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, July 11, 2018 @ 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** — **Rob Robbins, 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. **TRADE SECRETS: Pursuant to Health and Safety Code Section 32106, and Civil Code Section 3426.1**
   (1) TruBridge Agreement - Extension to April 2019 (Disclosure 07/11/18)
   (2) Riverside Community Hospital Affiliation (Disclosure 07/11/18)

4. **PUBLIC EMPLOYEE PERFORMANCE EVALUATION *Pursuant to Government Section Code: 54957**
   (1) Chief Executive Officer

OPEN SESSION

1. **CALL TO ORDER** — **Rob Robbins, President**

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

3. **FLAG SALUTE**

4. **ADOPTION OF AGENDA***

5. **RESULTS OF CLOSED SESSION** **Rob Robbins, 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. June 13, 2018 Board of Directors Meeting Minutes: Shelly Egerer, Executive Assistant
B. June 21, 2018 Special Board of Directors Meeting Minutes: Shelly Egerer, Executive Assistant
C. June 2018 Planning & Facilities Report: Michael Mursick, Plant Director
D. June 2018 Human Resource Report: Erin Wilson, Human Resource Director
E. June 2018 Infection Prevention Report: Heather Loose, Infection Preventionist
F. Policies & Procedures:
  (1) Hospital Plan for Provision of Patient Care Services
  (2) CT Scan
  (3) Diagnostic Imaging
  (4) Code Stroke
  (5) Emergency Preparedness
  (6) Mammography
  (7) Radiology
  (8) Handling of Soiled Instruments Outside of the Operating Room
  (9) Ultrasound
G. Board of Directors; Committee Meeting Minutes:
  (1) April 18, 2018 Affiliation Ad Hoc Committee Meeting Minutes
  (2) May 29, 2018 Special Human Resource Committee Meeting Minutes
  (3) June 01, 2018 Special Finance Committee Meeting Minutes
  (4) June 05, 2018 Finance Committee Meeting Minutes

10. OLD BUSINESS*

A. Discussion and Potential Approval of the May 2018 Human Resource Report: Erin Wilson, Human Resource Director

B. Discussion and Potential Approval of the Following Policies & Procedures
(1) Administration (Summary Attached)
(2) ID and Facility Access Badges
(3) Electrical Safety – ECMAM -1

C. Discussion and Potential Approval of the February 13, 2018 Human Resource Committee Meeting Minutes

11. NEW BUSINESS*

A. Discussion and Potential Approval of the TruBridge Agreement (Extension to April 2019)

B. Discussion and Potential Approval of Rescheduling the August 08, 2018 Board of Directors Business Board Meeting Due to the QHR Trustee Conference

C. Discussion and Potential Recommendation to the Board of Directors for Quorum Health Resources to Complete the Productivity Benchmarking Assessment and Approve Travel Expenses Not To Exceed $5,000.00

D. Discussion and Potential Approval of a Request From BVCHD Foundation Regarding the Tree of Lights

E. Discussion and Potential Approval of BVCHD Board of Directors Retreat: To Include Date and Agenda Items

F. Discussion and Potential Approval of the CEO & CFO 2017/2018 Retirement Contribution Paid By Bear Valley Community Healthcare District

G. Discussion and Update on the 340B Pharmacy

12. ACTION ITEMS*

A. **Acceptance of QHR Report**
Ron Vigus, AVP QHR
(1) July 2018 QHR Report

B. **Acceptance of CNO Report**
Kerri Jex, Chief Nursing Officer
(1) June 2018 CNO Report

C. **Acceptance of the CEO Report**
John Friel, Chief Executive Officer
(1) June 2018 CEO Report

D. **Acceptance of the Finance Report & CFO Report**
Garth Hamblin, Chief Financial Officer
(1) May 2018 Financials
(2) July 2018 CFO Report
(3) QHR Financial Operations Review Report (FOR)

(4) Information Technology 2019-2021 Strategic Plan

13. ADJOURNMENT* *** Denotes Possible Action Items**

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
BUSINESS BOARD MEETING MINUTES
41870 Garstin Drive, Big Bear Lake, Ca. 92315
June 13, 2018

PRESENT: Rob Robbins, President
Gail McCarthy 1st Vice President
Jack Roberts, 2nd Vice President
Donna Nicely, Treasurer
Peter Boss, MD, Secretary
John Friel, CEO

ABSENT: Shelly Egerer, Ex. Assist.

STAFF:

Garth Hamblin	Erin Wilson	Steven Knapik, DO
Nicole Wheeler	Kerri Jex	Michael Mursick
Mary Norman	Sheri Mursick	Kathy Gardner
Kathy Breuer	Jacob Phillips	Mary Norman

OTHER: Ken Ward, QHR
Holly Elmer, Foundation President
Gail Dick, Aux. President

COMMUNITY MEMBERS: Jeff Willis, Chief of Big Bear Fire Dept.
Mike Maltby, Big Bear Lake Fire Marshall

OPEN SESSION

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

CLOSED SESSION

1. **PUBLIC FORUM FOR CLOSED SESSION:**
   President Robbins opened the Hearing Section for Public Comment on Closed Session items at 1:00 p.m. Hearing no request to make public comment. President Robbins closed Public Forum for Closed Session at 1:01 p.m.

2. **ADJOURNED TO CLOSED SESSION:**
   President Robbins motioned to adjourn to Closed Session at 1:01 p.m. Second by Board Member Roberts to adjourn to Closed Session. President Robbins called for a vote. A vote in favor of the motion was 5/0.
   - Board Member Boss - yes
   - Board Member Nicely- yes
   - President Robbins - yes
   - Board Member McCarthy - yes
   - Board Member Roberts - yes

RECONVENE TO OPEN SESSION

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

2. **ROLL CALL:**
   Rob Robbins, Gail McCarthy, Jack Roberts, Donna Nicely, and Peter Boss, MD were present. Also, present were John Friel, CEO. Absent was Shelly Egerer, Executive Assistant.

3. **FLAG SALUTE:**
   Chief Jeff Willis led the flag salute, all present participated.

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

5. **RESULTS OF CLOSED SESSION:**
   President Robbins reported that the following action was taken in Closed Session:
   The following reports were approved.

   - Chief of Staff Report:
     - Request for Reappointment:
       - Nogba Pawoo, DO - Pathologist
       - Mahua Biswas, MD – Renaissance Radiology
     - Risk Report
     - QI Report

   President Robbins called for the vote. A vote in favor of the motion was 5/0.
   - Board Member Boss - yes
   - Board Member Nicely- yes
   - President Robbins - yes
   - Board Member McCarthy - yes
   - Board Member Roberts - yes

6. **PUBLIC FORUM FOR OPEN SESSION:**
   President Robbins opened the Hearing Section for Public Comment on Open Session items at 3:04 p.m. Hearing no request to make public comment. President Robbins closed Public Forum for Open Session at 3:04 p.m.

7. **DIRECTORS COMMENTS**
   - Board Member Robbins attended the Foundation Wine and Cheese Event, the event was great.

8. **INFORMATION REPORTS:**
   A. Foundation Report:
   - Ms. Elmer provided the following information:
     - Wine and Cheese Event will take place quarterly; this will keep the community informed of what the Foundation is participating in. This event is invitation only.
     - Wine Walk booth went well.
     - Booth at the hospital Health Fair.
     - Save the Date, 2nd annual Helen Walsh event will take place August 26th.
     - Donna Nicely would like to know if employees are able to make donations to the Foundation by automatic deduction. Holly Elmer and John Friel will attempt to find the answer.

   B. Auxiliary Report:
   - Ms. Dick provided the following information:
     - June 30th Health Fair Carnival.
     - Annual Golf Tournament will be Friday, August 31st, 9 am tee off, shotgun start. Cost is $85.00 for a team of 4, this includes 18 holes, cart, lunch, goody bag, prizes, raffles and baskets. Ms. Dick will be requesting donations and baskets for raffle items.

9. **CONSENT AGENDA:**
   A. May 09, 2018 Board of Directors Meeting Minutes: Shelly Egerer, Executive Assistant
   B. May 2018 Planning & Facilities Report: Michael Mursick, Plant Director
   C. May 2018 Human Resource Report: Erin Wilson, Human Resource Director
   D. May 2018 Infection Prevention Report: Heather Loose, Infection Preventionist
   E. Policies & Procedures:
   (1) Administration (Summary Attached)
   (2) ID and Facility Access Badges
   (3) Electrical Safety – ECMAM - 1
   F. Board of Directors; Committee Meeting Minutes:
   (1) February 13, 2018 Human Resource Committee Meeting Minutes
   (2) May 01, 2018 Finance Committee Meeting Minutes
   (3) May 24, 20148 Finance Committee Meeting Minutes

President Robbins called for a motion to approve the Consent Agenda with the items C. May 2018 Human Resource Report, E. Policies & Procedures and F. Board of Directors; Committee Meeting Minutes be pulled and under New Business. Motion by Board Member Nicely to approve the Consent Agenda with the items C. May 2018 Human Resource Report, E. Policies & Procedures and F. Second by Board Member Roberts to approve the Consent Agenda with the items C. May 2018 Human Resource Report, E. Policies & Procedures and F. President Robbins called for the vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins -yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

10. OLD BUSINESS:

- None.

11. NEW BUSINESS*

A. Discussion and Presentation of the Big Bear Lake Fire Department Master Plan Results Presented by Chief Willis:

- Chief Jeff Willis is present to provide information regarding the needs of expanding fire and ambulance services.
- Request of the Board, Chief Willis is asking for assistance for one or more members of the organization to be part of the working group for the Big Bear Lake Fire Department Master Plan.
- Ken Ward would like to know if the increase is due to a certain diagnosis or increase in population? Chief Willis is unsure of the exact reason; however there is an increase in medical calls.
- Board Member Boss would like to know if there is a possibility of increasing the number of ambulances transferring patients at one time, at this time one ambulance may transfer at a time.
- Chief Willis states that if there is an increase in ambulances, two vehicles may transfer at a time.

President Roberts reported no action required

B. Discussion and Potential Approval of the Following Contracts:

(1) Steven Knapik, D.O. Hospitalist Service Agreement
(2) Calvin Pramann, D.C. Chiropractor Service Agreement
(3) Jerrell Tucker, JWT & Associates

Board Member Roberts motioned to approve contracts one through three as presented. Second by Board Member Nicely to approve contracts one through three as presented. President Robbins called for the vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

C. Discussion and Potential Approval of the Fiscal Year 2018/2019 Operating Budget:

- Mr. Hamblin reported the following information;
  - The process of completing the budget with managers, the January financial information is provided to the managers who then review FTE's and minor equipment purchases, a request is then provided to Mr. Hamblin and Kathy

Breuer. Mr. Hamblin, Kathy Breuer and the managers then meet and discuss statistics, FTE's and other requests.
    - Answers to the committee's questions are included in the packet. Bear Valley does hold an obligation to First 5 to provide a $50,000.00 contribution toward the operation of the MOM & DAD project.
- Board Member Nicely reported that a contract is in place with First 5, this is assistance to the MOM & DAD Project, information such as this is important to be vetted when completing the budget. Board Member Nicely reported that there were several questions regarding the operating budget. Board Member Nicely would like to know what purchased services entail and the Finance Committee would like the process to begin in March and would like Kathy Breuer present during the Finance Committee meeting when the budget is to be presented. The Finance committee requests that line items and an addendum are included in the Finance Committee packets in the future budget.
- Board Member Roberts would like to know why the reductions in FTE's in areas that are expanding, this reduction is due to recommendations made by the managers. Board Member Roberts would like to know what the 18.2% increase in employee benefit entail.
- Mr. Hamblin reported that the request is the upcoming change in benefits, such as increase in PTO as employees will accrue more PTO the longer they are employed, workers comp insurance and an increase in health insurance.
- Board Member Nicely reported that the Finance Committee requested a $20,000.00 decrease in other expenses, outside training and this was not completed. Mr. Hamblin is to make the requested changes in minimizing the amount.
- A Special Human Resources and Special Board meetings must take place to discuss the Wage and Salary review, the implementation of employee raises are included in the budget and the Board would like answers regarding the review.
- Discussion took place with concerns by Board Member Roberts regarding approval of the Budget without review of the Wage and Salary. The two meetings will take place next week for clarification. This will not affect the approval of the Budget at this time. Board Member Roberts suggests that the meetings take place so that the implementation of possible employee raises will take place July 1st as previously discussed.

Board Member Roberts motioned to approve the Fiscal Year 2018/2019 Operating Budget with recommended changes. Second by Board Member Robbins to approve the Fiscal Year 2018/2019 Operating Budget with recommended changes. President Robbins called for the vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - yes
  Board Member Roberts - yes

D. Discussion and Potential Approval of the Fiscal Year 2018/2019 Capital Budget:

- Mr. Hamblin reported the following information;
    - Summary sheets provide a 3-year capital plan. Several changes depend on the upcoming years of what will be done within the facility with upgrades, remodeling and rebuilding.

- President Robbins commends the committee on their hard work and recommends that any questions are deferred to the Finance Committee.
- Board Member Nicely reported that the $50,000.00 remodeling for Administration has been removed, this was due to possible location changes of the Administrative office in the future. Board Member Nicely requests that every capital request in the future is included in packets with detail. If there is a request for a new piece of equipment, please provide estimates of cost.

Board Member Roberts motioned to approve the Fiscal Year 2018/2019 Capital Budget as presented. Second by Board Member Robbins to approve the Fiscal Year 2018/2019 Capital Budget as presented. President Robbins called for the vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

E. Discussion and Update on CalPERS Medical Benefits (Potential Withdraw & Proposed Options):

- The market is opening within the next 60 days to quote outside of CalPERS.
- Board Member Roberts recommends polling the employees to ask if the employees would like to have insurance offered for their families through the District or if the employee would prefer to receive the insurance from the exchange. Employees whom have their children or spouse on the District insurance are paying a high amount.
- President Robbins would like further explanation regarding the options of Benefits and where the District stands at this time.
- Ms. Wilson reported that the District is going out to market for other options outside of CalPERS, quotes are to be provided at the end of June.
- Board Member Roberts voiced concerns regarding the possibilities of insurance quotes for the upcoming year will not be realistic at this time because the quotes will change.

President Robbins reported no action required

F. Discussion and Potential Approval of Continuing to Provide Surgical Services:

- Mr. Friel reported the following information:
  - Data has been provided through May 2018, services have not increased. Mr. Friel recommends continuing with the study, continue with the process with Moon & Mayoras with the retrofit options and monitor services. A Surgeon from Riverside Community Hospital will be on site next week.
- Board Member Nicely stated that during the visit to Riverside Community, interest was shown by the Surgeons on staff.
- Board Member Roberts states that this may be a loss in the beginning, however, this is a service to the community.

Board Member Roberts motioned to approve the Continuing to Provide Surgical Services. Second by Board Member McCarthy to approve Continuing to Provide Surgical Services. President Robbins called for the vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - yes
- Board Member Roberts – yes

G. May 2018 Human Resource Report: Erin Wilson, Human Resource Director

- Board Member Nicely requests information on the evaluation delinquency reports and the report provided, Ms. Wilson is to verify the calculations and provide the information for the year 2018 to the Board.

Board Member Nicely motioned to delay approval of the May 2018 Human Resources Report pending update of calculations to the July 2018 Board meeting. Second by Board Member McCarthy to delay approval of the May 2018 Human Resources Report pending update of calculations to the July 2018 Board meeting. President Robbins called for the vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - yes
- Board Member Roberts – yes

H. Policies & Procedures:

(1) Administration (Summary Attached)
(2) ID and Facility Access Badges
(3) Electrical Safety – ECMAM – 1

- Jack Roberts reported that the Conflict of Interest and appendix do not match, the appendix is not up to date.
- Mr. Roberts is to contact Shelly Egerer, Executive Assistant to review policies and procedures.

Board Member Roberts motioned to table 9.E Policies and Procedures to July 2018 Board of Directors meeting. Second by President Robbins to table 9.E Policies and Procedures to July 2018 Board of Directors meeting. President Robbins called for the vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - yes
- Board Member Roberts – yes

I. Board of Directors; Committee Meeting Minutes:

(1) February 13, 2018 Human Resource Committee Meeting Minutes
(2) May 01, 2018 Finance Committee Meeting Minutes
(3) May 24, 2018 Finance Committee Meeting Minutes

- Board Member Roberts reported that there was a typo in the Human Resources Committee Meeting Minutes; the minutes are to be brought back to the meeting.
- Board Member Roberts recommends that all committee-meeting minutes with the exception of Medical Staff meeting minutes are brought directly to the Board of Directors versus waiting for approval by the committee, which causes delay in relay of information to the Board.

Board Member Roberts motioned to approve F. Board of Directors; Committee Meeting Minutes with the HR Committee Meeting Minutes be brought back at the July Board Meeting. Second by Donna Nicely to approve F. Board of Directors; Committee Meeting Minutes with the HR Committee Meeting Minutes be brought back at the July Board Meeting. President Robbins called for the vote. A vote in favor of the motion was 5/0.

- Board Member Boss – yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy – yes
- Board Member Roberts – yes

12. ACTION ITEMS*

A. Quorum Health Resource Report:

(1) June 2018 QHR Report:

- Mr. Ward reported the following information:
  - Compliance Assessment September 5th
  - Mock Survey scheduled in August
  - QHR Board Trustee Conference, rooms must be reserved by this Friday, rooms have been reserved.
  - Financial Operating review will be presented to the Finance committee in July.

Board Member Roberts motioned to approve the QHR Report as presented. Second by President Robbins to approve the QHR Report as presented. President Robbins called for the vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

B. CNO Report:

(1) May 2018 CNO Report:

- Ms. Jex provided the following information via telephone:
  - 2567 for relicensing survey response submitted to the State on 6/12/18.
  - Fax received for intent to site following a self-report.
  - Provided information regarding the BETA Heart Program and an update to where the facility is in the program and future plans.
  - There are several rounding programs taking place. Nursing Leadership are assigned days of the week that they complete rounds, Administrative Team has pairs that round quarterly to each department, Managers are to round 3x daily.

- SNF DON the position is advertised, there is one potential lead at this time.
- Board Member Nicely requests information regarding the Food and Nutritional Service Manual that was purchased, does the Dietary Manager not write department policies?
- Ms. Jex reported that the manual is necessary to purchase for guidelines to replace the previously used manual, the manual will need to go through the approval process just as policies and procedures do.
- Board Member McCarthy discussed suggestions that were made by the Patient Family Advisory committee, the potential inspirational quotes and pictures throughout the facility. Board Member McCarthy suggest speaking with local artists to request donating art on a rotation basis.
- Ms. Jex informed the Board that the committee has decided to request employees to present pictures from throughout the valley and those employees will be recognized on the picture.

Board Member Nicely motioned to approve the CNO Report as presented. Second by Board Member Roberts to approve the CNO Report as presented. President Robbins called for the vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

C. Acceptance of the CEO Report:

(1) May 2018 CEO Report:

- Mr. Friel reported the following information:
  - Meeting with potential physician candidate, decided not to move forward with the physician, will continue the search for a Family Practitioner.
  - Western University Medical Students will begin on June 25th.
  - First meeting with Moon & Mayoras, meeting with department managers on June 21st to discuss how departments operate.

Board Member Roberts motioned to approve the CEO Report as presented. Second by Board Member McCarthy to approve the CEO Report as presented. President Robbins called for the vote. A vote in favor was unanimously approved 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

(2) Strategic Plan

- Mr. Friel reported the following information:
  - The update has been provided with highlighted completions.

Board Member Boss motioned to approve the Strategic Plan as presented. Second by President Robbins to approve the Strategic Plan as presented. President Robbins called for the vote. A vote in favor was unanimously approved 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

D. Acceptance of the Finance Report:

(1) April 2018 Financials:

- Mr. Hamblin reported the following information:
  - Days cash on hand increased to 273.
  - YTD patient revenue is over budget.
  - Revenue deductions are over budget.
  - Acute and Swing beds are significantly lower than budget.
  - SNF days continue more than 10% over budget.
  - ER visits are 4.5% over budget.
  - FTE continue to run under budget.

(2) CFO Report:

- Mr. Hamblin reported the following information:
  - AB3087 will not move forward in 2018.
  - Revenue Cycle, Eva Pierce is working on the Patient Access services portion and evaluating Rycan and TruBridge performances.
  - June 30 is the end of a quarter, a $32,000.00 discount will be offered for telemetry equipment if a purchase order is completed within 30 days, the Board must agree that Garth Hamblin may sign the purchase order, a Special Board meeting will take place for potential approval of authorization.

Board Member Roberts motioned to approve the April 2018 Finance Report and the CFO Report as presented. Second by President Robbins to approve the April 2018 Finance Report and the CFO Report as presented. President Robbins called for the vote. A vote in favor was unanimously approved 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

13. ADJOURNMENT:

Board Member Nicely motioned to adjourn the meeting at 4:57 p.m. Second by Board Member Boss to adjourn. President Robbins called for the vote. A vote in favor of the motion was unanimously approved 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
SPECIAL BUSINESS BOARD MEETING MINUTES
41870 Garstin Drive, Big Bear Lake, Ca. 92315
June 21, 2018

PRESENT:	Rob Robbins, President	Donna Nicely, Treasurer
	Gail McCarthy, 1st Vice President	John Friel, CEO
	Jack Roberts, 2nd Vice President	Shelly Egerer, Exec. Assistant
ABSENT:	None	
STAFF:	Garth Hamblin	Erin Wilson
COMMUNITY MEMBERS:	None	

OPEN SESSION

1. **CALL TO ORDER:**
   President Robbins called the meeting to order at 12:00 p.m.

2. **ROLLCALL:**
   Rob Robbins, Gail McCarthy, Jack Roberts, Donna Nicely and Peter Boss, MD were present. Also present was John Friel, CEO and Shelly Egerer, Executive Assistant.

3. **FLAG SALUTE:**
   Ms. Egerer led the flag salute all present participated.

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

CLOSED SESSION

5. **PUBLIC FORUM FOR CLOSSED SESSION:**
   President Robbins opened the Hearing Section for Public Comment on Closed Session items at 12:00 p.m. Hearing no request to make public comment, President Robbins closed Public Forum for Closed Session at 12:01 p.m.

6. **ADJOURNED TO CLOSED SESSION:**
   President Robbins motioned to adjourn to Closed Session at 12:01 p.m. Second by Board Member McCarthy to adjourn to Closed Session. President Robbins called for a vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

RECONVENE TO OPEN SESSION

1. **CALL TO ORDER:**
   President Robbins opened the Hearing Section for Public Comment on Open Session items at 12:30 p.m. Hearing no request to make public comment, President Robbins closed Public Forum for Open Session at 12:30 p.m.

2. **RESULTS OF CLOSED SESSION:**
   President Robbins stated there was no reportable action taken in Closed Session.

3. **PUBLIC FORUM FOR OPEN SESSION**
   President Robbins opened the Hearing Section for Public Comment on Open Session items at 12:30 p.m. Hearing no request to make public comment, President Robbins closed Public Forum for Open Session at 12:30 p.m.

4. **DIRECTORS COMMENTS:**
   - None

5. **OLD BUSINESS:**
   - None

6. **NEW BUSINESS:**
   A. Discussion and Potential Approval Of The Wage And Salary Analysis As Recommended By The Human Resource Committee:

Board Member Roberts motioned to approve the Wage and Salary Analysis as recommended by the Human Resource Committee. Second by Board Member McCarthy to approve the Wage and Salary Analysis as recommended by the Human Resource Committee. President Robbins called for a vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - yes
- Board Member Roberts - yes

B. Discussion And Potential Approval Of Authorization For Management To Issue A Purchase Order Prior To July 1, 2018 For The Purchase Of Patient Monitoring Equipment In Fiscal Year 2018/2019:

Board Member Nicely motioned to approve Administration to issue a purchase order for the patient monitoring equipment. Second by Board Member Boss to approve Administration to issue a purchase order for the patient monitoring equipment. President Robbins called for a vote. A vote in favor of the motion was 5/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - yes

  Board Member Roberts - yes

7. **ADJOURNMENT**

   President Robbins called for a motion to adjourn the meeting at 12:32 p.m. Motion by Board Member Nicely to adjourn. Second by Board Member McCarthy to adjourn. President Robbins called for the vote. A vote in favor of the motion was unanimously approved 5/0.

   - Board Member Boss - yes
   - Board Member Nicely- yes
   - President Robbins - yes
   - Board Member McCarthy - yes
   - Board Member Roberts - yes

Bear Valley Community Healthcare District
Construction Projects 2018

Department / Project	Details	Vendor and all associated costs	Comments	Date Complete
Public Restroom/Acute Kitchen Plumbing Repair	Remove the concrete in areas to access damaged plumbing.	Pride Plumbing/Facilities	Public Restrooms Complete, Acute Kitchen in Progress	
Pyxis Replacement	Pyxis equipment is in place and seismic anchors will be installed soon.	Facilities	In Progress	
ASHRE 188 Risk Management Plan for Legionellosis	New Mandate for Hospitals	Forensic Analytical Consulting Services Inc.	In Progress	
Hospital- Medical Air Compressor	Compressors is failing and no longer meets code requirments	FS Medical	Equipment is on site, waiting on the design professionals and OSHPD	
OR Water Damage	Repair damaged ceiling from water leak and repaint ceiling.	Facilities	Complete	
HVAC Control Air Compressor	Replaced the failing compressor	ACS	Complete	

Bear Valley Community Healthcare District
Potential Equipment Requirements

Department / Project	Details	Vendor and all associated costs	Comments	Date Complete
Facilities- New SnowPlow for truck	Facilities would like to purchase a new plow with modern controls	N/A	Will include in next years Capital Budget	

Bear Valley Community Healthcare District
Repairs Maintenance

Department / Project	Details	Vendor and all associated costs	Comments	Date Complete
OR Shower	Had to replace the intire valve set that was leaking.	Maintenance	Complete	
OR Drywall Repairs	Repaired the walls in the OR while repairing the ceiling.	Maintenance	Complete	
Pharmacy	Replaced failing Med Freezer	Maintenance	Complete	

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

HR Monthly Report
June 2018

STAFFING	**Active as of 6/4/2018:** 203 – FT: 137; PT: 16; Per Diem: 50 **New Hires:** 3 **Terms:** 2 (2 Voluntary 0 Involuntary) **Open Positions:** 16
EMPLOYEE PERFORMANCE EVALUATIONS	**DELINQUENT: See attachment** 30 days: 7 60 days: 2 90 days: 0 90+ days: 1 (Business Office) **MOVING FORWARD:** Continue monitoring ongoing annual evaluations.
WORK COMP	**NEW CLAIMS: 1 Trip and Fall - Ankle** **OPEN:** 10 Indemnity (Wage Replacement, attempts to make the employee financially whole) - 5 Future Medical Care – 5 Medical Only - 0 **MOVING FORWARD:** Quarterly claims review.
FILE AUDIT/ LICENSING	**FIVE FILE AUDIT:** All Files are complete All Licenses are up to date All items returned from previous month **MOVING FORWARD:** Obtain required items, continue file audit.
JOB DESCRIPTIONS/ EVALUATIONS	**Job Descriptions:** In process (January target date) **Evaluations:** In process (January target date)
WAGE AND SALARY REVIEW	New market based wages are in the process of being implemented First pay period including July 1st

2019 BENEFIT REVIEW	Broker obtaining quotes to present early July Beginning implementation of self-service open enrollment benefits portal through ADP
EMPLOYEE EVENTS	Employee years of service recognition end of July
JUST CULTURE TRAINING	Implementation is in place Training is ongoing

BEAR VALLEY COMMUNITY HOSPITAL
Quality Improvement Indicator Tracking for 2018
Human Resources Dashboard

	Focus Studies	GOAL	2017	Jan	Feb	Mar	1st QTR	Apr	May	Jun	2nd QTR	Jul	Aug	Sept	3rd QTR	Oct	Nov	Dec	4th QTR	YTD
1	**Evaluations:** Performance evaluations are completed in a timely manner.	N	2373	209	210	208		202	193	193										0
		D	2507	214	216	214		212	202	203										0
		100%	95%	98%	97%	97%	#DIV/0!	95%	96%	95%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0%
2	**Licenses:** Monthly audit of 5 personnel files to confirm license verifications.	N	60	4	4	5		4	5	5										0
		D	60	5	5	5		5	5	5										0
		100%	100%	80%	80%	100%	#DIV/0!	80%	100%	100%	#DIV/0!	#DIV/0!	#DIV/0!	100%	#DIV/0!	100%	100%	100%	#DIV/0!	0%
3	**Work Related Injuries:**	N	6	1	0	0		1	0	1										0
		D	2497	214	216	214		212	202	203										0
		100%	0%	0%	0%	0%	#DIV/0!	0%	0%	0%	#DIV/0!	0%	0%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
5	**Background Checks/References:**	N	60	5	5	5		5	5	5										0
	Pre-Employment	D	60	5	5	5		5	5	5										0
		100%	100%	100%	100%	100%	#DIV/0!	100%	100%	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
7		N	0								0				0				0	0
		D	0								0				0				0	0
		100%	#####	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
8		N	0								0				0				0	0
		D	0								0				0				0	0
		100%	#####	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

BEAR VALLEY COMMUNITY HOSPITAL
Quality Improvement Indicator Tracking for 2017
Human Resources Dashboard

	Focus Studies	GOAL	2016	Jan	Feb	Mar	1st QTR	Apr	May	Jun	2nd QTR	Jul	Aug	Sept	3rd QTR	Oct	Nov	Dec	4th QTR	YTD
1	**Evaluations:** Performance evaluations are completed in a timely manner.	N	2279	186	183	182		196	198	203		202	205	205		211	200	202		0
		D	2429	204	203	206		202	199	205		209	211	213		217	213	215		0
		100%	94%	91%	90%	88%	#DIV/0!	97%	99%	99%	#DIV/0!	97%	97%	96%	#DIV/0!	97%	94%	94%	#DIV/0!	0%
2	**Licenses:** Monthly audit of 5 personnel files to confirm license verifications.	N	1246	5	5	5		5	5	5		5	5	5		5	5	5		0
		D	1246	5	5	5		5	5	5		5	5	5		5	5	5		0
		100%	100%	100%	100%	100%	#DIV/0!	100%	100%	100%	#DIV/0!	100%	100%	100%	#DIV/0!	100%	100%	100%	#DIV/0!	0%
3	**Work Related Injuries:**	N	1824	1	0	0		0	0	0		0	2	0		0	2	1		0
		D	1830	204	203	206		202	199	205		209	211	213		217	213	215		0
		100%	100%	0%	0%	0%	#DIV/0!	0%	0%	0%	#DIV/0!	0%	0%	0%	0%	0%	1%	0%	#DIV/0!	#DIV/0!
5	**Background Checks/References:** Pre-Employment	N	60	5	5	5		5	5	5		5	5	5		5	5	5		0
		D	60	5	5	5		5	5	5		5	5	5		5	5	5		0
		100%	100%	100%	100%	100%	#DIV/0!	100%	100%	100%	#DIV/0!	100%	100%	100%	#DIV/0!	100%	100%	100%	#DIV/0!	#DIV/0!
7		N	0								0				0				0	0
		D	0								0				0				0	0
		100%	#####	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
8		N	0								0				0				0	0
		D	0								0				0				0	0
		100%	#####	#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Infection Prevention Monthly Report

June 2018

TOPIC	UPDATE	ACTION/FOLLOW UP
1. Regulatory	• Continue to receive updates from APIC. • AFL (All Facility Letters) from CDPH have been reviewed. ▪ No AFLs related to infection control • Continue NHSN surveillance reporting. • Completion of CMR reports to Public Health per Title 17 and CDPH regulations. ▪ 2 positive Chlamydia cases	• Review ICP regulations. • AFL to be reviewed at Infection Control Committee and Regulatory committee. • Continue Monthly Reporting Plan submissions.
2. Construction	▪ ER remodel in progress. ▪ Pharmacy construction in progress. ▪ OR project complete and OR is open again. ▪ ICRA permits in place.	• Work with Maintenance and contractors to ensure compliance.
3. QI	• Continue to work towards increased compliance with Hand Hygiene. o Compliance at 61.8% o New hand hygiene monitoring tool will be used in June.	• Continue monitoring hand hygiene compliance.
4. Outbreaks/	▪ Public Health Report	

Surveillance	▪ Ebola outbreak in Democratic Republic of Congo – CDPH requests that ER providers resume asking patients about recent travel to Africa. ▪ Community Health Report o 1 case of C-diff in an outpatient. o 2 positive chlamydia cases in outpatients from FHC.	▪ Informational
5. Policy Updates	▪ Policies reviewed, approved: ▪ Care of Sterile Supplies- updated to include considering an instrument contaminated if it appears to be, or is in the closed position in its sterile packaging. ▪ Management of Patient with Malignant Hyperthermia – cold saline is now stored in OR 2 refrigerator near MH drug kit. ▪ Humidity and Temperature Control in OR Department – updated to reflect current ASHRE Guidelines in different areas of OR.	▪ Clinical Policy and Procedure Committee to review and update Infection Prevention policies.
6. Safety/Product	▪ IP gathering manufacturer's instructions for use and cleaning for equipment around the hospital. Will compile in folder for staff to use.	▪ Continue to monitor compliance with approved cleaning procedures. ▪ Ongoing
7. Antibiotic Stewardship	▪ Pharmacist continues to monitor antibiotic usage. ▪ IP had intended to report antibiotic usage and resistance data to NHSN, however, CPSI just got back to us that they are not set up yet for that program.	▪ Informational.
8. Education	▪ ICP continues to attend the APIC meetings in Ontario.	▪ ICP to share

	▪ IP attended ICRA Training at the Carpenter's Union in Ontario to learn about the Infection Control Risk Assessment as it applies to construction in the hospital. ▪ Class is free of charge and highly recommended for maintenance staff.	information at appropriate committees.
9. Informational	▪ Plan of correction for CHPH visit in progress. Most items have already been corrected. o IP to do monthly rounds monitoring OR storage, sterilizer cleaning, temperature and humidity logs, terminal cleaning in decontamination and sterile processing, proper cleaning of glucometers, and proper use of cleaning products around the hospital. The results will be reported monthly at the P & T meeting. ▪ Meeting took place between IP and Clinical Managers about the positive culture discrepancy process and log book. o IP to check log bi-weekly and be a backup if needed to help make sure follow ups are getting done.	▪ Informational
Heather Loose, BSN, RN	*Infection Preventionist*	*Date: July 3, 2018*

Department	Title (Version)	Summary
Administration	Hospital Plan for Provision of Patient Care Services (v.3)	Annual review, formatted.
CT Scan	CT Abdomen with and or without contrast (v.3)	Annual review, formatted.
CT Scan	CT Chest for Pulmonary Embolism (v.3)	Annual review, formatted.
CT Scan	CT Contrast Injector Use (v.2)	Annual review, formatted.
CT Scan	CT Scanning of the Head and Brain (v.2)	Annual review, formatted.
CT Scan	CT Scanning of the Lumbar Spine (v.2)	Annual review, formatted.
Diagnostic Imaging	CD or Film Copy Distribution for Radiology Images (v.2)	Annual review, formatted.
Diagnostic Imaging	Emergency Drug Boxes (v.3)	Annual review, formatted.
Diagnostic Imaging	Fluoroscopy Weekly Check Procedure (v.5)	Annual review, formatted.
Diagnostic Imaging	Diagnostic Contrast Agents Used and Storage Policy (v.4)	Annual review, formatted.
Diagnostic Imaging	Diagnostic Imaging Scope of Care (v.4)	Annual review, formatted.
Diagnostic Imaging	Emergency Department Patient Procedure and Preparation for	Annual review, formatted.
Diagnostic Imaging	General Guidelines for Radiation Safety (v.4)	Annual review, formatted.
Diagnostic Imaging	Gonadal Shielding (v.4)	Annual review, formatted.
Diagnostic Imaging	Inpatient Procedures (v.4)	Annual review, formatted.
Diagnostic Imaging	Lead Apron Inspection (v.3)	Annual review, formatted.
Diagnostic Imaging	Management of the Critically Ill Patient in the Radiology Department	Annual review, formatted.
Diagnostic Imaging	Mechanical and Electrical Safety for Radiology Equipment (v.3)	Annual review, formatted.
Diagnostic Imaging	Outpatient Critical Imaging Findings (v.2)	Annual review, formatted.
Diagnostic Imaging	Outpatient Imaging Procedure (v.3)	Annual review, formatted.
Diagnostic Imaging	Radiation Dosimeter Policy and Guidelines (v.3)	Annual review, formatted.
Diagnostic Imaging	Radiation Exposure for Women of Child Bearing Age (v.3)	Annual review, formatted.
Emergency Department	Code Stroke (v.1)	New policy.
Emergency Preparedness	EMP Addendum: After Hours Access to Disaster Supplies (v.4)	Annual review, formatted.
Emergency Preparedness	EMP Addendum Security Plan (v.1)	Annual review, formatted.
Emergency Preparedness	Use of HICS Forms (v.1)	New policy.
Emergency Preparedness	Hospital Emergency Codes (v.4)	Annual review, formatted.
Emergency Preparedness	GETS cards (Government Emergency Telecommunication Service)	Annual review. Revised to reflect current process.
Emergency Preparedness	EMP Safety Addendum (v.4)	Annual review. Revised to reflect current process.
Emergency Preparedness	EMP Addendum, Contacts, External (v.4)	Annual review, formatted.
Emergency Preparedness	EMP Addendum Wildfire (v.2)	Annual review. Revised to reflect current process.
Emergency Preparedness	EMP Addendum START Triage (v.4)	Annual review. Revised to reflect current process.
Emergency Preparedness	EMP Addendum Shelter in Place (v.4)	Annual review. Revised to reflect current process.
Emergency Preparedness	EMP Addendum Public Affairs (v.4)	Annual review. Formatted.

Emergency Preparedness	EMP Addendum Mass Casualty (v.4)	Annual review, revised to reflect current process.
Emergency Preparedness	EMP Addendum Hospital Surge Disaster (v.4)	Annual review. Formatted.
Emergency Preparedness	Code Yellow (v.1)	Annual review. Formatted.
Emergency Preparedness	EMP Addendum Pharmacy and Medication Access (v.2)	Annual review. Formatted.
Mammography	Consumer Complaints – PI-MAM-6 (v.3)	Annual review, formatted.
Mammography	Mammography Operator Quality of Performance & Safe Operating	Annual review, formatted.
Radiology	Diagnostic Imaging Patient Preparation (v.4)	Annual review, formatted.
Radiology	Fluoroscopy Procedures (v.3)	Annual review, formatted.
Radiology	Procedures Deemed Inappropriate by the Radiologist (v.3)	Annual review, formatted.
Radiology	Standard Radiographic Views (v.3)	Annual review, formatted.
Surgery	Handling of Soiled Instruments Outside of the Operating Room (v.2)	Annual review. Revised verbiage to reflect current
Ultrasound	Renal and Bladder Ultrasound Procedure (v.2)	Annual review, formatted.
Ultrasound	Scrotum Ultrasound Procedure (v.2)	Annual review, formatted.
Ultrasound	Ultrasound Procedure Patient Preparation (v.2)	Annual review, formatted.

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
AFFILIATION AD HOC COMMITTEE MEETING MINUTES
41870 Garstin Road Big Bear Lake, Ca. 92315
April 18, 2018

MEMBERS PRESENT:	Donna Nicely, Treasurer	John Friel, CEO
	Peter Boss, MD, Secretary	Shelly Egerer, Ex. Assistant
MEMBERS ABSENT:	Kerri Jex, CNO	
STAFF:	None	
GUESTS:	Brad Smithson w/Riverside Community Hospital CJ Lee w/ Riverside Community Hospital	

OPEN SESSION

1. **CALL TO ORDER:**
   Board Member Nicely called the meeting to order at 12:00 pm.

2. **ROLL CALL:**
   Donna Nicely and Peter Boss, MD, were present. Also present were John Friel, CEO, and Shelly Egerer, Exc. Asst. Absent was Kerri Jex, CNO.

3. **ADOPTION OF AGENDA:**
   Board Member Boss motioned to adopt the April 18, 2018 Agenda as presented. Second by Board Member Nicely to adopt the April 18, 2018 Agenda as presented. Board Member Nicely called for a vote. A vote in favor of the motion was unanimously approved.
   - Board Member Nicely- yes
   - Board Member Boss- yes

CLOSED SESSION

4. **PUBLIC FORUM FOR CLOSED SESSION:**
   Board Member Nicely opened the Hearing Section for Public Comment at 12:00 p.m. Hearing no request to address the Committee, Board Member Nicely closed the Hearing Section at 12:00 p.m.

5. **ADJOURN TO CLOSED SESSION:**
   Board Member Nicely motioned to adjourn to Closed Session at 12:00 pm. Second by Board Member Boss to adjourn to Closed Session. Board Member Nicely called for a vote. A vote in favor of the motion was unanimously approved.
   - Board Member Nicely- yes
   - Board Member Boss- yes

OPEN SESSION

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

2. **RESULTS OF CLOSED SESSION***
   Board Member Nicely reported no action was taken in Closed Session.

3. **PUBLIC FORUM FOR OPEN SESSION:**
   Board Member Nicely opened the Hearing Section for Public Comment at 1:24 p.m. Hearing no request to address the Committee, Board Member Nicely closed the Hearing Section at 1:24 p.m.

4. **APPROVAL OF MINUTES:**
   - None

5. **DIRECTORS COMMENTS**
   - None

6. **OLD BUSINESS***
   - None

7. **NEW BUSINESS***
   A. Discussion and Potential Approval of the Affiliation Ad Hoc Committee Meeting Calendar:

   Board Member Nicely motioned to approve the Affiliation Committee Meeting to be scheduled on an as needed basis. Second by Board Member Boss to approve the Affiliation Committee Meeting to be scheduled on an as needed basis. Board Member Nicely called for a vote. A vote in favor of the motion was unanimously approved.
   - Board Member Nicely- yes
   - Board Member Boss- yes

8. **ADJOURNMENT***
   Board Member Nicely motioned to adjourn at 1:26 pm. Second by Board Member Boss to adjourn. Board Member Nicely adjourned the meeting. Board Member Nicely called for a vote. A vote in favor of the motion was unanimously approved.
   - Board Member Nicely- yes
   - Board Member Boss- yes

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
SPECIAL HUMAN RESOURCES MEETING MINUTES
41870 Garstin Road Big Bear Lake, Ca. 92315
May 29, 2018

MEMBERS PRESENT:	Gail McCarthy, 1st Vice President	Erin Wilson, HR Director
	Rob Robbins, President	Shelly Egerer, Exec. Asst.
	John Friel, CEO	
MEMBERS ABSENT:	None	
STAFF:	None	
OTHER:	Cindy Henry	

OPEN SESSION

1. CALL TO ORDER:
Board Member McCarthy called the meeting to order at 12:30 p.m.

CLOSED SESSION

2. PUBLIC FORUM FOR CLOSED SESSION:
President Robbins opened the Hearing Section for Public Comment at 12:30 p.m. Hearing no request to address the Committee, President Robbins closed the Hearing Section at 12:30 p.m.

3. ADJOURN TO CLOSED SESSION:
President Robbins motioned to adjourn to Closed Session. Second by Board Member McCarthy to adjourn to Closed Session. Board Member McCarthy called for the vote. A vote in favor of the motion was unanimously approved.

- President Robbins - yes
- Board Member McCarthy - yes

OPEN SESSION

1. CALL TO ORDER:
Board Member McCarthy called the meeting order at 1:50 p.m.

2. ROLL CALL:
Gail McCarthy and Rob Robbins were present. Also, present were John Friel, CEO, Erin Wilson, Human Resource Director, and Shelly Egerer, Executive Asst.

3. ADOPTION OF AGENDA:
President Robbins motioned to adopt the May 29, 2018 Human Resource Committee Agenda as presented. Second by Board Member McCarthy adopt the May 29, 2018 Human Resource Committee Agenda as presented. Board Member McCarthy called for the vote. A vote in favor of the motion was unanimously approved.

- President Robbins - yes
- Board Member McCarthy- yes

4. **RESULTS OF CLOSED SESSION:**
   - Board Member McCarthy stated there was no reportable action.

5. **PUBLIC FORUM FOR OPEN SESSION:**
   President Robbins opened the Hearing Section for Public Comment at 1:51 p.m. Hearing no request to address the Committee, President Robbins closed the Hearing Section at 1:51 p.m.

6. **DIRECTORS COMMENTS:**
   - None

7. **APPROVAL OF MINUTES:**
   A. February 13, 2018

   Board Member Robbins motioned to approve the February 13, 2018 Human Resource Committee Meeting Minutes as presented. Second by Board Member McCarthy to approve the February 13, 2018 Human Resource Committee Meeting Minutes as presented. Board Member McCarthy called for the vote. A vote in favor of the motion was unanimously approved.
   - President Robbins- yes
   - Board Member McCarthy- yes

8. **OLD BUSINESS:**
   - None

9. **NEW BUSINESS***
   A. Discussion and Potential Recommendation to the Board of Directors of the Following Policies & Procedures:
   (1) Meal and Rest Breaks
   - Ms. Wilson stated that the Meal & Rest Breaks is a new policy and that we need to be in compliance with this policy.

   (2) Leave of Absence
   - Ms. Wilson reported this is a new policy that discusses leave of absence. The policy is in line with the current law.

   (3) Paid Time Off
   - Ms. Wilson reported this is an existing policy and had changes due to the completion of the Union Negotiations.

   - President Robbins asked if the HR policies & procedures are reviewed by Mike Sarrao, legal counsel and feels that when there are HR policies this would be a best practice to implement.

   President Robbins motioned to table the HR Policies and Procedures until legal counsel has reviewed the Policies & Procedures. Second by Board Member McCarthy to table the HR Policies and Procedures until legal counsel has reviewed the Policies & Procedures. Board Member McCarthy called for the vote. A vote in favor of the motion was unanimously approved.

- President Robbins- yes
- Board Member McCarthy- yes

10. HUMAN RESOURCE REPORT*:

A. Human Resource Assessment:

- **Staffing**
  - Ms. Wilson reported the following information
    - One new hire
    - 2 voluntary terms
    - 13 open positions

- **Employee Performance Evaluations:**
  - Ms. Wilson reported a monitoring report is maintained on employee's evaluations; an update on the evaluations has been provided.

- **Workers Comp Claims**
  - Ms. Wilson reported that there are currently twelve cases open.

- **Employee File Audit:**
  - Ms. Wilson reported that the files continue to be monitored.

- **Employee Job Description & Employee Evaluation Revisions (Update):**
  - Ms. Wilson stated that she provided a job description template; her goal is to get these items electronic. Physical requirement description has remained the same. The HR Department is working on the job descriptions and these will be sent to the manager for return by the end of June. Our current ADP system has the capability to track and maintain the employee evaluations.

- **CalPERS Insurance**
  - Mr. Wilson reported that we have 60 days after rates come out. The HR Department is reviewing information as it is released.

President Robbins motioned to approve the HR Report as presented. Second by Board Member McCarthy to approve the HR Report as presented. Board Member McCarthy called for the vote. A vote in favor of the motion was unanimously approved.

- President Robbins - yes
- Board Member McCarthy- yes

11. ADJOURNMENT*:

President Robbins motioned to adjourn the meeting at 2:15 p.m. Second by Board Member McCarthy to adjourn the meeting. Board Member McCarthy called for the vote. A vote in favor of the motion was unanimously approved.

- President Robbins - yes
- Board Member McCarthy- yes

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS
SPECIAL FINANCE COMMITTEE MEETING MINUTES
41870 Garstin Drive, Big Bear Lake, Ca. 92315
June 01, 2018

MEMBERS PRESENT:	Donna Nicely, Treasurer Peter Boss, MD, Secretary 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 12:00 p.m.

2. **ROLL CALL:**
   Donna Nicely and Peter Boss, MD 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 June 01, 2018 Finance Committee Agenda as presented. Second by Board Member Boss to adopt the June 01, 2018 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
   - Board Member Boss- yes

4. **PUBLIC FORUM FOR OPEN SESSION:**
   Board Member Nicely opened the Hearing Section for Public Comment on Open Session items at 12:00 p.m. Hearing no request to address the Finance Committee, Board Member Nicely closed the Hearing Section at 12:00 p.m.

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

6. **APPROVAL OF MINUTES:**
   - None

7. **OLD BUSINESS:**
   A. Discussion and Potential Recommendation to the Board of Directors the Fiscal Year 2018/2019 Operating Budget:
   - Mr. Hamblin stated that he tried to provide answers to all questions the committee had at the previous meeting and reported the following information:

- Total margin remained the same
- Workers comp remains the same
- Employee wages includes PTO
- Other expenses include, minor equipment, taxes and license outside training, and travel
- Marketing is budgeted at $100,000 under Administration
- Administration remodel was removed from the budget
- Surgery was removed
- Purchase of a home was raised to $300,000
- Grant Writer has been added to purchased services
- Budgeted for Interim DON and a full time DON
- Major categories of purchased services details will be emailed to the committee
- $7,000 donation for CNA program is being looked into, the donation will be set aside if not used

B. Discussion and Potential Recommendation to the Board of Directors the Fiscal Year 2018/2019 Capital Expenditure Budget:

- Mr. Hamblin reported the following information:
  - Budget reflects $750,000 for property
  - Budget for furnishings if home is purchased is at $75,000
  - Adjustment change is 6.5% on salary
  - FTE's transferred hours from Acute to SNF – this is the Restorative Program
  - Exploring cross training from clinic staff to ER
  - Decrease in CT .8 and ultrasound is an increase
    - Reduction in Radiology overall
  - PRIME Project breakdown has been included to show what the grant pays
  - Mom & Dad Project does receive approximately $50,000 from the district
  - 19 hospital grade TV @ $1,600 per unit and the budget includes installation
    - Foundation will be contributing $15,000 for this unit
  - Dietary budget is $18,000 for Point of Sale; this could decrease. To drop to $10,000
  - Camera needs to be installed in the parking area and if we rent additional office space cameras will be installed in the additional location
  - The three year plan in the Capital Budget has been implemented
  - 2nd laser is still being requested; this is due to the patient care and is a high demand.
- Board Member Nicely stated that there is a large amount of cost to contract out maintenance work and would like to know what the maintenance staff does. The lobby upgrade and landscaping should be completed by maintenance staff. Board Member Nicely stated that she would like the landscaping budget removed and is not in favor of this expense and would like the CER's made available to the committee in the future.

Board Member Nicely motioned to table both items until the June 6, 2018 Finance Committee Meeting. Second by Board Member Boss to table both items until the June 6, 2018 Finance Committee Meeting. Board Member Nicely called for a vote. A vote in favor of the motion was unanimously approved.

- Board Member Nicely- yes
- Board Member Boss- yes

8. **NEW BUSINESS***
   - None

9. **ADJOURNMENT***

Board Member Nicely motioned to adjourn at 12:50 p.m. Second by Board Member Boss to adjourn. Board Member Nicely called for a vote. A vote in favor of the motion was unanimously approved.

- Board Member Nicely- yes
- Board Member Boss- yes

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS
FINANCE COMMITTEE MEETING MINUTES
41870 Garstin Drive, Big Bear Lake, Ca. 92315
June 05, 2018

MEMBERS PRESENT:	Donna Nicely, Treasurer Peter Boss, MD, Secretary 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 1:00 p.m.

2. **ROLL CALL:**
   Donna Nicely and Peter Boss, MD 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 June 05, 2018 Finance Committee Agenda as presented. Second by Board Member Boss to adopt the June 05, 2018 Finance Committee Agenda as presented. Board Member Nicely called for a vote. A vote in favor of the motion was unanimously approved.
   - Board Member Nicely- yes
   - Board Member Boss- yes

CLOSED SESSION

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

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

OPEN SESSION

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

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

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

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

5. **APPROVAL OF MINUTES:**
   A. May 01, 2018
   B. May 24, 2018

   Board Member Nicely motioned to approve the May 01 and May 24, 2018 minutes as presented. Second by Board Member Boss to approve the May 01 and May 24, 2018 minutes as presented. Board Member Nicely called for a vote. A vote in favor of the motion was unanimously approved.
   - Board Member Nicely - yes
   - Board Member Boss- yes

6. **OLD BUSINESS:**
   A. Discussion and Potential Recommendation to the Board of Directors the Fiscal Year 2018/2019 Operating Budget:
      - Mr. Hamblin reported the budget packet has been updated and has provided additional information as requested.
        - Purchased service has been broken out.
        - Reserved over $200,000 for Stark Violation on agreements. Claim still not resolved.
        - Audit Cost Report is annual report.
        - Interim SNF cost $22,000 per month. We are advertising on various sites to fill this position.
        - Laboratory budget needs to have some cost removed from purchased services. There was a large cost on contracted staff. Will reduce that item to be less than $4 million.
          - To provide a list of items in this line item at the next Finance Meeting for informational purposes only.
        - HR Benefit Admin – what does this detail.
        - Quorum total does not add up.
        - Landscaping cost is helipad, area in front of CNO office.
        - Front lobby needs to be updated, remove wallpaper, paint and additional items to get the lobby cleaned up.

B. Discussion and Potential Recommendation to the Board of Directors the Fiscal Year 2018/2019 Capital Budget:

- Mr. Hamblin reported the following information:
  - Patient monitory equipment is $300,000. Vendor offered a $32,000 discount if we a get them a commitment by the end of June. There is a 90-day installation and training for the equipment. Could be used by September.

Board Member Nicely motioned to recommend to the Board of Directors the Fiscal year 2018/2019 Operating Budget and Capital Budget. Second by Board Member Boss to recommend to the Board of Directors the Fiscal year 2018/2019 Operating Budget and Capital Budget. Board Member Nicely called for a vote. A vote in favor of the motion was unanimously approved.

- Board Member Nicely - yes
- Board Member Boss- yes

7. NEW BUSINESS*

A. Discussion and Potential Recommendation to the Board of Directors of Jerrel Tucker, JWT & Associates Agreement to Complete the FYE June 30, 2018 Audit:

- Mr. Hamblin provided the agreement and recommends that we continued to work with Jerrell on the audit.
  - We pay travel expenses, approximately $2,000 and cost for audit is $25,000

Board Member Nicely motioned to recommend to the Board of Directors the Jerrell Tucker, JWT & Associates Agreement as presented. Second by Board Member Boss to recommend to the Board of Directors the Jerrell Tucker, JWT & Associates Agreement as presented. Board Member Nicely called for a vote. A vote in favor of the motion was unanimously approved.

- Board Member Nicely - yes
- Board Member Boss- yes

B. Discussion and Potential Recommendation to the Board of Directors to Enter Into An Agreement with WIPFLI or Quorum Health Resources to Complete the Productivity Benchmarking Assessment:

- Mr. Hamblin recommends that QHR completes the assessment; the cost would be travel expenses only. Mr. Hamblin asked that this item be tabled due to the report not being provided to the committee.

Board Member Nicely motioned to table the WIPFLI or QHR Benchmarking Assessment until the July Finance Committee Meeting. Second by Board Member Nicely to table the WIPFLI or QHR Benchmarking Assessment until the July Finance Committee Meeting. Board Member Nicely called for a vote. A vote in favor of the motion was unanimously approved.

- Board Member Nicely - yes
- Board Member Boss- yes

8. Presentation and Review of Financial Statements:

A. April 2018 Finances:

- Mr. Hamblin reported the following:
  - Surplus of $218,000.
  - Inpatient below budget.
  - SNF & ER are over budget.

- Cash is continuing to be strong.
- FTE's continue to run under budget.
- RHC volume is low.
- AR gross days are at 67.

- Board Member Nicely requested that clinic provider data (patients seen) be provided to the Finance Committee and wants to ensure that when the census is low all departments flex not just nursing staff.

B. CFO Report:

- Mr. Hamblin reported the following:
  - Healthcare Reform:
    - Assembly bill 3087 – did not pass out of appropriation.
    - Continues to be an issue but nothing more will happen this year.

  - Revenue Cycle Assessment Update:
    - Eva Pierce, HIM Manager is working on the Manager Action Plan to make changes.
    - Staff will meet to discuss changes and implementation.
    - Process improvement in registration accuracy.
    - Technology use – accessing websites for eligibility.
    - Will be completed in ER and clinic.

C. WIPFLI Benchmarking Information:

- Mr. Hamblin used 2016 OSHPD Reports for financial and productivity
  - This was information provided to the committee to show that there is a current benchmark report that has data available on various districts that are comparable to our district.

D. Revenue cycle Assessment Update:

- Mr. Hamblin reported the following information:
  - Report focuses on three items:
    - Patient access services need to be reviewed.
    - In source considerations.
    - AR Performance has been reviewed.

Board Member Nicely motioned to approve the April 2018 Finance Report and the CFO Report as presented and item C & D were informational only. Second by Board Member Boss to approve the April 2018 Finance Report and the CFO Report as presented and item C & D were informational only. Board Member Nicely called for a vote. A vote in favor of the motion was unanimously approved.

- Board Member Nicely- yes
- Board Member Boss- yes

9. ADJOURNMENT*

Board Member Nicely motioned to adjourn at 2:10 p.m. Second by Board Member Boss to adjourn. President Robbins called for a vote. A vote in favor of the motion was unanimously approved.

- Board Member Nicely- yes
- Board Member Boss- yes

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

HR Monthly Report
May 2018

STAFFING	**Active as of 6/4/2018:** 202 – FT: 136; PT: 17; Per Diem: 49 **New Hires:** 1 **Terms:** 9 (4 Voluntary 5 Involuntary) **Open Positions:** 18
EMPLOYEE PERFORMANCE EVALUATIONS	**DELINQUENT: See attachment** 30 days: 5 60 days: 2 90 days: 1 90+ days: 1 (ER) **MOVING FORWARD:** Continue monitoring ongoing annual evaluations.
WORK COMP	**NEW CLAIMS: 0** **OPEN:** 9 Indemnity (Wage Replacement, attempts to make the employee financially whole) - 4 Future Medical Care – 5 Medical Only - 0 **MOVING FORWARD:** Quarterly claims review.
FILE AUDIT/ LICENSING	**FIVE FILE AUDIT:** One missing Employee Handbook Acknowledgement One missing Meal and Rest Period Acknowledgement One missing Work Comp Fraud One missing Meal Waiver in Excess of 8 hours All Licenses are up to date All items returned from previous month **MOVING FORWARD:** Obtain required items, continue file audit.
JOB DESCRIPTIONS/ EVALUATIONS	**Job Descriptions:** In process (January target date) - working on updates. Samples of current job descriptions and template will be sent to managers for update. **Evaluations:** In process (January target date) – working with ADP to implement digital. Managers will be able to complete evaluation in ADP and send it to the employee for sign off and comments. Discuss the pros/cons of implementing annual evaluations at the same time each year.

ANNUAL GENERAL ORIENTATION	All employees must finish by 6/8/2018 or they are taken off of the schedule until complete
POLICIES	In process: Corrective Action and Discipline
2019 BENEFIT REVIEW	Termination resolutions must be filed with CalPERS no later than 60 days after the CalPERS Board approves the health premiums for the new contract year. Termination resolutions are irrevocable once filed. Terminated agencies may not re-enter for five years from the termination date. The CalPERS Board typically announces the health plan premium rates for the following year after the second week of June.
EMPLOYEE EVENTS	Committee meeting 6/6/2018 planning a picnic at the park for summer/Employee years of service award ceremony

BEAR VALLEY COMMUNITY HOSPITAL
Quality Improvement Indicator Tracking for 2018
Human Resources Dashboard

	Focus Studies	GOAL	2017	Jan	Feb	Mar	1st QTR	Apr	May	Jun	2nd QTR	Jul	Aug	Sept	3rd QTR	Oct	Nov	Dec	4th QTR	YTD
1	**Evaluations:** Performance evaluations are completed in a timely manner.	N	2373	209	210	208		212	202											0
		D	2507	214	216	214		202	193											0
		100%	95%	98%	97%	97%	#DIV/0!	105%	105%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0%
2	**Licenses:** Monthly audit of 5 personnel files to confirm license verifications.	N	60	4	4	5		4	5											0
		D	60	5	5	5		5	5											0
		100%	100%	80%	80%	100%	#DIV/0!	80%	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	100%	#DIV/0!	100%	100%	100%	#DIV/0!	0%
3	**Work Related Injuries:**	N	6	1	0	0		1	0											0
		D	2497	214	216	214		212	202											0
		100%	0%	0%	0%	0%	#DIV/0!	0%	0%	#DIV/0!	#DIV/0!	0%	0%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
5	**Background Checks/References:**	N	60	5	5	5		5	5											0
	Pre-Employment	D	60	5	5	5		5	5											0
		100%	100%	100%	100%	100%	#DIV/0!	100%	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
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Title	Ver #	Status
Abuse, Neglect – Identification and Mandatory Reporting Suspected Child Abuse	2	In Approval
Administrative Memorandums	2	In Approval
Administrator On Call	3	In Approval
Biennial Notice for Conflict of Interest Code	3	In Approval
Board Members Code of Conduct	3	In Approval
Board Policy on Receipt of Correspondence Regarding Personnel Matters	4	In Approval
Board/CEO Operating Governance Protocols	3	In Approval
Cash Handling	1	In Approval
Conflict of Interest Code	3	In Approval
Contracts and Agreements	4	In Approval
Contracts and Agreements with Physicians and Other Referral Sources Policy	2	In Approval
Critical Access Agreements	4	In Approval
Critical Access Compliance with Federal, State, and Local Laws and Regulations	3	In Approval
Critical Access Emergency Services	3	In Approval
Critical Access Number of Beds and Length of Stay	4	In Approval
Critical Access Organizational Structure	3	In Approval
Critical Access Periodic Evaluation and Quality Assurance Review	2	In Approval
Critical Access Periodic Evaluation	3	In Approval
Critical Access Staff and Staffing Responsibility	4	In Approval
Critical Access Status and Location	5	In Approval
Critical Access, Physical Plant and Environment	4	In Approval
Electrical Safety – EC-MAM-1	2	In Approval
Gifts to Hospital and Staff	3	In Approval
Guidelines to Planning New Programs or Services	3	In Approval
ID and Facility Access Badges	1	In Approval
Interpreter - Use of	3	In Approval
Leave of Absence	1	In Approval
Meal and Rest Breaks	1	In Approval
Notary Public Services	1	In Approval
Paid Time Off	4	In Approval
Policy Review and Approval Process	6	In Approval
Public Participation at Board of Directors Meetings	3	In Approval
Reimbursement for Training and Travel	3	In Approval
Subpoenas	3	In Approval

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
SPECIAL HUMAN RESOURCES MEETING MINUTES
41870 Garstin Road Big Bear Lake, Ca. 92315
February 13, 2018

MEMBERS PRESENT:	Gail McCarthy, 1st Vice President	Erin Wilson, HR Director
	Rob Robbins, President	Shelly Egerer, Exec. Asst.
	John Friel, CEO	
MEMBERS ABSENT:	None	
STAFF:	None	
OTHER:	Mike Sarrao, Legal Counsel/via conference call	

OPEN SESSION

1. CALL TO ORDER:
Board Member McCarthy called the meeting to order at 11:00 a.m.

CLOSED SESSION

2. PUBLIC FORUM FOR CLOSED SESSION:
Board Member McCarthy opened the Hearing Section for Public Comment at 11:00 a.m. Hearing no request to address the Committee, Board Member McCarthy closed the Hearing Section at 11:00 a.m.

3. ADJOURN TO CLOSED SESSION:
President Robbins motioned to adjourn to Closed Session. Second by Board Member McCarthy to adjourn to Closed Session. Board Member McCarthy called for the vote. A vote in favor of the motion was unanimously approved.

- President Robbins - yes
- Board Member McCarthy - yes

OPEN SESSION

1. CALL TO ORDER:
Board Member McCarthy called the meeting order at 11:30 a.m.

2. ROLL CALL:
Gail McCarthy and Rob Robbins were present. Also, present were John Friel, CEO, Erin Wilson, Human Resource Director, and Shelly Egerer, Executive Asst.

3. ADOPTION OF AGENDA:
President Robbins motioned to adopt the February 13, 2018 Agenda with the Garnishment of Wage Policy be removed from the agenda. Second by Board Member McCarthy adopt the February 13, 2018 Agenda with the Garnishment of Wage Policy be removed from the agenda.

Board Member McCarthy called for the vote. A vote in favor of the motion was unanimously approved.

- President Robbins - yes
- Board Member McCarthy- yes

4. RESULTS OF CLOSED SESSION:

- Board Member McCarthy stated there was no reportable action to report.

5. PUBLIC FORUM FOR OPEN SESSION:

Board Member McCarthy opened the Hearing Section for Public Comment at 11:31 a.m. Hearing no request to address the Committee, Board Member McCarthy closed the Hearing Section at 11:31 a.m.

6. DIRECTORS COMMENTS:

- None

7. APPROVAL OF MINUTES:

A. October 30, 2017

President Robbins motioned to approve the October 30, 2017 Human Resource Committee Meeting Minutes as presented. Second by Board Member McCarthy to approve the October 30, 2017 Human Resource Committee Meeting Minutes as presented. Board Member McCarthy called for the vote. A vote in favor of the motion was unanimously approved.

- President Robbins- yes
- Board Member McCarthy- yes

8. OLD BUSINESS:

- None

9. NEW BUSINESS*

A. Discussion and Information on BVCHD Employee Evaluations Revisions:

- Ms. Wilson reported that the HR Department is reviewing the employee evaluations and job descriptions due to the various formats. The goal is to have a unified format and will be using ADP for formatting the new evaluations. The district is researching a vendor to assist in a salary survey for market value. The HR Committee and Board of Directors will be kept apprised.
- The committee was under the impression that job descriptions would be eliminated due to the union negotiations. Mr. Friel informed the committee that due to the District being Critical Access Designation requires the District to have job descriptions

Board Member McCarthy reported there is no action required.

B. Discussion and Recommendation to the Board of Directors the Following Policies & Procedures:

(1) Dress Code Policy & Procedure

- President Robbins asked that the "women's piercings" be revised. President Robbins stated that if a female is a good employee and has 3 piercings in her ear it would be wrong to terminate that employee.
- The committee asked that this section be revised and can go to the March Board Meeting.

(2) Americans With Disabilities Act

(3) Confidential Information

- Ms. Wilson informed the committee that both policies are updated to reflect the new laws.

(4) Education Assistance

- Ms. Wilson reported that this policy was re-instated; during the last few years, the policy was archived due to the financial problems the District had. There are specific commitments that the employee has to follow in order to take advantage of this policy.
- Board Member McCarthy stated that she would like to see this item placed in the Grizzly and marketed to inform the community of this opportunity we off our staff.

(5) Employment Reference Checks

- Ms. Wilson reported that this policy reflects the law and only confirms the employees begin hire and end date.

(6) Compensation for Exempt Employees

- Ms. Wilson reported this policy has been revised and updated.

President Robbins motioned to recommend to the Board of Directors the Polices & Procedures with the Dress Code Policy revised as discussed. Second by Board Member McCarthy to recommend to the Board of Directors the Polices & Procedures with the Dress Code Policy revised as discussed. Board Member McCarthy called for the vote. A vote in favor of the motion was unanimously approved.

- President Robbins - yes
- Board Member McCarthy- yes

10. HUMAN RESOURCE REPORT*:

A. Human Resource Assessment:

- **Staffing (New Hires, Terms, and Open Positions):**
  - Ms. Wilson reported the following
    - Work comp cases are maintaining well, new claim due to back strain in the Dietary Department, the employee is back to work with limitations.
    - Quarterly reviews are completed.
  - The committee wanted to ensure that the HR Department is trending any claims with employees. The committee asked that the HR Report have this item in detail included on a quarterly basis; by department, injury type.

- **Employee Performance Evaluations:**
  - Ms. Wilson reported a monitoring report is maintained on employee's evaluations and the managers are responsible to ensure the evaluations are completed. The managers receive this report monthly.

- **Employee File Audit:**
  - Ms. Wilson reported that one license has expired and the employee has been removed from the schedule.

- **Exempt Employees:**
  - Mr. Wilson reported that this item was asked to be researched and brought back to the committee. The information provided in the HR report explains all question and concerns expressed at the last HR meeting.

President Robbins motioned to approve the HR Report as presented. Second by Board Member McCarthy to approve the HR Report as presented. Board Member McCarthy called for the vote. A vote in favor of the motion was unanimously approved.

- President Robbins - yes
- Board Member McCarthy- yes

11. ADJOURNMENT:

President Robbins motioned to adjourn the meeting at 12:04 p.m. Second by Board Member McCarthy to adjourn the meeting. Board Member McCarthy called for the vote. A vote in favor of the motion was unanimously approved.

- President Robbins - yes
- Board Member McCarthy- yes

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

MEMO

Date: 3 July 2018

To: BVCHD Finance Committee

From: Garth M Hamblin, CFO

Re: TruBridge contract extension through April 30, 2019

Recommended Action

Recommend that the board approve extension of our existing contract with TruBridge for Accounts Receivable Management through April 30, 2019.

Background

We have worked hard over the last several years to reduce Accounts Receivable days (see graph below) from a high of nearly 165 to our target of under 65. While we have made significant improvement, we have not been able to consistently get to 65 or below.

We have Eva, Health Information Manager department Director, working on front end processes with PAS (Patient Access Services) / Registration staff on items identified in the Revenue Cycle Review conducted by QHR staff in the early spring. In April of this year we went live with Rycan the Electronic Claims Management software that is available to us through CPSI. We continue to learn about and fine-tune that system to track status of claims, errors, and rejections.

Extension of the contract would allow further time for improvement of processes to see if we can consistently have Accounts Receivable days that under 65.

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

MEMO

Date: July 05, 2018

To: Board of Directors

From: John Friel, CEO

Re: Reschedule August Board of Directors Business Board Meeting

Recommendation:
To reschedule the August Board Meeting to August 15, 2018.

Background:
The Board of Directors regular scheduled Board Meeting is August 8, 2018; we have three Board members and myself attending the annual QHR Trustee Conference.

We would like to ask the Board of Directors to reschedule the August 8, 2018 Board Meeting to August 15, 2018.

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

MEMO

Date: 3 July 2018

To: BVCHD Finance Committee

From: Garth M Hamblin, CFO

Re: Productivity Benchmarking Assessment

Recommended Action

Recommend that the Board approve QHR to conduct Productivity Benchmarking Assessment. Cost will be only travel and out-of-Pocket costs for two consultants onsite for two to three days plus a single consultant to present the report in person upon completion. Total estimated travel and out of pocket cost for three trips not to exceed $5,000. Costs for consultants is included in the management agreement with QHR.

Background

Attached are the proposals we received from QHR and WIPFLi to conduct the proposed productivity benchmarking assessment. The cost for QHR to conduct this assessment is only the travel and out-of-pocket expenses for consultants visits to big Bear Lake since such consultation is included in the management fee already paid to QHR.

The WIPFLi proposal is for $20,000 plus reimbursement of travel and out-of-pocket expenses.

QUORUM | HEALTH RESOURCES®

5/01/2018

Garth Hamblin
Bear Valley Community Healthcare District
Big Bear Lake, CA

Dear Garth –

Thank you for considering Quorum's Workforce Productivity program at Bear Valley Community Health District. As we discussed, this program can provide significant value to your organization as you continue improving organizational performance.

At your request, we are submitting the enclosed agreements for your consideration. We recognize you have many options to consider, including partnering with another firm or undertaking this initiative on your own. It is a privilege to submit our qualifications and methodologies for your consideration. We would be pleased to serve your organization at this important time in your history.

Should you have any questions, please contact me at 615-371-4597 or tarmstrong@qhr.com

Sincerely,

Tim Armstrong
Senior Consultant, Workforce Efficiency

cc: Michele Mayes, Senior Vice President, Consulting

Staffing Assessment and Implementation Engagement Letter

Our Understanding of Your Needs

Having a workforce that is the right size, type, and efficiency level looks very different today than it did even two (2) years ago. Although traditional practices still provide value, market leaders are applying new tactics to offset declines in margin, while also preparing their organizations for success in a 'pay for value' environment. We are working with clients across the country to further instill traditional practices and holistically fortify them with new practices, such as aligning management and organization responsibilities with new care delivery requirements and addressing barriers to efficiency through process improvement. In this Project, Quorum will use this approach, described in more detail below, to identify opportunities to improve operational efficiency across the organization. Key aspects of this program will be:

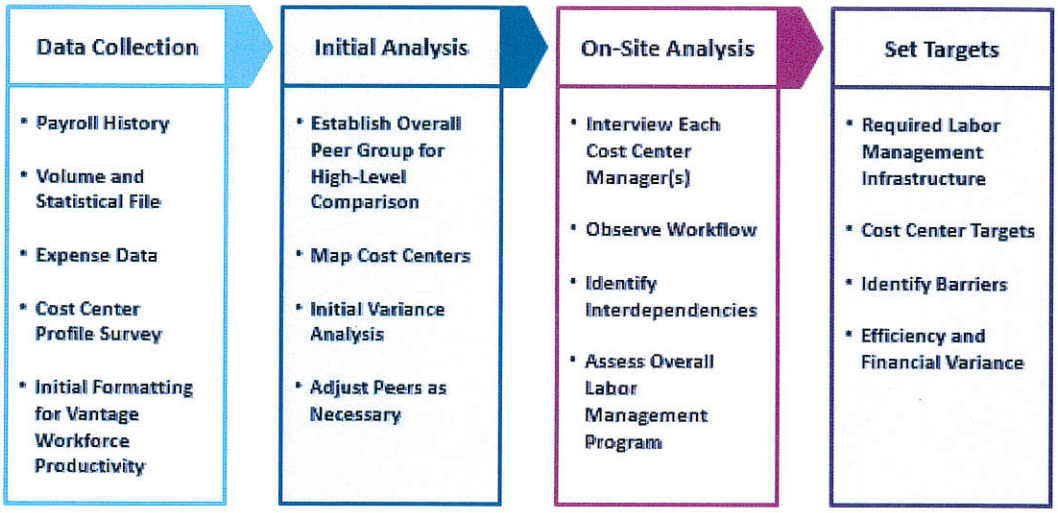
- Utilizing comparative benchmarks to gain a solid understanding of department opportunities;
- Setting realistic targets for staffing efficiency based on current operations;
- Providing education to managers on strategies for effective staffing management; and
- Utilizing a consistent set of tools to manage performance on an ongoing basis.

Our Approach

Quorum's workforce efficiency program enables leadership to establish appropriate labor productivity targets, monitor performance on a timely basis, and track improvements that can be sustained over time.

Staffing Assessment

The staffing assessment focuses on establishing labor productivity targets and identifying opportunities to improve labor cost utilizing the following methodology:



Quorum will deploy experienced healthcare professionals with departmental and content knowledge to assess staffing and productivity in key areas of the Hospital. The following is a brief outline of our typical project approach.

Data Request and Peer Group Benchmarking

Quorum consultants will request one (1) year's worth of relevant general ledger, payroll, contract labor, and volume/utilization data and will work with the Hospital's finance, accounting, and/or IT representatives to transfer data to Quorum for analysis. In addition, Quorum will request the necessary data to complete a productivity study and compensation comparison of the providers. This data includes work RVUs of providers, W2 information and current contract/compensation agreements.

Upon receipt of the data, Quorum analysts will create an initial performance gap analysis by comparing the Hospital's actual performance to that of an appropriate peer group, based on the hospital size, services, acuity, and region. Quorum utilizes a nationally recognized comparative database of over 400 hospitals submitting high-level and department-specific operational data.

On-Site Review of Hospital Departments and Clinics

After reviewing the data, Quorum consultants, including clinical and financial productivity specialists and subject matter experts (as needed), will attend on-site meetings with Hospital directors and/or managers. The purpose of these meetings is to help consultants understand the unique operational characteristics at the Hospital, in order to identify and recommend appropriate productivity targets for each Hospital department and clinic.

While on-site, the consultants will spend time observing the broader activities that impact workforce efficiency, including:

- Evaluating the overall labor management program against identified best practices;

- Examining the physical layout of the campus;
- Observing workflow and department processes; and
- Identifying interdependencies among departments that impact overall efficiencies.

Consultants will also spend time interviewing department managers. Topics will include:

- Department payroll and volume data;
- Department scope of operations;
- Current processes for scheduling and day-to-day management of staffing;
- Department skill mix;
- Space/equipment constraints that impact staffing;
- Management and staff allocations;
- Management effectiveness; and
- Premium pay ratios.

Staffing Recommendations

Upon completion of on-site meetings, Quorum consultants will use the quantitative and qualitative data gathered to compile an initial assessment of Hospital performance, including initial proposed department staffing standards and associated opportunities for improvement. The report will include identified barriers to achieving recommended targets, as well as high-level recommendations to increase efficiencies. This initial assessment will be reviewed with senior leadership to validate Quorum's assumptions and understanding of the current operations. Appropriate adjustments to the analysis will be made based on this feedback.

Quorum will provide the Hospital management team with both a verbal, on-site summary and a written report of findings and recommendations (the "Final Report"). The Final Report will include overall Hospital- and department-level FTE and dollar opportunity savings and recommendations for streamlining efficiencies in each department. In addition, Quorum will make recommendations on the clinic staffing.

Deliverables

Staffing Assessment

Quorum consultants will provide the Hospital a presentation and a Final Report that includes the following:

- Summary of targets and barriers to current workforce efficiency;
- High-level recommendations on processes and practices that can help improve overall and department-specific efficiency;
- Recommended departmental labor standards;
- Recommended improvements to agency, overtime, and other premium pay practices;
- Recommendations to better align provider productivity with compensation; and
- Expected financial impacts associated with productivity optimization and labor expense improvements.

Implementation Activities

At the conclusion of the Staffing Assessment, Hospital leadership and Quorum will identify the actions steps needed to achieve and sustain the labor productivity targets. Typically, some hospital cost centers are performing at or near the productivity target, while others require significant improvements in order to achieve target performance. In the latter cases, it is important to set a 'glide path' tied to a formal cost center improvement plan, with accountability to implement the plan and achieve the glide path targets until the actual productivity target is achieved.

Quorum will work with Hospital leadership to design a customized, rapid-cycle training and improvement plan. The implementation focus will be determined based on opportunities identified in the staffing assessment, and the overall financial and strategic goals of the organization. Training and implementation includes:

- Leadership training on managing productivity, including strategies and tactics for closing the gap between current and targeted performance;
- Development of customized electronic nursing staffing grids or tools for each in-scope inpatient nursing unit tied to the updated productivity targets;
- Development of staffing and scheduling plans to assist department leaders in achieving productivity targets; and

- As needed training for senior leadership, directors, and managers, focusing on tools and processes to improve and manage staff productivity.

Quorum's team of experienced consultants will assist in leading implementation efforts to address the opportunities identified.

Your Quorum Team

Quorum's team for this Project will consist of senior-level clinical and financial productivity experts who will draw from the experience of overall Quorum resources and subject matter experts as needed.

Michele Mayes, Senior Vice President, will serve as the Project lead, responsible for project planning, confirming that stated objectives are achieved, and that the Hospital is satisfied with the overall Project experience and deliverables.

Mark Henning, Director and Tim Armstrong, Senior Consultant, will serve as the consultants responsible for assisting the Hospital with the engagement day to day.

Consultant Travel Expenses

Quorum will initiate invoices for business travel and other expenses related to the Project ("Consultant Travel Expenses"). These typically include expenses such as transportation, lodging, meals, document preparation, shipping, etc.

WIPFLI LLP
CPAs and Consultants

HFS consultants
Complete Solutions for Healthcare Management

Wipfli LLP/HFS Consultants
505 Fourteenth Street | Fifth Floor
Oakland, California 94612-1912

May 21, 2018

Mr. Garth Hamblin
Chief Financial Officer
Bear Valley Community Hospital
41870 Garstin Drive
Big Bear Lake, CA 92315

RE: CONSULTING SERVICES TO PROVIDE LABOR PRODUCTIVITY ASSESSMENT & TRAINING

Dear Mr. Hamblin:

This Engagement Letter sets forth the terms and conditions under which WIPFLI LLP/HFS Consultants (Wipfli) will perform a labor productivity benchmarking and target setting along with a manager training program for Bear Valley Community Hospital (BVCH).

Per our conversations, Wipfli understands BVCH is interested in assistance with labor productivity benchmarking and setting appropriate productivity targets for each of its departments. In addition, BVCH desires that Wipfli provide training for BVCH managers on labor productivity management as workloads fluctuate.

OVERALL PROJECT OBJECTIVES AND SCOPE

We will perform a combination of a comparative benchmarking analysis along with onsite interviews of key BVCH executives, managers, staff and physicians, as appropriate, to develop reasonable and achievable labor productivity targets for each major department. We will also provide appropriate training to managers to enhance their abilities to meet those targets. As such, Wipfli will conduct the following activities:

- Determine an appropriate comparator group to compare BVCH labor productivity performance
- Evaluate and "clean" BVCH data for productive hours and units of service to ensure "apples to apples" comparison with the comparator group
- Identify and incorporate BVCH contractor/agency/traveler data to ensure "apples to apples" comparison
- Conduct labor productivity benchmarking analysis with identification of benchmark thresholds for Top, 2nd, 3rd and Bottom Quartile performance by each major department

- Identify for each BVCH department, which benchmark quartile they fall into
- Conduct onsite interviews with key hospital executives, managers/directors, staff as needed and physicians as needed to identify critical operational, facility, systems and data challenges impacting labor productivity performance
- Calculate potential opportunity in dollar savings and FTE savings if each BVCH department can meet Top or 2nd Quartile performance
- Develop summary PowerPoint document with benchmarking assessment findings including full table of benchmarks and opportunity summaries by department.
- Utilize assessment findings to help BVCH leadership team set realistic labor productivity targets for each major department
- Present findings and results to BVCH leadership team
- Conduct onsite training sessions with department managers on labor productivity management concepts, tools and processes

TIMELINE

Wipfli is prepared to schedule this engagement immediately upon receipt of a signed version of this engagement letter. We believe that benchmarking and target setting part of this engagement could be completed within 5-6 weeks after we receive the data requested from BVCH. However, meeting this schedule is contingent upon timely receipt of data and a dedicated BVCH resource that we can work with to collect the data and answer questions regarding the data. The timeframe for the manager training program will depend on the level of training needed for each manager.

PROJECT FEES AND EXPENSES

Wipfli's professional fees for the benchmarking and target setting portion of the project will be $20,000. ***Because it's difficult to determine how much time and effort will be required for the manager training sessions, we will bill hourly for that part of the engagement based on standard Wipfli hourly rates.*** In addition, BVCH shall reimburse Wipfli for direct expenses incurred with the performance of these services. Direct expenses include reasonable and customary out-of-pocket expenses such as incidental administration, travel, meals, accommodations and other expenses specifically related to this engagement.

Wipfli shall bill BVCH for 50% of the professional fees, for the benchmarking and target setting portion of the work, at the beginning of this engagement. The remaining 50% of professional fees, plus any expenses incurred, will be billed after the conclusion of the work. The fees for the training portion of the program will be billed as occurred based on standard hourly rates. Payment is due upon receipt of the invoice. The attached Professional Services Terms and Conditions are included herein by reference.

If there are additional services requested by BVCH that falls outside the scope of this letter, those services will be billed at Wipfli's standard hourly rates.

HIRING OF WIPFLI PERSONNEL

If any personnel provided by Wipfli is solicited by BVCH and becomes an employee of, or an independent contractor to, BVCH or any affiliated entity from the date of this letter until one year after the termination of the engagement, BVCH will pay Wipfli a referral fee of $35,000 or 40% of the first-year annual gross compensation or professional fees BVCH pays, whichever is greater.

HIPAA

Wipfli shall abide by all laws, regulations and directives of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as it pertains to services performed by Wipfli and information received by Wipfli from BVCH pursuant to this agreement. Since Wipfli may, in the course of performing services under this agreement, receive protected health information from BVCH, Wipfli will be deemed a Business Associate of BVCH. Wipfli LLP will sign and execute a Business Associate agreement with BVCH and will conform thereto.

EARLY TERMINATION

Should BVCH terminate this agreement before total fixed professional fees of the option selected are billed, Wipfli shall be entitled to a professional fee computed at the actual hours expended by associates through the termination date times the standard hourly rates for each associate plus out-of-pocket expenses incurred through that date.

To indicate your acceptance of this Engagement Letter please sign and date this letter and return to us. If you have any questions regarding the material in this letter, or if I can be of further assistance, please contact me at (510) 768-0066 or dkim@wipfli.com.

Very truly yours,
WIPFLI LLP/HFS Consultants

David Kim
Partner

AGREED & ACCEPTED:
Bear Valley Community Hospital

Signature: _____ Date: _____
By: Mr. Garth Hamblin, Chief Financial Officer

WIPFLI LLP
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HFS consultants
Complete Solutions for Healthcare Management

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505 Fourteenth Street | Fifth Floor
Oakland, California 94612-1912

WIPFLI LLP
Professional Services Terms and Conditions
Applicable to Non-Attest and Non-Tax Engagements

1. Entire Agreement

These Terms and Conditions, together with the engagement letter ("Engagement Letter") to which these Terms and Conditions are attached, the Engagement Letter's other appendixes, and applicable Change Orders, if any, constitute the entire agreement between the parties on the subject matter thereof and supersede and merge all prior proposals (including prior proposals of Wipfli regarding the engagement), understandings, and agreements (oral or written) between the parties relating to the subject matter including, without limitation, the terms of any request for proposal issued to Client or the standard printed terms on any purchase order issued by Client. No modification, amendment, supplement to, or waiver of these Terms and Conditions or the Engagement Letter shall be binding upon the parties unless made in writing and duly signed by both parties. To the greatest extent reasonably possible, the provisions of the Engagement Letter, its Appendixes (including these Terms and Conditions), Implementation Plan, Change Orders, and any other exhibit, attachment, schedule, or other document referenced in or by the Engagement Letter shall be read together and harmonized to give effect to the parties' intent. In the event of a direct conflict among the express provisions of the foregoing, the Engagement Letter shall be given controlling effect. These terms and conditions do not apply to any attest services that may be performed by Wipfli for Client, such services being governed exclusively by the Engagement Letters issued with respect thereto.

2. Commencement and Term

An Engagement Letter or Change Order shall become effective when signed by duly authorized representatives of both parties and shall remain in full force and effect until the services to be delivered under the Engagement Letter are complete (as reasonably determined by Wipfli) unless earlier terminated by either party as provided in the Engagement Letter or these Terms and Conditions. Each person executing an Engagement Letter or Change Order on behalf of a party represents and warrants to the other that he or she has all power and authority to bind the party on whose behalf he or she is executing same.

3. Fee Estimates and Change Orders

Wipfli's Engagement Letter may set forth certain ranges for Wipfli's fees charged on any project or work. Wipfli provides fee estimates as an accommodation to Client. Unless otherwise indicated in the Engagement Letter, fee estimates shall not be construed as or deemed to be a minimum or maximum fee quotation. Although Wipfli reasonably believes suggested fee ranges are accurate, Wipfli's actual fees may vary from its fee estimates.

A "Change Order" means a mutually agreed-upon change in the schedule or the time for Wipfli's performance of the work on a project, the scope of specifications of a project, and/or the fees chargeable by Wipfli to Client, which is reduced to writing using an agreed-upon form that is executed by an authorized representative of each for Wipfli and Client.

If, during the course of Wipfli's engagement, Wipfli determines that more work will be required than initially estimated, Wipfli will discuss, as soon as possible, the reasons with Client. Work that falls outside the agreed-upon scope of Wipfli's engagement shall be covered by a Change Order. Service completion times are estimated and subject to change. Where applicable, all such estimates assume that Client's hardware platform/computer system will, at the commencement of the services, be fully operable as intended and designed, functioning as necessary and available to Wipfli without material restriction for the duration of the services. Such estimates also include necessary and reasonable cooperation from client personnel.

Unless otherwise agreed in the Engagement Letter, miscellaneous expenses incurred by Wipfli in the course of performing the service will be charged in addition to Wipfli's professional fees. Miscellaneous expenses may include, but are not limited to: travel, lodging, transportation, and meals for projects requiring travel; clerical processing; telecommunications charges; delivery expenses; and all sales, use, ad valorem, excise, or other taxes or other governmental charges.

Fees

Unless otherwise agreed, all invoices are due and payable within thirty (30) days of the invoice date. All business or commercial accounts will be charged interest at the lesser of one percent (1%) per month or the maximum rate permitted by law, except where prohibited by law, on Client's balance due to Wipfli that is outstanding over thirty (30) days. At our discretion, work may be suspended if Client's account becomes overdue and will not be resumed until Client's account is paid in full. Client acknowledges and agrees that we are not required to continue work in the event of a failure to pay on a timely basis for services rendered as required. Client further acknowledges and agrees that in the event Wipfli stops work or withdraws from this engagement as a result of Client's failure to pay on a timely basis for services rendered as required by this Engagement Letter, Wipfli will not be liable to Client for any damages that occur as a result of our ceasing to render services.

In the event Client requests us to, or we are required to, respond to a subpoena, court order, government regulatory inquiries, or other legal process against Client or its management for the production of documents and/or testimony relative to information we obtained and/or prepared during the course of this or any prior engagements, Client agrees to compensate us for all time we expend in connection with such response, at our regular rates, and to reimburse us for all related out-of-pocket costs that we incur.

4. Tax Responsibilities

Client shall pay and be solely and exclusively liable for all sales, use, ad valorem, excise, or other taxes or governmental charges imposed on the installation, implementation, licensure, or sale of goods or services by Wipfli or third parties to Client related to the Engagement Letter.

5. Termination of Agreement
An Engagement Letter may be terminated as follows: (i) by either party immediately upon written notice to the other if either party hereto becomes the subject of voluntary or involuntary bankruptcy or other insolvency proceeding, (ii) by Wipfli or Client if either party defaults in the performance of any of its covenants and agreements set forth in an Engagement Letter or Change Order (except when such default is due to a cause beyond the control of the party) and such default is not cured within thirty (30) days after notice from either party specifying the nature of such default, and (iii) by Wipfli or Client with or without cause upon providing thirty (30) days written notice. Termination of an Engagement Letter shall have no effect on either party's obligation to pay any amount due and owing with respect to such periods prior to the effective date of such termination.

6. Ongoing Support and Advice
Wipfli ongoing support and advice, whether or not it is defined by an Engagement Letter or Change Order, shall be subject to Wipfli's Terms and Conditions and will be provided under the same terms and conditions that would apply to services defined in Wipfli's Engagement Letters or Change Orders.

7. Third-Party Products and Subcontractors
When Wipfli is requested by Client through an Engagement Letter or Change Order to provide assistance with third-party products, Wipfli will use commercially reasonable efforts (as defined by Wipfli) to research, learn, and assist Client in the use of third-party products. However, Wipfli shall not be held liable for software or other products or services that have been written, produced, or provided by third parties. Client accepts all responsibility for, and risk-of-loss associated with, Client's use of third-party software, hardware, and products. Client accepts full responsibility for all communications with, and indemnifies and holds Wipfli harmless from, claims by third-party software developers, vendors, contractors, and/or subcontractors who have not been directly commissioned, engaged, retained, or hired by Wipfli. Wipfli hereby expressly disclaims all liability to Client or to any third parties that might be affected by the services performed or equipment installed by a third party who has not been directly commissioned, engaged, retained, or hired by Wipfli.

8. Independent Contractor
The relationship between Wipfli and Client is solely and exclusively that of independently contracting parties.

9. Nonexclusivity
No right of exclusivity is granted, guaranteed, or implied by Wipfli and Client entering into any Engagement Letter or Change Order. Client acknowledges that Wipfli regularly performs the same or similar services as are being provided hereunder to third parties.

10. Wipfli Employees and Owners
Wipfli expressly reserves the right to replace, in its sole discretion upon notice to Client, any of our professional project team members, as necessary, to provide quality and timely service to Client. From time to time, and depending upon circumstances, personnel from affiliates of Wipfli and other Wipfli-related entities or any of their respective affiliates or from independent third-party service providers (including independent contractors) may participate in providing services related to our engagement hereunder. Some persons who own an interest in Wipfli may not be licensed as Certified Public Accountants and may provide services related to this engagement.

11. Limitation of Liability
Except for liability for personal injury damages caused by Wipfli's gross negligence or willful misconduct, and regardless of whether any remedy as set forth in these Terms and Conditions fails in its essential purpose, in no event shall Wipfli's cumulative liability to Client (or its successors, assigns, or affiliates) from all causes of any kind including liability based on contract, in tort, or otherwise arising from, out of, or related to the services or transactions contemplated in the Wipfli Engagement Letter or Change Order exceed the amount actually paid to Wipfli by Client under such Engagement Letter or Change Order.

12. Dispute Resolution
If any dispute arises among the parties regarding the subject matter hereof and such dispute cannot be resolved through informal negotiations and discussion, the parties agree to try in good faith to settle the dispute by mediation administered by the American Arbitration Association under its applicable rules for resolving professional accounting and related services disputes before resorting to arbitration or litigation. Costs of any mediation proceeding shall be shared equally by all parties.

13. Governing Law
All agreements between Wipfli and Client for any service shall be governed by and construed in accordance with the internal laws of the state in which the Wipfli office which issues the Engagement Letter related to the services is located.

14. Severability
The provisions of these Terms and Conditions shall be severable, so that the invalidity or unenforceability of any provisions will not affect the validity or enforceability of the remaining provisions; provided that no such severability shall be effective if it materially changes the economic benefit of these Terms and Conditions to either party.

15. Record Retention
We will retain records related to this engagement pursuant to our record retention policy. At the end of the relevant time period, we will destroy our records related to this engagement. However, original records will be returned to Client upon the completion of the engagement. When records are returned, it is Client's responsibility to retain and protect the records for possible future use, including potential examination by governmental or regulatory agencies.

16. Assignment
The Engagement Letter to which these Terms and Conditions are attached shall be binding on the parties hereto and their respective successors and assigns. Neither party may assign this Engagement Letter without prior written consent of the other, except that Wipfli may assign its rights and obligations under this Engagement Letter without approval of Client to an entity that acquires all or substantially all of the assets of Wipfli or to any subsidiary or affiliate or successor in a merger, acquisition, or change of control of Wipfli; provided that in no event shall such assignment relieve Wipfli of its obligations under this Engagement Letter.

17. **Intellectual Property Rights**

Client acknowledges that Wipfli owns all intellectual property rights, title, and interest to all information provided or developed throughout the duration of this engagement. Any use of this material, other than for the stated purposes in this Engagement Letter, is not authorized. In addition, Client shall not alter or remove any of Wipfli's trademarks, copyright registration marks, patent, or other intellectual property notices applicable to any of Wipfli's goods, marketing material, or advertising media and shall not in any way alter any of Wipfli's products. Client shall promptly notify Wipfli in writing of any infringement of Wipfli's intellectual property by third parties of which Client becomes aware. Neither party shall acquire any right, title, or interest in or to the other party's code, data, business processes, or other information to which such party may have access during the term of the engagement hereunder. All such code, data, business process, and other information shall be solely and exclusively the property of the originating party.

18. **Mutual Confidentiality**

During the course of performing services, the parties may have access to information that is confidential to one another, including, without limitation, source code, documentation, specifications, databases, system design, file layouts, tool combinations, development methods, or business or financial affairs, which may incorporate business methods, marketing strategies, pricing, competitor information, product development strategies and methods, customer lists, customer information, and financial results (collectively "Confidential Information"). Confidential Information may include information received from third parties, both written and oral, that each party is obligated to treat as confidential.

Confidential Information shall not include any information that (i) is already known by the recipient party or its affiliates, free of any obligation to keep it confidential, (ii) is or becomes publicly known through no wrongful act of the receiving party or its affiliates, (iii) is received by the receiving party from a third party without any restriction on confidentiality, (iv) is independently developed by the receiving party or its affiliates, (v) is disclosed to third parties by the disclosing party without any obligation of confidentiality, or (vi) is approved for release by prior written authorization of the disclosing party.

Without the advance written consent of the other party, neither party shall disclose to a third party Confidential Information of the other party. Each party agrees to maintain at least the same procedures regarding Confidential Information that it maintains with respect to its own Confidential Information. Each party may use the Confidential Information received from the other party only in connection with fulfilling its obligations under this Agreement. The parties further agree that expiration or termination of this Agreement, for any reason, shall not relieve either party, nor minimize their obligations with respect to Confidential Information, as set forth herein.

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

MEMO

Date: July 05, 2018

To: Board of Directors

From: John Friel, CEO

Re: CEO & CFO 401k contribution

As context for the Board Agenda item that follows this March 5, 2018 is offered.

John Friel

From: Penny Hayden <phayden@qhr.com>
Sent: Monday, March 05, 2018 2:13 PM
Subject: FROM THE DESKS OF BOB VENTO, TIM RYAN, AND JOHN MAHER: Regarding the 2017 401K Match

QHR Colleagues:

As most of you are aware, a notification was sent to 401K participants last week informing of the company's decision not to fund the 2017 match. We understand the concerns that this has raised for many over the decision that was made, as well as the communication of that decision. We wanted to reach out with a communication to everyone to address some of these concerns.

- This was a difficult decision for the company to make, as everyone understands the impact that this has on the employees. The decision was made based on the current financial position of the company. As the company continues to implement the strategy of divesting underperforming assets and paying down debt, the decision made not to fund the 401K match was in the best financial interests of the company. The decision impacts more than 7,300 of the almost 14,000 total eligible employees working in all of QHC.
- The letter that was sent out across the company was deemed the best way to reach the large number of participants at the same time. We recognize that people would have liked more personal communication or advanced notification, however that was not possible in this case. We are committed to providing you timely communication whenever it is possible to do so.
- We understand that when decisions are made like this it brings into question the health of the organization for people. We want to assure you that the company has concrete plans to improve its' performance.
    - From QHR's perspective, our goals continue to be:
        - Build the Business Intelligence and Analytics – Prospecting Model
            - Drive Pipeline growth
            - Increase warm introductions on leads
            - Connect Relationships (Qualified Leads – LinkedIn)
        - Leverage Business Line Structure
            - Marketing plans
            - Product and Service Development
            - Sales and Lead Development
        - Continued Development & Refinement of Business Line Metrics
        - Data and Technology Strategy
        - Leverage Touchstones
        - Leverage Core Values

Our hope is that this message gives some clarity on why the 401K match was not able to happen, and what our focus is as a company to mitigate this happening again for this year. We are going to schedule some open forums to discuss this and enable Q&A for everyone. We will also be further discussing our plans going forward on the all associate call next week.

In the meantime, please do not hesitate to reach out to any of us.

anks

Robert A. Vento

President & CEO
Quorum Health Resources, LLC

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QUORUM | HEALTH RESOURCES®

Board Report

July 2018

CEO Evaluation

Ron Vigus will be requesting Board input for John Friel's evaluation at the July meeting. The plan will be to finalize it at the August meeting as well as develop/approve goals for FY19 at that meeting.

Compliance Assessment

The Compliance Assessment engagement began with a pre-consulting call for the consultants and hospital team to discuss goals and scheduling. The QHR team will be on-site Sept. 9 – 7.

Mock Survey

The consultant that will review the Environment of Care and Life Safety compliance will be onsite in August to complete the Survey.

Upcoming Education Events – July

07/10/18 Board Leadership Series Topic #7

July 10, 2018 12:00 - 1:00 pm CST

07/12/18 Outpatient Clinical Documentation Improvement

July 12, 2018 2:00 - 3:00 pm CST

07/17/2018 Cyber Attack: Stories From the Field

July 17, 2018 2:00 - 3:00 pm CST

07/24/18 - 07/26/18 Reimbursement & Regulatory Update: Outpatient PPS & PFS Proposed Rules 3-part Series

July 24-26, 2018 2:00 - 3:00 pm CST

Other

- Ron Vigus is planning to attend the Board meeting.

2018 Quorum Health Board Essentials Workshop

August 8, 2018 – Omni Hotel, Nashville, TN
August 9-10, 2018 – Omni Hotel, Nashville, TN

QUORUM | HEALTH RESOURCES®

Upcoming Projects

- CAH Mock Survey – August 2018
- Cost Report Review – following preparation of Cost Report

Completed Projects

- IT Assessment
- Revenue Cycle Assessment
- Compliance Implementation/ Compliance Risk Assessment
- Mock Survey (Quality)
- QPA Supply Chain Review
- Contractual Allowances and Bad Debt Review
- Financial Operating Review

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

CNO Monthly Report

TOPIC	UPDATE	ACTION/FOLLOW UP
1. Regulatory Updates	▪ CDPH onsite for re-licensing survey. Plan of Correction was accepted. Monitoring for compliance is in process and will be reported through the appropriate Medical Staff Committee.	▪ Informational
2. Budget/Staffing	▪ Overtime, call offs assessed each shift ▪ Flexing of staff as warranted by census	▪ Continue to monitor
3. Departmental Reports		
▪ Emergency Department	▪ ED Manager is continuing to work with Plant Maintenance on "ED remodel" project. ▪ ED Manager attended Team STEPPS training, training will be rolled out to all ED staff and physicians within the next year as part of the Beta ED Quest for Zero Tier two program. ▪ Monitoring for compliance with Plan of Correction has been implemented. ED Manager will complete audits and report through QI Committee.	• Informational
▪ Acute	▪ New Admissions folder has been implemented to enhance patient experience. The folder will be given to each patient admitted to Acute. ▪ Feedback from folder has been positive, several areas are contributing information.	▪ Continue to monitor
▪ Skilled Nursing	▪ Interim DON has implemented monitoring from recent SNF survey POC. ▪ SNF remains at 5-star rating. ▪ Census is currently at 16 residents; new admissions are being evaluated for appropriate placement.	▪ Continue to monitor ▪ Informational

	▪ SNF QAPI meeting was held, several projects are ongoing including: Fall reduction, Restorative Nursing program & Hand Hygiene monitoring. ▪ SNF DON is revising SNF Policies. ▪ Permanent SNF DON job has been posted on Indeed, CAHF, BVCHD and AADNS website, as on 6/27/18 there are no viable outside candidates. 1 possible internal applicant has expressed interest in the position.	
▪ Surgical Services	▪ Orthopedic procedures being done weekly ▪ Ophthalmic procedures being done monthly ▪ Recommendations from mock CAH survey and Re-licensing survey have been implemented.	▪ Monitor surgical services costs and FTEs
▪ Case Management	▪ DON and Eligibility Worker are working on referrals for SNF residents and Swing patients. ▪ Case Manager attended Readmissions Collaborative at Loma Linda University Medical Center.	▪ Continue to monitor
▪ Respiratory Therapy	▪ Working with HR post position for Department Supervisor that will include management duties as necessary to run the Respiratory Department. ▪ RT will be participating in the upcoming laboratory survey in regards to blood gas analyzation.	▪ Informational
▪ Physical Therapy	▪ Department is experiencing staffing challenges; Manager has been working with HR to fill positions. ▪ Manager is working to plan for FY19 budgeted equipment replacement and department improvements.	▪ Continue to monitor
▪ Food and Nutritional Services	▪ New Policy manual has been purchased and is in the approval process ▪ Policies are being updated ▪ New cook has been hired ▪ Point of Sale system is being evaluated, webinar to be held 6/28.	▪ Informational

4. Infection Prevention	▪ Hand Hygiene monitoring continues. ▪ Infection Preventionist is rounding weekly to educate staff on hand hygiene and infection issues. ▪ Infection Preventionist attended an Infection Control Risk Assessment training. ▪ Infection Preventionist is conducting monthly rounds to monitor POC compliance and is reporting findings through Infection Control Committee	▪ Informational

5. QAPI	▪ All management staff have been trained on Just Culture, staff training has started and will continue through the end of July.
	▪ BETA HEART communication workgroup met 6/27 to evaluate progress from work group recommendations:
	  ▪ Rounding program
	  ▪ Stoplight boards
	  ▪ Huddle
	  ▪ Progress will be reported in QI committee.
	▪ PFAC project for ED lobby and ED art work is in process. Staff submissions for photographs have been approved and are in the process of being printed and framed for display.
	▪ BETA was onsite June 14th to present information to managers regarding SCORE survey debriefing.
	▪ SCORE survey results are in the process of being shared with each department manager. Each department will be debriefed and action plans will be made based on staff feedback.
		▪ Informational
		▪ Continue process for Just Culture/ BETA Heart implementation
		▪ Continue quarterly PFAC meetings

6. Policy Updates	▪ Policies reviewed weekly by Policy and Procedure committee. ▪ Nursing Admin and Employee Health Policies are in approval process.	▪ Reviewed through P&P Committee
7. Safety/Product	▪ Workplace Violence training is being provided to all BVCHD staff. ▪ Workplace Violence Plan was reviewed and approved by Safety Committee.	▪ Continue to monitor new regulation and compliance dates

	▪ Injury and Illness Prevention Plan was reviewed and approved by Safety Committee. ▪ Code Grey procedures reviewed with Clinical Managers. ▪ Active Shooter training has been assigned to all staff in Relias.	
8. Education	▪ BLS Classes scheduled monthly, ACLS & PALS scheduled quarterly ▪ Smoking Cessation classes being held as scheduled. ▪ Heart Rhythm class is being offered in a three session class to ED/ Acute staff by a clinical manager. ▪ Nursing skills orientation/ annual review of competency is being held quarterly for all clinical staff.	• Continue to monitor
9. Information Items/Concerns	▪ Nurse Leaders have been rounding daily to educate staff on current issues in the district and to encourage feedback on staff that need to be recognized for excellent performance. Staff feedback for this program has been positive.	▪ Informational
Respectfully Submitted by: *Kerri Jex, CNO*	*Date: June 27th, 2018*	

2018 Surgery Report

Apr-18		
Physician	**# of Cases**	**Procedures**
Critel - CRNA	3	LESI
Critel - CRNA	1	Shoulder Injection
Critel - CRNA	1	Hip Injection
Critel - CRNA	1	Carpal Tunnel Injection
Critel - CRNA	1	Trigger Point
Pautz - DO	2	Fulkerson's Osteotomy Knee
Pautz - DO	1	Orif Ankle
Tayani	10	Cataracts
Total	20	

May-18		
Physician	**# of Cases**	**Procedures**
Critel - CRNA	3	Hip Injection
Critel - CRNA	1	LESI
Critel - CRNA	1	Trigger Point
Critel - CRNA	1	Elbow Injection
Tayani	0	Cataracts
Total	6	

Jun-18		
Physician	**# of Cases**	**Procedures**
Critel - CRNA	1	LESI
Critel - CRNA	1	Trigger Point
Critel - CRNA	1	Foot Injection
Critel - CRNA	1	Elbow Injection
Pautz - DO	1	Repair Distal Biceps Tendon Right Elbow
Pautz - DO	1	A-1 Pulley Release
Pautz - DO	1	ORIF Ankle
Pautz - DO	1	Capsulectomy with Tenolysis 2-5th Metacarpals
Tayani	10	Cataracts
Total	18	

Jul-18		
Physician	**# of Cases**	**Procedures**
Critel - CRNA		
Critel - CRNA		
Critel - CRNA		
Pautz - DO		
Pautz - DO		
Pautz - DO		
Pautz - DO		
Pautz - DO		
Pautz - DO		
Tayani		
Total	0	

Aug-18

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

CHIEF EXECUTIVE OFFICER REPORT
June 2018

CEO Information:

The California Department of Public Health was on site May 17, 2018 to complete the Annual Licensing Survey. We submitted the Plan of Corrections, which was accepted.

Pharmacy, clinical laboratory and blood gas laboratory were surveyed by CDPH and the Board of Pharmacy on July 2, 2018 and all three departments did well. As expected suggestions were provided by the surveyors but no citation were given. Final reports will be provided in July's report.

The Department of Health Care Services conducted an unannounced audit on the FHC & RHC Medi-Cal Practice on January 18, 2018. The clinic (s) has completed the corrections of documentation.

It is with great pleasure to announce that the Mom & Dad Project was awarded a grant from Kaiser Permanente. The Kaiser Grant will help fund the Mom & Dad Project's Life with a New Baby: Education for the New Family.

We have our first medical student with Western University College of Osteopathic Medicine has begun his internship with Dr. Knapik.

We are also working with representatives of UC Riverside and RCH for a family residency program beginning in July 2019.

Our 2nd meeting with Moon & Mayoras regarding the retrofit vs replace project was conducted. Several department managers met with David Moon to discuss the needs of their departments. Administration is working with Mr. Moon to obtain information on the retrofit to possibly present to the Board of Directors at the Board Retreat.

On June 30, the District hosted the Annual Health Fair. We had approximately 32 vendors. The community showed up to participate and provided information on various services offered to our community.

The Wage & Salary implementation of the Board approved 2018 salary plan is going well. Feedback has been favorable as of this writing. Adjustments will be reflected in the July 13 paychecks.

I will be participating in the Bear Lake Fire Department, Community Service Coverage Workshop, on July 11, 13 & 21st and August 14. Board Members are welcome and encouraged to attend. Please let me know if you are interested.

I will be attending the QHR Executive Leadership & Trustee Conference, which is scheduled for August 7-10th in Tennessee. I will be on vacation from July 31 through August 3rd.

Marketing:

We are currently advertising Physical Therapy Department and the Smoking Cessation Class.

Attachment:
QHR Compliance Newsletter
Quorum Board Minutes
Second Annual Helen Walsh Humanitarian Award

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	CA240000002	A. BUILDING _____ B. WING _____	05/17/2018

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BEAR VALLEY COMMUNITY HOSPITAL	41870 GARSTIN DR BIG BEAR LAKE, CA 92315

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E 000	Initial Comments The following reflects the findings of the California Department of Public Health during a State Relicensing Survey conducted from May 15, 2018 to May 17, 2018. Representing the California Department Of Public Health: 34959, Health Facilities Evaluator Nurse 39474, Health Facilities Evaluator Nurse 34710, Pharmaceutical Consultant II, Specialist Census: 3 Sampled Patients: 30	E 000		
E 035	T22 DIV5 CH1 ART1-70035 Governing Body Governing body means the person, persons, board of trustees, directors or other body in whom the final authority and responsibility is vested for conduct of the hospital. This Statute is not met as evidenced by: Based on interview and record review, the Governing Body of the facility failed to ensure seven members of the Medical Staff were trained and educated on the prevention of abuse. This failure created the potential for abuse to occur in a universe of 3 patients. Findings: During a review of the personnel file for the Medical Director of Emergency Department (MDOED) on May 17, 2018 at 2:09 PM, indicated there was no documentation that abuse training was done for the MDOED. During a review of the personnel file for the	E 035	Medical Staff Coordinator immediately contacted contracted providers employment company to inform them of abuse training requirements. All current providers who have direct patient contact will be sent abuse training electronically on 6/11/18 and verification or training completion will be obtained and kept in their credentialing files. The on-boarding process for physicians has been updated to include verification of abuse training.	6/11/18 7/11/18

California Department of Public Health

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E 035	Continued From page 1 TelePsychiatrist (the delivery of psychiatric assessment and care through telecommunication and videoconferencing) (TP) on May 17, 2018 at 2:10 PM, indicated there was no documentation that abuse training was done for the TP. During a review of the personnel file for the Orthopedic Surgeon (specializing in the correction of deformities of bones and muscles) (OS 1) on May 17, 2018 at 2:11 PM, indicated there was no documentation that abuse training was done for the OS 1. During a review of the personnel file for the Ophthalmologist (treats disorders and diseases of the eye) (O 1) on May 17, 2018 at 2:12 PM, indicated there was no documentation that abuse training was done for the O 1. During a review of the personnel file for the Emergency Department Physician (ED MD 1) on May 17, 2018 at 2:14 PM, indicated there was no documentation that abuse training was done for the ED MD 1. During a review of the personnel file for the Emergency Department Physician (ED MD 2) on May 17, 2018 at 2:15 PM, indicated there was no documentation that abuse training was done for the ED MD 2. During a review of the personnel file for the Infections Disease (a physician that specializes in infectious diseases such as bacteria an viruses) (ID) on May 17, 2018 at 2:16 PM, indicated there was no documentation that abuse training was done for the ID. During an interview with the Medical Staff Coordinator (MSC) on May 17, 2018 at 2:08 PM,	E 035	Monitoring: Medical Staff Coordinator will complete monthly audits of credentialing files and will report findings bi-monthly to the MEC for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Medical Staff Coordinator	

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E 035	Continued From page 2 the MSC stated that there was no abuse training for physicians. The facility was unable to provide a policy and procedure regarding Physicians need to have abuse training.	E 035		
E 291	T22 DIV5 CH1 ART3-70215(a)(1) Planning and Implementing Patient Care (a) A registered nurse shall directly provide: (1) Ongoing patient assessments as defined in the Business and Professions Code, Section 2725(d). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area. This Statute is not met as evidenced by: Based on interview and record review, the facility's emergency department failed to ensure that the nursing staff implemented the policy and procedure for "Assessment/Reassessment of Patients" for one of 30 sampled patients (Patient 21). This failure had the potential for a delay in care for Patient 21. Findings: During a review of Patients 21's clinical record indicated Patient 21 presented to the Emergency Department on May 14, 2018 at 6:07 PM, with a chief complaint (the patient's reported reason for seeking medical care) of possible congestive heart failure (a weakness of the heart that leads	E 291	Policy titled 'Assessment/Reassessment of Patients-Interdisciplinary' was updated to include vital sign parameters for the ED. 6/18/18 Vital sign requirements were included on daily huddle sheets and an in-service provided to staff will be conducted at the nursing staff meeting. 6/22/18	

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E 291	Continued From page 3 to a buildup of fluid in the lungs and surrounding body tissues) and right heel wound (the skin is cut or broken). During a review of the Emergency Department Clinical Report document dated from May 14, 2018 to May 15, 2018, indicated Patient 21's vital signs were done on May 14, 2018 at 6:21 PM and 11:00 PM. There was no documentation that vital signs were done on May 14, 2018 every two hours for Patient 21 for the following times: 8:21 PM and 10:21 PM. During an interview with the Clinical Manager (CM) on May 17, 2018 at 3:37 PM, the CM stated that the vital signs for Patient 21 should have been done every two hours and confirmed the vital signs for 8:21 PM and 10:21 PM were missing. During a review of the facility's policy and procedure "Assessment/Reassessment of Patients" dated September 18, 2018, included the following..."Reassessments are based upon severity of illness and required resources..."	E 291	Monitoring: Random chart audits will be conducted on a monthly basis to review compliance with vital sign guidelines. Findings will be reported quarterly to Quality Improvement for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Director of Emergency Services	
E 475	T22 DIV5 CH1 ART3-70263(c)(1) Pharmaceutical Service General Requirements (1) The committee shall develop written policies and procedures for establishment of safe and effective systems for procurement, storage, distribution, dispensing and use of drugs and chemicals. The pharmacist in consultation with other appropriate health professionals and administration shall be responsible for the development and implementations of procedures. Policies shall be approved by the governing body. Procedures shall be approved by the	E 475		

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E 475	Continued From page 4 administration and medical staff where such is appropriate. This Statute is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure that: 1. High risk medications were not available to nursing staff for administration to patients without pharmacy review. Several concentrated electrolyte solutions (they regulate nerve, muscle function, hydrate the body, balance blood acidity, and help rebuild damaged tissue) were available in a storage room that could be accessed by nursing staff without pharmacist intervention. Administration of high risk concentrated electrolytes to patients without pharmacy review can lead to incorrect doses which may cause serious patient harm or death. 2. Two patients were not administered with fentanyl (a highly potent opioid pain medication) patch without evidence or confirmation that the patients were opioid tolerant (when the body adapts to the presence of the medication, resulting in a decrease in the drugs effectiveness over time). Administering fentanyl patch to an opioid naive patient can lead to serious respiratory depression and potential death. These failures had the potential to increase the risk of serious medication errors and death to a universe of three patients. Findings: 1. During a tour of a Emergency Department drug storage room, it was observed that more than 20 bags of 3% sodium chloride (a medication used	E 475	1. The key to the padlock to the rolling storage shelving that was kept in the Pyxis was immediately removed from the Pyxis, preventing Nursing from having any access	5/14/18

California Department of Public Health

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E 475	Continued From page 5 to replenish low sodium levels in the blood) 500 milliliters in each bag and more than 10 bags of potassium chloride (a medication used to treat low potassium levels in the blood) 20mEQ 100 milliliters in each bag were observed to be stored within a rolling shelf storage area. During a concurrent interview with the Emergency Department Manager (EDM), the EDM confirmed that nursing personnel had access to all the medications within the storage area. The EDM stated that the key to the padlock on the rolling storage shelving was kept within the Pyxis (an Automated Drug Dispensing System that stores drugs for nursing to administer to patients; it can also store miscellaneous items such as keys) and nursing was able to obtain the key without notifying the pharmacist. During an interview with the Director of Pharmacy (DOP) on May 16, 2018, at 9:45 AM, the Director of Pharmacy confirmed that nursing had access to a key which opened the Emergency Department medication storage room rolling shelves. The DOP also confirmed that nursing could remove the concentrated electrolytes from the room without approval from the pharmacy. The DOP stated that he had since removed the key from the Pyxis and that nursing could no longer access the rolling shelves drug storage. A review of hospital policy and procedure titled "Medications, High Risk (High Alert)", with a most recent approved date of "01/11/2016", under the section "Procedure", the policy states, "Hypertonic saline solution(a solution with a higher salt concentration than normal body cell so that water is drawn out of the cell) > 0.9% (e.g. 3% sodium chloride)...Storage of sodium chloride infusions of concentration > 0.9% is restricted by	E 475	to the rolling cabinet utilized for bulk medication storage. Pharmacist provided a memo to nursing staff regarding removal of key from Pyxis. 5/16/18 Policy titled 'Medications, High Risk (High Alert)' was updated to reflect that nursing does not have access to hypertonic solution. 6/8/18 Monitoring: Medication safety rounds to ensure the proper storage of high risk medications shall be conducted monthly and reported to the Pharmacy and Therapeutics Committee for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Director of Pharmacy	

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E 475	Continued From page 6 location (pharmacy only)." The policy further states, "Concentrated IV Potassium...Storage of concentrated solutions is restricted to pharmacy." A review of ISMP's (the Institute for Safe Medication Practices - a nonprofit organization considered the authority on medication error prevention and safe medication use) High-Alert Medications in Acute Care Settings indicates that both concentrated saline solutions and concentrated potassium solutions are listed and considered high risk medications. The document states, "High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating to patients". 2. During a medical record review for Patient 1 and Patient 2 on May 16, 2018, at 9:55 AM, it was revealed that both patients received fentanyl patch. Patient 1 was admitted on September 8, 2017 and was started on fentanyl patch 3 days later on September 11, 2017. Patient 2 was admitted on January 11, 2018 and was started on fentanyl patch 4 days later on January 15, 2018. A review of the hospital reconciliation list of medications both patients were taking at home did not include fentanyl patch. Further review of the medical record did not include any documentation or confirmation that either patient was opiate tolerant (the body adapts to the presence of the medication, resulting in a decrease in the drugs effectiveness over time) and safe to start on fentanyl patch. A review of hospital policy and procedure titled "Fentanyl Patch Safety", with a most recent approved date of "01/08/2016", under the section	E 475	2. Pharmacist will provide an in-service to the nursing staff regarding Fentanyl Patch Safety policy and Fentanyl Transdermal Patch Order Form completion for each Fentanyl order. In-service will be held during the nursing staff meeting. The Pharmacist will provide a memo to the Medical Staff regarding use if the Fentanyl Transdermal Patch Order Form. The memo will be presented at Pharmacy and Therapeutics Committee and MEC. Monitoring: Pharmacist will perform monthly monitoring of Fentanyl orders to ensure the Fentanyl Transdermal Patch Order Form is complete and in the chart. Findings shall be reported to the Pharmacy and Therapeutics Committee for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Director of Pharmacy	6/22/18 7/18/18

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E 475	Continued From page 7 "Procedure", the policy states, "The most important consideration in using fentanyl is that the patient is already opioid tolerant." The policy also states, "A. Upon receiving an order for fentanyl patches, the RN will complete the "Fentanyl Transdermal Patch Order Form" and confirm with the physician. B. Before the fentanyl patch is removed from the Pyxis, the form will be given to the pharmacist to verify and enter into the CPSI (electronic health record) system." During an interview with the Director of Pharmacy (DOP) on May 16, 2018, at 9:55 AM, the DOP confirmed that the "Fentanyl Transdermal Patch Order Form" was not available in the health record for Patient 1 or Patient 2. The DOP stated that they should have been filled out prior to the patients receiving fentanyl patch. The DOP also confirmed that neither patient could be classified as opiate tolerant based on the medications they received in the hospital or the information in the medical record. A review of the manufacturer's prescribing information for fentanyl patch, under the section "Contraindications", the manufacturer lists situations in which the medication should not be used. The manufacturer states, "Fentanyl transdermal system is contraindicated in: patients who are not opioid-tolerant; the management of acute or intermittent pain, or in patients who require opioid analgesia for a short period of time; the management of post-operative pain, including use after out-patient or day surgeries, (e.g., tonsillectomies)." A review of the diagnosis for admission for Patient 2 reveals that Patient 2 was post joint replacement surgery. Joint replacement surgery would be considered post-operative pain, for	E 475		

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E 475	Continued From page 8 which fentanyl patch is contraindicated. A review of the manufacturer's prescribing information for fentanyl patch, under the section "Boxed Warning (the strongest warning the FDA can place on a medication, usually reserved for when there is reasonable evidence of an association of a serious hazard with the drug)", the manufacturer states, "Life-threatening Respiratory Depression: Serious, life-threatening, or fatal respiratory depression may occur with use of fentanyl transdermal system. Monitor for respiratory depression, especially during initiation of fentanyl transdermal system or following a dose increase. Because of the risk of respiratory depression, fentanyl transdermal system is contraindicated for use as an as-needed analgesic, in non-opioid tolerant patients, in acute pain, and in postoperative pain". A review of ISMP's (the Institute for Safe Medication Practices - a nonprofit organization considered the authority on medication error prevention and safe medication use) High-Alert Medications in Acute Care Settings indicates that transdermal opioid medications (e.g. fentanyl patch) are listed and considered high risk medications. The document states, "High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating to patients".	E 475		
E 479	T22 DIV5 CH1 ART3-70263(f) Pharmaceutical Service General Requirements (f) Supplies of drugs for use in medical	E 479		

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E 479	Continued From page 9 emergencies only shall be immediately available at each nursing unit or service area as required. This Statute is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to have cold sodium chloride (a medication used to hydrate patients; commonly referred to as normal saline) available for a Malignant Hyperthermia (MH - a severe reaction that occurs to particular medications used during general anesthesia. Symptoms include muscle rigidity, high fever, and a fast heart rate). Without cold saline available during a MH emergency, a patient's temperature can reach dangerously high levels which can lead to serious patient harm or death in a universe of three patients. Findings: During a tour of the Surgery Department on May 15, 2018, at 2:20 PM, the MH emergency container was inspected. Observed to not be in the kit or a refrigerator designated to store MH contents were 3 bags of cold saline. During a concurrent interview with the Director of Pharmacy (DOP), the DOP confirmed that the hospital did not have any cold saline available for MH emergencies. During an interview with the DOP on May 16, 2018, at 9:45 AM, the DOP stated that he agreed cold saline should be part of the MH emergency container. He also stated that he had added cold saline to the refrigerator in the Surgery Department. A review of hospital policy and procedure titled	E 479	OR staff was immediately advised of new MHAUS guidelines for the addition of cooled saline to the Malignant Hyperthermia medication kit. Pharmacist will provide an in-service regarding the Malignant Hyperthermia Medication Kit at the next Nursing staff meeting. The policy titled 'Management of Patient with Malignant Hyperthermia' has been updated to state that cooled saline is stored in the OR medication refrigerator. Pharmacy and Therapeutics Committee will review 'Guidelines from the Malignant Hyperthermia Association of the United States' annually to ensure compliance with most recent recommendations. Monitoring: Pharmacist will complete medication safety rounds to ensure the proper storage of cooled saline shall be conducted monthly and reported to the Pharmacy and Therapeutics Committee for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Director of Pharmacy	5/15/18 6/22/18 6/8/18 7/12/18

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E 479	Continued From page 10 "Management of Patient with Malignant Hyperthermia (MH)", with a most recent revised date of "04/06/2016", under the section "Procedure", the policy states, "Cooling the patient is of vital importance. To reduce body temperature: Infusion of iced saline solutions ..three (3) times." References at the end of the policy include the Malignant Hyperthermia Association of the United States (MHAUS - a respected organization considered the leading authority on the treatment of MH emergencies). A review of the website for the Malignant Hyperthermia Association of the United States found at https://www.mhaus.org/healthcare-professionals/be-prepared/what-should-be-on-an-mh-cart/, MHAUS indicates the following should be stored in a MH emergency container, "Refrigerated cold saline solution - A minimum of 3,000 ml for IV cooling".	E 479		
E 480	T22 DIV5 CH1 ART3-70263(f)(1) Pharmaceutical Service General Requirements (1) Written policies and procedures establishing the contents of the supply procedures for use, restocking and sealing of the emergency drug supply shall be developed. This Statute is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure that content lists on the outside of emergency drug supply containers (commonly referred to as crash carts) accurately matched the medication contents of the carts. Without accurate and complete	E 480		

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(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
E 480	Continued From page 11 content lists matching the actual contents, medical personnel performing life-saving emergency procedures may use an incorrect dose or believe that a medication is not available when actually it is. Incorrect dosing and/or lack of knowledge on medication availability can lead to serious patient harm in a universe of three patients. Findings: During a tour of the Medical Surgical Unit on May 15, 2018, at 11:50 AM, the crash cart was inspected. A comparison of the content list on the outside of the crash cart with the actual contents of the cart revealed the following discrepancies: a. 1 vial Diphenhydramine (a medication used to treat allergic reaction) injection listed on the adult crash cart kit contents, but no diphenhydramine available in the adult kit. b. 1 vial hydrocortisone (a medication used to treat inflammation) injection listed on the adult crash cart kit contents, but no hydrocortisone available in the adult kit. c. 2 vials of verapamil (a medication used to reduce blood pressure) injection listed on the adult crash cart kit contents, but no verapamil available in the adult kit. d. 4 syringes of atropine (a medication used to treat abnormal heart rhythms) listed on the adult crash cart kit contents, but only 2 syringes available in the adult kit. Similar discrepancies were noted with the pediatric kit:	E 480	The Pharmacist has attached a list of all medications included in the Crash Cart to each cart. The Pharmacist updates the medication list with each change of medication tray. The policy titled 'Crash Cart' was updated to state that an accurate and comprehensive list of all medications and supplies included in the Crash Cart will be attached to the top of the cart. Monitoring: Medication safety rounds to ensure the proper labeling of Crash Cart medications shall be conducted monthly and reported to the Pharmacy and Therapeutics Committee for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Director of Pharmacy	5/15/18 6/8/18

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E 480	Continued From page 12 a. 2 syringes of atropine 0.5mg injection listed on the pediatric crash cart kit contents, but only 2 syringes of atropine 0.25mg, a lower dose, were available in the pediatric kit. During a concurrent interview with the Director of Pharmacy (DOP), the DOP confirmed that the content list on the outside of the crash cart did not match the actual contents of the cart. The DOP stated that the content list on the outside of the cart had not been updated. A review of an All Facilities Letter (AFL) from February 1, 2005, from the Department of Health Services to all licensed hospitals, AFL 05-02, states the following, "A content list must be posted on the outside of the portable container containing emergency medications and equipment." The AFL further states, "The content list must accurately and comprehensively reflect all medications in the cart".	E 480		
E 481	T22 DIV5 CH1 ART3-70263(f)(2) Pharmaceutical Service General Requirements (2) The emergency drug supply shall be stored in a clearly marked portable container which is sealed by the pharmacist in such a manner that a seal must be broken to gain access to the drugs. The contents of the container shall be listed on the outside cover and shall include the earliest expiration date of any drugs within. This Statute is not met as evidenced by: Based on observation and interview, the hospital failed to ensure that content lists were available on all emergency drug supply carts (commonly referred to as crash carts). Without content lists	E 481		

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E 481	Continued From page 13 posted on the outside of the containers, medical personnel performing life-saving emergency procedures may not be aware of the medications available in the crash carts. Medical personnel without knowledge of all medications in a crash cart can lead to patient harm in a universe of three patients. Findings: During a tour of the Emergency Department on May 15, 2018, at 11:15 AM, crash cart #1 was inspected It was observed that no content list was available on the outside of the container. During a concurrent interview with the Director of Pharmacy (DOP), the DOP confirmed that there was no content list available for crash cart #1. During a tour of the Emergency Department on May 15, 2018, at 2:50 PM, crash cart #2 was inspected. It was observed that no content list was available on the outside of the container. During a concurrent interview with the Director of Pharmacy (DOP), the DOP confirmed that there was no content list available for crash cart #2. A review of an All Facilities Letter (AFL) from February 1, 2005, from the Department of Health Services to all licensed hospitals, AFL 05-02, states the following, "A content list must be posted on the outside of the portable container containing emergency medications and equipment. A content list attached to a medication tray that is sealed and placed inside a movable cart doesn ' t meet the requirements of regulation".	E 481		

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E 504	Continued From page 14	E 504		
E 504	T22 DIV5 CH1 ART3-70263(q)(2) Pharmaceutical Service General Requirements (q) Labeling and storage of drugs shall be accomplished to meet the following requirements: (2) All drug labels must be legible and in compliance with state and federal requirements. This Statute is not met as evidenced by: Based on observation and interview, the hospital failed to ensure that medication was properly labeled. Without proper labeling, medication may be misidentified and used inappropriately which can lead to patient harm in a universe of three patients. Findings: During a tour of the facilities dental clinic with the Dental Assistant (DA) on May 16, 2018 at 11:52 AM, it was observed that a total of six pre-drawn syringes located inside a cabinet were not labeled with the time, name of the medication, date, and staff initials. The six pre drawn syringes contained a clear liquid substance. During a concurrent interview with the DA, stated that two of those pre-drawn syringes contained 70% isopropyl rubbing alcohol (a colorless, flammable, and water soluble liquid) used for a root canal (a dentist cleans and then seals that space inside a tooth originally occupied by it's nerve) and that the other four pre-drawn syringes contained bleach (used for whitening and during a root canal) used for a root canal. The DA also stated that they predrawn the syringes all the time and she did not know the syringes were supposed to be labeled.	E 504	Pre-filled, unlabeled syringes were immediately removed and disposed of properly. The Director of Operations for the Center for Oral Health (COH) was notified of the findings. Dental staff was advised immediately that storage of pre-drawn syringes is an unacceptable practice. The Director of Operations emailed Dental staff instructing them to never store pre-drawn syringes. Clinic staff were reminded of safe medication practices at the May 22, 2018 staff meeting. The Medication Administration-Clinic policy was revised to state 'Medications shall be prepared for immediate use'. Monitoring: Medication safety rounds to ensure the proper labeling and storage of medications shall be conducted monthly and reported to the Pharmacy and Therapeutics Committee for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance Person Responsible: Director of Pharmacy	5/16/18 5/22/18 5/8/18 6/2018-12/2018

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E 504	Continued From page 15 During an interview with the Director of Outpatient Services (DOOS) on May 16, 2018 at 12:00 PM, she stated that the dental assistants need to draw the bleach and alcohol right before administering to the patients and the syringes need to be labeled. The facility was unable to provide a policy and procedure regarding labeling medication and not to predrawn medication in syringes.	E 504		
E 508	T22 DIV5 CH1 ART3-70263(q)(6) Pharmaceutical Service General Requirements (6) Drugs shall be stored at appropriate temperatures. Refrigerator temperature shall be between 2.2oC (36oF) and 7.7oC (46oF) and room temperature shall be between 15oC (59oF) and 30oC (86oF). This Statute is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure that medications were stored at manufacturer specified temperatures. Medications that required refrigeration were stored at room temperature and medications with room temperature storage specifications were stored in the refrigerator. Not storing medications at appropriate temperatures may affect the potency or effectiveness of the medication. Less effective medication can lead to patient harm in a universe of three patients. Findings: 1. During a tour of the Emergency Department on May 15, 2018, at 11:00 AM, the medication	E 508	1. The Pharmacist immediately discarded all medication that was found to be stored out of compliance with manufacturer recommendation.	5/15/18

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E 508	Continued From page 16 storage refrigerator was inspected. Observed to be stored in the refrigerator was 1 box of 24 vials of levalbuterol (a medication used to improve breathing) 1.25 milligrams (mg) /3 milliliters (mL) inhalation solution. Also observed in the refrigerator was 1 box with 20 vials of levalbuterol 0.63mg/3mL. Lastly, approximately 15 vials of nicardipine (a medication used to reduce blood pressure) 25mg/10mL injection solution were observed to be stored in the refrigerator. During a concurrent interview with the Director of Pharmacy (DOP), the DOP confirmed that the manufacturer recommends room temperature storage. The DOP removed the medications from the refrigerator. A review of the manufacturer labeling for levalbuterol states the following for storage, "Store levalbuterol inhalation solution...in the protective foil pouch at 20° to 25°C (68° to 77°F) [see USP Controlled Room Temperature]". A review of the manufacturer labeling for nicardipine states the following for storage, "Store at 20° to 25°C (68° to 77°F) [See USP Controlled Room Temperature]." 2. During a tour of the Surgery Department on May 15, 2018, at 2:30 PM, the Pyxis (an Automated Drug Dispensing System used to store medications) machine was inspected. Observed to be stored in the Pyxis were 2 vials of Vasostrict (vasopressin - a medication used to increase blood pressure) at room temperature. There was no labeling on the vials to indicate when the vials had been removed from refrigeration. During a concurrent interview, the DOP confirmed	E 508	The policy titled 'Procurement of Pharmaceuticals' has been updated to state 'The Pharmacist is responsible for checking manufacturers guidelines for storage for all new medications and for stocking medications in compliance with stated guidelines'. The Pharmacist will provide written communication to nursing staff regarding any change to storage of medications based on manufacturer guidelines on an as needed basis. Monitoring: Medication safety rounds to ensure proper storage of medications shall be conducted monthly and reported to the Pharmacy and Therapeutics Committee for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Director of Pharmacy 2. The Pharmacist immediately labeled vasopressin storage container with expiration date (one year from date of purchase). Monitoring: Medication safety rounds to ensure the proper dating of vasopressin shall be conducted monthly and reported to the Pharmacy and Therapeutics Committee for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Director of Pharmacy	6.8.18 5/15/18

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E 508	Continued From page 17 that the medication should be stored in refrigeration or a label placed on the vial to indicate when it had been removed from refrigeration. The DOP confirmed that the vials were not labeled. A review of the manufacturer labeling for Vasostrict states, "Store between 2°C and 8°C (36°F and 46°F). Do not freeze. Vials may be held up to 12 months upon removal from refrigeration to room temperature storage conditions (20°C to 25°C [68°F to 77°F], USP Controlled Room Temperature), anytime within the labeled shelf life. Once removed from refrigeration, unopened vial should be marked to indicate the revised 12 month expiration date." A review of hospital policy and procedure titled "Drug Storage Temperatures", with a most recent approved date of "01/08/2016", under the section "Procedure", the policy states, "A. Medications will be stored at temperatures adhering to the pharmaceutical manufacturer requirements for storage." The policy also states, "B. Medications requiring room temperature storage shall be stored between 68-77 degrees F (Fahrenheit)." The policy further states, "C. Medications requiring refrigeration shall be stored between 36-46 degrees F."	E 508		
E 511	T22 DIV5 CH1 ART3-70263(q)(9) Pharmaceutical Service General Requirements (9) Drugs shall not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use. This Statute is not met as evidenced by:	E 511		

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E 511	Continued From page 18 Based on observation and interview, the hospital failed to ensure that expired and potentially contaminated or deteriorated drugs were not available for immediate patient use. Administering medications that are past the manufacturer expiration date or deteriorated may not be as effective as intended by the manufacturer or prescriber. Ineffective and contaminated medications may lead to significant patient harm in a universe of three patients. These failures occurred when: 1. Multiple injectable medications stored in an Operating Room medication cart were past the manufacturer's expiration date. 2. Thirteen providone swabsticks (is used on the skin to decrease the risk of infection) were expired. Findings: 1. During a tour of the Surgery Department on May 15, 2018, at 2:40 PM, the operating room medication cart was inspected Observed to be stored in the medication cart were numerous medications, the following which had expired. a. 2 vials of flumazenil (a medication used to reverse the effects of medications used to relax patients) with labeled manufacturer expiration dates of "3/18", indicating the medication was no longer safe to use beyond March 31, 2018. b. 3 vials of phenylephrine (a medication used to increase blood pressure) with labeled manufacturer expiration dates of "2/18", indicating the medication was no longer safe to use beyond February 28, 2018.	E 511	1. The Pharmacist immediately removed and discarded all medication that was found in the Operating Room Medication Cart BVCHD adopted a new Policy and Procedure titled "Anesthetic Cart Medications". This policy requires that medication is not stored on any anesthesia cart Anesthesia trays are stored in the medication room on the Acute unit and returned to the medication room after use Monitoring: Medication safety rounds to ensure the proper storage of anesthesia trays and medications shall be conducted monthly and reported to the Pharmacy and Therapeutics Committee for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Director of Pharmacy	5/15/18 6/1/18

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E 511	Continued From page 19 During a concurrent interview with the Director of Pharmacy (DOP), the DOP confirmed that the medication had expired and should have been discarded. During an interview with the DOP on May 16, 2018, at 9:45 AM, the DOP was asked if the hospital had a policy and procedure on storage of medications within the patient care units. The DOP stated that he did not think the hospital had such a policy. No such policy was provided to the survey team by the end of the survey. 2. During a tour of the facilities clinic medication room on May 16, 2018 at 11:34 AM, it was observed that thirteen Providone-Iodine swabsticks (is used on the skin to decrease the risk of infection) located inside a cabinet were expired on April 2018. During a concurrent interview with the Director of Outpatient Services (DOOS) confirmed that the thirteen Providone-Iodine swabstick were expired. The facility was unable to provide a policy and procedure regarding expired Iodine swabsticks.	E 511	2. The Providone-Iodine swabsticks were disposed of immediately. The Medical Assistant assigned to the Rural Health Clinic conducts monthly checks for outdates. The 'next to expire' is documented on the desk calendar as a second check. Additionally, containers are labeled/marked with expiration date. Clinic staff was reminded at the May 22, 2018 staff meeting to continue to check for outdates monthly. Staff was reminded that Providone-Iodine swabsticks have expiration dates and they also need to be monitored. Monitoring: Medication safety rounds to ensure stocked medications are in compliance with expiration dates shall be conducted monthly and reported to the Pharmacy and Therapeutics Committee for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Director of Pharmacy	5/16/18 On-going 5/22/18
E 738	T22 DIV5 CH1 ART6-70417 Basic Emergency Medical Service, Physician on All equipment and supplies necessary for life support shall be available, including but not limited to, airway control and ventilation equipment, suction devices, cardiac monitor defibrillator, pacemaker capability, apparatus to establish central venous pressure monitoring, intravenous fluids and administration devices.	E 738		

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E 738	Continued From page 20 Basic Emergency Medical Service, Physician on Duty, Equipment and Supplies This Statute is not met as evidenced by: Based on observations, interviews, and record reviews, the hospital failed to ensure the delivery of emergency services were provided in accordance with standard of practice when: 1. Instruments and supplies necessary for life support were expired. 2. The facility did not install a call light (a device used by a patient to signal his or her needs for assistance from staff) in the restroom located in the emergency department main lobby and also no call light in bed eight. These failures had the potential for patients not to receive emergency care in a timely manner, if an emergency occurred in the emergency room department which could result in accidents, injuries, and death for a universe of three patients. Findings: 1a) During an observation on May 15, 2018 at 9:00 AM, in the emergency department multipurpose room, a yellow colored cart labeled, "OB Cart" (an obstetric cart containing lifesaving supplies and equipment in the event a patient is in labor), contained the following items: A) Sterile processed instrument tray labeled "ER Delivery Instruments processed on January 18, 2018 and expiration date was on April 18, 2018.	E 738	1. All expired and compromised supplies were discarded. All Emergency Department carts were inventoried to ensure no out dates were present. Checklists and logs will be implemented to help monitor out dates in the following areas in the Emergency Department: Baby warmer, bedside carts, Ambu bags and Crash Carts. Staff was in-serviced regarding out dates in huddle notes and an in-service will be presented at the nursing staff meeting.	5/15/18 5/18/18 6/12/18 6/22/18

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E 738	Continued From page 21 B) An opened single used sterile pack, labeled "Precipitous Delivery" (emergent infant delivery). C) 3.5 French umbilical catheter tray (a device used to gain intravenous access in a newborn) lot number 122144 expiration date was August 2016 D) 3.5 French umbilical catheter tray (a device used to gain intravenous access in a newborn) lot number 122150 expiration date was August 2017. During a concurrent interview with the Emergency Department Manager (EDM), the EDM was asked if the items identified as expired are ready for use, the EDM stated, "No, we would not use those supplies that were expired." The EDM was asked who was responsible for checking for expiration dates on emergency supplies, the EDM stated, "I am responsible to ensure there were no expired items." 1b) During an observation on May 15, 2018 at 9:15 AM, in the emergency department storage room (emergency supply area) the following life support items were expired ready for patient use: A) Thirteen (13) electrocardiogram adhesive probes labeled with an expiration date March 2018. B) "Orthoglass" precut six centimeter by thirty centimeter fiberglass casting material (a device to splint injured bones) expiration date August 2015. C) "Fenem Carbon Dioxide indicator (a device used to assist in confirming lifesaving airways are properly placed) thirty millimeter internal diameter indicator," lot number 06602140606 expiration date was July 2016.	E 738	Monitoring: ED Director will review completed checklists monthly and will report findings to the Quality Improvement Committee on a quarterly basis for a period of six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Director of Emergency Services	

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E 738	Continued From page 22 D) "Orange four delivery module broselow-hinkle emergency pediatric kit" (a device used to care for infants and children in the event of a medical emergency) lot number 0000894105 expiration date was April, 2018. E) "BBG nasal aspirator" (a device used to suction an airway) lot number 1520155370 expiration date was March 21, 2018. During a concurrent interview with the EDM in the emergency department store room, the EDM was asked who was responsible for checking for expiration dates on emergency supplies in the emergency department store room, the EDM stated, "I am responsible to ensure there were no expired items in this area." 1c) During an observation on May 15, 2018 at 9:45 AM, in the Post Anesthesia Care Unit (PACU), the following emergency life support supplies in the "Emergency Cart" (an emergency cart containing lifesaving supplies and equipment in the event of a critically ill/injured patient), were expired: A) "Fenem carbon dioxide indicator," in adult intubation tray, lot number 06602141230 with an expiration date was December 2017. B) "Stat Carbon Dioxide Indicator" in the adult intubation tray, lot number 1520155370, expiration date was March 21, 2017. During a concurrent interview with the Surgery Department Manager, the (SDM) was asked who is responsible for checking for expiration dates on the emergency supplies in the PACU, the SDM stated, "I am responsible to ensure there are no expired supplies in the PACU."	E 738		

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E 738	Continued From page 23 During an observation on May 15, 2018 at 10:00 AM, in the emergency department, a cart labeled, "Emergency Cart" (an emergency cart containing lifesaving supplies and equipment in the event of a critically ill/ injured patient), contained the following: A) "BBG nasal aspirator" (a device used to suction an airway) lot number 10109 expiration date was November 2016. B) Two opened bottles of "Ultrasound Gel" missing date of first use and expiration date. During an observation on May 16, 2018 at 9:20 AM, in the laboratory storage area, twelve (12) gold top "vacutainers" (vacuum sealed tubes used for laboratory testing of bodily fluids) were identified with an expiration date April 30, 2018. During a concurrent interview with the Laboratory Manager (LM), the LM confirmed the gold top vacutainers were expired. During a review of the facility's policy and procedure "Stock Rotation"dated January 5, 2012 indicated, "...Dated items particularly must be checked by the stock clerk to ensure that the items with the earliest expiration date are issued first. The manager performed surveillance check at least once a month to verify that the rotation of stock procedure is implemented effectively..." 2. During initial tour of the emergency department with the Charge Nurse (CN 1) on May 15, 2018 at 2:16 PM, it was observed there was no call light in the restroom located in the emergency	E 738	2. A panic alarm was immediately installed in the ED waiting room bathroom. The Director of Facilities met with J Gollner Services to obtain proposal for installation of permanent call light in ED 3, bed 8.	5/15/18 6/8/18

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E 738	Continued From page 24 department main lobby. During a concurrent interview with the (CN 1), she confirmed there was no call light in the restroom located in the emergency department lobby. During a tour of the emergency department with the Emergency Department Manager (EDM) on May 15, 2018 at 2:53 PM, it was observed there was no call light located in bed eight. During a concurrent interview with the EDM, she confirmed there was no call light in bed eight. During an interview with the Director of Facilities (DOF) on May 16, 2018 at 08:14 AM, the DOF confirmed there was no call light in the restroom located in the emergency department lobby and also no call light in bed eight. The facility was unable to provide a policy and procedure regarding call lights.	E 738	Facilities Director placed a wireless door bell next to bed 8 for use until permanent call light is installed. Monitoring: Facilities Directors will report to the Safety Committee regarding the call light project. Person Responsible: Director of Facilities	6/8/18
E2105	T22 DIV5 CH1 ART7-70721(a) Employees (a) The hospital shall recruit qualified personnel and provide initial orientation of new employees, a continuing in-service training program and competent supervision designed to improve patient care and employee efficiency. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence of a current emergency room technician (works under the supervision of the registered nurse and assists with taking patients vital signs, restocking supplies, removing	E2105		

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E2105	Continued From page 25 waste material, and delivery of meals) (ERT) job description for one of ten sampled employee's. This failure had the potential to affect the health and well being in a universe of three patients. Findings: 1. During a review of the personnel file for the Emergency Room Technician (ERT 1) on May 17, 2018 at 2:07 PM indicated the ERT 1 did not have a current job description as an emergency room technician. During a review of the ERT 1 personnel file titled "Change of Status Request" indicated the ERT 1 transferred position from phlebotomist (a puncture of a vein in order to withdraw blood) to ERT, effective date on February 4, 2018. During a concurrent interview with the Human Resources Specialist (HRS), the HRS stated that there was no current job description as an ERT in the ERT 1's personnel file and that the ERT 1 should have had a signed job description as an ERT. During a review of the facility's policy and procedure "Transfers," dated November 28, 2014 indicated: "A transfer is defined as a position reassignment with or without job class change in a different department within the hospital...."	E2105	1. HR Director obtained signed job description for EPT 1. Policy titled 'Transfers' was updated to state that when a transfer has been completed, a new job description will be executed by employee, supervisor and Human Resources. Monitoring: HR will conduct personnel file audits monthly to ensure signed job description for all current job title(s) are located within the file. Results shall be reported quarterly to the Board of Directors HR Committee. Person Responsible: HR Director	5/29/18 6/8/18
E2115	T22 DIV5 CH1 ART7-70723(b)(3) Employee Health Examinations and Health Recor (b) A health examination, performed by a person lawfully authorized to perform such an examination, shall be required as a requisite for employment and must be performed within one	E2115		

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E2115	Continued From page 26 week after employment. Written examination reports, signed by the person performing the examination, shall verify that employees are able to perform assigned duties. (3) An annual tuberculosis test shall be performed on those individuals with a previously documented negative tuberculosis test. If an individual with a previously documented negative tuberculosis test has a subsequent positive tuberculosis test result, a chest X-ray shall be obtained. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence of a tuberculin skin test (a test to determine the presence of infection with tuberculosis, a bacterial infection of the lungs) (TB) annual screening for one of eight sampled physicians. This failure had the potential to spread undetected TB infection to a universe of three patients. Findings: During a review of the personnel file for the Ophthalmologist (O1) indicated the O 1 TB skin test results were documented as being negative on January 30, 2017. No current TB test was documented as being performed annually since January 30, 2017. During an interview with the Medical Staff Coordinator (MSC) on May 17, 2018 at 2:22 PM, 2017 at 1:11 PM, the MSC stated that the O 1 should have had his TB skin test done annually. During a review of the facility's policy and	E2115	Medical Staff Coordinator immediately contacted the Ophthalmologist and obtained a copy of his most recent TB skin test dated 12/2017. Monitoring: Medical Staff Coordinator will complete monthly audits of credentialing files and will report findings bi-monthly to the MEC for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Medical Staff Coordinator	5/25/18

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E2115	Continued From page 27 procedure "Tuberculosis Screening Policy and Treatment Plan," dated November 13, 2017 indicated: "Each employee shall complete a two -step purified protein derivative (a skin test that determines if you have tuberculosis) (PPD) upon initial employment, and an annual PPD thereafter..."	E2115		
E2150	T22 DIV5 CH1 ART7-70739(a) Infection Control Program (a) A written hospital infection control program for the surveillance, prevention and control of infections shall be adopted and implemented. The program shall include policies and procedures that: This Statute is not met as evidenced by: Based on observations, interviews, and record reviews, the hospital failed to ensure they had a system in place for evaluating and implementing a hospital wide infection control prevention program and failed to ensure their hospital infection control program had a system in place for the surveillance, prevention, and control of infections in a universe of three patients. These failures occurred when: 1. Eleven anesthesia circuits (used to deliver oxygen and anesthetic gases to the patient) that were inside a clear bag located in operating room two, contained a brown liquid substance. 2. In the hospital operating department one of two steam sterilizer machines (used to sterilize	E2150		

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E2150	Continued From page 28 surgical instruments) had brown stains located in the inside of the door. 3 No documented evidence that the temperatures and humidity (amount of moisture in the air) were monitored in the sterile processing department (where surgical instruments were sterilized and assembled). 4. There was no documentation that terminal cleaning (a cleaning method used in healthcare environments to control the spread of infections) was performed in the sterile processing department. 5. Sterilized instruments with hinged handles were not unlocked in the packages. 6. A staff in the clinic did not follow manufacturer guidelines on how to clean the glucometers. 7. An environmental service staff (they aid in the prevention of communicable diseases by thoroughly sanitizing the hospital) (EVS) did not follow disinfectant manufacturer guidelines regarding the drying time. Findings: 1. During a tour of the operating room number two on May 15, 2018 at 11:01 AM, it was observed brown liquid inside a clear bag where a total of twenty-four anesthesia circuits were stored. Brown stains were also observed on the ceiling tiles. Items that were stored next to the anesthesia circuits were the following: a) Seventeen adult hudson (oxygen masks) b) Eleven nasal cannula (a tube used to deliver	E2150	1. All items on storage rack directly under brown stains on ceiling were immediately discarded. Environmental culture was collected and submitted to Laboratory, final results indicated no fungus was present. 5/15/18 All surgeries were immediately cancelled. 5/15/18 Director of Facilities ensured that water damaged ceiling was removed, mold stop solution was applied for a preventative measure, new ceiling was installed. Work was completed on 6/6/18. 6/6/18 Inspector of Record submitted documentation to BVCHD of acceptable project completion as of 6/7/18. 6/7/18	

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E2150	Continued From page 29 oxygen for the patient) c) Twenty-seven adult elbow mask circuits (connector used for the delivery of oxygen to adults) d) Twenty pediatric filter elbow masks circuits (a connector used for the delivery of oxygen to children) e) Thirty-two eye guard protectors (to protect the eyes from contaminated fluids in the operating room) f) Ten slick stylet endotracheals (used to facility intubation of the patient) During a concurrent interview with the Surgery Department Manager and Infection Control (SDMIC), stated the last time they checked the sterilized equipment to make sure everything was intact was a week and a half ago. During an interview with the Director of Plant Maintenance (DOPM) on May 15, 2018 at 1:55 PM, the DOPM confirmed there were brown stains on the ceiling tile and did find stains on a beam and traced it to the area that most likely leaked during their most recent rainstrom which was two weeks ago. During a review of the facility's policy and procedure "Care of Sterile Supplies," dated June 7, 2016 indicated, "Sterile supplies are handled carefully. This care is taken to avoid dragging, sliding, crushing, bending, compressing, or otherwise compromising the sterility of the contents. Equipment or supplies shall be considered contaminated for the following reasons, outdated (if supplier has indicated date	E2150	Infection Preventionist, Director of Facilities and E/S Manager conducted thorough walk through of OR to ensure all work and terminal cleaning was completed. Monitoring: Infection Prevention rounds to ensure appropriate standards for OR supply storage are met shall be conducted monthly, findings shall be reported to the Pharmacy and Therapeutics Committee/Infection Control Committee for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Infection Preventionist	6/12/18

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E2150	Continued From page 30 of expiration on product), wrapper is damaged, and wrapper is damp or dusty..." 2. During a tour of the hospital operating department with the Operating Room Technician (ORT 1) on May 15, 2018 at 10:32 AM, one of two steam sterilizer machines (used to sterilize surgical instruments) had large amounts of brown stains inside the door of the sterilizer machine. During a concurrent interview with the ORT 1, the ORT 1 confirmed the brown stains located inside the door of the sterilizer machine. The ORT 1 also stated that they clean the inside of the chamber door by using "710" a multi-purpose disinfectant cleaner. During a review of the manufacturer IFU (information for use) manufacturer's recommendations dated June 2017, included the following:..."Steris Liqui-jet two detergent is approved cleaning solution that is specifically formulated to remove many common chamber deposits. Prepare a solution of Liqui-jet two detergent in one of the pump-up acid rated sprayer containers by diluting per the label instructions on the Liqui-jet two instrument Detergent Container. Clearly label pump-up acid-rated sprayer container with contents to prevent container mix-ups. Using a coarse spray pattern to avoid creating fine mist, evenly apply solution to inside surfaces of the sterilizer chamber, including inside surface of the door, Use a dampened lint-free cloth or soft brush attached to an extension handle to clean the chamber surface..." 3. During a review of the facility's Temperature and Humidity logs, indicated there was no proof of documentation that temperature and humidity	E2150	2. Brown stains on sterilizer were immediately cleaned. Manufacturers instructions and all associated cleaning solutions were obtained. The policy titled 'Operation of AMSCO (Steris) Sterilizer in Surgery and Central Supply' was updated to state that the sterilizer will be cleaned according to manufacturer's instructions and cleaning shall take place at a minimum of twice per year or if visibly soiled. Monitoring: Infection Prevention rounds to ensure proper cleaning of sterilizer shall be conducted monthly, findings shall be reported to the Pharmacy and Therapeutics Committee/Infection Control Committee for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Infection Preventionist 3. Monitoring of temperature and humidity has been implemented in the sterile processing department. A log has been placed in the department and staff monitors temperature and humidity each day that the department is open.	5/15/18 6/8/18 5/18/18 5/18/18

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E2150	Continued From page 31 was done in sterile processing department. During an with the Director of Plant Operations (DOPO) on May 15, 2018 at 9:40 AM, the DOPO confirmed they do not monitor temperatures and humidity in the sterile processing department. According to the CDC "Healthcare Infection Control Practices Advisory Committee Guideline for Disinfection and Sterilization in Healthcare Facilities", "...the sterile storage area should have controlled temperatures and may be as high as 75 degrees Fahrenheit and the relative humidity should be 30% to 60% in all work area except sterile storage, where the relative humidity should not exceed 70%." 4. During a review of the environmental service terminal cleaning logs, indicated there was no proof of documentation that terminal cleaning was done in the sterile processing department. During an interview with the Manager of Environmental Services (MOES) on May 17, 2018 at 8:05 AM, the MOES confirmed they do not have documentation that terminal cleaning was done in the sterile processing department. AORN, one of the nationally recognized infection control guidelines the hospital followed, defines terminal cleaning as "thorough environmental cleaning that is performed at the end of each day when the area is being used." Both AORN and AAMI (Association for the Advancement of Medical Instrumentation) ST79 recommend that sterile processing be terminally cleaned the same as the operating, delivery, and invasive procedure rooms. AAMI ST79 (Section 3.4) states that the best practice is to provide separate housekeeping	E2150	The policy titled 'Humidity and Temperature Control' was updated to state that BVCHD will follow the ANSI/ASHRAE/ASHE Standard 170-2013 for recommended parameters for temperature and RH. Monitoring: Infection Prevention rounds to ensure temperature and humidity monitoring of sterile processing shall be conducted monthly, findings shall be reported to the Pharmacy and Therapeutics Committee/Infection Control Committee for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Infection Preventionist	6/8/18
			4. A new policy was created titled 'Terminal Cleans in Decontamination' to state that sterile processing staff will complete a terminal clean following processing of instruments.	6/8/18
			A Terminal cleaning book was implemented to document that the Sterile Processing Department (Sterile processing, decontemination room) was cleaned on all days used.	6/1/18
			An in-service will be held for EVS and OR staff to review terminal clean policies. Monitoring: Infection Prevention rounds to ensure completion of terminal cleans in decontamination shall be conducted monthly, findings shall be reported to the Pharmacy and Therapeutics Committee/Infection Control Committee for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Infection Preventionist	6/12/18

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E2150	Continued From page 32 facilities for the decontamination and clean areas to avoid transferring contaminates from dirty to clean" areas." 5. During a tour of the facility's clinic medication room on May 16, 2018 at 10:48, it was observed that two ring forceps with hinged handles were noted to be in a locked position, in its packaging. During a concurrent interview with the Director of Outpatient Services (DOOS), the DOOS confirmed that two ring forceps should be in a unlocked position. During a review of the facility's policy and procedure "Care of Sterile Supplies," dated June 7, 2016 indicated,"Sterile supplies are handled carefully. This care is taken to avoid dragging, sliding, crushing, bending, compressing, or otherwise compromising the sterility of the contents. Equipment or supplies shall be considered contaminated for the following reasons, If in doubt as to the condition or contents of tray or wrap..." According to AAMI (Association for the Advancement of Medical Instrumentation - an organization for advancing the development, and safe and effective use of medical technology) - "Comprehensive Guide to Steam Sterilization and Sterility Assurance in Health Care Facilities", CDC (Centers for Disease Control) Guidelines, and AORN (Association of perioperative Registered Nurses - leaders in advocating for excellence in perioperative practice and healthcare) guidelines, their recommendations, stipulated the following: "Instruments should undergo an inspection for proper function and cleanliness.	E2150	5. All instruments found to be in the closed position were immediately removed from service and preprocessed according to proper sterilization procedures. Sterile processing staff performed an in-service to all ED, OR and Clinic staff regarding proper handling and storage of sterilized equipment. Instrument protectors were ordered and are now being utilized to ensure that instruments remain in the open position during sterilization and storage. Policy titled 'Care of Sterile Supplies- Surgery' was updated to state that equipment and/or supplies shall be considered contaminated if the instruments is found to be in the closed position. Monitoring: Infection Prevention rounds to ensure proper sterilization and storage of instruments shall be conducted monthly, findings shall be reported to the Pharmacy and Therapeutics Committee/Infection Control Committee for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Infection Preventionist	5/16/18 5/16/18 6/7/18 6/8/18

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E2150	Continued From page 33 Instruments should be inspected for a) cleanliness b) proper functioning and alignment, corrosion, pitting, burrs, nick, and cracks, sharpness of cutting edges c) any other defects. Instruments in disrepair should be labeled and taken out of service until properly repaired or replaced ..." 6. During an interview with the Registered Nurse (RN 1) on May 16, 2018 at 10:49 AM, the RN 1 was asked how does she disinfect the glucometer, the RN 1 stated, "I clean the glucometer by using alcohol." During a review of the manufacturer IFU (information for use) manufacturer's recommendations undated included the following:.."clean meter after each use, use only clorox bleach wipes, make sure wipe is damp, not dripping, wipe top, bottom, left, and right sides of meter. Wipe three times horizontally then three times vertically. Keep meter wet for one minute. Allow meter to dry for one minute..." 7. During an interview with the Environmental Service Staff (EVS 1) on May 17, 2018 at 8:14 AM, the EVS 1 was aked what is the multipurpose disinfectant cleaner dry time, the EVS 1 stated "three to five minutes." During a review of the manufacturer IFU (information for use) manufacturer's recommendations undated included the following:.."Apply solution with a mop, cloth, sponge, hand pump trigger sprayer or low pressure coarse sprayer so as to wet all surfaces thoroughly. Allow to remain wet for ten minutes then remove excess liquid..."	E2150	6. Clinic RN was remediated immediately regarding manufacturer's guidelines for cleaning the glucometer. The manufacturer's guidelines for cleaning were immediately posted near the glucometer docking station at the Family Health Center. Clinic staff were educated regarding the proper cleaning technique for the glucometer at the May 22, 2018 staff meeting. Clinical staff are required to complete annual competencies for glucometer use. Training is conducted by the Director of Laboratory Services. MONITORING: Infection Prevention rounds to ensure proper cleaning of glucometers shall be conducted monthly, findings shall be reported to the Pharmacy and Therapeutics Committee/Infection Control Committee for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. PERSON RESPONSIBLE: Infection Preventionist 7. Immediate remediation was conducted with EVS 1. EVS department held an annual training on ad a Department meeting 1/7/18, which included a comprehensive training on chemicals used in the facility. A representative from Waxie is scheduled to conduct an in-service for EVS staff regarding appropriate product use. Infection Preventionist will conduct an in-service for EVS staff on 6/12/18 to review appropriate dwell times according to manufacturer recommendations for cleaning products used by EVS. Monitoring: Infection Prevention rounds to ensure proper use of cleaning products shall be conducted monthly, findings shall be reported to the Pharmacy and Therapeutics Committee/Infection Control Committee for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Infection Preventionist	5/16/18 5/22/18 On-going 5/17/18 1/7/18 8/1/18 6/12/18

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E2278	Continued From page 34	E2278		
E2278	T22 DIV5 CH1 ART8-70805 Space Conversion Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of the Department. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to treat emergency department patients in a designated licensed care area. This failure had the potential for patients not to receive treatment in a safe environment in a universe of three patients. Findings: During an observation on May 15, 2018 at 3:08 PM, a room designated as an emergency department multipurpose room housed four patient care bays within the room designated as "Fast-track." with signage indicated bed nine, ten, 11, and 12 will be closed as a patient care area until the facility obtained written approval by the department of public health." During record review, the emergency department patient log indicated fifty-four patients were treated in one of four care areas, designated as "Fast Track nine, ten eleven, and twelve," from March 16, 2018 to May 15, 2018. The facility was unable to provide a policy and procedure regarding spaced approved for specific uses.	E2278	BVCHD immediately submitted a Program Flexibility request to CDPH on 5/16/18 requesting permission to utilize the Multipurpose Room for periods of ED surge and increased census. The Multipurpose Room was immediately returned to a storage room and patient chairs relocated to the hallway for purposes of treating ED patients during surge hours The policy titled "Surge Beds in Hallway During Increased Census" will be reviewed at the nursing staff meeting Monitoring: Chart audits to ensure the proper use of surge beds shall be conducted monthly and reported to the Quality Improvement Committee on a quarterly basis for six (6) months at which time the indicator shall be evaluated for change, continuance or discontinuance. Person Responsible: Director of Emergency Services	5/16/18 5/15/18 6/22/18

DHCS
JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

MAY 31 2018

Sheri Mursick, Director of Outpatient Services
41820 Garstin Drive
Big Bear Lake, CA 92315

PROVIDER NAME:	Bear Valley Community Healthcare District dba Family Health Center RHC
PROVIDER NUMBER(S):	1851576888
CASE NUMBER:	P-1851576888-01001-221-01
AUDIT PERIOD:	October 1, 2016 to September 30, 2017

Dear Ms. Mursick:

The Department of Health Care Services (DHCS) conducted an unannounced audit of your Medi-Cal practice on January 18, 2018. This review was conducted in accordance with Welfare and Institutions Code, sections 14124.2 and 14133, and California Code of Regulations (CCR), Title 22, sections 51452 and 51476. In conducting this audit, the auditors compared patient medical records relating to your Medi-Cal practice with paid claims information supplied by the fiscal intermediary. The purpose of the review was to ensure that appropriate Medi-Cal guidelines and requirements as outlined in California Code of Regulations, Title 22, the physician's Current Procedural Terminology, and the Medi-Cal Providers' Manual/Updates are being followed.

Review of medical records found limited or poor documentation of patient encounter on medical visits. This is not in compliance with CCR, Title 22, section 51476.

In order to participate in the Medi-Cal Program, CCR, Title 22, section 51483, Provider Requirements states that a Medi-Cal provider must comply with Medi-Cal regulations. You are expected to correct the deficiency identified in this letter.

Your billing practices may be monitored and a subsequent audit may follow to determine whether you are in compliance with the Medi-Cal regulations. The follow-up review may include services not reviewed in the previous audit. Failure to correct the problems identified in this letter and any findings of continued improper billing practices may result in imposing a Post-service, Prepayment Audit and/or an Audit for Recovery of Overpayment.

If you have any questions concerning this matter, please contact Leilani Reyes, Unit Manager, at (909)390-1496.

Sincerely,

Percival Carungay, Chief
Medical Review Section – South IV
Audits and Investigations
Department of Health Care Services

Via GSO mail

QHR Compliance Newsletter

QHR TEAM NEWS

(In case you missed it)

At QHR, our Compliance Practice is committed to helping you succeed by providing resources necessary for enhancing your infrastructure and protecting your organization.

We're happy to announce a new resource available to you for inquiries and key event reporting. We encourage you to utilize the email below to contact us with any compliance related questions or concerns you may have in addition to reporting potential key events.

(Refer to Operating Practice #15 for details on what is considered a Key Event)

CompliancePractice@qhr.com

INCENTIVIZING YOUR COMPLIANCE PROGRAM

"Incentives help drive behavior!"

Most of us focus all of our incentivizing attention around National Compliance & Ethics Week which is traditionally held in November of each year. Why not weave incentives into your annual compliance plan? While we don't want to incentive people for doing their jobs, we do want to reward behavior that sets examples for other people to follow.

A good example is annual compliance training. You assign the deadline; everyone knows the deadline, as well as, the discipline for not completing the training by the deadline. Why not incentive a select number of people who are the first to complete the training; this can set the stage and help drive future behavior. If you currently offer incentives as part of your program, we would love to hear about it! Email us at CompliancePractice@qhr.com

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COMPLIANCE NEWS

"Livingston Regional Hospital, LLC Agrees To Settle False Claims Act Allegations"

Click Here to read the full article

"Signature HealthCARE to Pay More Than $30 Million to Resolve False Claims Act Allegations Related to Rehabilitation Therapy"

Click Here to read the full article

"Healogics Agrees to Pay Up to $22.51 Million to Settle False Claims Act Liability for Improper Billing of Hyperbaric Oxygen Therapy"

Click Here to read the full article

"Caris Agrees to Pay $8.5 Million to Settle False Claims Act Lawsuit Alleging That It Billed for Ineligible Hospice Patients"

Click Here to read the full article

QHR Compliance Newsletter

OIG WORKPLAN UPDATES

https://oig.hhs.gov/reports-and-publications/workplan/updates.asp

> Review of Home Health Claims for Services With 5 to 10 Skilled Visits
> Medicare Part B Payments for End-State Renal Disease Dialysis Services
> Accountable Care Organizations' Strategies Aimed at Reducing Spending and Improving Quality
> Medicare Payments Made Outside of the Hospice Benefit
> Prescription Opioid Drug Abuse and Misuse Prevention – Prescription Drug Monitoring Programs
> Specialty Drug Pricing and Reimbursement in Medicaid

EDUCATION & TRAINING

QHR COMPLIANCE HOT TOPICS WEBINARS

February 15th	Compliance Risk Assessment
April 12th	Professional Development of the Compliance Officer
June 14th	Section 1557
August 16th	**Compliance Case Studies**
October 18th	Compliance & Risk Management Synergies
December 13th	Compliance Year in Review

Each webinar offers 1 CEU. **CLICK HERE** to register today!

[SAVE THE DATE] November 6 - 7, 2018

QUORUM ANNUAL COMPLIANCE CONFERENCE

Brentwood, TN

Click Here to learn more and register!

QHR hospital compliance professionals and industry thought leaders come together in this intensive compliance conference to help you master compliance issues and how to mitigate risk. You will leave this course with (14) of your required face to face CEU's in addition to answers to your most pressing compliance questions, best practices, tools and techniques to help you run an effective compliance program in your hospital.

QHR Compliance Newsletter

"What Would You Do?"

Where did the issues lie and what corrective action should be taken?

(June)

A staff member of a medical practice discussed HIV testing procedures with a patient in the waiting room, thereby disclosing PHI to several other individuals. Also, computer screens displaying patient information were easily visible to patients. Among other corrective actions to resolve the specific issues in the case, OCR required the provider to develop and implement policies and procedures regarding appropriate administrative and physical safeguards related to the communication of PHI. The practice trained all staff on the newly developed policies and procedures. In addition, OCR required the practice to reposition its computer monitors to prevent patients from viewing information on the screens, and the practice installed computer monitor privacy screens to prevent impermissible disclosures.

(Issue: Impermissible Uses and Disclosures)
https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/examples/all-cases/index.html

Contact Information:

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Stacey_Donegan@QuorumHealth.com

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Manager, Compliance
660.748.8268
Thagan@qhr.com

Michele Bear
Senior Consultant, Compliance
904.576.4166
Mbear@qhr.com

Compliance Practice
CompliancePractice@qhr.com

Quorum Board Minutes

Addressing Changes in the Healthcare Landscape

Innovation Needed in Non-Urban Markets

June 2018

Recent reports on health systems and hospitals in non-urban markets shine a light on the financial struggles facing so many organizations. According to the National Rural Hospital Association (NRHA), the percentage of rural hospitals operating at a loss ticked up from 41 to 44 percent just in the past year. Further, a new report from *Protect Our Care* and *Rural Forward*, found that of the 84 rural hospitals that have closed since 2010, 74 were in states that hadn't yet opted into the ACA's Medicaid expansion, stressing their margins."

Keeping the status quo is no longer an option for viability. Health systems nationwide must transform to meet community needs in today's healthcare environment. With rising rural hospital closures and deep financial burden, it's more important than ever for health systems to rebalance their cost structure.

Decreased inpatient admissions and declining Medicaid reimbursement are at the heart of the challenges health systems in non-urban markets are up against. Unable to adjust to these changes quickly, due to organizational roadblocks or lack of resources, many hospitals feel forced to consider strategic changes, closure or acquisition by a larger system. But several options exist for providers that are looking to preserve their independence and achieve sustainability. One option is to employ cost rebalancing strategies to improve their financial sustainability. Cost rebalancing, in this case, is defined as maximizing the benefit of organizational expenditures through reduction of variation. Improving efficiencies in this way can be achieved through two distinct approaches:

- Making sure patients are treated in the right setting of care, with the right clinical workforce and supply chain resources; and
- Prioritizing capital expenditure to achieve improved financial performance.

To do this, hospitals must think about the following four imperatives to rebalance the cost structure:

1. **Establish Strategic Direction:** By analyzing service lines, patient demographic trends, market share, and projected inpatient/outpatient needs, your organization can more easily focus on service lines that are aligned with the health needs of your community, while also being financially sustainable for your organization.

2. **Adjust to New Payment Models:** Today's hospitals must be focused on achieving the Triple Aim- increase quality, improve customer experience, and reduce costs.

(Continued)

3. **Assess your Debt Structure:** Determining whether your organization has sufficient capital is absolutely vital to assess organizational priorities for growth opportunities, such as facility, technology or service improvements.

4. **Conduct a Service Line Analysis:** Perform service line analyses for each of your organization's key services to understand their impact on your bottom line.

And according to the NRHA, this innovative spirit is essential for hospitals to survive in non-urban markets:

> **Innovation is essential to sustaining providers of care in rural communities, and as the single largest payer for rural care; Medicare has been the primary driver of innovation. However, from the program's inception in 1965, the vicious cycle of Medicare payment policy has forced rural hospitals to find creative solutions to keep operating.**

By taking steps to gather data about the costs associated with the continuum of care of your organization, and by using a systematic process to assess and improve upon the pockets of elevated costs within that system of care, your organization can make significant headway towards both sustainability and independence. Talk to your regional vice president about how we can help you rebalance your cost structure.

Heard in the News

Read more about the topics discussed above:

https://www.ruralhealthweb.org/blogs/ruralhealthvoices/june-2018/nrha-on-rural-health-innovation

http://www.modernhealthcare.com/article/20180609/NEWS/306099953

http://www.modernhealthcare.com/indepth/rural-providers-struggle-population-health-management/

http://www.modernhealthcare.com/indepth/rural-hospitals-look-for-help-to-survive/

http://www.modernhealthcare.com/indepth/arizona-hospital-shows-path-for-saving-rural-healthcare-policy-changes-needed/

https://www.politico.com/newsletters/politico-pulse/2018/06/14/inside-juuls-washington-strategy-250683

Save the Date

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT
FOUNDATION

Cordially invites you to save the date for the

Second Annual Helen Walsh Humanitarian Award honoring

the Bremers

Please join us on August 26th, 2018 from 3 P.M. to 6 P.M. as we honor Carol & the late Don Bremer

This celebration will bring together friends and families of the **BVCHD Foundation, the Hosptal, Rotary, Doves, Soroptimist, AAUW, The Corvette Club, Friends of the Library, Historical Society Museum, Mountain Top Strings, Community Members** and many other groups and organizations, as we "CELEBRATE" the marvelous involvement, commitment, and support that both *Don and Carol Bremer* contributed to the betterment of the Big Bear Valley!!!

To receive your formal invitations, please email the Foundation at **BVHospfoundation@gmail.com** by June 30th with a current mailing and email address of friends of the Bremers. A formal invitation will follow with event details, location and cost. Reservations and limited seating!

*Event table sponsorships available for $100. Contact Ron Peavy at pvbbl@charter.net

You are receiving this message because you are someone special to the Bremers, we need YOUR help by forwarding this on to people in your social circle, who would also like to applaud the Bremers. Please forward this "Save the Date" information on to anyone you think would be interested in celebrating Carol and Don!

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

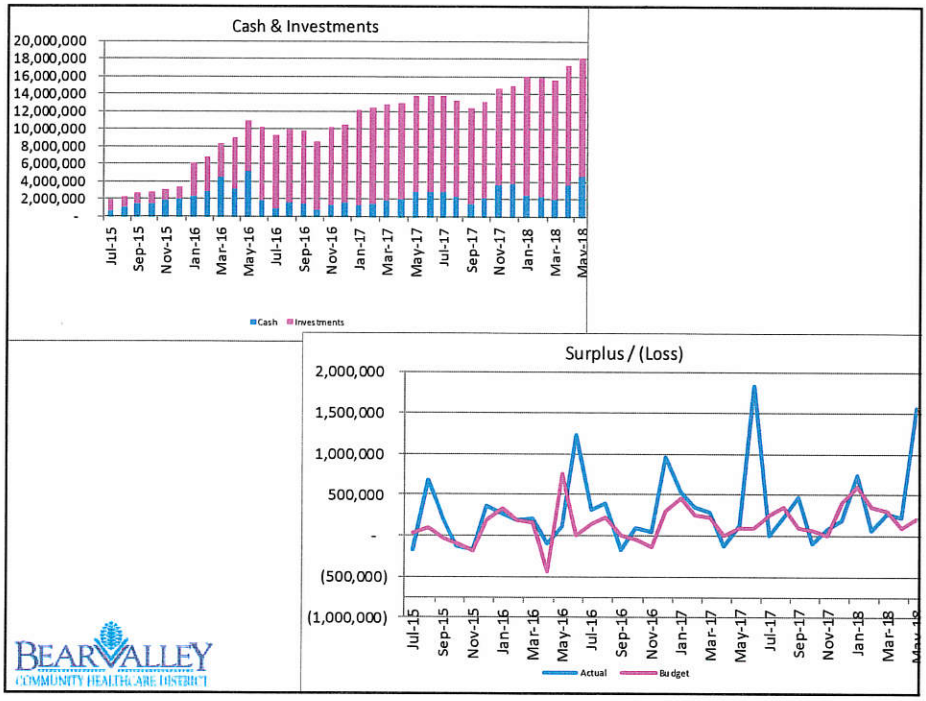
Finance Report

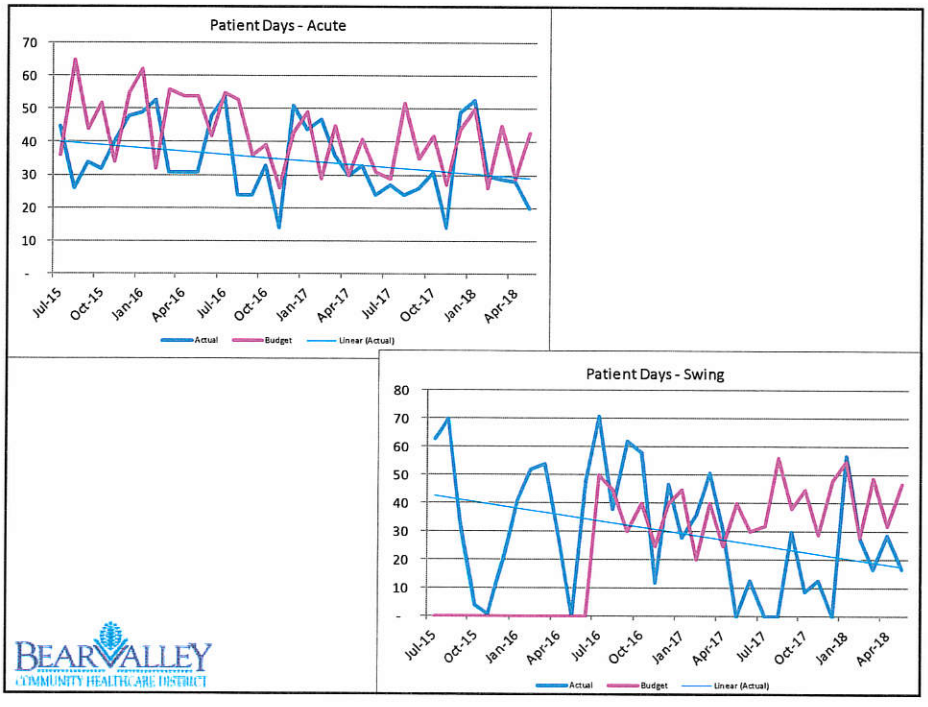
May 2018 Results

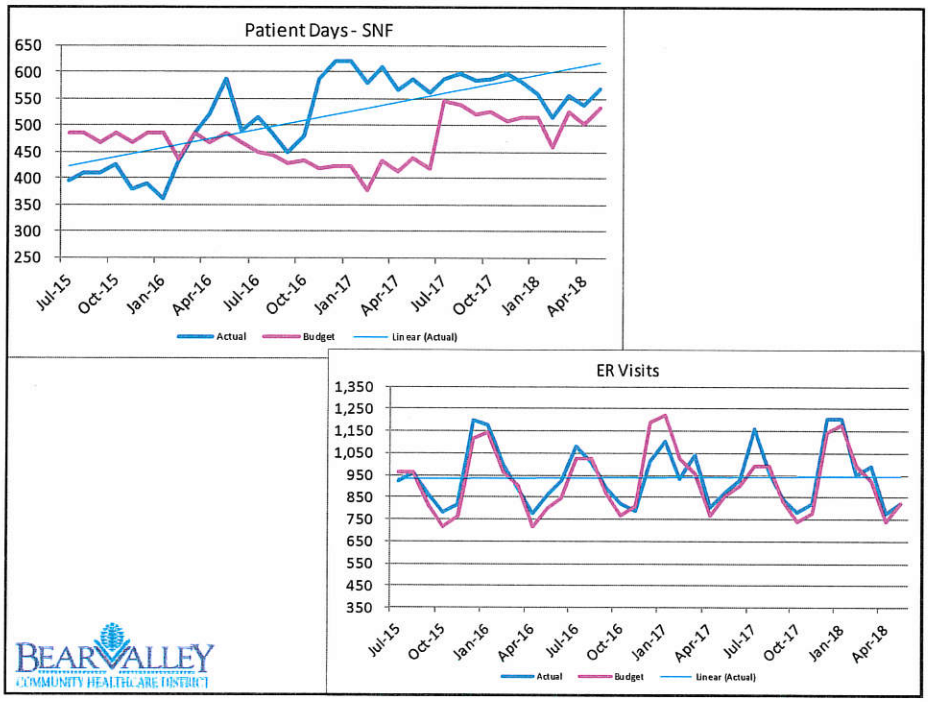
Summary for May 2018

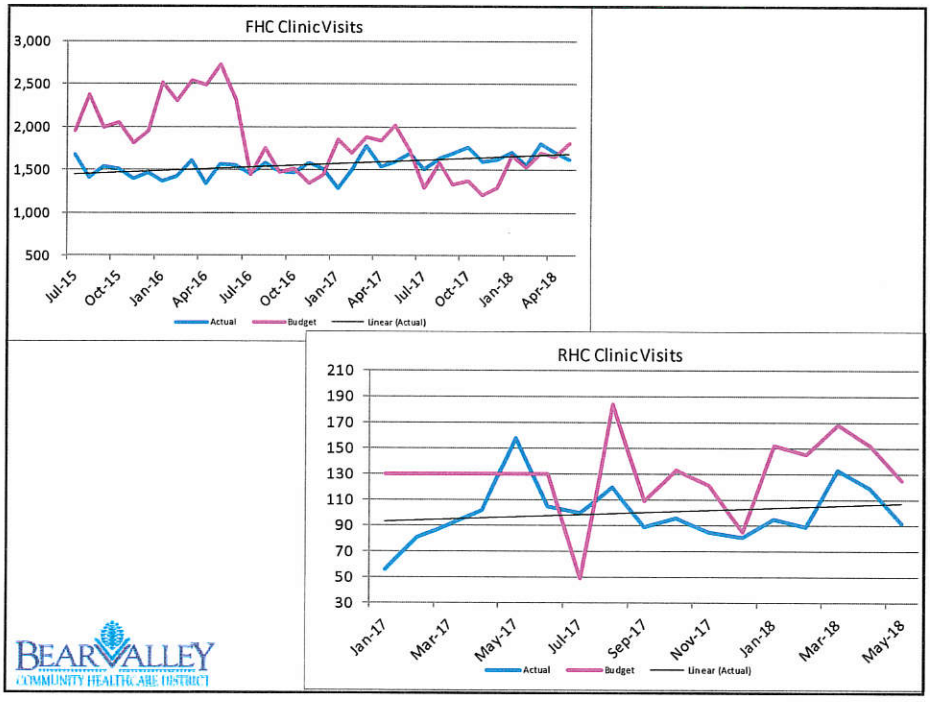
- Cash on Hand - $4,630,363
  Investments - $13,497,614
- Days Cash on hand, including investments with LAIF – 286
- Surplus of $1,567,604,for the month compared to budgeted surplus of $199,687 (we received some prior year Medi-Cal adjustments)
- Total Patient Revenue under Budget by 9.1% for the month
- Net Patient Revenue was 77.7% over budget.
- Total Expenses 6.1% more than budget

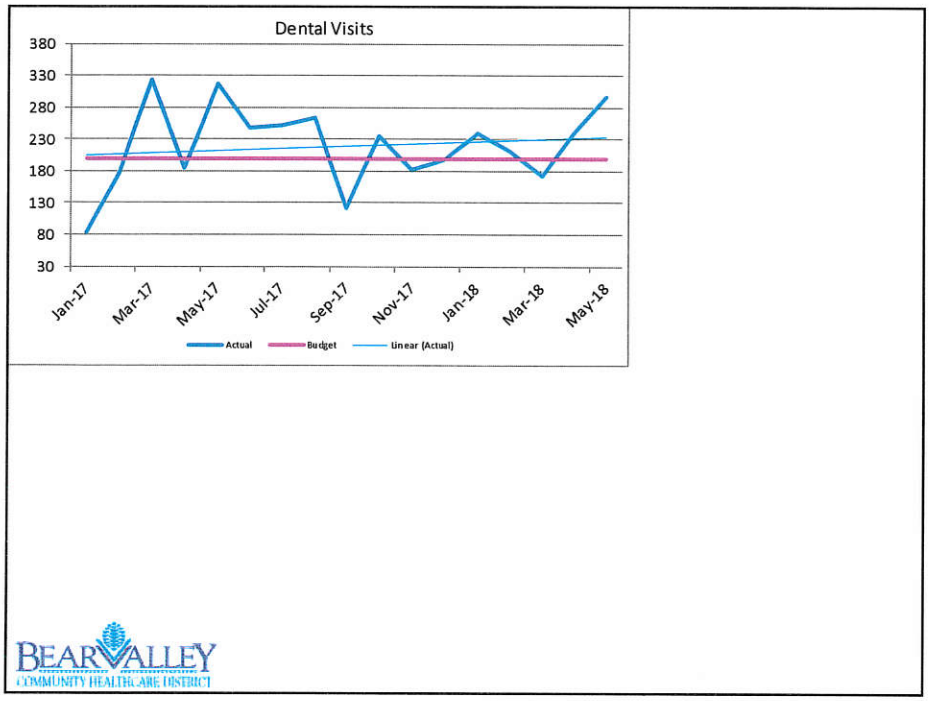
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

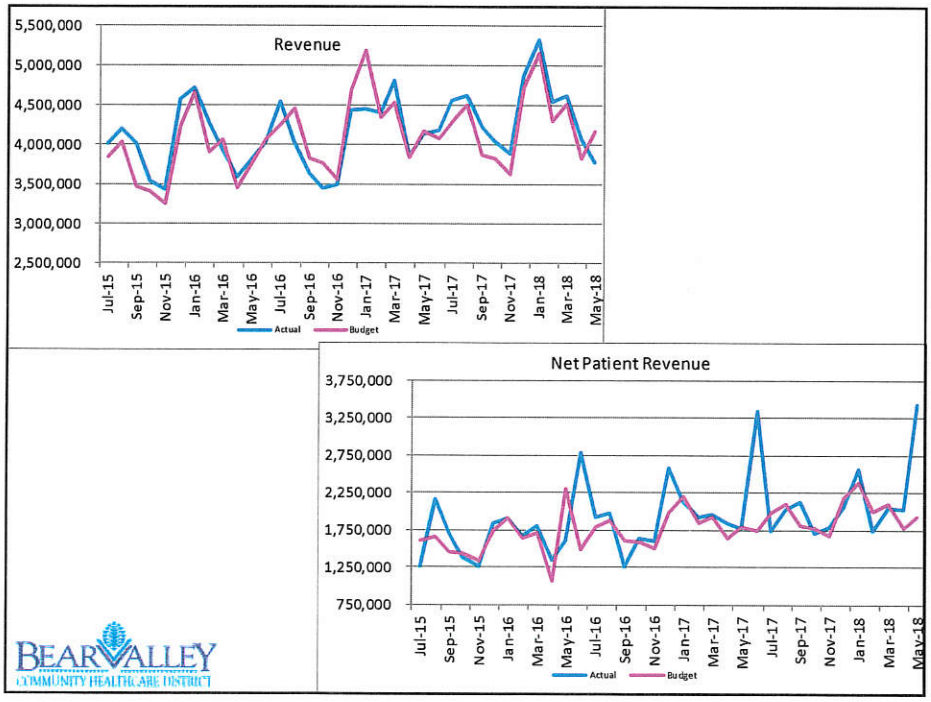

Cash & Investments
20,000,000
18,000,000
16,000,000
14,000,000
12,000,000
10,000,000
8,000,000
6,000,000
4,000,000
2,000,000
-
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Cash
Investments
Surplus / (Loss)
2,000,000
1,500,000
1,000,000
500,000
-
(500,000)
(1,000,000)
Actual
Budget
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

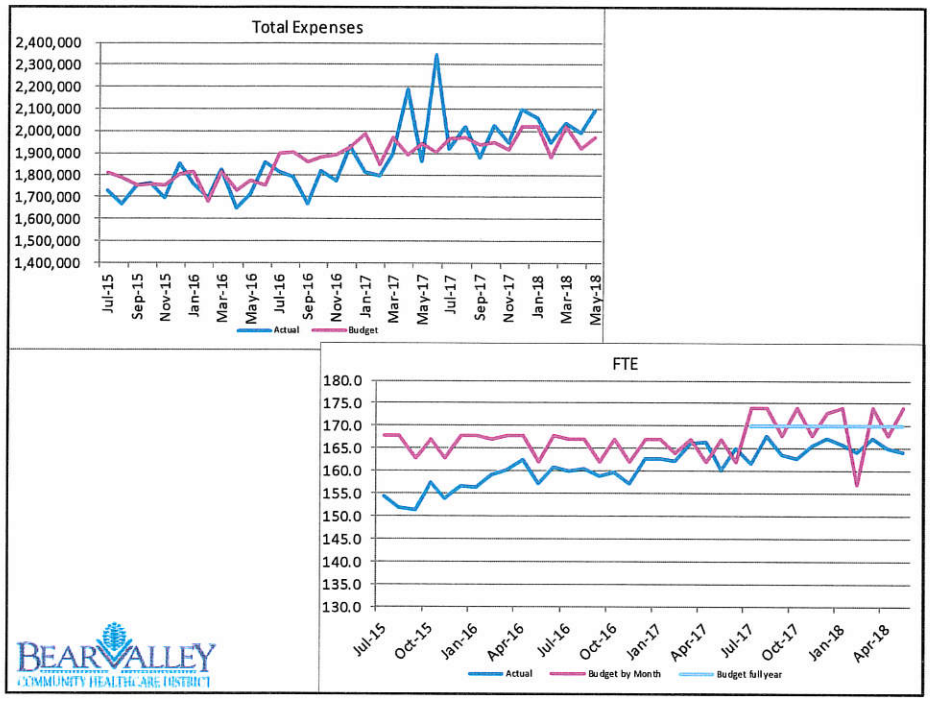

Patient Days - Acute
70
60
50
40
30
20
10
-
Jul-15
Oct-15
Jan-16
Apr-16
Jul-16
Oct-16
Jan-17
Apr-17
Jul-17
Oct-17
Jan-18
Apr-18
Actual
Budget
Linear (Actual)
Patient Days - Swing
80
70
60
50
40
30
20
10
-
Jul-15
Oct-15
Jan-16
Apr-16
Jul-16
Oct-16
Jan-17
Apr-17
Jul-17
Oct-17
Jan-18
Apr-18
Actual
Budget
Linear (Actual)
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

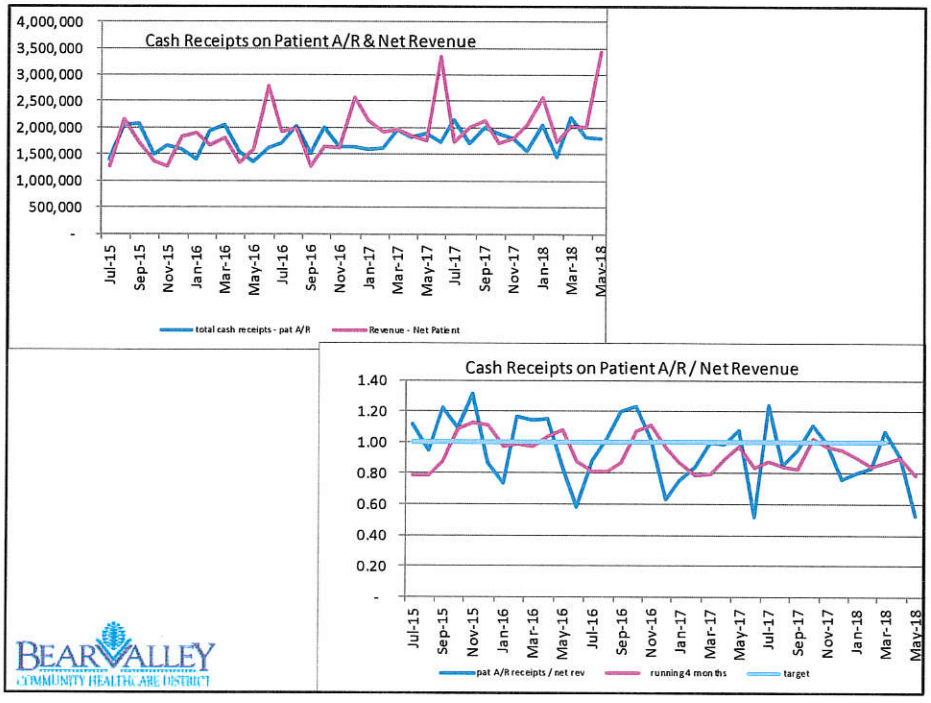

Patient Days - SNF
650
600
550
500
450
400
350
300
250
Jul-15
Oct-15
Jan-16
Apr-16
Jul-16
Oct-16
Jan-17
Apr-17
Jul-17
Oct-17
Jan-18
Apr-18
Actual
Budget
Linear (Actual)
ER Visits
1,350
1,250
1,150
1,050
950
850
750
650
550
450
350
Jul-15
Oct-15
Jan-16
Apr-16
Jul-16
Oct-16
Jan-17
Apr-17
Jul-17
Oct-17
Jan-18
Apr-18
Actual
Budget
Linear (Actual)
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

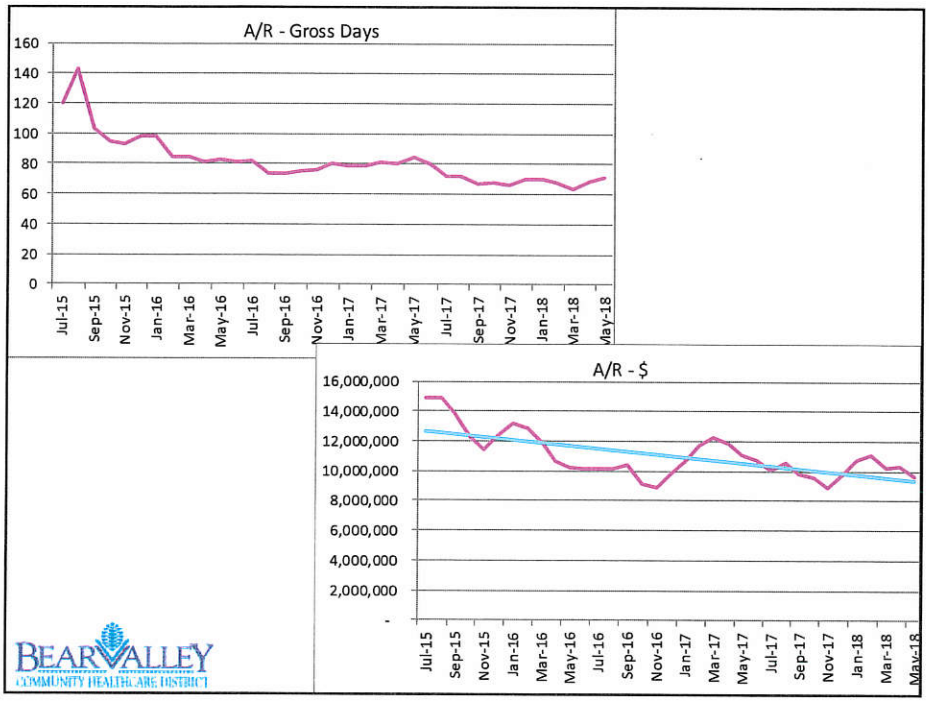

FHC Clinic Visits
3,000
2,500
2,000
1,500
1,000
500
Jul-15
Oct-15
Jan-16
Apr-16
Jul-16
Oct-16
Jan-17
Apr-17
Jul-17
Oct-17
Jan-18
Apr-18
Actual
Budget
Linear (Actual)
RHC Clinic Visits
210
190
170
150
130
110
90
70
50
30
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Actual
Budget
Linear (Actual)
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT


Dental Visits
380
330
280
230
180
130
80
30
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Actual
Budget
Linear (Actual)
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT


Revenue
5,500,000
5,000,000
4,500,000
4,000,000
3,500,000
3,000,000
2,500,000
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Actual
Budget
Net Patient Revenue
3,750,000
3,250,000
2,750,000
2,250,000
1,750,000
1,250,000
750,000
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Actual
Budget
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT


Total Expenses
2,400,000
2,300,000
2,200,000
2,100,000
2,000,000
1,900,000
1,800,000
1,700,000
1,600,000
1,500,000
1,400,000
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Actual
Budget
FTE
180.0
175.0
170.0
165.0
160.0
155.0
150.0
145.0
140.0
135.0
130.0
Jul-15
Oct-15
Jan-16
Apr-16
Jul-16
Oct-16
Jan-17
Apr-17
Jul-17
Oct-17
Jan-18
Apr-18
Actual
Budget by Month
Budget full year
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT


4,000,000
3,500,000
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
500,000
-
Cash Receipts on Patient A/R & Net Revenue
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
total cash receipts - pat A/R
Revenue - Net Patient
Cash Receipts on Patient A/R / Net Revenue
1.40
1.20
1.00
0.80
0.60
0.40
0.20
-
pat A/R receipts / net rev
running4 months
target
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT


A/R - Gross Days
160
140
120
100
80
60
40
20
0
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
A/R - $
16,000,000
14,000,000
12,000,000
10,000,000
8,000,000
6,000,000
4,000,000
2,000,000
-
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

May 2018 Financial Results

For the month . . .

Total Patient Revenue of $3,782,145 for May was 9.1% under budget. Clinic and SNF revenue for both over budget (clinic revenue by 39%). Inpatient, Outpatient, and Emergency Department were all under budget.

Deductions from Revenue of $344,925 were 84.5% lower than budgeted. In May we recorded significant reductions in contractual allowances for prior years as a result of retroactive payments for Medi-Cal - for FY 2014, FY 2015, and FY 2016.

As a result, total operating revenue was $1,486,668 over budget.

Total Expenses of $2,091,802 were 6.1% higher than budget. Much of this variance shows up in Purchased Services - higher volume in the Dental Clinic resulted in higher payments to the Center for Oral Health, we continue to incur expenses for a contract Interim Director of Nursing for SNF.

Our Surplus for the month of May 2018 was $1,567,604, this was $1,367,917 over budget. It brings our surplus year to date to nearly $1 million over budget.

Our Operating Cash and Investments total $18,127,977 as of the end of May. Total days cash on hand as of the end of May 2018 are 286.

Key Statistics

Acute patient days of 20 for the month were 47% of the budgeted amount. Swing Patient days of 17 were only 36% of the budgeted number. Patient days on SNF days totaled 571 which was 7% over budget. Emergency Room visits of 824 or within one of budget.

Through the first ten months of our Fiscal Year . . .

Patient revenue is 3.9% over budget, total revenue deductions are now 0.9% more than budget. Net Patient Revenue is 7.2% more than budget. Total expenses are 2.1% higher than budget, and our surplus of $3,735,885 is $978,270 higher than budget.

Acute and Swing patient days continue significantly lower than budgeted. SNF days are 10% over budget. ER Visits are 4.1% over budget. FTE continue to be under budget.

Bear Valley Community Healthcare District
Financial Statements May 31, 2018

Financial Highlights—Hospital

STATEMENT OF OPERATIONS

		A	B	C	D	E	F	G	H	I	J
		Current Month					Year-to-Date				
		FY 16/17	FY 17/18		VARIANCE		FY 16/17	FY 17/18		VARIANCE	
		Actual	Actual	Budget	Amount	%	Actual	Actual	Budget	Amount	%
1	Total patient revenue	4,136,519	3,782,142	4,162,373	(380,231)	-9.1%	45,260,154	48,572,586	46,763,603	1,808,983	3.9%
2	Total revenue deductions	2,367,036	344,925	2,228,396	(1,883,471)	-84.5%	24,593,509	25,271,184	25,035,685	235,499	0.9%
3	% Deductions	57%	9%	54%			54%	52%	54%		
4	Net Patient Revenue	1,769,483	3,437,217	1,933,977	1,503,240	77.7%	20,666,645	23,301,402	21,727,918	1,573,484	7.2%
5	% Net to Gross	43%	91%	46%			46%	48%	46%		
6	Other Revenue	27,638	35,409	51,981	(16,572)	-31.9%	299,070	338,293	569,406	(231,113)	-40.6%
7	Total Operating Revenue	1,797,121	3,472,626	1,985,958	1,486,668	74.9%	20,965,715	23,639,694	22,297,324	1,342,370	6.0%
8	Total Expenses	1,855,765	2,091,802	1,972,018	119,784	6.1%	20,277,366	22,041,209	21,582,926	458,283	2.1%
9	% Expenses	45%	55%	47%			45%	45%	46%		
10	Surplus (Loss) from Operations	(58,644)	1,380,824	13,940	1,366,884	-9805.5%	688,349	1,598,485	714,398	884,087	-123.8%
11	% Operating margin	-1%	37%	0%			2%	3%	2%		
12	Total Non-operating	187,770	186,780	185,747	1,033	0.6%	2,146,940	2,137,400	2,043,217	94,183	4.6%
13	Surplus/(Loss)	129,126	1,567,604	199,687	1,367,917	-685.0%	2,835,289	3,735,885	2,757,615	978,270	-35.5%
14	% Total margin	3%	41%	5%			6%	8%	6%		

BALANCE SHEET

		A	B	C	D	E
		May	May	April		
		FY 16/17	FY 17/18	FY 17/18	VARIANCE	
					Amount	%
15	Gross Accounts Receivables	11,783,203	9,608,828	10,279,582	(670,754)	-6.5%
16	Net Accounts Receivables	4,251,725	3,641,472	3,940,291	(298,819)	-7.6%
17	% Net AR to Gross AR	36%	38%	38%		
18	Days Gross AR	85	70.8	69	2	2.6%
19	Cash Collections	1,906,431	1,713,631	1,836,686	(123,055)	-6.7%
21	Investments	10,652,271	13,497,614	13,497,614	-	0.0%
22	Cash on hand	2,946,791	4,630,363	3,771,817	858,546	22.8%
23	Total Cash & Invest	13,799,062	18,127,977	17,269,431	858,546	5.0%
24	Days Cash & Invest	233	286	273	13	4.7%
	Total Cash and Investments	13,799,062	18,127,977			
	Increase Current Year vs. Prior Year		4,328,915			

Bear Valley Community Healthcare District
Financial Statements May 31, 2018

Statement of Operations

		A	B	C	D	E	F	G	H	I	J
		Current Month					Year-to-Date				
		FY 15/16	FY 16/17		VARIANCE		FY 15/16	FY 16/17		VARIANCE	
		Actual	Actual	Budget	Amount	%	Actual	Actual	Budget	Amount	%
	Gross Patient Revenue										
1	Inpatient	151,089	147,294	263,990	(116,696)	-44.2%	2,512,611	1,794,263	2,671,874	(877,611)	-32.8%
2	Outpatient	1,069,063	856,463	942,055	(85,592)	-9.1%	9,783,050	10,876,078	10,050,456	825,622	8.2%
3	Clinic Revenue	367,771	379,607	273,189	106,418	39.0%	2,484,043	3,968,512	2,561,813	1,406,699	54.9%
4	Emergency Room	2,285,069	2,142,156	2,433,308	(291,152)	-12.0%	27,744,628	29,132,065	28,776,826	355,239	1.2%
5	Skilled Nursing Facility	263,527	256,622	249,831	6,791	2.7%	2,735,822	2,801,668	2,702,634	99,034	3.7%
6	**Total patient revenue**	**4,136,519**	**3,782,142**	**4,162,373**	**(380,231)**	**-9.1%**	**45,260,154**	**48,572,586**	**46,763,603**	**1,808,983**	**3.9%**
	Revenue Deductions										
7	Contractual Allow	2,040,122	1,715,880	2,039,831	(323,951)	-15.9%	20,573,139	23,605,048	22,917,189	687,859	3.0%
8	Contractual Allow PY	70	(1,789,912)	-	(1,789,912)	#DIV/0!	(24,793)	(2,042,119)	-	(2,042,119)	#DIV/0!
9	Charity Care	-	7,748	8,914	(1,166)	-13.1%	89,563	84,761	100,148	(15,387)	-15.4%
10	Administrative	(11)	-	7,811	(7,811)	-100.0%	75,729	322,573	87,754	234,819	267.6%
11	Policy Discount	9,969	9,186	6,362	2,824	44.4%	77,714	122,119	71,478	50,641	70.8%
12	Employee Discount	5,880	3,358	3,462	(104)	-3.0%	40,774	66,388	38,890	27,498	70.7%
13	Bad Debts	(12,708)	299,027	162,016	137,011	84.6%	1,564,259	1,761,065	1,820,226	(59,161)	-3.3%
14	Denials	266,959	99,637	-	99,637	#DIV/0!	2,197,125	1,351,350	-	1,351,350	#DIV/0!
15	**Total revenue deductions**	**2,367,036**	**344,925**	**2,228,396**	**(1,883,471)**	**-84.5%**	**24,593,509**	**25,271,184**	**25,035,685**	**235,499**	**0.9%**
16	**Net Patient Revenue**	**1,769,483**	**3,437,217**	**1,933,977**	**1,503,240**	**77.7%**	**20,666,645**	**23,301,402**	**21,727,918**	**1,573,484**	**7.2%**
	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**	27,638	35,409	51,981	(16,572)	-31.9%	299,070	338,293	569,406	(231,113)	-40.6%
18	**Total Operating Revenue**	**1,797,121**	**3,472,626**	**1,985,958**	**1,486,668**	**74.9%**	**20,965,715**	**23,639,694**	**22,297,324**	**1,342,370**	**6.0%**
	Expenses										
19	Salaries	790,775	846,844	826,807	20,037	2.4%	8,424,751	8,964,454	8,922,337	42,117	0.5%
20	Employee Benefits	206,568	295,338	328,971	(33,633)	-10.2%	3,139,382	3,323,913	3,574,226	(250,313)	-7.0%
21	Registry	2,955	-	-	-	#DIV/0!	36,240	16,028	-	16,028	#DIV/0!
22	Salaries and Benefits	**1,000,298**	**1,142,182**	**1,155,778**	**(13,596)**	**-1.2%**	**11,600,372**	**12,304,395**	**12,496,563**	**(192,168)**	**-1.5%**
23	Professional fees	153,638	168,382	156,392	11,990	7.7%	1,634,696	1,850,447	1,754,003	96,444	5.5%
24	Supplies	113,462	137,008	127,376	9,632	7.6%	1,320,874	1,427,896	1,378,545	49,351	3.6%
25	Utilities	42,719	41,922	38,692	3,230	8.3%	490,018	455,233	489,721	(34,488)	-7.0%
26	Repairs and Maintenance	20,536	24,764	22,668	2,096	9.2%	283,053	305,366	248,730	56,636	22.8%
27	Purchased Services	370,698	386,930	296,132	90,798	30.7%	3,188,425	3,853,751	3,290,980	562,771	17.1%
28	Insurance	25,013	25,912	25,917	(5)	0.0%	275,340	285,790	285,087	703	0.2%
29	Depreciation	50,868	82,710	75,000	7,710	10.3%	533,382	796,745	825,000	(28,255)	-3.4%
30	Rental and Leases	38,734	15,621	16,297	(676)	-4.1%	236,989	247,994	179,267	68,727	38.3%
32	Dues and Subscriptions	4,974	5,999	5,046	953	18.9%	53,519	62,200	55,504	6,696	12.1%
33	Other Expense.	34,825	60,371	52,720	7,651	14.5%	660,698	451,391	579,526	(128,135)	-22.1%
34	**Total Expenses**	**1,855,765**	**2,091,802**	**1,972,018**	**119,784**	**6.1%**	**20,277,366**	**22,041,209**	**21,582,926**	**458,283**	**2.1%**
35	**Surplus (Loss) from Operations**	**(58,644)**	**1,380,824**	**13,940**	**1,366,884**	**-9805.5%**	**688,349**	**1,598,485**	**714,398**	**884,087**	**-123.8%**
36	**Non-Operating Income**										
37	Tax Revenue	189,917	186,047	186,047	-	0.0%	2,089,087	2,046,517	2,046,517	-	0.0%
38	Other non-operating	5,286	7,753	3,283	4,470	136.1%	101,988	60,334	36,113	24,221	67.1%
	Interest Income	510	516	4,167	(3,651)	-87.6%	44,124	116,174	45,837	70,337	153.4%
	Interest Expense	(7,943)	(7,536)	(7,750)	214	-2.8%	(88,259)	(85,624)	(85,250)	(374)	0.4%
39	**Total Non-operating**	**187,770**	**186,780**	**185,747**	**1,033**	**0.6%**	**2,146,940**	**2,137,400**	**2,043,217**	**94,183**	**4.6%**
40	**Surplus/(Loss)**	**129,126**	**1,567,604**	**199,687**	**1,367,917**	**-685.0%**	**2,835,289**	**3,735,885**	**2,757,615**	**978,270**	**35.5%**

Bear Valley Community Healthcare District
Financial Statements

Current Year Trending Statement of Operations

A Statement of Operations—CURRENT YEAR 2018

			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		95,787	98,514	150,843	142,719	77,702	202,529	368,022	205,698	153,559	151,595	147,294		1,794,263
2	Outpatient		868,939	1,205,964	1,063,953	1,047,978	997,359	857,747	1,077,117	960,070	973,262	967,226	856,463		10,876,078
3	Clinic		347,893	369,602	339,870	391,164	329,577	339,330	370,318	332,540	387,011	381,601	379,607		3,968,512
4	Emergency Room		2,985,253	2,686,283	2,407,574	2,203,306	2,221,976	3,207,446	3,260,191	2,822,859	2,856,980	2,338,042	2,142,156		29,132,065
5	Skilled Nursing Facility		261,793	265,487	262,653	261,572	265,920	259,078	248,635	228,695	248,065	243,147	256,622		2,801,668
6	**Total patient revenue**		**4,559,665**	**4,625,850**	**4,224,893**	**4,046,739**	**3,892,534**	**4,866,130**	**5,324,283**	**4,549,861**	**4,618,877**	**4,081,611**	**3,782,142**	**-**	**48,572,586**
	Revenue Deductions	C/A	0.56	0.47	0.47	0.47	0.44	0.53	0.46	0.58	0.48	0.42	0.45	#DIV/0!	0.49
7	Contractual Allow		2,548,409	2,192,333	1,994,911	1,909,156	1,696,412	2,569,127	2,429,042	2,617,795	2,213,838	1,718,143	1,715,880		23,605,048
8	Contractual Allow PY		-	463	1,249	(1,739)	-	-	(3)	(132,608)	(81,875)	(37,694)	(1,789,912)		(2,042,119)
9	Charity Care		7,675	12,842	-	-	9,999	1,812	7,644	7,866	20,144	9,031	7,748		84,761
10	Administrative		(746)	114,666	169,442	10,431	2,860	989	1,974	10,254	5,551	7,151	-		322,573
11	Policy Discount		11,532	11,940	7,202	10,680	10,915	9,781	13,595	12,725	13,413	11,150	9,186		122,119
12	Employee Discount		4,711	9,099	3,938	4,084	4,131	4,202	6,231	10,571	10,324	5,739	3,358		66,388
13	Bad Debts		(59,348)	69,295	45,428	236,304	205,433	130,228	201,297	96,436	262,428	274,537	299,027		1,761,065
14	Denials		307,852	190,797	(129,516)	169,768	162,874	89,070	93,291	177,257	122,427	67,892	99,637		1,351,350
15	**Total revenue deductions**		**2,820,085**	**2,601,437**	**2,092,654**	**2,338,683**	**2,092,624**	**2,805,209**	**2,753,071**	**2,800,296**	**2,566,251**	**2,055,950**	**344,925**	**-**	**25,271,184**
			0.62	0.56	0.50	0.58	0.54	0.58	0.52	0.62	0.56	0.50	0.09	#DIV/0!	
16	**Net Patient Revenue**		**1,739,580**	**2,024,413**	**2,132,239**	**1,708,056**	**1,799,911**	**2,060,921**	**2,571,212**	**1,749,565**	**2,052,626**	**2,025,661**	**3,437,217**	**-**	**23,301,402**
	net / tot pat rev		38.2%	43.8%	50.5%	42.2%	46.2%	42.4%	48.3%	38.5%	44.4%	49.6%	90.9%	#DIV/0!	48.0%
17	**Other Revenue**		7,162	35,245	20,043	45,312	35,896	16,992	35,338	72,429	25,710	8,758	35,409		338,293
18	**Total Operating Revenue**		**1,746,742**	**2,059,658**	**2,152,282**	**1,753,369**	**1,835,807**	**2,077,912**	**2,606,549**	**1,821,994**	**2,078,337**	**2,034,419**	**3,472,626**	**-**	**23,639,694**
	Expenses														
19	Salaries		800,028	842,003	802,366	798,066	721,536	884,119	849,855	786,053	837,872	795,713	846,844		8,964,454
20	Employee Benefits		286,721	318,469	300,954	292,526	296,309	316,321	315,442	285,480	319,765	296,588	295,338		3,323,913
21	Registry		12,718	-	-	-	-	3,310	-	-	-	-	-		16,028
22	Salaries and Benefits		**1,099,467**	**1,160,472**	**1,103,320**	**1,090,592**	**1,017,845**	**1,203,749**	**1,165,297**	**1,071,533**	**1,157,637**	**1,092,301**	**1,142,182**	**-**	**12,304,395**
23	Professional fees		163,392	159,614	149,941	191,107	168,319	157,808	173,264	169,956	179,324	169,338	168,382		1,850,447
24	Supplies		130,715	136,046	101,350	139,091	134,939	107,112	172,497	150,603	130,192	88,343	137,008		1,427,896
25	Utilities		42,342	42,209	43,009	40,689	40,990	39,869	41,326	42,100	39,834	40,945	41,922		455,233
26	Repairs and Maintenance		22,461	19,239	35,825	30,007	38,216	28,409	32,513	27,659	23,136	23,136	24,764		305,366
27	Purchased Services		302,014	346,148	281,012	373,876	381,162	395,485	308,903	329,029	342,334	406,858	386,930		3,853,751
28	Insurance		25,762	25,762	25,762	25,835	25,762	27,345	25,912	25,912	25,912	25,912	25,912		285,790
29	Depreciation		48,568	49,162	58,815	61,486	82,456	82,710	82,710	82,710	82,710	82,710	82,710		796,745
30	Rental and Leases		46,445	39,979	35,360	23,454	15,317	16,214	14,242	14,670	10,495	16,197	15,621		247,994
32	Dues and Subscriptions		5,518	5,427	5,725	5,181	4,523	5,207	2,710	1,944	12,026	7,941	5,999		62,200
33	Other Expense.		36,147	35,255	43,441	47,022	39,491	38,655	39,225	33,265	36,519	42,000	60,371		451,391
34	**Total Expenses**		**1,922,831**	**2,019,314**	**1,883,559**	**2,028,341**	**1,949,020**	**2,102,562**	**2,058,598**	**1,949,382**	**2,040,119**	**1,995,680**	**2,091,802**	**-**	**22,041,209**
35	**Surplus (Loss) from Operations**		**(176,089)**	**40,344**	**268,723**	**(274,973)**	**(113,213)**	**(24,650)**	**547,951**	**(127,388)**	**38,218**	**38,738**	**1,380,824**	**-**	**1,598,485**
36	**Non-Operating Income**														
37	Tax Revenue		186,047	186,047	186,047	186,047	186,047	186,047	186,047	186,047	186,047	186,047	186,047		2,046,517
38	Other non-operating			10,247	(130)	130	20,000	-	12,000	10,000	334	-	7,753		60,334
	Interest Income		1,906	626	30,375	693	965	31,840	1,071	591	46,706	884	516		116,174
	Interest Expense		(7,717)	(7,902)	(8,002)	(7,752)	(7,763)	(8,047)	(7,830)	(7,737)	(7,681)	(7,658)	(7,536)		(85,624)
39	**Total Non-operating**		**180,236**	**189,018**	**208,290**	**179,118**	**199,249**	**209,840**	**191,288**	**188,902**	**225,405**	**179,273**	**186,780**	**-**	**2,137,400**
40	**Surplus/(Loss)**		**4,147**	**229,362**	**477,013**	**(95,854)**	**86,036**	**185,190**	**739,240**	**61,513**	**263,623**	**218,011**	**1,567,604**	**-**	**3,735,885**

Input Trend Strnt Ops

2017-18 Actual BS

BALANCE SHEET
(Reflects 6/30/17 Y/E audit adjustments)

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	PY BS June
ASSETS:												
Current Assets												
Cash and Cash Equivalents (Includes CD's)	2,926,360	2,290,992	1,483,027	2,187,881	3,733,239	3,884,817	2,490,708	2,353,707	2,044,038	3,771,817	4,630,363	2,858,405
Gross Patient Accounts Receivable	10,084,033	10,529,969	9,819,853	9,516,577	8,883,930	9,771,838	10,764,545	11,059,822	10,231,024	10,281,906	9,607,258	10,749,524
Less: Reserves for Allowances & Bad Debt	6,481,129	6,632,089	5,818,066	5,954,203	5,590,675	6,111,008	6,570,468	6,769,875	6,318,873	6,341,615	5,965,786	6,824,943
Net Patient Accounts Receivable	3,602,904	3,897,880	4,001,787	3,562,374	3,293,255	3,660,830	4,194,077	4,289,947	3,912,152	3,940,291	3,641,472	3,924,581
Tax Revenue Receivable	2,232,569	2,232,569	2,232,569	2,232,569	1,944,288	970,958	827,168	800,445	768,696	32,882	-57,703	56,787
Other Receivables	88,537	55,474	750,144	324,224	-1,218,923	-1,160,647	-1,793,802	-1,735,250	-1,036,263	-973,905	-310,265	107,830
Inventories	217,948	220,580	221,025	226,011	222,712	222,388	229,341	236,269	234,002	234,041	230,426	212,805
Prepaid Expenses	330,877	339,259	336,340	352,943	342,699	313,470	295,570	279,301	250,181	260,592	233,374	192,216
Due From Third Party Payers	0											
Due From Affiliates/Related Organizations	0											
Other Current Assets	0											
Total Current Assets	9,399,195	9,036,754	9,024,893	8,886,002	8,317,270	7,891,816	6,243,062	6,224,418	6,172,806	7,265,719	8,367,666	7,352,624
Assets Whose Use is Limited												
Investments	10,894,184	10,894,184	10,921,640	10,921,640	10,921,640	10,952,520	13,452,520	13,452,520	13,497,614	13,497,614	13,497,614	10,894,184
Other Limited Use Assets	144,375	144,375	144,375	144,375	144,375	144,375	144,375	144,375	144,375	144,375	144,375	144,375
Total Limited Use Assets	11,038,559	11,038,559	11,066,015	11,066,015	11,066,015	11,096,895	13,596,895	13,596,895	13,641,989	13,641,989	13,641,989	11,038,559
Property, Plant, and Equipment												
Land and Land Improvements	547,472	570,615	570,615	570,615	570,615	570,615	570,615	570,615	570,615	570,615	570,615	547,472
Building and Building Improvements	9,657,088	9,659,388	9,686,383	9,696,603	9,699,157	9,699,804	9,737,717	9,752,367	9,752,367	9,752,367	9,757,277	9,657,088
Equipment	9,625,066	9,694,652	10,189,492	10,232,207	11,486,278	11,504,275	11,516,840	11,661,203	11,704,839	11,704,839	11,711,469	9,614,476
Construction In Progress	1,058,659	1,101,848	753,103	1,356,225	146,485	146,485	146,485	16,365	16,365	19,206	35,594	532,158
Capitalized Interest	0											
Gross Property, Plant, and Equipment	20,888,285	21,026,502	21,199,592	21,855,650	21,902,534	21,921,179	21,971,657	22,000,549	22,044,186	22,047,027	22,074,955	20,351,194
Less: Accumulated Depreciation	12,764,979	12,814,141	12,872,956	12,934,442	13,016,899	13,099,608	13,182,318	13,265,028	13,347,737	13,430,447	13,513,156	12,716,411
Net Property, Plant, and Equipment	8,123,306	8,212,362	8,326,636	8,921,208	8,885,636	8,821,571	8,789,339	8,735,522	8,696,449	8,616,580	8,561,798	7,634,783
TOTAL UNRESTRICTED ASSETS	28,561,060	28,287,674	28,417,544	28,873,224	28,268,920	27,810,282	28,629,297	28,556,836	28,511,243	29,524,287	30,571,453	26,025,966
Restricted Assets	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL ASSETS	28,561,060	28,287,674	28,417,544	28,873,224	28,268,920	27,810,282	28,629,297	28,556,836	28,511,243	29,524,287	30,571,453	26,025,966

2017-18 Actual BS

BALANCE SHEET (Reflects 6/30/17 Y/E audit adjustments)	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	PY BS June
LIABILITIES:												
Current Liabilities												
Accounts Payable	1,382,046	985,885	792,559	1,431,694	876,176	956,102	943,576	973,763	711,190	833,399	816,207	1,055,031
Notes and Loans Payable												
Accrued Payroll	775,117	846,351	884,291	975,116	996,448	697,894	802,910	817,096	891,764	940,378	992,846	684,799
Patient Refunds Payable												
Due to Third Party Payers (Settlements)	709,007	709,470	695,980	695,980	718,109	552,505	718,109	718,109	775,164	1,577,778	1,200,581	649,537
Advances From Third Party Payers												
Current Portion of Def Rev - Txs,	2,046,518	1,860,471	1,674,424	1,488,377	1,302,330	1,151,283	965,236	779,189	593,142	407,095	221,048	-4
Current Portion - LT Debt	35,000	35,000	35,000	35,000	35,000	35,000	35,000	35,000	35,000	35,000	35,000	35,000
Current Portion of AB915												
Other Current Liabilities (Accrued Interest & Accrued Other)	15,243	23,005	30,785	38,407	46,169	7,621	15,350	23,049	30,731	38,373	45,903	7,621
Total Current Liabilities	4,962,931	4,460,183	4,113,039	4,664,574	3,974,233	3,400,405	3,480,181	3,346,206	3,036,991	3,832,023	3,311,585	2,431,984
Long Term Debt												
USDA Loan	2,930,000	2,930,000	2,930,000	2,930,000	2,930,000	2,895,000	2,895,000	2,895,000	2,895,000	2,895,000	2,895,000	2,965,000
Leases Payable	0	0	0	0	0	0	0	0	0	0	0	0
Less: Current Portion Of Long Term Debt	35,000	35,000	35,000	35,000	35,000	35,000	35,000	35,000	35,000	35,000	35,000	35,000
Total Long Term Debt (Net of Current)	2,930,000	2,930,000	2,930,000	2,930,000	2,930,000	2,860,000	2,860,000	2,860,000	2,860,000	2,860,000	2,860,000	2,930,000
Other Long Term Liabilities												
Deferred Revenue	0	0	0	0	0	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	0	0	0	0	0
TOTAL LIABILITIES	7,892,931	7,390,183	7,043,039	7,594,574	6,904,233	6,260,405	6,340,181	6,206,206	5,896,991	6,692,023	6,171,585	5,361,984
Fund Balance												
Unrestricted Fund Balance	20,663,982	20,663,983	20,663,982	20,663,982	20,663,982	20,663,982	20,663,982	20,663,982	20,663,982	20,663,982	20,663,982	16,251,126
Temporarily Restricted Fund Balance	0	0				0						
Equity Transfer from FRHG	0	0				0						
Net Revenue/(Expenses)	4,147	233,510	710,523	614,668	700,705	885,895	1,625,134	1,686,648	1,950,271	2,168,282	3,735,886	4,412,856
TOTAL FUND BALANCE	20,668,129	20,897,491	21,374,505	21,278,650	21,364,687	21,549,877	22,289,116	22,350,630	22,614,253	22,832,264	24,399,868	20,663,982
TOTAL LIABILITIES & FUND BALANCE	28,561,060	28,287,674	28,417,544	28,873,224	28,268,920	27,810,282	28,629,297	28,556,836	28,511,243	29,524,287	30,571,453	26,025,966

Units of Service

For the period ending: May 31, 2018

Current Month							Year-To-Date					
May-18		May-17	Actual -Budget		Act.-Act.	Bear Valley Community Hospital	May-18		May-17	Actual -Budget		Act.-Act.
Actual	Budget	Actual	Variance	Var %	Var %		Actual	Budget	Actual	Variance	Var %	Var %
20	43	33	(23)	-53.7%	-39.4%	Med Surg Patient Days	331	422	390	(91)	-21.6%	-15.1%
17	47	-	(30)	-63.7%	#DIV/0!	Swing Patient Days	200	459	434	(259)	-56.4%	-53.9%
571	534	589	37	6.9%	-3.1%	SNF Patient Days	6,285	5,696	6,104	589	10.3%	3.0%
608	**624**	**622**	**(16)**	**-2.6%**	**-2.3%**	**Total Patient Days**	**6,816**	**6,577**	**6,928**	**239**	**3.6%**	**-1.6%**
6	15	9	(9)	-60.0%	-33.3%	Acute Admissions	136	165	148	(29)	-17.6%	-8.1%
7	15	9	(8)	-53.3%	-22.2%	Acute Discharges	139	165	155	(26)	-15.8%	-10.3%
2.9	-	3.7	2.9	#DIV/0!	-22.1%	Acute Average Length of Stay	2.4	-	2.5	2.4	#DIV/0!	-5.4%
0.6	1.4	1.1	(0.7)	-53.7%	-39.4%	Acute Average Daily Census	1.0	1	1.2	(0.3)	-21.6%	-15.1%
19.0	18.7	19.0	0.2	1.2%	-0.2%	SNF/Swing Avg Daily Census	19.4	18	19.5	1.0	5.4%	-0.8%
19.6	**20.1**	**20.1**	**(0.5)**	**-2.6%**	**-2.3%**	**Total Avg. Daily Census**	**20.3**	**20**	**20.7**	**0.7**	**3.6%**	**-1.6%**
44%	**45%**	**45%**	**-1%**	**-2.6%**	**-2.3%**	**% Occupancy**	**45%**	**44%**	**46%**	**2%**	**3.6%**	**-1.6%**
6	15	9	(9)	-60.0%	-33.3%	Emergency Room Admitted	123	165	131	(42)	-25.5%	-6.1%
818	1,000	877	(182)	-18.2%	-6.7%	Emergency Room Discharged	10,424	11,000	10,264	(576)	-5.2%	1.6%
824	**825**	**886**	**(1)**	**-0.1%**	**-7.0%**	**Emergency Room Total**	**10,547**	**10,131**	**10,395**	**416**	**4.1%**	**1.5%**
27	**27**	**29**	**(0)**	**-0.1%**	**-7.0%**	**ER visits per calendar day**	**31**	**30**	**31**	**1**	**4.1%**	**1.5%**
100%	**100%**	**100%**	**100%**	**100.0%**	**0.0%**	**% Admits from ER**	**90%**	**100%**	**89%**	**69%**	**69.0%**	**2.2%**
-	-	-	-	0.0%	#DIV/0!	Surgical Procedures I/P	2	-	-	2	0.0%	#DIV/0!
-	19	18	(19)	-100.0%	-100.0%	Surgical Procedures O/P	123	221	85	(98)	-44.3%	44.7%
-	**19**	**18**	**(19)**	**-100.0%**	**-100.0%**	**TOTAL Procedures**	**125**	**221**	**85**	**(96)**	**-43.4%**	**47.1%**
-	**295**	**1,114**	**(295)**	**-100.0%**	**-100.0%**	**Surgical Minutes Total**	**8,713**	**3,190**	**5,554**	**5,523**	**173.1%**	**56.9%**

Units of Service

For the period ending: May 31, 2018

Bear Valley Community Hospital

Current Month							Year-To-Date					
May-18		May-17	Actual -Budget		Act.-Act.		May-18		May-17	Actual -Budget		Act.-Act.
Actual	Budget	Actual	Variance	Var %	Var %		Actual	Budget	Actual	Variance	Var %	Var %
6,078	6,513	6,144	(435)	-6.7%	-1.1%	Lab Procedures	67,932	64,157	66,234	3,775	5.9%	2.6%
795	718	807	77	10.7%	-1.5%	X-Ray Procedures	8,825	8,331	9,183	494	5.9%	-3.9%
205	222	218	(17)	-7.7%	-6.0%	C.T. Scan Procedures	2,908	2,842	2,844	66	2.3%	2.3%
218	236	225	(18)	-7.6%	-3.1%	Ultrasound Procedures	2,592	2,214	2,270	378	17.1%	14.2%
52	50	-	2	0.0%	#DIV/0!	Mammography Procedures	697	550	414	147	26.7%	68.4%
250	285	278	(35)	-12.3%	-10.1%	EKG Procedures	3,390	2,814	3,048	576	20.5%	11.2%
106	106	127	-	0.0%	-16.5%	Respiratory Procedures	1,548	1,160	1,411	388	33.4%	9.7%
1,351	1,690	1,290	(339)	-20.1%	4.7%	Physical Therapy Procedures	15,220	17,473	17,744	(2,253)	-12.9%	-14.2%
1,719	1,943	1,751	(224)	-11.5%	-1.8%	Primary Care Clinic Visits	19,364	17,875	17,310	1,489	8.3%	11.9%
298	200	317	98	49.0%	-6.0%	Specialty Clinic Visits	2,423	2,200	1,090	223	10.1%	122.3%
2,017	**2,143**	**2,068**	**(126)**	**-5.9%**	**-2.5%**	**Clinic**	**21,787**	**20,075**	**18,400**	**1,712**	**8.5%**	**18.4%**
78	**82**	**80**	**(5)**	**-5.9%**	**-2.5%**	**Clinic visits per work day**	**120**	**110**	**101**	**9**	**8.5%**	**18.4%**
22.5%	20.00%	19.80%	2.50%	12.50%	13.64%	% Medicare Revenue	19.32%	20.00%	20.18%	-0.68%	-3.41%	-4.28%
41.10%	37.00%	42.00%	4.10%	11.08%	-2.14%	% Medi-Cal Revenue	39.51%	37.00%	38.95%	2.51%	6.78%	1.42%
32.00%	38.00%	33.10%	-6.00%	-15.79%	-3.32%	% Insurance Revenue	36.39%	38.00%	36.37%	-1.61%	-4.23%	0.05%
4.40%	5.00%	5.10%	-0.60%	-12.00%	-13.73%	% Self-Pay Revenue	4.78%	5.00%	4.49%	-0.22%	-4.36%	6.48%
142.8	155.00	143.0	(12.2)	-7.8%	-0.1%	Productive FTE's	145.00	152.27	143.6	(7.3)	-4.8%	1.0%
164.2	174.00	160.4	(9.8)	-5.6%	2.4%	Total FTE's	165.13	170.73	161.6	(5.6)	-3.3%	2.2%

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

CFO REPORT for

July 2018 Finance and Board meetings

Healthcare Reform / Healthcare Legislation

The Governor has signed the $201 billion State annual budget. Medi-Cal spending in the budget is $104 billion, approximately $7 billion more than last year. CHA reports that the Administration's proposal to eliminate the 340B drug discount program in Medi-Cal was rejected by the Legislature and, therefore, (elimination) is not included in the budget.

QHR FOR (Financial Operations Review)

Each year QHR conducts a Financial Operations Review or FOR. This is a tool used to assess key risk areas for managed hospitals. Attached is the Management Action Plan MAP from the FOR conducted in the spring of this year.

QHR Management Services

Bear Valley Community Hospital
Financial Operational Review
April 11th, 2018

Category	Recommendation	Status/Action Plan	Completion Status
Physician Arrangements	A "Stark Log" needs to be created to track all non-monetary compensation to physicians (gifts, etc.)	Create log and begin to track	ongoing
Patient Financial Services Operations	Credit balances totaling $437,875 as of 1/31/18 noted on hospital A/R aging reports. Some of the balances are greater than one year old and may be the result of posting discrepancies. Recommend hospital research and correct/refund as appropriate	Have begun review of oldest and "conversion" accounts. Will review with external auditor	

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Information Technology
2019 - 2021 Strategic Plan

Jon C. Booth
Director of Information Technology
Bear Valley Community Healthcare District

INFORMATION TECHNOLOGY MANAGER'S MESSAGE

Our patients, providers, and staff expect us to deliver highly effective, secure, and reliable Information Technology (IT) solutions that permit us to realize the district's mission without exception. I envision an agile and sustainable IT environment that will serve an increasingly proactive staff, enhance business processes, and ensure the best possible clinical outcomes for our patients and community.

Following a path of prudent planning, accurate technical selection and implementation, and responsible management of district funds, I believe we can meet the IT strategic goals defined in this plan.

MANAGEMENT SUMMARY

Since the first quarter of 2016, Bear Valley Community Healthcare District (BVCHD) has seen an increased investment and modernization of our technology infrastructure throughout the district. The stable and secure platform that resulted from this effort has better positioned the district when it comes to implementing new or improved patient care systems and business enhancement tools in a swiftly changing technical landscape.

To better assess our tactical position, in the first quarter of 2018 an IT operational assessment was conducted by Quorum Health Resources. The purpose for that assessment was to look at how IT conducts its day to day business and review the processes and procedures to complete these tasks. The final report and action plan that resulted from that assessment validated many of the initiatives undertaken since 2016, made meaningful process improvement recommendations, and provide foundational support for this plan.

Our dramatically improved infrastructure, along with the Quorum Assessment recommendations have created a strong foundation and platform to work from to achieve the goals of this plan. And in doing so we will:

1. Provide patients a better experience than they have become accustomed to at other hospitals and clinics.
2. Empower employees, providers, and consultants with the tools they need to ultimately deliver the quality care our patients deserve.
3. Ensure our technical environment is secure and reliable, so that the district can properly protect patient and business data and remain compliant with all regulatory requirements.

Strategic topics addressed in this plan include the following:

- Protecting the district from data leaks, breaches, and fines imposed that could result from these events.

- Improving patient care and their healthcare experience in our facilities.
- Ensuring business continuity during impactful events.
- Continued enhancement of data processing, network services and technical training.

IT VISION

BVCHD will employ well designed, technically relevant, and properly implemented technology tools that enhance patient-centered care, supported by an effective and efficient Information Technology department, within a pro-technology culture that embraces smart innovation in all areas of the organization.

IT VALUES

The IT staff and management fully support and strive to uphold the organizational values of Integrity, Compassion, Accountability, Respect, and Excellence.

THE PLANNING PROCESS

SCOPE

This document describes the strategic development of IT at BVCHD. The document is not intended to replace or supplant district strategic or master planning documents, rather it is intended to compliment and support them. This planning cycle began in the final quarter of the 2018 fiscal year. This is a three-year plan that will be assessed and updated annually or as required as goals are attained. The plan is a living document and as such is intended to serve as a guide that can evolve as the technical landscape dictates.

INTRODUCTION

The philosophy in developing this plan has been one of inclusion. Staff members have been invited to contribute, and their feedback was incorporated in the latest technical improvements and assimilated into the plan. We will continue to seek innovative solutions in all areas of the organization in alignment with BVCHD's vision. This technology plan has been constructed on the premise that there are no IT Projects. All the work that is managed and performed by the IT department is focused on supporting other departments and important functions of the district.

BVCHD technology has experienced a dramatic and critically needed evolution in the prior two fiscal years. The following is a sampling of the technologies and systems that have been enhanced or replaced in the absence of a formal plan:

- All obsolete business servers were replaced.

- Server performance was increased exponentially, while reducing server rack space/cooling/power requirements.
- Business server storage capacity has been doubled and deduplication technology was employed to further expand that capacity.
- For the first time, all business servers are operating in a clustered environment to minimize downtime and the need for maintenance windows.
- Five "household class" external connections and their corresponding obsolete firewalls were boiled down to a new clustered next generation firewall which is highly secure and manages two high performance enterprise fiber optic circuits (primary and backup connections).
- All obsolete server operating systems have been upgraded to current and fully licensed versions, and our server directory is now operating at a current and fully Microsoft supported level.
- District mail is now managed by a fully Microsoft supported version and endorsed configuration.
- All district endpoints have been upgraded to Windows 7 and 10, and all machines that require Microsoft office have been upgraded to version 2016 from their decade old version of that product.
- A minimum hardware specification has been defined and all systems that do not meet that specification have been replaced as part of a four-year desktop refresh plan launched in 2016.
- The districts' vendor disavowed and failing telephone system was replaced by a modern vendor supported system.
- All district copiers were replaced by highly functional print stations at a substantially reduced cost per year.
- Internet of Things (IOT) devices (non-computer network connected devices) that are typically ignored by antivirus and other common security safeguards are now protected by a new security monitoring system called Zingbox that offers us a layer of protection that is commonly overlooked by our peer healthcare facilities.

It is the opinion of the BVCHD IT team, all subject matter experts we have contracted in the prior year, and the Quorum IT assessment team that BVCHD is significantly ahead of our healthcare contemporaries when it comes to the current state of our systems security and modernization, and we are well positioned to support new healthcare initiatives and system optimization plans.

While much of the work that has been accomplished in the past two years to improve our technical standing is impressive by any measure, it is certainly not complete. When it comes to business support technology systems, upgrading and maintaining them is not a destination, it is a never-ending journey. It was the combination of poor funding and the assumption that we had effectively "arrived" technically that was the catalyst for our former state of disrepair just three short years ago. And we should strive to never allow things to degrade to that level again because the impact is felt in all supported sub-systems and departments, which is a

dynamic that will only expand in the years to come with the rapid advance of network convergence.

This document aims to provide the roadmap for where the District can be in the next 3 years. It is beyond dispute that technology changes quickly, and in order for BVCHD to be the medical care facility of choice for our community, we need to lead the way in patient and staff focused technology.

There are several themes and issues that run through this Strategic Plan that warrant continual focus and discussion:

> ***Security*** needs to continually be enhanced to safeguard from rapidly evolving threats, address the increasing sophistication of the network, and to protect patient information from potential compromise.
> ***Scalability*** is essential if BVCHD is going to meet the increased data needs and the projected growth of the districts services.
> ***Convergence*** is driving devices not traditionally network aware or connected to the network for more efficient information exchange and device management.
> ***Standardizing*** platforms and software will allow us to take advantage of volume purchasing discounts, reduce training requirements, and simplify our operations.
> ***Redundancy*** in our technology infrastructure will allow us to minimize single points of failure and help ensure systems remain functional in the event of a catastrophic emergency.

Plan Goals and Objectives

PRIORITY 1 – Compliance, Sustainability, and Standards

Need

To build a robust, stable, secure, scalable and maintainable infrastructure, which will enable all users across the district to access the data they need and require without interruption.

Objectives

A. Proactive CPSI Server Hardware and Storage Refresh

a. Upgrade server and storage hardware that is in its 5th year of service which the manufacturer has published an end of life notification which will occur the 4th quarter of 2019.

B. Software License Reconciliation and Compliance

a. Remove any software that is unlicensed or obsolete.
b. Purchase licensed software where needed.

c. Reallocate licensed software based on need.

C. Standardize Desktop Hardware (Desktop Refresh Plan)

a. Improve hardware functionality and compatibility by removing old, slower, mismatched hardware and upgrade with new hardware from the same vendor in.
b. Provide better pricing through volume purchase programs by purchasing the same equipment in quantity from same vendor.
c. Minimize training requirements by removing different brands/models and use a standardized brand and specific model.

D. Maintain Software Licenses and Service Contracts

a. Maintain software licensing and maintenance agreements so that we may maintain our vendor support to access to the most up-to-date patches, fixes, and technical support.
b. Ensure computer operating systems are current. Keeping our systems protected by maintaining supported software which includes security patches, fixes and firmware / system updates.
c. Migrate legacy EHR servers and data, where possible, to Nutanix and upgrade to the highest server software level permissible. Where not possible, isolate the server and remove all external access to minimize risk posed by obsolete software.

PRIORITY 2 – Data Protection, Backup, Disaster Recovery, and Security

Need

To build architecture that can maximize uptime and will ensure that our systems and data are backed up and recoverable. Build and/or relocate the infrastructure to sustain the server and network in the event of a disaster.

Objectives

A. Disaster Recovery Appliance

a. Backup all critical data to a redundant onsite and offsite location.
b. Deploy disaster recovery appliance.
c. Verify our backup data monthly and test server failover quarterly to validate our ability to recover from a disaster

B. Relocate Servers

a. Relocate a portion of our servers to the Brenda Boss Family Resource Center (BBFRC) IT room to protect against catastrophic loss.

C. Desktop and Portable Computer Encryption

a. Implement file and folder encryption on all desktop and laptop computers. In the event of a lost or stolen machine, the data payload would be fully encrypted and fully protect EPHI.

D. Redundant and Vendor Diverse External Network Paths

a. Complete the deployment of the Frontier fiber optic internet service providing our second fiber optic WAN circuit.
b. Complete Frontier fiber circuit and load balance with Charter fiber circuit.

E. IT Server and Communication Rooms Upgrade

a. Install appropriate clean agent fire suppression system rated for electronics in main server room.
b. Add access monitoring for all server / data storage locations and communication rooms.
c. Improve environmental monitoring for all server / data storage locations.

PRIORITY 3 – Risk Management

Need

To comply with HIPAA and HITECH Act assessment requirements.

Objectives

A. Risk Management and Testing

a. Annual Penetration Testing by an outside entity
   i. This will provide a plan of action to correct any deficiencies regarding our gateway / firewall security and our server access security.
   ii. Certify that we are in compliance with industry standards.
   iii. Ensures that we have done our due diligence according to HITECH Act.
b. Risk Management Assessment by an outside entity
   i. This will provide a 3 year plan of action to correct any deficiencies regarding our overall operations, physical security, and policies.
   ii. Certify that we are in compliance with industry standards.
   iii. Ensures that we have done our due diligence according to HITECH Act.

Conclusion:

BVCHD has made a commitment to continue its investment in technology and follow a roadmap to support its mission.

The intent of this plan is to provide a direction that is well conceived and incorporates strategies for present and future growth in the ever-changing world of technology.

An IT infrastructure is an ever-changing landscape made up of the needs of each and every department within the organization. To accomplish the goals listed in this Strategic Plan will take time, money, effort, manpower, collaboration, consultants, planning, and

commitment from all levels of management. But one thing is certain, this IT strategic plan will help bring us to the more confident point of knowing, rather than the uncertain and reactive point of hoping.