SONOMA VALLEY HEALTHCARE DISTRICT
BOARD OF DIRECTORS
REGULAR MEETING AGENDA
Thursday, November 6, 2014
6:00 p.m. Regular Session

COMMUNITY MEETING ROOM
177 First Street West, Sonoma, CA

AGENDA ITEM	RECOMMENDATION	
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER	*Nevins*	
2. PUBLIC COMMENT SECTION *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.*		
3. CONSENT CALENDAR A. Regular Board Minutes 10.02.14 B. QC Charter C. FC Minutes 9.23.14 D. QC Minutes 9.24.14 E. QC Policy and Procedures F. MEC Credentialing Report, 10.22.14	*Nevins*	Action
4. UPDATE ON SONOMA VALLEY SCHOOL DISTRICT HEALTH & EDUCATION INITIATIVES—Louann Carlomango, Superintendente, Sonoma Valley Unified School District	*L. Carlomagno*	Inform
5. EBOLA & OTHER INFECTIOUS DISEASE READINESS	*Mathews*	Inform
6. PRESIDENT OF MEDICAL STAFF REPORT	*Amara, M.D.*	Inform
7. FINANCIAL REPORT FOR SEPTEMBER 2014	*Jensen*	Inform
8. ADMINISTRATIVE REPORT FOR OCTOBER 2014	*Mather*	Inform
9. SVHF ANNUAL APPEAL	*Mather*	Inform
10. OFFICER & COMMITTEE REPORTS A. Board Chair Report (Nevins) i. Reschedule January 2015 meeting date ii. Board Education iii. ACHD Events and Dates B. Audit Committee (Nevins) i. SVHCD 2015 Audit Report C. ACHD/JPA Updates (Boerum)	*Committee*	Action
11. ADJOURN Next Regular Board meeting, December 4, 2014	*Nevins*	

3.

CONSENT CALENDAR

SVHCD BOARD OF DIRECTORS
MEETING MINUTES
Thursday, October 2, 2014
5:00 p.m. Closed Session
6:00 p.m. Regular Session
Community Meeting Room, 177 1st St W, Sonoma

Committee Members Present	Committee Members Absent/Excused	Admin Staff /Public/Other	
Sharon Nevins Peter Hohorst Bill Boerum Kevin Carruth Jane Hirsch		Kelly Mather Jeannette Tarver Robert Cohen, MD Leslie Lovejoy Beth Dadko Bonnie Durrance Dick Fogg Gigi Betta	

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
1. CALL TO ORDER	*Nevins*		
	Meeting called to order at 6:00PM. Announcements: Today's Closed Session will take place at the conclusion of the Regular Session. The Portrait of Sonoma County presentation (item 7 below) will be moved to accommodate.		
2. PUBLIC COMMENT ON CLOSED SESSION	*Nevins*		
	None		
3. CLOSED SESSION Calif. Government Code § 54957: Public Employment - Executive Employment Agreement with Chief Executive Officer	*Nevins*		
4. REPORT OF CLOSED SESSION	*Nevins*		
5. PUBLIC COMMENT SECTION *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*	None		

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
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.			
6. CONSENT CALENDAR	*Nevins*	Action	
A. Regular Board Minutes 9.4.14 B. FC Minutes 8.26.14 C. QC Minutes 8.27.14 D. QC Policy and Procedures E. MEC Credentialing Report, 9.24.14		**MOTION:** by - Hohorst and 2nd by Boerum. All in favor.	
7. PORTRAIT OF SONOMA COUNTY HUMAN DEVELOPMENT REPORT 2014	*Dadko*	Inform	
	Ms. Dadko with the Sonoma County Department of Health Services gave an enlightening and engaging report on human development in Sonoma County for 2014.		
8. SVH ANNUAL REPORT FY2015	*Durrance*	Inform	
	The Annual Report for 2015 is underway by Bonnie Durrance. This year's report will be infused with healing, joy and an abundance of photographs. The Board requests to review draft before goes to print. The first draft is due in mid-November.		
9. ACHD MEMBERSHIP	*Nevins*	Inform/Action	
	Ms. Nevins attended the ACHD meeting on 9.24.14 in Roseville, CA and shared her report from that meeting. Although the ACHD organization cannot offer a reduced fee based on distressed hospital status, they did concede to a quarterly payment schedule for the annual membership dues of $20,000. The Board voted in favor of continuing with the ACHD membership this year, to take advantage of the quarterly payment schedule. The worth and benefit of membership will be re-assessed after one year.	**MOTION:** by Hohorst to continue ACHD membership and 2nd by Carruth. All in favor.	
10. CHIEF MEDICAL OFFICER QUARTERLY REPORT	*Cohen*	Inform	
	Dr. Cohen reported on his accomplishments for 2014 as well as his goals for 2015 including the		

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
	completion of Stage Two Meaningful Use on 09.30.14, the highly successful relationship between SVH and Hospice by the Bay, clerkship opportunities for Touro University students in the SVH emergency room and the 10% reduction in physician stipends. In 2015, one of the largest projects will be to implement ICD-10 by October 2015.		
11. FINANCIAL REPORT FOR AUG. 2014	*Tarver*	Inform	
	Ms. Tarver presented the Financial Report for the month ending 8.31.14 including patient volumes, overall payer mix, operating revenue and expenses, cash collections on patient receivables.		
12. ADMINISTRATIVE REPORT FOR SEPTEMBER 2014	*Mather*	Inform	
	Ms. Mather presented the Administrative Report for September 2014 including the Performance Improvement Faire, organizational results, operation update, strategic update, August dashboard and FY2014 Trended Results.		
13. ADJOURN	*Nevins* Meeting adjourned at 8:00 PM Next Regular Board meeting, November 6, 2014		

SUBJECT: Quality Committee Charter	
	PAGE 1 OF 6
DEPARTMENT: Board of Directors	EFFECTIVE: 12/1/11
APPROVED BY: Board of Directors (12/1/11)	REVISED: 3/27/13

Purpose:
Consistent with the Mission of the District the Board, with the assistance of its Quality Committee (QC), serves as the steward for overall quality improvement for the District. The QC shall constitute a committee of the District Board of Directors. The Board shall refer all matters brought to it by any party regarding the quality of patient care, patient safety, and patient satisfaction to the QC for review, assessment, and recommended Board action. The QC makes recommendations and reports to the Board. It has no authority to make decisions or take actions on behalf of the District unless the Board specifically delegates such authority.
The QC shall assist the Board in its responsibility to ensure that the Hospital provides high-quality patient care, patient safety, and patient satisfaction. To this end the QC shall:

1. Formulate policy to convey Board expectations and directives for Board action;
2. Make recommendations to the Board among alternative courses of action, including but not limited to physician credentialing, and oversight activities;
3. Provide oversight, monitoring and assessment of key organizational processes, outcomes, and external reports.

Policy:

SCOPE AND APPLICABILITY
This is a SVHCD Board Policy and it specifically applies to the Board, the Quality Committee, the Audit Committee, the Medical Staff, and the CEO of SVH.

RESPONSIBILITY

Physician Credentialing

1. The QC shall ensure that recommendations from the Medical Executive Committee and Medical Staff are in accordance with the standards and requirements of the Medical Staff Bylaws, Rules, and Regulations with regard to: completed applications for initial medical staff and allied health staff appointment; initial staff category assignment, initial department/divisional affiliation; membership prerogatives and initial clinical privileges; completed applications for reappointment of medical staff, staff category; clinical privileges; establishment of categories of allied health professionals permitted to practice at the hospital; the appointment and reappointment of allied health professionals; and privileges granted to allied health professionals.

2. The QC shall, in closed session, on a case by case basis, fully, rigorously, and carefully review the recommendations of the Medical Staff regarding the appointment, reappointment, and privilege delineation of physicians and submit recommendations to the Board for review and action.

Develop Policies

1. The QC shall submit recommendations for action to the Board on draft policies developed by the QC and those developed by the Hospital regarding quality patient care, patient safety, and patient satisfaction.

Oversight

Annual Quality Improvement Plan

1. The QC shall review and analyze findings and recommendations from the CEO resulting from the Hospital's prior year Annual Quality Improvement Plan, including but not limited to a comparison of the plan to actual accomplishments, administrative review, and evaluation activities conducted, findings and actions taken, system or process failures and actions taken to improve safety, both proactively and in response to actual occurrences.

2. The QC shall review the Hospital's Annual Quality Improvement Plan for continuously improving quality, patient safety, and patient satisfaction and submit the analysis with recommendations establishing priorities to the Board for discussion and action. The Hospital's plans should include, but not be limited to, assessing the effectiveness and results of the quality review using metrics and benchmarks, utilization review, performance improvement, implementing and improving electronic medical/health records, professional education, risk management programs, and patient care related activities and policies of the Hospital and/or Medical Staff, as applicable.

Medical Staff Bylaws

1. The QC shall assure that the Medical Staff's Bylaws are reviewed and approved by the Board and are consistent with the District and Hospital Mission, Vision and Values, Board policy, and accreditation standard, prevailing standards of care, and evidence-based practices.

2. The QC shall review the Medical Staff's fulfillment of its responsibilities in accordance with the Medical Staff Bylaws, applicable law and regulation, and accreditation standards and make recommendations to the Board.

Quantitative Quality Measures

1. The QC shall assess and recommend quantitative measures to be used by our Board in assessing the quality of the Medical Staff's and Hospital's services and submit them to the Board for deliberation and action. The recommendations shall include descriptions that show how the organization measures and reports the improvement of patient care, as well as management accountability.

2. The QC shall review all reports by and Hospital responses to accreditation organizations, e.g., Fire Marshals, Environmental Health, State Department of Health Services (DHS), and other external organizations conducting management, programmatic, physical plant audits/assessments/reviews that are directly or indirectly related to the quality of health care delivery in the Hospital (quality patient care, patient safety, and patient satisfaction). Track all uncompleted/open items until remedied/closed by the Hospital, and make recommendations and report to the Board for its action as appropriate. This includes the final OSHPD report on a construction project prior to licensing by DHS, but it does not include on-going OSHPD reviews/inspections/reports while a project is in design or construction. This does not include routine financial audits, unless the audit identifies quality patient care, patient safety, and/or patient satisfaction issues, in which case the Audit Committee shall refer the audit to the QC for its review and recommendations to the Board.

3. The QC shall ensure there is an effective, supportive, and confidential process for anyone (the Medical Staff, other health care professionals; Hospital administration; leaders and staff; patients, and their families and friends; and the public) to bring issues to the QC directly or via the Hospital—as a group, personally or anonymously--in order to promote the reporting of quality and patient safety problems and medical errors, and to protect those who ask questions and report problems.

4. The QC shall review and assess the process for identifying, reporting, and analyzing "adverse patient events" and medical errors. The QC shall develop a process for the QC

to address these quality deficiencies, in the most transparent manner possible, without unnecessarily increasing the District's liability exposure.

5. The QC shall review the assessment of patient needs/satisfaction, and submit this assessment with recommendations to the Board for review and possible action. This may include, but is not limited to CMS Value Based Purchasing information; Press Ganey surveys; reports and comparisons to other hospitals, state and national standards; and patient and/or family compliments and complaints.

6. The QC shall review and assess the system for resolving interpersonal conflicts among individuals working within the Hospital environment that could adversely affect quality of care, patient safety or patient satisfaction, and make recommendations to the Board.

Hospital Policies

1. The QC shall assure that the Hospital's administrative policies and procedures, including the policies and procedures relative to quality, patient safety and patient satisfaction, are reviewed and approved by the appropriate Hospital leaders, submitted to the Board for action, and are consistent with the District and Hospital Mission, Vision and Values, Board policy, accreditation standards, and prevailing standards of care and evidence-based practices.

Other

1. Perform other duties related to high-quality patient care, patient safety, and patient satisfaction as assigned by the Board.

Annual QC Work Plan

The QC shall develop an Annual QC Work Plan comprised of the required annual activities and additional activities selected by the QC. The Annual QC Work Plan shall be reviewed and acted on by the Board after considering the CEO's work plan to support the QC.

Required Annual Calendar Activities:

1. The QC shall review the adequacy of financial and human resources currently allocated for maintaining high-quality care, patient safety, and patient satisfaction in April, in advance of the annual budget process and provide an assessment to the Board and CEO with recommendations for action.

2. The QC Work Plan shall be submitted to the Board for its review and action no later than December.

3. The QC shall report on the status of its prior year's work plan accomplishments by December.

4. The QC reviews and assesses all Board policies regarding quality specifically including the QC Charter, and makes recommendations to the Board for action in December.

QC Membership and Staff

The QC shall have seven voting members and three non-voting public member alternates appointed pursuant to Board policy. Pursuant to Health and Safety Code Section 32155, based on the need for Medical Staff quality assessments. Hospital employees who staff the QC are not voting members of the QC. QC membership is:

- Two Board members one of whom shall be the QC chair, the other the vice-chair. Substitutions may be made by the Board chair for Board QC members at any QC meeting--for one or both Board members.

- Two designated positions from the Medical Staff leadership, i.e., the President and the President-Elect. Substitutions may be made by the President for one Medical Staff member at any QC meeting.

- Three members of the public. In addition, substitutions may be made at all QC meetings from three prioritized non-voting members of the public as alternate public members. Alternates shall attend closed session QC meetings and vote as QC members when substituting for a voting public member. Alternates may attend QC meetings as non-voting alternates and fully participate in the open meeting discussions.

Staff to the QC include the Hospital's Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and the Director of Quality and Resource Management who shall be the lead staff in support of the QC Chair for meetings, documents, and activities. Staff is expected to attend the QC meetings. The CEO may attend all QC and subcommittee meetings and shall be a resource at the QC meetings upon request of the QC Chair.

Frequency of QC Meetings
The QC shall meet monthly, unless there is a need for additional meetings.

Public Participation
All QC meetings shall be announced and conducted pursuant to the Brown Act. Physician Credentialing and Privileges are discussed and action is taken in QC Closed Session without the general public.

The general public, patients and their families and friends, Medical Staff, and Hospital staff are always welcome to attend and provide input. Other Board members may attend but may not comment as it may be a Brown Act violation.

Narrowly focused and short term ad hoc subcommittees may meet to address specific issues that will be brought to the QC for review and referral to the Board for its deliberation and action. Subcommittee meetings are not subject to the Brown Act.

Reference:

POLICY HISTORY
December 1, 2011--Board Policy regarding the QC was first adopted.

FREQUENCY OF REVIEW/REVISION
This shall occur annually or more often if required. If revisions are needed they will be taken to the Board for action.

SONOMA VALLEY HEALTH CARE DISTRICT
FINANCE COMMITTEE
MEETING MINUTES
Tuesday, September 23, 2014
Schantz Conference Room

Voting Members Present	Members Absent/Excused	Staff/ Public/Other	Staff Excused/Absent
Phil Woodward Sharon Nevins Steve Barclay Mary Smith Keith Chamberlin Stephen Berezin Dick Fogg S. Mishra, MD (by phone)	Shari Glago Ken Jensen Peter Hohorst	Kelly Mather Sam McCandless Jeannette Tarver Gigi Betta	

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
MISSION AND VISION STATEMENTS	*The mission of the SVHCD is to maintain, improve and restore the health of everyone in our community.* *The vision of the SVHCD is that SVH will be a nationally recognized, compassionate place of healing known for excellence in clinical quality. We serve as the guide and indispensable link in our community members' health care journey.*		
1. CALL TO ORDER/ANNOUNCEMENTS			
	• Mr. Fogg thanked Ms. Glago for acting as Chair of the Finance Committee at the meeting on 8/26/14. • Ms. Mather announced that SVH received a phenomenal Value Based Purchasing (VBP) score of 71. VBP scores are calculated using CMS data from Midas over a 12 month period.		
2. PUBLIC COMMENT SECTION	*Fogg*		
	None		
3. CONSENT CALENDAR	*Fogg*	Action	
A. FC Minutes 08.26.14		**MOTION** to approve by Chamberlin; **2nd** by Berezin. All in favor.	.
4. AUGUST 2014 FINANCIALS	*Tarver*	Inform	
	• Ms. Tarver presented the Financial Report for the month ending		

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
	August 31, 2014 which included patient volumes, overall payer mix, total operating revenues, total operating expenses and cash collections on patient receivables. • Mr. McCandless requested use of a larger font on the Statement of Revenue and Expenses Comparative results. The FC discussed this request and decided to use a landscape orientation spread out over two pages. • Mr. Woodward questioned why the total amount borrowed does not appear on the *Statement of Cash Flows* (page 22). Currently the Finance Department is putting this total under *Other Liabilities (*see motion and decision next paragraph). • Ms. Nevins made a **MOTION TO ELIMINATE PAGE 22**, *Statement of Cash Flows for the period ending August 31, 2015* (except on an annual basis) because page 26, *Statement Projections FY2015* provides the same information. **ALL IN FAVOR.**		
5. CASH FLOW FORECAST	*Tarver*	Inform	
	Ms. Tarver presented the Cash Flow Forecast for FY2015 covering Sources, Uses and Project Funding.		
6. CEO BOARD REPORT SEPT. 2014			
	Updates: • The SVH-MGH Affiliation Agreement no longer includes Shared Services (i.e. finance, EHR and services provided to PDH). • Ken Jensen is still the Interim CFO and will make decision on an offer of permanent employment when he returns from vacation. Should he decide not to remain on a permanent basis, he is willing to act as Interim for 6 months. • SVH is no longer pursuing the West County Physical Therapy contract. • Revenue from parcel taxes runs out at end of 2017. The Hospital plans to get a new parcel tax initiative on the ballot in spring 2016. Reports: Ms. Mather presented the CEO Board Report for September 2014, the Hospital Performance Summary for FY2014 and the new Dashboard for FY2015.		
7. ADJOURN	*Fogg*		
	Adjourned at 6:16 PM Next meeting October 28, 2014		

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Wednesday, September 24, 2014
Schantz Conference Room

Committee Members Present	Committee Members Present continued	Committee Members Excused	Admin Staff /Other
Jane Hirsch Ingrid Sheets Cathy Webber Carol Snyder Michael Mainardi MD		Kelsey Woodward Howard Eisenstark MD Kevin Carruth Susan Idell	Robert Cohen M.D. Gigi Betta Leslie Lovejoy D. Paul Amara, MD

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
1. CALL TO ORDER	*Hirsch*		
	Meeting called to order at 5:05 PM		
2. PUBLIC COMMENT	*Hirsch*		
3. CONSENT CALENDAR	*Hirsch/Lovejoy*	Action	
a) Quality Committee Minutes, 07.23.14 b) *Multiple* Policy & Procedures, August 2014		**MOTION** to approve Minutes by Sheets and 2nd by Mainardi. All in favor. **MOTION** to approve P&Ps by Mainardi and 2nd by Sheets. All in favor.	
4. QUALITY REPORT JULY 2014 AND DASHBOARD 2Q2014	*Lovejoy*	Inform/Action	
a) Attachments from July 2014 Quality Report b) Quality and Resource Management Report, August 2014 c) Utilization Management Efforts & Outcomes d) Utilization Management Dashboard	The *Performance Improvement Fair: Improving Our Practice, Improving Our Care* will be on September 25, 2014 in the Basement Conference Room at SVH and all are welcome to attend. Ms. Lovejoy presented the Quality Report for August 2014 and the Utilization Reviews for 2011-2014 YTD. She noted that CMS had	**MOTION** to approve August Quality Report by Sheets and 2nd by Mainardi. All in favor.	

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
	suspended Hospital audits and they will start up again the first week of October. Ms. Lovejoy summarized Kelly Mather's First Annual Healing Hospital Showcase that took place here in the Hospital on September 22 & 23, 2014. The Healing Hospital concept is part of SVH's Strategic Plan and is intended to keep SVH viable and current in the changing world of health care. The event was very successful and well attended.		
5. CLOSING COMMENTS/ANNOUNCEMNTS	*Hirsch*		
	SVH is partnering with Hospice by the Bay to host *Planning Ahead: Making Your Health Care Wishes Known.* The event will take place at Vintage House on 264 1st Street East in Sonoma on November 13, 2014. The QC October meeting on 10.29.14 will have two educational presentations. Fe Sendaydiego will present on Meaningful Use Stage II and Michelle Donaldson will present on the Skilled Nursing Facility.		
6. ADJOURN	*Hirsch*		
	Regular Session adjourned at 5:43 PM		
7. UPON ADJOURNMENTOF REGULAR OPEN SESSION	*Hirsch*	Inform	
8. CLOSED SESSION	*Amara*	Action	
9. REPORT OF CLOSED SESSION	*Hirsch*	Inform	
10. ADJOURN	Closed Session adjourned at 5:47 PM		

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

POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following 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 Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Organizational: Information Management	
APPROVED BY:	DATE: **9/30/14**
Director's/Manager's Signature	Printed Name **Beverly Seyfert, Director Information Systems**

Fe Sendaydiego — 9/30/14

Fe Sendaydiego
Chief Information Officer — Date

Michael Brown, MD
Chair Surgery Committee — Date

Douglas S Campbell, MD
Chair Medicine Committee — Date

D. Paul Amara, MD
President of Medical Staff — Date

Kelly Mather
Chief Executive Officer — Date

Sharon Nevins
Chair, Board of Directors — Date

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SONOMA VALLEY HEALTH CARE DISTRICT
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Policy Submission Summary Sheet

Title of Document: Information Management

New document or revision written by: Fe Sendaydiego

Date: 9/30/2014

Type **X New Policy ❑ Revision**	**Regulatory** ❑ **CMS** ❑ **CDPH** (formerly DHS) ❑ **TJC** (formerly JCHAO) ❑ **Other:**
Organizational: Clinical/Non-clinical *(circle which type)*	❑ **Departmental** **X Interdepartmental** *(List departments effected)*

Please briefly state changes to existing document/form or overview of new document/form here:

Creating top-level policies to meet HIPAA Security Rule Standards:

IM8610-151 HIPAA Security-Assigned Security Responsibility

IM8610-157 HIPAA Security-Evaluation Policy

IM8610-161 HIPAA Security –Person or Entity Authentication

IM8610-164 HIPAA Security-Security Incident Procedures Policy

IM8610-167 HIPAA Security-Workforce Security Policy

Reviewed By	Date	Approved (Y/N)	Comment
Surgery Committee ✓	10/01/14	Yes	
Medicine Committee ✓	10/09/14	Yes	
Medical Executive ✓	10/16/14	Yes	
Quality Board ✓ 10/29/14	~~10/22/14~~	Yes	
Board of Directors	11/06/14		

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SONOMA VALLEY HEALTH CARE DISTRICT
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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

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- 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 Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Organizational: PC8610-122 Pressure Ulcer & Wound Care Assessment and Management	
APPROVED BY:	DATE: **10/08/14**
Director's/Manager's Signature	Printed Name **Mark Kobe, RN MPA**

Leslie Lovejoy, RN, PH.D. Chief Nursing Officer	Date
Douglas S Campbell, MD Chair Medicine Committee	Date
Michael Brown, MD Chair Surgery Committee	Date
D. Paul Amara, MD President of Medical Staff	Date
Robert Cohen, MD Chief Medical Officer	Date
Kelly Mather Chief Executive Officer	Date
Sharon Nevins Chair, Board of Directors	Date

Policy Submission Summary Sheet

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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Department: **Organizational Policy and Procedures**

New document or revision written by: **Mark Kobe, RN MPA**

Type **X Revision ❑ New Policy**	**Regulatory** **X CMS** **X CDPH** (formerly DHS) **X CIHQ** **❑ Other:**
Departmental: Clinical/Non-clinical *(circle which type)*	**❑ Departmental** **X Organizational** *(List departments effected)*

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

The following organizational policy has been revised:

PC8610-122 Pressure Ulcer & Wound Care Assessment and Management. Policy revised to state all SDC patients are to be photographed for potential pressure ulcers/ upon admission and upon discharge. Further, only Wound certified RNs may stage ulcers/wounds beyond Stage I.

Reviewed By	Date	Approved (Y/N)	Comment
Medicine Committee ✓	10/09/14	Yes	
Medical Executive Committee ✓	10/16/14	Yes	
Surgery Committee ✓	11/05/14	Yes	
Board of Directors	11/06/14		

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

POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following 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 Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Department: Emergency Department New Policy	
APPROVED BY:	DATE: **10/08/14**
Director's/Manager's Signature	Printed Name **Mark Kobe, RN MPA**

Jared Hubbell, MD
Emergency Department Medical Director — Date

Leslie Lovejoy, RN
Chief Nursing Officer — Date

Douglas S. Campbell, MD
Chair, Medicine Committee — Date

D. Paul Amara, MD
President of Medical Staff — Date

Kelly Mather
Chief Executive Officer — Date

Sharon Nevins
Chair, Board of Directors — Date

Policy Submission Summary Sheet

Department: **Emergency Department**

New document or revision written by: **Mark Kobe, RN MPA**

Type ☐ **Revision** **X New Policy**	**Regulatory** **X CMS** **X CDPH** (formerly DHS) **X CIHQ** ☐ **Other:**
Departmental: Clinical/Non-clinical *(circle which type)*	**X Departmental** ☐ **Organizational** *(List departments effected)*

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

The following ED Department policies have been created:

7010-18 CRITICAL CARE TRANSPORT DOCUMENTATION. This policy is newly created to establish protocol for responsibility and documentation by the ED RN during critical care transport

Reviewed By	Date	Approved (Y/N)	Comment
Medicine Committee	10/09/14	yes	
Medical Executive Committee	10/16/14	yes	
Surgery Committee	11/05/14	yes	
Board of Directors	11/06/14		

7.

FINANCIAL REPORT SEPTEMBER 2014

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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To: **SVH Finance Committee**
From: **Ken Jensen, CFO**
Date: **October 28, 2014**
Subject: **Financial Report for the Month Ending September 30, 2014**

The month of September was unfavorable compared to budget. Net Revenue was under the Hospital's budgeted revenue expectations. This was due to inpatient revenue and the payer mix for the month. Expenses were also unfavorable to budget, but overages in Salaries and Supplies were offset with favorable revenue. Salaries were over due to volume in Home Health Care and OB. Supplies were over due to the Surgery case mix. Information Technology (IT) and Patient Accounting are already reducing their Purchase Services for the remainder of the year.

Below is a summary of the variances for the month of September:

GROSS REVENUE was better than budget by $112,835
Inpatient revenue was off target by $1,461,278 and SNF was off by $336,251. This shortfall was offset by better than expected revenues for O/P $856,921, ER $971,638 and Home Health $81,805.

Deductions from revenue higher than budgeted due to changes in payer mix with lower Medicare and Commercial and higher MediCal volumes for both I/P and O/P. ($380,895)

Risk Contract Revenue was under budget by ($57,719)

Other Revenue was over budget by $10,907

Total Operating Revenue Variance ($314,872)
THE REVENUE SHORT-FALL WAS THE MAJOR FACTOR FOR NOT MEETING THE BUDGETED SEPTEMBER NET INCOME

The expenses' negative experiences improved over the prior months.
The average variance for the prior two months was $329,320.
September's negative expense variance is $141,568.

Total Staffing costs were over by ($69,641)
due to volume increases in several service lines including OB. FTEs were 267 vs. a budget of 266.

Supplies were over budget primarily due to the costs of implants that are offset by pass through revenue.	($20,934)	
Purchased Services were over budget Due to unbudgeted costs IT and Patient Accounting costs.	($79,329)	
Total Expense Variance		($141,568)
Total Operating Margin Variance		($456,440)
Non-Operating Income better than budget		$39,805
Capital Campaign Contributions lower than budget		($31,431)
Net Variance		($448,066)

The net income was a loss of ($327,165) vs. an expected profit of $120,901. After accounting for GO bond activity the aggregated net loss was ($289,045) vs. a budgeted profit of $130,886.

Patient Volumes - September

	ACTUAL	BUDGET	VARIANCE	PRIOR YEAR
Acute Discharges	**87**	**100**	**-13**	**107**
Acute Patient Days	**291**	**370**	**-79**	**405**
SNF Patient Days	**597**	**580**	**17**	**585**
Home Care Visits	**1,111**	**824**	**287**	**745**
OP Gross Revenue	**$11,149**	**$9,575**	**$1,574**	**$9,173**
Surgical Cases	**122**	**120**	**2**	**120**

Overall Payer Mix – September

	ACTUAL	BUDGET	VARIANCE	YTD ACTUAL	YTD BUDGET	VARIANCE
Medicare	**48.5%**	**50.1%**	**-1.6%**	**47.4%**	**49.7%**	**-2.4%**
Medi-Cal	**15.1%**	**11.3%**	**3.7%**	**16.8%**	**11.3%**	**5.5%**
Self Pay	**4.1%**	**3.5%**	**0.5%**	**3.1%**	**3.4%**	**-0.3%**
Commercial	**22.3%**	**24.6%**	**-2.3%**	**22.0%**	**24.9%**	**-2.9%**
Managed MC	**3.6%**	**4.4%**	**-0.8%**	**4.2%**	**4.4%**	**-0.2%**
Workers Comp	**3.2%**	**3.1%**	**0.0%**	**3.3%**	**3.3%**	**0.0%**
Capitated	**3.3%**	**2.9%**	**-0.5%**	**3.2%**	**2.9%**	**0.3%**
Total	**100%**	**100%**		**100%**	**100%**	

Cash Collections on Patient Receivables:

For the month of September the cash collection goal was $3,690,316 and the Hospital collected $3,605,456 or under the goal by ($84,860). The Year to date cash goal was $10,315,976 and the Hospital collected $11,216,691 or over the goal by $900,715. The cash collection goal is based upon net hospital revenue from 60 days ago. Days of cash on hand are 15 days at September 30, 2014.

Sonoma Valley Hospital
Sonoma Valley Health Care District
September 2014 Financial Report

Finance Committee
October 28, 2014

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

Patient Volumes
Month of September 30, 2014

	Actual	Budget	Variance	Prior Year
Acute Discharges	87	100	-13	107
Acute Patient Days	291	370	-79	405
SNF Patient Days	597	580	17	585
Home Health Care Visits	1,111	824	287	745
Outpatient Gross Revenue (in thousands)	$11,149	$9,575	$1,574	$9,173
Surgical Cases	122	120	2	120

Summary Statement of Revenues and Expenses Month of September 30, 2014

	Actual	Budget	Variance	Percentage	Prior Year
1Total Operating Revenue	$ 3,812,916	$ 4,127,788	$ (314,872)	-8%	$ 4,065,201
2Total Operating Expenses	$ 4,461,471	$ 4,319,903	$ (141,568)	-3%	$ 4,336,323
3Operating Margin	$ (648,555)	$ (192,115)	$ (456,440)	-238%	$ (271,122)
4NonOperating Rev/Exp	$ 266,571	$ 226,766	$ 39,805	18%	$ 1,199,252
5Net Income before Rest.Cont. & GO Bond	$ (381,984)	$ 34,651	$ (416,635)	-1202%	$ 928,130
6Restricted Contribution	$ 54,819	$ 86,250	$ (31,431)	-36%	$ 68,958
7Net Income with Restricted Contributions	$ (327,165)	$ 120,901	$ (448,066)	-371%	$ 997,088
8Total GO Bond Rev/Exp	$ 38,120	$ 9,985	$ 28,135	282%	$ 115,418
9Net Income with GO Bond	$ (289,045)	$ 130,886	$ (419,931)	-321%	$ 1,112,506
10EBIDA before Restricted Contributions	$ (37,719)	$ 392,528	$ (430,247)		$ 532,567
11EBIDA before Restricted Cont. %	-1%	10%	-10%		13%

Summary Statement of Revenues and Expenses Year to Date September 30, 2014 (3 months)

		Actual	Budget	Variance	Percentage	Prior Year
1	Total Operating Revenue	$ 12,665,531	$ 12,714,830	$ (49,299)	0%	$ 12,613,079
2	Total Operating Expenses	$ 13,864,996	$ 13,217,603	$ (647,393)	-5%	$ 13,245,767
3	Operating Margin	$ (1,199,465)	$ (502,773)	$ (696,692)	-139%	$ (632,688)
4	NonOperating Rev/Exp	$ 793,098	$ 738,984	$ 54,114	7%	$ 1,779,918
5	Net Income before Rest.Cont. & GO Bond	$ (406,367)	$ 236,211	$ (642,578)	-272%	$ 1,147,230
6	Restricted Contribution	$ 172,644	$ 258,750	$ (86,106)	-33%	$ 243,340
7	Net Income with Restricted Contributions	$ (233,723)	$ 494,961	$ (728,684)	-147%	$ 1,390,570
8	Total GO Bond Rev/Exp	$ 41,297	$ 29,942	$ 11,355	38%	$ 346,152
9	Net Income with GO Bond	$ (192,425)	$ 524,903	$ (717,328)	-137%	$ 1,736,721
10	EBIDA before Restricted Contributions	$ 623,073	$ 1,309,842	$ (686,769)		$ 1,699,830
11	EBIDA before Restricted Cont. %	5%	10%	-5%		13%

Sonoma Valley Health Care District
Statement of Revenue and Expenses
Comparative Results
For the Period Ended September 2014

		Month				Year-To- Date				YTD
		This Year		Variance		This Year		Variance		
		Actual	Budget	$	%	Actual	Budget	$	%	Prior Year
	Volume Information									
1	Acute Discharges	87	100	(13)	-13%	296	305	(9)	-3%	309
2	SNF Days	597	580	17	3%	1,935	1,732	203	12%	1,657
3	Home Care Visits	1,111	824	287	35%	3,366	2,683	683	25%	2,244
4	Gross O/P Revenue (000's)	11,149	9,575	1,575	16%	$ 32,774	$ 30,297	2,477	8%	$ 29,044
	Financial Results									
	Gross Patient Revenue									
5	Inpatient	$ 3,958,464	$ 5,419,742	(1,461,278)	-27%	$ 14,084,847	$ 16,507,239	(2,422,392)	-15%	$ 16,182,201
6	Outpatient	6,871,335	6,014,414	856,921	14%	19,664,022	19,392,442	271,580	1%	18,239,402
7	Emergency	4,278,117	3,306,479	971,638	29%	12,075,681	10,079,905	1,995,776	20%	10,118,228
8	SNF	1,987,199	2,323,450	(336,251)	-14%	6,852,469	6,839,450	13,019	0%	6,359,470
9	Home Care	335,513	253,708	81,805	32%	1,034,140	824,464	209,676	25%	686,818
10	Total Gross Patient Revenue	$ 17,430,628	$ 17,317,793	112,835	1%	$ 53,711,159	$ 53,643,500	67,659	0%	$ 51,586,118
	Deductions from Revenue									
11	Contractual Discounts	$ (13,713,803)	$ (13,367,589)	(346,214)	-3%	$ (41,593,645)	$ (41,384,649)	(208,996)	-1%	$ (39,497,813)
12	Bad Debt	(200,000)	(161,147)	(38,853)	-24%	(340,000)	(499,168)	159,168	32%	(600,000)
13	Charity Care Provision	(20,000)	(24,172)	4,172	17%	(70,000)	(74,876)	4,876	7%	(81,000)
14	Prior Period Adjustments	-	-	-	0%	-	-	-	0%	71,644
15	Total Deductions from Revenue	$ (13,933,803)	$ (13,552,908)	(380,895)	3%	$ (42,003,645)	$ (41,958,693)	(44,952)	0%	$ (40,107,169)
16	Net Patient Service Revenue	$ 3,496,825	$ 3,764,885	(268,060)	-7%	$ 11,707,514	$ 11,684,807	22,707	0%	$ 11,478,950
17	Risk contract revenue	$ 230,533	$ 288,252	(57,719)	-20%	$ 703,017	$ 864,756	(161,739)	-19%	$ 777,329
18	Net Hospital Revenue	$ 3,727,358	$ 4,053,137	(325,779)	-8%	$ 12,410,531	$ 12,549,563	(139,032)	-1%	$ 12,256,278
19	Other Op Rev & Electronic Health Records	$ 85,558	$ 74,651	10,907	-15%	$ 255,000	$ 165,267	89,733	54%	$ 356,800
20	Total Operating Revenue	$ 3,812,916	$ 4,127,788	(314,872)	-8%	$ 12,665,531	$ 12,714,830	(49,299)	0%	$ 12,613,079
	Operating Expenses									
21	Salary and Wages and Agency Fees	$ 1,958,767	$ 1,889,126	(69,641)	-4%	$ 6,042,715	$ 5,803,210	(239,505)	-4%	$ 5,971,082
22	Employee Benefits	746,859	$ 752,691	5,832	1%	2,263,477	2,287,838	24,361	1%	2,209,681
23	Total People Cost	$ 2,705,626	$ 2,641,817	(63,809)	-2%	$ 8,306,192	$ 8,091,048	(215,144)	-3%	$ 8,180,763
24	Med and Prof Fees (excld Agency)	$ 339,241	$ 332,423	(6,818)	-2%	$ 1,067,184	$ 976,995	(90,189)	-9%	$ 1,246,906
25	Supplies	468,210	447,276	(20,934)	-5%	1,613,980	1,423,870	(190,110)	-13%	1,543,148
26	Purchased Services	369,081	289,752	(79,329)	-27%	1,068,163	899,246	(168,917)	-19%	1,088,762
27	Depreciation	289,984	272,198	(17,786)	-7%	890,413	816,594	(73,819)	-9%	497,258
28	Utilities	108,020	80,567	(27,453)	-34%	325,030	241,701	(83,329)	-34%	248,040
29	Insurance	19,255	20,000	745	4%	57,765	60,000	2,235	4%	56,663
30	Interest	54,281	85,679	31,398	37%	139,027	257,037	118,010	46%	55,342
31	Other	107,773	150,191	42,418	28%	397,242	451,112	53,870	12%	328,885
32	Operating expenses	$ 4,461,471	$ 4,319,903	(141,568)	-3%	$ 13,864,996	$ 13,217,603	(647,393)	-5%	$ 13,245,767
33	Operating Margin	$ (648,555)	$ (192,115)	(456,440)	-238%	$ (1,199,465)	$ (502,773)	(696,692)	-139%	$ (632,688)
	Non Operating Rev and Expense									
34	Miscellaneous Revenue	$ 55,571	$ 933	54,638	5856%	$ 68,666	$ 2,799	65,867	*	$ 25,041
35	Donations	(0)	10,000	(10,000)	-100%	91,432	88,686	2,746	-3%	1,223,708
36	Physician Practice Support-Prima	(39,000)	(34,167)	(4,833)	14%	(117,000)	(102,501)	(14,499)	14%	(181,331)
37	Parcel Tax Assessment Rev	250,000	250,000	-	0%	750,000	750,000	-	0%	712,500
38	Total Non-Operating Rev/Exp	$ 266,571	$ 226,766	39,805	18%	$ 793,098	$ 738,984	54,114	7%	$ 1,779,918
39	Net Income / (Loss) prior to Restricted Contributions	$ (381,984)	$ 34,651	(416,635)	-1202%	$ (406,367)	$ 236,211	(642,578)	-272%	$ 1,147,230
40	Capital Campaign Contribution	$ 54,819	$ 86,250	(31,431)	-36%	$ 172,644	$ 258,750	(86,106)	-33%	$ 243,340
41	Restricted Foundation Contributions	$ -	$ -	-	0%	$ -	$ -	-	100%	$ -
42	Net Income / (Loss) w/ Restricted Contributions	$ (327,165)	$ 120,901	(448,066)	-371%	$ (233,723)	$ 494,961	(728,684)	-147%	$ 1,390,570
43	GO Bond Tax Assessment Rev	152,326	150,241	2,085	1%	458,666	450,723	7,943	2%	456,977
44	GO Bond Interest	(114,206)	(140,256)	26,050	-19%	(417,369)	(420,781)	3,412	-1%	(110,825)
45	Net Income/(Loss) w GO Bond Activity	$ (289,045)	$ 130,886	(419,931)	321%	$ (192,425)	$ 524,903	(717,328)	137%	$ 1,736,721
	EBIDA	$ (37,719)	$ 392,528			$ 623,073	$ 1,309,842			$ 1,699,830
		-1.0%	9.5%			4.9%	10.3%			13.5%

Sonoma Valley Health Care District
Balance Sheet
As of September 30, 2014

		Current Month	Prior Month	Prior Year
	Assets			
	Current Assets:			
1	Cash	$ 2,182,182	$ 1,757,489	$ 1,145,913
2	Trustee Funds	953,138	1,753,339	540,405
3	Net Patient Receivables	7,140,398	7,926,063	8,306,068
4	Allow Uncollect Accts	(639,759)	(765,750)	(1,787,350)
5	Net A/R	6,500,639	7,160,313	6,518,719
6	Other Accts/Notes Rec	8,522,094	7,187,423	7,978,170
7	3rd Party Receivables, Net	1,974,935	1,876,820	1,560,978
8	Due Frm Restrict Funds	-	-	-
9	Inventory	758,803	766,592	759,124
10	Prepaid Expenses	570,564	552,420	1,125,675
11	Total Current Assets	$ 21,462,355	$ 21,054,396	$ 19,628,984
12	Board Designated Assets	$ -	$ -	$ 5,381
13	Property,Plant & Equip, Net	56,247,706	56,486,369	13,471,956
14	Hospital Renewal Program	-	-	31,801,877
15	Unexpended Hospital Renewal Funds	-	-	4,024,455
16	Investments	-	-	-
17	Specific Funds	77,792	1,122,919	329,467
18	Other Assets	142,858	138,384	265,858
19	Total Assets	$ 77,930,711	$ 78,802,068	$ 69,527,977
	Liabilities & Fund Balances			
	Current Liabilities:			
20	Accounts Payable	$ 4,337,390	$ 4,229,266	$ 3,448,666
21	Accrued Compensation	4,083,949	3,992,303	3,858,544
22	Interest Payable	235,858	818,974	282,340
23	Accrued Expenses	3,005,235	2,589,123	1,538,703
24	Advances From 3rd Parties	400,235	441,536	1,749,500
25	Deferred Tax Revenue	4,643,008	5,842,977	3,656,125
26	Current Maturities-LTD	972,343	1,580,746	842,956
27	Line of Credit - Union Bank	5,698,734	4,901,091	3,973,734
28	Other Liabilities	144,243	144,243	50,156
29	Total Current Liabilities	$ 23,520,996	$ 24,540,259	$ 19,400,726
30	Long Term Debt, net current portion	$ 40,981,189	$ 40,544,239	$ 37,530,602
31	Fund Balances:			
32	Unrestricted	$ 12,080,095	$ 12,423,959	$ 8,242,727
33	Restricted	1,348,431	1,293,612	4,353,922
34	Total Fund Balances	$ 13,428,526	$ 13,717,571	$ 12,596,649
35	Total Liabilities & Fund Balances	$ 77,930,711	$ 78,802,068	$ 69,527,977

8.

ADMINISTRATIVE REPORT OCTOBER 2014

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

To: **Sonoma Valley Healthcare District Board of Directors**
From: **Kelly Mather**
Date: **10/29/14**
Subject: **Administrative Report**

Summary
Operating revenue is close to budget for the first three months of the year, but we had a poor payer mix in September that resulted in $314,872 less than budget for a monthly loss of $327,165. The expenses continue to be reduced in order to be below revenue. The FY 2015 budget is very challenging, but we have a few extra payments due this year which should help us meet our goal.

Organizational Results
As demonstrated by the September dashboard, we are experiencing a minor setback at inpatient satisfaction. The nursing leadership turnover has resulted in lower satisfaction scores than in the past. Our new leadership is re-training and working to ensure the staff will continue to be accountable and meet service expectations. Emergency satisfaction continues to exceed goal and the department continues to experience 10 – 20% higher volumes than in the past. We also had 21 births in September, which is the highest number we've experienced in years. Inpatient discharges were at an all time low in September at 87 and this led to a much lower census in Skilled Nursing. We continue to increase outpatient volumes and revenue in most areas and it is helping to offset this national trend of reduced inpatient volumes. We are on track to meet our community hours goals with the bi-national health fair and other community outreach activities.

Quality
The Skilled Nursing Facility and Home Care both were surveyed in October and passed with flying colors. Lisa, the germ zapping robot, is now on site and being used in our patient rooms and surgery. We will also use it in Emergency and other areas as needed. This technology further enhances the safety for our patients by reducing the chances of the spread of infectious disease. The physicians are now completing their satisfaction surveys and we should have the results in November.

Strategic Update
Our new CFO and Chief Revenue Officer are working with the health plans to bring our payments closer to the market rate. We are also determining if we can take capitation with several plans. SCAN (a Medicare Advantage plan) marketing campaigns has begun with several meetings and events around the community and at the hospital. We continue to work with our physicians on their referral patterns and are encouraging them to "keep Sonoma patients in Sonoma." We have a tool that shows us where our physicians are sending their patients and it has been enlightening. In reviewing our first quarter strategic plan goals for FY 2015, we have accomplished the following: Orthopedics marketing; Cost Accounting system; SNF marketing for outside referrals; increased Wound Care, Rehab and Occ Health volumes through marketing; inspiring employer choice in health plans; culture of health; enhanced Girl Talk and Compass education and health improvement through Health Round Table initiatives. We are working on the ancillary service volume increases, Employer Wellness, 3rd floor Cancer Healing and Disease Reversal programs and refurbishment of the 1st floor lobby, lab and corridors.

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

SEPTEMBER DASHBOARD

PILLAR	PERFORMANCE GOAL	METRIC	ACTUAL RESULT	GOAL LEVEL
Service Excellence	Highly satisfied Inpatients	Maintain at least 5 out of 8 HCAHPS domain results above the 50th percentile	5 out of 8	>7 = 5 (stretch) >6 = 4 >5 = 3 (Goal) >4 = 2 <3=1
Service Excellence	Highly satisfied Emergency Patients	Maintain a year to date average of at least 75th percentile	79th (rolling three month average)	>85th = 5 (stretch) >80th=4 >75th =3 (Goal) <75th = 2 <70th= 1
Quality	Excellent Clinical Outcomes	Value Based Purchasing Clinical Score at 68 or higher	70	72 = 5 (stretch) 70 =4 68 =3 (Goal) 66=2 <66 = 1
People	Highly Engaged and Satisfied Staff	Press Ganey percentile ranking of 75th percentile or higher	2013 76% mean score at 77th percentile	>80th = 5 (stretch) >77th=4 >75th=3 (Goal) >72nd=2 <70th =1
Finance	Financial Viability	YTD EBIDA	4.9%	>10% (stretch) >9%=4 >8% (Goal) <7%=2 <6%=1
	Efficiency and Financial Management	FY 2014 Budgeted Expenses	$13,864,996 (actual) $13,217,603 (budget)	<2% =5 (stretch) <1% = 4 <Budget=3 (Goal) >1% =2 >2% = 1
Growth	Surgical Cases	Increase surgeries by 2% over prior year	390 YTD FY2015 386 YTD FY 2014	>2% (stretch) >1%=4 >0% (Goal) <0%=2 <1%=1
	Outpatient & Emergency Volumes	2% increase (gross outpatient revenue over prior year)	$31.740 mm YTD $29.472 mm prior year	
Community	Community Benefit Hours	Hours of time spent on community benefit activities for the	455 hours for 3 months	>1500 = 5 >1200 = 4 >1000 = 3 >750 = 2 <500 = 1

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

FY 2014 TRENDED RESULTS

MEASUREMENT	Goal FY 2015	Jul 2014	Aug 2014	Sep 2014	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014
Inpatient Satisfaction	5/8	5	6	4									
Emergency Satisfaction	>75th	79	79	80	86.9	88.6	89.7	89.5	89.7	88.9	89.1	89.9	90.1
Value Based Purchasing Score	>68	68	71	70									
Staff Satisfaction	>75th	76	76	76	77	77	77	77	76	76	76	76	76
FY YTD Turnover	<10%	1.6	1.9	2.6									
YTD EBIDA	>8%	7	7	4.9	6	6	6	5	5	6	9	4	3
Net Revenues	>4.1m	4.26	4.6	3.8	4.5	3.9	4.1	3.75	3.46	5.54	3.9	3.9	4.9
Expense Management	<4.5m	4.6	4.7	4.4	5.0	4.3	4.4	4.55	4.27	5.0	4.4	4.4	4.8
Net Income	>75	-8	35	-381	990	-57	412	13	-12	401	-360	**-240**	567
Days Cash on Hand	>15	14	12	14	7	11	7	7	6	11	17	8	7
A/R Days	<50	47	45	48	48	50	52	51	47	51	55	46	48
Total FTE's	<301	309	305	303	312	313	315	310	301	318	320	309	303
FTEs/AOB	<4.0	3.92	3.77	3.49	4.12	4.39	4.39	4.39	4.4	3.81	3.86	3.89	3.74
Inpatient Discharges	>100	105	104	87	91	85	112	91	79	117	94	100	91
Outpatient Revenue	>$10m	10.8	10.4	11.1	10.2	9.3	8.8	9.1	8.6	9.99	9.91	10.2	10.1
Surgeries	>130	135	133	122	135	135	138	113	121	156	147	142	121
Home Health	>1000	1146	1109	1111	941	903	951	1040	872	1106	1218	1135	992
Births	>15	16	9	21	9	14	11	6	14	19	6	16	11
SNF days	>660	651	687	597	606	531	733	754	641	750	674	605	613
MRI	>120	132	139	143	125	111	83	103	108	122	103	118	124
Cardiology (Echos)	>70	49	53	62	76	61	50	45	50	55	62	61	57
Laboratory	>12.5	12.6	12.8	13.0	13.9	11.9	12.5	13.1	11.1	13.3	12.4	13.1	13.9
Radiology	>850	968	988	900	801	819	877	963	837	851	868	918	888
Rehab	>2587	3030	2859	2468	2471	2572	2899	2485	2403	2903	3394	2877	2945
CT	>300	376	345	323	277	295	285	332	295	334	301	332	335
ER	>800	889	868	851	801	665	751	811	655	769	788	**909**	716
Mammography	>475	414	417	433	677	569	489	430	445	447	404	519	429
Ultrasound	>325	348	361	367	342	341	307	290	350	438	424	497	339
Occupational Health	>575	656	678	758	521	642	535	579	504	534	595	600	618

9.

SVH FOUNDATION ANNUAL APPEAL

SONOMA VALLEY HOSPITAL FOUNDATION

XX XX, 2014

ADDRESSEE
ADDRESS
CITY, STATE ZIP

Dear SALUTATION,

Thank you for your support of the Sonoma Valley Hospital Foundation and our recent capital campaign. Because of your generosity, the campaign raised more than $11 million for emergency and surgical services, which have a significant, daily impact in the lives of the community. We owe you a debt of gratitude for the part you played.

We are writing to share that we aren't resting and we need your ongoing support. In 2014, the Hospital Foundation wants to support the Hospital in continuing to provide the highest level of care with improved support for patients and up-to-date equipment.

Before coming to you now, to make for the largest impact, we did important groundwork. We reached out to five families in our community and created a matching fund for our annual campaign. Leslie and Mac McQuown, Bill Jasper, Nancy and Tony Lilly, Marcia and Gary Nelson, and David Donnelley have collectively put forward $150,000 toward this annual campaign. We sincerely appreciate their endorsement and we hope you will join us in this effort to raise $300,000 or more toward important funding needs.

It is a time of opportunity for us to continue to sustain, and even exceed, in providing an even higher quality of care at the Hospital.

We are always grateful for your unrestricted contributions, which give us the flexibility to ensure uninterrupted excellence in the quality of *all* our programs and services. There will also always be specific current priorities to which you can designate your funds, if you so choose. These are the areas we are working on funding currently:

- **Cancer Care Program.** Getting a diagnosis of cancer is only the start of a difficult journey for most. Maintaining physical and emotional strength and health during cancer treatment is incredibly difficult. Patients need the support of family, friends and community. They need attention and care. To respond, the Hospital is creating a Cancer Care Program that will provide care, touch and community to get through this difficult time. Patients will receive massage, acupuncture, and other complementary therapies known to lessen symptoms of the disease and the side effects of treatment. The cost of services will be billed on a sliding scale; external grants and all other sources of funding to support this program will be added to your support.

- **State-of-the-art Imaging Equipment.** There is no disagreement that an early diagnosis has an incredible impact on the ability to survive and/or reverse a medical issue or disease. Imaging equipment is the diagnostic lifeblood of any hospital. The Hospital has a need for upgraded ultrasound and fluoroscopy equipment – every dollar we raise toward their cost allows for this very important equipment to be available to our community.

  Ultrasound images are used to detect cancer, blood clots that could lead to stroke, indications of heart disease, and issues in pregnancy, including birth defects and other significant issues.

  Fluoroscopy is critical to patients and the physicians who care for them – because it provides real-time, moving images of a patient's internal structures. This equipment is instrumental in helping patients who have suffered from stroke, to test their ability to eat and drink and to reduce aspiration risk. Additionally, this equipment is used to diagnose infections, tumors and arthritis in joints and the spine. Again, it is truly life-saving equipment.

Medical equipment is expensive – every dollar you donate during our campaign will be matched up to $150,000. The Foundation will also seek out all available opportunities for grant funding for capital equipment to be added to our community donations of support.

We would greatly appreciate your help and support. The Cancer Care Program and State-of-the-art Imaging Equipment are just two examples of the Hospital's priorities for the coming year. We know that our efforts will touch the lives of many – by providing care through a difficult time or helping provide an important diagnosis that allows for early treatment. Whether you designate your gift or make an unrestricted gift, you will enjoy the tax benefits of supporting our not-for-profit community hospital.

From this point forward, the importance of your *ongoing* support cannot be overstated. Your generosity is what really makes a difference. We have already seen this with the success of the campaign. Thanks to you and others like you, the new Emergency Department and Surgery Center are providing life-saving care here.

You and other campaign donors have given every indication that you place a high value on this community institution. Now we hope you will continue your support with your year-end gift to sustain the quality of patient care *throughout the Hospital*. We remain grateful for all your past generosity and your continued support.

With appreciation,

Selma Blanusa
Executive Director

David Good
Foundation Board Chair

P.S. If you have any questions about the Sonoma Valley Hospital Foundation or our work, please contact Selma at sblanusa@svh.com or 935-5070.

10.

OFFICER AND COMMITTEE REPORTS

The American Hospital Association's
CENTER FOR HEALTHCARE GOVERNANCE™

National Symposium on Leading and Governing Healthcare Organizations

February 22-25, 2015 | Arizona Biltmore, Phoenix, AZ

Agents of Change: Governing and Leading Transformation

Register by December 12th for the greatest savings with Early Bird tuition.

Plan a Retreat for Your Board during the Symposium

The Symposium offers an excellent opportunity for your board to meet in a retreat setting with select Symposium faculty. Opportunities are limited—call now to learn more.

Optional Pre-Symposium Workshop

Sunday, February 22nd

The Leadership Toolkit for Redefining the "H": Engaging Trustees and Communities

For more information, please contact the Center at (888) 540-6111 or visit the Center's Web site at www.americangovernance.com.

Who Should Attend

The Symposium is designed for governing boards, CEOs and senior executives, physicians and other clinicians with leadership and governance responsibilities, staff members who coordinate and support governing board activities, and executives in health care related industries.

Learning Objectives

Participants will:

- Expand their awareness of the changing context of health care and efforts to transform the delivery system through analyses of emerging trends in physician/hospital affiliations, population health management, patient engagement, and new payment and performance measurement models.
- Understand how heightened demands for improved quality, new partnerships, and enhanced efficiency and effectiveness are changing the board's role and oversight responsibilities.
- Gain insights into the innovative governance practices and critical leadership competencies that will move the board from good governance to excellent governance.

Plan a Retreat for Your Leadership Team

The Symposium offers an excellent opportunity for your board to meet in a customized retreat setting with select Symposium faculty. Debrief on what you've learned during the program and explore how it applies to your organization, or address a specific board issue that you're facing. Contact us at (888) 540-6111 for more information and to schedule your event. Retreat opportunities are limited, so please act quickly.

The Center for Healthcare Governance presents its winter Symposium on leading and governing health care organizations. In this three-day program, trustees and executive leadership will gain insights into the trends that are transforming the delivery system and learn strategies and tools for navigating an increasingly complex environment.

In plenary sessions, industry experts will offer analyses of the contextual issues framing the health care environment—from the strategic questions central to transformation of the delivery system and managing the health of a population, to the efforts of leaders to provide safe, equitable patient-centered care, and critical imperatives for payment system reform and clinical integration. In small group interactive sessions, we'll focus on innovative approaches for honing governance decision making and engagement, and explore emerging responsibilities for boards to oversee physician compensation and leverage affiliations for improved performance.

Consider arriving early to enjoy all that Phoenix has to offer and register for the pre-conference workshop on Sunday, February 22nd. In this new session, participants will learn how to redefine the hospital of the future through strong governance structures and practices, and community engagement. You'll get more out of your Symposium experience with the in-depth education that the workshop offers. Separate pre-registration is required.

Ample time will be provided for sharing, asking questions and seeking guidance from our top governance experts and your peers. By attending the Symposium, the leaders of your organization will acquire the new knowledge and skills to manage the complexities of health care transformation. You will learn to ask the tough questions, gain valuable insights on how to get the most from your leadership teams, and build new levels of commitment.

Sunday, February 22nd

12:00 – 5:00 pm
Registration Open

2:00 – 4:00 pm
OPTIONAL PRE-SYMPOSIUM WORKSHOP
(Separate registration required)

The Leadership Toolkit for Redefining the "H": Engaging Trustees and Communities

The blue and white hospital "H" carries the promise of help, hope and healing. While the hospital of the future will continue to extend that promise, it may do so in significantly new ways. Indeed, hospitals today are intently focused on redefining the "H," exploring what it means to be a hospital in a rapidly transforming health care world. As hospitals consider redefining themselves, it will be crucial that they have educated and engaged leaders at the governance level who can help the health care organization navigate new payment models, delivery system reforms and new community health challenges. It is equally important that these significant changes are planned for, not only within the hospital, but with strong input and engagement from the local community. This practical session will focus on the AHA's January 2015 leadership toolkit report on how to redefine the hospital of the future through strong governance structures and practices, and community engagement.

Monday, February 23rd

7:00 am – 4:00 pm
Registration Open

7:00 – 8:00 am
Continental Breakfast

8:00 – 8:15 am
Opening Remarks

John R. Combes, MD, *President and COO, Center for Healthcare Governance and SVP, American Hospital Association, Chicago, IL*

8:15 – 9:30 am
GENERAL SESSION
Governance, Leadership and Creative Destruction

James E. Orlikoff, *President, Orlikoff & Associates, Inc., and Senior Consultant, Center for Healthcare Governance, Chicago, IL*

Hospitals and health systems are the most complex businesses in human history—and that was before we faced imperatives for population health, clinical integration, and doing better with less. Disruptive innovation typically is driven by forces external to an organization but we are being asked to disrupt our own business model; to simultaneously destroy it while we create and implement another model. This is a daunting task and we cannot do it and lead our organizations successfully into the future with the same models and mentalities of governance that we use to govern our local churches and Boy Scout organizations. This presentation will outline the forces gathering to destroy our traditional business models and describe how governance and leadership must become agents of disruptive innovation in their own organizations—becoming the grain of sand that irritates the oyster causing it to produce a pearl.

9:30 – 9:45 am
Refreshment Break

9:45 – 11:00 am
GENERAL SESSION
How Trends Shape Organizations

David Nygren, PhD, *Founder, Nygren Consulting, LLC, Santa Barbara, CA*

The velocity of change to our care delivery systems, payment reforms, and physician engagement requires re-conceptualizing what we are governing and who is governing. This session will explore how we govern beyond the acute hospital as we enter broad networks. We will see the shift of information, metrics, board competencies and outcomes as we begin to govern population health.

11:00 – 11:15 am
Refreshment Break

11:15 am – 12:30 pm
GENERAL SESSION
Physician Governance in Quality, Safety and Supply Chain

D. Keith Fernandez, MD, FACG, *President and Physician in Chief, MHMD and Chief Medical Officer, Memorial Hermann ACO, Houston, TX*

The Memorial Hermann Health System and the Memorial Hermann Physician Network (with 2000 physician members, only 150 who are employed) provide governance of quality and safety in the health system using the Clinical Programs Committee and its 25 specialty and subspecialty groups and 15 task oriented subcommittees, made up of over 400 of the IPA network physicians. Learn how the direct relationship between this Committee and the Board of Memorial Hermann system has led to remarkable uniformity in quality and safety in each of the system's nine acute care hospitals.

12:30 – 1:30 pm
Lunch

...gain insights into the trends that are transforming the delivery system...

1:30 – 2:45 pm

STRATEGY SESSIONS

1 A New Model for Transforming and Engaging Board Meetings

Luanne Stout, MHA, *VP/ Chief Governance Officer, Texas Health Resources, Arlington, TX*

As health systems and hospitals face new models of health care delivery, population health, and coordinating care along the continuum, most current board meeting structures will not serve us well in the future. This very practical session presents a new model that will transform board meetings into engaging, highly effective events focused on prospective discussions on topics that advance the organization, rather than the retrospectively focused model most boards utilize today.

2 How Does Your Board Stack Up? The State of Governance with Insights from the 2014 National Governance Survey

John R. Combes, MD, *President and COO, Center for Healthcare Governance and SVP, American Hospital Association, Chicago, IL and* ***Debra Stock,*** *Vice President, American Hospital Association, Chicago, IL*

In the fall of 2014, the AHA's Center for Healthcare Governance will release the results of the 2014 National Governance Survey, the most comprehensive, state-of-the-art picture of hospital and health system governance in the United States. The survey, which was sent to all community hospital CEOs and Board Chairs, represents over 1,800 respondents. Participate in this session to learn how your board and governance practices compare to those of your peers in such critical areas as board member selection, assessment, competencies, and culture, and discuss the implications of the data for board performance in the evolving health care environment. Bring your toughest governance issues for discussion and deliberation. This session will be very interactive, so come prepared to talk, to question assumptions and offer your own thoughts.

3 From Volume to Value: Toward the Second Curve by Way of a Network Affiliation that Preserves Independence

Todd Linden, *President & CEO, Grinnell Regional Medical Center, Grinnell, IA*

As the transformation of the nation's health system begins to take shape, the focus on greater accountability for patient outcomes, patient experience, cost of care, and population health may present a particular challenge for independent hospitals. Learn how Grinnell Regional Medical Center working through its affiliation with Mercy Health Network and the University of Iowa Health Alliance established a Clinically Integrated Network for moving to population health. With the CIN focused on the care locally and in a structure that will allow connection into the larger statewide system, the strategy is to ease into value-based care over the next 12-24 months. With a manageable number of clinical professionals in a smaller market area, GRMC can work directly with its providers to determine what they need to improve outcomes and make more effective decisions about the care being provided to at-risk patients.

4 Physician Compensation Oversight: How Boards Create Effective Governance Systems to Improve Alignment and Reduce Risks

Marc Hallee*, Consulting Principal, Sullivan, Cotter and Associates, Inc., Houston, TX and* ***Erin Flanigan,*** *Vice President of Human Resources, Wentworth-Douglass Hospital, Dover, NH*

Hospital and health system board members understand the complexities associated with governing physician compensation arrangements and alignment strategies. When new entities are formed or acquired, the need to have a process that clearly defines the roles and responsibilities of the governing bodies increases, as do the risk of oversight issues and compliance failures. This session will address regulatory and compliance challenges associated with the governance of physician compensation. Participants will learn how to formulate their organization's approach and examine case studies that demonstrate how leading organizations address physician compensation requirements and challenges. The presenters will also share actionable steps board members can use to outline oversight strategies that manage risk at various levels in the process and build relationships needed to achieve goals.

2:45 – 3:00 pm

Refreshment Break

3:00 – 4:15 pm

STRATEGY SESSIONS REPEATED

5:00 – 6:30 pm

Networking Reception

Support for the reception is generously provided by

KORN FERRY

Tuesday, February 24th

6:45 – 8:00 am

Continental Breakfast

7:00 – 8:00 am

Special Breakfast Session for Center for Healthcare Governance Member CEOs/Chairs

8:00 – 8:15 am

Opening Remarks

John R. Combes, MD, *President and COO, Center for Healthcare Governance and SVP, American Hospital Association, Chicago, IL*

8:15 – 9:30 am

GENERAL SESSION
2015: The View from Washington, D.C.

Rick Pollack*, Executive Vice President for Advocacy and Public Policy, American Hospital Association, Washington, DC*

Mr. Pollack will provide an update on the latest federal activity and the

potential effect on America's hospitals and health systems. He will discuss the latest events as Congress and the Administration contend with deficit reduction, the debt ceiling, ACA implementation and other critical health care issues.

9:30 – 9:45 am
Refreshment Break

9:45 – 11:00 am
STRATEGY SESSIONS

1 Creative Affiliations for Success in the New Era: Disruption Is the New Normal


Patrick Allen, *Senior Vice President, Kaufman, Hall & Associates, Inc., Skokie, IL and* ***John Poziemski,*** *Vice President, Kaufman, Hall & Associates, Inc., El Segundo, CA*

Rapid changes under way for the nation's health care system are driving many hospitals and health systems to actively explore partnership discussions with providers, payers and/or other key stakeholders. These arrangements are disrupting, and in some instances converging traditional boundaries in markets nationwide. This session will provide insights into how organizations are using partnerships, acquisitions, and other affiliations to strengthen their market position in preparation for value-based care delivery and payment. The presenters will offer practical strategies to help hospitals and health systems assess their current strengths and weaknesses within their market, and determine whether a partnership with a payer or other stakeholder, including employers might be beneficial. You will gain a foundational understanding of the different types of affiliations that are emerging, and insights into the key questions to ask in evaluating potential partners and partnership types.

...learn strategies and tools for navigating an increasingly complex environment.

2 Your Obligation to Eliminating Patient Harm


Maulik S. Joshi, DrPH, *President, HRET / SVP, American Hospital Association, Chicago, IL and* ***Todd Linden,*** *President & CEO, Grinnell Regional Medical Center, Grinnell, IA*

Fiduciary role number one for all trustees is ensuring that your patients receive the highest quality and safest care. Although there are many ways to measure quality and safety, a bottom line patient safety number is elusive in health care. However, by looking at a total patient harm rate in your health system, you can begin to focus on an overall safety outcome and strategies. In this session, the presenters will strategically and practically help you develop and use a total patient harm rate for your hospital. Attendees will learn how to use a patient harm rate measure in the boardroom and the strategic discussion the trustees must have to strive to get the patient harm rate to zero.

3 Futurescan: Healthcare Trends and Implications for 2015–2020

Deborah Bowen, FACHE, *President, American College of Healthcare Executives, Chicago, IL*

This annual review of selected health care trends will help you plan for the future. Developed by a panel of experts, Futurescan highlights key trend areas that are impacting the nation's health care organizations: health care reform, transparency, provider structure, volume to value, innovations in primary care, private insurance exchanges, advance care plans, and innovations in iMED.

4 Surviving and Thriving in the New Commercial Environment

Sam Glick, *Principal, Health and Life Sciences, Oliver Wyman, San Francisco, CA*

By 2018, one in three patients who walk through a hospital's doors will be covered under a different insurance product than they are today, which they will have purchased through a channel that didn't exist three years ago. These patients will have higher deductibles, higher copays, more cost and quality information, and higher expectations for the experience that their health system provides than ever before. They will also have more options than ever for where to receive care, from retailers to mobile apps to medical tourism providers around the globe. Attracting commercial patients is key to the long-term viability of any health system—and the changes happening in the commercial market require whole new ways of engaging with customers. This session will help you understand the new expectations of payers, employers, and consumers, and what your health system can do to survive and thrive in the new commercial environment.

11:00 – 11:15 am
Refreshment Break

11:15 am – 12:30 pm
STRATEGY SESSIONS REPEATED

12:45 – 2:00 pm
Lunch with Interactive Governance Clinic

Grab lunch and join an open discussion around best practices in health care governance. Jamie Orlikoff will offer participants practical solutions and proactive ideas for solving your governance problems. This session will be very interactive, so come prepared to talk, and to challenge and be challenged!

2:00 – 3:15 pm
GENERAL SESSION
Evidence-Based Health Care Leadership

David H. Newman, MD, *Director of Clinical Research, Department of Emergency Medicine, Mt. Sinai School of Medicine, New York, NY*

Dr. Newman has become a leading voice calling for reforms in health care—in the ways we deliver care and in the 'system' through which care is delivered. He offers bold ideas on how to restore access, quality and efficiency as sovereign forces. He questions 'holding down costs' as the primary objective in reform and urges a much deeper respect for good science in a field that claims to be based in science. In this session Dr. Newman will address

The Center for Healthcare Governance recognizes its affiliate members and thanks them for their continued support.

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About the American Hospital Association's Center for Healthcare Governance

The Center for Healthcare Governance is a community of board members, executives and thought leaders dedicated to advancing excellence, innovation and accountability in health care governance. The Center offers new and seasoned board members, executive staff and clinical leaders a host of resources designed to progressively build knowledge, skills and competencies tailored to specific leadership roles, environments and needs.

how health systems can partner with communities by building trust and applying evidence. It is a message about the partnership between science and society, patient and doctor, health system and community. When these intertwined relationships are built on trust and honesty, satisfaction goes up, utilization goes down, and efficiency improves. Outcomes get better while costs are reduced—everyone wins.

Wednesday, February 25th

7:00 – 8:00 am
Continental Breakfast

8:00 – 9:15 am
GENERAL SESSION
Coming Together as One: The Baylor Scott & White Story

Joel Allison, *CEO, Baylor Scott & White Health, Dallas, TX*

This session will explore the story of two organizations coming together to create an integrated delivery network focused on population health management. Mr. Allison will describe the development of a clinically integrated model for transforming how health care is delivered.

9:15 – 9:30 am
Break

9:30 – 11:00 am
GENERAL SESSION
Having Enough Dots to Connect: Broadening Health Care's Perspective and Potential

Laura Adams, RN, *President & CEO, Rhode Island Quality Institute, Providence, RI*

Few would dispute that the U.S. health care system is not performing up to its potential. The problems are highly complex and no one entity acting alone can solve them. As we transition to new payment models, the greatest opportunity to deliver on the promise may lie not in "engaging patients" with us, but engaging in the lives of our patients. This presentation will address the need to create a health care system guided by a new definition of health, new ways to tell the truth about our performance, and the recognition that the patient/consumer is already in control of their health. When these principles guide design, we can create a health care system worthy of the trust of those who depend on it literally for their lives.

11:00 am
Adjourn

GOVERNANCE ASSESSMENT PROCESS™

Schedule a GAP (Governance Assessment Process) Now

The Governance Assessment Process is a comprehensive system used to assess the overall performance of health care organization boards. Through a variety of detailed surveys, GAP will reveal an organization's strengths and weaknesses, and help a board to thoroughly assess how well it is meeting its obligations and fulfilling its responsibilities. GAP also evaluates the quality of the board's structure, composition and infrastructure. Once completed your board will be able to develop a targeted action plan for improving its performance and establish a baseline for tracking changes in performance over time.

Designed for boards that are serious about continuous improvement, GAP is a Center member benefit that is also available to non-members as a standalone service. Contact us at (888) 540-6111 to schedule your GAP.

National Symposium on Leading and Governing Healthcare Organizations

February 22-25, 2015
Arizona Biltmore, Phoenix, AZ

How to Register

Online www.americangovernance.com/registration

Mail Center for Healthcare Governance
75 Remittance Drive, Suite 1976
Chicago, IL 60675-1976

For Information

(312) 422-3276
Tracey Johnson-Wilson
tjohnson@aha.org

Name _____ Credentials (MD, DO, etc.) _____

Nickname to appear on badge _____

Title _____

Organization Name _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Attendee's Email _____

Please select the appropriate Registration Type:

	Early Bird Rate *by December 12th*	**Regular Rate** *after December 12th*
Center for Healthcare Governance Member Rate: Contact us at *tjohnson@aha.org* if you are unsure as to whether your organization is a member of the Center. Please note that Center membership is separate from membership in the American Hospital Association.	☐ $1,200	☐ $1,300
Enter your Center for Healthcare Governance Membership Number to qualify for this rate: ☐☐☐		
CHG Educational Credits: Select this type if you would like to apply Center member educational credits to attend the symposium. If you are unsure as to the availability of your credits, email *tjohnson@aha.org*.	☐ Complimentary	☐ Complimentary
Enter your Center for Healthcare Governance Membership Number to qualify for this rate: ☐☐☐		
Non-Member Rate: For organizations that are not a member of the Center for Healthcare Governance.	☐ $1,500	☐ $1,600
Board Planner Complimentary Rate: For organizations sending **5 or more paid attendees**, the tuition fee is waived for one staff member who is responsible for coordinating governance activities. CEOs and trustees are not eligible for this offer. All registrations must be submitted at the same time.	☐ Complimentary	☐ Complimentary
Pre-Symposium Workshop Option, February 22nd *The Leadership Toolkit for Redefining the "H": Engaging Trustees and Communities*	☐ $200	☐ $250

Total Symposium Fees _____

Payment Methods (registration form must accompany payment)

Check or Money Order: Payable to Center for Healthcare Governance, please mail check or money order with this form to the address above.

Credit Card: To pay with a credit card, please submit the registration online at www.americangovernance.com/registration.

Center Member Educational Credits: Please visit online registration at www.americangovernance.com/registration.

Arizona Biltmore

Known throughout the world as the "Jewel of the Desert," the Arizona Biltmore provides a restful oasis of 39 acres covered with lush gardens, glistening swimming pools, and Frank Lloyd Wright-influenced architecture. Considered one of the most spectacular resorts in the world, the Biltmore features eight swimming pools, seven tennis courts, an 18-hole putting course, and a full-service European spa, salon, and fitness center. The adjacent Arizona Biltmore Country Club offers two 18-hole PGA golf courses, The Links and The Adobe.

Arizona Biltmore
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www.arizonabiltmore.com

To secure the special room rate of $279 plus tax, single or double occupancy plus a $14 per day resort fee (to cover high-speed Internet access, unlimited local calls, long distance access, spa and fitness center admittance, Fashion Park shuttle, morning newspaper, and use of the putting course), reserve your room by **February 1, 2015.** When calling please reference either the group code "CHG15" or "Center for Healthcare Governance." You may also reserve rooms via the resort's website. Simply enter the code CHG15 under the Group Code section of the reservations screen.

We strongly encourage you to call early to reserve your room, as the hotel is likely to sell out well before the cut-off date. Once the block is sold out, space and rate availability are at the hotel's discretion.

Travel Discounts

Airline Discounts: Special discounts are available for Symposium attendees on United and Delta airlines.

- **United Airlines:** Call (800) 426-1122 or www.united.com
  Online reservations offer code: **ZTDP367575**
  Phone reservations meeting codes: Z Code **ZTDP**
  & Agreement Code: **367575**
- **Delta Airlines:** (800) 328-1111 or www.delta.com
  (click on Advanced Search to enter the Meeting code).
  Meeting code: NMK5Z

Rental Car: Special rates from Hertz are available. Call (800) 654-2240 and provide the meeting number CV#03AB0011.

Continuing Education Credit

The Center for Healthcare Governance is authorized to award 15.75 hours of pre-approved ACHE Qualified Education credit (non-ACHE) for this program toward advancement or recertification in the American College of Healthcare Executives. Participants in this program wishing to have the continuing education hours applied toward ACHE Qualified Education credit should indicate their attendance when submitting application to the American College of Healthcare Executives for advancement or recertification.

Scholarships

Partial tuition scholarships are available. Please email Laura Woodburn at lwoodburn@healthforum.com for more information on how to apply. The scholarship deadline is January 1st.

Symposium Cancellation

The cancellation deadline for this conference is January 30, 2015. If you cannot attend the conference, you can always send a substitute, even at the last minute. (Please notify us of any changes in advance so that we can have a badge prepared.) If you must cancel entirely, your request for a refund (less a $250 processing fee) must be received in writing no later than January 30, 2015. Cancellations made after that date are not eligible for a refund.

Special Accommodations

The Center for Healthcare Governance complies with the Americans with Disabilities Act and strives to ensure that no individual with a disability is deprived of the opportunity to participate in an educational program solely by reason of that disability. The Center will attempt to provide a reasonable accommodation for an attendee with disability who requests accommodation. Please contact lwoodburn@healthforum.com at least 21 days in advance of the program to specify your accommodation.

The American Hospital Association's
CENTER FOR HEALTHCARE GOVERNANCE™

"The Center provides an excellent forum for connecting with and sharing in the best practices for hospital trustees."

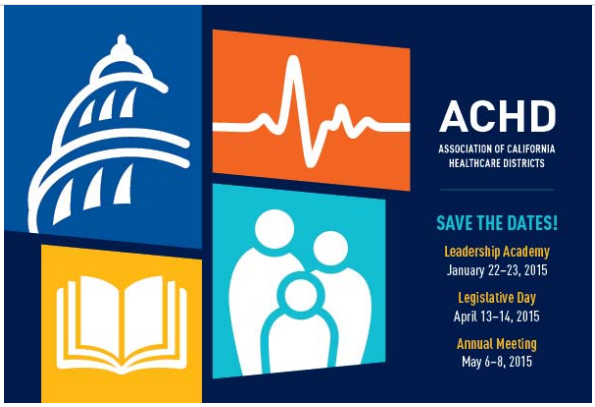
Jim Wilkins,
Vice Chair,
St. Joseph Hospital

The American Hospital Association's
CENTER FOR HEALTHCARE GOVERNANCE™

National Symposium on Leading and Governing Healthcare Organizations

February 22-25, 2015 | Arizona Biltmore, Phoenix, AZ

Agents of Change: Governing and Leading Transformation



Save the Dates!

Leadership Academy

When: January 22-23, 2015

Where: Hyatt Regency Sacramento, 1209 L Street, Sacramento, CA 95814

Event: Oriented towards Trustees and District Executives who are new to their roles, but open to all Trustees and Executives, this program will provide on overview of the key accountabilities associated with Healthcare District Governance.

Legislative Day

When: April 13-14, 2015

Where: Hyatt Regency Sacramento, 1209 L Street, Sacramento, CA 95814

Event: Learn about legislative issues that will impact your District in 2015, how ACHD is responding, and the important role that you can play in shaping public policy.

Annual Meeting

When: May 6-8, 2015

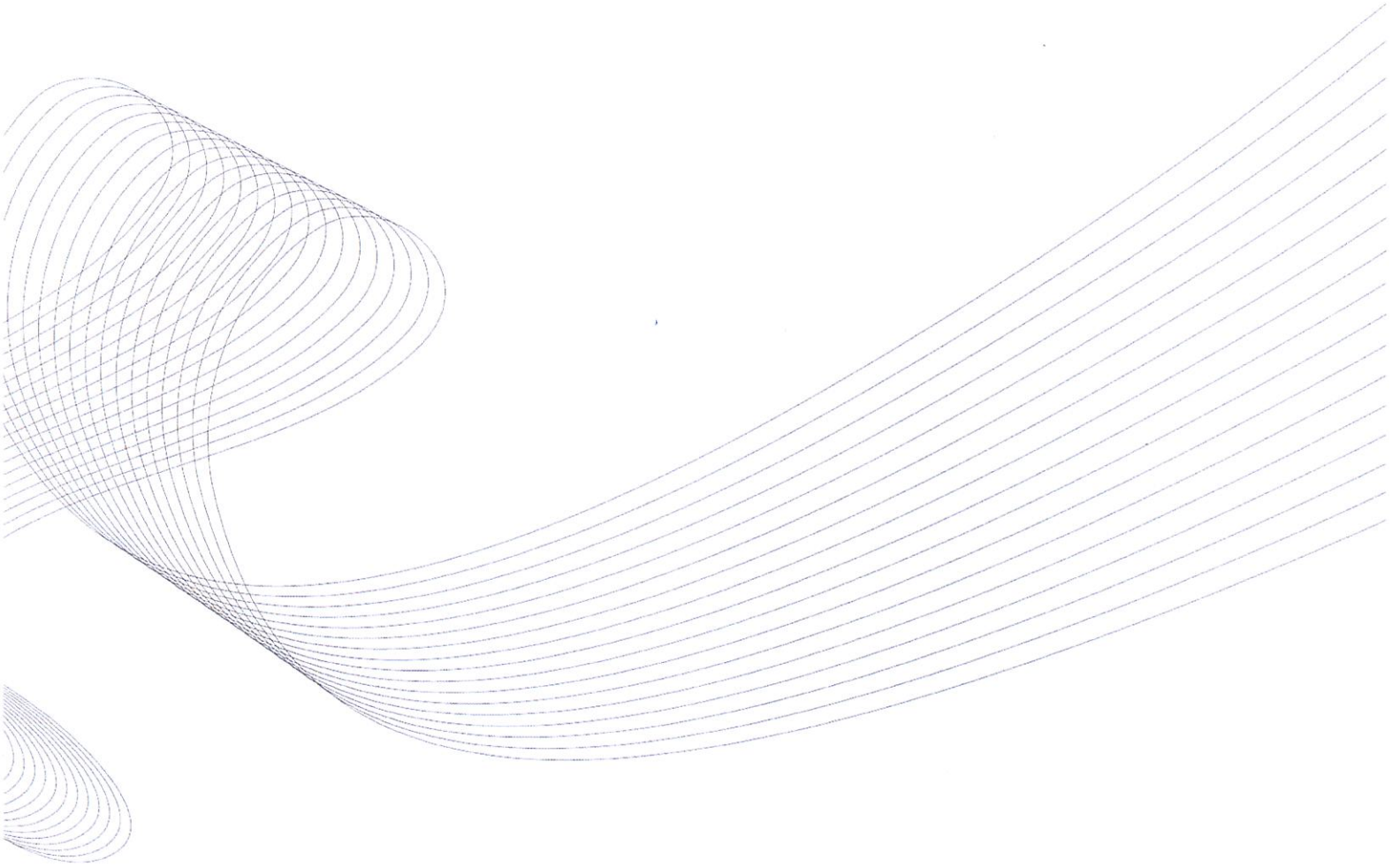
Where: Monterey Plaza Hotel and Spa, 400 Cannery Row Monterey, CA 93940

Event: The Annual Meeting is a great opportunity for Trustees and District Executives to learn about trends and issues of importance to Healthcare Districts.

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

Questions?

info@achd.org | 916.266.5216



Report of Independent Auditors and
Consolidated Financial Statements with
Supplementary Information

Sonoma Valley Health Care District

June 30, 2014 and 2013

MOSS-ADAMS LLP

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CONTENTS

Introduction – This management's discussion and analysis of the financial performance of Sonoma Valley Health Care District (the "District") provides an overview of the District's financial activities for the years ended June 30, 2014 and 2013. It should be read in conjunction with the accompanying consolidated financial statements and footnotes of the District.

Financial highlights

- The District's net position increased in 2014 by approximately $2,984,000 or 28% and increased in 2013 by approximately $1,959,000 or 22%.

- Cash, cash equivalents, and total investments decreased in 2014 by approximately $6,369,000 or 57% and decreased in 2013 by approximately $12,212,000 or 52%. This decrease was due to the use of the Series B General Obligation bond funds for the building of the new Emergency Room.

- Net patient accounts receivable increased in 2014 by approximately $361,000 or 6% and increased in 2013 by approximately $506,000 or 9%.

- The District reported operating losses in both 2014 ($4,036,000) and 2013 ($5,809,000). The operating loss in 2014 decreased by approximately $1,772,000 or 31% less than the operating loss reported in 2013. The decrease in the operating loss in 2014 was due to an increase in Net Patient Service Revenue. The increase in revenue was also due to an adjustment to bad debts for positive collections of old accounts receivable. The operating loss in 2013 was larger due to 2 material factors: 1) the Hospital received a large number of Recover Auditor Contractor ("RAC") audits which resulted in $1,109,000 of RAC take backs; 2) an exceptional amount of information systems training and non-capitalizable cost were incurred due to the Hospital implementing the electronic medical documentation systems, impact of $1,107,000; $757,000 for purchases services and $350,000 in salaries related to the Electronic Health Record. The 2012 operating loss included $1.2 million from the settlement of a 15 year old Medicare cost report Skilled Nursing Home appeal. There were no material positive prior year cost report settlements in 2013. The operating loss in 2013 increased by approximately $1,136,000 or 24% more than the operating loss reported in 2012.

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

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

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

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

The District's net position – The District's net position are the difference between its assets and liabilities reported in the balance sheet. The District's net position increased by $2,984,000 or 28% in 2014 over 2013 and increased by $1,959,000 or 22% in 2013 over 2012, as shown in Table 1.

The increases in net position in 2014 are largely the result of the Capital Campaign in that the District is working with the Sonoma Valley Hospital Foundation to raise funds for the building expansion.

In 2014, noncurrent investments decreased by $7,316,700 or 80% as compared to 2013. The reason for the decrease is the use of the General Obligation Bonds for renovating and retrofitting the District's existing hospital facility and to purchase equipment outlined in Note 6 to the consolidated financial statements.

In 2014, net patient accounts receivable increased by $361,000 or 6% compared to 2013. The reason for the increase was a slowdown in coding at year end due to the implementation of McKesson Intelligent Coding system. Estimated third-party payor settlements increased by $1,415,499 or 1261% compared to 2013. The reason for the increase is the recording of the Inter-Governmental Transfer of $824,000. During 2014, Napa State was paid quarterly, not yearly like in 2013, therefore the payable to Napa State in 2013 was $1,199,000, the payable is offsetting Other receivables. Property tax receivables, increased $777,000 or 16% from 2013, which is due to the increase in principal due on the General Obligation Bonds B.

Table 1: Assets, Liabilities, and Net Position

	2014	(As Restated) 2013	(As Restated) 2012
ASSETS			
Current assets			
Cash and cash equivalents	$ 2,849,986	$ 1,902,869	$ 926,083
Short-term investments	-	-	460,008
Patient accounts receivable, net of allowances for doubtful accounts of $965,414 and $1,471,799 in 2014 and 2013, respectively	6,793,990	6,433,401	5,927,300
Estimated third-party payor settlements	1,527,754	112,255	1,578,006
Property tax receivables	5,758,948	4,982,227	5,697,647
Other receivables	2,061,156	1,093,383	648,832
Pledge receivables, current	-	500,000	-
Supplies	771,028	805,424	872,171
Prepaid expenses	816,423	1,074,432	569,843
Total current assets	20,579,285	16,903,991	16,679,890
Noncurrent investments			
Board-designated funds	-	186,468	185,910
Restricted for capital acquisitions	220,748	3,474,239	16,978,806
Restricted for debt service	1,637,914	5,263,697	4,276,368
Principal of permanent endowments	-	-	36,839
Other long-term investments	23,756	274,738	449,562
	1,882,418	9,199,142	21,927,485
Capital assets, net of accumulated depreciation	56,350,250	42,476,327	25,216,306
Pledge receivables, long-term	-	1,500,000	-
Total assets	$ 78,811,953	$ 70,079,460	$ 63,823,681

LIABILITIES AND NET POSITION

Current liabilities			
Accounts payable and accrued expenses	$ 8,477,305	$ 10,400,356	$ 7,331,294
Accrued payroll and related liabilities	2,835,095	2,621,053	2,617,748
Deferred tax revenues	5,849,985	4,825,602	4,769,308
Current portion of bond payable	95,000	25,000	-
Current portion of capital lease obligations	1,697,107	832,760	832,323
Current portion of notes payable	124,814	38,795	738,924
Total current liabilities	19,079,306	18,743,566	16,289,597
Accrued workers' compensation liability	711,000	557,000	506,000
Line of credit	4,973,734	2,373,734	-
Bonds payable	35,437,000	35,282,223	35,292,111
Capital lease obligations, net of current portion	4,022,449	2,069,571	2,419,748
Notes payable, net of current portion	917,777	367,116	588,888
Total liabilities	65,141,266	59,393,210	55,096,344
Net Position			
Invested in capital assets, net of related debt	9,082,369	7,997,719	9,787,516
Restricted			
For debt service	1,637,914	1,263,697	276,368
Expendable for capital assets	3,757,072	3,858,727	2,043,087
Nonexpendable permanent endowments	-	-	36,839
Unrestricted (deficit)	(806,668)	(2,433,893)	(3,416,473)
Total net position	13,670,687	10,686,250	8,727,337
Total liabilities and net position	$ 78,811,953	$ 70,079,460	$ 63,823,681

In 2013, net patient accounts receivable increased by $506,000 or 9% compared to 2012. The reason for the increase was a slowdown in insurance payments on older patient accounts. Other receivables, property tax receivables, and pledge receivables increased $229,131 or 4% from 2012, which is due in part to a pledge receivable for the Capital Campaign. Estimated third-party payor settlements decreased $1,466,000 or 93%, which is due to a Medi-Cal 2012 settlement and the RAC reserve.

Operating results and changes in the District's net position – In 2014 the District's operating loss decreased by $1,772,400 or 31% from 2013. In 2013 the operating loss increased by $1,136,000 or 24% from 2012, as shown in Table 2 below:

Table 2: Operating results and changes in net position

	2014	(As Restated) 2013	(As Restated) 2012
Operating revenues			
Net patient service revenue, net of provision for bad debts of $1,458,255 and $2,901,255 in 2014 and 2013, respectively	$ 47,416,961	$ 43,247,566	$ 44,906,433
Capitation revenue	2,055,548	2,111,726	2,223,114
Other revenue	1,103,166	1,647,768	48,820
Total operating revenues	50,575,675	47,007,060	47,178,367
Operating expenses			
Salaries and wages	26,219,974	25,702,558	24,601,200
Purchased services	6,507,171	6,874,543	6,363,019
Supplies	5,889,441	6,119,299	6,277,110
Employee benefits	5,986,866	5,949,821	5,393,819
Medical fees	4,288,169	3,692,868	4,127,471
Other	2,191,737	1,180,790	2,042,418
Depreciation	2,339,876	2,132,706	1,970,238
Utilities	961,882	899,466	845,029
Insurance	226,650	243,608	230,967
Total operating expenses	54,611,766	52,795,659	51,851,271
Operating loss	(4,036,091)	(5,788,599)	(4,672,904)
Non operating revenues and (expenses)			
Property tax revenues	4,938,955	4,797,081	4,757,571
Investment income	32,714	32,614	32,190
Non capital grants and gifts	18,333	232,596	576,711
Interest expense	(1,088,851)	(721,567)	(736,084)
Bond issuance cost	(180,605)	-	-
Contribution to Prima Medical Foundation	(604,413)	(787,560)	(782,817)
Other	147,323	335,621	190,417
Total non operating revenues and (expenses)	3,263,456	3,888,785	4,037,988
(Deficit) excess of revenues over expenses before capital grants and contributions	(772,635)	(1,899,814)	(634,916)
Capital grants and contributions	3,757,072	3,858,727	2,043,087
Increase in net position	2,984,437	1,958,913	1,408,171
Cumulative effect of restatement	-	-	(241,990)
Total net position, beginning of year	10,686,250	8,727,337	7,561,156
Total net position, end of year	$ 13,670,687	$ 10,686,250	$ 8,727,337

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

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

	2014	2013	2012
Medicare	38.9%	40.6%	45.3%
Medicare HMO	4.6%	4.4%	0.5%
Medi-Cal	9.8%	6.7%	7.7%
Medi-Cal Managed Care	5.9%	5.4%	5.5%
Commercial Insurance	31.8%	31.4%	33.0%
Workers Compensation	3.2%	3.9%	3.2%
Capitated	1.6%	0.1%	0.1%
Self-pay - Other	4.2%	7.5%	4.7%
	100%	100%	100%

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

Operating losses – The first component of the overall change in the District's net position is its operating income or loss; generally, the difference between net patient services and other operating revenues and the expenses incurred to perform those services. In each of the past three years, the District has reported an operating loss. This is consistent with the District's recent operating history as the District was formed and operates primarily to serve residents of Sonoma Valley, regardless of their ability to pay. The District levies property taxes to provide sufficient resources to enable the facility to serve lower income and other residents. The decrease in the operating loss for 2014 was due to 2013 RAC audits and the cost of implementation of information technology during the fiscal year.

The operating loss for 2014 decreased by $1,772,400 or 31% as compared to 2013 and increased by $1,136,000 or 24% as compared to 2012. The major components of those changes in operating loss are:

- Total operating revenues increased by $3,569,000 or 8% in 2014. This is primarily due to the recording of the two IGT's during the year for $1,817,000 and the Medicare legal settlement of $488,000, and the reduction of the Bad Debt reserve of $572,000. In 2013 RAC audits for $1,109,000 reduced operating revenues. The increase in operating revenues in 2012 was primarily due to a Medicare settlement for $1,032,000.

- Salaries, wages, and benefits increased in 2014 by $517,400 or 2% due to an across the board salary increase of 3% in January 2014. Workers' compensation expense, a component of employee benefits, increased in 2014 as compared to 2013 due to increases in open claims and claim reserves required for payments made on outstanding claims. Salaries, wages, and benefits increased in 2013 by $1,101,000 or 4% due to an across the board salary increase of 3% in January 2013 and adjusting employees' salaries to market.

- Medical fees increased in 2014 by $595,300 or 16% compared to 2013 and decreased by $435,000 or 11% in 2013 compared to 2012. The increase in 2014 is due to the surgery call to Prima Medical Foundation. The decrease in 2013 is due to the elimination of the Certified Registered Nurse Anesthetists ("CRNA").

- Purchased services decreased in 2014 by $367,000 or 5% compared to 2013 and increased in 2013 by $512,000 or 8% compared to 2012. Decrease in 2014 is due to the cancellation of Sodexo contract in Plant Operations and Environmental Services of $214,000 and the decreased in Repair & Maintenance of $166,000 . Decreased use of outside consultants of $410,000 offset with an increase use of information technologies for $757,000, accounted for the increase in 2013.

- Depreciation expense increased in 2014 by $207,000 or 10% as compared to 2013 and increased $162,000 or 8% in 2013 as compared to 2012. During 2014 the new Emergency Room went into service.

- Other expenses increase in 2014 by $990,000 or 83% as compared to 2013 and decrease by $842,000 or 41% in 2013 compared to 2012. The increase in 2014 is due to the two Inter Governmental Transfers ("ITG"), for $645,000. And in 2014 there were more equipment leases by $121,000 than in 2013. The decrease in 2013 is due to the decrease in shared IT costs with Palm Drive Hospital of approximately $717,000.

Nonoperating revenues and expenses – Nonoperating revenues and expenses consist of property taxes levied by the District, investment income, interest expense and noncapital grants and gifts. Parcel taxes remained relatively unchanged in 2014 as compared to 2013. Tax assessments for the general obligation bonds increased by $133,000 over 2013. Interest expense increased by $367,000 or 51% in 2014. The increase in interest was due to our new building being completed in February 2014 and GO Bond interest was no longer being capitalized to the project. Investment income increased by $100 in 2014 and increased by $500 in 2013. Noncapital grants and gifts decreased by $214,000 in 2014 and decreased by $344,000 in 2013.

Capital grants and gifts – The District received gifts of $3,757,000 from a foundation and various individuals to purchase capital assets in 2014 and $3,859,000 in 2013, a decrease of $102,000 from 2014 to 2013 and an increase of $1,816,000, from 2013 and 2012, respectively.

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

Capital assets – At the end of 2014 and 2013, the District had $56,350,000 and $42,476,000, respectively, invested in capital assets, net of accumulated depreciation, as detailed in Note 6 to the consolidated financial statements. In 2014 and 2013, the District purchased new equipment and made capital improvements costing $16,200,000 and $19,452,000, respectively. The majority of the 2014 improvements and new equipment related to the preparation of a master plan, detailed planning, acquisition of equipment, and installation of the information systems wiring for the District's renovation project.

Debt – At June 30, 2014 and 2013, the District had $47,268,000 and $40,989,000, respectively, in bonds, equipment notes payable, and notes payable outstanding as detailed in Note 10 to the financial statements. In 2014, the District entered into leases and a note totaling $4,466,000 for purchases of an Electronic Health Record system and equipment for the new building. The implementation of the Electronic Health Record system is a multiyear project. The new building opened in February of 2014.

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

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

MOSS-ADAMS LLP
Certified Public Accountants | Business Consultants

REPORT OF INDEPENDENT AUDITORS

To the Board of Directors
Sonoma Valley Health Care District

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Sonoma Valley Health Care District, (the "District") which comprise the consolidated statements of net position as of June 30, 2014 and 2013, and the related statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Sonoma Valley Health Care District as of June 30, 2014 and 2013, and the consolidated changes in financial position and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 1, the Government Accounting Standard Board ("GASB") issued Statement No. 65, *Items Previously Reported as Assets and Liabilities* ("GASB No. 65"), which is effective for financial statements for periods beginning after December 15, 2012. GASB No. 65 establishes accounting and financial reporting standards that reclassify, as deferred outflows of resources or deferred inflows of resources, certain items that were previously reported as assets and liabilities and recognizes, as outflows of resources or inflows of resources, certain items that were previously reported as assets and liabilities. It also provides other financial reporting guidance related to the impact of the financial statement elements deferred outflows of resources and deferred inflows of resources, such as changes in the determination of the major fund calculations and limiting the use of the term deferred in financial statement presentations. The District has adopted this statement for the fiscal year ended June 30, 2014, and as a result, the consolidated financial statements presented herein have been restated retrospectively.

Other Matters

Required Supplementary Information

The accompanying Management's Discussion and Analysis on pages 1 through 6 are not required parts of the consolidated financial statements but are supplementary information required by the Governmental Accounting Standards Board who considers them to be an essential part of financial reporting for placing the consolidated financial statements in an appropriate operational economic, or historical context. This supplementary information is the responsibility of Sonoma Valley Health Care District's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the consolidated financial statements, and other knowledge we obtained during our audit of the consolidated financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Information

The accompanying supplementary information related to community support on page 27 is presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of Sonoma Valley Health Care District's management. The information has not been subjected to the auditing procedures applied in the audit of the consolidated financial statements and accordingly, we do not express an opinion or provide any assurance on it.

Moss Adams LLP

San Francisco, California
October 22, 2014

CONSOLIDATED FINANCIAL STATEMENTS

SONOMA VALLEY HEALTH CARE DISTRICT
CONSOLIDATED STATEMENTS OF NET POSITION
Years Ended June 30, 2014 and 2013 (AS RESTATED)

	2014	(As Restated) 2013
ASSETS		
Current assets		
Cash and cash equivalents	$ 2,849,986	$ 1,902,869
Patient accounts receivable, net of allowances for doubtful accounts of $965,414 and $1,471,799 in 2014 and 2013, respectively	6,793,990	6,433,401
Estimated third-party payor settlements (net)	1,527,754	112,255
Property tax receivables	5,758,948	4,982,227
Other receivables	2,061,156	1,093,383
Pledge receivables, current	-	500,000
Supplies	771,028	805,424
Prepaid expenses	816,423	1,074,432
Total current assets	20,579,285	16,903,991
Noncurrent investments		
Board-designated funds	-	186,468
Restricted for capital acquisitions	220,748	3,474,239
Restricted for debt service	1,637,914	5,263,697
Other long-term investments	23,756	274,738
	1,882,418	9,199,142
Capital assets, net of accumulated depreciation	56,350,250	42,476,327
Pledge receivables, long-term	-	1,500,000
Total assets	$ 78,811,953	$ 70,079,460

See accompanying notes.

LIABILITIES AND NET POSITION

Current liabilities		
Accounts payable and accrued expenses	$ 8,477,305	$ 10,400,356
Accrued payroll and related liabilities	2,835,095	2,621,053
Deferred tax revenues	5,849,985	4,825,602
Current portion of bond payable	95,000	25,000
Current portion of capital lease obligations	1,697,107	832,760
Current portion of notes payable	124,814	38,795
Total current liabilities	19,079,306	18,743,566
Accrued workers' compensation liability	711,000	557,000
Line of credit	4,973,734	2,373,734
Bonds payable, net of current portion	35,437,000	35,282,223
Capital lease obligations, net of current portion	4,022,449	2,069,571
Notes payable, net of current portion	917,777	367,116
Total liabilities	65,141,266	59,393,210
Net Position		
Invested in capital assets, net of related debt	9,082,369	7,997,719
Restricted		
For debt service	1,637,914	1,263,697
Expendable for capital assets	3,757,072	3,858,727
Nonexpendable permanent endowments	-	-
Unrestricted (deficit)	(806,668)	(2,433,893)
Total net position	13,670,687	10,686,250
Total liabilities and net position	$ 78,811,953	$ 70,079,460

See accompanying notes.

SONOMA VALLEY HEALTH CARE DISTRICT
CONSOLIDATED STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
Years Ended June 30, 2014 and 2013 (AS RESTATED)

	2014	(As Restated) 2013
Operating revenues		
Net patient service revenue, net of provision for bad debts of $1,458,255 and $2,901,255 in 2014 and 2013, respectively	$ 47,416,961	$ 43,247,566
Capitation revenue	2,055,548	2,111,726
Other revenue	1,103,166	1,647,768
Total operating revenues	50,575,675	47,007,060
Operating expenses		
Salaries and wages	26,219,974	25,702,558
Purchased services	6,507,171	6,874,543
Supplies	5,889,441	6,119,299
Employee benefits	5,986,866	5,949,821
Medical fees	4,288,169	3,692,868
Other	2,191,737	1,180,790
Depreciation	2,339,876	2,132,706
Utilities	961,882	899,466
Insurance	226,650	243,608
Total operating expenses	54,611,766	52,795,659
Operating loss	(4,036,091)	(5,788,599)
Nonoperating revenues and (expenses)		
Property tax revenues	4,938,955	4,797,081
Investment income	32,714	32,614
Noncapital grants and contributions	18,333	232,596
Interest expense	(1,088,851)	(721,567)
Bond issuance cost	(180,605)	-
Contribution to Prima Medical Foundation	(604,413)	(787,560)
Other	147,323	335,621
Total nonoperating revenues and (expenses)	3,263,456	3,888,785
Deficit of revenues over expenses before capital grants and contributions	(772,635)	(1,899,814)
Capital grants and contributions	3,757,072	3,858,727
Increase in net position	2,984,437	1,958,913
Total net position, beginning of year, as restated (Note 1)	10,686,250	8,727,337
Total net position, end of year	$ 13,670,687	$ 10,686,250

See accompanying notes.

SONOMA VALLEY HEALTH CARE DISTRICT
CONSOLIDATED STATEMENTS OF CASH FLOWS
Years Ended June 30, 2014 and 2013 (AS RESTATED)

	2014	(As Restated) 2013
Cash flows from operating activities:		
Receipts from patients and third-party payors	$ 47,806,587	$ 47,966,710
Payments to employees for services	(31,992,798)	(31,598,074)
Payments to physicians, suppliers, and contractors	(17,800,429)	(16,643,626)
Net cash (used in) operating activities	(1,986,640)	(274,990)
Cash flows from noncapital financing activities:		
Noncapital grants, contributions, and other	110,326	742,349
Contribution to Prima Medical Foundation	(604,413)	(787,560)
Parcel taxes supporting operations	3,075,631	3,058,550
Net cash from noncapital financing activities	2,581,544	3,013,339
Cash flows from capital and related financing activities:		
Purchases of capital assets	(12,204,010)	(18,958,018)
Principal payments on capital lease obligations	(1,192,564)	(843,514)
Principal payments on notes payable	(38,772)	(921,901)
Payment of line of credit	-	(128,000)
Principal payments on bond payable	(11,905,000)	-
Interest paid on long-term debt	(1,775,601)	(1,334,388)
Proceeds from issuance of notes payable	675,452	-
Proceeds from issuance of bonds	12,437,000	-
Proceeds from line of credit	2,600,000	2,501,734
Tax revenue related to general obligation bonds	2,112,351	2,701,559
Capital grants and gifts	2,293,919	2,858,727
Net cash from capital and related financing activities	(6,997,225)	(14,123,801)
Cash flows from investing activities:		
Proceeds from sale of investments	7,316,724	12,329,624
Interest and dividends on investments	32,714	32,614
Net cash from investing activities	7,349,438	12,362,238
Net change in cash and cash equivalents	947,117	976,786
Cash and cash equivalents at beginning of year	1,902,869	926,083
Cash and cash equivalents at end of year	$ 2,849,986	$ 1,902,869

See accompanying notes.

SONOMA VALLEY HEALTH CARE DISTRICT
CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)
Years Ended June 30, 2014 and 2013 (AS RESTATED)

Reconciliation of operating loss to net cash from operating activities		
Operating loss	$ (4,036,091)	$ (5,788,599)
Adjustments to reconcile operating loss to net cash from operating activities		
Depreciation	2,339,876	2,132,706
Provision for bad debts	1,458,255	2,901,255
Loss on disposal of fixed assets	-	59,065
Changes in assets and liabilities		
Patient accounts receivable	(1,818,844)	(3,407,356)
Estimated amounts due from and to third-party payors (net)	(1,415,499)	1,465,751
Accounts payable and accrued expenses	(147,450)	4,403,450
Other assets and liabilities	1,633,113	(2,021,336)
Net cash from operating activities	$ (1,986,640)	$ (255,064)
Supplemental disclosure of noncash transactions		
Acquisition of capital assets financed with long-term debt	$ 4,009,789	$ 493,774

See accompanying notes.

NOTE 1 – ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

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

Sonoma Valley Hospital Auxiliary (the "Auxiliary") was formed to render non-medical services on a volunteer basis to Sonoma Valley Hospital. The Auxiliary also raises monies for the benefit of the Hospital and its activities. As the sole purpose of the Auxiliary is to support the Hospital, the Auxiliary has been consolidated with the Hospital's financial statements.

Principles of consolidation – The accompanying consolidated financial statements include the accounts of the Hospital and the Auxiliary (collectively referred to as the "District"). All significant inter-company accounts and transactions have been eliminated in the consolidated financial statements.

Accounting standards – Pursuant to Government Accounting Standard Board ("GASB") Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 Financial Accounting Standards Board ("FASB") and AICPA Pronouncements*, the District's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989.

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

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

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

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

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

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

Pledges Receivable – Pledges have been recorded at their present value net of applicable discounts of $0 and $2,000,000 as of June 30, 2014 and 2013, respectively. An allowance for estimated uncollectible pledges receivable is recorded based on past experience and an analysis of current pledges receivable balances. There was no allowance recorded as of June 30, 2014 and 2013, as the pledges are deemed collectible.

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

Capital assets – Capital asset acquisitions over $500 are capitalized and recorded at cost. Donated property is recorded at its fair-market value on the date of donation. Equipment under capital lease is amortized on the straight-line basis over the shorter of the lease term or the estimated useful life of the equipment. Leasehold improvements are amortized using the straight-line method over the shorter of the lease term or the estimated useful life of the related assets. Depreciation is computed using the straight-line method over the estimated useful lives of the following asset groups:

Land Improvements	10 - 20 years
Buildings and fixtures	20 - 40 years
Equipment	2 - 10 years
Software	5 - 7 years

The District evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

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

Risk management – The District is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Workers' Compensation and Medical Malpractice Liabilities – The District maintains professional liability insurance on a claims-made basis, with liability limits of $15,000,000 in aggregate, which is subject to a $5,000 deductible.

The District purchases a Workers' Compensation Excess Policy that insures claims with no limits in the amounts and a $500,000 deductible. Actuarial estimates of uninsured losses for workers' compensation have been accrued as liabilities in the accompanying consolidated financial statements.

Net position – Net position of the District are classified as invested in capital assets, net of related debt, restricted net position, and unrestricted net position.

Invested in capital assets, net of related debt – Invested in capital assets, net of related debt consists of capital assets, net of accumulated depreciation and reduced by the outstanding balances of any borrowings that are attributable to the acquisition, construction, or improvement of those assets.

Restricted net position – Restricted net position consists of net position with limits on their use that are externally imposed by creditors (such as through debt covenants), grantors, contributors or by laws or regulations of other governments or constraints imposed by law through constitutional provisions or enabling legislation.

Unrestricted net position – Unrestricted net position are remaining net position that do not meet the definition of invested in capital assets, net of related debt or restricted.

Statements of revenues, expenses, and changes in net position – For purposes of display, transactions deemed by management to be ongoing, major, or central to the provisions of health care services are reported as revenues and expenses. Peripheral or incidental transactions are reported as gains and losses. These peripheral activities include investment income, property tax revenue, gifts and contributions, grants and bequests, and change in net unrealized gains and losses on investments in marketable securities and are reported as nonoperating.

Net patient service revenue and patient accounts receivable – Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered, and adjusted in future periods as final settlements are determined. At June 30, 2014 and 2013, the District provided allowances for losses on amounts receivable directly from patients totaling $965,414 and $1,471,799, respectively. The distribution of gross patient accounts receivable by payor at June 30, 2014 and 2013, is as follows:

	2014	2013
Medicare	38.9%	40.6%
Medicare HMO	4.6%	4.4%
Medi-Cal	9.8%	6.7%
Medi-Cal Managed Care	5.9%	5.4%
Commercial Insurance	31.8%	31.4%
Workers Compensation	3.2%	3.9%
Capitated	1.6%	0.1%
Self-pay - Other	4.2%	7.5%
	100%	100%

Uncollectible accounts – The District provides care to patients without requiring collateral or other security. Patient charges not covered by a third-party payor are billed directly to the patient if it is determined that the patient has the ability to pay. A provision for uncollectible accounts is recognized based on management's estimate of amounts that ultimately may be uncollectible.

Capitation revenues – The District, in association with Meritage Medical Network (formerly Marin Independent Practice Association) ("Meritage") has agreements with various health maintenance organizations ("HMOs") to provide medical services to subscribing participants. Under two of these agreements, the District receives monthly capitation payments based on the number of each HMO's participants, regardless of the services actually performed by the District. The District is not responsible for the cost of services provided to subscribing participants by other healthcare providers. The District reassesses the profitability of the agreements for exposure risks in the event future medical costs to provide medical services exceed the related future capitation payments.

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

In March 2002, the District voters adopted a special tax on each taxable parcel of land within the District at an annual rate of up to $130 per parcel for five years. In March 2007, the District voters extended the special tax at an annual rate of up to $195 per parcel through June 30, 2014. The purpose of the special parcel tax is to ensure continued local access to emergency room and acute hospital care and other medical services for residents of the District and for visitors to the area. The parcel tax extension was approved for 2013 – 2018 by the District's voters.

The District received approximately 165% in 2014 and 245% in 2013 of its total increase in net position from property taxes.

These funds were designated as follows:

	2014	2013
Designated for hospital operations	$ 2,963,353	$ 2,967,983
Levied for hospital operations and debt service payments	1,975,602	1,829,098
Property Tax Revenue	$ 4,938,955	$ 4,797,081

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

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

Grants and contributions – The District receives grants as well as contributions from individuals and private organizations. Revenues from grants and contributions are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as nonoperating revenues.

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

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

Restatement, **Change in Accounting Principle**–GASB issued GASB Statement No. 65, *Items Previously Reported as Assets and Liabilities* ("GASB No. 65"), which is effective for financial statements for periods beginning after December 15, 2012. GASB No. 65 establishes accounting and financial reporting standards that reclassify, as deferred outflows of resources or deferred inflows of resources, certain items that were previously reported as assets and liabilities and recognizes, as outflows of resources or inflows of resources, certain items that were previously reported as assets and liabilities. It also provides other financial reporting guidance related to the impact of the financial statement elements deferred outflows of resources and deferred inflows of resources, such as changes in the determination of the major fund calculations and limiting the use of the term deferred in financial statement presentations.

The District has adopted this statement for the fiscal year ended June 30, 2014, and as a result, the consolidated financial statements presented herein have been restated retrospectively as follows:

	As previously Reported	Adjustment	As Adjusted
Unrestricted net position, end of year	$ (2,211,829)	$ (222,064)	$ (2,433,893)
Total net position, beginning of year	$ 8,969,327	$ (241,990)	$ 8,727,337
Total net position, end of year	$ 10,908,314	$ (222,064)	$ 10,686,250
Other assets	$ 222,064	$ (222,064)	$ -
Depreciation and amortization expense	$ -	$ -	$ -
Total operating expenses	$ 52,815,585	$ (19,926)	$ 52,795,659
Increase in net position	$ 1,938,987	$ 19,926	$ 1,958,913

New accounting pronouncements – GASB issued GASB Statement No. 68, *Accounting and Financial Reporting for Pensions—an amendment of GASB Statement No. 27* ("GASB No. 68"), which is effective for financial statements for periods beginning after June 15, 2014. GASB No. 68 replaces the requirements of Statement No. 27, *Accounting for Pensions by State and Local Governmental Employers*, as well as the requirements of Statement No. 50, *Pension Disclosures*, as they relate to pensions that are provided through pension plans administered as trusts or equivalent arrangements (hereafter jointly referred to as trusts) that meet certain criteria. The requirements of Statements 27 and 50 remain applicable for pensions that are not covered by the scope of this Statement. It establishes standards for measuring and recognizing liabilities, deferred outflows of resources, and deferred inflows of resources, and expense/expenditures. For defined benefit pensions, this Statement identifies the methods and assumptions that should be used to project benefit payments, discount projected benefit payments to their actuarial present value, and attribute that present value to periods of employee service. Note disclosure and required supplementary information requirements about pensions also are addressed. The District is currently evaluating the impact of the adoption of GASB No. 68 for the fiscal year ending June 30, 2015.

GASB also issued GASB Statement No. 69, *Government Combinations and Disposals of Government Operations* ("GASB No. 69"), which is effective for financial statements for periods beginning after December 15, 2013. GASB No. 69 requires the use of carrying values to measure the assets and liabilities in a government merger. Conversely, government acquisitions are transactions in which a government acquires another entity, or its operations, in exchange for significant consideration. This Statement requires measurements of assets acquired and liabilities assumed generally to be based upon their acquisition values. It also provides guidance for transfers of operations that do not constitute entire legally separate entities and in which no significant consideration is exchanged. It defines the term operations for purposes of determining the applicability of this Statement and requires the use of carrying values to measure the assets and liabilities in a transfer of operations, and provides accounting and financial reporting guidance for disposals of government operations that have been transferred or sold. The District is currently evaluating the impact of the adoption of GASB No. 69 for the fiscal year ending June 30, 2015.

NOTE 2 – NET PATIENT SERVICE REVENUES

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

Medicare – Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge for the District. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. The District's classification of inpatients under the Medicare program and the appropriateness of their admissions are subject to an independent review by a peer review organization under contract with the District. Most outpatient services at District provided to Medicare beneficiaries are paid at prospectively determined rates per encounter that vary according to procedures performed. Medicare cost reports have been audited and final settled by the fiscal intermediary through 2013 for the District.

Medi-Cal – Prior to July 1, 2013, inpatient acute care services rendered to Medi-Cal program beneficiaries are were reimbursed under a cost reimbursement methodology; however, the District is also subject to per discharge limits. The District was paid for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by Medi-Cal. Medi-Cal cost reports have been audited through June 30, 2011. Per discharge limits have been determined by Medi-Cal through June 30, 2009, for the District. Beginning July 1, 2013, inpatient acute care services rendered to Medi-Cal program beneficiaries under a diagnostic related group (DRG) methodology. Under this methodology, similar to Medicare, services are paid at prospectively determined rates per discharge according to a patient classification system that is based on clinical, diagnostic, and other factors. Inpatient skilled nursing care services rendered to Medi-Cal program beneficiaries are reimbursed at prospectively determined per diem rates. Outpatient services rendered to Medi-Cal program beneficiaries are reimbursed based on prospectively determined fee schedules.

Others – Payments for services rendered to other than Medicare and Medi-Cal patients are based on established rates or agreements with certain commercial insurance companies, health maintenance organizations, Napa State, and preferred provider organizations which provide for various discounts from established rates.

Net patient service revenues for the years ended June 30, 2014 and 2013, were as follows:

	2014	2013
Patient service revenues at established charge rates		
Services provided to Medicare patients	$ 102,613,658	$ 92,776,198
Services provided to Medi-Cal patients	30,692,700	27,374,856
Services provided to other patients	70,953,915	71,230,691
Gross patient service revenues	204,260,273	191,381,745
Less contractual adjustments and provision for bad debts	(156,843,312)	(148,134,179)
Net patient service revenues	$ 47,416,961	$ 43,247,566

NOTE 3 – CASH DEPOSITS

At June 30, 2014 and 2013, the District cash accounts are recorded of $2,849,986 and $1,902,869, respectively. Bank balances were $2,925,164 and $1,737,128, respectively. All of the bank balances at June 30, 2014 and 2013 were covered by federal depository insurance.

NOTE 4 – BOARD - DESIGNATED, RESTRICTED FUNDS, AND OTHER LONG-TERM INVESTMENTS

District investment balances and average maturities were as follows at June 30, 2014 and 2013, respectively:

	2014		
		Investment Maturities (in years)	
Investment Type	Fair-Value	Less than 1	1 to 5
Short-term money market funds	$ 1,637,914	$ 1,637,914	$ -
Interest in irrevocable trust held in LAIF	-	-	-
LAIF (State Pool Demand Deposits)	244,504	244,504	-
Total fair-value	$ 1,882,418	$ 1,882,418	$ -

	2013		
		Investment Maturities (in years)	
Investment Type	Fair-Value	Less than 1	1 to 5
Short-term money market funds	$ 5,263,697	$ 5,263,697	$ -
LAIF (State Pool Demand Deposits)	3,935,445	3,935,445	-
Total fair-value	$ 9,199,142	$ 9,199,142	$ -

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

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

Interest rate risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest. The money market funds are presented as an investment with a maturity of less than one year because they are redeemable in full immediately.

Credit risk – Credit risk is the risk that the issuer or other counterparty to an investment will not fulfill its obligations. At June 30, 2014 and 2013, the District's investments in money market mutual funds were rated AAA by Standard and Poor's and AAA by Moody's Investors Service and the District's investments in LAIF were not rated.

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

Concentration of credit risk – This risk relates to the risk of loss attributed to the magnitude of the District's investment in a single issuer. The District had the following investments in a single issuer in excess of 5% of total investments as of June 30, 2014 and 2013:

	2014		2013	
LAIF (State Pool Demand Deposits)	$ 244,504	13.0%	$ 3,935,445	42.8%

NOTE 5 – PROPERTY TAX RECEIVABLES

Property tax receivables consisted of the following as of June 30, 2014 and 2013:

	2014	2013
Property tax receivables		
Special parcel tax	$ 3,078,743	$ 3,039,656
Tax for general obligation bond debt service payments	2,680,205	1,942,571
	5,758,948	4,982,227
Total property tax receivables	$ 5,758,948	$ 4,982,227

NOTE 6 – CAPITAL ASSETS

Capital assets activity for the year ended June 30, 2014, is as follows:

	Balance June 30, 2013	Increases	Decreases, Transfers, and Retirements	Balance June 30, 2014
Nondepreciable capital assets				
Land	$ 197,659	$ -	$ -	$ 197,659
Construction in progress	32,772,060	13,211,854	(43,416,608)	2,567,306
Total nondepreciable capital assets	32,969,719	13,211,854	(43,416,608)	2,764,965
Depreciable capital assets				
Land improvements	805,238	-	-	805,238
Buildings and improvements	22,446,088	1,037	42,095,243	64,542,368
Equipment	18,948,817	3,000,908	1,321,365	23,271,090
	42,200,143	3,001,945	43,416,608	88,618,696
Less accumulated depreciation	(32,693,535)	(2,339,876)	-	(35,033,411)
Total depreciable capital assets, net	9,506,608	662,069	43,416,608	53,585,285
Total capital assets, net	$ 42,476,327	$ 13,873,923	$ -	$ 56,350,250

Capital assets activity for the year ended June 30, 2013, is as follows:

	Balance June 30, 2012	Increases	Decreases, Transfers, and Retirements	Balance June 30, 2013
Nondepreciable capital assets				
Land	$ 197,659	$ -	$ -	$ 197,659
Construction in progress	17,586,721	18,870,019	(3,684,680)	32,772,060
Total nondepreciable capital assets	17,784,380	18,870,019	(3,684,680)	32,969,719
Depreciable capital assets				
Land improvements	838,336	-	(33,098)	805,238
Buildings and improvements	22,729,315	11,462	(294,689)	22,446,088
Equipment	16,875,798	570,311	1,502,708	18,948,817
	40,443,449	581,773	1,174,921	42,200,143
Less accumulated depreciation	(33,011,523)	(2,132,706)	2,450,694	(32,693,535)
Total depreciable capital assets, net	7,431,926	(1,550,933)	3,625,615	9,506,608
Total capital assets, net	$ 25,216,306	$ 17,319,086	$ (59,065)	$ 42,476,327

NOTE 7 – EMPLOYEE BENEFIT PLANS

Defined contribution plan – The District contributes to a defined contribution retirement plan (the "Plan") covering substantially all employees. Expense is recorded for the amount of the District's required contributions, determined in accordance with the terms of the Plan. The Plan is administered by the District's Board of Directors. The Plan provides retirement benefits to plan members and death benefits to beneficiaries of plan members. Benefit provisions are contained in the plan document and are established and can be amended by action of the District's governing body. Contribution rates for plan members and the District, expressed as a percentage of covered payroll, were 3.42% for 2014 and 2013.

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

The District's contributions to the defined contribution retirement plan and deferred compensation plan totaled $557,148 and $521,163 during 2014 and 2013, respectively.

NOTE 8 – MEDICAL MALPRACTICE COVERAGE AND CLAIMS

The District has joined together with other providers of health care services to form Beta Healthcare Group ("Beta"), a public entity risk pool (the "Pool") currently operating as a common risk management and insurance program for its members. The District purchases medical malpractice insurance from the Pool under a claims-made policy. The District pays an annual premium to the Pool for its torts insurance coverage. The District purchases excess liability insurance through a commercial insurer for amounts in excess of the coverage provided under Beta. The Pool's governing agreements specifies that the Pool will be self-sustaining through member premiums and will reinsure through commercial carriers for claims in excess of stop-loss amounts. Accounting principles generally accepted in the United States of America require a health care provider to accrue the expense of its share of malpractice claim costs, if any, for any reported and unreported incidents of potential improper professional service occurring during the year which will not be covered by an existing claims made insurance policy by estimating the probable ultimate costs of the incidents. Based upon the District's claims experiences, an estimated accrual of $0 and $15,000, as of June 30, 2014 and 2013, respectively, for malpractice costs was recorded and is included in accounts payable and accrued expenses in the consolidated statements of net position.

NOTE 9 – WORKERS' COMPENSATION CLAIMS

The District is self-insured for workers' compensation claims of its employees up to $500,000, with commercial stop-loss insurance coverage purchased for claims in excess of these amounts through. A provision is accrued for self-insured workers' compensation claims, including both claims reported and claims incurred but not yet reported of $711,000 and $557,000 as of June 30, 2014 and 2013, respectively. The District utilizes an actuary to estimate the ultimate costs to settle such claims. Estimated future payments related to workers' compensation claims have been discounted at a rate of 1% at June 30, 2014 and 2013. It is reasonably possible that the District's estimate will change by a material amount in the near term.

NOTE 10 – LONG-TERM DEBT

The following is a summary of the District's long-term debt transactions for the years ended June 30, 2014 and 2013:

	Balance June 30, 2013	Additions	Decreases/ Amortization	Balance June 30, 2014
General obligation bonds payable				
Principal	$ 35,000,000	$ 12,437,000	$ (11,905,000)	$ 35,532,000
Original issue premium	342,212	-	(307,223)	34,989
Deferred loss on early retirement of revenue bonds	(34,989)	-	-	(34,989)
	35,307,223	12,437,000	(12,212,223)	35,532,000
Notes payable	405,911	675,452	(38,772)	1,042,591
Total long-term debt	$ 35,713,134	$ 13,112,452	$ (12,250,995)	$ 36,574,591

	Balance June 30, 2012	Additions	Decreases/ Amortization	Balance June 30, 2013
General obligation bonds payable				
Principal	$ 35,000,000	$ -	$ -	$ 35,000,000
Original issue premium	373,866	-	(31,654)	342,212
Deferred loss on early retirement of revenue bonds	(81,756)	-	46,767	(34,989)
	35,292,110	-	15,113	35,307,223
Notes payable	1,327,812	-	(921,901)	405,911
Total long-term debt	$ 36,619,922	$ -	$ (906,788)	$ 35,713,134

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

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

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

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

In August 2010, the District issued $23,000,000 of additional general obligation bonds (Sonoma Valley Health Care District General Obligation Bonds, Election of 2008, Series B 2010) in order to finance the second and final phase of the Project. During this phase, which the District expects to complete in fiscal year 2013, the District will complete all construction and improvement aspects of the Project and finish purchasing the equipment budgeted in the Project. The Project was completed in March 2014.

In February 2014, the District issued $12,437,000 of additional general obligation bond (Sonoma Valley Health Care District 2014 General Obligation Refunding Bond) to refund all of the outstanding Sonoma Valley Health Care District General Obligation Bonds, Election of 2008, Series A 2009. The 2009 General Obligations Bonds were refunded in February 2014 and the funds were transferred to an escrow account held by a trustee until the bonds were fully called in August 2014. As of June 30, 2014, the District did not have a liability for these funds.

Interest on the Bonds is payable semi-annually at 3.780% with principal payments due annually beginning August 1, 2015.

Line of credit – The District entered into a line of credit agreement with a bank for $7,000,000, with an interest rate of 2.5% and maturing on January 31, 2017. The District is required to comply with certain restrictive covenants, including maintaining a total debt to EBIDA ratio of 2.0 to 1.0 and maintaining a minimum tangible net worth of not less than $9,000,000. The District had an unused credit of $2,026,265 as of June 30, 2014.

Debt service requirements – Debt service requirements for long-term debt are as follows at June 30, 2014:

Year Ending June 30,	General Obligation Bonds		Note Payable	
	Principal	Interest	Principal	Interest
2015	$ 95,000	$ 1,328,536	$ 124,814	$ 11,497
2016	1,236,000	1,149,770	127,013	9,297
2017	1,339,000	1,110,233	128,312	7,999
2018	1,433,000	1,065,791	129,597	6,713
2019 - 2023	8,754,000	4,523,669	532,855	4,758
2024 - 2028	12,448,000	2,849,409	-	2,523
2029 - 2033	10,227,000	618,897	-	-
	$ 35,532,000	$ 12,646,305	$ 1,042,591	$ 42,787

Interest costs – Interest costs incurred during the years ended June 30, 2014 and 2013, are summarized as follows:

	2014	2013
Interest cost		
Paid	$ 1,775,601	$ 1,334,388
Accrued	329,844	714,262
Total incurred	2,105,445	2,048,650
Amortization of deferred financing costs, original issue premium and deferred loss on early retirement of revenue bonds	31,573	15,112
Interest capitalized	(1,048,167)	(1,342,195)
Total interest expense	$ 1,088,851	$ 721,567

NOTE 11 – CAPITAL LEASE OBLIGATIONS

Capital lease obligations outstanding as of June 30, 2014, are as follows:

Description	Maturity	Interest Rates	Original Issue	June 30, 2014
Capital leases - equipment net of interest	October 2011 - July 2017	4.37% - 7.54%	$ 10,155,120	$ 5,719,556
Less current portion				(1,697,107)
				$ 4,022,449

Description	June 30, 2013	Increases	Decreases	Outstanding June 30, 2014
Capital lease - equipment	$ 2,902,331	$ 4,009,789	$ (1,192,564)	$ 5,719,556

Description	June 30, 2012	Increases	Decreases	Outstanding June 30, 2013
Capital lease - equipment	$ 3,252,071	$ 493,774	$ (843,514)	$ 2,902,331

Debt service requirements for capital lease obligations are as follows:

Year Ending June 30,	
2015	$ 1,697,107
2016	1,427,895
2017	973,990
2018	984,185
2019	510,355
Thereafter	126,024
Less interest	-
	5,719,556
Less current portion	(1,697,107)
	$ 4,022,449

NOTE 12 – TRANSACTIONS WITH SONOMA VALLEY HOSPITAL FOUNDATION

Sonoma Valley Hospital Foundation, Inc. (the "Foundation") is authorized by the District to solicit contributions on behalf of the Hospital. In the absence of donor restrictions, the Foundation has discretionary control over the amounts, timing, and use of their distributions. The District recorded contributions from the Foundation of $3,757,072 in 2014 and $858,727 in 2013. At June 30, 2014 and 2013, the Foundation's unaudited cash basis financial statements reported net position of $286,841 and $61,591, respectively. The Foundation is not considered a component unit of the District because the Foundation is not controlled by the District.

NOTE 13 – RELATED PARTY TRANSACTIONS

During 2010, the District contributed $100,000 to Meritage for the development of Prima Medical Foundation ("PMF"), a joint venture with Meritage, Marin Healthcare District ("MHD"), and Marin Medical Practice Concepts, Inc. ("MMPC"). The PMF's purpose is establishing, operating, and maintaining multi-specialty medical clinics. The successful establishment and operation of PMF in Marin and Sonoma Counties is expected to be a cornerstone in the District's plans to ensure adequate health care services to the greater Sonoma Area. The District's contribution to PMF totaled $604,413 and $787,560 for the years ended June 30, 2014 and 2013, respectively.

NOTE 14 – COMMITMENTS AND CONTINGENCIES

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

Operating leases – The District leases certain facilities and equipment under long-term, noncancelable operating lease agreements. Total rental expense for all operating leases amounted to $746,000 and $686,944 in 2014 and 2013, respectively, and is included in other expenses in the consolidated statements of revenues, expenses, and changes in net position. The following is a schedule by year of future minimum lease payments under operating leases that have initial or remaining terms in excess of one year:

Year Ending June 30,	
2015	$ 1,276,899
2016	581,142
2017	492,037
2018	401,679
2019	401,679
	$ 3,153,436

Regulatory environment – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medi-Cal fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. The District is subject to routine surveys and reviews by federal, state, and local regulatory authorities. The District has also received inquiries from health care regulatory authorities regarding its compliance with laws and regulations. Although the District's management is not aware of any violations of laws and regulations, it has received corrective action requests as a result of completed and on-going surveys from applicable regulatory authorities. Management continually works in a timely manner to implement operational changes and procedures to address all corrective action requests from regulatory authorities. Breaches of these laws and regulations and non-compliance with survey corrective action requests could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

NOTE 15 – CHARITY CARE

During the years ended June 30, 2014 and 2013, the District provided in estimated costs of $296,250 and $724,137, respectively, for free or discounted services for the poor and underserved. This includes services provided to persons who have health care needs and are uninsured, under-insured, and ineligible for a government program and are otherwise unable to pay for medically necessary care based on their individual financial situation. Costs are computed based on a relationship of costs to charges similar to a Medicare cost to charge ratio. During the year ended June 30, 2014, there were approximately 157 patient cases under this policy. During the year ended June 30, 2013, there were approximately 93 patient cases under this policy.

SUPPLEMENTARY INFORMATION

UNCOMPENSATED CARE AND COMMUNITY SUPPORT

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

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

Uncompensated charges relating to these services are as follows:

	2014	2013
Community benefits (charity care) allowances	$ 269,201	$ 186,468
State Medi-Cal and other public aid programs	25,003,025	21,942,805
Provision for uncollectible accounts	1,458,255	2,901,255
Total	$ 26,730,481	$ 25,030,528

The District's estimated costs of providing uncompensated care and community benefits to the poor and the broader community for 2014 and 2013 are as follows:

	2014	2013
Uncompensated costs of community benefits and uncollectible accounts	$ 51,363	$ 201,586
Medi-Cal and other public aid programs	2,776,415	2,359,502
	2,827,778	2,561,088
Benefits for the broader community	9,747,878	8,706,914
Total estimated community benefit costs	$ 12,575,656	$ 11,268,002

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

Community support – The District also commits significant time and resources to endeavors and critical services that meet otherwise unfilled community needs. Many of these activities are sponsored with the knowledge that they will not be self-supporting or financially viable. Such programs include recruitment of physicians, health screening and assessments, prenatal education and care, community educational services, and various support groups.

During 2014 and 2013, the District recorded the following amounts related to community support:

	2014	2013
Noncapital gifts and grants included in non operating revenues	$ 18,333	$ 232,596
Capital grants and contributions from		
Sonoma Valley Hospital Foundation	3,757,072	858,727
Others	-	3,000,000
	3,757,072	3,858,727
Total community support	$ 3,775,405	$ 4,091,323
Fundraising expenses included in operating expenses	$ 136,466	$ 417,691