Sonoma Valley Health Care District

Consolidated Financial Statements

June 30, 2016 and 2015

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INDEPENDENT AUDITOR'S REPORT

To the Board of Directors
Sonoma Valley Health Care District
Sonoma, California

We have audited the accompanying consolidated financial statements of Sonoma Valley Health Care District (the "District"), which comprise the consolidated statements of net position as of June 30, 2016 and 2015, and the related consolidated 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 consolidated financial statements in accordance with accounting principles generally accepted in the United States of America (the "U.S."); 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 consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the U.S. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated 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 consolidated 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 consolidated 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 consolidated financial statements referred to above present fairly, in all material respects, the financial position of Sonoma Valley Health Care District as of June 30, 2016 and 2015, and the changes in their net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the U.S.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 3 - 9 be presented to supplement the basic consolidated financial statements. Such information, although not a part of the basic consolidated financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic consolidated financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic consolidated financial statements, and other knowledge we obtained during our audit of the basic consolidated financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information on pages 37 - 38, which is the responsibility of management, is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information has not been subjected to the auditing procedures applied in the audit of the consolidated financial statements, and, accordingly, we do not express an opinion or provide any assurance on it.

Armanino LLP
San Ramon, California

December 5, 2016

Sonoma Valley Health Care District
Management's Discussion and Analysis (Unaudited)
As of, and for the Years Ended, June 30, 2016, 2015 and 2014

Introduction

This management's discussion and analysis of the financial performance of Sonoma Valley Health Care District (the "District") provides an overview of the District's financial activities for the years ended June 30, 2016 and 2015. It should be read in conjunction with the accompanying consolidated financial statements and footnotes of the District.

Financial highlights

- The District's net position increased in 2016 by approximately $1,380,000 or 10% and increased in 2015 by approximately $628,000 or 5%.
- Cash, cash equivalents, and total investments decreased in 2016 by approximately $845,000 or 33% and increased in 2015 by approximately $1,107,000 or 23%. The decrease was due to there being no reserve for the restricted debt to pay the general obligation bonds that was there in 2015.
- Net patient accounts receivable increased in 2016 by approximately $1,640,000 or 25% and decreased in 2015 by approximately $307,000 or 5%. The increase was due to the increase in Emergency Department volume and the take back of Self Pay from a outsourced vender during 2016.
- The District reported operating losses in both 2016 ($3,340,000) and 2015 ($4,679,000). The operating loss in 2016 decreased by approximately $1,338,000 or 29% from than the operating loss reported in 2015. The decrease in the operating loss in 2016 was due to an increase in revenues in Outpatient and the Emergency Department. The operating loss in 2015 increased by approximately $643,000 or 16% less than the operating loss reported in 2014.

Using this annual report

The District's consolidated financial statements consist of three statements—statement of net position, a statement of revenues, expenses and changes in net position, and a statement of cash flows. These statements provide information about the activities of the District, including resources held by the District but restricted for specific purposes by creditors, contributors, grantors or enabling legislation. The District is accounted for as a business-type activity and presents its consolidated financial statements using the economic resources measurement focus and the accrual basis of accounting.

The statement of net position and statement of revenues, expenses and changes in net position

The statement of net position and the statement of revenues, expenses, and changes in net position report information about the District's resources and its activities. One of the most important questions asked about the District's finances is, "Is the District as a whole, better or worse off as a result of the year's activities?" The statement of net position and the statement of revenues, expenses, and changes in net position report information about the District's resources and its activities in a way that helps answer this question. These statements include all restricted and unrestricted assets and all liabilities using the accrual basis of accounting. All of the current year's revenues and expenses are taken into account regardless of when cash is received or paid.

These two statements report the District's net position and changes in them. You can think of the District's net position - the difference between assets and liabilities - as one way to measure the District's financial health, or financial position. Over time, increases or decreases in the District's net position are one indicator of whether its financial health is improving or deteriorating. You will need to consider other non-financial factors, such as changes in the District's patient base and measures of the quality of service it provides to the community, as well as local economic factors to assess the overall health of the District.

The statement of cash flows

The final required statement is the statement of cash flows. The statement reports cash receipts, cash payments, and net changes in cash and cash equivalents resulting from four defined types of activities. It provides answers to such questions as where did cash come from, what was cash used for, and what was the change in cash and cash equivalents during the reporting period.

The District's net position

The District's net position are the difference between its assets and liabilities reported in the balance sheet. The District's net position increased by $1,380,000 or 10% in 2016 over 2015 and increased by $628,000 or 5% in 2015 over 2014, as shown in Table 1.

The increases in net position in 2016 are largely the result of the increase of Outpatient Revenue and Emergency Department Revenue.

In 2016, net patient accounts receivable increased by $1,640,000 or 25% compared to 2015. The reason for the increase was due to the increase in Emergency Department, and Self Pay increased due to the District taking back all Self Pay from an early out vendor. Estimated third-party payor settlements increased by $1,261,000 or 1426% compared to 2015. The increase in 2016 is due to the over payments on Medicare's Periodic Interim Payment ("PIP") being paid back. Other receivables decreased by $430,000 or 82% from 2015, which is due to the change in contract with Napa State Hospital. Current pledge receivables decreased by $185,000 or 12% compared to 2015. The decrease was due to receiving approximately $150,000 in pledges. Noncurrent investments increased from 2015 by $400,000 or 12%, which was due to the reserve for the payment on the general obligation bonds.

Table 1: Assets, Liabilities, and Net Position

	2016	2015	2014
ASSETS			
Current assets			
Cash and cash equivalents	$ 1,727,791	$ 2,572,829	$ 2,849,986
Patient accounts receivable, net of allowance for doubtful accounts of $925,572 and $535,555 in 2016 and 2015 and , respectively	8,127,229	6,487,389	6,793,990
Estimated third-party payor settlements, net	1,350,090	88,469	1,527,754
Property tax receivable	6,028,820	6,034,710	5,758,948
Other receivables	92,450	522,552	552,870
Pledge receivables, current	1,379,819	1,564,439	1,508,286
Inventories	815,080	835,425	771,028
Prepaid expenses and other current assets	868,839	670,891	816,423
Total current assets	20,390,118	18,776,704	20,579,285
Capital assets, net	52,341,277	54,857,279	56,350,250
Noncurrent investments			
Restricted for capital acquisitions	149,858	150,727	220,748
Restricted for debt service	3,420,699	3,021,372	1,637,914
Other long-term investments	96,125	94,375	23,756
Total noncurrent investments	3,666,682	3,266,474	1,882,418
Total assets	$ 76,398,077	$ 76,900,457	$ 78,811,953
LIABILITIES AND NET POSITION			
Current liabilities			
Accounts payable and accrued expenses	$ 5,761,043	$ 6,272,324	$ 8,477,305
Accrued payroll and related liabilities	3,627,274	3,039,179	2,835,095
Deferred tax revenue	5,962,904	5,913,329	5,849,985
Line of credit	6,723,734	5,923,734	-
Bonds payable, current portion	1,339,000	1,236,000	95,000
Capital lease obligations, current portion	997,778	1,391,816	1,697,107
Notes payable, current portion	153,675	127,014	124,814
Total current liabilities	24,565,408	23,903,396	19,079,306
Long-term liabilities			
Accrued workers' compensation liability	404,000	869,000	711,000
Line of credit	-	-	4,973,734
Bonds payable, net of current portion	32,862,000	34,201,000	35,437,000
Capital lease obligations, net of current portion	2,184,770	2,796,604	4,022,449
Notes payable, net of current portion	703,574	831,874	917,777
Total long-term liabilities	36,154,344	38,698,478	46,061,960
Total liabilities	60,719,752	62,601,874	65,141,266
Net position			
Net investment in capital assets	7,376,746	8,349,237	9,082,369
Restricted			
For debt service	3,420,699	3,021,372	1,637,914
Expendable for capital assets	1,819,558	1,796,562	3,757,072
Total restricted	5,240,257	4,817,934	5,394,986
Unrestricted	3,061,322	1,131,412	(806,668)
Total net position	15,678,325	14,298,583	13,670,687
Total liabilities and net position	$ 76,398,077	$ 76,900,457	$ 78,811,953

In 2015, net patient accounts receivable decreased by $307,000 or 5% compared to 2014. The reason for the decrease was an emphases on collections. Estimated third-party payor settlements decreased by $1,439,000 or 94% compared to 2014. The reason for the decrease was due to the recording of over payments on Medicare's Periodic Interim Payments ("PIP"). Property tax receivables increased by $276,000 or 5% from 2014, which was due to the increase in principal due on the General Obligation Bonds B.

Operating results and changes in the District's net position

In 2016 the District's operating loss decreased by $1,380,000 or 29% from 2015. In 2015 the operating loss increased by $643,000 or 16% from 2014, as shown in Table 2 below:

Table 2: Operating results and changes in net position

	2016	2015	2014
Operating revenues			
Net patient service revenue	$ 53,331,465	$ 49,256,295	$ 47,416,961
Capitation revenue	1,681,631	2,009,014	2,055,548
Other revenue	-	128,751	1,103,166
Total operating revenues	55,013,096	51,394,060	50,575,675
Operating expenses			
Salaries and wages	29,510,806	26,657,109	26,219,974
Employee benefits	6,157,663	6,429,922	5,986,866
Purchased services	3,733,841	4,449,247	6,507,171
Professional fees, medical	4,593,090	4,251,472	4,288,169
Professional fees, non medical	523,511	1,081,758	-
Supplies	6,236,012	5,706,439	5,889,441
Facilities and equipment	1,167,165	904,467	-
Utilities	1,118,493	1,077,817	961,882
Insurance	303,068	231,061	226,650
Depreciation and amortization	3,461,196	3,508,398	2,339,876
Other expenses	1,547,926	1,775,820	2,191,737
Total operating expenses	58,352,771	56,073,510	54,611,766
Loss from operations	(3,339,675)	(4,679,450)	(4,036,091)
Nonoperating income			
Property tax revenues	5,880,846	5,981,537	4,938,955
Investment income	12,988	39,510	32,714
Noncapital grants and contributions	-	34,351	18,333
Interest expense	(2,032,430)	(1,996,838)	(1,088,851)
Bond issuance costs	-	-	(180,605)
Contributions to Prima Medical Foundation	(576,618)	(446,130)	(604,413)
Other income, net	411,897	523,521	147,323
Total nonoperating income	3,696,683	4,135,951	3,263,456
Capital contributions	1,022,734	1,171,395	3,757,072
Changes in net position	1,379,742	627,896	2,984,437
Net position, beginning of year	14,298,583	13,670,687	10,686,250
Net position, end of year	$ 15,678,325	$ 14,298,583	$ 13,670,687

The District's net patient revenue is comprised of comprehensive services that span the continuum of healthcare services: inpatient and outpatient hospital patient care services, emergency services, skilled nursing facility services, and home health care services. The following is the payer mix based upon net patient service revenue. Net revenue represents payments made by insurance companies and patients and is not based upon the gross billed charges.

The following chart shows the percentage of Government programs (Medicare, Medicare HMO, Medi-Cal and Medi-Cal Managed Care), commercial insurance and other net patient revenue. Government programs generally do not cover the cost of providing patient care services and therefore are supplemented by commercial insurance payments. The District's payer mix is the reason that the parcel tax is so critical to the ongoing operations of the District.

Payer mix - Percentage of total cash collections

Total Hospital	FY 2016	FY 2015	FY 2014
Medicare	40.1 %	41.9 %	38.9 %
Medicare HMO	6.5 %	5.5 %	4.6 %
Medi-Cal	5.4 %	4.5 %	9.8 %
Medi-Cal Managed Care	9.7 %	8.4 %	5.9 %
Commercial Ins	31.7 %	29.7 %	31.8 %
Workers Comp	2.8 %	3.2 %	3.2 %
Capitated	1.2 %	0.9 %	1.6 %
Self Pay - Other	2.6 %	5.9 %	4.2 %
	100.0 %	100.0 %	100.0 %

Over the period, the District has experienced a shift from inpatient to outpatient care. The District's experience with this shift in patient care services is consistent across all hospitals in the United States. Insurance companies, including Medicare, the District's largest payer, are more frequently requiring services to be provided in the outpatient setting.

Operating losses

The first component of the overall change in the District's net position is its operating income or loss; generally, the difference between net patient services and other operating revenues and the expenses incurred to perform those services. In each of the past three years, the District has reported an operating loss. This is consistent with the District's recent operating history as the District was formed and operates primarily to serve residents of Sonoma Valley, regardless of their ability to pay. The District levies property taxes to provide sufficient resources to enable the facility to serve lower income and other residents.

The operating loss for 2016 decreased by $1,338,000 or 29% as compared to 2015. In 2015 the operating loss increased by $643,000 or 16% as compared to 2014. The major components of those changes in operating loss are:

- Total operating revenues increased by $3,619,000 or 7% in 2016. Total operating revenues increased by $818,000 or 2% in 2015 compared to 2014. The increase in 2016 is due to an increase in net revenues from outpatient and emergency department services, primarily due to the impact of prices increases during the current year.
- Salaries, wages, and benefits increased in 2016 by $2,581,000 or 8% due to an across the board salary increase of 3% in January 2016, a couple of consultants who became employees and the over all increase in volumes in clinical departments requiring more staffing than in prior years. Salaries, wages, and benefits increased in 2015 by $880,200 or 3% due to an across the board salary increase of 3% in January 2015.
- Medical fees increased in 2016 by $341,600 or 8% due to call payments due to surgical call with Prima and the ED physicians group. Medical fees remained consistent in 2015 and 2014.
- Purchased services decreased in 2016 by $715,000 or 16% compared to 2015 and decreased in 2015 by $976,200 or 15% compared to 2014. The decrease in 2016 is due to Information Systems reducing the number of purchases services used by their department. The decrease in 2015 is due to less repairs and maintenance compared to 2014.
- Non-medical fees decreased in 2016 by $558,200 or 52% compared to 2015. The decrease was due to the restructuring of the management fee for the pharmacy in 2016 and two employees who were consultants in 2015, but became employees in 2016.
- Facilities and equipment increased in 2016 by $262,800 or 29% compared to 2015. The increase was due to Information Systems rental of electronic healthcare system equipment.
- Supplies increased in 2016 by $529,600 or 9% compared to 2015. The increase was due to the restructuring of the drug costs for the pharmacy in 2016, which excluded high drug costs, which the Hospital paid directly.
- Other expenses decreased in 2016 by $227,900 or 13% as compared to 2015 and decreased by $415,900 or 11% in 2015 compared to 2014. The decrease in 2016 was due to less number of Inter-Governmental Transfers ("IGT") during 2016. The decrease in 2015 was also due to less number of Inter-Governmental Transfers ("IGT").

Nonoperating revenues and expenses

Nonoperating revenues and expenses consist of property taxes levied by the District, investment income, interest expense and noncapital grants and gifts. Property taxes decreased in 2016 compared to 2015, by $100,700 or 2%. In 2015 as compared to 2014, property taxes increased by $1,042,600 or 21%. This is due to the increase in the general obligation bonds payments. In 2016 interest expense remained consistent with 2015. Interest expense increased by $908,000 or 83% in 2015. The increase in interest was due the increase in our payment on the general obligation bonds. There were no noncapital grants and gifts in 2016. Noncapital grants and gifts increased by $16,000 in 2015 compared to 2014.

Capital grants and gifts

The District received gifts of $1,023,000 from a foundation and various individuals to purchase capital assets in 2016 and $1,171,000 in 2015, a decrease of $149,000 and a decrease of $2,586,000, from 2015 and 2014, respectively.

The District's cash flows

Changes in the District's cash flows are consistent with changes in operating losses and non-operating revenues and expenses, as discussed earlier.

Capital assets

At the end of 2016 and 2015, the District had $52,341,000 and $54,587,000, respectively, invested in capital assets, net of accumulated depreciation, as detailed in Note 8 to the financial statements. In 2016 and 2015, the District purchased new equipment and made capital improvements costing $1,375,000 and $2,022,000, respectively. The majority of the 2015 improvements and new equipment related to the finalization of a master plan, detailed planning, acquisition of equipment, and installation of the information systems wiring for the District's renovation project.

Debt

At June 30, 2016 and 2015, the District had $38,241,000 and $40,584,000, respectively, in bonds, equipment notes payable, and notes payable outstanding as detailed in Note 12 and Note 13 to the financial statements. The District has a line of credit agreement with a bank for an amount not to exceed $7,000,000, maturing on January 31, 2019. The District had unused credit on the line of $276,266 and $1,076,266 as of June 30, 2016 and 2015, respectively.

Future plans

The District has historically provided salary and practice supports for recruitment and retention of new physicians whose services meet the needs of our community. In the past, certain of these arrangements have been provided via contractual agreements with Prima Medical Group, a regional physician organization. The District has implemented plans to convert and consolidate these arrangements to a master agreement with Prima Medical Foundation. The District has made capital contributions to Prima Medical Foundation, which is a non-profit medical care, research, and community benefit organization. This is a more cost effective and longer term vehicle for physician support.

Contacting the District's financial management

This financial report is designed to provide our patients, suppliers, taxpayers and creditors with a general overview of the District's finances and to show the District's accountability for the money it receives. Questions about this report and requests for additional financial information should be directed to the Chief Financial Officer by telephoning (707) 935-5003.

Sonoma Valley Health Care District
Consolidated Statements of Net Position
June 30, 2016 and 2015

	2016	2015
ASSETS		
Current assets		
Cash and cash equivalents	$ 1,727,791	$ 2,572,829
Patient accounts receivable, net of allowance for doubtful accounts of $925,572 and $535,555 in 2016 and 2015, respectively	8,127,229	6,487,389
Estimated third-party payor settlements, net	1,350,090	88,469
Property tax receivable	6,028,820	6,034,710
Other receivables	92,450	522,552
Pledge receivables, current	1,379,819	1,564,439
Inventories	815,080	835,425
Prepaid expenses and other current assets	868,839	670,891
Total current assets	20,390,118	18,776,704
Capital assets, net	52,341,277	54,857,279
Noncurrent investments		
Restricted for capital acquisitions	149,858	150,727
Restricted for debt service	3,420,699	3,021,372
Other long-term investments	96,125	94,375
Total noncurrent investments	3,666,682	3,266,474
Total assets	$ 76,398,077	$ 76,900,457
LIABILITIES AND NET POSITION		
Current liabilities		
Accounts payable and accrued expenses	$ 5,761,043	$ 6,272,324
Accrued payroll and related liabilities	3,627,274	3,039,179
Deferred tax revenue	5,962,904	5,913,329
Line of credit	6,723,734	5,923,734
Bonds payable, current portion	1,339,000	1,236,000
Capital lease obligations, current portion	997,778	1,391,816
Notes payable, current portion	153,675	127,014
Total current liabilities	24,565,408	23,903,396
Long-term liabilities		
Accrued workers' compensation liability	404,000	869,000
Bonds payable, net of current portion	32,862,000	34,201,000
Capital lease obligations, net of current portion	2,184,770	2,796,604
Notes payable, net of current portion	703,574	831,874
Total long-term liabilities	36,154,344	38,698,478
Total liabilities	60,719,752	62,601,874
Net position		
Net investment in capital assets	7,376,746	8,349,237
Restricted		
For debt service	3,420,699	3,021,372
Expendable for capital assets	1,819,558	1,796,562
Total restricted	5,240,257	4,817,934
Unrestricted	3,061,322	1,131,412
Total net position	15,678,325	14,298,583
Total liabilities and net position	$ 76,398,077	$ 76,900,457

The accompanying notes are an integral part of these consolidated financial statements.

Sonoma Valley Health Care District
Consolidated Statements of Revenues, Expenses and Change in Net Position
For the Years Ended June 30, 2016 and 2015

	2016	2015
Operating revenues		
Net patient service revenue	$ 53,331,465	$ 49,256,295
Capitation revenue	1,681,631	2,009,014
Other revenue	-	128,751
Total operating revenues	55,013,096	51,394,060
Operating expenses		
Salaries and wages	29,510,806	26,657,109
Employee benefits	6,157,663	6,429,922
Purchased services	3,733,841	4,449,247
Professional fees, medical	4,593,090	4,251,472
Professional fees, non medical	523,511	1,081,758
Supplies	6,236,012	5,706,439
Facilities and equipment	1,167,165	904,467
Utilities	1,118,493	1,077,817
Insurance	303,068	231,061
Depreciation and amortization	3,461,196	3,508,398
Other expenses	1,547,926	1,775,820
Total operating expenses	58,352,771	56,073,510
Loss from operations	(3,339,675)	(4,679,450)
Nonoperating income		
Property tax revenues	5,880,846	5,981,537
Investment income	12,988	39,510
Noncapital grants and contributions	-	34,351
Interest expense	(2,032,430)	(1,996,838)
Contributions to Prima Medical Foundation	(576,618)	(446,130)
Other income, net	411,897	523,521
Total nonoperating income	3,696,683	4,135,951
Capital contributions	1,022,734	1,171,395
Increase in net position	1,379,742	627,896
Net position, beginning of year	14,298,583	13,670,687
Net position, end of year	$ 15,678,325	$ 14,298,583

The accompanying notes are an integral part of these consolidated financial statements.

Sonoma Valley Health Care District
Consolidated Statements of Cash Flows
For the Years Ended June 30, 2016 and 2015

	2016	2015
Cash flows from operating activities		
Cash received from patients and third-parties	$ 52,111,635	$ 53,139,946
Cash payments to contractors, vendors and suppliers	(19,981,349)	(21,671,286)
Cash payments to employees and benefit programs	(35,545,374)	(32,724,947)
Net cash used in operating activities	(3,415,088)	(1,256,287)
Cash flows from noncapital financing activities		
Noncapital grants, contributions, and other	1,026,619	532,037
Contribution to Prima Medical Foundation	(576,618)	(446,130)
District tax revenues	3,176,027	3,008,835
Net cash provided by noncapital financing activities	3,626,028	3,094,742
Cash flows from capital and related financing activities		
Net purchase of capital assets	(945,194)	(2,015,427)
Principal payments on note payable	(101,639)	(83,703)
Principal payments on capital lease obligations	(1,005,872)	(1,531,136)
Payment on line of credit	-	(350,000)
Principal payments on bond payable	(1,236,000)	(95,000)
Interest paid on long-term debt	(1,963,071)	(1,927,479)
Proceeds from line of credit	800,000	1,300,000
Tax revenue related to general obligation bonds	2,760,284	2,760,284
Capital grants and gifts	1,022,734	1,171,395
Net cash used in capital financing activities	(668,758)	(771,066)
Cash flows from investing activities		
Purchase of investments	(400,208)	(1,384,056)
Interest received from investments	12,988	39,510
Net cash used in investing activities	(387,220)	(1,344,546)
Net decrease in cash and cash equivalents	(845,038)	(277,157)
Cash and cash equivalents, beginning of year	2,572,829	2,849,986
Cash and cash equivalents, end of year	$ 1,727,791	$ 2,572,829

The accompanying notes are an integral part of these consolidated financial statements.

Sonoma Valley Health Care District
Consolidated Statements of Cash Flows
For the Years Ended June 30, 2016 and 2015

	2016	2015
Reconciliation of loss from operations to net cash used in operating activities		
Loss from operations	$ (3,339,675)	$ (4,679,450)
Adjustments to reconcile loss from operations to net cash to net cash used in operating activities		
Depreciation and amortization	3,461,196	3,508,398
Provision for bad debts	1,240,000	1,125,000
Changes in operating assets and liabilities		
Patient accounts receivable, net	(2,879,840)	(818,399)
Estimated third-party payor settlements	(1,261,621)	1,439,285
Accounts payable and accrued expenses	(457,545)	(1,912,256)
Other assets and liabilities	(177,603)	81,135
Net cash used in operating activities	$ (3,415,088)	$ (1,256,287)
Supplemental schedule of noncash investing and financing activities		
Acquisition of capital assets financed with long-term debt	$ 384,037	$ 4,009,789

The accompanying notes are an integral part of these consolidated financial statements.

1. NATURE OF OPERATIONS

Sonoma Valley Health Care District (the "District") is a political subdivision of the State of California organized under the State of California Local Health Care District Law as set forth in the Health and Safety Code of the State of California. The Health Care District is governed by an elected Board of Directors and is considered the primary government for financial reporting purposes.

The Health Care District owns and operates Sonoma Valley Hospital (the "Hospital"). The Hospital is located in Sonoma, California, and is licensed for 56 general acute care beds and 27 skilled nursing beds. It also provides 24-hour basic emergency care, outpatient diagnostic and therapeutic services, and operates a home health agency. The Hospital derives a significant portion of its revenues from third-party payors, including Medicare, Medi-Cal, and commercial insurance organizations.

Sonoma Valley Hospital Auxiliary (the "Auxiliary") was formed to render non-medical services on a volunteer basis to Sonoma Valley Hospital. The Auxiliary also raised monies for the benefit of the Hospital and its activities. As the sole purpose of the Auxiliary was to support the Hospital, the Auxiliary was consolidated within the District's June 30, 2015 financial statements. The auxiliary was dissolved as of July 31, 2015 and is not a component of the District's June 30, 2016 financial statements.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Principles of consolidation

The accompanying consolidated financial statements include the accounts of the Hospital and the Auxiliary (collectively referred to as the "District") as of and for the year ending June 30, 2015. All significant inter-company accounts and transactions have been eliminated in the consolidated financial statements. The Auxiliary is not consolidated with the accounts of the Hospital as of and for the year ending June 30, 2016.

Basis of preparation

The District's financial statements are presented in accordance with the pronouncements of the Governmental Accounting Standards Board (GASB). The financial statement presentation, required by GASB Statements No. 34, 37 and 38 provides a full accrual basis, comprehensive, entity-wide perspective of the District's assets, results of operations and cash flows. The District follows the "business-type activities" reporting requirements of GASB Statement No. 34. 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.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Basis of preparation (continued)

In June 2015, the GASB issued Statement No. 76, The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments ("GASB No. 76"), which is effective for financial statements for periods beginning after June 15, 2015. The objective of GASB No. 76 is to identify, in the context of the current governmental financial reporting environment, the hierarch of generally accepted accounting principles ("GAAP"). The "GAAP hierarchy" consists of the sources of accounting principles used to prepare financial statements of state and local governmental entities in conformity with GAAP and the framework for selecting those principles. This Statement reduces the GAAP hierarchy to two categories of authoritative GAAP and addresses the use of authoritative and nonauthoritative literature in the event that the accounting treatment for a transaction or other event is not specified within a source of authoritative GAAP.

Proprietary fund accounting and financial statement presentation

The District utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis and the financial statements are prepared using the economic resources measurement focus.

Net position of the District is comprised of the following three components:

- *Net investment in capital assets* - consists of capital assets (both restricted and unrestricted), net of accumulated depreciation and reduced by the outstanding balances of any borrowings that are attributable to the acquisition, construction, or improvement of those capital assets.
- *Restricted net position* - consists of net position with limits on their use that are externally imposed by creditors (such as through debt covenants), grantors, contributors or by laws or regulations of other governments or constraints imposed by law through constitutional provisions or enabling legislation.
- *Unrestricted net position* - consists of the remaining net position that does not meet the definition of invested in capital assets, net of related debt or restricted net position.

Use of estimates

The preparation of the consolidated 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 consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Cash and cash equivalents

Cash and cash equivalents include deposits with financial institutions and investments in highly liquid debt instruments with an original maturity of three months or less. Cash and cash equivalents exclude amounts whose use is limited by board designation or by legal restriction.

Patient accounts receivable and concentration of credit risk

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, providing appropriate reserves for contractual allowances and uncollectible accounts based upon historical net collections, the aging of individual accounts, as well as current economic and regulatory conditions. Patient accounts receivable from government agencies represent the only concentrated group of credit risk for the District and management does not believe there are any material credit risks 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. Medicare and Medi-Cal receivables account for approximately 39% and 42% of net patient accounts receivable as of June 30, 2016 and 2015, respectively.

Uncollectible accounts

The District provides care to patients without requiring collateral or other security. Patient charges not covered by a third-party payor are billed directly to the patient if it is determined that the patient has the ability to pay. A provision for uncollectible accounts is recognized based on management's estimate of amounts that ultimately may be uncollectible. At June 30, 2016 and 2015, the District provided allowances for losses on amounts directly from patients totaling $925,572 and $535,555, respectively.

Investment

The District maintains a portion of its cash in the State of California Local Agency Investment Fund ("LAIF") pooled investment. The funds deposited in LAIF are invested in accordance with Government Code Sections 16340 and 16480, the stated investment authority for the Pooled Money Investment Account. Balances are stated at their estimated fair market value.

Noncurrent investments consist of Board-designated and restricted funds set aside by the board for future capital improvements and other operational reserves, over which the board retains control and may at its discretion, use for other purposes; assets set aside for qualified capital outlay projects in compliance with state law and assets restricted by donors or grantors.

Investment income, realized gains and losses, and unrealized gains and losses on investments are reflected as nonoperating income or expense.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Fair value measurements

In February 2015, the GASB issued Statement No. 72, Fair Value Measurement and Application ("GASB No. 72"), which is effective for financial statements for periods beginning after June 15, 2015. GASB No. 72 addresses accounting and financial reporting issues related to fair value measurements. The definition of fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. This Statement provides guidance for determining a fair value measurement for financial reporting purposes. This Statement also provides guidance for applying fair value to certain investments and disclosures related to all fair value measurements.

The District reports the fair value of its investments in accordance with GASB 72. This standard requires an entity to maximize the use of observable inputs (such as quoted prices in active markets) and minimize the use of unobservable inputs (such as appraisals or other valuation techniques) to determine fair value. In addition, the District reports certain investments using the net asset value per share as determined by investment managers under the so called "practical expedient". The practical expedient allows net asset value per share to represent fair value for reporting purposes when the criteria for using this method are met. Fair value measurement standards also require the District to classify these financial instruments into a three-level hierarchy, based on the priority of inputs to the valuation technique or in accordance with net asset value practical expedient rules, which allow for either Level 2 or Level 3 reporting depending on lock up and notice periods associated with the underlying funds.

Instruments measured and reported at fair value are classified and disclosed in one of the following categories:

- *Level 1* - Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets.
- *Level 2* - Pricing inputs are other than quoted prices in active markets, which are either directly or indirectly observable as of the reporting date, and fair value is determined through the use of models or other valuation methodologies. Level 2 also includes practical expedient investments with notice periods for redemption of 90 days or less.
- *Level 3* - Pricing inputs are unobservable for the instrument and include situations where there is little, if any, market activity for the instrument. The inputs into the determination of fair value require significant management judgment or estimation. Level 3 also includes principal expedient investments with notice periods for redemption of more than 90 days.

In some instances, the inputs used to measure fair value may fall into different levels of the fair value hierarchy. In such instances, an instrument's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Fair value measurements (continued)

Market price is affected by a number of factors, including the type of instrument and the characteristics specific to the instrument, as well as the effects of market, interest and credit risk. Instruments with readily available active quoted prices or for which fair value can be measured from actively quoted prices generally will have a higher degree of market price observability and a lesser degree of judgment used in measuring fair value. It is reasonably possible that change in values of these instruments will occur in the near term and that such changes could materially affect amounts reported in the District's financial statements.

Pledges receivable

Pledges are recorded at their present value net of applicable discounts. There are no discounts recorded as of June 30, 2016 and 2015, as all pledge balances are expected to be collected within one year. An allowance for uncollectible pledges receivable is established based upon management's judgment including such factors as prior collection history and aging statistics of pledge balances. At June 30, 2016 and 2015, management determined that no allowance for uncollectible pledges was required, as all balances are considered to be fully collectible.

Inventories

Inventories consist primarily of hospital operating supplies and pharmaceuticals and are stated at cost, determined by the first-in, first-out method, not in excess of market.

Restricted for debt services

According to the terms of the General Obligation Bond indenture agreements, certain amounts are held by the bond trustee and paying agent and are maintained and managed by the trustee and are invested in noncurrent investments. These assets are available for the settlement of future current bond obligations.

Capital assets

Capital asset acquisitions over $5,000 are capitalized and recorded at cost. Donated property is recorded at its fair-market value on the date of donation. Equipment under capital lease is amortized on the straight-line basis over the shorter of the lease term or the estimated useful life of the equipment. Leasehold improvements are amortized using the straight-line method over the shorter of the lease term or the estimated useful life of the related assets.

Depreciation and amortization of capital assets is computed using the straight-line method over the following estimated useful lives:

Land improvements	10 - 20 years
Buildings and fixtures	20 - 40 years
Equipment	2 - 10 years

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Capital assets (continued)

Whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recovered, the District, using its best estimates and projections, reviews for impairment the carrying value of long-lived identifiable assets to be held and used in the future. Any impairment losses identified are recognized when determined. Recoverability of assets is measured by comparison of the carrying amount of the asset to the net undiscounted future cash flows expected to be generated from the asset. If the future undiscounted cash flows are not sufficient to recover the carrying value of the assets, the assets carrying value is adjusted to fair value. As of June 30, 2016 and 2015, the District has determined that no capital assets are significantly impaired.

Costs of borrowing

Except for capital assets acquired through gifts, contributions or capital grants, interest cost on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

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; employee health, dental, and accident benefits; and medical malpractice. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Self-insurance plan

The District maintains professional liability insurance on a claims-made basis, with liability limits of $15,000,000 per claim and $25,000,000 in aggregate, which is subject to a $5,000 per claim deductible. Additionally, the District is self-insured for workers' compensation benefits. The District purchases a Workers' Compensation Excess Policy that insures claims with no limits in the amounts and a $500,000 deductible. An Actuarial estimate of uninsured losses from workers' compensation claims has been accrued as a liability in the accompanying consolidated financial statements.

Statements of revenues, expenses, and changes in net position

The District's statement of revenues, expenses and changes in net position distinguishes between operating and nonoperating 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. Other transactions such as property tax revenue, investment income, gifts and contributions, and grants and bequests are reported as nonoperating income.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Net patient service revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered, and adjusted in future periods as final settlements are determined.

The distribution of net patient revenue, which represents both cash collected and expected to be collected, by payor is as follows:

	2016	2015
Medicare	40.1 %	41.9 %
Medicare HMO	6.5 %	5.5 %
Medi-Cal	5.5 %	4.5 %
Medi-Cal Managed Care	9.7 %	8.4 %
Commercial Insurance	31.7 %	29.7 %
Workers Compensation	2.8 %	3.2 %
Capitated	1.3 %	0.9 %
Self-pay-other	2.5 %	5.9 %

Charity care

The District provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the District does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

Capitation revenues

The District, in association with Meritage Medical Network (formerly Marin Independent Practice Association) ("Meritage") has an agreement with a health maintenance organization ("HMO") to provide medical services to subscribing participants. Under this agreement, the District receives monthly capitation payments based on the number of each HMO's participants, regardless of the services actually performed by the District. The District is not responsible for the cost of services provided to subscribing participants by other hospitals. The District reassesses the profitability of the agreements for exposure risks in the event future medical costs to provide medical services exceed the related future capitation payments.

Property tax revenues

Taxes for District operations and for debt service payments related to District General Obligation Bonds are levied annually on the taxable property within the District.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Property tax revenues (continued)

In March 2002, the District voters adopted a special tax on each taxable parcel of land within the District at an annual rate of up to $130 per parcel for five years. In March 2007, the District voters extended the special tax at an annual rate of up to $195 per parcel through June 30, 2013. The purpose of the special parcel tax is to ensure continued local access to emergency room and acute hospital care and other medical services for residents of the District and for visitors to the area. The parcel tax extension was approved for 2013 - 2018 by the District's voters.

The District received approximately 420% in 2016 and 953% in 2015, of its total increase in net position from property taxes.

Property tax revenue funds were designated as follows:

	2016	2015
Designated for hospital operations	$ 2,967,517	$ 2,924,785
Levied for hospital operations and debt service payments	2,913,329	3,056,752
	$ 5,880,846	$ 5,981,537

The District recognizes property taxes receivable when the enforceable legal claim arises (January 1) and recognizes revenues over the period for which the taxes are levied (July 1 to June 30). Property taxes are considered delinquent on the day following each payment due date. Property tax revenues are nonexchange transactions that are reported as nonoperating revenues.

Grants and contributions

The District receives grants as well as contributions from individuals and 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 for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as nonoperating revenues.

Compensated absences

District policies permit most employees to accumulate paid time-off benefits that may be realized as paid time-off or as a cash payment upon termination. Expense and the related liability are recognized as paid time-off benefits when earned. Compensated absence liabilities are computed using the regular pay and termination pay rates in effect at the balance sheet date plus an additional amount for compensation-related payments, such as social security and Medicare taxes computed using rates in effect at the date of computation.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Income taxes

The District operates under the purview of the Internal Revenue Code, Section 115, and corresponding California Revenue and Taxation Code provisions. As such, it is not subject to state or federal taxes on income. However, income from the unrelated business activities of the District and the Auxiliary may be subject to income taxes.

Subsequent events

The District has evaluated subsequent events through December 5, 2016, the date the financial statements were available to be issued. Other than as described below, no subsequent events have occurred that would have a material impact on the presentation of the District's financial statements.

On August 22, 2016, the District exercised a purchase option that was granted to them in their existing land lease dated August 30, 2011. The District purchased two parcels of land adjacent to the current Hospital site for an amount of $1,725,744.

On September 6, 2016, the District's Bank approved an increase in the line of credit from $7,000,000 up to $9,000,000 until December 31, 2016, when the maximum line amount will go back to $7,000,000. Any additional borrowings above the $7,000,000 must be repaid on December 31, 2016.

3. CASH DEPOSITS

At June 30, 2016 and 2015, the District cash deposits had carrying amounts of $1,727,791 and $2,572,829, respectively, and bank balances of $2,136,767 and $3,024,250, respectively. All of the bank balances at June 30, 2016 and 2015, were covered by federal depository insurance.

4. NEW PATIENT SERVICE REVENUES

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. The difference between the Hospital's established rates and the amounts paid under third-party contracts are reflected as contractual adjustments. Medicare and Medi-Cal settlements are estimated and recorded in the consolidated financial statements in the year services are provided. Laws and regulations governing the Medicare and Medi-Cal programs are complex and subject to interpretation. The District believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquires have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties, and exclusion from the Medicare and Medi-Cal programs. Changes in Medicare, Medi-Cal, or other programs or the reduction of program funding could have an adverse impact on future net patient service revenues.

4. NEW PATIENT SERVICE REVENUES (continued)

A summary of the payment arrangements with major third-party payors is as follows:

- Medicare - Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge for the District. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. The District's classification of inpatients under the Medicare program and the appropriateness of their admissions are subject to an independent review by a peer review organization under contract with the District. Most outpatient services at the District provided to Medicare beneficiaries are paid at prospectively determined rates per encounter that vary according to procedures performed. At June 30, 2016, Medicare cost reports have been audited and final settled by the fiscal intermediary through June 30, 2013 for the District.
- Medi-Cal - Payments for inpatient acute care services rendered to Medi-Cal program beneficiaries are reimbursed under a diagnostic related group (DRG) methodology. Under this methodology, similar to Medicare, services are paid at prospectively determined rates per discharge according to a patient classifications system that is based on clinical, diagnostic, and other factors. Inpatient skilled nursing care services rendered to Medi-Cal program beneficiaries are reimbursed at prospectively determined per diem rates. Outpatient services rendered to Medi-Cal program beneficiaries are reimbursed based on prospectively determined fee schedules. At June 30, 2016, the District's Medi-Cal cost reports have been audited and final settled through June 30, 2014.
- Others - Payments for services rendered to other than Medicare and Medi-Cal patients are based on established rates or agreements with certain commercial insurance companies, health maintenance organizations, Napa State, and preferred provider organizations which provide for various discounts from established rates.

New patient service revenues consist of the following:

	2016	2015
Services provided to Medicare patients	$ 113,035,696	$ 105,505,247
Services provided to Medi-Cal patients	46,602,291	41,679,971
Services provided to other patients	85,418,869	74,186,238
	245,056,856	221,371,456
Contractual allowance	(191,725,391)	(172,115,161)
	$ 53,331,465	$ 49,256,295

5. BOARD-DESIGNATED, RESTRICTED FUNDS, AND OTHER LONG-TERM INVESTMENTS

District investment balances and average maturities were as follows at June 30, 2016:

	Fair Value	Less than 1	1 to 5
Short-term money market mutual funds	$ 3,420,699	$ 3,420,699	$ -
LAIF (State pool demand deposits)	245,983	245,983	-
	$ 3,666,682	$ 3,666,682	$ -

District investment balances and average maturities were as follows at June 30, 2015:

	Fair Value	Less than 1	1 to 5
Short-term money market mutual funds	$ 3,021,372	$ 3,021,372	$ -
LAIF (State pool demand deposits)	245,102	245,102	-
	$ 3,266,474	$ 3,266,474	$ -

Except for the investment of unexpended funds borrowed for construction, the District's investment policy limits the first $5,000,000 of investments to the LAIF. Once investments exceed $5,000,000, the policy (California Government Code) limits investments to bonds and other obligations of the US Treasury, US agencies or instrumentalities, or the state of California; bonds of any city, county, school district, or special road district of the state of California; bonds of banks for cooperatives, federal land banks, federal intermediate credit banks, Federal Home Loan Bank, Tennessee Valley Authority, and the National Mortgage Association or certificates of deposit.

The investment policy does not specifically address interest rate risk, credit risk, custodial credit risk, concentration of credit risk or foreign currency risk.

Inherent 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. The money market mutual funds are presented as an investment with a maturity of less than one year because they are redeemable in full immediately.

Credit risk

Credit risk is the risk that the issuer or other counterparty to an investment will not fulfill its obligations. At June 30, 2016 and 2015, the District's investments in money market mutual funds were rated AAA by Standard and Poor's and AAA by Moody's Investors Service and the District's investments in LAIF were not rated.

5. BOARD-DESIGNATED, RESTRICTED FUNDS, AND OTHER LONG-TERM INVESTMENTS (continued)

Custodial credit risk

For an investment, custodial credit risk is the risk that, in the event of the failure of the counterparty, the District will not be able to recover the value of its investment or collateral securities that are in the possession of an outside party. The District's investments in US agency securities, LAIF, and money market mutual funds are held by the broker or by the bank's trust department in other than the District's name.

Concentration of credit risk

This risk relates to the risk of loss attributed to the magnitude of the District's investment in a single issuer.

The District had the following investments in a single issuer in excess of 5% of total investments as follows:

	2016	
LAIF (State pool demand deposits)	$ 245,983	6.7 %

	2015	
LAIF (State pool demand deposits)	$ 245,102	7.5 %

6. FAIR VALUE MEASUREMENTS

The following table sets forth by level, within the fair value hierarchy, the District's assets at fair value as of June 30, 2016:

	Level 1	Level 2	Level 3	Total
Money market mutual funds	$ 3,420,699	$ -	$ -	$ 3,420,699
LAIF (State pool demand deposits)	-	245,983	-	245,983
	$ 3,420,699	$ 245,983	$ -	$ 3,666,682

The following table sets forth by level, within the fair value hierarchy, the District's assets at fair value as of June 30, 2015:

	Level 1	Level 2	Level 3	Total
Money market mutual funds	$ 3,021,372	$ -	$ -	$ 3,021,372
LAIF (State pool demand deposits)	-	245,102	-	245,102
	$ 3,021,372	$ 245,102	$ -	$ 3,266,474

7. PROPERTY TAX RECEIVABLES

Property tax receivables consist of the following:

	2016	2015
Special parcel tax	$ 3,178,988	$ 3,121,381
Tax for general obligation bond debt service payments	2,849,832	2,913,329
	$ 6,028,820	$ 6,034,710

8. CAPITAL ASSETS

Capital assets activity as of June 30, 2016, consisted of the following:

	Balance, June 30, 2015	Increases	Decreases, Transfers, and Retirements	Balance, June 30, 2016
Non-depreciable capital assets				
Land	$ 197,659	$ -	$ -	$ 197,659
Construction in progress	57,208	584,782	(359,886)	282,104
Total non-depreciable capital assets	254,867	584,782	(359,886)	479,763
Depreciable capital assets				
	805,238	-	-	805,238
Buildings and improvements	65,898,790	412,678	-	66,311,468
Equipment	26,151,324	377,881	(168,483)	26,360,722
	92,855,352	790,559	(168,483)	93,477,428
Less accumulated depreciation	(38,252,940)	(3,461,196)	98,222	(41,615,914)
Total depreciable capital assets	54,602,412	(2,670,637)	(70,261)	51,861,514
Total capital assets, net	$ 54,857,279	$ (2,085,855)	$ (430,147)	$ 52,341,277

Capital assets activity as of June 30, 2015, consisted of the following:

	Balance, June 30, 2014	Increases	Decreases, Transfers, and Retirements	Balance, June 30, 2015
Non-depreciable capital assets				
Land	$ 197,659	$ -	$ -	$ 197,659
Construction in progress	2,567,306	1,519,495	(4,029,593)	57,208
Total non-depreciable capital assets	2,764,965	1,519,495	(4,029,593)	254,867
Depreciable capital assets				
Land improvements	805,238	-	-	805,238
Buildings and improvements	64,542,368	-	1,356,422	65,898,790
Equipment	23,271,090	502,843	2,377,391	26,151,324
	88,618,696	502,843	3,733,813	92,855,352
Less accumulated depreciation	(35,033,411)	(3,508,398)	288,869	(38,252,940)
Total depreciable capital assets	53,585,285	(3,005,555)	4,022,682	54,602,412
Total capital assets, net	$ 56,350,250	$ (1,486,060)	$ (6,911)	$ 54,857,279

9. EMPLOYEE BENEFITS PLAN

Defined contribution plan

The District contributes to a defined contribution pension plan (the "Plan") covering substantially all employees. Pension expense is recorded for the amount of the District's required contributions, determined in accordance with the terms of the Plan. The Plan is administered by the District's Board of Directors. The Plan provides retirement benefits to plan members and death benefits to beneficiaries of plan members. Benefit provisions are contained in the plan document and are established and can be amended by action of the District's governing body. Contribution rates for plan members and the District, expressed as a percentage of covered payroll, were 3.52% and 3.41% for 2016 and 2015, respectively.

Deferred compensation plans

The District offers its employees a deferred compensation plan created in accordance with Internal Revenue Code Section 457. The deferred compensation plan is available to all employees and permits them to defer a portion of their salary. An employer match is also provided and is vested at the rate of 16.7% per year.

The District's contributions to the defined contribution plan and deferred compensation plan totaled $648,841 and $571,484 during 2016 and 2015, respectively.

10. MEDICAL MALPRACTICE COVERAGE AND CLAIMS

The District has joined together with other providers of health care services to form Beta Healthcare Group ("Beta"), a public entity risk pool (the "Pool") currently operating as a common risk management and insurance program for its members. The District purchases medical malpractice insurance from the Pool under a claims-made policy. The District pays an annual premium to the Pool for its torts insurance coverage. The District purchases excess liability insurance through a commercial insurer for amounts in excess of the coverage provided under Beta. The Pool's governing agreements specifies that the Pool will be self-sustaining through member premiums and will reinsure through commercial carriers for claims in excess of stop-loss amounts. Accounting principles generally accepted in the United States of America require a health care provider to accrue the expense of its share of malpractice claim costs, if any, for any reported and unreported incidents of potential improper professional service occurring during the year by estimating the probable ultimate costs of the incidents. As of June 30, 2016 and 2015, there was no liability recorded for accrued malpractice costs.

11. WORKERS' COMPENSATION CLAIMS

The District is self-insured for workers' compensation claims of its employees up to $500,000, with commercial stop-loss insurance coverage purchased for claims in excess of these amounts through December 31, 2008. A liability is accrued for self-insured workers' compensation claims, including both claims reported and claims incurred but not yet reported of $404,000 and $869,000 as of June 30, 2016 and 2015, respectively. The District utilizes an actuary to estimate the ultimate costs to settle such claims. Estimated future payments related to workers' compensation claims have been discounted at a rate of 1% at June 30, 2016 and 2015. It is reasonably possible that the District's estimate could change by a material amount in the near term.

12. LONG-TERM DEBT

The District's long-term debt transactions as of June 30, 2016, consisted of the following:

	Balance, June 30, 2015	Additions	Decreases / Amortization	Balance, June 30, 2016
GO Bond Principal	$ 35,437,000	$ -	$ (1,236,000)	$ 34,201,000
Note payable	958,888	121,950	(223,589)	857,249
	$ 36,395,888	$ 121,950	$ (1,459,589)	$ 35,058,249

The District's long-term debt transactions as of June 30, 2015, consisted of the following:

	Balance, June 30, 2014	Additions	Decreases / Amortization	Balance, June 30, 2015
GO Bond Principal				
Principal	$ 35,532,000	$ -	$ (95,000)	$ 35,437,000
Note payable	1,042,591	-	(83,703)	958,888
	$ 36,574,591	$ -	$ (178,703)	$ 36,395,888

General obligation bonds payable

On November 4, 2008, the District electorate approved the authorization to issue a total of $35,000,000 in general obligation bonds. On April 1, 2009, the District issued $12,000,000 principal amount of general obligation bonds (Sonoma Valley Health Care District General Obligation Bonds, Election of 2008, Series A 2009). Bond proceeds are to be used to pay for a portion of the costs of renovating and retrofitting the District's existing hospital facility, to purchase equipment, to refund outstanding indebtedness, to pay costs of issuance and to pay bond interest due August 1, 2009. $4,000,000 of the proceeds were used to refund all of the then outstanding Revenue Bonds. $8,000,000 of the proceeds and the proceeds from all future bonds authorized by the election will be used to construct a new central utility plant, improve utility infrastructure, make all necessary seismic upgrades to existing facilities, and purchase additional medical equipment and install information systems wiring (the "Project").

12. LONG-TERM DEBT (continued)

General obligation bonds payable (continued)

Interest on the Bonds is payable semi-annually at rates ranging from 5.375% to 8.750% with principal payments due annually beginning August 1, 2013.

Bonds maturing on or before August 1, 2014, are not subject to redemption prior to their respective stated maturity dates. Bonds maturing on or after August 1, 2015, may be redeemed prior to maturity at the District's option at redemption prices equal to the par amount of Bonds redeemed. The Bonds are general obligations of the District payable from ad valorem taxes. In the event the District fails to provide sufficient funds for payment of principal and interest when due, a commercial insurance company has guaranteed to pay that portion of principal and interest for which funds are not available.

In the first phase of the Project, the District prepared a master plan, completed the detailed planning for the Project, acquired some equipment, installed the information systems wiring, and began construction.

In August 2010, the District issued $23,000,000 of additional general obligation bonds (Sonoma Valley Health Care District General Obligation Bonds, Election of 2008, Series B 2010) in order to finance the second and final phase of the Project. During this phase, which was completed in February 2014, the District completed all construction and improvement aspects of the Project and finished purchasing the equipment budgeted in the Project.

In February 2014, the District issued $12,437,000 of additional general obligation bond (Sonoma Valley Health Care District 2014 General Obligation Regunding Bond) to refund all of the outstanding Sonoma Valley Health Care District General Obligation Bonds, Election of 2008, Series A 2009. The 2009 General Obligations Bonds were refunded in February 2014 and the funds were transferred to an escrow account held by a trustee until the bonds were fully called in August 2014.

Line of credit

The District has a line of credit agreement with a bank for an amount not to exceed $7,000,000, with an interest rate of 2.5% plus LIBOR and maturing on January 31, 2019. The District is required to comply with certain restrictive covenants, including maintaining a total liabilities to tangible net worth ratio of not greater than 2.0 to 1.0, and the loan outstanding balance shall be limited to 70% of the sum of (i) net accounts receivable, (ii) contributions receivable, and (iii) special parcel tax. The District was in compliance with these covenants as of June 30, 2016.

The District had unused credit on the line of $276,266 and $1,076,266 as of June 30, 2016 and 2015, respectively. The line of credit limit was increased after June 30, 2016; see Subsequent Events under Note 2.

12. LONG-TERM DEBT (continued)

Debt service requirements

Debt service requirements for long-term debt as of June 30, 2016, are as follows:

	General Obligation Bonds		Note Payable	
Year ending June 30,	Principal	Interest	Principal	Interest
2017	$ 1,339,000	$ 1,347,132	$ 153,675	$ 8,238
2018	1,433,000	1,296,257	129,632	6,713
2019	1,529,000	1,239,272	130,897	5,414
2020	1,631,000	1,177,194	132,199	4,112
2021	1,743,000	1,110,973	41,600	1,157
2022 - 2026	10,745,000	4,391,310	269,246	3,376
2027 - 2031	13,851,000	1,834,063	-	-
2032 - 2036	1,930,000	43,425	-	-
	$ 34,201,000	$ 12,439,626	$ 857,249	$ 29,010

Interest costs

Interest costs incurred during the year are summarized as follows:

	2016	2015
Interest cost		
Paid	$ 1,461,149	$ 1,407,193
Accrued	571,281	589,645
Total interest expense	$ 2,032,430	$ 1,996,838

13. CAPITAL LEASE OBLIGATIONS

Capital lease obligations outstanding are as follows:

Description	Maturity	Interest Rates	Original Issue	June 30, 2016
Capital leases - equipment net of interest	October 2011 - January 2021	1.50% - 9.59%	$ 7,785,042	$ 3,182,548
Less current portion				(997,778)
				$ 2,184,770

13. CAPITAL LEASE OBLIGATIONS (continued)

Description	June 30, 2015	Increases	Decreases	Outstanding June 30, 2016
Capital lease - equipment	$ 4,188,420	$ 238,462	$ (1,244,334)	$ 3,182,548

Description	June 30, 2014	Increases	Decreases	Outstanding June 30, 2015
Capital lease - equipment	$ 5,719,556	$ -	$ (1,531,136)	$ 4,188,420

Future maturities of capital lease obligations are as follows:

Year ending June 30,	
2017	$ 1,187,212
2018	1,096,683
2019	976,124
2020	105,936
2021	31,196
	3,397,151
Imputed interest	(214,603)
	$ 3,182,548

14. TRANSACTIONS WITH SONOMA VALLEY HOSPITAL FOUNDATION

Sonoma Valley Hospital Foundation, Inc. (the "Foundation") is authorized by the District to solicit contributions on behalf of the Hospital. In the absence of donor restrictions, the Foundation has discretionary control over the amounts, timing, and use of their distributions. The District recorded contributions from the Foundation of $1,017,651 in 2016 and $1,217,000 in 2015. At June 30, 2016 and 2015, the Foundation's unaudited cash basis financial statements reported net position of $566,129 and $496,977, respectively. The Foundation is not considered a component unit of the District because the Foundation is not controlled by the District.

15. RELATED PARTY TRANSACTIONS

During 2010, the District contributed $100,000 to Meritage for the development of Prima Medical Foundation ("PMF"), a joint venture with Meritage, Marin Healthcare District ("MHD"), and Marin Medical Practice Concepts, Inc. ("MMPC"). The PMF's purpose is establishing, operating, and maintaining multi-specialty medical clinics. The successful establishment and operation of PMF in Marin and Sonoma Counties is expected to be a cornerstone in the District's plans to ensure adequate health care services to the greater Sonoma Area. The District's contribution to PMF totaled $576,618 and $446,130 for the years ended June 30, 2016 and 2015, respectively.

16. COMMITMENTS AND CONTINGENCIES

Litigation

The District is a defendant in various legal proceedings arising out of the normal conduct of its business. In the opinion of management and its legal representatives, the District has valid and substantial defenses, and settlements or awards arising from legal proceedings, if any, will not exceed existing insurance coverage, nor will they have a material adverse effect on the financial position, results of operations, or liquidity of the District.

Operating leases

The District leases certain facilities and equipment under the terms of noncancelable operating lease agreements expiring at various dates through July 2021. In 2015, the District began to sublease suites within its leased medical office under sublease agreements expiring through February 2019. Total rental expense for all operating leases amounted to $1,167,165 and $904,467 in 2016 and 2015, respectively. Total rental income during the years ended June 30, 2016 and 2015, amounted to $111,278 and $12,039, respectively.

The scheduled minimum lease payments under the lease terms are as follows:

Year ending June 30,	Facility and Equipment	Sub-Lease Income	Net Lease Commitment
2017	$ 966,886	$ (62,190)	$ 904,696
2018	784,674	-	784,674
2019	609,701	-	609,701
2020	157,839	-	157,839
2021	13,153	-	13,153
	$ 2,532,253	$ (62,190)	$ 2,470,063

16. COMMITMENTS AND CONTINGENCIES (continued)

Regulatory environment

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, reimbursement for patient services, and Medicare and Medi-Cal fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. The District is subject to routine surveys and reviews by federal, state, and local regulatory authorities. The District has also received inquiries from health care regulatory authorities regarding its compliance with laws and regulations. Although the District's management is not aware of any violations of laws and regulations, it has received corrective action requests as a result of completed and ongoing surveys from applicable regulatory authorities. Management continually works in a timely manner to implement operational changes and procedures to address all corrective action requests from regulatory authorities. Breaches of these laws and regulations and non-compliance with survey corrective action requests could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

17. CHARITY CARE

During the years ended June 30, 2016 and 2015, the District incurred estimated costs of $294,762 and $310,100, respectively, in free or discounted services for the poor and underserved. This includes services provided to persons who have health care needs and are uninsured, under-insured, and ineligible for a government program and are otherwise unable to pay for medically necessary care based on their individual financial situation. Costs are computed based on a relationship of costs to charges similar to a Medicare cost to charge ratio. During the year ended June 30, 2016, there were approximately 128 patient cases under this policy. During the year ended June 30, 2015, there were approximately 145 patient cases under this policy.

18. HEALTH CARE REFORM

In March 2010, President Obama signed the Health Care Reform Legislation into law. The new law may result in changes across the health care industry. The primary goal of this comprehensive legislation is to extend health care coverage to approximately 32,000,000 uninsured legal U.S. residents through a combination of public program expansion and private sector health insurance reforms. To fund the expansion of insurance coverage, the legislation contains measures designated to promote quality and cost efficiency in health care delivery and to generate budgetary savings in the Medicare and Medicaid programs. The District is unable to predict the full impact of the Health Care Reform Legislation at this time due to the law's complexity and current lack of implementing regulations and or interpretive guidance. However, the District expects that several provisions of the Health Care Reform Legislation will have a material effect on its business.

SUPPLEMENTARY INFORMATION

Sonoma Valley Health Care District
Supplementary Information Related to Community Support
For the Years Ended June 30, 2016 and 2015

Uncompensated care

In September 2004, the District adopted a formal community benefits policy, developed under guidelines provided by the California Hospital Association, and began to identify those patients who are medically indigent. The District's policy is to provide service to all who require it, regardless of their ability to pay. As such, it provides substantial amounts of uncompensated care. When this care is provided to patients who lack financial resources (and therefore are deemed medically indigent), it is classified as community benefits. When it is provided to patients who have the means to pay but decline to do so, it is classified as a provision for uncollectible accounts. Neither community benefits nor the provision for uncollectible accounts is reflected in net patient service revenues.

In addition, the District provides services to other medically indigent patients under certain government-reimbursed public aid programs. Such programs pay providers amounts that are less than established charges for the services provided to the recipients and frequently the payments are less than the cost of rendering the services. Finally, some undetermined portion of the provision for uncollectible accounts represents care to indigent patients who the District has been unable to identify.

Uncompensated charges relating to these services are as follows:

	2016	2015
Community benefits (charity care) allowances	$ 294,762	$ 310,100
State Medi-Cal and other public aid programs	46,602,291	41,679,971
Provision for uncollectible accounts	1,240,000	1,125,000
	$ 48,137,053	$ 43,115,071

The District's estimated costs of providing uncompensated care and community benefits to the poor and the broader community are as follows:

	2016	2015
Uncompensated costs of community benefits and uncollectible accounts	$ 63,177	$ 60,543
Medi-Cal and other public aid programs	4,370,788	6,676,218
	4,433,965	6,736,761
Benefits for the broader community	-	6,952,478
	$ 4,433,965	$ 13,689,239

Benefits for the broader community include the unpaid costs of providing service to the elderly, providing health screenings and other health-related services, training health professionals, educating the community with various seminars and classes, and the costs associated with providing free clinics and other community service programs.

Sonoma Valley Health Care District
Supplementary Information Related to Community Support
For the Years Ended June 30, 2016 and 2015

Community support

The District recorded the following amounts related to community service as follows:

	2016	2015
Noncapital gifts and grants included in non-operating revenues	$ 548,785	$ 449,407
Capital grants and contributions from Sonoma Valley Hospital Foundation	472,032	756,339
	$ 1,020,817	$ 1,205,746
Fundraising expenses included in operating expenses	$ -	$ 3,257

See accompanying independent auditor's report.