke Doors Functional Testing inspection log. Date Completed: 12/13/19 Director of Facilities performed just in time training with the Plant Maintenance staff regarding the NFPA 101 for emergency lighting and the addition of the E-generator room battery powered emergency lighting unit to the Fire Exit Sign/Smoke Doors Functional Testing inspection log. Date Completed: 12/16/19 Monitoring: Just in time training will be reported to the Safety Committee and up through the Governing Board. Completed checklist shall be reported to the Safety Committee and up through the Governing Board for six months at which time it will be evaluated for continuation, modification or deletion. Person Responsible: Director of Facilities	12/16/19

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K291	Continued From page 4 (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Findings: During document review, interview, and a tour of the facility with the Director of Facilities on 12/13/19, the surveyor requested the 30 second monthly and 90 minute annual testing records for the battery powered emergency lighting unit located by the emergency generator. 1. At 9:31 a.m., the battery powered emergency lighting unit located in the emergency generator room failed to illuminate when tested. 2. At 12:08 p.m., the Director of Facilities reported that the battery powered emergency lighting unit was not being tested for 30 seconds monthly or 90 minutes annually. At 4:20 p.m., the CEO, CFO, CDON, DON, Director of Facilities, Risk and Compliance staff, Environmental Services Supervisor, and HR Analyst acknowledged the above findings during the exit conference.	K291		
K341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied,	K341	Director of Facilities contacted Johnson Controls (fire alarm vendor) and requested a proposal to add a smoke detector to the mezzanine area where the primary fire alarm panel is located. This unit will be capable of transmitting a signal to the supervising station. Date Completed: 12/13/19 Johnson Controls proposal and service	12/30/19

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K341	Continued From page 5 detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their fire alarm system. This was evidenced by the failure to provide appropriate protection of the fire alarm control unit in the mezzanine room. This had the potential to result in failure of the fire alarm system to operate properly. This affected one of one smoke compartments. NFPA 101 - Life Safety Code, 2012 Edition 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.1.8.1* In areas that are not continuously occupied, and unless otherwise permitted by 9.6.1.8.1.1 or 9.6.1.8.1.2, automatic smoke detection shall be installed to provide notification of fire at the following locations: (1) Each fire alarm control unit NFPA 72 - National Fire Alarm and Signaling Code, 2010 Edition 10.15* Protection of Fire Alarm System. In areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit(s), notification appliance circuit power extenders, and supervising station transmitting equipment to provide notification of fire at that location. Findings:	K341	agreement dated December 16, 2019 was received and approved December 27, 2019. Purchase Order (PO) was issued December 30, 2019. Date to be installed is to be determined by vendor. The smoke detector will be added to the quarterly and annual inspections for the fire alarm system performed by Johnson Controls. Monitoring: Report of activity shall be submitted to the Safety Committee and up through the Governing Board. Fire alarm inspections shall be submitted to the Safety Committee and up through the Governing Board for one year at which time it shall be evaluated for continuation, modification or deletion. Person Responsible: Director of Facilities	

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	555468	A. BUILDING 02 - MAIN BUILDING 01 B. WING _____	12/13/2019

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K341	Continued From page 6 During a tour of the facility with the Director of Facilities on 12/13/19, the surveyor observed the fire alarm control unit. At 10:05 a.m., the fire alarm control unit located in the upstairs mezzanine room was not protected by a smoke detector capable of transmitting a signal to the supervising station. The mezzanine area is not a continuously occupied part of the building and is used for various building equipment and systems. At 4:20 p.m., the CEO, CFO, CDON, DON, Director of Facilities, Risk and Compliance staff, Environmental Services Supervisor, and HR Analyst acknowledged the above finding during the exit conference.	K341		
K345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain their fire alarm system. This was evidenced by the failure to conduct annual charge and discharge tests of the fire alarm control panel and alarm system transmitter sealed lead-acid batteries. This had the potential to result in failure of the fire alarm	K345	Director of Facilities contacted Johnson Controls (fire alarm vendor) regarding the fire alarm control panel and alarm system transmitter sealed lead-acid battery testing procedures December 13, 2019. The vendor stated they were not following current NFPA standards for testing the batteries charge and discharge. The Director of Facilities contacted Johnson Controls December 16, 2019 to discuss plan of correction at which time the vendor supervisor confirmed testing was being performed properly but not documented. On December 27, 2019, the Vendor confirmed via email that documentation would reflect current NFPA standards going forward. Date completed: 12/27/19 Fire/Life Safety Management Plan was updated to reflect current NFPA standards. Date Completed: 12/27/19	1/31/20

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K345	Continued From page 7 system. This affected one of one smoke compartments. NFPA 101 - Life Safety Code, 2012 Edition 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. NFPA 72 - National Fire Alarm and Signaling Code, 2010 Edition 14.3.1* Unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. Table 14.3.1: 3. Batteries (d) Sealed lead-acid: Semiannually 14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. Table 14.4.5: 6. Batteries - fire alarm system (d) Sealed lead-acid type (1) Charger test (Replace battery within 5 years after manufacture or more frequently as needed.): Initial/Reacceptance, Annually (2) Discharge test (30 minutes): Initial/Reacceptance, Annually (3) Load voltage test: Initial/Reacceptance,	K345	Next scheduled inspection will be in mid-January 2020 and will reflect current NFPA standards for fire alarm control panel and alarm system transmitter sealed lead-acid battery testing. Date Completed 1/31/20 Monitoring: Report of activity including the revised Fire/Life Safety Management Plan shall be submitted to the Safety Committee and up through the Governing Board. Fire alarm inspections shall be submitted to the Safety Committee and up through the Governing Board for one year at which time it shall be evaluated for continuation, modification or deletion. Person Responsible: Director of Facilities	

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K345	Continued From page 8 Semiannually Findings: During document review and interview with the Director of Facilities on 12/13/19, the surveyor requested maintenance records of the fire alarm control panel and alarm system transmitter sealed lead-acid batteries. At 10:51 a.m., the facility provided maintenance records that failed to indicate that charge and discharge testing of the fire alarm control panel and alarm system transmitter lead-acid batteries was being conducted. The Director of Facilities called the facility's fire alarm system vendor who confirmed they were not conducting the tests. At 4:20 p.m., the CEO, CFO, CDON, DON, Director of Facilities, Risk and Compliance staff, Environmental Services Supervisor, and HR Analyst acknowledged the above finding during the exit conference.	K345		
K353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K353	The Director of Facilities performed a visual inspection of the post-indicator valve (PIV) December 13, 2019. Date Completed: 12/13/19 The PIV is secured with a lock. The PIV inspection was added to the Main Building and Safety Checklist. The inspection shall be performed and documented monthly. Date Completed 12/13/19 Director of Facilities performed just in time training with the Plant Maintenance staff regarding the NFPA 25 standards for PIV inspection and the addition of the PIV inspection to the Main Building Safety Checklist. Date Completed: 12/16/19	12/27/19

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K353	Continued From page 9 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain their automatic sprinkler system. This was evidenced by the failure to conduct monthly sprinkler visual inspections of all required components. This had the potential to impact the operability of the fire sprinkler system. This affected one of one smoke compartments. NFPA 101 - Life Safety Code, 2012 Edition 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 - Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition 5.2.4.1* Gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. 13.3.2.1 All valves shall be inspected weekly. 13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. 13.3.2.2* The valve inspection shall verify that the valves are in the following condition: (1) In the normal open or closed position (2)* Sealed, locked, or supervised	K353	Fire/Life Safety Management Plan was updated to reflect current NFPA standards. Date Completed: 12/27/19 Monitoring: Just in time training and revised Fire/Life Safety Management Plan will be reported to the Safety Committee and up through the Governing Board. Completed checklist shall be reported to the Safety Committee and up through the Governing Board for six months at which time it will be evaluated for continuation, modification or deletion. Person Responsible: Director of Facilities	

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K353	Continued From page 10 (3) Accessible (4) Provided with correct wrenches (5) Free from external leaks (6) Provided with applicable identification Findings: During document review and interview with the Director of Facilities on 12/13/19, the surveyor requested records for the monthly sprinkler visual inspections. At 11:05 a.m., records showed monthly visual inspections of the fire sprinkler system riser including its gauges and control valve. Upon interview, the Director of Facilities stated he was not checking the post indicator valve (PIV) as part of the monthly visual inspections. At 4:20 p.m., the CEO, CFO, CDON, DON, Director of Facilities, Risk and Compliance staff, Environmental Services Supervisor, and HR Analyst acknowledged the above finding during the exit conference.	K353		
K712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7	K712	Director of Facilities performed just in time training with Plant Maintenance Staff regarding NFPA 101 requirements for fire drills. Fire drills are expected to be held at varying times and conditions at least quarterly on each shift. Date Completed: 12/16/19 Fire drill reminders were added to the Plant Maintenance staff calendars. Date Completed: 12/16/19 Monitoring: Just in time training will be reported to the Safety Committee and up through the	12/16/19

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K712	Continued From page 11 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain the requirements for staff fire drills. This was evidenced by the failure to complete one fire drill quarterly for each shift. This had the potential to impact staff response in the event of a fire. This affected staff on the PM and NOC shifts. NFPA 101 - Life Safety Code, 2012 Edition 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. Findings: During document review and interview with the Director of Facilities on 12/13/19, the surveyor requested records for the fire drills. At 11:50 a.m., records for fire drills were missing for the second quarter (NOC shift) and third quarter (PM shift). At 4:20 p.m., the CEO, CFO, CDON, DON, Director of Facilities, Risk and Compliance staff, Environmental Services Supervisor, and HR Analyst acknowledged the above finding during the exit conference.	K712	Governing Board. Completed fire drill evaluation sheets shall be reported to the Safety Committee and up through the Governing Board for six months at which time it will be evaluated for continuation, modification or deletion. Person Responsible: Director of Facilities	
K754 SS=D	Soiled Linen and Trash Containers CFR(s): NFPA 101 Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall	K754	The Director of Facilities ordered an automatic door closing device December 30, 2019 for the SNF tub room in the instance that more than 32 gallons of dirty linen is stored. Equipment will be installed	1/31/20

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K754	Continued From page 12 not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their soiled linen and trash containers. This was evidenced by the failure to not properly store the containers in an area protected as hazardous. This had the potential to result in spread of a fire and/or smoke during an emergency. This affected one of one smoke compartments. NFPA 101 - Life Safety Code, 2012 Edition 19.7.5.7.1 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity and shall meet all of the following requirements: (1) The average density of container capacity in a room or space shall not exceed 0.5 gal/ft2 (20.4 L/m2). (2) A capacity of 32 gal (121 L) shall not be exceeded within any 64 ft2 (6 m2) area. (3)* Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal	K754	once received from vendor. Date Completed: 1/31/20 The soiled linen receptacles by resident room 10 were moved immediately in the SNF shower room. The door is remained closed when unattended. Date Completed: 12/13/19 A Purchase Order (PO) was issued December 30, 2019 for three additional 32-gallon soiled linen receptacles. A single soiled linen receptacle shall be housed in each sub-acute room and shall not exceed 32 gallons. Date Completed: 12/30/19 Memo was posted for Environmental Services and Nursing Staff regarding soiled linen receptacle requirements. Date Completed: 12/16/19 Monitoring: Routine rounding shall be completed and documented to ensure compliance with linen storage. Results of rounding shall be reported through the Quality Improvement Committee and up through the Governing Board for six months at which time it shall be evaluated for continuation, modification or deletion. Person Responsible: Environmental Services Supervisor and Director of Nursing	

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K754	Continued From page 13 (121 L) shall be located in a room protected as a hazardous area when not attended. (4) Container size and density shall not be limited in hazardous areas. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1. 19.3.2.1.2* Where the sprinkler option of 19.3.2.1 is used, the areas shall be separated from other spaces by smoke partitions in accordance with Section 8.4. 19.3.2.1.3 The doors shall be self-closing or automatic-closing. Findings: During a tour of the facility with the Director of Facilities on 12/13/19, the surveyor observed the soiled linen and trash containers. 1. At 3:36 p.m., the Shower room located by resident Room 30 contained three 30 gallon soiled linen containers and one 13 gallon trash container for a potential total capacity of 103 gallons. The door to the Shower room did not contain a self-closing device. 2. At 3:52 p.m., the hallway in the sub-acute section by resident room 10 contained four 30 gallon soiled linen/trash containers for a potential total capacity of 120 gallons. The containers were unattended and not stored in an area protected as hazardous. At 4:20 p.m., the CEO, CFO, CDON, DON, Director of Facilities, Risk and Compliance staff, Environmental Services Supervisor, and HR Analyst acknowledged the above findings during	K754		

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K754	Continued From page 14 the exit conference.	K754		
K907 SS=D	Gas and Vacuum Piped Systems - Maintenance Pr CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Maintenance Program Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain their gas and vacuum piped system. This was evidenced by the failure to make the appropriate corrections following the annual maintenance service. This had the potential to result in failure of the system to operate properly. This affected one of one smoke compartments. NFPA 99 - Health Care Facilities Code, 2012 Edition 5.1.14.2 Maintenance of Medical Gas, Vacuum, WAGD, and Medical Support Gas Systems. 5.1.14.2.1* General. Health care facilities with installed medical gas, vacuum,WAGD, or	K907	Plant Maintenance department ran new low voltage wiring for the N2O pressure switch December 19, 2019. The Director of Facilities requested a proposal from FS Medical to land and test the low voltage wiring for the N2O pressure switch on December 20, 2019. A proposal was received, and Purchase Order (PO) issued on December 20, 2019. FS Medical is scheduled for testing January 6, 2020. Date Completed: 1/6/20. Monitoring: Report of activity shall be submitted to the Safety Committee and up through the Governing Board. The medical gas and equipment inspection shall be submitted to the Safety Committee and up through the Governing Board for one year at which time it shall be evaluated for continuation, modification or deletion. Person Responsible: Director of Facilities	1/6/20 12:

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K907	Continued From page 15 medical support gas systems, or combinations thereof, shall develop and document periodic maintenance programs for these systems and their subcomponents as appropriate to the equipment installed. Findings: During document review and interview with the Director of Facilities on 12/13/19, the surveyor requested the annual piped medical gas and vacuum system maintenance records. At 11:58 a.m., the annual piped medical gas and vacuum system report titled "Medical Gas Inspection Report" indicated that the system was inspected on 6/19/19. In the report, it was noted that the "N2O line pressure high did not work. Wires are mixed with the right vacuum pressure switch located at the vacuum pump." The report indicated that compliance for this finding was required. At 4:20 p.m., the CEO, CFO, CDON, DON, Director of Facilities, Risk and Compliance staff, Environmental Services Supervisor, and HR Analyst acknowledged the above finding during the exit conference.	K907		
K918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the	K918	Director of Facilities ordered a Midtronics MPPBT100 digital battery tester on December 16, 2019. Date Completed: 12/16/19 The battery conductivity test was added to the Monthly Emergency Generator Log. Date Completed: 12/16/19 Director of Facilities performed just in time training with the Plant Maintenance staff regarding the NFPA 101 standards for	12/23/19

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAR VALLEY COMMUNITY HOSPITAL	41870 GARSTIN RD BIG BEAR LAKE, CA 92315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K918	Continued From page 16 generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain their emergency generator. This was evidenced by the failure to maintain monthly testing of the lead-acid batteries connected to the generator. This had the potential to result in failure of the generator to operate properly in the event of an emergency. This affected one of one smoke compartments. NFPA 101 - Life Safety Code, 2012 Edition 9.1.3 Emergency Generators and Standby Power Systems.	K918	essential electrical systems and the addition of the battery conductivity test to the Monthly Emergency Generator Log. Date Completed: 12/16/19 Midtronics MPPBT100 digital battery tester training per manufacturer recommendations was performed with Plant Maintenance staff. Date Completed: 12/23/19 The generator lead-acid battery conductivity test was performed and found to have adequate voltage. Date Completed 12/23/19 Monitoring: Just in time training will be reported to the Safety Committee and up through the Governing Board. The Monthly Emergency Generator Log shall be reported to the Safety Committee and up through the Governing Board for six months at which time it will be evaluated for continuation, modification or deletion. Person Responsible: Director of Facilities	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555468	A. BUILDING 02 - MAIN BUILDING 01 B. WING _____	12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAR VALLEY COMMUNITY HOSPITAL	41870 GARSTIN RD BIG BEAR LAKE, CA 92315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K918	Continued From page 17 Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2. 9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 - Standard for Emergency and Standby Power Systems, 2010 Edition 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. Findings: During document review and interview with the Director of Facilities on 12/13/19, the surveyor requested the emergency generator battery electrolyte specific gravity testing records. At 11:20 a.m., the Director of Facilities reported that electrolyte specific gravity testing of the two lead-acid batteries connected to the generator was not being conducted. At 4:20 p.m., the CEO, CFO, CDON, DON, Director of Facilities, Risk and Compliance staff, Environmental Services Supervisor, and HR Analyst acknowledged the above finding during the exit conference.	K918		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Recommendation for Action

Date: November 07, 2019

To: Board of Directors

From: John Friel, CEO

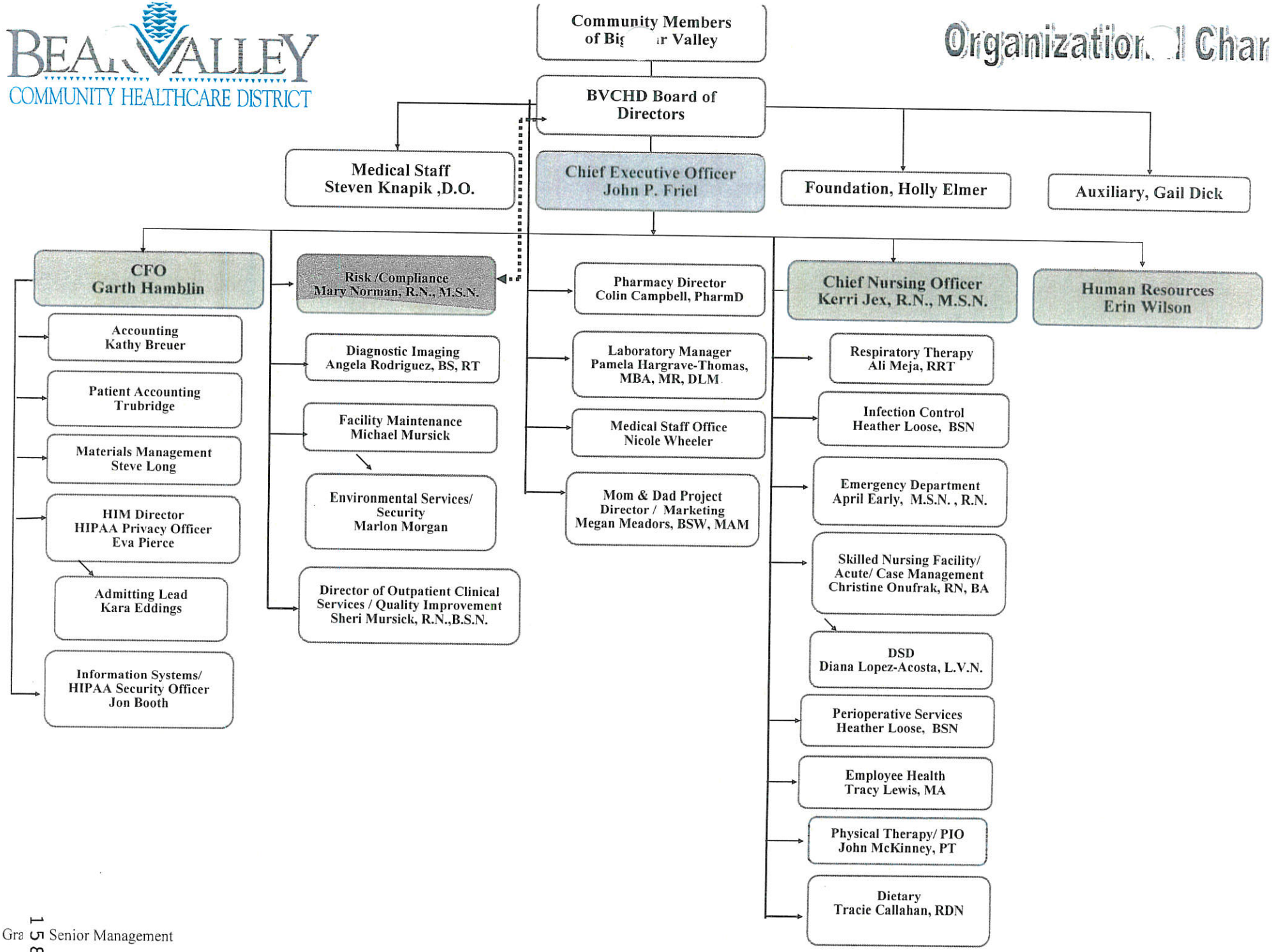
Re: Organizational Chart

Recommendation: To approve the Organizational Chart as presented.

Discussion: The Board of Directors are required to approve BVCHD Organizational Chart. We have updated the organizational chart with the new ER Director and RD/Dietary Director.

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Organizational Chart



Gra Senior Management

Up 1 1/13/2020

Signature

Date

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Recommendation for Action

Date: February 05,2020

To: Board of Directors

From: John Friel, CEO

Re: Board Meeting & Committee Meeting Calendar

Recommendation: To approve the Board Meeting & Committee Meeting Calendar as presented.

Discussion: According to the District Bylaws we are to provide a calendar of the monthly Business Board Meeting and Committee Meeting Calendar for approval.

COMMITTEE MEETING DATES 2020

BUSINESS BOARD MEETING/ President - Peter Boss, MD

Monthly Public Meeting ▼ 2nd Wednesday of the Month ▼ Closed Session at 1:00 pm ▼ Open Session at 3:00 pm

1/8/20	2/12/20	3/11/20	4/8/20	5/13/20	6/10/20	7/8/20	8/12/20	9/9/20	10/7/20	11/11/20	12/9/20

PLANNING & FACILITIES MEETING/ Chair -Peter Boss; Vice Chair -Steven Baker

Quarterly Public Meeting ▼ 1st Wednesday of the Month ▼ 12:00 pm : March-June-September-December

3/4/20	6/3/20	9/2/20	12/2/20								

FINANCE MEETING / Chair -Perri Melnick: Vice Chair - Steven Baker

Monthly Public Meeting ▼ First Tuesday of the Month ▼ 1:00 pm

1/7/20	2/4/20	3/3/20	4/7/20	5/5/20	6/2/20	7/7/20	8/4/20	9/8/20	10/6/20	11/3/20	12/1/20

HUMAN RESOURCES MEETING/ Chair - Gail McCarthy ; Vice Chair - Donna Nicely

Annual Public Meeting ▼ 3rd Monday Annual Meeting ▼ 12:00 pm

7/15/20						

* Indicates change in scheduling

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

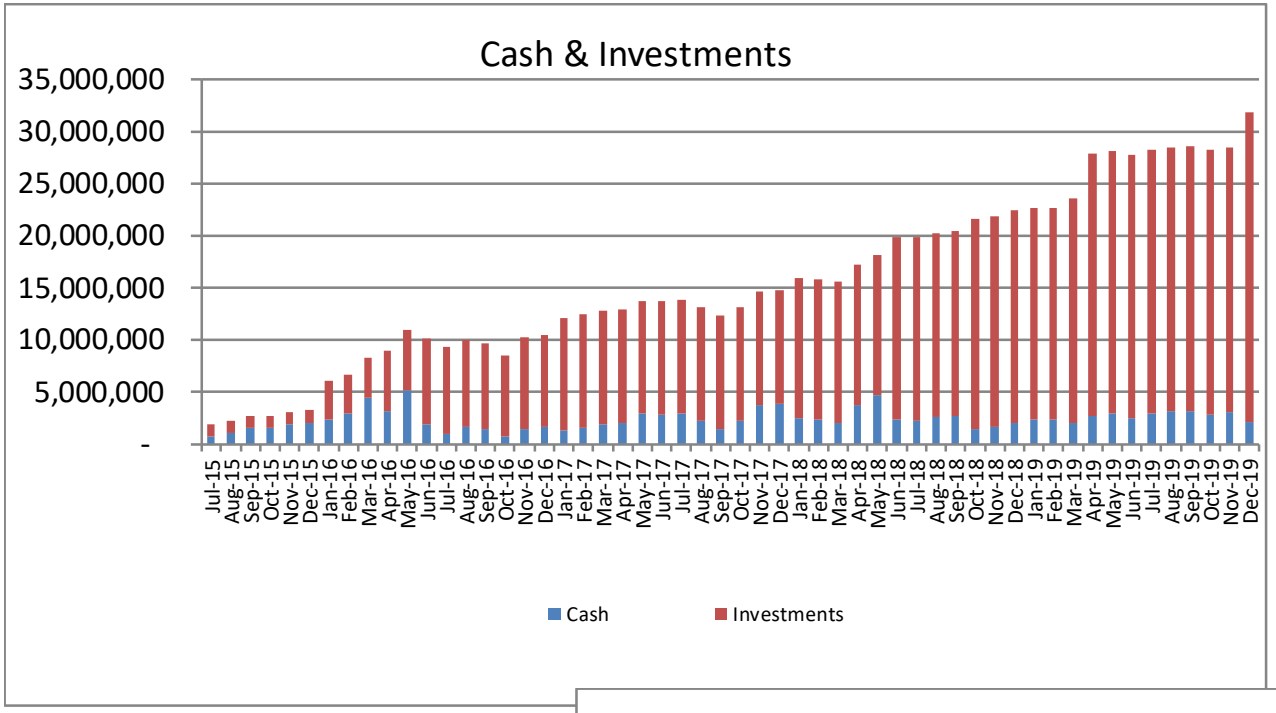
Finance Report

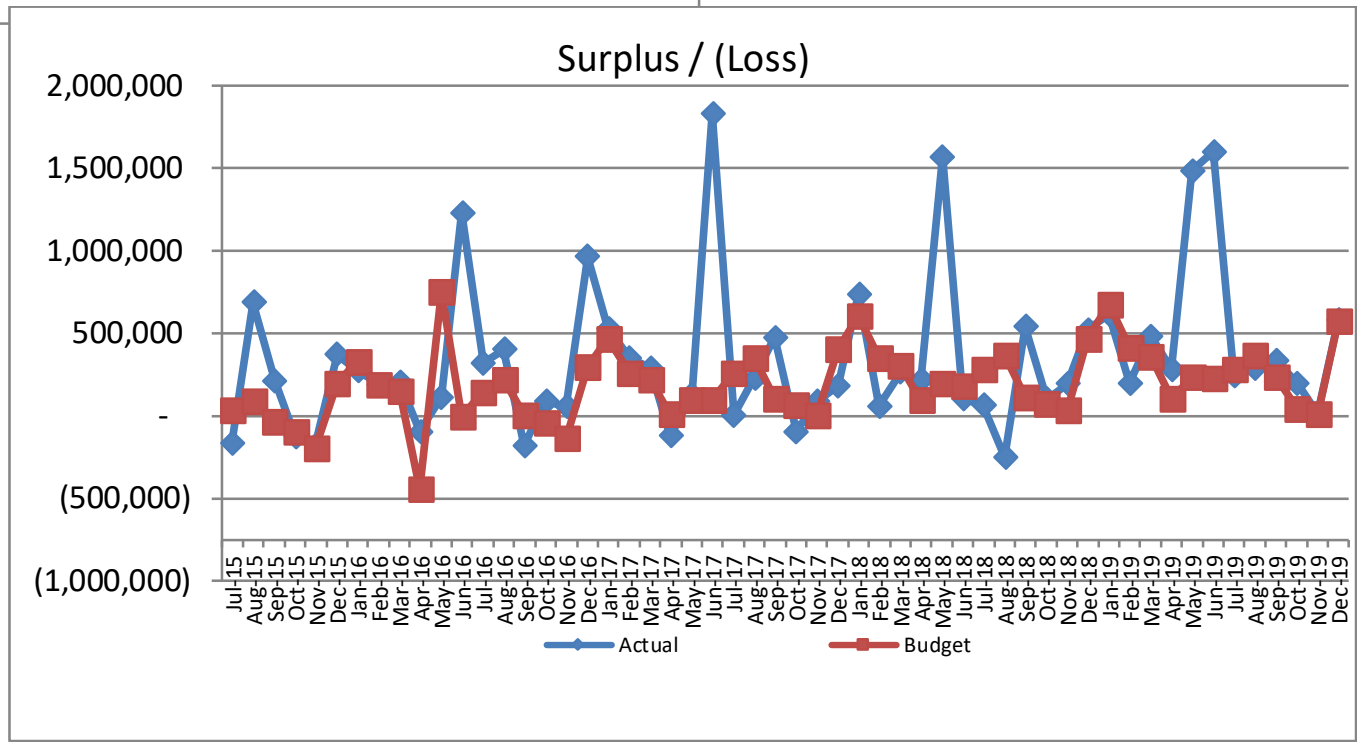
December 2019 Results

Summary for December 2019

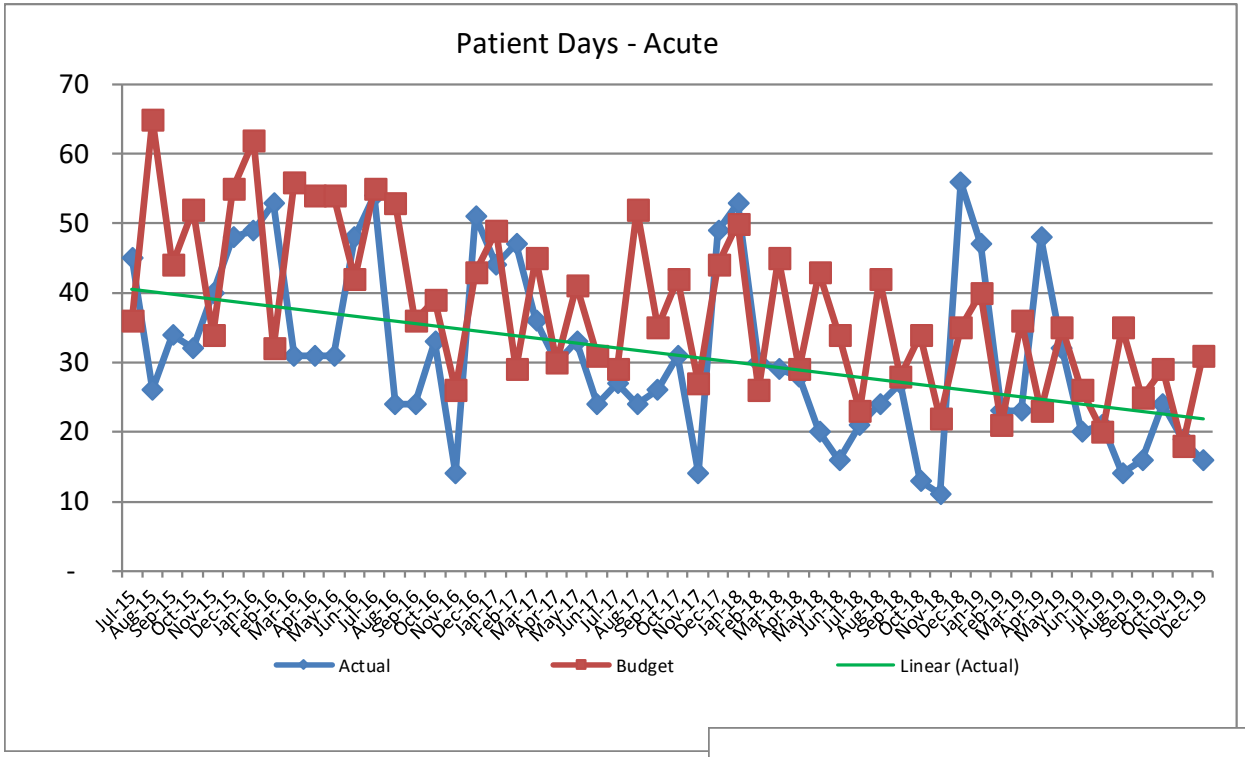
- Cash on hand $ 2,131,639
  Investments $27,602,939
- Days Cash on hand, including investments with LAIF – 434
- Surplus of $586,082 for the month was over budget by $8,732
- Total Patient Revenue was under Budget by 2.7% for the month
- Net Patient Revenue was 0.9% over budget.
- Total Expenses were 2.0% higher than budget

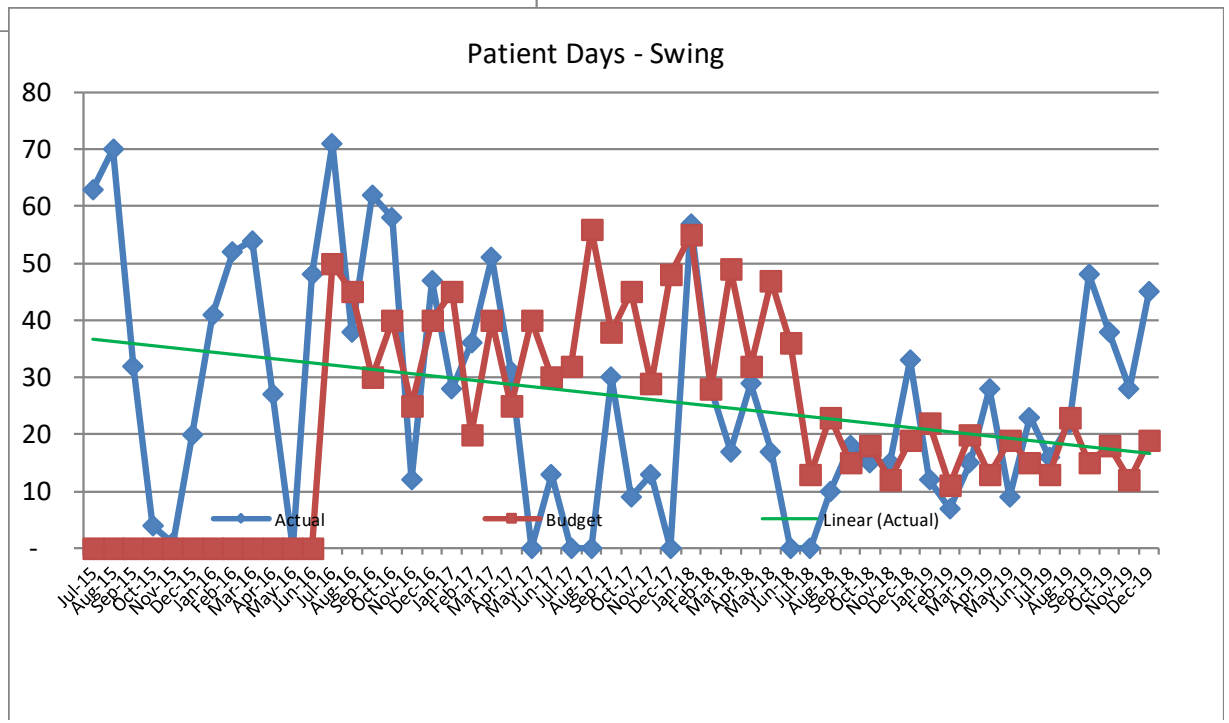
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT



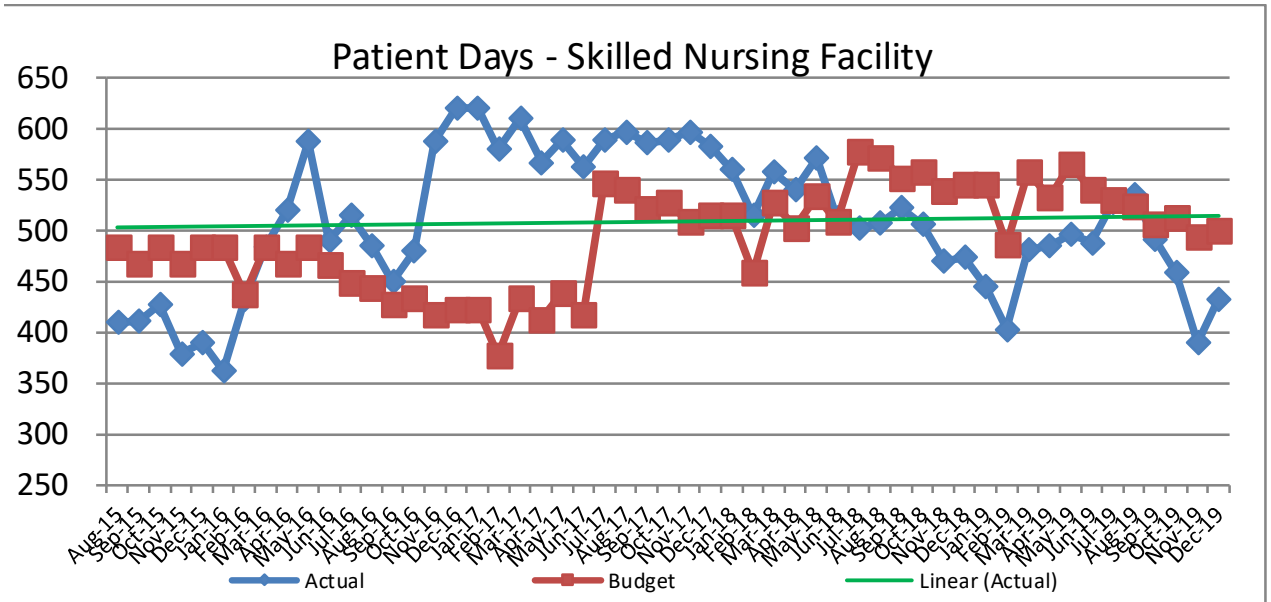


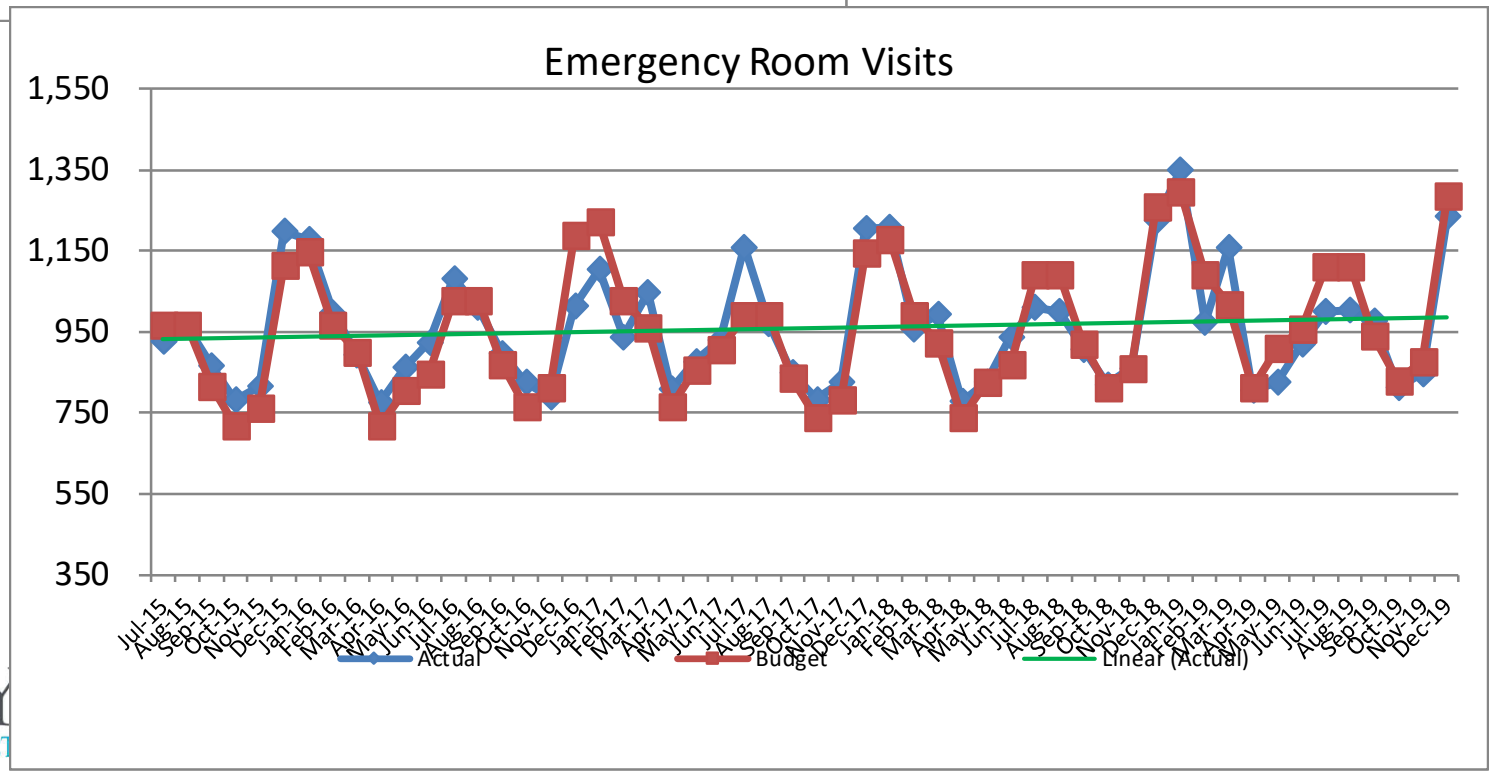
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT



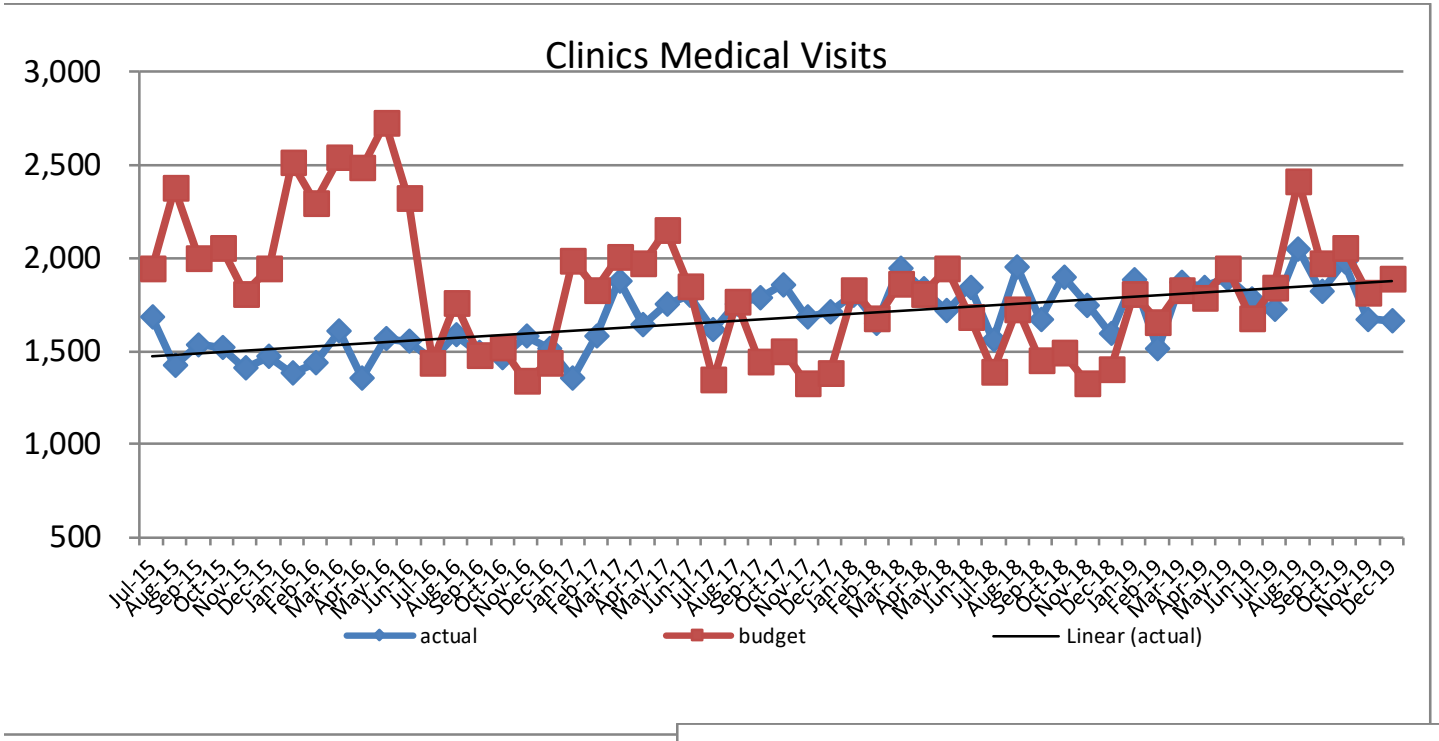


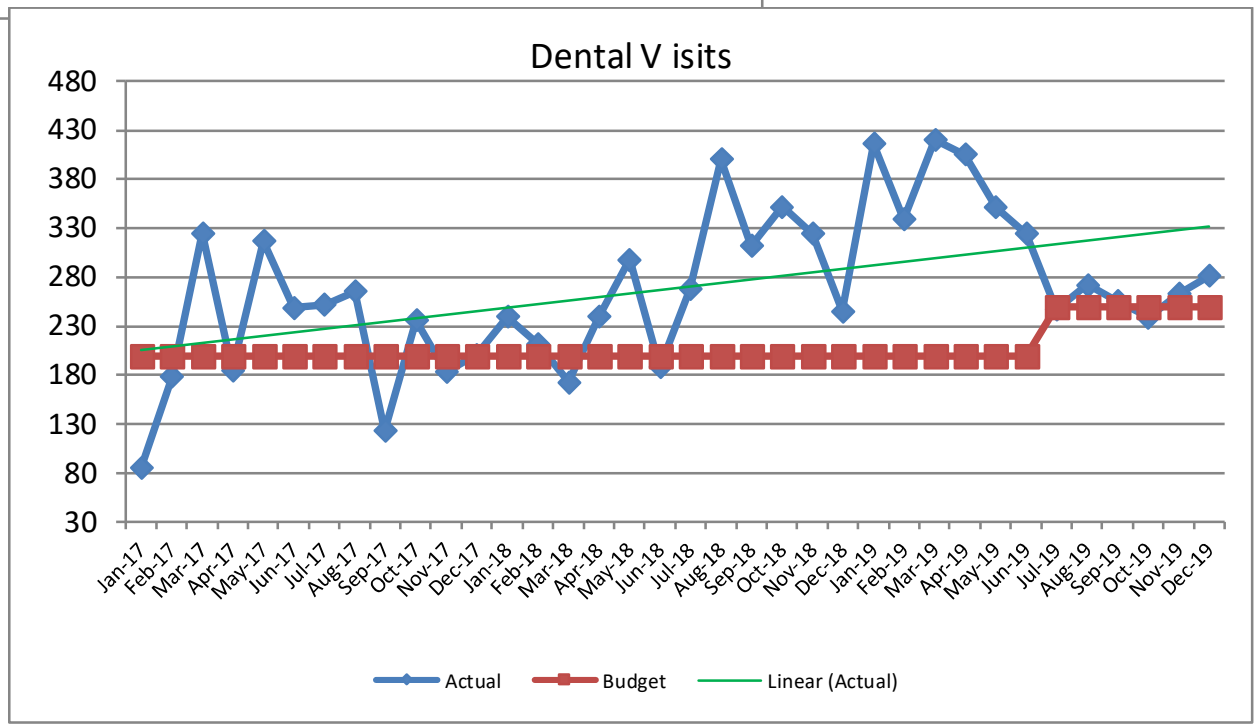
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT



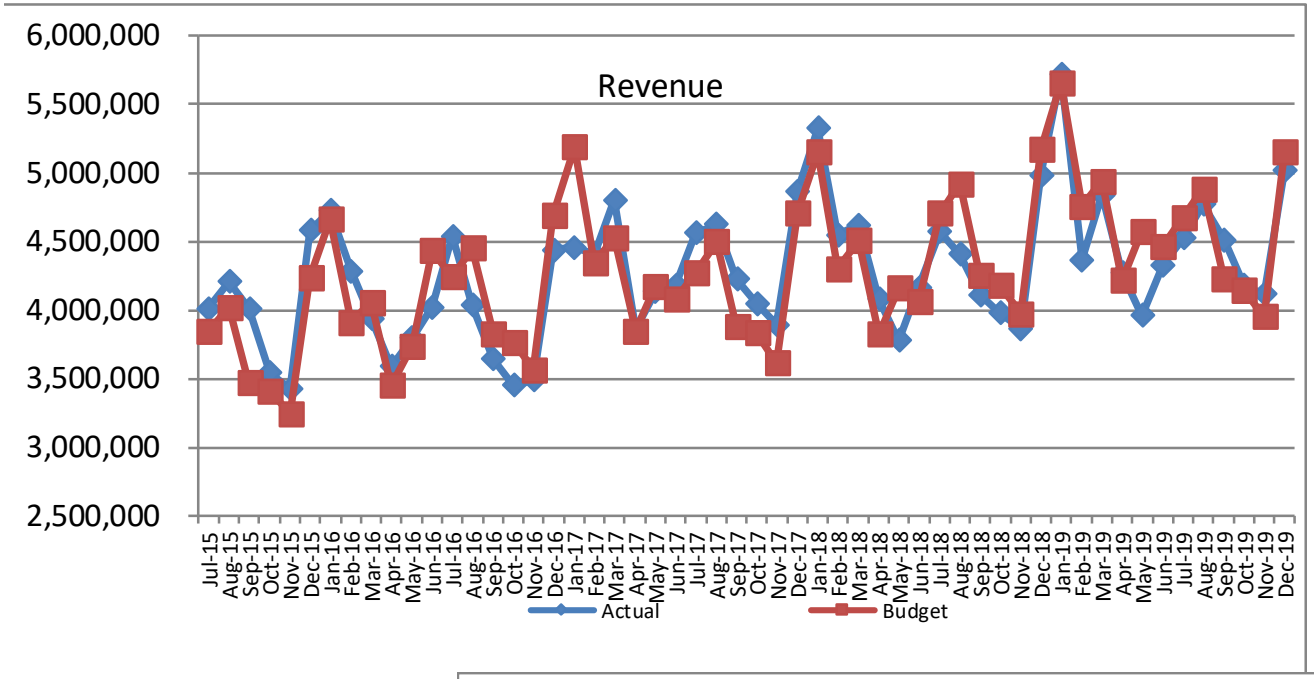


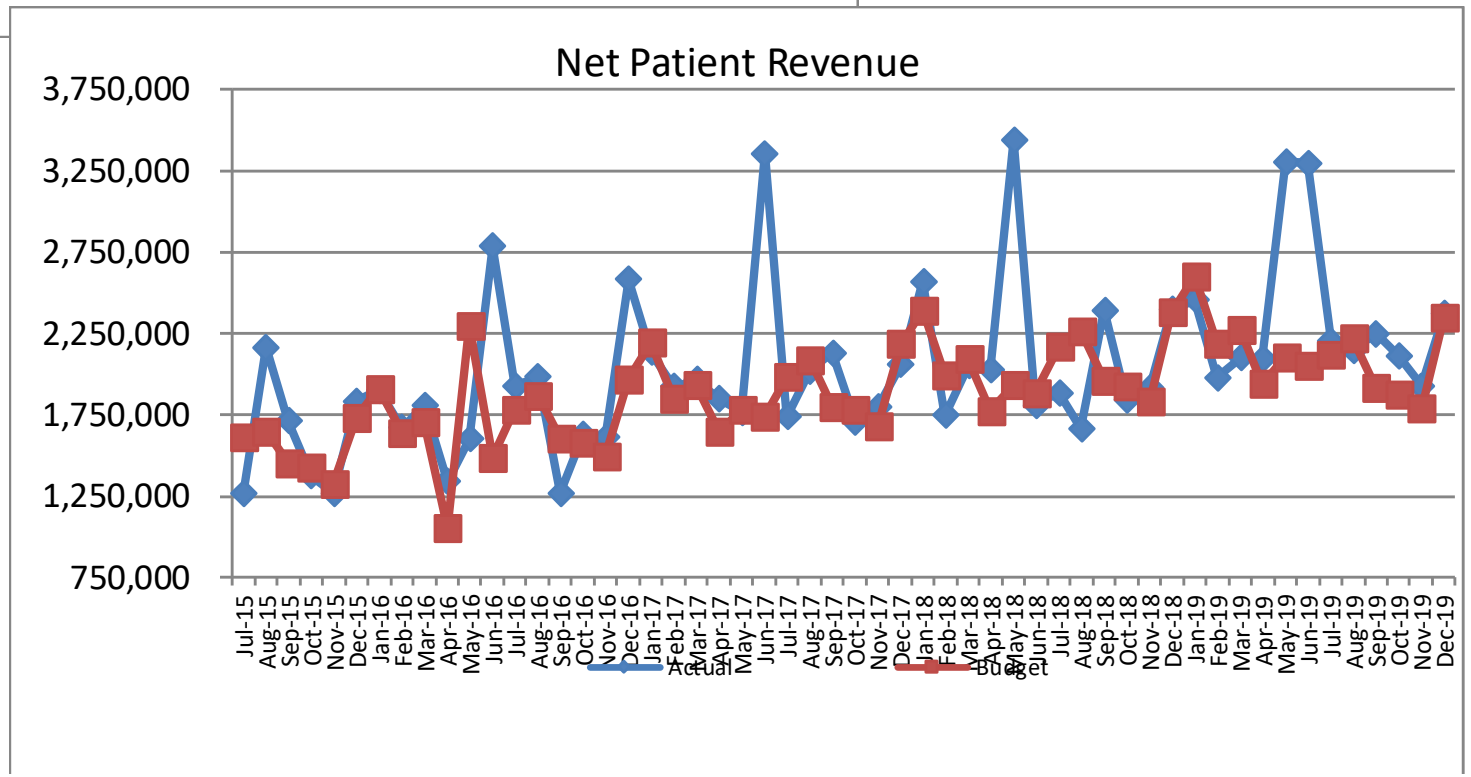
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT



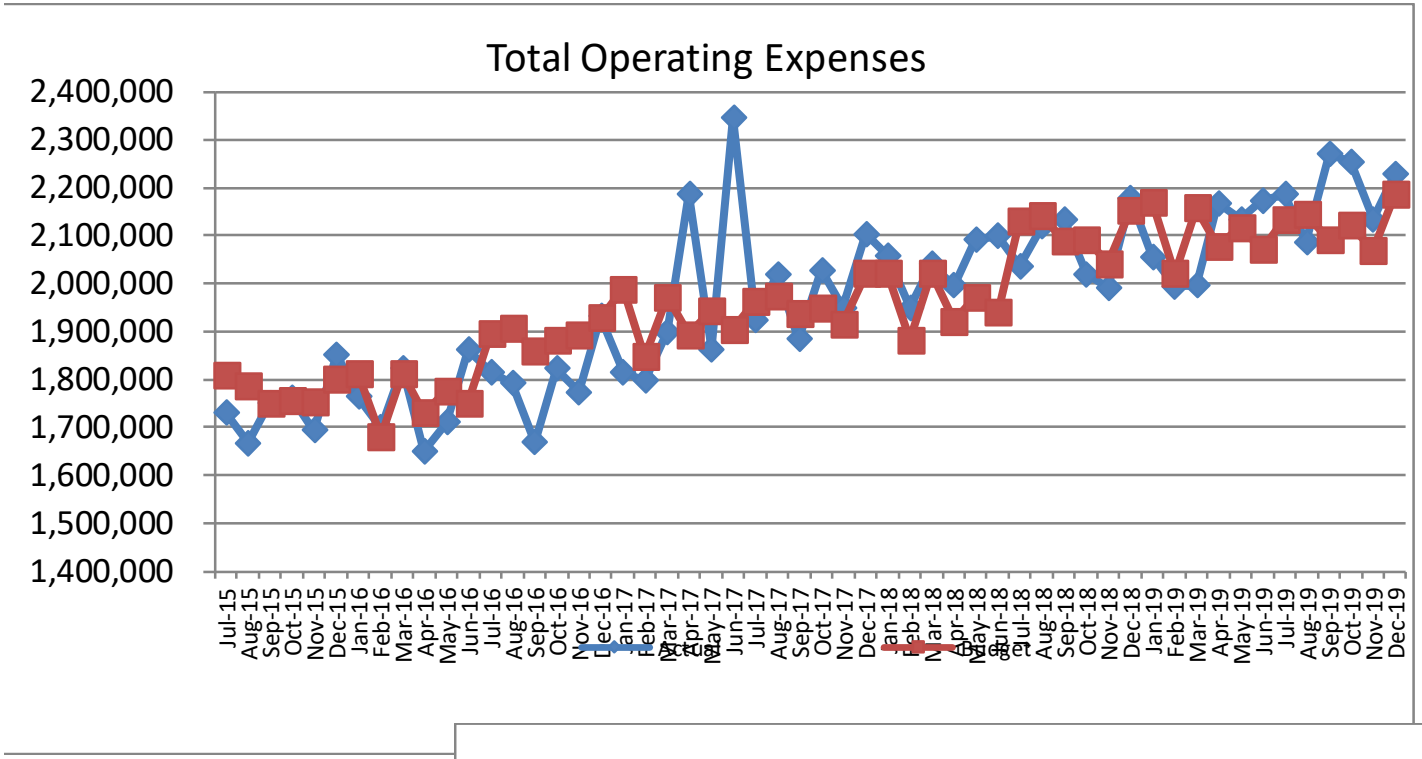


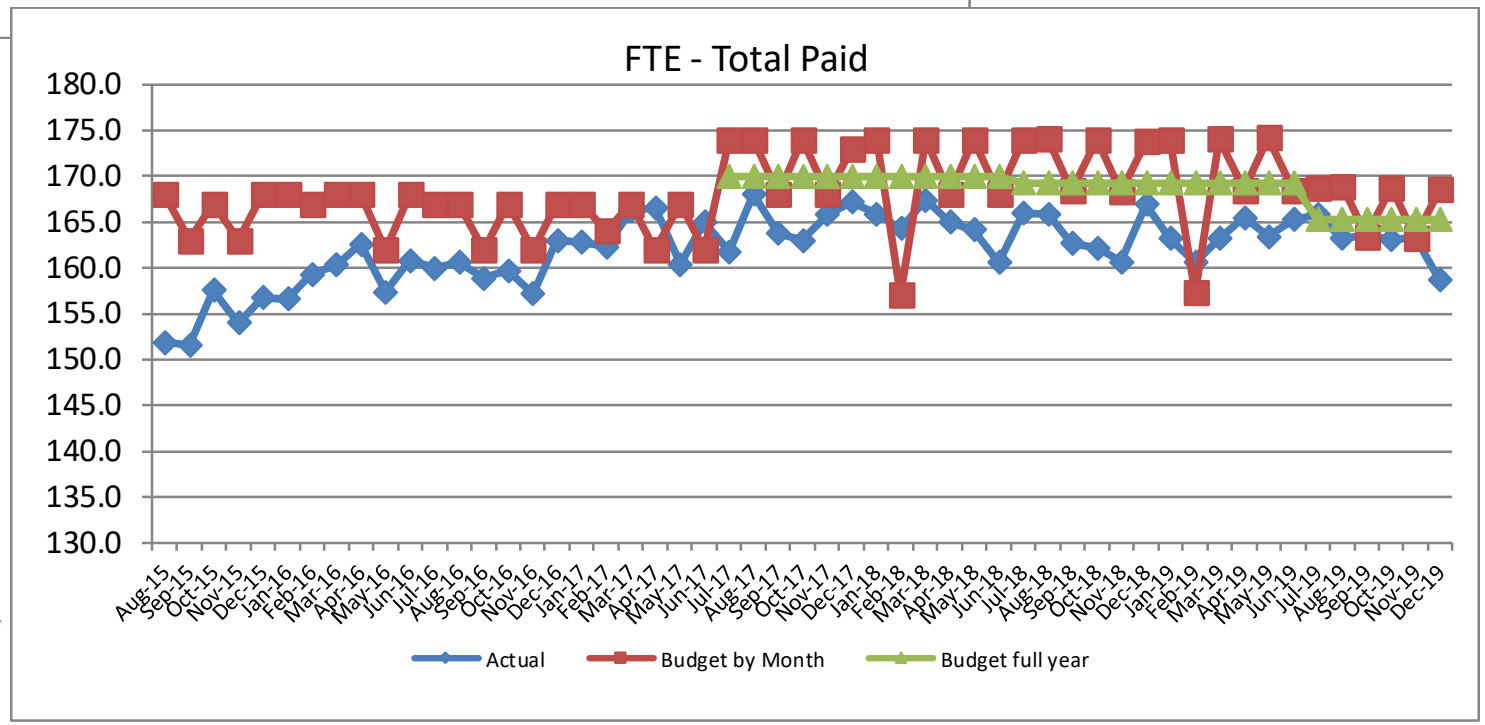
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT



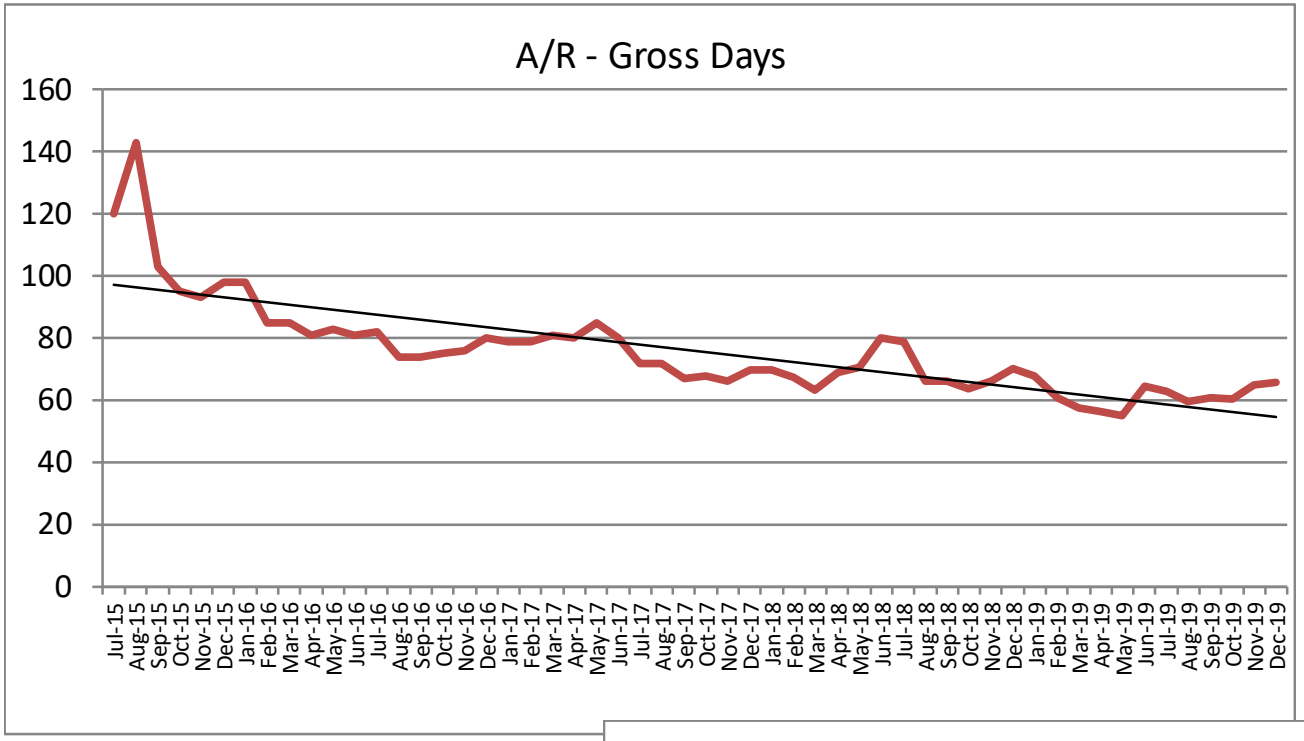


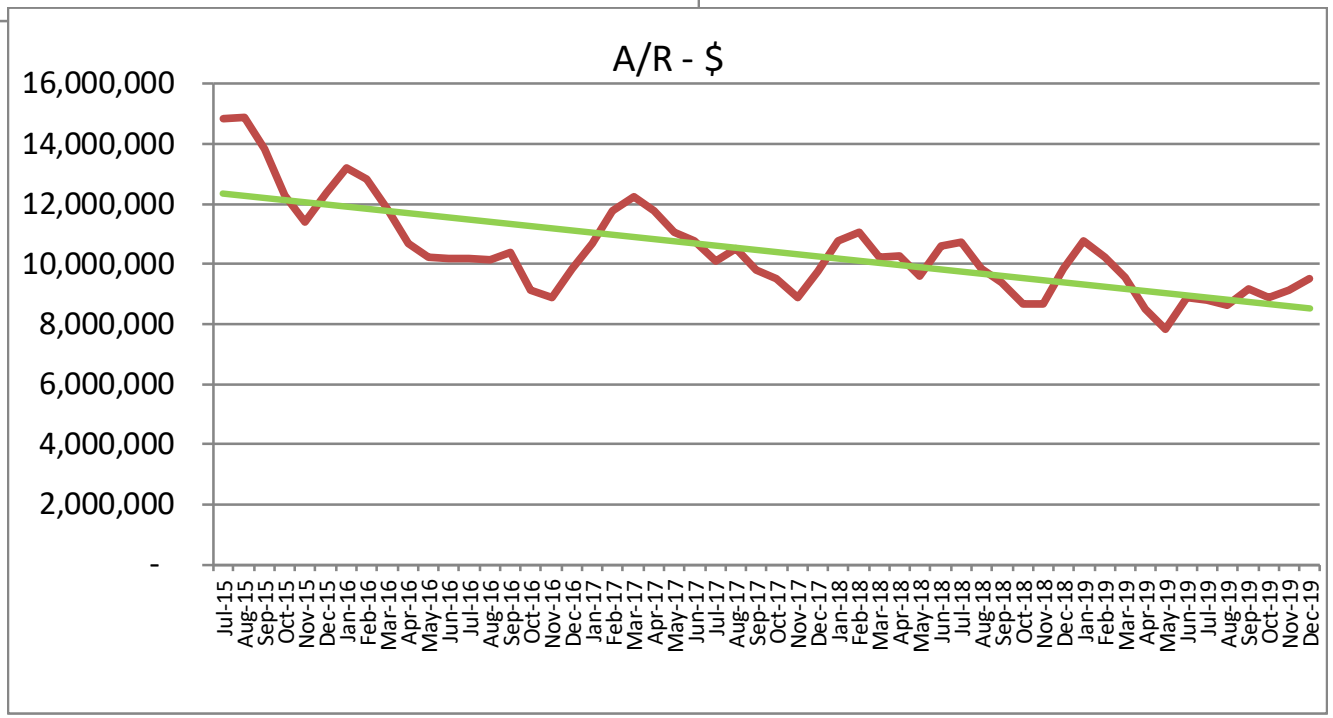
BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT





BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT





BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

December 2019 Financial Results

For the month . . .

Total Patient Revenue for December 2019 was $5,018,492 - this was $138,714 or 2.7% lower than budget. While lower than budget, total patient revenue for the month was $902,091 more than the previous month (November 2019). Emergency Room revenue was 4.9% more than budget. Inpatient revenue was 12.5% higher than budget.

Revenue deductions of $2,647,107 were lower than budget by 5.7%.

Total Operating Revenue of $2,396,757 was $42,154 or 1.7% lower than budget.

Total Expenses of $2,229,691 were 2.0% higher than budget.

Our surplus for the month of December 2019 was $586,082. This was $8,732 higher than the budgeted amount for the month.

Our Operating Cash and Investments total $29,734,578 as of the end of month. Total days cash on hand as of the end of December 2019 are 434.

Key Statistics

Acute patient days of 16 were about half the budgeted number of 31. Swing days of 45 were more than 2 times the budgeted number. Skilled Nursing Facility days of 432 were 145% lower than budget – our Average Daily Census was 13.9. ER Visits of 1,236 were 3.8% lower than budget. Clinics Medical visits were under budget while Dental visits were over budget.

FTE continue to run under budget.

Year To Date - Through the first 6 months of our Fiscal Year

Total Patient Revenue is 0.3% higher than budget
Total Operating Revenue is 3.2% higher than budget
Total Operating Expenses are 2.9% more than budget
Our Surplus of $1,724,157 is $202,700 more than budget, and $554,157 more than the first 6 months of last year

Bear Valley Community Healthcare District

Financial Statements December, 2019

Financial Highlights—Hospital

STATEMENT OF OPERATIONS

		A	B	C	D	E	F	G	H	I	J
		Current Month					Year-to-Date				
		FY 17/18	FY 18/19		VARIANCE		FY 17/18	FY 18/19		VARIANCE	
		Actual	Actual	Budget	Amount	%	Actual	Actual	Budget	Amount	%
1	Total patient revenue	4,986,477	5,018,492	5,157,206	(138,714)	-2.7%	25,923,624	27,123,276	27,039,568	83,708	0.3%
2	Total revenue deductions	2,588,523	2,647,107	2,807,021	(159,914)	-5.7%	13,813,777	14,098,152	14,753,664	(655,512)	-4.4%
3	% Deductions	52%	53%	54%			53%	52%	55%		
4	Net Patient Revenue	2,397,954	2,371,385	2,350,185	21,200	0.9%	12,109,847	13,025,124	12,285,904	739,220	6.0%
5	% Net to Gross	48%	47%	46%			47%	48%	45%		
6	Other Revenue	4,359	25,372	88,726	(63,354)	-71.4%	215,530	205,448	531,766	(326,318)	-61.4%
7	Total Operating Revenue	2,402,313	2,396,757	2,438,911	(42,154)	-1.7%	12,325,377	13,230,572	12,817,670	412,902	3.2%
8	Total Expenses	2,176,983	2,229,691	2,186,757	42,934	2.0%	12,477,620	13,111,959	12,747,394	364,565	2.9%
9	% Expenses	44%	44%	42%			48%	48%	47%		
10	Surplus (Loss) from Operations	225,330	167,066	252,154	(85,088)	33.7%	(152,243)	118,613	70,275	48,337	-68.8%
11	% Operating margin	5%	3%	5%			-1%	0%	0%		
12	Total Non-operating	294,474	419,017	325,197	93,820	28.9%	1,322,243	1,605,544	1,451,182	154,362	10.6%
13	Surplus/(Loss)	519,805	586,082	577,351	8,732	-1.5%	1,170,000	1,724,157	1,521,457	202,700	-13.3%
14	% Total margin	10%	12%	11%			5%	6%	6%		

BALANCE SHEET

		A	B	C	D	E
		December	December	November		
		FY 17/18	FY 18/19	FY 18/19	VARIANCE	
					Amount	%
15	Gross Accounts Receivables	8,675,554	9,512,758	9,129,843	382,915	4.2%
16	Net Accounts Receivables	2,990,625	3,014,176	2,852,276	161,900	5.7%
17	% Net AR to Gross AR	34%	32%	31%		
18	Days Gross AR	66.0	65.7	64.9	0.8	1.2%
19	Cash Collections	1,642,959	1,981,049	1,500,891	480,158	32.0%
20	Settlements/IGT Transactions	204,278	159,520	57,346	102,174	178.2%
21	Investments	20,260,225	27,602,939	25,454,833	2,148,106	8.4%
22	Cash on hand	1,688,071	2,131,639	3,058,371	(926,732)	-30.3%
23	Total Cash & Invest	21,948,296	29,734,578	28,513,204	1,221,374	4.3%
24	Days Cash & Invest	339	434	417	17	4.1%
	Total Cash and Investments	21,948,296	29,734,578			
	Increase Current Year vs. Prior Year		7,786,282			

Bear Valley Community Healthcare District

Financial Statements December, 2019

Statement of Operations

		A	B	C	D	E	F	G	H	I	J
		Current Month					Year-to-Date				
		FY 17/18	FY 18/19		VARIANCE		FY 17/18	FY 18/19		VARIANCE	
		Actual	Actual	Budget	Amount	%	Actual	Actual	Budget	Amount	%
	Gross Patient Revenue										
1	Inpatient	284,233	160,880	143,022	17,858	12.5%	799,893	769,735	760,404	9,331	1.2%
2	Outpatient	765,170	714,674	910,564	(195,890)	-21.5%	5,256,697	5,033,404	5,298,504	(265,099)	-5.0%
3	Clinic Revenue	339,847	338,589	410,336	(71,747)	-17.5%	2,239,262	2,247,229	2,516,846	(269,617)	-10.7%
4	Emergency Room	3,383,606	3,636,063	3,466,260	169,803	4.9%	16,289,624	17,814,284	17,116,317	697,967	4.1%
5	Skilled Nursing Facility	213,621	168,287	227,024	(58,737)	-25.9%	1,338,147	1,258,623	1,347,498	(88,875)	-6.6%
6	**Total patient revenue**	**4,986,477**	**5,018,492**	**5,157,206**	**(138,714)**	**-2.7%**	**25,923,624**	**27,123,276**	**27,039,568**	**83,708**	**0.3%**
	Revenue Deductions										
7	Contractual Allow	2,406,874	2,425,259	2,497,033	(71,774)	-2.9%	12,880,266	13,413,076	13,128,375	284,701	2.2%
8	Contractual Allow PY	(150,000)	(175,000)	-	(175,000)	#DIV/0!	(1,243,374)	(1,024,101)	-	(1,024,101)	#DIV/0!
9	Charity Care	4,625	38,889	13,854	25,035	180.7%	80,630	96,123	72,638	23,485	32.3%
10	Administrative	26,102	68	16,882	(16,814)	-99.6%	44,449	23,065	88,513	(65,448)	-73.9%
11	Policy Discount	9,975	16,444	15,085	1,359	9.0%	78,951	87,336	79,091	8,245	10.4%
12	Employee Discount	5,688	2,568	6,307	(3,739)	-59.3%	36,321	25,125	33,069	(7,944)	-24.0%
13	Bad Debts	198,143	253,297	257,860	(4,563)	-1.8%	1,211,634	1,043,844	1,351,978	(308,134)	-22.8%
14	Denials	177,395	85,583	-	85,583	#DIV/0!	724,901	433,685	-	433,685	#DIV/0!
15	**Total revenue deductions**	**2,588,523**	**2,647,107**	**2,807,021**	**(159,914)**	**-5.7%**	**13,813,777**	**14,098,152**	**14,753,664**	**(655,512)**	**-4.4%**
16	**Net Patient Revenue**	**2,397,954**	**2,371,385**	**2,350,185**	**21,200**	**0.9%**	**12,109,847**	**13,025,124**	**12,285,904**	**739,220**	**6.0%**
	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**	4,359	25,372	88,726	(63,354)	-71.4%	215,530	205,448	531,766	(326,318)	-61.4%
18	**Total Operating Revenue**	**2,402,313**	**2,396,757**	**2,438,911**	**(42,154)**	**-1.7%**	**12,325,377**	**13,230,572**	**12,817,670**	**412,902**	**3.2%**
	Expenses										
19	Salaries	945,048	914,346	886,673	27,673	3.1%	5,269,800	5,470,712	5,269,316	201,396	3.8%
20	Employee Benefits	295,949	305,507	329,791	(24,284)	-7.4%	1,642,013	1,853,651	1,926,294	(72,643)	-3.8%
21	Registry	29,974	-	-	-	#DIV/0!	29,974	5,100	-	5,100	#DIV/0!
22	Salaries and Benefits	**1,270,971**	**1,219,853**	**1,216,464**	**3,389**	0.3%	**6,941,787**	**7,329,464**	**7,195,610**	**133,854**	**1.9%**
23	Professional fees	169,550	174,740	216,812	(42,072)	-19.4%	1,047,087	1,056,064	1,173,642	(117,578)	-10.0%
24	Supplies	136,723	177,659	150,192	27,467	18.3%	797,752	986,975	849,799	137,176	16.1%
25	Utilities	42,170	36,316	46,171	(9,855)	-21.3%	256,370	257,141	273,222	(16,081)	-5.9%
26	Repairs and Maintenance	42,197	77,722	47,756	29,966	62.7%	182,400	345,715	285,938	59,777	20.9%
27	Purchased Services	320,095	342,734	326,453	16,281	5.0%	2,217,686	1,936,881	1,872,514	64,367	3.4%
28	Insurance	28,560	31,653	30,917	736	2.4%	170,008	189,641	185,502	4,139	2.2%
29	Depreciation	81,905	83,739	78,725	5,014	6.4%	464,348	499,166	472,350	26,816	5.7%
30	Rental and Leases	11,158	15,541	12,370	3,171	25.6%	67,624	73,289	74,220	(931)	-1.3%
32	Dues and Subscriptions	10,898	6,272	6,488	(216)	-3.3%	38,090	36,048	38,928	(2,880)	-7.4%
33	Other Expense.	62,756	63,462	54,409	9,053	16.6%	294,467	401,575	325,669	75,906	23.3%
34	**Total Expenses**	**2,176,983**	**2,229,691**	**2,186,757**	**42,934**	**2.0%**	**12,477,620**	**13,111,959**	**12,747,394**	**364,565**	**2.9%**
35	**Surplus (Loss) from Operations**	**225,330**	**167,066**	**252,154**	**(85,088)**	**33.7%**	**(152,243)**	**118,613**	**70,275**	**48,337**	**-68.8%**
36	**Non-Operating Income**										
37	Tax Revenue	184,244	201,917	201,917	-	0.0%	1,105,464	1,211,502	1,211,502	-	0.0%
38	Other non-operating	-	75,040	5,750	69,290	1205.0%	44,095	132,743	34,500	98,243	284.8%
	Interest Income	117,923	149,497	125,100	24,397	19.5%	218,540	306,633	250,600	56,033	22.4%
	Interest Expense	(7,693)	(7,438)	(7,570)	132	-1.7%	(45,856)	(45,333)	(45,420)	87	-0.2%
	IGT Expense	-	-	-	-	#DIV/0!	-	-	-	-	#DIV/0!
39	**Total Non-operating**	**294,474**	**419,017**	**325,197**	**93,820**	**28.9%**	**1,322,243**	**1,605,544**	**1,451,182**	**154,362**	**10.6%**
40	**Surplus/(Loss)**	**519,805**	**586,082**	**577,351**	**8,732**	**-1.5%**	**1,170,000**	**1,724,157**	**1,521,457**	**202,700**	**-13.3%**

Bear Valley Community Healthcare District
Financial Statements

Current Year Trending Statement of Operations

A Statement of Operations—CURRENT YEAR 2020

			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		132,376	109,683	117,618	135,332	113,846	160,880							769,735
2	Outpatient		852,704	893,759	883,248	900,575	788,445	714,674							5,033,404
3	Clinic		369,855	413,535	386,658	398,761	339,831	338,589							2,247,229
4	Emergency Room		2,937,844	3,116,633	2,904,860	2,531,862	2,687,022	3,636,063							17,814,284
5	Skilled Nursing Facility		234,536	237,879	218,184	212,481	187,257	168,287							1,258,623
6	**Total patient revenue**		**4,527,315**	**4,771,490**	**4,510,568**	**4,179,010**	**4,116,401**	**5,018,492**	**-**	**-**	**-**	**-**	**-**	**-**	**27,123,276**
	Revenue Deductions	C/A	0.45	0.53	0.47	0.48	0.56	0.48	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.49
7	Contractual Allow		2,048,634	2,523,579	2,128,363	1,986,465	2,300,777	2,425,259							13,413,076
8	Contractual Allow PY		(100,000)	(150,040)	(150,000)	(150,000)	(299,061)	(175,000)							(1,024,101)
9	Charity Care		21,771	10,036	2,177	5,803	17,447	38,889							96,123
10	Administrative		9,113	(337)	5,344	3,687	5,190	68							23,065
11	Policy Discount		11,209	16,516	14,783	15,253	13,132	16,444							87,336
12	Employee Discount		7,850	3,870	1,620	6,914	2,302	2,568							25,125
13	Bad Debts		262,975	160,654	203,254	98,670	64,994	253,297							1,043,844
14	Denials		56,797	58,918	53,258	96,348	82,780	85,583							433,685
15	**Total revenue deductions**		**2,318,349**	**2,623,196**	**2,258,799**	**2,063,140**	**2,187,561**	**2,647,107**	**-**	**-**	**-**	**-**	**-**	**-**	**14,098,152**
			0.51	0.55	0.50	0.49	0.53	0.53	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
16	**Net Patient Revenue**		**2,208,966**	**2,148,293**	**2,251,769**	**2,115,870**	**1,928,841**	**2,371,385**	**-**	**-**	**-**	**-**	**-**	**-**	**13,025,124**
	net / tot pat rev		48.8%	45.0%	49.9%	50.6%	46.9%	47.3%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	48.0%
17	**Other Revenue**		4,070	26,718	4,820	140,781	3,687	25,372							205,448
18	**Total Operating Revenue**		**2,213,036**	**2,175,012**	**2,256,589**	**2,256,651**	**1,932,528**	**2,396,757**	**-**	**-**	**-**	**-**	**-**	**-**	**13,230,572**
	Expenses														
19	Salaries		909,799	920,881	905,534	902,906	917,246	914,346							5,470,712
20	Employee Benefits		314,164	285,924	374,193	257,931	315,932	305,507							1,853,651
21	Registry		-	-	-	4,380	720	-							5,100
22	Salaries and Benefits		**1,223,962**	**1,206,805**	**1,279,728**	**1,165,217**	**1,233,898**	**1,219,853**	**-**	**-**	**-**	**-**	**-**	**-**	**7,329,464**
23	Professional fees		227,413	134,001	176,263	176,896	166,751	174,740							1,056,064
24	Supplies		157,037	146,720	158,949	174,312	172,298	177,659							986,975
25	Utilities		45,550	47,425	46,842	40,886	40,122	36,316							257,141
26	Repairs and Maintenance		38,865	29,353	29,812	135,968	33,995	77,722							345,715
27	Purchased Services		302,946	319,068	323,112	365,076	283,943	342,734							1,936,881
28	Insurance		32,000	31,410	31,548	31,515	31,515	31,653							189,641
29	Depreciation		82,105	82,105	83,739	83,739	83,739	83,739							499,166
30	Rental and Leases		12,010	11,891	12,918	10,463	10,466	15,541							73,289
32	Dues and Subscriptions		7,130	5,446	5,785	5,299	6,116	6,272							36,048
33	Other Expense.		56,525	72,916	73,560	64,758	70,355	63,462							401,575
34	**Total Expenses**		**2,185,543**	**2,087,141**	**2,222,256**	**2,254,129**	**2,133,199**	**2,229,691**	**-**	**-**	**-**	**-**	**-**	**-**	**13,111,959**
35	**Surplus (Loss) from Operations**		**27,492**	**87,870**	**34,333**	**2,522**	**(200,671)**	**167,066**	**-**	**-**	**-**	**-**	**-**	**-**	**118,613**
36	**Non-Operating Income**														
37	Tax Revenue		201,917	201,917	201,917	201,917	201,917	201,917							1,211,502
38	Other non-operating		25,040	9,000	20	40	23,603	75,040							132,743
	Interest Income		300	286	156,148	212	190	149,497							306,633
	Interest Expense		(7,711)	(7,590)	(7,541)	(7,540)	(7,513)	(7,438)							(45,333)
	IGT Expense		-	-	-	-	-	-							-
39	**Total Non-operating**		**219,546**	**203,612**	**350,544**	**194,629**	**218,196**	**419,017**	**-**	**-**	**-**	**-**	**-**	**-**	**1,605,544**
40	**Surplus/(Loss)**		**247,038**	**291,483**	**384,877**	**197,151**	**17,526**	**586,082**	**-**	**-**	**-**	**-**	**-**	**-**	**1,724,157**

2019-20 Actual BS

BALANCE SHEET Includes Final Entries 6-30-19	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**PY June**
ASSETS:							
Current Assets							
Cash and Cash Equivalents (Includes CD's)	2,992,558	3,178,108	3,141,519	2,853,286	3,058,371	2,131,639	2,406,940
Gross Patient Accounts Receivable	8,667,951	8,621,871	9,149,724	8,858,810	9,128,887	9,511,803	8,792,362
Less: Reserves for Allowances & Bad Debt	5,919,643	5,911,721	6,297,145	6,112,108	6,276,611	6,497,627	5,906,428
Net Patient Accounts Receivable	2,748,308	2,710,149	2,852,579	2,746,702	2,852,276	3,014,176	2,885,934
Tax Revenue Receivable	2,423,000	2,423,000	2,423,000	2,423,000	2,040,789	1,100,642	46,556
Other Receivables	90,680	126,745	113,997	605,220	-118,588	-87,096	80,710
Inventories	130,378	130,687	123,077	117,611	124,523	132,932	136,982
Prepaid Expenses	420,319	422,235	425,830	473,165	415,216	397,410	406,467
Due From Third Party Payers	0	0					
Due From Affiliates/Related Organizations	0	0					
Other Current Assets	0	0					
Total Current Assets	8,805,242	8,990,924	9,080,003	9,218,984	8,372,587	6,689,703	5,963,589
Assets Whose Use is Limited							
Investments	25,298,992	25,298,992	25,454,833	25,454,833	25,454,833	27,602,939	25,298,992
Other Limited Use Assets	144,375	144,375	144,375	144,375	144,375	144,375	144,375
Total Limited Use Assets	25,443,367	25,443,367	25,599,208	25,599,208	25,599,208	27,747,314	25,443,367
Property, Plant, and Equipment							
Land and Land Improvements	570,615	570,615	570,615	570,615	570,615	570,615	570,615
Building and Building Improvements	10,063,006	10,087,902	10,105,802	10,110,802	10,110,802	10,110,802	10,063,006
Equipment	12,367,216	12,390,920	12,483,917	12,555,150	12,624,831	12,677,717	12,365,728
Construction In Progress	220,454	221,354	221,354	221,886	221,886	233,163	220,454
Capitalized Interest							
Gross Property, Plant, and Equipment	23,221,290	23,270,791	23,381,687	23,458,453	23,528,134	23,592,297	23,219,802
Less: Accumulated Depreciation	14,657,536	14,739,641	14,823,380	14,907,119	14,990,857	15,074,596	14,575,430
Net Property, Plant, and Equipment	8,563,754	8,531,150	8,558,308	8,551,334	8,537,277	8,517,700	8,644,372
TOTAL UNRESTRICTED ASSETS	42,812,363	42,965,441	43,237,518	43,369,526	42,509,072	42,954,717	40,051,328
Restricted Assets	0	0	0	0	0	0	0
TOTAL ASSETS	42,812,363	42,965,441	43,237,518	43,369,526	42,509,072	42,954,717	40,051,328

2019-20 Actual BS

BALANCE SHEET Includes Final Entries 6-30-19	July	Aug	Sept	Oct	Nov	Dec	PY June
LIABILITIES:							
Current Liabilities							
Accounts Payable	1,109,879	948,094	1,080,601	1,024,845	1,022,614	968,794	922,125
Notes and Loans Payable							
Accrued Payroll	814,113	894,578	1,021,042	1,105,147	666,489	886,860	733,342
Patient Refunds Payable							
Due to Third Party Payers (Settlements)	3,279,267	3,416,509	3,287,677	3,388,603	3,145,949	3,118,768	3,311,092
Advances From Third Party Payers							
Current Portion of Def Rev - Txs,	2,256,083	2,054,166	1,852,249	1,655,332	1,453,415	1,251,498	35,000
Current Portion - LT Debt	35,000	35,000	35,000	40,000	40,000	40,000	35,000
Current Portion of AB915							
Other Current Liabilities (Accrued Interest & Accrued Other)	15,339	22,930	30,471	37,971	45,451	7,560	7,689
Total Current Liabilities	7,509,682	7,371,277	7,307,040	7,251,897	6,373,917	6,273,481	5,044,247
Long Term Debt							
USDA Loan	2,860,000	2,860,000	2,860,000	2,855,000	2,855,000	2,815,000	2,860,000
Leases Payable	0	0	0	0	0	0	0
Less: Current Portion Of Long Term Debt	35,000	35,000	35,000	40,000	40,000	40,000	35,000
Total Long Term Debt (Net of Current)	2,825,000	2,825,000	2,825,000	2,815,000	2,815,000	2,775,000	2,825,000
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	10,334,682	10,196,277	10,132,040	10,066,897	9,188,917	9,048,481	7,869,248
Fund Balance							
Unrestricted Fund Balance	32,230,643	32,230,643	32,182,080	32,182,080	32,182,080	32,182,080	24,871,960
Temporarily Restricted Fund Balance	0	0				0	
Equity Transfer from FRHG	0	0				0	
Net Revenue/(Expenses)	247,038	538,521	923,398	1,120,549	1,138,075	1,724,157	7,310,120
TOTAL FUND BALANCE	32,477,681	32,769,164	33,105,478	33,302,629	33,320,154	33,906,237	32,182,080
TOTAL LIABILITIES & FUND BALANCE	42,812,363	42,965,441	43,237,518	43,369,526	42,509,072	42,954,717	40,051,328

Units of Service

For the period ending: December 31, 2019

31 184

Bear Valley Community Hospital

Current Month							Year-To-Date					
Dec-19		Dec-18	Actual -Budget		Act.-Act.		Dec-19		Dec-18	Actual -Budget		Act.-Act.
Actual	Budget	Actual	Variance	Var %	Var %		Actual	Budget	Actual	Variance	Var %	Var %
16	31	56	(15)	-48.4%	-71.4%	Med Surg Patient Days	197	158	152	39	24.7%	29.6%
45	19	33	26	136.8%	36.4%	Swing Patient Days	110	100	91	10	10.0%	20.9%
432	500	474	(68)	-13.6%	-8.9%	SNF Patient Days	2,835	3,066	2,981	(231)	-7.5%	-4.9%
493	**550**	**563**	**(57)**	**-10.4%**	**-12.4%**	**Total Patient Days**	**3,142**	**3,324**	**3,224**	**(182)**	**-5.5%**	**-2.5%**
10	14	21	(4)	-28.6%	-52.4%	Acute Admissions	48	84	66	(36)	-42.9%	-27.3%
6	14	20	(8)	-57.1%	-70.0%	Acute Discharges	45	84	65	(39)	-46.4%	-30.8%
2.7	2.2	2.8	0.5	20.4%	-4.8%	Acute Average Length of Stay	4.4	1.9	2.3	2.5	132.7%	87.2%
0.5	1.0	1.8	(0.5)	-48.4%	-71.4%	Acute Average Daily Census	1.1	1	0.8	0.2	24.7%	29.6%
15.4	16.7	16.4	(1.4)	-8.1%	-5.9%	SNF/Swing Avg Daily Census	16.0	17	16.7	(1.2)	-7.0%	-4.1%
15.9	**17.7**	**18.2**	**(1.8)**	**-10.4%**	**-12.4%**	**Total Avg. Daily Census**	**17.1**	**18**	**17.5**	**(1.0)**	**-5.5%**	**-2.5%**
35%	**39%**	**40%**	**-4%**	**-10.4%**	**-12.4%**	**% Occupancy**	**38%**	**40%**	**39%**	-2%	**-5.5%**	**-2.5%**
6	13	13	(7)	-53.8%	-53.8%	Emergency Room Admitted	32	78	51	(46)	-59.0%	-37.3%
1,230	1,272	5,770	(42)	-3.3%	-78.7%	Emergency Room Discharged	5,844	6,075	5,770	(231)	-3.8%	1.3%
1,236	**1,285**	**5,783**	**(49)**	**-3.8%**	**-78.6%**	**Emergency Room Total**	**5,876**	**6,153**	**5,821**	**(277)**	**-4.5%**	**0.9%**
40	**41**	**187**	**(2)**	**-3.8%**	**-78.6%**	**ER visits per calendar day**	**32**	**33**	**32**	**(2)**	**-4.5%**	**0.9%**
60%	**93%**	**62%**	**57%**	**61.5%**	**-3.1%**	**% Admits from ER**	**67%**	**93%**	**77%**	**78%**	**84.3%**	**-13.7%**
-	-	-	-	0.0%	#DIV/0!	Surgical Procedures I/P	1	-	-	1	0.0%	#DIV/0!
15	12	12	3	25.0%	25.0%	Surgical Procedures O/P	56	76	77	(20)	-26.3%	-27.3%
15	**12**	**12**	**3**	**25.0%**	**25.0%**	**TOTAL Procedures**	**57**	**76**	**77**	**(19)**	**-25.0%**	**-26.0%**
826	**1,047**	**751**	**(221)**	**-21.1%**	**10.0%**	**Surgical Minutes Total**	**4,838**	**6,214**	**4,018**	**(1,376)**	**-22.1%**	**20.4%**

Units of Service

For the period ending: December 31, 2019

Bear Valley Community Hospital

Current Month							Year-To-Date					
Dec-19		Dec-18	Actual -Budget		Act.-Act.		Dec-19		Dec-18	Actual -Budget		Act.-Act.
Actual	Budget	Actual	Variance	Var %	Var %		Actual	Budget	Actual	Variance	Var %	Var %
5,955	5,742	5,742	213	3.7%	3.7%	Lab Procedures	38,407	36,823	4,919	1,584	4.3%	680.8%
999	1,043	1,039	(44)	-4.2%	-3.8%	X-Ray Procedures	4,909	5,072	4,178	(163)	-3.2%	17.5%
378	350	336	28	8.0%	12.5%	C.T. Scan Procedures	1,907	1,635	1,664	272	16.6%	14.6%
170	180	163	(10)	-5.6%	4.3%	Ultrasound Procedures	1,202	1,252	1,289	(50)	-4.0%	-6.7%
43	62	36	(19)	-30.6%	19.4%	Mammography Procedures	323	372	328	(49)	-13.2%	-1.5%
353	288	262	65	22.6%	34.7%	EKG Procedures	1,760	1,658	1,537	102	6.2%	14.5%
146	135	107	11	8.1%	36.4%	Respiratory Procedures	643	584	588	59	10.1%	9.4%
1,052	1,078	1,176	(26)	-2.4%	-10.5%	Physical Therapy Procedures	9,111	8,484	8,357	627	7.4%	9.0%
1,665	1,892	1,593	(227)	-12.0%	4.5%	Primary Care Clinic Visits	10,911	11,995	10,418	(1,084)	-9.0%	4.7%
281	250	245	31	12.4%	14.7%	Specialty Clinic Visits	1,558	1,500	1,901	58	3.9%	-18.0%
1,946	**2,142**	**1,838**	**(196)**	**-9.2%**	**5.9%**	**Clinic**	**12,469**	**13,495**	**12,319**	**(1,026)**	**-7.6%**	**1.2%**
75	**82**	**71**	**(8)**	**-9.2%**	**5.9%**	**Clinic visits per work day**	**69**	**74**	**68**	**(6)**	**-7.6%**	**1.2%**
15.5%	20.00%	16.70%	-4.50%	-22.50%	-7.19%	% Medicare Revenue	18.48%	20.00%	19.37%	-1.52%	-7.58%	-4.56%
33.30%	39.00%	34.20%	-5.70%	-14.62%	-2.63%	% Medi-Cal Revenue	38.48%	39.00%	37.57%	-0.52%	-1.32%	2.44%
45.00%	36.00%	42.90%	9.00%	25.00%	4.90%	% Insurance Revenue	38.47%	36.00%	37.95%	2.47%	6.85%	1.36%
6.20%	5.00%	6.20%	1.20%	24.00%	0.00%	% Self-Pay Revenue	4.57%	5.00%	5.12%	-0.43%	-8.67%	-10.75%
140.2	152.0	150.6	(11.9)	-7.8%	-6.9%	Productive FTE's	144.13	150.4	142.9	(6.3)	-4.2%	0.8%
158.7	168.6	164.1	(9.9)	-5.9%	-3.3%	Total FTE's	162.95	167.0	164.1	(4.0)	-2.4%	-0.7%

CFO REPORT for

February 2020 Finance Committee and Board Meetings

FY 2021 (July 1, 2020 through June 30, 2021) Budget Preparation Plan

Attached is a plan for budget preparation over the next several months.

District Credit Card – Limit

The limit on the district credit card was established in 1999 at $5,000. There are times when we need to make purchases of large amounts or when a number of purchases combine to near the limit purchases need tio be delayed unto q payment is made. We propose that the limit be raised to as much as $10,00.

Purchasing Assessment by QHR

Two consultants from Quorum Health Resources were on-site on January 27 and 28th to work with our new Purchasing Coordinator.

CMS Proposed Rule

CMS has proposed a rule regarding Medicaid (the Medicaid Fiscal Accountability Regulation – MFAR). The proposal would impact virtually every state. Concerns are that - The proposed changes would have a devastating effect on the health care safety net in California and on the lives of many patients. State flexibility in funding the non-federal share of Medicaid is essential in making the Medi-Cal program work. Without it, the Medi-Cal program would not be able to provide coverage to 13 million Californians. A concern is CMS should not adopt a one-size-fits-all approach and restrict the legitimate use of local governmental funds, health-care related taxes, or provider-related donations in a manner that gives the agency unrestrained authority, using overly broad standards that could lead to arbitrary decisions and an uneven application across state Medicaid programs.

Pricing Transparency Issue – Update

We continue to monitor the issue of Pricing Transparency. Originally this was scheduled to be in place by January 2020. During the fall the effective date was moved to January 2021. I have included some key points from a recent presentation by QHR relative to this topic.

The Call from President Trump:

"Hospitals will be required to publish prices that reflect what people actually pay for services in a way that is clear, straightforward and accessible to all, and you will be able to price it among many different potential providers, and you will get great pricing. Prices will come down by numbers that you wouldn't believe… and the cost of healthcare will go way, way down." "We should also require drug companies, insurance companies, and hospitals to disclose real prices to foster competition and bring costs down."

In November 2019, following the publishing of final regulations the effective date was changed to January 2021

"The Administration had previously proposed plans to force only hospitals to reveal pricing information. This goes one step further and requires the same information from insurers." – CMS Administrator Seema Verma

Definition of Shoppable Services

• A service that can be scheduled in advance.

• Commonly provided by the hospital to its patient population.

• Includes all ancillary/supporting services associated with the designated primary shoppable service.

• Minimum of 300 Shoppable Services, 70 of which are specified by CMS Regulation. If hospital does not provide one or more of the 70 noted by CMS, the hospital must select additional shoppable services required to meet the total 300 minimum threshold

Definition of "Standard Charges"

• The Gross Charge (the charge for an individual item or service that is reflected on a hospital's chargemaster).

• The discounted cash price (the charge that applies toan individual who pays cash for a hospital item or service).

• The Payer-specific negotiated charge (the charge that a hospital has negotiated with a third-party payer for an item or service).

• The de-identified minimum negotiated charges (the lowest charge that hospital has negotiated with all third-party payers).

• The de-identified maximum negotiated charges (the highest charge that a hospital has negotiated with all third-party payers)

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

FY 2021 (July 1, 2020 through June 30, 2021)
BUDGET PREPARATION CALENDAR

Feb 19, 2020 Budget Packets / Details to Managers

Feb 21, 2020 Capital Budget Requests due to Accounting

Mar 16, 2020 Managers - budgets due to Accounting

Mar 31, 2020 Accounting – complete input & review of budgets

Apr 01 through 10, 2020 meetings with Managers

Apr 07, 2020 regular Finance Committee

- begin review of Capital Budget requests

April 11 through 24, 2020 – Budget Review by Admin Team

May 05, 2020 regular Finance Committee

- Include budget work

May 2020 additional review by Finance Committee as needed for final review, recommendation

June 02, 2020 Regular Finance Committee including review of Budget for Submission to full Board of Directors for approval

June 10, 2020 Regular Board of Directors meeting including approval of FY 2021 Budget including 3 year Capital Budget Plan