November 19, 2021

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in the Sequoia Regional Cancer Center Maynard Faught Conference Room on Monday November 22, 2021 beginning at 4:00PM in open session followed by a closed session beginning at 4:01PM pursuant to Government 54956.9(d)(2) and Health and Safety Code 1461 and 32155 followed by an open session at 4:20PM.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings (special meetings are posted 24 hours prior to meetings) in the Kaweah Health Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

The disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Health Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via phone 559-624-2330 or email: cmoccio@kdhcd.org, or on the Kaweah Delta Health Care District web page http://www.kaweahhealth.org.

KAWEAH DELTA HEALTH CARE DISTRICT
Garth Gipson, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk / Executive Assistant to CEO

DISTRIBUTION:
Governing Board
Legal Counsel
Executive Team
Chief of Staff
www.kaweahhealth.org

KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING

Sequoia Regional Cancer Center - Maynard Faught Conference Room
4945 W. Cypress Avenue

Monday November 22, 2021

OPEN MEETING AGENDA {4:00PM}

1. **CALL TO ORDER**
2. **APPROVAL OF AGENDA**
3. **PUBLIC PARTICIPATION –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdictions of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.
4. **APPROVAL OF THE CLOSED AGENDA – 4:01PM**
   - 4.1. **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case **-** *Evelyn McEntire, Director of Risk Management and Rachele Berglund, Legal Counsel*
   - 4.2. **Credentialing** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 – *Monica Manga, MD Chief of Staff*
   - 4.3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Monica Manga, MD Chief of Staff & Gary Herbst, CEO*
   - 4.4. **Approval of the closed meeting minutes** – October 25, 2021.

   Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

   Action Requested – Approval of the November 22, 2021 closed meeting agenda.
5. **ADJOURN**

CLOSED MEETING AGENDA {4:01PM}

1. **CALL TO ORDER**

2. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case.

   Evelyn McEntire, Director of Risk Management and Rachele Berglund, Legal Counsel

3. **CREDENTIALING** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 & 32155.

   Monica Manga, MD Chief of Staff

4. **QUALITY ASSURANCE** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee.

   Monica Manga, MD Chief of Staff

5. **APPROVAL OF THE CLOSED MEETING MINUTES** – October 25, 2021.

   Action Requested – Approval of the closed meeting minutes – October 25, 2021.

6. **ADJOURN**

OPEN MEETING AGENDA {4:20PM}

1. **CALL TO ORDER**
2. **APPROVAL OF AGENDA**
3. **PUBLIC PARTICIPATION –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdictions of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.
4. **CLOSED SESSION ACTION TAKEN** – Report on action(s) taken in closed session.
5. **OPEN MINUTES** – Request approval of the October 25, 2021 open minutes.

   Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

   Action Requested – Approval of the open meeting minutes – October 25, 2021 open board of directors meeting minutes.

6. **RECOGNITIONS** – *Director Francis*

6.1. Presentation of Resolution 2143 to Brisana Flores in recognition as the World Class Employee of the Month recipient – November 2021

7. **ANNUAL AUDITED FINANCIAL STATEMENT** – Report to Board from Moss Adams relative to the annual audited financial statement for fiscal year 2020/2021.

Kaweah Delta; Malinda Tupper, VP & Chief Financial Officer, Jennifer Stockton, Director of Finance, Moss Adams; John Feneis, Chris Pritchard, and Nini Pham

Recommended Action: Approval of the 2020/2021 Annual Audited Financial Statement.

8. **CREDENTIALS** - Medical Executive Committee requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the Medical Executive Committee be reviewed for approval.
Monica Manga, MD Chief of Staff

Public Participation – Members of the public may comment on agenda items before action is taken and after the Board has discussed the item.

Recommended Action: Whereas a thorough review of all required information and supporting documentation necessary for the consideration of initial applications, reappointments, request for additional privileges, advance from provision al status and release from proctoring and resignations (pursuant to the Medical Staff bylaws) has been completed by the Directors of the clinical services, the Credentials Committee, and the MEC, for all of the medical staff scheduled for reappointment, Whereas the basis for the recommendations now before the Board of Trustees regarding initial applications, reappointments, request for additional privileges, advance from provision al status and release from proctoring and resignations has been predicated upon the required reviews, including all supporting documentation, Be it therefore resolved that the following medical staff be approved or reappointed (as applicable), as attached, to the organized medical staff of Kaweah Delta Health Care District for a two year period unless otherwise specified, with physician-specific privileges granted as recommended by the Chief of Service, the Credentials Committee, and the Executive Committee of the Medical Staff and as will be documented on each medical staff member's letter of initial application approval and reappointment from the Board of Trustees and within their individual credentials files.

9. **CHIEF OF STAFF REPORT** – Report relative to current Medical Staff events and issues.
Monica Manga , MD Chief of Staff

10. **CONSENT CALENDAR -** All matters under the Consent Calendar will be approved by one motion, unless a Board member requests separate action on a specific item.

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

Action Requested – Approval of the October 25, 2021 Consent Calendar.

10.1. REPORTS

A. Urgent Care Centers
B. Home Health
C. Renal Services
D. Sequoia Integrated Health, LLC
E. 202 West Willow, LLC
F. Medical Staff Recruitment

10.2. Approval to reject the claim of Patricia Jean Forrester and James M. Forrester vs. Kaweah Health.

10.3. Kaweah Delta Health Care District Employees' Salary Deferral Plan (401(k)) and Kaweah Delta Health Care District 457(b) Deferred Compensation Plan.

A. Approval of Resolution 2144 of the Board of Directors of Kaweah Delta Health Care District amending the Employee Salary Deferral Plan effective January 1, 2021 and January 1, 2022.

B. Approval of Resolution 2145 of the Board of Directors of Kaweah Delta Health Care District amending the 457(b) Deferred Compensation Plan effective January 1, 2021 and January 1, 2022.

10.4. Medical Executive Committee Recommendations (November 2021)

A. MS 47 Code of Conduct for Medical Staff & Advanced Practice Providers (Revised)
B. MS 55 Peer Review Sharing Information (Revised)
C. MS 43 Informed Consent for Surgical, Diagnostic, or Therapeutic Procedure (Reviewed)

11. QUALITY – Healthgrades 2022 Quality Ratings Report and Leapfrog Safety Score Review– A review of Healthgrades ratings based on population specific mortality and complications rates from 2018-2020 and the fall 2021 Leapfrog Safety Grade and associated indicators.

Sandy Volchko, DNP, RN, Director of Quality and Patient Safety

12. QUALITY – Disparities in Care Committee – A review of data analysis to identify disparities in care related to defined population groups.

Inbal Epstein, MD, Emergency Medicine Resident & Lori Winston, MD, VP Medical Education

13. MASTER PLANNING – Review and discussion of master planning process and options for Kaweah Delta Health Care District.

Gary Herbst, CEO and Marc Mertz, Vice President, Chief Strategy Officer

14. **PATIENT THROUGHPUT CONSULTING ENGAGEMENT** - Review a proposal from The Chartis Group consulting firm to assist Kaweah Health with a comprehensive patient throughput engagement.

Keri Noeske, RN, BSW, DNP, Vice President & Chief Nursing Officer.

Public Participation – Members of the public may comment on agenda items before action is taken and after the Board has discussed the item.

Recommended Action: Authorized management to enter into the necessary agreements and take all necessary steps to execute a comprehensive patient throughput engagement with The Chartis Group to be funded from operations and cash reserves.

15. **FINANCIALS** – Review of the most current fiscal year financial results and budget.

Malinda Tupper –Vice President & Chief Financial Officer

16. REPORTS

16.1. Chief Executive Officer Report - Report relative to current events and issues.
Gary Herbst, Chief Executive Officer

16.2. Board President - Report relative to current events and issues.
David Francis, Board President

17. ADJOURN

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors meeting.

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY NOVEMBER 22, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-49

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY OCTOBER 25, 2021, AT 4:00PM, IN THE SEQUOIA REGIONAL CANCER CENTER MAYNARD FAUGHT CONFERENCE ROOM

PRESENT: Directors Francis, Gipson, Havard Mirviss, Olmos & Rodriguez; G. Herbst, CEO; M. Manga, MD, Chief of Staff, K. Noeske, VP& CNO; M. Tupper, VP & CFO; D. Cox, VP Chief HR Officer; M. Mertz, VP & Chief Strategy Officer; D. Leeper, VP & CIO; R. Gates, VP Population Health; D. Allain, VP Cardiac & Surgical Services; J. Batth, VP of Rehabilitation & Post-Acute Care; B. Cripps, Chief Compliance Officer, R. Berglund, Legal Counsel; and C. Moccio, recording

The meeting was called to order at 4:00PM by Director Francis.

Director Francis entertained a motion to approve the agenda.

MMSC (Gipson/Havard Mirviss) to approve the open agenda. . This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Gipson, Rodriguez and Francis

PUBLIC PARTICIPATION – none

APPROVAL OF THE CLOSED AGENDA – 4:01PM

- **Conference with Legal Counsel** – Existing Litigation – Pursuant to Government Code 54956.9(d)(1) – *Richard Salinas, Legal Counsel and Evelyn McEntire, Director of Risk Management*
  - Edison v. Barcenas: Case # VCU265419
  - Martinez (Santillan) v. KDHCD Case # VCU279163
  - Richards v KDHCD Case # VCU280708
  - Foster v KDHCD Case # 280726
  - Stalcup v KDHCD Case # 284918
  - Stanger v Visalia Medical Center Case # VCU284760
  - Taylor v KDHCD Case # VCU285079
  - Dunlap v KDHCD Case # VCU285988
  - Price v. KDHCD Case # VCU287060
  - Rocha v. KDCHD Case # VCU288014
  - Serrins v. KDHCD Case # VCU287823
  - Shipman v. KDHCD Case # VCU287291
- **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 3 Cases **-** *Richard Salinas, Legal Counsel and Evelyn McEntire, Director of Risk Management*
- **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee —*Evelyn McEntire, Director of Risk Management*
- **Conference with Legal Counsel** – Existing Litigation – Pursuant to Government Code 54956.9(d)(1) Kaweah Delta Health Care District vs. Xavier Becerra: Case # 1:21-at-00921– *Rachele Berglund, Legal Counsel*
- **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case **–** *Rachele Berglund, Legal Counsel*

- **Credentialing** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 – *Monica Manga, MD Chief of Staff*
- **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Monica Manga, MD Chief of Staff & Gary Herbst, CEO*

○ **Approval of the closed meeting minutes** – September 27, 2021.

MMSC (Havard Mirviss/Rodriguez) to approve the closed agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

ADJOURN - Meeting was adjourned at 4:01PM

David Francis, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:
Garth Gipson, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY OCTOBER 25, 2021, AT 5:00PM, IN THE SEQUOIA REGIONAL CANCER CENTER MAYNARD FAUGHT CONFERENCE ROOM

PRESENT: Directors Francis, Gipson, Havard Mirviss, Olmos & Rodriguez; G. Herbst, CEO; M. Manga, MD, Chief of Staff, K. Noeske, VP& CNO; M. Tupper, VP & CFO; D. Cox, VP Chief HR Officer; M. Mertz, VP & Chief Strategy Officer; D. Leeper, VP & CIO; R. Gates, VP Population Health; D. Allain, VP Cardiac & Surgical Services; J. Batth, VP of Rehabilitation & Post-Acute Care; B. Cripps, Chief Compliance Officer, R. Berglund, Legal Counsel; and C. Moccio, recording

The meeting was called to order at 5:19PM by Director Francis.

Director Francis asked for approval of the agenda.

MMSC (Rodriguez/Olmos) to approve the open agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

PUBLIC PARTICIPATION – none

CLOSED SESSION ACTION TAKEN: On the motion of Director Olmos and second by Director Havard Mirviss the Board ratified and approved initiation of litigation against Xavier Becerra, Secretary of the US Department of Health and Human Services. This was supported unanimously by those present. Vote: Yes – Gipson, Olmos, Havard Mirviss, Rodriguez, and Francis

MMSC (Gipson/Havard Mirviss) to approve the closed minutes from October 25, 2021. This was supported unanimously by those present. Vote: Yes – Gipson, Olmos, Havard Mirviss, Rodriguez, and Francis

OPEN MINUTES – Request approval of the open meeting minutes from October 25, 2001.

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

MMSC (Gipson/Havard Mirviss) to approve the open minutes from October 25, 2021. This was supported unanimously by those present. Vote: Yes – Gipson, Olmos, Havard Mirviss, Rodriguez, and Francis

RECOGNITIONS – Introduction of Frank Martin, Director of Trauma Program and presentation of Resolution 2142 to Wendy Walters in recognition as the World Class Employee of the Month recipient – October 2021.

CREDENTIALING – Medical Executive Committee requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the Medical Executive Committee be reviewed for approval.

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

Director Francis requested a motion for the approval of the credentials report excluding the resignation of Inderbir Gill, MD.

MMSC (Gipson/Havard Mirviss) Whereas a thorough review of all required information and supporting documentation necessary for the consideration of initial applications, reappointments, request for additional privileges, advance from provisional status and release from proctoring and resignations (pursuant to the Medical Staff bylaws) has been completed by the Directors of the clinical services, the Credentials Committee, and the Executive Committee of the Medical Staff, for all of the medical staff scheduled for reappointment, Whereas the basis for the recommendations now before the Board of Trustees regarding initial applications, reappointments, request for additional privileges, advance from provisional status and release from proctoring and resignations has been predicated upon the required reviews, including all supporting documentation, Be it therefore resolved that the following medical staff, excluding Emergency Medicine Providers as highlighted on Exhibit A (copy attached to the original of these minutes and considered a part thereof), be approved or reappointed (as applicable), to the organized medical staff of Kaweah Delta Health Care District for a two year period unless otherwise specified, with physician-specific privileges granted as recommended by the Chief of Service, the Credentials Committee, and the Executive Committee of the Medical Staff and as will be documented on each medical staff member's letter of initial application approval and reappointment from the Board of Trustees and within their individual credentials files . This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

CHIEF OF STAFF REPORT – Report from Monica Manga, MD – Vice Chief of Staff (copy attached to the original of these minutes and considered a part thereof).

- No Report.

CONSENT CALENDAR – Director Francis entertained a motion to approve the consent calendar (copy attached to the original of these minutes and considered a part thereof).

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

MMSC (Havard Mirviss/Gipson) to approve the consent calendar as submitted. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

QUALITY – SEPSIS – Quality Focus Team Report – A review of Centers for Medicare & Medicaid Services SEP-1 measure performance, outcomes and associated action plan for continuous improvement (copy attached to the original of these minutes and considered a part thereof) - *Sandy Volchko, DNP, RN, CLSSBB, Director of Quality and Patient Safety, and Tom Gray, MD, Medical Director of Quality and Patient Safety*

QUALITY – MERP (MEDICAL ERROR REDUCTION PROGRAM) – A review of the Medication Error Reduction Program, goals and associated action plans (copy attached to the original of these minutes and considered a part thereof) - *James McNulty, PharmD, Director of Pharmacy*

STRAGEGIC PLAN

Quarterly review of the Kaweah Health Strategic Plan (copy attached to the original of these minutes and considered a part thereof) - *Marc Mertz, Vice President & Chief Strategy Office*

Review of request to amend the metrics for Strategic Plan Initiatives; (copy attached to the original of these minutes and considered a part thereof) - Outstanding Health Outcomes – *Doug Leeper;* Empower Through Education – *Dianne Cox & Amy Shaver;* Ideal Work Environment – *Dan Allain & Raleen Larez*

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

MMSC (Gipson/Rodriguez) to approve the *revised Strategic Plan amending the metrics for the Outstanding Health Outcomes, Empower Through Education, and Ideal Work Environment initiatives*. This was supported unanimously by those present. Vote: Yes – Gipson, Olmos, Havard Mirviss, Rodriguez, and Francis

Review of the Kaweah Health Strategic Plan Initiative – Patient and Community Experience (copy attached to the original of these minutes and considered a part thereof) - *Keri Noeske, Vice President & Chief Nursing Officer & Ed Largoza Director of Patient Experience*

FINANCIALS – Review of the most current fiscal year financial results and budget (copy attached to the original of these minutes and considered a part thereof) - *Malinda Tupper –Vice President & Chief Financial Officer*

NORTHWEST VISALIA SENIOR HOUSING, LLC – Request authorization for officers and agents of Kaweah Delta Health Care District dba Kaweah Health relative to planned refinancing by Northwest Visalia Senior Housing, LLC. (copy attached to the original of these minutes and considered a part thereof) - *Marc Mertz, Vice President & Chief Strategy Officer*

Public Participation – Members of the public may comment on agenda items before action is taken and after the Board has discussed the item.

MMSC (Havard Mirviss/Rodriguez) to *authorize the officers and agents of Kaweah Delta Health Care District dba Kaweah Health to approve and execute any and all documents necessary to accomplish the planned refinancing by Northwest Visalia Senior Housing, LLC {NVSH} of the loan(s) secured by the real property owned by NVSH.* This was supported unanimously by those present. Vote: Yes – Gipson, Olmos, Havard Mirviss, Rodriguez, and Francis

CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY ROUND 3 GRANT – Review of the grant application for the Investment in Mental Health Wellness Grant Program for Children & Youth. Kaweah Health will be the co-applicant and the Tulare County Health & Human Services Agency will serve as the lead applicant (copy attached to the original of these minutes and considered a part thereof).

Public Participation – Members of the public may comment on agenda items before action is taken and after the Board has discussed the item.

MMSC (Havard Mirviss/Gipson) to *authorize the officers and agents of Kaweah Delta Health Care District dba Kaweah Health to approve and execute any and all documents necessary to submit the grant application to the California Health Facilities Financing Authority for the Investment in Mental Health Wellness Grant Program in an amount not to exceed $4,932,779 to specifically address a continuum of crisis services for children and youth, 21 years of age and under. This authorization is contingent upon Kaweah Health receiving an irrevocable agreement from the County of Tulare to provide annual funds to sustain the CSU.* This was supported unanimously by those present. Vote: Yes – Gipson, Olmos, Havard Mirviss, Rodriguez, and Francis

CHIEF EXECUTIVE OFFICER REPORT – Report relative to current events and issues - Gary Herbst, Chief Executive Officer

- The Medical Center still have over 100 COVID patients (117 as of today), the San Joaquin Valley has the highest number of new cases in the State.
- This morning we were at 106% occupancy.
- Proposal of having the annual holiday gather of the Board/ET/MEC Officers, asked for everyone to provide their feedback relative to the proposed event.

BOARD PRESIDENT REPORT – Report from David Francis, Board President

- Director Francis noted that next month we will provide dinner for the Board meeting.

ADJOURN - Meeting was adjourned at 8:11PM

David Francis, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

Garth Gipson, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

RESOLUTION 2143

WHEREAS, Kaweah Delta Health Care District dba Kaweah Health recognizes Brisana Flores with the World Class Employee of the Month Award – November 2021 for consistent outstanding performance and,

WHEREAS, Brisana embodies the Mission of Kaweah Health; *Health is our passion, Excellence is our focus, Compassion is our promise* and,

WHEREAS, Brisana embraces the Pillar of Kaweah Health - *Deliver Excellent Service* and,

WHEREAS, the Board of Directors of the Kaweah Delta Health Care District is aware of her excellence in caring and service,

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District on behalf of themselves, the Kaweah Health staff, and the community they represent, hereby extend their congratulations to Brisana for this honor and in recognition thereof, have caused this resolution to be spread upon the minutes of the meeting.

PASSED AND APPROVED this 22nd day of November 2021 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

Secretary/Treasurer, Kaweah Delta Health Care District
and of the Board of Directors, thereof

When I think of Brisana, I think of a strong, intelligent, compassionate social worker who thrives on advocating for our most vulnerable patients and families. Her knowledge and understanding of the social worker profession helps guide her ability to navigate our most challenging cases with a graceful professionalism that helps everyone involved in the case feel better about the services provided.
Brisana is a social worker assigned to our CVICU and CVICCU. Her daily practice consists of navigating her team and patients through difficult situations. She manages family dynamics that create barriers for treatment planning. Things like a patients lacking capacity and do not have a decision maker, or a patient who came in as a “John Doe” and we have no family contact, are challenges that Brisana overcomes on a regular basis. She walks patients and families through end of life decisions with a calming and supportive demeanor. She provides a sense of security and comfort to our patients and teams as they know Brisana will walk them though the current challenge.
Brisana consistently performs her duties with a heartfelt smile and genuine desire to help. She is always willing to assist every patient, every family and every team member any way she can. Brisana also takes on the extra tasks like managing/supervising a Fresno State student. Brisana is reliable and consistent in her professional practice. She is someone that I can depend.
I support the nomination of Brisana Flores for the employee of the month award. She demonstrates the characteristics and values of the social work professional as well as Kaweah Health. I am honored to have Brisana as part of my Patient and Family Services team.

MOSSADAMS

Kaweah Delta Healthcare District

2021 Audit Results

Board of Directors

Kaweah Delta Health Care District

Dear Board of Directors:

Thank you for your continued engagement of Moss Adams LLP. We are pleased to have the opportunity to meet with you to discuss the results of our audit of the consolidated financial statements of Kaweah Delta Health Care District ("the District") for the year ended June 30, 2021.

The accompanying report, which is intended solely for the use of the Board of Directors and management, presents important information regarding the Kaweah Delta Health Care District consolidated financial statements and our audit that we believe will be of interest to you. It is not intended to be, and should not be, used by anyone other than these specified parties.

We conducted our audit with the objectivity and independence that you expect. We received the full support and assistance of the Kaweah Delta Health Care District personnel. We are pleased to serve and be associated with the Kaweah Delta Health Care District as its independent public accountants and look forward to our continued relationship.

We look forward to discussing our report or any other matters of interest with you during this meeting.

Agenda

- Auditor Opinion and Report
- Communication with Those Charged with Governance
- Financial Ratios and Metrics
  - Statement of Financial Position
  - Operations

MOSSADAMS

Auditor Opinion and Report

Scope of Services

We have performed the following services for Kaweah Delta Health Care District:

- Annual consolidated financial statement audit as of and for the year ended June 30, 2021

Auditor Report on the Financial Statements

Unmodified Opinion

- Consolidated financial statements are presented fairly and in accordance with United States Generally Accepted Accounting Principles (“U.S. GAAP”)
- 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*

Communication with Those Charged with Governance

- Our responsibility under U.S. GAAP and *Government Auditing Standards*
- Planned scope and timing of the audit
- Significant audit findings
- Qualitative aspects of accounting practices
- Significant accounting estimates
- Financial statement disclosures
- Difficulties encountered in performing the audit
- Corrected and uncorrected misstatements
- Disagreements with management
- Management representations
- Management consultations with other independent accountants
- Independence
- Other audit findings or issues

MOSSADAMS

Financial Ratios and Metrics

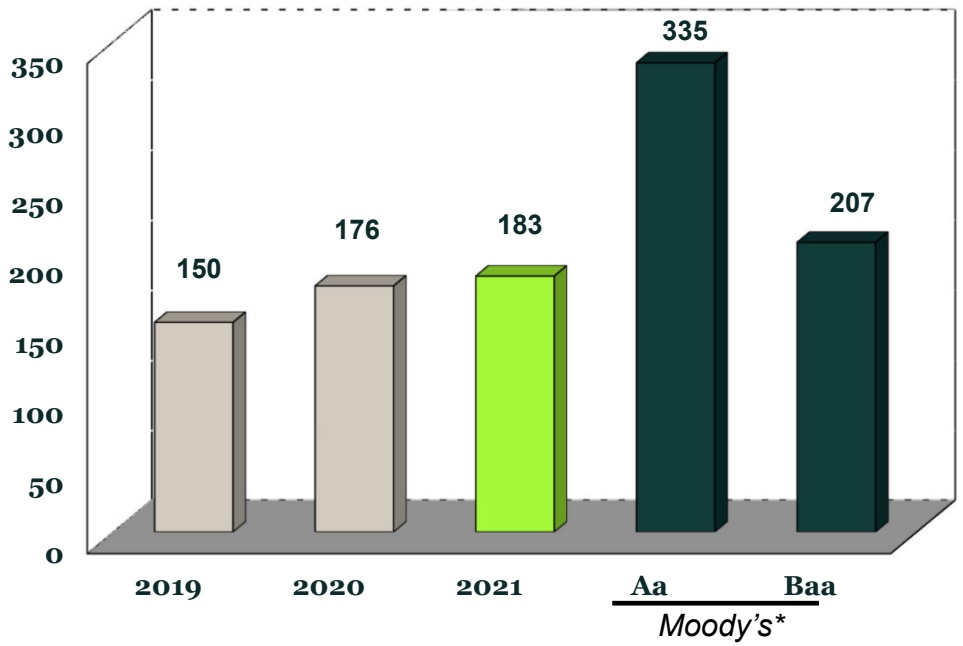
MOSSADAMS

Statement of Financial Position

Cash on Hand (days)

- Liquidity indicator
- Measures the ability of the hospital to sustain operations with existing cash
- The higher the number, the more cash reserves available
- (Unrestricted cash and investments plus funds designated for capital improvements x 365)/(total operating expenses – depreciation and amortization expenses)

Cash on Hand (days)

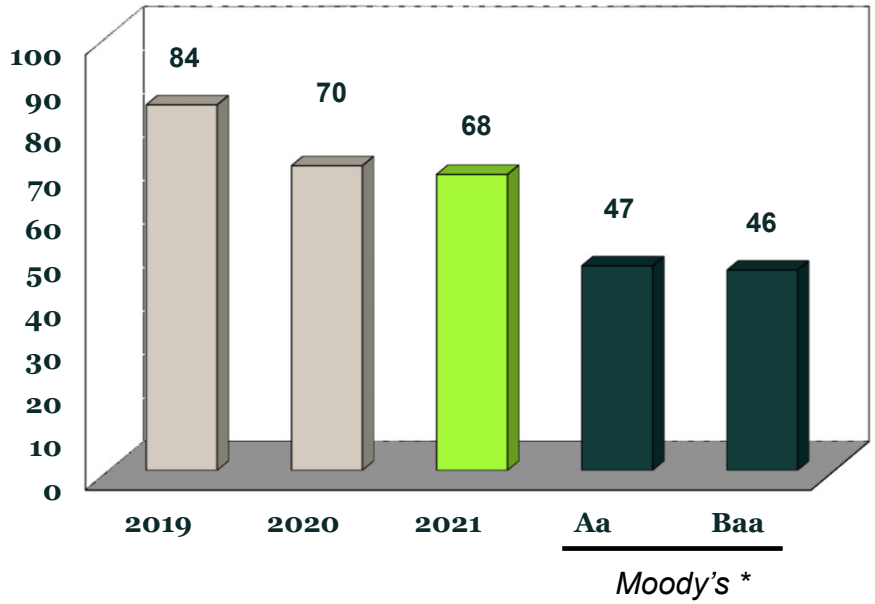


* Moody's Ratings: *2019 Median Ratios for Nonprofit Hospitals and Healthcare Systems*

Days in Accounts Receivable

- Liquidity indicator
- Measures the average number of days that accounts receivable are outstanding
- Lower number indicates that outstanding balances are being collected within a shorter duration
- (Net accounts receivable)/(net patient revenue/365)

Days in Accounts Receivable

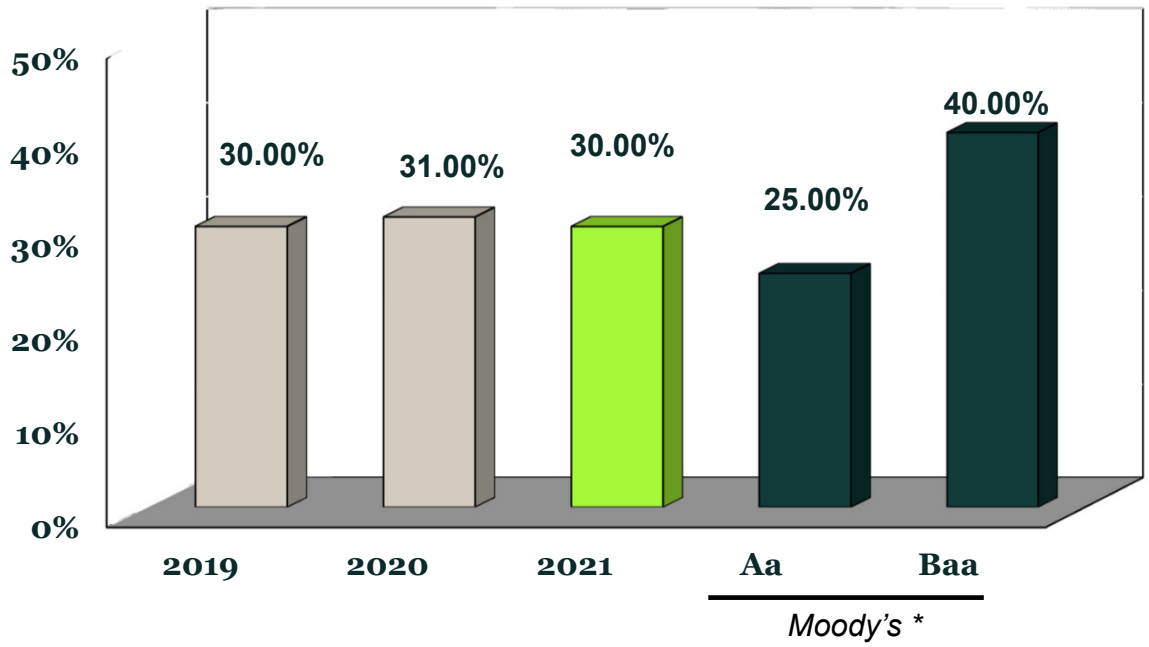


* Moody's Ratings: *2019 Median Ratios for Nonprofit Hospitals and Healthcare Systems*

Debt to Capitalization

- Leverage indicator
- Indicates extent assets are financed with debt as opposed to paid for with cash
- Lower number indicates assets are “bought and paid for”
- (Long-term and current portion of debt)/(long-term and current portion of debt plus net assets)

Debt to Capitalization

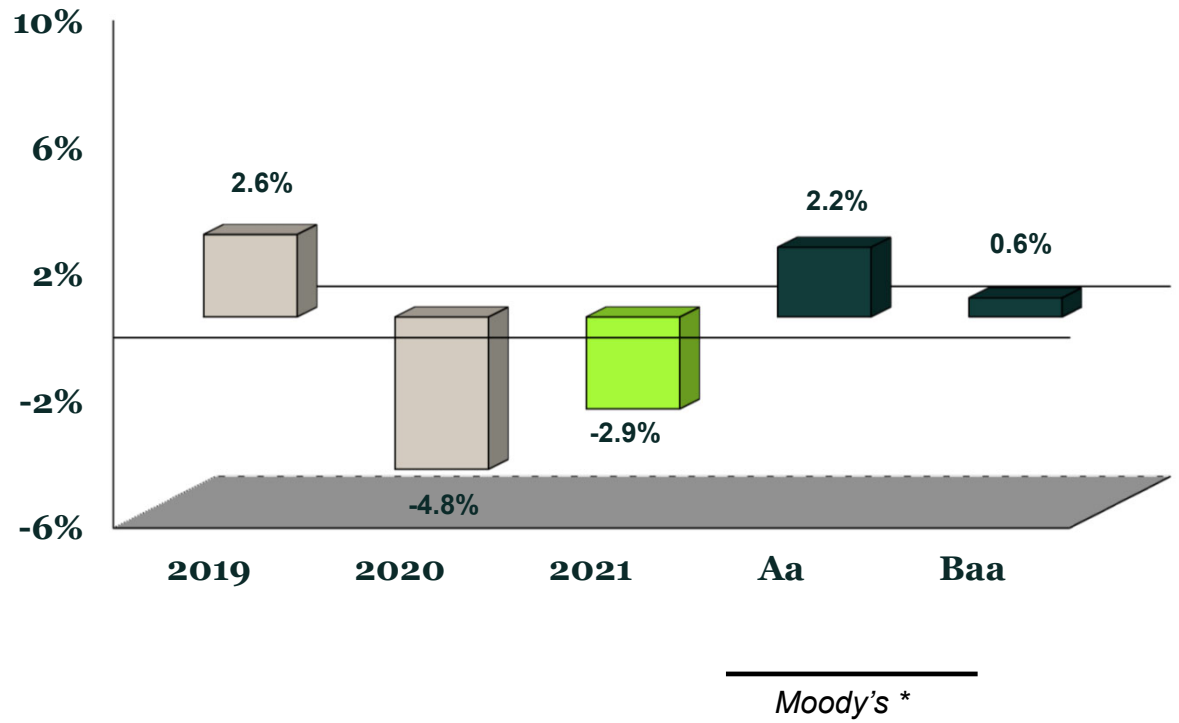


* Moody's Ratings: *2019 Median Ratios for Nonprofit Hospitals and Healthcare Systems*

MOSSADAMS

Operations

Operating Margin
(Operating Income / Total Revenue)



* Moody's Ratings: *2019 Median Ratios for Nonprofit Hospitals and Healthcare Systems*

Chris Pritchard
Chris,Pritchard@mossadams.com
(415) 6770-8262

John Feneis
John.Feneis@mossadams.com
(415) 677-8341

THANK YOU

Report of Independent Auditors and
Consolidated Financial Statements with
Supplementary Information

Kaweah Delta Health Care District

June 30, 2021 and 2020

Table of Contents

Management's Discussion and Analysis

Kaweah Delta Health Care District's (the "District") discussion and analysis is designed to assist the reader in focusing on significant financial issues, provide an overview of the District's financial activity, identify changes in the District's financial position, and identify any material deviations from the financial plan (the "approved budget"). Unless otherwise noted, all discussion and analysis pertains to the District's financial condition, results of operations, and cash flows as of and for the year ended June 30, 2021. Please read it in conjunction with the consolidated financial statements in this report.

Financial Highlights

- The District's net position increased by $13.9 million, or 2.9%, primarily attributable to the year's net income (income before contributions). Total assets increased by $48.8 million, or 5.1%. Cash and investments increased by $13.7 million, or 3.4%, due to the $33.1 million increase in the Medicare advance payment liability. The addition of the net pension asset of $22.3 million also contributed to the increase. Capital assets increased $6.4 million to $344.8 million with $36.7 million in net additions to buildings, equipment, and construction-in-progress, exceeding a $30.3 million net increase in accumulated depreciation.

- The District's total operating revenues increased to $776.3 million, a 5.7% increase from the prior year, while total operating expenses increased to $798.6 million, an increase of 3.8%. The current year increase in total operating revenues is primarily due to a $37.8 million increase in net patient services revenue and a $7.2 million increase in premium revenue. The increase in net patient services revenue is driven by an increase in patient volumes. The increase in premium revenue is due to an increase in the number of covered lives as well as an increase in the per member payment amount.

- Capital contributions to Kaweah Delta Hospital Foundation (the "Foundation") were $1,515,000 in fiscal year 2021, an increase of $664,000 compared to fiscal year 2020.

- During the fiscal year, the District made the following significant capital expenditures:

    - Construction costs and related equipment for the expansion of the emergency department, the inpatient pharmacy remodel and a new rural health clinic

    - PET CT machine

    - New patient care beds and patient monitoring equipment

The source of funding for these projects was derived from operations, capital contributions, bond project funds, and funds reserved for capital acquisition.

Required Consolidated Financial Statements

The consolidated financial statements of the District include: (a) a consolidated statement of net position, (b) a consolidated statement of revenues, expenses, and changes in net position, and (c) a consolidated statement of cash flows. The consolidated statement of net position includes information about the nature of the District's assets and liabilities and classifies them as current or noncurrent. It also provides the basis for evaluation of the capital structure of the District and for assessing the liquidity and financial flexibility of the District. The District's revenues and expenses are accounted for in the consolidated statement of revenues, expenses, and changes in net position. This statement measures the District's operations and can be used to determine whether the District has been able to recover all of its operating costs from patient services and other operating revenue sources. The primary purpose of the consolidated statement of cash flows is to provide information about the District's cash from operating, noncapital financing, capital and related financing, and investing activities. It provides answers to such questions as what were the District's sources of cash, what was cash used for, and what was the change in cash balances during the reporting period.

TABLE 1

Financial Analysis of the District

Condensed Consolidated Statements of Net Position

(in thousands)

A summary of the District's consolidated statements of net position is presented in Table 1 below:

	June 30, 2021	June 30, 2020	Dollar Change	Total % Change
Current and other assets	$ 656,696	$ 614,300	$ 42,396	6.9%
Capital assets	344,759	338,399	6,360	1.9%
Total assets	1,001,455	952,699	48,756	5.1%
Deferred outflows	3,490	9,354	(5,864)	-62.7%
Total assets and deferred outflows	$ 1,004,945	$ 962,053	$ 42,892	4.5%
Current and other liabilities	$ 228,458	$ 226,958	$ 1,500	0.7%
Long-term debt outstanding	250,798	262,656	(11,858)	-4.5%
Total liabilities	479,256	489,614	(10,358)	-2.1%
Deferred inflows	39,321	-	39,321	
Net investment in capital assets	107,949	104,433	3,516	3.4%
Restricted	31,712	30,567	1,145	3.7%
Unrestricted	346,707	337,439	9,268	2.7%
Total net position	486,368	472,439	13,929	2.9%
Total liabilities, deferred inflows, and net position	$ 1,004,945	$ 962,053	$ 42,892	4.5%

As reflected in Table 1, net position increased $13.9 million to $486.4 million for the year ended June 30, 2021, primarily attributable to the District's $12.4 million income before contributions.

TABLE 2

Financial Analysis of the District (continued)

Condensed Consolidated Statements of Net Position

(in thousands)

A summary of the District's consolidated statements of net position is presented in Table 2 below:

	June 30, 2020	June 30, 2019	Dollar Change	Total % Change
Current and other assets	$ 614,300	$ 567,685	$ 46,615	8.2%
Capital assets	338,399	336,359	2,040	0.6%
Total assets	952,699	904,044	48,655	5.4%
Deferred outflows	9,354	5,866	3,488	59.5%
Total assets and deferred outflows	$ 962,053	$ 909,910	$ 52,143	5.7%
Current and other liabilities	$ 226,958	$ 163,738	$ 63,220	38.6%
Long-term debt outstanding	262,656	258,727	3,929	1.5%
Total liabilities	489,614	422,465	67,149	15.9%
Deferred inflows	-	8,206	(8,206)	-100.0%
Net investment in capital assets	104,433	105,427	(994)	-0.9%
Restricted	30,567	30,090	477	1.6%
Unrestricted	337,439	343,722	(6,283)	-1.8%
Total net position	472,439	479,239	(6,800)	-1.4%
Total liabilities, deferred inflows, and net position	$ 962,053	$ 909,910	$ 52,143	5.7%

As reflected in Table 2, net position decreases $6.8 million to $472.4 million for the year ended June 30, 2020, primarily attributable to the District's $7.7 million loss before contributions.

TABLE 3

Financial Analysis of the District (continued)

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

(in thousands)

The following table presents a summary of the District's revenues, expenses, and changes in net position:

	Years Ended			
	June 30, 2021	June 30, 2020	Dollar Change	Total % Change
Net patient services revenue	$ 652,256	$ 614,435	$ 37,821	6.2%
Premium revenue	58,107	50,903	7,204	14.2%
Management services revenue	34,167	32,805	1,362	4.2%
Other operating revenue	31,788	36,205	(4,417)	-12.2%
Total operating revenues	776,318	734,348	41,970	5.7%
Salaries and benefits	382,418	384,975	(2,557)	-0.7%
Medical and other supplies	162,660	148,816	13,844	9.3%
Medical and other fees and services	167,751	151,487	16,264	10.7%
Maintenance, utilities, and rent	39,842	37,974	1,868	4.9%
Depreciation and amortization	31,646	30,678	968	3.2%
Other	14,292	15,537	(1,245)	-8.0%
Total operating expenses	798,609	769,467	29,142	3.8%
Operating loss	(22,291)	(35,119)	12,828	-36.5%
Nonoperating revenues – net of nonoperating expenses	34,705	27,468	7,237	-26.3%
Income (loss) before contributions	12,414	(7,651)	20,065	-262.3%
Capital contributions	1,515	851	664	78.0%
Change in net position	13,929	(6,800)	20,729	-304.8%
Net position, beginning of year	472,439	479,239	(6,800)	-1.4%
Net position, end of year	$ 486,368	$ 472,439	$ 13,929	2.9%

TABLE 4

Financial Analysis of the District (continued)

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

(in thousands)

The following table presents a summary of the District's revenues, expenses, and changes in net position:

	Years Ended			
	June 30, 2020	June 30, 2019	Dollar Change	Total % Change
Net patient services revenue	$ 614,435	$ 638,382	$ (23,947)	-3.8%
Premium revenue	50,903	40,871	10,032	24.5%
Management services revenue	32,805	31,751	1,054	3.3%
Other operating revenue	36,205	40,569	(4,364)	-10.8%
Total operating revenues	734,348	751,573	(17,225)	-2.3%
Salaries and benefits	384,975	363,289	21,686	6.0%
Medical and other supplies	148,816	141,150	7,666	5.4%
Medical and other fees and services	151,487	145,592	5,895	4.0%
Maintenance, utilities, and rent	37,974	37,743	231	0.6%
Depreciation and amortization	30,678	30,851	(173)	-0.6%
Other	15,537	13,285	2,252	17.0%
Total operating expenses	769,467	731,910	37,557	5.1%
Operating (loss) income	(35,119)	19,663	(54,782)	-278.6%
Nonoperating revenues – net of nonoperating expenses	27,468	8,245	19,223	-233.1%
(Loss) income before contributions	(7,651)	27,908	(35,559)	-127.4%
Capital contributions	851	861	(10)	-1.2%
Change in net position	(6,800)	28,769	(35,569)	-123.6%
Net position, beginning of year	479,239	450,470	28,769	6.4%
Net position, end of year	$ 472,439	$ 479,239	$ (6,800)	-1.4%

Sources of Revenue

Operating revenues – For fiscal year 2021, the District derived 94.7% of its total revenues from operations. Operating revenues include, among other items, patient care revenue from Medicare, Medi-Cal, and other federal, state, and local government programs, and commercial insurance payers and patients; management services revenue associated with the District's forty-five percent (45%) ownership in SRCC-Medical Oncology, LLC, a management services organization providing staff, facilities, and administrative services to a medical oncology physician group; premium revenue associated with a capitated Medicare Advantage contract; cafeteria sales; PRIME program revenue; membership sales and dues from a District-owned health and fitness center; and minority ownership interests in a free-standing ambulatory surgery center, an assisted living center, and a memory care facility.

Nonoperating revenues – For fiscal year 2021, the District derived 5.3% of its total revenues from nonoperating revenues. Nonoperating revenues include investment income, Federal stimulus funds, gain on the sale of capital assets and property tax revenue including that associated with the general obligation bonds as well as an allocation of general property taxes assessed by the County of Tulare on properties residing within the District's geographical boundaries.

Operating and Financial Performance

The following summarizes the District's consolidated statements of revenues, expenses, and changes in net position between 2021 and 2020:

Acute admissions decreased by 945 or 3.9%, to 23,346 but acute patient days increased by 7,856, or 6.4%, to 131,332. Skilled nursing and long-term subacute patient days decreased by 5.8% with 19,936 days in 2021, and 21,162 days in 2020. Outpatient equivalent patient days, a measure of overall outpatient activity, decreased by 1.0% from 2020 levels. Increases in rural health clinic registrations, home health visits, and urgent care visits, were offset by decreases in radiation oncology and dialysis treatments, and emergency department visits. Inpatient admissions and outpatient activity was significantly impacted by COVID-19 during the last quarter of fiscal year 2020, with volumes recovering in fiscal year 2021.

Net patient services revenue increased $37.8 million, or 6.2%, in 2021. The increase in net patient services revenue can mainly be attributed to the increase in inpatient volume noted above.

The District participates in various supplemental payment programs administered by the State of California as discussed in detail in the notes to the consolidated financial statements. In fiscal year 2021, net patient services revenue includes $14.6 million related to the QAF Managed Care Medi-Cal program, $10.1 million related to the AB113 IGT FFS Medi-Cal Inpatient program, and $17.2 million related to the Rate Range IGT Managed Medi-Cal program.

Management services revenue increased $1.4 million, or 4.2%, from 2020. The increase in revenue is primarily associated with the increase in revenue generated by the SRCC-Medical Oncology joint venture.

Premium revenue associated with a capitated Medicare Advantage contract increased by $7.2 million, or 14.2%, from 2020, due to an increase in the number of covered lives as well as an increase in the per member payment amount.

Other operating revenue consists primarily of PRIME program revenue, cafeteria sales, equity ownership in an ambulatory surgery center, assisted living center, and memory care facility, contributions, and health and fitness center membership sales and dues. Other operating revenue decreased by $4.4 million, or 12.2%. This decrease is primarily related to a decrease in PRIME revenue recognized.

Salaries and benefits expense decreased $2.6 million, or 0.7%. Salaries and wages increased $15.6 million, or 5.0%, and employee benefits expense decreased $18.2 million, or 24.4%, from 2020. The increase in salaries and wages was attributable to an increase in hours paid ($2.1 million increase due to activities related to COVID-19) and wage related adjustments. The excess of investment earnings on the defined benefit pension plan assets was the main driver of the decrease in benefits expense.

Medical and other supplies increased $13.8 million, or 9.3%, from 2020, including an $8.4 million increase related to COVID-19 purchases for testing and personal protective equipment purchases, as well as increase in pharmaceutical costs associated with increased inpatient volumes, SRCC-Medical Oncology volume and the retail pharmacy.

Medical and other fees and services increased $16.3 million, or 10.7%, mainly due to a $11.3 million increase in third party purchased service cost related to the Medicare Advantage contract for which the District receives revenue on a capitation basis, and the remainder related to an increase in physician fees.

Maintenance, utilities, and rent increased by $1.9 million, or 4.9%, during 2021, primarily due to an increase in utilities.

Depreciation and amortization expense increased $968,000, or 3.2%.

Other expenses decreased $1.2 million, or 8.0%, resulting mainly from decreases in recruiting cost and professional liability expense.

Total operating expenses increased by $29.1 million, or 3.8%.

Nonoperating revenues of $43.1 million for fiscal year 2021, are comprised of $32.5 million of federal stimulus, or provider relief funding, $5.0 million of tax revenue received from the County of Tulare and $5.7 million in investment income on cash and investments. Investment income represents interest income and realized and unrealized gains and losses on District and Foundation investments. District investments by law may only be invested in high-grade, governmental and commercial fixed income securities and money market funds.

Nonoperating expenses represent interest on the District's short-term and long-term debt consisting of revenue and general obligation bonds and capital leases, loss on disposal of capital assets, and bond issuance expense. Total interest expense of $8.4 million increased by $1 million, or 13.4%, from 2020. Bond issuance expense decreased by $172,000 in 2021.

For fiscal year 2021, capital contributions of $1.5 million represent amounts received from Foundation donors to support specific capital purposes. The Foundation exists to support the needs of the District and to help build support for the District and our community.

The following summarizes the District's consolidated statements of revenues, expenses, and changes in net position between 2020 and 2019:

Acute admissions decreased by 2,659 or 9.9%, to 24,291 and acute patient days decreased by 9,330, or 7.0%, to 123,476. Skilled nursing and long-term subacute patient days also decreased by 1.7% with 21,162 in 2020, and 21,536 in 2019. Outpatient equivalent patient days, a measure of overall outpatient activity, increased slightly, 0.3%, from 2019 levels. Increases in rural health clinic registrations, home health visits, and cardiology clinic visits, were offset by decreases in outpatient therapy and dialysis treatments, and emergency department and urgent care visits. Inpatient admissions and outpatient activity was significantly impacted by COVID-19 during the last quarter of the fiscal year.

Net patient services revenue decreased $23.9 million, or 3.8%, in 2020. The decrease in net patient services revenue can mainly be attributed to the decrease in volume noted above as well as the $19.7 million decrease in Medi-Cal disproportionate share funding and other supplemental payment programs.

The District participates in various supplemental payment programs administered by the State of California as discussed in detail in the notes to the consolidated financial statements. In fiscal year 2020, net patient services revenue includes an increase of $20.8 million related to the QAF Managed Care Medi-Cal program, a decrease of $3.7 million related to the AB113 IGT FFS Medi-Cal Inpatient program, and an increase of $17.8 million related to the Rate Range IGT Managed Medi-Cal program.

Management services revenue increased $1.1 million, or 3.3%, from 2019. The increase in revenue is primarily associated with the increase in revenue generated by the SRCC-Medical Oncology joint venture.

Premium revenue associated with a capitated Medicare Advantage contract increased by $10.0 million, or 24.5%, from 2019, due to an increase in the number of covered lives as well as an increase in the per member payment amount.

Other operating revenue consists primarily of PRIME program revenue, cafeteria sales, equity ownership in an ambulatory surgery center, assisted living center, and memory care facility, contributions, and health and fitness center membership sales and dues. Other operating revenue decreased by $4.4 million, or 10.8%. This decrease is primarily related to a decrease in PRIME revenue recognized.

Salaries and benefits expense increased $21.7 million, or 6.0%. Salaries and wages increased $20.8 million, or 7.2%, and employee benefits expense increased $934,000, or 1.3%, from 2019. The increase in salaries and wages was attributable to an increase in hours paid ($2.3 million due to activities related to COVID-19), the conversion of contract labor to employed labor and wage related adjustments.

Medical and other supplies increased $7.7 million, or 5.4%, from 2019, including $1.4 million related to COVID-19 purchases for testing and personal protective equipment purchases, as well as increases in lab supplies, surgical supplies, minor medical equipment and pharmaceutical costs associated with SRCC-Medical Oncology volume and the retail pharmacy.

Medical and other fees and services increased $5.9 million, or 4.0%, mainly due to a $4.3 million increase in third party purchased service cost related to the Medicare Advantage contract for which the District receives revenue on a capitation basis, and the remainder related to an increase in physician fees.

Maintenance, utilities, and rent increased by $231,000, or 0.6%, during 2020, primarily due to an increase in utilities.

Depreciation and amortization expense decreased $173,000, or 0.6%.

Other expenses increased $2.3 million, or 17.0%, resulting mainly from a increases in recruiting cost and professional liability expense.

Total operating expenses increased by $37.6 million, or 5.1%.

Nonoperating revenues of $35.1 million for fiscal year 2020 are comprised of $15.0 million of federal stimulus, or provider relief funding, a $3.5 million gain on the sales of property not used in operations, $4.7 million of tax revenue received from the County of Tulare and $11.8 million in investment income on cash and investments. Investment income represents interest income and realized and unrealized gains and losses on District and Foundation investments. District investments by law may only be invested in high-grade, governmental and commercial fixed income securities and money market funds.

Nonoperating expenses represent interest on the District's short-term and long-term debt consisting of revenue and general obligation bonds and capital leases, loss on disposal of capital assets, and bond issuance expense. Total interest expense of $7.4 million increased by $200,000, or 2.8%, from 2019. Bond issuance expense increased by $172,000 in 2020.

For fiscal year 2020, capital contributions of $851,000 represent amounts received from Foundation donors to support specific capital purposes. The Foundation exists to support the needs of the District and to help build support for the District and our community.

Budget Results

The Board of Directors approves the annual operating budget of the District. The budget remains in effect the entire year, but is updated as needed for internal management use to reflect changes in activity and approved variances. A fiscal year 2021 budget comparison and analysis is presented below.

TABLE 5

Actual vs. Budget

(in thousands)

	Years Ended June 30,			
	2021 Actual	2021 Budget	Dollar Variance	Total % Variance
Net patient services revenue	$ 652,256	$ 658,056	$ (5,800)	-0.9%
Management services revenue	34,167	32,398	1,769	5.5%
Premium revenue	58,107	51,312	6,795	13.2%
Other operating revenue	31,788	28,606	3,182	11.1%
Total operating revenues	776,318	770,372	5,946	0.8%
Salaries and benefits	382,418	388,210	(5,792)	-1.5%
Medical and other supplies	162,660	151,540	11,120	7.3%
Medical and other fees and services	167,751	143,092	24,659	17.2%
Maintenance, utilities, and rent	39,842	40,647	(805)	-2.0%
Depreciation and amortization	31,646	32,173	(527)	-1.6%
Other	14,292	9,350	4,942	52.9%
Total operating expenses	798,609	765,012	33,597	4.4%
Operating (loss) income	(22,291)	5,360	(27,651)	-515.8%
Nonoperating revenues – net of nonoperating expenses	34,705	433	34,272	7915.0%
Income before contributions	$ 12,414	$ 5,793	$ 6,621	114.3%

In comparing actual versus budgeted 2021 results, the following is noted:

The District completed its fiscal year 2021 $6.6 million, or 114.3%, in excess of the budgeted income before contributions of $5.8 million. Operating income fell short of budget expectations but nonoperating income exceeded budget by $34.3 million due the receipt of $32.5 million of federal stimulus funds.

The District's operating income fell short of budget expectations by $27.7 million. Net patient services revenue fell short of budget by $5.8 million, or 0.9%, due to lower-than-expected patient volumes offset by an unbudgeted increase in Medi-Cal supplemental payment programs. Management services revenue, premium revenue, and other operating revenue exceeded budget expectations by $1.8 million, or 5.5%, $6.8 million, or 13.2%, and $3.2 million, or 11.1%, respectively. The District realized an unfavorable variance in total operating expenses of $33.6 million, or 4.4%, in fiscal year 2021. In addition to the $17.1 million of unbudgeted costs related to COVID-19, this unfavorable expense variance was mainly due to medical and other fees and services, which were $24.7 million, or 17.2%, higher than expected. The unfavorable variance in this area related to contract labor, purchased medical services for third party costs related to the capitated Medicare managed care contract, and physician fees. These unfavorable expense variances were partially offset by a $12.0 million favorable variance in employee benefits cost due to a $12.8 million positive difference between actual and expected earnings on pension plan assets.

Capital Assets

At June 30, 2021, the District had $344.8 million invested in a variety of capital assets, as reflected in the following schedule (in thousands), which represents a net increase (additions less retirements and depreciation) of $6.4 million from the end of the prior year.

	June 30, 2021	June 30, 2020	Dollar Change	Total % Change
Land	$ 17,542	$ 17,542	$ -	0.0%
Buildings and improvements	384,399	378,313	6,086	1.6%
Equipment	316,636	299,378	17,258	5.8%
Construction in progress	53,113	38,837	14,276	36.8%
	771,690	734,070	37,620	5.1%
Less: accumulated depreciation	427,169	396,060	31,109	7.9%
	344,521	338,010	6,511	1.9%
Property under capital leases, net of accumulated amortization	238	389	(151)	-38.8%
Capital assets, net	$ 344,759	$ 338,399	$ 6,360	1.9%

Material additions during fiscal year 2021 included (in thousands):

Construction and equipment costs related to:		
Emergency department expansion	$	14,570
Buidling improvements for new rural health clinic	$	3,689
Inpatient pharmacy remodel and related equipment	$	2,160
PET CT machine	$	1,890
Patient monitoring equipment	$	1,665
Cardiac catheterization lab equipment	$	893
Surgical equipment	$	882
Laboratory equipment	$	836
Radiology equipment	$	815
Patient beds	$	449

Long-Term Debt

At June 30, 2021, the District had approximately $261.9 million in capital lease obligations and revenue and general obligation bonds outstanding as described in Notes 8 and 9 to the consolidated financial statements. The general obligation bonds represent the general obligation of the District. The District has the power and is obligated to cause annual ad valorem taxes to be levied upon all property within the District, subject to taxation by the District, and collected by the County of Tulare for payment, when due, of the principal and interest on the bonds. The bond indenture agreements contain various restrictive covenants that include, among other things, minimum debt service coverage, maintenance of minimum liquidity, restrictions on certain additional indebtedness, and requirements to maintain certain financial ratios.

2020A and 2020B Bonds – During January 2020, the District issued $6.8 million Series 2020A and $8.2 million Series 2020B of Kaweah Delta Health Care District Revenue Bonds. Both the 2020A and the 2020B revenue bonds bear interest at a rate of 2.37%. The net proceeds were used to fund capital projects and equipment. The 2020A and 2020B revenue bonds maturing on or after June 1, 2020 to May 31, 2025, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to 102% of the principal amount of the bonds. The 2020A and 2020B revenue bonds maturing on or after June 1, 2025 to May 31, 2030, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to 101% of the principal amount of the bonds. The 2020A and 2020B revenue bonds maturing on or after June 1, 2030, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to the principal amount of the bonds, without premium.

Economic Outlook

The District's Board of Directors and management considered many factors when setting the fiscal year 2022 budget. Of primary importance in setting the 2022 budget is the status of the California economy, the fiscal policy of state and federal governments, the availability and affordability of labor, the general rise of health care related costs, and local and regional competition for health care services. Specific factors and assumptions incorporated in the District's fiscal year 2022 budget include:

- Inpatient utilization is projected to increase by 2.8% from 2021 levels reflecting an average daily patient census of 442. Outpatient activity expressed in equivalent inpatient days is projected to increase 10.5% from 2021.

- A 4.8% increase in gross patient services revenue due to increased patient care volume and mix of services, although no retail price increase was budgeted.
- A Medicare general acute care rate increase of approximately 1.0%, an increase of 2.4% for outpatient services, an increase of 0.7% for skilled nursing and for subacute services, an increase of 0.5% for home health services, an increase of 1.4% for rural health clinic services, an increase of 4.3% for acute rehabilitation, and a 4.8% increase for acute psychiatric services.
- No change in reimbursement anticipated for Medi-Cal fee-for-service acute medical/surgical, rehabilitation services, skilled nursing, subacute, psychiatric, home health, and outpatient fee-for-service reimbursement. Includes $16.7 million in disproportionate share payments, $4.0 million in anticipated fee-for-service intergovernmental transfer revenues and $16.1 million in provider fee intergovernmental transfer and grant revenue.
- Medi-Cal managed care reimbursement rate increases of approximately 1.3% based on scheduled rate increases included in multi-year contracts. Includes $16.4 million of Medi-Cal managed care rate range program intergovernmental transfer revenue.
- Annual scheduled rate increases for nongovernment managed care payers for contracts negotiated in prior years as well as expected new negotiated increases with managed care plans averaging 2.6%.

  The successful improvement of health care delivery system improvement initiatives under various care transformation programs resulting in the recognition of $8.0 million in related revenue.

- Overall expense per adjusted patient day is projected to decrease by 5.6% from the prior year.

District's Fiduciary Responsibility

The District is the trustee, or fiduciary, for certain amounts held on behalf of retirement plan participants. The District's fiduciary activities are reported in separate Statements of Fiduciary Net Position and Changes in Fiduciary Net Position. These activities are excluded from the District's other financial statements because the District cannot use these assets to finance operations. The District is responsible for ensuring that the assets reported in these funds are used for their intended purposes.

TABLE 6

Fiduciary Activities

(in thousands)

	RETIRMENT PLAN		
	2021	2020	2019
ASSETS			
Receivables	$ 365	$ 419	$ 1,076
Investments, at fair value	319,682	250,439	246,746
NET POSITION RESTRICTED FOR PENSIONS	$ 320,047	$ 250,858	$ 247,822
ADDITIONS			
Employer contributions	$ 11,400	$ 11,400	$ 11,400
Net income from investments	73,603	6,328	20,001
Total additions	85,003	17,728	31,401
DEDUCTIONS			
Deductions	15,814	14,692	13,500
INCREASE (DECREASE) IN NET POSITION RESTRICTED FOR PENSIONS	$ 69,189	$ 3,036	$ 17,901

Report of Independent Auditors

To the Board of Directors
Kaweah Delta Health Care District

Report on Financial Statements

We have audited the accompanying consolidated financial statements of the business-type activities and the aggregate remaining fund information of Kaweah Delta Health Care District (the "District"), as of and for the years ended June 30, 2021 and 2020, and the related notes to the financial statements, which collectively comprise the District's basic consolidated financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

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

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

Opinions

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the business-type activities and the aggregate remaining fund information of the Kaweah Delta Health Care District as of June 30, 2021 and 2020, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 1 through 15, and the supplemental pension information on pages 56 and 57 be presented to supplement the basic consolidated financial statements. Such information, although not a part of the basic consolidated financial statements, is required by the Governmental Accounting Standards Board, which considers it to be an essential part of financial reporting for placing the basic consolidated financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic consolidated financial statements, and other knowledge we obtained during our audit of the basic consolidated financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated _____, 2021, on our consideration of the District'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 District'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 District's internal control over financial reporting and compliance.

Stockton, California
_____, 2021

Consolidated Financial Statements

Kaweah Delta Health Care District
Consolidated Statements of Net Position
June 30, 2021 and 2020
(In Thousands)

	2021	2020
ASSETS AND DEFERRED OUTFLOWS		
CURRENT ASSETS		
Cash and cash equivalents	$ 30,081	$ 11,766
Current portion of Board designated and trustee assets	13,695	13,954
Accounts receivable:		
Patient accounts receivable	121,551	118,451
Other	16,050	16,669
Total accounts receivable	137,601	135,120
Inventories	10,800	8,479
Medicare and Medi-Cal settlements	37,339	36,726
Prepaid expenses	12,210	10,317
Total current assets	241,726	216,362
NONCURRENT CASH AND INVESTMENTS, net of current portion		
Board designated assets	349,933	338,785
Bond assets held by trustee	22,271	36,092
Assets in self-insurance trust fund	2,073	3,727
	374,277	378,604
CAPITAL ASSETS		
Land	17,542	17,542
Buildings and improvements	384,399	378,313
Equipment	316,636	299,378
Construction in progress	53,113	38,837
	771,690	734,070
Less: accumulated depreciation	427,169	396,060
	344,521	338,010
Property under capital leases, net of accumulated amortization	238	389
Total capital assets	344,759	338,399
NET PENSION ASSET	22,273	-
OTHER ASSETS		
Property not used in operations	1,635	1,686
Health-related investments	5,216	6,888
Other	11,569	10,760
	18,420	19,334
Total assets	1,001,455	952,699
DEFERRED OUTFLOWS OF RESOURCES		
Unamortized loss on defeasance of debt	2,845	3,244
Unamortized goodwill	236	290
Deferred outflows - actuarial	409	5,820
Total deferred outflows	3,490	9,354
Total assets and deferred outflows of resources	$ 1,004,945	$ 962,053

See accompanying notes.

(In Thousands)

	2021	2020
LIABILITIES, DEFERRED INFLOWS, AND NET POSITION		
CURRENT LIABILITIES		
Accounts payable and accrued expenses	$ 38,053	$ 38,146
Accrued payroll and related liabilities	71,537	63,411
Medicare accelerated payments payable	76,846	43,750
Long-term debt, current portion	11,128	10,647
Total current liabilities	197,564	155,954
LONG-TERM DEBT, net of current portion		
Bonds payable	250,675	262,436
Capital leases	123	220
	250,798	262,656
NET PENSION LIABILITY	-	40,378
OTHER LONG-TERM LIABILITIES	30,894	30,626
Total liabilities	479,256	489,614
DEFERRED INFLOWS OF RESOURCES		
Deferred inflows - actuarial	39,321	-
	39,321	-
NET POSITION		
Invested in capital assets, net of related debt	107,949	104,433
Restricted:		
Expendable	17,109	18,567
Nonexpendable - minority interest	2,083	2,608
Nonexpendable - permanent endowments	12,520	9,392
Unrestricted	346,707	337,439
Total net position	486,368	472,439
Total liabilities, deferred inflows of resources, and net position	$ 1,004,945	$ 962,053

Kaweah Delta Health Care District
Consolidated Statements of Revenues, Expenses, and Changes in Net Position
Years Ended June 30, 2021 and 2020
(In Thousands)

	2021	2020
OPERATING REVENUES		
Net patient services revenue	$ 652,256	$ 614,435
Premium revenue	58,107	50,903
Other revenues:		
Management services revenue	34,167	32,805
Other	31,788	36,205
Total other revenues	65,955	69,010
Total operating revenues	776,318	734,348
OPERATING EXPENSES		
Salaries and wages	326,062	310,423
Employee benefits	56,356	74,552
Total employment expenses	382,418	384,975
Medical and other supplies	162,660	148,816
Medical and other fees	113,218	107,399
Purchased services	54,533	44,088
Repairs and maintenance	26,155	25,516
Utilities	7,495	6,085
Rents and leases	6,192	6,373
Depreciation and amortization	31,646	30,678
Other	14,292	15,537
Total operating expenses	798,609	769,467
OPERATING LOSS	(22,291)	(35,119)
NONOPERATING REVENUES (EXPENSES)		
Property tax revenue	4,982	4,742
Federal stimulus funds	32,463	14,966
Investment income, net	5,664	11,823
Bond issuance expense	-	(172)
Interest expense	(8,407)	(7,411)
Gain on disposal of capital assets	3	3,520
Total nonoperating revenues	34,705	27,468
INCOME (LOSS) BEFORE CAPITAL CONTRIBUTIONS	12,414	(7,651)
CAPITAL CONTRIBUTIONS	1,515	851
CHANGES IN NET POSITION	13,929	(6,800)
NET POSITION, beginning of year	472,439	479,239
NET POSITION, end of year	$ 486,368	$ 472,439

See accompanying notes.

Kaweah Delta Health Care District
Consolidated Statements of Cash Flows
Years Ended June 30, 2021 and 2020
(In Thousands)

	2021	2020
CASH FLOWS FROM OPERATING ACTIVITIES		
Cash received from net patient services revenue	$ 648,433	$ 638,327
Cash received from management services and other operating revenues	124,647	116,651
Cash received from Medicare accelerated payments	33,096	43,750
Cash payments for salaries, wages, and related benefits	(374,292)	(380,727)
Cash payments for other operating expenses	(406,662)	(350,114)
Net cash from operating activities	25,222	67,887
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Property tax revenue	1,552	1,412
Federal stimulus funds	32,463	14,966
Net cash from noncapital financing activities	34,015	16,378
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Bond issuance costs	-	(172)
Interest payments on bonds payable and capital leases	(9,589)	(9,436)
Principal payments on bonds payable and capital leases	(10,643)	(9,442)
Proceeds from revenue bonds	-	15,000
Contributions received for capital expenditures	1,514	851
Tax revenue related to general obligation bonds	3,430	3,330
Purchase of capital assets	(36,724)	(30,956)
Proceeds from disposal of capital assets	11	5,608
Net cash used for capital and related financing activities	(52,001)	(25,217)
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest income on investments	4,818	6,493
Purchase of investments	(85,387)	(78,549)
Net health-related investment contributions	830	(6)
Proceeds from sales and maturities of investments	86,579	73,519
Net cash from investing activities	6,840	1,457
NET CHANGES IN CASH AND CASH EQUIVALENTS	14,076	60,505
CASH AND CASH EQUIVALENTS, beginning of year	205,474	144,969
CASH AND CASH EQUIVALENTS, end of year	$ 219,550	$ 205,474

See accompanying notes.

Kaweah Delta Health Care District
Consolidated Statements of Cash Flows (Continued)
Years Ended June 30, 2021 and 2020
(In Thousands)

	2021	2020
RECONCILIATION OF CASH AND CASH EQUIVALENTS TO THE STATEMENT OF NET POSITION		
Cash and cash equivalents in current assets	$ 30,081	$ 11,766
Cash and cash equivalents in noncurrent cash and investments:		
Board designated cash and investments	162,561	152,780
Bond assets held by trustee	26,893	40,921
Assets in self-insurance trust fund	15	7
	$ 219,550	$ 205,474
RECONCILIATION OF OPERATING LOSS TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating loss	$ (22,291)	$ (35,119)
Adjustments to reconcile operating loss to net cash from operating activities:		
Depreciation and amortization	31,646	30,678
Provision for bad debts	35,288	33,358
Changes in operating assets and liabilities:		
Accounts receivable	(37,770)	(7,965)
Inventories, prepaid expenses, and other assets	(4,879)	(3,261)
Accounts payable and accrued expenses, accrued payroll, related liabilities, Medicare accelerated payments payable, and other long-term liabilities	23,228	50,196
Net cash from operating activities	$ 25,222	$ 67,887

See accompanying notes.

Kaweah Delta Health Care District
Statements of Fiduciary Net Position
June 30, 2021 and 2020
(In Thousands)

	KAWEAH DELTA HEALTH CARE DISTRICT EMPLOYEES' RETIREMENT PLAN	
	2021	2020
ASSETS		
Receivables		
Accrued interest and dividends receivable	$ 365	$ 419
Total receivables	365	419
Investments at fair value:		
Cash and cash equivalents	4,625	5,818
Fixed income investments	67,686	47,678
Alternative investments	-	34,200
Equities	247,371	162,743
Total investments	319,682	250,439
TOTAL ASSETS AND NET POSITION RESTRICTED FOR PENSIONS	$ 320,047	$ 250,858

See accompanying notes.

Kaweah Delta Health Care District
Statements of Changes in Fiduciary Net Position
Years Ended June 30, 2021 and 2020
(In Thousands)

	KAWEAH DELTA HEALTH CARE DISTRICT EMPLOYEES' RETIREMENT PLAN	
	2021	2020
ADDITIONS		
Contributions		
Employer contributions	$ 11,400	$ 11,400
Investments income		
Net increase in fair value of investments	67,199	2,587
Interest and dividend income	8,053	5,107
Investment expense	(1,649)	(1,366)
Net income from investing	73,603	6,328
Total additions	85,003	17,728
DEDUCTIONS		
Benefit payments	15,527	14,448
Administrative expenses	287	244
Total deductions	15,814	14,692
INCREASE IN NET POSITION	69,189	3,036
NET POSITION RESTRICTED FOR PENSIONS		
Beginning of year	250,858	247,822
End of year	$ 320,047	$ 250,858

See accompanying notes.

NOTE 1 – BASIS OF PRESENTATION AND ACCOUNTING POLICIES

A summary of significant accounting policies applied in the preparation of the accompanying consolidated financial statements follows:

Reporting entity – Kaweah Delta Health Care District (the "District") is a political subdivision of the State of California, organized and existing under the State of California Local Health Care District Law as set forth in the Health and Safety Code of the state of California. The District is governed by a separately-elected Board of Directors (the "Board").

The accounting policies of the District conform to those recommended by the Health Care Committee of the American Institute of Certified Public Accountants. The District's consolidated financial statements are presented in accordance with the pronouncements of the Governmental Accounting Standards Board ("GASB"), and the Financial Accounting Standards Board ("FASB"), when applicable. The District is not generally subject to state and federal income taxes. The District provides health care services to individuals who reside primarily in the local geographic area.

Principles of consolidation – The consolidated financial statements of the District include the accounts of the District, Kaweah Delta Hospital Foundation (the "Foundation"), Kaweah Health Medical Group ("KHMG"), Sequoia Regional Cancer Center, LLC ("SRCC"), Sequoia Regional Cancer Center – Medical Oncology, LLC ("SRCC-MO"), and TKC Development, LLC ("TKC"). KHMG, SRCC, SRCC-MO, TKC, and the Foundation are component units that have been blended for presentation purposes. The District has a 75% interest in TKC, which leases real estate and equipment from the District and then subleases the real estate and equipment to SRCC and SRCC-MO. The District has a 75% interest in SRCC and a 45% interest in SRCC-MO, management services organizations providing staff, facilities, and administration services to the radiation oncology department of the District and a medical oncology physician group, respectively. The District provides key management, administrative, and support services to SRCC and SRCC-MO, including all of their employees, leased buildings and equipment, accounting, human resources, information technology, housekeeping, risk management, and maintenance services.

The Foundation was established in March 1980, as an exempt organization under Internal Revenue Code Section 501(c)(3) to raise funds to support the operation of the District. The Foundation's bylaws provide that all funds raised be distributed to or be held for the benefit of the District. The Foundation's general funds, which represent the Foundation's unrestricted resources, will be distributed to the District in amounts and in periods determined by the Foundation's Board of Trustees.

Effective November 1, 2015, the District and its subsidiary, Kaweah Delta Health Care, Inc., a California nonprofit 501(c)(3) public benefit corporation, doing business as KHMG, entered into an affiliation with Visalia Medical Clinic ("VMC"), a California professional medical corporation. VMC is the largest multi-specialty medical group in Visalia and has been in existence for over 75 years. KHMG provides primary and specialty care health services to patients. The District is the sole corporate member of KHMG, with the nonprofit entity operating as a California medical foundation pursuant to Section 1206(l) of the California Health and Safety Code. VMC transferred its personal property, payor agreements, and nonphysician staff, among other assets, to KHMG. All physicians and mid-level providers will continue to be employed by VMC. VMC has entered into a professional services agreement with KHMG and provides medical services to patients of KHMG.

All intercompany transactions have been eliminated in the District's consolidated financial statements.

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

Fiduciary fund accounting – Fiduciary funds for which the District acts only as an agent or trust are not included in the business-type activities of the District. These funds are reported in the Statement of Fiduciary Net Position and Statement of Change in Fiduciary Net Position at the fund financial statement level.

Kaweah Delta Health Care District Employees' Retirement Plan – The "Retirement Plan" was originally adopted as a defined benefit plan effective July 1, 1984. Effective June 30, 2011, the Retirement Plan was restated and amended (see Note 11). The Retirement Plan is administered by the sponsor, the District, and Retirement Plan assets are held by the custodian of the Retirement Plan, First State Trust Company. The Retirement Committee (the "Committee") of the District retains the responsibility to oversee the management of the Retirement Plan, including the requirement that investments and assets held within the Retirement Plan continually adhere to the requirements of the California Government Code which specifies that the trustee's primary role is to preserve capital, then maintain investment liquidity and thirdly, to protect investment yield. As such, the District acts as the fiduciary of the Retirement Plan.

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 disclosures of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Accounting standards – Pursuant to GASB Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 Financial Accounting Standards Board ("FASB") and American Institute of Certified Public Accountants ("AICPA") Pronouncements*, the District's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989 and State Controller's *Minimum Audit Requirement*s for California Special districts and the State Controller's office prescribed reporting guidelines.

Net patient services revenue and patient accounts receivable – Net patient services revenue is reported at the estimated net realizable amount from patients, governmental programs, health maintenance and preferred provider organizations, and insurance contracts under applicable laws, regulations, and program instructions. Net realizable amounts are generally less than the District's established rates. Final determination of certain amounts payable is subject to review by appropriate third-party representatives. Subsequent adjustments, if any, arising from such reviews are recorded in the year final settlement becomes known. Significant concentrations of net patient accounts receivable at June 30, 2021 and 2020, include Medicare, 38.71% and 31.16%, respectively, and Medi-Cal, 33.92% and 36.05%, respectively. The District provides for estimated losses on amounts receivable directly from patients based on historical bad debt experience. Past due status is based on the date the account is determined to be payable directly from the patient. When the account is deemed uncollectible in accordance with District policy, it is written off to bad debt expense. Recoveries from previously written-off accounts are recorded when received. At June 30, 2021 and 2020, the District provided allowances for losses on amounts receivable directly from patients totaling $72.4 million and $68.6 million, respectively. Amounts written off to bad debt expense included in net patient services revenue totaled approximately $35.3 million and $33.4 million for 2021 and 2020, respectively.

The District renders service to patients under contractual arrangements with the Medicare and Medi-Cal programs. Medicare payments are primarily prospective for inpatients, while Medicare payments for outpatients are based on a combination of a fee-for-service schedule and prospective reimbursement. Medi-Cal inpatient payments are subject to the state's prospective payment system. Medi-Cal outpatient services are reimbursed on a fee-for-service schedule. The programs' administrative procedures preclude final determination of amounts due for services to program patients until after the cost reports are audited or otherwise reviewed by and settled with the respective administrative agencies. Medicare and Medi-Cal cost reports for 2018 and 2019, are subject to audit and possible adjustment. Net Medicare and Medi-Cal program patient services revenue amounted to approximately $364.9 million and $396.2 million in 2021 and 2020, respectively. The District recognized in the consolidated statements of revenues, expenses, and changes in net position increases of approximately $731,000 and $921,000 in 2021 and 2020, respectively, in net patient services revenue pertaining to the settlement of previous years' cost reports.

Cash and cash equivalents – Cash and cash equivalents include cash in bank checking, savings, and time deposit accounts, money market funds, and investments in highly liquid debt instruments with a maturity of three months or less when purchased.

Charity care – The District provides care without charge or at amounts less than its established rates to patients who meet certain criteria under its charity care policy. The District accepts all patients regardless of their ability to pay. Partial payments, to which the District is entitled from public assistance programs on behalf of patients that meet the District's charity care criteria, are reported as net patient services revenue. Charity care, which is excluded from recognition as receivables or revenue in the consolidated financial statements, provided in 2021 and 2020, measured on the basis of uncompensated cost, was $4.6 million and $5.2 million, respectively.

Inventories – Inventories are reported at cost (determined by the first-in, first-out method), which is not in excess of market value.

Prepaid expenses – Certain payments to vendors reflect costs applicable to future accounting periods and are recorded as prepaid expenses.

Investments – Investments are reported at fair value, based on quoted market prices when applicable, and realized and unrealized gains and losses are included in nonoperating revenues as investment income. The fair market value of money market funds, guaranteed investment contracts, and investments in the Local Agency Investment Funds ("LAIF"), an external investment pool for government agencies administered by the State of California, approximates cost due to the liquid nature of these investments.

Noncurrent cash and investments – Noncurrent cash and investments include unrestricted cash and investments designated by the Board for future capital improvements, over which the Board retains control and may at its discretion subsequently use for other purposes, cash, and investments held by trustees under bond indentures, and cash and investments held in the District's self-insurance trust fund.

Intangible asset – The District has contributed $2.0 million of the 2004 general obligation bond proceeds to the city of Visalia (the "City") for the construction of a parking garage in exchange for 84 parking spaces for District use (see Note 9). The District's use of the parking spaces is indefinite and the District is amortizing the asset over the estimated 25-year useful life of the parking garage. Amortization began in 2007 when the parking garage was completed and placed into service by the City.

Capital assets – Property, plant, and equipment are reported on the basis of cost or, in the case of donated items, on the basis of fair market value at the date of donation. Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase values, change capacities, or extend useful lives are capitalized. The District capitalizes interest cost net of any interest earned on temporary investments of the proceeds for construction projects funded by tax-exempt borrowings. Interest expense is also capitalized for projects financed with operating funds.

Depreciation expense and amortization of property under capital leases are combined in the consolidated statements of revenues, expenses, and changes in net position and are computed by the straight-line method for financial reporting purposes over the estimated useful lives of the assets or the life of the lease, whichever is less, which range from 5 to 40 years for buildings and improvements, and 3 to 25 years for equipment and leasehold improvements.

At times the District may dispose of capital assets prior to the end of the assets' projected useful life. In cases when an associated gain or loss is recognized due to the disposal, the related gain or loss is shown as a nonoperating revenue or expenditure in the consolidated statement of revenue, expenses, and changes in net position.

Consolidated statements of revenues, expenses, and changes in net position – All revenues and expenses directly related to the delivery of health care services are included in operating revenues and expenses in the consolidated statements of revenues, expenses, and changes in net position. Nonoperating revenues and expenses consist of those revenues and expenses that are related to financing and investing types of activities and result from nonexchange transactions or investment income.

Medical malpractice and general liability self-insurance – The District maintains a self-insurance policy against malpractice and comprehensive general liability loss with supplemental coverage for losses in excess of $4.0 million per incident and $6.0 million in aggregate with a coverage limit of $20.0 million per incident and in aggregate. The current portion of the related liability is reported in accounts payable and accrued expenses on the consolidated balance sheet, while the long-term portion is included in other long-term liabilities. The District has established an irrevocable trust for the purpose of appropriating assets to cover such losses. Under the trust agreement, the trust assets can only be used for payment of malpractice losses, general liability losses, related expenses, and the cost of administering the trust. The assets of the trust and related liabilities are reported on the consolidated balance sheet. Income from the trust assets, estimated losses from claims, and administrative costs are reported in the consolidated statements of revenues, expenses, and changes in net position.

Losses from asserted and unasserted claims identified under the District's incident reporting system are accrued based on estimates that incorporate the District's past experience as well as other considerations, including the nature of each claim or incident and relevant trend factors. The District's accrued malpractice losses also include an estimate of possible losses attributable to incidents that may have occurred, but have not been identified under the incident reporting system. The District has employed independent actuaries to estimate the ultimate costs, if any, of the settlement of such claims. Estimated future payments relating to malpractice losses have been discounted at a 3.0% rate.

Workers' compensation self-insurance – The District maintains a self-insurance policy against workers' compensation losses with supplemental coverage for losses in excess of $1.5 million. The Board has designated funds for the payment of workers' compensation claims. The current portion of the related liability is reported in accrued payroll and related liabilities on the consolidated balance sheet, while the long-term portion is included in other long-term liabilities. Losses from asserted and unasserted claims identified under the District's incident reporting system are accrued based on estimates that incorporate the District's past experience, as well as other considerations including the nature of each claim or incident and relevant trend factors. The District's accrued workers' compensation losses also include an estimate of possible losses attributable to incidents that may have occurred, but have not been identified under the incident reporting system. The District has employed independent actuaries to estimate the ultimate costs, if any, of the settlement of such claims. Estimated future payments relating to workers' compensation losses have been discounted at a 1.5% rate.

Medical benefits self-insurance – The District maintains a policy of self-insuring medical costs up to $1 million per employee. The related liability is reported in accrued payroll and related liabilities on the consolidated balance sheet. Losses from asserted and unasserted claims identified under the District's reporting system are accrued based on estimates that incorporate the District's past experience and relevant trend factors. The District's accrued medical insurance liability also includes an estimate of possible losses attributable to incidents that may have occurred, but have not been reported.

Compensated absences – The District's benefits-eligible employees earn vacation, short-term illness, and holiday leave, referred to as Paid Time Off ("PTO"), at varying rates based upon qualifying service hours. Employees may accumulate PTO up to a specified maximum. Accrued PTO is paid to the employee upon termination of employment or upon conversion to nonbenefits-eligible status. The estimated amount of PTO payable to employees is reported as a current liability in both 2021 and 2020. Extended Illness Bank ("EIB") time is also earned at a specific rate per qualified service hour. Employees who were vested in the District's defined benefit retirement plan as of June 30, 2011 (the effective date it was "frozen") were offered a one-time opportunity to have their accrued EIB time applied to length of service up to a maximum of one-year service credit. However, no payment is made for accrued EIB time when employment is terminated.

Medicare accelerated payments and CARES Act grants – The District, along with most other healthcare providers across the United States, has experienced operational challenges related to the COVID-19 pandemic. COVID-19 was declared a global pandemic by the World Health Organization on March 11, 2020, and on March 13, 2020, the President of the United States declared a national emergency as a result of the pandemic. On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") was signed into law, which aimed to direct economic assistance for American workers, families, and small businesses, and preserve jobs for American industries. The District recognizes these federal stimulus funds in nonoperating revenues (expense) in the consolidated statements of revenues, expenses, and changes in net position, and will have to submit required reports documenting lost revenue and expenses incurred to support the grant funds, among other terms and conditions. Management is closely monitoring the evolution of this pandemic, including how it may affect operations and the general population. On September 19, 2020, and July 1, 2021, the Department of Health and Human Services ("HHS") released updated information for health care providers that received Provider Relief Fund ("PRF") payments, which may impact the recognition of the payments and the available uses for the funds. Management believes that these changes will not have a material impact to the consolidated financial statements as of and for the year ended June 30, 2021 (See Note 14).

Separately, CMS initiated an Accelerated Payment Program ("MAPP") to hospitals. The accelerated payments represent advance payments for services to be provided and were based on a hospital's historical Medicare volume. The District received approximately $40.5 million and $43.8 million in FY21 and FY20, respectively, in MAPP funds, included in Medicare accelerated payments payable on the consolidated statements of net position. One year after receipt of MAPP funds, CMS has begun recouping the accelerated payments from billing for services rendered and will do so until they are fully repaid. Any MAPP funds not recouped after 17 months from the start of CMS recoupment will be charged interest at 4% per annum.

Premium revenue and health care services cost recognition – The District contracts with a Medicare Advantage company ("Humana") to provide health care services for certain members for which it receives revenue on a capitated basis. Under this agreement, the District receives monthly capitation payments based upon the number of participants covered under the agreements, regardless of services actually performed by the District or others under the agreements. Revenue is recognized during the period in which the District is obligated to provide services to the participants. The agreement for which the District is compensated on a capitated basis requires that the District provide or arrange for certain covered health care services to all members covered under the contract, which results in the District compensating other providers on a fee-for-services basis for the services. The cost of these services is accrued in the period the services are provided to the members, based in part, on estimates by management. The accrual of expense for such services provided includes an estimate of services provided but not reported to the District as of the fiscal year end.

Reclassifications – Certain reclassifications have been made to prior year balances to conform to the current year presentation.

Net position – Net position is divided into three components: net investment in capital assets, restricted, and unrestricted.

These classifications are defined as follows:

Net investment in capital assets – This component of net position consists of capital assets, including restricted capital assets, net of accumulated depreciation and reduced by the outstanding balances of any bonds, mortgages, notes, or other borrowings that are attributable to the acquisition, construction, or improvement of those assets.

Restricted – This component of net position consists of restricted expendable net position, the use of which is restricted through external constraints imposed by creditors (such as through debt covenants), grantors, contributors, laws or regulations of other governments, or constraints imposed by law through constitutional provisions or enabling legislation and includes assets in self-insurance trust funds, revenue bond reserve fund assets, and net position restricted to use by donors. Restricted nonexpendable net position equals the principal portion of permanent endowments as well as minority interest.

Unrestricted – This component of net position consists of net position that does not meet the definition of "restricted" or "invested in capital assets, net of related debt."

New accounting pronouncements – The GASB issued Statement No. 84, *Fiduciary Activities* ("GASB No. 84"), which provides improved guidance regarding the identification of fiduciary activities for accounting and financial reporting purposes and how those activities should be reported. The statement also provides for recognition of a liability to the beneficiaries in a fiduciary fund when an event has occurred that compels the government to disburse fiduciary resources. The GASB also issued Statement No. 97, *Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation* ("GASB No. 97"). GASB 97 amends the criteria for reporting governmental fiduciary component units – separate legal entities included in a government's financial statements. GASB 97 clarifies rules related to reporting of fiduciary activities under Statements No. 14 and No. 84 for defined contribution plans and to enhance the relevance, consistency, and comparability of the accounting and financial reporting of IRC Code section 457 plans that meet the definition of a pension plan. The District adopted GASB No. 84 and GASB No. 97 in the current fiscal year and has reflected the activities of the Retirement Plan fund in the accompanying statements of fiduciary net position and statements of changes in fiduciary net position.

The GASB also issued GASB Statement No. 87, *Leases* ("GASB No. 87"), which intends to better meet the information needs of financial statement users by improving accounting and financial reporting for leases by governments. GASB No. 87 increases the usefulness of governments' financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. The statement establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. Under this statement, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset, and a lessor is required to recognize a lease receivable and a deferred inflow of resources, thereby enhancing the relevance and consistency of information about governments' leasing activities. GASB No. 95 extended the effective date for GASB No. 87 to reporting periods beginning July 1, 2021. The District is currently assessing the impact of this standard on the District's consolidated financial statements.

The GASB also issued GASB Statement No. 89, *Accounting for Interest Cost Incurred Before the End of a Construction Period* ("GASB No. 89"). GASB No. 89 establishes accounting requirements for interest cost incurred before the end of a construction period. This statement requires that interest cost incurred before the end of a construction period be recognized as an expense in the period in which the cost is incurred for financial statements prepared using the economic resources measurement focus. As a result, interest cost incurred before the end of a construction period will not be included in the historical cost of a capital asset reported in a business-type activity or enterprise fund. GASB No. 95 extended the effective date for GASB No. 89 to reporting periods beginning July 1, 2021. The District is currently assessing the impact of this standard on the District's consolidated financial statements.

The GASB also issued GASB Statement No. 91, *Conduit Debt Obligation* ("GASB No. 91"). GASB No. 91 provides a single method of reporting conduit debt obligations by issuers and eliminate diversity in practice associated with (1) commitments extended by issuers, (2) arrangements associated with conduit debt obligations, and (3) related note disclosures. This Statement achieves those objectives by clarifying the existing definition of a conduit debt obligation; establishing that a conduit debt obligation is not a liability of the issuer; establishing standards for accounting and financial reporting of additional commitments and voluntary commitments extended by issuers and arrangements associated with conduit debt obligations; and improving required note disclosures. GASB No. 95 extended the effective date for GASB No. 91 to reporting periods beginning July 1, 2022. The District is currently assessing the impact of this standard on the District's consolidated financial statements.

The GASB also issued Statement No. 93, *Replacement of Interbank Offered Rates* ("GASB No. 93"). GASB No. 93 establishes accounting and reporting requirements related to the replacement of Interbank Offered Rates such as the London Interbank Offered Rate ("LIBOR") for hedging derivative instruments. As a result of global reference rate reform, LIBOR is expected to cease to exist in its current form after December 31, 2021. The requirements of this statement, except for paragraphs 11b, 13, and 14, are effective for reporting periods beginning after June 15, 2020. The requirement in paragraph 11b is effective for reporting periods ending after December 31, 2021. GASB No. 95 extended the effective date for paragraphs 13 and 14 to fiscal years beginning after June 15, 2021. The District is currently assessing the impact of this standard on the District's consolidated financial statements.

NOTE 2 – NONCURRENT CASH AND INVESTMENTS

Noncurrent cash and investments required for obligations classified as current liabilities are reported as current assets. The composition of noncurrent cash and investments at June 30 were as follows (in thousands):

	2021	2020
Board designated assets:		
Cash and cash equivalents	$ 162,561	$ 152,780
U.S. Treasury obligations	66,474	66,899
Federal agency obligations	23,011	19,821
Municipal obligations	25,611	18,178
Corporate obligations	45,187	54,670
Equity securities	11,209	8,554
Mutual funds	1,456	1,328
Asset and mortgage-backed securities	17,764	19,724
Supranational Agency	2,798	2,768
Alternative investments	1,023	788
Interest receivable	598	1,034
Current portion	(7,759)	(7,759)
	$ 349,933	$ 338,785

	2021	2020
Bond assets held in trust:		
Cash and cash equivalents	$ 26,893	$ 40,921
Interest receivable	1	53
Current portion	(4,623)	(4,882)
	$ 22,271	$ 36,092

	2021	2020
Assets in self-insurance trust fund:		
Cash and cash equivalents	$ 15	$ 7
U.S. Treasury obligations	2,748	3,009
Federal agency obligations	157	409
Municipal obligations	-	269
Corporate obligations	452	985
Asset and mortgage-backed securities	-	338
Interest receivable	13	22
Current portion	(1,312)	(1,312)
	$ 2,073	$ 3,727

NOTE 3 – FAIR VALUE OF ASSETS AND LIABILITIES

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 requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value.

The three levels of inputs that may be used to measure fair value within the fair value hierarchy are:

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 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.

Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. If quoted market prices are not available, then fair values are estimated by using pricing models, quoted prices of securities with similar characteristics, or discounted cash flows.

The following tables present the fair value measurements of assets recognized in the accompanying consolidated statements of net position reported at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall (in thousands):

	June 30, 2021				
Description	Level 1	Level 2	Level 3	Investments Held at Net Asset Value	Balance
Cash and cash equivalents	$ 181,170	$ -	$ -	$ -	$ 181,170
U.S. Treasury obligations	69,222	-	-	-	69,222
Federal agency obligations	-	23,169	-	-	23,169
Municipal obligations	-	25,611	-	-	25,611
Corporate obligations	-	45,639	-	-	45,639
Asset and mortgage-backed securities	-	17,764	-	-	17,764
Supranational Agency	-	2,798	-	-	2,798
Other Foundation assets	12,665	-	-	1,023	13,688
	$ 263,057	$ 114,981	$ -	$ 1,023	$ 379,061

	June 30, 2020				
Description	Level 1	Level 2	Level 3	Investments Held at Net Asset Value	Balance
Cash and cash equivalents	$ 185,017	$ -	$ -	$ -	$ 185,017
U.S. Treasury obligations	69,907	-	-	-	69,907
Federal agency obligations	-	20,230	-	-	20,230
Municipal obligations	-	18,447	-	-	18,447
Corporate obligations	-	55,655	-	-	55,655
Asset and mortgage-backed securities	-	20,062	-	-	20,062
Supranational Agency	-	2,768	-	-	2,768
Other Foundation assets	9,882	-	-	788	10,670
	$ 264,806	$ 117,162	$ -	$ 788	$ 382,756

NOTE 4 – BANK DEPOSITS

At June 30, 2021 and 2020, the District had bank balances totaling $38.3 million and $20.4 million, respectively, which approximate book balances. Of these balances, $6.4 million and $7.0 million were insured by the Federal Deposit Insurance Corporation at June 30, 2021 and 2020, respectively, and the remainder was collateralized. The California Government Code (the “Code”) requires financial institutions to secure the District’s deposits, in excess of insured amounts, by pledging government securities as collateral. The fair value of pledged securities must equal at least 110% of the District’s deposits.

NOTE 5 – INVESTMENTS

GASB Statement No. 40, *Deposit and Investment Risk Disclosures*, requires the District to disclose its deposit and investment policies related to investments with credit risk or deposits with custodial credit risk, the credit ratings and maturities of its investments (other than U.S. government obligations or obligations guaranteed by the U.S. government), and additional disclosures related to uninsured deposits. A summary of scheduled maturities by investment type at June 30, 2021, follows (in thousands):

		Investment Maturities (in Years)		
	Fair Value	Less than 1	1–5	More than 5
U.S. Treasury obligations	$ 69,222	$ 137	$ 68,988	$ 97
Federal agency obligations	23,169	17	23,110	42
Corporate obligations	45,640	4,134	41,407	99
Municipal obligations	25,611	765	24,846	-
Asset and mortgage-backed securities	17,764	2,555	15,209	-
Supranational Agency	2,798	-	2,798	-
Local Agency Investment Funds	87,916	87,916	-	-
CAMP	79,900	79,900	-	-
Money market funds	13,353	13,353	-	-
	365,373	$ 188,777	$ 176,358	$ 238
Equity securities	11,209			
Alternative investments	1,023			
Mutual funds	1,456			
	$ 379,061			

A summary of scheduled maturities by investment type at June 30, 2020, follows (in thousands):

		Investment Maturities (in Years)		
	Fair Value	Less than 1	1–5	More than 5
U.S. Treasury obligations	$ 69,907	$ 4	$ 69,728	$ 175
Federal agency obligations	20,230	10	20,164	56
Corporate obligations	55,655	14,662	40,966	27
Municipal obligations	18,447	3,230	15,217	-
Asset and mortgage-backed securities	20,062	92	19,970	-
Supranational Agency	2,768	-	2,768	-
Local Agency Investment Funds	87,444	87,444	-	-
CAMP	84,985	84,985	-	-
Money market funds	12,588	12,588	-	-
	372,086	$ 203,015	$ 168,813	$ 258
Equity securities	8,554			
Alternative investments	788			
Mutual funds	1,328			
	$ 382,756			

Investment activities of the District are governed by sections of the Code, which specify the authorized investments that may be made by the District. The District's investment policy (the "Policy") requires that all investing activities of the District comply with the Code and also sets forth certain additional restrictions that exceed those imposed by the Code. The Foundation is governed by the Internal Revenue Code; therefore, its investment activities are not subject to the same requirements as the District.

Interest rate risk is the risk that changes in interest rates will adversely affect the fair value of an investment. Investments held for longer periods are subject to increased risk of adverse interest rate changes. The District's investment policy provides that no investment shall be made in any security having a term remaining to maturity exceeding five years at the time of investment. The Foundation's Policy allows for longer-term investments.

Credit risk is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. The Policy requires that, to be eligible for investment, corporate notes shall be rated "A," or its equivalent, or better by a nationally-recognized rating service at the time of purchase. The Policy also limits investment in collateralized mortgage obligations to obligations rated "AA," or its equivalent, or better. All of the District's investments in corporate obligations and collateralized mortgage obligations met these requirements as of June 30, 2021. The Policy allows for investments in LAIF up to the maximum amount allowed by the state of California. The investment in LAIF is sufficiently liquid to permit withdrawal of cash at any time without prior notice or penalty. The state of California Treasurer's office has regulatory oversight of LAIF. The Policy includes no limitations or restrictions related to investments in United States Treasury or federal agency obligations. The Policy also allows for investment in shares of beneficial interest issued by a joint power authority ("JPA") organized pursuant to the Code that invests in the securities and obligations authorized under the Code. The Code requires that the JPA issuing the shares shall have retained an investment adviser with appropriate size and experience as outlined in the Code. The District is a participant in two JPA programs, including the Investment Trust of California, commonly known as CalTRUST, and the California Asset Management Program, commonly known as CAMP, for the purpose of pooling local agency assets for investing. Participation in the JPA programs is open to any public agency in California. Both JPA programs are governed by a Board of Trustees ("Trustees"), all of whom are experienced investment officers or employees of the public agency members. The Trustees are responsible for setting the overall policies and procedures for and for overall administration of the JPA. CalTRUST is measured at net asset value ("NAV"), which is calculated daily. The CAMP pool is managed to maintain a dollar-weighted portfolio maturity of 60 days or less and seeks to maintain a constant NAV of one dollar per share.

Concentration of credit risk is the risk of loss attributed to the magnitude of the District's investment in a single issuer. The market value of LAIF investments represented 23.2% and 22.8% of the District's total investment market value at June 30, 2021 and 2020, respectively. The market value of CAMP investments represented 21.1% and 22.2% at June 30, 2021 and 2020, respectively.

NOTE 6 – CAPITAL ASSETS

A summary of changes in capital assets during 2021 is as follows (in thousands):

	Beginning Balance 2020	Additions	Deletions	Transfers	Ending Balance 2021
Land	$ 17,542	$ -	$ -	$ -	$ 17,542
Buildings and improvements	378,313	282	-	5,804	384,399
Equipment	299,378	17,372	(353)	239	316,636
Construction in progress	38,837	20,319	-	(6,043)	53,113
Property under capital leases	1,568	-	(913)	-	655
	735,638	37,973	(1,266)	-	772,345
Accumulated depreciation and amortization	397,239	31,553	(1,206)	-	427,586
	$ 338,399	$ 6,420	$ (60)	$ -	$ 344,759

A summary of changes in capital assets during 2020 is as follows (in thousands):

	Beginning Balance 2019	Additions	Deletions	Transfers	Ending Balance 2020
Land	$ 16,137	$ 1,405	$ -	$ -	$ 17,542
Buildings and improvements	356,887	612	(9)	20,823	378,313
Equipment	275,513	11,657	(5,500)	17,708	299,378
Construction in progress	42,299	18,681	-	(22,143)	38,837
Property under capital leases	17,699	257	-	(16,388)	1,568
	708,535	32,612	(5,509)	-	735,638
Accumulated depreciation and amortization	372,176	30,481	(5,418)	-	397,239
	$ 336,359	$ 2,131	$ (91)	$ -	$ 338,399

NOTE 7 – HEALTH-RELATED INVESTMENTS

The following table summarizes the District's health-related investments recorded on the equity method at June 30 (in thousands):

	2021	2020
Cypress Company, LLC	$ 732	$ 734
Sequoia Surgery Center, LLC	890	817
Northwest Visalia Senior Housing, LLC	1,613	3,422
Sequoia Integrated Health Plan, LLC	1,004	937
202 West Willow, LLC	928	930
Visalia Kidney Center	49	48
	$ 5,216	$ 6,888

Investment in Cypress Company, LLC ("CyCo") – In August 2010, Cypress Surgery Center formed CyCo, a real estate holding company organized as a California limited liability company, and transferred all of its real property and associated real estate debt, along with certain other assets and liabilities, to CyCo. The District holds a 40% investment in CyCo.

Investment in Sequoia Surgery Center, LLC (formerly Cypress Surgery Center) – At June 30, 2017, the District held a 31% investment in a free-standing ambulatory surgery center located within the District. In August 2010, Cypress Surgery Center completed a "merger" with the Center for Ambulatory Medicine and Surgery ("CAMS"), a local ambulatory surgery center, and changed its legal name to Sequoia Surgery Center, LLC, as well as its organizational structure from a California limited partnership to a California limited liability company. To effect the merger, Cypress Surgery Center acquired 100% of the assets and outstanding ownership interests of CAMS in exchange for approximately 52% ownership in Cypress Surgery Center (now Sequoia Surgery Center, LLC). As a result of this acquisition, the District's ownership interest in Sequoia Surgery Center, LLC, was diluted from 64.9% to approximately 31%. Sequoia Surgery Center, LLC, leases its ambulatory surgery center facility from CyCo.

Investment in Northwest Visalia Senior Housing, LLC – In January 2017, the District made its initial capital contribution to establish its investment in a joint venture company. Northwest Visalia Senior Housing, LLC, was formed in furtherance of the members' elder care mission and to put into practice innovative approaches to care of the elderly, simultaneously addressing the housing and health care needs of the elderly. This will be accomplished in part by constructing, developing, owning, maintaining, and operating a full service assisted living retirement facility in Visalia, California. Northwest Visalia Senior Housing, LLC, is owned 33.33% by the District, 33.33% by Shannon Senior Care, LLC, 20% by BTV Senior Housing, LLC, and 13.34% by Millennium Advisors, Inc. The District has recorded its interest in the joint venture based upon its initial capital contributions.

Investment in Sequoia Integrated Health, LLC – In August 2016, the District made its initial capital contribution to establish its investment in a joint venture company formed in furtherance of the members' common purpose to better serve and coordinate health care services for the communities of Tulare and Kings Counties, and to own and operate an integrated delivery network in California and activities incident thereto. Sequoia Integrated Health, LLC, is owned 50% by the District, 25% by Key Medical Group, Inc., and 25% by Foundation for Medical Care of Tulare and Kings Counties, Inc. The District has recorded its interest in the joint venture based upon its initial capital contributions.

Investment in Quail Park Retirement Village, LLC – The District holds an investment in a joint venture company that operates an assisted living facility in Visalia, California. The joint venture company, Quail Park Retirement Village, LLC, is owned 44% by the District and 56% by Living Care Visalia, LLC, and its affiliated investors. Under the terms of the joint venture agreement, the District has an option to purchase an additional 5% of Living Care Visalia, LLC's equity interest at fair market value determined at the time of sale. Distributions have exceeded initial capital contributions resulting in a deficit equity position for Quail Park Retirement Village, LLC. The District has recorded its interest in the joint venture company at $0 in accordance with U.S. Generally Accepted Accounting Principles ("U.S. GAAP") as the District is not liable for obligations of the joint venture company.

Investment in Laurel Court at Quail Park, LLC – In June 2011, the District made its initial capital contribution to establish its investment in a joint venture company formed to construct, develop, own, maintain, and operate a full service memory care retirement facility in Visalia, California. The joint venture company, Laurel Court at Quail Park, LLC, is owned 44% by the District and 56% by Living Care Visalia, LLC. Distributions have exceeded initial capital contributions resulting in a deficit equity position for Laurel Court at Quail Park, LLC. The District has recorded its interest in the joint venture company at $0 in accordance with U.S. GAAP as the District is not liable for obligations of the joint venture company.

Investment in 202 West Willow, LLC – The District received a donation of 3,000 shares in a California limited liability company that owns and rents a 32,293 square foot medical building. The District recorded the investment based upon its allocated capital account balance at the time of the contribution. 202 West Willow, LLC, is owned 30% by the District, 37% by The Malli Family Trust, 15% by the Johnson Family Revocable Trust, 10% by the Kneeland Family Revocable Trust, 5% by the Spade Family Revocable Trust, and 3% by the May Family Revocable Trust.

Income or loss from equity method investments is included in other revenues in the corresponding consolidated statement of revenues, expenses, and changes in net position.

NOTE 8 – CAPITAL LEASES

The District and KHMG have entered into various capital leases to purchase medical equipment.

Future minimum payments, by year and in the aggregate, for all capital leases consist of the following at June 30, 2021 (in thousands):

Year Ending June 30,	
2022	$ 105
2023	57
2024	57
2025	15
Future minimum lease payments	234
Less: amount representing interest	14
Present value of minimum lease payments	220
Less: current portion	97
	$ 123

Capital assets include the following amounts that have been initially or are currently capitalized under the leases at June 30 (in thousands):

	2021	2020
Equipment	$ 655	$ 1,568
Less: accumulated depreciation	417	1,179
	$ 238	$ 389

A summary of changes in capital lease obligations during 2021 and 2020, is as follows (in thousands):

	Beginning Balance 2021	Additions	Payments	Ending Balance 2021
Capitalized lease obligations	$ 384	$ -	$ 164	$ 220

	Beginning Balance 2020	Additions	Payments	Ending Balance 2020
Capitalized lease obligations	$ 2,141	$ 293	$ 2,050	$ 384

NOTE 9 – BONDS PAYABLE

During July 2012, the District issued $75.8 million of Kaweah Delta Health Care District Revenue Bonds, Series 2012. The 2012 revenue bonds bear interest at rates of 2.0% to 5.0%. Approximately $9.8 million of the net proceeds of the bonds were used by the District to expand its ambulatory surgery services, to complete capital improvements related to the graduate medical education program, and for other infrastructure improvements. Approximately $68.0 million of the net proceeds was used to prepay existing debt, including the 1999A, 2003B, and 2004 revenue bonds.

The 2012 revenue bonds maturing on or after June 1, 2017, are subject to redemption at the option of the District prior to their respective stated maturities at amounts ranging from 100% to 102% of face value. The 2012 revenue bonds require the District to make minimum sinking fund payments beginning in June 2036. In December 2017, $46 million of the outstanding 2012 bonds were refunded as discussed below.

During January 2014, the District issued $48.9 million of Kaweah Delta Health Care District General Obligation Refunding Bonds, Series 2014, at rates of 3.6% to 4.1%, solely to advance refund $47.3 million of the outstanding 2004 General Obligation bonds, bearing interest rates of 5.0% to 5.5%. Mandatory sinking fund redemption payments on the bonds began on August 1, 2015. The final maturity of the bonds is August 1, 2034. The advance refunding of the 2004 bonds resulted in decreased debt service payments of approximately $6.3 million over the next 21 years, and an economic gain (difference between the present value of the debt service payments on the old and new debt) of approximately $4.3 million.

The general obligation bonds represent the general obligation of the District. The District has the power and is obligated to cause annual ad valorem taxes to be levied upon all property within the District, subject to taxation by the District, and collected by the County for payment, when due, of the principal and interest on the bonds.

During October 2015, the District issued $19.4 million of Kaweah Delta Health Care District Revenue Bonds, Series 2015A. The 2015A revenue bonds bear interest at a rate of 2.975%. The net proceeds were used to prepay existing debt, including a portion of the 2006 and 2011B revenue bonds as well as the outstanding amount of the 2003A and 2011A revenue bonds. The 2015A revenue bonds maturing on or after June 1, 2025, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to the principal amount of the bonds, without premium. The current refunding of the 2003A and 2006 bonds and the advanced refunding of the 2011A and 2011B bonds resulted in decreased debt service payments of approximately $3.9 million over the next 18 years, and an economic gain (difference between the present value of the debt service payments on the old and new debt) of approximately $3.0 million.

During December 2015, the District issued $98.4 million of Kaweah Delta Health Care District Revenue Bonds, Series 2015B. The 2015B revenue bonds bear interest rates of 3.25% to 5.0%. The net proceeds were for the acquisition, construction, installation, and equipping of the second, fifth, and sixth floors of the Kaweah Delta Medical Center's Acequia Wing, expansion and improvement of the emergency department, expansion of outpatient endoscopy services, acquisition and implementation of a new information technology platform (Cerner), acquisition and construction of a new urgent care center, improvements to the Exeter Health Clinic campus, and other projects. The 2015B revenue bonds maturing on or after June 1, 2025, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to the principal amount of the bonds, without premium.

During April 2017, the District issued $13.7 million Series 2017A and $20 million Series 2017B of Kaweah Delta Health Care District Revenue Bonds. Both the 2017A and the 2017B revenue bonds bear interest at a rate of 3.24%. The net proceeds were used to prepay existing debt, including the remaining outstanding amounts of the 2006 and 2011B revenue bonds. The 2017A and 2017B revenue bonds maturing on or after June 1, 2029, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to the principal amount of the bonds, without premium. The current refunding of the 2006 and 2011B bonds resulted in decreased debt service payments of approximately $8.0 million over the next 17 years and an economic gain (difference between the present value of the debt service payments on the old and new debt) of approximately $4.3 million.

During December 2017, the District issued $59.5 million Series 2017C of Kaweah Delta Health Care District Revenue Bonds. The 2017C revenue bonds bear interest at a rate of 2.71%. The net proceeds were used to refund $46.0 million of the 2012 revenue bonds and to prepay the remaining 2011 Siemens lease obligation. The 2017C revenue bonds maturing on or after June 1, 2028, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to the principal amount of the bonds, without premium. The advance refunding of the 2012 revenue bonds and lease obligations resulted in decreased debt service payments of approximately $8.6 million over the next 24 years and an economic gain (difference between the present value of the debt service payments on the old and new debt) of approximately $5.9 million.

During January 2020, the District issued $6.8 million Series 2020A and $8.2 million Series 2020B of Kaweah Delta Health Care District Revenue Bonds. Both the 2020A and the 2020B revenue bonds bear interest at a rate of 2.37%. The net proceeds were used to fund capital projects and equipment. The 2020A and 2020B revenue bonds maturing on or after June 1, 2020 to May 31, 2025, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to 102% of the principal amount of the bonds. The 2020A and 2020B revenue bonds maturing on or after June 1, 2025 to May 31, 2030, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to 101% of the principal amount of the bonds. The 2020A and 2020B revenue bonds maturing on or after June 1, 2030, are subject to redemption at the option of the District prior to their respective stated maturities at a price equal to the principal amount of the bonds, without premium.

Principal and interest payments due on the revenue and general obligation bonds over the next five years, and in five-year increments thereafter, calculated at the interest rate in effect at June 30, 2021, are as follows (in thousands):

Year Ending June 30,	Principal	Interest
2022	$ 11,027	$ 9,179
2023	11,549	8,769
2024	11,952	8,433
2025	12,382	8,084
2026	12,834	7,713
2027–2031	71,482	32,447
2032–2036	45,796	21,976
2037–2041	39,535	14,143
2042–2046	42,665	4,433
	259,222	$ 115,177
Unamortized premium	2,480	
	261,702	
Less: current portion	11,027	
	$ 250,675	

The bond indenture agreements contain various restrictive covenants that include, among other things, minimum debt service coverage, maintenance of minimum liquidity, restrictions on certain additional indebtedness, and requirements to maintain certain financial ratios.

The District paid approximately $9.6 million and $9.7 million in interest in 2021 and 2020, respectively, on all debt, including revenue and general obligation bonds, capital leases, and notes payable. The District capitalized interest expense of approximately $795,000 and $1.9 million in 2021 and 2020, respectively.

A summary of changes in bonds payable for the years ended June 30, is as follows (in thousands):

	Beginning Balance	Additions	Payments	Ending Balance
2021	$ 269,705	$ -	$ 10,483	$ 259,222
2020	$ 262,098	$ 15,000	$ 7,393	$ 269,705

NOTE 10 – SELF-INSURED CLAIMS

As discussed in Note 1, the District is self-insured for medical malpractice and general comprehensive liability, medical benefits, and workers' compensation, and discounts the medical malpractice and general comprehensive and workers' compensation liabilities using a 3.0% and 1.5% discount rate, respectively. The following is a summary of the changes in the self-insured plan liabilities for the years ended June 30 (in thousands):

	Beginning Balance	Additions	Payments	Ending Balance	Current Portion
2021	$ 34,382	$ 34,719	$ 35,008	$ 34,093	$ 3,199
2020	$ 31,403	$ 35,028	$ 32,049	$ 34,382	$ 3,756

NOTE 11 – EMPLOYEES' RETIREMENT PLAN

The Kaweah Delta Health Care District's Employees' Retirement Plan (the "Retirement Plan") is a single-employer defined benefit pension plan established to provide retirement benefits for District employees based on length of service and the average of the highest consecutive three years of earnings. The Retirement Plan is administered by a retirement plan committee appointed by the Board of the District. The Retirement Plan issues a separate financial report that includes financial statements and required supplemental information.

Employees were eligible to participate on the first day of a pay period following six months of service if hired prior to January 1, 2003, and elected not to participate in the salary deferral plan's matching contribution component. Employees hired on or after January 1, 2003, were not eligible to participate in the Retirement Plan. Employees' retirement benefits vested 100% after five years of completed service.

Effective June 30, 2011, the Retirement Plan was amended to suspend all accruals and otherwise freeze benefits under the plan.

The Retirement Plan complies with the Internal Revenue Code and Employee Retirement Income Security Act of 1974 ("ERISA") as they apply to governmental plans. As a government plan, the Retirement Plan is exempt from the annual minimum funding requirements of ERISA. The Retirement Plan's funding policy is to contribute an annual amount necessary to amortize any unfunded net pension liability over a 15-year period. The District contributed $11.4 million to the plan in both 2021 and 2020.

Investment activities of the Retirement Plan are governed by sections of the California Government Code, which allow any type of prudent investment. The Plan's investment policy is intended to assist the Retirement Committee (the "Committee") in prudently evaluating investment options and establishing an allocation strategy for the assets of the Plan. The objective of the Committee is to ensure the security of all accrued benefits. The Committee's asset allocation strategy is predicated on meeting its objective with a desire to effectively manage funded status volatility and mitigate undue risk exposure, taking into consideration performance expectations, risk tolerance and volatility, liquidity, and the Plan's time horizon. An analysis of Plan liabilities, projected liquidity needs and assets is used to determine the Plan's long-term investment strategy. The Committee intends to utilize a range of investment alternatives to achieve the return and risk objectives of the Plan.

Concentration of credit risk is the risk of loss attributed to the magnitude of the Retirement Plan's investment in a single issuer. As of June 30, 2021, there were no investments held with a single corporate or government agency issuer that exceeded 5% of the Plan's total investments (excluding investments issued by the U.S. government and mutual funds that are exempt from reporting).

There were no other concentrations of investments at or exceeding 5% of the Retirement Plan's fiduciary net position (excluding investments issued by the U.S. government and mutual funds that are exempt from reporting).

Investments are measured at fair value on a recurring basis. Recurring fair value measurements are those that GASB require or permit in the statement of net position at the end of each reporting period. Fair value measurements are categorized based on the valuation inputs used to measure an asset's fair value: Level 1 inputs are quoted prices in active markets for identical assets; Level 2 inputs are significant other observable inputs; Level 3 inputs are significant unobservable inputs. The mutual funds are priced using a net asset value (NAV). The mutual funds may include several different underlying investments, including equities, bonds, real estate, and global securities. The NAV price is derived from the value of these investments, accrued income, anticipated cash flows (maturities), management fees, and other fund expenses. Certain investments within the fund may be deemed unobservable and not considered to be in an active market.

The following table presents the fair value measurements of financial instruments recognized by the Retirement Plan in the accompanying fiduciary statements of net position measured at fair value on a recurring basis and the level within the GASB No. 72 fair value hierarchy in which the fair value measurements fall at June 30 (in thousands):

	2021			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 4,625	$ -	$ -	$ 4,625
Fixed income investments	42,699	24,987	-	67,686
Equity securities	247,371	-	-	247,371
Total assets in the fair value hierarchy	$ 294,695	$ 24,987	$ -	$ 319,682

	2020			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 5,818	$ -	$ -	$ 5,818
Fixed income investments	26,515	21,163	-	47,678
Equity securities	162,743		-	162,743
Total assets in the fair value hierarchy	$ 195,076	$ 21,163	$ -	216,239
Investments measured at NAV practical expedient Alternative investments				34,200
Total assets, at fair value				$ 250,439

The Plan had investments in five alternative investment funds for the year ended June 30, 2020. The fair values of these investments have been determined using the net asset value per share or its equivalent. Each fund invests all of its assets through a master-feeder structure into master funds that have the same objectives as the feeder funds. The master funds invest with funds of hedge funds and other experienced portfolio managers or otherwise utilize the services of investment advisors or other investment managers employing a variety of trading styles or strategies. The objectives of the alternative investments are to generate consistent long-term capital appreciation with low volatility and little correlation with the equity and bond markets and to provide a partial inflation hedge with an attractive risk/return profile as compared to other products using a commodity index and investments in numerous futures markets.

The following table provides the fair value and redemption terms and restrictions for investments redeemable NAV at June 30 (in thousands), for the fiduciary funds investments:

	Fair value June 30, 2021	Fair value June 30, 2020	Unfunded Commitments	Redemption Frequency	Redemption Notice Period
Multi-strategy hedge fund	$ -	$ 6,084	$ -	Quarterly	95 days
Diversified multi-portfolio fund	-	5,628	-	Quarterly	35 days
Merger arbitrage fund	-	9,352	-	Quarterly	95 days
Focused technology fund	-	8,024	-	Quarterly	65 days
Diversified futures hedge fund	-	5,112	-	Monthly	35 days
	$ -	$ 34,200	$ -		

The District uses a measurement date of June 30 for each year presented. The actuarial valuation for fiscal years 2021 and 2020 is based on participant data as of June 30, 2020 and 2019, respectively. Update procedures were used to roll forward the total pension liability to the measurement date, including the mortality assumption change described below.

Components of pension cost and deferred outflows and deferred inflows of resources under the requirements of GASB No. 68 are as follows for the years ended June 30 (in thousands):

	2021	2020
PENSION COST		
Service cost	$ -	$ -
Administrative expense	287	245
Interest	21,157	20,967
Expected return on assets, net of investment expenses	(18,556)	(18,987)
Recognition of deferred outflows	1,102	822
Recognition of deferred inflows	(10,505)	5,391
Total pension cost	$ (6,515)	$ 8,438
DEFERRED OUTFLOWS OF RESOURCES		
Established July 1		
Difference between expected and actual experience	$ 2,855	$ 840
Net difference in expected and actual earnings	-	4,454
Changes in assumptions	925	6,738
Deferred outflows of resources, beginning of year	3,780	12,032
AMOUNT RECOGNIZED IN CURRENT YEAR PENSION COST		
Established July 1		
Difference between expected and actual experience	1,525	956
Net difference in expected and actual earnings	-	1,501
Changes in assumptions	1,846	3,755
Amount recognized in current year	3,371	6,212
CONTRIBUTIONS BETWEEN THE MEASUREMENT DATE AND FISCAL YEAR END RECOGNIZED AS DEFERRED OUTFLOW OF RESOURCES	-	-
Deferred outflows of resources, end of year	$ 409	$ 5,820

	2021	2020
DEFERRED INFLOWS OF RESOURCES		
Established July 1		
Difference between expected and actual experience	$ -	$ -
Net difference in expected and actual earnings	(52,095)	-
Changes in assumptions	-	-
Deferred inflows of resources, beginning of year	(52,095)	-
AMOUNT RECOGNIZED IN CURRENT YEAR PENSION COST		
Established July 1		
Difference between expected and actual experience	-	-
Net difference in expected and actual earnings	(12,774)	-
Changes in assumptions	-	-
Amount recognized in current year	(12,774)	-
Deferred inflows of resources, end of year	$ (39,321)	$ -

Amounts reported as deferred outflows (inflows) of resources to be recognized in pension cost for future years (in thousands):

Year Ending June 30,	
2022	$ (10,479)
2023	(8,946)
2024	(8,477)
2025	(11,010)
	$ (38,912)

Participant data for the plan is as follows for June 30:

	2021	2020
Active employees	650	697
Terminated vested	999	1,011
Retirees receiving benefits	832	780
Total participants	2,481	2,488

The following table summarizes changes in net pension liability for the years ended June 30 (in thousands):

	2021	2020
TOTAL PENSION LIABILITY		
Service cost	$ -	$ -
Interest	21,157	20,967
Differences between expected and actual experience	2,972	(572)
Changes in assumptions	(2,059)	6,216
Benefit payments	(15,530)	(14,446)
NET CHANGES IN TOTAL PENSION LIABILITY	6,540	12,165
TOTAL PENSION LIABILITY, beginning of year	291,236	279,071
TOTAL PENSION LIABILITY, end of year	297,776	291,236
PLAN FIDUCIARY NET POSITION		
Employer contributions	11,400	11,400
Net investment income	73,603	6,328
Benefit payments	(15,527)	(14,448)
Administrative expenses	(287)	(244)
NET CHANGES IN PLAN FIDUCIARY NET POSITION	69,189	3,036
PLAN FIDUCIARY NET POSITION, beginning of year	250,858	247,822
PLAN FIDUCIARY NET POSITION, end of year	320,047	250,858
NET PENSION (ASSET) LIABILITY, end of year	$ (22,271)	$ 40,378
Plan fiduciary net position as percentage of total pension liability	107.48%	86.14%
Covered employee payroll	N/A	N/A
Net pension liability as percent of covered payroll	N/A	N/A

The following table summarizes the actuarial assumptions used to determine net pension liability and plan fiduciary net position as of June 30, 2021:

Valuation date	June 30, 2020
Actuarial cost method	Entry Age Normal
Amortization method	Level Dollar
Asset valuation method	Fair Value
Actuarial assumptions (including 2% inflation)	
Discount Rate	7.50%
Mortality	RP-2014 table, projected using MP-2020
Projected Salary Increases	N/A

The mortality assumptions are updated annually with the most recent tables published by the Society of Actuaries.

Sensitivity of Net Pension Liability at June 30, 2021, to changes in the Discount Rate (in thousands):

1% Decrease (6.50%)	$9,682,116
Current Discount Rate (7.50%)	($22,272,931)
1% Increase (8.5%)	($49,180,157)

The District also administers a salary deferral plan (the “Salary Plan”) available to substantially all full-time employees meeting certain service requirements. The Salary Plan qualifies under the Internal Revenue Code Section 401(k) and was established to provide supplemental retirement income for employees of the District. Under the Salary Plan, the District makes matching contributions to participants in accordance with an established schedule based upon each participant’s years of service with the District. The District made matching contributions of $9.0 million and $8.7 million in 2021 and 2020, respectively. The District recognized pension expense of $2.4 million and $3.9 million related to the Salary Plan in 2021 and 2020, respectively. The liability related to the Salary Plan was $2.4 million and $9.0 million at June 30, 2021 and 2020, respectively. The Salary Plan does not meet the definition of a blended component unit or a fiduciary activity.

Employees are immediately vested in their own contributions and earnings on those contributions. Employees become vested in the District contributions and earnings on District contributions after completion of five years of service. Nonvested contributions are forfeited upon termination of employment and such forfeitures are used to offset future District contributions. For the years ended June 30, 2021 and 2020, forfeitures reduced the District’s pension expense by $0 and $239,000, respectively.

The District offers its employees a deferred compensation plan (the “457 Plan”) created in accordance with Internal Revenue Code Section 457. The 457 Plan, available to all District employees with at least one year of service, permits them to defer a portion of their salary until future years. The deferred compensation is not available to employees until termination, retirement, death, or certain emergency situations. The 457 Plan does not meet the definition of a blended component unit or a fiduciary activity.

NOTE 12 – COMMITMENTS

At June 30, 2021, the District has projects in progress to construct, improve, and equip various routine, ancillary, and support services. Major projects in progress include an expansion of the emergency department, and various improvement projects to existing facilities. Total costs expended as of June 30, 2021, related to these projects and others are approximately $53.0 million. The total estimated cost of these projects at completion is approximately $64.1 million, of which approximately $56.5 million has been expended or contractually obligated. Funding for the projects is expected to include a combination of revenue bond funds, operating cash flows, community donations, and funded reserves.

The District has entered into various physician income guarantees whereby, pursuant to the terms in the agreement, the District has extended income guarantees to certain doctors in exchange for the doctors maintaining a medical practice in the District's service area. Payments under the guarantees are expected to be forgiven over a two- to three-year period, should the physician remain in practice in the community. If a doctor terminates his medical practice in the community prior to the completion of the term, the remaining balance under the guarantee is immediately due and payable. The District records expenses under these guarantees as payments are made to physicians. Accounts receivable are recorded when defaults under the agreements occur and are evaluated for collectability.

NOTE 13 – CONTINGENCIES

Malpractice, workers' compensation, and comprehensive general liability claims have been asserted against the District by various claimants. The claims are in various stages of processing and some may ultimately be brought to trial. There are also known incidents that have occurred through June 30, 2021, that may result in the assertion of additional claims. District management has accrued their best estimate of these contingent losses.

The health care 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 unknown and unasserted at this time. Over the last several years, government activity has increased with respect to investigations and allegations concerning possible violations of regulations by health care providers, which could result in the imposition of significant fines and penalties as well as significant repayment of previously billed and collected revenue for patient services. Management believes that the District is in substantial compliance with current laws and regulations and that any potential liability arising from compliance issues have been properly reflected in the District's consolidated financial statements or are not considered to be material to the District's financial position and results of operations as of and for the year ended June 30, 2021 and 2020.

As disclosed in Note 1, the Medicare and Medi-Cal government reimbursement programs account for a substantial amount of the District's net patient services revenue. Expenditure reduction efforts and budget concerns within the United States, and California legislature continue to create uncertainty over the volume of future health care funding. It is at least reasonably possible that future reimbursements for patient services under these programs could be negatively impacted.

NOTE 14 – INTERGOVERNMENTAL AND DIRECT GRANT SUPPLEMENTAL PAYMENT PROGRAMS

The District participates in various supplemental payment programs administered by the State of California including intergovernmental transfer and direct grant funding mechanisms. A summary of these programs is as follows:

Quality Assurance Fee Managed Care Medi-Cal Payment Program – The District receives payments under the Quality Assurance Fee ("QAF") Managed Care Medi-Cal payment program. The California Hospital Fee Program (the "Program") was signed into law by the Governor of California and became effective on April 1, 2009. The Program is ongoing but requires an extension or revision of the methodology approved by CMS periodically. The Program required a "hospital fee" or "QAF" to be paid by certain hospitals to a state fund established to accumulate the assessed QAF and receive matching federal funds. QAF and corresponding matching federal funds are then paid to participating hospitals in two supplemental payment methodologies: a fee-for-service methodology and a managed care plan methodology.

In the 2009-10 Program, the District, as a nondesignated public hospital ("NDPH") in California, was not subject to the QAF assessment according to the legislation, but rather received net supplemental payments. The Program evolved in 2010 through 2014, with District hospitals participating in a variety of ways. Legislation for the Program that ran from January 1, 2014 through December 31, 2016 ("SB239"), allowed for direct grant funding for rural District hospitals and additional funding available in the form of Intergovernmental Transfer ("IGT") payments offered for a match of funding. Passage of Proposition 52 in November 2016, made SB239 permanent and allowed for the creation of the HQAF V program that provides for direct grants for District hospitals as well as IGT-generated funding. The HQAF V program runs from January 1, 2017 through December 31, 2019. The HQAF VI program runs from January 1, 2019 through December 31, 2020. In fiscal years 2021 and 2020, the District recognized QAF program related net patient services revenue of $14.6 million and $20.8 million, respectively.

NDPH IGT Program – The District also receives AB113 IGT fee-for-service ("FFS") Medi-Cal Inpatient payments. Legislation in March 2011 ("SB 90") extended the QAF Program for the period from January 1, 2011, through June 30, 2011; however, the extension under SB 90 included only private hospitals and thus excluded the District related to the FFS portion of the QAF Program. As an alternative, the NDPH IGT Program was established under AB 113 in 2011 to allow NDPH facilities to access additional federal funds. Under this legislation, the District recognized net patient services revenue of a $10.1 million increase and a $3.7 million decrease related to this program for the years ended June 30, 2021 and 2020, respectively.

Rate Range IGT Program – The District receives "Rate Range" IGT managed Medi-Cal payments. Federal rules allow that NDPH facilities may access managed care rate range room as determined by negotiations with Medi-Cal managed care plans. As defined by law, rate range room is the difference between the amount that the State pays the managed care plans, referred to as a "lower bound" rate, and the maximum allowed, or the "upper bound" rate. This difference, or rate range, is then available through supplemental IGT payments to public entities that participate in the program in each county. The District recognized net patient services revenue of $17.2 million and $17.8 million related to this program in fiscal years 2021 and 2020, respectively.

Public Hospital Redesign and Incentives in Medi-Cal Program – The Public Hospital Redesign and Incentives in Medi-Cal ("PRIME") program was approved as a part of the Medi-Cal 2020 Section 1115 demonstration waiver. The program participants include both designated public hospitals and district and municipal public hospitals. PRIME supported activities encourage participants to improve the manner in which care is delivered in order to maximize health care value and also to position participants to successfully transition managed care payments to alternative payment methodologies. The District's participation in the program in 2016, its initial year of participation, and 2017 included creating the five-year implementation plan, completing related process measures, and developing PRIME project infrastructure. Participation in 2018 included submission of baseline data, and participation in 2018 and 2019 included the measurement and achievement of quality improvement metrics. The State of California's share of the Medi-Cal funding for the PRIME program is furnished by IGT's from the participants. The District recognized other operating revenue of $10.7 million and $16.2 million related to the PRIME program in fiscal years 2021 and 2020, respectively.

Provider relief funds – The District received approximately $32.5 million and $15.0 million in related grants in fiscal year 2021 and fiscal year 2020, respectively. The District was required to and did timely sign attestations agreeing to the terms and conditions of payment. Those terms and conditions include measures to prevent fraud and misuse. Documentation is required to ensure that these funds are used for health care related expenses or lost revenue attributable to the coronavirus, limitations of out of pocket payments from certain patients, and the acceptance of several other reporting and compliance requirements. It is noted that anti-fraud monitoring and auditing will be performed by HHS and the Office of the Inspector General. For the years ended June 30, 2021 and 2020, the District has determined it met the terms and conditions of the CARES Act, and has recorded grant revenue $32.5 million and $15.0 million, respectively, of the Provider Relief Fund in nonoperating revenues in the consolidated statements of revenues, expenses, and changes in net position. Refunding of amounts received may be required by the CARES Act if a receiving entity is unable to quantify the financial losses intended to be covered by funding. The District continues to reconcile and analyze its health care related expenses and lost revenue based on known reporting guidance.

NOTE 15 – SUBSEQUENT EVENTS

Subsequent events are events or transactions that occur after the consolidated statement of net position date but before the consolidated financial statements are issued. The District 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. The District'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 consolidated statement of net position date and before the consolidated financial statements are issued.

Supplemental Pension Information

The following table summarizes the number of total plan participants at June 30:

	2021	2020
Active employees	650	697
Terminated vested	999	1,011
Retirees receiving benefits	832	780
Total participants	2,481	2,488

The following table summarizes changes in net pension liability for the years ended June 30, 2021 and 2021 (in thousands):

	2021	2020
TOTAL PENSION LIABILITY		
Service cost	$ -	$ -
Interest	21,157	20,967
Differences between expected and actual experience	2,972	(572)
Changes in assumptions	(2,059)	6,216
Benefit payments	(15,530)	(14,446)
NET CHANGES IN TOTAL PENSION LIABILITY	6,540	12,165
TOTAL PENSION LIABILITY, beginning of year	291,236	279,071
TOTAL PENSION LIABILITY, end of year	297,776	291,236
PLAN FIDUCIARY NET POSITION		
Employer contributions	11,400	11,400
Net investment income	73,603	6,328
Benefit payments	(15,527)	(14,448)
Administrative expenses	(287)	(244)
NET CHANGES IN PLAN FIDUCIARY NET POSITION	69,189	3,036
PLAN FIDUCIARY NET POSITION, beginning of year	250,858	247,822
PLAN FIDUCIARY NET POSITION, end of year	320,047	250,858
NET PENSION (ASSET) LIABILITY, end of year	$ (22,271)	$ 40,378
Plan fiduciary net position as percentage of total pension liability	107.48%	86.14%
Covered employee payroll	N/A	N/A
Net pension liability as percent of covered payroll	N/A	N/A

The District's actuarially determined contribution and actual contributions, since 2012, are presented in the following table (in thousands):

Fiscal Year Ended	Actuarially Determined Contribution	Actual Contribution	Contribution Excess	Covered Payroll	Actual Contribution as a Percentage of Covered Payroll
2012	$ 2,233	$ 2,235	$ 2	NA	N/A
2013	4,093	4,095	2	N/A	N/A
2014	3,972	4,058	86	N/A	N/A
2015	2,673	3,720	1,047	N/A	N/A
2016	3,224	5,000	1,776	N/A	N/A
2017	6,879	9,000	2,121	N/A	N/A
2018	5,818	11,400	5,582	N/A	N/A
2019	4,533	11,400	6,867	N/A	N/A
2020	3,466	11,400	7,934	N/A	N/A
2021	4,414	11,400	6,986	N/A	N/A
	$ 41,305	$ 73,708	$ 32,403		

KAWEAH HEALTH ANNUAL BOARD REPORT

URGENT CARE CLINICS - Summary

FY2021

KEY METRICS - FY 2021

Patient Cases	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
72,714	$9,691,526	$6,519,369	$3,172,157	($512,663)
▲ 15%	▲ 1%	▲ 5%	▼ -5%	▼ -462%

*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

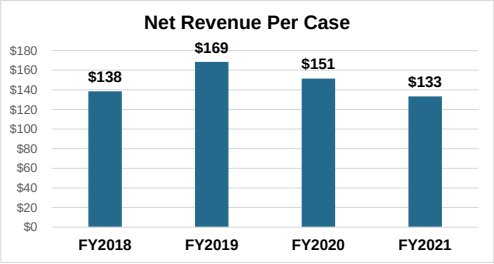
METRICS BY SERVICE LINE - FY 2021

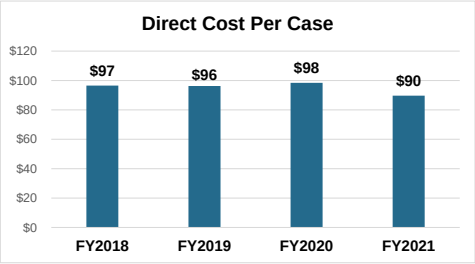
SERVICE LINE	Patient Cases	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
Urgent Care Court	49,265	$6,390,032	$4,328,950	$2,061,082	($156,559)
Urgent Care Demaree	23,449	$3,301,494	$2,190,419	$1,111,075	($356,104)
Urgent Care Clinic Totals	72,714	$9,691,526	$6,519,369	$3,172,157	($512,663)

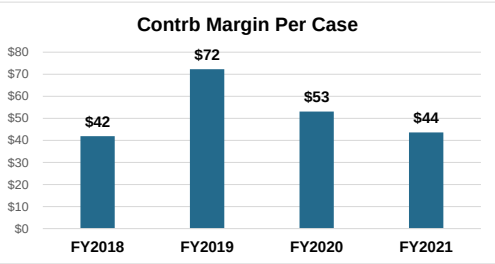
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	59,546	66,583	63,181	72,714 ▲	15%	
Net Revenue	$8,243,648	$11,220,550	$9,570,822	$9,691,526 ▲	1%	
Direct Cost	$5,747,904	$6,407,328	$6,216,506	$6,519,369 ▲	5%	
Contribution Margin	$2,495,744	$4,813,222	$3,354,316	$3,172,157 ▼	-5%	
Indirect Cost	$2,445,943	$3,032,691	$3,212,524	$3,684,820 ▲	15%	
Net Income	$49,801	$1,780,531	$141,792	($512,663) ▼	-462%	
Net Revenue Per Case	$138	$169	$151	$133 ▼	-12%	
Direct Cost Per Case	$97	$96	$98	$90 ▼	-9%	
Contrb Margin Per Case	$42	$72	$53	$44 ▼	-18%	

GRAPHS







Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Lines Uregent Care Center
Criteria: specific selection for each Service Line (noted on the individual Service Line Tabs)

KAWEAH HEALTH ANNUAL BOARD REPORT

URGENT CARE CLINICS - Urgent Care Court

FY2021

KEY METRICS - FY 2021

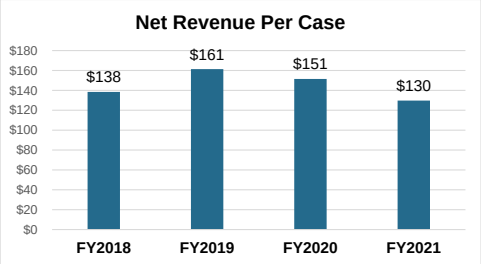
Patient Cases	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
49,265	$6,390,032	$4,328,950	$2,061,082	($156,559)
▲ 24%	▲ 6%	▲ 11%	▼ -2%	▲ 19%

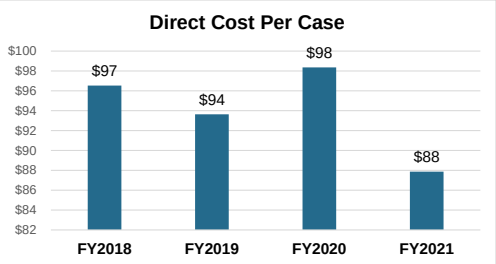
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

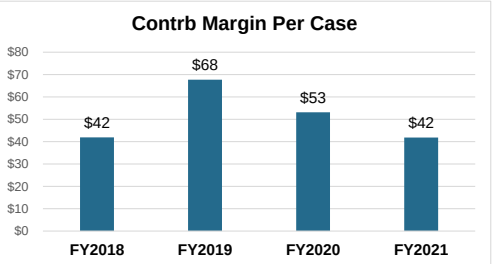
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	59,546	47,718	39,674	49,265	▲ 24%	
Net Revenue	$8,243,648	$7,699,342	$6,010,220	$6,390,032	▲ 6%	
Direct Cost	$5,747,904	$4,468,243	$3,902,301	$4,328,950	▲ 11%	
Contribution Margin	$2,495,744	$3,231,099	$2,107,919	$2,061,082	▼ -2%	
Indirect Cost	$2,445,943	$2,511,115	$2,301,921	$2,217,641	▼ -4%	
Net Income	$49,801	$719,984	($194,003)	($156,559)	▲ 19%	
Net Revenue Per Case	$138	$161	$151	$130	▼ -14%	
Direct Cost Per Case	$97	$94	$98	$88	▼ -11%	
Contrb Margin Per Case	$42	$68	$53	$42	▼ -21%	

PER CASE TRENDED GRAPHS

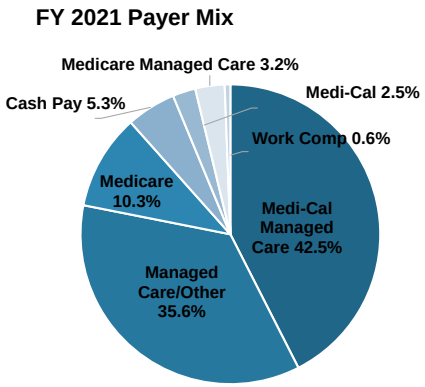






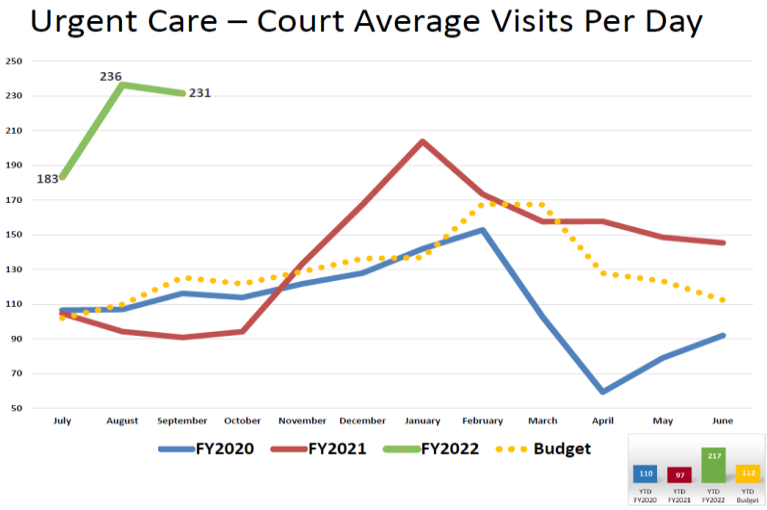
PAYER MIX - 4 YEAR TREND (Based on Volume)

PAYER	FY2018	FY2019	FY2020	FY2021
Medi-Cal Managed Care	59.4%	56.5%	53.8%	42.5%
Managed Care/Other	22.9%	24.2%	26.0%	35.6%
Medicare	7.1%	7.5%	7.6%	10.3%
Cash Pay	4.0%	5.2%	6.0%	5.3%
Medi-Cal	4.3%	3.9%	3.8%	2.5%
Medicare Managed Care	1.7%	2.1%	2.3%	3.2%
Work Comp	0.6%	0.6%	0.6%	0.6%



Level Of Care	FY2018	FY2019	FY2020	FY2021
Level I	0%	0%	0%	0%
Level II	9%	8%	9%	6%
Level III	23%	30%	21%	41%
Level IV	57%	61%	69%	51%
Level V	0%	0%	0%	0%
No Level	11%	0%	1%	3%

KEY METRICS - FY 2021



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line is Urgent Care and Secondary Service Line is Urgent Care Court

KAWEAH HEALTH ANNUAL BOARD REPORT

URGENT CARE CLINICS - Urgent Care Demaree

FY2021

KEY METRICS - FY 2021

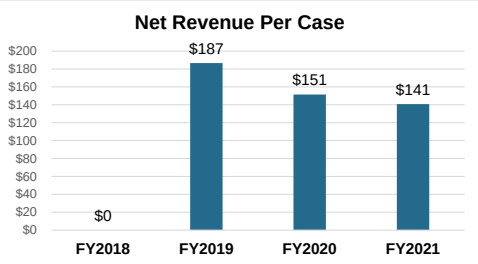
Patient Cases	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
23,449	$3,301,494	$2,190,419	$1,111,075	($356,104)
0%	-7%	-5%	-11%	-206%

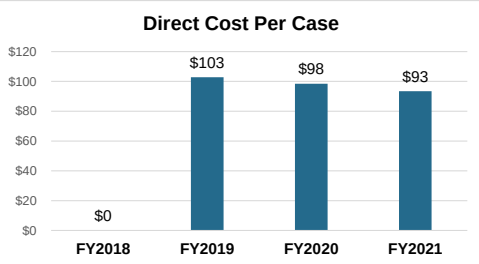
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

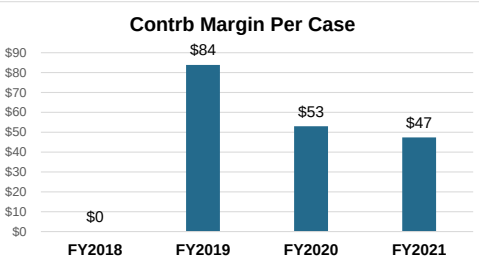
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	0	18,865	23,507	23,449	0%	
Net Revenue	$0	$3,521,208	$3,560,602	$3,301,494	-7%	
Direct Cost	$0	$1,939,085	$2,314,205	$2,190,419	-5%	
Contribution Margin	$0	$1,582,123	$1,246,397	$1,111,075	-11%	
Indirect Cost	$0	$521,576	$910,603	$1,467,179	61%	
Net Income	$0	$1,060,547	$335,794	($356,104)	-206%	
Net Revenue Per Case	$0	$187	$151	$141	-7%	
Direct Cost Per Case	$0	$103	$98	$93	-5%	
Contrb Margin Per Case	$0	$84	$53	$47	-11%	

PER CASE TRENDED GRAPHS (Based on Volume)



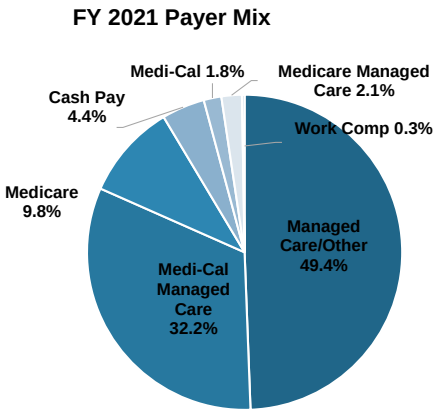




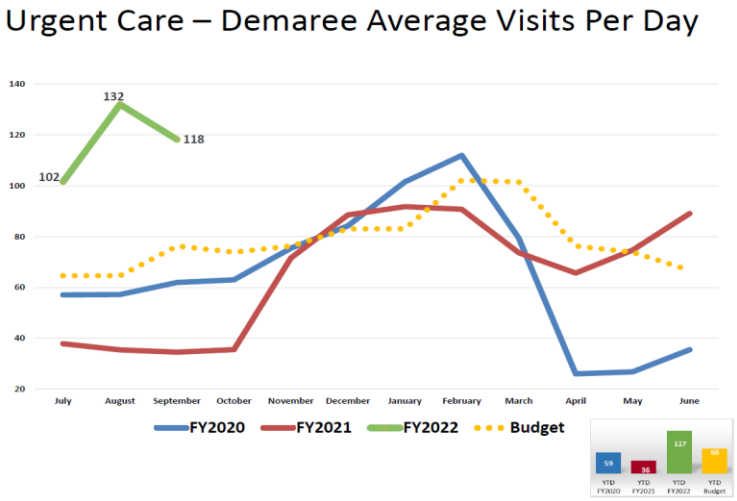
PAYER MIX - 4 YEAR TREND

PAYER	FY2018	FY2019	FY2020	FY2021
Managed Care/Other	0.0%	46.4%	44.8%	49.4%
Medi-Cal Managed Care	0.0%	40.1%	40.6%	32.2%
Medicare	0.0%	6.3%	6.2%	9.8%
Cash Pay	0.0%	3.2%	3.8%	4.4%
Medi-Cal	0.0%	2.3%	2.5%	1.8%
Medicare Managed Care	0.0%	1.3%	1.8%	2.1%
Work Comp	0.0%	0.3%	0.3%	0.3%

Level Of Care	FY2018	FY2019	FY2020	FY2021
Level I	0%	0%	0%	0%
Level II	0%	8%	8%	5%
Level III	0%	24%	16%	32%
Level IV	0%	67%	75%	62%
Level V	0%	0%	0%	0%
Level VI	0%	0%	0%	0%
No Level	0%	1%	1%	1%



KEY METRICS - FY 2021



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line is Urgent Care and Secondary Service Line is Urgent Care Demaree

Home Health Agency, Private/Specialty Home Care, and Lifeline

Tiffany Bullock, Director, Home Health, Private/Specialty Home Care and Lifeline
Contact number: 559-624-6447
November 10, 2021

Summary Issue/Service Considered

1. Achieving optimum balance of program priorities to address quality of care, compliance, profitability, and quality of work environment.
2. Ensuring that all home care services continue to provide the full continuum of services to the community.

Analysis of financial/statistical data:

Home Health Agency, Home Care Services, and Lifeline experienced an increase in contribution margin. The three programs had a contribution margin of $3,128,510 this fiscal year compared to $2,549,956 last fiscal year.

Home Health Agency: The program had a 7% increase in total visits compared to last year. The average direct cost per visit decreased by $3 (-2%), averaging $166 per visit, while net revenue per visit increased by $12 (6%), averaging $223 per visit. Overall, home health experienced a contribution margin of $2,022,152. Payer mix stayed stable, with approximately 70.5% Medicare/Medicare Managed Care. Admissions to home health increased by 13 per month compared to the prior year. The average census also increased by 27 per month compared to the preceding year.

Home Care: The program had a 5% decrease in volume compared to 2020. There has historically been a challenge to increase staffing to meet patient/clients volume demands, but due to COVID, 2021 brought even more challenges with recruiting and retaining staff. Home Care leadership is working with recruiting to hire more staff and has begun outreach to local healthcare related schools in the community to attend job fairs and discuss the benefits of obtaining employment with Kaweah Health Home Care. Additionally, LVN staff will soon be given a rate increase to help wages remain competitive, with the goal of attracting more nursing staff for Specialty Home Care.

At the end of June, the director of Home Care retired after many years of service in her role. In an effort to further remain financially sound, rather than replace this position, there was a management realignment which resulted in a cost saving of approximately $70,000 per year to the department. Despite staffing challenges and COVID related decreases, overall, Home Care services had a contribution margin of $1,088,365.

Lifeline: Lifeline experienced a decrease in volume by -6% resulting in -5% decrease in net revenue. Direct cost increased from $34 to $37 per unit in 2021. The result was a decrease of -21% in the contribution margin compared to prior year. Overall, Lifeline experienced a contribution margin of $17,993 down from $22,891 the prior year. While it is a small

contribution margin, it still has a positive margin. This service line will be monitored closely by leadership with the ongoing goal of determining if this is a service that should continue to be offered by Kaweah Health or outsourced.

Quality/Performance Improvement Data

Home Health Agency: Overall, patient quality of care exceeds national benchmarks. Currently, the Home Health Compare website notes overall quality performance at a 4-star rating (1 through 5 rating scale). The agency has made excellent gains with a number of quality care initiatives, out-performing the national average with how often patients got better at getting in and out of bed, timely initiation of care, medication education, how often patients' breathing improved, preventing re-hospitalization, preventing emergency room visits without admission to the hospital and increase in ability to remain in the community after discharge from Home Health. Performance and trends are carefully monitored and appropriate action plans are developed for any area that is below the national average. Overall, patient satisfaction is averaging 86% compared to the California average of 80% and the National average of 84%. The HHA patient satisfaction continues to remain a 4-star rating on the publically reported website-Home Health Compare, a rating shared by only a few local agencies.

Patient satisfaction continues to be a top priority for the agency. Data is continually analyzed by Home Health leadership and changes/adjustments made as needed as well as to allow the opportunity at service recovery.

In June 2021, staff participated in the District employee engagement survey. Home Health scored very high on this survey. As it was the previous year, Home Health was assigned a Team Index 1 level, the highest possible. This designation comes from all three-survey domains: organization, manager and employee. Teams at this level require minimal improvement planning. A fact that is reinforced by the lower than average turnover rate Home Health continues to maintain.

Home Care Services: Client satisfaction/employee engagement scores are measured twice a year. The results continue to indicate a high degree satisfaction for both employees and clients. For 2021, the average results of the two satisfaction surveys given to clients indicate 96% satisfaction in the following areas: courtesy of staff in their home as excellent; confidence and trust in the staff that provided care in their home and; the Home Care agency met their expectations. Additionally 97% of those surveyed indicated they would recommend the agency to family and friends.

Employee engagement score on a scale 1- 5 resulted in a 5 this past year; meaning that the employees would recommend this agency to others as a good place to work.

Policy, Strategic or Tactical Issues

1. The Home Health Agency underwent a significant change in the structure of payment for Medicare patients effective January 1, 2020. In 2021, we were able to capture a year's worth of data that could be analyzed to evaluate our performance under this new payment structure. By hiring a consultant, we ascertained that our coders were accurately capturing proper coding sequences to optimize payment and clinical staff were managing patient episodes well, balancing patient needs and financial stability.
2. All Home Care services continue to work closely with revenue cycle, finance and the managed care team to ensure proper billings and collections, negotiations of insurance rates, and the overall cost of providing the care is being managed well. Significant

strides have been made under this model as can be noted in increase of revenue for the service line and a strong decrease in accounts receivable.

3. Retention and recruitment of clinical staff continues to be a priority. We are working closely with Human Resources to remain competitive with benefits, salaries, and employee engagement.
4. Increase compensation for LVN staff in Specialty Home Care to attract additional LVN staff to handle increase volume demands.
5. Work closely with HR to hire Aides and Homemakers to meet the community demand for Private Home Care. Increase participation in local job fairs and possibility of Kaweah Health conducting an interview day specific for aides, homemakers and LVNs.
6. Due to the extremely competitive market in the region, we will continue to market services to ensure capturing the market share in our area.
7. Home Health continues to play a vital role in assisting with the overwhelming census the acute hospital has experienced related to COVID admissions by ensuring these patients can be safely discharged to home with Home Health rather than remain hospitalized. Home Health staff including nurses, physical, occupational and speech therapist, home health aides and medical social workers provide care for patients as they recuperate. During the code triage experienced in the acute setting in late 2020, Home Health was able to prioritize patient care needs and two Home Health nurses were able to assist by working as impact nurses for acute care to help with staffing shortages.

Recommendations/Next Steps

1. Maintain positive productivity in support of improved or sustained positive financial performance for all programs.
2. Monitor all publicly reported quality measures to achieve or sustain performance that exceeds national benchmarks. This will include the following:
    i. ongoing audits of both start of care and discharge documentation
    ii. timeliness completion and staff education in regards to documentation
    iii. Continue to work closely with Patient Billing to ensure all revenues issues are being addressed promptly. This will include the following:
    -in-depth analysis of revenue, payments, and denials
    -monthly review of financial reports with the patient billing department
    -electronic billing implementation with payers
3. Participate in outreach programs and opportunities such as community forums and health fairs to market to consumers, physicians, and the overall community.
4. Develop and implement a plan to address employee satisfaction using the result of the Employee Engagement survey administered in June 2021.
5. Work with Greeley consultants to ensure readiness for the survey which is conducted every 3 years by the Joint Commission scheduled for approximately Fall 2022.

Approvals/Conclusions

In the coming year, Home Health Services will focus on:

1. Implementation of goals related to District cornerstones for Home Health, Private Home Care, and Lifeline to enhance program development, the satisfaction of all stakeholders, program marketing, and clinical quality of services.
2. Work with the entire continuum of care from the Acute Care Hospital to the post-acute care providers to meet patient needs and timely placement in the Home Care services.
3. Continue to review profitability, contribution margin to identify opportunities for volume, growth cost containment, customer satisfaction, and clinical excellence.

KAWEAH HEALTH ANNUAL BOARD REPORT

Home Health Agency

FY2021

KEY METRICS - FY 2021

HOME HEALTH VISITS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
35,402	7,897,273	5,875,121	2,022,152	940,627
▲ 7%	▲ 13%	▲ 5%	▲ 44%	▲ 449%

*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

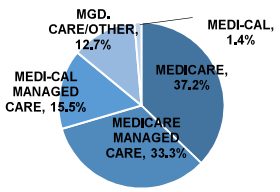
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	% CHANGE PRIOR YR	4 YR TREND
HOME HEALTH VISITS	30,513	32,091	33,110	35,402	▲ 7%	
NET REVENUE	$5,214,446	$5,766,927	$6,998,811	$7,897,273	▲ 13%	
DIRECT COST	$5,468,379	$5,162,334	$5,591,992	$5,875,121	▲ 5%	
CONTRIBUTION MARGIN	($253,933)	$604,593	$1,406,819	$2,022,152	▲ 44%	
INDIRECT COST	$1,156,906	$1,130,015	$1,235,562	$1,081,525	▼ -12%	
NET INCOME	($1,410,839)	($525,422)	$171,257	$940,627	▲ 449%	
NET REVENUE PER UOS	$171	$180	$211	$223	▲ 6%	
DIRECT COST PER UOS	$179	$161	$169	$166	▼ -2%	
CONTRB MARGIN PER UOS	($8)	$19	$42	$57	▲ 34%	
PROXY REIMBURSEMENT	$640,000	$779,530	$1,411,573	$1,520,386	▲ 8%	
PROXY REIMB PER UOS	$21	$24	$43	$43	▲ 1%	
CM PER UOS W/O PROXY	($29)	($5)	($0.14)	$14	▲ 10021%	
NET REV PER UOS W/O PROXY	$158	$156	$168	$180	▲ 7%	

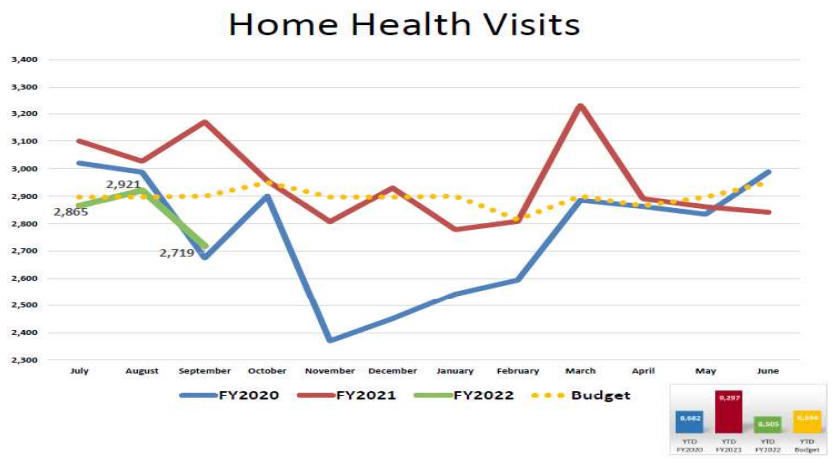
PAYER MIX - 4 YEAR TREND (VOLUME)

PAYER	FY2018	FY2019	FY2020	FY2021
MEDICARE	48.4%	45.9%	44.3%	37.2%
MEDICARE MANAGED CARE	22.7%	26.3%	30.0%	33.3%
MEDI-CAL MANAGED CARE	12.4%	11.6%	12.1%	15.5%
MGD. CARE/OTHER	13.3%	14.2%	10.8%	12.7%
MEDI-CAL	2.1%	1.1%	2.5%	1.4%
MEDICARE COMBINED	71.0%	72.2%	74.4%	70.5%

FY2021 PAYER MIX



STATISTIC - GRAPH OF 3 YEAR TREND



Notes:
Source: Non-Cerner Service Line Reports
Criteria: Home Health Agency
Reimbursement by payer calculation = ([Gross Revenue]-[Deductions])/[visits]

KAWEAH HEALTH ANNUAL BOARD REPORT

Private and Specialty Home Care

FY2021

KEY METRICS - FY 2021

HOME CARE HOURS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
145,530	4,247,774	3,159,409	1,088,365	548,729
▼ -5%	▼ -1%	▼ -1%	▼ -3%	▲ 79%

**Note: Arrows represent the change from prior year and the lines represent the 4-year trend*

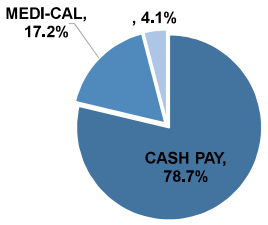
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	% CHANGE PRIOR YR	4 YR TREND
HOME CARE HOURS	152,854	144,019	152,714	145,530	▼ -5%	
NET REVENUE	$3,544,415	$3,717,520	$4,302,591	$4,247,774	▼ -1%	
DIRECT COST	$2,931,280	$2,938,228	$3,182,345	$3,159,409	▼ -1%	
CONTRIBUTION MARGIN	$613,135	$779,292	$1,120,246	$1,088,365	▼ -3%	
INDIRECT COST	$914,926	$701,857	$813,407	$539,636	▼ -34%	
NET INCOME	($301,791)	$77,435	$306,839	$548,729	▲ 79%	
NET REVENUE PER UOS	$23	$26	$28	$29	▲ 4%	
DIRECT COST PER UOS	$19	$20	$21	$22	▲ 4%	
CONTRB MARGIN PER UOS	$4	$5	$7	$7	▲ 2%	

PAYER MIX - 4 YEAR TREND (VOLUME)

PAYER	FY2018	FY2019	FY2020	FY2021
CASH PAY	77.5%	78.7%	79.7%	78.7%
MEDI-CAL	19.3%	18.0%	17.3%	17.2%
THIRD PARTY - TRAD.	3.2%	3.3%	3.0%	4.1%

FY2021 PAYER MIX



Notes:
Source: Non-Cerner Service Line Reports
Criteria: Home Care

KAWEAH HEALTH ANNUAL BOARD REPORT

Lifeline

FY2021

KEY METRICS - FY 2021

UNITS IN USE	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,267	65,242	47,249	17,993	9,124
▼ -6%	▼ -5%	▲ 3%	▼ -21%	▼ -32%

**Note: Arrows represent the change from prior year and the lines represent the 4-year trend*

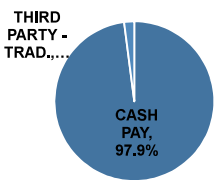
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	% CHANGE PRIOR YR	4 YR TREND
UNITS IN USE	1,751	1,592	1,355	1,267	▼ -6%	
NET REVENUE	$84,312	$78,847	$68,685	$65,242	▼ -5%	
DIRECT COST	$62,255	$58,181	$45,794	$47,249	▲ 3%	
CONTRIBUTION MARGIN	$22,057	$20,666	$22,891	$17,993	▼ -21%	
INDIRECT COST	$12,257	$11,144	$9,485	$8,869	▼ -6%	
NET INCOME	$9,800	$9,522	$13,406	$9,124	▼ -32%	
NET REVENUE PER UOS	$48	$50	$51	$51	▲ 2%	
DIRECT COST PER UOS	$36	$37	$34	$37	▲ 10%	
CONTRB MARGIN PER UOS	$13	$13	$17	$14	▼ -16%	

PAYER MIX - 4 YEAR TREND (VOLUME)

PAYER	FY2018	FY2019	FY2020	FY2021
CASH PAY	99.3%	99.1%	98.1%	97.9%
THIRD PARTY - TRAD.	0.7%	0.7%	1.9%	2.1%

FY2021 PAYER MIX



Notes:
Source: Non-Cerner Service Line Reports
Criteria: Lifeline

REPORT TO THE BOARD OF DIRECTORS

Renal Services

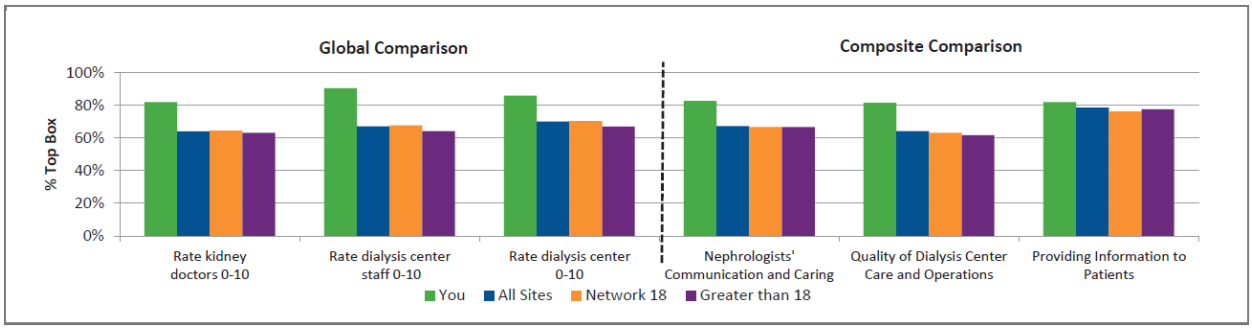
Amy Baker, MSN, RN
Director of Renal Services
(559) 624-5423
November 22, 2021

Summary Issue/Service Considered

- Successfully recruited employees to fill all open positions and have eliminated contract labor.
- A new experienced Nurse Manager started in July 2021.
- Continue to improve internal processes to expedite care of patients at clinic. This includes optimizing patient treatment schedule and employee work schedule.
- Actively monitor all quality measures with a focused effort on Kt/V goals, our fistula rate and blood stream infections. (Kt/V is explained below.)
- Nursing remains focused on patient satisfaction scores and patient education.
- Focused on increasing census for hemodialysis and continuous peritoneal dialysis.
- Address specific renal population needs related to Covid Pandemic.
- Upgraded all operating systems within the Hemodialysis machines.

Quality/Performance Improvement Data

Patient Satisfaction Scores:



Press Ganey completes our clinic patient satisfaction surveys twice a year. For April 2021 to July 2021 twenty two patients completed the survey. The Dialysis Center staff was rated at 90.5% putting us in the 99th percentile compared to other networks within our region (Network 18). The Dialysis Center (building) was rated at 85.7% putting us in the 95th percentile compared to other newtworks within our region.

KT/V Scores:

	Goal 2019	Goal 2020	Goal 2021	Actual 2019	Actual 2020	Actual 2021
%KT/V>1.2	97.5%	99.15%	97.61%	98.08%	98.38%	95.66%

A KT over V score measures how well a patient is being dialyzed. It measures the adequacy of the dialysis treatments. Last year in 2020, we did not met our goal of 99.15%. We increased our goal in 2020 from 97.5% to 99.15%. For 2020 we improved from 98.08% to 98.38%. This is due to it being a priority for everyone involved. Even with the improvements becoming standardized, we have had obstacles this year. The covid pandemic is increasing hospitilizations which prevents the patient from obtaining the KT/V lab and or meeting clearance. This is causing our percentage to decrease. We are working with inpatient leadership to get labs for dialysis clinic patients drawn while in the hospital. We continue to ensure everyone on the treatment floor is working closely with the physicians making sure the appropriate clearence is achieved and maintained.

Fistula and Catheter Rates:

	Goal 2019	Actual 2019	Goal 2020	Actual 2020	Goal 2021	Actual 2021
Fistula Rate	75%	56.43%	70%	59.27%	62%	53.46%
Long term Catheter Rate (Greater than 90 days)	10.7%	27.00%	10.7%	23.40%	17%	24.39%

Our team strongly believes in Fistula First to prevent complications associated with catheters. This is the industry standard. With our new Renal Access Coordinator things have began to change at the clinic. Our catheter rate is the lowest its ever been at 23.40%. The RAC organized the process and includes transport now when scheduling procedures. This has resulted in greater compliance. For 2021, we have had an increase in new patients to help build our census back up. This causes the rate of catheters to increase until these new patients get a fistula created.

Bloodstream Infection Rates (BSI):

	Goal 2019	Actual 2019	Goal 2020	Actual 2020	Goal 2021	Actual 2021
BSI Ratio (SIR)	0	1.964	0	1.758	0	2.679

Bloodstream infections can occur when bacteria or fungus enter the blood stream. With patients receiving hemodialysis three times a week their chances of obtaining a blood stream infection is higher than the general population. At the Dialysis Clinic, we take every precaution to prevent blood stream infections and this is evident by our ratio decreasing from a SIR of 1.964 in 2019 to a SIR of 1.758 in 2020. The number of actual infections is divided by the number of expected infections, which gives us a standard infection ratio (SIR). For 2021, we have had an increase in blood stream infections. We have worked with Infection Prevention and identified trends in practice that contributed to the increase. We have reeducated staff about importance of using chlorhexidine properly and reeducated the patients about washing their fistulas with soap and water when entering the treatment floor.

Policy, Strategic or Tactical Issues

- Review monthly, all quality data, in our Quality Assessment and Performance Improvement committee (QAPI) meeting to ensure we are meeting our goals. If a goal is not met then an action plan is created to address the problem.
- Work to recruit more patients to the clinic. This involves reaching out to nephrologists to request more admissions to clinic. Work with inpatient Renal Access Coordinator to recruit more patients
- Continue to perform 20 different audits to validate best practice is being performed at chairside. We have streamlined the process for holding staff accountable for any fallouts in care at bedside.
- Continuing to stay up to date on Covid 19 care at the clinic. This includes continuous education for patients and employees. Refining our screening process to ensure compliance. Safeguarding our isolation shift to keep patients and employees safe.
- Reviewing current policies for clinic and updating order sets for admission. Created new Do Not Resuscitate policy to ensure patient's wishes are maintained even when on dialysis.
- Made patient dialysis schedule efficient and created isolation shift for Covid positive hemodialysis patients. Continue to monitor and balance new admissions with isolation shift demand.

Recommendations/Next Steps

- Focus on employee engagement by focusing on top opportunities from last Employee Engagement survey. They include increasing recognition, ensuring the team has tools and resources needed, and provide career development opportunities.
- Continue with employee weekly updates to facilitate information from leadership to employees.
- Focus on improving supply utilization by eliminating unnecessary items on supply list.
- Look at vendor contracts to explore better pricing options.
- Work closely with pharmacy to monitor medication trends and evaluate cost versus benefit to patient. Made reductions in expensive medications and looking at renegotiating contracts with Kaweah Health Home Infusion Pharmacy.
- Evaluate need to update facility. For example new flooring in treatment room.

Approvals/Conclusions

- Strive for overall quality outcomes and set goals to continue to improve. Specifically focusing on blood stream infections.
- Increase CAPD and Hemodialysis patient volumes to improve financial strength of clinic.
- Continue to work with supply vendors specifically Fresenius to decrease supply cost.
- Evaluate hemodialysis standards in care to make appropriate pharmaceutical decisions for patients and clinic.

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2021

Outpatient Dialysis Services

KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021

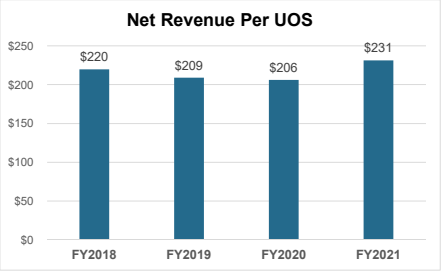
UNITS OF SERVICE	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
26,621	$6,153,237	$6,831,721	($678,484)	($4,092,536)
▼ -18%	▼ -8%	▼ -8%	▲ 10%	▲ 7%

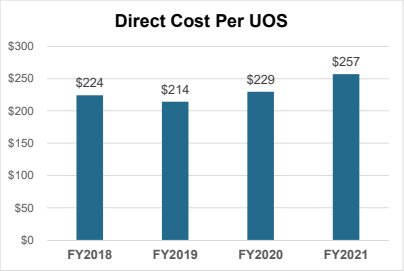
*Note: Arrows represent the change from prior year and the lines represent the 4-year t

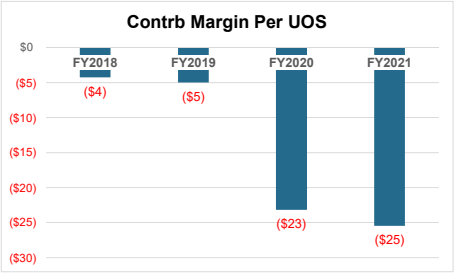
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	30,012	32,445	32,468	26,621 ▼	-18%	
Net Revenue	$6,591,144	$6,778,611	$6,690,952	$6,153,237 ▼	-8%	
Direct Cost	$6,718,963	$6,941,671	$7,444,819	$6,831,721 ▼	-8%	
Contribution Margin	($127,819)	($163,060)	($753,867)	($678,484) ▲	10%	
Indirect Cost	$2,464,953	$2,301,100	$3,648,310	$3,414,051 ▼	-6%	
Net Income	($2,592,772)	($2,464,160)	($4,402,177)	($4,092,536) ▲	7%	
Net Revenue Per UOS	$220	$209	$206	$231 ▲	12%	
Direct Cost Per UOS	$224	$214	$229	$257 ▲	12%	
Contrb Margin Per UOS	($4)	($5)	($23)	($25) ▼	-10%	

PER CASE TRENDED GRAPHS

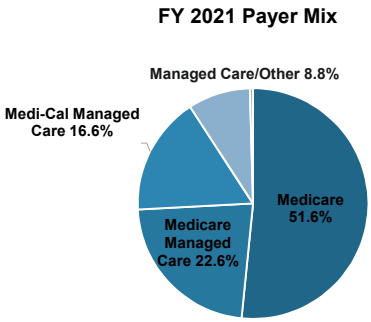




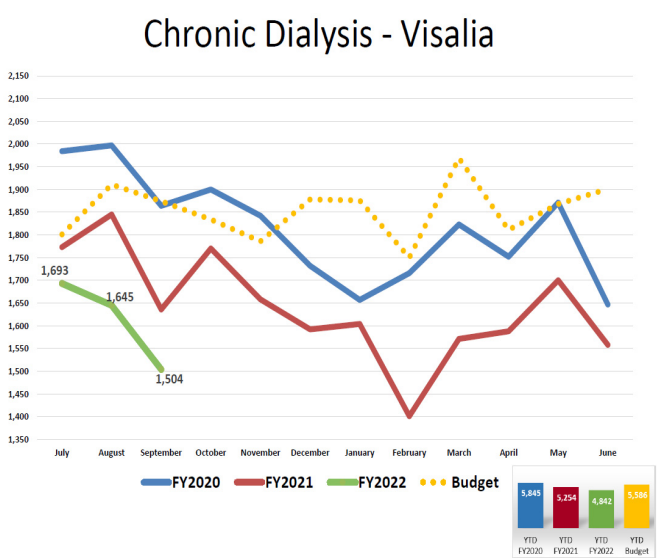


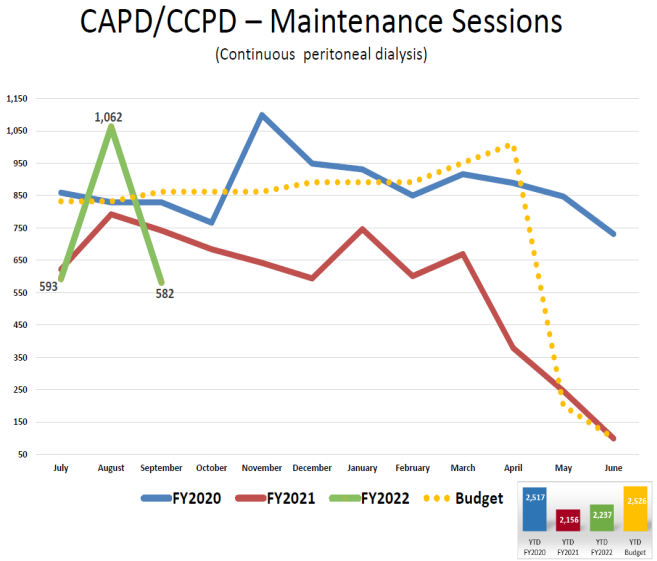
PAYER MIX - 4 YEAR TREND (Gross Revenue)

PAYER	FY2018	FY2019	FY2020	FY2021
Medicare	68.9%	63.6%	60.2%	51.6%
Medicare Managed Care	11.7%	11.5%	15.6%	22.6%
Medi-Cal Managed Care	13.9%	16.0%	16.0%	16.6%
Managed Care/Other	5.1%	8.0%	6.9%	8.8%
Medi-Cal	0.3%	0.9%	1.3%	0.4%
Medicare Combined	80.7%	75.1%	75.7%	74.2%



STATISTIC GRAPHS





Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Lines Dialysis (includes CAPD and Hemodialysis)

Financial Property & Acquisition Committee Report

November 17, 2021

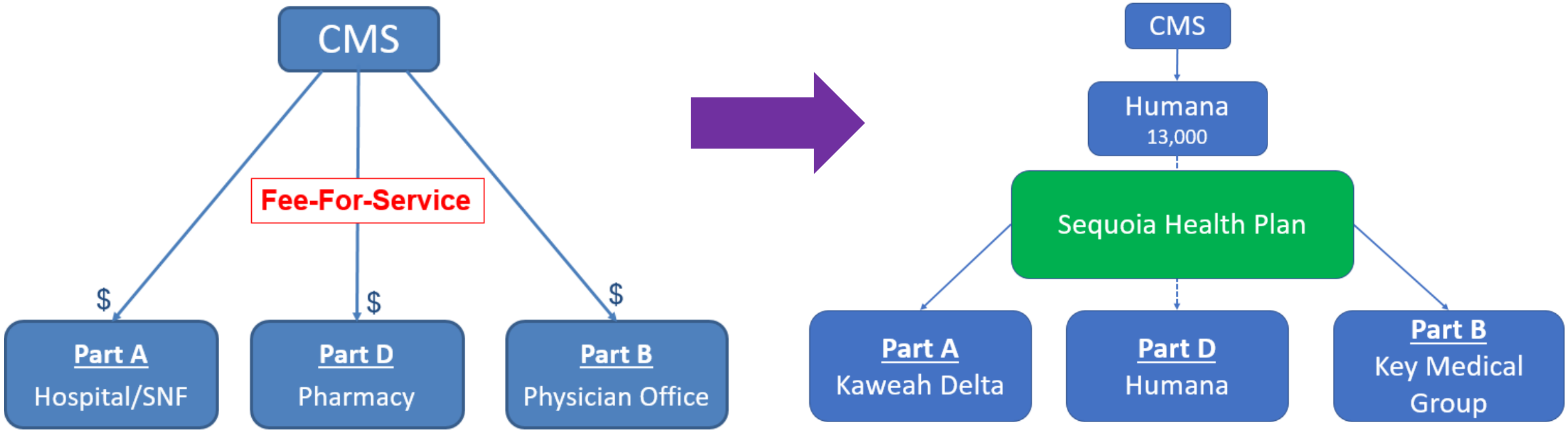
Sequoia Integrated Health Humana Medicare Advantage

Sequoia Integrated Health

What is our why?

Our Why

Develop an Integrated Delivery Network that improves the health and wellness of our community in a way that is financially sustainable



Sequoia Integrated Health

What is our how?

Understanding the Financial Mechanics of Medicare Advantage

- **Revenue**
  - Largest variables we can impact
    - Risk Adjustment Factor (RAF)
    - CMS Star Quality Score
  - Annual CMS rate adjustments

- **Expenses**
  - Largest variables we can impact
    - Preventable hospitalizations and ED visits
    - Improving efficiencies and decreasing the cost of care

Our How

Improving Care and Decreasing Avoidable Utilization (= savings)

- Virtual Care Team & Dedicated Hospitalists
- Comprehensive Care Clinic (CCC)
- End-Stage Renal Disease (ESRD) Program
- Clinical Pharmacists & Medication Management
- Streamlining the Medicare benefit

Improving Documentation & Coding (= revenue)

- Annual Wellness/Physician Assessment Form (PAF) Visits:
  - Assessing Hierarchical Chronic Conditions (HCC) = Risk Adjustment Factor (RAF) scores

Importance of the RAF Score

GOLD/DSNP Blend RAF Revenue and Split (PMPM)	
Value of RAF .01 Change	$ 6.80
Value of .01 RAF to KH	$ 3.50
Value of .01 RAF to Key MG	$ 2.80

End Stage Renal Disease (ESRD) RAF Revenue and Split (PMPM)	
Value of RAF .01 Change	$ 86.80
Value of .01 RAF to KH	$ 44.63
Value of .01 RAF to Key	$ 35.76

Incremental PMPM Increase		
RAF Improvement	**Kaweah's Portion**	**Annualized** (n=13,000)
0.01	$ 3.50	$ 545,463.36
0.02	$ 6.99	$ 1,090,926.72
0.03	$ 10.49	$ 1,636,390.08
0.04	$ 13.99	$ 2,181,853.44
0.05	$ 17.48	$ 2,727,316.80

Incremental PMPM Increase		
RAF Improvement	**Kaweah's Portion**	**Annualized** (n=84)
0.01	$ 44.63	$ 44,987.04
0.10	$ 446.30	$ 449,870.40
0.20	$ 892.60	$ 899,740.80
0.30	$ 1,338.90	$ 1,349,611.20
0.40	$ 1,785.20	$ 1,799,481.60

Kaweah Health RAF and Quality Scores

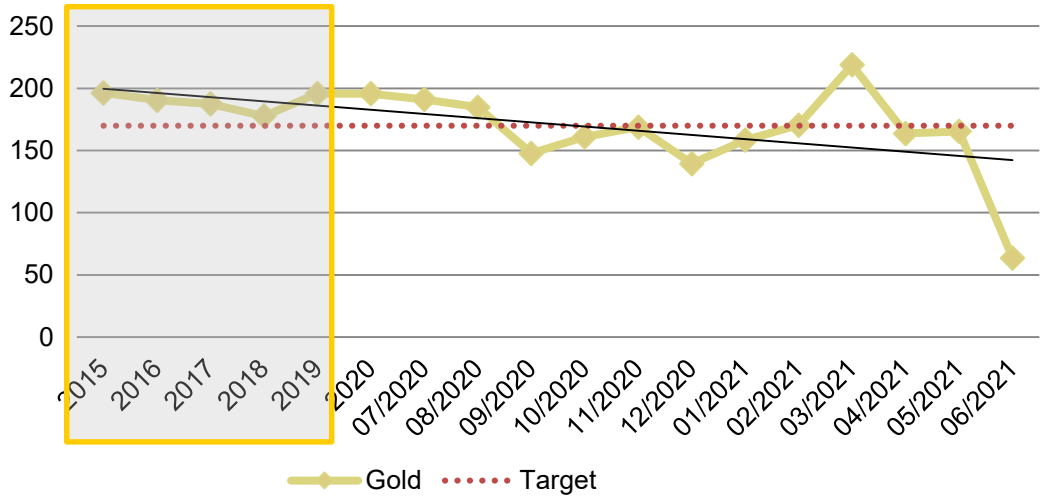
Group	STAR Score	RAF	Members	Group	STAR Score	RAF	Members
Group A	4.30	1.40	333	Group F	3.80	1.09	179
Group B	4.10	1.33	305	Group G	3.80	1.07	309
Group C	3.50	1.16	185	Group H	4.61	1.03	595
Group D	3.90	1.15	122	Group I	3.10	1.01	333
Kaweah Delta RHC's	3.73	1.14	1077	Kaweah Health Medical Group	3.46	0.92	2162
Group E	3.51	1.10	616	Entire Network	3.47	0.99	12089

Sequoia Integrated Health

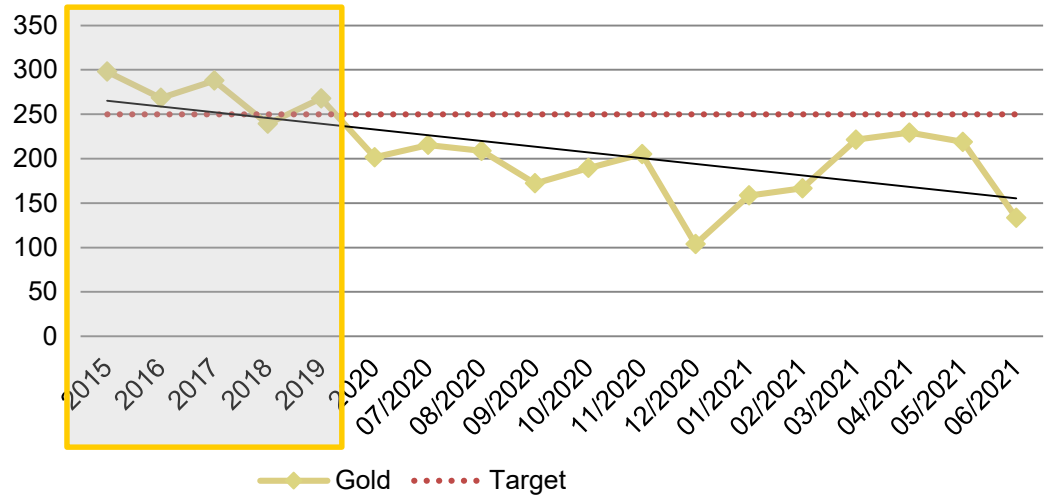
Where are we today?

Humana Members – Tracking Healthcare Utilization

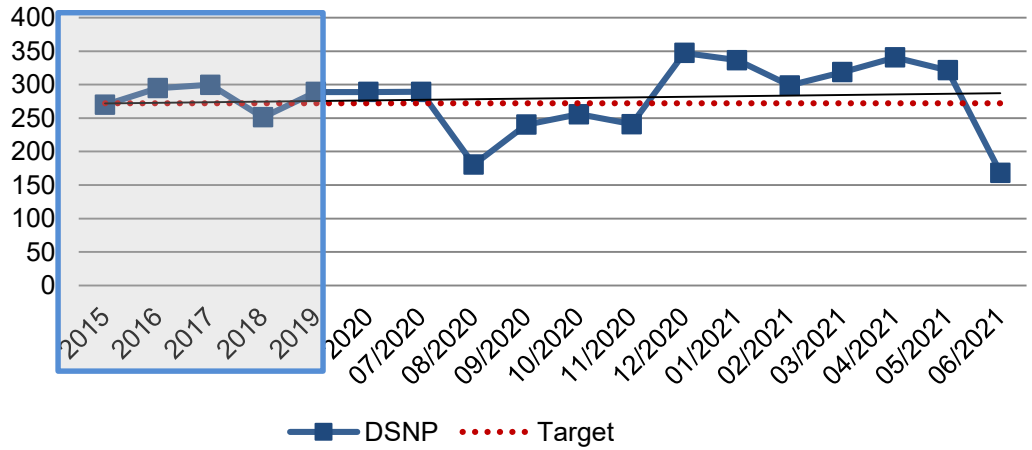
Gold Acute Admits per 1000



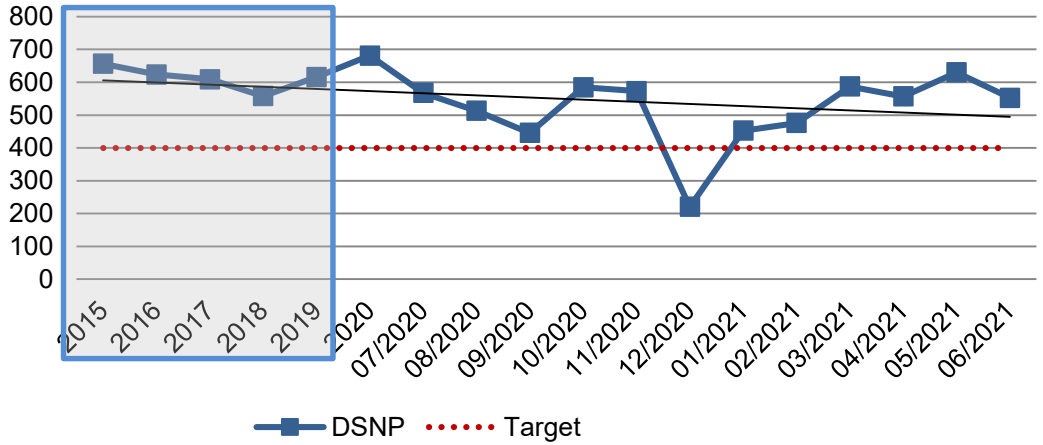
Gold ED Visits per 1000



D-SNP Admits per 1000



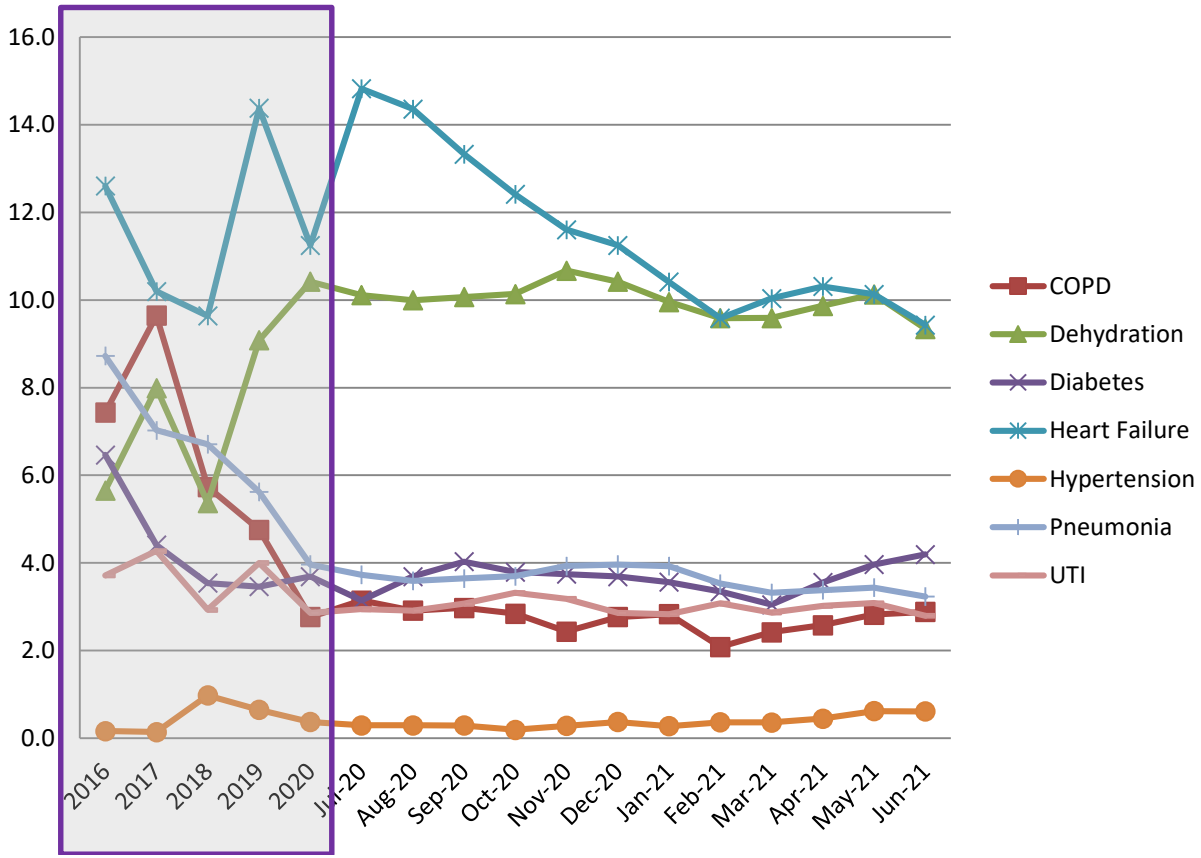
D-SNP ED Visits per 1000



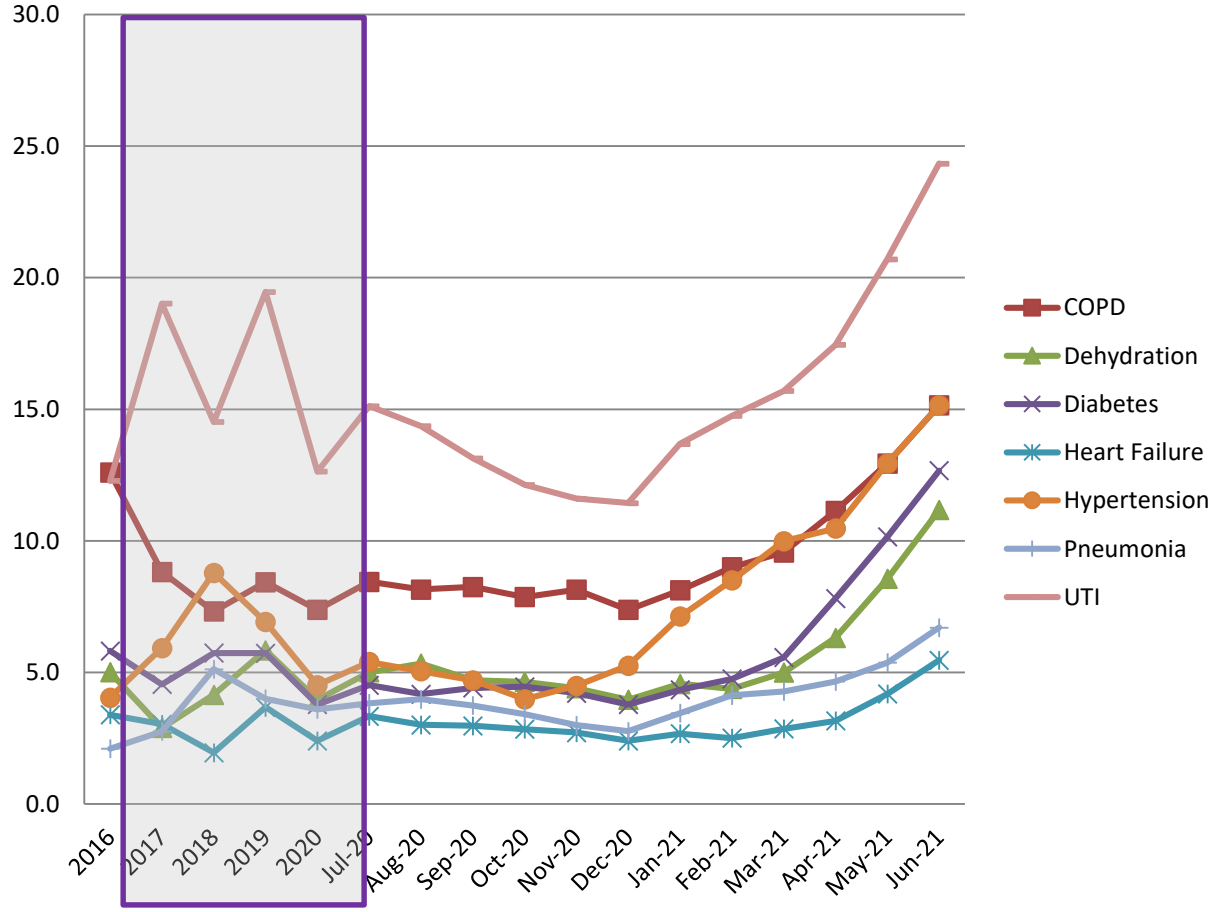
Humana Member – Chronic Condition Admissions & ED Visits

Using Data to Prioritize Disease Management Programs

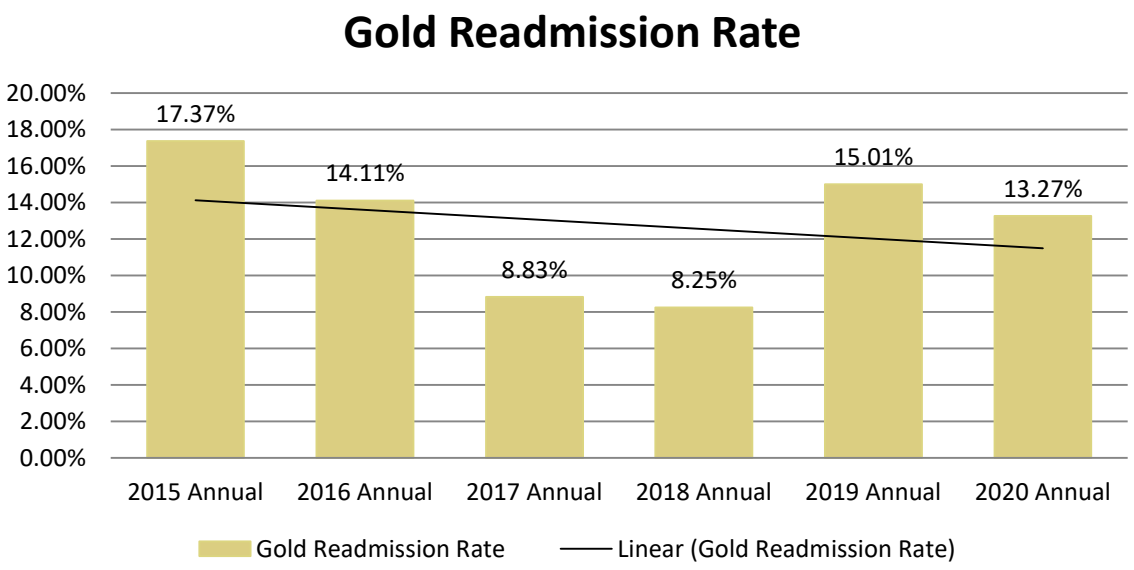
PQI 90 Potentially Avoidable Admits Per 1000

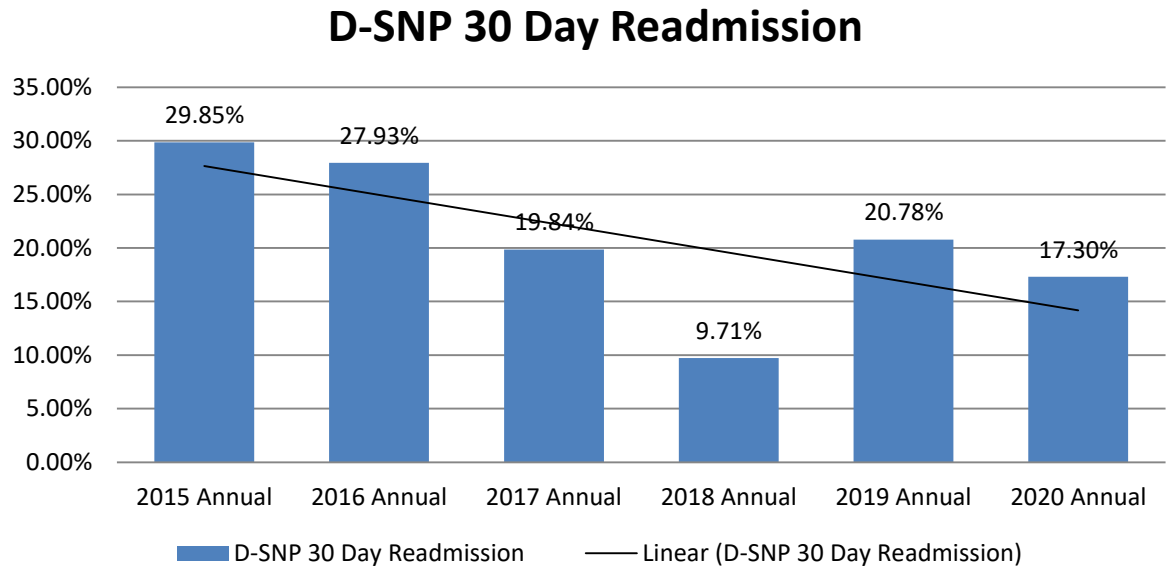


PQI 90 Potentially Avoidable ED Visits Per 1000



Impact on 30-Day Readmissions

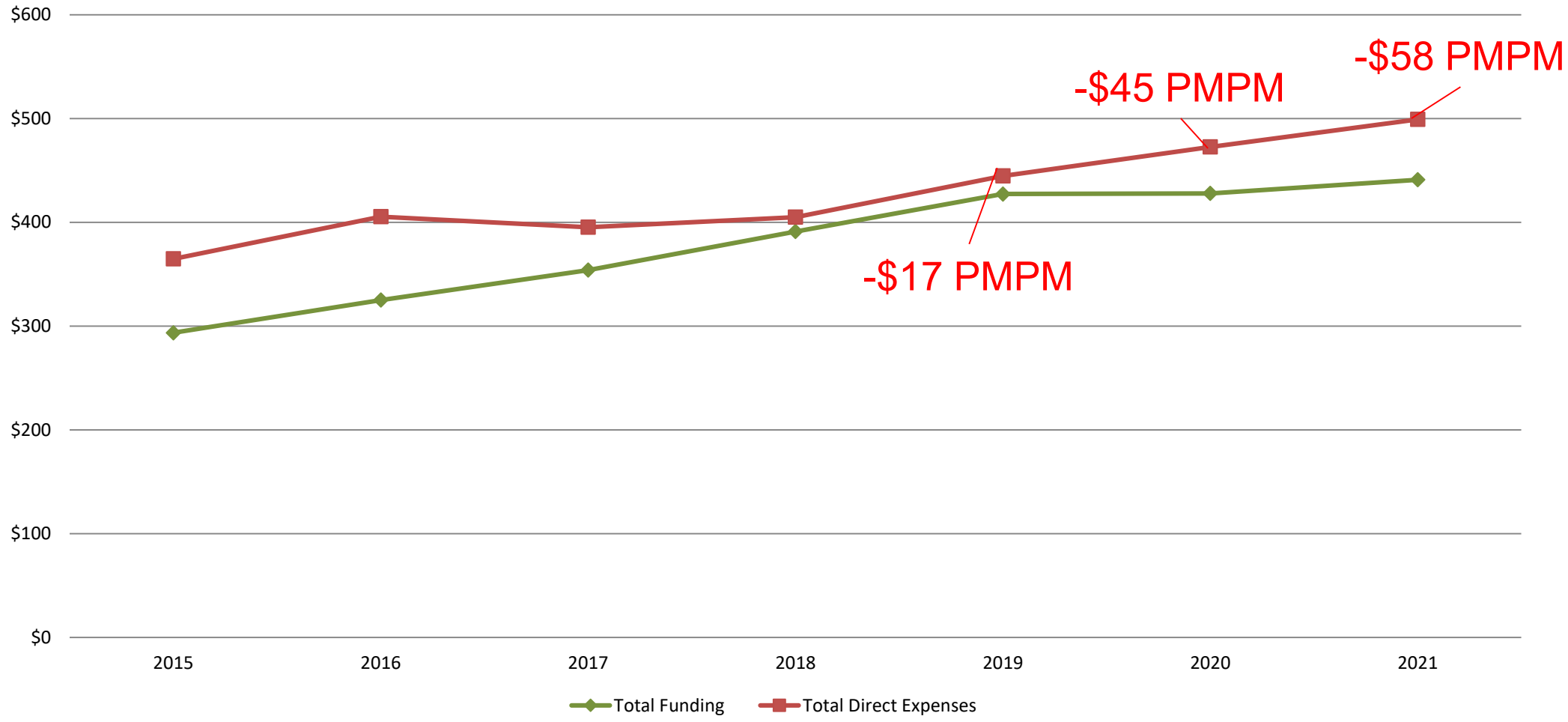




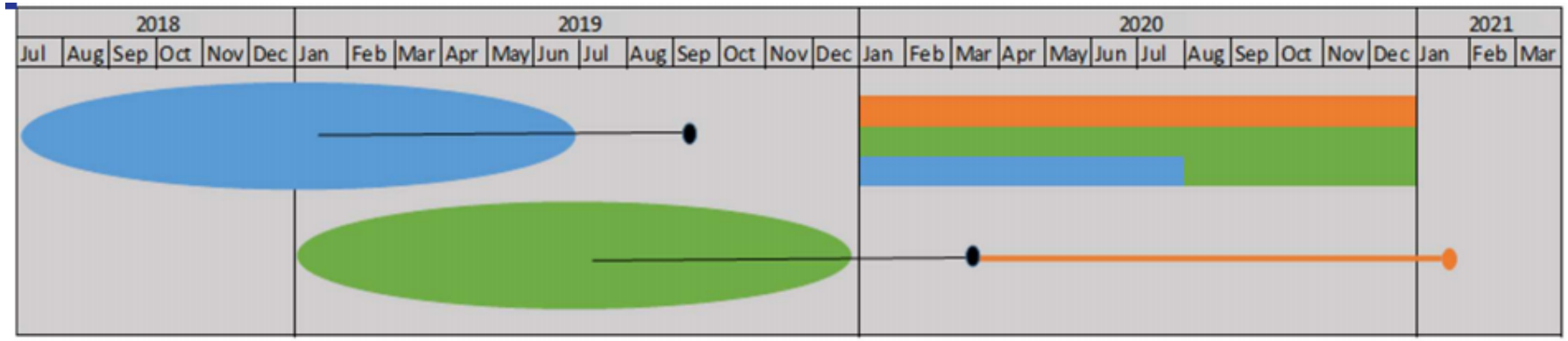
Humana Part A Year-Over-Year Funding vs Expenses

	2019						2020						YTD September 2021					
	GOLD	PMPM	DSNP	PMPM	Total	PMPM	GOLD	PMPM	DSNP	PMPM	Total	PMPM	GOLD	PMPM	DSNP	PMPM	Total	PMPM
Annual Funding[1]	$35,545,177	$378	$10,402,670	$593	$45,947,847	$412	$38,275,878	$368	$15,203,405	$594	$53,479,283	$413	$31,029,455	$372	$14,994,903	$618	$46,024,358	$428
Reinsurance Payments	$130,174	$1			$130,174	$1												
VCT Revenue	$203,796	$2	$35,964	$2	$239,760	$2	$383,995	$4	$152,525	$6	$536,520	$4	$278,074	$3	$134,378	$6	$412,452	$4
KDHCD Employee	$145,625	$2	$25,699	$1	$171,324	$2	$87,990	$1	$34,950	$1	$122,940	$1	$0	$0	$0	$0	$0	$0
Indirect Medical Education[3]	$884,791	$9	$258,943	$15	$1,143,735	$10	$902,019	$9	$358,287	$14	$1,260,307	$10	$692,588	$8	$334,691	$14	$1,027,279	$10
Total Revenue	**$36,909,563**	**$393**	**$10,723,276**	**$611**	**$47,632,840**	**$427**	**$39,649,882**	**$382**	**$15,749,167**	**$615**	**$55,399,049**	**$428**	**$32,000,116**	**$384**	**$15,463,973**	**$638**	**$47,464,089**	**$441**
Kaweah Delta - Direct Cost[6]	$19,298,368	$205	$4,892,176	$279	$24,190,544	$217	$21,491,762	$207	$6,088,103	$238	$27,579,865	$213	$17,783,559	$213	$7,032,584	$290	$24,816,144	$231
Third Party Facilities Net Paid Claims[4]	$17,310,541	$184	$4,403,457	$251	$21,713,998	$195	$20,502,849	$197	$8,534,329	$333	$29,037,179	$224	$12,979,377	$156	$6,844,651	$282	$19,824,029	$184
IBNR - Third Party Claims[5]	$5,911	$0	$1,730	$0	$7,641	$0	$30,719	$0	$12,202	$0	$42,921	$0	$3,921,745	$47	$1,895,173	$78	$5,816,918	$54
Estimated Home Health Cost	$2,165,589	$23	$633,782	$36	$2,799,371	$25	$2,517,678	$24	$1,000,037	$39	$3,517,714	$27	$1,595,815	$19	$771,173	$32	$2,366,988	$22
Total Pat Related Expenses	**$38,780,409**	**$413**	**$9,931,145**	**$566**	**$48,711,554**	**$437**	**$44,543,009**	**$429**	**$15,634,671**	**$611**	**$60,177,679**	**$465**	**$36,280,497**	**$435**	**$16,543,582**	**$682**	**$52,824,079**	**$491**
Admin Fee – Foundation	$668,788	$7	$195,728	$11	$864,516	$8	$725,128	$7	$288,025	$11	$1,013,153	$8	$607,653	$7	$293,647	$12	$901,299	$8
Total Direct Expenses	$39,449,197	$420	$10,126,873	$577	$49,576,069	$445	$45,268,136	$436	$15,922,696	$622	$61,190,832	$473	$36,888,149	$442	$16,837,228	$694	$53,725,378	$499
Contribution Margin	**($2,539,633)**	**($27)**	**$596,403**	**$34**	**($1,943,230)**	**($17)**	**($5,618,255)**	**($54)**	**($173,528)**	**($7)**	**($5,791,783)**	**($45)**	**($4,888,033)**	**($59)**	**($1,373,256)**	**($57)**	**($6,261,289)**	**($58)**
Kaweah Delta - Indirect Cost[7]	$5,857,700	$62	$1,536,368	$88	$7,394,069	$66	$6,461,366	$62	$1,852,172	$72	$8,313,537	$64	$5,285,394	$63	$2,204,272	$91	$7,489,666	$70
Total Expenses	$45,306,897	$482	$11,663,241	$665	$56,970,138	$511	$51,729,502	$498	$17,774,868	$694	$69,504,370	$537	$42,173,543	$506	$19,041,500	$785	$61,215,044	$569
Profit/Loss	**($8,397,334)**	**($89)**	**($939,965)**	**($54)**	**($9,337,299)**	**($84)**	**($12,079,620)**	**($116)**	**($2,025,700)**	**($79)**	**($14,105,320**	**($109)**	**($10,173,427)**	**($122)**	**($3,577,527)**	**($148)**	**($13,750,954)**	**($128)**

Humana Part A Year-Over-Year Funding vs Expenses Per Member Per Month (PMPM)

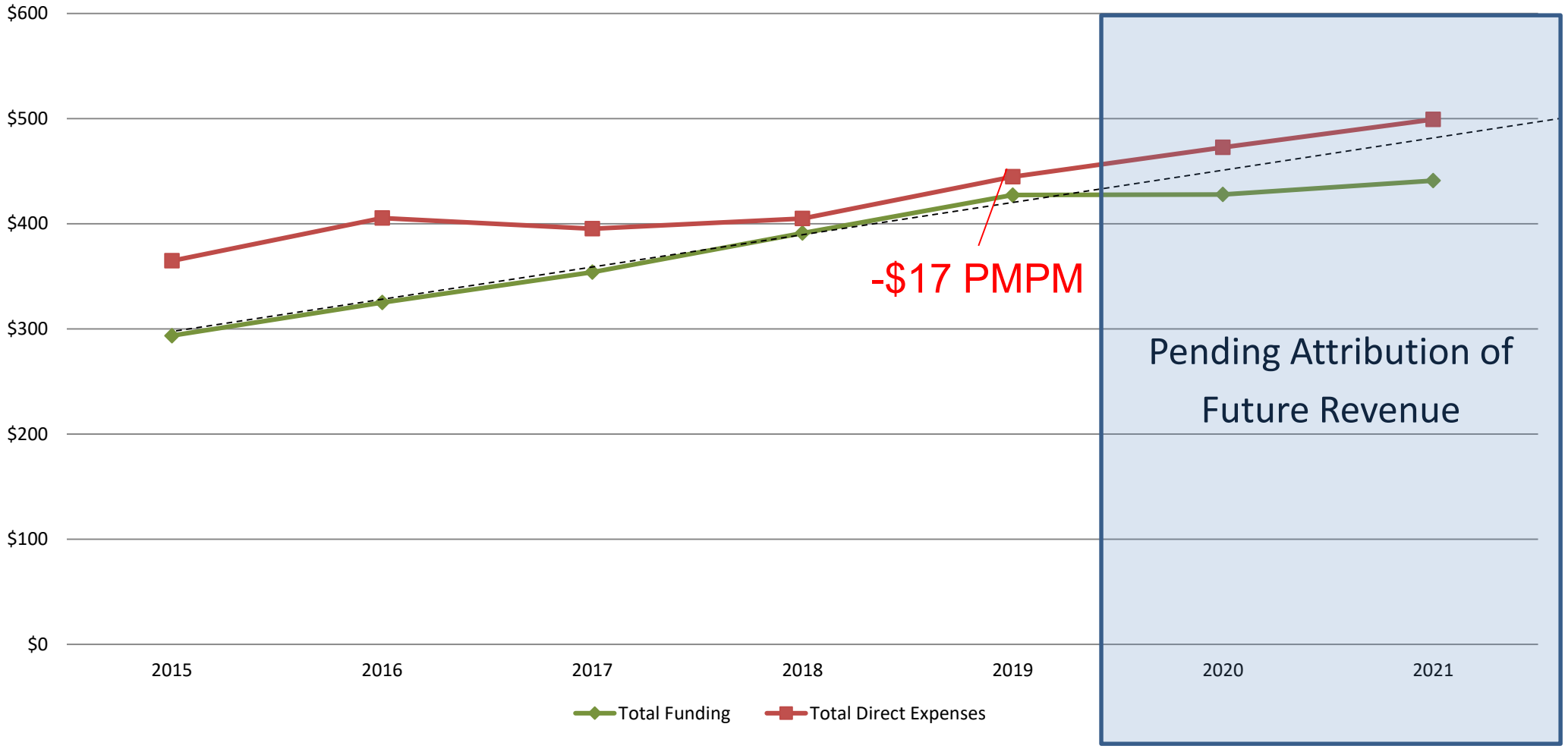


Lag Time in Medicare Advantage Reconciliations and Payment



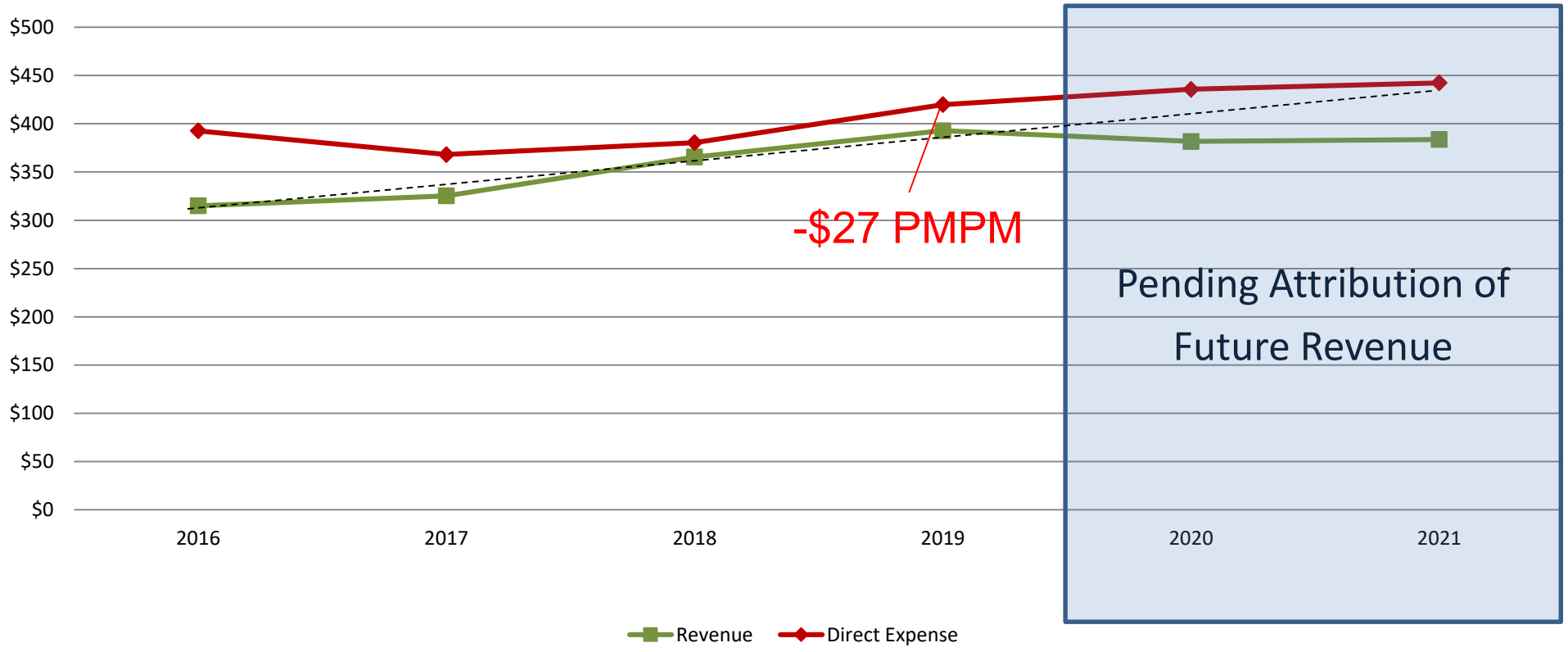
Payment	RAPS/EDS Blend	Dates of Service	Submission Deadline	Month Reflected in MMR
Payment Year 2019				
Initial	75/25	7/1/17 – 6/30/18	Early Sep '18	January '19
Mid-Year	75/25	1/1/18 – 12/31/18	Early Mar '19	August '19
Final	75/25	1/1/18 – 12/31/18	Jan 31, 2020	July '20
Payment Year 2020				
Initial	50/50	7/1/18 – 6/30/19	Early Sep '19	January '20
Mid-Year	50/50	1/1/19 – 12/31/19	Early Mar '20	August '20
Final	50/50	1/1/19 – 12/31/19	Jan 31, 2021	July '21

Humana Part A Year-Over-Year Funding vs Expenses Per Member Per Month (PMPM)



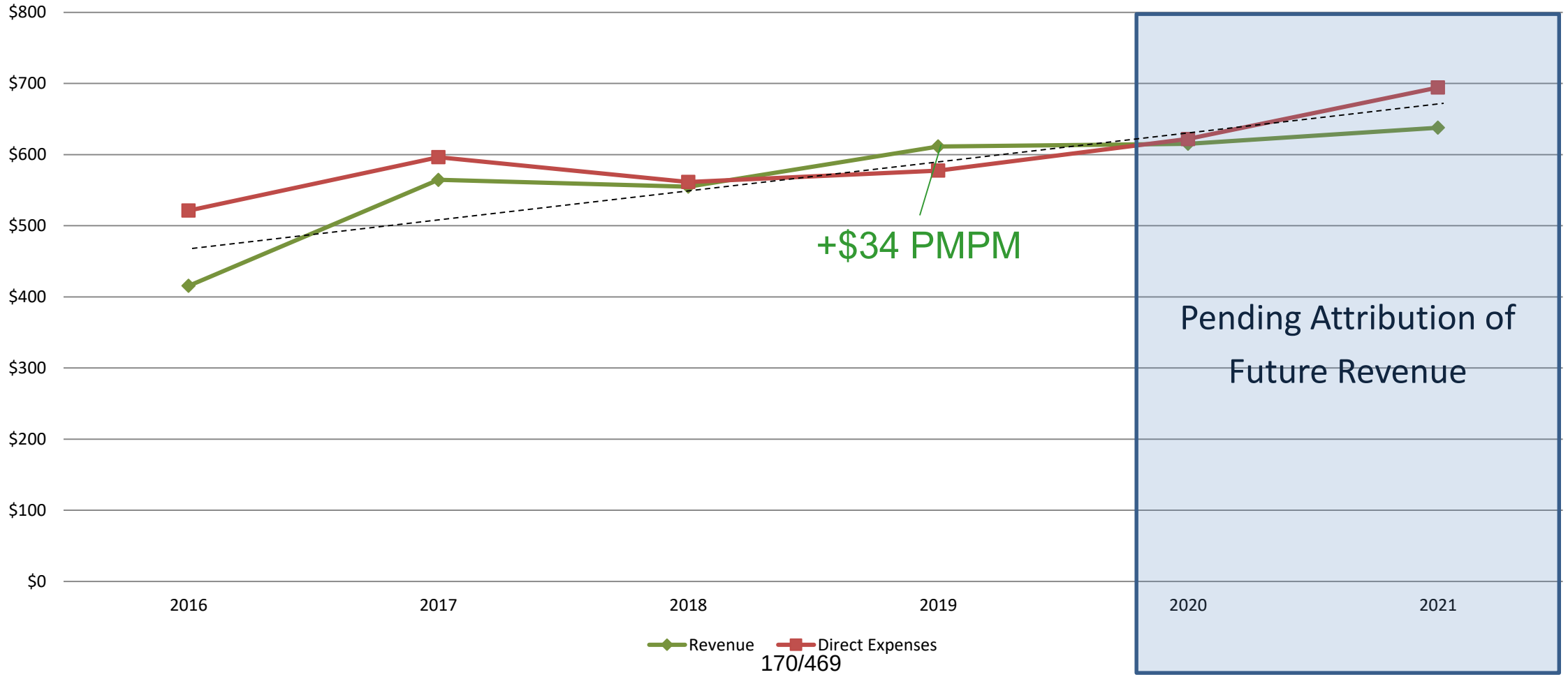
Humana Part A – GOLD Membership

Year-Over-Year Funding vs Expenses Per Member Per Month (PMPM)



Humana Part A – DSNP

Year Over Year Funding vs Expenses Per Member Per Month (PMPM)



Closing the Financial Gap

Plan to Close Negative Contribution Margin	
PMPM Deficit *[(Current CM) – Future estimated true-up)]*	($43.00)
With Cost Increase *(5%)*	**($45.15)**

CMS Reimbursement Changes	
County Base Rate Change *(GOLD membership only)*	$ 26.00
Population RAF Change *(Increase by 0.02)*	$ 6.99
Net After Reimbursement	**($12.16)**

SIH Quality Improvement Plan	
End Stage Renal Disease (ESRD) RAF Change	$ 8.87
ESRD Utilization Change	$ 0.86
Comprehensive Care Clinic (CCC) RAF Change	$ 0.94
CCC Utilization Change	$ 2.99
Total of PMPM Change	$ 13.66
Net	**$ 1.50**

End Stage Renal Disease (ESRD) Program Assumptions

Revenue Increases from Increase in RAF	
Patients *(75% of patients n=84)*	63
Current Average RAF	1.04
ESRD Average RAF	1.45
RAF Change	0.41
PMPM Increase/0.01 RAF	$ 44.63
PMPY ESRD (KH Change)	$ 21,957.96
Total PMPY Annual $ Change	$ 1,383,351.48
PMPM Increase to KH	**$ 8.87**

Savings from Hospital Admissions	
Cost Per Admission (PQI-90)	$11,120
Avoided Admissions	12
Total Annual $ Savings	$133,440
PMPM Savings to KH	**$ 0.86**
Total PMPM Increase to KH	**$ 9.72**

PMPM = Per Member Per Month

PMPY = Per Member Per Year

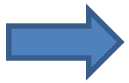
The How: Improved Care Coordination

- Dedicated ESRD Nurse Case-Manager
- Dialysis Centers
- Nephrologist & PCP
- Dedicated PA performing annual assessments
- Vascular Surgeon - Access Management
- Patient and Caretaker Education
- Transplant Evaluation

CCC Program Assumptions

Revenue Increases from Increase in RAF	
Patients	100
Current Average RAF	1.45
ESRD Average RAF	1.80
RAF Change	0.35
PMPM Increase/0.01 RAF	$ 3.50
PMPY CCC (KH Change)	$ 1,468.56
Total PMPY Annual $ Change	$ 146,855.52
PMPM Increase to KH	**$ 0.94**

Savings from Hospital Admissions	
Cost Per Admission (PQI-90)	$11,120
Avoided Admissions	42
Total Annual $ Savings	$467,040
PMPM Savings to KH	**$ 2.99**
Total PMPM Increase to KH	**$ 3.94**



Revenue Increases from Increase in RAF	
Patients	400
Current Average RAF	1.45
ESRD Average RAF	1.80
RAF Change	0.35
PMPM Increase/0.01 RAF	$ 3.50
PPPY CCC (KH Change)	$ 1,468.56
Total PMPY Annual $ Change	$ 587,422.08
PMPM Increase to KH	**$ 3.77**

Savings from Hospital Admissions	
Cost Per Admission (PQI-90)	$11,120
Avoided Admissions	169
Total Annual $ Savings	$1,879,280
PMPM Savings to KH	**$ 12.05**
Total PMPM Increase to KH	**$ 15.81**

Closing the Financial Gap

Plan to Close Negative Contribution Margin	
PMPM Deficit *[(Current CM) – Future estimated true-up)]*	($43.00)
With Cost Increase *(5%)*	**($45.15)**

CMS Reimbursement Changes	
County Base Rate Change *(GOLD membership only)*	$ 26.00
Population RAF Change *(Increase by 0.02)*	$ 6.99
Net After Reimbursement	**($12.16)**

SIH Quality Improvement Plan	
End Stage Renal Disease (ESRD) RAF Change	$ 8.87
ESRD Utilization Change	$ 0.86
Comprehensive Care Clinic (CCC) RAF Change	$ 0.94
CCC Utilization Change	$ 2.99
Total of PMPM Change	**$ 13.66**
Net	**$ 1.50**


Kaweah Health
MORE THAN MEDICINE. LIFE.
Questions?

REPORT TO THE BOARD OF DIRECTORS

202 W Willow, LLC

Marc Mertz, VP/Chief Strategy Officer, 624-2511
November 10, 2021

Summary Issue/Service Considered

Kaweah Health is a 33% owner in the property legally known as 202 W. Willow, Visalia, CA 93291. The initial investment of $858,026 was donated by Dr. Rupi K. Malli, of the Malli Family Trust, in 2017.

Kaweah Health currently leases the following spaces in 202 W. Willow:

Suite 102	Outpatient Pharmacy
Suite 202	Neurology
Suite 204	Subleased to Humana
Suite 205	Sequoia Health and Wellness Centers
Suite 305	Employee Health
Suite 502	Family Medicine Clinic

Quality/Performance Improvement Data

For the fiscal year 2021, income from investment, or profit allocation, is $12,587.

KAWEAH HEALTH ANNUAL BOARD REPORT

202 W. Willow, LLC

FY2021	
Profit distributions	$15,000
Total cash inflow (outflow) from investment	$15,000
Total income (loss) from Investment (profit allocation)	$12,587

FY2020	
Capital Contributions - Elevators	($22,064)
Total cash inflow (outflow) from investment	($22,064)
Total income (loss) from Investment (profit allocation)	$38,853

From Inception	
Initial investment - donated portion of LLC	$858,026
Capital Contributions - Elevators	($22,064)
Profit distributions	$63,000
Total cash inflow (outflow) from investment	$40,936
Total income (loss) from Investment (profit allocation)	$110,812

Policy, Strategic or Tactical Issues

This property is home to several of our clinics and departments. It is also strategically located immediately adjacent to the Medical Center.

The 202 W Willow, LCC ownership group has authorized Kaweah Health to install a large "Kaweah Health Medical Plaza" sign on the top of this building. This is in our future plans.

Recommendations/Next Steps

Continue to own a portion of the 202 W Willow building and to occupy multiple suites.

Physician Recruitment and Relations
Medical Staff Recruitment Report - November 2021

Prepared by: Brittany Taylor, Director of Physician Recruitment and Relations - btaylor@kaweahhealth.org - (559)624-2899

Date prepared: 11/17/2021

Central Valley Critical Care Medicine	
Hospitalist	2
Intensivist	3

Delta Doctors Inc.	
OB/Gyn	1

Frederick W. Mayer MD Inc.	
Cardiothoracic Surgery	2

Kaweah Delta Faculty Medical Group	
Family Medicine Core Faculty	1

Kaweah Health Medical Group	
Advanced Practice Provider - Quick Care	1
Audiology	1
Dermatology	2
Family Medicine	3
Internal Medicine	1
Gastroenterology	2
Neurology	1
Orthopedic Surgery (Hand)	1
Otolaryngology	2

Kaweah Health Medical Group (Cont.)	
Pulmonology	1
Radiology - Diagnostic	1
Rheumatology	1
Urology	3

Oak Creek Anesthesia	
Anesthesia - Cardiac	1
Anesthesia - Critical Care	1
Anesthesia - Obstetrics	1

Orthopaedic Associates Medical Clinic, Inc.	
Orthopedic Surgery (Trauma)	1

Other Recruitment	
Neurology - Inpatient	1

Sequoia Oncology Medical Associates Inc.	
Hematology/Oncology	1

Valley Children's Health Care	
Maternal Fetal Medicine	2
Neonatology	1

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Anesthesia - Cardiac	Oak Creek Anesthesia	Nagm, M.D.	Hussam	TBD	Direct Referral	Site Visit: 11/9/21
Anesthesia	Oak Creek Anesthesia	Berg, M.D.	Lamont	TBD	Direct	Offer accepted
Anesthesia	Oak Creek Anesthesia	He, M.D.	Chaoying	ASAP	Direct	Site Visit: 9/21/21; Offer accepted; Tentative Start Date: January 2022
Anesthesia	Oak Creek Anesthesia	Lin, M.D.	Steven	ASAP	Direct	Site Visit: 9/21/21; Offer accepted; Tentative Start Date: January 2022
Certified Registered Nurse Anesthetist	Oak Creek Anesthesia	Caceres	Cesar	ASAP	Direct - 5/21/21	Offer accepted; Credentialing in process
Certified Registered Nurse Anesthetist	Oak Creek Anesthesia	Knittel	Michael	03/22	Direct - 10/19/21	Offer accepted; contract in process
Certified Registered Nurse Anesthetist	Oak Creek Anesthesia	Lopez	Ramon	03/22	Direct - 11/2/21	Offer accepted; contract in process
Certified Registered Nurse Anesthetist	Oak Creek Anesthesia	Sobotka	Tyler	01/22	Direct - 6/1/21	Offer accepted; Tentative start date: January 2022
Certified Registered Nurse Anesthetist	Oak Creek Anesthesia	Spolsdoff	Allison	12/21	Direct	Offer accepted; Tentative start date: December 1, 2021
Family Medicine	Kaweah Health Medical Group/Key Medical Associates	Shin, M.D.	Chang-Sung	09/22	Kaweah Health Resident	Initial interview: 10/15/21
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Rangel-Orozco, M.D.	Daniela	08/22	Kaweah Health Resident	Site Visit: 10/28/21; Offer pending

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Gastroenterology	Kaweah Health Medical Group	Ali, M.D.	Asad	08/22	Direct - PracticeLink	Site Visit: 12/10/21
Gastroenterology - APP	Kaweah Health Medical Group	Almonte, NP-C	Wendy	01/22	Direct referral	Site Visit: 11/3/21; Offer accepted
Gastroenterology	Key Medical Associates	Eskandari, M.D.	Armen	11/21	Direct	Offer accepted
Hospitalist	Central Valley Critical Care Medicine	Grewal, M.D.	Sarbjot	07/22	Direct	Currently under review
Hospitalist	Central Valley Critical Care Medicine	Legesse, M.D.	Ash	01/22	Direct	Current under review
Hospitalist	Central Valley Critical Care Medicine	Nagy, D.O.	Omar	08/22	Vista Staffing Solutions - 11/8/21	Site Visit: 11/13/21
Hospitalist	Central Valley Critical Care Medicine	Zaidi, M.D.	Syeda	07/22	Direct - CareerMD Career Fair	Currently under review
Interventional Radiology	Mineral King Radiology	Schwenke, M.D.	Matthew	08/22	Merritt Hawkins - 11/10/21	Currently under review
Intensivist	Central Valley Critical Care Medicine	Bolonduro, M.D.	Oluwamuyiwa	08/22	CompHealth - 11/10/21	Currently under review
Intensivist	Central Valley Critical Care Medicine	Sinha, M.D.	Nupur	TBD	CompHealth - 10/22/21	Site Visit: 11/23/21
Interventional Cardiology	Sequoia Cardiology Medical Group	Singla, M.D.	Atul	01/22	Direct referral	Site Visit: 6/14/21; Offer accepted
Neonatology	Valley Children's	Agu, D.O.	Cindy	TBD	Valley Children's - 9/1/21	Site Visit: 9/20/21; Offer extended
Neonatology	Valley Children's	Singh, M.D.	Himanshu	08/22	Valley Children's - 3/31/21	Site Visit: 4/19/2021; Offer accepted. Start date 8/29/2022
Orthopedic Surgery (Trauma)	Orthopaedic Associates Medical Clinic, Inc.	Zourabian, M.D.	Steven	09/22	Direct outreach to program	Site Visit: 11/19/21

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Otolaryngology	Kaweah Health Medical Group	Zhang, M.D.	Huan	09/22	Curative - 10/15/21	Phone Interview: 11/11/21; Site visit pending dates
Otolaryngology	Kaweah Health Medical Group	Nguyen, D.O.	Cang	07/22	Curative - 3/15/21	Offer accepted; contract in process
Pediatrics	Kaweah Health Medical Group	Galindo, M.D.	Ramon	09/22	Direct referral - 6/28/21	Site visit: 9/14/21; Offer accepted
Physical Therapy	Kaweah Health Medical Group	Zigo	Dominique	Jan-22	CliniPost - 8/25/21	Offer accepted; Tentative start date: January 2022

November 22, 2021

Sent via Certified Mail
No. 70160340000002569081
Return Receipt Required

Benjamin Fogel, Inc.
16933 Parthenia Street, Suite 110
Northridge, CA 91343

RE: Notice of Rejection of Claim of Patricia Jean Forrester and James M. Forrester vs. Kaweah Health

Notice is hereby given that the claim, which you presented to the Board of Directors of Kaweah Health on October 21, 2021, was rejected on its merits by the Board of Directors on November 22, 2021

WARNING

Subject to certain exceptions, you have only six (6) months from the date this notice was personally delivered or deposited in the mail to file a court action on this claim. See Government Code Section 945.6. You may seek the advice of an attorney of your choice in connection with this matter. If you desire to consult an attorney, you should do so immediately.

Sincerely,

Garth Gipson
Secretary/Treasurer, Board of Directors

cc: Richard Salinas, Attorney at Law

MEMORANDUM

To: Kaweah Delta Health Care District (KDHCD) Board of Directors

From: Dianne Cox, Vice President Human Resources

Subject: Plan Amendments, Loan Administration Policy and Board Resolutions
Kaweah Delta Health Care District Employees' Salary Deferral Plan (401(k))
Kaweah Delta Health Care District 457(b) Deferred Compensation Plan

DATE: November 16, 2021

Each year, Kaweah Delta Health Care District (KDHCD) reviews our retirement plans and makes several plan amendments and administration updates to these plans. These amendments reflect administrative best practices, business strategy changes at KDHCD and legal requirements to administer these plans. This Memorandum is an overview of the changes that are proposed for our retirement plans at this time.

Employees' Salary Deferral Plan (401(k) Plan)

KDHCD has reviewed the plan document and proposes to amend the Employees' Salary Deferral Plan as follows:

Effective January 1, 2021:

- The definition of Eligible Compensation will become an Exhibit to the Plan. Currently, Human Resources and Payroll maintain a spreadsheet that displays all Payroll Codes and the handling of these Payroll Codes for purposes of the 401(k) and 457(b) Plans. This spreadsheet will become an Exhibit added to the Plan and will be the plan's definition of Eligible Compensation. The purpose of the amendment is to simplify plan administration and to align the plan document with the current procedures utilized by KDHCD staff.

Effective January 1, 2022:

- The Plan will be amended to permit In-Plan ROTH Rollovers. This provision will permit current plan participants to convert Salary Deferral Plan Assets into ROTH Deferral Plan Assets. This provision will permit individual plan participants to align their individual tax strategy with personal objectives. This is an enhanced benefit to the Plan.
- Employer Non-Elective Contributions will be amended to permit KDHCD more flexibility in making these Contributions in the future. This flexibility will permit KDHCD to utilize this provision for recruiting new Employees, retaining current Employees and other business-related objectives

Effective January 1, 2022, the Loan Administration Policy needs to be updated. This updated policy includes:

- loan minimum payment period – change from 36 months to 1 month. This is being updated to provide flexibility to participants in loan repayments

The Employer Matching Contributions are now defined as discretionary from year to year. This permits KDHCD the ability to define the Matching Contribution Formula each year to align with business strategies. There was no Employer Match Contribution to the plan for the January 1, 2020 – December 31, 2020 Plan Year.

- For the January 1, 2021 – December 31, 2021 Plan Year, the Board needs to approve the Employer Matching Contribution Formula for the Plan. The Employer Matching Contribution Formula is reflected in the following table:

Years of Service	Matching Contribution	Maximum Matching Salary Deferral or ROTH Deferral Contribution
1-2	50%	3% of Compensation
3-5	50%	4% of Compensation
6-10	50%	5% of Compensation
11 or more	50%	6% of Compensation

457(b) Deferred Compensation Plan

KDHCD has reviewed the plan document and proposes to amend the 457(b) Deferred Compensation Plan as of January 1, 2022, to reflect business strategy changes at KDHCD and to comply with current regulations. The proposed Adoption Agreement amendment includes:

- **In-Plan Roth Rollover** - allow additional in-service distribution options for In-Plan Roth Rollover; in-service distributions will not be permitted from an In-Plan Roth Rollover account until the earliest date a distribution would otherwise be permitted for any contribution source eligible for conversion, without regard to the Roth rollover distribution
- **457 Special Catch-Up Contribution** – allow special catch-up contribution to be made; amend normal retirement age (NRA) from age 65 to a date range from age 65-70.5 to allow participants to declare their NRA for the 3-year period prior to this date to make the special catch-up contribution

For the Board's information, the Secure Act and Related Provisions are being adopted in both the Employees' Salary Deferral Plan and the 457(b) Plan. These are regulatory plan design features that can be added to the Plan, but these plan amendments are currently not written nor available and are not required to be adopted until 2024. These features will be outlined and adopted in 2024 when the actual amendment is required for plan purposes.

RESOLUTION 2144
OF THE BOARD OF DIRECTORS OF
KAWEAH DELTA HEALTH CARE DISTRICT
AMENDING THE EMPLOYEES' SALARY DEFERRAL PLAN

WHEREAS the Board of Directors (the "Board") of the Kaweah Delta Health Care District (the "District") adopted the Kaweah Delta Heath Care District Employees' Salary Deferral Plan, as amended and restated effective January 1, 2021 (the "Plan"); and

WHEREAS the District reserves the right to amend or restate the Plan in Section 14.01 of the Plan's Base Plan Document.

WHEREAS the District desires to restate the Plan document effective January 1, 2021, to reflect the following:

- **Plan Compensation** will amend the Definition of Plan Compensation to replace the narrative, and reference adjustments to compensation specific to Deferral, Match, and Employer, and changes from time to time, as indicated by specific pay code and their respective effective date on the detailed pay code listing kept in HR and Finance

WHEREAS the District desires to restate the Plan document effective January 1, 2022, to reflect the following:

- **In-Plan Roth Rollover** allow additional in-service distribution options for In-Plan Roth Rollover; not including outstanding loan balances; in-service distributions will not be permitted from an In-Plan Roth Rollover account until the earliest date a distribution would otherwise be permitted for any contribution source eligible for conversion, without regard to the Roth rollover distribution
- **Employer Non-elective Contribution** will be amended from a pro-rata allocation as a uniform percentage of plan compensation to all eligible participants, to 6-3 (e)(1) as a separate ER contribution which may be made to each Participant of the Employer, i.e., each Participant is his/her own allocation group, with the allocation to be determined by Kaweah Health each Plan Year for the $ amount or % of eligible compensation to be made

WHEREAS the District desires to restate the Loan Administration Policy effective January 1, 2021, to reflect the following:

- loan minimum payment period – change from 36 months to 1 month

WHEREAS the District desires to define the Rules for determining Matching Contribution Formula for the January 1, 2021 – December 31, 2021 Play Year to reflect the following:

- The Matching Contribution will be based on the number of Years of Service a Participant has per the definition of Years of Service for the purpose of the Matching Contribution and the formula for each Year of Service tier has a separate limit above which Salary Deferrals and ROTH Deferrals will not be matched. Matching Contributions are subject to a specific definition of Plan Compensation. Kaweah Delta Health Care District staff will need to check the definitions of the specific Plan Compensation applicable to Matching Contributions. The March Contribution Formula is outlined in the following table:

Years of Service	Matching Contribution	Maximum Matching Salary Deferral or ROTH Deferral Contribution
1-2	50%	3% of Compensation
3-5	50%	4% of Compensation
6-10	50%	5% of Compensation
11 or more	50%	6% of Compensation

NOW, THEREFORE, BE IT RESOLVED, that an authorized officer be and herby is directed and authorized to the Restatement to the plan which is attached hereto**.**

This Resolution is adopted by the Board of Directors of Kaweah Delta Health Care District at a duly constituted meeting held on the 22nd day of November 2021.

KAWEAH DELTA HEALTH CARE DISTRICT

_____

President, Kaweah Delta Health Care District

ATTEST:

_____

Secretary/Treasurer
Kaweah Delta Health Care District
and of the Board of Directors, thereof

RESOLUTION 2145
OF THE BOARD OF DIRECTORS OF
KAWEAH DELTA HEALTH CARE DISTRICT
AMENDING THE 457(b) DEFERRED COMPENSATION PLAN

WHEREAS the Board of Directors (the "Board") of the Kaweah Delta Health Care District (the "District") adopted the Kaweah Delta Heath Care District 457(b) Deferred Compensation Plan, as amended and restated effective January 1, 2021 (the "Plan"); and

WHEREAS, the District reserves the right to amend or restate the Plan in Section X. of the Plan Document;

WHEREAS the District desires to restate the Plan document effective January 1, 2022, to reflect the following:

- **In-Plan Roth Rollover** - allow additional in-service distribution options for In-Plan Roth Rollover; in-service distributions will not be permitted from an In-Plan Roth Rollover account until the earliest date a distribution would otherwise be permitted for any contribution source eligible for conversion, without regard to the Roth rollover distribution
- **457 Special Catch-Up Contribution** – allow special catch-up contribution to be made; amend normal retirement age (NRA) from age 65 to a date range from age 65-70.5 to allow participants to declare their Normal Retirement Age for the 3-year period prior to this date to make the special catch-up contribution

NOW, THEREFORE, BE IT RESOLVED, that an authorized officer be and hereby is directed and authorized to sign the Restatement to the plan which is attached hereto.

This Resolution is adopted by the Board of Directors of Kaweah Delta Health Care District at a duly constituted meeting held on the 22nd day of November, 2021.

KAWEAH DELTA HEALTH CARE DISTRICT

_____
President, Kaweah Delta Health Care District

ATTEST:

_____
Secretary/Treasurer
Kaweah Delta Health Care District and
of the Board of Directors, thereof

Appendix D

Policy Submission Summary

Manual Name: Medical Staff Services			**Date: 11/8/21**
Support Staff Name: April McKee			
Routed to:			**Approved By: (Name/Committee – Date)**
☐ **Department Director** ☐ **Medical Director** *(if applicable)* ☐ **Medical Staff Department** *(if applicable)* ☐ **Patient Care Policy** *(if applicable)* ☐ **Pharmacy & Therapeutics** *(if applicable)* ☐ **Interdisciplinary Practice Council** *(if applicable)* ☐ **Credentials Committee** *(if applicable)* ☐ **Executive Team** *(if applicable)* ☒ **Medical Executive Committee** *(if applicable)* ☒ **Board of Directors**			
Policy/Procedure Title	**#**	**Status** (New, Revised, Reviewed, Deleted)	**Name and Phone # of person who wrote the new policy or revised an existing policy**
Medical Staff & Advanced Practice Provider Education Policy	MS 56	New	April McKee x2344
Code of Conduct for Medical Staff & Advanced Practice Providers	MS 47	Revised	Glenda Zarbock & Teresa Boyce x2365
Peer Review Sharing Information	MS 55	Revised	Glenda Zarbock & Teresa Boyce x2365
Informed Consent for Surgical, Diagnostic, or Therapeutic Procedure	MS 43	Reviewed	No Changes Needed per Risk Management

Kaweah Health
MORE THAN MEDICINE. LIFE.

Subcategories of District Manuals not selected.

Policy Number: MS 56	Date Created: No Date Set
Document Owner: April McKee (Medical Staff Svcs Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee	

Medical Staff & Advanced Practice Provider Education Policy

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Policy: Kaweah Health is committed to providing education to credentialed staff as outlined below. As noted, specific education is mandatory per the Medical Executive Committee or State Law.

1. Education provided at Orientation for Active Staff, Courtesy Staff, Consulting Staff, Advanced Practice Providers, and Temporary Practitioners:
    a. Time Out & Informed Consent
    b. Provider Restraint
    c. Workplace Violence Prevention
    d. Environment of Care Standards
    e. Pain Management
    f. Antimicrobial Stewardship

2. Mandatory Anti-Harassment Education Module to be completed at initial appointment and at reappointment for the following Practitioners:
    a. Active Staff
    b. Courtesy Staff
    c. Consulting Staff
    d. Advanced Practice Providers
    e. Temporary Practitioners covering more than 6 months

3. Mandatory Glucommander Education Module to be completed at initial appointment for the following departments:
    a. Cardiovascular Services
    b. Critical Care, Pulmonary, and Adult Hospitalists Medicine
    c. Family Medicine (Inpatient Practitioners Only)
    d. Internal Medicine (Admitting Practitioners Only)

4. Mandatory Implicit Bias Training Education Module to be completed at initial appointment and at reappointment for all practitioners that provide perinatal care:
    a. Department of OB/GYN OB Practitioners
    b. Department of Family Medicine Practitioners with OB privileges
    c. Department of Emergency Medicine Practitioners

The required anti-harassment education and implicit bias course is offered at Kaweah Health but can be met if proof of completion at another facility within the last year is provided at initial and reappointment.

Additional education provided as needed.

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Kaweah Delta Health Care District

Medical Staff Services

Policy Number: MS 47	**Date Created: 03/26/2021**
Document Owner: April McKee (Medical Staff Svcs Manager)	**Date Approved: 04/27/2021**
Approvers: Board of Directors (Administration), Medical Executive Committee, April McKee (Medical Staff Svcs Manager), Cindy Moccio (Board Clerk/Exec Assist-CEO), Teresa Boyce (Director of Medical Staff Svcs)	

Code of Conduct For Medical Staff & Advanced Practice Providers

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Purpose:

The purpose of this policy is to encourage behavior that promotes a culture of safety, quality and respect.

A high standard of professional behavior, ethics and integrity are expected of individual Medical Staff and Advanced Practice Staff (collectively, Practitioners) at Kaweah ~~Delta~~ Health ~~Care District (KDHCD)~~. The Code of Conduct is a statement of the ideals and guidelines for professional behavior of Practitioners in all dealings with patients, their families, other health professionals, employees, students, vendors, government agencies, and others they may encounter.

Policy:

Practitioners have a responsibility for the welfare of their patients, along with a responsibility to maintain their own professional and personal well-being. Each Practitioner is expected to treat all fellow colleagues, hospital staff, students, patients and others with courtesy and respect.

When a practitioner is found to have fallen short of these expectations, the Medical Staff supports tiered, non-confrontational intervention strategies focused on restoring trust, placing accountability on, and rehabilitating the offending Practitioner. However, the safeguarding of patient care and safety is paramount, and the Medical Staff will enforce this policy with disciplinary measures whenever necessary.

I. DEFINITIONS

A. "Ethical behavior" includes behavior that demonstrates adherence to Medical Staff Bylaws, Rules and Regulations, Policies, Kaweah Health's behavior standards and State and Federal laws.

B. "Appropriate behavior" includes any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized Medical Staff, or to engage in professional practice including practice that may be in competition

with the hospital. Appropriate behavior is not subject to discipline under the ~~b~~Bylaws.

~~A.~~

~~B.~~C. "Inappropriate behavior" means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as disruptive behavior.

~~C.~~D. "Disruptive behavior" means any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised.

~~D.~~E. "Harassment" means conduct toward others based on but not limited to their race, religious creed, color, national origin, physical or mental disability, marital status, sex, age, sexual orientation, or veteran status that~~; which~~ has the purpose or direct effect of unreasonably interfering with a person's work performance or that~~which~~ creates an offensive, intimidating or otherwise hostile work environment.

F. "Sexual harassment" means unwelcome ~~sexual~~ advances, requests for sexual favors, or verbal or physical activity of a sexual nature when: (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or work performance, or ~~through which submission to sexual advances is made an explicit or implicit condition of employment or future employment related decisions; unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person's work performance or which~~ creates an offensive, intimidating, or otherwise hostile work environment.

~~E.~~G. "Practitioner" means a Medical Staff member ~~physicians~~ or ~~a~~Advanced ~~p~~Practice ~~p~~Provider~~s~~ who~~that~~ has ~~have~~ been granted membership and/or clinical privileges at Kaweah Health~~Delta~~ by the Board of Directors.

II. TYPES OF CONDUCT

~~A. "Ethical behavior" includes behavior that demonstrates adherence to Medical Staff Bylaws, Rules and Regulations, Policies, KDHCD's behavior standards and State and Federal laws.~~

~~B. "Unethical Behavior" includes behavior that is unprofessional and or illegal.~~

~~C.~~A. Appropriate Behavior~~:~~

Examples of appropriate behavior include, but are not limited to, the following:

- Criticism communicated in a reasonable manner and offered in good faith with the aim of improving patient care and safety;

- Encouraging clear communication;
- Expressions of concern about a patient's care and safety;
- Expressions of dissatisfaction with policies through appropriate grievance channels or other civil non-personal means of communication;
- Use of cooperative approaches to problem resolution;
- Constructive criticism conveyed in a respectful and professional manner;
- Professional comments to any professional, managerial, supervisory, or administrative staff, ofr members of the bBoard of Directors about patient care or safety provided by others; and
- Active participation in mMedical sStaff and hospital meetings.

D.B. Inappropriate Behavior

Inappropriate behavior by Practitioners is prohibited. Examples of inappropriate behavior include, but are not limited to, the following:

- Belittling or berating statements;
- Name calling;
- Use of profanity or disrespectful language;
- Inappropriate comments written in the medical record;
- Blatant failure to respond to patient care needs or staff requests;
- Personal sarcasm or cynicism;
- Lack of cooperation without good cause;
- Refusal to return phone calls, pages, or other messages concerning patient care; and
- Condescending language; and degrading or demeaning comments regarding patients and their families,; nurses, physicians, hospital personnel, and/or the hospital.

E.C. Disruptive Behavior

Disruptive behavior by Practitioners is prohibited. Examples of disruptive behavior include, but are not limited to, the following:

- Physically threatening language directed ant anyone in the hospital, including physicians, nurses, other Practitioners, or any hospital employees, administrators, or member of the Board of Directors, patients, their families, and visitors;
- Physical contact with another individual that is threatening, unwelcome, or intimidating;
- Throwing instruments, charts, or other things;
- Threats of violence or retribution or retaliation;
- Sexual harassment;
- Other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation; and
- Behavior that disrupts patient care, hospital operations, and/or meetings of the Medical Staff, Medical Staff Ccommittees, or hospital.

F.D. Unethical Behavior

Unethical Behavior includes behavior that is unprofessional and or illegal.
Examples of unethical behavior include, but are not limited to, the following:

- Fraudulent ~~B~~billing ~~P~~practices;
- Theft or destruction of hospital property, including diversion of drugs or supplies;
- Violation of patient privacy laws; and
- Knowingly providing false information to the Medical Staff or hospital.

III. PROCEDURE

A. Delegation by Chief of Staff
At the discretion of the Chief of Staff (or Vice Chief if the Chief of Staff is the subject of the complaint), the duties here assigned to the Chief of Staff can be delegated to a designee. Designees may be ~~the Chief Medical Officer,~~ other Medical Staff Officers, the Chief Medical Officer, or Department Chairs/Vice Chairs.

B. Initiation of Complaints
Complaints about a Practitioner regarding allegedly inappropriate or disruptive behavior are encouraged to be entered into the event reporting system or conveyed to the Medical Staff Peer Review Manager or Peer Review Coordinator (Peer Review Personnel~~PRC~~). Information should include ~~the following~~:

1. Date, time and location of the behavior;
2. A factual description of the behavior;
3. The circumstances that~~which~~ precipitated the incident;
4. The name and medical record number of any patient or other persons who were involved in or witnessed the incident;
5. The consequences, if any, of the inappropriate or disruptive behavior as it relates to patient care o~~f~~r safety, hospital personnel, or operations; and
6. Any action taken to intervene in or remedy the incident, including names of those intervening.

The complainant will be provided a written acknowledgement of receipt of the complaint.

C. Processing Behavioral Event Reports
The process whereby the event report is processed is as follows (see attached flow chart):

1. The ~~I~~incident report is submitted through MIDAS or directly to the Peer Review Personnel~~RC~~. M~~I~~DAS~~idas~~ reports involving Practitioners~~physicians~~ will be~~are~~ immediately routed to the ~~Medical Staff~~ Peer Review ~~C~~Personnel. On a daily basis, the Peer Review Personnel will forward such MIDAS reports by email to the Medical Staff Officers and

the Director of Medical Staff Services. ~~and, after redacting the identifying information regarding the Practitioner at issue, to the Director of Risk Management.~~ Reports alleging ~~(VP of HR is also notified on all H~~hostile ~~W~~work ~~E~~environment or ~~H~~harassment ~~incidents~~ directed toward hospital employees will also be reported to the Vice President of Human Resources. Incidents involving an allegation of abuse, illegal activity, or unethical behavior will be forwarded to Risk Management.

2. The Chief of Staff will reply with an initial response or action (e.g., a request for follow-up inquiry by a designee) and state whether the MIDAS report should be escalated to the Chief Executive Officer immediately in accordance with the Just Culture Physician Behavior Scoring System (Scoring System), attached as Appendix A. The other Medical Staff Officers, ~~Director of Risk Management,~~ and/or Director of Medical S~~If the incident involves alleged abuse, or an illegal activity Risk Management is also informed.)~~taff Services may provide additional input on the recommended initial response or action and escalation decision.

~~1.~~3. The Peer Review Personnel will provide a daily report to the Chief Executive Officer of the number of event reports and the details of any reports escalated by the Chief of Staff.

~~2.~~4. The P~~eer R~~eview Personnel~~C~~ will perform ~~does~~ an initial screening of the allegations in the event report and report~~s~~ the result~~s of inquiry~~ to Chief of Staff.

5. The Chief of Staff or designee may dismiss or redirect reports that are determined to be unfounded or that do not constitute inappropriate, disruptive, or unethical behavior.

~~3.~~6. In the discretion of the Chief of Staff or designee, ~~M~~minor incidents (i.e., 1st and 2nd degree conduct per Scoring System) may be addressed with coaching by the Chief of Staff or Department Chair, a letter of education or warning, or ~~are~~ tracked and trended~~, with follow up/educational call or email to physician, at the discretion of the Chief of Staff~~.

~~4.~~7. Significant incidents (i.e., 3rd, 4th, or 5th degree conduct per Scoring System) are subject to detailed review by ~~sent to~~ the P~~eer Review Personnel~~RC ~~for detailed Case Review~~, which must include communicating with the complainant and the Practitioner who is the subject of the report. The ~~R~~results will be ~~are~~ reported to the Chief of Staff ~~(COS).~~. The following action~~s~~ may be taken as determined by the Chief of Staff or designee:

a. Prompt ~~C~~collegial ~~i~~intervention by the Chief of Staff or designee~~COS, or Designee~~;
b. Referral to the ~~Forward to~~ Department Chair for ~~C~~collegial ~~i~~intervention;
~~b.~~c. Requesting a written response to the allegations from the Practitioner within 15 days;
~~c.~~d. Referral ~~Forward~~ to the Medical Staff Behavior Committee, composed of the Medical Staff Officers. Possible actions include, but are not limited to ~~(which consists of COS, VCOS, PCOS, Secretary Treasurer):~~

~~i. Letter will be sent to practitioner containing a synopsis of the event, asking for practitioner's view of the event with a response expected within 30 days~~
~~ii. Incident and response letter discussed at subsequent Behavior Committee~~
~~iii. Action may include:~~
~~1.~~i. Dismiss as unfounded or if unable to substantiate~~authenticate~~;
~~2.~~ii. Track and ~~T~~trend;
~~3.~~iii. In-person meeting with ~~1:1 conversation with p~~Practitioner and Behavior Committee or subset of members~~COS or other officer~~;
iv. Request for further inquiry and follow up~~additional information~~;
~~4.~~v. Focused Professional Practice Evaluation overseen by the Department Chair or other designee;
vi. ~~Educational l~~Letter of education, warning, or reprimand~~to physician.~~;
vii. Referral to the Well Being Committee; and/or
~~5.~~viii. Referral to the Medical Executive Committee.
~~iv. Direct Three (3) incidents in a rolling 12 months require action~~
~~1. Behavior Committee meets with and advises practitioner that recurring behavior must cease or corrective action will be initiated. This "final warning" shall be sent to the offending Practitioner in writing.~~
~~2. FPPE Developed by Department Chair~~
~~d. Track and Trend~~

e. referral ~~Forward~~ to the Medical Executive Committee ~~MEC~~ for consideration of further action consistent with the Medical Staff ~~per b~~Bylaws, including, but not limited to~~; Options include, but are not limited to~~:
i. Referral to the Well Being Committee;
~~i.~~ii. Letter of warning or reprimand;
~~ii.~~iii. Imposition of a Professional Conduct Agreement;
~~iii.~~iv. Requirement to attend ~~continuing~~ educational course or program at the ~~p~~Practitioner's expense;
v. Initiation of a~~e~~ formal investigation; and/or
~~iv.~~vi. Disciplinary action, including a suspension or restriction on Medical Staff membership or clinical privileges and/or recommendation for formal corrective action.

8. If additional incidents occur or the Chief of Staff or designee determines that a pattern of inappropriate behavior has developed or is developing, the Chief of Staff, in his or her discretion, may meet in person with the Practitioner, issue a letter of warning or reprimand, and/or refer the matter to the Medical Staff Behavior Committee or to the Medical Executive Committee.

~~5.~~ Reports

~~Reports~~ alleging a Practitioner has engaged in illegal activity will be immediately subjected to an inquiry by the Chief of Staff or designee and forwarded to the Medical Executive Committee ~~for review~~.

Nothing in this Policy is intended to prohibit the Chief of Staff or other appropriate person or committee from imposing immediate corrective action, such as a summary suspension, if warranted by the facts, including in response to a single incident that

9. ~~Formal corrective action, such as a summary suspension of clinical privilege, may be warranted if one or more incidents of disruptive behavior~~ presents a risk of imminent danger to the health or safety of any individual. In the event of corrective action that constitutes grounds for a hearing under Article 9 of the Medical Staff Bylaws, the Practitioner is entitled to the procedural rights set forth in the Medical Staff Bylaws.
10. The Chief of Staff and Chief Executive Officer will make any reports required by state or federal law arising from actions taken or recommended or other occurrences that trigger such reports in connection with implementing this policy.
11. In the event of inconsistencies between this policy and the Medical Staff Bylaws, the Medical Staff Bylaws will prevail.

~~D. In the event of inconsistencies between this policy and the Medical Staff Bylaws, the Medical Staff Bylaws will prevail.~~

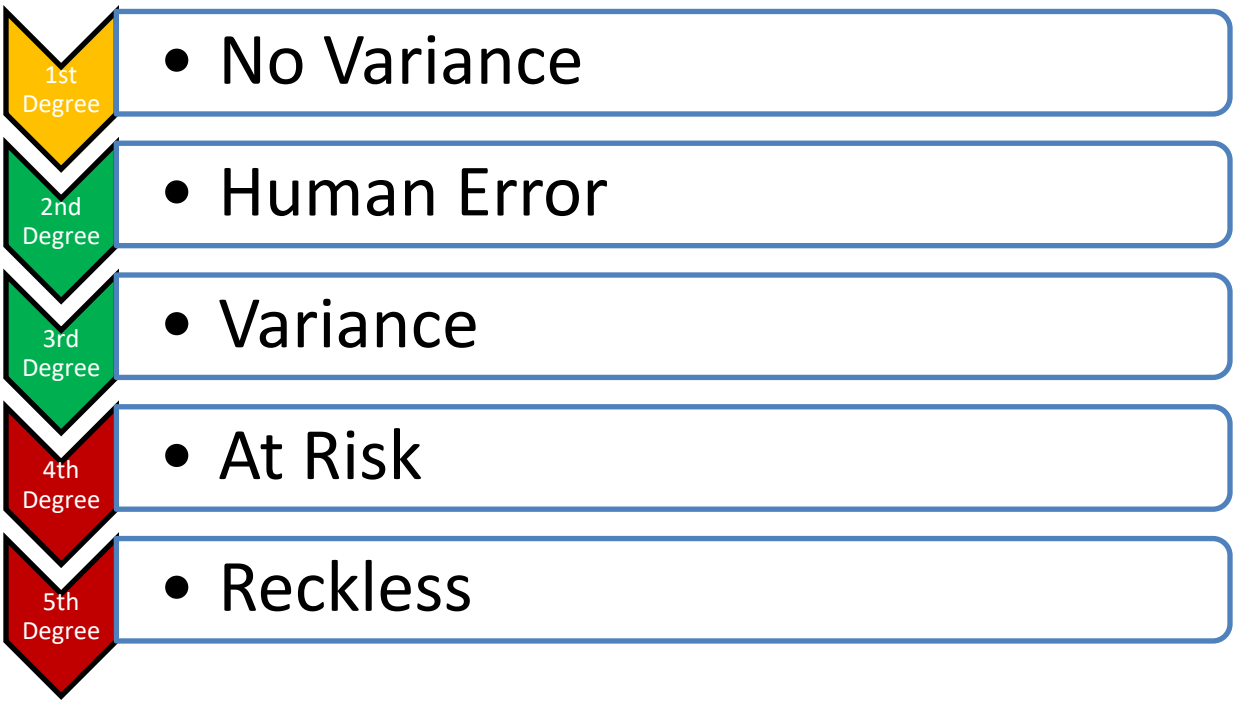
References:

Kaweah Health~~Delta~~ Medical Staff Bylaws

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

APPENDIX A

JUST CULTURE PHYSICIAN BEHAVIOR SCORING SYSTEM

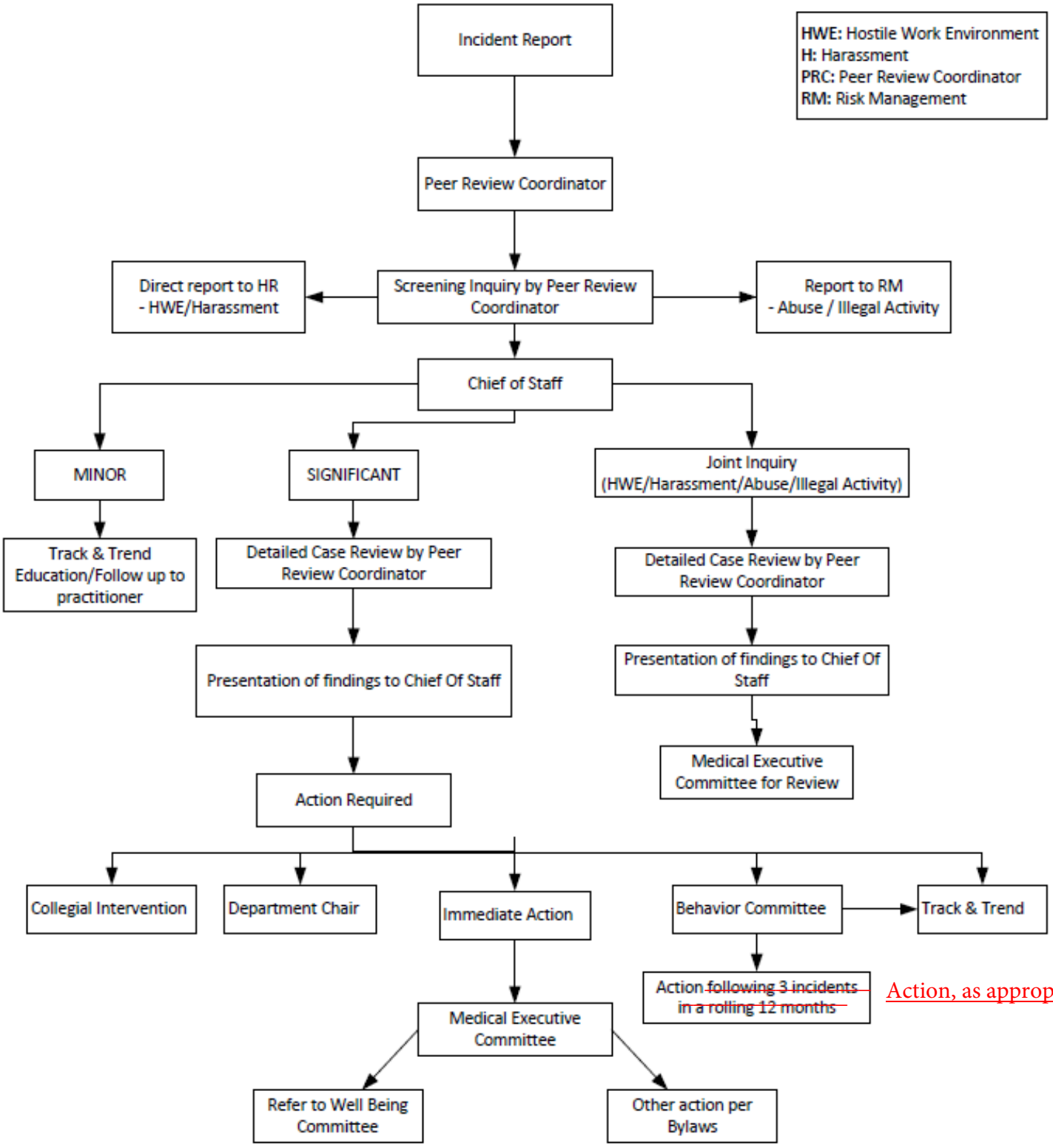


1. **1st Degree No Variance** –
   Examples: Raised voice, hanging up on staff, eye-rolling at staff/peers.
   Possible Actions: Track & trend.
2. **2nd Degree Human Error** –
   Examples: Shouting outbursts, use of profanity, rude remarks to staff/peers.
   Possible Actions: Coaching by Chief of Staff or Department Chair, letter of education or warning, track & trend.
3. **3rd Degree Variances** –
   Examples: Verbal abuse, degrading/belittling Staff, throwing things, threatening behavior, retaliation, repetitive 1st and 2nd degree conduct after coaching.
   Possible Actions: Request written response; referral to Behavior Committee Meeting.
4. **4th Degree At Risk Behavior** –
   Examples: Impairment, sexual harassment, creating hostile work environment, unwarranted physical contact.
   Possible Actions: Referral to Behavior Committee or Well Being Committee, required educational course, FPPE, summary suspension or other disciplinary action.
5. **5th Degree Reckless Behavior** –
   Examples: Diversion, physical abuse, intentional violation of patient privacy, repetitive non-compliance with Medical Staff Bylaws.
   Possible Actions: Referral to Medical Executive Committee; disciplinary action.

Escalation of per Reports:

- 4th and 5th Degree: immediate escalation to Chief Executive Officer.
- 4th Degree involving sexual harassment, hostile work environment, physical abuse: report to Risk Management and Human Resources.

Behavior Flow Chart



Formal Corrective Action, such as a summary suspension of Clinical Privilege, may be warranted if one or more incidents presents a risk of imminent danger to the health or safety of any individual

Kaweah Delta Health Care District

Medical Staff Services

Policy Number: MS 55	**Date Created: 02/22/2021**
Document Owner: April McKee (Medical Staff Svcs Manager)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Medical Executive Committee, April McKee (Medical Staff Svcs Manager), Cindy Moccio (Board Clerk/Exec Assist-CEO), Teresa Boyce (Director of Medical Staff Svcs)	

Peer Review Information Sharing Guidelines

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Policy:

Confidential peer review documents, ~~i.e.~~including~~,~~ case reviews, case synopsis, event reports, peer review committee meeting minutes etc.~~,~~ require review by physicians for the purpose of completion of the Peer Review Process, Trauma Grand Rounds and/or confidential communications between Medical Staff Committee members. The purpose of this policy is to provide a standardized process for relaying information to physicians so that confidential peer review documents remain t~~hat will provide the~~ protected ~~ions afforded~~ by California Evidence Code section 1157.

Procedure:

I. Communication of peer review information via email.

~~I.~~a. All confidential peer review documents and communications that occur via email must take place through Kaweah ~~Delta~~ Health email **ONLY**.

~~a.~~ Physicians may request a ~~KD~~ Kaweah Health email through the Medical Staff Office.

~~II.~~ b. All emails must have a header that states: “Confidential Peer Review Communication – Protected by Evidence Code section 1157.”

~~III.~~ c. Emails are **ONLY** to be sent to and from members of the Medical Staff Peer Review Committees and their assigned support staff.

II. Communication of peer review information to GME

When it is determined that a member of the Medical Staff who supervises ~~residents~~learners is the subject of a corrective action that involves limitations or restriction on their clinical privileges, it will be the responsibility of the Chair of the Graduate Medical Executive Committee (GMEC) to ensure that members of the GME leadership receive sufficient information regarding the Practitioner’s limitations to oversee their program.

a. To effectively identify teaching physicians:
    i. A database of physician with supervisory responsibility will be maintained be the Director of GME
    ii. Practitioners who are the subject of limitations or restrictions on their clinical privileges will be asked if they are responsible for supervising learners.

b. The GMEC Chair will coordinate communication between Practitioner and Program Director.
c. GMEC Chair will be responsible for maintaining the confidentiality of peer review information regarding the Practitioner to the maximum extent possible under the circumstances, in accordance with Section 15.A of the Medical Staff Bylaws.

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

November 2021

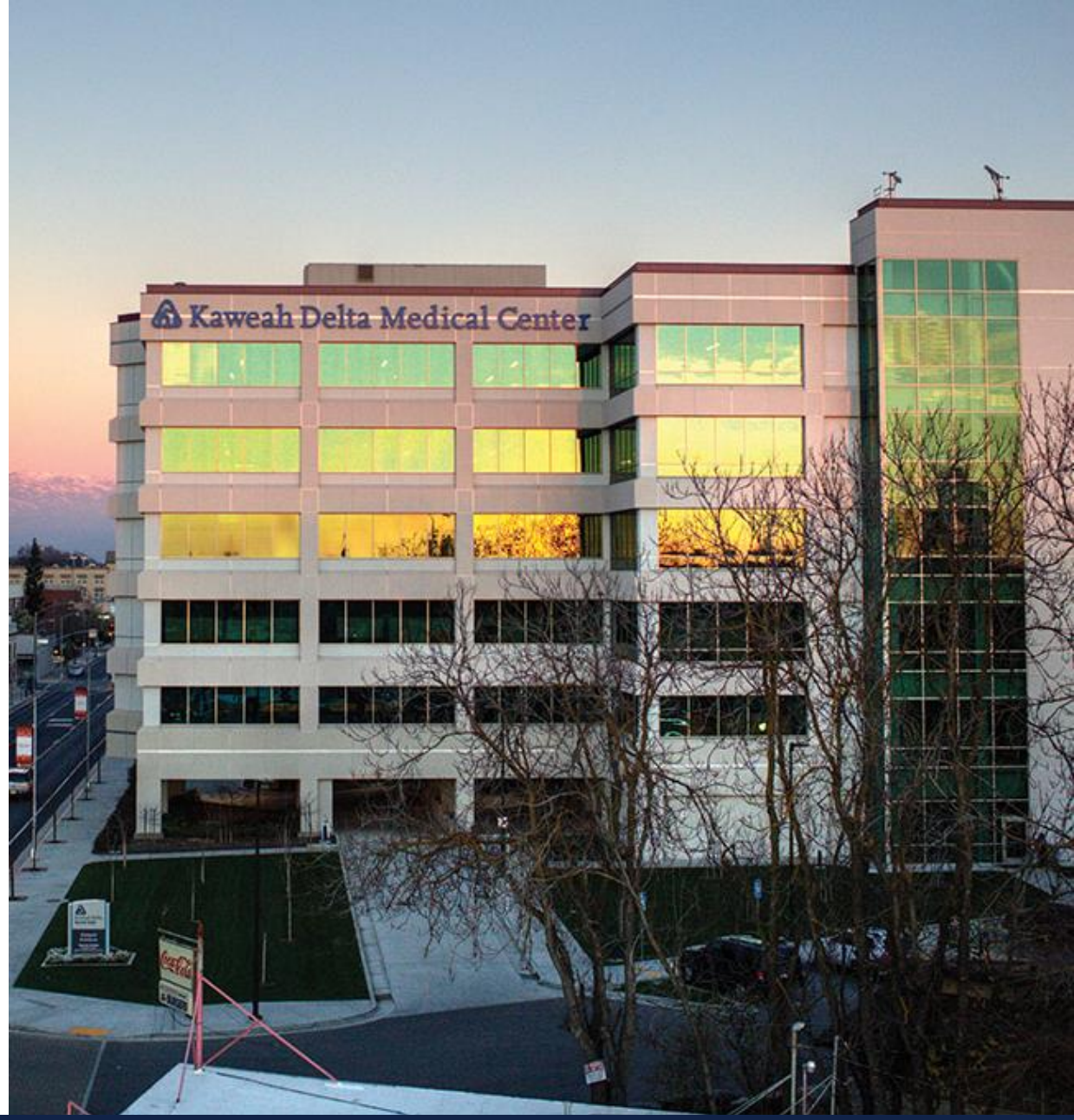
Fall Ratings Review Healthgrades & Leapfrog Safety Grade

Sandy Volchko, DNP, RN, CPHQ, CLSSBB
Director of Quality & Patient Safety

Acronyms

- Pts - Patients
- C. Diff – Clostridium difficile
- SSI – Surgical Site Infection
- MRSA – Methicillin-Resistant Staphylococcus Aureus
- CLABSI – Central Line-Associated Bloodstream Infection
- CAUTI – Catheter-Associated Urinary Tract Infections
- PSI – Patient Safety Indicator
- HAC – Healthcare Acquired Condition
- HAI – Healthcare Acquired Infection
- H-COMP – Consumer Assessment of Healthcare Providers and Systems Composite Score
- HCAHPS – Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- MEDPAR – Medicare Provider Analysis and Review (contains records for 100% of Medicare beneficiaries who use hospital inpatient services. The records are stripped of most data elements that will permit identification of beneficiaries)
- GI – Gastrointestinal
- CMS – Centers for Medicare and Medicaid Services

Healthgrades Ratings Report



Fall 2021

Healthgrades

Me

Healthgrades® 2022 Clinical Outcomes Methodology

- *Independently analyze each short-term acute care hospital in the country: ~4,500 hospitals*
- ***Hospitals may not opt-in or opt-out***
- *3-years of Medicare patient data (2018-2020)**
- *Risk-Adjusted statistical model considers patient acuity, driving a predicted value*
- *Star ratings determined by actual performance vs. predicted performance*

★★★★★ Outcomes **better** than expected ~ 15%

★★★ Outcomes **as expected** ~ 70%

★ Outcomes **worse** than expected ~ 15%

Mortality Rates

Did patients die during or after their care?

Complication Rates

Did patients experience unexpected issues during their hospital stay?

*All pts with a diagnosis of COVID-19 from Jan 1- Sept. 30, 2020 removed from analysis

healthgrades.

Kaweah Healthgrades

Kaweah Health

(MEDPAR 2018-2020) STAR REPORT (1 of 3)

healthgrades.

Kaweah Healthgrades

Kaweah Health
(MEDPAR 2018-2020) STAR REPORT (2 of 3)

2022 Medpar Ratings		Mortality Inhospital	Mortality Inhospital + 30	Complications	
Neurosciences					
Cranial Neurosurgery		★★★	★★★		
Stroke	❖	★★★★★	★★★★★		
Pulmonary	❖				
Chronic Obstructive Pulmonary Disease		★★★★★	★★★		
Pneumonia		★★★★★	★★★★★		
Vascular					
Repair of Abdominal Aorta				★★★	
Carotid Procedures				★★★	
Peripheral Vascular Bypass				★★★	
Prostate Surgery					
Prostate Removal Surgery				★	▼

▲▼ Indicates rating change from previous year

❖ Recipient of Specialty Excellence Award

healthgrades.

Kaweah Healthgrades

Kaweah Health

(MEDPAR 2018-2020) STAR REPORT (3 of 3)

2022 Medpar Ratings	Mortality Inhospital	Mortality Inhospital + 30	Complications
Gastrointestinal			
Upper Gastrointestinal Surgeries	★★★	★★★	
Colorectal Surgeries	★★★	★★★	
GI Bleed	★★★★★ ▲	★★★	
Bowel Obstruction	★★★	★★★	
Pancreatitis	★★★	★★★	
Gallbladder Removal Surgery			★★★ ▼
Critical Care ❖			
Sepsis	★★★★★	★★★★★	
Pulmonary Embolism	★★★	★★★	
Respiratory Failure	★★★★★	★★★★★	
Diabetic Emergencies			★★★

▲▼ Indicates rating change from previous year

❖ Recipient of Specialty Excellence Award

healthgrades.

Kaweah Achievements

Cardiac

Recipient of the Healthgrades Cardiac Surgery Excellence Award™ for 6 Years in a Row (2017-2022)
Named Among the Top 5% in the Nation for Cardiac Surgery for 5 Years in a Row (2018-2022)
Named Among the Top 10% in the Nation for Cardiac Surgery for 6 Years in a Row (2017-2022)
Five-Star Recipient for Coronary Bypass Surgery for 6 Years in a Row (2017-2022)
Five-Star Recipient for Valve Surgery for 2 Years in a Row (2021-2022)
Five-Star Recipient for Treatment of Heart Attack in 2022
Five-Star Recipient for Treatment of Heart Failure for 2 Years in a Row (2021-2022)

Neurosciences

Recipient of the Healthgrades Stroke Care Excellence Award™ for 4 Years in a Row (2019-2022)
Named Among the Top 10% in the Nation for Treatment of Stroke for 4 Years in a Row (2019-2022)
Five-Star Recipient for Treatment of Stroke for 8 Years in a Row (2015-2022)

Pulmonary

Recipient of the Healthgrades Pulmonary Care Excellence Award™ for 9 Years in a Row (2014-2022)
Named Among the Top 5% in the Nation for Overall Pulmonary Services for 2 Years in a Row (2021-2022)
Named Among the Top 10% in the Nation for Overall Pulmonary Services for 9 Years in a Row (2014-2022)
Five-Star Recipient for Treatment of Chronic Obstructive Pulmonary Disease for 2 Years in a Row (2021-2022)
Five-Star Recipient for Treatment of Pneumonia for 9 Years in a Row (2014-2022)

Gastrointestinal

Five-Star Recipient for Treatment of GI Bleed in 2022

Critical Care

Recipient of the Healthgrades Critical Care Excellence Award™ for 3 Years in a Row (2020-2022)
Named Among the Top 5% in the Nation for Critical Care for 2 Years in a Row (2021-2022)
Named Among the Top 10% in the Nation for Critical Care for 3 Years in a Row (2020-2022)
Five-Star Recipient for Treatment of Sepsis for 10 Years in a Row (2013-2022)
Five-Star Recipient for Treatment of Respiratory Failure for 4 Years in a Row (2019-2022)

healthgrades.

Kaweah Achievements

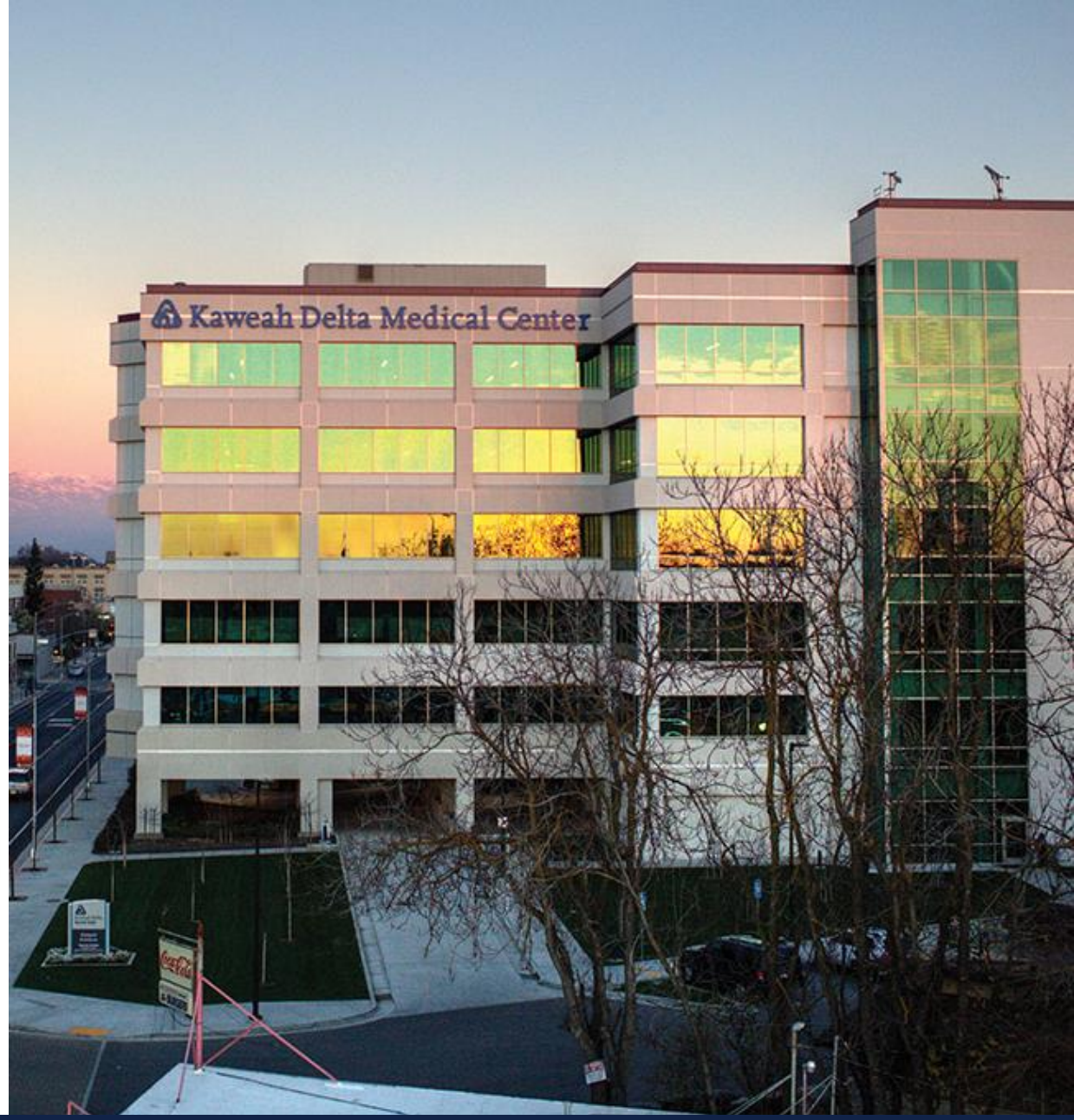
Kaweah Healthgrades

Summary and follow up:

- Improvements: 3 to 5 stars in Heart Attack and GI Bleed In-hospital Mortality, 1 to 3 star Back Surgery Complications
- Decrease: 5 to 3 star Heart Failure In-hospital Mortality, Gallbladder Removal Surgery Complications. Prostate Removal Surgery, 3 to 1 star (8 / 85 cases, five with post op ileus resolved in 1-2 days, one transient hypotension, one post op fever) to be reviewed with Surgical Quality Medical Director
- Detailed review of each population with Healthgrades to include all stakeholders. Healthgrades reviews assist in identifying potential opportunities for continued improvement

Leapfrog Safety Grade

Fall 2021



Leapfrog Safety Grade

Released November 10, 2021

- Leapfrog Hospital Safety Grades (formerly known as Hospital Safety Scores) are assigned to over 2,700 general acute-care hospitals across the nation twice annually.
- 32 Measures included in the safety grade calculation and are taken from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Hospital Survey. Included measures focused on:
  - Healthcare acquired infections (5)
  - Patient experience (5)
  - Safe practices such as hand hygiene program, safety culture measurement & quality improvement and bar code medication administration, computerized provider order entry, ICU physician staffing, and nurse staffing/adverse events (7)
  - Post op complications, healthcare acquired conditions (15 – PSI90 is a composite measure based on 10 different complications)
- Performance on each component is based on a z-score. This means a hospital's score is dependent on how other hospitals perform

Kaweah Health Hospital Safety Score Fall 2021 = 3.205
Letter Grade Key: A = >3.133 B= >2.964 C= >2.476 D= >2.047

Kaweah Health Past Safety Grades

Leapfrog Safety Grade

Improvement from Spring 2021 “B” to Fall 2021 “A”

Since the Spring 2021 Score Kaweah Health has achieved:

- Reductions in 4 of the 5 Healthcare Acquired Infections included in the grade calculation (CAUTI, CLABSI, SSI, C. Diff).
- Continued strong execution of 7 organizational safe practices such as a comprehensive hand hygiene program, safety culture measurement and improvement, bar code medication administration, ICU physician staffing, etc).
- Better than national rates in post-operative complications and healthcare acquired conditions

Changes in the Fall 2021 Leapfrog Safety Grade Measures/Calculations:

1) Points available for the Org Hand Hygiene Program were increased from 60 to 100, and
2) Replaced 5 individual PSI measures (post op complications) with the 1 PSI 90 composite measure (8 PSIs used to calculate 1 measure).

Leapfrog Safety Grade

Data Date Ranges

Safe Practices/Leapfrog Survey – June 2021

HCAHPS (CMS)- 01/01/2019–12/31/2019

HACs (CMS) - 07/01/2017–06/30/2019

HAIs (CMS) - 04/01/2019–12/31/2019 and

07/01/2020– 9/30/2020

PSIs (CMS) - 07/01/2018–12/31/2019

	Leapfrog Safety Grade Measure	Kaweah Health Fall 2021 Scores	Kaweah Health Spring 2021 Scores	Mean Fall 2021	Mean Spring 2021	Final Weight
Process/Structural Measures Higher is better	Computerized Physician Order Entry (CPOE) (Leapfrog Survey)	100	100	85.77	82.19	5.9%
	Bar Code Medication Administration (BCMA) (Leapfrog Survey)	100	100	83.25	81.76	5.8%
	ICU Physician Staffing (IPS) (Leapfrog Survey)	100	100	62.82	60.72	7.1%
	Safe Practice 1: Culture of Leadership Structures and Systems	120.00	120	116.85	117.30	3.2%
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	110.00	120	116.49	117.11	3.3%
	Safe Practice 9: Nursing Workforce	100.00	100	98.16	98.38	4.3%
	Hand Hygiene (Leapfrog Survey)	100	60	74.36	59.22	4.9%
	H-COMP-1: Nurse Communication	90	90	91.10	91.03	3.1%
	H-COMP-2: Doctor Communication	89	89	91.00	90.91	3.1%
	H-COMP-3: Staff Responsiveness	86	86	84.38	84.20	3.1%
	H-COMP-5: Communication about Medicines	77	77	77.66	77.52	3.1%
	H-COMP-6: Discharge Information	87	87	86.51	86.49	3.1%
Outcome Measures Lower is better	Foreign Object Retained (HAC)	0.065	0.065	0.02	0.02	4.3%
	Air Embolism (HAC)	0.000	0	0.0004	0.0004	2.5%
	Falls and Trauma (HAC)	0.327	0.327	0.42	0.43	4.7%
	CLABSI (HAI)	1.063	1.071	0.81	0.67	4.6%
	CAUTI (HAI)	1.124	1.627	0.75	0.72	4.5%
	SSI: Colon (HAI)	0.266	0.498	0.80	0.81	3.4%
	MRSA (HAI)	1.865	1.454	0.84	0.80	4.5%
	C. Diff. (HAI)	0.192	0.291	0.54	0.58	4.3%
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	155.29	168.71	159.67	164.57	2.0%
	CMS Medicare PSI 90: Patient safety and adverse events composite	0.86	n/a	1.00	n/a	15.2%

Process Measure Domain Score:	0.159152
Outcome Measure Domain Score:	0.04632
Process/Outcome Domains - Combined Score:	0.205472
Normalized Numerical Score:	3.205472
Hospital Safety Grade (Letter Grade):	A

Leapfrog Safety Grade

Sustaining the "A"

- Continued focus on Healthcare Acquired Infections (CAUTI, CLABSI, MRSA & SSI)
  - Quality Focus Teams – multidisciplinary approach to ensure Infection Prevention best practices are evaluated, implemented and adhered to
- Diligent measurement and oversight quality improvement work in: safety culture, organizational hand hygiene program
- Steady focus on using technology that improves patient safety including bar code medication administration and computerized provider order entry
- Concentrated efforts in improving patient experience through leader rounding
- Continued work on Patient Safety Indicators through a multidisciplinary approach to case review, and quality improvement work through the Surgical Quality Improvement Committee

Questions?

Live with passion.

Health is our passion. Excellence is our focus. Compassion is our promise.

Kaweah Health

CULTURAL DIVERSITY COMMITTEE

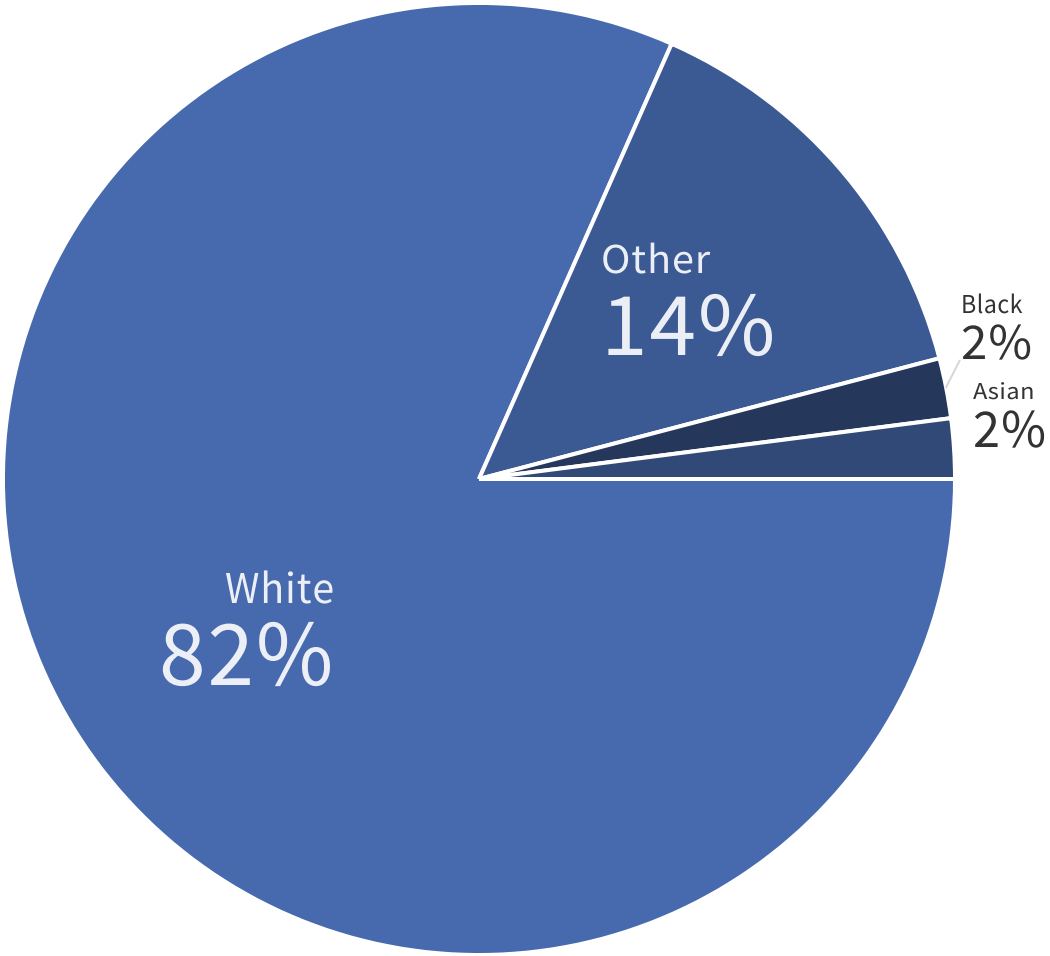
October 21, 2021

Inbal Epstein, MD, PGY2
Kaweah Health Emergency Medicine Residency

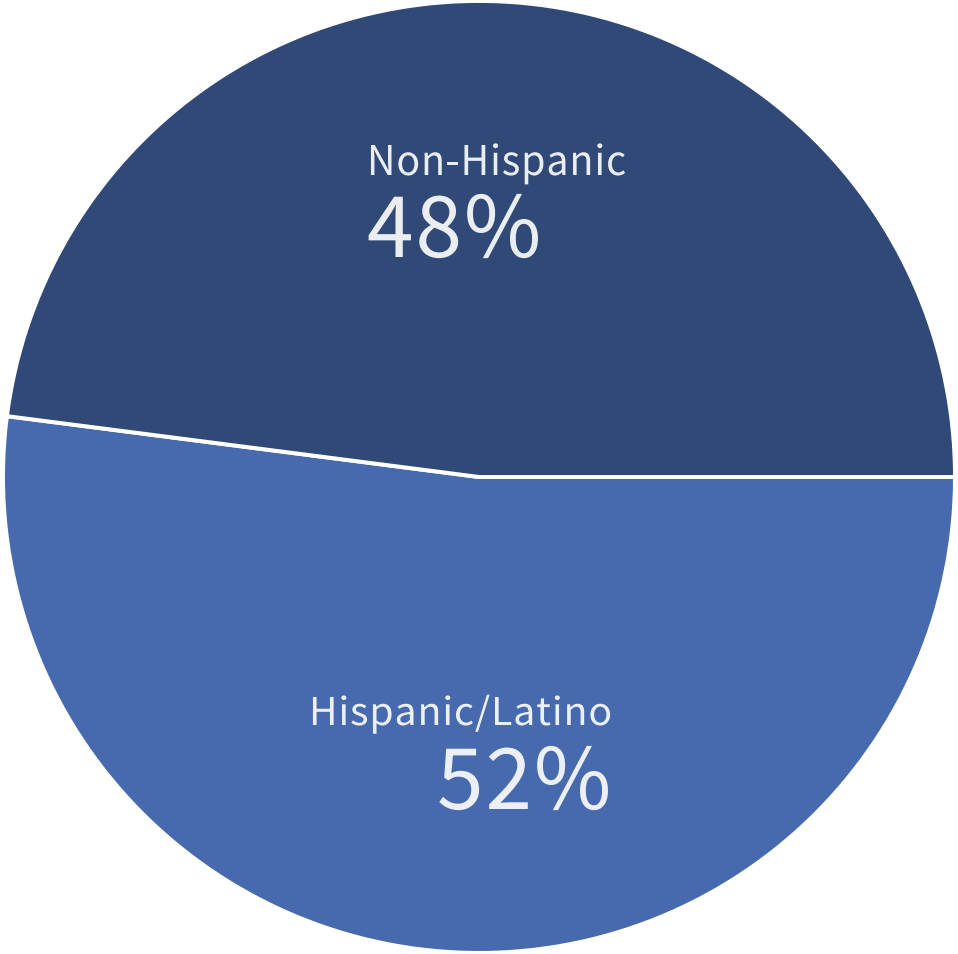
COMMON REASONS FOR ADMISSION

PREGNANCY AND CHILDBIRTH	TRAUMA	RESPIRATORY	INFECTION
KIDNEY DISEASE	DIABETES	CARDIAC	NEUROLOGIC
GASTROINTESTINAL		SUBSTANCE USE	
MENTAL HEALTH	ELECTIVE SURGERY	CANCER	

RACE

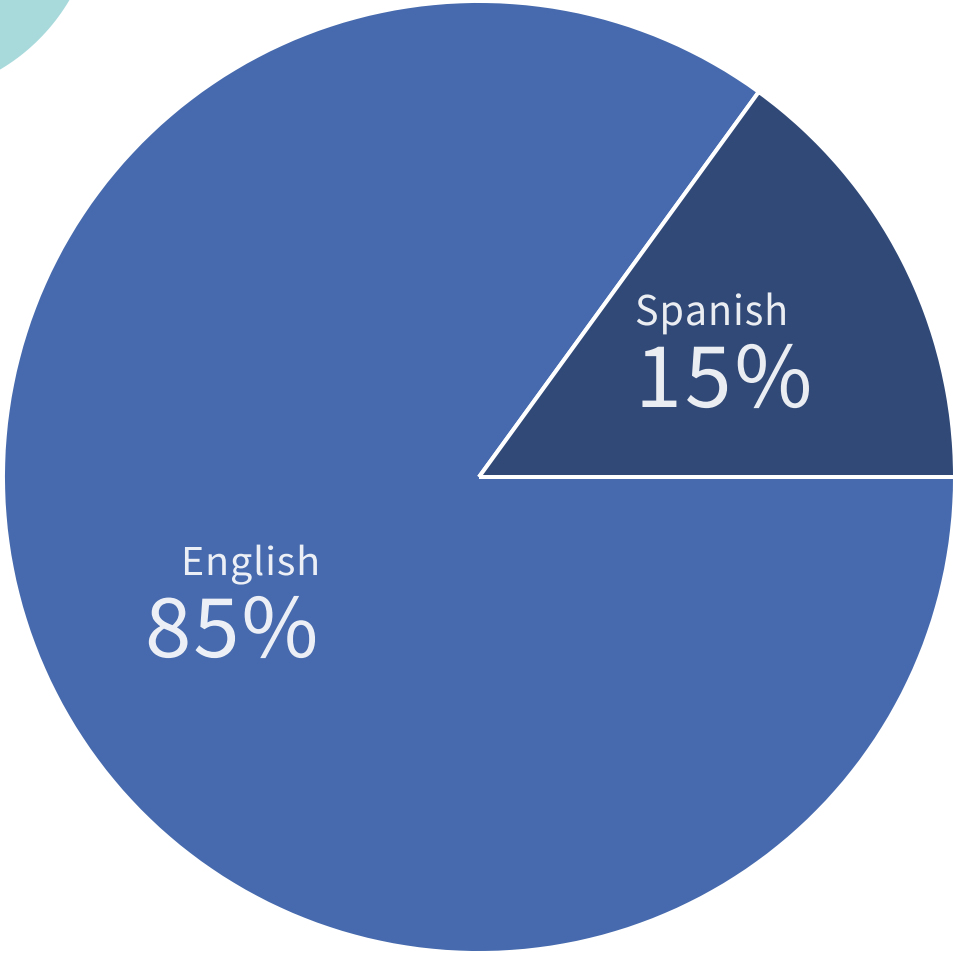


ETHNICITY



LANGUAGE

<1%
Lao
Portuguese
Arabic



INPATIENT MORTALITY, %

	Kaweah 2018-2021	US (2010)*
All-Cause	2.72%	2.00%
Sepsis	11.79%	16.30%
Kidney Disease	5.27%	3.50%
Stroke	3.50%	4.70%
Pneumonia (Non-COVID)	3.29%	3.30%
Heart Disease	3.28%	3.10%
COVID	17.97%	10-20%**

“OTHER” RACE - MORTALITY

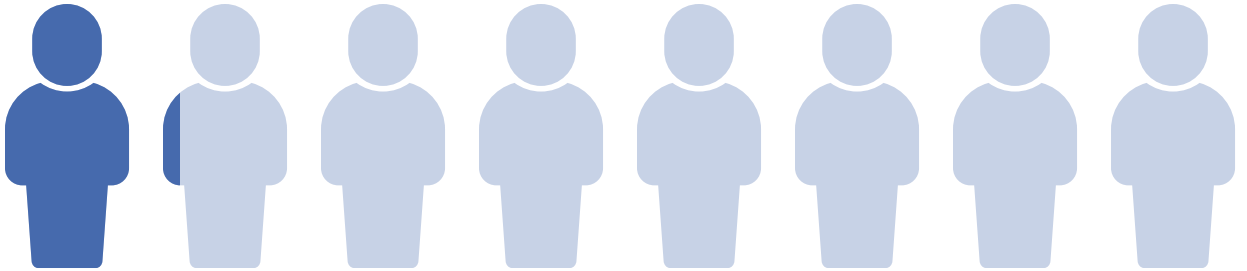
	n	Overall	Sepsis	Cardiac	COPD	COVID	Kidney Disease	Stroke
White	66,129	2.58%	10.82%	2.68%	8.50%	18.33%	5.07%	3.42%
Other	11,655	3.64%	18.27%	7.43%	27.20%	17.50%	11.03%	5.44%

MORTALITY- LANGUAGE

ENGLISH	PANJABI	LAO
2.68%	6.25%	7.89%

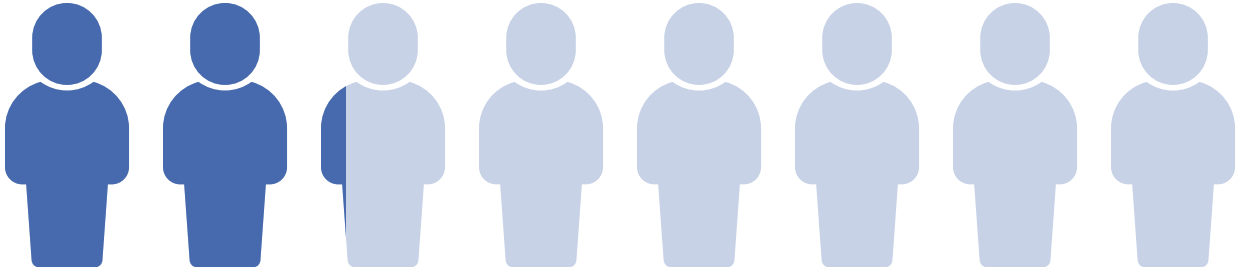
COVID ADMISSIONS AMONG SPANISH-SPEAKING PATIENTS

13.8%



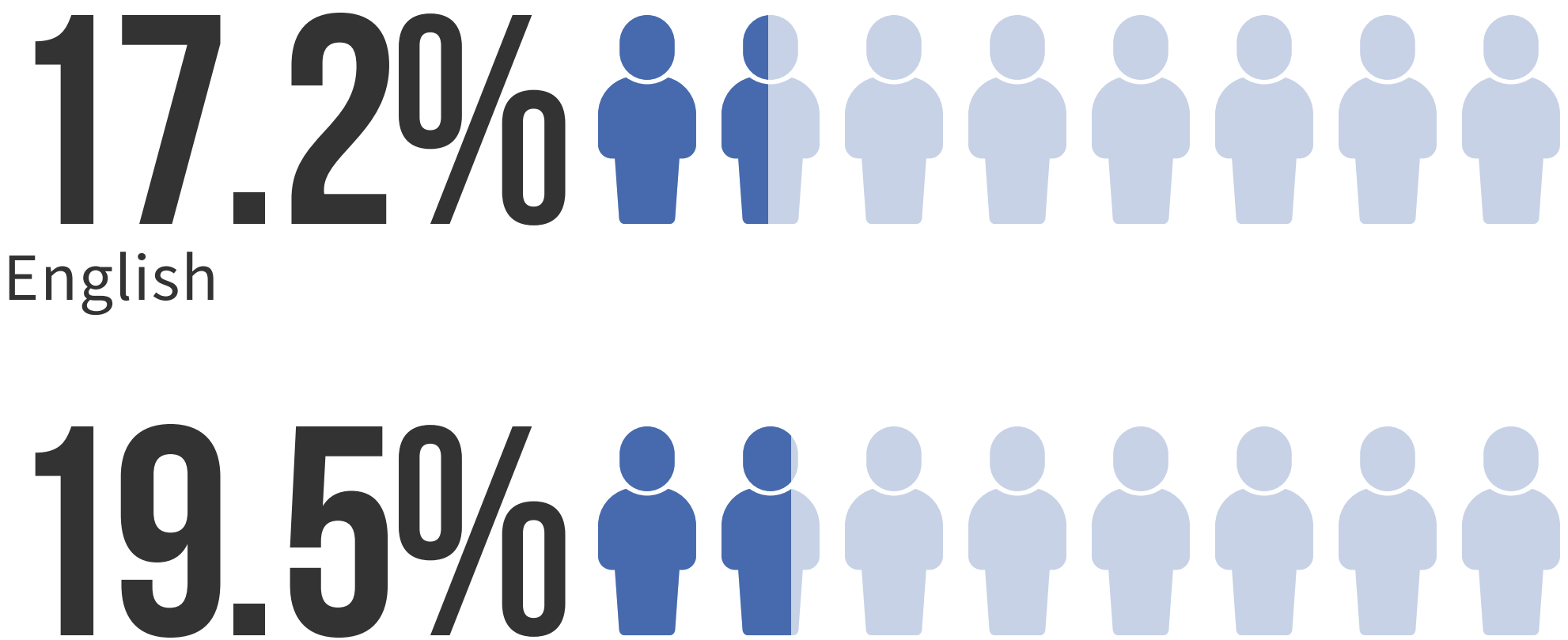
All Admissions

26.9%

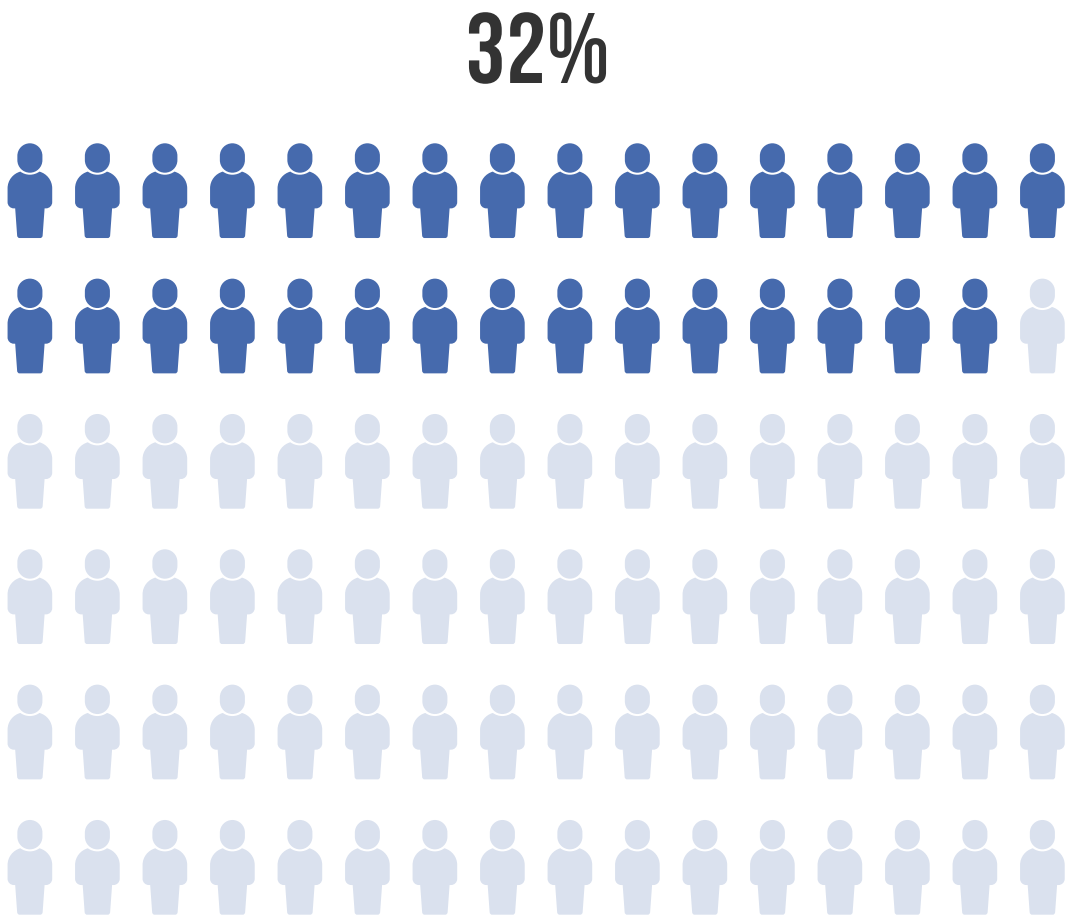


COVID Admissions

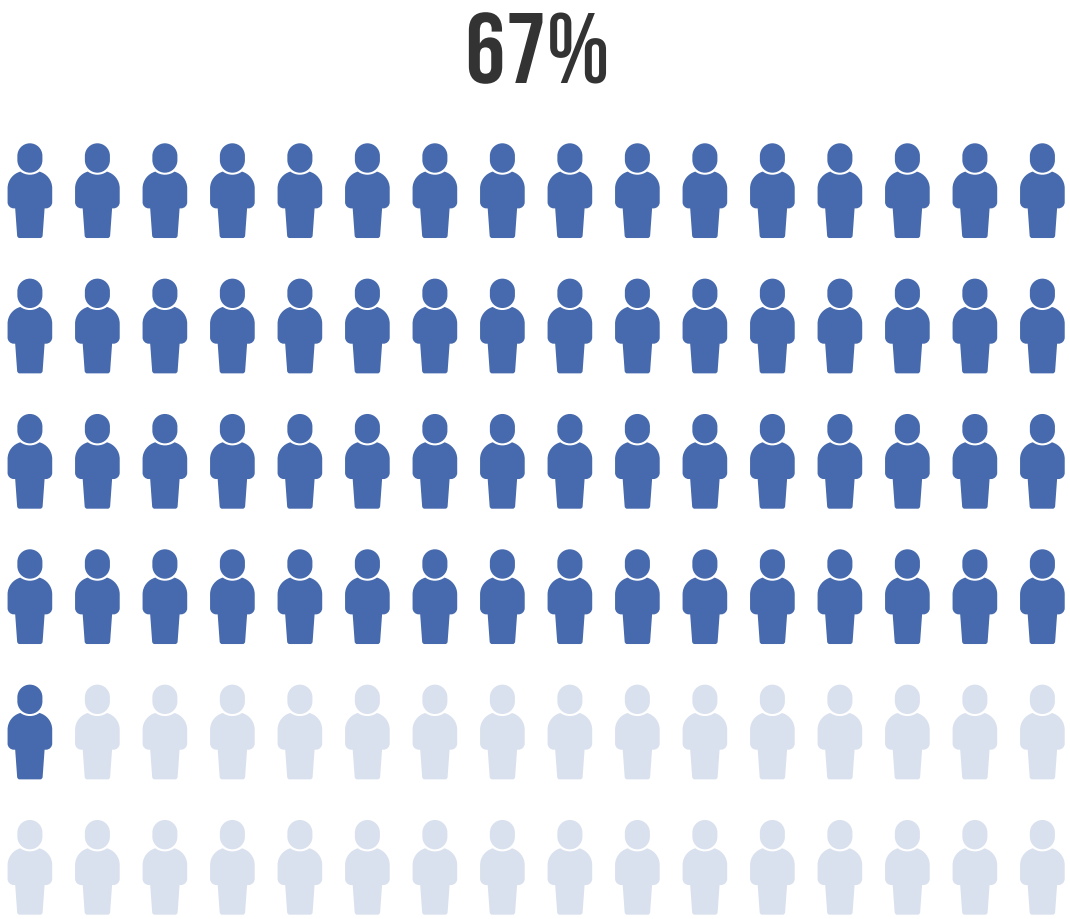
COVID MORTALITY



CHRONIC OBSTRUCTIVE PULMONARY DISEASE - ADMISSION



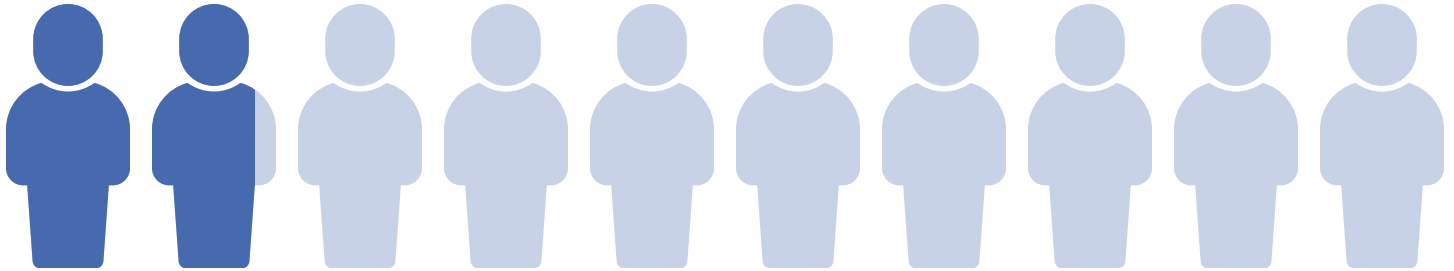
Hispanic



Non-Hispanic

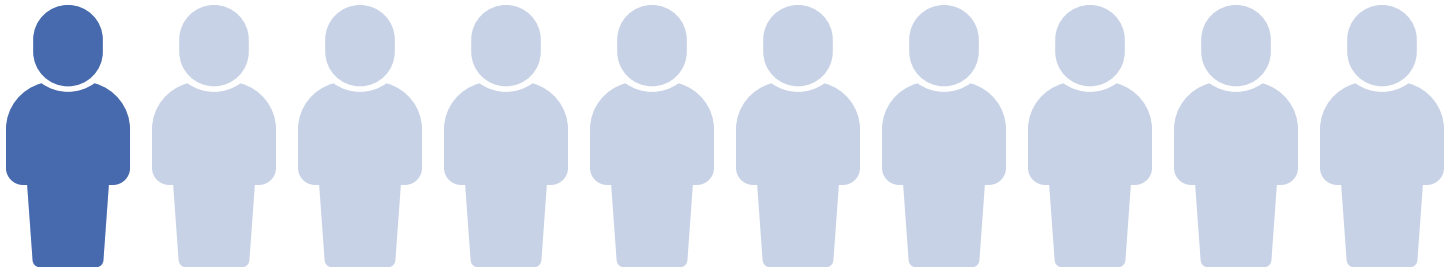
CHRONIC OBSTRUCTIVE PULMONARY DISEASE MORTALITY RATE

17%



Hispanic/Latino

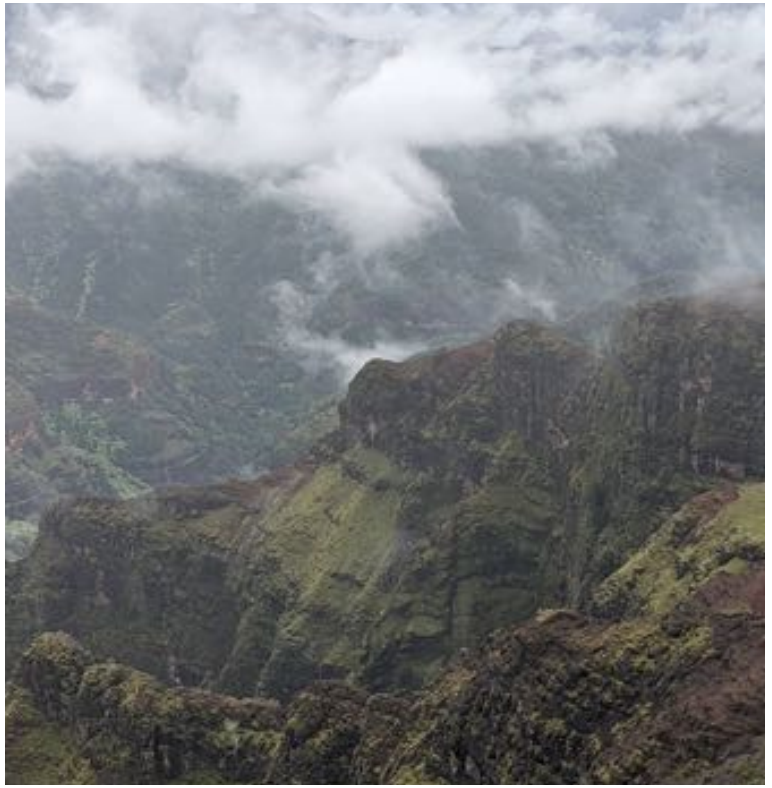
10%



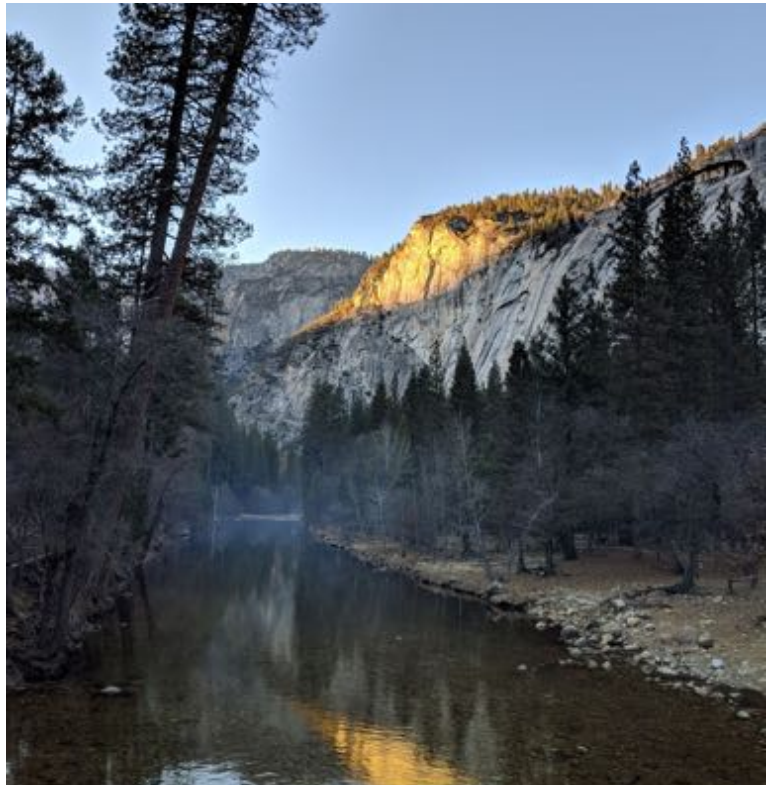
Non-Hispanic

SUMMARY

Kaweah serves a diverse range of patients



Demographic information highlights disparities among patient groups



This information can be used to improve patient outcomes

REFERENCES

https://www.cdc.gov/nchs/products/databriefs/db118.htm

https://www.census.gov/quickfacts/tularecountycalifornia

https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2778237

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7920817/

Master Facility Plan

Summer/Fall 2021 Community Education

kaweahhealth.org

Kaweah Health
MORE THAN MEDICINE. LIFE.

Summary of Participants

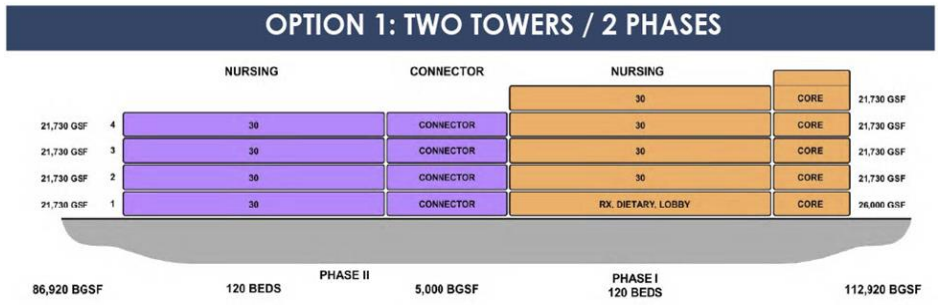
	Probolsky	NRC	Community Stakeholders	Public via Website Survey
Groups	Online Focus Groups 54 Participants (Likely Voters who live in the District)	Online Survey 906 Participants (Staff, Physicians, Community Engagement)	In-Person Meetings 177 Participants (Community Members)	255 responses
Votes between Options	*"Residents generally prefer the 'cheaper' Option 2, citing less congestion and the elimination of elevator waiting time and congestion. Of residents that prefer Option 1, they cite the 'phase approach' because it leaves more room for error and corrections."* Probolsky Report June 2021	Option 1 - 35% Option 2 – 65%	Option 1 – 16% Option 2 – 84%	Option 1 – 39% Option 2 – 61%
Support for Bond	*"Residents overwhelmingly say that they would support a bond measure."* *"Residents say that they would like to see action on a bond measure sooner rather than later.* *Probolsky Report June 2021*	Yes – 60% Unsure – 34% No – 7%	Only two groups were asked to vote. 100% of those two groups voted in support of a bond measure.	Yes – 59% Unsure – 30% No – 11%

Stakeholder Groups

This was a series of small group meetings that were held between October 11, 2021 and November 17, 2021. Gary Herbst was the presenter.

Emergency Department Advisory Council (8)	Ambassadors 1 (10)	Faith Leaders (8)	Hospital of Future (6)
Ambassadors (8)	Foundation Board (15)	Latino Leaders (9)	Realtors (12)
Young Professionals (9)	Employee Leaders (13)	Industrial Park (10)	Employee Ambassadors (17)
County Leaders (8)	City of Visalia Leaders (10)	Farmers/Land Owners (12)	Business Leaders (8)
Community Relations (9)	Physicians at MEC (20)	Board Members (5)	

Stakeholder Meetings Feedback on Option One



Phase 1 : 5-Storeys,120 beds, Pharmacy, Dietary, Lobby, 452-car Parking Structure
: Construction Start mid 2026 - Completion by January 2030
: $318.5 Million ($231 M 2020 cost + 4.5% yearly escalation to 2027 mid-point of construction+ EIR)

Phase 2 : 4-storeys,120 beds, 348-car Parking Structure
: Construction Start 2036 - Completion by January 2040
: $365 Million ($170 M 2020 cost + 4.5% yearly escalation to 2037 mid-point of construction + EIR)

OPTION 1 - SITE VIEW

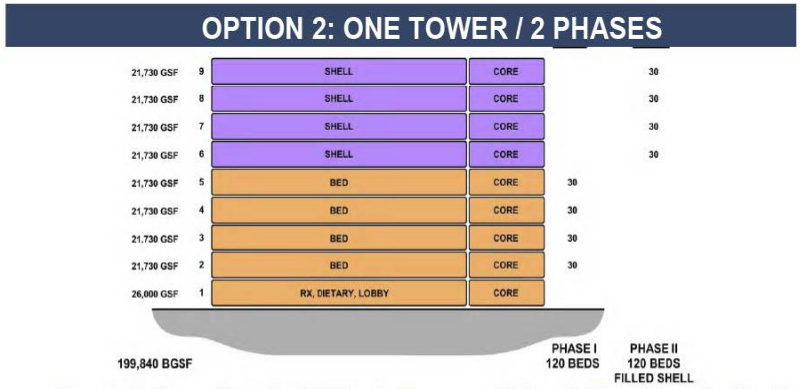
- Two towers gives Kaweah more time to communicate with the community.
- Two towers helps build trust in the community. If they see the first one completed on time and on budget, they will be more likely to give to a second bond.
- The 3D visual of two towers is beautiful.
- Multiple towers give it more of a complex look.
- Multiple towers would have smaller bond amount and right now people do not have an appetite for debt.
- The 9 story tower is too tall. What about power outages, evacuations, stalled elevators, etc.?

NRC Survey Feedback on Option One

More Parking, Two Towers

- ✓ “Fills the bed needs and parking needs of the hospital”
- ✓ “The cost at this day in time could change with in year’s difference if you do not have it locked in might even be higher than the quote.”
- ✓ “From a tax payer standpoint, it's not that much more per year. We should be build and expand as much as possible as quickly as possible.”
- ✓ “Buildings are united and have various benefits solely from having connecting buildings. If going with option 2, the other building should be dividing out Mother Baby/2E/Peds/NICU instead of having adult patients there.”
- ✓ “More room, more parking , etc.”
- ✓ “I like the layout... but the additional parking in option 1 is crucial to patients and employee’s.”
- ✓ “more feasible evacuation if necessary, less disruption in the event of electrical or mechanical failures, less dependence on elevators”
- ✓ “The two towers makes more sense for our downtown. Also having one fully completed by 2030 gives the best patient usage”
- ✓ “I like the two towers rather than the one tower. The extra costs per year is minimal related to property taxes. As more detailed information is presented than feedback may vary. I may vary feedback but feedback is a quick look into the question.”
- ✓ “Kaweah already has poor parking capacity, and needs more.”
- ✓ “It would allow for the continued growth and medical services needed for our expanding community and its needs. The difference is negligible to the homeowner/taxpayer. If understood, and while no one likes an increase in taxes, this would be for tangible services that most use at some point in they or their families lives.”
- ✓ “Keeps the structure height more in line with the existing hospital. Provides more future parking for patients, visitors, and employees.”
- ✓ “More parking, one tower might seem too high? Probably better to have two towers in the long run”

Stakeholder Meetings Feedback on Option Two



Phase1 : 9-Storeys (4 shelled),120 beds, Pharmacy, Dietary, Lobby, 500-car Parking Structure
: Construction Start mid 2026 - Completion by January 2030
: $440 Million ($319 M 2020 cost + 4.5% yearly escalation to 2027 mid-point of construction + EIR)

Phase 2 : Infill 4-storeys,120 beds
: Construction Start 2036 (tentative) - Completion January 2040
: $101.5 Million ($48 M 2020 cost + 4.5% yearly escalation to 2037 mid-point of construction)

- The 9 story will allow us to build a second tower if we need to in the future.
- Smaller footprint and more green space.
- One building seems much more efficient for staff and patients.
- Lower cost
- If there are two towers it might be difficult to manage ancillary services.
- Fill in the whole tower and do one ask. Go big, go once!
- The one tower is less confusing for patients and visitors.

NRC Survey Feedback on Option Two

One Building, Less Cost

- ✓ “Less cost to the taxpayers who will be voting on this. Especially in these Covid times we have already had several financial burdens”
- ✓ “Smaller footprint. Lower cost.”
- ✓ “Less buildings which bodes to the Kaweah is taking over everything. Also cheaper up front.
- ✓ “Would prefer a smaller footprint in the already crowded downtown area.”
- ✓ “Does not take away parking that was just built”
- ✓ “I believe it is easier to transfer patients in one building instead of two. In addition, it takes less ground space and if more space is needed than it can be rebuild in the future.”
- ✓ “Less cost, so easier to get funding.”
- ✓ “I like the idea building once and filling in as needed and the money is available. Building costs will only go up.”
- ✓ “logistically, one taller tower makes more sense. it also costs less overall.”
- ✓ “It's cheaper but still fulfills the hospital / community needs.”
- ✓ “Less cost overall, seems the more fiscally responsible option”
- ✓ “As a health care worker, going up/down in the same building is much easier than going from building to building, especially if there aren't easy pass-throughs in between. This is especially important for people who respond to codes.”
- ✓ “To me makes sense to take up less land and build higher and leave room for growth after 2040. Also net impact to the tax payers is less.”
- ✓ “Less cost and utilizes less land for the 240 bed renovation.”
- ✓ “Seems more ergonomically sound and efficient rather than having 2 separate buildings”
- ✓ “Cheaper, smaller foot print which preserves more land around the facility for green spaces, etc. Also becomes a dominant physical feature in the skyline people will clearly see driving by on HWY 198. This last point I think brings intangible value. Throughout human history the height of buildings inspires societies and has always been a sign of greatness.”

Common Feedback/Questions in all Three Methods

District

- Why do people outside of the healthcare district not have to pay but are able to use the hospital?
- What are other health care districts that don't have hospitals doing with their special district monies?
- Can a merger of other health care districts be forced?

SB1953

- What if the 2030 deadline gets extended? Is there still a need?

Mineral King Wing

- What is the plan for the MK Wing? Remodel, Educational Training Center, Offices?

General Obligation Bond

- Was the community aware of what KH was contributing themselves during the Measure H campaign?
- 2022 is too soon. There is a lot of distrust for everything and everyone. Afraid to spend money.
- Do one bond vs. multiple bonds.
- How long will the bond last and when does Measure M end?
- Is there a cap to how much we can charge taxpayers?
- Do not go out in 2022, go in 2023
- Go now. Positive perception for healthcare in general and we don’t want to miss opportunity.
- It seems like a heavy lift to be going to the public in this current political environment.
- Can you just max out the bond amount to save KH reserves and go for what you need?
- There has to be more education on the limitations around district hospital, why we are a district hospital, what KH is contributing, and how the money is monitored and spent.
- What does the polling data say?

Common Feedback/Questions in all Three Methods, Cont'd

Messaging

- If you decide to go in 2022, leverage the good-will in messaging. This is also a time when we have never before seen such a low capacity in hospitals.
- Kaweah Health must be physically visible at all events in the community.
- Don't desert regular traditional media.
- Partner with businesses on the messaging.
- There needs to be little one minute videos of the frequently asked questions being answered.
- Need to reach out to high school kids, who will soon be voters.
- People need to be more aware of the accolades and awards that Kaweah has earned.
- We need to reach the Hispanic community because non-English speaking parents rely on their kids for information.
- Talk about the strict regulations that are put on district hospitals in regards to spending the money as detailed in the voting details/explanation. The hospital does not change directions after a bond is passed like other organizations.
- Greatest opportunity for marketing is our employees. We need our employees to be educated.

Live with passion.

Health is our passion. Excellence is our focus. Compassion is our promise.

Kaweah Health

Kaweah Health™ **Interoffice Memorandum**

To: Board of Directors
From: Keri Noeske, RN, BSW, DNP, Vice President & Chief Nursing Officer
Date: November 19, 2021
Re: Throughput Project / Chartis Engagement

The last two years have provided a rapidly changing landscape in health care. Kaweah Health has transitioned to being the largest provider of health care services to a growing community across several counties. The increased demand for health care has created a strain on our confined space and resources in the inpatient care setting. We need to improve the efficiency of our inpatient care delivery while working with limited resources created by an extended epidemic in our region. Improvement in patient throughput is critical to decreasing patient length of stay, creating capacity for admissions in the inpatient hospital and addressing continual patient holds in the emergency department and emergency department length of stay times.

Through ongoing internal analysis and recent confirmation by industry experts with The Chartis Group, LLC (Chartis) we have identified opportunities to create changes in our systems and processes related to the movement of patients from presentation to the inpatient care to discharge.

Engaging Chartis will provide our Kaweah Health leadership team with a more rapid and focused opportunity to enact the proposed changes. The team from Chartis will be dedicated to this project and the management of the 14 identified opportunities. The project timeline is 7 months with 7 dedicated team members from Chartis leading the project with Kaweah Health team members. Chartis offers leading practices and industry experts to support the changes. They also offer change management support as we rapidly change processes around patient admission, discharge and decision making throughout the organization. Our current leadership team will actively engage but are not able to dedicate 100% of their time to these changes with other organizational demands and responsibilities. Engaging Chartis ensures faster turn around and experienced health care partners to lead the changes with our Kaweah Health leaders and teams.

These changes will decrease our length of stay in the Emergency Department and the Inpatient Care areas. We will also create processes easier for our team members to navigate and complete care tasks. The redesign of reports, communications and expectations will eliminate redundant work.

Long-term sustainment and commitment to these processes are crucial to the success. The leadership team, led by the executive team is engaged in the process. The leaders involved have reviewed the work efforts outlined by Chartis for this project; they are committed to the work and the changes for the long-term improvements they bring.

The executive team members and the Finance, Property, Services and Acquisitions Committee members unanimously recommend moving forward with the partnership with Chartis to undertake this throughput project. The cost for the 7 month project is 1.6 million dollars. The anticipated return annually from successful implementation of the changes is $10 million as well as improved satisfaction for team members and patients in the more streamlined access to inpatient care.

Optimizing Patient Throughput

The Chartis Group Experience

November 2021

THE CHARTIS GROUP

Kaweah Health
MORE THAN MEDICINE. LIFE.

Table of Content

Your partner in navigating what's next.

We are in a moment of tremendous change and disruption in the healthcare industry. Today's healthcare needs, economics, and disparities demand the next set of solutions.

Navigating the healthcare delivery landscape ahead will require bold thinking, incisive leadership, and powerful collaboration. We're helping our clients bring together human experience and judgement with cutting-edge data, analytics, and technology to navigate through uncertainty.

We call this **Next Intelligence**.

Healthcare is in our DNA.

The Chartis Group comprises Chartis Consulting, The Greeley Company, and Jarrard Phillips Cate & Hancock. We operate under our unique brands in the market but share a singular focus on improving healthcare.

OUR MISSION

To materially improve the delivery of healthcare in the world.

OUR PEOPLE

500+

professionals dedicated to healthcare, drawing on decades of experience as advisors and practitioners, deeply committed to partnering with our clients.

OUR CAPABILITIES

Deep clinical and operational design and performance improvement experience, including patient throughput, workforce management and labor productivity, clinical transformation, information technology, revenue cycle, change management, etc.

OUR CLIENTS

19 OF THE 20
Top NIH-Funded Academic Health Systems

18 OF THE 20
Best Hospitals Honor Roll, US News & World Report

14 OF THE 20
Largest Not-For-Profit Health Systems

15 OF THE 20
Best Children's Hospitals Honor Roll, US News & World Report

THE TEAM

Highly experienced, senior resources with a deep understanding of workforce and provider operations

THE APPROACH

Rooted in experience and leading practice, but tailored to your unique needs

THE OUTCOME

Oriented to achieve measurable results quickly – but sustained over time

THE DIFFERENCE

Designed with sustainability at the forefront - change leadership and management, infrastructure development, and shoulder-to-shoulder redesign

Recognized as an Industry Leader

Selected as one of

Forbes 2021 America's Best Management Consulting Firms

By our peers and clients in the following categories:

1 IT Strategy

2 Organization

3 Strategy

Overall Healthcare Management Consulting Firm

Clinical Optimization

Financial Improvement Consulting

Ranked **#1 in Three Categories**

Ranked in Top 3 in 2 additional categories:

#2 in Implementation Leadership – Small (teams of <15 consultants)

#3 in HIT Advisory (the 11th year ranking in the top 10)

Modern Healthcare **Best Places to Work** 2021™

Top Healthcare & Consulting Workplace

We are consistently recognized by Vault among its top-ranking consulting firms and have been ranked by Modern Healthcare among the top 20 "Best Places to Work in Healthcare" for six consecutive years.*

*Note: Chartis did not participate in 2020 due to the pandemic and the timing of the survey.

The Case for Change

Optimizing inpatient throughput is a goal for most organizations and the pandemic has highlighted existing and new hurdles to success.

TRADITIONAL GOALS
for Optimizing Inpatient Throughput

- Ensure highest quality, most efficient care
- Reduce ED wait times
- Accept all appropriate transfers
- Minimize/delay need for capital expansion
- Consistently deploy specialized staff in CM, UM, SW to their highest and best use
- Accelerate reimbursement/ reduce clinical denials

EXISTING AND NEW ISSUES
Exacerbating the Need to Focus on Throughput

- Limited options for post-acute patients, especially those with complex needs (financial or psychosocial)
- Increasing number of patients with behavioral health issues
- Need for bed availability to serve Covid-19 patients
- Provider and staff exhaustion
- Fewer staff available (RNs, CNAs, etc.) to keep beds open

CHARTIS APPROACH

Expected Results

Our work drives a positive impact on LOS and capacity management while equipping our clients with the tools and infrastructure to make the solutions sustainable.

.5 DAY
REDUCTION
in length of stay

Infrastructure for leadership to drive
CONTINUAL OPTIMIZATION

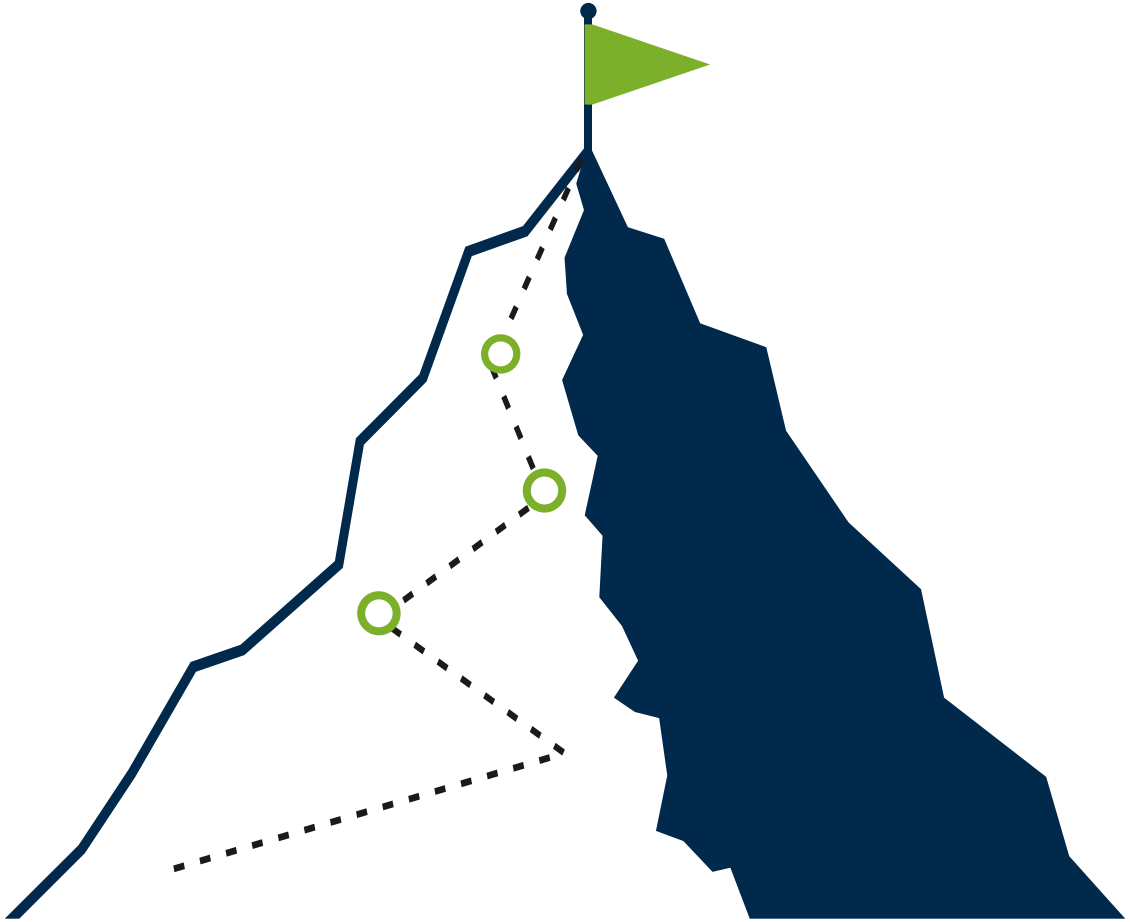
INCREASED QUALITY OF CARE
and patient experience by **reduced time in ED**

Established tools and processes for managers to
SUSTAIN OUTCOMES

REDUCTION
IN LONG STAY
CASES (30%)

Enhanced analytics and reporting to provide
ACTIONABLE INSIGHTS

Keys to Success



- **Alignment around goals** that go "beyond the numbers" e.g., release capacity to support growth, eliminate the operational gridlock associated with late discharges, improve quality of care
- **Broad engagement of stakeholders** from the outset including care management, nursing, and physicians to gain agreement on adoption of leading practices and required changes
- Comprehensive approach that **addresses the complex, interconnected clinical, support and business processes** from admission through discharge that drive efficient and effective patient progression and throughput
- **Hardwiring solutions** by ensuring clarity of roles, responsibilities and authority for decision-making; leveraging data, tools and technology to support efficiency and compliance with new processes; and implementing performance measurement and reporting to drive and sustain impact
- **Proactive change management** including stakeholder communication, engagement and activation to address the human dimensions of organizational change and the personal impact to stakeholders

Our Experience: Inpatient Throughput

The Chartis Group has extensive experience partnering with health systems to develop leading practice approaches to the different components of Patient Progression

St. Bernards Designed, piloted, and are implementing new patient admission/service assignment process, care progression, care management facilitation, discharge process and transformed hospitalist care model	Health Augusta University Redesigned the Utilization Management function to improve overall effectiveness and reduce clinical denials	CMC Catholic Medical Center Refined care management and patient progressions roles, processes and unit based standards to improve inpatient capacity	OU Medicine Design and implementation of clinical pathways and care coordination protocols for top conditions. Assessment and design of Utilization Management committee.	ECMC Redefine bed management and care management functions to support increased demand for inpatient capacity from newly expanded ED	Wake Forest Baptist Medical Center Improved LOS and enhance capacity through the development and execution of a multi-hospital care management transformation plan.
Virtua Health Designed, piloted, and implemented a new patient progression and case management model across three hospitals	UAB Medicine Stabilized the care management department, rolled out new discharge processes, and optimized care coordination tools	Houston Methodist Leading Medicine Revised roles associated with patient flow on unit and across hospital including the role of the care manager and daily huddle process	Western Connecticut Health Network Danbury Hospital Implemented changes to the care team model, services contributing to discharge delays and care coordination processes	Beth Israel Deaconess Medical Center Designed enhanced roles and processes to support patient discharge and long-stay patient management, and clinical management of CHF patients	Loyola Medicine Redesigned the patient placement function and developed a clinically oriented patient placement function and geographic cohorting of patients
Montefiore Performed a comprehensive Inpatient Access and Throughput assessment and implemented performance improvements in care management, patient placement and early discharges	Advocate Health Care Redesigned the roles, tools, and organizational structure for acute care coordination and transitions across 10 hospitals	The University of Chicago Medicine Implemented a new patient throughput model to support the opening of the Center for Care and Discovery	University of Maryland Medical Center Redesigned the bed management infrastructure supporting inpatient throughput including roles, responsibilities, processes. policies and monitoring	Dartmouth-Hitchcock Implemented bed base redesign, refined bed management office roles and responsibilities, launched a transfer center and optimized discharge process	Barnes-Jewish Hospital Established a central bed mgmt. dept.; revised roles on the nursing units with a "free" charge nurse resp. for flow, pulled patients from ED

* Projects listed in reverse chronological order

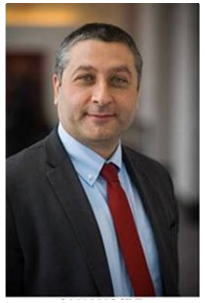
Pamela Damsky

Director, Performance Practice Leader

Pamela Damsky is a Director at The Chartis Group and is the co-leader of the Performance Practice area and leader of the firm's Financial Performance Improvement practice. Ms. Damsky has over 30 years of healthcare experience, the majority of which is in advisory services. She brings deep expertise in organizational strategy, alignment, clinical transformation and performance transformation to help organizations succeed today while preparing for new and future environments.

Ms. Damsky has partnered with national and regional health system clients across the country in developing and executing a broad range of strategic and operational initiatives. She has led numerous clinical transformation and performance transformation engagements encompassing all aspects of performance including vision development, organizational strategy, leadership alignment, redesign of all aspects of care delivery and operations, change management and implementation planning. Her work in Perioperative Performance improvement has included OR suites ranging in size from 4 to 80+ rooms in community hospitals, Academic Health Systems and safety net organizations. Her strategic planning includes enterprise-wide strategy, strategic positioning and portfolio balancing, service line planning initiatives and due diligence reviews of specific strategic opportunities. Recent clients include University of Chicago Medicine, University of Virginia Health System, Augusta University Health, Catholic Medical Center, Erie County Medical Center, Houston Methodist, George Washington Medical Faculty Associates and Albany Medical Center.

Before joining The Chartis Group, Ms. Damsky was the co-Founder and Chief Operating Officer of Hælth LLC, the first of its kind freestanding Complementary Medical Center. At Hælth, Ms. Damsky was responsible for all aspects of day to day operations, human resource support functions and financial functions. She also was a prime contributor to the company's marketing and strategic planning efforts. Prior to Hælth, Ms. Damsky was a Senior Consultant and leader of the Operations Practice at CSC and its predecessor, APM Management Consultants.



Mark Krivopal, MD

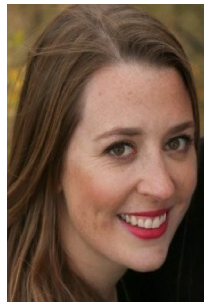
Principal

Dr. Mark Krivopal is a Principal with The Chartis Group and a senior physician executive with 25 years of healthcare experience in academic medical centers, complex IDNs, independent community hospitals, and a healthcare information technology start-up. In the last six years, Dr. Krivopal's focus has been on enterprise financial and operational performance improvement, innovative operating care models and clinical service lines redesign, and acute care capacity and throughput optimization. Dr. Krivopal also serves as the clinical leader in Chartis *Digital*, leading Chartis' work with clients in operationalizing digital clinical transformations such as Hospital at Home care model deployment.

Prior to joining The Chartis Group, Dr. Krivopal was a Vice President at GE Healthcare Camden Group providing clinical performance improvement and population health advisory services. Previously, he served as a Vice President of Clinical Programs for a healthcare information technology company focused on improving patient access. In this role, he led clinical product development and worked with clients to improve clinician engagement and alignment, leading to successful adoption of healthcare information technology products in large academic medical centers and physician groups. Dr. Krivopal's prior experience includes transitioning a large provider organization to an integrated value-based care model and overseeing operations of a multi-state acute care clinical service line.

Dr. Krivopal's career as a physician executive includes co-founding and leading Beth Israel Deaconess HealthCare Hospitalist Services at an academic and community hospitals. He was accountable for clinical quality, financial, and operational performance, provider communication and relationship management, risk mitigation, and provider staff professional development.

Dr. Krivopal received a Master of Business Administration with honors from Babson College, F.W. Olin Graduate School of Business in Wellesley, Massachusetts. He earned his Doctorate of Medicine with honors from the University of Massachusetts Medical School in Worcester, Massachusetts, and completed his internal medicine residency training at Boston's Beth Israel Deaconess Medical Center and Harvard Medical School, where he continued his clinical practice and held an academic appointment for many years.



Martha Bailey

Associate Principal

Martha Bailey is an Associate Principal with The Chartis Group whose career in healthcare spans over 13 years, 11 of which have been spent in healthcare operations.

Ms. Bailey's areas of expertise include patient throughput and capacity management, patient flow and transfer center operations, service line management, electronic medical record (EMR) optimization, operational planning for new facilities, post-merger clinical and operational integration, and enterprise project management.

Prior to joining The Chartis Group, Ms. Bailey was a Director in Guidehouse's healthcare operations consulting practice where she led the firm's command center and patient throughput solutions. Before consulting, Ms. Bailey held various senior leadership positions at NYU Langone Health and Planned Parenthood of Greater New York.

In addition, Ms. Bailey has published in peer review journals and presented at national healthcare conferences on various components of hospital patient throughput as well as leveraging EMR optimization for clinical and operational process improvement and redesign.

Ms. Bailey received her Master of Science in Health Systems Management from Rush University and her Bachelor of Arts in Spanish Linguistics (Pre-Med) from Loyola Marymount University.

Thank you!

www.chartis.com

THE CHARTIS GROUP

ATLANTA
150 E. Ponce de Leon Avenue
Suite 400
Decatur, GA 30030

BOSTON
560 Harrison Avenue
Suite 501
Boston, MA 02118

CHICAGO
220 West Kinzie Street
Third Floor
Chicago, IL 60654

MINNEAPOLIS
218 Washington Avenue North
Suite 240
Minneapolis, MN 55401

NEW YORK
740 Broadway
Suite 1001
New York, NY 10003

SAN FRANCISCO
1 Market Street
36th Floor
San Francisco, CA 94105

Emergency Department / Inpatient Throughput and Emergency Department Workforce Rapid Assessment

Final Deliverable

October 2021

THE CHARTIS GROUP

Kaweah Health
MORE THAN MEDICINE. LIFE.

Table of Contents

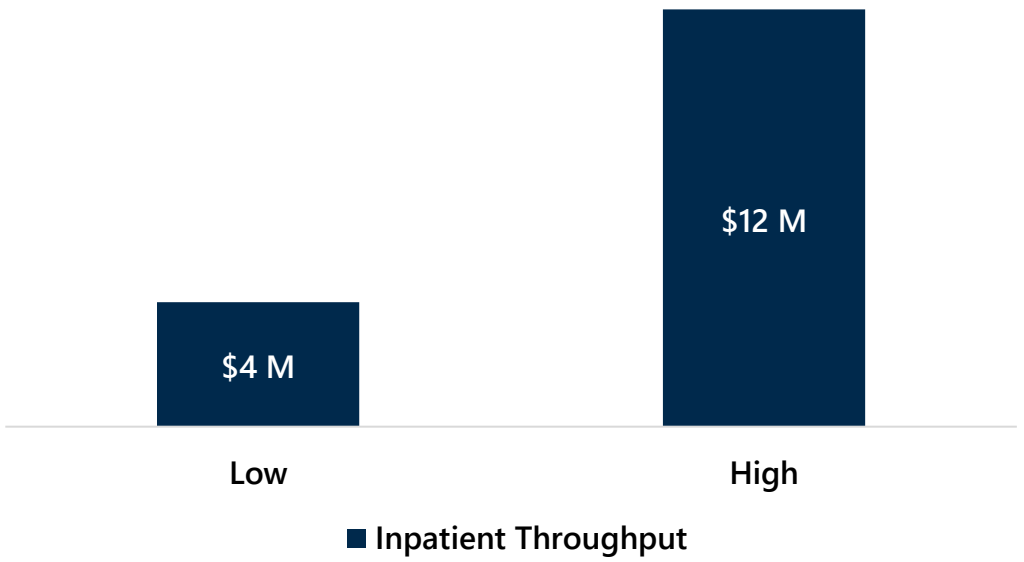
❶ Executive Summary

ED and Inpatient Throughput Overview

- Recent focus on analyzing patient throughput opportunities by Kaweah Health leadership; however, **no one coordinated improvement effort has been implemented and sustained**
- On-going areas for opportunity coalesce around the following themes:
  - ✓ **Expand existing patient progression facilitation and inpatient throughput structure** and augment active daily huddle participation with providers
  - ✓ **Integrate CM, SW, RNs, and MD/APPs**, etc. to create a robust and multidisciplinary care facilitation team
  - ✓ Optimize **existing technology resources** to effect underlying processes in support of patient throughput goals and to enhance clinicians' efficiency
- Improving inpatient throughput is essential to address current Emergency Department holds and lack of bed availability for elective surgical admissions and outside hospital transfer requests

Opportunity Range*

Contribution Margin



**Opportunity Range Methodology found in Appendix 7: Benefit Realization Methodology*

❷ Problem and Engagement Scope

Project Objectives

- Targeted evaluation of **workforce deployment** and **opportunities to improve efficiency in nurse staffing in the ED** and **optimize the overall patient flow**
- Focused assessments and analyses highlighting the **priority areas of opportunity to appropriately reduce acute care ALOS**

Project Deliverables

- A **transformation roadmap** outlining improvement initiatives, identified owners and resource requirements
- Qualitative description of the **measures of success** of the transformation effort
- High-level **estimates of the value impact** for the transformation roadmap and initiatives
- *Added: High-level **estimate of rehabilitative, respite and residential needs** for patients covered by MediCal who are discharged from Kaweah Health*

❸ Inpatient Throughput: Our Perspective

Inpatient throughput performance requires commitment and collaboration around workflows and roles by nursing, case management, social work, utilization management, hospital-based providers, bed management, etc.

Alignment on Vision

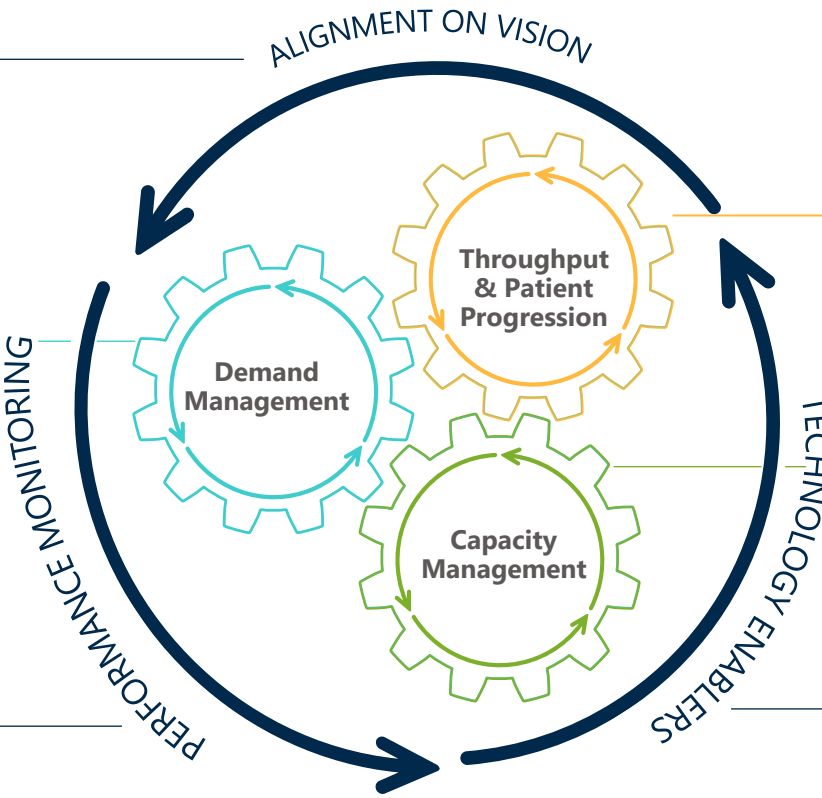
- Inpatient throughput vision is clearly articulated and aligned with overall strategic goals
- Leadership structures reflect the collaborative, multidisciplinary nature of inpatient throughput
- Leaders role model collaboration and data drive decision making

Demand Management

- Criteria-based decision-making to determine appropriateness of admission and level-of care
- Hard-wired care pathways and standard order sets for common conditions
- Efficient assignment of admitting service
- Effective initial and concurrent level of care review
- Availability of alternative care options (e.g., hospital at home)

Performance Monitoring

- Inpatient throughput dashboard
- Transparent and daily reporting on performance to support throughput management
- Standard processes in place for routine performance review and mitigation



Throughput and Patient Progression

- Emergent and urgent patient care triage
- Daily bed management huddles
- Patient progression huddles
- "Pull" to floors vs. "Push" from ED
- Clear core workflows and roles:
  - CM, SW, UM, and discharge planning
  - Unit-based staff
  - Physician advisors
  - Hospitalists, attendings and APPs
- Patient transport and EVS turnaround times

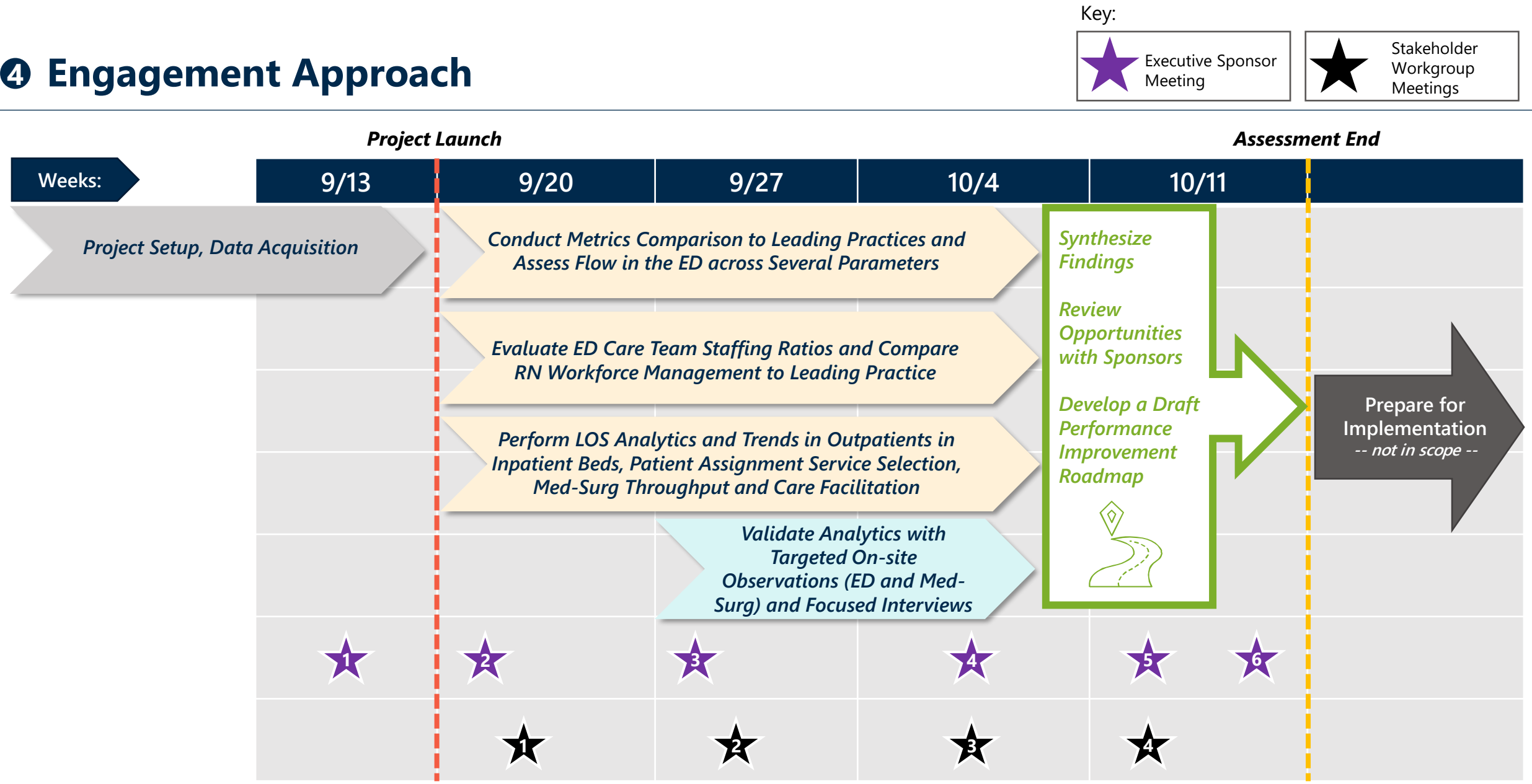
Capacity Management

- Bed types are aligned with service line demands to enable patient aggregation
- Patient placement protocols based on clinical needs
- Staffing levels are flexed to meet demand
- Compliance to levels of care criteria
- Bed management has standard work across shifts

Technology Enablers

- Interfaces between disparate systems needed to manage throughput (e.g., EMR, Rev Cycle, UM/CM technology)
- Documentation in systems is standardized to improve communication (e.g., discharge date)
- Optimized functionality of UM/CM systems

❹ Engagement Approach



❺ Assessment Themes: Interviews, Observations & Stakeholder Survey

- The **tenure** of organization's management and frontline staff varies widely; this will impact the timing within which material change will be realized
- **Compassion fatigue** is wearing on staff across the organization
- A sense of real and perceived **crises** exacerbates **inefficiencies and siloed processes**
- **Staffing challenges** are magnified by difficulties in critical **staff retention**
- The organization appears to be open to an infusion of fresh perspectives and leading performance improvement practices but will require **intentional efforts to foster and support high performance goals**
- Data and reports are plentiful but their **actionability varies** widely
- **Standard processes**, including policies, procedures, and guidelines are not readily available, not utilized or need to be modernized
- **Information Technology tools** are underutilized with teams falling back on paper-based processes
- **Accountability for performance** may need to be clarified and enforced to create a burning platform for intentional performance improvement efforts
- Caring for a large proportion of **underserved patients** with inadequate follow up ambulatory services contributes to higher percentage of admissions and inpatient LOS
- **Clinician engagement** is inconsistent (particularly as it relates to participation in patient progression rounds) and the mechanisms are not in place to foster a platform of effective and collaborative **physician leadership**

❺ Assessment Themes: Data Analytics

ED Length of Stay is Likely Impacted by Hospitalist Switch Days

- Average ED LOS is longest at 7 hours on Wednesdays despite being the 4th highest day from a volume perspective
- Wednesdays also have the longest average ED LOS for admitted patients (11.7 hours), coinciding with Hospitalist switch day

Observation Length of Stay Will Likely Continue to Increase Unless It Is Specifically Addressed

- The average LOS (in hours) for patients placed in observation status has increased recently from the low-40s to mid-40s
- The proportion of observation patients with a LOS greater than 72 hours is increasing, while those with a LOS of 12-23 hours is decreasing

Timely Discharge Is Not Where It Needs to Be to Drive ED Patient Throughput or Respond To Demand

- Providers have a goal to enter discharge orders by 10 am; however, between May 1, 2020 – August 31, 2021, this is accomplished only 23% of the time
- 9% of patients are discharged before 12 pm. The leading practice is closer to 40% or higher

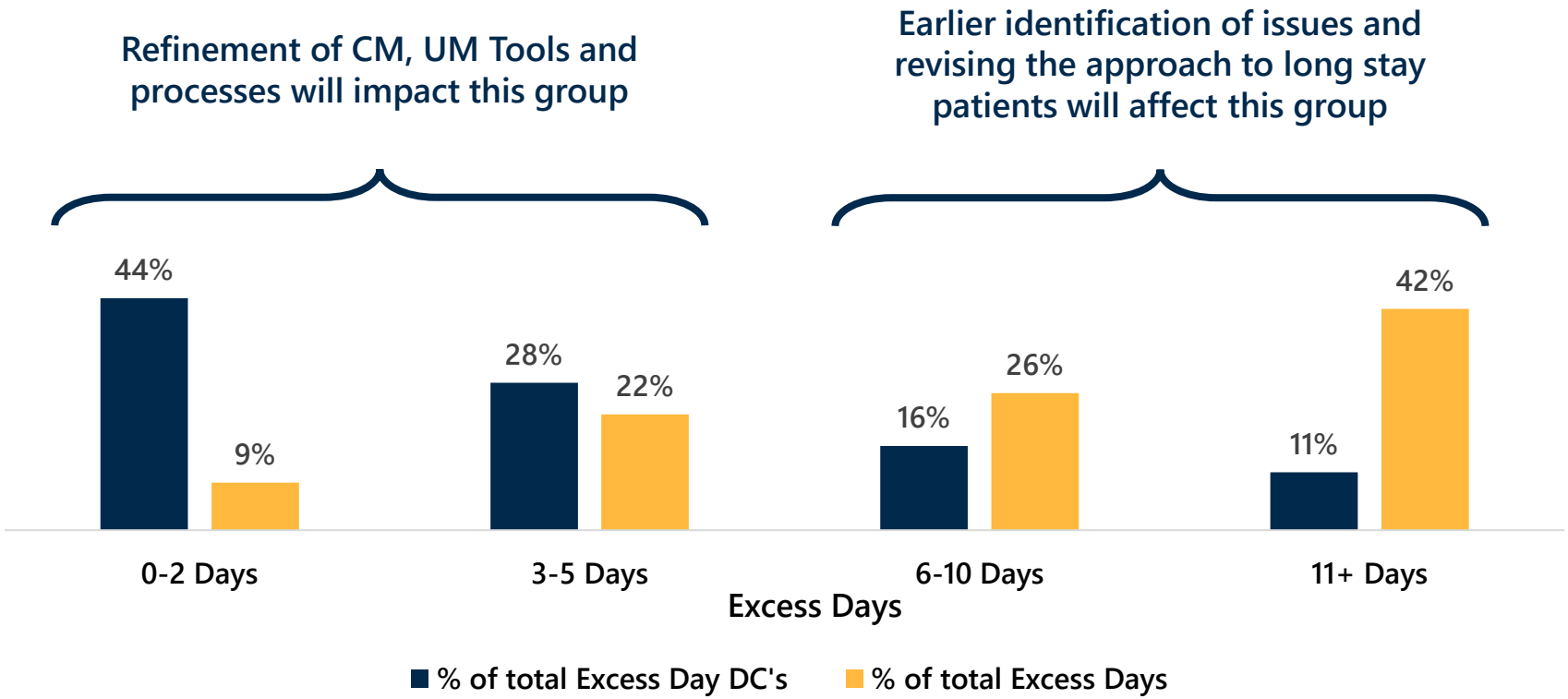
Discharge Planning for Patients Going to SNFs Will Require Both Enhanced Internal and External Collaboration

- Between May 1, 2020 – August 31, 2021, a combined 33% of inpatients were discharged to home with services (18%), a skilled nursing facility (12%) or acute rehabilitation hospital (3%)
- Patients discharged to a skilled nursing facility (SNF) had an ALOS of 9.7 days and O/E LOS of 2.08, partially due to SNF bed availability or insurance authorization

❺ Assessment Themes: Long Stay Patient Opportunity

More frequent review of patients exceeding their expected LOS, including reviews of patients exceeding their LOS by a "small" amount, will help to reduce the number of patients who stay at Kaweah Health 5+ days

Kaweah Health Distribution of Excess Days



Data period: January 1, 2019 – August 31, 2021

Legend								
Impact			Effort			Priority		
H High	M Medium	L Low	H High	M Medium	L Low	H High	M Medium	L Low

❻ Key Patient Throughput Solutions (1 of 3)

#	Solution	Description	Impact	Effort	Priority
1	**Throughput and Patient Progression**				
1.A	Care Management Roles & Responsibilities	Clarify workflows / accountabilities of the care management team (inclusive of Case Management, Social Work, Utilization Management, Nurses, Residents, and Providers); ensure all activities are integrated into the broader care team to promote patient throughput, staff efficiency, and denial reductions	H	H	H
1.B	Discharge Planning & Timely Discharge	Develop process for identifying and documenting anticipated date of discharge (ADD) on admission; integrate ADD into Cerner for all care team members and collaborating services to prioritize patient throughput accordingly; incorporate discharge time into multidisciplinary huddles; develop standard patient / family communication	H	M	H
1.C	Hospitalist Deployment & Scheduling	Optimize hospitalist-to-hospitalist handover to minimize patient progression delays on switch day; evaluate opportunities to streamline rounds, stagger switch days, and further cohort hospitalist patients across Kaweah Health as appropriate	M	H	M
1.D	Multidisciplinary Huddles	Transform daily huddles to pro-actively manage day-to-day throughput and increase institutional awareness of throughput needs; implement targeting scripting for all participants to streamline huddle time and drive decision-making	H	M	H
1.E	Long Stay Committee	Implement Long Stay Committee structure to review barriers to safe discharge for patients with LOS > 5 days; develop standardized report outs and escalation pathways; incorporate leadership from Care Management, Finance, Medical Staff, Population Health, Managed Care, among others	H	L	H
1.F	Post-Acute Network	Evaluate need for post-acute network; assess current post-acute transition processes (including to Kaweah Health rehab and skilled nursing) and implement streamlined processes where possible; review current contracts for authorization turnaround times, educate Case Management, and develop tracking and escalation process	M	H	M

❻ Key Patient Throughput Solutions (2 of 3)

Legend								
Impact			Effort			Priority		
H High	M Medium	L Low	H High	M Medium	L Low	H High	M Medium	L Low

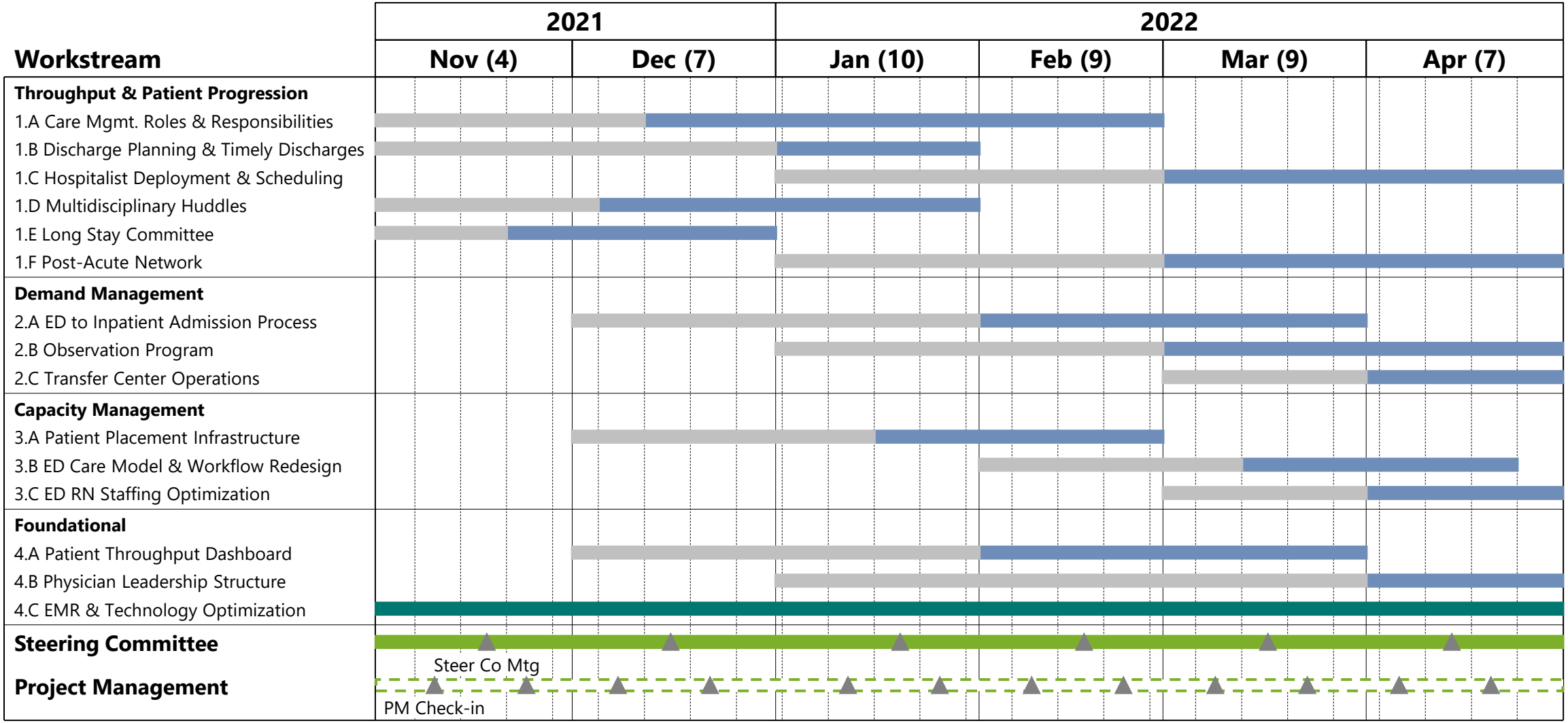
#	Solution	Description	Impact	Effort	Priority
2	**Demand Management**				
2.A	ED to Inpatient Admission Process	Develop admission guidelines by service to streamline service identification; optimize hospitalist identification and admission process; identify opportunities for parallel processes in ED admission process (i.e., hospitalist acceptance patient transport request, nurse-to-nurse handover, etc.)	M	H	M
2.B	Observation Program	Develop observation admission criteria, order sets / protocols based on top 5-10 diagnoses, communication / education strategy to interdisciplinary team and collaborating services (e.g., Cardiology, Radiology, etc.); evaluate possibility of re-establishing space for a dedicated observation unit; leverage Cerner tools to proactively monitor LOS of currently admitted observation patients; conduct ongoing case review and track conversion rate to inpatient	H	H	M
2.C	Transfer Center Operations	Develop clinical prioritization algorithm for transfer requests and escalation process for transfer requests not accepted due to bed availability; track and quantify financial impact of lost or cancelled transfers	L	M	L
3	**Capacity Management**				
3.A	Patient Placement Infrastructure	Realign bed supply with demand to allow for aggregation and optimal patient placement; develop patient placement matrix and prioritization algorithms	M	M	M
3.B	ED Care Model & Workflow Redesign	Streamline ED workflows to enable improved throughput / reduced LOS for treat & release patients; optimize triage processes to decrease number of patients in waiting room	M	H	M
3.C	ED RN Staffing Optimization	Align nurse, licensed vocational nurse (LVN), and licensed psychiatric technician (LPT) staffing to patient arrivals and ED census by time of day and day of week	M	M	L

Legend								
Impact			Effort			Priority		
H High	M Medium	L Low	H High	M Medium	L Low	H High	M Medium	L Low

❻ Key Patient Throughput Solutions (3 of 3)

#	Solution	Description	Impact	Effort	Priority
4	**Foundational**				
4.A	Patient Throughput Dashboard	Design and launch an all-encompassing patient throughput dashboard (including process and outcome metrics) and corresponding communication / education plan (see illustrative example in Appendix 8); leverage available Cerner real-time patient throughput dashboards for day-to-day clinical operations	H	M	M
4.B	Physician Leadership Structure	Evaluate current physician leadership structure as it relates to supporting and driving throughput; outline physician leadership opportunities, including Chief Medical Officer role, and organizational / medical staff readiness	H	H	H
4.C	EMR & Technology Optimization	Align upcoming Cerner implementation with redesigned processes; identify other Cerner optimization opportunities related to throughput and patient progression, demand management, and capacity management	H	M	H

❼ Proposed Implementation Timeline



❽ Project Structure Overview

Kaweah Health Leadership

- Provides oversight and guidance
- Approves recommendations

Co-Chairs
Keri Noeske and Marc Mertz

Implementation Steering Committee

- Review/provide input to Design & Implementation Workstreams' proposed solution sets
- Ensure solutions maintain "system mindset" perspective rather than local
- Role model transparency and communicate broadly and effectively
- Champion the project and engage colleagues

PMO Support & Communications

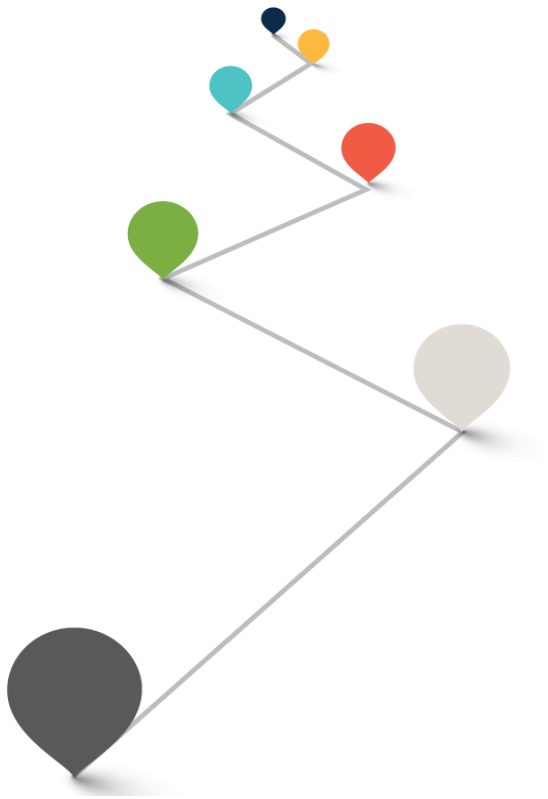
- Manages implementation
- Recommends refinements to implementation plan
- Measures overall progress and impact
- Facilitates communication launch and ongoing updates
- Fields inquires

Design & Implementation Workstreams

1.A Care Mgmt. Roles & Responsibilities	1.B Discharge Planning & Timely Discharge	1.C Hospitalist Deployment & Scheduling	1.D Multidisciplinary Huddles	1.E Long Stay Committee	1.F Post-Acute Network	2.A ED to Inpatient Admission Process
2.B Observation Program	2.C Transfer Center Operations	3.A Patient Placement Infrastructure	3.B ED Care Model & Workflow Redesign	3.C ED RN Staffing Optimization	4.A Patient Throughput Dashboard	4.B Physician Leadership Structure
4.C EMR & Technology Optimization						

Each Design & Implementation Workstream will report progress and results up through the Steering Committee; at any given time, there will be 4-10 Workstreams in motion

⑨ Next Steps



- Socialize proposed implementation plan with Stakeholders
- Determine Chartis' support required for implementation
- Prepare for implementation
- Launch implementation

APPENDIX 1

Engagement Approach

Project Logistics – Interviews

Weekly Stakeholder Group

Stakeholder	Role
Marc Mertz	VP, Chief Strategy Officer
Keri Noeske	VP, Chief Nursing Officer
Malinda Tupper	VP, Chief Financial Officer
Dr. Kathy Reynolds	Case Management Physician Advisor
Dan Allain	VP, Cardiac & Surgical Services
Rebekah Foster	Director, Throughput / Specialty Care
Dr. Kona Seng	ED Medical Director
Michelle Petersen	Director, Emergency Services
Dr. Niraj Patel	Hospitalist Medical Director
Dr. Onsy Said	Hospitalist Medical Director
Ryan Gates	VP, Population Health
Dr. Steve Carstens	Physician Engagement Leader

Nursing Leadership Team

Stakeholder	Role
Keri Noeske	VP, Chief Nursing Officer
Amy Baker	Director, Renal Services
Shannon Cauthen	Director, Critical Care Services
Theresa Croushore	Director, Mental Heath Services
Kipling Cummins	Director, Trauma SVS
Rebekah Foster	Director, Throughput / Specialty Care
Kari Knudsen	Director, Post Surgical Care Services
Mary Laufer	Director, Clinical ED and Nursing Practice
Emma Mozier	Director, Med/Surg Services
Michelle Petersen	Director, Emergency Services
Tracie Sherman	Director, Maternal Child Health Services
Kassie Waters	Director, Cardiac Critical Care Services

Rehab & Post-Acute Services Leadership Team

Stakeholder	Role
Jag Batth	VP, Ancillary & Post-Acute Services
Wendy Jones	Director, Respiratory Services
Randy Kokka	Director, Laboratory Services
Renee Lauck	Director, Imaging & Radiation Oncology Services
Elisa Venegas	Director, Nursing-Rehab & Skilled Services

Other

Stakeholder	Role
Dr. Joe Malli	ICU Medical Director
Tendai Zinyemba	Director, EVS & Patient Transport

Project Logistics – Observations

Tuesday, September 28th	Wednesday, September 29th	Thursday, September 30th
• ~1:45 pm: arrive to Kaweah Health • 4-5 pm: Executive Sponsor meeting	• 7:45 am: Hospital huddle • 8:30-9 am: Hospital tour • 7-9 am: Hospitalist rounds • 10 am: CM / Charge RN / RN discharge rounds • Late morning: ED observations • 4 pm: Staffing huddle • 4-5 pm: Stakeholder meeting	• 9-10:30 am: Nursing Directors meeting • 10 am: CM / Charge RN / RN discharge rounds • 10:30-11:30 am: Ancillary Directors meeting • 12-1 pm: CFO follow-up interview • 1:30-2 pm: ED follow-up tour

APPENDIX 2

Stakeholder Survey Results

Received 10 of 14 survey responses as of 10/8

SURVEY RESULTS

Leading Practice Evaluation

The admission process from the Emergency Department to inpatient or observation status may be an area to focus on near-term while the Emergency Department continues to optimize use of its new space

Kaweah Health
MORE THAN MEDICINE. LIFE.

Legend: 1 2 3 4 5

Framework Category	Leading Characteristics	Participant										KH	Chartis
		A	B	C	D	E	F	G	H	I	J		
Emergency Department	Patient Flow Management	3	2	2	1	2	2	2	2	3	2	2	2
	Staffing Complement, Ratios, and Assignments	4	2	3	1	2	2	4	2	3	2	3	2
	Collaborative Working Environment	3	3	3	3	3	3	2	3	3	2	3	2
	Ancillary Services	3	2	3	3	2	3	2		4	3	3	2
	Consult Services	3	3	2	3	4	4	2		3	2	3	2
	ED Boarding	3	3	2	3		2	2	4	2	1	2	1
	Admission Process from ED	3	2	2	3	2	3	3	1	4	1	2	2

> **We definitely work in silos at times. Communication between teams doesn't always occur in a timely manner and delays care.**

> **I think that the staffing plan is based on patient volumes, but the reality is that with so many vacancies the plan rarely matches reality.**

SURVEY RESULTS

Leading Practice Evaluation

Kaweah Health has an opportunity to significantly improve inpatient flow by leveraging more coordinated and integrated multidisciplinary huddles, including physician / provider stakeholders

Kaweah Health
MORE THAN MEDICINE. LIFE.

Legend: 1 2 3 4 5

Framework Category	Leading Characteristics	Participant										KH	Chartis
		A	B	C	D	E	F	G	H	I	J		
Inpatient	Patient Flow Management	4	2	2	4	5		2		4	3	3	1
	Staffing Complement, Ratios, and Assignments	4	2	1	3	4		3		2	5	3	3
	Collaborative Working Environment	4	4	3	4	5		2		3	3	4	2
	Clinical Variation Management		3	3	3	5		2			2	3	1
	Discharges and Handovers	3	3	2	3	4		2		4	3	3	2

> **Continuity of care for Case management would be helpful for effective discharge planning.**

> **With new processes and expectations we have put in place, we are closer than ever to having a more efficient discharge practice.**

> **CM staff is so short, we are unable to complete all of the tasks needed for safe discharge for many patients.**

SURVEY RESULTS

Leading Practice Evaluation

Case Managers are responsible for a myriad of tasks, some of which may not require a clinical skill mix; there could be an opportunity to centralize some of these tasks and allocate to a non-clinical skill mix

Kaweah Health
MORE THAN MEDICINE. LIFE.

Legend: 1 2 3 4 5

Framework Category	Leading Characteristics	Participant										KH	Chartis
		A	B	C	D	E	F	G	H	I	J		
Case Management	Organization and Management Structure	3	3	4	2	4		3			3	3	3
	Core Workflows and Roles	3	3	2	2	5		2			2	3	3
	Staffing Complement, Ratios and Requirements	4	2	2	2	4		2			2	3	2
	Technology	4	3	3	3	4		4			2	4	2
	Performance Monitoring	2	3	3	2	4		4			2	3	2

With our staffing at crisis level for CM, many of our roles and responsibilities have been put on the back burner and feel that we are just putting out fires instead of being proactive many times.

Physician advisor is really for the physicians, would like more drive and ownership from the case managers.

Since switching over to Cerner and MCG, we have found that documentation is very cumbersome and many important things get missed.

SURVEY RESULTS

Leading Practice Evaluation

Senior and middle management are generally aligned on the challenges, but an opportunity exists to optimize a targeted and focused approach to performance improvement.
Policies and procedures may exist, but they are not rapidly available or consistently followed, contributing to "parallel processing" and practice variability.

Kaweah Health
MORE THAN MEDICINE. LIFE.

Legend: 1 2 3 4 5

Framework Category	Leading Characteristics	Participant										KH	Chartis
		A	B	C	D	E	F	G	H	I	J		
Foundational	Leadership and Management Competencies	4	4	4	4	4		4		3	3	4	2
	Capacity and Demand Management	3	4	2	3	3		3		4	3	3	2
	Policies and Procedures	4	4	2	3	5		3		3	3	3	2
	Collaborative Work Environment	3	3	3	4	4		2		4	3	3	3

> **Like most large companies, we are swimming in a sea of policies. We have a policy for everything and a policy management software system that is extremely difficult and time consuming to navigate.**

> **I'm not sure data is being used for accountability and I also believe the Execs have a hard time prioritizing work.**

> **Our executive team does a great job of working hard to collaborate and share data.**

Stakeholder Survey Questions

Page 1 of 4

Emergency Department	**Patient Flow Management** Both treat & release and admitted patients are registered, triaged, treated and dispositioned safely and efficiently to avoid long wait times, left without being seen (LWBS) and holds
Emergency Department	**Staffing Complement, Ratios and Assignments** Staffing is based on demand as patient volume varies by time of day and day of week
Emergency Department	**Collaborative Working Environment** Emergency department physicians, advanced practice providers, nurses, technicians and administrators collaborate effectively to drive quality of care, emergency department length of stay and patient safety
Emergency Department	**Ancillary Services** Turnaround times for lab, pharmacy, radiology, non-invasive cardiology, transport, etc. support safe and efficient clinical decision-making and emergency department length of stay for both treat & release and admitted patients
Emergency Department	**Consult Services** Turnaround times for medical and surgical consults are timely to support safe and effective clinical decision-making and emergency department length of stay for both treat & release and admitted patients
Emergency Department	**ED Boarding** Hospital measures and sets goals for mitigating and managing patients boarding in the emergency department
Emergency Department	**Admission Process from ED** Minimal (below 2%) left without being seen (LWBS) and holds, admission service agreements in place, effective bed management, and good handoff communication

Stakeholder Survey Questions

Page 2 of 4

Inpatient	**Patient Flow Management** Multi-disciplinary rounds and huddles are in place with high levels of provider engagement; there is patient and team co-horting as well as clinical coverage models, co-management agreements
Inpatient	**Staffing Complement, Ratios and Assignments** Aligned with current national benchmarks; staffing is appropriate during days / nights and weekdays / weekends
Inpatient	**Collaborative Working Environment** There are unit-based triads (MD/RN/CM) with roles defined, coordinated responsibilities to drive progression of care, length of stay and transitions of care, multi-disciplinary rounds are standard, physician-led / team driven and support interdisciplinary decision-making
Inpatient	**Clinical Variation Management** Appropriate utilization of acute care resources from admission through discharge; use of evidence-based guidelines to support clinical practice and decision-making to optimize care delivery and outcomes
Inpatient	**Discharges and Handovers** Medication reconciliation and medications to beds, home health and post-acute care (PAC) network that meet patient population needs, seamless information sharing within the acute care settings and across the continuum to support patient progression

Stakeholder Survey Questions

Page 3 of 4

Case Management	**Organization and Management Structure** Care Management has a clear vision, defined roles & responsibilities / accountability, is well coordinated throughout the continuum of care, and has meaningful physician leadership (Physician Advisor) and engagement
Case Management	**Core Workflows and Roles** Each role has clarity on their respective responsibilities, care managers assume ownership role of length of stay and are considered length of stay experts
Case Management	**Staffing Complement, Ratios and Assignments** Aligned with current national benchmarks; staffing is appropriate during days / nights and weekdays / weekends
Case Management	**Technology** Electronic medical record (or other IT-driven tools) support coordination between transitions of care, utilization management communications with payors, and across the care team
Case Management	**Performance Monitoring** Reports and dashboards are available to monitor performance; leadership utilizes them to drive performance and accountability

Stakeholder Survey Questions

Page 4 of 4

Foundational	**Leadership and Management Competencies** Executive leaders foster a proactive and collaborative culture, utilize data to manage performance, and demonstrate value of work to the organization
Foundational	**Capacity & Demand Management** Right-sized, configured and allocated acute care capacity based on demand; patients are assigned to the right level of care the majority of the time; patients are placed on the right unit the majority of the time; predictable sources of demand are managed to reduce variability of physical and staffed capacity utilization
Foundational	**Policies and Procedures** There are common departmental and hospital-wide policies and procedures in place that are routinely followed to support patient throughput (e.g., escalation pathways to address barriers to discharge)
Foundational	**Collaborative Working Environment** Clinical, operational and information technology leaders, managers and frontline staff across all hospital areas collaborate effectively to support safe and efficient patient throughput

APPENDIX 3

Interview & Observation Themes

What We Are Hearing

"The issue is the hustle"

"Inefficient processes are discouraging"

"People don't want to impose expectations"

"Provider education around Observation patients is an opportunity"

"People are able to make things happen when they want to; however, project management skills vary among leaders"

"We don't care what her ferritin level is. We need to know what her discharge needs are going to be."

"Sometimes doctors are writing conflicting orders"

"Compassion with the group is work in progress"

"We have been able to handle these volumes before. COVID has stressed staffing and resources."

"The right people aren't all hearing daily reports"

What We Are Seeing

Page 1 of 3

- **Daily Hospital Huddle (7:45 am):**
  - **Information-sharing vs. problem solving**
  - Not **anticipatory** (ED boarders, pending ICU transfers, surgical volume, outside hospital transfers, etc.)
  - Some **key disciplines missing** (Environmental Services, Patient Transport, Pharmacy, Clinical Engineering, Infection Prevention & Control, Executive Sponsorship, etc.)
  - **No physician** participation
  - **Not fully scripted**
  - Is it necessary/efficient to have these meetings **in person**?

What We Are Seeing

Page 2 of 3

- **Daily Discharge Rounds (10 am):**
  - **Physician participation** in daily discharge rounds is inconsistent at best
  - Nursing staff are **well informed** of patients' clinical / disposition needs and barriers
  - Nursing and case management appear to **work collaboratively** but neither were clear on anticipated discharges for following day(s)
  - Hospitalists are **not documenting in real-time** (placement of orders are batched)
  - Daily discharge rounds are not truly multidisciplinary
  - **Relying on paper**; no central patient unit whiteboard with tasks, accountability and timelines
  - Charge RN and / or Case Manager facilitates daily discharge rounds and **keeps everyone focused**; still lasts about 40-60 min (depending on the unit and number of patients)
  - Case management and nursing appear to be **managing DME-associated discharge needs** and follow-up appointments – can these tasks be delegated?

What We Are Seeing

- **General Observations:**
  - **Telemetry** capacity does not seem to be a major inhibitor of patient flow
  - Patient movement (aka bed changes / **intra-hospital transfers**) is not a major barrier and does not seem to consume significant administrative time
  - **Charge nurses** take patient volume if needed
  - **Patient assignment** is bed availability driven → there is little cohorting occurring; Observation patients are not cohorted
  - Batched discharges may be **hiding virtual bed availability**
  - **Timely discharges (i.e., before 12 pm) are not a priority**
  - Environmental Services & Transport **staffing does not always match demand** for evenings and nights
  - Bed Coordinators pivot between TeleTracking and Cerner all day

APPENDIX 4

Emerging Insights

Emerging Insights – Emergency Department Flow

Page 1 of 2

INSIGHTS

- Between May 1, 2020 – August 14, 2021, daily Emergency Department (ED) volumes have **increased significantly to mid-220s**[1] since early spring 2020 (Chart 1); however, **current ED daily volumes are similar to FY 2019 daily volumes**
  - FY 2019 average daily ED volume = 225[2]
  - FY 2020 average daily ED volume = 213[2]
- See Appendix 5 for **ED workforce analysis**
- Including ED & 1E patients, **average ED census peaks at 7 pm with 73 patients** (Chart 2); on Mondays average ED census peaks between 6 – 8 pm at 81 patients
- **ED holds** (inpatient or observation patients waiting in virtual 1E unit for a hospital bed) **peak at 31 patients between 5-7 pm** (Chart 3)
- **Door to provider in triage** trended down and is now between 10-11 minutes for July – September 2021, which is **better than leading practice**

SUPPORTIVE ANALYTICS

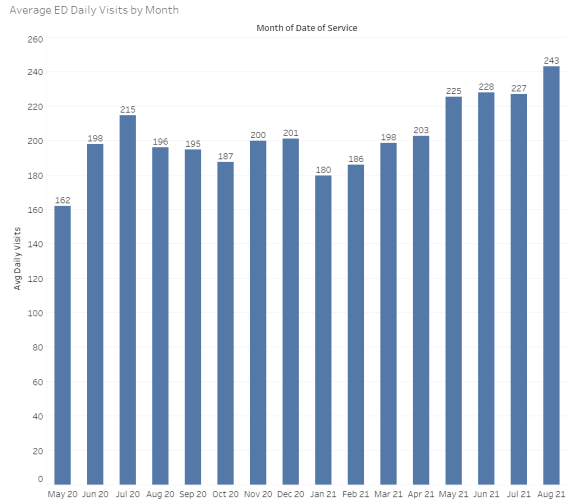


Chart 1: Average Daily ED Visits by Month

Census Date Time

Weekday of..	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	0	1	2	3	4	5
Mon	37	38	39	43	49	56	63	70	75	78	78	80	81	81	81	79	76	71	57	54	50	46	42	39
Tue	36	37	39	42	48	54	60	65	69	72	73	75	76	78	77	73	70	66	67	61	54	48	44	40
Wed	34	34	35	38	42	50	56	63	67	70	72	74	74	75	73	71	68	64	62	56	50	44	40	36
Thu	33	34	36	41	47	54	61	67	71	73	75	77	78	79	76	73	70	66	60	54	50	45	40	37
Fri	32	32	33	38	43	51	58	64	69	73	73	74	76	78	76	72	69	66	61	55	50	44	39	35
Sat	32	31	32	34	39	45	50	56	60	62	62	64	65	66	64	63	62	60	61	55	49	43	39	34
Sun	33	33	34	37	41	46	51	55	59	61	62	62	61	62	61	62	61	60	56	53	48	44	40	36
Grand Total	33	33	34	38	43	50	56	61	65	68	69	71	72	73	72	69	67	64	60	55	49	44	40	36

Chart 2: ED Census by Day of Week & Hour of Day

Census Date Time

Encounter Type	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	0	1	2	3	4	5
Emergency	17	16	17	20	23	27	31	34	37	38	39	40	41	42	42	41	40	39	36	33	29	25	22	19
Inpatient	12	13	13	14	15	17	19	20	22	22	23	23	23	23	22	21	20	19	18	17	15	14	14	13
Observation	4	4	4	5	5	6	6	7	7	7	7	8	7	8	7	7	6	6	6	5	5	5	4	4
Grand Total	33	33	34	38	43	50	56	61	65	68	69	71	72	73	72	69	67	64	60	55	49	44	40	36

Chart 3: ED Census by Encounter Type & Hour of Day

[1]Reconciliation with Kaweah Health metric definitions in progress
[2]Kaweah Health Annual Board Report, Emergency Services Summary, Key Metrics – FY 2021 Ten Months Ended April 30, 2021 Annualized

Emerging Insights – Emergency Department Throughput

Page 2 of 2

INSIGHTS

- Average ED **length of stay (LOS) climbs** throughout the day as the velocity of arrivals increases (Chart 1); morning discharges will be key to decanting the ED before peak arrivals
- **Average ED LOS is longest at 7 hours on Wednesdays** despite being the 4th highest day from a volume perspective (Chart 2)
- Wednesdays also have the **longest average ED LOS for admitted patients** (11.6 hours), coinciding with **Hospitalist switch day**[1]
- **Admission criteria are not readily available** or referenced; many layers of clinicians are reviewing admission for appropriateness
- **20% of ED visits are admitted to inpatient** services (excluding observation status)[1]
- **Left without being seen** visits are trending up, close to 2.0% in June 2021 and August 2021

SUPPORTIVE ANALYTICS

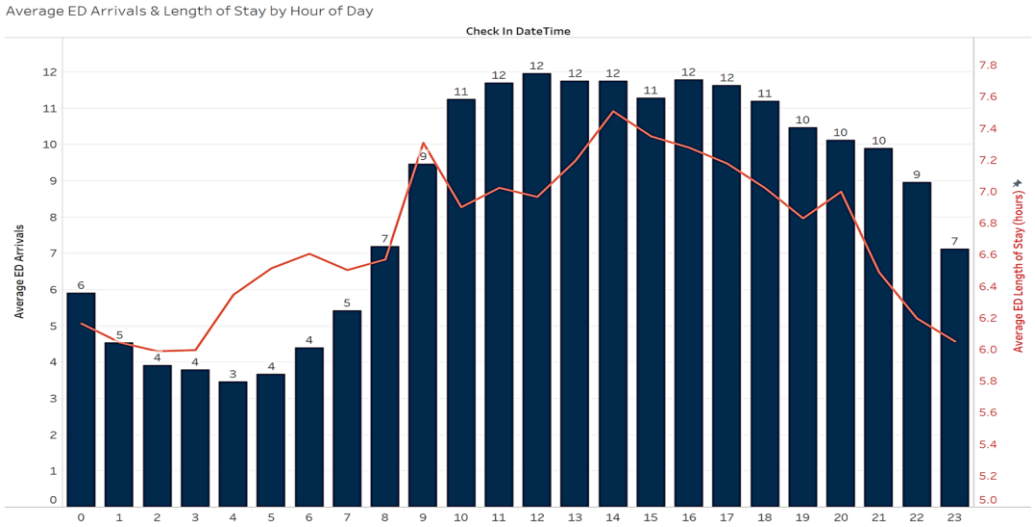


Chart 1: Average ED Arrivals & LOS by Hour of Day

Average ED Length of Stay by Day of Week & Disposition

Disposition Type	Date of Service: Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Grand Total
Admitted	11.3	10.9	11.6	10.6	10.9	10.6	10.8	11.0
Divert/Transfer	12.6	12.2	11.9	12.0	12.0	14.1	13.7	12.6
Expired	7.2	7.0	6.0	5.5	6.6	6.2	6.2	6.4
Left/Not Seen	1.6	2.0	2.4	2.3	1.6	2.3	1.3	1.9
Treat & Release	4.8	4.6	4.8	4.9	4.9	4.6	4.6	4.7
Other	4.8	4.2	4.6	4.7	4.7	4.9	4.4	4.6
Grand Total	6.9	6.6	7.0	6.7	6.9	6.6	6.6	6.8

Average Daily Visits by Day of Week & Disposition

Disposition Type	Date of Service: Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Grand Total
Admitted	55	52	54	54	57	49	46	53
Divert/Transfer	10	10	10	11	10	10	10	10
Expired	1	1	1	1	0	0	0	1
Left/Not Seen	3	2	2	2	2	2	2	2
Treat & Release	135	123	124	127	126	126	123	126
Other	9	8	9	9	9	7	7	8
Grand Total	213	196	200	204	205	194	189	200

Chart 2: Average ED LOS by Day of Week & Disposition

Emerging Insights – Observation Status Utilization

INSIGHTS

- Between May 1, 2020 and August 14, 2021, **24%** of patients admitted to Kaweah Health were **placed in observation status** (Chart 1). This percentage is trending upwards and above leading practice of ~20%
- Although dedicated space for observation patients existed pre-COVID, **observation patients are now scattered** throughout the hospital
- The average LOS (in hours) for patients placed in observation status has **also increased recently from the low-40s to mid-40s** (Chart 2)
- **31%** of observation patients have an average LOS of **greater than 48 hours**
- The proportion of observation patients with a **LOS greater than 72 hours is also increasing**, while those with a LOS of 12-23 hours is decreasing (Chart 3)
- Education around appropriateness of observation vs. inpatient status may be an area of opportunity as **conflicting admission orders are reported to be somewhat frequent**

SUPPORTIVE ANALYTICS

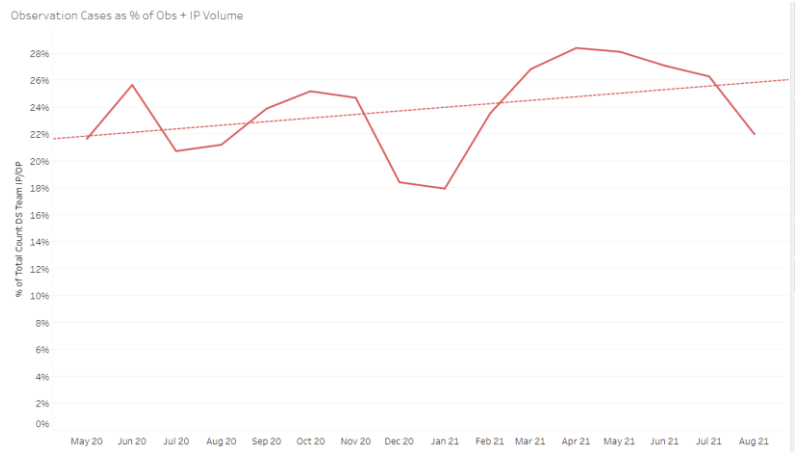


Chart 1: Observation Cases as % of Obs + Inpatient Volume

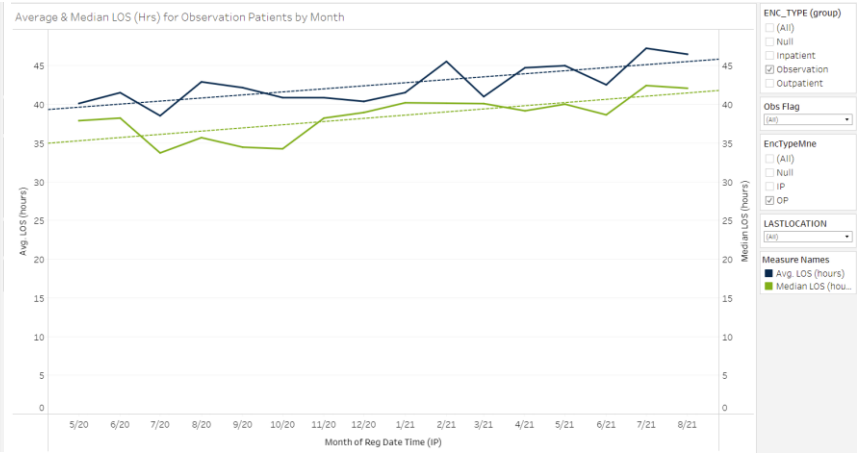


Chart 2: Average & Median LOS (Hours) for Obs by Month

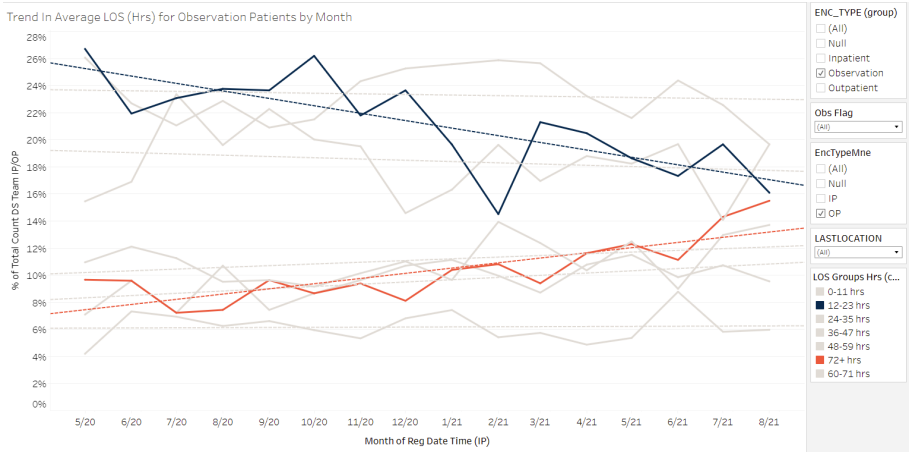


Chart 3: Trend in Average LOS (hours) for Obs by Month

Emerging Insights – Progression of Care

INSIGHTS

- Multidisciplinary huddles occur throughout the day and at varying levels of the organization; however, the huddles **lack provider involvement** and are more **focused on information-sharing** than problem solving (Chart 1)
- **Anticipated date of discharge is not transparent** to all disciplines (i.e., Lab, Radiology, Pharmacy, Therapies, etc.) to enable corresponding prioritization of resources
- **Lack of integration between Cerner and TeleTracking** systems can cause delays around ED patient placement, patient progression to lower levels of care, and terminal EVS cleaning
- Between May 1, 2020 – August 31, 2021, inpatients **admitted on Wednesdays and Thursdays have the highest observed-to-expected** (O/E LOS) of 1.42 & 1.44 respectively, potentially due to availability of certain services on weekends (Chart 2)
- Based on recent inpatient discharges between January 1 – August 31, 2021, if **O/E LOS of 1.44 is decreased by 5 – 15%** to between 1.22 – 1.37, Kaweah Health could **gain an estimated 13 – 40 available beds** (see Appendix 7 for **benefit realization methodology**)
- These available beds could be used for **ED holds, backlog of elective surgical admissions and transfer requests**

SUPPORTIVE ANALYTICS

Meeting	Time	MD / APP	Bedside RN	Charge RN	CM	RN Supv	Bed Coord	Staff Coord	Goal(s)
Safety Huddle	6:00 AM		X	X					Patient safety discussion
Hospital Huddle	7:45 AM			X		X	X	X	Bed management & staffing touch base
Provider Rounds	~7-9:00 AM	X	+/-						Patient care progression
Discharge Rounds	10:00 AM		X	+/-	X				Discharge planning
Staffing Huddle	4:00 PM			X		X	X	X	Bed management & staffing touch base
Safety Huddle	6:00 PM		X	X					Patient safety discussion

Chart 1: Hospital Huddles & Rounds by Participant

	Discharge Day							
Admission Day: Weekday of Admit Date..	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Grand Total
Mon	1.72	1.13	1.21	1.25	1.35	1.53	1.67	**1.33**
Tue	1.60	1.96	1.09	1.16	1.34	1.29	1.42	**1.36**
Wed	1.66	1.92	1.70	1.26	1.21	1.18	1.26	**1.42**
Thu	1.44	1.75	1.89	1.76	1.36	0.97	1.09	**1.44**
Fri	1.24	1.54	1.56	1.67	1.79	1.08	0.92	**1.38**
Sat	1.13	1.30	1.44	1.56	1.83	1.79	0.85	**1.38**
Sun	1.28	1.15	1.41	1.49	1.59	1.66	1.46	**1.39**
Grand Total	**1.41**	**1.48**	**1.43**	**1.39**	**1.44**	**1.26**	**1.15**	**1.38**

Chart 2: O/E LOS by Admission & Discharge Day of Week

Emerging Insights – Inpatient Timely Discharges

INSIGHTS

- Providers have a goal to enter **discharge orders by 10 am**; however, between May 1, 2020 – August 31, 2021, this is accomplished **only 23%** of the time (Chart 1)
- It appears that providers are **not documenting in the electronic medical record (EMR) in real-time**, which may cause progression of care and disposition delays for other care team members
- Although there is an organizational focus on discharges before 12 noon, this **does not seem to be a priority for frontline staff**
- Only **9% of patients are discharged before 12 pm** (Chart 1). The leading practice is closer to 40% or higher. The average time between discharge order and discharge time is 8.8 hours (median of 3.4 hours)
- Late afternoon discharges coupled with existing ED holds **create a backlog of demand for inpatient beds in the ED and elsewhere**, which in turn can cause patient throughput delays for other ED patients (Chart 2)
- Inpatient bed availability limits progression of care out of the intensive care units and Kaweah Health's **ability to accept direct admissions or external transfers**

SUPPORTIVE ANALYTICS

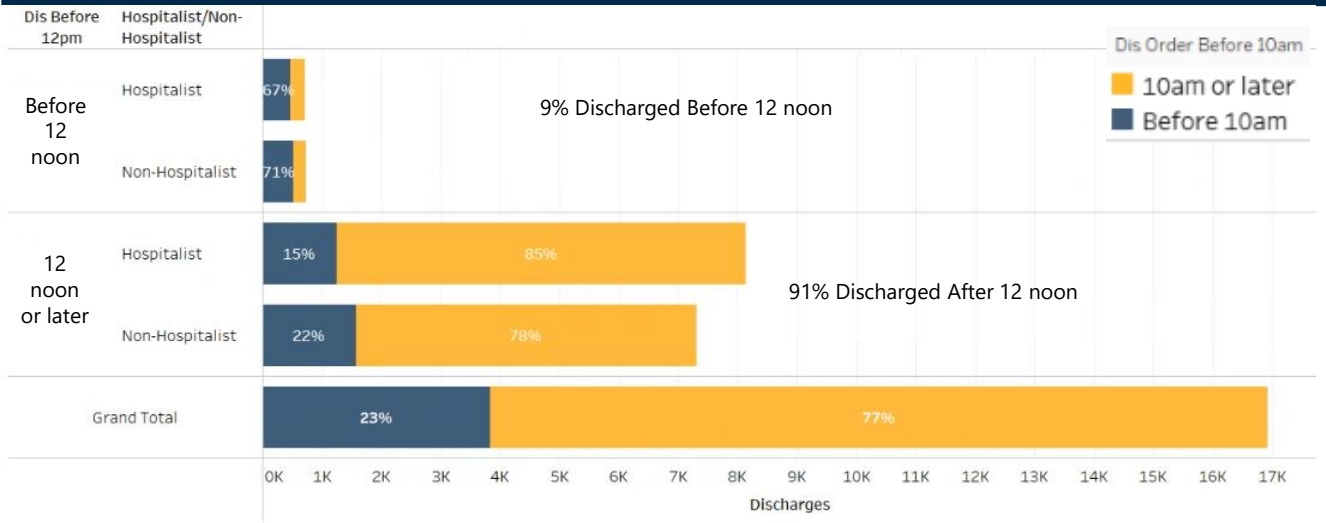


Chart 1: Inpatient Discharge Volume by Discharge Order Time & Discharge Time

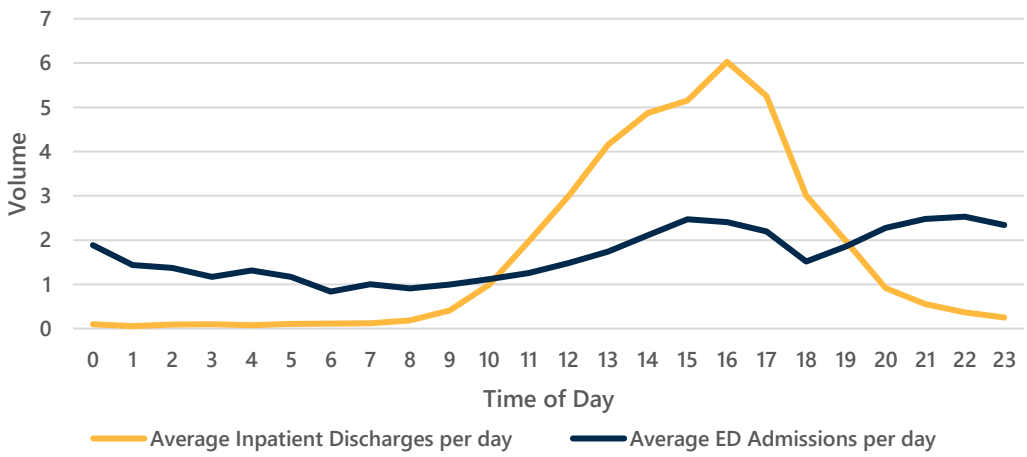


Chart 2: ED Admissions to Inpatient & Inpatient Discharges by Time of Day

Emerging Insights – Transitions of Care

INSIGHTS

- Between May 1, 2020 – August 31, 2021, a combined 33% of inpatients were discharged to **home with services (18%), a skilled nursing facility (12%) or acute rehabilitation hospital (3%)** (Chart 1)
- Patients discharged to **home with services had an ALOS of 6.6 days** and O/E LOS of 1.42 (Chart 1)
- Patients discharged to a **skilled nursing facility (SNF) had an ALOS of 9.7 days** and O/E LOS of 2.08, partially due to SNF bed availability or insurance authorization (Chart 1)
- During discharge round observations, many patients were pending **SNF bed availability or insurance authorization, DME and/or oxygen**, which required lots of follow-up from the Case Managers
- Throughput rounding tool (TRT) data does **not capture barriers that arise on Saturdays or Sundays**, likely due to minimal Care Management staffing
- Between July 1 – August 31, 2021, **O/E LOS was significantly higher for patients with documented TRT barriers**, especially those discharged home with services or to a SNF (Chart 2)

SUPPORTIVE ANALYTICS

Discharge Disposition	Inpatient Discharge Volume	% of Total	ALOS	O/E LOS
D/T to home w/ home health care	3,401	18%	6.6	1.42
D/T to SNF	2,370	12%	9.7	2.08
Expired	1,189	6%	10.1	1.57
Left against Medical Advice	543	3%	4.0	1.00
D/T to Rehab	540	3%	10.1	1.93
D/T to hospice - home	474	2%	7.8	1.71
D/T to other Acute Hospital	302	2%	7.0	1.37
All other <300 discharges	435	2%	8.7	1.26
Grand Total	18,985	100%	6.0	1.31

Chart 1: Inpatient Discharge Volume, % of Total, ALOS & O/E LOS by Discharge Disposition

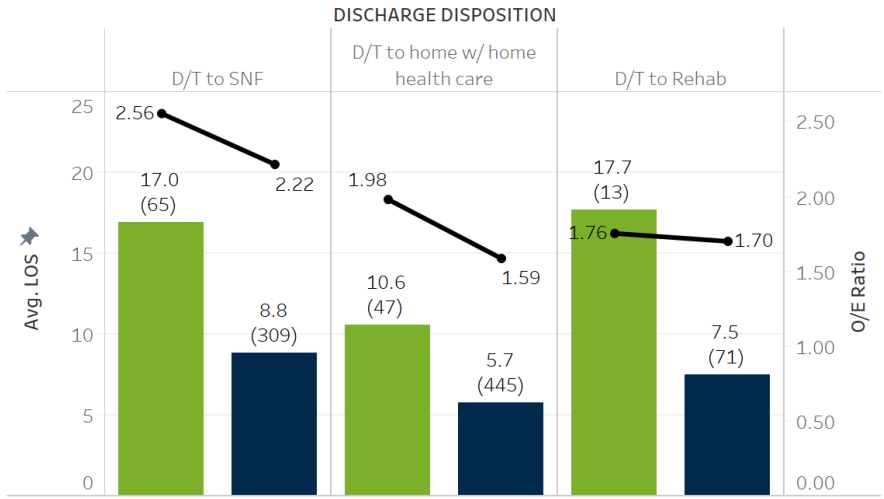


Chart 2: Throughput Rounding Tool Barriers by Discharge Disposition

Emerging Insights – Post-Acute Care Opportunity

INSIGHTS

- Between July 1 – August 31, 2021, within the Throughput Rounding Tool, **second to placement to SNF, placement for homeless was the most frequently documented barrier**, followed closely by DME (Charts 1 & 2)
- The 23 patients with a **placement for homeless** barrier had an average LOS of 13.6 and an **O/E LOS of 3.01** (Chart 2); this equates to almost 210 excess days or 57% of 1 med / surg bed for a year
- Between May 1, 2020 – August 31, 2021, **19% of MediCal patients** were discharged from Kaweah Health with **post-acute care (PAC) services** (including home w/services, skilled nursing facility or acute rehabilitation) **compared to 46% of Medicare patients** (Chart 3)
- If Kaweah Health **increases the proportion of MediCal patients discharged with post-acute services to its overall PAC utilization rate of 33%**, closer to industry standard of 35%, it would require an estimated 10-12 SNF beds and 5-7 medical respite / respite / post-discharge housing beds (see Appendix 7 for **PAC methodology**)

SUPPORTIVE ANALYTICS

Parent Barrier Name	Encoun..	Avg. LOS	O/E Ratio
Clinical Services	38	9.0	1.99
Finance	8	24.0	4.30
Placement	116	14.4	2.51
Procedures	50	9.8	2.39
Providers	27	11.3	3.13
Support Services	20	9.5	2.17
Transport	4	9.0	2.29

Chart 1: Throughput Rounding Tool Barriers by Parent Barrier

Placement	SNF	65	14.9	2.76
	Homeless - SB1152 in pro..	23	13.6	3.01
	Family/Social Issues	18	13.7	2.48
	Acute Rehab	13	14.5	3.33
	New Dialysis Setup	6	18.2	2.79
	Mental Health	3	10.3	3.10
	Pending Acute Transfer	2	11.5	2.77

Chart 2: Throughput Rounding Tool Placement Barriers by Barrier

Discharge Disposition	Medicare		MediCal		Overall	
	DCs	% of Total	DCs	% of Total	DCs	% of Total
Home w/ home health care	2,284	23%	694	12%	3,401	18%
Skilled nursing facility	1,980	20%	255	4%	2,370	12%
Acute rehabilitation	280	3%	150	3%	540	3%
Post-Acute Care Subtotal	4,544	46%	1,099	19%	6,311	33%
Total DCs	**9,952**		**5,724**		**18,985**	

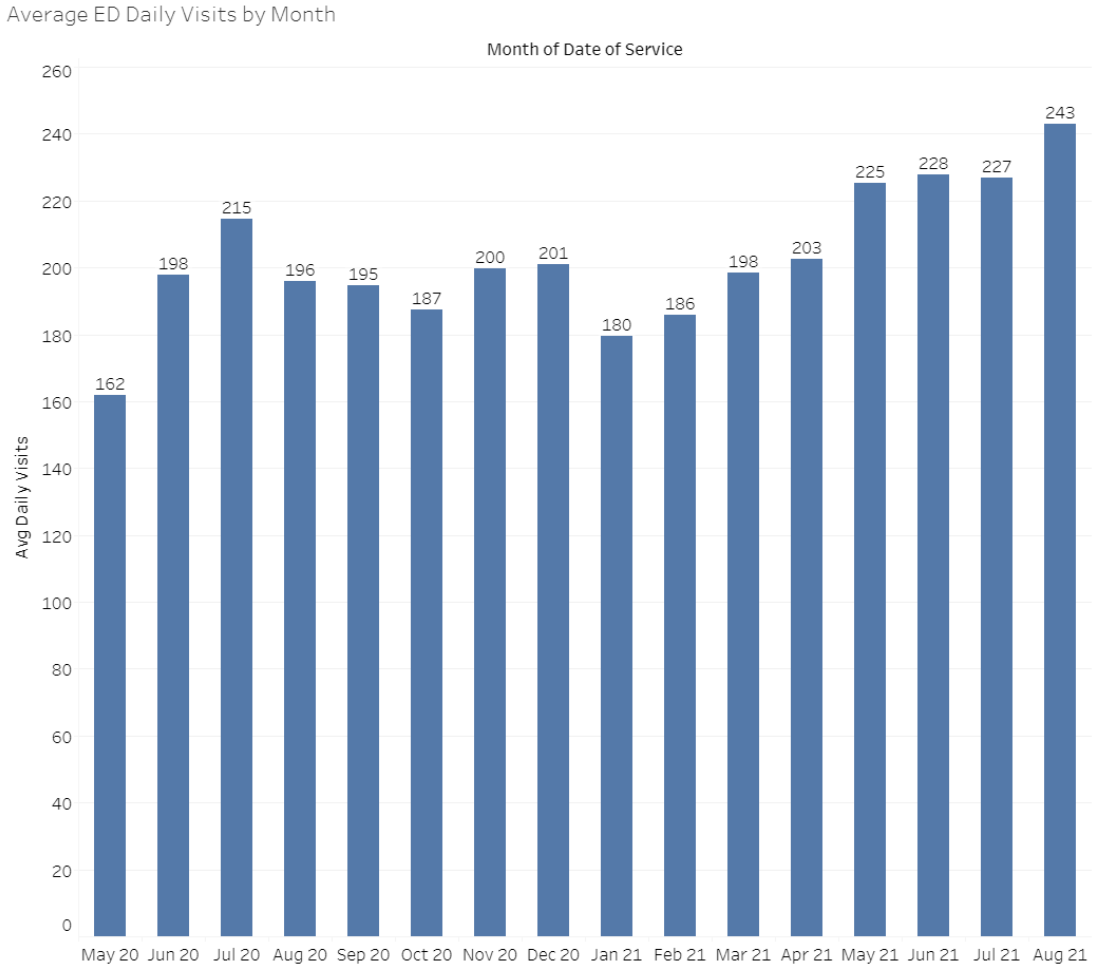
Chart 3: Post-Acute Care Utilization by Payor

APPENDIX 5

Data Analytics

Preliminary Insights from Data Analytics

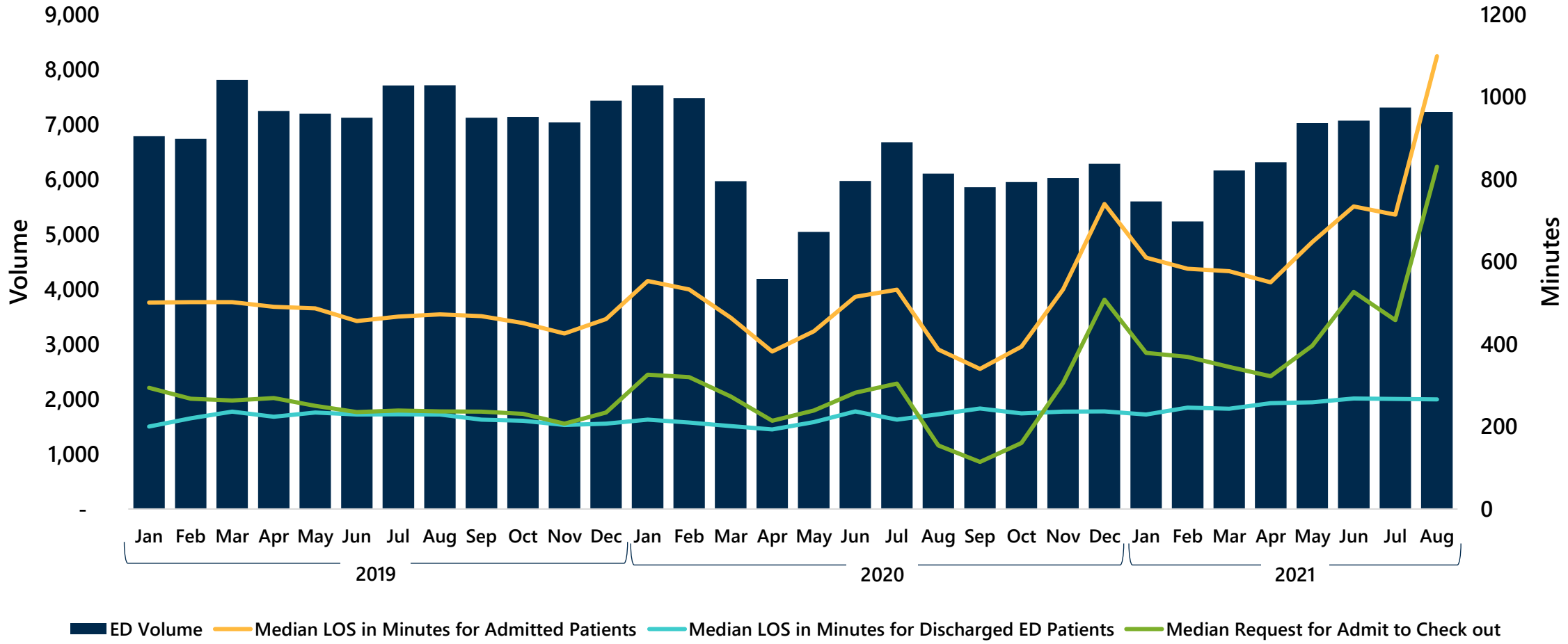
Between May 1, 2020 – August 14, 2021, daily Emergency Department (ED) volumes have increased significantly to mid-220s since early spring 2020; however, current ED daily volumes are similar to FY 2019 daily volumes….



Data period: May 1, 2020 – August 14, 2021
Excludes: "Null" ESI values, Moms and Newborns, Behavioral Health

Preliminary Insights from Data Analytics

Between May 1, 2020 – August 14, 2021, daily Emergency Department (ED) volumes have increased significantly to mid-220s since early spring 2020; however, current ED daily volumes are similar to FY 2019 daily volumes



Data period: January 1, 2019 – August 31, 2021

Preliminary Insights from Data Analytics

Including ED & 1E patients, average ED census peaks at 7 pm with 73 patients (Chart 2). On Mondays average ED census peaks between 6 – 8 pm at 81 patients

	Census Date Time																						
Weekday of..	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	0	1	2	3	4	5
Mon	37	38	39	43	49	56	63	70	75	78	78	80	81	81	81	79	76	71	57	54	50	46	42	39
Tue	36	37	39	42	48	54	60	65	69	72	73	75	76	78	77	73	70	66	67	61	54	48	44	40
Wed	34	34	35	38	42	50	56	63	67	70	72	74	74	75	73	71	68	64	62	56	50	44	40	36
Thu	33	34	36	41	47	54	61	67	71	73	75	77	78	79	76	73	70	66	60	54	50	45	40	37
Fri	32	32	33	38	43	51	58	64	69	73	73	74	76	78	76	72	69	66	61	55	50	44	39	35
Sat	32	31	32	34	39	45	50	56	60	62	62	64	65	66	64	63	62	60	61	55	49	43	39	34
Sun	33	33	34	37	41	46	51	55	59	61	62	62	61	62	61	62	61	60	56	53	48	44	40	36
Grand Total	33	33	34	38	43	50	56	61	65	68	69	71	72	73	72	69	67	64	60	55	49	44	40	36

Data period: May 1, 2020 – August 14, 2021
Includes: All Encounter Types

Preliminary Insights from Data Analytics

ED holds (inpatient or observation patients waiting in virtual 1E unit for a hospital bed) peak at 31 patients between 5-7 pm

	Census Date Time																							
Encounter Type	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	0	1	2	3	4	5
Emergency	17	16	17	20	23	27	31	34	37	38	39	40	41	42	42	41	40	39	36	33	29	25	22	19
Inpatient	12	13	13	14	15	17	19	20	22	22	23	23	23	23	22	21	20	19	18	17	15	14	14	13
Observation	4	4	4	5	5	6	6	7	7	7	7	8	7	8	7	7	6	6	6	5	5	5	4	4
Grand Total	33	33	34	38	43	50	56	61	65	68	69	71	72	73	72	69	67	64	60	55	49	44	40	36

Data period: May 1, 2020 – August 14, 2021
Excludes: "Other" Encounter Types

Preliminary Insights from Data Analytics

Left without being seen visits are trending up, close to 2.0% in June 2021 and August 2021

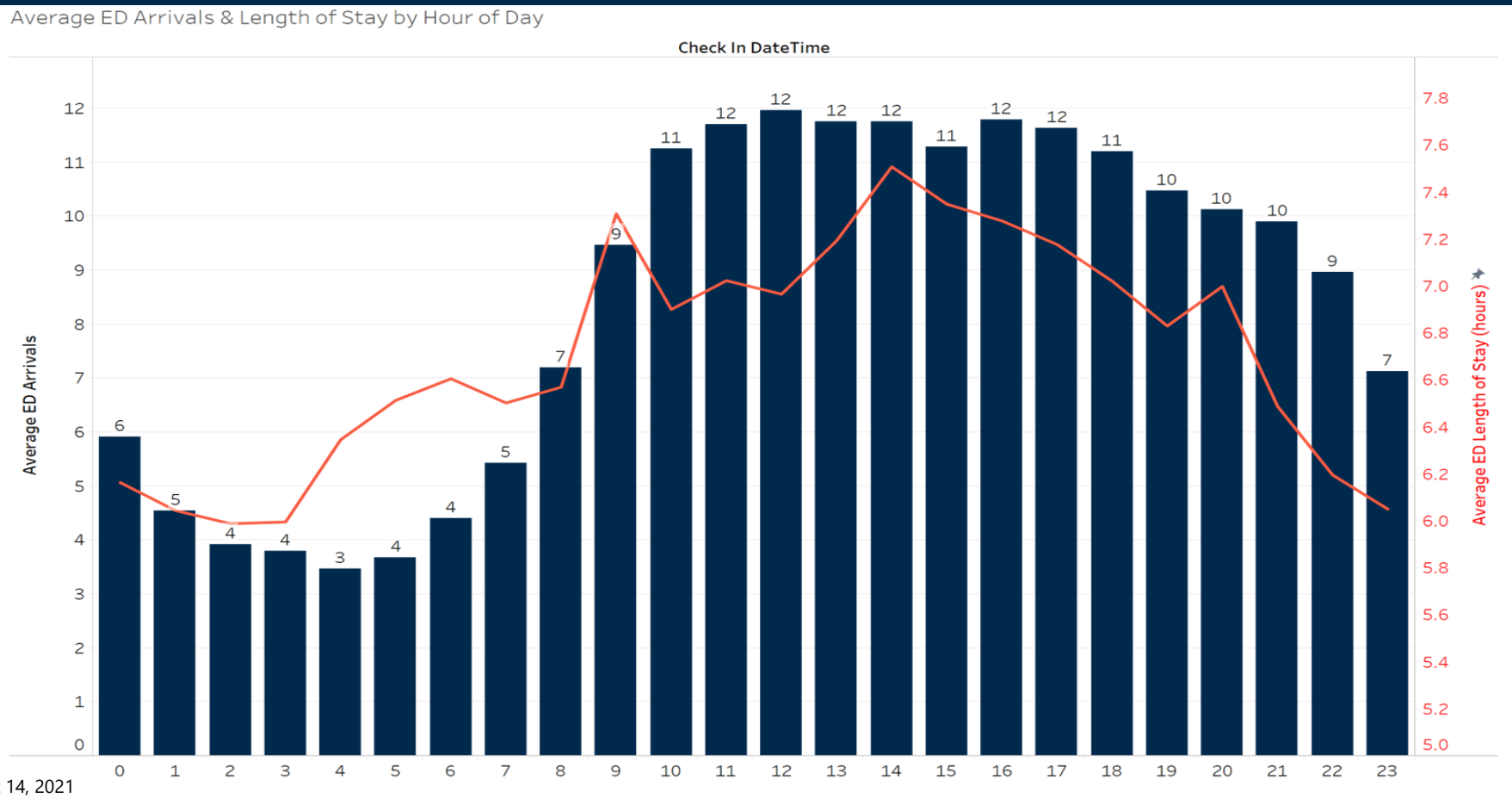
Average Daily Visits by Day of Week & Disposition

	Disposition Type						
Month, Year of Date of Service	Treat & Release	Admitted	Divert/ Transfer	Left During Treatment	Left against Medical Advice	Left/Not Seen	Expired
May 2020	61.9%	29.1%	5.4%	2.0%	0.9%	0.5%	0.2%
June 2020	64.2%	26.6%	5.4%	2.3%	1.0%	0.4%	0.1%
July 2020	66.6%	25.3%	3.8%	2.5%	1.2%	0.4%	0.2%
August 2020	64.4%	26.3%	5.0%	2.0%	1.4%	0.7%	0.2%
September 2020	62.2%	26.8%	6.0%	2.5%	1.7%	0.7%	0.2%
October 2020	63.5%	26.9%	5.2%	2.1%	1.5%	0.6%	0.2%
November 2020	63.2%	26.9%	5.0%	2.5%	1.1%	0.9%	0.4%
December 2020	64.1%	26.3%	4.3%	2.5%	1.4%	0.8%	0.6%
January 2021	63.2%	27.0%	5.5%	2.2%	1.4%	0.4%	0.3%
February 2021	60.5%	28.6%	5.5%	2.9%	1.4%	0.7%	0.4%
March 2021	61.9%	28.0%	5.6%	2.3%	1.3%	0.6%	0.3%
April 2021	61.9%	26.7%	5.5%	3.2%	1.5%	1.0%	0.2%
May 2021	62.5%	25.6%	5.0%	3.4%	1.7%	1.6%	0.1%
June 2021	63.1%	24.2%	4.8%	3.8%	2.0%	1.8%	0.2%
July 2021	65.1%	23.3%	5.3%	3.3%	1.7%	1.3%	0.1%
August 2021	64.0%	22.0%	4.8%	5.3%	2.1%	1.6%	0.3%

Data period: May 1, 2020 – August 14, 2021
Excludes: "Null" ESI values, "Other" Disposition Types, Moms and Newborns, Behavioral Health, and Peds

Preliminary Insights from Data Analytics

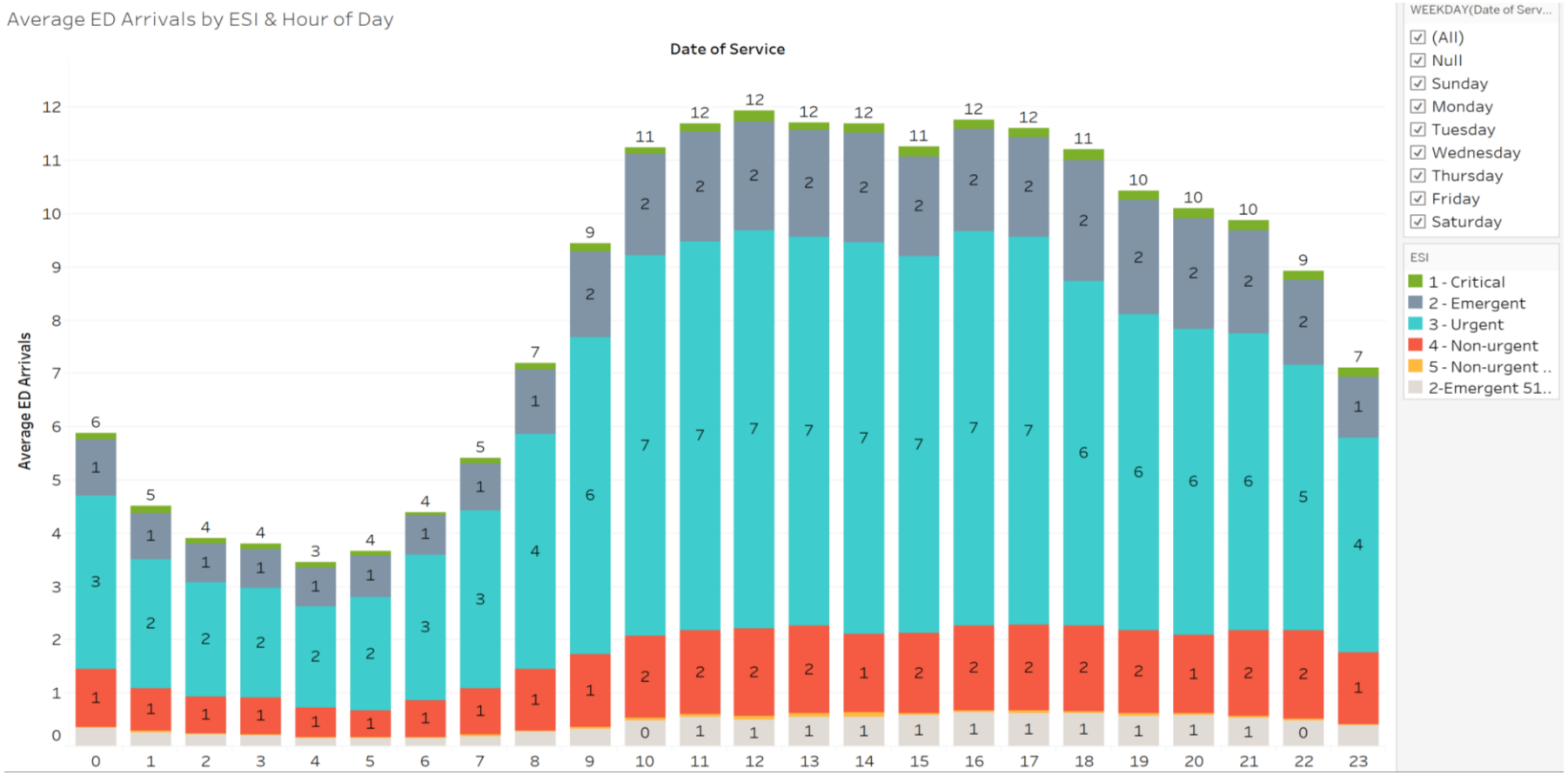
ED length of stay (LOS)[1] climbs as the velocity of arrivals increases. Morning discharges will be key to decanting the ED before peak arrivals.



Data period: May 1, 2020 – August 14, 2021
[1]ED LOS = Hours between check-in date/time and check-out date/time
Excludes: Moms and Newborns, Behavioral Health, and Peds

Preliminary Insights from Data Analytics

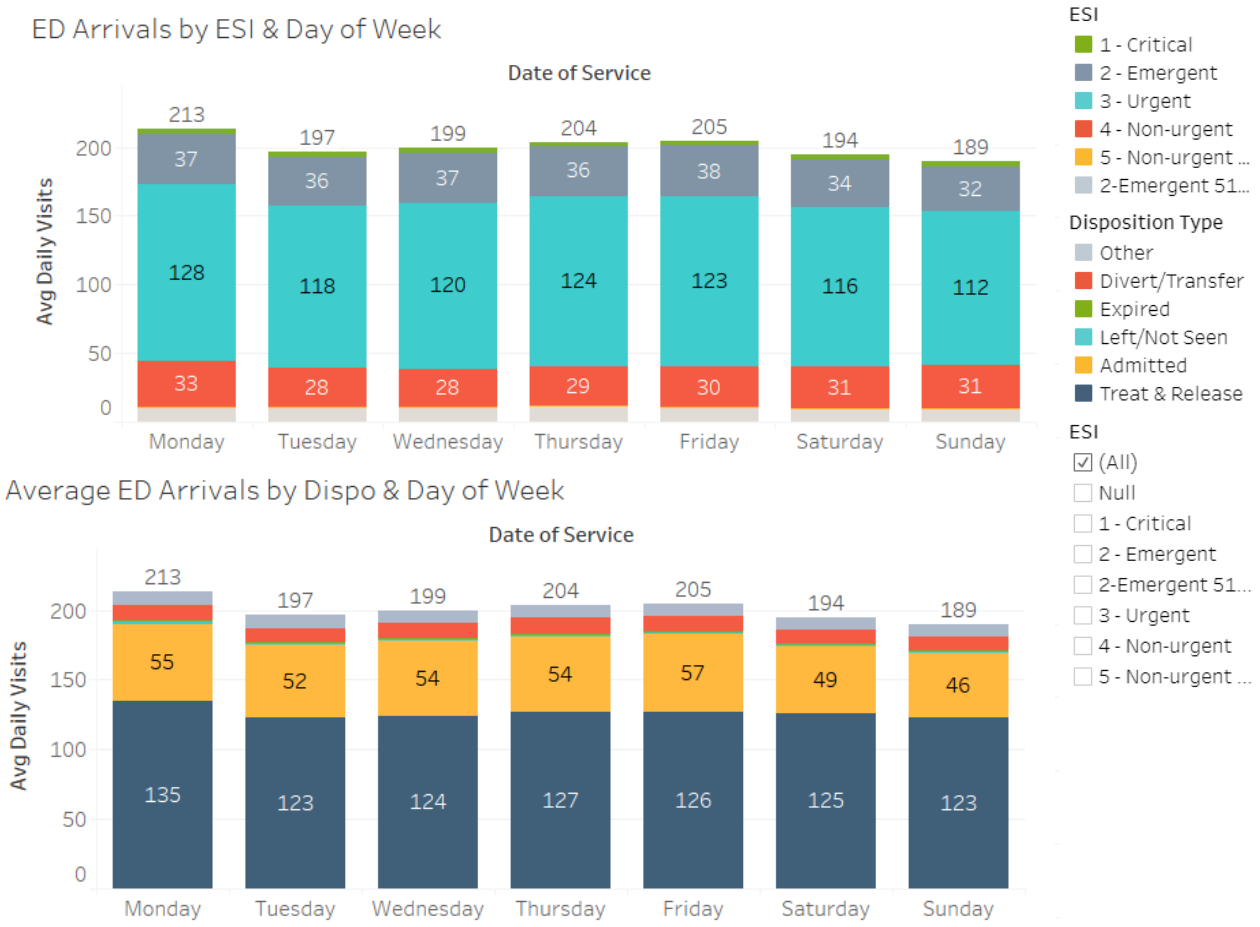
An analysis of arrivals to the ED follows an expected pattern, with an increase in the hourly arrival rate beginning at 7 am and peaking midday.



Data period: May 1, 2020 – August 14, 2021
[1]ED LOS = Hours between check-in date/time and check-out date/time
Excludes: Moms and Newborns, Behavioral Health, and Peds

Preliminary Insights from Data Analytics

ED volumes peak early in the week…



Data period: May 1, 2020 – August 14, 2021
Excludes: Moms and Newborns, Behavioral Health, and Peds

Preliminary Insights from Data Analytics

Average ED LOS[1] is longest at 7 hours on Wednesdays despite being the 4th highest day from a volume perspective.

Average ED Length of Stay by Day of Week & Disposition

	Date of Service							
Disposition Type	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Grand Total
Admitted	11.3	10.9	11.6	10.6	10.9	10.6	10.8	11.0
Divert/Transfer	12.6	12.2	11.9	12.0	12.0	14.1	13.7	12.6
Expired	7.2	7.0	6.0	5.5	6.6	6.2	6.2	6.4
Left/Not Seen	1.6	2.0	2.4	2.3	1.6	2.3	1.3	1.9
Treat & Release	4.8	4.6	4.8	4.9	4.9	4.6	4.6	4.7
Other	4.8	4.2	4.6	4.7	4.7	4.9	4.4	4.6
Grand Total	6.9	6.6	7.0	6.7	6.9	6.6	6.6	6.8

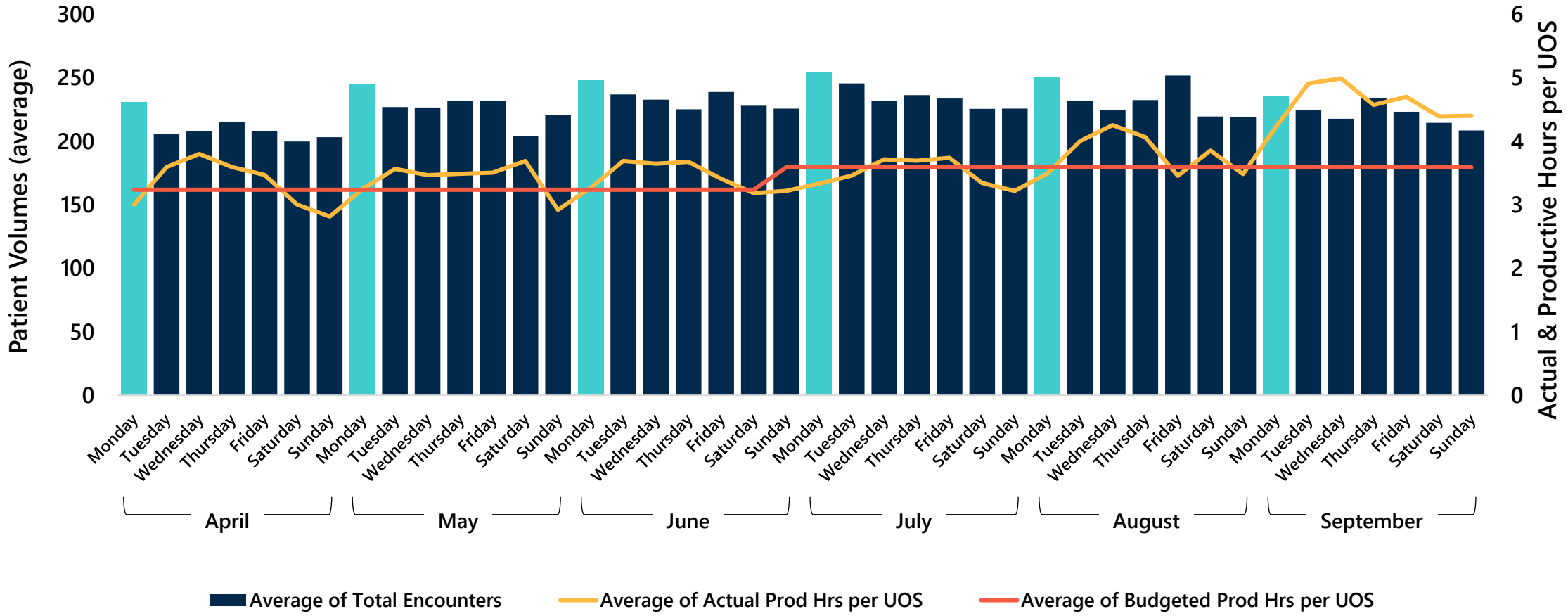
Average Daily Visits by Day of Week & Disposition

	Date of Service							
Disposition Type	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Grand Total
Admitted	55	52	54	54	57	49	46	53
Divert/Transfer	10	10	10	11	10	10	10	10
Expired	1	1	1	1	0	0	0	1
Left/Not Seen	3	2	2	2	2	2	2	2
Treat & Release	135	123	124	127	126	126	123	126
Other	9	8	9	9	9	7	7	8
Grand Total	213	196	200	204	205	194	189	200

Data period: May 1, 2020 – August 14, 2021
[1]ED LOS = Hours between check-in date/time and check-out date/time
Excludes: Moms and Newborns, Behavioral Health, and Peds

Preliminary Insights from Data Analytics

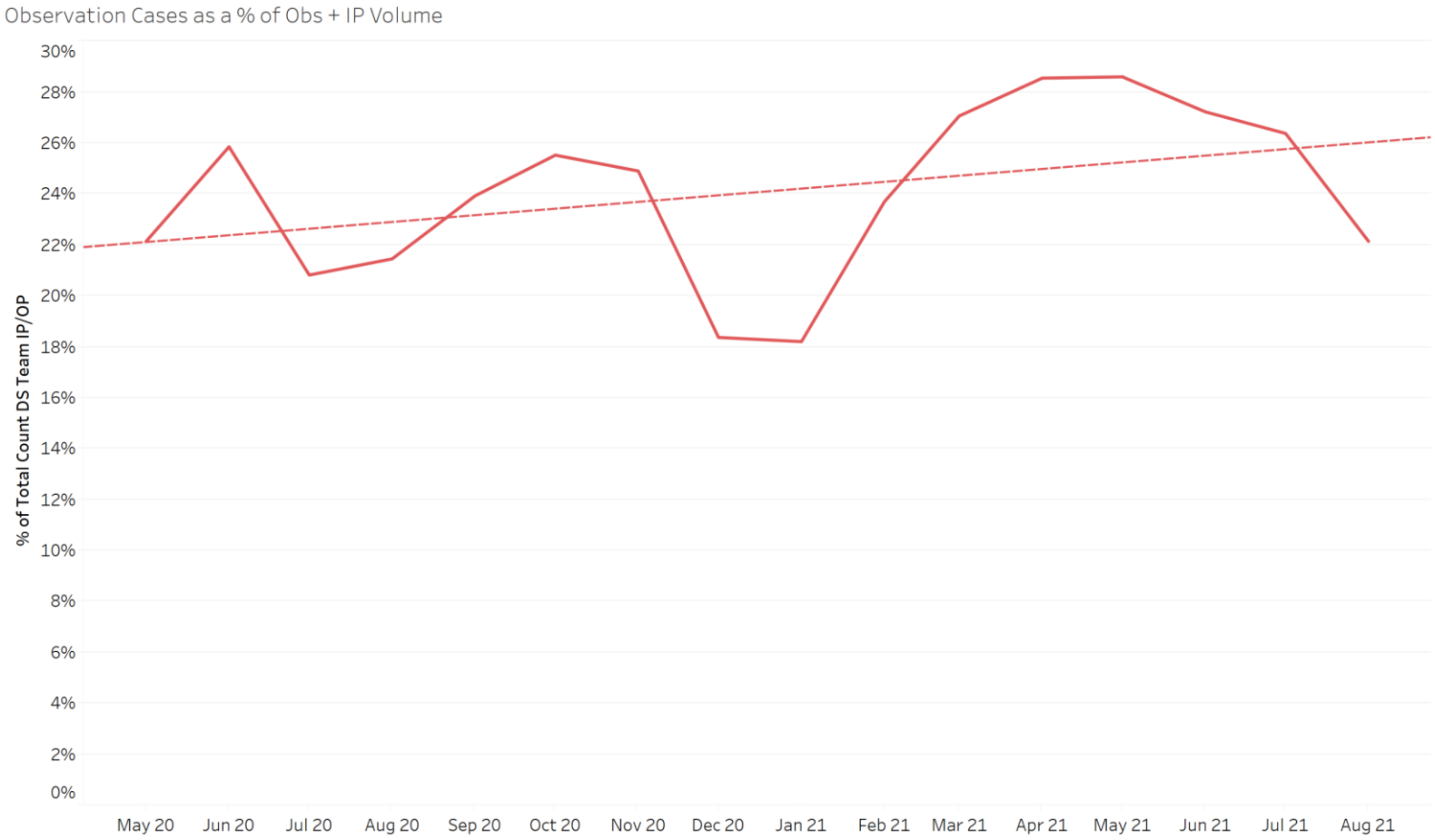
Despite Mondays being the busiest days, the average actual productive hours per unit of service (UOS) are highest mid-week. There may be an opportunity to look at developing specific staffing schedules for Mondays, Tuesdays – Thursdays and Saturdays / Sundays.



Data period: April 1, 2021 – September 30, 2021

Preliminary Insights from Data Analytics

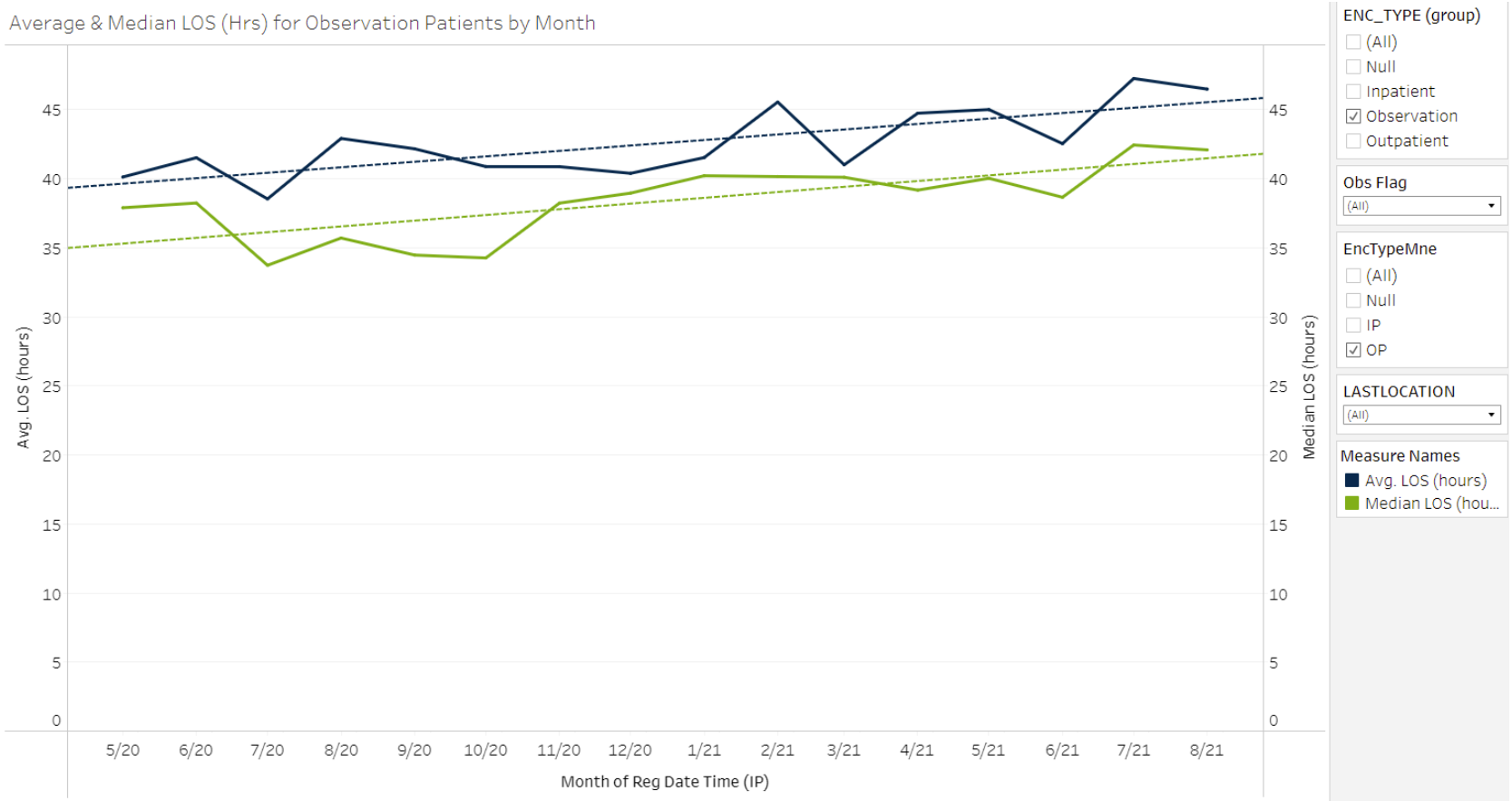
Between May 1, 2020 - August 14, 2021, 24% of patients admitted to Kaweah Health were placed in observation status.



Data period: May 1, 2020 – August 14, 2021
Includes: "Inpatient" and "Observation" Encounter Types; Excludes: Moms and Newborns, Behavioral Health, and Peds

Preliminary Insights from Data Analytics

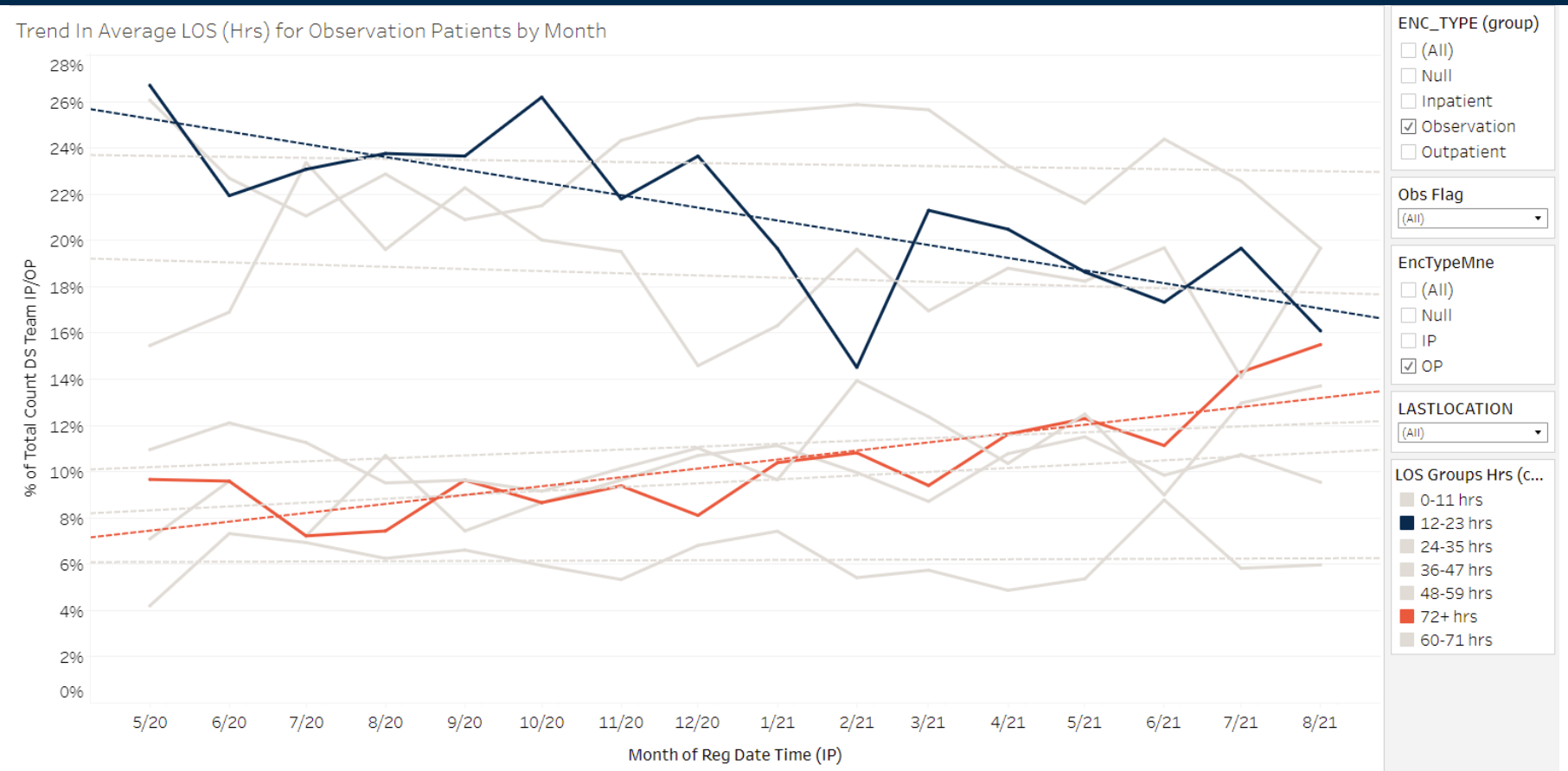
The average LOS[1] (in hours) for patients placed in observation status has also increased recently from the low-40s to mid-40s.



Data period: May 1, 2020 – August 14, 2021
[1]Observation LOS = Hours between registration time and discharge time
Includes: "Observation" Encounter Types; Excludes: Moms and Newborns, Behavioral Health, and Peds

Preliminary Insights from Data Analytics

The proportion of observation patients with a LOS[1] greater than 72 hours is also increasing, while those with a LOS of 12-23 hours is decreasing.



Data period: May 1, 2020 – August 14, 2021
[1]Observation LOS = Hours between registration time and discharge time
Includes: "Observation" Encounter Types; Excludes: Moms and Newborns, Behavioral Health, and Peds, Value "36-47 hrs, 4/1/20 00:00"

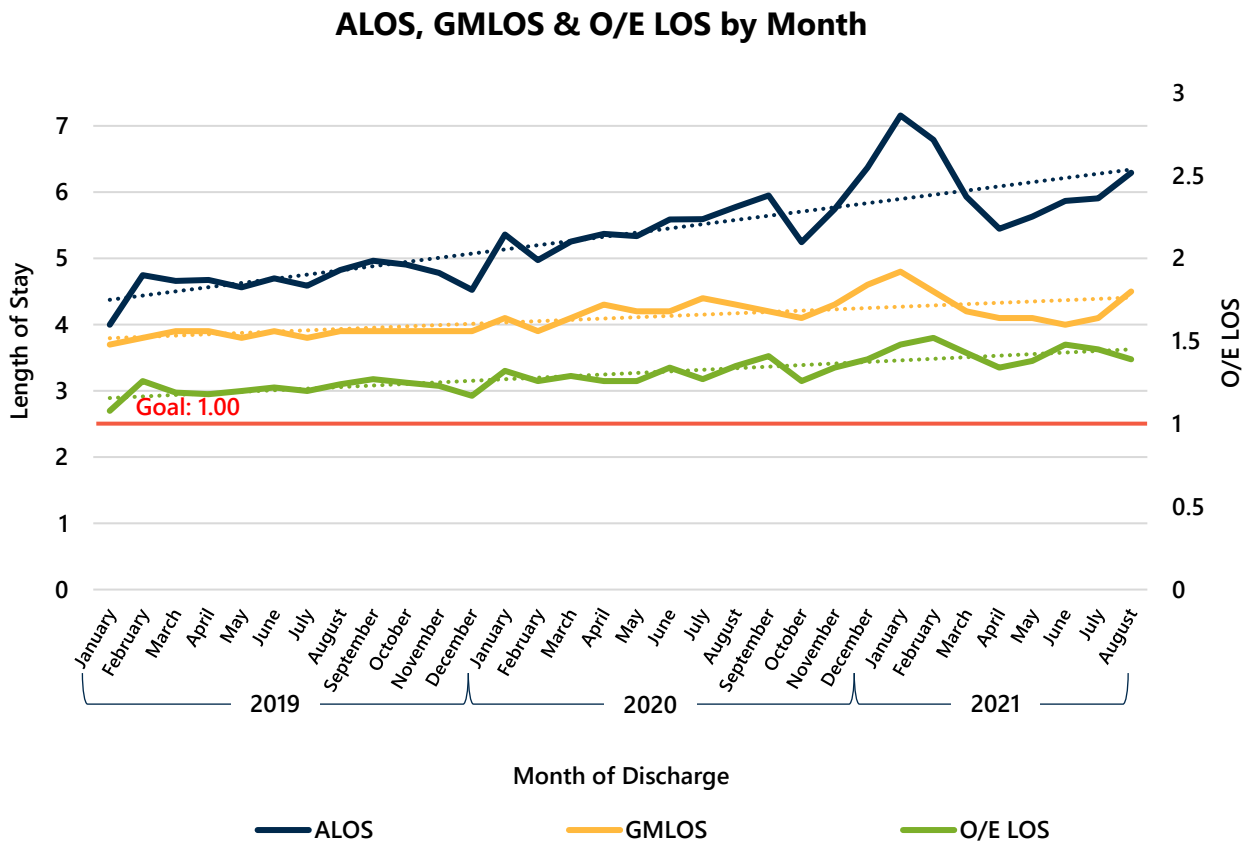
Preliminary Insights from Data Analytics

Multidisciplinary huddles occur throughout the day and at varying levels of the organization; however, the huddles lack provider involvement and are more focused on information-sharing than problem solving.

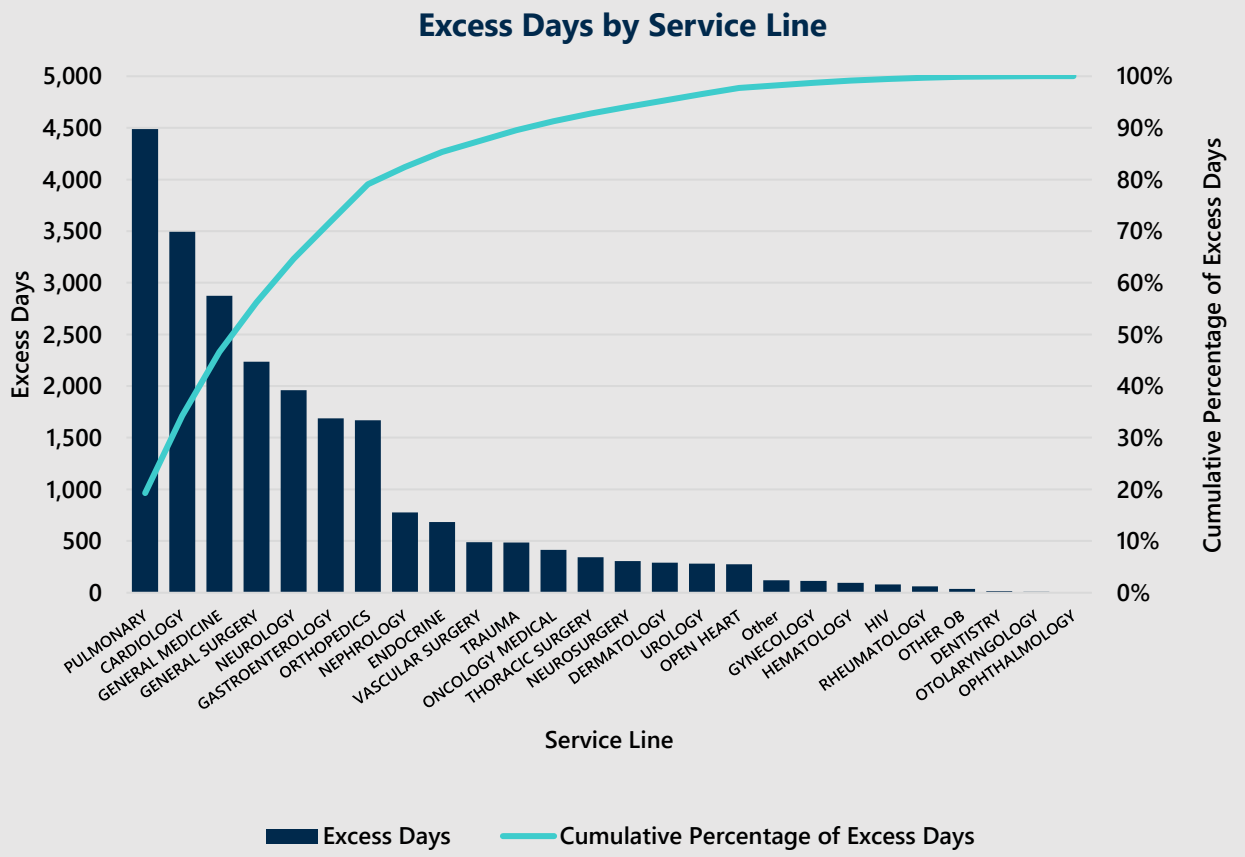
Meeting	Time	MD / APP	Bedside RN	Charge RN	CM	RN Supervisor	Bed Coordinator	Staffing Coordinator	Goal(s)
Safety Huddle	6:00 AM		X	X					Patient safety discussion
Hospital Huddle	7:45 AM			X		X	X	X	Bed management & staffing touch base
Provider Rounds	~7-9:00 AM	X	+/-						Patient care progression
Discharge Rounds	10:00 AM		X	+/-	X				Discharge planning
Staffing Huddle	4:00 PM			X		X	X	X	Bed management & staffing touch base
Safety Huddle	6:00 PM		X	X					Patient safety discussion

Preliminary Insights from Data

Average length of stay (ALOS) is trending up at a faster rate than geometric mean length of stay (GMLOS). Additionally, 4 services lines (Pulmonary, Cardiology, General Medicine & General Surgery) make up 56% of the total excess days.



Data period: January 1, 2019 – August 31, 2021



Data period: January 1, 2021 – August 31, 2021

Preliminary Insights from Data Analytics

Between May 1, 2020 – August 31, 2021, inpatients admitted on Wednesdays and Thursdays have the highest observed-to-expected (O/E LOS) of 1.42 & 1.44 respectively, potentially due to availability of certain services on weekends.

IP O/E By Admit and Discharge Day of Week

Admission Day: Weekday of Admit Date..	Discharge Day: Mon	Tue	Wed	Thu	Fri	Sat	Sun	Grand Total
Mon	1.72	1.13	1.21	1.25	1.35	1.53	1.67	**1.33**
Tue	1.60	1.96	1.09	1.16	1.34	1.29	1.42	**1.36**
Wed	1.66	1.92	1.70	1.26	1.21	1.18	1.26	**1.42**
Thu	1.44	1.75	1.89	1.76	1.36	0.97	1.09	**1.44**
Fri	1.24	1.54	1.56	1.67	1.79	1.08	0.92	**1.38**
Sat	1.13	1.30	1.44	1.56	1.83	1.79	0.85	**1.38**
Sun	1.28	1.15	1.41	1.49	1.59	1.66	1.46	**1.39**
Grand Total	**1.41**	**1.48**	**1.43**	**1.39**	**1.44**	**1.26**	**1.15**	**1.38**

Data period: May 1, 2020 – August 31, 2021
Excludes: Moms and Newborns, Behavioral Health, and Peds

Preliminary Insights from Data Analytics

Based on recent inpatient discharges between January 1 – August 31, 2021, if O/E LOS of 1.44 is decreased by 5 – 15% to between 1.22 – 1.37, Kaweah Health could gain an estimated 13 – 40 available beds.

IP O/E By Admit and Discharge Day of Week

Admission Day: Weekday of Admit Date..	Discharge Day: Mon	Tue	Wed	Thu	Fri	Sat	Sun	Grand Total
Mon	1.75	1.21	1.27	1.24	1.27	1.67	1.82	**1.36**
Tue	1.68	1.94	1.18	1.10	1.48	1.27	1.50	**1.41**
Wed	1.76	1.69	1.74	1.36	1.19	1.21	1.38	**1.43**
Thu	1.37	1.72	2.00	1.79	1.36	1.06	1.11	**1.46**
Fri	1.34	1.71	1.66	1.73	1.71	1.10	0.98	**1.46**
Sat	1.23	1.29	1.63	1.63	2.00	1.93	0.91	**1.47**
Sun	1.47	1.33	1.52	1.58	1.55	1.69	1.47	**1.49**
Grand Total	**1.48**	**1.51**	**1.53**	**1.42**	**1.46**	**1.32**	**1.21**	**1.44**

Data period: January 1, 2020 – August 31, 2021
Excludes: Moms and Newborns, Behavioral Health, and Peds

Preliminary Insights from Data Analytics

Overall occupancy rates for adult med/surg units range between 81% and 91%. During 7 of the past 15 months, the overall occupancy rate was at or above 85%, the recommended maximum occupancy rate to maintain efficient patient throughput.

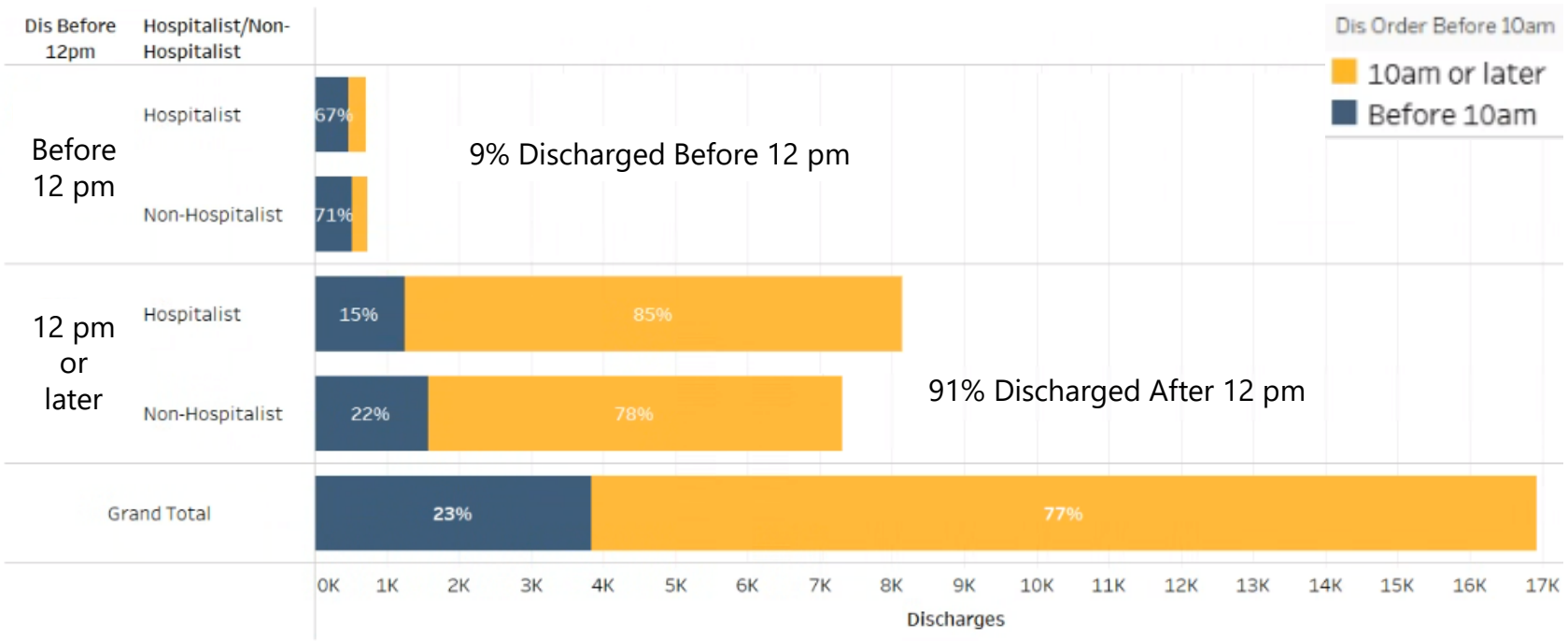
Occupancy Month

Department	Month of Date: Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21
2 N Cardiac Services - 6150	88%	84%	89%	83%	88%	93%	94%	92%	91%	92%	91%	95%	94%	92%	94%	92%
2 S Med/Surg - 6181	84%	92%	76%	81%	71%	95%	105%	102%	99%	98%	94%	98%	101%	103%	106%	103%
3 E Broderick Pavilion - 6175	64%	55%	61%	70%	67%	73%	76%	62%	76%	73%	70%	68%	72%	71%	80%	83%
3 N Medical/Surgical - 6172	91%	91%	91%	94%	92%	93%	93%	92%	94%	95%	93%	96%	96%	95%	95%	93%
3 S Oncology - 6173	89%	87%	92%	91%	87%	94%	94%	93%	94%	95%	92%	96%	95%	94%	95%	95%
3 W ICCU - 6151	58%	61%	63%	61%	55%	60%	81%	82%	77%	58%	52%	56%	58%	56%	67%	86%
4 N Medical/Renal - 6174	76%	75%	77%	78%	76%	78%	79%	79%	79%	80%	77%	79%	80%	80%	80%	79%
4 S Orthopedics - 6177	90%	92%	92%	95%	92%	93%	94%	94%	95%	96%	94%	96%	94%	95%	96%	94%
4T Telemety - 6152	90%	88%	90%	88%	86%	92%	94%	93%	92%	92%	91%	93%	92%	93%	94%	94%
CVICU - 6030		56%	67%	59%	44%	45%	72%	75%	69%	51%	57%	63%	55%	61%	70%	83%
ICCU - 5 Tower -6186	64%	89%	90%	87%	89%	91%	93%	93%	91%	87%	88%	92%	93%	94%	93%	91%
ICU - 6010	78%	82%	79%	80%	67%	75%	85%	88%	73%	70%	69%	66%	72%	71%	83%	92%
Grand Total	81%	81%	83%	82%	78%	84%	90%	89%	87%	84%	83%	85%	85%	85%	89%	91%

Data period: June 1, 2020 – September 28, 2021
Excludes "Null" values and values where the department was listed as "1E"

Preliminary Insights from Data Analytics

Providers have a goal to enter discharge orders by 10 am; however, between May 1, 2020 – August 31, 2021, this is accomplished only 23% of the time.

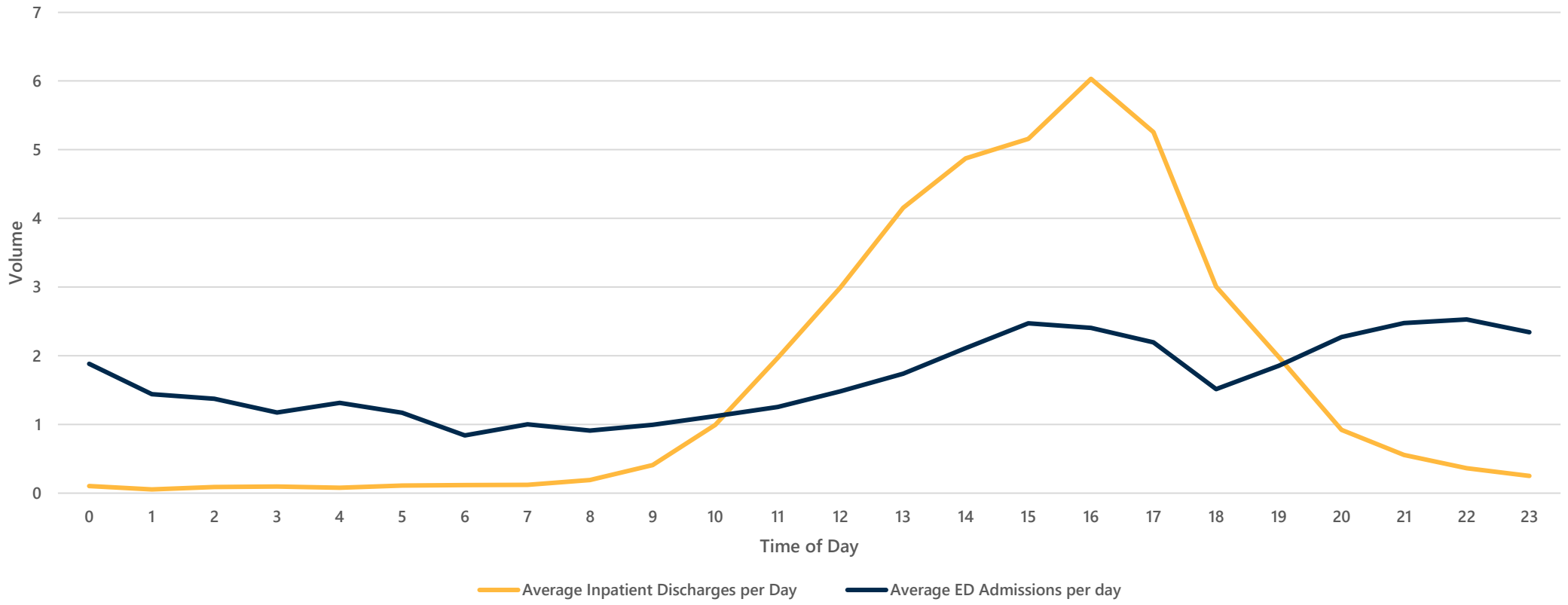


Hospitalist/Non-..	IP Discharges	Median Dis Order to Dis Time	Avg. Dis Order to Dis Time
Grand Total	18,985	3.4	8.8
Hospitalist	9,578	3.4	8.8
Non-Hospitalist	9,407	3.4	8.8

Data period: May 1, 2020 – August 31, 2021
Excludes: Moms and Newborns, Behavioral Health, and Peds

Preliminary Insights from Data Analytics

Late afternoon discharges coupled with existing ED holds create a backlog of demand for inpatient beds in the ED and elsewhere, which in turn can cause patient throughput delays for other ED patients.



Data period: May 1, 2020 – August 31, 2021

Preliminary Insights from Data Analytics

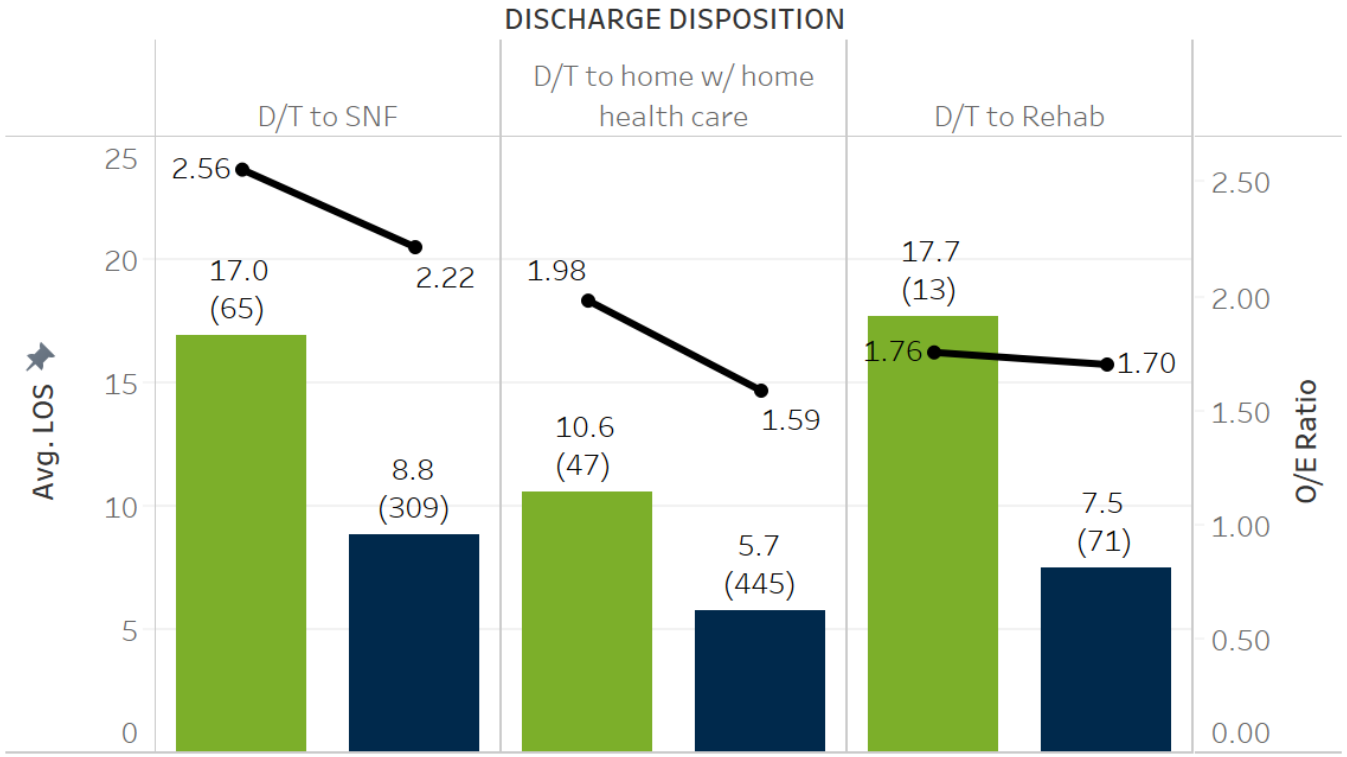
Between May 1, 2020 – August 31, 2021, a combined 34% of inpatients were discharged to home with services (18%), a skilled nursing facility (12%) or acute rehabilitation hospital (3%).

Discharge Disposition	Inpatient Discharge Volume	% of Total	ALOS	O/E LOS
Discharge to Home (Routine)	9,731	51%	4.1	1.06
D/T to home w/ home health care	3,401	18%	6.6	1.42
D/T to SNF	2,370	12%	9.7	2.08
Expired	1,189	6%	10.1	1.57
Left against Medical Advice	543	3%	4.0	1.00
D/T to Rehab	540	3%	10.1	1.93
D/T to hospice - home	474	2%	7.8	1.71
D/T to other Acute Hospital	302	2%	7.0	1.37
All other <300 discharges	435	2%	8.7	1.26
Grand Total	18,985	100%	6.0	1.31

Data period: May 1, 2020 – August 31, 2021
Excludes: Moms and Newborns, Behavioral Health, and Peds

Preliminary Insights from Data Analytics

Between July 1 – August 31, 2021, O/E LOS was significantly higher for patients with documented TRT issues, especially those discharged home with services or to a SNF.



Data period: July 1, 2021 – August 31, 2021
Excludes: Moms and Newborns, Behavioral Health, and Peds

Preliminary Insights from Data Analytics

Between July 1 – August 31, 2021, secondary to placement to SNF, placement for homeless was the most frequently documented barrier, followed closely by DME.

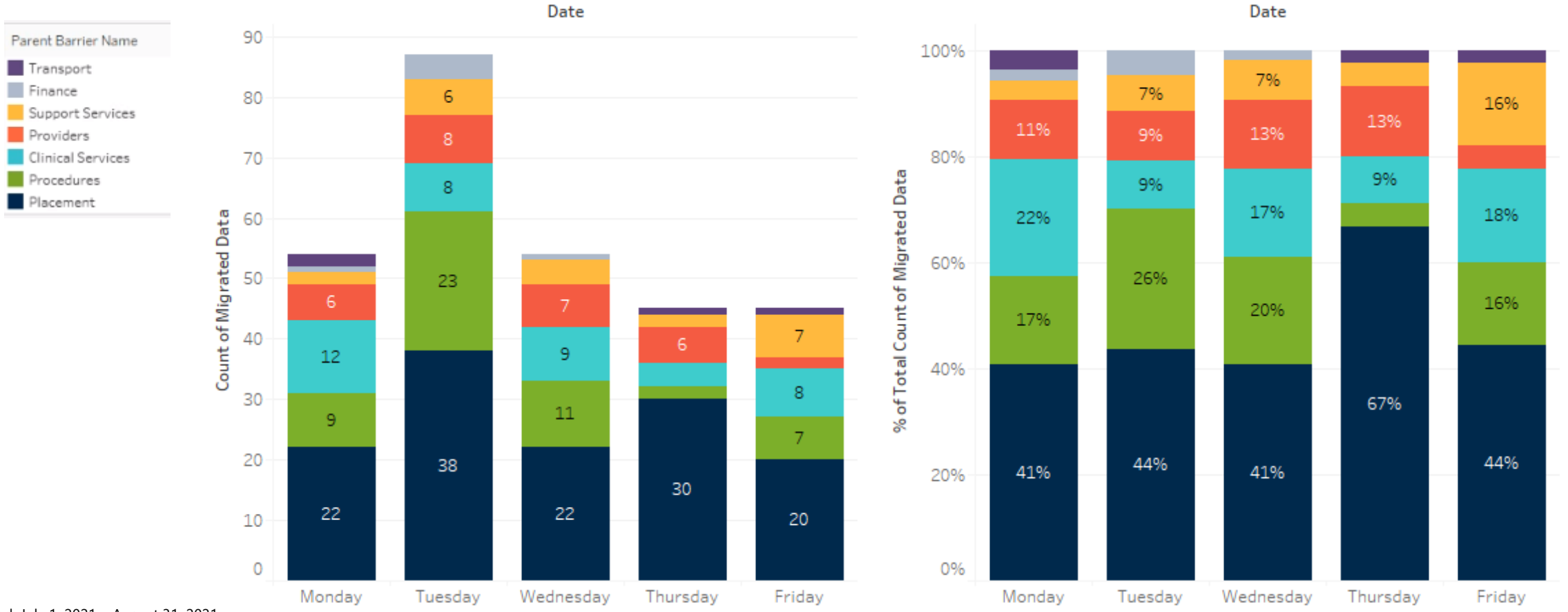
Parent Barrier Name	Encoun..	Avg. LOS	O/E Ratio
Clinical Services	38	9.0	1.99
Finance	8	24.0	4.30
Placement	116	14.4	2.51
Procedures	50	9.8	2.39
Providers	27	11.3	3.13
Support Services	20	9.5	2.17
Transport	4	9.0	2.29

Parent Barrier Na..	DelayReason	Enco..	Avg. LOS	O/E Rat..
Clinical Services	Therapy - PT	17	9.4	1.96
	PFS	7	6.3	1.92
	Palliative Care	5	8.8	2.15
	Lab	3	1.7	0.89
	Hospice	2	8.0	2.00
	Wound	1	10.0	1.72
	Therapy - Speech	1	6.0	1.58
	Therapy - OT	1	7.0	2.41
	Therapy	1	25.0	3.62
	Pharmacy	1	34.0	2.39
	Home Health	1	10.0	
Finance	Self Pay-Change Insurance	6	24.8	5.07
	Insurance Auth	2	21.5	2.81
Placement	SNF	65	14.9	2.76
	Homeless - SB1152 in pro..	23	13.6	3.01
	Family/Social Issues	18	13.7	2.48
	Acute Rehab	13	14.5	3.33
	New Dialysis Setup	6	18.2	2.79
	Mental Health	3	10.3	3.10
	Pending Acute Transfer	2	11.5	2.77
Procedures	Cath Lab	10	4.4	2.05
	Ultrasound	9	17.3	3.33
	IR	8	16.3	2.65
	Echo	8	2.9	2.25
	Radiology	4	5.0	1.90
	Nuclear Med	3	2.5	0.94
	Endoscopy	3	12.0	3.27
	Dialysis	3	21.0	2.06
	OR	2	6.5	1.60
	CV/OR	2	9.5	1.94
	Treadmill	1	4.0	
Providers	Consult - Other	13	14.8	3.37
	Consult - Cardiac	12	6.9	2.56
	Consult - Psych	2	14.0	8.00
	Consult - GI	1	9.0	2.05
Support Services	DME	20	9.5	2.17
Transport	Family delays	4	9.0	2.29

Data period: July 1, 2021 – August 31, 2021
Excludes: Moms and Newborns, Behavioral Health, and Peds

Preliminary Insights from Data Analytics

Placement is the most prevalent barrier group, followed by procedures, then clinical services; however, barriers are not tracked on the weekends. Anecdotally, lack of certain services on weekends appear to be a major barrier to patient progression and discharge.



Data period: July 1, 2021 – August 31, 2021
Excludes: Moms and Newborns, Behavioral Health, and Peds

APPENDIX 6

Data Definitions

Project Logistics – Data Analytics

Notes on Tableau Analyses

These analyses span three workbooks workbook: Consolidated IP / OP, ED Census, and Throughput Rounding Tool

CONSOLIDATED IP/ OP

IP Files

* DS Team IP/OP: IP and OP visits (ED, OP surg, cath lab) from Jan 2019-Aug 2021. Includes encounter type (IP/OP), admit & disch dates, attending specialty, hospitalist, service line, flags for covid/ED/obs, and financial info.
* IP v2: IP and OP visits (ED, OP surg, cath lab) from Jan 2019-Aug 2021. Includes date/times for admit (reg), disch order, and disch; enc type (IP/OP/Obs); disch dispo, last location.

ED Files

* ED Log MLN: ED visits from May 2020 to Sep 2021. Includes date/times, Acuity_Display, ED dispo.
* ED Log SF: Similar to ED Log MLN but contains age, sex, diag codes, attending & admitting. Does NOT include any date variable.
* KDHD ED Time: ED visits from mid Feb 2020 to mid-Aug 2021. Includes dispo type, decision to dispo time, ESI (Acuity)

In general, we have ED data from May 1, 2020 to Aug 14, 2021 and IP data from Jan 2019 to Aug 2021. We created two filters to filter on the ED date range of May 2020 to Aug 14, 2021 and the IP date range of Jan 2019 to Aug 2021. One of these filters should be on every analytics workpage.

We created "uniform" variables for encounter ID, start date (e.g., check in date, reg date), and DRG that use a composite of the values from the source datasets.

Joining these files created duplicate records. To avoid counting duplicates we created "count" variables for each source, e.g,. Count ED Time, which counts only unique records in the ED Time file. In general you should try to match the "count" variable with the primary data source you're using in an analysis. There is also a Count of Uniform Encounters that represents the unique number of encounters for all files combined.

The IP files IP v2 included deliveries and newborns while the DS Team IP/OP did not. We created the filters Moms and Newborns Peds: Adult, and Behavioral Health and applied it to all tabs in the workbook. Definitions for exclusion criteria can be found in the subsequent slides.

Project Logistics – Data Analytics

Notes on Tableau Analyses

ED CENSUS

File:
* Kaweah ED Census v2: ED visits from May 2020 to August 2021. Includes date/times, FIN, Acuity_Display, Admit Src Display, Encntr Dc Display, Encntr Dc Dispo, Ed Checkout Dispo, Enc Type Display, Dc Nurse Unit Display, Encounter ID, Medical Record Number, Age, Sex, ED Attending Physician, ED Attending Name, Admitting Phys NPI, Admitting Name, Primary Payer, Primary Diagnosis, ED LOS (Hrs), Encounters, Covid Dx, Encounter Type

In general, we have ED data from May 1, 2020 to Aug 14, 2021.

To measure ED Census by day, we calculated the average daily visits by counting encounters.

No type of patient was omitted, we look at Emergency, Inpatient, Observation and All Other.

THROUGHPUT ROUNDING TOOL

File:
* Kaweah TRT Jul-Aug 2021 + IPv2 - visits from May 2020 to August 2021. Includes dates, Attending Physician, BarrierStatus, Date, DelayReason, ecdno, NursSta, Parent Barrier Name, WorkingDRG, WorkingDX

In general, we have data from July 1, 2021 to September 30, 2021.

We created the filters, Moms and Newborns, Peds: Adult, and Behavioral Health and applied it to all tabs in the workbook. Definitions for exclusion criteria can be found in the subsequent slides.

Project Logistics – Data Analytics

Page 3 of 7

Consolidated IP / OP

Chartis Metric	Field(s)	Definition
Admitted	DISPOS_TYPE	Admitted to this Hospital as Inpatient
Divert / Transfer	DISPOS_TYPE	D/T to Assis Living or Board and Care D/T to Cancer or Children Hospital D/T to Court / Law Enforcement D/T to Fed Health Care Facility D/T to home w/ home health care D/T to hospice – home D/T to LTC hospital D/T to Medical fac / hospice care D/T to other Neonatal Care Hos aftercare D/T to Psych Hosp or Unit D/T to Rehab D/T to SNF D/T to Sub Acute
Discharged Home	DISPOS_TYPE	Discharged to Home (Routine)
Expired	DISPOS_TYPE	Expired Expired Died in Emergency Expired Died on Arrival
Left/Not Seen	DISPOS_TYPE	Not Seen

Chartis Metric	Field(s)	Definition
Other	DISPOS_TYPE	Left Against Medical Advice Left During Treatment Null Still a patient ZZCancelled Encounter
Inpatient	ENC_TYPE	Inpatient
Outpatient	ENC_TYPE	Outpati Outpatient
Observation	ENC_TYPE	Observati Observatio

Project Logistics – Data Analytics

Page 4 of 7

Consolidated IP / OP

Chartis Metric	Field(s)	Definition
ED Length of Stay (hours)	Check In DateTime, Check Out Date Time, ENC_TYPE_DISPLAY	Check in date to check out date
Observation Length of Stay (hours)	Reg Date Time, DisDate Time	Registration date to discharge date (from the Inpatient data, length of stay was only calculated for Observation patients)
Dis Before 12pm	DisDate Time	IF DATEPART('hour',[DisDate Time])<12 THEN 'Before 12pm' ELSE '12pm or later' END
Dis Order Before 10am	Discharge Order Date Time	IF DATEPART('hour',[Discharge Order Date Time])<10 THEN 'Before 10am' ELSE '10am or later' END
Moms and Newborns	Uniform DRG	IF ([Uniform DRG]>=765 AND [Uniform DRG]<=770 OR [Uniform DRG]>=774 AND [Uniform DRG]<=788 OR [Uniform DRG]>=796 AND [Uniform DRG]<=798 OR [Uniform DRG]>=805 AND [Uniform DRG]<=807) THEN 'Delivery' ELSEIF [Uniform DRG]>=789 AND [Uniform DRG]<=794 THEN 'Neonate' ELSEIF [Uniform DRG]=795 THEN 'Normal newborn' ELSE 'Not mom or newborn' END
Behavioral Health	DRG_CODE, MSDRG	IF ([DRG_CODE]>=876 AND [DRG_CODE]<=899) or ([MSDRG]>=876 AND [MSDRG]<=899) THEN 'BH' ELSE 'Non BH' END

Project Logistics – Data Analytics

Page 5 of 7

Consolidated IP / OP

Chartis Metric	Field	Definition
Peds	AGE	IF [AGE]<18 THEN 'Peds' ELSEIF [AGE]>=18 THEN 'Adult' ELSE 'Missing' END
Dis Order to Dis Time	Disch	DATEDIFF('minute',[Discharge Order Date Time],[DisDate Time])/60
Observed / Expected Length of Stay	Length of Stay, GMLOS	SUM([Length of Stay]) / SUM([GMLOS])
Potential Days Saved	Length of Stay, GMLOS	MAX(SUM([Length of Stay]-[GMLOS]),0)

Project Logistics – Data Analytics

Page 6 of 7

ED Census

Chartis Metric	Field	Definition
ED LOS (Hrs)	CheckIn Date Time, CheckOut Date Time	DATEDIFF('minute',([CheckIn Date Time]),([CheckOut Date Time]))/60

Project Logistics – Data Analytics

Page 7 of 7

Throughput Rounding Tool

Chartis Metric	Field	Definition
Moms and Newborns	Uniform DRG	IF ([Uniform DRG]>=765 AND [Uniform DRG]<=770 OR [Uniform DRG]>=774 AND [Uniform DRG]<=788 OR [Uniform DRG]>=796 AND [Uniform DRG]<=798 OR [Uniform DRG]>=805 AND [Uniform DRG]<=807) THEN 'Delivery' ELSEIF [Uniform DRG]>=789 AND [Uniform DRG]<=794 THEN 'Neonate' ELSEIF [Uniform DRG]=795 THEN 'Normal newborn' ELSE 'Not mom or newborn' END
Behavioral Health	DRG_CODE, MSDRG	IF ([DRG_CODE]>=876 AND [DRG_CODE]<=899) or ([MSDRG]>=876 AND [MSDRG]<=899) THEN 'BH' ELSE 'Non BH' END
Peds	AGE	IF [AGE]<18 THEN 'Peds' ELSEIF [AGE]>=18 THEN 'Adult' ELSE 'Missing' END
Expected ALOS	GMLOS, Encounters	SUM([GMLOS])/[Encounters]
LOS	Reg Date Time, Dis Date Time	MAX(1,DATEDIFF('day',[Reg Date Time],[Dis Date Time]))
O/E Ratio	LOS, Expected ALOS	AVG([LOS])/([Expected ALOS])

APPENDIX 7

Benefit Realization & Post-Acute Care Methodologies

Benefit Realization Methodology

Based on recent inpatient discharges between January 1 – August 31, 2021, if O/E LOS of 1.44 is decreased by 5 – 15% to between 1.22 – 1.37, Kaweah Health could gain an estimated 13 – 40 available beds.

Encounter Current State		
Discharges	*A*	10767
Average Length of Stay (ALOS)	*B*	6.12
Geometric Mean Length of Stay (GMLOS)	*C*	4.26
Observed-to-Expected Length of Stay (O/E LOS)	*D*	1.44
Inpatient Patient Days	*E = A * B*	65894
Average Inpatient Daily Census (ADC)[1]	*F = E / 243 days*	271
Available Med / Surg Beds	*G*	336
Average Inpatient Occupancy Rate[1]	*H = F / G*	81%
Average Contribution Margin per Case	*I*	$5,122

Design & Implementation Approach	% O/E LOS Reduction	Potential O/E LOS	Potential ALOS	Potential Patient Days	Difference in Patient Days	Potential Available Beds
Calculation	*J*	*K = D * J*	*L = C * K*	*M = A * L*	*N = E - M*	*O = N / 243 days*
Conservative	5.0%	1.37	5.83	62747	3295	13.6
Moderate	10.0%	1.30	5.52	59444	6589	27.1
Optimistic	15.0%	1.22	5.21	56142	9884	40.7

Design & Implementation Approach	Potential Available Bed Days[2]	Potential ALOS	Potential Annual Incremental Discharges	Potential Incremental Discharges per Day	Potential Incremental Contribution Margin	Potential Average Inpatient Occupancy Rate
Calculation	*P = O * 365 days * 85%*	*Q = D * (1 - J) * C*	*R = P / Q*	*S = R / 365 days*	*T = R * I*	*U = (((A / 8) * 12) + P) * Q) / 365 days) / 336 beds*
Conservative	4207	5.83	722	2	$3,697,137	80%
Moderate	8413	5.52	1524	4	$7,805,067	80%
Optimistic	12620	5.21	2420	7	$12,396,283	79%

[1]Does not include Observation patients or Outpatients in a bed

[2]85% backfill assumption

Post-Acute Care Methodology

Based on recent inpatient discharges between May 1, 2020 – August 31, 2021, if Kaweah Health increases the proportion of MediCal patients discharged with PAC services to its overall utilization rate of 33%, it would require an estimated 10-12 additional SNF beds and 5-7 medical respite / respite / post-discharge housing beds.

Kaweah Discharges to Post-Acute Care (PAC)

Time period:	May 2020 - Aug 2021
Days:	488

PAC Bed Needs Assumptions

% of Excess Days due to PAC Barriers:	60%
PAC Occupancy Rate:	90%
Additional PAC Bed Needs for Medicare:	50%

Discharge Dispo	Payor													
	Medicare				MediCal				Commercial				Overall	
	Discharges	% of Total	ALOS	O/E Ratio	Discharges	% of Total	ALOS	O/E Ratio	Discharges	% of Total	ALOS	O/E Ratio	Discharges	% of Total
Discharge to Home (Routine)	3,798	38%	3.85	1.01	3,733	65%	4.44	1.14	1,940	66%	3.69	0.97	9,731	51%
D/T to home w/ home health care	2,284	23%	5.85	1.33	694	12%	8.00	1.64	402	14%	7.80	1.44	3,401	18%
D/T to SNF	1,980	20%	9.01	1.99	255	4%	13.55	2.53	122	4%	10.59	2.23	2,370	12%
D/T to Rehab	280	3%	7.74	1.66	150	3%	12.83	2.22	93	3%	11.41	1.95	540	3%
Discharges to Post-Acute Services	**4,544**	**46%**			**1,099**	**19%**			**617**	**21%**			**6,311**	**33%**
Total Discharges	**9,952**	**52%**			**5,724**	**30%**			**2,943**	**16%**			**18,985**	

Discharge Dispo	**Current State MediCal** (No Change in PAC Utilization)							
	Discharges	% of Total	ALOS	O/E Ratio	GMLOS	Patient Days	Excess Days	PAC Bed Needs
D/T to home w/ home health care	694	12%	8.00	1.64	4.88	5,552	2,167	3.0
D/T to SNF	255	4%	13.55	2.53	5.36	3,455	2,090	2.9
D/T to Rehab	150	3%	12.83	2.22	5.78	1,925	1,058	1.4
Discharge to Post-Acute Services	**1,099**	**19%**				**10,932**	**5,314**	**7.3**

Discharge Dispo	**Future State MediCal** (Optimistic = Overall Current State for PAC)								
	Discharges	% of Total	ALOS	O/E Ratio	GMLOS	Patient Days	Excess Days	PAC Bed Needs	Plus Medicare
D/T to home w/ home health care	1,030	18%	8.00	1.64	4.88	8,243	3,217	4.4	6.6
D/T to SNF	687	12%	13.55	2.53	5.36	9,307	5,628	7.7	11.5
D/T to Rehab	172	3%	12.83	2.22	5.78	2,203	1,211	1.7	2.5
Discharge to Post-Acute Services	**1,889**	**33%**				**19,753**	**10,056**	**13.7**	**20.6**

APPENDIX 8

Example Solutions

Example Solutions: Improving Emergency Department Operations and Implementing Workforce Changes

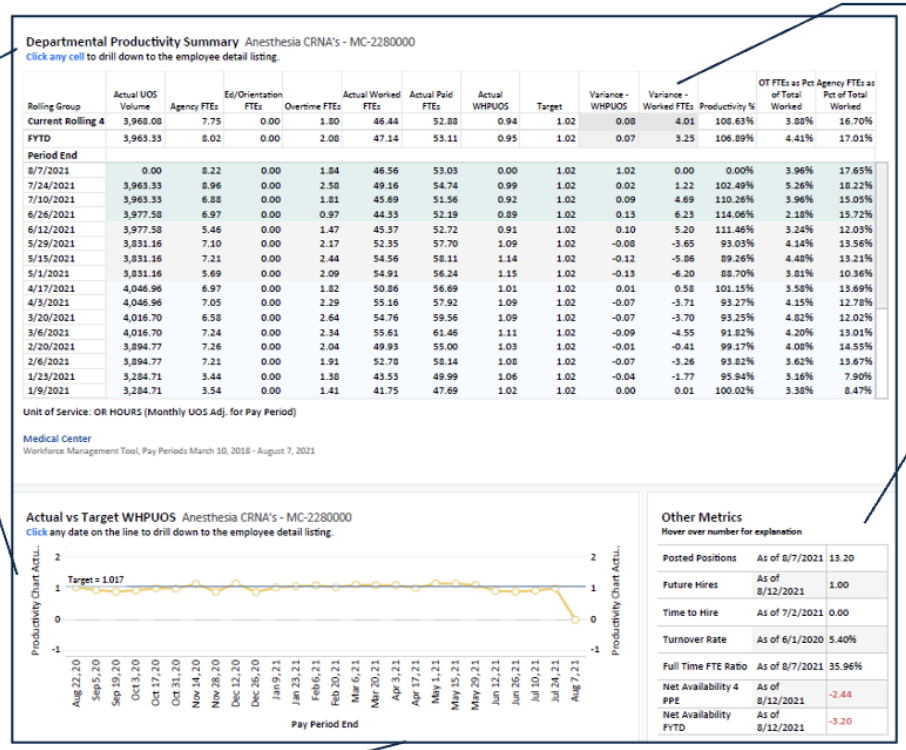
KEY COMPONENTS

- Design and build ED staffing model and pod plan
- Create and implement Waiting Room Monitoring plan via Triage RN, Paramedic, Tech partnership
- Develop and operationalize Adult Fast Track in partnership with physician leadership
- Operationalize paramedic deployment plan in front end support and Trauma Pod in coordination with physicians
- Design and implement visual patient tracking board in each pod
- Coach ED leadership to build their understanding of the link between staffing decisions and their WHPUOS target

Department-Specific
Displays snapshot of department's current status

Progress Tracking
Visualizes performance trends over time

Accountability
Transparency of performance data holds leadership accountable



Departmental Productivity Summary Anesthesia CRNA's - MC-2280000

Click any cell to drill down to the employee detail listing.

Rolling Group	Actual UOS Volume	Agency FTEs	Ed/Orientation FTEs	Overtime FTEs	Actual Worked FTEs	Actual Paid FTEs	Actual WHPUOS	Target	Variance - WHPUOS	Variance - Worked FTEs	Productivity %	OT FTEs as Pct of Total Worked	Agency FTEs as Pct of Total Worked
Current Rolling 4	3,968.08	7.75	0.00	1.80	46.44	52.88	0.94	1.02	0.08	4.01	108.63%	3.88%	16.70%
FYTD	3,963.33	8.02	0.00	2.08	47.14	53.11	0.95	1.02	0.07	3.25	106.89%	4.41%	17.01%
Period End													
8/7/2021	0.00	8.22	0.00	1.84	46.56	53.03	0.00	1.02	1.02	0.00	0.00%	3.96%	17.65%
7/24/2021	3,963.33	8.96	0.00	2.58	49.16	54.74	0.99	1.02	0.02	1.22	102.49%	5.26%	18.22%
7/10/2021	3,963.33	6.88	0.00	1.81	45.69	51.56	0.92	1.02	0.09	4.69	110.26%	3.96%	15.05%
6/26/2021	3,977.58	6.97	0.00	0.97	44.33	52.19	0.89	1.02	0.13	6.23	114.06%	2.18%	15.72%
6/12/2021	3,977.58	5.46	0.00	1.47	45.37	52.72	0.91	1.02	0.10	5.20	111.46%	3.24%	12.03%
5/29/2021	3,831.16	7.10	0.00	2.17	52.35	57.70	1.09	1.02	-0.08	-3.65	93.03%	4.14%	13.56%
5/15/2021	3,831.16	7.21	0.00	2.44	54.56	58.11	1.14	1.02	-0.12	-5.86	89.26%	4.48%	13.21%
5/1/2021	3,831.16	5.69	0.00	2.09	54.91	56.24	1.15	1.02	-0.13	-6.20	88.70%	3.81%	10.36%
4/17/2021	4,046.96	6.97	0.00	1.82	50.86	56.69	1.01	1.02	0.01	0.58	101.15%	3.58%	13.69%
4/3/2021	4,046.96	7.05	0.00	2.29	55.16	57.92	1.09	1.02	-0.07	-3.71	93.27%	4.15%	12.78%
3/20/2021	4,016.70	6.58	0.00	2.64	54.76	59.56	1.09	1.02	-0.07	-3.70	93.25%	4.82%	12.02%
3/6/2021	4,016.70	7.24	0.00	2.34	55.61	61.46	1.11	1.02	-0.09	-4.55	91.82%	4.20%	13.01%
2/20/2021	3,894.77	7.26	0.00	2.04	49.93	55.00	1.03	1.02	-0.01	-0.41	99.17%	4.08%	14.55%
2/6/2021	3,894.77	7.21	0.00	1.91	52.78	58.14	1.08	1.02	-0.07	-3.26	93.82%	3.62%	13.67%
1/23/2021	3,284.71	3.44	0.00	1.38	43.53	49.99	1.06	1.02	-0.04	-1.77	95.94%	3.16%	7.90%
1/9/2021	3,284.71	3.54	0.00	1.41	41.75	47.69	1.02	1.02	0.00	0.01	100.02%	3.38%	8.47%

Unit of Service: OR HOURS (Monthly UOS Adj. for Pay Period)

Medical Center

Workforce Management Tool, Pay Periods March 10, 2018 - August 7, 2021

Actual vs Target WHPUOS Anesthesia CRNA's - MC-2280000

Click any date on the line to drill down to the employee detail listing.

Target = 1.017

Productivity Chart Actu...

Aug 22,20 Sep 5,20 Sep 19,20 Oct 3,20 Oct 17,20 Oct 31,20 Nov 14,20 Nov 28,20 Dec 12,20 Dec 26,20 Jan 9,21 Jan 23,21 Feb 6,21 Feb 20,21 Mar 6,21 Mar 20,21 Apr 3,21 Apr 17,21 May 1,21 May 15,21 May 29,21 Jun 12,21 Jun 26,21 Jul 10,21 Jul 24,21 Aug 7,21

Pay Period End

Other Metrics

Hover over number for explanation

Posted Positions	As of 8/7/2021	13.20
Future Hires	As of 8/12/2021	1.00
Time to Hire	As of 7/2/2021	0.00
Turnover Rate	As of 6/1/2020	5.40%
Full Time FTE Ratio	As of 8/7/2021	35.96%
Net Availability 4 PPE	As of 8/12/2021	-2.44
Net Availability FYTD	As of 8/12/2021	-3.20

Actual-Target WHPUOS & FTE Variance
Compares actuals with agreed upon targets from Staffing Grid development

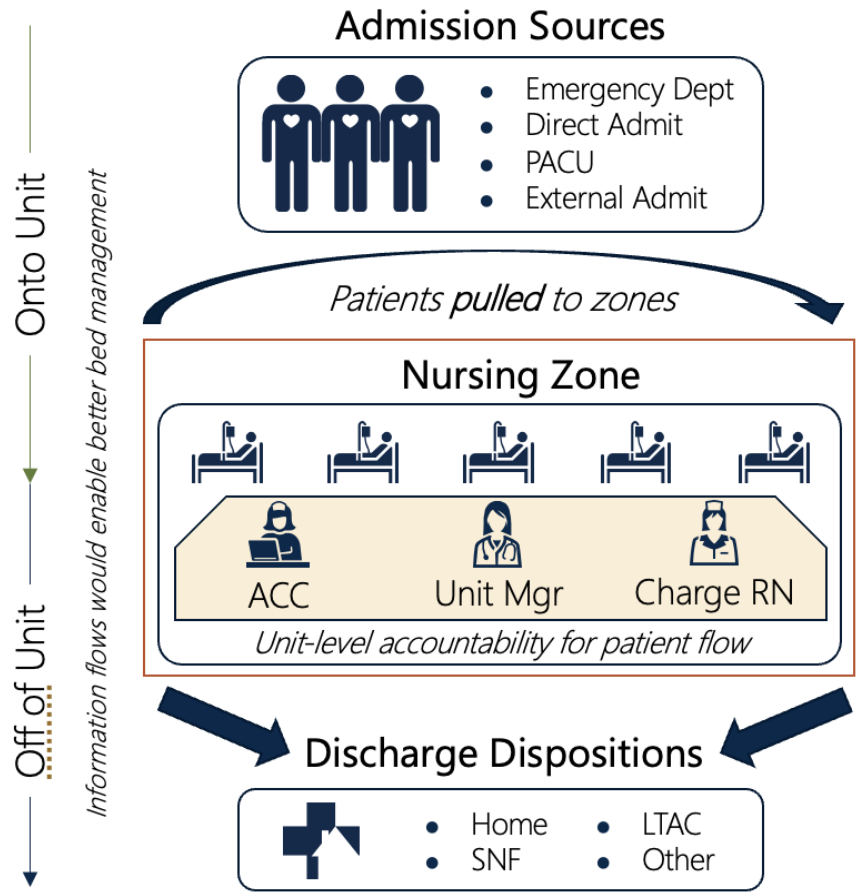
Hiring Availability
Highlights posted positions and future hires

Illustrative

Example Solutions: Streamlining Unit-Based Patient Flow Facilitation

KEY COMPONENTS

- Align staffing by shift to address admission variability and develop a process to approve additional nursing FTEs
- Implement workflows to drive patient flow for multiple units remotely
- Re-imagine which unit-based roles are able to support patient flow responsibilities
- Realign incentives to drive unit-based patient flow accountability



Patient Flow Facilitation Tasks:

- ❑ Manage patient flow / throughput on unit
- ❑ Provide unit-level view of bed base
- ❑ Lead and / or participate in Patient Progression Huddles
- ❑ Gather projected admits for the day
- ❑ Act as the single point of contact for bed management
- ❑ Ensure nurse to nurse report is taken in a timely manner
- ❑ Coordinate patient placement in conjunction with bed management, as needed
- ❑ Escalate unit-based issues
- ❑ Pro-actively address unit-level staffing needs in coordination with central nurse staffing
  - ✓ Create daily shift staffing assignments
  - ✓ Communicate with central staffing to request flex staff, approves call-ins
  - ✓ Create daily schedules for unit staff

Illustrative

Example Solutions: Augmenting Multidisciplinary Huddles

KEY COMPONENTS

- Core workflows and roles:
  - •CM /DC planning roles
  - •Physician advisor program
  - •UM processes, roles and feedback loops
- Emergent & urgent care triage:
- Daily bed management huddles:
  - •Improve house-wide communication, provide transparency around bed capacity, develop plans around patient flow for the day, and anticipate potential problem areas and how to address them in real time
- Patient progression huddles :
  - •Allow rapid, structured discussion of patients and barriers to discharge, ultimately driving patient progression
- Units "pull" patients from the ED vs "push"
- Patient transport efficiency
- EVS bed TAT

DAILY BED MANAGEMENT HUDDLE –
Transparency into Daily Demand and Capacity Action Planning

- ✓ State of the House
- ✓ ED/ICU capacity updates
- ✓ OR demand updates
- ✓ Floors/zones/units turnover updates
- ✓ Action plan for the day
- ✓ Support action planning: *Physician engagement*
- ✓ Support action planning: *Care Management*
- ✓ Support action Planning: *Physical Therapy/EVS /Transport*

DAILY PATIENT PROGRESSION HUDDLE – Identification and resolution **of clinical, social, fiscal and other** discharge barriers

- Roles are clearly defined to facilitate communication
- Standard elements are part of every conversation
- Tools and reference materials like scripts, whiteboards, and checklists ensure consistency

Standardization

Timing

- Strict timing ensures focus on the most important information
- Limits impact of huddles on patient care
- Ensures long-term viability of huddles

- Interdisciplinary structure ensures visibility across roles, reducing silos and improving communication
- All voices are heard, all participants understand needs and roles of others

Inclusion

Information

- Participants are prepared with details of patients' care plans, dispositions, and anticipated discharge dates
- Focused information ensures that only essential details are shared, limiting discussion that does not advance patient progression

- Clearly identified next steps, barriers to discharge, and other action items ensure focus is on patient progression
- Individuals are assigned to follow up, reducing chances of issues falling through cracks

Accountability

Feedback

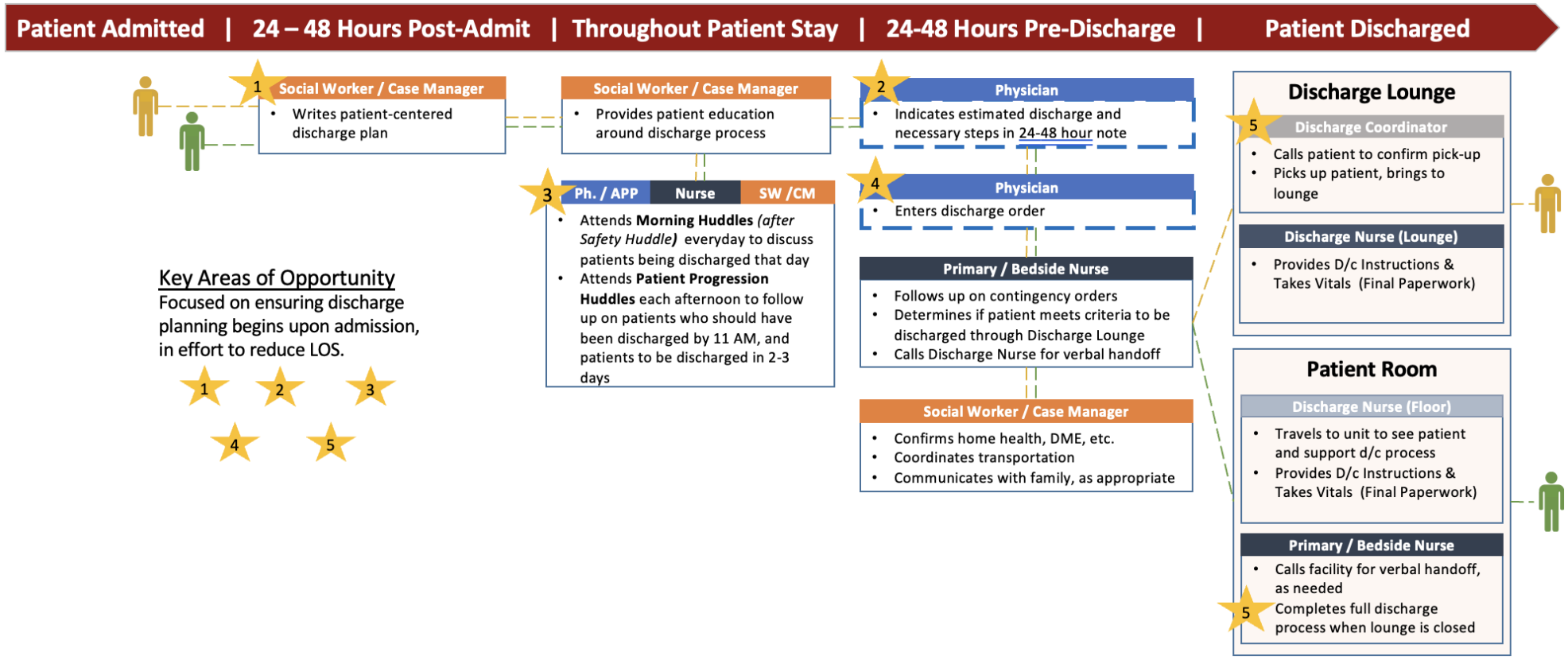
- Feedback on presentation improves participant accountability
- Identification of trends could allow for recognition of potential improvement opportunities
- Ongoing PDSA cycles to improve huddles

Illustrative

Example Solutions: Proactively Managing Discharge Planning

KEY COMPONENTS

- Delineate roles between the Social Worker and Case Manager
- Increase physician's utilization of the 24-48 hour note pre-estimated discharge date
- Better utilize daily huddles to prepare for patient discharge
- Enable physicians to write "cleaner" discharge orders, that indicate when patient is clinically ready to be discharged and only contain true contingencies
- Increase communications, including with Discharge Coordinators (ex. follow-ups if patients are not initially ready to move to the lounge) and with Bedside Nurses (ex. transition for when lounge closes)

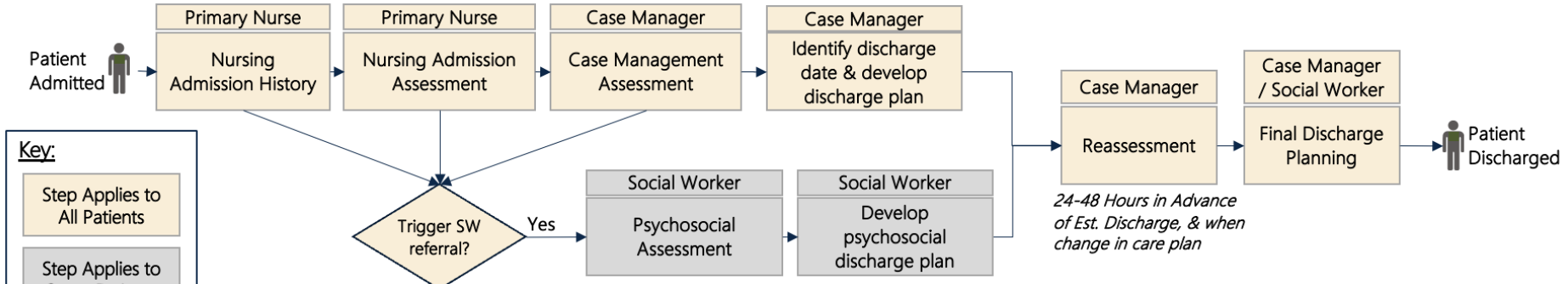


Illustrative

Example Solutions: Optimizing Case Managers Roles & Responsibilities

KEY COMPONENTS

- Clarify roles and responsibilities between Case Managers and Social Workers, refreshing assessments, and building a comprehensive training platform
- Strengthen Case Manager roles to become the care progression experts, ensuring that every patient has an expected discharge date and tracking towards that date through daily, multi-disciplinary conversations and addressing barriers to discharge
- Clearly identify triggers that result in Social Workers becoming the primary over socially-complex patients, as appropriate
- Increase training platform, including InterQual training (eg., Avoidable Days), Case Management training platform (eg., ACMA)



Social Worker Referral Triggers

- Facility placement
- Rx Assistance Programs
- Uninsured or underinsured patients with post discharge needs
- Homeless patients with post discharge needs
- Patients with post DC needs who have inadequate or absent caregiver / social support
- Catastrophic illness / injury
- Suspected victim of abuse / neglect / exploitation
- Complex psychosocial issue
- Difficulty in compliance with treatment plans

Assessment	Goal
Nursing Assessments	• Gather data from patient and/or family so that the health care team and the patient can collaboratively create a plan that will promote health, address acute health problems, and minimize chronic health conditions • Initial understanding of level of CM / SW support that will be needed
Case Management Assessment	• Collect information and identify tasks that need to be performed, questions answered and gaps in care that must be closed between admission and discharge • Use InterQual clinical guidelines as references to permit gap identification
Psychosocial Assessment	• Identify steps needed to address patient's psychosocial needs to ensure patient receives necessary support and discharge is not delayed due to any common barriers
Reassessment	• Update records with new information related to patient discharge plan

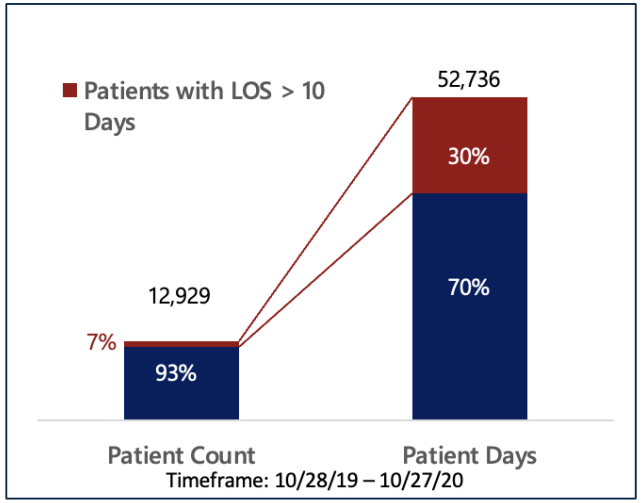
Illustrative

Example Solutions: Improving Long LOS Committee's Effectiveness

KEY COMPONENTS

- Address barriers to discharge that are keeping patients in the hospital for > 10 days
- Design, launch and facilitate Long LOS Committee with structured agenda, led by the CM Committee Chair and Physician Advisor
- Develop Long LOS Tracker database to collect data including attending physician, DRG, LOS, avoidable and excess days, charges, expected reimbursement, meeting criteria
- Identify primary barrier to discharge for each patient
- Problem solve in real-time, tracking next steps and action item owners responsible for addressing the barriers
- Assess trends and enlist additional leadership to develop escalation pathway and guidelines

*Patients with LOS > 10 days have an **ALOS of 20 days** and account for **30% of total bed days.** They represent a meaningful opportunity for throughput improvement…*



…while the Case Management & Social Work teams already meet weekly to discuss patients with LOS > 10 days, current efforts have revamped the Long LOS Committee to focus on structural barriers to discharge and multi-disciplinary solutions.

Committee Chair *Physician Advisor*

Department	Lead
Revenue Integrity	
Transition of Care and UR	
Nurse Executive	
CDS	
ICU	
Palliative Care	
Case Managers & Social Workers	
Additional Physician	To be determined

*Yellow indicates new member

- ✓ Create structure in agenda, report-outs, and data tracking
- ✓ Establish process, assigned responsibility and action-item owners
- ✓ Enlist additional leadership to develop escalation pathway and guidelines
- ✓ Emphasize to broader organization that reducing LOS is a collective responsibility; does not land solely on Case Managers

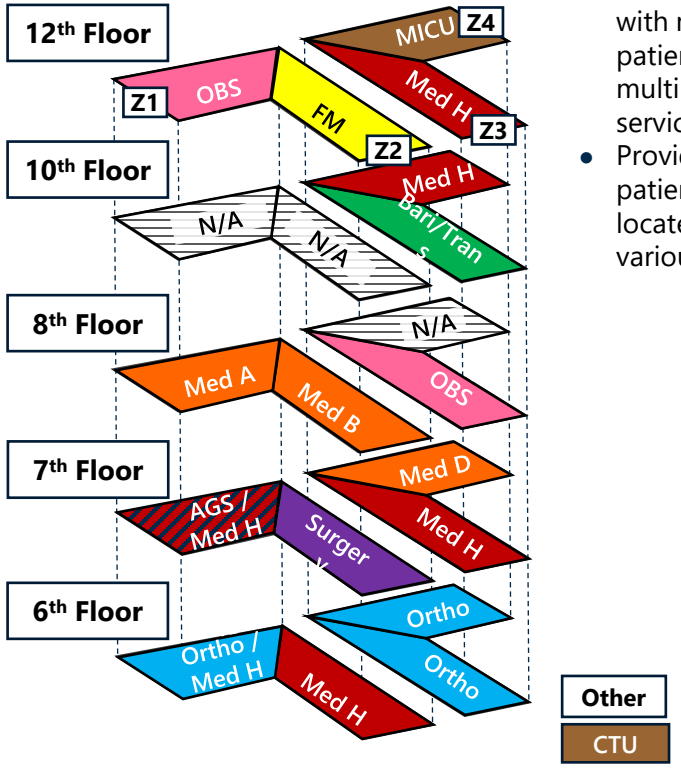
Illustrative

Example Solutions: Refining Patient Aggregation and Service Selection

KEY COMPONENTS

- Beds types are aligned with service demands to enable patient aggregation
- Patient placement protocols based on clinical needs
- Staffing levels are flexed to meet demand
- Compliance to levels of care criteria
- Bed management has standard work across shifts

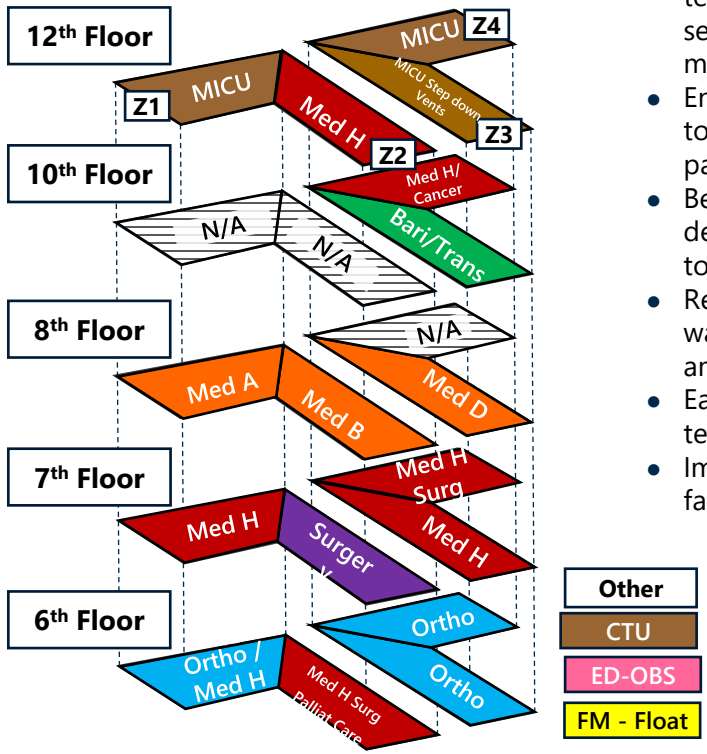
Before



CHALLENGES

- Zones with mixed patients from multiple services lines
- Providers with patients located in various zones

After



RESULTS

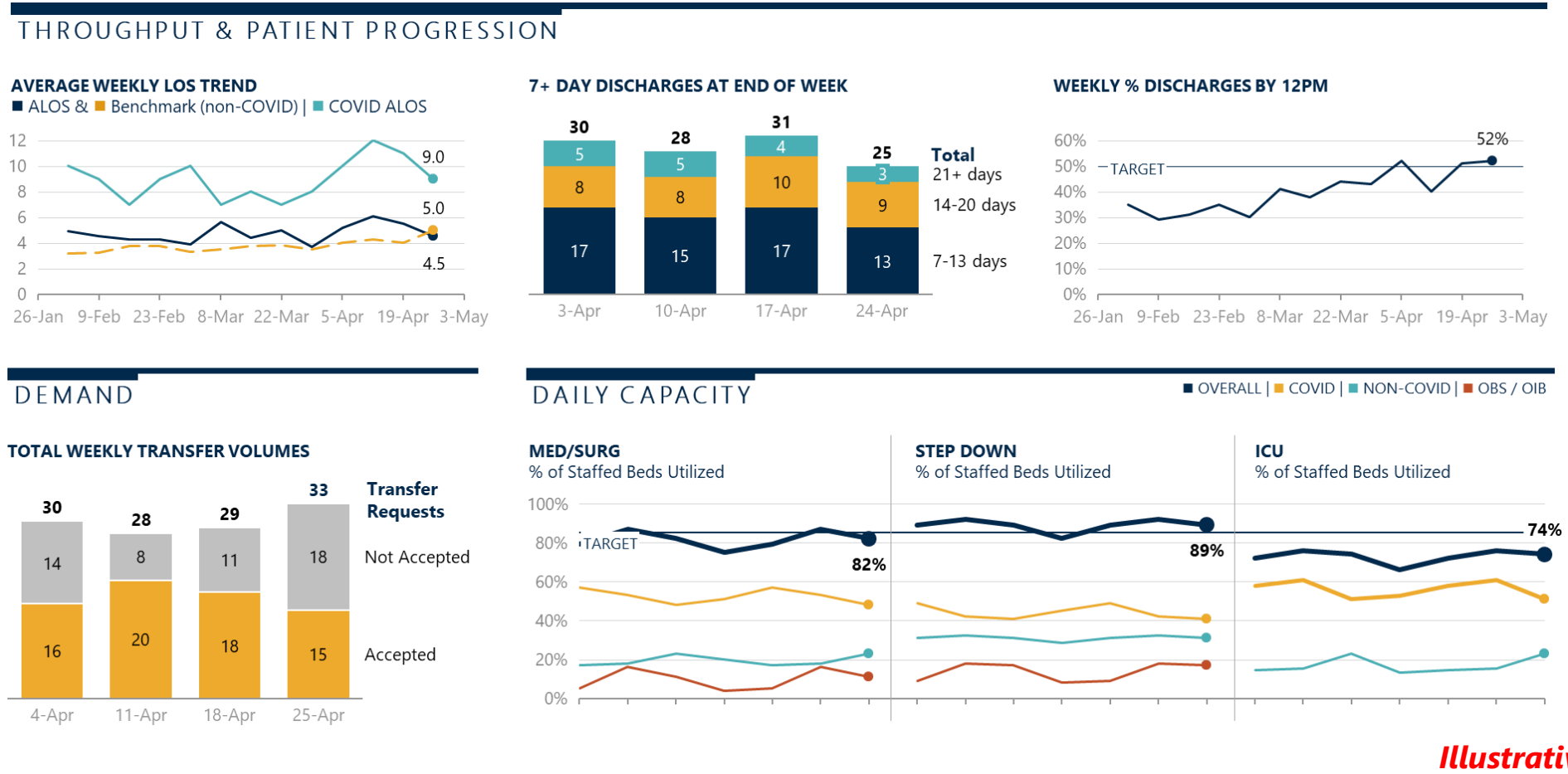
- Co-located medicine teaching teams better serving the academic mission
- Enhanced capacity to cohort hospitalists' patients
- Better matched bed demand by service to the supply
- Reduced providers' wasted time travelling among zones
- Easier multidisciplinary teams' collaboration
- Improved care facilitation efficiency

Illustrative

Example Solutions: Creating an Actionable Patient Throughput Performance Management Dashboard

KEY COMPONENTS

- Inpatient throughput dashboard
- Transparent and daily reporting on performance to support throughput management
- Standard processes in place for routine performance review and mitigation
- Shared reporting
- Track avoidable delays/days

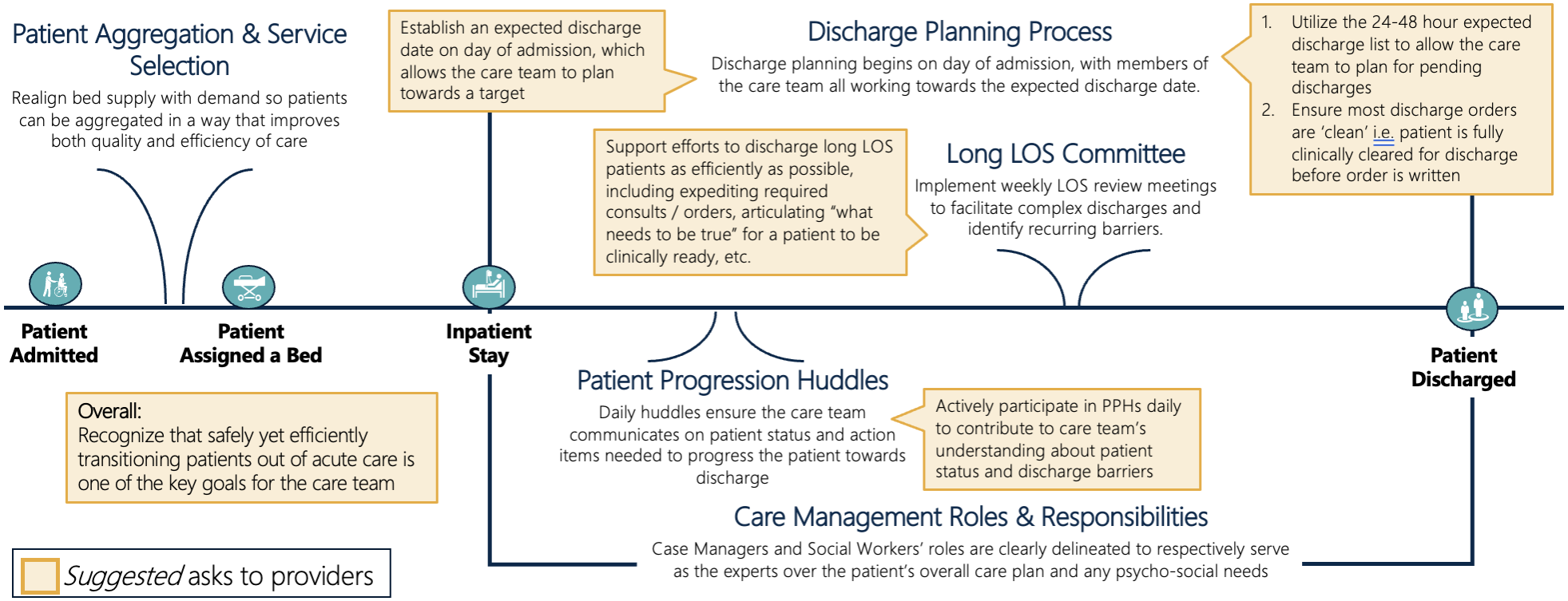


Illustrative

Example Solutions: Activating Physician Engagement

KEY COMPONENTS

- Physician leaders are given both accountability and authority to make the changes needed to achieve and sustain performance improvements
- Physician and other clinicians work together in high performing teams to drive the transformation
- Meaningful performance goals and functional requirements are established across all dimensions
- Information and tools are deployed to support clinical decision making and transparency
- Achieved consensus on clinical guidelines, protocols, and expected outcomes
- Continuous performance improvements in quality, patient experience, and reliability
- Enhanced provider and staff satisfaction

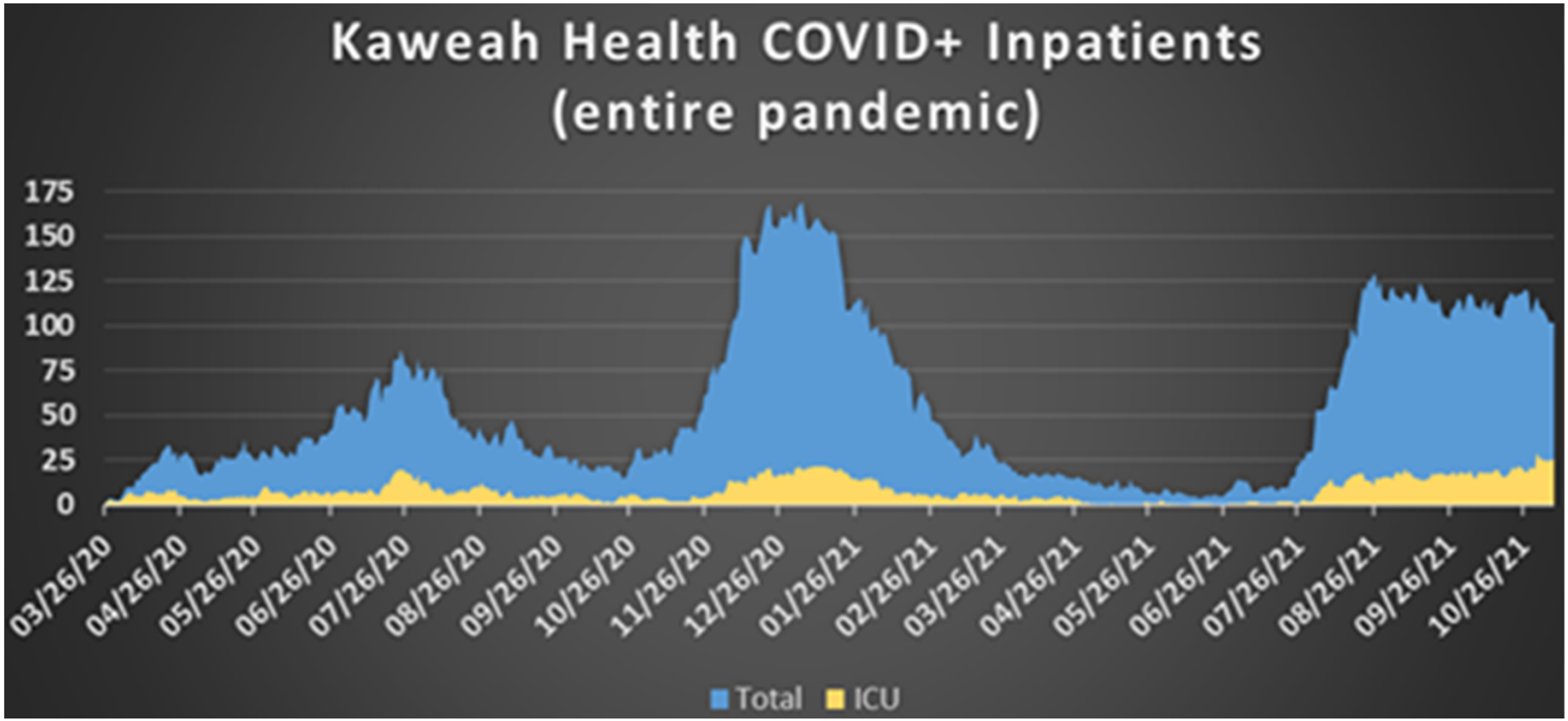


Illustrative

CFO Financial Report
November 17, 2021

kaweahhealth.org

Kaweah Health
MORE THAN MEDICINE. LIFE.


Kaweah Health COVID+ Inpatients
(entire pandemic)
175
150
125
100
75
50
25
0
03/26/20
04/26/20
05/26/20
06/26/20
07/26/20
08/26/20
09/26/20
10/26/20
11/26/20
12/26/20
01/26/21
02/26/21
03/26/21
04/26/21
05/26/21
06/26/21
07/26/21
08/26/21
09/26/21
10/26/21
Total
ICU

COVID-19 Financial Activity – **Round 4 Stimulus Funds**

On Friday September 10th, the U.S. Department of Health and Human Services announced it will allocate $25.5 billion in additional COVID-19 relief funding for Providers. Hopefully funding will occur before the new calendar year. There remains $20B left for a potential 5th round.

Allocation method

$17B from the Provider Relief Fund

- 75% will be based on Revenue Losses and COVID-19 related expenses: Large providers will receive minimum payment amount that is based on their loss revenues and expenses. (Qtrs.3&4 2020 & Qtr.1 2021) Medium and small providers will receive a base payment plus a supplement
- 25% will be used for bonus payments to providers based on the amount and type of services delivered to Medicaid, Children's Health Insurance Program, and Medicare patients. Providers who serve any patients living in rural areas and who meet the eligibility requirement will receive a minimum payment

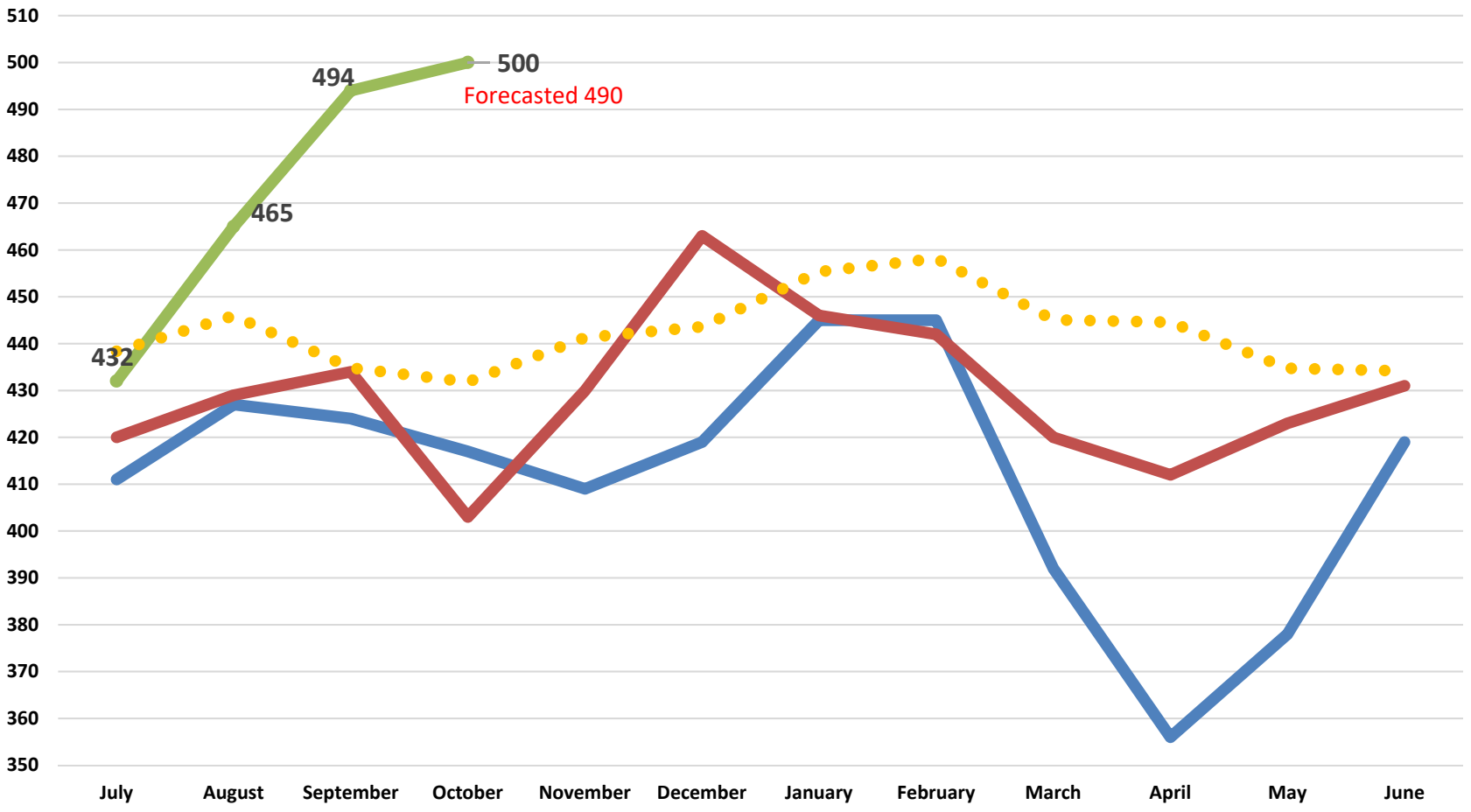
$8.5B from the American Rescue Plan

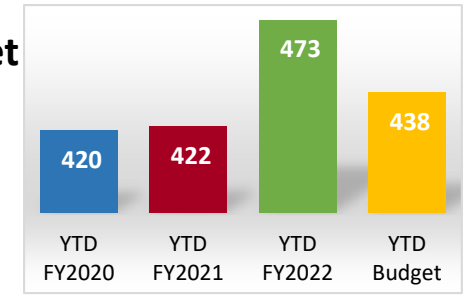
- Providers who service Medicaid, CHIP and Medicare patients who live in rural communities, as defined by the Federal Office of Rural Health Policy are eligible. Payments will be based on the amount and type of services provided to rural patients.

COVID IMPACT (000's)

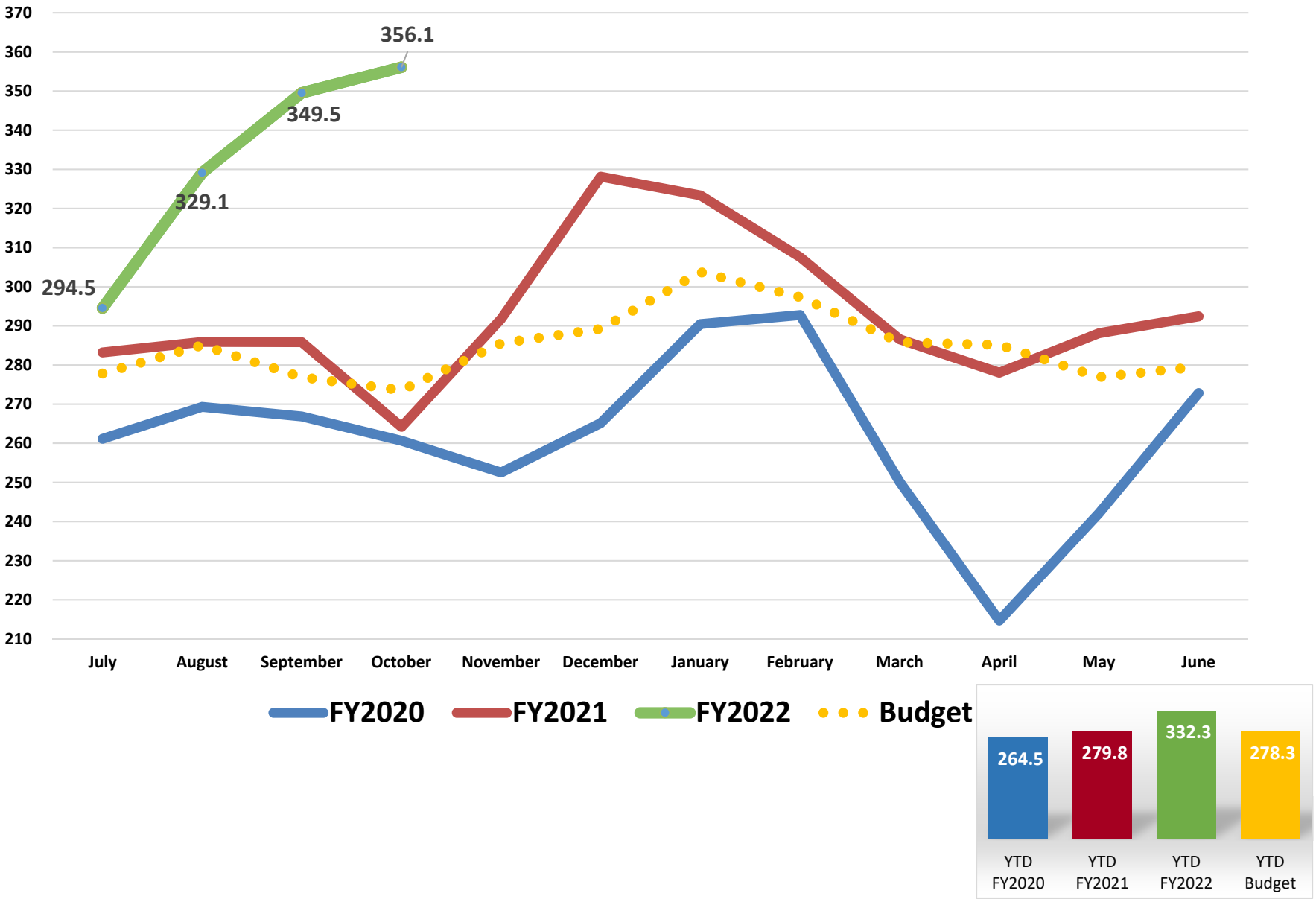
	March 2020 - Oct 2021
Operating Revenue	
Net Patient Service Revenue	**$964,605**
Supplemental Gov't Programs	93,716
Prime Program	21,355
Premium Revenue	96,704
Management Services Revenue	58,482
Other Revenue	36,863
Other Operating Revenue	307,120
Total Operating Revenue	**1,271,722**
Operating Expenses	
Salaries & Wages	546,374
Contract Labor	17,946
Employee Benefits	94,523
Total Employment Expenses	**658,843**
Medical & Other Supplies	217,478
Physician Fees	162,378
Purchased Services	31,832
Repairs & Maintenance	44,341
Utilities	12,252
Rents & Leases	10,265
Depreciation & Amortization	52,981
Interest Expense	11,238
Other Expense	33,800
Humana Cap Plan Expenses	56,640
Management Services Expense	58,091
Total Other Expenses	**691,292**
Total Operating Expenses	**1,350,136**
Operating Margin	**($78,414)**
Stimulus Funds	$48,002
Operating Margin after Stimulus	**($30,412)**
Nonoperating Revenue (Loss)	15,980
Excess Margin	**($14,431)**

Average Daily Census

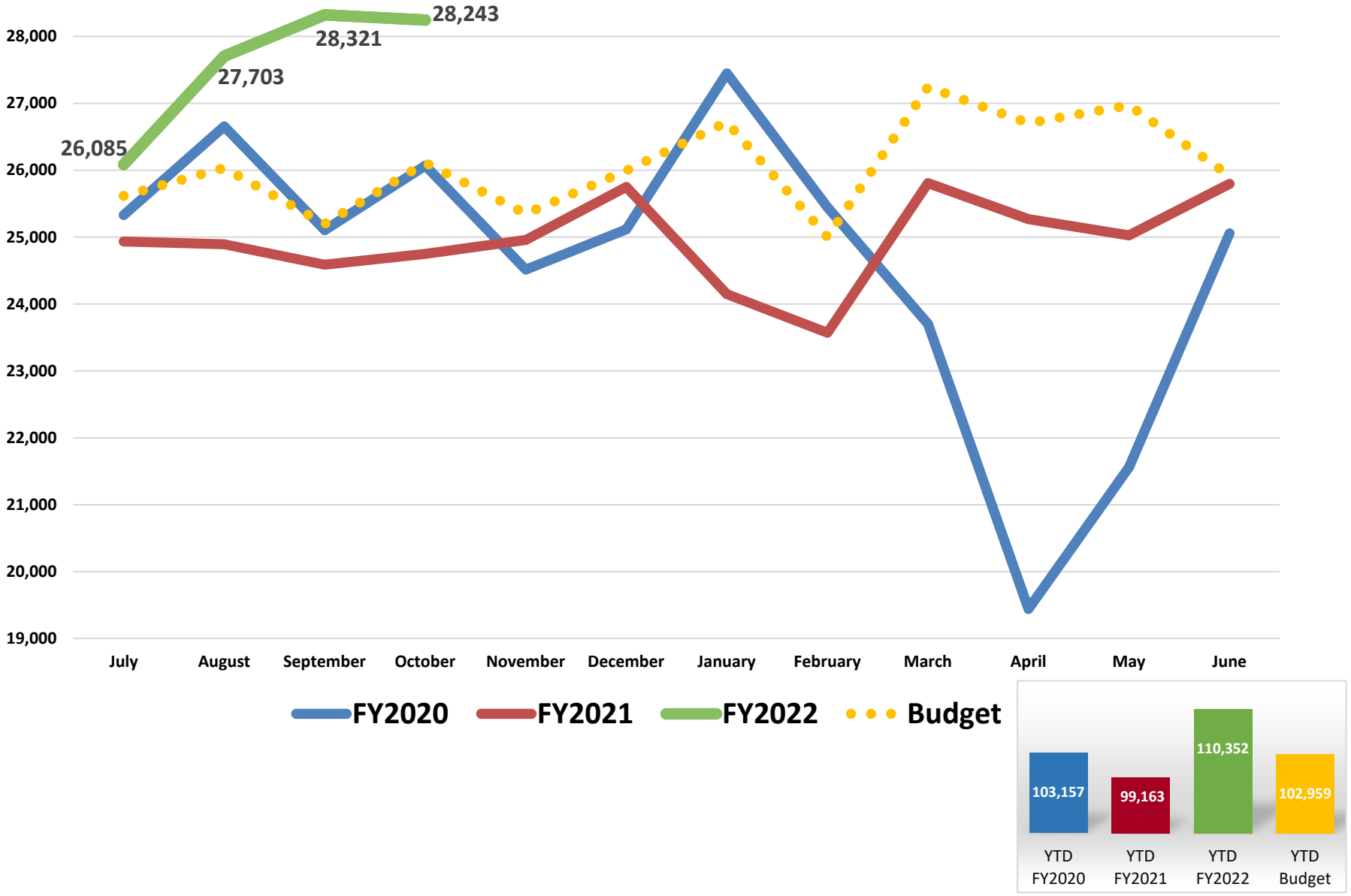




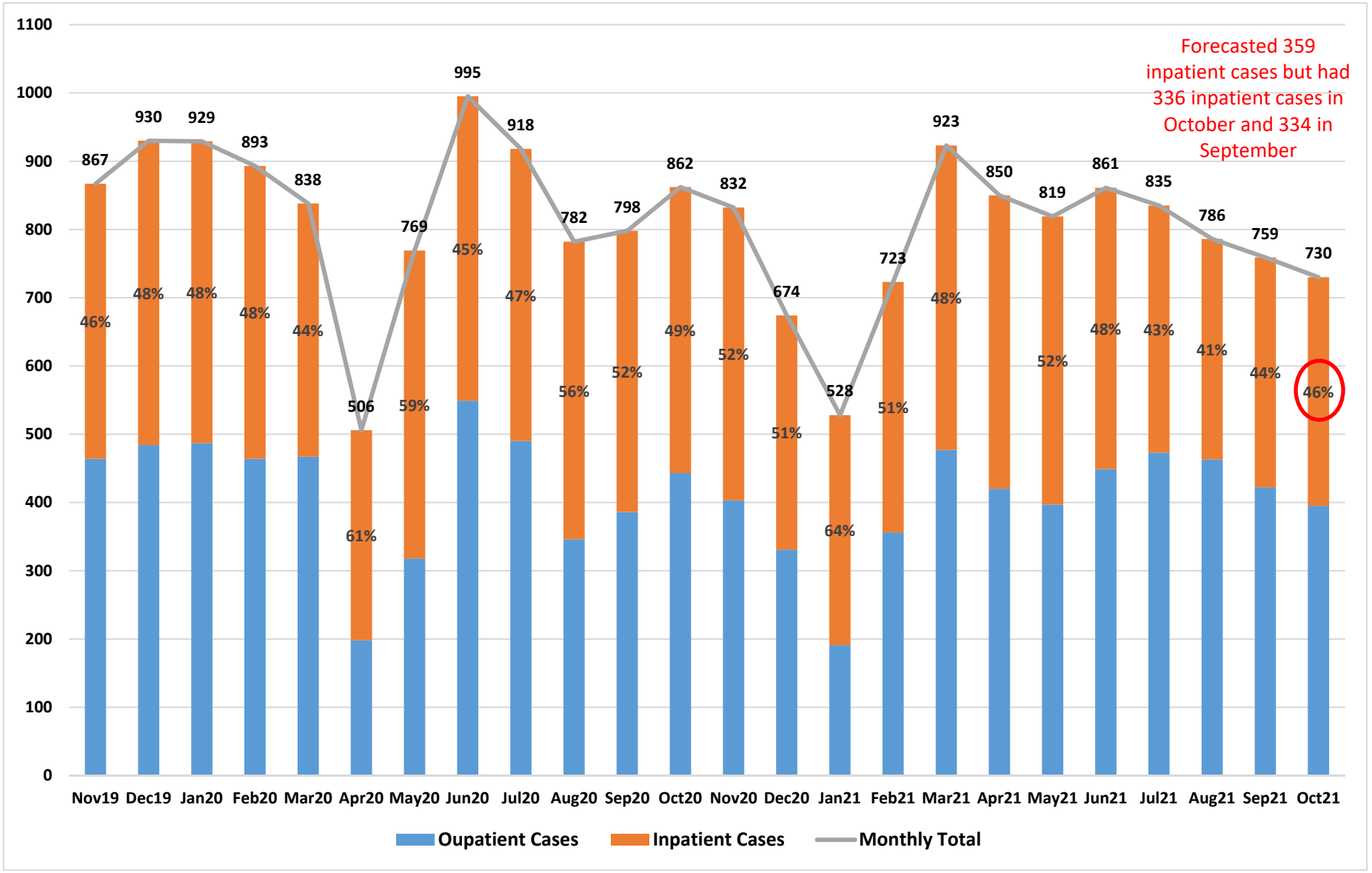
Medical Center – Average Daily Census



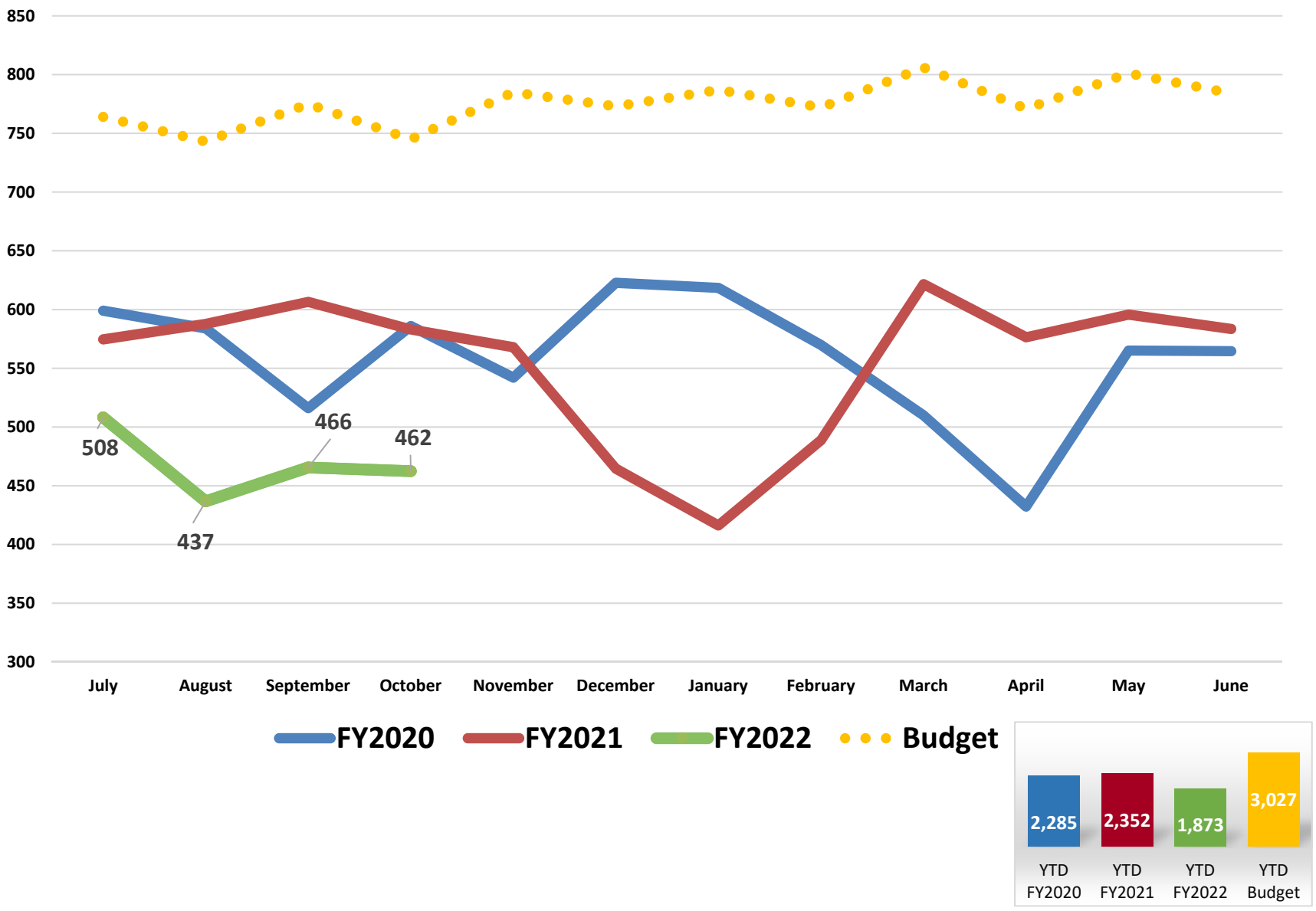
Adjusted Patient Days



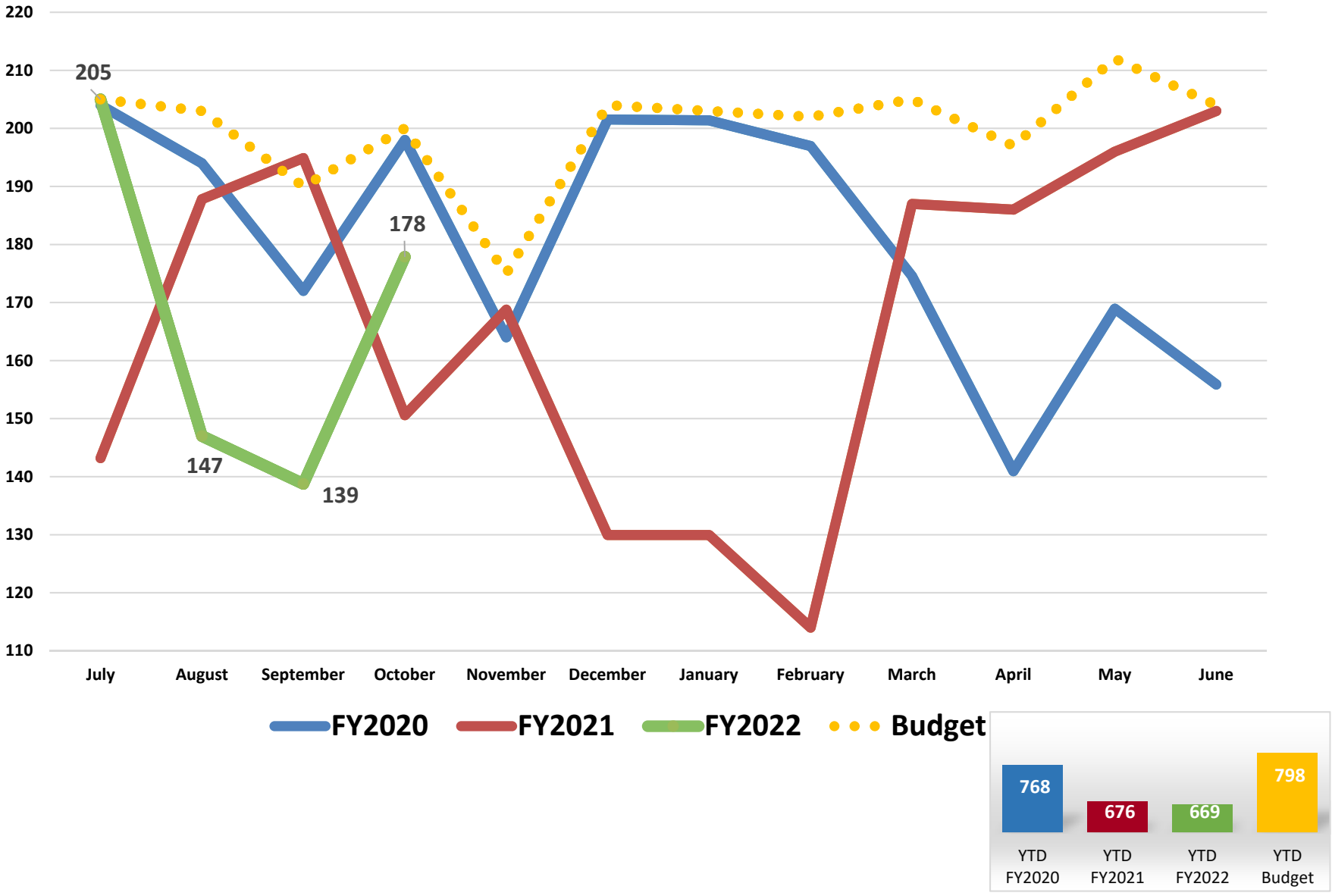
Surgery Volume



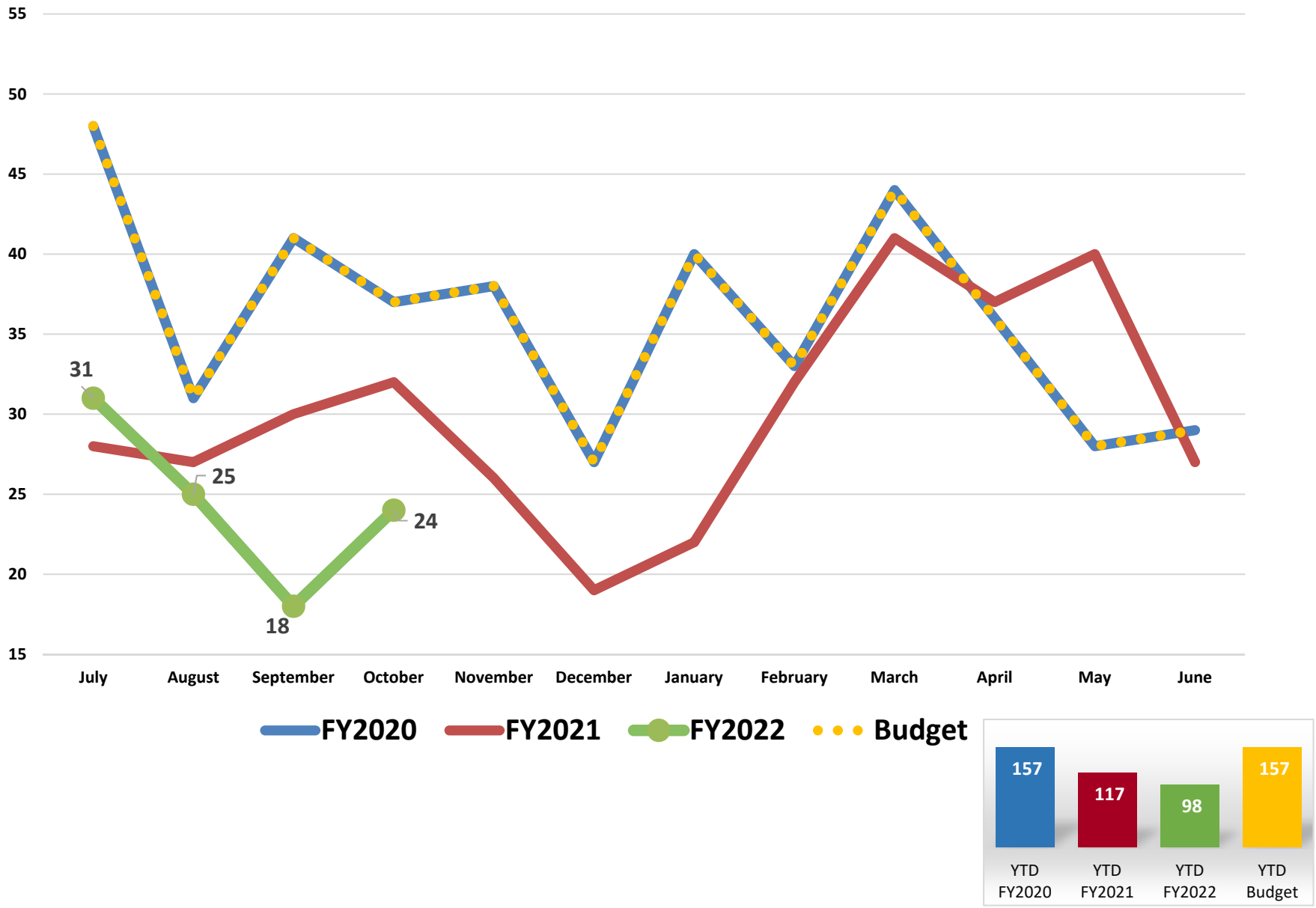
Surgery (IP Only) – 100 min units



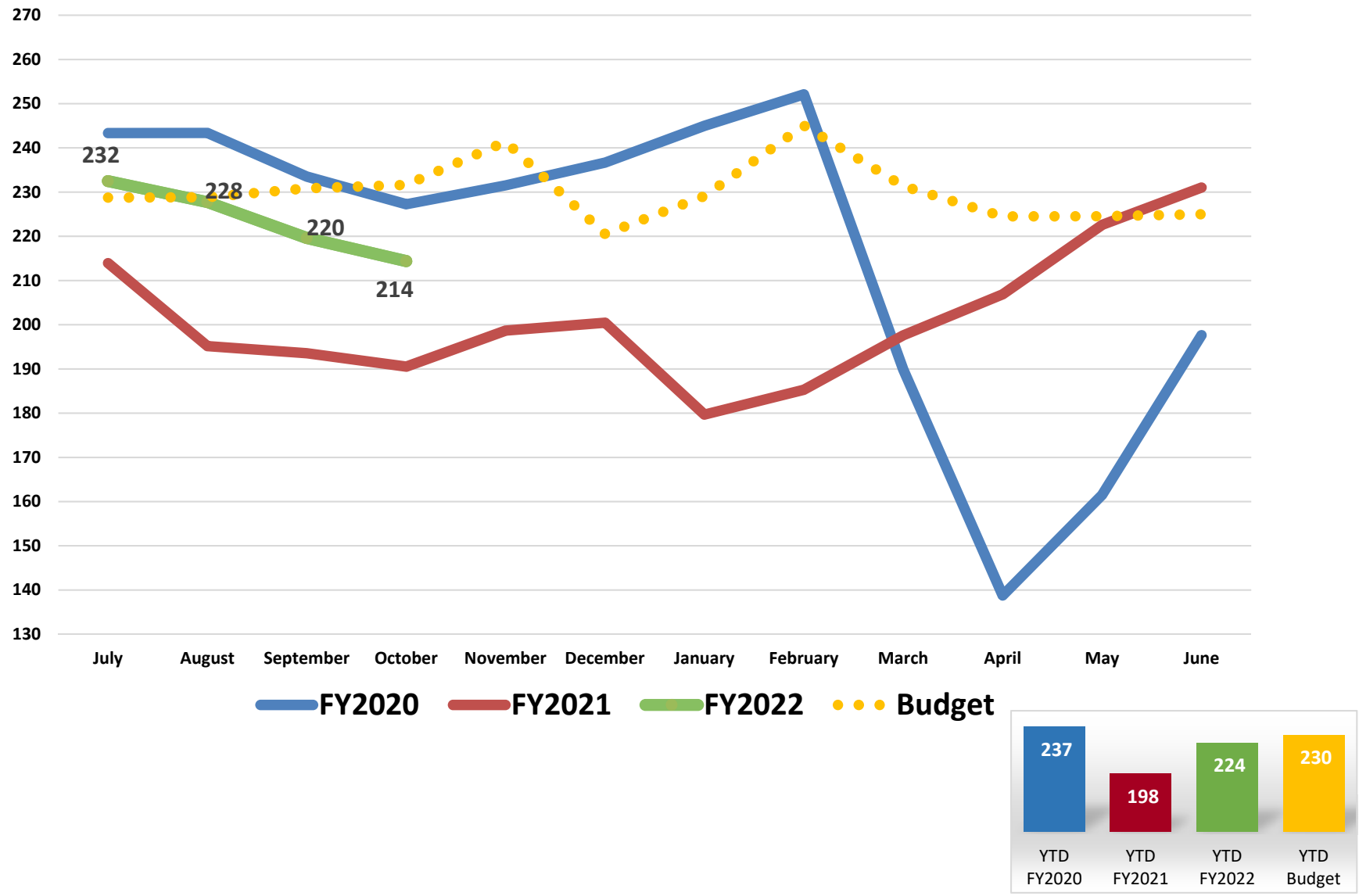
Cath Lab (IP Only) – 100 min units



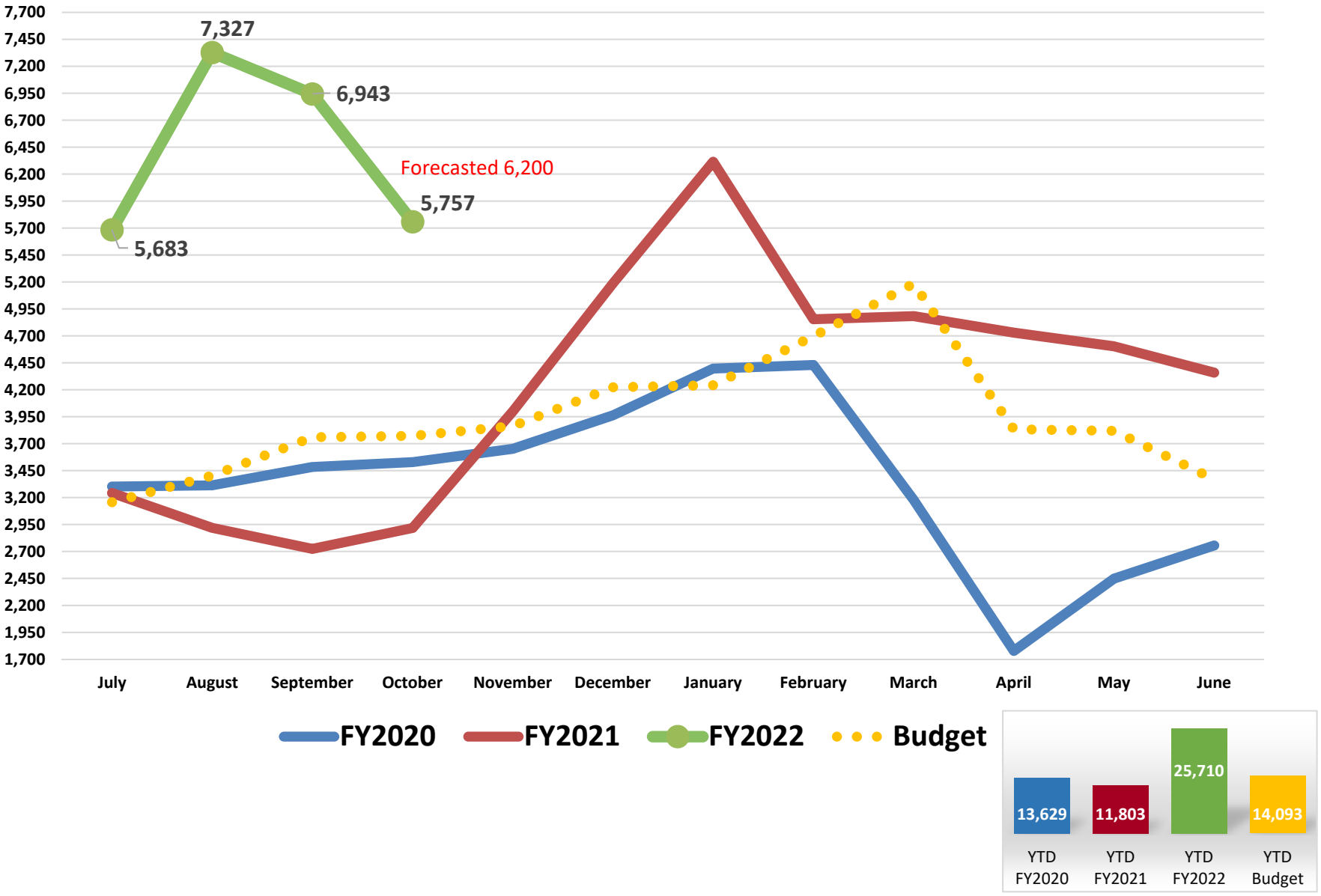
Cardiac Surgery - Cases



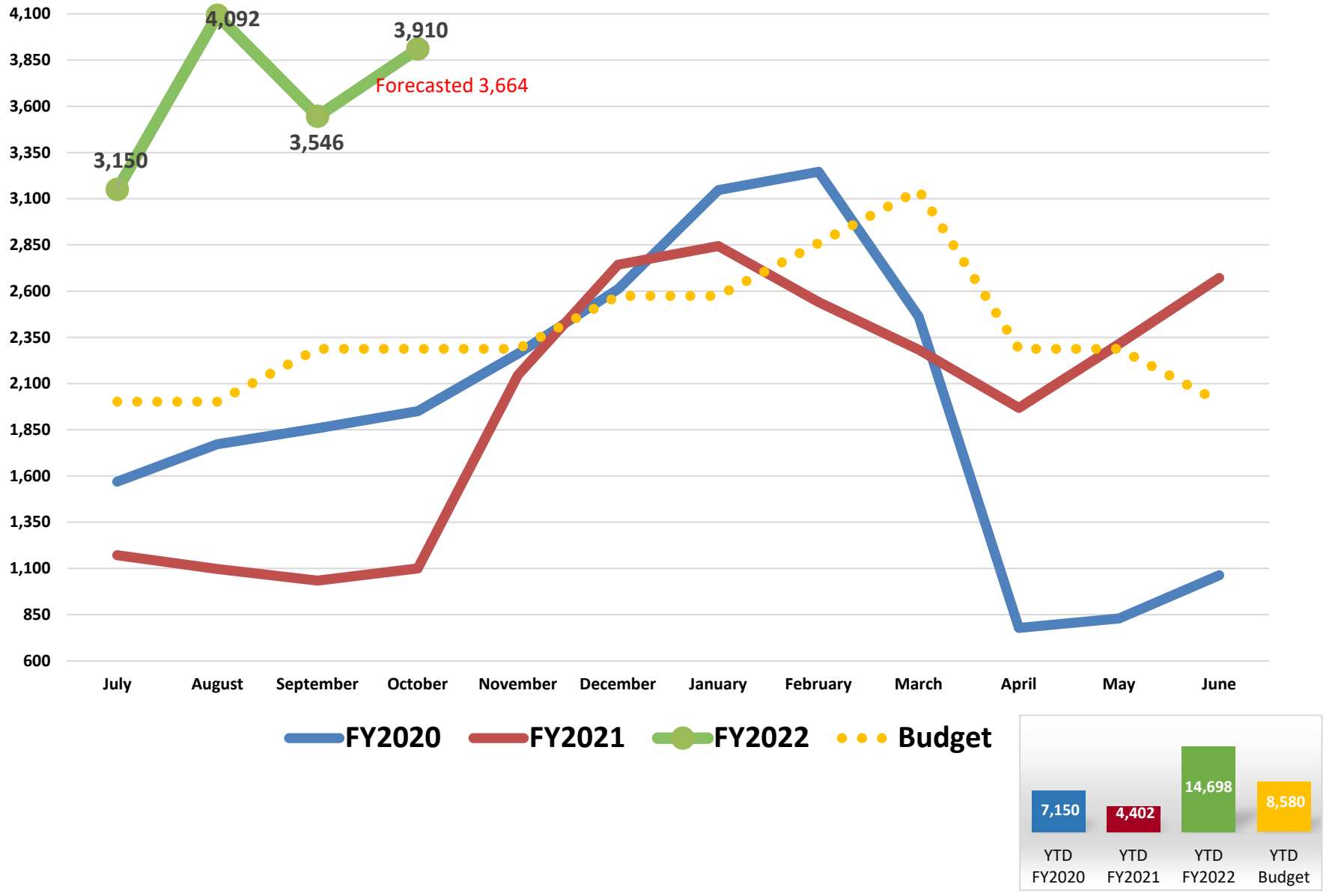
Emergency Department – Average # Treated Per Day



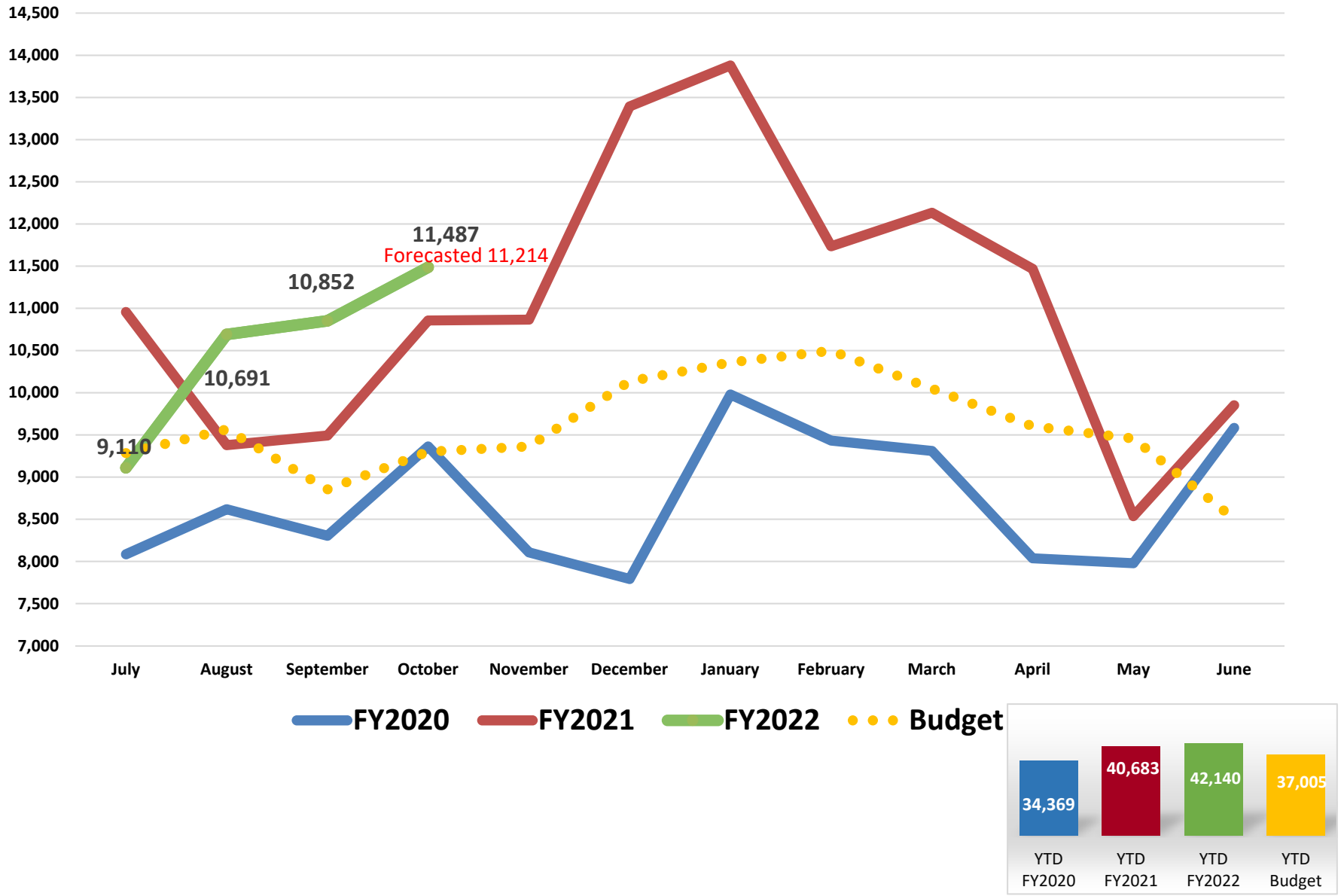
Urgent Care – Court Total Visits



Urgent Care – Demaree Total Visits



Rural Health Clinic Registrations



Statistical Results – Fiscal Year Comparison (Oct)

	Actual Results			Budget	Budget Variance	
	Oct 2020	Oct 2021	% Change	Oct 2021	Change	% Change
Average Daily Census	**403**	**500**	**24.3%**	**432**	**68**	**15.8%**
KDHCD Patient Days:						
Medical Center	8,190	11,039	34.8%	8,480	2,559	30.2%
Acute I/P Psych	1,408	1,168	(17.0%)	1,490	(322)	(21.6%)
Sub-Acute	901	870	(3.4%)	951	(81)	(8.5%)
Rehab	374	492	31.6%	606	(114)	(18.8%)
TCS-Ortho	314	360	14.6%	409	(49)	(12.0%)
TCS	442	479	8.4%	506	(27)	(5.3%)
NICU	372	503	35.2%	400	103	25.8%
Nursery	477	594	24.5%	544	50	9.2%
Total KDHCD Patient Days	**12,478**	**15,505**	**24.3%**	**13,386**	**2,119**	**15.8%**
Total Outpatient Volume	**40,114**	**47,492**	**18.4%**	**47,657**	**(165)**	**(0.3%)**

Statistical Results – Fiscal Year Comparison (Jul-Oct)

	Actual Results			Budget	Budget Variance	
	FYTD 2021	FYTD 2022	% Change	FYTD 2022	Change	% Change
Average Daily Census	**421**	**473**	**12.2%**	**438**	**35**	**7.9%**
KDHCD Patient Days:						
Medical Center	34,408	40,859	18.7%	34,236	6,623	19.3%
Acute I/P Psych	5,629	4,551	(19.2%)	5,830	(1,279)	(21.9%)
Sub-Acute	3,627	3,320	(8.5%)	3,779	(459)	(12.1%)
Rehab	1,536	2,090	36.1%	2,333	(243)	(10.4%)
TCS-Ortho	1,291	1,433	11.0%	1,607	(174)	(10.8%)
TCS	1,670	1,593	(4.6%)	2,010	(417)	(20.7%)
NICU	1,730	2,064	19.3%	1,713	351	20.5%
Nursery	1,923	2,208	14.8%	2,337	(129)	(5.5%)
Total KDHCD Patient Days	**51,814**	**58,118**	**12.2%**	**53,845**	**4,273**	**7.9%**
Total Outpatient Volume	**162,721**	**190,008**	**16.8%**	**189,089**	**919**	**0.5%**

Other Statistical Results – Fiscal Year Comparison (Oct)

	Actual Results				Budget	Budget Variance	
	Oct 2020	Oct 2021	Change	% Change	Oct 2021	Change	% Change
Adjusted Patient Days	**24,749**	**28,243**	**3,495**	**14.1%**	**27,082**	**1,161**	**4.3%**
Outpatient Visits	**40,114**	**47,492**	**7,378**	**18.4%**	**47,657**	**(165)**	**(0.3%)**
Urgent Care - Demaree	1,100	3,910	2,810	**256%**	2,288	1,622	**70.9%**
Urgent Care - Court	2,918	5,757	2,839	**97.3%**	3,772	1,985	**52.6%**
Radiology/CT/US/MRI Proc (I/P & O/P)	14,868	17,055	2,187	**14.7%**	15,550	1,505	**9.7%**
Infusion Center	349	398	49	**14.0%**	449	(51)	**(11.4%)**
ED Total Registered	5,950	6,729	779	**13.1%**	7,181	(452)	**(6.3%)**
OB Deliveries	379	427	48	**12.7%**	400	27	**6.8%**
RHC Registrations	10,856	11,487	631	**5.8%**	9,301	2,186	**23.5%**
GME Clinic visits	1,109	1,165	56	**5.0%**	1,220	(55)	**(4.5%)**
Physical & Other Therapy Units	17,319	17,800	481	**2.8%**	19,307	(1,507)	**(7.8%)**
Cath Lab Minutes (IP & OP)	332	330	(2)	**(0.6%)**	403	(73)	**(18.1%)**
Hospice Days	4,475	4,256	(219)	**(4.9%)**	4,150	106	**2.6%**
Home Health Visits	2,956	2,744	(212)	**(7.2%)**	2,950	(206)	**(7.0%)**
O/P Rehab Units	21,022	18,448	(2,574)	**(12.2%)**	19,587	(1,139)	**(5.8%)**
Radiation Oncology Treatments (I/P & O/P)	2,208	1,889	(319)	**(14.4%)**	2,368	(479)	**(20.2%)**
Surgery Minutes-General & Robotic (I/P & O/P)	1,104	940	(164)	**(14.9%)**	1,326	(386)	**(29.1%)**
KDMF RVU	38,122	32,313	(5,809)	**(15.2%)**	42,956	(10,643)	**(24.8%)**
Endoscopy Procedures (I/P & O/P)	604	510	(94)	**(15.6%)**	604	(94)	**(15.6%)**
Dialysis Treatments	1,770	1,416	(354)	**(20.0%)**	1,834	(418)	**(22.8%)**

Other Statistical Results – Fiscal Year Comparison (Jul-Oct)

	Actual Results				Budget	Budget Variance	
	FY 2021	FY 2022	Change	% Change	FY 2022	Change	% Change
Adjusted Patient Days	**99,165**	**110,357**	**11,192**	**11.3%**	**107,232**	**3,125**	**2.9%**
Outpatient Visits	**162,721**	**190,008**	**27,287**	**16.8%**	**189,089**	**919**	**0.5%**
Urgent Care - Demaree	4,402	14,698	10,296	**234%**	8,580	6,118	**71.3%**
Urgent Care - Court	11,803	25,710	13,907	**118%**	14,093	11,617	**82.4%**
Infusion Center	1,230	1,709	479	**38.9%**	1,514	195	**12.9%**
ED Total Registered	24,565	27,946	3,381	**13.8%**	28,291	(345)	**(1.2%)**
Radiology/CT/US/MRI Proc (I/P & O/P)	59,585	67,500	7,915	**13.3%**	61,913	5,587	**9.0%**
OB Deliveries	1,498	1,661	163	**10.9%**	1,623	38	**2.3%**
Physical & Other Therapy Units	67,874	72,078	4,204	**6.2%**	76,136	(4,058)	**(5.3%)**
RHC Registrations	40,683	42,140	1,457	**3.6%**	37,005	5,135	**13.9%**
GME Clinic visits	4,759	4,784	25	**0.5%**	5,235	(451)	**(8.6%)**
Hospice Days	16,895	16,923	28	**0.2%**	16,058	865	**5.4%**
O/P Rehab Units	79,639	77,488	(2,151)	**(2.7%)**	78,655	(1,167)	**(1.5%)**
KDMF RVU	135,538	129,614	(5,924)	**(4.4%)**	151,015	(21,401)	**(14.2%)**
Cath Lab Minutes (IP & OP)	1,390	1,307	(83)	**(6.0%)**	1,586	(279)	**(17.6%)**
Endoscopy Procedures (I/P & O/P)	2,174	2,027	(147)	**(6.8%)**	2,196	(169)	**(7.7%)**
Home Health Visits	12,253	11,249	(1,004)	**(8.2%)**	11,644	(395)	**(3.4%)**
Radiation Oncology Treatments (I/P & O/P)	8,876	8,052	(824)	**(9.3%)**	9,655	(1,603)	**(16.6%)**
Surgery Minutes-General & Robotic (I/P & O/P)	4,321	3,901	(420)	**(9.7%)**	5,314	(1,413)	**(26.6%)**
Dialysis Treatments	7,024	6,258	(766)	**(10.9%)**	7,420	(1,162)	**(15.7%)**

Trended Financial Comparison (000's)

Kaweah Delta Health Care District

Trended Income Statement (000's)

Adjusted Patient Days	*24,749*	*24,958*	*25,750*	*24,148*	*23,570*	*25,807*	*25,268*	*25,026*	*25,797*	*26,085*	*27,703*	*28,321*	*28,243*
	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Operating Revenue													
Net Patient Service Revenue	**$51,454**	**$50,994**	**$50,409**	**$49,949**	**$44,505**	**$56,144**	**$52,593**	**$50,531**	**$43,233**	**$51,502**	**$49,714**	**$57,879**	**$55,674**
Supplemental Gov't Programs	3,980	3,979	3,979	4,822	5,279	5,279	4,990	4,990	6,845	4,286	4,286	4,286	4,383
Prime Program	429	429	429	713	358	715	4,872	715	721	667	667	667	667
Premium Revenue	4,408	4,271	4,318	4,690	5,027	4,894	4,710	5,036	6,584	4,902	5,425	5,163	5,156
Management Services Revenue	2,396	2,569	2,583	2,867	2,430	3,303	3,301	2,877	3,251	3,172	3,298	3,523	3,137
Other Revenue	1,871	1,471	2,008	1,022	1,425	2,915	1,810	2,074	2,188	2,009	2,348	1,873	2,250
Other Operating Revenue	13,083	12,719	13,317	14,115	14,519	17,106	19,684	15,692	19,589	15,036	16,024	15,513	15,592
Total Operating Revenue	**64,537**	**63,713**	**63,726**	**64,064**	**59,024**	**73,250**	**72,277**	**66,223**	**62,822**	**66,537**	**65,737**	**73,391**	**71,266**
Operating Expenses													
Salaries & Wages	27,583	25,984	28,026	28,111	25,134	28,879	26,741	27,786	26,249	27,474	28,198	31,872	30,538
Contract Labor	488	242	303	226	1,404	887	1,694	1,169	2,080	1,116	1,358	1,721	1,872
Employee Benefits	5,314	4,998	5,969	5,671	5,027	5,739	8,650	5,087	(7,812)	4,087	3,878	4,728	4,217
Total Employment Expenses	**33,385**	**31,225**	**34,298**	**34,008**	**31,565**	**35,505**	**37,084**	**34,042**	**20,517**	**32,678**	**33,434**	**38,321**	**36,627**
Medical & Other Supplies	10,713	10,999	11,492	12,014	9,685	10,923	11,011	10,170	11,772	9,596	13,004	11,942	11,714
Physician Fees	7,746	8,079	8,024	8,421	8,484	8,278	8,320	7,754	8,207	7,922	8,527	7,736	9,674
Purchased Services	1,685	1,592	1,628	1,935	1,507	1,538	1,520	1,383	2,697	1,100	1,368	1,680	1,683
Repairs & Maintenance	2,166	2,091	2,146	2,192	2,115	2,019	2,544	2,282	2,319	2,074	2,425	2,425	2,702
Utilities	644	491	439	537	467	523	630	729	1,175	688	740	696	860
Rents & Leases	529	543	504	546	519	487	535	489	504	475	519	487	474
Depreciation & Amortization	2,509	2,473	2,458	2,451	2,423	2,412	2,413	2,923	3,924	2,635	2,632	2,636	2,634
Interest Expense	556	555	555	555	555	555	555	555	666	555	646	499	501
Other Expense	1,747	1,863	1,610	1,808	1,280	2,762	1,840	1,537	2,053	1,450	1,466	1,641	1,563
Humana Cap Plan Expenses	2,750	2,677	2,935	2,217	2,707	3,164	3,771	3,780	3,018	3,472	2,503	3,642	3,982
Management Services Expense	2,447	2,553	2,876	2,860	2,256	3,531	3,088	2,892	3,521	2,768	3,115	3,734	2,988
Total Other Expenses	**33,491**	**33,915**	**34,668**	**35,536**	**31,998**	**36,191**	**36,227**	**34,493**	**39,856**	**32,735**	**36,945**	**37,116**	**38,774**
Total Operating Expenses	**66,876**	**65,140**	**68,965**	**69,544**	**63,562**	**71,696**	**73,310**	**68,535**	**60,373**	**65,413**	**70,379**	**75,437**	**75,402**
Operating Margin	**($2,339)**	**($1,427)**	**($5,240)**	**($5,480)**	**($4,538)**	**$1,554**	**($1,033)**	**($2,312)**	**$2,449**	**$1,124**	**($4,642)**	**($2,046)**	**($4,136)**
Stimulus Funds	$4,538	$1,724	$0	$5,758	$3,460	$3,449	$920	$1,076	$525	$0	$438	$0	$137
Operating Margin after Stimulus	**$2,199**	**$297**	**($5,240)**	**$278**	**($1,078)**	**$5,003**	**($113)**	**($1,236)**	**$2,974**	**$1,124**	**($4,204)**	**($2,046)**	**($3,999)**
Nonoperating Revenue (Loss)	638	1,083	1,963	605	513	(1,182)	1,725	753	248	582	552	(388)	595
Excess Margin	**$2,837**	**$1,380**	**($3,276)**	**$883**	**($565)**	**$3,821**	**$1,612**	**($483)**	**$3,222**	**$1,706**	**($3,651)**	**($2,434)**	**($3,404)**

October Financial Comparison (000's)

	Actual Results		Budget	Budget Variance	
	Oct 2020	Oct 2021	Oct 2021	Change	% Change
Operating Revenue					
Net Patient Service Revenue	**$51,454**	**$55,674**	**$53,315**	**$2,359**	**4.4%**
Other Operating Revenue	13,083	15,592	15,390	203	1.3%
Total Operating Revenue	**64,537**	**71,266**	**68,704**	**2,562**	**3.7%**
Operating Expenses					
Employment Expense	33,385	36,627	32,895	3,732	11.3%
Other Operating Expense	33,491	38,774	35,253	3,521	10.0%
Total Operating Expenses	**66,876**	**75,402**	**68,148**	**7,253**	**10.6%**
Operating Margin	**($2,339)**	**($4,136)**	**$556**	**($4,692)**	
Stimulus Funds	4,538	137	101	36	
Operating Margin after Stimulus	**$2,199**	**($3,999)**	**$657**	**($4,656)**	
Non Operating Revenue (Loss)	639	595	542	53	
Excess Margin	**$2,837**	**($3,404)**	**$1,199**	**($4,602)**	

Operating Margin %	**(3.6%)**	**(5.8%)**	**0.8%**
OM after Stimulus%	**3.4%**	**(5.6%)**	**1.0%**
Excess Margin %	**4.1%**	**(4.7%)**	**1.7%**
Operating Cash Flow Margin %	**1.1%**	**(1.4%)**	**5.7%**

YTD (July-Oct) Financial Comparison (000's)

	Actual Results FYTD Jul-Oct		Budget FYTD	Budget Variance	FYTD
	FYTD2021	FYTD2022	FYTD2022	Change	% Change
Operating Revenue					
Net Patient Service Revenue	**$196,017**	**$214,768**	**$211,380**	**$3,388**	**1.6%**
Other Operating Revenue	53,578	62,163	61,312	851	1.4%
Total Operating Revenue	**249,595**	**276,931**	**272,692**	**4,239**	**1.6%**
Operating Expenses					
Employment Expense	130,639	141,071	131,041	10,031	7.7%
Other Operating Expense	132,133	145,570	138,908	6,662	4.8%
Total Operating Expenses	**262,772**	**286,641**	**269,949**	**16,692**	**6.2%**
Operating Margin	**($13,177)**	**($9,710)**	**$2,743**	**($12,453)**	
Stimulus Funds	15,549	575	403	172	
Operating Margin after Stimulus	**$2,372**	**($9,135)**	**$3,146**	**($12,281)**	
Nonoperating Revenue (Loss)	1,752	1,341	2,014	(673)	
Excess Margin	**$4,124**	**($7,794)**	**$5,160**	**($12,954)**	

Operating Margin %	**(5.3%)**	**(3.5%)**	**1.0%**
OM after Stimulus%	**1.0%**	**(3.3%)**	**1.2%**
Excess Margin %	**1.5%**	**(2.8%)**	**1.9%**
Operating Cash Flow Margin %	**(0.3%)**	**1.1%**	**5.6%**

October Financial Comparison (000's)

	Actual Results			Budget	Budget Variance	
	Oct 2020	Oct 2021	% Change	Oct 2021	Change	% Change
Operating Revenue						
Net Patient Service Revenue	**$51,454**	**55,674**	**8.2%**	**$53,315**	**$2,359**	**4.4%**
Supplemental Gov't Programs	3,980	4,383	10.1%	4,426	(43)	(1.0%)
Prime Program	429	667	55.4%	679	(13)	(1.9%)
Premium Revenue	4,408	5,156	17.0%	5,116	39	0.8%
Management Services Revenue	2,396	3,137	30.9%	3,082	55	1.8%
Other Revenue	1,871	2,250	20.3%	2,086	163	7.8%
Other Operating Revenue	13,083	15,592	**19.2%**	15,390	203	1.3%
Total Operating Revenue	**64,537**	**71,266**	**10.4%**	**68,704**	**2,562**	**3.7%**
Operating Expenses						
Salaries & Wages	27,583	30,538	10.7%	27,810	2,729	9.8%
Contract Labor	488	1,872	283.5%	504	1,368	271.5%
Employee Benefits	5,314	4,217	(20.6%)	4,581	(364)	(8.0%)
Total Employment Expenses	**33,385**	**36,627**	**9.7%**	**32,895**	**3,732**	**11.3%**
Medical & Other Supplies	10,713	11,714	9.3%	10,427	1,287	12.3%
Physician Fees	7,746	9,674	24.9%	8,537	1,137	13.3%
Purchased Services	1,685	1,683	(0.1%)	1,348	335	24.9%
Repairs & Maintenance	2,166	2,702	24.8%	2,418	284	11.7%
Utilities	644	860	33.5%	769	91	11.8%
Rents & Leases	529	474	(10.4%)	510	(35)	(6.9%)
Depreciation & Amortization	2,509	2,634	5.0%	2,780	(146)	(5.3%)
Interest Expense	556	501	(9.9%)	614	(114)	(18.5%)
Other Expense	1,747	1,563	(10.5%)	1,917	(354)	(18.5%)
Humana Cap Plan Expenses	2,750	3,982	44.8%	2,883	1,099	38.1%
Management Services Expense	2,447	2,988	22.1%	3,049	(61)	(2.0%)
Total Other Expenses	**33,491**	**38,774**	**15.8%**	**35,253**	**3,521**	**10.0%**
Total Operating Expenses	**66,876**	**75,402**	**12.7%**	**68,148**	**7,253**	**10.6%**
Operating Margin	**($2,339)**	**($4,136)**	**(76.8%)**	**$556**	**($4,692)**	**(844%)**
Stimulus Funds	4,538	137	(97.0%)	101	36	35.6%
Operating Margin after Stimulus	**$2,199**	**($3,999)**	**(282%)**	**$657**	**($4,656)**	**(709%)**
Nonoperating Revenue (Loss)	639	595	(6.8%)	542	53	9.8%
Excess Margin	**$2,837**	**($3,404)**	**(220.%)**	**$1,199**	**($4,602)**	**(384%)**

Operating Margin %	**(3.6%)**	**(5.8%)**		**0.8%**
OM after Stimulus%	**3.4%**	**(5.6%)**		**1.0%**
Excess Margin %	**4.1%**	**(4.7%)**		**1.7%**
Operating Cash Flow Margin %	**1.1%**	**(1.4%)**		**5.7%**

YTD Financial Comparison (000's)

	Actual Results FYTD Jul-Oct			Budget FYTD	Budget Variance	FYTD
	FYTD2021	FYTD2022	% Change	FYTD2022	Change	% Change
Operating Revenue						
Net Patient Service Revenue	**$196,017**	**$214,768**	**9.6%**	**$211,380**	**$3,388**	**1.6%**
Supplemental Gov't Programs	15,917	17,242	8.3%	17,702	(460)	(2.6%)
Prime Program	1,716	2,667	55.4%	2,696	(29)	(1.1%)
Premium Revenue	17,559	20,646	17.6%	20,409	237	1.2%
Management Services Revenue	10,986	13,130	19.5%	12,229	900	7.4%
Other Revenue	7,400	8,479	14.6%	8,276	203	2.5%
Other Operating Revenue	53,578	62,163	**16.0%**	61,312	851	1.4%
Total Operating Revenue	**249,595**	**276,931**	**11.0%**	**272,692**	**4,239**	**1.6%**
Operating Expenses						
Salaries & Wages	107,242	118,094	10.1%	110,801	7,293	6.6%
Contract Labor	1,772	6,067	242.3%	2,048	4,019	196.2%
Employee Benefits	21,625	16,910	(21.8%)	18,191	(1,281)	(7.0%)
Total Employment Expenses	**130,639**	**141,071**	**8.0%**	**131,041**	**10,031**	**7.7%**
Medical & Other Supplies	43,088	46,255	7.4%	42,145	4,110	9.8%
Physician Fees	31,123	33,859	8.8%	33,195	665	2.0%
Purchased Services	5,429	5,829	7.4%	5,345	484	9.1%
Repairs & Maintenance	8,435	9,626	14.1%	9,628	(2)	(0.0%)
Utilities	2,401	2,984	24.3%	2,850	135	4.7%
Rents & Leases	2,066	1,955	(5.4%)	2,046	(92)	(4.5%)
Depreciation & Amortization	10,170	10,536	3.6%	10,073	463	4.6%
Interest Expense	2,222	2,200	(1.0%)	2,438	(238)	(9.8%)
Other Expense	5,838	6,121	4.8%	7,613	(1,492)	(19.6%)
Humana Cap Plan Expenses	10,489	13,600	29.7%	11,478	2,122	18.5%
Management Services Expense	10,872	12,604	15.9%	12,097	506	4.2%
Total Other Expenses	**132,133**	**145,570**	**10.2%**	**138,908**	**6,662**	**4.8%**
Total Operating Expenses	**262,772**	**286,641**	**9.1%**	**269,949**	**16,692**	**6.2%**
Operating Margin	**($13,177)**	**($9,710)**	**26.3%**	**$2,743**	**($12,453)**	**(454%)**
Stimulus Funds	15,549	575	(96.3%)	403	172	42.7%
Operating Margin after Stimulus	**$2,372**	**($9,135)**	**(485%)**	**$3,146**	**($12,281)**	**(390%)**
Nonoperating Revenue (Loss)	1,752	1,341	(23.5%)	2,014	(673)	(33.4%)
Excess Margin	**$4,124**	**($7,794)**	**(289%)**	**$5,160**	**($12,954)**	**(251%)**

Operating Margin %	**(5.3%)**	**(3.5%)**		**1.0%**
OM after Stimulus%	**1.0%**	**(3.3%)**		**1.2%**
Excess Margin %	**1.5%**	**(2.8%)**		**1.9%**
Operating Cash Flow Margin %	**(0.3%)**	**1.1%**		**5.6%**

Kaweah Health Medical Group
Fiscal Year Financial Comparison (000's)

	Actual Results FYTD July - Oct			Budget FYTD	Budget Variance	FYTD
	Oct 2020	Oct 2021	% Change	Oct 2021	Change	% Change
Operating Revenue						
Net Patient Service Revenue	**$16,195**	**$15,187**	**(6.2%)**	**$17,694**	**($2,508)**	**(14.2%)**
Other Operating Revenue	117	245	109.7%	283	(39)	(13.7%)
Total Operating Revenue	**16,311**	**15,431**	**(5.4%)**	**17,978**	**(2,546)**	**(14.2%)**
Operating Expenses						
Salaries & Wages	3,788	3,864	2.0%	4,183	(319)	(7.6%)
Contract Labor	0	0	0.0%	0	0	0.0%
Employee Benefits	719	597	(17.0%)	683	(86)	(12.5%)
Total Employment Expenses	**4,507**	**4,461**	**(1.0%)**	**4,866**	**(404)**	**(8.3%)**
Medical & Other Supplies	2,019	2,414	19.6%	2,360	54	2.3%
Physician Fees	8,698	9,186	5.6%	10,041	(855)	(8.5%)
Purchased Services	267	326	22.0%	285	41	14.2%
Repairs & Maintenance	848	733	(13.6%)	913	(180)	(19.7%)
Utilities	188	174	(7.5%)	210	(36)	(17.1%)
Rents & Leases	927	830	(10.4%)	866	(35)	(4.1%)
Depreciation & Amortization	385	265	(31.2%)	367	(102)	(27.9%)
Interest Expense	1	1	(62.6%)	0	0	54.5%
Other Expense	355	424	19.4%	567	(143)	(25.3%)
Total Other Expenses	**13,689**	**14,352**	**4.8%**	**15,610**	**(1,257)**	**(8.1%)**
Total Operating Expenses	**18,196**	**18,814**	**3.4%**	**20,475**	**(1,661)**	**(8.1%)**
Stimulus Funds	0	0	0.0%	0	0	0.0%
Excess Margin	**($1,885)**	**($3,382)**	**(79.5%)**	**($2,497)**	**($885)**	**(35.4%)**
Excess Margin %	**(11.6%)**	**(21.9%)**		**(13.9%)**		

October 2021 | Forecast Variances to Actual

	Actual	Forecast	Actual - Forecast Variance		
	Oct 2021	Oct 2021	Change	% Change	
Operating Revenue (000's)					
Net Patient Service Revenue	**55,674**	**54,142**	**1,532**	**2.8%**	Record High Inpatient Volumes
Other Operating Revenue	15,592	15,491	**101**	0.6%	
Total Operating Revenue	**71,266**	**69,633**	**1,633**	**2.3%**	
Operating Expenses					
Employment Expense	36,627	38,621	(1,994)	(5.4%)	Actual Shift bonus was ($769K) and Overtime ($505K) less than forecasted
Other Operating Expense	38,775	36,981	1,794	4.6%	Actual Physician fees $1.6M and Humana third party claims $1M higher than forecasted
Total Operating Expenses	**75,402**	**75,602**	**(200)**	**(0.3%)**	
Operating Margin	**($4,136)**	**($5,969)**	**$1,833**		
Stimulus Funds	137	0	0		
Operating Margin after Stimulus	**($3,999)**	**($5,969)**	**$1,970**		
NonOperating Revenue (Loss)	595	542	53		
Excess Margin (000's)	**($3,404)**	**($5,427)**	**$2,023**		

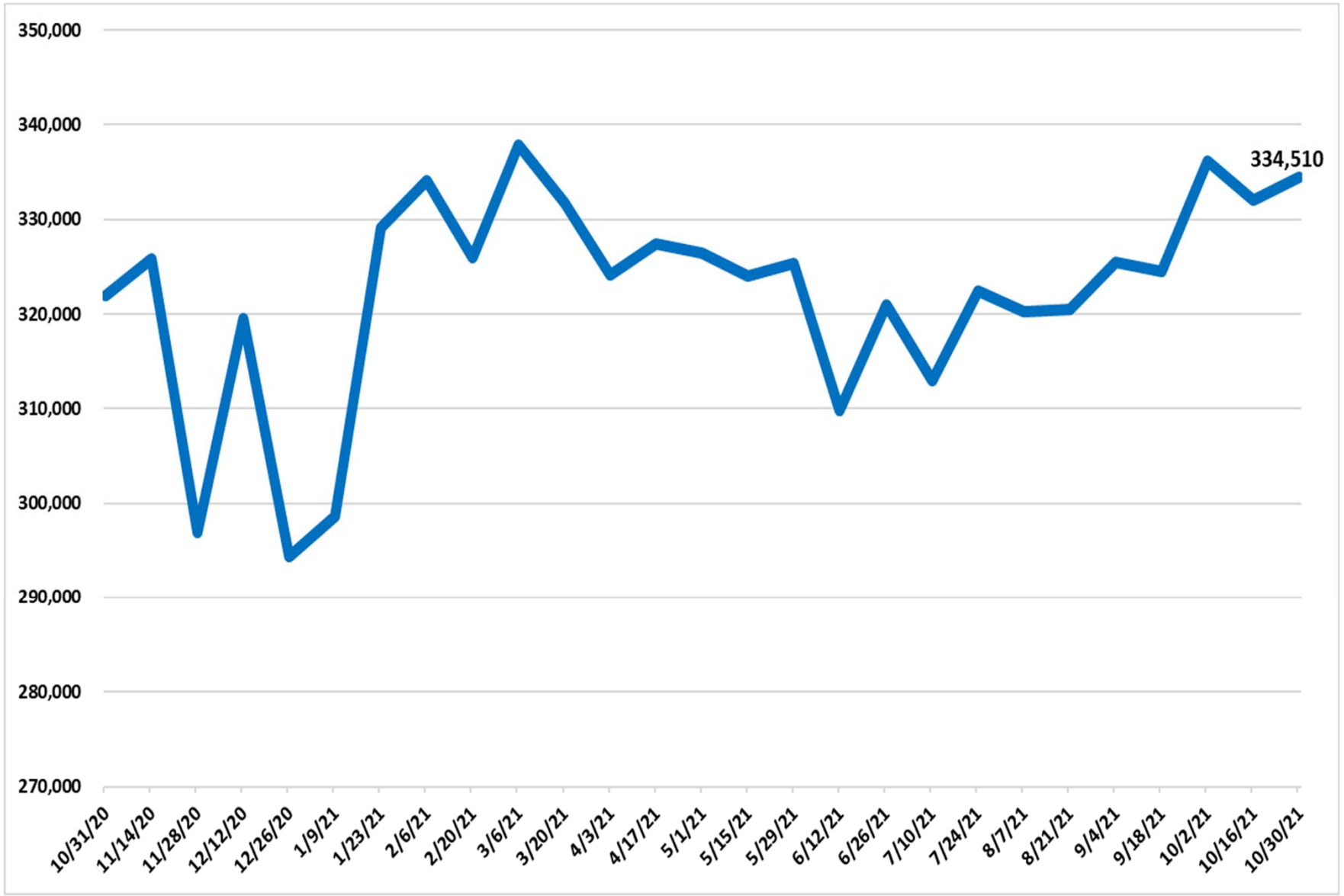
Month of October - Budget Variances

- **Net Patient Revenues:** Net patient revenue exceeded budget by $2.4M (4.4%). This is primarily due to a 15.8% increase in inpatient days.
- **Salaries and Contract Labor**: We experienced an unfavorable budget variance of $4.1M in October. The unfavorable variance is primarily due to the higher patient volume as well as the rates associated with contract labor hours ($1.4M), shift bonuses ($2M), overtime ($575K) and COVID related costs ($220K).
- **Medical Supplies:** The $1.3M unfavorable budget variance is mainly due to supplies purchases for COVID ($1.1M), and an increase in pharmacy and lab costs.
- **Physician Fees:** Physician fees exceeded budget by $1.1M primarily due to the increased use of locums and timing of collections due to a change in billing company.
- **Humana Cap Plan Expenses:** The $1.1M unfavorable variance resulted from higher utilization of non-Kaweah medical care provided to members during the month of October. The main difference we are seeing is an increase in our Skilled Nursing Facility Days. SNF Days. Jul-Oct 2020 =1,114 days compared to Jul-Oct 2021 = 2,105($557K). COVID YTD Impact ($796K).

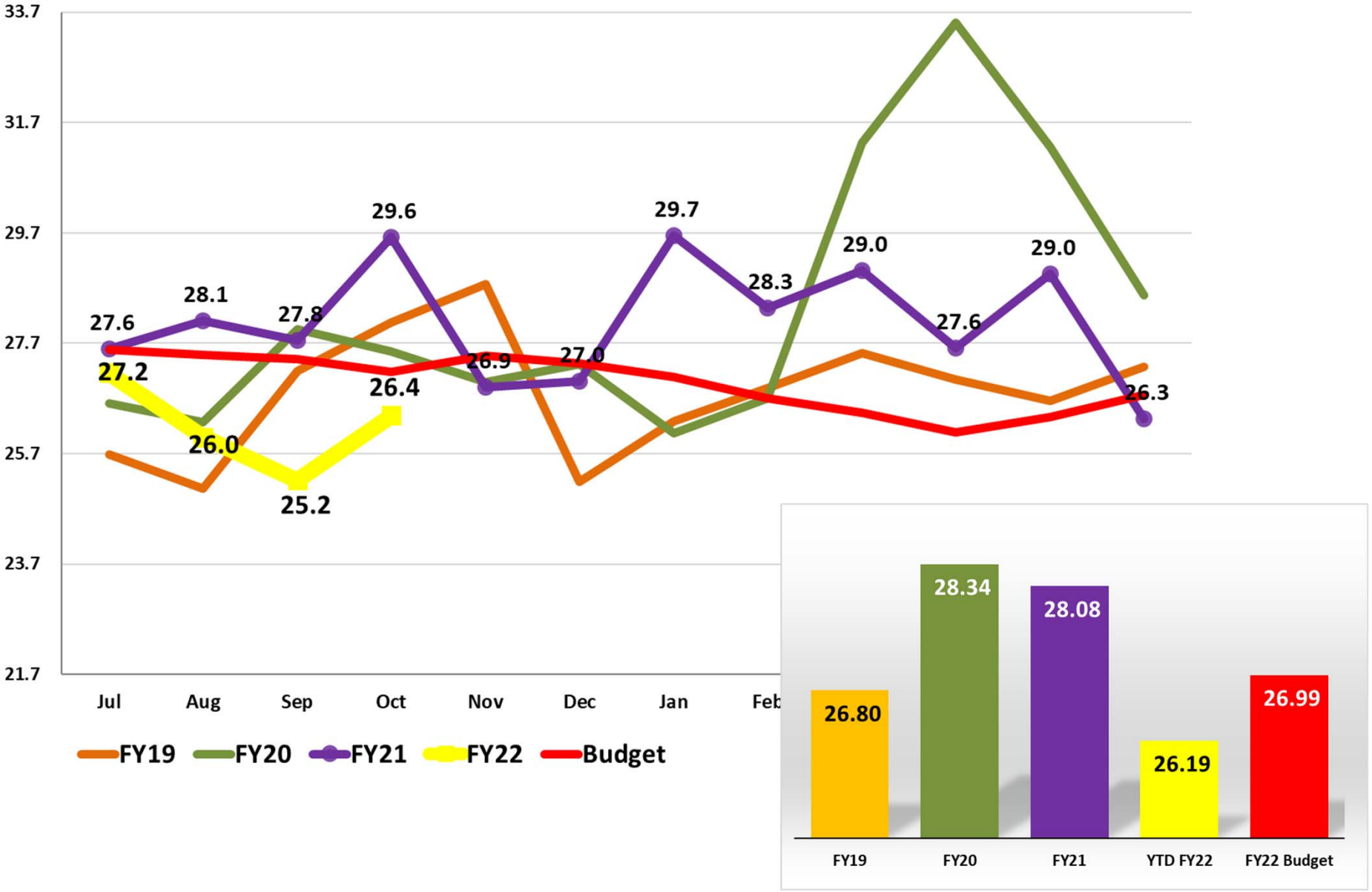
Bond Covenant Forecast (Consolidated Financial Statements)

	Annualized Jun-21	Oct-21	FY22 Budget	FY22 Forecast
DAYS CASH ON HAND COMPUTATION				
Cash, cash equivalents and board designated funds	$ 387,774,000	$ 334,902,836	$ 308,003,000	$ 255,212,369
Total operating expenses	$ 804,384,156	$ 850,601,809	$ 809,419,000	$ 846,060,000
Less depreciation and amortization	(31,645,725)	(31,266,078)	(33,552,000)	(34,237,000)
Adjusted operating expenses	$ 772,738,431	$ 819,335,731	$ 775,867,000	$ 811,823,000
Number of days in the period	365	365	365	365
Average daily adjusted operating expenses	$ 2,117,092	$ 2,244,755	$ 2,125,663	$ 2,224,173
Days cash on hand	**183.2**	**149.2**	**144.9**	**114.7**
Requirement Measured at 6/30				**90**
LONG-TERM DEBT SERVICE COVERAGE RATIO CALCULATION				
Net income (loss)	$ 12,413,788	$ (23,128,575)	$ 18,937,000	$ (16,369,000)
Depreciation and amortization	31,645,725	31,266,078	33,552,000	34,237,000
Interest (non-GO)	6,770,637	6,528,407	7,234,000	7,109,000
GO Bond tax revenue (net of interest)	(1,792,963)	(1,750,756)	(1,780,916)	(1,780,916)
Net income available for debt service	$ 49,037,187	$ 12,915,154	$ 57,942,084	$ 23,196,084
Maximum annual debt service (without GO bonds)	$ 16,967,599	$ 16,967,599	$ 16,967,599	$ 16,967,599
Long-term debt service coverage ratio	**2.89**	**0.76**	**3.41**	**1.37**
Requirement:				
Measured at 12/31 and 6/30 - if below must fund Reserve Fund ($17M)				**1.35**
Measured at 6/30 if below must employ independent consultant				**1.25**
After compliance with independent consultant recommendations - not below				**1.10**

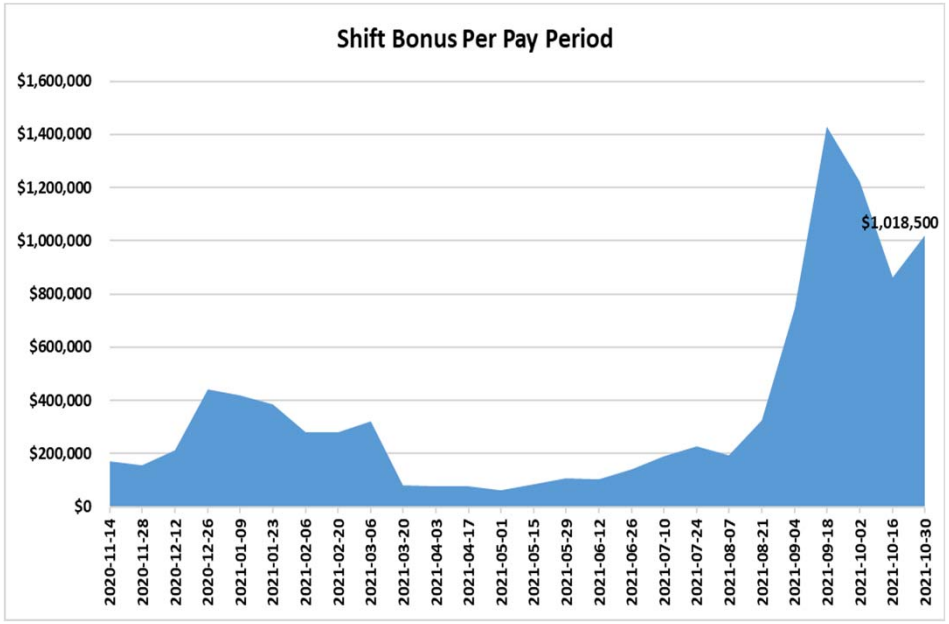
Productive Hours

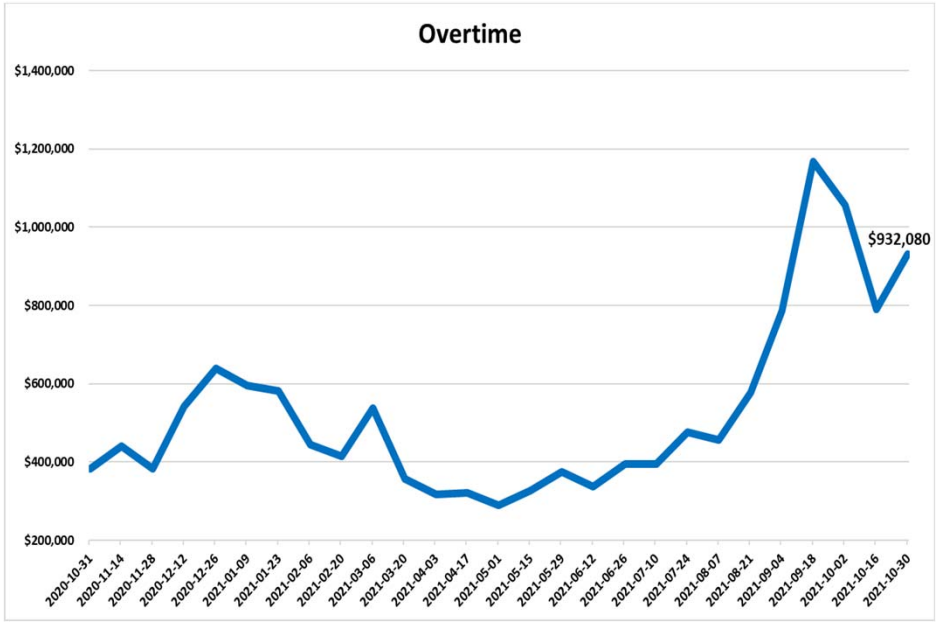


Productivity: Worked Hours/Adjusted Patient Days

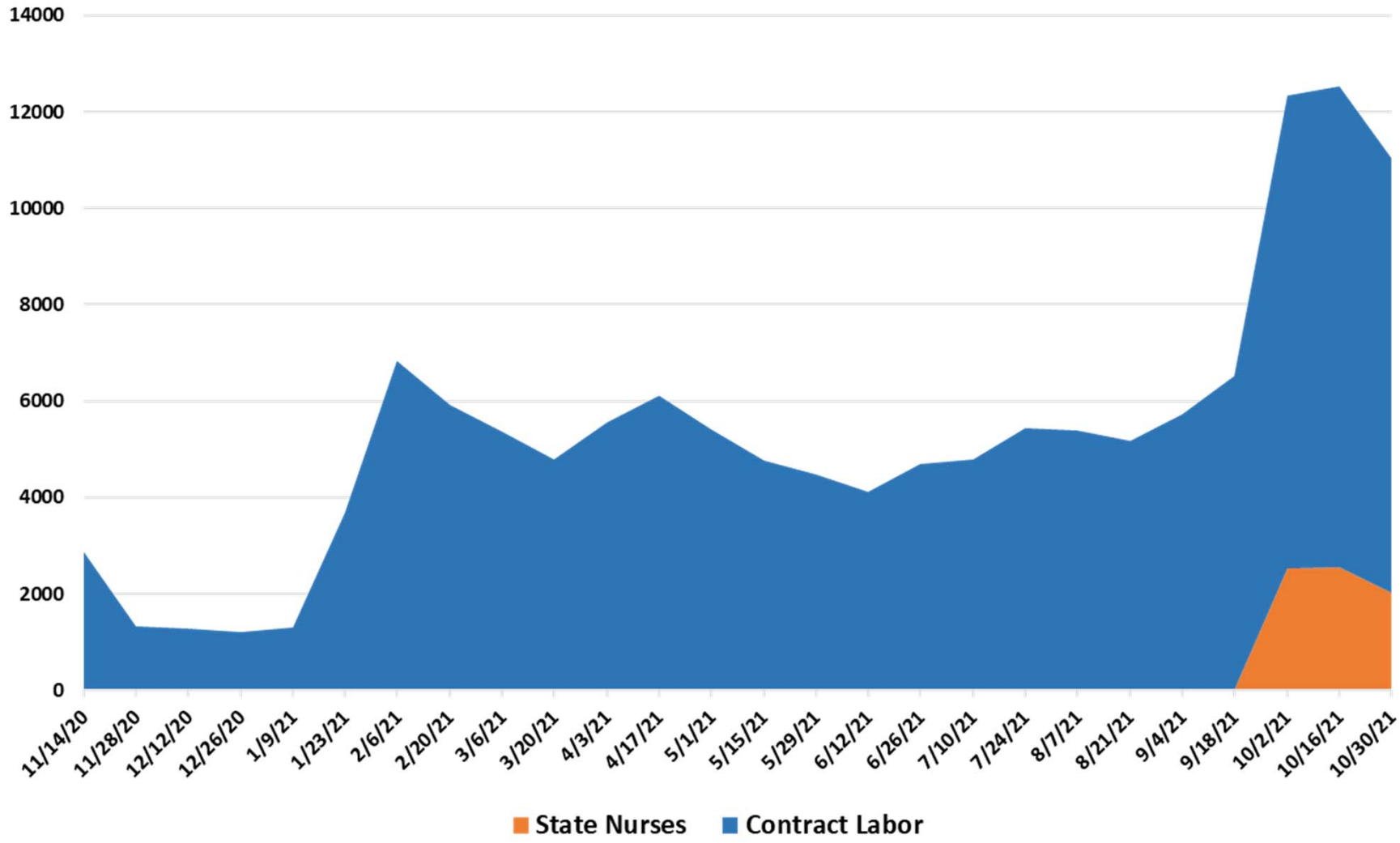


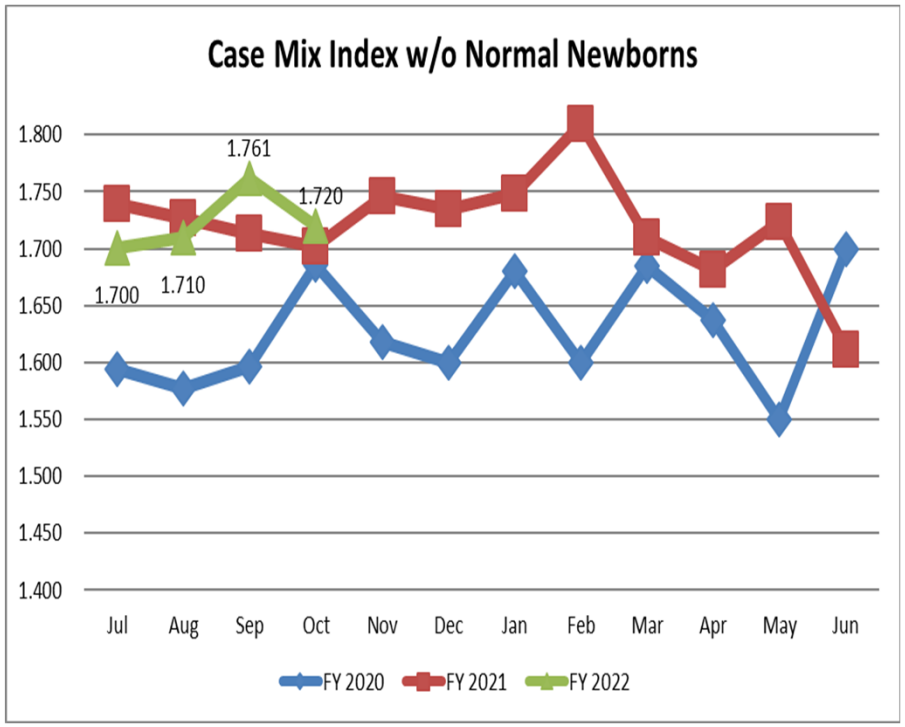
Premium & Extra Pay Impact on Rates

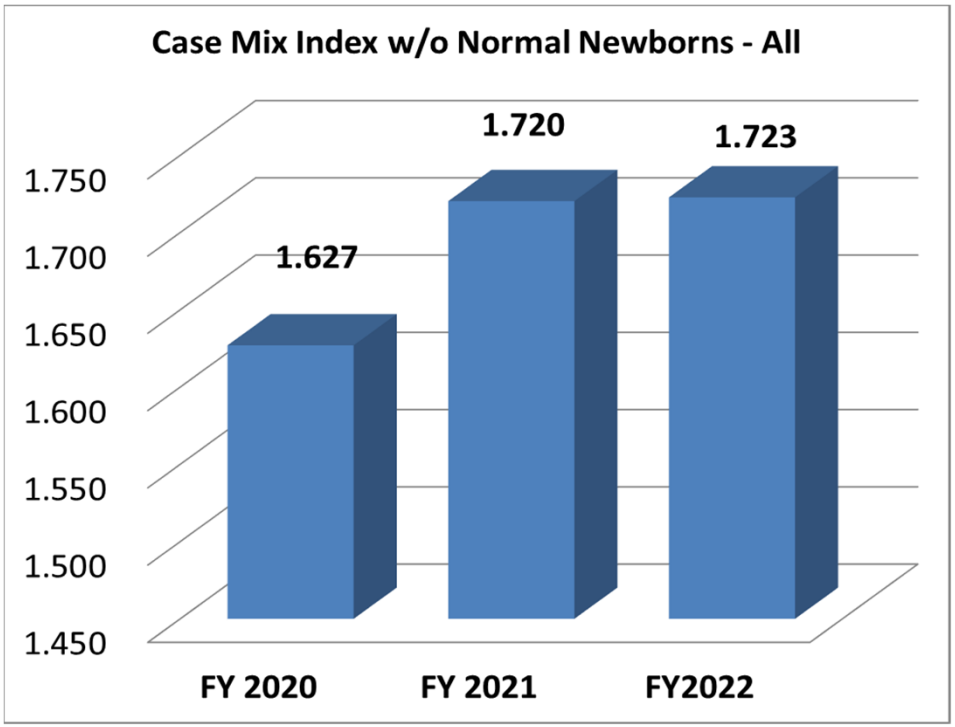


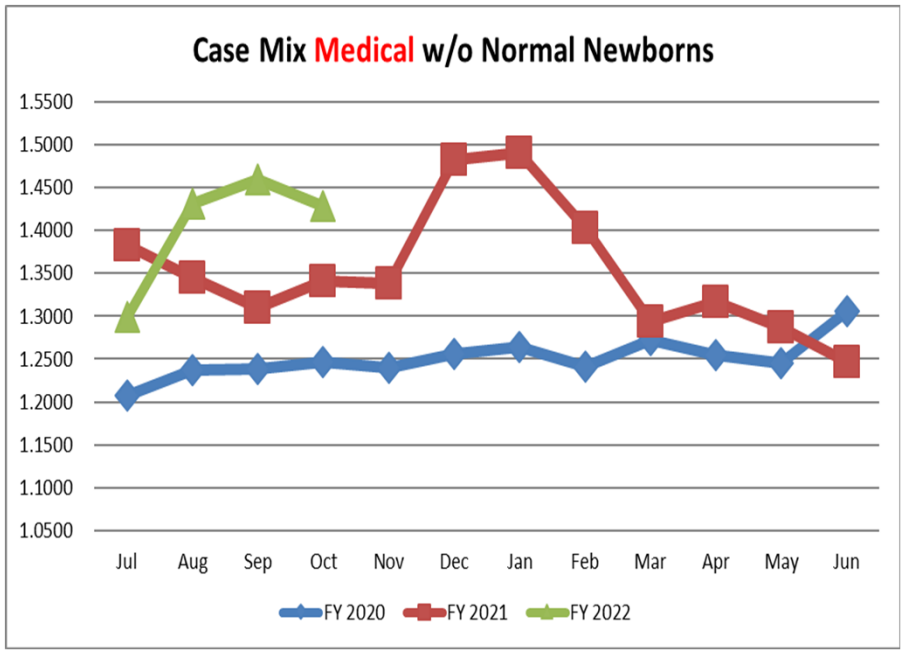


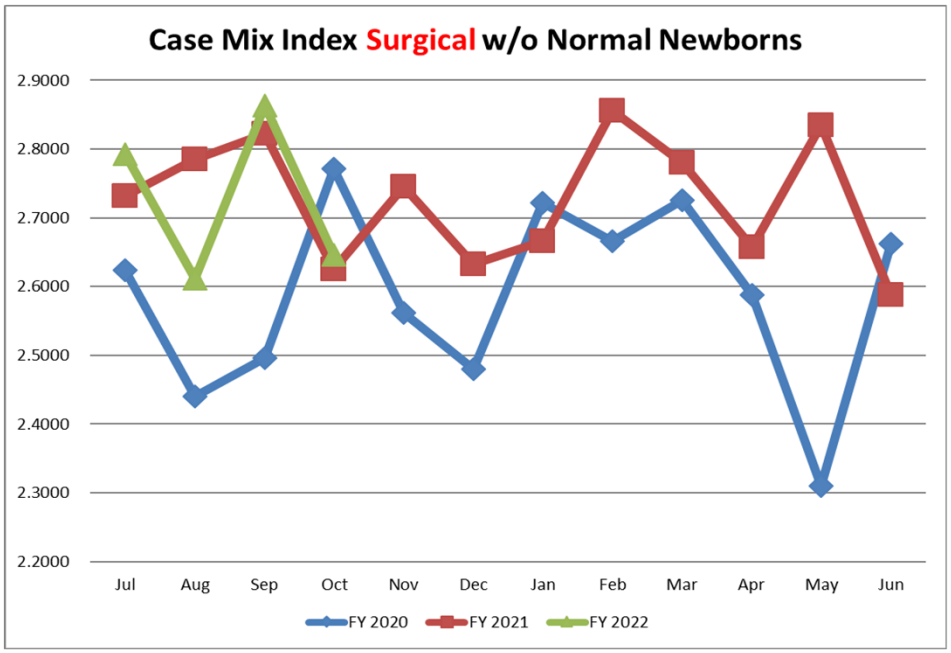
Contract Labor Hours



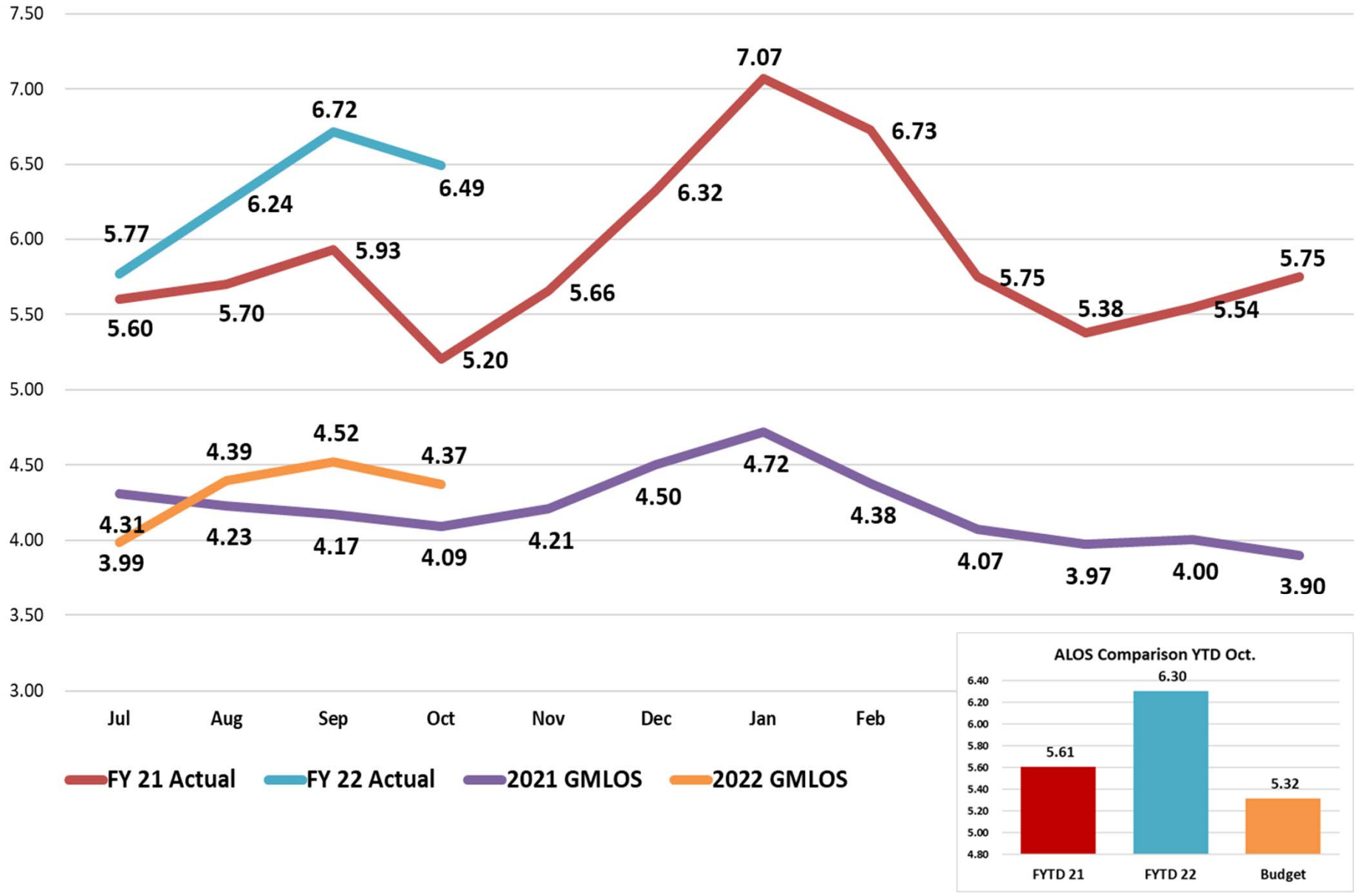

Case Mix Index w/o Normal Newborns
1.800
1.750
1.700
1.650
1.600
1.550
1.500
1.450
1.400
1.761
1.720
1.700
1.710
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2020
FY 2021
FY 2022


Case Mix Index w/o Normal Newborns - All
1.750
1.700
1.650
1.600
1.550
1.500
1.450
1.627
1.720
1.723
FY 2020
FY 2021
FY2022


Case Mix Medical w/o Normal Newborns
1.5500
1.5000
1.4500
1.4000
1.3500
1.3000
1.2500
1.2000
1.1500
1.1000
1.0500
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2020
FY 2021
FY 2022

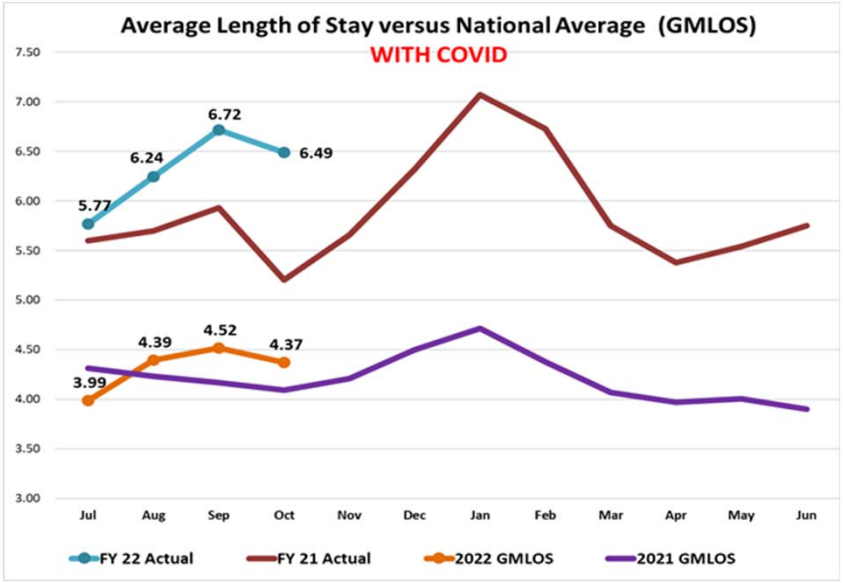

Case Mix Index Surgical w/o Normal Newborns
2.9000
2.8000
2.7000
2.6000
2.5000
2.4000
2.3000
2.2000
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2020
FY 2021
FY 2022

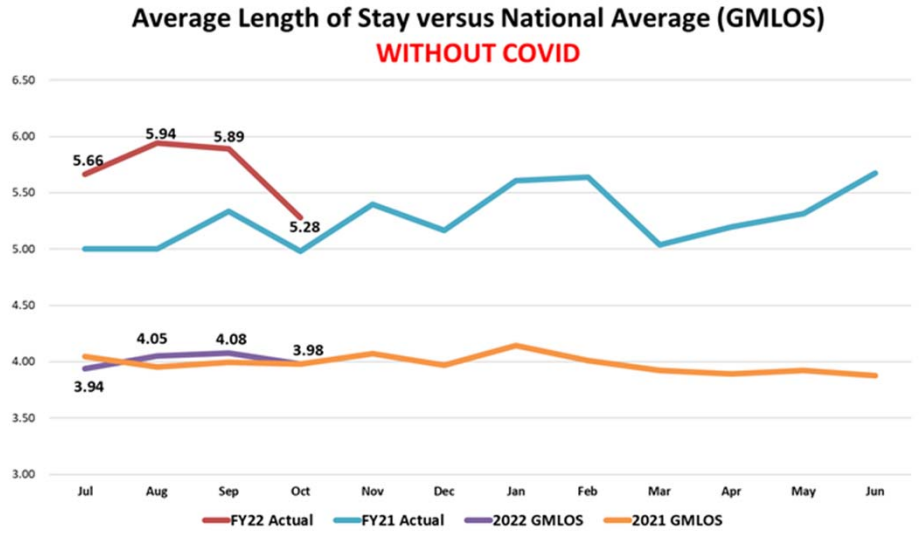
Average Length of Stay versus National Average (GMLOS)



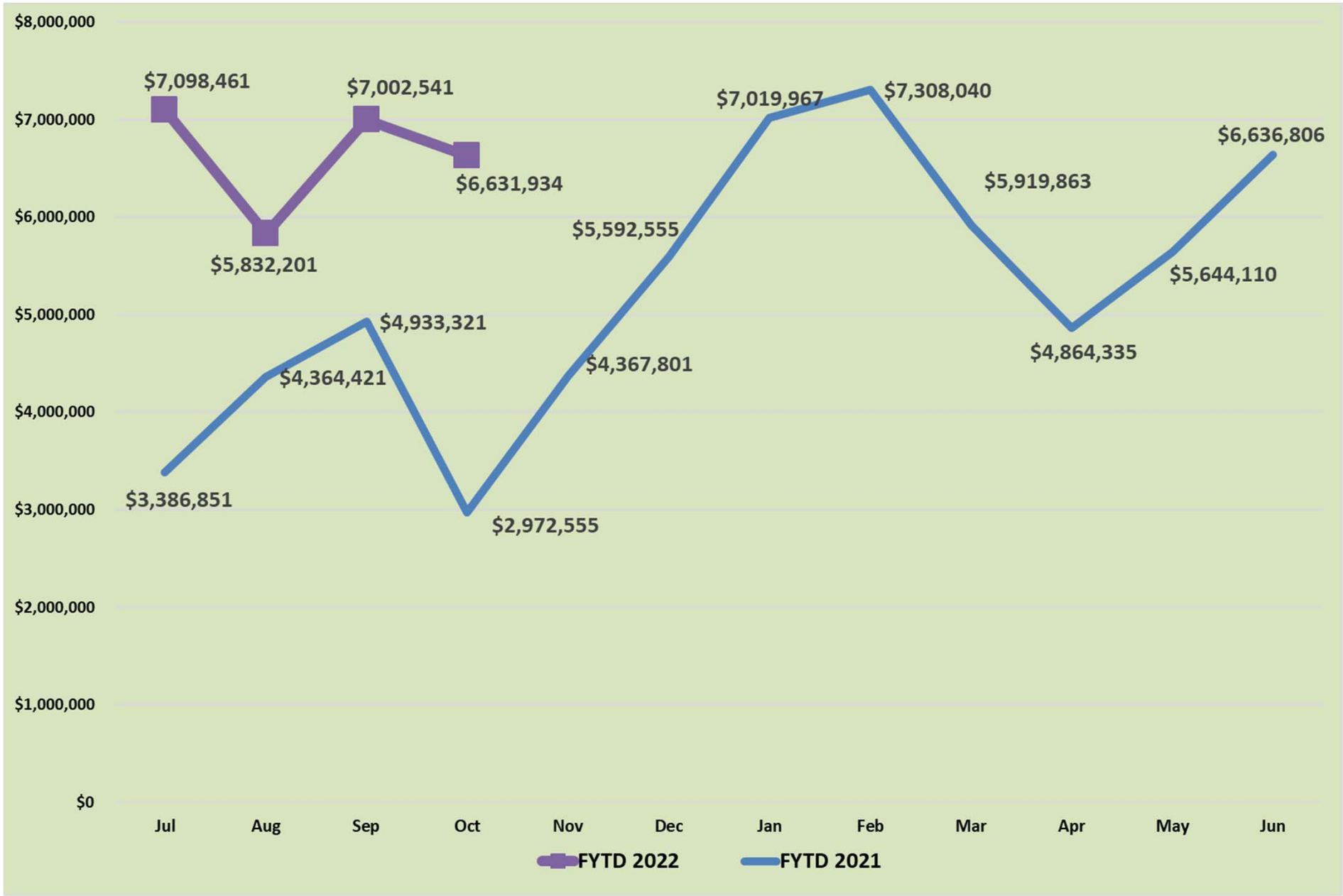
Average Length of Stay versus National Average (GMLOS)

	Including COVID Patients			Excluding COVID Patients				
	ALOS	GMLOS	GAP	ALOS	GMLOS	GAP	Gap Diff	%
Mar-20	5.20	4.04	1.16	5.16	4.03	1.13	0.03	2%
Apr-20	5.30	4.25	1.05	5.19	4.17	1.03	0.02	2%
May-20	5.25	4.16	1.09	4.74	4.06	0.68	0.40	37%
Jun-20	5.61	4.11	1.50	4.98	3.95	1.03	0.47	31%
Jul-20	5.60	4.31	1.29	5.00	4.05	0.96	0.33	26%
Aug-20	5.70	4.23	1.47	5.00	3.95	1.05	0.42	28%
Sep-20	5.93	4.17	1.76	5.33	3.99	1.34	0.42	24%
Oct-20	5.20	4.09	1.11	4.98	3.98	1.00	0.11	10%
Nov-20	5.66	4.21	1.45	5.40	4.07	1.33	0.12	8%
Dec-20	6.32	4.50	1.82	5.16	3.97	1.19	0.63	34%
Jan-21	7.07	4.72	2.35	5.61	4.14	1.47	0.89	38%
Feb-21	6.73	4.38	2.35	5.64	4.01	1.63	0.72	31%
Mar-21	5.75	4.07	1.68	5.04	3.92	1.12	0.56	33%
Apr-21	5.38	3.97	1.41	5.20	3.89	1.31	0.10	7%
May-21	5.54	4.00	1.54	5.32	3.92	1.40	0.14	9%
Jun-21	5.75	3.90	1.85	5.67	3.88	1.79	0.06	3%
Jul-21	5.77	3.99	1.78	5.66	3.94	1.72	0.06	3%
Aug-21	6.24	4.39	1.85	5.94	4.05	1.89	(0.04)	-2%
Sep-21	6.72	4.52	2.20	5.89	4.08	1.81	0.39	18%
Oct-21	6.49	4.37	2.12	5.28	3.98	1.30	0.82	39%
Average	**5.86**	**4.22**	**1.64**	**5.31**	**4.00**	**1.31**	**0.33**	**20%**

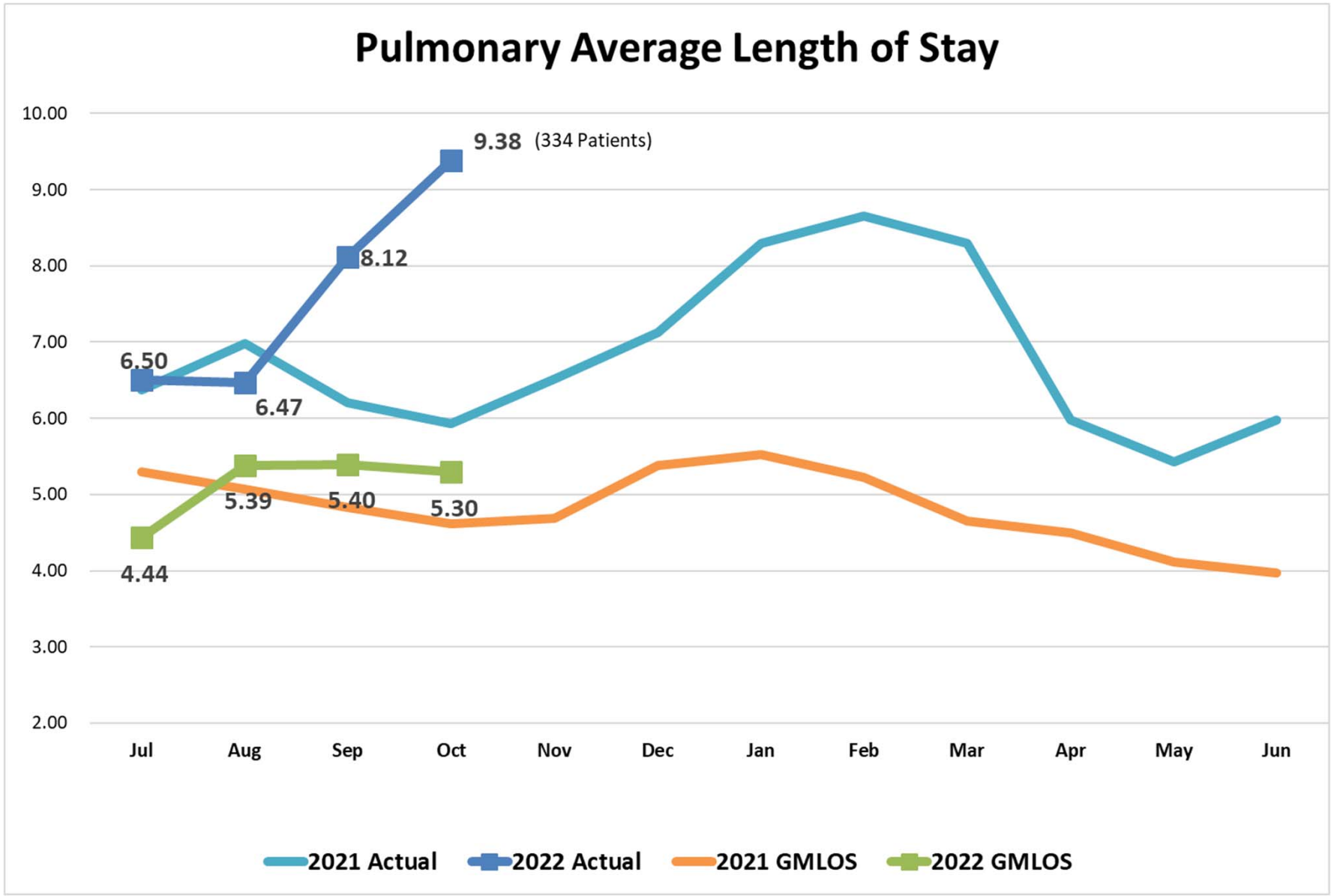




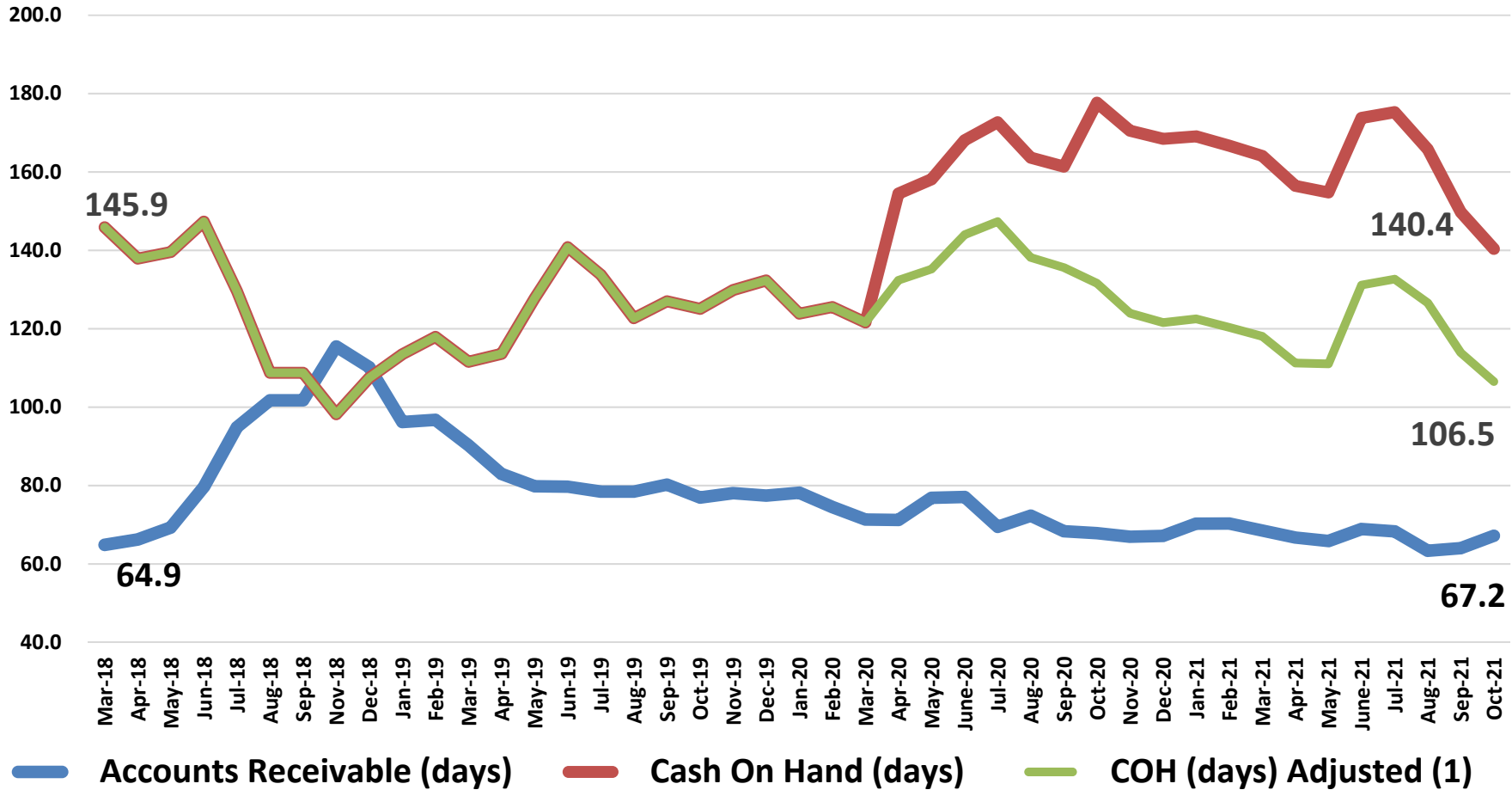
Opportunity Cost of Reducing LOS to National Average - $62.7M FY21



Pulmonary Diagnosis Grouping : Length of Stay



Trended Liquidity Ratios



(1) Adjusted for Medicare accelerated payments and the deferral of employer portion of FICA as allowed by the CARES act.

KAWEAH DELTA HEALTH CARE DISTRICT
RATIO ANALYSIS REPORT
OCTOBER 31, 2021

	Current Month Value	Prior Month Value	June 30, 2021 Unaudited Value	2019 Moody's Median Benchmark		
				Aa	A	Baa
LIQUIDITY RATIOS						
Current Ratio (x)	1.3	1.3	1.2	1.5	**1.8**	1.9
Accounts Receivable (days)	67.2	64.0	67.0	48.2	**46.2**	46.6
Cash On Hand (days)	140.4	149.8	173.3	276.1	**215.1**	162.5
Cushion Ratio (x)	19.8	20.7	22.9	37.8	**23.5**	14.6
Average Payment Period (days)	80.2	80.7	93.2	74.6	**60.5**	61.1
CAPITAL STRUCTURE RATIOS						
Cash-to-Debt	141.1%	148.2%	164.4%	244.9%	**176.8%**	121.2%
Debt-To-Capitalization	31.7%	31.6%	31.2%	24.4%	**30.9%**	38.4%
Debt-to-Cash Flow (x)	17.3	11.8	4.6	2.1	**2.7**	4.0
Debt Service Coverage	0.8	1.1	2.9	8.2	**5.5**	3.4
Maximum Annual Debt Service Coverage (x)	0.8	1.1	2.9	7.1	**4.7**	3.1
Age Of Plant (years)	14.0	13.9	13.5	10.6	**12.0**	12.2
PROFITABILITY RATIOS						
Operating Margin	(3.5%)	(2.7%)	(3.5%)	4.4%	**2.7%**	0.5%
Excess Margin	(2.8%)	(2.1%)	1.5%	7.6%	**5.2%**	2.6%
Operating Cash Flow Margin	1.1%	2.0%	1.4%	10.0%	**8.7%**	6.3%
Return on Assets	(2.4%)	(1.8%)	1.3%	5.3%	**4.4%**	2.6%

KAWEAH DELTA HEALTH CARE DISTRICT

CONSOLIDATED INCOME STATEMENT (000's)

FISCAL YEAR 2021 & 2022

	Operating Revenue			Operating Expenses									
Fiscal Year	Net Patient Revenue	Other Operating Revenue	Operating Revenue Total	Personnel Expense	Physician Fees	Supplies Expense	Other Operating Expense	Operating Expenses Total	Operating Income	Non-Operating Income	Net Income	Operating Margin %	Excess Margin
2021													
Jul-20	47,402	13,608	61,009	32,213	7,807	10,036	13,502	63,559	(2,550)	4,542	1,993	(4.2%)	3.0%
Aug-20	48,393	13,339	61,732	32,203	8,699	10,720	14,744	66,366	(4,634)	4,444	(191)	(7.5%)	(0.3%)
Sep-20	48,769	13,548	62,317	32,837	6,871	11,619	14,643	65,971	(3,654)	3,138	(515)	(5.9%)	(0.8%)
Oct-20	51,454	13,083	64,537	33,385	7,746	10,713	15,033	66,876	(2,339)	5,177	2,837	(3.6%)	4.1%
Nov-20	50,994	12,719	63,713	31,225	8,079	10,999	14,837	65,140	(1,427)	2,807	1,380	(2.2%)	2.1%
Dec-20	50,409	13,317	63,726	34,298	8,024	11,492	15,152	68,965	(5,240)	1,963	(3,276)	(8.2%)	(5.0%)
Jan-21	49,949	14,115	64,064	34,008	8,421	12,014	15,101	69,544	(5,480)	6,363	883	(8.6%)	1.3%
Feb-21	44,505	14,519	59,024	31,565	8,484	9,685	13,829	63,562	(4,538)	3,973	(565)	(7.7%)	(0.9%)
Mar-21	56,144	17,106	73,250	35,505	8,278	10,923	16,990	71,696	1,554	2,267	3,821	2.1%	5.1%
Apr-21	52,593	19,684	72,277	37,084	8,320	11,011	16,895	73,310	(1,033)	2,645	1,612	(1.4%)	2.2%
May-21	50,531	15,692	66,223	34,042	7,754	10,170	16,569	68,535	(2,312)	1,829	(483)	(3.5%)	(0.7%)
Jun-21	45,033	20,967	66,000	21,557	8,207	12,067	20,023	61,854	4,146	773	4,919	6.3%	7.4%
2021 FY Total	**$ 596,175**	**$ 181,697**	**$ 777,872**	**$ 389,923**	**$ 96,690**	**$ 131,449**	**$ 187,317**	**$ 805,379**	**$ (27,507)**	**$ 39,921**	**$ 12,414**	**(3.5%)**	**1.5%**
2022													
Jul-21	51,502	15,035	66,537	32,678	7,922	9,596	15,217	65,413	1,124	582	1,706	1.7%	2.5%
Aug-21	49,714	16,024	65,737	33,434	8,527	13,004	15,414	70,379	(4,642)	990	(3,651)	(7.1%)	(5.5%)
Sep-21	57,879	15,513	73,391	38,332	7,736	11,942	17,438	75,448	(2,056)	(388)	(2,445)	(2.8%)	(3.3%)
Oct-21	55,674	15,592	71,266	36,627	9,674	11,714	17,386	75,402	(4,136)	732	(3,403)	(5.8%)	(4.8%)
2022 FY Total	**$ 214,768**	**$ 62,163**	**$ 276,931**	**$ 141,071**	**$ 33,859**	**$ 46,255**	**$ 65,455**	**$ 286,641**	**$ (9,710)**	**$ 1,916**	**$ (7,794)**	**(3.5%)**	**(2.8%)**
FYTD Budget	**211,380**	**61,715**	**273,095**	**131,041**	**33,195**	**42,145**	**63,568**	**269,949**	**3,146**	**2,014**	**5,160**	**1.2%**	**1.9%**
Variance	**$ 3,388**	**$ 448**	**$ 3,836**	**$ 10,031**	**$ 665**	**$ 4,110**	**$ 1,887**	**$ 16,692**	**$ (12,856)**	**$ (97)**	**$ (12,954)**		
Current Month Analysis													
Oct-21	**$ 55,674**	**$ 15,592**	**$ 71,266**	**$ 36,627**	**$ 9,674**	**$ 11,714**	**$ 17,386**	**$ 75,402**	**$ (4,136)**	**$ 732**	**$ (3,403)**	**(5.8%)**	**(4.7%)**
Budget	**53,315**	**15,491**	**68,805**	**32,895**	**8,537**	**10,427**	**16,289**	**68,148**	**657**	**542**	**1,199**	**1.0%**	**1.7%**
Variance	**$ 2,359**	**$ 102**	**$ 2,461**	**$ 3,732**	**$ 1,137**	**$ 1,287**	**$ 1,097**	**$ 7,253**	**$ (4,793)**	**$ 191**	**(4,602)**		

KAWEAH DELTA HEALTH CARE DISTRICT

FISCAL YEAR 2021 & 2022

Fiscal Year	Patient Days	ADC	Adjusted Patient Days	I/P Revenue %	DFR & Bad Debt %	Net Patient Revenue/ Ajusted Patient Day	Personnel Expense/ Ajusted Patient Day	Physician Fees/ Ajusted Patient Day	Supply Expense/ Ajusted Patient Day	Total Operating Expense/ Ajusted Patient Day	Personnel Expense/ Net Patient Revenue	Physician Fees/ Net Patient Revenue	Supply Expense/ Net Patient Revenue	Total Operating Expense/ Net Patient Revenue
2021														
Jul-20	13,016	420	24,934	52.2%	76.8%	1,901	1,292	313	403	2,549	68.0%	16.5%	21.2%	134.1%
Aug-20	13,296	429	24,893	53.4%	75.7%	1,944	1,294	349	431	2,666	66.5%	18.0%	22.2%	137.1%
Sep-20	13,024	434	24,587	53.0%	75.6%	1,984	1,336	279	473	2,683	67.3%	14.1%	23.8%	135.3%
Oct-20	12,478	403	24,749	50.4%	74.2%	2,079	1,349	313	433	2,702	64.9%	15.1%	20.8%	130.0%
Nov-20	12,898	430	24,958	51.7%	74.0%	2,043	1,251	324	441	2,610	61.2%	15.8%	21.6%	127.7%
Dec-20	14,389	464	25,827	55.7%	75.2%	1,952	1,328	311	445	2,670	68.0%	15.9%	22.8%	136.8%
Jan-21	14,002	452	24,471	57.2%	75.5%	2,041	1,390	344	491	2,842	68.1%	16.9%	24.1%	139.2%
Feb-21	12,388	442	23,578	52.5%	77.3%	1,888	1,339	360	411	2,696	70.9%	19.1%	21.8%	142.8%
Mar-21	13,030	420	25,820	50.5%	74.9%	2,174	1,375	321	423	2,777	63.2%	14.7%	19.5%	127.7%
Apr-21	12,361	412	25,268	48.9%	75.8%	2,081	1,468	329	436	2,901	70.5%	15.8%	20.9%	139.4%
May-21	13,115	423	25,026	52.4%	76.4%	2,019	1,360	310	406	2,739	67.4%	15.3%	20.1%	135.6%
Jun-21	12,916	431	25,797	50.1%	79.6%	1,746	836	318	468	2,398	47.9%	18.2%	26.8%	137.4%
2021 FY Total	**156,913**	**430**	**300,105**	**52.3%**	**75.9%**	**1,987**	**1,299**	**322**	**438**	**2,684**	**65.4%**	**16.2%**	**22.0%**	**135.1%**
2022														
Jul-21	13,388	432	26,085	51.3%	76.2%	1,974	1,253	304	368	2,508	63.4%	15.4%	18.6%	127.0%
Aug-21	14,401	465	27,703	52.0%	77.3%	1,795	1,207	308	469	2,540	67.3%	17.2%	26.2%	141.6%
Sep-21	14,824	494	28,321	52.3%	75.0%	2,044	1,353	273	422	2,664	66.2%	13.4%	20.6%	130.4%
Oct-21	15,505	500	28,243	54.9%	75.8%	1,971	1,297	343	415	2,670	65.8%	17.4%	21.0%	135.4%
2022 FY Total	**58,118**	**473**	**110,357**	**52.7%**	**76.0%**	**1,946**	**1,278**	**307**	**419**	**2,597**	**65.7%**	**15.8%**	**21.5%**	**133.5%**
FYTD Budget	**53,845**	**438**	**107,232**	**50.2%**	**75.4%**	**1,971**	**1,222**	**310**	**393**	**2,446**	**62.0%**	**15.7%**	**19.9%**	**127.7%**
Variance	**4,273**	**35**	**3,124**	**2.5%**	**0.6%**	**(25)**	**56**	**(3)**	**26**	**151**	**3.7%**	**0.1%**	**1.6%**	**5.8%**
Current Month Analysis														
Oct-21	**15,505**	**500**	**28,243**	**54.9%**	**75.8%**	**1,971**	**1,297**	**343**	**415**	**2,670**	**65.8%**	**17.4%**	**21.0%**	**135.4%**
Budget	**13,386**	**432**	**27,082**	**49.4%**	**75.4%**	**1,969**	**1,215**	**315**	**385**	**2,413**	**61.7%**	**16.0%**	**19.6%**	**127.8%**
Variance	**2,119**	**68**	**1,161**	**5.5%**	**0.3%**	**3**	**82**	**27**	**30**	**257**	**4.1%**	**1.4%**	**1.5%**	**7.6%**

KAWEAH DELTA HEALTH CARE DISTRICT
CONSOLIDATED STATEMENTS OF NET POSITION (000's)

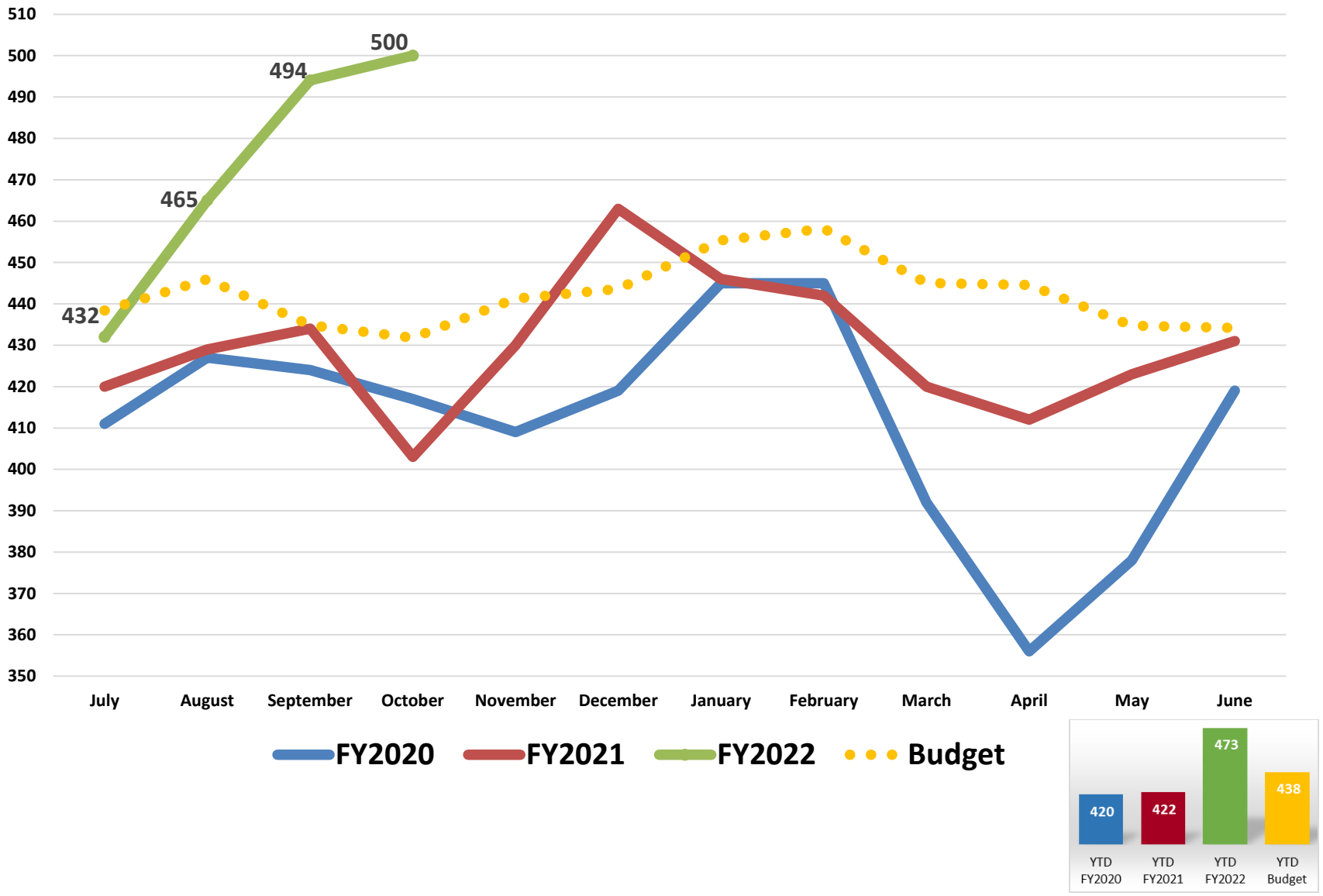
	Oct-21	Sep-21	Change	% Change	Jun-21 (Unaudited)
ASSETS AND DEFERRED OUTFLOWS					
CURRENT ASSETS					
Cash and cash equivalents	$ 862	$ 13,024	$ (12,162)	-93.38%	$ 30,081
Current Portion of Board designated and trusted assets	17,511	16,205	1,306	8.06%	13,695
Accounts receivable:					
Net patient accounts	128,690	119,698	8,991	7.51%	121,553
Other receivables	25,378	15,802	9,576	60.60%	16,048
	154,067	135,500	18,567	13.70%	137,601
Inventories	12,048	11,945	103	0.87%	10,800
Medicare and Medi-Cal settlements	41,357	46,416	(5,059)	-10.90%	37,339
Prepaid expenses	12,079	10,753	1,326	12.33%	12,210
Total current assets	237,924	233,842	4,082	1.75%	241,726
NON-CURRENT CASH AND INVESTMENTS -					
less current portion					
Board designated cash and assets	326,280	330,106	(3,825)	-1.16%	349,933
Revenue bond assets held in trust	22,299	22,290	9	0.04%	22,271
Assets in self-insurance trust fund	2,075	2,070	4	0.21%	2,073
Total non-current cash and investments	350,654	354,466	(3,812)	-1.08%	374,277
CAPITAL ASSETS					
Land	17,542	17,542	-	0.00%	17,542
Buildings and improvements	384,488	384,420	68	0.02%	384,399
Equipment	317,875	317,647	228	0.07%	316,636
Construction in progress	56,487	55,315	1,172	2.12%	53,113
	776,392	774,925	1,467	0.19%	771,690
Less accumulated depreciation	437,516	434,317	3,199	0.74%	427,307
	338,876	340,607	(1,731)	-0.51%	344,383
Property under capital leases -					
less accumulated amortization	124	(468)	592	-126.53%	376
Total capital assets	339,000	340,139	(1,139)	-0.33%	344,759
OTHER ASSETS					
Property not used in operations	1,618	1,622	(4)	-0.26%	1,635
Health-related investments	5,523	5,266	257	4.89%	5,216
Other	11,885	11,873	11	0.10%	11,569
Total other assets	19,026	18,761	264	1.41%	18,419
Total assets	946,604	947,209	(605)	-0.06%	979,182
DEFERRED OUTFLOWS	(35,961)	8,800	(44,761)	-508.64%	(35,831)
Total assets and deferred outflows	**$ 910,643**	**$ 956,009**	**$ (45,366)**	**-4.75%**	**$ 943,351**

KAWEAH DELTA HEALTH CARE DISTRICT
CONSOLIDATED STATEMENTS OF NET POSITION (000's)

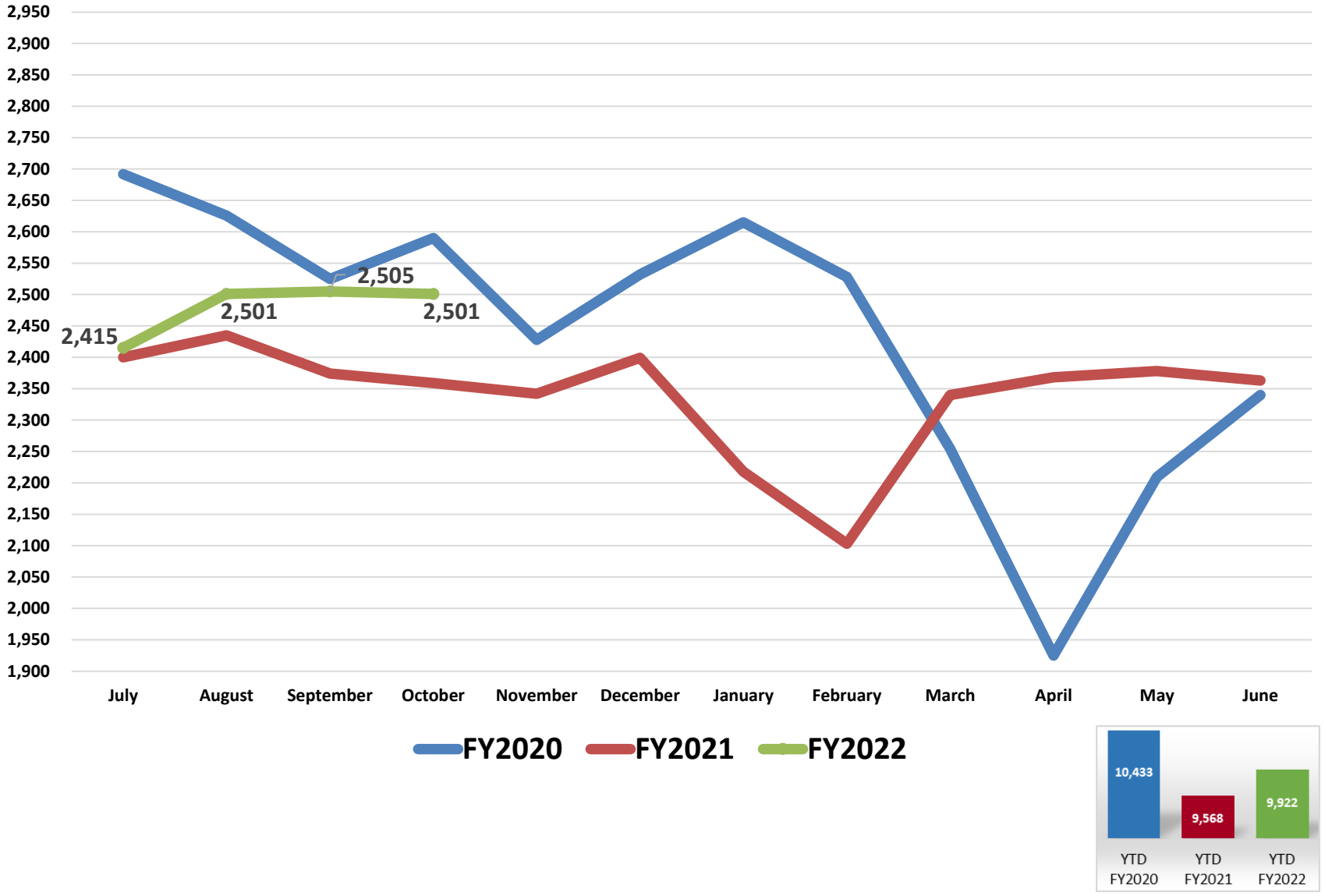
	Oct-21	Sep-21	Change	% Change	Jun-21
					(Unaudited)
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES					
Accounts payable and accrued expenses	$ 95,867	$ 97,636	$ (1,769)	-1.81%	$ 114,900
Accrued payroll and related liabilities	73,022	69,438	3,584	5.16%	71,537
Long-term debt, current portion	11,245	11,251	(6)	-0.05%	11,128
Total current liabilities	180,134	178,325	1,809	1.01%	197,565
LONG-TERM DEBT, less current portion					
Bonds payable	248,544	248,596	(52)	-0.02%	250,675
Capital leases	104	117	(12)	-10.58%	123
Total long-term debt	248,648	248,712	(64)	-0.03%	250,797
NET PENSION LIABILITY	(30,436)	15,295	(45,732)	-298.99%	(22,273)
OTHER LONG-TERM LIABILITIES	32,482	32,185	297	0.92%	30,894
Total liabilities	430,828	474,518	(43,689)	-9.21%	456,983
NET ASSETS					
Invested in capital assets, net of related debt	104,139	105,224	(1,085)	-1.03%	107,949
Restricted	35,709	33,892	1,817	5.36%	31,668
Unrestricted	339,967	342,375	(2,408)	-0.70%	346,751
Total net position	479,815	481,491	(1,676)	-0.35%	486,368
Total liabilities and net position	**$ 910,643**	**$ 956,009**	**$ (45,366)**	**-4.75%**	**$ 943,351**

Statistical Report
November 2021

Average Daily Census

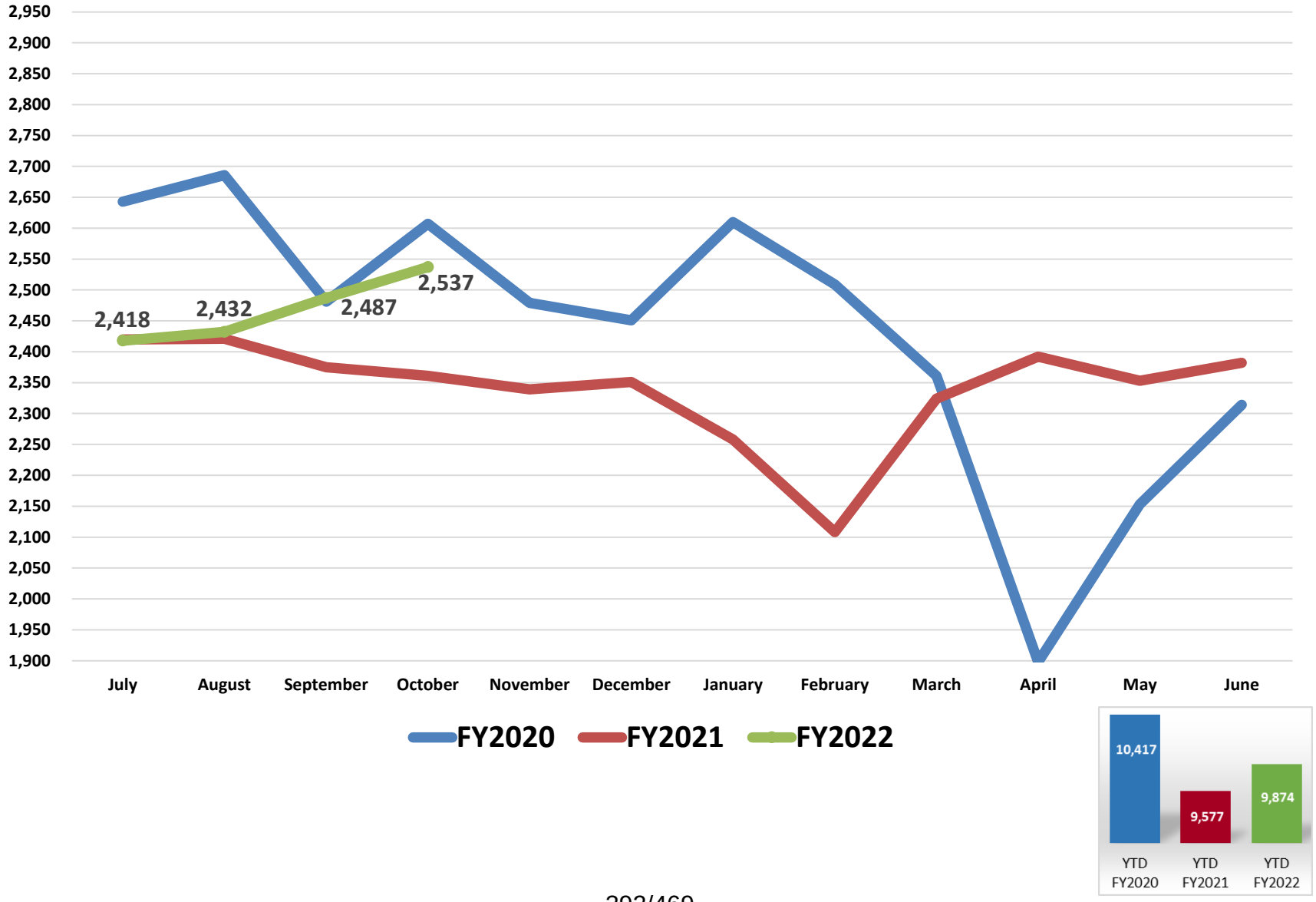


Admissions


2,950
2,900
2,850
2,800
2,750
2,700
2,650
2,600
2,550
2,500
2,450
2,400
2,350
2,300
2,250
2,200
2,150
2,100
2,050
2,000
1,950
1,900
2,415
2,501
2,505
2,501
July
August
September
October
November
December
January
February
March
April
May
June
FY2020
FY2021
FY2022

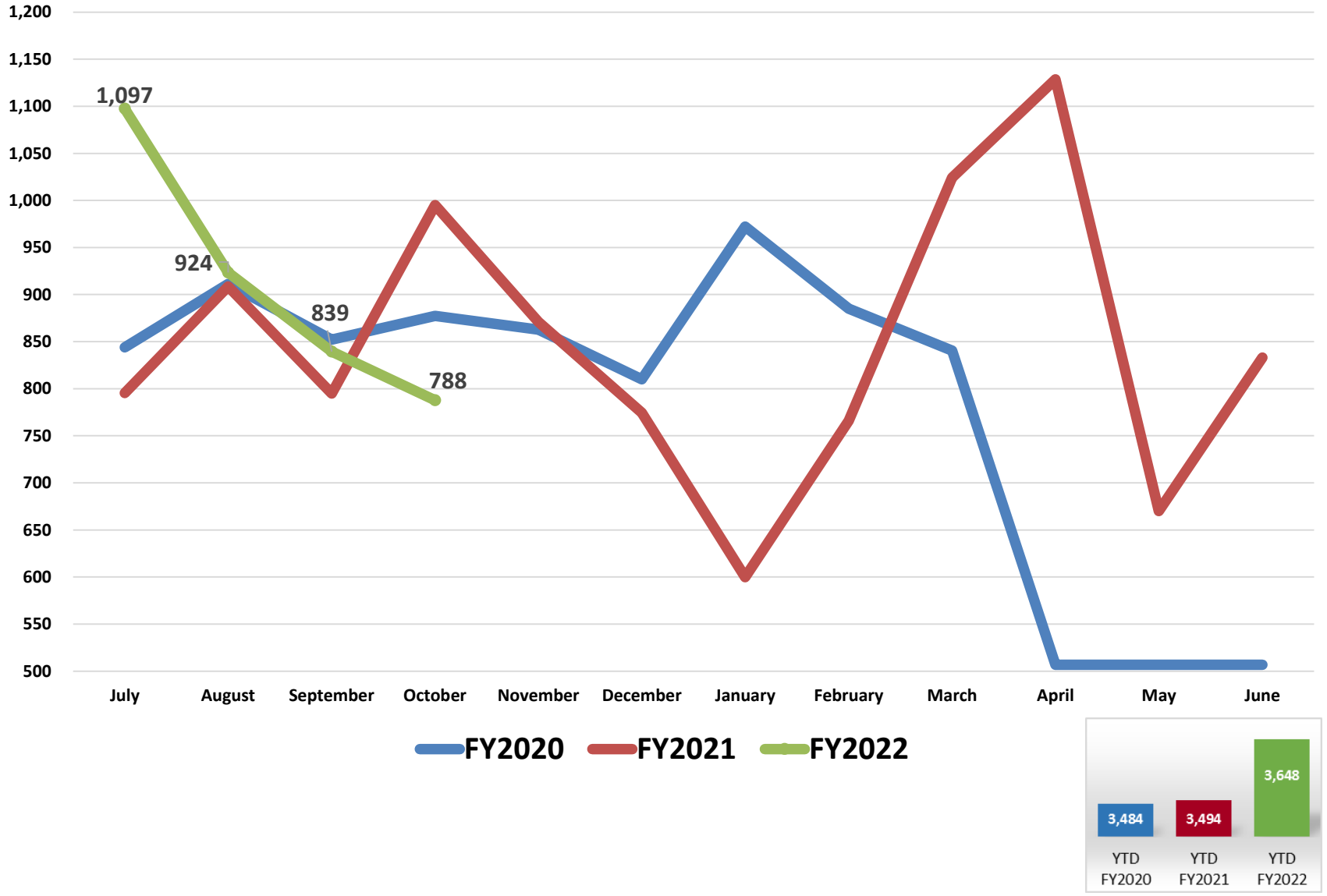
10,433
9,568
9,922
YTD FY2020
YTD FY2021
YTD FY2022

Discharges

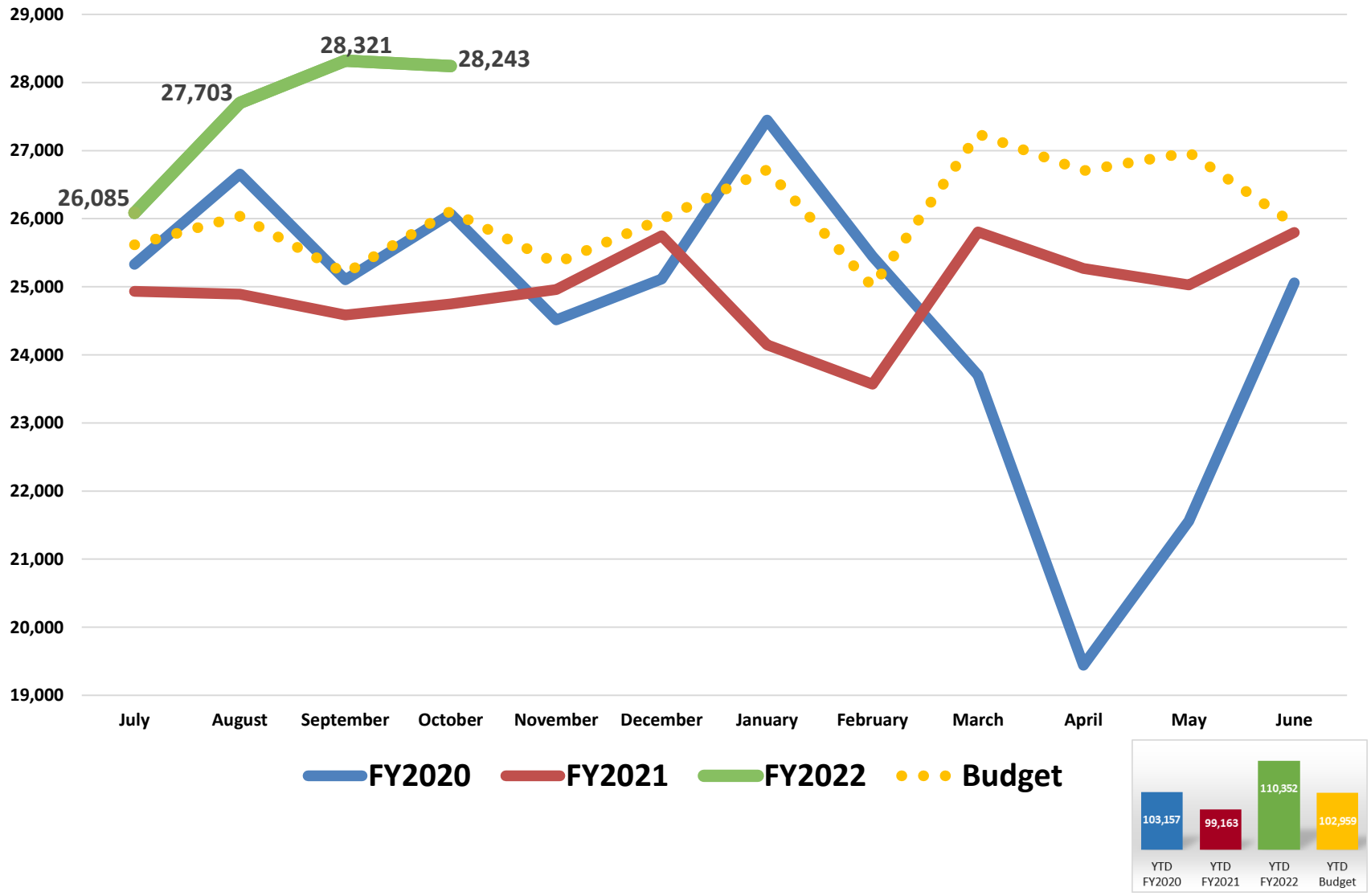

2,950
2,900
2,850
2,800
2,750
2,700
2,650
2,600
2,550
2,500
2,450
2,400
2,350
2,300
2,250
2,200
2,150
2,100
2,050
2,000
1,950
1,900
2,418
2,432
2,487
2,537
July
August
September
October
November
December
January
February
March
April
May
June
FY2020
FY2021
FY2022

10,417
9,577
9,874
YTD FY2020
YTD FY2021
YTD FY2022

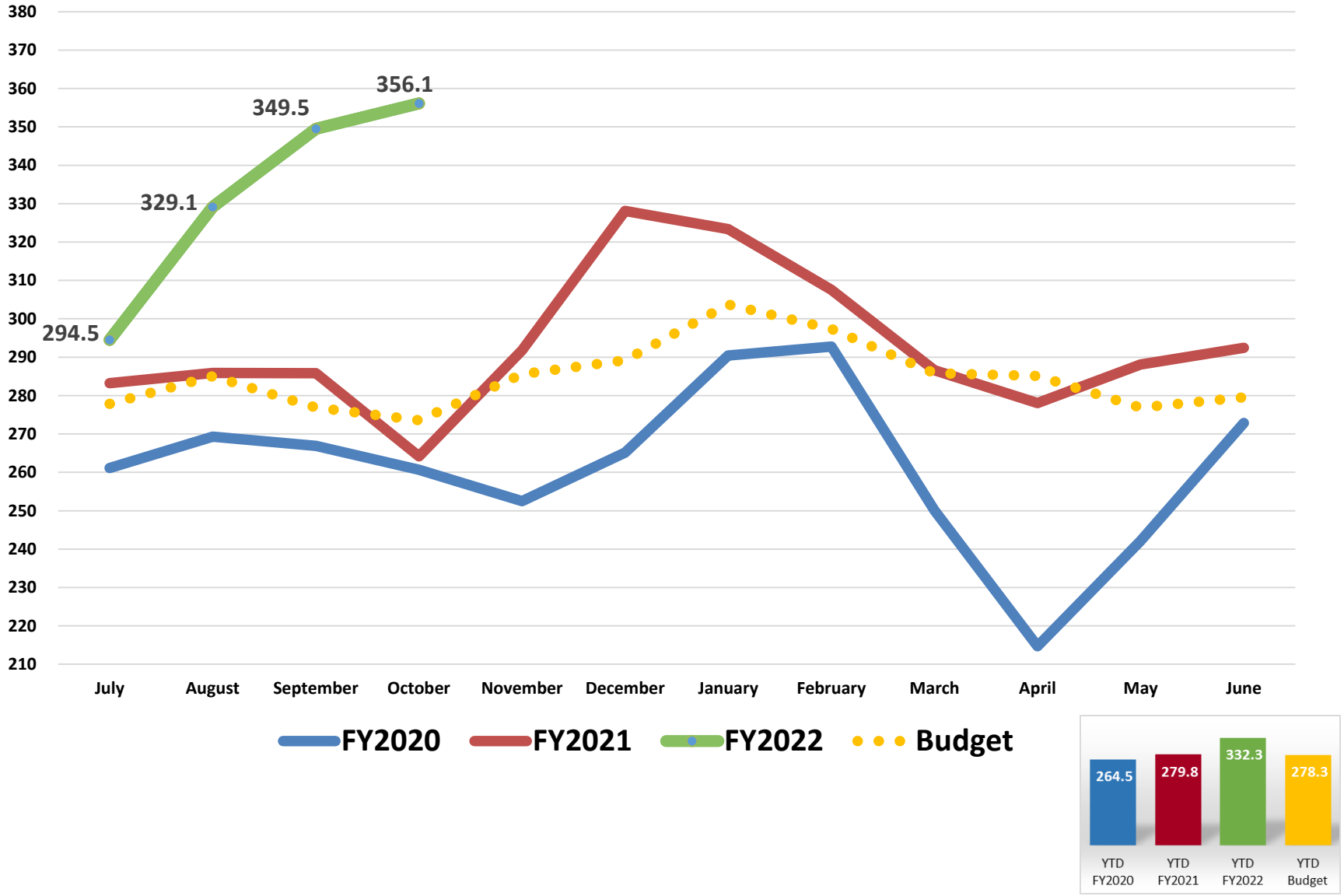
Observation Days



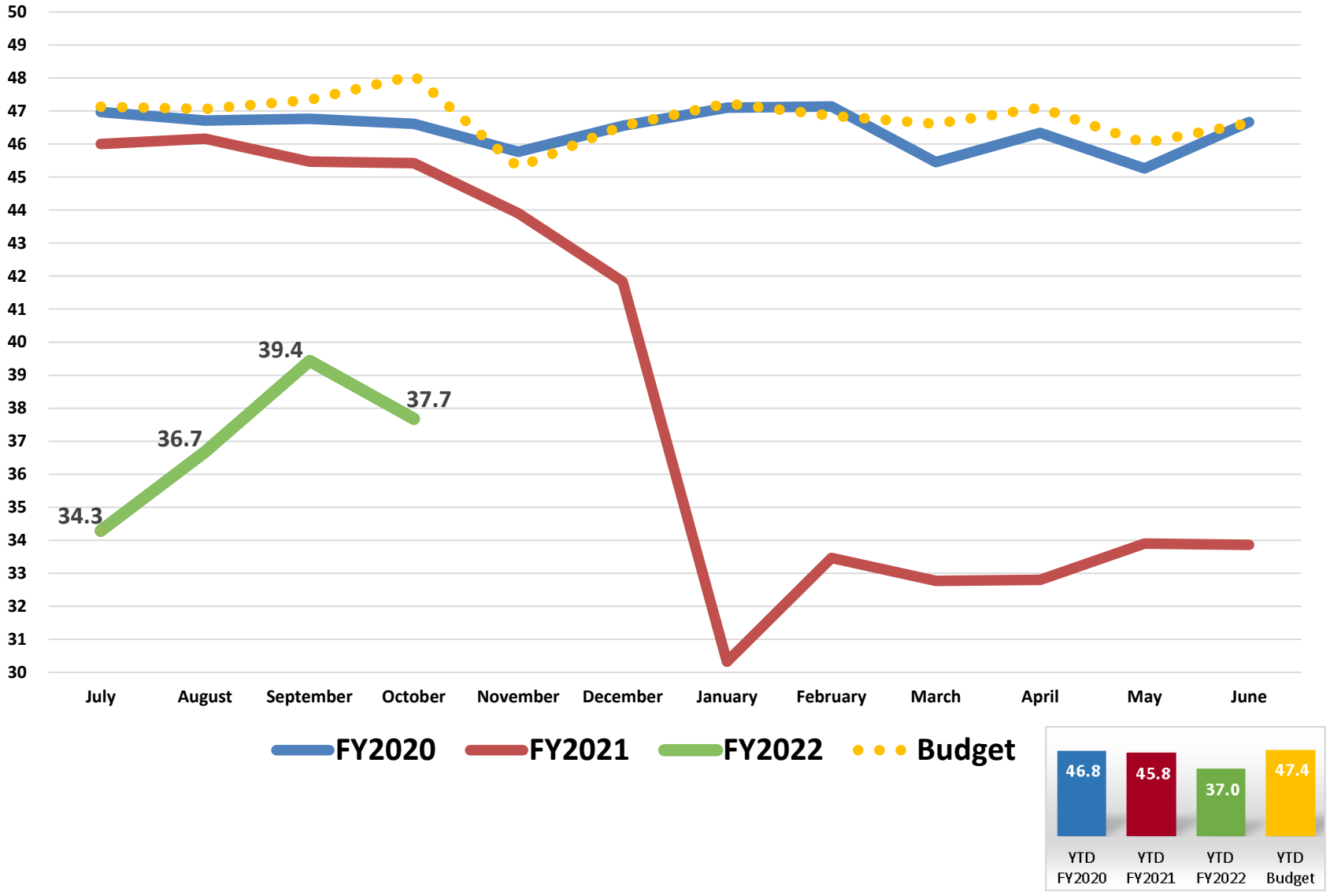
Adjusted Patient Days



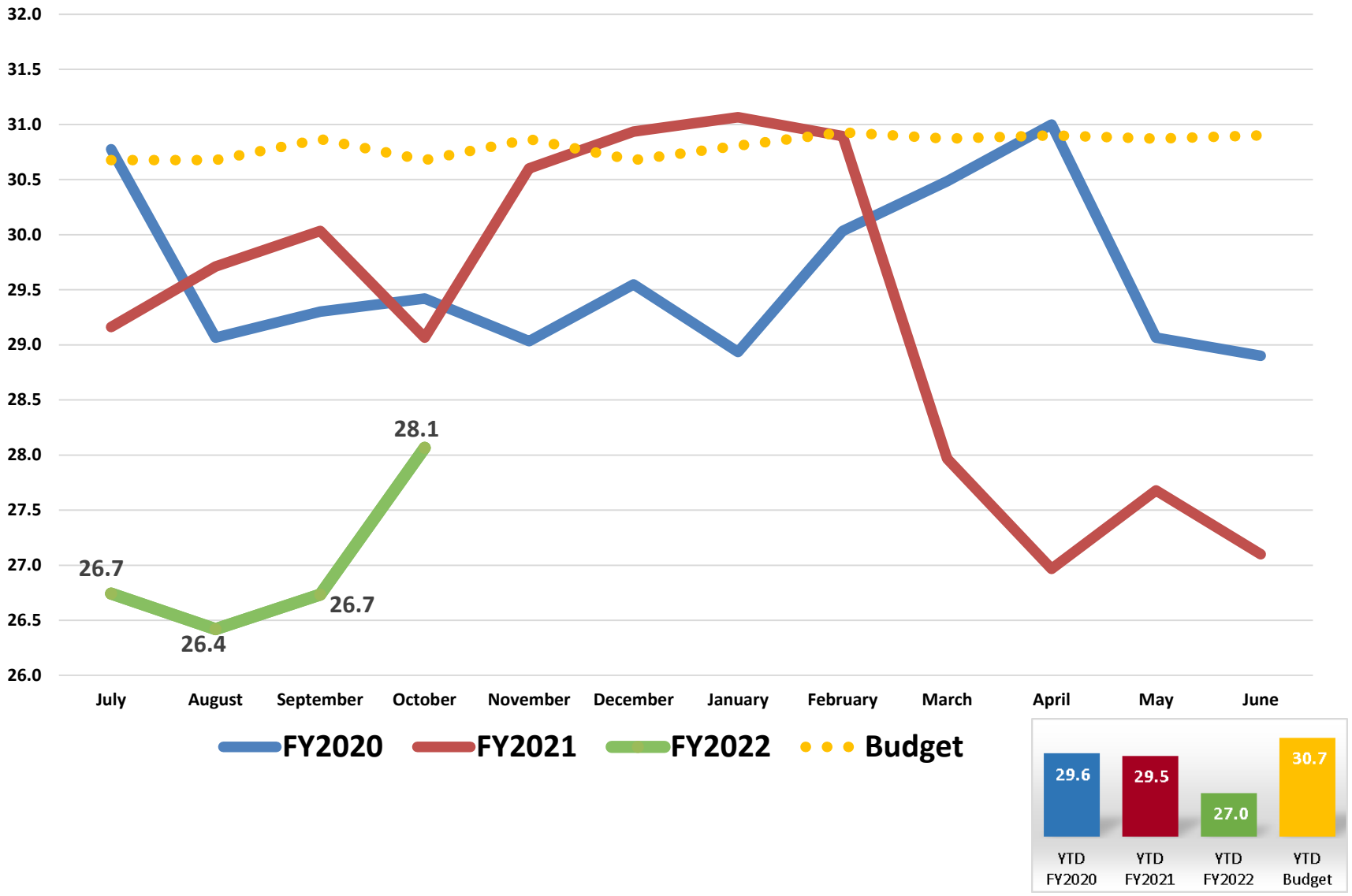
Medical Center – Avg. Patients Per Day



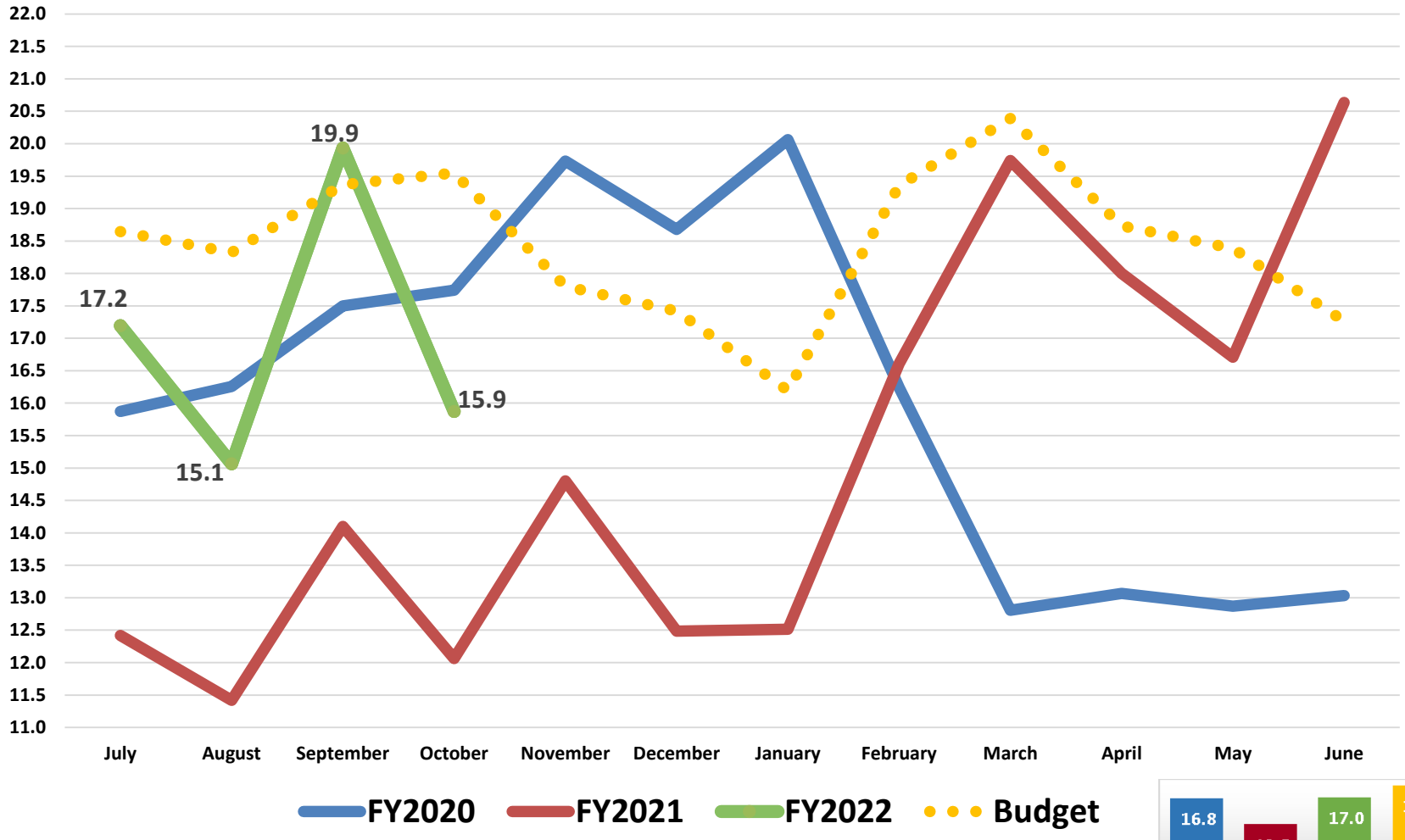
Acute I/P Psych - Avg. Patients Per Day

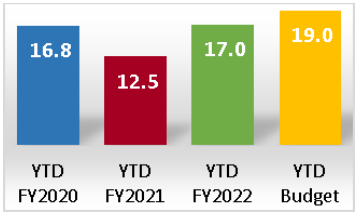


Sub-Acute - Avg. Patients Per Day

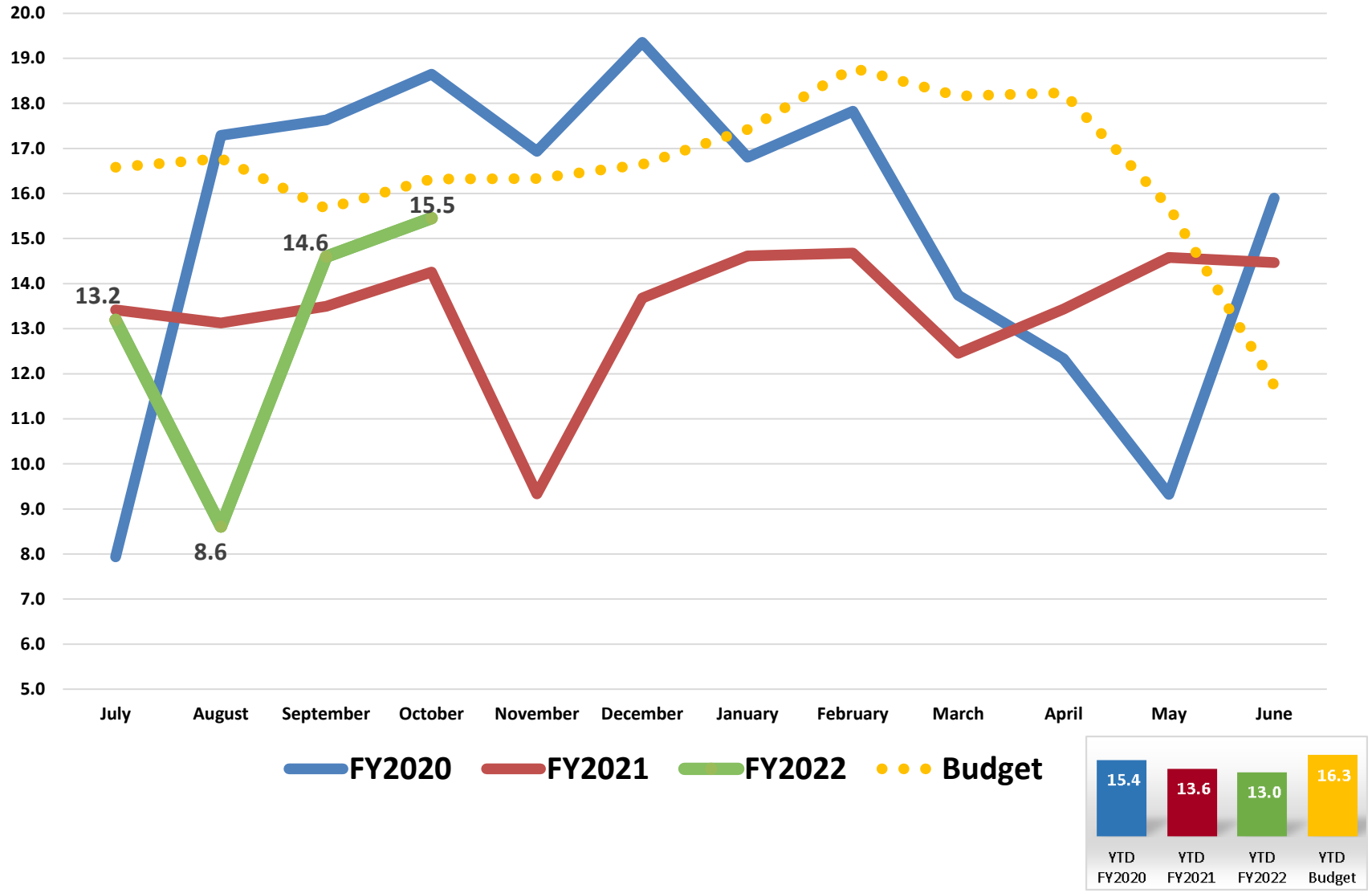


Rehabilitation Hospital - Avg. Patients Per Day

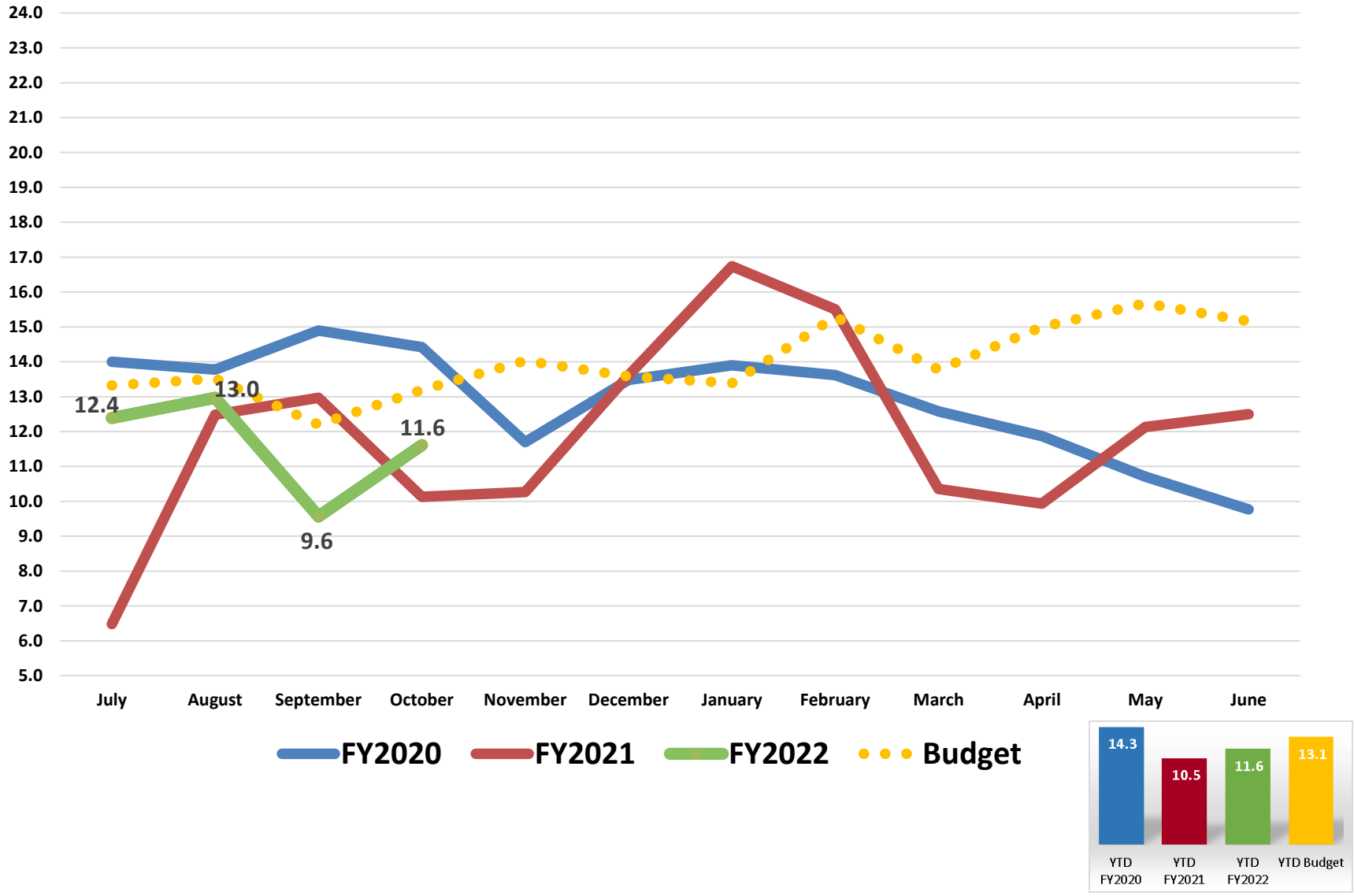




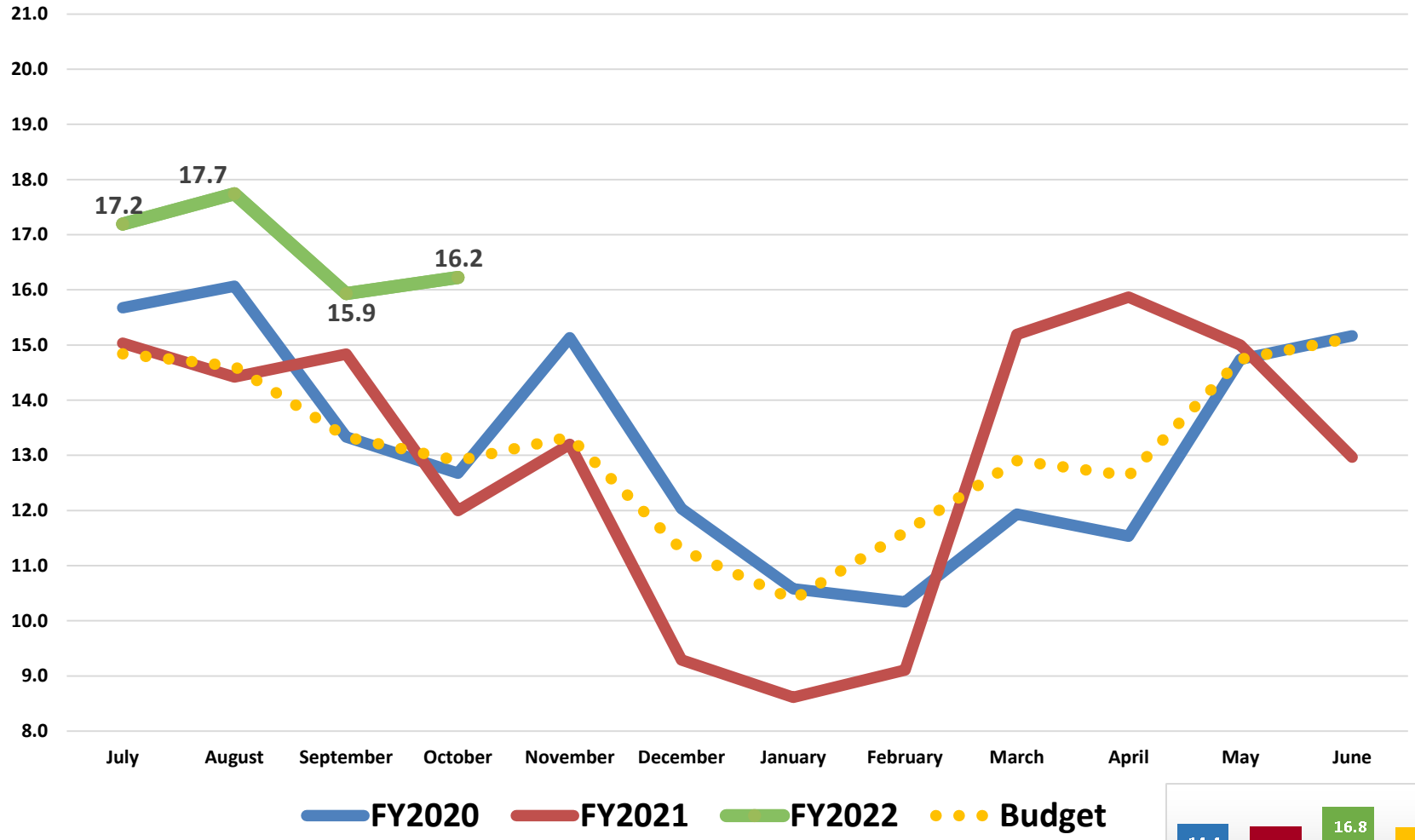
Transitional Care Services (TCS) - Avg. Patients Per Day

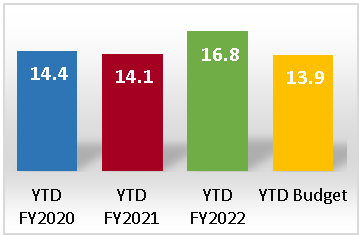


TCS Ortho - Avg. Patients Per Day

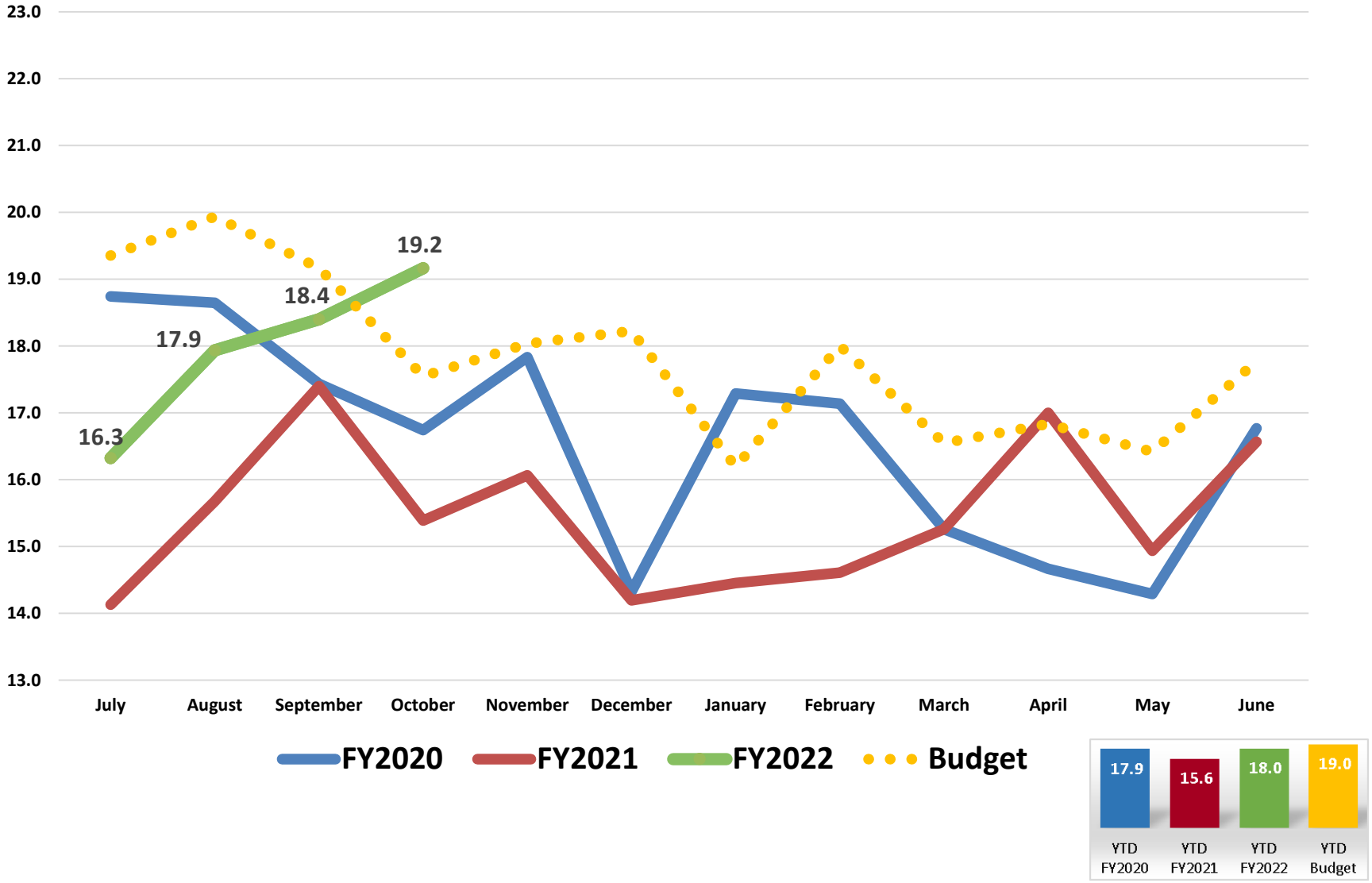


NICU - Avg. Patients Per Day

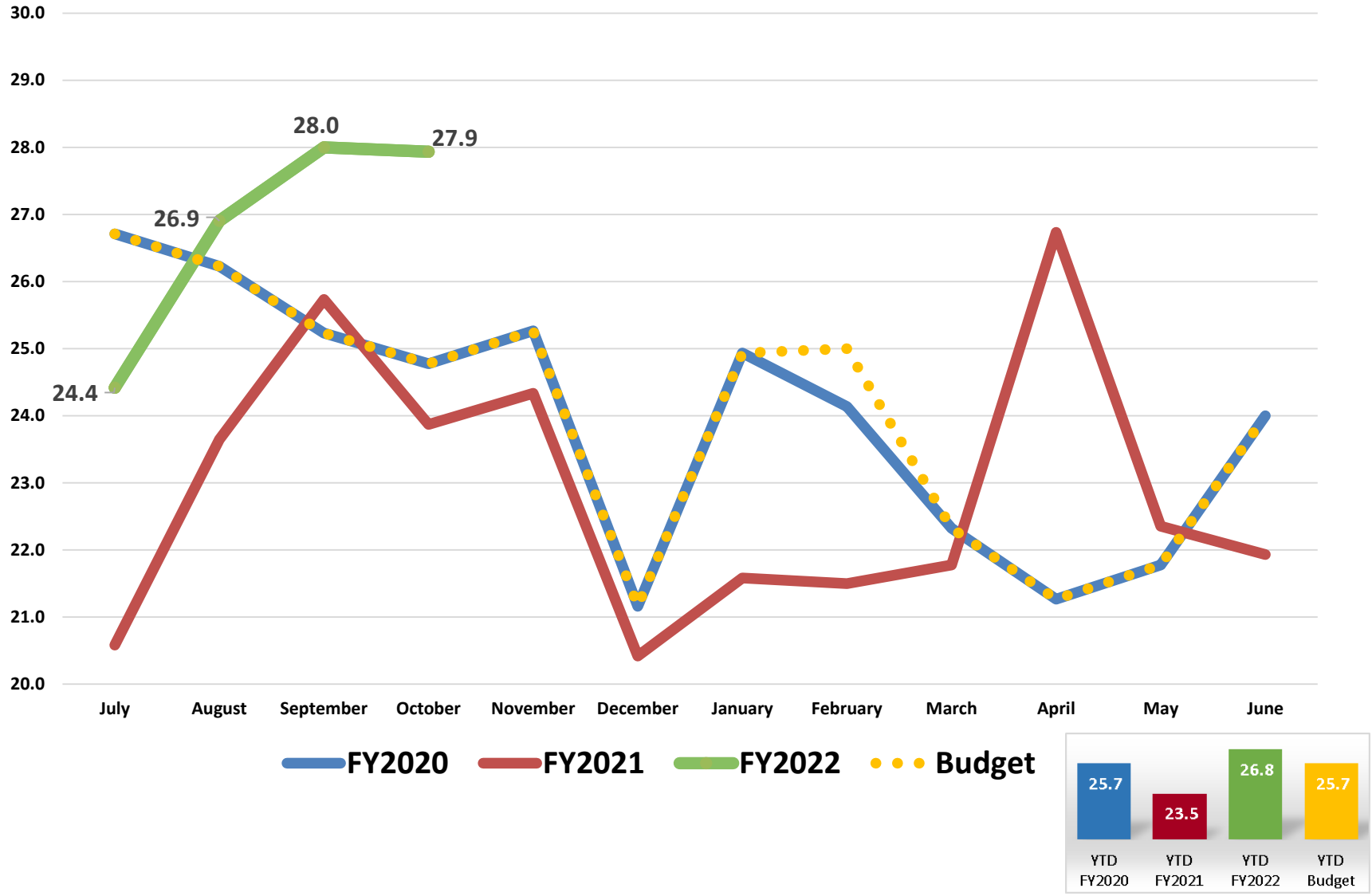




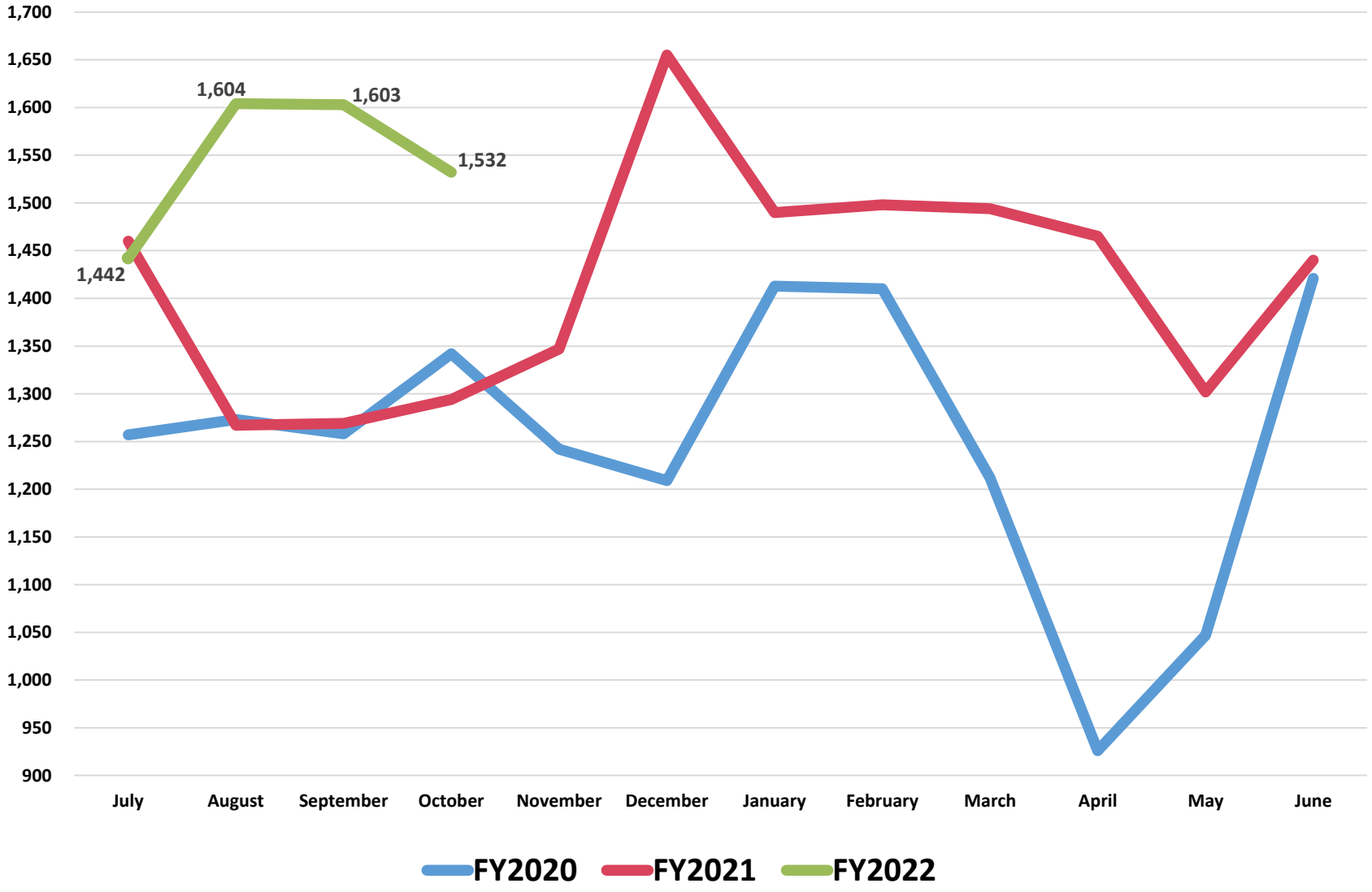
Nursery - Avg. Patients Per Day



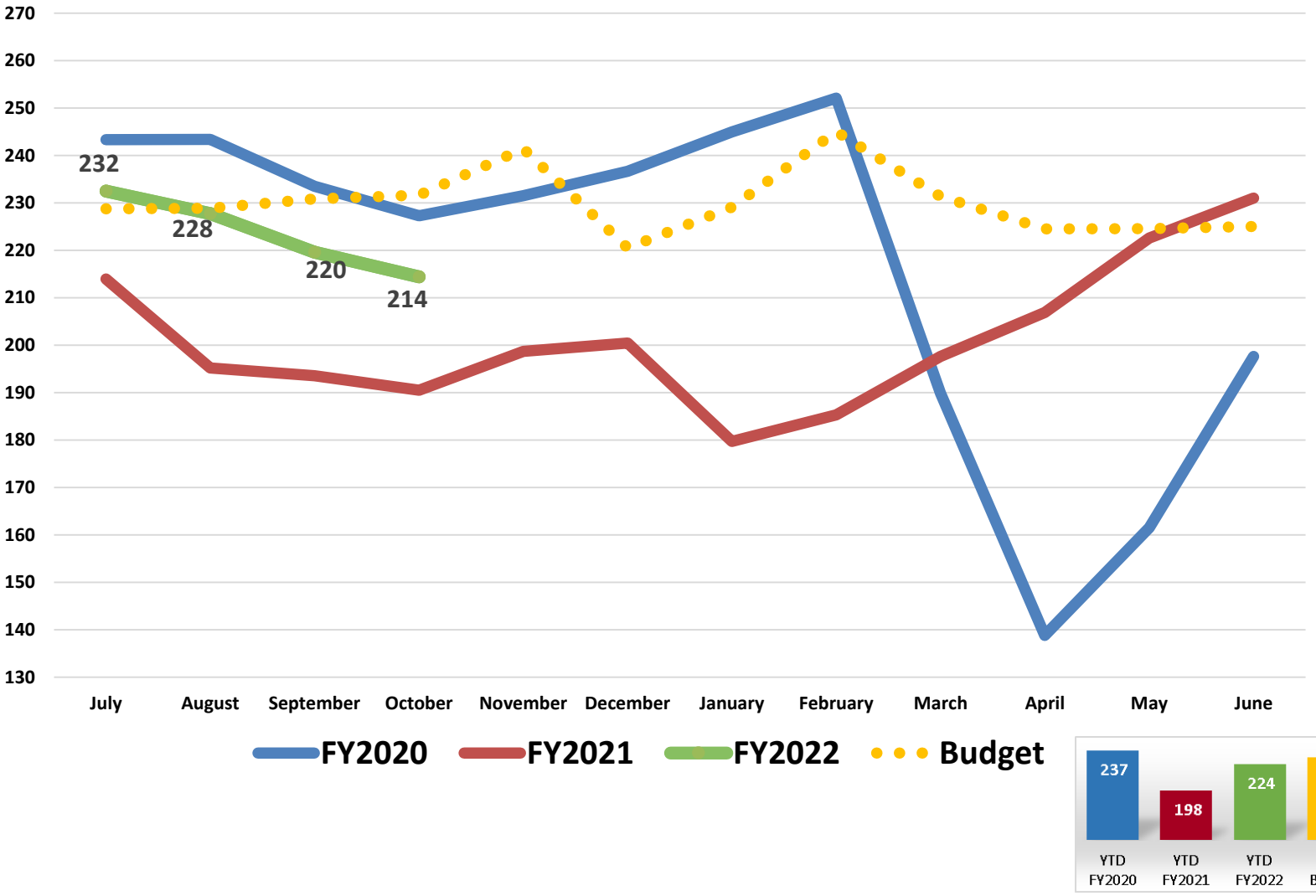
Obstetrics - Avg. Patients Per Day



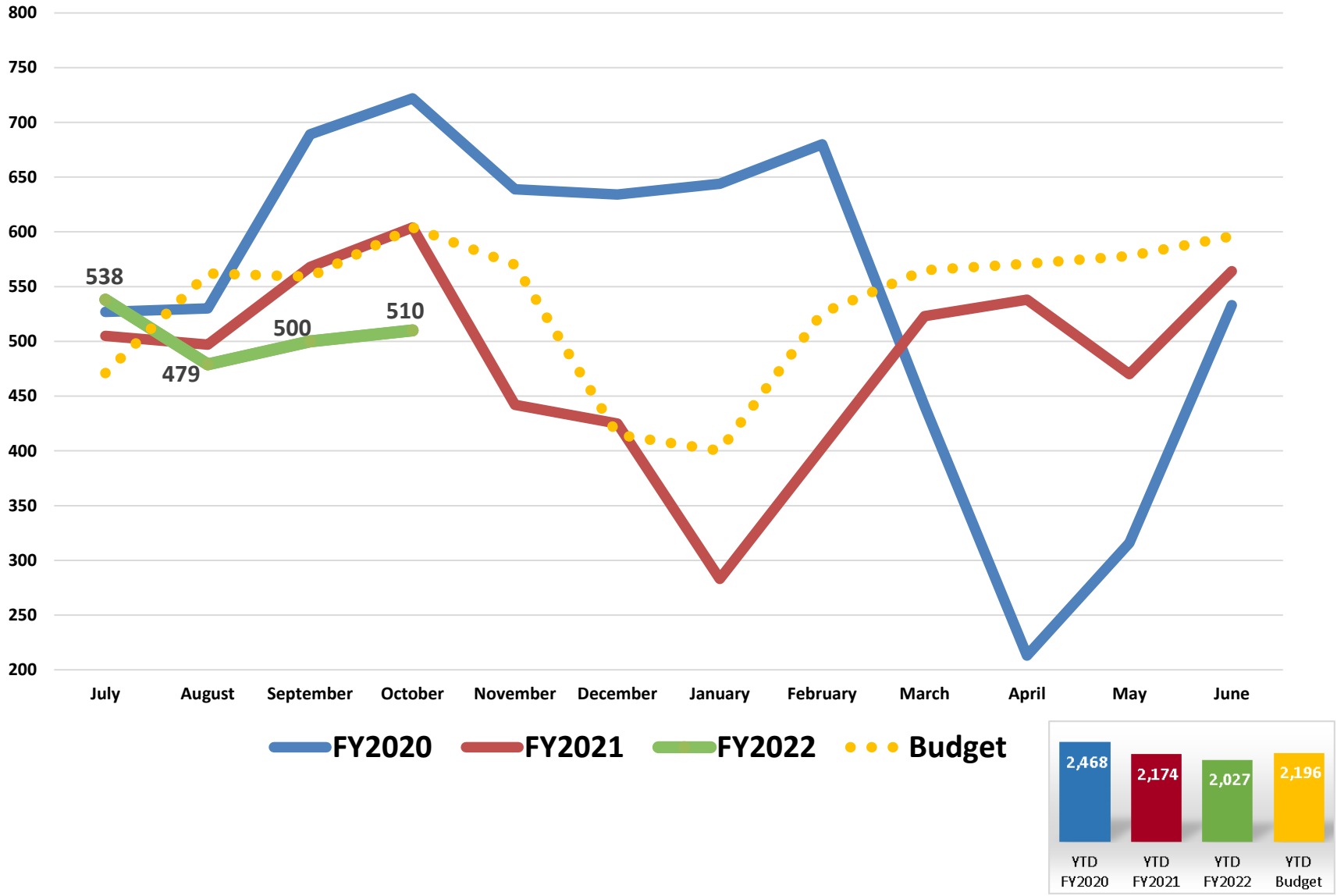
Outpatient Registrations per Day



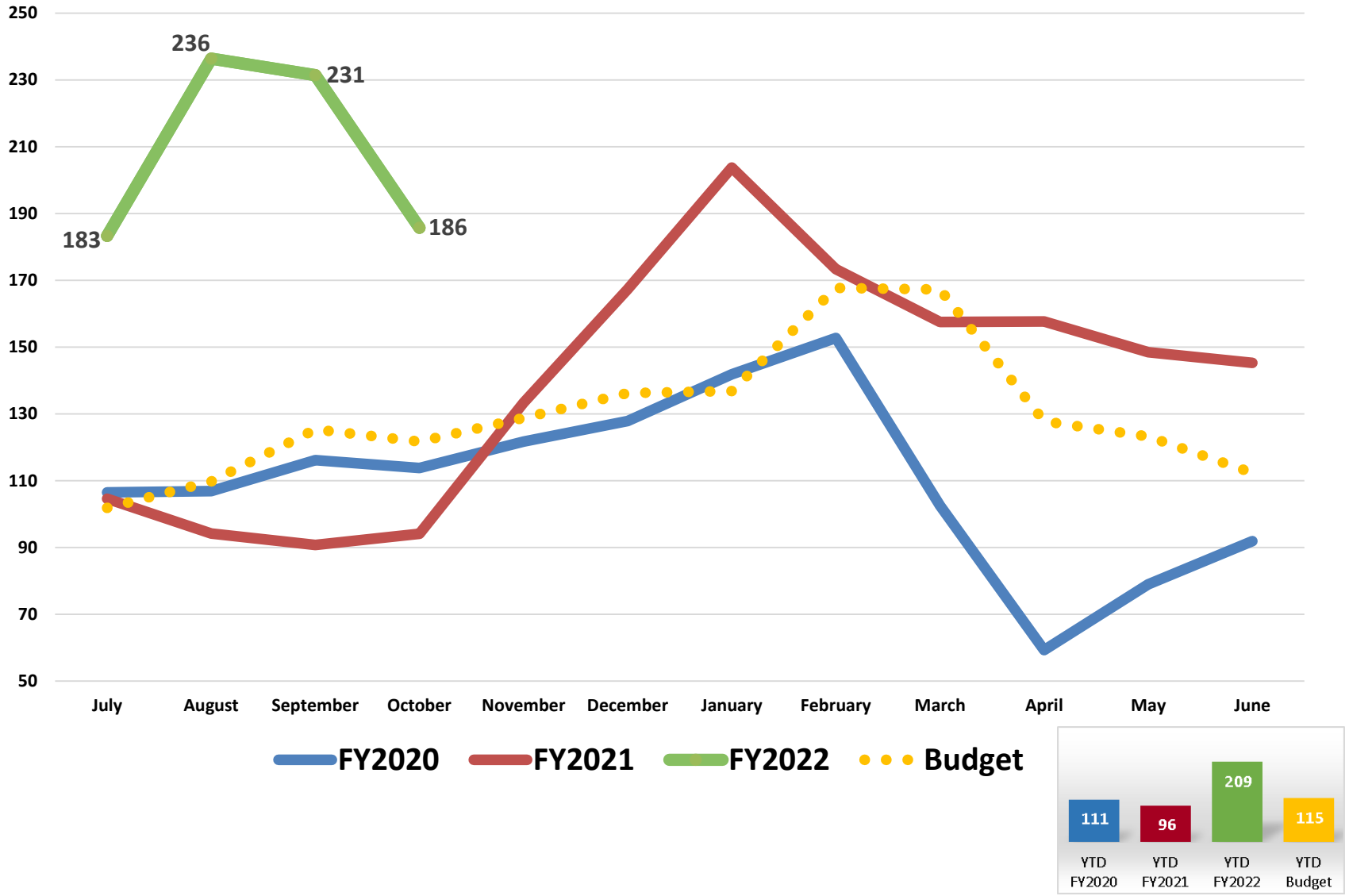
Emergency Dept – Avg Treated Per Day



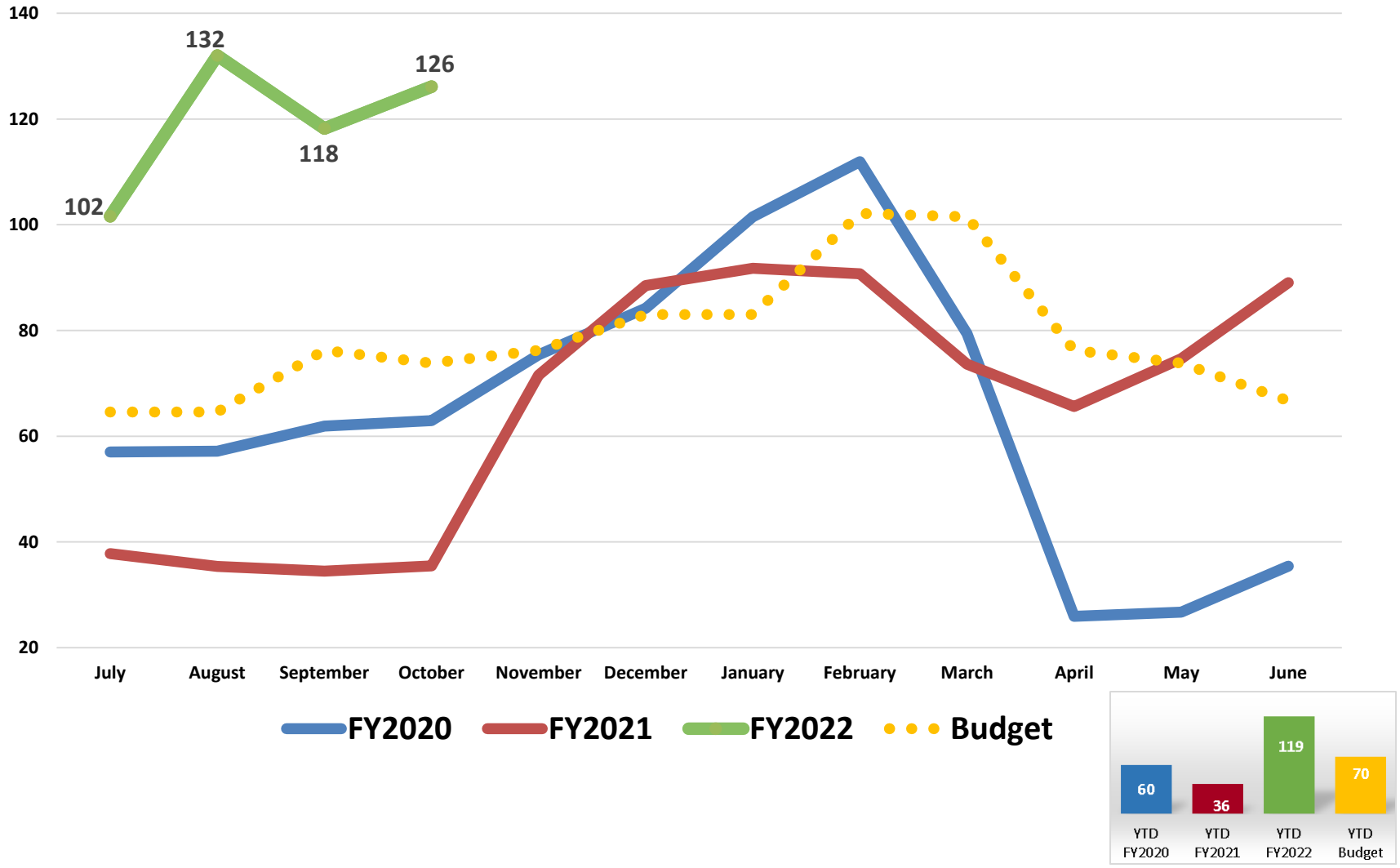
Endoscopy Procedures



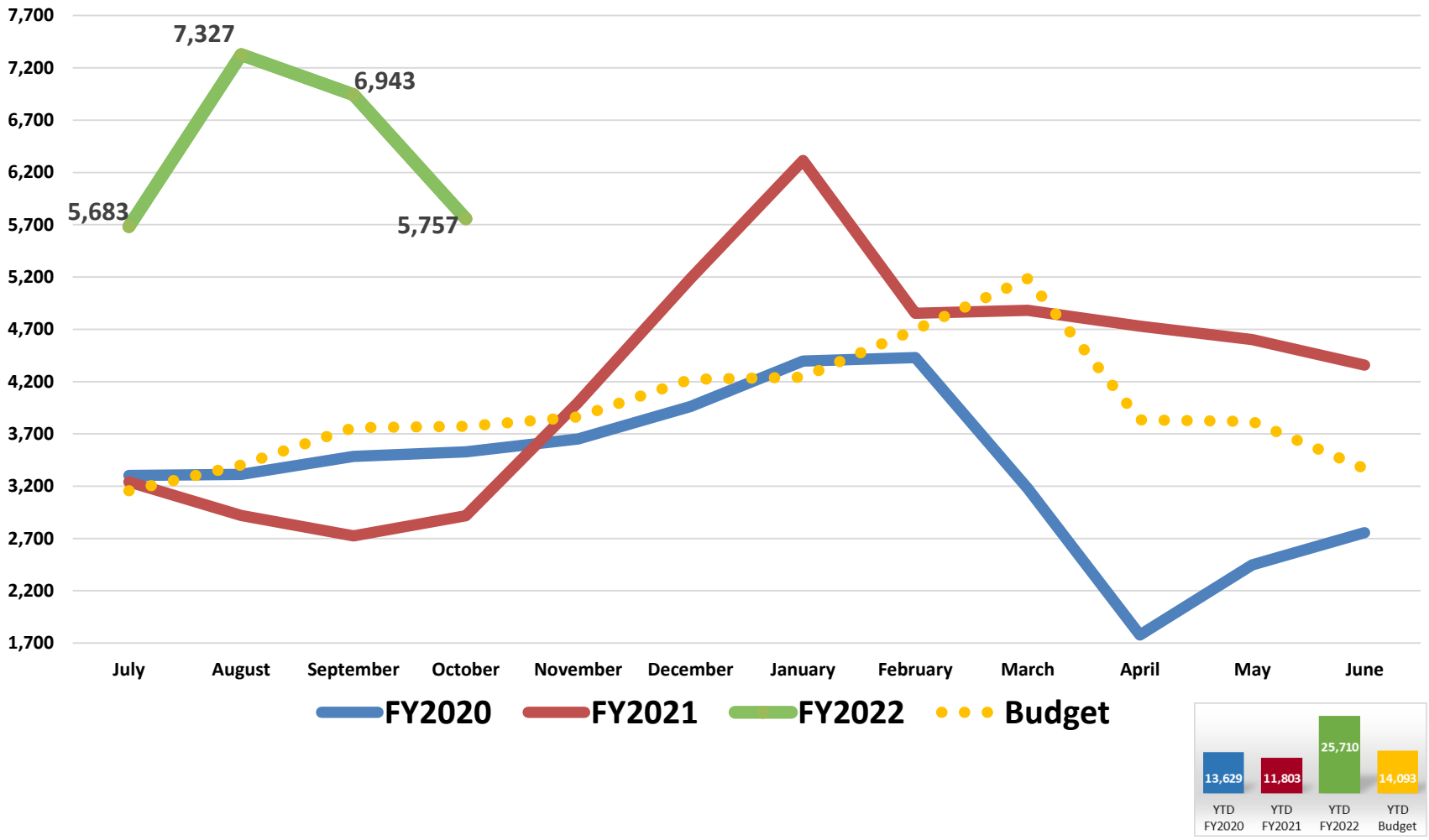
Urgent Care – Court Average Visits Per Day



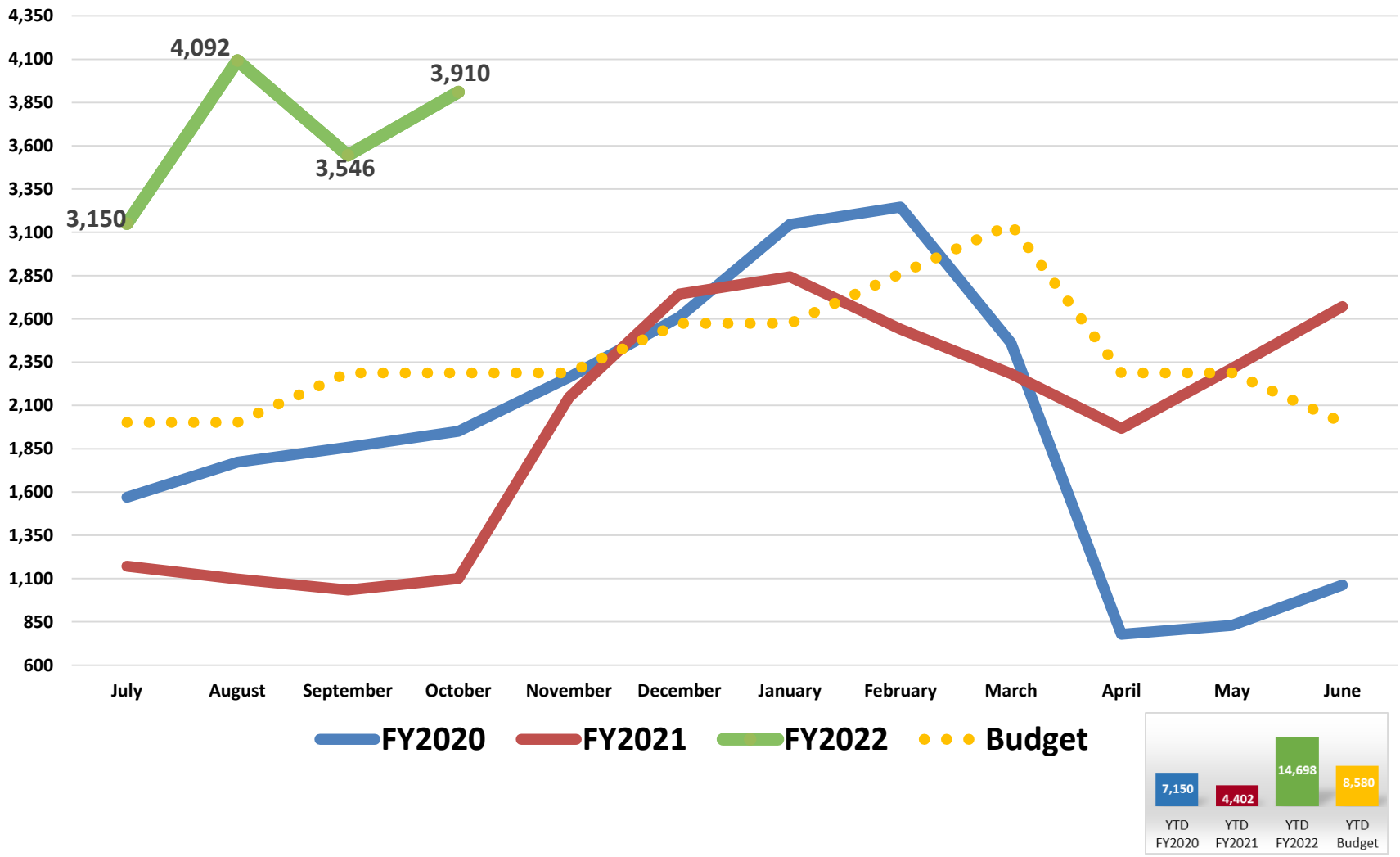
Urgent Care – Demaree Average Visits Per Day



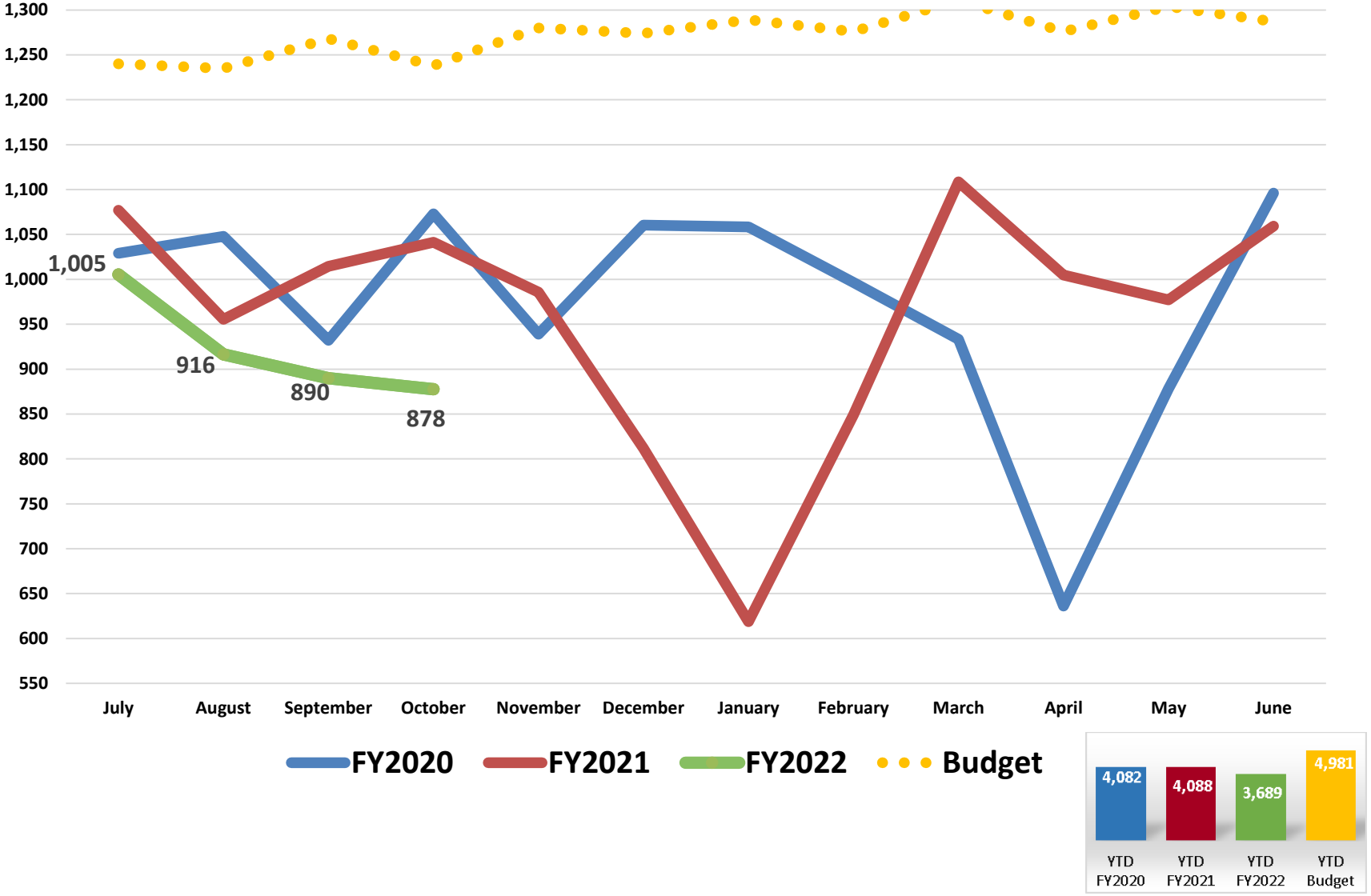
Urgent Care – Court Total Visits



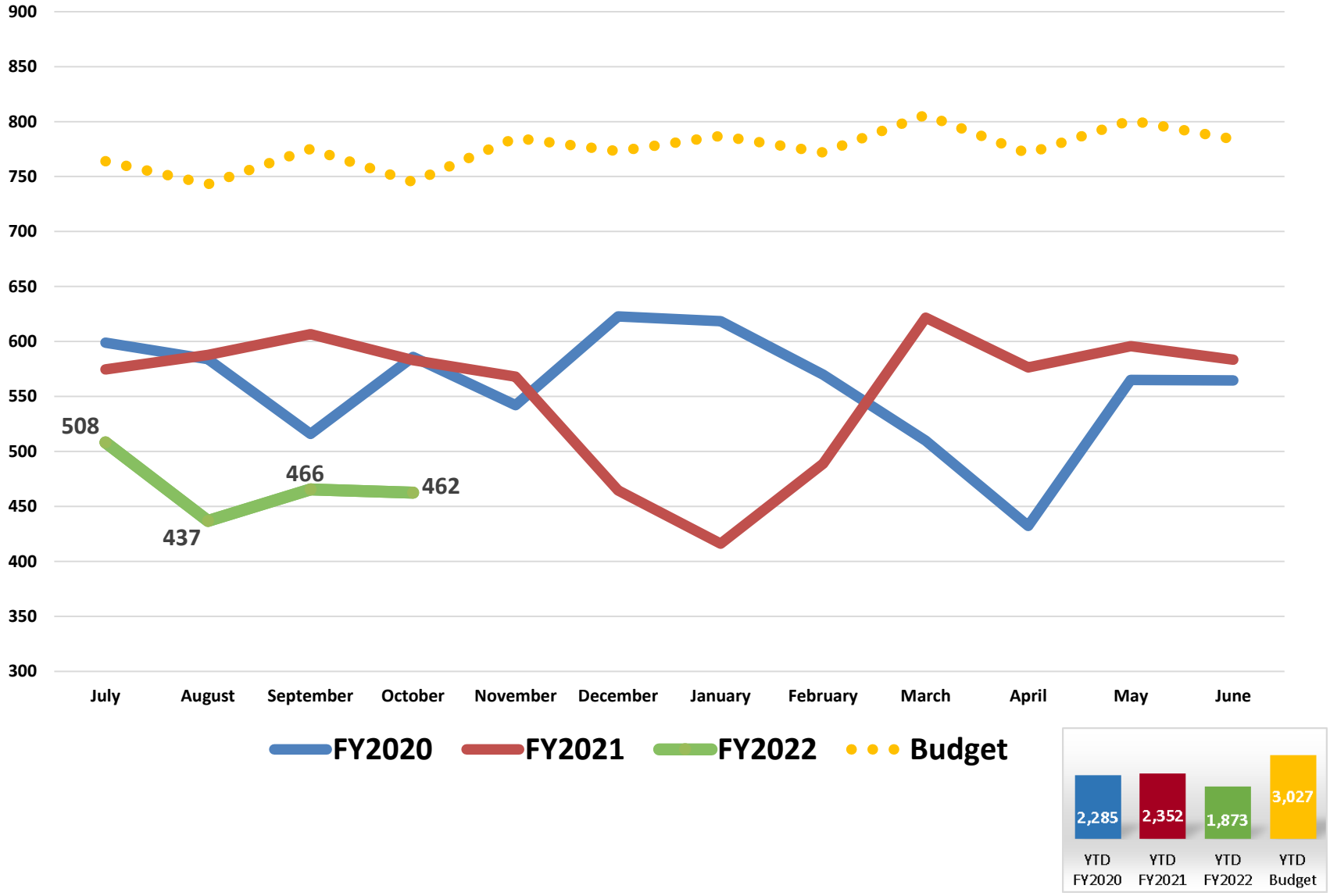
Urgent Care – Demaree Total Visits



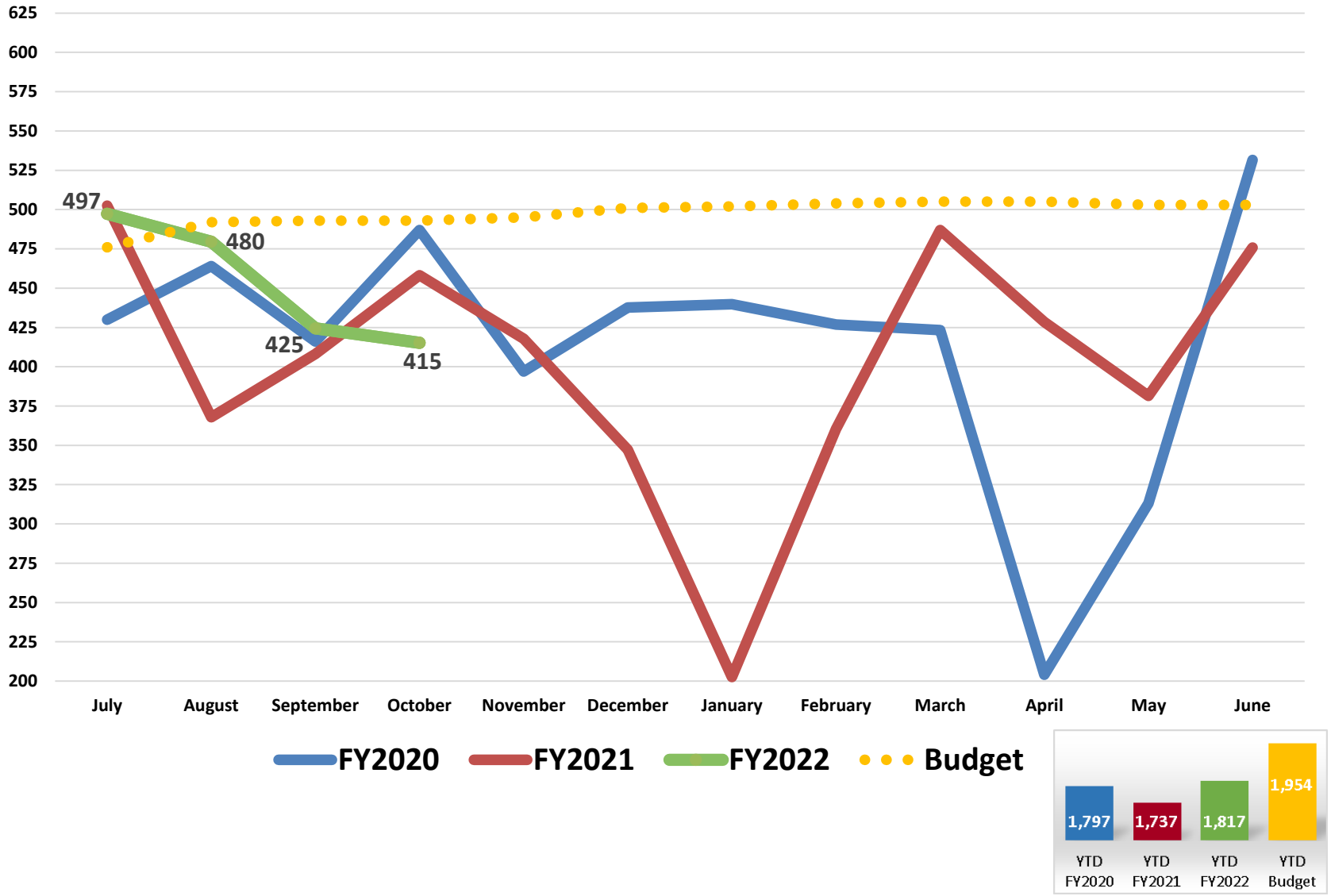
Surgery (IP & OP) – 100 Min Units



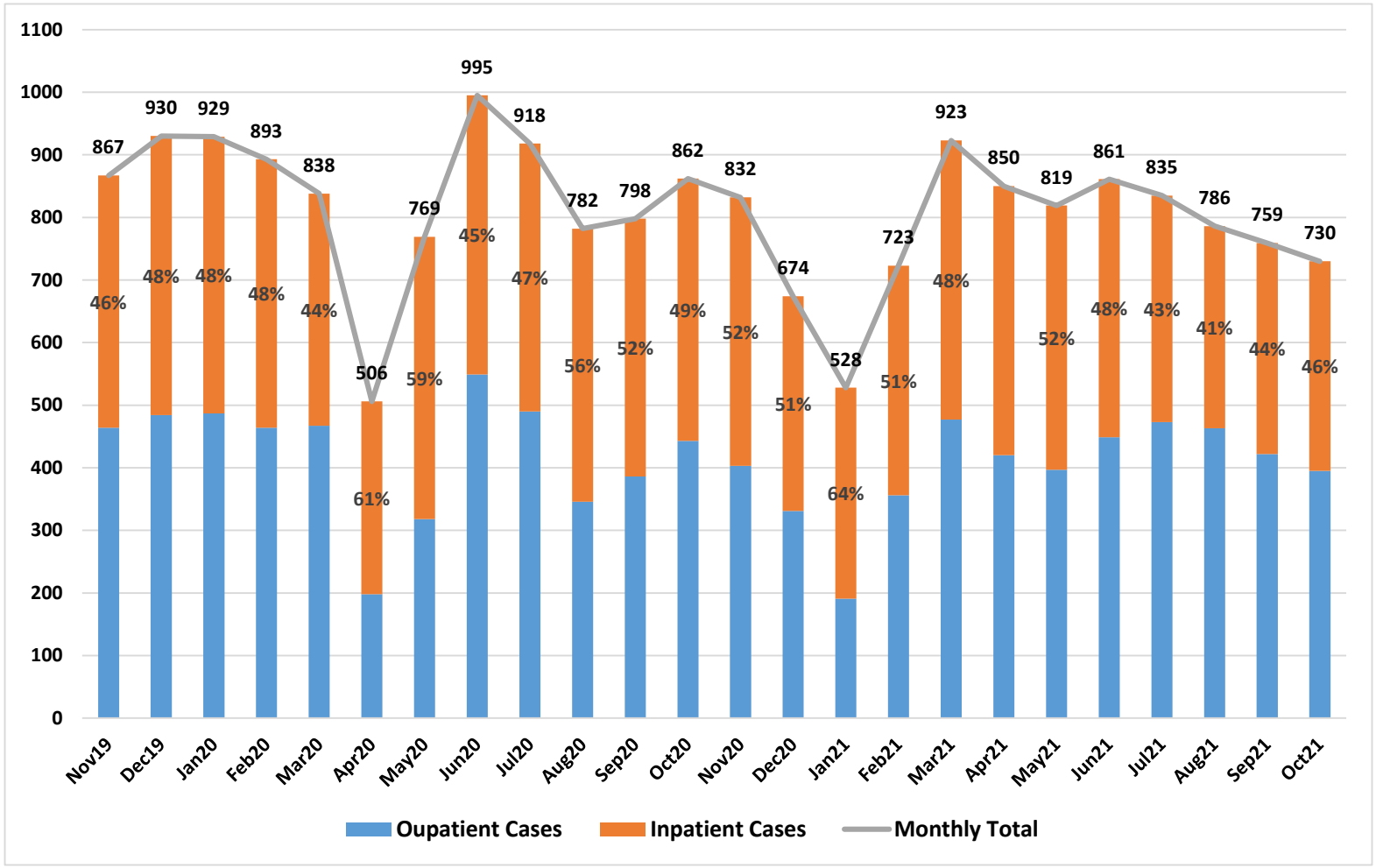
Surgery (IP Only) – 100 Min Units



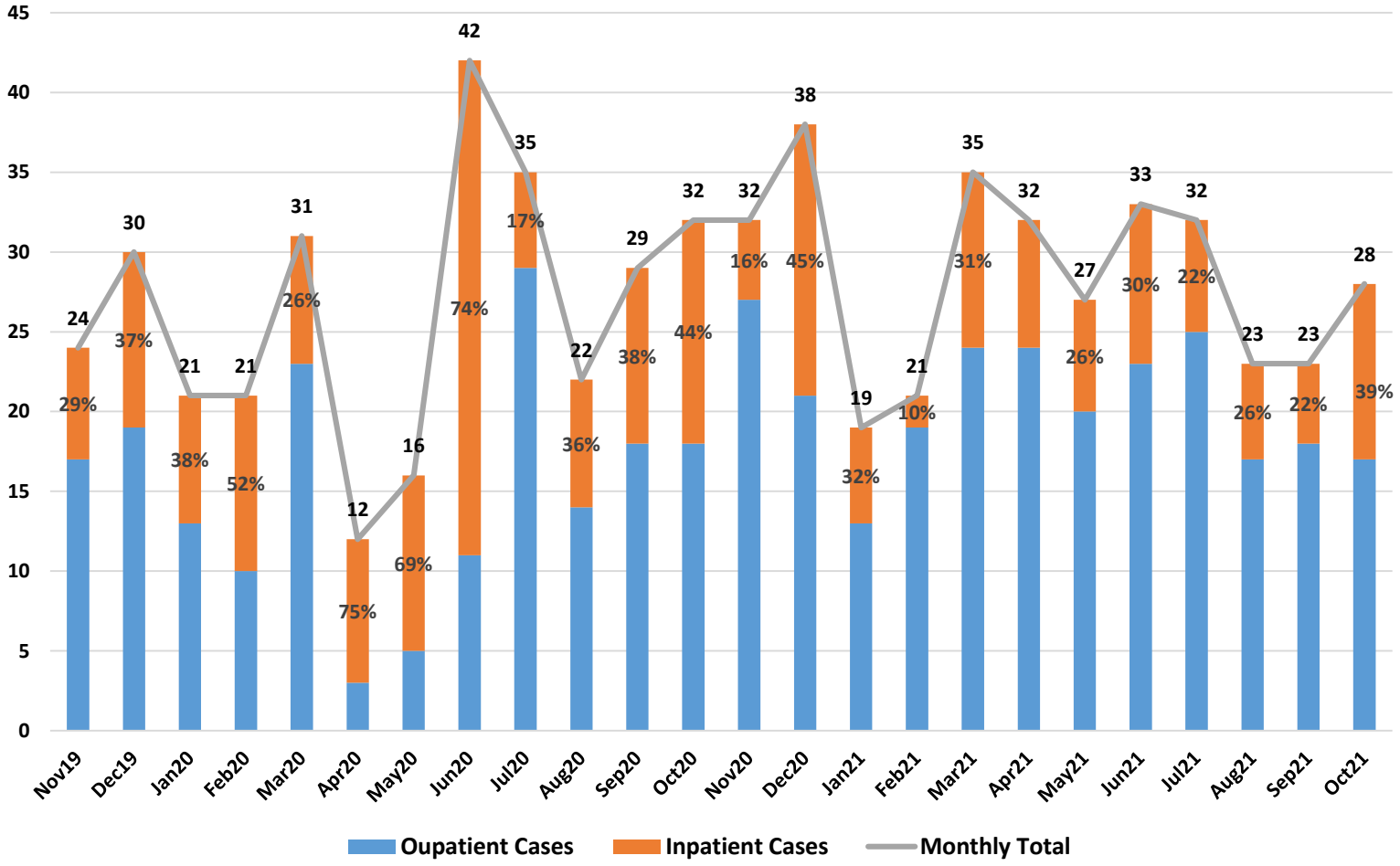
Surgery (OP Only) – 100 Min Units



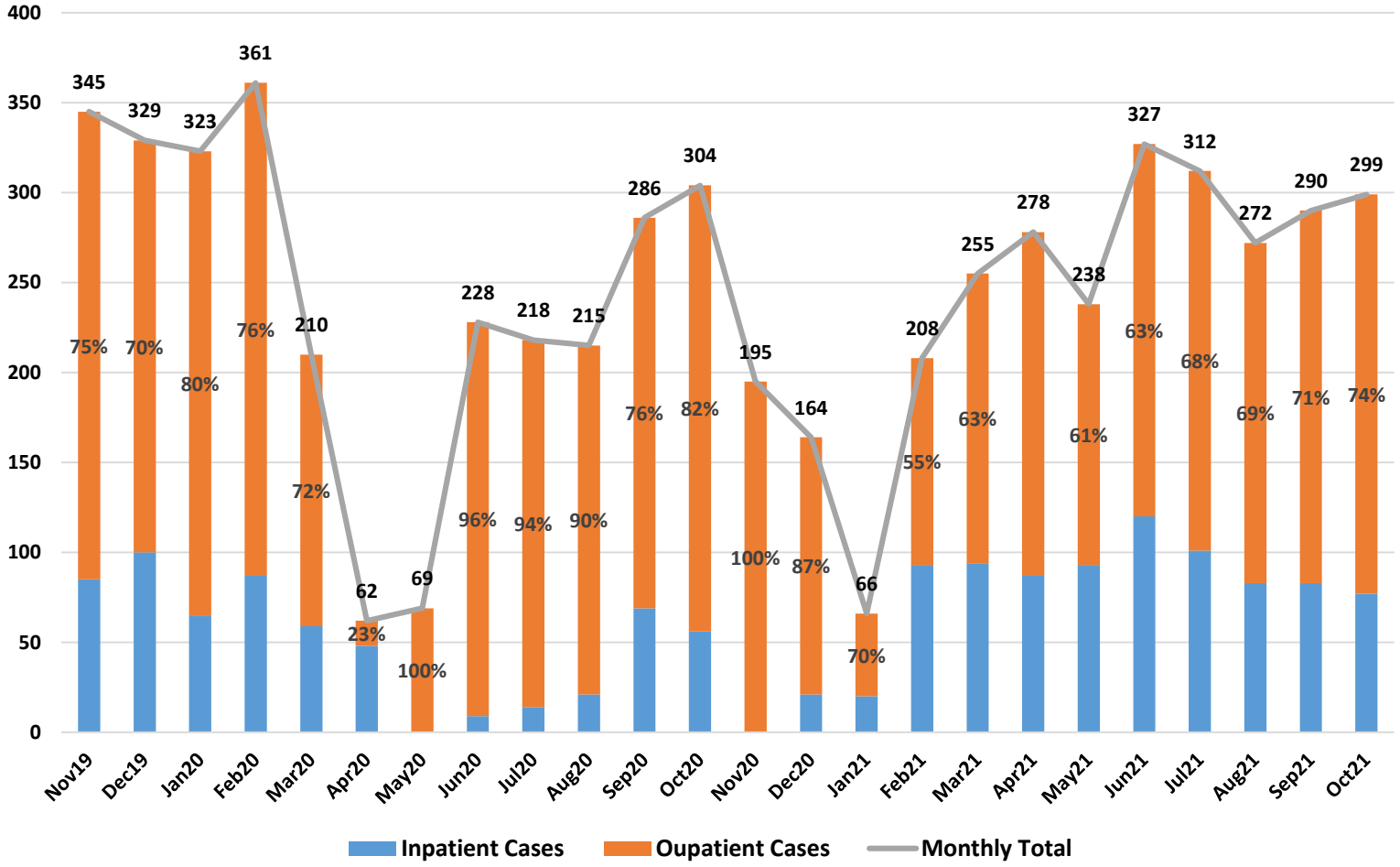
Surgery Cases



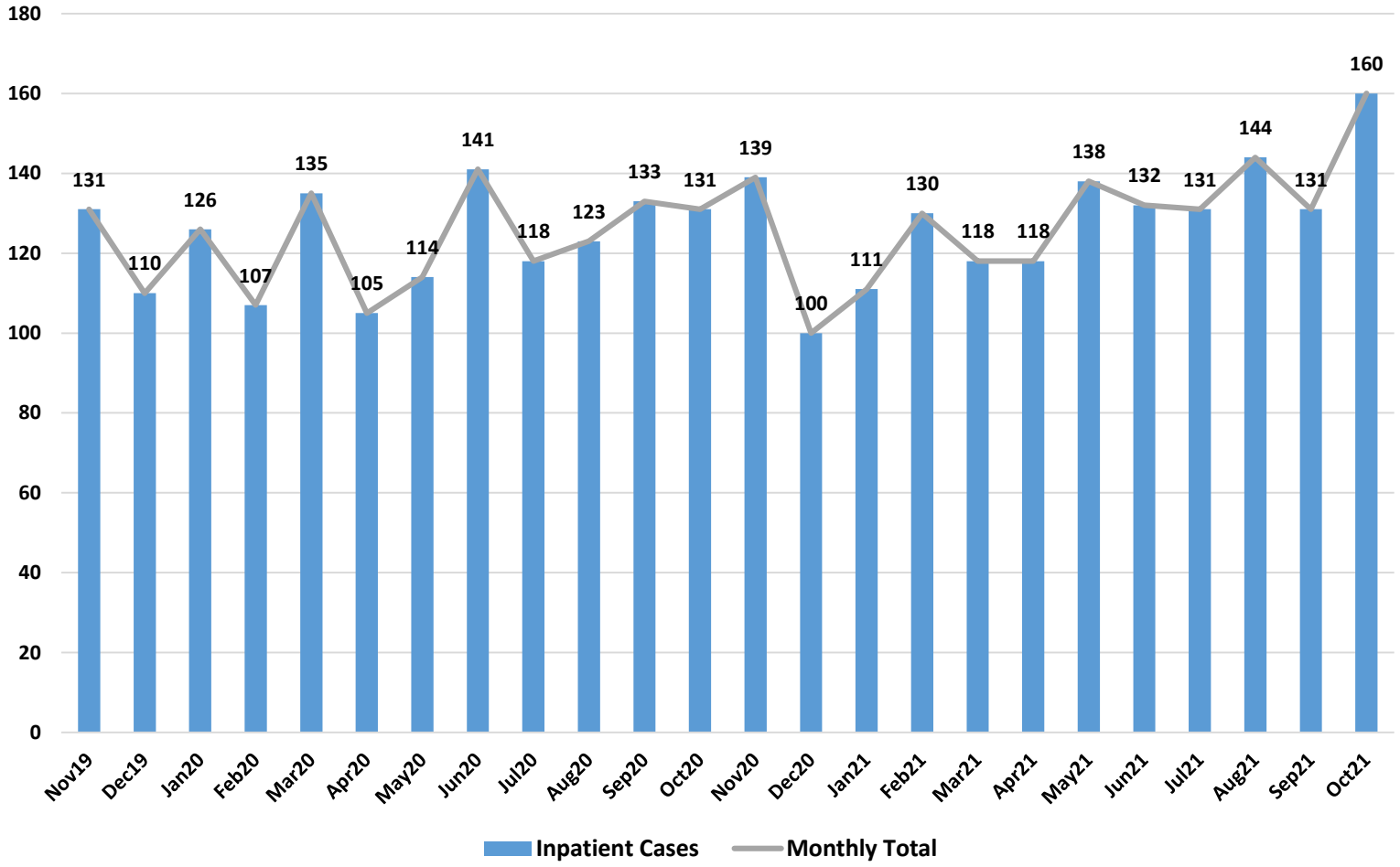
Robotic Cases



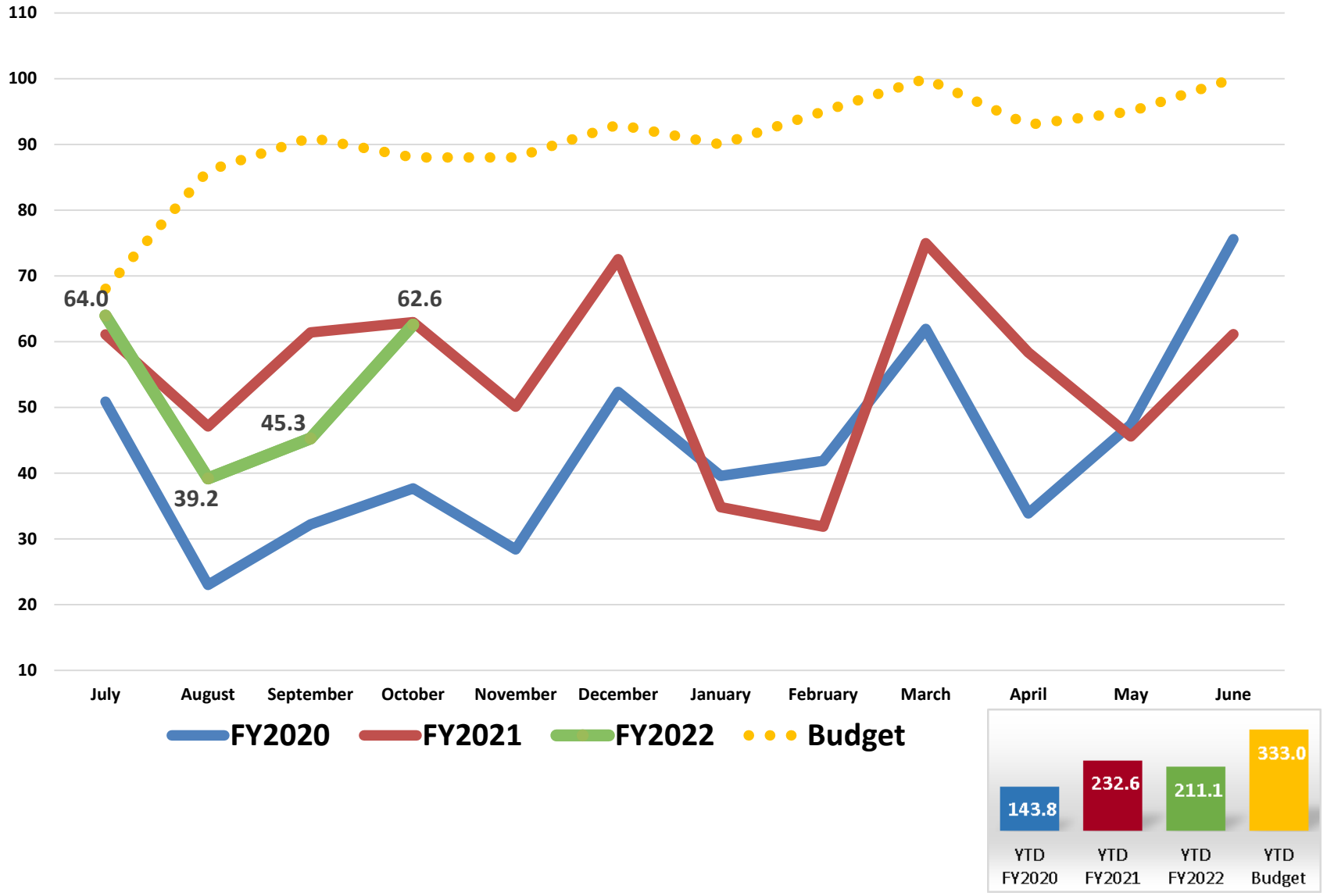
Endo Cases (Endo Suites)



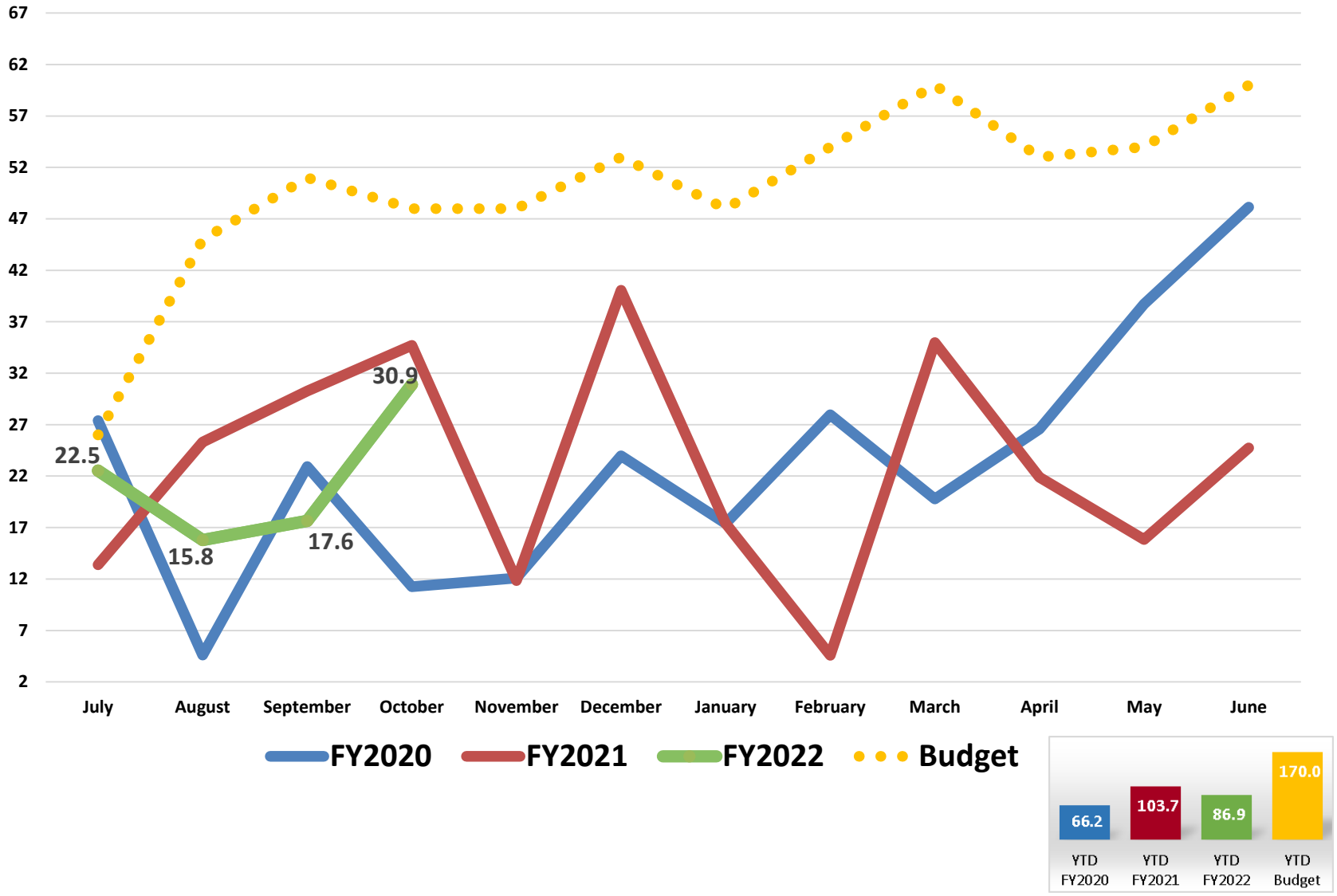
OB Cases


180
160
140
120
100
80
60
40
20
0
131
110
126
107
135
105
114
141
118
123
133
131
139
100
111
130
118
118
138
132
131
144
131
160
Nov19
Dec19
Jan20
Feb20
Mar20
Apr20
May20
Jun20
Jul20
Aug20
Sep20
Oct20
Nov20
Dec20
Jan21
Feb21
Mar21
Apr21
May21
Jun21
Jul21
Aug21
Sep21
Oct21
Inpatient Cases
Monthly Total

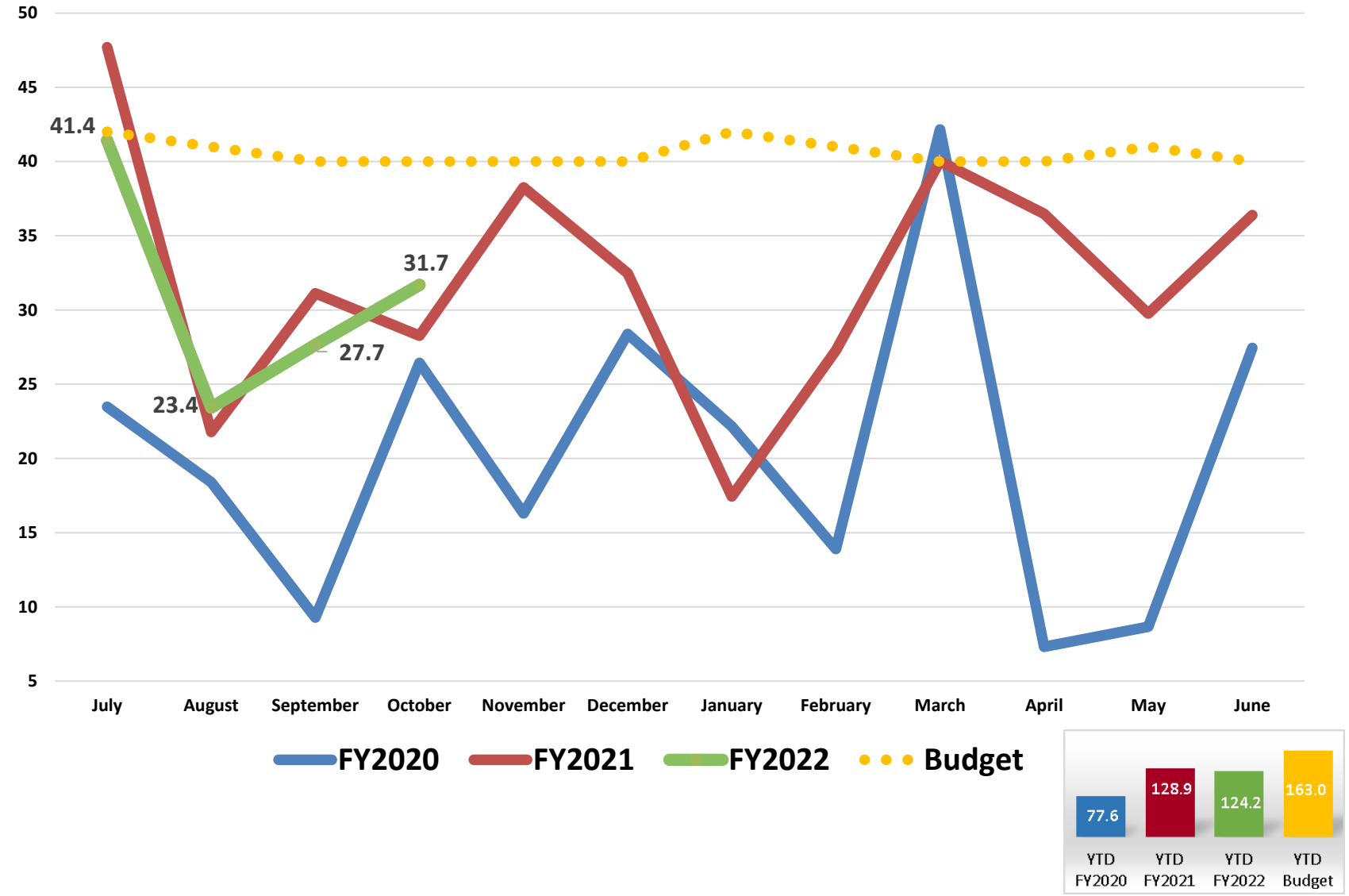
Robotic Surgery (IP & OP) – 100 Min Units



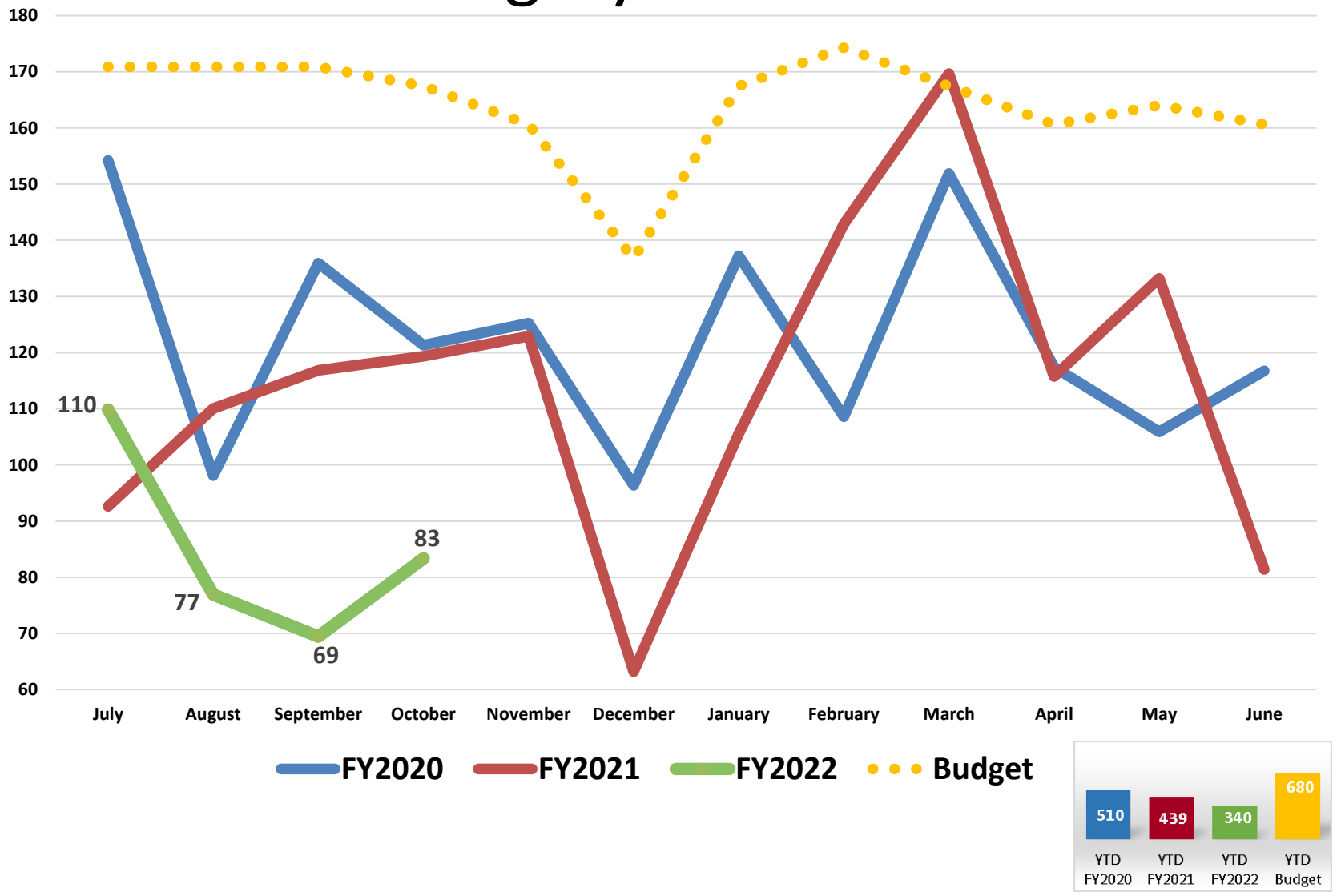
Robotic Surgery (IP Only) – 100 Min Units



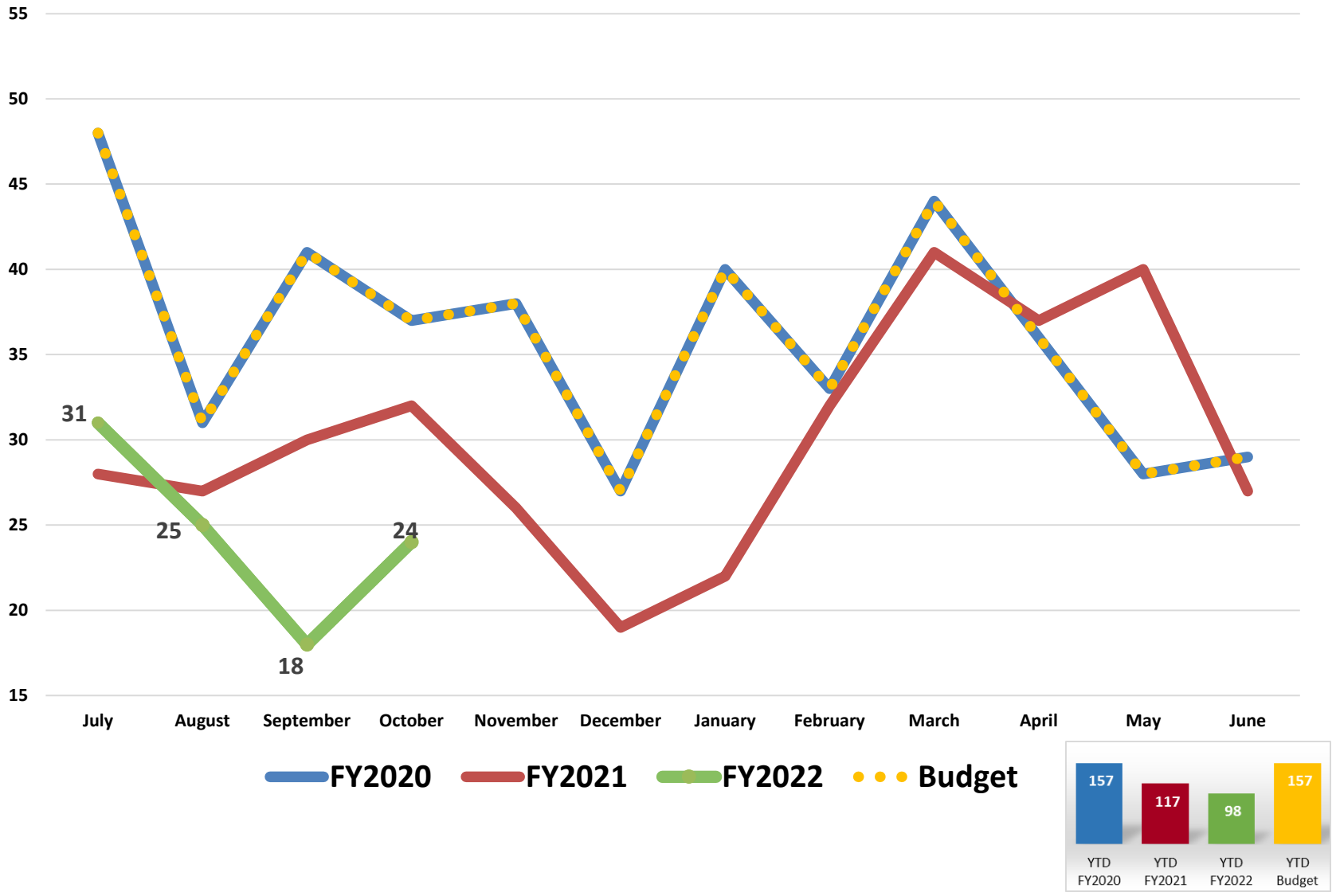
Robotic Surgery (OP Only) – 100 Min Units



Cardiac Surgery – 100 Min Units

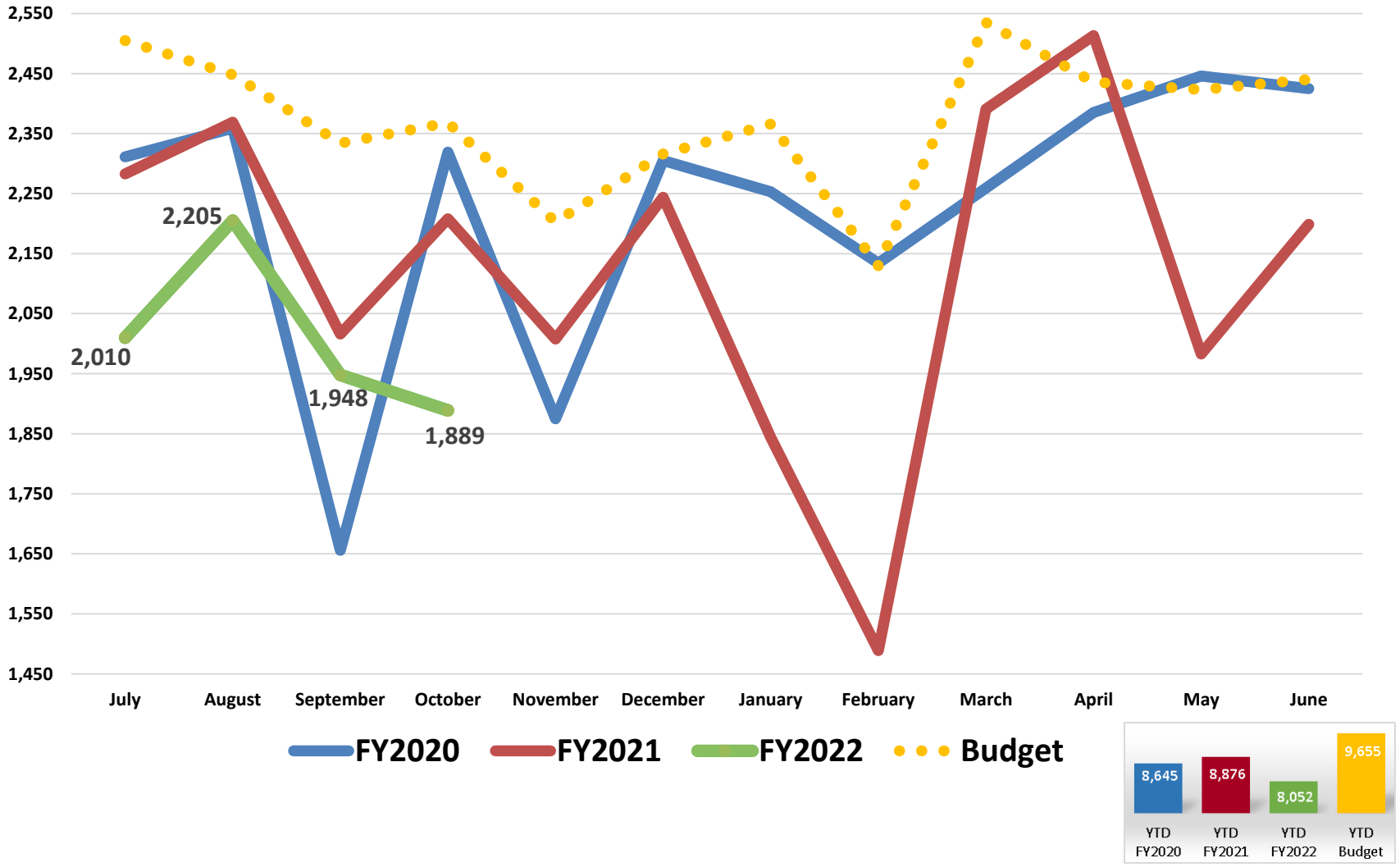


Cardiac Surgery – Cases

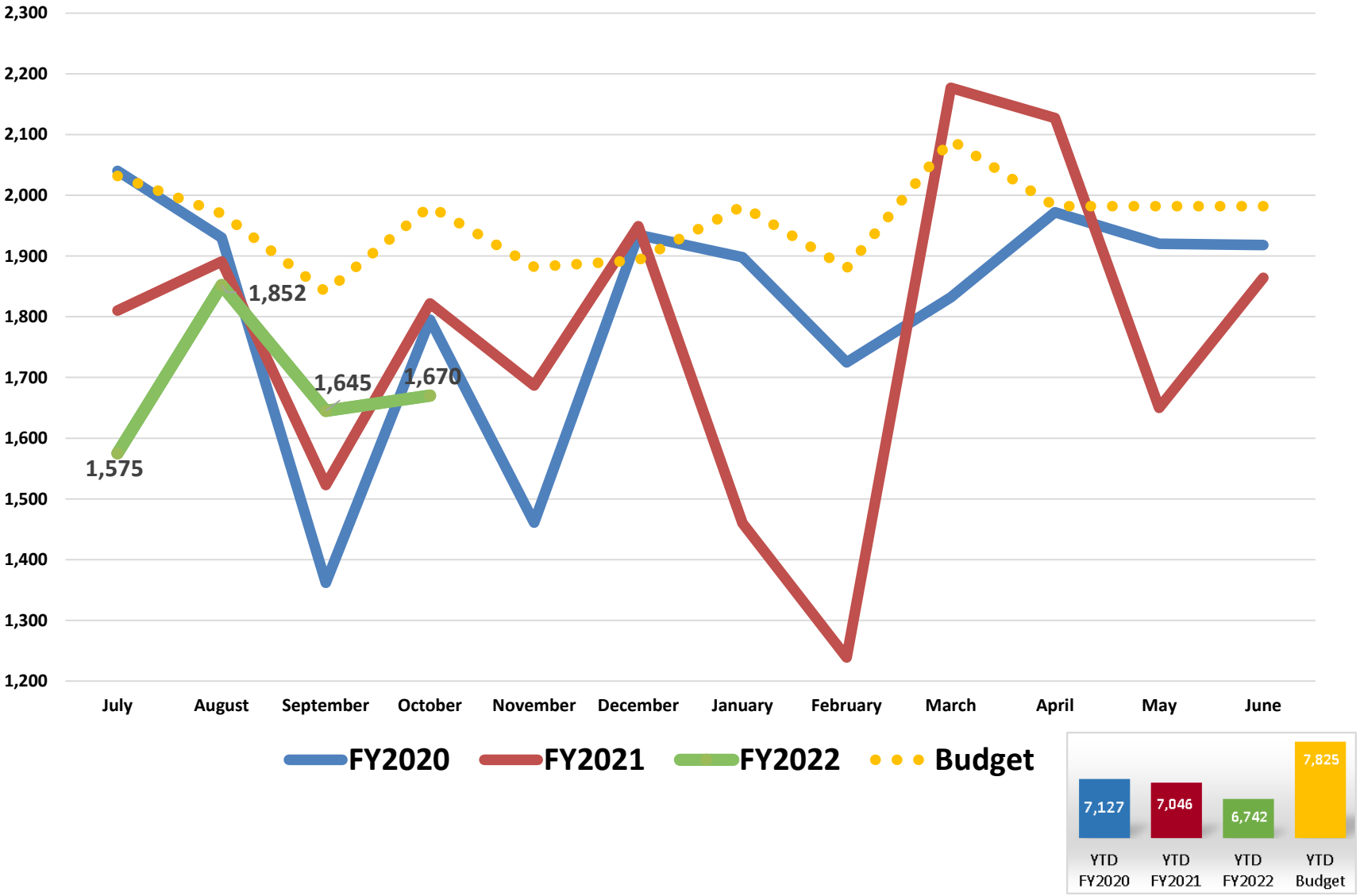


Radiation Oncology Treatments

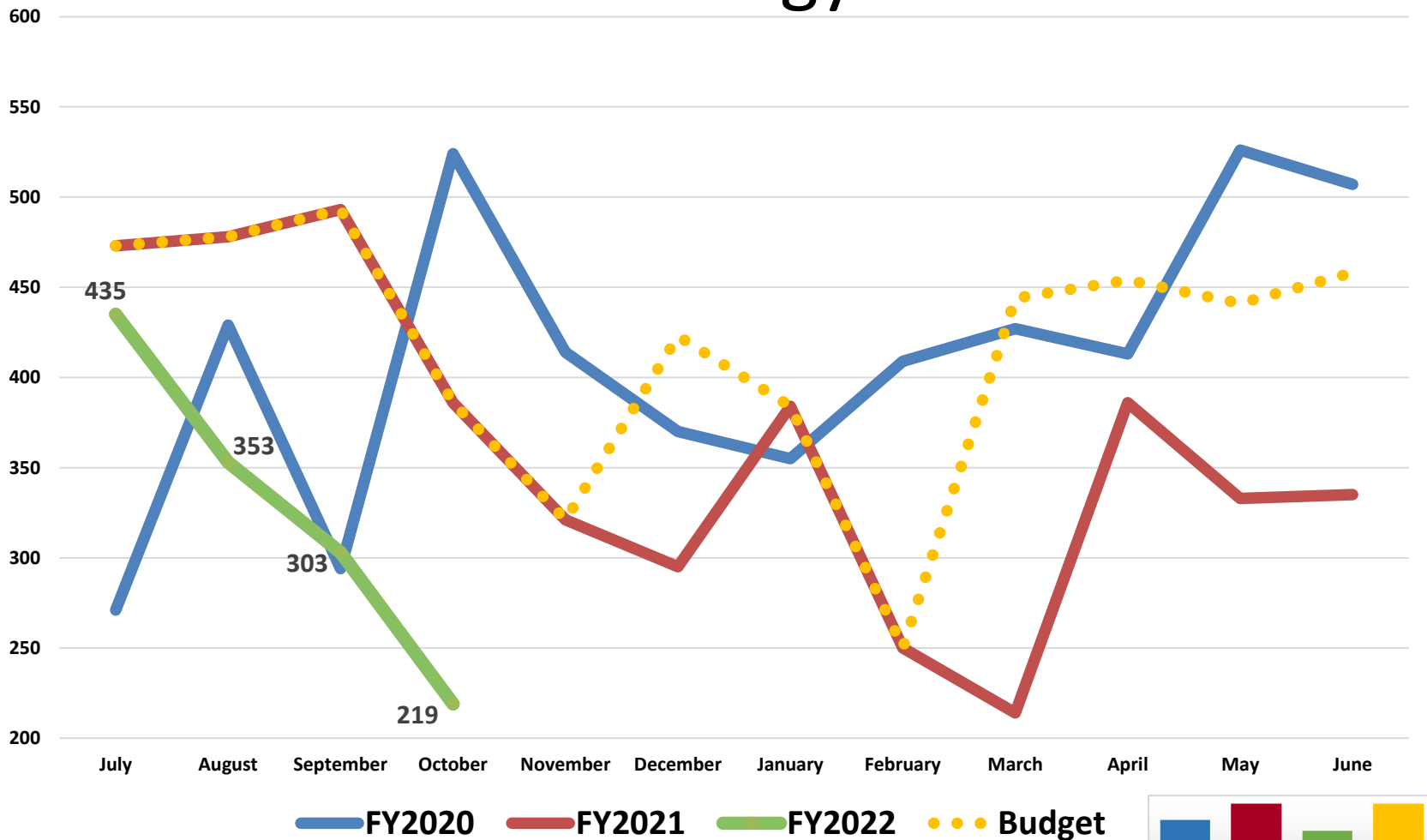
Hanford and Visalia

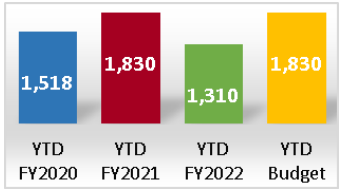


Radiation Oncology - Visalia

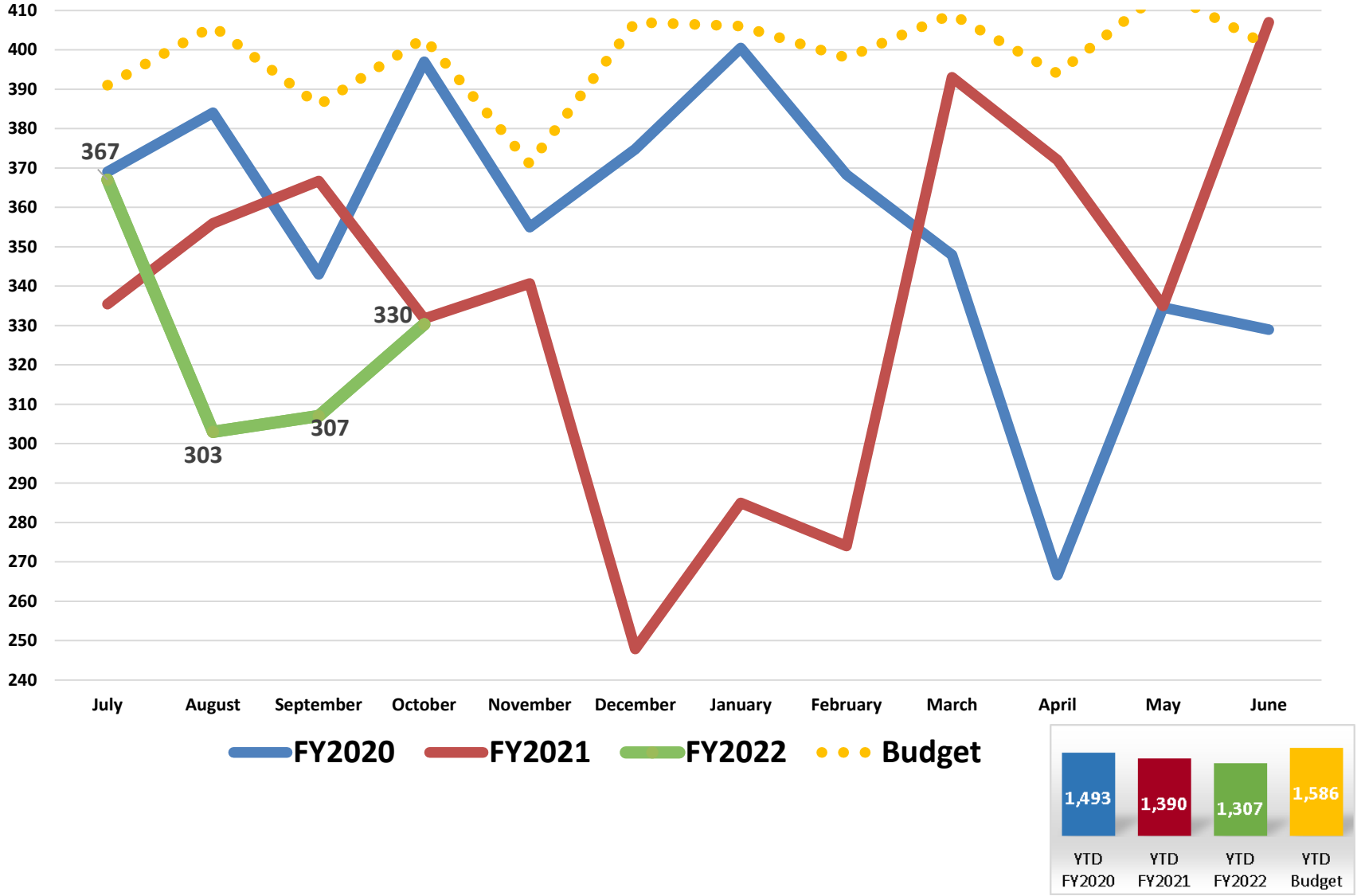


Radiation Oncology - Hanford

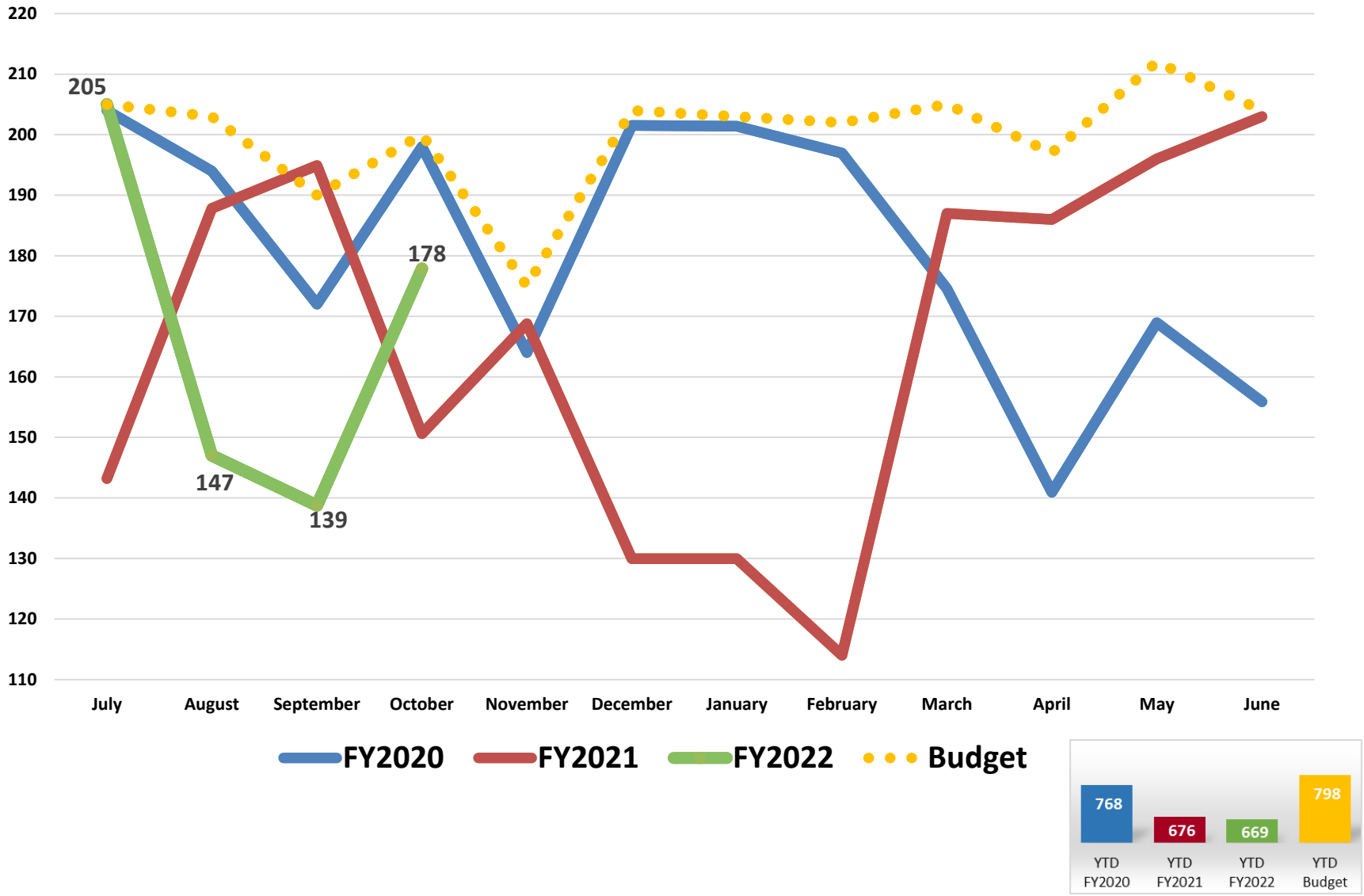




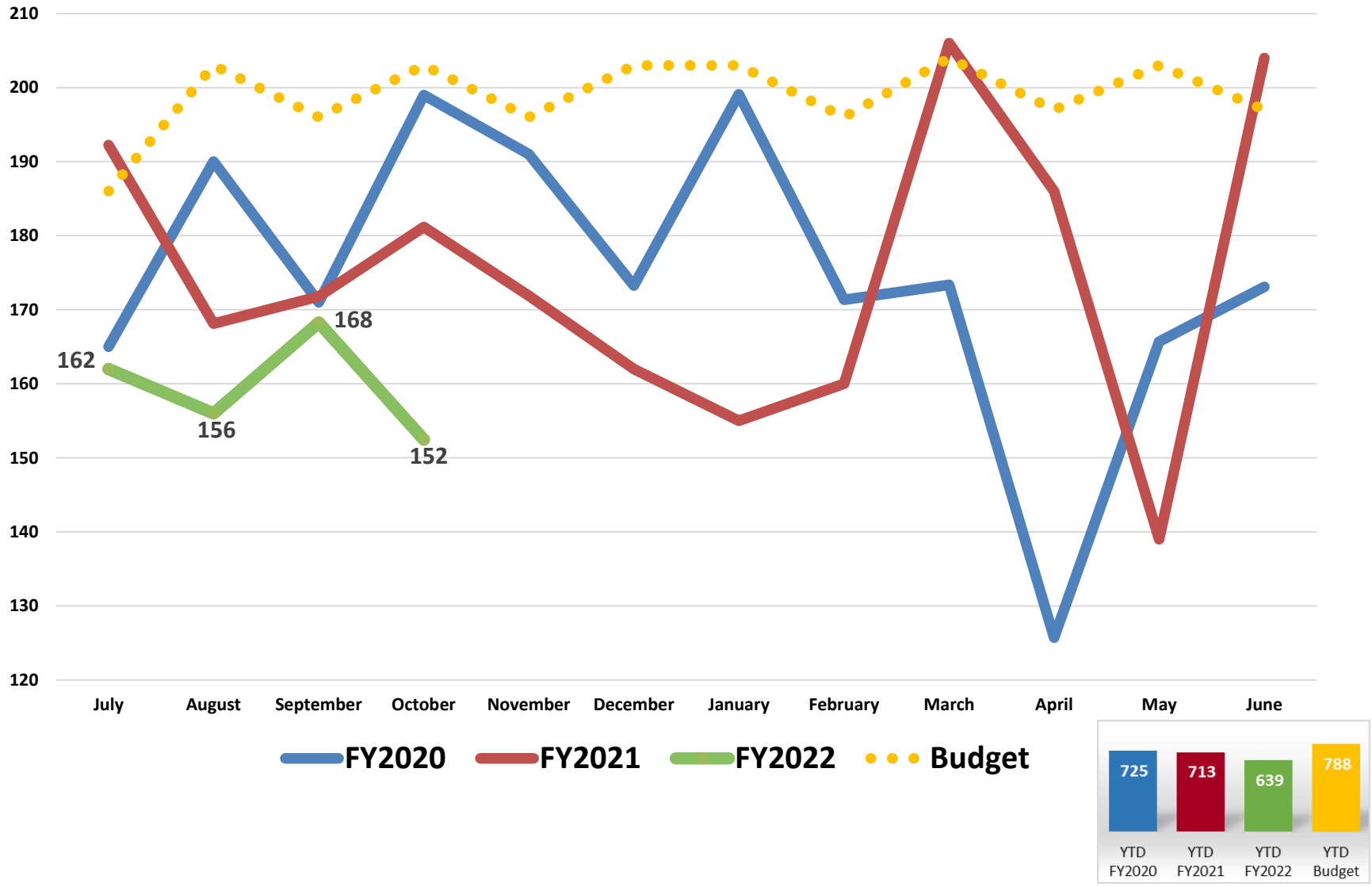
Cath Lab (IP & OP) – 100 Min Units



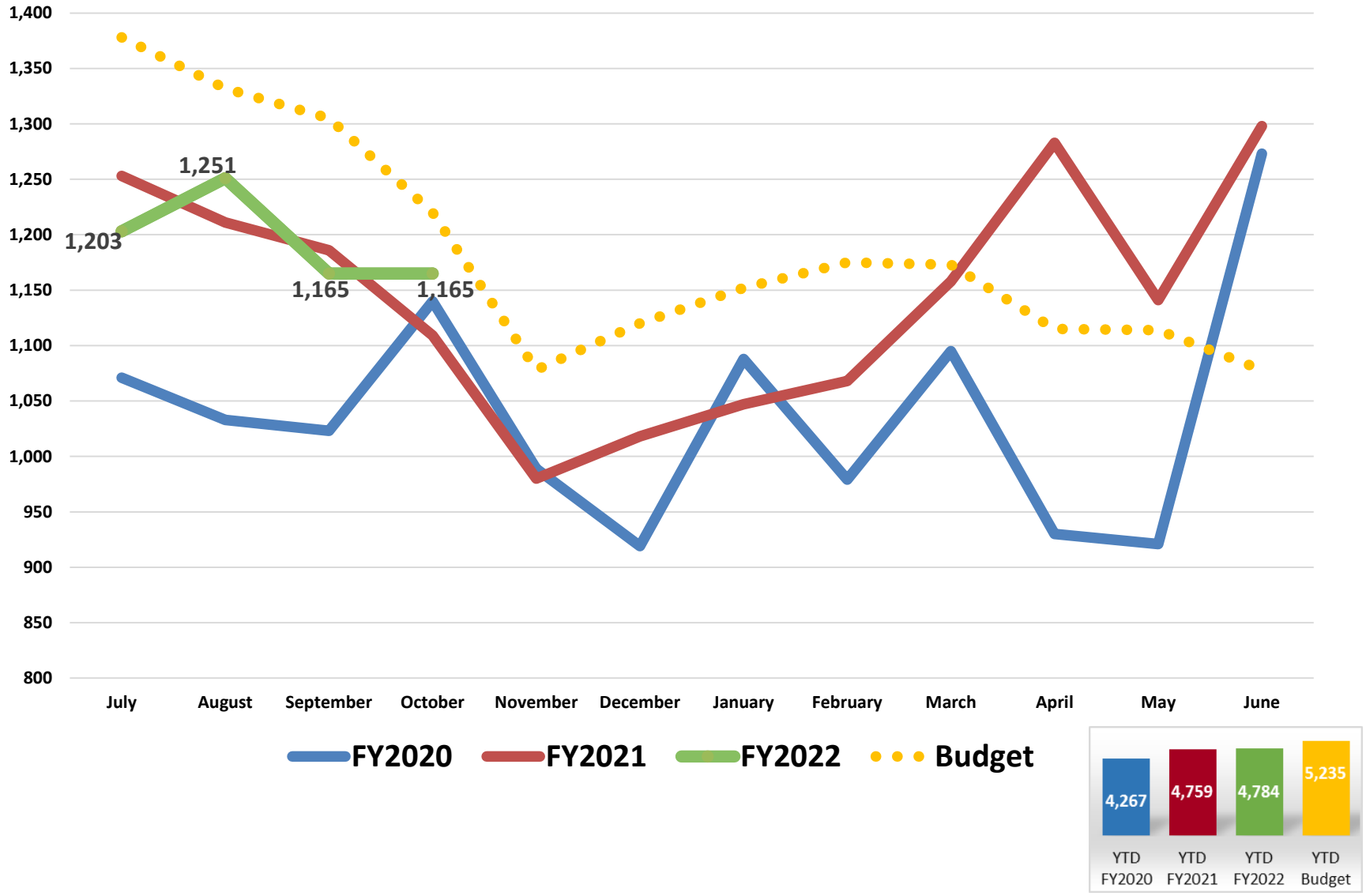
Cath Lab (IP Only) – 100 Min Units



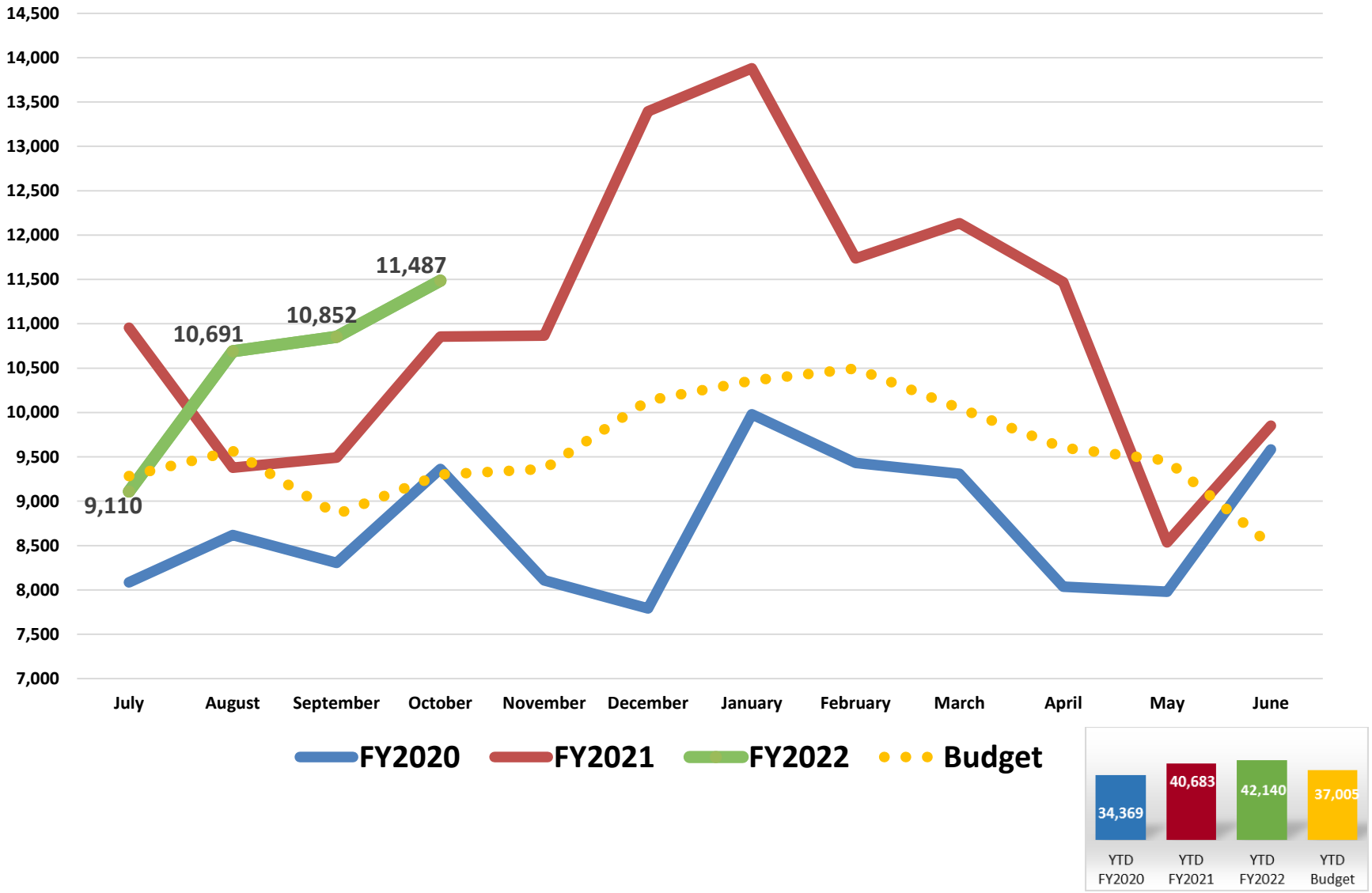
Cath Lab (OP Only) – 100 Min Units



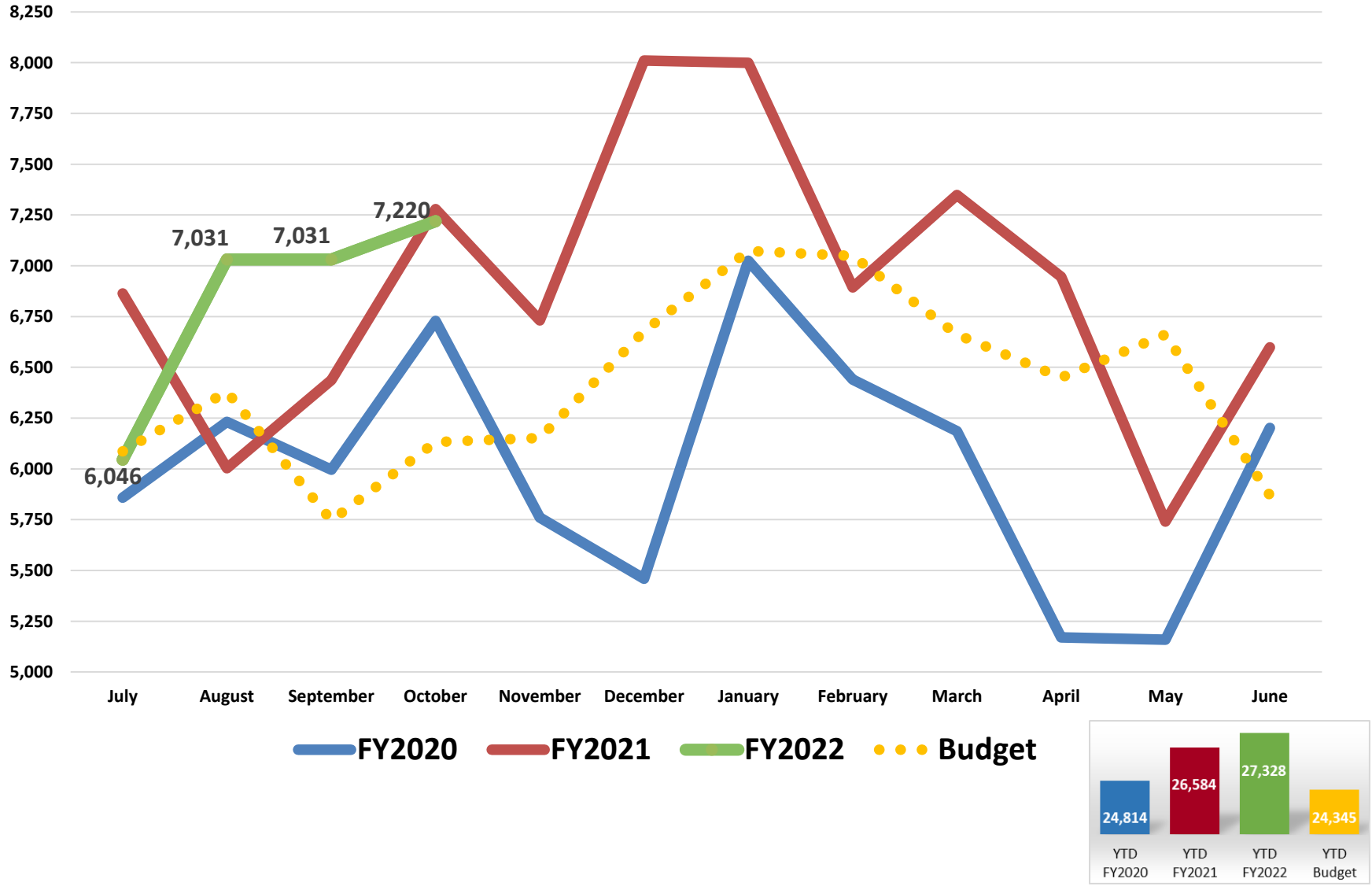
GME Family Medicine Clinic Visits



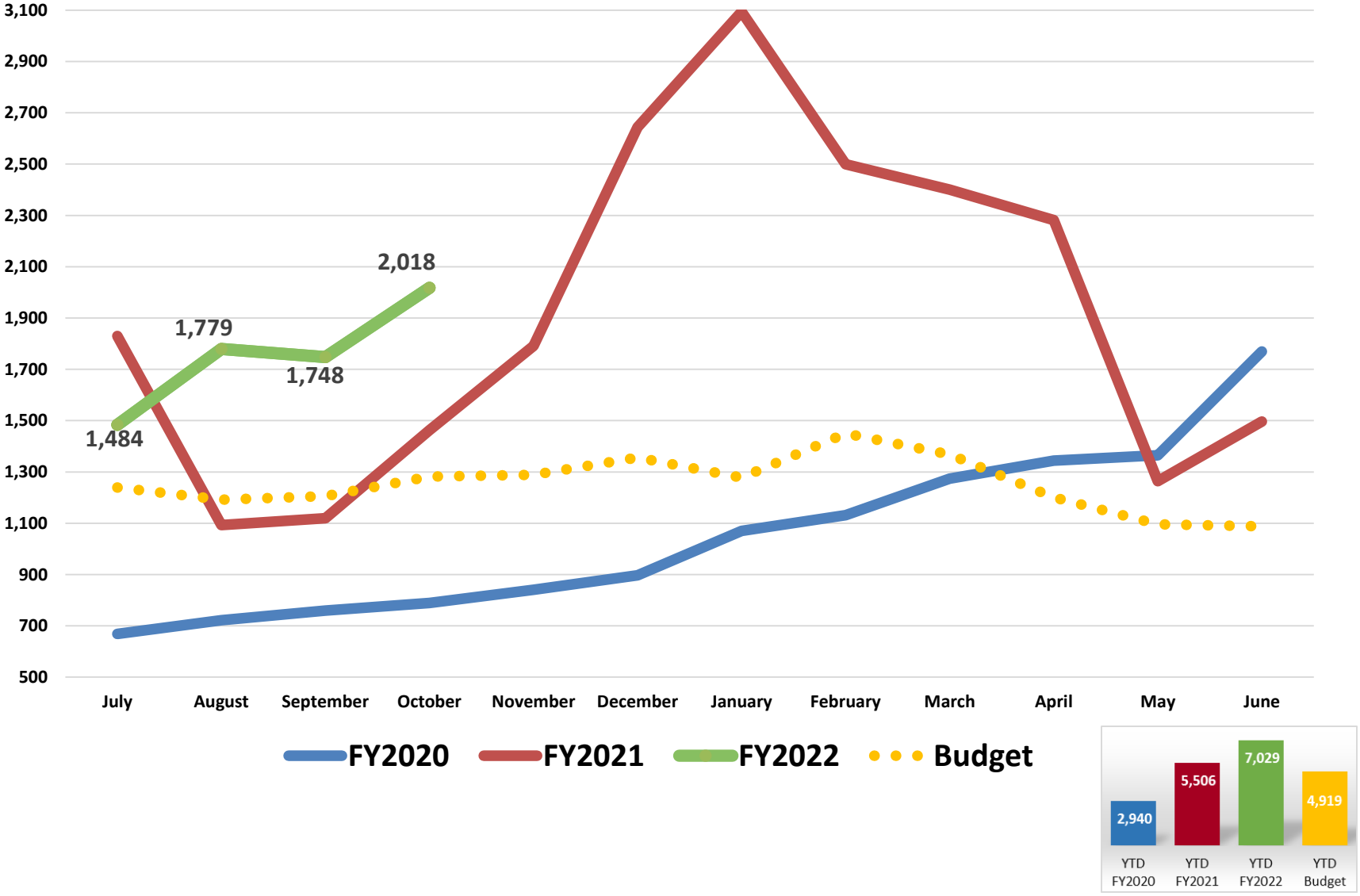
Rural Health Clinic Registrations



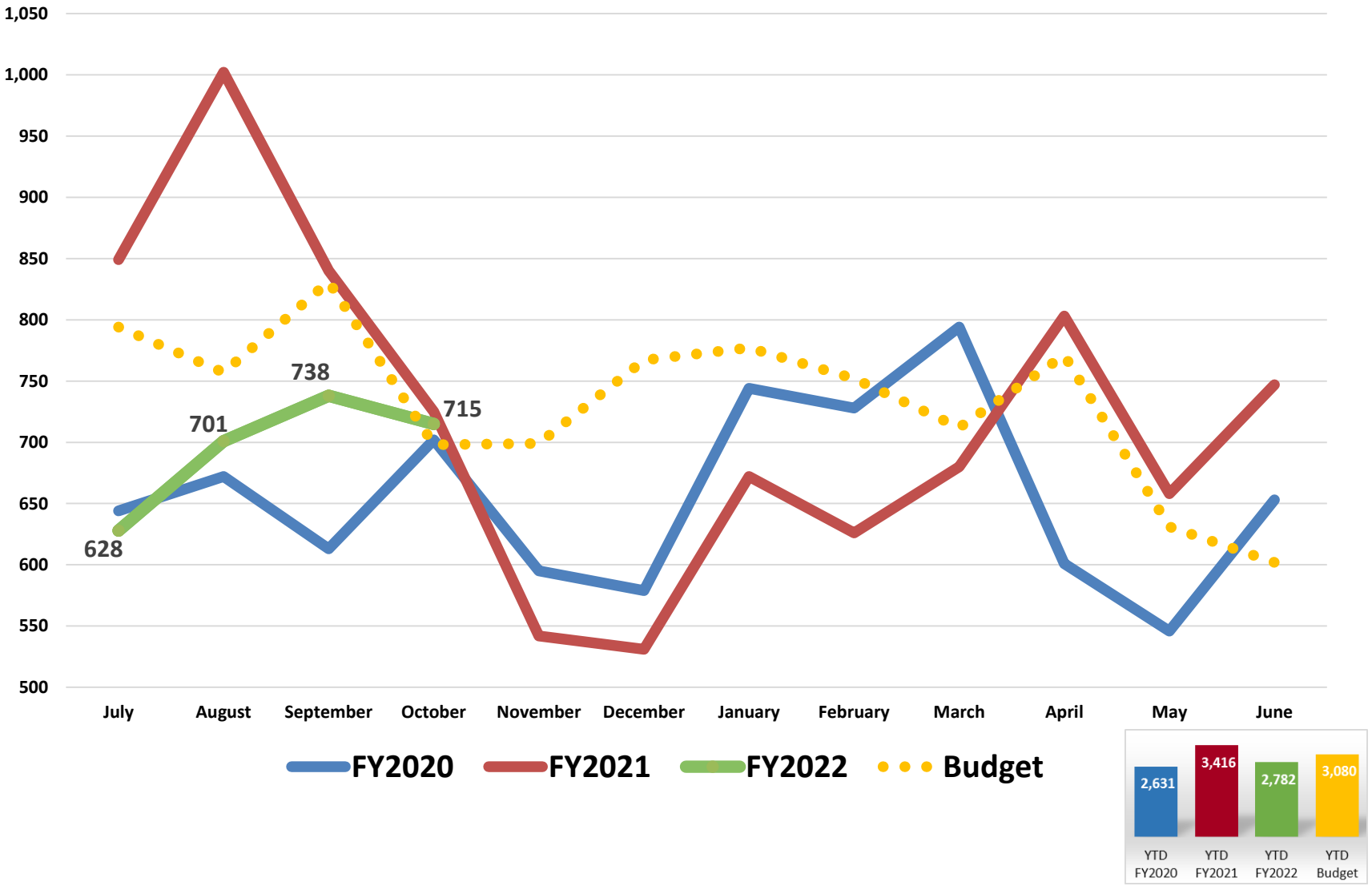
Exeter RHC - Registrations



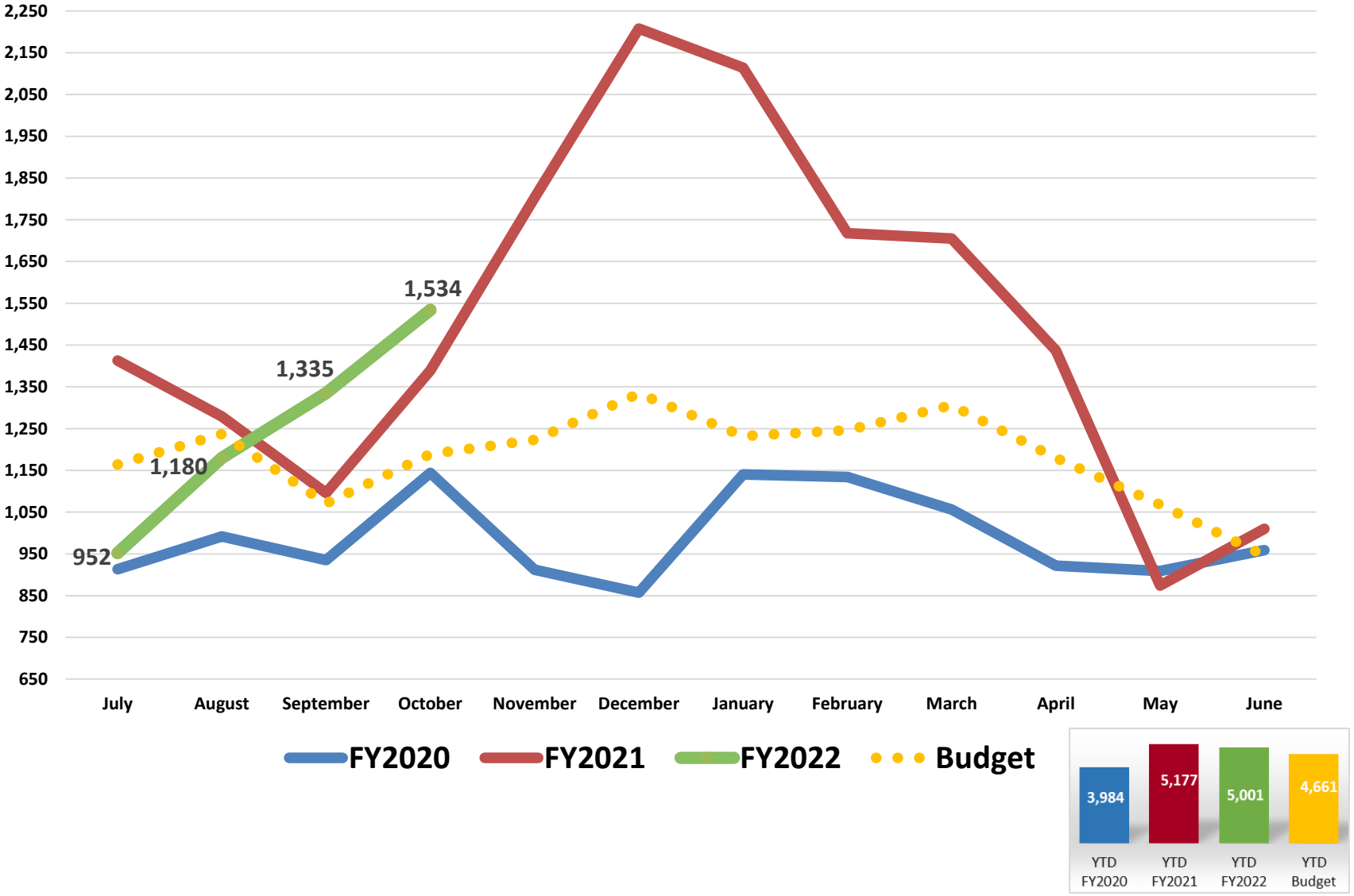
Lindsay RHC - Registrations



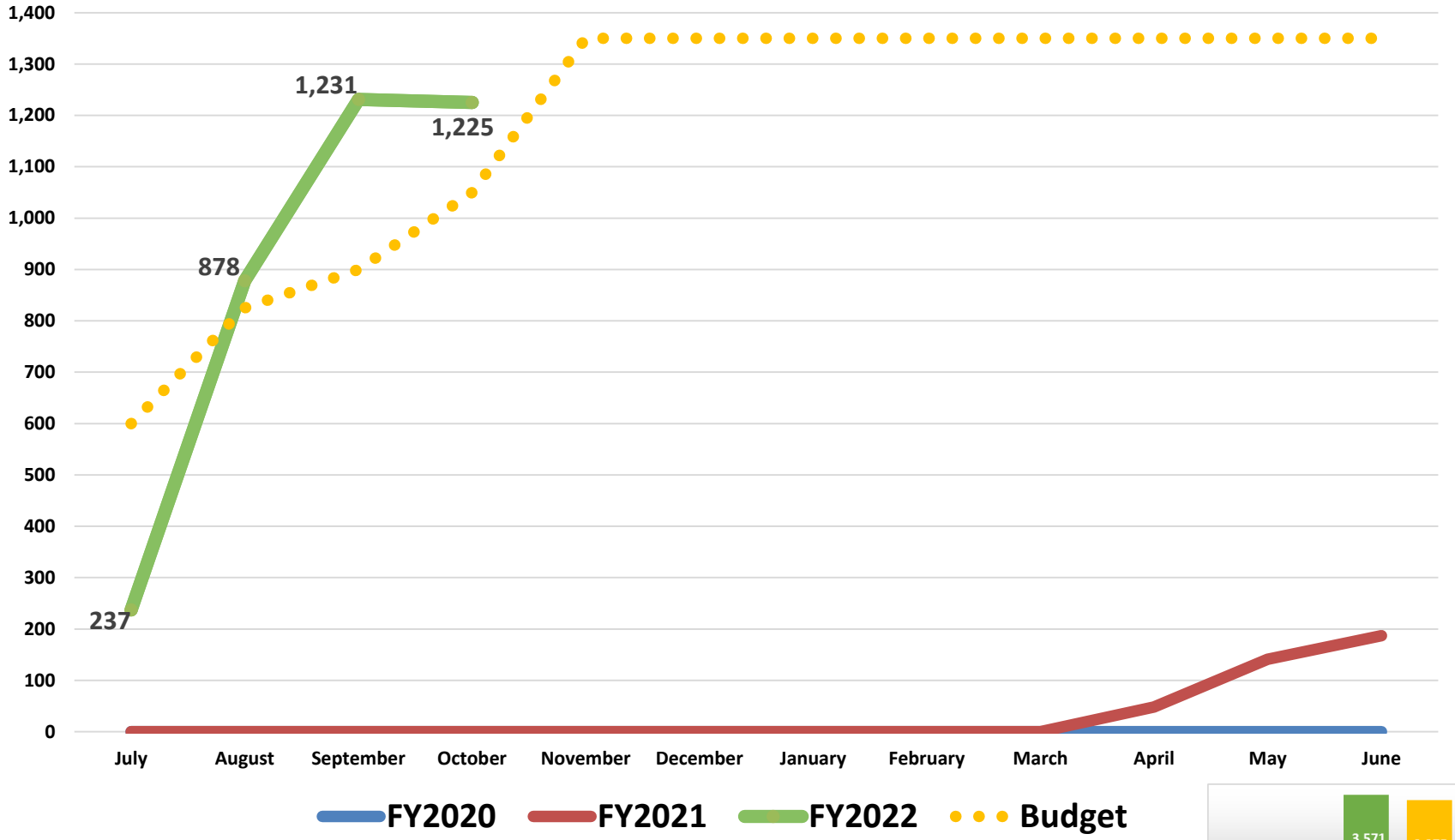
Woodlake RHC - Registrations

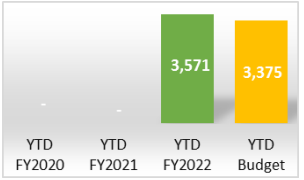


Dinuba RHC - Registrations

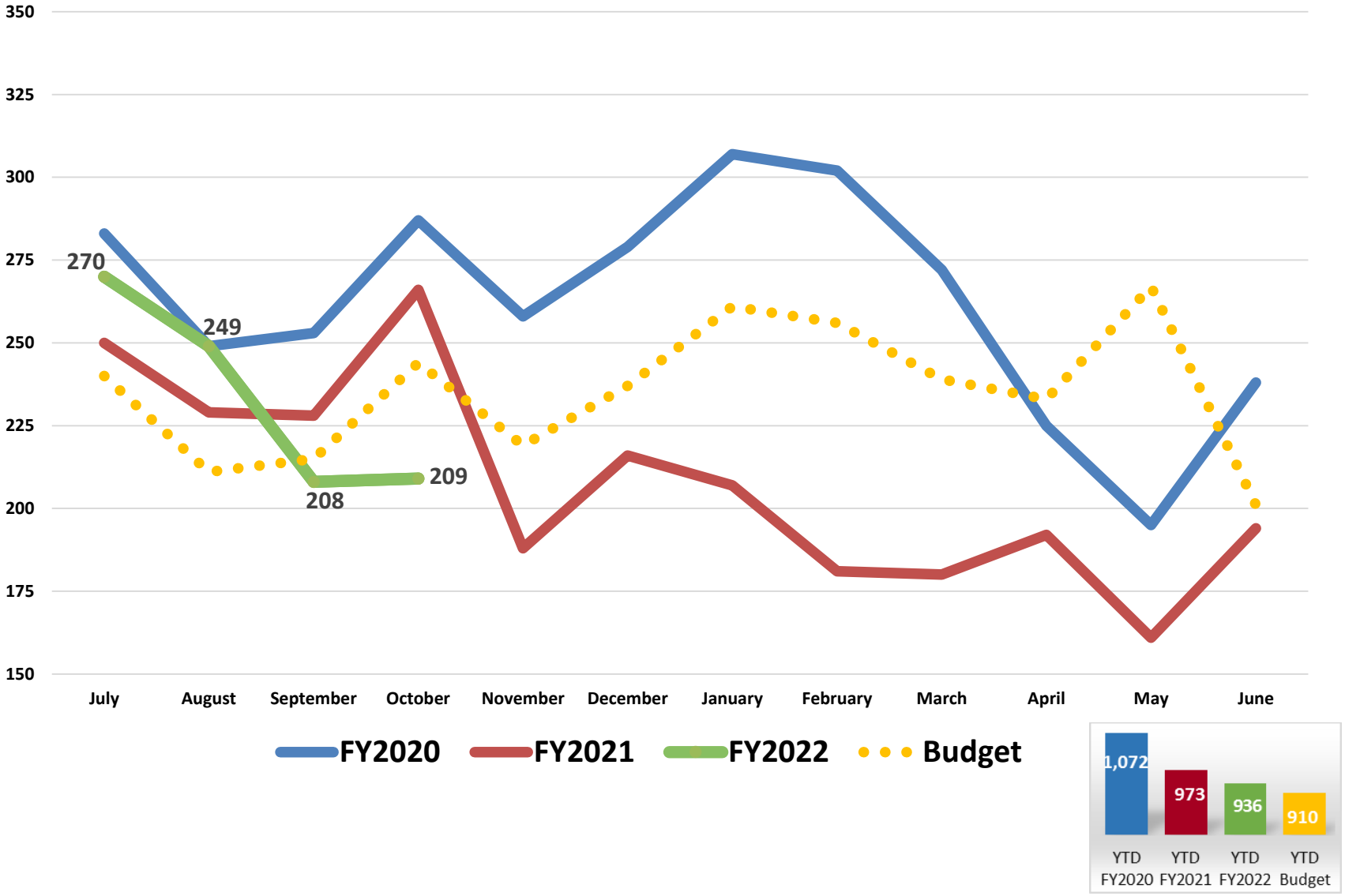


Tulare RHC - Registrations

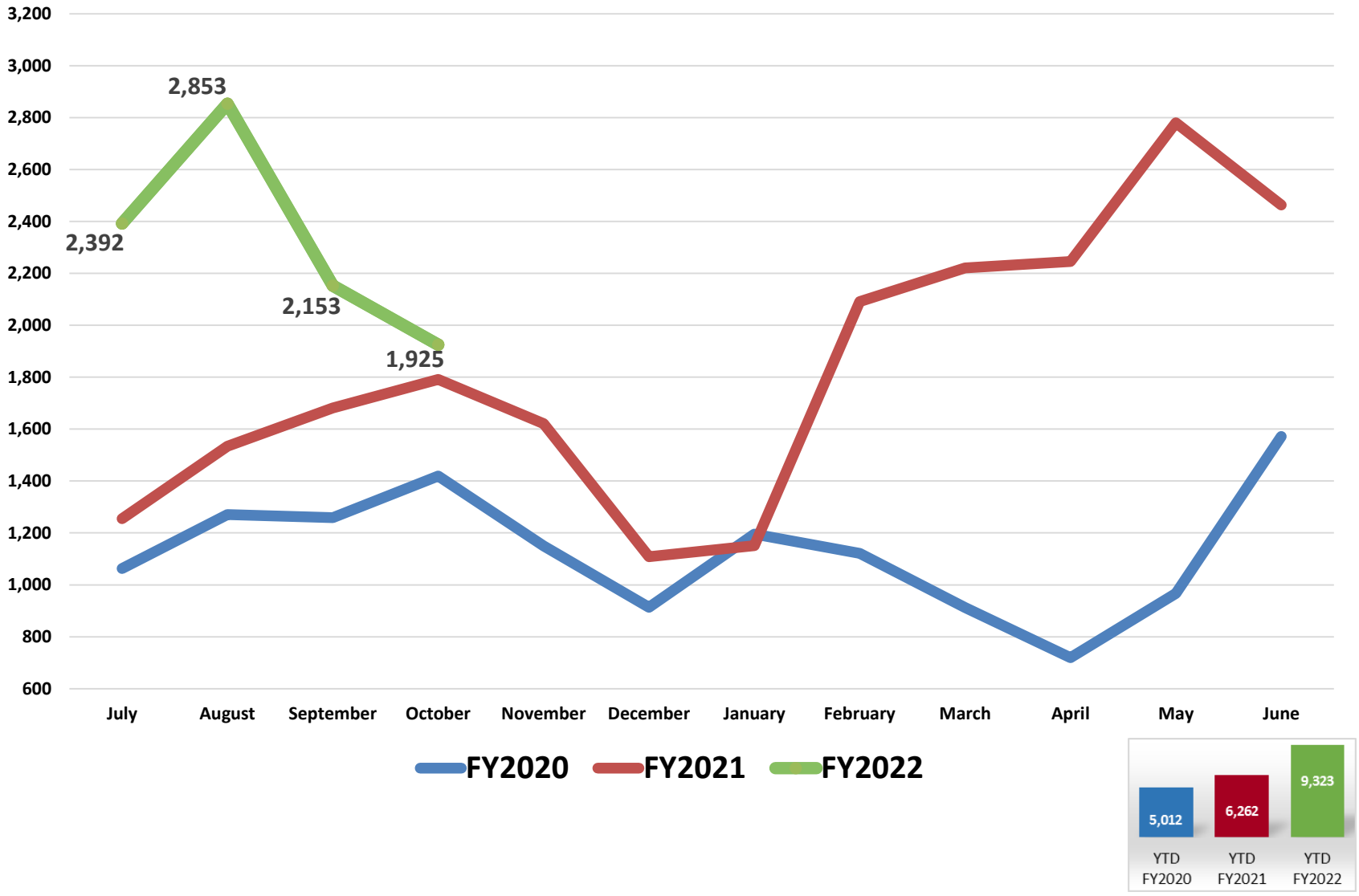




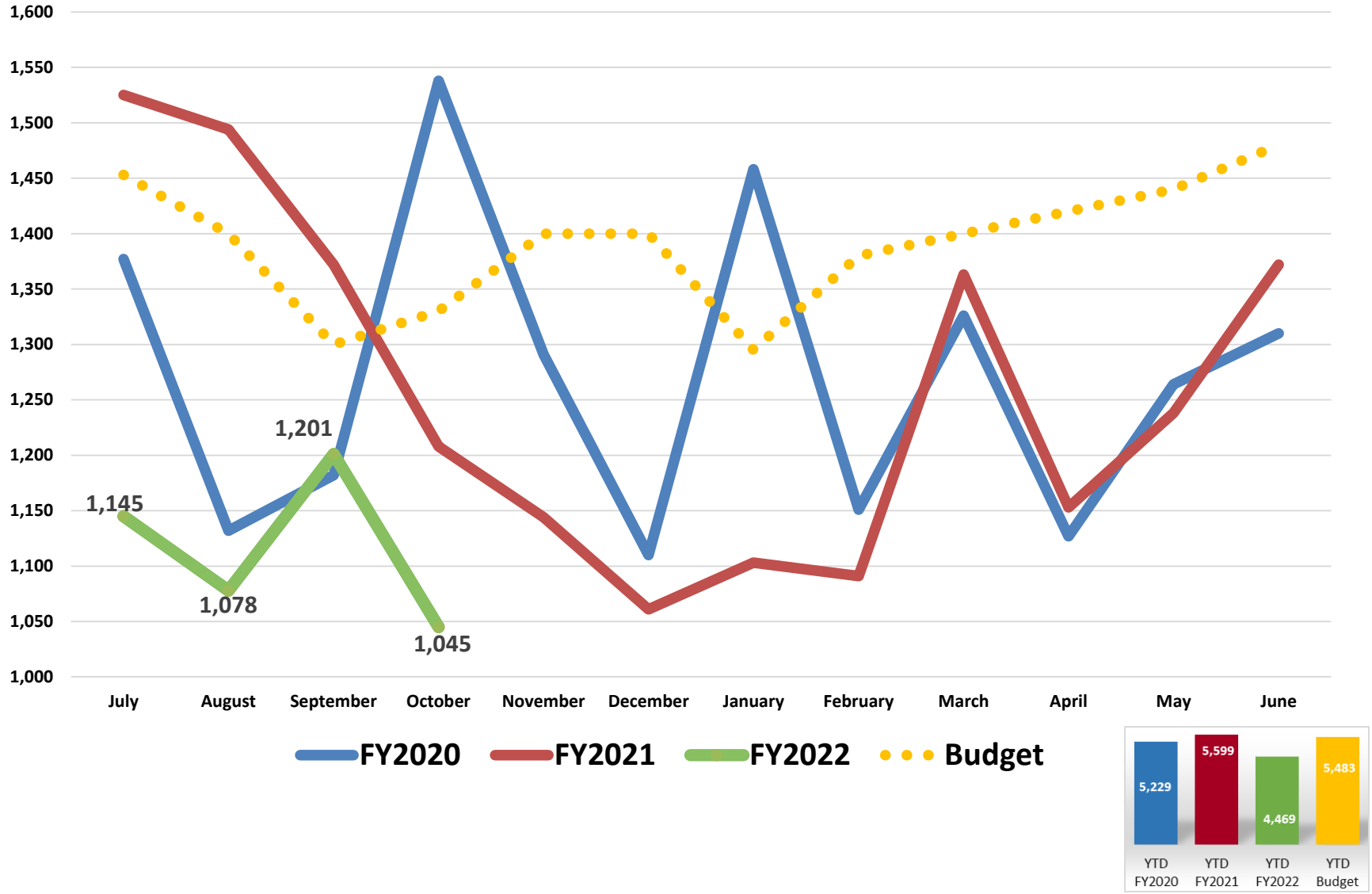
Neurosurgery Clinic - Registrations



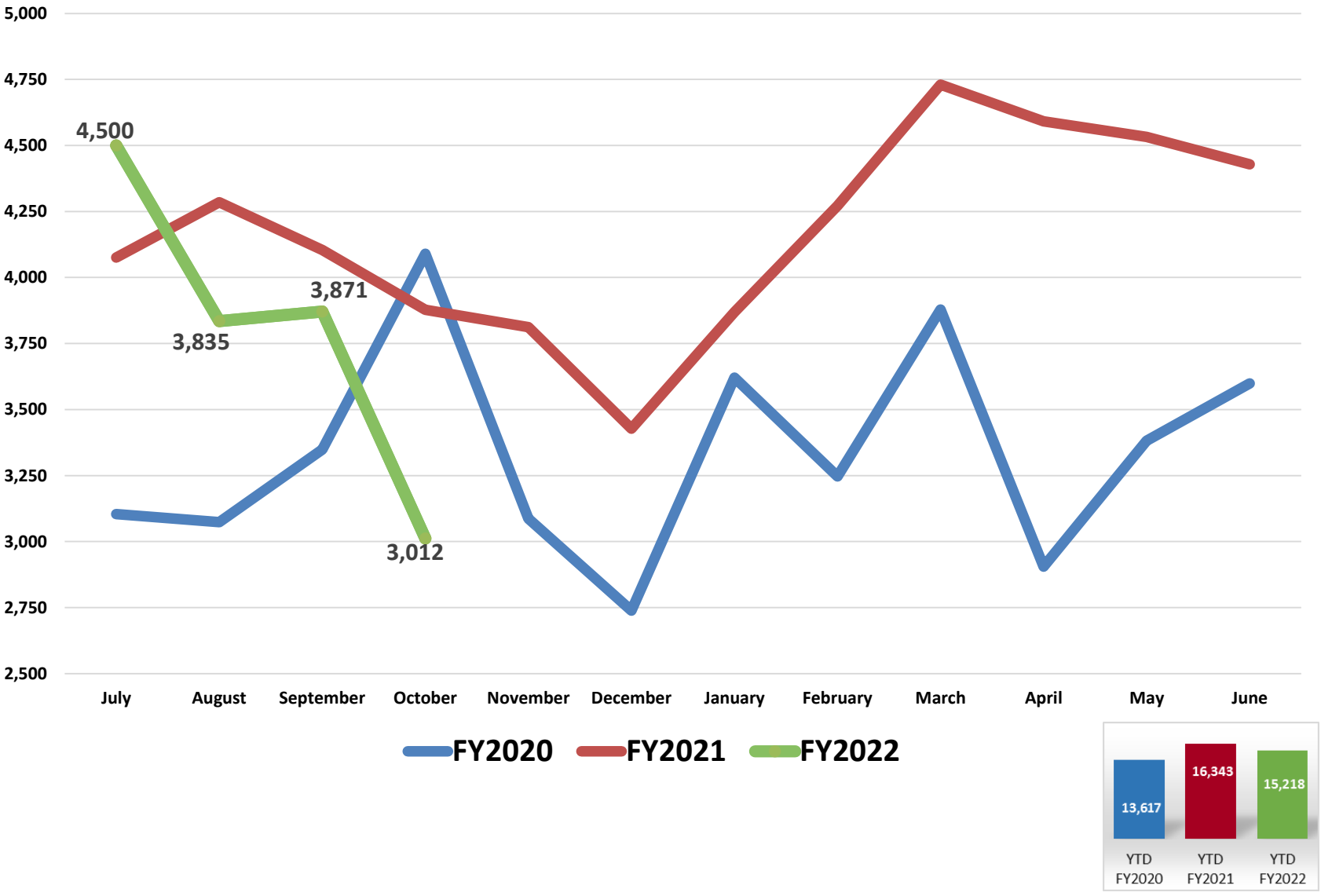
Neurosurgery Clinic - wRVU's



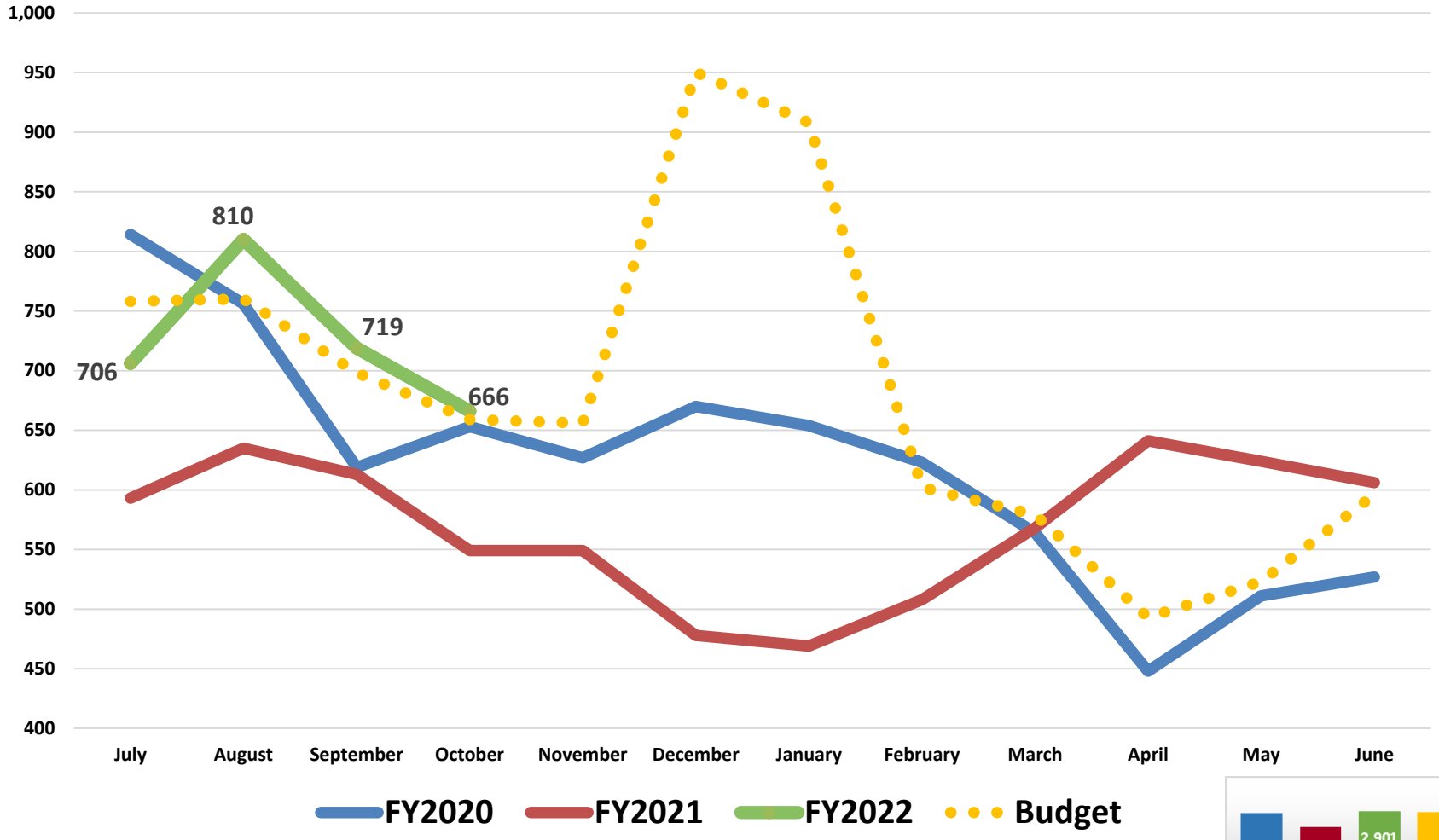
Sequoia Cardiology - Registrations

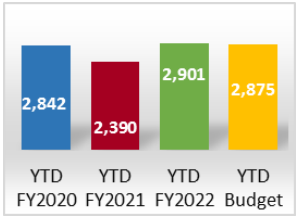


Sequoia Cardiology – wRVU's

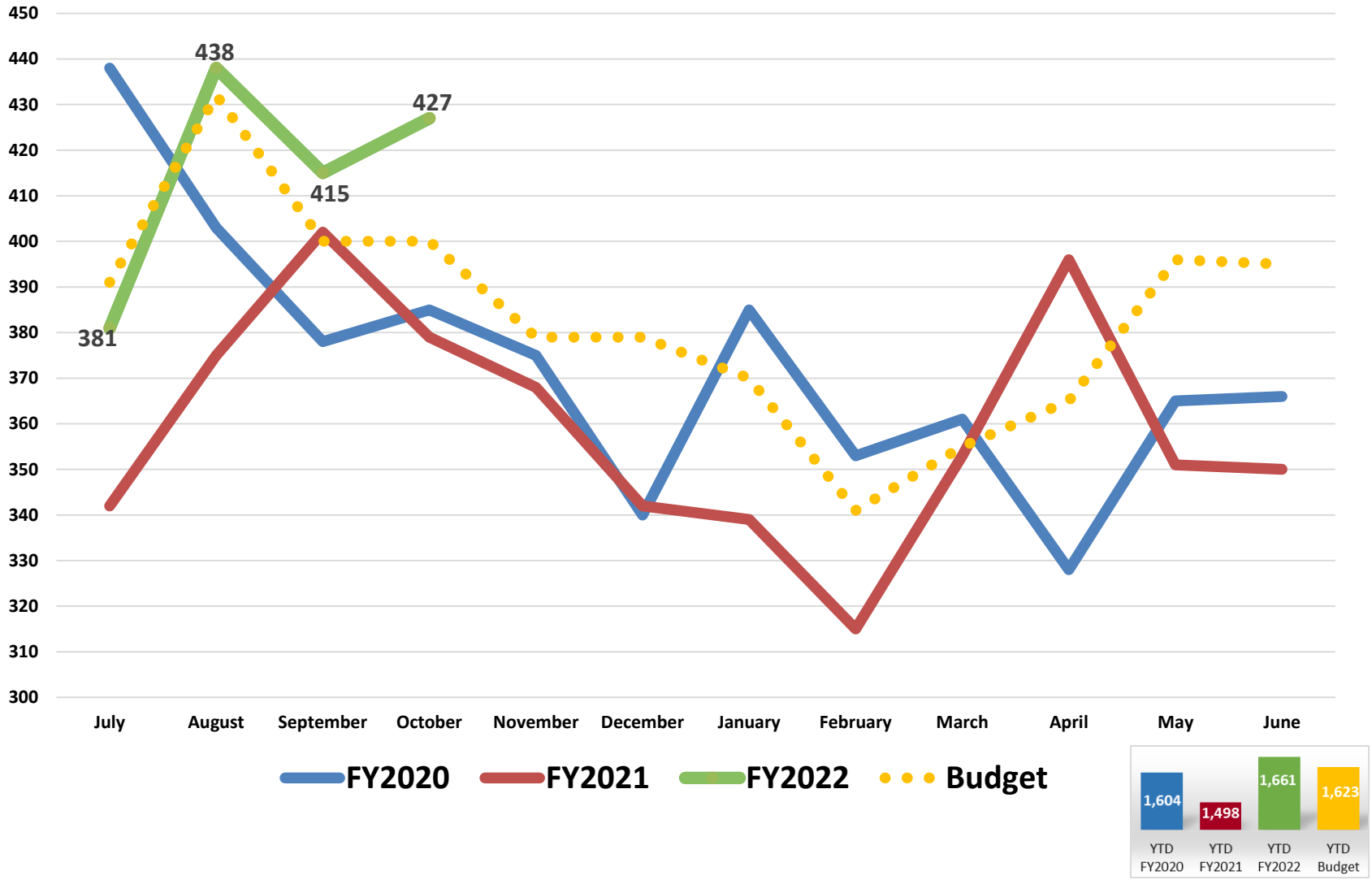


Labor Triage Registrations

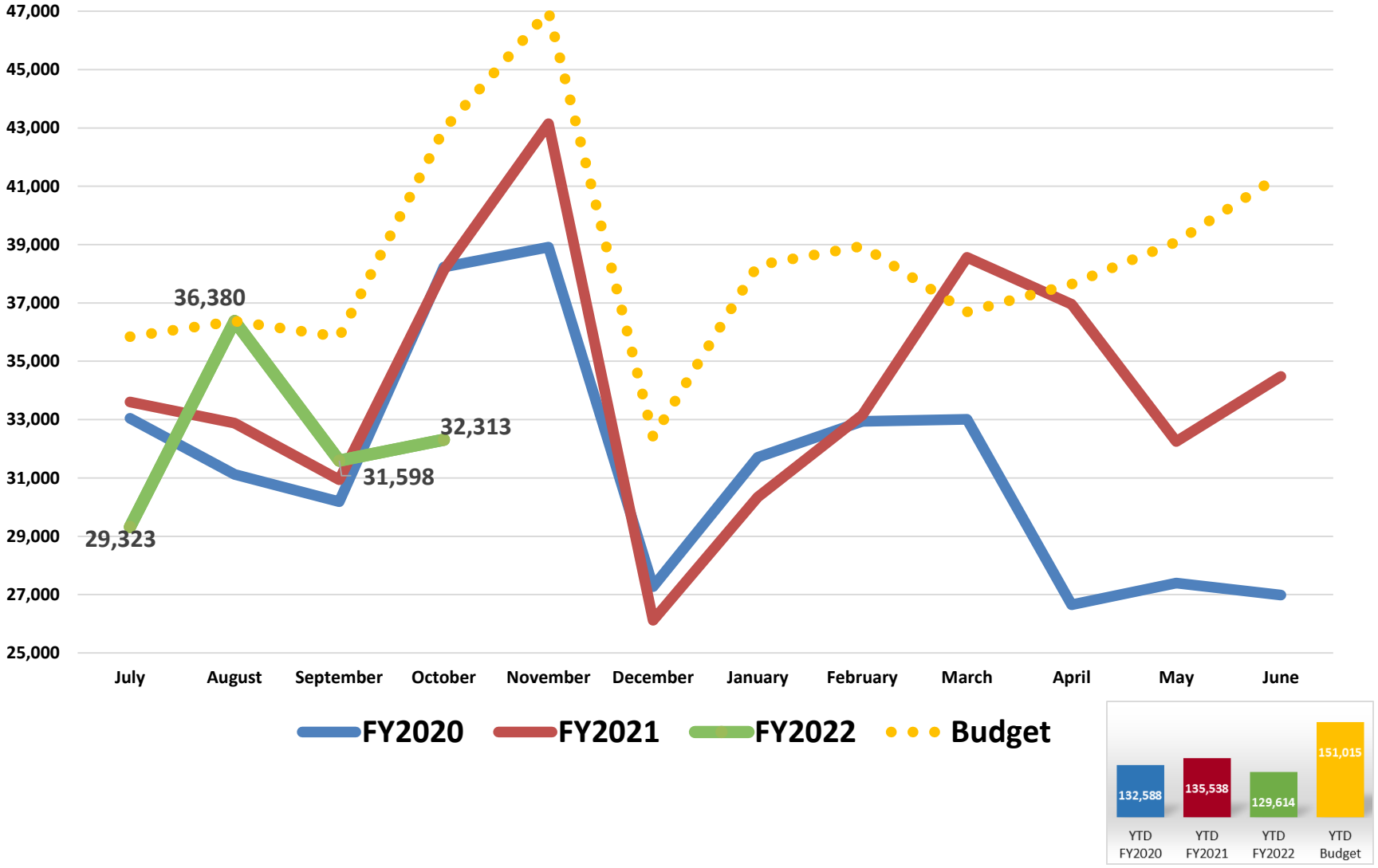




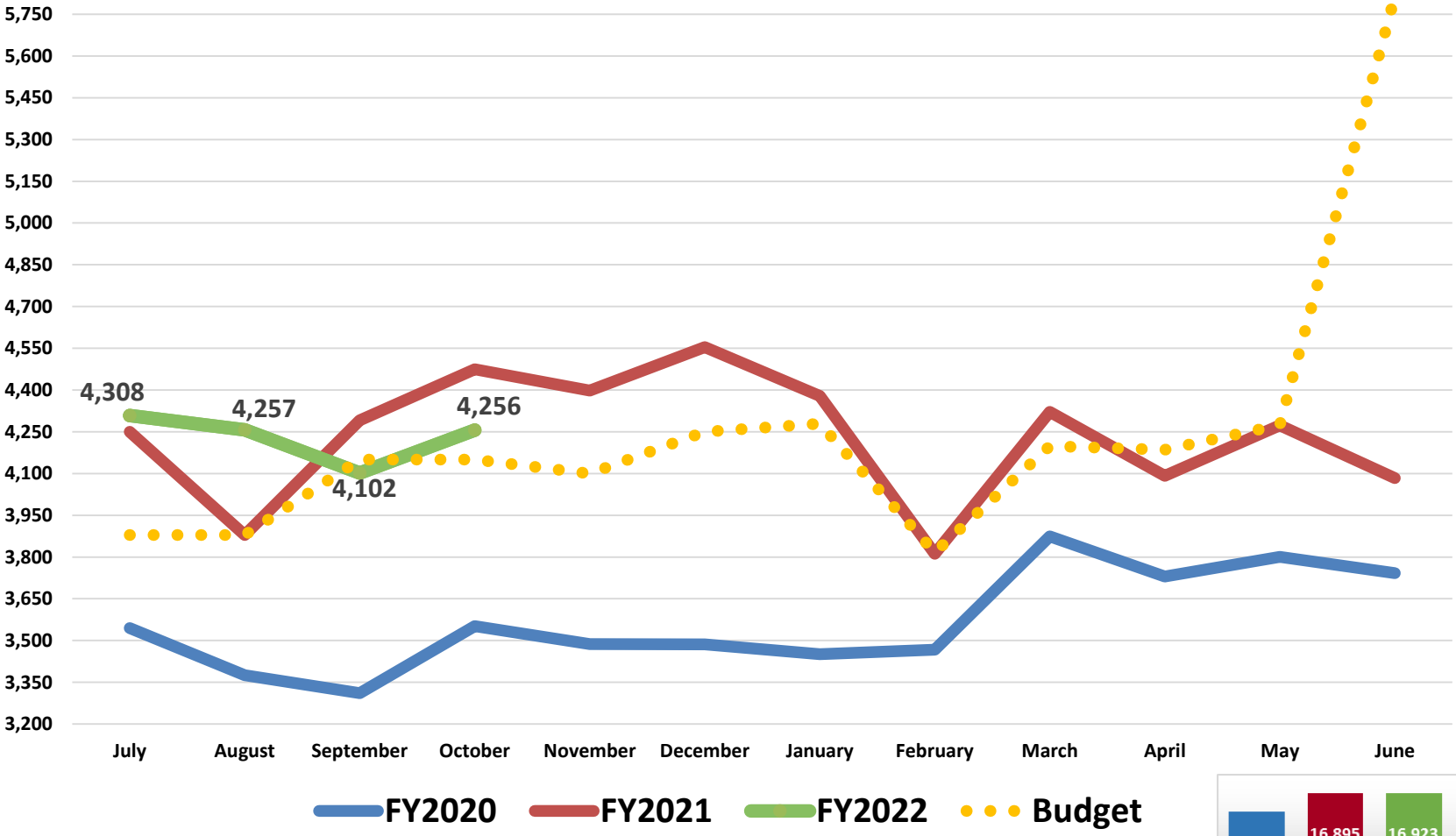
Deliveries

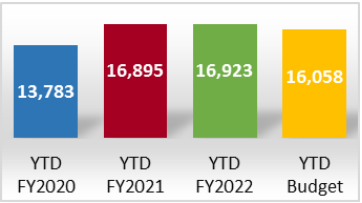

450
440
430
420
410
400
390
380
370
360
350
340
330
320
310
300
438
427
415
381
July
August
September
October
November
December
January
February
March
April
May
June
FY2020
FY2021
FY2022
Budget
1,604
1,498
1,661
1,623
YTD FY2020
YTD FY2021
YTD FY2022
YTD Budget

KHMG RVU's

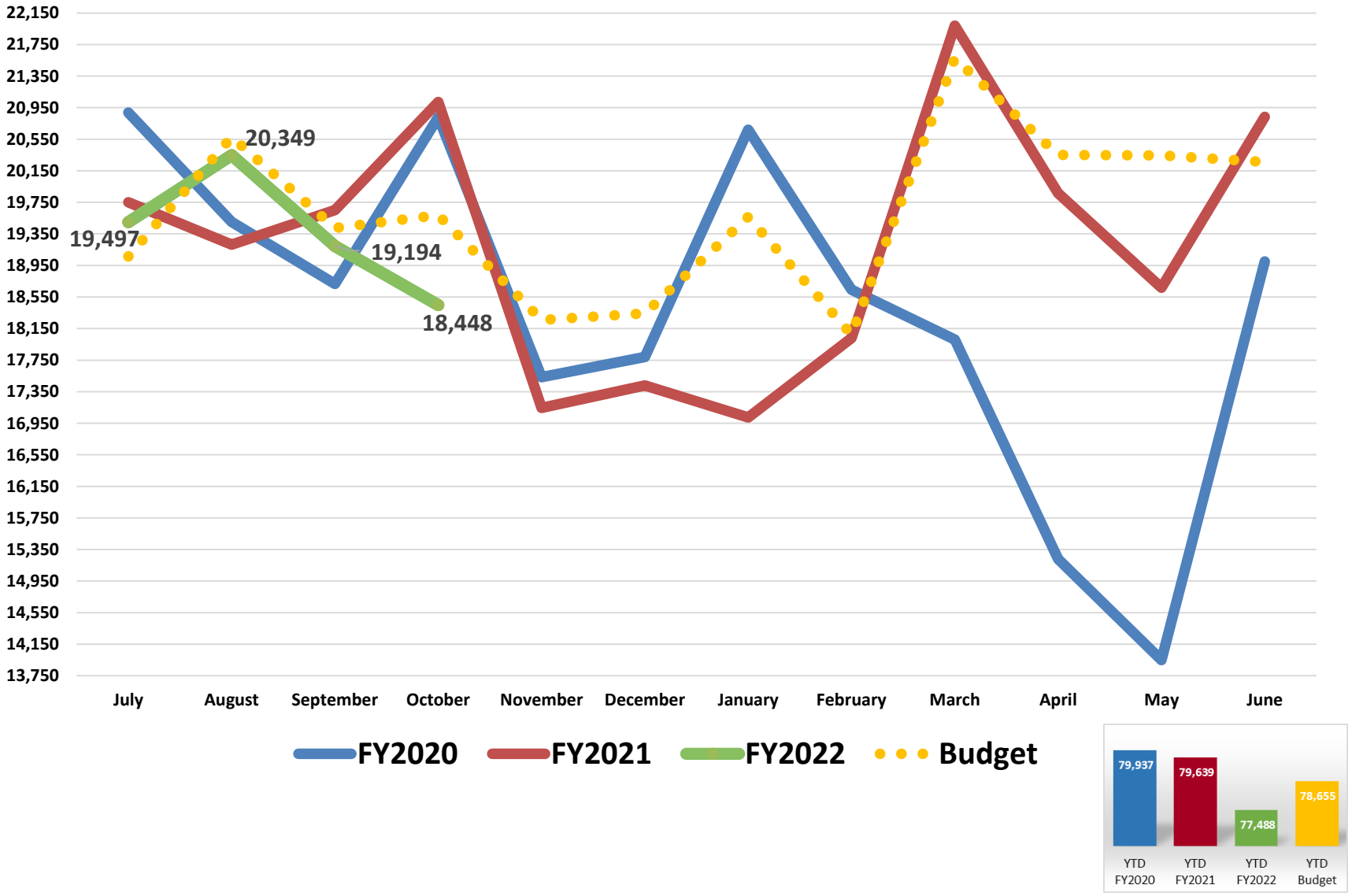

47,000
45,000
43,000
41,000
39,000
37,000
35,000
33,000
31,000
29,000
27,000
25,000
36,380
32,313
31,598
29,323
July
August
September
October
November
December
January
February
March
April
May
June
FY2020
FY2021
FY2022
Budget
132,588
135,538
129,614
151,015
YTD FY2020
YTD FY2021
YTD FY2022
YTD Budget

Hospice Days

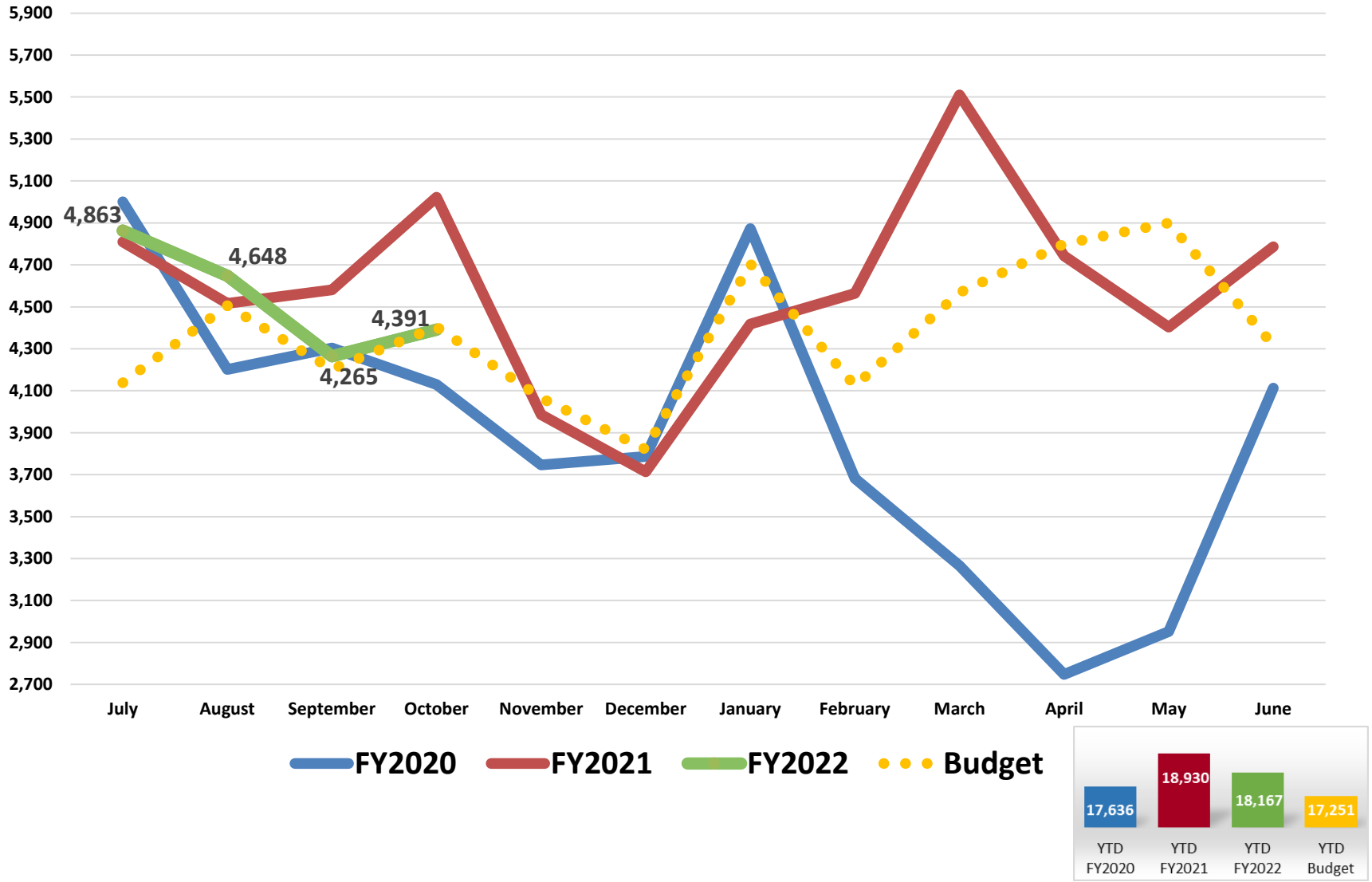




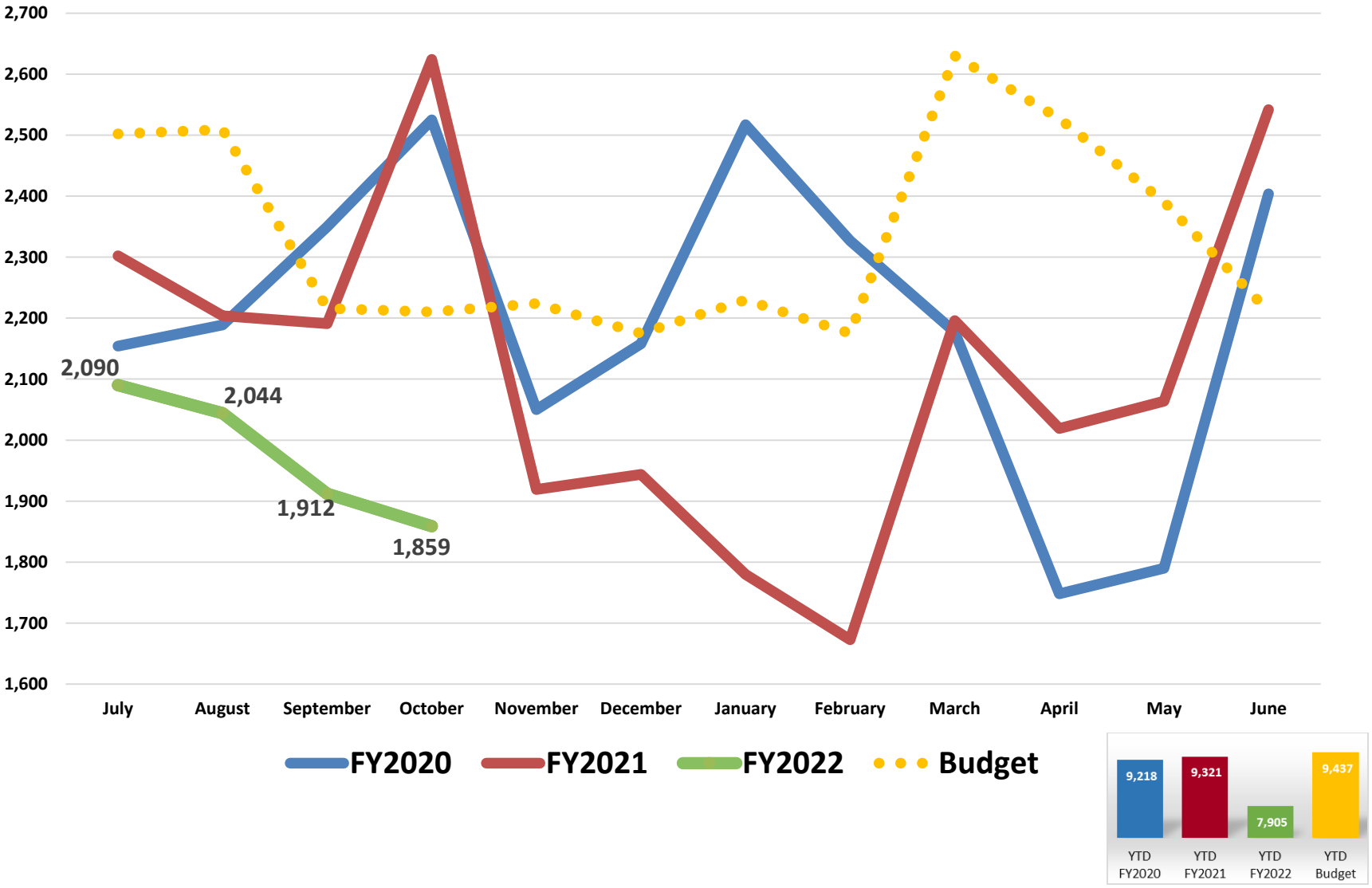
All O/P Rehab Services Across District



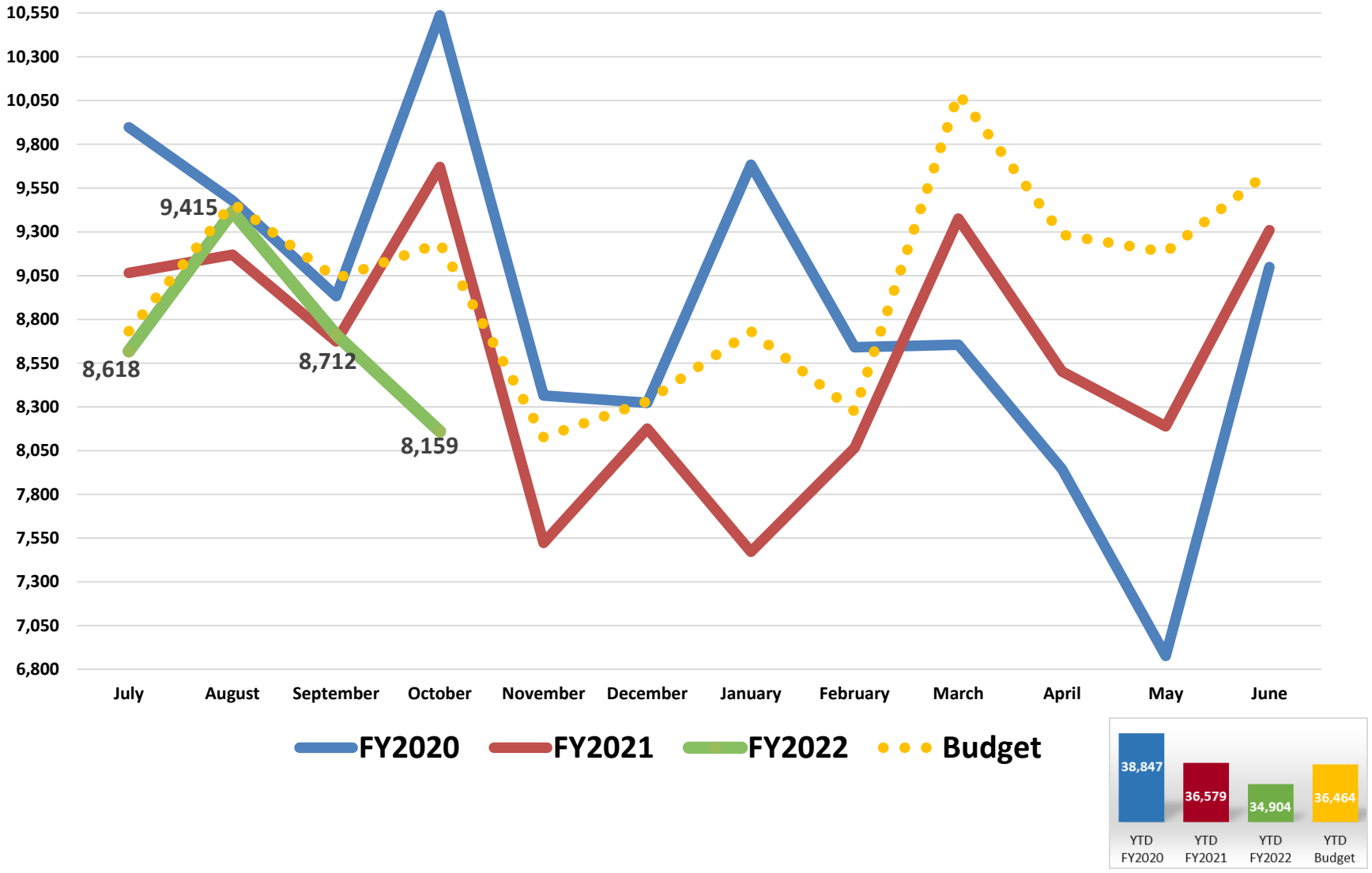
O/P Rehab Services



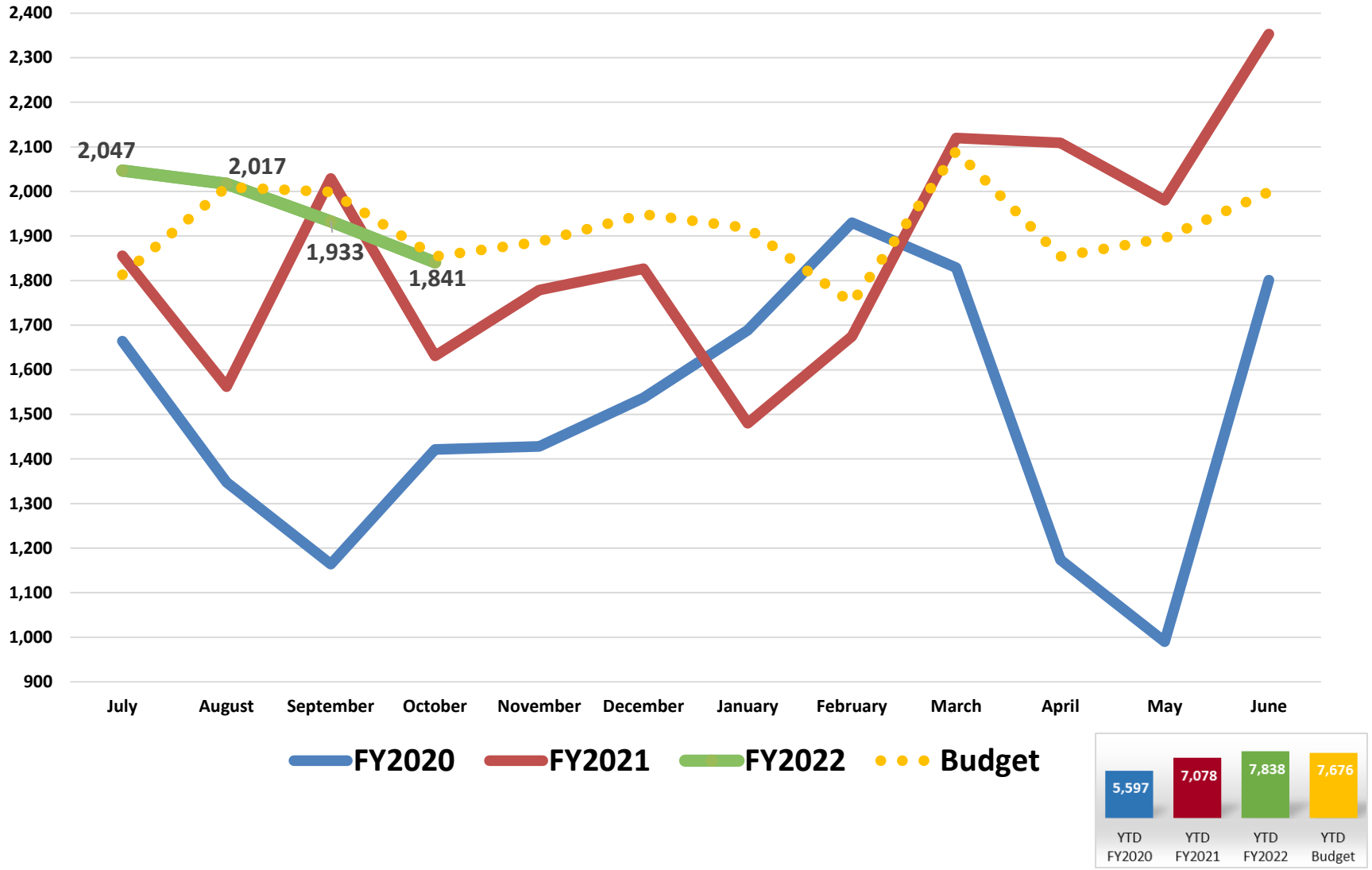
O/P Rehab - Exeter



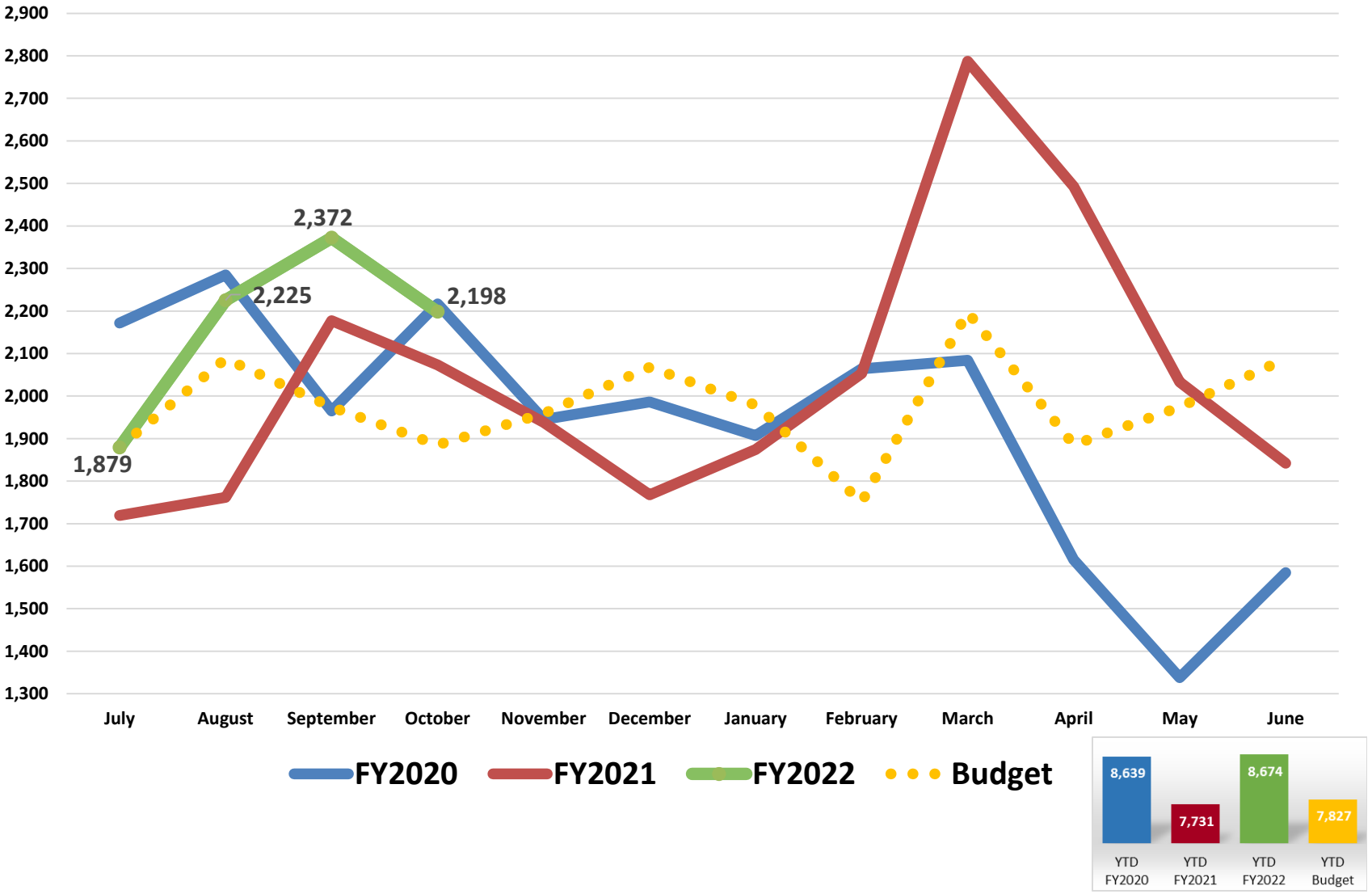
O/P Rehab - Akers



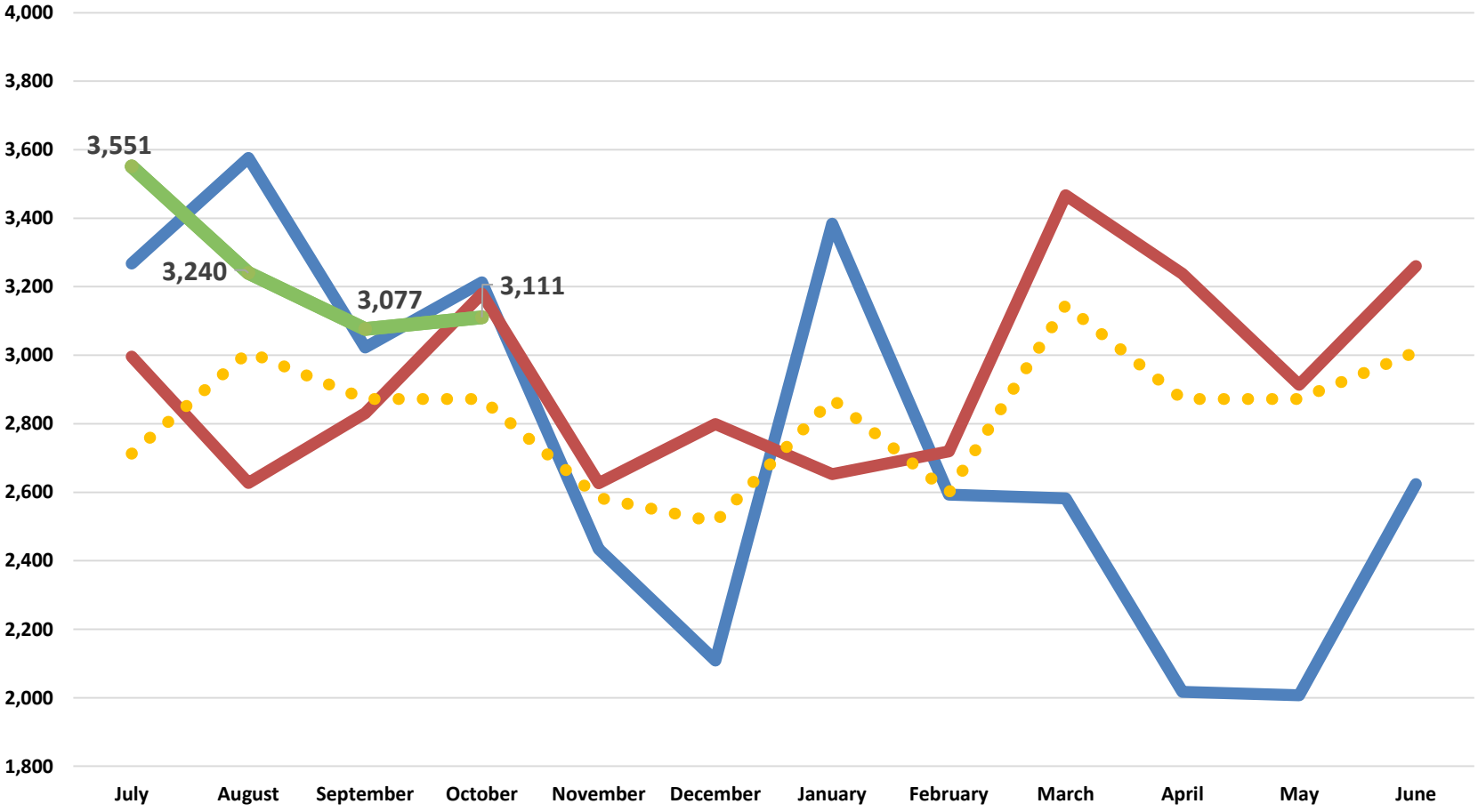
O/P Rehab - LLOPT

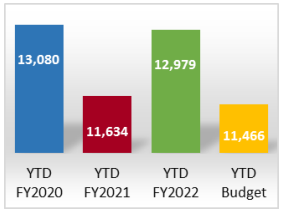


O/P Rehab - Dinuba

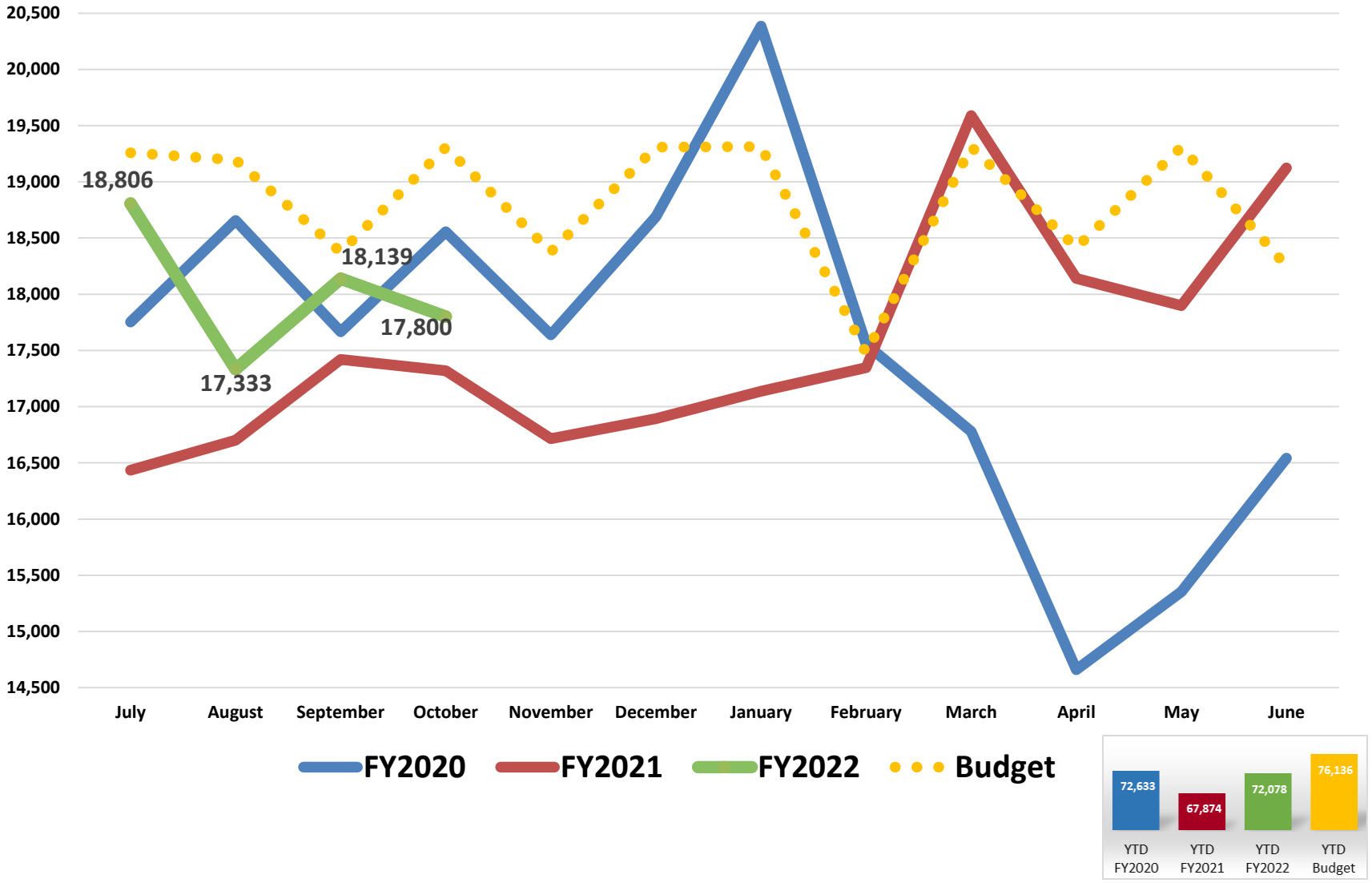


Therapy - Cypress Hand Center

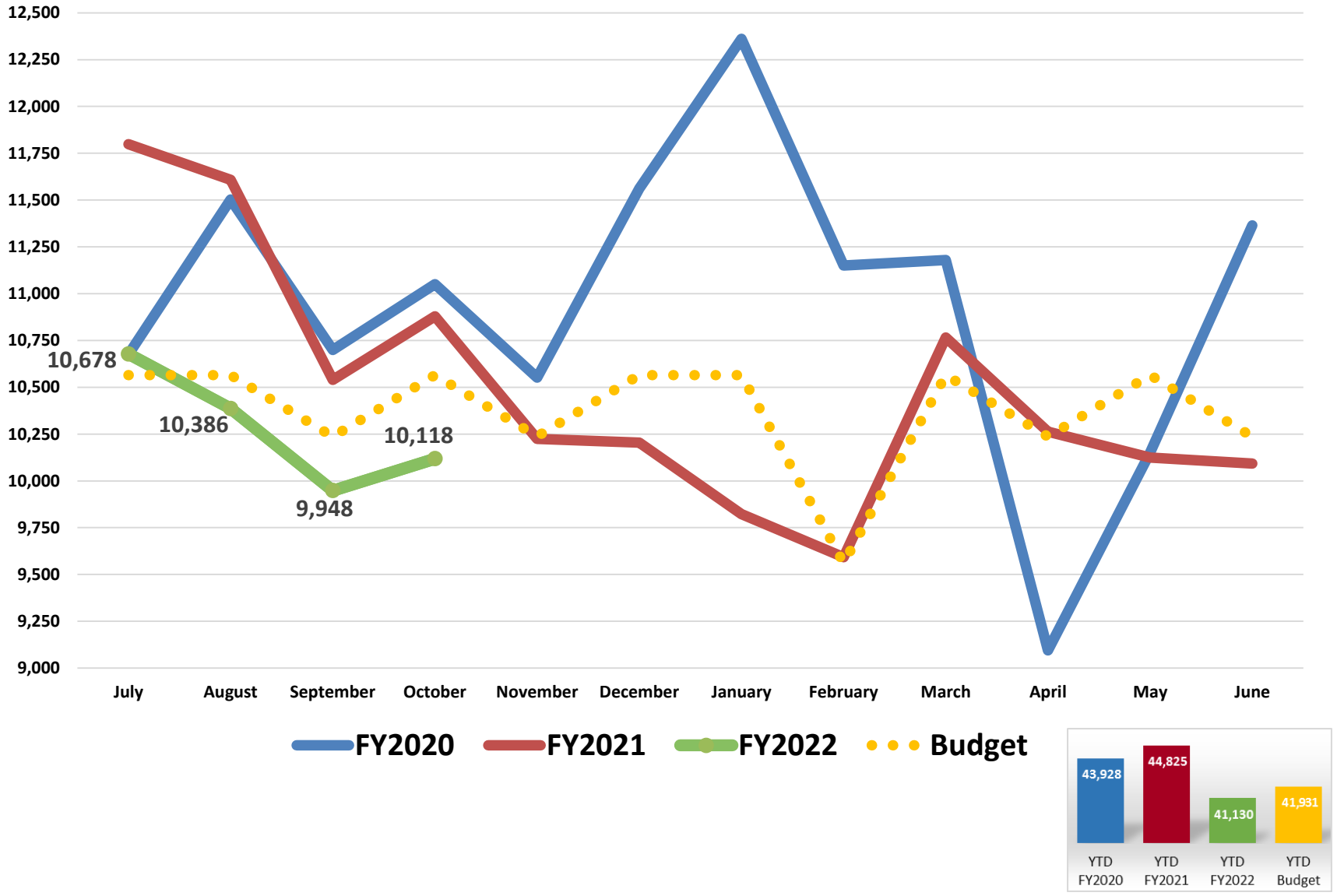




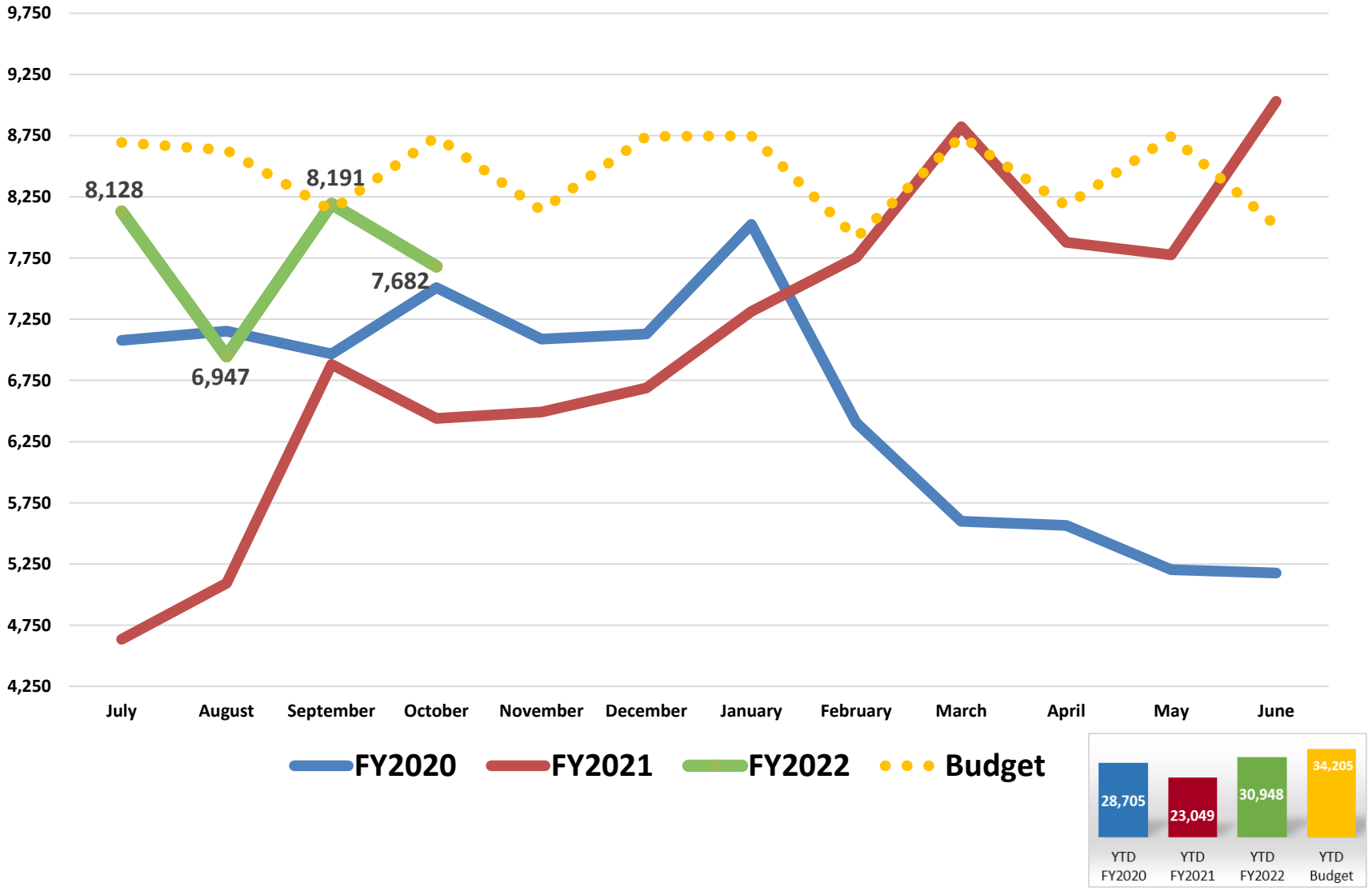
Physical & Other Therapy Units (I/P & O/P)



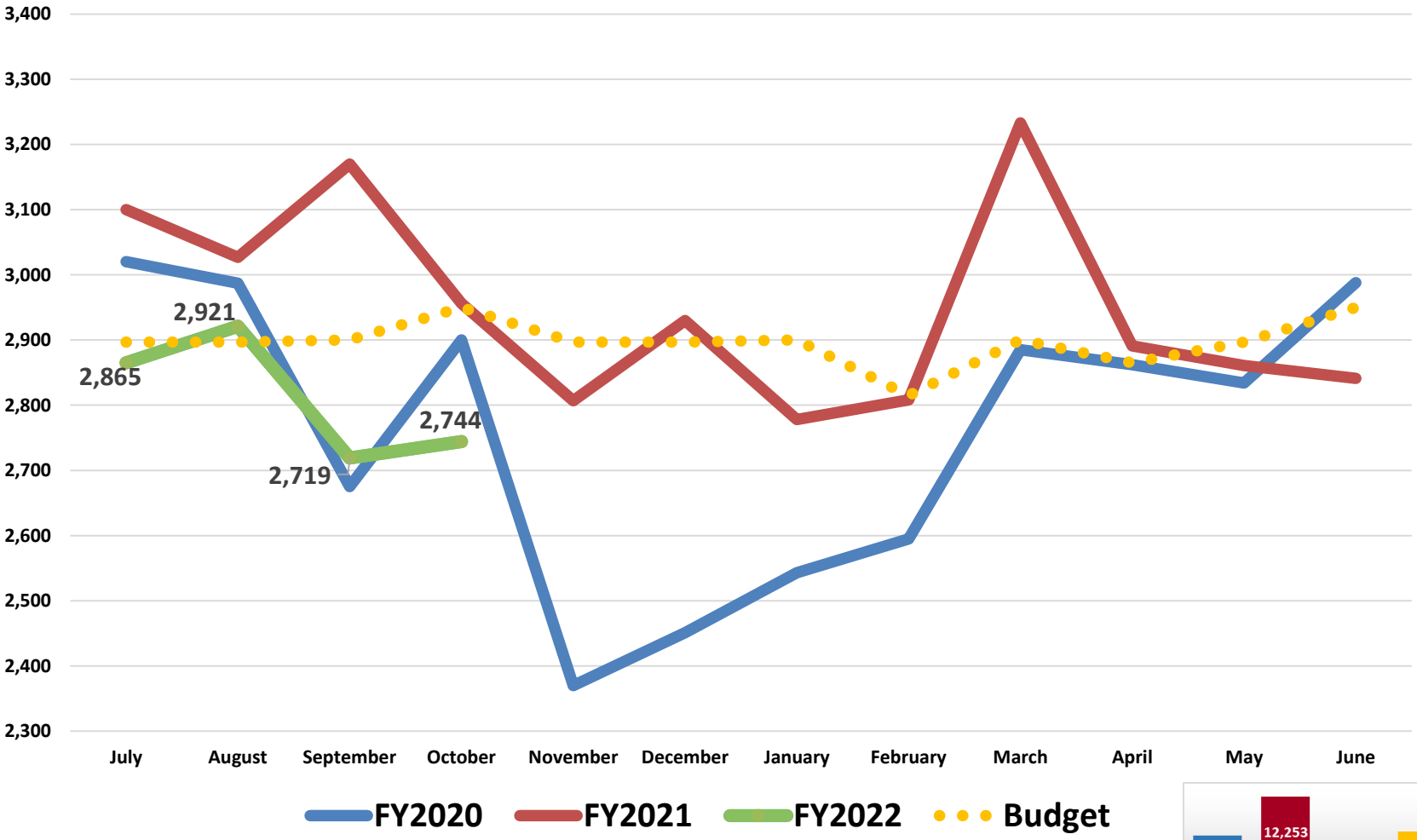
Physical & Other Therapy Units (I/P & O/P)-Main Campus

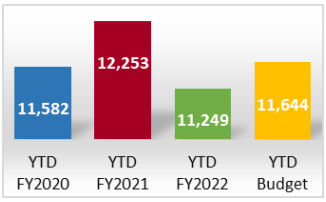


Physical & Other Therapy Units (I/P & O/P)-KDRH & South Campus

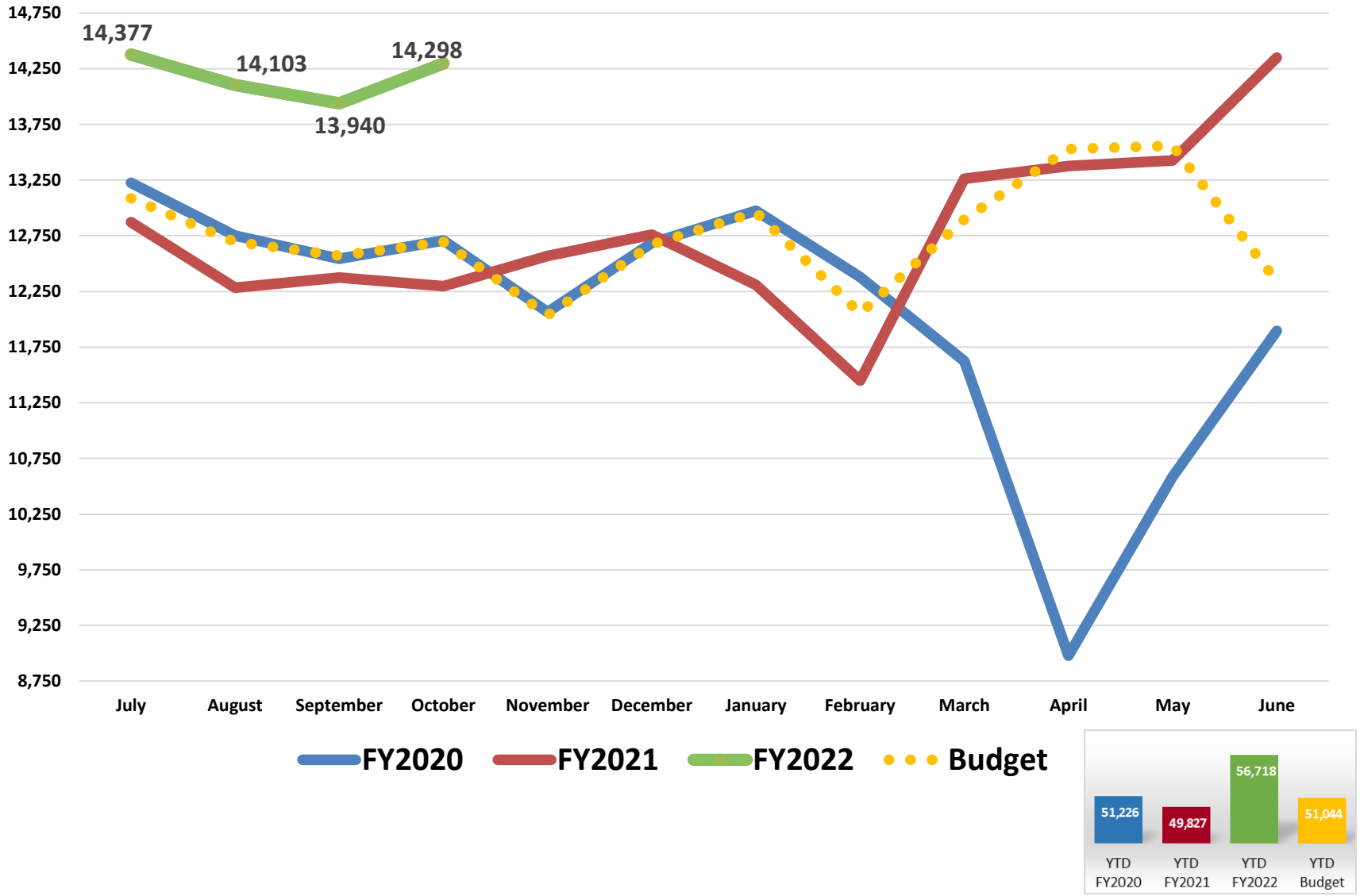


Home Health Visits

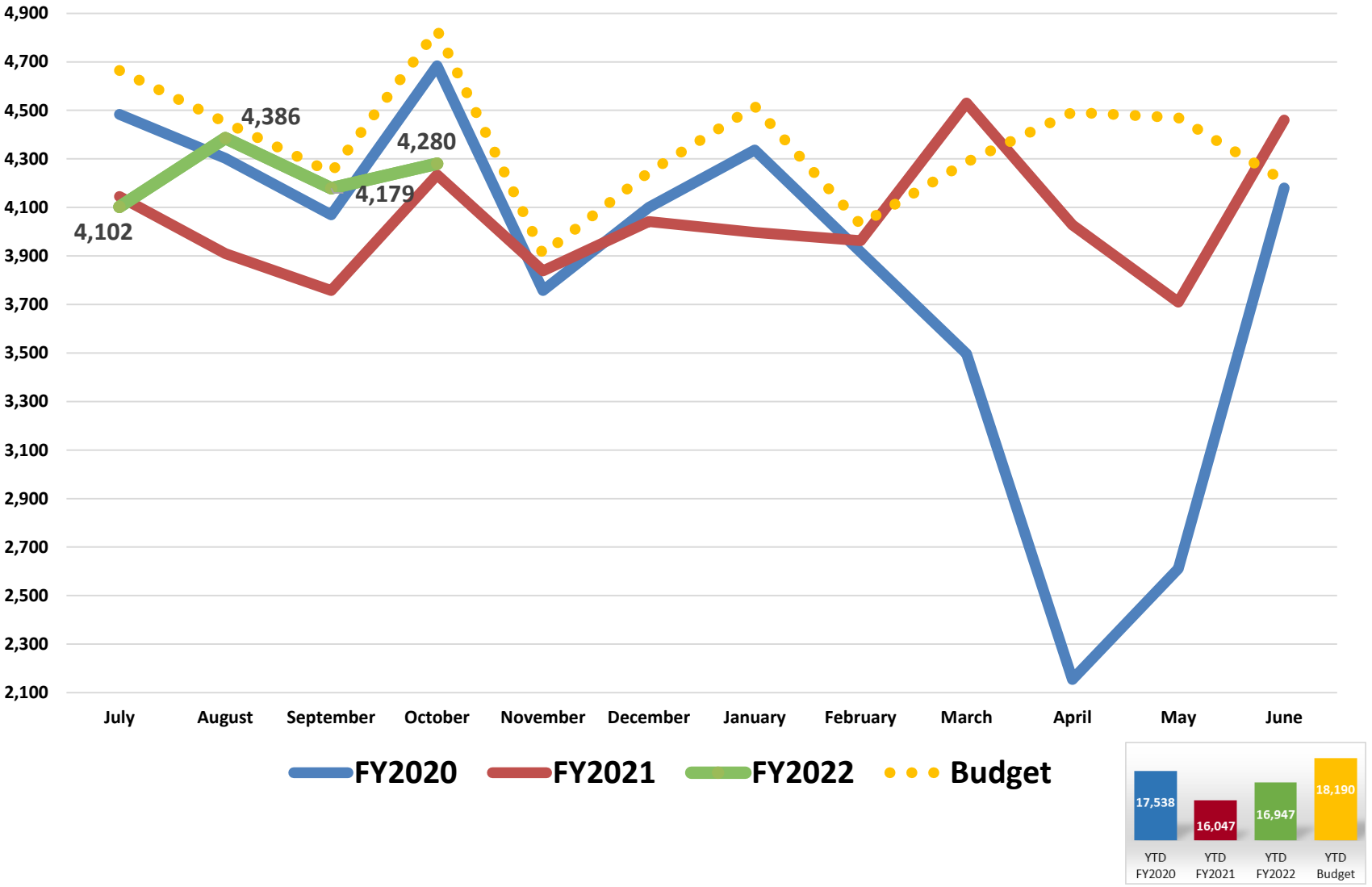




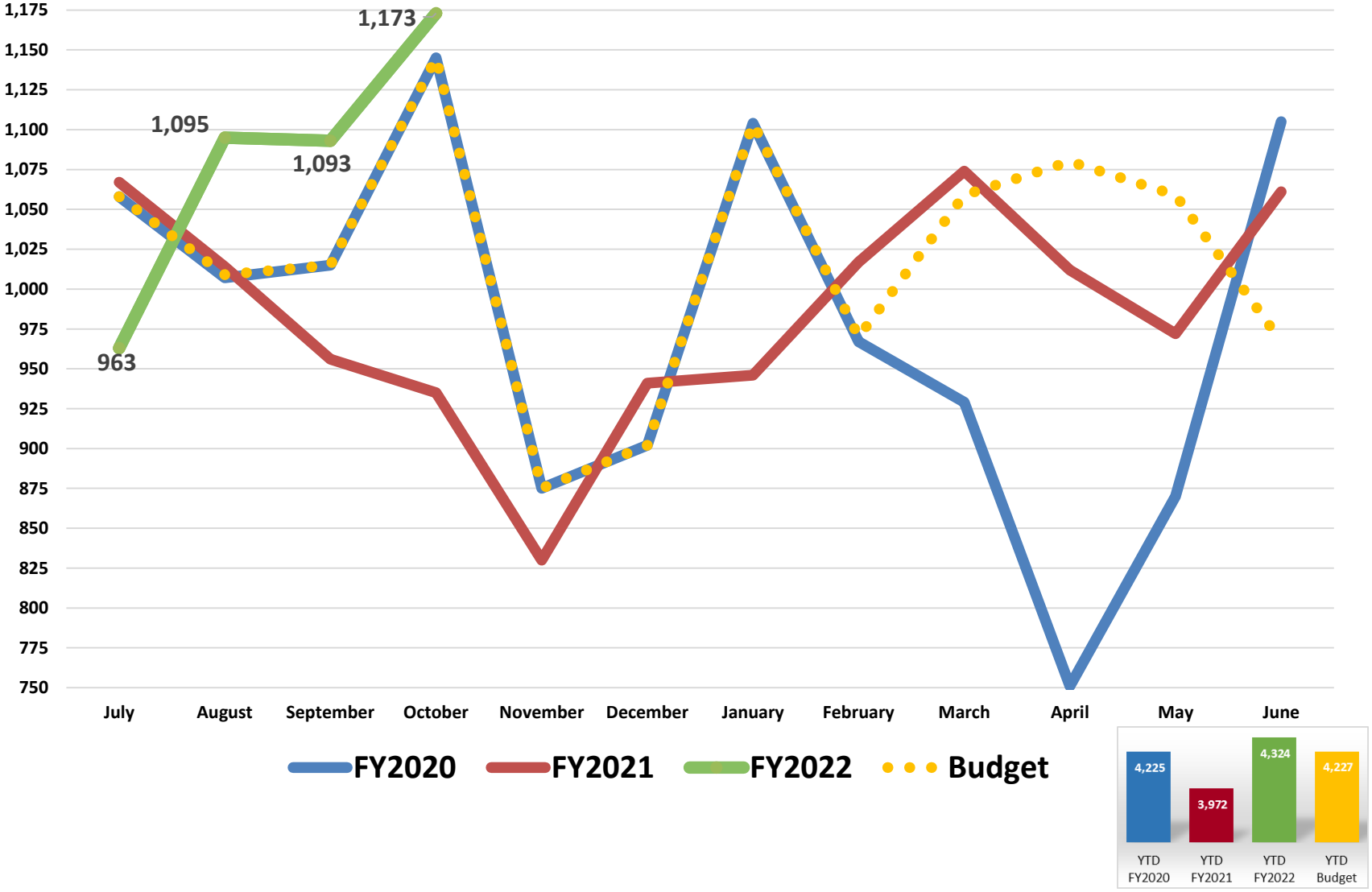
Radiology – Main Campus



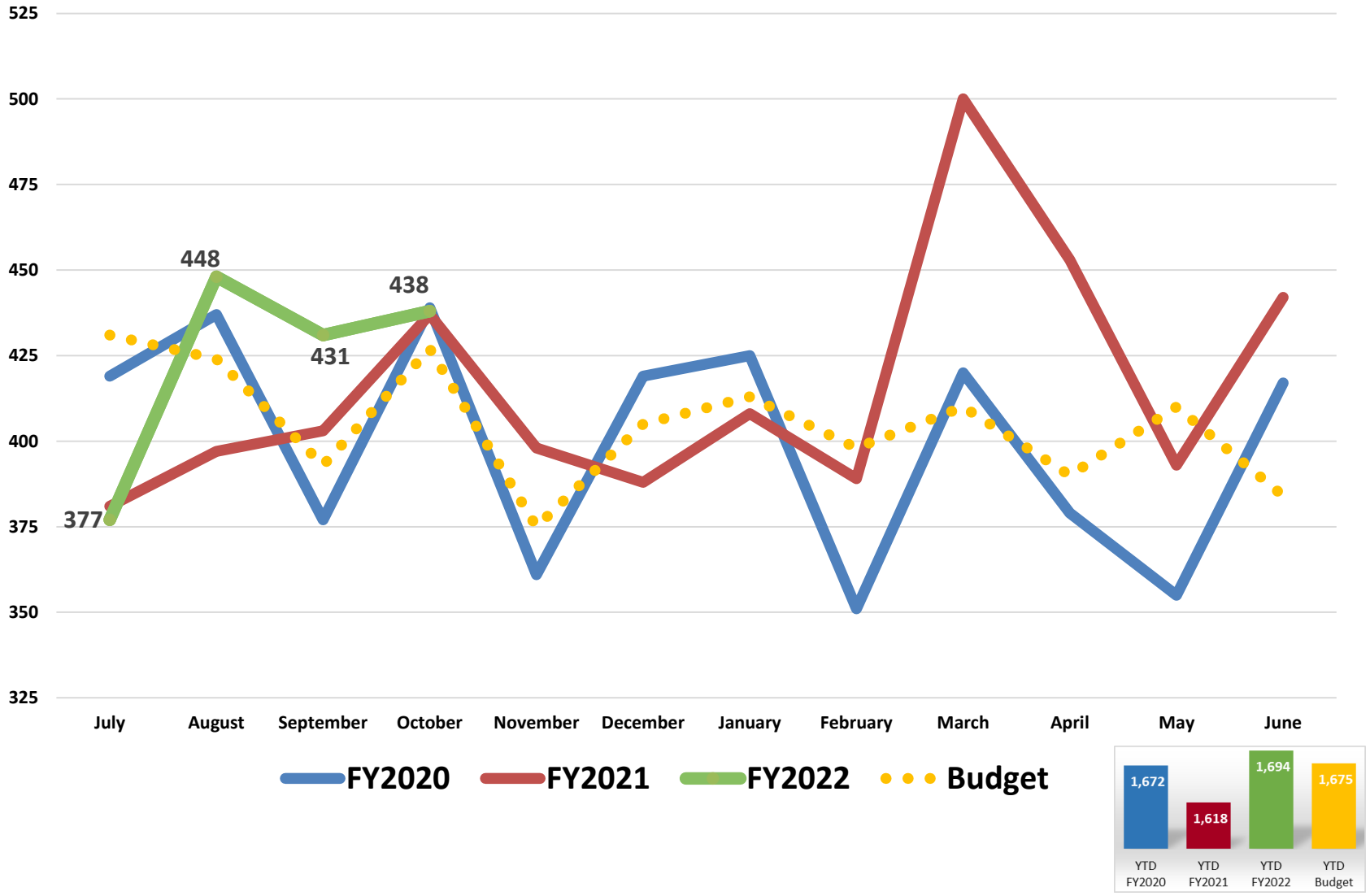
Radiology – West Campus Imaging



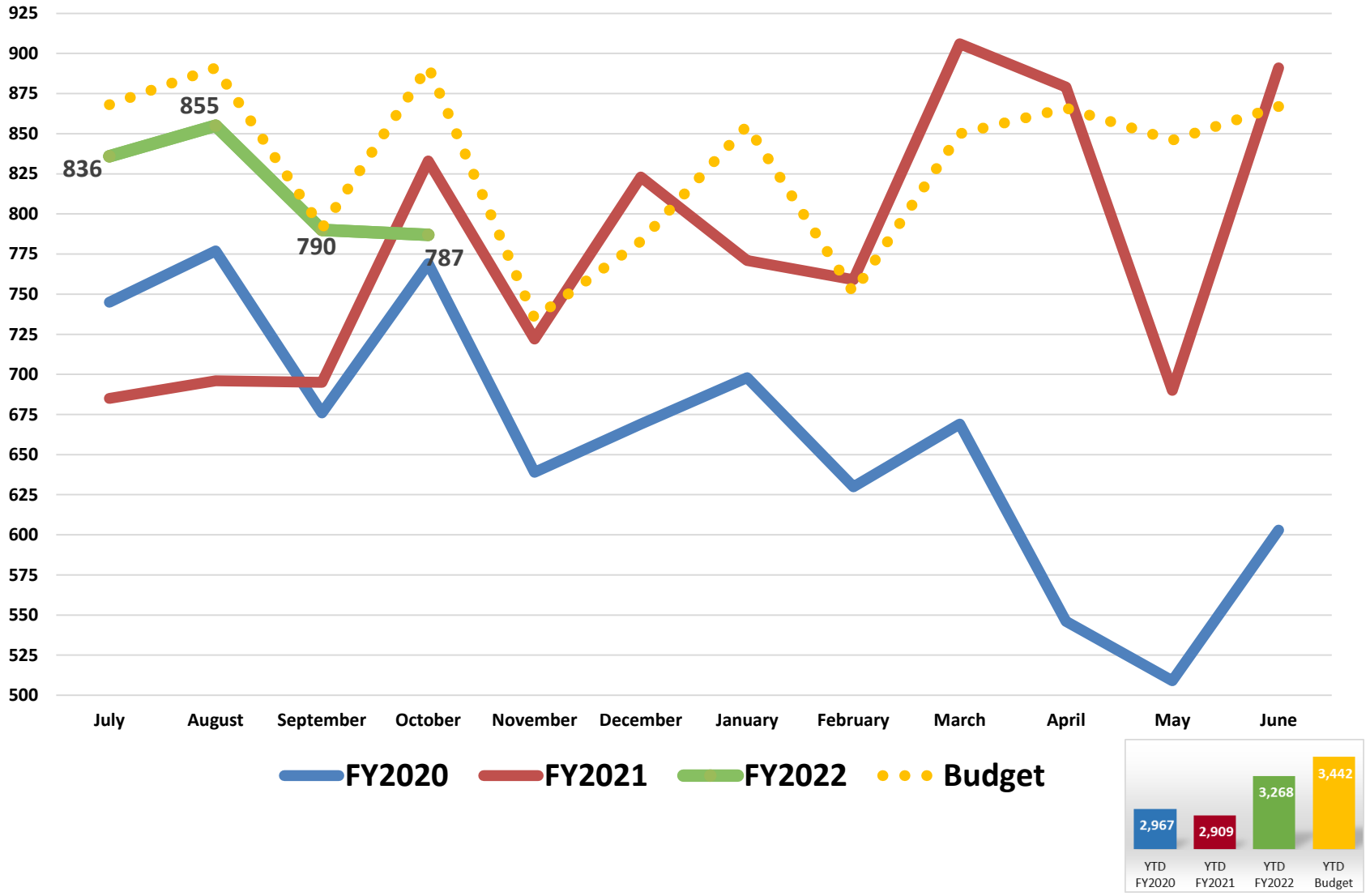
West Campus – Diagnostic Radiology



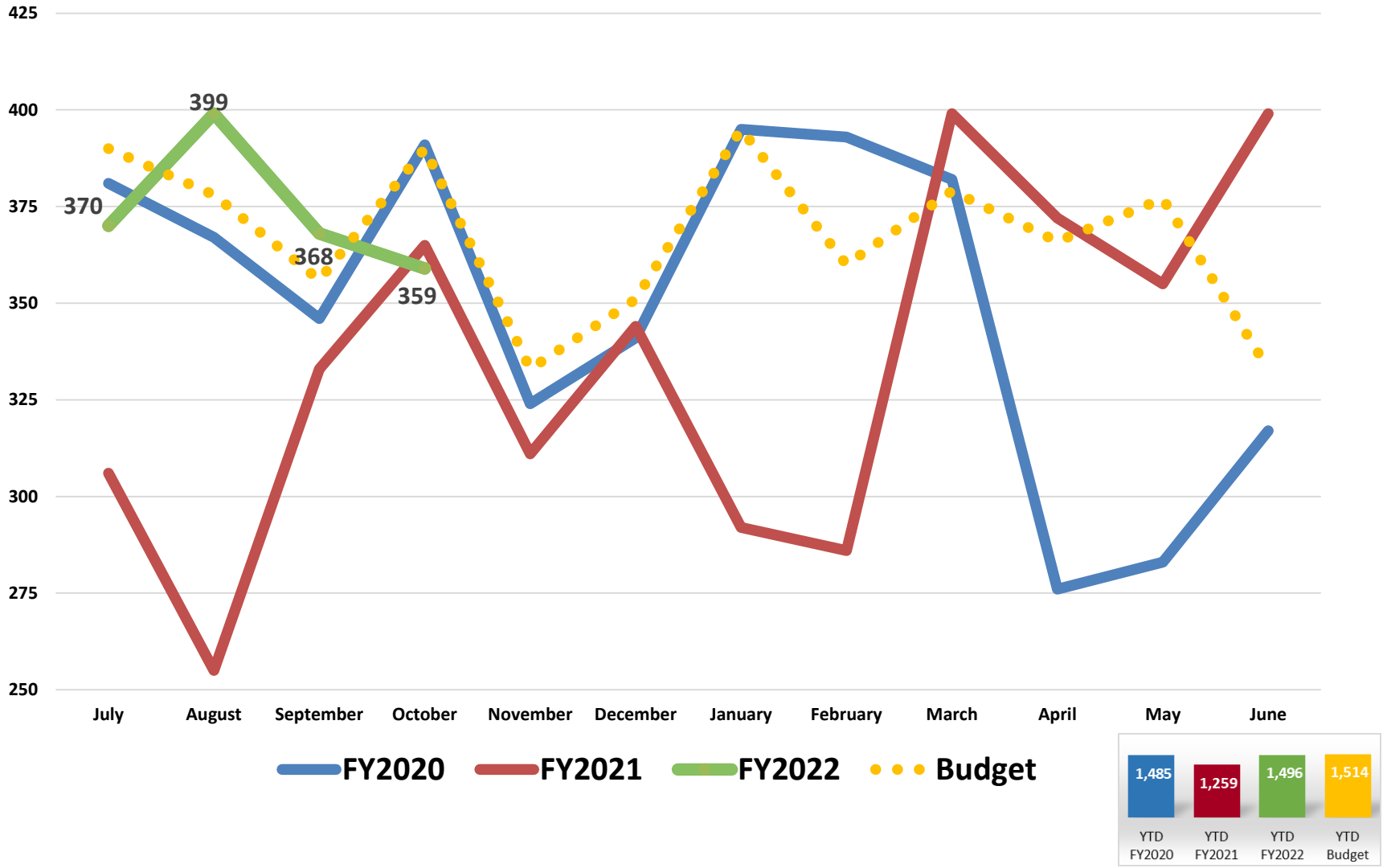
West Campus – CT Scan



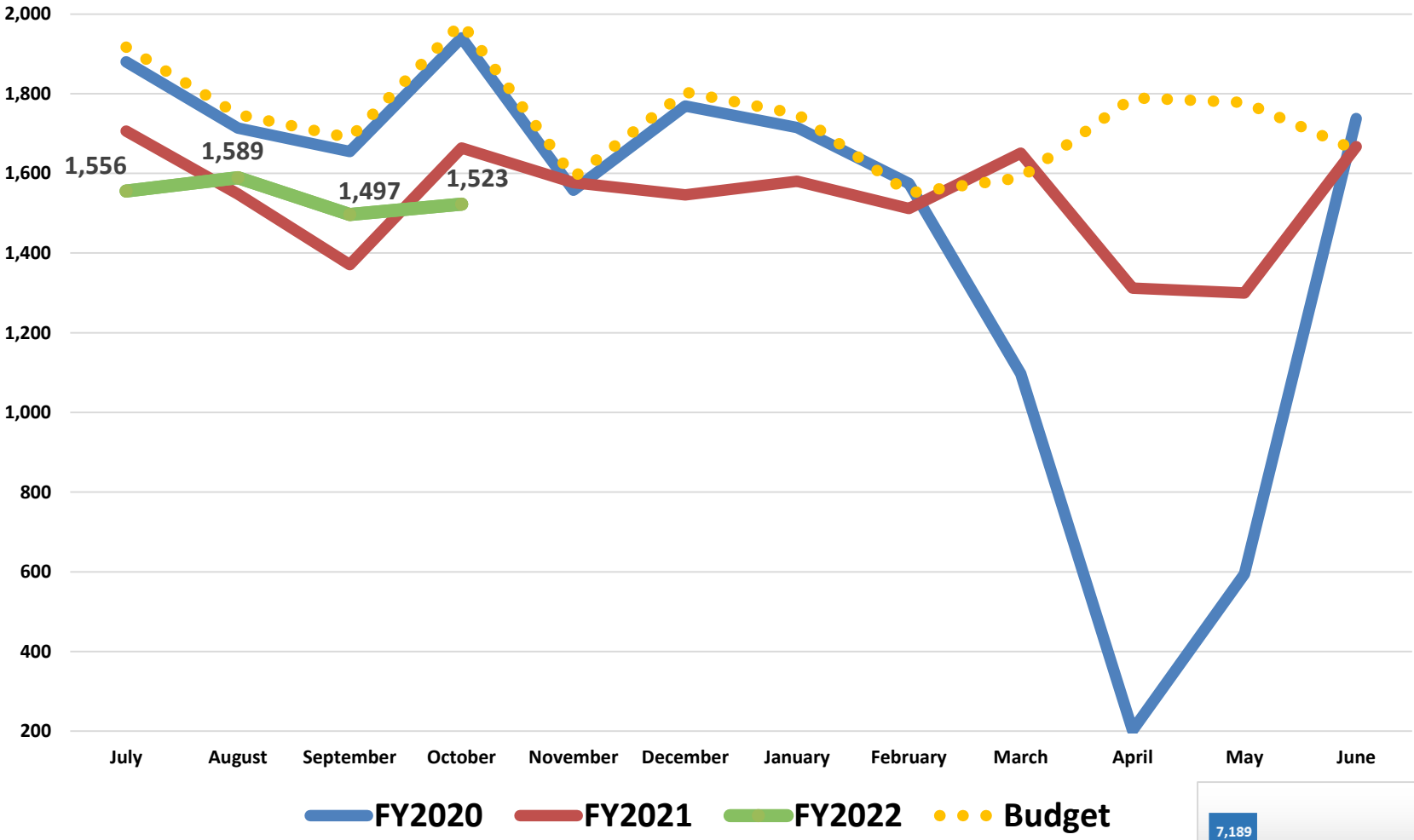
West Campus - Ultrasound

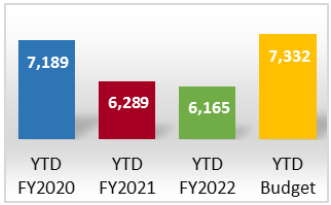


West Campus - MRI

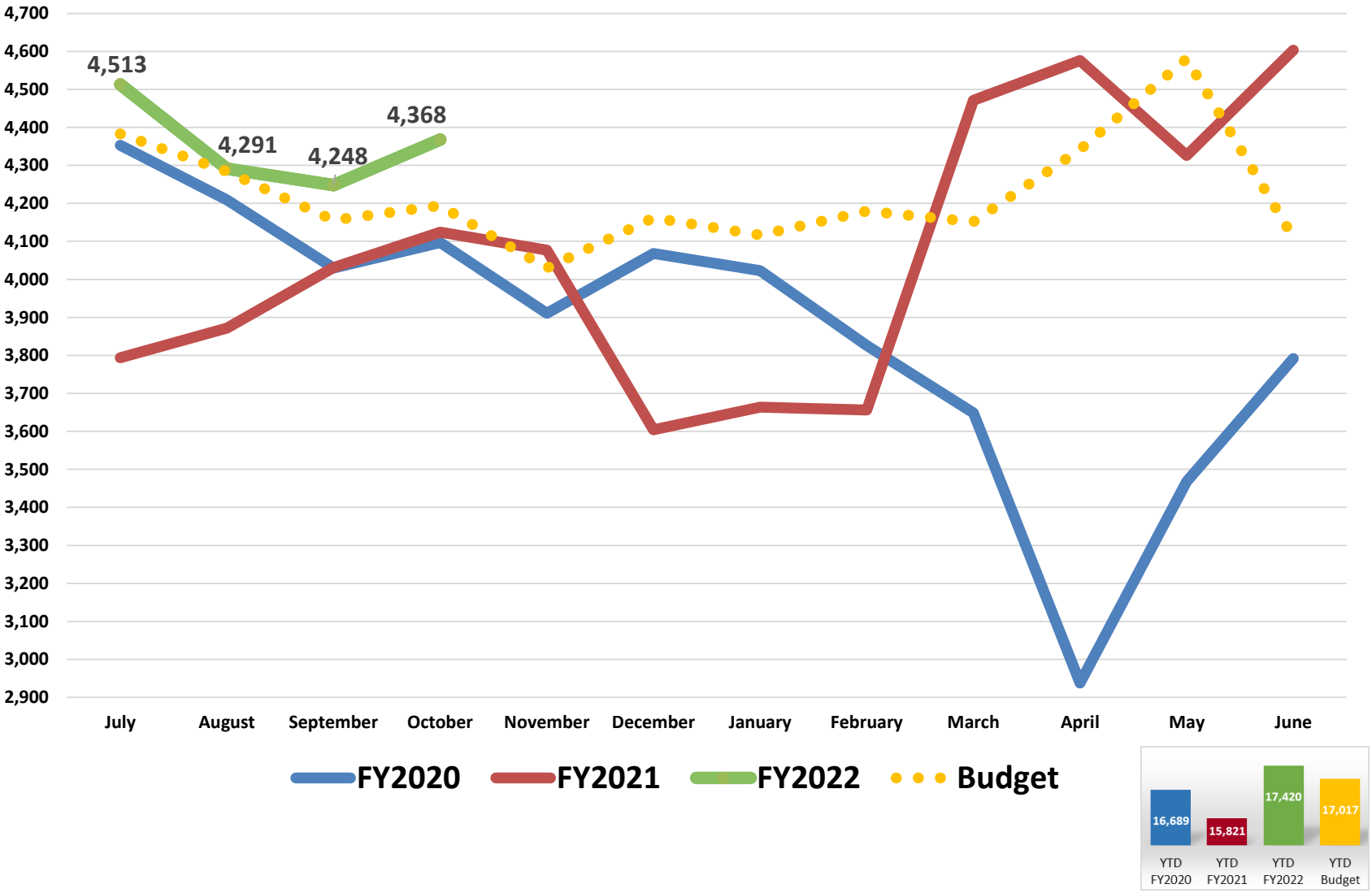


West Campus – Breast Center

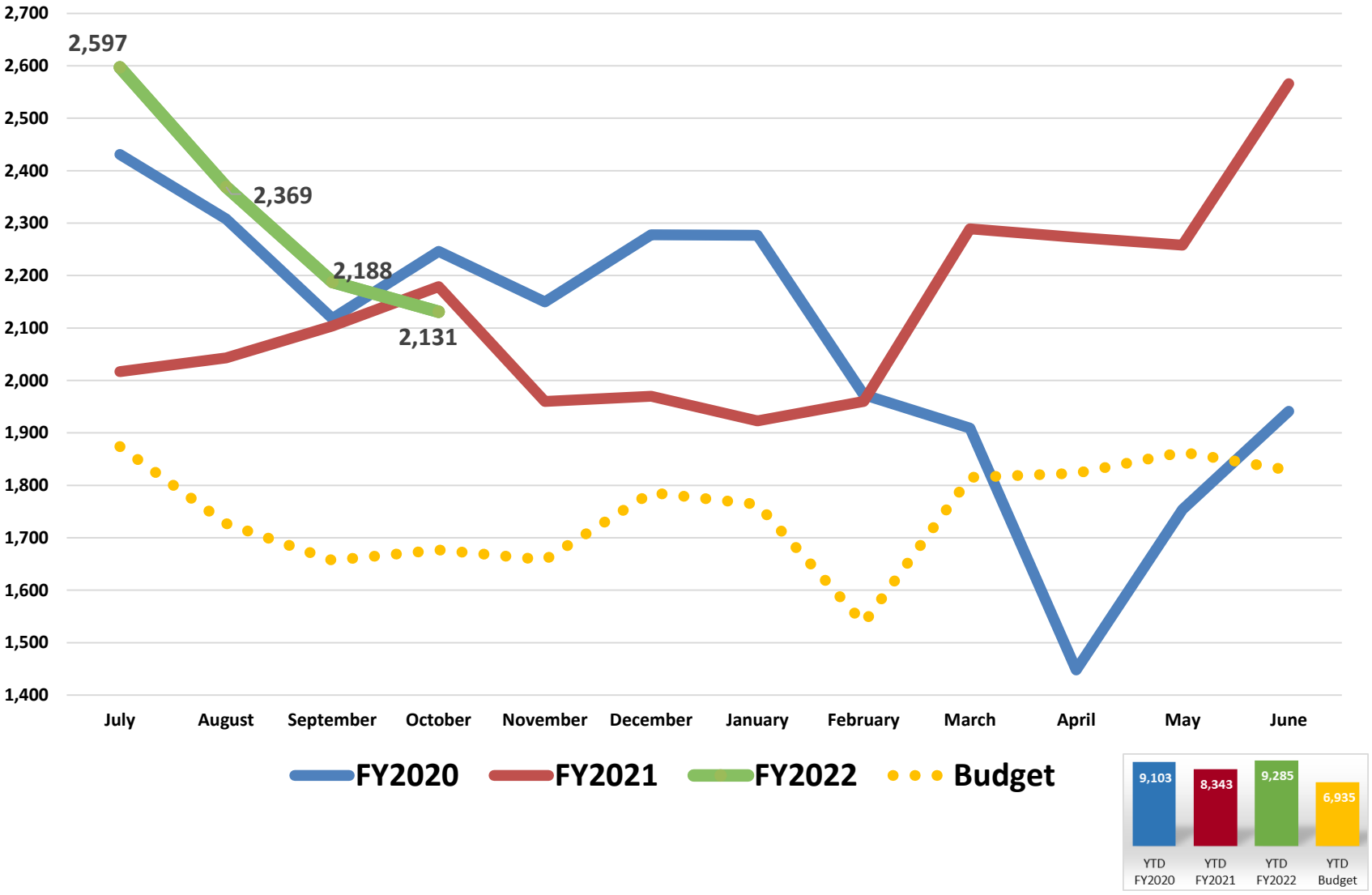




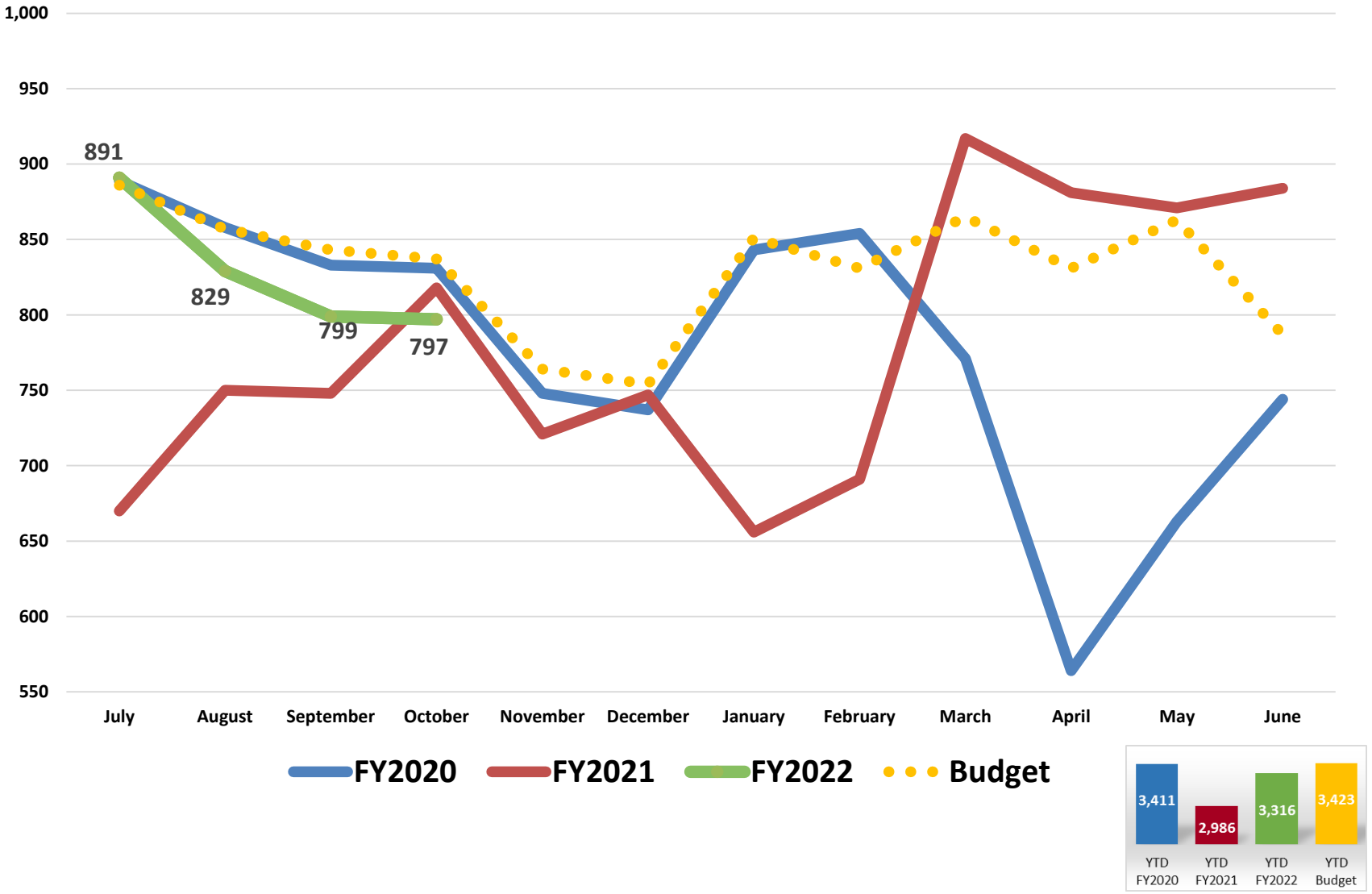
Radiology all areas – CT



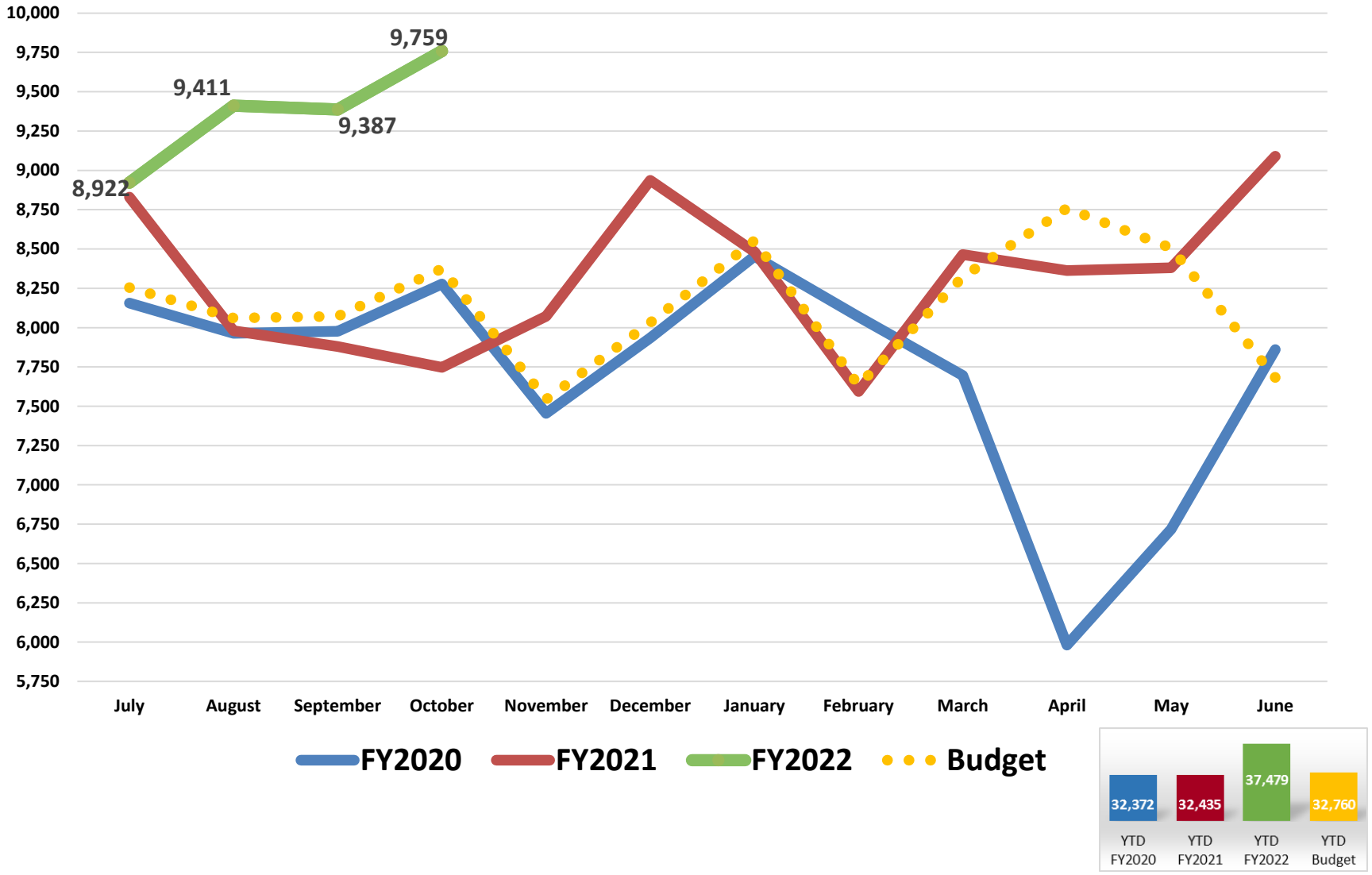
Radiology all areas – Ultrasound



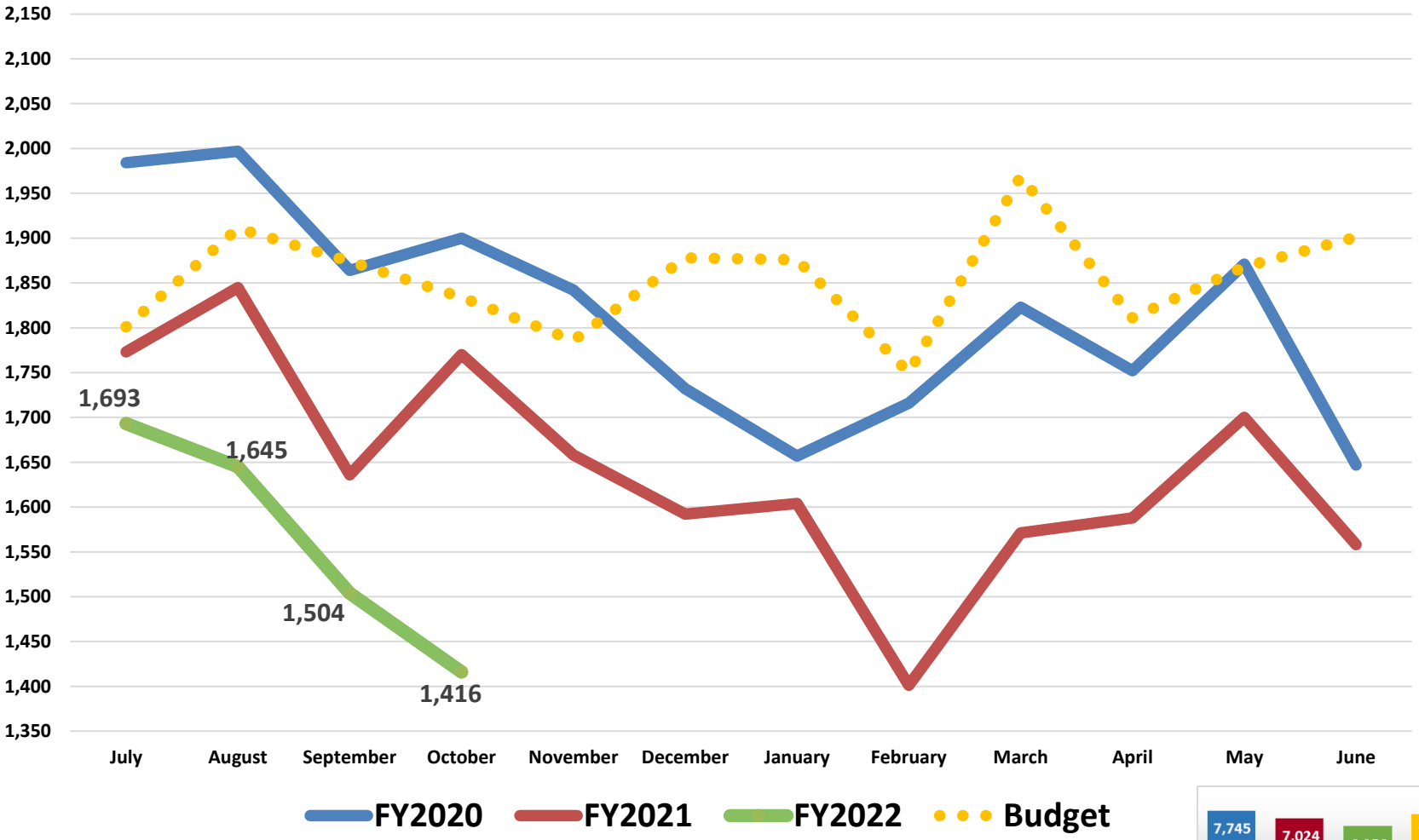
Radiology all areas – MRI

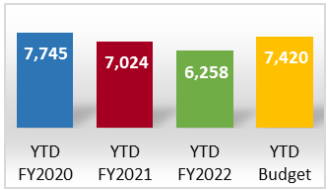


Radiology Modality – Diagnostic Radiology



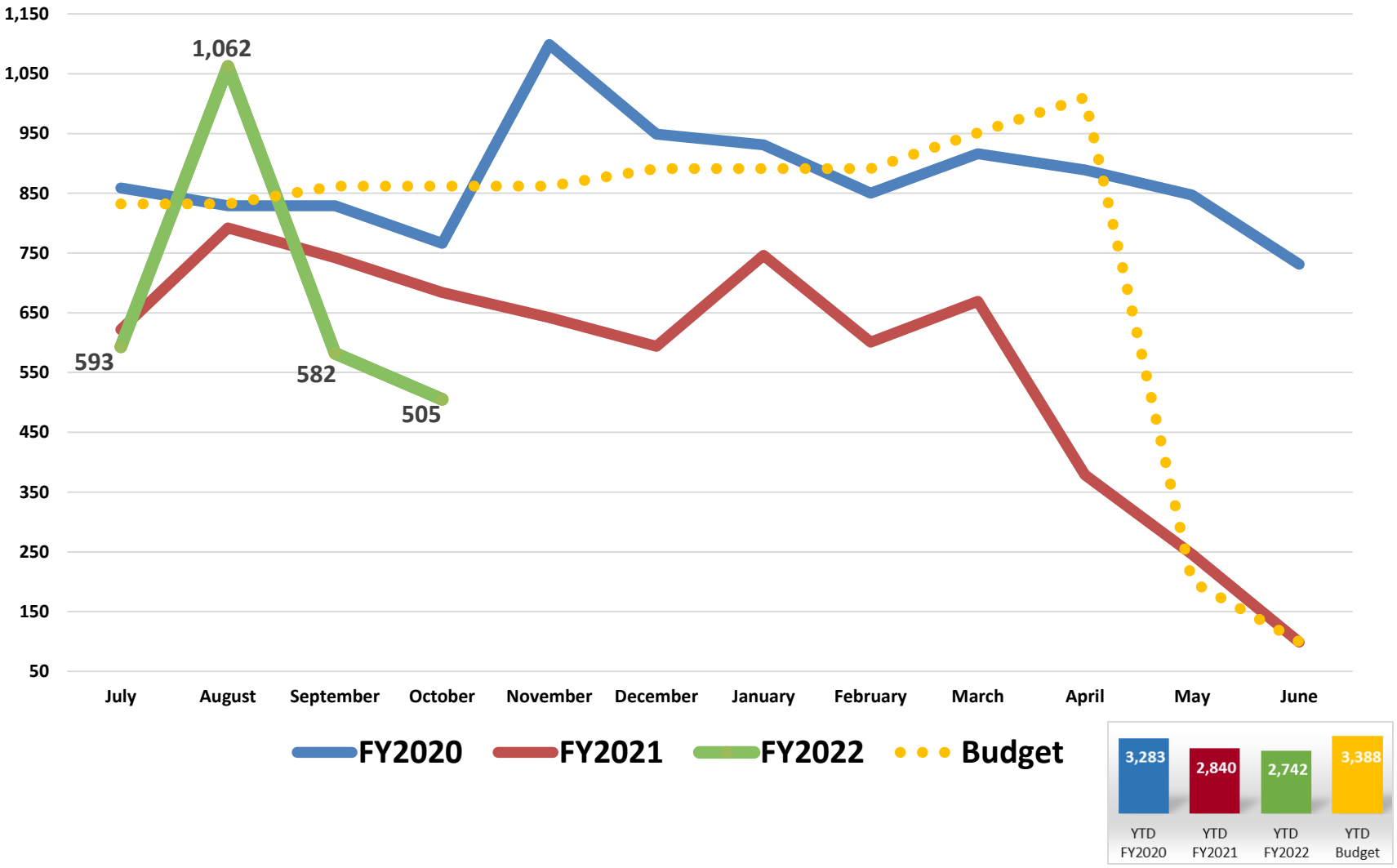
Chronic Dialysis - Visalia





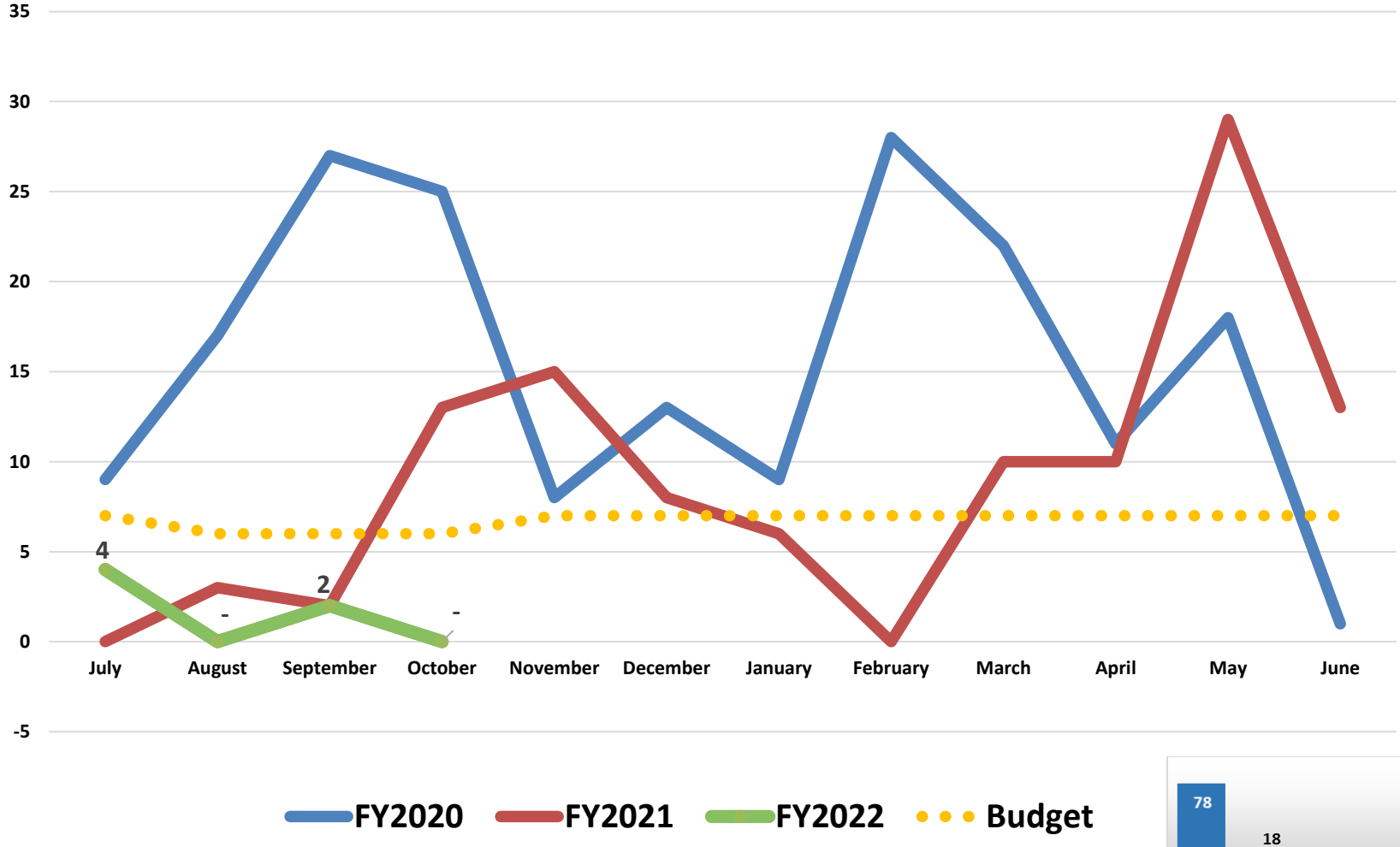
CAPD/CCPD – Maintenance Sessions

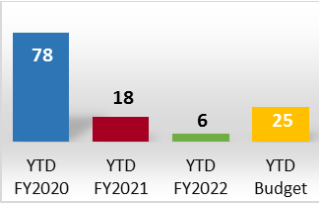
(Continuous peritoneal dialysis)



CAPD/CCPD – Training Sessions

(Continuous peritoneal dialysis)





Infusion Center – Outpatient Visits