December 8, 2023

TO: Legal Counsel

News Media
Salinas Californian
El Sol
Monterey County Herald
Monterey County Weekly
KION-TV
KSBW-TV/ABC Central Coast
KSMS/Entravision-TV

The **ANNUAL MEETING** of the **BOARD OF DIRECTORS OF SALINAS VALLEY HEALTH**[1] will be held **THURSDAY, DECEMBER 14, 2023, AT 4:00 P.M., DOWNING RESOURCE CENTER, ROOMS A, B, & C, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA** or via **TELECONFERENCE** (*visit* **SalinasValleyHealth.com/virtualboardmeeting** *for Access Information*).

Allen Radner, MD
Interim President/Chief Executive Officer

[1] Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

ANNUAL MEETING OF THE BOARD OF DIRECTORS
SALINAS VALLEY HEALTH[1]

THURSDAY, DECEMBER 14, 2023, 4:00 P.M.
DOWNING RESOURCE CENTER, ROOMS A, B & C

SALINAS VALLEY HEALTH MEDICAL CENTER
450 E. ROMIE LANE, SALINAS, CALIFORNIA
or via TELECONFERENCE

(Visit salinasvalleyhealth.com/virtualboardmeeting for Access Information)

AGENDA

		Presented By
1.	**CALL TO ORDER / ROLL CALL**	*Victor Rey, Jr.*
2.	**CLOSED SESSION** *(See Attached Closed Session Sheet Information)*	*Victor Rey, Jr.*
3.	**RECONVENE OPEN SESSION/CLOSED SESSION REPORT** *(Estimated time 4:30 pm)*	*Victor Rey, Jr.*
4.	**PUBLIC COMMENT** This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on issues or concerns within the jurisdiction of this District Board which are not otherwise covered under an item on this agenda.	*Victor Rey, Jr.*
5.	**AWARDS & RECOGNITION**	*Allen Radner, MD*
6.	**ANNUAL BOARD OF DIRECTORS REPORT** Overall Performance of Salinas Valley Health for 2023	*Board President*
7.	**BOARD MEMBER COMMENTS**	*Board Members*
8.	**CONSENT AGENDA - GENERAL BUSINESS** *(Board Member may pull an item from the Consent Agenda for discussion.)*	*Victor Rey, Jr.*

A. Minutes of November 16, 2023, Regular Meeting of the Board of Directors
B. Financial Report
C. Statistical Report
D. Policies Requiring Approval
   1. Chargemaster Available to the Public Payer's Bill of Rights AB 1627
   2. Financial Assistance Program/Full Charity Care and Discount Partial Charity Care
   3. Infant Driven Feeding Protocol
   4. Information Technology Acquisition
   5. Intraosseous Infusion Nursing Standardized Procedure
   6. Neonate Gavage Feeding
   7. Percutaneous Ventricular Assist Device Implantation (Clinical)
   8. Scope of Service: Critical Care
   9. Visitors

[1]Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

- Questions to Board President/Staff
- Public Comment
- Board Discussion/Deliberation
- Motion/Second
- Action by Board/Roll Call Vote

9. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. FINANCE COMMITTEE

Joel Hernandez Laguna

Minutes of the December 11, 2023 Finance Committee meeting have been provided to the Board for their review. The following recommendations have been made to the Board.

1. Consider Recommendation for Board Approval of AMN Healthcare Solutions Service Justification and Contract Renewal Award

    - Questions to Committee Chair/Staff
    - Public Comment
    - Board Discussion/Deliberation
    - Motion/Second
    - Action by Board/Roll Call Vote

2. Consider Recommendation for Board Approval of Lease Agreement Terms for 225 East Romie Lane, Salinas, CA Between SVMHS and Hilltop Family Medical Group, Inc.

    - Questions to Committee Chair/Staff
    - Public Comment
    - Board Discussion/Deliberation
    - Motion/Second
    - Action by Board/Roll Call Vote

B. PERSONNEL, PENSION AND INVESTMENT COMMITTEE

Juan Cabrera

Minutes of the November 12, 2023 Personnel, Pension and Investment Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

C. CORPORATE COMPLIANCE COMMITTEE

Juan Cabrera

Minutes of the November 12, 2023 Corporate Compliance Committee meeting have been provided to the Board for their review. The following recommendations have been made to the Board.

1. Consider Recommendation for Board of Directors Approval of the Years Ended June 30, 2023 and 2022 Draft Audited Financial Statements for Salinas Valley Memorial Healthcare System. Consider Recommendation for Board of Directors Approval of the Year Ended June 30, 2023 Draft Single Audit Report for Salinas Valley Memorial Healthcare System.

- Questions to Committee Chair/Staff
- Public Comment
- Board Discussion/Deliberation
- Motion/Second
- Action by Board/Roll Call Vote

2. Consider Recommendation for Board of Directors Approval of the Years Ended December 31, 2022 and 2021 Draft Audited Financial Statements for the Salinas Valley Memorial Healthcare District Employee's Pension Plan.

- Questions to Committee Chair/Staff
- Public Comment
- Board Discussion/Deliberation
- Motion/Second
- Action by Board/Roll Call Vote

10. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF DECEMBER 14, 2023, AND RECOMMENDATIONS FOR BOARD APPROVAL OF THE FOLLOWING: *Rakesh Singh, MD*

A. Reports

1. Credentials Committee Report
2. Interdisciplinary Practice Committee Report

B. Policies/Procedures/Plans:

1. Clinical Privilege Delineation – Critical Care/Pulmonary Medicine Revision
2. Clinical Privilege Delineation – Emergency Medicine

C. Medical Staff Bylaws/General Rules and Regulations

1. Article II, Section 2.3: Responsibility of the Attending Provider
2. Article VII, Section 1-16: Emergency Call Panel
3. Focused Professional Practice Evaluation: Article VII, Section C: Termination of Proctorship

- Questions to Chief of Staff
- Public Comment
- Board Discussion/Deliberation
- Motion/Second
- Action by Board/Roll Call Vote

11. EXTENDED CLOSED SESSION *Victor Rey, Jr.*

12. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, January 25, 2023, at 4:00 p.m.**

The complete Board packet including subsequently distributed materials and presentations is available at the Board Meeting and in the Human Resources Department of the District. All items appearing on the agenda are subject to action by the Board. Staff and Committee recommendations are subject to change by the Board.

Requests for a disability related modification or accommodation, including auxiliary aids or services, in order to attend or participate in a meeting should be made to the Board Clerk during regular business hours at 831-759-3050. Notification received 48 hours before the meeting will enable the District to make reasonable accommodations.

SALINAS VALLEY HEALTH BOARD OF DIRECTORS

AGENDA FOR CLOSED SESSION

Pursuant to California Government Code Section 54954.2 and 54954.5, the board agenda may describe closed session agenda items as provided below. No legislative body or elected official shall be in violation of Section 54954.2 or 54956 if the closed session items are described in substantial compliance with Section 54954.5 of the Government Code.

CLOSED SESSION AGENDA ITEMS

REPORT INVOLVING TRADE SECRET

(Government Code §37606 & Health and Safety Code § 32106)

Discussion will concern: (Specify whether discussion will concern proposed new service, program, or facility): Trade Secret, Strategic Planning, Proposed New Programs and Services

Estimated date of public disclosure: (Specify month and year): Unknown

HEARINGS/REPORTS

(Government Code §37624.3 & Health and Safety Code §§1461, 32155)

Subject matter: (Specify whether testimony/deliberation will concern staff privileges, report of medical audit committee, or report of quality assurance committee):

1. Medical Executive Committee Report as presented the same day December 14, 2023.
   A. Credentials Committee Report
   B. Interdisciplinary Practice Committee Report

PUBLIC EMPLOYMENT

(Government Code §54957)

Title: (Specify description of position to be filled): President/Chief Executive Officer

ADJOURN TO OPEN SESSION

CALL TO ORDER/ROLL CALL

(VICTOR REY, JR.)

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

(VICTOR REY, JR.)

RECONVENE OPEN SESSION/
CLOSED SESSION REPORT

(VICTOR REY, JR.)

PUBLIC COMMENT

AWARDS AND RECOGNITION

(VERBAL)

(RADNER)

BOARD MEMBER COMMENTS

(VERBAL)

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM[1]
REGULAR MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
NOVEMBER 16, 2023

Committee Members Present:
In-person: President Victor Rey, Jr., Vice-President Joel Hernandez Laguna, Juan Cabrera, Rolando Cabrera MD., and Catherine Carson
Via Teleconference: None
Absent: None

Also Present:
Pete Delgado, President/Chief Executive Officer
Rakesh Singh, MD., Chief of Staff
Matthew Ottone, Esq., District Legal Counsel
Kathie Haines, Board Clerk

1. CALL TO ORDER/ROLL CALL

A quorum was present and President Victor Rey, Jr., called the meeting to order at 4:06 p.m. in the Downing Resource Center, Rooms A, B, and C.

1.1 PROPOSED ADDITIONS TO THE AGENDA

A request was made by President Rey pursuant to Government Code Section 54954.2(b)(2) to add two items to the Open Session Agenda. Each of the matters require immediate action and the need for action came to the attention of the Board subsequent to the posting of the Amended Agenda. Item 12 *Consideration of Essential Terms and Conditions of Addendum to Employment Agreement of Dr. Allen Radner, M.D. to serve as Interim President/CEO* and Item 13 *Consideration of Essential Terms and Conditions of Addendum to Employment Agreement of Pete Delgado* are to be heard after conclusion of the Extended Closed Session.

MOTION:

Upon motion by Board member R. Cabrera and second by Board member Hernandez Laguna, citing the need to add two Open Session items that came to the attention of the Board Meeting subsequent to the Board amended agenda being posted, the Board of Directors approved adding two Open Session items Item 12 *Consideration of Essential Terms and Conditions of Addendum to Employment Agreement of Dr. Allen Radner, M.D. to serve as Interim President/CEO* and Item 13 *Consideration of Essential Terms and Conditions of Addendum to Employment Agreement of Pete Delgado* to be heard after conclusion of the Extended Closed Session.

Public Comment
None

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, Hernandez Laguna, and Rey
Noes: None;

[1]Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

Abstentions: None;
Absent: None

Motion Carried

2. CLOSED SESSION

President Rey announced items to be discussed in Closed Session as listed on the posted Agenda are *(1) Reports Involving Trade Secret, (2) Hearings and Reports and (3) Public Appointment: Interim President/Chief Executive Officer*. The meeting recessed into Closed Session under the Closed Session Protocol at 4:10 p.m. The Board completed its business of the Closed Session at 5:28 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 5:33 p.m. President Rey reported that in Closed Session, the Board discussed *(1) Reports Involving Trade Secret, and (2) Hearings and Reports*. The Board received and accepted the reports listed on the Closed Session agenda.

President Rey announced there is a need for an extended closed session. The item to be discussed in Extended Closed Session will be *Public Appointment: Interim President/Chief Executive Officer.*

4. PUBLIC COMMENT

The following public input was received:

Check Presentation: Credit Union for Kids (Partners: Bay Federal, Central Coast, and Santa Cruz Community Credit Unions). Leonela Gonzalez, CMN Program Coordinator introduced the representatives for Credit Unions for Kids as follows: Leinette Limtiaco, CEO, Central Coast Federal Credit Union, Katie Fairbairn, Chief Experience Office, from Santa Cruz Community Credit Union, Beth Carr, CEO, Santa Cruz Community Credit Union, and Cameron Haste, EVP & COO, Bay Federal Credit Union who. Credit union for kids. Cameron Haste. Mr. Haste described the joint venture Credit Unions for Kids which raised $52,495 for the Foundation to fund CMN. The group was thanked for their generous donation.

Stephanie Chaney spoke about Christmas in Closter Park, thanking Salinas Valley Health for their support.

5. BOARD MEMBER COMMENTS

Vice President Joel Hernandez Laguna: none

Director Rolando Cabrera, MD: Recognized Kathie Haines for stepping up to support Administration and the Board.

Director Juan Cabrera: Spoke to the importance of having a mobile clinic at the high schools. Many take advantage of the mobile clinic and students are able to obtain their sports physicals. This is a great thing we do for community. Director Cabrera has received positive feedback regarding our Flu Clinic. Director Cabrera has been asked by city of Gonzales to speak to their city council and the Gonzales rotary Club regarding Salinas Valley Health and the Mobile Clinic.

Director Catherine Carson: none.

President Victor Rey, Jr.: This is Diabetes Awareness Month. This is a big initiative in our county and community and Director Rey suggested checking social media for national tobacco avoidance, beach clean-ups and other activities that support diabetes awareness and health.

6. CONSENT AGENDA – GENERAL BUSINESS

A. President's Report
B. Minutes of October 19, 2023, Special Meeting of the Board of Directors
C. Minutes of October 26, 2023, Regular Meeting of the Board of Directors
D. Minutes of November 1, 2023, Special Meeting of the Board of Directors
E. Financial Report
F. Statistical Report
G. Policies Requiring Approval
    1. Background Checks
    2. Business Plan
    3. California Paid Sick Leave
    4. CCS Paneled Pediatrician/Neonatologist
    5. Electronic Communications (Acceptable Use)
    6. Emergency Management Program Plan
    7. Falls, Management of the Patient
    8. Hazardous Materials & Waste Management Plan
    9. Nursing Record - Surgery Intraoperative
    10. Patient Safety Attendant Guidelines
    11. Policy and Procedure Management
    12. Preceptor
    13. Sale, Purchase, and Lease of District Real Property
    14. Scope of Service: Physician and Business Development
    15. Staff Nurse III Application
    16. Withdrawing Life-Sustaining Treatment and Withholding Cardiopulmonary Resuscitation
H. Board Member Compensation and Expenditure Reimbursement Policy

- Board President Report
- Questions to Board President/Staff
- Public Comment
- Board Discussion/Deliberation
- Motion/Second
- Action by Board/Roll Call Vote

PUBLIC COMMENT:
None

BOARD MEMBER DISCUSSION: Further discussion with staff clarified the Emergency Management Program Plan states the Board is to receive an annual report; Mr. Miller will agendize for an upcoming Board of Directors Meeting. The Board Member Compensation and Expenditure Reimbursement Policy will require annual approval.

MOTION:

Upon motion by Director R. Cabrera, MD, second by Director J. Cabrera, the Board of Directors approved the Consent Agenda, Items (A) through (H), as presented.

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, Hernandez Laguna, and Rey
Noes: None;
Abstentions: None;
Absent: None

Motion Carried

7. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

A report was received from Director Catherine Carson regarding the Quality and Efficient Practices Committee. SVHMC Patient and Employee Quality & Safety Dashboard 2023 reflects the quality of care in this institution.

B. FINANCE COMMITTEE

A report was received from Director Hernandez Laguna regarding the Finance Committee. During this time of financial struggles in healthcare, the Salinas Valley Health team is working diligently to diminish its impact.

C. PERSONNEL, PENSION, AND INVESTMENT COMMITTEE

A report was received from Director Juan Cabrera regarding the Personnel, Pension, and Investment Committee. Creative Planning Retirement Services reviewed policy decisions, provided training on best practices for fiduciaries, and provided an Investment Performance update for Quarter Ending September 30, 2023 of SVMHS's 403 (b) Plan, 457 Plan, and Employee Pension Plan.

The following recommendation was made:

1. ***Consider recommendation for Board approval of:***
    a. ***Findings Supporting Recruitment of Ramaiaha Indudhara, MD.;***
    b. ***Contract Terms for Dr. Indudhara's Recruitment Agreement, and;***
    c. ***Contract Terms for Dr. Indudhara's Urology Professional Services Agreement***

- Staff Report
- Committee Questions to Staff
- Public Comment
- Committee Discussion/Deliberation
- Motion/Second
- Action by Committee/Roll Call Vote

BOARD MEMBER DISCUSSION:
None

PUBLIC COMMENT:
None

MOTION:

Upon motion by Director R. Cabrera, MD, second by Director J. Cabrera, the Board of Directors approved the findings supporting recruitment as provided in the Board Packet, the Recruitment Agreement and the Urology Professional Service Agreement for Ramaiaha Indudhara, MD.

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, Hernandez Laguna, and Rey
Noes: None;
Abstentions: None;
Absent: None

Motion Carried

C. COMMUNITY ADVOCACY COMMITTEE

A report was received from Director Rolando Cabrera, MD, regarding the Community Advocacy Committee. The Mobile Clinic is providing sports physicals, clinical services, and has partnered with the Monterey County Food Bank. The Blue Zones Project (BZP) provided and update on current activities including tremendous work with policy, grocery stores and diabetes education. The Service League will have an Appreciation Angel Tree this holiday and there is a Therapy Dogs International evaluation in December. The Foundation provided an update on ways they are serving our community including diabetes equipment for the Mobile Clinic. Much is being done to improve the health of our Latino population. Additionally, the Community Advocacy Committee meeting time is changing to Wednesdays at 12:00 pm.

8. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON NOVEMBER 9, 2023, AND RECOMMENDATION FOR BOARD APPROVAL OF THE FOLLOWING

David Ramos, MD, Former Chief of Staff, reviewed the reports of the Medical Executive Committee (MEC) meeting of November 9, 2023, and Rules and Regulations revision. A full report was provided in the Board packet.

Recommend Board Approval of the Following:

a. Reports
    1. Credentials Committee Report
    2. Interdisciplinary Practice Committee Report
b. Policies/Procedures/Plans:
    1. Hyperbilirubinemia-Infant Management Policy
    2. Vacuum-Induced Management of OB Hemorrhage Policy

PUBLIC INPUT:
None

BOARD MEMBER DISCUSSION:
None

MOTION:

Upon motion by Director Carson, second by Director Hernandez Laguna, the Board of Directors receives and approves the Medical Executive Committee Credentials Committee Report and the Interdisciplinary

Practice Committee Report, and the Policies, Plans and Privilege Forms, as follows:

a. Reports
    1. Credentials Committee Report
    2. Interdisciplinary Practice Committee Report
b. Policies/Procedures/Plans:
    1. Hyperbilirubinemia-Infant Management Policy
    2. Vacuum-Induced Management of OB Hemorrhage Policy

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, Hernandez Laguna, and Rey
Noes: None;
Abstentions: None;
Absent: None

Motion Carried

9. CONSIDERATION OF LETTER AGREEMENT WITH WITTKIEFFER FOR RECRUITMENT OF PRESIDENT/CEO

Michelle Childs stated the Statement of Work by Wittkieffer to provide services to search for Chief Executive Officer was included in the packet. The $325K + expenses proposal is in line with the Wittkieffer presentation to the Board of Directors October 26, 2023.

PUBLIC COMMENT:
None

BOARD MEMBER DISCUSSION: Further discussion with staff clarified that additionally, a CEO compensation report has been commissioned. Board members suggested that it was important to form a Search Committee soon.

MOTION:

Upon motion by Director Carson, second by Director Hernandez Laguna, the Board of Directors approves the Letter of Agreement with Wittkieffer for recruitment of a Chief Executive Officer.

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, Hernandez Laguna, and Rey
Noes: None;
Abstentions: None;
Absent: None

Motion Carried

10. CONSIDER RESOLUTION 2023-05 AUTHORIZING DESIGNATED OFFICERS TO EXECUTE FINANCIAL INSTITUTION DOCUMENTS

Matthew Ottone, Esq., District Legal Counsel, reported the resolution was included in the Board Packet for the Boards consideration. The resolution is necessary to for purposes of information for bank and financial institutions necessary to change of administrators through signature cards.

MOTION:

Upon motion by Director J. Cabrera, second by Director Hernandez Laguna, the Board of Directors the

adopted RESOLUTION NO. 2023-05 AUTHORIZING DESIGNATED OFFICERS TO EXECUTE FINANCIAL INSTITUTION DOCUMENTS

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, Hernandez Laguna, and Rey
Noes: None;
Abstentions: None;
Absent: None

Motion Carried

11. EXTENDED CLOSED SESSION

President Rey announced item to be discussed in Extended Closed Session is *Public Employee Appointment - Chief Executive Officer.* The meeting recessed into Closed Session under the Closed Session Protocol at 6:07 p.m. The Board completed its business of the Closed Session at 7:53 p.m. President Rey announced that the following action was taken in Closed Session:

The Board approved the essentials terms and conditions of an Addendum to the Employment Agreement of Pete Delgado requiring a lump sum payment equal the amount of compensation that would have been earned through June 30, 2024, including COBRA payments through June 30, 2024. The date of separation of Mr. Delgado from the District will be effective November 30, 2023. The motion to approve the essential terms and conditions of the Addendum to the Employment Agreement of Pete Delgado was made by Director Carson, second by Director Juan Cabrera. The vote was 5-0.

12. CONSIDER APPROVAL OF ESSENTIAL TERMS AND CONDITIONS OF ADDENDUM TO EMPLOYMENT AGREEMENT OF DR. ALLEN RADNER, M.D. FOR THE POSITION OF INTERIM PRESDIENT/CHIEF EXECUTIVE OFFICER.

Matthew Ottone, Legal Counsel summarized the essential terms and conditions of the proposed Addendum to the Employment Agreement for Dr. Allen Radner, M.D. for the Position of Interim President/Chief Executive Officer: Annual salary will be increased to $800,000.00; Increase to 25% from 20% in the Executive Incentive Plan, Removal of existing section 2.1.2 from the Agreement, and a modification regarding Dr. Radner's ability to continue to work at the Monterey County HIV Clinic and other services as an Infectious Disease Specialist.

PUBLIC COMMENT:
None

BOARD MEMBER DISCUSSION: No Board Member Discussion.

MOTION:

Upon motion by Director Juan Cabrera, second by Director Dr. Rolando Cabrera, the Board of Directors approves the Addendum to the Employment Agreement of Dr. Allen Radner, M.D. as presented.

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, Hernandez Laguna, and Rey
Noes: None;
Abstentions: None;
Absent: None

Motion Carried

14. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, December 14 at 4:00 p.m.** There being no further business, the meeting was adjourned at 7:58 p.m.

_____

Rolando Cabrera, MD
Secretary, Board of Directors

Financial Performance Review

November 2023

Finance Committee – Open Session

Augustine Lopez

Chief Financial Officer

Consolidated Financial Summary
For the Month of November 2023

$ in Millions	For the Month of November 2023			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue (*)	$ 59.4	$ 58.6	$ 0.8	1.4%
Operating Expense	$ 62.0	$ 58.4	$ (3.6)	-6.2%
Income from Operations	**$ (2.6)**	**$ 0.2**	**$ (2.8)**	**-1400.0%**
Operating Margin %	*-4.2%*	*0.4%*	*-4.6%*	*-1150.00%*
Non Operating Income	$ 5.3	$ 1.9	$ 3.4	178.9%
Net Income	**$ 2.7**	**$ 2.1**	**$ 0.6**	**28.6%**
Net Income Margin %	*4.8%*	*3.6%*	*1.2%*	*33.3%*

(*) The above incorporates a full month of revenue for the Anthem business considering the terms on the final negotiated contract.

Non-Operating Income was over budget by $3.4 million predominately driven from favorable bond market investment earnings.

Consolidated Financial Summary
YTD November 2023

$ in Millions	FY 2023 YTD November			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue (*)	$ 284.8	$ 299.4	$ (14.6)	-4.9%
Operating Expense	$ 300.8	$ 298.2	$ (2.6)	-0.9%
Income from Operations	**$ (16.0)**	**$ 1.2**	**$ (17.2)**	**-1433.3%**
Operating Margin %	*-5.6%*	*0.4%*	*-6.0%*	*-1500.0%*
Non Operating Income	$ 15.3	$ 9.5	$ 5.8	61.1%
Net Income	**$ (0.7)**	**$ 10.7**	**$ (11.4)**	**-106.5%**
Net Income Margin %	*-0.2%*	*3.6%*	*-3.8%*	*-105.6%*

SVHMC Revenue Highlights November 2023

Gross Revenues were 4.6% *favorable* to budget

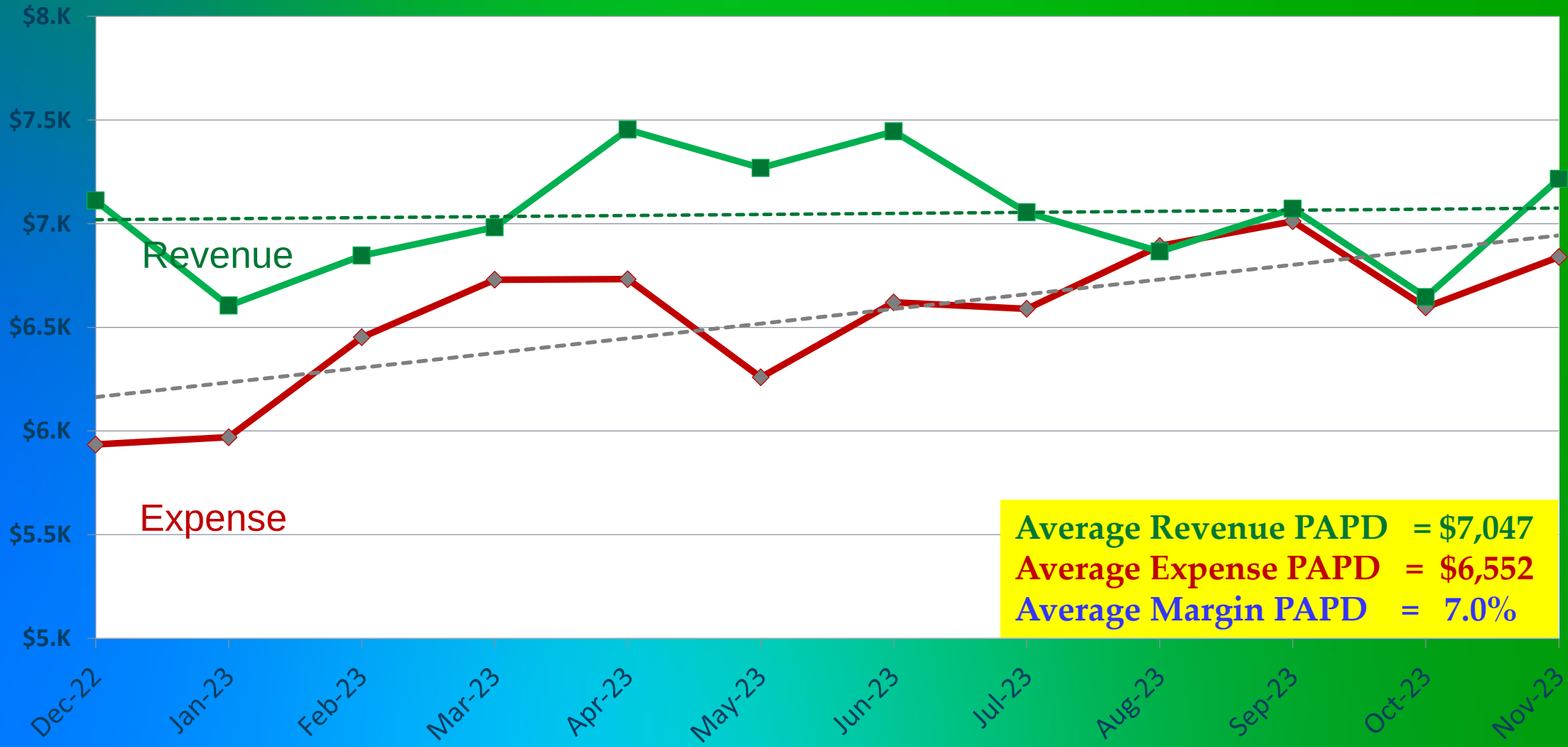
- **IP Gross Revenues** were 2% un*favorable* to budget
- **ED Gross Revenues** were 6% un*favorable* to budget
- **OP Gross Revenues** were 19% *favorable* to budget in the following areas:
  - OP Surgery
  - Mammography
  - Clinical Lab
  - Cath Lab
  - Sleep Lab
  - Nuclear Medicine

- **Commercial:** 5% *below* budget
- **Medicaid: 6%** *above* budget
- **Medicare:** 8% *above* budget

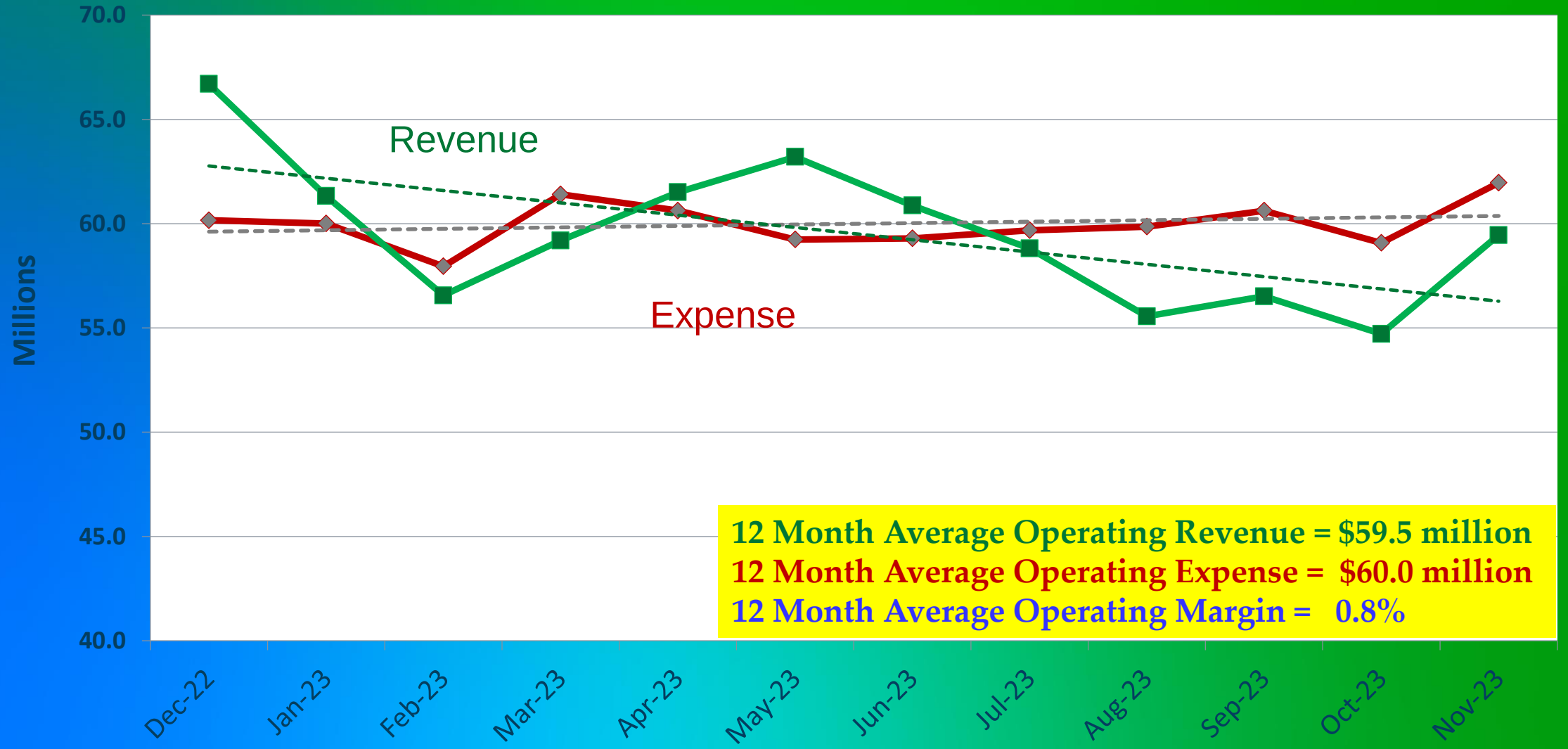
Payor Mix – Unfavorable

Total Net Patient Revenues were **$49.6M**, which was *favorable* to budget by **$1.1M** or 2.2%

SVHMC Revenues & Expenses Per Adjusted Patient Day
Rolling 12 Months: Dec 22 to November 23



SVH Consolidated Revenues & Expenses Rolling 12 Months: Dec 22 to November 23



12 Month Average Operating Revenue = $59.5 million
12 Month Average Operating Expense = $60.0 million
12 Month Average Operating Margin = 0.8%

Salinas Valley Health Key Financial Indicators

Statistic	YTD 11/30/23	SVH Target	+/-	S&P A+ Rated Hospitals	+/-	YTD 11/30/22	+/-
Operating Margin*	-5.6%	5.0%		4.0%		4.0%	
Total Margin*	-0.2%	6.0%		6.6%		5.4%	
EBITDA Margin**	-0.6%	7.4%		13.6%		7.9%	
Days of Cash*	339	305		249		339	
Days of Accounts Payable*	47	45		-		52	
Days of Net Accounts Receivable***	56	45		49		47	
Supply Expense as % NPR	14.3%	14.0%		-		12.8%	
SWB Expense as % NPR	58.0%	53.0%		53.7%		53.2%	
Operating Expense per APD*	6,711	6,739		-		6,204	

*These metrics have been adjusted for normalizing items

**Metric based on Operating Income (consistent with industry standard)

***Metric based on 90 days average net revenue (consistent with industry standard)

Days of Cash and Accounts Payable metrics have been adjusted to ***exclude*** accelerated insurance payments (COVID-19 assistance)

Questions/Comments

SALINAS VALLEY HEALTH MEDICAL CENTER
SUMMARY INCOME STATEMENT
November 30, 2023

	Month of November,		Five months ended November 30,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 49,585,165	$ 55,286,912	$ 236,883,945	$ 257,916,990
Other operating revenue	1,149,044	974,157	5,634,400	3,806,587
Total operating revenue	50,734,209	56,261,069	242,518,345	261,723,577
Total operating expenses	48,088,527	48,373,405	235,992,490	233,701,233
Total non-operating income	627,615	(819,410)	(6,291,872)	(13,824,694)
Operating and non-operating income	$ 3,273,297	$ 7,068,253	$ 233,982	$ 14,197,650

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
November 30, 2023

	Current year	Prior year
ASSETS:		
Current assets	$ 346,274,962	$ 397,401,674
Assets whose use is limited or restricted by board	161,965,370	153,117,307
Capital assets	248,190,717	239,356,248
Other assets	280,630,319	187,898,336
Deferred pension outflows	116,911,125	95,857,027
	$ 1,153,972,493	$ 1,073,630,592
LIABILITIES AND EQUITY:		
Current liabilities	91,389,739	104,107,160
Long term liabilities	22,149,754	18,514,233
Lease deferred inflows	2,081,365	1,911,058
Pension liability	118,792,064	79,111,485
Net assets	919,559,571	869,986,656
	$ 1,153,972,493	$ 1,073,630,592

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF NET PATIENT REVENUE
November 30, 2023

	Month of November,		Five months ended November 30,	
	current year	prior year	current year	prior year
Patient days:				
By payer:				
Medicare	1,725	2,053	8,706	9,723
Medi-Cal	1,203	1,082	5,146	5,557
Commercial insurance	552	895	3,169	3,926
Other patient	69	98	485	505
Total patient days	3,549	4,128	17,506	19,711
Gross revenue:				
Medicare	$ 110,155,535	$ 98,555,970	$ 545,172,033	$ 495,914,639
Medi-Cal	70,955,608	69,880,176	336,478,145	329,928,527
Commercial insurance	49,272,318	55,150,166	257,018,342	263,670,875
Other patient	8,261,786	7,985,184	43,247,054	40,985,119
Gross revenue	238,645,247	231,571,496	1,181,915,574	1,130,499,161
Deductions from revenue:				
Administrative adjustment	311,440	542,573	1,306,512	1,242,728
Charity care	873,259	452,357	4,212,752	3,594,966
Contractual adjustments:				
Medicare outpatient	33,439,918	26,264,780	168,445,376	146,550,732
Medicare inpatient	43,845,699	43,877,421	224,560,391	217,227,444
Medi-Cal traditional outpatient	2,793,674	3,115,903	13,789,444	16,093,264
Medi-Cal traditional inpatient	5,152,729	5,381,718	23,377,239	23,378,779
Medi-Cal managed care outpatient	28,538,615	29,240,501	146,113,252	133,055,180
Medi-Cal managed care inpatient	27,984,579	23,111,034	117,893,595	120,289,867
Commercial insurance outpatient	23,272,284	18,950,929	117,080,123	89,700,417
Commercial insurance inpatient	18,071,382	20,600,241	102,745,887	97,335,812
Uncollectible accounts expense	4,129,670	3,918,025	21,107,153	19,554,056
Other payors	646,833	829,103	4,399,905	4,558,927
Deductions from revenue	189,060,082	176,284,584	945,031,629	872,582,170
Net patient revenue	$ 49,585,165	$ 55,286,912	$ 236,883,945	$ 257,916,990
Gross billed charges by patient type:				
Inpatient	$ 120,766,440	$ 123,757,004	$ 594,898,797	$ 596,912,215
Outpatient	90,546,786	76,776,952	440,367,412	388,652,541
Emergency room	27,332,021	31,037,540	146,649,364	144,934,405
Total	$ 238,645,247	$ 231,571,496	$ 1,181,915,573	$ 1,130,499,161

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES
November 30, 2023

	Month of November,		Five months ended November 30,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 49,585,165	$ 55,286,912	$ 236,883,945	$ 257,916,990
Other operating revenue	1,149,044	974,157	5,634,400	3,806,587
Total operating revenue	50,734,209	56,261,069	242,518,345	261,723,577
Operating expenses:				
Salaries and wages	16,576,708	16,922,532	82,285,948	87,092,024
Compensated absences	3,296,786	3,041,626	15,737,003	14,240,826
Employee benefits	7,383,163	7,433,562	40,727,482	37,302,348
Supplies, food, and linen	7,250,308	6,627,842	35,237,574	33,593,273
Purchased department functions	3,740,831	4,658,075	18,240,846	20,761,103
Medical fees	3,245,376	2,098,008	12,940,854	9,551,956
Other fees	2,289,582	4,178,407	10,701,816	13,889,111
Depreciation	2,585,045	2,007,177	11,994,054	9,470,232
All other expense	1,720,728	1,406,176	8,126,913	7,800,360
Total operating expenses	48,088,527	48,373,405	235,992,490	233,701,233
Income from operations	2,645,682	7,887,664	6,525,855	28,022,344
Non-operating income:				
Donations	146,621	(500,000)	1,333,552	1,301,378
Property taxes	333,333	333,333	1,666,667	1,666,667
Investment income	5,565,006	2,636,873	12,580,815	(1,507,462)
Taxes and licenses	0	0	0	0
Income from subsidiaries	(5,417,345)	(3,289,616)	(21,872,906)	(15,285,277)
Total non-operating income	627,615	(819,410)	(6,291,872)	(13,824,694)
Operating and non-operating income	3,273,297	7,068,253	233,982	14,197,650
Net assets to begin	916,286,274	862,918,402	919,325,588	855,789,006
Net assets to end	$ 919,559,571	$ 869,986,656	$ 919,559,571	$ 869,986,656
Net income excluding non-recurring items	$ 3,273,297	$ 7,068,253	$ 233,982	$ 14,197,650
Non-recurring income (expense) from cost report settlements and re-openings and other non-recurring items	0	0	0	0
Operating and non-operating income	$ 3,273,297	$ 7,068,253	$ 233,982	$ 14,197,650

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF INVESTMENT INCOME
November 30, 2023

	Month of November,		Five months ended November 30,	
	current year	prior year	current year	prior year
Detail of income from subsidiaries:				
Salinas Valley Health Clinics				
Pulmonary Medicine Center	$ (222,902)	$ (111,770)	$ (979,190)	$ (908,702)
Neurological Clinic	(89,187)	(12,047)	(360,595)	(304,371)
Palliative Care Clinic	(106,470)	(79,251)	(430,805)	(327,015)
Surgery Clinic	(187,752)	(134,218)	(914,980)	(690,614)
Infectious Disease Clinic	(46,535)	(26,451)	(171,209)	(146,410)
Endocrinology Clinic	(306,258)	(194,621)	(1,123,131)	(806,969)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(647,334)	(438,292)	(2,746,754)	(2,106,205)
OB/GYN Clinic	(516,410)	(401,220)	(1,960,535)	(1,446,870)
PrimeCare Medical Group	(1,033,538)	(758,596)	(4,323,445)	(2,394,173)
Oncology Clinic	(345,487)	(107,818)	(1,562,636)	(1,298,752)
Cardiac Surgery	(337,757)	(368,742)	(1,604,763)	(1,203,158)
Sleep Center	(73,557)	(55,564)	(235,667)	(99,596)
Rheumatology	(79,272)	(64,385)	(334,674)	(300,553)
Precision Ortho MDs	(600,976)	(344,796)	(2,327,379)	(1,775,261)
Precision Ortho-MRI	0	0	0	0
Precision Ortho-PT	(47,878)	(6,132)	(214,405)	(181,546)
Vaccine Clinic	16	0	16	(683)
Dermatology	(43,062)	(1,343)	(202,822)	(77,398)
Hospitalists	0	0	0	0
Behavioral Health	(41,595)	(32,677)	(206,982)	(150,164)
Pediatric Diabetes	(49,805)	(46,126)	(242,687)	(228,380)
Neurosurgery	(42,327)	(17,899)	(155,140)	(146,591)
Multi-Specialty-RR	2,558	16,825	23,392	64,046
Radiology	(569,824)	(230,896)	(1,447,615)	(866,632)
Salinas Family Practice	(160,753)	(53,339)	(696,528)	(454,376)
Urology	(164,278)	20,154	(835,999)	(457,190)
Total SVHC	(5,710,383)	(3,449,204)	(23,054,533)	(16,307,563)
Doctors on Duty	55,470	84,670	242,499	397,775
Vantage Surgery Center	0	0	0	0
LPCH NICU JV	0	0	0	0
Central Coast Health Connect	0	0	0	0
Monterey Peninsula Surgery Center	162,327	131,188	591,705	596,143
Coastal	34,801	(74,597)	182,389	(132,122)
Apex	0	0	0	0
21st Century Oncology	(14,474)	(18,264)	(29,183)	(46,210)
Monterey Bay Endoscopy Center	54,914	36,591	194,216	206,699
Total	$ (5,417,345)	$ (3,289,616)	$ (21,872,906)	$ (15,285,277)

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
November 30, 2023

	Current year	Prior year
A S S E T S		
Current assets:		
Cash and cash equivalents	$ 228,564,413	$ 290,229,340
Patient accounts receivable, net of estimated uncollectibles of $27,815,393	93,284,701	85,648,398
Supplies inventory at cost	8,083,218	7,742,643
Current portion of lease receivable	1,442,959	534,201
Other current assets	14,899,672	13,247,092
Total current assets	346,274,962	397,401,674
Assets whose use is limited or restricted by board	161,965,370	153,117,307
Capital assets:		
Land and construction in process	69,244,463	44,208,973
Other capital assets, net of depreciation	178,946,254	195,147,275
Total capital assets	248,190,717	239,356,248
Other assets:		
Right of use assets, net of amortization	7,349,769	7,137,296
Long term lease receivable	788,673	1,462,610
Subscription assets, net of amortization	8,781,398	0
Investment in Securities	242,630,408	142,841,904
Investment in SVMC	3,540,645	12,189,118
Investment in Coastal	1,864,030	1,511,578
Investment in other affiliates	21,745,472	23,318,527
Net pension asset	(6,070,076)	(562,697)
Total other assets	280,630,319	187,898,336
Deferred pension outflows	116,911,125	95,857,027
	$ 1,153,972,493	$ 1,073,630,592
L I A B I L I T I E S A N D N E T A S S E T S		
Current liabilities:		
Accounts payable and accrued expenses	$ 61,222,400	$ 65,155,039
Due to third party payers	5,293,261	17,909,653
Current portion of self-insurance liability	17,963,703	18,106,500
Current subscription liability	4,371,672	0
Current portion of lease liability	2,538,703	2,935,968
Total current liabilities	91,389,739	104,107,160
Long term portion of workers comp liability	13,027,333	14,058,922
Long term portion of lease liability	5,028,217	4,455,311
Long term subscription liability	4,094,204	0
Total liabilities	113,539,493	122,621,393
Lease deferred inflows	2,081,365	1,911,058
Pension liability	118,792,064	79,111,485
Net assets:		
Invested in capital assets, net of related debt	248,190,717	239,356,248
Unrestricted	671,368,854	630,630,408
Total net assets	919,559,571	869,986,656
	$ 1,153,972,493	$ 1,073,630,592

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
November 30, 2023

	Month of November,				Five months ended November 30,			
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var
Operating revenue:								
Gross billed charges	$ 238,645,247	$ 228,115,069	10,530,178	4.62%	$ 1,181,915,574	$ 1,163,476,672	18,438,902	1.58%
Dedutions from revenue	189,060,082	179,597,671	9,462,411	5.27%	945,031,629	914,993,393	30,038,236	3.28%
Net patient revenue	49,585,165	48,517,398	1,067,767	2.20%	236,883,945	248,483,279	(11,599,334)	-4.67%
Other operating revenue	1,149,044	1,332,540	(183,496)	-13.77%	5,634,400	6,662,700	(1,028,300)	-15.43%
Total operating revenue	**50,734,209**	**49,849,938**	**884,271**	**1.77%**	**242,518,345**	**255,145,979**	**(12,627,634)**	**-4.95%**
Operating expenses:								
Salaries and wages	16,576,708	16,370,471	206,237	1.26%	82,285,948	84,539,523	(2,253,575)	-2.67%
Compensated absences	3,296,786	3,338,348	(41,562)	-1.24%	15,737,003	15,675,698	61,305	0.39%
Employee benefits	7,383,163	7,299,643	83,520	1.14%	40,727,482	39,225,923	1,501,559	3.83%
Supplies, food, and linen	7,250,308	6,679,670	570,638	8.54%	35,237,574	34,057,175	1,180,399	3.47%
Purchased department functions	3,740,831	3,539,228	201,603	5.70%	18,240,846	17,696,146	544,700	3.08%
Medical fees	3,245,376	2,359,060	886,316	37.57%	12,940,854	11,795,301	1,145,553	9.71%
Other fees	2,289,582	2,222,815	66,767	3.00%	10,701,816	11,254,215	(552,399)	-4.91%
Depreciation	2,585,045	2,084,695	500,350	24.00%	11,994,054	10,588,146	1,405,908	13.28%
All other expense	1,720,728	1,801,863	(81,135)	-4.50%	8,126,913	9,127,717	(1,000,804)	-10.96%
Total operating expenses	**48,088,527**	**45,695,794**	**2,392,733**	**5.24%**	**235,992,490**	**233,959,843**	**2,032,647**	**0.87%**
Income from operations	**2,645,682**	**4,154,144**	**(1,508,462)**	**-36.31%**	**6,525,855**	**21,186,135**	**(14,660,280)**	**-69.20%**
Non-operating income:								
Donations	146,621	166,667	(20,046)	-12.03%	1,333,552	833,333	500,219	60.03%
Property taxes	333,333	333,333	(0)	0.00%	1,666,667	1,666,667	0	0.00%
Investment income	5,565,006	1,185,806	4,379,201	369.30%	12,580,815	5,929,028	6,651,787	112.19%
Income from subsidiaries	(5,417,345)	(3,899,437)	(1,517,908)	38.93%	(21,872,906)	(19,763,516)	(2,109,390)	10.67%
Total non-operating income	**627,615**	**(2,213,632)**	**2,841,247**	**-128.35%**	**(6,291,872)**	**(11,334,488)**	**5,042,616**	**-44.49%**
Operating and non-operating income	**$ 3,273,297**	**$ 1,940,513**	**1,332,785**	**68.68%**	**$ 233,983**	**$ 9,851,647**	**(9,617,665)**	**-97.62%**

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of Nov and five months to date

	Month of Nov		Five months to date		
	2022	2023	2022-23	2023-24	Variance
NEWBORN STATISTICS					
Medi-Cal Admissions	42	47	195	183	(12)
Other Admissions	98	83	443	412	(31)
Total Admissions	140	130	638	595	(43)
Medi-Cal Patient Days	64	0	303	221	(82)
Other Patient Days	170	221	738	777	39
Total Patient Days of Care	234	221	1,041	998	(43)
Average Daily Census	7.8	7.4	6.8	6.5	(0.3)
Medi-Cal Average Days	1.6	0.0	1.6	1.3	(0.3)
Other Average Days	1.2	2.7	1.7	1.9	0.2
Total Average Days Stay	1.8	1.8	1.7	1.7	0.1
ADULTS & PEDIATRICS					
Medicare Admissions	414	361	1,958	1,820	(138)
Medi-Cal Admissions	352	320	1,463	1,297	(166)
Other Admissions	415	289	1,575	1,442	(133)
Total Admissions	1,181	970	4,996	4,559	(437)
Medicare Patient Days	1,718	0	8,088	5,942	(2,146)
Medi-Cal Patient Days	1,122	0	5,766	4,053	(1,713)
Other Patient Days	1,071	3,329	5,118	6,325	1,207
Total Patient Days of Care	3,911	3,329	18,972	16,320	(2,652)
Average Daily Census	130.4	111.0	124.0	106.7	(17.3)
Medicare Average Length of Stay	4.3	0.0	4.2	3.3	(0.9)
Medi-Cal AverageLength of Stay	3.3	0.0	3.5	2.7	(0.8)
Other Average Length of Stay	2.6	9.0	2.6	3.5	0.9
Total Average Length of Stay	3.4	3.0	3.4	3.2	(0.2)
Deaths	17	26	103	126	23
Total Patient Days	4,145	3,550	20,013	17,318	(2,695)
Medi-Cal Administrative Days	6	0	38	5	(33)
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	6	0	38	5	(33)
Percent Non-Acute	0.14%	0.00%	0.19%	0.03%	-0.16%

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of Nov and five months to date

	Month of Nov		Five months to date		
	2022	2023	2022-23	2023-24	Variance
PATIENT DAYS BY LOCATION					
Level I	271	231	1,357	1,172	(185)
Heart Center	341	306	1,708	1,614	(94)
Monitored Beds	637	597	3,210	3,019	(191)
Single Room Maternity/Obstetrics	394	373	1,770	1,630	(140)
Med/Surg - Cardiovascular	888	836	4,513	4,053	(460)
Med/Surg - Oncology	296	274	1,278	1,356	78
Med/Surg - Rehab	518	442	2,596	2,174	(422)
Pediatrics	156	151	660	649	(11)
Nursery	234	221	1,041	998	(43)
Neonatal Intensive Care	216	119	749	653	(96)
PERCENTAGE OF OCCUPANCY					
Level I	69.49%	59.23%	68.23%	58.92%	
Heart Center	75.78%	68.00%	74.42%	70.33%	
Monitored Beds	78.64%	73.70%	77.71%	73.08%	
Single Room Maternity/Obstetrics	35.50%	33.60%	31.27%	28.79%	
Med/Surg - Cardiovascular	65.78%	61.93%	65.55%	58.87%	
Med/Surg - Oncology	75.90%	70.26%	64.25%	68.17%	
Med/Surg - Rehab	66.41%	56.67%	65.26%	54.65%	
Med/Surg - Observation Care Unit	0.00%	0.00%	0.00%	0.00%	
Pediatrics	28.89%	27.96%	23.97%	23.57%	
Nursery	47.27%	44.65%	20.62%	19.77%	
Neonatal Intensive Care	65.45%	36.06%	44.50%	38.80%	

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of Nov and five months to date

	Month of Nov		Five months to date		
	2022	2023	2022-23	2023-24	Variance
DELIVERY ROOM					
Total deliveries	132	83	617	535	(82)
C-Section deliveries	38	44	181	191	10
Percent of C-section deliveries	28.79%	53.01%	29.34%	35.70%	6.37%
OPERATING ROOM					
In-Patient Operating Minutes	18,841	14,628	98,916	79,005	(19,911)
Out-Patient Operating Minutes	29,659	30,161	132,968	150,951	17,983
Total	48,500	44,789	231,884	229,956	(1,928)
Open Heart Surgeries	16	11	68	50	(18)
In-Patient Cases	119	105	688	583	(105)
Out-Patient Cases	298	300	1,379	1,484	105
EMERGENCY ROOM					
Immediate Life Saving	28	40	134	187	53
High Risk	637	691	2,802	3,465	663
More Than One Resource	3,059	2,843	15,024	14,227	(797)
One Resource	3,089	2,203	11,413	9,845	(1,568)
No Resources	93	78	464	530	66
Total	6,906	5,855	29,837	28,254	(1,583)

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of Nov and five months to date

	Month of Nov		Five months to date		
	2022	2023	2022-23	2023-24	Variance
CENTRAL SUPPLY					
In-patient requisitions	14,316	12,198	73,351	64,539	-8,812
Out-patient requisitions	9,480	10,247	47,420	52,103	4,683
Emergency room requisitions	453	634	2,753	3,907	1,154
Interdepartmental requisitions	7,119	6,830	35,100	32,325	-2,775
Total requisitions	31,368	29,909	158,624	152,874	-5,750
LABORATORY					
In-patient procedures	40,584	36,882	193,803	176,973	-16,830
Out-patient procedures	9,630	37,539	53,391	92,710	39,319
Emergency room procedures	14,597	12,702	66,200	64,771	-1,429
Total patient procedures	64,811	87,123	313,394	334,454	21,060
BLOOD BANK					
Units processed	278	301	1,645	1,537	-108
ELECTROCARDIOLOGY					
In-patient procedures	1,054	1,087	5,360	5,217	-143
Out-patient procedures	350	421	1,751	1,985	234
Emergency room procedures	1,047	1,140	5,526	5,948	422
Total procedures	2,451	2,648	12,637	13,150	513
CATH LAB					
In-patient procedures	85	131	465	610	145
Out-patient procedures	85	129	429	542	113
Emergency room procedures	0	0	1	0	-1
Total procedures	170	260	895	1,152	257
ECHO-CARDIOLOGY					
In-patient studies	388	390	1,932	1,791	-141
Out-patient studies	219	301	1,100	1,323	223
Emergency room studies	1	1	5	7	2
Total studies	608	692	3,037	3,121	84
NEURODIAGNOSTIC					
In-patient procedures	155	139	734	650	-84
Out-patient procedures	17	23	84	101	17
Emergency room procedures	0	0	0	0	0
Total procedures	172	162	818	751	-67

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of Nov and five months to date

	Month of Nov		Five months to date		
	2022	2023	2022-23	2023-24	Variance
SLEEP CENTER					
In-patient procedures	0	0	1	0	-1
Out-patient procedures	143	230	719	1,139	420
Emergency room procedures	0	0	1	0	-1
Total procedures	143	230	721	1,139	418
RADIOLOGY					
In-patient procedures	1,506	1,311	6,835	6,290	-545
Out-patient procedures	340	385	1,772	2,007	235
Emergency room procedures	1,707	1,504	7,787	7,474	-313
Total patient procedures	3,553	3,200	16,394	15,771	-623
MAGNETIC RESONANCE IMAGING					
In-patient procedures	139	137	784	708	-76
Out-patient procedures	104	102	541	601	60
Emergency room procedures	9	7	37	37	0
Total procedures	252	246	1,362	1,346	-16
MAMMOGRAPHY CENTER					
In-patient procedures	3,767	4,214	20,766	20,918	152
Out-patient procedures	3,745	4,151	20,609	20,668	59
Emergency room procedures	0	3	2	9	7
Total procedures	7,512	8,368	41,377	41,595	218
NUCLEAR MEDICINE					
In-patient procedures	20	23	105	96	-9
Out-patient procedures	77	94	449	513	64
Emergency room procedures	0	1	1	1	0
Total procedures	97	118	555	610	55
PHARMACY					
In-patient prescriptions	93,329	80,960	460,727	403,779	-56,948
Out-patient prescriptions	14,508	15,539	74,447	79,342	4,895
Emergency room prescriptions	10,456	9,593	45,536	46,345	809
Total prescriptions	118,293	106,092	580,710	529,466	-51,244
RESPIRATORY THERAPY					
In-patient treatments	15,773	18,583	78,452	77,938	-514
Out-patient treatments	1,253	831	5,408	5,216	-192
Emergency room treatments	644	551	2,117	2,618	501
Total patient treatments	17,670	19,965	85,977	85,772	-205
PHYSICAL THERAPY					
In-patient treatments	2,821	2,774	12,662	12,725	63
Out-patient treatments	172	297	889	1,312	423
Emergency room treatments	0	0	0	0	0
Total treatments	2,993	3,071	13,551	14,037	486

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of Nov and five months to date

	Month of Nov		Five months to date		
	2022	2023	2022-23	2023-24	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,474	1,222	8,035	7,253	-782
Out-patient procedures	153	273	796	1,199	403
Emergency room procedures	0	0	0	0	0
Total procedures	1,627	1,495	8,831	8,452	-379
SPEECH THERAPY					
In-patient treatments	398	519	2,134	2,445	311
Out-patient treatments	27	31	126	174	48
Emergency room treatments	0	0	0	0	0
Total treatments	425	550	2,260	2,619	359
CARDIAC REHABILITATION					
In-patient treatments	0	6	1	9	8
Out-patient treatments	624	476	2,572	2,483	-89
Emergency room treatments	0	0	0	0	0
Total treatments	624	482	2,573	2,492	-81
CRITICAL DECISION UNIT					
Observation hours	392	262	1,846	1,413	-433
ENDOSCOPY					
In-patient procedures	66	84	451	358	-93
Out-patient procedures	82	67	305	291	-14
Emergency room procedures	0	0	0	0	0
Total procedures	148	151	756	649	-107
C.T. SCAN					
In-patient procedures	714	694	3,538	3,436	-102
Out-patient procedures	346	270	1,983	1,828	-155
Emergency room procedures	620	674	3,421	3,706	285
Total procedures	1,680	1,638	8,942	8,970	28
DIETARY					
Routine patient diets	21,215	13,125	127,166	90,282	-36,884
Meals to personnel	25,715	27,438	126,994	139,964	12,970
Total diets and meals	46,930	40,563	254,160	230,246	-23,914
LAUNDRY AND LINEN					
Total pounds laundered	102,767	97,293	494,081	482,757	-11,324

Memorandum

To: Board of Directors

From: Clement Miller, COO

Date: December 4, 2023

Re: Policies Requiring Approval

As required under Title 22, CMS, and The Joint Commission (TJC), please find below a list of regulatory required policies with summary of changes that require your approval.

	Policy Title	Summary of Changes	Responsible Executive
1.	Chargemaster Available to the Public Payer's Bill of Rights AB 1627	Removing OSHPD and replacing with HCAi. References updated.	Augustine Lopez, CFO
2.	Financial Assistance Program/Full Charity Care & Discount Partial Charity Care	Hospital name change, OSHPD name change, and added language related to transaction codes.	Augustine Lopez, CFO
3.	Infant Driven Feeding Protocol	General information statement updates: will changed to should.	Lisa Paulo, CNO
4.	Information Technology Acquisition	Policy Statement and purpose shortened to be more concise. Formatting changes. References updated.	Audrey Parks, CIO
5.	Intraosseous Infusion Standardized Procedure Nursing Standardized Procedure	New Standardized Procedure.	Lisa Paulo, CNO
6.	Neonate Gavage Feeding	Updated references and hang time attachment. Policy template and approval flow corrections made.	Lisa Paulo, CNO
7.	Percutaneous Ventricular Assist Device Implantation (Clinical)	Added Sodium bicarb solution for purge, updated references, added info for RP, removed Heparin purge.	Lisa Paulo, CNO
8.	Scope of Service: Critical Care	Adding language about the Intensivists.	Clement Miller, COO
9.	Visitors	Updates to NICU visitor procedure.	Lisa Paulo, CNO

Status **Pending** PolicyStat ID **14710061**

Last Approved	N/A
Last Revised	11/2023
Next Review	3 years after approval
Owner	Charlotte Wayman: Director Pt Financial Svcs/Pt Registration
Area	Administration

Chargemaster Available to the Public Payer's Bill of Rights AB 1627

I. POLICY STATEMENT

A. An uncomplicated version of the Salinas Valley Health Medical Center (SVHMC) chargemaster (CDM) will be made available to the general public. Said version will consist of a listing of all supplies and services billed to the general population at large. At a minimum, the list will consist of the billing description and associated charge(s). A copy of the abbreviated CDM will be located in Patient Financial Services. Said version(s) will be updated periodically as required by law and/or as directed by senior management.

II. PURPOSE

To meet the requirements of California State Law (AB1627) Payers Bill of Rights.

III. DEFINITIONS

A. The chargemaster is a database utilized by all departments for accurate charge generation and capture. It defines services performed and supplies provided. It also allows for appropriate selection of charges with correct CPT, HCPCS and other required codes, consistent with all payer requirements. It facilitates accurate generation of statistical information for internal and external reporting requirements.

IV. GENERAL INFORMATION

A. Where an outpatient fee schedule is listed in the CDM, such fee will be included in the listing available to the general public.

B. The CDM will be available for viewing by any individual upon written request. Viewing will be by appointment and under the supervision of a hospital designee knowledgeable of the CDM content and related issues. No copies will be provided to any individual for viewing off the

hospital premises. Should the CDM be published on the hospital web site, it will be in view only format.

C. A list of twenty-five commonly provided outpatient services or procedures will be developed in co-ordination with members of senior management. It will be available for public inspection upon request.

D. Salinas Valley Health Medical Center will respond timely and accurately to all ~~OSHPD~~HCAi requests for CDM data and reports.

E. As required, a notice of the CDM availability and contact phone number will be posted in the hospital Emergency Department, Admitting and Patient Financial Services.

F. Calculation of the percentage change in gross revenue from any rate changes in the prior year is submitted to ~~OSHPD~~HCAi.

G. Compliance with AB 1627 and AB 1045 requirements affects, but is not limited to, Patient Financial Services, General Accounting, and Internal Audit/ Compliance (Audit).

H. California State Law AB 1627 (Payer's Bill of Rights) requires the publication for public review of all charges available to the general public. In addition hospitals are required to publish a listing of the charges for twenty-five commonly performed procedures or services. Such publications may be in written or electronic format.

I. The law does not require any viewing of CDM documents to be at a location other than the hospital or on the hospital Internet Web site.

J. This law also requires the submission of related data to the ~~Office of Statewide~~Department of Health ~~Planning and Development~~Care Access and Information (~~OSHPD~~HCAi).

V. PROCEDURE

A. Data submission to ~~OSHPD~~HCAi.

1. Patient Financial Services along with Information Technology Department obtains a utilization report for the past year and selects procedure utilization data as requested by ~~OSHPD~~HCAi. Utilization data submitted to ~~OSHPD~~HCAi is included with the CDM provided to Patient Financial Services for public viewing.
2. Obtain the annual revenue change report from the Controller or designee.
3. Complete data report requests for ~~OSHPD~~HCAi as required and submit data reports in accordance with stated requirements annually before July 1.

B. Post notices of CDM availability in the Emergency Department, Admitting, and Patient Financial Services.

C. Requests to view the chargemaster

1. Upon request to view the CDM and/or abbreviated list of services, have requestor complete attached form. (Form may be faxed to the requestor for completion.)
2. Schedule time for document viewing with designated staff within 10 working days of the request.
   NOTE: Do not provide any copies to be removed from the premises.
3. Allow requestor to review CDM and answer any questions the requestor may have.

4. Maintain a file of all requests, tracking appointments and any required follow-up.

D. Documentation:

1. Documentation of compliance with AB 1627 and AB 1045 will be through the maintenance of all requests to view the CDM and/or the abbreviated listing and completion of requests for ~~OSHPD~~HCAi data and related compliance.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. California State Assembly Bill No. 1627; Business and Professions Code Chapter 2 of Division 2, Article 11 Section 1339.50 of the Health and Safety Code

B. California Hospital Association Implementation Fact Sheet

C. ~~Office of Statewide Health Planning and Development Frequently Asked Questions: Chargemaster Reporting as of 5-26-04.~~Department of Health Care Access and Information Frequently Asked Questions: Hospital Chargemasters.

D. California State Assembly Bill No. 1045; business and Professions Code *Chapter532, Statutes of 2005.*

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2023
Policy Owner	Charlotte Wayman: Director Pt Financial Svcs/Pt Registration	11/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 14695690

Last Approved	N/A
Last Revised	11/2023
Next Review	3 years after approval
Owner	Charlotte Wayman: Director Pt Financial Svcs/Pt Registration
Area	Administration

Financial Assistance Program/Full Charity Care & Discount Partial Charity Care

I. POLICY STATEMENT

A. No individual who is determined to be eligible for financial assistance will be charged more for emergency or other medically necessary care than the Amounts Generally Billed to individuals who have insurance covering such care.

II. PURPOSE

A. California acute care hospitals must comply with Health & Safety Code requirements for written policies providing discounts and charity care to financially qualified patients. This Policy is intended to meet such legal obligations and provides for both charity care and discounts to patients who financially qualify under the terms and conditions of the Salinas Valley ~~Memorial Hospital~~Health Medical Center Financial Assistance Program.

B. The finance department has responsibility for general accounting policy and procedure. Included within this purpose is a duty to ensure the consistent timing, recording and accounting treatment of transactions at SVHMC. This includes the handling of patient accounting transactions in a manner that supports the mission and operational goals of Salinas Valley Health Medical Center ~~(SVHMC). This includes the handling of patient accounting transactions in a manner that supports the mission and operational goals of Salinas Valley Memorial Hospital.~~

III. DEFINITIONS

A. **Amounts Generally Billed**: The amounts generally billed (~~"~~"AGB~~"~~") for emergency or other medically necessary services to individuals eligible for Discount Partial Charity Care. SVHMC calculates the AGB for a patient using the Prospective Method as defined in the Federal Income Tax Regulations. Under the Prospective Method, AGB is calculated using the billing and coding process SVHMC would use if the individual were a Medicare fee-for-service

beneficiary using the currently applicable Medicare rates provided by the Centers for Medicare & Medicaid Services.

B. **Discount Partial Charity Care**: Discount Partial Charity Care is defined as any emergency or medically necessary inpatient or outpatient hospital service provided to a patient who is uninsured or underinsured and 1) desires assistance with paying their hospital bill; 2) has an income between 201% and 400% of the current federal poverty level; and 3) who has established qualification in accordance with requirements contained in the Policy. The discount will be applied against the gross charges for hospital services provided.

C. **Emergency and Medically Necessary:** Emergency and medically necessary services are defined as any hospital emergency, inpatient, outpatient, or emergency medical care that is not entirely elective for patient comfort and/or convenience. This includes those procedures that are scheduled and the patient has minimal benefit coverage, i.e., heart procedures, infusion therapy services and chemotherapy. This generally excludes those patients with a benefit design that requires them to utilize a designated facility.

D. **Eligibility for Financial Assistance**: Eligibility is available for any patient receiving emergency or medically necessary services whose family income is less than 400% of the current federal poverty level, if not covered by third party insurance or if covered by third party insurance and unable to pay the patient liability amount owed after insurance has paid its portion of the account. Depending upon individual patient eligibility, financial assistance may be granted for Full Charity Care or Discount Partial Charity Care. Financial assistance may be denied when the patient or other responsible family representative does not meet the SVHMC Financial Assistance Policy requirements.

E. **Extraordinary Collection Actions**: Extraordinary Collection Actions means a collection action requiring a legal or judicial process, involving selling debt to another party, reporting adverse information to credit agencies or bureaus, or deferring or denying, or requiring a payment before providing, medically necessary care because of an individual''s nonpayment of one or more bills for previously provided care covered under SVHMC''s Financial Assistance Policy. The actions that require legal or judicial process for this purpose include 1) placing a lien; 2) foreclosing on real property; 3) attaching or seizing of bank accounts or other personal property; 4) commencing a civil action against an individual; 5) taking actions that cause an individual''s arrest; 6) taking actions that cause an individual to be subject to body attachment; and 7) garnishing wages.

F. **Family**: A patient''s family is defined as: 1) For persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and 2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent of caretaker relative.

G. **Full Charity Care**: Full Charity Care is defined as any emergency or medically necessary inpatient or outpatient hospital service provided to a patient who has an income below 200% of the current federal poverty level and is unable to pay for care and who has established qualification in accordance with requirements contained in the SVHMC Financial Assistance Policy.

H. **Medi-Cal Share of Cost**. As required by state law, patient obligations for Medi-Cal share of cost payments will not be waived under any circumstance.

IV. GENERAL INFORMATION

A. This Financial Assistance Policy pertains to financial assistance provided by Salinas Valley ~~Memorial~~Health Medical Center. Under California law, hospitals are not permitted to employ physicians and, accordingly, physician services are provided by independent physician groups not controlled by SVHMC and who are not bound by this policy. Accordingly, this Financial Assistance Policy is applicable only to hospital services provided by SVHMC and specifically excludes medical care provided by physicians who may be members of the SVHMC Medical Staff. Specifically, this Policy applies only to charges for hospital services and is not binding upon other providers of medical services who are not employed or contracted by Hospital~~. Under California law, hospitals are not permitted to employ~~ to provide medical services, including physicians ~~and, accordingly,~~who treat hospital patients on an emergency, inpatient or outpatient basis. For Financial Assistance regarding your emergency room physician ~~services are provided by independent physician groups not controlled by SVHMC and who are not bound by this policy. Accordingly, this Financial Assistance Policy is applicable only to hospital services provided by SVHMC and specifically excludes medical care provided by physicians who may be members of the SVHMC~~billing please contact Salinas Valley Emergency Medical ~~Staff. Specifically, this Policy applies only to charges for hospital services and is not binding upon other providers of medical services who are not employed or contracted by Hospital to provide medical services, including physicians who treat hospital patients on an emergency, inpatient or outpatient basis. For Financial Assistance regarding your emergency room **physician** billing please contact Salinas Valley Emergency Medical~~ Group at (831) 649-1000. Physicians providing services to patients who are uninsured or cannot pay their medical bills due to high medical costs may have their own financial assistance policy to provide assistance.

B. Salinas Valley ~~Memorial Hospital~~Health Medical Center (SVHMC) serves all persons in Salinas and the larger surrounding community area. As a California Healthcare District, Salinas Valley ~~Memorial Hospital~~Health Medical Center is committed to providing high quality, cost effective services to our patients. SVHMC strives to meet the health care needs of all patients who seek inpatient, outpatient and emergency services and is committed to providing access to financial assistance programs when patients are uninsured or underinsured and may need help in paying their hospital bill. Providing patients with opportunities for financial assistance coverage for healthcare services is an important element in fulfilling the Salinas Valley ~~Memorial Hospital~~Health Medical Center mission. This Financial Assistance Program/Full Charity Care & Discount Partial Charity Care Policy (the ~~"~~"Policy~~"~~") defines the SVHMC Financial Assistance Program; its criteria, systems, and methods. The intent of this Policy is to satisfy the requirements of Section 501(r) of the Internal Revenue Code and all provisions should be interpreted accordingly.

C. **FULL CHARITY CARE AND DISCOUNT PARTIAL CHARITY CARE REPORTING**

1. SVHMC will report actual Charity Care provided in accordance with regulatory requirements of the ~~Office of Statewide~~California Department of Health ~~Planning and Development~~Care Access and Information (~~OSHPD~~HCAi) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. To comply with regulation, the hospital will maintain written documentation regarding its Charity Care criteria, and for individual patients, the hospital will maintain written documentation regarding all Charity Care determinations. As required by

~~OSHPD~~HCAi, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.

2. SVHMC will provide ~~OSHPD~~HCAi with a copy of this Financial Assistance Policy which includes the Full Charity Care and Discount Partial Charity Care policies within a single document. The Financial Assistance Policy also contains: 1) all eligibility and patient qualification procedures; 2) the unified application for Full Charity Care and Discount Partial Charity Care; and 3) the review process for both Full Charity Care and Discount Partial Charity Care. These documents shall be supplied to ~~OSHPD~~HCAi every two years or whenever a significant change is made. Emergency room physicians are independent of SVHMC, therefore they have their own financial assistance program.

D. **APPLYING FOR FINANCIAL ASSISTANCE**

1. The SVHMC Financial Assistance Program utilizes a single, unified patient application for both Full Charity Care and Discount Partial Charity Care. The process is designed to give each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify. The financial assistance application provides patient information necessary for determining patient qualification by the hospital and such information will be used to qualify the patient or family representative for maximum coverage under the SVHMC Financial Assistance Program. The application includes the office and phone number to call if the patient has any question concerning the Financial Assistance Program or applying for the same. ~~Application Form~~ Application Form A patient has up to two hundred forty (240) days following the date of first post-discharge statement in which to submit an application for financial assistance.
2. Eligible patients may qualify for the SVHMC Financial Assistance Program by following application instructions and making every reasonable effort to provide the hospital with the requested documentation and health benefits coverage information such that the hospital may make a determination of the patient's qualification for coverage under the program. In determining eligibility for financial assistance, SVHMC will not request any additional information other than the information requested in the financial assistance application. A patient seeking financial assistance, however, may voluntarily provide additional information if they so choose. Eligibility alone is not an entitlement to coverage under the SVHMC Financial Assistance Program. SVHMC must complete a process of applicant evaluation and determine coverage before Full Charity Care or Discount Partial Charity Care may be granted. The following information will be considered in determining the eligibility of the patient for Financial Assistance: patient or family income, patient's family size, family income.
3. The SVHMC Financial Assistance Program relies upon the cooperation of individual patients who may be eligible for full or partial assistance. All patients unable to demonstrate financial coverage by third party insurers will be offered an opportunity to complete the financial assistance application. In addition, uninsured patients will be offered information, assistance and referral to government sponsored programs for which they may be eligible. Insured patients who are unable to pay patient liabilities after their insurance has paid, or those who experience high medical costs,

may also be eligible for financial assistance. Any patient who requests financial assistance will be asked to complete a financial assistance application.

4. The financial assistance application should be completed within fourteen days by the patient or as soon as practical thereafter. The application form may be completed, during a patient stay, or after services are completed and the patient has been discharged.
5. Completion of a financial assistance application provides:
    a. Information necessary for the hospital to determine if the patient has income sufficient to pay for services;
    b. Documentation useful in determining qualification for financial assistance; and
    c. An audit trail documenting the hospital's commitment to providing financial assistance.
6. However, a completed financial assistance application is not required if SVHMC determines it has sufficient patient financial information from public sources which to make a financial assistance qualification decision. Patients deemed presumptively eligible may be documented for financial assistance as reflected in the transaction code used to adjudicate the patient's claim, including but not limited to transactions related to full charity care, partial charity care, non-covered services and payer denials.

V. PROCEDURES

A. **Qualification: Full Charity Care and Discount Partial Charity Care**

1. Qualification for full or discount partial financial assistance shall be determined solely by the patient's and/or patient family representative's ability to pay. Qualification for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.
2. The patient and/or patient family representative who requests assistance in meeting their financial obligation to the hospital shall make every reasonable effort to provide information necessary for the hospital to make a financial assistance qualification determination. The hospital will provide guidance and/or direct assistance to patients or their family representative as necessary to facilitate completion of program applications. Completion of the financial assistance application and submission of any or all required supplemental information may be required for establishing qualification for the Financial Assistance Program.
3. Financial Assistance Program qualification is determined after the patient and/or patient family representative establishes eligibility according to criteria contained in this Policy. While financial assistance shall not be provided on a discriminatory or arbitrary basis, the hospital retains full discretion, consistent with laws and regulations, to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.
4. Patients or their family representative may complete an application for the Financial

Assistance Program. The application and required supplemental documents are submitted to the Patient Financial Services located at 3 Rossi Cir, Ste C, Salinas, CA 93907. This office shall be clearly identified on the application instructions and a telephone number and ~~websiteforwebsite for~~ patients seeking assistance in completing the application shall be provided.

5. SVHMC will provide personnel who have been trained to review financial assistance applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient''s need for a timely response.
6. A financial assistance determination will be made only by approved hospital personnel according to the following levels of authority:
    a. Director of Patent Financial Services: Accounts less than $75,000
    b. CFO: Accounts between $75,000.01 and $250,000
    c. CEO: Accounts greater than $250,000.00.
7. Accounts with a value greater than $75,000 require two signatures for approval.
8. Qualification criteria are used in making each individual case determination for coverage under the SVHMC Financial Assistance Program. Financial assistance will be granted based upon each individual determination of financial need in accordance with the Financial Assistance Program eligibility criteria contained in this Policy.
9. Financial Assistance Program qualification may be granted for Full Charity Care (100% free services) or Discount Partial Charity Care (charity care of less than 100%), depending upon the patient or family representative''s level of eligibility as defined in the criteria of this Financial Assistance Program Policy.
10. Once determined, Financial Assistance Program qualification will apply to the specific services and service dates for which application has been made by the patient and/or patient family representative. In cases of continuing care relating to a patient diagnosis which requires on-going, related services, the hospital, at its sole discretion, may treat continuing care as a single case for which qualification applies to all related on-going services provided by the hospital. Other pre-existing patient account balances outstanding at the time of qualification determination by the hospital may be included as eligible for write-off at the sole discretion of management.

B. **Full and Discount Partial Charity Care Income Qualification Levels**

1. ~~If the patient's gross family income is 200% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, the entire (100%) patient liability portion of the bill for services will be written off.~~
2. If the patient''s gross family income is ~~between 201~~200% ~~and 400%~~or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, the ~~following~~entire (100%) patient liability portion of the bill for services will ~~apply:~~be written off.

3. ~~Patient~~If the patient's ~~care~~gross family income is ~~not covered by a payer. If the services are not covered by any third party payer so that~~between 201% and 400% of the established poverty income level, based upon current FPL Guidelines, and the patient ~~ordinarily would be responsible for the full- billed charges~~meets all other Financial Assistance Program qualification requirements, the ~~patient's payment obligation~~following will ~~be the gross amount the Medicare program would have paid for the service if the patient were a Medicare beneficiary.~~apply:
    - Patient's care is not covered by a payer. If the services are not covered by any third party payer so that the patient ordinarily would be responsible for the full- billed charges, the patient's payment obligation will be the gross amount the Medicare program would have paid for the service if the patient were a Medicare beneficiary.
    - Patient's care is covered by a payer. If the services are covered by a third party payer so that the patient is responsible for only a portion of the billed charges (i.e., a deductible or co-payment), the patient's payment obligation will be an amount equal to the difference between what insurance has paid and the gross amount that Medicare would have paid for the service if the patient were a Medicare beneficiary. If the amount paid by insurance exceeds what Medicare would have paid, the patient will have no further payment obligation.
4. ~~Patient's care is covered by a payer. If the services are covered by a third party payer so that the patient is responsible for only a portion of the billed charges (i.e., a deductible or co-payment), the patient's payment obligation will be an amount equal to the difference between what insurance has paid and the gross amount that Medicare would have paid for the service if the patient were a Medicare beneficiary. If the amount paid by insurance exceeds what Medicare would have paid, the patient will have no further payment obligation.~~

C. **Payment Plans**

1. When a determination of Discount Partial Charity Care has been made by the hospital, the patient shall have the option to pay any or all outstanding amount due in one lump sum payment, or through a scheduled term payment plan.
2. The hospital will discuss payment plan options with each patient that requests to make arrangements for term payments. Individual payment plans will be arranged based upon the patient's ability to pay. As a general guideline, payment plans will be structured to last no longer than 12 months. The hospital shall negotiate in good faith with the patient; however where an agreement cannot be reached regarding a payment plan the payment plan bill will require that monthly payments do not exceed 10% of a patient's family income for one month excluding deductions for "essential living expenses"." Essential living expenses are defined as expenses for any of the following: rent or house payments (including maintenance expenses), food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child and spousal support, transportation and automobile expenses (including insurance, fuel, and repairs), installment payments, laundry and cleaning expenses, and other extraordinary expenses. No interest will be charged to the patient for the duration of any payment plan arranged under the provisions of the

Financial Assistance Policy.

D. **Special Circumstances**

1. Any evaluation for financial assistance relating to patients covered by the Medicare Program must include a reasonable analysis of all patient assets, liabilities, income and expenses, prior to eligibility qualification for the Financial Assistance Program. Such financial assistance evaluations must be made prior to service completion by SVHMC.
2. If the patient is determined to be homeless he/she will be deemed presumptively eligible for the Financial Assistance Program and Full Charity Care.
3. Patients seen in the emergency department, for whom the hospital is unable to issue a billing statement, may have the account charges written off as Charity Care. All such circumstances shall be identified on the patient's account notes as an essential part of the documentation process..

E. **Other Presumptively Eligible Circumstances**

1. SVHMC deems those patients that are eligible for government sponsored low-income assistance program (e.g. Medi-Cal, Healthy Families, California Children's Services and any other applicable state or local low-income program) to be indigent and presumptively eligible for Full Charity Care under this Policy. Therefore, such patients are eligible under the Financial Assistance Policy when payment is not made by the governmental program.
2. The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payer including Medi-Cal, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as charity care if:
    a. The patient is a beneficiary under Medi-Cal or another program serving the health care needs of low-income patients; or
    b. The patient otherwise qualifies for financial assistance under this Policy and then only to the extent of the write-off provided for under this Policy.
3. Any patient who has an income which exceeds 400% of the FPL and experiences a catastrophic medical event may be deemed eligible for financial assistance. Such patients, who have high incomes do not qualify for routine Full Charity Care or Discount Partial Charity Care. However, consideration as a catastrophic medical event may be made on a case-by-case basis. The determination of a catastrophic medical event shall be based upon the amount of the patient liability at billed charges, and consideration of the individual's income and assets as reported at the time of occurrence. Management shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $75,000 may be considered for eligibility as a catastrophic medical event.
4. Any account returned to the hospital from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care. Documentation of the patient or family

representative's inability to pay for services will be maintained in the Charity Care documentation file.

5. All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by hospital personnel prior to any re-classification within the hospital accounting system and records.

F. **Dispute Resolution**

1. In the event that a dispute arises regarding qualification, the patient may file a written appeal for reconsideration with the hospital. The written appeal should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any or all additional relevant documentation to support the patient's claim should be attached to the written appeal.
2. Any or all appeals will be reviewed by the hospital director of ~~patient financial services~~Patient Financial Services. The director shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the director shall provide the patient with a written explanation of findings and determination.
3. In the event that the patient believes a dispute remains after consideration of the appeal by the director of Patient Financial Services, the patient ~~financial services, the patient~~ may request in writing, a review by the hospital's CFO. The CFO shall review the patient's written appeal and documentation, as well as the findings of the director of patient financial services. The Chief Financial Officer shall make a determination and provide a written explanation of findings to the patient. All determinations by the Chief Financial Officer shall be final. There are no further appeals.

G. **Extraordinary Collection Actions**

1. If a patient does not apply for financial assistance or is denied financial assistance and fails to pay their bill, the patient may be subject to various collection actions, including Extraordinary Collection Actions.
2. Notwithstanding the foregoing, neither SVHMC nor any collection agency with which it contracts shall engage in any Extraordinary Collection Actions: (1) within the first one hundred eighty (180) days of the first post-discharge statement sent to a patient, and (2) without first making reasonable efforts to determine whether a patient is eligible for financial assistance under this Policy. In addition, and even if the above two conditions are satisfied, no Extraordinary Collection Actions may be taken at any time unless written notice is first provided to the patient at least 30 days in advance of initiating the intended ECAs and such notice clearly sets forth the Extraordinary Collection Action that will be taken in the event of nonpayment and also includes a copy of the Plain Language Summary of the Policy (~~**Exhibit A**~~Exhibit A). If the patient applies for financial assistance, any Extraordinary Collection Actions that may be in process will be suspended immediately pending the decision on the patient's application. If the patient is determined to be eligible for financial assistance, SVHMC will (i)refund any amount collected in excess of the revised charges within 30 days, (ii)take reasonably available measures to reverse any Extraordinary Collections Actions previously initiated, and (iii)provide a new billing statement if the

patient is eligible for Discount Partial Charity Care, indicating the revised amount due, stating how the amount was determined, and stating or describing how the patient can obtain information regarding AGB.

H. **Public Notice**

1. SVHMC shall widely disseminate the existence and terms of its Financial Assistance Policy throughout its service area. To that end, SVHMC shall post clear and conspicuous notices informing the public of the Financial Assistance Program in locations that are visible to the public, including but not limited to the emergency department, billing office, inpatient admission and outpatient registration areas and other common outpatient areas of the hospital. Notices shall also be posted at any location where a patient may pay their bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance. In addition, SVHMC shall post a copy of this Policy, the Plain Language Summary and the financial assistance application on its website and make all such documents available for free download.
2. SVHMC shall include the Plain Language Summary of this policy (Exhibit A) as part of the Condition of Admission during the registration process. If the patient is not conscious or otherwise able to receive the Plain Language Summary at the time of registration, the notice shall be provided during the discharge process (or when the patient leaves the facility, if not admitted). If for any reason the patient leaves the facility without receiving the written notice, SVHMC shall mail the notice to the patient within 72 hours. In all cases SVHMC will include the Plain Language Summary) in at least one post-discharge mailing. In addition, every invoice to a patient post discharge shall include a conspicuous written notice as an insert of the Plain Language Summary that: (1) informs the patient as to the availability of financial assistance; (2) includes a phone number of the office or department that can advise patients as to the availability of financial assistance; and (3) includes a direct website address (URL) where copies of this Policy, the Plain Language Summary and the financial assistance application may be downloaded.
3. Finally, SVHMC shall make translations of this Policy, the Plain Language Summary, and the financial assistance application available in Spanish and any other language that is the primary language of the lesser of 1,000 individuals or 5% of the population of the communities served by SVHMC.

I. **Confidentiality**

1. It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this Policy should be guided by these values.

J. **Good Faith Requirements**

1. SVHMC makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate.

2. Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, or purposely inaccurate information has been provided by the patient or family representative. In addition, SVHMC reserves the right to seek all remedies, including but not limited to civil and criminal damages from those patients or family representatives who have provided fraudulent or purposely inaccurate information in order qualify for the SVHMC Financial Assistance Program.

K. **Documentation**

1. SVHMC Financial Assistance Application, Financial Assistance Worksheet and Federal Poverty Guidelines
2. Plain Language Summary

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed.

VII. REFERENCES

A. California Health and Safety Code section 127400 et seq.

B. B. Federal Poverty Guidelines

C. Internal Revenue Code Section 501(r)

EXHIBIT A

PLAIN LANGUAGE SUMMARY
~~As a vital part of its charitable mission, Salinas Valley Memorial Hospital (SVHMC) serves all persons in Salinas and the larger surrounding community area and provides financial assistance for eligible hospital emergency and medically necessary services to patients who may be unable to pay their hospital bills and who apply for and meet the eligibility requirements in our Financial Assistance Policy (the "Policy"). Under the Policy, if the patient's gross family income is 200% or less of the established Federal Poverty Level ("FPL") and the patient meets all other Financial Assistance Program qualification requirements, the entire patient bill for hospital services will be written off. In addition, if the patient's gross family income is between 201% and 400% of the FPL, and the patient applies for and meets all other Financial Assistance Program qualification requirements, the patient may be eligible for discounts off their financial obligations. Please note that physician services are provided by independent Medical Groups that are not employed by SVHMC and accordingly are not covered under this Policy and are billed for separately by the physician group.~~ ~~To apply for financial assistance, a patient must simply fill out an application form requesting financial assistance and provide the information requested in the application. The application may be obtained and filed at 3 Rossi Circle, Suite C, Salinas, CA 93907. If you prefer, you may request an application for financial assistance (as well as a copy of the Financial Assistance Policy) by mail at 3 Rossi Circle, Suite C, Salinas, CA 93907 or you may download copies for free off the internet at https://www.SVHMC.com/Patients-Visitors/For-Patients/Billing-Insurance.aspx~~

~~The application and the Policy are also available in Spanish if needed and requested. If you need help obtaining or completing an application, please contact Patient Financial Services b at 831-755-0732.~~

~~If you have any questions about SVHMC's Financial Assistance Policy including whether you are eligible for financial assistance and how to apply for financial assistance, please contact Patient Financial Services at 831-755-0732.~~

~~As described in greater detail in the Policy, patients eligible for financial assistance will not be charged more than the amounts generally billed for patients covered by Medicare fee for service insurance. The Financial Assistance Policy, Financial Assistance Application and this Plain Language Summary are translated into Spanish.~~

As a vital part of its charitable mission, Salinas Valley Health Medical Center (SVHMC) serves all persons in Salinas and the larger surrounding community area and provides financial assistance for eligible hospital emergency and medically necessary services to patients who may be unable to pay their hospital bills and who apply for and meet the eligibility requirements in our Financial Assistance Policy (the "Policy"). Under the Policy, if the patient's gross family income is 200% or less of the established Federal Poverty Level ("FPL") and the patient meets all other Financial Assistance Program qualification requirements, the entire patient bill for hospital services will be written off. In addition, if the patient's gross family income is between 201% and 400% of the FPL, and the patient applies for and meets all other Financial Assistance Program qualification requirements, the patient may be eligible for discounts off their financial obligations. Please note that physician services are provided by independent Medical Groups that are not employed by SVHMC and accordingly are not covered under this Policy and are billed for separately by the physician group.

To apply for financial assistance, a patient must simply fill out an application form requesting financial assistance and provide the information requested in the application. The application may be obtained and filed at 3 Rossi Circle, Suite C, Salinas, CA 93907. If you prefer, you may request an application for financial assistance (as well as a copy of the Financial Assistance Policy) by mail at 3 Rossi Circle, Suite C, Salinas, CA 93907 or you may download copies for Free off the internet at https://www.svmh.com/Patients-Visitors/For-Patients/Billing-Insurance.aspx

The application and the Policy are also available in Spanish if needed and requested. If you need help obtaining or completing an application, please contact Patient Financial Services at 831-755-0732.

If you have any questions about SVHMC's Financial Assistance Policy including whether you are eligible for financial assistance and how to apply for financial assistance, please contact Patient Financial Services at 831-755-0732.

As described in greater detail in the Policy, patients eligible for financial assistance will not be charged more than the amounts generally billed for patients covered by Medicare fee for service insurance. The Financial Assistance Policy, Financial Assistance Application and this Plain Language Summary are translated into Spanish.

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2023
Policy Owner	Charlotte Wayman: Director Pt Financial Svcs/Pt Registration	11/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 14493092

Last Approved	N/A	Owner	Natassia Gillis: Clinical Manager
Last Revised	N/A	Area	Women's and Children's Services
Next Review	3 years after approval		

Infant Driven Feeding Protocol

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To assist staff in facilitating developmentally appropriate, infant-guided feedings that optimize respiratory stability, swallowing safety, and positive learning experiences while minimizing infant stress.

B. To support the long-term goals of good growth, pulmonary health, parent-infant attachment, and decreased future development of feeding aversions.

III. DEFINITIONS

A. IDFP: Infant Driven Feeding Protocol

B. Oral Feeding: Direct breast feeding or bottle feeding

C. CGA: Corrected Gestational Age

D. SSB: Suck, Swallow, and Breathe

IV. GENERAL INFORMATION

A. Premature and other high-risk neonates ~~will~~should receive feedings appropriate to their gestational age and clinical condition. Families ~~will~~should be encouraged to participate in the feeding of their infant.

V. PROCEDURE

A. Equipment

1. Standard Precautions

2. Routine enteral and oral feeding supplies

B. Guide oral feeding progression according to:
    1. Infant's medical and clinical condition
    2. Feeding readiness and quality scores
        a. Initiate Readiness Scoring at 33 weeks CGA.
        b. When infant's readiness scores are consistently 4's and 5's for approximately 24 hours, oral feeding attempts may be initiated per physician order.
        c. Complete a Feeding Quality Score after each oral feeding attempt.
        d. See Attachment A for Readiness and Quality Scales
    3. Feeding readiness, engagement, stress, and disengagement cues
        a. Continually evaluate cues before and throughout each feeding.
        b. Infants communicate through cues and their physiologic state.
        c. Caregiver competence in recognizing, interpreting, respecting, and responding appropriately to infant cues is essential to safe, successful feeding progression.
        d. See Attachment B for overview of feeding readiness, engagement, stress, and disengagement cues.

C. Promote safe, successful feedings
    1. Feeding positions
        a. Postural support, through swaddling and neutral head/neck alignment, promotes motoric stability
        b. Side-lying or semi-elevated sidelying positions promote better flow regulation for infants with immature SSB coordination and infants at higher risk for aspiration
        c. Fully upright position may benefit infants with craniofacial abnormalities
        d. Other feeding positions may also be appropriate dependent on infant's clinical condition
        e. See Attachment C for aspiration risks/signs
    2. Nipple choice
        a. Appropriate selection can assist infants to self-pace feedings.
        b. Slow Flow – allows infants with immature SSB coordination, disorganized feeding patterns, and higher risk for aspiration to better manage swallowing without bolus loss, aspiration, or compromised respiratory status.
        c. Special Needs and Natural Flow – use dependent on individual need.
        d. Regular Flow (Single Hole or Cross Cut) – can be used for infants with

mature SSB and with lower risk for aspiration

3. Duration
    a. 30 minute maximum feeding duration recommended
    b. Discontinue oral feeding attempt sooner for disengagement cues or physiologic decompensation.

D. Parental Involvement
    1. Engage parents in feedings through anticipatory guidance, participatory learning, reflection on feeding progress, and planning/adaptation for future feedings.
    2. See NICU FAMIL.Y CENTERED CARE/PARENT PARTICIPATION

E. Documentation
    1. Feeding assessment and intervention documentation completed in the electronic medical record.
    2. Family education and discharge planning is documented in the electronic medical record.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. National Association of Neonatal Nursing. (2013). Infant-Directed Oral Feeding for Premature and Critically Ill Hospitalized Infants. Guideline for Practice. Chicago, IL: National Association of Neonatal Nursing.

B. Shaker, C. S. (2017). Infant-Guided, co-regulated feeding in the neonatal intensive care Unit. Part II: Interventions to promote neuroprotection and safety. Seminars in Speech & Language, 38(2), 106–115.

C. Thoyre, S.M., Hubbard, C., Park, J., Pridham, K., & McKechnie, A. (2016). Implementing co-regulated feeding with mothers of preterm infants. American Journal of Maternal Child Nursing. 41(4), 204—221.

D. Waitzman, K. A., Ludwig, S. M., & Nelson, C. L. A. (2014). Contributing to Content Validity of the Infant-Driven Feeding Scales through Delphi surveys, Newborn and Infant Nursing Reviews 14(3), 88-91.

Attachments

Attachment A-Feeding Readiness and Quality Scales.pdf

Attachment B-Feeding Readiness, Engagement, Stress, and Disengagement Cues.pdf

Attachment C- Aspiration Risk and Signs.pdf

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
NICU Medical Director	Robert Castro: PHYSICIAN	11/2023
Director of Women's and Children's Services	Julie Vasher: Director Women's & Children's Services	11/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2023
Policy Owner	Natassia Gillis: Clinical Manager	10/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14758584**

Last Approved	N/A	Owner	Audrey Parks: Chief Information Officer
Last Revised	12/2023	Area	Information Technology
Next Review	3 years after approval		

Information Technology Acquisition

I. POLICY

1. All new contracts related to information technology solutions or new technologies **must** be reviewed by TAC and include legal counsel as appropriate

II. PURPOSE

1. ~~The purpose of this policy is to assess and recommend approval of new technologies for the advancement of Salinas Valley Memorial Hospital (SVMH) that incorporates the mission, vision and values, and promotes the organization, staff, and physicians as a whole.~~

~~III. POLICY~~

1. ~~This policy is to provide a Policy and Procedure for the consistent coordinated introduction of new computing technology with SVMH.~~
2. ~~This policy applies to all SVMH staff.~~
3. ~~The TAC Technology Assessment Committee (TAC) is a work-group of stakeholders from IT, Engineering, Materials Management, and involves ad-hoc members from Clinical Informatics and the physician advisory committee as needed. TAC reviews purchase requests prior to approval by the Executive Team. See the TACTAC site, https://eportal/sites/committees/ecare/wd/TAC/default.aspx.~~
4. ~~The TAC TAC charter is to streamline the purchase request process with a timely review by all key stakeholders. TAC provides for a global strategic implementation plan for purchases that aligns resources and the processes of tour EMR and existing technologies.~~
5. ~~All procurement will continue to be subject to competitive solicitation and purchase procedures. See the "COMPETITIVE SOLICITATION POLICY " #5657.~~
6. ~~If the request meets any of these criteria, TAC must review and Executive Team approval is required.~~

a. ~~Uses electrical power~~

b. ~~Interfaces with a patient~~

c. ~~Generates data for reporting and/or operations, including clinical decision support. This also applies to hosted or web-based information services and solutions.~~

d. ~~Accepts data such as through an interface~~

e. ~~Requires a network connection~~

f. ~~Impacts the Hospital's physical infrastructure~~

7. ~~All new contracts related to information technology solutions or new technologies **must** be reviewed by TAC and include legal counsel as appropriate.~~

A. To assess and recommend approval of new technologies for the advancement of Salinas Valley Health (SVH) that incorporates the mission, vision and values, and promotes the organization, staff, and physicians as a whole.

IV. DEFINITIONS

1. ~~New Computing Technology – hardware and software for information systems.~~
2. ~~Technology Brief – A form with the description of a new technology request that assists in determining what approval process is necessary for acquisition of the new technology (see page 5).~~
3. ~~Assessment Criteria – If the new technology request crosses multiple departments or is an information system the Technology Assessment Committee must review and approve the request then forward their recommendations to the Executive Team.~~
4. ~~New Requests – A more detailed look at the project goals, systems requirements, and costs required prior to presentation at the TAC Committee may be required. This should include rough order of magnitude estimated costs, resource needs and timelines for the project. Estimates on resource, capital, and time requirements to develop a business plan or technology implementation plan. Please complete the TAC request form, https://eportal/sites/committees/ecare/wd/edna/Lists/EDNA%20Requests/Pending%20Requests.aspx.~~

1. EMR - Electronic Medical Record
2. HISSC - Hospital Information Systems Steering Committee
3. New Computing Technology – hardware and software for information systems.
4. Technology Brief – A form with the description of a new technology request that assists in determining what approval process is necessary for acquisition of the new technology (see page 5).

V. GENERAL INFORMATION

A. A work-group of stakeholders from Information Technology (IT), Biomedical Engineering, Engineering, Materials Management, and ad-hoc participants from Informatics reviews purchase requests as determined by IT during the course of new information services and systems procurements.

B. The above interdisciplinary group provides for an enterprise strategic review of technology-based purchases to aligns resources and the processes of our current hospital information systems and electronic health record environment.

C. Assessment Criteria – If the new technology request crosses multiple departments or is an information system, IT must review and approve the request as part of the procurement process. IT will engage with other stakeholders as needed.

D. All procurement will continue to be subject to competitive solicitation and purchase procedures. See the "COMPETITIVE SOLICITATION POLICY.

E. New Requests – A more detailed look at the project goals, systems requirements, systems security posture and costs may be required. Inform IT as early as possible to minimize delays during the assessment, selection and procurement processes.

F. If the request meets any of these criteria, IT must review.

1. Uses electrical power
2. Interfaces with a patient
3. Generates data for reporting and/or operations, including clinical decision support. This also applies to hosted or web-based information services and solutions.
4. Accepts data such as through an interface
5. Requires a network connection
6. Impacts the Hospital's physical infrastructure

VI. PROCEDURE

1. User Department (requester) has identified a business need, utilizing new computing technology. ~~Please follow the attached decision tree to help determine whether or not the new technology acquisition~~All projects and products requiring use of the Salinas Valley Health wireless network must be reviewed by ~~the New~~Information Technology ~~Assessment Committee~~. ~~All projects and products requiring use of the SVMH wireless network must come to the New Technology Assessment Committee.~~
2. ~~Technology Assessment Committee meets~~Interdisciplinary team will meet to review each request on an as needed basis. IT may perform ~~a~~systems security, technical and strategic review of the proposed technology and assess how the proposed technology aligns with ~~SVMH~~Salinas Valley Health's business strategies, IT strategies, other emerging technologies and current IT technical standards. The requester's department, IT and/or Biomedical Engineering measure the request against the assessment criteria to determine whether the request should be treated on one of the following ways:
    a. If approved or mutually agreed to proceed, then prepare for presentation at HISSC for further review.
    b. If approved or mutually agreed to by ~~IT and/or Biomed~~the interdisciplinary team and IT as a Departmental project, then proceed as a department project.

VII. EDUCATION/TRAINING

1. ~~Education and training on the intent and use of this policy, and its processes and forms is provided by the Technology Assessment Committee by communication to all Department Heads through inclusion on the "Housewide Orientation For Managers and Supervisors." This form is filed and maintained by Human Resources. Additional detailed education to be provided on an as-needed basis.~~
2. ~~This policy is posted for review by all personnel or otherwise circulated.~~
3. ~~This policy may be reviewed with each employee at departmental meetings or other staff communications, and may be reviewed with each new employee during departmental orientation and may be found on the MEMnet.~~
4. ~~This policy may be reviewed with new or existing employees and affiliates during General Orientation, Education/Safety Faires, or by specially scheduled inservices, e.g., Code of Ethical Behavior, Standard of Conduct, and Corporate Compliance.~~

~~VIII. DOCUMENTATION~~

1. ~~This policy outlines the steps required for approval of new technology, which includes presentation of appropriate forms including the New Technology Request Form and the development of a Technology Implementation Plan.~~
2. ~~Completed TAC Request and supporting documentation.~~
3. ~~Documentation of general orientation, in-services such as Manager Orientation is retained in Human Resources.~~

1. Education and/or training is provided as needed.

IX. REFERENCES

1. ~~The Joint Commission, Management of Information Standards~~
2. ~~# 1076 – VALUE ANALYSIS COMMITTEE POLICY~~
3. ~~# 644 – EVALUATION OF HOSPITAL PROPERTY FOR SURPLUS AND/OR DISPOSAL~~
4. ~~# 1078 – PURCHASE ORDER AND PURCHASE ORDER REQUISITION PROCEDURE~~
5. ~~Management of Information/Environment Assessment Policy~~
6. ~~Management of Information/Application Data Interfacing Policy~~

1. The Joint Commission, Management of Information Standards
2. Value Analysis
3. Surplus and/or Disposal of Hospital Property
4. Purchase Order and Purcahse Order Requisition

Approval Signatures

Step Description	Approver	Date
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	12/2023
Policy Owner	Audrey Parks: Chief Information Officer	11/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 14043236

Last Approved	N/A	Owner	Darlene Vaughan: Director Nursing
Last Revised	05/2017	Area	Nursing Standardized Procedures
Next Review	3 years after approval		

Intraosseous Infusion Standardized Procedure Nursing Standardized Procedure

I. POLICY

A. Intraosseous access and infusion is to provide an alternate means of vascular access when the IV route is not available or IV access attempts were unsuccessful and the patient would benefit from the timely administration of medications or fluids.

B. Circumstances:

- Setting:

A. Adult and pediatric patients where at least two attempts at IV access have been unsuccessful or it is determined that an IV attempt would be unsuccessful, and one of the following:

I. Cardiac arrest or impending arrest

II. Shock or evolving shock. This is a patient considered in Extremis.

- Supervision:

A. Intraosseous access and infusion may be performed in the emergency department by Registered Nurses who have successfully completed approved training within the past 12 months.

- Patient Condition:

Indications

A. Intraosseous access and infusion is approved for adult and pediatric patients.

B. Intraosseous access and infusion will never be performed to establish prophylactic vascular access

C. Intraosseous access and infusion is approved only in the proximal tibia for children. The patient must weigh 3kg or more in order to use the EZ-IO

D. Intraosseous access and infusion is approved only in the proximal tibia and the proximal humerus for patients age 8 and older. Sternal placement is prohibited

Contraindications

A. Recent fracture of the involved bone.

B. Infection at the site selected for insertion

C. Inability to locate anatomical landmarks for insertion.

D. Those patients who have a patent IV or in whom an IV may be established in a timely manner.

E. Second attempt on the same bone.

II. DEFINITIONS

A. Intraosseous access and infusion: Establishing vascular access through bone marrow

B. In Extremis: A profound state where death appears imminent

C. EZ-IO- Type of Drill Intraosseous

III. PROCEDURE

A. Database

- Subjective

1. Assure that indications for use have been met.
    a. At least two attempts at IV access have been unsuccessful or it is determined that an IV attempt would be unsuccessful, and one of the following:
        i. Cardiac arrest or impending arrest
        ii. Shock or evolving shock. This is the patient in extremis.
2. Assure that contra-indications for use are not present.
    a. Recent fracture of the involved bone
    b. Infection at the insertion site
    c. Inability to locate anatomical landmarks for insertion
    d. Patients who have a patent IV or in whom an IV may be established in a timely manner.
    e. Second attempt in the same bone.

- Objective

1. Determine patient age and weight to select the appropriate IO insertion device.
    a. For a patient 3kg and under use a manual IO device
    b. For a patient over 3kg and under 40kg and under age 8 use the Pediatric EZ-IO or manual device.
    c. For a patient over age 8 or a weight over 40kg, use the Adult EZ-IO.
2. Approved insertion sites:
    a. Proximal Tibia for pediatric patients. This is less than 8 year of age or less than 40kg.
    b. Proximal Tibia or proximal humerus for adult patients. This is age 8 or older and 40kg or more.

B. Diagnosis:
    a. Cardiac Arrest
    b. Shock or evolving shock.

C. Plan

- Treatment
    1. Process for Insertion
        a. Use body substance isolation precautions
        b. Obtain age/weight appropriate supplies
        c. Rule out contra-indications
        d. Locate appropriate insertion site
        e. Prepare insertion site using aseptic technique
        f. Prepare the Intraosseous device
        g. Stabilize the site and insert the needle at a 90 degree angle to the bone
        h. Remove the sty let for the catheter
        i. Confirm placement of the catheters by flushing the catheter with 10cc normal saline
        j. Consider the administration of Lidocaine 2% solution, 20 mg for the adult or 0.5mg/kg (up to 20mg) for the pediatric patient who is conscious and complains of pain.
        k. Dress insertion site, stabilize and secure the catheter
- Patient conditions requiring consultation/reportable conditions:
    a. Signs of infiltration of fluids
    b. Redness or swelling at the site of insertion

c. Duration of access approaching 24 hours

- Education-Patient/Family
    a. Instruct patient or care provider to alert staff if site becomes painful or if the catheter becomes dislodged
    b. Necessity of intravenous therapy
- Follow-up
    a. As needed to maintain continuity of care
- Documentation of Patient Treatment
    a. Document all patient procedures and care on the appropriate nursing clinical documents along with any patient response from the interventions

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education
- A registered nurse who has completed orientation and has demonstrated clinical competency may perform the procedures listed in this protocol. Education will be given upon hire with an RN preceptor/designee.

B. Training
- Clinical competency must be demonstrated and approved by supervising personnel or preceptor.

C. Experience
- Current California RN license and designated to work in ED

D. Initial Evaluation
- Competency will be verified and documented upon hire

E. Ongoing Evaluation
- Ongoing evaluation of competency to perform this procedure will be evaluated by the department supervising personnel and/or designee as needed.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Method
- Review and approval every three (3) years
- Policy goes through the Emergency Department Physician group every three (3) years.
- Policy goes through the interdepartmental policy committee (IDPC) upon creation of

policy and when changes are made

- Chief Nursing Officer upon creation of policy and with significant changes.

B. Review Schedule

- Review of policy occurs every three (3) years.

C. Signatures of Authorized Personnel Approving the Standardized Procedure and Dates

1. Nursing – Director of Emergency Services
2. Medicine – Medical Director, Emergency Department
3. Administration – Chief Nursing Officer

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. All Registered Nurses who have completed orientation and education regarding this standardized procedure.

B. The list of qualified individuals who may perform this standardized procedure is available in the department and available upon request.

VII. REFERENCES

A. Lowther A (2011) Intraosseous access and adults in the Emergency Department. *Nursing Standard*. 25, 48, 35-48.

B. Ashford and St Peter's Hospitals NHS Trust (2008) *Intraosseous Needle Placement Using EZ-IO System*. http://tiny.cc/Ashford748.

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	11/2023
IDPC	Katherine DeSalvo: Director Medical Staff Services	11/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2023
Policy Owner	Darlene Vaughan: Director Nursing	11/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 12949823

Last Approved	N/A	Owner	Natassia Gillis: Clinical Manager
Last Revised	10/2023	Area	Women's and Children's Services
Next Review	3 years after approval		

Neonate Gavage Feeding

I. POLICY STATEMENT:

A. N/A

II. PURPOSE:

A. To guide the staff in providing enteral nutrition when bottle or breastfeeding are contraindicated or when infant is unable to meet minimum nipple feeding requirements as ordered.

III. DEFINITIONS:

A. N/A

IV. GENERAL INFORMATION:

A. N/A

V. PROCEDURE:

A. Equipment
    1. Appropriate size feeding tube
    2. Enteral syringe
    3. Stethoscope.
    4. Formula or breast milk.
    5. Pectin barrier and transparent dressing or tape
    6. Pacifier (as appropriate for comfort measures)

B. Standard Precautions

C. Before initiating feedings, establish and record infant's baseline GI status in the following manner:
    1. Observe abdomen size, shape and color. Measure and document abdominal girth and note any changes from previous measurements. Note any discoloration and document.
    2. Gently palpate abdomen for softness, tenderness, or unusual masses.
    3. Auscultate abdomen for bowel sounds. Note quantity and quality and document.
    4. Report abnormal findings to Physician before proceeding with feeding.

D. Prepare patient. If the infant is very active or vigorous, swaddle to comfort and to prevent the infant from pulling on the tube.

E. Explain procedure to parent/guardian if present.
    1. Determine the amount of formula or breast milk according to Physician's order, the infant's size, gestational age, physical condition, amount and toleration of previous feeding, and feeding regimen.

F. Hold infant/offer mother opportunity for skin to skin/non-nutritive sucking when possible. If possible hold the infant in arms during gavage feeding.

G. Feeding Tube Insertion
    1. Choose the appropriate size and type of tube.
    2. Orogastric placement is preferred over nasogastric placement for occasional gavage feedings. Infants are obligate nose breathers. However, the nasal route is easier to secure, more comfortable and preferred for indwelling tubes. The respiratory status needs to be assessed prior to placing nasally. The determination of placement is subject to infant's individual tolerance and to nurses' judgment.
    3. A short term (polyvinylchloride) feeding tube should be changed every 24-72 hours per manufacturer's recommendation.
    4. Long term catheters, such as silicone, feeding tubing should be changed every 30 days per manufacturer's recommendation.
    5. When a gastric tube is placed nasally, it should be moved from one nares to the other when changed.

H. Place the infant on his or her back or right side with the head slightly elevated. Provide support for the infant and place in a flexed position. Offer a pacifier during nasal tube insertion.

I. Open the gavage tube and prepare for insertion, taking care to prevent contamination.

J. Determine the length of tubing required to reach the stomach: measure the distance from the tip of the nose to the ear lobe to midway between the xiphoid process and the umbilicus.

K. Insert the tube in the mouth or nose toward the back of the throat, gently pushing it down the esophagus until reaching the pre-determined mark on the tubing.

L. Smooth, rapid passage of the tube will minimize vagal stimulation and potential for bradycardia as well as minimize potential for gagging. Tactile stimulation usually will cause the symptoms to subside. If the symptoms do not subside or there are any signs of respiratory

distress, withdraw the tube.

M. Confirmation of tube placement:

N. Aspiration Method: Aspirate stomach contents through the tube with a syringe. Assess color and consistency of aspirate to determine stomach contents.

O. ~~Auscultation Method: Place stethoscope over the stomach on the abdomen (upper left quadrant just below ribs). Inject 1 – 2 ml air through the tube into the stomach and gently aspirate gastric contents.~~Check the aspirate for pH to confirm aspirate of stomach contents. If in the stomach, the pH should be less than 5.0

P. X-ray: Confirmation by X-ray is usually is indicated only when duodenal or jejunal placement is desired.

Q. If placement cannot be verified by these methods, or the infant becomes cyanotic, remove the tube, stabilize the infant, and reinsert the feeding tube.

R. The tube should be secured in place with tape. Use a pectin barrier and transparent dressing or tape for indwelling tubes.

S. Label the tube with size, insertion depth and date of insertion.

T. Record in the medical record and ~~in the Kardex~~ the cm marking of the tubing as well as the location.

U. Pre-Feeding

1. Confirm cm marking on feeding tube has not changed after initial confirmation of placement.
2. Assess for abdominal distention and bowel loops. Notify physician if abdominal circumference increases by 3cms.
3. Assess residuals per order or only if abnormal finding are present.
    a. Check for residual by pulling back slowly on the syringe. Notify Physician of any abnormal findings (i.e., bloody, "coffee grounds" or bilious) or residual amounts greater than 25% of feeding volume (incompletely digested aspirates of 2 to 4 ml may be considered normal; consult with physician). Large aspirates may indicate partial ileus or early signs of sepsis, necrotizing enterocolitis or obstruction. Withhold feeding pending a decision about the feeding plan by physician.
    b. To prevent electrolyte loss, slowly return aspirate to the stomach. It may be advisable to reduce the feeding by the amount of the refed aspirate. For example, if a baby is to receive 30 ml and 5 ml of residual is aspirated, return the 5 ml and give only 25 ml of additional formula or breast milk. Exceptions to return of the stomach contents include aspirates that are bloody or "coffee ground", green or bright yellow, or contain large amounts of mucus.
4. ~~To prevent electrolyte loss, slowly return aspirate to the stomach. It may be advisable to reduce the feeding by the amount of the refed aspirate. For example, if a baby is to receive 30 ml and 5 ml of residual is aspirated, return the 5 ml and give only 25 ml of additional formula or breast milk. Exceptions to return of the stomach~~

~~contents include aspirates that are bloody or "coffee ground", green or bright yellow, or contain large amounts of mucus.~~

5. When infants are tolerating full enteral gavage supplemented feeds with no changes in abdominal exam, residuals should be checked according to physician order.

V. ~~Attach syringe without plunger.~~

W. ~~Pour predetermined amount of formula/breast milk into the syringe. Flow may begin spontaneously or require a gentle nudge with the plunger.~~

X. ~~Administer feeding by gravity, adjust the height of the barrel to control flow speed. Do not push fluid in, but allow it to flow by gravity over an amount of time that that may be expected for a feeding. Gravity allows for a natural "burp" through the tube and avoids direct forceful pressure into the GI tract.~~Intermittent Feeds

1. Attach syringe without plunger.
2. Pour predetermined amount of formula/breast milk into the syringe. Flow may begin spontaneously or require a gentle nudge with the plunger.
3. Administer feeding by gravity, adjust the height of the barrel to control flow speed. Do not push fluid in, but allow it to flow by gravity over an amount of time that that may be expected for a feeding. Gravity allows for a natural "burp" through the tube and avoids direct forceful pressure into the GI tract.
4. Offer a pacifier for non-nutritive sucking during feeding. Non-nutritive sucking accelerates maturation of the sucking reflex, improves weight gain, decreases oxygen consumption and facilitates earlier advancement to full oral feedings and thus earlier discharge to home.
5. After intermittent feeding, clear the feeding tube of residuals with approximately 2 mls of water or air, the recap.
6. If the tube is to be removed, pinch the tube and withdraw quickly.
7. After the feeding, burp the infant. Infants with frequent aspirates may need to be positioned in right side-lying or prone positions more frequently to aid digestion.

Y. ~~Offer a pacifier for non-nutritive sucking during feeding. Non-nutritive sucking accelerates maturation of the sucking reflex, improves weight gain, decreases oxygen consumption and facilitates earlier advancement to full oral feedings and thus earlier discharge to home.~~

Z. ~~Observe infant for feeding intolerance and complications (i.e., abdominal distention, emesis, bradycardia, respiratory distress, or apnea). Notify physician of emesis greater than 25% of feeding volume, change in abdominal exam (loops, distention, tenderness, or change in stools (foul smelling, loose, mucus, or bloody). All infants should be kept on the monitor during gavage feeds.~~

AA. ~~Following the feeding, clear the tube with air and then cap. If the tube is to be removed, pinch the tube and withdraw quickly.~~

AB. ~~After the feeding, burp the infant. Infants with frequent aspirates may need to be positioned in right side-lying or prone positions more frequently to aid digestion.~~

AC. ~~Beside Hang-time for continuous gavage or gastrostomy feedings. See Attachment A~~

AD. ~~**Documentation**~~:

1. ~~Record the following in the electronic health record:~~
    a. ~~Abdominal assessment~~
    b. ~~Type of feeding.~~
    c. ~~Method of feeding.~~
    d. ~~Time of feeding.~~
    e. ~~Amount of feeding.~~
    f. ~~Amount, color and consistency of residual or regurgitation, if any. Discarded residual amounts are recorded under Intake and Output.~~
    g. ~~Infant's toleration of feeding.~~
    h. ~~Size of feeding tube used.~~

AE. Continuous Feeds

1. Fill the syringe with formula/breast milk.
2. Connect the extension tubing to the syringe and purge milk through tubing.
3. Load syringe and set the infusion rate.
4. Confirm tube placement as described above.
5. Attach extension tube to gavage tube and begin the feeding infusion.
6. Label syringe and tubing with date and time changed.
7. Provide developmental support for the infant and periodically offer opportunities for nonnutrative sucking.
8. Beside Hang-time for continuous gavage or gastrostomy feedings. See Attachment A

- With all feeding modes observe infant for feeding intolerance and complications (i.e., abdominal distention, emesis, bradycardia, respiratory distress, or apnea). Notify physician of emesis greater than 25% of feeding volume, change in abdominal exam (loops, distention, tenderness, or change in stools (foul smelling, loose, mucus, or bloody). All infants should be kept on the monitor during gavage feeds.

A. **Documentation**:

1. Record the following in the electronic health record:
    a. Abdominal assessment
    b. Type of feeding.
    c. Method of feeding.
    d. Time of feeding.
    e. Amount of feeding.
    f. Amount, color and consistency of residual or regurgitation, if any. Discarded residual amounts are recorded under Intake and Output.

g. Infant's toleration of feeding.

h. Size of feeding tube used.

VI. EDUCATION/TRAINING:

A. Education and/or training is provided as needed.

VII. REFERENCES:

~~A. Ikuta, LM., Beauman, S.S., (2011) National Association of Neonatal Nurses. Policies, Procedures and Competencies for Neonatal Nursing Care.~~

~~B. Gardner, S. (Ed.). (2016). Merenstein & Gardner's Handbook of Neonatal Intensive Care (8thed.). Elsevier, Inc.~~

~~C. Verklan, M.T. & Walden, M. (2015) Core Curriculum for Neonatal Intensive Care Nursing (5th Ed.) – a joint publication of the Association of Women's Health, Obstetric and Neonatal Nursing, American Association of Critical Care Nurses, & the National Association of Neonatal Nurses. St. Louis, Saunders Elsevier.~~

~~D. Pediatric Nutrition Practice Group of the American Dietetic Association. (2011). Infant Feedings: Guidelines for preparation of formula and breast milk in health care facilities. http://www.neogenii.com/wpcontent/themes/enfold/pdfs/ADA.pdf~~

A. Beauman, S.S., Bowels, S., (2019) National Association of Neonatal Nurses. Policies, Procedures and Competencies for Neonatal Nursing Care. 6th Ed.

B. Steele, C. & Collins, E. (Eds.). (2019). Infant feeding: Guidelines for preparation of human milk and formula in health care facilities. (3rd ed.). USA: Academy of Nutrition and Dietetics.

Attachments

A: Beside Hang-Time Practices for Infant Formulas

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
NICU Medical Director	Robert Castro: PHYSICIAN	11/2023
Director of Women's and Children's Services	Julie Vasher: Director Women's & Children's Services	11/2023

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2023
Policy Owner	Natassia Gillis: Clinical Manager	10/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 13676886

Last Approved	N/A	Owner	Kelly Flower: Clinical Manager
Last Revised	10/2023	Area	Patient Care
Next Review	3 years after approval		

Percutaneous Ventricular Assist Device Implantation (Clinical)

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the staff in the safe use of the Percutaneous Ventricular Assist Device (Impella CP, 5.5 or RP).

III. DEFINITIONS

A. Impella- Left Ventricular assist device that is inserted percutaneously

B. CCL- Cardiac Cath Lab

C. ICU- Intensive Care Unit

IV. GENERAL INFORMATION

A. Percutaneous Ventricular Assist device (Impella) may be placed in Cardiac Cath Lab or OR. The device may be maintained in the ICU.

B. **CONSIDERATIONS**

- The Percutaneous Ventricular Assist Device ® partial left ventricular-assistance therapy is designed to increase coronary artery perfusion, increase systemic perfusion, decrease myocardial workload, and decrease preload and afterload. It achieves improvement in microvascular perfusion by physically lowering the left ventricular end-diastolic pressure so that the subendocardial capillaries can more easily perfuse
- The Percutaneous Ventricular Assist Device ~~2~~CP, 5.5~~, CP and 5.0~~ and RP are

percutaneously inserted:

1. via the femoral artery under fluoroscopy and advanced retrograde through the aorta and across the aortic valve, OR
2. via cut down directly into the ascending Aorta and across the AO valve, or via axillary cut down in the O.R. and placed through a graft conduit

- The ~~2.5 and~~ CP device has an arterial line integrated into the pump that is designed to reflect aortic arch systolic and diastolic pressures. This is required to verify placement, but should not be used for pressure monitoring as there is no ability to zero and calibrate it. ~~The 5.0 and LD use a differential pressure sensor to determine placement.~~
- The 5.5 is only a surgical device and inserted in the OR, not CCL. The 5.5 provides up to 6L/min of flow.
- The RP is indicated up to 14 days of use and facilitates biventricular support in the setting of cardiogenic shock related to RV dysfunction.
- The Percutaneous Ventricular Assist Device ® system uses a purge system with concentrated dextrose and ~~heparin~~sodium bicarbinate delivered under high pressure to prevent blood from entering the motor, and to keep the motor turning at high speed. The purge system must be maintained continuously, or the pump will fail.
- Prior to Percutaneous Ventricular Assist Device insertion, the cardiologist, the interventional cardiologist, or CV surgeon (or their designee) will notify the cardiac catheterization lab (CCL) or Operating Room OR, anesthesia, circulatory support, the cardiac surgeon, and the ICU charge nurse to coordinate needed assistance and convene a brief huddle or phone conversation.
- Patient care will be managed by the cardiologist, the interventional cardiologist, or CV surgeon. The cardiac surgeon or vascular surgery consultant may be contacted for vascular/surgical issues. ABIOMED may be contacted for additional issues via their 24 hour support line at: 800-422-8666.
- For patients leaving the CCL or operating room with a Percutaneous Ventricular Assist Device, admission to ICU is required with a 1:1 staffing ratio.
- Device repositioning is performed only by trained physicians (cardiologists, intervention cardiologists, cardiothoracic surgeons~~,~~) ~~Optimal placement of the device inlet is approximately 3.5 cm- 4cm below the aortic valve, as indicated via echocardiography in the parasternal long axis view (TTE) or long axis view (TEE), only.~~
    1. Optimal placement of the CP and 5.5 device inlet is approximately 3.5 cm-4cm below the aortic valve, as indicated via echocardiography in the parasternal long axis view (TTE) or long axis view (TEE), only.
    2. Optimal positioning of the RP device is obtained via CXR to identify the landmark where the PA line crosses the RP device. Once placement is confirmed via CXR, the guidewire is removed and the RP may not be repositioned further.
- ~~Pump~~CP and 5.5 pump speed should be maintained (>/= P2 level in performance

mode) when the device is in correct position, unless the physician is at the bedside to remove the device.

- RP pump speed should be maintained >/=P6 level in performance mode when device is in correct position, unless MD is at bedside performing a trial wean.
- Resuscitative measures, including external chest compressions and defibrillation, should be administered according to standard criteria during Percutaneous Ventricular Assist Device support unless ordered by the MD.
    1. During chest compressions: decrease flow rate to (P2 in performance mode) for CP, 5.5 or RP devices.
    2. During defibrillation: the Percutaneous Ventricular Assist Device system does not have to be stopped or unplugged to defibrillate. Do not touch catheter, cables, or console during defibrillation. ~~After successful defibrillation and resuscitation, obtain an echocardiogram to verify pump position and return ro previous P-level~~
        a. After successful defibrillation and resuscitation,
            i. obtain an echocardiogram fro CP or 5.5 devices to verify pump position and return to previous P-level
            ii. Obtain a CXR for RP device to verify pump position and return to previous P-level
- Do not hold the 'ON' key longer than 3 seconds during operation; this causes the console to go into emergency STOP mode.
- The Percutaneous Ventricular Assist Device is latex-free, and is NOT compatible with MRI/MRA.

C. **POTENTIAL COMPLICATIONS:**

- Complications of Percutaneous Ventricular Assist Device support may include hemolysis, ventricular and atrial arrhythmias, perforation, cardiac tamponade, stroke, thrombocytopenia, vascular injury, device malfunction, or access site complications such as bleeding, hematoma, and infection.

V. PROCEDURE

A. **INITIAL ASSESSMENT AND SETTINGS**

- The CCL nurse will perform a head-to-toe assessment of the patient with the treating Cardiologist including a review of the Percutaneous Ventricular Assist Device settings, orders, site assessment (including length/depth of Percutaneous Ventricular Assist Device placement) and Touhy-Borst valve lock status.
- ~~A~~If the CP or 5.5 device was inserted, a bedside echocardiogram should be performed on arrival to the CCU/ICU to confirm device placement following transport, within 3 hours.
    - If a RP device was inserted, a bedside CXR should be performed upon arrival to ICU/ccu to confirm device placement following transport

- Vital signs, hemodynamics, access site, distal pulses, and device parameters are assessed every 15 minutes X 4, every 30 minutes X 2, and then hourly when clinically stable for the duration of Percutaneous Ventricular Assist Device support, and more frequently as needed.
- Optimal hemodynamics during support require an adequate circulating blood volume as indicated by a CVP > 12 mmHg and PCWP > 16 mmHg, or as otherwise ordered.
- Pump flow rates are indicated on the console in L/min and/or performance levels (P0P9). The pump speed is adjusted to maintain pump flow rates > 1.5L/min (> P2) at all times, using the lowest P level possible to generate the highest flow rate. P levels of P3–P8 are recommended for CP and 5.5, and P6-P9 for RP. However, flow rates should be lowered to 1.5 L/min (P2) during catheter repositioning, when troubleshooting suction alarms, and during CPR.

B. ~~**TRANSFER TO STANDARD CONFIGURATION** –If Impella CP Catheter in place, do not need to perform this operation with the Impella CP with Smart Assist catheter~~

- ~~Transitioning from the *initial setup configuration* to *standard configuration* is recommended as soon as practical, usually after transfer and admission to the ICU.~~
- ~~After 3 hours of operation, if the system is still in the set-up configuration, the controller displays a message that it has automatically switched to the P-level mode. The AUTO setting is no longer an options. Select OK to acknowledge.~~
  - ~~Press PURGE SYSTEM and select "Transfer to Standard Configuration" from the menu. The unit will prompt through the process.~~
  - ~~Using Standard Precautions, set up the 0.9% NaCl infusion bag with pressure bag and straight IV tubing.~~
  - ~~Disconnect the red luer on the Y connector from the red pressure sidearm on the red Impella plug. Clamp and cap the red luer on the Y connector.~~
  - ~~Create a slow drip from the NaCl pressure bag to flood the luer connector of the red pressure sidearm to displace any air, then connect to the sidearm. Fully open the roller clamp. The controller may alarm during this step.~~
  - ~~Select the OK button to confirm the transfer. (Refer to Attachment).~~

C. **PUMP PURGE SYSTEM**

- Ongoing pump lubrication is required via a continuous, fluid filled purge system integrated with the Automated Percutaneous Ventricular Assist Device Controller (AIC).
- The AIC automatically adjusts itself to maintain the desired purge pressure of 300 – 1100 mmHg. Alarms will sound if the purge pressure is outside of this range.
- ~~The recommended concentration for purge fluid is 500 ml, D5W with 12,500 units of heparin (25 IU/ml heparin) continuous infusion via the yellow check valve sidearm of PVAD device.~~
  1. ~~Do not use saline in the purge fluid as it corrodes the pump. The fluid~~

~~viscosity may be adjusted to optimize pump flow rates (↓viscosity will ↑flow).~~

2. ~~For bleeding or HIT (Heparin Induced Thrombocytopenia), Heparin may be reduce in ½ (12.5 unit/ml then 6.25 unit/ml) or removed temporarily (maximum 12 hours) from the purge fluid per MD orders.~~
3. ~~HIGH ALERT: DIFFERENT CONCENTRATIONS OF HEPARIN MAY BE USED. LABEL ALL LINES AND USE TWO PERSON INDEPENDENT DOUBLE-CHECK CO-SIGN PROTOCOL.~~

- The recommended concentration for purge fluid is D5w 1000ml with 25 mEq Sodium Bicarbonate continuous infusion via the yellow check valve sidearm of PVAD device.
- Do not use saline in the purge fluid as it corrodes the pump. The fluid viscosity may be adjusted to optimize pump flow rates (↓viscosity will ↑flow).
- Change purge fluid bag every 24 hours and purge cassette every 96 hours
- A purge pressure alarm is potentially life threatening – low purge pressure may allow blood to enter the motor which can form thrombus and emboli. To troubleshoot:

Low Purge Flow **Purge flow rate < 2 cc/hr** **High Pressure >1100mmHg**	**Look for kinks in tubing, sidearm, or catheter** **Reduce concentration/viscosity of purge fluid**
Low Purge Pressure **Purge pressure < 300mmHg** **Purge flow rate > 30 cc/hr**	**Look for leak in tubing, sidearm, or catheter** **Increase concentration/viscosity of purge fluid**

- When replacing the purge cassette, the process must be completed within 90 seconds . The Impella catheter may be damaged if replacement takes longer than 2~~.5™ or Impella CP® Catheter may be damaged if replacement takes longer than 2~~ minutes. A replacement cassette is stored in the basket of the device. CCL will stock basket
- Use a true arterial line or non-invasive cuff for blood pressure assessment and patient management. The arterial pressure displayed by the Percutaneous Ventricular Assist Device console is a reflected pressure of the aorta with the ~~2~~5.5 and CP device, ~~it is a differential in the 5.0~~ (used for catheter positioning only) and not an accurate arterial pressure. Do NOT treat the patient based on this number
  Automatic Integrated Console information:
  1. Do not block the cooling vents of the power supply.
  2. When unplugged, the Percutaneous Ventricular Assist Device console will operate for about 60 minutes when fully charged.
  3. Holding down the console's ON key for more than 3 seconds during operation will cause the device to go into emergency STOP mode.
  4. The "Home" screen displays the following information:

- Alarm conditions, when present (at top)
- Catheter position (central display) shows heart illustration with positioning
- Flow rate/P level, purge system, and power supply information (bottom)

Alarm Conditions:

Alarm conditions will appear on the display and are color coded by severity: white = advisory, yellow = serious, red = critical. Alarms provide troubleshooting measures:

1. Percutaneous Ventricular Assist Device position wrong: notify MD to verify and reposition stat.
2. Reduced flow: check position, assess patient's volume status, ↓ flow setting if persistent
3. Suction: If the pump is completely emptying the left ventricle, it can 'suck-down' around the catheter, but will open back up once there is additional blood filling the space.
    - Assess the patient's volume status, administer fluid replacement as appropriate
    - Verify catheter position
    - Consider reducing pump flow rates if persistent
    - Assess right heart failure

D. **ANTICOAGULATION & LABORATORY ASSESSMENTS:**

- Anti-coagulation is required for the duration of Percutaneous Ventricular Assist Device support. In cardiac cath lab, maintain ACT at 250 seconds during Impella ® insertion and per procedural guidelines.

~~ICU CARE~~ **ICU CARE**

- Once patient is admitted to ICU, monitor post procedure Activated Clotting Time (ACT) q 1hr until ACT is within goal range of 160-180 seconds.

~~PURGE Solution~~

- ~~Upon transfer to the ICU from the Cardiac Cath Lab, The ACT may be high >180, due to the amount of heparin given intra-procedure. The purge solution will have D5W running. The purge solution rate is determined by the pump. Usual purge solution rate is 15mLs/hr.~~
- ~~Once the ACT is <180, change purge solution to standard dose of D5W 500ml with 12,500 units of heparin (25 units/ml)~~
    1. ~~Once purge fluid contains heparin, check ACT every 2 hours~~

~~a. If ACT<140 x1 or >200 x2, call MD~~

- ~~If during therapy the ACT is >180 and remains above 180 x2 or >200 x1~~
    1. ~~Ensure there is no systemic heparin infusing~~
    2. ~~Reduce Heparin strength in half to 12.5 units/ml and recheck ACT in 2 hours. If ACT remains >180, decrease Heparin strength to 6.25 unit/ml and recheck ACT in 2 hours. If ACT continues to be >180, remove heparin from purge solution, **Notify MD** and continue to check ACT every 2 hours. **Max 12 hours without heparin in purge solution**~~
    3. ~~If purge solution does not contain Heparin and ACT<180 x2, add Heparin back to purge solution at lowest concentration (6.25 units/ml)~~

PURGE Solution

- **SODIUM BICARBONATE**
    - The recommended purge solution is 25 mEq/L of Sodium Bicarbonate in D5W 1000ml continuous infusion via the yellow check valve sidearm of device. If purge solution unavailable temporarily, D5W must be infused until sodium bicarbonate is available
- 1.

SYSTEMIC HEPARIN- SYSTEMIC ~~HEPARIN~~ANTICOAGULATION will be provided with systemic heparin

- Begin systemic heparin infusion per MD order if ACT <150 for 2 hours ~~and there is already Heparin in purge solution~~
- Check ACT every 2 ~~hours~~hour
- Goal is to maintain an ACT of 160 - 180.
- No initial heparin bolus
- Initial rate and adjustment for SYSTEMIC Heparin 25,000/500 ml D5W (50 units/ml):

Initial Infusion	300 units/hr
ACT less than 160	Increase by 100 units/hr
ACT 160-180	NO CHANGE
ACT greater than 180	Decrease infusion by 100 units/hr
ACT greater than 200	Decrease infusion by 200 units/hr

- ~~*Systemic heparin is last to initiate but first to wean before changing purge fluid~~
- Monitor PTT, CBC, CMP, CMP, Liver enzymes and Plasma Free Hemoglobin (PFHb)

levels per physician's orders. If patient develops signs of hemolysis (blood in urine, hemolyzed lab samples, ↑PFHb), contact the cardiologist or interventional cardiologist. Hemolysis may indicate the device is not optimally placed within the ventricle or the patient requires additional fluid volume. Notify cardiologist or interventional cardiologist of falling platelet count; evaluate for Heparin Induced Thrombocytopenia (HIT) as appropriate. HIT should be confirmed with positive ELISA test and positive serotonin release test.

1. Resource for HIT positive patient direct thrombin inhibitor protocols: http://www.abiomed.us/npi-search

E. PATIENT CARE ISSUES

- Maintain head of bed (HOB) at or below 30° at all times and avoid groin flexion. Do NOT torque chest or hips. Patient may be log-rolled.
- Avoid tension/movement of device; maintain strict bed rest and use a knee immobilizer if necessary to maintain a straight leg on the side of the access site.
- Monitor access site/pedal pulses for bleeding, hematoma, infection.
- Bladder catheter recommended for all patients unless contraindicated.
- Sterile dressing change of femoral insertion site per hospital protocol and PRN if dressing becomes compromised or site appears wet or soiled. Use additional staff to stabilize catheter and monitor Impella ~~2.5 ™ or Impella CP ®~~ device position throughout dressing change.
- Change purge fluid bag every 24 hours. Change purge cassette every 96 hours..
- With increased blood flow from the supported left heart, the right heart may be overwhelmed, monitor for s/s right heart failure: ↓ pump flow, suction alarms, ↑CVP, ↑PAP, liver dysfunction. Initiate supportive care as appropriate.

F. DEVICE WEANING AND REMOVAL:

- Weaning from the Percutaneous Ventricular Assist Device must be coordinated with the physician who is managing the patient.
- ~~Maintain Impella ® Catheter P-level at P-2 or above until the catheter is ready to be removed from the left ventricle.~~
- ~~Remove all heparin from system 2 hours prior to removal. Replace purge bag with plain D5W.~~
- ~~Decrease pump speed per physician orders and assess tolerance:~~
    - ~~Rapid wean(Cath Lab): ↓ performance level by 2 levels q15 minutes (ie, P6 to P4 to P2)~~
- ~~Maintain at P2 for 10 minutes. If patient remains stable notify the physician.~~
    1. ~~Gradual wean (ICU): ↓ performance level by 2 levels q2 – 3 hours~~
- ~~Maintain at P2 for 2 – 3 hours. If patient remains stable, notify the physician.~~
    1. ~~Adjust anticoagulation as ordered; achieve ACT < 150sec prior to introducer removal.~~

- ~~**The MD will remove the Impella device.**~~
    1. ~~When the MD arrives at the bedside, decrease to P1.~~
- ~~As soon as the MD pulls the catheter back into the aorta, decrease to P0. Note: Do not decrease to P0 until the distal tip of the Impella is in the aorta. Disconnect the white power plug from the front of the console.~~
- ~~Following percutaneous device removal, hemostasis can be achieved by either manual hold 40 continuous minutes or per hospital protocol until homeostasis achieved.~~
- **CP or 5.5**
    - Maintain Impella ® Catheter P-level at P-2 or above until the catheter is ready to be removed from the left ventricle.
    - Remove all heparin from system 2 hours prior to removal. Replace purge bag with plain D5W.
    - Decrease pump speed per physician orders and assess tolerance:
        - Rapid wean(Cath Lab): ↓ performance level by 2 levels q15 minutes (ie, P6 to P4 to P2)
    - Maintain at P2 for 10 minutes. If patient remains stable notify the physician.
        1. Gradual wean (ICU): ↓ performance level by 2 levels q2 – 3 hours
    - Maintain at P2 for 2 – 3 hours. If patient remains stable, notify the physician.
        1. Adjust anticoagulation as ordered; achieve ACT < 150sec prior to introducer removal.
    - **The MD will remove the Impella device.**
        1. When the MD arrives at the bedside, decrease to P1.
    - As soon as the MD pulls the catheter back into the aorta, decrease to P0. Note: Do not decrease to P0 until the distal tip of the Impella is in the aorta. Disconnect the white power plug from the front of the console.
    - Following percutaneous device removal, hemostasis can be achieved by either manual hold 40 continuous minutes or per hospital protocol until homeostasis achieved.
- **RP**
    - Maintain Impella RP catheter at P6 or above until MD is at bedside to perform a trial wean of Impella RP and view ECHO to confirm RV contractility.
    - To perform a trial wean:
        - Decrease to P-2 temporarily
        - Record the VAD flow. P-level, CVP, ECHO parameters and

hemodynamics

- After 15-20 Min and no adverse effect, the process can be continued and further weaning can be undertaken.
- Once RV contractility is confirmed, resume previous P-level and initiate slow wean

- To perform a Slow Wean
  - Once trial wean above is performed with MD at bedside, decrease by 2 P-levels every 2-3 hours and monitor patient hemodynamics as ordered by MD.
- While weaning always maintain flow >1.5 L/min until removal of Impella RP device
  - If flows are </= 1.5 L/min, >/=20 min, consider increasing ACT to >/=250 seconds.
- The Impella RP device is ready to be removed when the weaning steps are complete and the ACT is </= 150 seconds.

- In the event the patient needs to be transferred to a higher level of care at another facility, the patient will be transported on the Impella device with the critical care transport team. The critical care transport team will return the device to our facility after the transport.

G. **REPORTABLE CONDITIONS:**

- The patient develops signs of hemolysis or thrombocytopenia.
- Malpositioning of the device.
- Purge pressure alarms that cannot be corrected.
- Suction alarms that cannot be corrected without decreasing flow rates.
- Loss of distal pulses to device entry site.

H. Initiate the Percutaneous Ventricular Assist Device Flow sheet on the worklist.

I. Document ~~the following parameters~~ hourly and PRN during entire course of Percutaneous Ventricular Assist Device support~~:~~ in the Percutaneous Ventricular Assist Device (Impella) Flow ~~L/min, Pump Position, Purge Pressure – mmHg, Infusion Rate, Power – AC (alternating current) or B (battery).~~sheet in Meditech

VI. EDUCATION/TRAINING

A. Education and/or training will be provided as needed.

VII. REFERENCES

A. Percutaneous Ventricular Assist Device Instructions for Use for the Percutaneous Ventricular Assist Device 2.5, CP, and 5.0 Circulatory Support System, Abiomed 2020

B. Percutaneous Ventricular Assist Device 2.5, CP, and 5.0 Circulatory Support System Quick Reference Guide, Abiomed 2020

C. ~~Abiomed (2016, December). Impella Program Protocols & Tools. Danvers, MA, USA: Abiomed.~~Abiomed. Impella Program Protocols & Tools. Retreived on May 16, 2023 from https://www.heartrecovery.com/products-and-services/impella/impella-cp-with-smartassist.

Attachments

A: Percutaneous Ventricular Assist Device Insertion Criteria

B: Direct Thrombin Inhibitors in Percutaneous Ventricular Assist Device Purge Pressure Solution

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Cath Lab Medical Director	Katherine DeSalvo: Director Medical Staff Services	11/2023
Director Critical Care Services	Carla Spencer: Director Critical Care Services	10/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023
Policy Owner	Kelly Flower: Clinical Manager	10/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14781222**

Last Approved	N/A	Owner	Carla Spencer: Director Critical Care Services
Last Revised	11/2023	Area	Scopes Of Service
Next Review	1 year after approval		

Scope of Service: Critical Care

I. SCOPE OF SERVICE

The Critical Care Units support the Mission, Vision, Values and Strategic Plan of Salinas Valley Health Medical Center (SVHMC) and has designed services to meet the needs and expectations of patients, families and the community.

The purpose of the Critical Care Units are to enhance patient services and health programs that help SVHMC remain a leading provider of medical care. The goal of Critical Care Units are to ensure that all customers will receive high quality care / service in the most expedient and professional manner possible.

II. GOALS

In addition to the overall SVHMC goals and objectives, the Critical Care units develop goals to direct short term projects and address opportunities evolving out of quality management activities. These goals will have input from other staff and leaders as appropriate and reflect commitment to annual hospital goals.

The goals of the Critical Care Units are:

A. ***1st Main Telemetry*** provides monitoring and care of patients with moderate or potentially severe physiologic instability, requiring technical support including but not necessarily artificial life support. The Unit is reserved for those patients requiring less care than standard Intensive Care, but more than that which is available from a general care unit.

B. ***5 Tower Telemetry*** provides care for and continuous cardiac monitoring of patients in a stable condition, having or suspected of having a cardiac condition or a disease requiring the electronic monitoring, recording, retrieval and display of cardiac electrical signals.

C. ***4 Tower Telemetry*** provides care for and continuous cardiac monitoring of patients in a stable condition, having or suspected of having a cardiac condition or a disease requiring the electronic monitoring, recording, retrieval and display of cardiac electrical signals.

D. ***ICU/CCU*** is to provide monitoring and care of critically ill patients. ICU patients may be housed in other locations during an emergency situation.

E. ***Observation Care Unit (OCU)*** provides care to patients who may require clinical services while a decision is made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. OCU is also capable of providing short term care for patients requiring pre and post procedural care in the Diagnostic Imaging and interventional Cardiology procedures. Additionally, the unit provides short term care for patient requiring injections, infusions or treatments that do not meet criteria for inpatient status and will be discharged post procedure.

F. ***Heart Center*** provides monitoring and care of acute inpatients that do not require intensive care, but more than what is available from the general care unit. Up to four beds are designated intensive care bed to accommodate ICU overflow.

III. DEPARTMENT OBJECTIVES

A. To support the SVHMC and Department of Nursing objectives.

B. To support the delivery of safe, effective, and appropriate care/service in a cost effective manner.

C. To plan for the allocation of human/material resources.

D. To provide high level medical and nursing management with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions through patient/significant other education and to restore the patient to as high a level of wellness as possible.

E. To collect data about the Unit function, staff performance, and patient care for quality management purposes and continuous quality improvement.

F. To provide a therapeutic environment appropriate for the patient population in order to promote healing of the whole person.

G. To provide necessary expertise, technology, instrumentation and equipment for the management of patients.

H. To provide nursing care based on the nursing process.

I. If not covered by SVHMC's policies, nursing follows guidelines as outlined in Lippincott Manual of Nursing Practice.

J. To evaluate staff performance on an ongoing basis.

K. To provide appropriate staff orientation and development.

L. To monitor the Critical Care Units functions, staff performance and care/service for quality management and continuous quality improvement.

IV. POPULATION SERVED

Clinical:

A. The 1st Main Telemetry Unit provides care for adolescent patients, 16 years and older, along with adult and geriatric populations.

B. The 5th Tower Telemetry Unit provides care for adolescent patients 16 years and older, along with adult and geriatric populations.

C. The 4th Tower Telemetry Unit provides care for adolescent patients 16 years and older, along with adult and geriatric populations.

D. The Observation Care Unit provides care for patients 16 years and older, along with adult and geriatric populations.

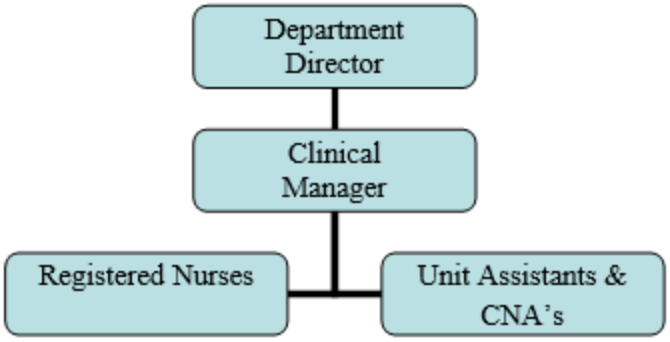
E. The ICU/CCU provides care for infant, pediatric, adolescent patients, 16 years and older, along with adult and geriatric populations.

F. The Heart Center provides care for patients 16 years and older, along with adult and geriatric populations.

V. ORGANIZATION OF THE DEPARTMENT (include organizational chart)

A. Hours of Operation:

The 1st Main Telemetry Unit, 5th Tower Telemetry Unit, 4th Tower Telemetry Unit ICU/CCU, Observation Care Telemetry Unit and the Heart Center provide services seven days a week, twenty-four hours a day.



B. Location of departments:

- 1st Main Telemetry Unit is located on the 1st floor of the main hospital between the Heart Center and the Intensive Care Unit. Rooms 107-116 have been designated as Outpatient Surgical Services.
- The 5th Tower Telemetry Unit is located in the 5th Floor Tower of the main hospital.
- The 4th Tower Telemetry Unit is located in the 4th Floor Tower of the main hospital.
- The ICU/CCU Unit is located on the 1st floor of the main hospital.
- The Observation Care Unit is located on the fifth floor of the main hospital.
- The Heart Center is located on the first floor of the hospital. Up to four beds are designated intensive care bed to accommodate ICU overflow.

C. Major Services/Modalities of care may include:

1st Main Telemetry provides care / services to patients with primary diagnoses, including but not limited to: gastrointestinal bleed, pulmonary edema, respiratory failure, COPD, renal infection, and out-of-control diabetes mellitus. The Unit also provides care for hemodynamically stable patients requiring ventilator support, vasopressor therapy, and invasive pressure monitoring (arterial/CVP lines). Modalities may include Invasive pressure monitoring- Arterial/ CVP lines and Cardiac Monitoring Therapy. The unit consists of thirteen (13) single occupancy rooms with cardiac monitoring/ telemetry capacity. Seven (7) rooms are equipped to provide renal dialysis.

5th Tower Telemetry provides care / services to patients with primary diagnoses, including but not limited to: Stroke, COPD, heart failure, pneumonia, chest pain, GI Bleeds and renal failure. Care is also provided to hemodynamically stable patient's requiring vasopressor therapy and invasive pressure monitoring (arterial/CVP lines). Modalities may include Invasive pressure monitoring- Arterial/ CVP lines and Cardiac Monitoring Therapy. All rooms provide renal dialysis. The unit consists of twelve (12) single occupancy rooms and two (2) double occupancy.Two (2) of the rooms have negative pressure isolation capabilities with an anteroom adjacent to the patient's room. 4th ***Tower Telemetry*** provides care / services to patients with primary diagnoses, including but not limited to: Stroke, COPD, heart failure, pneumonia, chest pain, GI Bleeds and renal failure. Care is also provided to hemodynamically stable patient's requiring vasopressor therapy and invasive pressure monitoring (arterial/CVP lines). Modalities may include Invasive pressure monitoring- Arterial/ CVP lines and Cardiac Monitoring Therapy. All rooms provide renal dialysis. The unit consists of eleven (11) single occupancy rooms and two (2) double occupancy. One (1) of the rooms have negative pressure isolation capabilities with an anteroom adjacent to the patient's room

D. ***ICU/CCU*** provides care / services to patients with primary diagnoses, including but not limited to: Acute Myocardial Infarction, Pre-Post Open Heart Surgery, Congestive Heart Failure, Acute/ Chronic Renal Failure, Acute Respiratory Failure, Anoxic Brain Injury, Cerebral Vascular Accident, Intracerebral Hemorrhage, Subdural Hemorrhage, Septicemia, Pre-Post Abdominal Surgery, Pre-Post Thoracic Surgery and Multiple Trauma. Modalities may include: Invasive Hemodynamic Monitoring/PA and Arterial Catheterization, Cardiac Monitoring, Intra-aortic Balloon Pump Monitoring and Management, Continuous Renal Replacement Therapy. The unit consists of thirteen (13) single occupancy rooms.

- The Critical Care Intensivist/Pulmonologist coordinates and leads multidisciplinary rounds on all patients, daily in ICU/CCU. The assist in the evaluation and management of the patients and may intervene in the care of the patients if necessary. The information from rounds is documented in the patient's electronic medical record and reported to the attending Physician if it is not them.
- Physicians with admitting privileges may admit to ICU/CCU, however, a Critical Care Intensivist/Pulmonologist consultation is available 24 hours per day, 7 days per week. They may also assist with the coordination of patient admission, discharge and/or transfer from Critical Care with the attending physician.
- Critical Care Intensivist/Pulmonologists have the authority to intervene and manage the care of any ICU/CCU patient even if they are not the attending of record. They may order tests, initiate treatments and perform procedures if medically indicated.

E.

Observation Care Unit provides care / services to patients requiring observation, treatments and pre and post procedure preparation within the scope of services at SVMH. Patients may be admitted with primary diagnoses, including but not limited to: Chest pain or similar symptoms suggestive but not diagnostic of an acute MI, Acute asthma attack, Acute exacerbation of chronic lung disease, uncontrolled hypertension not requiring titrating drips, drug reactions, allergic reactions, dehydration requiring intravenous repletion (e.g. secondary to vomiting, diarrhea, anorexia, etc.), short term therapy such as seizure disorder requiring anticonvulsant loading, sickle cell pain crisis, transfusion of blood, abdominal pain suggesting an acute abdominal process, but not readily defined, gastrointestinal bleeding of uncertain nature of significance, infections requiring short-term parenteral antibiotic therapy (e.g., pneumonia, cellulitis, urinary tract infection). Assessments will be completed by registered nurses and reassessment will be completed for those patients monitored by telemetry every four hours or as needed and non-monitored patients will be assessed once a shift or as needed to support or facilitate the decision for admission or discharge.

Heart Center provides care / services to patients with primary diagnoses, including but not limited to: Acute Myocardial Infarction, Pre- Post PTCA, Ablation, Congestive Heart Failure, Angina, Pre-Post Pacemaker Placement, Pre-Post Automatic Implantable Cardioverter Defibrillator (AICD), COPD and Pre-Post Cardiac Surgery, Cerebral Vascular Accident (CVA). Care is also provided to hemodynamically stable patient's requiring vasopressor therapy and invasive pressure monitoring (arterial/CVP lines). Modalities may include: Invasive pressure monitoring (arterial/CVP lines) and Cardiac Monitoring. The unit consists of fifteen (15) single occupancy rooms.

VI. DEFINITION OF PRACTICE AND ROLE IN MULTIDISCIPLINARY CARE /SERVICE

The inpatient care is delivered by a multidisciplinary team comprised of medical staff, registered nurses and ancillary support according to the needs of the patients. A registered nurse (RN) performs an admission assessment on patients optimally within two (2) hours of admission to the unit. The RN selects and initiates the nursing care plans within the shift of admission and updates as indicated. Services are provided based upon patient assessments, patient and/or family preferences, plans of care and medical staff orders.

The Director and Clinical Manager(s) assume twenty-four (24) hour responsibility for nursing care provided on the Unit.

The Director of the Unit is directly responsible to the Chief Nursing Officer. It is the Director's duty to attend all administrative and technical functions within the department. All personnel within the department are under the guidance and direction of the Director. In the Director's absence, the position is filled by the Manager or Nursing Leader on call, or their designee. It is his/her responsibility to carry out the duties of the Director in his/her absence.

VII. EVALUATION OF CARE

Systems, services and patient care are evaluated to determine their timeliness, appropriateness, clinical necessity and the extent to which the level of care or services provided meets the patient's needs through any one or all of the following quality improvement practices:

A. Multidisciplinary Performance Improvement Teams
B. Patient/ Family satisfaction surveys
C. Focused studies
D. Patient relation services
E. Employee forums
F. Staff meetings and staff input
G. Nursing Leadership

VIII. REQUIREMENTS FOR STAFF (applicable to department)

All individuals who provide patient care services are licensed or registered (according to applicable state law and regulation) and have the appropriate training and competence.

A. Licensure / Certifications:

The basic requirements for ***Registered Nurses*** include:

1. Current state licensure
2. Current BLS
3. Current ACLS
4. PALS preferred *(ICU/CCU Unit)*
5. PCCN or CCRN Certification preferred
6. Basic Arrhythmia Certification.
7. Completion of competency-based orientation
8. Completion of annual competency
9. TNCC- preferred *(ICU/CCU Unit)*
10. Completion of an approved Critical Care Course or equivalent experience *(ICU/CCU Unit)*

The basic requirements for *Certified Nursing Assistants and Clinical Assistants* include:

1. Current state licensure
2. Current BLS
3. Completion of competency-based orientation

4. Completion of annual competency

The basic requirements for *Unit Assistants/Monitor Tech (UA II)* include:

1. High school diploma or equivalent
2. Current BLS
3. Basic Arrhythmia competency
4. Completion of competency-based orientation
5. Completion of annual competency

B. Competency

Staff are required to have routine competence assessments in concert with the unit's ages of the population and annual performance appraisals. The assessment could be in a written, demonstrated, observed or verbal form. The required competency for staff depends primarily on their work areas and duties. Once a year staff are required to complete the online education modules that have been defined by the organization.

During the year in-services are conducted routinely. The in-services are part of the department's on-going efforts to educate staff and further enhance performance and improve staff competencies. These in-services are in addition to the annual competency assessments. Department personnel who attend educational conferences are strongly encouraged to share pertinent information from the conferences with other staff members at in-services. Additional teleconferences, videoconferences, and speakers are scheduled for staff on occasion. Other internal and external continuing education opportunities are communicated to staff members.

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

- Employee educational needs assessment at the time of hire and annually as part of developmental planning
- Performance improvement planning, data collections and activities
- Staff input
- Evaluation of patient population needs
- New services/programs/technology implemented
- Change in the standard of practice/care
- Change in regulations and licensing requirements
- Needs assessment completed by Nursing Education

The educational needs of the department are assessed through a variety of means, including:

- STAR Values
- Quality Assessment and Improvement Initiatives

- Strategic Planning (Goals & Objectives)
- New / emerging products and/or technologies
- Changes in Practice
- Regulatory Compliance
- Feedback and requests for future topics are regularly solicited from staff via UPC referrals, email, surveys, in-service evaluation forms, and in person.

D. Continuing Education

Continuing education is required to maintain licensure / certifications. Additional in-services and continuing education programs are provided to staff in cooperation with the Department of Education.

IX. STAFFING PLAN

Staffing is adequate to service the customer population. The unit is staffed with a sufficient number of professional, technical and clerical personnel to permit coverage of established hours of care / service, to provide a safe standard of practice and meet regulatory requirements. Patient acuity level is determined each shift to plan for staffing needs for the following shift. Patient assignments are made based upon staff skill level and total patient acuity.

General Staffing Plan:

Staffing is based on patient volume and acuity. In the telemetry departments, the RN to patient ratio is one RN to no greater than four (4) patients. In ICU/CCU the RN to patient ratio is one RN to no greater than two (2) patients. Assignments are made by the charge nurse based on acuity and needs of the patients, technology involved, competencies of the staff, the degree of supervision required, and the level of supervision available. Staff provides either total patient care or "partners" care depending on the patient needs, acuity, and the licensed staff scheduled.

In the event staffing requirements cannot be met, the unit will meet staffing requirements by utilizing the on-call system, registry, traveler and per diem RN's.

X. EVIDENCED BASED STANDARDS

The SVHMC staff will correctly and competently provide the right service, do the right procedures, treatments, interventions, and care by following evidenced based policies and practice standards that have been established to ensure patient safety. Efficacy and appropriateness of procedures, treatments, interventions, and care provided will be demonstrated based on patient assessments/reassessments, state of the art practice, desired outcomes and with respect to patient rights and confidentiality.

The SVHMC staff will design, implement and evaluate systems and services for care / service delivery which are consistent with a "Patient First" philosophy and which will be delivered:

- With compassion, respect and dignity for each individual without bias.
- In a manner that best meets the individualized needs of the patient.

- In a timely manner.
- Coordinated through multidisciplinary team collaboration.
- In a manner that maximizes the efficient use of financial and human resources.

SVHMC has developed administrative and clinical standards for staff practice and these are available on the internal intranet site.

XI. CONTRACTED SERVICES

Contracted services under this Scope of Service are maintained in the electronic contract management system.

XII. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

The Critical Care Units support SVHMC's commitment to continuously improving the quality of patient care to the patients we serve and to an environment which encourages performance improvement within all levels of the organization. Performance improvement activities are planned in a collaborative and interdisciplinary manner, involving teams/committees that include representatives from other hospital departments as necessary. Participation in activities that support ongoing improvement and quality care is the responsibility of all staff members. Improvement activities involve department specific quality improvement activities, interdisciplinary performance improvement activities and quality control activities.

Systems and services are evaluated to determine their timeliness, appropriateness, necessity and the extent to which the care / service(s) provided meet the customers' needs through any one or all of the quality improvement practices / processes determined by this organizational unit.

In addition to the overall SVHMC Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure, the Critical Care Units will develop measures to direct short-term projects and deal with problem issues evolving out of quality management activities.

Unit based measurement indicators are found within the Quality dashboard folder.

Attachments

Organization of the Department

Approval Signatures

Step Description	Approver	Date

Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2023
Policy Owner	Carla Spencer: Director Critical Care Services	11/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14803996**

Last Approved	N/A
Last Revised	11/2023
Next Review	3 years after approval
Owner	Cynthia Vargas: Manager Patient Experience
Area	Administration

Visitors

I. POLICY STATEMENT

A. Salinas Valley Health Medical Center (SVHMC) will not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, or disability. Visitors shall enjoy full and equal visitation privileges consistent with patient preferences.

B. The patient has the right to both a support person and visitors while under the care, treatment, and service of SVHMC. Refer to Section V F.

C. The patient has the right to request anonymity (Confidential Status). If a patient requests to be designated as "Confidential" no visitors or support person is allowed. Refer to Section V E.

D. Patients are responsible to manage visitors. SVHMC does not manage "Lists" of patient requested visitors.

E. SVHMC has the right to restrict visitors for concerns such as, but not limited to, mental health crisis, infectious diseases, patient safety, etc.

II. PURPOSE

A. To define the patient's right to visitation while receiving care, treatment, and service.

B. To guide staff in the creation of a positive visiting experience for both patients and visitors at SVHMC.

C. To support a patient and family centered care environment by incorporating a support person, family and visitors into the patient's plan of care.

III. DEFINITIONS

A. Immediate family: Parents, parent's children, siblings, grandparents, grandchildren and spouse/ domestic partner. In the absence of immediate family, individuals whom the patient designates as "family" may visit at the attending nurse's discretion.

B. Patient: Patient or their designated surrogate decision maker

C. Significant other: spouse, domestic partner, girlfriend or boyfriend, caregiver or constant companion - not counted as a visitor.

D. Support Person: family member, friend or other individual over 18 years of age who, at the request of the patient, can provide emotional support during the patient's stay. The support person is not authorized to make medical / care decisions nor receive patient information unless authorized by the patient.

E. Authorized responsible party: Custodial parent(s), legal guardian/custodian, legal responsible party, designated surrogate decision maker.

IV. GENERAL INFORMATION

A. The right of a patient to have visitors may be limited or restricted when visitation would interfere with the care of the patient and/or the care of other patients. Circumstances reasonably related to the care of the patient and/or the care of other patients that provide a basis to impose restrictions or limitations on visitors include (but are not limited to) when:

1. There may be infection control issues.
2. Visitation may interfere with the care of other patients.
3. The hospital is aware that there is an existing court order restricting contact.
4. Visitors engage in disruptive, threatening, violent or criminal type behavior of any kind.
5. The patient or patient's roommate(s) need rest or privacy.
6. The patient is undergoing care interventions.
7. Visitation is otherwise clinically contraindicated.

B. Visiting hours at SVHMC are generally from 9AM - 8 P.M, 7 days a week. (Exceptions are managed on a case by case basis with consideration of the patient's medical condition and in collaboration with the unit charge nurse and nursing supervisor.)

1. In most areas, there are NO age restrictions for visitors unless indicated due to health considerations or special circumstances such as influenza season.
2. Specific units may have different visiting hours and/or age limitations. Detailed information will be given to patients, families and visitors in those units.

C. The organization may limit the number of visitors during a specific period of time, as well as establish minimum age requirements for child visitors when reasonably necessary to provide safe care.

D. If there are multiple family members they should be encouraged to designate a spokesperson to **minimize interruptions** of patient care.

E. SVHMC is committed to providing a quiet healing atmosphere. Some strategies include, but are not limited to:

1. Offering a "Quiet pack"
2. Lowering the volume of the TV or other electronic devices

3. Dimming the lights in the hallways or in rooms
4. Putting all cell phones and pagers on vibrate
5. Closing doors
6. Offering aromatherapy or soft music
7. Offering warm tea in accordance with the patient nutrition orders

F. The patient shall be informed of the reason for any restriction or limitation of visitors and this restriction will be recorded in the electronic health record.

G. QUIET TIME: In order to provide time for patients to rest and recover, quiet time is from 2 p.m. to 4 p.m. each day. During quiet time, visiting may prohibited.

H. END OF LIFE: Special visitation arrangements are made for patients who are receiving end of life care, including a declaration of brain death/organ donation. Flexibility for end-of-life allowed based on space constraints and maintaining privacy of other patients.

I. Patients be informed, verbally or in writing of their visitation rights, including any clinical restriction or limitation on such rights.

V. PROCEDURE

A. **VISITING GUIDELINES**

1. Visitors will check in at the Information Desk in the Main Lobby with the Concierge, Volunteer or Security officer on duty to receive a pass.
    a. After hours, security officer will request approval from the appropriate nursing unit prior to issuing a visitor pass.
2. Nursing staff should educate visitors to:
    a. The unit specific visitation processes.
    b. Limit the number to 2 (two) visitors at a time. Exceptions are made on a case by case basis.
    c. Limit their visits to a reasonable duration based on patient's condition.
    d. No consumption or under the influence of alcoholic beverages or illegal substances is allowed on hospital property.
    e. SVHMC is a smoke free facility including all tobacco products and e-cigarettes / vaping products.
    f. The hospital reserves the right to limit or disallow visitors at any time.

B. **AFTER HOURS VISITATION**

1. An announcement will be made prior to the end of visiting hours informing all visitors that regular visiting hours are over at 8:00PM. All visitors, except the patient's support person, will be asked to leave the hospital at the end of visitation hours. See **Section D** for unit specific exceptions.
2. Special after hours visits will be approved by the Administrative Supervisor or Unit Director/Designee on a case by case basis utilizing the following criteria:

a. Critical or terminally ill patient.

b. Extreme safety concern for the patient.

c. Severe language barrier not accommodated by Hospital designated interpreter service.

d. Other situations as determined by the Administrative Supervisor or Unit Director/Designee.

3. Starting at 8:00 PM, a Security Officer will make rounds of nursing units to inform visitors that visiting hours are over.

    a. If any after-hours visitors are authorized, the Security Officer will issue a new visitor's identification badge.

    b. If visitors are not authorized after hours, the visitors will be politely informed that visiting hours are over and requested to leave.

    c. Should the visitor insist on visitation or special circumstances, the Security Officer or Concierge on duty will contact the charge nurse of the unit. If visitor(s) are authorized the charge nurse will inform the Administrative Supervisor for the final authorization.

C. **LIMITING VISITATION IN SPECIFIC CARE SETTINGS**

1. The number of visitors and length of visitation may be limited in specific care settings such as intensive care units and post-operative/invasive recovery areas due to the critical nature of a patient's illness and the level of required medical care.
2. General visitor access to areas where newborn infants and pediatric patients are housed may be limited due to security concerns and the need to protect these vulnerable populations from abduction.
3. Due to care and safety concerns, visitation is not permitted during the performance of operative, invasive, or other high-risk procedures. To protect patient privacy, visitation is generally not permitted when a patient is receiving personal care such as toileting, bathing, etc.

D. **UNIT SPECIFIC VISITING POLICIES**

1. **INTENSIVE CARE / CORONARY CARE UNIT (ICU/CCU)**

    a. Visiting hours in the ICU/CCU are open and visitors are allowed at any time 24/7.

    b. Limit the number to 2 (two) visitors at a time. Exceptions are made on a case by case basis.

    c. Phones with auto dial are located at both the ICU and CCU doors and shall be used by visitors to gain access to the unit.

    d. Visitors shall generally be limited to immediate family members, significant others or by patient request.

    e. Children are welcomed as appropriate to the situation but limited due to the nature of care and the equipment used in ICU settings.

2. **PEDIATRIC**
    a. Authorized responsible parties are encouraged to visit and participate in the child's care anytime during the day and evening. Due to space restraints, only one authorized responsible party is encouraged to stay overnight.
    b. Visitors under the age of 12 may visit in the pediatric unit if they are siblings of the patient.
    c. The Pediatric unit may limit sibling visitation at the discretion of the charge nurse.

3. **PERINATAL SERVICES**
    a. **Labor and Delivery Unit**
        i. When a patient is in labor, they determine who may visit throughout the labor process.
        ii. Children under the age of 12, if child of the patient, may visit. Children under the age of 12 must be supervised by an adult (not the patient) at all times and not be disruptive to nursing staff or other patients.
            1. The name(s) of the patient's child(ren) will be obtained from the patient upon admission.
        iii. Visiting hours are open for laboring patients unless there is a medical or social reason to limit visitation at the discretion of the patient or staff.
        iv. Visitors are encouraged to limit the number of visitors to 4 at a time. Exceptions are made on a case by case basis.

    b. **Mother Baby Unit**
        i. After a patient transfers to the Mother/Baby Unit, regular visiting hours will apply. Visitors should limit the time of their visits to allow the new mother and baby time to rest, bond, and allow for the necessary patient education.
        ii. A Parent/Guardian/Support Person of the baby is welcomed to spend the day/night and participate in the plan of care as directed by the patient.
        iii. Children under the age of 12, if child of the patient, may visit. Children under the age of 12 must be supervised by an adult (not the patient) at all times and not be disruptive to nursing staff or other patients.
        iv. Visitors are encouraged to limit the number of visitors to 2 at a time.
        v. A Parent/Guardian/Support Person of the baby is not counted as a visitor.

c. **OBED**

i. Only one visitor per patient is allowed while patients are being checked for possible admission or antepartum testing

d. **Neonatal Intensive Care Unit (NICU)**

i. The NICU fosters the Philosophy of Family Centered Care. Parents/guardians are encouraged to visit and participate in infant feeding and care in the NICU. The ~~Nurse or Physician~~Charge RN has authority to restrict or allow visitors based on unit activity. The nurse or physician will assess each situation and provide support, instruction, and assistance to the parents/guardians.

ii. It is important to note that parents/guardians are not considered visitors and are encouraged to be present at any time, especially during change of shift report, to actively participate in the plan for care.

iii. In general, visitation in the NICU is limited to parents/~~authorized responsible party~~guardians and grandparents for the first twenty-four (24) hours. Thereafter, other visitors may accompany the parent/guardians. ~~Parents~~Visitors who present without the presence of the parent/~~guardians may provide a~~guardian will not be allowed visitation unless they have been included on the parent/guardian provided list ~~of persons who are authorized to visit the infant when parents/guardians are not present~~and with a photo ID. ~~Photo ID will be required.~~

iv. ~~Visiting~~To encourage family-centered care, visiting hours are ~~as flexible as possible for the convenience of the visitor~~24 hours a day, 7 days a week. ~~In~~However, in order to maintain patient confidentiality, visitors ~~will NOT~~may not be allowed in the NICU during ~~change~~the following times: Change of shift report: 0700-0730 hours~~, 1500-1530~~ and 1900-1930 hours~~, and 2300-2330 hours, or during work rounds~~. ~~Parents/guardians are not considered visitors and are encouraged to be present during report times to participate in the plan of care.~~

v. ~~Siblings may visit with completion of the "visitation checklist".~~Siblings may visit with completion of the "visitation checklist". During seasonal restrictions, visitation will be limited to siblings aged 12 years and older. In consideration of health and safety, if anyone at home or any visitor exhibits signs of illness, masks will be required to be worn.

vi. Information pertaining to the infant's condition will be released only to the parents/guardians, unless the parent/guardians ~~sign a written release of information authorizing otherwise~~has provided the PIN.

vii. ~~The Charge RN has authority to restrict or allow visitors based~~

~~on unit activity.~~

4. **EMERGENCY DEPARTMENT**
    a. All visitors must check in with the security officer at the Emergency Department entrance.
    b. One visitor is allowed in the waiting room unless the Emergency Department is over capacity at which time staff will ask visitors to vacate to make room for patients.
    c. One visitor is allowed with patients in patient's room unless otherwise authorized by the medical staff.
    d. No visitors allowed in the Result Waiting or Fast Track areas.
    e. Pediatric patients are required to have one parental figure or authorized responsible party with them at all times but will not be allowed a visitor unless authorized by the hospital staff.
5. **OUTPATIENT INFUSION**
    a. Visitation will be limited to one visitor at a time due to space limitations and to optimize patient privacy. If the patient is a child, a parent/authorized responsible party must remain with the child the whole time.
    b. Children 12 and older may visit.
6. **OUTPATIENT SURGERY/CATH HOLDING**
    a. Visitation will be limited to one visitor at a time due to space limitations and to optimize patient privacy. If the patient is a child, a parent/authorized responsible party must remain with the child the whole time.
7. **MAIN OR POST-ANESTHESIA CARE UNIT (PACU)**
    a. The authorized responsible party for a pediatric or special needs patient may stay.
8. **MEDITATION ROOM**
    a. The Meditation Room is an area providing privacy for families of patients in crisis and during consultation with health care providers. Guidelines have been established for use of the Meditation Room.
    b. The Meditation Room may be accessed by Security and/or Concierge and the Administrative Supervisor as deemed appropriate.

E. **CONFIDENTIAL STATUS:**

1. A patient may, at any time, request to be Confidential Status, which is entered by Patient Registration staff.
2. When a patient requests Confidential Status, No visitors are allowed, except as stated in 5. This includes, immediate and other family, friends and visitors that present.
3. When a patient status is updated during their stay, after they have been registered,

Nursing staff will inform Registration staff to update their status in Meditech and the Patient Status Board and will notify the Main Lobby Concierge and Security of the change in status.

4. When visitors ask for the location of a patient flagged as confidential, they will be informed that a patient by that name is not in the hospital. PBX operators will not transfer calls to the patient's room and will inform the caller that there is no patient by that name. Mail and floral deliveries will not be accepted for confidential patients.
5. Exceptions to visitors for Confidential Status patients must be approved by the Administrative Supervisor, after determining, with input from the unit charge nurse/ designee and the Patient Safety Officer/Patient Experience team, that the exception is in the best interest of the patient. Safety of the organization, patients and staff will take precedence over visitors.

F. **DESIGNATING A SUPPORT PERSON:**

1. A patient has the right to designate a support person to provide emotional support during their stay. A patient's "support person" does not have to be the same person as the patient's representative who is legally responsible for making medical/care decisions on the patient's behalf.
2. The organization shall accept a patient's support person designation, orally or in writing. The name of the support person should be recorded in the electronic health record and may, at the patient's request, be changed at any time.
3. In a shared room of same-gender (or gender stated) patient where the support person is the opposite gender, the patient will be asked if they oppose the support person staying the night. If the patient is opposed, the support person will be offered to stay in the waiting area.
4. When a patient is unable to make their own medical decisions processes will be followed as defined by California laws. The Patient Safety Officer may be contacted as necessary.

G. **INFORMING THE PATIENT OF THEIR RIGHT TO VISITATION**

1. The organization shall inform patients of their visitation rights. This information shall generally be provided during the admission process.
2. The written notice shall address any clinically necessary or reasonable limitations or restrictions imposed by hospital policy on visitation rights, providing the clinical reasons for such limitations/restrictions, including how they are aimed at protecting the health and safety of all patients.
3. The information shall be sufficiently detailed to allow a patient) to determine what the visitation hours are and what restrictions, if any, apply to that patient's visitation rights.
4. The notice must also inform the patient of the patient's right to:
    a. Receive the visitors they have designated, including but not limited to, a spouse, a domestic partner, another family member, or a friend; and
    b. Withdraw or deny his/her consent to receive specific visitors, either verbally or in writing.

5. The medical record must contain documentation that the written notice was provided to the patient.

H. **RESOLVING DISPUTES REGARDING VISITATION**

If there is a question or disagreement surrounding who may visit the patient, it shall be resolved as quickly as possible.

1. The patient shall decide who may visit as long as they have been deemed capable of decision making.
2. If the patient is unable, the patient's designated surrogate decision maker shall decide who may visit. In the event there is no designated surrogate, the support person may be consulted, but the organization will determine visitors based on the best interests of the patient and on a good faith understanding of the patient's likely wishes. The Patient Safety Officer may be consulted if necessary.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as necessary.

VII. REFERENCES

A. The Joint Commission Hospital Accreditation Standards, Patient's Rights Chapter
B. CMS Conditions of Participation 482.13

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Lisa Paulo: Chief Nursing Officer	11/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2023
Policy Owner	Cynthia Vargas: Manager Patient Experience	11/2023

Standards

No standards are associated with this document

FINANCE COMMITTEE

Minutes of the
Finance Committee
will be distributed
at the Board Meeting

Background information supporting the
proposed recommendations from the
Committee is included in the Board Packet

(JOEL HERNANDEZ LAGUNA)

- *Committee Chair Report*
- *Board Questions to Committee Chair/Staff*
- *Motion/Second*
- *Public Comment*
- *Board Discussion/Deliberation*
- *Action by Board/Roll Call Vote*

Board Paper: Review and Approval by Board

Agenda Item:	Consider Recommendation for Board Approval of AMN Healthcare Solution Service Justification and Contract Renewal Award
Executive Sponsor:	Augustine Lopez, CFO Philip Katzenberger, Director of Health Information Management
Date:	**December 7, 2023**

Executive Summary

AMN Healthcare Solutions is the leader in cost-effective workforce management solutions. For Salinas Valley Health, AMN Healthcare Solutions is primarily a credentialed coding service with comprehensive health information management (HIM) service resources available as needed to meet operational demands. Since 2008, Salinas Valley Health (SVH) has used AMN Healthcare Solutions primarily to support the high volume of Emergency department visits to help ensure timely, mid-revenue compliance and achieve consistency to process emergency encounters. AMN commits to utilizing only vetted personnel to service Salinas Valley Health's HIM operations.

AMN Healthcare Solutions has clinical credentialed workforce with services covering coding, clinical documentation integrity (CDI) and revenue integrity (RI) who are skilled to accurately decipher diagnosis/procedures. AMN Healthcare Solutions' competitive edge is their commitment to utilizing only vetted personnel by the client. To ensure quality is upheld, AMN provides an in-depth monthly quality validation report to ensure AMN's services are compliant and unified with SVH's claim submission accuracy requirements and reimbursement guidelines.

In June 2016, AMN acquired Peak Health Solutions, a growing health information management services company, providing remote medical coding and consulting solutions to hospitals and physician medical groups nationwide. In April 2018, AMN acquired MedPartners, expanding national market shares to deliver a full range of mid-revenue cycle solution services to clients and healthcare professionals. The combined acquisitions of Peak Health Solutions and MedPartners positions AMN Healthcare as the leading provider of mid-revenue cycle workforce solutions.

KLAS, an independent service review company, recognized AMN Healthcare Solutions as above average compared to AMN's competition in capability functionality, scalability, integration, customization, administration, and relationship loyalty.

Unique to market, when compared to other vendors, AMN is priced to market. Other vendors rotate staff, require longer onboarding time frames and lack the depth of workforce as AMN has via their acquisitions. SVH has other vendors as alternatives, however AMN's performance is best at meeting our existing and foreseeable needs.

There is risk of operational disruption during the learning curve while adapting to a new workforce methodology and adapting to SVH's deliverables and these are expected during the transition. We estimate a hit to staff productivity (20% reduction) due to a learning curve to our systems and an increase in Salinas Valley Health's mid revenue collection days valued at several millions of dollars of unclaimed/unprocessed cases. There is no proven operational advantage to switching vendors.

AMN Healthcare Solutions workforce flexibility functions well giving us elasticity to patient volume.
We recommend the five (5) year AMN Healthcare Solutions contract renewal as proposed.

Key Contract Terms	AMN Healthcare Solutions, LLC
1. Proposed contract signing date	December 7, 2023
2. Term of agreement	December 7, 2023 – December 1, 2028
3. Renewal terms	Auto one-year renewal
4. Termination provision(s)	14 days' written notice to terminate
5. Payment Terms	Net 45
6. Average Annual cost(s)	$364,457
7. Cost over life of agreement **	$1,822,285
8. Budgeted (yes or no)	Yes
9. Contract	1001.4823C

** Cost over Life of Agreement

Description	Baseline - Paid 12 Months Ending Sept 23	Year1 (12/28/23 - 12/27/24)	Year 2 (12/28/24 - 12/27/25)	Year 3 (12/28/25 - 12/27/26)	Year 4 (12/28/26 - 12/27/27)	Year 5 (12/28/27 - 12/27/28)
Expense Rate		3%	3%	3%	3%	3%
ED Estimated Annual Total (based on 3,328 hours x $74 rate)	238,884	$246,272	$253,660	$261,270	$269,108	$277,181
CDI Estimated Annual Total (based on 1020 hours x $95 rate)	80,000	$96,900	$99,807	$102,801	$105,885	$109,061
Annual Expense Cost	$318,884	$343,172	$353,807	$364,071	$374,993	$386,242
Total Cost of 5 Year Contract:						**$1,822,285**

Recommendation

Consider recommendation for Board approval of AMN Healthcare Solution contract renewal justification and contract award in the estimated amount of $1,822,285, over the five-year term.

Attachments

- Contract Renewal Amendment
- Master Software and Services Agreement

RFP - Score Card
Assessing professional services for Health Information Management.
Three vendors were evaluated to determine best to meet the needs for the HIM Department for Salinas Valley Health
November 21, 2023

Criteria scale 1-5. (1) Does not provide (2) Unable to meet demand (3) Mets (4) Mets needs, provides additional value, is clear and specific (5) provides #4 is best industry or willing to negotiate to be the best.

Question	AMN Healthcare Solutions	ECatalyst	Kiwi Coding	Notes
1. Provide Remote Coding Workforce, CDI, Rev. Integrity, with the ability to review and select staff.	5	4	3	(5) Overall does what is needed, (4) Delivers good candidates
a. Credential staff	3	3	3	
b. Offers Seasoned staff	3	3	3	
c. Commits resource to our site with priority	3	2	2	
d. Meets specific criteria, staff and experience with Meditech, 3M, skilled to specific needs (APRs)	4	2	2	(4) One was able to provide specific needs
2. Pricing- Is competitive to market	3	3	3	
a. Willing to negotiate	4	2	2	(4) discounted to what was asked
b. Limit annual expensive rates 3% or less	3	2	3	
3. Onboarding new workforce within 2 weeks	3	2	2	
4. Offers special project resources, such as developing education	3	1	1	
5. Termination notices flexibility, 14 days notice	3	2	2	(2) offer 30 days or 90 days preferred.
6. Quality transparency - Offers Monthly reports	5	3	3	(5) conducts audits, scores, provides action plan.
Score Total:	42	29	29	

AMENDMENT TO MASTER SERVICES AGREEMENT BY AND BETWEEN
AMN WORKFORCE SOLUTIONS, LLC AND SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

AMN Workforce Solutions, LLC f/k/a MedPartners HIM, LLC ("Agency") and Salinas Valley Memorial Healthcare System, a local health care district organized and operating pursuant to Division 23 of the California Health and Safety Code, operating as Salinas Valley Health ("Client") entered into a Master Services Agreement on or about 7th day of July, 2017, as amended from time to time, (collectively, the "Agreement"). The parties hereby enter into this amendment to that Agreement ("Amendment") for the purpose of amending and modifying the terms of the Agreement. Effective as of the date of last signature below ("Amendment Effective Date") the terms and conditions of the Agreement, as amended and modified below, shall apply. Except as modified herein, the Agreement shall remain in full force and effect in accordance with its terms and conditions. Unless the context so indicates otherwise, capitalized terms used herein shall have the meanings ascribed to them in the Agreement.

1. MedPartners HIM, LLC changed its legal name to AMN Workforce Solutions, LLC effective July 1, 2019. By executing this Amendment, the parties agree to ratify all actions under the Agreement, and the substitution of AMN Workforce Solutions, LLC as the legally bound party to the Agreement.
2. The parties hereby agree to delete and replace Section 1 of the Agreement in its entirety with the following:

    1. TERM: This Agreement shall continue until December 1st, 2028, and shall automatically renew for one additional year thereafter. The term of the Agreement can be further extended upon written agreement by both parties. This agreement may be terminated by either party upon thirty (30) days prior written notice.

3. The parties hereby agree to delete and replace Exhibit A of the Agreement in its entirety with Exhibit A-1, attached hereto by this reference.
4. The parties hereby agree to incorporate the FCRA User Certification Form, attached hereto as Exhibit A-2, into the Agreement by this reference.
5. The parties hereby agree to incorporate the Business Associate Agreement, attached hereto as Exhibit B, into the Agreement by this reference.

Salinas Valley Memorial Healthcare System	**AMN WORKFORCE SOLUTIONS, LLC**
By:_____	By:_____
Name:_____	Name:_____
Title:_____	Title:_____
Date:_____	Date:_____

EXHIBIT A-1
TERMS of SERVICE LINE
SUPPLEMENTAL STAFFING

AMN Workforce Solutions, LLC ("Agency") will provide supplemental staffing services in accordance with the Master Services Agreement that was entered into by and between Salinas Valley Memorial Healthcare System, a local health care district organized and operating pursuant to Division 23 of the California Health and Safety Code, operating as Salinas Valley Health ("Client") and Agency on or about July 7th, 2017, as modified by these additional terms. This exhibit sets forth the terms for supplemental staffing assignments effective as of August 21st, 2023 **(**the "Supplemental Staffing Effective Date").

1. **STAFFING NEEDS.** Client shall submit a job description detailing the duties and minimum qualifications for each Consultant required by Client from time to time (each a "Job Description"), the duration of the assignment, and the number of hours to be worked per week. Agency will identify and present candidates that meet Client's minimum qualifications as set forth in the Job Description. Client shall have the opportunity to interview each presented candidate. Client shall have three (3) business days to accept or reject the candidate following the interview. Once a candidate has been accepted, Agency will confirm the placement in a confirmation email (a "Placement Confirmation"). Client shall have two (2) days to review the Placement Confirmation and approve or raise any objections. If Client fails to raise any objections within ten (10) business days, the Placement Confirmation shall be deemed accepted by Client. Each Placement Confirmation issued pursuant to this Section 1 shall be incorporated into this Agreement.

   Client shall be responsible for all oversight of Consultants in connection with the services provided by Consultants for Client. Placements shall not exceed one year, except as mutually agreed to by the parties in writing, including the negotiation of additional fees, taxes or other expenses applicable to such placement.

2. **SCHEDULE OF RATES.** The rates below will go into effect for any Consultant beginning an assignment or extension after the Supplemental Staffing Effective Date.

   On the first annual anniversary of this Agreement, and each anniversary thereafter, a rate increase equal to three percent (3%) shall be incorporated automatically.

   Rate Schedule is subject to change a maximum of one (1) time per year based on support of a higher skill level warranting a value increase. Should rates increase in accordance with this section, excluding COLA increases, during the term of the Agreement, Agency will give Client 30 days' written notice prior to the effective date of the increase**.**

POSITION	REGULAR RATE PER HOUR ALL-INCLUSIVE
Appeals and Denials Case Manager - Remote	$93.00
Appeals and Denials Case Manager - Onsite	$123.00

CDI Manager	$140.00
CDI Director	$160.00
CDI Pre-Bill Auditor/2nd level Review - Remote	$95.00
CDI Specialist - Remote	$95.00
CDI Specialist – Onsite	$135.00
HIM Director	$160.00
Medical Coding Auditor – Remote	$95.00
Medical Coding Auditor - Onsite	$135.00
Medical Coder- DRG Validator - Remote	$85.00
Medical Coding Manager - Remote	$100.00
Medical Coding Manager - Onsite	$140.00
Trauma Registrar - Remote	$75.00
Trauma Registrar - Onsite	$125.00
Consulting and Advisory	$125.00

POSITION WITH AUDIT SERVICES	REGULAR RATE PER HOUR ALL-INCLUSIVE
Medical Coder - Inpatient	$82.00
Interventional Radiology/Cardiology Coder	$79.00
Medical Coder – Outpatient SDS/OBS	$77.00
Medical Coder- Outpatient ED	$74.00
Medical Coder- Outpatient Ancillary/Diagnostic	$68.50
Medical Coder - Pro Fee	$65.00

Holiday Rate: Client will pay one and one half times the applicable rate for all time worked by Consultants on a Holiday. For purposes of the Agreement, "Holidays" are: New Year's Eve Day, New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, Christmas Eve Day, and Christmas Day.

For purposes of clarification, all Holidays begin at 12:00 a.m. the day of the Holiday and run through 11:59 p.m. the day of the Holiday.

Overtime Rate: Overtime will be billed at one and one half times the applicable rate for all hours worked in excess of forty hours in a single week, or as required by law.

Training and Orientation: Client agrees to pay Agency for all Client or legally required training and orientation hours worked by Consultants.

Quality Assurance Program: For each Position listed under "POSITION WITH AUDIT SERVICES", Agency shall perform internal quality assurance tasks for each Position staffed and the cost is included in the hourly rate. Quality assurance tasks include but are not limited to onboarding and recurring quality reviews. Additional training and education shall occur with each review conducted.

Quality Assurance activities are only conducted for rate options listed under "POSITION WITH AUDIT SERVICES."

3. **TRAVEL.** Agency will make travel and housing arrangements, as necessary. For travel assignments, the Client shall reimburse Agency for all travel and housing expenses incurred *en* route or during the placement including, but not limited to, airfare (including ticketing and service charges), car rental, mileage based on IRS regulations, hotel accommodations, and a per diem rate for each employee. The parties acknowledge that a reimbursement arrangement exists between the parties with respect to housing and meals. The reimbursement amount is included in the fees paid for services by Client, and for which Agency will provide substantiation of the reimbursement amount. Amounts reimbursed by Client may be subject to tax deduction limitations.

4. **CONVERSION FEE.** The Client agrees not to allow the Consultant to work at the Client part-time, full-time, temporary or as a contracted employee, except through Agency, for one year period following the later of (a) completion of an assignment and (b) the date Consultant is presented to Client. If at any time Client, Client's affiliates and/or any of its subsidiaries or any other organization to which Client supplies information, hires the Consultant received from the Agency, the Client will be charged thirty percent (30%) of the individual's estimated first year base compensation, except in Minnesota or where otherwise prohibited by law. The invoice is due upon receipt. It is understood that Agency is solely responsible for the introduction of a Consultant to Client, unless Client notifies Agency within forty-eight (48) hours of such introduction of Client's prior knowledge of said Consultant's availability. Should Client directly refer Consultant to an affiliated organization for either permanent employment or temporary services, Client will be billed for services rendered pursuant to this section. An affiliate of the Client includes, but is not limited to, an organization or person that has any form of direct or indirect business relationship with Client or any successor to Client's business.

5. **CANCELLATION OF PLACEMENT**. Client may cancel a Placement Confirmation by providing Agency with written notice no less than seven (7) days prior to the start date of the assignment. If Client cancels scheduled Consultant(s) less than seven (7) days from the start date, Client is subject to 7 days of billing at the bill rate set forth in the Placement Confirmation.

   Client may terminate a Placement Confirmation at any time by providing Agency with fourteen (14) days prior written notice. Once notice to terminate a Placement Confirmation is given, the Client is responsible for the payment of two weeks billings at the bill rate and work schedule identified on the Placement Confirmation.

   In the event of a cancellation without cause, including cancellations with proper notice, Client shall be responsible for any housing and travel costs actually incurred by Agency as a result of such cancellation.

If Client is unsatisfied with the performance of any Consultant scheduled under this Service Line Exhibit, Client shall provide Agency with a detailed notice of the specific performance issues. Agency shall have five (5) business days to address the issues with the Consultant and attempt to correct the performance issues. If the performance issues are not corrected to Client's satisfaction, Client shall have the right to request that Agency provide a replacement Consultant. Agency will make reasonable efforts to find a suitable replacement. At Client's option, the original Consultant may continue to provide services while a replacement is identified. Client shall be responsible for the payment of all hours worked up to and including the date of termination.

6. **CLIENT REQUIREMENTS TABLE.** For each Consultant who has been confirmed for an assignment Agency will obtain and maintain documentation of the requirements set forth below. The costs associated with these requirements are included in the bill rates set forth above. Any changes to these requirements will require mutual agreement of the parties. Client shall pay for all costs associated with additional Client requirements and shall provide sufficient time to adopt such new requirements. Agency shall follow its standard certification and credential requirements for its Consultants. For onsite assignments, upon Consultant's arrival at Client facility, Client will verify the identity and credentials of each Consultant by a visual check of the Consultant's photo identification and professional license or certification. Client agrees to interview candidates within 48 hours of file submission.

Type	Requirement	Requirement Description	Applicable Divisions
Federal	I-9	I-9 for employment eligibility, supporting documents, and E-Verify completed in compliance with federal regulation. Documentation to be retained by staffing agency.	Remote Onsite
Federal	OIG, SAM/GSA	OIG and SAM/GSA verifications completed within 30 days prior to first assignment and monthly thereafter. Documentation to be retained by staffing agency.	Remote Onsite
State	Licensed Providers	Current license and primary source verification prior to start of assignment for all licensed Providers.	Remote Onsite
State	Non-Licensed Providers	National certification, if applicable, and primary source verification prior to start of assignment for all non-licensed Providers.	Remote Onsite
State and/or Federal	Other Regulatory Requirements	Human Resources, Employee Health, Education/Training as required by county/state/federal regulations for applicable practice settings.	Remote Onsite
Human Resources	Background Check	Attestation of completion of 7-year search for-SSN Trace, County Resided and Employed search, National Criminal, OFAC, and VSOP (Violent Sexual Offender Predatory) completed prior to first assignment with agency. Updated every 3 years thereafter. If break in service > 90 days must run counties listed during break in service.	Remote Onsite
Human Resources	Background Check - DMV Check	Attestation of completion of 7-year Department of Motor Vehicle Check, prior to start of first assignment with agency, updated every 3 years thereafter, for home health assignments only. Documentation to be retained by staffing agency. If break in service >90 days, must run counties listed during break in service.	Remote Onsite
Human Resources	Education Verification for Non-Licensed Providers	A diploma, degree or transcripts is acceptable.	Remote Onsite
Human Resources	Facility Specific Documents	Collection and/or DocuSign for business-critical facility documents include the following: facility confidentially agreement, IT security facility access, and related policies and procedures.	Remote Onsite
Employee Health	Drug Screening	Attestation of completion of Standard 9 panel drug screen (does not include marijuana) prior to start of first assignment with agency, updated annually thereafter. If break in service > 90 days, retesting required.	Remote Onsite

Employee Health	Hepatitis B	Declination, 2 or 3 vaccine series (depending on manufacturer), or positive antibody titer. If negative titer, booster, or declination after titer.	Onsite Only
Employee Health	COVID-19 Vaccine Status	1 or 2 vaccines depending on manufacture or an approved religious/medical exemption by agency on file prior to start of assignment.	Onsite Only
Employee Health	Influenza	Seasonal vaccine or declination updated annually.	Onsite only
Employee Health	Measles, Mumps, Rubella, Varicella	2 vaccines or positive IGG titer. If negative titer booster or declination after titer. Not applicable to Allied clinicians.	Onsite Only
Employee Health	Statement of Good Health	Statement of good health or completed physical exam prior to first assignment with agency, if break in service > 90 days; then needs to be within the previous year.	Onsite Only
Employee Health	Tdap	Vaccine required every 10 years or declination.	Onsite Only
Employee Health	Tuberculosis Screening	Annual negative TB skin test or QuantiFERON Gold or T-Spot. Must state negative results. If positive, must show proof of positive history, initial Chest x-ray and annual TB Questionnaire thereafter.	Onsite Only
Education	Basic Life Support (BLS)	Current Card from acceptable agency (AHA (American Hospital Association), American Red Cross, US Military, Canadian Heart & Stroke Foundation, ASHI (American Safety & Health Institute)). BLS is required for those Providers in an acute care setting, providing direct patient care.	Onsite Only
Education	Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR)	Current Card from acceptable agency (AHA, Red Cross, US Military, Canadian Heart & Stroke Foundation, ASHI). BLS is required for those Providers in a direct patient care position. CPR or Online cards accepted for LPNs, CNAs, and unlicensed Providers.	Onsite Only
Education	Regulatory Education	Documentation of agency educational training to the requirements of OSHA and other regulatory agencies, completed annually.	Remote Onsite
Education	Specialty Certification	Facility or unit specific.	Remote Onsite

7. **CONSULTANT PERSONAL INFORMATION**. Client agrees to use appropriate security measures to protect Agency and its subsidiaries' employee, client and/or Consultant personal information from unauthorized access, destruction, use, modification, or disclosure in accordance with all federal and state privacy laws.

In the event of a conflict between the terms of the Agreement and this Exhibit as it relates to supplemental staffing assignments, the terms of this Exhibit shall prevail.

AGREED AND ACCEPTED

Salinas Valley Memorial Healthcare System	**AMN Workforce Solutions, LLC**
By:_____	By:_____
Name:_____	Name:_____
Title:_____	Title:_____
Date:_____	Date:_____

Exhibit A-2
Fair Credit Reporting Act User Certification Acknowledgement

Salinas Valley Memorial Healthcare System, a local health care district organized and operating pursuant to Division 23 of the California Health and Safety Code, operating as Salinas Valley Health (the "Client") affirms that it may upon written notice request a copy of a Consumer Report and/or an Investigative Consumer Report ("Report") and by signing below hereby certifies that as a "User" of a Report, the Client will restrict the use of the information in the Report to personnel selection for employment purposes only.

In compliance with The Fair Credit Reporting Act, as amended by the Consumer Reporting Reform Act of 1996 (the "Act"), no information in the Report(s) will be given to any other "person" or "user," as those terms are defined in the Act, unless the "person" or "user" agrees (i) to keep the Report(s) strictly confidential and to use the Report(s) for employment purposes only; and (ii) to adhere to the Notice to Users of Consumer Reports: Obligations of Users under the Fair Credit Reporting Act ("FCRA") 15 U.S.C. Section 1681 which can be found online at: www.consumer.ftc.gov/articles/pdf-0111-fair-credit-reporting-act.pdf

The Client will also have in place procedures to properly retain and dispose of records containing this information in compliance with the Act and other applicable state and federal law. Client further certifies that it will not use any information contained in the Report in violation of any applicable Federal or State privacy or equal employment laws or regulations.

AGREED AND ACCEPTED

Salinas Valley Memorial Healthcare System	**AMN Workforce Solutions, LLC**
By:_____	By:_____
Name:_____	Name:_____
Title:_____	Title:_____
Date:_____	Date:_____

EXHIBIT B

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is made and entered into effective as of signing below ("Effective Date") by and between **Salinas Valley Memorial Healthcare System**, a local health care district organized and operating pursuant to Division 23 of the California Health and Safety Code ("SVMHS"), and AMN Workforce Solutions, LLC **(**"AMNWS").

RECITALS

A. SVMHS is the owner and operator of Salinas Valley Memorial Hospital ("SVMH"), an acute care hospital located at 450 East Romie Lane, Salinas, California 93901, and is a Covered Entity ("CE") as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

B. AMNWS has been engaged to provide certain services on behalf of CE, under one or more Agreements, and in connection with those services, CE wishes to disclose certain information to AMNWS some of which may constitute Protected Health Information (PHI) and AMNWS may meet the definition of a Business Associate

C. CE and AMNWS intend to protect the privacy and provide for the security of PHI disclosed to AMNWS pursuant to their Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, ("HITECH"), regulations promulgated thereunder by the U.S. Department of Health and Human Services ("HIPAA Regulations") and other applicable state or federal laws affecting or regulating the privacy or security of health information.

D. AMNWS has agreed to comply with the requirements of this Agreement, when accessing PHI via remote access utilizing equipment owned by AMNWS. The parties expressly acknowledge that the terms of this Agreement do not apply to instances where AMNWS performs the Services on-site at CE's facilities utilizing equipment owned, operated, or maintained by AMNWS.

E. CE and AMNWS intend to fully comply with the HIPAA Regulation codified at 45 C.F.R. Parts 160 and 164, Subparts A and E ("Privacy Rule") and the HIPAA Regulation codified at 45 C.F.R. Parts 160 and 164, Subparts A and C ("Security Rule").

F. The Privacy Rule and the Security Rule require CE to enter into a contract containing specific requirements with AMNWS prior to the disclosure of PHI.

In consideration of the mutual promises below and the exchange of information pursuant to the AMNWS, the parties agree as follows:

1. **Definitions: All capitalized terms used but not otherwise defined in this Agreement shall have the same meaning as those terms in HIPAA.**

   a. **Breach** shall have the meaning given to such term under the HITECH Act and HIPAA Regulations.

   b. **Breach Notification Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and D.

   c. **Business Associate** shall have the meaning given to such term under the Privacy Rule, the Security Rule, and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17938 and 45 C.F.R. Section 160.103.

   d. **Covered Entity** shall have the meaning given to such term under the Privacy Rule and the Security Rule,

including, but not limited to 45 C.F.R. Section 160.103.

e. **Data Aggregation** shall have the meaning given to such term under the Privacy Rule, including, but not limited to 45 C.F.R. Section 164.501.

f. **Designated Record Set** shall have the meaning given to such term under the Privacy Rule, including, but not limited to 45 C.F.R. Section 164.501.

g. **Electronic Protected Health Information** means Protected Health Information that is maintained in or transmitted by electronic media.

h. **Electronic Health Record** shall have the meaning given to such term under the HITECH Act, including, but not limited to 42 U.S.C. Section 17921.

i. **Health Care Operations** shall have the meaning given to such term under the Privacy Rule, including, but not limited to 45 C.F.R. Section 164.501.

j. **Individually Identifiable Health Information** is a subset of health information, including demographic information collected from an individual and is created or received by a health care provider, health plan, employer or health care clearinghouse and (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is reasonable bases to believe the information can be used to identify the individual. 45 C.F.R. 160.103

k. **Protected Health Information or PHI** means any Individually Identifiable Health Information transmitted by electronic media, maintained in electronic media, transmitted, or maintained in any other form of medium (whether oral or recorded). 45 C.F.R. 160.103.

l. **Protected Information** shall mean PHI provided by CE to AMNWS or created, maintained, received, or transmitted by AMNWS on CE's behalf.

m. **Security Incident** shall have the meaning given to such term under the Security Rule, including, but not limited to 45 C.F.R. Section 164.304.

n. **Unsecured PHI** shall have the meaning given to such term under the HITECH Act and any guidance issued pursuant to such Act including, but not limited to 42 U.S.C. Section 17932(h) and 45 C.F.R. Section 164.402.

2. **Obligations of Business Associate**

a. **Permitted Uses and Disclosures**. AMNWS shall use and disclose Protected Information only for the purpose of performing AMNWS 's obligations under the Agreement and as permitted or required under the AMNWS Agreement, or as required by law. AMNWS shall not use Protected Information in any manner that would constitute a violation of the Privacy Rule or HITECH. However, AMNWS may use Protected Information as necessary (i) for the proper management and administration of AMNWS; (ii) to carry out the legal responsibilities of BA or (iii) as required by law; relating to the Health Care Operation of CE.

If AMNWS discloses Protected Information to a third party, AMNWS must obtain prior to making any such disclosure, reasonable written assurances from such third party that such Protected Information will be held confidential as provided pursuant to this Agreement and used or disclosed only as required by law or for the purposes for which it was disclosed to such third party. Third party will agree to immediately notify AMNWS of any breaches, suspected breaches, security incidents, or unauthorized uses or disclosures of the Protected Information in accordance with paragraph 2.j. of this Agreement, to the extent it has obtained knowledge of such occurrences.

b. **Prohibited Uses and Disclosures**. AMNWS shall not use or disclose PHI other than as permitted or required by the Agreement, or as required by law. AMNWS shall not use or disclose Protected Information for fundraising

or marketing purposes. AMNWS shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of CE and as permitted by HITECH, and the HIPAA Regulations; however, this prohibition shall not affect payment by CE to AMNWS for services provided pursuant to the Agreement.

c. **Appropriate Safeguards**. AMNWS shall implement appropriate safeguards to prevent the use or disclosure of Protected Information other than as permitted by the Agreement, including, but not limited to, administrative, physical and technical safeguards in accordance with the Security Rule, including, but not limited to, 45 C.F.R. Sections 164.308, 164.310, and 164.312. AMNWS shall comply with the policies and procedures and documentation requirements of the Security Rule, including, but not limited to, 45 C.F.R. Section 164.316.

d. **Business Associate's Subcontractors and Agents**. AMNWS shall ensure that any agent and subcontractors that create, receive, maintain or transmit Protected Information on behalf of AMNWS, shall agree in writing to the same restrictions and conditions that apply to AMNWS with respect to such Protected Information and implement the safeguards required by paragraph 2.c. above with respect to Electronic PHI. AMNWS shall implement and maintain sanctions against agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation.

e. **Access to Protected Information.** AMNWS shall make Protected Information maintained by AMNWS or its agents or subcontractors in Designated Record Set available to CE for inspection and copying within ten business (10) days of a request by CE to enable CE to fulfill its obligations under state law [Health and Safety Code section 123110] and the Privacy Rule. If AMNWS maintains Protected Information in electronic format, BA shall provide such information in electronic format as necessary to enable CE to fulfill its obligations under HITECH Act and HIPAA Regulations.

If an individual requests an amendment of Protected Information directly from AMNWS or its agents or subcontractors, AMNWS must notify CE in writing within ten business (10) days of the request and of any approval or denial or amendment of Protected Information maintained by AMNWS or its agents or subcontractors.

f. **Accounting of Disclosures**. Within ten business (10) days of a request by CE for an accounting of disclosures of Protected Information, AMNWS and its agents and subcontractors shall make available to CE the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, and HITECH, as determined by CE. AMNWS agrees to implement a process that allows an accounting to be collected and maintained by AMNWS and its agents and subcontractors for at least six (6) years prior to the request. However, accounting of disclosures from an Electronic Health Records for treatment, payment or health care operations are required to be collected and maintained for only three (3) years prior to the request and only to the extent that AMNWS maintains an Electronic Health Record. At minimum, the information collected and maintained shall include: (i) the date of disclosure; (ii)the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. If a patient submits a request for an accounting directly to AMNWS or its agents or subcontractors, AMNWS shall within ten business (10) days of the request forward it to CE in writing.

g. **Governmental Access to Records.** AMNWS shall make its internal practices, books, and records relating to the use and disclosure of Protected Information available to CE and to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") for purposes of determining AMNWs 's compliance with HIPAA [45 C.F.R. Section 164.504(e)(2)(ii)(I)].

h. **Minimum Necessary.** AMNWS, its agents and subcontractors shall request, use and disclose only the minimum amount of Protected Information necessary to accomplish the purpose of the request, use or disclosure. AMNWS understands and agrees that the definition of "Minimum Necessary" is in flux and shall keep itself informed of guidance issued by the Secretary with respect to what constitutes "minimum necessary".

i. **Data Ownership.** AMNWS acknowledges that AMNWS has no ownership rights with respect to the Protected Information.

j. **Notification of Possible Breach.** AMNWS shall notify CE within ten business days (10) of any actual breach of CE's Protected Information; any use or disclosure of Protected Information not permitted by the Agreement ; any security incident (i.e., any successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system) related to CE's Protected Information, and any use or disclosure of data in violation of any applicable federal or state laws by AMNWS or its agents or subcontractors 45 C.F.R Section 164.410. The notification shall include, to the extent possible, the identification of each individual whose unsecured Protected Information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, used, or disclosed, as well as any other available information that CE is required to include in notification to the individual, the media, the Secretary, and any other entity under the Breach Notification Rule and any other applicable state or federal laws, including but not limited to 45 C.F.R. Section 164.404 through 45 C.F.R. Section 164.408, at the time of the notification required by this paragraph or promptly thereafter as information becomes available. AMNWS shall take (i) prompt corrective action to cure any deficiencies and (ii) any action pertaining to unauthorized uses or disclosures required by applicable federal and state laws.

k. **Breach Pattern or Practice by Business Associate's Subcontractor and Agents**. Pursuant to 42 U.S.C. Section 17934(b) and 45 C.F.R. Section 164.504 (e)(1)(ii); if the AMNWS knows of a pattern of activity or practice of a subcontractor or agent that constitutes a material breach or violation of the subcontractor or agent's obligations under the Agreement or other arrangement, the AMNWS must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the AMNWS must terminate the contract with the subcontractor or agent or other arrangement if feasible.

l. **Audits, Inspection and Enforcement**. AMNWS shall notify CE within ten business (10) days of learning that AMNWS has become the subject of an audit, compliance review, or complaint investigation by the Office for Civil Rights or other state or federal government entity.

3. **Obligations of Covered Entity.**

a. **Notifications.** CE shall notify AMNWS of limitation(s) in its Notice of Privacy Practices, to the extent such limitation will affect AMNWS' permitted uses and disclosures under the Agreement and notify AMNWS of changes in, or revocation of permission by an Individual to use or disclose PHI if such restriction affects AMNWS' permitted uses and disclosures under the Agreement.

b. **Minimum Necessary.** CE shall not request of nor provide AMNWS with more PHI than what is minimally necessary for AMNWS to perform its obligations under the Agreement. CE will not request AMNWS to use or disclose PHI in any manner that would not be permissible under HIPAA if done by CE.

4. **Termination.**

a. **Material Breach.** A breach by AMNWS of any provision of this Agreement, as determined by CE, shall constitute a material breach of the Agreement and shall provide grounds for termination of the Agreement, any provision in the Agreement to the contrary notwithstanding.

b. **Judicial or Administrative Proceedings.** CE may terminate the Agreement, effective immediately if, (i) AMNWS is named as a defendant in a criminal proceeding for a violation of HIPAA, HITECH, or other security or privacy laws or (ii) a finding or stipulation that the AMNWS has violated any standard or requirement of HIPAA, HITECH, or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

c. **Effect of Termination.** Upon termination of the Agreement for any reason, BA shall, at the option of CE, return or destroy all Protected Information that AMNWS and its agents and subcontractors still maintain in any form,

and shall retain no copies of such Protected Information. If return or destruction is not feasible, as determined by CE, BA shall continue to extend the protections and satisfy the obligations of paragraph 2 of this Agreement to such information, and limit further use and disclosure of such PHI to those purposes that make the return or destruction of the information infeasible. If CE elects destruction of the PHI, AMNWS shall certify in writing to CE that such PHI has been destroyed in accordance with the Secretary's guidance regarding proper destruction of PHI.

5. **Amendment to Comply with Law.** The parties agree and acknowledge that state and federal laws relating to data security and privacy are evolving and that amendment of the Agreement may be required to ensure compliance with such developments. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this BAA embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable laws.

6. **Interpretation.** The provisions of this BAA shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this BAA. The parties agree that any ambiguity in this BAA shall be resolved in favor of a meaning that complies and is consistent with HIPAA, HITECH, the HIPAA regulations, and other state and federal laws related to security and privacy.

The parties hereto have duly executed this Business Associate Agreement as of the Effective Date below.

Salinas Valley Memorial Healthcare System	**AMN Workforce Solutions, LLC**
By:_____	**By:** _____
Print Name: _____	**Print Name:** _____
Title: _____	**Title:** _____
Date: _____	**Date:** _____

CONTACTS	
PLEASE PROVIDE CONTACT INFORMATION AS REQUIRED FOR OCR AUDIT REPORTING	
COMPANY NAME	***AMN WORKFORCE SOLUTIONS, LLC***
PRIMARY CONTACT	***SHANE PLANTZ, ACCOUNT MANAGER***
PHONE	***858-465-2182***
CELL	***813-919-7935***
FAX	
ADDRESS	***2999 OLYMPUS BLVD., SUITE 500, DALLAS, TX 75019***
EMAIL	***SHANE.PLANTZ@AMNHEALTHCARE.COM***
SECONDARY CONTACT	***NATE NUDEN, DVP***
PHONE	***813-373-7034***
CELL	
FAX	
ADDRESS	***SAME AS ABOVE***
EMAIL	***NATE.RUDEN@AMNHEALTHCARE.COM***

MedPartners

MASTER SERVICES AGREEMENT

THIS STAFFING SERVICES AGREEMENT ("Agreement") is entered into, on the 7th Day of July, 2017 by and between MedPartners HIM, LLC (MPH), a Florida Corporation, and **Salinas Valley Memorial Health System** (the "Client") at 450 E Romie Lane Salinas, CA 93901.

WHEREAS, MPH is engaged in the consulting and temporary staffing services business providing temporary personnel to customers with staffing needs; and

WHEREAS, the Client desires to engage MPH to provide temporary staffing services and MPH desires to be engaged by the Client, all on the terms and conditions of this Agreement; and

WHEREAS, as used herein, the term "Contract Employee" means a MPH employee temporarily placed with the Client pursuant to this Agreement;

THEREFORE, in consideration of the premises and mutual promises contained herein, the parties agree as follows:

1. **TERM:** This Agreement shall commence on the date this Agreement is executed by all parties, and continue for an initial term of 1 year, and shall continue thereafter on a year-to -year basis unless earlier termination as provided herein. This Agreement may be terminated by either party upon thirty (30) days prior written notice.

2. **CONTRACT EMPLOYEES:** MPH shall provide to the Client one or more Contract Employees as requested by the Client from time to time. Such Contract Employees shall provide services under the Client's management and supervision at a facility or in an environment controlled by the Client. Attached hereto as *Exhibit A* is the rate for Contract Employee.

   MPH is an equal opportunity employer and refers Contract Employees, regardless of race, sex, color, religion, creed, ancestry, national origin, disability, age, marital status, sexual orientation or other protected class status pursuant to applicable law. The Client agrees and warrants that it will not reject Contract Employees, or otherwise deem Contract Employees unacceptable, or take any other action for any reason prohibited by federal, state or local laws including, but not limited to, laws pertaining to employment discrimination or employee safety. The Client will indemnify and defend MPH with respect to any and all claims that the Client took action in violation of federal, state and/or local laws, including costs of suit, settlement and attorneys' fees.

   2.1 Once Contract Employee(s) has been scheduled, Client may cancel the Contract Employee(s) at no charge up until 6 days prior to Contract Employee(s) start date. If Client Cancels scheduled Contract Employee(s) 5 days or less from start date, Client is subject to 14 days of billing at the agreed rate, set forth in Exhibit A

3. **INDEPENDENT CONTRACTOR STATUS:** With respect to the services provided by MPH, MPH shall be an independent contractor. MPH shall be responsible for providing any salary or other benefits to such Contract Employees; will make all appropriate tax, social security, Medicare and other withholding deductions and payments; will provide worker's compensation insurance coverage for its Contract Employees; and will make all appropriate unemployment tax payments.

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4. **INVOICES:** MPH shall submit weekly invoices to the Client for services rendered by Contract Employee(s) for the number of hours worked by Contract Employee(s) the previous week. Overtime will be billed at the rates listed on *Exhibit A*, or as otherwise agreed by both parties, for hours worked by Contract Employee(s) in excess of forty (40) hours per week, or as otherwise required by law. For weeks that have one (1) National or client observed holiday, overtime rates shall be billed for hours worked in excess of thirty-two (32) hours per week. Invoices submitted by MPH to the Client are presumed to be accurate and fully payable on the terms contained therein unless disputed by the Client within five (5) business days of the Client's receipt of the invoice

5. **PAYMENT; DEFAULT:** Payment in full for invoices shall be due within thirty (30) days from invoice date, at MPH Staffing Corporation d/b/a MedPartners HIM, P.O. Box 4729, Winter Park, FL 32793-4729. Late charges shall be calculated using the U.S. Method, therefore interest will not be compounded on the past due balance. If the Client's account is past due and MPH has notified the Client verbally or in writing of the past due balance, MPH may, without advance notice, immediately cease providing any and all further Contract Employee services without any liability to MPH for interruption of pending work.

6. **TRAVEL EXPENSES:** MedPartners HIM, LLC will make travel and housing arrangements, as necessary. The Client shall pay no additional costs in regards to travel. See Exhibit A.

   The Client agrees to a 2 week cancellation policy. Cancellation must be provided in writing.

7. **COLLECTION:** If the Client's account, after default, is referred to an attorney or collection agency for collection, the Client shall pay all of MPH's expenses incurred in such collection efforts including, but not limited to, court costs and reasonable attorneys' fees.

8. **RESTRICTIVE-COVENANT CONVERSION/RIGHT TO HIRE.** In the event the Client employs or otherwise retains the services of a MPH employee during the term of this Agreement, or within six months after providing services, the Client shall pay to MPH a sum equal to 1% per $1,000 (not exceeding 30%) of the employee's annual salary paid by Client to recognize MPH substantial investment in advertising, screening, testing and/or training its employees.

9. **CONTRACT EMPLOYEE PERFORMANCE:** Within **5 Business Days** from any Contract Employee(s) starting date, the Client shall review the Contract Employee(s) performance and decide whether to continue the engagement of such Contract Employee. If the Client is dissatisfied with the performance of the Contract Employee, and the Client wishes MPH to terminate its engagement of such Contract Employee, the Client must notify MPH within the initial **5 business days** period, specifying the reasons for its dissatisfaction, and the Client shall be released from the contract and MPH will make reasonable efforts to find a suitable replacement, provided its reasons for termination are not unlawful and are bona fide in MPH's reasonable judgment. If the Client becomes dissatisfied with the performance of a Contract Employee after the initial **5 Business Day** period, the Client may request that MPH terminate the engagement of that Contract Employee upon written notice to MPH, but the Client shall pay for all hours worked by the terminated Contract Employee from the first hour of work up to and including the date of termination.

9.1 A two week written notice is required to cancel a candidate when an "End Date" has not been identified at the beginning of each Contract Employee assignment. If a Contract Employee is ended early for reasons due to "lack of work/backlog" or other reason not caused by MPH, client is responsible for two weeks of billing or the remainder of hours not work within a two week notice.

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10. **LIMITATION OF LIABILITY:** MPH does not warrant or guarantee that the Contract Employee(s) placed pursuant to this Agreement will produce any particular result or any solution to the Client's particular needs. Because MPH is providing supplemental staffing services only, and the Client is directing and supervising the Contract Employees who render these services, MPH shall not be liable (i) for any claims, costs, expenses, damages, obligations or losses arising from or in connection with the acts or omission of any Contract Employee, including, but not limited to, work on engineering or design concepts or calculations or related drawings, software programs, designs or documentation, or (ii) for any indirect, special or consequential damages (including, but not limited to, loss of profits, interest, earnings or use) whether arising in contract, tort or otherwise. Neither party shall be liable for any indirect, special or consequential damages whether arising in contract, tort or otherwise. Each party (the "Indemnifying Party") shall indemnify the other party, defend it and hold it harmless against and from any claims for Losses made or brought by third parties to the extent such Losses are caused by the negligent acts or omissions or willful misconduct of the Indemnifying Party.

11. **CLIENT PROPERTY:**

11.1 ***Work Product***: All work product of every kind performed by any Contract Employee on behalf of the Client shall be the sole and exclusive property of the Client.

11.2 ***Confidentiality***: MPH recognizes that while performing its duties under this Agreement, MPH and its Contract Employees may be granted access to certain proprietary and confidential information regarding the Client's business, customers, and employees. MPH agrees to keep such information confidential and the obligations of this paragraph will survive the termination of this Agreement. This paragraph does not apply to information that was previously known or information that is available in the public domain.

12. **TIME RECORDS:** A MPH time-card shall be the official time record for purposes of payment under *Sections 4 and 5* herein. *(Client initial one).*

13. **PURCHASE ORDERS:** Payment of MPH invoices shall not be dependent upon the Client's generated purchase order. If a purchase order is required pursuant to this Section, the Client shall deliver to MPH a written purchase order before the first Contract on *Exhibit A*. As stated in Section 15.7 herein, this Agreement and *Exhibit A* constitute the entire agreement between the parties. If there is any inconsistency or conflicting terms between this Agreement and the Client's purchase order, this Agreement shall prevail. All purchase orders must be signed on behalf of the parties to this Agreement by their authorized representatives executing this Agreement.

13.1 Bill Rates are subject to change with a 30 day written notice to the client.

14. **NOTICES:**

14.1 ***Manner***: Any notice or other communication ("Notice") required or permitted under this Agreement shall be in writing and either delivered personally or sent by facsimile, overnight delivery, express mail, or certified or registered mail, postage prepaid, return receipt requested.

14.2 ***Addressee***: A Notice shall be addressed, in the case of MedPartners HIM, LLC, to Bob Bradley, President, 302 Knights Run Avenue, Suite # 1025, Tampa, FL 33602; or, in the case of the Client, to_____, 450 E Romie Lane Salinas, CA 93901.

14.3 ***Delivery***: A Notice delivered personally shall be deemed given only if acknowledged in writing by the person to whom it is given. A Notice sent by facsimile shall be deemed given when transmitted; provided that the sender obtains written confirmation that the transmission was sent. A Notice sent by overnight delivery or express mail shall be deemed given twenty-four (24) hours after having been sent. A Notice that is sent by certified mail or registered mail shall be deemed given forty-eight (48) hours after it is mailed. If any time period in this Agreement commences upon the delivery of Notice to any one or more parties, the time period shall commence only when all of the required Notices have been deemed given.

14.4 ***Changes***: Either party may designate, by Notice to the other, substitute addressees, addresses or facsimile numbers for Notices, and thereafter, Notices are to be directed to those substitute addresses, or facsimile numbers.

15. **MISCELLANEOUS:**

15.1 ***Governing Law***: The laws of the State of Florida shall govern the validity and construction of this Agreement and any dispute arising out of or relating to this Agreement, without regard to the principles of conflict of laws.

15.2 ***Severability***: A ruling by any court that one or more of the provisions contained in this Agreement is invalid, illegal or unenforceable in any respect shall not affect any other provision of this Agreement so long as the economic or legal substance of the transactions contemplated hereby is not affected in any manner materially adverse to any party. Thereafter, this Agreement shall be construed as if the invalid, illegal, or unenforceable provision had been amended so as to make this Agreement valid and enforceable as originally contemplated by this Agreement to the greatest extent possible.

15.3 ***Counterparts***: This Agreement may be executed simultaneously in two or more counterparts, each of which shall be deemed an original. In that event, in providing this Agreement it shall not be necessary to produce or account for the counterpart signed by the party against whom the proof is being presented.

15.4 ***Headings***: The section and subsection headings have been included for convenience only, are not part of this Agreement and shall not be taken as an interpretation of any provision of this Agreement.

15.5 ***Binding Effect***: This Agreement shall be binding upon and shall inure to the benefit of the parties and their respective heirs, legatees, personal representatives and other legal representatives, successors and permitted assigns. MPH and the Client specifically acknowledge and agree that this Agreement governs and applies to the relationship between MPH and the Client, and not to any other relationship between the Client and any other division, company, business unit, subsidiary or affiliate of MPH. Except as otherwise specifically provided, this Agreement is not intended and shall not be construed to confer upon or to give any person, other than the parties hereto, any rights or remedies.

15.6 ***Amendments and Modifications***: This Agreement, including all applicable Exhibits (*Exhibit A*, *Exhibit B* and/or *Exhibit C*) hereto, may be amended, waived, changed, modified or discharged only by an agreement in writing signed on behalf of all of the parties by the authorized representatives executing this Agreement.

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15.7 ***Entire Agreement***: This Agreement, including all applicable Exhibits (*Exhibit A*, *Exhibit B* and/or *Exhibit C*) hereto constitute the entire agreement between the parties, and there are no representations, warranties, covenants or obligations except as set forth in this Agreement. This Agreement supersedes all prior and contemporaneous agreements, understandings, negotiations and discussions, written or oral, of the parties, relating to any transaction contemplated by this Agreement.

15.8 ***Waiver***: Failure to insist upon strict compliance with any of the terms, covenants or conditions of this Agreement shall not be deemed a waiver of that term, covenant or condition or of any other term, covenant or condition of this Agreement. Any waiver or relinquishment of any right or power hereunder at any one or more times shall not be deemed a waiver or relinquishment of that right or power at any other time.

15.9 ***Remedies Cumulative***: The remedies set forth in this Agreement are cumulative and are in addition to any other remedies allowed at law or in equity. Resort to one form of remedy shall not constitute a waiver of alternate remedies.

15.10 ***Legal Disputes***: All disputes, controversies or differences arising in connection with the validity, execution, performance, breach, non-renewal or termination of this Agreement shall be settled in a court of law of appropriate jurisdiction in Hillsborough County. The prevailing party shall be entitled to damages, attorney fees, filing fees, and any other expenses allowed by law.

15.11 ***Assignment:*** No party shall transfer or assign any or all of its rights or interests under this Agreement or delegate any of its obligations without the prior written consent of the other party.

15.12 ***System Availability/Downtime:*** The Client will make all electronic systems and medical records available for personnel. As the client is responsible for these systems, the Client agrees to be billed for down time in the event work flow is prohibited by no fault of contract employee.

15.13 ***Training Time:*** Any mandatory training required by the client is deemed billable at the agreed hourly bill rates reflected in Exhibit A

IN WITNESS WHEREOF, the parties have executed this Agreement, under seal, the day and year first above written.

Salinas Valley Memorial Health System

Robert J. Have 7/21/17
Signature Date

Robert J. Have
Name

Mgr. CDI & Coding Compliance
Title

MedPartners HIM, LLC

Doug Montgomery 7/24/17
Signature Date

~~George Klimis~~ Doug Montgomery
Name

~~Senior~~ Vice President
Title

MedPartners

Exhibit A -Master Services Agreement

Start Date: 7/7/2017

End Date: 12/31/2018 (Assignments need to be ended by the client with a two week notice)

Client: **Salinas Valley Memorial Health System**

Rates are for onsite/remote services. No change of rate for Overtime. No additional fees or expenses for travel. The hourly rate below is an all-inclusive rate.

SPECIALTY	BILL RATE	OT RATE
CDI Specialist All Inclusive	$150.00	$150.00
CDI Lead All Inclusive	$160.00	$240.00
Inpatient ICD-10 Coding	$65.00	$97.50
Outpatient ICD-10 Coding	$62.00	$93.00
Interim Coding Manager	$90.00	$135.00
Interim HIM Director	$105.00	$157.50
RN Acute Care Case Manager (ED, UR, Floor, and DCP All Inclusive)	$130.00	$130.00
Appeals and Denials Case Manager (All Inclusive)	$135.00	$135.00
Interim Case Management Leadership (Director Level All Inclusive)	$174.00	$174.00
Interim CM/SW Manager/Supervisor (All Inclusive)	$143.00	$143.00
Social Worker (All Inclusive)	$120.00	$120.00
Cancer Registry Full Scope Services	$65.00	$97.50
Cancer Registry Coordinator/Manager	$70.00	$105.00
CoC Trained Consultant / CoC Consultation	$85.00	$127.50
Bone Marrow Transplant Specialist	$90.00	$135.00
Trauma Registrar	$75.00	$112.50
Trauma Program Manager	$110.00	$165.00
Trauma PI Coordinator	$85.00	$127.50
Trauma Program Director	$135.00	$202.50

Expenses:

There will be no incurred expenses.

Salinas Valley Memorial Health System

Robert J. Kane 7/21/17

Signature Date

Robert J. Kane

Name

Manager, CDI & Coding Compliance

MedPartners HIM, LLC

Doug Montgomery 7/24/17

Signature Date

~~George Kilmis~~ Doug Montgomery

Name

~~Senior~~ Vice President

Finance Committee Board Paper

Agenda Item: **Consider Recommendation for Board Approval of Lease Agreement Terms for 225 East Romie Lane, Salinas, CA Between SVMHS and Hilltop Family Medical Group, Inc.**

Executive Sponsor: Allen Radner, MD, Interim Chief Executive Officer
Gary Ray, Chief Legal & Administrative Officer

Date: December 7, 2023

Executive Summary

Sonia Rodriguez, MD has been operating a women's health clinic in Salinas for many years, providing comprehensive medical care for women in our community. Dr. Rodriguez is retiring and closing her practice effective December 28, 2023. SVMHS is assisting with the winding down of her clinic—assisting with patient transition, taking custody of and managing patient records, acquiring certain assets, and leasing the clinic location for other SVH Clinics programs. SVH Clinics would like to enter into a three (3) year lease, with an additional two (2) year option for the clinic location at 225 East Romie Lane, Salinas.

Timeline

December 11, 2023 – Request SVH Finance Committee Recommendation for Board Approval
December 14, 2023 – SVH Board of Directors Meeting/Consider Recommendation for Approval
January 1, 2024 – Commencement date of Lease Agreement

Meeting our Mission, Vision, Goals
Strategic Plan Alignment

This transaction is aligned with the strategic initiatives outlined in our most recent strategic planning work for growth, in developing healthcare clinics and programs that drive value for our patients.

Pillar/Goal Alignment: ☑ Service ☐ People ☐ Quality ☑ Finance ☑ Growth ☐ Community

Financial/Quality/Safety/Regulatory Implications

Lease Agreement Terms for 225 East Romie Lane, Salinas, CA:

1. Lease Commencement Date	January 1, 2024
2. Term of Lease	Three (3) years
3. Option to Extend	One option to extend for 2 years
4. Payment Terms	Rent due the 1st of each month
5. Initial Rent (per sq. ft.)	$2.00 per square foot (Negotiation range $1.80 to $2.20
6. Rentable square feet	Approximately 1,660 square feet
7. Initial Rent	Approximately $3,320/month $39,840/first year
8. Annual Increases	Negotiation range 2.5 to 3.0% per year
9. Budgeted (Y/N)	No. Not budgeted—new location for SVHC Clinic

Recommendation

Administration requests that the Board Finance Committee make a recommendation to the Board of Directors for approval (pending final review by District legal counsel of the Lease Agreement) of the following lease terms:

- Lease Agreement Terms with Hilltop Family Medical Group, Inc. for 225 East Romie Lane, Salinas, CA, as presented above.

PERSONNEL, PENSION AND INVESTMENT COMMITTEE

Minutes of the Personnel, Pension and Investment Committee will be distributed at the Board Meeting

(JUAN CABRERA)

CORPORATE COMPLIANCE
AND AUDIT COMMITTEE

Minutes of the
Corporate Compliance and Audit Committee
will be distributed at the Board Meeting

Background information supporting the
proposed recommendations from the
Committee is included in the Board Packet

(JUAN CABRERA)

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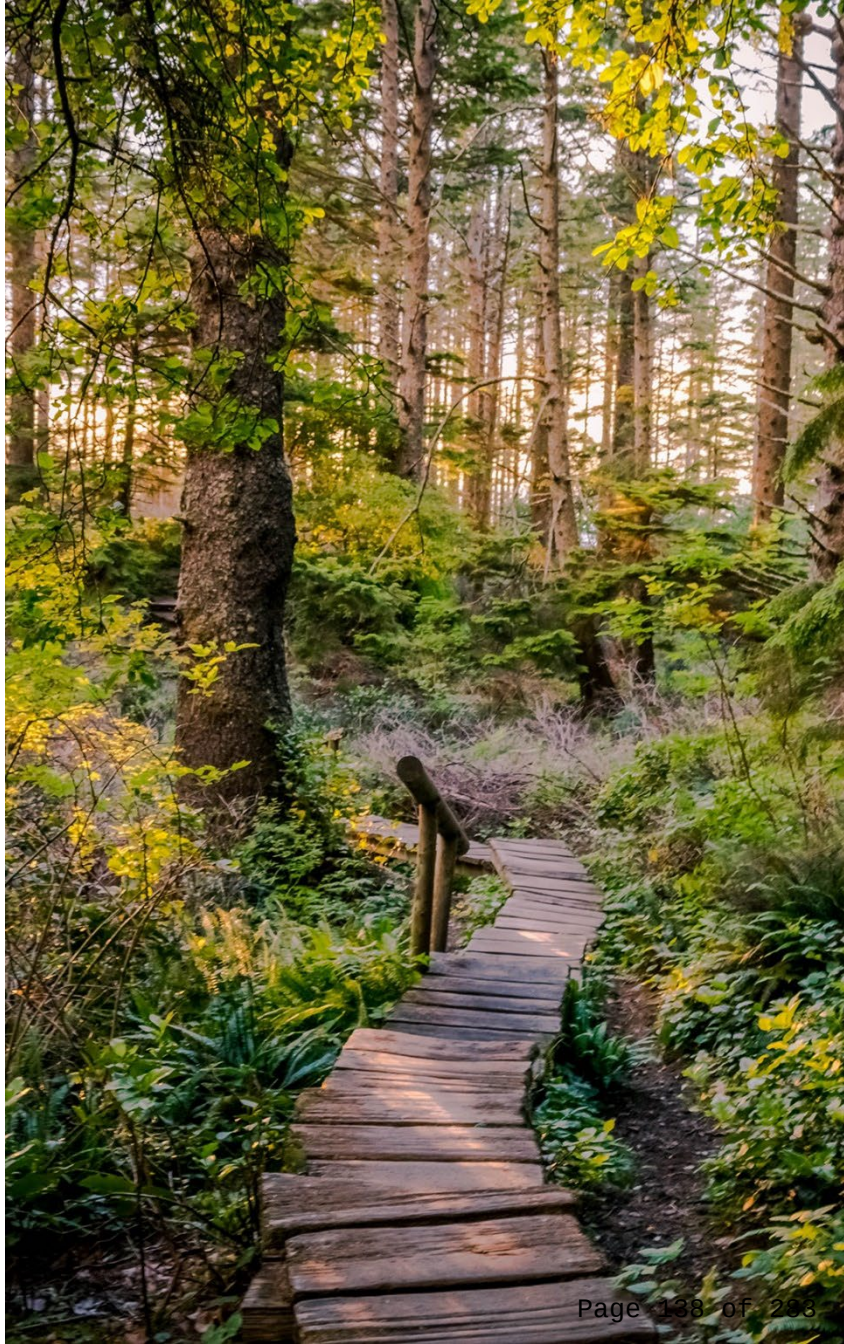
Salinas Valley Health

2023 AUDIT RESULTS

Agenda

1. Scope of Services
2. Auditor Opinion and Report
3. Significant Risks
4. Matters to be Communicated to the Governing Body
5. Consolidated Statements of Net Position
6. Consolidated Operations
7. Other Information



Scope of Services

We have performed the following services for Salinas Valley Memorial Healthcare System ("Salinas Valley Health"):

Annual Audits

- Annual consolidated financial statement audit as of and for the year ended June 30, 2023
- Annual single audit as of and for the year ended June 30, 2023

Nonattest Services

- Assisted in drafting the consolidated financial statements and related footnotes as of and for the year ended June 30, 2023
- Assisted management with drafting the auditee portion of the OMB data collection form
- Assisted management with implementation of GASB 96, Subscription-Based Information Technology Arrangements, required to be implemented for the year ended June 30, 2023

Auditor Report on the Consolidated Financial Statements

- Unmodified Opinion – The consolidated financial statements are presented fairly and in accordance with U.S. generally accepted accounting principles (“U.S. GAAP”).

- Emphasis of matter – Adoption of new accounting standards

Other Auditor Reports

GAGAS Report on Internal Control over Financial Reporting and on Compliance and Other Matters

- No financial reporting findings
- No compliance findings

Report on Compliance with Requirements that Could Have a Direct and Material Effect on the Major Federal Programs and on Internal Control Over Compliance in accordance with the Uniform Guidance for Federal Awards
(2 CFR Part 200)

- No control findings
- No compliance findings

Significant Risks

During the audit, we noted the following:

Significant Risks	Procedures
Valuation of patient accounts receivable	- Tie-out of reserving schedules - Zero Balance Accounts (“ZBA”) analysis - Lookback analysis & subsequent collections analysis
Revenue recognition	- Patient revenue analysis & cut-off analysis - Journal entry testing focusing on revenue reversals
Management override of controls	- Journal entry testing using risk-based criteria - Inquiries with executive, finance, and operational personnel

Hospital Patient Accounts Receivable – trend analysis

($ in 000's)	2023	2022	2021	2020	2019
Net Patient Accounts Receivable	$85,106	$83,766	$70,975	$69,081	$77,310
Subsequent Cash Receipts 2 months after 6/30	$55,127	$53,349	$55,047	$46,733	$45,427
% Collected 2 months after 6/30	65%	64%	66%	68%	59%
Exposure after 2 months' collections	$29,979	$30,417	$15,928	$22,348	$31,883
Collected 14 months after 6/30	n/a	$89,091	$83,550	$75,674	$83,906
% Collected 14 months after 6/30	n/a	106%	118%	110%	109%

Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with *accounting principles generally accepted in the United States of America*. Our audit of the financial statements does not relieve you or management of your responsibilities. The objectives of our audit are also to evaluate the presentation of the supplementary information in relation to the financial statements as a whole and report on whether the supplementary information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We conducted our audit in accordance with auditing standards generally accepted in the United States of America ("U.S. GAAS"), *Government Auditing Standards*, issued by the Comptroller General of the United States, as well the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. As part of an audit conducted in accordance with these auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit.

Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We are also responsible for communicating significant matters related to the financial statement audit that are, in our professional judgment, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

- Significant Unusual Transactions
- Significant Difficulties Encountered During the Audit
- Disagreements with Management
- Circumstances that affect the form and content of the auditor's report
- Other findings or issues arising from the audit that are, in the auditor’s professional judgment, significant and relevant to those charged with governance regarding their oversight of the financial reporting process
- Corrected and uncorrected misstatements
- Management’s consultation with other accountants

MOSS ADAMS COMMENTS

No significant unusual transactions or other required communication matters were identified during our audit of the entity’s financial statements.

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Significant Accounting Practices:

Our views about qualitative aspects of the entity's significant accounting practices, including accounting policies, accounting estimates, and financial statement disclosures

MOSS ADAMS COMMENTS

The quality of the entity's accounting policies and underlying estimates are discussed throughout this presentation. There were no changes in the entity's approach to applying the critical accounting policies.

- Management has the responsibility for selection and use of appropriate accounting policies. The significant accounting policies used by Salinas Valley Health are described in the notes to the consolidated financial statements. During the year, SVMH adopted GASB GASB 96, *Subscription-Based Information Technology Arrangements*. There were no other changes to significant accounting policies for the year ended June 30, 2023.
- We believe management has selected and applied significant accounting policies appropriately and consistent with those of the prior year.

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Management Judgments & Accounting Estimates:

The Audit Committee should be informed about the process used by management in formulating particularly sensitive accounting estimates and about the basis for the auditor's conclusions regarding the reasonableness of those estimates.

MOSS ADAMS COMMENTS

- Management's judgments and accounting estimates are based on knowledge and experience about past and current events and assumptions about future events. We apply audit procedures to management's estimates to ascertain whether the estimates are reasonable under the circumstances and do not materially misstate the consolidated financial statements.
- Significant management estimates impacted the consolidated financial statements including the following: useful lives of capital assets and right-of-use assets, discount rates and lease terms related to SVH's operating lease right-of-use assets, lease liabilities, lease receivable, deferred inflows of resources – leases, subscription assets, and subscription liabilities.

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Management Judgments & Accounting Estimates:

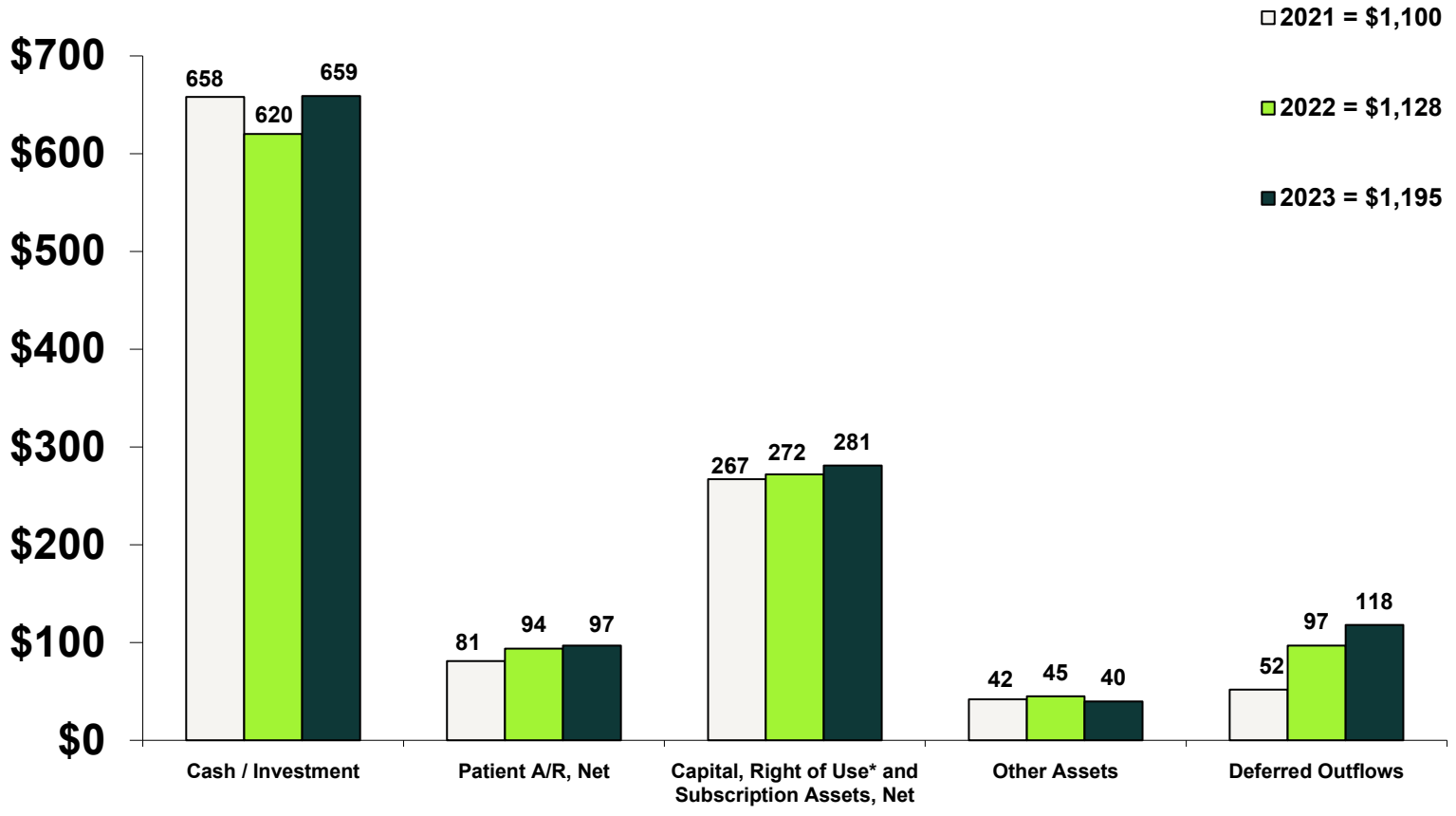
The Audit Committee should be informed about the process used by management in formulating particularly sensitive accounting estimates and about the basis for the auditor's conclusions regarding the reasonableness of those estimates.

MOSS ADAMS COMMENTS

- The disclosures in the consolidated financial statements are clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. We call your attention to the following notes: significant concentration of net patient accounts receivable, investments and fair value of investments, capital assets, employee benefit plans, post-retirement medical benefits, insurance plans, leases, and subscription-based information technology arrangements.

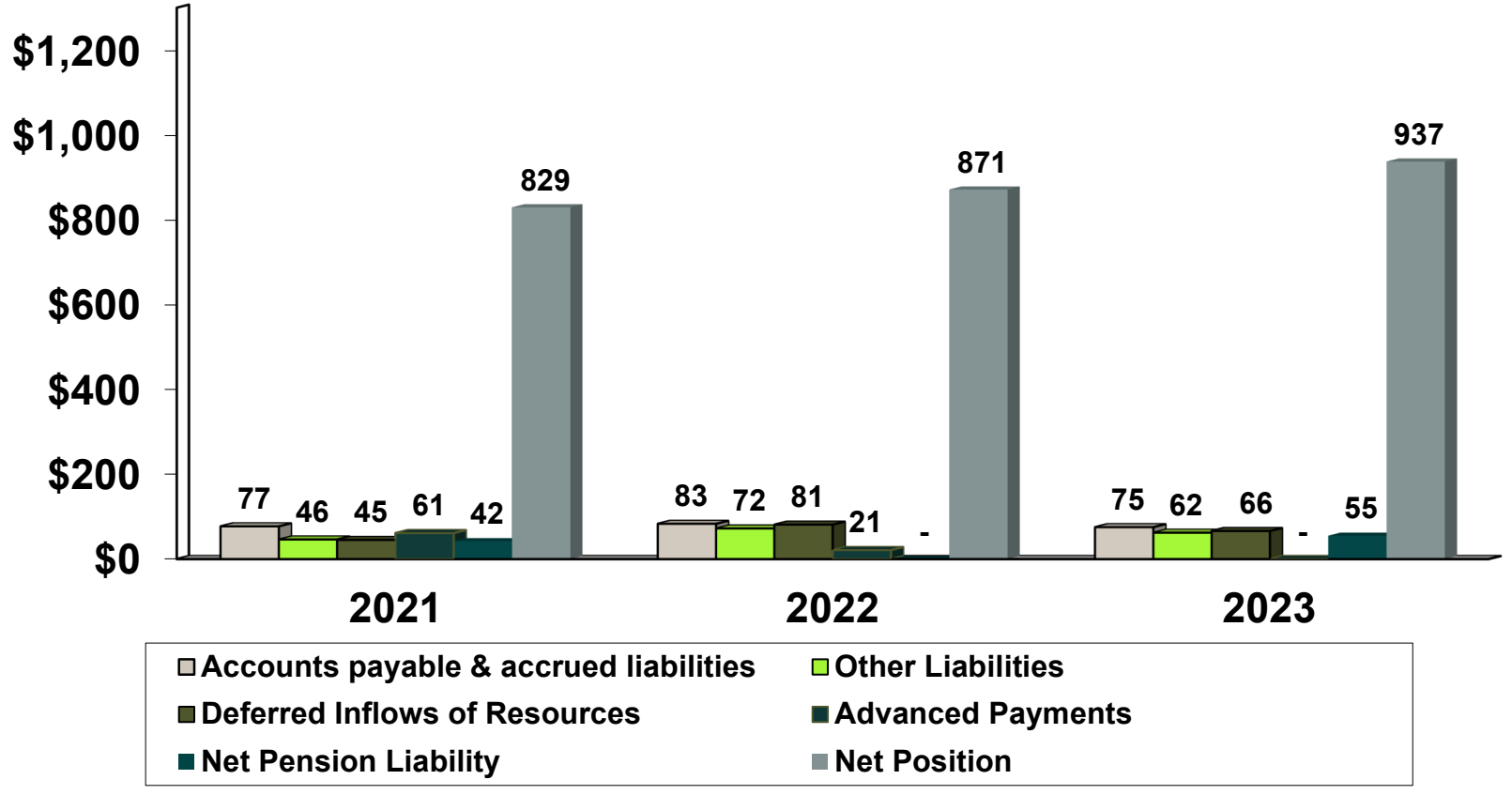
Consolidated Statements of Net Position

Asset and Deferred Outflows (in millions)



*represents GASB 87 operating lease right of use asset

Liabilities, Deferred Inflows, and Net Position (in millions)



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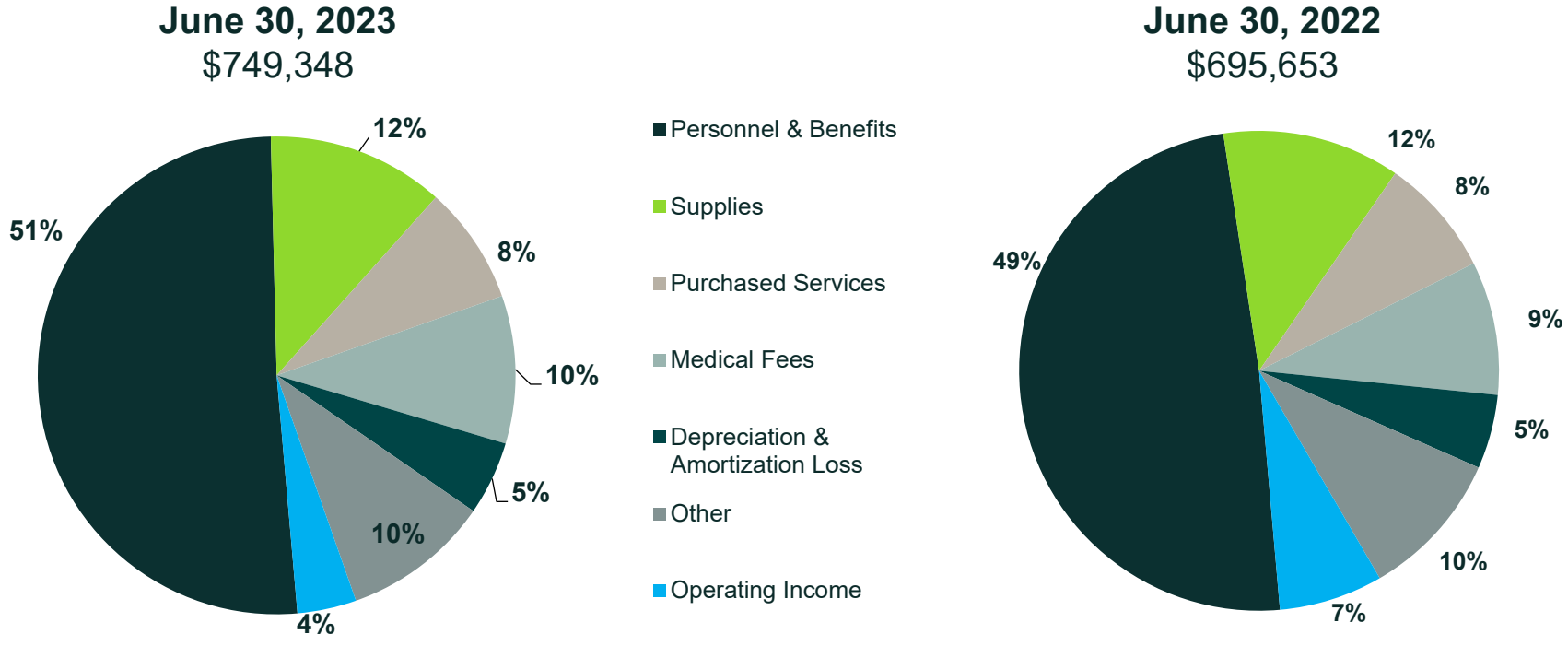
Consolidated Operations

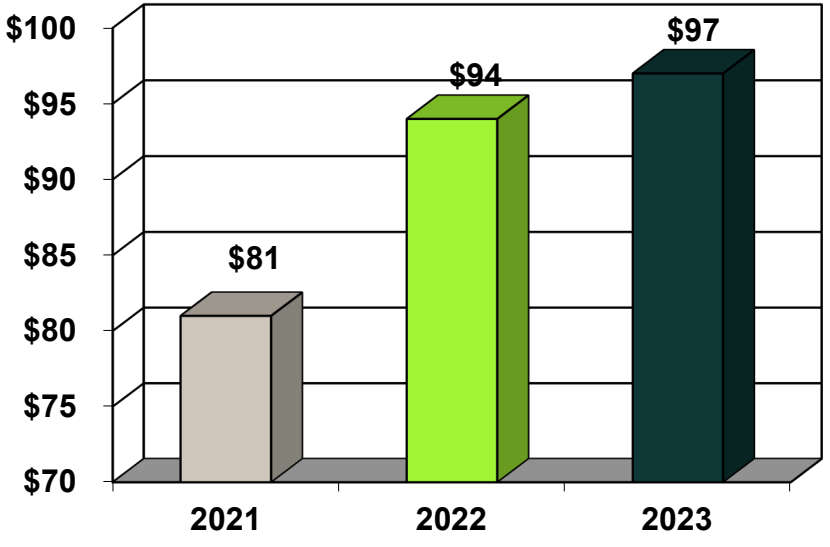
Income Statements Year-to-Year Comparison

Total Operating Revenues (in thousands) and Expense Categories as a Percentage of Total Operating Revenues

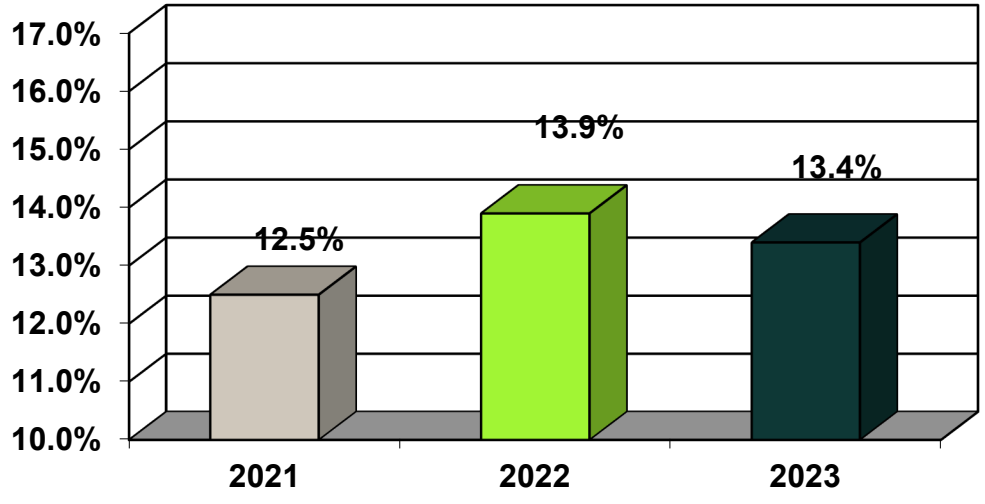


Net Patient Service Accounts Receivable

Dollars (in millions)

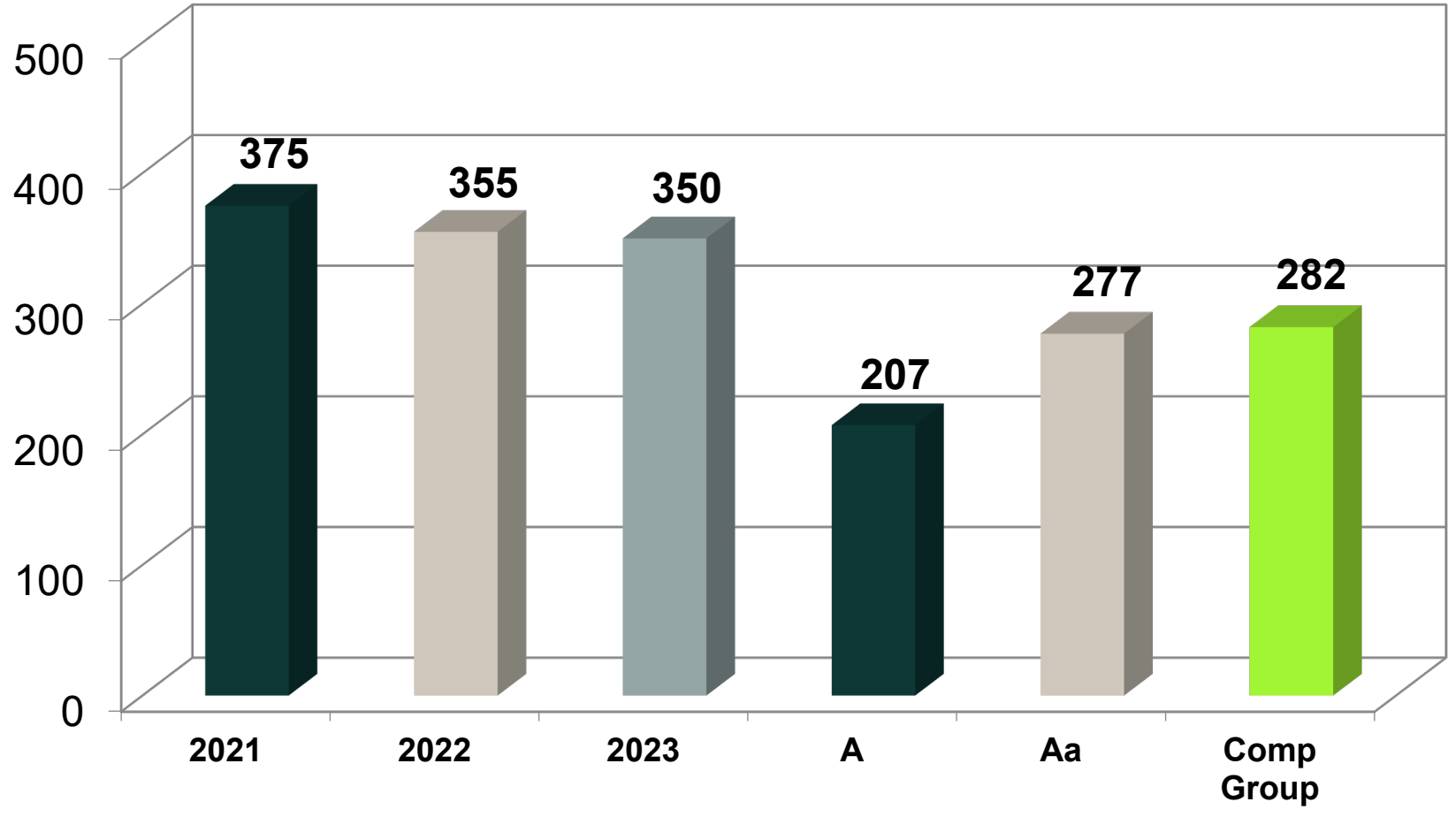


% Net Revenues



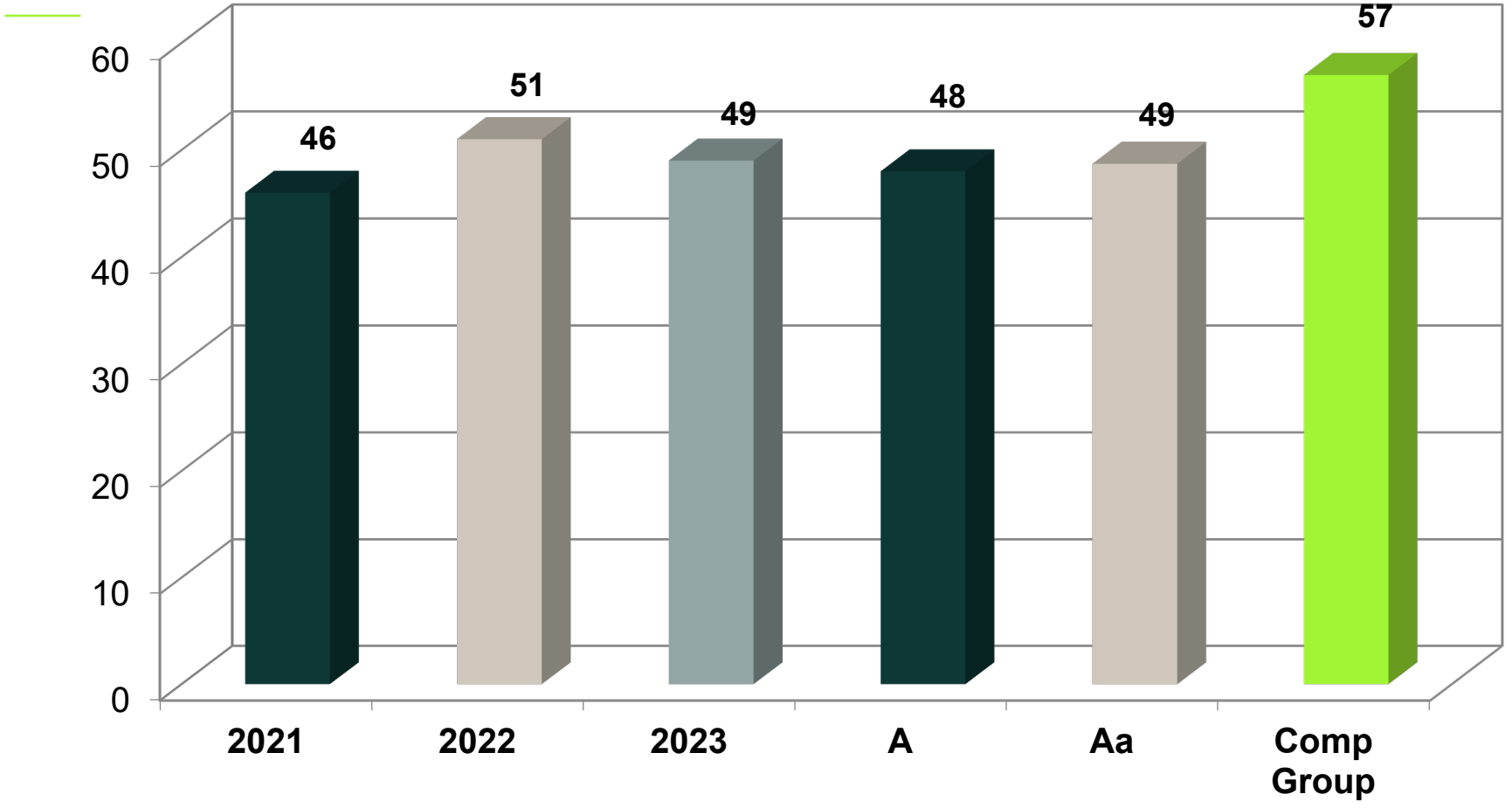
Other Information

Days Unrestricted Cash and Investments



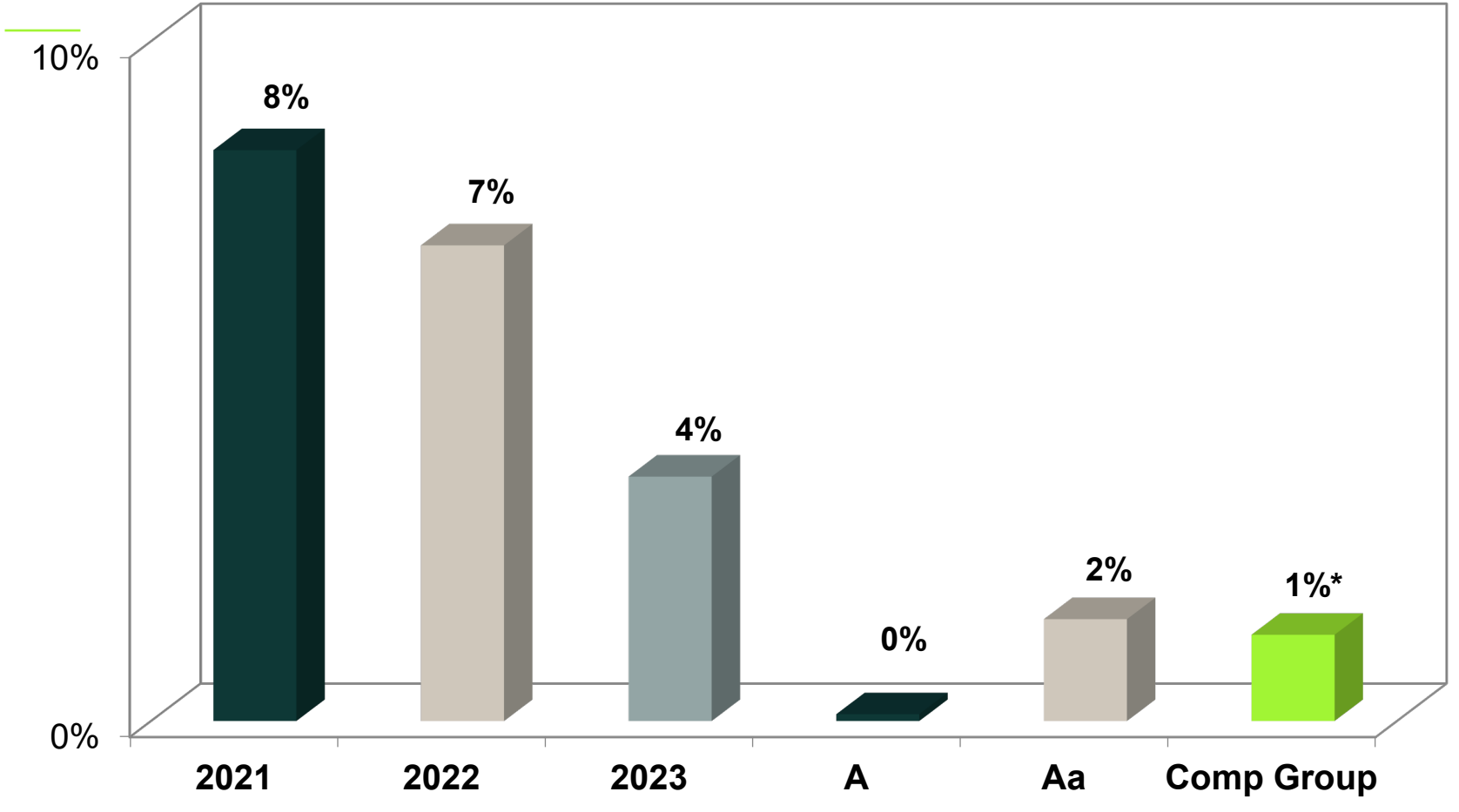
Moody's Investors Services: *Fiscal Year 2022 Not-for-Profit Health Care Medians September 2023*

Days in Accounts Receivable



Moody's Investors Services: *Fiscal Year 2022 Not-for-Profit Health Care Medians September 2023*

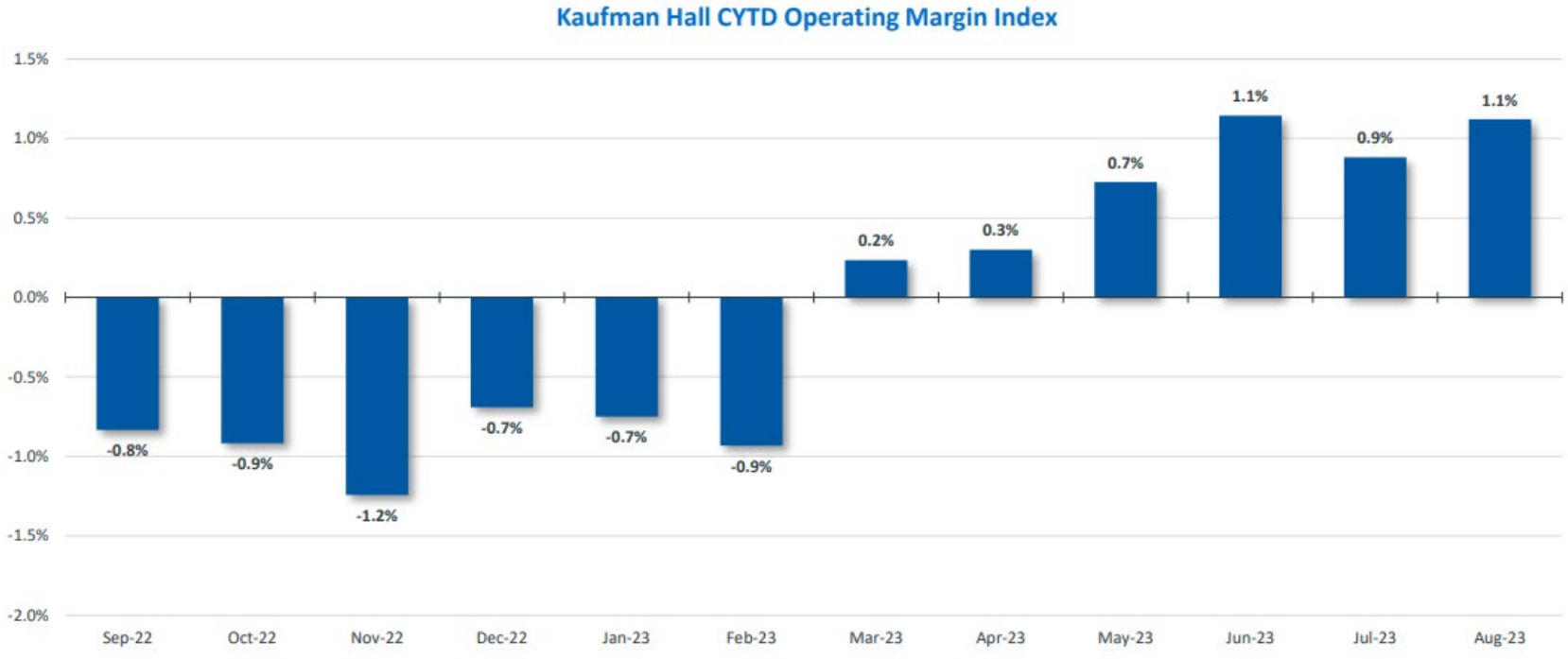
Operating Margin
(Operating Income/Total Revenue)



**Comp Group Operating Margin ranges from (5.6%) to 12.2% with 1 positive margin and 3 negative margins*

Moody's Investors Services: *Fiscal Year 2022 Not-for-Profit Health Care Medians September 2023*

Operating Margin Index



Source: *National Hospital Flash Report,* September 2023, Kaufman Hall

GASB Accounting Updates

- GASB Statement No. 100, Accounting Changes and Error Corrections—an amendment of GASB Statement No. 62. Effective for Salinas Valley Health beginning July 1, 2023.

- GASB Statement No. 101, Compensated Absences. Effective for Salinas Valley Health beginning July 1, 2024.

Your Service Team

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THANK YOU

Reports of Independent Auditors and
Consolidated Financial Statements with
Supplementary Information

Salinas Valley Memorial Healthcare System

June 30, 2023 and 2022

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Table of Contents

Management's Discussion and Analysis

Salinas Valley Memorial Healthcare System
Management's Discussion and Analysis
As of and for the Years Ended June 30, 2023, 2022, and 2021

INTRODUCTION

This section of Salinas Valley Memorial Healthcare System's ("Salinas Valley Health" or "SVH") annual financial report provides an overview of SVH's financial activities as of and for the year ended June 30, 2023, with comparative financial information as of and for the years ended June 30, 2022 and 2021. Additionally, this section provides an overview of the financial activities of the Salinas Valley Memorial Healthcare District Employees Pension Plan (the "Plan" or "Fiduciary") as of and for the year ended June 30, 2023, with comparative financial information as of and for the years ended June 30, 2022 and 2021. During the year ended June 30, 2023, SVH adopted the provisions of Governmental Accounting Standards Board ("GASB") Statement No. 96, *Subscription-Based Information Technology Arrangements*, retroactive to July 1, 2021. The 2021 amounts in the tables below have not been adjusted for the impact of GASB No. 96. The discussion and analysis has been prepared by management and should be read in conjunction with SVH's audited consolidated financial statements and the Plan's audited financial statements, which follow this section.

MANAGEMENT'S DISCUSSION AND ANALYSIS – Salinas Valley Health

General Salinas Valley Health Description

The Salinas Valley Memorial Hospital, now known as the Salinas Valley Health ("SVH"), was formed in 1947 pursuant to California Health and Safety Code Section 32000 and follows Healthcare District Law. The authority and responsibility to govern SVH is vested in a five-member elected Board of Directors from zones within the Hospital District. Opened in 1953, SVH is dedicated as a memorial to those brave men and women who gave their lives in World War II to preserve our American heritage. We honor their memory by our commitment to our mission: "to provide quality healthcare to our patients and to improve the health and well-being of our community."

SVH is anchored by Salinas Valley Health Medical Center (the "Hospital"), an acute care facility licensed for 263 beds. As one of the area's largest employers, the Hospital has a staff of approximately 2,100 people and is recognized as a leader in providing nationally recognized quality care. Principal services include a comprehensive heart program providing advanced diagnostics and treatments such as those in its structural heart program, heart catheterization labs, and heart surgical suites; and orthopedic, perinatal, and oncology services. Collaboration is an important operating principle for SVH in such key areas as SVH's Level III Neonatal Intensive Care Unit and Perinatal Diagnostic Center, which are operated in a joint venture with Stanford Children's Health; the Madison Clinic for Pediatric Diabetes, a partnership with UCSF; Aspire Health Plan, Monterey County's only Medicare Advantage program; Taylor Family Farms Health and Wellness Center (Rural Health Clinic); and Blue Zones Project Monterey County, dedicated to building a community where people live longer and healthier lives. SVH includes Salinas Valley Health Clinics, a multi-location clinic expanding access to primary and specialty care. SVH includes 9 urgent care locations and a system-wide information network.

Overview of the Consolidated Financial Statements

The financial report consists of two parts – management's discussion and analysis (this section), and the consolidated financial statements together with the related notes, as mandated by certain pronouncements of the GASB. The consolidated financial statements present information about SVH's financial position and results of operations, as well as cash flows for the respective fiscal years, presented on a consolidated basis whereby the consolidated financial statements include the accounts of all affiliates owned 50% or more for which day-to-day operations are managed by SVH. The consolidated financial statements also include explanatory notes, which are an integral part of the consolidated financial statements.

Components of the Basic Consolidated Financial Statements

The consolidated statement of net position displays the assets, deferred outflows, liabilities, deferred inflows, and resulting net position of SVH as of the end of the fiscal year. Separate amounts of net position are reported for each of the classes of net position: (a) permanently restricted principal (expendable earnings only), (b) temporarily restricted net position (expendable by Board action for donor designation), (c) unrestricted net position, and (d) invested in capital assets, net of related debt. Net position classifications are based on the existence or absence of donor-imposed or other third-party restrictions.

Unrestricted net position generally results from providing or agreeing to provide healthcare services, receiving unrestricted contributions and grants, receiving income from investing in income-producing assets minus expenses incurred to provide healthcare services, providing other community benefits, and performing administrative functions. The limits on the use of unrestricted net position are broad, resulting from the California Government Code, which regulates the environment in which SVH operates, as well as limits resulting from contractual agreements with suppliers, creditors, and others in the ordinary course of business. Information about the nature and amounts of different types of restrictions are provided either by reporting the amounts in the consolidated financial statements or by including relevant details in the notes to the consolidated financial statements.

Financial Highlights

The following table illustrates comparable statistics (excluding newborns) for the year ended June 30, 2023, as compared to the years ended June 30, 2022 and 2021:

	Year Ended June 30,			Change	
	2023	2022	2021	2023/2022	2022/2021
Admissions	11,808	10,926	10,101	882	825
Average daily census	130	118	117	12	1
Average length of stay	4	4	4	-	-
Patient days:					
Medicare	23,421	21,162	20,289	2,259	873
Managed care	8,590	8,763	8,733	(173)	30
Medi-Cal and CCAH	13,892	11,895	12,391	1,997	(496)
Other	1,435	1,241	1,345	194	(104)
Total patient days	47,338	43,061	42,758	4,277	303
Outpatient visits:					
Hospital outpatients	67,746	66,695	70,835	1,051	(4,140)
Emergency room	65,873	56,626	47,630	9,247	8,996
Total outpatient visits	133,619	123,321	118,465	10,298	4,856

As shown above, patient days increased 9.9% during 2023, from the levels of the prior year. Outpatient visits increased 8.4% during 2023, from the levels of the prior year, with increases in both hospital outpatient visits and emergency room visits.

Abbreviated Consolidated Statements of Net Position

The following abbreviated consolidated statements of net position compare the balances as of June 30, 2023, to that of June 30, 2022 and 2021 (in thousands):

	As of June 30,			Change	
	2023	2022 (As restated)	2021	2023/2022	2022/2021
Current assets:					
Cash and cash equivalents	$ 335,989	$ 315,889	$ 360,939	$ 20,100	$ (45,050)
Patient accounts receivable, net	97,434	94,115	80,932	3,319	13,183
Other	85,886	107,364	151,022	(21,478)	(43,658)
Total current assets	519,309	517,368	592,893	1,941	(75,525)
Board-designated funds	157,875	148,633	143,257	9,242	5,376
Capital assets, net	256,235	249,724	256,934	6,511	(7,210)
Other assets, net	143,852	115,625	55,096	28,227	60,529
Total assets	1,077,271	1,031,350	1,048,180	45,921	(16,830)
Deferred outflows	118,048	97,245	51,757	20,803	45,488
Total assets and deferred outflows	$ 1,195,319	$ 1,128,595	$ 1,099,937	$ 66,724	$ 28,658
Current liabilities	$ 101,993	$ 141,390	$ 156,812	$ (39,397)	$ (15,422)
Noncurrent liabilities	89,839	34,881	69,641	54,958	(34,760)
Deferred inflows	66,000	81,468	44,553	(15,468)	36,915
Total liabilities and deferred inflows	257,832	257,739	271,006	93	(13,267)
Net position:					
Invested in capital assets, net	254,730	236,018	254,906	18,712	(18,888)
Reserved for minority interest	(4,705)	(4,003)	(3,914)	(702)	(89)
Restricted - expendable	5,602	5,900	5,917	(298)	(17)
Restricted - nonexpendable	1,205	1,131	1,130	74	1
Unrestricted	680,655	631,810	570,892	48,845	60,918
Total net position	937,487	870,856	828,931	66,631	41,925
Total liabilities, deferred inflows, and net position	$ 1,195,319	$ 1,128,595	$ 1,099,937	$ 66,724	$ 28,658

Analysis – 2023 and 2022

Total current assets increased by $1.9 million in 2023, compared to 2022, due primarily to an increase in cash and cash equivalents partially offset by a decrease in short-term investments within other current assets.

Board-designated funds increased by $9.2 million in 2023 as compared to 2022 due to incoming transfers from the operating account. Capital assets, net, increased by $6.5 million in 2023 as compared to 2022, due primarily to capital asset acquisitions in excess of depreciation expense incurred. Other assets increased by $28.2 million, primarily due to an increase in long-term investments.

Current liabilities decreased by $39.4 million in 2023, primarily due to recoupment in Medicare Advance Payments and release in deferred grants. Noncurrent liabilities increased by $55.0 million in 2023, primarily due to an increase in the net pension liability.

SVH adopted GASB Statement No. 96, *Subscription-Based IT Arrangements* ("GASB No. 96"), as of July 1, 2022, applied retrospectively. SVH evaluated contracts for subscription-based information technology arrangements ("SBITAs"), and as a result, SVH recognized subscription assets of $19.4 million and subscription liabilities of $19.4 million on its consolidated statements of net position, that were formerly accounted for as operating expenses. The impact to beginning net position was not significant. See Note 15 to the consolidated financial statements for further discussion of impact of the adoption on SVH's consolidated financial statements.

Analysis – 2022 and 2021

Total current assets decreased by $75.5 million in 2022, compared to 2021, due primarily to a decrease in cash and cash equivalents.

Board-designated funds increased by $5.4 million in 2023, compared to 2022 due to incoming transfers from the operating account. Capital assets, net, decreased in 2022 as compared to 2021 due to the sale of the Salinas Valley Assisted Living Center. Other assets increased by $60.5 million due to transfer of investments to long-term and adoption of GASB No. 96.

Current liabilities decreased by $15.4 million in 2023, primarily due to recoupment in Medicare Advance Payments. Long-term liabilities decreased by $34.8 million in 2023, primarily due to a decrease in the net pension liability.

Abbreviated Consolidated Statements of Revenues, Expenses, and Changes in Net Position

The following abbreviated consolidated statements of revenues, expenses, and changes in net position and detail summary of net patient service revenues compare the activity for the year ended June 30, 2023, to that of the years ended June 30, 2022 and 2021 (in thousands):

	Year Ended June 30,			Change	
	2023	2022 (As restated)	2021	2023/2022	2022/2021
Net patient service revenues	$ 726,870	$ 676,259	$ 648,689	$ 50,611	$ 27,570
Other revenues	22,478	19,394	17,579	3,084	1,815
Total operating revenues	749,348	695,653	666,268	53,695	29,385
Total operating expenses	(721,916)	(649,641)	(611,748)	(72,275)	(37,893)
Operating income	27,432	46,012	54,520	(18,580)	(8,508)
Total nonoperating income (loss), net	39,199	(4,087)	16,059	43,286	(20,146)
Increase in net position	$ 66,631	$ 41,925	$ 70,579	$ 24,706	(28,654)

Analysis – 2023 and 2022

Operating revenues increased by 7.7% in 2023 as compared to 2022, driven primarily by net patient service revenues. Net patient service revenues in 2023 increased by $50.6 million to $726.8 million from $676.2 million in 2022. Management attributes the change in net patient service revenues to a return to normalized Hospital operations during 2023 including growth in inpatient and outpatient volumes.

Operating expenses increased in 2023 by approximately $72.3 million or 11.1% over 2022 primarily from increases in salaries, wages, and benefits at the Hospital. Operating income in 2023 decreased by $18.6 million to $27.4 million from $46.0 million for 2022.

Nonoperating income, net, for 2023 was $39.2 million as compared to a nonoperating loss, net of $4.1 million in 2022. An increase in investment income drove the change in nonoperating income for 2023 compared to 2022. Increase in net position as a percentage of total operating revenues was 8.9% for 2023, compared to 6.0% for 2022.

Analysis – 2022 and 2021

Operating revenues increased by 4.4% in 2022 as compared to 2021, driven primarily by net patient service revenues. Net patient service revenues in 2022 increased by $27.5 million to $676.2 million from $648.7 million in 2021. Management attributes the change in net patient service revenues to an increase in patient acuity related to the novel coronavirus ("COVID-19"), which drove the increase in multiple service lines of outpatient services in 2022.

Operating expenses increased in 2022 by approximately $37.9 million or 6.2% over 2021, primarily due to increases in salaries, wages, and benefits at the Hospital. Operating income for 2022 decreased by $8.5 million to $46.0 million from $54.5 million for 2021.

Nonoperating loss, net, for 2022 was $4.1 million as compared to nonoperating income, net, of $16.1 million in 2021. A decrease in investment income drove the change in nonoperating income for 2022 compared to 2021. Increase in net position as a percentage of total operating revenues was 6.0% for 2022, compared to 10.6% for 2021.

Net Patient Service Revenues

Net patient service revenues by funding source for 2023, 2022, and 2021 (in thousands) were as follows:

	Year Ended June 30,			Change	
	2023	2022 (As restated)	2021	2023/2022	2022/2021
Payor:					
Hospital operations:					
Medicare	$ 174,595	$ 135,237	$ 120,447	$ 39,358	$ 14,790
Managed care	322,294	320,067	306,889	2,227	13,178
Medi-Cal and CCAH	104,474	79,771	89,914	24,703	(10,143)
Other	23,916	43,244	46,126	(19,328)	(2,882)
Consolidated subsidiaries	101,591	97,940	85,313	3,651	12,627
Total net patient service revenues	$ 726,870	$ 676,259	$ 648,689	$ 50,611	$ 27,570

Net patient service revenues increased by 7.5% in 2023, compared to 2022. Net patient service revenues increased by 4.3% in 2022, as compared to 2021.

Liquidity and Other Key Ratios

Following is a table showing liquidity and other key ratios for the fiscal year ended June 30, 2023, as compared to June 30, 2022 and 2021:

	Year Ended June 30,		
	2023	2022	2021
Liquidity ratios:			
Current ratio	5.1	3.7	3.8
Days of revenue in patient accounts receivable	48.9	50.8	45.7
Margins:			
Operating income to total operating revenues	3.7%	6.6%	8.4%
Increase in net position (net income) to total operating revenues	8.9%	6.0%	10.5%
Return on total net position	7.1%	4.8%	9.3%

SVH's current ratio (ratio of current assets to current liabilities) increased substantially year over year from 2022 to 2023, while it remained consistent year over year in 2021 and 2022.

Other Operational Information

Significant operational issues impacting SVH in the near and long term include the following:

Physician Recruitment

Anticipated physician retirement and the growth of the local community have caused SVH to continue its emphasis on physician recruitment in 2023, which will be a continuing issue for SVH in the next several years. In order to keep the facility in the forefront of medical excellence, SVH has adopted a recruitment program to attract physicians in various specialties to the area.

As financial pressures continue to impact SVH and all other healthcare providers in California and the rest of the country, we look for additional investment opportunities in healthcare operations and facilities to supplement and enhance our programs. Through this strategy we are continuing to augment our core activity with partnerships and other forms of alliances with physicians (within the constraints of the law), to continue to have the necessary resources to provide the local community with state-of-the-art healthcare facilities.

Management Focus

It is the mission of Salinas Valley Health to provide quality healthcare to our patients and to improve the health and well-being of our community. Our vision is to be a center of excellence where an inspired team delivers compassionate and culturally sensitive care, outstanding quality, and an exceptional patient experience.

To carry out this mission and vision, we must have the best professionals, personnel, state-of-the-art equipment, facilities, services, supplies, and infrastructure. We focus on the following:

- Investing only in resources and services that enhance or supplement our core mission.
- Managing our resources by utilizing measurable objectives that tie to our core mission and holding management accountable for continuing performance improvements.

Federal and State Net Revenue Estimates

Entities doing business with governmental payors, including Medicare and Medicaid (Medi-Cal in California), are subject to risks unique to the government-contracting environment that are difficult to anticipate and quantify. Revenues are subject to adjustment as a result of examination by government agencies as well as auditors, contractors, and intermediaries retained by the federal, state, or local governments (collectively, "Government Agents"). Resolution of such audits or reviews often extends (and in some cases does not even commence until) several years beyond the year in which services were rendered and/or fees received.

Moreover, different Government Agents frequently interpret government regulations and other requirements differently. For example, Government Agents might disagree on a patient's principal medical diagnosis, the appropriate code for a clinical procedure, or many other matters. Such disagreements might have a significant effect on the ultimate payout due from the government to fully recoup sums already paid. Governmental agencies may make changes in program interpretations, requirements, or "conditions of participation," some of which may have implications for amounts previously estimated. In addition to varying interpretation and evolving codification of the regulations, standards of supporting documentation and required data are subject to wide variation.

In accordance with generally accepted accounting principles, to account for the uncertainty around Medicare and Medicaid revenues, SVH estimates the amount of revenue that will ultimately be received under the Medicare and Medi-Cal programs.

California Intergovernmental Transfers Received

Section 14164 of the California Welfare & Institutions Code provides for transfers between participating hospitals and the State Department of Healthcare Services to be used as a portion of the nonfederal share of providing services to Medi-Cal recipients. SVH received $9.7 million, $7.9 million, and $14.9 million net funding under this program in the years ended June 30, 2023, 2022, and 2021, respectively.

Charity Care and Community Funding

SVH delivered charity care, community benefits, and unreimbursed patient care totaling $160 million, $132 million, and $126 million in the years ended June 30, 2023, 2022, and 2021, respectively. SVH has made additional investments in the community with the goal to develop collaborative community partnerships that create a lasting, healthy impact by changing the environment in which people live, work, learn, and play.

Cautionary Note Regarding Forward-Looking Statements

Certain information provided by SVH, including written as outlined above or oral statements made by its representatives, may contain forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995. All statements, other than statements of historical facts, which address activities, events, or developments that SVH expects or anticipates will or may occur in the future, contain forward-looking information.

MANAGEMENT'S DISCUSSION AND ANALYSIS – FIDUCIARY

Overview

The Salinas Valley Memorial Healthcare District Employees Pension Plan (the "Plan") was established in November 1966 by the Salinas Valley Memorial Healthcare District (now known as the Salinas Valley Health or SVH) and has been amended from time to time since that date, as further described below. The Plan provides retirement, disability, and death benefits to permanent employees of SVH with union representation based on the employee's years of service, age, and annual compensation during covered employment.

General Plan Description

The Plan was amended effective January 1, 2004, to provide that the benefit formula be equal to 2.45% of the participant's earnings in a plan year. The benefit formula was previously 2.25% of the participant's earnings in a plan year (for plan years 2000 through 2003).

Participation in the Plan was frozen effective March 31, 2011, for nonunion employees. These employees are entitled to benefits earned before that date but do not accrue further benefits under the Plan.

The Plan was amended effective January 1, 2013, to comply with the applicable provisions of the California Public Employees' Pension Reform Act of 2013 ("PEPRA"). These provisions include limitations on pensionable compensation and retirement benefits and contribution provisions, including the establishment of participant contributions, for new participants who are hired on or after January 1, 2013, and meet the eligibility and vesting requirements of the Plan.

The Plan was amended and restated effective January 1, 2016, to update the Plan for legislative changes according to PEPRA and to remove the three-year service requirement to participate in the Plan for eligible employees.

The Plan's policies allow investments consisting of fixed income and equity marketable securities, and money market funds. The Plan's investments are held in a portfolio of registered investment companies ("mutual funds"). Benefit payments to members and beneficiaries continue to increase each year due to the increased number of retirees and beneficiaries receiving benefits.

Plan documents contain a more detailed description of the Plan's provisions and should be referred to for a more complete understanding of the terms of the Plan. Copies of the appropriate documents are available through the administrative offices of SVH.

Overview of the Basic Fiduciary Financial Statements - Salinas Valley Memorial Healthcare District Employees Pension Plan

The basic fiduciary financial statements present information about the Plan's fiduciary net position and changes in its fiduciary net position. The basic fiduciary financial statements also include notes to explain some of the information in the fiduciary financial statements and to provide more details. The notes are followed by a section of required supplementary information that displays additional detail information not in the basic fiduciary financial statements, but which is required by the pronouncements of the GASB and relate to funding progress and required contributions. The statement of fiduciary net position displays the assets (at fair value), liabilities, and resulting net position of the Plan as of the end of the fiscal year. The statement of changes in fiduciary net position reflects the employer contributions and investment return, net of investment expenses, less benefits paid.

Financial Analysis of the Plan

Total contributions have exceeded the actuarially determined contribution amounts since 2015, due to decisions made by the SVH's Board of Directors to fund the Plan at amounts above actuarially determined contributions.

Abbreviated Fiduciary Financial Statements - Salinas Valley Memorial Healthcare District Employees Pension Plan

The following are abbreviated statements of fiduciary net position as of June 30, 2023, 2022, and 2021 (in thousands):

	As of June 30,			Change	
	2023	2022	2021	2023/2022	2022/2021
Cash and investments	$ 403,720	$ 442,375	$ 386,006	$ (38,655)	$ 56,369
Net position held in trust for pension benefits	$ 403,720	$ 442,375	$ 386,006	$ (38,655)	$ 56,369

The following are abbreviated statements of changes in fiduciary net position as of June 30, 2023, 2022, and 2021 (in thousands):

	Year Ended June 30,			Change	
	2023	2022	2021	2023/2022	2022/2021
Investment (loss) income, net	$ (83,746)	$ 47,033	$ 43,531	$ (130,779)	$ 3,502
Employer contributions	61,579	23,127	23,766	38,452	(639)
Member contributions	2,578	2,673	1,976	(95)	697
Benefit payments to members and beneficiaries	(18,961)	(16,352)	(14,267)	(2,609)	(2,085)
Administrative expenses	(105)	(112)	(116)	7	4
Net change in fiduciary net position	$ (38,655)	$ 56,369	$ 54,890	$ (95,024)	$ 1,479

Analysis – 2023 and 2022

During 2023, the net position held in trust for pension benefits decreased by approximately 8.7%, compared to 2022. Employer contributions were $61.6 million in 2023 compared to $23.1 million in 2022. Benefit payments were $19.0 million in 2023 compared to $16.4 million in 2022. Net investment loss was $83.8 million in 2023 compared to net investment income of $47.0 million in 2022.

Analysis – 2022 and 2021

During 2022, the net position held in trust for pension benefits increased by approximately 14.6%, compared to 2021. Employer contributions were $23.1 million in 2022 compared to $23.8 million in 2021. Benefit payments were $16.4 million in 2022 compared to $14.3 million in 2021. Net investment income was $47.0 million in 2022 compared to $43.6 million in 2021.

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Report of Independent Auditors

The Board of Directors
Salinas Valley Memorial Healthcare System

Report on the Audit of the Financial Statements

Opinions

We have audited the consolidated financial statements of the business-type activities and the aggregate remaining fund information of Salinas Valley Memorial Healthcare System (the "System") as of and for the years ended June 30, 2023 and 2022, and the related notes to the financial statements, which collectively comprise the System's consolidated financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and the aggregate remaining fund information of Salinas Valley Memorial Healthcare System as of June 30, 2023 and 2022, and the respective changes in financial position and, where applicable, cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinions

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS); the California Code of Regulations, Title 2, Section 1131.2, State Controller's Minimum Audit Requirements for California Special Systems; and the standards applicable to financial audits contained in *Government Auditing Standards (Government Auditing Standards)*, issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the System and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the System's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.

- Obtain an understanding of internal control relevant to the audit 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 System's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the System's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Emphasis of Matter – New Accounting Standard

As discussed in Note 2 to the consolidated financial statements, the System adopted Governmental Accounting Standards Board ("GASB") Statement No. 96, *Subscription-Based Information Technology Arrangements*, as of July 1, 2022. Our opinion is not modified with respect to this matter.

Other Matters

Required Supplementary Information

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

Supplementary Information

Our audit was conducted for the purpose of forming opinions on the consolidated financial statements that collectively comprise the System's consolidated financial statements. The schedule of expenditures of federal awards as required by Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), the consolidating statement of net position and consolidating statement of revenues, expenses, and changes in net position are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating statement of net position and consolidating statement of revenues, expenses, and changes in net position are fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

The accompanying supplemental schedule of community benefit 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.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated October 20, 2023, on our consideration of the System's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the System's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the System's internal control over financial reporting and compliance.

San Francisco, California
October 20, 2023

Consolidated Financial Statements

Salinas Valley Memorial Healthcare System
Consolidated Statements of Net Position
June 30, 2023 and 2022
(in Thousands)

	2023	2022 (As restated)
ASSETS AND DEFERRED OUTFLOWS		
CURRENT ASSETS		
Cash and cash equivalents	$ 335,989	$ 315,889
Patient accounts receivable, net of estimated uncollectibles of $27,288 and $29,007 at June 30, 2023 and 2022, respectively	97,434	94,115
Short-term investments	62,285	81,147
Supplies inventory	8,171	8,116
Lease receivable, current portion	1,267	705
Other current assets	14,163	17,396
Total current assets	519,309	517,368
BOARD-DESIGNATED FUNDS	157,875	148,633
CAPITAL ASSETS		
Nondepreciable	60,067	37,650
Depreciable, net	196,168	212,074
Total capital assets, net	256,235	249,724
OTHER ASSETS		
Right-of-use assets, net of amortization	13,922	7,291
Subscription assets, net of amortization	10,755	15,253
Lease receivable, net of current portion	1,169	1,752
Long-term investments	102,498	74,674
Investments in affiliates	14,067	13,266
Net pension asset	-	1,890
Other long-term assets	1,441	1,499
Total other assets	143,852	115,625
Total assets	1,077,271	1,031,350
DEFERRED OUTFLOWS - ACTUARIAL	116,911	95,857
DEFERRED OUTFLOWS - GOODWILL	1,137	1,388
Total deferred outflows	118,048	97,245
Total assets and deferred outflows	$ 1,195,319	$ 1,128,595

See accompanying notes.

Salinas Valley Memorial Healthcare System
Consolidated Statements of Net Position
June 30, 2023 and 2022
(in Thousands)

	2023	2022 (As restated)
ASSETS AND DEFERRED OUTFLOWS		
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Total assets and deferred outflows	$ 1,195,319	$ 1,128,595

See accompanying notes.

Salinas Valley Memorial Healthcare System
Consolidated Statements of Net Position (Continued)
June 30, 2023 and 2022
(in Thousands)

	2023	2022 (As restated)
LIABILITIES, DEFERRED INFLOWS, AND NET POSITION		
CURRENT LIABILITIES		
Notes payable, current portion	$ 101	$ 101
Accounts payable	11,788	18,117
Accrued expenses	63,545	64,390
Deferred grants	-	12,237
Advance payments - Medicare	-	21,045
Estimated third-party payor settlements	5,404	5,166
Lease liabilities, current portion	3,650	2,674
Subscription liabilities, current portion	4,631	5,319
Self-insurance liabilities, current portion	12,874	12,341
Total current liabilities	101,993	141,390
NET PENSION LIABILITY	55,011	-
NET POST-RETIREMENT MEDICAL BENEFITS LIABILITY	4,001	5,007
NOTES PAYABLE, net of current portion	654	754
LEASE LIABILITIES, net of current portion	11,431	4,946
SUBSCRIPTION LIABILITIES, net of current portion	5,715	10,115
SELF-INSURANCE LIABILITIES, net of current portion	13,027	14,059
Total liabilities	191,832	176,271
DEFERRED INFLOWS - ACTUARIAL	63,781	79,111
DEFERRED INFLOWS - LEASES	2,219	2,357
Total deferred inflows	66,000	81,468
Total liabilities and deferred inflows	257,832	257,739
NET POSITION		
Invested in capital assets, net of related debt	254,730	236,018
Reserved for minority interest	(4,705)	(4,003)
Restricted - expendable	5,602	5,900
Restricted - nonexpendable	1,205	1,131
Unrestricted	680,655	631,810
Total net position	937,487	870,856
Total liabilities, deferred inflows, and net position	$ 1,195,319	$ 1,128,595

See accompanying notes.

Salinas Valley Memorial Healthcare System
Consolidated Statements of Revenues, Expenses, and Changes in Net Position
Years Ended June 30, 2023 and 2022
(in Thousands)

	2023	2022 (As restated)
OPERATING REVENUES		
Net patient service revenues	$ 726,870	$ 676,259
Other revenues	22,478	19,394
Total operating revenues	749,348	695,653
OPERATING EXPENSES		
Salaries and wages	233,119	213,593
Compensated absences	37,885	35,457
Employee benefits	112,372	93,379
Supplies	90,793	86,507
Purchased services	60,878	50,507
Medical fees	74,168	64,588
Other fees	49,074	43,492
Depreciation and amortization	35,844	34,481
Other expenses	27,783	27,637
Total operating expenses	721,916	649,641
Operating income	27,432	46,012
NONOPERATING REVENUES AND EXPENSES		
Forgiveness of loan payable	-	1,079
Grants and contributions	20,467	3,046
Property tax revenue	5,721	4,987
Investment income (loss), net	19,282	(13,285)
Provision for credit losses	(5,914)	(4,414)
(Loss) gain on disposal of capital assets	(1,042)	1,864
Income from investments in affiliates	2,171	2,948
Other	(2,023)	1
Nonoperating income (loss), net	38,662	(3,774)
INCOME BEFORE MINORITY INTEREST	66,094	42,238
MINORITY INTEREST IN INCOME (LOSS) OF CONSOLIDATED AFFILIATES	537	(313)
INCREASE IN NET POSITION	66,631	41,925
NET POSITION, beginning of year	870,856	828,931
NET POSITION, end of year	$ 937,487	$ 870,856

See accompanying notes.

Salinas Valley Memorial Healthcare System
Consolidated Statements of Cash Flows
Years Ended June 30, 2023 and 2022
(in Thousands)

	2023	2022 (As restated)
CASH FLOWS FROM OPERATING ACTIVITIES		
Cash received from patients and third-party payors	$ 676,191	$ 580,863
Cash paid to employees for services	(384,270)	(342,429)
Cash paid to suppliers for goods and services	(270,582)	(272,359)
Other receipts from operations	22,478	19,394
Net cash provided by (used in) operating activities	43,817	(14,531)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Proceeds from property taxes levied by the County	5,721	4,987
Grants and donations received	20,467	3,046
Net cash provided by noncapital financing activities	26,188	8,033
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchases of capital assets	(35,346)	(19,631)
Proceeds from sale of capital assets	352	1,973
Proceeds from lease receivable	21	832
Payments on lease liabilities	(2,572)	(3,051)
Payments on subscription liabilities	(5,906)	(4,924)
Purchase of subscription assets	(360)	(474)
Principal payments on notes payable	(100)	(94)
Net cash used in capital and related financing activities	(43,911)	(25,369)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of investments	(99,886)	(110,174)
Proceeds from sales of investments	110,206	95,156
Changes in board designated funds	(9,242)	(5,376)
Other nonoperating income receipts	(9,110)	2,193
Distributions from minority interest in affiliates	2,038	5,018
Net cash used in investing activities	(5,994)	(13,183)
NET CHANGE IN CASH AND CASH EQUIVALENTS	20,100	(45,050)
CASH AND CASH EQUIVALENTS, beginning of year	315,889	360,939
CASH AND CASH EQUIVALENTS, end of year	$ 335,989	$ 315,889

See accompanying notes.

Salinas Valley Memorial Healthcare System
Statements of Cash Flows (Continued)
Years Ended June 30, 2023 and 2022
(in Thousands)

	2023	2022 (As restated)
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES		
Operating income	$ 27,432	$ 46,012
Adjustments to reconcile operating income to net cash provided by (used in) operating activities:		
Depreciation and amortization	35,844	34,481
Provision for doubtful accounts	47,598	45,609
Loss (gain) on disposal of capital assets	1,042	(1,864)
Changes in operating assets and liabilities:		
Patient accounts receivable, net	(50,917)	(58,792)
Supplies and other assets	3,236	(7,861)
Net pension asset	1,890	(1,890)
Net pension liability	55,011	(42,238)
Deferred grants	(12,237)	12,237
Deferred outflows	(20,803)	(45,488)
Deferred inflows	(15,468)	36,915
Accounts payable and accrued expenses	(7,174)	5,738
Advance payments - Medicare	(21,045)	(39,887)
Self-insurance liabilities	(1,505)	(226)
Estimated third-party payor settlements	238	2,351
Right-of-use assets/lease liabilities	(143)	-
Subscription liabilities/assets	818	372
Net cash provided by (used in) operating activities	$ 43,817	$ (14,531)
SUPPLEMENTAL DISCLOSURE OF NONCASH INVESTING AND FINANCING ACTIVITY		
Noncash acquisition (disposition) of right of use assets	$ 10,176	$ -

See accompanying notes.

Salinas Valley Memorial Healthcare System
Employees' Pension Plan – Statements of Fiduciary Net Position
June 30, 2023 and 2022
(in Thousands)

	2023	2022
ASSETS		
Investments, at fair value:		
Mutual funds	$ 403,720	$ 442,375
NET POSITION HELD IN TRUST FOR PENSION BENEFITS	$ 403,720	$ 442,375

See accompanying notes.

Salinas Valley Memorial Healthcare System
Statements of Changes in Fiduciary Net Position
Years Ended June 30, 2023 and 2022
(in Thousands)

	2023	2022
ADDITIONS		
Investment income:		
Net (deprecation) appreciation in fair value of investments	$ (93,981)	$ 25,858
Dividends	10,235	21,175
Net investment (loss) income	(83,746)	47,033
Contributions:		
Employer	61,579	23,127
Members	2,578	2,673
Total contributions	64,157	25,800
Total (reductions) additions	(19,589)	72,833
DEDUCTIONS		
Benefit payments	18,961	16,352
Administrative expenses	105	112
Total deductions	19,066	16,464
NET CHANGE IN NET POSITION	(38,655)	56,369
NET POSITION HELD IN TRUST FOR PENSION BENEFITS		
Beginning of the year	442,375	386,006
End of the year	$ 403,720	$ 442,375

See accompanying notes.

Note 1 – Organization

The Salinas Valley Memorial Healthcare System ("Salinas Valley Health" or "SVH") is a special district created in 1947, administered by a Board of Directors elected by the registered voters of the Hospital District (the "District"). SVH is a political subdivision of the State of California and operates the Salinas Valley Memorial Hospital ("Salinas Valley Health Medical Center" or "SVHMC" or the "Hospital") and Subsidiaries.

The consolidated SVH includes an 85% interest in a partnership, Central Coast Medical Service Organization ("CCMSO"), an outpatient medical clinic organization; 100% of Salinas Valley Memorial Hospital Foundation (the "Foundation"), which is authorized to solicit contributions on the Hospital's behalf; 100% of Salinas Valley Health Clinics ("SVHC"), a multi-specialty physician practice; and 50% of a joint venture with Lucille Packard Children's Hospital to operate the Neonatal Intensive Care Unit in the Hospital ("SVMH-LPCH NICU JV").

Fiduciary plan description – The Plan is a single-employer noncontributory employee retirement system established by SVH. SVH is a political subdivision that was organized under the provisions of the Health and Safety Code of the State of California. Permanent employees of SVH with union representation are eligible to participate in the Plan upon the later of their employment commencement date or reaching the age of 21.

The Plan provides retirement, disability, and death benefits based on the employee's years of service, age, and annual compensation during covered employment. Plan provisions and all other requirements are established by SVH's five-member Board of Directors (the "Board"), which has been elected by the registered voters of the District.

Effective March 31, 2011, participation of nonunion employees in the Plan was frozen. Nonunion employees are entitled to benefits earned before March 31, 2011, but do not accrue further benefits under the Plan.

Effective January 1, 2013, the Plan was amended to adopt the applicable provisions of the California Public Employees' Pension Reform Act of 2013 ("PEPRA").

The following description of Salinas Valley Memorial Healthcare District Employees Pension Plan (the "Plan") provides only general information. Participants should refer to the plan document for a more complete description of the Plan's provisions.

Note 2 – Summary of Significant Accounting Policies

Principles of consolidation – The consolidated financial statements include the accounts of SVHMC and all subsidiaries that are controlled and owned more than 50% for which day-to-day operations are managed by SVH. All intercompany accounts and transactions are eliminated upon consolidation. Investments for which SVH has 50% or less ownership and over which SVH does not have control are recorded using the equity method. Minority interest represents the proportionate share of the equity in affiliates that is attributable to the minority owners.

Acquired businesses are included in the consolidated financial statements from the date of acquisition.

Basis of accounting – The accompanying consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America as prescribed by the Governmental Accounting Standards Board ("GASB") using the "economic resources measurement focus"; the accrual basis of accounting; the California Code of Regulations, Title 2, Section 1131, State Controller's *Minimum Audit Requirements* for California Special Districts; and the State Controller's Office prescribed reporting guidelines. In addition, these statements follow generally accepted accounting principles applicable to the healthcare industry, which are included in the American Institute of Certified Public Accountants' *Audit and Accounting Guide, Healthcare Entities*, to the extent that these principles do not contradict GASB standards.

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

Recently adopted accounting pronouncements – In May 2020, the GASB issued Statement No. 96, *Subscription-Based IT Arrangements* ("GASB No. 96"). The statement provides guidance on the accounting and financial reporting for subscription-based information technology arrangements ("SBITAs") for government end users (governments). This statement defines an SBITA; establishes that an SBITA results in a right-to-use subscription asset ("subscription asset") — an intangible asset — and a corresponding subscription liability; provides the capitalization criteria for outlays other than subscription payments, including implementation costs of an SBITA; and requires disclosures regarding SBITAs. SVH adopted GASB No. 96 as of July 1, 2022, applied retrospectively. SVH calculated and recognized subscription assets, net, of $19.4 million and subscription liabilities of $19.4 million as of July 1, 2022. The impact to net position at July 1, 2022, was not significant. See Note 14 for further discussion of subscription assets and liabilities. See Note 15 for further discussion of impact of the adoption on SVH's consolidated financial statements.

New accounting pronouncements – In June 2022, the GASB issued Statement No. 100*, Accounting Changes and Error Corrections—an amendment of GASB Statement No. 62*. This statement enhances accounting and financial reporting requirements for accounting changes and error corrections. It defines accounting changes as changes in accounting principles, changes in accounting estimates, and changes to or within the financial reporting entity. This statement requires that (1) changes in accounting principles and error corrections be reported retroactively by restating prior periods, (2) changes to or within the financial reporting entity be reported by adjusting beginning balances of the current period, and (3) changes in accounting estimates be reported prospectively by recognizing the change in the current period. The statement is effective for fiscal years beginning after June 15, 2023. SVH is currently evaluating the impact of the adoption of this statement on its consolidated financial statements.

In June 2022, the GASB issued Statement No. 101, *Compensated Absences*. The statement updates the recognition and measurement guidance for compensated absences. This statement requires that liabilities for compensated absences be recognized for (1) leave that has not been used, and (2) leave that has been used but not yet paid, provided the services have occurred, the leave accumulates, and the leave is more likely than not to be used for time off or otherwise paid in cash or noncash means. In estimating the leave that is more likely than not to be used or otherwise paid or settled, a government should consider relevant factors such as employment policies related to compensated absences and historical information about the use or payment of compensated absences. The statement amends the existing requirements to disclose only the net change in the liability instead of the gross additions and deductions to the liability. This statement is effective for fiscal years beginning after December 15, 2023. SVH is currently evaluating the impact of the adoption of this statement on its consolidated financial statements.

Use of estimates – The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting period. The most significant estimates relate to patient accounts receivable allowances, amounts due to third-party payors, self-insurance liabilities, and employee benefit costs including pension. Actual results could differ from those estimates.

Fair value of financial instruments – Unless otherwise indicated, the fair value of all reported assets and liabilities that represents financial instruments approximates their carrying values. SVH's policy is to recognize transfers in and transfers out of Levels 1, 2, and 3 as of the end of the reporting period. See Note 5 for further discussion of fair value measurements in the consolidated financial statements.

Cash and cash equivalents – Cash and cash equivalents include investments in highly liquid debt instruments with an initial maturity of three months or less, excluding amounts whose use is limited by Board designation or other arrangements. Cash and cash equivalents also include investments in the Local Agency Investment Fund ("LAIF"), the State Treasurer's pooled investment program, and values participants' shares on an amortized cost basis.

Supplies inventory – Supply inventories are valued at the lower of cost (first-in, first-out method) or market.

Lease receivable – SVH's lease receivable is measured at the present value of lease payments expected to be received during the lease term. Under the lease agreement, SVH may receive variable lease payments that are dependent upon the lessee's revenue. The variable payments are recorded as an inflow of resources in the period the payment is received. The deferred inflow of resources is recorded at the initiation of each lease in an amount equal to the initial recording of the lease receivable. The deferred inflows of resources are amortized using the effective-interest method over the term of each lease.

(in Thousands)

Investments – U.S. Treasury securities, federal agency debt securities, corporate notes, and equity securities, which are reported as board-designated funds and investments, are carried at fair value based on published market values, as quoted on a recognized exchange or an industry standard pricing service. Short-term investments in commercial paper, certificates of deposit, and money market accounts are recorded at amortized cost, which approximates market value. Mutual funds are carried at fair value based on the fund's current share price. These investments are subject to various risks, such as interest rate, market, and credit risks.

Investment transactions are recorded on the date the investments are purchased or sold (trade date). Realized gains or losses are recorded as the difference between the proceeds from the sale and the cost of the investment sold.

Board-designated funds – Board-designated funds include assets set aside by the Board of Directors for future capital improvements or for certain contingencies, over which the Board retains control and may at its discretion subsequently use for other purposes, and assets held by trustees under agreements with third parties.

Capital assets – Capital asset acquisitions are recorded at cost. Capital assets donated for SVH operations are recorded at fair value at the date of receipt. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed on the straight-line method. Equipment under capital lease is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the consolidated financial statements. SVH capitalizes all purchases of computers and copiers over $1 thousand, general acquisitions over $2 thousand, and group purchases over $10 thousand. Depreciation expense is computed using the straight-line method over the estimated useful lives of the assets as follows:

Land improvements	20 to 40 years
Buildings and improvements	20 to 40 years
Moveable equipment	3 to 20 years

Upon disposition or retirement of capital assets, the undepreciated cost basis less proceeds from sale, if any, are reflected in nonoperating gains and losses in the period of disposition.

SVH 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. Management evaluates prominent events or changes in circumstances to determine whether an impairment loss should be recognized. There were no impairment losses during the years ended June 30, 2023 and 2022.

Right-of-use assets – SVH has recorded right-of-use assets as a result of implementing GASB Statement No. 87, *Leases* ("GASB No. 87"). The right-of-use assets are initially measured at an amount equal to the initial measurement of the related lease liability, plus any lease payments made prior to the lease term and ancillary charges necessary to place the lease into service, less any lease incentives received. The right-of-use assets are amortized on a straight-line basis over the life of the related lease. See Note 13 for further discussion of right-of-use assets.

Subscription assets – SVH has recorded subscription assets as a result of implementing GASB No. 96. The subscription assets are initially measured at an amount equal to the initial measurement of the sum of the related subscription liability, any contract payments made to the subscription-based IT arrangement ("SBITA") vendor at subscription term commencement, and any capitalizable initial implementation costs, less any incentive payments received from the vendor at the subscription term commencement. Subscription assets are amortized on a straight-line basis over the shorter of the subscription term or the useful life of the underlying assets. See Note 14 for further discussion of subscription assets.

Deferred outflows and inflows – SVH records deferred outflows or inflows of resources in its consolidated financial statements for consumption or acquisition of its consolidated net position that is applicable to future reporting periods. These consolidated financial statement elements are distinct from assets and liabilities. The table below reflects the components of deferred outflows and inflows as of June 30, in thousands:

	2023	2022
Deferred outflows - actuarial:		
Pension	$ 116,122	$ 95,009
Post-retirement medical plans	789	848
Total deferred outflows - actuarial	116,911	95,857
Deferred outflows - goodwill	1,137	1,388
Total deferred outflows	$ 118,048	$ 97,245
Deferred inflows - actuarial:		
Pension	$ 62,029	$ 78,360
Post-retirement medical plans	1,752	751
Total deferred inflows - actuarial	63,781	79,111
Deferred inflows - leases	2,219	2,357
Total deferred inflows	$ 66,000	$ 81,468

Lease liabilities – SVH recognizes lease contracts or equivalents that have a term exceeding one year and the cumulative undiscounted future payments on the contract exceeding $50 thousand that meet the definition of an other-than-short-term lease. Lease liabilities are recorded as the present value of the undiscounted future lease payments. SVH uses a discount rate that is explicitly stated or implicit in the contract. When a readily determinable discount rate is not available, the discount rate is determined using SVH's incremental borrowing rate at start of the lease for a similar asset type and term length to the contract. Short-term lease payments for leases with an original term of one year or less are expensed as incurred. See Note 13 for further discussion of lease liabilities.

Subscription liabilities – SVH has recorded subscription liabilities as a result of implementing GASB No. 96. SVH recognizes SBITA contracts or equivalents that have a term exceeding one year and the cumulative future payments on the contract exceeding $50 thousand that meet the definition of an other-than-short-term SBITA. Subscription liabilities are initially measured at an amount equal to the present value of the undiscounted future payments under the SBITA. SVH uses a discount rate that is explicitly stated or implicit in the contract to determine the value of the subscription liability. When a readily determinable discount rate is not available, the discount rate is determined using SVH's incremental borrowing rate at start of the subscription term for a similar asset type and term length to the contract. As variable payments based upon the use of the underlying subscription asset are not fixed in nature, such amounts are excluded from subscription liabilities. Short-term subscription payments with an original subscription term of one year or less are expensed as incurred. See Note 14 for further discussion of subscription liabilities.

Risk management – SVH is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; employee health and accident benefits; and medical malpractice. SVH utilizes both commercial insurance and self-insurance for claims arising from such matters. SVH is self-insured for workers' compensation claims, professional liability, and health benefits. Settled claims have not exceeded SVH's policy limits in any of the past three fiscal years.

Self-insurance plans – SVH is self-insured for workers' compensation benefits for employees. An actuarial estimate is accrued based on an expected, undiscounted estimate as of June 30, 2023 and 2022.

SVH is a member of and participates in a professional liability self-insurance program through BETA Healthcare Group ("BETA"), a joint powers authority whose members include district and private not-for-profit hospitals and county facilities in California. Amounts paid by each member to BETA represent actuarially determined assessments of claims payable and estimated incurred-but-not-reported claims that are adjusted periodically based on the claims experience for each member at each hospital. Claims in excess of specified amounts are the responsibility of individual program participants.

SVH provides eligible employees with health benefits through a self-insured program. The liability for claims arising from this program is estimated based upon historical experience and trending information.

Net position – Net position is required to be classified for accounting and reporting purposes in the following categories:

- *Invested in capital assets, net of related debt* – Capital assets, net of accumulated depreciation, reduced by outstanding principal balances of debt attributable to the acquisition, construction, or improvement of those assets.

- *Reserved for minority interest* – Net position of legally separate organization attributable to other participants.

- *Restricted* – SVH classifies net position resulting from transactions with purpose restrictions as restricted net assets until the resources are used for the specific purpose or for as long as the provider requires the resources to remain intact.

- *Expendable* – Net position whose use by SVH is subject to externally imposed restrictions that can be fulfilled by actions of SVH pursuant to those restrictions or that expire by the passage of time.
- *Nonexpendable* – Net position that includes donor restricted requirements to invest the principal portion in perpetuity.

- *Unrestricted* – Net position that is neither restricted nor invested in capital assets, net of related debt. Unrestricted net position may be designated for specific purposes by management or the Board of Directors.

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 provision of healthcare services are reported as operating revenues and expenses. Peripheral or incidental transactions, including investment income, interest expense, and gains or losses on the disposal of capital assets, are reported as nonoperating income and expense.

Net patient service revenues – Net patient service revenues are reported at the estimated net realizable amounts from patients, third-party payors including Medicare and Medi-Cal, and others for services rendered, including estimated retroactive audit 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. Laws and regulations governing the Medicare and Medi-Cal programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates may change by a material amount in the near term.

Grants and contributions – On March 11, 2020, the World Health Organization officially declared COVID-19, the disease caused by the novel coronavirus, a pandemic. Management is closely monitoring the evolution of this pandemic, including how it may affect operations and the general population. Management has not yet determined the full financial impact of these events. The Centers for Medicare & Medicaid Services (“CMS”) distributed $50 billion of the $100 billion in the form of grants to hospitals. For the year ended June 30, 2022, SVH received approximately $12.2 million of provider relief funds. SVH did not receive additional funds in the fiscal year ended June 30, 2023. SVH recognized $12.2 million for the year ended June 30, 2023, included as grants and contributions in the consolidated statement of revenues, expenses, and changes in net position. SVH will have to submit reports documenting lost revenue and expenses incurred to support the grant funds, among other terms and conditions.

Separately, CMS initiated an Accelerated Payment Program (“Medicare Accelerated Payments”) to hospitals. The Medicare Accelerated Payments represent advance payments for services to be provided and were based on a hospital’s historical Medicare volume. In April 2020, SVH received approximately $66 million in Medicare Accelerated Payments. CMS began recoupment of these payments in April 2021 and will continue to recoup the accelerated payments from billings for services rendered until they are fully repaid. As of June 30, 2023 and 2022, SVH had $0 million and $21.0 million, respectively, in Medicare Accelerated Payments, included in Advanced payments – Medicare in the consolidated statements of financial position. During the years ended June 30, 2023 and 2022, approximately $21.0 million and $39.0 million, respectively, was recouped.

For the year ended June 30, 2023, SVH was obligated and received approximately $5,643,000 in Disaster Relief Funds from the Federal Emergency Management Agency and has recognized this in grant and contribution revenue in the consolidated statements of revenues, expenses and changes in net position.

Charity care – SVH provides care without charge or at less than its established rates to patients who meet certain criteria under its charity care policy. Because SVH does not pursue collection of amounts determined to qualify as charity care, such amounts are not included in net patient service revenues. Charges forgone, based on established rates for the years ended June 30, 2023 and 2022, were $7.7 million and $9.6 million, respectively.

Property taxes – SVH, as part of a California special district, receives property taxes that are assessed by Monterey County. Such amounts are recorded within nonoperating income in the consolidated statements of revenues, expenses, and changes in net position.

Aspire Health Plan – SVH provided funding to Aspire Health Plan, a California nonprofit mutual benefit corporation that operates a Medicare Advantage plan, in exchange for a 49% membership voting interest. Initial funding of $1.5 million was reported as other long-term assets in the consolidated statement of net position as of June 30, 2017. Additional funding of $6.4 million and $4.8 million was included within nonoperating expenses in the consolidated statements of revenue, expense, and changes in net position, for the years ended June 30, 2023 and 2022, respectively, due to the uncertain nature of repayments of ongoing funding.

Concentration of credit risk – SVH is highly dependent upon government programs and nongovernmental third-party payors for its revenues. Net patient service revenue from Medicare amounted to 24% and 20% and negotiated third-party payors amounted to 44% and 47% of total net patient service revenues for the years ended June 30, 2023 and 2022, respectively. Significant concentrations of net patient accounts receivable include Medicaid at 14% and 15% and negotiated third-party payors at 67% and 70% at June 30, 2023 and 2022, respectively.

Income taxes – SVH, being a governmental entity, is therefore tax-exempt. All of its consolidated subsidiaries are either not-for-profit corporations or partnerships and are, therefore, not subject to income taxes.

Note 3 – Net Patient Service Revenues

Net patient service revenues for the years ended June 30 consisted of the following, in thousands:

	2023	2022
Gross patient service revenues:		
Routine inpatient services	$ 448,297	$ 379,768
Ancillary services	2,017,083	1,776,262
Outpatient services	553,109	500,787
Total gross patient service revenues	3,018,489	2,656,817
Deductions from gross patient service revenues:		
Contractual allowance for statutory and negotiated rates	(2,236,297)	(1,925,356)
Provision for doubtful accounts	(47,598)	(45,609)
Charity care	(7,724)	(9,593)
Net patient service revenues	$ 726,870	$ 676,259

SVHMC has agreements with third-party payors that provide for payments to SVHMC at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare – Medicare patient revenues include traditional reimbursement under Title XVIII of the Social Security Act. Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification SVH that is based on clinical, diagnostic, and other factors. Medicare reimburses hospitals for covered outpatient services rendered to its beneficiaries by way of an outpatient prospective payment SVH based upon ambulatory payment classifications.

Certain inpatient and outpatient pass-through costs related to Medicare beneficiaries are paid based on a cost reimbursement methodology. SVHMC is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by SVHMC and audits thereof by the Medicare administrative contractor. SVHMC's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization under contract with SVHMC. SVHMC's Medicare cost reports have been audited by the Medicare administrative contractor through June 30, 2019.

Medi-Cal – Medi-Cal patient revenues include traditional reimbursement under the California State Department of Health Services for patients covered under Title XIX of the Social Security Act. Inpatient services rendered to Medi-Cal program beneficiaries are reimbursed under a contract at prospectively determined negotiated per diem rates. Outpatient services are reimbursed based on a schedule of maximum allowances. For certain inpatient services, SVHMC is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by SVHMC and audits thereof by Medi-Cal. SVHMC's Medi-Cal cost reports have been audited by Medi-Cal through June 30, 2019.

Other – SVHMC has entered into agreements with numerous nongovernment third-party payors to provide patient care to beneficiaries under a variety of payment arrangements. These include arrangements with commercial insurance companies, including workers' compensation plans, which reimburse SVHMC at a percentage of SVHMC's charges.

Billings relating to services rendered are recorded as net patient service revenues in the period in which the service is performed, net of contractual and other allowances that represent differences between gross charges and the estimated receipts under such programs. Net patient service revenues are 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. Receivables for patient care are also reduced for allowances for uncollectible accounts.

The process for estimating the ultimate collection of receivables involves significant assumptions and judgments. Account balances are written off against the allowance when management determines it is probable the receivable will not be recovered. The use of historical collection and payor reimbursement experience is an integral part of the estimation of reserves for uncollectible accounts. Revisions in reserves for uncollectible accounts estimates are recorded as an adjustment to the provision for bad debts.

At the current time there is uncertainty about reimbursements from government programs. Centers for Medicare & Medicaid Services has proposed reductions in rates, which would result in a decrease in Medicare reimbursements. The state budget contains healthcare budget cuts that may affect reimbursements for noncontracted Medi-Cal services. The ultimate outcome of these proposals and other market changes cannot presently be determined.

Under Assembly Bill 1383 of 2009, as amended by Assembly Bill 1653 on September 8, 2010 (collectively, the "Bill"), which establishes a hospital fee program, SVH is exempt from the quality assurance fee but is eligible for supplemental payments under the second part of the Bill, and received $0 million and $3.9 million, respectively, in the years ended June 30, 2023 and 2022, as included in net patient service revenue in the accompanying consolidated statements of revenues, expenses, and changes in net position.

Note 4 – Cash, Cash Equivalents, Investments, and Board-Designated Funds

As of June 30, cash and cash equivalents, investments, and board-designated funds, at fair value, consisted of the following, in thousands:

	2023	2022
Cash and cash equivalents	$ 335,989	$ 315,889
Short-term investments	62,285	81,147
Board-designated funds	157,875	148,633
Long-term investments	102,498	74,674
Total	$ 658,647	$ 620,343

As of June 30, Board-designated funds, at fair value, have been set aside as follows, in thousands:

	2023	2022
By Board for capital improvements	$ 157,785	$ 148,543
By agreement with secured vendor	90	90
Total	$ 157,875	$ 148,633

As of June 30, 2023, maturities for SVH's holdings were as follows, in thousands:

	Fair Value	12 Months or Less	13 to 24 Months	25 to 60 Months	More Than 60 Months
Cash and cash equivalents	$ 335,989	$ 335,989	$ -	$ -	$ -
U.S. Treasury notes	99,766	-	80,088	13,816	5,862
Municipal notes	128,977	-	35,320	52,477	41,180
Corporate notes	71,133	-	16,841	5,305	48,987
Bank certificates of deposit	90	-	90	-	-
Money market accounts	4,201	4,201	-	-	-
Mutual funds	18,491	18,491	-	-	-
Total	$ 658,647	$ 358,681	$ 132,339	$ 71,598	$ 96,029

As of June 30, 2022, maturities for SVH's holdings were as follows, in thousands:

	Fair Value	12 Months or Less	13 to 24 Months	25 to 60 Months	More Than 60 Months
Cash and cash equivalents	$ 315,889	$ 315,889	$ -	$ -	$ -
U.S. Treasury notes	62,869	-	47,079	-	15,790
Municipal notes	153,867	-	23,034	35,132	95,701
Corporate notes	62,967	-	10,947	16,956	35,064
Bank certificates of deposit	90	-	90	-	-
Money market accounts	7,102	7,102	-	-	-
Mutual funds	17,559	17,559	-	-	-
Total	$ 620,343	$ 340,550	$ 81,150	$ 52,088	$ 146,555

The following table below identifies the investment types that are authorized for SVHMC by the California Government Code (or SVHMC's investment policy, where more restrictive). There are no restrictions over the maximum percentage that one investment can represent of the total portfolio, nor any restrictions over the maximum amount of investment in any one issuer. The Foundation and CCMSO are not required to follow the California Government Code.

Authorized Investment Type	Maturity
U.S. Treasury obligations	5 years
U.S. agency securities	5 years
Corporate bonds	5 years
Commercial paper	180 days
Mutual funds	N/A
Money market mutual funds	N/A

Interest rate risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. One of the ways that SVH manages its exposure to interest rate risk is by purchasing a combination of shorter-term and longer-term investments and by maintaining fully liquid investments as needed to fund operations.

Credit risk – Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of a rating by a nationally recognized statistical rating organization.

The following table illustrates the fair value and associated credit ratings of investments held by SVH at June 30, 2023 and 2022, in thousands:

Investment Type	Fair Value at June 30, 2023	Fair Value at June 30, 2022	Ratings
Cash and cash equivalents	$ 335,989	$ 310,204	N/A
U.S. Treasury notes	99,766	62,869	Unrated
Municipal notes	128,977	153,867	Various
Corporate notes	71,133	62,967	Various
Bank certificates of deposit	90	90	AAA
Money market accounts	4,201	12,787	N/A
Mutual funds	18,491	17,559	Not rated
Total	$ 658,647	$ 620,343	

Concentration of credit risk – The investment policy of SVH contains no limitation on the amount that can be invested in any one issuer beyond that stipulated by the California Government Code.

Custodial credit risk – Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, a government will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The custodial credit risk for investments is the risk that, in the event of the failure of the counterparty (e.g., broker-dealer) to a transaction, a government will not be able to recover the value of its investment or collateral securities that are in the possession of another party.

The California Government Code and SVHMC's investment policy do not contain legal or policy requirements that would limit the exposure to custodial risk for deposits or investments, other than the following provision for deposits: the California Government Code requires that a financial institution secure deposits made by state or local governmental units by pledging securities in an undivided collateral pool held by a depositor regulated under state law (unless so waived by the governmental unit). The market value of the pledged securities in the collateral pool must equal at least 110% of the total amount deposited by public agencies. This requirement does not apply to the consolidated subsidiaries of SVH.

As of June 30, 2023 and 2022, approximately $6.4 million and $13.8 million, respectively, of SVH's consolidated subsidiaries' deposits with financial institutions in excess of federal depositor insurance limits were held in accounts not subject to collateralization. SVH's securities are registered under the specific entity's name by the custodial bank as an agent for SVH. Other types of investments represent ownership interests that do not exist in physical or book-entry form. As a result, management considers custodial credit risk to be remote.

Note 5 – Fair Value Measurement

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A fair value hierarchy is also established, which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value.

The following describes three levels of inputs that may be used to measure fair value under GASB Statement No. 72, *Fair Value Measurement and Application*:

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in active markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

The following is a description of the valuation methodologies used for instruments measured at fair value on a recurring basis and recognized in the consolidated statements of net position at June 30, 2023 and 2022, as well as the general classification of such instruments pursuant to the valuation hierarchy:

Mutual funds – Valued at the net asset value of shares held by SVH and are valued at the closing price reported on the active market on which the individual securities are traded.

Municipal notes, corporate notes, U.S. Treasury notes, other fixed income, and federal agency notes – Valued using pricing models maximizing the use of observable inputs for similar securities, which includes basing value on yields currently available on comparable securities of issuers with similar credit ratings.

The following tables present the assets measured at fair value on a recurring basis in the accompanying consolidated statements of net position at June 30, 2023 and 2022, as stratified by fair value hierarchy level, in thousands:

Description	Level 1	Level 2	Level 3	June 30, 2023
Investments by fair value level:				
U.S. Treasury notes	$ 99,766	$ -	$ -	$ 99,766
Municipal notes	128,977	-	-	128,977
Corporate notes	71,133	-	-	71,133
Mutual funds	18,491	-	-	18,491
Total by fair value level	$ 318,367	$ -	$ -	318,367
Cash equivalents:				
Local agency investment fund				94
Cash holdings				335,895
Total cash equivalents				335,989
Bank certificates of deposit				90
Money market accounts				4,201
Total investments				$ 658,647

Description	Level 1	Level 2	Level 3	June 30, 2022
Investments by fair value level:				
U.S. Treasury notes	$ 62,869	$ -	$ -	$ 62,869
Municipal notes	153,867	-	-	153,867
Corporate notes	62,967	-	-	62,967
Mutual funds	17,559	-	-	17,559
Total by fair value level	$ 297,262	$ -	$ -	297,262
Cash equivalents:				
Local agency investment fund				64,450
Cash holdings				245,754
Total cash equivalents				310,204
Bank certificates of deposit				90
Money market accounts				12,787
Total investments				$ 620,343

Fiduciary – Employees' Pension Plan – The following tables present the assets measured at fair value on a recurring basis in the accompanying fiduciary statements of net position at June 30, 2023 and 2022, as stratified by fair value hierarchy level, in thousands:

June 30, 2023	Level 1	Level 2	Level 3	Total
Mutual funds:				
Equity securities	$ 282,251	$ -	$ -	$ 282,251
Fixed income	121,469	-	-	121,469
Total	$ 403,720	$ -	$ -	$ 403,720

June 30, 2022	Level 1	Level 2	Level 3	Total
Mutual funds:				
Equity securities	$ 305,051	$ -	$ -	$ 305,051
Fixed income	137,324	-	-	137,324
Total	$ 442,375	$ -	$ -	$ 442,375

Note 6 – Capital Assets

The following table summarizes SVH's capital asset activity during the year ended June 30, 2023, in thousands:

	June 30, 2022	Increases	Decreases	Transfers	June 30, 2023
Capital assets not depreciated:					
Land	$ 26,059	$ -	$ -	$ -	$ 26,059
Construction in progress	11,591	24,599	-	(2,182)	34,008
Total capital assets not depreciated	37,650	24,599	-	(2,182)	60,067
Capital assets being depreciated/amortized:					
Buildings and improvements	387,344	92	-	1,956	389,392
Movable equipment	237,435	10,651	(6,374)	226	241,938
Intangibles	4,570	4	-	-	4,574
Land improvements	2,080	-	-	-	2,080
Total capital assets being depreciated	631,429	10,747	(6,374)	2,182	637,984
Less: accumulated depreciation and amortization for:					
Buildings and improvements	229,936	11,867	-	-	241,803
Movable equipment	182,859	15,256	(4,980)	-	193,135
Intangibles	5,041	265	-	-	5,306
Land improvements	1,519	53	-	-	1,572
Total accumulated depreciation and amortization	419,355	27,441	(4,980)	-	441,816
Total capital assets being depreciated, net	212,074	(16,694)	(1,394)	2,182	196,168
Capital assets, net	$ 249,724	$ 7,905	$ (1,394)	$ -	$ 256,235

The following table summarizes SVH's capital asset activity during the year ended June 30, 2022, in thousands:

	June 30, 2021	Increases	Decreases	Transfers	June 30, 2022
Capital assets not depreciated:					
Land	$ 26,059	$ -	$ -	$ -	$ 26,059
Construction in progress	8,601	10,662	-	(7,672)	11,591
Total capital assets not depreciated	34,660	10,662	-	(7,672)	37,650
Capital assets being depreciated/amortized:					
Buildings and improvements	382,851	161	-	4,332	387,344
Moveable equipment	226,505	8,802	(1,212)	3,340	237,435
Intangibles	4,564	6	-	-	4,570
Land improvements	2,080	-	-	-	2,080
Total capital assets being depreciated	616,000	8,969	(1,212)	7,672	631,429
Less: accumulated depreciation and amortization for:					
Buildings and improvements	217,729	12,207	-	-	229,936
Movable equipment	169,755	14,207	(1,103)	-	182,859
Intangibles	4,777	264	-	-	5,041
Land improvements	1,465	54	-	-	1,519
Total accumulated depreciation and amortization	393,726	26,732	(1,103)	-	419,355
Total capital assets being depreciated, net	222,274	(17,763)	(109)	7,672	212,074
Capital assets, net	$ 256,934	$ (7,101)	$ (109)	$ -	$ 249,724

SVH reached an agreement with the State of California to meet the California Hospital Seismic Safety Act ("SB1953") by retrofitting and strengthening the existing building. These improvements will result in compliance with SB1953 until January 1, 2030.

Note 7 – Investments in Affiliates

SVH has the following investments in joint ventures, which are accounted for in accordance with GASB Statement No. 14, *The Financial Reporting Entity*:

- Community Health Innovations, LLC ("CHI"), an integrated population health initiative.
- Monterey Peninsula Surgery Center ("MPSC"), a partnership that operates an outpatient Surgery Center.

(in Thousands)

- Monterey Bay Endoscopy Center, LLC ("MBEC"), an outpatient diagnostic center for gastroenterology procedures.
- 21st Century Oncology ("USCC"), a partnership with GenesisCare (formerly known as U.S. Cancer Care).
- Mood Health ("MOOD HEALTH"), equity investment in a start-up company specializing in using technology to help provide psychiatry and therapy and is used by Salinas Valley Health patients.

The following table summarizes the percentage interest of and balance of investments in affiliates at June 30, 2023 and 2022:

	Percentage Interest		Investment Balance	
Affiliate	2023	2022	2023	2022
CHI	49%	49%	$ 1,681	$ 1,644
MPSC	12%	13%	6,523	6,876
USCC	40%	40%	2,577	2,981
MBEC	14%	14%	1,786	1,765
MOOD HEALTH	6%	n/a	1,500	-
			$ 14,067	$ 13,266

Financial information for these affiliates can be obtained from SVH at 450 E. Romie, Salinas, California 93901.

Note 8 – Related-Party Transactions

Central Coast VNA & Hospice, Inc., leases building space from SVH and paid rent in the amount of $309 thousand and $300 thousand during the years ended June 30, 2023 and 2022, respectively.

The Salinas Valley Memorial Hospital Service League ("Service League") is an organization formed for the benefit of SVHMC. Expenses paid by SVHMC on behalf of the Service League during the years ended June 30, 2023 and 2022, totaled $2.2 million and $1.7 million, respectively.

Note 9 – Self-Insurance Liability

SVHMC is self-insured for workers' compensation claims. Estimated losses of $15.5 million and $15.6 million have been accrued under actuarially determined calculations at June 30, 2023 and 2022, of which approximately $2.5 million and $2.4 million are considered current liabilities, respectively.

The following is a summary of changes in workers' compensation self-insurance liabilities for 2023 and 2022, in thousands:

	Beginning Balance	Increases	Decreases	Ending Balance	Current Portion
2023	$ 15,594	$ 3,757	$ (3,828)	$ 15,523	$ 2,495
2022	$ 16,087	$ 3,717	$ (4,210)	$ 15,594	$ 2,378

SVHMC is self-insured for employee medical coverage. The estimated liability for employee medical coverage claims incurred but not reported is based on historical claims experience and is considered a current liability. The balances at June 30, 2023 and 2022, were approximately $8.0 million and $8.0 million, respectively.

SVHMC maintains a $40.0 million claims-made medical malpractice policy with BETA, a shared risk pool for California hospital districts. Membership of the Board of BETA is comprised of management of district hospitals. Hospital premiums are established annually based on the experience of the pool and SVHMC. SVHMC paid premiums of approximately $1.8 million and $1.9 million to BETA for the years ended June 30, 2023 and 2022, respectively. SVHMC's policy with BETA is renewed every 12 months; the most recent renewal date was July 1, 2023. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during its term but reported subsequently will be uninsured. SVHMC may purchase extended reporting endorsements upon cancellation. The length of the reporting endorsement is not limited. As SVHMC has retained risk for claims incurred during the policy period that are not reported prior to the expiration of the policy, the liability for such retained medical malpractice risk has been recorded on SVH's consolidated financial statements. Such liability has been actuarially determined, is considered a current liability, and at June 30, 2023 and 2022, was approximately $2.3 million and $2.8 million, respectively.

Note 10 – Notes Payable, Net

The following table summarizes activity in notes payable, net, during the year ended June 30, 2023, in thousands:

	June 30, 2022	Decreases	June 30, 2023 Total	June 30, 2023 Current Portion	June 30, 2023 Long-Term Portion
Note payable, due in monthly installments of approximately $10 thousand including interest at 3.99%, with balance due in 2030, collateralized by specified property.	$ 855	$ (100)	$ 755	$ 101	$ 654
	855	$ (100)	755	$ 101	$ 654
Less: current portion	101		101		
Notes payable, net of current portion	$ 754		$ 654		

The following table summarizes activity in notes payable, net, during the year ended June 30, 2022, in thousands:

	June 30, 2021	Decreases	June 30, 2022 Total	June 30, 2022 Current Portion	June 30, 2022 Long-Term Portion
Note payable, due in monthly installments of approximately $10 thousand including interest at 3.99%, with balance due in 2030, collateralized by specified property.	$ 949	$ (94)	$ 855	$ 101	$ 754
CCMSO loan under the Paycheck Protection Program under the CARES Act. The loan bears interest at 1% with no payments for the first six months. Monthly payments of principal and interest of approximately $61 thousand begin in November 2020 and continue through maturity in April 2022, if required. The loan is subject to partial or full forgiveness if the CCMSO uses all proceeds for eligible purposes; maintains certain employment levels; and maintains certain compensation levels in accordance with and subject to the CARES Act and the rules, regulations, and guidance.	1,079	(1,079)	-	-	-
	2,028	$ (1,173)	855	$ 101	$ 754
Less: current portion	765		101		
Notes payable, net of current portion	$ 1,263		$ 754		

Certain bank loans contain clauses that allow the bank to accelerate the amount due, without objective criteria (subjective acceleration clauses); management considers the likelihood of these clauses being invoked to be remote and has therefore classified this debt as current and noncurrent based on scheduled payment due dates.

Future debt service payments for each of the five fiscal years subsequent to June 30, 2023, and thereafter are as follows, in thousands:

Years Ending June 30,	Principal	Interest	Total
2024	$ 101	$ 24	$ 125
2025	109	20	129
2026	109	20	129
2027	114	15	129
2028	123	6	129
Thereafter	199	79	278
Total	$ 755	$ 164	$ 919

Note 11 – Employee Benefit Plans

Salinas Valley Memorial Healthcare District employees' pension plans – All permanent employees, including executive management, are eligible to participate in appropriate pension plans sponsored by SVHMC (the "Plans").

Under the various plans sponsored by SVHMC, permanent employees can participate after completing three years of service and reaching the age of 21 and, in other cases, eligible employees can participate after one year of service. The Plans are single-employer defined benefit retirement plans administered by SVHMC. The Plans also provide retirement, disability, and death benefits based on the employee's years of service, age, and annual compensation during covered employment. Employees generally vest after five years of service, are eligible to receive benefits after 10 years, and may receive early retirement benefits at age 50 with 15 years of service. Normal retirement is at age 65 with at least 10 years of service. In other cases, employees are not eligible to receive benefits until reaching normal retirement at age 65 or an agreed-upon date of retirement beyond age 65. Effective March 31, 2011, the Plans were amended to cease further benefit accruals for nonunion employees. These benefit provisions and all other requirements are established by the District's Board of Directors. Separate financial statements are issued for the Salinas Valley Memorial Healthcare District employees' pension plan.

Contributions – The Plan directs SVH to make contributions based on actuarially determined contribution amounts. SVH reserves the right to suspend or reduce contributions to the Plan at any time, upon appropriate action by the Board. In accordance with PEPRA, certain members are required to make contributions based on a percentage of their eligible compensation to the Plan.

Benefits – The benefit formula payable to a participant who retires on his or her normal retirement date of age 65 shall be a monthly benefit for the life of the member. The benefit payable to a participant is computed as 2.45% of the participant's earnings during a year of credited service, as defined by the Plan, multiplied by the number of years of credited service for the participant.

In accordance with the provisions of PEPRA, certain participants hired after January 1, 2013, who retire at their normal retirement age of age 65, shall receive a retirement benefit computed as 2.30% of the participant's final annual compensation multiplied by their number of years of service in the Plan.

A participant who has attained age 52, completed 15 years of service, and five years of plan participation may elect early retirement on the first day of any month prior to the participant's normal retirement date, with certain defined-benefit reductions. A participant may elect to receive benefits in the form of a single life annuity, alternate annuity option, certain period option, or Social Security adjustment option, as defined in the plan document. Upon the death of a participant who is currently employed by SVH and prior to commencement of payments of benefits under this Plan, death benefits are distributed to the designated beneficiary.

Vesting – Employees are eligible to receive benefits after a minimum of 10 years of service. Participants may receive early retirement benefits after a minimum of 15 years of service.

Plan termination – SVH expects to continue the Plan indefinitely but reserves the right to terminate the Plan at any time by appropriate action. In the event of such termination, each affected employee shall become 100% vested in the participant's accrued benefit.

Summary of Significant Accounting Policies – Fiduciary

Basis of accounting – The Plan's financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America as applied to governmental units, using the accrual basis of accounting. The GASB is the accepted standard setting body for establishing governmental accounting and financial reporting principles.

Use of estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, and changes therein, disclosure of contingent assets and liabilities, and the actuarial value of assets and actuarial accrued liability at the date of the financial statements. Actual results could differ from those estimates.

Investment valuation – Investments are reported at fair value. Securities traded on national exchanges are valued at the last reported sales price on the last business day of the plan year. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

Income recognition – Purchases and sales of investments are recorded on a trade-date basis. Dividends are recorded on the ex-dividend date. Net appreciation (depreciation) in fair value of investments consists of both the realized gains and losses and unrealized appreciation and depreciation of those investments.

Benefit payments – Benefit payments to participants are recorded when paid.

(in Thousands)

Administrative expenses – The Plan's administrative expenses are paid either by the Plan or SVH, as provided by the plan document. Certain expenses for the general administration of the Plan are paid directly by SVH and are excluded from the fiduciary financial statements. Certain investment-related expenses are included in investment income within the accompanying statements of changes in fiduciary net position.

SVHMC's net pension liability (asset) was measured as of June 30, 2023 and 2022, as determined by an actuarial valuation as of December 31, 2022 and 2021, rolled forward to June 30, 2023 and 2022, respectively.

Employer contributions – Employer contributions are determined by SVH's Board of Directors each year based on the actuarially determined required contribution amount calculated by the Plan's independent actuary. The actuarially determined required contribution is determined as part of an actuarial valuation on January 1 of each year, using the traditional unit credit actuarial cost method. Actuarially determined contribution amounts were $10.1 million and $13.1 million for the years ended June 30, 2023 and 2022, respectively, all of which were contributed to the Plan as directed and approved by the Board. SVH, at the decision of the Board of Directors, contributed amounts greater than the actuarially determined contribution amounts. During the years ended June 30, 2023 and 2022, actual contributions were $61.6 million and $23.1 million, respectively, representing excesses of $51.5 million and $10.0 million, respectively.

Pension expense – Pension expense for SVHMC's Plan is based upon GASB Statement No. 68, *Accounting and Financial Reporting for Pensions—An Amendment of GASB Statement 27* ("GASB No. 68"). SVHMC's funding policy is to contribute to the plans based on actuarial estimates of the annual required contributions, calculated using the traditional unit credit cost method.

Participant data for the Plan, as of the measurement dates, as follows:

	January 1, 2023	January 1, 2022
Active	1,265	1,261
Inactive	236	223
Retired and beneficiaries	438	744
Vested terminated	794	379
Total participants	2,733	2,607

Components of pension cost and deferred outflows and inflows of resources as calculated under the requirements of GASB No. 68 are as follows, in thousands:

	June 30, 2023	June 30, 2022
Deferred outflows - actuarial:		
Difference between expected and actual experience	$ 2,895	$ 3,848
Changes in assumptions	16,331	26,532
Net difference between projected and actual earnings on pension plan investments	91,858	6,862
Contribution to the pension plan after measurement date	5,038	57,767
Total	$ 116,122	$ 95,009
Deferred inflows - actuarial:		
Difference between expected and actual experience	$ 7,794	$ 9,110
Changes in assumptions	10,379	12,780
Net difference between projected and actual earnings on pension plan investments	28,189	43,470
Additional pension expense recognition	15,667	13,000
Total	$ 62,029	$ 78,360

Amounts reported as deferred outflows – actuarial and deferred inflows – actuarial to pensions (net) will be recognized in pension expense as follows, in thousands:

Years Ending June 30,	
2024	$ 15,511
2025	5,039
2026	10,021
2027	14,093
2028	21,059
Thereafter	(1,001)
	$ 64,722

The following tables summarize changes in pension liability for fiscal years ended June 30, 2023 and 2022, with a measurement date of January 1, 2023 and 2022, respectively, in thousands:

	2023	2022
Total pension liability:		
Service cost	$ 10,508	$ 9,971
Interest on total pension liability	28,712	27,965
Difference between expected and actual experience	(2,138)	4,183
Changes of assumptions	-	(13,645)
Benefit payments	(18,836)	(16,233)
Net change in total pension liability	18,246	12,241
Total pension liability, beginning of year	440,485	428,244
Total pension liability, end of year	$ 458,731	$ 440,485

The following table summarizes the net pension liability (asset) at June 30, 2023 and 2022, as well as other required disclosures of financial measures, in thousands:

	2023	2022
Total pension liability	$ 458,731	$ 440,485
Plan fiduciary net position	(403,720)	(442,375)
Net pension liability (asset)	$ 55,011	$ (1,890)
Plan fiduciary net position as a percentage of the total pension liability	88.01%	100.43%
Covered-employee payroll	$ 142,050	$ 138,820
Plan net pension liability as of a percentage of covered-employee payroll	38.73%	-1.36%

The following table summarizes the actuarial assumptions used to determine net pension liability and plan fiduciary net position as of June 30, 2023 and 2022:

Valuation date:	Actuarially determined contributions are calculated as of January 1, the first day of the fiscal year in which the contributions are reported
Methods and assumptions used:	
Actuarial cost method	Entry age normal
Inflation	2.25%
Salary increases	3.50% or 3.75% depending on unit, including inflation, plus step increases
Investment rate of return	6.50%, net of investment expense, including inflation
Retirement age:	
Normal retirement	65
Early retirement	50 and 15 years of vesting service
Mortality	PubG-2010 Generational Mortality Table for Males & Females, projected using MP-2021

The following table summarizes the impact of a 1% change in discount rate on the value of the net pension liability at June 30, 2023 and 2022, in thousands:

	1% Decrease (5.50%)	Current Discount Rate (6.50%)	1% Increase (7.50%)
June 30, 2023	$ 115,491	$ 55,011	$ 4,568
June 30, 2022	$ 56,596	$ (1,890)	$ (50,752)

Defined benefit post-retirement medical plans – SVHMC administers single-employer defined benefit healthcare reimbursement plans providing limited reimbursement for health insurance premiums paid by members of two bargaining units who retire early from their retirement date until they are eligible for Medicare. Benefit provisions are established through negotiations between SVHMC and the bargaining units and are renegotiated when bargaining agreements expire. The retiree health plans do not issue publicly available financial reports.

SVHMC funds the benefits on a pay-as-you-go basis. During the years ended June 30, 2023 and 2022, SVHMC contributed $189 thousand and $132 thousand, respectively, to fund benefits.

At June 30, the following employees were covered by SVHMC:

	2023	2022
Active employees	1,194	1,194
Retirees receiving benefits	100	100
Total plan participants	1,294	1,294

Components of post-retirement medical benefits expense, as calculated under the requirements of GASB No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions* ("GASB No. 75"), were as follows as of June 30, in thousands:

	2023	2022
Service cost	$ 211	$ 188
Interest	111	103
Differences between expected and actual experience	(48)	(7)
Changes of assumptions	(36)	7
Total post-retirement medical benefits expense	$ 238	$ 291

Deferred inflows and outflows of resources to post-retirement medical benefits under GASB No. 75 are as follows as of June 30, in thousands:

	2023	2022
Deferred outflows of resources as of June 30:		
Difference between expected and actual experience	$ 348	$ 376
Changes in assumptions	441	472
Total	$ 789	$ 848
Deferred inflows of resources as of June 30:		
Difference between expected and actual experience	$ 893	$ 407
Changes in assumptions	859	344
Total	$ 1,752	$ 751

Amounts reported as deferred outflows and inflows of resources to post-retirement medical benefits will be recognized in post-retirement medical benefits expense as follows for the years ending June 30, in thousands:

Year Ending June 30,	
2024	$ (84)
2025	(84)
2026	(84)
2027	(84)
2028	(84)
Thereafter	(543)
	$ (963)

The following table summarizes changes in post-retirement medical benefits liability, reflected as other long-term liabilities on the consolidated statements of net position, as of June 30, 2023 and 2022, with a measurement date of June 30, 2022 and 2021, respectively, in thousands:

	2023	2022
Service cost	$ 211	$ 188
Interest	111	103
Differences between expected and actual experience	(556)	352
Changes in assumptions	(583)	(61)
Contributions - employer	(189)	(132)
Net change	(1,006)	450
Net post-retirement medical benefits liability, beginning of year	5,007	4,557
Net post-retirement medical benefits liability, end of year	$ 4,001	$ 5,007

The following table summarizes the actuarial assumptions used to determine net pension asset and plan fiduciary net position as of June 30, 2023 and 2022:

Valuation Date	June 30, 2021
Actuarial cost method	Entry Age Normal
Asset valuation method	Not applicable
Actuarial assumptions:	
Projected salary increases	3.25%
Mortality	PubG-2010 Generational Mortality Tables projected using scale MP-2021 improvement table
Discount rate	4.09%
Healthcare cost trend rates:	6.25% for 2023, graded to 5.00% for year 2028 and beyond for ages pre-65; and 5% for year 2021 and beyond for ages post-65.

The following table summarizes the impact of a 1% change in discount rate on the value of the post-retirement medical benefits liability at June 30, 2023 and 2022, in thousands:

	1% Decrease	Current Discount Rate	1% Increase
June 30, 2023	$ 4,272	$ 4,001	$ 3,783
June 30, 2022	$ 5,256	$ 5,007	$ 4,761

The following table summarizes the impact of a 1% change in healthcare cost trend rate on the value of the post-retirement medical benefits liability at June 30, 2023 and 2022, in thousands:

	1% Decrease	Current Cost Trend Rate	1% Increase
June 30, 2023	$ 3,996	$ 4,001	$ 4,084
June 30, 2022	$ 4,968	$ 5,007	$ 5,035

Note 12 – Compensated Absences

The employees of SVH can earn paid leave at varying rates depending on the length of service and job classification. Earned paid leave consists of vacation and holiday pay, which vests to the employee immediately, and sick leave, which is available to the employee only for absences for valid medical reasons. Employees can accumulate up to two years' accruals of paid leave. Upon termination, unused earned paid leave balances are paid in full. The following table summarizes changes in compensated absences for the years ended June 30, in thousands:

	Beginning Balance	Increases	Decreases	Ending Balance	Current Portion
2023	$ 20,753	$ 34,443	$ (33,733)	$ 21,463	$ 21,463
2022	$ 20,232	$ 35,457	$ (34,936)	$ 20,753	$ 20,753

Note 13 – Leases

As discussed in Note 2, SVH recognizes right-of-use assets and lease liabilities at lease inception in an amount equal to the present value of the undiscounted future minimum lease payments. SVH uses a discount rate that is explicitly stated or implicit in the contract. When a readily determinable discount rate is not available, the discount rate is determined using SVH's incremental borrowing rate at start of the lease for a similar asset type and term length to the contract.

SVH is a lessee for various noncancelable leases of office space and equipment with lease terms through 2031. During the years ended June 30, 2023 and 2022, there were no residual value guarantees included in the measurement of SVH's lease liabilities, and SVH did not incur any commitments at the commencement of any leases. There were no amounts recognized as variable lease payments as lease expense in the consolidated statements of changes of revenues, expenses, and net position during the years ended June 30, 2023 and 2022. SVH incurred no termination penalties during the years ended June 30, 2023 and 2022.

The following tables summarize right-of-use asset activity during the years ended June 30, 2023 and 2022, in thousands:

June 30, 2023	Beginning Balance	Increases	Decreases	Ending Balance
Right-of-use assets	$ 13,118	$ 11,207	$ (2,487)	$ 21,838
Less: accumulated amortization	(5,827)	(3,545)	1,456	(7,916)
Right-of-use assets, net	$ 7,291	$ 7,662	$ (1,031)	$ 13,922

June 30, 2022	Beginning Balance	Increases	Decreases	Ending Balance
Right-of-use assets	$ 12,485	$ 633	$ -	$ 13,118
Less: accumulated amortization	(2,745)	(3,082)	-	(5,827)
Right-of-use assets, net	$ 9,740	$ (2,449)	$ -	$ 7,291

During the years ended June 30, 2023 and 2022, SVH recognized $3,545 thousand and $3,082 thousand, respectively, in amortization expense included within depreciation and amortization expense in the consolidated statements of revenues, expenses, and changes in net position.

The following table summarizes lease liability activity during the years ended June 30, 2023 and 2022, in thousands:

Year Ended June 30,	Beginning Balance	Increases	Decreases	Ending Balance	Current Portion
2023	$ 7,620	$ 10,033	$ (2,572)	$ 15,081	$ 3,650
2022	$ 10,038	$ 638	$ (3,056)	$ 7,620	$ 2,674

SVH's future principal and interest lease payments under lease agreements as of June 30, 2023, were as follows, in thousands:

Year Ending June 30,	Principal	Interest	Total
2024	$ 3,650	$ 432	$ 4,082
2025	3,209	306	3,515
2026	2,463	217	2,680
2027	2,094	147	2,241
2028	1,370	92	1,462
Thereafter	2,295	146	2,441
Total	$ 15,081	$ 1,340	$ 16,421

SVH evaluated the right-of-use assets for impairment and determined no impairment occurred during the years ended June 30, 2023 and 2022.

SVH is also a lessor for noncancelable leases of office space with lease terms through 2026. For the years ended June 30, 2023 and 2022, SVH recognized $138 thousand and $849 thousand, respectively, in lease revenue released from the deferred inflows of resources related to the office lease included in other revenue within the consolidated statement of revenues, expenses, and changes in net position. No inflows of resources were recognized in the year related to termination penalties or residual value guarantees during fiscal years ended June 30, 2023 and 2022.

Note 14 – Subscription-Based Information Technology Arrangements

As discussed in Note 2, SVH accounts for SBITAs in accordance with GASB No. 96. SVH has entered into various SBITAs, with ranging maturities extending until 2028. During the years ended June 30, 2023 and 2022, total payments under SBITAs were $5.9 million and $4.9 million, respectively. Additionally, the SVH incurred no variable SBITA expenses during the years ended June 30, 2023 and 2022. SVH did not enter into any additional SBITAs that have yet to commence as of June 30, 2023.

The following tables summarize subscription asset activity during the years ended June 30, 2023 and 2022, in thousands:

June 30, 2023	Beginning Balance	Increases	Decreases	Ending Balance
Subscription assets	$ 19,920	$ 360	$ -	$ 20,280
Less: accumulated amortization	(4,667)	(4,858)	-	(9,525)
Subscription assets, net	$ 15,253	$ (4,498)	$ -	$ 10,755

June 30, 2022	Beginning Balance	Increases	Decreases	Ending Balance
Subscription assets	$ 19,446	$ 474	$ -	$ 19,920
Less: accumulated amortization	-	(4,667)	-	(4,667)
Subscription assets, net	$ 19,446	$ (4,193)	$ -	$ 15,253

The following table summarizes subscription liability activity during the years ended June 30, 2023 and 2022, in thousands:

Year Ended June 30,	Beginning Balance	Increases	Decreases	Ending Balance	Current Portion
2023	$ 15,434	$ 359	$ (5,447)	$ 10,346	$ 4,631
2022	$ 19,446	$ 474	$ (4,486)	$ 15,434	$ 5,319

SVH's future principal and interest payments under SBITAs as of June 30, 2023 were as follows, in thousands:

Year Ending June 30,	Principal	Interest	Total
2024	$ 4,631	$ 224	$ 4,855
2025	3,727	113	3,840
2026	1,327	59	1,386
2027	312	22	334
2028	322	12	334
Thereafter	27	1	28
Total	$ 10,346	$ 431	$ 10,777

Note 15 – Restatements

The adoption of GASB No. 96 resulted in the following adjustments to the prior-period consolidated financial statements as of and for the year ended June 30, 2022, in thousands:

	As Previously Presented	Adjustment	As restated
Consolidated statement of net position:			
Assets and deferred outflows:			
Subscription assets, net of amortization	$ -	$ 15,253	$ 15,253
Total other assets	$ 100,191	$ 15,434	$ 115,625
Total assets	$ 1,015,916	$ 15,434	$ 1,031,350
Total assets and deferred outflows	$ 1,113,161	$ 15,434	$ 1,128,595
Liabilities, deferred inflows, and net position:			
Subscription liabilities, current portion	$ -	$ 5,319	$ 5,319
Total current liabilities	$ 136,071	$ 5,319	$ 141,390
Subscription liabilities, net of current portion	$ -	$ 10,115	$ 10,115
Total liabilities	$ 160,837	$ 15,434	$ 176,271
Total liabilities and deferred inflows	$ 242,305	$ 15,434	$ 257,739
Net position, end of year	$ 870,856	$ -	$ 870,856
Total liabilities, deferred inflows, and net position	$ 1,113,161	$ 15,434	$ 1,128,595

(in Thousands)

Consolidated statement of revenues, expenses, and changes in net position:						
Depreciation and amortization expense	$	29,814	$	4,667	$	34,481
Purchased services	$	55,533	$	(5,026)	$	50,507
Total operating expenses	$	650,000	$	(359)	$	649,641
Operating income	$	45,653	$	359	$	46,012
Increase in net position	$	41,925	$	-	$	41,925
Net position, end of year	$	870,856	$	-	$	870,856
Consolidated statement of cash flows:						
Cash flows from operating activities:						
Cash payments to suppliers for goods and services	$	(277,757)	$	5,398	$	(272,359)
Net cash (used in) provided by operating activities	$	(19,929)	$	5,398	$	(14,531)
Cash flows from capital and related financing activities:						
Payments on subscription liabilities	$	-	$	(4,924)	$	(4,924)
Purchase of subscription assets	$	-	$	(474)	$	(474)
Net cash used in capital and related financing activities	$	(19,971)	$	(5,398)	$	(25,369)
Reconciliation of operating income to net cash (used in) provided by operating activities:						
Operating income	$	45,653	$	359	$	46,012
Depreciation and amortization	$	29,814	$	4,667	$	34,481

Note 16 – Commitments and Contingencies

Litigation –SVH is involved in litigation related to various matters. In the opinion of management, after consultation with legal counsel, the outcome of these matters will not have a material adverse effect on SVH's consolidated financial position.

Compliance – The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions. Recently, government activity has increased with respect to investigations and allegations concerning possible violations by healthcare providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. SVH is subject to such regulatory reviews, and, while these reviews may result in repayments and/or civil remedies, management believes, based on its current knowledge and information, that such repayments and/or civil remedies would not have a material effect on SVH's consolidated financial position.

Regulatory environment – The healthcare 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, and government healthcare 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 healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. While no regulatory inquiries have been made, 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 17 – Subsequent Events

Subsequent events are events or transactions that occur after the date of the consolidated statement of net position, but before the date the consolidated financial statements are available to be issued. SVH recognizes in the consolidated financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the consolidated statement of net position, including the estimates inherent in the process of preparing the consolidated financial statements. SVH's consolidated financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the consolidated statement of net position, but arose after the date of the consolidated statement of net position and before the consolidated financial statements are available to be issued.

Supplementary Information

Salinas Valley Memorial Healthcare System
Consolidating Statement of Net Position
June 30, 2023

	Salinas Valley Memorial Hospital	Central Coast Medical Service Organization	Salinas Valley Memorial Hospital Foundation	SVMH-LPCH NICU JV	SVHC	Eliminations Increase (Decrease)	Salinas Valley Memorial Healthcare System
ASSETS AND DEFERRED OUTFLOWS							
CURRENT ASSETS							
Cash and cash equivalents	$ 328,844	$ 4,456	$ 714	$ -	$ 1,975	$ -	$ 335,989
Patient accounts receivable, net of estimated uncollectibles of $27,288 at June 30, 2023	89,620	1,127	-	-	6,687	-	97,434
Short-term investments	62,285	-	-	-	-	-	62,285
Supplies inventory	8,016	155	-	-	-	-	8,171
Lease receivable, current portion	1,922	277	-	-	150	(1,082)	1,267
Other current assets	10,620	1,083	13	-	3,101	(654)	14,163
Total current assets	501,307	7,098	727	-	11,913	(1,736)	519,309
BOARD-DESIGNATED FUNDS	157,875	-	-	-	-	-	157,875
CAPITAL ASSETS							
Nondepreciable	58,876	1,191	-	-	-	-	60,067
Depreciable, net	186,953	3,872	-	590	4,753	-	196,168
Total capital assets, net	245,829	5,063	-	590	4,753	-	256,235
OTHER ASSETS							
Right-of-use assets, net of amortization	5,682	4,537	-	-	4,741	(1,038)	13,922
Subscription assets, net of amortization	10,755	-	-	-	-	-	10,755
Lease receivable, net of current portion	1,116	53	-	-	-	-	1,169
Long-term investments	83,122	-	19,376	-	-	-	102,498
Investments in affiliates	31,011	-	-	-	-	(16,944)	14,067
Other long-term assets	-	1,139	493	-	-	(191)	1,441
Total other assets	131,686	5,729	19,869	-	4,741	(18,173)	143,852
Total assets	1,036,697	17,890	20,596	590	21,407	(19,909)	1,077,271
DEFERRED OUTFLOWS - ACTUARIAL	116,911	-	-	-	-	-	116,911
DEFERRED OUTFLOWS - GOODWILL	532	-	-	-	605	-	1,137
Total deferred outflows	117,443	-	-	-	605	-	118,048
Total assets and deferred outflows	$ 1,154,140	$ 17,890	$ 20,596	$ 590	$ 22,012	$ (19,909)	$ 1,195,319

Salinas Valley Memorial Healthcare System
Consolidating Statement of Net Position (Continued)
June 30, 2023

	Salinas Valley Memorial Hospital	Central Coast Medical Service Organization	Salinas Valley Memorial Hospital Foundation	SVMH-LPCH NICU JV	SVHC	Eliminations Increase (Decrease)	Salinas Valley Memorial Healthcare System
LIABILITIES, DEFERRED INFLOWS, AND NET POSITION (DEFICIT)							
CURRENT LIABILITIES							
Notes payable, current portion	$ -	$ 262	$ -	$ -	$ -	$ (161)	$ 101
Accounts payable	10,069	43	564	-	1,112	-	11,788
Accrued expenses	51,569	1,887	-	-	10,089	-	63,545
Estimated third-party payor settlements	5,404	-	-	-	-	-	5,404
Lease liabilities, current portion	1,895	907	-	-	1,930	(1,082)	3,650
Subscription liabilities, current portion	4,631	-	-	-	-	-	4,631
Self-insurance liabilities, current portion	12,874	-	-	-	-	-	12,874
Total current liabilities	86,442	3,099	564	-	13,131	(1,243)	101,993
NET PENSION LIABILITY	55,011	-	-	-	-	-	55,011
NET POST-RETIREMENT MEDICAL BENEFITS LIABILITY	4,001	-	-	-	-	-	4,001
NOTES PAYABLE, net of current portion	-	845	-	-	-	(191)	654
LEASE LIABILITIES, net of current portion	3,980	4,463	-	-	2,988	-	11,431
SUBSCRIPTION LIABILITIES, net of current portion	5,715	-	-	-	-	-	5,715
SELF-INSURANCE LIABILITIES, net of current portion	13,027	-	-	-	-	-	13,027
Total liabilities	168,176	8,407	564	-	16,119	(1,434)	191,832
DEFERRED INFLOWS - ACTUARIAL	63,781	-	-	-	-	-	63,781
DEFERRED INFLOWS - LEASES	2,857	300	-	-	100	(1,038)	2,219
Total deferred inflows	66,638	300	-	-	100	(1,038)	66,000
Total liabilities and deferred inflows	234,814	8,707	564	-	16,219	(2,472)	257,832
NET POSITION (DEFICIT)							
Invested in capital assets, net of related debt	246,045	3,123	-	590	4,576	396	254,730
Reserved for minority interest	-	-	-	-	-	(4,705)	(4,705)
Restricted - expendable	-	-	5,602	-	-	-	5,602
Restricted - nonexpendable	-	-	1,205	-	-	-	1,205
Unrestricted	673,281	6,060	13,225	-	1,217	(13,128)	680,655
Total net position (deficit)	919,326	9,183	20,032	590	5,793	(17,437)	937,487
Total liabilities, deferred inflows, and net position (deficit)	$ 1,154,140	$ 17,890	$ 20,596	$ 590	$ 22,012	$ (19,909)	$ 1,195,319

Salinas Valley Memorial Healthcare System
Consolidating Statement of Revenues, Expenses, and Changes in Net Position
Year Ended June 30, 2023

	Salinas Valley Memorial Hospital	Central Coast Medical Service Organization	Salinas Valley Memorial Hospital Foundation	SVMH-LPCH NICU JV	SVHC	Eliminations Increase (Decrease)	Salinas Valley Memorial Healthcare System
OPERATING REVENUES							
Net patient service revenues	$ 625,279	$ 20,676	$ -	$ 10,702	$ 70,213	$ -	$ 726,870
Other revenues	17,574	-	-	-	13,958	(9,054)	22,478
Total operating revenues	642,853	20,676	-	10,702	84,171	(9,054)	749,348
OPERATING EXPENSES							
Salaries and wages	196,206	8,724	-	4,592	23,597	-	233,119
Compensated absences	33,521	838	-	922	2,604	-	37,885
Employee benefits	103,337	1,392	-	2,272	5,371	-	112,372
Supplies	81,354	1,418	-	765	7,256	-	90,793
Purchased services	44,450	815	1,540	348	15,265	(1,540)	60,878
Medical fees	24,389	2,961	-	2,455	54,605	(10,242)	74,168
Other fees	35,095	1,050	-	24	12,905	-	49,074
Depreciation and amortization	28,938	1,696	-	252	5,996	(1,038)	35,844
Other expenses	20,424	2,353	3,022	86	3,431	(1,533)	27,783
Total operating expenses	567,714	21,247	4,562	11,716	131,030	(14,353)	721,916
Operating income (loss)	75,139	(571)	(4,562)	(1,014)	(46,859)	5,299	27,432
NONOPERATING REVENUES AND EXPENSES							
Grants and contributions	16,407	210	4,254	-	3,850	(4,254)	20,467
Property tax revenue	5,721	-	-	-	-	-	5,721
Investment income (loss), net	15,819	76	1,689	-	1,885	(187)	19,282
(Provision for) reversal of credit losses	(6,362)	339	-	-	109	-	(5,914)
Gain (loss) on disposal of capital assets	(1,202)	160	-	-	-	-	(1,042)
(Loss) income from investments in affiliates	(43,415)	-	-	-	-	45,586	2,171
Other	1,429	(418)	512	-	2,975	(6,521)	(2,023)
Nonoperating (loss) income, net	(11,603)	367	6,455	-	8,819	34,624	38,662
Income before minority interest	63,536	(204)	1,893	(1,014)	(38,040)	39,923	66,094
CAPITAL TRANSFERS	-	(1,100)	-	861	33,085	(32,846)	-
MINORITY INTEREST IN NET INCOME OF CONSOLIDATED AFFILIATES	-	-	-	-	-	537	537
INCREASE (DECREASE) IN NET POSITION	63,536	(1,304)	1,893	(153)	(4,955)	7,614	66,631
NET POSITION, beginning of year	855,790	10,487	18,139	743	10,748	(25,051)	870,856
NET POSITION (DEFICIT), end of year	$ 919,326	$ 9,183	$ 20,032	$ 590	$ 5,793	$ (17,437)	$ 937,487

Salinas Valley Memorial Healthcare System
Supplementary Schedule of Community Benefit (Unaudited)
Year Ended June 30, 2023

SVH maintains records to identify and monitor the level of direct community benefit it provides. These records include the charges foregone for providing the patient care furnished under its charity care policy. For the years ended June 30, 2023 and 2022, the estimated costs of providing community benefit in excess of reimbursement from governmental programs were as follows, in thousands:

	2023	2022
Unpaid costs of Medi-Cal programs	$ 148,730	$ 121,368
Indigent charity care and bad debt	11,005	10,981
	$ 159,735	$ 132,349

In furtherance of its purpose to benefit the community, SVH provides numerous other services to the community for which charges are not generated and revenues have not been accounted for in the accompanying consolidated financial statements. The services include health related programming and education that reached over 37,000 people in the community and participation in health fairs that reached over 7,000 people. The estimated costs of Medicare programs in excess of reimbursement from Medicare were $184.3 million and $164.4 million for the years ended June 30, 2023 and 2022, respectively.

SVH also provides services to the community through the operations of the Service League. Services provided by volunteers of the Service League, free of charge to the community, include assistance and counseling to patients and visitors, daily personal contact with members of the community who are living alone, career counseling and programs for local students, spiritual care volunteers representing many local faith community congregations, palliative care program assistance, and provision of scholarship awards to qualifying students in the medical professions. During the year ended June 30, 2023 and 2022, these volunteers contributed approximately 13,800 and 14,170 hours, respectively, in providing these services, the value of which is not recorded in the accompanying consolidated financial statements.

Salinas Valley Memorial Healthcare System
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2023

Federal Grantor/Pass - Through Grantor/Program or Cluster Title	Federal Assistance Listing Number	Pass-Through Entity Identifying Number	Federal Expenditures
U.S. Department of Health and Human Services			
Direct Programs			
COVID-19 Provider Relief Funds and American Rescue Plan (ARP) Rural Distribution	93.498	N/A	$ 12,150,139
COVID-19 Testing and Mitigation for Rural Health Clinics	93.697	N/A	100,000
Total U.S. Department of Health and Human Services			12,250,139
U.S. Department of Homeland Security			
Pass-Through Programs From The California Governor's Office of Emergency Services:			
COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)	97.036	PA-09-CA-4482-PW-00626(1293)	2,641,961
COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)	97.036	PA-09-CA-4482-PW-01246(1277)	1,056,024
COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)	97.036	PA-09-CA-4482-PW-01302(1220)	843,047
COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)	97.036	PA-09-CA-4482-PW-01752(1188)	427,840
COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)	97.036	PA-09-CA-4482-PW-02281(1411)	674,497
Total U.S. Department of Homeland Security			5,643,369
Total Expenditures of Federal Awards			$ 17,893,508

See accompanying notes to schedule of expenditures of federal awards.

Salinas Valley Memorial Healthcare System
Notes to Schedule of Expenditures of Federal Awards
Year Ended June 30, 2023

Note 1 – Basis of Presentation

The accompanying schedule of expenditures of federal awards (the "Schedule") includes the federal grant activity of Salinas Valley Memorial Healthcare System ("Salinas Valley Health" or "SVH"), under programs of the federal government for the year ended June 30, 2023. The information in the Schedule is presented in accordance with the requirements of the Office of Management and Budget ("OMB") Title 2 U.S. *Code of Federal Regulations* ("CFR") Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* ("Uniform Guidance"). Because the Schedule presents only a selected portion of the operations of SVH, it is not intended to, and does not, present the financial position, changes in net position, or cash flows of SVH. The Schedule includes expenditures of federal awards from Salinas Valley Health (Taxpayer Identification Number 94-6004020), Salinas Valley Medical Clinic (Taxpayer Identification Number 35-2401992), and Doctors on Duty Medical Group, Inc. (Taxpayer Identification Number 77-0439213).

Salinas Valley Health received Provider Relief Funds from the Department of Health and Human Services during the year ended June 30, 2022; however, in accordance with the *2023 OMB Compliance Supplement*, Period 4 (received between July 1, 2021, and December 31, 2021) and Period 5 (received between January 1, 2022, and June 30, 2022), Provider Relief Fund payments are reflected in the attached Schedule for the year ended June 30, 2023. For Provider Relief Funds, Salinas Valley Health expended $12,150,139 in federal awards, which is included in Salinas Valley Health's schedule of expenditures of federal awards during the year ended June 30, 2023.

The Schedule includes $5,643,369 of expenditures for U.S. Department of Homeland Security Disaster Grants – Public Assistance (Presidentially Declared Disasters) Assistance Listing No. 97.036. These awards were approved during the year ended June 30, 2023, and relate to expenditures that were incurred during the years ended June 30, 2022, 2021, and 2020.

Note 2 – Summary of Significant Accounting Policies

Expenditures reported on the schedule of expenditures of federal awards are reported on the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in the Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement. SVH has elected not to use the 10% de minimis indirect cost rate allowed under the Uniform Guidance.

Note 3 – Subrecipients

SVH did not provide federal awards to subrecipients during the year ended June 30, 2023.

Required Supplementary Information

Defined Benefit Pension Plan

The following table summarizes the number of total plan participants at June 30:

	2023	2022
Number of active members	1,265	1,261
Number of frozen active participants	236	223
Number of retired members and beneficiaries	794	744
Number of vested terminated members	438	379
	2,733	2,607

The following table summarizes the funding status of the defined benefit pension plan at various measurement dates, in thousands:

Year Ended	Actuarially Determined Contribution	Actual Employer Contribution	Contribution (Excess) Deficiency	Covered Payroll	Contribution as a Percentage of Covered Payroll
December 31, 2008	$ 8,756	$ 10,766	$ (2,010)	$ 107,149	10.05%
December 31, 2009	$ 13,096	$ 13,096	$ -	$ 119,940	10.92%
December 31, 2010	$ 12,570	$ 12,570	$ -	$ 129,273	9.72%
December 31, 2011	$ 11,226	$ 11,226	$ -	$ 96,774	11.60%
December 31, 2012	$ 11,648	$ 11,648	$ -	$ 96,172	12.11%
December 31, 2013	$ 11,308	$ 11,311	$ (3)	$ 94,394	11.98%
December 31, 2014	$ 10,799	$ 10,799	$ -	$ 97,719	11.05%
December 31, 2015	$ 12,147	$ 17,190	$ (5,043)	$ 121,074	14.20%
December 31, 2016	$ 11,970	$ 16,970	$ (5,000)	$ 130,810	12.97%
December 31, 2017	$ 12,883	$ 19,883	$ (7,000)	$ 108,395	18.34%
December 31, 2018	$ 11,927	$ 21,927	$ (10,000)	$ 112,353	19.52%
December 31, 2019	$ 11,809	$ 26,809	$ (15,000)	$ 119,261	22.48%
December 31, 2020	$ 18,766	$ 23,766	$ (5,000)	$ 127,771	18.60%
December 31, 2021	$ 13,127	$ 23,127	$ (10,000)	$ 138,820	16.66%
December 31, 2022	$ 10,158	$ 61,580	$ (51,422)	$ 142,050	43.35%

MOSSADAMS

Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

The Board of Directors
Salinas Valley Memorial Healthcare System

We have audited, in accordance with the auditing standards generally accepted in the United States of America; the California Code of Regulations, Title 2, Section 1131.2, State Controller's Minimum Audit Requirements for California Special Systems; and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the consolidated financial statements of Salinas Valley Memorial Healthcare System (the "System"), which comprise the consolidated statements of the business-type activities and the aggregate remaining fund information of Salinas Valley Memorial Healthcare System as of and for the year ended June 30, 2023, and the related notes to the financial statements, which collectively comprise Salinas Valley Memorial Healthcare System's consolidated financial statements as listed in the table of contents, and the related notes to the consolidated financial statements, and have issued our report thereon dated November XX, 2023.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the consolidated financial statements, we considered the System's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control. Accordingly, we do not express an opinion on the effectiveness of the System's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the System's consolidated financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses or significant deficiencies may exist that were not identified.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether the System's consolidated financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the System's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the System's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

San Francisco, California
November XX, 2023

MOSSADAMS

Report of Independent Auditors on Compliance for Each Major Federal Program and Report on Internal Control over Compliance

The Board of Directors
Salinas Valley Memorial Healthcare System

Report on Compliance for Each Major Federal Program

Opinion on Each Major Federal Program

We have audited Salinas Valley Memorial Healthcare System's compliance with the types of compliance requirements identified as subject to audit in the Office of Management and Budget *Compliance Supplement* that could have a direct and material effect on each of Salinas Valley Memorial Healthcare System's major federal programs for the year ended June 30, 2023. Salinas Valley Memorial Healthcare System's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

In our opinion, Salinas Valley Memorial Healthcare System complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended June 30, 2023.

Basis for Opinion on Each Major Federal Program

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America ("GAAS"), the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States *("Government Auditing Standards")*; and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200*, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* ("Uniform Guidance"). Our responsibilities under those standards and the Uniform Guidance are further described in the Auditor's Responsibilities for the Audit of Compliance section of our report.

We are required to be independent of Salinas Valley Memorial Healthcare System and to meet our other ethical responsibilities, in accordance with relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion on compliance for its major federal program. Our audit does not provide a legal determination of Salinas Valley Memorial Healthcare System's compliance with the compliance requirements referred to above.

Responsibilities of Management for Compliance

Management is responsible for compliance with the requirements referred to above and for the design, implementation, and maintenance of effective internal control over compliance with the requirements of laws, statutes, regulations, rules, and provisions of contracts or grant agreements applicable to Salinas Valley Memorial Healthcare System's federal programs.

Auditor's Responsibilities for the Audit of Compliance

Our objectives are to obtain reasonable assurance about whether material noncompliance with the compliance requirements referred to above occurred, whether due to fraud or error, and express an opinion on Salinas Valley Memorial Healthcare System's compliance based on our audit. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance will always detect material noncompliance when it exists. The risk of not detecting material noncompliance resulting from fraud is higher than for that resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Noncompliance with the compliance requirements referred to above is considered material, if there is a substantial likelihood that, individually or in the aggregate, it would influence the judgment made by a reasonable user of the report on compliance about Salinas Valley Memorial Healthcare System's compliance with the requirements of each major federal program as a whole.

In performing an audit in accordance with GAAS, *Government Auditing Standards,* and the Uniform Guidance, we

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material noncompliance, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding Salinas Valley Memorial Healthcare System's compliance with the compliance requirements referred to above and performing such other procedures as we considered necessary in the circumstances.
- Obtain an understanding of Salinas Valley Memorial Healthcare System's internal control over compliance relevant to the audit in order to design audit procedures that are appropriate in the circumstances and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of Salinas Valley Memorial Healthcare System's internal control over compliance. Accordingly, no such opinion is expressed.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and any significant deficiencies and material weaknesses in internal control over compliance that we identified during the audit.

Report on Internal Control Over Compliance

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the Auditor's Responsibilities for the Audit of Compliance section above and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies in internal control over compliance. Given these limitations, during our audit we did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above. However, material weaknesses or significant deficiencies in internal control over compliance may exist that were not identified.

Our audit was not designed for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, no such opinion is expressed.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

San Francisco, California
November XX, 2023

Section I – Summary of Auditor's Results

Financial Statements

Type of auditor's report issued on whether the financial statements audited were prepared in accordance with GAAP: *Unmodified*

Internal control over financial reporting:

- Material weakness(es) identified? ☐Yes ☒ No
- Significant deficiency(ies) identified? ☐Yes ☒ None reported

Noncompliance material to financial statements noted? ☐Yes ☒ No

Federal Awards

Internal control over major federal programs:

- Material weakness(es) identified? ☐Yes ☒ No
- Significant deficiency(ies) identified? ☐Yes ☒ None reported

Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)? ☐Yes ☒ No

Identification of Major Federal Programs and Type of Auditor's Report Issued on Compliance for the Major Federal Programs:

Federal Assistance Listing Number	*Name of Federal Program or Cluster*	*Type of Auditor's Report Issued on Compliance for the Major Federal Program*
93.498	*COVID-19 Provider Relief Fund and American Rescue Plan (ARP) Rural Distribution*	*Unmodified*
97.036	*COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)*	*Unmodified*

Dollar threshold used to distinguish between type A and type B programs: $750,000

Auditee qualified as low-risk auditee? ☐Yes ☒ No

Section II – Financial Statement Findings

None reported.

Section III – Federal Award Findings and Questioned Costs

No findings noted.

Salinas Valley Memorial Healthcare System
Summary Schedule of Prior Audit Findings
Year Ended June 30, 2023

Salinas Valley Memorial Healthcare System
A Public Healthcare District

Name of Auditee: Salinas Valley Memorial Healthcare System
Period Covered by Audit: April 2020 through June 30, 2020
Name of Audit Firm: Moss Adams LLP

Finding 2021-001 REPORTING: SIGNIFICANT DEFICIENCY IN INTERNAL CONTROL OVER COMPLIANCE

Criteria – The System should have appropriate internal controls in place to ensure that reporting requirements are met and amounts utilized in reports are calculated accurately and in accordance with 45 CFR 75.342.

Condition/Context – The Period 1 Provider Relief Fund (PRF) report submitted for Salinas Valley Memorial Healthcare System (SVMHS) was tested. The System elected to use Lost Revenues Option 1 to report lost revenue based on quarterly actuals. Amounts reported as quarterly net patient service revenue were not reconciled properly to supporting documents, resulting in an incorrectly reported total lost revenue. Further, during our testing of allowable cost, an error was discovered in the Period 1 PRF report submitted on September 30, 2021 for Salinas Valley Medical Clinic (SVMC). The error resulted in an overstatement of $231,000 in expenditures. The overstatement had no impact in the amounts retained by SVMC as there is sufficient unreimbursed expenses reported by SVMC.

Effect – Errors were made in the quarterly reporting of Total Revenue/Net Charges from Patient Care for SVMHS, as well as Other PRF expenses reporting for SVMC. However, we note there was no impact to total funding received or retained by SVMC and the System overall due to the error. Independent calculations of the lost revenue utilizing the amounts that should have been reported were performed and will be accurately reported on the next PRF reporting. Based on these calculations, lost revenue exceeded total PRF amounts received in period 1. The total amount of funding recognized on the basis of lost revenue for period 1 was accurate and the amount reported per the Schedule of Expenditures for Federal Awards ("SEFA") was also accurate. Independent testing was also performed on the corrected Other PRF expenses for SVMC, resulting in no change in amounts retained by SVMC.

Cause – PRF guidance was not thoroughly reviewed and researched.

Recommendation – Policies and procedures over federal grant reporting should be modified to ensure reports are prepared using complete and accurate information. Review controls should be in place by someone other than the preparer of the report to ensure information is accurate prior to submission of the report.

Status – Fully remediated.

Augustine Lopez

Augustine Lopez
Chief Financial Officer

Communications with the Board of Directors

Salinas Valley Memorial Healthcare System

June 30, 2023

MOSSADAMS

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Communications with the Board of Directors

The Board of Directors
Salinas Valley Memorial Healthcare System

We have audited the consolidated financial statements of Salinas Valley Memorial Healthcare System (the "System") its aggregate discretely presented component units, the Salinas Valley Memorial Healthcare District Employees Pension Plan, as of and for the year ended June 30, 2023 and have issued our report thereon dated November XX, 2023. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility Under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated January 13, 2023, we are responsible for forming and expressing an opinion about whether the consolidated financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. We will also report on whether the consolidating statement of net position, consolidating statement of revenues, expenses, and changes in net position, and supplemental pension and postretirement benefit information, presented as supplementary information, are fairly stated, in all material respects, in relation to the consolidated financial statements as a whole. Our audit of the consolidated financial statements does not relieve you or management of your responsibilities.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS), Government Auditing Standards issued by the Comptroller General of the United States, and the California Code of Regulations, Title 2 Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Systems. As part of an audit conducted in accordance with the standards, we exercise professional judgment and maintain professional skepticism throughout the audit.

An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control over financial reporting. Accordingly, we considered the System's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the consolidated financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you in our engagement letter dated January 13, 2023.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the System are described in Note 2 to the consolidated financial statements. In 2023, the System adopted Governmental Accounting Standards Board ("GASB") Statement No. 96, *Subscription Based IT Arrangements*. See Note 14 for impact of adoption. No other new accounting policies were adopted and there were no changes in the application of existing policies during 2023. We noted no transactions entered into by the System during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the consolidated financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the consolidated financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the consolidated financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the consolidated financial statements were:

- 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. We evaluated the key factors and assumptions used to develop the estimated net realizable amounts and determined that it is reasonable in relation to the consolidated financial statements taken as a whole.

- The System 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. We evaluated the key factors and assumptions used to develop the provision for uncollectible accounts and determined that it is reasonable in relation to the consolidated financial statements taken as a whole.

- Management's estimate of the fair market values of investments in the absence of readily-determinable fair values is based on information provided by the fund managers. We have gained an understanding of management's estimate methodology and examined the documentation supporting this methodology. We evaluated the key factors and assumptions used to develop the fair market value of investments. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.

- The System is self-insured for workers' compensation benefits for employees. An actuarial estimate is accrued based on an expected, undiscounted estimate. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.

- The System provides eligible employees with health benefits through a self-insured program. The liability for claims arising from this program is estimated based upon historical experience and trending. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.

- The useful lives of capital assets have been estimated based on the intended use and are within accounting principles generally accepted in the United States of America. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.

- Management's estimate of the net pension (asset) liability is actuarially determined using assumptions on the long-term rate of return on pension plan assets, the discount rate used to determine the present value of benefit obligations, and the rate of compensation increases. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.

- Management's estimated liability for post-retirement medical benefits is actuarially determined using assumptions on the long-term rate of return on plan assets, the discount rate used to determine the present value of benefit obligations, and the rate of compensation increases. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.

- Management's estimates of the discount rate, useful lives, lease terms related to the System's operating lease right of use assets, lease liabilities, lease receivable, and deferred inflows of resources - leases. We have gained an understanding of management's key factors and assumptions and examined the documentation supporting the estimates. We found management's basis to be reasonable in relation to the System's consolidated financial statements taken as a whole.

- Management's estimates of the discount rate, useful lives, subscription terms related to the System's subscription assets and subscription liabilities. We have gained an understanding of management's key factors and assumptions and examined the documentation supporting the estimates. We found management's basis to be reasonable in relation to the System's consolidated financial statements taken as a whole.

Actual results could differ from these estimates. In accordance with accounting principles generally accepted in the Unites States of America, any change in these estimates is reflected in the consolidated financial statements in the year of change.

Financial Statement Disclosures

The disclosures in the consolidated financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the consolidated financial statements were disclosures relating to significant concentrations of net patient accounts receivable and revenue, investments in affiliates, fair value of investments, self-insurance liabilities and net pension liability, leases, and subscription-based IT arrangements.

Significant Unusual Transactions

We encountered no significant unusual transactions during our audit of the System's consolidated financial statements.

Significant Difficulties Encountered in Performing the Audit

Professional standards require us to inform you of any significant difficulties encountered in performing the audit. No significant difficulties were encountered during our audit of the System's consolidated financial statements.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the consolidated financial statements or the auditor's report. No such disagreements arose during the course of our audit.

Circumstances that Affect the Form and Content of the Auditor's Report

There may be circumstances in which we would consider it necessary to include additional information in the auditor's report in accordance with auditing standards generally accepted in the United States of America (GAAS) and the California Code of Regulations, Title 2 Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Systems. There were no circumstances that affected the form and content of the auditor's report.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. There were no corrected or uncorrected misstatements the effects of which, as determined by management, are material, both individually and in the aggregate, to the consolidated financial statements as a whole.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated November XX, 2023.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the System's consolidated financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Significant Audit Findings or Issues

We are required to communicate to you other findings or issues arising from the audit that are, in our professional judgment, significant and relevant to your oversight of the financial reporting process. There were no such items identified.

This information is intended solely for the use of the Board of Directors and management of the System, and is not intended to be, and should not be, used by anyone other than these specified parties.

San Francisco, California
November XX, 2023

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Salinas Valley Memorial Healthcare District Employees Pension Plan

Report to Corporate Compliance and Audit Committee

December 12, 2023

Issued Report

Report of Independent Auditors

- Financial statements of Salinas Valley Memorial Healthcare District Employees Pension Plan for year ended December 31, 2022
- Audit report will be dated following management approval

Unmodified Opinion

Financial statements are presented fairly in accordance with accounting principles generally accepted in the United States of America

Non-Attest Service

Moss Adams assisted management with drafting the Plan's financial statements and required supplementary information

Pension Financial Highlights

	2020	2021	2022
Total pension liability (a)	**$ 428,243,730**	**$ 440,485,078**	**$ 458,730,891**
Plan fiduciary net position			
Employer contributions	$ 23,765,862	$ 23,126,725	$ 61,579,392
Member contributions	1,975,665	2,673,070	2,577,706
Net investment income (loss)	43,530,843	47,033,347	(83,884,411)
Administrative expense	(115,720)	(111,880)	(92,272)
Benefit payments	(14,266,188)	(16,352,414)	(18,835,673)
Net change in plan fiduciary net position	54,890,462	56,368,848	(38,655,258)
Plan fiduciary net position			
Beginning of year	331,115,464	386,005,926	442,374,774
End of year **(b)**	**$ 386,005,926**	**$ 442,374,774**	**$ 403,719,516**
System net pension liability (asset) (a) - (b)	**$ 42,237,804**	**$ (1,889,696)**	**$ 55,011,375**
Funded status (GASB basis)	**90.1%**	**100.4%**	**88.0%**

Significant Audit Areas

- Internal Controls
- Investments
- Contributions (employer and member)
- Benefit payments
- Participant data and eligibility
- Actuarial valuation and assumptions
- Expenses
- Financial reporting

Required Communications

- Memo will be issued with required audit communications
- Representations requested and received from management
- No proposed adjusting entries or uncorrected misstatements noted
- No significant new accounting pronouncements applied during 2022 that affected the Plan's reporting
- Consideration of fraud in a financial statement audit
  - ➢ Procedures performed included journal entry testing and interviews of personnel
- Moss Adams is independent with respect to the Plan and its sponsoring employer

THANK YOU

- Audit performed within the scope and timeline discussed during planning
- Management, staff, and the Plan's outside service providers were helpful, candid and open in response to audit requests and discussion points

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Report of Independent Auditors and
Financial Statements with
Required Supplementary Information

Salinas Valley Memorial Healthcare District
Employees Pension Plan

December 31, 2022 and 2021

Table of Contents

Salinas Valley Memorial Healthcare District
Employees Pension Plan
Management's Discussion and Analysis

This section of Salinas Valley Memorial Healthcare District Employees Pension Plan's (the Plan's) annual financial report presents the management discussion and analysis of the Plan's financial performance as of and for the years ended December 31, 2022 and 2021. This section also includes selected comparative information as of and for the year ended December 31, 2020. It should be read in conjunction with the Plan's annual audited financial statements, which follow this section.

Overview – The Plan was established in November 1966 by the Salinas Valley Memorial Healthcare District (now known as the Salinas Valley Memorial Healthcare System or the System) and has been amended from time to time since that date, as further described below. The Plan provides retirement, disability, and death benefits to permanent employees of the System with union representation based on the employee's years of service, age, and annual compensation during covered employment.

Plan background – The Plan was amended effective January 1, 2004 to provide that the benefit formula be equal to 2.45% of the participant's earnings in a plan year. The benefit formula was previously 2.25% of the participant's earnings in a plan year (for plan years 2000 through 2003).

Participation in the Plan was frozen effective March 31, 2011 for nonunion employees. These employees are entitled to benefits earned before that date but do not accrue further benefits under the Plan.

The Plan was amended effective January 1, 2013 to comply with the applicable provisions of the California Public Employees' Pension Reform Act of 2013 (PEPRA). These provisions include limitations on pensionable compensation and retirement benefits and contribution provisions, including the establishment of participant contributions, for new participants who are hired on or after January 1, 2013 and meet the eligibility and vesting requirements of the Plan.

The Plan was amended and restated effective January 1, 2016 to update the Plan for legislative changes according to PEPRA and to remove the three-year service requirement to participate in the Plan for eligible employees.

Plan documents contain a more detailed description of the Plan's provisions and should be referred to for a more complete understanding of the terms of the Plan. Copies of the appropriate documents are available through the administrative offices of the System.

Financial highlights – During the year ended December 31, 2022, the net position held in trust for pension benefits decreased by approximately 9%. Employer contributions were $61.6 million in 2022 compared to $23.1 million in 2021. Benefit payments were $19.0 million during 2022 compared to $16.4 million during 2021. Net investment loss was $83.7 million during 2022 compared to a net investment income of $47.0 million during 2021.

Financial analysis – Total contributions have exceeded the actuarially determined contribution amounts since 2015, due to decisions made by the System's Board of Directors to fund the Plan at amounts above actuarially determined contributions. During the year ended December 31, 2022, the System's Board of Directors approved and funded employer contributions totaling $61,579,392 to the Plan.

Actuarial measurement – The actuarial cost method used to attribute the actuarial present value of projected benefit payments of each plan member is the entry age cost method. Under the entry age cost method, the actuarial present value of the projected benefits for each individual included in the actuarial valuation is allocated on a level basis over the earnings or service of the individual between entry age and assumed exit ages. The portion of this actuarial present value allocated to a valuation year is called the normal cost. The portion of this actuarial present value not provided for at a valuation date by the actuarial present value of future normal costs is the actuarial accrued liability.

The System's net pension liability (asset) is calculated as the total pension liability, defined as the portion of the actuarial present value of projected benefit payments that is attributed to past periods of member service, less the Plan's fiduciary net position. A comparison of the components of the net position liability (asset) as of December 31, 2022, 2021, and 2020 are as follows:

	December 31,		
	2022	2021	2020
Total pension liability	$ 458,730,891	$ 440,485,078	$ 428,243,730
Plan fiduciary net position	(403,719,516)	(442,374,774)	(386,005,926)
System's net pension liability (asset)	$ 55,011,375	$ (1,889,696)	$ 42,237,804
System's fiduciary net position as a percentage of total pension liability	88.01%	100.43%	90.14%

Overview of the financial statements – The financial statements consist of three parts: management's discussion and analysis (this section), the basic financial statements together with the related notes, and required supplementary information, as mandated by certain pronouncements of the Governmental Accounting Standards Board (GASB).

The basic financial statements present information about the Plan's fiduciary net position and changes in fiduciary net position for the respective years. The basic financial statements also include notes to explain some of the information in the financial statements and to provide more details. The notes are followed by a section of required supplementary information that displays additional detail information not in the basic financial statements, but which is required by the pronouncements of the GASB and relate to funding progress and required contributions.

The statement of fiduciary net position displays the assets and liabilities and resulting net position of the Plan as of the end of the year. All assets are valued at fair value.

The following are abbreviated statements of fiduciary net position (in thousands):

	December 31,		
	2022	2021	2020
Cash and investments	$ 403,720	$ 442,375	$ 386,006

During the years ended December 31, 2022, and 2021, the Plan's fiduciary net position decreased by 9% and increased by 15%, respectively. The Plan's policies allow investments consisting of fixed income securities, equity securities, and money market funds. The Plan's investments are held in a portfolio of registered investment companies (mutual funds).

The statement of changes in fiduciary net position reflects the employer contributions and investment return, net of investment expenses, less benefits paid. Changes in fiduciary net position are summarized as follows (in thousands):

	Year Ended December 31,		
	2022	2021	2020
Investment (loss) income, net	$ (83,746)	$ 47,033	$ 43,531
Employer contributions	61,579	23,127	23,766
Member contributions	2,578	2,673	1,976
Benefit payments to members and beneficiaries	(18,961)	(16,352)	(14,266)
Administrative expenses	(106)	(112)	(116)
Change in fiduciary net position	$ (38,656)	$ 56,369	$ 54,891

The change in fiduciary net position during the years ended December 31, 2022, 2021, and 2020 is due primarily to the investment (loss) income from the performance of equity markets during each year. Benefit payments to members and beneficiaries continue to increase each year due to the increased number of retirees and beneficiaries receiving benefits.

Financial Statements

Salinas Valley Memorial Healthcare District
Employees Pension Plan
Statements of Fiduciary Net Position
December 31, 2022 and 2021

	2022	2021
ASSETS		
Investments, at fair value		
Mutual funds	$ 403,719,516	$ 442,374,774
NET POSITION HELD IN TRUST FOR PENSION BENEFITS	$ 403,719,516	$ 442,374,774

See accompanying notes to these financial statements.

Salinas Valley Memorial Healthcare District
Employees Pension Plan
Statements of Changes in Fiduciary Net Position
Years Ended December 31, 2022 and 2021

	2022	2021
INVESTMENT (LOSS) INCOME		
Net (depreciation) appreciation in fair value of investments	$ (93,981,045)	$ 25,857,851
Dividends	10,235,226	21,175,496
Net investment (loss) income	(83,745,819)	47,033,347
CONTRIBUTIONS		
Employer	61,579,392	23,126,725
Members	2,577,706	2,673,070
Total contributions	64,157,098	25,799,795
DEDUCTIONS		
Benefit payments	18,960,982	16,352,414
Administrative expenses	105,555	111,880
Total deductions	19,066,537	16,464,294
CHANGE IN NET POSITION	(38,655,258)	56,368,848
NET POSITION HELD IN TRUST FOR PENSION BENEFITS		
Beginning of the year	442,374,774	386,005,926
End of the year	$ 403,719,516	$ 442,374,774

See accompanying notes to these financial statements.

Note 1 – Description of the Plan

General – The following description of Salinas Valley Memorial Healthcare District Employees Pension Plan (the Plan) provides only general information. Participants should refer to the plan document for a more complete description of the Plan's provisions.

The Plan is a single-employer noncontributory employee retirement system established by Salinas Valley Memorial Healthcare System (the System). The System is a political subdivision that was organized under the provisions of the Health and Safety Code of the State of California. Permanent employees of the System with union representation are eligible to participate in the Plan upon the later of their employment commencement date or reaching the age of 21.

The Plan provides retirement, disability, and death benefits based on the employee's years of service, age, and annual compensation during covered employment. Plan provisions and all other requirements are established by the System's five-member Board of Directors (the Board), which has been elected by the registered voters in the District.

Effective March 31, 2011, participation in the Plan for nonunion employees was frozen. Nonunion employees are entitled to benefits earned before March 31, 2011, but do not accrue further benefits under the Plan.

Effective January 1, 2013, the Plan was amended to adopt the applicable provisions of the California Public Employees' Pension Reform Act of 2013 (PEPRA).

Membership in the Plan consists of the following:

	December 31, 2022	December 31, 2021
Active members		
Number of active members under and over the normal retirement age	1,265	1,261
Nonactive members and other beneficiaries receiving benefits		
Number of retirees or beneficiaries	794	744
Number terminated with vested benefits	438	379
Inactive members	236	223
Total	2,733	2,607

Contributions – The Plan directs the System to make contributions based on actuarially determined contribution amounts. The System reserves the right to suspend or reduce contributions to the Plan at any time, upon appropriate action by the Board. In accordance with PEPRA, certain members are required to make contributions based on a percentage of their eligible compensation to the Plan.

Benefits – The benefit formula payable to a participant who retires on his or her normal retirement date of age 65 shall be a monthly benefit for the life of the member. The benefit payable to a participant is computed as 2.45% of the participant's earnings during a year of credited service, as defined by the Plan, multiplied by the number of years of credited service for the participant.

In accordance with the provisions of PEPRA, certain participants hired after January 1, 2013 who retire at their normal retirement age of age 65, shall receive a retirement benefit computed as 2.30% of the participant's final annual compensation multiplied by their number of years of service in the Plan.

A participant who has attained age 52 and completed 15 years of service and 5 years of plan participation may elect early retirement on the first day of any month prior to the participant's normal retirement date, with certain defined-benefit reductions. A participant may elect to receive benefits in the form of a single life annuity, alternate annuity option, certain period option, or social security adjustment option, as defined in the plan document. Upon the death of a participant who is currently employed by the System and prior to commencement of payments of benefits under this Plan, death benefits are distributed to the designated beneficiary.

Vesting – Employees are eligible to receive benefits after a minimum of ten years of service. Participants may receive early retirement benefits with 15 years of service.

Plan termination – The System expects to continue the Plan indefinitely but reserves the right to terminate the Plan at any time by appropriate action. In the event of such termination, each affected employee shall become 100% vested in the participant's accrued benefit.

Note 2 – Summary of Significant Accounting Policies

Basis of accounting – The Plan's financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America as applied to governmental units, using the accrual basis of accounting. The Governmental Accounting Standards Board (GASB) is the accepted standard setting body for establishing governmental accounting and financial reporting principles.

Use of estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, and changes therein, disclosure of contingent assets and liabilities, and the actuarial value of assets and actuarial accrued liability at the date of the financial statements. Actual results could differ from those estimates.

Investment valuation – Investments are reported at fair value. Securities traded on national exchanges are valued at the last reported sales price on the last business day of the plan year. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

Income recognition – Purchases and sales of investments are recorded on a trade-date basis. Dividends are recorded on the ex-dividend date. Net (depreciation) appreciation in fair value of investments consists of both the realized gains and losses and unrealized appreciation and depreciation of those investments.

Benefit payments – Benefit payments to participants are recorded when paid.

Administrative expenses – The Plan's administrative expenses are paid either by the Plan or the System, as provided by the plan document. Certain expenses for the general administration of the Plan are paid directly by the System and are excluded from these financial statements. Certain investment related expenses are included in investment (loss) income presented in the accompanying statements of changes in fiduciary net position.

Note 3 – Investments

Investment policy – The Personnel and Pension Committee, appointed by the System's Board of Directors, is responsible for the oversight of the Plan's investments and investment policy. The investment policy presents ranges for investment types as follows:

Domestic and international equities	65%
Fixed income securities and cash equivalents	35%

The investment policy specifically prohibits investments in short sales, margin purchases, private placements, derivatives, commodities, and annuities.

Investments – As of December 31, the Plan's investments are summarized as follows:

	2022		2021	
	Fair Value	%	Fair Value	%
Mutual funds				
Domestic equity	$ 173,431,007	43%	$ 186,981,586	40%
Fixed income	121,469,099	30%	137,323,515	32%
International equity	88,364,818	22%	94,269,950	23%
Real estate fund	20,454,592	5%	23,799,723	5%
Total	$ 403,719,516	100%	$ 442,374,774	100%

Fair value measurements – The Plan uses a framework for measuring fair value that provides a hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3).

The three levels of the fair value hierarchy are described as follows:

Level 1 – Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities the Plan has the ability to access.

Level 2 – Inputs to the valuation methodology include quoted prices for similar assets or liabilities in active markets; quoted prices for identical or similar assets or liabilities in inactive markets; inputs other than quoted prices that are observable for the asset or liability; and inputs that are derived principally from or corroborated by observable market data by correlation or other means. If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 – Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

Following is a description of the valuation technique used for assets measured at fair value. There have been no changes in the techniques used at December 31, 2022 or 2021.

Mutual funds – Shares held in registered investment companies (mutual funds) are valued at the daily closing price as reported by the fund. These funds are required to publish their daily net asset value (NAV) and to transact at that price. The funds held by the Plan are deemed to be actively traded. Mutual funds held by the Plan are open-end mutual funds that are registered with the U.S. Securities and Exchange Commission.

The following tables disclose the fair value hierarchy of the Plan's assets by level:

		Fair Value Measurements		
	December 31, 2022	Level 1	Level 2	Level 3
Mutual funds				
Equity securities	$ 282,250,417	$ 282,250,417	$ -	$ -
Fixed income	121,469,099	121,469,099	-	-
Total	$ 403,719,516	$ 403,719,516	$ -	$ -

		Fair Value Measurements		
	December 31, 2021	Level 1	Level 2	Level 3
Mutual funds				
Equity securities	$ 305,051,259	$ 305,051,259	$ -	$ -
Fixed income	137,323,515	137,323,515	-	-
Total	$ 442,374,774	$ 442,374,774	$ -	$ -

Money-weighted rate of return – During the years ended December 31, 2022 and 2021, the annual money-weighted rate of return on the Plan's investments, net of investment expenses, was (18.04)% and 12.01%, respectively. The money-weighted rate of return expresses investment performance, net of investment fees, adjusted for the changing amounts actually invested.

Investment risk factors – There are many factors that can affect the value of investments. Some, such as custodial credit risk, concentration of credit risk, and foreign currency risk may affect both equity and fixed income securities. Equity securities respond to such factors as economic conditions, individual company earnings performance, and market liquidity, while fixed income securities are particularly sensitive to credit risks and changes in interest rates. The Plan manages its investment risk factors by diversifying its portfolio through investments in a group annuity contract that invests in various registered investment companies, and U.S. and international equity securities, which are all readily marketable.

The fixed income portfolio consists of shares held in various registered investment companies (mutual funds) with underlying investments in fixed and variable rate U.S Government and corporate securities. There are no restrictions to the Plan's ability to sell shares in these mutual funds on any given trading date.

Interest rate risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of investments. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. The prices of fixed income securities with a longer time to maturity, measured by effective duration, tend to be more sensitive to changes in interest rates and more volatile than those with shorter durations.

The Plan holds fixed income investments in various mutual funds with underlying investments in fixed and variable rate securities. There are no restrictions to the Plan's ability to sell shares in these mutual funds on any given trading date, which mitigates the interest rate risk of the underlying securities.

Credit risk – Credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of a rating by a nationally recognized statistical rating organization. The Plan held fixed income investments in various mutual funds with underlying investments in fixed and variable rate securities.

Custodial credit risk – Custodial credit risk is the risk that in the event of the failure of the investment custodian, the Plan will not be able to recover the value of its investments or collateral securities that are in the possession of an outside party. As of December 31, 2022 and 2021, the Plan's investments are held by third-party safekeeping custodians selected by the Board and registered in the Plan's name. As a result, management believes custodial credit risk is remote.

Concentration of credit risk – Concentration of credit risk is the risk associated with a lack of diversification, such as having substantial investments with a few individual issuers, thereby exposing the Plan to greater risks resulting from adverse economic, political, regulatory, geographic, or credit developments. As of December 31, 2022 and 2021, the Plan's investments are entirely held in mutual funds with diversified holdings in underlying investments.

Note 4 – Employer Contributions

Employer contributions are determined by the System's Board of Directors each year based on the actuarially required contribution amount calculated by the Plan's independent actuary. The actuarially determined contribution is determined as part of an actuarial valuation on January 1 of each year, using the traditional unit credit actuarial cost method. Actuarially determined contribution amounts were $10,157,917 and $13,126,725 for the year ended December 31, 2022 and 2021, respectively, and contributed to the Plan as directed and approved by the Board of Directors. Employer contributions in excess of the actuarially determined contribution amounts totaling $51,421,475 and $10,000,000 were also contributed at the direction of the Board of Directors for the years ended December 31, 2022 and 2021, respectively.

Note 5 – System Net Pension Liability (Asset)

The components of the net pension liability (asset) of the System were as follows:

	December 31, 2022	December 31, 2021
Total pension liability	$ 458,730,891	$ 440,485,078
Plan fiduciary net position	(403,719,516)	(442,374,774)
System net pension liability (asset)	$ 55,011,375	$ (1,889,696)
Plan fiduciary net position as a percentage of total pension liability (funded status)	88.01%	100.43%

Note 6 – Actuarial Methods and Significant Assumptions

The total pension liability was determined as part of actuarial valuations as of December 31, 2022 and 2021, respectively, using actuarial methods and assumptions in accordance with GASB No. 67, *Financial Reporting for Pension Plans*. The total pension liability was calculated using the entry age cost method and PubG-2010 Generational Mortality Tables projected using MP-2021 as of December 31, 2022 and 2021. The actuarial assumptions included (a) 6.50% investment long-term expected rate of return, net of investment expenses and (b) projected salary increases of 3.50% plus merit for Certified Nursing Assistants (CNA) and 3.75% plus merit for National Union of Healthcare Workers (NUHW).

Long-term expected rate of return – The long-term expected rate of return on the Plan's investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of investment expense and inflation) are developed for a hypothetical investment portfolio allocation of 65% equity and 35% fixed income. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation at a long-term inflation rate of 2.25%.

As of December 31, 2022 and 2021, the long-term expected rates of return for each major investment class in the Plan's portfolio are as follows:

Investment Class	Long-Term Expected Rate of Return
Domestic equity	
U.S. large cap equity	8.0%
U.S. small cap equity	9.0%
International	
Equity	8.0%
Emerging market equity	9.0%
Alternative	
Real estate investment trust	8.0%
Commodities	5.0%
Money market	2.0%
Fixed income	
High yield bonds	6.5%
Core bonds	4.0%
Long-term corporate bonds	6.0%
Short-term bonds	2.5%

Discount rate – As of December 31, 2022 and 2021, the discount rate used to measure the total pension liability was 6.50% based on the expected rate of return on pension plan investments. Based on the stated assumptions and the projection of cash flows, the Plan's fiduciary net position and future contributions were projected to be available to finance all projected future benefit payments of current pension plan members. Therefore, the long-term expected rate of return on Plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

Sensitivity of the net pension liability to changes in the discount rate – The following presents the net pension liability of the System, calculated using the discount rate of 6.50%, as well as what the System's net pension liability would be if it were calculated using a discount rate that is 1% point lower (5.50%) or 1% point higher (7.50%) than the current rate:

	1% Decrease (5.50%)	Current Discount Rate (6.50%)	1% Increase (7.50%)
System net pension liability	$ 115,491,223	$ 55,011,375	$ 4,567,815

Note 7 – Tax Status

The Internal Revenue Service has determined and informed the System by a letter dated March 21, 2017, that the Plan is designed in accordance with the applicable sections of the Internal Revenue Code (IRC). Management believes that the Plan is designed and is currently being operated in compliance with the applicable requirements of the IRC and is not subject to federal income taxes.

Note 8 – Risks and Uncertainties

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks (see Note 3). Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statement of net position available for benefits.

Plan contributions are made, and the total pension liability is reported based on certain assumptions pertaining to interest rates, inflation rates, and member demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near-term would be material to the financial statements.

Required Supplementary Information

Salinas Valley Memorial Healthcare District
Employees Pension Plan
Schedules of Changes in Employer Net Pension (Asset) Liability and Related Ratios

	Year Ended December 31,								
	2022	2021	2020	2019	2018	2017	2016	2015	2014
Total pension liability									
Service cost	$ 10,507,936	$ 9,971,347	$ 9,739,474	$ 8,353,779	$ 8,078,739	$ 7,171,959	$ 7,005,009	$ 7,743,929	$ 6,982,137
Interest on total pension liability	28,712,023	27,964,724	26,944,092	25,007,386	24,405,221	22,569,994	21,000,849	19,178,200	18,169,063
Change of benefit terms	-	-	(201,797)	-	-	-	-	-	-
Difference between expected and actual experience	(2,138,473)	4,182,887	(3,872,216)	(8,841,924)	(3,353,687)	(3,076,492)	4,487,813	(280,070)	(4,074,023)
Changes in actuarial assumptions	-	(13,644,957)	(1,835,817)	36,231,315	14,767,302	11,277,838	2,602,234	(1,465,873)	15,352,227
Benefit payments	(18,835,673)	(16,232,653)	(14,266,188)	(12,525,484)	(11,578,811)	(10,404,996)	(8,726,267)	(7,762,380)	(7,344,187)
Net change in total pension liability	18,245,813	12,241,348	16,507,548	48,225,072	32,318,764	27,538,303	26,369,638	17,413,806	29,085,217
Total pension liability									
Beginning of year	440,485,078	428,243,730	411,736,182	363,511,110	331,192,346	303,654,043	277,284,405	259,870,599	230,785,382
End of year (a)	$ 458,730,891	$ 440,485,078	$ 428,243,730	$ 411,736,182	$ 363,511,110	$ 331,192,346	$ 303,654,043	$ 277,284,405	$ 259,870,599
Plan fiduciary net position									
Employer contributions	$ 61,579,392	$ 23,126,725	$ 23,765,862	$ 26,808,785	$ 21,927,309	$ 19,883,437	$ 16,938,956	$ 17,189,514	$ 10,798,666
Member contributions	2,577,706	2,673,070	1,975,665	1,593,730	1,209,498	840,013	474,659	-	-
Net investment income (loss)	(83,884,411)	47,033,347	43,530,843	52,346,352	(13,802,482)	32,509,516	8,198,171	1,301,163	14,217,051
Administrative expenses	(92,272)	(111,880)	(115,720)	(115,586)	(112,397)	(109,194)	(64,788)	-	-
Benefit payments	(18,835,673)	(16,352,414)	(14,266,188)	(12,525,484)	(11,578,811)	(10,404,996)	(8,726,267)	(7,762,380)	(7,344,187)
Net change in plan fiduciary net position	(38,655,258)	56,368,848	54,890,462	68,107,797	(2,356,883)	42,718,776	16,820,731	10,728,297	17,671,530
Plan fiduciary net position									
Beginning of year	442,374,774	386,005,926	331,115,464	263,007,667	265,364,550	222,645,774	205,825,043	195,096,746	177,425,216
End of year (b)	$ 403,719,516	$ 442,374,774	$ 386,005,926	$ 331,115,464	$ 263,007,667	$ 265,364,550	$ 222,645,774	$ 205,825,043	$ 195,096,746
Employer net pension (asset) liability (a) - (b)	$ 55,011,375	$ (1,889,696)	$ 42,237,804	$ 80,620,718	$ 100,503,443	$ 65,827,796	$ 81,008,269	$ 71,459,362	$ 64,773,853
Discount rate	6.5%	6.5%	6.5%	7.0%	7.5%	7.5%	7.5%	7.5%	7.5%
Plan fiduciary net position as percentage of total pension liability	88.01%	100.43%	90.14%	80.42%	72.35%	80.12%	73.32%	74.23%	75.07%
Covered payroll	$ 142,049,836	$ 138,819,740	$ 127,771,097	$ 119,260,723	$ 112,353,126	$ 108,395,254	$ 95,639,978	$ 92,759,619	$ 97,718,804
Net pension liability as percentage of covered payroll	38.73%	-1.36%	33.06%	67.60%	89.45%	60.73%	84.70%	77.04%	66.29%

Notes to schedule

Changes in actuarial assumptions with significant impact on the total pension liability include discount rate changes and the following:

1) For 2018, the salary scale changed from 4.0% to 3.5% plus merit (CNA) and 3.75% plus merit (NUHW).
2) For 2017, the plan was amended for legislative changes according to PEPRA and to remove the three-year service requirement to participate for eligible employees.
3) For 2014, the actuarial cost method changed from Traditional Unit Credit to Entry Age Normal.

This schedule is presented to illustrate the requirement to show information for 10 years. However, until a full ten-year trend is compiled, the Plan will present information for those years for which information is available.

Salinas Valley Memorial Healthcare District
Employees Pension Plan
Schedules of Employer Contributions

Year Ended December 31,	Actuarially Determined Contribution	Actual Employer Contribution	Contribution Excess	Covered Payroll	Contribution as a % of Covered Payroll
2022	$ 10,157,917	$ 61,579,392	$ 51,421,475	$ 142,049,836	43.35%
2021	13,126,725	23,126,725	10,000,000	138,819,740	16.66%
2020	18,765,859	23,765,862	5,000,003	127,771,097	18.60%
2019	11,808,783	26,808,785	15,000,002	119,260,723	22.48%
2018	11,927,309	21,927,309	10,000,000	112,353,126	19.52%
2017	12,883,435	19,883,437	7,000,002	108,395,254	18.34%
2016	11,970,458	16,938,956	4,968,498	95,639,978	17.71%
2015	12,146,278	17,189,514	5,043,236	92,759,619	18.53%
2014	10,798,666	10,798,666	-	97,718,804	11.05%

Notes to schedule

Valuation date	Actuarially determined contributions are calculated as of January 1, the first day of the fiscal year in which the contributions are reported.
Methods and assumptions used	
Actuarial cost method	Entry Age
Inflation	2.25%
Salary increases	2015 - 2017: 3.75% (NUHW) and 4.00% (CNA), including inflation 3.75% plus merit increases (NUHW) and 4.00% plus merit increases (CNA) 2018 - 2022: 3.75% (NUHW) and 3.50%(CNA), including inflation 3.75% plus merit increases (NUHW) and 3.50% plus merit increases (CNA)
Investment rate of return	2014 - 2017: 7.50%, net of investment expense, including inflation 2018: 7.00%, net of investment expense, including inflation 2019 - 2022: 6.50%, net of investment expense, including inflation
Retirement age	
Normal retirement	65
Early retirement	50 and 15 years of vesting service
Mortality	2015 - 2017: RP-2000 Mortality Table for Males and Females, projected to 2033 2018: RP-2014 Mortality Table for Males and Females, projected to 2033 2019: PubG-2010 Generational Mortality Tables for Males and Females, projected using MP-2019 2020: PubG-2010 Generational Mortality Tables for Males and Females, projected using MP-2020 2021 - 2022: PubG-2010 Generational Mortality Tables for Males and Females, project using MP-2021

This schedule is presented to illustrate the requirement to show information for ten years. However, until a full ten-year trend is compiled, the Plan will present information for those years for which information is available.

Salinas Valley Memorial Healthcare District
Employees Pension Plan
Schedules of Investment Returns

	Year Ended December 31,								
	2022	2021	2020	2019	2018	2017	2016	2015	2014
Annual money-weighted rate of return, net of investment expenses	-18.04%	12.01%	12.92%	19.53%	-5.11%	14.22%	3.74%	0.68%	8.17%

This schedule is presented to illustrate the requirement to show information for ten years. However, until a full ten-year trend is compiled, the Plan will present information for those years for which information is available.

COMMUNICATIONS WITH THE
PERSONNEL AND PENSION COMMITTEE

SALINAS VALLEY MEMORIAL HEALTHCARE DISTRICT EMPLOYEES PENSION PLAN

December 31, 2022

MOSSADAMS

MOSSADAMS

Communications with the Personnel and Pension Committee

The Personnel and Pension Committee
Salinas Valley Memorial Healthcare District Employees Pension Plan

We have audited the financial statements of Salinas Valley Memorial Healthcare District Employees Pension Plan (the Plan) as of and for the year ended December 31, 2022, and have issued our report thereon dated November __, 2023. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility Under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated December 19, 2022, we are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS). As part of an audit conducted in accordance with U.S. GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit.

An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control over financial reporting. Accordingly, we considered the Plan's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the consolidated financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you in our engagement letter dated December 19, 2022, and planning discussions during June 2023.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the Plan are described in Note 2 to the financial statements.

No new accounting policies were adopted and there were no changes in the application of existing policies during 2022. We noted no transactions entered into by the Plan during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimate affecting the financial statements was:

Management's estimate of the long-term expected rate of return on the Plan's investments, which is also used as the discount rate, was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of investment expense and inflation) are developed for a hypothetical investment portfolio allocation of 65% equity and 35% fixed income. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. We evaluated the key factors and assumptions used to develop the long-term expected rate of return in determining that it is reasonable in relation to the financial statements as a whole.

Financial Statement Disclosures

The disclosures in the financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosure affecting the financial statements were:

- Investment valuations and types in Note 3 to the financial statements. The Plan's investment portfolio consists of mutual funds where market valuations are readily available.
- Disclosure of the employer's net pension liability (asset) in Note 5 to the financial statements.
- Actuarial methods and significant assumptions in Note 6 to the financial statements, which describes the significant actuarial methods and assumptions used in the valuation of the Plan. This disclosure provides details of the valuation date, actuarial method, long-term expected rate of return for each investment class in the portfolio, and the discount rate.

Significant Unusual Transactions

We encountered no significant unusual transactions during our audit of the Plan's financial statements.

Significant Difficulties Encountered in Performing the Audit

Professional standards require us to inform you of any significant difficulties encountered in performing the audit. No significant difficulties were encountered during our audit of the Plan's financial statements.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. No such disagreements arose during the course of our audit.

Circumstances that Affect the Form and Content of the Auditor's Report

There may be circumstances in which we would consider it necessary to include additional information in the auditor's report in accordance with U.S. GAAS. There were no circumstances that affected the form and content of the auditor's report.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated November __, 2023.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Plan's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Significant Audit Findings or Issues

We are required to communicate to you other findings or issues arising from the audit that are, in our professional judgment, significant and relevant to your oversight of the financial reporting process. There were no such items identified.

This information is intended solely for the use of the Personnel and Pension Committee and management of the Plan and is not intended to be and should not be used by anyone other than these specified parties..

Albuquerque, New Mexico

November __, 2023

MEDICAL EXECUTIVE COMMITTEE REPORT OF DECEMBER 14, 2023 MEETING

A Report will be Handed Out at the Board of Directors Meeting

(Rakesh Singh, MD)

EXTENDED CLOSED SESSION
(if necessary)

(VICTOR REY, JR.)

ADJOURNMENT