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, December 12, 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. **REAL PROPERTY NEGOTIATIONS:*Government Code Section 54956.8 / TRADE SECRETS: Pursuant to Health and Safety Code Section 32106, and Civil Code Section 3426.1**
   (1) Potential Acquisition (To Be Determined)

4. **TRADE SECRETS: Pursuant to Health and Safety Code Section 32106, and Civil Code Section 3426.1**
   (1) Gary Hicks, Financial Advisor Service Agreement (Disclosure 12/12/18)
   (2) Teleconnect Therapies Amendment to Service Agreement (Disclosure 12/12/18)
   (3) Isaias Paja, MD. Clinic Physician Service Agreement (Disclosure 12/12/18)
   (4) Steven Knapik, D.O. Clinic Physician Service Agreement (Disclosure 12/12/18)
   (5) Bhani Chawla-Kondal, M.D. Surgical Service Agreement (Disclosure 12/12/18)
   (6) Bhani Chawla-Kondal, M.D. Clinic Physician Service Agreement (Disclosure 12/12/18)

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. November 14, 2018 Board of Directors Board Retreat Meeting Minutes: Shelly Egerer, Executive Assistant

B. November 2018 Planning & Facilities Report: Michael Mursick, Plant Director

C. November 2018 Human Resource Report: Erin Wilson, Human Resource Director

D. November 2018 Infection Prevention Report: Heather Loose, Infection Preventionist

E. Policies and Procedures: Summary Attached

(1) Reimbursement for Travel and Training
(2) Medicare Secondary Payer
(3) Discharge of Homeless Patient
(4) FHC/RHC
(5) HCW Masking During Flu Season
(6) Skilled Nursing Facility

10. OLD BUSINESS*

A. Discussion and Potential Approval of Gary Hicks, Financial Advisor Service Agreement

11. NEW BUSINESS*

A. Discussion and Potential Approval of QHR Report: Presented by Ron Vigus

B. Discussion and Potential Approval of Bear Valley Community Healthcare District Election of Officers:
(1) President
(2) 1st Vice President
(3) 2nd Vice President
(4) Secretary
(5) Treasurer

C. Discussion and Potential Approval of Bear Valley Community Healthcare District Committee Members:
(1) Planning & Facilities Committee Meeting
(2) Finance Committee Meeting (Treasurer and Committee Member)
(3) Human Resource Committee Meeting

D. Discussion and Potential Approval of the Following Contracts/Service Agreement's:
(1) Teleconnect Therapies Amendment to Service Agreement
(2) Isaias Paja, MD. Clinic Physician Service Agreement
(3) Steven Knapik, D.O. Clinic Physician Service Agreement
(4) Bhani Chawla-Kondal, M.D. Surgical Service Agreement
(5) Bhani Chawla-Kondal, M.D. Clinic Physician Service Agreement

E. Discussion and Potential Approval of the FY 2017/18 Audited Financial Report: Presented by JWT & Associates

F. Discussion and Potential Approval of the Medicare Cost Report for Fiscal Year 2018 Cost Report July 1, 2017 through June 30, 2018

G. Discussion and Potential Approval of Bear Valley Community Healthcare District Board of Directors Reimbursement for Travel Expenses to Attend the American Hospital Association Rural Healthcare Leadership Conference: Expenses Not to Exceed $1,500.00

12. ACTION ITEMS*

A. Acceptance of CNO Report
Kerri Jex, Chief Nursing Officer
(1) November 2018 CNO Report

B. Acceptance of the CEO Report
John Friel, Chief Executive Officer
(1) November 2018 CEO Report

C. Acceptance of the Finance Report & CFO Report
Garth Hamblin, Chief Financial Officer
(1) October 2018 Financials
(2) December 2018 CFO Report

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

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
BUSINESS BOARD MEETING MINUTES
41870 Garstin Drive, Big Bear Lake, CA 92315
November 14, 2018

PRESENT:	Rob Robbins, President	Peter Boss, MD, Secretary
	Gail McCarthy 1st Vice President	John Friel, CEO
	Donna Nicely, Treasurer	Shelly Egerer, Exe. Assistant
ABSENT:	Jack Roberts, 2nd Vice President	Holly Elmer, Foundation
STAFF:	Garth Hamblin	Steven Knapik, DO
	Sherry Greenaway	Sheri Mursick
	Christine Onufrak	
	Mary Norman	
	Kerri Jex	
OTHER:	Connie Friel, Foundation	Ron Vigus, QHR
	Gail Dick, Auxiliary	
COMMUNITY MEMBERS:	Chief Willis, B. B. Fire Authority	

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 Boss to adjourn to Closed Session. President Robbins called for a vote. A vote in favor of the motion was 4/0.
   - Board Member Boss - yes
   - Board Member Nicely- yes
   - President Robbins - yes
   - Board Member McCarthy – 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, Donna Nicely, and Peter Boss, MD were present. Also, present was John Friel, CEO and Shelly Egerer, Executive Assistant. Absent was Jack Roberts.

3. **FLAG SALUTE:**
Board Member Nicely led the flag salute and 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 a vote. A vote in favor of the motion was 4/0.
- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - 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:
  - Initial Appointment:
    - Brian Park, MD – Renaissance Radiology
    - Beverly Wood, NP – Family Health Center
  - Request for Reappointment:
    - Gregory Timm, MD – Renaissance Radiology
    - Edward Cooper, MD – Emergency Medicine
    - Charles Ananian, DPM – Podiatry
    - Pamela Powers, NP – Emergency Department
    - Autumn Johnson, PA – Acute / Emergency Department
  - Voluntary Resignation:
    - Lucas Payor, MD – Renaissance Radiology
    - Anthony Dike, MD – Internal Medicine
    - Juan Esteva, MD – Renaissance Radiology
    - Lauren Brown – Berchtold, MD – Internal Medicine
  - Risk Report
  - QI Report

President Robbins called for the vote. A vote in favor of the motion was 4/0.
- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy – yes

6. **PUBLIC FORUM FOR OPEN SESSION:**
   President Robbins opened the Hearing Section for Public Comment on Open Session items at 3:02 p.m. Hearing no request to make public comment. President Robbins closed Public Forum for Open Session at 3:02 p.m.

7. **DIRECTORS COMMENTS**
   - Board Member Boss stated that he is happy to be an elected official to the Hospital Board of Directors for a four year term.
   - Board Member Nicely reported the Chamber Mixer was well attended and a very nice event.
   - Board Member McCarthy stated that she is privileged and honored to be on the Hospital Board of Directors for four years.
   - President Robbins stated that he is thrilled on the election results and congratulated Board Member Boss and Board Member McCarthy. President Robbins also stated that he received an email from Board Member Roberts stating that he will be resigning from the Hospital Board of Directors effective November 30, 2018. Administration will begin the process to fill the vacant seat.

8. **INFORMATION REPORTS:**
   A. Foundation Report:
   - Ms. Friel reported the following:
     - Thanked the Board of Directors for supporting the Tree of Lights Event. Seventy to ninety people were in attendance.
       - The event raised approximately $39,000.

   B. Auxiliary Report:
   - Ms. Dick reported the following:
     - Mall in the Hall is scheduled for November 26 through Friday November 30

9. **CONSENT AGENDA:**
   A. October 03, 2018 Board of Directors Meeting Minutes: Shelly Egerer, Executive Assistant
   B. October 10, 2018 Special Board of Directors Board Retreat Minutes, Shelly Egerer Assistant
   C. October 2018 Planning & Facilities Report: Michael Mursick, Plant Director
   D. October 2018 Human Resource Report: Erin Wilson, Human Resource Director
   E. October 2018 Infection Prevention Report: Heather Loose, Infection Preventionist
   F. Board of Directors; Committee Meeting Minutes:
   (1) October 02, 2018 Finance Committee Meeting Minutes

Board Member Nicely motioned to approve the Consent Agenda as presented. Second by President Robbins to approve the Consent Agenda as presented. President Robbins called for the vote. A vote in favor of the motion was 4/0.

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

10. OLD BUSINESS:

A. Discussion and Potential Approval of the Following Policies and Procedures:

(1) FMLA/CFRA Leaves of Absence
(2) Meal and Rest Breaks
(3) Extended Sick Leave
(4) Ad mitting Patient to the Clinic (Check – In)

President Robbins called for a motion to approve the policies and procedures, one through four as presented. Motion by Board Member Nicely to approve policies and procedures, one through four as presented. Second by Board Member Boss to approve policies and procedures, one through four as presented. President Robbins called for the vote. A vote in favor of the motion was 4/0.

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

11. NEW BUSINESS*

A. Discussion and Presentation of Big Bear Lake Fire Authority: Revenue Required to Maintain Desired Service Levels (Parcel Tax): Presented by Chief Jeff Willis:

- Chief Willis reported the following information:
  - Thanked the Board of Directors for the time to provide information on a potential parcel tax.
  - 2014-2017 15.7% increase in calls.
  - We need the resources and equipment to meet the current service demands.
  - Staffing needs to increase in order to adjust response time.
  - Is proposing three options on a parcel tax and would like feedback.

President Robbins reported no action required.

B. Discussion and Potential Approval of Gary Hicks, Financial Advisor Service Agreement:

- President Robbins stated that the Board of Directors discussed the agreement in Closed Session.

President Robbins called for a motion to table Gary Hicks, Financial Advisor Service Agreement. Motion by Board Member Nicely to table Gary Hicks, Financial Advisor Service Agreement. Second by President Robbins to table Gary Hicks, Financial Advisor Service Agreement. President Robbins called for the vote. A vote in favor of the motion was 4/0.

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

C. Discussion and Potential Approval of Ordinance No. 0001: Adjusting Compensation of Directors of Bear Valley Community Healthcare District:

- Mr. Friel provided the following information:

- Legal has created the ordinance which allows the Board to receive a 5% increase in there stipend for any Brown Act Meetings.

President Robbins called for a motion to approve Ordinance No. 0001 as presented. Motion by Board Member Boss to approve Ordinance No. 0001 as presented. Second by Board Member Nicely to approve Ordinance No. 0001 as presented. President Robbins called for the vote. A vote in favor of the motion was 4/0.

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

D. Discussion and Potential Approval of Bear Valley Community Healthcare District Amendment to Bylaws:

- Mr. Friel reported that the District Bylaws required amendment to reflect the Board stipend increase. Legal counsel has revised the amendment and has been provided to the Board in their packet.

Board Member Nicely motioned to approve the amendment to BVCHD Bylaws. Second by President Robbins to approve the amendment to BVCHD Bylaws. President Robbins called for the vote. A vote in favor of the motion was 4/0.

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

12. ACTION ITEMS*

A. Quorum Health Resource Report:

(1) October 2018 QHR Report:

- Mr. Vigus reported the following information:
  - Manage Care Contracting review of Heritage and Riverside Community Hospital.
  - IT Assessment; has been reviewed by Bob Vento and being discussed and suggestions are being provided to staff.
  - Price transparency: CMS law requires the Hospital to post charges on the website by the first of the year.
  - Trustee Conference was conducted last year and information will be distributed to the Board.
  - Annual Benefit report has been provided to the Board and allows opportunity to improve compliance and purchasing contract.
  - Educational programs have been utilized by staff and Board Members.

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

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

B. CNO Report:

(1) September 2018 CNO Report:

- Ms. Jex reported the following:
  - Received BETA Award; ED Award, third consecutive award.
  - Second year of being tier two.
  - Introduced Christine Onufrak, new DON.
  - New patient monitoring systems have been installed.
  - ER monitoring system also installed.
  - ER will require some staffing.
  - State Wide Disaster Drill conducted November 15.
  - Total gym has been purchased for the PT Department, very beneficial for our patients.
  - Potential Annual SNF Survey is expected any time, we have been preparing for the survey.

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

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

C. Acceptance of the CEO Report:

(1) October 2018 CEO Report:

- Mr. Friel reported
  - Leadership meeting with Riverside Community Hospital on Dec. 7.
  - Potential changes with Heritage Agreement.
  - In contact with a Kaiser Representative to assist in the possibility to provide services to our community members that have Kaiser insurance.

(2) 2018/2019 Goals:

- Mr. Friel reported the following:
  - Evaluation completed and developed seven goals that will be worked on for the next year.

(3) Organizational Chart

- Mr. Friel reported the following information:
  - Updated Organizational Chart has been provided reflecting new staff and would like Board approval.

Board Member Boss motioned to approve the CEO Report, 2018/19 Goals and Organizational Chart as presented. Second by President Robbins to approve the CEO Report, 2018/19 Goals and Organizational Chart as presented. President Robbins called for the vote. A vote in favor was unanimously approved 4/0.

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

D. Acceptance of the Finance Report:

(1) September 2018 Financials:

- Mr. Hamblin reported the following information:
  - Cash remains strong.
  - Days cash on hand 311.
  - Favorable adjustments with IGT.
  - YTD surplus $350,000.
  - AR days continue under 65.

(2) CFO Report:

- Mr. Hamblin reported the following information:
  - Continue to monitor TruBridge.
  - QHR was on site for the Productivity Assessment.
  - Debt capacity analysis is being vetted with QHR.

President Robbins motioned to approve the September 2018 Finance Report and the CFO Report as presented. Second by Board Member Nicely to approve the September 2018 Finance Report and the CFO Report as presented. President Robbins called for the vote. A vote in favor was unanimously approved 4/0.

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

13. ADJOURNMENT:

Board Member Boss motioned to adjourn the meeting at 4:16 p.m. Second by Board Member Nicely to adjourn. President Robbins called for the vote. A vote in favor of the motion was unanimously approved 4/0.

- Board Member Boss - yes
- Board Member Nicely- yes
- President Robbins - yes
- Board Member McCarthy - 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	Nearly complete, waiting for Pyxis to send last mount that was not recivied during original delivery.	
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	
Business Office- Heater Replacement	Replace the old damaged heater in the west part of the building	Facilities/ACS	In Progress	

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	Trying to locate Vendor, local vendor is not very reliable.	
Camera for Plumbing Inspections	Purchase Camera to assist Facilities repair plumbing.	Amazon	Will Purchase in November	

Bear Valley Community Healthcare District
Repairs Maintenance

Department / Project	Details	Vendor and all associated costs	Comments	Date Complete
RHC- Hot water leak	Broken line in ceiling repaired	Facilities	Complete	
Hospital- Winterized sprinklers	Drained lines and isolated water	Facilities	Complete	
Hospital- Emergency Generator oil leak	During our Bi-Annual test the generator sprung a leak. Had to find an old manifold on the East coast and have it over nighted	Facilities/Odyessy Power	Complete	
Hospital- Housekeeping building	Repaired the leaking rain gutter	Facilities	Complete	
Event Support	BVCHD supported the Turkey Trot on Thanksgiving day	Facilities/ER	Complete	
PT- New Equipment	Facilities built the new total gym equipment	Facilities	Complete	

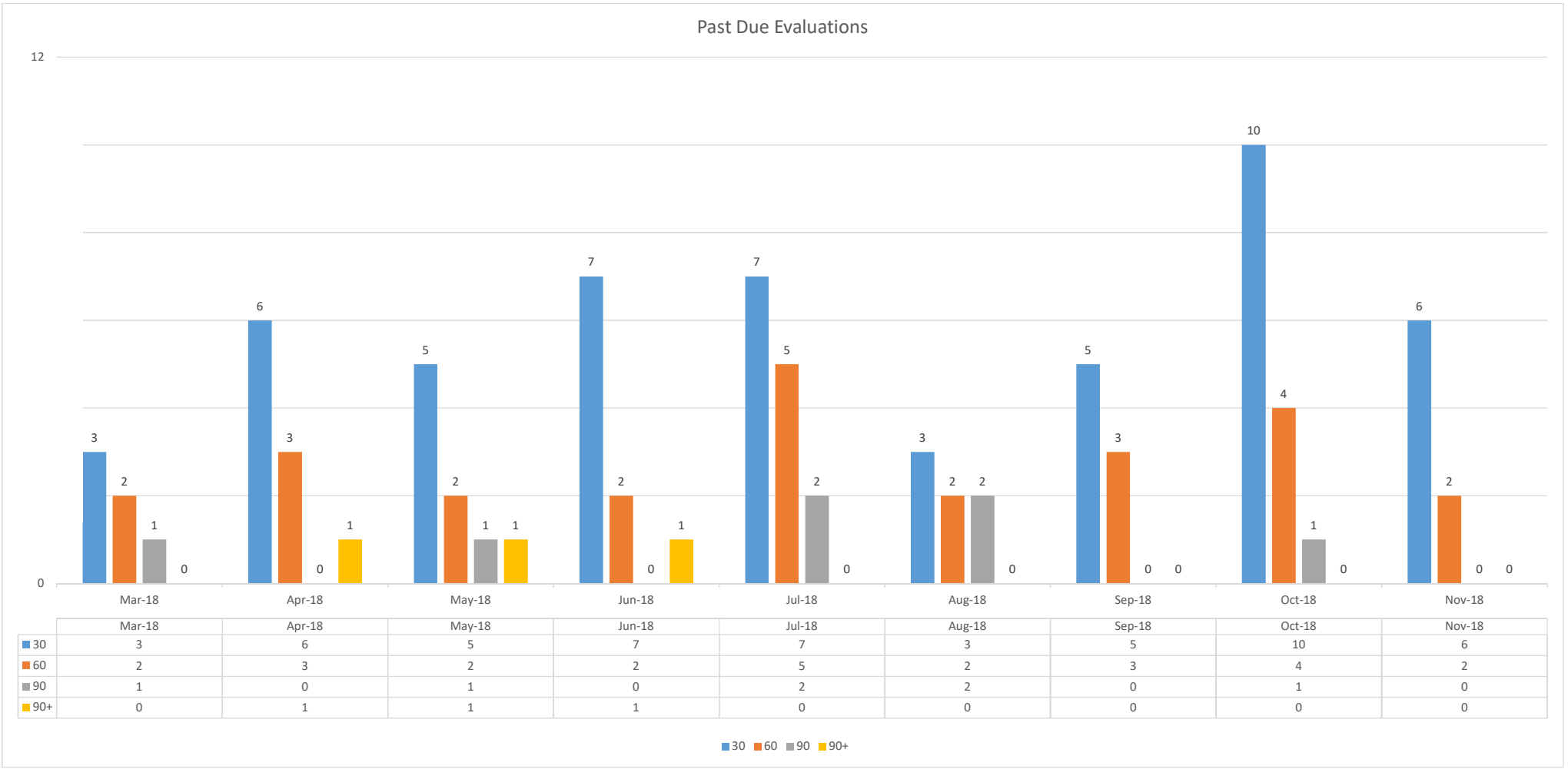
Bear Valley Community Healthcare District
Repairs Maintenance

Hospital/FHC/PT	Trimmed Trees	Facilities	Complete	

HR Monthly Report
November 2018

STAFFING	**Active:** 215 – FT: 142; PT: 13; Per Diem: 60 **New Hires:** 4 **Terms:** 1 (1 Voluntary 0 Involuntary) **Open Positions:** 19
EMPLOYEE PERFORMANCE EVALUATIONS	**DELINQUENT: See attachment** 30 days: 6 60 days: 2 90 days: 0 90+ days: 0 **MOVING FORWARD:** Continue monitoring ongoing annual evaluations.
WORK COMP	**NEW CLAIMS: 1** **OPEN:** 8 Indemnity (Wage Replacement, attempts to make the employee financially whole) - 3 Future Medical Care – 4 Medical Only - 1 **MOVING FORWARD:** Quarterly claims review. **SAFETY:** Working with Beta Loss Prevention for safety initiatives.
FILE AUDIT/ LICENSING	**FILE AUDIT:** One missing signed Job Description Licenses: All up to date **MOVING FORWARD:** Continue file audit
JOB DESCRIPTIONS/ EVALUATIONS	**Job Descriptions:** In process (January target date) **Evaluations:** In process (March target date, need to complete job descriptions first)
EMPLOYEE EVENTS	Christmas party 12/15

State/Fed audit found no HR deficiencies



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
30	3	6	5	7	7	3	5	10	6
60	2	3	2	2	5	2	3	4	2
90	1	0	1	0	2	2	0	1	0
90+	0	1	1	1	0	0	0	0	0

Infection Prevention Monthly Report

November 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. ▪ 3 reports filed this month	• Review ICP regulations. • AFL to be reviewed at Infection Control Committee and Regulatory committee. • Continue Monthly Reporting Plan submissions.
2. Construction	▪ ER remodel in almost complete ▪ ICRA permits in place, will revise as needed.	• Work with Maintenance and contractors to ensure compliance.
3. QI	• Continue to work towards increased compliance with Hand Hygiene. o Compliance at 83% for November.	• Continue monitoring hand hygiene compliance.
4. Outbreaks/ Surveillance	o Public Health Report • Flu season began November 1	▪ Informational

	• Those employees who have not received a flu shot will be required to wear a hospital-provided mask while in patient care areas. • Those employees who have received a flu vaccine will have a star sticker on their badges as an indication. o Community Health Report o 3 cases of MRSA in wounds, outpatients o 3 cases of c-diff in outpatients	
5. Policy Updates	▪ Policies reviewed, approved: o Multiple policies put through for annual review.	▪ Clinical Policy and Procedure Committee to review and update Infection Prevention policies.
6. Safety/Product	▪ IP working with EVS to create policy outlining who is responsible for cleaning what and how often.	▪ Continue to monitor compliance with approved cleaning procedures.
7. Antibiotic Stewardship	▪ Pharmacist continues to monitor antibiotic usage.	▪ Informational.
8. Education	▪ ICP continues to attend the APIC meetings in Ontario when possible.	▪ ICP to share information at appropriate committees.

9. Informational	Statistics on Immediate Use Steam Sterilization will now be included with the monthly surgery stats and reported to P&T Committee monthly. • Number of times IUSS utilized in November = 0 • Number of surgical cases in November = 11 Infection Prevention Rounds for POC IP monitors the following on a monthly / ongoing basis: For November: • Storage standards are met. • Cleaning schedule of the autoclaves is up to date. • Temperature and humidity monitoring and logs are up to date. • Terminal cleaning is being done in OR, Sterile Processing, and Decontamination and logs are up to date. • Clinical staff is able to verbalize proper cleaning procedure and solution for the glucometer. • Clinical staff is able to verbalize proper dwell times for different cleaning solutions. CDPH has informed us that their employees are required to receive flu vaccinations. Any CDPH employee entering the facility will have an"18/19" sticker on his or her badge to identify that a vaccine was received. Those not taking the vaccine are required to wear a hospital-provided mask while in patient care areas.	▪ Informational
Heather Loose, BSN, RN Infection Preventionist		*Date: December 3, 2018*

Department	Title (Version)	Date Reviewed	Summary
Administration	Reimbursement for Travel and Training Policy	11/16/2018	Annual review, revised to reflect current process.
Case Management	Discharge of Homeless Patient	11/30/2018	Annual review. Revised to reflect the new law.
FHC/RHC	Sample Medications (v.3)	10/26/2018	Annual review. No changes.
FHC/RHC	Standardized Procedures-Mid-Level Providers (v.1)	10/26/2018	Annual review. No changes.
FHC/RHC	Mandatory Laboratory Testing Provided at the FHC/RHC	11/30/2018	Annual review. Changed policy name from 'Waived Testing - Clinic'. Revised to reflect current process.
Infection Control	HCW Masking during flu season (v.5)	10/26/2018	Annual review. Revised verbiage to reflect current process.
Patient Financial Services	Medicare Secondary Payer Policy	11/2/2018	New Policy.
SNF	Abuse of a Resident by Another Resident (v.5)	10/26/2018	Annual review. Formatted.
SNF	Charting-SNF (v.4)	10/26/2018	Annual review. Revised verbiage and formatted.
SNF	Antimicrobial Stewardship - Distinct Part SNF (v.1)	10/26/2018	Annual review. Formatted.
SNF	Administration of Medications and Treatments (v.4)	10/26/2018	Annual review. Revised verbiage and formatted.
SNF	Antipsychotic Medications in the SNF (v.2)	10/26/2018	Annual review. Formatted.
SNF	Discharge/Transfer from the Distinct Part SNF (v.1)	10/26/2018	Annual review. Revised verbiage and formatted.
SNF	Away From The Facility-SNF (v.5)	10/26/2018	Annual review. Revised verbiage and formatted.
SNF	Admission, Transfer, and Discharge Skilled Nursing (v.5)	10/26/2018	Annual review. Revised verbiage and formatted.
SNF	Use of Hoyer Lifts in Public Hallways (v.2)	10/26/2018	Annual review. Formatted.
SNF	Urinary Incontinence Management (v.1)	10/26/2018	New policy.
SNF	Dementia Care (v.1)	10/26/2018	New policy.
SNF	Behavioral Assessment and Monitoring (v.1)	10/26/2018	New policy.
SNF	Elopement & Wandering (v.6)	11/16/2018	Annual review. Changed policy name from 'Elopement and Wanderguard', attached assessment document and revised verbiage to reflect current process.
SNF	Hospice Services (v.1)	11/16/2018	New policy.

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Recommendation for Action

Date: 05 December 2018

To: BVCHD Finance Committee

From: Garth M Hamblin, CFO

Re: Letter of Agreement for Financial Advisory Services
G. L. Hicks Financial, LLC

Recommended Action

Approve attached Letter of Agreement for Financial Advisory Services with GL Hicks Financial, LLC.

Background

Revisions were made and approved by legal to this final agreement. The Finance Committee reviewed the agreement at the December 4th meeting.

Gary Hicks, President of G. L, Hicks Financial LLC has extensive experience working with Facilities in California regarding financing of major Remodel / Renovation projects.

As we move forward with consideration of remodel / expansion plans for BVCHD and our capacity to meet the financial needs of such project; we need to further explore options for funding the project.

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Contract Cover Sheet

Contract Name: GL Hicks

Purpose of Contract: Financial Advisor

Contract # / Effective Date / Term _____ / _____

Originating Dept. Name / Number: _____

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

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

Administrative Officer	**Signature:**	NA	**Date:** NA
HIPAA/Privacy Officer (as appropriate)	**Signature**	NA	**Date:** NA
Legal Counsel	**Signature:**	via email	**Date:** 11-27-18
Compliance Officer	**Signature:**	Mary Norman	**Date:** 11-14-18 FMV?
Chief Financial Officer	**Signature:**		**Date:** 27 Nov 2018
Chief Executive Officer	**Signature:**		**Date:** 11-13-18
Board of Directors When Applicable	**Signature**		**Date:** _____

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

Contract Cover Sheet

G.L. Hicks Financial, LLC

337 S. Palisades Drive
Orem, UT 84097
(801) 225-0731

October 31, 2018

Mr. John Friel, Chief Executive Officer
Bear Valley Community Healthcare District
41870 Garstin Drive
Big Bear Lake, California 92315

Re: Bear Valley Community Healthcare District
Letter of Agreement for Financial Advisory Services

Dear Mr. Friel:

G.L. Hicks Financial, LLC ("Hicks") would be pleased to act as financial advisor to Bear Valley Community Healthcare District ("Bear Valley") to assist in the issuance of debt pursuant to the USDA Direct Loan Program and/or other forms of debt, the proceeds of which will be used to finance the construction and equipping of a renovation and expansion to the Bear Valley health facility located in Big Bear Lake, California (the "Engagement"). Bear Valley, acting by and through its duly authorized representative, and Hicks, acting by and through its President, Gary Hicks, agree that Hicks shall furnish certain services to Bear Valley and Bear Valley agrees to accept said services and to make payment of fees and expenses regarding this Engagement, upon the terms and conditions herein set forth.

This document contains the entire agreement between both parties. All prior negotiations between Hicks and Bear Valley are merged in this agreement, and there are no understandings or agreements other than those incorporated or referred to herein. This agreement may not be modified except by an instrument in writing, dated and signed by the duly authorized representatives of both Hicks and Bear Valley.

I. Hicks shall offer its professional services and facilities as financial advisor to Bear Valley in connection with this Engagement and, in that capacity, Hicks agrees to perform the following services and such other duties which in the exercise of its professional judgment may be necessary or advisable.

   a. Provide consulting services relating to the analysis of options available to accomplish Bear Valley's objectives to complete this Engagement with the issuance of debt and a construction loan, as needed (the "Debt").

   b. Coordinate meetings with Bear Valley and other parties engaged by Bear Valley and arrange for the preparation and presentation of all necessary and required financial and disclosure information, as needed.

   c. With Bear Valley's input, prepare a timetable to indicate the steps and dates by which events should be completed. Discuss with Bear Valley representatives what steps are required to accomplish issuance of the Debt.

   d. Review and consult with Bear Valley regarding various structures and any financial implications relating to the issuance of the Debt, in reviewing financing documents and in the selection of other financing participants.

   e. Review with Bear Valley, its legal counsel and management team regarding the structure of the Debt and the design and implementation of its financing plan. Meet with Bear Valley's governing board and management team.

   f. Prepare a closing memorandum detailing steps leading up to and including closing of the Debt.

Hicks does not provide investment advisory, placement agent, broker or dealer related services. Hicks is a municipal advisor registered with the MSRB (ID # K0275) and the SEC (ID # 867-01010-00) and information regarding Hicks and its representatives can be found at www.sec.gov/edgar/searchedgar/companysearch.html using our CIK # 0001617606. Hicks will be compensated by an hourly fee. Because our fee is based on hourly work to be provided, we hereby notify you that a potential conflict exists. While this form of compensation is customary in the municipal securities market, it presents a potential conflict since we could have an incentive to recommend to Bear Valley a transaction that is unnecessary; however, Hicks agrees to not recommend or perform work on transactions that are unnecessary. Hicks does not have any other known conflicts of interest in relation to this Engagement. Total fees charged pursuant to this agreement will be dependent on the time it takes to complete the financing and the level of services required. Should you become dissatisfied with our services and therefore wish to file a complaint please see the MSRB brochure regarding the filing of complaints with the MSRB on its webpage at (http://www.msrb.org/~/media/Files/Resources/MSRB-MA-Clients-Brochure.ashx?la=en).

II. In consideration of the foregoing services, it is agreed that fees and expenses of Hicks relating to this Engagement shall be paid by Bear Valley as follows:

a. Bear Valley will make monthly payment to Hicks, within 30 days after receipt of an invoice from Hicks, at a rate of $325.00 per hour for work performed on its behalf. The total amount to be paid pursuant to this agreement is difficult to estimate due to the nature and scope of the financing and the extent of services to be provided; however, I believe the total hours for this Engagement will range from 200 hours to 450 hours. If the hours required to perform the services under this agreement exceed 200 hours, then Hicks will promptly notify Bear Valley of the same and obtain written approval before incurring additional fees beyond the 200 hours estimated. In addition, Bear Valley agrees to reimburse out-of-pocket expenses of Hicks incurred in relation to this engagement.

b. Bear Valley shall engage the services of legal counsel, and shall commission other necessary services. Bear Valley shall be responsible for the payment of all expenses and costs incurred in connection therewith.

c. Fees and expenses described in paragraphs II.a. and II.b. above may be paid or reimbursed with Debt proceeds to the extent allowable by law.

The term of this agreement shall be thirty-six months from the date this agreement is executed by Bear Valley, unless extended in writing by mutual consent of the parties to this agreement. Bear Valley and Hicks shall have the ability to terminate this agreement, without cause, with 30 days written notice to the other party. If either party initiates any legal proceedings in connection with any breach or default by the other party under the terms of this agreement, then the party prevailing in said proceeding shall be entitled to recover reasonable attorney's fees, together with costs of suit, from the non-prevailing party.

This agreement shall bind the successors and assignees of the parties hereto. The rights, duties and obligations hereunder, however, shall not be assigned by either party without the prior written consent of the other party having been obtained. When accepted by Bear Valley, this agreement will constitute the entire agreement between Hicks and Bear Valley for the purpose and consideration herein specified. Bear Valley's acceptance will be indicated by proper signature of its authorized officer or representative on both copies of this agreement and the returning of one executed copy to the undersigned.

If you have any questions or concerns about any disclosures provided herein, please make those questions or concerns known immediately to the undersigned. In addition, you should consult with your legal, accounting, tax and other advisors, as applicable, to the extent you deem appropriate.

I appreciate this opportunity to serve Bear Valley Community Healthcare District as herein described, and look forward to the successful completion of this Engagement.

Sincerely,

Gary Hicks
President

The undersigned has read this agreement as set forth above and understands it fully and hereby accepts said agreement and further agrees to the terms, amounts, conditions and schedules of payment of said agreement.

ACKNOWLEDGED AND ACCEPTED:

Bear Valley Community Healthcare District

SIGNATURE: _____
NAME: _____
TITLE: _____
DATE: _____

Board Report

December 2018

Debt Capacity Analysis

This consulting engagement will be completed by the end of the year.

Cost Report Review

Our consultants have completed this review.

Productivity Assessment

The consultants have sent their draft report to management for review and the consultants have reviewed the report with them. It will be finalized within 30 days.

Managed Care

We have facilitated a call with John and our Managed Care consultant to discuss efforts to contract with Heritage and managed care insurers.

Upcoming Education Events – December

12/13/18 Compliance Officer Hot Topics: Compliance Year in Review
December 13, 2018 10:30 - 11:30 am CST

The Role of the Hospitalist in Population Health Webinar
Date: Thursday, December 6, 2018

http://www.qhrevents.com/innovation/continuing-innovation/

Other

- Due to scheduling conflicts we will not be able to attend the Board meeting.

Upcoming Projects

- Contractual and Bad Debt Analysis
- Productivity Benchmarking Assessment
- Debt Financing Capability Analysis
- Community Health Needs Analysis

Completed Projects

- Mock Survey – Quality and Life Safety
- Compliance Assessment
- Cost Report Review – following preparation of Cost Report

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Contract Cover Sheet

Contract Name: TeleConnect Therapies

Purpose of Contract: Tele Mental Health

Contract # / Effective Date / Term _____ / 12.31.2020

Originating Dept. Name / Number: FHC

Department Manager **Signature:** [signature] **Date:** 11.8.18

BAA: ✓ Yes __ No on file **W-9:** ✓ Yes __ No on file

Administrative Officer	**Signature:**	NA	**Date:** NA
HIPAA/Privacy Officer (as appropriate)	**Signature**	NA	**Date:** NA
Legal Counsel	**Signature:**	via email	**Date:** 11-21-18
Compliance Officer	**Signature:**	Mary Norman	**Date:** 11-13-18 FMV? 1 yr term?
Chief Financial Officer	**Signature:**	[signature]	**Date:** 27 NOV 2018
Chief Executive Officer	**Signature:**	[signature]	**Date:** 11-28-18
Board of Directors When Applicable	**Signature**		**Date:** _____

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

FIRST AMENDMENT TO
OPERATIONAL AGREEMENT
BETWEEN
TELECONNECT THERAPIES AND
BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
MENTAL HEALTH SERVICES PROGRAM

This First Amendment to the Operational Agreement, effective January 1, 2019, is made by and between TeleConnect Therapies, a mental health services partnership ("TCT"), and Bear Valley Community Healthcare District Rural Health Clinic ("Clinic").

WHEREAS, the parties previously entered into the Operational Agreement effective as of November 12, 2016; and

WHEREAS, in accordance with Section XII.G. of the Operational Agreement relative to written amendments, Clinic and TCT mutually agree to the changes herein.

NOW THEREFORE, Clinic and TCT hereby agree to amend the Operational Agreement as follows:

1. Section IV. Term and Termination, subsection A. Term, is deleted in its entirety and replaced with a new Section IV.A. as follows:

IV. Term and Termination

A. Term. This Agreement shall commence on January 1, 2017 and continue to December 31, 2020.

Except as otherwise expressly set forth in this First Amendment, all other terms and conditions set forth in the Operational Agreement shall remain in full force and effect. In the event of conflict between the provisions of this Amendment and any other provisions in the Operational Agreement, the intent of the provisions in this Amendment shall prevail.

IN WITNESS WHEREOF, the parties have caused this First Amendment to be executed by their duly authorized officers.

TeleConnect Therapies,
A Professional Partnership
P.O. Box 1665
Avalon, Ca. 90704

Dawn Sampson, LCSW, CEO, TeleConnect Therapies Date

Mindy Mueller, Psy.D., Clinical Director, TeleConnect Therapies Date

Clinic:

Rob Robbins, Board President
Bear Valley Community Healthcare District
41870 Garstin Drive
Big Bear Lake, CA 92315

OPERATIONAL AGREEMENT
BETWEEN
TELECONNECT THERAPIES AND
BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
MENTAL HEALTH SERVICES PROGRAM

This Operational Agreement (the "Agreement") is made by and between TeleConnect Therapies, a mental health services partnership ("TCT"), and Bear Valley Community Healthcare District Rural Health Clinic ("Clinic"), effective on the date last signed by the parties.

WITNESSETH

WHEREAS, Clinic is a Rural Health Clinic owned and operated by Bear Valley Community Healthcare District and provides Rural Health Services. Clinic is engaged in the business of providing mental health services; and

WHEREAS, TCT is a professional partnership engaged in the business of providing mental health services to rural clinics throughout California via teleconferencing technology; and

WHEREAS, Clinic desires to enhances its level of mental services in its facilitating telemedicine consultations by specialist physicians and other properly qualified healthcare personnel under arrangement with TCT using equipment designed for such services; and

WHEREAS, Clinic desires to ensure and facilitate the highest level of psychiatric consultation to patients meeting criteria and presenting at designated Clinic location, and in furtherance thereof, shall obtain appropriate equipment to facilitate consults by physicians and other properly qualified healthcare personnel under arrangement with TCT. TCT desires to arrange the provision of such services.

NOW, THEREFORE, for and in consideration of the agreements contained herein and other good and valuable consideration, the receipt and adequacy all of which are forever acknowledged and confessed, the parties hereto agree as follows:

I. Preliminary Statement

A. Contractor Relationship: TCT is a contractor of mental health services to Clinic. TCT arranges for specialists engaged by one or more of its affiliated behavioral health practices, to provide remote specialty services to Clinic patients ("Contracted Services"). For purposes of this Agreement, each affiliated specialist providing or anticipated to provide Contracted Services is a Licensed Mental Health Practitioner. Clinic and Licensed Mental Health Practitioners shall agree on a process by which TCT may obtain, or have access to, all the necessary patient records from Clinic.
B. This Agreement describes mental health services that shall be provided to recipients who are enrolled by both TCT and Clinic.
C. The components of the TCT/ Clinic program include the following:

1. On-site visits to Clinic at least annually by a TCT representative for face-to-face program coordination.
2. A defined system of referral of Clinic patients to TCT for evaluation for provision of telemental health services.
3. A system of telemental health appointment scheduling agreed upon by TCT and Clinic.
4. A procedure for delivery of telemental health services from TCT to qualifying Clinic patients, compliant with all applicable governmental regulations and professional association guidelines regarding telemental health services.
5. Consultation space, videoconferencing apparatus and other necessary hardware and software maintained by both TCT and Clinic.

II. Program Operation

A. Clinic shall determine the number of contracted hours per month for TCT services. Clinic will also identify a Clinic contact person for TCT services.

B. Clinic shall provide teleconferencing equipment and consultation space at Clinic site that is compliant with all Department of Mental Health/ Medi-Cal requirements.

C. Patient Eligibility Criteria:

1. Must be a registered patient of Clinic, with identified Clinic staff medical provider.
2. Must meet Medi-Cal Medical Necessity Criteria for mental health services.
3. Must consent to receive telemental health services and consent to all other procedures associated with the TCT program including sharing of medical records between TCT and Clinic.
4. Must be deemed clinically appropriate for TCT telemental health services by TCT staff.

D. The Clinic provider or his/her representative shall complete the TCT referral form with sufficient information to permit TCT staff to determine the reason for referral and to contact the Clinic patient. Provider shall also obtain the patient signature on the Telemedicine Consent Form. Referral form and signed consent form shall be delivered to TCT in a mutually agreed upon process.

E. If informed consent is obtained, TCT staff shall review referrals received from clinic, select specific referrals for professional assessment on the basis of clinical appropriateness and need, and contact Clinic patients to offer evaluative services. TCT or Clinic will schedule patients for TCT evaluations following the agreed upon scheduling system.

F. Those Clinic patients who accept appointment for evaluative services and present for evaluation become TCT clients and will be evaluated by TCT staff via an initial telemental health visit.

G. When a TCT patient arrives for an appointment at Clinic, the patient is registered for a visit in the Clinic system and the Clinic will provide the patient with an orientation to the telemental health system.

H. When the Clinic patient has been oriented by the Clinic staff, the remote TCT therapist is contacted and a videoconference link compliant with telemental health policies is established.

I. The TCT therapist verifies the technical and clinical suitability of the linkage, and delivers telemental health services.
J. Those individuals who, as a result of TCT evaluation are found to meet criteria for ongoing telemental health services are given regularly scheduled appointments, as clinically indicated, within the time frame previously agreed upon by TCT and Clinic, and Clinic staff are notified.
K. If the TCT therapist determines that a general medical assessment is recommended, the TCT provider coordinates care with the Clinic staff. Consultations will be held between Clinic medical providers and TCT therapists as needed to coordinate the care of the patient.
L. If the TCT therapist determines that a psychiatric consult is recommended, the patient will be referred to the appropriate psychiatrist within the community, or to the telepsychiary program, if one exists at the Clinic. If the patient is seen by a psychiatrist, the Clinic will obtain signed patient authorization for TCT to exchange protected mental health information with the psychiatrist. Consultations will be held between the psychiatrist and TCT therapists as needed to coordinate the care of the patient.
M. If TCT therapist or Clinic licensed staff determine patient is unstable medically or psychologically during TCT service, TCT therapist will contact Clinic at which time clinical and/or security staff escort patient to nearest ER for evaluation and treatment. If the Clinic has alternative procedures for evaluation of patients who may be a danger to themselves or others, or who are gravely disabled and are unable to care for themselves, TCT and Clinic will jointly establish and clearly document a procedure for this situation prior to initiating TCT services.
N. If at any time TCT staff believe the patient is no longer appropriate for TCT telemental health services, Clinic staff will be notified and appropriate referrals will be made.
O. TCT and Clinic shall maintain their own separate clinical records systems. TCT will transmit records of each patient visit, copies of initial assessment, QuickPsycho Diagnostic Panel results, and discharge summaries to clinic through an agreed-upon method determined to be confidential and HIPAA Complaint.
P. TCT will submit monthly statements to Clinic based on agreed upon hours of service. Bills are payable within 30 days.
Q. TCT mental health providers shall have 4 scheduled weeks off per year, for which Clinic will not be charged. Time off will be scheduled at least 1-month in advance. During each TCT provider's days off another licensed mental health professional will be available by telephone for emergencies, as needed.
R. If TCT or Clinic must cancel a date of service due to unforeseen illness, injury or other unavoidable event, the Clinic will not be billed, unless the patients can be rescheduled during the same week. In the event of a cancellation, the Clinic and patients will be notified as soon as possible.

III. Clinic Responsibilities

In addition to the Clinic responsibilities outlined in the "Program Operation" section above, the Clinic shall:

A. Perform all patient billing functions, including obtaining insurance pre-authorizations.
B. Guarantee a minimum of 2-hours of mental health services per week, to be paid at a rate of $120 per hour for 50-minute sessions for individuals, couples or families. Clinic may

schedule patients for 45- minute sessions if desired as clinically appropriate, at a rate of $90 per 45-minute session, to maximize the number of patients seen in each date of service.

C. Clinic will pay $40 for each patient who does not show for a scheduled one-hour appointment, or $30 for each patient who does not show for a scheduled 45-minute appointment, when the patient does not cancel the appointment prior to the scheduled appointment time.
D. Provide onsite Clinic staff to assist the TCT patient as necessary and assure safety during the provision of telemental health services.
E. Clinic and TCT together shall agree on procedures for evaluation and treatment of patients who are determined to be a danger to themselves, to others, or to be gravely disabled and unable to care for themselves.
F. Collaborate with TCT on an ongoing basis in order to effectively coordinate care of individuals receiving telemental health services.
G. Provide to TCT staff available resource information on health care services, social services, educational services, religious services, 12-step programs, and other services available to patients within the rural community, and contact information for each of these, to enable TCT staff to better serve the Clinic patients.
H. If psychiatric services are not readily available in the Clinic community, TCT will provide the Clinic with information on various telepsychiatry services available. These telepsychiatrists are independent contractors and have no affiliation with TCT or TCT staff. The decision whether or not to contract with a telepsychiatrist is entirely the decision of the Clinic

IV. TCT Responsibilities:

In addition to the TCT responsibilities outlined in the "Program Operation" section, TCT shall:

A. Complete and submit a credentialing application for all professional staff to Clinic as required by Bear Valley Community Healthcare District's Medical Staff Bylaws.
B. Work together with Clinic, if desired by Clinic, to advertise TCT services to the rural community via local media.
C. Collaborate with Clinic on an ongoing basis in order to effectively coordinate care of individuals receiving TCT services.
D. Provide the services of mental health professionals (LCSW or Psy. D.) licensed to practice in the State of California, and allowable as providers under Medicare's Rural Health Clinic guidelines.
E. Provide written information as desired by Clinic on Medi-Cal and Medicare billing guidelines for telemental health services.
F. Provide information on telepsychiatry services available in California as specified under "H" above. Coordinate mental health services with psychiatrists who serve the community, as needed.
G. Provide provisional diagnosis within 1 business day after initial appointment.
H. Provide a written psychosocial assessment on each patient, using standardized reporting format (as required by patient's third –party payor, if applicable) within 2 business days following each patient's second visit.
I. Schedule patients for 2 or 4 sessions per month, depending upon client need and insurance coverage. Provide written progress notes in the "Goal, Intervention, Response,

Plan" format by fax or other confidential method to be agreed upon by Clinic and TCT, by the following business day.

J. Provide a written treatment plan within one business day following the patient's third visit. Update each patient's treatment plan a minimum of annually.
K. Provide a discharge summary within 3 months following the patient's final session.
L. Provide appointment reminder calls for follow-up appointments.
M. Work with the community's existing system for placing involuntary psychiatric holds (5150s); work with the community's existing resources for referrals.
N. Provide emergency telephone access to a licensed mental health professional 7 days a week between the hours of 8:00 am – 8:00 pm.
O. Mail to patients patient-education booklets and workbooks on mental-health topics as needed.
P. Retain all records pertinent to this Agreement for a period of seven (7) years from the date of expiration or termination of this Agreement.

V. Confidentiality and Disclosure of Information

A. TCT and Clinic agree that the clinical records of both entities are confidential information. To the extent permitted by State and Federal laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA), the parties may exchange confidential information for the purpose of care coordination including names, addresses, physical and mental health data, family history and the like, as necessary and appropriate to coordinate care. The parties, and their respective directors, officers, employees and agents shall hold such confidential information in strict confidence and shall not disclose the same unless permitted or required by law. The parties' obligations in this section shall survive the Agreement's termination or expiration.

B. When a patient requests Protected Mental Health Information from Clinic for him/herself or for a 3rd party provider, Clinic agrees to provide the patient's therapist with the appropriate authorization signed by the patient or legal representative, specifying what records have been requested and for what purpose, and Clinic will await the therapist's decision on release of records. As specified under California Health and Safety Code 123115 (b) the therapist may decline to provide a requested record to a patient under certain conditions, or under California Health and Safety Code 123130 (a) the therapist may provide a written summary of the record in lieu of a requested record under certain conditions.

C. Confidentiality of Credentialing Information: The parties shall treat all credentialing information shared, and all quality-related information shared as privileged and confidential. Such information is to be used for credentialing, quality improvement, and peer review activities only. Each party shall ensure that no portion of any materials or information received from the other party are disclosed by it or its agents to any employee or third party for reasons unrelated to evaluating the practitioner's quality and credentials to provide Contracted Services, except as required by law. It is TCT's responsibility to obtain the individual practitioner's written consent for release of any and all information shared for credentialing, privileging, and peer review purposes.

VI. Term and Termination

A. **Term.** This Agreement shall commence on January 1, 2017 and continue to December 31, 2018.

B. **Termination Upon Notice.** Either party may terminate the Agreement without cause on 30 days notification.

C. **Termination Upon Material Breach.** A non-breaching party may terminate this Agreement for cause at any time upon 30 days written notice of intent to terminate. In defaulting party cures such default within such 30 day notice period, the non-breaching party may elect, at its discretion, to rescind the termination notice in writing, in which case this Agreement shall continue in full force and effect.

VII. Legislative/Regulatory Modification

If any law, regulation or standard is enacted, promulgated, or modified in a manner that, in the opinion of a party's legal counsel (i) prohibits, restricts or in any way materially affects this Agreement; (ii) subjects either Clinic or TCT to a fine or penalty in connection with its representations or responsibilities hereunder, or (iii) subjects either party to a loss of Medicare or Medicaid certification or accreditation body because of the existence of this Agreement or the applicable party's representations or performance of obligations hereunder, then within 30 days following notice from one party to the other, the parties shall complete the good faith negotiation of an amendment to this Agreement or a substitute agreement that will carry out the original intention of the parties to the extent possible in light of such law, regulation or standard and each party shall execute such amendment or new agreement.

If the parties cannot reach agreement on new terms within 60 days following the notice provided hereunder or such earlier date as necessary to avoid substantial penalties or fines, then this Agreement shall immediately terminate, following written notice of termination from either party.

VIII. Liability

No party is responsible for the acts of third parties. Each party is responsible for its own acts or omissions and those of its directors, officers, employees and agents.

IX. Insurance

Each party warrants that it maintains general liability and professional liability insurance with limits of not less than $1 million each occurrence, and $3 million aggregate to cover any claims that may arise with respect to its own acts or omissions arising from the services described herein. For entities with employees, workers' compensation insurance shall be maintained with limits of not less than $1 million each occurrence and $3 million aggregate. Each agency also agrees to maintain any other insurance which may be required to comply with all applicable Federal, State, and local laws, rules, regulations, ordinances and directives. Coverages shall be maintained throughout the term of this agreement. Each party's coverage shall be primary and not contributing with any other insurance or self-insurance programs maintained by the other. Each party, at the request of the other, agrees to provide a certificate of insurance or other acceptable evidence of its coverage to the requesting party.

X. Indemnification

Each party to this agreement shall indemnify, defend and hold harmless the other party from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, and expenses (including attorney and expert witness fees), arising from or connected with the indemnifying party's acts and/or omissions arising from and/or relating to the services under this Agreement. Each party agrees to notify the other party upon learning of any accident, incident, claim or lawsuit relating to the services performed by any of the parties pursuant to this Agreement.

XI. HIPAA Requirements

To the extent applicable to this Agreement, TCT agrees to comply with the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"), the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 USC 1320d through d-8 ("HIPAA") and any current and future regulations promulgated under either the HITECH Act or HIPAA, including without limitation the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Parts 160, 162 and 164 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the Federal electronic Transactions Regulations"), all as may be amended from time to time, and all collectively referred to herein as "HIPAA Requirements." The parties have concurrently with the execution for this Agreement, executed Exhibit "A" entitled HIPAA Business Associate Agreement, which Exhibit is attached hereto and incorporated by reference herein. TCT agrees to enter into any further agreements as necessary to facilitate compliance with HIPAA Requirements. In the event the Business Associate Agreement is breached by TCT or TCT's Agent, TCT shall provide assistance to BVCHD in notifying individuals pursuant to 45 C.F.R. 164.404 and 164.406. BVCHD shall provide TCT with documentation of its reasonable costs incurred to accomplish the required breach notifications. TCT shall reimburse BVCHD for such reasonable costs and all other damages, including reasonable attorney's fees, incurred as a result of the breach.

XII. General Provisions.

A. **Independent Contractor**: This agreement shall not create the relationship of employer and employee, a partnership, or a joint venture between the parties. Each party shall determine the number of days and hours of work of its employees, agents and sub-contractors and shall be solely liable for the wages, employment taxes, fringe benefits, work schedules, and work conditions of its employees, agents and subcontractors.

B. **Third Parties:** Nothing in this Agreement, express or implied, is intended to nor shall be construed to confer upon any person or entity, other than the parties to this Agreement, any remedy or claim under or by reason of this Agreement as third-party beneficiaries or otherwise. The terms of this Agreement are for the sole and exclusive benefit of the parties to this Agreement.

C. **Non-assignment:** No party to this Agreement may assign this Agreement, and any rights or obligations, hereunder, whether by written agreement, operation of law or in any manner whatsoever, without the non-assigning party's prior written consent, which consent shall be unreasonably withheld.

D. **Amendment.** Parties may amend this Agreement from time to time by a written Agreement signed by an authorized representative from each Party.

E. **Other Agreements:** This Agreement, including all exhibits hereto, contains the entire understanding and agreement of the parties. In the event of a conflict between a provision contained in this Agreement and a provision contained in an agreement or arrangement that existed prior to the Effective Date of this Agreement, the terms of this Agreement shall control and govern the sections of the parties.

F. **Notice.** Any notice required by this Agreement or desired to be given by one party to the other shall be effective when personally delivered (personal service), or one (1) business day after the day on which any such notice is sent by overnight mail, addressed as follows:

For Bear Valley Community Health Care District:
Chief Executive Officer
P.O. Box 1649
Big Bear Lake, CA 92315

For TeleConnect Therapies:
Dawn Sampson, LCSW
TeleConnect Therapies
P.O. Box 1665
Avalon, CA 90704

Acknowledged and Accepted this 11 day of November, 2016.

TeleConnect Therapies,
A Professional Partnership
P.O. Box 1665
Avalon, Ca. 90704

D Sampson LCSW 11-12-16

Dawn Sampson, LCSW, CEO, TeleConnect Therapies Date

Psy.D 11/12/16

Mindy Mueller, Psy.D., Clinical Director, TeleConnect Therapies Date

Clinic:

John Friel 11-10-16

John Friel, CEO
Bear Valley Community Healthcare District
41870 Garstin Drive
Big Bear Lake, CA 92315

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Contract Cover Sheet

Contract Name: ISAIAS Pajar, MD

Purpose of Contract: Physician Services Clinic

Contract # / Effective Date / Term _____ / 1-16-19 – 1-17-21

Originating Dept. Name / Number: _____

Department Manager **Signature:** [signature] **Date:** 10-23-18

BAA: X Yes __No on file **W-9:** X Yes __No on file

Administrative Officer	**Signature:**	NA	**Date:** NA
HIPAA/Privacy Officer (as appropriate)	**Signature**	NA	**Date:** NA
Legal Counsel	**Signature:**	via email	**Date:** 10-23-18
Compliance Officer	**Signature:**	Mary Norman	**Date:** 10-26-18 need FMV doc.
Chief Financial Officer	**Signature:**	[signature]	**Date:** 5 NOV 2018
Chief Executive Officer	**Signature:**	[signature]	**Date:** 11-28-18
Board of Directors When Applicable	**Signature**		**Date:**

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

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
PHYSICIAN AGREEMENT FOR PHYSICIAN SERVICES AT THE RURAL HEALTH CLINICS
WITH
ISAIAS PAJA, M.D.

THIS PHYSICIAN AGREEMENT ("Agreement") is made and entered into as of the 16th day of January 2019 by and between Bear Valley Community Healthcare District (a public entity), ("Hospital") and Isaias Paja, M.D., ("Physician").

RECITALS

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

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

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

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

AGREEMENTS

SECTION I. RESPONSIBILITIES OF PHYSICIAN.

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

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

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

1. Until the expiration of four (4) years after the furnishing of such Services, Physician shall, upon written request, make available to the Secretary of the Department of Health and Human Services (the "Secretary'), the Secretary's duly-authorized representative, the Comptroller General, or the Comptroller General's duly-authorized representative, such books, documents and records as may be necessary to certify the nature and extent of the cost of such Services; and
2. If any such Services are performed by way of subcontract with another organization and the value or cost of such subcontracted services is Ten Thousand Dollars ($10,000.00) or more over a twelve (12) month period, such subcontract shall contain, and Physician shall enforce, a clause to the same effect as subparagraph 1. immediately above.

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

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

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

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

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

G. NOTIFICATION OF CERTAIN EVENTS. Physician shall notify Hospital in writing within three (3) business days after the occurrence of any one or more of the following events:
1. Physician's medical staff membership or clinical privileges at any hospital are denied, suspended, restricted, revoked or voluntarily relinquished;
2. Physician becomes the subject of any suit, action or other legal proceeding arising out of Physician's professional services;
3. Physician is required to pay damages or any other amount in any malpractice action by way of judgment or settlement;
4. Physician becomes the subject of any disciplinary proceeding or action before any state's medical board or similar agency responsible for professional standards or behavior;
5. Physician becomes incapacitated or disabled from practicing medicine;
6. Any act of nature or any other event occurs which has a material adverse affect on Physician's ability to perform the Services under this Agreement;

7. Physician changes the location of his offices;
8. Physician is charged with or convicted of a criminal offense; or
9. Physician is debarred, suspended, or otherwise excluded from any federal and/or state health care payment program by action of the Office of Inspector General of the Department of Health and Human Services or Medi-Cal Office, or by any equivalent or coordinating governmental agencies.

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

SECTION II. REPRESENTATIONS AND WARRANTIES

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

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

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

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

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

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

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

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

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

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

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

SECTION III. INDEMNIFICATION OF LIABILITY.

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

SECTION IV. INDEPENDENT CONTRACTOR.

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

SECTION V. COMPENSATION.

At the end of each month, Physician shall submit to the administration a completed time sheet of time spent in the Family Health Clinic seeing patients. Upon receipt of completed and signed provider time sheet for services rendered under this Agreement, Hospital shall pay Physician, as for sole compensation hereunder, on a fee per visit basis at $65.00 (Sixty-Five Dollars) per visit. A billable visit is a face to face encounter where services are rendered at a level that justifies a clinic charge of 99201 or higher for a new patient, or 99212 or higher for an established patient, or 99381 or higher for a preventative medicine visit. "No charge/courtesy" visits are not eligible for provider payment. Hospital will provide Physician a list of patients seen per Hospital records that supports the payment made to Physician. All patient billings for Physician services remain the property of Hospital. Monthly payments to Physician shall be made on or before the 10th (tenth) day of the month, following the month in which services are rendered.

SECTION VI. COMPLIANCE.

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

At a minimum, Physician is expected to:

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

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

SECTION VII. TERM.

This Agreement is effective from January 16, 2019 to January 17, 2021; however this Agreement is subject to early termination as provided in Section. VIII. below.

SECTION VIII. EARLY TERMINATION.

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

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

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

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

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

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

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

SECTION IX. CONFIDENTIALITY.

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

SECTION X. INSURANCE.

PROFESSIONAL LIABILITY. Physician shall maintain at Physician's sole expense, a policy or policies of professional liability insurance as required by this Section. Such insurance shall provide coverage for Physician as the named insured, and such policy shall cover any acts of Physician's professional negligence which may have occurred during the relevant term and said policies of insurance shall be written with limits of liability of at least the minimum coverage required from time to time by the Medical Staff bylaws, but in any event no less than One Million Dollars ($1,000,000) per claim/Three Million Dollars ($3,000,000) annual aggregate for "claims made" insurance coverage. Physician further shall maintain "continuous coverage," as defined by this Section for the entire relevant term. The relevant term shall commence with the date of this Agreement and shall continue through the term of this Agreement, as well as any extensions or renewals hereof, and for a period thereafter of no less than three (3) years. In order to maintain continuous coverage for the entire relevant term Physician shall, if it changes insurers for any reason, take the necessary actions required in order to provide continuous coverage by either obtaining "tail" insurance from the preceding carriers, or "nose" insurance from the subsequent carriers. In order to satisfy the requirements of this Section, the "tail" insurance must be of either

an unlimited type or of the type which would extend the discovery period beyond the last effective day of the last contract between the parties for a period of three (3) years. In order to satisfy the requirements of this Section for "nose" insurance, the retroactive effective date for such insurance must be at least the first date of the relevant term noted above. Physician shall provide proof of current insurance and, in the event of modification, termination, expiration, non-renewal or cancellation of any of the aforesaid policies of insurance, Physician shall give Hospital written notice thereof within thirty (30) business days of Physician's receipt of such notification from any of its insurers. In the event Physician fails to procure, maintain or pay for said insurance as required herein, Hospital shall have the right, but not the obligation to obtain such insurance. In that event, Physician shall reimburse Hospital for the cost thereof, and failure to repay the same upon demand by Hospital shall constitute a material breach hereunder.

SECTION XI. ASSIGNMENT.

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

SECTION XII. NOTICES.

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

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

Physician: Isaias Paja, M.D.
85 Cottonwood Circle
Rolling Hills Estates, CA 90274

SECTION XIII. PRE EXISTING AGREEMENT.

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

SECTION XIV. HOSPITAL NOT PRACTICING MEDICINE.

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

SECTION XV. ENTIRE AGREEMENT.

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

SECTION XVI. SEVERABILITY.

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

SECTION XVII. GOVERNING LAW.

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

SECTION XVIII. REFERRALS.

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

SECTION XIX. ANTI-HARASSMENT/DISCRIMINATION/RETALIATION

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

SECTION XXI. HIPAA BUSINESS ASSOCIATE AGREEMENT.

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

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

Dated: _____ **By:** _____

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

Dated: _____ **By:** _____

Isaias Paja, M.D.
85 Cottonwood Circle
Rolling Hills Estates, CA 90274

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Contract Cover Sheet

Contract Name: Steven Knapik, DO

Purpose of Contract: Physician Services Clinic

Contract # / Effective Date / Term _____ / 2-1-19 - 1-31-21

Originating Dept. Name / Number: _____

Department Manager **Signature:** [signature] **Date:** 10.23.18

BAA: ✓Yes __No on file **W-9:** ✓Yes __No on file

Administrative Officer	**Signature:**	NA	**Date:** NA
HIPAA/Privacy Officer (as appropriate)	**Signature**	NA	**Date:** NA
Legal Counsel	**Signature:**	via email	**Date:** 10/23/18
Compliance Officer	**Signature:**	Mary Norman	**Date:** 10/26/18 need FMV doc.
Chief Financial Officer	**Signature:**	[signature]	**Date:** 5 NOV 2018
Chief Executive Officer	**Signature:**	[signature]	**Date:** 11-28-18
Board of Directors When Applicable	**Signature**	_____	**Date:** _____

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

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
PHYSICIAN AGREEMENT FOR SERVICES AT THE RURAL HEALTH CLINICS
WITH
STEVEN M. KNAPIK, D.O.

THIS PHYSICIAN AGREEMENT ("Agreement") is made and entered into as of the 1ST day of February, 2019 by and between Bear Valley Community Healthcare District (a public entity), ("Hospital") and Steven M. Knapik, D.O. ("Physician").

RECITALS

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

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

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

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

AGREEMENTS

SECTION I. RESPONSIBILITIES OF PHYSICIAN.

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

1. Physician shall provide part-time professional medical services at the Clinics, practicing a minimum of four (4) hours per week and/or as needed.
2. Physician shall maintain medical records for all patients consistent with standard industry practices and shall provide such other record keeping and administrative services as may be reasonably requested by Hospital. All medical records remain the property of the Hospital.
3. Physician shall cooperate with any quality management and utilization management programs instituted by Hospital.

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

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

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

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

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

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

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

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4. Physician becomes the subject of any disciplinary proceeding or action before any state's medical board or similar agency responsible for professional standards or behavior;
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B. Physician's license to practice medicine in the State of California or in any other jurisdiction has never been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action or made subject to terms of probation or any other restriction;

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

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

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

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

misconduct raised against Physician by any person, organization governmental agency, health care facility, peer review organization or professional society;

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

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

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

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

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

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established patient, or 99381 or higher for a preventative medicine visit. "No charge/courtesy" visits are not eligible for provider payment. Hospital will provide Physician a list of patients seen per Hospital records that supports the payment made to Physician. All patient billings for Physician services remain the property of Hospital. Monthly payments to Physician shall be made on or before the 10th (tenth) day of the month, following the month in which services are rendered.

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At a minimum, Physician is expected to:

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

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

SECTION VII. TERM.

This Agreement is effective from February 1, 2019 to January 31, 2021, however this Agreement is subject to early termination as provided in Section. VIII. below.

SECTION VIII. EARLY TERMINATION.

A. Hospital may terminate this Agreement with or without cause or immediately in the event that:

1. Physician's license to practice medicine is suspended, revoked, terminated or otherwise restricted;
2. Physician's medical staff privileges at the Hospital, or any other healthcare facility, are in any way suspended, revoked or otherwise restricted;
3. Medicare and/or Medi-Cal significantly changes the RHC program;
4. Hospital fails to maintain RHC status;
5. Physician Services Agreement is terminated or expires;
6. Physician's failure to comply with the standards of the Hospital's Compliance Program to the extent that such failure results in material fine and or sanction from Medicare or Medi-Cal Program;
7. Physician breaches any material term of this Agreement;
8. Physician fails to complete medical records in a timely fashion;
9. Physician fails to maintain the minimum professional liability insurance coverage;
10. Physician inefficiently manages patients and such inefficient management has not been cured after 30 days written notice from the Hospital;
11. Physician's inability to work with and relate to others, including, but not limited to patients and ancillary staff, in a respectful, cooperative and professional manner and such inability has not been cured after 30 days written notice from the Hospital;

12. Physician is unable to provide medical services under the terms of this Agreement due to a physical or mental disability;
13. Physician becomes impaired by the use of alcohol or the abuse of drugs;
14. Physician is convicted of any criminal offense, regardless of whether such action arose out of Physician's provision of professional services;
15. Physician commits any act of fraud, as determined by reasonable discretion of the Board, whether related to the Physician's provision of professional services or otherwise; or
16. A mutual written agreement terminating this Agreement is entered into between the Hospital and Physician.

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

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

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

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

SECTION IX. CONFIDENTIALITY.

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

SECTION X. INSURANCE.

PROFESSIONAL LIABILITY. Physician shall maintain at Physician's sole expense, a policy or policies of professional liability insurance as required by this Section. Such insurance shall provide coverage for Physician as the named insured and such policy shall cover any acts of Physician's professional negligence which may have occurred during the relevant term and said policies of insurance shall be written with limits of liability of at least the minimum coverage required from time to time by the Medical Staff Bylaws, but in any event no less than One Million Dollars ($1,000,000.00) per claim/Three Million Dollars ($3,000,000.00) annual aggregate for "claims made" insurance coverage. Physician further shall maintain "continuous coverage," as defined by this Section for the entire relevant term. The relevant term shall commence with the date of this Agreement and shall continue through the term of this Agreement, as well as any extensions or renewals thereof, and for a period thereafter of

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

SECTION XI. ASSIGNMENT.

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

SECTION XII. NOTICES.

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

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

Physician: Steven M. Knapik, D.O.
P.O. Box 7007
Big Hear Lake, CA 92315

SECTION XIII. PRE EXISTING AGREEMENT.

With an exception for Physician's Hospitalist Agreement, this Agreement replaces and supersedes any and all prior arrangements or understandings by and between Hospital and Physician with regard to the subject matter hereof.

SECTION XIV. HOSPITAL NOT PRACTICING MEDICINE.

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

SECTION XV. ENTIRE AGREEMENT.

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

SECTION XVI. SEVERABILITY.

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

SECTION XVII. GOVERNING LAW.

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

SECTION XVIII. REFERRALS.

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

SECTION XIX. ANTI-HARASSMENT/DISCRIMINATION/RETALIATION

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

SECTION XXI. HIPAA BUSINESS ASSOCIATE AGREEMENT.

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

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

Dated: _____ **By:** _____

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

Dated: _____ **By:** _____

Steven M. Knapik, D.O.
P.O. Box 7007
Big Bear Lake, CA 92315

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Recommendation for Action

Date: December 03, 2018

To: Board of Directors

From: John Friel

Re: Bhani Chawla-Kondal, MD Surgery Service Agreement
Bhani Chawla-Kondal, MD Physician Clinic Service Agreement

Recommended Action: The Board of Directors to approve the contracts as presented.

Background: Dr. Kondal will provide surgical services at the district and will also provide patient services at the Family Health Center.

Legal counsel has drafted both agreements.

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Contract Cover Sheet

Contract Name: Bhanu Chawla - Kunal, MD

Purpose of Contract: Surgery Services

Contract # / Effective Date / Term _____ / Jan 1, 2019 - Dec 31, 2019

Originating Dept. Name / Number: Admin

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

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

Administrative Officer	**Signature:**		**Date:**
HIPAA/Privacy Officer (as appropriate)	**Signature**		**Date:**
Legal Counsel	**Signature:**	Via email	**Date:**
Compliance Officer	**Signature:**	Mary Norman	**Date:** 12/6/2018
Chief Financial Officer	**Signature:**		**Date:** 6 Dec 2018
Chief Executive Officer	**Signature:**		**Date:** 12.6.18
Board of Directors When Applicable	**Signature**		**Date:**

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

Contract Cover Sheet

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
PHYSICIAN AGREEMENT FOR SERVICES AT BEAR VALLEY COMMUNITY HOSPITAL
WITH
BHANI KAUR CHAWLA-KONDAL, M.D.

THIS PHYSICIAN AGREEMENT ("Agreement") is made and entered into as of the 1st day of January, 2019 by and between Bear Valley Community Healthcare District (a public entity), ("Hospital") and Bhani Kaur Chawla-Kondal M.D., ("Physician").

RECITALS

WHEREAS the District (hereafter "Hospital" or "District"), is the owner and operator of a general acute care hospital located in Big Bear Lake, California.

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

WHEREAS, the District desires Physician to provide surgical services; and Physician is willing and so desires to contract with the District to furnish said services to the District and its patients.

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

AGREEMENTS

SECTION I. RESPONSIBILITIES OF PHYSICIAN.

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

1. Physician shall provide surgical services at the Hospital to patients pursuant to and in accordance with the medical staff privileges granted to Physician. Physician shall provide medical care to patients at the Hospital consistent with Federal and State regulations. Care and treatment rendered by Physician must be compliant with the prevailing standard of care for surgeons in California. This Agreement is subject to and conditional upon Physician obtaining medical staff surgical privileges at the Hospital.
2. Physician shall maintain medical records for all patients consistent with standard industry practices and shall provide such other record keeping and administrative services as may be reasonably requested by Hospital. All medical records remain the property of the Hospital.
3. Physician shall cooperate with any quality management and utilization management programs instituted by Hospital.

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

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

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

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

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

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

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

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

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

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

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

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

SECTION II. REPRESENTATIONS AND WARRANTIES

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

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

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

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

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

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

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

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

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

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

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

SECTION III. INDEMNIFICATION OF LIABILITY.

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

SECTION IV. INDEPENDENT CONTRACTOR.

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

SECTION V. BILLING AND COLLECTION.

Hospital shall have the authority to determine the charges to be established for Services rendered by Physician. It is agreed that the Hospital, solely, shall bill patients and/or third-party payors and receive any fees or charges for the Services of Physician(s) furnished to patients at the Hospital's facilities. Hospital shall be responsible for the accuracy of all bills submitted. Hospital shall also be responsible for completing and filing all forms necessary to facilitate such collections from Medicare, Medicaid, and other third-party payors. Physician shall not bill or seek payment from any patient or third-party payor for any Services rendered by any Physician under this Agreement.

Physician hereby assigns and grants to Hospital, as necessary, the right to bill and collect for all Services rendered by the Physician pursuant to this Agreement, and all accounts receivable and the proceeds thereof arising out of such Services.

Physician agrees to cooperate in all matters necessary to obtain timely payment, including but not limited to timely completion of all medical records. Physician shall provide Hospital personnel with adequate information in a timely manner to allow the Hospital to bill for all services provided by Physician. Physician shall sign all forms and substantiation required for submission of bills to third party payors.

SECTION VI. COMPENSATION.

Physician agrees to accept, as payment in full for all services rendered hereunder, the fees for the Physician's professional services collected by Hospital on Physician's behalf pursuant to Section V. Monthly payments to Physician shall be made on or before the 10th (tenth) day of the month, following the month in which payment for the services was received by the Hospital.

SECTION VII. COMPLIANCE.

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

   At a minimum, Physician is expected to:

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

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

SECTION VIII. TERM.

This Agreement is effective from January 1, 2019 to December 31 2019; however this Agreement is subject to early termination as provided in Section. VIII. below

SECTION VIX. EARLY TERMINATION.

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

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

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

B. Either party may terminate this Agreement for material breach; provided that the non-defaulting party shall give written notice of the claimed default, and the other party shall have 10 days to cure such performance, failing which, this Agreement may thereafter be immediately terminated by the non-defaulting party.

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

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

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

SECTION X. CONFIDENTIALITY.

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

SECTION XI. INSURANCE.

PROFESSIONAL LIABILITY. Physician shall procure and maintain a policy or policies of professional liability insurance as required by this Section. Such insurance shall provide coverage for Physician as the named insured, and such policy shall cover any acts of Physician's professional negligence which may have occurred during the relevant term and said policies of insurance shall be written with limits of liability of at least the minimum coverage required from time to time by the Medical Staff bylaws, but in any event no less than One Million Dollars ($1,000,000) per claim/Three Million Dollars ($3,000,000) annual aggregate for "claims made" insurance coverage. Physician further shall maintain "continuous coverage," as defined by this Section for the entire relevant term. The relevant term shall commence with the date of this Agreement and shall continue through the term of this Agreement, as well as any extensions or renewals hereof, and for a period thereafter of no less than three (3) years. In order to maintain continuous coverage for the entire relevant term Physician shall, if it changes insurers for any reason, take the necessary actions required in order to provide continuous coverage by either obtaining "tail" insurance from the preceding carriers, or "nose" insurance from the subsequent carriers. In order to satisfy the requirements of this Section, the "tail" insurance must be of either an unlimited type or of the type which would extend the discovery period beyond the last effective day of the last contract between the parties for a period of three (3) years. In order to satisfy the requirements of this Section for "nose" insurance, the retroactive effective date for such insurance must be at least the first date of the relevant term noted above. Physician shall provide proof of current insurance and, in the event of modification, termination, expiration, non-renewal or cancellation of any of the aforesaid policies of insurance, Physician shall *give* Hospital written notice thereof within thirty (30) business days of Physician's receipt of such notification from any of its insurers. In the event Physician fails to procure, maintain or pay for said insurance as required in this section, Hospital shall have the right, but not the obligation to obtain such insurance. In that event, Physician shall reimburse Hospital for the cost thereof, and failure to repay the same upon demand by Hospital shall constitute a material breach hereunder.

PREMIUM REIMBURSEMENT. Hospital agrees to reimburse Physician up to $5,000.00 (Five Thousand Dollars) total per year during the Agreement term for professional liability insurance premiums paid by Physician while providing professional services under this or any other Agreement. As a condition to reimbursement, Physician shall submit written proof of payment of professional liability insurance premiums to Hospital and, within thirty (30) days of receipt, Hospital shall directly reimburse Physician for premiums paid, up to $5,000.00 per year of Agreement term. Should Hospital terminate this Agreement for cause or Physician terminate this Agreement before the expiration of the term, Hospital has the right to demand Physician repay Hospital a prorated portion of paid insurance premiums based on the number of months remaining in the Agreement term at termination.

SECTION XII. ASSIGNMENT.

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

SECTION XIII. NOTICES.

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

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

Physician: Bhani Chawla-Kondal M.D.
5400 Kodiak Mountain Dr.
Yorba Linda, CA 92887

SECTION XIV. PRE EXISTING AGREEMENT.

With an exception for Physician's Clinic Agreement, this Contract replaces and supersedes any and all prior arrangements or understandings by and between Hospital and Physician with regard to the subject matter hereof.

SECTION XV. HOSPITAL NOT PRACTICING MEDICINE.

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

SECTION XVI. ENTIRE AGREEMENT.

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

SECTION XVII. SEVERABILITY.

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

SECTION XVIII. GOVERNING LAW.

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

SECTION XIX. REFERRALS.

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

SECTION XX. ANTI-HARASSMENT/DISCRIMINATION/RETALIATION

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

SECTION XXI. HIPAA BUSINESS ASSOCIATE AGREEMENT.

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

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

Dated: _____ **By:** _____

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

Dated: _____ **By:** _____

Bhani Kaur Chawla-Kondal M.D.

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Contract Cover Sheet

Contract Name: Bhasi Chawla-Kondal, MD

Purpose of Contract: Physician Clinic Agreement

Contract # / Effective Date / Term _____ / Jan 1, 2019 – Dec 31, 2019

Originating Dept. Name / Number: ADMIN

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

BAA: ✓Yes __No **W-9:** ✓Yes __No

Administrative Officer	**Signature:**	NS	**Date:** _____
HIPAA/Privacy Officer (as appropriate)	**Signature**	NS	**Date:** _____
Legal Counsel	**Signature:**	Via email	**Date:** _____
Compliance Officer	**Signature:**	Mary Norman	**Date:** 12/6/2018 FMV doc needed
Chief Financial Officer	**Signature:**		**Date:** 6 Dec 2018
Chief Executive Officer	**Signature:**		**Date:** 12-6-18
Board of Directors When Applicable	**Signature**	_____	**Date:** _____

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

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT
PHYSICIAN AGREEMENT FOR SERVICES AT THE RURAL HEALTH CLINICS
WITH
BHANI KAUR CHAWLA-KONDAL, M.D.

THIS PHYSICIAN AGREEMENT ("Agreement") is made and entered into as of the 1ST day of January, 2019 by and between Bear Valley Community Healthcare District (a public entity), ("Hospital") and Bhani Kaur Chawla-Kondal M.D. ("Physician").

RECITALS

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

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

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

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

AGREEMENTS

SECTION I. RESPONSIBILITIES OF PHYSICIAN.

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

1. Physician shall provide professional medical services at the Clinics, practicing a minimum of four (4) hours per assigned shift as determined by the Hospital and Physician and/or as needed.
2. Physician shall maintain medical records for all patients consistent with standard industry practices and shall provide such other record keeping and administrative services as may be reasonably requested by Hospital. All medical records remain the property of the Hospital.
3. Physician shall cooperate with any quality management and utilization management programs instituted by Hospital.

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

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

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

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

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

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

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

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

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

1. Physician's medical staff membership or clinical privileges at any hospital are denied, suspended, restricted, revoked or voluntarily relinquished;
2. Physician becomes the subject of any suit, action or other legal proceeding arising out of Physician's professional services;
3. Physician is required to pay damages or any other amount in any malpractice action by way of judgment or settlement;

4. Physician becomes the subject of any disciplinary proceeding or action before any state's medical board or similar agency responsible for professional standards or behavior;
5. Physician becomes incapacitated or disabled from practicing medicine;
6. Any act of nature or any other event occurs which has a material adverse affect on Physician's ability to perform the Services under this Agreement;
7. Physician changes the location of his offices;
8. Physician is charged with or convicted of a criminal offense; or
9. Physician is debarred, suspended or otherwise excluded from any federal and/or state health care payment program by action of the Office of Inspector General of the Department of Health and Human Services or Medi-Cal Office, or by any equivalent or coordinating governmental agencies.

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

SECTION II. REPRESENTATIONS AND WARRANTIES

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

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

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

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

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

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

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

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

misconduct raised against Physician by any person, organization governmental agency, health care facility, peer review organization or professional society;

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

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

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

SECTION III. INDEMNIFICATION OF LIABILITY.

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

SECTION IV. INDEPENDENT CONTRACTOR.

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

SECTION V. COMPENSATION.

At the end of each month, Physician shall submit to Hospital Administration a completed time sheet of time spent in the Clinic seeing patients. Upon receipt of the completed and signed provider time sheet for services rendered under this Agreement, Hospital shall pay Physician, as sole compensation hereunder, as follows:

- Half day rate: when Physician spends no less than 3 hours and up to 6 hours seeing patients in clinic, Physician will be paid a half day rate of $600.00;

- Full day rate: when physician spends over 6 hours seeing patients in clinic, Physician will receive $1,200.00 for services rendered.

All patient billings for Physician services remain the property of Hospital. Physician shall not bill for any services separately. Monthly payments to Physician shall be made on or before the 10th (tenth) day of the month, following the month in which services are rendered.

SECTION VI. COMPLIANCE.

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

At a minimum, Physician is expected to:

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

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

SECTION VII. TERM.

This Agreement is effective from January 1, 2019 to December 31, 2019, however this Agreement is subject to early termination as provided in Section. VIII. below.

SECTION VIII. EARLY TERMINATION.

A. Hospital may terminate this Agreement with or without cause or immediately in the event that:

1. Physician's license to practice medicine is suspended, revoked, terminated or otherwise restricted;
2. Physician's medical staff privileges at the Hospital, or any other healthcare facility, are in any way suspended, revoked or otherwise restricted;
3. Medicare and/or Medi-Cal significantly changes the RHC program;
4. Hospital fails to maintain RHC status;
5. Physician Services Agreement is terminated or expires;
6. Physician's failure to comply with the standards of the Hospital's Compliance Program to the extent that such failure results in material fine and or sanction from Medicare or Medi-Cal Program;
7. Physician breaches any material term of this Agreement;
8. Physician fails to complete medical records in a timely fashion;
9. Physician fails to maintain the minimum professional liability insurance coverage;
10. Physician inefficiently manages patients and such inefficient management has not been cured after 10 days' written notice from the Hospital;
11. Physician's inability to work with and relate to others, including, but not limited to patients and ancillary staff, in a respectful, cooperative and professional manner

and such inability has not been cured after 10 days' written notice from the Hospital;

12. Physician is unable to provide medical services under the terms of this Agreement due to a physical or mental disability;
13. Physician becomes impaired by the use of alcohol or the abuse of drugs;
14. Physician is convicted of any criminal offense, regardless of whether such action arose out of Physician's provision of professional services;
15. Physician commits any act of fraud, as determined by reasonable discretion of the Board, whether related to the Physician's provision of professional services or otherwise; or
16. A mutual written agreement terminating this Agreement is entered into between the Hospital and Physician.

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

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

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

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

SECTION IX. CONFIDENTIALITY.

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

SECTION X. INSURANCE.

PROFESSIONAL LIABILITY. Physician shall procure and maintain a policy or policies of professional liability insurance as required by this Section. Such insurance shall provide coverage for Physician as the named insured, and such policy shall cover any acts of Physician's professional negligence which may have occurred during the relevant term and said policies of insurance shall be written with limits of liability of at least the minimum coverage required from time to time by the Medical Staff bylaws, but in any event no less than One Million Dollars ($1,000,000) per claim/Three Million Dollars ($3,000,000) annual aggregate for "claims made" insurance coverage. Physician further shall maintain "continuous coverage," as defined by this Section for the entire relevant term. The relevant term shall commence

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

PREMIUM REIMBURSEMENT. Hospital agrees to reimburse Physician up to $5,000.00 (Five Thousand Dollars) total per year during the Agreement term for professional liability insurance premiums paid by Physician while providing professional services for Hospital under this or any other Agreement. As a condition to reimbursement, Physician shall submit written proof of payment of professional liability insurance premiums to Hospital and, within thirty (30) days of receipt, Hospital shall directly reimburse Physician for premiums paid, up to $5,000.00 per year of Agreement term. Should Hospital terminate this Agreement for cause or Physician terminate this Agreement before the expiration of the term, Hospital has the right to demand Physician repay Hospital a prorated portion of paid insurance premiums based on the number of months remaining in the Agreement term at termination.

SECTION XI. ASSIGNMENT.

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

SECTION XII. NOTICES.

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

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

Physician: Bhani Chawla-Kondal M.D.
5400 Kodiak Mountain Dr.
Yorba Linda, CA 92887

SECTION XIII. PRE EXISTING AGREEMENT.

With an exception for Physician's Hospital Agreement, this Agreement replaces and supersedes any and all prior arrangements or understandings by and between Hospital and Physician with regard to the subject matter hereof.

SECTION XIV. HOSPITAL NOT PRACTICING MEDICINE.

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

SECTION XV. ENTIRE AGREEMENT.

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

SECTION XVI. SEVERABILITY.

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

SECTION XVII. GOVERNING LAW.

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

SECTION XVIII. REFERRALS.

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

SECTION XIX. ANTI-HARASSMENT/DISCRIMINATION/RETALIATION

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

SECTION XXI. HIPAA BUSINESS ASSOCIATE AGREEMENT.

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

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

Dated: _____ **By:** _____

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

Dated: _____ **By:** _____

Bhani Chawla-Kondal M.D.
5400 Kodiak Mountain Dr.
Yorba Linda, CA 92887

Recommendation for Action

Date: 05 December 2018

To: Board of Directors

From: Garth M Hamblin, CFO

Re: Audited Financial Statements – Fiscal Year Ended June 30, 2018

Recommended Action

Accept and approve the Bear Valley Community Healthcare District Audited Financial Statements for the Fiscal Year ended June 30, 2018 (July 1, 2017, through June 30, 2018.)

Background

Attached are DRAFT Audited Financial Statements for FY 2018. The DRAFT watermark is on the audit report until approved by the board when final statements will be issued.

The Finance Committee reviewed the AFS at their meeting on December 4, 2018.

Our auditor, Jerrell Tucker, is scheduled to attend the December 12, 2018, Board meeting to present Statements to the full board.

Report of Independent Auditors
And Financial Statements

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT

June 30, 2018 & 2017

JWT & Associates, LLP
Advisory Assurance Tax

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT

Audited Financial Statements

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JWT & Associates, LLP

Advisory Assurance Tax

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

Report of Independent Auditors

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

Report on the Financial Statements

We have audited the accompanying financial statements of Bear Valley Community Healthcare District (the District) as of June 30, 2018 and 2017, which comprise the statements of net position as of June 30, 2018 and 2017, and the related statements of revenues, expenses and changes in net position, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the District at June 30, 2018 and 2017, and the results of its operations and its cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

Required Supplementary Information

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

JWT & Associates, LLP

Fresno, California
December 12, 2018

BEAR VALLEY COMMUNITY HEALTHCARE DISTRICT

Management's Discussion and Analysis

June 30, 2018

The administration of the Bear Valley Community Healthcare District (the District) prepared the following Management Discussion and Analysis of the financial performance of the District for the fiscal year ended June 30, 2018 (FYE 2018) to accompany the financial statements prepared in accordance with the Governmental Accounting Standards Board Statement Numbers 34, 37 and 38. This discussion and the associated schedules are intended to provide an analysis, explanation, and historical basis of comparison for the reporting of financial results of the District for FYE 2018. The audited financial statements included herewith have been prepared and submitted with an unmodified opinion from the District's independent auditor.

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

This annual financial report consists of the audited financial statements included herewith and the associated notes to those statements that describe the District's combined financial position and results of operations for the FYE 2018. The audited financial statements of the District include the statement of net position, statement of revenues, expenses and changes in net position, and statement of cash flows.

• The statement of net position includes all of the District's assets and liabilities, using the accrual basis of accounting, as well as any indication as to which assets are intended for use to fund future capital asset expenditures or otherwise designated as to use by board of director policy.

• The Statement of Revenues, Expenses, and Changes in Net Position present the results of operating and non-operating activities during the fiscal year and the associated incomes.

• The Statement of Cash Flows reports the net cash provided by operating activities, as well as other sources and uses of cash from investing, non-capital financing activities, and capital and related financing activities.

Financial Highlights

				Change	
	2018	2017	2016	2018	2017
Current assets	$ 6,916,234	$ 7,427,624	$ 5,855,921	$ (511,391)	$ 1,571,703
Current liabilities	5,477,074	2,506,983	2,074,260	2,970,090	432,723
Investments	17,668,421	10,894,184	8,415,234	6,774,237	2,478,950
Capital assets, net of depreciation	8,515,004	7,634,783	7,019,232	880,221	615,551
Long term debt	2,895,000	2,930,000	2,965,000	(35,000)	(35,000)
Total net position	24,871,960	20,663,982	13,263,740	4,207,978	7,400,242
Excess of revenues over expenses	$ 4,207,978	$ 4,412,856	$ 1,812,792	$ (204,878)	$ 2,600,064

CURRENT ASSETS

Current assets are cash or other assets that could reasonably be expected to be converted into cash in one year. Current assets decreased by $511,391 during the year. Most of the decrease, $604,581 was in Cash (with transfers from Cash to Investments). We also saw an increase of $260,001 in net patient receivables.

Current Assets

				Change	
	2018	**2017**	**2016**	**2018**	**2017**
Current assets	**$ 6,916,234**	**$ 7,427,624**	**$ 5,855,921**	**$ (511,391)**	**$ 1,571,703**
Cash	2,253,824	2,858,405	1,762,127	(604,581)	1,096,278
Net patient receivables	4,184,582	3,924,581	3,448,876	260,001	475,705
Other Assets	148,672	239,655	242,260	(90,983)	(2,605)
Assets whose use is limited	-	-	-	-	-
Inventory	129,318	212,805	178,366	(83,488)	34,439
Prepaid expenses	199,838	192,178	224,292	7,660	(32,114)
Investments	$ 17,668,421	$ 11,038,559	$ 8,415,234	$ 6,629,862	$ 2,623,325

Cash and Investments

The District maintains sufficient cash balances to pay its short-term liabilities. Excess funds are invested with the Local Agency Investment Fund (LAIF) or in interest bearing fully guaranteed certificates of deposit distributed among various financial institutions to ensure FDIC protection of principal amounts invested. LAIF is a voluntary fund created by statute in 1977 as an investment alternative for California's local governments and special districts.

During the year, our investments grew by $6,629,862 bringing the total to $17,668,421.

For the year ending June 30, 2018, the District's cash and investments increased by $6,169,656. Total days cash on hand increased by 231 to 333. See audited financial statements for additional information.

Cash and Investments

				Change	
	2018	**2017**	**2016**	**2018**	**2017**
Cash and cash equivalents	$ 2,253,824	$ 2,858,405	$ 1,762,127	$ (604,581)	$ 1,096,278
Assets whose use is limited	$ 144,375	$ 144,375	$ -	-	144,375
Investments	17,668,421	10,894,184	8,415,234	6,774,237	2,478,950
Total cash and investments	$ 20,066,620	$ 13,896,964	$ 10,177,361	$ 6,169,656	$ 3,719,603
Days cash on hand	333	231	187	102	44

Net Patient Accounts Receivables

Net patient accounts receivables at June 30, 2018, as compared to June 30, 2017, were higher by $260,001. Management and staff continue to work with our Accounts Receivable Management company (outsourced Patient Financial Services / Billing functions) to reduce Accounts Receivable and Accounts Receivable Days. During the year, we saw a reduction - from 80 to 59 days.

				Change	
	2018	2017	2016	2018	2017
Net Patient Receivables	4,184,582	5,091,546	3,448,876	(906,964)	1,642,670

Inventory

				Change	
	2018	2017	2016	2018	2017
Inventory	$ 129,318	$ 212,805	$ 178,366	$ (83,487)	$ 34,439

The inventory at June 30, 2018 is lower than prior year by $83,487. The decrease is in Central Supply inventory.

CAPITAL ASSETS

Capital assets are long term assets such as buildings, improvements and equipment with a purchase cost of $5,000 or more and a useful life greater than one year. Items costing less than $5,000 are expensed as minor equipment. Capital assets, net of accumulated depreciation, increased $880,221 as of June 30, 2018, over the prior year balance.

Capital additions totaled $1,772,519 during FYE 2018. We have continued to closely monitor capital expenditures. Notable expenditures in FY 2018 included – construction related to remodel of the area for our replacement CT scanner and Digital Mammography unit, adding DR (digital radiography) detectors in x-ray, new ultrasound unit, replacement of defibrillators, and installation of T-System (electronic health record for the emergency department).

Capital Assets

				Change	
	2018	2017	2016	2018	2017
Property and equipment	$ 22,123,712	$ 20,351,193	$ 19,116,052	$ 1,772,519	$ 1,235,141
Less: accumulated depreciation	(13,608,708)	(12,716,410)	(12,096,820)	(892,298)	(619,590)
	$ 8,515,004	$ 7,634,783	$ 7,019,232	$ 880,221	$ 615,551

CURRENT LIABILITIES

Current liabilities are short-term debts due in less than one year. At June 30, 2018, current liabilities increased by $2,970,090.

Current Liabilities

				Change	
	2018	2017	2016	2018	2017
Current Liabilities	**$ 5,477,074**	**$ 2,506,983**	**$ 2,074,260**	**$ 2,970,090**	**$ 432,723**
Current portion of long term debt	35,000	35,000	35,000	-	-
Accounts payable	913,724	1,137,648	566,494	(223,924)	571,154
Unearned Income	-	-	-	-	-
Accrued compensation	758,370	684,799	897,750	73,571	(212,951)
Third-party payor settlements	3,769,980	649,537	575,016	3,120,443	74,521

Accounts Payable

Accounts payable decreased by $223,924 from the FYE June 30, 2018 amount. Days in Accounts Payable decreased to 33.1 from 44.8 at the end of the previous fiscal year.

Third party settlements

The estimated third party settlements are higher by $3,120,443 at June 30, 2018, as compared to the prior year-end. The balance includes settlement estimates on prior year Cost Reports and $2,000,000 in deferred IGT revenue.

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

PATIENT REVENUE AND DEDUCTIONS FROM REVENUE

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

Gross patient revenue for FYE 2018 increased over the previous fiscal year by $3,298,512 or 6.7%. The largest increase is seen in Outpatient Revenue where we saw a 9.2% increase. Skilled Nursing Revenue grew with a 2.0% increase and Inpatient Revenue saw a decrease by 29.5% in visits.

Gross Patient Charges

				Change			
	2018	**2017**	**2016**	**2018**		**2017**	
Gross Patient Charges							
Inpatient	$ 1,860,155	$ 2,636,880	$ 2,440,411	$ (776,725)	-29.5%	$ 196,469	8.1%
Outpatient	47,845,388	43,815,116	43,363,326	4,030,272	9.2%	451,790	1.0%
Skilled Nursing Facility	3,032,416	2,987,451	2,335,227	44,965	1.5%	652,224	27.9%
Total gross revenue	$ 52,737,960	$ 49,439,447	$ 48,138,964	$ 3,298,512	6.7%	$ 1,300,483	2.7%
Acute Inpatient Census Statistics							
Staffed beds 5							
Patient days	330	457	428	(127)	-27.8%	29	6.8%
Days in the year	365	365	366	-	0.0%	(1)	-0.3%
Average Daily Census	0.9	1.3	1.2	(0.3)	-27.8%	0.1	7.1%
Average Length of Stay	2.0	2.8	2.6	(0.8)	-28.6%	0.2	7.7%
Swing Inpatient Census Statistics							
Staffed beds 5							
Patient days	200	497	358	(297)	-59.8%	139	38.8%
Days in the year	365	365	366	-	0.0%	(1)	-0.3%
Average Daily Census	0.5	1.4	1.0	(0.8)	-59.8%	0.4	39.2%
Discharges	166	166	166	-	0.0%	-	0.0%
Average Length of Stay	1.2	3.0	2.2	(1.8)	-60.0%	0.8	36.4%
Skilled Nursing Facility Census Statistics							
Staffed beds 21							
Patient days	6,802	6,667	5,289	135	2.0%	1,378	26.1%
Average Daily Census	18.6	18.3	14.5	0.4	2.0%	3.8	26.4%
Discharges	12	13	25	(1)	-7.7%	(12)	-48.0%
Emergency Department Visits	11,485	11,315	11,184	170	1.5%	131	1.2%
Clinic Visits	23,820	21,093	17,939	2,727	12.9%	3,154	17.6%

Deductions from Revenue

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

Contractual adjustments are accrual-based estimates derived from historical reimbursement experience using remittance advices by payor and by type of account (inpatient, outpatient, or clinic), adjusted for known exposures, such as payment denials, and are used to reduce the gross charges to the expected realizable value. Contractual adjustments as a percentage of gross patient charges, excluding prior year third-party settlement adjustments, were 55.6% for FYE 2018 compared to 49.9% for FYE 2017. FY 2015 was our first year as a Critical Access Hospital (CAH). We continue to review CAH status and impacts each year.

Additionally, deductions from revenue include other uncompensated care categories such as Charity Care, Administrative Adjustments, Patient Discounts (principally discounts offered to uninsured or private pay patients who do not qualify for financial assistance) and Employee Discounts. Effective January 1, 2007, the California State Assembly passed AB 774, which requires all hospitals in California to follow a specific state-mandated means testing process to determine if a patient qualifies for financial assistance. The charity care can range from a full write-off to a partial write-off of the patient's outstanding balance. Furthermore, OSHPD requires every hospital to file an electronic copy of its financial assistance policy. As of June 30, 2018, the District is in compliance with the financial assistance policy reporting requirement.

Total deductions from revenue, including the provision for bad debts, as a percent of gross patient revenue, was 54.3% for FYE 2018 versus 51.9% for FYE 2017.

Provision for Bad Debts

The provision for bad debts decreased for FYE 2018, as compared to the previous fiscal year. As a percent of gross revenue, bad debts were 3.7% for the current fiscal in comparison to 3.9% for the prior year.

Allowance for Doubtful Accounts

				Change	
	2018	2017	2016	2018	2017
Bad debt expense	$ 1,958,381	$ 1,929,651	$ 762,369	$ 28,730	$ 1,167,282
Bad debt expense as a percent of gross revenue	3.7%	3.9%	1.6%	-0.2%	2.3%

	2018	2017	Change 2018
Deductions from Revenue			
Contractual adjustments	$ 27,506,494	$ 24,678,858	$ 2,827,636
Prior year contractual allowances	(3,254,582)	(1,270,633)	$ (1,983,949)
Charity Care	100,789	109,125	$ (8,336)
Administrative	323,093	79,497	$ 243,596
Patient discount	132,221	98,401	$ 33,820
Employee discount	68,758	43,792	$ 24,966
Bad Debts	1,958,381	1,929,651	$ 28,730
	$ 26,835,154	$ 25,668,691	
Deductions from Revenue as a percent of gross revenue			
Contractual adjustments	52.2%	49.9%	2.2%
Prior year contractual allowances	-6.2%	-2.6%	-3.6%
Charity Care	0.2%	0.2%	0.0%
Administrative	0.6%	0.2%	0.5%
Patient discount	0.3%	0.2%	0.1%
Employee discount	0.1%	0.1%	0.0%
Bad Debts	3.7%	3.9%	-0.2%
Total	50.9%	51.9%	-1.0%

Net Patient Service Revenue

Net patient service revenue is the difference between gross patient charges and revenue deductions. For FYE June 30, 2018, net patient services revenues increased $1,939,020 or 8.1% higher than the previous fiscal year. Net patient revenue increased due to increases in volume in Skilled Nursing, ER and Clinic revenues along with the reduction that we experienced in Deductions from Revenue.

Net Patient Revenue

	2018	2017	2016	Change 2018	Change 2017
Net patient service revenue	$ 25,902,805	$ 23,963,785	$ 21,125,312	$ 1,939,020	$ 2,838,473
				8.1%	13.4%

OPERATING EXPENSES

Total operating expenses in FYE 2018 were $24,428,874 as compared to $22,625,387 for FYE 2017 – an increase of 8.0%. Salaries, Wages, and Benefits (which comprised just over 55% of Total Operating Expenses) increased by 5.7%. During the year we cashed out PTO (Paid Time Off) balances in excess of 300 hours. We also saw increases in retirement cost and health insurance costs. We saw an increase in Professional Fees, and an increase in Purchased Services with the addition of fees related to provision of Dental Services and having contract staff fill in interim management positions.

	2018		2017		2016		Change 2018	Change 2017
Salaries and wages	$ 9,777,302	40.0%	$ 9,168,859	40.5%	$ 9,613,427	46.2%	$ 608,443	$ (444,568)
Employee benefits	3,683,114	15.1%	3,568,108	15.8%	2,260,524	10.9%	115,006	1,307,584
Total salaries and benefits	13,460,417	55.1%	12,736,967	56.3%	11,873,951	57.1%	723,450	863,016
Professional fees	2,014,551	8.2%	1,832,258	8.1%	2,530,215	12.2%	182,293	(697,957)
Purchased services	4,286,052	17.5%	3,531,964	15.6%	2,308,298	11.1%	754,088	1,223,666
Supplies	1,649,154	6.8%	1,469,773	6.5%	1,587,249	7.6%	179,381	(117,476)
Repairs and maintenance	342,890	1.3%	314,833	1.3%	214,492	0.9%	28,057	100,341
Utilities	501,421	2.1%	533,430	2.4%	573,178	2.8%	(32,009)	(39,748)
Rentals and leases	270,708	1.1%	277,463	1.2%	241,127	1.2%	(6,755)	36,336
Depreciation and amortization	892,298	3.7%	619,591	2.7%	845,561	4.1%	272,707	(225,970)
Insurance	311,702	1.3%	300,352	1.3%	266,904	1.3%	11,350	33,448
Other operating expenses	699,682	2.9%	1,008,756	4.5%	372,903	1.8%	(309,074)	635,853
Total Operating Expenses	$ 24,428,874	100%	$ 22,625,387	100%	$ 20,813,878	100%	$ 1,803,487	$ 1,811,509
							8.0%	8.7%

Supply Costs

Supply costs as a percentage of gross revenue increased from 3.1% in FYE 2017 to 3.6% in FYE 2018. Management continues to work with our group purchasing organization (GPO), HealthTrust Purchasing Group (HPG) to identify opportunities for supply cost reductions.

	2018	2017	2016	Change 2018	Change 2017
Supply costs	$ 1,769,781	$ 1,469,773	$ 1,587,249	$ 300,008	$ (117,476)
Supply costs as a percent of gross revenue	3.4%	3.0%	3.3%	0.4%	-0.3%

FISCAL YEAR 2018 BUDGET AND ECONOMIC FACTORS

The District's Board of Directors approved the Budget for FYE June 30, 2019 (FY 2019) at a general board meeting. The financial plan for FYE 2019 includes a 4.3% increase in Gross Revenue and a 7.9% increase in Net Revenue. Operating Expense is budgeted to increase by 6.5%. The net result is a budgeted Surplus of $3,352,622.

Capital expenditure plans include completion of the remodel and installation of a replacement CAT scanner and new Digital Mammography unit. We also have budgeted expenditures to CPSI, our electronic health record vendor, to meet the requirements of Meaningful Use 3. Also, replacement of laboratory equipment, the telephone system, some cosmetic work in the emergency department, and the number of maintenance projects.

Current and future favorable operations are helped by the continuation of a parcel tax assessed on property located in the Big Bear Valley area and an allocation of county tax revenue. During FYE 2018, the District received $2,343,776 in such tax revenue. The projected tax revenue for FYE 2019 is $2,210,931.

BUSINESS STRATEGIES

In May 2014, the District converted to Critical Access Hospital (CAH) status. Our Analysis after filing FYE 2017 Cost Report showed a favorable impact of $1,199,103 for the year from CAH status as compared to payments we would have received as a PPS (Prospective Payment System) Hospital. FY 2016 favorable impact was $1,247,514.

Revenue cycle management and cost containment strategies

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

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

Status of Regulatory Requirements

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

Administration is working to meet the SB 1953 deadline under NPC-3 performance levels that requires healthcare institutions to be in compliance by the year 2030. Accordingly, the objective is to identify the full extent of equipment and non-structural items that must meet NPC-3 anchorage requirement. Once a plan is established develop a timetable to ensure compliance with NPC-3 performance level as quickly as possible.

Bear Valley Community Healthcare District

Statements of Net Position

June 30, 2018 and 2017

	2018	2017
Assets		
Current Assets		
Cash and cash equivalents	$ 19,066,727	$ 13,002,589
Investments	855,518	750,000
Patient accounts receivable, net of allownaces	4,184,582	3,924,581
Other receivables and physician advances	149,632	239,655
Assets whose use is limited	144,375	144,375
Supplies	129,318	212,805
Prepaid expenses and deposits	198,879	192,178
Total current assets	24,729,031	18,466,183
Capital assets, net of accumulated depreciation	8,515,004	7,634,783
Total assets	$ 33,244,035	$ 26,100,966
Liabilities and Net Position		
Current liabilities		
Current portion of long-term debt	$ 35,000	$ 35,000
Accounts payable and accrued expenses	913,725	1,137,647
Accrued payroll and related liabilities	758,370	684,799
Third-party payor settlements	3,769,980	649,537
Total current liabilities	5,477,075	2,506,983
Long-term debt, less current portion	2,895,000	2,930,000
Total liabilities	8,372,075	5,436,983
Net position		
Invested in capital assets, net of related debt	5,585,004	4,669,783
Unrestricted	19,286,956	15,994,200
Total net position	24,871,960	20,663,983
Total liabilities and net position	$ 33,244,035	$ 26,100,966

See accompanying notes to the financial statements

Bear Valley Community Healthcare District

Statements of Revenues, Expenses and Changes in Net position

For The Years Ended June 30, 2018 and 2017

	2018	2017
Operating revenues		
Net patient service revenue	$ 25,902,806	$ 23,963,785
Other operating revenue	2,332,109	2,034,802
Total operating revenues	28,234,915	25,998,587
Operating expenses		
Salaries & wages	10,737,894	9,168,859
Employee benefits	2,722,522	3,568,108
Professional Fees	2,155,360	1,832,258
Purchased services	4,170,602	3,531,964
Supplies	1,736,781	1,469,773
Repairs & maintenance	342,890	314,833
Utilities	545,065	533,430
Rentals and leases	270,708	277,463
Depreciation & amortization	892,298	619,591
Insurance	311,702	300,352
Other operating expenses	543,053	1,008,756
Total operating expenses	24,428,875	22,625,387
Operating income (loss)	3,806,040	3,373,200
Nonoperating revenues (expenses)		
District tax revenues	2,343,776	2,301,190
Capital grants and donations	75,046	64,441
Investment income	287,303	88,397
Interest expense	(93,113)	(96,343)
Total nonoperating revenues (expenses)	2,613,012	2,357,685
Excess of revenues (expenses)	6,419,052	5,730,885
Inter-governmental transfers	(2,211,075)	(1,318,029)
Increase in net position	4,207,977	4,412,856
Net position, beginning of the year	20,663,983	16,251,127
Net position, end of year	$ 24,871,960	$ 20,663,983

See accompanying notes to the financial statements

Bear Valley Community Healthcare District

Statements of Cash Flows

For The Years Ended June 30, 2018 and 2017

	2018	2017
Cash flows from operating activities		
Cash received from patients and third-party payers	$ 28,763,248	$ 23,562,601
Other receipts	2,422,132	2,037,407
Cash payments to suppliers and contractors	(10,223,297)	(8,700,001)
Cash payments to employees and benefit programs	(13,386,845)	(12,949,918)
Net cash provided by operating activities	7,575,238	3,950,089
Cash flows from non-capital and related financing activities		
District tax revenue	2,343,776	2,301,190
Net cash provided by non-capital and related financing activities	2,343,776	2,301,190
Cash flows from capital and related financing activities		
Purchase of property, plant & equipment	(1,772,519)	(1,235,142)
Capital grants and contributions	75,046	64,441
Payments of long-term debt	(35,000)	(35,000)
Interest paid on capital debt	(93,113)	(96,343)
Net cash used in capital and related financing activities	(1,825,586)	(1,302,044)
Cash flows from investing activities		
Net sale of investments	(105,518)	-
Inter-governmental transfers	(2,211,075)	(1,318,029)
Investment income	287,303	88,397
Net cash provided by investing activities	(2,029,290)	(1,229,632)
Increase (decrease) in cash and cash equivalents	6,064,138	3,719,603
Cash and cash equivalents at beginning of year	13,002,589	9,282,986
Cash and cash equivalents at end of year	$ 19,066,727	$ 13,002,589

See accompanying notes to the financial statements

Bear Valley Community Healthcare District

Statements of Cash Flows (continued)

For The Years Ended June 30, 2018 and 2017

	2018	2017
Reconciliation of operating income (loss) to net cash provided by operating activities		
Operating income (loss)	$ 3,806,040	$ 3,373,200
Adjustments to reconcile operating income to net cash provided by operating activities		
Depreciation	892,298	619,591
Changes in operating assets and liabilities		
Patient accounts receivable	(260,001)	(475,705)
Other receivables	90,023	2,605
Supplies	83,487	(34,439)
Prepaid expenses	(6,701)	32,114
Accounts payable and accrued expenses	(223,922)	571,153
Accrued payroll and related expenses	73,571	(212,951)
Third-party payor settlements	3,120,443	74,521
Net cash provided by (used in) operating activities	$ 7,575,238	$ 3,950,089

See accompanying notes to the financial statements

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES

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

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

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

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

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

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

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

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

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

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

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

Capital Assets: Capital assets consist of property and equipment and are reported on the basis of cost, or in the case of donated items, on the basis of fair market value at the date of donation. Routine maintenance and repairs are charged to expense as incurred. Expenditures which increase values, change capacities, or extend useful lives are capitalized. Depreciation of property and equipment and amortization of property under capital leases are computed by the straight-line method for both financial reporting and cost reimbursement purposes over the estimated useful lives of the assets, which range from 10 to 30 years for buildings and improvements, and 3 to 10 years for equipment. The District periodically reviews its capital assets for value impairment. As of June 30, 2018, and 2017, the District has determined that no capital assets are impaired.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Compensated Absences: The employees of the District earn paid time off ("PTO") benefits at varying rates. The rate is determined based on their years of service. This PTO benefit can accumulate up to specified maximum levels. Employees may use their accumulated PTO for vacation, holidays and sick leave. Accumulated PTO benefits are paid to an employee upon either termination or retirement. Accrued PTO liabilities as of June 30, 2018, and 2017 are $516,171 and $489,455, respectively.

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

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

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

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

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

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

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

District Tax Revenues: The District receives financial support from property taxes. These funds are used to support operations. They are classified as non-operating revenue as the revenue is not directly linked to patient care. Property taxes are levied by the County on the Hospital's behalf during the year, and are intended to help finance the District's activities during the same year. Amounts are levied on the basis of the most current property values on record with the County. The County has established certain dates to levy, lien, mail bills, and receive payments from property owners during the year. Property taxes are considered delinquent on the day following each payment due date.

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

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

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

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

NOTE 2 – CASH AND CASH EQUIVALENTS

As of June 30, 2018 and 2017, the District had deposits invested in various financial institutions in the form of cash and cash equivalents amounting to $19,821,970 and $13,143,813. All of these funds were held in deposits, which are collateralized in accordance with the California Government Code (CGC), except for $250,000 per account that is federally insured.

NOTE 2 – CASH AND CASH EQUIVALENTS (continued)

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

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

NOTE 3 - NET PATIENT SERVICE REVENUES AND REIMBURSEMENT PROGRAMS

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

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

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

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

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

Medicare and Medi-Cal revenue accounts for approximately 57% and 59% of the District's net patient revenues for the years ended June 30, 2018 and 2017, respectively. Laws and regulations governing the Medicare and Medi-Cal programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

NOTE 4 - INVESTMENTS

The District's investment balances and average maturities were as follows at June 30, 2018 and 2017:

2018		Investment Maturities in Years		
	Fair Value	Less than 1	1 to 5	Over 5
Government investment funds	$ 16,812,903	$ 16,812,903	$ -	$ -
Money market accounts	613,518	613,518	-	-
Certificates of deposit	242,000	-	242,000	-
Total investments	$ 17,668,421	$ 17,426,421	$ 242,000	$ -

2017		Investment Maturities in Years		
	Fair Value	Less than 1	1 to 5	Over 5
Government investment funds	$ 10,144,184	$ 10,144,184	$ -	$ -
Money market accounts	144,375	144,375	-	-
Certificates of deposit	750,000	508,000	242,000	-
Total investments	$ 11,038,559	$ 10,288,559	$ 242,000	$ -

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

Interest income, dividends, and both realized and unrealized gains and losses on investments are recorded as investment income. These amounts were $287,303 and $88,397 for the years ended June 30, 2018 and 2017, respectively. Total investment income includes both income from operating cash and cash equivalents and cash and cash equivalents related to assets limited as to use. Debt securities, when present, are recorded at market price or the fair market value as of the date of each balance sheet.

NOTE 4 – INVESTMENTS (continued)

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

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

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

Concentration of Credit Risk: Concentration of credit risk is the risk of loss attributed to the magnitude of the District's investment in a single issuer. The District's investments are held as follows: governmental agencies 95% and banks 5%. The District believes that there is minimal custodial credit risk with their investments at this time. District management monitors the entities which hold the various investments to ensure they remain in good standing.

NOTE 5 - ASSETS LIMITED AS TO USE

Assets limited as to use as of June 30, 2018 were comprised of cash held in a Debt Service Reserve Fund as required by the terms of a sale and leaseback agreement entered into by the District in January 2018. Under the agreement the District is required to make annual payments into the Debt Service Reserve Fund equal to $1/10^{th}$ of the current annual lease payment. The District established this fund accordingly and at June 30, 2018 the balance totaled $144,375. See Note 9.

NOTE 6 - CONCENTRATION OF CREDIT RISK

The District grants credit without collateral to its patients and third-party payors. Patient accounts receivable from government agencies represent the only concentrated group of credit risk for the District and management does not believe that there is any credit risk associated with these governmental agencies. Contracted and other patient accounts receivable consist of various payors including individuals involved in diverse activities, subject to differing economic conditions and do not represent any concentrated credit risks to the District. Concentration of patient accounts receivable at June 30, 2018 and 2017 were as follows:

	2018	2017
Medicare	$ 880,476	$ 1,046,991
Medi-Cal and Medi-Cal pending	3,533,838	3,802,028
Other third party payors	3,921,858	3,667,786
Self pay and other	2,261,762	2,232,719
Gross patient accounts receivable	10,597,934	10,749,524
Less allowances for contractual adjustments and bad debts	(6,413,352)	(6,824,943)
Net patient accounts receivable	$ 4,184,582	$ 3,924,581

NOTE 7 - OTHER RECEIVABLES

Other receivables as of June 30, 2018 and 2017 were comprised of the following:

	2018	2017
Grants	$ 35,023	$ 58,006
Workers Compensation refund	-	26,512
Physician advance	59,978	98,312
District tax revenue	52,044	56,788
Other	2,587	37
	$ 149,632	$ 239,655

NOTE 8 - CAPITAL ASSETS

Capital assets as of June 30, 2018 and 2017 were comprised of the following:

	Balance at June 30, 2017	Transfers & Additions	Transfers & Retirements	Balance at June 30, 2018
Land and land improvements	$ 547,472	$ 23,143	$ -	$ 570,615
Buildings and improvements	9,657,087	101,584	-	9,758,671
Equipment	9,614,476	2,147,434	-	11,761,910
Construction-in-progress	532,159	-	(499,642)	32,517
Totals at historical cost	20,351,194	$ 2,272,161	$ (499,642)	22,123,713
Less accumulated depreciation	(12,716,411)	$ (892,298)	$ -	(13,608,709)
Capital assets, net	$ 7,634,783			$ 8,515,004

	Balance at June 30, 2016	Transfers & Additions	Transfers & Retirements	Balance at June 30, 2017
Land and land improvements	$ 532,272	$ 15,200	$ -	$ 547,472
Buildings and improvements	9,583,080	74,007	-	9,657,087
Equipment	8,877,216	737,260	-	9,614,476
Construction-in-progress	123,484	408,675	-	532,159
Totals at historical cost	19,116,052	$ 1,235,142	$ -	20,351,194
Less accumulated depreciation	(12,096,820)	$ (619,591)	$ -	(12,716,411)
Capital assets, net	$ 7,019,232			$ 7,634,783

NOTE 9 - DEBT BORROWINGS

Long-term debt at June 30, 2018 and 2017 consists of the following:

	2018	2017
Note payable to the Public Property Financing Corporation of California, original amount of $3,000,000, bearing interest at 3.125%, principal payable annually and interest payable biannually per schedule, maturing in December 2055, secured by property, building and improvements.	$ 2,930,000	$ 2,965,000
Total debt borrowings	2,930,000	2,965,000
Less current maturities	(35,000)	(35,000)
Debt borrowings, net of current maturities	$ 2,895,000	$ 2,930,000

Effective January 1, 2016, the District entered into a sale and leaseback agreement with the United States Department of Agriculture, acting through the Rural Housing Service and the Public Property Financing Corporation of California, for the Brenda Boss Family Resource Center. The Brenda Boss Family Resource Center is a building recently constructed by the District on the District's main hospital campus and was put into service during the fiscal year ended June 30, 2014. In accordance with GAAP, the sale and leaseback agreement will be treated as a financing transaction. The principal amount borrowed totaled $3,000,000, with an annual interest rate of 3.125%. Principal is payable annually on December 1st starting in 2016 and continuing through 2055 per a schedule with payments ranging in amounts from $35,000 to $140,000. Interest is payable biannually on June 1st and December 1st in an amount equal to the current outstanding principal balance multiplied by the annual interest rate of 3.125% and divided by two, for a six-month interest amount. There is no provision for a pre-payment penalty. The District must establish and maintain a Debt Service Reserve Fund throughout the term of the sale and leaseback agreement. The District is required to make annual payments into the Debt Service Reserve Fund equal to 1/10th of the current annual lease payment. The District established this fund and at June 30, 2018 the balance totaled $144,375. Upon completion of the sale and leaseback agreement, ownership and title of the Brenda Boss Building will revert to the District with no encumbrances.

Future principal maturities for debt borrowings for the next five years are: $35,000 in 2019; $40,000 in 2020; $40,000 in 2021; $40,000 in 2022; $45,000 in 2023; and $2,730,000 thereafter.

NOTE 10 - RETIREMENT PLANS

The District has a defined contribution retirement plan covering substantially all of the District's employees. In a defined contribution retirement plan, benefits depend solely on amounts contributed to the plan plus investment earnings. The District contributes to the plan at a rate of two to four percent of eligible compensation, based on the length of the employee's service as defined by the plan. The District's contributions become fully vested after three years of continuous service. The District's pension expense for the plan was $167,078 and $183,803 during the years ended June 30, 2018 and 2017, respectively.

NOTE 11 – INCOME TAXES

The District is a political subdivision of the state of California organized under the Local Health Care District Law as set forth in the Health and Safety Code of the State of California. The Hospital has been determined to be exempt from income taxes under Local Health Care District Law. Accordingly, no provision for income taxes is included in the accompanying financial statements. The District is no longer subject to examination by federal or state authorities for years prior to June 30, 2015, nor has it been notified of any impending examination and no examinations are currently in process.

NOTE 12 - COMMITMENTS AND CONTINGENCIES

Construction-in-Progress: As of June 30, 2018, the District has $32,516 recorded as construction-in-progress which represents cost capitalized for various remodeling, major repair, and expansion projects on the District's premises. No interest was capitalized under FAS 62 during the years ended June 30, 2018 and 2017. Estimated costs to complete current obligated construction-in-progress projects as of June 30, 2018 are approximately $373,000. Costs are to be financed with District reserves and continued District operations.

Operating Leases: The District has operating leases for office space and various medical and office equipment. Rental expense under operating leases was $270,708 and $277,463 for the years ended June 30, 2018 and 2017, respectively. Future minimum lease payments for the succeeding years under operating leases with a remaining term in excess of one year as of June 30, 2018, are as follows: $58,287 in 2019; $29,640 in 2020; and $28,309 in 2021.

Litigation: The District may from time-to-time be involved in litigation and regulatory investigations which arise in the normal course of doing business. After consultation with legal counsel, management estimates that matters existing as of June 30, 2018, will be resolved without material adverse effect on the District's future financial position, results from operations or cash flows.

NOTE 12 - COMMITMENTS AND CONTINGENCIES (continued)

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

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

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

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

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

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Recommendation for Action

Date: 05 December 2018

To: Board of Directors

From: Garth M Hamblin, CFO

Re: Medicare Cost Report - FY 2018 (July 1, 2017 through June 30, 2018)

Recommended Action

Accept / Approve submittal of Medicare Cost Report for the Fiscal Year ended June 30, 2018, signed by John Friel, CEO.

Background

The Cost Report for our Fiscal Year ended June 30, 2018, (attached) shows an amount due to BVCHD of $271,554.

Wipfli, LLP, prepared the Cost Report and David Perry of QHR reviewed the Cost Report.

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 05-1335	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/30/2018 10:25 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/30/2018 Time: 10:25 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BEAR VALLEY COMMUNITY HOSPITAL (05-1335) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

Encryption Information

ECR: Date: 11/30/2018 Time: 10:25 am
mf41mOgZtrCRO:wRB8e0fucEvpkq20
:Iu570Cy1PL4XR.ju2ci9QR0gRgZak
tli604v3Q909Vz3h

PI: Date: 11/30/2018 Time: 10:25 am
CCVac33.3avE..81fR9wd9E1sfFp90
YvLRp0MpsjX1gt3cv4N2wGW2eE:Kl5
e7De0QXkIy0vm.i7

(Signed) _____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	14,914	167,671	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	38,090	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
10.00	RURAL HEALTH CLINIC I	0		61,763		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-10,884		0	10.01
200.00	Total	0	53,004	218,550	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

Recommendation for Action

Date: December 03, 2018

To: Board of Directors

From: John Friel

Re: Travel Expense Reimbursement for Board of Directors Attending the Rural Healthcare Leadership Conference

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Recommended Action: The Board of Directors to approve the reimbursement of travel expenses for Board Members attending the American Hospital Association Rural Healthcare Leadership Conference not to exceed $1,500.00 per person.

Background: The American Hospital Association Rural Healthcare Leadership Conference scheduled for February 3 through February 6, 2019 in Phoenix Arizona.

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BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

CNO Monthly Report

TOPIC	UPDATE
1. Regulatory Updates	▪ CDPH and CMS on site for annual SNF survey 11/26-11/28/2018.
2. Budget/Staffing	▪ Overtime and call offs are assessed each shift. ▪ Flexing of staff is done daily as warranted by census. ▪ All departments participated in the productivity study and are awaiting results.
3. Departmental Reports	
▪ Emergency Department	▪ 2 FT ED RN new hires declined their positions during the hiring process. ▪ 1 FT RN resignation, 1 FT RN out on FMLA ▪ 2 travel RNs have been scheduled for the winter season to help fill ED staffing needs. ▪ ED council (staff advisory group) is meeting regularly to work on ED process improvements.
▪ Acute	▪ In-services were held: o Bedside shift report/ patient & family centered care o Oral suctioning
▪ Skilled Nursing	▪ Census is currently at 15 residents (2 pending admissions). ▪ 1 resident was discharged 11/21/18. ▪ Case Manager is faxing bed availability for SNF and Swing on a weekly basis to surrounding facilities. ▪ SNF annual survey completed 11/28/18- awaiting 2567. CMS and CDPH on site.
▪ Surgical Services	▪ Orthopedic procedures are being done weekly. ▪ Ophthalmic procedures are being done monthly. ▪ OR manager is reviewing possible equipment purchase to prepare for general surgeon/ expanded ortho services. (budgeted purchase) ▪ OR Manager is working on OR supply inventory and ordering in anticipation of a general surgeon. ▪ OR is in need of repair (flooring, painting, medical gases etc.), OR Manager is working with Plant Maintenance director to facilitate repairs.

▪ Case Management	▪ DON and Eligibility Worker are working on referrals for SNF residents and Swing patients. ▪ Case Management continues to attend re-admissions collaborative.
▪ Respiratory Therapy	▪ RT Supervisor has started a QI workgroup to focus on outdates and inventory management, she will be working with several departments.
▪ Physical Therapy	▪ PT is running volumes at budget. ▪ New PTA has been hired and will start Dec. 3rd. ▪ The department is fully staffed.
▪ Food and Nutritional Services	▪ Point of Sale system has been approved and will be implemented, the new system will allow for credit card use in the cafeteria as well as payroll deductions for employee cafeteria use. ▪ FT cook has been hired. ▪ FNS department hosted a Thanksgiving themed candlelight dinner for SNF residents. ▪ RD submitted for the "Healthy Hospital" recognition program. BVCHD has been accepted to the program.
4. Infection Prevention	▪ Hand Hygiene monitoring continues. ▪ Infection Preventionist is rounding weekly to educate staff on hand hygiene and infection issues. ▪ Infection Preventionist is conducting monthly rounds to monitor POC compliance and is reporting findings through Infection Control Committee ▪ Flu shots have been administered to staff. Employees who declined the flu shot will be required to wear a mask through the flu season-per SB County guidelines.
5. Quality Improvement	▪ SCORE action plan has been developed and is in the process of being reviewed by Administration and the QI committee. Anticipated roll out in January. ▪ PFAC project for ED lobby and ED art work is in process. Photographs have arrived and are waiting to be hung for display. ▪ PFAC will meet again in December for this cohort's final meeting and a recognition luncheon.
6. Policy Updates	▪ Policies reviewed weekly by Policy and Procedure committee.
7. Safety & Products	▪ Workplace Violence training is being provided to all BVCHD staff. ▪ Workplace Violence reports are submitted to CalOSHA on an ongoing basis.

	▪ BVCHD will be participated in the Statewide Medical and Health Exercise on Nov15th. ▪ Annual Security assessment is being reviewed and updated by departments. The safety committee will review the annual plan in January.
8. Education	▪ BLS Classes scheduled monthly, ACLS & PALS scheduled quarterly ▪ Smoking Cessation classes being held as scheduled. ▪ Heart Rhythm class is being held. The class is open to all RNs, LVNs, EMTs and BBFD. ▪ Critical care medication class is scheduled for RNs. ▪
9. Information Items/Concerns	▪ CARE Grant application submitted- proposed project is a community outreach for diabetic education and assistance. 15,000 was requested for the project.
Respectfully Submitted by: *Kerri Jex, CNO* *Date: November 30th, 2018*	

2018 Surgery Report

Aug-18		
Physician	**# of Cases**	**Procedures**
Pautz - DO	2	Carpal Tunnel Release
Pautz - DO	1	ORIF Phalanx Foot
Pautz - DO	1	ORIF Radius
Pautz - DO	1	Fulkerson Osteotomy Knee
Pautz - DO	1	Excision of Ossicle Foot
Critel - CRNA	4	LESI
Critel - CRNA	2	Hip Injection
Critel - CRNA	1	Shoulder Injection
Tayani	2	Cataract
Total	15	
Sep-18		
Physician	**# of Cases**	**Procedures**
Pautz - DO	1	Removal of Hardware Ankle
Pautz - DO	1	ORIF Scaphoid
Pautz - DO	1	ORIF Radius/Ulna
Pautz - DO	1	Carpal Tunnel Release
Critel - CRNA	1	Shoulder Injection
Critel - CRNA	2	LESI
Critel - CRNA	1	Wrist Injection
Tayani	17	Cataracts
Total	25	
Oct-18		
Physician	**# of Cases**	**Procedures**
Pautz - DO	1	ORIF Wrist
Pautz - DO	1	Rotator Cuff Repair
Pautz - DO	2	Athodesis of Finger Joint
Pautz - DO	1	Carpal Tunnel Release
Pautz - DO	1	Removal of Foreign Body Wrist
Pautz - DO	1	Partial Palmar Fasciectomy
Critel - CRNA	1	Shoulder Injection
Critel - CRNA	1	Knee Injection
Critel - CRNA	2	LESI
Tayani	10	Cataracts
Total	21	
Nov-18		
Physician	**# of Cases**	**Procedures**
Pautz - DO	1	ORIF Ankle
Pautz - DO	1	Removal of Foreign Body Foot
Critel - CRNA	8	LESI
Tayani	9	Cataracts
Total	19	

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

CHIEF EXECUTIVE OFFICER REPORT

November 2018

CEO Information:

California Department of Public Health was on site to complete the Annual SNF Survey. The deficiencies are minimal according to the exit with the State. We expect to receive the written report December 6th and we will have 10 days to respond. Additional information at the November Board Meeting.

AHA Rural Health Care Leadership conference is scheduled for February 3 through February 6, 2019 in Phoenix, AZ. If you would like to attend, please contact Administration.

Due to the winter storm this week Administration rescheduled the RCH meeting. Senior Staff will be meeting with Riverside Community Hospital Senior Team to further develop alliances opportunities. Attached for information purposes only is an article in a recent publication of Modern Healthcare regarding HCA-The parent of Riverside Community Hospital.

BVCHD Annual Christmas Party is scheduled for December 15, 2018 at the Convention Center. Invitations have been mailed.

A meeting with AirMethods and staff was conducted to discuss the helipad landing area and how we can improve the landing zone.

BVCHD Board of Directors Self Evaluation will begin. We will be using the same format as in the past. Administration will provide the details to the full Board of Directors as soon as we receive it.

Ongoing discussion with Quorum Resources regarding managed care issues continue. Most recently with Wanda Wright, QHR expert in managed care. Wanda works with our consultant Andy Werking and will reach out to begin to identify strategies to pursue.

I am scheduled to meet with Rick Howells, Heritage COO on December 5th and discussion with Kaiser has been initiated.

Lab Corp Matter: we were notified on November 26th that BVCHD would no longer be a "blood draw station" for Lab Corp, effective December 1, 2018. This created a significant problem for dozens of patients, particularly those with Heritage HMO coverage who get weekly draws to monitor their medications. We have provided this service for over 15 years without a written contract for a minimal fee. We were blindsided by this decision and are working with Heritage Medical Group to mitigate the impact on patients.

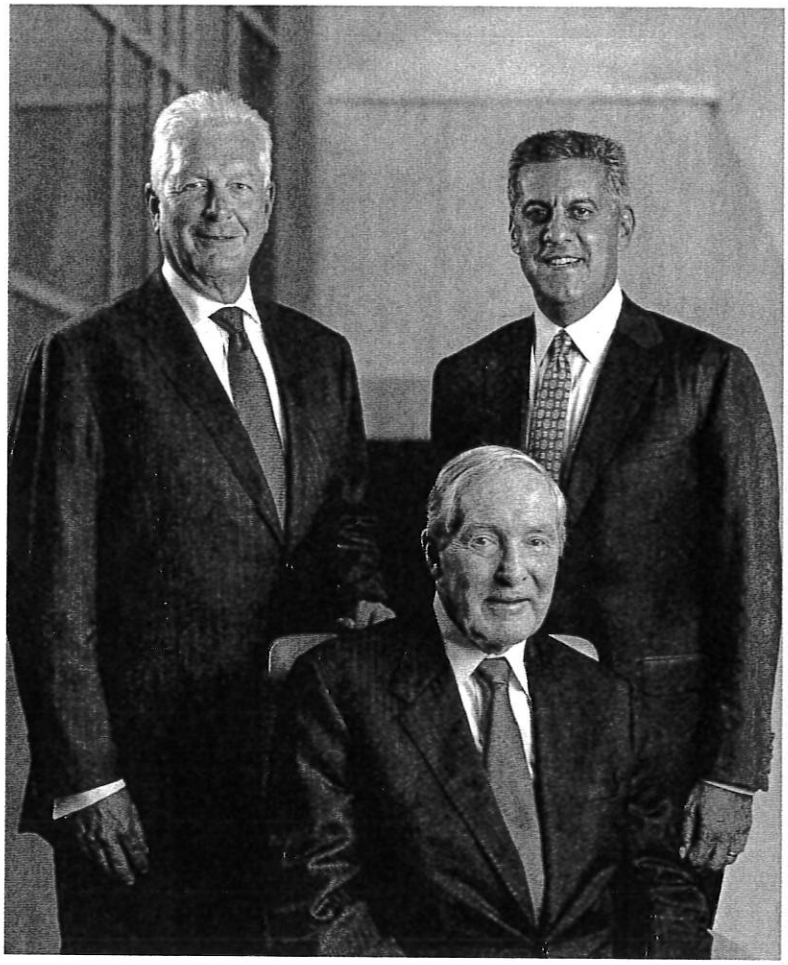
Marketing:

We are currently advertising the SNF and Physical Therapy.

Attachment:
QHR Board Minutes
QHR November Compliance Newsletter

Q&A

'At the end of the day, healthcare is delivered on a local market basis'



Clockwise from left, outgoing HCA CEO R. Milton Johnson; President and Chief Operating Officer and incoming CEO Sam Hazen; and co-founder and former CEO Dr. Thomas Frist Jr.

MARK MOSRIE

Over the past 50 years, HCA Healthcare has ridden the waves of a turbulent healthcare economy. It survived an intense investigation into Medicare fraud, which, by 2003, had the company ponying up $1.7 billion to the federal government. Today, the Nashville-based for-profit hospital company boasts healthy margins and satisfactory outcomes. Unlike many of its competitors, HCA has not strayed from its core service lines. **Three generations of HCA CEOs** talked with Modern Healthcare Editor Aurora Aguilar to reflect on where the company has been and where it is going. **Dr. Thomas Frist Jr.**, a co-founder of HCA, returned in 1997 for a second stint as CEO to right the ship after fraud investigations took a heavy toll on the company. **R. Milton Johnson**, a 36-year HCA veteran, became CEO in 2014. He recently announced he is retiring at the end of the year. He'll be replaced by President and Chief Operating Officer **Sam Hazen**. The following is an edited transcript.

MH: What do you credit with HCA's ability to recover from one of the biggest fraud investigations in the industry's history?

Frist: We were at the right place, in Nashville. When I came back, within the first 24 to 48 hours, I let go of 12 or 16 of the top officers. And only in Nashville could you resource and replace that type of talent. We also had wonderful assets. Besides getting the talent, we needed to re-instill a culture that put the patient and the patient's family first. Once we got that, it was smooth sailing.

Johnson: I always like to put that era in our company's history in perspective. It was a period of three years, 21 years ago. What Tommy said is absolutely right. He came back and led a cultural change that brought the company back and has instilled that into the company's DNA and its fabric today. We won't lose that culture.

MH: How has HCA's size facilitated quality healthcare and safety for your patients?

Frist: Size alone is not a determining factor in success. Back when we started HCA, there were six or seven other hospital companies. None of those companies are still around. It has to do with getting the right people and executing a well-thought-out business plan. And we needed to be very flexible as the world changed.

Back in 1985 or so, people said, "Ambulatory surgery is going to put you out of business." Today, our revenue is about 40% outpatient versus back then when it was 95% inpatient.

Johnson: We believe healthcare is fundamentally a local business. Each market will have its nuances and obviously having scale really gives us an advantage with respect to determining some clinical best practices. It can give scale relative to supply chain, revenue cycle and back-office functions, and technology as well. But at the end of the day, healthcare is delivered on a local market basis. And that's one thing I think HCA has understood for 50 years. We approach every market uniquely in terms of understanding the healthcare needs.

"Besides getting the talent, we needed to re-instill a culture that put the patient and the patient's family first. Once we got that, it was smooth sailing." —Dr. Thomas Frist Jr.

MH: Size has been linked time and again with higher spending. What's been HCA's role in that?

Johnson: First of all, healthcare spending all over the nation does account for almost 20% of the GDP. And yes, we're a piece of it with the hospital sector, no doubt about it. But if you look at HCA's growth in particular and our success, I would say fundamentally it goes back to the great markets we're in. We're in some of the fastest-growing markets in the country in terms of population growth and job growth, so there's an increase in demand for healthcare services. We have invested to meet that need, first and foremost.

From a pricing standpoint, if you look at HCA based on payer mix, we are usually the largest provider in many states we operate in—the largest provider of Medicaid services; largest provider of uncompensated care. So our payer mix reflects the communities in which we operate. So if you look at the pricing metric being net revenue per adjusted admission, over the past several years we've been averaging probably around 2.5% to 2.7%. It's been a mix of meeting the demands of the local markets along with what I would call just inflationary pricing growth for us. That's kind of been our revenue model.

MH: You're currently in a contract battle with nurses. How do you reconcile their staffing concerns with your outcomes?

Johnson: When it comes to the workforce, we're a big company. We're going to find pockets of issues with union organizations from time to time. But I can tell you, when I go out and walk the hallways at our hospitals, I am very proud of our management teams and the clinical capability of our nurses. They provide compassionate care to our patients. We employ about 87,000 nurses across the country. So we are committed to nursing 100%.

Hazen: Let me just speak to what's going on. It's a very exciting time to be a nurse leader in HCA because the company has made a renewed commitment to how we support nursing across our 180 hospitals. And part of that centers around technology. When we're finished by the end of 2019 or early 2020, we'll have close to $1 billion invested in consistent technology in each of our nursing units centered around nurse call-system standards, certain bed standards, communication standards that allow nurses to communicate easily across the unit, across the hospital and with our physicians, and then finally with documentation systems that have been standardized so we can extract nursing information and start to leverage nursing best practices across the company.

We've also trained our nurse leaders to manage a growing, more acute patient population and we think having strong leadership allows our nurses to use their skills more effectively. And we've also leveraged clinical education, nurse education, in a way that allows the nurses to provide the best care they can possibly deliver. Also, because of our size, because of the career opportunities that we have, we offer nurses career pathways and career development that we think makes HCA, for lack of a better term, the nursing employer of choice. So it's very exciting to give our nurses the training, the voice and the overall capabilities they need to deliver the kind of care that all of us want.

MH: What's your growth strategy and how has the potential of tightening reimbursement affected those plans?

Hazen: We have roughly 2,000 outpatient facilities. We think that's very important for the patients so that they have convenience. For our payers, it gives them different price points that are important to their network configurations. We have been very focused on building our outpatient capabilities for the past five to seven years. HCA has about 40% of its revenue in outpatient services, including the emergency department.

There are always adjustments to reimbursement coming out of Washington. I don't think what's there today is necessarily going to be that material to us because we have a fairly diversified class of outpatient facilities. Underneath that, we have a diversified revenue stream, so the implications are not overly material. Obviously we're not looking for any kind of reimbursement cuts from Medicare because, in our opinion, we're not fully being reimbursed for all of our costs. But nonetheless, it doesn't pose a unique risk to the organization because of the platform of outpatient capabilities that we have.

The company's acquisition strategy has been well-articulated. If it's complementary to an existing network and helps us respond to the community more effectively, then those are very attractive acquisition opportunities. In some instances, just like recently with Memorial Health in Savannah, Ga., we felt that system was very capable, with great employees, great physicians and great program offerings. We think we can create value in the right circumstances and that's how we approach it. We're very excited about the Mission Health acquisition, and we're hopeful that acquisition will transpire. Again, we think we can bring unique value to that system, which is doing a great job in meeting the needs of the Asheville, N.C., community.

MH: While other systems have had issues with declining patient volume, HCA is "killing it," according to LifePoint CEO Bill Carpenter. What's your secret?

Johnson: Bill is referring to the companies that are

"Each market will have its nuances and obviously having scale really gives us an advantage with respect to determining some clinical best practices." —*R. Milton Johnson*

primarily rural hospital operators and have been struggling with volumes. But, we're in seven of the top 10 or 12 of the 20 fastest-growing markets in the U.S. So we're not competing against LifePoint or Tenet. It would be the large not-for-profit systems. In Nashville, we compete with Ascension and Vanderbilt. So in these markets, I'm not so sure the other systems are seeing the sort of pressure on volumes that some of the rural hospital operators have been reporting.

Hazen: We've been very intentional over the past seven or eight years about improving our service. We've improved our quality metrics, we've improved our efficiency metrics, and we've ultimately improved our patient-satisfaction metrics. And that's what's been driving some of our growth. Additionally we've made investments in building out our networks, whether it's outpatient development or even service-line capabilities so that we have a comprehensive array of services and are much more than a primary-care hospital or a secondary-care hospital. We've moved way beyond that in a lot of our markets, and that's been a piece of our growth strategy.

And then finally, I would point to our capital investments. The company has been very intentional about resourcing our strategy, resourcing our networks so that we have adequate capacity, we have sufficient technology for physicians, and we've put ourselves in a position to respond to the needs of our constituencies. The company has made great strides in responding to our physicians and creating what we believe to be preferable places to practice medicine. So it's a combination of all of those things. And we think that's against the backdrop of a very positive market environment that Milton was alluding to.

MH: What are you proudest of?

Frist: We are very well organized for a large system. For example with Hurricane Florence recently, we moved all the patients safely out of a hospital in Myrtle Beach, S.C. The same goes for how we dealt with Katrina. HCA was (treating the wounded) in Las Vegas after the shooting. When we're in the path of natural and man-made disasters, we respond.

Johnson: Whether it's our supply chain, our transfer center capability or our supplemental workforce capability, we have numerous resources we can utilize. We have figured out how to scale disaster management, and we continue to learn from it. We've faced these natural disasters almost annually. We have the ability to make the investments in human capital as well as technology and other aspects and processes to be able to manage through these disasters as well as anyone. So it's something that we're proud of. I think it's ingrained in our culture now. When there is a disaster, a risk to the organization, we're going to do whatever it takes to protect our patients and our staff.

Hazen: I'm also proud of how we are scaling some of the analytics that we have. One of our initiatives is something we call at-scale analytics where we're using scaled analytics with clinical data, with human resource data, with nursing data, with efficiency data, whatever the case may be, to support best-practice identification, best-performance identification inside this massive database we have. To improve quality outcomes in many instances, to drive better engagement and better performance for our employees—all those kinds of things are happening inside what I call the scaled initiatives of HCA.

We've developed specialized capabilities to support research, quality improvements, training, accreditation, all those kind of things to support our trauma network. This is another version of how scale inside of HCA can make a difference for our patients, our communities and our organization.

Frist: I am so proud of our presence in cancer. We probably are the second- or third-largest in the whole U.S. as far as clinical research on cancer.

Hazen: We may be the first.

Johnson: We're heavily involved in cutting-edge clinical research with oncology. Also, a few years ago, we worked with Harvard to find the best treatment protocol in ICUs to reduce MRSA. That research was published in the New York Journal of Medicine and was later recognized as one of the most important, or one of the top 10 most important, studies conducted in that year.

And then, we conducted a clinical trial along with the March of Dimes looking at the impact of elective deliveries before 39 weeks. And we deliver about 5% of all the babies in this country, 200,000 to 225,000 a year. So we could do this research faster than any other system, again, because of scale. And the output and the outcome of that clinical trial determined that it was best for the mother and for the child to avoid elective deliveries before 39 weeks. And that later became the standard of clinical practice. ●

"The company has made great strides in responding to our physicians and creating what we believe to be preferable places to practice medicine." —*Sam Hazen*

The HCA playbook

By Shelby Livingston

HCA Healthcare's recipe for success in a complex and technical industry is pretty simple. It comes down to size, deep pockets and unparalleled operational savvy.

The sheer size of Nashville-based HCA, the nation's largest health system with 178 hospitals and thousands of other facilities, has given it an advantage over others by allowing it to spread the expense of back-office functions, the latest technology, and tasks like billing and purchasing supplies across its vast network, driving efficiency and lowering unit costs.

See Q&A on p. 34 for a discussion among three generations of HCA CEOs.

Size and dominant market share have enabled HCA to negotiate higher prices from health insurers. And lots of cash has allowed it to invest in the buildings, equipment, and clinical research that smaller health systems or stand-alone hospitals don't necessarily have the capital to do.

Industry experts say that over its 50 years, HCA's executives have also gotten really good at the day-to-day running of hospitals and understanding changes in the broader healthcare landscape. "It has to do with execution and getting the right people and executing a well-thought-out business plan, and being very entrepreneurial and flexible as the world changes," co-founder Dr. Thomas Frist Jr. said.

Focused on growth

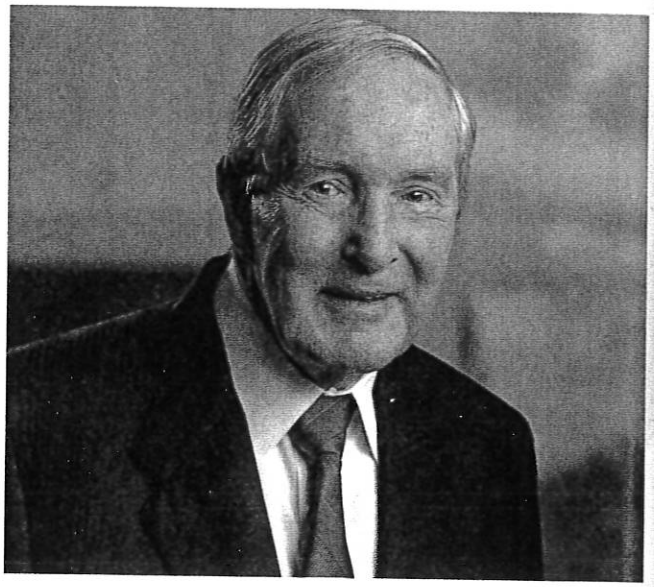
Being big was always the goal. In 1968, Frist, along with his cardiologist father, Dr. Thomas Frist Sr., and Jack Massey, the former owner of fast-food chain KFC, combined their medical expertise with business savvy to build what was then known as the Hospital Corporation of America, which has grown from a 200-bed hospital in Nashville to the behemoth it is today, representing 5%-6% of all U.S. healthcare spending, according to the company.

From the beginning, HCA grew rapidly by buying up hospitals and building new ones as demand surged on the heels of the creation of Medicare and Medicaid. It has had periods characterized by organic growth and others by fast-paced mergers and acquisitions. It has gone private and then back to public at times when valuations were most attractive. And it survived one of the industry's largest fraud investigations to solidify its reputation as a well-oiled, well-managed corporate machine.

Its net income in 2017 totaled $2.7 billion on revenue of $43.6 billion. That year, HCA's net patient revenue of $40.1 billion dwarfed that of not-for-profit Kaiser Foundation Hospitals, the next biggest system with net patient revenue of $21.4 billion. Its stock price has grown to nearly $140 per share from $46 five years ago.

THE TAKEAWAY

A combination of scale and operational savvy honed over its 50-year history has made HCA the well-oiled, well-managed corporate machine it is today.



MARK MOSRIE

"It has to do with execution and getting the right people and executing a well-thought-out business plan, and being very entrepreneurial and flexible as the world changes."

Dr. Thomas Frist Jr.
Co-founder
HCA

Blocking and tackling

HCA's focus on booming markets where the population is growing, unemployment is low and thus, the demand for healthcare is rising—places like Houston, Nashville, Florida, and Ashville, N.C., where it recently struck a deal to acquire market leader Mission Health—have helped it grow admissions from paying customers even as other hospitals suffer from softer volumes. Its net revenue per adjusted admission has averaged between 2.5% and 2.7% over the past several years, driven by the local markets' growing population and aging seniors' demand for services, said CEO R. Milton Johnson, who is retiring at the end of this year to be succeeded by HCA President and Chief Operating Officer Sam Hazen.

When expanding into new territories, HCA eyes areas where it will dominate in terms of market share, which it can leverage into negotiating power to secure better rates from insurers.

"They want to be the No. 1 or No. 2 player in every market they go into," said Brian Tanquilut, a Nashville-based equity analyst at investment firm Jefferies & Co. "They are very methodical, and they stick to a strategic playbook."

That approach also means HCA generally steers clear of communities with less-than-favorable payer mixes.

"They tend not to open hospitals in impoverished neighborhoods and in states that pay poorly," said Scott Phillips, managing director for Healthcare Management Partners.

Before 2017, HCA hadn't entered a new market since 2003. In the years prior it invested in facilities, doctors and capabilities in areas where it already operated, taking share from its competitors. In Nashville, for instance, HCA expanded its pediatric services and is siphoning customers away from the renowned Monroe Carell Jr. Children's Hospital at Vanderbilt, which has the higher prices typical of academic systems, Tanquilut said.

Under the direction of Johnson and Hazen, HCA has aggressively added outpatient clinics, urgent-care centers, free-standing emergency departments and ambulatory surgery centers to complement its hospitals. The company ended 2017 with 72 free-standing EDs and 123 urgent-care centers with plans to add more. Hazen said the company now has roughly 2,000 facilities providing outpatient care, which makes up 38% of HCA's revenue.

"They were buyers of outpatient businesses and imaging clinics at the right time of the cycle, and now with the inpatient hospital being out of favor, they've been able to take advantage of the market," said Nephron Research analyst Joshua Raskin.

He noted that HCA also empowers its hospital leaders with the tools necessary to drive change in their markets, such as the technologies needed to understand what staffing levels are necessary and what patient volumes will look like.

Those investments were possible because HCA generates a lot cash. Through its internal revenue-cycle management business, a service it also sells to other hospitals, HCA is adept at collecting payment from patients for services and making sure health plans pay up, Tanquilut said. In 2018, HCA will have generated $2.4 billion in free cash flows after investments, while other hospitals are pulling back on investments to pay off debt.

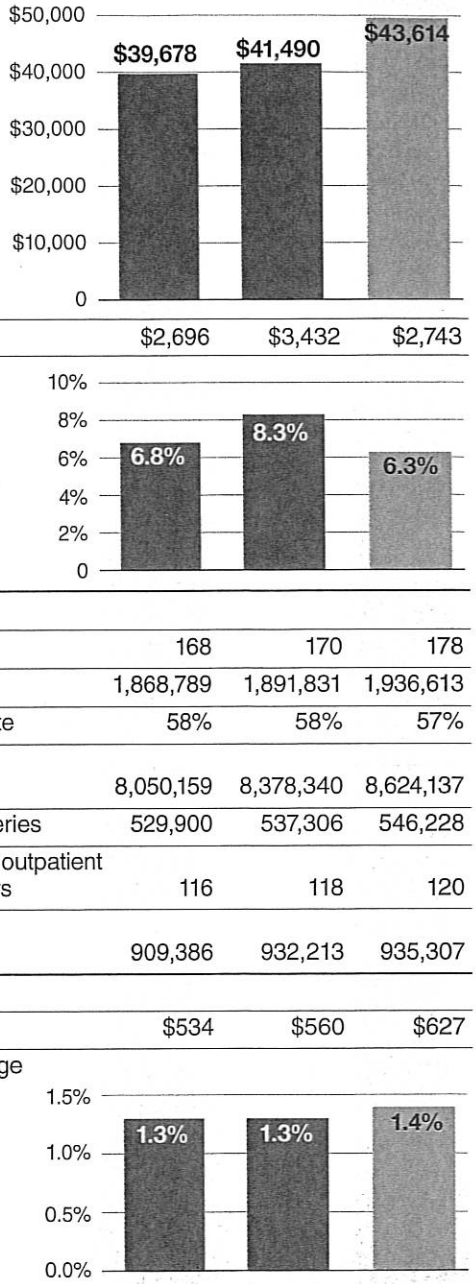
"They are operationally savvy," said Paul Keckley, an industry analyst in Nashville. HCA leadership understands where to build its hospitals, how many beds to allot, how to staff and how to buy supplies. And their financial, operational and clinical decisions have been backed by hard data that HCA collected before it was necessary for compliance standards, Keckley said.

Importantly, HCA's executives and managers are trained to demand and use that information, and are held accountable for producing results, said Dr. Mike Schatzlein, former CEO of Ascension Health's St. Thomas Health who has also worked for HCA-owned hospitals. "Their operators know their numbers, and so they can react in real time and operate efficiently," he said. "If you operate efficiently, that means you have reduced variation, waste and rework—and that results in higher quality."

Analytics also gives HCA an edge in setting prices.

HCA's footprint ($ in millions)

	2015	2016	2017
Financial			
Revenue	$39,678	$41,490	$43,614
Net income	$2,696	$3,432	$2,743
Margin	6.8%	8.3%	6.3%
Facilities			
Hospitals	168	170	178
Admissions	1,868,789	1,891,831	1,936,613
Occupancy rate	58%	58%	57%
Emergency room visits	8,050,159	8,378,340	8,624,137
Inpatient surgeries	529,900	537,306	546,228
Free-standing outpatient surgery centers	116	118	120
Outpatient surgeries	909,386	932,213	935,307
Charity care			
At cost	$534	$560	$627
As a percentage of revenue	1.3%	1.3%	1.4%



Sources: HCA Healthcare financials, Modern Healthcare Metrics

"They are the absolute leaders in maintaining discipline with their cost structure, but they also have world-class analytics to know where and when they can successfully raise prices, down to the smallest unit," Paul Hughes-Cromwick, co-director of sustainable health spending strategies for consultancy Altarum, said in an email.

HCA's aggressive pricing, enabled by its market share and patient volume, is a major factor in its financial success. Researchers have found that HCA's negotiating power with insurers allows it to set high prices for its healthcare services. The high cost of healthcare in the U.S. is in part attributed to

high prices, not the actual cost of services, experts say.

"They're out to maximize profit, and one of the ways you can do it is by raising prices," said Gerard Anderson, a health policy professor at Johns Hopkins University who has studied HCA's prices.

Anderson and Johns Hopkins associate professor Ge Bai's 2015 Health Affairs study found that HCA owned more than one-quarter of the top 50 U.S. hospitals with the highest ratio of charges to Medicare-allowable costs in 2012. Those 50 hospitals marked up charges by 1,000% on average. For-profit competitor Community Health Systems owned more than half of the hospitals. While charges don't reflect the payment rates that most patients pay, uninsured patients often do end up paying full charges, Anderson said. About 28 million people were uninsured in 2016.

In another Health Affairs study published this month, Andserson and Bai found that the 20 hospitals in Florida with the highest prices for auto, workers compensation, liability and travel insurers in 2016 were all owned by HCA. Oftentimes, these nontraditional insurers pay for consumers' medical expenses when an accident occurs, for example. But such insurers are smaller than giant HMO and PPO payers, and so have less negotiating power with big health systems.

The 20 HCA hospitals with the highest prices set them at 7.8 to 14.1 times the rate of Medicare, with a median price twice that of the other 124 hospitals operating in Florida that year, researchers found. Those 20 HCA hospitals received about a quarter of their commercial net revenue from such insurers—twice that of other payers—despite treating a small number of patients covered by them. The stakes are high for patients, because policies such as an auto insurance plan often have low coverage limits and high out-of-pocket spending.

HCA's prices for HMOs and PPOs were largely in line with the other hospitals in Florida, the researchers said. The 20 highest-priced hospitals set prices at 1.7 to 4.1 times Medicare rates.

An analysis using the Modern Healthcare Metrics database, which relies on Medicare cost reports, found that HCA hospitals were docked $38.3 million in readmissions penalties and $9.1 million in value-based purchasing penalties in 2017.

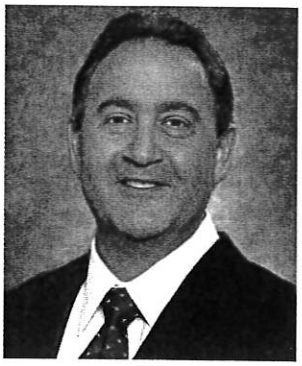
A learning system

HCA has leveraged its scale to solve big problems in clinical care and produce better outcomes for patients. The health system stores information from its 32 million patient visits per year in a clinical data warehouse and has a dedicated team of 300 professionals who find ways to use that data to improve best practices, said Dr. Jonathan Perlin, HCA's chief medical officer. Some of HCA's research into best practices have led to changes in clinical processes across the nation, he said.

In one case, HCA studied the difference in the rate of newborns going to the neonatal intensive-care unit after an early elective delivery. Over decades, the term of a mother's pregnancy had been shortened from the normal 39 weeks because of convenience, but it wasn't known if shorter terms meant higher risk of newborn complications.

"It didn't take one hospital 64 years to get these data. It took 43 hospitals 18 months."

Dr. Jonathan Perlin
Chief medical officer
HCA Healthcare



Because so many babies are delivered at HCA hospitals, the health system was in a position to find out. It studied 18,000 births over 90 days and found that the risk for complications requiring a baby to go to the NICU was four times greater when delivered electively at 37 weeks and more than two times greater at 38 weeks than delivering at full term.

Similarly, HCA used its patient data to test the best approaches to preventing MRSA and other hospital-acquired infections over 18 months. The chain managed to reduce MRSA rates by 37% and cut all potentially life-threatening blood stream infections in the ICU by 44%. The study changed practice in the U.S. and worldwide, Perlin said.

"This is really what a learning health system can allow, which was research conducted during the course of normal operations by normal care providers at speed and at scale to definitively answer a question that's important for the patients we're privileged to treat," Perlin said. "It didn't take one hospital 64 years to get these data. It took 43 hospitals 18 months."

HCA's track record isn't spotless. Its ill-fated 1994 merger with Louisville, Ky.-based Columbia Hospital Corp. ended with one of the largest Medicare fraud settlements when Rick Scott, who is now the governor of Florida and running for the U.S. Senate, was at the helm of the merged company. The investigation and a roughly $2 billion settlement were an embarrassment to HCA's culture and tarnished its reputation at the time. It is is largely now considered a distant memory by many in the industry.

The hospital system has also been criticized for refusing to treat patients who came to the emergency department with nonurgent conditions unless they paid upfront, a strategy that helped reduce ED costs and overcrowding. A 2012 New York Times story also accused several HCA Florida hospitals of performing unnecessary cardiac procedures to grow profits.

Critics might take issue with HCA's for-profit model, Keckley said. HCA doesn't take many risks, and it doesn't chase trends. It makes decisions about clinical programs based on potential payoff, and will leave a market if it's not profitable enough, Keckley said.

"They don't want to be on the bleeding edge of anything," he said. But "it's an interesting model and you have to respect their success. It's their efficiency and their data-driven approach to looking at opportunity that I think is exceptional bar none." ●

Quorum Board Minutes

Addressing Changes in the Healthcare Landscape

Accomplishing Patient Safety Still Difficult for Many Hospitals

November 2018

According to a new study by Health Affairs, hospitals are falling short when it comes to patient safety. The study assessed safety at 535 hospitals in four large states twice between 2005 and 2016. The "disappointing" results found that only 21 percent of hospitals demonstrate "sizeable improvements" in "work environment scores," while seven percent saw their scores worsen. 71 percent of hospitals remained the same.

Directly related to this patient safety concern is nurse satisfaction. Nurses, in particular, aren't impressed. Over 80 percent of nurses rated the clinical work environments in their hospitals as less than excellent. Close to 30 percent of nurses gave their hospital an unfavorable grade on infection prevention, and more than 30 percent scored in the high burnout range on standardized tests.

For years, hospitals have made efforts to improve patient safety efforts. In 1999, the Institute of Medicine concluded in *To Err Is Human* in 1999 that transformation of nurse work environments was needed to reduce patient harm. Tactics such as increasing ICU staff or improving nurse-patient ratios have helped, but hospitals need more.

"Our recent study of nurses and patients suggests that hospitals have not uniformly adopted [the Institute of Medicine's] recommendations," said Linda Aiken, director of Penn's Center for Health Outcomes and Policy Research, "which may be hampering progress toward improving patient safety and preventing patient harm."

Here are some key areas hospitals should focus to accomplish patient safety and improved provider satisfaction:

- The right tools, benchmarks, and training for all providers to determine if and when a patient deviates from the traditional care plan
- A multidisciplinary team ready to assess the complication and define the most appropriate action
- A customized approach to making certain staffing levels meet the needs of patient populations, and align with provider experience
- An efficient electronic medical record system to facilitate ease of communication and workflow
- An appropriate number of staff members to avoid burnout among providers

(Continued)

There is no one-size-fits-all approach. Quorum's solutions focused on workforce improvement and reducing variation in care provide nurses and other care team partners the opportunity to increase efficiency, improve outcomes and consistently work at the top of their license. Talk to your regional vice president about how your hospital can continually strive for improved patient safety as well as strategies to invest in your providers.

Related articles:

- https://www.healthcarefinancenews.com/news/patient-safety-hospitals-still-concern-investment-nurses-recommended
- https://www.medpagetoday.com/nursing/nursing/76176
- http://www2.philly.com/philly/health/one-in-three-nurses-say-patient-safety-unfavorable-at-hospitals-penn-survey-finds-20181107.html
- https://www.healthleadersmedia.com/nursing/massachusetts-voters-say-no-mandatory-nurse-patient-ratios

QUORUM | HEALTH RESOURCES®

November Compliance Newsletter

CMS' Inpatient Prospective Payment System Rule 2019: Publishing Hospital Prices

Hospitals are required to publish a list and update annually their standard charges online in a machine-readable format. Currently, hospitals are required to make this information publicly available or upon request.

https://www.beckershospitalreview.com/finance/cms-final-inpatient-payment-rule-for-2019-9-things-to-know.html

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2019 Physician Fee Schedule Final Rule – Telehealth Updates:

Under the SUPPORT Act, CMS has allowed for expansion of the use of telehealth services for the treatment of opioid use disorder and other substance use disorder. This interim final rule removes the originating site requirement for telehealth services and allows the patient to receive services in their home that are furnished for the treatment of substance use disorder or a co-occurring mental health disorder **after July 1, 2019**.

Thank you to all the 2018 Compliance Conference Attendees. It was our pleasure to host such an engaged and enthusiast group of fellow Healthcare Compliance professionals.

EDUCATION & TRAINING

Reimbursement & Regulatory Update: Final Outpatient Physician Fee Schedule Rules 3-part Series

Date: November 27-29th 2018 **Time**: 2:00 - 3:00pm CST

This series will cover the final rules regarding Medicare outpatient prospective payment system and Medicare physician fee schedules final rules scheduled for release on November 1, 2018 by the Centers for Medicare and Medicaid Services (CMS). In addition, we will cover other major regulatory developments including Physician Quality Program (MIPS) updates; recent federal court decisions impacting Medicare reimbursements and Medicaid DSH funding; other CMS regulatory developments impacting hospital, CAH and physician practice reimbursements from the Medicare and Medicaid programs.

Presenter:
John Waltko, Vice President, Financial and Regulatory Reporting, Quorum Health Resources

Sign Up

As we plan our education programs for next year, we would like to make sure we are covering topics that are most relevant to your current compliance challenges.

Please reach out to **Phillip Stubblefield** with topic suggestions for **2019 Compliance webinars.**

Compliance Team Contact Information

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

Phillip Stubblefield
Associate Consultant, Compliance
865.607.6255
pstubblefield@qhr.com

Our Mailing Address is:
1573 Mallory Lane, Suite 200 | Brentwood, TN | 37027

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

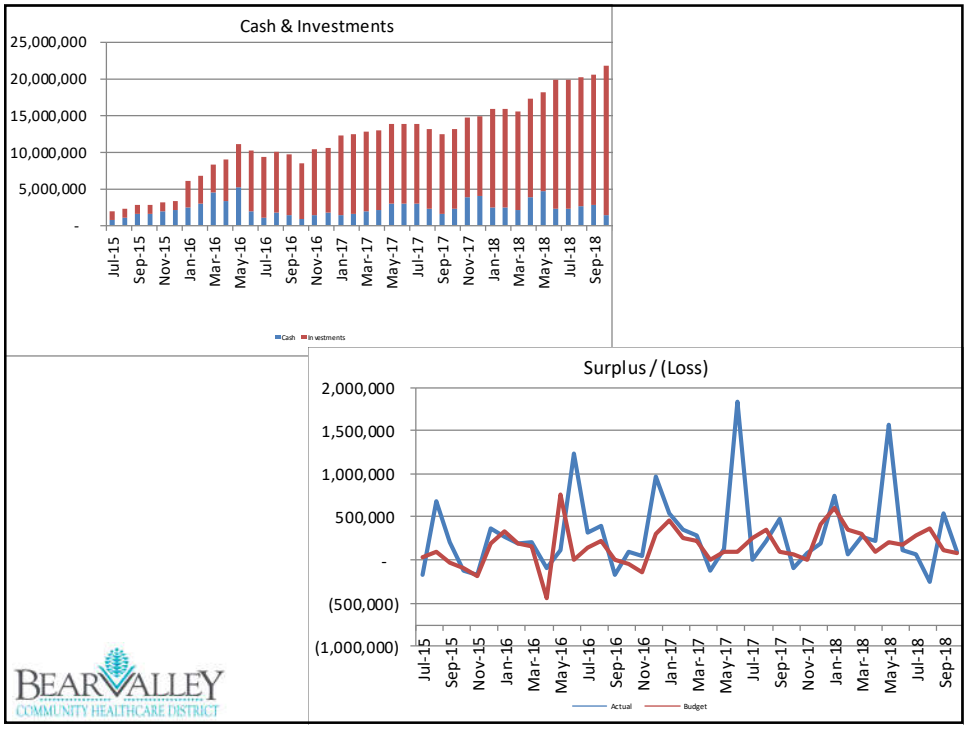
Finance Report

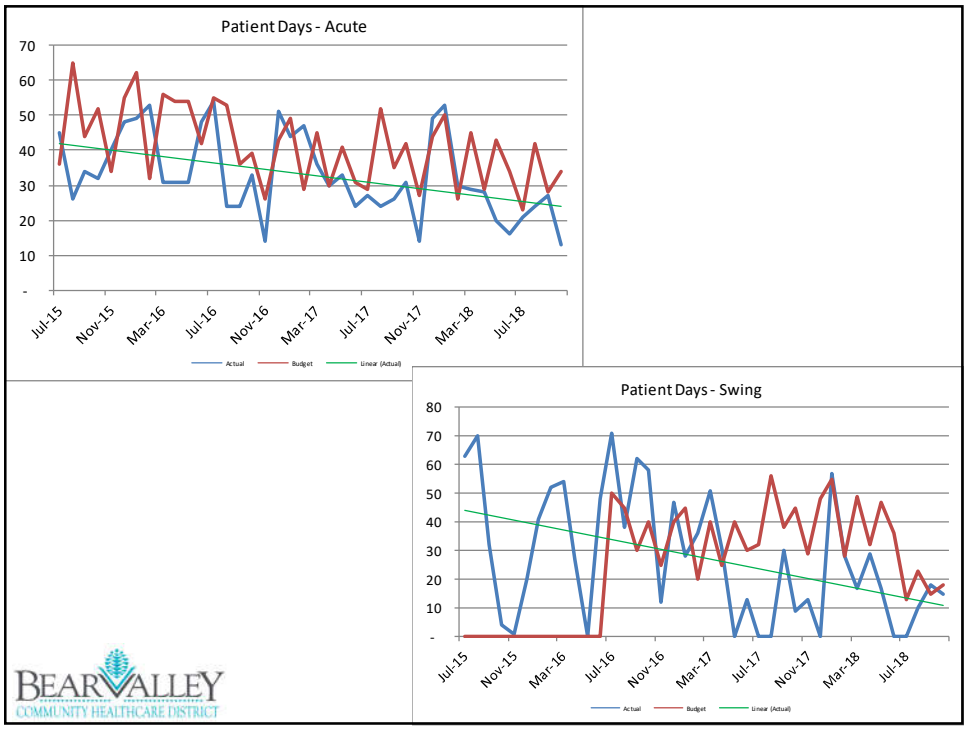
October 2018 Results

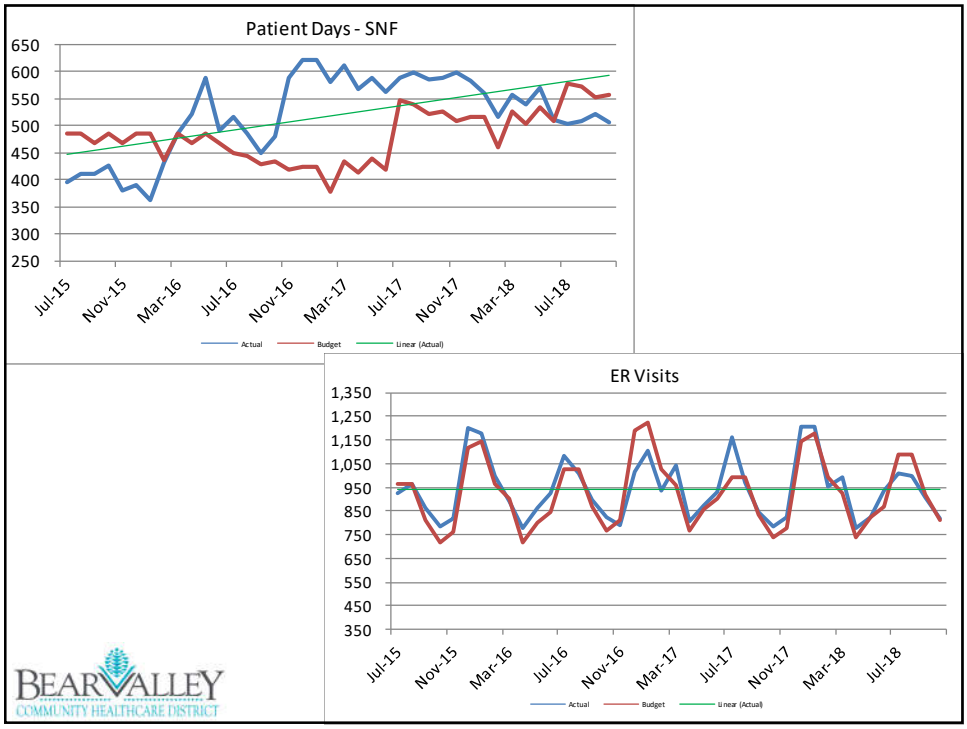
Summary for October 2018

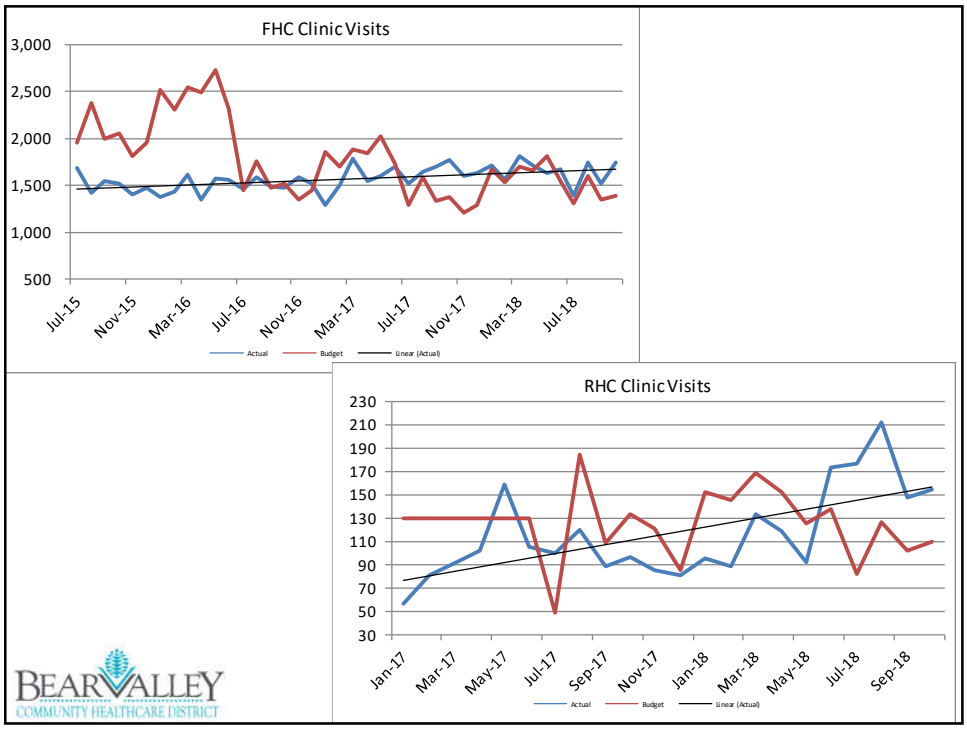
- Cash on Hand - $ 1,877,795
  Investments - $20,260,225
- Days Cash on hand, including investments with LAIF – 340
- Surplus of $101,384 for the month is $27,149 higher than budgeted Surplus
- Total Patient Revenue was under Budget by 4.8% for the month
- Net Patient Revenue was 4.2% under budget.
- Total Expenses were 3.5% lower than budget

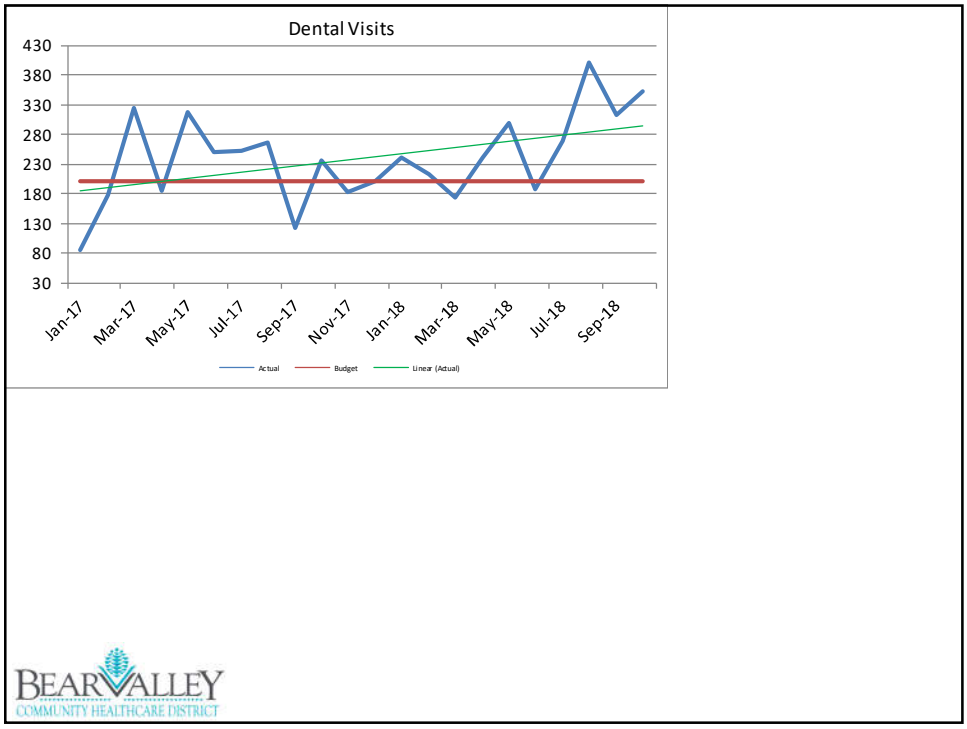
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

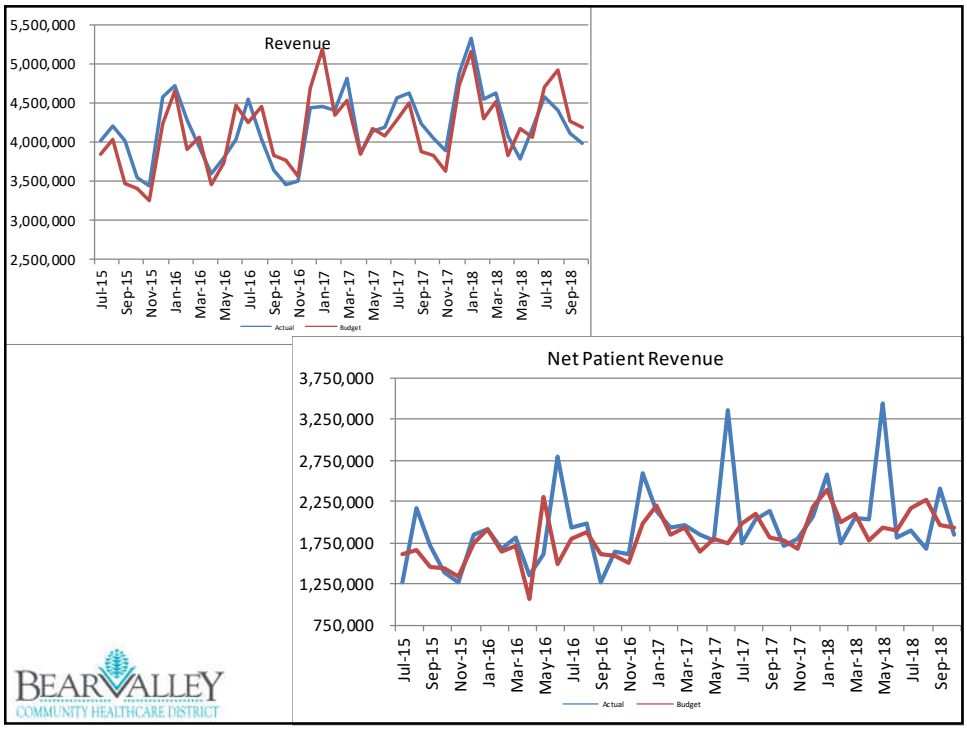

Cash & Investments
25,000,000
20,000,000
15,000,000
10,000,000
5,000,000
-
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Cash
Investments
Surplus / (Loss)
2,000,000
1,500,000
1,000,000
500,000
-
(500,000)
(1,000,000)
Actual
Budget
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

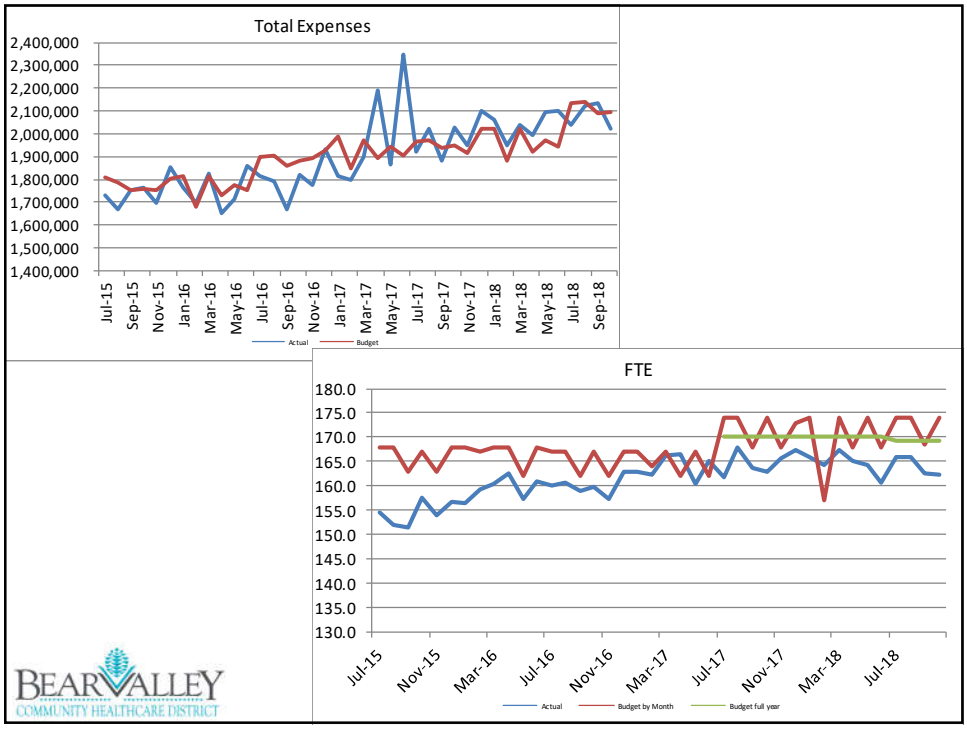

Patient Days - Acute
70
60
50
40
30
20
10
-
Jul-15
Nov-15
Mar-16
Jul-16
Nov-16
Mar-17
Jul-17
Nov-17
Mar-18
Jul-18
Actual
Budget
Linear (Actual)
Patient Days - Swing
80
70
60
50
40
30
20
10
-
Jul-15
Nov-15
Mar-16
Jul-16
Nov-16
Mar-17
Jul-17
Nov-17
Mar-18
Jul-18
Actual
Budget
Linear (Actual)
BEAR VALLEY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

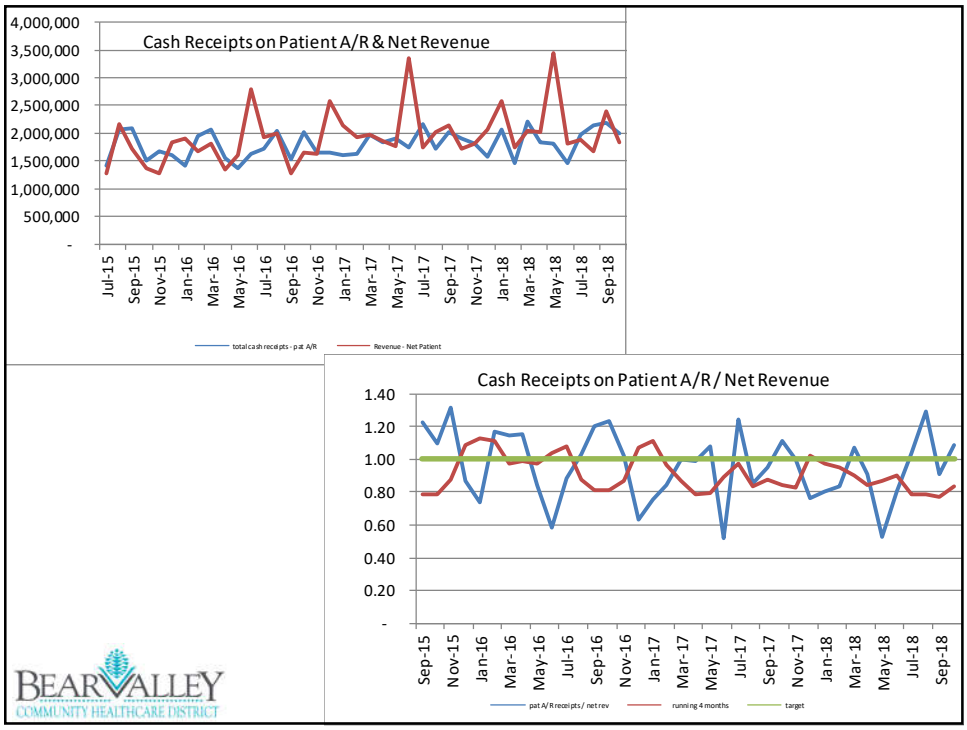

Patient Days - SNF
650
600
550
500
450
400
350
300
250
Jul-15
Nov-15
Mar-16
Jul-16
Nov-16
Mar-17
Jul-17
Nov-17
Mar-18
Jul-18
Actual
Budget
Linear (Actual)
ER Visits
1,350
1,250
1,150
1,050
950
850
750
650
550
450
350
Jul-15
Nov-15
Mar-16
Jul-16
Nov-16
Mar-17
Jul-17
Nov-17
Mar-18
Jul-18
Actual
Budget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

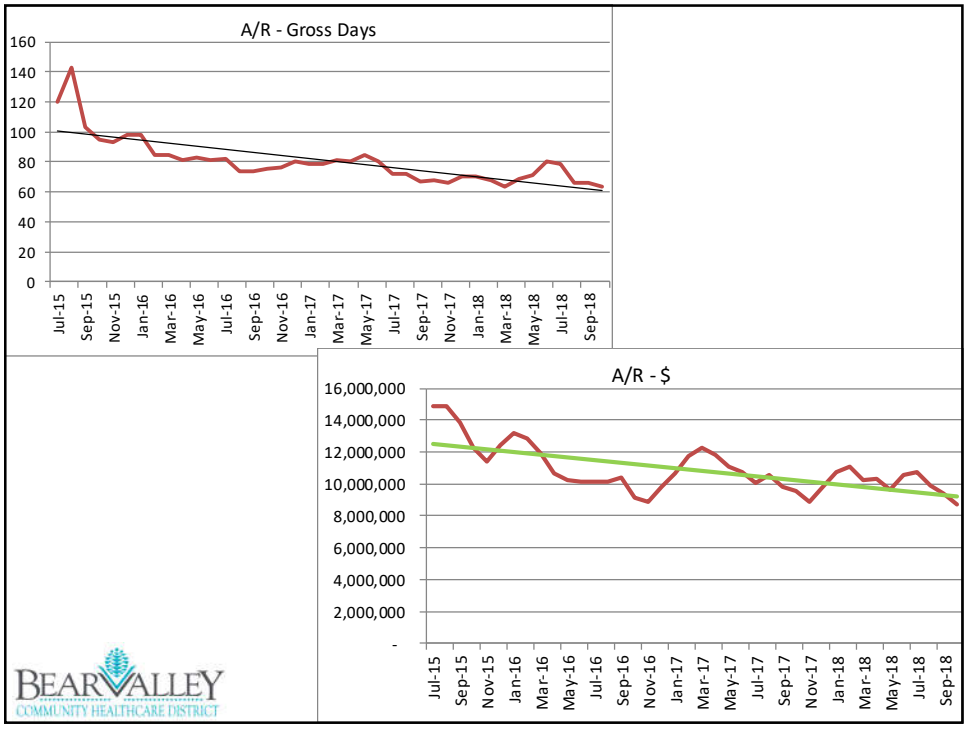

FHC Clinic Visits
3,000
2,500
2,000
1,500
1,000
500
Jul-15
Nov-15
Mar-16
Jul-16
Nov-16
Mar-17
Jul-17
Nov-17
Mar-18
Jul-18
Actual
Budget
Linear (Actual)
RHC Clinic Visits
230
210
190
170
150
130
110
90
70
50
30
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Actual
Budget
Linear (Actual)
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT


Dental Visits
430
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
Jul-18
Sep-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
Jul-18
Sep-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
Jul-18
Sep-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
Jul-18
Sep-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
Nov-15
Mar-16
Jul-16
Nov-16
Mar-17
Jul-17
Nov-17
Mar-18
Jul-18
Actual
Budget by Month
Budget full year
BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT


Cash Receipts on Patient A/R & Net Revenue
4,000,000
3,500,000
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
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
Jul-18
Sep-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
-
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
Jul-18
Sep-18
pat A/R receipts / net rev
running 4 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
Jul-18
Sep-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

October 2018 Financial Results

For the month . . .

Total Patient Revenue of $3,978,707 for October was 4.8% % under budget. For the month, acute patient days of 13 were 62% under budget and swing days of 15 were 17% under budget. SNF Days of 506 were 9% lower than budget. ER Visits of 820 were 1% more than budget.

Revenue Deductions of $2,135,158 were 5.2% lower than budget.

Total Expenses of $2,019,782 were 3.5% lower than budget. Salaries, Wages, and Benefits it came in 12.5% below budget with a favorable adjustment to workers comp expense reconciling 2018 amounts to the General Ledger. Professional Fees were again over budget with higher volumes in Clinics. Purchased Services were over budget due to increased Dental volume and therefore increased fees payment.

Our Surplus for the month of October 2018 was $101,384 - $27,149 more than budgeted.

Our Operating Cash and Investments total $22,138,020 as of the end of month. Total days cash on hand as of the end of October 2018 are 340.

Key Statistics

Acute patient days of 13 were 62% under budget, Swing days of 15 were 17% under budget. SNF days of 506 were 9% lower than budget. ER Visits of 820 were 1% more than budget.

FTE continue to be under budget.

Year-to-Date

Total Patient Revenue of $17,068,709 is 5.5% below budget. Net patient revenue of $7,793,570 is 6.4% below budget. Total expenses of $8,309,267 are 1.7% below budget. Our surplus of $456,387 is $380,165 below budget.

Acute days are 33% below budget. Swing days are 38% below budget. SNF days are 10% below budget. ER visits are 4.5% below budget. All clinic visit categories are above budget

Bear Valley Community Healthcare District
Financial Statements October 31, 2018

Financial Highlights—Hospital

STATEMENT OF OPERATIONS

		A	B	C	D	E	F	G	H	I	J
		Current Month					Year-to-Date				
		FY 17/18	FY 18/19		VARIANCE		FY 17/18	FY 18/19		VARIANCE	
		Actual	Actual	Budget	Amount	%	Actual	Actual	Budget	Amount	%
1	Total patient revenue	4,046,739	3,978,707	4,178,328	(199,621)	-4.8%	17,457,147	17,068,709	18,066,369	(997,660)	-5.5%
2	Total revenue deductions	2,338,683	2,135,158	2,253,276	(118,119)	-5.2%	9,852,859	9,275,139	9,742,777	(467,639)	-4.8%
3	%Deductions	58%	54%	54%			56%	54%	54%		
4	Net Patient Revenue	1,708,056	1,843,550	1,925,052	(81,502)	-4.2%	7,604,289	7,793,570	8,323,592	(530,021)	-6.4%
5	%Net to Gross	42%	46%	46%			44%	46%	46%		
6	Other Revenue	45,312	90,789	46,585	44,204	94.9%	107,762	140,994	186,029	(45,035)	-24.2%
7	Total Operating Revenue	1,753,369	1,934,339	1,971,637	(37,298)	-1.9%	7,712,050	7,934,565	8,509,621	(575,056)	-6.8%
8	Total Expenses	2,028,341	2,019,782	2,092,121	(72,339)	-3.5%	7,854,045	8,309,267	8,451,946	(142,679)	-1.7%
9	%Expenses	50%	51%	50%			45%	49%	47%		
10	Surplus (Loss) from Operations	(274,973)	(85,443)	(120,483)	35,041	29.1%	(141,995)	(374,702)	57,675	(432,377)	749.7%
11	%Operating margin	-7%	-2%	-3%			-1%	-2%	0%		
12	Total Non-operating	179,118	186,827	194,719	(7,892)	-4.1%	756,662	831,089	778,877	52,212	6.7%
13	Surplus/(Loss)	(95,854)	101,384	74,236	27,149	-36.6%	614,668	456,387	836,552	(380,165)	45.4%
14	%Total margin	-2%	3%	2%			4%	3%	5%		

BALANCE SHEET

		A	B	C	D	E
		October	October	September		
		FY 17/18	FY 18/19	FY 18/19	VARIANCE	
					Amount	%
15	Gross Accounts Receivables	9,514,168	8,676,705	9,393,508	(716,803)	-7.6%
16	Net Accounts Receivables	3,562,374	2,914,596	3,246,260	(331,664)	-10.2%
17	%Net AR to Gross AR	37%	34%	35%		
18	Days Gross AR	68.0	63.9	66.0	(2.1)	-3.2%
19	Cash Collections	1,897,526	2,000,267	2,183,830	(183,563)	-8.4%
21	Investments	10,921,640	20,260,225	17,760,225	2,500,000	14.1%
22	Cash on hand	2,187,881	1,877,795	2,710,313	(832,518)	-30.7%
23	Total Cash & Invest	13,109,521	22,138,020	20,470,538	1,667,482	8.1%
24	Days Cash & Invest	211	340	311	29	9.4%
	Total Cash and Investments	13,109,521	22,138,020			
	Increase Current Year vs. Prior Year		9,028,499			

Bear Valley Community Healthcare District

Financial Statements October 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	142,719	89,286	181,500	(92,215)	-50.8%	487,863	417,539	708,879	(291,340)	-41.1%
2	Outpatient	1,047,978	957,181	987,328	(30,147)	-3.1%	4,186,834	3,707,723	4,014,166	(306,443)	-7.6%
3	Clinic Revenue	391,164	399,238	335,855	63,383	18.9%	1,448,529	1,523,974	1,362,262	161,712	11.9%
4	Emergency Room	2,203,306	2,309,030	2,412,906	(103,877)	-4.3%	10,282,416	10,503,644	10,945,906	(442,262)	-4.0%
5	Skilled Nursing Facility	261,572	223,973	260,738	(36,765)	-14.1%	1,051,505	915,830	1,035,156	(119,326)	-11.5%
6	**Total patient revenue**	**4,046,739**	**3,978,707**	**4,178,328**	**(199,621)**	**-4.8%**	**17,457,147**	**17,068,709**	**18,066,369**	**(997,660)**	**-5.5%**
	Revenue Deductions										
7	Contractual Allow	1,909,156	1,725,475	2,104,946	(379,471)	-18.0%	8,644,809	8,438,336	9,101,420	(663,084)	-7.3%
8	Contractual Allow PY	(1,739)	6,564	-	6,564	#DIV/0!	(27)	(693,374)	-	(693,374)	#DIV/0!
9	Charity Care	-	15,115	8,774	6,341	72.3%	20,517	58,473	37,939	20,534	54.1%
10	Administrative	10,431	2,378	7,939	(5,561)	-70.0%	293,795	12,851	34,327	(21,476)	-62.6%
11	Policy Discount	10,680	40,364	6,267	34,097	544.1%	41,354	82,350	27,099	55,251	203.9%
12	Employee Discount	4,084	3,317	3,343	(26)	-0.8%	21,832	27,654	14,454	13,200	91.3%
13	Bad Debts	236,304	231,008	122,007	109,001	89.3%	291,679	802,570	527,538	275,032	52.1%
14	Denials	190,797	110,936	-	110,936	#DIV/0!	538,901	546,278	-	546,278	#DIV/0!
15	**Total revenue deductions**	**2,338,683**	**2,135,158**	**2,253,276**	**(118,119)**	**-5.2%**	**9,852,859**	**9,275,139**	**9,742,777**	**(467,639)**	**-4.8%**
16	**Net Patient Revenue**	**1,708,056**	**1,843,550**	**1,925,052**	**(81,502)**	**-4.2%**	**7,604,289**	**7,793,570**	**8,323,592**	**(530,021)**	**-6.4%**
	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**	45,312	90,789	46,585	44,204	94.9%	107,762	140,994	186,029	(45,035)	-24.2%
18	**Total Operating Revenue**	**1,753,369**	**1,934,339**	**1,971,637**	**(37,298)**	**-1.9%**	**7,712,050**	**7,934,565**	**8,509,621**	**(575,056)**	**-6.8%**
	Expenses										
19	Salaries	798,066	891,749	875,096	16,653	1.9%	3,242,463	3,499,880	3,472,633	27,247	0.8%
20	Employee Benefits	292,526	185,368	351,144	(165,776)	-47.2%	1,198,669	1,071,003	1,407,163	(336,160)	-23.9%
21	Registry	-	-	-	-	#DIV/0!	12,718	-	-	-	#DIV/0!
22	Salaries and Benefits	**1,090,592**	**1,077,117**	**1,226,240**	**(149,123)**	-12.2%	**4,453,851**	**4,570,883**	**4,879,796**	**(308,913)**	**-6.3%**
23	Professional fees	191,107	179,265	161,233	18,032	11.2%	664,055	708,988	642,416	66,572	10.4%
24	Supplies	139,091	135,960	127,701	8,259	6.5%	507,202	529,655	528,570	1,085	0.2%
25	Utilities	40,689	40,116	41,827	(1,711)	-4.1%	168,248	173,251	172,600	651	0.4%
26	Repairs and Maintenance	30,007	41,525	28,074	13,451	47.9%	107,533	114,416	112,182	2,234	2.0%
27	Purchased Services	373,876	381,061	317,021	64,041	20.2%	1,303,051	1,537,411	1,356,259	181,151	13.4%
28	Insurance	25,835	28,460	26,975	1,485	5.5%	103,121	113,233	107,900	5,333	4.9%
29	Depreciation	61,486	76,489	81,667	(5,178)	-6.3%	218,031	305,955	326,668	(20,713)	-6.3%
30	Rental and Leases	23,454	11,158	21,112	(9,954)	-47.1%	145,238	45,307	84,448	(39,141)	-46.3%
32	Dues and Subscriptions	5,181	5,746	5,910	(164)	-2.8%	21,851	25,607	23,640	1,967	8.3%
33	Other Expense.	47,022	42,884	54,361	(11,477)	-21.1%	161,865	184,561	217,467	(32,906)	-15.1%
34	**Total Expenses**	**2,028,341**	**2,019,782**	**2,092,121**	**(72,339)**	**-3.5%**	**7,854,045**	**8,309,267**	**8,451,946**	**(142,679)**	**-1.7%**
35	**Surplus (Loss) from Operations**	**(274,973)**	**(85,443)**	**(120,483)**	**35,041**	**29.1%**	**(141,995)**	**(374,702)**	**57,675**	**(432,377)**	**749.7%**
36	**Non-Operating Income**										
37	Tax Revenue	186,047	184,244	184,244	(0)	0.0%	744,188	736,976	736,977	(1)	0.0%
38	Other non-operating	130	9,020	3,133	5,887	187.9%	10,247	24,320	12,532	11,788	94.1%
	Interest Income	693	1,124	15,125	(14,001)	-92.6%	33,600	100,239	60,500	39,739	65.7%
	Interest Expense	(7,752)	(7,561)	(7,783)	222	-2.9%	(31,373)	(30,446)	(31,132)	686	-2.2%
	IGT Expense	-	-	-	-	#DIV/0!	-	-	-	-	#DIV/0!
39	**Total Non-operating**	**179,118**	**186,827**	**194,719**	**(7,892)**	**-4.1%**	**756,662**	**831,089**	**778,877**	**52,212**	**6.7%**
40	**Surplus/(Loss)**	**(95,854)**	**101,384**	**74,236**	**27,149**	**-36.6%**	**614,668**	**456,387**	**836,552**	**(380,165)**	**-454%**

2018-19 Actual BS

BALANCE SHEET Includes Final Entries 6-30-18	**July**	**Aug**	**Sept**	**Oct**	**PY June**
ASSETS:					
Current Assets					
Cash and Cash Equivalents (Includes CD's)	2,296,309	2,551,340	2,710,313	1,422,386	2,253,824
Gross Patient Accounts Receivable	10,740,258	9,856,844	9,392,893	8,676,040	10,597,934
Less: Reserves for Allowances & Bad Debt	6,470,520	6,125,057	6,146,633	5,761,444	6,413,352
Net Patient Accounts Receivable	4,269,738	3,731,787	3,246,260	2,914,596	4,184,582
Tax Revenue Receivable	2,210,931	2,210,931	2,210,931	2,210,931	52,044
Other Receivables	50,484	78,234	93,056	651,781	96,628
Inventories	130,292	134,606	136,936	139,583	129,318
Prepaid Expenses	299,848	293,739	345,377	346,209	199,838
Due From Third Party Payers	0	0			
Due From Affiliates/Related Organizations	0	0			
Other Current Assets	0	0			
Total Current Assets	9,257,602	9,000,637	8,742,873	7,685,486	6,916,233
Assets Whose Use is Limited					
Investments	17,668,421	17,668,421	17,760,225	20,260,225	17,668,421
Other Limited Use Assets	144,375	144,375	144,375	144,375	144,375
Total Limited Use Assets	17,812,796	17,812,796	17,904,600	20,404,600	17,812,796
Property, Plant, and Equipment					
Land and Land Improvements	570,615	570,615	570,615	570,615	570,615
Building and Building Improvements	9,758,672	9,772,522	9,772,522	9,772,522	9,758,672
Equipment	11,779,820	11,844,577	11,912,516	12,010,795	11,761,910
Construction In Progress	48,953	101,798	127,293	166,571	32,516
Capitalized Interest					
Gross Property, Plant, and Equipment	22,158,060	22,289,512	22,382,945	22,520,503	22,123,712
Less: Accumulated Depreciation	13,685,197	13,761,686	13,838,174	13,914,663	13,608,708
Net Property, Plant, and Equipment	8,472,863	8,527,826	8,544,771	8,605,840	8,515,004
TOTAL UNRESTRICTED ASSETS	35,543,261	35,341,260	35,192,244	36,695,926	33,244,034
Restricted Assets	0	0	0	0	0
TOTAL ASSETS	35,543,261	35,341,260	35,192,244	36,695,926	31,316,969

2018-19 Actual BS

BALANCE SHEET Includes Final Entries 6-30-18	**July**	**Aug**	**Sept**	**Oct**	**PY June**
LIABILITIES:					
Current Liabilities					
Accounts Payable	954,160	880,513	1,028,412	1,133,880	906,103
Notes and Loans Payable					
Accrued Payroll	705,323	806,989	844,952	990,998	758,370
Patient Refunds Payable					
Due to Third Party Payers (Settlements)	3,983,651	4,173,225	3,473,225	4,800,692	3,769,980
Advances From Third Party Payers					
Current Portion of Def Rev - Txs,	2,061,687	1,877,443	1,693,199	1,508,955	35,000
Current Portion - LT Debt	35,000	35,000	35,000	35,000	35,000
Current Portion of AB915					
Other Current Liabilities (Accrued Interest & Accrued Other)	7,630	22,873	30,494	38,055	7,621
Total Current Liabilities	7,747,451	7,796,043	7,105,281	8,507,580	5,512,074
Long Term Debt					
USDA Loan	2,895,000	2,895,000	2,895,000	2,895,000	2,895,000
Leases Payable	0	0	0	0	0
Less: Current Portion Of Long Term Debt	35,000	35,000	35,000	35,000	35,000
Total Long Term Debt (Net of Current)	2,860,000	2,860,000	2,860,000	2,860,000	2,860,000
Other Long Term Liabilities					
Deferred Revenue	0	0	0	0	0
Other	0	0	0	0	
Total Other Long Term Liabilities	0	0	0	0	0
TOTAL LIABILITIES	10,607,451	10,656,043	9,965,281	11,367,580	8,372,074
Fund Balance					
Unrestricted Fund Balance	24,871,960	24,871,960	24,871,960	24,871,960	20,663,982
Temporarily Restricted Fund Balance	0	0			
Equity Transfer from FRHG	0	0			
Net Revenue/(Expenses)	63,851	-186,743	355,003	456,387	4,207,978
TOTAL FUND BALANCE	24,935,811	24,685,217	25,226,963	25,328,347	24,871,960
TOTAL LIABILITIES & FUND BALANCE	35,543,261	35,341,260	35,192,244	36,695,926	33,244,034

Bear Valley Community Healthcare District
Financial Statements

Current Year Trending Statement of Operations

A Statement of Operations—CURRENT YEAR 2019

			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		74,791	120,993	132,469	89,286									417,539
2	Outpatient		972,222	931,894	846,425	957,181									3,707,723
3	Clinic		342,650	422,712	359,375	399,238									1,523,974
4	Emergency Room		2,957,516	2,703,194	2,533,903	2,309,030									10,503,644
5	Skilled Nursing Facility		223,604	228,589	239,665	223,973									915,830
6	**Total patient revenue**		**4,570,784**	**4,407,382**	**4,111,836**	**3,978,707**	-	-	-	-	-	-	-	-	**17,068,709**
	Revenue Deductions	C/A	0.51	0.53	0.50	0.43	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.49
7	Contractual Allow		2,320,958	2,352,744	2,039,158	1,725,475									8,438,336
8	Contractual Allow PY		62	-	(700,000)	6,564									(693,374)
9	Charity Care		15,343	-	28,015	15,115									58,473
10	Administrative		806	2,818	6,849	2,378									12,851
11	Policy Discount		13,989	15,616	12,381	40,364									82,350
12	Employee Discount		12,793	5,188	6,356	3,317									27,654
13	Bad Debts		215,076	186,926	169,560	231,008									802,570
14	Denials		103,506	177,395	154,441	110,936									546,278
15	**Total revenue deductions**		**2,682,534**	**2,740,687**	**1,716,760**	**2,135,158**	-	-	-	-	-	-	-	-	**9,275,139**
			0.59	0.62	0.42	0.54	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
16	**Net Patient Revenue**		**1,888,250**	**1,666,694**	**2,395,076**	**1,843,550**	-	-	-	-	-	-	-	-	**7,793,570**
	net / tot pat rev		41.3%	37.8%	58.2%	46.3%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	45.7%
17	**Other Revenue**		19,441	19,594	11,170	90,789									140,994
18	**Total Operating Revenue**		**1,907,691**	**1,686,288**	**2,406,246**	**1,934,339**	-	-	-	-	-	-	-	-	**7,934,565**
	Expenses														
19	Salaries		885,068	891,463	831,600	891,749									3,499,880
20	Employee Benefits		303,328	293,241	289,066	185,368									1,071,003
21	Registry		-	-	-	-									-
22	Salaries and Benefits		**1,188,396**	**1,184,704**	**1,120,666**	**1,077,117**	-	-	-	-	-	-	-	-	**4,570,883**
23	Professional fees		173,695	181,120	174,907	179,265									708,988
24	Supplies		121,217	135,487	136,991	135,960									529,655
25	Utilities		46,712	43,958	42,464	40,116									173,251
26	Repairs and Maintenance		17,407	23,079	32,405	41,525									114,416
27	Purchased Services		325,455	373,332	457,562	381,061									1,537,411
28	Insurance		28,258	28,258	28,258	28,460									113,233
29	Depreciation		76,489	76,489	76,489	76,489									305,955
30	Rental and Leases		11,421	11,509	11,219	11,158									45,307
32	Dues and Subscriptions		6,882	7,101	5,879	5,746									25,607
33	Other Expense.		40,078	55,169	46,430	42,884									184,561
34	**Total Expenses**		**2,036,009**	**2,120,207**	**2,133,270**	**2,019,782**	-	-	-	-	-	-	-	-	**8,309,267**
35	**Surplus (Loss) from Operations**		**(128,318)**	**(433,918)**	**272,977**	**(85,443)**	-	-	-	-	-	-	-	-	**(374,702)**
36	**Non-Operating Income**														
37	Tax Revenue		184,244	184,244	184,244	184,244									736,976
38	Other non-operating		15,020	245	35	9,020									24,320
	Interest Income		543	6,457	92,115	1,124									100,239
	Interest Expense		(7,638)	(7,621)	(7,626)	(7,561)									(30,446)
	IGT Expense		-	-	-	-									-
39	**Total Non-operating**		**192,169**	**183,325**	**268,768**	**186,827**	-	-	-	-	-	-	-	-	**831,089**
40	**Surplus/(Loss)**		**63,851**	**(250,594)**	**541,745**	**101,384**	-	-	-	-	-	-	-	-	**456,387**

Units of Service

For the period ending: October 31, 2018

31 123

Current Month						Bear Valley Community Hospital	Year-To-Date					
Oct-18		Oct-17	Actual -Budget		Act.-Act.		Oct-18		Oct-17	Actual -Budget		Act.-Act.
Actual	Budget	Actual	Variance	Var %	Var %		Actual	Budget	Actual	Variance	Var %	Var %
13	34	31	(21)	-61.8%	-58.1%	Med Surg Patient Days	85	127	108	(42)	-33.1%	-21.3%
15	18	15	(3)	-16.7%	0.0%	Swing Patient Days	43	69	43	(26)	-37.7%	0.0%
506	558	589	(52)	-9.3%	-14.1%	SNF Patient Days	2,037	2,260	2,361	(223)	-9.9%	-13.7%
534	**610**	**635**	**(76)**	**-12.5%**	**-15.9%**	**Total Patient Days**	**2,165**	**2,456**	**2,512**	**(291)**	**-11.8%**	**-13.8%**
6	14	14	(8)	-57.1%	-57.1%	Acute Admissions	41	56	51	(15)	-26.8%	-19.6%
7	14	11	(7)	-50.0%	-36.4%	Acute Discharges	39	56	50	(17)	-30.4%	-22.0%
1.9	2.4	2.8	(0.6)	-23.5%	-34.1%	Acute Average Length of Stay	2.2	2.3	2.2	(0.1)	-3.9%	0.9%
0.4	1.1	1.0	(0.7)	-61.8%	-58.1%	Acute Average Daily Census	0.7	1	0.9	(0.3)	-33.1%	-21.3%
16.8	18.6	19.5	(1.8)	-9.5%	-13.7%	SNF/Swing Avg Daily Census	16.9	19	19.5	(2.0)	-10.7%	-13.5%
17.2	**19.7**	**20.5**	**(2.5)**	**-12.5%**	**-15.9%**	**Total Avg. Daily Census**	**17.6**	**20**	**20.4**	**(2.4)**	**-11.8%**	**-13.8%**
38%	**44%**	**46%**	**-5%**	**-12.5%**	**-15.9%**	**% Occupancy**	**39%**	**44%**	**45%**	-5%	**-11.8%**	**-13.8%**
5	13	9	(8)	-61.5%	-44.4%	Emergency Room Admitted	34	52	42	(18)	-34.6%	-19.0%
815	799	774	16	2.0%	5.3%	Emergency Room Discharged	3,703	3,861	3,717	(158)	-4.1%	-0.4%
820	**812**	**783**	**8**	**1.0%**	**4.7%**	**Emergency Room Total**	**3,737**	**3,913**	**3,759**	**(176)**	**-4.5%**	**-0.6%**
26	**26**	**25**	**0**	**1.0%**	**4.7%**	**ER visits per calendar day**	**30**	**32**	**31**	**(1)**	**-4.5%**	**-0.6%**
83%	**93%**	**64%**	**100%**	**107.7%**	**29.6%**	**% Admits from ER**	**83%**	**93%**	**82%**	**83%**	**89.7%**	**0.7%**
-	-	-	-	0.0%	#DIV/0!	Surgical Procedures I/P	-	-	-	-	0.0%	#DIV/0!
17	10	8	7	70.0%	112.5%	Surgical Procedures O/P	54	38	53	16	42.1%	1.9%
17	**10**	**8**	**7**	**70.0%**	**112.5%**	**TOTAL Procedures**	**54**	**38**	**53**	**16**	**42.1%**	**1.9%**
709	**1,047**	**162**	**(338)**	**-32.3%**	**337.7%**	**Surgical Minutes Total**	**3,672**	**4,154**	**412**	**(482)**	**-11.6%**	**791.3%**

Units of Service

For the period ending: October 31, 2018

Bear Valley Community Hospital

Current Month							Year-To-Date					
Oct-18		Oct-17	Actual -Budget		Act.-Act.		Oct-18		Oct-17	Actual -Budget		Act.-Act.
Actual	Budget	Actual	Variance	Var %	Var %		Actual	Budget	Actual	Variance	Var %	Var %
6,337	6,013	6,172	324	5.4%	2.7%	Lab Procedures	26,520	24,792	25,884	1,728	7.0%	2.5%
713	644	768	69	10.7%	-7.2%	X-Ray Procedures	3,144	2,886	2,560	258	8.9%	22.8%
248	235	256	13	5.5%	-3.1%	C.T. Scan Procedures	1,072	983	1,044	89	9.1%	2.7%
223	226	213	(3)	-1.3%	4.7%	Ultrasound Procedures	916	916	933	-	0.0%	-1.8%
67	62	79	5	8.1%	-15.2%	Mammography Procedures	233	248	308	(15)	-6.0%	-24.4%
211	309	274	(98)	-31.7%	-23.0%	EKG Procedures	1,058	1,235	1,220	(177)	-14.3%	-13.3%
82	105	121	(23)	-21.9%	-32.2%	Respiratory Procedures	405	437	414	(32)	-7.3%	-2.2%
1,341	1,607	1,616	(266)	-16.6%	-17.0%	Physical Therapy Procedures	5,917	5,445	5,556	472	8.7%	6.5%
1,899	1,492	1,859	407	27.3%	2.2%	Primary Care Clinic Visits	7,077	6,061	7,016	1,016	16.8%	0.9%
352	200	236	152	76.0%	49.2%	Specialty Clinic Visits	1,332	800	876	532	66.5%	52.1%
2,251	**1,692**	**2,095**	**559**	**33.0%**	**7.4%**	**Clinic**	**8,409**	**6,861**	**7,892**	**1,548**	**22.6%**	**6.6%**
87	**65**	**81**	**21**	**33.0%**	**7.4%**	**Clinic visits per work day**	**46**	**38**	**43**	**9**	**22.6%**	**6.6%**
19.8%	20.00%	22.20%	-0.20%	-1.00%	-10.81%	% Medicare Revenue	20.30%	20.00%	20.28%	0.30%	1.50%	0.12%
40.40%	39.00%	42.30%	1.40%	3.59%	-4.49%	% Medi-Cal Revenue	37.63%	39.00%	40.55%	-1.38%	-3.53%	-7.21%
35.00%	36.00%	31.60%	-1.00%	-2.78%	10.76%	% Insurance Revenue	37.25%	36.00%	35.03%	1.25%	3.47%	6.35%
4.80%	5.00%	3.90%	-0.20%	-4.00%	23.08%	% Self-Pay Revenue	4.83%	5.00%	4.15%	-0.18%	-3.50%	16.27%
142.5	156.88	142.8	(14.4)	-9.1%	-0.2%	Productive FTE's	141.69	155.61	144.6	(13.9)	-8.9%	-2.0%
162.2	173.97	163.0	(11.7)	-6.8%	-0.5%	Total FTE's	164.21	172.59	164.1	(8.4)	-4.9%	0.0%

CFO REPORT for

December 2018 Board meetings

FYE June 30, 2018, DRAFT Audited Financial Statements

We have made a recommendation for Board approval of our FY June 30, 2018, DRAFT Audited Financial Statements. Our auditor, Jerrell Tucker, is scheduled to attend the December 12, 2018, board meeting to present the results of the audit and for the board to approve the Audited Financial Statements.

Fiscal Year Ended June 30, 2018, Cost Report

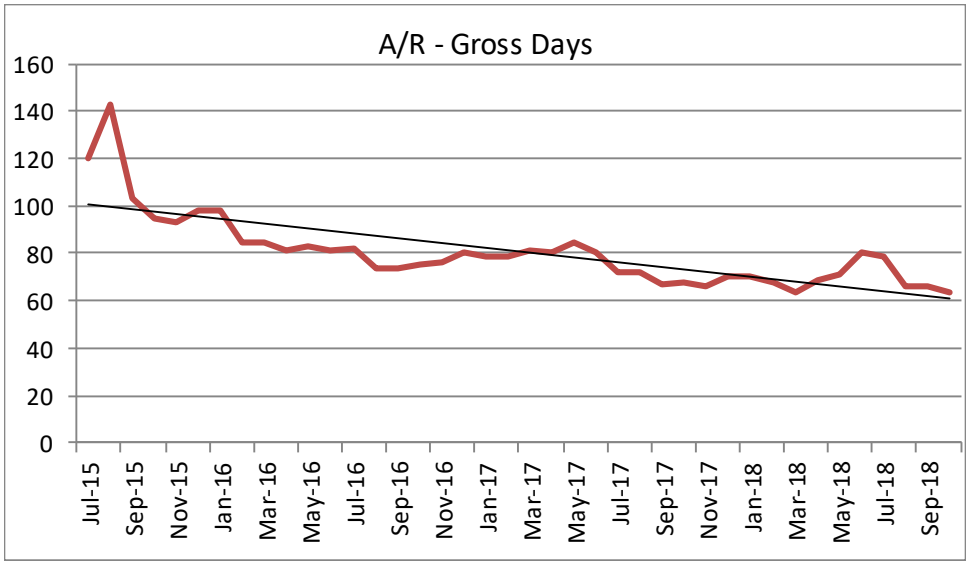
We have made a recommendation for Board approval of our FY 2018 Medicare Cost Report. WIPLIFi has completed work on Fiscal Year Ended June 30, 2018 Cost Report and David Perry of QHR completed his review. Final report shows $271,554 due to us. Board approval will authorize signature by John Friel, CEO, and submission to Medicare.

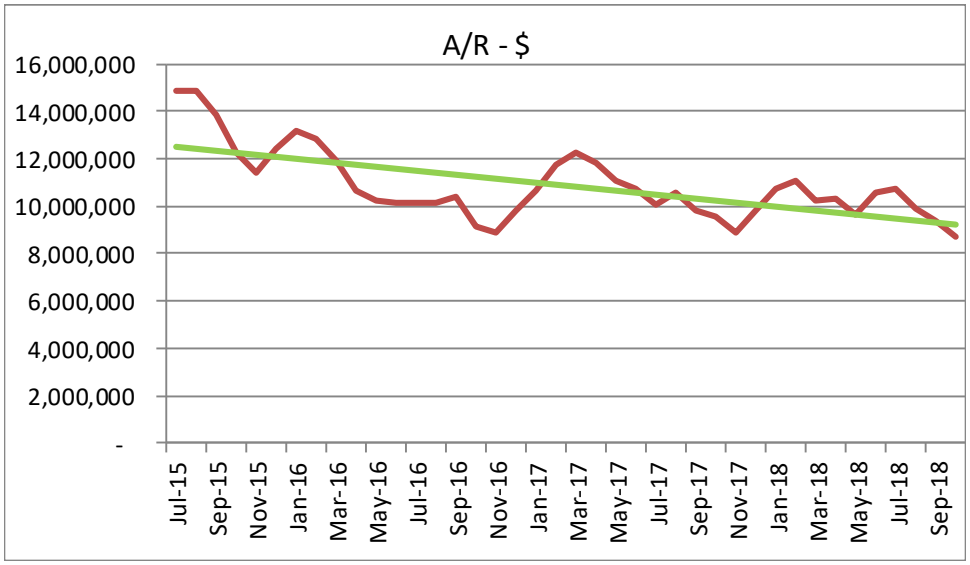
TruBridge – Accounts Receivable Management

Accounts Receivable days our averaging 64.7 over the last six weeks.

We had a good meeting in the middle of November with a new person from TruBridge who will be working with us on our account. She has good experience at a small hospital as a Revenue Cycle Manager using CPSI. She is helping us review denials.

Graphs from the October 2018 Financial report (below) show monthly trends of reductions in Accounts Receivable days and Gross dollars.





Productivity Benchmarking Assessment

We need to complete our review of preliminary Productivity Benchmarking Assessment report from QHR. The final report should be ready for presentation to department managers and the board in January.

Financial Advisory Services and Debt Capacity Assessment

The final agreement with Gary Hicks for Financial Advisory Services will go to the board for approval that the December 12th meeting. We have been exchanging final information to complete the Debt Capacity Assessment that QHR is helping us to conduct.