SONOMA VALLEY HEALTH CARE DISTRICT

BOARD OF DIRECTORS
REGULAR MEETING AGENDA
NOVEMBER 1, 2018

CLOSED SESSION 5:00 P.M.

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 ON CLOSED SESSION	*Rymer*	
3. CLOSED SESSION Calif. Government Code & Health and Safety Code§ 54947 Performance Evaluation Regarding Chief Executive Officer	*Board*	
4. REPORT ON CLOSED SESSION	*Rymer*	
5. 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*	
6. CONSENT CALENDAR A. Board Minutes 10.04.18 B. Finance Committee Minutes 09.25.18 C. Quality Committee Minutes 09.26.18 D. Executed Policies and Procedures E. Medical Staff Credentialing Report *Pages 3-23*	*Rymer*	Action
7. OUTPATIENT DIAGNOSTIC CENTER *Pages 24- 78*	*Mather*	Inform/Action
8. FY 2019 BUDGET *Pages 79- 87*	*Jensen*	Inform/Action
9. CEO INCENTIVE COMPENSATION *Pages 88- 91*	*Rymer/Hohorst*	Inform/Action
10. ADMINISTRATIVE REPORT NOV. 2018 *Pages 92-94*	*Mather*	Inform
11. CMO UPDATE *Page 95*	*Kidd*	Inform
12. FINANCIAL REPORT MONTH END 09.30.18 *Pages 96- 108*	*Jensen*	Inform

13. COMMITTEE REPORTS	*Rymer*	Inform
14. BOARD COMMENTS • SVHCD Annual Report	*Board Members*	Inform
15. ADJOURN	*Rymer*	Inform

Note: To view this meeting you may visit http://sonomatv.org/ or YouTube.com.

SONOMA VALLEY HEALTH CARE DISTRICT
BOARD OF DIRECTORS' MEETING
MINUTES
THURSDAY, OCTOBER 4, 2018
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 6:00 pm.	*Rymer*	
2. PUBLIC COMMENT	*Rymer*	
None		
3. CONSENT CALENDAR: A. Board Minutes 09.06.18 B. Finance Committee Minutes 08.28.18 C. Quality Committee Minutes 08.22.18 D. Governance Committee Minutes 08.21.18 E. Executed Policies and Procedures F. Medical Staff Credentialing Report	*Rymer*	
Policies: Aminoglycoside Protocol MM8610-111 Controlled Substance Management MM8610-102 Dispensing of Medication MM8610-148 Automatic Stop Orders MM8610-138 Look Alike Sound Alike MM8610-101 Ordering and Prescribing Medications MM8610-133 Healing at Home Administrative and Clinical Policies		**MOTION**: by Hirsch to approve, 2nd by Boerum. All in favor.
4. IT ANNUAL REPORT	*Sendaydiego*	
Ms. Sendaydiego gave a report on our Health Information Exchange provider, the issues we have experienced, and options for the future, including those with UCSF. She also gave a cyber security update. This reviewed the initiatives from 2017 and current 2018 initiatives.		
5. MEDICAL TOURISM	*Boerum*	
Mr. Boerum spoke about medical tourism as a concept and the potential for it at SVH. Ms. Renee Stephano, Co- Founder and President of the Medical Tourism Association gave a presentation on medical tourism.		
6. SNF TASK FORCE UPDATE	*Hirsch*	

Ms. Hirsch gave an interim report on the SNF Task Force She spoke about the consultant's report and the identified issues. The narrative portion of the consultant's report will be made available to the public in the next week. In response to some of the issues identified by the Task Force, the following changes have been initiated: the admission criteria for patients coming to the SNF have been revised, nursing staffing changes are being piloted, pre authorizations are now being done by patient financial services, and there has been a tracking tool created for admissions and rehab services. In addition, the hospital has hired contract physical therapists to ensure that patients are provided with the full amount of therapy prescribed when admitted to the SNF. All of these changes will all be evaluated over the next few months. Ms. Hirsch also spoke about the public comment suggestions made during the Task Force meeting and said that the three specific recommendations from the public will be evaluated and then addressed at a future meeting. A public comment was made regarding how patients from outside facilities are placed in the SNF.		
7. ADMINISTRATIVE REPORT OCTOBER 2018	*Mather*	Inform
Ms. Mather gave her administrative report for October. This included the Home Care transfer, current initiatives, Dr. Brown's move into the hospital, the start of the Urologist, the Pain Management specialty clinic, UCSF men's health clinic, and the master facility plan.		
8. CMO UPDATE	*Kidd*	Inform
Dr. Kidd gave an update on her current projects which include the review of the medical director's contracts, meetings and collaboration with UCSF, updates to the surgery block schedule, and the education and training of the ED staff in preparation to the OB closure at the end of the month. She said that the hospital should be stroke ready by the first of the year. She identified opportunities for improvement with the physician contracts and call pay.		
9. FINANCIAL REPORT MONTH END AUGUST 31, 2018	*Jensen*	
Mr. Jensen gave his financial report for the month end August 31, 2018. After accounting for all income and expenses , but not including Restricted Contributions and GO bond activity, the net loss for August was ($130,246) vs. a budgeted net loss of ($188,179). The total net income for August after all activity was $32,110 vs. a budgeted net income of $41,441. EBIDA was 4.3% vs. the budgeted 3.1%. Days of cash on hand was 10. Accounts Payable was at 47.6 days and Accounts Receivable was at 43 days.		
10. COMMITTEE REPORTS	*Board*	
Governance Committee: Mr. Hohorst presented the following policies for approval: *a.* Community Funding Policy *b.* Board Member and Chair Legal Duties, Roles and Responsibilities and Limits on Power and Authority Policy		**MOTION**: by Hohorst, 2nd by Boerum to approve policy A and B. All in favor.

11. BOARD COMMENTS	*Board*	
Ms. Mather presented the following letters: *a.* Opposition letter SB 1288 – SB 1288 speaks to the penalty for not meeting nursing staffing ratios. *b.* Letter regarding AB 2798 – This letter is asking for a signature by the Governor to hold CDPH to a response time frame. Mr. Rymer spoke about the upcoming Board Retreat November 14 and topics that will be covered.		
12. ADJOURN		
7:45 pm		

SVHCD
FINANCE COMMITTEE MEETING
MINUTES
TUESDAY, SEPTEMBER 25, 2018
Schantz Conference Room

Present	Excused	Staff	Public
Sharon Nevins Dr. Subhash Mishra via telephone Susan Porth Joshua Rymer Keith Hughes John Perez		Kelly Mather Sarah Dungan Ken Jensen Dave Pier Dawn Kuwahara	

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
MISSION & VISION STATEMENT *The mission of SVHCD is to maintain, improve and restore the health of everyone in our community.*			
1. CALL TO ORDER/ANNOUNCEMENTS	*Nevins*		
	Called to order 4:59 pm		
2. PUBLIC COMMENT SECTION	*Nevins*		
	None		
3. CONSENT CALENDAR	*Nevins*		
		MOTION: by Rymer 2nd by Porth. All in favor	
4. CASH PROJECTIONS AND FUNDING SUMMARY FOR THE OUTPATIENT DIAGNOSTIC CENTER	*Mather*		
	Mr. Pier updated the committee on the accounted for pledges. Ms. Mather reviewed the funding summary.	Request to have Kathleen Carroll prepare a draft format for the reporting budget	

		versus actual expenses and change orders.	
5. FY18 AUDIT UPDATE	*Dungan*		
	Ms. Dungan said that findings are consistent with last year's findings. The final report will be ready for the Oct. 23rd meeting 4pm.		
6. REVIEW OF CURRENT INSURANCE POLICIES	*Jensen*		
	Mr. Jensen reviewed the new rates for insurance policies.	Mr. Jensen requested to obtain a quote on earthquake insurance.	
7. ADMINISTRATIVE REPORT SEPTEMBER 2018	*Mather*		
	Ms. Mather informed the committee that our legal firm dissolved and that the Board has approved continuing with our attorney at another firm. She also spoke about the restructuring of the inpatient and outpatient services.		
8. FINANCIAL REPORT MONTH END AUGUST 30, 2018	*Jensen*		
	Budget update – Ms. Dungan gave an update of the finalization of the budget. She reported it will be complete by next meeting. Ms. Mather spoke about a staffing and logistics pilot that will occur in SNF from October 1st through November. Mr. Jensen reviewed the financials for August 2018. He reported that the days of cash on hand was 10 days. Accounts Receivable was at 43 days and Accounts Payable was at 47.6 days. The August net income was $32,110 vs. the budgeted net income of $41,441 with a monthly EBIDA of 4.3% vs. a budgeted 3.1%.	Ms. Dugan requested by the committee to calculate the average days of cash for the preceding four months for the next meeting.	
8. ADJOURN	*Nevins*		

	Meeting adjourned at 5:58 pm		

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
September 26, 5:00 PM
MINUTES
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch Peter Hohorst Carol Snyder *Howard Eisenstark, MD* *Michael Mainardi, MD*	Cathy Webber *Susan Idell*	Michael Brown, MD Ingrid Sheets	Leslie Lovejoy Sabrina Kidd, MD

**Italisized names indicate voting member*

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Meeting called to order at 5:00 pm	
2. PUBLIC COMMENT	*Hirsch*	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 08.22.18		**MOTION:** by Eisenstark to approve, 2nd by Mainardi. All in favor.
4. POLICIES AND PROCEDURES	*Lovejoy*	Inform/Action
	Policies: A. Ventilator Associated Pneumonia (VAP) and Nonventilator Pneumonia Prevention IC8610-179- *needs to come back with clarification on mortality data and addition of references.* B. Hiring Process Recruitment and Selection HR8610-325 C. References HR8610-196 D. *Retired*: Requisition for Employee HR8610-101 E. Scribes in the Emergency Department 7010-21 F. Scheduling Per Diem Policy 8560-01 G. Medical Imaging Dept Policies per TOC	**MOTION:** by Eisenstark to approve policies B – H 2nd by Idell. All in favor

AGENDA ITEM	DISCUSSION	ACTION
	H. *Retired* – Ventilator Associated Pneumonia (VAP) Prevention 6010-17	
5. QUALITY COMMITTEE CHARTER	*Hirsch*	Inform/Action
	Discussion regarding proposed revisions. These revisions included alignment with Medical Staff ByLaws, membership, voting members and attendance, how often the charter should be reviewed and the alignment with the language from the 2014 revision that was never approved. The 2014 version will be emailed out for committee review. Stated revisions will come back for review at the next meeting.	
8. REPORT OF CLOSED SESSION	Adjourn to closed session at 5:52 pm	Action
	Medical Staff credentialing report reviewed and approved.	**MOTION:** by Hohorst to approve, 2nd by Eisenstark. All in favor.
9. ADJOURN	*Hirsch*	
	Meeting adjourned at 6:00 pm	

Policy and Procedures – Summary of Changes
Board of Directors, November 1st, 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:

Ventilator Associated Pneumonia (VAP) and Nonventilator Pneumonia Prevention IC8610-179
This Organizational policy was developed to replace ICU Departmental Policy, Ventilator Associated Pneumonia (VAP) Prevention 6010-17

REVISIONS:

Hiring Process Recruitment and Selection HR8610-325
Removed a significant amount of language that was redundant in other policies and added more specific and relevant language associated with the current recruitment and selection process. Revised to reflect best practices and ensure compliance with applicable employment laws and strengthen our success rate in hiring qualified candidates. Added information about the newly developed Signing & Retention Bonus Agreement designed to attract and retain clinical new hires and new nursing graduates (with six months of work experience or less) in hard-to-fill nursing and clinical positions.

References & Employment Verification Requests HR8610-196
Removed language referring to how SVH conducts references for potential new hires and clarified language of how SVH responds to requests for reference checks and employment inquires. The process of how SVH conducts references for potential new hires is now covered under separate policy: Hiring Process: Recruitment and Selection #HR8610-325. Changed title of policy from “References” to “References & Employment Verification Requests”.

RETIRED:

Requisition for Employee HR8610-101
Information included in revised Hiring Process: Recruitment & Selection, #HR8610-325

DEPARTMENTAL

NEW:

Scribes in the Emergency Department 7010-21
This is a policy for Medical Staff. The ED MDs will be using Scribes for documentation and this policy outlines the Scribes scope of practice.

Scheduling Per Diem Policy 8560-01
To provide a scheduling guideline to any per diem status employee.

REVIEWED/NO CHANGES:
Medical Imaging Departmental Policies - Table of Contents Attached

RETIRED:
Ventilator Associated Pneumonia (VAP) Prevention 6010-17
Replaced ICU department policy with organizational policy: Ventilator Associated Pneumonia (VAP) and Nonventilator Pneumonia Prevention IC8610-179

SUBJECT: Ventilator Associated Pneumonia (VAP) and Nonventilator Hospital-Acquired Pneumonia Prevention	POLICY #IC8610-179 PAGE 1 OF 2
DEPARTMENT: Organizational	EFFECTIVE:
REVIEW/REVISED:	

POLICY:

Healthcare providers will implement measures for the prevention of ventilator associated events (VAE) and pneumonia (VAP) and nonventilator hospital-acquired pneumonia (NV-HAP).

Background
Ventilator-associated pneumonia (VAP) is a nosocomial lung infection that occurs in patients receiving mechanical ventilation. NHSN reports that the incidence of VAP is from 0.0-4.4 per 1000 ventilator days. VAP and ventilator associated events (VAE) are identified according to the Centers for Disease Control (CDC) definitions by using a combination of radiologic, clinical, and laboratory criteria. VAP/VAE are suspected when a patient receiving mechanical ventilation develops a new or progressive pulmonary infiltrate with fever, leukocytosis, and purulent tracheobronchial secretions. VAP is considered as ventilator associated if the patient was intubated and ventilated at the time or within 48 hours before the onset of infection. Although a serious infection, VAP represents only 38% of total hospital-acquired pneumonia cases. Although it carries the same mortality as VAP (recent meta-analysis reports rates at 4.4-13%), the incidence of NV-HAP is higher, and therefore associated costs and deaths are higher. NV-HAP patients are at greater risk for readmission within 30 days than patients without HAIs.

PROCEDURE:

- **Clean hands** with soap and water or an alcohol-based hand rub before and after touching the patient or the ventilator.
- **Assess the patient's risk for aspiration.** Utilize Speech Therapy consultation as indicated.
- **Implement oral care for ALL patients in accordance with the Oral Care procedure**
- **Collaborate** to identify patients where implementation of noninvasive positive pressure ventilation may be appropriate to prevent the need for intubation
- **Keep the head of the patient's bed raised** between 30 and 45 degrees unless clinically contraindicated in ventilated and nonventilated patients at high risk for aspiration
- **Assess readiness to extubate ventilated patients daily** through combined spontaneous awakening trials (SATs: sedation interruption/minimization) and spontaneous breathing trials (SBTs), unless clinically contraindicated.

SUBJECT: Ventilator Associated Pneumonia (VAP) and Nonventilator Hospital-Acquired Pneumonia Prevention	POLICY #IC8610-179 PAGE 2 OF 2
DEPARTMENT: Organizational	EFFECTIVE:
REVIEW/REVISED:	

- **Minimize pooling of secretions above the endotracheal tube cuff** by using an endotracheal tube with subglottic suction capability in patients with anticipated intubation greater than 48-72 hours.
- **Maintain and improve physical conditioning** through early exercise and mobility.
- **Change ventilator circuits only if visibly soiled.**
- **Promote lung expansion (pulmonary toilet)** for non-ventilated patients

REFERENCES:

CDC. Guidelines for the Management of Adults with Hospital-acquired, Ventilator-associated, and Healthcare-associated Pneumonia, 2005.
Lippincott: http://procedures.lww.com/lnp/procedureselect.do
AACN: http://www.aacn.org/wd/practice/docs/130300-standards_for_acute_and_critical_care_nursing.pdf
AACN Practice Alert, Critical Care Nurse, Vol 37, No. 3, June 2017

OWNER:
Chief Nursing Officer

AUTHORS/REVIEWERS:
Kathy Mathews, Infection Preventionist

APPROVALS:
Policy & Procedure Team: 6/19/18
Performance Improvement Committee: 8/23/18
Medical Executive Committee: 9/20/18
Board Quality Committee: 9/26/18
The Board of Directors:

SUBJECT: Scribes in the Emergency Department	POLICY: 7010-21
	PAGE 1 OF 4
DEPARTMENT: Medical Staff	EFFECTIVE:
REVIEWED:	

PURPOSE:

This Policy is to establish the requirements and scope of duties for the use of Scribes by physicians in the Emergency Department at Sonoma Valley Hospital.

POLICY:

Scribes work under the direction of the Provider to record information into the medical record with the goal of allowing the provider to spend more time with the patient and improve accuracy and detail of documentation. The scribe never performs clinical or medical tasks.

PROCEDURE:

I. **Qualifications of a Scribe**:

a. Minimum of a high school diploma or equivalency.

b. The scribe must be employed, in good standing, with ScribeConnect who contracts with Valley Emergency Physicians Healthcare (VEP).

c. Successful completion of an approved scribe training course specific to Emergency Medicine.

II. **Scribe Training, Requirements and Employment**:

a. Scribes will be oriented to information necessary for compliance with all Policies of Sonoma Valley Hospital (including Human Resources, Information Services, and Rights and Responsibilities).

b. Scribes will complete a comprehensive orientation and training course through ScribeConnect - specific to Emergency Medicine - that includes didactic classroom training, Electronic Medical Record (EMR) training and bedside training.

c. Scribes must pass a comprehensive competency exam prior to working independently with the Provider.

d. As Employees of ScribeConnect, all scribes are paid by ScribeConnect, are

covered under ScribeConnect's Worker's Compensation Policy and receive benefits based on their employment status. Scribes are required to take a meal period and rest breaks per California law.

e. All Scribes must sign a job description that recognizes the Scribe's unlicensed status and clearly defines the qualifications and extent of their responsibilities.

f. Scribes must meet all information management, HIPAA, HITECH, confidentiality and patient rights standards, as do other hospital personnel.

III. **Scope of Service:**

a. Scribes assists the physician or provider with chart documentation by entering data into the electronic medical record information system as the licensed provider collects it during the ED encounter.

b. Scribes may document ONLY at the direction of the provider any dictations of medical decision-making, treatment plan and/or activities (i.e. family meetings, patient counseling, re-evaluations, etc.)

c. A Scribe must document ONLY under his or her own log-in credentials and password. Sharing of credentials and password information is not permitted.

d. Notifies physician or provider of pending or completed lab, x-ray, EKG results, nursing orders and any other recommendations noted in the patient's medical record.

e. Scribes perform no clinical duties, do not provide direct patient care, and do not discuss care or results with patient or family at any time.

f. Scribes may assist the provider as he or she rounds on their patients and may update patients and family members with the status of pending tests at the direction of the provider. Scribes may not discuss results, values or independently (out of the presence of the provider) elicit/obtain information from patients or family.

g. Scribes do not transcribe, enter orders, or write prescriptions.

h. Verbal orders cannot be given to nor entered by Scribes.

i. The physician or provider is responsible for introducing the Scribe to the patient

and obtaining consent for the presence of a Scribe.

j. The physician or provider is responsible for the accuracy of the documentation by the Scribe performing this duty.

k. Scribe must sign, including their name and title, date and time of all entries into the medical record-electronic or manual. The role and signature of the Scribe must be clearly identifiable and distinguishable from that of the Physician or Provider or of other staff.
Example: "Scribed for Dr. X by name of the scribe and title" with the date and time of the entry.

IV. **Provider Responsibilities:**

a. The physician or provider must complete a scribe attestation for every medical record in which the Scribe made an entry on behalf of the physician or provider.

b. The physician or provider must sign and date the attestation through the clinical information system.

c. The attestation must take place before the physician or provider and scribe leave the patient care area since other providers may be using the documentation to inform their decisions regarding care, treatment and services.

d. The attestation, physician signature and date cannot be delegated to another physician or provider or the scribe.

V. Scribe Supervision & Reappraisal:

a. The “Site Manager” (SM) will oversee the scribe program in the Emergency Department at Sonoma Valley Hospital. The SM is an employee of ScribeConnect and will collaborate with Sonoma Valley Hospital and VEP staff to ensure compliance with all facility requirements, scribe performance and any other scribe-related topics.

b. The Physician/Provider who is utilizing a Scribe is responsible to ensure that the Scribe is not acting outside of his/her job description, that authentication is occurring as required and that no orders are being entered into the medical record by Scribes. The Provider is responsible for the accuracy of the documentation by the Scribe performing this duty.

c. ScribeConnect will verify the competency of the Scribe in writing to the designated department at Sonoma Valley Hospital within 90 days of hire, and then at least every two (2) years.

REFERENCES:
CIHQ 482.12 GL-6 Directing Medical Care of the Patient

OWNER:
Chief Executive Officer

AUTHORS/REVIEWERS:
Mark Kobe, Chief Nursing Officer

APPROVALS:
Policy & Procedure Team: 6/19/18
Medicine Committee: 9/13/18
Medical Executive Committee: 9/20/18
Board Quality Committee: 9/26/18
The Board of Directors:

SUBJECT: Scheduling Policy for Per Diem Status Employees	POLICY # 8560-01
	PAGE 1 OF 2
DEPARTMENT: Admitting	EFFECTIVE:
REVISED:	

PURPOSE:

To clarify the structure and requirements of Per Diem staff according to the needs of the Admitting department.

POLICY:

Employees hired on as Per Diem status are done so with the understanding that they are scheduled according to the needs of the department in either Admitting, Concierge, PBX or Emergency Department Registration. Likewise they are hired with the knowledge that we are a 24 hour operation and shifts vary from AM, PM, nights (NOC), weekdays, weekends and holidays.

Employees hired as Per Diem are required to give one month of availability submitted to the Admitting Manager no later than the Thursday before the last week of the schedule. Schedules are made for one month at a time. Availability may only consist of either unavailable days, or specify availability on days just for the AM (5:30 AM – 5:30 PM), PM (1:00 PM – 10:30 PM), or NOC (10pm – 630am) timeframes. Availability may not specify specific shifts.
Per Diem employees are required to be available at least 2 weekends out of each schedule period and at least 2-3 shifts each week of a 4-week schedule. They must make themselves available for at least 4 of the 11 holidays (8 of which are recognized SVH holidays plus Easter, Christmas Eve and New Year's Eve).

Per Diem employees must notify the Admitting Manager in advance of required prolonged periods of unavailability. Total unavailability may not exceed eight (8) weeks in a calendar year (56 days).

PROCEDURE:

It is the responsibility of the Per Diem employee to give the Admitting Manager one month of availability either by email or written calendar. This is due no later than the Thursday before the last week of the current schedule.

The Admitting Manager will provide a yearlong calendar in the Admitting Department where each employee (benefitted and per diem) will write down dates that are being requested off. Requests for time off will not be approved for any day or week where there are already two people scheduled off. Per Diem employees are asked to consider this posted calendar when providing their availability and make every effort to be available to help cover the absences. In the event of extenuating circumstances, every effort will be made to accommodate such request if the needs of the department can still be met, at the discretion of the manager.

SUBJECT: Scheduling Policy for Per Diem Status Employees	POLICY # 8560-01
	PAGE 2 OF 2
DEPARTMENT: Admitting	EFFECTIVE:
REVISED:	

REFERENCES:
Organizational Policy – Classification of Employees, Per Diem section with guidance from example of Nursing per diem requirements.

OWNER:
Lisa Duarte, Admitting Manager

AUTHORS/REVIEWERS:
Lisa Duarte, Admitting Manager
Lynn McKissock, Director of Human Resources
Cynthia Denton, Director of Admitting and Patient Financial Services

APPROVALS:
Policy & Procedure Team: 9/18/18
Board Quality Committee: 9/26/18
The Board of Directors:

Medical Imaging Department Policies and Procedures
Table of Contents

7630-173 MRI Screening Procedure
7630-169 MRI Code Blue Procedure
7630-157 Intravenous Administration of Radiopharmaceuticals Policy
7630-155 Infection Control during Imaging Procedures Procedure
7630-199 Physician Orders - Verbal and Written Policy
7630-137 ED and Radiologist Discrepancy

4. Safety

7630-102 MRI, Patient Preparation
7630-135 Departmental Safety Measures
7630-197 Personal Protective Equipment Technologist Safety Procedure
7630-195 Patient Transport Procedure
7630-145 Fire Safety - Imaging Department Procedure
7630-147 Fire Safety - MRI
7630-171 MRI Safety
7630-229 Routine Department Disinfection Procedure

5. Radiation Safety

ALARA (As Low As Reasonably Achievable)
7630-216 Radiation Protection for Patients Policy
7630-217 Radiation Safety Post Injection of Radioisotopes
7630-210 Portable Fluoroscopy Usage Policy and Procedure
7630-211 Radiation and Decontamination Procedure
7630-179 Nuclear Medicine Emergency Procedure
Radiation Contamination Telephone List
7630-213 Radiation Physicist Policy
7630-139 Dosimetry Procedure
7630-151 General Rules for the Safe Use of Radioactive Material
7630-153 Hot Lab Requirements Procedure
7630-167 Misadministration of Radioisotopes Procedure
7630-177 Nuclear Medicine Department Security Procedure
7630-185 Nuclear Medicine Safety Measures
7630-235 Sign Posting Requirements Procedure
7630-219 Radiation Safety- Staff
7630-215 Radiation Safety Instructions
7630-205 Pregnant Worker in a Radiation Environment
Procedure Declaration of Pregnancy
Undeclaration of Pregnancy
7630-175 Non Radiologist and Fluoroscopic Procedures Procedure

6. Procedures/Preps

7630-149 Gastrograffin Oral Prep for Adult ED Patients Prior to CT Scans of the Abdomen and/or Pelvis
7630-232 Scheduling Procedures
7630-231 Scheduling Biopsies Procedure
7630-183 Nuclear Medicine Procedures

7630-187 Nuclear Medicine Studies
7630-239 Virtual Radiology Services Procedure (Nighthawk)
7630-131 CT Oral Preparation ProcedureInpatient Abdomen and/or Pelvis CT Preps
Prep Instructions for an Abdominal-Pelvic (or Pelvic Only) CT Scan Examination Form
Abdominal-Pelvic CT Exam Appointment Form with Prep Kit Warnings
7630-221 Radiography in the Surgical Suite
7630-236 Trophon Environmental Probe Reprocessor (EPR) Quality Control

7. Quality Control Procedure

7630-161 Mammographic Compliance
7630-209 Routine QC Procedures in Nuclear Medicine
7630-133 CT Scanner Quality Control Procedure
Quality Control Indicators for Radiology, Mammography, Nuclear Medicine, Ultrasound, CT Scan
7630-181 Nuclear Medicine Equipment Calibrations

8. Personnel

7630-141 Duties of Medical Director of Imaging Department
7630-223 Radiologist Availability Procedure
7630-189 Paid Time Off (PTO) Procedure
7630-237 Venipuncture by Technologists
7360-238 Certification of Technologists Procedure
7630-109 Medical Imaging Operational Hours and Support Services

APPROVALS:
Policy & Procedure Team: 7/17/18
Surgery Committee: 9/13/18
Medical Executive Committee: 9/20/18
Board Quality Committee: 9/26/18
The Board of Directors:

Board Meeting

Sonoma Valley Health Care District Board of Directors

November 1, 2018

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

dome CONSTRUCTION TAYLOR Design VERTRANASSOCIATES SONOMA VALLEY HOSPITAL

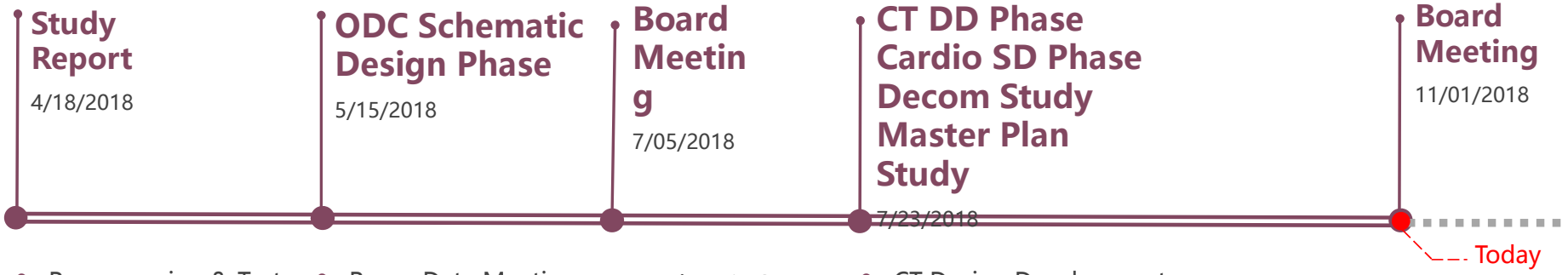
Agenda

ODC Mission & Vision

Mission: To provide patients with **easy access to an efficient, positive, and healing experience** by providing the **latest diagnostic equipment, outpatient procedures and testing close to home**.

Vision: To be **an efficient, high technology outpatient diagnostic center** for the North Bay with services **preferred by patients and physicians**, known for **exceptional quality and compassionate healthcare**.

Timeline



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

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

- Project 1 (CT)
- Project 2 (Cardio)
- Decommissioning
- Master Planning

TOTAL: $1,323,420

- CT Design Development
- Cardio Schematic Design
- Decommissioning Investigations
- Master Plan Workshops #1-3
- Update cost estimates

Asking for approval of projects 1 & 3 through permitting

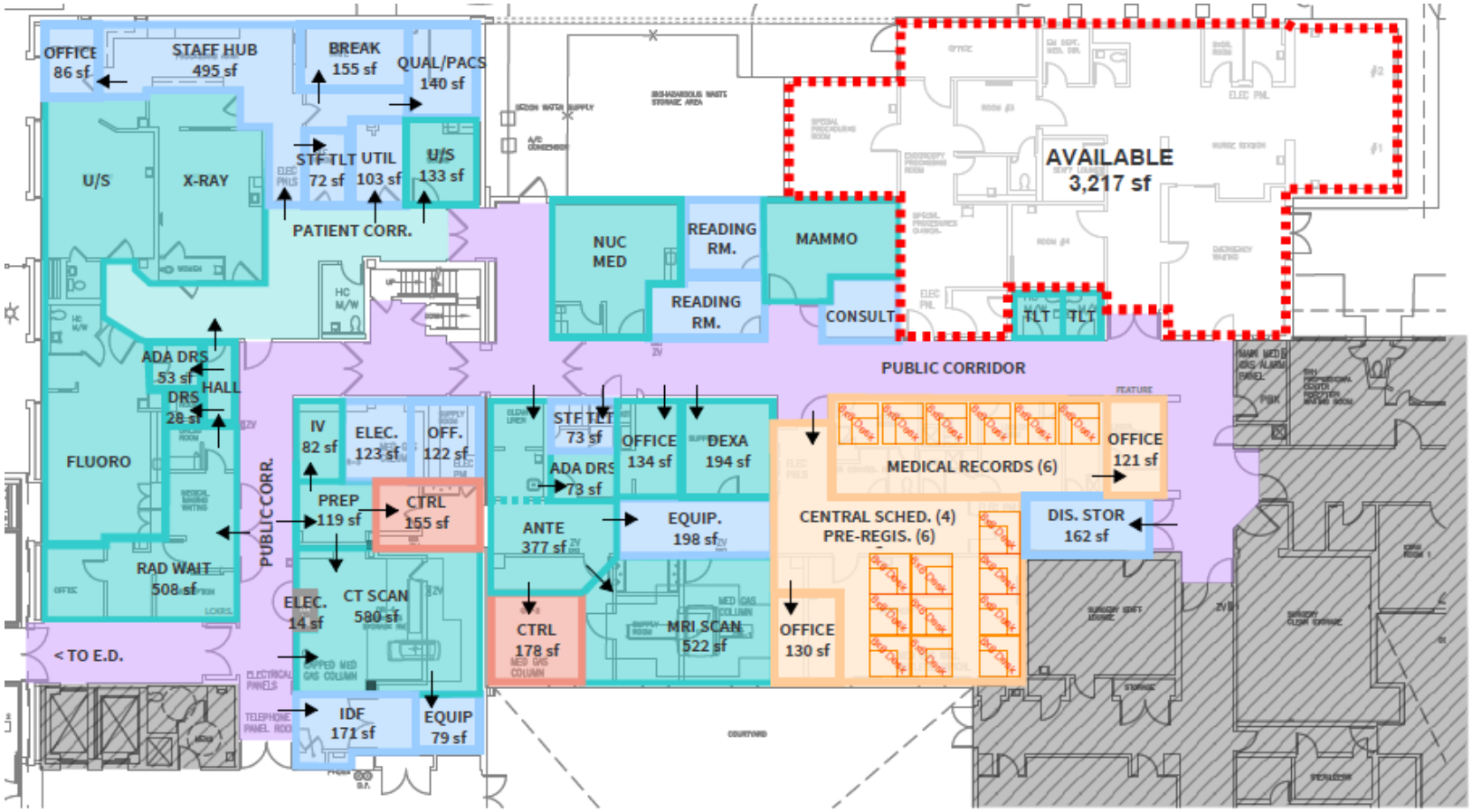
Priorities

1. CT replacement is imminent, essential and needs more space
2. Upgrade from 64-slice to 128-slice CT brings new revenue
3. Bring MRI inside building to improve the patient experience
4. Upgrade the MRI to a 3 Tesla to be the first in the North Bay increasing referrals and reducing patient drive time
5. Enhance efficiencies and patient flow through Centralized Scheduling (Patient Access Center)
6. Upgrade the Lab & Cardiology services, flow and equipment
7. Enhance hospitality and self registration options in the lobby

Scope of Work Studied

- Replace CT
- Provide an efficient connection from new ED to CT
- Expand and improve Outpatient Reception/Waiting areas
- Co-locate Imaging and Cardiopulmonary services together
- Provide MRI services inside the hospital
- Consolidate and upgrade IT components
- Assess SPC-4D option for 2030 seismic requirements in the West Wing (Inpatient Tower)
- Study the costs/benefits for decommissioning some wings

Outpatient Diagnostic Center



Project 1: Imaging/CT/Hospitality

LOBBY FEATURE WALL

vith
h

in

Project 1: Imaging/CT/Hospitality

Project 1: Imaging/CT/Hospitality

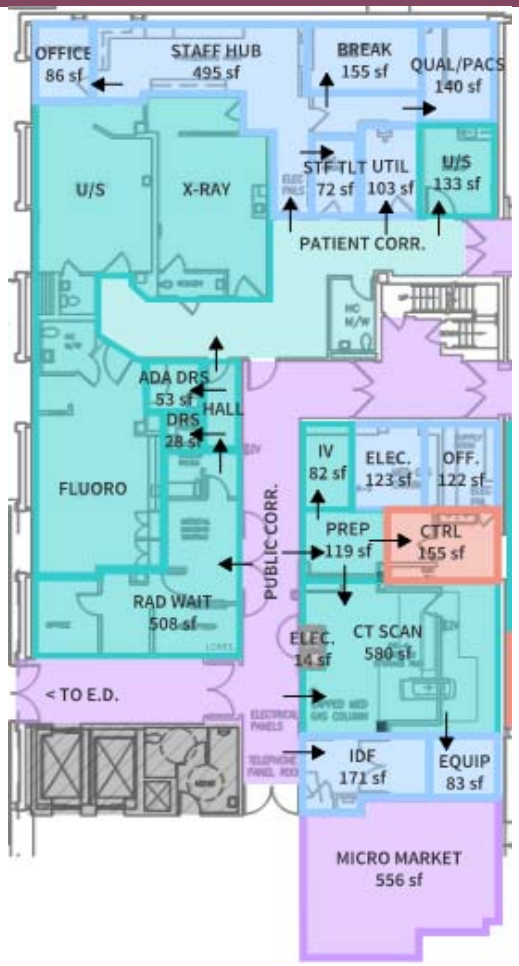
Project 1: Imaging/CT/Hospitality

CT SCAN ROOM

Project 1: Imaging/CT/Hospitality

CT CONTROL ROOM

Project 1: Imaging/CT/Hospitality



Project Scope:

- New CT Scan Suite in former OR
- Enlarged reception & waiting area
- Added ADA compliant dressing room
- New IDF room with upgraded equipment, nurse call
- Staff Hub renovations include staff restroom, breakroom and offices
- Flooring upgrades in imaging rooms & corridors
- Public corridor upgrades
- Micro market in former gift shop
- Scheduling software & self check-in kiosks
- New Phone System
- New Imaging PACS

Project Budget: $9,365,951

- Approved funding 7/5/18 = $694,038
- Next funding request 11/1/18 = $204,729

Project 2: Cardiology & North Entrance

Project 2: Cardiology & North Entrance

Project 2: Cardiology & North Entrance

Outpatient Diagnostics Center

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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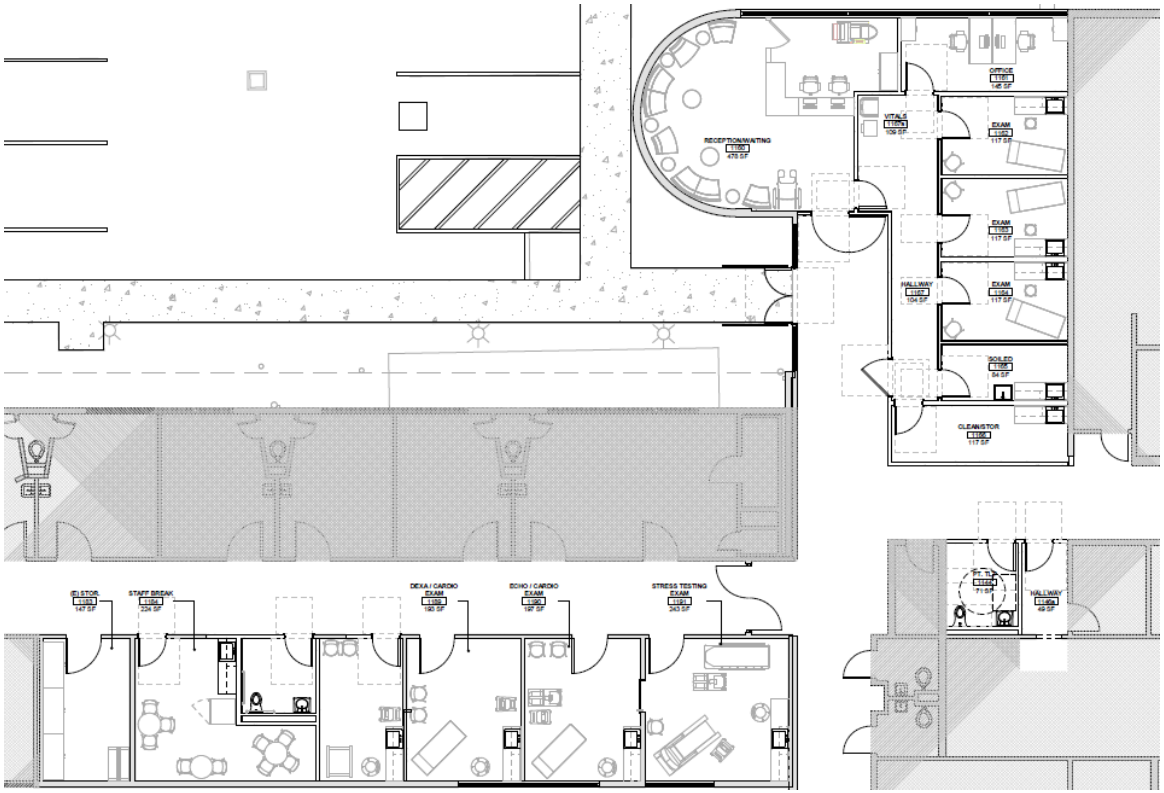
Project 2: Cardiology & North Entrance



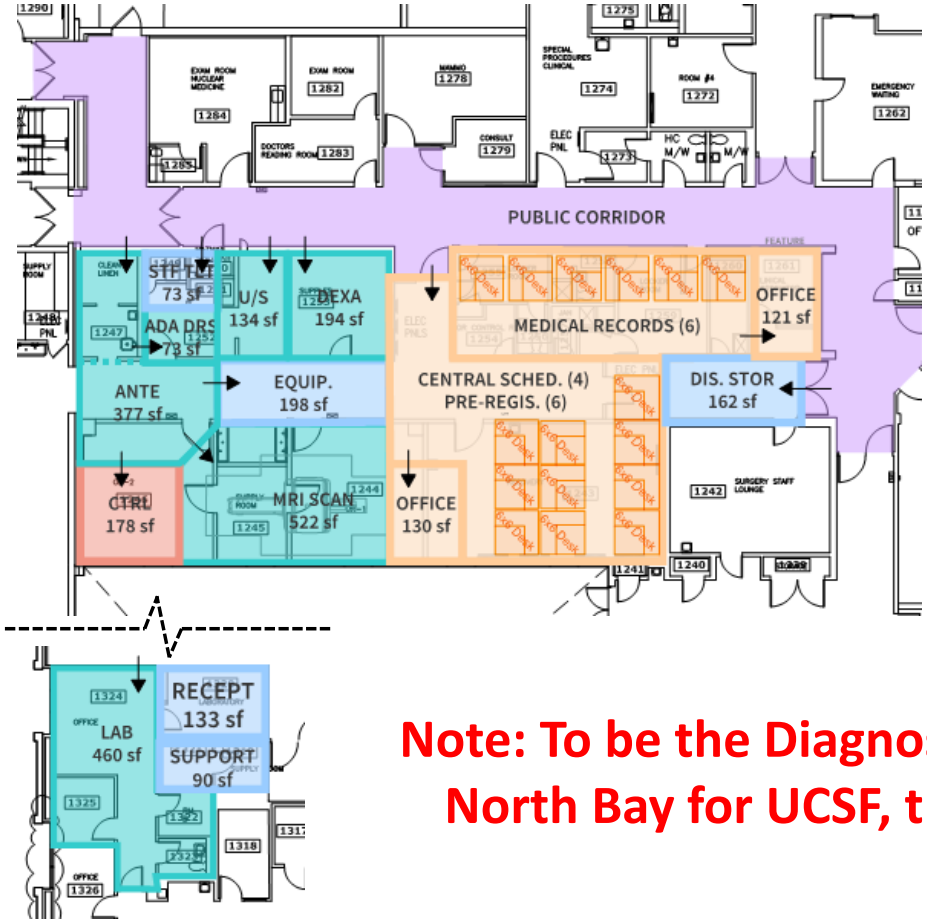
Project Scope:

- Reconfigure Occupational Health & Wound Care to allow Cardiology spaces
- Construct Cardiology Reception, Waiting, Physician Offices and Exam Rooms
- Construct entry canopy & new operable doors
- Renovate parking area and landscaping
- Cardiology PACS System

Project Budget: ON HOLD

- Approved funding 7/5/18 = $187,422
- Requested funding 11/1/18 = $30,000 to develop smaller scope of work

Project 3: MRI/ Central Scheduling/ Lab



Project Scope:

- 3T MRI inside the building
- Create a Patient Access Center and Co-locate Scheduling, Registration & Medical Records
- Patient facing lab renovation
- Equipment & IT Upgrades

Estimated Budget: $10,000,000

- Requested funding 11/1/18 = $729,347

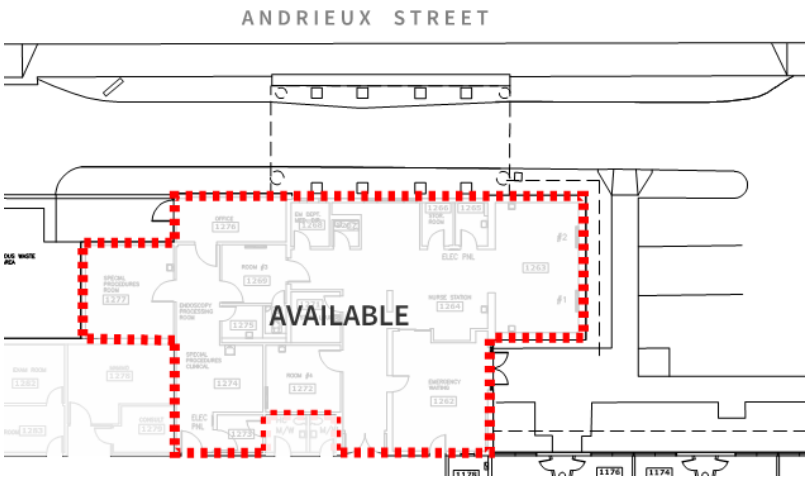
Note: To be the Diagnostic Center of the North Bay for UCSF, this is essential!

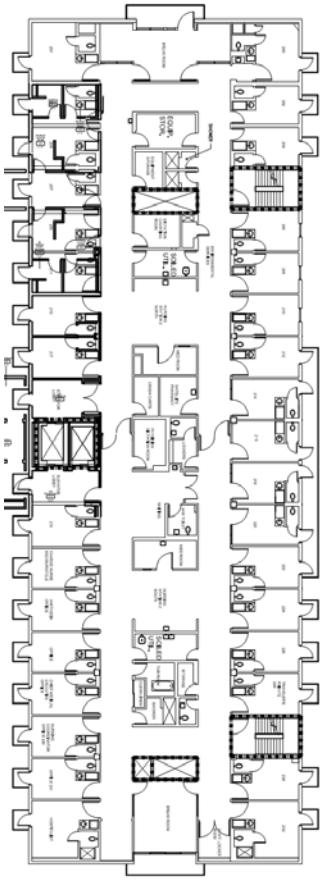
Project 3: 3T MRI Benefits

3T MRI with endorectal coil is the now state of the art technology for diagnosis of prostate cancer!

- Used for detection and staging of untreated prostate cancer and improves staging accuracy which helps discriminate between operable disease and residual or recurrent prostate cancer

Project 4: TBD





Project Scope:

- Explore Options

Estimated Budget: $XXXX

- Requested funding 11/1/18 = $50,000

UCSF Outpatient Diagnostic Center of North Bay

dome CONSTRUCTION TAYLOR Design VERTRANASSOCIATES SONOMA VALLEY HOSPITAL SONOMA VALLEY HEALTH CARE DISTRICT Healing Here at Home

Incremental Direct Margin (over base year by year)

	Imaging	Outpt Lab	Cardiology	Total ODC
Baseline FY 2018	$1,881,267	($68,950)	$450,896	
Year 1 (2020)	$794,304	$252,472	$551,914	+$1,598,690

See Attached Pro-forma

Capital Spending Schedule

Cash Balance 9/30/18	$792,639
Net contributions due by 8/31/19	$3,135,505
Available Cash for the ODC	$3,928,144
New Funding Request	$1,409,176
Today's Cash Balance for ODC	$2,518,968

Decommissioning Study Central/East Wings

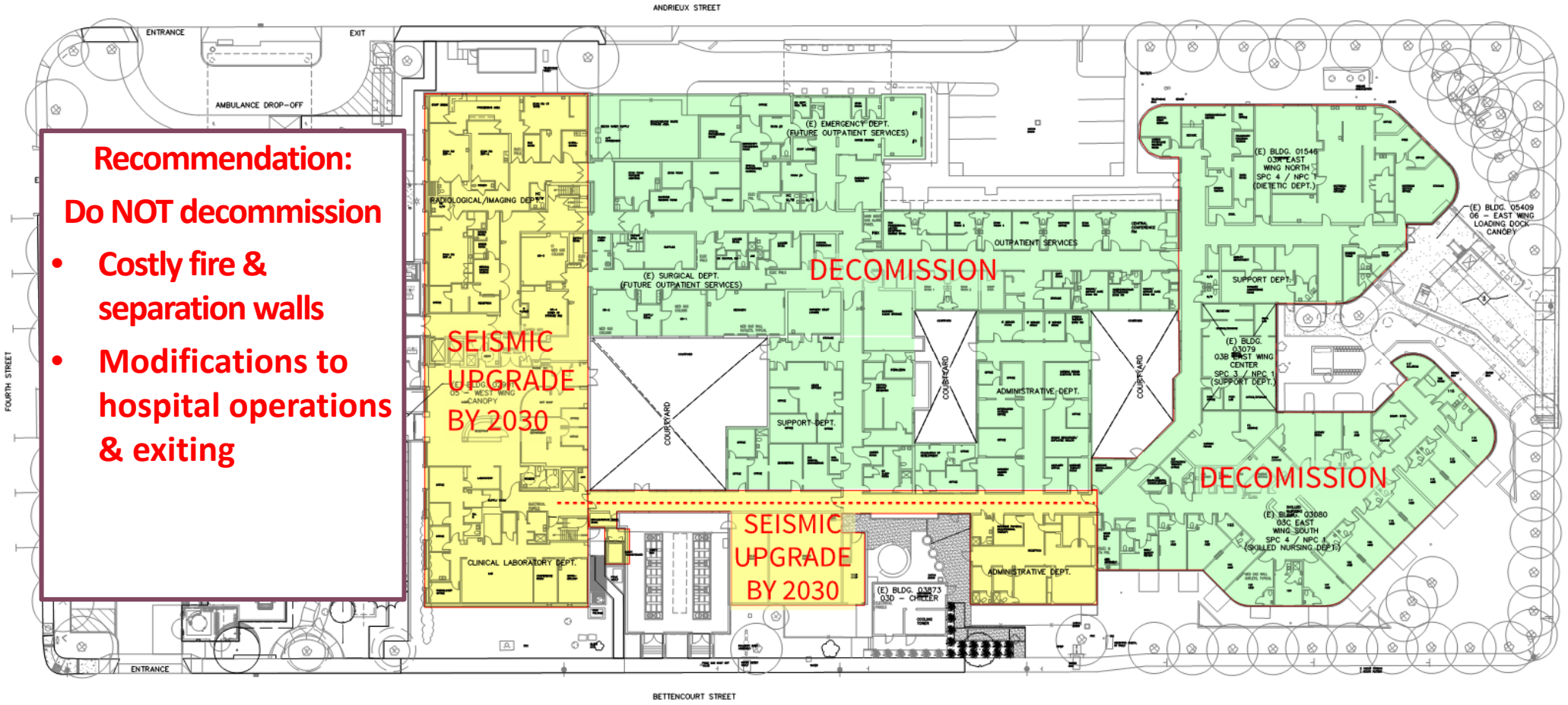
- Decommissioning was considered because future modifications in Central and East Wings can be designed, reviewed, and constructed more quickly and at less cost if they are not classified as a Hospital (OSHPD-1)
- The study investigated the requirements that included costly fire and structural separation walls as well as modifications for hospital operations and exiting
- Decommissioning the Central and East Wings before 2030 would not be a wise investment

Decommissioning Study Central/East Wings

Recommendation:

Do NOT decommission

- **Costly fire & separation walls**
- **Modifications to hospital operations & exiting**



Recommendation

For November 1st Board Meeting:

- Approve Project 1: CT/Imaging/Hospitality Project at $9,365,951
- Project 1: CT/Imaging/Hospitality to Permit = $204,729
- Project 2: Cardiology Alternative Options = $30,000
- Project 3: MRI/Central Scheduling/Lab to Permit = $729,347
- Project 4: Test Fit = $50,000
- Other Costs = $395,100

Total New Funding Request: $1,409,176

Next Steps

- Master Facility Plan discussion & Project 4 – November 14th
- Continue to raise funds for the project – On going
- Finance to monitor the cash flows each month – On going
- Return to the board once permit has been received to demonstrate we have the funds to break ground – Summer 2019

Next Steps for Design Build Team

- Imaging/CT/Hospitality:
  - Submit to OSHPD late January 2019
  - Start Construction August 2019, complete by February 2020
- MRI/Central Scheduling/Lab:
  - Submit to OSHPD September 2019
  - Start Construction January 2020, complete by December 2020
- Explore smaller scope for Cardiology
- Project 4 is to be decided

Questions?

dome CONSTRUCTION

TAYLOR Design

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SONOMA VALLEY HEALTH CARE DISTRICT
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Outpatient Diagnostics Center (ODC) Pro Forma

	Outpatient Imaging	Baseline FY 18	Projected YR 1 - 30%	Projected YR 2 - 10%	Projected YR 3 - 10%	Projected YR 1 through YR 3
1	**Volumes - Outpatient**					
2	Mammography	4,144	5,387	5,926	6,519	17,832
3	CT Scan	1,299	1,689	1,858	2,043	5,590
4	Ultrasound	2,507	3,259	3,585	3,944	10,788
5	MRI	1,293	1,681	1,849	2,034	5,564
6	Radiology	5,431	7,060	7,766	8,543	23,370
7	**Total Volumes - Outpatient**	**14,674**	**19,076**	**20,984**	**23,082**	**63,142**
8						
9	**Imaging Reimbursement**					
10	Mammography	$ 282,487	$ 367,234	$ 403,957	$ 444,353	$ 1,215,543
11	CT Scan	1,008,442	1,310,975	1,442,072	1,586,279	4,339,326
12	Ultrasound	537,520	698,776	768,653	845,518	2,312,947
13	MRI	912,170	1,185,821	1,304,403	1,434,843	3,925,067
14	Radiology	673,473	875,515	963,066	1,059,373	2,897,954
15	**Total Reimbursement**	**$ 3,414,092**	**$ 4,438,319**	**$ 4,882,151**	**$ 5,370,366**	**$ 14,690,837**
16						
17	**Imaging Direct Costs**					
18	Mammography	$ (194,788)	$ (224,006)	$ (235,207)	$ (246,967)	$ (706,180)
19	CT Scan	(538,444)	(619,211)	(650,171)	(682,680)	(1,952,061)
20	Ultrasound	(266,999)	(307,048)	(322,401)	(338,521)	(967,970)
21	MRI	(230,225)	(264,758)	(277,996)	(291,896)	(834,651)
22	Radiology	(302,369)	(347,724)	(365,111)	(383,366)	(1,096,201)
23	**Total Direct Costs**	**$ (1,532,824)**	**$ (1,762,748)**	**$ (1,850,885)**	**$ (1,943,430)**	**$ (5,557,063)**
24						
25	**Imaging Projected Direct Margin**					
26	Mammography	$ 87,699	$ 143,227	$ 168,751	$ 197,386	$ 509,364
27	CT Scan	469,998	691,764	791,901	903,600	2,387,264
28	Ultrasound	270,521	391,727	446,252	506,998	1,344,977
29	MRI	681,945	921,062	1,026,406	1,142,947	3,090,416
30	Radiology	371,104	527,790	597,956	676,007	1,801,753
31	**Total Projected Direct Margin Imaging**	**$ 1,881,267**	**$ 2,675,571**	**$ 3,031,266**	**$ 3,426,937**	**$ 9,133,774**
32						
33	**Outpatient Lab**					
34	Volumes	81,322	105,719	116,290	127,920	349,929
35	Reimbursement	$ 1,297,107	$ 1,686,239	$ 1,854,863	$ 2,040,349	$ 5,581,452
36	Direct Costs	(1,365,697)	(1,502,267)	(1,577,380)	(1,656,249)	(4,735,897)
37	**Total Projected Direct Margin - Lab OP**	**$ (68,590)**	**$ 183,972**	**$ 277,483**	**$ 384,100**	**$ 845,555**
38						
39	**Outpatient Cardiology**					
40	Volumes	1,558	2,409	2,650	2,915	7,974
41	Reimbursement	$ 720,290	$ 1,195,319	$ 1,321,534	$ 1,453,255	$ 3,970,108
42	Rent Revenue	$ -	$ 105,996	$ 108,646	$ 111,362	$ 326,004
43	Direct Costs	(269,394)	(298,505)	(309,664)	(321,382)	(929,551)
44	**Total Projected Direct Margin - Cardiology OP**	**$ 450,896**	**$ 1,002,810**	**$ 1,120,516**	**$ 1,243,236**	**$ 3,366,561**

TAYLOR Design

MEMORANDUM

To: Kathleen Carroll
Project Manager
Vertran Associates

From: Matt Johnson
Project Director
Taylor Design

Date: September 14, 2018

Project: **SONOMA VALLEY HOSPITAL**
Decommissioning Study
Taylor Design Project No.: 5344.103L

Re: **Summary of 8/29/18 Presentation**

Pursuant to the decision by the Owner to not continue the Study of Decommissioning either the Central and/or East Wing of the Sonoma Valley Hospital (SVH) campus from OSHPD-1 classification, we have prepared the following memo to summarize our preliminary findings based on the 2016 CBC 3418A and OSHPD Code Application Notice 1-6-1.4.5.1.4.

BASIC SERVICES

The Owner had originally requested the design team study the requirements for decommissioning two buildings from OSHPD-1 to OSHPD-3 classification and provide a report outlining next steps with costs. The two scenarios to be studied were 1) the removal of the Central Wing from acute care service or 2) the removal of the Central and East Wings from acute care service.

The basic services required for Hospitals are the following:

1. Nursing (CBC 1224.14)
2. Surgery (CBC 1224.15)
3. Anesthesia/Recovery (CBC 1224.16)
4. Clinical Lab (CBC 1224.17)
5. Radiology (CBC 1224.18)
6. Pharmacy (CBC 1224.19)
7. Dietary (CBC 1224.20)
8. Support (CBC 1224.21 thru 1224.27)

General Acute Care for SVH are currently located in the ED/OR Wing (Surgery, PACU, Support), West Wing (Nursing, Radiology, Support, Lab, Pharmacy), and East Wing (Dietary and Support). No Acute Care services are provided in the Central Wing.

REMOVAL OF HOPSITAL BUILDINGS FROM GENERAL ACUTE CARE SERVICES (GACS)

OSHPD CAN 1-6-1.4.5.1.4 provides guidelines for the removal of a building from acute care service for either conversion of buildings (or portions thereof) to other uses or demolition. SVH would be seeking to classify the Central and/or East Wings as a "Freestanding Nonhospital Building" apart from the hospital as defined in the code. A building would be considered eligible for removal if the following criteria are met per CBC 3418A.3:

1. All basic acute care services or supplemental services on the hospital's license are provided in compliant GACS buildings.
2. Compliant structural separation between buildings are provided.
3. Compliant fire resistive rated construction between buildings are provided.
4. Height and area limitations for buildings on the same lot comply with codes.
5. All egress requirements comply with code for all buildings and no egress from any GACS services area pass through SPC building removed from GACS
6. Separate/independent fire alarm system, fire sprinkler system, control zone. Flexible connections for conduits etc. are provided for crossing seismic separation joints.
7. Patient access complies with CBC 1224.4.7.5 and does not pass through the proposed building.
8. Primary accessible entrance to GACS or Hospital building does not through the proposed building removed from GACS.
9. Utilities do not pass through under or over building removed from GACS that serve the GAC building.
10. Utilities originating in a GAC building feed a building removed from GACS provides fail-safe or shut-off valves to isolate the GACS building from the building with GACS removed.

A set of construction documents shall be submitted to OSHPD to confirm the above items and a permit shall be issued. Once it has been determined that the requirements for the new occupancy classifications have been met, a certificate of occupancy shall be issued and the building(s) could be considered "Freestanding Nonhospital Buildings."

It should be noted that upon internal review and discussion with OSHPD during a consultation on 8/28/18 (see attached meeting minutes), it would be recommended that all buildings remain under the jurisdiction of OSHPD to limit the exposure to compliance upgrades possible should the buildings change jurisdiction to the local authority (City of Sonoma). The fire separation between buildings of the same construction type would also be beneficial as they would remain a fire barrier as opposed to a fire wall if splitting jurisdictions.

DECOMMISSIONING SCENARIOS

Scenario #1 – Remove of Central and East Wings from acute care service as shown in Exhibit A1. The below would be required:

1. Construction of a Standby Kitchen in the West Wing to comply with the requirement for Hospitals to provide Dietary Services. Existing East Wing Kitchen would continue to serve patients as an Outside Service per CBC 1224.20.3, contingent on approval by CDPH based on a functional program proving that the Standby Kitchen would be able to be put into operation immediately should there be an interruption to service from the East Wing. It should be noted that the Hospital would be required to prove to CDPH that deliveries would be able to be made to the Standby Kitchen without use of the existing East Wing Loading Dock should services be interrupted by an event in the non GACS building.
2. Removal of Skilled Nursing from East Wing.
3. Relocation of Medical Records to the West Wing from the East Wing.
4. Construction of a structural and fire resistive separation along the intersection of the West Wing to the Central Wing including portions of the building along the south corridor of the Central Wing to maintain utilities and Engineering that feed the West Wing.

horizontal exit. It should be noted that further study is needed within the Decommissioned building to ensure compliant independent exiting does not pass through the GACS building.

6. Adoption and upgrade or construction of a new portion of the West Wing where it abuts the Central Wing along the north corridor to maintain independent exiting to the street from the West Wing that does not pass through the Central Wing.
7. Demolition of non-permitted construction in west Courtyard adjacent to existing Engineering office near south Central Wing.

Scenario #2 – Remove of the Central Wing from acute care service as shown in Exhibit A2. The below would be required:

1. Construction of a structural and fire resistive separation along the intersection of the West Wing to the Central Wing and East Wing to the Central Wing including portions of the building along the south corridor of the Central Wing to maintain utilities and Engineering that feed the West and East Wings.
2. Construction of new exit doors from central corridor in the Central Wing to horizontal exit adjacent to Engineering. It should be noted that further study is needed within the Decommissioned building to ensure compliant independent exiting does not pass through the GACS building.
3. Adoption and upgrade or construction of a new portion of the West Wing where it abuts the Central Wing along the north corridor to maintain independent exiting to the street from the West Wing that does not pass through the Central Wing.
4. Demolition of non-permitted construction in west Courtyard adjacent to existing Engineering office near south Central Wing.

RESULTS OF 8/29/2018 MEETING WITH OWNER

The information described herein, along with Structural and MEPT findings were presented to the Owner on August 29, 2018. It was clear that Decommissioning Scenario #2 was more attractive, especially considering that the East Wing is already SPC compliant. However, after some discussion regarding the deficiencies of the buildings, upgrades required to properly remove the Central and/or East Wing buildings, future remodels or demolition being considered to the buildings, and estimated decommissioning timeline, the Owner decided to halt the further study of the project.

Thank you for the opportunity to be a part of this project.

Sincerely,

Matt Johnson, AIA, LEED AP BD+C
Project Director
License #C34413
mjohnson@WeAreTaylor.com

Attachments: Exhibit A1 – Decommissioning Scenario #1, dated September 14, 2018
Exhibit A2 – Decommissioning Scenario #2, dated September 14, 2018
Exhibit A3 – OSHPD Meeting Notes, dated 8/28/18
Exhibit B – Simpson Gumpertz + Heger Memo, dated September 11, 2018
Exhibit C – Guttman & Blaevoet Memo, dated September 11, 2018

EXHIBIT A1

ED/OR WING
BUILT 2014
SPC-5 / NPC-4

WEST WING
BUILT 1970
SPC-2 / NPC-2

CENTRAL WING
BUILT 1958
SPC-2 / NPC-2

EAST WING
BUILT 1986
SPC-3 & 4 / NPC-2

ANDRIEUX STREET

AMBULANCE DROP–OFF

BASIC SERVICE
ED
CBC 1224.33

BASIC SERVICE
RAD
CBC 1224.18

BASIC SERVICE
ADMIT.
CBC 1224.21

BASIC SERVICE
LAB
CBC 1224.17

OUTPATIENT SERVICES

DEMO THIS NON-PERMITTED CONSTRUCTION

ENG.

BASIC SERVICE
DIETARY
CBC 1224.20
RELOCATE TO WEST WING

BASIC SERVICE
MED RCDS.
CBC 1224.21
RELOCATE TO WEST WING

SNF
(TO BE REMOVED FROM SERVICES IN THIS SCENARIO)

BETTENCOURT ROAD

Req'd Fire and Structural Separation

OSHPD-1 Hospital

Proposed RACS Area

Proposed Horizontal Exit

SCENARIO 1
RACS For Central and East Wings

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SONOMA VALLEY HEALTH CARE DISTRICT
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FIRST FLOOR PLAN

SEPTEMBER 14, 2018

SCALE: N.T.S.

EXHIBIT A2

ED/OR WING
BUILT 2014
SPC-5 / NPC-4

WEST WING
BUILT 1970
SPC-2 / NPC-2

CENTRAL WING
BUILT 1958
SPC-2 / NPC-2

EAST WING
BUILT 1986
SPC-3 & 4 / NPC-2

ANDRIEUX STREET

AMBULANCE DROP-OFF

BASIC SERVICE
ED
CBC 1224.33

BASIC SERVICE
RAD
CBC 1224.18

BASIC SERVICE
ADMIT.
CBC 1224.21

BASIC SERVICE
LAB
CBC 1224.17

OUTPATIENT SERVICES

DEMO THIS NON-PERMITTED CONSTRUCTION

ENG.

BASIC SERVICE
DIETARY
CBC 1224.20

BASIC SERVICE
MED RCDS.
CBC 1224.21

SNF
CBC 1225

BETTENCOURT ROAD

Req'd Fire and Structural Separation

OSHPD-1 Hospital

Proposed RACS Area

Proposed Horizontal Exit

SCENARIO 2
RACS For Central Wing only

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SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

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FIRST FLOOR PLAN

SEPTEMBER 14, 2018

SCALE: N.T.S.

TAYLOR Design

EXHIBIT A3

MEETING NOTES

FACILITY	Sonoma Valley Hospital
PROJECT NAME	Decommissioning Study
PROJECT NO.	Taylor Design 5344.103
MEETING ID	OSHPD Meeting #1 (AHJ-01)
DATE / TIME	August 28, 2018 / 2:00pm-3:00pm
LOCATION	OSHPD – 2020 W. El Camino Avenue, Suite 800, Sacramento, CA 95833

DISTRIBUTION

	NAME	COMPANY	E-MAIL ADDRESS	TELEPHONE
X	Dave Ring (DR)	OSHPD – North Region Supervisor	Dave.Ring@oshpd.ca.gov	(916) 440-8385
X	Richard Tannahill (RT)	OSHPD – Senior Architect	Richard.Tannahill@oshpd.ca.gov	(916) 440-8393
X	Antonia De Luca (AD)	OSHPD – Senior Architect	Antonio.DeLuca@oshpd.ca.gov	(916) 440-8392
X	Patrick White (PW)	OSHPD – FLSO II	Patrick.White@oshpd.ca.gov	(916) 440-8395
X	Todd Kohagura (TK)	OSHPD – Senior Structural Eng.	Todd.Kohagura@oshpd.ca.gov	(916) 440-8389
X	Kathleen Carroll (KC)	Vertran Associates – Project Mgr.	kathleen.carroll@vertranassociates.com	(415) 297-2068
X	Matt Johnson (MJ)	Taylor Design – Project Director	mjohnson@WeAreTaylor.com	(415) 857-8093
X	Vani Singh (VS)	Taylor Design – Project Architect	vsingh@WeAreTaylor.com	(415) 857-8036

NOTES

ITEM#	SUBJECT	DISCUSSION	RESP. PARTY	DUE
01-01	Project Summary	MJ introduced the facility buildings on the campus with the current SPC and NPC ratings, construction types, and MEP service flow. He explained that the Owner is studying the decommissioning of acute care services from the Central Wing or both the Central and East Wing buildings.		
01-02	Decommissioning Scenarios	VS discussed the two scenarios with the intention of keeping the decommissioned areas under OSHPD jurisdiction: *Scenario #1* – Remove Central and East Wings from acute care services per OSHPD CAN 1-6-1.4.5.1.4 *Scenario #2* – Remove only Central Wing from acute care services per OSHPD CAN 1-6-1.4.5.1.4. Scenario #1 involves providing Dietetic Services on the second floor of the West Wing with appropriate Standby Kitchen and storage. The Loading Dock would remain in the current location. The intention was to utilize the existing Kitchen and Loading Dock as an Outside Service for patient food service as outlined in CBC 1224.20.3. Medical Records could be located to first or second floor of West Wing. Portions of existing engineering would need to be relocated to south of connecting corridor at Central Wing to enable a clean separation and exiting requirements for Central and East Wings.		

		Scenario #2 removes Central Wing only from acute care services to comply with CAN 1-6-1.4.5.1.4 as a Free-Standing Non-Hospital building under OSHPD jurisdiction as OSHPD 3. The current space usage in this building would remain unchanged as it currently housing no acute care services. MJ explained the existing structural systems and seismic separations.
01-03	Existing Uses	RT and DR explained that it was important to show documentation of current usage (vacant or occupied) against their existing permits. RT cited cases where the spaces indicated as vacant were being used for other purposes. DR provided draft OSHPD PIN #64 regarding vacant spaces for reference. RT said that OSHPD will need to review a detailed program of current uses of space to verify that they are compliant to the governing codes at time of permit. This applies to the seismic separation and fire wall construction as well.
01-04	Standby Kitchen	AD said that even though Section 1224.20.3 allows outside catering services, licensing approval of this must be achieved and that it can be a long and complex process. He advised the design team start the process with CDPH immediately, if it will be pursued. DR said that CDPH would take the lead and that the OSHPD team would assist as needed through this process. AD noted that Standby Kitchens would be required to be built like a conventional kitchen with functional elements per 1224.20.2 and is required to be submitted as an Alternate Means of Compliance with OSHPD. AD also noted that licensing for outside food delivery would require detailed documentation of the path of travel from delivery at site to patient space as well as an inspection area in immediate proximity of the delivery area of loading dock. He advised reviewing the occupancy separations required for the Standby Kitchen, if pursued. DR volunteered help in discussions with CDPH and Health Department for Dietetic services, if pursued.
01-05	Fire Separations and Egress	PW clarified that a fire wall would be required from West Wing to Central Wing due to different Construction Types whereas only a fire barrier would be required between Central and East Wing because they are the same Construction Type, if kept under OSHPD jurisdiction, whereas fire walls would be required for separation between hospital and any decommissioning area if placed under local AHJ. He also noted that separate exiting, fire alarm, and fire sprinkler system would be required.
01-06	Title 24 Energy Calcs	MJ asked if Title 24 Energy Calcs would be required and/or reviewed by OSHPD for decommissioned spaces kept under OSHPD jurisdiction. RT indicated that he believed so.

01-07	OSHPD-1R Designation	RT explained the in-progress provisions for forthcoming OSHPD-1R designation (non-conforming Hospitals removed from acute care services but under OSHPD jurisdiction) in the 2019 CBC. RT also mentioned that OSHPD has planned seminars in November to present these changes to the code.
01-08	Documentation Required for Existing Construction	MJ inquired upon the level and type of documentation required to verify existing construction. OSHPD indicated that programmatic information could be submitted along with original permitted plans for reference. In the absence of permitted drawings, drawings documenting existing conditions based on field verification would be required to indicate compliance for OSHPD field staff. OSHPD team said that existing photos would not be sufficient.
01-09	Accessibility Compliance	MJ asked for confirmation that accessibility upgrades would not be required for existing non-compliant conditions in entire decommissioned building wings unless a remodel was pursued. DR confirmed that only construction projects would trigger CBC 11B-202 for accessibility upgrades to code threshold based on construction cost.
01-10	SNF Services	OSHPD inquired upon the future usage of the Skilled Nursing Facility in the East wing. MJ responded that Skilled Nursing services may be removed from the program in the future.
01-11	Decommissioned Jurisdiction	VS asked if OSHPD saw any advantages to staying under the OSHPD jurisdiction after removal of acute care services in both scenarios versus local AHJ. OSHPD team felt it was simpler and better for the buildings to remain in OSHPD jurisdiction since transfer to local jurisdiction could trigger several unknowns including possible code compliance to entire wing. RT cited an example of a hospitals converting to local AHJ and later realizing that it would have been more practical and financially beneficial to remain under OSHPD. OSHPD team encouraged design team to have a meeting with the Senior Architect (AD) to review the whole process and the documentation before submitting to OSHPD.
01-12	CDPH Coordination during Project	MJ inquired upon coordination with CDPH during project, if it was pursued; whether Arch was responsible for coordinating or OSHPD would do so. DR indicated OSHPD would do so.

AUTHORED BY: Vani Singh and Matt Johnson on 8/31/18.
NEXT MEETING: None scheduled at this time.

ENCLOSURES: ~~1. Decommissioning Scenario #1, dated 8/28/2018~~
~~2. Decommissioning Scenario #2, dated 8/28/2018~~ NOT INCLUDED FOR 9/14/18 MEMO

The preceding notes represent Taylor Design's understanding of the items discussed and conclusions reached. Recipients are requested to review these items and notify the author in writing of any required revisions or clarifications within five (5) business days or they will be considered final.

EXHIBIT B

SIMPSON GUMPERTZ & HEGER

Engineering of Structures and Building Enclosures

Memorandum

Date: 11 September 2018

To: Matt Johnson, TAYLOR Design

From: Kevin S. Moore

Project: 187048 – Decommissioning Study

Subject: Brief Summary of Site Visit and Analysis Findings

At your request, we provide a summary of findings for the above-referenced project.

Our review of drawings developed by Forell/Elsesser for an OSHPD/HAZUS evaluation, coupled with our site visit of August 21, 2018 results in the following related to decommissioning the Central Wing and/or East Wing.

The East Wing is adequately separated from the Central Wing, with established and well defined "seismic separations" between the two buildings. Structurally, the two buildings can be separated on an occupancy basis.

The Central Wing is essentially separated from the West Wing and East Wing, except at the southern corridor. The west end of this corridor has direct continuity between the Central Wing and the West Wing that will not accommodate anticipated movement between the two buildings, necessitating a seismic separation that will physically separate the two buildings, leaving at least a 3 in. gap between structural elements. Because of the framing and wall construction in the southern corridor, new structural elements will be required to ensure the separated portion of the building can remain viable during an earthquake. The eastern portion of the building along this corridor will require a different type of separation north of the engineering building to accommodate CMU walls at the roof level. We depicted much of the work and issues surrounding structural separation and the related complications in a graphic sent 30 August 2018 (attached).

Encls.
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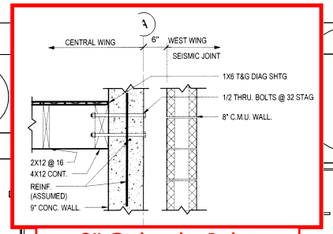
SIMPSON GUMPERTZ & HEGER

Engineering of Structures and Building Enclosures



6" Seismic Joint Concrete Wall and CMU Wall (WW)

6" Seismic Joint

Central Wing Roof Wood Framed, TYP.

CMU Wall, TYP. (only some walls shown)

Additional Areas Suggested to Remain GAC (and SPC 4D)

CMU Wall Above Roof Supports High Roof (only some walls shown)

Wood framed roof, spanning between CMU walls, TYP.

Wood framed roof, spanning between CMU walls, TYP.

Glass Wall

6" Seismic Joint

Ledger is bolted to concrete wall No Seismic Joint

Area Required to Remain GAC (and SPC 4D)

THIRD STREET

INTRODUCTION

Guttman and Blaevoet was retained to assess the existing MEPT services/systems which support the west, central and east wings of the facility. The primary focus of the study was to document the origin of the respective services/systems and how their associated infrastructure is routed throughout the west, central and east wings of the facilities. In addition, our systems assessment will include comments and analysis detailing how the existing services/systems may be impacted by the proposed renovation options.

- Option 1: The central wing is decommissioned, and the west wing, east wing and south corridor in the central wing remain OSHPD 1

- Option 2: The central and east wings are decommissioned, and the west wing and south corridor in the central wing remain OSHPD 1.

In our assessment we have established the main MEPT services/systems which support the west, central and east wings of the facility. Additionally, we have identified the potential impacts to the referenced systems/services as a result of the proposed decommissioning options. In summary the majority of services/systems in which support the facility, do so from an area of higher acuity, to an area of lower acuity as required by OSHPD. The report also identifies services/systems which potentially would be serving from an area of lower acuity, to higher acuity (not allowed per OSHPD) if the south corridor of the central wing were to be decommissioned.

Lastly it should be noted that there are other potential elements that require further consideration for the proposed Option-2. The east wing contains the kitchen and other services which are essential to the operation of the hospital (acute care services). If the east wing is to be decommissioned, these essential services will need to be relocated to another acute care area within the facility. The impact to the MEPT systems has not been addressed for this condition and would require further evaluation if/and when the relocated site is identified.

MECHANICAL SYSTEMS

OVERVIEW

CHILLED WATER SYSTEM

The chilled water needs for the west, central and east wings are supported by two, 272-Ton, 600gpm air cooled chillers located in the central utility plant (CUP). Each chiller is paired with a dedicated variable speed chilled water pump, and chillers/pumps run in a lead-lag mode of operation. The chillers and their associated pumps are combined into an 8”- chilled water piping manifold, and then distribute to each wing.

HEATING WATER SYSTEM

The heating water needs for the west, central and east wings are supported by three, 105hp, 220gpm condensing type boilers located in the CUP. Each boiler is paired with a primary pump, and there are three 220 gpm variable speed secondary pumps. The boilers and their associated pumps are combined into a 6”- heating water piping manifold, and then distribute to each wing.

The controls system for the facility are a hybrid DDC / pneumatic type system. The main building management system (BMS) is DDC along with control for the entire central plant. The original controls for the facility were

pneumatic, and most the mechanical equipment control is still via pneumatic control which is integrated into the overall BMS.

AIR SYSTEMS

There are numerous air systems which support the west, central and east wings of the facility. Each wing has its own dedicated air systems, which do not support any other wings in the facility.

WEST WING

AIR SYSTEMS

All airside systems and equipment serving the West Wing are independent of the Central and East Wings.

The exception with the air systems is in regards to the associated environmental controls. The associated controls for the west wing air handling units requires control air from the compressors located in the CUP. The pneumatic tubing beings in the CUP, enters the south corridor of the central wing and then into the west wing.

CHILLED WATER SYSTEM

Chilled water needs to the west wing is provided by 6” supply and return piping that taps off the main 8” piping in the CUP, and then runs exposed along the southeast corner, and into the basement. From the basement the piping travels throughout the west wing to the associated air handling units and fan coils units.

HEATING WATER SYSTEM

Heating water needs to the west wing are provided by 4” supply and return piping that taps off the main 6” piping in the CUP, and then is routed into the ceiling of the south corridor of the central wing. From the corridor the piping is routed directly into the first floor of the west wing and then travels throughout the west wing to the associated air handling units and fan coils units.

DECOMISSIONING

Option-1:

The air systems are independent of the central wing and are not affected by the proposed decommissioning option with the exception being their controls. In order to accommodate the proposed decommissioning plan without significant alterations and additions to the existing controls system, the south corridor will need to remain within the footprint of the remaining areas still providing acute care services. OSHPD requirements indicate that systems are not permitted to serve areas of higher acuity, from areas of lower acuity, and as such the controls system cannot pass through the south corridor into the west wing unless it remains under the same acuity as the west wing, and is not included in the central wing decommissioning. The chilled water systems are not affected as they communicate directly from the CUP into the west wing. Heating water systems follow a similar path to the control air, and as such the south corridor will again need to be excluded from decommissioned area if alterations to the referenced system are to be avoided.

Option-2:

This option follows the same comments noted above under option-1.

CENTRAL WING

AIR SYSTEMS

All airside systems and equipment serving the central wing are independent of the west and east wings.

The exception with the air systems is in regards to the associated environmental controls. The associated controls for the central wing air handling units require control air from the compressors located in the CUP. The pneumatic tubing begins in the CUP and enters into the ceiling of the south corridor in the central wing. The tubing then travels distributes throughout the central wing to the associated air handling units.

CHILLED WATER SYSTEM

Chilled water needs to the central wing are provided by two separate paths comprised of 2" & 3" supply and return piping that tap off the 6" branch main in the CUP. Both sets of piping enter directly from the CUP into the ceiling of the south corridor, and then distribute throughout the central wing to the associated handlers.

HEATING WATER SYSTEM

Heating water needs to the central wing are provided by two separate paths. The first route is a 4" supply and return that enters directly into the south corridor ceiling from the CUP, and then distributes throughout the central wing to the associated air handlers. The second path is from the CUP and directly up on to the roof of the CUP, then across the roof around the central courtyard and then down to the package heat pump units located at grade.

DECOMISSIONING

Option-1:

There are utilities which communicate between the west and east wings through the south corridor of the central wing. As such the south corridor will need to remain within the footprint of the remaining areas still providing acute care services and not included in the decommissioned area to avoid significant revisions to the existing utilities infrastructure. The air systems are independent of all other wings and the majority of the systems are not affected by the proposed decommissioning. Air handling system CAH-10 is located on the roof at the southeast corner of the central wing and sits above the administrative area. The unit serves the HR department which is just south of the central corridor from where the unit is located. Air distribution travels across the corridor to serve the HR department. For the scenario where the HR department is not included in the decommissioning, the air handling system would be serving an area from lower acuity to higher acuity which is not allowed. If the HR department is included in the decommissioned area, the unit and associated distribution as currently situated can remain as is, with the exception that any air distribution which travels through corridor (higher acuity) will need to meet the seismic bracing requirements established for the referenced area. The chilled water and heating water systems are not affected as they communicate directly from the CUP into the central wing.

Option-2:

The mechanical systems which support the central wing are generally unaffected by this option as they would be serving from an area of higher acuity to an area of lower acuity.

AIR SYSTEMS

All airside systems and equipment serving the central wing are independent of the west and east wings.

The exception with the air systems is in regards to the associated environmental controls. The associated controls for the east wing air handling units and fan coil units require control air from the compressors located in the CUP. The pneumatic tubing begins in the CUP and enters into the ceiling of the south corridor in the central wing. The tubing then travels through the south corridor and into the east wing, and to the associated air handling units and fan coil units.

CHILLED WATER SYSTEM

Chilled water needs to the east wing are provided by 4" supply and return piping that taps off the 6" branch main in the CUP. The piping exits the boiler room in the CUP to the exterior and below grade on the south side of the facility. The chilled water piping travels in a utility trench to the east wing and enters the building in the electrical/mechanical room 1131. The piping then enters the ceiling and distributes throughout the east wing to the associated air handling units and fan coil units.

HEATING WATER SYSTEM

Heating water needs to the west wing are provided by 4" supply and return piping that taps off the main 6" piping in the CUP. The piping routes up to the roof from the CUP and then across the roof of the south corridor in the central wing. The piping then routes to the roof of the east wing and enters the building at the south corridor of the east wing. Once in the building the piping distributes throughout the east wing to the associated air handling units and fan coils units.

DECOMISSIONING

Option-1:

The air systems are independent of the central wing and are not affected by the proposed decommissioning option with the exception being their controls. In order to accommodate the proposed decommissioning plan without significant alterations and additions to the existing controls system, the south corridor will need to remain within the footprint of the remaining areas still providing acute care services. The chilled water system is not affected, as the system does not route through a potential area of lower acuity, and is routed directly from the CUP to the east wing. As the heating water system follows a similar path to the control air, the south corridor will again need to be excluded from decommissioned area if alterations to the referenced system are to be avoided.

Option-2:

The mechanical systems which support the central wing are generally unaffected by this option as they would be serving from an area of higher acuity to an area of lower acuity.

PLUMBING SYSTEMS

WEST WING

DOMESTIC COLDER WATER

The DCW for the west wing passes through a meter and 6" RPBP at the south side of the CUP. A 3" branch goes back underground and routes along the south of the CUP to the basement of the west wing.

DOMESTIC HOT WATER

The DHW and DHWR originate from the CUP and enter the ceiling of the south corridor of central wing. From the corridor the piping routes directly into the west wing

FIRE PROTECTION

The fire water is supplied from Bettencourt Street in a 6" service directly into the south of the West Wing. T

MEDICAL GASES

Vacuum service to the west wing is accommodated by two dedicated vacuum pumps in the CUP. From the CUP the piping enters the ceiling of the south corridor of the central wing. From there it travels west along the corridor and into the west wing.

Medical Air originates from the CUP and enters the south corridor of the central wing. From there it travels west along the corridor and into the west wing.

N2O & O2 lab gasses originate in a utility yard on the southwest corner of the property. From the N2O and O2 storage tanks the piping is routed below grade along the south side in a trench until they pass the boiler room. They then turn North and enter the East wing in electrical / mechanical room 1131. The piping then enters the ceiling of the south corridor of the east wing and travels west into the central wing. The piping travels through the south corridor of the central wing and into the west wing.

NATURAL GAS

The gas system originates from the central utility yard and enters the West Wing from the Central Wing southern corridor. It is stated on the As-Builts to be abandoned.

SANITARY

The main sanitary lines that serves the West Wing are independent from the other wings and exits the building south near the fire department connection.

CENTRAL WING

DOMESTIC COLDER WATER

The DCW for the central wing passes through a meter and 6" RPBP at the south side of the CUP. A 4" branch then enters the CUP. goes back underground and routes along the south of the CUP to the basement of the west wing.

The DCW for the Central Wing passes through a meter and 6" RPBP in the central utility yard and splits to serve the west and central wings respectively

DOMESTIC HOT WATER

The DHW and DHWR originates from the CUP and enters the ceiling of the south corridor of central wing. From the corridor the piping routes directly into the west wing

FIRE PROTECTION

The fire water is supplied from Bettencourt Street in a 6" service directly into the south of the West Wing. This service also supports the central wing of the facility.

MEDICAL GASES

The Central Wing vacuum service is supplied by one dedicated vacuum pump in the boiler room. The piping travels north to enter the Central Wing southern corridor.

Medical Air originates from the boiler room and travels north to the Central Wing corridor.

N2O & O2 lab gasses originate in a utility yard on the southwest corner of the property. From the N2O and O2 storage tanks the piping is routed below grade along the south side in a trench until they pass the boiler room. They then turn North and enter the East wing in electrical / mechanical room 1131. The piping then enters the ceiling of the south corridor of the east wing and travels west into the central wing.

NATURAL GAS

The natural gas system originates at the CUP. There are no gas demands for the central wing.

SANITARY

The main sanitary line that serves the Central Wing is independent from the other wings and exits the building from the north side.

EAST WING

DOMESTIC COLDER WATER

The DCW meter for the East Wing is located adjacent to Bettencourt Street just east of the cooling tower. The DCW passes through a RPBP and serves only the East Wing.

DOMESTIC HOT WATER

The DHW and DHWR originates from the CUP and enters the ceiling of the south corridor of central wing. From the south corridor the piping routes east directly into the east wing.

FIRE PROTECTION

The fire water is supplied from Bettencourt Street in a 4" service directly into the east wing.

MEDICAL GASES

N2O & O2 lab gasses originate in a utility yard on the southwest corner of the property. From the N2O and O2 storage tanks the piping is routed below grade along the south side in a trench until they pass the boiler room. They then turn North and enter the East wing in electrical / mechanical room 1131. The piping then enters the ceiling of the south corridor of the east wing.

NATURAL GAS

The natural gas system originates at the CUP. The gas system then enters the ceiling of the south corridor of the central wing and routes down the corridor into the east wing.

SANITARY

The main sanitary lines that serve the east wing are independent from the other wings and exits the building at both the north and south sides.

ELECTRICAL SYSTEMS

WEST WING

NORMAL POWER

Normal power to the West, Central and East Wings is supplied from the main electrical room located in the basement of the West Wing. Power is supplied to panel boards located throughout the site via underground and overhead conduits.

Within the West Wing branch circuit power is distributed via panel boards located in corridors and electrical rooms

UTILITY PG&E

Normal power to the site is provided by (2) PG&E services. One service is dedicated to the new ED Building and the other serves the main electrical room located in the basement of the West Wing via a pad mounted transformer.

EMERGENCY POWER

Emergency power is provided by a 900kW 480/277V package generator located adjacent to the ED Building

Emergency power to the West, Central and East is distributed from the main electrical room located in the basement of the West Wing. Power is supplied to panel boards located thought out the site via underground and overhead conduits.

ATS for the Equipment, Critical and Life Safety branches are available in the West Wing main electrical room. The respective branches are distributed throughout the building. The electrical system in the West Wing appears the have a compliant emergency power electrical system.

The generator NFPA 110 annunciator panel is located in the PBX of the new ED Building. In the engineer's office in the central wing duplicate panels are installed.

CENTRAL WING

NORMAL POWER

Normal power to the Central Wing is supplied from the main electrical room located in the basement of the West Wing. Power is supplied to panel boards located throughout the Central Wing via underground and overhead conduits.

Within the Central Wing branch circuit power is distributed via panel boards located in corridors and store rooms

No major conduits are installed within the Central Wing South corridor

EMERGENCY POWER

Emergency power to the Central Wing is distributed from the main electrical room located in the basement of the West Wing. Equipment, Life Safety and Critical branch power is supplied to panel boards located thought out the site via underground and overhead conduits.

Within the Central Wing branch circuit power is distributed via panel boards located in corridors and electrical room

No major conduits are installed within the Central Wing South corridor

Not all areas have the compliant electrical system.

ALARM and GENERATOR ANNUNCIATOR PANEL

The emergency generator NFPA 110 alarm panels are located the engineer's office. There are; however, duplicated by NFPA 110 panels located in the compliant ED building PBX room.

EAST WING

NORMAL POWER

Normal power to the East Wing is supplied from the main electrical room located in the basement of the West Wing. Power is supplied to panel boards located throughout the East Wing via underground conduits.

Within the East Wing branch circuit power is distributed via panel boards located in corridors and one electrical room

Power to the IT room in the East Wing is supplied via underground conduits installed around the perimeter of the building to the main electrical room in the West Wing

EMERGENCY POWER

Emergency power to the East Wing is distributed from the main electrical room located in the basement of the West Wing. Equipment, Life Safety and Critical branch power is supplied to panel boards located thought out the site via underground and overhead conduits.

Within the East Wing branch circuit power is distributed via panel boards located in corridors and electrical room

Not all areas have the compliant electrical system.

DECOMMISIONING

The main electrical systems that serve the East Wing, emanate from the West Wing main electrical room. They are distributed via overhead and underground conduits that do not pass though the Central Wing. Therefore, the Central Wing and South Corridor could be removed from acute care services, without impacting the distribution to the East Wing.

The provision of flexible connections and means of disconnection to the Central Wing, would have to be further evaluated to ensure compliance with OSHPD CAN: 1-6-1.4.5.1.4.

For the purposes of this report decommissioning will encompass removing from acute care services, OSHPD will remain the AHJ per OSHPD CAN: 1-6-1.4.5.1.4:

Option-1:

Only the central wing is decommissioned, and the west wing, east wing and south corridor in the central wing remain OSHPD 1

Electrical Impact

The main electrical systems that serve the East Wing, emanate from the West Wing main electrical room. They are distributed via overhead and underground conduits that do not pass though the Central Wing. Therefore, the Central Wing could be removed from acute care services, without impacting the distribution to the East Wing.

The provision of flexible connections and means of disconnection to the Central Wing, would have to be further evaluated to ensure compliance with OSHPD CAN: 1-6-1.4.5.1.4.

Option 2

The central and east wings are decommissioned, and the west wing and south corridor in the central wing remain OSHPD 1

The main electrical systems that serve the East Wing, emanate from the West Wing main electrical room. They are distributed via overhead and underground conduits that do not pass though the Central Wing. Therefore, the Central Wing and South Corridor could be removed from acute care services, without impacting the distribution to the East Wing.

The provision of flexible connections and means of disconnection to the Central Wing, would have to be further evaluated to ensure compliance with OSHPD CAN: 1-6-1.4.5.1.4.

LOW VOLTAGE

WEST WING

The west wing appears to encompass critical services for telecom and fire alarm routed through the wing to the central and east wings. The main FACP and MPOE are in the new addition emergency area and from as built documents indicates that services originate within this building that feed through the West Wing to Central Wing and East Wing structures. It appears that the main fire alarm circuits from the main FACP and routed through the West wing to Central and feed a 2nd FACP and NODE in engineering. It is presumed since the MPOE is located in the emergency area, that critical voice and data circuits are routed through the West Wing, Central wing to IT servers and network and voice systems critical for operation. Those systems, back bone lines, etc. would have to be rerouted outside decommissioned or OSHPD 1 space, since they service OSHPD 3 facilities. Any nurse call system tie lines critical for annunciation at the PBX for Code Blue, etc. would have to be relocated outside the decommissioned bldg. and those critical services would have to be relocated, such as PBX, etc. into OSHPD 3 rated facility. Other systems for security cameras, door access control, etc. are not critical systems and can be reviewed on a as needed basis per area. Critical voice and data circuits may be routed through this area and down to the basement to voice and data systems.

The West Wing area/bldg. is a pass through for data, fire alarm and nurse call systems. Routed through the central lobby area in branching off to the central corridor and to the imaging area and old ER area, now abandoned for reuse. Service cables were found above suspended ceilings and viewed via access hatches through the area. Cabling is also fed to upper floors in this area and into the basement. Decommissioning the West Wing to OHSPD 3 would require an OSHPD 1 envelope of the critical cabling serving the higher OSHPD 1 rated areas in the facility.

CENTRAL WING

The Central wing appears to encompass critical services for telecom and fire alarm routed through the wing to the West and East wings. The secondary annunciation and control NODE 2 FACP in the engineering area and from as built documents indicates that services feed through the Central Wing to West Wing and East Wing structures. The main FACP fire alarm circuits are routed through this wing. It appears that some voice and data circuits are feed to the basement via the Central Wing. Any nurse call system tie lines critical for annunciation at the PBX for Code Blue, etc. would have to be relocated outside the decommissioned bldg. and those critical services would have to be relocated, such as PBX, etc. into OSHPD 3 rated facility. Other systems for security cameras, door access control, etc. are not critical systems and can be reviewed on a as needed basis per area. Critical voice and data circuits may be routed through this area and down to the basement to voice and data systems. Voice and data back bone lines, etc. would have to be rerouted outside decommissioned or OSHPD 1 space, since they service OSHPD 3 facilities

The Central Wing area/bldg. is a termination and pass through for data, fire alarm and nurse call systems. Cabling was found routed through the central corridor and also branches of data cabling and fire alarm into sub-corridors in the Central Wing. The Central Wing encloses a data services area or IT space with main data switches and points of connection for voice and data. The Fire Alarm system includes remote nodes in facility / engineering dept. and also the main feed into the east wing from the main fire alarm panel. Decommissioning the Central Wing to OHSPD 3 would require an OSHPD 1 envelope of the critical cabling serving the higher rated OSHPD 1 areas in the facility.

EAST WING

The East wing is fed from West, Central Wings for telecom and fire alarm services, as well as it is connected to the code blue system in the new addition wing PBX. Critical data, voice and telecom services are located within the East

Wing and connect to Central and West Wings. Any nurse call system tie lines critical for annunciation at the PBX for Code Blue, etc. would have to be relocated outside the decommissioned bldg. and those critical services would have to be relocated, such as PBX, etc. into OSHPD 1 rated facility. Other systems for security cameras, door access control, etc. are not critical systems and can be reviewed on a as needed basis per area. Critical voice and data circuits may be routed through this area and down to the basement to voice and data systems or to IT servers in the Central Wing. Voice and data back bone lines, etc. would have to be rerouted outside decommissioned or OSHPD 3 space, since they service OSHPD 1 facilities

The East Wing incorporates the main server room and racks of equipment, adjacent to the medical records area. The server room appears to have been recently installed or updated to service the facility. Site investigations found fiber optic and copper horizontal cabling terminated in the space. Additionally, the nurse call is back fed for Code Blue/One service via the central and west wings to the PBX. Network cabling for horizontal distribution feeding workstations in the east wing were found originating from the central and east wing data rooms. The fire alarm system terminates in the east wing with booster panels located to serve audible and visual devices at the end of the fire alarm circuits. Decommissioning the East Wing to OHSPD 3 would require relocation of critical mission-oriented services and equipment into an OSHPD 1 envelope or building for the critical cabling serving the higher rated OSHPD 1 areas in the facility.

ED / OR

The OR/ED area encompasses the incoming data services for the facility with multiple fiber optic cables for service providers terminating at the rack in the MPOE space in the ED. The fiber was terminated on the provider equipment, then redistributed to the hospital from the MPOE through the OR/ED area and into the West Wing. The main fire alarm panel is also located in the OR/ED area in the main electrical room and is then distributed into the OR/ED area and on into the West Wing of the facility. Nurse Call Code Blue / One system resides at the central PBX location and is fed from the various Rauland systems located in the West Wing, OR/ED and East Wings. This cabling is fed for fire alarm and nurse call through the east, central and west wings, comprising the nurse call and fire alarm backbones. The cables continue through the west wing into the central corridor to the east wing. During our site reviews we lifted ceiling tiles, opened access hatches and view cabling routed open and in inner duct through the area.

END OF REPORT

KEYNOTES:

CP. CHILLER PLANT.

HP. HEATING WATER PLANT.

CA. CONTROL AIR COMPRESSORS.

W1. 6"CHILLED WATER FROM CHILLER PLANT AND INTO BASEMENT.

W2. 4"HEATING WATER FROM S. CORRIDOR CENTRAL WING.

W3. CONTROL AIR FROM S. CORRIDOR CENTRAL WING.

W4. MAIN AIR HANDLING SYSTEMS ON ROOF. SUPPLAMENTAL FAN COIL UNITS IN CEILING SPACE NOT SHOWN.

C1. 2" HEATING WATER FROM HEATING WATER PLANT ON ROOF.

C2. 4"HEATING WATER FROM HEATING WATER PLANT.

C3. 2" & 3" CHILLED WATER FROM CHILLER PLANT..

C4. CONTROL AIR FROM S. CORRIDOR CENTRAL WING.

C5. MAIN AIR HANDLING SYSTEMS ON ROOF.

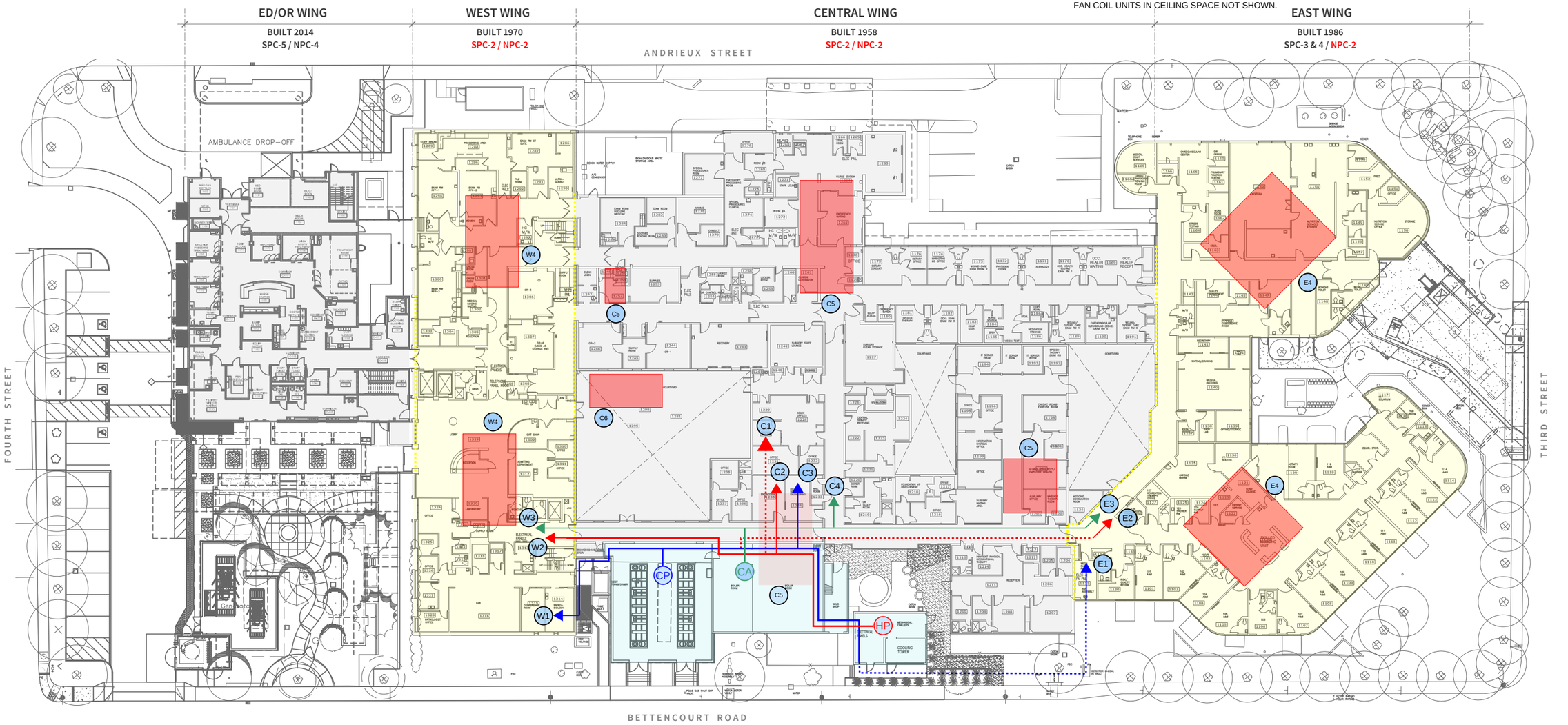
C6. MAIN AIR HANDLING SYSTEMS AT GRADE.

E1. 4"CHILLED WATER FROM EXTERIOR BELOW GRADE.

E2. 4"HEATING WATER FROM ROOF ABOVE S. CORRIDOR IN THE CENTRAL WING, AND THEN DN. TO EAST WING.

E3. CONTROL AIR FROM S. CORRIDOR CENTRAL WING.

E4. MAIN AIR HANDLING SYSTEMS ON ROOF. SUPPLAMENTAL FAN COIL UNITS IN CEILING SPACE NOT SHOWN.



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SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

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N

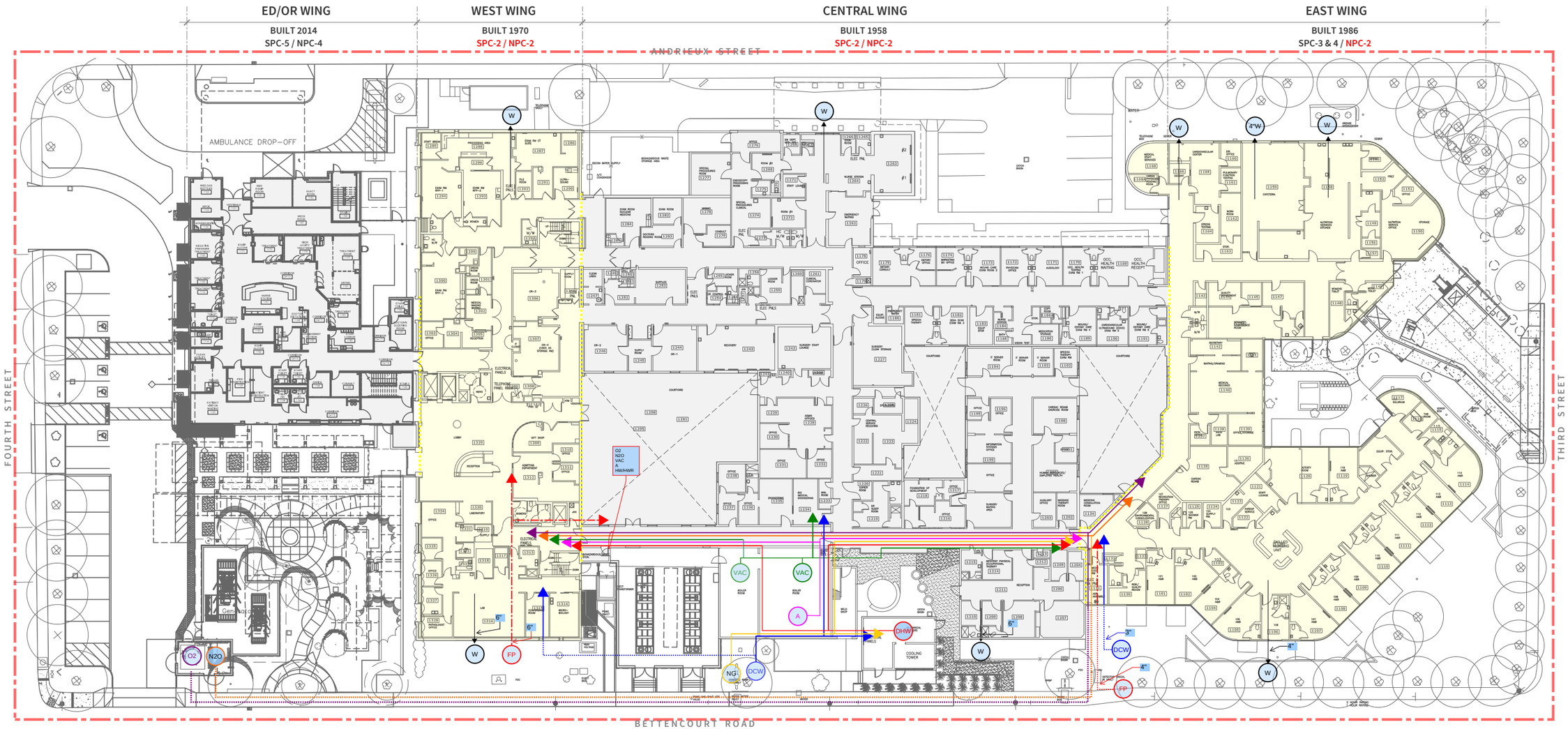
MECH. SERVICES PLAN

SEPTEMBER 11, 2018 SCALE: NTS

MSK-1

KEYNOTES:

W. SANITARY WASTE.
A. COMPRESSED AIR.
DCW. DOMESTIC COLD WATER
DHW. DOMESTIC HOT WATER.
FP. FIRE PROTECTION
VAC. VACUUM FROM CENTRAL UTILITY PLANT.
O2. OXYGEN FROM MED GAS STORAGE YARD.
N2O. NITROUS OXIDE FROM MED GAS STORAGE YARD.



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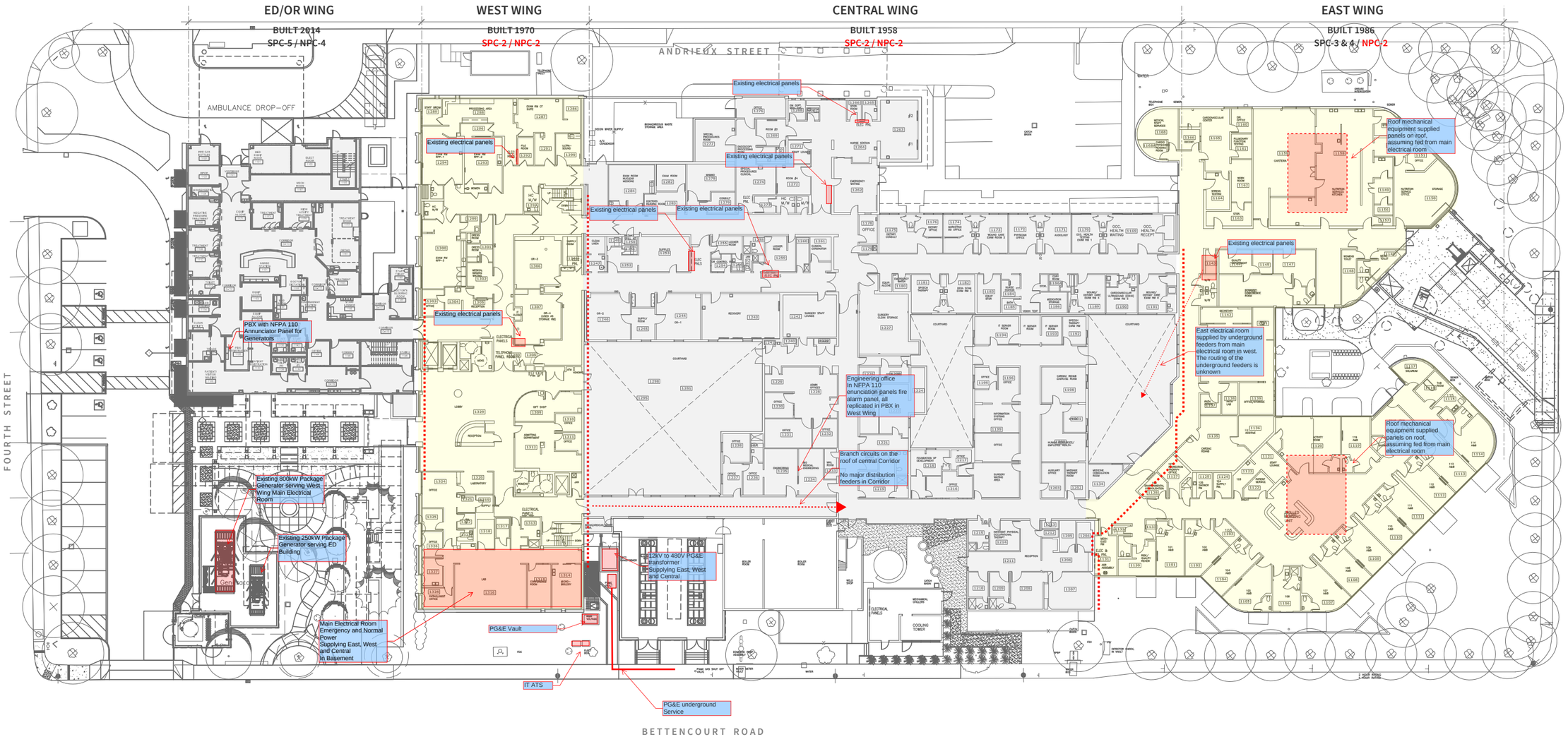
PLUMB SERVICES PLAN

SEPTEMBER 11, 2018 SCALE: NTS

PSK-1



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ELECTRICAL SERVICES PLAN

SEPTEMBER 11, 2018

SCALE: NTS

ESK-1

OVERVIEW OF SYSTEMS ROUTING IT NETWORK:

1. MAIN FIBER OPTIC NETWORK IS ROUTED FROM ER/OR AREA INTO CENTRAL WING MDF AND SERVER ROOMS.

2. NETWORK IS THEN BACK FED FROM CENTRAL WING IT SERVER ROOMS TO CENTRAL WING, WEST WING, ER/OR, AND EAST WINGS.

3.ALL CRITICAL IT EQUIPMENT IS LOCATED IN THE CENTRAL WING AREA AND IN EAST WING.

OVERVIEW OF SYSTEMS ROUTING FIRE ALARM:

1. MAIN FIRE ALARM PANEL IS S ROUTED FROM ER/OR AREA ELECTRICAL ROOM INTO ALL WINGS.

2. REMOTE NODES AND ANNUNCIATORS ARE IN ENGINEERING AND AT MAIN PBX IN OR/ER AREA.

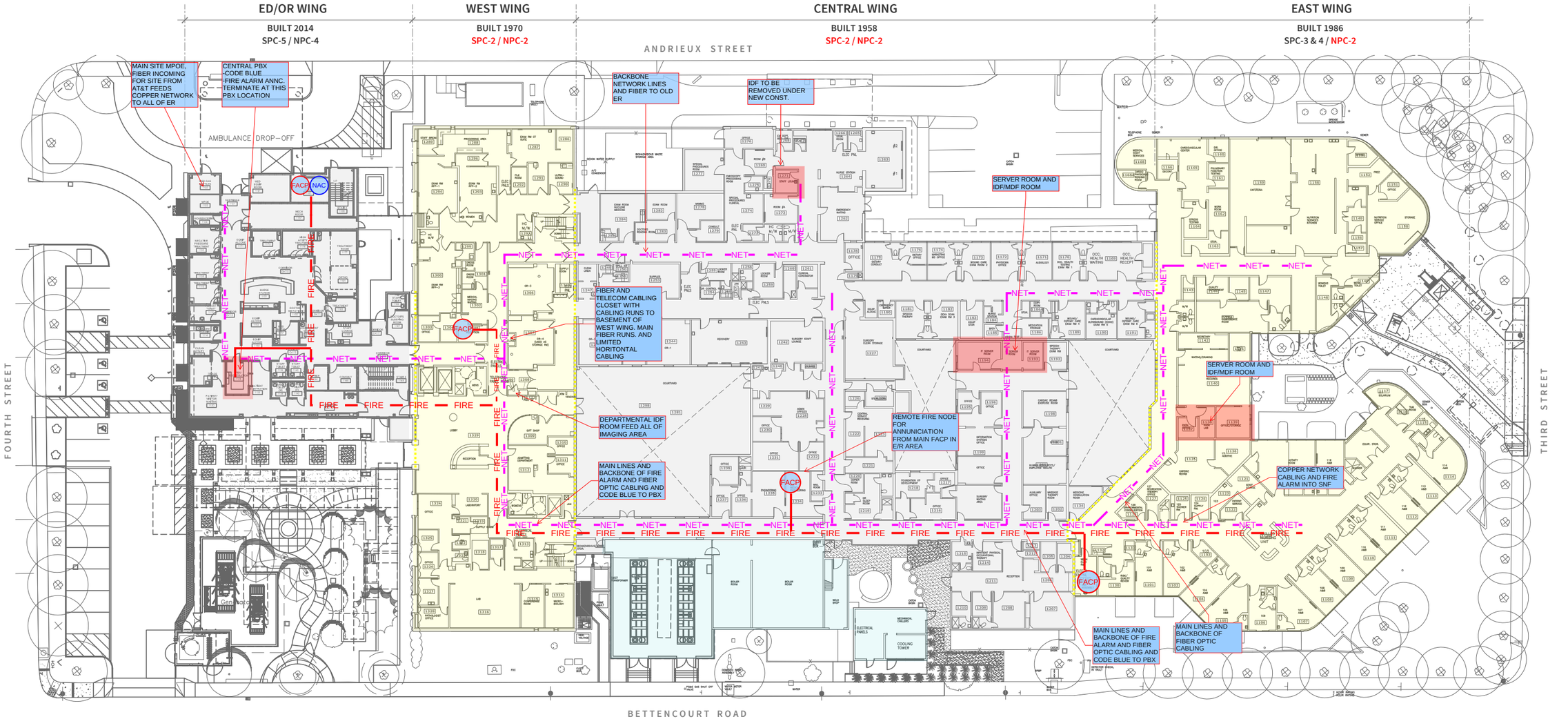
3. MAIN FIRE ALARM BACKBONE RUNS THROUGH WEST WING AND CENTRAL WING TO EAST WING.

OVERVIEW OF SYSTEMS ROUTING NURSE CALL:

1. NURSE CALL SYSTEMS ARE LOCATION IN THE EAST WING, WEST WING, AND OR/ER AREAS.

2. NURSE CALL IS INTERCONNECTED FOR CODE CALLS TO PBX AND CONNECTS TO NURSE CALL HEAD IN , LOCATED IN THE ELECTRICAL ROOM OF THE OR/ER BUILDING.

3. BACK BONE INTERCONNECT RUNS THROUGH THE CENTRAL AND WEST WINGS FOR NURSE CALL.



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LOW VOLTAGE SERVICES

SEPTEMBER 11, 2018 SCALE: NTS

LVSK-1

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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To: **SVH Board of Directors**
From: **Sonoma Valley Hospital Administration**
Date: **October 23, 2018**
Subject: **Proposed FY 2019 Budget for the 6-Months of January 2019 to June 2019**

During the middle part of Fiscal Year 2018 operating budget process, management needed time to review the then current operating structure before proposing an annual budget for Fiscal Year 2019. To give management time to adequately formulate a new hospital structure, the Board was presented with an approved budget for the first three months of the new fiscal year with the remaining nine months to be presented at a later time. Since the Skilled Nursing Facility and the transfer of Home Health were still under review, management subsequently presented a proposed budget for the next three months of October 2018 through December 2018. Now, since the Skilled Nursing Facility is still under review, management is proposing the final 6-month budget and presenting the entire budget for Fiscal Year 2019. The significant assumptions are:

-Volume is based upon a 12 month rolling average and adjusted for current volume.
- Gross Revenue includes a 6% price increase with a projected 1.4% increase in net revenue
-Contractual discounts/Bad debt are based upon actual experience
-A significant increase in reimbursement for capitated Medi-Cal
-Board approved closing of the Obstetrical Service unit at 10/31/2018
-Board approved transfer of Home Health department at 9/30/2018

The Net operating loss for the 12-months ending at June 30, 2018 is budgeted at ($5,940,372). After accounting for Non-Operating income, the net loss prior to restricted donations and GO bond activity is ($2,871,869). Including all other activity the Net loss for the 12-months ending June 30, 2019 is ($166,529) with an EBDA of 1.1%.

ATTACHMENTS:
-Attachment A - Approved FY 2019 6-Month Budget for July 2018 through December 2018 and proposed 6-month budget for January 2019 through June 2019
-Attachment B - FY 2019 12-Month Budget Preliminary Cost Savings for July 2018 through June 2019
-Attachment C - FY 2019 12-Month Budget Payer Mix for July 2018 through June 2019
-Attachment D - FY 2019 12-Month Budget Cash Flow for July 2018 through June 2019
-Attachment E – Projected 12-month Statement of Revenue and Expenses without Obstetrics and Home Health.

Sonoma Valley Health Care District **Schedule A**
Statement of Revenue and Expenses
FY 2019 Budget
July 1, 2018 through June 30, 2019

	Approved FY 2019 Budget - 6 Months July 1, 2018 - December 31, 2018	FY 2019 Budget - 6 Months January 1, 2019 - June 30, 2019	FY 2019 Budget
Volume Information			
Acute Discharges	539	552	1,091
Patient Days	1,880	1,967	3,847
SNF Days	3,150	2,715	5,865
Emergency Room Visits	5,449	5,322	10,771
Surgeries - Inpatient	152	194	346
Surgeries - Outpatient	815	791	1,606
Special Procedures	383	395	778
Home Care Visits	4,640	-	4,640
Gross O/P Revenue (000's)	$ 86,092	$ 89,227	$ 173,691
Financial Results			
Gross Patient Revenue			
Inpatient	$ 34,696,418	$ 39,689,678	$ 74,386,096
Outpatient	46,607,665	49,247,252	95,854,917
Emergency	37,856,816	39,979,562	77,836,378
SNF	11,439,929	7,216,535	18,656,464
Home Health	1,627,347	-	1,627,347
Total Gross Patient Revenue	**$ 132,228,175**	**$ 136,133,027**	**$ 268,361,202**
Deductions from Revenue			
Contractual Discounts	$ (106,385,676)	$ (111,319,061)	$ (217,704,737)
Bad Debt	(600,000)	(600,000)	(1,200,000)
Charity Care Provision	(148,380)	(148,385)	(296,765)
Prior Period Adj/Government Program Revenue	2,115,330	2,115,331	4,230,661
Total Deductions from Revenue	**$ (105,018,726)**	**$ (109,952,115)**	**$ (214,970,841)**
Net Patient Service Revenue	**$ 27,209,449**	**$ 26,180,912**	**$ 53,390,361**
Risk contract revenue	$ 665,391	$ 575,994	$ 1,241,385
Net Hospital Revenue	$ 27,874,840	$ 26,756,906	$ 54,631,746
Other Op Rev & Electronic Health Records	$ 83,808	$ 83,813	$ 167,621
Total Operating Revenue	**$ 27,958,648**	**$ 26,840,719**	**$ 54,799,367**
Operating Expenses			
Salary and Wages and Agency Fees	$ 13,308,264	$ 12,222,522	$ 25,530,786
Employee Benefits	5,087,620	4,647,910	9,735,530
Total People Cost	$ 18,395,884	$ 16,870,432	$ 35,266,316
Med and Prof Fees (excld Agency)	$ 3,019,832	$ 2,999,929	$ 6,019,761
Supplies	3,260,345	3,550,241	6,810,586
Purchased Services	2,218,263	2,265,100	4,483,363
Depreciation	1,727,946	1,745,244	3,473,190
Utilities	662,986	584,169	1,247,155
Insurance	206,247	211,921	418,168
Interest	298,373	298,274	596,647
Other - a)	722,755	640,959	1,363,714
Matching Fees (Government Programs)	530,418	530,421	1,060,839
Operating expenses	**$ 31,043,049**	**$ 29,696,690**	**$ 60,739,739**
Operating Margin	**$ (3,084,401)**	**$ (2,855,971)**	**$ (5,940,372)**
Non Operating Rev and Expense			
Miscellaneous Revenue/(Expenses)	$ (31,778)	$ (63,095)	$ (94,873)
Donations	16,032	16,038	32,070
Physician Practice Support-Prima	(340,596)	(328,098)	(668,694)
Parcel Tax Assessment Rev	1,900,000	1,900,000	3,800,000
Total Non-Operating Rev/Exp	**$ 1,543,658**	**$ 1,524,845**	**$ 3,068,503**
Net Income / (Loss) prior to Restricted Contributions	**$ (1,540,743)**	**$ (1,331,126)**	**$ (2,871,869)**

Sonoma Valley Health Care District
Statement of Revenue and Expenses
FY 2019 Budget
July 1, 2018 through June 30, 2019

Schedule A

	Approved FY 2019 Budget - 6 Months July 1, 2018 - December 31, 2018	FY 2019 Budget - 6 Months January 1, 2019 - June 30, 2019	FY 2019 Budget
Capital Campaign Contribution	$ 125,694	$ 125,689	$ 251,383
Restricted Foundation Contributions	$ 330,018	$ 330,024	$ 660,042
Net Income / (Loss) w/ Restricted Contributions	**$ (1,085,031)**	**$ (875,413)**	**$ (1,960,444)**
GO Bond Tax Assessment Rev	1,525,041	1,526,616	3,051,657
GO Bond Interest	(609,617)	(648,125)	(1,257,742)
Net Income/(Loss) w GO Bond Activity	**$ (169,607)**	**$ 3,078**	**$ (166,529)**
EBIDA - Using Net Income/(Loss) prior to Restricted Contributions	$ 485,576	$ 712,392	$ 1,197,968
	1.7%	2.7%	2.2%
EBDA - Using Net Income/(Loss) prior to Restricted Contributions	$ 187,203	$ 414,118	$ 601,321
	0.7%	1.5%	1.1%

a) - Education, travel, rents, operating leases, dues & subscriptions, licenses & taxes, etc..

Sonoma Valley Health Care District **Schedule B**
Schedule of Preliminary Cost Savings & Additions
FY 2019 Budget - 12 Months
July 1, 2018 through June 30, 2019

	FY 2019 Budget - 12 Months July 1, 2018 - June 30, 2019	
Peliminary Cost Savings & Additions:		
1. Closure of Obstetrics Department at 10/31/18:		
Net Revenue	(688,481)	
Direct and Attributable Costs	1,000,580	312,100
2. Transfer of Home Health:		
Net Revenue	(1,209,171)	
Direct and Attributable Costs	1,376,548	167,377
3. Restructure of Staffing in the Skilled Nursing Facility:		
Reduction of FTE's from 29.6 to 21.8		393,902
4. Physical and Occupational Therapists registry for SNF (6 months)		(237,438)
5. Bariatric surgeries - Additional 8 cases annually		
Direct Margin - $144,000 annually = $12,000/Monthly		144,000
6. Reduction in Administration - Contracted labor		21,216
7. Reduction in Finance Overhead Departments - Salaries		14,577
8. Salary increase at 2.5% - January 2019		(255,376)
9. Partnership Healthcare - Increase in Contract ($650,000/Annual)		650,000
10. Disproportionate Share Hospital (DSH)		
Based on reduction of Medi-Cal Days		(96,000)
11. 6% Price increase, net		690,423
12. Severence Pay - October 2018		(27,590)
13. Costs of closing/moving units		(15,000)
Total Preliminary Cost Savings & Additions		1,762,191

Note: Items #1 and #2 are based on Administrations analysis

Sonoma Valley Health Care District **Schedule C**
Schedule of Payor Mix
FY 2019 Budget - 12 Months
July 1, 2018 through June 30, 2019

	FY 2019 Budget - 12 Months July 1, 2018 - June 30, 2019	Fiscal YTD at 6/30/2018	Variance
Medicare	43.1%	44.4%	-1.3%
Medicare Managed Care	12.6%	13.3%	-0.7%
Medi-Cal	17.8%	17.9%	-0.1%
Self Pay	1.3%	1.2%	0.1%
Commercial	20.8%	19.0%	1.8%
Worker's Comp.	2.4%	2.1%	0.3%
Capitated	2.0%	2.1%	-0.1%
	100.0%	100.0%	

Sonoma Valley Health Care District **Schedule D**
Cash Forecast - FY 2019 Budget - 12 Months

		FY 2019 Budget	
		July 1, 2018 - December 31, 2018	January 1, 2019 - June 30, 2019
	Hospital Operating Sources		
1	Patient Payments Collected	25,022,348	23,993,810
2	Capitation Revenue	665,391	575,994
3	Napa State	71,772	71,771
4	Other Operating Revenue	83,808	83,813
5	Other Non-Operating Revenue	178,038	168,765
6	Unrestricted Contributions	16,032	16,038
7	Line of Credit	-	
	Sub-Total Hospital Sources	**26,037,389**	**24,910,191**
	Hospital Uses of Cash		
8	Operating Expenses	29,335,097	27,980,982
10	Add Capital Lease Payments	477,050	477,050
11	Additional Liabilities	-	
12	Capital Expenditures	455,712	330,024
	Total Hospital Uses	**30,267,859**	**28,788,056**
	Net Hospital Sources/Uses of Cash	**(4,230,470)**	**(3,877,865)**
	Non-Hospital Sources		
13	Restricted Cash/Capital Donations	510,167	455,712
14	Parcel Tax Revenue	1,900,000	1,900,000
15	Net Proceeds - South Lot	-	
16	Other:		
17	IGT	1,740,330	1,740,331
18	IGT - AB915 (Net)	-	
19	PRIME	375,000	375,000
	Sub-Total Non-Hospital Sources	**4,525,497**	**4,471,043**
	Non-Hospital Uses of Cash		
20	Matching Fees	530,418	530,421
	Sub-Total Non-Hospital Uses of Cash	530,418	530,421
	Net Non-Hospital Sources/Uses of Cash	**3,995,079**	**3,940,622**
	Net Sources/Uses	**(235,391)**	**62,757**
	Cash and Equivalents at beginning of period	1,671,426	1,436,035
	Cash and Equivalents at end of period	**1,436,035**	**1,498,792**

Sonoma Valley Health Care District **Schedule E**
Statement of Revenue and Expenses
FY 2019 Budget - 6-Months January 1, 2019 to June 30, 2019 Annualized

	FY 2019 Budget - 6 Months January 1, 2019 - June 30, 2019	12- Month Annualized
Volume Information		
Acute Discharges	552	1,104
Patient Days	1,967	3,934
SNF Days	2,715	5,430
Emergency Room Visits	5,322	10,644
Surgeries - Inpatient	194	388
Surgeries - Outpatient	791	1,582
Special Procedures	395	790
Home Care Visits	-	-
Gross O/P Revenue (000's)	$ 89,227	$ 178,454
Financial Results		
Gross Patient Revenue		
Inpatient	$ 39,689,678	$ 79,379,356
Outpatient	49,247,252	98,494,504
Emergency	39,979,562	79,959,124
SNF	7,216,535	14,433,070
Home Health	-	-
Total Gross Patient Revenue	**$ 136,133,027**	**$ 272,266,054**
Deductions from Revenue		
Contractual Discounts	$ (111,319,061)	$ (222,638,122)
Bad Debt	(600,000)	(1,200,000)
Charity Care Provision	(148,385)	(296,770)
Prior Period Adj/Government Program Revenue	2,115,331	4,230,662
Total Deductions from Revenue	**$ (109,952,115)**	**$ (219,904,230)**
Net Patient Service Revenue	**$ 26,180,912**	**$ 52,361,824**
Risk contract revenue	$ 575,994	$ 1,151,988
Net Hospital Revenue	$ 26,756,906	$ 53,513,812
Other Op Rev & Electronic Health Records	$ 83,813	$ 167,626
Total Operating Revenue	**$ 26,840,719**	**$ 53,681,438**
Operating Expenses		
Salary and Wages and Agency Fees	$ 12,222,522	$ 24,445,044
Employee Benefits	4,647,910	$ 9,295,820
Total People Cost	$ 16,870,432	$ 33,740,864
Med and Prof Fees (excld Agency)	$ 2,999,929	$ 5,999,858
Supplies	3,550,241	7,100,482
Purchased Services	2,265,100	4,530,200
Depreciation	1,745,244	3,490,488
Utilities	584,169	1,168,338
Insurance	211,921	423,842
Interest	298,274	596,548
Other - a)	640,959	1,281,918
Matching Fees (Government Programs)	530,421	1,060,842
Operating expenses	**$ 29,696,690**	**$ 59,393,380**
Operating Margin	**$ (2,855,971)**	**$ (5,711,942)**

Non Operating Rev and Expense				
Miscellaneous Revenue/(Expenses)	$	(63,095)	$	(126,190)
Donations		16,038		32,076
Physician Practice Support-Prima		(328,098)		(656,196)
Parcel Tax Assessment Rev		1,900,000		3,800,000
Total Non-Operating Rev/Exp	**$**	**1,524,845**	**$**	**3,049,690**
Net Income / (Loss) prior to Restricted Contributions	**$**	**(1,331,126)**	**$**	**(2,662,252)**
Capital Campaign Contribution	$	125,689	$	251,378
Restricted Foundation Contributions	$	330,024	$	660,048
Net Income / (Loss) w/ Restricted Contributions	**$**	**(875,413)**	**$**	**(1,750,826)**
GO Bond Tax Assessment Rev		1,526,616		3,053,232
GO Bond Interest		(648,125)		(1,296,250)
Net Income/(Loss) w GO Bond Activity	**$**	**3,078**	**$**	**6,156**
EBIDA - Not including Restricted Contributions	$	712,392	$	1,424,784
		2.7%		2.7%
EBDA - Not including Restricted Contributions	$	414,118	$	828,236
		1.5%		1.5%

a) - Education, travel, rents, operating leases, dues & subscriptions, licenses & taxes, etc..

Meeting Date: November 1, 2018

Prepared by: Peter Hohorst and Joshua Rymer

Agenda Item Title: Award of CEO's Performance Incentive Payment

Recommendations:
That the Board approve the CEO's Performance Incentive Payment

Background:
The contract offer that was made to Kelly Mather on July 2, 2010 included a provision "for an incentive compensation program of up to 15%" of base salary. This provision was incorporated into her official employment contract. Each year the Board in consultation with Kelly has approved specific objectives for the ensuing year and the criteria for translating the actual performance on these metrics into an incentive award.

At the September 7, 2017 Board meeting, the Board approved six CEO objectives for the 2018 fiscal year and the formula for calculating the amount of incentive that would be awarded. Four of the objectives related to quality metrics, one was for financial performance and one was for community service. Each objective stipulated 5 potential levels of incentive compensation.

Levels 1 and 2 would not earn any incentive compensation.
Level 3, the Base Goal, would earn 66.7 % of the maximum incentive compensation for the objective.
Level 4 would earn 86.7% of the maximum incentive compensation for the objective.
Level 5 or higher would earn 100% of the maximum incentive compensation for the objective.

Based on actual performance for the year the calculation of the incentive earned is as follows:

Service Excellence, High In-Patient Satisfaction, (maximum of 3.0% of annual salary.)
CMS scores from In-Patient satisfaction surveys for 10 questions compared to all other hospitals.
Note: On the CMS survey only scores of 9s or 10s are counted.
Level 3, Base Goal, 6 of 10 HCAPS scores above the 60th percentile average for the year.
Actual result: Level 2, 3 of 10 HCAPS scores above the 60th percentile average.
No Incentive earned.
Note: CMS refers to the Center for Medicare and Medicaid Services

Service Excellence, High Outpatient Department Satisfaction, (maximum of 1.5% of annual salary.)

Scores from Rate My Hospital for all Outpatient Departments.
Level 3 Base Goal, 4.5 score or higher for all Outpatient Departments measured per year.
Actual result: Level 3, 4.5 score for all Outpatient Departments
Incentive calculation 1.5% of base salary ($5,356) X 66.7% = $3,573 earned.

Excellent Patient Outcomes, (maximum of 3.0% of annual salary)

Maintain low all cause Re-Admission rate for the year
Level 3, Base Goal, Re-Admission rate below 10% for the year.
Level 4, Re-Admission rate at or below 9% for the year
Actual result: Level 4, Re-Admission rate 9% for the year
Incentive calculation 3.0% of base salary ($10.713) X 86.7% = $9,288 earned

Highly Engaged and Satisfied Staff, (maximum 1.5% of annual salary)

Percentile ranking of Press Ganey annual staff satisfaction survey compared to other hospitals.
Level 3, Base Goal, 75th percentile
Actual result: Level 1, 61th percentile
No incentive earned

Financial Viability, (maximum 9.5% of annual salary)

Achieve Earnings, Before Interest, Depreciation, and Amortization (EBIDA) before restricted donations and GO Bond income and expense.
Level 3, Base Goal, EBIDA, $2.2 million
Actual result: below Level 1, EBIDA $782,008
No incentive earned

Healthy Community, (maximum 1.5% of annual salary)

Staff Hours Spent on Community Health Projects
Level 3, Base Goal, 1200 hours
Actual result: Level 3, 1,333.5 hours spent
Incentive calculation 1.5% of base salary ($5,356) X 66.7% = $3,573 earned.

Total Incentive Earned

$16,433

Consequences of Negative Action/Alternative Actions:

Failure to approve the incentive award as calculated would be a breach of contract.

Attachments:

FY 2018 CEO Incentive Compensation Results
FY 2018 CEO Incentive Compensation Calculation

FY 2018 CEO GOALS

Levels 1 & 2: 0 Salary Incentive Compensation
Level 3: 66.7% Salary Incentive Compensation
Level 4: 86.7% Salary Incentive Compensation
Level 5: 100% Salary Incentive Compensation

PERFORMANCE GOAL	OBJECTIVE	METRIC	ACTUAL RESULT FY 2018	GOAL LEVEL
Service Excellence 3.0% of annual salary	High In-Patient Satisfaction	6 out of 10 HCAHPS questions above 60th percentile average for the year	3/10	> 8 = 5 > 7 = 4 > 6 = 3 < 6 = 2 < 3 = 1
Service Excellence 1.5% of annual salary	High Outpatient Department Satisfaction	4.5 score in Rate My Hospital or higher for all Outpatient departments measured per year	4.5	>4.8 =5 >4.7=4 >4.5= 3 <4.5 = 2 < 4.4 = 1
Quality 3.0% of annual salary	Excellent Patient Outcomes	Maintain all cause Re-admission rate below 10% for the year	9%	< 8% = 5 < 9% =4 < 10% =3 > 10% = 2 > 11% = 1
People 1.5% of annual salary	Highly Engaged and Satisfied Staff	Press Ganey percentile ranking of current mean score for the year	61st	>80th = 5 >78th=4 >75h=3 <75th=2 <70th =1
Finance 9.5% of annual salary	Financial Viability	Achieve Earnings, Before Interest, Depreciation and Amortization (EBIDA) before restricted donations and GO Bond income & expense at year end	$782,008	> $2,8 million = 5 > $2.5 million = 4 > $2.2 million = 3 < $2.2 million = 2 < $1.9 million = 1
Healthy Community 1.5% of annual salary	Community Hours	Numbers of hours for community benefit per year	1333.5	>1500 hours = 5 > 1350 hours = 4 >1200 hours = 3 < 1200 = 2 < 1000 hours = 1

Salary		$357,094
Bonus Payout Levels		% of Comp
	5	100%
	4	87%
	3	67%
	2	0%
	1	0%

Performance Goal	Maximum % of Salary	Maximum Compensation	Achieved Metric	Calculated Score	Bonus Calculation
Service Excellence	3.0%	$10,713	3 of 10	2	$0
Service Excellence/ER	1.5%	$5,356	4.5	3	$3,573
Quality	3.0%	$10,713	9%	4	$9,288
People	1.5%	$5,356	61%	1	$0
Finance	9.5%	$33,924	$ 782,008	1	$0
Healthy Community	1.5%	$5,356	1333.5	3	$3,573
Total	20.0%	$71,419			$ 16,433

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

To: **SVHCD Board of Directors**
From: **Kelly Mather**
Date: **10/25/18**
Subject: **Administrative Report**

Summary
We are on track with the budget for FY 2019. The FY 2018 Audited financial statements are complete noting that both salaries and benefits were the same as FY 2017 due to the reductions we made in management. Supplies were also lower than the previous year, therefore SVH continues to manage expenses extremely well. The only area of concern is that the physician costs increased by $800,000 due to market increases. The OB closure is effective 10/31/18 and the team is prepared for this change. We want to acknowledge and thank all of the staff and physicians for providing such an excellent service to our community for over 70 years.

Strategic Update from FY 2019 Strategic Plan:

Strategic Priorities	Update
Highest levels of health care safety, quality and value	➢ With the planned consolidation of Inpatient Services, we implementing a plan to become one of the only 5 Star hospitals in the Bay Area. ➢ Our mid-cycle accreditation survey is still due any day now with CIHQ. ➢ We hope to be "Stroke Ready" in early 2019. UCSF is overseeing this program. ➢ SVH was named as one of the top 14 hospitals in Safety in our region and our team presented our best practices for medications and hospital acquired infections ➢ The annual SNF accreditation survey is happening this week
Be the preferred hospital for patients, physicians, employers and health plans	➢ Canopy Health has been doing some marketing in Sonoma during open enrollment as an option outside of Kaiser ➢ Dr. Kaplan, Urologist, started this month ➢ Great progress is being made with bringing Dr. Carroll from UCSF to Sonoma ➢ We are starting a Patient Access Center which will include smoother pre-registration, texting and email reminders for outpatient appointments
Implement new and enhanced revenue strategies as measured by increased direct margins in each service unit	➢ The Outpatient Diagnostic Center is projected to increase revenue by over $1 million per year and should begin next Summer ➢ The Pain Management physicians are starting to work together on a referral network ➢ Cardiology volumes are going up and revenues are increasing
Continue to improve financial stability as measured by margin	➢ The OB closure and the Home Care transfer will improve the bottom line by over $1 million per year ➢ We are doing a Master Facility Plan for the campus which addresses the future of the Central and West Wing. The East Wing will be more compliant for 2030. ➢ The first quarter SNF financials were reviewed at Finance committee and it was better than projected but most of the changes had not been made yet
Lead progress toward becoming a Healthier community	➢ The Active Aging series at Vintage House was very well received and had great feedback from the community ➢ We did several health fairs this fall

SEPTEMBER 2018

Patient Experience	Current Performance	FY 2019 Goal	National Benchmark
Would Recommend Hospital	77th	> 60th percentile	50th percentile
Inpatient Overall Rating	66th	>60th percentile	50th percentile
Outpatient Services	4.8	Rate My Hospital	4.5
Emergency	4.5	Rate My Hospital	4.5
Quality & Safety	**YTD Performance**	**FY 2019 Goal**	**Benchmark**
CLABSI	0	<1	<.51
CAUTI	0	<1	<1.04
SSI – Colon Surgery	0	<1	N/A
SSI – Total Joint	0	<1.5%	N/A
MRSA Bacteremia	0	<.13	<.13
C. Diff	9.9	3.5	7.4/10,000 pt days
PSI – 90 Composite	.046	<1	<1
Heart Failure Mortality Rate	12.5%	TBD	17.3%
Pneumonia Mortality Rate	18.1%	TBD	23.6%
Stroke Mortality Rate	14.7%	TBD	19.7%
Sepsis Mortality Rate	10.2%	<18%	25%
30 Day All- Cause Readmissions	9.30%	< 10 %	< 18.5%
Serious Safety Events	0	0	0
Falls	2	< 2.3	2.3
Pressure Ulcers	0	<3.7	3.7
Injuries to Staff	1	< 10	17
Adverse Drug Events with Harm	0	0	0
Reportable HIPAA Privacy Events	0	0	0
SNF Star Rating	4	4	3
Hospital Star Rating	4	4	3
Our People	**YTD Performance**	**FY 2019 Goal**	**Benchmark**
Press Ganey Engagement Survey	61st percentile	75th percentile	50th percentile
Turnover	14.4%	< 10%	< 15%
Financial Stability	**YTD Performance**	**FY 2019 Goal**	**Benchmark**
EBDA	1.6%	1%	3%
FTE's/AOB	4.38	4.3	5.3
Days Cash on Hand	13.2	20	30
Days in Accounts Receivable	48	49	50
Length of Stay	3.9	3.85	4.03
Funds raised by SVHF	>$14 million	$20 million	$1 million
Strategic Growth	**YTD Performance**	**FY 2019 Goal**	**Benchmark**
Inpatient Discharges	256/1024	1000	1000
Outpatient Visits	12,901/51,603	53,000	51,924
Emergency Visits	2525/10,099	10,000	11,040
Surgeries + Special Procedures	798/3192	2500	2,568
Community Benefit Hours	412/1647	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 2019	Jul 2018	Aug 2018	Sep 2018	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
FY YTD Turnover	<10%	1.6	3.3	3.6	6.8	9.7	9.7	11.3	12.9	14.2	16.2	17.8	20.3
Leave of Absences	<12	13	11	8	11	11	9	10	15	13	15	12	11
EBDA	>1%	0	1.7	1.6	.1	-1.2	-1.4	2.2	-.6	-1.7	-1.8	-1.2	.4
Operating Revenue	>5m	4.5	4.9	4.6	4.6	4.5	4.5	4.9	4.7	4.2	4.4	4.8	5.2
Expense Management	<5.3m	5.1	5.3	5.0	4.8	5.3	5.1	5.3	5.2	5.1	5.0	5.1	4.9
Net Income	>50k	214	32	208	62	-379	-226	125	-174	-395	220	369	543
Days Cash on Hand	>20	19.1	10	13	12.5	14	17.4	23.5	14.1	6.7	6.8	6.2	10.6
A/R Days	<50	41	43	48	45	48	51	51	47	43	43	47	42
Total FTE's	<320	310	309	314	304	329	307	312	305	302	307	306	298
FTEs/AOB	<4.0	3.62	3.29	4.38	4.04	4.86	3.85	3.68	3.87	4.17	4.06	4.35	3.82
Inpatient Discharges	>90	81	85	90	87	99	96	111	82	106	103	108	99
Outpatient Revenue	>$13m	14.8	**16.8**	13.9	11.9	12.9	14.1	14.7	12.5	13.1	14.1	15.2	13.6
Surgeries	>150	150	**165**	**182**	120	155	160	141	139	151	144	175	151
ER	>900	901	810	814	827	816	919	996	811	871	864	934	856
Births	>11	8	14	13	12	11	10	7	11	8	6	9	16
SNF days	>550	664	**628**	457	624	468	563	646	494	566	525	423	545
MRI	>120	99	**145**	92	100	80	105	106	112	122	154	153	148
Cardiology (Echos)	>50	88	**135**	97	54	80	93	96	65	84	95	84	78
Laboratory	>12	12.4	13.4	11.7	10.8	12.0	11.4	12.9	10.6	12.3	11.5	12.5	13.0
Radiology	>850	894	951	929	757	882	891	1072	829	968	905	968	877
Rehab	>2700	2414	2860	1788	2078	2945	2884	2593	2773	3091	2455	2586	2670
CT	>350	359	387	331	271	272	386	346	288	305	367	394	358
Mammography	>200	280	243	221	191	253	249	190	155	**363**	202	220	221
Ultrasound	>250	181	280	246	188	236	258	274	221	258	293	311	267
Occupational Health	>600	570	639	489	707	588	416	504	555	734	774	822	625
Wound Care	>200	290	256	198	287	203	277	204	122	182	210	237	225

CMO Board Report 11/1/2018

1. What is going well:
    a. UCSF meeting regarding e-consults, telemedicine, future service lines
    b. New database and process for monitoring patient care contracts

2. Follow up previous agenda items:
    a. Progress on developing a voluntary call pool and ER transfer tool for consultants
    b. Rolling out evidence based order sets and standardized physician documentation templates to increase quality metric compliance with sepsis, stroke, etc.
    c. OB closure complete.
        i. Dr. Amara remains on call for ER.
        ii. Transfer agreements with Queen of the Valley and PVH in place.
        iii. Essential equipment in place in ER and trainings complete.

3. Opportunities for growth / improvement / on-going projects:
    a. Stroke Ready Process – will have medical director through UCSF, finalizing CMEs, etc.
    b. SNF Task Force and pilot project remains active. Preliminary data being compiled after 1 month of pilot project. Monitoring safety, quality, and financial impact.

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

To: **SVH Finance Committee**
From: **Ken Jensen, CFO**
Date: **October 23, 2018**
Subject: **Financial Report for the Month Ending September 30, 2018**

September's actual loss of ($488,205) from operations was ($17,855) unfavorable to the budgeted loss of ($470,350). After accounting for all other activity; the September net income was $208,930 vs. the budgeted net income of $16,482 with a monthly EBIDA of 2.5% vs. a budgeted 2.6%.

Gross patient revenue for September was $21,967,312; $95,737 over budget. Inpatient gross revenue was over budget by $160,645. Inpatient days were over budget by 13 days and inpatient surgeries were over budgeted expectations by 2 cases. Outpatient revenue was under budget by ($50,607). Outpatient visits were under budgeted expectations by (615) visits, and outpatient surgeries were under budgeted expectations by (3) cases and special procedures were over budgeted expectations by 24 cases. The Emergency Room gross revenue was under budget by ($48,671) with ER visits under budgeted expectations by (107). SNF gross charges were over budgeted expectations by $60,980 and SNF patient days were close to budget at 457 days. Home Health was under budget by ($26,610) with visits under budget by (119) visits.

Gross revenue from surgical implants in September is $405,354 with $299,225 from inpatient surgeries and $106,129 from outpatient surgeries, and total implant costs were ($74,924). The net, before any revenue deductions, is $330,430.

Deductions from revenue were unfavorable to budgeted expectations by ($210,328). Of the variance, ($101,283) is from the prior period adjustments or IGT payments. Without the IGT variance, the deductions from revenue variance is unfavorable by ($109,045) which is due to gross revenue being over budgeted expectations and adjustments to Accounts Receivable.

After accounting for all other operating revenue, the **total operating revenue** was unfavorable to budgeted expectations by ($149,358).

Operating Expenses of $5,044,673 were favorable to budget by $131,503. Salaries and wages and agency fees were over budget by ($81,622) with the overage in salaries and wages being ($11,168) and agency fees over by ($70,454). Supplies were under budget by $39,806 due to a lower volume of surgical cases with implants. There was no matching fee in the September.

After accounting for all income and expenses, but not including Restricted Contributions and GO bond activity, the net loss for September was ($231,021) vs. a budgeted net loss of ($213,138). The hospital received SVHF donations of $286,283 for the outpatient diagnostic center. The total net income for September after all activity was $208,930 vs. a budgeted net income of $16,482.

EBIDA for the month of September was 2.5% vs. the budgeted 2.6%.

Patient Volumes – September

	ACTUAL	BUDGET	VARIANCE	PRIOR YEAR
Acute Discharges	90	91	-1	87
Newborn Discharges	16	4	12	5
Acute Patient Days	337	324	13	325
SNF Patient Days	457	479	-22	479
Home Care Visits	682	801	-119	789
OP Gross Revenue	$13,946	$14,060	($114)	$14,364
Surgical Cases	182	183	-1	187

Gross Revenue Overall Payer Mix – September

	ACTUAL	BUDGET	VARIANCE	YTD ACTUAL	YTD BUDGET	VARIANCE
Medicare	39.8%	43.1%	-3.3%	39.9%	43.0%	-3.1%
Medicare Mgd Care	16.7%	12.7%	4.0%	16.1%	12.8%	3.3%
Medi-Cal	20.0%	17.8%	2.2%	18.8%	17.8%	1.0%
Self Pay	1.7%	1.3%	0.4%	1.2%	1.3%	-0.1%
Commercial	18.3%	20.7%	-2.4%	19.9%	20.7%	-0.8%
Workers Comp	1.8%	2.4%	-0.6%	1.9%	2.4%	-0.5%
Capitated	1.7%	2.0%	-0.3%	2.2%	2.0%	0.2%
Total	100.0%	100.0%		100.0%	100.0%	

Cash Activity for September:

For the month of September the cash collection goal was $3,628,615 and the Hospital collected $3,498,174 or under the goal by ($130,441). The year-to-date cash collection goal was $11,185,726 and the Hospital has collected $11,118,910 or under goal by ($66,816). Days of cash on hand are 13.2 days at September 30, 2018, this calculation includes the cash in the Money Market account. Accounts Receivable increased from August, from 43.0 days to 47.9 days in September. Accounts Payable decreased by $473,131 from August and Accounts Payable days are at 41.9.

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

Sonoma Valley Hospital
Payer Mix for the month of September 30, 2018

ATTACHMENT A

	September-18				YTD			
Gross Revenue:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	8,747,016	9,416,767	-669,751	-7.1%	28,111,323	28,605,796	-494,473	-1.7%
Medicare Managed Care	3,677,175	2,764,813	912,362	33.0%	11,316,947	8,406,473	2,910,474	34.6%
Medi-Cal	4,400,791	3,898,569	502,222	12.9%	13,244,579	11,845,673	1,398,906	11.8%
Self Pay	363,390	285,968	77,422	27.1%	857,606	881,597	-23,991	-2.7%
Commercial & Other Government	3,995,014	4,542,679	-547,665	-12.1%	14,066,732	13,795,526	271,206	2.0%
Worker's Comp.	405,523	528,003	-122,480	-23.2%	1,331,623	1,615,092	-283,469	-17.6%
Capitated	378,403	434,776	-56,373	-13.0%	1,567,518	1,342,048	225,470	16.8%
Total	**21,967,312**	**21,871,575**	**95,737**		**70,496,328**	**66,492,205**	**4,004,123**	

Net Revenue:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	1,256,214	1,318,347	-62,133	-4.7%	4,090,260	4,152,442	-62,182	-1.5%
Medicare Managed Care	544,580	354,961	189,619	53.4%	1,700,812	1,163,088	537,724	46.2%
Medi-Cal	654,398	530,778	123,620	23.3%	2,026,896	1,540,780	486,116	31.5%
Self Pay	203,498	128,891	74,607	57.9%	428,778	438,621	-9,843	-2.2%
Commercial & Other Government	1,457,516	1,729,963	-272,447	-15.7%	4,827,633	5,039,221	-211,588	-4.2%
Worker's Comp.	75,023	136,467	-61,444	-45.0%	258,421	392,588	-134,167	-34.2%
Capitated	8,968	14,098	-5,130	-36.4%	36,485	41,412	-4,927	-11.9%
Prior Period Adj/IGT	251,272	352,555	-101,283	-28.7%	376,272	1,057,665	-681,393	-64.4%
Total	**4,451,469**	**4,566,060**	**(114,591)**	**-2.5%**	**13,745,557**	**13,825,817**	**(80,260)**	**-0.6%**

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Percent of Net Revenue:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	28.2%	28.9%	-0.7%	-2.4%	29.7%	30.1%	-0.5%	-1.7%
Medicare Managed Care	12.3%	7.8%	4.5%	57.7%	12.4%	8.4%	4.0%	47.6%
Medi-Cal	20.3%	19.3%	1.0%	5.2%	17.5%	18.8%	-1.3%	-6.9%
Self Pay	4.6%	2.8%	1.8%	64.3%	3.1%	3.2%	-0.1%	-3.1%
Commercial & Other Government	32.7%	37.9%	-5.2%	-13.6%	35.1%	36.4%	-1.3%	-3.6%
Worker's Comp.	1.7%	3.0%	-1.3%	-43.3%	1.9%	2.8%	-0.9%	-32.1%
Capitated	0.2%	0.3%	-0.1%	-33.3%	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	14.4%	14.0%	0.4%	2.9%	14.0%	14.5%	-0.5%	-3.4%
Medicare Managed Care	14.8%	12.8%	2.0%	15.6%	15.0%	13.8%	1.2%	8.7%
Medi-Cal	20.6%	22.7%	-2.1%	-9.3%	18.1%	21.9%	-3.8%	-17.4%
Self Pay	56.0%	45.1%	10.9%	24.2%	50.0%	49.8%	0.2%	0.4%
Commercial & Other Government	36.5%	38.1%	-1.6%	-4.2%	34.3%	36.5%	-2.2%	-6.0%
Worker's Comp.	18.5%	25.8%	-7.3%	-28.3%	19.4%	24.3%	-4.9%	-20.2%
Capitated	2.4%	3.2%	-0.8%	-25.0%	2.3%	3.1%	-0.8%	-25.8%

SONOMA VALLEY HOSPITAL
OPERATING INDICATORS
For the Period Ended September 30, 2018

ATTACHMENT B

	CURRENT MONTH				YEAR-TO-DATE			YTD
	Actual 09/30/18	Budget 09/30/18	Favorable (Unfavorable) Variance		Actual 09/30/18	Budget 09/30/18	Favorable (Unfavorable) Variance	Prior Year 09/30/17
				Inpatient Utilization				
				Discharges				
1	79	78	1	Acute	230	239	(9)	213
2	11	13	(2)	ICU	26	36	(10)	44
3	90	91	(1)	Total Discharges	256	275	(19)	257
4	16	4	12	Newborn	35	20	15	23
5	106	95	11	Total Discharges inc. Newborns	291	295	(4)	280
				Patient Days:				
6	274	230	44	Acute	763	727	36	632
7	63	94	(31)	ICU	226	258	(32)	258
8	337	324	13	Total Patient Days	989	985	4	890
9	37	8	29	Newborn	83	37	46	30
10	374	332	42	Total Patient Days inc. Newborns	1,072	1,022	50	920
				Average Length of Stay:				
11	3.5	2.9	0.5	Acute	3.3	3.0	0.3	3.0
12	5.7	7.2	(1.5)	ICU	8.7	7.2	1.5	5.9
13	3.7	3.6	0.2	Avg. Length of Stay	3.9	3.6	0.3	3.5
14	2.3	2.0	0.3	Newborn ALOS	2.4	1.9	(0.5)	1.3
				Average Daily Census:				
15	9.1	7.7	1.5	Acute	8.3	7.9	0.4	6.9
16	2.1	3.1	(1.0)	ICU	2.5	2.8	(0.3)	2.8
17	11.2	10.8	0.4	Avg. Daily Census	10.8	10.7	0.0	9.7
18	1.2	0.3	1.0	Newborn	0.90	0.40	0.5	0.33
				Long Term Care:				
19	457	479	(22)	SNF Patient Days	1,749	1,507	242	1,507
20	20	27	(7)	SNF Discharges	83	85	(2)	80
21	15.2	16.0	(0.7)	Average Daily Census	19.0	16.4	2.6	16.4
				Other Utilization Statistics				
				Emergency Room Statistics				
22	814	921	(107)	Total ER Visits	2,525	2,735	(210)	2,735
				Outpatient Statistics:				
23	3,707	4,322	(615)	Total Outpatients Visits	12,901	13,515	(614)	13,520
24	31	29	2	IP Surgeries	80	80	-	84
25	151	154	(3)	OP Surgeries	417	429	(12)	429
26	99	75	24	Special Procedures	301	204	97	204
27	682	801	(119)	Home Health Visits	2,027	2,328	(301)	2,372
28	301	331	(29)	Adjusted Discharges	957	1,031	(74)	1,010
29	2,175	2,251	(76)	Adjusted Patient Days (Inc. SNF)	7,740	7,136	605	7,189
30	72.5	75.0	(2.5)	Adj. Avg. Daily Census (Inc. SNF)	84.1	77.6	6.6	78.1
31	1.7275	1.4000	0.328	Case Mix Index -Medicare	1.4579	1.4000	0.058	1.5866
32	1.4269	1.4000	0.027	Case Mix Index - All payers	1.4502	1.4000	0.050	1.4858
				Labor Statistics				
33	278	267	(11.1)	FTE's - Worked	276	272	(3.6)	280
34	314	303	(11.1)	FTE's - Paid	311	308	(2.9)	316
35	42.48	42.46	(0.02)	Average Hourly Rate	42.67	41.59	(1.08)	42.46
36	24.7	23.0	(1.7)	Manhours / Adj. Pat Day	21.0	22.6	1.6	23.0
37	178.0	156.4	(21.6)	Manhours / Adj. Discharge	170.2	156.5	(13.6)	164.0
38	22.8%	23.7%	0.9%	Benefits % of Salaries	22.5%	23.4%	1.0%	22.9%
				Non-Labor Statistics				
39	11.2%	11.7%	0.5%	Supply Expense % Net Revenue	12.5%	11.7%	-0.8%	11.3%
40	1,696	1,665	(31)	Supply Exp. / Adj. Discharge	1,833	1,608	(225)	1,603
41	17,261	16,127	(1,134)	Total Expense / Adj. Discharge	16,663	15,670	(993)	16,504
				Other Indicators				
42	13.2			Days Cash - Operating Funds				
43	47.9	50.0	(2.1)	Days in Net AR	43.8	50.0	(6.2)	44.7
44	96%			Collections % of Net Revenue	99%			100.8%
45	41.9	55.0	(13.1)	Days in Accounts Payable	41.9	55.0	(13.1)	17.2
46	20.7%	21.5%	-0.8%	% Net revenue to Gross revenue	19.9%	21.4%	-1.5%	21.6%
47	21.7%			% Net AR to Gross AR	21.7%			22.6%

ATTACHMENT C

Sonoma Valley Health Care District
Balance Sheet
As of September 30, 2018

		Current Month	Prior Month	Prior Year
	Assets			
	Current Assets:			
1	Cash	$ 1,130,954	$ 636,295	$ 1,535,825
2	Trustee Funds	2,482,503	3,945,791	2,104,929
3	Net Patient Receivables	8,588,498	8,143,167	8,570,235
4	Allow Uncollect Accts	(1,272,002)	(1,255,318)	(1,342,952)
5	Net A/R	7,316,496	6,887,849	7,227,283
6	Other Accts/Notes Rec	6,632,224	6,875,990	7,114,147
7	3rd Party Receivables, Net	981,576	1,048,765	2,798,090
8	Inventory	852,258	848,499	838,755
9	Prepaid Expenses	855,096	899,891	857,849
10	Total Current Assets	$ 20,251,107	$ 21,143,080	$ 22,476,878
12	Property,Plant & Equip, Net	$ 51,673,320	$ 51,664,079	$ 52,641,781
13	Specific Funds/ Money Market	957,496	957,422	1,143,122
14	Other Assets	-	-	-
15	Total Assets	$ 72,881,923	$ 73,764,581	$ 76,261,781
	Liabilities & Fund Balances			
	Current Liabilities:			
16	Accounts Payable	$ 3,415,072	$ 3,888,203	$ 3,700,568
17	Accrued Compensation	3,538,598	3,461,612	4,045,441
18	Interest Payable	201,523	520,732	211,552
19	Accrued Expenses	1,303,922	1,502,382	1,987,798
20	Advances From 3rd Parties	99,490	110,058	437,041
21	Deferred Tax Revenue	5,139,926	5,711,029	5,106,150
22	Current Maturities-LTD	1,092,672	1,113,197	1,274,224
23	Line of Credit - Union Bank	6,973,734	6,973,734	6,973,734
24	Other Liabilities	1,701,386	201,386	1,501,386
25	Total Current Liabilities	$ 23,466,323	$ 23,482,333	$ 25,237,894
26	Long Term Debt, net current portion	$ 33,119,851	$ 34,195,429	$ 35,475,785
27	Fund Balances:			
28	Unrestricted	$ 10,752,074	$ 10,829,427	$ 11,643,951
29	Restricted	5,543,675	5,257,392	3,904,151
30	Total Fund Balances	$ 16,295,749	$ 16,086,819	$ 15,548,102
31	Total Liabilities & Fund Balances	$ 72,881,923	$ 73,764,581	$ 76,261,781

ATTACHMENT D

Sonoma Valley Health Care District
Statement of Revenue and Expenses
Comparative Results
For the Period Ended September 30, 2018

	Month						Year-To- Date					YTD
	This Year		Variance				This Year		Variance			
	Actual		$	%			Actual	Budget	$	%		Prior Year
					Volume Information							
1	90	91	(1)	-1%	Acute Discharges		256	275	(19)	-7%		257
2	457	479	(22)	-5%	SNF Days		1,749	1,507	242	16%		1,507
3	682	801	(119)	-15%	Home Care Visits		2,027	2,328	(301)	-13%		2,372
4	13,946	14,060	(114)	-1%	Gross O/P Revenue (000's)	$	45,509	$ 43,240	2,268	5%	$	44,063
					Financial Results							
					Gross Patient Revenue							
5	$ 6,170,844	$ 6,010,199	160,645	3%	Inpatient	$	18,097,592	$ 17,567,777	529,815	3%	$	16,330,125
6	7,669,855	7,720,462	(50,607)	-1%	Outpatient		25,613,001	23,963,049	1,649,952	7%		24,612,670
7	6,019,966	6,068,637	(48,671)	-1%	Emergency		19,159,336	18,489,415	669,921	4%		18,640,229
8	1,850,182	1,789,202	60,980	3%	SNF		6,863,952	5,648,541	1,215,411	22%		5,781,395
9	256,465	283,075	(26,610)	-9%	Home Care		762,447	823,423	(60,976)	-7%		848,890
10	**$ 21,967,312**	**$ 21,871,575**	**95,737**	**0%**	**Total Gross Patient Revenue**	**$**	**70,496,328**	**$ 66,492,205**	**4,004,123**	**6%**	**$**	**66,213,309**
					Deductions from Revenue							
11	$ (17,592,915)	$ (17,533,340)	(59,575)	0%	Contractual Discounts	$	(56,698,718)	$ (53,349,863)	(3,348,855)	-6%	$	(53,450,500)
12	(160,000)	(100,000)	(60,000)	-60%	Bad Debt		(360,000)	(300,000)	(60,000)	-20%		(403,000)
13	(14,200)	(24,730)	10,530	43%	Charity Care Provision		(68,325)	(74,190)	5,865	8%		(38,569)
14	251,272	352,555	(101,283)	-29%	Prior Period Adj/Government Program Revenue		376,272	1,057,665	(681,393)	*		1,569,162
15	**$ (17,515,843)**	**$ (17,305,515)**	**(210,328)**	**1%**	**Total Deductions from Revenue**	**$**	**(56,750,771)**	**$ (52,666,388)**	**(4,084,383)**	**8%**	**$**	**(52,322,907)**
16	**$ 4,451,469**	**$ 4,566,060**	**(114,591)**	**-3%**	**Net Patient Service Revenue**	**$**	**13,745,557**	**$ 13,825,817**	**(80,260)**	**-1%**	**$**	**13,890,402**
17	$ 96,054	$ 125,798	(29,744)	-24%	Risk contract revenue	$	282,950	$ 377,394	(94,444)	-25%	$	390,154
18	$ 4,547,523	$ 4,691,858	(144,335)	-3%	Net Hospital Revenue	$	14,028,507	$ 14,203,211	(174,704)	-1%	$	14,280,556
19	$ 8,945	$ 13,968	(5,023)	**-36%**	Other Op Rev & Electronic Health Records	$	35,512	$ 41,904	(6,392)	-15%	$	65,433
20	**$ 4,556,468**	**$ 4,705,826**	**(149,358)**	**-3%**	**Total Operating Revenue**	**$**	**14,064,019**	**$ 14,245,115**	**(181,096)**	**-1%**	**$**	**14,345,989**
					Operating Expenses							
21	$ 2,278,112	$ 2,196,490	(81,622)	-4%	Salary and Wages and Agency Fees	$	6,948,788	$ 6,709,782	(239,006)	-4%	$	7,034,285
22	795,256	$ 851,075	55,819	7%	Employee Benefits		2,473,235	2,571,392	98,157	4%		2,650,930
23	$ 3,073,368	$ 3,047,565	(25,803)	-1%	Total People Cost	$	9,422,023	$ 9,281,174	(140,849)	-2%	$	9,685,215
24	$ 498,938	$ 503,334	4,396	1%	Med and Prof Fees (excld Agency)	$	1,431,467	$ 1,510,816	79,349	5%	$	1,184,160
25	510,891	550,697	39,806	7%	Supplies		1,754,206	1,657,279	(96,927)	-6%		1,619,645
26	364,739	370,487	5,748	2%	Purchased Services		1,109,731	1,113,688	3,957	0%		1,110,154
27	292,997	285,255	(7,742)	-3%	Depreciation		877,109	855,765	(21,344)	-2%		855,496
28	113,865	120,931	7,066	6%	Utilities		336,877	361,493	24,616	7%		351,961
29	35,320	33,429	(1,891)	-6%	Insurance		105,960	100,287	(5,673)	-6%		95,457
30	49,710	49,598	(112)	0%	Interest		147,476	149,343	1,867	1%		139,864
31	104,845	126,477	21,632	17%	Other		288,379	379,180	90,801	24%		360,071
32	-	88,403	88,403	*	Matching Fees (Government Programs)		0	265,208	265,208	100%		775,755
33	**$ 5,044,673**	**$ 5,176,176**	**131,503**	**3%**	**Operating expenses**	**$**	**15,473,228**	**$ 15,674,233**	**201,005**	**1%**	**$**	**16,177,778**
34	**$ (488,205)**	**$ (470,350)**	**(17,855)**	**-4%**	**Operating Margin**	**$**	**(1,409,209)**	**$ (1,429,118)**	**19,909**	**1%**	**$**	**(1,831,789)**

ATTACHMENT D

Sonoma Valley Health Care District
Statement of Revenue and Expenses
Comparative Results
For the Period Ended September 30, 2018

	Month						Year-To- Date					YTD
	This Year		Variance				This Year		Variance			
	Actual		$	%			Actual	Budget	$	%		Prior Year
					Non Operating Rev and Expense							
35	$ (5,215)	$ (5,361)	146	-3%	Miscellaneous Revenue/(Expenses)	$	(28,975)	$ (16,677)	(12,298)	*	$	25,905
36	415	2,672	(2,257)	-84%	Donations		818	8,016	(7,198)	90%		8,478
37	(54,683)	(56,766)	2,083	-4%	Physician Practice Support-Prima		(166,132)	(170,298)	4,166	-2%		(170,298)
38	316,667	316,667	-	0%	Parcel Tax Assessment Rev		950,001	950,001	-	0%		950,001
39	0	0	-	0%	Extraordinary Items		0	0	-	0%		
40	**$ 257,184**	**$ 257,212**	**(28)**	**0%**	**Total Non-Operating Rev/Exp**	**$**	**755,712**	**$ 771,042**	**(15,330)**	**-2%**	**$**	**814,086**
41	**$ (231,021)**	**$ (213,138)**	**(17,883)**	**8%**	**Net Income / (Loss) prior to Restricted Contributions**	**$**	**(653,497)**	**$ (658,076)**	**4,579**	**-1%**	**$**	**(1,017,703)**
42	$ -	$ 20,949	(20,949)	-100%	Capital Campaign Contribution	$	29,530	$ 62,847	(33,317)	-53%	$	12,750
43	$ 286,283	$ 55,003	231,280	0%	Restricted Foundation Contributions	$	622,889	$ 165,009	457,880	100%	$	-
44	**$ 55,262**	**$ (137,186)**	**192,448**	**-140%**	**Net Income / (Loss) w/ Restricted Contributions**	**$**	**(1,078)**	**$ (430,220)**	**429,142**	**-100%**	**$**	**(1,004,953)**
45	254,436	254,436	-	0%	GO Bond Tax Assessment Rev		763,308	763,308	-	0%		752,049
46	(100,768)	(100,768)	-	0%	GO Bond Interest		(307,312)	(307,312)	-	0%		(321,818)
47	**$ 208,930**	**$ 16,482**	**192,448**	**1168%**	**Net Income/(Loss) w GO Bond Activity**	**$**	**454,918**	**$ 25,776**	**429,142**	**1665%**	**$**	**(574,722)**
	$ 111,686	$ 121,715			**EBIDA - Not including Restricted Contributions**	$	371,088	$ 347,032			$	(22,343)
	2.5%	2.6%					2.6%	2.4%				-0.2%
	$ 61,976	$ 72,117			**EBDA - Not including Restricted Contributions**	$	223,612	$ 197,689				
	1.4%	1.5%					1.6%	1.4%				

Sonoma Valley Health Care District **ATTACHMENT E**

Statement of Revenue and Expenses Variance Analysis

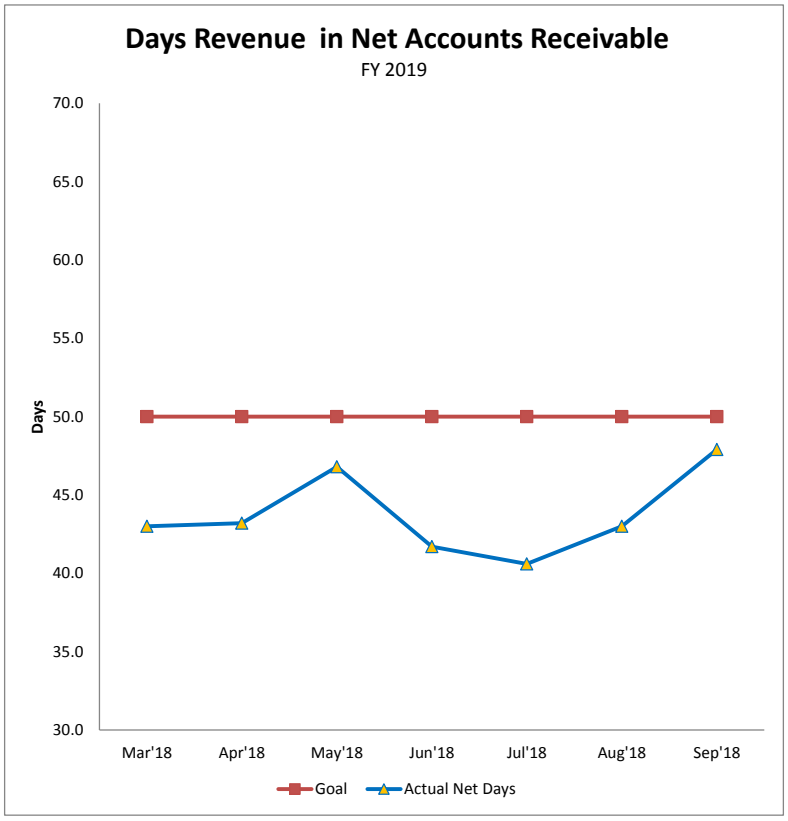
For the Period Ended September 30, 2018

		YTD	MONTH	
	Description	**Variance**	**Variance**	
	Volume Information			
1	Acute Discharges	(19)	(1)	
2	SNF Days	242	(22)	
3	Home Care Visits	(301)	(119)	
4	Gross O/P Revenue (000's)	2,268	(114)	
	Financial Results			
	Gross Patient Revenue			
5	Inpatient	529,815	160,645	Inpatient days are 337 days vs. budgeted expectations of 324 days and inpatient surgeries are 31 vs. budgeted expectations 29.
6	Outpatient	1,649,952	(50,607)	Outpatient visits are 3,707 vs. budgeted expectations of 4,322 visits and outpatient surgeries are 151 vs. budgeted expectations 154.
7	Emergency	669,921	(48,671)	ER visits are 814 vs. budgeted visits of 921.
8	SNF	1,215,411	60,980	SNF patient days are 457 vs. budgeted expected days of 479.
9	Home Care	(60,976)	(26,610)	HHA visits are 682 vs. budgeted expectations of 801.
10	**Total Gross Patient Revenue**	**4,004,123**	**95,737**	
	Deductions from Revenue			
11	Contractual Discounts	(3,348,855)	(59,575)	
12	Bad Debt	(60,000)	(60,000)	
13	Charity Care Provision	5,865	10,530	
14	Prior Period Adj/Government Program Revenue	(681,393)	(101,283)	AB915 supplemental payment of $384,837 for FY 16-17 and accrual of $62,500 for the prime grant.
15	**Total Deductions from Revenue**	**(4,084,383)**	**(210,328)**	
16	**Net Patient Service Revenue**	**(80,260)**	**(114,591)**	
17	Risk contract revenue	(94,444)	(29,744)	
18	Net Hospital Revenue	**(174,704)**	**(144,335)**	
19	Other Op Rev & Electronic Health Records	(6,392)	(5,023)	
20	**Total Operating Revenue**	**(181,096)**	**(149,358)**	
	Operating Expenses			
21	Salary and Wages and Agency Fees	(239,006)	(81,622)	Salaries and Wages are over budget by ($11,168) and the Agency fees are over budget by ($70,454).
22	Employee Benefits	98,157	55,819	
23	Total People Cost	**(140,849)**	**(25,803)**	
24	Med and Prof Fees (excld Agency)	79,349	4,396	
25	Supplies	(96,927)	39,806	Supplies were under budget due to implants being under budget by $90,087 and pharmaceuticals were over budget by ($66,806).
26	Purchased Services	3,957	5,748	
27	Depreciation	(21,344)	(7,742)	
28	Utilities	24,616	7,066	
29	Insurance	(5,673)	(1,891)	
30	Interest	1,867	(112)	
31	Other	90,801	21,632	
32	Matching Fees (Government Programs)	265,208	88,403	No matching fee in September
33	**Operating expenses**	**201,005**	**131,503**	
34	**Operating Margin**	**19,909**	**(17,855)**	
	Non Operating Rev and Expense			
35	Miscellaneous Revenue	(12,298)	146	
36	Donations	(7,198)	(2,257)	
37	Physician Practice Support-Prima	4,166	2,083	
38	Parcel Tax Assessment Rev	-	-	
39	Extraordinary Items	-	-	
40	**Total Non-Operating Rev/Exp**	(15,330)	(28)	
			-	
41	**Net Income / (Loss) prior to Restricted Contributions**	**4,579**	**(17,883)**	

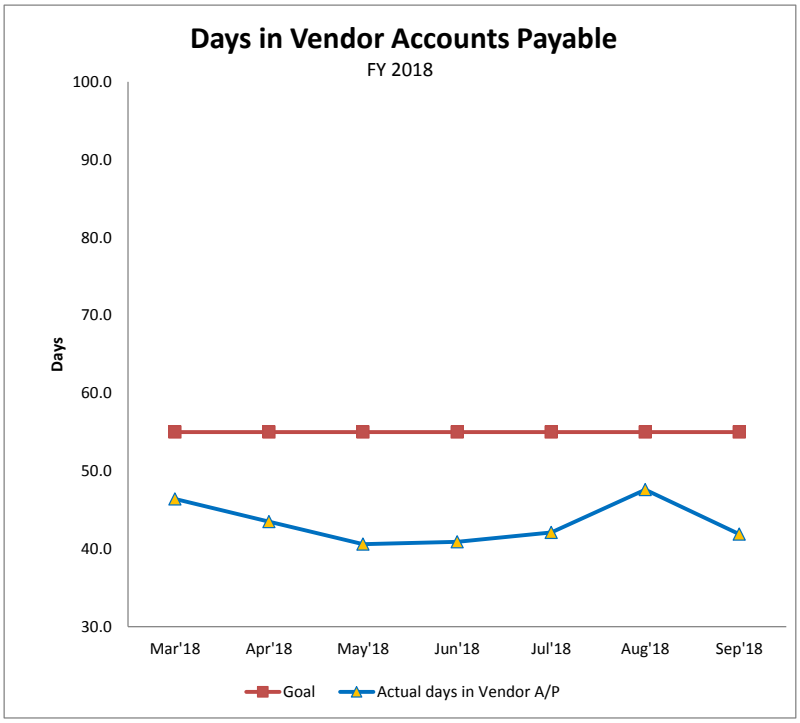
Sonoma Valley Health Care District
Statement of Revenue and Expenses Variance Analysis
For the Period Ended September 30, 2018

ATTACHMENT E

	Description	YTD Variance	MONTH Variance	
			-	
42	Capital Campaign Contribution	(33,317)	(20,949)	
43	Restricted Foundation Contributions	457,880	231,280	
44	**Net Income / (Loss) w/ Restricted Contributions**	**429,142**	**192,448**	
45	GO Bond Tax Assessment Rev	-	-	
46	GO Bond Interest	-	-	
47	**Net Income/(Loss) w GO Bond Activity**	**429,142**	**192,448**	



Days in A/R	Mar'18	Apr'18	May'18	Jun'18	Jul'18	Aug'18	Sep'18
Actual days in A/R	43.0	43.2	46.8	41.7	40.6	43.0	47.9
Goal	50.0	50.0	50.0	50.0	50.0	50.0	50.0



Days in A/P	Mar'18	Apr'18	May'18	Jun'18	Jul'18	Aug'18	Sep'18
Actual days in Vendor A/P	46.4	43.5	40.6	40.9	42.1	47.6	41.9
Goal	55.0	55.0	55.0	55.0	55.0	55.0	55.0

Sonoma Valley Hospital
Statistical Analysis
FY 2019

ATTACHMENT G

	ACTUAL	BUDGET	ACTUAL												
	Sep-18	Sep-18	Aug-18	Jul-18	Jun-18	May-18	Apr-18	Mar-18	Feb-18	Jan-18	Dec-17	Nov-17	Oct-17	Sep-17	Aug-17
Statistics															
Acute															
Acute Patient Days	337	324	361	291	354	374	341	335	289	394	386	321	315	325	325
Acute Discharges (w/o Newborns)	90	91	85	81	99	108	103	106	82	111	96	99	87	87	94
SNF Days	457	479	628	664	545	423	525	566	494	646	563	468	624	479	500
HHA Visits	682	801	585	760	871	747	755	684	821	801	798	630	871	789	713
Emergency Room Visits	814	921	810	901	856	934	864	871	811	996	919	816	827	921	894
Gross Outpatient Revenue (000's)	$13,946	$14,060	$16,762	$14,801	$13,677	$15,188	$14,170	$13,064	$12,519	$14,741	$14,051	$12,952	$11,864	$14,364	$15,524
Equivalent Patient Days	2,175	2,251	2,911	2,654	2,343	2,178	2,265	2,272	2,212	2,629	2,471	2,030	2,334	2,266	2,591
Births	13	4	14	8	16	9	6	8	11	7	10	11	12	5	10
Surgical Cases - Inpatient	31	29	26	23	28	29	30	34	16	32	24	34	23	33	22
Surgical Cases - Outpatient	151	154	139	127	123	146	114	117	123	109	136	121	97	154	142
Total Surgical Cases	182	183	165	150	151	175	144	151	139	141	160	155	120	187	164
Total Special Procedures	99	75	124	78	97	72	87	75	75	65	59	73	52	75	77
Medicare Case Mix Index	1.73	1.40	1.33	1.32	1.45	1.46	1.48	1.45	1.34	1.50	1.57	1.55	1.49	1.54	1.57
Income Statement															
Net Revenue (000's)	$4,548	$4,692	$4,924	$4,557	$5,265	$4,817	$4,389	$4,218	$4,590	$4,909	$4,466	$4,474	$4,543	$4,518	$4,775
Operating Expenses (000's)	$5,045	$5,176	$5,314	$5,114	$4,968	$5,134	$5,053	$5,179	$5,270	$5,357	$5,122	$5,332	$4,872	$5,206	$5,380
Net Income (000's)	$209	$16	$32	$214	$859	$369	$221	($395)	($175)	$125	($226)	($380)	$62	($230)	($165)
Productivity															
Total Operating Expense Per Equivalent Patient Day	$2,319	$2,300	$1,826	$1,927	$2,120	$2,357	$2,231	$2,280	$2,382	$2,038	$2,073	$2,627	$2,087	$2,297	$2,076
Productive FTEs	278	267	278	270	259	279	281	279	274	276	255	316	246	289	279
Non-Productive FTE's	36	36	31	40	39	27	26	23	31	36	52	13	58	27	35
Total FTEs	314	303	309	310	298	306	307	302	305	312	307	329	304	316	314
FTEs per Adjusted Occupied Bed	4.38	4.04	3.29	3.62	3.82	4.35	4.06	4.17	3.87	3.68	3.85	4.86	4.04	4.19	3.75
Balance Sheet															
Days of Expense In General Operating Cash	13.2		10	19	11	6	7	7	14	24	18	14	12	9	11
Net Days of Revenue in AR	48	50	43	41	42	47	43	43	47	51	51	48	45	47	43

Sonoma Valley Hospital
Cash Forecast
FY 2019

ATTACHMENT H

		Actual July	Actual Aug	Actual Sept	Forecast Oct	Forecast Nov	Forecast Dec	Forecast Jan	Forecast Feb	Forecast Mar	Forecast Apr	Forecast May	Forecast Jun	TOTAL
	Hospital Operating Sources													
1	Patient Payments Collected	4,372,057	4,288,459	3,963,236	4,170,252	4,172,901	4,206,895							25,173,800
2	Capitation Revenue	94,582	92,314	96,054	95,999	95,999	95,999							570,947
3	Napa State	12,295	4,713	-	11,962	11,962	11,962							52,894
4	Other Operating Revenue	40,299	47,536	18,852	13,968	13,968	13,968							148,591
5	Other Non-Operating Revenue	45,944	12,250	51,133	26,673	26,673	26,673							189,346
6	Unrestricted Contributions	403		415	2,672	2,672	2,672							8,834
7	Line of Credit													-
	Sub-Total Hospital Sources	**4,565,580**	**4,445,271**	**4,129,690**	**4,321,526**	**4,324,175**	**4,358,169**	**-**	**-**	**-**	**-**	**-**	**-**	**26,144,411**
	Hospital Uses of Cash													
8	Operating Expenses	4,897,828	5,636,984	5,473,847	4,852,985	4,639,141	4,718,310							30,219,095
9	Add Capital Lease Payments	44,847	193,141	46,104										284,092
10	Additional Liabilities													-
11	Capital Expenditures	331,168		286,200	75,952	75,952	75,952							845,224
	Total Hospital Uses	**5,273,843**	**5,830,125**	**5,806,151**	**4,928,937**	**4,715,093**	**4,794,262**	**-**	**-**	**-**	**-**	**-**	**-**	**31,348,411**
	Net Hospital Sources/Uses of Cash	**(708,263)**	**(1,384,854)**	**(1,676,461)**	**(607,411)**	**(390,918)**	**(436,093)**	**-**	**-**	**-**	**-**	**-**	**-**	**(5,204,000)**
	Non-Hospital Sources													
12	Restricted Cash/Money Market	(809,886)	524,043		154,000									(131,843)
13	Restricted Capital Donations	357,448	8,688	286,283	75,952	75,952	75,952							
14	Parcel Tax Revenue	207,015		1,500,000			400,000							2,107,015
15	Payment - South Lot													-
16	Other:													-
17	IGT (Net)													-
18	IGT - AB915	20,681		384,837										405,518
19	PRIME	750,000												750,000
	Sub-Total Non-Hospital Sources	**525,258**	**532,731**	**2,171,120**	**229,952**	**75,952**	**475,952**	**-**	**-**	**-**	**-**	**-**	**-**	**3,130,690**
	Non-Hospital Uses of Cash													
20	Matching Fees													-
	Sub-Total Non-Hospital Uses of Cash	-	-	-	-	-	-	-	-	-	-	-	-	-
	Net Non-Hospital Sources/Uses of Cash	**525,258**	**532,731**	**2,171,120**	**229,952**	**75,952**	**475,952**	**-**	**-**	**-**	**-**	**-**	**-**	**3,130,690**
	Net Sources/Uses	**(183,005)**	**(852,123)**	**494,659**	**(377,459)**	**(314,966)**	**39,859**	**-**	**-**	**-**	**-**	**-**	**-**	
	Cash and Equivalents at beginning of period	**1,671,423**	1,488,418	636,295	1,130,954	753,495	438,529	478,388	478,388	478,388	478,388	478,388	478,388	
	Cash and Equivalents at end of period	**1,488,418**	**636,295**	**1,130,954**	**753,495**	**438,529**	**478,388**	**478,388**	**478,388**	**478,388**	**478,388**	**478,388**	**478,388**	