SONOMA VALLEY HEALTH CARE DISTRICT

BOARD OF DIRECTORS
REGULAR MEETING AGENDA
JULY 5, 2018

REGULAR SESSION 6:00 P.M.

COMMUNITY MEETING ROOM
177 FIRST STREET WEST, SONOMA

In compliance with the Americans Disabilities Act, if you require special accommodations to participate in a District meeting, please contact District Clerk Stacey Finn at sfinn@svh.com (707) 935.5004 at least 48 hours prior to the meeting.	**RECOMMENDATION**	
AGENDA ITEM		
MISSION STATEMENT *The mission of SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER	*Rymer*	
2. PUBLIC COMMENT *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Board consideration. At all times please use the microphone.*	*Rymer*	
3. CONSENT CALENDAR A. Board Minutes 06.07.18 B. Joint Budget Session 06.05.18 C. Quality Committee Minutes 05.23.18 D. Governance Committee Minutes 03.27.18 E. Executed Policies and Procedures F. Medical Staff Credentialing Report *pages 3-25*	*Rymer*	Action
4. OUTPATIENT DIAGNOSTIC CENTER PROJECT *pages 26-62*	*Mather*	Inform/Action
5. SVH FOUNDATION ANNUAL UPDATE *pages 63-71*	*Pier*	Inform
6. ADMINISTRATIVE REPORT JULY 2018 *pages 72-75*	*Mather*	Inform
7. FINANCIAL REPORT MONTH END MAY 31, 2018 *pages 76-91*	*Jensen*	Inform
8. SOUTH LOT LOAN MODIFICATION *pages 92-106*	*Jensen*	Inform
9. COMMITTEE REPORTS A. Governance Committee 1. Community Funding Policy #P-2018.07.05-1 2. Ethics Training Policy #P-2018.07.05-2 3. Residency Requirements Policy for Members of the Board Committees #P2018.07.05-3 4. Proposed JPA By-Law Amendment 5. Medical Staff By-Law Amendment *pages 107-118*	*Hohorst*	Inform/Action

9. BOARD COMMENTS A. SVH Support Letter for SOS Funding B. SB 538 Oppose Letter C. CEO 2018-2019 Objectives Committee D. CEO Performance Review Committee *Pages 119-123*	*Board Members/Rymer*	Inform/Action
10. ADJOURN *A special Joint Board and Finance meeting is July 25, 2018, in the SVH Basement* *The next Regular Board meeting is August 2, 2018.*	*Rymer*	

3.

CONSENT CALENDAR

SONOMA VALLEY HEALTH CARE DISTRICT
BOARD OF DIRECTORS' MEETING
MINUTES
THURSDAY, JUNE 7, 2018
CLOSED SESSION 4:30 P.M.
REGULAR SESSION 6:00 P.M.
COMMUNITY MEETING ROOM
177 First Street West, Sonoma, CA

	RECOMMENDATION	
MISSION STATEMENT *The mission of SVHCD is to maintain, improve and restore the health of everyone in our community.*		
1. CALL TO ORDER The meeting was called to order at 6:06 pm.	*Rymer*	
2. PUBLIC COMMENT ON CLOSED SESSION	*Rymer*	
None		
3. CLOSED SESSION A. Calif. Govt. Code §37606 & Calif. Health and Safety Code §32106 – Report Involving Trade Secrets/Business Strategies: Discussion concerning restructure scenarios B. Calif. Govt. Code §54956.95 – Potential Liability Claim: Claimant: Unspecified; Agency claimed against: Sonoma Valley Health Care District	*Rymer*	Action
4. REPORT ON CLOSED SESSION	*Rymer*	Inform
A. There was a discussion and no decisions were made. B. A liability claim was discussed and was rejected.		
5. PUBLIC COMMENT	*Rymer*	
None		
6. CONSENT CALENDAR: A. Board Minutes 04.26.18 B. Board Minutes 05.03.18 C. Board Minutes 05.16.18 D. Quality Committee Minutes 04.25.18 E. Governance Committee Minutes 03.27.18 F. Executed Policies and Procedures G. Medical Staff Credentialing Report	*Rymer*	**MOTION**: by Boerum to approve, 2nd by Hirsch. All in favor.
6. HOSPICE BY THE BAY PRESENTATION	*Whitaker*	Inform
Ms. Kitty Whitaker reviewed Hospice's presence and operations in the Bay Area. Hospice worked with SVH to create a hospice bed at the hospital which is occupied about 70% of the time. The room is free for patients, with Hospice and the hospital sharing costs. In 2015 Hospice established an affiliation with UCSF. Last year Hospice purchased a home care agency. Ms. Whitaker explained they are looking at the continuum of care and taking care of patients where patients are – primarily in the home (with home care, palliative care, and end of life care). That is the reason Hospice went into home care.		

8. ANNUAL MARKETING/PUBLIC RELATIONS UPDATE	*Kenney*	Inform
Bob Kenney reviewed marketing goals, FY 2018 priorities and results (such as A Woman's Place launch, new advertising in Spanish and English, digital advertising for bariatric surgery, Conversations with a Doctor, the ConforMIS (custom) knee replacement, and an expanded PCP direct mail program). Digital advertising has been very impactful, has the ability to geo-target, has a broader reach demographically, and is highly cost-effective. He briefly reviewed marketing priorities for FY 2019. Mr. Kenney discussed community outreach through blogs, the SVH annual report, health and wellness supplement to the Index-Tribune, outreach to the Latino community, and SVH Foundation support. Social media was critical to communication during emergencies such as the October fires, and SVH is being proactive in connecting with various community and emergency organizations to implement this into its plans, get news out, and correct misconceptions.		
9. ADMINISTRATIVE REPORT JUNE 2018	*Mather*	Inform
Ms. Mather reported that Rate My Hospital scores continue to be very high. Staff forums were held in May and the issue of job security was addressed. A practice administrator for the physician offices was hired in May. The second UCSF meeting went well, and an initial focus will be teleneurology and cancer clinics. DeNova is hoping to close the South Lot sale by the end of the year. She indicated that management is working on a new dashboard starting July 1. The turnover rate is a bit higher than it has been in the past. In addition, the CMO position has been posted, and we have two candidates from among our own physicians who are interviewing.		
10. FINANCIAL REPORT MONTH ENDED APRIL 30, 2018	*Jensen*	Inform
Mr. Jensen mentioned that the Finance Committee had not reviewed the financials for April. April volumes continued to be under budgeted expectations. Net patient revenue was $4.3 million or ($440,696) below budget. There was a continued increase in government payors and a decrease in commercial. Accounts receivable were 42.9 days, accounts payable 40.6, and days of cash were 6.8. Total operating revenue was ($477, 816) less than expected. Employee costs were below budget. Operating expenses were also better than budget by $274,142. Net income after restricted contributions and GO bond activity was $221,000 on a budget of ($34,898).		
11. FY 2019 THREE-MONTH OPERATING BUDGET	*Jensen*	Action
A study session was held previously on a three-month budget for FY 2019. Mr. Jensen said the budget process was begun using a 12-month rolling average, which was not realistic given the volumes SVH has been experiencing, so a three-month budget was prepared while management reviews plans for addressing the decreases in In-Patient volumes. Mr. Boerum complimented Mr. Jensen on the excellent plan.		**MOTION:** by Hirsch to approve, 2nd by Rymer. All in favor.
12. BOARD COMMENTS A. AB 3087 Oppose Letter B. SB 1152 Oppose Letter	*Board Members*	Inform

Ms. Mather briefly reviewed the legislative letters. There were no other board comments.		
13. ADJOURN	*Rymer*	
Meeting adjourned at 7:15 pm		

SVHCD JOINT FINANCE COMMITTEE-
BOARD OF DIRECTORS
BUDGET STUDY SESSION
MINUTES
TUESDAY, JUNE 5, 2018
STUDY SESSION 5:00 P.M.

SCHANTZ CONFERENCE ROOM, SVH
347 Andrieux St Sonoma, CA 95476

	RECOMMENDATION	
MISSION STATEMENT *The mission of SVHCD is to maintain, improve and restore the health of everyone in our community.*		
1. CALL TO ORDER The meeting was called to order at 5:00 p.m.	*Nevins*	
2. PUBLIC COMMENT SECTION	*Nevins*	
None		
3. FY 2019 THREE-MONTH OPERATING BUDGET	*Jensen*	Inform/Action
Ms. Mather gave a brief introduction with a review of the prior year. This budget is for the first three months of the new fiscal year, and the plan is to have the remaining nine-month budget by the end of July. Mr. Jensen said a 12 month budget was not feasible based on fluctuating inpatient volumes and a three-month budget was created based on July, August and September of 2017. Home Care is in the budget at present at breakeven. The company which has expressed interest in taking over that service has asked for another 90 days. Mr. Jensen said the budgeted volumes seemed attainable. Budgeted operating expenses include salary increases that were given to employees in January 2018 and reductions by some departments planned for this summer. Total operating revenue is projected at $4.7 million per month, and operating expenses at $5.2 million per month. The cash forecast was reviewed; cash is expected to remain below 10 days for the next few months.		No action was requested.
4. ADJOURN The meeting adjourned at 5:39 pm.	*Nevins*	

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
MAY 23, 2018, 5:00 PM
MINUTES
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch	Kelsey Woodward	Howard Eisenstark, MD	Mark Kobe
Peter Hohorst	Cathy Webber	Michael Mainardi, MD	Danielle Jones
Carol Snyder	Michael Brown, MD		Deborah Bishop
Susan Idell			Sally Staples
Ingrid Sheets			Leslie Lovejoy

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Meeting called to order at 5:00 pm	
2. PUBLIC COMMENT	*Hirsch*	
	None	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 04.25.18		**MOTION:** by Idell to approve, 2nd by Hohorst. All in favor.
4. EMERGENCY DEPARTMENT TRIAGE	*Bishop*	Inform
	In response to a request from the Committee, Deborah Bishop discussed the updated ER triage process in which one RN is now responsible for all breaks and there are three RNs on the ER floor. There is more communication with registration and techs. There are new nursing protocols in place. The triage RN carries a triage phone and registration calls her; if she could not respond, registration pages the ER nurses' desk. Ms. Bishop is monitoring daily triage times. Ms. Idell asked about medical services. MDs have changed their hours so each shift overlaps. Occasionally an extra MD has been called in. Also, with the new nursing protocols RNs can initiate treatment if the MD is busy with other patients.	

AGENDA ITEM	DISCUSSION	ACTION
5. A WOMAN'S PLACE ANNUAL REPORT	*Staples*	Inform
	Sally Staples gave the Woman's Place annual review. New physicians include: Dr. Levy-Gantt and Dr. LaFollette (both OB/GYN), and Dr. Alexandridis is doing breast surgery. The Woman's Place consists of 10 patient beds, with six rooms being remodeled. There is one OR in the suite which is for C-sections only. All other surgery patients go to the main ORs and return. Ms. Staples discussed staffing and nursing competencies. Although SVH has had a low birth rate over the past year, most nurses work at other facilities as well, they receive annual training, and shifts at other hospitals are being explored. Patients are very happy with the new suite.	
6. QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT PROGRAM REVIEW 2017	*Jones*	Action
	Ms. Jones reviewed improvements for 2017 [catheter associated urinary tract infections, with improvement especially in Skilled Nursing; the medication reconciliation project (a three-year project); and the Prime Grant (standardizing the patient care transition) (a five-year project)]. There were 12 clinical and seven non-clinical PI projects at the 2017 fair, which was open to the public. Goals for 2018 include medication reconciliation, patient care transition, healthcare acquired pneumonia, and stroke ready certification (from CIHQ). SVH is also working toward being a "highly reliable organization."	**MOTION:** by Hohorst to approve, 2nd by Idell. All in favor
7. PATIENT CARE SERVICES DASHBOARD	*Kobe*	Inform
	Mr. Kobe reviewed the dashboard for the first quarter.	
8. POLICIES & PROCEDURES	*Jones*	Action
	Ms. Jones reviewed the policies briefly. There were no questions.	**MOTION:** by Woodward to approve, 2nd by Hohorst. All in favor.
9. UPON ADJOURNMENT OF REGULAR SESSION	*Hirsch*	
	Regular session adjourned at 6:20 p.m.	

AGENDA ITEM	DISCUSSION	ACTION
10. CLOSED SESSION a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Jones*	Action
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
		MOTION: by Woodward to approve credentialing, 2nd by Sheets. All in favor.
12. ADJOURN	*Hirsch*	
	Meeting adjourned at 6:24 p.m.	

SONOMA VALLEY HEALTH CARE DISTRICT
GOVERNANCE COMMITTEE MEETING
MINUTES
TUESDAY, March 27, 2018
8:30 AM

ADMINISTRATION CONFERENCE ROOM
347 ANDRIEUX STREET, SONOMA, CA 95476

	RECOMMENDATION	
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER/ANNOUNCEMENTS	*Hohorst*	
Called to order at 8:30 am		
2. PUBLIC COMMENT SECTION	*Hohorst*	
No public comment		
3. CONSENT CALENDAR • GC Minutes For 01.23.18	*Hohorst*	Action
		MOTION: by Hohorst to approve. All in favor.
4. REVIEW OF GIFT ACCEPTANCE POLICY #P-2013.06.06-3	*Hohorst*	Inform/Action
The Board's Gift Acceptance Policy was compared with the Foundation's Gift Acceptance Policy. Both were identical. No changes were recommended.		**MOTION:** by Boerum to forward the existing policy to the Board for re-approval. All in favor.
5. REVIEW OF GIFT, TICKET, AND HONORARIA POLICY #P-2014.02.06-2	*Hohorst*	Inform/Action
The Gift, Ticket and Honoraria Policy was reviewed. A change in the maximum value of a gift that can be accepted was increased from $440 to $470 as now allowed by the Political Reform Act (at Government Code Section 89503) and the Fair Political Practices Commission (FPPC) Regulations. No other changes were recommended.		**MOTION:** by Boerum to forward the revised policy to the Board for approval. All in favor.
6. ADJOURN	*Hohorst*	
Meeting adjourned at 9:15 am		

Policy and Procedures – Summary of Changes
The Board of Directors Meeting, July 5th, 2018

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the appropriate organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

- Consistent with the Mission, Vision and Values of the Sonoma Valley Health Care District
- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Sonoma Valley Health Care District Board.

ORGANIZATIONAL

NEW (Full Policies are attached)**:**

Code Stroke Practice Guidelines NS8610-122

This policy was created to outline the process for when patients present with a signs and symptoms consistent of acute stroke. Sonoma Valley Hospital has adopted these practice guidelines in order to delineate a consistent, evidence-based approach to treating the patient who presents with signs and symptoms consistent with acute stroke.

Code Stroke Paging NS8610-124

This policy was created to outline the process of paging overhead when patients present with a signs and symptoms consistent of acute stroke. Sonoma Valley Hospital has adopted these practice guidelines in order to delineate a consistent, evidence-based approach to treating the patient who presents with signs and symptoms consistent with acute stroke in accordance with CIHQ requirement for Stroke Ready Certification.

Wound Care Protocol NS8610-120

This policy was created to enable the wound care technician to perform wound care without delay in compliance with state and federal regulations.

SUBJECT: Code Stroke Practice Guidelines	POLICY: NS8610-122
	PAGE 1 OF 5
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:

To outline the process for when patients present with a signs and symptoms consistent of acute stroke.

Goals:

- Rapid identification of vascular events.
- Manage appropriately and efficiently according to the 2018 AHA Guidelines for Management of Acute Ischemic Stroke.
- Evaluate in a cost-effective manner.

POLICY:

Sonoma Valley Hospital has adopted these practice guidelines in order to delineate a consistent, evidence-based approach to treating the patient who presents with or develops signs and symptoms consistent with acute stroke.

Definitions:

Stroke Team: ED Attending MD, Primary ED RN, House Supervisor, Telemedicine MD (if indicated).
EVT: Endovascular Treatment

Compliance-Key Elements:

EMS**:**

1. When EMS calls into Emergency Department with an early Stroke notification, call PBX operator to page “Code Stroke ED eta ____minutes”.

2. EMS will stop at the Nursing Station, give MD and RN quick report of events, to include last known well. MD and Primary RN will do a rapid Neuro assessment together. EMS will then take patient directly to CT, accompanied by Primary RN with SVH portable monitor.

3. EMS will assist staff with moving patient over to CT table. Primary RN will attach patient on portable cardiac monitor and remain with patient in designated radiologically safe area of CT.

4. EMS will return to service.

5. ED Technician will bring weighted gurney to CT. Patient will be transferred from CT table to weighted gurney upon completion of CT/CTA. RN will accompany patient back to ED and continue with policy guidelines.

PBX**:**

1. Page Code Stroke overhead according to Code Stroke Policy.

Registration**:**

1. If patient presents stating they feel as if they are having a stroke, notify RN immediately.

2. Prioritize for bedside registration.

Triage**:**

1. Screen all patients for suspected stroke.

2. If a suspected stroke; document chief complaint, to include but not limited to sudden onset of numbness, weakness, difficulty speaking, vision changes, changes in coordination.

3. Document last known well, onset of symptoms, and whether improving or resolved.

4. If signs and symptoms have not fully resolved, notify PBX operator to page “Code Stroke Now ED”.

5. Move patient immediately to a room with weighted gurney, weigh patient and document in EHR.

6. Call in house Pharmacy with weight, during pharmacy in house hours.

7. Enter EDNUR CODE STROKE PROTOCOL for persistent symptoms with onset <3 hrs.

SUBJECT: Code Stroke Practice Guidelines	POLICY: NS8610-122
	PAGE 3 OF 5
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

Stroke Team**:**

1. MD and Primary RN complete a rapid assessment prior to CT. If available, second RN to attempt IV access and draw labs while MD/RN completing initial assessment.
2. RN to place patient on portable monitor and accompany patient to CT
3. MD to consider consulting Telemedicine Neurologist and/or Neurologist via phone.
4. RN to attempt IV access and draw labs in CT (do not delay CT for IV access).
5. If unable to draw labs within 5mins, notify ED MD. *Per new guidelines, for patients who otherwise meet criteria for EVT, it is reasonable to proceed with a CTA if indicated in patients with suspected intracranial LVO before obtaining a serum creatinine concentration in patients without a history of renal impairment. 2.2.9
6. Return patient to ED upon completion of CT and CTA.
7. RN and MD to complete full NIH Stroke Scale together upon patients return from CT.
8. RN to confirm O2 Saturation greater than 94%. * Supplemental oxygen is not recommended in nonhypoxic patients with AIS. 3.1.3
9. RN to establish 2nd IV access (do not delay alteplase for access).
10. ECG, 12 lead (do not delay alteplase for ECG).
11. CXR (do not delay alteplase for CXR).
12. MD to assure CT scan resulted and note time of read in patient's medical record.
13. Only the assessment of blood glucose must precede the initiation of IV alteplase in all patients. *Given the extremely low risk of unsuspected abnormal platelet counts or coagulation studies in a population, IV alteplase treatment should not be delayed while waiting for hematologic or coagulation testing if there is no reason to suspect an abnormal test. 2.3.1
14. MD to finalize decision on alteplase administration after reviewing the CT results, timeline of events, and contraindications. MD to also consider alteplase for patients with onset of <4.5 hours of last known well per AHA recommended criteria.

15. MD to enter order for alteplase and communicate with primary RN that alteplase has been ordered.

16. Confirm verbal informed consent for alteplase is obtained, complete consent.

17. Patients who have elevated BP and are otherwise eligible for treatment with IV alteplase should have their BP carefully lowered so that systolic BP is <185 mm Hg and their diastolic BP is <than 110 mm Hg before IV fibrinolytic therapy initiated.

18. RN to administer alteplase per dosing guidelines.

19. RN to waste any unneeded alteplase, if necessary, per pharmacy policy.

20. RN to complete and document Neuro assessments and vital signs every 15mins during and after IV alteplase infusion for 2hrs, then every 30min for 6 hrs, then hourly until 24hr after IV alteplase.

21. If the patient develops severe headache, acute hypertension, nausea, or vomiting or has a worsening neurological examination, discontinue the infusion, alert the MD, and obtain an emergency head CT scan.

22. If MD has decided that patient does not meet administration criteria, MD and RN to document time decision made that no alteplase will be given.

23. Sources of hyperthermia (temperature >38*C) should be identified and treated, and antipyretic medications should be administered to lower temperature in hyperthermic patients with stroke.

24. Hypotension and hypovolemia should be corrected to maintain systemic perfusion levels necessary to support organ function.

25. MD to consider transport to higher level of care if additional intervention may be indicated.

REFERENCES:

2018 Guidelines for Management of Acute Ischemic Stroke American Heart Association
CIHQ Disease Specific Guidelines Policies, Standards, and Survey Process

OWNER:

Mark Kobe, Chief Nursing Officer

SUBJECT: Code Stroke Practice Guidelines	POLICY: NS8610-122
	PAGE 5 OF 5
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

AUTHOR/REVIEWERS:
Deborah Bishop, Director of ED/ICU
Dr. Cynthia Lawder, ED Medical Director
Mark Kobe, Chief Nursing Officer
Danielle Jones, Director of Quality and Risk Management
Sonya Todorova, Diagnostic Imaging Manager
Lois Valenzuela, Laboratory Manager
Lisa Duarte, Admitting Manager
Chris Kutza, Director of Pharmacy

APPROVALS:
Policy & Procedure Team: 4/17/18
Medicine Committee: 5/10/18
Medical Executive Committee: 5/17/18
Board Quality Committee: 5/23/18
The Board of Directors:

SUBJECT: Code Stroke Paging	POLICY : NS8610-124
	PAGE 1
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

PURPOSE:

To provide a mechanism to assure that trained staff respond efficiently to a Code Stroke in a timely fashion. To assure that other departments are alerted that a patient has arrived or will be arriving soon with time sensitive procedures needed. To promote the health and safety of patients under our care.

POLICY:

Code Stroke is activated by dialing 5-5-5-5, stating Code Stroke, providing location, and ETA. Code Stroke is announced in all areas of the hospital, including the Emergency Department.

PROCEDURE:

PBX**:**

1. When alerted by 5-5-5-5 call, the operator will page “Code Stroke”.

2. The operator will announce Code Stroke and location on the overhead paging system three times in succession, pause 30 seconds and repeat announcement x 1.

When notified by ED staff that Code Stroke can be cancelled, PBX operator will do a one-time overhead announcement “Code Stroke, All Clear”.

Emergency Department:
MD and RN will respond to any area of the hospital for a rapid assessment of the patient. Code Stroke Practice Guideline Policy will be initiated, if indicated.

Radiology:
Will emergently ready the CT table in anticipation of the patient’s arrival. Facilitate rapid CT completion, allow nursing to establish an IV between CT and CTA when necessary. CT Technician to phone Radiologist to confirm CT has been received.

Laboratory:
Phlebotomist will respond to location to rapidly draw patient’s blood, return to lab, and assure blood is immediately processed.

Pharmacy:
During in house hours, Pharmacist will facilitate the mixing of alteplase and assure proper dosing guidelines are followed.

OWNER:
Mark Kobe, Chief Nursing

AUTHOR/REVIEWERS:
Deborah Bishop, Director of ED/ICU
Dr. Cynthia Lawder, ED Medical Director
Mark Kobe, Chief Nursing Officer
Danielle Jones, Director of Quality and Risk Management
Sonja Todorova, Diagnostic Imaging Manager
Lois Valenzuela, Laboratory Manager
Lisa Duarte, Admitting Manager
Chris Kutza, Director of Pharmacy

APPROVALS:
Policy & Procedure Team: 4/17/18
Medicine Committee: 5/10/18
Medical Executive Committee: 5/17/18
Board Quality Committee: 5/23/18
The Board of Directors:

SUBJECT: Wound Care Protocol	POLICY #
	PAGE 1 OF 6
DEPARTMENT: Organizational	EFFECTIVE:
REVIEW/REVISED:	

PURPOSE:

To define the scope of practice and process for wound care referrals made by in-patient departments. All in-patients are to receive prompt, effective care of wounds.

POLICY:

This policy addresses the scope of practice for wound care in the acute care hospital and skilled nursing facility. It is applicable to:

- All locations within the hospital including the Medical/Surgical Unit, Intensive Care Unit, Emergency Department, Skilled Nursing Facility, and the Surgical Care Unit.
- All hospital patients, except hospice patients which are taken care of by an outside service for their wound care.
- The wound and ostomy nurse and any assigned designee such as a physical therapist whom is trained in wound care.

Definitions

Wound Care: Any activities dealing with the repair of a patients skin such as wound healing, interventions to prevent skin breakdown, training the patient to care for wound(s), or repairing compromised skin. Referred to in the following policy as the "Wound Care Clinician".

Ostomy Care: Any activities dealing with pouching system maintenance, problems with stoma periarea, and training the patient to perform self-care of their ostomy.

ABI: Ankle Brachial Index

NPWT: Negative Pressure Wound Therapy

SNAP: NPWT device

PROCEDURE:

Clinicians are to adhere to the following protocol:

SUBJECT: Wound Care Protocol	POLICY #
	PAGE 2 OF 6
DEPARTMENT: Organizational	EFFECTIVE:
REVIEW/REVISED:	

- The wound care clinician receives a request for wound evaluation and treatment from the MD via verbal or electronic notification through Paragon.

- This order entitles the Wound Care Clinician to perform the following:
    - Assess the wound.
    - Evaluate the type of wound.
    - Determine the appropriate treatment following the moist warm healing environment, the TIME wound assessment tool, as well as other various wound care objectives.
    - Perform treatment as determined by the wound conditions .outlined in this policy
    - Inform the provider of findings and treatments preformed and additional recommendation.
        - TIME stands for:
            - T= Tissue management- The wound bed and wound periarea.
                - Elimination (debridement) of Non-viable tissue from the wound bed is critical to wound healing. Examples of non-viable tissue are: Eschar, Slough, and hypergranulated tissue.
                - Techniques use to remove eschar and slough from the wound bed are:
                    - Biological- Using medical grade maggots.
                    - Enzymatic- Santyl is the only FDA approved enzymatic.
                    - Autolytic- Controlling the discharge in the wound bed by holding it in the wound bed without causing damage to the wound periarea. This allows the various enzymes in the discharge to break down the slough and eschar.
                        - Products that work to achieve autolytic debridement are:
                            - Iodosorb, hydrocoloid dressings, clear film dressings.
                    - Mechanical Debridement- By using cotton swabs, 4x4 gauze and other materials, the slough and eschar are removed by wiping and/or scrubbing the wound bed.
                    - Sharp conservative debridement- With MD order, perform conservative sharp debridement following organization policy Conservative Sharp Debridement Policy # PC7740-103.

- I= Infection/inflammation management- Of the wound environment. By controlling the bioburden (microbial activity) in the bed and wound periarea, the wound can progress from the inflammatory stage of wound healing to the proliferative stage.
    - Examples of products that work toward reducing bioburden in the wound bed are:
        - Iodosorb, Restore Ag Contact layer, Acticoat flex, Xeroform, Silvasorb, Iodoform,
- M= Moisture management- The discharge from the wound needs to be controlled to enable a moist healing environment and to prevent any complications from excessive moisture in the wound.
    - The discharge from the wound can cause several complications with wound healing such as:
        - Increase the pH of the wound bed and wound periarea making the area susceptible to fungal and bacterial infections.
        - Enzymes in the discharge can break down collagen in viable tissue cause the wound to get bigger.
    - The type of moisture in the wound bed is important to achieve wound healing:
        - Examples of products that encourage the right amount and type of moisture are:
            - Adaptic, Iodosorb, Iodoform, Restore Ag Contact layer, Xeroform, Santyl, and Silvasorb.
    - For moderate to copious discharge, choose a dressing that control the discharge.
        - Examples of adsorbent dressings are:
            - Foam dressings, Ca Alginate, Ag Alginate, and Xtrasorb dressings.
- E= Edge management- The quality and character of the wound edge needs to be controlled for epithelialization to occur.
    - If wound edge has epibole, consider AgNO3 or mechanical debridement.
    - If wound edges are dry, consider adding more moisture to the wound by choosing Adaptic, Iodosorb, Iodoform, Restore Ag Contact layer, Xeroform, Santyl, Silvasorb.
    - If wound edges are macerated, consider adding one of the following products: Ca Alginate, Ag Alginate, and Xtrasorb dressings.

- If wound edge has callus, consider conservative sharp debridement of the callus.

- Other Wound Care objectives:
  - Keep the wound bed warm (at body temperature) - this warmth is for optimal cellular activity.
    - The warmest dressing is a foam dressing, consider this dressing for most wounds.
  - Off-load the wound (reduce trauma)- Reducing the trauma to the wound bed by, but not limited to the following:
    - A foam dressing has attenuation which cushions the wound bed, consider this bandage for most wounds.
    - Off-loading shoes.
    - Mattress type
    - Floating heals
    - Pillows and/or foam cushions
    - Wheel chair cushions
    - Bandaging technique
    - Limit activities
    - Turning patient in bed every 2 hours
    - Reposition patient in wheel chair every 15 minutes.
  - Protect wound from contamination:
    - Choose a dressing that protects the wound from contamination from outside sources and bodily fluids.
      - Most foam dressings have an adhesive boarder and achieve a seal that can withstand showering and contamination from bodily fluids.
  - Improve quality and quantity of blood to the wound.
    - If the wound is on a Lower extremity and there is edema present consider on of the following compression options:
      - Coban2 compression system for ABI >0.9
      - Coban2 Lite compression system for ABI 0.5-0.9.
      - Compression stockings 20-30mmHg
      - Elevate legs
      - Ambulation/exercises, as tolerated by the patient that does not cause trauma to wound bed.
    - If the patient is nutritionally compromised consult with Doctor and Registered Dietitian.
    - If patient is a diabetic, review blood glucose levels for the recent past and patient A1C for compliance with tight blood glucose levels.

- Frequency of dressing change should be as infrequent as possible:
    - This reduces the trauma and cooling of the wound bed.
    - It can take up to 4 hours for a wound bed to return to body temperature after a dressing change and start growing granular tissue.
    - The biggest factor that will determine frequency of dressing change is the level of discharge and the bandage one is able to use on the wound.
- Fill the wound bed:
    - General guide line is that if the wound bed is deeper than 0.5cm some sort of product should be used to fill the wound bed and prevent formation of abscess, consider:
        - Iodoform, Ca Alginate, Ag Alginate, foam or Gauze.
- Cleaning the wound bed:
    - Should be performed every dressing change.
    - Wound cleanser should be used primarily unless patient has a reaction to the product.
    - Normal saline is acceptable except when a silver product is used in wound bed or Santyl is used due to the neutralizing effect saline has on those products.

- The wound care clinician then enters the order determined by the wound care clinician and the provider into the Paragon EMR system.

- The wound care clinician then documents finding with the wound into the Paragon EMR system.

REFERENCES:
Wound, Ostomy, and Continence Society Core Curriculum: Wound Management 1st edition, Authors: Dorothy B. Doughty MN RN CWOCN FAAN ,and Laurie L. McNichol MSN RN GNP CWOCN CWON, **Publisher:** LWW; 1 edition (September 17, 2015)

OWNER:
Chief Nursing Officer

AUTHORS/REVIEWERS:
Joe Cornett, Wound and Ostomy Nurse
Alexis Alexandridis, MD, Wound Care Medical Director

SUBJECT: Wound Care Protocol	POLICY #
	PAGE 6 OF 6
DEPARTMENT: Organizational	EFFECTIVE:
REVIEW/REVISED:	

APPROVALS:
Policy & Procedure Team: 4/17/18
Medicine Committee: 5/10/18
Medical Executive Committee: 5/17/18
Board Quality Committee: 5/23/18
The Board of Directors:

4.

OUTPATIENT DIAGNOSTIC CENTER PROJECT

Meeting Date: July 5, 2018

Prepared by: Kelly Mather & Team

Agenda Item Title: Outpatient Diagnostics Project – Phase 1

Recommendation:
The board to approve Phase 1 of the Outpatient Diagnostic project to include a new CT suite with 128 slice ability with room for patient flow and comfort. This suite will now be across from the Emergency Department to improve patient care. This phase also includes an expanded waiting room to improve the patient experience and centralized scheduling next to Admitting. This project includes required imaging staff toilets, staff hub and will meet regulatory requirements. Finally, in order to increase Cardiology volumes, we also recommend creating a Cardiology office in the Central & East Wing. The cost for the Phase 1 is $9,591,378 and will be completed no later than the end of 2020.

We also recommend the board approve a study by Dome & Taylor on the cost of decommissioning the Central Wing and East Wing for which is included in the project request at $378,735 to be completed no later than October, 2018. Finally, we recommend we do a Master Facility Plan for $138,000 to address the 2030 seismic upgrade regulations and plan for a Medical Office Building for the new Rural Health Center and possibly the MRI.

Background:
In June of 2016, we presented a vision and plan to fund a new Outpatient Diagnostic department to the board. Since then, the Sonoma Valley Hospital Foundation has begun the capital campaign to raise funds for Outpatient Diagnostics and has already raised over $8 million in cash and pledges toward the goal of $20 million.

The CT scanner is vital to the Emergency Department. Since our current CT is over eleven years old, it is at the end of life. We must keep the CT operating during construction, therefore it is ideal to move the CT across from the Emergency Department in the larger vacant space. In addition, the current CT scanner is a 64 slice machine. The 64 slice and the workstation that comes with it are considered older technology. The scans are slower and have software limitations. To compete with other hospitals we need a minimum of a 128 slice scanner. It is the standard and has been for the last five years.

We studied the cost of creating a new Outpatient Diagnostic entrance off of Andrieux Street, moving Cardiopulmonary close to imaging, improving the exterior and parking lot on the North

side of the building. While the designs/plans were well done and provided for the expanded reception and waiting area desired, it is does not make sense to upgrade the Central Wing since it is over 70 years old.

The current imaging waiting room is way too small and often patients are waiting in the hallways. There is not enough space for patients in wheelchairs. The dressing area is outdated and very small. While expanding the current waiting room does not create a new entrance and the ideal large waiting area needed, it does address the imminent problems to improve the patient and staff experience. This change also requires some regulatory upgrades such as staff toilets.

We aim to begin centralized scheduling for all outpatient diagnostics. Currently patients and physician offices must call each department to schedule a test. We have identified that the old gift shop is an ideal place for the new centralized scheduling space since it is next to Admitting and Imaging. With this project, we will be able to offer a one call option for patients scheduling diagnostics, including Cardiology. We also plan to add on line appointments and digital appointment reminders. This will improve customer service to both referring physicians and patients.

One of our major goals was to bring the Imaging department together to improve staff efficiency. With CT upgraded and in a larger space, centralized scheduling in place and an expanded Imaging waiting area – we will have created a new Outpatient Diagnostic department. Currently Nuclear Medicine, the Physician reading room and Mammography are in the Central Wing and are considered part of this department. Finally, we envision bringing the Cardiologists into the hospital next to the testing services to increase Cardiology volumes.

While we studied many options for Outpatient Diagnostics, we found that the best approach is to start with Phase 1 and focus on replacing the CT in the West Wing. At this time, we are not recommending investment in refurbishing the Central Wing. Instead, we recommend studying the option of decommissioning the Central Wing and East Wing. This would take the building out of the OSHPD jurisdiction and decrease future costs of construction.

Consequences of Negative Action/Alternative Actions:
If we choose not to move forward with this project, it is likely our CT scanner will go down or be in need of highly expensive repairs. In addition, if we don't stay up to date with technology, patients may be referred elsewhere. There is an immediate need to begin this project as it will likely take at least 18 months to complete this project and the CT is already at the end of life. In addition, our current imaging waiting room would continue to be too small and inefficient. Finally, we could lose revenue if patients are redirected to hospitals with better technology and could lose out on potential revenue from increasing the outpatient CT scans and Cardiology diagnostics.

Business Case/Financial Impact:
The CT volumes are currently 3900/year with 40% Emergency and 17% Inpatient volumes. Therefore the Outpatient CT volumes make up 43%. The direct margin for Outpatient CT is currently $550,000. When we purchase the 128 slice CT, we have the capability of doing Cardiac testing which could increase outpatient CT revenues by over 20% or $110,000. When we bring the Cardiologists to the hospital next to the testing, we will increase Cardiology volumes for an increase in direct margin of $150,000 per year. We will also increase inpatient admissions with a Cardiologist on site for an estimated 36 admissions or $180,000 per year. The total impact of phase 1 on revenues is $440,000/year.

The design of phase 1 of the project cost is $1,111,362 and will be completely funded by donations. The cash outlay for 2018 is $1,323,420. This includes the purchase of a new portable Xray machine for $200,000. By January, 2019 we will have at least $2,755,154 in cash which will more than cover the expenses as we proceed. We plan to begin the Cardiology suite project this in 2019 which is estimated to cost less than $2 million. Current cash and pledges through 2020 is $6,524,052. We will need to have additional cash donations of $3,067,326 to cover the total cost of this project which we expect to have by early 2019. The Phase 1 CT project will likely break ground in fall of 2019.

Cash collected for project to date: $1,308,890
Cash spent on the project to date: $754,530
Current Cash for funding this phase 1 project: $524,080
Cash pledges still expected per year:

2018	**$2,231,074**
2019	**$1,385,609**
2020	**$2,383,289**
2021	**$318,232**
2022	**$268,102**

Attachments:

- Presentation by Vertran & Associates, Dome & Taylor
- Board Recommendation Letter from June, 2016

Meeting Date: June 2, 2016

Prepared by: Dawn Kuwahara, Chief Ancillary Officer

Agenda Item Title: Outpatient Diagnostics Center

Recommendation: To transform the current imaging and old operating area of the hospital into a centralized, full featured, streamlined Outpatient Diagnostics Center that focuses on a patient centric environment resulting in high quality care, outstanding patient and staff satisfaction, exceptional level of access and cost effective delivery of care. We plan to finance this project through the Sonoma Valley Hospital Foundation in a Capital Campaign starting in 2017.

Background: The current outpatient diagnostics department is in four separate areas. The current status is inefficient and requires an increased number of staff to operate in each area. The other limitations are as follows:

- The imaging and cardiopulmonary are poorly designed and inefficient, which is not productive and affects patient, physician and staff satisfaction.
- The 1950's layout in imaging is outdated and affects patient perception of quality.
- The MRI is in a trailer outside the lobby whereby patients need to access in all kinds of weather which is a consistent complaint from patients.
- The Mammography and Dexa Scanner are in another building several blocks away which requires separate registration and increases costs for connection to our hospital information technology at $45,000 per year.
- The patient flow from the Emergency department through radiology to the C.T. Scanner could be greatly improved by adding direct access.
- The waiting room in radiology is too small and insufficient which affects the patient satisfaction. Often times people are standing in the hallway.
- Cardiopulmonary is in rear of hospital and this means that the Nuclear Medicine patients have to walk down through the hospital for their tests.
- We currently have three reception areas for all of these departments.
- The staff work area is inadequate and affects staff productivity.

Consequences of Negative Action/Alternative Actions: To stay relevant in the health care industry, SVH must have modern equipment in efficient facilities focusing on patient centered care. Unnecessary costs will continue due to the inefficiencies of having the departments in separate areas. In addition, we could see revenue leakage if we do not update the department.

Financial Impact: The investment of approximately $20M with the assumption of at least 10% growth in revenue for several diagnostic procedures and a reduction in costs of at least $175,000 per year. This will be funded by the SVHF Capital Campaign.

Attachments: Map of the old area.

Sonoma Valley Hospital
Project Budgets - Phase 1, Cardiology, Decommissioning, Master Planning
6/29/18

Description	Phase 1 CT, Imaging Suite, Cent. Sched.	Cardiology Suite ROM	Central & East Wing Decomm Study/MRI	Master Planning ROM	TOTAL	2018 Funds Needed
Design: DD, CD, CA, Preconstruction Services (Dome/Taylor Pricing dated 6/26/208)	624,672	130,000	256,690	100,000	**1,111,362**	**835,445**
Permit Fees, Inspections	135,680	43,440	1,500		**180,620**	**50,630**
Dome Construction Preliminary Budget dated 6/25/2018	2,784,624	1,448,000	91,778	12,000		**146,778**
10% Contingency	278,462					
5% Escalation	153,154					
IDF - Metropolitan Electric	175,770					
Subtotal Construction	**3,392,011**	**1,448,000**	**91,778**	**12,000**	**4,943,789**	
Equipment + Furniture						
Furniture	35,000	25,000				
Equipment	210,000	45,000				**200,000**
CT	1,566,515					
Subtotal Equipment & Furniture	**1,811,515**	**70,000**	**-**	**-**	**1,881,515**	
IT and Communication						
IT Hardware/Software	50,000					
Phone system and VOIP	310,000					
Nurse Call	54,000					
IT Contingency (15%)	64,584	-				
Subtotal IT	**478,584**	**-**	**-**	**-**	**478,584**	
Operational Costs	32,500	10,000			**42,500**	
Project Management	128,000	43,440	15,000	25,000	**211,440**	**75,000**
Project Contingency (15% of Construction)	508,802	217,200	13,767	1,800	**741,568**	**15,567**
PROJECT TOTAL	**$ 7,111,764**	**$ 1,962,080**	**$ 378,735**	**$ 138,800**	**$ 9,591,378**	**$ 1,323,420**
Project Gross Square Footage (SF) =	**3,612**		**2,600**			
Project $/SF =	**$ 1,968.93**		**$ 754.65**			

Notes (Phase 1)
1.) Scope of Work in Schematic Design Phase
2.) Project Square Footage = 3,612
3.) Construction Project Budget as of 6/28/18 is preliminary based on Schematic Design documents.
4.) Furniture and Equipment scope of work unstudied. CT quote dated 6/28/18 is a preliminary proposal from Siemens
5.) IT and Communication scope of work not fully studied.
6.) Architect and Engineering Fees based upon proposal dated 6/26/18. Includes DD, CD and CA with Taylor et al and preconstruction services from Dome.
7.) Permit Fees and Inspection Services costs are an allowance.
8.) Project Schedule dated 6/25/18 to be further studied. Construction target start is August 2019 and target completion is 2nd quarter of 2020.
9.) Project Scope includes CT Suite, IDF, Reading Room, Elec. Closet, ADA Dressing Room, Reception/Subwait, Central Scheduling, Rad Hub, Staff Toilet, Linen Closet, Small Ultra Sound, Office, Patient and Public Corridor and WAH 5.

Notes (Cardiology)
1.) Scope of Work in Conceptual Phase
2.) Project Square Footage = 2,600
3.) Rough Order of Magnitude Budget is preliminary based on conceptual review on 6/28/18.
4.) Furniture and Equipment scope of work unstudied.
5.) IT and Communication scope of work unstudied.
6.) Architect and Engineering Fees based upon conceptual review.
7.) Permit Fees and Inspection Services costs are an allowance.
8.) Budget does not include replacing entry doors.

Board Meeting

Sonoma Valley Health Care District Board of Directors

July 5, 2018

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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Agenda

Mission & Vision

Mission: To provide patients with **easy access to an efficient, positive, and healing experience** by providing the **latest imaging equipment and cardiology testing** that will allow SVH to stay **relevant** in the current healthcare environment.

Vision: To transform the current **imaging department into an efficient, high technology** service area for our patients and staff. To provide Outpatient Diagnostic services **preferred by patients and physicians**, known for **exceptional quality and compassionate healthcare**.

Timeline

Discover

- Seismic Study
- Visioning Workshop, 3/06/2018
- Building Analysis
- Field Research, Observations, and Interviews, 3/13 – 3/14/2018
- Engineering Investigations, 3/14/2018

Define

- Programming & Test-Fits
- Insights & Planning Meeting, 4/04/2018
- Design concepts
- Engineering narratives
- Preliminary cost estimate

Develop

- Room Data Meetings, 4/30/2018
- City of Sonoma Meeting, 5/2/2018
- Concept development
- Landscape development
- Topographical survey
- Engineering drawings
- Update cost estimate

Deliver

- Design Development
- Construction Documents
- Agency Approval
- Construction

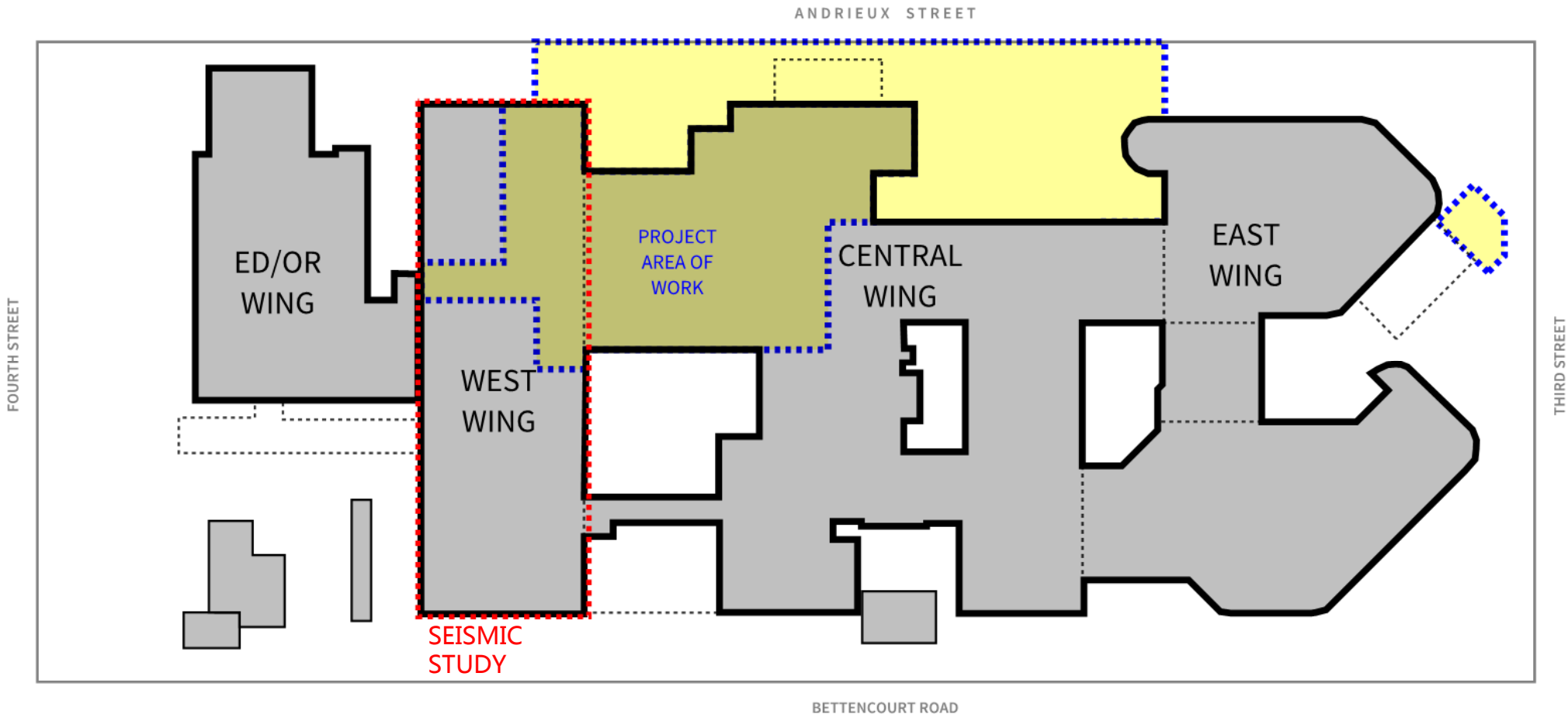
Priorities & Needs

- CT replacement is imminent, essential and needs more space
- Upgrade from 64-slice to 128-slice CT allows new revenue
- Upgrade the Cardiology services with physicians on site to increase revenue and improve patient experience
- Bring MRI inside building to improve the patient experience to better compete with upgraded technology
- Enhance efficiencies through Centralized Scheduling
- Assess West Wing for seismic upgrade
- Support case for single source capital fundraising campaign

Scopes of Work Studied

- Replace end-of-life CT
- Provide an efficient connection from new ED to CT
- Expand and improve Outpatient Reception/Waiting areas
- Repurpose currently vacated spaces
- Co-locate Imaging and Cardiopulmonary services together
- Provide MRI services inside the hospital
- Consolidate and upgrade IT components
- Assess scope of SPC-4D seismic upgrade to West Wing

Outpatient Diagnostic Project



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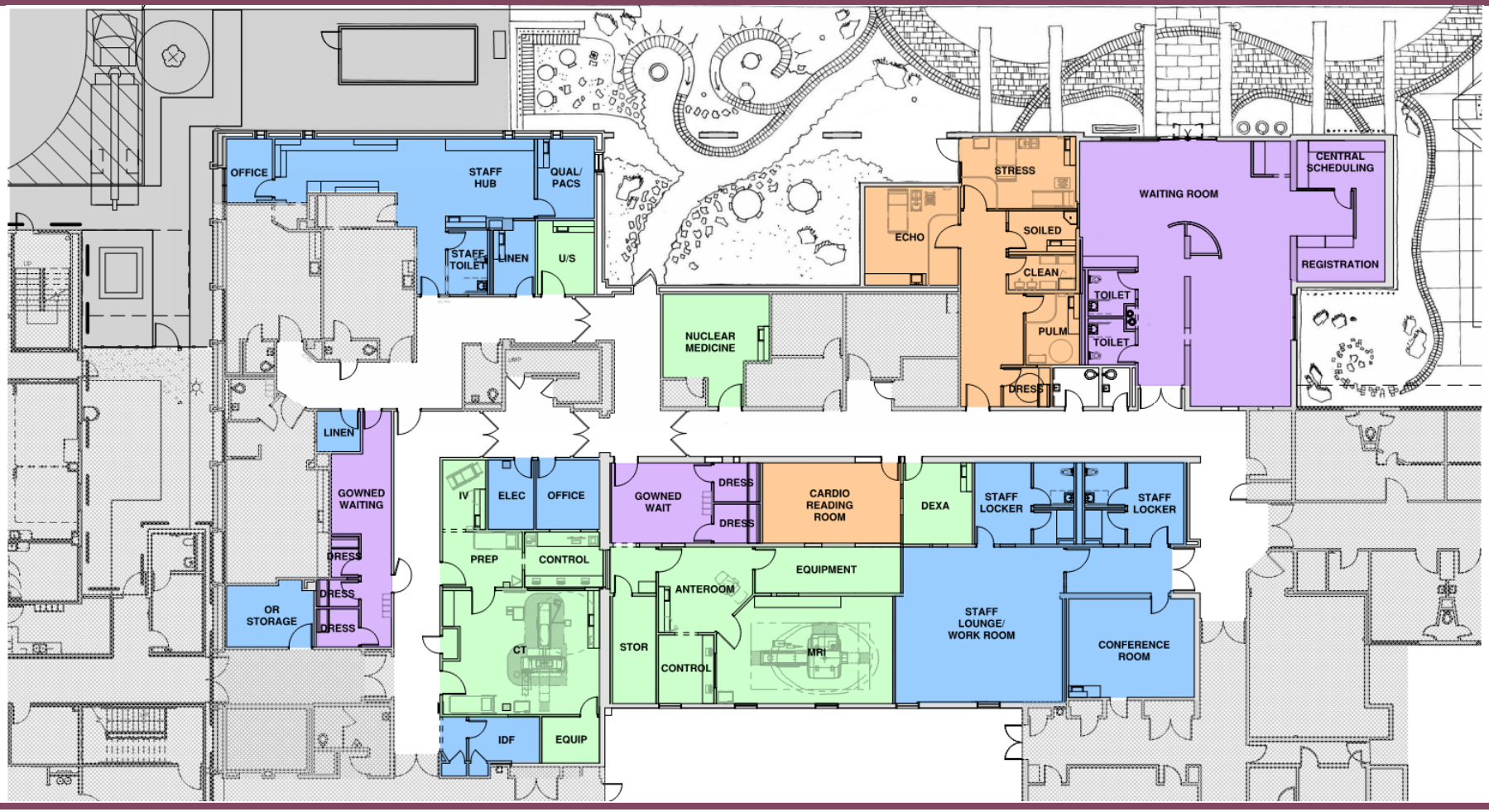
OD Schematic Design



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OD Schematic Design

OD Schematic Design

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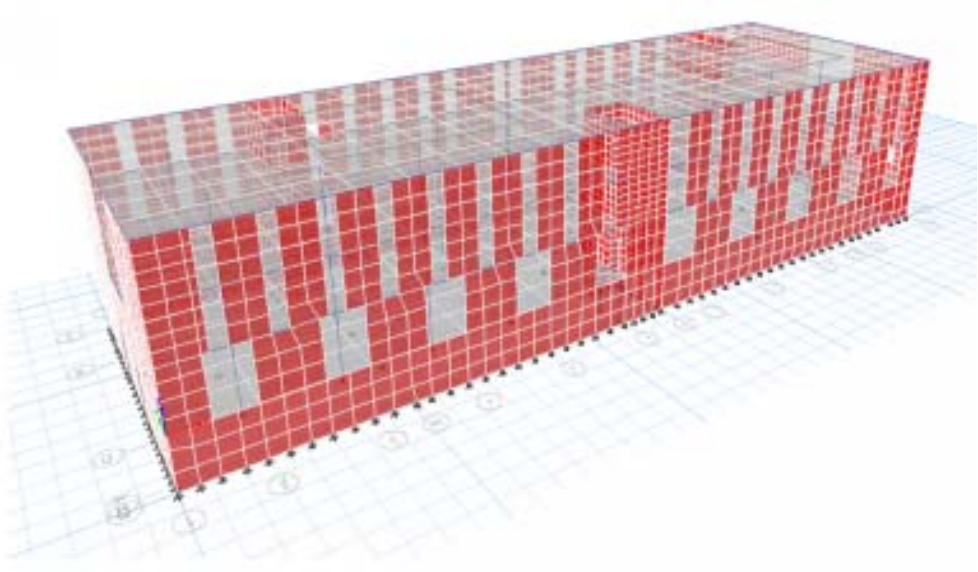
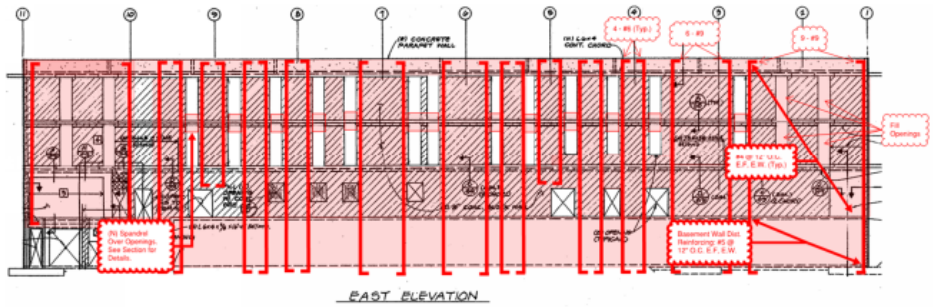
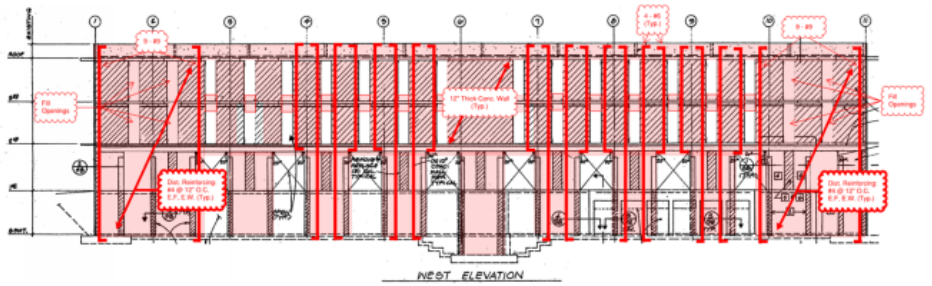
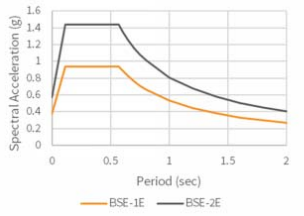


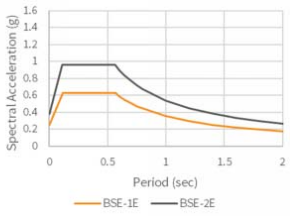


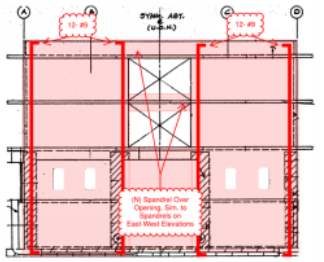


Hazard	Mapped Spectral Acceleration Parameters	Site Coefficients[1]	Site-Class Adjusted Spectral Acceleration Parameters
BSE-1E	S_s = 0.793 g	F_a = 1.183	S_{XS} = 0.938 g
	S_1 = 0.295 g	F_v = 1.810	S_{X1} = 0.534 g
BSE-2E	S_s = 1.431 g	F_a = 1.000	S_{XS} = 1.431 g
	S_1 = 0.539 g	F_v = 1.500	S_{X1} = 0.809 g

[1]For Site Class D



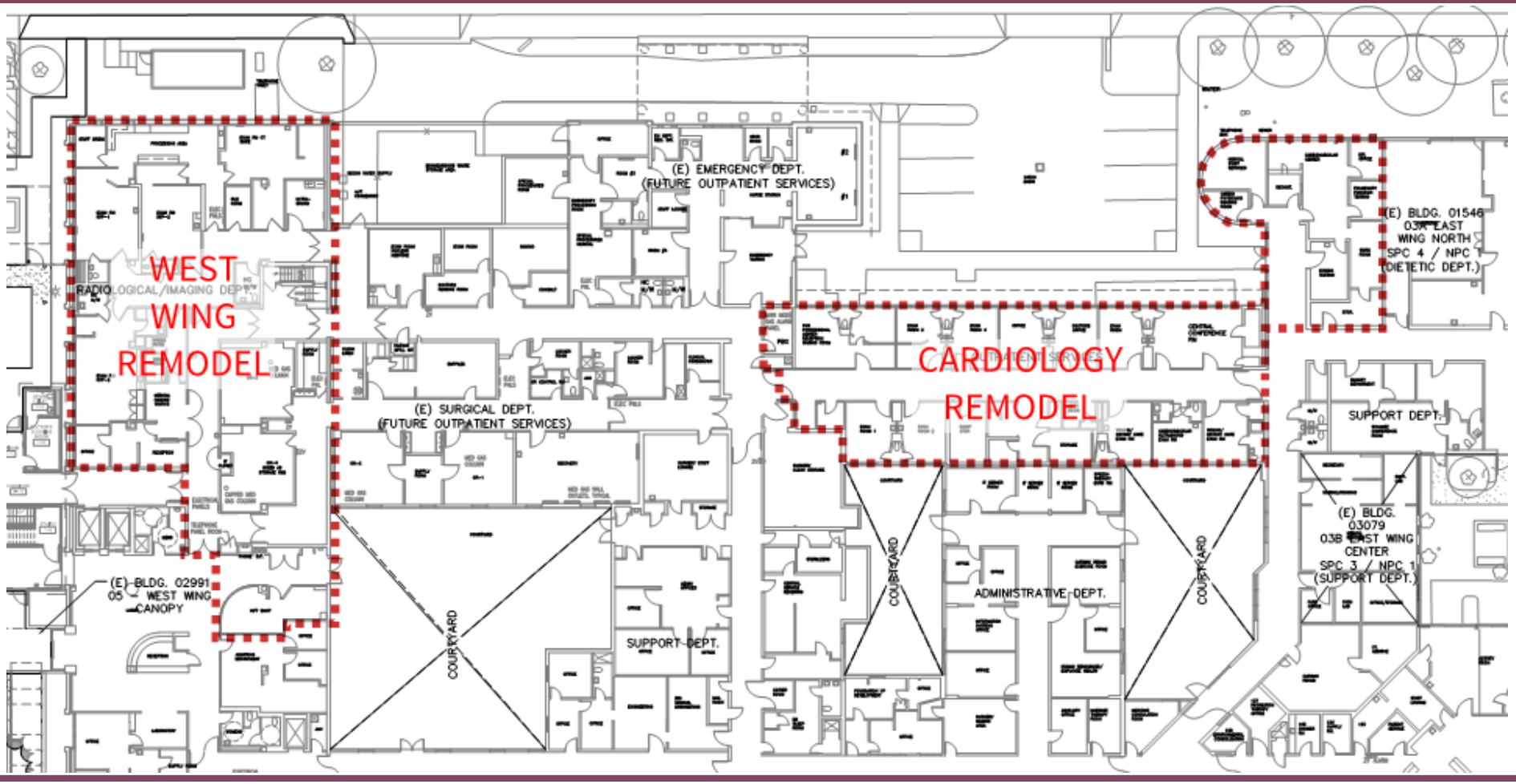




Current Recommendations

- Phase 1 Remodel: Provide new CT Scan suite, enlarge Imaging Reception/Waiting and Staff Hub, Central Scheduling in Main Lobby, and bring Cardiology on site.
- West Wing Seismic Upgrade – HOLD due to prohibitive costs
- Study Central and East Wing Decommissioning
- Master plan campus beyond 2030

Phase 1 Remodel



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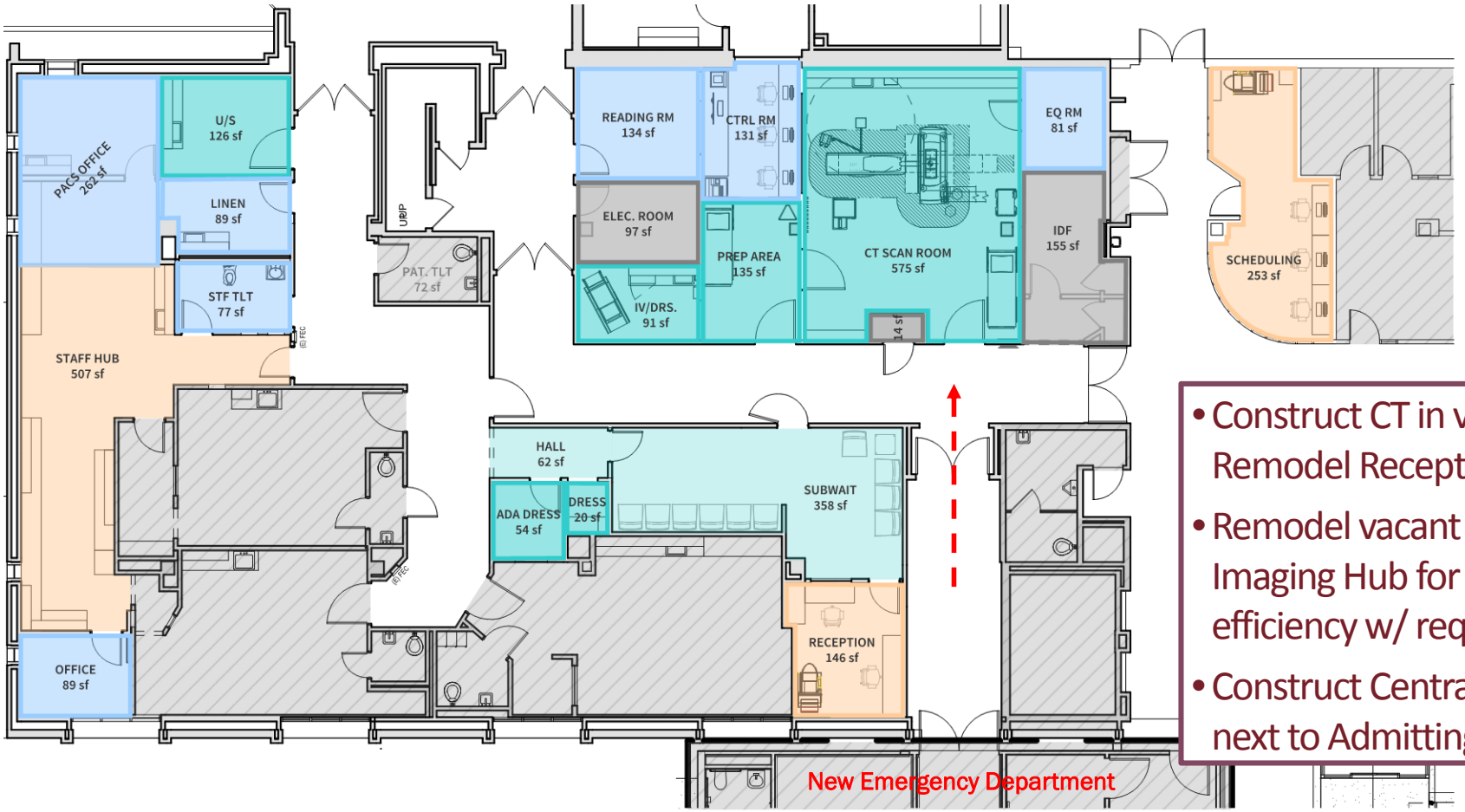
Phase 1 Remodel - West Wing



- Construct CT in vacant OR & Remodel Reception/Dressing
- Remodel vacant CT into Imaging Hub for staff efficiency w/ req'd Staff Toilet
- Construct Central Scheduling next to Admitting

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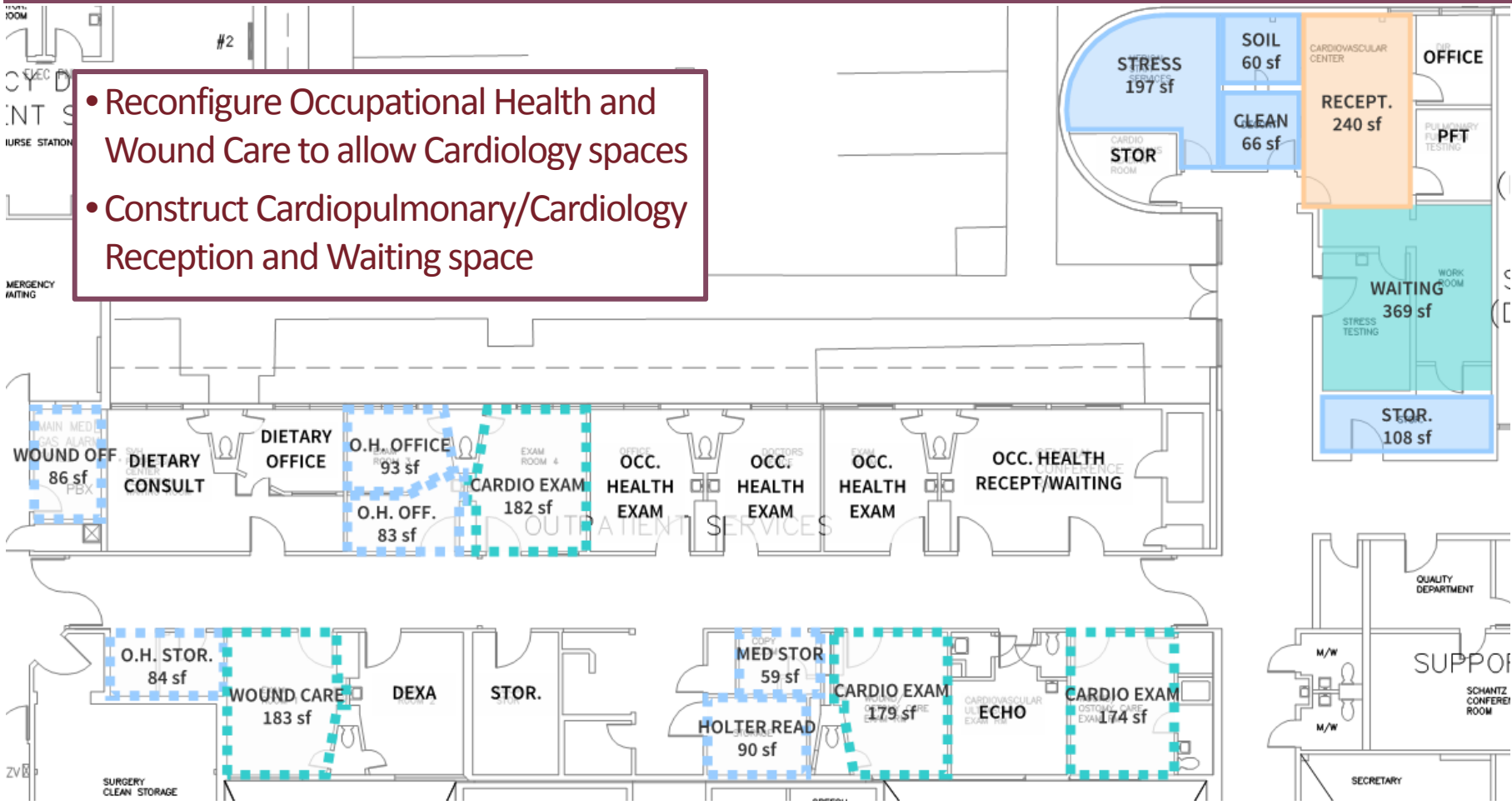
Phase 1 Remodel - Cardiology

- Reconfigure Occupational Health and Wound Care to allow Cardiology spaces
- Construct Cardiopulmonary/Cardiology Reception and Waiting space



Central & East Wings - Options

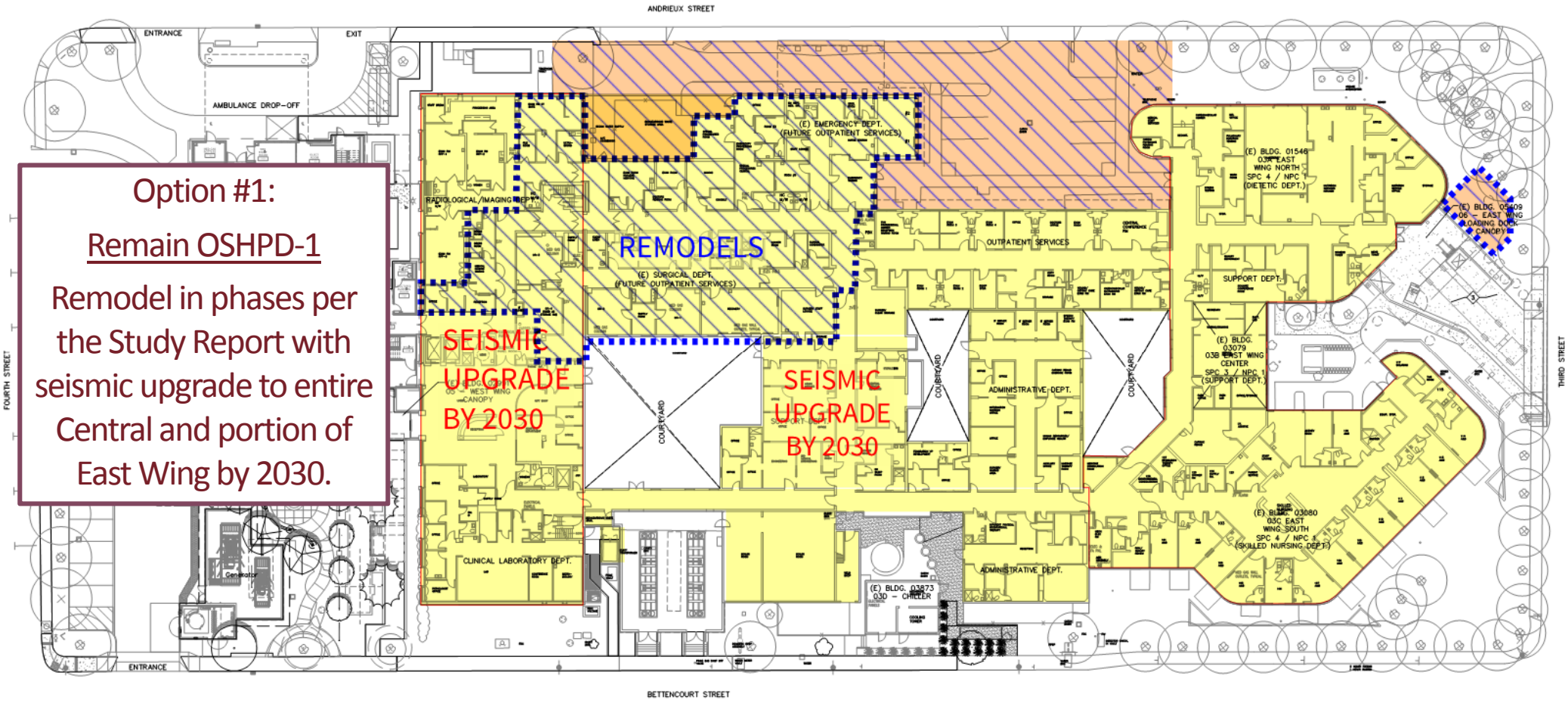
Central and East Wings – Option #1

- Remain OSHPD-1: Remodel in phases per the Study Report with seismic upgrade to Central Wing by 2030.

Central and East Wings – Option #2

- Decommission: Decommission Central and East Wings for future remodels, but leave south corridor in Central Wing as OSHPD-1 with seismic upgrade by 2030.

Central/East Wings Option #1 - Remain OSHPD



Option #1:

Remain OSHPD-1

Remodel in phases per the Study Report with seismic upgrade to entire Central and portion of East Wing by 2030.

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Central/East Wings Option #1 - Remain OSHPD

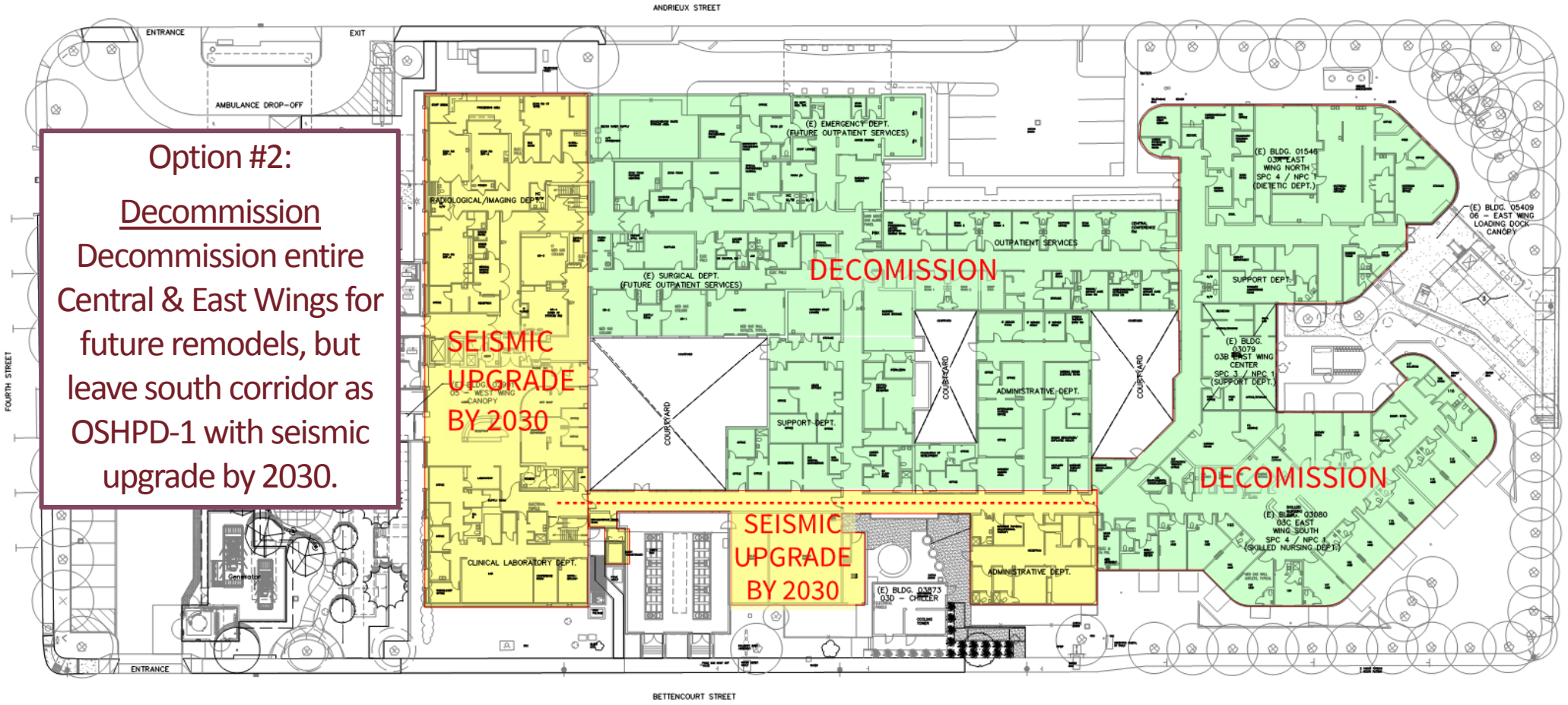
- Current and future modifications in Central and East Wings will continue to pay OSHPD premium
- Requires structural justification for remodels to Central Wing in short-term and costly seismic upgrade long-term
- Re-use of building limits ability to expand patient services long-term

Central/East Wings Option #2 - Decommission

Option #2:

Decommission

Decommission entire Central & East Wings for future remodels, but leave south corridor as OSHPD-1 with seismic upgrade by 2030.



Central/East Wings Option #2 - Decommission

- Future modifications in Central and East Wings can be reviewed more quickly at less cost and built faster
- Requires fire and structural separation walls
- Re-use of building limits ability to expand patient services long-term

SVH Campus Master Plan 2030+

Board Action Recommended

1. Approve Funding Request for Phase 1 Remodel
2. Approve Funding Request for Central and East Wing Decommissioning and MRI Studies
3. Approve Funding Request for Master Planning beyond 2030
4. Approve release of funds needed in 2018

Funding source will be the Sonoma Valley Hospital Foundation.

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Funding Requests

1. Funding request for completing design and construction services for the Phase 1 Remodel to CT / Imaging Suite / Central Scheduling/ Cardiology in the amount of $9,073,844.

• West Wing Design/Construction	$7,111,764
• CT Equipment Cost $1,566,515 included above	
• Cardiology Suite ROM	$1,962,080
• **Total Project Cost**	**$9,073,844**

Funding Requests

2. Funding request for the Central & East Wing Decommissioning Study & MRI in the amount of $378,735.
3. Funding request for Master Planning beyond 2030 in the amount of $138,800.
4. Funding needed in 2018 for the above design, construction and studies in the amount of $1,323,420.

Next Steps

- Complete Design and Construct Phase 1 Remodel
- Perform Central & East Wing Decommissioning Study
- Begin Master Planning beyond 2030
- Present Decommissioning Study Findings at Board Meeting in November 2018

Questions?

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5.

SVH FOUNDATION ANNUAL UPDATE

SVHF Progress & Goals

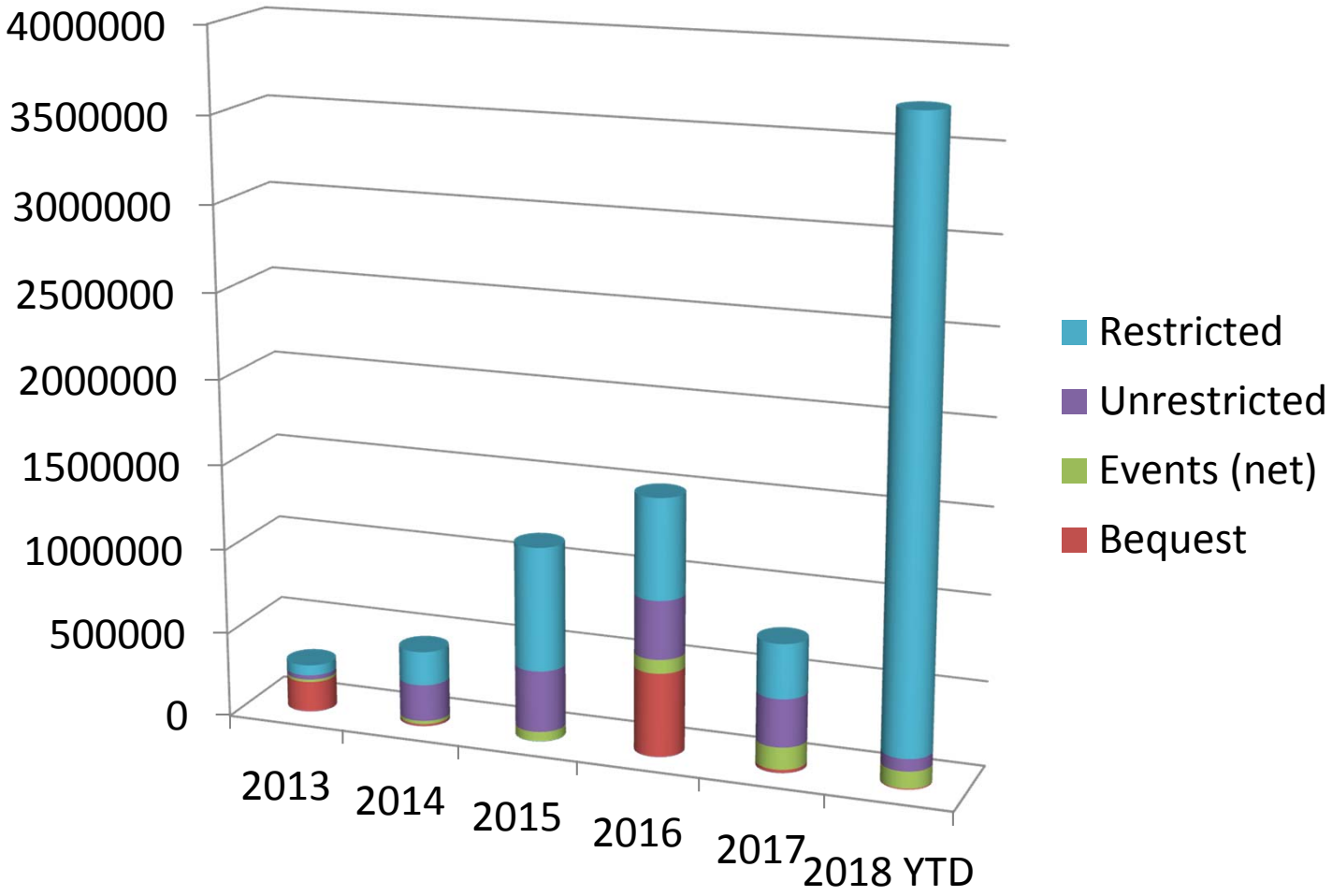
SONOMA VALLEY HOSPITAL
FOUNDATION
Inspiring Support for Sonoma Valley Hospital


EMERGENCY

SVHF Teamwork

- Board of volunteers
- Team
- Relationship with SVH

SVHF Revenue



Recent Accomplishments

- **Recently raised funds that have paid for:**
  - Stryker System in surgery suites
  - Women's Health equipment—Neoprobe, Hysteroscope
  - A Woman's Place remodel, equipment, and marketing needs to get started
  - Preparation and planning costs for the ODC Capital Campaign.
  - Construction costs for 3D Mammo placement at SVH.
  - Continued Education for Nurses and SVH staff $31,000 in 2017
  - Free mammograms for uninsured women
  - IT System Upgrade
  - Small Equipment needs ($89k in 2017)
- Collected $1.2M of ER Campaign Pledges in 2017

Foundation Focus

- ODC Capital Campaign
- Major gifts/significant foundations
- Stewardship
- Legacy Giving
- Marketing and Messaging

Outpatient Diagnostic Center Capital Campaign

- Campaign Timeline
  - Internal (Boards and Leadership)
  - Lead Gifts (quiet phase)
  - Employee Gifts Division
  - Medical Staff Gifts Division
  - Community Campaign
- Progress To Date

QUESTIONS?

6.

ADMINISTRATIVE REPORT JULY 2018

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

To: **SVHCD Board of Directors**
From: **Kelly Mather**
Date: **6/28/18**
Subject: **Administrative Report**

Summary
We are reinventing the hospital and have started the restructuring this summer. The board will discuss the new FY 2019 budget which starts in October at a special meeting in July.

Strategic Update from FY 2018 Strategic Plan:

Strategic Priorities	Update
Highest levels of health care safety, quality and value	➢ We have a new CMO – Dr. Sabrina Kidd ➢ We are changing the patient experience and quality sections of the organization dashboard in July. This will reflect more of the national quality measures and compare us to benchmarks. ➢ The first 100 day workout with 11 improvement projects are complete. This was a great exercise to increase urgency and make positive changes. ➢ Our mid-cycle accreditation survey is due any day now with CIHQ ➢ Dr. Adrienne Green, CMO of UCSF, has attended Medical Executive and the Board Quality committees
Be the preferred hospital for patients, physicians, employers and health plans	➢ Sonoma Family Practice is now a part of SVH and we have a nurse practitioner to increase access to primary care in Sonoma. ➢ Dr. Rainow, new Cardiologist, started in June and is going to be great for our patients and the community. Dr. Dunlap has also increased his presence to 4 days a week and plans to bring in another Cardiologist. ➢ We are doing a Master Facility Plan for the campus which will likely include a new Medical Office Building.
Implement new and enhanced revenue strategies as measured by increased direct margins in each service unit	➢ The UCSF collaboration is going well and we are moving forward with Tele-neurology. We are also setting up meetings with our physicians to gain input on a Urology service line. ➢ The Pain Management Network is moving forward and we are collaborating with the Health Center on this initiative. ➢ We have a new strategic process report that reflects volumes and margins that is very helpful.
Continue to improve financial stability as measured by operating margin	➢ We are recommending restructuring the hospital effective October 1st. ➢ The loan for the south lot is now with DeNova homes. ➢ Home Care has not yet been transferred but will be decided by the end of August. ➢ We are implementing a change in shift differential and PTO accruals effective July 27th.
Lead progress toward being a healthier community as measured by community benefit	➢ We have exceeded the goal for community benefit hours this year. Thanks to all the leaders for going above and beyond in their volunteer efforts. ➢ We are working with UCSF on telemedicine for Stroke and Neurology and also have Psychiatry coming on telemedicine this summer.

MAY 2018

Patient Experience	Current Performance	FY 2018 Goal	National Benchmark
Would Recommend Hospital	98th percentile	> 60th percentile	50th percentile
Inpatient Overall Rating	99th percentile	>60th percentile	50th percentile
Home Health	92%	> 90%	> 80%
Outpatient Services	4.8	Rate My Hospital	4.5
Emergency	4.5	Rate My Hospital	4.5
Quality & Safety	**YTD Performance**	**FY 2018 Goal**	**Benchmark**
Hospital Acquired Infections	5 of 6 <benchmark	5 of 6 <benchmark	6 of 6 < benchmark
30 Day All- Cause Readmissions	9.70%	< 10 %	< 18.5%
Serious Safety Events	0	0	0
Overall Surgical Site Infection Rate	0.43%	0.50%	n/a
Hand Hygiene	98%	>90%	>80%
Falls	1.6	< 2.3	2.3
Pressure Ulcers	0	<3.7	3.7
Injuries to Staff	13	< 10	17
Adverse Drug Events with Harm	1	0	0
C Section rate	11.3%	<20%	< 20%
Wound Care time to heal	22 days	< 30 days	< 31 days
Repeat Analysis in Radiology	3.25%	< 5%	< 5%
Reportable HIPAA Privacy Events	0	0	0
SNF Star Rating	4	4	3
Hospital Star Rating	4	4	3
Our People	**YTD Performance**	**FY 2018 Goal**	**Benchmark**
Press Ganey Engagement Survey	61st percentile	75th percentile	50th percentile
Wellness Ambassadors	253	250	> 200
Turnover	17.8%	< 10%	< 15%
Financial Stability	**YTD Performance**	**FY 2018 Goal**	**Benchmark**
EBDA	-1.2%	2.9%	3%
FTE's/AOB	4.35	4.3	5.3
Days Cash on Hand	6.2	20	30
Days in Accounts Receivable	47	49	50
Length of Stay	3.5	3.85	4.03
Cost per Medicare Beneficiary	$18,430	<$20,000	$20,473
Funds raised by SVHF	$8 million	$20 million	$1 million
Strategic Growth	**YTD Performance**	**FY 2018 Goal**	**Benchmark**
Inpatient Discharges	1049/1144	1193	1225
Outpatient Visits	48,807/53,244	57,771	55,566
Emergency Visits	9773/10,661	11,022	11,019
Surgeries	1698/1852	1,800	1,680
Births	97/106	132	120
Home Health Visits	8479/9249	11,053	11,400
Community Benefit Hours	1235/1348	1200	1200

Note: Colors demonstrate comparison to National Benchmark

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

TRENDED MONTHLY RESULTS

MEASUREMENT	Goal FY 2018	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2017
FY YTD Turnover	<10%	.9	3.1	5.3	6.8	9.7	9.7	11.3	12.9	14.2	16.2	17.8	9
Leave of Absences	<12	10	10	11	11	11	9	10	15	13	15	12	
EBDA	>3%	.1	-.9	-1.1	.1	-1.2	-1.4	2.2	-.6	-1.7	-1.8	-1.2	3.6
Operating Revenue	>5m	5.0	4.8	4.6	4.6	4.5	4.5	4.9	4.7	4.2	4.4	4.8	5.2
Expense Management	<5m	5.1	5.3	5.2	4.8	5.3	5.1	5.3	5.2	5.1	5.0	5.1	5.2
Net Income	>50k	-197	-164	-230	62	-379	-226	125	-174	-395	220	369	180
Days Cash on Hand	>20	16	10	9	12.5	14	17.4	23.5	14.1	6.7	6.8	6.2	20
A/R Days	<50	45	43	47	45	48	51	51	47	43	43	47	45
Total FTE's	<320	318	314	316	304	329	307	312	305	302	307	306	321
FTEs/AOB	<4.0	4.23	3.75	4.19	4.04	4.86	3.85	3.68	3.87	4.17	4.06	4.35	4.14
Inpatient Discharges	>90	76	94	87	87	99	96	111	82	106	103	108	87
Outpatient Revenue	>$13m	14.1	15.5	14.3	11.9	12.9	14.1	14.7	12.5	13.1	14.1	15.2	15.4
Surgeries	>150	162	164	187	120	155	160	141	139	151	144	175	197
Home Health	>950	870	713	789	871	630	798	801	821	684	755	747	940
Births	>11	6	10	5	12	11	10	7	11	8	6	9	15
SNF days	>550	528	500	479	624	468	563	646	494	566	525	423	458
MRI	>120	102	134	128	100	80	105	106	112	122	154	153	109
Cardiology (Echos)	>50	62	93	73	54	80	93	96	65	84	95	84	79
Laboratory	>12	11.9	12.2	11.6	10.8	12.0	11.4	12.9	10.6	12.3	11.5	12.5	11.8
Radiology	>850	881	966	870	757	882	891	1072	829	968	905	968	1137
Rehab	>2700	2362	2872	2502	2078	2945	2884	2593	2773	3091	2455	2586	2802
CT	>300	326	390	354	271	272	386	346	288	305	367	394	376
ER	>900	920	894	921	827	816	919	996	811	871	864	934	964
Mammography	>200	223	235	201	191	253	249	190	155	**363**	202	220	219
Ultrasound	>300	287	326	265	188	236	258	274	221	258	293	311	312
Occupational Health	>600	642	705	552	707	588	416	504	555	734	774	822	659
Wound Care	>200	226	263	287	287	203	277	204	122	182	210	237	307

7.

FINANCIAL REPORT
MONTH END MAY 31, 2018

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

To: **SVH Finance Committee**
From: **Ken Jensen, CFO**
Date: **June 25, 2018**
Subject: **Financial Report for the Month Ending May 31, 2018**

For the month of May inpatient volumes were close to budget with higher acuity levels which led to a higher gross revenue. Outpatient volumes were above budget primarily in outpatient surgeries and special procedures. Emergency volume was at budgeted expectations.

The actual loss of ($305,498) from operations in May was $179,947 favorable to the budgeted loss of ($485,445). After accounting for all other activity; May's net income was $369,158 vs. the budgeted loss of ($72,948) with a monthly EBIDA of 5.5% vs. a budgeted 1.8%.

Gross patient revenue for May was $23,960,938; $1,087,391 over budget. Inpatient gross revenue was over budget by $912,791. Inpatient days were under budget by (10) days and inpatient surgeries were under budgeted expectations by (5) cases but there was an overall higher acuity than budgeted. Outpatient revenue was over budget by $142,646. Outpatient visits were over budgeted expectations by 37 visits, and outpatient surgeries were over budgeted expectations by 26 case. The Emergency Room gross revenue was over budget by $375,465 with ER visits close to budgeted expectations at 934 visits. SNF gross charges were under budgeted expectations by ($308,258) and SNF patient days were under budget by (106) days. Home Health was under budget by ($35,253) with visits under budget by (148) visits which is due to seeing a reduced number of Kaiser HHA patients.

Gross revenue from surgical implants in May is $490,523 with $280,355 from inpatient surgeries and $210,168 from outpatient surgeries, and total implant costs were ($183,473). The net, before any revenue deductions, is $307,050.

Deductions from revenue were unfavorable to budgeted expectations by ($1,129,559). Of the variance, ($116,747) is from the budgeted prior period adjustments or IGT payments. Without the budgeted IGT variance, the deductions from revenue variance is unfavorable by ($1,012,812) which is due primarily to gross revenue being over budgeted expectation.

The variance was also impacted by a continued negative shift in payer mix with Medicare volume increasing by 2.7% points over budget and Commercial volume dropping by -2.8% points.

After accounting for all other operating revenue, the **total operating revenue** was unfavorable to budgeted expectations by ($85,063).

Operating Expenses of $5,134,151 were favorable to budget by $265,010. Salaries and wages and agency fees were under budget by $84,080. Salaries and wages were under budget by $161,166 and agency fees were over budget by ($77,086). Professional fees were under budget by $23,097 due to the reconciliation of the Sound Physicians year-end bonus invoice. There was no matching fee in May.

For the month of May, the hospital saved $83,049 attributable to the cost savings plan implemented January 1, 2018. From January 1, 2018 through May, the total savings is $512,643. See attachment I for details.

After accounting for all income and expenses, but not including Restricted Contributions and GO bond activity, the net loss for May was ($64,533) vs. a budgeted net loss of ($236,683). The hospital received $288,617 in restricted donations from the Foundation for the Women's Place, 3D mammography and OP Diagnostic Center projects. The total net income for May after all activity was $369,158 vs. a budgeted net loss of ($72,948).

EBIDA for the month of May was 5.5% vs. the budgeted 1.8%.

Patient Volumes – May

	ACTUAL	BUDGET	VARIANCE	PRIOR YEAR
Acute Discharges	**108**	**99**	**9**	**100**
Newborn Discharges	**9**	**15**	**-6**	**7**
Acute Patient Days	**374**	**384**	**-10**	**388**
SNF Patient Days	**423**	**529**	**-106**	**559**
Home Care Visits	**747**	**895**	**-148**	**966**
OP Gross Revenue	**$15,188**	**$14,690**	**$498**	**$15,523**
Surgical Cases	**175**	**154**	**21**	**173**

Gross Revenue Overall Payer Mix – May

	ACTUAL	BUDGET	VARIANCE	YTD ACTUAL	YTD BUDGET	VARIANCE
Medicare	**42.7%**	**44.9%**	**-2.2%**	**44.3%**	**45.5%**	**-1.2%**
Medicare Mgd Care	**14.9%**	**10.0%**	**4.9%**	**13.2%**	**10.0%**	**3.2%**
Medi-Cal	**18.2%**	**17.9%**	**0.3%**	**17.9%**	**17.9%**	**0.0%**
Self Pay	**1.6%**	**1.3%**	**0.3%**	**1.2%**	**1.2%**	**0.0%**
Commercial	**17.9%**	**20.7%**	**-2.8%**	**19.1%**	**20.4%**	**-1.3%**
Workers Comp	**2.6%**	**3.1%**	**-0.5%**	**2.2%**	**3.0%**	**-0.8%**
Capitated	**2.1%**	**2.1%**	**0.0%**	**2.1%**	**2.0%**	**0.1%**
Total	**100.0%**	**100.0%**		**100.0%**	**100.0%**	

Cash Activity for May:

For the month of May the cash collection goal was $3,098,675 and the Hospital collected $3,594,966 or over the goal by $496,291. The year-to-date cash collection goal was $38,596,753 and the Hospital has collected $40,260,499 or over goal by $1,663,746. Days of cash on hand are 6.2 days at May 31, 2018. Accounts Receivable increased from April, from 42.9 days to 46.8 days in May. Accounts Payable increased by $22,497 from April and Accounts Payable days are at 40.9.

ATTACHMENTS:

-Attachment A is the Payer Mix Analysis which includes the projected collection percentage by payer.
-Attachment B is the Operating Indicators Report
-Attachment C is the Balance Sheet
-Attachment D (two pages) is the Statement of Revenue and Expense. The first page breaks out the hospital operations and page two includes all other activity.
-Attachment E is the Variance Analysis. The line number tie to the Statement of Revenue and Expense line numbers and explains any significant variances.
-Attachment F are the graphs for Revenue and Accounts Payable.
-Attachment G is the Statistical Analysis
-Attachment H is the Cash Forecast
-Attachment I is the Cash Savings from cost reduction plan implemented 1/1/2018

Sonoma Valley Hospital
Payer Mix for the month of May, 2018

ATTACHMENT A

	May-18				YTD			
Gross Revenue:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	10,234,754	10,267,301	-32,547	-0.3%	107,600,759	114,535,533	-6,934,774	-6.1%
Medicare Managed Care	3,571,377	2,284,437	1,286,940	56.3%	31,991,171	25,073,305	6,917,866	27.6%
Medi-Cal	4,366,549	4,082,474	284,075	7.0%	43,400,654	45,004,975	-1,604,321	-3.6%
Self Pay	391,364	289,535	101,829	35.2%	2,839,430	3,119,494	-280,064	-9.0%
Commercial & Other Government	4,296,189	4,749,624	-453,435	-9.5%	46,383,581	51,508,490	-5,124,909	-9.9%
Worker's Comp.	618,627	725,052	-106,425	-14.7%	5,289,408	7,677,090	-2,387,682	-31.1%
Capitated	482,078	475,124	6,954	1.5%	4,998,762	5,129,600	-130,838	-2.6%
Total	**23,960,938**	**22,873,547**	**1,087,391**		**242,503,765**	**252,048,487**	**(9,544,722)**	

Net Revenue:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	1,523,218	1,506,585	16,633	1.1%	16,348,578	17,160,070	-811,492	-4.7%
Medicare Managed Care	475,709	293,288	182,421	62.2%	4,604,302	3,219,105	1,385,197	43.0%
Medi-Cal	775,394	596,641	178,753	30.0%	6,351,636	6,235,812	115,824	1.9%
Self Pay	223,077	130,499	92,578	70.9%	1,487,596	1,495,801	-8,205	-0.5%
Commercial & Other Government	1,371,884	1,723,285	-351,401	-20.4%	15,095,163	18,882,533	-3,787,370	-20.1%
Worker's Comp.	143,212	187,396	-44,184	-23.6%	1,137,683	1,909,269	-771,586	-40.4%
Capitated	15,185	15,406	-221	-1.4%	157,168	172,774	-15,606	-9.0%
Prior Period Adj/IGT	196,525	313,272	-116,747	-37.3%	4,346,863	3,445,992	900,871	26.1%
Total	**4,724,204**	**4,766,372**	**(42,168)**	**-0.9%**	**49,528,989**	**52,521,356**	**(2,992,367)**	**-5.7%**

Percent of Net Revenue:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	32.3%	31.6%	0.7%	2.2%	33.0%	32.7%	0.2%	0.6%
Medicare Managed Care	10.1%	6.2%	3.9%	62.9%	9.3%	6.1%	3.2%	52.5%
Medi-Cal	20.6%	19.1%	1.5%	7.9%	21.6%	18.4%	3.2%	17.4%
Self Pay	4.7%	2.7%	2.0%	74.1%	3.0%	2.8%	0.2%	7.1%
Commercial & Other Government	29.0%	36.2%	-7.2%	-19.9%	30.5%	36.1%	-5.6%	-15.5%
Worker's Comp.	3.0%	3.9%	-0.9%	-23.1%	2.3%	3.6%	-1.3%	-36.1%
Capitated	0.3%	0.3%	0.0%	0.0%	0.3%	0.3%	0.0%	0.0%
Total	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**-0.1%**	**-0.1%**

Projected Collection Percentage:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	14.9%	14.7%	0.2%	1.4%	15.2%	15.0%	0.2%	1.3%
Medicare Managed Care	13.3%	12.8%	0.5%	3.9%	14.4%	12.8%	1.6%	12.5%
Medi-Cal	22.3%	22.3%	0.0%	0.0%	24.7%	21.5%	3.2%	14.9%
Self Pay	56.9%	45.1%	11.8%	26.2%	52.4%	48.0%	4.4%	9.2%
Commercial & Other Government	31.9%	36.3%	-4.4%	-12.1%	32.5%	36.7%	-4.2%	-11.4%
Worker's Comp.	23.1%	25.8%	-2.7%	-10.5%	21.5%	24.9%	-3.4%	-13.7%
Capitated	3.1%	3.2%	-0.1%	-3.1%	3.1%	3.4%	-0.3%	-8.8%

SONOMA VALLEY HOSPITAL
OPERATING INDICATORS
For the Period Ended May 31, 2018

ATTACHMENT B

	CURRENT MONTH				YEAR-TO-DATE			YTD
	Actual 05/31/18	Budget 05/31/18	Favorable (Unfavorable) Variance		Actual 05/31/18	Budget 05/31/18	Favorable (Unfavorable) Variance	Prior Year 05/31/17
				Inpatient Utilization				
				Discharges				
1	96	84	12	Acute	897	981	(84)	995
2	12	15	(3)	ICU	152	175	(23)	126
3	108	99	9	Total Discharges	1,049	1,156	(107)	1,121
4	9	15	(6)	Newborn	97	156	(59)	124
5	117	113	4	Total Discharges inc. Newborns	1,146	1,312	(166)	1,245
				Patient Days:				
6	282	292	(10)	Acute	2,716	3,391	(675)	3,355
7	92	92	-	ICU	929	1,081	(152)	1,079
8	374	384	(10)	Total Patient Days	3,645	4,472	(827)	4,434
9	16	30	(14)	Newborn	168	320	(152)	236
10	390	414	(24)	Total Patient Days inc. Newborns	3,813	4,792	(979)	4,670
				Average Length of Stay:				
11	2.9	3.5	(0.5)	Acute	3.0	3.5	(0.4)	3.4
12	7.7	6.2	1.5	ICU	6.1	6.2	(0.1)	8.6
13	3.5	3.9	(0.4)	Avg. Length of Stay	3.5	3.9	(0.4)	4.0
14	1.8	2.0	(0.3)	Newborn ALOS	1.7	2.0	0.3	1.9
				Average Daily Census:				
15	9.1	9.4	(0.3)	Acute	8.1	10.1	(2.0)	10.0
16	3.0	3.0	-	ICU	2.8	3.2	(0.5)	3.2
17	12.1	12.4	(0.3)	Avg. Daily Census	10.9	13.3	(2.5)	13.2
18	0.5	1.0	(0.4)	Newborn	0.50	0.96	(0.5)	0.70
				Long Term Care:				
19	423	529	(106)	SNF Patient Days	5,816	6,203	(387)	6,095
20	24	23	1	SNF Discharges	328	273	55	329
21	13.6	17.1	(3.4)	Average Daily Census	17.4	18.5	(1.2)	18.2
				Other Utilization Statistics				
				Emergency Room Statistics				
22	934	940	(6)	Total ER Visits	9,773	10,115	(342)	10,181
				Outpatient Statistics:				
23	4,810	4,773	37	Total Outpatients Visits	48,807	52,391	(3,584)	50,710
24	29	34	(5)	IP Surgeries	306	362	(56)	408
25	146	120	26	OP Surgeries	1,392	1,163	229	1,171
26	72	26	46	Special Procedures	762	352	410	477
27	747	895	(148)	Home Health Visits	8,479	10,144	(1,665)	10,177
28	361	342	19	Adjusted Discharges	3,721	3,702	19	3,749
29	2,178	2,556	(378)	Adjusted Patient Days (Inc. SNF)	25,578	27,671	(2,093)	27,175
30	70.2	82.4	(12.2)	Adj. Avg. Daily Census (Inc. SNF)	76.4	82.6	(6.2)	81.1
31	1.4642	1.4000	0.064	Case Mix Index -Medicare	1.5099	1.4000	0.110	1.6480
32	1.4381	1.4000	0.038	Case Mix Index - All payers	1.4756	1.4000	0.076	1.5675
				Labor Statistics				
33	279	287	7.4	FTE's - Worked	277	285	8.2	283
34	306	328	22.3	FTE's - Paid	311	326	15.3	318
35	44.17	42.61	(1.55)	Average Hourly Rate	42.87	42.72	(0.14)	40.85
36	24.8	22.7	(2.1)	Manhours / Adj. Pat Day	23.2	22.5	(0.7)	22.3
37	149.6	169.4	19.8	Manhours / Adj. Discharge	159.5	168.2	8.7	161.9
38	22.0%	21.6%	-0.5%	Benefits % of Salaries	22.5%	22.0%	-0.5%	23.1%
				Non-Labor Statistics				
39	11.4%	11.6%	0.2%	Supply Expense % Net Revenue	11.8%	10.7%	-1.1%	12.7%
40	1,517	1,655	139	Supply Exp. / Adj. Discharge	1,610	1,556	(54)	1,751
41	14,686	16,263	1,577	Total Expense / Adj. Discharge	15,934	16,249	315	15,502
				Other Indicators				
42	6.2			Days Cash - Operating Funds				
43	46.8	50.0	(3.2)	Days in Net AR	46.2	50.0	(3.8)	49.1
44	116%			Collections % of Net Revenue	104%			106.5%
45	40.9	55.0	(14.1)	Days in Accounts Payable	40.9	55.0	(14.1)	26.8
46	20.1%	21.4%	-1.3%	% Net revenue to Gross revenue	21.0%	21.4%	-0.5%	21.4%
47	21.6%			% Net AR to Gross AR	21.6%			21.6%

Sonoma Valley Health Care District

ATTACHMENT C

Balance Sheet

As of May 31, 2018

		Current Month	Prior Month	Prior Year
	Assets			
	Current Assets:			
1	Cash	$ 798,439	$ 1,101,646	$ 2,951,248
2	Trustee Funds	4,427,002	3,628,488	3,962,198
3	Net Patient Receivables	8,024,134	7,523,327	8,930,499
4	Allow Uncollect Accts	(1,140,279)	(1,091,983)	(1,412,630)
5	Net A/R	6,883,855	6,431,344	7,517,869
6	Other Accts/Notes Rec	(119,068)	819,250	(37,582)
7	3rd Party Receivables, Net	2,462,520	2,333,644	1,510,169
8	Inventory	825,295	818,935	828,042
9	Prepaid Expenses	728,235	924,013	810,003
10	Total Current Assets	$ 16,006,278	$ 16,057,320	$ 17,541,947
12	Property,Plant & Equip, Net	$ 51,903,277	$ 51,903,384	$ 53,317,990
13	Specific Funds/ Money Market	203,535	203,518	918,635
14	Other Assets	-	-	-
15	Total Assets	$ 68,113,090	$ 68,164,222	$ 71,778,572
	Liabilities & Fund Balances			
	Current Liabilities:			
16	Accounts Payable	$ 3,159,819	$ 3,137,322	$ 3,450,471
17	Accrued Compensation	4,288,600	3,963,962	4,274,878
18	Interest Payable	423,097	317,320	441,063
19	Accrued Expenses	1,343,607	1,408,467	1,466,823
20	Advances From 3rd Parties	144,347	126,897	160,112
21	Deferred Tax Revenue	567,350	1,134,700	496,909
22	Current Maturities-LTD	1,186,364	1,206,336	1,296,874
23	Line of Credit - Union Bank	6,973,734	6,973,734	6,973,734
24	Other Liabilities	2,001,386	2,001,386	1,386
25	Total Current Liabilities	$ 20,088,304	$ 20,270,124	$ 18,562,250
26	Long Term Debt, net current portion	$ 32,875,471	$ 33,113,941	$ 37,239,907
27	Fund Balances:			
28	Unrestricted	$ 10,100,898	$ 10,020,524	$ 12,172,504
29	Restricted	5,048,416	4,759,632	3,803,912
30	Total Fund Balances	$ 15,149,315	$ 14,780,157	$ 15,976,415
31	Total Liabilities & Fund Balances	$ 68,113,090	$ 68,164,222	$ 71,778,572

ATTACHMENT D

Sonoma Valley Health Care District
Statement of Revenue and Expenses
Comparative Results
For the Period Ended May 31, 2018

	Month					Year-To- Date				YTD
	This Year		Variance			This Year		Variance		
	Actual	Budget	$	%		Actual	Budget	$	%	Prior Year
					Volume Information					
1	108	99	9	9%	Acute Discharges	1,049	1,156	(107)	-9%	1,121
2	423	529	(106)	-20%	SNF Days	5,816	6,203	(387)	-6%	6,095
3	747	895	(148)	-17%	Home Care Visits	8,479	10,144	(1,665)	-16%	10,177
4	15,188	14,690	498	3%	Gross O/P Revenue (000's)	$ 152,612	$ 154,701	(2,089)	-1%	$ 148,360
					Financial Results					
					Gross Patient Revenue					
5	$ 7,154,464	$ 6,241,673	912,791	15%	Inpatient	$ 67,760,250	$ 74,710,772	(6,950,522)	-9%	$ 72,534,650
6	8,185,712	8,043,066	142,646	2%	Outpatient	83,902,662	83,025,803	876,859	1%	77,721,749
7	6,734,598	6,359,133	375,465	6%	Emergency	65,764,933	68,393,300	(2,628,367)	-4%	67,298,923
8	1,613,265	1,921,523	(308,258)	-16%	SNF	21,973,271	22,429,459	(456,188)	-2%	21,302,265
9	272,899	308,152	(35,253)	-11%	Home Care	3,102,649	3,489,153	(386,504)	-11%	3,565,972
10	**$ 23,960,938**	**$ 22,873,547**	**1,087,391**	**5%**	**Total Gross Patient Revenue**	**$ 242,503,765**	**$ 252,048,487**	**(9,544,722)**	**-4%**	**$ 242,423,559**
					Deductions from Revenue					
11	$ (19,262,985)	$ (18,297,840)	(965,145)	-5%	Contractual Discounts	$ (195,527,910)	$ (201,624,446)	6,096,536	3%	$ (192,948,826)
12	(150,000)	(100,000)	(50,000)	-50%	Bad Debt	(1,603,000)	(1,100,000)	(503,000)	-46%	(1,615,000)
13	(20,274)	(22,607)	2,333	10%	Charity Care Provision	(190,729)	(248,677)	57,948	23%	(333,043)
14	196,525	313,272	(116,747)	-37%	Prior Period Adj/Government Program Revenue	4,346,863	3,445,992	900,871	*	2,878,020
15	**$ (19,236,734)**	**$ (18,107,175)**	**(1,129,559)**	**6%**	**Total Deductions from Revenue**	**$ (192,974,776)**	**$ (199,527,131)**	**6,552,355**	**-3%**	**$ (192,018,849)**
16	**$ 4,724,204**	**$ 4,766,372**	**(42,168)**	**-1%**	**Net Patient Service Revenue**	**$ 49,528,989**	**$ 52,521,356**	**(2,992,367)**	**-6%**	**$ 50,404,710**
17	$ 92,993	$ 128,521	(35,528)	-28%	Risk contract revenue	$ 1,263,243	$ 1,413,731	(150,488)	-11%	$ 1,424,750
18	$ 4,817,197	$ 4,894,893	(77,696)	-2%	Net Hospital Revenue	$ 50,792,232	$ 53,935,087	(3,142,855)	-6%	$ 51,829,460
19	$ 11,456	$ 18,823	(7,367)	**-39%**	Other Op Rev & Electronic Health Records	$ 169,920	$ 207,053	(37,133)	-18%	$ 323,693
20	**$ 4,828,653**	**$ 4,913,716**	**(85,063)**	**-2%**	**Total Operating Revenue**	**$ 50,962,152**	**$ 54,142,140**	**(3,179,988)**	**-6%**	**$ 52,153,153**
					Operating Expenses					
21	$ 2,383,565	$ 2,467,645	84,080	3%	Salary and Wages and Agency Fees	$ 25,437,939	$ 26,600,810	1,162,871	4%	$ 24,794,840
22	869,736	$ 905,718	35,982	4%	Employee Benefits	9,534,075	9,908,895	374,820	4%	9,735,340
23	$ 3,253,301	$ 3,373,363	120,062	4%	Total People Cost	$ 34,972,014	$ 36,509,705	1,537,691	4%	$ 34,530,180
24	$ 386,234	$ 409,331	23,097	6%	Med and Prof Fees (excld Agency)	$ 4,638,226	$ 4,503,294	(134,932)	-3%	$ 4,255,099
25	546,968	565,903	18,935	3%	Supplies	5,988,809	5,759,685	(229,124)	-4%	6,563,590
26	384,880	376,471	(8,409)	-2%	Purchased Services	4,008,986	4,140,096	131,110	3%	3,569,006
27	278,851	282,312	3,461	1%	Depreciation	3,132,436	3,105,432	(27,004)	-1%	3,100,581
28	95,885	101,622	5,737	6%	Utilities	1,099,454	1,117,842	18,388	2%	1,089,403
29	31,819	27,614	(4,205)	-15%	Insurance	350,009	303,754	(46,255)	-15%	325,155
30	49,579	42,185	(7,394)	-18%	Interest	519,351	488,816	(30,535)	-6%	491,662
31	106,634	133,927	27,293	20%	Other	1,295,347	1,505,477	210,130	14%	1,513,331
32	-	86,433	86,433	*	Matching Fees (Government Programs)	1,491,827	950,763	(541,064)	-57%	1,032,445
33	**$ 5,134,151**	**$ 5,399,161**	**265,010**	**5%**	**Operating expenses**	**$ 57,496,459**	**$ 58,384,864**	**888,405**	**2%**	**$ 56,470,452**
34	**$ (305,498)**	**$ (485,445)**	**179,947**	**37%**	**Operating Margin**	**$ (6,534,307)**	**$ (4,242,724)**	**(2,291,583)**	**-54%**	**$ (4,317,299)**

ATTACHMENT D

Sonoma Valley Health Care District
Statement of Revenue and Expenses
Comparative Results
For the Period Ended May 31, 2018

	Month						Year-To- Date				YTD
	This Year		Variance			This Year		Variance		
	Actual	Budget	$	%		Actual	Budget	$	%	Prior Year
					Non Operating Rev and Expense					
35	$ (19,436)	$ (13,222)	(6,214)	47%	Miscellaneous Revenue/(Expenses)	$ (75,397)	$ (143,034)	67,637	*	$ (100,322)
36	500	-	500	0%	Donations	27,546	-	27,546	0%	101,351
37	(56,766)	(54,683)	(2,083)	4%	Physician Practice Support-Prima	(624,426)	(601,513)	(22,913)	4%	(412,500)
38	316,667	316,667	-	0%	Parcel Tax Assessment Rev	3,483,337	3,483,337	-	0%	2,750,378
39	0	0	-	0%	Extraordinary Items	(26,875)	0	(26,875)	0%	
40	**$ 240,965**	**$ 248,762**	**(7,797)**	**-3%**	**Total Non-Operating Rev/Exp**	**$ 2,784,185**	**$ 2,738,790**	**72,270**	**2%**	**$ 2,338,907**
41	**$ (64,533)**	**$ (236,683)**	**172,150**	**-73%**	**Net Income / (Loss) prior to Restricted Contributions**	**$ (3,750,122)**	**$ (1,503,934)**	**(2,219,313)**	**148%**	**$ (1,978,392)**
42	$ 167	$ 18,828	(18,661)	-99%	Capital Campaign Contribution	$ 140,831	$ 180,640	(39,809)	-22%	$ 206,150
43	$ 288,617	$ -	288,617	0%	Restricted Foundation Contributions	$ 1,028,451	$ -	1,028,451	100%	$ -
44	**$ 224,251**	**$ (217,855)**	**442,106**	**-203%**	**Net Income / (Loss) w/ Restricted Contributions**	**$ (2,580,840)**	**$ (1,323,294)**	**(1,257,546)**	**95%**	**$ (1,772,243)**
45	250,683	250,683	-	0%	GO Bond Tax Assessment Rev	2,757,513	2,757,513	-	0%	2,715,999
46	(105,776)	(105,776)	-	0%	GO Bond Interest	(1,168,026)	(1,168,026)	-	0%	(1,228,569)
47	**$ 369,158**	**$ (72,948)**	**442,106**	**-606%**	**Net Income/(Loss) w GO Bond Activity**	**$ (991,353)**	**$ 266,193**	**(1,257,546)**	**-472%**	**$ (284,813)**
	$ 263,897	$ 87,814			**EBIDA - Not including Restricted Contributions**	$ (98,335)	$ 2,090,314			$ 1,613,851
	5.5%	1.8%				-0.2%	3.9%			3.1%
	$ 214,318	$ 45,629			**EBDA - Not including Restricted Contributions**	$ (617,686)	$ 1,601,498			
	4.4%	0.9%				-1.2%	3.0%			

Sonoma Valley Health Care District **ATTACHMENT E**

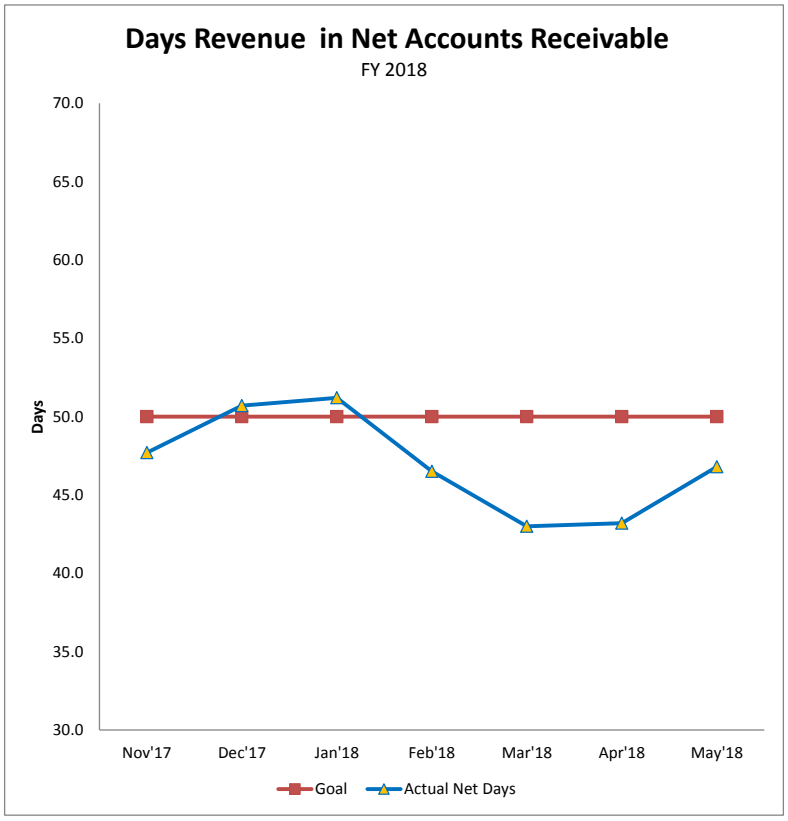
Statement of Revenue and Expenses Variance Analysis

For the Period Ended May 31, 2018

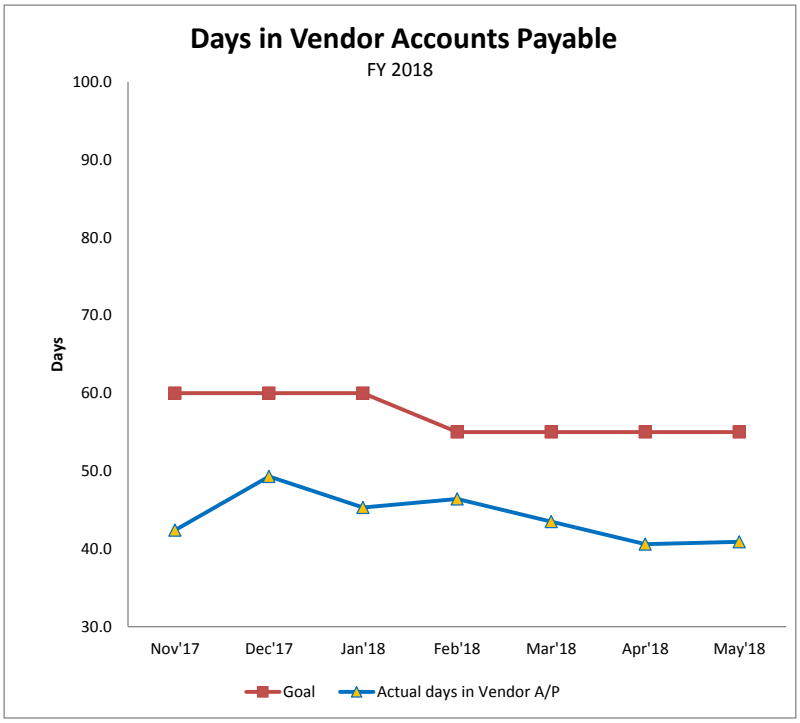
		YTD	MONTH	
	Description	**Variance**	**Variance**	
	Volume Information			
1	Acute Discharges	(107)	9	
2	SNF Days	(384)	(103)	
3	Home Care Visits	(1,665)	(148)	
4	Gross O/P Revenue (000's)	(2,089)	499	
	Financial Results			
	Gross Patient Revenue			
5	Inpatient	(6,950,522)	912,791	Inpatient days are 374 days vs. budgeted expectations of 384 days and inpatient surgeries are 29 vs. budgeted expectations 34. There was higher acuity in the month of May.
6	Outpatient	876,859	142,646	Outpatient visits are 4,810 vs. budgeted expectations of 4,773 visits and outpatient surgeries are 146 vs. budgeted expectations 120.
7	Emergency	(2,628,367)	375,465	ER visits are 934 vs. budgeted visits of 940.
8	SNF	(456,188)	(308,258)	SNF patient days are 423 vs. budgeted expected days of 529.
9	Home Care	(386,504)	(35,253)	HHA visits are 747 vs. budgeted expectations of 895.
10	**Total Gross Patient Revenue**	**(9,544,722)**	**1,087,391**	
	Deductions from Revenue			
11	Contractual Discounts	6,096,536	(965,145)	
12	Bad Debt	(503,000)	(50,000)	
13	Charity Care Provision	57,948	2,333	
14	Prior Period Adj/Government Program Revenue	900,871	(116,747)	Received $134,025 AB915 FY 14-15 and accrued $62,500 for the prime grant.
15	**Total Deductions from Revenue**	**6,552,355**	**(1,129,559)**	
16	**Net Patient Service Revenue**	**(2,992,367)**	**(42,168)**	
17	Risk contract revenue	(150,488)	(35,528)	
18	Net Hospital Revenue	**(3,142,855)**	**(77,696)**	
19	Other Op Rev & Electronic Health Records	(37,133)	(7,367)	
20	**Total Operating Revenue**	**(3,179,988)**	**(85,063)**	
	Operating Expenses			
21	Salary and Wages and Agency Fees	1,162,871	84,080	Salaries and Wages are under budget by $161,166 and the Agency fees are over budget by ($77,086).
22	Employee Benefits	374,820	35,982	PTO is under budget by $10,697 and employee benefits are under budget by $25,285.
23	Total People Cost	**1,537,691**	**120,062**	
24	Med and Prof Fees (excld Agency)	(134,932)	23,097	Adjustment to hospitalist year-end bonus accrual per invoice - $34,496.
25	Supplies	(229,124)	18,935	
26	Purchased Services	131,110	(8,409)	
27	Depreciation	(27,004)	3,461	
28	Utilities	18,388	5,737	
29	Insurance	(46,255)	(4,205)	
30	Interest	(30,535)	(7,394)	
31	Other	210,130	27,293	
32	Matching Fees (Government Programs)	(541,064)	86,433	No matching fee in May.
33	**Operating expenses**	**888,405**	**265,010**	
34	**Operating Margin**	**(2,291,583)**	**179,947**	
	Non Operating Rev and Expense			
35	Miscellaneous Revenue	67,637	(6,214)	
36	Donations	27,546	500	Foundation grants for employee education
37	Physician Practice Support-Prima	(22,913)	(2,083)	
38	Parcel Tax Assessment Rev	-	-	
39	Extraordinary Items	(26,875)	-	
40	**Total Non-Operating Rev/Exp**	72,270	(7,797)	
			-	

Sonoma Valley Health Care District **ATTACHMENT E**
Statement of Revenue and Expenses Variance Analysis
For the Period Ended May 31, 2018

	Description	YTD Variance	MONTH Variance	
41	**Net Income / (Loss) prior to Restricted Contributions**	**(2,219,313)**	**172,150**	
			-	
42	Capital Campaign Contribution	(39,809)	(18,661)	
43	Restricted Foundation Contributions	1,028,451	288,617	Foundation donations 3D Mammography ($10,752), A Women's Place ($14,837), OP Diagnositic Center ($259,533), and SNF furniture (3,495).
44	**Net Income / (Loss) w/ Restricted Contributions**	**(1,257,546)**	**442,106**	
45	GO Bond Tax Assessment Rev	-	-	
46	GO Bond Interest	-	-	
47	**Net Income/(Loss) w GO Bond Activity**	**(1,257,546)**	**442,106**	



Days in A/R	Nov'17	Dec'17	Jan'18	Feb'18	Mar'18	Apr'18	May'18
Actual days in A/R	47.7	50.7	51.2	46.5	43.0	43.2	46.8
Goal	50.0	50.0	50.0	50.0	50.0	50.0	50.0



Days in A/P	Nov'17	Dec'17	Jan'18	Feb'18	Mar'18	Apr'18	May'18
Actual days in Vendor A/P	42.4	49.3	45.3	46.4	43.5	40.6	40.9
Goal	60.0	60.0	60.0	55.0	55.0	55.0	55.0

Sonoma Valley Hospital
Statistical Analysis
FY 2018

ATTACHMENT G

	ACTUAL	BUDGET	ACTUAL												
	May-18	May-18	Apr-18	Mar-18	Feb-18	Jan-18	Dec-17	Nov-17	Oct-17	Sep-17	Aug-17	Jul-17	Jun-17	May-17	Apr-17
Statistics															
Acute															
Acute Patient Days	374	384	341	335	289	394	386	321	315	325	325	240	346	388	368
Acute Discharges (w/o Newborns)	108	99	103	106	82	111	96	99	87	87	94	76	87	100	89
SNF Days	423	529	525	566	494	646	563	468	624	479	500	528	458	559	512
HHA Visits	747	895	755	684	821	801	798	630	871	789	713	870	940	966	934
Emergency Room Visits	934	940	864	871	811	996	919	816	827	921	894	920	964	1,069	921
Gross Outpatient Revenue (000's)	$15,188	$14,690	$14,170	$13,064	$12,519	$14,741	$14,051	$12,952	$11,864	$14,364	$15,524	$14,175	$15,454	$15,523	$13,168
Equivalent Patient Days	2,178	2,556	2,265	2,272	2,212	2,629	2,471	2,030	2,334	2,266	2,591	2,332	2,328	2,654	2,227
Births	9	15	6	8	11	7	10	11	12	5	10	6	15	7	11
Surgical Cases - Inpatient	29	34	30	34	16	32	24	34	23	33	22	29	36	30	47
Surgical Cases - Outpatient	146	120	114	117	123	109	136	121	97	154	142	133	161	143	124
Total Surgical Cases	175	154	144	151	139	141	160	155	120	187	164	162	197	173	171
Total Special Procedures	72	26	87	75	75	65	59	73	52	75	77	52	66	58	44
Medicare Case Mix Index	1.46	1.40	1.48	1.45	1.34	1.50	1.57	1.55	1.49	1.54	1.57	1.65	1.66	1.69	1.64
Income Statement															
Net Revenue (000's)	$4,817	$4,895	4,389	4,218	4,590	4,909	4,466	4,474	4,543	4,518	4,775	4,988	5,188	5,330	4,924
Operating Expenses (000's)	$5,134	$5,399	$5,053	$5,179	$5,270	$5,357	$5,122	$5,332	$4,872	$5,206	$5,380	$5,592	$5,250	$5,678	$5,308
Net Income (000's)	$369	($73)	$ 221	$ (395)	$ (175)	$ 125	$ (226)	$ (380)	$ 62	$ (230)	$ (165)	$ (198)	$ 690	$ 16	$ (24)
Productivity															
Total Operating Expense Per Equivalent Patient Day	$2,357	$2,112	$2,231	$2,280	$2,382	$2,038	$2,073	$2,627	$2,087	$2,297	$2,076	$2,398	$2,255	$2,139	$2,383
Productive FTEs	279	287	281	279	274	276	255	316	246	289	279	271	278	291	285
Non-Productive FTE's	27	41	26	23	31	36	52	13	58	27	35	47	43	28	28
Total FTEs	306	328	307	302	305	312	307	329	304	316	314	318	321	319	313
FTEs per Adjusted Occupied Bed	4.35	3.98	4.06	4.17	3.87	3.68	3.85	4.86	4.04	4.19	3.75	4.23	4.14	3.73	4.22
Balance Sheet															
Days of Expense In General Operating Cash	6.2		7	7	14	24	18	14	12	9	11	16	20	19	11
Net Days of Revenue in AR	47	50	43	43	47	51	51	48	45	47	43	45	45	44	47

Sonoma Valley Hospital
Cash Forecast
FY 2018

ATTACHMENT H

		Actual July	Actual Aug	Actual Sept	Actual Oct	Actual Nov	Actual Dec	Actual Jan	Actual Feb	Actual Mar	Actual Apr	Actual May	Forecast Jun	TOTAL
	Hospital Operating Sources													
1	Patient Payments Collected	4,502,585	4,253,229	4,093,599	4,253,616	3,890,115	3,814,761	4,401,932	3,677,850	4,283,702	4,214,618	4,134,637	4,451,807	49,972,452
2	Capitation Revenue	133,404	128,220	128,530	131,210	128,781	122,912	93,640	106,306	99,290	97,957	92,993	99,290	1,362,533
3	Napa State	39,561	4,166	35,361	26,125	5,181	21,341	30,259	-		14,854	25,117	20,762	222,727
4	Other Operating Revenue	10,971	25,415	37,380	30,930	42,863	35,092	33,639	57,291	45,083	42,239	36,038	18,827	415,767
5	Other Non-Operating Revenue	26,914	38,081	68,232	33,898	48,014	43,511	47,501	9,459	32,528	34,738	41,208		424,085
6	Unrestricted Contributions		8,478	150			19,590	835		2,810	1,080	500		33,443
7	Line of Credit													-
	Sub-Total Hospital Sources	**4,713,435**	**4,457,589**	**4,363,253**	**4,475,779**	**4,114,954**	**4,057,207**	**4,607,806**	**3,850,906**	**4,463,413**	**4,405,486**	**4,330,493**	**4,590,686**	**52,431,007**
	Hospital Uses of Cash													
8	Operating Expenses	5,146,037	5,273,336	5,040,006	4,799,145	5,326,497	4,701,617	4,944,257	4,794,729	5,813,204	5,109,358	4,528,964	4,770,733	60,247,883
9	Add Capital Lease Payments	52,503	186,389	69,999	179,596	109,938	70,502	45,558	181,715	71,338	47,220	258,442	169,180	1,442,380
10	Additional Liabilities								375,000			-		375,000
11	Capital Expenditures	15,965	56,034	1,755	88,906	88,829	59,065	546,421		37,792	81,693	269,103		1,245,563
	Total Hospital Uses	**5,214,505**	**5,515,759**	**5,111,761**	**5,067,647**	**5,525,264**	**4,831,184**	**5,536,236**	**5,351,443**	**5,922,334**	**5,238,271**	**5,056,509**	**4,939,913**	**63,310,826**
	Net Hospital Sources/Uses of Cash	**(501,070)**	**(1,058,171)**	**(748,508)**	**(591,868)**	**(1,410,310)**	**(773,977)**	**(928,430)**	**(1,500,538)**	**(1,458,921)**	**(832,785)**	**(726,016)**	**(349,227)**	**(10,879,819)**
	Non-Hospital Sources													
12	Restricted Cash/Capital Donations		527,977	(727,205)	(100,755)	382,167	417	551,467	-	227,056	1,213,518	288,784	(549,858)	1,813,568
13	Parcel Tax Revenue	152,275		1,500,000			482,664	532,571			1,061,899			3,729,409
14	Payment - South Lot				(25,205)		(25,205)			(24,658)			(24,932)	(100,000)
15	Other:													-
16	IGT (Net)				1,877,696							134,025	1,635,622	3,647,343
17	IGT - AB915							811,535		138,554				950,089
18	PRIME					1,350,000								1,350,000
	Sub-Total Non-Hospital Sources	**152,275**	**527,977**	**772,795**	**1,751,736**	**1,732,167**	**457,876**	**1,895,573**	**-**	**340,952**	**2,275,417**	**422,809**	**1,060,832**	**11,390,409**
	Non-Hospital Uses of Cash													
19	Matching Fees		509,543	266,212	675,000						716,072		203,909	2,370,736
	Sub-Total Non-Hospital Uses of Cash	-	509,543	266,212	675,000	-	-	-	-	-	716,072	-	203,909	2,370,736
	Net Non-Hospital Sources/Uses of Cash	**152,275**	**18,434**	**506,583**	**1,076,736**	**1,732,167**	**457,876**	**1,895,573**	**-**	**340,952**	**1,559,345**	**422,809**	**856,923**	**9,019,673**
	Net Sources/Uses	**(348,795)**	**(1,039,737)**	**(241,925)**	**484,868**	**321,857**	**(316,101)**	**967,143**	**(1,500,538)**	**(1,117,969)**	**726,560**	**(303,207)**	**507,696**	
	Cash and Equivalents at beginning of period	3,166,281	2,817,486	1,777,750	1,535,825	2,020,693	2,342,550	2,026,449	2,993,592	1,493,055	375,086	1,101,646	798,439	
	Cash and Equivalents at end of period	**2,817,486**	**1,777,750**	**1,535,825**	**2,020,693**	**2,342,550**	**2,026,449**	**2,993,592**	**1,493,055**	**375,086**	**1,101,646**	**798,439**	**1,306,135**	

Sonoma Valley Hospital **ATTACHMENT H**
Cash Forecast
FY 2018

		Actual July - Dec	Actual Jan	Actual Feb	Actual Mar	Actual Apr	Actual May	Forecast Jun	TOTAL
	Hospital Operating Sources								
1	Patient Payments Collected	24,807,906	4,401,932	3,677,850	4,283,702	4,214,618	4,134,637	4,451,807	49,972,452
2	Capitation Revenue	773,056	93,640	106,306	99,290	97,957	92,993	99,290	1,362,533
3	Napa State	131,735	30,259	-	-	14,854	25,117	20,762	222,727
4	Other Operating Revenue	182,650	33,639	57,291	45,083	42,239	36,038	18,827	415,767
5	Other Non-Operating Revenue	258,651	47,501	9,459	32,528	34,738	41,208	-	424,085
6	Unrestricted Contributions	28,218	835	-	2,810	1,080	500	-	33,443
7	Line of Credit								-
	Sub-Total Hospital Sources	**26,182,217**	**4,607,806**	**3,850,906**	**4,463,413**	**4,405,486**	**4,330,493**	**4,590,686**	**52,431,007**
	Hospital Uses of Cash								
8	Operating Expenses	30,286,638	4,944,257	4,794,729	5,813,204	5,109,358	4,528,964	4,770,733	60,247,883
10	Add Capital Lease Payments	668,927	45,558	181,715	71,338	47,220	258,442	169,180	1,442,380
11	Additional Liabilities			375,000	-	-	-	-	375,000
12	Capital Expenditures	310,554	546,421		37,792	81,693	269,103	-	1,245,563
	Total Hospital Uses	**31,266,120**	**5,536,236**	**5,351,443**	**5,922,334**	**5,238,271**	**5,056,509**	**4,939,913**	**63,310,826**
	Net Hospital Sources/Uses of Cash	**(5,083,903)**	**(928,430)**	**(1,500,538)**	**(1,458,921)**	**(832,785)**	**(726,016)**	**(349,227)**	**(10,879,819)**
	Non-Hospital Sources								
13	Restricted Cash/Capital Donations	82,601	551,467	-	227,056	1,213,518	288,784	(549,858)	1,813,568
14	Parcel Tax Revenue	2,134,939	532,571	-	-	1,061,899	-	-	3,729,409
15	Payment - South Lot	(50,410)		-	(24,658)	-	-	(24,932)	(100,000)
16	Other:	-		-	-	-	-	-	-
17	IGT	1,877,696		-	-	-	134,025	1,635,622	3,647,343
18	IGT - AB915 (Net)	-	811,535	-	138,554	-	-	-	950,089
19	PRIME	1,350,000			-	-	-	-	1,350,000
	Sub-Total Non-Hospital Sources	**5,394,826**	**1,895,573**	**-**	**340,952**	**2,275,417**	**422,809**	**1,060,832**	**11,390,409**
	Non-Hospital Uses of Cash								
20	Matching Fees	1,450,755				716,072		203,909	2,370,736
	Sub-Total Non-Hospital Uses of Cash	1,450,755	-	-	-	716,072	-	203,909	2,370,736
	Net Non-Hospital Sources/Uses of Cash	**3,944,071**	**1,895,573**	**-**	**340,952**	**1,559,345**	**422,809**	**856,923**	**9,019,673**
	Net Sources/Uses	**(1,139,832)**	**967,143**	**(1,500,538)**	**(1,117,969)**	**726,560**	**(303,207)**	**507,696**	
	Cash and Equivalents at beginning of period	3,166,281	2,026,449	2,993,592	1,493,055	375,086	1,101,646	798,439	
	Cash and Equivalents at end of period	**2,026,449**	**2,993,592**	**1,493,055**	**375,086**	**1,101,646**	**798,439**	**1,306,135**	

Sonoma Valley Hospital

ATTACHMENT I

Schedule of Cash Savings from Cost Reduction Plan

For the months of January Through May 2018

			Savings						
Department	**Department**	**Job Code**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Total**	**Notes**
7290	Home Health	Total department	$ 23,660	$ 34,779	$ 14,939	$ 40,731	$ 9,218	$ 123,327	Cost reduction, net
7721	Respiratory Therapy	0000 - Management	727	909	257	615	760	3,268	Cardiopulmanary Manager
7770	Rehab	0000 - Management	9,431	9,008	6,754	6,152	6,498	37,843	Consolidation of Rehab managers (New hire in February)
8361/8750	CareTransitions/Quality	0000 - Management	2,872	3,015	3,317	2,632	3,689	15,525	Chief of Quality
8480	IT	0000 - Management	10,523	10,390	8,719	9,746	9,337	48,715	IT Manager
8510	Accounting	0000 - Management	8,386	6,828	6,997	7,523	6,905	36,639	Controller
8610	Administration	0000 - Management	6,120	6,243	6,733	6,427	7,039	32,562	CFO (.8 to .5)
8710	Medical Staff	0000 - Management	13,807	12,178	13,445	13,012	13,445	65,887	CMO/CMIO (To be replaced by UCSF CMO)
9550	Community Health	0000 - Management	3,787	3,602	3,787	3,665	3,787	18,628	Wellness Coordinator
		Gross Salary savings	**$ 79,313**	**$ 86,952**	**$ 64,948**	**$ 90,503**	**$ 60,678**	**$ 382,394**	
		Employer portion FICA	**6,067**	**6,652**	**4,968**	**6,923**	**4,642**	**29,253**	
		Health Benefits	**16,511**	**22,948**	**26,123**	**17,685**	**17,729**	**100,996**	
		Total Savings	**$ 101,891**	**$ 116,552**	**$ 96,039**	**$ 115,111**	**$ 83,049**	**$ 512,643**	

8.

SOUTH LOT LOAN MODIFICATION

To: SVHCD Board of Directors

Meeting Date: July 5, 2018

Prepared by: Ken Jensen

Agenda Item Title: South Lot Loan Replacement and Sale Modification

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Recommendation:

It is recommended that the hospital accept the offer from DeNova Homes with the terms noted in order to pay off the existing loan.

Background:

Up until August 2016 the hospital was leasing what is now called the South Lot. The hospital had and did exercise and option to purchase the lot for approximately $1.7 million prior to the deadline (the hospital had already invested $250k to obtain the option). The acquisition was funded through a private party loan to the hospital in the amount of $2 million with an interest rate of 5%. Originally the intent of the lender was have the term of the loan through August of 2018 but before it was finalized it was changed to June of 2018. The property was sold and is now in escrow for approximately $3.3 million.

The property is in escrow and due to terms in the agreement the sale probably will not close until December 2018. The current private party lender is now insisting upon the repayment of the loan per the agreement date of June 30, 2018. The hospital is not in a situation where it can repay $2 million on June 30th. DeNova Homes, the purchaser of the property, was approached to lend the transaction the $2 million due to the original lender. They have agreed to lend the money with the following changes to the Purchase and Sales agreement:

-DeNova will lend the $2m at 6.5% interest

-Since they will be removing the hard deadline to repay the current private lender, they want to amend the Purchase and Sales Agreement to extend the Close of Escrow to when they get the Final Map done on the property (rather than the Tentative Map terms)

-Since they are putting out $2m much sooner than originally expected they want to remove the Profit Participation terms in the Purchase and Sales Agreement (not a price reduction, just removing the Profit Participation terms)

Consequences of Negative Action/Alternative Actions:

Consequences of not accepting the new replacement loan will put the District in default of the existing loan that is due June 30, 2018.

Financial Impact:

Financial impact of the increase interest cost is $2,500 per month with a seven month probable cost of $17,500.

The elimination of the profit sharing should have no financial impact.

Attachments:

A. DeNova loan agreement
B. Third amendment to purchase and sale agreement and join escrow instructions.

LOAN AGREEMENT

THIS LOAN AGREEMENT ("**Agreement**") is made as of June ___, 2018, by and between Meadow Creek Group, LLC, a California limited liability company ("**Lender**") and Sonoma Valley Health Care District, a California Health Care District ("**Borrower**").

Recitals

A. WHEREAS, Borrower and Lender have agreed that, upon and subject to the terms and conditions contained herein, the Lender would advance by way of loan to the Borrower, and the Borrower will borrow from Lender, the sum of Two Million Dollars ($2,000,000.00);

B. WHEREAS, Borrower as "Seller" is a party to that certain Purchase and Sale Agreement and Joint Escrow Instructions with an effective date of November 6, 2017, with Civic Property Group, Inc. as "Buyer" (the "**Purchase Agreement**"). The Purchase Agreement has been amended by a First Amendment dated December 13, 2017, a Second Amendment dated January 4, 2018 and by a Third Amendment dated June __, 2018.

C. WHEREAS, the Purchase Agreement relates to the purchase and sale of portions of that real property identified as 853 4th Street West, Sonoma, California, with APNs 018-392-001 and 018-392-0545 (the "**Property**").

D. WHEREAS, Seller is currently obligated to pay back a loan to a third party, with the maturity date of the current loan on June 30, 2018 (the "**Current Loan**"). Said Current Loan is secured by a deed of trust against the Property, recorded August 22, 2016 as Instrument No. 2016072294 (the "**Current Deed of Trust**").

E. WHEREAS, Seller needs funds to pay off the Current Loan and have the Current Deed of Trust reconveyed.

F. WHEREAS, Lender is willing to loan funds in the amount of $2,000,000 to Seller for the sole purpose of Seller paying off the Current Note in its entirety and having the Current Deed of Trust fully reconveyed pursuant to the terms and conditions of this Agreement.

NOW THEREFORE, in consideration of the mutual covenants and agreements contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged by each of the parties hereto, the parties hereto hereby covenant and agree as follows:

Agreement

ARTICLE 1 - INTERPRETATION

1.1 **Definition**. In this Agreement, unless the context otherwise requires, the following words and phrases shall have the meanings set out below, respectively:

(a) "**Advance**" means the advance of the Loan.

(b) "**Business Day**" means a day other than a Saturday, Sunday or public holiday and on which banks are open for business in California.

(c) "**Loan**" has the meaning ascribed thereto in Section 2.1 below;

(d) "**Loan Documents**" means this Loan Agreement, the Promissory Note, the Deed of Trust, Security Agreement, and any other documents to be executed and/or delivered to the Lender by the Borrower and;

(e) "**Deed of Trust**" has the meaning ascribed thereto in Section 2.4(b).

(f) "**Promissory Note**" has the meaning ascribed in Section 2.4(a).

1.2 **Headings, etc.** The division of this Agreement into Articles and Sections and the insertion of headings are for convenience of reference only and shall not affect the construction or interpretation of this Agreement.

1.3 **Number and Gender.** In this Agreement words importing the singular number only shall include the plural and vice versa, words importing a specific gender shall include the other genders, and references to persons shall include individuals, partnerships, trusts, associations, unincorporated organizations and corporations.

1.4 **Currency.** All dollar amounts referred to in this Loan Agreement are in United States funds.

ARTICLE 2 - LOAN

2.1 **Loan.** The Lender has agreed to advance the sum of Two Million Dollars ($2,000,000.00) (the "**Loan**") by way of loan to the Borrower upon and subject to the terms and conditions contained in this Agreement. Borrower shall use the Loan for the sole purpose of paying off the Current Deed of Trust. The Advance of the Loan shall occur by way of escrow through First American Title Company, 4750 Willow Road, Suite 100, Pleasanton, California 94588, Diane Burton, escrow officer.

2.2 **Repayment of Loan.** The principal amount of the Loan together with accrued and unpaid interest shall be repayable on the Maturity Date which shall be the earlier to occur of (i) Borrower's transfer of the "Residential Parcel" portion of the Property to Civic Property Group, Inc. pursuant to the Purchase Agreement; or (ii) thirty six (36) months from the date of issuance of the Loan pursuant to the terms of this Agreement and the Promissory Note.

2.3 **Interest.** The Loan shall bear interest at the rate of Six and One-Half Percent (6.5%) per annum. Interest shall accrue and shall be payable on the Maturity Date, as more fully set forth in the Promissory Note.

2.4 **Security.** Payment of the Loan will be memorialized and secured by:

(a) a promissory note, in the form attached hereto as Exhibit "A" hereto (the "**Promissory Note**"); and

(b) a deed of trust on real property at 853 4th Street West, Sonoma, California, in the form set out in Exhibit "B" hereto (the "**Deed of Trust**").

2.5 **Costs**. Borrower shall pay all fees, expenses and costs incurred by Lender associated with issuance of the Loan, including but not limited to (i) any appraisal of the Property; (ii) all escrow fees and closing costs, and (iii) title issuance fees for an ALTA Lender's policy of title insurance and any endorsements requested by Lender (collectively, the "**Costs**"). All such Costs shall be paid by Borrower upon Advance of the Loan directly out of Escrow.

ARTICLE 3 - REPRESENTATIONS AND WARRANTIES

The Borrower hereby represents and warrants to the Lender as follows, and acknowledges and confirms that the Lender is relying on such representations and warranties in connection with the Loan:

3.1 **Corporate Status.** The Borrower was incorporated under the laws of the State of California and has not been dissolved or suspended.

3.2 **Corporate Power.** The Borrower has all requisite power and capacity to own or lease its property, to carry on its business, to enter into each of the Loan Documents and to complete the transaction provided for herein.

3.3 **Corporate Authorization.** The execution and delivery of each of the Loan Documents by the Borrower and the completion of the transaction provided for herein have been duly authorized by all necessary corporate action and proceedings of the Borrower.

3.4 **No Contravention.** The execution and delivery of the Loan Documents and the performance by the Borrower of its obligations thereunder will not result in the violation of any indenture or other agreement, written or oral, to which the Borrower is a party or by which it is bound.

3.5 **Enforceability.** This Loan Agreement and the other Loan Documents have been duly executed and delivered by the Borrower and constitute legal, valid and binding obligations of the Borrower enforceable against the Borrower in accordance with their respective terms, subject only to any limitation under applicable laws relating to bankruptcy, insolvency, arrangement or creditors' rights generally, and the discretion that a court may exercise in the granting of equitable remedies.

3.6 **Title of Assets.** The property and assets of the Borrower are beneficially owned by it, with good and marketable title thereto, free and clear of any mortgages, charges, pledges, assignments, liens, security interests or encumbrances whatsoever.

ARTICLE 4 - COVENANTS

So long as the Loan or any part thereof remains outstanding, the Borrower covenants and agrees with the Lender as follows:

4.1 **Existence.** The Borrower will preserve and maintain its existence and its power and capacity to own or lease its property and assets and carry on its business.

4.2 **Conduct of Business.** The Borrower shall do or cause to be done all things necessary or desirable to maintain its existence, to maintain its power and capacity to own its properties and assets, and to carry on its business in a commercially reasonable manner in accordance with

normal industry standards.

4.3 **Punctual Payment.** The Borrower shall pay or cause to be paid all obligations falling due hereunder on the dates and in the manner specified herein and in the Loan Documents.

4.4 **Compliance with Applicable Law and Contracts.** The Borrower shall comply in all material respects with the requirements of all applicable law, and all obligations which, if contravened, could give rise to a lien over any of the Borrower's assets, and all contracts to which it is bound, non-compliance with which would, singly or in the aggregate, have a material adverse effect upon its business or upon the ability of the Borrower to perform its obligations under any Loan Document to which it is a party.

ARTICLE 5 - CONDITIONS PRECEDENT

5.1 **Conditions of Advance.** The obligations of the Lender to make available the Advance to the Borrower are subject to compliance with each of the following conditions precedent, which conditions precedent are for the sole and exclusive benefit of the Lender and may be waived in writing by the Lender in its sole discretion:

(a) the representations and warranties set out in Article 4 shall be true and correct on the date of the Advance as if made on and as of such date;

(b) the Borrower shall have delivered the Loan Documents to the Lender, executed and notarized where required for recordation;

(c) the Lender shall have received a certificate of insurance from the Borrower's insurer showing the Lender as loss payee;

(d) Escrow Agent has received binding escrow instructions from Lender's counsel and Lender has authorized the closing of the transaction and issuance of the Advance of the Loan;

(e) Escrow Agent has received payoff instructions from the third-party lender under the Current Loan for payment in full of the Current Loan, and Escrow Agent has received from such third-party lender an acknowledged Request for Reconveyance of the Current Deed of Trust, subject only to payment of the Current Loan;

(f) Escrow Agent has received irrevocable instructions from Borrower to utilize the funds advanced by Lender to Borrower under this Loan Agreement to pay off in full the Current Loan;

(g) Escrow Agent is prepared to record the Reconveyance of the Current Deed of Trust;

(h) Lender has received an irrevocable commitment from First American Title Company that it is unconditionally prepared to issue a lender's policy of title insurance, in a form approved by Lender; and

(i) The Borrower has funded into Escrow amounts sufficient to pay all Costs.

ARTICLE 6 - EVENTS OF DEFAULT

6.1 **Events of Default.** The occurrence of any of the following events shall constitute an Event of Default.

(a) default by the Borrower, in payment of money to the Lender unless such default is remedied within five (5) days of the receipt of the notice;

(b) default by the Borrower in the performance or observance of any warranty, representation, covenant, condition or obligation contained in any Loan Document to which it is a party that does not require the payment of money to the Lender unless such default is remedied within ten (10) days after notice thereof by the Lender to the Borrower;

(c) default by the Borrower in the performance or observance of any warranty, representation, covenant, condition or obligation contained in any agreement between the Borrower and any person, where such default gives rise to a right to enforce security against the Borrower and such security is being enforced;

(d) the Borrower takes any action or commences any proceedings or any action or proceeding is taken or commenced by another person or persons against the Borrower in respect of the liquidation or dissolution of the Borrower and same is not contested in good faith by the Borrower;

(e) the Borrower commits or threatens to commit any act of bankruptcy pursuant to or set out under the provisions of applicable United States bankruptcy laws;

(f) the filing of a petition for a receiving order against the Borrower pursuant to the provisions of applicable United States bankruptcy laws and the same is not contested in good faith by the Borrower;

(g) any execution, sequestration or other process of any court or other tribunal becoming enforceable against the Borrower or a distress or analogous action or proceeding being taken, commenced or issued against the Borrower;

(h) a receiver, receiver and manager, agent liquidator or other similar administrator being appointed in respect of the assets of the Borrower or any part thereof or the taking by a secured party, lien claimant, other encumbrancer, judgment creditor or a person asserting similar rights of possession of the assets of the Borrower or any part thereof and the same is not contested in good faith by the Borrower;

(i) any material, uncured default of Borrower, as the "Seller", under the Purchase Agreement.

6.2 **Remedies Upon Default.** Upon any event of default of Borrower that has not been completely cured within any applicable cure period, Lender shall have all rights and

remedies available to it in the Loan Documents, including but not limited to:

(a) declaring the entire principle amount and all accrued interest to be immediately due and payable, without presentment, demand, protest or notice of any kind;

(b) realizing upon all or part of the Security; and

(c) taking such actions and commence such proceedings as may be permitted at law or in equity (whether or not provided for herein or in the Loan Documents) at such times and in such manner as Lender in its sole discretion may consider expedient.

ARTICLE 7 - GENERAL PROVISIONS

7.1 **Reliance.** All covenants, agreements, representations and warranties of the Borrower made herein or in another Loan Document are material, shall be deemed to have been relied upon by the Lender notwithstanding any investigation heretofore or hereafter made by the Lender or any employee or other representative of the Lender and shall survive the execution and delivery of this Loan Agreement and the other Loan Documents until the Borrower shall have satisfied and performed all of the Obligations.

7.2 **Notices.** Any notice or other communication to be given hereunder to any of the parties hereto shall be in writing and may be given by delivery, or sent by facsimile or other similar means of electronic communication, or if postal services and deliveries are then operating, mailed by registered mail to such party at its address set out below or at such other address as such party may have designated by notice so given to the other parties hereto.

To Lender: Meadow Creek Group, LLC
c/o David B. Sanson
1500 Willow Pass Court
Concord, California 94520

To Borrower: Sonoma Valley Health Care District
347 Andrieux Street
Sonoma, California 95476
Attn: Kelly Mather

Any notice or other communication shall be deemed to have been given, if delivered, on the date of delivery, or if sent by facsimile or other similar means of electronic communication, on the Business Day next following the date of sending, or if mailed by registered mail as aforesaid, on the third Business Day following the date of the mailing if postal service and deliveries are then operating.

7.3 **Governing Law.** This Agreement shall be construed in accordance with and governed in all respects by the laws of the State of California.

7.4 **Successors and Assigns.** This Loan Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors and assigns.

7.5 **Further Assurances.** Whether before or after the happening of an Event of Default, the Borrower shall at its own expense do, make execute or deliver, or cause to be done, made

executed or delivered by other Persons, all such further acts, documents and things in connection with the Loan and the Loan Documents as the Lender may reasonably require from time to time for the purpose of giving effect to the Loan Document including, without limitation, for the purpose of facilitating the enforcement of the Security, all immediately upon the request of Lender.

7.6 **Counterparts**. This Agreement may be executed in counterparts, each of which when so executed and delivered shall be deemed to be an original and such counterparts together shall constitute one and the same Agreement.

7.7 **Attorney's Fees.** If any attorney is engaged by Lender to enforce or construe any provision of this Agreement or any of the Loan Documents, or as a consequence of any event of default, with or without the filing of any legal action or proceeding, then Borrower will immediately pay to Lender on demand all attorneys' fees and other costs incurred by Lender, together with interest from the date of the demand until paid.

7.8 **Integration/Modification**. This Agreement and the Loan Documents set forth the entire agreement between the Parties with regard to the subject matter hereof. All prior and contemporaneous agreements, conversations, negotiations, possible and alleged agreements and representations, covenants and warranties with respect to the subject matter herein are waived and are superseded. It is expressly understood and agreed that this Agreement may not be altered, amended, modified or otherwise changed in any respect or particular whatsoever, except by a writing duly executed by both Lender and Borrower, or their authorized representatives, and the parties hereto, and each of them, acknowledge and agree that none of them will make any claim that this Agreement has been orally altered or modified in any respect whatsoever.

IN WITNESS WHEREOF the parties hereto have duly executed this Loan Agreement as of the date first written above.

Borrower:

SONOMA VALLEY HEALTH CARE DISTRICT
a California Health Care District

Dated: June 22, 2018

By: Kelly Mather
Its: President and CEO

Lender:

MEADOW CREEK GROUP, LLC
a California limited liability company

Dated: June 26, 2018

By: David B. Sanson
Its: President and CEO

THIRD AMENDMENT TO PURCHASE AND SALE AGREEMENT AND JOINT ESCROW INSTRUCTIONS

This Third Amendment to Purchase and Sale Agreement and Joint Escrow Instruction ("**Third Amendment**") is made and effective as of June 22, 2018, and is entered into by and between SONOMA VALLEY HEALTH CARE DISTRICT, a California Health Care District ("**Seller**") and CIVIC PROPERTY GROUP, INC., a California corporation or its related assign ("**Buyer**") with respect to that certain Purchase and Sale Agreement and Joint Escrow Instructions with an effective date of November 6, 2017 by and between the Seller and the Buyer (the "**Purchase Agreement**"). Capitalized terms not defined herein shall have the same meaning as set forth in the Purchase Agreement.

RECITALS

A. WHEREAS, Buyer and Seller entered into that certain First Amendment to Purchase and Sale Agreement and Joint Escrow Instructions on or about December 13, 2017 ("**First Amendment**"), and that certain Second Amendment to Purchase and Sale Agreement and Joint Escrow Instructions on or about January 4, 2018 ("**Second Amendment**"). As amended by the First Amendment and Second Amendment, the Purchase Agreement is referred to as the "**Agreement.**"

B. WHEREAS, Seller is currently obligated to pay back a loan to a third party, with the maturity date of the current loan on June 30, 2018 (the "**Current Loan**"). Said Current Loan is secured by a deed of trust against the real property that is the subject of the Agreement, recorded August 22, 2016 as Instrument No. 2016072294 (the "**Current Deed of Trust**").

C. WHEREAS, Seller needs funds to pay off the Current Loan and have the Current Deed of Trust reconveyed, and Buyer has located a third-party lender for Seller.

D. WHEREAS, a third party, Meadow Creek Group, LLC ("MCG"), is willing to enter into a loan agreement to loan funds in the amount of $2,000,000 to Seller for the sole purpose of Seller paying off the Current Note in its entirety and having the Current Deed of Trust fully reconveyed (the "**New Loan**").

E. WHEREAS, concurrent with execution of this Third Amendment, MCG would advance the New Loan to Seller as "Borrower," Seller would pay off the Current Loan and have the Current Deed of Trust fully reconveyed, and a new deed of trust securing repayment of the New Loan would be recorded against the real property subject to the Agreement (the "**New Deed of Trust**").

F. WHEREAS, Buyer and Seller desire to further amend the Agreement to modify and extend the Closing Date, to remove the profit participation component, and to make such other changes, all on the terms and conditions set forth in this Third Amendment.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

1. Reference is hereby made to Paragraph 2(f) of the Agreement. Paragraph 2(f) is deleted in its entirety and replaced with the following new Paragraph 2(f): "Closing Date. The Closing or Close of Escrow of the Purchase and Sale of the Property shall occur on the later to occur of either: (i) thirty six (36) months after the Due Diligence Expiration Date; or (ii) fifteen (15) business days following Approval of the final map (the "**Closing Date**"). Notwithstanding the foregoing, Buyer may elect to close escrow if the final map is Approved before the date set forth in (i) above."

2. Reference is hereby made to Paragraph 2(d) of the Agreement and Paragraph 2(d) is deleted in its entirety and replaced with the following: "**Approved or Approval**. "Approved" or "Approval" means (i) in the case of the tentative map, the approval of the tentative map for development of residential units on the Property, and the expiration of all applicable periods for challenging or appealing such approval, without an appeal having been filed, resulting in a subdivision with approved residential units for the Property, referred to herein as "Approved Lots"; and (ii) in the case of the final map, the approval of the final map in substantial conformance with the tentative map, the expiration of all applicable periods for challenging or appealing such approval without an appeal having been filed, and the final map being "ready to record" (as used herein, the term "ready to record" means that the final map has been approved by the City Council and the mylar map has been signed by all requisite parties).

3. Reference is hereby made to Paragraph 2(o) of the Agreement and Paragraph 2(o) related to Profit Participation is deleted in its entirety. Further, Exhibit D, relating to profit sharing participation payments, is hereby deleted in its entirety from the Agreement.

4. Reference is hereby made to Paragraph 4.7.1 of the Agreement and Paragraph 4.7.1 related to Profit Participation is deleted in its entirety.

5. Reference is hereby made to Section 5.1 and a new Section 5.1(f) is added to the Agreement as follows: "(f). Seller shall have paid off the New Note and caused the New Deed of Trust to be fully reconveyed."

6. Reference is hereby made to Section 5.1 and a new Section 5.1(g) is added to the Agreement as follows: "(g). The final map for the Residential Parcel shall have been Approved."

7. Pursuant to Section 4.3 of the Agreement, Buyer and Seller have agreed upon the configuration and legal descriptions of the Residential Parcel and the Seller Retained Parcel and hereby attach those completed and approved descriptions to this Third Amendment as **Exhibit B-1** and **Exhibit B-2** respectively.

8. Any default by Seller as "Borrower" under the Loan Agreement or under the New Note, or by Seller as "Trustor" or under the New Deed of Trust shall constitute a default of the Agreement. In the event of any such default, Buyer shall have all remedies available to it under the terms of the Agreement.

9. Miscellaneous Provisions.

A. Successors. This Third Amendment shall be binding upon the heirs, administrators, executors, successors and assigns of each of the parties hereto.

B. Continued Validity of Agreement. Except as expressly amended as set forth in this Third Amendment, the Agreement shall remain in full force and effect.

C. Counterparts. This Third Amendment may be executed in counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

D. Signatures. Signatures by facsimile or electronically scanned shall be deemed binding on the parties. The parties agree to promptly exchange signatures in cyberspace or via facsimile.

E. Governing Law. This Third Amendment shall be construed in accordance with and all disputes hereunder shall be governed by the internal laws of the State of California, where the Property is located.

F. Attorney's Fees. In the event of any controversy or dispute arising out of this Third Amendment, the prevailing party or parties shall be entitled to recover from the non-prevailing party or parties, reasonable expenses, including, without limitation, attorneys' fees and costs actually incurred.

[Remainder of this page left blank intentionally.]

IN WITNESS WHEREOF, the parties have executed this Third Amendment as of the date first set forth above.

"SELLER"

SONOMA VALLEY HEALTH CARE DISTRICT,
a California Health Care District,

By: Kelly Mather
Its: President and CEO

"BUYER"

CIVIC PROPERTY GROUP, INC.
a California corporation

By: David B. Sanson
Its: President and CEO

AGREED TO AND ACCEPTED BY:

ESCROW AGENT:
First American Title Insurance Company

By: _____
Diane Burton, Escrow Officer

Exhibit B-1
Residential Parcel

Exhibit B-2
Seller Retained Parcel

9.

COMMITTEE REPORTS

Meeting Date: **July 5, 2018**

Prepared by: Peter Hohorst

Agenda Item Title: **Community Funding Policy**

Recommendations:
That the Board approve the restated Community Funding Policy
Background:

At its February 6, 2014 Board meeting the Board approved a Community Funding Policy. The Policy contained seven pages of instructions and forms for handling requests for community benefit support, including the possible establishment of a Committee to "maintain the integrity of the procedures set forth in the policy."
In view of the infrequent requests that have been made for community benefit support over the past three years, the policy has been simplified and condensed to two pages.
The revised policy contains the two key provisions of the old policy:

- All expenditures for community support must be approved in advance by the Board.
- The Chief Executive Officer (CEO) of the District shall be responsible for carrying out the duties and responsibilities assigned in the Policy.

Consequences of Negative Action/Alternative Actions:

The old cumbersome policy will continue to be used.

Attachment:

Community Funding Policy 7-5-18

Community Funding Policy #P-2018.07.05-1

Purpose

The purpose of this Community Funding Policy ("Policy") is to ensure that all funds and other resources of Sonoma Valley Health Care District (the District) are expended in furtherance of valid public purposes in full accordance with applicable laws and the rules in this Policy.

This Policy sets forth procedures and standards for consideration, approval and administration of potential expenditures of the District's resources in the areas of community benefit support and community benefit marketing.

Policy

It is the general policy of the District to deny requests for community benefit or community marketing support.

However, any Board Member, or the CEO, can bring a written request to the Board for its consideration at a Regular or Special Board meeting. Only the Board can approve such an expenditure, and all approvals must be in advance of the event/expenditure.

When considering such an expenditure it is the policy that the District shall:

- Ensure compliance with State law prohibitions on unlawful expenditures or gifts of public funds, including as specifically addressed in Sections 5 and 6 of Article XVI of the California Constitution, Government Code Section 8314, Code of Civil Procedure Section 526a and Penal Code Sections 424, et seq.
- Expend District resources only in furtherance of the District's statutory purposes and in the exercise of powers set forth or implied in SVHCD's enabling legislation (California Health and Safety Code Sections 32000, et seq.)
- Expend District resources only in the furtherance of its mission and vision related to improving the healthcare in the District.

The District shall not provide Community funding:

- In support of or opposition to campaigns for or against political candidates or ballot measures.

- In support of any religious sect, church, creed, or sectarian purpose, or to support or sustain any school, college, university, hospital, or other institution controlled by any religious creed, church, or sectarian denomination.
- In support of endowment funds of any organization.
- In support of any requests for funding that are not made in writing and are received less than 60 days prior to the event.

The District shall not make commitments of multi-year contributions, although requests may be funded in successive years if approved separately each year.

Definitions

"Community Funding" means District resources – including tax revenue or other funds, materials or in-kind support – given to or spent to support any individual, organization, or entity for the purpose of benefitting the healthcare of the District. Community Funding can include money or materials/in-kind benefits.

There are two types of Community Funding: Community Benefit Support and Marketing Support.

- "Community Benefit Support" is resources given or spent for the purpose of improving the healthcare of the District. Examples include contributions to community events at which individuals can benefit from health screenings or wellness screenings, community health education, and contributions to community health clinics.
- "Marketing Support" means resources given or spent to promote the business, mission and goals of the District and the services the District provides. Examples include advertisements of District services at community events or in local organization publications. "Marketing Support" does ***not*** include advertising in, on or through newspaper, radio, television, social media or direct mail, except when such advertising is associated with a specific community event hosted by an entity other than District itself.
- "Materials or In-kind Support" is resources other than money, including time and materials.

Procedures

The Chief Executive Officer (CEO) of the District shall be responsible for carrying out the duties and responsibilities assigned in this Policy.

Meeting Date: July 5, 2018

Prepared by: Peter Hohorst

Agenda Item Title: Ethics Training Policy for District Board Members

Recommendations:
That the Board approve the revised Ethics Training Policy

Background:
The Board approved the existing Ethics Training Policy in July 2012.
No changes have been made to the wording of that policy, except to format the policy to keep it consistent with other policies.
The policy mandates the completion of a self-serve training every two years in order for a Board member to receive reimbursement for expenses.

Consequences of Negative Action/Alternative Actions:
The existing policy will continue to be used

Attachment:
Ethics Training Policy for Board Members 2018-07-05-2

Ethics Training Policy for District Board Members
#P-2018-07-05-2

Purpose:
To establish guideline whereby the members of the Board of Directors maintain the mandated ethics training.

Policy:
On October 7, 2005 the Governor signed Assembly Bill No. 1234. AB 1234 requires that if a local agency provides any type of compensations, salary, stipend to, or reimburses the expenses of a member of its "legislative body" that local agency's officials must receive training in ethics. Sonoma Valley Hospital Board members are required to take the ethics training every other year and the District is required to keep records of course completion.

Procedure:
The District will notify Board members of the need to complete the required ethics training as near to Jan1st as practical with an expectation of completion by March 31st. The Governance Committee will be responsible for monitoring the training and report the completion of the training to the Board of Directors. Each Board member is expected to notify the District Board Clerk of completing of the testing by presenting the certificate to the Clerk.

Free online training is offered at www.fppc.ca.gov as a self-serve training program, therefore, there will be no expense reimbursement for this mandatory training.

Reference:
AB 1234 (Chapter 700, Statutes of 2005) Government Code sections 53232 and 53235
Health and Safety Code section 32103

Developed By: **Governance Committee**

Accountability/Responsibility for Review: Governance Committee

Meeting Date: **July 5, 2018**

Prepared by: Peter Hohorst

Agenda Item Title: **Residency Requirements Policy for Board Committees**

Recommendation**:**
That the Board approve the restated policy stipulating the residency requirements for members of Board Committees.

Background:
At its January 9, 2014 Board meeting the Board approved a policy defining the residency requirements for Board Committees.

The requirements were very broad:

"It is the policy of the District that stakeholders of the District shall be defined, for the purposes of Board committee membership policy only as:

- *Living some or all of the time in the District or,*
- *Being employed at a place of business in the District, or*
- *Being an accredited member of the Hospital Medical Staff*

And may be appointed to and serve on Standing and Ad Hoc Board Committees as long as they regularly attend the committee meetings."

The attached policy does not change the definition of a stakeholder of the District. It is merely a restatement of the January 9, 2014 policy put in a standard policy format.

Consequences of Negative Action/Alternative Actions:

The old policy will prevail, but will look out of place if compared to other policies.

Residency Requirements Policy for Members of Board Committees

P# 2018.07.05-3

Overview

There is a significant and important part of the Sonoma Valley Health Care District community who do not reside in the District full-time, but are actively involved in the community and/or District/Hospital affairs. These include:

- Members of the Hospital Medical Staff who do not reside in the District.
- Individuals who live in the District less than fulltime, e.g., individuals having multiple residences one of which is in the District.
- Individuals who work in the District but do not live in the District (including District and Hospital employees.)

Excluding these individuals from participation on either Standing or Ad Hoc Committees because they are not residents of the District denies the District access to their expertise and experience.

Policy

It is the policy of the Sonoma Valley Health Care District (the District) that all members of Standing and Ad Hoc Board Committees shall be stakeholders of the District.

It is the policy of the District that stakeholders of the District shall be defined, for the purposes of Board committee membership policy only as:

- Living some or all of the time in the District or,
- Being employed at a place of business in the District, or
- Being an accredited member of the Hospital Medical Staff

And may be appointed to and serve on Standing and Ad Hoc Board Committees as long as they regularly attend the committee meetings.

Meeting Date: **July 5, 2018**

Prepared by: Bill Boerum

Agenda Item Title: Proposed JPA By-law Amendment

Recommendations:
That the Sonoma Valley Health Care District Board approve the proposed JPA By-laws amendment as follows:

Change the final sentence in the first paragraph of section "4.04 Meetings" of the JPA By-laws From:

"The Board shall establish its meeting schedule each year by resolution, which resolution shall provide for **not less than 6 meetings** per year."

To:

"The Board shall establish its meeting schedule each year by resolution, which resolution shall provide for **at least one meeting** per year."

Background:
The JPA By-laws requires that changes to its By-laws be approved by the district boards of all five District Boards.

The JPA By-laws stipulates a minimum of 6 meetings per year. Given the policy informally adopted last year to minimize the number of board meetings in order to save on expenses as well as to call meetings only when there are substantive matters to consider, the JPA Board held less than 6 meetings last year.

The JPA Board has scheduled only one meeting for fiscal 2019.

The JPA Board, at its meeting on June 12, 2018, approved amending its By-laws to reduce the number of required meetings from six to one per year.

Consequences of Negative Action/Alternative Actions:
The JPA Board will be required to hold meetings that may not be productive and which will deplete its cash balance unnecessarily.

Meeting Date: **July 5, 2018**

Prepared by: Leslie Lovejoy and Peter Hohorst

Agenda Item Title: Amendment to the Medical Staff By-Laws

Recommendations:

That the Sonoma Valley Health Care District Board approve the proposed wording changes to the Medical Staff By-Laws as shown on the attached document.

Background:

All amendments to the Medical Staff By-Laws must be approved by the District Board before they become effective.

The Medical Staff at their quarterly meeting on June 13, 2018 approved the attached amendment to the Medical Staff By-Laws

The changes affect the process for credentialing medical professionals who provide Telemedicine services to Sonoma Valley Hospital.

- The present Medical Staff By-Laws do not contain language that allows for delegated credentialing from an independent agency (including VRAD). They restrict the delegation only to other hospitals. The change will substitute the word **hospital** with the phrase **"Hospital/contracted Telemedicine organization."** As shown on the attached document.
- The present Medical Staff By-Laws restrict the telemedicine category of privileges to a "Distant Site" with regards to quality review and proctoring. The change will clarify the intent of the provision by substituting the words **Distant Site** with the phrase **Distant Site/contracted Telemedicine Organization.**

Consequences of Negative Action/Alternative Actions:

Approval of requests for credentialing will be unnecessarily delayed.

Attachment

Letter from Leslie Lovejoy to the Medical Executive Committee

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

To: Medical Executive Committee
From: Leslie Lovejoy
Date: 06/13/18
Subject: Proposed By-Laws change

Recently the hospital entered into a contract with Specialists On Call, a TJC/CMS accredited Telemedicine service provider organization. They will be providing TeleNeurology and TelePsychiatry services beginning in July. They anticipate a panel of as many as 38 physicians moving through the privileging process. Specialists On Call credentials its physicians much in the same way as VRAD but without the web based portal for application storage. We will store their application in our internal database not with Verge.

Problem: Our by-laws do not contain language that allows for delegated credentialing from an independent agency (including VRAD) just other hospitals. See below:

The initial appointment of practitioners to the Telemedicine Staff may be based upon
1) The practitioner's full compliance with this hospital's credentialing and privileging standards; or

2) By using this hospital's standards but relying in whole or in part on information provided by the hospital(s) at which the practitioner routinely practices; or

3) By relying entirely on the credentialing and privileging of that other hospital, if the hospital where the practitioner routinely practices is a Medicare-participating hospital and it agrees to provide a comprehensive report of the practitioner's qualifications. This comprehensive report includes at least the following:
i. Confirmation that the practitioner is privileged at that hospital for those services to be provided at this hospital (i.e., list of current privileges)
ii. Evidence of that hospital's internal review of the practitioner's performance of the requested privileges, including information useful to assist in this hospital's assessment of the practitioner's quality of care, treatment, and services. This must include, at a minimum: all adverse outcomes related to sentinel events that result from the telemedicine services provided and any complaints received at that hospital related to telemedicine services provided at this hospital.

iii. An attestation signed by an authorized representative of that hospital indicating that the packet is complete, accurate, and up-to-date.

Proposed solution: insert "Hospital/contracted Telemedicine organization"

Problem: Telemedicine category of privileges refers to a "Distant Site" with regards to quality review and proctoring. See below.

Additional Provisions Applicable to Telemedicine Staff:

i. Responsibility to Communicate Concerns/Problems:

1) There is a need for clear delineation of reporting responsibilities respecting the Telemedicine providers' performance. At the very least, the Medical Staff officials at this hospital must be informed of any practitioner-specific problems that arise in the delivery of services to this hospital's patients.

2). Additionally, this hospital should communicate to the Medical Staff officials at the Distant Site, through peer review channels, any problems that may arise in the delivery of care by the Telemedicine provider to patients at this hospital.

3). Similarly, when a member of this hospital's Medical Staff is providing telemedicine services to patients at another facility, this hospital's Medical Staff should communicate to the Medical Staff officials at the Originating Site, through peer review channels, any problems that may arise in the delivery of telemedicine services by members of this hospital's Medical Staff.

4). The Chief of Staff may enter into appropriate information sharing agreements and/or develop and implement appropriate protocols to effectuate these provisions.

ii. Responsibility to Review Practitioner-Specific Performance:

1). Special proctoring arrangements may be made for qualified practitioners at the Distant Site to proctor cases performed by new members of the Telemedicine Staff.

2). Primary responsibility to assess what, if any, practitioner-specific performance improvement and/or corrective action may be warranted rests with the Originating Site. If such action gives rise to procedural rights at this hospital, the provisions of Article 13 of the Bylaws will apply. However, this Medical Staff is authorized to develop integrated peer review policies and procedures with other System members, whereby representatives of both the Originating Site's and the Distant Site's Medical Staffs engage in integrated review and recommendation**.**

iii. Requirement for Contract with Distant Site: This Hospital must have a written agreement with each Distant Site from which a Telemedicine Provider delivers telemedicine services that specifies the following:

1) The Distant Site is a contractor of services to the Hospital

2) The Distant Site furnishes services in a manner that permits this hospital to be in compliance with the Medicare Conditions of Participation.

3) This hospital makes certain through the written agreement that all Distant Site Telemedicine Providers' credentialing and privileges meet, at a minimum the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4).

Proposed solution: Distant Site/contracted Telemedicine Organization

10.

BOARD COMMENTS

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

June 1, 2018

Sonoma County Board of Supervisors
575 Administration Drive, Room 100A
Santa Rosa, CA 95403

Re: Request for $30,000 in County Funds for a Winter Shelter in Sonoma Valley Managed by Sonoma Overnight Support (SOS) for FY 2018-2019

Dear Board of Supervisors:

On behalf of Sonoma Valley Hospital (SVH), I am urging the Board of Supervisors to provide $30,000 in funding for winter shelter homeless services in Sonoma Valley.

Sonoma County has provided approximately $30,000 each year in funding for the past two years in support of the only Winter Shelter in the Sonoma Valley managed by Sonoma Overnight Support, a local non-profit. Unfortunately, during this current funding cycle, the initial recommendation by staff and the Community Development Commission (CDC) provided no funding for a winter shelter in Sonoma Valley as submitted by Sonoma Overnight Support. We understand that in early May, the CDC received the County of Sonoma's federal grant allocation notification from the US Department of Housing and Urban Development (HUD), which included more funding than what had been anticipated, and it has been confirmed that Sonoma Overnight Support meets the requirements to operate this program. With these additional funds and clarify on operations, County staff and the CDC is now recommending that the SOS Emergency Winter Shelter to be funded at the same level through County funding as last year, $30,000. We are extremely appreciative of this revised recommendation and support for homeless services in the Sonoma Valley.

SVH's Emergency Department sees homeless people every day. Our staff do everything possible to coordinate and facilitate the patient's discharge to community-based services, often dedicating additional time and resources due to the complexities of the patient's situation and the general lack of available services in the community. Many social services agencies have limited operating hours essentially requiring hospitals to 'shelter' these patients and ultimately reducing emergency room availability. Our Emergency Department is often full and cannot shelter patients for long periods of time. That said, if we have a homeless patient we would never discharge them without connection to social services or another agency that could receive the patient.

SVH participates in the Sonoma County Health Needs Assessment and, together with County Health Services, started the Nightingale services in Sonoma County as a result of the homeless healthcare needs. We remain committed to creating strong partnerships with homeless advocates, community providers, nonprofit groups, local governments, faith-based organizations and others dedicated to

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addressing the needs of the homeless. Homelessness remains a serious issue for the City of Sonoma and Sonoma Valley.

On behalf of Sonoma Valley Hospital, we request support from the Board of Supervisors to fund $30,000 to assist SOS in financing the operation of a winter shelter during FY 2018-2019. Based on its costs of operating the 2017-2018 Winter Shelter, SOS estimates it will cost approximately $87,000 to operate the Winter Shelter for four months beginning on December 1, 2018 and ending on March 31, 2019. The remaining funds will come from fundraising and local community support. Without County help, the most vulnerable of our Sonoma and Sonoma Valley homeless population will be even more at risk.

Thank you for your support.

Sincerely,

Kelly Mather
President and Chief Executive Officer

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

June 12, 2018

The Honorable Jim Wood
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, CA 95814

SUBJECT: SB 538 (Monning) – Oppose

Dear Assemblymember Wood:

I am writing today on behalf of Sonoma Valley Hospital to voice our concerns about Senate Bill 538 (Monning, D-Carmel). The bill would prohibit certain contract provisions between hospitals and payers, including prohibiting hospitals from requiring multiple facilities in their system to be included in a contract.

SB 538 moves California in the wrong direction. The bill picks winners and losers: large, dominant health plans and their third-party clients win, while physicians, hospitals and the patients we serve – especially those in underserved communities – lose. The four largest insurers control 85 percent of the health care market in California. SB 538 gives these dominant health plans and their third-party clients an even greater market advantage. Under the bill, they are allowed to access the services of doctors and hospitals without being subject to decades of California consumer and provider protections.

- SB 538 enables an unregulated segment of the market to continue and expand its negative practices. Organizations often establish their own self-funded health insurance plans to save costs, then lease provider networks from health plans to access discounted rates. These plans are exempt from California's robust consumer protection laws and should not be further advantaged through legislation at the expense of responsible providers and consumers. Leased networks have a huge impact on timely and adequate access to care, and no one is tracking the effects.

- SB 538 allows "cherry-picking" of hospitals and other providers. Even community hospitals that are not part of larger systems have affiliations, partnerships and joint ventures with various community providers. Fragmented care is more costly and confusing for patients. Health care systems also ensure that weaker hospitals can continue to provide services in rural and underserved communities because of financially stable hospitals within the system.

- SB 538 appears to only impact hospitals, but because many providers have integrated into systems of hospitals and physician groups, it also negatively affects the physician community. Integrated systems provide both hospital and physician services in a seamless delivery system.

Supporters of SB 538 paint the bill as a solution to reducing health care costs and dismantling what they perceive as "market dominant" providers. In reality, this bill will not only inflate costs across the health care market by allowing them to abuse the system and be the "winners," but ultimately reduce access to care by shutting down vital health care services across the state. Nearly every region in California has a struggling hospital. SB 538 penalizes these hospitals, physicians and the communities they serve – the real "losers" under this bill.

For these reasons, we respectfully ask for your **"NO"** vote on **SB 538**.

Sincerely,

Kelly Mather
President and Chief Executive Officer
Sonoma Valley Hospital