AGENDA

REGULAR MEETING OF THE BOARD OF DIRECTORS
Tuesday, December 6, 2022 – 4:00 PM

Modular C Classroom
600 N. Highland Springs Avenue, Banning, CA 92220

In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting, please contact the Administration Office at (951) 769-2160. **Notification 48 hours prior to the meeting** will enable the Hospital to make reasonable arrangement to ensure accessibility to this meeting. [28 CFR 35.02-35.104 ADA Title II].

			TAB
I.	Call to Order	S. DiBiasi, Chair	
II.	Public Comment		

A five-minute limitation shall apply to each member of the public who wishes to address the Hospital Board of Directors on any matter under the subject jurisdiction of the Board. A thirty-minute time limit is placed on this section. No member of the public shall be permitted to "share" his/her five minutes with any other member of the public. (Usually, any items received under this heading are referred to staff for future study, research, completion and/or future Board Action.) (PLEASE STATE YOUR NAME AND ADDRESS FOR THE RECORD.)

On behalf of the Hospital Board of Directors, we want you to know that the Board acknowledges the comments or concerns that you direct to this Board. While the Board may wish to occasionally respond immediately to questions or comments if appropriate, they often will instruct the Hospital CEO, or other Hospital Executive personnel, to do further research and report back to the Board prior to responding to any issues raised. If you have specific questions, you will receive a response either at the meeting or shortly thereafter. The Board wants to ensure that it is fully informed before responding, and so if your questions are not addressed during the meeting, this does not indicate a lack of interest on the Board's part; a response will be forthcoming.

GENERAL TOPIC

III.	Designated Stroke Program Update	J. Peleuses	A

OLD BUSINESS

IV.	***Proposed Action - Approve Minutes**	S. DiBiasi	
	• November 1, 2022, Regular Meeting		B
	• November 16, 2022, Special Meeting		C

NEW BUSINESS

V.	Hospital Board Chair Monthly Report	S. DiBiasi	verbal
VI.	CEO Monthly Report	S. Barron	verbal
VII.	December, January, & February Board/Committee Meeting Calendars	S. DiBiasi	D
VIII.	Foundation Monthly Report	V. Hunter	E
IX.	*** Proposed Action – Approve Mission/Vision/Values Statement** (no staff recommended changes) ▪ **ROLL CALL**	S. Barron	F
X.	FOR REVIEW – Hospital Bylaws (Scheduled for approval at January 2023 meeting per Bylaws Section 4.05. i)	S. DiBiasi	G
XI.	*** Proposed Action – Approve Amended 2023 Meeting Dates** ▪ **ROLL CALL**	S. DiBiasi	H
XII.	*** Proposed Action – Appoint Ad Hoc Nomination Committee** ▪ **ROLL CALL**	S. DiBiasi	verbal
XIII.	Committee Reports:		

- Finance Committee — E. Ngo/ D. Heckathorne — I
  - November 29, 2022, regular meeting minutes

  *** Proposed Action – Approve October 2022 Financial Statement (Unaudited)**
  (Approval recommended by Finance Committee 11/29/2022)
  ▪ **ROLL CALL**

  *** Proposed Action – Recommend approval to the Healthcare District Board of the District Hospital Leadership Forum (DHLF) Annual Dues Renewal** — D. Heckathorne — J
  (Approval recommended by Finance Committee 11/29/2022)
  ▪ **ROLL CALL**

  *** Proposed Action – Recommend approval to the Healthcare District Board of the FYE 22 Financial Audit** — D. Heckathorne/ Wipfli, LLP — K
  (Approval recommended by Finance Committee 11/29/2022)
  ▪ **ROLL CALL**

- Human Resources Committee — R. Rader/ A. Karam — L
  - November 16, 2022, regular meeting minutes
  - Reports

- Community Planning Committee — S. Rutledge/ S. Barron — M
  - November 15, 2022, regular meeting minutes

  *** Proposed Action – Approve 2022 Community Health Needs Assessment**
  (Approval recommended by Community Planning Committee 11/15/2022)
  - **ROLL CALL**

XIV. Chief of Staff Report — S. Khalil, MD, Chief of Staff — N
*** Proposed Action - Approve Recommendations of the Medical Executive Committee**
- **ROLL CALL**

XV. *** Proposed Action - Approve Policies and Procedures** — Staff — O
- **ROLL CALL**

XVI. Community Benefit events/Announcements/ and newspaper articles — S. DiBiasi — P

XVII. Future Agenda Items

***** ITEMS FOR DISCUSSION/APPROVAL IN CLOSED SESSION** — S. DiBiasi

- Proposed Action - Recommend approval to Healthcare District Board - Medical Staff Credentialing
  (Health & Safety Code §32155; and Evidence Code §1157)

- Telephone Conference with Legal Counsel – Anticipated Litigation
  (Government Code §54956.9(d)(2))

XVIII. **ADJOURN TO CLOSED SESSION**

*** The Board will convene to the Open Session portion of the meeting approximately 2 minutes after the conclusion of Closed Session.**

RECONVENE TO OPEN SESSION

***** REPORT ON ACTIONS TAKEN DURING CLOSED SESSION** — S. DiBiasi

XIX. **ADJOURN** — S. DiBiasi

***Action Required**

In accordance with The Brown Act, *Section 54957.5*, all public records relating to an agenda item on this agenda are available for public inspection at the time the document is distributed to all, or a majority of all, members of the Board. Such records shall be available at the Hospital Administration office located at 600 N. Highland Springs Avenue, Banning, CA 92220 during regular business hours, Monday through Friday, 8:00 am - 4:30 pm.

I certify that on December 2, 2022, I posted a copy of the foregoing agenda near the regular meeting place of the Board of Directors of San Gorgonio Memorial Hospital, and on the San Gorgonio Memorial Hospital website, said time being at least 72 hours in advance of the regular meeting of the Board of Directors

(*Government Code Section 54954.2*).

Executed at Banning, California, on December 2, 2022

Ariel Whitley, Executive Assistant

TAB A

Primary Stroke Certification Update
SGMH Governing Board Meeting

DECEMBER 6, 2022

MOBILE MRI PAD CONSTRUCTION

Mobile MRI Pad Construction

- RFP Sent to contractors – April 20, 2022
  - Bids Received and Reviewed
  - Contractor selected – Sayco Builders Inc - June 6th
    - Construction meetings commenced every two weeks - July 12th
    - Modifications to plans submitted to Heath Care Access and Information (HCAI) to accommodate Mobile CT Scanner and MRI Scanners
  - On-site construction began October 20th
  - Estimated completion of construction January 2023
  - Licensing of site by CDPH January 2023

Mobile MRI Pad Construction Schedule

San Gorgonio Memorial hospital MRI Relocation

ID	Task Mode	Task Name	Duration	Start	Finish	Predecessors
1		Mobilization	1 day	Thu 10/20/22	Thu 10/20/22	
2		Demolition	5 days	Fri 10/21/22	Thu 10/27/22	
3		Rough Plumbing	3 days	Wed 10/26/2	Fri 10/28/22	
4		Concrete footings	6 days	Wed 10/26/2	Wed 11/2/22	
5		Onsite Steel Fabrication	14 days	Wed 11/9/22	Mon 11/28/22	
6		Concrete Flatwork	4 days	Wed 11/23/2	Mon 11/28/2	
7		Sheet Metal And gutters	3 days	Wed 11/23/22	Fri 11/25/22	
8		Trailer Placement	2 days	Wed 11/23/2	Thu 11/24/22	
9		Trailer Anchorage	3 days	Wed 11/23/2	Fri 11/25/22	
10		Rough electrical	15 days	Wed 11/9/22	Tue 11/29/22	
11		Finish Plumbing	3 days	Wed 11/30/2	Fri 12/2/22	
12		Painting	5 days	Wed 11/30/2	Tue 12/6/22	
13		Fire Alarm	5 days	Wed 11/30/2	Tue 12/6/22	
14		Fencing	3 days	Wed 11/30/2	Fri 12/2/22	
15		Striping	1 day	Wed 12/7/22	Wed 12/7/22	
16		Finish Electrical	10 days	Wed 11/30/2	Tue 12/13/22	
17		FLSO Sign Off	7 days	Wed 12/7/22	Thu 12/15/22	
18		DSE Sign Off	7 days	Wed 12/14/2	Thu 12/22/22	
19		ACO Sign Off	10 days	Tue 12/27/22	Mon 1/9/23	

Sayco Builders Inc

Mobile MRI Pad Construction Schedule

10/20/2022

10/24/2022

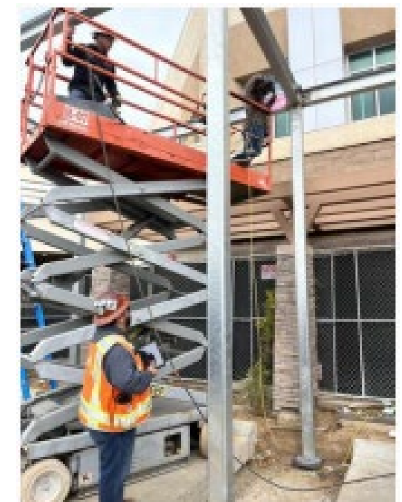
10/24/2022

11/03/2022

11/15/2022

11/12/2022

11/12/2022


11/28/2022

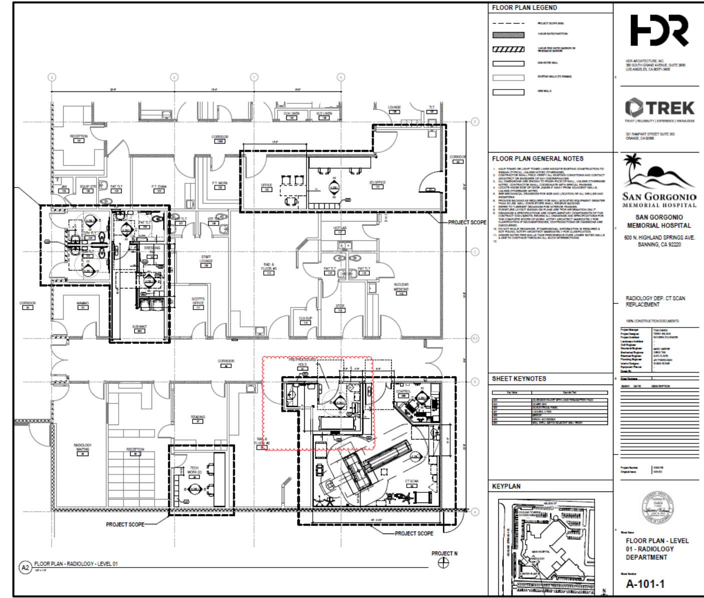
Mobile MRI Pad Construction - Photos

CT UNIT SELECTION PROCESS

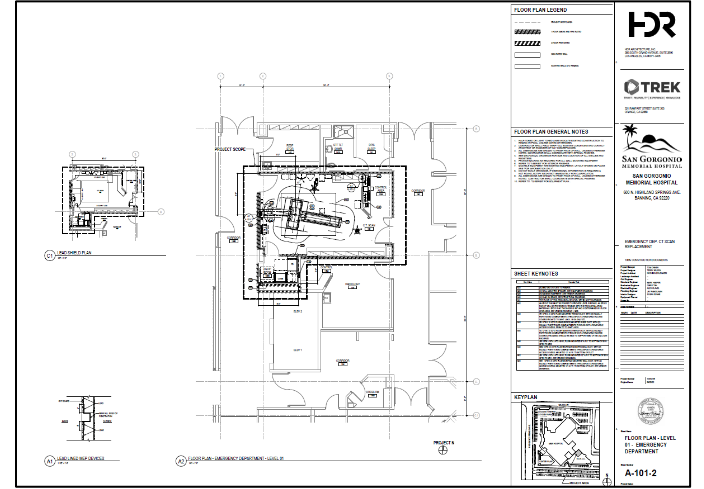
CT Unit

- Vendor Selected – Canon Medical Systems USA Inc.
  - Order Placed: June 14th, 2022, for two each 160-slice Aquilion Fast Whole-Body Scanners
  - Diagnostic Imaging currently working with Hospital Facilities-contracted architect HDR and Canon began design of locations for installations of CT Scanners (2).
  - Designs developed and submitted to Heath Care Access and Information (HCAI) for review process (multiple submissions and returns for questions). Each design proposal submitted separately (Emergency Department and Diagnostic Imaging)

160 Slice Aquilion Fast Whole-Body Scanners



Diagnostic Imaging



Emergency Department

Canon CT Scanner - Photos

NEXT STEPS

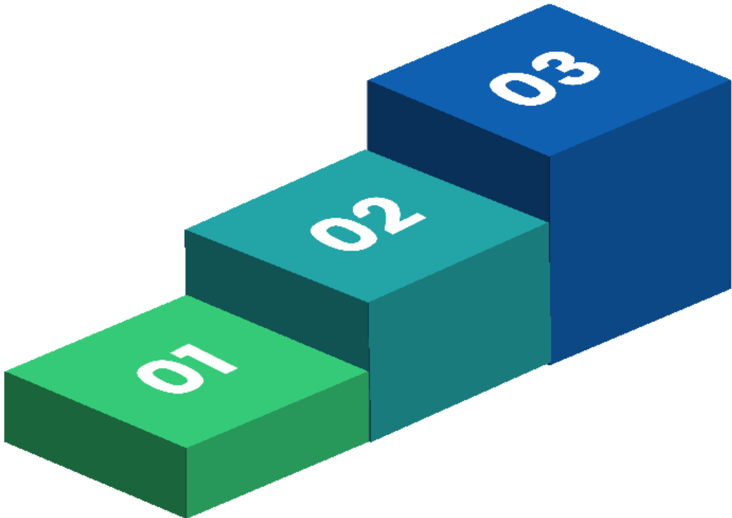
Task	Time Fame	Estimated Completion
Hire New Stroke Coordinator	Starts December 2022	Completed
Planning and Design **(Phase 2 and 3)** • Phase 2 Design Emergency Department CT Scanner • Phase 2 Design Diagnostic Imaging CT Scanner	4-6 Months	November 2022
RFP for MRI Selection	2 Months	January 2023
Construction **(Phase 2 and 3)** • Secure Bids for Construction upon HCAI approval of design • Place Mobile CT Trailer outside of ED Department • Phase 2 ED CT Installation (Emergency Department) • Begin Construction of area for placement of CT in Diagnostic Imaging Department	6-10 Months	August 2023
Policy and Procedure Development	6 Months	March 2023
Hiring Staff	Varies *(with position)*	July 2023
Staff Education	Ongoing	August 2023
Licensing and Accreditation Primary Stroke Center	8-10 Months	October 2023
Design Modular Structure for Permanent MRI • Submit design to HCAI for approval • Select contractor	8-10 Months	October 2023
Licensing and Accreditation of MRI	8-12 Months	November 2023

Process involves traveling multiple roads simultaneously

Next Steps

Hospital construction projects must be reviewed and approved by the California Department of Health Care Access and Information (HCAI)

Multi-Step Review Process



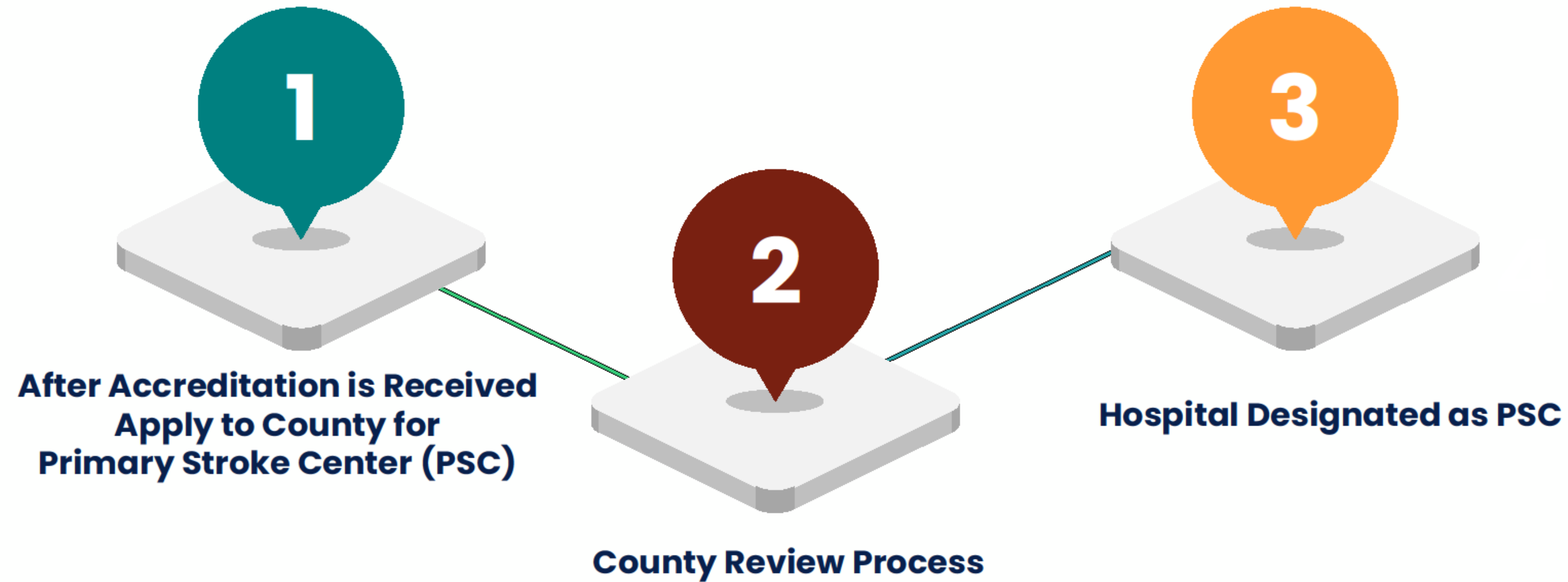
01
Initial submission to HCAI

02
HCAI reviews and returns with questions or comments (Backcheck)

03
Responses to HCAI
(can be multiple rounds of review)

Design and Approval

Regulatory Requirements | Accreditation Process


1
2
3
After Accreditation is Received
Apply to County for
Primary Stroke Center (PSC)
County Review Process
Hospital Designated as PSC

QUESTIONS

TAB B

MINUTES: Not Yet Approved
By Board

REGULAR MEETING OF THE
SAN GORGONIO MEMORIAL HOSPITAL
BOARD OF DIRECTORS

November 1, 2022

The regular meeting of the San Gorgonio Memorial Hospital Board of Directors was held on Tuesday, November 1, 2022, in Modular C meeting room, 600 N. Highland Springs Avenue, Banning, California.

Members Present: Phillip Capobianco, Susan DiBiasi (Chair), Ehren Ngo, Ron Rader, Steve Rutledge (Vice Chair), Randal Stevens, Dennis Tankersley

Members Absent: Joel Labha, Siri Welch

Required Staff: Steve Barron (CEO), Pat Brown (CNO/COO), Daniel Heckathorne (CFO), Sherif Khalil, MD (Chief of Staff), Annah Karam (CHRO), Ariel Whitley (Executive Assistant), Angie Brady (ED Director), Joey Hunter (Security Director), Peter Kim (Performance Improvement Director)

AGENDA ITEM		ACTION / FOLLOW-UP
Call To Order	Chair, Susan DiBiasi, called the meeting to order at 4:09 pm.	
Public Comment	No public comment.	
OLD BUSINESS		
Proposed Action - Approve Minutes **October 4, 2022, regular meeting.**	Chair, Susan DiBiasi, asked for any changes or corrections to the minutes of the October 4, 2022, regular meeting as included on the board tablets.	**The minutes of the October 4, 2022, regular meeting will stand correct as presented.**
NEW BUSINESS		
Hospital Board Chair Monthly Report	No report.	
CEO Monthly Report	Steve reported that we had a good first quarter financially. Volume in surgery is picking up. Census has been low. Influenza is going around.	
November, December, & January 2023 Board/Committee meeting calendars	Calendars for November, December, & January 2023 were included on the board tablets.	
For Review – Mission/Vision/Values Statement	Steve Barron noted that the current Mission, Vision, and Values Statement is included in the Board packets for review. The Mission, Vision, and Value Statement is scheduled for its annual approval at the December board meeting.	

<table>
<tr><th>AGENDA ITEM</th><th></th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Proposed Action – Approve 2023 Meeting Dates</td><td>Chair DiBiasi reported that included on the board tablets is a list of suggested meeting dates for 2023.

There was an error on the agenda to approve the “2022 Meeting Dates” which should have read “2023 Meeting Dates”. This error was brought to the attention of the Board, and they voted to approve the 2023 Meeting Dates.

BOARD MEMBER ROLL CALL:

<table><tr><td>Capobianco</td><td>Yes</td><td>DiBiasi</td><td>Yes</td></tr><tr><td>Labha</td><td>Absent</td><td>Ngo</td><td>Yes</td></tr><tr><td>Rader</td><td>Yes</td><td>Rutledge</td><td>Yes</td></tr><tr><td>Stevens</td><td>Yes</td><td>Tankersley</td><td>Yes</td></tr><tr><td>Welch</td><td>Absent</td><td>Motion carried.</td><td></td></tr></table></td><td>M.S.C. (Tankersley/Stevens), the SGMH Board of Directors approved the 2023 Meeting Dates as presented.</td></tr>
<tr><td>For Review – Existing Slate of Officers</td><td>Chair DiBiasi noted that the 2022 Slate of Officers was included on the board tablets as informational. The proposed approval for the 2023 Slate of Officers is scheduled for the December 2022 meeting to be effective at the January 2023 board meeting.</td><td></td></tr>
<tr><td>Bi-Monthly Patient Care Services Report</td><td>Pat Brown briefly reviewed the Bi-Monthly Patient Care Services report as included on the board tablets.</td><td></td></tr>
<tr><td colspan="3">COMMITTEE REPORTS:</td></tr>
<tr><td>Finance Committee

Proposed Action – Recommend Approval of the September 2022 Financial Statement (Unaudited).</td><td>Dan Heckathorne, CFO, reviewed the Executive Summary of the September 2022 Financial report which was included on the board tablet. A copy of the Finance Committee’s October 25, 2022, meeting minutes were also included on the board tablet. It was noted that the Finance Committee recommends approval of September 2022 Financial report as presented.

BOARD MEMBER ROLL CALL:

<table><tr><td>Capobianco</td><td>Yes</td><td>DiBiasi</td><td>Yes</td></tr><tr><td>Labha</td><td>Absent</td><td>Ngo</td><td>Yes</td></tr><tr><td>Rader</td><td>Yes</td><td>Rutledge</td><td>Yes</td></tr><tr><td>Stevens</td><td>Yes</td><td>Tankersley</td><td>Yes</td></tr><tr><td>Welch</td><td>Absent</td><td>Motion carried.</td><td></td></tr></table></td><td>M.S.C., (Rader/Rutledge), the SGMH Board of Directors approved the September 2022 Financial Statement as presented.</td></tr>
</table>

<table>
<tr><th>AGENDA ITEM</th><th></th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td>Proposed Action – Approve Resolution No. 2022-01</td><td>The Board voted to approve Resolution No. 2022-01, a resolution authorizing Joey Hunter Sr. to execute for and on behalf of the named Applicant, a public entity established under the laws of the State of California any actions necessary for the purpose of obtaining federal financial assistance provided by the federal Department of Homeland Security and subgranted through the State of California for the FY 2022 Nonprofit Security Grant Program

BOARD MEMBER ROLL CALL:

<table>
<tr><td>Capobianco</td><td>Yes</td><td>DiBiasi</td><td>Yes</td></tr>
<tr><td>Labha</td><td>Absent</td><td>Ngo</td><td>Yes</td></tr>
<tr><td>Rader</td><td>Yes</td><td>Rutledge</td><td>Yes</td></tr>
<tr><td>Stevens</td><td>Yes</td><td>Tankersley</td><td>Yes</td></tr>
<tr><td>Welch</td><td>Absent</td><td>Motion carried.</td><td></td></tr>
</table></td><td>M.S.C., (Ngo/Stevens), the SGMH Board of Directors voted to approve Resolution No. 2022-01 as presented.</td></tr>
<tr><td>Chief of Staff Report

Proposed Action – Approve Recommendations of the Medical Executive Committee</td><td>Sherif Khalil, MD, Chief of Staff, briefly reviewed the Medical Executive Committee report as included on the board tablets.

Approval Items:
• 2022 Annual Approval of Policies and Procedures
• Medical Staff Bylaws – Recommended Addition

BOARD MEMBER ROLL CALL:

<table>
<tr><td>Capobianco</td><td>No</td><td>DiBiasi</td><td>Yes</td></tr>
<tr><td>Labha</td><td>Absent</td><td>Ngo</td><td>Yes</td></tr>
<tr><td>Rader</td><td>Yes</td><td>Rutledge</td><td>Yes</td></tr>
<tr><td>Stevens</td><td>Yes</td><td>Tankersley</td><td>Yes</td></tr>
<tr><td>Welch</td><td>Absent</td><td>Motion carried.</td><td></td></tr>
</table></td><td>M.S.C., (Rader/Tankersley), the SGMH Board of Directors approved the Medical Executive Committee recommended approval items as submitted.</td></tr>
<tr><td>Proposed Action – Approve Policies and Procedures</td><td>There were twenty-nine (29) policies and procedures included on the board tablets presented for approval by the Board.

BOARD MEMBER ROLL CALL:

<table>
<tr><td>Capobianco</td><td>Yes</td><td>DiBiasi</td><td>Yes</td></tr>
<tr><td>Labha</td><td>Absent</td><td>Ngo</td><td>Yes</td></tr>
<tr><td>Rader</td><td>Yes</td><td>Rutledge</td><td>Yes</td></tr>
<tr><td>Stevens</td><td>Yes</td><td>Tankersley</td><td>Yes</td></tr>
<tr><td>Welch</td><td>Absent</td><td>Motion carried.</td><td></td></tr>
</table></td><td>M.S.C., (Rutledge/Rader), the SGMH Board of Directors approved the policies and procedures as submitted.</td></tr>
<tr><td>Community Benefit events/Announcements/and newspaper articles</td><td>Miscellaneous information was included on the board tablets.

Ron Rader announced that the Good Morning Beaumont Breakfast will be changing venues. The new location is the Noble Creek Copper Room located at 390 Oak Valley Parkway in Beaumont.</td><td></td></tr>
</table>

AGENDA ITEM		ACTION / FOLLOW-UP
Future Agenda Items	• Community Health Needs Assessment • Potential Special Meeting	
Adjourn to Closed Session	Chair, DiBiasi reported the items to be reviewed and discussed and/or acted upon during Closed Session will be: ➢ Recommend approval to the Healthcare District Board – Medical Staff Credentialing ➢ Receive Quarterly Performance Improvement Committee Report ➢ Receive Quarterly Security/Safety & Emergency Preparedness Report ➢ Receive Quarterly Corporate Compliance Report The meeting adjourned to Closed Session at 4:43 pm.	
Reconvene to Open Session	The meeting adjourned from closed session at 5:32 pm. At the request of Chair DiBiasi, Ariel Whitley reported on the actions taken/information received during the Closed Session as follows: ➢ Recommended approval to the Healthcare District Board – Medical Staff Credentialing ➢ Received Quarterly Performance Improvement Committee Report ➢ Received Quarterly Security/Safety & Emergency Preparedness Report ➢ Received Quarterly Corporate Compliance Report	
Adjourn	The meeting was adjourned at 5:35 pm.	

In accordance with The Brown Act, *Section 54957.5*, all reports and handouts discussed during this Open Session meeting are public records and are available for public inspection. These reports and/or handouts are available for review at the Hospital Administration office located at 600 N. Highland Springs Avenue, Banning, CA 92220 during regular business hours, Monday through Friday, 8:00 am - 4:30 pm.

Respectfully submitted by Ariel Whitley, Executive Assistant

TAB C

MINUTES: Not Yet Approved By Board

REGULAR MEETING OF THE
SAN GORGONIO MEMORIAL HOSPITAL
BOARD OF DIRECTORS

November 16, 2022

The regular meeting of the San Gorgonio Memorial Hospital Board of Directors was held on Wednesday, November 16, 2022, in the Administration Boardroom meeting room, 600 N. Highland Springs Avenue, Banning, California.

Members Present: Phillip Capobianco, Susan DiBiasi (Chair), Ehren Ngo, Ron Rader, Steve Rutledge, Randal Stevens

Members Absent: Joel Labha, Dennis Tankersley, Siri Welch

Required Staff: Steve Barron (CEO), Annah Karam (CHRO), Ariel Whitley (Executive Assistant)

AGENDA ITEM		ACTION / FOLLOW-UP
Call To Order	Chair, Susan DiBiasi, called the meeting to order at 12:02 pm.	
Public Comment	No public comment.	
Adjourn to Closed Session	Chair, DiBiasi reported the items to be reviewed and discussed and/or acted upon during Closed Session will be: ➢ Telephone Conference with Legal Counsel regarding pending litigation The meeting adjourned to Closed Session at 12:04 pm.	
Reconvene to Open Session	The meeting reconvened to open session at 12:17 pm. There were no community members waiting to return to the meeting. At the request of Chair DiBiasi, Ariel Whitley reported on the actions taken/information received during the Closed Session as follows: ➢ Participated in a conference call with legal counsel regarding pending litigation	
Adjourn	The meeting was adjourned at 12:19 pm.	

In accordance with The Brown Act, *Section 54957.5*, all reports and handouts discussed during this Open Session meeting are public records and are available for public inspection. These reports and/or handouts are available for review at the Hospital Administration office located at 600 N. Highland Springs Avenue, Banning, CA 92220 during regular business hours, Monday through Friday, 8:00 am - 4:30 pm.

Respectfully submitted by Ariel Whitley, Executive Assistant

TAB D

December 2022

Board of Directors Calendar

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6 **4:00 pm Hospital Board Meeting** **6:00 pm Healthcare District Board Meeting**	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26 ***Christmas Observed ADMIN. CLOSED***	27 **9:00 am Finance Committee** **10:00 am Executive Committee**	28	29	30	31 ***New Year's Eve***

Items in **bold** = Board/Committee meetings

Items with * = Associate functions that Board members are invited to attend

January 2023

Board of Directors Calendar

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 *New Year's Day*	2 *Admin. Closed—New Years Day Observed*	3 **4:00 pm Hospital Board Meeting** **6:00 pm Healthcare District Board Meeting**	4	5	6	*7*
8	9	10	11	12	13	*14*
15	16	17	18 **9:00 am HR Committee Meeting** **10:00 am Community Planning Meeting**	19	20	*21*
22	23	24	25	26	27	*28*
29	30	31 **9:00 am Finance Committee**				

Items in **bold** = Board/Committee meetings

Items with * = Associate functions that Board members are invited to attend

February 2023

Board of Directors Calendar

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	*2*	*3*	*4*
5	*6*	*7* **4:00 pm Hospital Board Meeting** **6:00 pm Healthcare District Board Meeting**	*8*	*9*	*10*	*11*
12	*13*	*14*	*15*	*16*	*17*	*18*
19	*20* ***Administration Closed Presidents Day***	*21*	*22*	*23*	*24*	*25*
26	*27*	*28* **9:00 am Finance Committee**				

Items in **bold** = Board/Committee meetings

Items with * = Associate functions that Board members are invited to attend

TAB E

SGMH Foundation November 2022 Report

Foundation Finances for September 2022 **(as of September 28, 2022)**

Bank of Hemet Checking Acct:	$288,580.84	(actual as of 11/30/2022)
Bank of Hemet Money Market Acct:	$128,224.50	(actual as of 11/30/2022)
I.E. Community Foundation Acct:	$89,968.96	Actual for Oct 2022 (Nov 2022 not available)
Total	$506,774.30	

Foundation Report

- The SGMH Foundation is currently holding a raffle for the employees of SGMH as it was very popular in 2021.
- The Foundation board is working hard to get its website up and running.
- Reminder: The Foundation's golf tournament is slated for October 2023 at Morongo Golf Club at Tukwet Canyon.
- Once again, SGMH'S Auxiliary is in the need for new Auxiliary members.

TAB F

Mission

To provide safe, high quality, personalized healthcare services

Vision

Patients trust San Gorgonio Memorial Hospital to provide safe, personalized healthcare services.

Values

We make those we serve our highest priority

We respect privacy and confidentiality

We communicate effectively

We conduct ourselves professionally

We have a sense of ownership

We are committed to each other and to our community

We Care for Our Community

Safe Care • Quality Care • ***Our*** *Care*

S*afe,* ***G****reat,* ***M****odern* ***H****ealthcare*

Approved by the Board of Directors
December 7, 2021

TAB G

AMENDED AND RESTATED BYLAWS

OF

SAN GORGONIO MEMORIAL HOSPITAL

HOSPITAL BOARD

A CALIFORNIA NONPROFIT PUBLIC BENEFIT CORPORATION

Approved by SGMH Board of Directors on January 4, 2022

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OF

SAN GORGONIO MEMORIAL HOSPITAL

A CALIFORNIA NONPROFIT PUBLIC BENEFIT CORPORATION

ARTICLE 1
OFFICES

Section 1.01 Principal Office

The principal office of the Corporation for the transaction of its business shall be located at San Gorgonio Memorial Hospital, which is located at the southeastern corner of Highland Springs Avenue and West Wilson Street in the City of Banning, in the County of Riverside, State of California, or such other place or places within the boundaries of the San Gorgonio Memorial Healthcare District ("District") as the Board of Directors may from time to time designate.

ARTICLE 2
NONPROFIT NATURE

Section 2.01 Goals and Purposes

The Corporation manages the San Gorgonio Memorial Hospital for the San Gorgonio Memorial Healthcare District, a local healthcare district under California Health & Safety Code Section 32000. Under the management services agreement between the District and the Corporation, the Corporation is charged with providing management and pharmacy services to the Hospital for the benefit of the communities served by the District. The goals and purposes of this Corporation are to:

a. operate and maintain the Hospital and provide hospital services for the benefit of the communities served by the San Gorgonio Memorial Healthcare District.

b. maintain a hospital for the care of persons suffering from illnesses or disabilities which require that the patients receive hospital care.

c. carry on any activities related to healthcare services which, in the opinion of the Board of Directors, may be justified by the facilities, personnel, funds or other assets that are or can be made available.

d. participate, so far as circumstances may warrant, in any activity designed and carried on to promote the general health of the community.

e. provide health education to the Hospital's patients and members of the community regarding wellness and prevention.

f. attract and retain a diverse staff of qualified well trained and competent healthcare practitioners and support personnel who will provide care in a competent manner.

Section 2.02 Exempt Purposes

The purposes for which this Corporation is organized are exclusively charitable and educational within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended from time to time (or any successor statute). Notwithstanding any other provisions of these Bylaws, the Corporation shall not, except to an insubstantial degree, engage in or carry on any activities or exercise any power that is not in furtherance with the goals and purposes of this Corporation, or which are not permitted to be carried on (i) by a corporation exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended from time to time (or any successor statute) or Section 23701d of the California Revenue and Taxation Code, as amended from time to time (or any successor statute) or (ii) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code of 1986, as amended from time to time (or any successor statute) or under Section 17201 and related Sections of the California Revenue and Taxation Code, as amended from time to time (or any successor statute).

Section 2.03 Dedication of Assets

The property of this Corporation is irrevocably dedicated to the charitable and educational purposes set forth in these Bylaws, and no part of the net income or assets of this Corporation shall inure to the personal benefit of any Director, Officer, or Member of this Corporation or to the benefit of any other private person. Upon the winding up and dissolution of this Corporation, its assets remaining after payment of, or provision for payment of, all the Corporation's debts and liabilities shall be distributed to the San Gorgonio Memorial Healthcare District, or any successor public agency charged with carrying out the purposes of the District, to continue to promote and accomplish the public purpose of this Corporation as set forth in these Bylaws. If the District, or the successor entity referred to in the preceding sentence, shall no longer exist at such time, then upon the winding up and dissolution of this Corporation, its assets remaining after payment of, or provision for payment of, all the Corporation's debts and liabilities shall be distributed to another non-profit corporation, trust or fund which is organized and operated exclusively for charitable purposes and which has established its tax exempt status within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended from time to time (or any successor statute), and Section 23701(d) of the California Revenue and Taxation Code, as amended from time to time (or any successor statute), such assets to be used exclusively for the purpose of continuing to promote and accomplish the charitable purpose of this Corporation as set forth in the Articles and in the Bylaws of the Corporation.

ARTICLE 3
MEMBERS

Section 3.01 No Members

The Corporation shall have no members, within the meaning of California Corporations Code Section 5056.

ARTICLE 4
DIRECTORS

Section 4.01 Number

This Corporation shall have nine (9) regular Directors, who shall be known collectively as the Board of Directors. Members of the Board of Directors shall be elected, as set forth in Article 5, provided that each individual who takes office as a Director of the District shall be an *ex officio* Director of the Corporation, with full voting rights and shall count for purposes of establishing a quorum. All of the Directors, including *ex officio* Directors, shall be subject to the same terms and provisions of these Bylaws and applicable law except as expressly provided to the contrary by these Bylaws. Subject to the discretion of the Board, two members of the Board of Directors may be members of the Medical Staff of San Gorgonio Memorial Hospital.

The Chief of Staff shall be an invited guest at all meetings of the Board of Directors, but shall excuse himself or herself from Board meetings when requested to do so by the Chair, and may not attend closed session meetings of the Board unless his or her experience and expertise is required by the Board and he or she is asked to attend by the Board. As the Chief of Staff is not a Director, the Chief of Staff shall have no voting rights and shall not count for purposes of establishing a quorum. The Chief of Staff shall abide by all policies of the Corporation applicable to Directors with respect to conflicts of interests and maintaining the confidentiality of trade secret, competitively sensitive information and closed session information.

Section 4.02 Use of Terms "Directors" and "Board"

The words "Directors" and "Board", as used in the Articles of Incorporation of this Corporation, or in these Bylaws, in relation to any power or duty requiring collective action, mean "Board of Directors".

Section 4.03 Restriction on Interested Persons and Employees as Directors

Subject to the additional restrictions in Section 4.18 of these Bylaws, no more than forty-nine percent (49%) of the persons serving on the Board may be interested persons. An interested person is (a) any person compensated by the Corporation for services rendered to it within the previous twelve (12) months, such as an independent contractor, or otherwise, excluding any reasonable compensation paid to a Director as Director; and (b) any brother, sister, ancestor, descendant, spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, or father-in-law of such person. Employees of the Corporation or District may not serve on the Board. However, except as provided to the contrary by Government Code Section 1090, any violation of the provisions of this paragraph shall not affect the validity or enforceability of any transaction entered into by the Corporation.

Section 4.04 Powers

The Directors shall exercise the powers of the Corporation, control its property, and conduct its affairs, except as otherwise provided by law, by the Articles of Incorporation, or by these Bylaws. The Directors shall not be personally liable for the debts, liabilities, or other obligations of the Corporation.

Section 4.05 Duties

The Board of Directors has responsibility to establish policy for the Hospital and its business including, but not limited to, all matters pertaining to quality of care rendered within the Hospital. The Board of Directors shall exercise this authority in conformity with applicable laws, regulations and accreditation requirements. In furtherance of the foregoing, the role of the Directors shall be as follows:

a. establish policy for the operation, maintenance and development of the Hospital and its business including, but not limited to, assuring the quality of care within the Hospital.

b. appoint a competent and experienced Chief Executive Officer who shall be its direct representative in the management of the Hospital.

c. review the performance of the Chief Executive Officer on an annual basis.

d. approve the annual operating budget and capital expenditures.

e. approve the strategic plan on an annual basis.

f. review and approve periodic financial statements and other financial matters of the Corporation.

g. assure that adequate revenues are retained by the Corporation and expended in accordance with its charitable purposes.

h. review and act on financing arrangements recommended by the Chief Executive Officer for the Corporation.

i. review these Bylaws, the Bylaws of the Medical Staff and all committees on an annual basis, and approve needed changes.

j. review and approve written personnel policies and establish a procedure for notifying employees of changes in such personnel policies.

k. review and, where appropriate, approve policies and procedures to promote care, treatment and rehabilitation of patients.

l. review and revise, as appropriate, all department and service policies and procedures when warranted and ensure that the Medical Staff participates, as appropriate.

m. act as the final decision-making authority with respect to all matters pertaining to credentialing and privileges. Upon the recommendation and advice of the Medical Staff, the Board shall appoint members of the Medical Staff and grant such privileges as may, in their judgments, be warranted by the experience and training of the applicant.

Section 4.06 Compensation

The members of the Board of Directors shall be entitled to receive compensation equivalent in amount to that which is payable to the members of the Board of Directors of a California Healthcare District pursuant to the terms of Health & Safety Code Sections 32103. Such amounts shall not be mandatory and Board Members choosing not to accept compensation may do so. Additionally, each Board member shall also be entitled to receive reimbursement for expenses reasonably incurred in conjunction with educational seminars directly related to their function as a hospital board member, subject to such annual budgetary limitations as may be determined from time to time by the Board of Directors.

Section 4.07 Meetings Generally: Organizational Meeting

The meetings of the Board of Directors of the Corporation are subject to the Ralph M. Brown Act, as provided in California Government Code Section 54952(c). The Board of Directors shall hold its meetings in accordance with the agenda, open meeting and other requirements of the Ralph M. Brown Act, Government Code Section 54950 et seq. The Board of Directors shall annually hold organizational meeting where it shall organize by electing from its number the officers provided in Article 6 hereof to hold office until their successors are appointed as herein provided.

Section 4.08 Place

Meetings of the Board of Directors shall be held on the campus of the San Gorgonio Memorial Hospital or at such other place within the boundaries of the District as may be designated from time to time by the Board of Directors.

Section 4.09 Regular Meetings

Regular meetings of the Board of Directors shall be held at such times as may be prescribed from time to time by resolution of the Board of Directors, but not less than ten times annually. Upon adoption of such a resolution, a copy of the resolution shall be delivered to each member of the Board of Directors. Thereafter, no notice of any meeting held pursuant to the schedule described in the resolution shall be required, other than as may be required by law.

Section 4.10 Special Meetings

Special meetings of the Board of Directors shall be held whenever called by the Chair, or not less than four (4) of the Directors.

Section 4.11 Meeting by Telephone

Members of the Board may participate in a meeting through use of conference telephone, electronic video screen communication, or other communications equipment so long as (i) each member participating in the meeting can communicate with all of the other members concurrently, and (ii) each member is provided the means of participating in all matters before the Board, including the capacity to propose, or to interpose an objection, to a specific action to be taken by this Corporation, provided that it complies with California Government Code Section 54953(b).

Section 4.12 Notice and Agenda

At least 72 hours before a regular meeting and at least 24 hours before a special meeting, the Corporation shall post an agenda containing a brief but descriptive general description of each item of business to be transacted or discussed at the meeting, including items to be discussed in closed session in accordance with the Ralph M. Brown Act.

Notice of the time and place of all special meetings of the Board of Directors shall be given to each Director by one of the following methods: (a) by personal delivery of written notice; (b) by first-class mail, postage prepaid; (c) by telephone, including a voice messaging system or technology designed to record and communicate messages, or electronic transmission by the corporation (as defined in California Corporations Code Section 20). All such notices shall be given or sent to the Director's address or telephone number as shown on the records of the Corporation.

Notices sent by first-class mail shall be deposited in the United States mails at least four (4) days before the time set for the meeting. Notices given by personal delivery, telephone, telegraph, facsimile, electronic mail, or other electronic means shall be delivered, telephoned or given to the telegraph company at least forty-eight (48) hours before the time set for the meeting.

The notice shall state the time of the meeting, and the place if the place is other than the principal office of the Corporation. It need not specify the purpose of the meeting.

Notice of the time and place of holding an adjourned meeting need not be given to absent Directors if the time and place are fixed at the meeting adjourned.

Section 4.13 Quorum

A quorum shall consist of a majority of the members of the Board of Directors, unless a greater number is expressly required by statute, by the Articles of Incorporation of this Corporation, or by these Bylaws. Every act or decision done or made by a majority of the Directors present at a meeting duly held at which a quorum is present shall be the act of the Board of Directors, except where any law, regulation, or policy of any governmental agency requires a larger minimum vote in favor of any resolution.

Section 4.14 Conduct of Meetings

The Chair, or in his absence, the Vice Chair or, in the absence of both, a chair chosen by a majority of the Directors present, shall preside at all meetings of the Board of Directors. Meetings shall be governed by such rules of procedure as may be reasonably appropriate under the circumstances, insofar as such rules are not inconsistent or in conflict with these Bylaws, with the Articles of Incorporation of this Corporation, or with law. Each Director present shall have an affirmative duty to vote for or against each matter presented for a vote unless the Director has a conflict of interest that requires the Director to recuse himself. If a Board Member abstains from voting the abstention shall be counted on the side of the matter receiving the highest number of votes. Recusal for these purposes means (i) not voting, and (ii) leaving the meeting after answering any questions posed by the other Directors.

Section 4.15 Meetings Public

All meetings of the Board of Directors shall be open to the public in accordance with the Ralph M. Brown Act, Government Code Section 54950, et seq. and subject to the other terms of said Act. However, certain items, including but not limited to personnel matters, labor negotiations, quality improvement and other protected Medical Staff matters and litigation matters, are not appropriate for public discussion. Accordingly, where an exception to the open meeting requirement exists under the Brown Act, the Health & Safety Code or other applicable law and where the matter is properly agendized the Board of Directors may meet in closed session.

Section 4.16 Adjournment

The Board may adjourn any regular, adjourned, special or adjourned special meeting to a time and place specified in the order of adjournment. A copy of the notice of adjournment shall be conspicuously posted on or near the door of the place where the regular, adjourned regular, special or adjourned special meeting was held within 24 hours after the time of adjournment in accordance with Government Code Section 54955.

Section 4.17 Ethics Training and Sexual Harassment Avoidance Training Requirements

All members of the Board of Directors shall complete a course with a minimum of two hours of training in ethics pursuant to Government Code 54235 (AB 1234), similar to that as is required of the District Board of Directors. Such training will be required of newly appointed Directors within one year of assuming office and shall be renewed each two years thereafter. A certificate of completion showing at least two hours of training must be submitted and placed in each board member's file.

In addition to ethics training, all members of the Board of Directors shall complete a course with a minimum of two hours of training in sexual harassment avoidance pursuant to Government Code 12950.1 (AB 1825 & AB 1661) and 2 CCR 11024. Such training will be required of newly appointed Directors within six months of assuming office and shall be renewed each two years thereafter. A certificate of completion showing at least two hours of training must be submitted and placed in each board member's file.

Section 4.18 Conflicts of Interest and Other Policies

Members of the Board of Directors shall comply with the District's Conflict of Interest Code, as it may be amended or supplemented from time to time, applicable provisions of the Political Reform Act, Government Code Section 81000, et seq., Government Code Section 1090, et seq. and other policies adopted by the Board, including but not limited to its confidentiality policies. As required by the forgoing laws, Board members shall file an FPPC Form 700 with the Corporation within 30 days of taking office, annually, and within 30 days of leaving office.

Section 4.19 Confidentiality: Public Statements

The Board of Directors, and each of its members, shall maintain the confidentiality of any and all information that has been discussed in closed session or that is normally discussed in closed

session. Further, each Director with access to confidential information regarding this Corporation or this Corporation's business is expected to hold such information in confidence and to refrain from either using such information for personal gain or disclosing it unnecessarily outside the scope of the Director's duty with respect to this Corporation. No Board member shall make a public statement on behalf of the Board, or in a manner that appears to be on behalf of the Board, unless a majority of the Board has given prior authorization for the public statement at a duly noticed meeting of the Board of Directors.

Section 4.20 Appropriation of Business Opportunity and Confidential Information

No Director of this Corporation may appropriate or divert to others any opportunity for profit in connection with a transaction in which it is known or could be anticipated that this Corporation is or would be interested. Such opportunities include but are not limited to, acquisition of real or personal property, appointment of suppliers, or design or development of new products, services or areas of business related to this Corporation's present or planned services or service areas.

ARTICLE 5
ELECTION OF DIRECTORS

Section 5.01 Votes Required to Elect Director

Except as provided in Section 4.01 with respect to *ex officio* Directors, a candidate must receive the vote of a majority of the Directors present to be elected as a Director.

Section 5.02 Term of Office of Directors

Directors shall serve a term of four (4) years. Each Director may serve a maximum of two (2) consecutive terms. Former directors will be eligible to serve again after one (1) year of non-service. However, *ex officio* Board members shall serve for a term equal to their term on the District Board, and upon their resignation or removal from the District Board for any reason whatsoever, their terms of office as Directors of this Corporation shall cease and terminate, and their successors on the District Board shall be *ex officio* Directors of this Corporation in their place and stead. Each Director other than *ex-officio* Directors, including a Director elected to fill a vacancy, shall hold office until the expiration of the term for which elected, and until a successor has been appointed. The successor Director shall serve the unexpired term of the predecessor Director. If the unexpired term is two (2) years or less, then the successor Director shall serve a term of four (4) years plus the unexpired term. If the unexpired term is more than two (2) years, then the successor Director shall serve the unexpired term and face re-election to serve a new four (4)-year term.

5.03 Vacancies

a. Events Causing Vacancies. A Board member, including but not limited to an *ex officio* Director as a consequence of being a District Board member, shall be deemed to have vacated his seat on the occurrence of any of the following:

    (1) The death or resignation of the Director.

(2) The declaration or resolution of the Board of the vacancy of the office of a Director who has been declared of unsound mind by an order of court or convicted of a felony or has been found by a final order or judgment of any court to have breached a duty under Sections 5230, et seq., of the California Nonprofit Public Benefit Corporation Law.

(3) Except as provided in Section 4.01 with respect to *ex officio* Directors, any Director may be removed, either with or without cause, by majority vote of the Directors then in office, at any regular or special meeting of the Board of Directors.

(4) Except as provided in Section 4.01 with respect to *ex officio* Directors, the absence of a Director from three consecutive meetings of the Board of Directors, and the determination of a majority of the remaining members of the Board of Directors that such absence was not excused.

(5) An increase in the authorized number of Directors.

(6) The failure of the Directors, at any meeting of the Directors at which any Director or Directors are to be elected, to fill a vacancy scheduled to be filled by election at such meeting.

b. Resignations. Any Director may resign, which resignation shall be effective upon giving written notice to the Chair, the Chief Executive Officer, the Secretary, or the Board of Directors, unless the notice specifies a later time for the resignation to be effective. If the resignation of a Director is effective at a future time, the Board of Directors may elect a successor to take office when the resignation becomes effective.

c. Vacancies of Directors. An Ad Hoc nominating committee will be formed for the purpose of recommending candidates to fill vacancies of Directors. This committee will be appointed in adherence with Section 7.06 and will include no less than two (2) *ex officio* Directors from the District Board. The Directors may elect a Director or Directors at any time to fill any vacancy or vacancies in the Board of Directors. Directors elected to fill a vacancy or vacancies in the Board of Directors of *ex officio* Directors by virtue of being a District Board member need to be the Director elected to the District Board to fill the vacancy on the District Board.

d. No Vacancy on Reduction of Number of Directors. No reduction of the authorized number of Directors shall have the effect of removing any Director before that Director's term of office expires unless such an intent is shown in the records of the meeting and a majority of the directors approve the reduction in number of directors.

ARTICLE 6
OFFICERS

Section 6.01 Number and Titles

The Officers of this Corporation shall be a Chair of the Board, a Vice Chair, a Secretary, and a Treasurer. This Corporation may also have, at the Board's discretion, one or more Assistant Secretaries, one or more Assistant Treasurers, and such other officers as may be appointed in accordance with these Bylaws. Any number of offices may be held by the same person, except that neither the Secretary nor the Treasurer may serve concurrently as the Chair of the Board. The Board shall also appoint a Chief Executive Officer and a Chief Financial Officer of the Corporation who shall be salaried employees of the Corporation.

Section 6.02 Other Officers

The Board may appoint and may authorize the Chair of the Board, or other officer, to appoint such additional officers that the Corporation may require. Each Officer so appointed shall have the title, hold office for the period, have the authority, and perform the duties specified in these Bylaws or determined by the Board.

Section 6.03 Qualification, Election, and Term of Office

The Officers of the Corporation, except those appointed under Section 6.02 of these Bylaws, shall be elected by majority vote of the Directors present at the annual organizational meeting of the Board of Directors. No more than two (2) Officers of the Corporation may be Directors of the District serving as ex officio Directors. Each such Officer shall hold office until the next organizational meeting, or until his removal, death, or resignation. The Officers shall hold their respective offices at the pleasure of the Board of Directors and shall be subject to removal by the Board of Directors at any time.

Section 6.04 Removal and Resignation

Any Officer may be removed, either with or without cause, by majority vote of the Directors then in office, at any regular or special meeting of the Board of Directors, and such Officer shall be removed should he cease to be qualified for the office as herein required. Subject to the terms of any written employment agreement between an officer and the Corporation, any Officer may resign at any time by delivering written notice to the Board of Directors or to the Chair or to the Secretary of the Corporation. Acceptance by the Board of Directors of any such resignation shall not be necessary to make it effective.

Section 6.05 Vacancies

Any vacancy caused by the death, resignation, removal, disqualification, or the like, of an Officer shall be filled by majority vote of the Board of Directors for the unexpired portion of the term.

Section 6.06 Duties of Chair

The Chair of the Board shall preside at meetings of the Board and shall exercise and perform such other powers and duties as the Board may assign from time to time.

Section 6.07 Duties of Vice Chair

If the Chair is absent or disabled, the Vice Chair shall perform all duties of the Chair. When so acting, the Vice Chair shall have all powers of and be subject to all restrictions on the Chair. The Vice Chair shall have such other powers and perform such other duties as the Board or these Bylaws may prescribe.

Section 6.08 Duties of Secretary

The Secretary shall keep or cause to be kept, at the Corporation's principal office or such other place as the Board may direct, a book of minutes of all meetings, proceedings, and actions of the Board and Committees of the Board. The Secretary shall keep or cause to be kept, at the principal office in California, a copy of the Articles of Incorporation and Bylaws, as amended to date.

The Secretary shall give, or cause to be given, notice of all meetings of the Board and of Committees of the Board required by these Bylaws or the California Corporations Code. The Secretary shall keep the Corporate Seal in safe custody and shall have such other powers and perform such other duties as the Board or these Bylaws may prescribe.

Section 6.09 Duties of Treasurer

The Treasurer shall keep and maintain, or cause to be kept and maintained, adequate and correct books and accounts of the Corporation's properties and transactions. The Treasurer shall send or cause to be given to the Directors such financial statements and reports as are required to be given by law, by these Bylaws, or by the Board. The books of account shall be open to inspection by any Director at all reasonable times.

The Treasurer shall deposit or cause to be deposited, all money and other valuables in the name and to the credit of the Corporation with such depositories as the Board may designate, shall disburse the Corporation's funds as the Board may order, shall render to the Chair of the Board, to the Chief Executive Officer, and to the Board, when requested, an account of all transactions as Treasurer and of the financial condition of the Corporation, and shall have such other powers and perform such other duties as the Board or these Bylaws may prescribe. If required by the Board, the Treasurer shall give the Corporation a bond in the amount and with the surety or sureties specified by the Board for faithful performance of the duties of the office and for restoration to the Corporation of all of its books, papers, vouchers, money, and other property of every kind in the possession or under the control of the Treasurer on his or her death, resignation, retirement or removal from office.

Section 6.10 Duties of Chief Executive Officer

Subject to such supervisory powers as the Board may give to the Chair of the Board, if any, and subject to the control of the Board, the Chief Executive Officer ("CEO") shall be the General Manager of the Corporation and shall supervise, direct, and control the Corporation's activities, affairs, and officers. The Chief Executive Officer shall have such other powers and duties as the Board or these Bylaws may prescribe. The authority and responsibility of the CEO shall include

a. carrying out all policies established by the Board.

b. development, and submission to the Board for approval, of a strategic plan for the organization and operation of the Hospital.

c. preparation of an annual budget showing the expected receipts and expenditures of the Corporation.

d. selection, employment, control and discharge of employees, and development and maintenance of personnel policies and practices for the Hospital.

e. maintenance of physical properties in a good state of repair and operating condition.

f. supervision of all business affairs to ensure that funds are collected and expended to the best possible advantage.

g. cooperation with the Medical Staff and with all those concerned with the rendering of professional services to the end that high quality care shall be rendered to the patients.

h. presentation to the Board of periodic reports reflecting the services provided by the Hospital and the financial activities of the Corporation and preparation and submission of such special reports as may be required by the Board.

i. attendance at all meetings of the Board and committees thereof.

Section 6.11 Execution of Contracts

The Board may authorize any officer or officers, agent or agents, including but not limited to the Chief Executive Officer, to enter into any contract or execute any instrument in the name of and on behalf of the Corporation. Such authority may be general or confined to specific instances and may be established by the Bylaws, Resolutions or the adoption of specific policies and procedures from time to time; provided, however, that unless so authorized by the Board, no officer, agent, or employee shall have any power or authority to bind the Corporation by a contract or engagement, or to pledge its credit, or to render it liable for any purpose or any amount.

ARTICLE 7
COMMITTEES

Section 7.01 Committees of the Board

The committees of the Board may be standing or special. Standing committees shall be the Finance Committee, the Human Resources Committee, and the Community Planning Committee, and other standing committees may also be authorized by the approval of the Board of Directors (collectively, "standing committees").

For special committees, the Board, by resolution adopted by a majority of the Directors then in office, provided a quorum is present, may create one (1) or more special Committees ("special committees"). Each special committee will have a minimum of three (3) and a maximum of five (5) members who may be Directors and persons who are not Directors who serve at the pleasure of the Board. No more than two (2) members of any special committee may be Directors of the District serving as *ex officio* Directors.

Except as otherwise provided in these Bylaws, all committee member appointments (including the appointment of Committee Chairs) shall be made by the Chair of the Board. The Chair of each Committee must be a member of the Board of Directors. A committee member shall serve his or her designated term unless he or she resigns, is removed or otherwise disqualified to serve, and all committee member terms shall terminate with the reorganization of the Board of Directors at the annual organizational meeting. Committee members shall not be entitled to compensation.

Each committee member shall be entitled to one (1) vote, to be exercised in person. Neither cumulative, substitute, nor proxy voting shall be allowed. A majority of the committee members shall constitute a quorum. All matters submitted to the committee for determination shall be decided by a minimum of a majority of a quorum of committee members.

Except as otherwise provided in these Bylaws, meetings of the committee may be called at any time by the Board Chair or the Chair of the committee. Meetings of all committees shall be open to the public in accordance with the Ralph M. Brown Act, Government Code Section 54950, et seq. and subject to the other terms of said Act as set forth in Section 4.15 of these Bylaws. A summary of all committee meetings including but not limited to all action of such committees shall be reported to the Board of Directors at the next regular or special meeting thereof.

Except as otherwise specifically described herein, the following Sections of these Bylaws pertaining to the Board of Directors shall pertain to members of committees: Section 4.17 Ethics Training and Sexual Harassment Avoidance Training Requirements, Section 4.18 Conflicts of Interest and Other Policies, Section 4.19 Confidentiality: Public Statements, and Section 4.20 Appropriation of Business Opportunity and Confidential Information.

All committees shall be advisory and no committee shall have the power to bind the Board, except when specifically authorized by the Board. The Board may delegate management of certain activities of the Corporation to any such committee as specified in the Board resolution, provided that the activities and affairs of the Corporation shall be managed and all corporate powers shall

be exercised under the ultimate direction of the Board and provided further that no committee, regardless of Board resolution, may:

a. Take any final action on any matter that, under the California Nonprofit Public Benefit Corporation Law, also requires approval of the members or of the Board of Directors or approval of a majority of all members or of the Board of Directors;

b. Fill vacancies on the Board or on any Committee that has the authority of the Board;

c. Fix compensation of the Directors for serving on the Board or on any Committee;

d. Amend or repeal Bylaws or adopt new Bylaws;

e. Amend or repeal any resolution of the Board that by its express terms is not so amendable or repealable;

f. Create any other Committees of the Board or appoint the members of the Committees of the Board;

g. Expend corporate funds to support a nominee for Director after more people have been nominated for Director than can be elected; or

h. Approve any contract or transaction to which the Corporation is a party and in which one (1) or more of its Directors has a material financial interest, except as special approval is provided for in Section 5233(d)(3) of the California Corporations Code.

Section 7.02 Executive Committee

The Executive Committee of the Board of Directors, shall consist of the Board Chair, the Board Vice Chair, the Board Secretary, the Board Treasurer and one (1) Director to be selected via a vote held by the Directors of the District serving as ex officio Directors. Each member of the Executive Committee must be a Director. No more than two (2) members of the Executive Committee may be Directors of the District serving as ex officio Directors.

The Executive Committee shall be delegated all powers and authority of the Board of Directors in the management of the business and affairs of the Corporation, except those powers reserved to the Board of Directors as a whole pursuant to Section 7.01. The Executive Committee shall meet quarterly to conduct its business, at a time and place to be designated by the members, or as otherwise provided by an appropriate resolution. The Executive Committee shall also hold special meetings on the call of the Chair.

Section 7.03 Finance Committee

The Finance Committee shall consist of a minimum of three (3) and a maximum of five (5) members of the Board of Directors, together with the Chief Executive Officer and the Chief Financial Officer. No more than two (2) members of the Finance Committee may be Directors of the District serving as *ex officio* Directors. The Finance Committee shall meet monthly, and shall be responsible for advising the Board for the management of all funds of the Corporation. It shall review and submit to the Board each year a proposed budget showing the expected receipts and income for the ensuing year. It shall make recommendations on all major capital expenditures, and significant hospital rate changes. It shall review and make recommendations to the Board of Directors with respect to all salary and wage adjustments, and for overall budget projections. It shall recommend a written plan for annual operations and for a three-year capital expenditure plan, which shall be updated annually.

Section 7.04 Human Resources Committee

The Human Resources Committee shall consist of a minimum of three (3) and a maximum of five (5) members of the Board of Directors, together with the Chief Executive Officer and the Director of Human Resources. No more than two (2) members of the Human Resources Committee may be Directors of the District serving as *ex officio* Directors. The Human Resources Committee shall meet bi-monthly for the purpose of determining the changing personnel requirements of the Hospital, reviewing and analyzing potential modifications to the Hospital's wage and benefit plans, and generally making recommendations to the full Board of Directors regarding personnel matters within the Hospital.

Section 7.05 Community Planning Committee

The Community Planning Committee shall consist of a minimum of three (3) and a maximum of five (5) members of the Board of Directors in addition to the Chief Executive Officer. No more than two (2) members of the Community Planning Committee may be Directors of the District serving as *ex officio* Directors. Community Planning Committee shall meet quarterly for the purpose of determining proposed long range goals for the Hospital and recommendations for methods whereby such goals may be accomplished. Areas of planning shall include, but shall not be limited to, potential expansion, contraction or modification of services rendered by the Hospital, determining and seeking methods of accomplishing marketing goals for the Hospital, including but not limited to those relating to advertising, community involvement, physician recruitment, patient relations and insurance and other third party payment programs (such as HMOs, PPOs and employer groups). All recommendations shall be presented to the Board of Directors for approval or action.

Section 7.06 Ad Hoc Committees

Ad hoc committees may be appointed by the Chair of the Board, with the concurrence of the majority of the Board and in such numbers and for such special tasks as circumstances warrant. Such special Committees shall limit their activities to the accomplishment of the task for which created and appointed, and shall have no power to act except such as is specifically conferred by

action of the Board. Upon completion of the tasks for which appointed, each such special committee shall stand discharged.

ARTICLE 8
MEDICAL STAFF

Section 8.01 Organization

The Board shall cause to be created a Medical Staff organization, to be known as the Medical Staff of San Gorgonio Memorial Hospital, whose membership shall be comprised of all duly licensed physicians, dentists, psychologists and podiatrists who are privileged to attend patients in the Hospital. Membership in this Medical Staff organization shall be a prerequisite to the exercise of clinical privileges in the Hospital, except as otherwise specifically provided in the Medical Staff Bylaws. No applicant to the Medical Staff shall be denied Medical Staff membership on the basis of sex, race, creed, color or national origin, or on the basis of any other criterion lacking professional justification.

Section 8.02 Medical Staff Bylaws, Rules and Regulations

a. **Purpose.** The Medical Staff organization shall propose and adopt by vote bylaws, rules and regulations for its internal governance ("Medical Staff Bylaws") which shall be effective when approved by the Board. These Medical Staff Bylaws shall create an effective administrative unit to discharge the functions and responsibilities assigned to the Medical Staff by the Board. The Medical Staff Bylaws, rules and regulations shall state the purposes, functions and policies by which the Medical Staff exercises its responsibilities. The Board of Directors will review and approve the Medical Staff Bylaws annually.

b. **Procedure.** The Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. If the Medical Staff fails to exercise this responsibility in good faith and in a reasonable, timely and responsible manner and after written notice from the Board to such effect including a reasonable period of time for response, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws. In such event, staff recommendations and views shall be carefully considered by the Board during its deliberation and in its actions.

Section 8.03 Medical Staff Membership and Clinical Privileges

a. **Responsibilities of the Medical Staff Members.** Each member of the Medical Staff shall have appropriate authority and responsibility for the care of his/her patients, subject to such limitations as are contained in these Bylaws, and in the Medical Staff Bylaws, and subject, further, to limitations attached to his/her appointment. The attending physician shall be responsible for preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include, at a minimum: identification data; chief complaint; past history; family history; history of present illness;

physical examination; special reports such as necessary consultations; clinical laboratory reports and radiology reports and others; provisional diagnosis; appropriate consents; medical and surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; discharge summary and autopsy report when applicable. The CEO shall arrange for all administrative assistance to receive appointment applications to the Medical Staff, and further to provide for necessary administration support to process all materials pertinent to the application of any potential member of the Medical Staff. All applications for and appointments to the Medical Staff shall be in writing and addressed to the Medical Staff Office. The application shall contain full information concerning the applicant's education, licensure, practice, previous hospital experience, and any unfavorable history with regard to licensure and hospital privileges. This information shall be verified by the appropriate body within the Medical Staff. Upon appointment, the applicant will agree in writing to follow the Bylaws, rules and regulations of the Corporation and of the Medical Staff, and all other approved policies of the Medical Staff and the Corporation. All applications shall be reviewed by the Medical Staff prior to being submitted to the Governing Body for approval. When an appointment is not renewed or when privileges have been proposed to be reduced, altered, suspended, or terminated, the staff member shall be afforded the opportunity of a hearing in accordance with the Fair Hearing Plan then in effect. It is the Board of Directors' policy that: (1) only a member of the Medical Staff with admitting privileges shall admit patients to the Hospital; (2) only an appropriately licensed practitioner with clinical privileges shall be directly responsible for a patient's diagnosis and treatment within the area of his privileges; (3) each patient's general medical condition shall be the responsibility of a physician member of the Medical Staff; (4) each patient admitted to the Hospital shall receive a baseline history and physician examination by a physician who is either a member of, or approved by, the Medical Staff; and (5) direct medical care of patients provided by Allied Health Personnel shall be under the appropriate degree of supervision by a licensed practitioner with clinical privileges.

b. **Delegation to the Medical Staff.** The Board shall delegate to the Medical Staff the responsibility and authority to investigate and evaluate all matters relating to Medical Staff membership status, clinical privileges and corrective action, and shall require that the Medical Staff adopt and forward to it specific written recommendations with appropriate supporting documentation that will allow the Board to take informed action.

c. **Action by the Board.** Final action on all matters relating to Medical Staff membership status, clinical privileges and corrective action shall be taken by the Board after considering the Medical Staff recommendations, provided that the Board shall act in any event if the Medical Staff fails to adopt and submit any such recommendation within the time period set forth in the Medical Staff Bylaws. Such Board action without a Medical Staff recommendation shall be based on the same kind of documented investigation and evaluation of current

ability, judgment and character as is required for Medical Staff recommendation, and shall be taken only after written notice to the Medical Executive Committee.

d. **Criteria for Board Action.** In acting on matters of Medical Staff membership status, the Board shall consider the Medical Staffs recommendations and the extent of applicant's utilization of this Hospital, the Hospital's and the community's needs, and such additional criteria as are set forth in the Medical Staff Bylaws. No aspect of membership status nor any specific clinical privileges shall be limited or denied to a practitioner on the basis of sex, race, creed, color, or national origin, nor on the basis of any other criterion unrelated to: (i) good patient care at the Hospital, (ii) professional qualifications, (iii) the Hospital's purposes, needs and capabilities, or (iv) community needs.

e. **Terms and Conditions of Medical Staff Membership and Clinical Privileges.** The terms and conditions of membership status in the Medical Staff, and the exercise of clinical privileges, shall be as specified in the Medical Staff Bylaws or as more specifically defined in the notice of individual appointment. At a minimum, however, each member of the Medical Staff shall (1) exhibit the skill necessary to allow him to appropriately carry out his duties and (2) carry such malpractice insurance as may be determined to be appropriate from time to time by the Board of Directors. Additionally, each member of the Medical Staff having active staff privileges shall provide on-call back-up coverage within his field of specialty to the Hospital's Emergency Room, pursuant to such back-up call schedule as may be adopted by his Service of the Medical Staff. If no other back-up call coverage schedule is adopted by a Service, Emergency Room back-up call coverage for such Service shall be scheduled on the basis of alphabetical order by last name within such Service, rotating among all active staff physicians within the Service, each being responsible for 24 hour back-up coverage.

f. **Ethics.** The Principles of Ethics of the appropriate National Association as now in effect or as may be hereinafter amended by that association shall govern the professional conduct of the members of the Medical Staff.

g. **Procedure.** The procedure to be followed by the Medical Staff and the Board in acting on matters of membership status, clinical privileges, and corrective action shall be specified in the Medical Staff Bylaws. However, each member of the Medical Staff shall be required to obtain and maintain, at his or her own expense, malpractice insurance in such amount as may be determined to be appropriate from time to time by the Board of Directors.

h. **Fair Hearing Plan.** The Board shall require that any adverse recommendation made by the Medical Executive Committee or any adverse action taken by the Board of Directors with respect to a practitioner's staff appointment, reappointment, Service affiliation, staff category, admitting prerogative or clinical privileges, shall, except under circumstances for which specific

provision is made in the Medical Staff Bylaws, be accomplished in accordance with the Fair Hearing Plan then in effect. Such plan shall provide for procedures to assure fair treatment and afford an opportunity for presentation of all pertinent information. For the purposes of this Section an "adverse recommendation" of the Medical Executive Committee and "adverse action" of the Board shall be defined in the Fair Hearing Plan. The Fair Hearing Plan shall provide for an appeals procedure whereby any applicant for Medical Staff Membership feels a decision of the Medical Staff has been unjust shall have recourse to a hearing by a joint committee composed of Directors and Medical Staff Members. The appellant in such a case shall have the opportunity to present any and all evidence and testimony bearing upon his qualifications for appointment to the Medical Staff. Following such presentation of evidence, the Committee shall present evidence in support of its findings. Failure of an applicant to request a hearing within the time frames set forth in the Fair Hearing Plan shall constitute a waiver of the applicant's rights to a hearing under the Fair Hearing Plan.

ARTICLE 9
QUALITY OF PROFESSIONAL SERVICES

Section 9.01 Board Responsibility

The Board shall require, after considering the recommendations of the Medical Staff, and the other health care professional staffs providing patient care services, the conduct of specific review and evaluation activities to assess, preserve and improve the overall quality and efficiency of patient care in the Hospital. The Board, through the CEO, shall provide whatever administrative assistance is reasonably necessary to support and facilitate the implementation and the ongoing maintenance and operation of these review and evaluation activities.

Section 9.02 Accountability to Board

The Medical Staff and the other health care professionals providing patient care services shall conduct and be accountable to the Board for conducting activities that contribute to the preservation and improvement of the quality, safety and efficiency of patient care provided in the Hospital. These activities include:

a. Review and evaluation of the quality of patient care (generally on a retrospective basis) through a valid and reliable patient care review procedure.

b. Ongoing monitoring and evaluation of patient care practices through the defined functions of the Medical Staff, the other professional services, and the Hospital administration.

c. Delineation of clinical privileges for members of the Medical Staff commensurate with individual credentials and demonstrated ability and judgment and assignment of patient care responsibilities to other health care professionals consistent with individual qualification and demonstrated ability.

d. Review of utilization of the Hospital's resources to provide appropriate allocation of those resources to patients in need of them.

e. Such other measures as the Board may, after considering the advice of the Medical Staff, the other professional services and the Hospital administration, deem necessary for the preservation and improvement of the quality, safety and efficiency of patient care.

Section 9.03 Documentation

The Board shall require, receive, consider and act upon the findings and recommendations emanating from the activities required by Article 8. All such findings and recommendations shall be in writing, and shall be supported and accompanied by appropriate documentation upon which the Board can take informed action.

ARTICLE 10
BOARD OF DIRECTORS INITIATION OF PEER REVIEW

Section 10.01 Basic Policy

It is the policy of this Hospital that peer review be performed by members of the Medical Staff, inasmuch as only licentiates who possess the same or similar education, training and experience have the requisite expertise to insure an efficient, fair and responsive peer review system. Notwithstanding the foregoing, however, in those instances in which the Medical Staffs failure to investigate or to initiate disciplinary action is contrary to the weight of the evidence, the Board of Directors shall have the authority to direct the Medical Executive Committee to initiate an investigation or disciplinary action, but only after consultation with the Chief of Staff. No action shall be taken in an unreasonable manner. In the event the Medical Staff fails to take action in response to a direction from the Board of Directors, the Board of Directors shall have the authority to take action against a member of the Medical Staff. Such action shall be taken only after written notice to the Medical Staff and shall fully comply with the procedures and rules applicable to peer review proceedings established by Sections 809.1 through 809.6, inclusive, of the Business and Professions Code of the State of California.

Section 10.02 Suspension of Privileges

When no person authorized by the Medical Staff is available to summarily suspend or restrict clinical privileges, the Board of Directors, or its designee, may immediately suspend the clinical privileges of a member of the Medical Staff if the failure to summarily suspend those privileges is likely to result in an imminent danger to the health of any individual; provided the Board of Directors has, before the suspension, made reasonable attempts to contact the Medical Executive Committee. A suspension by the Board of Directors which has not been ratified by the Medical Executive Committee within two working days, excluding weekends and holidays, shall terminate automatically.

ARTICLE 11
INDEMNIFICATION

Section 11.01 Right of Indemnity

To the fullest extent permitted by law, this Corporation shall indemnify its Directors, Officers, employees, and other persons described in Section 5238(a) of the California Corporations Code, including persons formerly occupying any such position, against all expenses, judgments, fines, settlements and other amounts actually and reasonably incurred by them in connection with any "proceeding", as that term is used in that section, and including an action by or in the right of the Corporation, by reason of the fact that the person is, or was, a person described in that section. "Expenses", as used in these Bylaws, shall have the same meaning as in Section 5238(a) of the California Corporations Code.

Section 11.02 Approval of Indemnity

On written request to the Board by any person seeking indemnification under Section 5238(b) or Section 5238(c) of the California Corporations Code, the Board shall promptly determine under Section 5238(e) of the California Corporations Code whether the applicable standard of conduct set forth in Section 5238(b) or Section 5238(c) has been met and, if so, the Board shall authorize indemnification.

Section 11.03 Advancement of Expenses

To the fullest extent permitted by law, and except as otherwise determined by the Board in a specific instance, expenses incurred by a person seeking indemnification under Sections 11.01, 11.02 or 11.03 of this Article in defending any proceeding covered by those sections shall be advanced by the Corporation before final disposition of the proceeding, on receipt by the Corporation of an undertaking by or on behalf of that person that the advance will be repaid unless it is ultimately determined that the person is entitled to be indemnified by the Corporation for those expenses.

Section 11.04 Insurance

The Corporation shall have the right to purchase and maintain insurance to the full extent permitted by law on behalf of its Officers, Directors, and employees.

Section 11.05 Other Fiduciary Positions

This Article does not apply to any proceeding against any trustee, investment manager or other fiduciary of an employee benefit plan in such person's capacity as such, even though such person may also be covered by the first sentence of Section 1 of this Article 11. This Corporation shall have power to indemnify such trustee, investment manager or other fiduciary to the extent permitted by subsection (f) of Section 5140 of the California Corporations Code.

Section 11.06 Provisions Not Exclusive

The indemnification and advancement of expenses provided by this Article 11 of these Bylaws shall not be deemed exclusive of any rights to which those seeking indemnification or expense advancement may be entitled under any agreement, vote of disinterested Directors, or otherwise, both as to action in his or her official capacity while holding such office, and shall continue as to a person who has ceased to be a Director, officer, or employee and agent, and shall inure to the benefit of the heirs, executors and administrators of such person.

Section 11.07 Contractual Rights of Non-Directors and Non-Officers

Nothing contained in this Article 11 shall affect any right to indemnification to which persons other than Directors of the Corporation, or any of its subsidiaries, may be entitled by contract or otherwise.

ARTICLE 12
CORPORATE RECORDS, REPORTS, AND SEAL

Section 12.01 Minutes of Meetings

The Corporation shall keep at its principal office, or at such other place as the Board of Directors may order, a book of the minutes of all meetings of Directors with the time and place of holding, whether regular or special, and, if special how authorized, the notice given and the names of those Directors and presenting staff present.

Section 12.02 Books of Account

The Corporation shall keep and maintain adequate and correct accounts of its properties and business transactions, including accounts of its assets, liabilities, receipts, disbursements, gains, and losses.

Section 12.03 Annual Report

The Corporation shall cause an annual report or statement to be sent to the Board of Directors not later than 120 days after the close of the fiscal year in accordance with the provisions of Sections 1500 and 1501. Such report shall contain a balance sheet as of the end of the fiscal year, an income statement and a statement of changes in financial position for such fiscal year, all prepared according to generally accepted accounting procedures, and accompanied by any report thereon of an independent accountant, or if there is no such report, a certificate of the Chief Financial Officer or Chief Executive Officer that such statements were prepared without audit from the books and records of the Corporation. The report shall also provide any information required by California Corporations Code Section 6322.

Section 12.04 Maintenance of Records and Inspection by Directors

The Corporation shall keep at its principal executive office the original or a copy of the Articles of Incorporation, Bylaws, and other records of the Corporation. Every Director shall have the absolute right at any reasonable time to inspect all books, records, and documents of every

kind and the physical properties of the Corporation and each subsidiary corporation. This inspection by a Director may be made in person or by an agent or attorney, and the right of inspection includes the right to copy and make extract of documents.

Section 12.05 Corporate Seal

The Board of Directors shall provide a corporate seal consisting of two concentric circles with the words "San Gorgonio Memorial Hospital", and the words and figures, "INCORPORATED May 8, 1990, CALIFORNIA."

ARTICLE 13
HOSPITAL AUXILIARY AND FOUNDATION

The Hospital Auxiliary shall be an integral part of this Corporation, and shall have no separate existence as a corporation or other unincorporated association. The Bylaws of the Hospital Auxiliary shall be approved by the Board of Directors of the Hospital. The Hospital Foundation shall be a separate and independent corporation existing for the benefit of the Hospital.

ARTICLE 14
EFFECTIVE DATE & AMENDMENT

Section 14.01 Effective Date

These Bylaws shall become effective immediately upon their adoption and shall supersede and replace all previous Bylaws of the Corporation. Amendments to these Bylaws shall become effective immediately upon their adoption.

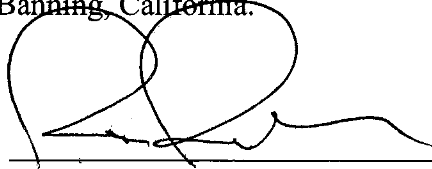
Section 14.02 Amendment

Except as otherwise provided herein or by law, the Board may, after lawful notice to all Directors then in office, adopt, amend or repeal these Bylaws upon the majority vote of the Directors, provided a quorum is present.

CERTIFICATE OF SECRETARY

I certify that I am the duly elected and acting Secretary of SAN GORGONIO MEMORIAL HOSPITAL, and that the above Amended and Restated Bylaws, consisting of 28 pages, are the Bylaws of this Corporation as adopted by the Corporation's Board of Directors on January 4, 2022, that they supersede all previous versions of the Bylaws for the Corporation.

Executed on January 21, 2022, at Banning, California.



Ron Rader, Secretary

TAB H

HOSPITAL BOARD
2023 MEETING DATES FOR BOARD APPROVAL

Hospital Board – meeting begins at 4:00 pm

Tuesday, January 3
Tuesday, February 7
Tuesday, March 7
Tuesday, April 4
Tuesday, May 2
Tuesday, June 6
Tuesday, July 11 → Administration is closed on July 4.
Tuesday, August 1
Tuesday, September 5
Tuesday, October 3
Tuesday, November 7
Tuesday, December 5

Executive Committee – 10:00 am

Tuesday, March 28
Tuesday, June 27
Tuesday, September 26
Tuesday, December 26

Finance Committee – meeting begins at 9:00 am

Tuesday, January 31
Tuesday, February 28
Tuesday, March 28
Tuesday, April 25
Tuesday, May 30
Tuesday, June 27
Tuesday, July 25
Tuesday, August 29
Tuesday, September 26
Tuesday, October 31
Tuesday, November 28
Tuesday, December 26

Human Resources Committee – meeting begins at 9:00 am

Wednesday, January 18, 2023~~February 15~~
Wednesday, April 19, 2023~~May 17~~
Wednesday, July 21, 2023~~August 16~~
Wednesday, October 18, 2023~~November 15~~

Community Planning Committee – meetings begins at 10:00 am ~~9:00 am~~

Wednesday, January 18, 2023~~Tuesday, February 14~~
Wednesday, April 19, 2023~~Tuesday, May 16~~
Wednesday, July 21, 2023~~Tuesday, August 15~~
Wednesday, October 18, 2023~~Tuesday, November 14~~

TAB I

MINUTES: Not Yet Approved by Committee

REGULAR MEETING OF THE
SAN GORGONIO MEMORIAL HOSPITAL
BOARD OF DIRECTORS

FINANCE COMMITTEE
Tuesday, November 29, 2022

The regular meeting of the San Gorgonio Memorial Hospital Board of Directors Finance Committee was held on Tuesday, November 29, 2022, in Classroom B, 600 N. Highland Springs Avenue, Banning, California.

Members Present: Susan DiBiasi, Ron Rader, Steve Rutledge, Siri Welch

Members Absent: Ehren Ngo (Chair)

Required Staff: Steve Barron (CEO), Daniel Heckathorne (CFO), Annah Karam (CHRO), Ariel Whitley (Executive Assistant), Angela Brady (ED Director)

AGENDA ITEM	DISCUSSION	ACTION / FOLLOW-UP
Call To Order	Susan DiBiasi called the meeting to order at 9:03 am.	
Public Comment	No public present.	
OLD BUSINESS		
Proposed Action - Approve Minutes **October 25, 2022, regular meeting**	Susan DiBiasi asked for any changes or corrections to the minutes of the October 25, 2022, regular meeting. There were none.	**The minutes of the October 25, 2022, regular meeting will stand correct as presented.**
NEW BUSINESS		
Proposed Action – Recommend Approval to Hospital Board of Directors - Monthly Financial Report (Unaudited) – October 2022	Daniel Heckathorne, CFO, reviewed the Unaudited October 2022 finance report as included in the committee packets. The month of October resulted in negative $1.25M EBIDA compared to budgeted EBIDA loss of $1.55M. Adjustments and items of note include: • Surgery visits remained high at 157 plus 13 G.I. procedures. • Emergency visits were high again at 3,619. • Deductions from Revenues were favorably impacted by $41K for the Residency Program. • Total Operating Expenses were $812K below budget. It was noted that approval is recommended to the Hospital Board.	**M.S.C. (Rader/Welch), the SGMH Finance Committee voted to recommend approval of the Unaudited October 2022 Financial report to the Hospital Board of Directors.**

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION</th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td></td><td>ROLL CALL:
<table><tr><td>DiBiasi</td><td>Yes</td><td>Ngo</td><td>Absent</td></tr><tr><td>Rader</td><td>Yes</td><td>Rutledge</td><td>Yes</td></tr><tr><td>Welch</td><td>Yes</td><td colspan="2">Motion carried.</td></tr></table></td><td></td></tr>
<tr><td>Proposed Action – Recommend Approval to Hospital Board and Healthcare District Board of District Hospital Leadership Forum (DHLF) Annual Dues Renewal</td><td>San Gorgonio Memorial Healthcare District & Hospital have been members of the DHFL for many years. The DHLF is the group which formally oversees the overall guidance and planning for all matters related to Supplemental Funding on behalf of California Healthcare Districts. DHLF also coordinates their efforts with numerous California agencies (including CHA) in areas that impact the Healthcare Districts.

It was noted that approval is recommended to the Hospital Board and Healthcare District Board.
ROLL CALL:
<table><tr><td>DiBiasi</td><td>Yes</td><td>Ngo</td><td>Absent</td></tr><tr><td>Rader</td><td>Yes</td><td>Rutledge</td><td>Yes</td></tr><tr><td>Welch</td><td>Yes</td><td colspan="2">Motion carried.</td></tr></table></td><td>M.S.C. (Rutledge/Rader), the SGMH Finance Committee voted to recommend approval of the District Hospital Leadership Forum (DHLF) Annual Dues Renewal to the Hospital Board and Healthcare District Board.</td></tr>
<tr><td>Proposed Action – Recommend Approval to Hospital Board and Healthcare District Board – FYE 22 Financial Audit</td><td>Dan Heckathorne, CFO, introduced David Imus of Wipfli, LLP. David presented the FYE 22 Financial Audit.

It was noted that approval is recommended to the Hospital Board and Healthcare District Board.

ROLL CALL:
<table><tr><td>DiBiasi</td><td>Yes</td><td>Ngo</td><td>Absent</td></tr><tr><td>Rader</td><td>Yes</td><td>Rutledge</td><td>Yes</td></tr><tr><td>Welch</td><td>Yes</td><td colspan="2">Motion carried.</td></tr></table></td><td>M.S.C. (Rader/Rutledge), the SGMH Finance Committee voted to recommend approval of the FYE 22 Financial Audit to the Hospital Board and Healthcare District Board.</td></tr>
<tr><td>Future Agenda Items</td><td>• Line of Credit Renewal</td><td></td></tr>
<tr><td>Next Meeting</td><td>The next regular Finance Committee meeting will be held on December 27, 2022.</td><td></td></tr>
<tr><td>Adjournment</td><td>The meeting was adjourned 10:07 am.</td><td></td></tr>
</table>

In accordance with The Brown Act, *Section 54957.5*, all reports, and handouts discussed during this Open Session meeting are public records and are available for public inspection. These reports and/or handouts are available for review at the Hospital Administration office located at 600 N. Highland Springs Avenue, Banning, CA 92220 during regular business hours, Monday through Friday, 8:00 am - 4:30 pm.

Minutes respectfully submitted by Ariel Whitley, Executive Assistant

SAN GORGONIO MEMORIAL HOSPITAL

BANNING, CALIFORNIA

Unaudited Financial Statements

for

FOUR MONTHS ENDING OCTOBER 31, 2022

FY 2023

Certification Statement:
To the best of my knowledge, I certify for the hospital that the attached financial statements, except for the uncertainty of IGT revenue accruals, do not contain any untrue statement of a material fact or omit to state a material fact that would make the financial statements misleading. I further certify that the financial statements present in all material respsects the financial condition and results of operation of the hospital and all related organizations reported herein. Note: Certain Balance Sheet items, including "Total Net Assets" do not include or reflect all of the final audit entries from the FYE June 30, 2022. Because these reports are prepared for internal users only, they do not purport to conform to the principles contained in U.S. GAAP.

Certified by:
Daniel R. Heckathorne
Daniel R. Heckathorne

CFO

San Gorgonio Memorial Hospital

Financial Report - Executive Summary

For the Month of October, 2022 and Four Months Ended October 31, 2022 (Unaudited)

Profit/Loss (EBIDA) Summary (MTD) Negative and (YTD) Negative

The month of October resulted in negative $1.25M Earnings before Interest, Depreciation and Amortization (EBIDA) compared to budgeted EBIDA loss of $1.55M.
YTD – The YTD October results were a negative $4.43M Earnings before Interest, Depreciation and Amortization (EBIDA) compared to budgeted EBIDA loss of $5.57M.

Month – Adjustments and Items of note:

- The October Surgery visits remained high again at 157 plus 13 G.I. procedures.
- The Emergency visits were also high at 3,619.
- Deductions from Revenues were favorably impacted by $41K for the Residency Program.
- Total Operating Expenses were $812K below budget (see comments below)
- A revised September and YTD September Statement of Revenues and Expenses are included with this packet to update the Medicare Contractuals consistent with the FYE 2022 cost report. (see Pages 12 and 13 of the October Financial Report).

October's inpatient average daily census was 18.8. Adjusted Patient Days were 7.3% under budget (1,772 vs. 1,911) which includes the Patient Days which were 39% below budget (582 vs. 960). Emergency Visits were 11.8% over budget (3,619 vs. 3,237), and overall Surgeries were over budget by 30% (157 vs. 121).
YTD - Inpatient average daily census was 20.9. Adjusted Patient Days were 8.9% under budget (7,051 vs. 7,708) and Patient Days were 34% below budget (2,567 vs. 3,872). Emergency Visits were 9.3% over budget (14,359 vs. 13,136), and overall Surgeries were over budget by 26% (621 vs. 492).

Patient Revenues (MTD) Negative (YTD) Negative

Month - The Net Patient Revenue in October was $491K (9.6%) below budget. This is impacted by the low volume of Inpatient Days, again being somewhat offset by the high Outpatient revenues. The Residency Program recovery was $41K and is included in the Deductions from Revenues. Managed care rate increases negotiated a year ago were estimated at $159K for the month.
YTD – Net Patient Revenues were $1.82M (8.7%) below budget. Again, this is impacted by the low count of Inpatient Days, and is somewhat offset by the high Outpatient revenues and the $194K Residency Program recovery. Managed care rate increases negotiated a year ago are estimated at $725K combined for the four months.

Total Operating Revenues (MTD) Negative & (YTD) Negative

Month – Operating Revenue in October was $508K below budget. This was impacted by the negative variances in Net Patient Revenues and $17K negative variance in Other Income.
YTD - Operating Revenue was $1.94M below budget. This was impacted by the $1.8M negative variance in Net Patient Revenues for the four months and the $121K negative variance in Other Income.

Operating Expenses (MTD) Positive & (YTD) Positive

Month - Operating Expenses in October were $6.92M and were under budget by $812K. Key items that impacted overall Expenses were as follows: 1) Salaries and Wages, Benefits, and Contract Labor were collectively $289K below budget, primarily impacted by the lower inpatient workloads. 2) Physician fees were under budget by $56K partially due to the Residency costs being lower than expected at this point; 3) Purchased Services were $ 240K below budget due to legal fees and various other services coming in under budget; 4) Supplies were under budget by $213K, which can be attributed to a) much lower than expected Inpatient Admissions, b) no covid surges thus far, and c) not

experiencing the full impact of inflation which is expected to accelerate over the remainder of the year; 5) Repairs and Maintenance costs were $36K over budget due mainly to routine repairs not incurred in the previous month. 6) Leases and Rentals were $50K under budget primarily due to the new reclassification methodology adopted in the FY 2022 audit for lease accounting, with a corresponding impact mostly to Depreciation and Amortization expense.

YTD – Operating Expenses were $27.7M and were under budget by $3.1M. Key items that impacted overall Expenses were as follows: 1) Salaries, Benefits, and Contract Labor were a combined $779K under budget which was impacted by the PTO Flex-Down variance during the summer months along with the much lower than expected Patient Days workloads; 2) Physician fees were $250K under budget and some of the major variances are related to the Residency Program and the Physician On-Call costs being lower than expected ; 3) Purchased Services showed a favorable variance of $746K due to legal fees variance, various Service Agreements, and Allscripts/Navigant being slightly lower than expected; 4) Supplies were under budget by $1.1M, and large favorable variances, as in the current month, can be attributable to a) much lower than expected Inpatient Admissions, b) no covid surges thus far, and c) not experiencing the full impact of inflation which is expected to accelerate over the remainder of the year; 5) Utilities were under budget by $82K which is due to "monthly historical allocation methodology" and some avoidance to date of inflationary costs to these areas (which we don't think have fully materialized); 6) Other Operating Expenses were $115K below budget due to numerous matters – some of the larger variances relate to "timing" of various events, fees, and licenses which will occur later in the year. This, coupled with our efforts to minimize expenditures have led to this favorable variance; 7) Leases and Rentals are $71K under budget primarily due to the change in Lease accounting mentioned above.

Balance Sheet/Cash Flow

Note: Certain Balance Sheet items, including "Total Net Assets" include the impact of the final audit entries from the FYE June 30, 2022. Because these reports are prepared for internal users only, they do not purport to conform to the principles contained in U.S. GAAP.

Patient cash collections in October were $5.89M compared to September ($5.12M). The Gross A/R Days increased just slightly from 63.6 in September to 64.1 in October. Cash balances were $3.3M compared to $2.93M in September. Again, the major factor causing the low Cash balance was that the Line of Credit was still paid down to -0- starting on September 16, and the Line of Credit was not accessed until early November. Even with this, the Accounts Payable increased slightly to $10.17M compared to $10.14M in September. Other notable activity on the Balance Sheet: Prepaid Expenses due to audit reclassifications of leases for $2.0M and booking a legal settlement estimated at $3.4M,

Concluding Summary

Positive takeaways:

1) Total Surgeries were 30% over budget.
2) Emergency Visits were 12% over budget
3) Operating Expenses were $812K under budget.
4) EBIDA performance was $304K better than expected and $1.1M on a YTD basis

Negative takeaways:

1) Inpatient Days are less than expected.

3-A

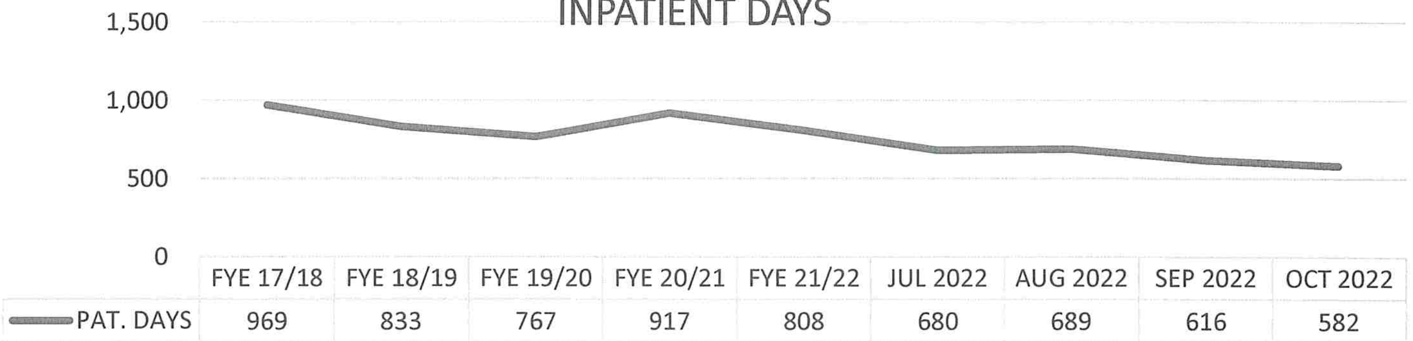
STATISTICS

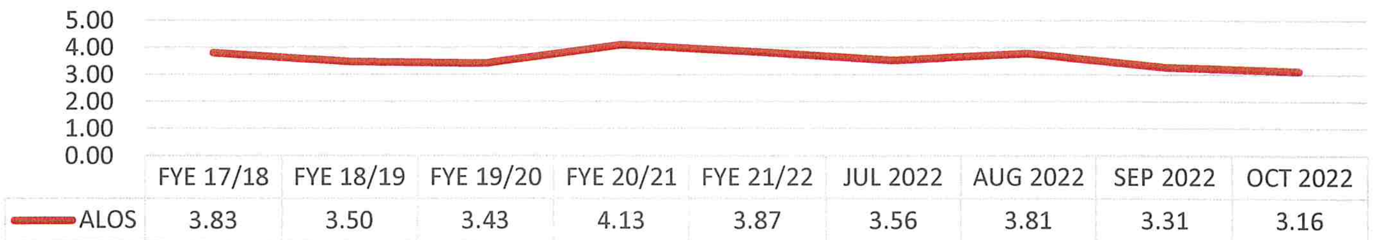
Term	Definition
Inpatient Admissions/Discharges (Monthly Average)	Represents number of patients admitted/discharged into and out of the hospital.
Patient Days (Monthly Average)	Each day a patient stays in the hospital is counted as a patient day. This count is normally done at midnight.
Average Daily Census (Inpatient)	Equals the average number of inpatients in the hospital on any given day or month.
Average Length of Stay (Inpatient)	Represents that average number of days that inpatients stay in the hospital.
Emergency Visits (Monthly Average)	Represents the number of patients who sought services at the emergency room.
Surgery Cases - Excluding G.I. (Monthly Average)	Equals the number of patients who had a surgical procedure(s) performed.
G.I. Cases (Monthly)	Number of patients who had a gastrointestinal exam performed.
Newborn Deliveries (Monthly)	Number of babies delivered.

PRODUCTIVITY

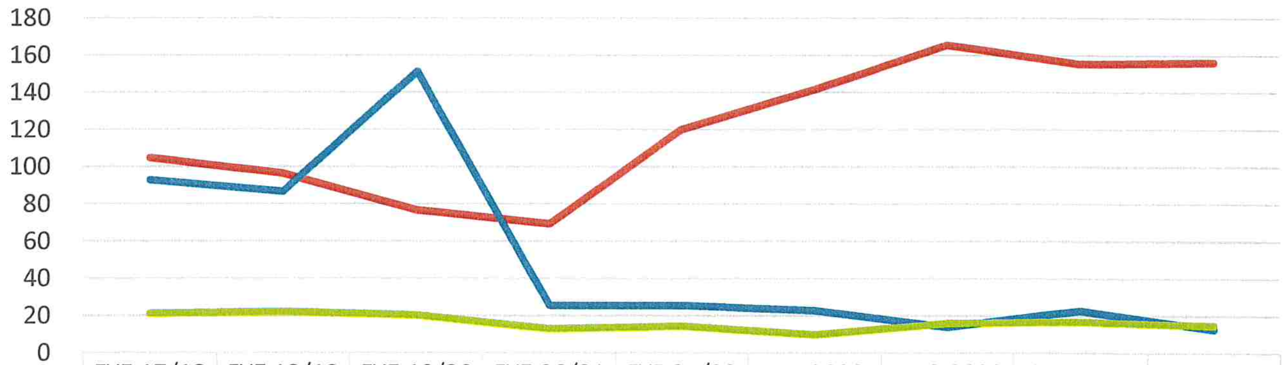
Term	Definition
Worked FTEs (includes Registry FTEs)	Represents an equivalancy of full-time staff worked. One FTE is equivalent of working 40 hours per week, 80 hours per pay period, 173.3 hours per 30 day month, or 2,080 hours in a 52 week year. This calculation divides the number of hours worked by the number of hours in the respective work period (40, 80, etc.) Example: 340 hours worked in an 80 hour pay period = 4.25 FTE's
Worked FTES per APD	Divides the Total Worked FTE's by the daily average of the Adjusted Patient Days.
Paid FTEs (includes Registry FTEs)	Represents an equivalancy of full-time staff paid. One FTE is equivalent of working 40 hours per week, 80 hours per pay period, 173.3 hours per 30 day month, or 2,080 hours in a 52 week year. This calculation divides the number of hours paid (includes all hours paid consisting of worked hours, PTO hours, sick pay, etc.) by the number of hours in the respective work period (40, 80, etc.) Example: 500 hours paid in an 80 hour pay period = 6.25 FTE's.
Paid FTES per APD	Divides the Total Paid FTE's by the daily average of the Adjusted Patient Days.
ADJUSTED PATIENT DAYS	This is a blend of total patient days stayed in the hospital for a month, plus an equivalency factor (based on average inpatient revenue per patient day) applied to the outpatient revenues in order to account for outpatient workloads.

SAN GORGONIO MEMORIAL HOSPITAL

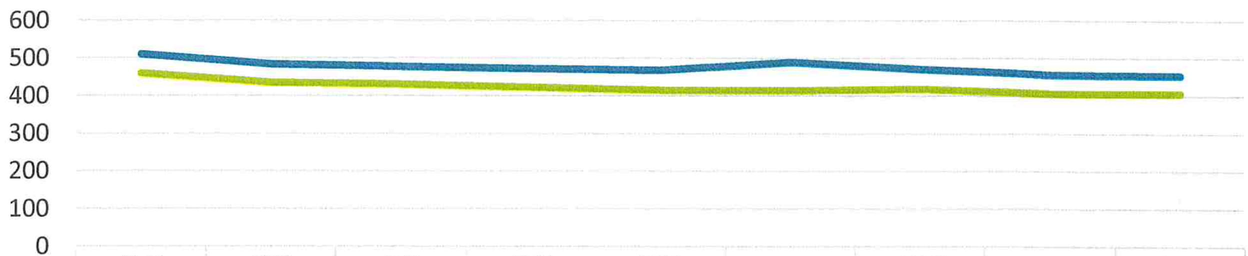




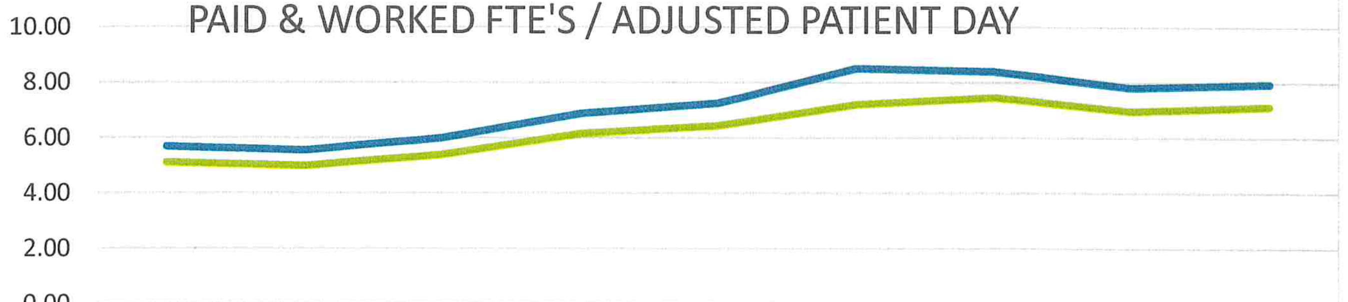
SAN GORGONIO MEMORIAL HOSPITAL



	FYE 17/18	FYE 18/19	FYE 19/20	FYE 20/21	FYE 21/22	JUL 2022	AUG 2022	SEP 2022	OCT 2022
SURG.	105	97	77	70	121	142	166	156	157
G.I. CASES	93	87	152	26	26	23	14	23	13
BIRTHS	21	22	21	13	15	10	16	17	15



	FYE 17/18	FYE 18/19	FYE 19/20	FYE 20/21	FYE 21/22	JUL 2022	AUG 2022	SEP 2022	OCT 2022
P FTE's	511	484	479	474	470	491	473	459	457
W FTE's	461	436	431	425	417	416	419	409	409



	FYE 17/18	FYE 18/19	FYE 19/20	FYE 20/21	FYE 21/22	JUL 2022	AUG 2022	SEP 2022	OCT 2022
PFTES/APD	5.69	5.55	6.01	6.89	7.27	8.54	8.43	7.85	7.99
WFTES/APD	5.13	5.00	5.41	6.18	6.45	7.22	7.48	6.99	7.15

3-C

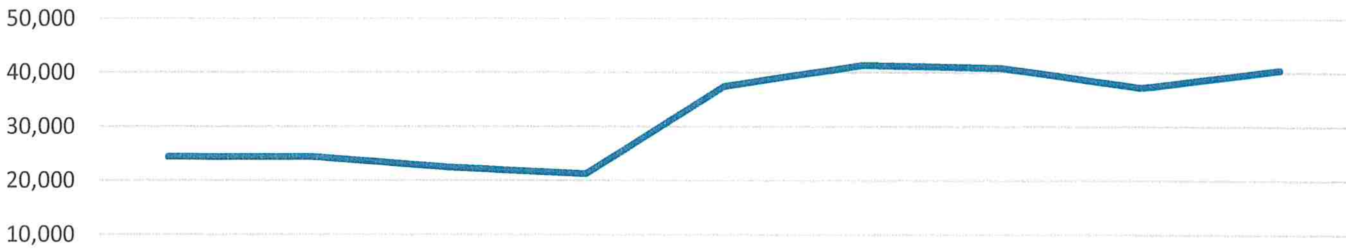
INCOME STATEMENT

Measure	Description
Gross Patient Revenue (000's) (Monthly Ave.)	Represents total charges (before discounts and allowances) made for all patient services provided.
Net Patient Revenue (NPR) (000's) (Monthly Ave.)	Equals the sum of all (patient) charges for services provided that are due to the hospital, less estimated adjustments for discounts and other contractual disallowances for which the patients may be entitled.
NPR as % of Gross	Reflects the percentage of Gross Patient Revenues (charges) that are expected to be collected. Calculated by dividing Net Patient Revenue by the Gross Patient Revenue.
Total Operating Revenue (000's) (Monthly Ave.)	This reflects all Revenues available for payment of Operating Expenses. This includes Net Patient Revenue plus all other forms of miscellaneous Revenues.
Salaries, Wages, Benefits & Contract Labor (000's) (Monthly Ave.)	Represents the total staffing expenses of the Hospital
SWB + Contract Labor as % of Total Operating Revenue	Identifies what portion the Operating Revenues are spent on staffing costs.
Total Operating Expense (TOE) (000's)(Monthly Ave.)	Operating Expense reflects all costs needed to fund the Hospital's business operations.
TOE as % of Total Operating Revenue	Identifies the relationship that Operating Expenses have to the Total Operating Revenues.
EBIDA (000's)(Monthly Average)	Earnings Before Interest, Depreciation, and Amortization. This reflects the difference between Net Operating Revenues and Total Operating Expense. This is a quick measurment of the Hospital's ability to meet its financial obligations and have additional funds for equipment replacement and future growth of the organization.
EBIDA as % of NPR	This measurement is a guage of the surplus (or deficit) of funds available for operations and future growth.
Net Patient Revenue vs. Total Labor Expense	This measurement illustrates that Net Patient Revenues basically only cover Total Labor Expense, and that all of the Other Revenues and Supplemental Incomes are necessary to cover the remaining operational Expenses and EBIDA required to operate the Hospital.
Operating Revenues (Normalized), Expenses, Staffing Expenses, and EBIDA (Normalized)	This graph illustrates the "normalization" of Operating Revenues and EBIDA, by reallocating proportionate Supplemental Revenues and related Expenses into the current month and YTD results.

3-J

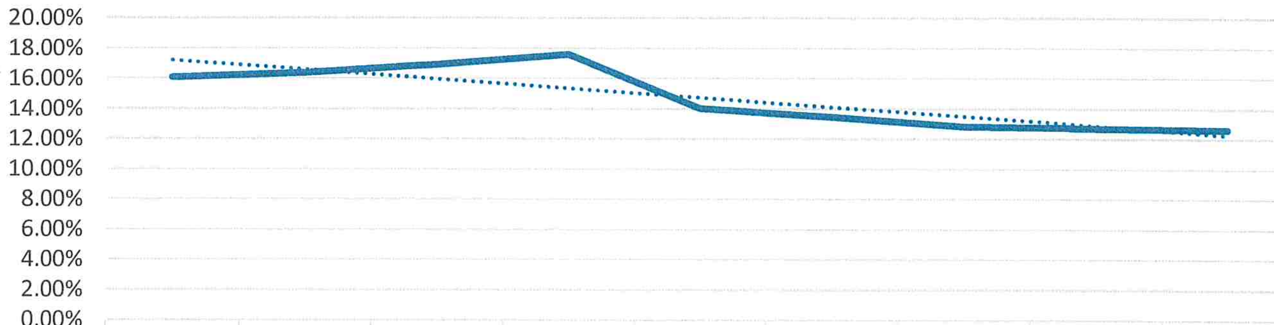
SAN GORGONIO MEMORIAL HOSPITAL

GROSS PATIENT REVENUE



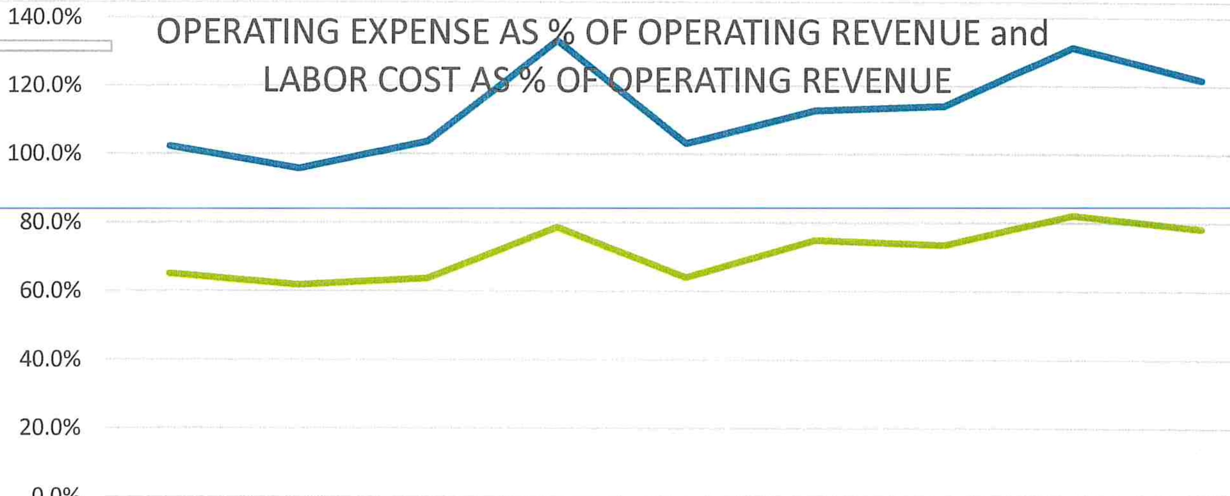
	FYE 17/18	FYE 18/19	FYE 19/20	FYE 20/21	FYE 21/22	JUL 2022	AUG 2022	SEP 2022	OCT 2022
GPR	24,382	24,433	22,416	21,265	37,535	41,471	40,945	37,279	40,582

NET PATIENT REVENUE AS % OF GROSS



	FYE 17/18	FYE 18/19	FYE 19/20	FYE 20/21	FYE 21/22	JUL 2022	AUG 2022	SEP 2022	OCT 2022
NPR%GROSS	16.08%	16.38%	16.93%	17.61%	14.05%	13.49%	12.86%	12.74%	12.65%

OPERATING EXPENSE AS % OF OPERATING REVENUE and LABOR COST AS % OF OPERATING REVENUE

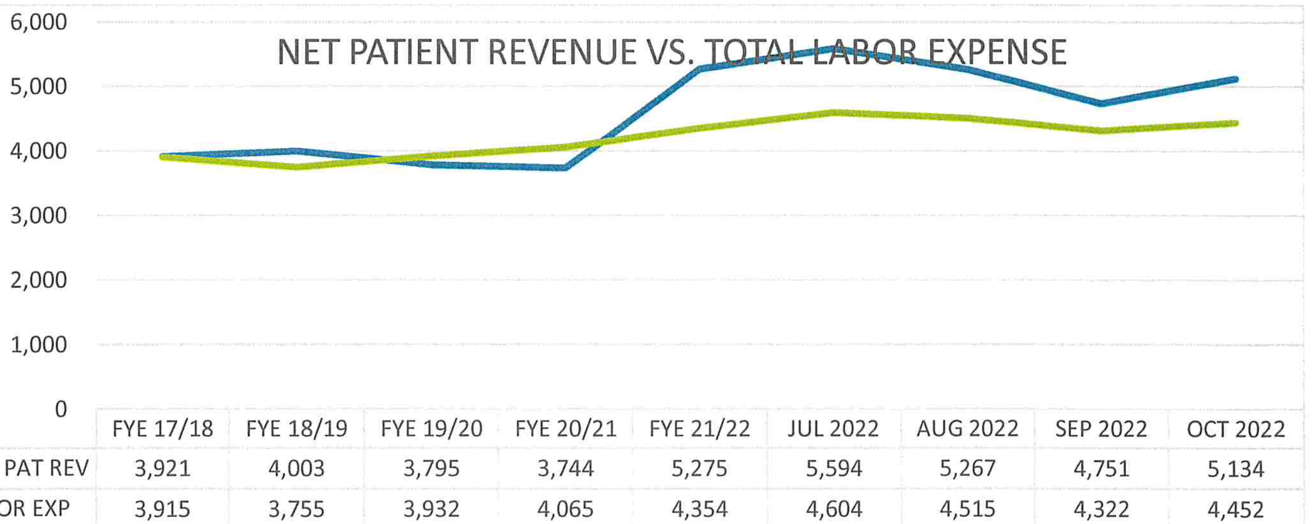


	FYE 17/18	FYE 18/19	FYE 19/20	FYE 20/21	FYE 21/22	JUL 2022	AUG 2022	SEP 2022	OCT 2022
OP EXP%OP REV	102.3%	95.8%	103.8%	133.3%	103.2%	112.8%	114.2%	131.4%	122.0%
LABOR%OP REV	65.2%	61.9%	63.8%	78.8%	64.1%	75.1%	73.6%	82.4%	78.5%

SAN GORGONIO MEMORIAL HOSPITAL

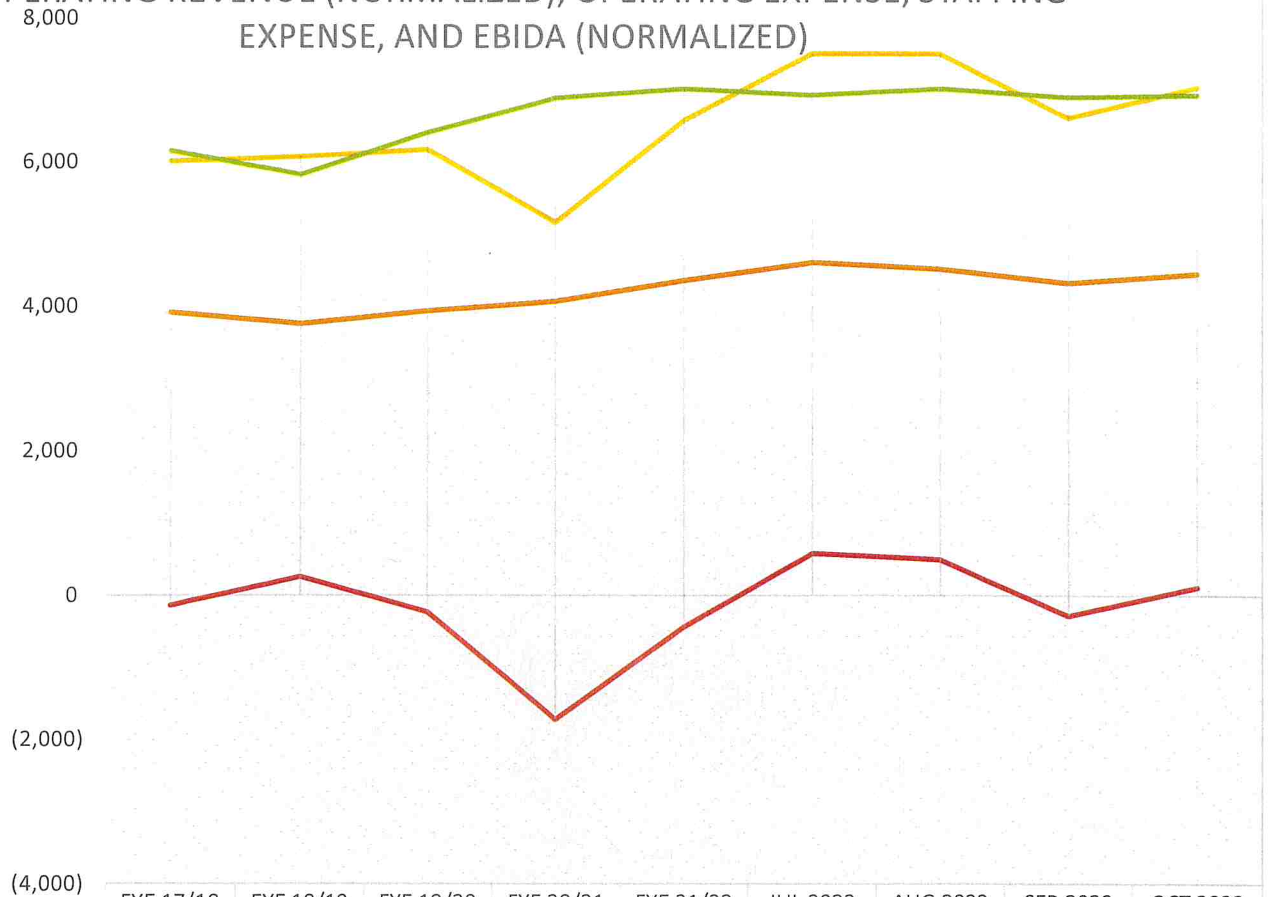
OPERATING REVENUE, OPERATING EXPENSE, STAFFING EXPENSE, AND EBIDA

	FYE 17/18	FYE 18/19	FYE 19/20	FYE 20/21	FYE 21/22	JUL 2022	AUG 2022	SEP 2022	OCT 2022
OP REV	6,006	6,069	6,165	5,160	6,791	6,132	6,137	5,246	5,674
OP EXP	6,147	5,817	6,398	6,878	7,007	6,920	7,010	6,893	6,923
STAFF EXP	3,915	3,755	3,932	4,065	4,354	4,604	4,515	4,322	4,452
EBIDA	(141)	252	(233)	(1,719)	(216)	(788)	(873)	(1,648)	(1,249)



	FYE 17/18	FYE 18/19	FYE 19/20	FYE 20/21	FYE 21/22	JUL 2022	AUG 2022	SEP 2022	OCT 2022
NET PAT REV	3,921	4,003	3,795	3,744	5,275	5,594	5,267	4,751	5,134
LABOR EXP	3,915	3,755	3,932	4,065	4,354	4,604	4,515	4,322	4,452

SAN GORGONIO MEMORIAL HOSPITAL



	FYE 17/18	FYE 18/19	FYE 19/20	FYE 20/21	FYE 21/22	JUL 2022	AUG 2022	SEP 2022	OCT 2022
REV NORMAL	6,006	6,069	6,165	5,160	6,569	7,494	7,499	6,608	7,037
OP EXP	6,147	5,817	6,398	6,878	7,007	6,920	7,010	6,893	6,923
LABOR EXP	3,915	3,755	3,932	4,065	4,354	4,604	4,515	4,322	4,452
EBIDA NORMAL	(141)	252	(233)	(1,719)	(438)	574	489	(285)	113

3-G

SAN GORGONIO HEALTHCARE DISTRICT & HOSPITAL - BANNING, CA
Month-to Month FYE June 30, 2023
Statement of Revenue and Expense

As of 11/23/22

	FYE17/18	FYE18/19	FYE19/20	FYE 20/21	FYE 21/22	FYE 21/22	FYE 22/23 4	FYE 22/23	FYE 22/23	FYE 22/23		FYE 22/23	FYE 22/23	FYE 22/23	FYE 22/23
	MONTHLY AVE.	MONTHLY AVE.	MONTHLY AVE.	MONTHLY AVE.	6/30/2022	MONTHLY AVE.	MONTHLY AVE.	7/31/2022	8/31/2022	9/30/2022	Reclass/Adjust.	10/31/2022	11/30/2022	12/31/2022	6/30/2023
Gross Patient Revenue															
Inpatient Revenue	$ 8,652,325	$ 7,667,883	$ 7,401,282	$ 9,331,371	$ 199,240,684	$ 16,603,390	$ 13,903,270	$ 15,786,344	$ 13,463,161	$ 13,156,157		$ 13,207,417	$ -	$ -	$ 55,613,079
Inpatient Psych/Rehab Revenue	0	0	0	0		0		-	-	-		-	-	-	
Outpatient Revenue	15,730,069	16,765,365	15,067,104	11,933,682	251,184,896	20,932,075	26,165,968	25,684,830	27,481,674	24,122,862		27,374,507	-	-	104,663,872
Long Term Care Revenue	0	0	0	0		0		-	-	-		-	-	-	
Home Health Revenue	0	0	0	0	0	0	0	-	-	-		-	-	-	-
Total Gross Patient Revenue	24,382,394	24,433,247	22,468,386	21,265,053	450,425,580	37,535,465	40,069,238	41,471,174	40,944,835	37,279,018	0	40,581,924	0	0	$ 160,276,951
Deductions From Revenue															
Discounts and Allowances	(19,635,639)	(19,588,148)	(17,845,730)	(16,635,734)	(375,205,782)	(31,267,149)	(33,827,129)	(34,966,058)	(34,797,135)	(30,986,845)	124,810	(34,683,286)	0	0	(135,308,515)
Bad Debt Expense	(806,002)	(858,023)	(653,280)	(824,395)	(12,546,840)	(1,045,570)	(886,263)	(883,157)	(813,947)	(1,113,485)		(734,463)	0	0	(3,545,052)
GI HMO Discounts	0	0	0	0	0	0	0	0	0	0		0	0	0	-
Charity Care	(80,410)	(56,168)	(86,517)	(41,362)	(1,643,365)	(136,947)	(138,114)	(28,117)	(66,596)	(427,789)		(29,952)	0	0	(552,455)
Total Deductions From Revenue	(20,522,051)	(20,502,339)	(18,585,527)	(17,501,490)	(389,395,987)	(32,449,666)	(34,851,505)	(35,877,331)	(35,677,679)	(32,528,120)	124,810	(35,447,702)	0	0	(139,406,022)
	-84.2%	-83.9%	-82.7%	-82.3%	-85.9%	-86.5%	-87.0%	-86.5%	-87.1%	-87.3%		-87.3%	#DIV/0!	#DIV/0!	-87.0%
Net Patient Revenue	3,860,343	3,930,908	3,882,859	3,763,563	61,029,593	5,085,799	5,217,732	5,593,843	5,267,156	4,750,899	124,810	5,134,222	0	0	$ 20,870,930
Non- Patient Revenues															
IGT/DSH Revenues	1,530,975	1,485,337	1,157,326	869,707	6,016,888	501,407	0	0	0	0		0	0	0	-
Grants & Other Op Revenues	193,507	205,590	750,434	505,190	8,700,786	725,066	209,204	136,873	468,018	93,358		138,568	0	0	836,818
Clinic Net Revenues	20,106	22,382	15,743	0	0	0	0	0	0	0		0	0	0	-
Tax Subsidies Measure D	174,852	196,524	199,469	209,744	2,752,857	229,405	246,994	246,994	246,994	246,994		246,994	0	0	987,975
Tax Subsidies Prop 13	105,376	115,388	114,061	142,552	1,753,245	146,104	154,500	154,500	154,500	154,500		154,500	0	0	618,000
Tax Subsidies County Suplmtl Funds	16,858	16,159	9,064	16,163	306,727	25,561	0	0	0	0		0	0	0	-
Non-Patient Revenues	2,041,675	2,041,381	2,246,097	1,743,355	19,530,503	1,627,542	610,698	538,367	869,512	494,852	0	540,062	0	0	$ 2,442,793
Total Operating Revenue	5,902,018	5,972,289	6,128,956	5,506,919	80,560,096	6,713,341	5,828,431	6,132,210	6,136,668	5,245,751	124,810	5,674,284	0	0	$ 23,313,723
Operating Expenses															
Salaries and Wages	3,000,485	2,941,226	3,104,224	3,125,159	41,051,690	3,420,974	3,499,521	3,566,637	3,581,670	3,344,149		3,505,628	0	0	13,998,084
Fringe Benefits	784,204	702,477	752,708	856,889	9,967,193	830,599	891,800	898,552	868,467	904,958		895,221	0	0	3,567,198
Contract Labor	130,625	106,628	59,516	114,886	1,199,720	99,977	81,642	138,575	64,443	72,561		50,991	0	0	326,569
Physicians Fees	211,630	246,631	331,858	350,783	3,966,400	330,533	302,752	273,621	277,977	293,059	57,575	308,777	0	0	1,211,009
Purchased Services	581,239	513,857	691,337	772,336	10,710,257	892,521	856,530	829,624	848,417	1,003,052	(57,575)	802,604	0	0	3,426,122
Supply Expense	699,167	685,518	751,025	903,883	11,945,347	995,446	826,316	698,214	888,903	823,019		895,128	0	0	3,305,264
Utilities	74,205	75,471	80,680	92,287	1,334,299	111,192	103,904	104,925	97,819	113,507		99,363	0	0	415,614
Repairs and Maintenance	53,574	58,325	58,592	139,712	930,286	77,524	90,443	74,098	124,767	51,558		111,348	0	0	361,772
Insurance Expense	86,537	85,267	103,277	110,683	1,352,942	112,745	129,469	137,478	127,547	133,709		119,141	0	0	517,875
All Other Operating Expenses	68,153	70,922	160,745	148,752	1,213,701	101,142	70,542	97,102	53,610	47,279		84,177	0	0	282,168
IGT Expense	217,249	58,743	109,484	172,366	0	0	0	0	0	-		0	0	0	-
Leases and Rentals	57,507	76,150	79,233	79,424	455,428	37,952	83,732	101,241	76,060	106,555		51,072	0	0	334,928
1206 (b) CLINIC	80,927	98,810	94,628	34,096	0	0	0	0	0	0		0	0	0	-
Total Operating Expenses	6,045,502	5,720,023	6,377,306	6,901,255	84,127,263	7,010,605	6,936,651	6,920,067	7,009,680	6,893,407	0	6,923,449	0	0	$ 27,746,603
EBIDA	(143,485)	252,266	(248,351)	(1,394,337)	(3,567,167)	(297,264)	(1,108,220)	(787,858)	(873,012)	(1,647,656)	124,810	(1,249,165)	0	0	$ (4,432,881)
Interest, Depreciation, and Amortization															
Depreciation and Amortization	512,466	497,808	506,497	494,721	5,667,801	472,317	452,381	550,044	406,450	406,450		446,580	0	0	1,809,523
Interest Expense	432,490	418,193	422,094	447,994	4,699,271	391,606	451,026	427,682	571,834	409,794		394,794	0	0	1,804,103
Total Interest, Depr, & Amort.	944,956	916,000	928,591	942,715	10,367,072	863,923	903,407	977,726	978,283	816,243	0	841,374	0	0	3,613,627
Non-Operating Revenue:															
Contributions & Other	14,354	7,745	27,759	7,121	300,815	25,068	348,911	1,387,913	2,599	3,065		2,068	0	0	1,395,645
Tax Subsidies for GO Bonds - M-A	652,487	692,457	666,966	598,410	7,392,706	616,059	627,353	627,353	627,353	627,353		627,353	0	0	2,509,413
Total Non Operating Revenue/(Expe	666,841	700,202	694,725	605,531	7,693,521	641,127	976,264	2,015,266	629,952	630,418	0	629,421	0	0	3,905,057
Total Net Surplus/(Loss)	(421,599)	36,467	(482,217)	(1,731,521)	(6,240,718)	(520,060)	(1,035,363)	249,682	(1,221,343)	(1,833,481)		(1,461,118)	0	0	$ (4,141,450)
Change in Interest in Foundation	0	0	0	0	0	0	0	0	0	0		0	0	0	-
Extra-ordinary Loss	0	0	(689,574)	(650)	(3,417,500)	(284,792)	0	0	0	0		0	0	0	-
Increase/(Decrease in Unrestricted Net	$ (421,599)	$ 36,467	$ (1,171,791)	$ (1,732,171)	$ (9,658,218)	$ (804,852)	$ (1,035,363)	$ 249,682	$ (1,221,343)	$ (1,833,481)	$ -	$ (1,461,118)	$ -	$ -	$ (4,141,450)
Total Profit Margin	-7.1%	0.6%	-7.9%	-31.4%	-7.7%	-7.7%	-17.8%	4.1%	-19.9%	-35.0%		-25.7%	#DIV/0!	#DIV/0!	-17.8%
EBIDA %	-2.4%	4.2%	-4.1%	-25.3%	-4.4%	-4.4%	-19.0%	-12.8%	-14.2%	-31.4%		-22.0%	#DIV/0!	#DIV/0!	-19.0%

Note: Variances in the FYE 22/23 monthly columns are explained in the respective monthly financial reports.

	7/31/2022	8/31/2022	9/30/2022	10/31/2022	6/30/2023
Estimated Value of Supplemental Accruals (Updated 10/19/22)	1,362,273	1,362,273	1,362,273	1,362,273	5,449,090
Estimated EBIDA If Supplementals were Accrued Monthly (Updated 10/19/22)	574,415	489,261	(285,383)	113,108	891,400

SAN GORGONIO HEALTHCARE DISTRICT & HOSPITAL - BANNING, CA
5 Year Monthly Averages and 12 Rolling Months Ended 10/31/2022

	FYE17/18	FYE18/19	FYE19/20	FYE 20/21	FYE 21/22 12	FYE 21/22	FYE 21/22	FYE 21/22	FYE 21/22	FYE 21/22	FYE 21/22	FYE 21/22	FYE 21/22	FYE 22/23	FYE 22/23	FYE 22/23	FYE 22/23
	MONTHLY AVE.	MONTHLY AVE.	MONTHLY AVE.	MONTHLY AVE.	MONTHLY AVE.	11/30/2021	12/31/2021	1/31/2022	2/28/2022	3/31/2022	4/30/2022	5/31/2022	6/30/2022	7/31/2022	8/31/2022	9/30/2022	10/31/2022
Gross Patient Revenue																	
Inpatient Revenue	$ 8,652,325	$ 7,667,883	$ 7,401,282	$ 9,331,371	$ 16,603,390	$ 18,051,448	$ 17,581,450	$ 29,180,538	$ 16,023,727	$ 14,009,575	$ 12,985,480	$ 12,699,299	$ 13,219,644	$ 15,793,211	$ 16,241,100	$ 13,156,157	$ 13,207,417
Inpatient Psych/Rehab Revenue	0	0	0	0		-	-	-	-	-	-	-	-	-	-	-	-
Outpatient Revenue	15,730,069	16,765,365	15,067,104	11,933,682	20,932,075	19,318,269	21,397,485	17,754,388	18,699,730	22,781,003	22,348,929	21,153,874	23,646,523	25,672,092	24,753,736	24,078,732	27,374,507
Long Term Care Revenue	0	0	0	0		-	-	-	-	-	-	-	-	-	-	-	-
Home Health Revenue	0	0	0	0	0	-	-	-	-	-	-	-	-	-	-	-	-
Total Gross Patient Revenue	24,382,394	24,433,247	22,468,386	21,265,053	37,535,465	37,369,717	38,978,936	46,934,926	34,723,457	36,790,578	35,334,409	33,853,172	36,866,167	41,465,303	40,994,836	37,234,888	40,581,924
Deductions From Revenue																	
Discounts and Allowances	(19,635,639)	(19,588,148)	(17,845,730)	(16,635,734)	(31,267,149)	(30,704,377)	(31,514,954)	(38,941,080)	(28,951,935)	(29,655,536)	(27,674,758)	(26,569,751)	(36,229,684)	(34,966,058)	(34,797,135)	(30,862,035)	(34,683,286)
Bad Debt Expense	(806,002)	(858,023)	(653,280)	(824,395)	(1,045,570)	(1,418,564)	(1,744,778)	(1,661,127)	(1,097,242)	(1,207,381)	(1,432,016)	(1,104,585)	2,536,474	(883,157)	(813,947)	(1,113,485)	(734,463)
GI HMO Discounts	0	0	0	0	0	0	0	0	0	0	-	-	-	-	-	-	-
Charity Care	(80,410)	(56,168)	(86,517)	(41,362)	(136,947)	(97,440)	(23,772)	(177,583)	(29,837)	(22,283)	(25,690)	(887,352)	(59,144)	(28,117)	(66,596)	(427,789)	(29,952)
Total Deductions From Revenue	(20,522,051)	(20,502,339)	(18,585,527)	(17,501,490)	(32,449,666)	(32,220,382)	(33,283,504)	(40,779,789)	(30,079,014)	(30,885,200)	(29,132,464)	(28,561,688)	(33,752,355)	(35,877,331)	(35,677,679)	(32,403,310)	(35,447,702)
	-84.2%	-83.9%	-82.7%	-82.3%	-86.5%	-86.2%	-85.4%	-86.9%	-86.6%	-83.9%	-82.4%	-84.4%	-91.6%	-86.5%	-87.0%	-87.3%	-87.3%
Net Patient Revenue	3,860,343	3,930,908	3,882,859	3,763,563	5,085,799	5,149,335	5,695,431	6,155,137	4,644,443	5,905,378	6,201,945	5,291,484	3,113,812	5,587,972	5,317,157	4,831,579	5,134,222
Non- Patient Revenues																	
IGT/DSH Revenues	1,530,975	1,485,337	1,157,326	869,707	501,407	0	6,016,888	0	0	0	0	-	-	-	-	-	-
Grants & Other Op Revenues	193,507	205,590	750,434	505,190	725,065	573,166	51,070	257,227	1,025,766	1,404,234	404,979	1,221,031	2,657,264	136,873	468,018	93,358	138,568
Clinic Net Revenues	20,106	22,382	15,743	0	0	0	0	0	0	0	0	-	-	-	-	-	-
Tax Subsidies Measure D	174,852	196,524	199,469	209,744	229,405	233,333	233,333	233,333	233,333	233,333	233,333	233,333	186,194	246,994	246,994	246,994	246,994
Tax Subsidies Prop 13	105,376	115,388	114,061	142,552	146,104	150,000	150,000	150,000	150,000	150,000	150,000	150,000	103,245	154,500	154,500	154,500	154,500
Tax Subsidies County Suplmtl Funds	16,858	16,159	9,064	16,163	25,561	0	0	0	0	0	0	-	306,727	-	-	-	-
Non-Patient Revenues	2,041,675	2,041,381	2,246,097	1,743,355	1,627,542	956,499	6,451,291	640,560	1,409,099	1,787,567	788,312	1,604,364	3,253,430	538,367	869,512	494,852	540,062
Total Operating Revenue	5,902,018	5,972,289	6,128,956	5,506,919	6,713,341	6,105,833	12,146,722	6,795,697	6,053,542	7,692,944	6,990,257	6,895,848	6,367,242	6,126,339	6,186,669	5,326,431	5,674,284
Operating Expenses																	
Salaries and Wages	3,000,485	2,941,226	3,104,224	3,125,159	3,420,974	3,731,115	3,541,554	3,869,331	3,024,051	3,508,794	3,443,890	3,522,753	3,245,290	3,566,637	3,581,670	3,344,149	3,505,628
Fringe Benefits	784,204	702,477	752,708	856,889	830,599	806,996	755,181	1,176,353	851,149	828,985	886,002	755,019	790,636	898,552	868,467	904,958	895,221
Contract Labor	130,625	106,628	59,516	114,886	99,977	62,832	108,418	114,375	(76,550)	145,598	244,817	39,673	110,598	138,575	64,443	72,561	50,991
Physicians Fees	211,630	246,631	331,858	350,783	330,533	343,587	198,313	298,243	318,078	437,958	497,575	195,777	243,800	273,621	277,977	350,634	308,777
Purchased Services	581,239	513,857	691,337	772,336	892,521	1,034,039	953,575	877,171	992,328	1,036,315	966,521	912,287	792,287	829,624	848,417	945,477	802,604
Supply Expense	699,167	685,518	751,025	903,883	995,446	1,033,756	1,044,298	931,808	907,500	1,024,948	1,455,590	683,784	1,026,266	698,214	888,903	823,019	895,128
Utilities	74,205	75,471	80,680	92,287	111,192	83,919	145,701	135,515	130,260	102,218	114,367	99,273	114,902	104,925	97,819	113,507	99,363
Repairs and Maintenance	53,574	58,325	58,592	139,712	77,524	89,547	48,900	47,901	58,986	37,984	183,195	73,948	63,450	74,098	124,767	51,558	111,348
Insurance Expense	86,537	85,267	103,277	110,683	112,745	115,494	129,887	130,590	119,850	122,460	115,996	29,026	120,427	137,478	127,547	133,709	119,141
All Other Operating Expenses	68,153	70,922	160,745	148,752	101,142	46,020	75,944	154,765	50,537	67,757	75,734	194,597	208,464	97,102	53,610	47,279	84,177
IGT Expense	217,249	58,743	109,484	172,366	0	0	0	0	0	0	-	-	-	-	-	-	-
Leases and Rentals	57,507	76,150	79,233	79,424	37,952	81,362	76,968	72,138	51,487	69,694	113,459	112,625	(408,504)	101,241	76,060	106,555	51,072
1206 (b) CLINIC	80,927	98,810	94,628	34,096	0	0	0	0	0	0	-	-	-	-	-	-	-
Total Operating Expenses	6,045,502	5,720,023	6,377,306	6,901,255	7,010,605	7,428,666	7,078,738	7,808,187	6,427,676	7,382,712	8,097,148	6,618,763	6,307,616	6,920,067	7,009,680	6,893,407	6,923,449
EBIDA	(143,485)	252,266	(248,351)	(1,394,337)	(297,264)	(1,322,832)	5,067,984	(1,012,491)	(374,133)	310,232	(1,106,891)	277,085	59,626	(793,729)	(823,011)	(1,566,976)	(1,249,165)
Interest, Depreciation, and Amortization																	
Depreciation and Amortization	512,466	497,808	506,497	494,721	472,317	504,865	504,865	504,865	504,865	504,865	504,865	504,865	114,286	550,044	406,450	406,450	446,580
Interest Expense	432,490	418,193	422,094	447,994	391,606	421,092	374,425	393,735	591,013	393,056	374,425	452,092	159,730	427,682	571,834	409,794	394,794
Total Interest, Depr, & Amort.	944,956	916,000	928,591	942,715	863,923	925,957	879,290	898,600	1,095,878	897,921	879,290	956,957	274,016	977,726	978,283	816,243	841,374
Non-Operating Revenue:																	
Contributions & Other	14,354	7,745	27,759	7,121	25,068	1,695	4,381	963	186,373	9,437	183,295	52,869	(175,971)	1,387,913	2,599	3,065	2,068
Tax Subsidies for GO Bonds - M-A	652,487	692,457	666,966	598,410	616,059	613,966	613,966	613,966	613,966	613,966	613,966	613,966	639,084	627,353	627,353	627,353	627,353
Total Non Operating Revenue/(Expe	666,841	700,202	694,725	605,531	641,127	615,661	618,347	614,928	800,339	623,403	797,260	666,835	463,113	2,015,266	629,952	630,418	629,421
Total Net Surplus/(Loss)	(421,599)	36,467	(482,217)	(1,731,521)	(520,060)	(1,633,129)	4,807,040	(1,296,162)	(669,672)	35,714	(1,188,921)	(13,037)	248,723	243,811	(1,171,342)	(1,752,801)	(1,461,118)
Change in Interest in Foundation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Extra-ordinary Loss on Financing	0	0	(689,574)	(650)	(284,792)	0	0	0	0	0	0	0	(3,417,500)	0	0	0	0
Increase/(Decrease in Unrestricted Net /	$ (421,599)	$ 36,467	$ (1,171,791)	$ (1,732,171)	$ (804,852)	$ (1,633,129)	$ 4,807,040	$ (1,296,162)	$ (669,672)	$ 35,714	$ (1,188,921)	$ (13,037)	$ (3,168,777)	$ 243,811	$ (1,171,342)	$ (1,752,801)	$ (1,461,118)
Total Profit Margin	-7.1%	0.6%	-7.9%	-31.4%	-7.7%	-26.7%	39.6%	-19.1%	-11.1%	0.5%	-17.0%	-0.2%	3.9%	4.0%	-18.9%	-32.9%	-25.7%
EBIDA %	-2.4%	4.2%	-4.1%	-25.3%	-4.4%	-21.7%	41.7%	-14.9%	-6.2%	4.0%	-15.8%	4.0%	0.9%	-13.0%	-13.3%	-29.4%	-22.0%

3-I

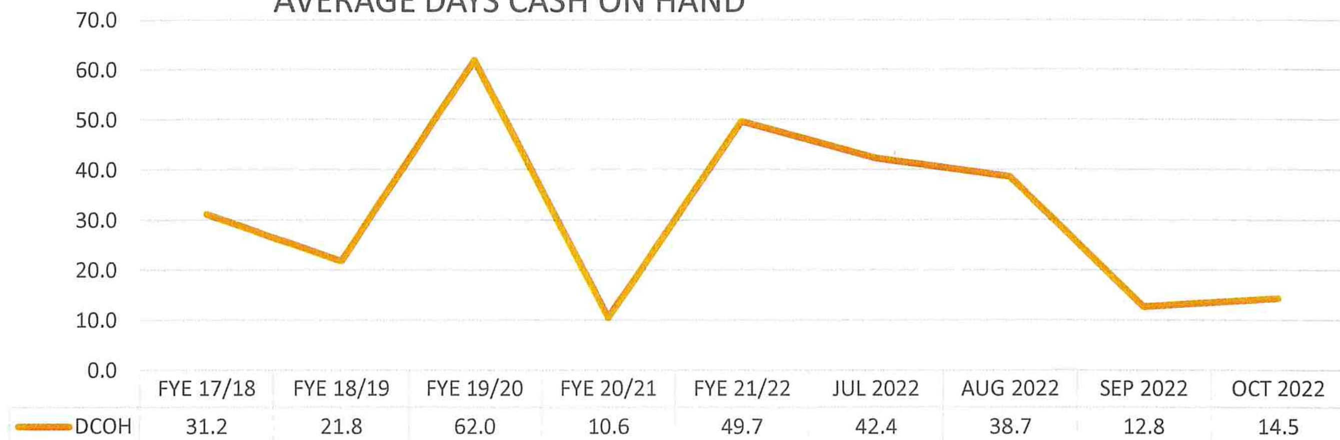
BALANCE SHEET (Period End)

Cash (000's)	Represents all unrestricted cash in the bank at each month-end.
Days Cash on Hand	Calculated by dividing amount of Cash on Hand by the historical average daily amount of cash requirmements to cover operating expenses.
Accounts Receivable - Net (000's)	Equals the sum of all (patient) accounts that are due to the hospital, less estimated adjustments for discounts and other contractual disallowances for which the patients may be entitled.
A/R Days - Net	This measures the average number of days it takes to collect payment of the Net Accounts Receivable. Lower values are desired.
Current Ratio (Current Assets/Current Liabilities)	A measure that illustrates the ability for the hospital to pay its obligations that come due over the course of the next year. The greater the Current Assets as compared to the Current Liabilities, the stronger position the organization is in to pay its upcoming obligations. Desired position is greater than 1:00 to 1:00, preferably at least 1:25 to 1:00 or greater.
Quick Ratio	This measures the Cash + Net Accounts Receivable compared to the Current Liabilities. Desired ratio is greater than 1.00 : 1.00.
Accounts Payable (000's)	Reflects payment obligations of the Hospital as of a point in time. Excludes Loans, Payroll and other Debt obligations. Lower values are desired.
Accounts Payable Days	Reflects the average number of days that it takes to pay routine bills. Lower numbers are desired. Calculated by dividing the Accounts Payable amount by the historical average daily cost of routine expenses.
Line of Credit Balance (000's)	The amount that is currently borrowed from a lending institution as of a given point in time.

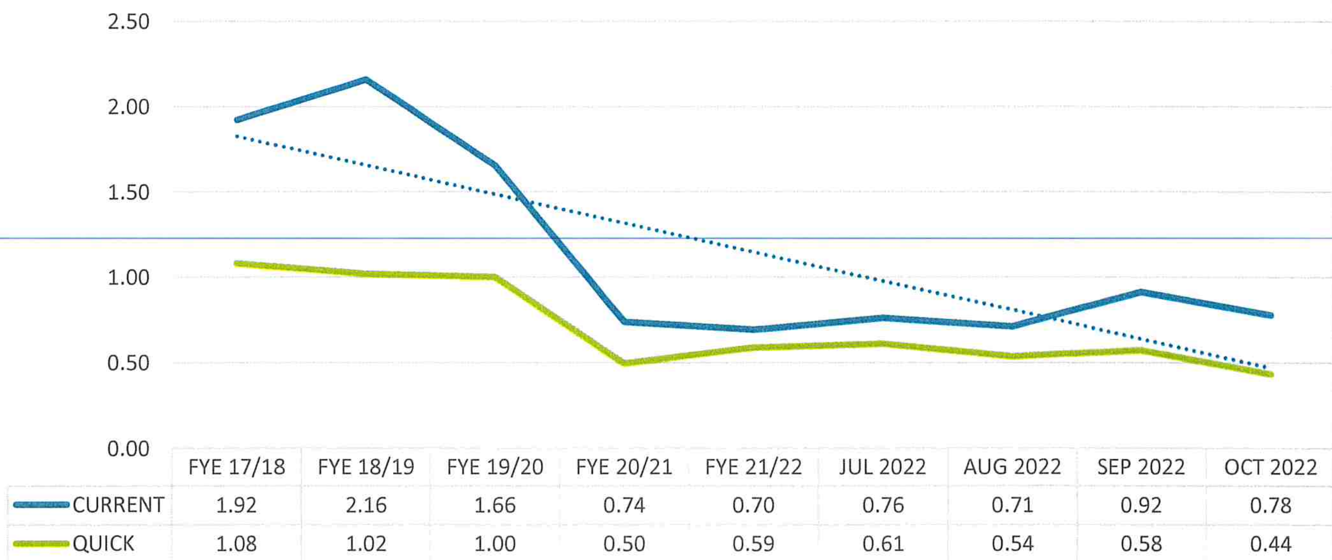
3-J

SAN GORGONIO MEMORIAL HOSPITAL

	FYE 17/18	FYE 18/19	FYE 19/20	FYE 20/21	FYE 21/22	JUL 2022	AUG 2022	SEP 2022	OCT 2022
CASH	$6,309	$4,175	$13,031	$2,396	$11,340	$9,671	$8,830	$2,927	$3,307
LOC	$0	$0	$6,000	$0	$12,000	$12,000	$12,000	$0	$0



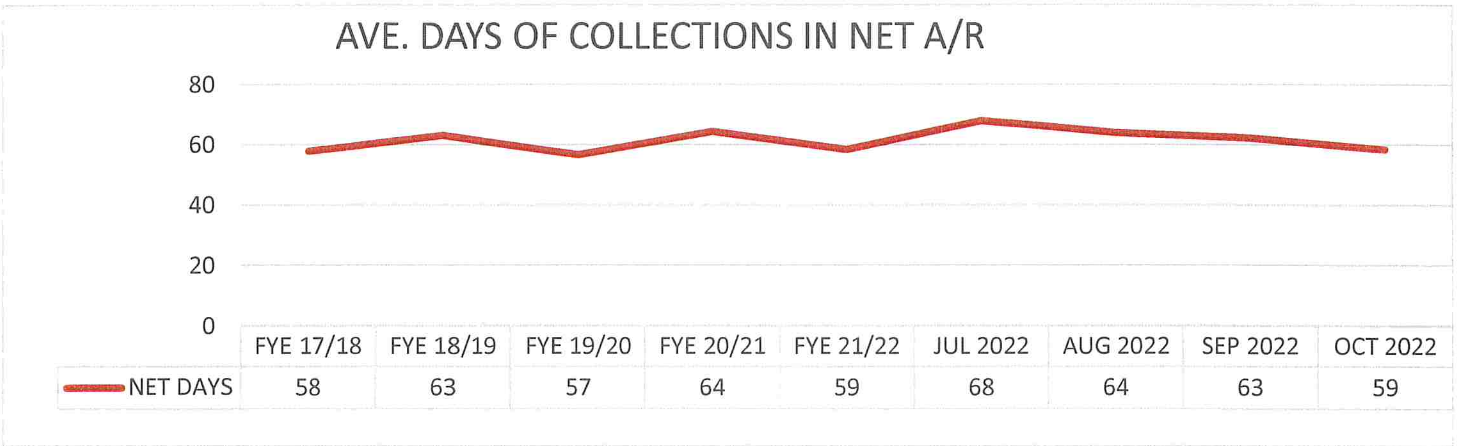
	FYE 17/18	FYE 18/19	FYE 19/20	FYE 20/21	FYE 21/22	JUL 2022	AUG 2022	SEP 2022	OCT 2022
DCOH	31.2	21.8	62.0	10.6	49.7	42.4	38.7	12.8	14.5



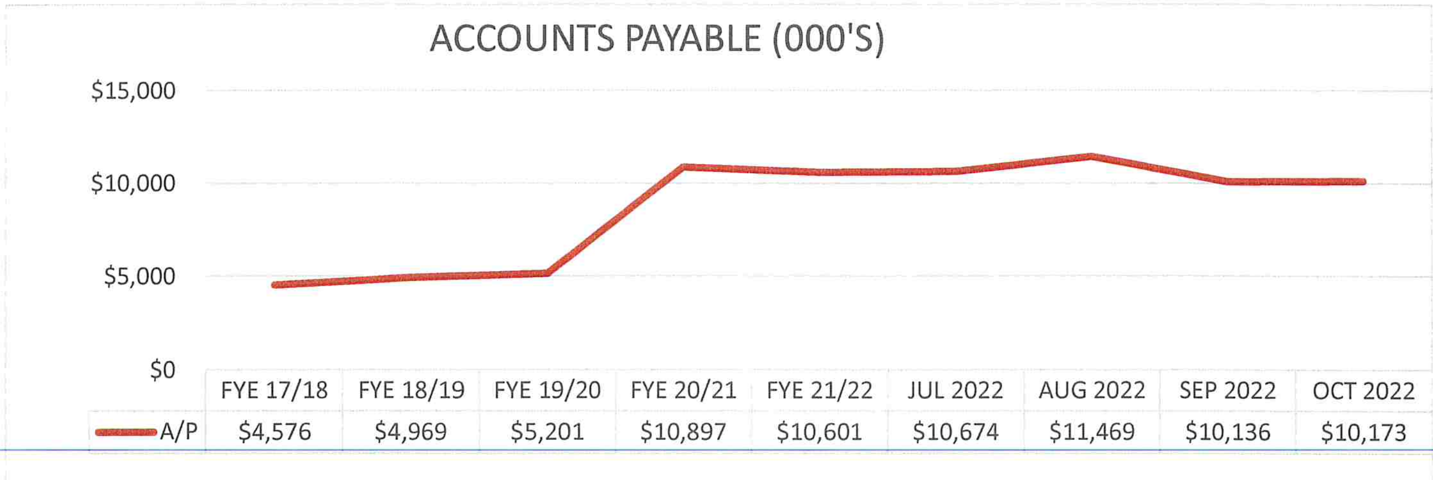
	FYE 17/18	FYE 18/19	FYE 19/20	FYE 20/21	FYE 21/22	JUL 2022	AUG 2022	SEP 2022	OCT 2022
CURRENT	1.92	2.16	1.66	0.74	0.70	0.76	0.71	0.92	0.78
QUICK	1.08	1.02	1.00	0.50	0.59	0.61	0.54	0.58	0.44

SAN GORGONIO MEMORIAL HOSPITAL

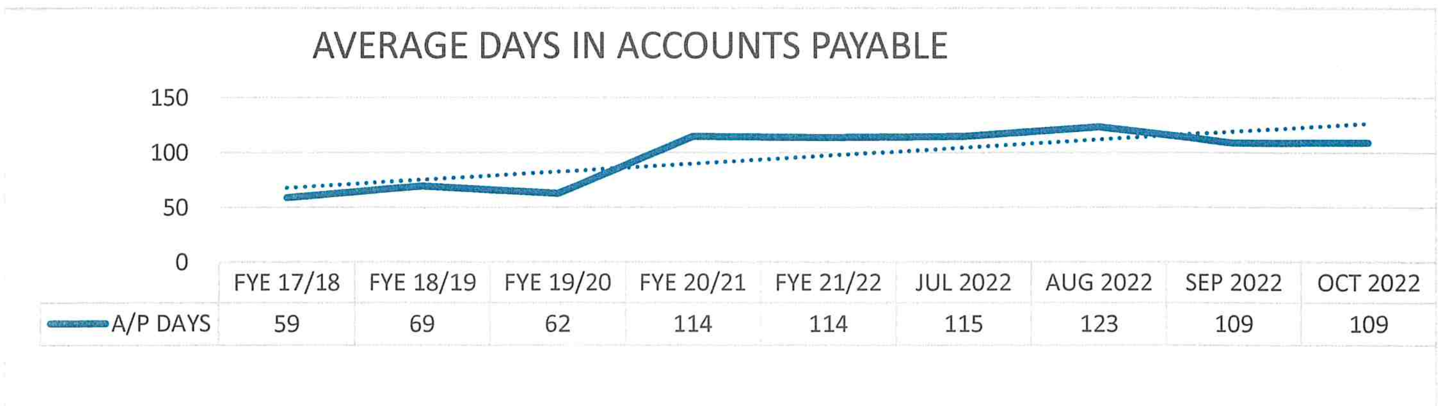
	FYE 17/18	FYE 18/19	FYE 19/20	FYE 20/21	FYE 21/22	JUL 2022	AUG 2022	SEP 2022	OCT 2022
NET A/R	$7,470	$8,330	$7,089	$7,939	$8,495	$9,899	$9,307	$9,084	$8,521



	FYE 17/18	FYE 18/19	FYE 19/20	FYE 20/21	FYE 21/22	JUL 2022	AUG 2022	SEP 2022	OCT 2022
NET DAYS	58	63	57	64	59	68	64	63	59



	FYE 17/18	FYE 18/19	FYE 19/20	FYE 20/21	FYE 21/22	JUL 2022	AUG 2022	SEP 2022	OCT 2022
A/P	$4,576	$4,969	$5,201	$10,897	$10,601	$10,674	$11,469	$10,136	$10,173



	FYE 17/18	FYE 18/19	FYE 19/20	FYE 20/21	FYE 21/22	JUL 2022	AUG 2022	SEP 2022	OCT 2022
A/P DAYS	59	69	62	114	114	115	123	109	109

SAN GORGONIO MEMORIAL HOSPITAL
EXECUTIVE FINANCIAL SUMMARY
FOUR MONTHS ENDING OCTOBER 31, 2022

STATEMENT OF REVENUE AND EXPENSES - MONTH & YTD

REF LINE#		10/31/22 ACTUAL	10/31/22 BUDGET	YTD ACTUAL	YTD BUDGET	YTD DIFFERENCE
	Revenue:					
[1]	Gross Patient Revenues	$ 40,581,924	$ 43,100,940	$ 160,276,951	$ 173,859,193	$ (13,582,242)
[2]	Deductions From Revenue	(35,447,702)	(37,475,309)	(139,406,022)	(151,166,703)	11,760,681
[3]	Net Patient Revenues	**5,134,222**	**5,625,631**	**20,870,929**	**22,692,490**	**(1,821,560)**
[4]	IGT Revenue	-	-	-	-	-
[5]	Other Operating Revenue	540,062	557,030	2,442,793	2,564,183	(121,390)
[6]	**Total Operating Revenues**	**5,674,284**	**6,182,661**	**23,313,722**	**25,256,673**	**(1,942,951)**
	Expenses:					
[7]	Salaries, Benefits	4,400,849	4,664,962	17,565,282	18,373,177	807,895
	Contract Labor	50,991	76,043	326,569	297,396	(29,173)
	Physicians Fees	308,777	365,231	1,211,009	1,460,924	249,915
	Other Purchase Services	802,604	1,042,961	3,426,122	4,171,845	745,723
[8]	Purchased Serv. & Physician Fees	1,162,371	1,484,235	4,963,700	5,930,165	966,464
[9]	Supply Expenses	895,128	1,108,678	3,305,264	4,432,180	1,126,916
[10]	Other Operating Expenses & Clinic Loss	465,101	477,945	1,912,357	2,095,325	182,968
[11]	Supplimental and Grant Expense	-	-	-	-	-
[12]	**Total Expenses**	**$ 6,923,449**	**$ 7,735,820**	**$ 27,746,603**	**$ 30,830,847**	**$ 3,084,243**
						0
[13]	**EBIDA**	**$ (1,249,165)**	**$ (1,553,160)**	**$ (4,432,881)**	**$ (5,574,174)**	**$ 1,141,293**
						0
[14]	Depreciation & Interest Expense	841,374	1,006,530	3,613,627	3,817,611	203,984
[15]	Non-Operating Revenue/(Exp.)	629,421	1,092,982	3,905,057	4,371,927	(466,869)
[16]	**TOTAL NET SURPLUS (LOSS)**	**$ (1,461,118)**	**$ (1,466,708)**	**$ (4,141,450)**	**$ (5,019,858)**	**$ 878,407**

SAN GORGONIO MEMORIAL HOSPITAL
EXECUTIVE FINANCIAL SUMMARY
FOUR MONTHS ENDING OCTOBER 31, 2022

	BALANCE SHEET	YTD 10/31/2022	Prior FYE 6/30/2022
	ASSETS		
[1]	Current Assets	$ 21,191,427	$ 23,401,085
[2]	Assets Whose Use is Limited	8,439,726	12,704,494
[3]	Property, Plant & Equipment (Net)	73,044,777	73,514,801
[4]	Other Assets	594,861	503,000
[5]	**Total Unrestricted Assets**	**103,270,792**	**110,123,380**
[6]	Restricted Assets	0	0
[7]	**Total Assets**	**$ 103,270,792**	**$ 110,123,380**
	LIABILITIES AND NET ASSETS		
[8]	Current Liabilities	$27,115,169	$33,649,575
[9]	Long-Term Debt	111,789,323	105,323,946
[10]	Other Long-Term Liabilities	2,231,628	2,231,626
[11]	**Total Liabilities**	**$ 141,136,120**	**$ 141,205,147**
[12]	Net Assets	$ (37,865,328)	$ (31,081,767)
[13]	**Total Liabilities and Net Assets**	**$ 103,270,792**	**$ 110,123,380**

KEY STATISTICS AND RATIOS

		09/30/22 ACTUAL	10/31/22 ACTUAL	10/31/22 BUDGET	2023 YTD	2022 YR END TOTAL
		FY 23	FY 23	FY 23	FY 23	FY 22
[1]	Total Acute Patient Days	616	582	960	2,567	9,689
[2]	Average Daily Census	20.5	18.8	31.0	20.9	26.5
[3]	Average Acute Length of Stay	3.5	3.2	4.1	3.5	3.9
[4]	Patient Discharges	175	184	237	742	2,502
[5]	Observation Days	273	239	237	1,017	2,775
[6]	Total Emergency Room Visits	3,599	3,619	3,237	14,359	39,374
[7]	Average ED Visits Per Day	120	117	104	117	108
[9]	Total Surgeries	156	157	121	680	1,446
[10]	Deliveries/Births	17	15	13	58	175

Statement of Revenue and Expense

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
FOUR MONTHS ENDING OCTOBER 31, 2022

		DISTRICT ONLY ACTUAL 10/31/22	CURRENT MONTH FY 23 ACTUAL 10/31/22	FY 23 CUR MO BUD 10/31/22	Positive (Negative) Variance	Percentage Variance
	Gross Patient Revenue					
[1]	Inpatient Revenue	$ -	$ 13,331,273	$ 20,997,083	$ (7,665,810)	-57.5%
[2]	Inpatient Psych/Rehab Revenue	-	-			
[3]	Outpatient Revenue	-	27,250,651	$ 22,103,857	5,146,794	18.9%
[4]	Long Term Care Revenue	-	-			
[5]	Home Health Revenue	-	-			
[6]	Total Gross Patient Revenue	$ -	$ 40,581,924	$ 43,100,940	**$ (2,519,016)**	-6.2%
	Deductions From Revenue					
[7]	Discounts and Allowances	-	(34,683,286)	$ (35,879,417)	$ 1,196,130	-3.4%
[8]	Bad Debt Expense	-	(734,463)	$ (1,517,804)	783,341	-106.7%
[9]	Prior Year Settlements	-	-	$ -	-	
[10]	Charity Care	-	(29,952)	$ (78,088)	48,136	-160.7%
[11]	Total Deductions From Revenue	-	(35,447,702)	(37,475,309)	**$ 2,027,607**	-5.7%
[12]			-87.3%	-86.9%		
[13]	Net Patient Revenue	$ -	$ 5,134,222	$ 5,625,631	**$ (491,409)**	-9.6%
	Non Patient Operating Revenues					
[14]	IGT/DSH Revenues	-	-	$ -	$ -	0.0%
[15]	Grants & Other Op Revenues	-	138,568	$ 144,286	(5,718)	-4.1%
[16]	Clinic Net Revenues	-	-	$ -	-	
[17]	Tax Subsidies Measure D	246,994	246,994	$ 246,994	(0)	0.0%
[18]	Tax Subsidies Prop 13	154,500	154,500	$ 154,500	-	0.0%
[19]	Tax Subsidies County Supplemental Funds	-	-	$ 11,250	(11,250)	0.0%
	Non- Patient Revenue	$ 401,494	$ 540,062	$ 557,030	$ (16,968)	-3.1%
	Total Operating Revenue	**$ 401,494**	**$ 5,674,284**	**$ 6,182,661**	**$ (508,376)**	-9.0%
	Operating Expenses					
[20]	Salaries and Wages	-	3,505,628	3,744,517	$ 238,889	6.8%
[21]	Fringe Benefits	-	895,221	920,446	25,224	2.8%
[22]	Contract Labor	-	50,991	76,043	25,052	49.1%
[23]	Physicians Fees	-	308,777	365,231	56,454	18.3%
[24]	Purchased Services	1,118	802,604	1,042,961	240,357	29.9%
[25]	Supply Expense	-	895,128	1,108,678	213,551	23.9%
[26]	Utilities	1,857	99,363	78,567	(20,797)	-20.9%
[27]	Repairs and Maintenance	8,960	111,348	75,564	(35,784)	-32.1%
[28]	Insurance Expense	-	119,141	122,979	3,838	3.2%
[29]	All Other Operating Expenses	-	84,177	99,325	15,147	18.0%
[30]	Supplimental and Grant Expense	-	-	0	-	0.0%
[31]	Leases and Rentals	-	51,072	101,511	50,439	98.8%
[32]	Clinic Expense	-	-	0	-	0.0%
[33]	**Total Operating Expenses**	**$ 11,934**	**$ 6,923,449**	**$ 7,735,820**	**$ 812,371**	**11.7%**
[34]	**EBIDA**	**$ 389,560**	**$ (1,249,165)**	**$ (1,553,160)**	**$ 303,995**	**-24.3%**
	Interest Expense and Depreciation					
[35]	Depreciation	406,450	446,580	550,579	$ 103,999	23.3%
[36]	Interest Expense and Amortization	313,245	394,794	455,951	61,157	15.5%
[37]	**Total Interest & depreciation**	**719,695**	**841,374**	**1,006,530**	**165,156**	19.6%
	Non-Operating Revenue:					
[38]	Contributions & Other	1,523	2,068	466,744	(464,677)	-22474.1%
[39]	Tax Subsidies for GO Bonds - M-A	627,353	627,353	626,237	1,116	0.2%
[40]	**Total Non Operating Revenue/(Expense)**	**628,876**	**629,421**	**1,092,982**	**$ (463,561)**	-73.6%
[41]	**Total Net Surplus/(Loss)**	**$ 298,741**	**$ (1,461,118)**	**$ (1,466,708)**	**$ 5,590**	-0.4%
[42]	Extra-ordinary loss on FInancing	-	-	-		
		-	-	-		
[43]	**Increase/(Decrease in Unrestricted Net Assets**	**$ 298,741**	**$ (1,461,118)**	**$ (1,466,708)**	**$ 5,590**	-0.4%
[44]	**Total Profit Margin**	**74.41%**	**-25.75%**	**-23.72%**		
[45]	**EBIDA %**	**97.03%**	**-22.01%**	**-25.12%**		

Statement of Revenue and Expense

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
FOUR MONTHS ENDING OCTOBER 31, 2022

		YEAR-TO-DATE				
		DISTRICT ONLY Actual 10/31/22	Actual 10/31/22	Budget 10/31/22	Positive (Negative) Variance	Percentage Variance
Gross Patient Revenue						
[1]	Inpatient Revenue	$ -	$ 58,518,299	$ 84,164,413	$ (25,646,114)	-43.8%
[2]	Inpatient Psych/Rehab Revenue	-	-		-	
[3]	Outpatient Revenue	-	101,758,652	$ 89,694,780	12,063,872	11.9%
[4]	Long Term Care Revenue	-	-			
[5]	Home Health Revenue	-	-			
[6]	Total Gross Patient Revenue	$ -	$ 160,276,951	$ 173,859,193	**$ (13,582,242)**	**-8.5%**
Deductions From Revenue						
[7]	Discounts and Allowances	-	(135,308,515)	$ (144,729,243)	$ 9,420,728	7.0%
[8]	Bad Debt Expense	-	(3,545,052)	$ (6,122,470)	2,577,418	72.7%
[9]	Prior Year Settlements	-	-	$ -	-	
[10]	Charity Care	-	(552,455)	$ (314,990)	(237,465)	-43.0%
[11]	Total Deductions From Revenue	-	(139,406,022)	(151,166,703)	**$ 11,760,681**	**8.4%**
[12]			87.0%	-86.9%		
[13]	Net Patient Revenue	$ -	$ 20,870,929	$ 22,692,490	**$ (1,821,560)**	**-8.7%**
Non Patient Operating Revenues						
[14]	IGT/DSH Revenues	-	-	$ -	$ -	0.0%
[15]	Grants & Other Op Revenues	-	836,818	$ 913,208	(76,390)	-9.1%
[16]	Clinic Net Revenues	-	-	$ -	-	
[17]	Tax Subsidies Measure D	466,666	987,975	$ 987,975	(0)	0.0%
[18]	Tax Subsidies Prop 13	618,000	618,000	$ 618,000	-	0.0%
[19]	Tax Subsidies County Supplemental Funds	-	-	$ 45,000	(45,000)	0.0%
	Non- Patient Revenue	$ 1,084,666	$ 2,442,793	$ 2,564,183	$ (121,390)	-5.0%
	Total Operating Revenue	**$ 1,084,666**	**$ 23,313,722**	**$ 25,256,673**	**$ (1,942,951)**	**-8.3%**
Operating Expenses						
[20]	Salaries and Wages	-	13,998,084	$ 14,711,462	$ 713,378	5.1%
[21]	Fringe Benefits	-	3,567,198	$ 3,661,715	94,517	2.6%
[22]	Contract Labor	-	326,569	$ 297,396	(29,173)	-8.9%
[23]	Physicians Fees	-	1,211,009	$ 1,460,924	249,915	20.6%
[24]	Purchased Services	4,012	3,426,122	$ 4,171,845	745,723	21.8%
[25]	Supply Expense	-	3,305,264	$ 4,432,180	1,126,916	34.1%
[26]	Utilities	8,909	415,614	$ 497,814	82,200	19.8%
[27]	Repairs and Maintenance	41,416	361,772	$ 302,255	(59,517)	-16.5%
[28]	Insurance Expense	-	517,875	$ 491,915	(25,960)	-5.0%
[29]	All Other Operating Expenses	-	282,168	$ 397,299	115,131	40.8%
[30]	Supplimental and Grant Expense	-	-	$ -	-	0.0%
[31]	Leases and Rentals	-	334,928	$ 406,042	71,114	21.2%
[32]	Clinic Expense	-	-	$ -	-	0.0%
[33]	**Total Operating Expenses**	**$ 54,337**	**$ 27,746,603**	**$ 30,830,847**	**$ 3,084,243**	**11.1%**
[34]	**EBIDA**	**$ 1,030,329**	**$ (4,432,881)**	**$ (5,574,174)**	**$ 1,141,293**	**-25.7%**
Interest Expense and Depreciation						
[35]	Depreciation	1,769,393	1,809,523	$ 2,130,889	$ 321,365	17.8%
[36]	Interest Expense and Amortization	1,379,718	1,804,103	$ 1,686,722	(117,381)	-6.5%
[37]	**Total Interest & depreciation**	**3,149,111**	**3,613,627**	**3,817,611**	**203,984**	5.6%
Non-Operating Revenue:						
[38]	Contributions & Other	1,393,126	1,395,645	$ 1,866,977	(471,332)	-33.8%
[39]	Tax Subsidies for GO Bonds - M-A	2,509,413	2,509,413	$ 2,504,950	4,463	0.2%
[40]	**Total Non Operating Revenue/(Expense)**	**3,902,539**	**3,905,057**	**4,371,927**	**(466,869)**	-12.0%
[41]	**Total Net Surplus/(Loss)**	**$ 1,783,757**	**$ (4,141,450)**	**$ (5,019,858)**	**$ 878,407**	-21.2%
[42]	Extra-ordinary loss on FInancing	-	-	-		
		-	-	-		
[43]	**Increase/(Decrease in Unrestricted Net Assets**	**$ 1,783,757**	**$ (4,141,450)**	**$ (5,019,858)**	**$ 878,407**	-21.2%
[44]	**Total Profit Margin**	**164.45%**	**-17.76%**	**-19.88%**		
[45]	**EBIDA %**	**94.99%**	**-19.01%**	**-22.07%**		

Balance Sheet - Assets

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
FOUR MONTHS ENDING OCTOBER 31, 2022

		DISTRICT ONLY Current Month 10/31/2022	ASSETS Current Month 10/31/2022	Prior Month 9/30/2022	Positive/ (Negative) Variance	Prior Year End 6/30/2022
Current Assets						
[1]	Cash and Cash Equivalents	2,303,148	$3,306,606	$2,926,986	$ 379,620	$ 11,340,002
[2]	Gross Patient Accounts Receivable	$0	$82,740,982	$82,802,146	$ (61,164)	77,594,807
[3]	Less: Bad Debt and Allowance Reserves	$0	($74,220,043)	($74,126,240)	$ (93,804)	(69,099,845)
[4]	Net Patient Accounts Receivable	$0	$8,520,939	$8,675,906	$ (154,968)	8,494,961
[5]	Taxes Receivable	$5,136,355	$5,136,355	$4,107,409	$ 1,028,946	1,178,859
[6]	Other Receivables (includes advances)	660,465	$449,019	$273,155	$ 175,865	738,141
[7]	Inventories	$0	$2,270,526	$2,693,773	$ (423,247)	2,297,204
[8]	Prepaid Expenses	126,169	$3,051,852	$1,396,657	$ 1,655,195	1,197,395
[9]	Due From Third Party Payers-DSH	$0	($1,543,869)	($1,332,477)	$ (211,392)	(1,845,477)
[10]	Malpractice Receivable	$0	$0	$0	$ -	-
[11]	Supplimental Receivables	$0	$0	$0	$ -	-
	Total Current Assets	**8,226,136**	**21,191,427**	**18,741,408**	**$ (736,481)**	**$ 23,401,085**
Assets Whose Use is Limited						
[12]	Cash					
[13]	Investments					
[14]	Bond Reserve/Debt Retirement Fund	$8,439,726	$8,439,726	$8,395,962	$ 43,764	12,704,494
[15]	Trustee Held Funds					
[16]	Funded Depreciation					
[17]	Board Designated Funds					
[18]	Other Limited Use Assets					0
	Total Limited Use Assets	**8,439,726**	**8,439,726**	**8,395,962**	**$ (223,324)**	**$ 12,704,494**
Property, Plant, and Equipment						
[19]	Land and Land Improvements	4,828,182	4,828,182	4,828,182	$ -	$ 4,828,182
[20]	Building and Building Improvements	129,281,491	129,281,491	129,281,491	$ -	129,281,491
[21]	Equipment	27,060,543	27,060,543	27,045,243	$ 15,300	26,856,789
[22]	Construction In Progress	1,862,472	1,862,472	1,754,216	$ 108,256	1,694,007
[23]	Capitalized Interest					
[24]	Gross Property, Plant, and Equipment	163,032,688	163,032,688	162,909,132	$ 123,556	162,660,469
[25]	Less: Accumulated Depreciation	($89,987,911)	($89,987,911)	($89,581,461)	$ (406,450)	(89,145,667)
[26]	**Net Property, Plant, and Equipment**	**73,044,777**	**73,044,777**	**73,327,671**	**$ (475,050)**	**$ 73,514,801**
Other Assets						
[27]	Unamortized Loan Costs	$627,385	$594,861	$606,673	$ (11,812)	$ 614,440
[28]	Assets Held for Future Use		$0	$0	$ -	485
[29]	Investments in Subsidiary/Affiliated Org.	$28,967,972	$0	$0	$ -	(111,925)
[30]	Other					
[31]	**Total Other Assets**	**29,595,356**	**594,861**	**606,673**	**$ (11,812)**	**$ 503,000**
[32]	**TOTAL UNRESTRICTED ASSETS**	**119,305,996**	**103,270,792**	**101,071,714**	**$ 2,199,078**	**$ 110,123,381**
Restricted Assets		0	0	0	0	0
[33]	**TOTAL ASSETS**	**$119,305,996**	**$103,270,792**	**$101,071,714**	**$ 2,199,078**	**$ 110,123,381**

Note: Certain Balance Sheet items, including "Total Net Assets" do not include or reflect all of the final audit entries from the FYE June 30, 2022. Because these reports are prepared for internal users only, they do not purport to conform to the principles contained in U.S. GAAP.

Balance Sheet - Liabilities and Net Assets

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
FOUR MONTHS ENDING OCTOBER 31, 2022

	DISTRICT ONLY	LIABILITIES AND FUND BALANCE			
	Current Month 10/31/2022	Current Month 10/31/2022	Prior Month 9/30/2022	Positive/ (Negative) Variance	Prior Year End 6/30/2022
Current Liabilities					
[1] Accounts Payable	$ 347,298	$ 10,172,892	$ 10,135,826	$ (37,066)	$ 10,600,622
[2] Notes and Loans Payable (Line of Credit)	-	0	0	$ -	12,000,000
[3] Accounts Payable- Tax advance	-	-	-	$ -	-
[4] Accrued Payroll Taxes	-	7,417,886	6,422,302	$ (995,584)	5,597,527
[5] Accrued Benefits	-	-	-	$ -	-
[6] Accrued Benefits Current Portion	-	-	-	$ -	-
[7] Other Accrued Expenses	-	-	-	$ -	-
[8] Accrued GO Bond Interest Payable	1,248,544	1,248,544	1,376,337	$ 127,793	2,526,756
[9] Stimulus Advance	-	7,355	4,779	$ (2,576)	4,259
[10] Due to Third Party Payers (Settlements)	-	3,417,500	-	$ (3,417,500)	-
[11] Advances From Third Party Payers	-	-	-	$ -	-
[12] Current Portion of LTD (Bonds/Mortgages)	2,335,000	2,335,000	2,335,000	$ -	2,335,000
[13] Current Portion of LTD (Leases)	-	-	-	$ -	-
[14] Other Current Liabilities	-	2,515,991	593,374	-	585,411
Total Current Liabilities	**3,930,842**	**27,115,169**	**20,867,618**	**$ 791,861**	**33,649,575**
Long Term Debt					
[15] Bonds/Mortgages Payable (net of Cur Portion)	99,542,891	$99,996,280	$ 101,936,923	$ 1,940,643	$ 103,030,598
[16] Leases Payable (net of current portion)	$11,793,043	$11,793,043	$11,804,064	$ 11,021	$2,293,348
[17] **Total Long Term Debt (Net of Current)**	**111,335,934**	**111,789,323**	**113,740,987**	**$ 313,358**	**105,323,946**
Other Long Term Liabilities					
[18] Deferred Revenue					
[19] Accrued Pension Expense (Net of Current)					
[20] Other-Bridge Loan	0	2,231,628	2,231,628	$ -	2,231,628
[21] **Total Other Long Term Liabilities**	**0**	**2,231,628**	**2,231,628**	**0**	**2,231,628**
TOTAL LIABILITIES	**$ 115,266,776**	**$ 141,136,120**	**$ 136,840,233**	**$ (4,295,886)**	**$ 141,205,148**
Net Assets:					
[22] Unrestricted Fund Balance	2,255,463	(33,723,878)	$ (33,723,878)	$ -	$ (25,347,940)
[23] Temporarily Restricted Fund Balance	-	-	-	-	-
[24] Restricted Fund Balance	-	-	-	-	-
[25] Net Revenue/(Expenses)	1,783,757	(4,141,450)	(2,044,642)	2,096,808	(5,733,827)
[26] **TOTAL NET ASSETS**	**4,039,220**	**(37,865,328)**	**$ (35,768,520)**	**$ 2,096,808**	**$ (31,081,767)**
[27] **TOTAL LIABILITIES AND NET ASSETS**	**$ 119,305,996**	**$ 103,270,792**	**$ 101,071,714**	**$ (2,199,078)**	**$ 110,123,381**
	$ 0	$ 0	$ (0)	($0) 0	$ -

Note: Certain Balance Sheet items, including "Total Net Assets" do not include or reflect all of the final audit entries from the FYE June 30, 2022. Because these reports are prepared for internal users only, they do not purport to conform to the principles contained in U.S. GAAP.

Statement of Cash Flows

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
FOUR MONTHS ENDING OCTOBER 31, 2022

	HEALTHCARE SYSTEM CASH FLOW		CASH FLOW Current Month 10/31/2022
	BEGINNING CASH BALANCES		
[1]	Cash: Beginning Balances- HOSPITAL	$	272,096
[2]	Cash: Beginning Balances- DISTRICT		2,303,148
[3]	Cash: Beginning Balances TOTALS	$	2,575,244
	Receipts		
[4]	Pt Collections	$	5,911,700
[5]	Tax Subsidies Measure D/Prop 13		-
[6]	Misc Tax Subsidies		-
[7]	Donations/Grants		42,303
[8]	IGT & other Supplemental (Net)		-
[9]	Draws/(Paydown) of LOC Balances		-
[10]	Other Misc Receipts/Transfers		96,265
	TOTAL RECEIPTS	**$**	**6,050,268**
	Disbursements		
[11]	Payroll/ Benefits	$	4,600,849
[12]	Other Operating Costs		757,145
[13]	Capital Spending		0
[14]	Debt serv payments (Hosp onlyw/ LOC interest)		
[15]	Other (increase) in AP /other bal sheet		(37,066)
[16]	**TOTAL DISBURSEMENTS**	**$**	**5,318,906**
[17]	**TOTAL CHANGE in CASH**	**$**	**731,362**
	ENDING CASH BALANCES		
[18]	Ending Balances- HOSPITAL	$	1,003,459
[19]	Ending Balances- DISTRICT		2,303,148
[20]	Ending Balances- TOTALS	$	3,306,606

ADDITIONAL INFO

[21]	LOC CURRENT BALANCES	$	-
			$80,000

Statement of Revenue and Expense

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
THREE MONTHS ENDING SEPTEMBER 30, 2022

		DISTRICT ONLY ACTUAL 09/30/22	CURRENT MONTH FY 23 ACTUAL 09/30/22	FY 23 CUR MO BUD 09/30/22	Positive (Negative) Variance	Percentage Variance
	Gross Patient Revenue					
[1]	Inpatient Revenue	$ -	$ 13,156,157	$ 20,881,459	$ (7,725,302)	-58.7%
[2]	Inpatient Psych/Rehab Revenue	-	-			
[3]	Outpatient Revenue	-	24,122,862	$ 22,663,136	1,459,725	6.1%
[4]	Long Term Care Revenue	-	-			
[5]	Home Health Revenue	-	-			
[6]	Total Gross Patient Revenue	$ -	$ 37,279,018	$ 43,544,595	$ (6,265,577)	-16.8%
	Deductions From Revenue					
[7]	Discounts and Allowances	-	(30,986,845)	$ (36,248,738)	$ 5,261,893	-17.0%
[8]	Bad Debt Expense	-	(1,113,485)	$ (1,533,428)	419,942	-37.7%
[9]	Prior Year Settlements	-	-	$ -	-	
[10]	Charity Care	-	(427,789)	$ (78,892)	(348,897)	81.6%
[11]	Total Deductions From Revenue	-	(32,528,119)	(37,861,057)	$ 5,332,938	-16.4%
[12]			-87.3%	-86.9%		
[13]	Net Patient Revenue	$ -	$ 4,750,899	$ 5,683,538	$ (932,639)	-19.6%
	Non Patient Operating Revenues					
[14]	IGT/DSH Revenues	-	-	$ -	$ -	0.0%
[15]	Grants & Other Op Revenues	-	93,358	$ 144,286	(50,928)	-54.6%
[16]	Clinic Net Revenues	-	-	$ -	-	
[17]	Tax Subsidies Measure D	246,994	246,994	$ 246,994	0	0.0%
[18]	Tax Subsidies Prop 13	154,500	154,500	$ 154,500	-	0.0%
[19]	Tax Subsidies County Supplemental Funds	-	-	$ 11,250	(11,250)	0.0%
	Non- Patient Revenue	$ 401,494	$ 494,852	$ 557,030	$ (62,178)	-12.6%
	Total Operating Revenue	**$ 401,494**	**$ 5,245,751**	**$ 6,240,568**	**$ (994,816)**	-19.0%
	Operating Expenses					
[20]	Salaries and Wages	-	3,344,149	3,662,607	$ 318,458	9.5%
[21]	Fringe Benefits	-	904,958	914,545	9,588	1.1%
[22]	Contract Labor	-	72,561	74,695	2,134	2.9%
[23]	Physicians Fees	-	293,059	365,231	72,172	24.6%
[24]	Purchased Services	2,462	1,003,052	1,042,961	39,909	4.0%
[25]	Supply Expense	-	823,019	1,116,539	293,520	35.7%
[26]	Utilities	1,876	113,507	156,818	43,311	38.2%
[27]	Repairs and Maintenance	14,937	51,558	75,564	24,005	46.6%
[28]	Insurance Expense	-	133,709	122,979	(10,730)	-8.0%
[29]	All Other Operating Expenses	-	47,279	99,325	52,046	110.1%
[30]	Supplimental and Grant Expense	-	-	0	-	0.0%
[31]	Leases and Rentals	-	106,555	101,511	(5,044)	-4.7%
[32]	Clinic Expense	-	-	0	-	0.0%
[33]	**Total Operating Expenses**	**$ 19,275**	**$ 6,893,407**	**$ 7,732,775**	**$ 839,368**	**12.2%**
[34]	**EBIDA**	**$ 382,219**	**$ (1,647,656)**	**$ (1,492,207)**	**$ (155,448)**	**9.4%**
	Interest Expense and Depreciation					
[35]	Depreciation	406,450	406,450	550,579	$ 144,130	35.5%
[36]	Interest Expense and Amortization	355,607	409,794	372,757	(37,036)	-9.0%
[37]	**Total Interest & depreciation**	**762,057**	**816,243**	**923,336**	**107,093**	13.1%
	Non-Operating Revenue:					
[38]	Contributions & Other	2,538	3,065	466,744	(463,679)	-15128.6%
[39]	Tax Subsidies for GO Bonds - M-A	627,353	627,353	626,237	1,116	0.2%
[40]	**Total Non Operating Revenue/(Expense)**	**629,891**	**630,418**	**1,092,982**	**$ (462,564)**	-73.4%
[41]	**Total Net Surplus/(Loss)**	**$ 250,054**	**$ (1,833,481)**	**$ (1,322,562)**	**$ (510,919)**	27.9%
[42]	Extra-ordinary loss on FInancing	-	-	-		
		-	-	-		
[43]	**Increase/(Decrease in Unrestricted Net Assets**	**$ 250,054**	**$ (1,833,481)**	**$ (1,322,562)**	**$ (510,919)**	27.9%
[44]	**Total Profit Margin**	**62.28%**	**-34.95%**	**-21.19%**		
[45]	**EBIDA %**	**95.20%**	**-31.41%**	**-23.91%**		

Statement of Revenue and Expense

SAN GORGONIO MEMORIAL HOSPITAL

BANNING, CALIFORNIA

THREE MONTHS ENDING SEPTEMBER 30, 2022

		YEAR-TO-DATE			
	DISTRICT ONLY Actual 09/30/22	Actual 09/30/22	Budget 09/30/22	Positive (Negative) Variance	Percentage Variance
Gross Patient Revenue					
[1] Inpatient Revenue	$ -	$ 45,187,026	$ 63,167,330	$ (17,980,305)	-39.8%
[2] Inpatient Psych/Rehab Revenue	-	-		-	
[3] Outpatient Revenue	-	74,508,001	$ 67,590,923	6,917,079	9.3%
[4] Long Term Care Revenue	-	-			
[5] Home Health Revenue	-	-			
[6] Total Gross Patient Revenue	$ -	$ 119,695,027	$ 130,758,253	$ (11,063,226)	-9.2%
Deductions From Revenue					
[7] Discounts and Allowances	-	(100,750,038)	$ (108,849,827)	$ 8,099,789	8.0%
[8] Bad Debt Expense	-	(2,810,589)	$ (4,604,666)	1,794,076	63.8%
[9] Prior Year Settlements	-	-	$ -	-	
[10] Charity Care	-	(522,502)	$ (236,902)	(285,600)	-54.7%
[11] Total Deductions From Revenue	-	(104,083,129)	(113,691,394)	$ 9,608,265	9.2%
[12]		87.0%	-86.9%		
[13] Net Patient Revenue	$ -	$ 15,611,898	$ 17,066,859	$ (1,454,961)	-9.3%
Non Patient Operating Revenues					
[14] IGT/DSH Revenues	-	-	$ 336,064	$ (336,064)	#DIV/0!
[15] Grants & Other Op Revenues	-	698,249	$ 432,858	265,391	38.0%
[16] Clinic Net Revenues	-	-	$ -	-	
[17] Tax Subsidies Measure D	493,988	740,981	$ 740,981	0	0.0%
[18] Tax Subsidies Prop 13	309,000	463,500	$ 463,500	-	0.0%
[19] Tax Subsidies County Supplemental Funds	-	-	$ 33,750	(33,750)	0.0%
Non- Patient Revenue	$ 802,988	$ 1,902,731	$ 2,007,153	$ (104,423)	-5.5%
Total Operating Revenue	**$ 802,988**	**$ 17,514,629**	**$ 19,074,012**	**$ (1,559,384)**	**-8.9%**
Operating Expenses					
[20] Salaries and Wages	-	10,492,456	$ 10,966,945	$ 474,490	4.5%
[21] Fringe Benefits	-	2,671,977	$ 2,741,269	69,292	2.6%
[22] Contract Labor	-	275,578	$ 221,353	(54,225)	-19.7%
[23] Physicians Fees	-	861,465	$ 1,095,693	234,228	27.2%
[24] Purchased Services	433	2,664,285	$ 3,128,884	464,598	17.4%
[25] Supply Expense	-	2,410,136	$ 3,323,502	913,365	37.9%
[26] Utilities	5,177	316,251	$ 419,247	102,996	32.6%
[27] Repairs and Maintenance	17,519	250,424	$ 226,691	(23,733)	-9.5%
[28] Insurance Expense	-	398,734	$ 368,937	(29,798)	-7.5%
[29] All Other Operating Expenses	-	197,991	$ 297,974	99,983	50.5%
[30] Supplimental and Grant Expense	-	-	$ -	-	0.0%
[31] Leases and Rentals	-	283,856	$ 304,532	20,675	7.3%
[32] Clinic Expense	-	-	$ -	-	0.0%
[33] **Total Operating Expenses**	**$ 23,128**	**$ 20,823,154**	**$ 23,095,026**	**$ 2,271,873**	**10.9%**
[34] **EBIDA**	**$ 779,859**	**$ (3,308,525)**	**$ (4,021,014)**	**$ 712,489**	**-21.5%**
Interest Expense and Depreciation					
[35] Depreciation	956,493	1,362,943	$ 1,580,309	$ 217,366	15.9%
[36] Interest Expense and Amortization	710,866	1,409,310	$ 1,230,772	(178,538)	-12.7%
[37] **Total Interest & depreciation**	**1,667,359**	**2,772,253**	**2,811,081**	**38,828**	1.4%
Non-Operating Revenue:					
[38] Contributions & Other	1,391,604	1,393,577	$ 1,400,233	(6,656)	-0.5%
[39] Tax Subsidies for GO Bonds - M-A	1,882,059	1,882,059	$ 1,878,712	3,347	0.2%
[40] **Total Non Operating Revenue/(Expense)**	**3,273,663**	**3,275,636**	**3,278,945**	**(3,309)**	-0.1%
[41] **Total Net Surplus/(Loss)**	**$ 2,386,163**	**$ (2,805,141)**	**$ (3,553,150)**	**$ 748,008**	-26.7%
[42] Extra-ordinary loss on Financing	-	-	-		
	-	-	-		
[43] **Increase/(Decrease in Unrestricted Net Assets**	**$ 2,386,163**	**$ (2,805,141)**	**$ (3,553,150)**	**$ 748,008**	-26.7%
[44] **Total Profit Margin**	**297.16%**	**-16.02%**	**-18.63%**		
[45] **EBIDA %**	**97.12%**	**-18.89%**	**-21.08%**		

TAB J

San Gorgonio Memorial Hospital and San Gorgonio Memorial Health Care District

To: Finance Committee, Board of Directors, and District Board

Agenda Item for November 29, 2022 Finance Committee and December 6, 2022 Board Meetings

Subject:

Renewal of 2023 Annual Dues for the District Hospital Leadership Forum (DHLF)

San Gorgonio Memorial Healthcare District & Hospital have been members of the DHFL for many years. The DHLF is the group which formally oversees the overall guidance and planning for all matters related to Supplemental Funding on behalf of California Healthcare Districts. DHLF also coordinates their efforts with numerous California agencies (including CHA) in areas that impact the Healthcare Districts.

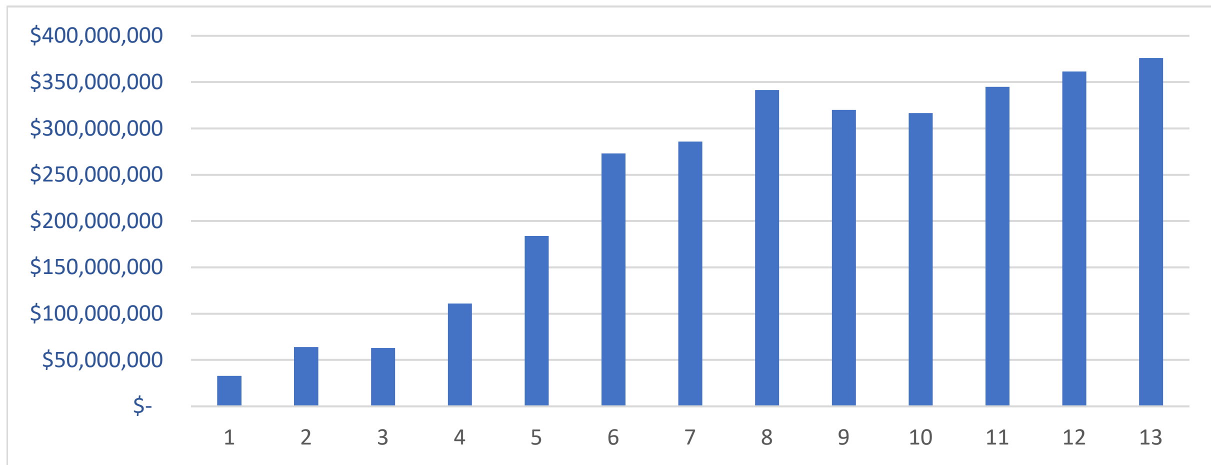
A summary of the Supplemental Funding programs is attached. These programs have procured over $376M for District/Municipal Hospitals since 2010. As you will recall, San Gorgonio is expected to receive $16M+ of Supplemental Funding in the current FY 2023.

The DHLF has regular Board Meetings and weekly CFO meetings, both of which are very helpful to the CEO and CFO in planning, forecasting, and budgeting for SGMHD's Supplemental Funding.

Recommended Action: To approve the 2023 membership dues of $77,669.71 as outlined.

Copies of the supporting documents are included in the packet.

2022 DHLF Value Statement: Aggregate Supplemental Funding for District/Municipal Hospitals, 2010-2022



	AB 113	Provider Fee	Rate Range	PRIME	TOTAL
2010		27,000,000	6,000,000		33,000,000
2011	36,000,000	18,000,000	10,000,000		64,000,000
2012	30,000,000	18,000,000	15,000,000		63,000,000
2013	30,000,000	26,000,000	55,000,000		111,000,000
2014	52,000,000	71,000,000	61,000,000		184,000,000
2015	38,000,000	73,000,000	62,000,000	100,000,000	273,000,000
2016	38,000,000	73,000,000	75,000,000	100,000,000	286,000,000
2017	35,000,000	108,000,000	100,000,000	100,000,000	343,000,000
2018	22,000,000	108,000,000	100,000,000	90,000,000	320,000,000
2019	17,000,000	108,000,000	115,000,000	76,500,000	316,500,000
2020	14,350,000	110,000,000	142,946,000	83,275,000	350,571,000
2021	13,170,000	107,600,000	147,420,000	93,250,000	361,440,000
2022	20,301,000	108,400,000	147,420,000	100,000,000	376,121,000

***Excludes Medi-Cal DSH, AB 915 and DP/NF supplemental payments**

Ongoing representation of district/municipal hospitals to address issues related to Medicare/Medi-Cal programs, and the relevant supplemental payment programs as identified above; as well as many of the organizations listed below:

- California Health and Human Services (CHHS)
- Department of Health Care Services (DHCS)
- Health & Human Services (HHS)
- Centers for Medicare and Medicaid Services (CMS)
- California Hospital Association (CHA)
- Hospital constituency groups (California Association of Public Hospital (CAPH) and others)
- California State Assembly / California State Senate
- California Congressional Delegation
- California Department of Finance and California Treasurer’s Office
- California Department of Managed Health Care and Department of Insurance
- Medi-Cal managed care health plans and the California Association of Health Plans
- Various patient/consumer advocacy organizations
- County Supervisors Association of California

DISTRICT HOSPITAL LEADERSHIP FORUM

950 Glenn Road, Suite 250
Folsom, CA 95630
(916) 443-7401 T
(916) 552-7606 F

November 14, 2022

Mr. Dan Heckathorne
Chief Financial Officer
San Gorgonio Memorial Hospital
600 North Highland Springs Avenue
Banning, CA 92220

Invoice - L23024

Dues for participation in the District Hospital Leadership Forum:

- 2023 Annual Dues for the period Jan 1, 2023 – Dec 31, 2023, is: $77,669.71
- ***At the 11/08/2022 board of directors meeting, the Board agreed to the current dues Amount and 2023 budget.***

Amount Due.. $77,669.71

Please make check payable to: **District Hospital Leadership Forum**

Mail To:

California Hospital Association
1215 K Street, Suite 700
Sacramento, CA 95814

If you have any questions regarding this invoice or prefer a payment plan, please contact Erin Hagstrom Clark at eclark@cadhlf.org or 916-673-2020.

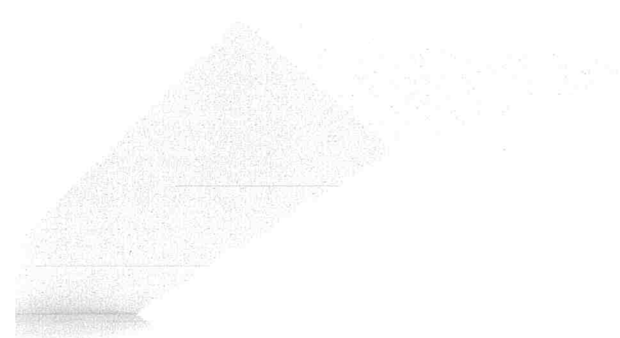
The following information is for tax-exempt entities: For calendar year 2022, 990 and Medicare reporting, 20.3% of your consolidated dues are for direct lobbying expenses.

TAB K

San Gorgonio Healthcare District

Financial Statements and Supplementary Information

Years ended June 30, 2022 and 2021



WIPFLI

Independent Auditor's Report

Board of Directors
San Gorgonio Healthcare District
Banning, California

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of San Gorgonio Healthcare District (the "District"), which comprise the statements of net position as of June 30, 2022 and 2021, and the related statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the financial position of San Gorgonio Healthcare District as of June 30, 2022 and 2021, and the results of its operations for the years then ended in accordance with accounting principles generally accepted in the United States of America ("GAAP").

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America ("GAAS") and the standards applicable to financial audits contained in *Government Auditing Standards (Government Auditing Standards)* issued by the Comptroller General of the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of San Gorgonio Healthcare District and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about San Gorgonio Healthcare District's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

WIPFLI

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

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

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

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of San Gorgonio Healthcare District's internal control. Accordingly, no such opinion is expressed.

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

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

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

WIPFLI

Supplementary Information

Our audits were conducted for the purpose of forming opinions on the financial statements as a whole. The accompanying schedule of expenditures of federal awards, as required by Title 2 U.S. *Code of Federal Regulations* ("CFR") Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, and combining statements of net position and combining statements of revenues, expenses, and changes in net position are presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. The information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards GAAS. In our opinion, the information is fairly stated in all materiality respects in relation to the basic financial statements as a whole.

Change in Accounting Principle

As discussed in Note 1 to the financial statements, during the year ended June 30, 2022 the District adopted new accounting guidance, Governmental Accounting Standards Board Statement No. 87 - *Leases*. Our opinion is not modified with respect to this matter.

Other Matters

Management has omitted the management's discussion and analysis that GAAP requires to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinion on the basic financial statements is not affected by this missing information.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated November 22, 2022 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 San Gorgonio Healthcare 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.

Wipfli LLP
Oakland, California
November 22, 2022

San Gorgonio Healthcare District

Statements of Net Position

June 30,	2022	2021
Current assets:		
Cash and cash equivalents:		
Unrestricted	$ 9,995,092	$ 2,395,672
Restricted, available for current debt service	1,078,770	25,281
Receivables:		
Patient accounts - Net	8,746,991	7,939,203
Other accounts	1,517,880	2,015,108
Estimated third-party payor settlements	-	1,169,887
Inventories	1,829,462	1,776,554
Prepaid expenses and other	346,202	21,485
Total current assets	23,514,397	15,343,190
Noncurrent assets:		
Capital assets - Nondepreciable	2,575,768	1,173,204
Capital assets - Net of accumulated depreciation	74,007,055	77,635,139
Cash and cash equivalents - Restricted, net of amount available for current debt service	12,449,588	9,566,747
Cash and cash equivalents - Board designated	284,694	279,619
Beneficial interest in the net assets of San Gorgonio Hospital Foundation	409,634	551,194
Total noncurrent assets	89,726,739	89,205,903
Deferred outflows of resources - Loss on bond refunding	605,217	645,507
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 113,846,353	$ 105,194,600

San Gorgonio Healthcare District

Statements of Net Position (Continued)

June 30,	2022	2021
Current liabilities:		
Accounts payable	$ 10,416,438	$ 10,897,079
Accrued salary, payroll taxes, and benefits	6,546,139	4,865,852
Estimated third-party payor settlements	1,543,868	-
Accrued interest	1,929,921	1,943,680
Line of credit	12,000,000	-
Current portion of refundable advance	-	2,120,577
Current maturities of long-term debt	2,917,257	2,640,000
Current portion of leases payable	608,561	444,396
Legal settlement	3,417,500	-
Total current liabilities	39,379,684	22,911,584
Noncurrent liabilities:		
Long-term debt, less current portion	106,916,622	105,840,892
Obligations under leases payable, less current portion	1,273,925	507,783
Total noncurrent liabilities	108,190,547	106,348,675
Total liabilities	147,570,231	129,260,259
Net position:		
Net investment in capital assets	(29,376,096)	(27,540,332)
Restricted	13,528,358	9,592,028
Unrestricted	(17,876,140)	(6,117,355)
Total net position	(33,723,878)	(24,065,659)
TOTAL LIABILITIES AND NET POSITION	$ 113,846,353	$ 105,194,600

San Gorgonio Healthcare District

Statements of Revenues, Expenses, and Changes in Net Position

Years Ended June 30,	2022	2021
Operating revenue:		
Net patient service revenue	$ 72,601,782	$ 55,592,504
Other operating income	1,855,472	1,553,151
Total operating revenue	74,457,254	57,145,655
Operating expenses:		
Salaries and wages	40,816,267	37,724,583
Employee benefits	9,967,192	10,282,665
Legal and professional fees	4,030,984	4,024,802
Contract labor	1,256,177	992,041
Supplies	11,847,237	10,846,597
Utilities	1,312,180	1,107,443
Purchased service	6,075,302	7,348,384
Building and equipment rent	460,787	467,274
Depreciation	5,667,801	6,427,719
Other operating expense	8,193,755	9,463,186
Total operating expenses	89,627,682	88,684,694
Loss from operations	(15,170,428)	(31,539,039)
Nonoperating revenue (expenses):		
Taxes	12,205,535	11,558,266
Grants, contributions, and other nonoperating revenue	1,460,299	4,594,587
Interest expense	(4,736,125)	(5,410,496)
Total nonoperating revenue - Net	8,929,709	10,742,357
Deficit in revenue over expenses	(6,240,719)	(20,796,682)
Impairment loss on capital assets	-	(7,800)
Legal settlement loss	(3,417,500)	-
Decrease in net position	(9,658,219)	(20,804,482)
Net position - Beginning of year	(24,065,659)	(3,261,177)
Net position - End of year	$ (33,723,878)	$ (24,065,659)

San Gorgonio Healthcare District

Statements of Cash Flows

Years Ended June 30,	2022	2021
Cash flows from operating activities:		
Receipts from and on behalf of patients	$ 72,387,170	$ 61,388,313
Receipts from other operating revenue	2,352,702	2,426,657
Payments to employees	(49,103,172)	(47,043,419)
Payments to suppliers, contractors, and others	(34,034,688)	(29,007,939)
Net cash used in operating activities	(8,397,988)	(12,236,388)
Cash flows from noncapital financing activities:		
Taxation for operations	2,059,972	1,860,424
Cash received from grants and stimulus funding	1,601,860	4,621,512
Proceeds from line of credit	12,000,000	-
Payments on line of credit	-	(6,000,000)
Proceeds from QIP Loan	2,254,170	-
Net cash provided by noncapital financing activities	17,916,002	481,936
Cash flows from capital and related financing activities:		
Principal payments on debt	(1,199,016)	(24,538,866)
Proceeds from debt	-	22,491,911
Interest paid	(4,926,584)	(5,387,890)
Purchase of capital assets	(1,997,152)	(377,004)
Taxation for debt service	10,145,563	9,697,842
Other	-	(63,638)
Net cash provided by (used in) capital and related financing activities	2,022,811	1,822,355
Change in cash and cash equivalents	11,540,825	(9,932,097)
Cash and cash equivalents - Beginning of year	12,267,319	22,199,416
Cash and cash equivalents - End of year	$ 23,808,144	$ 12,267,319

Supplemental disclosure of noncash capital and related financing activities:

Acquisition of assets under lease agreements	$ 1,445,129	$ -

San Gorgonio Healthcare District

Statements of Cash Flows (Continued)

Years Ended June 30,	2022	2021
Reconciliation of loss from operations to net cash used in operating activities:		
Loss from operations	$ (15,170,428)	$ (31,539,039)
Adjustments to reconcile loss from operations to net cash used in operating activities:		
Depreciation	5,667,801	6,427,719
Provision for bad debt	12,546,840	10,122,151
Change in assets and liabilities:		
Patient accounts receivable	(13,354,630)	(10,918,475)
Other accounts receivable	497,230	11,132,264
Estimated third-party payor settlements	2,713,755	(3,605,235)
Inventories	(52,908)	12,521
Prepaid expenses and other	(324,717)	267,098
Accounts payable	(480,641)	5,580,571
Accrued salary, payroll taxes, and benefits	1,680,287	741,150
Refundable advance	(2,120,577)	(457,113)
Total adjustments	6,772,440	19,302,651
Net cash used in operating activities	$ (8,397,988)	$ (12,236,388)

Note 1: Summary of Significant Accounting Policies

Reporting Entity

San Gorgonio Healthcare District (the "District") was organized in 1944 under the terms of the Local Health Care District Law and is operated and governed by five elected directors. The District includes a 79-bed acute care facility that provides inpatient, outpatient, behavioral health, and emergency care services in Banning, California, and its surrounding area.

San Gorgonio Memorial Hospital (the "Hospital") is a nonprofit corporation and is exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code. The Hospital provides healthcare services primarily to individuals who reside in the geographic boundaries of the District under a lease agreement with the District. The Hospital is governed by a nine-member Board of Directors. All of the District's Board members are also members of the Hospital's Board. For this reason, the Hospital is a blended component unit of the District.

Basis of Accounting

The accounting policies of the District conform to accounting principles generally accepted in the United States of America (GAAP) as applicable to proprietary funds of governments. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body in the United States for establishing governmental accounting and financial reporting principles. The District's statements are reported using the economic resources measurement focus and full-accrual basis of accounting. Revenue is recorded when earned, and expenses are recorded when the liability is incurred, regardless of the timing of the cash flows. Property taxes are recognized as revenue in the year in which they are levied. Grants and similar items are recognized as revenue as soon as eligibility requirements have been met. Unbilled hospital services receivable are recorded at year-end.

Use of Estimates

The preparation of the accompanying financial statements in conformity with GAAP requires management to make estimates and assumptions that directly affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results may differ from these estimates.

The District considers significant accounting estimates to be those which require significant judgments and include the valuation of patient accounts receivable, including contractual adjustments and allowance for uncollectible accounts and estimated third-party payor settlements.

Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid debt instruments with original maturity dates of three months or less. Cash and cash equivalents are carried at cost, which approximates fair value.

Note 1: Summary of Significant Accounting Policies (Continued)

Patient Accounts Receivable and Credit Policy

Patient accounts receivable are uncollateralized patient obligations that are stated at the amount management expects to collect from outstanding balances. These obligations are primarily from local residents, most of whom are insured under third-party payor agreements. The District bills third-party payors on the patients' behalf, or if a patient is uninsured, the patient is billed directly. Once claims are settled with the primary payor, any secondary insurance is billed, and patients are billed for copay and deductible amounts that are the patients' responsibility. Payments on patient accounts receivable are applied to the specific claim identified on the remittance advice or statement.

Patient accounts receivable are recorded in the accompanying statements of net position, net of contractual adjustments and allowances for doubtful accounts, which reflect management's estimate of the amounts that won't be collected. Management provides for contractual adjustments under terms of third-party reimbursement agreements through a reduction of net patient revenue and a credit to a contractual allowance. In addition, management provides for probable uncollectible amounts, primarily for uninsured patients and amounts patients are personally responsible for, through a reduction of net patient revenue and a credit to a valuation allowance.

In evaluating the collectibility of patient accounts receivable, the District analyzes past results and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. Specifically, for receivables associated with services provided to patients who have third-party coverage, the District analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely. For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the District records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

Property Taxes

The District received approximately 16.39% and 17.30% of its financial support from property taxes for the years ended June 30, 2022 and 2021, respectively.

Property taxes are levied by the District and collected by the Riverside County Treasurer for operations and debt service obligations. Taxes estimated to be collectible are recorded as revenue in the year of the levy. No allowance for doubtful taxes receivable is considered necessary. Taxes levied are recorded as nonoperating revenue. The taxes are levied on July 1 each year and are intended to finance the District's activities of the same fiscal year.

Note 1: Summary of Significant Accounting Policies (Continued)

Property Taxes (Continued)

Amounts levied are based on assessed property values as of September 30 each year.

Taxes levied to support operations and for debt service were $12,205,535 and $11,558,266, for the years ended June 30, 2022 and 2021, respectively.

Inventories

Inventories are valued at the lower of cost, determined on the first-in, first-out method, or net realizable value. Inventories consist of pharmaceutical, medical-surgical, and other supplies used in the operation of the District.

Restricted Cash and Cash Equivalents

Restricted cash and cash equivalents include certain cash and other assets whose use is limited under debt instruments, by donors, and by grant and service contracts.

Capital Assets and Depreciation

Capital asset acquisitions exceeding $5,000 are capitalized and recorded at cost. Expenditures for maintenance and repairs are charged to expense as incurred. Contributed capital assets are reported at their acquisition value at the time of their donation. All capital assets other than land are depreciated or amortized using the straight-line method of depreciation using these asset lives:

Land improvements	15 to 20 years
Buildings and building improvements	5 to 40 years
Equipment, computers, and furniture	3 to 20 years

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

Impairment of Long-Lived Assets

The District reviews long-lived assets, including property and equipment and intangible assets, for impairment whenever events or changes in business circumstances indicate that the carrying amount of an asset may not be fully recoverable. An impairment loss would be recognized when the estimated future cash flows from the use of the asset and its fair value are less than the carrying amount of that asset.

Note 1: Summary of Significant Accounting Policies (Continued)

Deferred Outflows of Resources

In addition to assets, the statement of net position reports a separate section of deferred outflows of resources. This separate financial statement element, *deferred outflows of resources,* represents a consumption of net position that applies to a future periods and so will not be recognized as an outflow of resources (expense) until then. The District has one item that qualifies for reporting in this category, the deferred charge on refunding reported in the statements of net position.

A deferred charge on refunding results from the difference in the carrying value of refunded debt and its reacquisition price. This amount is deferred and amortized over the shorter of the life of the refunded or refunding debt.

Bonds Payable

Premiums and discounts are deferred and amortized over the life of the debt using the effective interest method. Bonds Payable is reported net of the applicable premium or discount.

Compensated Absences

The District's employees earn paid time-off (PTO) benefits at varying rates depending on years of service and the number of hours worked. PTO benefits can accumulate up to specified maximum levels. Employees are paid for PTO accumulated benefits upon separation.

The District considers compensated absence liabilities to be a current liability of the District. These obligations are expected to be liquidated with current assets.

Patient Service Revenue

Net patient service 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 audit by appropriate third-party representatives. Subsequent adjustments, if any, arising from such audits are recorded in the year the final settlement becomes known.

Operating Revenue and Expenses

The District's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenue and expenses. Operating revenue results from exchange transactions associated with providing healthcare services, the District's principal activity. Nonexchange revenue, including grants, property taxes, and contributions received for purposes other than capital asset acquisition, is reported as nonoperating revenue. Operating expenses are all expenses incurred to provide healthcare services, other than financing costs.

Note 1: Summary of Significant Accounting Policies (Continued)

Grants and Contributions

From time to time, the District receives grants from the federal government and the State of California as well as contributions from individuals and private organizations. Revenue from grants and contributions (including contributions of capital assets) is recognized when all eligibility requirements, including time requirements, are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as nonoperating revenue in the year received.

Gifts, grants, and bequests restricted by donors for specific purposes are recorded as restricted net position and transferred to unrestricted net position when amounts are expended for their restricted purpose. When restricted funds are used for operations, these amounts are reflected in the statements of revenues, expenses, and changes in net position as other operating revenue.

Charity Care

The District provides care to patients who meet certain criteria under its charity care (financial assistance) policy without charge or according to a sliding scale based on income. The District maintains records to identify and monitor the level of charity care provided.

Net Position

Net position is reported in three categories:

Net investment in capital assets - This category consists of capital assets, net of accumulated depreciation, reduced by the outstanding balance of any long-term debt used to build, acquire, or improve those assets. Deferred outflows of resources and deferred inflows of resources that are attributable to the construction, acquisition, or improvement of those assets or the related debt are also included in this category.

Restricted - This category consists of noncapital assets whose use is restricted, reduced by liabilities and deferred inflows of resources related to those assets. Net position is reported as restricted when there are limitations imposed on an asset's use through external restrictions imposed by creditors, donors, grantors, or laws or regulations of other governments or imposed by law through constitutional provisions or enabling legislation.

Unrestricted - This category consists of the remaining net position that does not meet the definition of the two preceding categories.

When both restricted and unrestricted resources are available for use, it is the District's policy to use externally restricted resources first.

Note 1: Summary of Significant Accounting Policies (Continued)

Reclassifications

Certain reclassifications have been made to the 2021 financial statements to conform to the 2022 presentation. The amounts of previously reported net position were unchanged by these reclassifications.

New Accounting Pronouncements

In June 2017, the GASB issued GASB Statement No. 87 - *Leases*. The statement enhances the relevance and consistency of reporting for the District's leasing activities by establishing requirements for lease accounting based on the principle that leases are financings of underlying right-of-use assets. A lessee is required to recognize a lease liability and intangible right-of-use lease asset, and a lessor is required to recognize a lease receivable and deferred inflow of resources. The District adopted this guidance for the year ended June 30, 2022. The adoption of this guidance did not affect beginning net position for the year ended June 30, 2021, and, accordingly, restatement of beginning June 30, 2021 net position was not necessary. Ending June 30, 2021, net position decreased insignificantly by $18,431 from $(24,047,228) to $(24,065,659).

Note 2: Cash and Cash Equivalents

The District maintains depository relationships with area financial institutions that are Federal Deposit Insurance Corporation (FDIC) insured institutions. Depository accounts are insured by the FDIC up to $250,000 for demand deposits and an additional $250,000 for time deposits per insured institution.

Credit risk - The risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is typically measured by the assignment of a rating by a nationally recognized statistical rating organization.

Concentration of credit risk - The inability to recover the value of deposits, investments, or collateral securities in the possession of an outside party, caused by a lack of diversification (investments acquired from a single issuer).

Interest rate risk - The possibility that an interest rate change could adversely affect an investment's fair value.

Custodial credit risk - The risk that in the event of a bank failure the District's deposits may not be returned. The District does not have a deposit policy for custodial credit risk.

The California Government Code requires that a financial institution secure deposits made by state or local governmental units by pledging securities in an undivided collateral pool held by a depository regulated under state law (unless so waived by the governmental unit). The market value of the pledged securities in the collateral pool must equal at least 110% of the total amount deposited by the public agencies.

California law also allows financial institutions to secure public deposits by pledging first deed of mortgage notes having a value of 150% of the secured public deposits and letters of credit issued by the Federal Home Loan Bank of San Francisco having a value of 105% of the secured deposits.

For the years ended June 30, 2022 and 2021 , the District had a bank balance of $25,993,096 and $13,105,445, respectively.

Note 2: Cash and Cash Equivalents (Continued)

Of this balance, $1,750,000 was covered by federal deposit insurance, and $13,620,148 and $9,211,260 were collateralized (i.e., with securities held by the pledging financial institutions of at least 110% of the District's cash deposits, in accordance with the California Government Code), for the years ended June 30, 2022 and 2021, respectively.

Cash and cash equivalents consisted of the following:

June 30,	2022	2021
Demand deposits	$ 23,798,868	$ 12,258,143
Cash on hand	4,448	4,348
Local government investment pool	4,828	4,828
Total cash and cash equivalents	$ 23,808,144	$ 12,267,319

The composition of cash and cash equivalents consisted of the following:

June 30,	2022	2021
Current:		
Unrestricted cash and cash equivalents	$ 9,995,092	$ 2,395,672
Restricted for debt service	1,078,770	25,281
Noncurrent:		
Restricted for debt service, net of amount currently available for debt service	12,449,588	9,566,747
Unrestricted board designated	284,694	279,619
Totals	$ 23,808,144	$ 12,267,319

Restricted for Debt Service

County deposits held in trust for debt service payments.

Board-Designated Held-for-Capital Projects and Equipment

Capital project funds are funded with bond proceeds and consist of assets restricted to fund future construction of capital assets.

Note 3: Patient Accounts Receivable - Net

Patient accounts receivable - net consisted of the following:

June 30,	2022	2021
Patient receivables:		
Medicare	$ 7,869,219	$ 23,731,821
Medicaid	17,356,678	10,978,470
Commercial and other	45,981,058	16,020,448
Self-pay	6,387,854	8,069,264
Total patient receivables	77,594,809	58,800,003
Less:		
Contractual adjustments	61,540,004	41,161,237
Allowance for uncollectible amounts	7,307,814	9,699,563
Patient accounts receivable - Net	$ 8,746,991	$ 7,939,203

Note 4: Patient Service Revenue

Patient service revenue consisted of the following:

Years Ended June 30,	2022	2021
Gross patient service revenue:		
Inpatient	$ 199,279,419	$ 111,976,457
Outpatient	251,181,109	143,204,184
Totals	450,460,528	255,180,641
Less:		
Contractual adjustments	365,311,906	189,688,665
Provision for bad debts	12,546,840	9,899,472
Net patient service revenue	$ 72,601,782	$ 55,592,504

Note 5: Capital Assets

Capital assets consisted of the following:

	Balance July 1, 2021	Additions	Retirements	Transfers	Balance June 30, 2022
Nondepreciable capital assets:					
Land	$ 881,760	$ -	$ -	$ -	$ 881,760
Construction in progress	291,446	1,402,562	-	-	1,694,008
Total nondepreciable capital assets	1,173,206	1,402,562	-	-	2,575,768
Depreciable capital assets:					
Land improvements	2,774,116	-	-	-	2,774,116
Buildings and improvements	122,335,676	-	-	-	122,335,676
Equipment	36,103,703	2,039,719	-	-	38,143,422
Total depreciable capital assets	161,213,495	2,039,719	-	-	163,253,214
Total capital assets before depreciation	162,386,701	3,442,281	-	-	165,828,982
Less accumulated depreciation	(83,578,358)	(5,667,801)	-	-	(89,246,159)
Capital assets - Net	$ 78,808,343	$ (2,225,520)	$ -	$ -	$ 76,582,823

Note 5: Capital Assets (Continued)

	Balance July 1, 2020	Additions	Retirements	Transfers	Balance June 30, 2021
Nondepreciable capital assets:					
Land	$ 881,760	$ -	$ -	$ -	$ 881,760
Construction in progress	116,444	175,002	-	-	291,446
Total nondepreciable capital assets	998,204	175,002	-	-	1,173,206
Depreciable capital assets:					
Land improvements	2,774,116	-	-	-	2,774,116
Buildings and improvements	122,335,676	-	-	-	122,335,676
Equipment	35,901,701	202,002	-	-	36,103,703
Total depreciable capital assets	161,011,493	202,002	-	-	161,213,495
Total capital assets before depreciation	162,009,697	377,004	-	-	162,386,701
Less accumulated depreciation	(77,642,460)	(5,935,898)	-	-	(83,578,358)
Capital assets - Net	$ 84,367,237	$ (5,558,894)	$ -	$ -	$ 78,808,343

The District recorded an impairment loss of $0 and $7,800 for the years ended June 30, 2022 and 2021, respectively, related to the write-off of a defunct tower project. This impairment loss is also recorded in the statement of revenues, expenses, and changes in net position.

Construction in progress (CIP) at June 30, 2022, consisted of costs incurred to create a stroke center and capital equipment. Management estimates projects included in CIP at June 30, 2022, will be completed by July 2023 with estimated remaining costs to complete of approximately $7,680,000, of which management expects approximately $5,580,000 to be funded by grant and donation income.

Note 5: Capital Assets (Continued)

Intangible right-of-use equipment included in capital assets - net, consisted of the following:

	Balance June 30, 2021	Additions	Retirements	Transfers	Balance June 30, 2022
Intangible right-of-use assets: Equipment	$ 1,423,383	$ 1,745,129	$ -	$ -	$ 3,168,512
Less accumulated depreciation	(491,071)	(536,570)	-	-	(1,027,641)
Intangible right-of-use assets - Net	$ 932,312	$ 1,208,559	$ -	$ -	$ 2,140,871

	Balance July 1, 2020	Additions	Retirements	Transfers	Balance June 30, 2021
Intangible right-of-use assets: Equipment	$ 1,423,383	$ -	$ -	$ -	$ 1,423,383
Less accumulated depreciation	(491,071)	-	-	-	(491,071)
Intangible right-of-use assets - Net	$ 932,312	$ -	$ -	$ -	$ 932,312

Note 6: Long-Term Debt Obligations

Long-term debt obligations consisted of the following:

	Balance July 1, 2021	Additions	Reductions	Balance June 30, 2022	Amounts Due Within One Year
Long-term debt- Direct placements:					
GO Refunding Bonds 2014	$ 58,905,000	$ -	$ (1,375,000)	$ 57,530,000	$ 1,515,000
GO Refunding Bonds 2015	23,550,000	-	(530,000)	23,020,000	600,000
GO Refunding Bonds 2020	20,275,000	-	(735,000)	19,540,000	715,000
Revenue Bonds 2021	315,000	2,000,000	(21,652)	2,293,348	87,257
QIP Bridge Loan	-	2,254,170	(22,542)	2,231,628	-
Premium - 2020 Series	1,901,911	-	(10,459)	1,891,452	-
Premium - 2014 Series	3,064,920	-	(160,908)	2,904,012	-
Premium - 2015 Series	469,061	-	(45,622)	423,439	-
Total long-term debt	$ 108,480,892	$ 4,254,170	$ (2,901,183)	$ 109,833,879	$ 2,917,257

	Balance July 1, 2020	Additions	Reductions	Balance June 30, 2021	Amounts Due Within One Year
Long-term debt- Direct placements:					
GO Refunding Bonds 2013	$ 22,395,000	$ -	$(22,395,000)	$ -	$ -
GO Refunding Bonds 2014	60,150,000	-	(1,245,000)	58,905,000	1,375,000
GO Refunding Bonds 2015	24,020,000	-	(470,000)	23,550,000	530,000
GO Refunding Bonds 2020	-	20,275,000	-	20,275,000	735,000
Revenue Bonds 2021	-	315,000	-	315,000	-
Premium - 2020 Series	-	1,901,911	-	1,901,911	-
Premium - 2013 Series	231,921	-	(231,921)	-	-
Premium - 2014 Series	3,234,409	-	(169,489)	3,064,920	-
Premium - 2015 Series	496,517	-	(27,456)	469,061	-
Total long-term debt	$ 110,527,847	$ 22,491,911	$(24,538,866)	$ 108,480,892	$ 2,640,000

Note 6: Long-Term Debt Obligations (Continued)

The terms of the District's long-term obligations are as follows:

Direct placements:

- General Obligation Refunding Bonds, Series 2013; principal due each August 1 at various amounts through August 1, 2036; interest is fixed with coupon rates ranging from 3.25%-5.00%, sold at a premium with an initial true interest yield of 3.73%, due semiannually each August 1 and February 1; collateralized by ad valorem property tax revenue.

- General Obligation Refunding Bonds, Series 2014; principal due each August 1 at various amounts through August 1, 2039; interest is fixed with coupon rates ranging from 3.00%-5.25%, sold at a premium with an initial true interest yield of 4.49%, due semiannually each August 1 and February 1; collateralized by ad valorem property tax revenue.

- General Obligation Refunding Bonds, Series 2015; principal due each August 1 at various amounts through August 1, 2038; interest is fixed with coupon rates ranging from 3.00%-5.00%, sold at a premium with an initial true interest yield of 3.73%, due semiannually each August 1 and February 1; collateralized by ad valorem property tax revenue.

- General Obligation Refunding Bonds, Series 2020; principal due each August 1 at various amounts through August 1, 2029; interest is fixed with coupon rates ranging from 2.00%-4.00%, sold at a premium with an initial true interest yield of 2.70%, due semiannually each August 1 and February 1; collateralized by ad valorem property tax revenue.

- Revenue Bonds, Series 2021; principal due each April 1 and October 1 at various amounts through April 1, 2042; interest is fixed at 3%, due semiannually each April 1 and October 1; collateralized by revenues of the district. The total advances of the Revenue Bonds are not to exceed $2,350,000 and were $315,000 at June 30, 2021.

- Quality Improvement Program (QIP) loan; During the year ended June 30, 2022, the District entered into a loan agreement with California Health Facilities Financing Authority (CHFFA) for a maximum amount of $2,852,500 with interest at 0% for operational financing of an ongoing activities. The outstanding principal balance at June 30, 2022 was $2,231,628. The CHFFA loan matures during February 2024 with no payments due until that time and is secured by an interest in the District's future Medi-Cal payments.

Note 6: Long-Term Debt Obligations (Continued)

Scheduled principal and interest payments on long-term obligation are as follows:

	Direct Placements		
Years Ending June 30,	Principal	Interest	Total
2023	$ 2,917,257	$ 7,270,600	$ 10,187,857
2024	5,446,523	7,421,625	12,868,148
2025	3,527,611	7,575,250	11,102,861
2026	3,835,410	7,738,250	11,573,660
2027	4,193,294	3,894,838	8,088,132
2028-2032	26,532,874	16,337,464	42,870,338
2033-2037	37,894,224	16,831,640	54,725,864
2038-2042	20,267,783	1,409,000	21,676,783
Totals	$ 104,614,976	$ 68,478,667	$ 173,093,643

Bond premium amortization in the amount of $216,989 and $428,866 was recognized for the years ended June 30, 2022 and 2021, respectively. The annual amortization of the bond premium will result in reductions in interest expense as follows:

Years Ending June 30,	
2023	$ 236,536
2024	258,113
2025	281,582
2026	302,529
2027	269,223
2028-2032	1,491,500
2032-2037	1,996,574
2038-2042	382,846
Totals	$ 5,218,903

Note 7: Leases

Changes in leases payable consisted of the following:

Year Ended June 30, 2022	Balance June 30, 2021	Additions	Reductions	Balance June 30, 2022	Amounts due Within One Year
Abbott Laboratories	$ 91,517	$ -	$ (26,256)	$ 65,261	$ 27,325
Intouch Robots	48,689	-	(28,035)	20,654	20,655
Olympus America	48,891	-	(48,891)	-	-
Roosevelt LP	299,960	-	(81,797)	218,163	88,794
TIAA Bank	5,956	-	(1,608)	4,348	1,674
Shared Imaging	457,166	-	(257,809)	199,357	199,356
Intuitive Surgical	-	1,445,129	(70,426)	1,374,703	270,757
Leases payable	$ 952,179	$ 1,445,129	$ (514,822)	$ 1,882,486	$ 608,561

Year Ended June 30, 2021	Balance July 1, 2020	Additions	Reductions	Balance June 30, 2021	Amounts due Within One Year
Abbott Laboratories	$ 117,134	$ -	$ (25,617)	$ 91,517	$ 26,256
Intouch Robots	75,982	-	(27,293)	48,689	28,035
Olympus America	138,276	-	(89,385)	48,891	48,891
Roosevelt LP	376,285	-	(76,325)	299,960	81,797
TIAA Bank	7,526	-	(1,570)	5,956	1,608
Shared Imaging	708,179	-	(251,013)	457,166	257,809
Leases payable	$ 1,423,382	$ -	$ (471,203)	$ 952,179	$ 444,396

The terms of the District's leases payable are as follows:

- Abbott Laboratories - Lease agreement dated October 19, 2019, in the original principal amount of $117,134, due in monthly installments of $2,453, including interest imputed at 4.0%, through October 2024, collateralized by leased asset.
- Intouch Robots - Lease agreement dated March 18, 2020, in the original principal amount of $75,982, due in monthly installments of $2,441, including interest imputed at 4.0%, through March 2023, collateralized by leased asset.
- Olympus America - Lease agreement dated December 5, 2018, in the original principal amount of $138,275, due in monthly installments of $7,699, including interest imputed at 3.5%, through January 2022, collateralized by leased asset.

- Roosevelt LP - Lease agreement dated May 14, 2019, in the original principal amount of $376,285, due in monthly installments of $7,194, including interest imputed at 4.0%, through October 2024, collateralized by leased asset.

- TIAA Bank - Lease agreement dated January 7, 2020, in the original principal amount of $7,526, due in monthly installments of $151, including interest imputed at 4.0%, through January 2025, collateralized by leased asset.

- Shared Imaging - Lease agreement dated March 19, 2018, in the original principal amount of $708,179, due in monthly installments of $22,475, including interest imputed at 3.5%, through March 2023, collateralized by leased asset.

- Intuitive Surgical - Lease agreement dated November 3, 2021, in the original principal amount of $1,745,129, due in monthly installments of $26,213, including interest imputed at 3.5%, through March 2027, collateralized by leased asset.

Future minimum lease payments consist of the following:

Years Ending June 30,	Principal	Interest
2023	$ 608,561	$ 56,391
2024	406,643	38,686
2025	334,083	24,563
2026	300,687	13,869
2027	232,512	3,404
Totals	$ 1,882,486	$ 136,913

Note 8: Line of Credit

The District maintains a line of credit dated January 7, 2021, with First Foundation Public Finance Trust in the amount of $12,000,000 with interest at 5.25% at June 30, 2022. The line of credit expires on January 6, 2023. The line of credit had a balance of $12,000,000 and $0 at June 30, 2022 and 2021, respectively. The line of credit is collateralized by receivables and capital assets.

Note 9: Intergovernmental Transfer Program

The District participates in the intergovernmental transfer (IGT) program and other related supplemental programs sponsored by the State of California for the state's local healthcare districts. These programs are an integral part of the overall Quality Assurance Fee programs, supported by funding from the federal government. IGT and related program revenue, net of related expenses, was $11,537,242 and $10,436,480 for the years ended June 30, 2022 and 2021, respectively, and is recorded as a reduction to contractual adjustments in the statements of revenues, expenses, and changes in net position.

Note 10: Charity Care

The District provides healthcare services and other financial support through various programs that are designed to enhance the health of the community, including the health of low-income patients. Consistent with the mission of the District, care is provided to patients regardless of their ability to pay, including providing services to those persons who cannot afford health insurance because of inadequate resources.

Patients who meet certain criteria for charity care, generally based on federal poverty guidelines, are provided care based on criteria defined in the District's charity care policy. The District maintains records to identify and monitor the level of charity care it provides.

Gross charges related to patients under the District's charity care policy were $1,635,568 and $496,340 during the years ended June 30, 2022 and 2021, respectively, and were not included in patient service revenue because there is no effort to collect these charges.

Note 11: Retirement Plan

The District offers a tax-sheltered annuity (TSA) program covering substantially all employees with at least 90 days of service. Matching contributions are made at the discretion of the District's management and are based on a percentage of gross salary. District contributions to the TSA program were $1,755,675 and $1,503,101 during the years ended June 30, 2022 and 2021, respectively.

Note 12: Risk Management

Liability Insurance

The District has its professional liability insurance coverage with Beta Risk Management Authority ("Beta"). The policy provides protection on a "claims made" basis whereby malpractice claims related to services provided in the current year are covered by the current policy.

Coverage is provided a policy with limits of $20,000,000 for each medical incident and a $30,000,000 annual aggregate limit. The policy includes a deductible of $25,000 per incident.

Under a claims-made policy, the risk for claims and incidents not asserted within the policy period remains with the District. The District does not believe potential claims are significant and, accordingly, has not provided a reserve for potential claims from services provided to patients through June 30, 2022, that have not yet been asserted.

Note 12: Risk Management (Continued)

The District is also exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; business interruption; data breaches; errors and omissions; injuries to employees; and natural disasters. The District carries commercial insurance for these risks of loss. Settled claims resulting from these risks have not exceeded the commercial insurance coverage in any of the past three years.

Contingent Liabilities

In September 2022, the District reached a settlement with the plaintiffs in a class action matter, which was asserted prior to June 30, 2022. As a result, $3,417,500 has been accrued for legal losses at June 30, 2022, in order to reflect them amount of the settlement agreed upon by the parties to the matter. Because the transaction is both unusual in nature and infrequent in occurrence, the outflow of resources associated with the payment of the settlement has been reported as an extraordinary item on the statements of revenues, expenses, and changes in net position.

Additionally, the District is a defendant in a legal matter wherein the plaintiff is seeking in damages for breach of contract. The District intends to vigorously defend itself in this matter. Although a loss is reasonably possible, it is not possible to reasonably estimate the amount of any obligation that would be material to the District's financial statements at November 22, 2022.

Note 13: Concentration of Credit Risk

Financial instruments that potentially subject the District to credit risk consist principally of patient and resident accounts receivable. Patient accounts receivable consist of amounts due from patients, their insurers, or governmental agencies (primarily Medicare and Medicaid) for healthcare provided to the patients.

The mix of receivables from patients, residents, and third-party payors consisted of the following:

June 30,	2022	2021
Medicare	11 %	40 %
Medicaid	22 %	21 %
Other third-party payors	59 %	27 %
Self-pay	8 %	12 %
Totals	100 %	100 %

Note 14: Reimbursement Arrangements With Third-Party Payors

Agreements are maintained with third-party payors that provide for reimbursement at amounts which vary from its established rates. A summary of the basis of reimbursement with major third-party payors follows:

Medicare - Inpatient hospital acute care services provided by the District are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Outpatient and other services are reimbursed primarily on a prospective payment methodology based upon a patient classification system or fixed fee schedules. Cost reimbursed items include bad debts and physician residency costs.

Medicaid - Inpatient and outpatient services are reimbursed primarily based upon prospectively determined rates.

Other payors - The District has entered into payment agreements with commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment under these agreements includes prospectively determined rates per discharge, discounts from established charges, fee schedules, and prospectively determines daily rates.

Note 15: Beneficial Interest in Assets Held by San Gorgonio Hospital Foundation

San Gorgonio Hospital Foundation, Inc. (the "Foundation") was established to solicit contributions for the District and to support healthcare services in the geographical areas of Banning and Beaumont, California. The Foundation has a Board of Directors separate from the District, but exists primarily to support the District. The Foundation contributed $72,889 and $551,194 during the years ended June 30, 2022 and 2021, respectively.

The District records its interest in the net assets of the Foundation, assets that have been collected by the Foundation but not yet distributed to the District as of the end of each fiscal year. The District recorded $409,634 and $551,194 at June 30, 2022 and 2021, respectively, as interest in the net assets of the Foundation in the statements of net position.

Note 16: COVID-19 Relief Funds and Grant Revenue

During the years ended June 30, 2022 and 2021, the District received $1,601,860 and $4,621,512, respectively, in grant funding from the HHS Provider Relief Fund (PRF), which was established as a result of the CARES Act. Based on the terms and conditions of the grant, the District earns the grant by incurring healthcare-related expenses attributable to COVID-19 that another source has no reimbursed and is not obligated to reimburse or by incurring lost revenues, defined as a negative change in year-over-year net patient service revenue. During the years ended June 30, 2022 and 2021, the District recognized $1,601,860 and $4,621,512, respectively, in revenue related to this program which reflects management's estimate of the amount of the grant earned, including consideration for uncertainties related to reporting guidance still developing as of the date the financial statements were available to be issued.

Note 17: Medicare Refundable Advance

As a result of the COVID-19 pandemic, CMS offered an accelerated and advance payment program that gave healthcare providers the opportunity to receive an advance on future Medicare payments. The District received a non-interest-bearing Medicare Refundable Advance of $2,577,690 during the year ended June 30, 2020.

The balance of the Medicare Refundable Advance liability was $0 and $2,120,577 at June 30, 2022 and 2021, respectively.

Note 18: Condensed Financial Information for Component Units

The following is condensed financial information rounded to the nearest thousand for the blended component unit of the District:

Condensed statements of net position - Blended component unit - Hospital

June 30, (in thousands)		2022		2021
Assets:				
Current assets	$	20,237	$	12,524
Noncurrent assets		2,563		1,491
Total assets	$	22,800	$	14,015
Liabilities:				
Current liabilities	$	53,862	$	36,062
Noncurrent liabilities		3,506		508
Total liabilities		57,368		36,570
Net position		(34,568)		(22,555)
Total liabilities and net position	$	22,800	$	14,015

Note 18: Condensed Financial Information for Component Units (Continued)

Condensed statements of revenues, expenses, and changes in net position - Blended component unit - Hospital

Years Ended June 30, (in thousands)	2022	2021
Operating revenue	$ 74,229	$ 57,101
Operating expenses	83,792	81,929
Loss from operations	(9,563)	(24,828)
Nonoperating revenue (expense)	968	4,145
Decrease in net position	(8,595)	(20,683)
Legal settlement loss	(3,418)	-
Net Position - Beginning of year	(22,555)	(1,872)
Net position - End of year	$ (34,568)	$ (22,555)

Condensed statements of cash flows - Blended component unit - Hospital

Years Ended June 30, (in thousands)	2022	2021
Cash flows from operating activities	$ (5,796)	$ (5,237)
Cash flows from noncapital financing activities	14,232	(2,011)
Cash flows from capital and related financing activities	(853)	(506)
Change in cash and cash equivalents	7,583	(7,754)
Cash and cash equivalents - Beginning of year	1,640	9,394
Cash and cash equivalents - End of year	$ 9,223	$ 1,640

Note 19: Subsequent Events

On September 14, 2022, the District issued $9,175,000 of 8.0% revenue bonds for the purpose of providing working capital for the District. These revenue bonds are payable in equal semi-annual installments of $465,462 through October 1, 2042, and are secured by a pledge of the District's general purpose operating ad valorem property tax revenues.

Supplementary Information

San Gorgonio Healthcare District

Combining Statement of Net Position

June 30, 2022	Hospital	District	Eliminations	Total
Current assets:				
Cash and cash equivalents:				
Unrestricted	$ 9,222,965	$ 772,127	$ -	$ 9,995,092
Restricted, available for current debt service	-	1,078,770	-	1,078,770
Receivables:				
Patient accounts - net	8,746,991	-	-	8,746,991
Other accounts	217,810	22,012,750	(20,712,680)	1,517,880
Inventories	1,829,462	-	-	1,829,462
Prepaid expenses and other	220,033	126,169	-	346,202
Total current assets	20,237,261	23,989,816	(20,712,680)	23,514,397
Noncurrent assets:				
Capital assets - Nondepreciable	-	2,575,768	-	2,575,768
Capital assets - Net of accumulated depreciation	2,140,871	71,866,184	-	74,007,055
Cash and cash equivalents - Restricted, net of amount available for current debt service	-	12,449,588	-	12,449,588
Cash and cash equivalents - Board designated	11,894	272,800	-	284,694
Beneficial interest in the net assets of San Gorgonio Hospital Foundation	409,634	-	-	409,634
Total noncurrent assets	2,562,399	87,164,340	-	89,726,739
Deferred outflows of resources - Loss on bond refunding	-	605,217	-	605,217
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 22,799,660	$ 111,759,373	$ (20,712,680)	$ 113,846,353

San Gorgonio Healthcare District

Combining Statement of Net Position (Continued)

June 30, 2022	Hospital	District	Eliminations	Total
Current liabilities:				
Current portion of long-term debt	$ -	$ 2,917,257	$ -	$ 2,917,257
Accounts payable	29,742,090	1,387,028	(20,712,680)	10,416,438
Accrued salary, payroll taxes, and benefits	6,546,139	-	-	6,546,139
Estimated third-party payor settlements	1,543,868	-	-	1,543,868
Current portion of leases payable	608,561	-	-	608,561
Legal settlement payable	3,417,500	-	-	3,417,500
Line of credit	12,000,000	-	-	12,000,000
Legal settlement	3,417,500	-	-	3,417,500
Accrued interest	4,010	1,925,911	-	1,929,921
Total current liabilities	53,862,168	6,230,196	(20,712,680)	39,379,684
Noncurrent liabilities:				
Long-term debt, less current portion	-	5,218,903	-	5,218,903
Leases payable, less current portion	1,273,925	-	-	1,273,925
Bonds and notes payable, less current portion	2,231,628	99,466,091	-	101,697,719
Total noncurrent liabilities	3,505,553	104,684,994	-	108,190,547
Total liabilities	57,367,721	110,915,190	(20,712,680)	147,570,231
Net position:				
Net investment in capital assets	866,946	(30,243,042)	-	(29,376,096)
Restricted	-	13,528,358	-	13,528,358
Unrestricted	(35,435,007)	17,558,867	-	(17,876,140)
Total net position	(34,568,061)	844,183	-	(33,723,878)
TOTAL LIABILITIES AND NET POSITION	$ 22,799,660	$ 111,759,373	$ (20,712,680)	$ 113,846,353

San Gorgonio Healthcare District

Combining Statement of Revenues, Expenses, and Changes in Net Position

Year Ended June 30, 2022	Hospital	District	Eliminations	Total
Operating revenue:				
Net patient service revenue	$ 72,601,782	$ -	$ -	$ 72,601,782
Other operating revenue	1,627,539	227,933	-	1,855,472
Total operating revenue	74,229,321	227,933	-	74,457,254
Operating expenses:				
Salaries and wages	40,816,267	-	-	40,816,267
Employee benefits	9,967,192	-	-	9,967,192
Legal and professional fees	3,867,786	163,198	-	4,030,984
Contract labor	1,256,177	-	-	1,256,177
Supplies	11,847,237	-	-	11,847,237
Utilities	1,312,180	-	-	1,312,180
Purchased services	5,937,340	137,962	-	6,075,302
Building and equipment rent	460,787	-	-	460,787
Depreciation	536,570	5,131,231	-	5,667,801
Other operating expense	7,790,754	403,001	-	8,193,755
Total operating expenses	83,792,290	5,835,392	-	89,627,682
Loss from operations	(9,562,969)	(5,607,459)	-	(15,170,428)
Non operating revenue (expense):				
Taxes	-	12,205,535	-	12,205,535
Grants, contributions, and other nonoperating revenue	1,376,645	83,654	-	1,460,299
Interest expense	(408,970)	(4,327,155)	-	(4,736,125)
Total nonoperating revenue - Net	967,675	7,962,034	-	8,929,709
Deficit in revenue over expenses	(8,595,294)	2,354,575	-	(6,240,719)
Legal settlement loss	(3,417,500)	-	-	(3,417,500)
Decrease in net position	(12,012,794)	2,354,575	-	(9,658,219)
Net position - Beginning of year	(22,555,267)	(1,510,392)	-	(24,065,659)
Net position - End of year	$ (34,568,061)	$ 844,183	$ -	$ (33,723,878)

See Independent Auditor's Report.

San Gorgonio Healthcare District

Schedule of Expenditures of Federal Awards

Year Ended June 30, 2022	Contract Number		Federal Assistance Listing Number		Federal Expenditures
Direct Programs:					
COVID 19 - Provider Relief Funds	N/A	$	93.498	$	2,800,000
Total U.S. Department of Health and Human Services					2,800,000
Total expenditures of federal awards				$	2,800,000

See accompanying notes to schedule of expenditures of federal awards.

San Gorgonio Healthcare District

Notes to Schedule of Expenditures of Federal Awards

Year Ended June 30, 2022

Note 1: Basis of Presentation

The accompanying schedule of expenditures of federal awards (SEFA) includes the federal award activity of San Gorgonio Healthcare District (the "District"). The information in this SEFA is presented in accordance with the requirements of Title 2 *U.S. Code of Federal Regulations* Part 200 - *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (the "Uniform Guidance"). Because the schedule presents only a selected portion of the operations of the District, it is not intended and does not present the financial position, changes in net position, or cash flows of the District.

Note 2: Summary of Significant Accounting Policies

With the exception of expenditures related to the Provider Relief Fund (PRF), expenditures on the SEFA are reported on the accrual basis of accounting and are recognized following the cost principles contained in the Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement. The PRF is not subject to cost principles requirements contained in the Uniform Guidance. Expenditures reported on the the SEFA for PRF are based on the PRF period of availability, terms and conditions of the PRF program, and amounts reported in the PRF portal for the reporting period 2, due March 31, 2022.

Note 3: Indirect Cost

The District has elected not to use the 10-percent de minimis indirect cost rate allowed under the Uniform Guidance.

Note 4: Subrecipients

The District passed no federal awards through to subrecipients.

WIPFLI

Independent Auditor's Report 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*

Board of Directors
San Gorgonio Healthcare District
Banning, California

We have audited, 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*, issued by the Comptroller General of the United States, the financial statements of San Gorgonio Healthcare District (the "District") as of and for the year ended June 30, 2022, and the related notes to the financial statements, which comprise the statements of net position as of June 30, 2022, and the related statements of revenues, expenses, and changes in net position and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated November 22, 2022.

Auditor's Responsibility

In planning and performing our audit of the financial statements, we considered the District's internal control over financial reporting ("internal control") to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing opinions on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect and correct misstatements on a timely basis. A material weakness is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be deficiencies, significant deficiencies, or material weaknesses. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. We did identify a deficiency in internal control that we consider to be a significant deficiency, which is described in the accompanying schedule of findings and questioned costs as finding 2022.001.

WIPFLI

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the District's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance, and the results of that testing, and not to provide an opinion on the effectiveness of the District's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the the District's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Wipfli LLP
Oakland, California
November 22, 2022

WIPFLI

Independent Auditor's Report on Compliance for Each Major Federal Program and on Internal Control Over Compliance Required by the Uniform Guidance

Board of Directors
San Gorgonio Healthcare District
Banning, California

Report on Compliance for Each Major Federal and State Program

Opinion on the Major Federal Program

We have audited San Gorgonio Healthcare District's (the "District") compliance with the types of compliance requirements identified as subject to audit in the OMB Compliance Supplement that could have a direct and material effect on its major federal program for the year ended June 30, 2022. The District's major federal program is identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

In our opinion, the District complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on its major federal program for the year ended June 30, 2022.

Basis for Opinion on the Major Federal Program

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America ("GAAS"); the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States (*Government Auditing Standards*); and the audit requirements of Title 2 *U.S. Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* ("Uniform Guidance"). Our responsibilities under those standards and the Uniform Guidance are further described in the Auditor's Responsibilities for the Audit of Compliance section of our report.

We are required to be independent of the District and to meet our other ethical responsibilities, in accordance with relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion on compliance for the major federal program. Our audit does not provide a legal determination of the District's compliance with the compliance requirements referred to above.

Responsibilities of Management for Compliance

Management is responsible for compliance with the requirements referred to above and for the design, implementation, and maintenance of effective internal control over compliance with the requirements of laws, statutes, regulations, rules and provisions of contracts or grant agreements applicable to the District's federal program.

Auditor's Responsibility for the Audit of Compliance

Our objectives are to obtain reasonable assurance about whether material noncompliance with the compliance requirements referred to above occurred, whether due to fraud or error, and express an opinion on the District's compliance based on our audit. Reasonable assurance is a high level of assurance, but is not absolute assurance and, therefore, is not a guarantee that an audit conducted in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance will always detect material noncompliance when it exists. The risk of not detecting material noncompliance resulting from fraud is higher than for that resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Noncompliance with the compliance requirements referred to above is considered material, if there is a substantial likelihood that, individually or in the aggregate, it would influence the judgment made by a reasonable user of the report on compliance about the District's compliance with the requirements of the major federal program as a whole.

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

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

- Identify and assess the risks of material noncompliance, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the District's compliance with the compliance requirements referred to above and performing such other procedures as we considered necessary in the circumstances.

- Obtain an understanding of the District's internal control over compliance relevant to the audit in order to design audit procedures that are appropriate in the circumstances and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control over compliance. Accordingly, no such opinion is expressed.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and any significant deficiencies and material weaknesses in internal control over compliance that we identified during the audit.

WIPFLI

Report on Internal Control Over Compliance

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the Auditor's Responsibilities for the Audit of Compliance section above and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies in internal control over compliance. Given these limitations, during our audit we did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above. However, *material weaknesses* or *significant deficiencies in internal control over compliance* may exist that were not identified.

Our audit was not designed for the purpose of expressing an opinion on the effectiveness of internal control over-compliance. Accordingly, no such opinion is expressed.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Wipfli LLP
Oakland, California
November 22, 2022

San Gorgonio Healthcare District

Schedule of Findings and Questioned Costs

Year Ended June 30, 2022

Section I - Summary of Auditor's Results

Financial Statements

Type of auditor's report issued on whether the financial statements were prepared in accordance with GAAP: Unmodified

Internal control over financial reporting:

- Material weakness(es) identified? ______ Yes __X__ No
- Significant deficiency(ies) identified? __X__ Yes ______ None Reported

Noncompliance material to financial statements noted? ______ Yes __X__ No

Federal Awards

Internal control over major programs:

- Material weakness(es) identified? ______ Yes __X__ No
- Significant deficiency(ies) identified? ______ Yes __X__ None Reported

Type of auditor's report issued on compliance for major programs: Unmodified

Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)? ______ Yes __X__ No

Identification of major programs

CFDA Number(s)	Federal Program or Cluster
93.498	COVID 19 - Provider Relief Funds

Dollar threshold used to distinguish between Type A and Type B programs: $750,000

Auditee qualified as low-risk auditee? ______ Yes __X__ No

Section II - Financial Statement Finding

Finding 2022.001 – Internal Control Over Account Reconciliation Process

Condition: The District's internal control over preparation of the financial statements includes review and approval of key account reconciliations, including cash deposits. It is the responsibility of management to design procedures to ensure timely and meaningful approvals of account reconciliations. Because there were instances when reconciliations were not being approved or approvals were not being documented, a significant deficiency exists in the District's internal controls.

Criteria: Government Auditing Standards considers the lack of evidence of account reconciliations, including sufficient reviews and approvals, to be a significant deficiency in internal controls.

Cause: As with many organizations, the turnover experienced in key accounting positions and existing resources being limited create an environment where internal control deficiencies can exist.

Effect: The accuracy of the cash balances on the financial statements and related disclosures and the accuracy of the overall financial presentation can be negatively impacted, since there is a level of review missing for the cash cycle.

Repeat: Yes, 2021.001

Recommendations: We recommend management and those charged with governance continue to evaluate the degree of risk associated with this condition and implement a review process that includes meaningful review of each cash account reconciliation.

Views of Responsible Officials and Planned Corrective Actions: Management has indicated an approach to correcting this deficiency that involves bringing additional staff into the process, as well as retaining outside consultants for the purposes of staff training and to improve the control environment. Temporary staffing was brought in for special reporting needed for COVID-19 and for the system conversion, but time constraints prevented this assistance for regular key reconciliations. Throughout the year, a daily cash report was maintained by staff other than those who processed payables and made payments, so there was a degree of separation to ensure control. Regular reports were made to the CEO and new CFO regarding deficiencies in reporting and status updates as to where the staffing requirements were and what was needed. In the new fiscal year (2022), an accounts payable position and a staff accountant have been added. Duty separations have been reviewed and revised to ensure maximum compliance even though staffing is minimal. Cross-training has started to ensure coverage of all duties. Multiple checks and balances are being established, with the CFO taking a more active role in verifying information and establishing controls over the division of duties. Multiple checklists have been enacted to track accuracy and completeness of the financial standings for the District.

Section III - Federal Award Findings - None reported.

San Gorgonio Healthcare District

Schedule of Prior Year Audit Findings

Year Ended June 30, 2022

Finding 2021.001 – Internal Control Over Account Reconciliation Process

Repeated as finding 2022.001.

WIPFLI

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Oakland, CA 94612-7546

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November 22, 2022

Board of Directors
San Gorgonio Healthcare District
600 North Highland Springs Avenue
Banning, CA 92220

Dear Directors:

We have audited the financial statements of San Gorgonio Healthcare District (the "District") and for the year ended June 30, 2022, and have issued our report thereon dated November 22, 2022. Professional standards require that we provide you with the following information related to our audit:

Our Responsibility Under Auditing Standards Generally Accepted in the United States and *Government Auditing Standards*

As stated in our engagement letter dated August 23, 2022, our responsibility, as described by professional standards, is to express an opinion about whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States. Our audit of the financial statements does not relieve you or management of your responsibilities.

As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we performed tests of the District's compliance with certain provisions of laws, regulations, contracts, and grants. However, the objective of our tests was not to provide an opinion on compliance with such provisions.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope, timing, and with respect to significant risks identified by us, all of which were previously communicated to your representatives, Susan DiBiasi and Dennis Tankersley, communicated in our letter dated August 24, 2022, in addition to our engagement letter dated August 23, 2022, accepted by Steve Barron.

Significant Audit Matters

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the District are described in Note 1 to the financial statements. As described in Note 1, the District changed accounting policies related to accounting and disclosure of leases by adopting GASB Statement No. 87 - *Leases*, during the year ended June 30, 2022.

Accordingly, the accounting change has been retrospectively applied to prior periods presented based on the facts and circumstances which existed as of the earliest period presented.

We noted no transactions entered into by the District during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the financial statements were:

- The adequacy of the allowance for accounts receivable is one of the most subjective estimates affecting the financial statements. The allowance for accounts receivable is maintained at a level that management believes is adequate to provide for possible write-offs. Management periodically evaluates the adequacy of the allowance using the District's past bad debt experience, known and inherent risks in accounts receivable, current economic conditions, and other relevant factors. We evaluated the key factors and assumptions used to develop the allowance for accounts receivable in determining that it is reasonable in relation to the financial statements taken as a whole.

- The estimated final settlements on the Medicare cost reports are based on audits conducted by the fiscal intermediary. Management periodically evaluates the adequacy of the balance using the District's experience, known and inherent risks in the preparation of these cost reports, and risks associated with doing business in the healthcare industry. We reviewed the estimated settlements recorded for each open year to determine the reasonableness of the estimates based on the results of previous audits by the fiscal intermediary.

- The portion of Provider Relief Funds, allocated by the CARES Act and administered by the Department of Health and Human Services (HHS), recognized in revenue. The estimated amount recorded as revenue is based on the most current guidance for the recognition of lost revenues provided by HHS at November 22, 2022.

The disclosures in the financial statements are neutral, consistent, and clear. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosure affecting the financial statements was:

The disclosure of risk management in Note 12 to the financial statements describes legal matters which existed at June 30, 2022.

Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. We proposed and the District recorded a number of adjusting journal entries. The attached schedule summarizes misstatements of the financial statements proposed and accepted by management.

Disagreements With Management

For purposes of this letter, a disagreement with management is a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated November 22, 2022, a copy of which accompanies this letter.

Management Consultations With Other Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the District's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the District's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not, in our judgment, a condition of our retention.

Other Matters

Supplementary Information Accompanying Audited Financial Statements

With respect to the supplementary information accompanying the financial statements, we made certain inquiries of management and evaluated the form, content, and methods of preparing the information to determine that the information complies with accounting principles generally accepted in the United States, the method of preparing it has not changed from the prior period, and the information is appropriate and complete in relation to our audit of the financial statements.

We compared and reconciled the supplementary information to the underlying accounting records used to prepare the financial statements or to the financial statements themselves.

Other Information in Documents Containing Audited Financial Statements

The auditor's responsibility for other information in documents containing audited financial statements does not extend beyond the financial information identified in our report, and we have no obligation to perform any procedures to corroborate other information contained in a document. Our responsibility is to read the other information and consider whether such information, or the manner of its presentation, is materially inconsistent with information, or the manner of its presentation, appearing in the financial statements.

This communication is intended solely for the information and use of the board of directors and, if appropriate, management and is not intended to be, and should not be, used by anyone other than these specified parties.

We appreciate the opportunity to be of service to San Gorgonio Healthcare District.

Sincerely,

Wipfli LLP
Oakland, California

Enc.

November 22, 2022

Wipfli LLP
66 Franklin Street, Suite 300
Oakland, California, 95612

This representation letter is provided in connection with your audits of the financial statements of San Gorgonio Healthcare District (the District) and its blended component unit, which comprise the statements of net position as of June 30, 2022 and 2021, and the related statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the financial statements for the purpose of expressing an opinion as to whether the financial statements are presented fairly, in all material respects in accordance with accounting principles generally accepted in the United States (GAAP).

This representation letter is also provided in connection with your audit of the federal award programs of the District as of and for the year ended June 30, 2022 which was performed in accordance with auditing standards generally accepted in the United States; Title 2 U.S. Code of Federal Regulations (CFR) Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance) and the standards for financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States.

We understand that the purpose of your testing of transactions and records from the District's federal programs was to obtain reasonable assurance that the District had complied, in all material respects, with the compliance requirements that could have a direct and material effect on each of its major programs.

Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement. An omission or misstatement that is monetarily small in amount could be considered material as a result of qualitative factors.

We confirm, to the best of our knowledge and belief as of date of this letter, the following representations made to you during your audits.

600 N. Highland Springs Avenue • Banning, CA 92220 • (951) 845-1121 • Fax (951) 845-2836

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated August 23, 2022, including our responsibility for the preparation and fair presentation of the financial statements in accordance with GAAP.

2. The financial statements referred to above are fairly presented in conformity with GAAP.

3. We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

4. We acknowledge our responsibility for the design, implementation, and maintenance of internal control to prevent and detect fraud.

5. Significant assumptions we used in making accounting estimates, including those measured at fair value, are reasonable.

6. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of GAAP.

7. All events subsequent to the date of the financial statements and for which GAAP requires adjustment or disclosure have been adjusted or disclosed.

8. We agree with the adjusting journal entries proposed by you and which are given effect to in the financial statements.

9. The effects of all known actual or possible litigation, claims, and assessments have been accounted for and disclosed in accordance with GAAP.

10. Material concentrations have been properly disclosed in accordance with GAAP.

11. Guarantees, whether written or oral, under which the District is contingently liable, have been properly recorded or disclosed in accordance with GAAP.

12. We acknowledge our responsibility as it relates to the following nonattest/nonaudit services, including that we assume all management responsibilities; oversee the services by designating an individual, preferably within senior management, who possesses suitable skill, knowledge, or experience; evaluate the adequacy and results of the services performed; and accept responsibility for the results of the services.

    a. Prepared the draft financial statements and related notes and prepared the Schedule of expenditures of federal awards (the "SEFA"). We have reviewed, approved, and accepted responsibility for the financial statements and related notes and the SEFA.
    b. Tax return preparation
    c. AB-915 Supplemental payment report preparation
    d. Cost report preparation for third party payors (S-10, Medicare, T-18, others)
    e. Lease consulting
    f. Other reimbursement consulting
    g. RHC Medi-Cal PPS reconciliation

Information Provided

1. We have provided you with:

   a. Access to all information, of which we are aware, that is relevant to the preparation and fair presentation of the financial statements, such as records, documentation, and other matters.

   b. Additional information that you have requested from us for the purpose of the audit.

   c. Unrestricted access to persons within the District from who you determined it necessary to obtain audit evidence.

   d. Minutes of the meeting of the governing board or summaries of actions of recent meetings for which minutes have not yet been prepared.

2. All material transactions have been recorded in the accounting records and are reflected in the financial statements.

3. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

4. We have no knowledge of any fraud or suspected fraud affecting the District involving:

   a. Management.

   b. Employees who have significant roles in internal control.

   c. Others where the fraud could have a material effect on the financial statements.

5. We have no knowledge of any allegations of fraud or suspected fraud affecting the District's financial statements communicated by employees, former employees, grantors, regulators, or others.

6. We have disclosed to you all known instances of noncompliance or suspected noncompliance with laws, regulations, and provisions of contracts and grant agreements applicable to us whose effects should be considered when preparing financial statements. Specifically:

   a. There are no violations or possible violations of laws or regulations, such as those related to the Medicare and Medicaid antifraud and abuse statutes, including but not limited to the Medicare and Medicaid Anti-Kickback Statute, Limitations on Certain Physician Referrals (the Stark law), and the False Claims Act, in any jurisdiction, whose effects should be considered for disclosure in the financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the financial statements.

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b. Billings to third-party payors comply in all material respects with applicable coding guidelines (for example, ICD-10-CM and CPT-4) and laws and regulations (including those dealing with Medicare and Medicaid antifraud and abuse), and billings reflect only charges for goods and services that were medically necessary; properly approved by regulatory bodies, if required; and properly rendered.

c. There have been no communications (oral or written) from regulatory agencies, governmental representatives, employees, or others concerning investigations or allegations of noncompliance with laws and regulations in any jurisdiction (including those related to the Medicare and Medicaid antifraud and abuse statutes), deficiencies in financial reporting practices, or other matters that could have a material adverse effect on the financial statements.

7. We have disclosed to you all known actual or possible litigation, asserted and unasserted claims, and assessments whose effects should be considered when preparing the financial statements. Adequate and reasonable provision has been made for losses related to asserted and unasserted malpractice, health insurance, worker's compensation, and any other claims or assessments.

8. We have disclosed to you the identity of the District's related parties and all the related party relationships and transactions of which we are aware.

9. The District has satisfactory title to all owned assets, and there are no liens or encumbrances on such assets nor has any material asset been pledged, except as disclosed in the notes to the financial statements.

10. Receivables recorded in the financial statements represent valid claims for charges arising on or before the balance sheet date and have been appropriately reduced to their estimated net realizable value as follows:

a. Adequate consideration has been given to, and appropriate provision made for, estimated adjustments to revenue, such as for denied claims and changes to prospective payment system assignments.

b. Recorded valuation allowances are necessary, appropriate, and properly supported.

c. All peer review organizations, fiscal intermediary, and third-party payor reports and information have been made available to you.

11. Provision has been made, when material, for estimated retroactive adjustments by third-party payors under reimbursement agreements. In regards to cost reports filed with third-parties:

a. All required Medicare, Medicaid, and similar reports have been properly filed on a timely basis.

b. Management is responsible for the accuracy and propriety of all cost reports filed.

c. All costs reflected on such reports are appropriate and allowable under applicable reimbursement rules and regulations and are patient-related and properly allocated to

applicable payors.

d. The reimbursement methodologies and principles employed are in accordance with applicable rules and regulations.

e. Adequate consideration has been given to, and appropriate provision made for, audit adjustments by intermediaries, third-party payors, or other regulatory agencies.

f. All items required to be disclosed, including disputed costs that are being claimed to establish a basis for a subsequent appeal, have been fully disclosed in the cost report.

g. Recorded third-party settlements include differences between filed (and to be filed) cost reports and calculated settlements, which are necessary based on historical experience or new or ambiguous regulations that may be subject to differing interpretations. While management believes the entity is entitled to all amounts claimed on the cost reports, management also believes the amounts of these differences are appropriate.

12. We have reviewed long-lived assets and certain identifiable intangibles to be held and used for impairment whenever events or changes in circumstances have indicated that the carrying amount of assets might not be recoverable and have appropriately recorded the adjustment.

13. We have fully disclosed to you all terms of contracts with customers that affect the amount and timing of revenue recognized in the financial statements, including delivery terms, rights of return or price adjustments, side adjustments, implicit provisions, unstated business conventions, and all warranty provisions.

14. The District has identified all accounting estimates that could be material to the financial statements, including the key factors and significant assumptions underlying those estimates, and I we believe the estimates are reasonable in the circumstances.

15. There are no estimates that may be subject to a material change in the near term that have not been properly disclosed in the financial statements. We understand that near term means the period within one year of the date of the financial statements. In addition, we have no knowledge of concentrations existing at the date of the financial statements that make the District vulnerable to the risk of severe impact that have not been properly disclosed in the financial statements.

16. We have complied with all restrictions on resources (including donor restrictions) and all aspects of contractual and grant agreements that would have a material effect on the financial statements in the event of noncompliance. The District has obtained waivers for noncompliance with debt covenants, and we believe debt is properly classified as noncurrent.

17. Inventories fairly represent the value of inventories at the lower of cost on the first-in, first-out method, or net realizable value.

18. We) acknowledge our responsibility for presenting the [Identify supplementary information] in accordance with GAAP, and I (we) believe the [Identify supplementary information], including its form and content, is fairly presented in accordance with GAAP. The methods of measurement and presentation of the [Identify supplementary information] have not changed from those used in the prior period, and we have disclosed to you any significant assumptions or interpretations underlying the measurement and presentation of the supplementary information.

19. The financial statements include all component units as well as joint ventures with a material equity interest, and properly disclose all other joint ventures and other related organizations.

20. Components of net position net investment in capital assets, restricted, and unrestricted are properly classified and, if applicable, approved.

21. We have appropriately disclosed the District's policy regarding whether to first apply restricted or unrestricted resources when an expense is incurred for purposes for which both restricted and unrestricted net position are available and have determined that net position was properly recognized under the policy.

22. We are responsible for the management's discussion and analysis and have chosen not to present it, which will require disclosure in the auditor's report.

With Respect to Federal Award Programs

1. With respect to federal award programs:

    a. We are responsible for understanding and complying with and have complied with the requirements of the Uniform Guidance and any other applicable laws and regulations and provisions of contracts and grant agreements, including requirements relating to preparation of the SEFA.

    b. We are responsible for understanding and complying with, and have complied with, the requirements of federal statutes, regulations, and the terms and conditions of federal awards related to each of our federal programs and have identified and disclosed to you the requirements of federal statutes, regulations and the terms and conditions of federal awards that are considered to have a direct and material effect on each major federal program.

    c. We are responsible for establishing and maintaining, and have established and maintained, effective internal control over compliance for federal programs that provides reasonable assurance that we are managing our federal awards in compliance with federal statutes, regulations, and the terms and conditions of federal awards. We believe the internal control system is adequate and is functioning as intended.

d. We have made available to you all federal awards (including amendments, if any) and any other correspondence with federal agencies or pass-through entities relating to federal programs and related activities.

e. We have received no requests from a federal agency to audit one or more specific programs as a major program.

f. We have complied with the direct and material compliance requirements (except for noncompliance disclosed to you), including when applicable, those set forth in the *OMB Compliance Supplement*, relating to federal awards confirm that there were no amounts questioned and no known noncompliance with the direct and material compliance requirements of federal awards.

g. We have disclosed any communications from federal awarding agencies and pass-through entities concerning possible noncompliance with the applicable compliance requirements, including communications received from the end of the period covered by the compliance audit to the date of the auditor's report.

h. We have disclosed to you the findings received and related corrective actions taken for previous audits, attestation engagements, and internal or external monitoring that directly relate to the objectives of the compliance audit, including findings received and corrective actions taken from the end of the period covered by the compliance audit to the date of the auditor's report.

i. Amounts claimed or used for matching were determined in accordance with relevant guidelines in OMB's Uniform Guidance (2CFR Part 200, Subpart E).

j. We have disclosed to you our interpretation of compliance requirements that have varying interpretations, if any.

k. We have made available to you all documentation relating to the compliance with the direct and material compliance requirements, including information related to federal program financial reports and claims for advances and reimbursements.

l. We have disclosed to you the nature of any subsequent events that provide additional evidence about conditions that existed at the end of the reporting period affecting noncompliance during the reporting period.

m. There are no such known instances of noncompliance with direct and material compliance requirements that occurred subsequent to the period covered by the auditor's report.

n. No changes have been made in internal control over compliance or other factors that might significantly affect internal control, including any corrective action we have taken regarding significant deficiencies or material weaknesses in internal

control over compliance subsequent to the date as of which compliance was audited.

o. Federal program financial reports and claims for advances and reimbursements are supported by the books and records from which the basic financial statements have been prepared.

p. The copies of federal program financial reports provided you are true copies of the reports submitted, or electronically transmitted, to the respective federal agency or pass-through entity, as applicable.

q. We have charged costs to federal awards in accordance with applicable cost principles.

r. We are responsible for and have accurately prepared the summary schedule of prior audit findings to include all findings required to be included by the Uniform Guidance, and we have provided you with all information on the status of the follow-up on prior audit findings by federal awarding agencies and pass-through entities, including all management decisions.

s. We are responsible for and have ensured the reporting package does not contain protected personally identifiable information.

t. We are responsible for and will accurately complete the auditee section of the Data Collection Form as required by the Uniform Guidance.

u. We are responsible for taking corrective action on each audit finding of the compliance audit and have developed a corrective action plan that meets the requirements of the Uniform Guidance.

2. There have been no irregularities or instances of fraud involving management, employees who administer federal or state programs, or other employees that could have a material effect on federal programs.

3. We have a process to track the status of audit findings and recommendations.

4. We have identified to you any previous audits, attestation engagements, or other studies related to the audit objectives and whether related recommendations have been implemented.

5. We have provided our views on reported findings, conclusions, and recommendations, as well as our planned corrective actions, for the report.

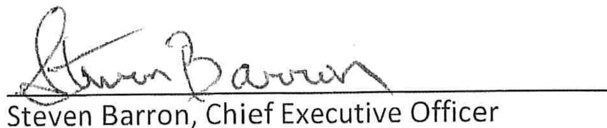
Schedule of Expenditures of Federal Awards

6. We acknowledge our responsibility for presenting the SEFA in accordance with the requirements of the Uniform Guidance, and we believe the SEFA, including its form and content, is fairly presented in accordance with the Uniform Guidance. The methods of measurement and presentation of the SEFA have not changed from those used in the prior period, and we have disclosed to you any significant assumptions and interpretations underlying the measurement and presentation of the SEFA.

7. We have identified and disclosed to you all of our government programs and related activities subject to the Uniform Guidance compliance audit, and have included in the SEFA, expenditures made during the audit period for all awards provided by federal agencies in the form of federal awards, federal cost-reimbursement contracts, loans, loan guarantees, property (including donated surplus property), cooperative agreements, interest subsidies, insurance, food commodities, direct appropriations, and other direct assistance.

Sincerely,

San Gorgonio Healthcare District



Steven Barron, Chief Executive Officer

Daniel Heckathorne, Chief Financial Officer

Number	Date	Name	Account No	Debit	Credit
AJE22	6/30/2022	ACCRUED TAX RECEIVABLE_PROP 13	02-1064-123601	1,141,141.00	
AJE22	6/30/2022	ACCRUED TAX RECEIVABLE_MEASURE D	02-1064-123602		-604,629.00
AJE22	6/30/2022	ACCRUED TAX RECEIVABLE_MEASURE A	02-1064-123603		-536,512.00
		To Correct Tax Accrual			
AJE 12	6/30/2022	OTHER MISC INCOME	9040-0000	141,560.00	
AJE 12	6/30/2022	Found FOUND	01-1850-185000		-141,560.00
		To record the beneficial interest in the net assets of the Foundation			
AJE 13	6/30/2022	Due From Medicare Settlement	01-1051-124005	1,456,289.00	
AJE 13	6/30/2022	DSH ACCRUAL OTHER RECEIVABLES	01-1052-123704		-3,389,728.00
AJE 13	6/30/2022	Due from LLUMC	01-1065-124002		-106,033.00
AJE 13	6/30/2022	Supplemental Funding Revenue Receivable	01-1069-124301	4,000,548.00	
AJE 13	6/30/2022	INTERCOMPANY TRANSFER	01-1090-126101		-660,465.00
AJE 13	6/30/2022	UNRESTRICTED FUND BALANCE	01-2310-354001		-1,300,611.00
AJE 13	6/30/2022	ACCRUED TAX RECEIVABLE_PROP 13	02-1064-123601	99.00	
AJE 13	6/30/2022	UNRESTRICTED FUND BALANCE_UNRESTRICTED FUND BALANCE	02-2310-354001		-99.00
		Net position closeout reconciliation - Prepared by Wipfli			
AJE 14	6/30/2022	INTERCOMPANY TRANSFER	01-1090-126101	111,925.00	
AJE 14	6/30/2022	REBATES & REFUNDS	01-5680-701498		-111,925.00
		Immaterial adjustment to reconcile intercompany activity			
AJE 15	6/30/2022	ALLOW - HMO/PPO	01-1049-123106	203,024.00	
AJE 15	6/30/2022	REV DED_ CNTRL ADJ CONTRACTUAL ALLOWANCES	01-5800-501052		-203,024.00
		To adjust contractual allowance based on estimate			
AJE 18	6/30/2022	UNAMTZ LOAN_1352_GO BONDS 2015	02-1352-134001		-9,223.00
AJE 18	6/30/2022	BONDS PAYABLE_2013 BOND DISCOUNT	02-2251-245102	24,828.00	
AJE 18	6/30/2022	BONDS PAYABLE_2014 BOND ISSUE PREMIUM	02-2251-245105		-2,605.00
AJE 18	6/30/2022	BONDS PAYABLE_2015 BONDS PREMIUM	02-2251-245107	34,472.00	
AJE 18	6/30/2022	AMORTIZATION EXPENSE_AMORTIZATION EXPENSE	02-8850-602929		-47,472.00
		To correct LTD balance of Bond Discount/Premium			
AJE 19	6/30/2022	ACCRUED PAYROLL	01-2031-243022		-320,007.00
AJE 19	6/30/2022	RN'S	01-6170-601502	320,007.00	
		To correct accrued Payroll expense			
AJE 20	6/30/2022	Liability for legal settlements	01-2039-243016		-3,417,500.00
AJE 20	6/30/2022	Class action settlement losses - Employee pay	01-9900-903731	3,417,500.00	
		To record settlement payments			
AJE 21	6/30/2022	ACCRUED GO BOND INTEREST PAYABLE_2015 ACCRUED INTE	02-2041-244504	494,729.00	
AJE 21	6/30/2022	AMORTIZATION EXPENSE_AMORTIZATION EXPENSE	02-8850-602929		-494,729.00
		To correct accrued interest			

Number	Date	Name	Account No	Debit	Credit
AJE 22	6/30/2022	Outlier Estimate	WIPFLI 124005		-1,500,000.00
AJE 22	6/30/2022	Due From Medicare Settlement	01-1051-124005	1,141,145.00	
AJE 22	6/30/2022	DSH ACCRUAL OTHER RECEIVABLES	01-1052-123704	2,593,903.00	
AJE 22	6/30/2022	Due From Medi-Cal AB 915	01-1053-124001	188,789.00	
AJE 22	6/30/2022	Supplemental Funding Revenue Receivable	01-1069-124301		-4,000,548.00
AJE 22	6/30/2022	REV DED_ CNTRL ADJ CONTRACTUAL ALLOWANCES	01-5800-501052	1,576,711.00	
AJE 22	6/30/2022	SUPPLEMENTAL FUNDING REVENUE RECEIVABLE OTHER RECE	02-1069-124301	24,621.00	
AJE 22	6/30/2022	NON_OPER REV90609060NON PT REVOTHER INTR INCOME OT	02-9060-703098		-24,621.00
		To record estimated 2022 cost report activity			
AJE 23	6/30/2022	SUPPLEMENTAL FUNDING REVENUE RECEIVABLE OTHER RECE	02-1069-124301	96,489.00	
AJE 23	6/30/2022	OPER REV_(MOVED 9170)_TAX REVENUE MD	02-5170-703232	47,139.00	
AJE 23	6/30/2022	OPER REV_(MOVED 9171)_PROP 13 INCOME OTHER INCOME	02-5171-703533	46,755.00	
AJE 23	6/30/2022	OPER REV_(MOVED 9173)_ABX 163 SUPPLEMENTAL TAX	02-5173-703634		-165,265.00
AJE 23	6/30/2022	NON_OPER REV9172_TAX REVENUE MA. OTHER INCOME	02-9172-903430		-25,118.00
		To true up tax income to support			
PBC 01	6/30/2022	Accrued Payables	01-2010-241003		-95,742.92
PBC 01	6/30/2022	PURCHASED SERVICES	01-8480-601969	95,742.92	
		To add AP accruals			
PBC 02	6/30/2022	CITY NATIONAL BANK - ACCT 403	01-1000-120001	38,499.65	
PBC 02	6/30/2022	BANK OF HEMET GENERAL CASH	01-1000-120003	117,375.84	
PBC 02	6/30/2022	SECURITY BANK PAYROLL	01-1000-120018	1,800,000.00	
PBC 02	6/30/2022	SECURITY BANK PAYROLL	01-1000-120018		-544,104.88
PBC 02	6/30/2022	SECURITY BANK GENERAL CHECKING	01-1000-120020		-1,648,121.63
PBC 02	6/30/2022	Accrued Payables	01-2010-241003		-307,753.86
PBC 02	6/30/2022	SALES TAX PAYABLE	01-2049-243001	544,104.88	
		To reconcile cash balances			
RJE 22	6/30/2022	INTERCOMPANY TRANSFER	1090-0000	320,007.00	
RJE 22	6/30/2022	RN'S	01-6170-601502		-320,007.00
RJE 22	6/30/2022	INTERCOMPANY_INTERCOMPANY DIST	02-1090-126102		-320,007.00
RJE 22	6/30/2022	AMORTIZATION EXPENSE_AMORTIZATION EXPENSE	02-8850-602929	320,007.00	
		To reclass unreconciled differences in accrued salaries and accrued interest between interest expense and salaries			
AJE LEASE 2022	6/30/2022	UNRESTRICTED FUND BALANCE	2310-0000	18,430.00	
AJE LEASE 2022	6/30/2022	BEHAVIORAL HEALTH AMORTIZATION EXPENSE	BH 602727	86,835.00	
AJE LEASE 2022	6/30/2022	ROU LEASED ASSETS	ROU 131400	3,168,512.00	
AJE LEASE 2022	6/30/2022	TIAA SHARP LEASE AMORTIZATION EXPENSE	TIAA 602727	1,665.00	
AJE LEASE 2022	6/30/2022	ABBOTT LEASE AMORTIZATION EXPENSE	ABBOT 602727	27,066.00	
AJE LEASE 2022	6/30/2022	LEASE ACCUMULATED AMORTIZATION	LEASE 132001		-1,027,641.00
AJE LEASE 2022	6/30/2022	LEASE ACCRUED INTEREST	LEASE 244500		-4,010.00
AJE LEASE 2022	6/30/2022	SHARED IMAGING LEASE AMORTIZATION EXPENSE	SHARED 602727	257,520.00	
AJE LEASE 2022	6/30/2022	INTERCOMPANY TRANSFER	01-1090-126101		-300,000.00
AJE LEASE 2022	6/30/2022	RENTAL/LEASE	01-6010-602676		-1,665.00
AJE LEASE 2022	6/30/2022	RENTAL/LEASE	01-6170-602676		-27,969.00
AJE LEASE 2022	6/30/2022	RENTAL/LEASE	01-7160-602676		-86,835.00
AJE LEASE 2022	6/30/2022	RENTAL/LEASE	01-7421-602676		-85,085.00
AJE LEASE 2022	6/30/2022	RENTAL/LEASE	01-7500-602676		-27,066.00
AJE LEASE 2022	6/30/2022	MRI - RENTAL & LEASE	01-7660-602676		-319,234.00
AJE LEASE 2022	6/30/2022	LINE OF CREDIT INTEREST	01-8870-602928	38,479.00	
AJE LEASE 2022	6/30/2022	INTERCOMPANY_INTERCOMPANY DIST	02-1090-126102	300,000.00	
AJE LEASE 2022	6/30/2022	PREPD_1108_DUES	02-1108-126010		-300,000.00
AJE LEASE 2022	6/30/2022	IN TOUCH ROBOTS AMORTIZATION EXPENSE	INTOUCH 602727	27,969.00	

Number	Date	Name	Account No	Debit	Credit
AJE LEASE 2022	6/30/2022	OLYMPUS LEASE AMORTIZATION EXPENSE	OLYMPUS 602727	48,259.00	
AJE LEASE 2022	6/30/2022	Current portion of leases payable	CP LEASE 245100		-608,561.00
AJE LEASE 2022	6/30/2022	LONG TERM PORTION OF LEASES PAYABLE	LT LEASE 245100		-1,273,925.00
AJE LEASE 2022	6/30/2022	Intuitive Lease amortization expense	INTUITIVE 602727	87,256.00	

Entry necessary to convert lease
accounting to conform to GASB Statement No. 87 principles

TAB L

MINUTES: NOT YET APPROVED
BY COMMITTEE

REGULAR MEETING OF THE
SAN GORGONIO MEMORIAL HOSPITAL
BOARD OF DIRECTORS

HUMAN RESOURCES COMMITTEE
November 16, 2022

The regular meeting of the San Gorgonio Memorial Hospital Board of Directors Human Resources Committee was held on Wednesday, November 16, 2022, in the Administration Boardroom, 600 N. Highland Springs Avenue, Banning, California.

Members Present: Susan DiBiasi, Ron Rader (C), Steve Rutledge, Siri Welch

Excused Absence: Joel Labha

Staff Present: Annah Karam (CHRO), Ariel Whitley (Executive Assistant)

AGENDA ITEM	DISCUSSION	ACTION / FOLLOW-UP
Call To Order	Chair Ron Rader called the meeting to order at 9:07 am.	
Public Comment	No public was present.	
OLD BUSINESS		
Proposed Action - Approve Minutes: **September 16, 2022, Regular Meeting**	Chair Rader asked for any changes or corrections to the minutes of the September 16, 2022, regular meeting. There were none.	**The minutes of the September 16, 2022, regular meeting was reviewed and will stand as presented.**
NEW BUSINESS		
Reports		
A. Employment Activity/Turnover Reports		
1. Employee Activity by Job Class/ Turnover Report (09/13/2022	Annah Karam, Chief Human Resources Officer, reviewed the report “Employee Activity by Job Class/Turnover Report” for the period of 09/13/2022 through 11/09/2022 as included in the Committee packet.	

AGENDA ITEM	DISCUSSION	ACTION / FOLLOW-UP
through 11/09/2022)		
2. Separation Reasons Analysis All Associates (09/13/2022 through 11/09/2022)	Annah reviewed the “Separation Reason Analysis for All Associates” for the period of 09/13/2022 through 11/09/2022 as included in the Committee packet. For this period, there were 25 Voluntary Separations and 1 Involuntary Separations for a total of 26.	
3. Separation Reason Analysis Full and Part Time Associates (09/13/2022 through 11/09/2022)	Annah reviewed the “Separation Reason Analysis for Full and Part Time Associates” for the period of 09/13/2022 through 11/09/2022 as included in the Committee packet. For this period, there were 17 Voluntary Separations and 1 Involuntary Separations for a total of 18.	
4. Separation Reason Analysis Per Diem Associates (09/13/2022 through 11/09/2022)	Annah reviewed the “Separation Reason Analysis for Per Diem Associates” for the period of 09/13/2022 through 11/09/2022 as included in the Committee packet. For this period, there were 8 Voluntary Separations and 0 Involuntary Separations for a total of 8.	
5. FTE Vacancy Summary (09/13/2022 through 11/09/2022)	Annah reviewed the “FTE Vacancy Summary” for the period of 09/13/2022 through 11/09/2022 as included in the Committee packet. Annah reported that the Facility Wide vacancy rate as of 11/09/2022 was 15.51%.	
6. RN Vacancy Summary (09/13/2022 through 11/09/2022)	Annah reviewed the “RN Vacancy Summary” for the period of 09/13/2022 through 11/09/2022 as included in the Committee packet. Annah reported that the Overall All RN Vacancy rate as of 11/09/2022 was 16.50%.	

AGENDA ITEM	DISCUSSION	ACTION / FOLLOW-UP
B. Workers Compensation Report		
Workers Compensation Report (10/01/2022 through 10/31/2022)	Annah reviewed the Workers Compensation Reports covering the period of 10/01/2022 through 10/31/2022 as included in the Committee packet.	
Education	Annah reviewed each education article as included in the committee packets: • Personal Best Newsletter: November • Top Performance Newsletter	
Future Agenda items	None.	
Next regular meeting	The next regular Human Resources Committee meeting is scheduled for November 16, 2022.	
Adjournment	The meeting was adjourned at 9:45 am.	

In accordance with The Brown Act, *Section 54957.5*, all reports and handouts discussed during this Open Session meeting are public records and are available for public inspection. These reports and/or handouts are available for review at the Hospital Administration office located at 600 N. Highland Springs Avenue, Banning, CA 92220 during regular business hours, Monday through Friday, 8:00 am - 4:30 pm.

Minutes respectfully submitted by Ariel Whitley, Executive Assistant

A B C D E F G H I J K

EMPLOYEE ACTIVITY BY JOB CLASS / TURN OVER REPORT

09/13/2022 THROUGH 11/09/2022

JOB CLASS/FAMILY	CURRENT NEW HIRES	2021 NEW HIRES	YTD NEW HIRES	CURRENT SEPARATIONS	2021 SEPARATIONS	YTD TERMS	ACTIVE ASSOCIATE COUNT	LOA ASSOCIATE COUNT	CURRENT TURNOVER	ANNUALIZED TURNOVER	1 2 3
	09/13/2022 THROUGH 11/09/2022		01/01/2022 THROUGH 11/09/2022	09/13/2022 THROUGH 11/09/2022		01/01/2022 THROUGH 11/09/2022	AS OF 11/09/2022	AS OF 11/09/2022	AS OF 11/09/2022		4
ADMIN/CLERICAL	3	17	18	5	22	20	79	4	6.33%	25.32%	5
ANCILLARY	2	28	13	1	24	15	62	1	1.61%	24.19%	6
CLS	0	7	2	0	8	3	19	1	0.00%	15.79%	7
DIRECTORS/MGRS	0	2	2	0	3	2	27	1	0.00%	7.41%	8
LVN	1	5	2	2	8	6	19	3	10.53%	31.58%	9
OTHER NURSING	4	30	23	4	27	20	75	0	5.33%	26.67%	10
PT	0	3	0	1	3	2	9	0	11.11%	22.22%	11
RAD TECH	1	6	5	2	7	6	34	0	5.88%	17.65%	12
RN	7	59	40	6	51	43	168	4	3.57%	25.60%	13
RT	0	4	0	0	2	1	22	0	0.00%	4.55%	14
SUPPORT SERVICES	4	34	27	5	32	25	79	3	6.33%	31.65%	15
											16
FACILITY TOTAL	**22**	**195**	**132**	**26**	**187**	**143**	**593**	**17**	**4.38%**	24.11%	17
											18
Full Time	13	113	81	17	97	75	394	14	*4.31%*	19.04%	19
Part Time	2	15	8	1	17	11	51	1	*1.96%*	21.57%	20
Per Diem	7	67	43	8	73	57	148	2	*5.41%*	38.51%	21
TOTAL	***22***	***195***	***132***	***26***	***187***	***143***	***593***	***17***	**4.38%**		22

23

Current Turnover: J22

Annualized Turnover: K22

Southern California Hospital Association (HASC) Benchmark:			24
Turnover for all Associates	=	13.90%	25
Turnover for all RNs	=	16.30%	26

11/10/2022
2:27 PM

SEPARATION ANALYSIS

ALL ASSOCIATES

09/13/2022 THROUGH 11/09/2022

REASON	Current Qtr % by Category	Length Of Service						Total Separations
		Less than 90 days	*90 days - 1 year*	*1-2 years*	*2-5 years*	*5-10 years*	*10+ years*	
Voluntary Separations								
Full-Time	61.5%	4	6	2	2	0	2	16
Part-Time	3.8%	0	0	1	0	0	0	1
Per Diem	30.8%	2	2	2	2	0	0	8
Subtotal, Voluntary Separations	96.2%	6	8	5	4	0	2	25
Involuntary Separations								
Full-Time	3.8%	0	0	0	1	0	0	1
Part-Time	0.0%							0
Per Diem	0.0%							0
Subtotal, Involuntary Separations	3.8%	0	0	0	1	0	0	1

Total Separations	**100.0%**	**6**	**8**	**5**	**5**	**0**	**2**	**26**

Separation Reason Analysis

FULL AND PART TIME ASSOCIATES

09/13/2022 THROUGH 11/09/2022

REASON	Current Qtr % by Category	Length Of Service						Total Separations
		Less than 90 days	*90 days - 1 year*	*1-2 years*	*2-5 years*	*5-10 years*	*10+ years*	
Voluntary Separations								
Family/Personal Reasons	27.8%	1	1	2	0	1	0	5
New Job Opportunity	38.9%	1	4	0	1	1	0	7
Job Dissatisfaction	5.6%	0	0	1	0	0	0	1
Relocation	5.6%	0	0	0	1	0	0	1
Medical Reasons	0.0%							0
Did not Return from LOA	0.0%							0
Job Abandonment	5.6%	1	0	0	0	0	0	1
Return to School	0.0%							0
Pay	0.0%							0
Employee Death	0.0%							0
Not Available to Work	11.1%	1	1	0	0	0	0	2
Unknown	0.0%							0
Retirement	0.0%							0
Subtotal, Voluntary Separations	94.4%	**4**	**6**	**3**	**2**	**2**	**0**	**17**
Involuntary Separations								
Attendance/Tardiness	0.0%							0
Didn't meet certification deadline	0.0%							0
Didn't meet scheduling needs	0.0%							0
Conduct	5.6%	0	0	0	1	0	0	1
Poor Performance	0.0%							0
Temporary Position	0.0%							0
Position Eliminations	0.0%							0
Subtotal, Involuntary Separations	5.6%	**0**	**0**	**0**	**1**	**0**	**0**	**1**
Total Separations	**100.0%**	**4**	**6**	**3**	**3**	**2**	**0**	**18**

Separation Reason Analysis

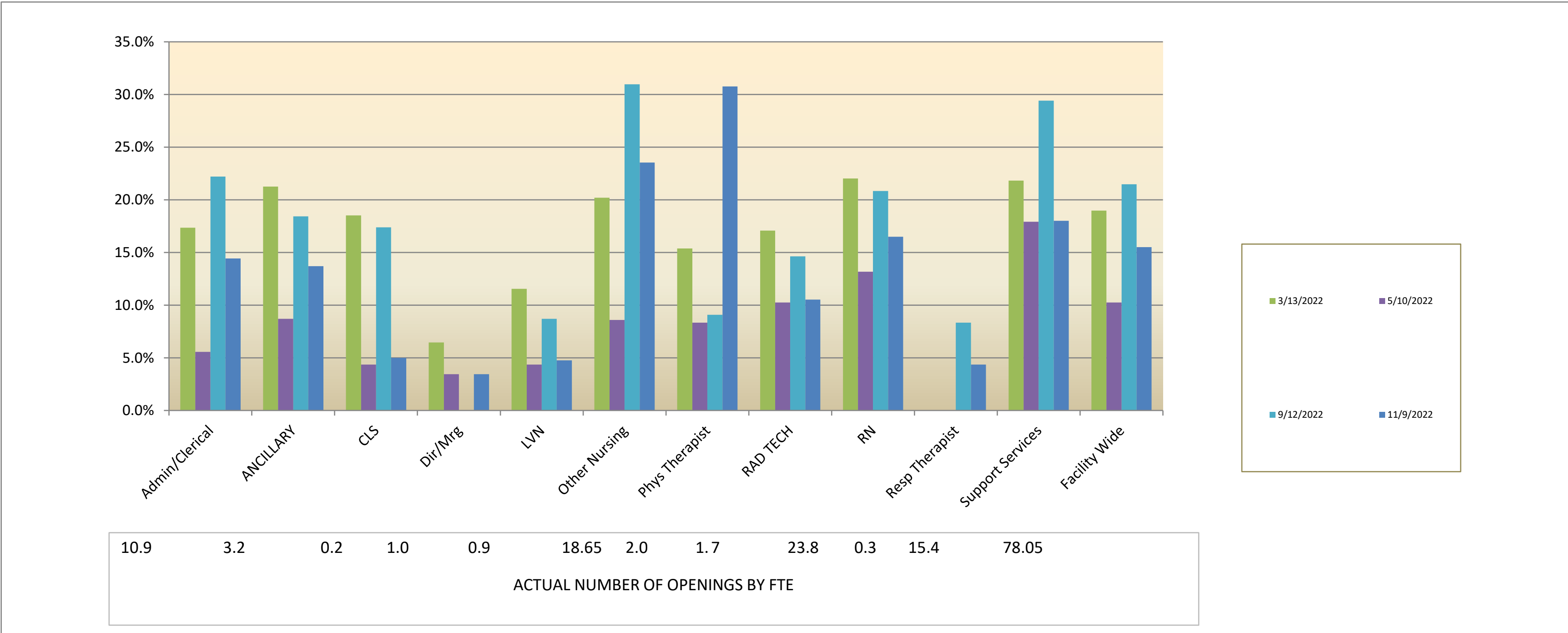
Per Diem Associates Only

09/13/2022 THROUGH 011/09/2022

REASON	Current Qtr % by Category	Length Of Service: Less than 90 days	90 days - 1 year	1-2 years	2-5 years	5-10 years	10+ years	Total Separations
Voluntary Separations								
Family/Personal Reasons	0.0%							*0*
New Job Opportunity	50.0%	1	1	1	1	0	0	*4*
Job Dissatisfaction	0.0%							*0*
Relocation	12.5%	0	0	1	0	0	0	*1*
Medical Reasons	0.0%							*0*
Did not Return from LOA	12.5%	0	0	0	1	0	0	*1*
Job Abandonment	0.0%							*0*
Return to School	0.0%							*0*
Pay	0.0%							*0*
Employee Death	0.0%							*0*
Not Available to Work	25.0%	1	1	0	0	0	0	*2*
Unknown	0.0%							*0*
Retirement	0.0%							*0*
Subtotal, Voluntary Separations	100.0%	***2***	***2***	***2***	***2***	***0***	***0***	***8***
Involuntary Separations								
Attendance/Tardiness	0.0%							*0*
Didn't meet certification deadline	0.0%							*0*
Didn't meet scheduling needs	0.0%							*0*
Conduct	0.0%							*0*
Poor Performance	0.0%							*0*
Temporary Position	0.0%							*0*
Position Eliminations	0.0%							*0*
Subtotal, Involuntary Separations	0.0%	***0***	***0***	***0***	***0***	***0***	***0***	***0***
Total Separations	**100.0%**	**2**	**2**	**2**	**2**	**0**	**0**	**8**

FTE Vacancy Summary: 09/13/2022 THROUGH 11/09/2022

	Admin/Clerical	ANCILLARY	CLS	Dir/Mrg	LVN	Other Nursing	Phys Therapist	RAD TECH	RN	Resp Therapist	Support Services	Facility Wide
3/13/2022	17.35%	21.25%	18.52%	6.45%	11.54%	20.19%	15.38%	17.07%	22.03%	0.00%	21.82%	18.97%
5/10/2022	5.56%	8.70%	4.35%	3.45%	4.35%	8.60%	8.33%	10.26%	13.17%	0.00%	17.92%	10.25%
9/12/2022	22.20%	18.42%	17.39%	0.00%	8.70%	30.97%	9.09%	14.63%	20.83%	8.33%	29.41%	21.48%
11/9/2022	14.43%	13.70%	5.00%	3.45%	4.76%	23.53%	30.77%	10.53%	16.50%	4.35%	18.00%	15.51%

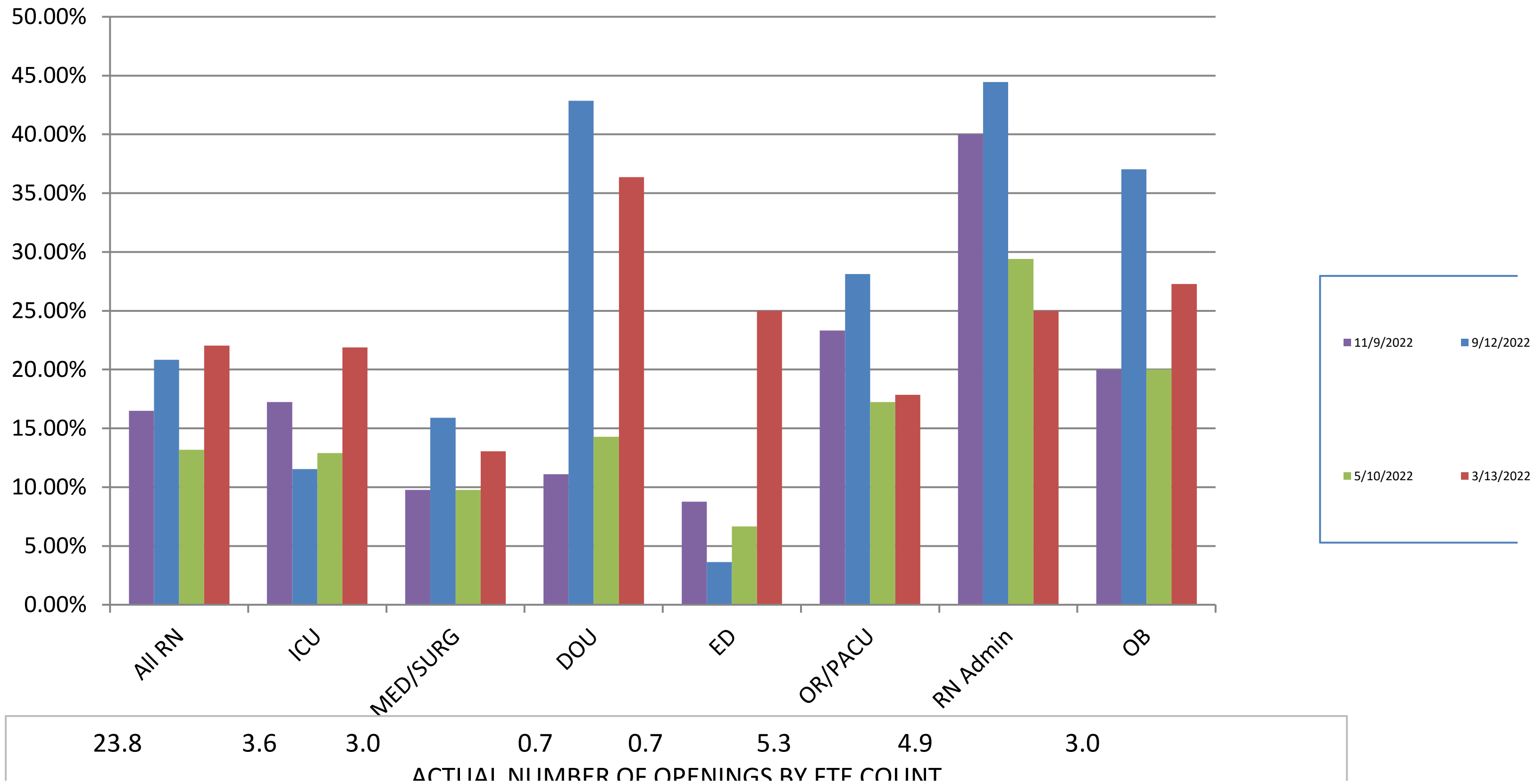


RN FTE Vacancy Summary: 09/13/2022 through 11/09/2022

	11/9/2022	9/12/2022	5/10/2022	3/13/2022
All RN	16.50%	20.83%	13.17%	22.03%
ICU	17.24%	11.54%	12.90%	21.88%
MED/SURG	9.76%	15.91%	9.76%	13.04%
DOU	11.11%	42.86%	14.29%	36.36%
ED	8.77%	3.64%	6.67%	25.00%
OR/PACU	23.33%	28.13%	17.24%	17.86%
RN Admin	40.00%	44.44%	29.41%	25.00%
OB	20.00%	37.04%	20.00%	27.27%

VACANCY RATE = Number of openings/(total staff + openings

	OPEN POSITIONS	TOTAL STAFF	VACANCY RATE
All RN	34	172	16.50%
ICU	5	24	17.24%
Med Surg	4	37	9.76%
DOU	1	8	11.11%
ER	5	52	8.77%
OR/PACU	7	23	23.33%
RN Adm.	8	12	40.00%
OB	4	16	20.00%



23.8 3.6 3.0 0.7 0.7 5.3 4.9 3.0

ACTUAL NUMBER OF OPENINGS BY FTE COUNT

DASHBOARD REPORT

Fiscal Year Basis: July

San Gorgonio Memorial Hospital

Data as of 10/31/2022

Reporting Period 10/1/2022 - 10/31/2022

SUMMARY DATA

		Values				
FiscalYear	ValuationDate	Total Paid	Total Reserves	Total Incurred	Count	Open Count
2015-2016	2022-10-31	843,082	81,342	924,425	40	4
2016-2017	2022-10-31	205,546	-	205,546	27	-
2017-2018	2022-10-31	72,312	-	72,312	18	-
2018-2019	2022-10-31	87,684	7,313	94,997	15	1
2019-2020	2022-10-31	68,021	6,544	74,565	15	2
2020-2021	2022-10-31	228,795	69,662	298,457	22	3
2021-2022	2022-10-31	70,839	55,470	126,309	18	6
2022-2023	2022-10-31	905	24,444	25,349	3	2
Grand Total		**1,577,183**	**244,776**	**1,821,959**	**158**	**18**

CONTINUE TO NEXT PAGE

DASHBOARD REPORT

San Gorgonio Memorial Hospital

Fiscal Year Basis: July

Data as of 10/31/2022

Reporting Period 10/1/2022 - 10/31/2022

TOP TEN CLAIMS

Claim Number	Claimant	Department	Cause	DOI	Status	Total Paid	Total Reserves	Total Incurred
16000811		Environmental Services	Fall, Slip or Trip Injury	2016-05-31	Open	172,482	19,434	191,915
20805905		Surgical Services	Fall, Slip or Trip Injury	2020-08-04	Open	128,541	52,151	180,692
16000026		Obstetrics	Fall, Slip or Trip Injury	2016-01-05	Open	136,724	20,723	157,446
16001005		Medical Surgical	Burn or Scald - Heat or Cold Exposures -	2016-07-21	Closed	98,814	-	98,814
16000233		Environmental Services	Strain or Injury By	2016-02-20	Closed	93,934	-	93,934
16000357		Medical Surgical	Struck or Injured By	2016-03-16	Open	82,643	10,906	93,549
16000185		Medical Surgical	Fall, Slip or Trip Injury	2016-02-13	Closed	77,289	-	77,289
15000959		Environmental Services	Miscellaneous Causes	2015-07-06	Closed	61,315	-	61,315
15001161		CT/Echotechnology	Strain or Injury By	2015-08-20	Re-Open	27,084	30,280	57,364
15001966		Emergency Department	Cut, Puncture, Scrape Injured by	2015-12-05	Closed	55,952	-	55,952

FREQUENCY BY DEPARTMENT

Department	Claim Count	% of Claims	Total Incurred	% of Total Incurred
Environmental Services	**34**	21.52%	583,872	32.05%
Medical Surgical	**33**	20.89%	456,495	25.06%
Dietary	**18**	11.39%	18,098	0.99%
Emergency Department	**18**	11.39%	95,949	5.27%
Surgical Services	**7**	4.43%	216,077	11.86%
Intensive Care Unit (ICU)	**7**	4.43%	5,706	0.31%
Obstetrics	**5**	3.16%	214,744	11.79%
Laboratory	**5**	3.16%	7,777	0.43%
Medical Staff	**4**	2.53%	14,706	0.81%
Business Office	**4**	2.53%	27,225	1.49%

SEVERITY BY DEPARTMENT

Department	Claim Count	% of Claims	Total Incurred	% of Total Incurred
Environmental Services	34	21.52%	**583,872**	32.05%
Medical Surgical	33	20.89%	**456,495**	25.06%
Surgical Services	7	4.43%	**216,077**	11.86%
Obstetrics	5	3.16%	**214,744**	11.79%
Emergency Department	18	11.39%	**95,949**	5.27%
CT/Echotechnology	1	0.63%	**57,364**	3.15%
Security Department	3	1.90%	**47,323**	2.60%
Nursing Administration	2	1.27%	**36,846**	2.02%
Business Office	4	2.53%	**27,225**	1.49%
Dietary	18	11.39%	**18,098**	0.99%

FREQUENCY BY CAUSE

Cause	Claim Count	% of Claims	Total Incurred	% of Total Incurred
Strain or Injury By	**44**	27.85%	428,712	23.53%
Fall, Slip or Trip Injury	**25**	15.82%	767,138	42.11%
Struck or Injured By	**20**	12.66%	189,209	10.38%
Burn or Scald - Heat or Cold Exposures - Contact	**16**	10.13%	131,230	7.20%
Cut, Puncture, Scrape Injured by	**13**	8.23%	73,001	4.01%
Exposure	**12**	7.59%	62,314	3.42%
Caught In, Under or Between	**11**	6.96%	25,369	1.39%
Miscellaneous Causes	**8**	5.06%	88,426	4.85%
Rubbed or Abraded By	**8**	5.06%	43,560	2.39%
Motor Vehicle	**1**	0.63%	13,000	0.71%

SEVERITY BY CAUSE

Cause	Claim Count	% of Claims	Total Incurred	% of Total Incurred
Fall, Slip or Trip Injury	25	15.82%	**767,138**	42.11%
Strain or Injury By	44	27.85%	**428,712**	23.53%
Struck or Injured By	20	12.66%	**189,209**	10.38%
Burn or Scald - Heat or Cold Exposure	16	10.13%	**131,230**	7.20%
Miscellaneous Causes	8	5.06%	**88,426**	4.85%
Cut, Puncture, Scrape Injured by	13	8.23%	**73,001**	4.01%
Exposure	12	7.59%	**62,314**	3.42%
Rubbed or Abraded By	8	5.06%	**43,560**	2.39%
Caught In, Under or Between	11	6.96%	**25,369**	1.39%
Motor Vehicle	1	0.63%	**13,000**	0.71%

Personal Best 4.u
LIVE WELL, BE WELL
November 2022

Boost Brain Health

Thinking about your mental fitness? Many everyday habits and conditions can impact our brain power — up or down. Memory lapses can occur at any age, and aging alone is generally not a cause of mental decline.

When significant memory loss occurs as we age, it is likely due to physical disorders, brain injury or neurological illness. Many studies indicate we can help protect our brain health and reduce dementia risk with basic good health habits. Do your best to:

- **Stay physically active.** People who regularly exercise throughout life are less likely to experience a decline in mental function as they age and have a lower risk of developing dementia, including Alzheimer's disease.
- **Get adequate sleep.** For body and brain health, we need seven to nine consecutive hours of sleep every 24 hours.
- **Manage stress and guard brain health and recall.** Your brain is similar to a muscle; use it or lose it. Choose enjoyable mental activities that may boost brain power, such as doing crossword puzzles, reading for learning or taking classes.
- **Socialize.** Regular interaction with family, friends, coworkers and others helps us manage stress or depression; both may contribute to memory loss.
- **Choose a Mediterranean-style diet.** Studies suggest those who do may be less likely to develop cognitive decline compared to people who follow a typical Western diet. Foods in the Mediterranean eating pattern include vegetables, fruit, whole grains, legumes, fish, olive oil, dairy, chicken, eggs and herbs, while reducing highly processed foods, sweets and red meat.

Habits to avoid: If you drink, limit alcohol use to no more than one drink a day for women or two drinks for men. Don't smoke. And avoid long periods of sitting. Get up and move frequently.

> "It's better to look ahead and prepare, than to look back and regret."
>
> — Jackie Joyner-Kersee

The Smart Moves Toolkit, including this issue's printable download, **Conquer That Cough**, is at **personalbest.com/extras/22V11tools**.

Note: Due to production lead time, this issue may not reflect the current COVID-19 situation in some or all regions of the U.S. For the most up-to-date pandemic information visit **coronavirus.gov**.

BEST bits

To reduce your risk of coronary heart disease (CHD) it may help to limit screen time that involves sitting. Excessive TV viewing and leisure time screen use have been linked to CHD. Limiting leisure screen time to less than one hour a day could help prevent more than one in ten cases, regardless of your genetic makeup, according to recent University of Cambridge research. In this study, **people who viewed screens more than four hours per day were at greatest risk for CHD,** regardless of their risk for other genetic disorders. To examine the link between time spent in screen-based sedentary behaviors, including TV viewing and leisure computer use, an individual's DNA, and their CHD risk, researchers reviewed about 12 years of data from more than 500,000 adults.

The U.S. Surgeon General has designated Thanksgiving as Family Health History Day. Many of us have family members who have developed type 2 diabetes, heart disease or cancer — some of the most common serious conditions that can threaten our health and shorten our lives. You are more likely to get the same disease as your parent or sibling and you should consider earlier screening. Ask your health care provider about (1) when to start screening for identified diseases and (2) what other steps to take to prevent or manage the disease. Take action to protect your health.

November is National Family Caregivers Month, a time to remember those who clean and shop for, as well as comfort and tend to millions of elderly, ill and disabled loved ones. Are you or someone you know a caretaker? You aren't alone. According to National Alliance for Caregiving (NAC) and AARP research, 53 million Americans are providing unpaid care for relatives and friends. If you are a caregiver, don't forget to care for yourself. The NAC offers self-care tips and information about finding community services, communicating with health care providers and more at **caregiving.org**.

Type 2 Diabetes: Are You at Risk?

November is Diabetes Month.

Diabetes is a complex disease that affects your body's primary source of energy — glucose (sugar). Most people with diabetes have type 2, in which the body doesn't use the hormone **insulin** properly.

When this happens, glucose accumulates in your bloodstream, leading to serious health complications. *Eventually, high blood sugar levels can create disorders of your circulatory, nervous and immune systems.* The longer you've had type 2, the higher your risk for medical side effects. Once diabetes is treated with medication, blood sugar levels can drop to dangerously low levels, too, so it's important to keep track.

How common is type 2 diabetes? More than 37 million Americans have diabetes (about one in ten), and more than 90% of them have type 2 diabetes. Type 2 most often affects people in middle age, but increasing numbers of children, teens and young adults are also diagnosed.

What are your chances of developing type 2 diabetes? It depends on multiple factors, including your genes and lifestyle. While you can't change your family history, age or ethnicity, you can control lifestyle risk factors. You are more likely to develop type 2 if you are physically inactive, eat mostly ultra-processed foods and are overweight or obese. Other risks include:

- Age 45 or older.
- A family history of diabetes.
- High blood pressure.
- Low HDL (good) cholesterol or high LDL (bad) cholesterol.
- A history of gestational diabetes or giving birth to a baby weighing nine pounds or more.

To learn more, search for **risk** at **diabetes.org**.

What are symptoms of type 2 diabetes? Common symptoms include increased thirst, frequent urination and unintended weight loss. Overall, symptoms can be mild and develop slowly for several years; many people will have no symptoms. You may not be aware of the disease until you have related health problems, including blurred vision, heart trouble or circulation problems.

Managing diabetes requires healthy eating, weight control and being physically active. Your health care provider may prescribe insulin, other injectable medications or oral diabetes medicines. You'll need to eat healthy, exercise regularly and keep your blood pressure and cholesterol close to your provider-recommended targets, and get regular screening for related health problems.

Tobacco: Quit to Win

The Great American Smokeout is November 17.

No Tobacco '22 is this year's national program sponsored by the American Lung Association, helping people to stop using all tobacco products. You'll find quit tips and resources on social media and at **lung.org**.

Cigarette smoking is a leading cause of death in the U.S., taking nearly a half million lives every year, including deaths from secondhand smoking. That's about one in five deaths due to preventable diseases caused by smoking. It is also linked to nearly half of the deaths from 12 types of cancer combined.

Fortunately, the number of cigarette smokers continues to decline. The number of smokers has dropped from nearly 21 of every 100 adults, or 20.9% (age 18 and older) in 2005 to about 13 of every 100 adults (12.5%) in 2020. Among youth (12 to 17 years old) who smoked, 44% have quit smoking cigarettes since 2013.

Most smokers want to kick cigarettes and there is help for saying goodbye to tobacco and vaping for good. One common approach is a combination of medicine, emotional support and changing lifestyle habits. Here are three great sources to help motivate you:

- See your health care provider for guidance.
- Get quitting advice and tools at **smokefree.gov**.
- Visit **cancer.org** for phone and app quitline counseling services that show a high rate of quitting success.

Quitters share one thing in common: They have a strong desire to be tobacco-free.

Prediabetes Research Update

There's good news from a 21-year follow-up of more than 3,200 adults with prediabetes who participated in the original Diabetes Prevention Program trial. The trial period confirmed that lifestyle interventions or the medication metformin were effective long-term in preventing or delaying type 2 diabetes among adults with prediabetes compared to participants who received standard care. Participants in the lifestyle change program lowered their chances of developing type 2 diabetes by 58% while those who took metformin lowered their diabetes risk by 31%.

Celebrate Healthy Eating

By Cara Rosenbloom, RD

Holiday season is a time to celebrate with family and friends, and many events revolve around food. Sometimes this can be challenging for people who have special dietary needs or follow a rigid eating pattern. The influx of treats, sweets and celebrations focused on eating can be overwhelming.

Here are five tips on how to manage the festive season:

1. **Remember moderation.** You may be invited to many holiday events, and it's nice to enjoy a decadent treat at each party. Moderation allows you to enjoy small portions without overdoing it. Plan ahead, pick your favorites and savor them.
2. **Slow down.** When conversation (and alcohol) is flowing, it's easy to become distracted, ignore fullness cues and eat too much too quickly. Practice portion control with your first plate of food. Take your time with every bite.
3. **Give yourself permission to indulge.** While accommodating any food intolerances, make sure to enjoy some holiday favorites, too. Mix nutrient-dense foods, such as turkey and vegetables, with side dishes, such as candied yams and stuffing, so you can enjoy a bit of everything.
4. **Don't skip meals.** You may think you should save up your calories for a festive dinner by passing on breakfast or lunch, but this often backfires. It can make you ravenous and grumpy by dinnertime, forcing you to overeat. Instead, eat sensibly all day long, and enjoy your meal.
5. **Bring a dish.** If you are concerned about meal choices to accommodate your needs, ask your host about making your own additions to the meal. Hosts are usually happy to have an extra vegetable dish, salad or protein option. Remember to make enough for everyone.

Play is essential for children's mental health. Unfortunately, free play time has decreased in modern life. This has taken a toll on some youngsters' emotional well-being, according to the American Academy of Pediatrics. The good news? A University of Exeter study revealed that youngsters who were able to play more, even during the COVID-19 lockdown, were happier and experienced less anxiety and depression. Researchers suggest supporting children's mental health by encouraging adventurous activities (with appropriate supervision), such as camping, exploring a forest and trying out new skills on a skateboard or bike.

TIP of the MONTH

Think Before You Drink

Alcohol is common during holiday meals, and it's easy to drink too much. As part of your healthy eating regimen, remember to be moderate with alcohol. If you don't drink alcohol, don't start. If you enjoy alcohol, remember that moderate drinking is considered one drink a day for women, or two drinks a day for men (one drink is 5 ounces of wine, 12 ounces of beer or 1.5 ounces of other alcohol). Alternate alcoholic drinks with water, tea or seltzer. And never drink and drive.

EASY recipe

Parmesan-Roasted Broccoli

6 cups broccoli florets
2 tbsp extra-virgin olive oil
¼ tsp salt or more to taste
⅓ cup grated Parmesan cheese
1 tbsp balsamic glaze (thick vinegar)
Freshly ground pepper to taste
¼ cup fresh chopped basil

Preheat oven to 400°F. **Line** baking sheet with parchment paper. **On** baking sheet, toss broccoli with olive oil and salt. **Bake** 15 minutes; then remove from oven. **Add** Parmesan, stir to coat, and bake 10–15 minutes more. **Pour** broccoli onto serving platter and top with glaze, pepper and basil. **Toss** and serve.

Makes 4 servings. Per serving: 142 calories | 7g protein | 10g total fat | 2g saturated fat 5g mono fat | 2g poly fat | 10g carbohydrate | 2g sugar | 4g fiber | 316mg sodium

Stay in Touch

Keep those questions and suggestions coming!

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EXPERT advice

— Eric Endlich, PhD

Q: Tips to overcome fear of missing out (FOMO)?

A: Since we can't be everywhere at once, we're always missing out on something and that's normal. While many people turn to social media when feeling dissatisfied, it can actually worsen FOMO. Instead, choose to pay attention to the things that make you feel ***better*** rather than worse. In addition:

- Know what situations trigger your FOMO and limit your exposure to them.
- Prioritize quality over quantity of experiences. Choose your commitments thoughtfully.
- Limit multitasking. Trying to do multiple things simultaneously is inefficient, stressful and unsatisfying.
- Let go of having it all. It's not realistic or necessary for a fulfilling life.
- Take time to be thankful. What do you appreciate in your life?
- Focus on enjoying what you already have in the here and now. Savor your experiences.

Nighttime Commuting

It's late, you've worked a long day and you have a long commute home. How do you reduce the dangers of drowsy driving? Here are some ways:

- Get adequate sleep every night. Sleep experts recommend seven to nine hours.
- Avoid taking medications that can make you sleepy or tired before driving. **Examples:** antihistamines, muscle relaxants, opioid pain relievers and antidepressants.
- Consider carpooling or taking public transportation if you work a long day and are tired.
- Never drink alcohol before driving.
- Don't drive if you've been awake for 16 hours or more.
- Maintain your vehicle to avoid breaking down at night.
- Make sure your headlights are clean and adjusted correctly.
- Make sure your windshield is clean.
- Slow down to compensate for limited visibility.
- Watch for wildlife.

Drowsy Driving Prevention Week is November 6 to 12.

DR. ZORBA'S corner

— Zorba Paster, MD

Coconut oil is more hype than truth. There are lots of claims that it's good for the heart, but they're not backed up by rigorous, peer-reviewed scientific research published in reputable medical journals. When reputable journals review these studies as a whole (what's known as a meta-analysis), they find that coconut oil may raise LDL cholesterol levels, which is detrimental to heart health. As such, coconut oil is not recommended as the primary oil in a heart-healthy diet. My suggestion: Stick with heart-friendly oils. Extra-virgin olive oil is clearly the best one hands down. It's high in unsaturated fats and lower in saturated fats. Canola, avocado, peanut and flax oils are also healthful.

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The Art of Listening

According to the International Listening Association, we remember about half of what someone says immediately after hearing it, and we only recall about 20% of what we hear over the long term. The key to learning and retaining more of what you hear — and to having more productive workplace conversations — is listening.

Practice the art of listening with these tips:

Seek to understand. Often, our goal in conversations is getting our own point across or trying to be right. Flip your attitude so you view workplace interactions as opportunities to understand your colleagues' opinions.

Observe. Instead of filling every conversational pause with words, closely observe the speaker. Check body language, vocal tone and facial expression, as well as words spoken. Give others a chance to complete their thoughts before you jump in with your own ideas and ask questions.

Listen. Maintain eye contact and give the speaker your full attention. Turn off your phone or tablet unless you're taking notes.

In today's fast-paced world, it may seem that talking is prized, but listening is crucial to a productive workplace.

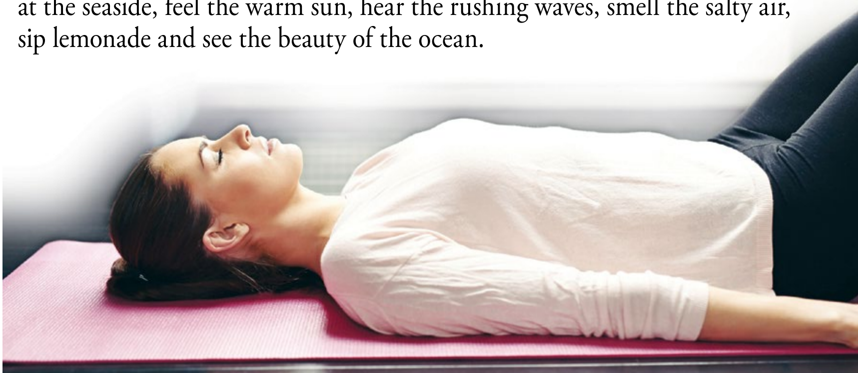
Easy Relaxation Techniques

When you feel tension rising, take a quick break with one of these easy relaxation techniques, and return to your work refreshed and ready to take on anything.

❶ **Breathe.** You can practice sitting, standing or lying down: Place your hand on your abdomen and breathe in slowly and deeply so you feel your hand rise. Count to three slowly as you hold your breath in, then breathe out and pause again for a count of three. Repeat this several times.

❷ **Scan.** Sit down, close your eyes and internally scan your body for any signs of tension, from your toes to your head. Consciously release any tension you find — for example, let your arms hang loose, open your mouth slightly, shrug your shoulders and let them drop, uncross your legs and feel yourself sink into your chair.

❸ **Visualize.** Close your eyes, and picture yourself in a relaxing place. Engage all five senses in your mental picture. For example, if you're mentally at the seaside, feel the warm sun, hear the rushing waves, smell the salty air, sip lemonade and see the beauty of the ocean.



Staying CONNECTED on the Road

Today's workforce is increasingly mobile, and you can work just about anywhere you have an electronic device and a reliable internet signal. Follow these strategies to stay productive and keep your information private while traveling:

Pack smart. Make sure you have everything you need on hand, including chargers and headphones, to ensure a smooth connection to those who need you.

Communicate. Set up check-in times with your home base and your supervisor. Automate outgoing work email and voice mail messages so people know you are out of the office and how to reach you. **Note:** Don't leave a message on your personal phone that you're away from home, and don't advertise your absence on social media.

Plan connection spots. Internet on the road can be spotty depending on where you're traveling. Plan a stop in a hotel, café or business center that has free Wi-Fi, or explore mobile (Mi-Fi) services services or tethering options for connectivity on the go.

Take precautions. Keep sensitive work and personal data safe from prying eyes by being cautious and using an encryption program when you access public Wi-Fi connections. Also, avoid leaving your work materials and electronic devices unattended or unlocked to prevent theft and damage.

Working well or over-working?

Productivity experts agree there's more to productivity than checking off items on a to-do list and working longer, which doesn't ensure working better. Aim for efficiency and quality in your work, and always work toward your larger goals. **These three habits can help:**

1. Give one task your complete focus, instead of multitasking.
2. Identify the work that furthers your important goals, and spend more time and energy on it.
3. Batch low-priority tasks and schedule a standing appointment to complete them so you spend the bulk of your time on work that truly matters.

Parenting and Marriage

Parenting adds a new dimension to home life and relationships. In particular, keeping a marriage strong through parenthood can be challenging. Here are ways to offset the stress:

Share the duties. University of Missouri researchers found that when fathers shared the day-to-day household chores, beyond just child care, the marriage was happier. How the partners divided their duties didn't much matter. What counted was that both partners felt equally responsible for all aspects of running the home and raising the children.

Ask for help. Decades ago, extended families lived in close proximity and helped each other with child rearing. Today, that's often not the case. Build a support network so you can call upon friends, neighbors, fellow parents, a religious organization or babysitters to provide support.

Take time for yourself. Schedule time free of responsibilities to care for yourself and your relationship. Regular date nights help, even if they consist of ordering takeout and watching a movie after the kids go to bed. Be sure to exercise, eat nutritiously and do solo activities you enjoy. When both partners take care of themselves, the entire family is the better for it.

Turning Wishes Into *ACTIONS*

Too often, our goals go unrealized. Go beyond simply setting goals, and do something that will help you reach your mark.

According to Shane J. Lopez, a senior scientist with the Gallup organization and a leading researcher on hope, people can learn to be more hopeful and focus on a better future. In his book *Making Hope Happen,* Lopez outlines ways to cultivate hope and use it to turn wishes into actions, including the GPA method:

- **Goals thinking:** Set goals, and then refine them so they are reachable.
- **Pathways thinking:** Map out concrete strategies for how to get from where you are now to where you want to be.
- **Agency thinking:** Develop the skills, confidence and stamina you need to follow the path toward your goals.

As you work to think about your goals in these three different ways, use these strategies to help you along the path:

- **Focus.** Break down goals into small, achievable steps and focus only on the step you are working to complete.
- **Schedule.** Find creative ways to use the time you have, such as getting up earlier, using your work breaks productively, or giving up time spent watching television or using electronics to work on your goal.
- **Share.** Tell other people about your wishes and plans. This will strengthen your commitment and provide a ready-made support network to help you through the tough parts.

People in positions of power

perceive time differently, according to a University of California at Berkeley study. Researchers found that authority figures often think they have more control over time than their subordinates. However, as people gain power, they may tend to over-commit themselves or adhere to an unrealistic schedule.

Note: Due to production lead time, this issue may not reflect the current COVID-19 situation in some or all regions of the U.S. For the most up-to-date information visit **coronavirus.gov**.

The **Smart Moves Toolkit**, including this issue's printable download, **Conquer That Cough,** is at **personalbest.com/extras/22V11tools**.

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TAB M

MINUTES: Not Yet Approved by Committee

REGULAR MEETING OF THE
SAN GORGONIO MEMORIAL HOSPITAL
BOARD OF DIRECTORS

COMMUNITY PLANNING COMMITTEE
November 15, 2022

The Regular Open Session Meeting of the Community Planning Committee of the San Gorgonio Memorial Hospital Board of Directors was held on Tuesday, November 15, 2022, in the Administration Boardroom, Banning, California

Members Present: Susan DiBiasi, Ron Rader, Steve Rutledge (C), Dennis Tankersley, Siri Welch

Absent: Joel Labha

Staff Present: Steve Barron (CEO), Dan Heckathorne (CFO), Ariel Whitley (Executive Assistant), Annah Karam (CHRO)

AGENDA ITEM	DISCUSSION	ACTION / FOLLOW-UP
Call To Order	Committee Chair Steve Rutledge called the meeting to order at 9:12 am.	
Public Comment	No members of public present.	
OLD BUSINESS		
*** Proposed Action - Approve minutes** **February 24, 2022, regular open session meeting**	Chair Rutledge asked for any changes or corrections to the minutes of the February 24, 2022, regular open session meeting. There were none.	**The minutes of the February 24, 2022, regular open session meeting was reviewed and will stand correct as presented.**
NEW BUSINESS		
Community Health Needs Assessment Presentation	Steve Barron, CEO, presented the Community Health Needs Assessment data that was specific to San Gorgonio Memorial Hospital.	

AGENDA ITEM	DISCUSSION	ACTION / FOLLOW-UP
Proposed Action – Recommend Approval to Hospital Board • **2022 Community Health Needs Assessment**	It is noted that approval of the Community Health Needs Assessment is recommended to the Hospital Board of Directors. BOARD MEMBER ROLL CALL: DiBiasi: Yes; Labha: Absent Rader: Yes; Rutledge: Yes Tankersley: Yes; Welch: Yes Motion Carried	**M.S.C., (DiBiasi/Rader), The Community Planning Committee voted to recommend approval of the 2022 Community Health Needs Assessment to the Hospital Board of Directors as presented.**
Future Agenda Items	• Community Health Implementation Plan	
Next Meeting	The next Community Planning Committee meeting will be held on Tuesday, February 14, 2023, at 9:00 am.	
Adjournment	The meeting was adjourned at 10:40 am.	

In accordance with The Brown Act, *Section 54957.5*, all reports and handouts discussed during this Open Session meeting are public records and are available for public inspection. These reports and/or handouts are available for review at the Hospital Administration office located at 600 N. Highland Springs Avenue, Banning, CA 92220 during regular business hours, Monday through Friday, 8:00 am - 4:30 pm.

Minutes respectfully submitted by Ariel Whitley, Executive Assistant

San Gorgonio Memorial Hospital

San Gorgonio Memorial Hospital (SGMH) is a 79-bed general acute care hospital located in Banning, California, a rural area in the northwestern region of Riverside County.

The community-based hospital is dedicated to providing acute care services to the residents of the San Gorgonio Pass area. It is the only acute care hospital in the San Gorgonio Memorial Health Care District, which has approximately 90,000 year-round residents. The district includes the cities of Banning and Beaumont, a portion of Calimesa and the neighboring unincorporated areas of Cabazon, Cherry Valley and Whitewater.

SGMH offers many services, including 24-hour emergency care, robotic surgery, cardiology, teleneurology and advanced imaging.

The hospital's primary service area comprises zip codes 92220 and 92223; its secondary service area is the rest of the hospital district.

Appendix A *provides demographic information about the San Gorgonio Memorial Hospital PSA.*

Hospital Disease Data

The following disease findings specific to San Gorgonio Memorial Hospital's PSA were compiled by SpeedTrack. The 2016 – 2020 hospital data were derived from California's Department of Health Care Access and Information (HCAI) and integrated with data from the federal Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and the U.S. Census Bureau.

- Black/African American males and females over age 65 have the highest number of chronic conditions.
- Hypertension is the primary chronic condition in males and females ages 35 – 64 and over 65, especially in Black/African American populations.
- Anemia, diabetes, kidney disease and obesity are major issues for all people over 35.
- Depression and depressive disorders are the primary chronic conditions in male and female youth ages 0 – 17.
- Medi-Cal is the primary payer for Black/African American and Hispanic/Latino adults under age 65.
- ED mental health use declined in 2020, likely due to COVID-19.

Appendix P *provides detailed information about chronic conditions, avoidable ED visits, payers and mental health visits.*

Burden of Disease and Vital Conditions

The following indicators for each burden of disease and vital conditions priority note some of the specific causal factors in San Gorgonio Memorial Hospital's primary service area. The information below also highlights opportunities for improvement identified by comparing the hospital PSA results to the state benchmark.

Cardiovascular Disease and Diabetes

- High obesity rate
- High cholesterol rate
- High rate of hypertension
- High rate of smoking
- High stroke rate
- High diabetes rate
- High rate of heart attack, heart disease and heart failure
- Low rates of heart disease hospitalizations in Medicare beneficiaries

Mental and Behavioral Health

- Shortage of mental health providers
- HPSA (Health Professional Shortage Area) — Mental Health
- High rate of drug use disorder deaths
- High rate of depression in Medicare beneficiaries

Infant and Maternal Health

- High infant death rate
- High percentage of low birthweight babies
- High rate of tobacco use during pregnancy
- High rate of pre-term births

Basic Needs for Health and Safety

- High percentage of people without supermarket access
- HPSA (Health Professional Shortage Area) — Mental Health
- HPSA (Health Professional Shortage Area) — Dental
- High percentage of uninsured adults
- High rate of premature death
- High population of people with disabilities

Humane Housing

- Low rate of multi-family housing

Meaningful Work and Wealth

- Lack of high-paying jobs
- High rate of people on public assistance
- Low median household income
- High poverty rate
- High child poverty rate

Next Steps

Our communities are far better off when everyone has the opportunity to live their healthiest life. We must work collectively to support and improve the many systems that influence health — not only health care and social services, but also vital services such as education, housing, transportation and public safety.

As stewards of our communities — parents, educators, health providers, business leaders and other community members — we all have important roles in improving health and well-being, eliminating preventable health inequities and building communities with truly equal opportunities for all people.

To advance this work, all community members are encouraged to review the data and priorities in this report and identify where and how they might contribute to improvement. Along with that support, community stakeholders will continue to meet, study the community data, collaborate on implementation strategies and align regional investments to focus on the priorities identified.

Additional support and information are available and will be expanded. All community members have access to much of the IP3 | Assess data through links in Appendices F–K in this report as well as many other resources at ConnectIE.org. A comprehensive community needs assessment on the Inland Empire as well as Riverside and San Bernardino counties also will be released to the public later in 2022. In addition, an IP3 | Assess platform of data and information will be made available to stakeholders to support their collaboration.

Together, we can build a vibrant Inland Empire. It will take each of us seeing the possibilities and working together for good as stewards of our communities.

San Gorgonio Memorial Hospital PSA Population Projections by Demographic Cohort

The fastest-growing population group in race in the San Gorgonio PSA is White, followed by Black/African American and Multiracial. The number of people 65+ is expected to increase significantly, while the 1–17 group will decline (although the number of births is expected to increase.

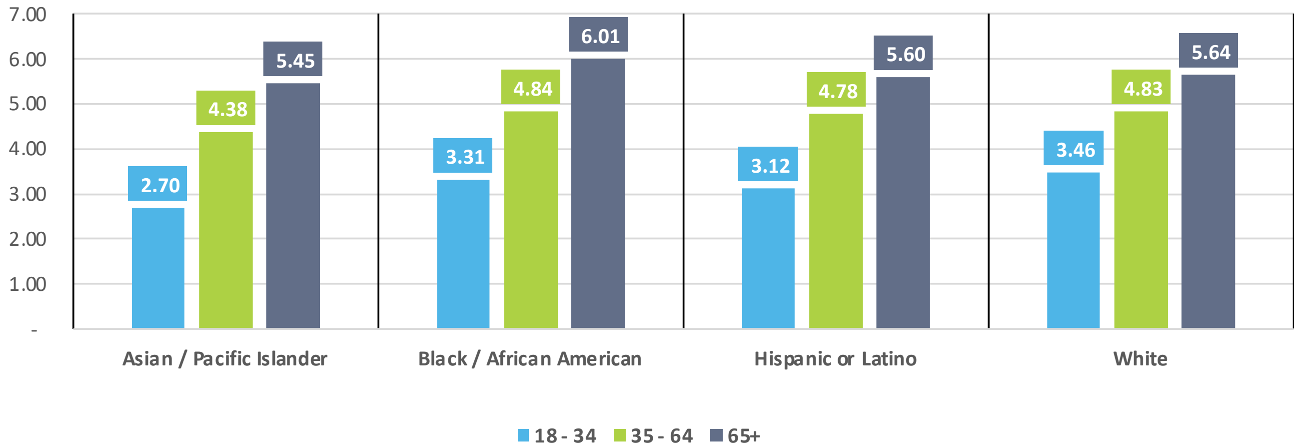
Gender	2023	2024	2025	2026	2027	% Change
Female	45,925	46,553	47,155	47,715	48,225	5.0%
Male	43,417	44,062	44,623	45,090	45,570	5.0%

Race	2023	2024	2025	2026	2027	% Change
American Indian / Alaskan Native / Eskimo / Aleut	1,370	1,386	1,396	1,407	1,423	3.9%
Asian / Pacific Islander	5,482	5,559	5,625	5,671	5,729	4.5%
Black / African American	5,075	5,182	5,245	5,300	5,343	5.3%
Hispanic or Latino	33,732	34,127	34,562	34,877	35,204	4.4%
Multiracial	2,036	2,055	2,082	2,118	2,139	5.1%
Native Hawaiian / Other Pacific Islander	127	127	130	131	130	2.4%
Other Race	107	107	107	107	107	0.0%
White	41,413	42,072	42,631	43,194	43,720	5.6%

Ethnicity	2023	2024	2025	2026	2027	% Change
Hispanic or Latino	33,732	34,127	34,562	34,877	35,204	4.4%
Non-Hispanic or Non-Latino	55,610	56,488	57,216	57,928	58,591	5.4%

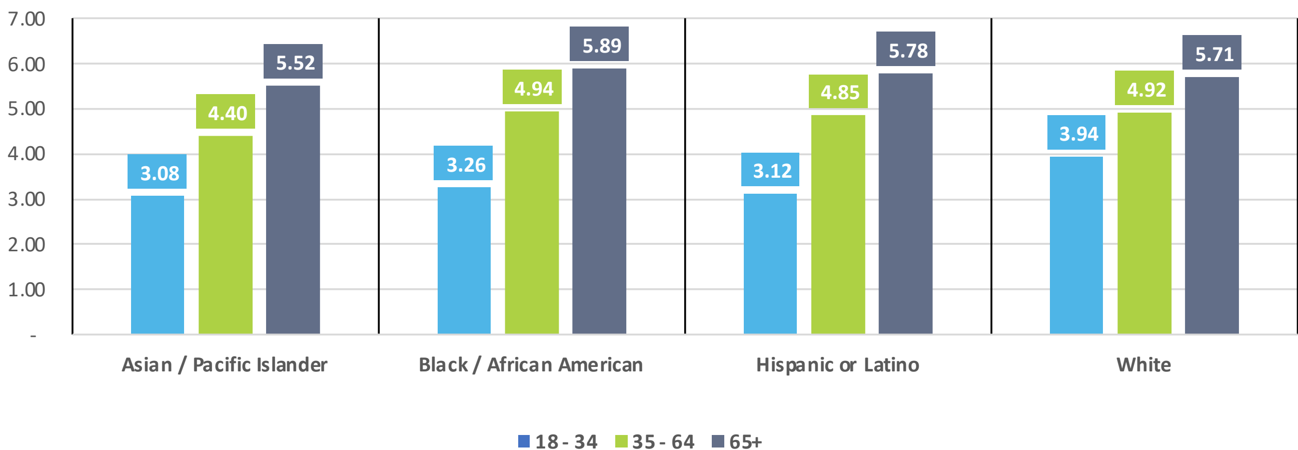
Age Range	2023	2024	2025	2026	2027	% Change
Under 1 Year	1,084	1,097	1,110	1,117	1,118	3.1%
1–17 Years	17,632	17,612	17,561	17,576	17,574	-0.3%
18 – 34 Years	20,196	20,438	20,629	20,781	20,858	3.3%
35 – 64 Years	28,504	28,757	29,023	29,193	29,494	3.5%
65 Years or Greater	21,926	22,711	23,455	24,138	24,751	12.9%
Total Population Trend	**89,342**	**90,615**	**91,778**	**92,805**	**93,795**	**5.0%**

Male Average Number of Chronic Conditions by Race and Age Range 2016–2019 Discharges



The chronic condition numbers for 2020 continue to reflect ethnic disparities

Average Number of Chronic Conditions by Race and Age Range 2020 Discharges



State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Poverty - *percentage of adults over 18 whose incomes are below the federal poverty level*							
13.4	15.5	14.5	16.7	13.4	15.3	11.7	13.7

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Child poverty - *percentage of children under 18 who live below the federal poverty level*							
16.9	18.3	18.3	18.3	18.3	15.1	13.8	17.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Income inequality — Gini coefficient - *statical dispersion of income distribution; the higher the Gini coefficient, the greater the gap between the incomes of an area's richest and poorest people.*							
0.4	0.0	0.0	0.0	0.4	0.4	0.4	0.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High-paying jobs - *percentage of jobs within five miles with earnings greater than $3,333 per month (2015 numbers are most recent available)*							
50.4	37.3	39.8	38.9	47.5	35.9	40.5	39.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Unemployment - *annual percentage of the labor force that is unemployed*							
10.0	9.7	9.9	9.4	12.3	9.8	9.7	9.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Median household income - *median household income for the population*							
$83,398	$67,326	$69,261	$64,943	$74,027	$67,337	$79,461	$71,277

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Homeownership - *percentage of occupied housing units with owner occupants*							
54.8	62.9	66.3	59.6	45.8	63.5	63.1	66.3

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Residential segregation (Black/White) — *Index of dissimilarity – between 0 (complete integration) and 100 (complete segregation) representing residential segregation between Black and White residents*							
49.1	38.0	39.4	36.7	56.3	38.7	38.0	39.4

Appendix K: Meaningful Work and Wealth Indicator Report

To access the full report, which includes population breakouts where available, click to view Meaningful Work and Wealth. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: *Indicators that are worse than the state benchmark are noted in red. The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.*

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Absolute upward mobility - *expected income by percentile rank for children whose parents are at the 25th percentile of the national income distribution*							
46.2	45.2	45.4	44.9	44.4	45.0	45.1	45.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Public assistance - *percentage of families with cash public assistance or Supplemental Nutrition Assistance Program (SNAP) benefits in the past 12 months*							
13.3	15.4	14.6	18.6	14.0	13.6	17.6	14.6

Appendix J: Humane Housing Indicator Report

To access the full report, which includes population breakouts where available, click to view Humane Housing. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: *Indicators that are worse than the state benchmark are noted in red. The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.*

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High housing costs - *percentage of occupied housing units for which housing costs are greater than 30% of household income*							
42.1	40.6	39.7	40.7	47.4	36.3	39.2	39.7

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Multi-family housing - *percentage of housing structures with two or more units per structure*							
23.5	18.2	11.9	19.8	29.5	18.9	19.8	11.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Incomplete plumbing or kitchen facilities - *percentage of occupied housing units that lack plumbing or kitchen facilities*							
1.3	1.0	0.9	1.1	1.2	1.4	1.0	0.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Overcrowded housing - *percentage of housing units with more than one occupant per room*							
12.0	8.4	10.7	9.4	16.6	5.4	9.3	10.7

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Population with any disability – *percentage of the population with a disability*							
10.6	12.2	11.6	11.8	10.0	13.5	11.3	11.6

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Life expectancy at birth – *estimated life expectancy at birth*							
81.7	79.9	80.9	78.8	82.4	80.4	79.9	80.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Violent crimes – *number of reported violent crimes per 100,000 people*							
418	358.8	291.0	442.0	488.0	389.3	366.5	291.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Binge drinking - *percentage of adults 18+ who report an occasion of binge drinking in the past month*							
17.8	17.3	15.0	17.2	17.4	16.9	15.9	15.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Recent primary care visit - *percentage of adults 18+ who have had a routine checkup in the past year*							
70.7	69.1	74.2	68.4	71.7	70.3	71.8	74.2

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High blood pressure management - *percentage of adults 65+ who have high blood pressure and are taking medicine for it*							
67.1	67.4	72.8	66.6	66.9	69.4	70.8	72.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Exercise opportunities - *percentage of population with access to areas for physical activity*							
86.1	86.6	88.9	84.4	97.7	87.8	86.6	88.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Breast cancer screening - *percentage of females 50–74 who have had a mammogram within the past two years*							
77.9	76.4	76.4	76.5	78.5	76.3	76.5	76.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Premature death - *Age-adjusted number of years of potential life lost (YPLL) (under age 75) per 100,000 population*							
5,292.9	6,344.0	5,842.4	6,845.6	5,005.0	6,093.2	6,344.0	5,842.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Food insecurity - *percentage of the population that is food insecure*							
10.0	9.3	9.0	9.6	10.7	9.2	9.3	9.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Health Professional Shortage Area (HPSA) — Mental Health - *percentage of the population that is underserved by mental health providers*							
23.9	33.5	36.3	30.4	22.1	21.7	33.4	36.3

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Health Professional Shortage Area (HPSA) — Primary Care – *percentage of the population that is underserved by primary care providers*							
26.4	38.2	39.6	38.1	36.0	11.1	39.1	39.6

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Health Professional Shortage Area (HPSA) — Dental – *percentage of the population that is underserved by dental health providers*							
76.0	79.3	80.1	79.1	86.9	100.0	78.0	80.1

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Insured adults - *percentage of uninsured adults 18–65*							
88.0	85.7	85.6	86.2	84.9	88.7	86.2	85.6

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Early prenatal care - *percentage of births for which prenatal care began in the first trimester*							
85.5	**84.5**	**84.7**	**84.2**	**86.0**	**84.4**	**84.5**	**84.7**

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Teen births - *number of infants per 1,000 to females aged 15–19*							
26.2	**23.5**	**20.7**	**26.3**	**19.2**	**22.1**	**23.5**	**20.7**

Appendix I: Basic Needs for Health and Safety Indicator Report

To access the full report, which includes population breakouts where available, click to view Basic Needs for Health and Safety. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: *Indicators that are worse than the state benchmark are noted in red. The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.*

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Grocery stores - *number of grocery stores per 1,000 population*							
0.2	**0.1**	**0.1**	**0.1**	**0.2**	**0.1**	**0.1**	**0.1**

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Low food access - *percentage of the population living beyond one mile (urban) or 10 miles (rural) from a supermarket*							
29.4	**36.3**	**34.7**	**38.5**	**25.6**	**35.4**	**25.8**	**34.3**

Appendix H: Infant and Maternal Health Indicator Report

To access the full report, which includes population breakouts where available, click to view Maternal & Infant Health. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: *Indicators that are worse than the state benchmark are noted in red. The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.*

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Infant death - *number of deaths in infants younger than one year per 1,000 live births*							
4.2	5.1	4.2	5.9	3.9	4.7	5.1	4.3

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Low birthweight - *percentage of births with low birthweight*							
6.9	7.1	6.8	7.4	7.2	7.0	7.1	6.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Tobacco use during pregnancy - *percentage of births for which tobacco use is a maternal risk factor*							
1.3	2.0	1.7	2.2	0.6	1.8	2.0	1.7

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Pre-term births - *percentage of births occurring before the 37th week of pregnancy*							
9.1	9.5	9.1	10.0	9.5	9.7	9.6	9.1

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Mental health care providers — *number of mental health care providers per 100,000 people*							
373.3	229.9	217.1	242.7	362.6	223.5	229.9	217.1

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Health Professional Shortage Area (HPSA) — Mental Health - *percentage of population that is underserved by mental health providers*							
23.9	30.4	30.4	30.4	22.1	21.7	33.4	36.3

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Drug use disorder deaths - *age-adjusted number of drug use disorder deaths per 100,000*							
8.8	10.1	10.9	9.1	5.8	9.7	10.0	10.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Depression among Medicare beneficiaries - *percentage of Medicare beneficiaries with diagnosed depression*							
14.7	15.0	15.0	15.0	No data	15.8	15.5	16.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Diabetes death - *number of deaths due to type 2 diabetes per 100,000 people*							
17.7	22.8	15.7	29.8	21.1	19.2	22.8	15.7

Appendix G: Mental and Behavioral Health Indicator Report

To access the full data report, which includes population breakouts where available, click to view Mental & Behavioral Health. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: *Indicators that are worse than the state benchmark are noted in red. The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.*

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Poor mental health days - *age-adjusted number of reported mentally unhealthy days per month*							
4.2	4.5	4.5	4.5	4.3	4.4	4.5	4.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Frequent mental distress - *percentage of adults 18+ who report 14+ days of poor mental health per month*							
13.6	14.9	13.0	15.1	14.0	14.5	14.0	13.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Self-harm deaths - *age-adjusted number of self-harm deaths per 100,000 people*							
14.7	10.7	10.5	11.0	8.0	10.8	10.7	10.5

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Heart disease among Medicare beneficiaries - *percentage of Medicare beneficiaries with ischemic heart disease*							
22.2	24.5	25.0	24.0	No data	24.8	25.4	25.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Heart disease - *percentage of adults 18+ who have been told they have angina or coronary heart disease*							
5.5	5.2	5.2	7.4	5.7	5.7	6.6	7.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Heart disease hospitalizations among Medicare beneficiaries - *number of hospitalizations for heart disease per 1,000 Medicare beneficiaries*							
55.7	61.5	56.9	67.1	66.6	63.5	62.0	56.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Diagnosed diabetes - *percentage of adults 20+ who have been told they have diabetes (including gestational)*							
9.4	10.4	10.4	10.4	9.5	10.2	10.2	10.2

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Diabetes management - *percentage of diagnosed Medicare beneficiaries having an annual A1c test*							
81.9	78.6	80.4	76.0	81.2	75.9	78.6	80.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Heart attack deaths - *number of deaths due to acute myocardial infarction per 100,000 people*							
25.8	25.8	27.0	24.8	25.9	26.5	25.9	27.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Heart failure deaths - *number of deaths due to heart failure per 100,000 people*							
19.4	21.8	22.8	20.8	21.4	22.3	21.4	22.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Diagnosed stroke - *percentage of adults 18+ who have ever been diagnosed with a stroke*							
3.2	3.1	4.0	3.0	3.4	3.3	3.7	4.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High blood pressure - *percentage of adults 18+ who have been told they have hypertension*							
28.7	29.9	36.3	28.0	29.1	30.8	33.8	36.3

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High blood pressure management - *percentage of adults 18+ with diagnosed hypertension who report taking hypertension medication*							
67.1	67.4	72.6	66.6	66.9	69.4	70.8	72.8

Appendix F: Cardiovascular Disease and Diabetes Indicator Report

To access the full data report, which includes population breakouts where available, click to view Cardiovascular Disease & Diabetes. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: *Indicators that are worse than the state benchmark are noted in red. The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.*

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Obesity - *percentage of adults 18+ with BMI of 30 or above*							
27.5	32.6	31.2	32.6	28.5	31.2	31.8	31.2

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High cholesterol - *percentage of adults 18+ reporting high cholesterol*							
30.2	36.2	36.2	30.1	29.6	31.8	34.2	36.2

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Current smoking - *percentage of adults 18+ who report smoking 100+ cigarettes in their lifetime, and currently smoke daily or some days*							
13.4	14.8	12.8	15.5	13.8	14.7	14.3	12.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Hypertension deaths - *Number of deaths due to hypertensive heart disease per 100,000 people*							
14.0	22.7	20.8	24.5	12.3	21.7	22.7	20.8

Top Priorities Identified by Stakeholders

Burden of Disease

- Cardiovascular disease and diabetes
- Mental and behavioral health
- Maternal and infant health

Vital Conditions

- Basic needs for health and safety
- Humane housing
- Meaningful work and wealth

Populations Disproportionately Impacted

- Low-income areas
- Remote and rural communities
- African American, Latinos and Pacific Islanders
- Seniors

Next Steps

HOSPITALS

- Request board approval of CHNA
- Develop Community Health Implementation Plan (CHIP)
- Request board approval of CHIP
- Post CHNA and CHIP on hospital website
- Continue to participate in the regional CHNA Stakeholder Committee efforts
- Budget and invest in priority areas

REGION

- Promote community stewardship: Acknowledge existing efforts and identify synergies and alignment.
- Review the data and make improvements or corrections in investments.
- Make targeted coordinated investments.
- Spotlight pacesetters
- Chart progress with measurement, learning and evaluation
- Expand platforms and collaboratives to build capacity and exchange resources

CHNA Vision: Data to Action

- CHNA: Assess the local/regional landscape and look at collective action through a stewardship lens
- Align CHNA and hospital CB Investments
- Remember where we started and where we are today
- Partner with local communities
- Institutionalize the commitment

  - Form board committees
  - Engage operations with the CHNA
  - Establish incentives for desired behavior
  - Create new positions to ensure accountability)
  - Change job responsibilities
  - Integrate internal functions
  - Establish new functions (e.g., collect data on SDH)
  - Establish new relationships (e.g., share data with community)

2022 Inland Empire

Community Health Needs Assessment | Hospital Edition

Inland Empire Health Plan
Montclair Hospital Medical Center
Redlands Community Hospital
San Antonio Regional Hospital
San Gorgonio Memorial Hospital

2022 Inland Empire

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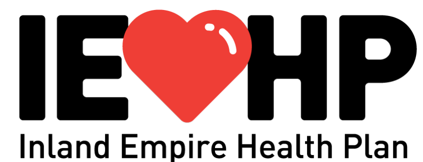

Sponsors

Inland Empire Health Plan
Hospital Association of Southern California
Montclair Hospital Medical Center
Redlands Community Hospital
San Antonio Regional Hospital
San Gorgonio Memorial Hospital
Riverside County Department of Public Health
San Bernardino County Department of Public Health

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Welcome

Dear Friends,

Stewardship is the foundation of this Inland Empire Community Health Needs Assessment (CHNA) – Hospital Edition. This document is not just a collection of data about our community. Rather, the CHNA and its transformational tools bring an opportunity for renewal — a time for new ways of thinking about how we invest together in our community's health, well-being and equity to support a vibrant Inland Empire region.

It's no secret that our world is more complicated than ever. The COVID-19 pandemic is just one of a bewildering array of threats to community health: public safety, environmental hazards, homelessness, under-resourced schools, illness and injury, poverty, unemployment and social exclusion.

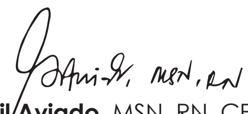
Rather than focusing only on the urgent conditions and services related to these threats, we want to focus on the vital conditions our communities need to achieve vibrant health. The IP3 | Assess tool with the Vital Conditions for Well-Being framework is used in this CHNA. This framework quickly integrates data from multiple sources and transforms it into actionable information, allowing us to move straight to collaborative priority-setting that will foster collective action for well-being and equity.

In addition to the initial CHNA for the participating hospitals, we are launching the IP3 | Assess online platform as a support and engagement resource for collective investments by multiple community stakeholders. This is just the beginning of collaboration to support vibrant health in the Inland Empire. Our hospitals — in partnership with the Inland Empire Health Plan (IEHP) and other key stakeholders in nonprofit, public health and health care delivery spaces — are embarking on an even longer journey to develop collective priorities for our entire region.

We are immensely proud of this work. Our fervent hope is that this Community Health Needs Assessment and the IP3 | Assess platform will inspire you — as they have us — to work together across our sectors to be better stewards of this Inland Empire region that has been entrusted to us.

Jarrod McNaughton, CEO
Inland Empire Health Plan

Megan Barajas, HASC
Inland Empire, Hospital Association of Southern California



Gail Aviado, MSN, RN, CEO
Montclair Hospital Medical Center

James R. Holmes, President and CEO
Redlands Community Hospital

John Chapman, President and CEO
San Antonio Regional Hospital

Steven Barron, CEO
San Gorgonio Memorial Hospital

Executive Summary

This 2022 Inland Empire Community Health Needs Assessment (CHNA) is the work of a diverse group of stakeholders that set out to identify the top health and well-being needs of Inland Empire residents. Stakeholders will use the findings to build community interventions that generate collective investments addressing the identified priorities.

There are seven assessments within this document. The first three target the entire Inland Empire region, along with Riverside and San Bernardino counties. The remaining four assessments comprise drilled-down analyses for Montclair Hospital Medical Center, Redlands Community Hospital, San Antonio Regional Hospital and San Gorgonio Memorial Hospital service areas. In addition to hospital CHNAs, an online platform will be launched as a support and engagement center for collective action.

This document includes burden of disease data, vital conditions data and hospital utilization data along with information gathered through key informant interviews and facilitated listening sessions with community residents.

The 2022 CHNA process followed these steps:

1. Key data were collected for the 2022 Inland Empire CHNA Stakeholder Committee's review. Quantitative data also were integrated into the IP3 | Assess platform, which has two frameworks that are used to identify specific levers that stakeholders can pull to improve community health through collective action.
    a. The **Burden of Disease framework** focuses on 12 health conditions, which were reduced to 10 for the purposes of this CHNA. (The domains of cardiovascular disease and diabetes were combined into one, and brain health was not included due to a dearth of indicators.)
    b. The **Vital Conditions for Well-Being framework** highlights seven conditions vital to the well-being of people and places (social and environmental drivers of health).
2. After reviewing the data, the 2022 Stakeholder Committee used a poll with five questions to rank disease and condition priorities for collective action in the Inland Empire. Additionally, the stakeholders selected four populations for special focus to address health disparities in their communities.
3. Based on the poll, the Stakeholder Committee selected the following priorities and populations for focus in the 2022 CHNA.
    a. Burden of disease framework
        - Cardiovascular disease and diabetes
        - Mental and behavioral health
        - Maternal and infant health
    b. Vital conditions
        - Basic needs for health and safety
        - Humane housing
        - Meaningful work and wealth

c. Populations of focus (addressing health disparities)
   - Communities of color
   - Individuals with low income and those living in poverty
   - Seniors
   - Communities in remote and rural areas

4. After this meeting, representatives of Montclair Hospital Medical Center, Redlands Community Hospital, San Antonio Regional Hospital and the Hospital Association of Southern California met again to select priorities for their primary service areas (PSA). They validated that the above priorities and populations were also the most important for their service areas. San Gorgonio Memorial Hospital representatives selected the same priorities and populations at a subsequent meeting.

Vision for Collaboration

This document and all the corresponding data represent just one element in the stewardship required for health and well-being transformation in the Inland Empire. As the stakeholders continue to meet this year and beyond, they intend to leverage the COVID-19 disruption to develop and implement collaborative, measurable action plans that address the priorities identified in this regional CHNA and tracked through the IP3 | Assess platform.

Stakeholders recognize that this collaboration, which will enhance the vital condition of belonging and civic muscle, forms the foundation for all efforts leading to healthy, vital conditions and lives. Building a community engagement process that includes civic participation from diverse communities — in solving problems and taking collective responsibility for each other — is crucial to positive change. That work is the very definition of stewardship.

Background

A community health needs assessment (CHNA) uses systematic processes to evaluate a community's health and social needs as well as its assets. Information gathered through that evaluation is then used to identify priorities for action. The development of CHNAs and related plans was voluntary until the 1990s. In 1994, the California Legislature passed a statute that required not-for-profit hospitals to conduct comprehensive CHNAs every three years. Hospitals were asked to report annually on the progress of their implementation plans developed to meet the identified community needs. The passage of the federal Affordable Care Act in 2010 set forth a similar requirement for all not-for-profit hospitals in the United States. The CHNA process was to give special consideration to low-income, minority and underserved members of the community.

Health Equity as an Emerging Issue

In 2020, the COVID-19 pandemic increased public awareness of the health and socioeconomic inequities in health care and the rest of society. The pandemic turned the spotlight on the millions of people who live in poverty, do not make a livable wage, live in substandard housing and lack access to healthy food and affordable transportation, childcare, health care and other basic services.

The pandemic led to catastrophic job loss, unprecedented unemployment rates and severe economic hardship in renter households. In 2016, the percentage of home evictions in the United States hovered around 3.7 million. In 2020, more than 40 million people were at risk of eviction, and more than 75% of them were people of color. Eviction has been linked to increased hospitalizations in children, substance use, physical and sexual abuse and depression and anxiety *("Eviction and Health: A Vicious Cycle Exacerbated by a Pandemic," Health Affairs, April 1, 2021)*.

Health inequities were widespread before they were highlighted by the COVID-19 pandemic. Policies and practices at every level of society have created deep-rooted barriers to good health. Many neighborhoods and communities have experienced generations of isolation from the opportunities that others experience. The inequities are reflected in differences in length of life, quality of life, rates of disease, disability and death, severity of disease and access to treatment. However, the political will to address these injustices is growing.

Health equity is achieved when every person has the opportunity to "attain his or her full health potential," notes the Centers for Disease Control and Prevention (CDC). To build vibrant communities, we must increase opportunities for everyone to live the healthiest life possible, no matter who we are, where we live or how much money we earn.

Public Health and Prevention

Public health is defined as the health of a population as a whole. The regional CHNA took this "population level" approach in identifying priorities to support vibrant health in the community.

This regional CHNA was strategically designed as a collaborative process that included county public health departments, a local Medi-Cal managed care organization (Inland Empire Health Plan), local hospitals, community clinics and other community-based organizations working towards health improvement in the Inland Empire region.

Many of the essential public health approaches have been intentionally adopted in this regional hospital CHNA process:

- Assess and monitor community needs and assets, population health status and factors that influence health.
- Investigate, diagnose and address health problems and hazards affecting the population.
- Communicate effectively to inform and educate people about health, factors that influence it and ways to improve it.
- Strengthen, support and mobilize communities and partnerships to improve health.
- Build and maintain a strong organizational infrastructure for public health.

As we work to address the health issues, social conditions and inequities identified in this CHNA, taking a public health approach will be critical.

2022 Inland Empire CHNA Stakeholder Committee

The 2022 Inland Empire CHNA Stakeholder Committee represented many key public health, health care delivery systems and community partners in the Inland Empire region of Southern California. Stakeholders were intentionally selected to represent organizations that work with vulnerable populations in the region.

To guide development of a hospital edition of the regional CHNA in partnership with the participating hospitals, the stakeholders held virtual meetings in February, March, April and May 2022. The stakeholders will continue to meet throughout 2022 and beyond to inform a broad regional assessment that supports the work of all non-hospital partners, as well.

2022 Inland Empire Stakeholder Committee members represented the following organizations:

Listed in Alphabetical Order by Organization

- Erin Managbanag, MBA
  Arrowhead Regional Medical Center
- Rolando Mantilla, MS
  Arrowhead Regional Medical Center
- Brian Cotter, MBA
  Barstow Community Hospital
- Christian Starks, MPA
  CommonSpirit Health
- Linda Pearson
  Corona Regional Medical Center
- Martin Kleinbart DPM,
  Corona Regional Medical Center
- Linda Evans, MHA, MS
  Desert Regional Medical Center
- Tammi Graham
  First 5 Riverside County
- Erica Williams, MPA
  First 5 Riverside County
- Scott McGrath, MS
  First 5 San Bernardino County
- Karen Scott
  First 5 San Bernardino County
- Jenna LeComte-Hinely, PhD
  HARC (Health Assessment and Research for Communities)
- Dora Barilla, DrPH, Facilitator
  HC² Strategies, Inc
- Muder Alkrisat, MD
  Hemet Valley Medical Center
- Megan Barajas, MPA
  Hospital Association of Southern California
- Michelle Decker, MA
  Inland Empire Community Foundation
- Priya Batra, MD, MS, Chair
  Inland Empire Health Plan
- Marci Coffey, MPH
  Inland Empire Health Plan
- Sylvia Lozano, MHA, FACHE
  Inland Empire Health Plan
- Jessica Miller, DrPH
  Inland Empire Health Plan
- Natalie Miller, MS
  Inland Empire Health Plan
- Rosie Nava, MPH, MCHES
  Inland Empire Health Plan

- Nishtha Patel, MBA, MPH, PMP
  Inland Empire Health Plan
- Jane Wang, MPH, RDN
  Inland Empire Health Plan
- Cecelia Arias, MPH, MCHES
  Kaiser Permanente
- Martha Valencia, MPH
  Kaiser Permanente
- Marti Baum, MD
  Loma Linda University Health
- Juan Carlos Belliard, PhD, MPH
  Loma Linda University Health
- Jasmine Hutchinson, MSPH
  Loma Linda University Health
- Marti Baum, MD
  Loma Linda University Health
- Gail Aviado, MSN, RN
  Montclair Hospital Medical Center
- Karen Zirkle, MSHSA
  Redlands Community Hospital
- Erin Curlee
  Riverside University Health System, Public Health
- Wendy Hetherington, MPH
  Riverside University Health System, Public Health
- Kevin Meconis, MPH
  Riverside University Health System, Public Health
- John Chapman, MBA
  San Antonio Regional Hospital
- Aileen Dinkjian, EdD, MPH
  San Antonio Regional Hospital
- Cathy Rebman
  San Antonio Regional Hospital
- Anthony Arce, MPH
  San Bernardino County Department of Public Health, Community Vital Signs
- Dori Baeza
  San Bernardino County Department of Public Health, Community Vital Signs
- Steven Barron
  San Gorgonio Memorial Hospital
- Ariel Whitley, MHA
  San Gorgonio Memorial Hospital
- Kathleen McDonnell
  St. Bernardine Medical Center
- Michelle Burroughs, MPH
  University of California Riverside Medical School
- Maria Lemus
  Visión y Compromiso

Demographic Data for the Inland Empire, Riverside County and San Bernardino County

Understanding the community to be served is a crucial step in conducting a CHNA and setting priorities for action.

Demographics and population projections help tell the story. The demographic data for this CHNA, which were compiled by SpeedTrack, look at population projections by demographic cohort (gender, race, ethnicity and age).

The Inland Empire

The **Inland Empire** encompasses all of Riverside and San Bernardino counties. It covers more than 27,000 square miles and is larger than 10 U.S. states, according to the U.S. Census Bureau. Its 2022 population is 4.765 million.

Demographic data for the Inland Empire project an overall population growth of 3.7% by 2027. The fastest-growing ethnic group is Multiracial; the Hispanic/Latino and Black/African American populations will continue to grow at a slightly higher rate than the White population. The 65+ population will grow by 13%, while the number of children ages 1–17 is projected to decline by 0.7%.

Riverside County

Riverside County is home to 2.545 million people (2022) and covers 7,208 square miles. It is the fourth most-populous county in California and the ninth most-populous in the United States.

Riverside County is growing faster than the Inland Empire as a whole. The greatest ethnic growth by 2027 will be in the Multiracial population, followed by the Hispanic/Latino and Black/African American populations. There will also be significant growth in the Asian and White populations. Again, there is a large increase in the over-65 population and a decline in the 1–17-year-old population group.

San Bernardino County

San Bernardino County has 2.22 million residents in 2022. It is the fifth most-populous county in California and the 13th most-populous in the United States. It covers 20,105 square miles.

San Bernardino County is growing at a slightly slower rate than Riverside County and the Inland Empire as a whole. By far, the fastest-growing ethnic group is Multiracial, followed by Hispanic/Latino and Black/African American people. There will be a significant increase in people 65 and older and a decrease in children ages 1–17.

Appendix A *provides additional demographic data on the Inland Empire, Riverside and San Bernardino counties and the primary service areas of Montclair Hospital Medical Center, Redlands Community Hospital, San Antonio Regional Hospital and San Gorgonio Memorial Hospital.*

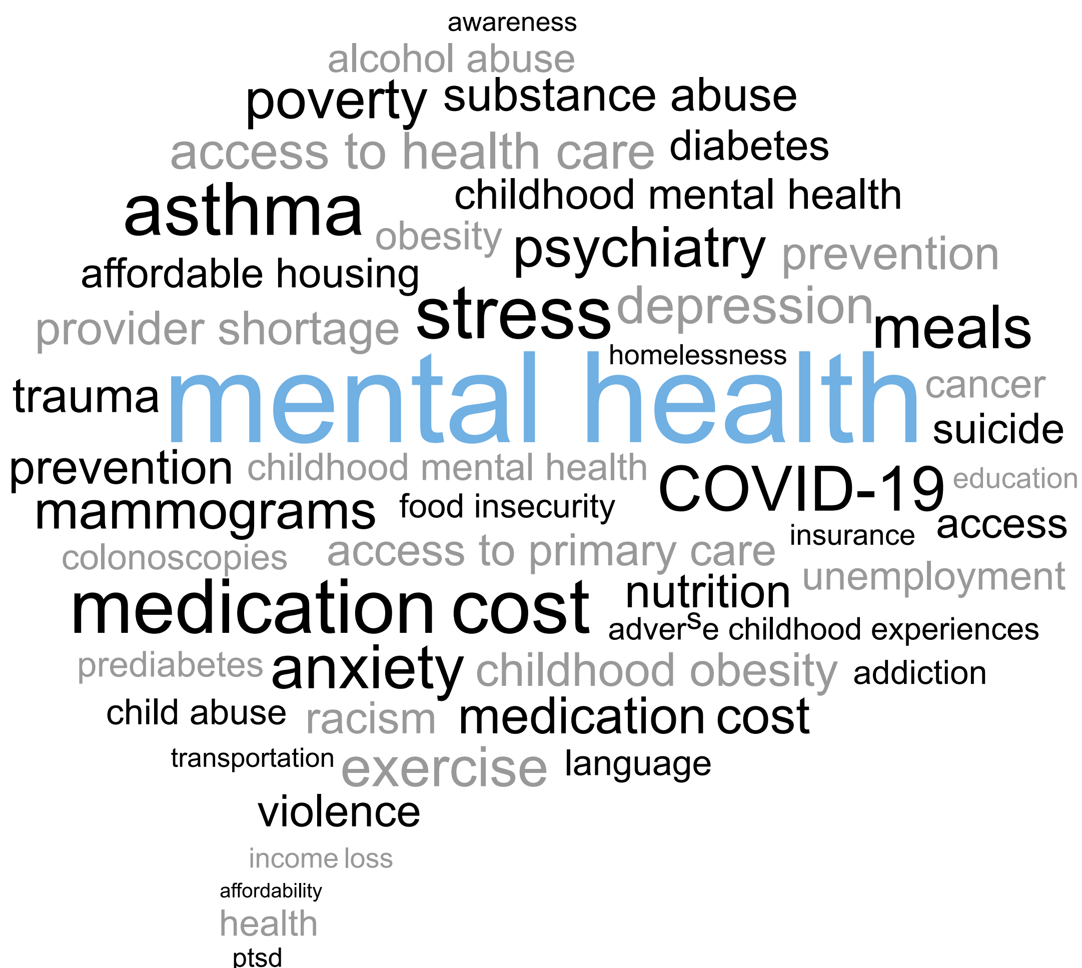
Data Sources and Findings

This Community Health Needs Assessment synthesized primary and secondary data sources. Primary data are new data collected or observed directly from first-hand experience. Secondary data have already been collected and published by another party.

Primary Data

The stakeholders reviewed primary data that were collected for the Inland Empire regional CHNA from two sources: key informant interviews and community listening sessions.

In both the interviews and the listening sessions, participants were asked to describe — in their own words — what they saw to be the important health and social needs and the challenges that influence these needs. Participants were not shown any additional data (e.g., previously completed CHNAs, publicly available secondary data) in advance of the primary data collection sessions.



Key Informant Interviews

The CHNA stakeholders identified nine key informants who were interviewed individually in person or by telephone in March, April and May 2022 by HC² Strategies. The informants represented community, civic and government leaders in the Inland Empire. Questions focused on key health needs, social factors and community conditions that affect health as well as community assets that could be used to address these issues. Key themes (health priorities) that emerged from these interviews are listed below.

Most Common Themes

- Mental health — especially depression and anxiety
- Substance use disorder
- Education — learning loss among youth
- Financial strain — job and income loss
- Unemployment and lack of appropriate job skills training

Other Themes

- Delayed or deferred preventive care services
- Digital divide and technology gaps exposed by the pandemic and lockdown
- Housing instability and homelessness
- Safety and violence
- Convenient access to health care

Equity Themes

- Infant mortality — particularly in populations that identify as Black/African American
- Health equity among lower-income communities
- Health equity in communities of color
- Lack of prenatal care in rural and remote areas

Appendix B lists the key informants.

Listening Sessions

The Social Impact Artists, Inc. conducted eight listening sessions at multiple locations throughout the Inland Empire to gain insights from diverse communities on regional health priorities. Efforts were taken to include interviewees identifying with populations whose voices CHNA stakeholders wanted to elevate in the prioritization of regional health issues: immigrants, youth, working-class community members and individuals who identified as BIPOC (Black, indigenous and people of color).

In the sessions, which were conducted in English and Spanish, participants discussed community health problems as well as concerning environmental and community conditions.

About 90% of the 49 participants were female. They came from:

- Riverside County — Hemet, Perris, Menifee, Moreno Valley, Homeland (unincorporated area)
- San Bernardino County — Ontario, Rialto, Big Bear/Arrowhead, Victorville/Hesperia

Efforts to recruit participants included phone calls, emails, social media posts and direct outreach in community locations (health fairs, hospitals, pharmacies, laundromats, libraries). Recruitment for listening sessions was also pursued via door-to-door visits to homes and businesses.

Most Common Themes

The following health themes emerged in the listening sessions:

- Mental health/depression and anxiety/substance use
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Hypertension and heart disease
- Cancer
- Obesity

Environmental and community themes included:

- Air quality
- Affordable housing
- More green spaces
- Lack of entertainment, activities and a center for youth
- Role of faith communities in caring for community members
- Crime and violence
- More community celebrations

The themes uncovered in the listening sessions varied somewhat by geographical area.

Appendix Q contains the Listening Session Report.

Secondary Data

Hospital Data

Hospital secondary data in this needs assessment focus on hospital inpatient and emergency department (ED) utilization data, the top causes of death, morbidities (health conditions), chronic conditions and the social determinants affecting hospital use.

The 2016–2020 hospital data were derived from California's Department of Health Care Access and Information (HCAI) and integrated with data from the federal Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and the U.S. Census Bureau.

The hospital data were stratified by the Inland Empire as a whole and by San Bernardino and Riverside counties. In addition, SpeedTrack pulled utilization data specific to each hospital service area; these findings are noted in the hospital-specific CHNA reports found later in this document.

The California hospital data for inpatient admissions — flagged for Prevention Quality Indicators (PQIs) and "Z" type diagnosis codes (International Classification of Diseases, Tenth Revision – ICD 10) — are important because they highlight the most common chronic conditions and social drivers of health in the designated regions.

Hospital Prevention Quality Indicators (PQIs)

Prevention Quality Indicators (PQIs) help identify hospital inpatient admissions that might have been avoided if a patient had access to outpatient care, including follow-up after discharge.

All California hospitals report PQIs to the state's Department of Healthcare Access and Information (HCAI). Hospitals across the nation use the PQI algorithms, which are set by the federal Agency for Healthcare Research and Quality (AHRQ). PQIs measure hospital inpatient admission rates for:

- **PQI 01** - diabetes, short-term complications
- **PQI 03** - diabetes, long-term complications
- **PQI 05** - COPD or asthma in older adults
- **PQI 07** - hypertension
- **PQI 08** - heart failure
- **PQI 11** - bacterial pneumonia
- **PQI 12** - urinary tract infections
- **PQI 14** - uncontrolled diabetes
- **PQI 15** - asthma in younger adults
- **PQI 90** - overall composite
- **PQI 91** - acute composite
- **PQI 92** - chronic composite
- **PQI 93** - diabetes composite

Hospital Z Codes for Social Determinants of Health

Hospitals are now capturing data on the social needs of their patient's populations through what are commonly called "Z codes." These ICD 10 codes, which are documented in the patients' medical records, identify non-medical factors that may influence a patient's health status. These data are valuable not only for understanding a patient's health status but also for identifying unmet social needs in a community, which can inform and support community health investments.

Z code categories focus on social determinants of health that may impact patients' use of hospital services versus outpatient care. The social determinants are defined as the economic and social conditions that influence individual and group differences in health status. They include social drivers of health such as education level, employment, social and family supports, upbringing, housing, environmental stability and other psychosocial factors.

Unfortunately, Z codes are underused. While the data represented in this CHNA are limited by what have been collected, they provide some information on the greatest social needs being reported in the Inland Empire. With a collective approach to CHNAs and strategies, the hope is to encourage use of this standard approach for screening and tracking social needs, which will expand the community's collective knowledge for solutions.

Avoidable ED Visits

Avoidable emergency department (ED) visits are defined as conditions managed in the ED that likely could have been treated in a primary care setting. When community members visit the ED instead of a primary care doctor, they miss the opportunity for coordinated and comprehensive treatment for their ongoing medical needs.

Avoidable ED rates in the Inland Empire are largely associated with having Medi-Cal insurance and are more commonly seen in the infant and adolescent populations. The most common potentially avoidable conditions leading to ED use are abdominal pain, upper respiratory infections, musculoskeletal pain and urinary tract infections.

It is interesting to note that, overall, avoidable ED visits were down in 2020, possibly due to COVID-19 and the corresponding delays in health care utilization.

When designing interventions to reduce avoidable ED visits and health disparities, it is important to consider factors that affect the populations most represented in the data.

For example, individuals struggling with homelessness tend to visit the ED or urgent care for basic health services instead of a primary care provider, driving up the number of avoidable ED visits. They also tend to be difficult to reach or track for follow-up care. Establishing trust and relationships with this population and developing care pathways to simultaneously address housing and health needs must be a priority when incorporating interventions.

In addition, disparities exist in the diagnosis and management of cardiovascular diseases, diabetes, hypertension and cancer, among other diseases, which also can lead to avoidable ED visits. For example, populations who identify as Latinx and Black/African American in the Inland Empire do not achieve the same disease outcomes in these areas as compared to their counterparts who identify as White. These populations are also disproportionately more likely to seek care for these conditions in the ED — a site where care coordination and long-term condition management cannot be realistically prioritized. Partnering with these communities to address the structural barriers contributing to avoidable ED use will be key to improving health in historically excluded communities.

Appendix C *contains data tables of avoidable ED rates for the Inland Empire and Riverside and San Bernardino counties.*

Appendix P *lists avoidable ED rates for the Montclair Hospital Medical Center, Redlands Community Hospital, San Antonio Regional Hospital and San Gorgonio Memorial Hospital primary service areas.*

IP3 | Assess

Additional secondary data for this assessment were derived from the IP3 | Assess platform developed by the Institute for People, Place, and Possibility (IP3). IP3 | Assess uses two frameworks: Burden of Disease and Vital Conditions for Well-Being. The domains in the Burden of Disease framework consist of common health conditions, and the domains in the Vital Conditions framework comprise seven community conditions that affect health and well-being. The IP3 | Assess data were reviewed systematically by regional CHNA stakeholders in prioritizing key health and environmental issues to support health in the Inland Empire.

Users can drill down into indicators in each domain to identify specific focus areas and prioritize efforts. They can toggle between different geographies to see how scores vary across service areas and explore driving factors for positive and negative composite domain scores.

Appendix D *offers an in-depth description of the IP3 | Assess tool.*

Other Community Needs Assessments

The Inland Empire CHNA stakeholders also considered primary and secondary data findings from other needs assessments conducted in Riverside and San Bernardino counties.

Riverside County

A COVID-19 Needs Assessment examined community attitudes and behaviors related to COVID-19 in Riverside County in 2021. The Riverside University Health System – Public Health conducted the assessment in cooperation with the Health Association and Research for Communities (HARC).

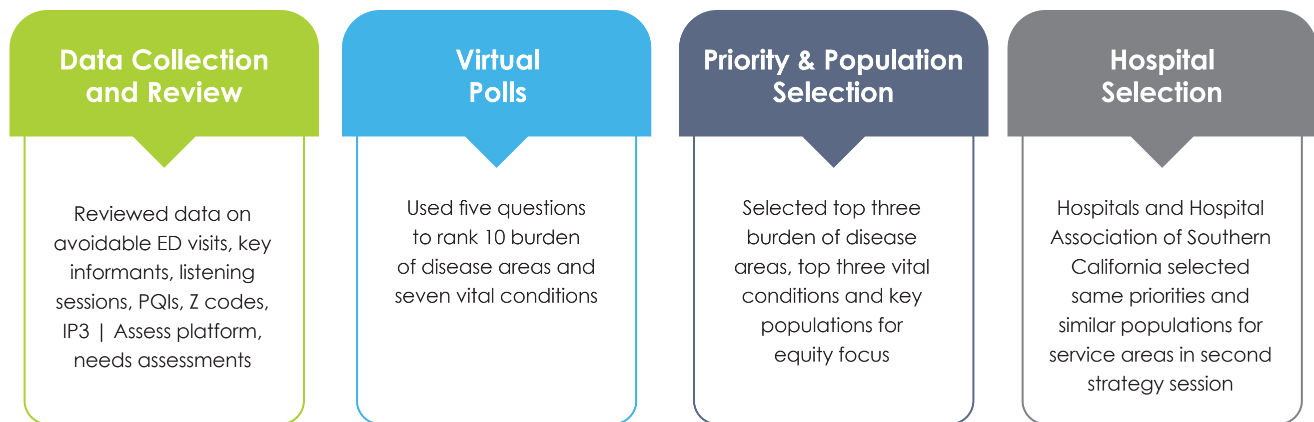
The assessment consisted of interviews with 9,200 county residents regarding fear of being sick, hospitalized or dying; COVID-19's impact on social life and work/school participation; travel avoidance; financial losses; delays in health and dental care; vaccination status and beliefs; and the burden of COVID-19 disease. Most participants "somewhat agreed" or "strongly agreed" that the pandemic had a disproportionate impact on people of color.

San Bernardino County

The San Bernardino County Department of Public Health published the Community Vital Signs survey in collaboration with the Community Vital Signs (CVS) initiative in 2020. This initiative is a collaboration of community leaders and decision-makers from different sectors across the county. The group identified and prioritized health equity issues in the county. The indicators incorporated demographics, health and wellness, education, economic factors and safety. The survey results have been used to create collaborative action plans in San Bernardino County.

Stakeholder Prioritization Process to Determine Key Issues

After a series of monthly preparatory discussion sessions, HC² Strategies facilitated a virtual strategy meeting with the 2022 Inland Empire CHNA Stakeholder Committee on April 19, 2022. Their task was to review the results of the various data sets and to identify and prioritize critical health and community issues. They followed this process in their work.



In the April 19 strategy session, the stakeholders first considered the data they had received from the Montclair, Redlands and San Antonio regional hospitals, data in the IP3 | Assess Burden of Disease and Vital Conditions for Well-Being frameworks and qualitative findings from key informant interviews and listening sessions.

Stakeholders used virtual polling to rank the burden of disease and vital conditions data. The poll asked five key questions regarding these data. The stakeholders ranked their selections from one to five, with one being the highest and five being the lowest.

The five questions were:

1. How acute is this need?
2. Are there energy, capacity and resources for improving the need?
3. Does the issue disproportionately affect certain populations? (Consider race, ethnicity, income, geography and education.)
4. Are there investment opportunities for collaborative partners and/or practice — or evidence-based approaches to address these needs?
5. Has COVID-19 impacted the area of focus?

Burden of Disease Priorities

The Stakeholder Committee reviewed the most common diseases listed below, and asked Questions 1–5 regarding 10 health conditions in the IP3 | Assess Burden of Disease framework. While IP3 | Assess provides 12 categories in this framework, this CHNA includes 10. (The domains of cardiovascular disease and diabetes were combined into one, and brain health was not included due to a dearth of indicators.)

- Cardiovascular disease/diabetes
- Cancers
- Respiratory disease
- Kidney disease
- HIV/AIDs and sexually transmitted infections (STIs)
- Infectious disease
- Maternal and infant health
- Injury and violence
- Mental and behavioral health
- Oral health

The committee used the virtual polling process described above to determine the most critical health conditions in the Inland Empire. The number of responses in each question set the priorities for the below top three burden of disease areas in the Inland Empire.

Detailed data and information about these burden of disease categories and their indicators may be viewed using the links below. A drop-down menu on the top right corner of the page allows website visitors to review data for the Inland Empire and 13 other geographic areas within the region. Stakeholders will use these data to identify and collaborate on interventions focused on these priority conditions.

- Cardiovascular disease and diabetes
- Mental and behavioral health
- Maternal and infant health

The other conditions rank as secondary issues that may also be addressed if the need is large in a particular community.

Appendix E *shows committee poll rankings for the burden of disease areas.*

Appendices F, ***G*** *and* ***H*** *list the selected IP3 | Assess Burden of Disease categories, the indicators that illuminate the causal factors, high-level results and links to the reports.*

Appendix L *details the IP3 | Assess Burden of Disease data sources for the indicators.*

Vital Conditions Priorities

Next, the Stakeholder Committee members reviewed the seven IP3 | Assess Vital Conditions:

- Basic needs for health and safety
- Lifelong learning
- Meaningful work and wealth
- Humane housing
- Reliable transportation
- Thriving natural world
- Belonging and civic muscle

Again, using virtual polls, stakeholders were asked to rank the five vital conditions that they considered to be most important for the Inland Empire. Questions 1–5 (noted above) were again used in this virtual polling process. Raw vote counts identified the priorities for the top three vital conditions in the Inland Empire.

Detailed data and information about these vital conditions and their indicators may be viewed using the links below. A drop-down menu on the top right corner of the page allows website visitors to review data for the Inland Empire and 13 other geographic areas within the region. Stakeholders will use these data to identify and collaborate on interventions.

- Basic needs for health and safety
- Humane housing
- Meaningful work and wealth

The other conditions rank as secondary issues that may also be addressed if the need is large in a particular community.

Appendix E *shows committee poll rankings for the vital conditions.*

Appendices I, ***J*** *and* ***K*** *list the selected IP3 | Assess Vital Conditions for Well-Being categories, the indicators that illuminate the causal factors, high-level results and links to the reports.*

Appendix M *details the data sources for the IP3 | Assess Vital Conditions for Well-Being indicators.*

Appendix N *provides information about the 2019 Inland Empire community health priorities, which are very similar to the 2022 priorities, and subsequent work on the issues.*

Populations Disproportionately Impacted

The stakeholders then turned to identifying populations who — based on available data sources — might be experiencing a disproportionate share of the burden of disease conditions or obstacles to achieving the vital conditions for well-being. Through data review by the group, the following key populations were identified:

- Individuals with low incomes
- Individuals identifying as Black/African American, Latinx and/or Pacific Islander
- Remote and rural communities
- Senior citizens

Appendix O *contains stakeholder comments from the strategy meeting.*

Priority Selection Process for Participating Hospitals

A second strategy session was facilitated by HC² Strategies on April 26, 2022, for the Hospital Association of Southern California (HASC) and three of the Inland Empire hospitals that participated in this Hospital Edition of the regional Community Health Needs Assessment:

- Montclair Hospital Medical Center
- Redlands Community Hospital
- San Antonio Regional Hospital

The HASC and the hospitals had already participated in the larger strategy session that selected priorities for the Inland Empire as a whole. They had also studied the burden of disease, vital conditions and data indicators specific to their hospitals' primary service areas (PSAs).

The purpose of these additional two meetings was to determine whether broader regional priorities identified by all stakeholders would be carried over as hospital PSA priorities. After the groups reviewed the burden of disease and vital conditions priorities for the Inland Empire, each hospital voted to adopt the same priorities for their PSA. They also agreed to give special focus to the following underserved populations: low-income people; remote and rural communities; individuals identifying as Black/African American, Latinx and/or Pacific Islander; and senior citizens.

A strategy group for Montclair Hospital Medical Center, Redlands Community Hospital and San Antonio Regional Hospital met on June 14, 2022, to review and approve the drafts of their hospitals' respective CHNAs.

The strategy group for San Gorgonio Memorial Hospital met on July 12, 2022. This group agreed to the same priorities as the regional CHNA and the other three hospitals. They also selected a special focus on the following underserved populations: low-income people; remote and rural communities; individuals identifying as Black/African American, Latinx and/or Pacific Islander; and senior citizens.

The hospital CHNAs will go to all four hospital boards for final approval prior to the end of 2022. In addition, each hospital will focus on the six priority areas and special populations as they build collaborative and measurable 2023-2025 community health implementation plans for their service areas; they will also participate in the larger regional efforts around collective investments. The final CHNAs will also be used in the hospitals' strategic planning efforts over the next three years.

Findings in the Hospital Community Health Needs Assessments

The four participating hospitals will address the six priority areas identified for the larger Inland Empire region. The indicator tables (Appendices F–K) for the IP3 Burden of Disease and Vital Conditions for Well-Being frameworks show some variation in the contributing indicators for each hospital PSA (primary service area) and the rest of the Inland Empire region.

These hospital variations and the opportunities for improvement are noted below.

***Appendix P** provides detailed information about chronic conditions, avoidable ED visits, payers and mental health visits.*

Montclair Hospital Medical Center

Montclair Hospital Medical Center, established in 1973, is an award-winning, 106-bed facility located in the heart of Montclair. With a multidisciplinary team of experts and state-of-the-art technology, the hospital team is committed to serving the community with personalized, high-quality care. Montclair Hospital Medical Center offers a full range of comprehensive services, including 24-hour emergency care, advanced diagnostic services, cardiopulmonary services and rehabilitation care.

Located in southwestern San Bernardino County, the hospital's primary service area includes the cities of Montclair, Pomona, Ontario, Upland and Claremont. Its secondary service area comprises Rancho Cucamonga, La Verne, Diamond Bar and Chino.

Appendix A *provides demographic information about the Montclair Hospital Medical Center PSA.*

Hospital Disease Data

The following disease findings specific to Montclair Hospital Medical Center's PSA were compiled by SpeedTrack. The 2016–2020 hospital data were derived from California's Department of Health Care Access and Information (HCAI) and integrated with data from the federal Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and the U.S. Census Bureau.

- Black/African American males and females 65+ have the highest number of chronic conditions.
- The top chronic conditions in males ages 18 – 34 are substance use disorders, mental illness and tobacco use.
- Males over 35 have high rates of hypertension, diabetes, kidney disease and hyperlipidemia. In addition, males over 65 have higher rates of heart disease and prostate conditions.
- The top chronic conditions in females 18 – 34 are obesity and anemia, following by depression and anxiety.
- Hypertension is the top condition for females ages 35 – 64, especially in the Black/African American population; anemia and diabetes are also high in this group. White females 65+ have the lowest rates of hypertension compared to the other ethnicities.

***Appendix P** provides detailed information about chronic conditions, avoidable ED visits, payers and mental health visits.*

Burden of Disease and Vital Conditions

The following indicators for each burden of disease and vital conditions priority note some of the specific causal factors in Montclair Hospital Medical Center's primary service area. The information below also highlights opportunities for improvement identified by comparing the hospital PSA results to the state benchmark.

Cardiovascular Disease and Diabetes

- High smoking rate
- Low rate of blood pressure management
- High death rates for diabetes
- High heart disease hospitalization rates for Medicare beneficiaries
- High diabetes rate

Mental and Behavioral Health

- Frequent mental distress
- Shortage of mental health providers

Infant and Maternal Health

- Low birthweight babies
- Pre-term births

Basic Needs for Health and Safety

- Shortage of dental providers
- HPSA (Health Professional Shortage Area) — Primary Care
- People with diagnosed hypertension who are not taking medication
- High rate of violent crime

Humane Housing

- High housing costs
- High rate of overcrowded housing
- High rate of residential segregation

Meaningful Work and Wealth

- Lack of high-paying jobs
- High unemployment rate
- Low median household income
- Low homeownership rate
- High child poverty rate

Redlands Community Hospital

Redlands Community Hospital (RCH) is a 229-bed facility that has cared for the community of Redlands and its surrounding areas since 1904. It is founded on a mission to promote an environment where members of the hospital's community receive high-quality care and service by working in concert with the patients, physicians, staff and associates of RCH.

RCH is an independent, not-for-profit, full-service community hospital serving as a major health care provider in its primary service area of East San Bernardino Valley and a hospital of choice for medical staff.

Located in the most densely populated area of San Bernardino County, communities identified as being in the hospital's primary service area (from which 75% – 80% of patients come) are Banning, Beaumont, Cabazon, Colton, Calimesa, Forest Falls, Highland, Mentone, Redlands and Yucaipa. The hospital's secondary service area is described as including Bloomington, Bryn Mawr, Crestline, Fontana, Grand Terrace, Hemet, Loma Linda, Patton, Rialto, San Bernardino and several mountain communities.

Appendix A *provides demographic information about the Redlands Community Hospital PSA*. Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and the U.S. Census Bureau.

Hospital Disease Data

The following disease findings specific to Redlands Community Hospital's PSA were compiled by SpeedTrack. The 2016 – 2020 hospital data were derived from California's Department of Health Care Access and Information (HCAI) and integrated with data from the federal Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and the U.S. Census Bureau.

- For males, the number of chronic conditions ranges from 5.52 to 5.89 per individual. Black/African American males have the highest number followed by Hispanic/Latino males. Asian/Pacific Islander males have the lowest.
- For females, the number of chronic conditions ranges from 4.88 to 6.06 per individual. Black/African American females have the highest number, followed closely by White females and Hispanic/Latina. Again, females of Asian/Pacific Islander descent have the lowest.
- The top chronic condition for all four ethnicities is depression, followed by depressive disorders and asthma. White females report high levels of anxiety disorders.
- ED visits dropped in 2020 compared to prior years. The main social determinants for avoidable ED visits are primary support group and family, occupational risk, other psychosocial circumstances and social environment.
- Medicaid and Medi-Cal are, by far, the largest payers. Asian/Pacific Islanders and White people under age 65 have higher rates of private insurance than the other ethnic groups.

Appendix P *provides detailed information about chronic conditions, avoidable ED visits, payers and mental health visits.*

Burden of Disease and Vital Conditions

The following indicators for each burden of disease and vital conditions priority note some of the specific causal factors in Redlands Community Hospital's primary service area. The information below also highlights opportunities for improvement identified by comparing the hospital PSA results to the state benchmark.

Cardiovascular Disease and Diabetes

- High obesity rate
- High smoking rates
- High rate of hypertension deaths
- High rate of heart failure deaths
- High diabetes rate
- High hospitalization rates for Medicare beneficiaries
- Low proportion of completed A1c tests for Medicare recipients
- High death rate for diabetes

Mental and Behavioral Health

- High rate of depression among Medicare beneficiaries
- Frequent mental distress
- Shortage of mental health providers

Infant and Maternal Health

- High infant death rate
- High rate of tobacco use during pregnancy
- High rate of pre-term births
- Below benchmark in early prenatal care

Basic Needs for Health and Safety

- HPSA (Health Professional Shortage Area) — Dental
- High rate of premature death
- High rate of people living with disabilities
- Lower life expectancy than the state average

Humane Housing

- High rate of homes with incomplete plumbing or kitchen facilities
- Low rate of multi-family housing

Meaningful Work and Wealth

- Lack of high-paying jobs
- Low median household income

San Antonio Regional Hospital

Founded in 1907, San Antonio Regional Hospital is a 363-bed, nonprofit, acute care hospital in Upland, California. In addition to its main campus, the hospital has satellite locations across the Inland Empire. Services include adult and neonatal intensive care; emergency and urgent care; robotic, open heart and other surgical procedures; dedicated obstetrics, oncology and orthopedic units; and imaging, lab, rehabilitation and other outpatient services.

San Antonio's primary service area comprises the cities of Chino, Claremont, Eastvale, Fontana, Montclair, Ontario, Rancho Cucamonga and Upland. The hospital's secondary service area extends to Pomona to the west, Chino Hills to the southwest, Norco to the southeast and Rialto at the eastern edge of the service area.

Appendix A *provides demographic information about the San Antonio Regional Hospital PSA.*

Hospital Disease Data

The following disease findings specific to San Antonio Regional Hospital's PSA were compiled by SpeedTrack. The 2016 – 2020 hospital data were derived from California's Department of Health Care Access and Information (HCAI) and integrated with data from the federal Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and the U.S. Census Bureau.

- Black/African American males and females over age 65 have the highest number of chronic conditions.
- Hypertension is the primary chronic condition in males and females ages 35 – 64 and over 65, especially in Black/African American populations.
- Anemia, diabetes, kidney disease and obesity are major issues for all people over 35.
- Depression and depressive disorders are the primary chronic conditions in male and female youth ages 0 –17.
- Medi-Cal is the primary payer for Black/African American and Hispanic/Latino adults under age 65.
- ED mental health use declined in 2020, likely due to COVID-19.

***Appendix P** provides detailed information about chronic conditions, avoidable ED visits, payers and mental health visits.*

Burden of Disease and Vital Conditions

The following indicators for each burden of disease and vital conditions priority note some of the specific causal factors in San Antonio Regional Hospital's primary service area. The information below also highlights opportunities for improvement identified by comparing the hospital PSA results to the state benchmark.

Cardiovascular Disease and Diabetes

- High obesity rate
- High cholesterol rate
- HPSA (Health Profession Shortage Area — Primary Care
- High rate of hypertension deaths
- High rate of smoking
- High stroke rate
- High rate of heart disease
- High diabetes rate
- Low diabetes management rate in Medicare beneficiaries
- High diabetes death rate

Mental and Behavioral Health

- Shortage of mental health providers
- HPSA (Health Professional Shortage Area) — Mental Health
- High rate of substance use disorder deaths
- High rate of depression in Medicare beneficiaries

Infant and Maternal Health

- High infant death rate
- High percentage of low birthweight babies
- High rate of tobacco use during pregnancy
- High rate of pre-term births

Basic Needs for Health and Safety

- HPSA (Health Professional Shortage Area) – mental health
- HPSA (Health Professional Shortage Area) – Dental
- High rate of premature death
- High population of people with disabilities
- Lower life expectancy

Humane Housing

- Low rate of multi-family housing

Meaningful Work and Wealth

- Lack of high-paying jobs
- Low median household income

San Gorgonio Memorial Hospital

San Gorgonio Memorial Hospital (SGMH) is a 79-bed general acute care hospital located in Banning, California, a rural area in the northwestern region of Riverside County.

The community-based hospital is dedicated to providing acute care services to the residents of the San Gorgonio Pass area. It is the only acute care hospital in the San Gorgonio Memorial Health Care District, which has approximately 90,000 year-round residents. The district includes the cities of Banning and Beaumont, a portion of Calimesa and the neighboring unincorporated areas of Cabazon, Cherry Valley and Whitewater.

SGMH offers many services, including 24-hour emergency care, robotic surgery, cardiology, teleneurology and advanced imaging.

The hospital's primary service area comprises zip codes 92220 and 92223; its secondary service area is the rest of the hospital district.

Appendix A *provides demographic information about the San Gorgonio Memorial Hospital PSA.*

Hospital Disease Data

The following disease findings specific to San Gorgonio Memorial Hospital's PSA were compiled by SpeedTrack. The 2016 – 2020 hospital data were derived from California's Department of Health Care Access and Information (HCAI) and integrated with data from the federal Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and the U.S. Census Bureau.

- Black/African American males and females over age 65 have the highest number of chronic conditions.
- Hypertension is the primary chronic condition in males and females ages 35 – 64 and over 65, especially in Black/African American populations.
- Anemia, diabetes, kidney disease and obesity are major issues for all people over 35.
- Depression and depressive disorders are the primary chronic conditions in male and female youth ages 0 – 17.
- Medi-Cal is the primary payer for Black/African American and Hispanic/Latino adults under age 65.
- ED mental health use declined in 2020, likely due to COVID-19.

Appendix P *provides detailed information about chronic conditions, avoidable ED visits, payers and mental health visits.*

Burden of Disease and Vital Conditions

The following indicators for each burden of disease and vital conditions priority note some of the specific causal factors in San Gorgonio Memorial Hospital's primary service area. The information below also highlights opportunities for improvement identified by comparing the hospital PSA results to the state benchmark.

Cardiovascular Disease and Diabetes

- High obesity rate
- High cholesterol rate
- High rate of hypertension
- High rate of smoking
- High stroke rate
- High diabetes rate
- High rate of heart attack, heart disease and heart failure
- Low rates of heart disease hospitalizations in Medicare beneficiaries

Mental and Behavioral Health

- Shortage of mental health providers
- HPSA (Health Professional Shortage Area) — Mental Health
- High rate of drug use disorder deaths
- High rate of depression in Medicare beneficiaries

Infant and Maternal Health

- High infant death rate
- High percentage of low birthweight babies
- High rate of tobacco use during pregnancy
- High rate of pre-term births

Basic Needs for Health and Safety

- High percentage of people without supermarket access
- HPSA (Health Professional Shortage Area) — Mental Health
- HPSA (Health Professional Shortage Area) — Dental
- High percentage of uninsured adults
- High rate of premature death
- High population of people with disabilities

Humane Housing

- Low rate of multi-family housing

Meaningful Work and Wealth

- Lack of high-paying jobs
- High rate of people on public assistance
- Low median household income
- High poverty rate
- High child poverty rate

Next Steps

Our communities are far better off when everyone has the opportunity to live their healthiest life. We must work collectively to support and improve the many systems that influence health — not only health care and social services, but also vital services such as education, housing, transportation and public safety.

As stewards of our communities — parents, educators, health providers, business leaders and other community members — we all have important roles in improving health and well-being, eliminating preventable health inequities and building communities with truly equal opportunities for all people.

To advance this work, all community members are encouraged to review the data and priorities in this report and identify where and how they might contribute to improvement. Along with that support, community stakeholders will continue to meet, study the community data, collaborate on implementation strategies and align regional investments to focus on the priorities identified.

Additional support and information are available and will be expanded. All community members have access to much of the IP3 | Assess data through links in Appendices F–K in this report as well as many other resources at ConnectIE.org. A comprehensive community needs assessment on the Inland Empire as well as Riverside and San Bernardino counties also will be released to the public later in 2022. In addition, an IP3 | Assess platform of data and information will be made available to stakeholders to support their collaboration.

Together, we can build a vibrant Inland Empire. It will take each of us seeing the possibilities and working together for good as stewards of our communities.

Appendix A: Additional Demographic Information

Population trends for the Inland Empire region as well as Riverside and San Bernardino counties are provided in the main body of this report.

Inland Empire Population Projections by Demographic Cohort

Gender	2023	2024	2025	2026	2027	% Change
Female	2,373,485	2,395,289	2,416,737	2,440,123	2,462,993	3.8%
Male	2,359,370	2,382,216	2,405,735	2,426,260	2,445,601	3.7%

Race	2023	2024	2025	2026	2027	% Change
American Indian / Alaskan Native / Eskimo / Aleut	21,633	1,760	22,014	22,150	22,206	2.6%
Asian / Pacific Islander	291,036	293,368	295,738	297,660	299,231	2.8%
Black / African American	334,977	338,671	341,630	344,981	347,789	3.8%
Hispanic or Latino	2,250,730	2,272,451	2,295,437	2,316,419	2,337,963	3.9%
Multiracial	106,257	107,703	108,987	110,865	112,667	6.0%
Native Hawaiian / Other Pacific Islander	12,561	12,577	12,746	12,801	12,756	1.6%
Other Race	7,737	7,737	7,737	7,737	7,737	0.0%
White	1,707,924	1,723,238	1,738,183	1,753,770	1,768,245	3.5%

Ethnicity	2023	2024	2025	2026	2027	% Change
Hispanic or Latino	2,250,730	350,933	353,100	355,501	357,908	2.5%
Non-Hispanic or Non-Latino	2,482,125	277,552	278,966	280,112	281,212	1.7%

Age Range	2023	2024	2025	2026	2027	% Change
Under 1 Year	60,424	61,134	61,844	62,399	62,899	4.1%
1–17 Years	1,105,211	1,101,949	1,099,304	1,097,307	1,097,482	-0.7%
18–34 Years	1,205,453	1,215,750	1,223,150	1,229,053	1,228,899	1.9%
35–64 Years	1,642,415	1,655,593	1,670,291	1,685,505	1,706,690	3.9%
65 Years or Greater	719,352	743,079	767,883	792,119	812,624	13.0%
Total Population Trend	**4,732,855**	**4,777,505**	**4,822,472**	**4,866,383**	**4,908,594**	**3.7%**

Riverside County Population Projections by Demographic Cohort

Gender	2023	2024	2025	2026	2027	% Change
Female	1,259,921	1,274,589	1,287,868	1,300,862	1,314,108	4.3%
Male	1,254,752	1,269,117	1,283,501	1,295,323	1,306,311	4.1%

Race	2023	2024	2025	2026	2027	% Change
American Indian / Alaskan Native / Eskimo / Aleut	12,226	12,301	12,518	12,588	12,627	3.3%
Asian / Pacific Islander	151,820	153,662	155,336	156,764	158,106	4.1%
Black / African American	149,366	151,629	153,129	154,850	156,077	4.5%
Hispanic or Latino	1,139,918	1,152,607	1,165,830	1,174,882	1,185,636	4.0%
Multiracial	56,282	56,905	57,645	58,464	59,224	5.2%
Native Hawaiian / Other Pacific Islander	6,363	6,365	6,494	6,545	6,521	2.5%
Other Race	3,682	3,682	3,682	3,682	3,682	0.0%
White	995,016	1,006,555	1,016,735	1,028,410	1,038,546	4.4%

Ethnicity	2023	2024	2025	2026	2027	% Change
Hispanic or Latino	1,139,918	1,152,607	1,165,830	1,174,882	1,185,636	4.0%
Non-Hispanic or Non-Latino	1,374,755	1,391,099	1,405,539	1,421,303	1,434,783	4.4%

Age Range	2023	2024	2025	2026	2027	% Change
Under 1 Year	30,356	30,642	31,027	31,282	31,346	3.3%
1–17 Years	563,756	562,895	561,203	559,991	559,789	-0.7%
18 – 34 Years	630,188	638,382	644,228	648,823	650,879	3.3%
35 – 64 Years	872,610	880,225	888,795	896,641	908,014	4.1%
65 Years or Greater	417,763	431,562	446,116	459,448	470,391	12.6%
Total Population Trend	**2,514,673**	**2,543,706**	**2,571,369**	**2,596,185**	**2,620,419**	**4.2%**

San Bernardino County Population Projections by Demographic Cohort

Gender	2023	2024	2025	2026	2027	% Change
Female	1,113,564	1,120,700	1,128,869	1,139,261	1,148,885	4.3%
Male	1,104,618	1,113,099	1,122,234	1,130,937	1,139,290	4.1%

Race	2023	2024	2025	2026	2027	% Change
American Indian / Alaskan Native / Eskimo / Aleut	9,407	9,459	9,496	9,562	9,579	1.8%
Asian / Pacific Islander	139,216	139,706	140,402	140,896	141,125	1.4%
Black / African American	185,611	187,042	188,501	190,131	191,712	3.3%
Hispanic or Latino	1,110,812	1,119,844	1,129,607	1,141,537	1,152,327	3.7%
Multiracial	49,975	50,798	51,342	52,401	53,443	6.9%
Native Hawaiian / Other Pacific Islander	6,198	6,212	6,252	6,256	6,235	0.6%
Other Race	4,055	4,055	4,055	4,055	4,055	0.0%
White	712,908	716,683	721,448	725,360	729,699	2.4%

Ethnicity	2023	2024	2025	2026	2027	% Change
Hispanic or Latino	1,110,812	1,119,844	1,129,607	1,141,537	1,185,636	4.0%
Non-Hispanic or Non-Latino	1,107,370	1,113,955	1,121,496	1,128,661	1,434,783	4.4%

Age Range	2023	2024	2025	2026	2027	% Change
Under 1 Year	30,068	30,492	30,817	31,117	31,553	4.9%
1–17 Years	541,455	539,054	538,101	537,316	537,693	-0.7%
18 – 34 Years	575,265	577,368	578,922	580,230	578,020	0.5%
35 – 64 Years	769,805	775,368	781,496	788,864	798,676	3.8%
65 Years or Greater	301,589	311,517	321,767	332,671	342,233	13.5%
Total Population Trend	**2,218,182**	**2,233,799**	**2,251,103**	**2,270,198**	**2,288,175**	**3.2%**

Montclair Hospital Medical Center PSA
Population Projections by Demographic Cohort

The Montclair service area is projected to grow by 2.1% by 2027. The primary growth will be in the Multiracial population, followed by Hispanic/Latinos and Black/African Americans. The ages 1–34 group shows a decline while the 65+ group shows an increase of 12.5%.

Gender	2023	2024	2025	2026	2027	% Change
Female	315,236	316,516	318,182	320,227	322,172	2.2%
Male	310,481	311,969	313,884	315,386	316,948	2.1%

Race	2023	2024	2025	2026	2027	% Change
American Indian / Alaskan Native / Eskimo / Aleut	1,431	1,442	1,444	1,447	1,454	1.6%
Asian / Pacific Islander	68,812	68,842	68,908	68,883	68,770	-0.1%
Black / African American	40,278	40,468	40,722	40,975	41,234	2.4%
Hispanic or Latino	349,281	350,933	353,100	355,501	357,908	2.5%
Multiracial	11,601	11,716	11,803	11,992	12,202	5.2%
Native Hawaiian / Other Pacific Islander	1,261	1,263	1,274	1,276	1,273	1.0%
Other Race	1,249	1,249	1,249	1,249	1,249	0.0%
White	151,804	152,572	153,566	154,290	155,030	2.1%

Ethnicity	2023	2024	2025	2026	2027	% Change
Hispanic or Latino	349,281	350,933	353,100	355,501	357,908	2.5%
Non-Hispanic or Non-Latino	276,436	277,552	278,966	280,112	281,212	1.7%

Age Range	2023	2024	2025	2026	2027	% Change
Under 1 Year	7,738	7,821	7,882	7,936	8,046	4.0%
1–17 Years	145,436	144,411	143,577	142,830	142,217	-2.2%
18 – 34 Years	165,316	165,191	165,397	165,355	164,809	-0.3%
35 – 64 Years	222,399	223,536	224,864	226,386	228,632	2.8%
65 Years or Greater	84,828	87,526	90,346	93,106	95,416	12.5%
Total Population Trend	**625,717**	**628,485**	**632,066**	**635,613**	**639,120**	**2.1%**

Redlands Community Hospital PSA Population Projections by Demographic Cohort

The fastest-growing population group in race is Multiracial, followed by Black/African American and White populations. The number of people 65+ is expected to increase significantly, while the 1–17 group will decline.

Gender	2023	2024	2025	2026	2027	% Change
Female	169,435	170,907	172,436	174,156	175,724	3.7%
Male	159,409	160,991	162,393	163,823	165,165	3.6%

Race	2023	2024	2025	2026	2027	% Change
American Indian / Alaskan Native / Eskimo / Aleut	2,420	2,441	2,463	2,483	2,500	3.3%
Asian / Pacific Islander	25,823	25,992	26,135	26,312	26,434	2.4%
Black / African American	19,218	19,459	19,636	19,828	20,000	4.1%
Hispanic or Latino	109,970	111,002	112,064	113,175	114,259	3.9%
Multiracial	8,542	8,687	8,774	8,977	9,141	7.0%
Native Hawaiian / Other Pacific Islander	774	775	786	784	785	1.4%
Other Race	498	498	498	498	498	0.0%
White	161,599	163,044	164,473	165,922	167,272	3.5%

Ethnicity	2023	2024	2025	2026	2027	% Change
Hispanic or Latino	109,970	111,002	112,064	113,175	114,259	3.9%
Non-Hispanic or Non-Latino	218,874	220,896	222,765	224,804	226,630	3.5%

Age Range	2023	2024	2025	2026	2027	% Change
Under 1 Year	3,747	3,782	3,826	3,861	3,914	4.5%
1–17 Years	66,395	66,084	65,881	65,771	65,656	-1.1%
18 – 34 Years	76,936	77,400	77,584	77,760	77,527	0.8%
35 – 64 Years	114,484	115,093	115,802	116,530	117,692	2.8%
65 Years or Greater	67,282	69,539	71,736	74,057	76,100	13.1%
Total Population Trend	**328,844**	**331,898**	**334,829**	**337,979**	**340,889**	**3.7%**

San Antonio Regional Hospital PSA Population Projections by Demographic Cohort

The greatest population growth in the region will be in the Multiracial ethnic group and seniors.

Gender	2023	2024	2025	2026	2027	% Change
Female	480,557	483,690	487,304	491,931	496,091	3.2%
Male	475,832	479,682	483,663	487,425	491,026	3.2%

Race	2023	2024	2025	2026	2027	% Change
American Indian / Alaskan Native / Eskimo / Aleut	2,344	2,359	2,369	2,380	2,381	1.6%
Asian / Pacific Islander	84,289	84,698	85,255	85,650	85,886	1.9%
Black / African American	67,697	68,226	68,691	69,306	69,920	3.3%
Hispanic or Latino	526,275	530,779	535,550	541,315	546,385	3.8%
Multiracial	18,798	19,087	19,288	19,624	20,003	6.4%
Native Hawaiian / Other Pacific Islander	2,092	2,097	2,122	2,126	2,120	1.3%
Other Race	1,833	1,833	1,833	1,833	1,833	0.0%
White	253,061	254,293	255,859	257,122	258,589	2.2%

Ethnicity	2023	2024	2025	2026	2027	% Change
Hispanic or Latino	526,275	530,779	535,550	541,315	546,385	3.8%
Non-Hispanic or Non-Latino	430,114	432,593	435,417	438,041	440,732	2.5%

Age Range	2023	2024	2025	2026	2027	% Change
Under 1 Year	12,393	12,553	12,686	12,813	12,987	4.8%
1–17 Years	230,736	229,832	229,327	228,954	229,016	-0.7%
18 – 34 Years	258,604	259,874	260,879	261,671	260,916	0.9%
35 – 64 Years	342,455	345,332	348,484	352,262	357,167	4.3%
65 Years or Greater	112,201	115,781	119,591	123,656	127,031	13.2%
Total Population Trend	**956,389**	**963,372**	**970,967**	**979,356**	**987,117**	**3.2%**

San Gorgonio Memorial Hospital PSA Population Projections by Demographic Cohort

The fastest-growing population group in race in the San Gorgonio PSA is White, followed by Black/African American and Multiracial. The number of people 65+ is expected to increase significantly, while the 1–17 group will decline (although the number of births is expected to increase.

Gender	2023	2024	2025	2026	2027	% Change
Female	45,925	46,553	47,155	47,715	48,225	5.0%
Male	43,417	44,062	44,623	45,090	45,570	5.0%

Race	2023	2024	2025	2026	2027	% Change
American Indian / Alaskan Native / Eskimo / Aleut	1,370	1,386	1,396	1,407	1,423	3.9%
Asian / Pacific Islander	5,482	5,559	5,625	5,671	5,729	4.5%
Black / African American	5,075	5,182	5,245	5,300	5,343	5.3%
Hispanic or Latino	33,732	34,127	34,562	34,877	35,204	4.4%
Multiracial	2,036	2,055	2,082	2,118	2,139	5.1%
Native Hawaiian / Other Pacific Islander	127	127	130	131	130	2.4%
Other Race	107	107	107	107	107	0.0%
White	41,413	42,072	42,631	43,194	43,720	5.6%

Ethnicity	2023	2024	2025	2026	2027	% Change
Hispanic or Latino	33,732	34,127	34,562	34,877	35,204	4.4%
Non-Hispanic or Non-Latino	55,610	56,488	57,216	57,928	58,591	5.4%

Age Range	2023	2024	2025	2026	2027	% Change
Under 1 Year	1,084	1,097	1,110	1,117	1,118	3.1%
1–17 Years	17,632	17,612	17,561	17,576	17,574	-0.3%
18–34 Years	20,196	20,438	20,629	20,781	20,858	3.3%
35–64 Years	28,504	28,757	29,023	29,193	29,494	3.5%
65 Years or Greater	21,926	22,711	23,455	24,138	24,751	12.9%
Total Population Trend	**89,342**	**90,615**	**91,778**	**92,805**	**93,795**	**5.0%**

Appendix B: Key Informants

The key informants interviewed for this CHNA are:

Dori Baeza, project manager, Community Vital Signs, San Bernardino County Department of Public Health

Kyoni Cummings, education coordinator, National Alliance on Mental Illness, Pomona Valley, San Bernardino County

Matt Holden, superintendent, Chaffey Joint Union High School District, San Bernardino County

Sarah Kahn, **MD**, director of medical affairs, San Antonio Regional Hospital, Upland, San Bernardino County

Geoffrey Leung, **MD**, public health officer, Riverside University Health System, Public Health

Scott McGrath, deputy director, systems and impact, First Five Riverside County

Kevin Meconis, **MPH**, epidemiologist, Riverside University Health System

Bill Ruh, mayor pro tem, City of Montclair, San Bernardino County

Karen Scott, executive director, First Five Riverside County

Dennis Trigueros, **MD**, medical director, emergency department, and San Antonio Regional Hospital, Upland, San Bernardino County

The interviews were conducted by HC² Strategies.

Appendix C: Emergency Department (ED) Avoidable Visits and Volumes by Social Determinants

For the Inland Empire as a whole, and for Riverside and San Bernardino counties and the four hospitals, avoidable ED rates were driven in large part by a combination of visits associated with the Medi-Cal, infant and adolescent populations. The charts below show avoidable hospitalizations associated with social determinants as identified by Z codes using the New York University algorithm, the tool most widely used to evaluate use of emergency services.

The left side of the charts shows the number of avoidable hospitalizations, and the right side shows the percentage of total ED visits that were considered avoidable. As noted earlier in this report, social determinant Z codes are severely under-reported.

Inland Empire

Category	Visits by Volume 2017	2018	2019	2020	2019-2020 Vol Change	Avoidable Visits 2017	2018	2019	2020	Point Change
Inland Empire Total	1,468,326	1,441,897	1,487,418	1,179,052	-308,366	53%	53%	53%	49%	-4

Top 5 Payers by Volume	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Medicaid (Medi-Cal)	762,077	732,603	736,132	540,831	-195,301	56%	56%	57%	52%	-5
Health Maintenance Organization (HMO)	213,757	209,967	222,708	193,186	-29,522	51%	51%	51%	47%	-3
Health Maintenance Organization (HMO) Medicare Risk	158,794	165,679	182,988	156,627	-26,361	49%	49%	50%	46%	-3
Self-Pay	99,847	100,038	104,011	86,737	-17,274	50%	50%	51%	48%	-3
Medicare Part B	91,927	91,015	89,531	68,920	-20,611	50%	51%	52%	47%	-3

Age Groups	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Under 1 Year	44,327	40,702	41,704	23,812	-17,892	65%	65%	64%	58%	-7
1–17 Years	306,320	290,443	302,614	171,829	-130,785	57%	57%	58%	51%	-5
18 – 34 Years	404,405	396,068	403,582	347,254	-56,328	51%	51%	51%	47%	-4
35 – 64 Years	507,341	504,234	514,545	450,562	-63,983	53%	53%	53%	49%	-3
65 Years or Greater	205,933	210,450	224,973	185,595	-39,378	49%	49%	50%	46%	-3

Social Determinants	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Housing and Economic	3,588	2,275	1,219	1,563	344	39%	39%	42%	36%	-3
Other Psychosocial Circumstances	193	278	854	687	-167	32%	27%	29%	30%	-2
Primary Support Group and Family	331	471	507	661	154	31%	29%	35%	30%	-1
Employment	85	98	122	425	303	34%	26%	30%	44%	10
Upbringing	275	299	286	256	-30	40%	32%	34%	23%	-17
Social Environment	154	223	267	222	-45	26%	32%	29%	31%	5
Occupational Risk	223	194	150	127	-23	16%	14%	14%	15%	-1
Psychosocial Circumstances	9	9	33	40	7	56%	44%	33%	40%	-16
Education and Literacy	11	41	35	28	-7	73%	24%	14%	11%	-62

Race/Ethnicity	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Asian / Pacific Islander	35,337	36,574	37,356	30,121	-7,235	53%	53%	53%	49%	-4
Black / African American	170,378	168,556	173,264	132,139	-41,125	56%	56%	55%	52%	-4
Hispanic or Latino	675,502	677,820	715,771	564,598	-151,173	55%	55%	56%	50%	-5
White	495,703	470,152	479,869	382,649	-97,220	49%	49%	50%	46%	-3

Riverside County

Category	Visits by Volume 2017	2018	2019	2020	2019-2020 Vol Change	Avoidable Visits 2017	2018	2019	2020	Point Change
Riverside County Total	722,692	707,863	731,694	566,008	-165,686	53%	53%	54%	48%	-4

Top 5 Payers by Volume	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Medicaid (Medi-Cal)	369,094	354,445	360,025	258,450	-101,575	56%	56%	56%	51%	-5
Health Maintenance Organization (HMO)	99,761	95,453	102,074	86,728	-15,346	50%	50%	51%	47%	-3
Health Maintenance Organization (HMO) Medicare Risk	79,783	84,796	93,722	80,684	-13,038	50%	50%	51%	46%	-3
Self-Pay	51,632	51,932	52,501	41,950	-10,551	50%	50%	51%	47%	-2
Medicare Part B	51,415	50,393	49,472	37,594	-11,878	50%	50%	53%	47%	-3

Age Groups	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Under 1 Year	20,304	18,727	19,633	10,687	-8,946	65%	65%	64%	57%	-8
1–17 Years	147,905	140,679	147,542	81,081	-66,461	56%	56%	57%	51%	-5
18 – 34 Years	192,052	187,464	190,596	159,992	-30,604	51%	51%	51%	47%	-4
35 – 64 Years	248,295	244,679	250,933	213,910	-37,023	53%	53%	54%	49%	-4
65 Years or Greater	114,136	116,314	122,990	100,338	-22,652	49%	49%	51%	46%	-3

Social Determinants	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	Point Change
Housing and Economic	1,611	955	789	918	129	41%	41%	45%	40%	-2
Employment	38	32	41	305	264	29%	19%	32%	47%	18
Primary Support Group and Family	129	172	190	278	88	36%	30%	43%	34%	-1
Social Environment	80	97	103	105	2	25%	36%	37%	35%	10
Upbringing	88	125	115	94	-21	36%	33%	37%	19%	-17
Other Psychosocial Circumstances	107	70	57	94	37	36%	24%	30%	27%	-9
Occupational Risk	109	101	86	66	-20	17%	17%	13%	14%	-3
Education and Literacy	1	10	6	9	3	100%	20%	33%	11%	-89
Psychosocial Circumstances	1	1	1	5	4	100%	100%	0%	100%	0

Race/Ethnicity	2017	2018	2019	2020	2019-2020 Vol Change	2017	2018	2019	2020	% Change
Asian / Pacific Islander	16,231	16,788	18,073	13,910	-4,163	54%	54%	54%	49%	-5
Black / African American	73,337	72,729	73,012	55,053	-17,959	56%	55%	56%	52%	-4
Hispanic or Latino	322,456	323,957	344,199	262,771	-81,428	55%	55%	56%	50%	-6
White	274,728	260,039	259,377	204,788	-54,589	49%	49%	50%	46%	-4

San Bernardino County

Category	Visits by Volume 2017	2018	2019	2020	2019-2020 Vol Change	Avoidable Visits 2017	2018	2019	2020	Point Change
San Bernardino County Total	676,939	664,846	683,844	550,739	-133,105	53%	53%	54%	49%	-4
Top 5 Payers by Volume										
Medicaid (Medi-Cal)	361,307	347,197	344,961	257,199	-87,762	57%	57%	57%	53%	-4
Health Maintenance Organization (HMO)	102,691	102,832	107,626	94,372	-13,254	51%	52%	52%	48%	-4
Health Maintenance Organization (HMO) Medicare Risk	71,096	72,678	80,421	67,675	-12,746	49%	49%	49%	47%	-2
Self-Pay	42,910	42,582	45,792	39,899	-5,893	51%	51%	52%	48%	-3
Medicare Part B	37,178	37,259	36,678	28,674	-8,004	50%	51%	51%	48%	-3
Age Groups										
Under 1 Year	21,468	19,537	19,496	11,314	-8,182	66%	65%	65%	60%	-6
1–17 Years	143,863	135,957	140,721	81,323	-59,398	58%	57%	59%	52%	-6
18 – 34 Years	192,838	188,739	192,914	168,410	-24,504	52%	52%	51%	48%	-4
35 – 64 Years	235,274	235,348	238,311	212,727	-25,584	53%	53%	53%	50%	-3
65 Years or Greater	83,496	85,265	92,402	76,965	-15,437	49%	49%	49%	46%	-3
Social Determinants										
Other Psychosocial Circumstances	78	203	771	577	-194	24%	27%	30%	30%	6
Housing and Economic	1,808	1,220	363	540	177	38%	38%	35%	31%	-7
Primary Support Group and Family	189	269	294	331	37	29%	28%	29%	27%	-1
Upbringing	171	158	150	137	-13	44%	31%	30%	26%	-18
Employment	43	59	76	112	36	37%	31%	30%	38%	1
Social Environment	60	112	151	98	-53	28%	28%	25%	26%	-3
Occupational Risk	79	66	45	34	-11	18%	17%	22%	24%	6
Psychosocial Circumstances	7	8	31	30	-1	43%	38%	35%	33%	-10
Education and Literacy	9	26	23	16	-7	67%	27%	9%	13%	-54
Race/Ethnicity										
Asian / Pacific Islander	16,893	17,465	16,856	14,103	-2,753	53%	52%	52%	49%	-5
Black / African American	89,084	87,823	92,064	70,081	-21,983	56%	56%	56%	53%	-4
Hispanic or Latino	323,197	323,383	338,915	273,318	-65,597	55%	56%	56%	50%	-6
White	195,656	185,139	195,642	156,839	-38,803	49%	49%	49%	46%	-4

Appendix P provides hospital-level data on avoidable ED visits.

Appendix D: In-Depth Description of the IP3 | Assess Tool

IP3 | Assess is a web-based data platform that allows users to combine and compare data from different sources, surface community insights, align data across organizations and sectors and use information to guide community action. IP3 | Assess was originally designed by IP3 (Institute for People, Place, and Possibility) in partnership with Kaiser Permanente to support the community health needs assessment (CHNA) process. The platform is now being used to support broader assessment needs among statewide and local community coalitions throughout the nation.

The platform's three main features help users identify and prioritize community needs: data frameworks, z-score analyses, integration of qualitative data and stakeholder engagement through IP3 | Assess Reports.

Data Frameworks

IP3 | Assess automatically applies data frameworks to help analyze and present indicators that are organized in an actionable way. Data frameworks are a series of "domains" or categories; each domain is populated by multiple data indicators from a variety of sources that are updated as new information is released. Data frameworks can translate data into solutions by sorting indicators into categories that both are more easily connected to real-life programming and can inform planning efforts.

Long lists of indicators alone fail to shed light on levers that organizations can actually pull to improve their community. Instead, computing scores for both individual indicators and composite scores for each domain in a framework allows users to compare data not traditionally comparable.

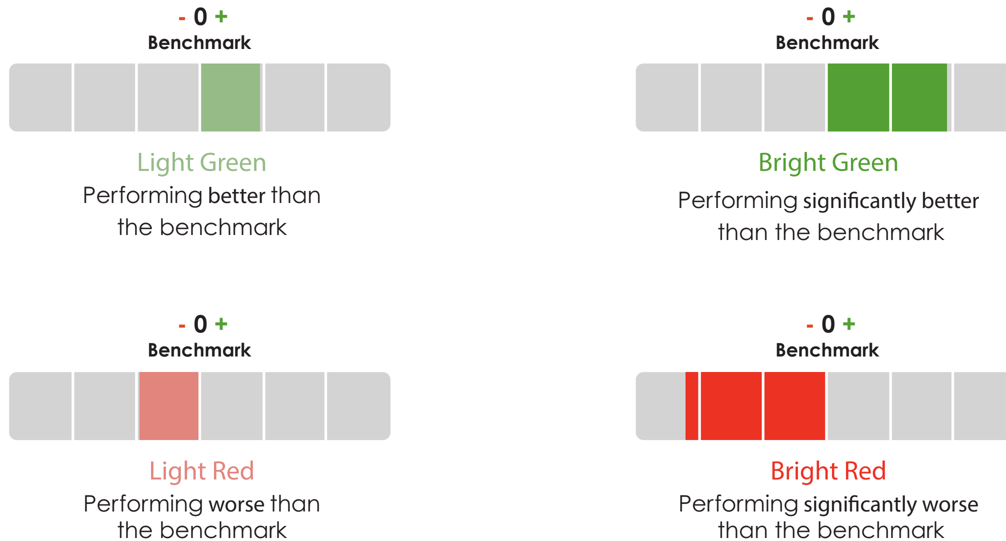
For example, a community may have an above-average commute time, with a disproportionate effect on low-income residents, and the community's rate of unemployment may also be higher than average. But what does that mean for that community's implementation plan? IP3 | Assess can compare the relative score for transportation to the relative score for meaningful work and wealth, which can in turn help guide decision-making around the best area in which to invest.

Users can also drill down indicators in each domain (see Appendix D) to identify specific focus areas and prioritize efforts. They can toggle between different geographies to see how scores vary across service areas and explore any different driving factors for good and bad composite domain scores.

Z-Score Analysis

IP3 | Assess uses a z-score approach to score individual indicators and data across domains in frameworks. Z-scores show where the score lies on a normal distribution curve. "Fuel gauge" visualizations depict z-scores relative to the selected benchmark (such as the corresponding state or national value). In this way, users can see how a given community or geographic area performs relative to the state or nation. This allows an apples-to-apples comparison of data from a variety of sources and with a variety of units and collection methods. It also builds in prioritization for improvement efforts (similar to the County Health Rankings methodology).

The fuel gauge provides users with a clear view of how an area performs for specific indicators or domains compared to a benchmark. The gauge shows up bright red if an indicator or domain scores significantly worse than the benchmark, light red or light green if the data are not significantly different (within one standard deviation) from the benchmark and bright green if the data are significantly better than the benchmark.



IP3 | Assess Reports

Quantitative data do not tell the whole story of what is happening in a community or service area.

Therefore, qualitative data can be collected through key informant interviews and/or community conversations, alongside stories from people with lived experience in a community. These data give a fuller picture of what life is really like in a given community and prompt decision-makers to consider more than just quantitative data when setting priorities.

IP3 | Assess reports include additional data information to provide a more complete picture of the community and the domains.

Appendix E: Stakeholder Committee Ranking of Priorities

During the April 19, 2022, strategy session, the 2022 Inland Empire CHNA Stakeholder Committee members ranked burden of disease areas and vital conditions, using five questions as ranking guides. The responses were used to identify priorities for the Inland Empire regional CHNA. Below are the top-voted responses under each question.

Burden of Disease

Q1. How acute is each need?

Cardiovascular disease and diabetes

Mental and behavioral health

Respiratory diseases

Maternal and infant health

Cancer

Q2. Are there energy, capacity and resources for improving the need?

Cardiovascular disease and diabetes

Mental and behavioral health

Respiratory disease

Maternal and infant health

Infectious disease

Q3. Does the issue disproportionally affect certain populations?
(Consider race, ethnicity, income, geography and education.)

Cardiovascular disease and diabetes

Mental and behavioral health

Maternal and infant health

Infectious disease

Q4. Are there investment opportunities for collaborative partners and/or practice — or evidence-based approaches to address these needs?

Mental and behavioral health

Cardiovascular disease and diabetes

Maternal and infant health

Infectious disease

Injury and violence

Q5. Has COVID-19 impacted the area of focus?

Mental and behavioral health

Cardiovascular disease and diabetes

Maternal and infant health

Oral health

Respiratory disease

Seven Vital Conditions

Q1. How acute is each need?

Basic needs for health and safety

Humane housing

Meaningful work and wealth

Lifelong learning

Thriving natural world

Q2. Are there energy, capacity and resources for improving the need?

Basic needs for health and safety

Humane housing

Meaningful work and wealth

Lifelong learning

Reliable transportation

Q3. Does the issue disproportionally affect certain populations?
(Consider race, ethnicity, income, geography and education)

Basic needs for health and safety

Humane housing

Meaningful work and wealth

Lifelong learning

Reliable transportation

Q4. Are there investment opportunities for collaborative partners and/or practice — or evidence-based approaches to address these needs?

Basic needs for health and safety

Humane housing

Meaningful work and wealth

Reliable transportation

Civic muscle and belonging

Q5. Has COVID-19 impacted the area of focus?

Basic needs for health and safety

Meaningful work and wealth

Humane housing

Civic muscle and belonging

Reliable transportation

Appendix F: Cardiovascular Disease and Diabetes Indicator Report

To access the full data report, which includes population breakouts where available, click to view Cardiovascular Disease & Diabetes. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: *Indicators that are worse than the state benchmark are noted in red. The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.*

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Obesity - *percentage of adults 18+ with BMI of 30 or above*							
27.5	32.6	31.2	32.6	28.5	31.2	31.8	31.2

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High cholesterol - *percentage of adults 18+ reporting high cholesterol*							
30.2	36.2	36.2	30.1	29.6	31.8	34.2	36.2

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Current smoking - *percentage of adults 18+ who report smoking 100+ cigarettes in their lifetime, and currently smoke daily or some days*							
13.4	14.8	12.8	15.5	13.8	14.7	14.3	12.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Hypertension deaths - *Number of deaths due to hypertensive heart disease per 100,000 people*							
14.0	22.7	20.8	24.5	12.3	21.7	22.7	20.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Heart attack deaths - *number of deaths due to acute myocardial infarction per 100,000 people*							
25.8	25.8	27.0	24.8	25.9	26.5	25.9	27.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Heart failure deaths - *number of deaths due to heart failure per 100,000 people*							
19.4	21.8	22.8	20.8	21.4	22.3	21.4	22.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Diagnosed stroke - *percentage of adults 18+ who have ever been diagnosed with a stroke*							
3.2	3.1	4.0	3.0	3.4	3.3	3.7	4.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High blood pressure - *percentage of adults 18+ who have been told they have hypertension*							
28.7	29.9	36.3	28.0	29.1	30.8	33.8	36.3

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High blood pressure management - *percentage of adults 18+ with diagnosed hypertension who report taking hypertension medication*							
67.1	67.4	72.6	66.6	66.9	69.4	70.8	72.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Heart disease among Medicare beneficiaries - *percentage of Medicare beneficiaries with ischemic heart disease*							
22.2	24.5	25.0	24.0	No data	24.8	25.4	25.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Heart disease - *percentage of adults 18+ who have been told they have angina or coronary heart disease*							
5.5	5.2	5.2	7.4	5.7	5.7	6.6	7.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Heart disease hospitalizations among Medicare beneficiaries - *number of hospitalizations for heart disease per 1,000 Medicare beneficiaries*							
55.7	61.5	56.9	67.1	66.6	63.5	62.0	56.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Diagnosed diabetes - *percentage of adults 20+ who have been told they have diabetes (including gestational)*							
9.4	10.4	10.4	10.4	9.5	10.2	10.2	10.2

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Diabetes management - *percentage of diagnosed Medicare beneficiaries having an annual A1c test*							
81.9	78.6	80.4	76.0	81.2	75.9	78.6	80.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Diabetes death - *number of deaths due to type 2 diabetes per 100,000 people*							
17.7	22.8	15.7	29.8	21.1	19.2	22.8	15.7

Appendix G: Mental and Behavioral Health Indicator Report

To access the full data report, which includes population breakouts where available, click to view Mental & Behavioral Health. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: *Indicators that are worse than the state benchmark are noted in red. The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.*

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Poor mental health days - *age-adjusted number of reported mentally unhealthy days per month*							
4.2	4.5	4.5	4.5	4.3	4.4	4.5	4.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Frequent mental distress - *percentage of adults 18+ who report 14+ days of poor mental health per month*							
13.6	14.9	13.0	15.1	14.0	14.5	14.0	13.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Self-harm deaths - *age-adjusted number of self-harm deaths per 100,000 people*							
14.7	10.7	10.5	11.0	8.0	10.8	10.7	10.5

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Mental health care providers — *number of mental health care providers per 100,000 people*							
373.3	229.9	217.1	242.7	362.6	223.5	229.9	217.1

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Health Professional Shortage Area (HPSA) — Mental Health - *percentage of population that is underserved by mental health providers*							
23.9	30.4	30.4	30.4	22.1	21.7	33.4	36.3

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Drug use disorder deaths - *age-adjusted number of drug use disorder deaths per 100,000*							
8.8	10.1	10.9	9.1	5.8	9.7	10.0	10.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Depression among Medicare beneficiaries - *percentage of Medicare beneficiaries with diagnosed depression*							
14.7	15.0	15.0	15.0	No data	15.8	15.5	16.0

Appendix H: Infant and Maternal Health Indicator Report

To access the full report, which includes population breakouts where available, click to view Maternal & Infant Health. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: *Indicators that are worse than the state benchmark are noted in red. The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.*

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Infant death - *number of deaths in infants younger than one year per 1,000 live births*							
4.2	5.1	4.2	5.9	3.9	4.7	5.1	4.3

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Low birthweight - *percentage of births with low birthweight*							
6.9	7.1	6.8	7.4	7.2	7.0	7.1	6.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Tobacco use during pregnancy - *percentage of births for which tobacco use is a maternal risk factor*							
1.3	2.0	1.7	2.2	0.6	1.8	2.0	1.7

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Pre-term births - *percentage of births occurring before the 37th week of pregnancy*							
9.1	9.5	9.1	10.0	9.5	9.7	9.6	9.1

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Early prenatal care - *percentage of births for which prenatal care began in the first trimester*							
85.5	84.5	84.7	84.2	86.0	84.4	84.5	84.7

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Teen births - *number of infants per 1,000 to females aged 15–19*							
26.2	23.5	20.7	26.3	19.2	22.1	23.5	20.7

Appendix I: Basic Needs for Health and Safety Indicator Report

To access the full report, which includes population breakouts where available, click to view Basic Needs for Health and Safety. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: *Indicators that are worse than the state benchmark are noted in red. The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.*

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Grocery stores - *number of grocery stores per 1,000 population*							
0.2	0.1	0.1	0.1	0.2	0.1	0.1	0.1

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Low food access - *percentage of the population living beyond one mile (urban) or 10 miles (rural) from a supermarket*							
29.4	36.3	34.7	38.5	25.6	35.4	25.8	34.3

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Food insecurity - *percentage of the population that is food insecure*							
10.0	9.3	9.0	9.6	10.7	9.2	9.3	9.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Health Professional Shortage Area (HPSA) — Mental Health - *percentage of the population that is underserved by mental health providers*							
23.9	33.5	36.3	30.4	22.1	21.7	33.4	36.3

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Health Professional Shortage Area (HPSA) — Primary Care – *percentage of the population that is underserved by primary care providers*							
26.4	38.2	39.6	38.1	36.0	11.1	39.1	39.6

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Health Professional Shortage Area (HPSA) — Dental – *percentage of the population that is underserved by dental health providers*							
76.0	79.3	80.1	79.1	86.9	100.0	78.0	80.1

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Insured adults - *percentage of uninsured adults 18–65*							
88.0	85.7	85.6	86.2	84.9	88.7	86.2	85.6

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Recent primary care visit - *percentage of adults 18+ who have had a routine checkup in the past year*							
70.7	69.1	74.2	68.4	71.7	70.3	71.8	74.2

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High blood pressure management - *percentage of adults 65+ who have high blood pressure and are taking medicine for it*							
67.1	67.4	72.8	66.6	66.9	69.4	70.8	72.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Exercise opportunities - *percentage of population with access to areas for physical activity*							
86.1	86.6	88.9	84.4	97.7	87.8	86.6	88.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Breast cancer screening - *percentage of females 50–74 who have had a mammogram within the past two years*							
77.9	76.4	76.4	76.5	78.5	76.3	76.5	76.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Premature death - *Age-adjusted number of years of potential life lost (YPLL) (under age 75) per 100,000 population*							
5,292.9	6,344.0	5,842.4	6,845.6	5,005.0	6,093.2	6,344.0	5,842.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Population with any disability – *percentage of the population with a disability*							
10.6	12.2	11.6	11.8	10.0	13.5	11.3	11.6

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Life expectancy at birth – *estimated life expectancy at birth*							
81.7	79.9	80.9	78.8	82.4	80.4	79.9	80.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Violent crimes – *number of reported violent crimes per 100,000 people*							
418	358.8	291.0	442.0	488.0	389.3	366.5	291.0

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Binge drinking - *percentage of adults 18+ who report an occasion of binge drinking in the past month*							
17.8	17.3	15.0	17.2	17.4	16.9	15.9	15.0

Appendix J: Humane Housing Indicator Report

To access the full report, which includes population breakouts where available, click to view Humane Housing. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: *Indicators that are worse than the state benchmark are noted in red. The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.*

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High housing costs - *percentage of occupied housing units for which housing costs are greater than 30% of household income*							
42.1	40.6	39.7	40.7	47.4	36.3	39.2	39.7

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Multi-family housing - *percentage of housing structures with two or more units per structure*							
23.5	18.2	11.9	19.8	29.5	18.9	19.8	11.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Incomplete plumbing or kitchen facilities - *percentage of occupied housing units that lack plumbing or kitchen facilities*							
1.3	1.0	0.9	1.1	1.2	1.4	1.0	0.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Overcrowded housing - *percentage of housing units with more than one occupant per room*							
12.0	8.4	10.7	9.4	16.6	5.4	9.3	10.7

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Residential segregation (Black/White) — *Index of dissimilarity – between 0 (complete integration) and 100 (complete segregation) representing residential segregation between Black and White residents*							
49.1	38.0	39.4	36.7	56.3	38.7	38.0	39.4

Appendix K: Meaningful Work and Wealth Indicator Report

To access the full report, which includes population breakouts where available, click to view Meaningful Work and Wealth. Use the drop-down menu at the top right of the screen to select the region you wish to view, and toggle between the state and national benchmarks under each fuel gauge to see how the comparison changes.

NOTES: *Indicators that are worse than the state benchmark are noted in red. The below indicators were published prior to June 1, 2022; data on the live links will be updated as new data become available.*

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Absolute upward mobility - *expected income by percentile rank for children whose parents are at the 25th percentile of the national income distribution*							
46.2	45.2	45.4	44.9	44.4	45.0	45.1	45.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Public assistance - *percentage of families with cash public assistance or Supplemental Nutrition Assistance Program (SNAP) benefits in the past 12 months*							
13.3	15.4	14.6	18.6	14.0	13.6	17.6	14.6

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Income inequality — Gini coefficient - *statical dispersion of income distribution; the higher the Gini coefficient, the greater the gap between the incomes of an area's richest and poorest people.*							
0.4	0.0	0.0	0.0	0.4	0.4	0.4	0.4

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
High-paying jobs - *percentage of jobs within five miles with earnings greater than $3,333 per month (2015 numbers are most recent available)*							
50.4	37.3	39.8	38.9	47.5	35.9	40.5	39.8

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Unemployment - *annual percentage of the labor force that is unemployed*							
10.0	9.7	9.9	9.4	12.3	9.8	9.7	9.9

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Median household income - *median household income for the population*							
$83,398	$67,326	$69,261	$64,943	$74,027	$67,337	$79,461	$71,277

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Homeownership - *percentage of occupied housing units with owner occupants*							
54.8	62.9	66.3	59.6	45.8	63.5	63.1	66.3

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Poverty - *percentage of adults over 18 whose incomes are below the federal poverty level*							
13.4	15.5	14.5	16.7	13.4	15.3	11.7	13.7

State Benchmark	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital
Child poverty - *percentage of children under 18 who live below the federal poverty level*							
16.9	18.3	18.3	18.3	18.3	15.1	13.8	17.0

Appendix L: IP3 | Assess Burden of Disease Categories and Indicators with Source List

Indicators in the Burden of Disease Framework

Learn more at www.i-p3.org Updated February 2021

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years
Brain health	Alzheimer's Disease	Number of deaths due to Alzheimer's disease per 100,000 population	CDC WONDER	County	2020
	Parkinson's Disease	Number of deaths due to Parkinson's disease per 100,000 population	CDC WONDER	County	2020
	Hemorrhagic Stroke Deaths	Age-adjusted number of deaths due to hemorrhagic strokes per 100,000 population	Institute for Health Metrics and Evaluation	County	2020
	Ischemic Stroke Deaths	Age-adjusted number of deaths due to hemorrhagic strokes per 100,000 population	Institute for Health Metrics and Evaluation	County	2020
Brain health; Cardiovascular diseases	Stroke Deaths	Number of deaths due to strokes (includes transient cerebral ischaemic attacks and related syndromes, central retinal artery occlusion, subarachnoid haemorrhage, intracerebral haemorrhage, other nontraumatic intracranial haemorrhage, cerebral infarction and stroke not specified as haemorrhage or infarction) per 100,000 population	CDC WONDER	County	2020
Cancers	Diagnosed Cancer	Percentage of adults aged 18 years and older who report ever being told by a health-care provider that they have cancer (excludes skin cancer)	Places	Tract	2014, 2015, 2016, 2017, 2018, 2019
	Cancer Deaths	Number of deaths due to cancer (all sites) per 100,000 population	CDC WONDER	County	2020
	Breast Cancer Deaths	Number of deaths due to breast cancer per 100,000 females	CDC WONDER	County	2020
	Cervical Cancer Deaths	Number of deaths due to cervical cancer per 100,000 females	CDC WONDER	County	2020
	Colorectal Cancer Deaths	Number of deaths due to cancers of the colon, rectosigmoid junction and rectum per 100,000 population	CDC WONDER	County	2020
	Lung Cancer Deaths	Number of deaths due to cancers of the bronchus and lung per 100,000 population	CDC WONDER	County	2020
	Prostate Cancer Deaths	Number of deaths due to prostate cancer per 100,000 males	CDC WONDER	County	2020
	Breast Cancer Incidence	5-year age-adjusted average number of new breast cancer cases (all stages) among women per 100,000 population	NIH State Cancer Profiles	County	2018
	Cancer Incidence	5-year age-adjusted average number of new cancer cases (all stages) per 100,000 population	NIH State Cancer Profiles	County	2018
	Cervical Cancer Incidence	5-year age-adjusted average number of new cervical cancer cases (all stages) among women per 100,000 population	NIH State Cancer Profiles	County	2018
	Colon and Rectum Cancer Incidence	5-year age-adjusted average number of new colon and rectum cancer cases (all stages) per 100,000 population	NIH State Cancer Profiles	County	2018
	Lung Cancer Incidence	5-year age-adjusted average number of new lung cancer cases (all stages) per 100,000 population	NIH State Cancer Profiles	County	2018
	Prostate Cancer Incidence	5-year age-adjusted average number of new prostate cancer cases (all stages) among men per 100,000 population	NIH State Cancer Profiles	County	2018

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years
Cancers; Cardiovascular diseases; Diabetes	Obesity	Percentage of adults aged 18 years and older with obesity (BMI of 30 or above)	Places	Tract	2014, 2015, 2016, 2017, 2018, 2019
Cancers; Cardiovascular diseases; Respiratory diseases	Current Smoking	Percentage of adults aged 18 years and older who report having smoked 100 or more cigarettes in their lifetime, and currently smoke every day or some days	Places	Tract	2014, 2015, 2016, 2017, 2018, 2019
Cardiovascular diseases	High Blood Pressure Management	Percentage of adults aged 18 years and older with high blood pressure who report taking medicine for high blood pressure	Places	Tract	2013, 2015, 2017, 2019
	Heart Disease	Percentage of adults aged 18 years and older who report ever being told by a health-care provider that they have angina or coronary heart disease	Places	Tract	2014, 2015, 2016, 2017, 2018, 2019
	Diagnosed Stroke	Percentage of adults aged 18 years and older who report ever being told by a health-care provider that they had a stroke	Places	Tract	2014, 2015, 2016, 2017, 2018, 2019
	High Blood Pressure	Percentage of adults aged 18 years and older who report ever being told by a health-care provider that they have high blood pressure (excludes high blood pressure occurring only during pregnancy and borderline hypertension)	Places	Tract	2013, 2015, 2017, 2019
	High Cholesterol	Percentage of adults aged 18 years and older who report ever being told by a health-care provider that they have high cholesterol	Places	Tract	2013, 2015, 2017, 2019
	Heart Disease Deaths	Number of deaths due to ischaemic heart diseases (e.g., angina pectoris, acute and subsequent myocardial infarction, certain current complications following acute myocardial infarction and other acute and ischaemic heart diseases) per 100,000 population	CDC WONDER	County	2020
	Heart Attack Deaths	Number of deaths due to acute myocardial infarction per 100,000 population	CDC WONDER	County	2020
	Heart Failure Deaths	Number of deaths due to heart failure per 100,000 population	CDC WONDER	County	2020
	Hypertension Deaths	Number of deaths due to hypertensive heart disease per 100,000 population	CDC WONDER	County	2020
	Heart Disease	Percentage of Medicare beneficiaries with ischemic heart disease	Mapping Medicare Disparities Tool	County	2018, 2019, 2008
	Heart Attack Hospitalization	Number of hospitalizations among adults aged 35 years and older for acute myocardial infarction (heart attack) per 10,000 population	National Environmental Public Health Tracking Network	County	2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018
	Heart Disease Hospitalizations	Number of hospitalizations for coronary heart disease per 1,000 Medicare beneficiaries aged 65 years and older	Interactive Atlas of Heart Disease and Stroke	County	2016
Diabetes	Diabetes Deaths	Number of deaths due to type 2 diabetes per 100,000 population	CDC WONDER	County	2020
	Diabetes Management	Percentage of diabetic Medicare enrollees aged 65–75 years having an annual hemoglobin A1c test	Dartmouth Atlas of Health Care	County	2015
	Diagnosed Diabetes	Percentage of adults aged 20 years and older who report ever being told by a health-care provider that they have diabetes (excludes gestational diabetes)	US Diabetes Surveillance System	County	2016, 2017, 2018, 2019
	Newly Diagnosed Diabetes	Age-adjusted number of new diabetes diagnoses among adults aged 20 years and older per 1,000 population	US Diabetes Surveillance System	County	2016, 2017, 2018

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years
HIV/AIDS and STIs	HIV/AIDS Deaths	Number of deaths due to human immunodeficiency virus (HIV) disease per 100,000 population	CDC WONDER	County	2020
	Active Syphilis	Number of new active syphilis cases per 100,000 population	CDC AtlasPlus	County	2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019
	Chlamydia	Number of new chlamydia cases per 100,000 population	CDC AtlasPlus	County	2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019
	Congenital Syphilis	Number of new congenital syphilis cases per 100,000 population	CDC AtlasPlus	County	2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017
	Gonorrhea	Number of new gonorrhea cases per 100,000 population	CDC AtlasPlus	County	2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019
	HIV Diagnoses	Number of HIV diagnoses per 100,000 population	CDC AtlasPlus	County	2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019
	HIV Prevalence	Number of HIV cases per 100,000 population	CDC AtlasPlus	County	2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019
	Latent Syphilis	Number of new latent syphilis cases per 100,000 population	CDC AtlasPlus	County	2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019
	HIV/AIDS Deaths	Age-adjusted number of HIV/AIDS deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
IEHP: Cardiovascular diseases	Hypertension Admissions	Admissions with a principal diagnosis of hypertension per 100,000 adults aged 18 years and older	SpeedTrack	County	2018, 2019, 2020
	Heart Failure Admissions	Admissions with a principal diagnosis of heart failure per 100,000 adults aged 18 years and older	SpeedTrack	County	2018, 2019, 2020

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years
IEHP: Diabetes	Short-Term Diabetes Complications	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity or coma) per 100,000 adults aged 18 years and older	SpeedTrack	County	2018, 2019, 2020
	Long-Term Diabetes Complications	Admissions for a principal diagnosis of diabetes with long-term complications (renal, eye, neurological, circulatory or complications not otherwise specified) per 100,000 population	SpeedTrack	County	2018, 2019, 2020
	Uncontrolled Diabetes Admissions	Admissions with a principal diagnosis of diabetes without mention of short-term or long-term complications per 100,000 adults aged 18 years and older	SpeedTrack	County	2018, 2019, 2020
	Lower-Extremity Amputation	Lower-extremity amputations (excludes toe amputations) with diabetes diagnosis per 100,000 adults aged 18 years and older	SpeedTrack	County	2018, 2019, 2020
	Chronic Admissions	Admissions with one or more of the following chronic conditions per 100,000 adults aged 18 years and older: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension or heart failure without a cardiac procedure	SpeedTrack	County	2018, 2019, 2020
IEHP: Infectious diseases	Community-Acquired Pneumonia Admissions	Admissions with a principal diagnosis of community-acquired bacterial pneumonia per 100,000 adults aged 18 years and older	SpeedTrack	County	2018, 2019, 2020
IEHP: Respiratory diseases	COPD or Asthma Admissions	Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 adults aged 40 years and older	SpeedTrack	County	2018, 2019, 2020
	Asthma Admissions	Admissions with a principal diagnosis of asthma per 100,000 aged 18 to 39 years	SpeedTrack	County	2018, 2019, 2020
IEHP: TRUE	Urinary Tract Infection Admissions	Admissions with a principal diagnosis of urinary tract infection per 100,000 adults aged 18 years and older	SpeedTrack	County	2018, 2019, 2020
	Acute Admissions	Admissions with one or more of the following acute conditions per 100,000 adults aged 18 years and older: bacterial pneumonia or urinary tract infection	SpeedTrack	County	2018, 2019, 2020
	Diabetes Admissions	Admissions with one or more of the following diabetic conditions per 100,000 adults aged 18 years and older: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation	SpeedTrack	County	2018, 2019, 2020
	Overall Admissions	Admissions with one or more of the following conditions per 100,000 adults aged 18 years and older: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia or urinary tract infection	SpeedTrack	County	2018, 2019, 2020
Infectious diseases	Pneumonia and Influenza Deaths	Number of deaths due to pneumonia and influenza per 100,000 population	CDC WONDER	County	2020
	Tuberculosis	Number of new tuberculosis cases per 100,000 population	CDC AtlasPlus	County	2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019
	Flu Vaccination	Percentage of Medicare enrollees who had an annual flu vaccination	County Health Rankings	County	2016, 2017

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years
	Pneumonia Vaccination	Percentage of Medicare beneficiaries who had pneumonia vaccination	Mapping Medicare Disparities Tool	County	2018, 2019, 2010
	Tuberculosis Deaths	Age-adjusted number of tuberculosis deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Meningitis Deaths	Age-adjusted number of meningitis deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Hepatitis Deaths	Age-adjusted number of hepatitis deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Diarrheal Disease Deaths	Age-adjusted number of diarrheal disease deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
Injury and violence	Opioid Overdose Deaths	Number of deaths for which opioids, including opium, heroin, methadone and other opioids and synthetic narcotics, were a contributing cause	CDC WONDER	County	2019
	Intentional Self-Harm Deaths	Number of deaths due to intentional self-harm, including intentional poisonings due to drugs and alcohol, per 100,000 population	CDC WONDER	County	2020
	Violent Crimes	Number of reported violent crime offenses per 100,000 population	County Health Rankings	County	2014, 2016
	Motor Vehicle Crash Deaths	Number of deaths due to traffic collisions involving a motor vehicle per 100,000 population	County Health Rankings	County	2015, 2016, 2017, 2018, 2019
	Alcohol-Impaired Driving Deaths	Percentage of driving deaths with alcohol involvement	County Health Rankings	County	2015, 2016, 2017, 2018, 2019
	Injury Deaths	Number of deaths due to injury per 100,000 population	County Health Rankings	County	2015, 2016, 2017, 2018, 2019
	Drug Overdose Deaths	Number of deaths due to drug poisoning per 100,000 population	County Health Rankings	County	2015, 2016, 2017, 2018, 2019
	Gun Deaths	Number of deaths due to firearms per 100,000 population	County Health Rankings	County	2015, 2016, 2017, 2018, 2019
	Interpersonal Violence Deaths	Number of deaths due to homicide per 100,000 population	County Health Rankings	County	2015, 2016, 2017, 2018, 2019
	Interpersonal Violence Deaths	Age-adjusted number of interpersonal violence deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
Kidney diseases	Chronic Kidney Disease	Percentage of adults aged 18 years and older who report ever being told by a health-care provider that they have kidney disease	PLACES	Tract	2014, 2015, 2016, 2017, 2018, 2019
	Renal Failure Deaths	Number of deaths due to renal failure per 100,000 population	CDC WONDER	county	2020
Maternal and infant health	Pre-Term Births	Percent of births occurring before the 37th week of pregnancy	CDC WONDER	county	2019
	Early Prenatal Care	Percent of births for which prenatal care began in the first trimester	CDC WONDER	county	2019
	Tobacco Use During Pregnancy	Percent of births for which tobacco use is a maternal risk factor	CDC WONDER	county	2019

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years
	Low Birthweight	Percentage of live births with low birthweight (less than 2,500 grams)	County Health Rankings	County	2016, 2017, 2018, 2019
	Teen Births	Number of births per 1,000 females aged 15–19 years	County Health Rankings	County	2014, 2016, 2017, 2018
	Infant Deaths	Number of deaths among infants (less than one year of age) per 1,000 live births	County Health Rankings	County	2013, 2016, 2017, 2018, 2019
Mental + behavioral health	Frequent Mental Distress	Percentage of adults aged 18 years and older who report 14 or more days of poor mental health per month	PLACES	Tract	2014, 2015, 2016, 2017, 2018, 2019
	Mental Health Care Providers	Number of mental health care providers per 100,000 population	County Health Rankings	County	2016, 2017, 2018, 2019, 2020
	Poor Mental Health Days	Age-adjusted average number of reported mentally unhealthy days per month	County Health Rankings	County	2015, 2016, 2017, 2018
	Health Professional Shortage Area	Federally designated area that indicates health provider shortages in mental health care; indicator displays the percent of population that is underserved	HRSA	Tract	2019
	Depression — Medicare	Percentage of Medicare beneficiaries with diagnosed depression	Mapping Medicare Disparities Tool	County	2015, 2016, 2017, 2018
	Alcohol Use Disorder Deaths	Age-adjusted number of alcohol use disorder deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Drug Use Disorder Deaths	Age-adjusted number of drug use disorder deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Self-Harm Deaths	Age-adjusted number of self-harm deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
Oral health	Recent Dental Visit	Percentage of adults aged 18 years and older who report having been to the dentist or dental clinic in the past year	PLACES	Tract	2014, 2016, 2018
	Teeth Loss	Percentage of adults aged 65 years and older who report having lost all of their natural teeth because of tooth decay or gum disease	PLACES	Tract	2014, 2016, 2018
	Oral Cancer Deaths	Number of deaths due to cancers of the lip, oral cavity and pharynx per 100,000 population	CDC WONDER	County	2020
	Health Professional Shortage Area	Federally designated area that indicates health provider shortages in dental health care; indicator displays the percent of population that is underserved	HRSA	Tract	2019
	Oral Cavity and Pharynx Cancer	5-year age-adjusted average number of new oral cavity and pharynx cases (all stages) per 100,000 population	NIH State Cancer Profiles	County	2018
Respiratory diseases	Current Asthma	Percentage of adults aged 18 years and older who report having asthma	PLACES	Tract	2014, 2015, 2016, 2017, 2018, 2019
	Chronic obstructive pulmonary disease (COPD)	Percentage of adults aged 18 years and older who report ever being told by a health-care provider that they have chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis	PLACES	Tract	2014, 2015, 2016, 2017, 2018, 2019
	Particulate Matter (PM) 2.5 Level	Average annual ambient concentrations of PM 2.5 in micrograms per cubic meter	National Environmental Public Health Tracking Network	County	2018

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years
	Asthma ER Visits	Number of emergency department visits for asthma per 10,000 population	National Environmental Public Health Tracking Network	County	2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018
	Asthma Hospitalizations	Number of hospitalizations for asthma per 10,000 population	National Environmental Public Health Tracking Network	County	2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018
	COPD ER Visits	Number of emergency department visits among adults aged 25 years and older for chronic obstructive pulmonary disease (COPD) per 10,000 population	National Environmental Public Health Tracking Network	County	2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018
	COPD Hospitalizations	Number of hospitalizations among adults aged 25 years and older for chronic obstructive pulmonary disease (COPD) per 10,000 population	National Environmental Public Health Tracking Network	County	2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018
	Chronic Respiratory Disease Death	Age-adjusted number of chronic respiratory disease deaths per 100,000 population	National Environmental Public Health Tracking Network	County	2014
	COPD Deaths	Age-adjusted number of chronic obstructive pulmonary deaths per 100,000 population	National Environmental Public Health Tracking Network	County	2014
	Asbestosis Deaths	Age-adjusted number of asbestosis deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Asthma Deaths	Age-adjusted number of asthma deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Coal Workers Pneumoconiosis Deaths	Age-adjusted number of coal workers pneumoconiosis deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Interstitial Lung Disease Death	Age-adjusted number of interstitial lung disease deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Other Chronic Respiratory Disease	Age-adjusted number of other chronic respiratory disease deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Other Pneumoconiosis Deaths	Age-adjusted number of other pneumoconiosis deaths	Institute for Health Metrics and Evaluation	County	2014
	Pneumoconiosis Deaths	Age-adjusted number of pneumoconiosis deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
	Silicosis Deaths	Age-adjusted number of silicosis deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014
Respiratory diseases; Infectious diseases	Lower Respiratory Infection Deaths	Age-adjusted number of lower respiratory infection deaths per 100,000 population	Institute for Health Metrics and Evaluation	County	2014

Appendix M: IP3 | Assess Vital Conditions of Well-Being and Indicators with Source List

Indicators in the Burden of Disease Framework

Learn more at www.i-p3.org Updated February 2021

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years	R/E Breakouts
Basic Needs for Health and Safety	Exercise Opportunities	Percentage of population with access to locations for physical activity	County Health Rankings	County	2016, 2018, 2019	No
	Food Environment Index	Food Environment Index number — between 0 (worst) and 10 (best) — representing factors that contribute to a healthy food environment	County Health Rankings	County	2016, 2017	No
	Food Insecurity	Percentage of population who are food insecure	Map the Meal Gap	County	2017	No
	Grocery Stores	Number of grocery stores per 1,000 population	County Business Patterns	County	2017	No
	Health Professional Shortage Area — Dental	Federally designated area that indicates health provider shortages in dental health care; indicator displays the percent of population that is underserved	HRSA	Tract	2019	No
	Health Professional Shortage Area — Mental	Federally designated area that indicates health provider shortages in mental health care; indicator displays the percent of population that is underserved	HRSA	Tract	2019	No
	Health Professional Shortage Area — Primary	Federally designated area that indicates health provider shortages in primary care; indicator displays the percent of population that is underserved	HRSA	Tract	2019	No
	High Blood Pressure Management	Percentage of adults aged 18 years and older with high blood pressure who report taking medicine for high blood pressure	PLACES	Tract	2013, 2015, 2017	No
	Insured Adults	Percentage of the civilian noninstitutionalized population aged 19 to 64 years who are insured	American Community Survey	Tract	2018, 2019	No
	Life Expectancy at Birth	Estimated life expectancy at birth	Institute for Health Metrics and Evaluation	County	2014	No
	Low Food Access	Percentage of population with low food access, defined as living beyond 1 mile (urban) or 10 miles (rural) of supermarket	USDA Food Access Research Atlas	Tract	2015	No
	Property Crimes		FBI Uniform Crime Reports			No
	Recent Primary Care Visit	Percentage of adults aged 18 years and older who report having been to a doctor for a routine checkup in the past year	PLACES	Tract	2014, 2015, 2016, 2017, 2018	No
	Violent Crimes	Number of reported violent crime offenses per 100,000 population	County Health Rankings	County	2014, 2016	No
	Breast Cancer Screening	Percentage of women aged 50–74 years who report having had a mammogram within the previous 2 years	PLACES	Tract	2014, 2016, 2018	No
	Population with any Disability	Percentage of the civilian noninstitutionalized population with a disability	American Community Survey	Tract	2018, 2019	No
	Premature Death	Age-adjusted number years of potential life lost (YPLL) (under age 75) per 100,000 population	County Health Rankings	County	2014, 2016, 2017, 2018	No

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years	R/E Breakouts
	Binge Drinking	Percentage of adults aged 18 years and older who report binge drinking (five or more drinks for men, or four or more drinks for women) on a single occasion at least once in the past month	PLACES	Tract	2014, 2015, 2016, 2017, 2018	No
Belonging and Civic Muscle	Cultural, Arts and Entertainment Institutions	Number of cultural, arts and entertainment institutions per 10,000 population	County Business Patterns	County	2018	No
	Libraries	Number of libraries per 10,000 population	Institute of Museum and Library Services	Tract	2018	No
	Population Change	Percentage change in population over a 5-year period	American Community Survey	Tract	2018, 2019	No
	Inadequate Social and Emotional Support	Percentage of adults 18 years and over who report not receiving adequate social-emotional support	County Health Rankings	County	2010	No
	Social Associations	Number of membership associations per 10,000 population	County Business Patterns	County	2017	No
	Voting Participation	Percentage of total voting age population who cast votes in the most recent presidential election	New York Times	County	2020	No
	Youth Not In School, Not Working	Percentage of the population aged 16–19 years who are not enrolled in school and not working	American Community Survey	Tract	2018, 2019	No
	Limited English Proficiency	Percentage of the population aged 5 years and older who speak English less than "very well"	American Community Survey	Tract	2018, 2019	No
	Social Capital Index	Standardized index combining measures of voter turnout rates, the fraction of people who return their census forms and measures of participation in community organizations	Opportunity Insights	County	2016	No
	Computer and Internet Access	Percentage of the population in households with a computer and a broadband internet subscription	American Community Survey	Tract	2019	Yes
	Incarcerated Population	Proportion of the population residing in federal detention centers, federal prisons, state prisons, local jails, residential correctional facilities, military jails or juvenile correctional facilities on the day of the 2010 Census (April 1, 2010)	Opportunity Insights			No
	Census Engagement	Percent of 2010 Census mail forms that were completed and returned	Opportunity Insights	Tract	2010	No
Humane Housing	Accessible Housing	Zero-step entrances	American Housing Survey			No
	High Housing Costs	Percentage of occupied housing units for which housing costs amount to 30% or more of household income	American Community Survey	Tract	2018, 2019	No
	Incomplete Plumbing or Kitchen Facilities	Percentage of occupied housing units that lack complete plumbing or kitchen facilities	CHAS Consolidated Planning/CHAS Data	Tract	2016	No
	Multi-family Housing	Percentage of housing structures with two or more housing units per structure	American Community Survey	County	2018, 2019	No
	Residential Mobility	Percentage of renter-occupied housing units for which the householder moved in within the past year	American Community Survey	Tract	2018, 2019	No

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years	R/E Breakouts
	Overcrowded Households	Percentage of occupied housing units with more than one occupant per room	American Community Survey	Tract	2018, 2019	No
	Residential Segregation — Black/White	Index of dissimilarity — between 0 (complete integration) and 100 (complete segregation) — representing residential segregation between Black and White county residents	County Health Rankings	County	2015, 2016, 2017, 2018	No
	Subsidized Housing		Public and Affordable Housing Research Corporation; National Low Income Housing Coalition's 2015 National Housing Preservation Database; HUD Public Housing Buildings Database		2018	No
	Vacant Housing	Percentage of residential addresses that are vacant	HUD, U.S. Postal Service	Tract	2020	No
Lifelong Learning	Access to Child Care Facilities		County Business Patterns	County		No
	Adult Literacy	Percentage of adults who are illiterate	US Skills Map	County		No
	Adults with at Least Some College	Percentage of the population aged 25 years and older with at least some college	American Community Survey	Tract	2018, 2019	No
	On-Time High School Graduation	Percentage of students who graduate high school within 4 years of entering 9th grade	County Health Rankings	County	2020	No
	Per-Pupil Spending	Amount spent per student in public K–12 schools	Opportunity Insights	County	2016	No
	Preschool Enrollment	Percentage of the population aged 3–4 years who are enrolled in school	American Community Survey	Tract	2018, 2019	No
	Reading Proficiency	Average Reading Language Arts test scores for students in grades 3–8 relative to the national average	Stanford Education Data Archive	County	2016	Yes
	Adults with a High School Diploma	Percentage of the population aged 25 years and older who are high school graduates or higher	American Community Survey	Tract	2019	No
	Math Proficiency	Average math test scores for students in grades 3–8 relative to the national average	Stanford Education Data Archive	County	2018	No
Meaningful Work and Wealth	Absolute Upward Mobility	Expected income by percentile rank for children whose parents are at the 25th percentile of the national income distribution	Opportunity Insights	County	2016	No
	Banking Institutions	Number of banking institutions per 10,000 population	County Business Patterns	County	2017	No
	Child Poverty — Below 100% FPL	Percentage of the population under 18 years of age for whom poverty is determined who are below the federal poverty level (FPL)	American Community Survey	Tract	2018, 2019	No

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years	R/E Breakouts
	Homeownership	Percentage of occupied housing units with owner-occupants	American Community Survey	Tract	2018, 2019	Yes
	Income Inequality — Gini Coefficient	Gini Index of income inequality, a measure of statistical dispersion representing income distribution	American Community Survey	Tract	2018, 2019	No
	Median Household Income	Median household income (in U.S. dollars) for the population	American Community Survey	Tract	2018, 2019	Yes
	Poverty — Below 100% FPL	Percentage of the population for whom poverty is determined who are below the federal poverty level (FPL)	HUD, U.S. Postal Service	Tract	2018, 2019	Yes
	Proximity to Jobs		Opportunity Insights	Tract	2018	No
	Public Assistance	Percentage of families with cash public assistance income or households that received food stamps/ Supplemental Nutrition Assistance Program (SNAP) benefits in the past 12 months	American Community Survey	Tract	2018, 2019	No
	Unemployment	Average annual percentage of the labor force that is unemployed	Bureau of Labor Statistics	Tract	2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019	No
	High-Paying Jobs	Percent of jobs within 5 miles with earnings greater than $3,333 (2015 dollars)	Opportunity Insights	Tract	2015	No
	Income Segregation	Rank-order income segregation index	Opportunity Insights	County	2018	No
	Segregation of Affluence	Rank-order segregation index of highest quartile incomes	Opportunity Insights	County	2016	No
	Segregation of Poverty	Rank-order segregation index of lowest quartile incomes	Opportunity Insights	County	2016	Yes
	Wage Growth	Difference in logarithms between high school graduate wages over a five-year period	Opportunity Insights	Tract	2018	No
	Annualized Job Growth	Average annual percent job growth over a 10-year period	Opportunity Insights	Tract	2013	No
Meaningful Work and Wealth	Active Transportation	Percentage of workers aged 16 years and older who commute to work via public transportation, bicycle or walking	American Community Survey	Tract	2018, 2019	No
	ADA-accessible stations and vehicles		National Transit Database			No
	Commute Time	Mean travel time to work (in minutes) for workers aged 16 years and older who do not work from home	American Community Survey	Tract	2018, 2019	No
	Driving Alone to Work	Percentage of workers aged 16 years and older who drive alone to work	American Community Survey	Tract	2018, 2019	No
	Household Transportation Costs		HUD Location Affordability Index	Tract		No
	Motor Vehicle Crash Deaths	Number of deaths due to traffic collisions involving a motor vehicle per 100,000 population	County Health Rankings	County	2015, 2016, 2017, 2018	Yes
	National Walkability Index	Walkability Score	EPA Smart Location Database	Tract		No

Burden of Disease	Indicator Name	Definition	Source	Granularity	Years	R/E Breakouts
Thriving Natural World	Climate-Related Mortality Impacts	Number of deaths due to climate impacts per 100,000 population	Climate Impact Lab	County	2017	No
	Drinking Water Violations	Presence or absence of water systems violations	County Health Rankings	County	2016, 2017	No
	Flood Vulnerability	Percentage of housing units that are within FEMA-designated flood hazard areas	National Environmental Public Health Tracking Network	County	2011	No
	Developed Land	Percentage of land cover that is developed imperviousness	National Environmental Public Health Tracking Network	Tract	2011, 2016	No
	Extreme Heat	Percentage of days per year for which the daily maximum temperature is at or above the 90th percentile	National Environmental Public Health Tracking Network	Tract	2010, 2011, 2012, 2013, 2014, 2015, 2016	No
	Proximity to Highways	Percentage of the population living within 150 meters, or less than one-tenth mile, of a highway	National Environmental Public Health Tracking Network	County	2010	No
	Ozone Above Regulatory Standard	Number of person-days per year for which ozone levels were above the regulatory standard	National Environmental Public Health Tracking Network	County	2010, 2011, 2012, 2013, 2014	No
	Particulate Matter 2.5 Level	Average annual ambient concentrations of PM 2.5 in micrograms per cubic meter	National Environmental Public Health Tracking Network	County	2010, 2011, 2012, 2013, 2014	No
	Particulate Matter 2.5 Level		City Health Dashboard	Tract		No
	Respiratory Hazards	Respiratory Hazard Index number summarizing total noncancer respiratory hazard risk	EPA National Air Toxics Assessment	Tract	2014	No
	Tree Canopy Cover		National Environmental Public Health Tracking Network	Tract	2001, 2006, 2011, 2016	Yes
	Particulate Matter 2.5 Above Regulatory Standard	Percentage of days per year for which PM 2.5 levels were above the regulatory standard	National Environmental Public Health Tracking Network	County	2010, 2011, 2012, 2013, 2014	No

Appendix N: 2022 Inland Empire Priorities as Compared to 2019 Priorities

Hospital community health needs assessments (CHNAs) are conducted every three years in the Inland Empire. Many of the 2019 priorities outlined below are the same as those identified in the 2022 assessment.

Following the 2019 assessment, the CHNA stakeholder group was working to build collaborative interventions when their work was dramatically interrupted and superseded by the COVID-19 pandemic that hit in March 2020. The pandemic generated multiple crises; in fact, most of the identified community priorities were likely magnified by the pandemic.

With the easing of the pandemic, the 2022 CHNA stakeholders will move forward with collaborative efforts to address the ongoing community conditions as well as those spawned or worsened by COVID-19.

2019 Hospital CHNA Disease Priorities

- Mental and behavioral health
- Alcohol/Substance use
- Chronic disease
- Asthma
- Diabetes — higher in the Latino population
- Heart disease and stroke
- COPD
- Cancer — colorectal, lung
- Obesity

2019 Hospital CHNA Clinical Care Priorities

- Access to care
- Provider shortage
- Poor provider access to primary care and behavioral health
- Insurance
- Lack of preventive cancer screenings
- Inadequate prenatal care

2019 Hospital CHNA Built Environment Priorities

- Housing shortages
- Lack of access to healthy food

Appendix O: Stakeholder Committee Member Comments in Priority Session

Following the ranking and priority area efforts, members of the Stakeholder Committee provided verbal feedback during the virtual meeting and in the Zoom Chat Room. Following are committee members' verbatim comments.

Equity

- Everything we do should be run through a broad Equity lens.
- This is a big Equity reveal.
- Great job getting the Listening Sessions out to the more isolated areas and in Spanish.

Access to Care

- People delayed preventive medical care due to fears about COVID. Will this have an impact in this year's data and beyond, especially in cancers?
- Many people do not have access to Telehealth due to a lack of internet and computers.

COVID-19

- Fewer people commuting may have improved air quality.
- Virtual learning may have led to poorer education outcomes.
- A fear of COVID likely sparked a fear of public transit.
- The lockdown in 2020 result in layoffs.
- Is the 2020 homeless count complete? There may be a data delay in the count.
- How do we regroup after COVID to get diseases managed?

Education

- Preschool enrollment was down in 2020-21 because of COVID.
- This and other Education issues provide important opportunities.
- It would be helpful to see the data specific to ages 1-17.

CHNA Action Plans

- I have seen some of these plans organized by "health issues across the life span."

Appendix P: Hospital PSA Chronic Conditions, Avoidable ED Visits, Mental Health Visits

The hospital data noted below are derived from the California Department of Health Care Access and Information (HCAI).

Montclair Hospital Medical Center

Montclair Hospital Medical Center PSA Chronic Conditions — Males

The primary chronic conditions in males in the Montclair Hospital Medical Center PSA vary by age. Young males of all ethnicities have substance use disorders, followed by mental health and tobacco use. Hypertension is the primary chronic condition for males 35–64, followed by diabetes, kidney disease and hyperlipidemia. This is the same for males 65+; many of them also have heart disease and prostate issues.

18–34 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**
Drug Use Disorders	24.7%	Drug Use Disorders	42.8%	Drug Use Disorders	34.9%	Drug Use Disorders	41.2%
Depression	21.9%	Schizophrenia and Other Psychotic Disorders	32.3%	Tobacco Use	21.8%	Tobacco Use	31.2%
Tobacco Use	20.9%	Tobacco Use	26.8%	Schizophrenia and Other Psychotic Disorders	20.2%	Depression	24.0%
Depressive Disorders	20.7%	Schizophrenia	22.6%	Obesity	17.7%	Alcohol Use Disorders	20.3%
Schizophrenia and Other Psychotic Disorders	20.2%	Anemia	20.6%	Alcohol Use Disorders	17.6%	Schizophrenia and Other Psychotic Disorders	20.3%
Hypertension	17.2%	Hypertension	18.1%	Chronic Kidney Disease	17.0%	Depressive Disorders	20.0%
Anemia	17.2%	Chronic Kidney Disease	17.8%	Hypertension	15.7%	Anxiety Disorders	14.5%
Chronic Kidney Disease	16.5%	Depression	16.2%	Depression	15.7%	Schizophrenia	14.0%
Schizophrenia	14.5%	Asthma	14.3%	Depressive Disorders	13.9%	Hypertension	12.9%
Anxiety Disorders	14.2%	Alcohol Use Disorders	13.6%	Anemia	13.6%	Bipolar Disorder	12.7%

35–64 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**
Hypertension	63.2%	Hypertension	67.9%	Hypertension	57.4%	Hypertension	56.5%
Hyperlipidemia	41.4%	Chronic Kidney Disease	41.7%	Diabetes	45.4%	Chronic Kidney Disease	31.0%
Diabetes	40.0%	Diabetes	34.1%	Chronic Kidney Disease	42.3%	Diabetes	30.5%

35 – 64 Males (continued)

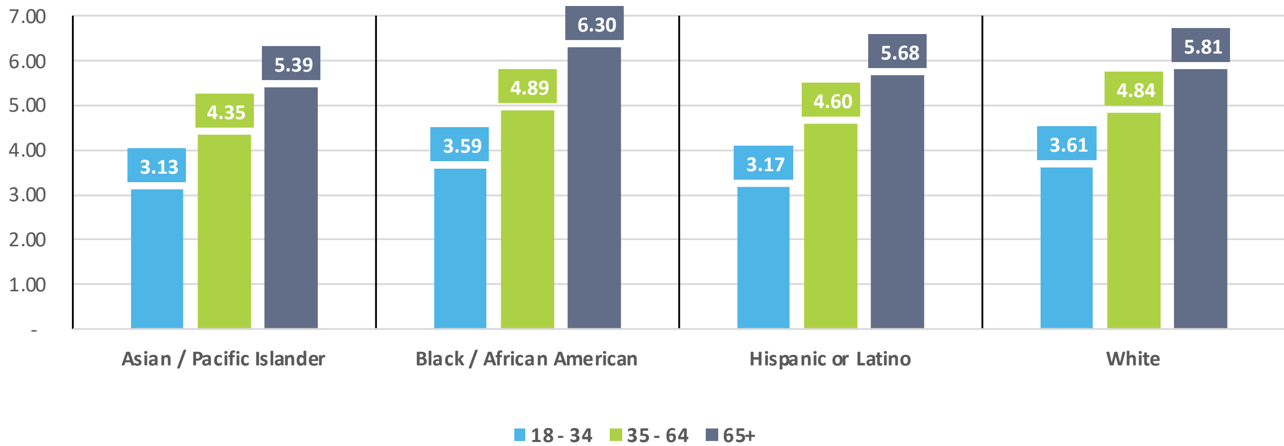
Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Chronic Kidney Disease	37.0%	Anemia	30.9%	Hyperlipidemia	30.5%	Hyperlipidemia	29.6%
Anemia	33.8%	Hyperlipidemia	26.3%	Anemia	29.5%	Tobacco Use	23.9%
Ischemic Heart Disease	25.0%	Tobacco Use	25.5%	Obesity	22.9%	Anemia	22.6%
Tobacco Use	17.7%	Drug Use Disorders	21.7%	Alcohol Use Disorders	16.8%	Obesity	22.4%
Heart Failure	14.5%	Heart Failure	21.4%	Liver Disease, Cirrhosis and Other Liver Conditions (Except Viral Hepatitis)	16.5%	Ischemic Heart Disease	18.4%
Liver Disease, Cirrhosis and Other Liver Conditions (Except Viral Hepatitis)	13.0%	Obesity	20.4%	Tobacco Use	15.8%	Drug Use Disorders	16.3%
Obesity	10.8%	Ischemic Heart Disease	18.0%	Ischemic Heart Disease	15.5%	Heart Failure	16.1%

65+ Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	83.6%	Hypertension	87.4%	Hypertension	80.6%	Hypertension	77.6%
Hyperlipidemia	52.9%	Chronic Kidney Disease	60.5%	Diabetes	56.5%	Hyperlipidemia	49.4%
Chronic Kidney Disease	52.1%	Anemia	52.4%	Chronic Kidney Disease	53.8%	Chronic Kidney Disease	46.6%
Diabetes	50.9%	Hyperlipidemia	51.4%	Anemia	47.6%	Anemia	44.5%
Anemia	48.8%	Diabetes	49.7%	Hyperlipidemia	46.7%	Ischemic Heart Disease	39.8%
Ischemic Heart Disease	39.2%	Ischemic Heart Disease	35.4%	Ischemic Heart Disease	34.4%	Diabetes	36.6%
Benign Prostatic Hyperplasia	27.6%	Heart Failure	32.9%	Heart Failure	29.2%	Heart Failure	30.0%
Heart Failure	24.1%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	23.5%	Benign Prostatic Hyperplasia	25.5%	Benign Prostatic Hyperplasia	26.4%
Chronic Obstructive Pulmonary Disease and Bronchiectasis	18.2%	Benign Prostatic Hyperplasia	23.3%	Peripheral Vascular Disease (PVD)	17.6%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	25.0%
Peripheral Vascular Disease (PVD)	13.9%	Peripheral Vascular Disease (PVD)	21.3%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	15.5%	Rheumatoid Arthritis / Osteoarthritis	16.8%

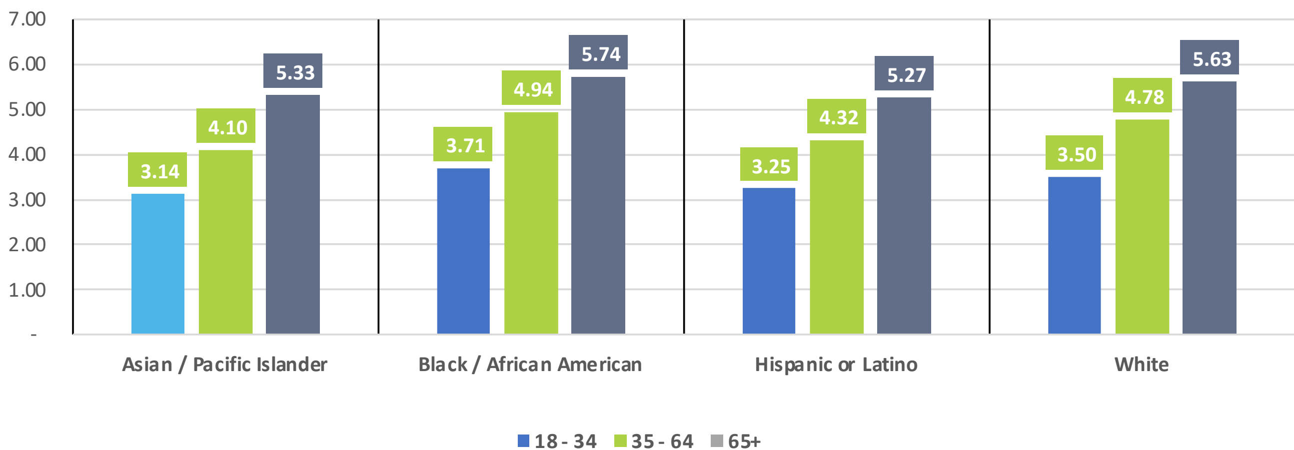
Black/African American males 65+ in the Montclair Hospital Medical Center PSA had an average of 6.3 chronic conditions from 2016 to 2019. They also had the most — 4.89 — in the 35–64 age group, followed by White males. Males 65+ averaged the highest number of chronic conditions across all ethnic groups.

Male Average Number of Chronic Conditions by Race and Age Range 2016–2019 Discharges



In 2020, the distribution among race/ethnicity groups was similar to 2016–2019, but the average number of chronic conditions decreased among 65+ groups and all White age groups.

Average Number of Chronic Conditions by Race and Age Range 2020 Discharges



Montclair Hospital Medical Center

Montclair Hospital Medical Center PSA Chronic Conditions — Females

From 2016 to 2019, the top chronic conditions for all ethnic groups in the 18–34 female group in the Montclair Hospital Medical Center PSA were obesity and anemia, followed by depression and anxiety. For ages 35–64, hypertension was the top diagnosis, especially among Black/African American females; anemia and diabetes are also high in the group. For older females, hypertension is the highest in Black/African American females followed by Hispanic/Latina and Asian/Pacific Islander females.

18–34 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Anemia	23.1%	Anemia	35.7%	Obesity	34.7%	Obesity	22.5%
Obesity	13.8%	Obesity	25.8%	Anemia	24.5%	Depression	21.8%
Depression	12.2%	Asthma	20.7%	Depression	11.5%	Anxiety Disorders	19.4%
Depressive Disorders	11.5%	Drug Use Disorders	19.6%	Drug Use Disorders	10.2%	Depressive Disorders	18.6%
Acquired Hypothyroidism	10.2%	Depression	18.7%	Depressive Disorders	10.1%	Anemia	17.7%
Asthma	7.3%	Depressive Disorders	16.2%	Asthma	9.9%	Drug Use Disorders	17.4%
Anxiety Disorders	6.9%	Anxiety Disorders	14.2%	Anxiety Disorders	9.9%	Asthma	13.2%
Drug Use Disorders	4.7%	Tobacco Use	11.3%	Chronic Kidney Disease	8.8%	Tobacco Use	12.7%
Chronic Kidney Disease	4.5%	Schizophrenia and Other Psychotic Disorders	10.4%	Diabetes	7.4%	Diabetes	8.9%
Diabetes	4.2%	Sickle Cell Disease	9.5%	Tobacco Use	6.0%	Hypertension	7.7%

35–64 Females

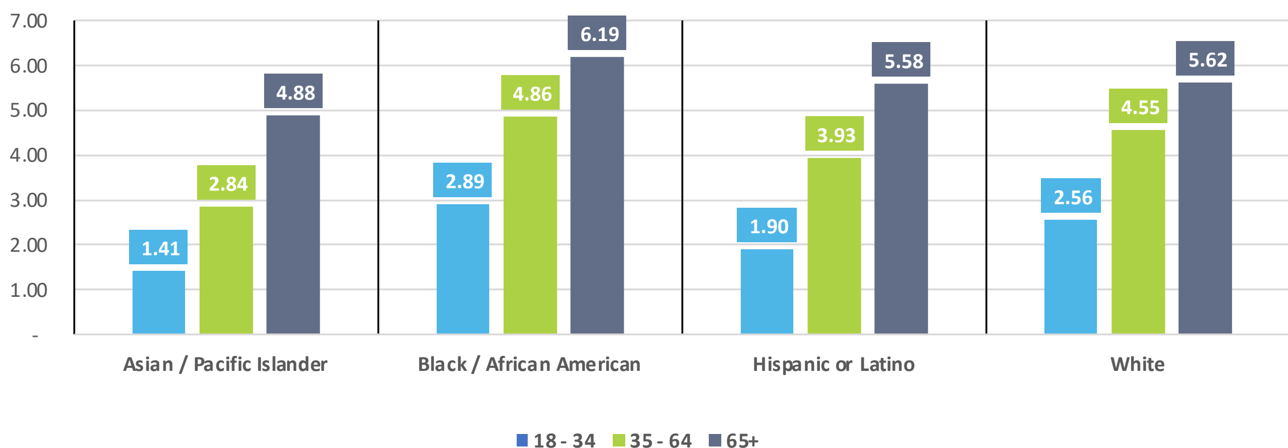
Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	38.4%	Hypertension	62.6%	Hypertension	45.7%	Hypertension	45.8%
Anemia	32.2%	Anemia	35.5%	Diabetes	38.6%	Obesity	27.8%
Hyperlipidemia	23.2%	Diabetes	33.0%	Obesity	33.8%	Anemia	25.7%
Diabetes	23.1%	Obesity	32.2%	Chronic Kidney Disease	32.6%	Hyperlipidemia	24.1%
Chronic Kidney Disease	22.0%	Chronic Kidney Disease	32.0%	Anemia	31.6%	Diabetes	23.7%
Obesity	10.5%	Hyperlipidemia	27.4%	Hyperlipidemia	27.3%	Chronic Kidney Disease	22.8%
Acquired Hypothyroidism	10.3%	Tobacco Use	17.8%	Depression	13.0%	Anxiety Disorders	21.2%
Liver Disease, Cirrhosis and Other Liver Conditions (Except Viral Hepatitis)	7.3%	Heart Failure	17.8%	Anxiety Disorders	13.0%	Depression	20.5%
Depression	7.3%	Depression	15.4%	Acquired Hypothyroidism	12.6%	Depressive Disorders	18.4%
Anxiety Disorders	7.0%	Anxiety Disorders	15.2%	Depressive Disorders	12.1%	Tobacco Use	18.3%

65+ Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	80.4%	Hypertension	87.2%	Hypertension	81.9%	Hypertension	75.9%
Anemia	50.1%	Anemia	55.3%	Diabetes	55.2%	Anemia	45.7%
Hyperlipidemia	48.3%	Chronic Kidney Disease	53.8%	Anemia	49.4%	Hyperlipidemia	43.6%
Diabetes	45.9%	Diabetes	51.7%	Chronic Kidney Disease	48.5%	Chronic Kidney Disease	38.8%
Chronic Kidney Disease	42.3%	Hyperlipidemia	49.5%	Hyperlipidemia	46.2%	Diabetes	30.2%
Ischemic Heart Disease	24.9%	Heart Failure	32.8%	Heart Failure	25.9%	Acquired Hypothyroidism	29.3%
Heart Failure	22.1%	Ischemic Heart Disease	29.7%	Ischemic Heart Disease	25.4%	Heart Failure	26.0%
Rheumatoid Arthritis / Osteoarthritis	17.2%	Rheumatoid Arthritis / Osteoarthritis	23.0%	Acquired Hypothyroidism	22.0%	Rheumatoid Arthritis / Osteoarthritis	25.2%
Acquired Hypothyroidism	15.5%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	22.8%	Rheumatoid Arthritis / Osteoarthritis	21.3%	Ischemic Heart Disease	24.7%
Osteoporosis	11.6%	Obesity	20.7%	Obesity	20.2%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	24.0%

Older Black/African American females in the Montclair Hospital Medical Center PSA had an average of 6.19 chronic conditions from 2016 to 2019; their numbers were also the highest for ages 18–34 and 35–64. White and Hispanic/Latina females had the next highest number of conditions across all age groups.

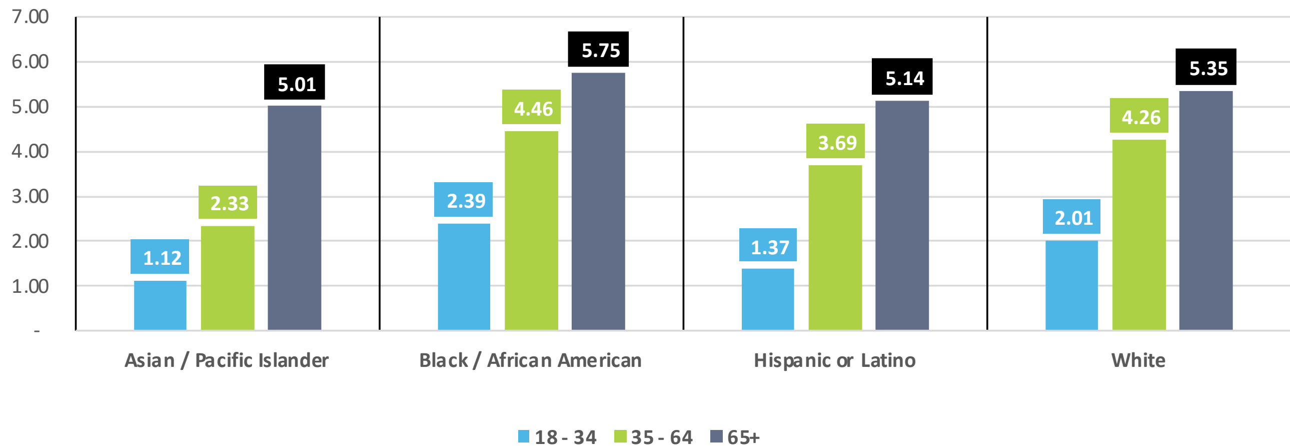
Female Average Number of Chronic Conditions by Race and Age Range 2016 - 2019 Discharges



Older Black/African American females had the highest number — an average of 5.75 per individual — of chronic conditions in 2020; this number is lower than in 2016–2019. This is also true of other ethnic groups except Asian/Pacific Islander females; their average number increased from 4.88 to 5.01.

Montclair Hospital Medical Center PSA
Chronic Conditions — Youth

Average Number of Chronic Conditions by Race and Age Range 2020 Discharges



Depression and depressive disorders were the primary chronic conditions for females ages 0–17 in the Montclair Hospital Medical Center PSA; the rate is especially high in the White group. Depression, depressive disorders and asthma rates were highest in males 0–17; Asian/Pacific Islander youth had higher rates of epilepsy than other ethnic groups.

1–17 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Depression	47.0%	Depression	35.1%	Depression	36.2%	Depression	44.0%
Depressive Disorders	47.0%	Depressive Disorders	31.3%	Depressive Disorders	34.1%	Depressive Disorders	41.0%
Anxiety Disorders	45.8%	Asthma	20.8%	Asthma	14.4%	Anxiety Disorders	17.8%
Epilepsy	13.3%	Anemia	18.5%	Anxiety Disorders	11.9%	Asthma	14.1%
Anemia	11.4%	Diabetes	10.9%	Obesity	11.5%	Epilepsy	12.9%
Asthma	11.4%	Obesity	9.4%	Anemia	11.1%	Drug Use Disorders	9.6%
Chronic Kidney Disease	8.4%	ADHD Conduct Disorders and Hyperkinetic Syndrome	9.4%	Epilepsy	9.2%	Anemia	8.8%
Obesity	7.8%	Anxiety Disorders	8.7%	Drug Use Disorders	8.5%	Obesity	7.9%
Leukemias and Lymphomas	6.0%	Epilepsy	8.3%	Intellectual Disabilities and Related Conditions	8.0%	ADHD Conduct Disorders and Hyperkinetic Syndrome	7.7%
Drug Use Disorders	6.0%	Sickle Cell Disease	7.2%	Schizophrenia and Other Psychotic Disorders	6.2%	Schizophrenia and Other Psychotic Disorders	6.2%

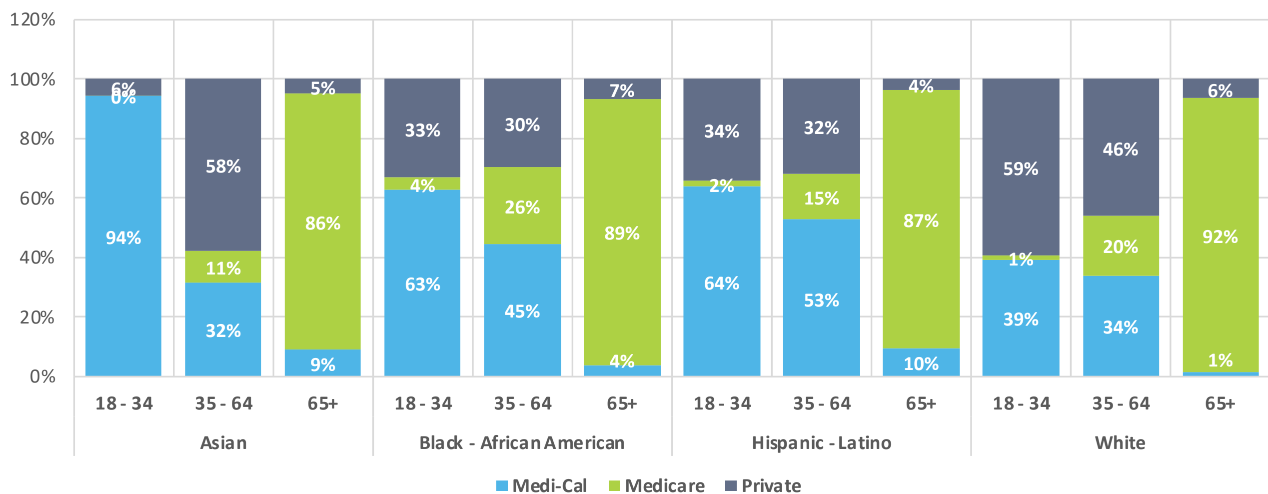
1–17 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Depression	14.9%	Asthma	29.2%	Depression	20.0%	Depression	32.6%
Epilepsy	13.7%	Depression	27.1%	Depressive Disorders	18.8%	Depressive Disorders	29.7%
Asthma	13.7%	Depressive Disorders	21.9%	Asthma	18.3%	Asthma	20.8%
Depressive Disorders	12.9%	Anemia	19.8%	Epilepsy	12.0%	ADHD Conduct Disorders and Hyperkinetic Syndrome	13.2%
Anemia	11.4%	ADHD Conduct Disorders and Hyperkinetic Syndrome	17.0%	Anemia	10.9%	Drug Use Disorders	12.3%
Other Developmental Delays	6.7%	Sickle Cell Disease	11.1%	Obesity	10.1%	Anxiety Disorders	10.2%
ADHD Conduct Disorders and Hyperkinetic Syndrome	6.7%	Epilepsy	10.4%	Intellectual Disabilities and Related Conditions	9.1%	Epilepsy	10.1%
Leukemias and Lymphomas	5.9%	Drug Use Disorders	10.4%	Drug Use Disorders	8.9%	Anemia	7.1%
Intellectual Disabilities and Related Conditions	4.7%	Obesity	7.6%	Chronic Kidney Disease	7.4%	Bipolar Disorder	6.4%
Chronic Kidney Disease	4.7%	Bipolar Disorder	7.3%	ADHD Conduct Disorders and Hyperkinetic Syndrome	7.4%	Autism Spectrum Disorders	6.2%

Montclair Hospital Medical Center PSA Payer and Avoidable ED Visits

Percent Primary Payer by Race/Ethnicity and Age Range

Medi-Cal is the primary payer for Black/African American and Hispanic/Latino patients ages 18–34 and 35–64 in the Montclair Hospital Medical Center PSA. Asian/Pacific Islander and White females under age 65 have the highest rates of private insurance. All ethnic groups have very small percentages of Medi-Cal payers in people 65+.



Avoidable ED Visits

The charts below show avoidable ED visits associated with social determinants as identified by Z codes using the New York University algorithm, the tool most widely used to evaluate use of emergency services. The primary determinants for avoidable ED visits in the Montclair Hospital Medical Center PSA in 2020 were occupational risk and other psychosocial conditions (crime, incarceration, release from prison, legal issues, etc.) followed by employment and social conditions. Z codes, which are used to identify social determinants, are severely underreported.

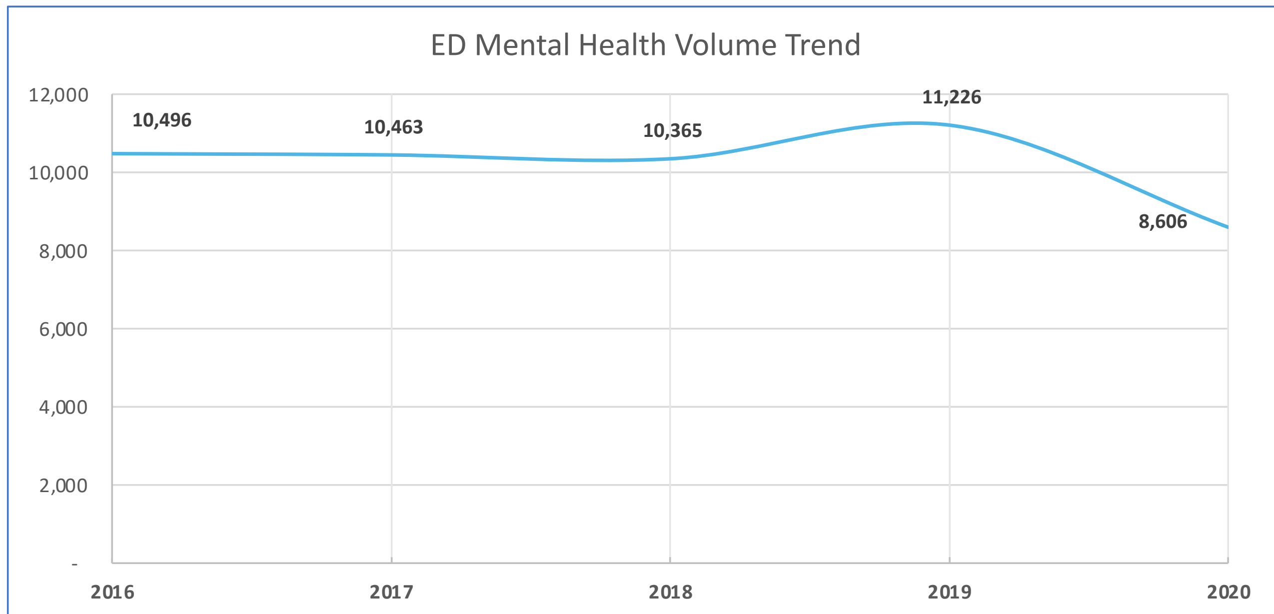
	Visits by Volume					Avoidable Visits				
Category	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
PSA Total ED Visits	196,975	196,846	206,618	158,328	-48,290	54%	53%	54%	50%	-4
Top 5 Payers by Volume	**2017**	**2018**	**2019**	**2020**	**2019–2020 Vol Change**	**2017**	**2018**	**2019**	**2020**	**Point Change**
Medicaid (Medi-Cal)	77,176	78,522	80,651	57,649	-23,002	59%	57%	58%	53%	-5
Health Maintenance Organization (HMO)	26,092	26,101	29,379	24,778	-4,601	54%	54%	55%	50%	-4
Health Maintenance Organization (HMO) Medicare Risk	21,948	21,505	23,416	18,424	-4,992	49%	49%	50%	48%	-1
Self-Pay	11,115	10,815	11,719	8,586	-3,133	51%	50%	52%	47%	-4
Medicare Part B	9,215	9,168	9,093	6,719	-2,374	51%	50%	50%	49%	-2
Age Groups	**2017**	**2018**	**2019**	**2020**	**2019–2020 Vol Change**	**2017**	**2018**	**2019**	**2020**	**Point Change**
Under 1 Year	5,032	4,514	4,781	2,426	-2,355	69%	66%	67%	62%	-7
1–17 Years	37,029	35,143	36,648	19,373	-17,275	60%	59%	60%	54%	-5
18–34 Years	43,736	44,194	45,559	38,316	-7,243	53%	52%	52%	49%	-4
35–64 Years	54,653	55,884	58,836	50,272	-8,564	54%	54%	54%	51%	-3
65 Years or Greater	22,958	23,796	25,685	20,026	-5,659	50%	49%	50%	48%	-2
Social Determinants	**2017**	**2018**	**2019**	**2020**	**2019–2020 Vol Change**	**2017**	**2018**	**2019**	**2020**	**Point Change**
Housing and Economic	47	61	89	76	-13	28%	31%	31%	29%	1
Other Psychosocial Circumstances	912	334	95	76	-19	38%	44%	45%	37%	-1
Primary Support Group and Family	15	15	25	66	41	33%	27%	28%	39%	6
Employment	17	19	48	53	5	29%	37%	17%	42%	12
Upbringing	26	29	56	26	-30	23%	38%	41%	27%	4
Social Environment	12	19	27	23	-4	25%	16%	30%	4%	-21
Occupational Risk	22	25	15	8	-7	23%	12%	13%	38%	15
Psychosocial Circumstances	1	3	8	7	-1	100%	33%	13%	29%	-71
Education and Literacy	1	-	2	2	-	0%	0%	50%	0%	0

Race/Ethnicity	Visits by Volume 2017	2018	2019	2020	2019–2020 Vol Change	Avoidable Visits 2017	2018	2019	2020	Point Change
Asian / Pacific Islander	35,337	36,574	37,356	30,121	(7,235)	53%	53%	53%	49%	-4
Black / African American	170,378	168,556	173,264	132,139	(41,125)	56%	56%	55%	52%	-4
Hispanic or Latino	675,502	677,820	715,771	564,598	(151,173)	55%	55%	56%	50%	-5
White	495,703	470,152	479,869	382,649	(97,220)	49%	49%	50%	46%	-3

Montclair Hospital Medical Center PSA Mental Health ED Visits

ED visits for mental health conditions

Mental health ED primary diagnoses in the Montclair Hospital Medical Center PSA took a large jump between 2018 and 2019 but dropped significantly in 2020.



Redlands Community Hospital

Redlands Community Hospital PSA Chronic Conditions — Males

For younger males in the Redlands Community Hospital PSA, substance and tobacco use were the most common chronic conditions. There are high rates of annual and kidney disease in the Asian/Pacific Islander group. For males over age 35, hypertension was the most common condition in all race/ethnic groups, followed by diabetes, chronic kidney disease and anemia.

18–34 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**
Anemia	23.8%	Tobacco Use	36.0%	Drug Use Disorders	38.3%	Drug Use Disorders	42.8%
Drug Use Disorders	21.9%	Schizophrenia and Other Psychotic Disorders	35.3%	Tobacco Use	26.6%	Tobacco Use	34.4%
Chronic Kidney Disease	21.9%	Drug Use Disorders	35.0%	Alcohol Use Disorders	19.6%	Depression	24.3%
Hypertension	20.5%	Schizophrenia	26.3%	Schizophrenia and Other Psychotic Disorders	18.4%	Depressive Disorders	20.9%
Obesity	19.2%	Anemia	19.3%	Depression	18.4%	Alcohol Use Disorders	18.9%
Tobacco Use	17.9%	Diabetes	18.0%	Hypertension	17.3%	Anxiety Disorders	16.9%
Asthma	15.9%	Hypertension	17.3%	Depressive Disorders	16.8%	Schizophrenia and Other Psychotic Disorders	15.7%
Depression	13.9%	Chronic Kidney Disease	16.8%	Chronic Kidney Disease	15.0%	Hypertension	15.5%
Depressive Disorders	12.6%	Asthma	15.0%	Anemia	13.9%	Opioid Use Disorder (OUD) #3 - Opioid-Related Hospitalizations/Ed Visits	14.4%
Anxiety Disorders	11.3%	Alcohol Use Disorders	13.0%	Anxiety Disorders	13.7%	Opioid Use Disorder (OUD) #1	14.4%

35–64 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**
Hypertension	73.7%	Hypertension	67.7%	Hypertension	61.4%	Hypertension	58.2%
Diabetes	44.0%	Chronic Kidney Disease	42.7%	Diabetes	44.0%	Diabetes	29.6%
Chronic Kidney Disease	41.7%	Diabetes	37.0%	Chronic Kidney Disease	38.4%	Hyperlipidemia	28.0%
Hyperlipidemia	40.5%	Anemia	28.5%	Anemia	29.9%	Chronic Kidney Disease	27.4%
Anemia	29.7%	Hyperlipidemia	25.8%	Hyperlipidemia	28.5%	Tobacco Use	27.1%
Ischemic Heart Disease	29.3%	Tobacco Use	24.6%	Obesity	19.8%	Anemia	21.9%
Heart Failure	21.4%	Heart Failure	24.2%	Tobacco Use	19.0%	Obesity	20.7%

35–64 Males (continued)

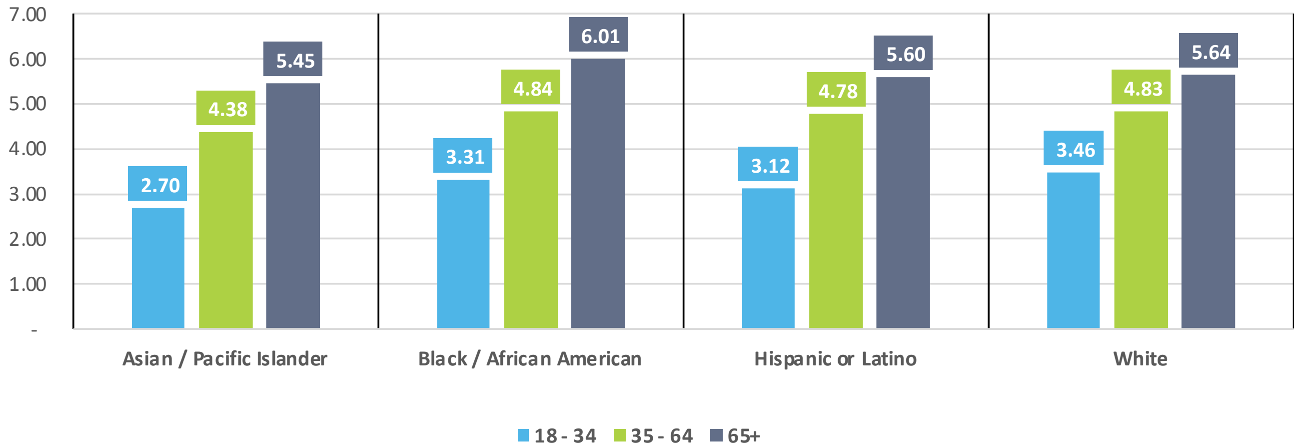
Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Tobacco Use	13.7%	Drug Use Disorders	21.2%	Drug Use Disorders	17.7%	Ischemic Heart Disease	19.4%
Obesity	11.4%	Schizophrenia and Other Psychotic Disorders	17.7%	Ischemic Heart Disease	17.1%	Heart Failure	17.7%
Liver Disease, Cirrhosis and Other Liver Conditions (Except Viral Hepatitis)	10.4%	Obesity	16.6%	Heart Failure	16.8%	Drug Use Disorders	17.5%

65+ Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	82.2%	Hypertension	85.9%	Hypertension	79.8%	Hypertension	75.9%
Chronic Kidney Disease	57.2%	Chronic Kidney Disease	58.1%	Diabetes	53.3%	Chronic Kidney Disease	46.5%
Diabetes	50.7%	Anemia	50.6%	Chronic Kidney Disease	51.8%	Hyperlipidemia	43.9%
Hyperlipidemia	47.7%	Diabetes	48.9%	Anemia	44.2%	Ischemic Heart Disease	38.7%
Anemia	47.7%	Hyperlipidemia	41.3%	Hyperlipidemia	42.0%	Anemia	38.0%
Ischemic Heart Disease	39.7%	Heart Failure	32.3%	Ischemic Heart Disease	33.4%	Diabetes	35.3%
Heart Failure	33.8%	Ischemic Heart Disease	30.7%	Heart Failure	29.0%	Heart Failure	31.0%
Benign Prostatic Hyperplasia	27.2%	Benign Prostatic Hyperplasia	26.9%	Benign Prostatic Hyperplasia	26.1%	Benign Prostatic Hyperplasia	28.1%
Chronic Obstructive Pulmonary Disease and Bronchiectasis	15.4%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	20.8%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	17.8%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	27.5%
Rheumatoid Arthritis / Osteoarthritis	12.3%	Rheumatoid Arthritis / Osteoarthritis	14.2%	Peripheral Vascular Disease (PVD)	14.4%	Rheumatoid Arthritis / Osteoarthritis	17.0%

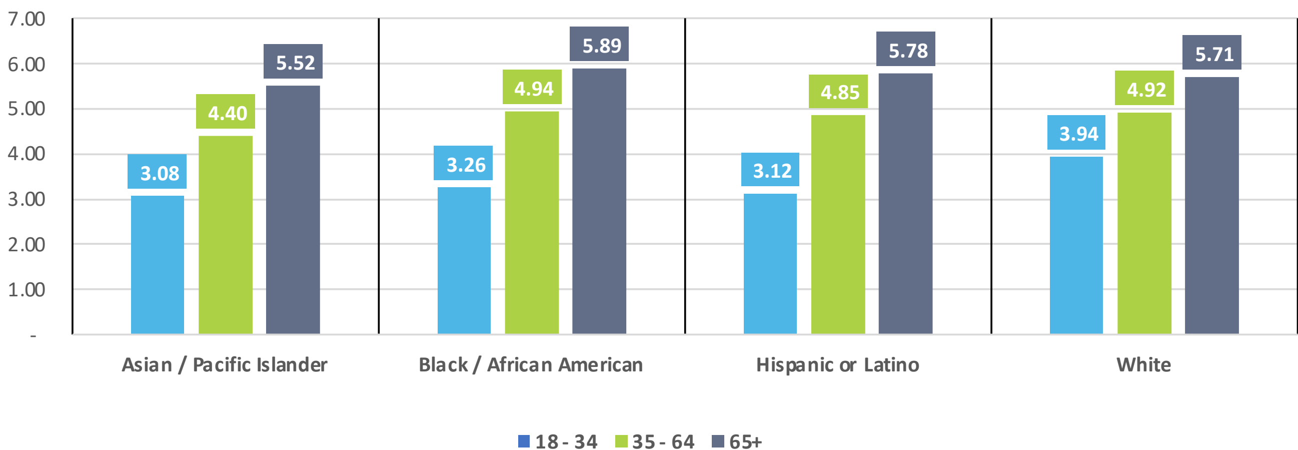
From 2016 to 2019, Black/African American males over 65 in the Redlands Community Hospital PSA had an average of 6.01 chronic conditions per person; they and White males had the most in the 35–64 age group. Among males 18–34, White males had an average of 3.46 conditions per person, the highest of this age group.

Male Average Number of Chronic Conditions by Race and Age Range 2016–2019 Discharges



The chronic condition numbers for 2020 continue to reflect ethnic disparities

Average Number of Chronic Conditions by Race and Age Range 2020 Discharges



Redlands Community Hospital PSA
Chronic Conditions — Females

The most common chronic condition in females ages 18–34 in the Redlands Community Hospital PSA was anemia, followed by obesity. Hypertension is the most common condition in the two older groups; anemia is also high in these groups. Diabetes is highest in the Black/African American and Hispanic/Latina populations.

18–34 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Anemia	37.3%	Anemia	37.4%	Anemia	34.6%	Anemia	29.8%
Obesity	11.6%	Obesity	23.2%	Obesity	26.3%	Obesity	17.8%
Asthma	11.5%	Asthma	22.0%	Drug Use Disorders	10.7%	Depression	17.7%
Depression	10.8%	Drug Use Disorders	17.9%	Anxiety Disorders	10.5%	Anxiety Disorders	16.2%
Depressive Disorders	9.9%	Anxiety Disorders	14.2%	Depression	10.4%	Depressive Disorders	15.9%
Chronic Kidney Disease	8.3%	Depression	13.0%	Asthma	10.1%	Drug Use Disorders	14.5%
Acquired Hypothyroidism	8.3%	Tobacco Use	12.0%	Depressive Disorders	9.5%	Asthma	14.0%
Hypertension	7.6%	Depressive Disorders	11.6%	Diabetes	6.9%	Tobacco Use	12.1%
Diabetes	5.9%	Schizophrenia and Other Psychotic Disorders	8.7%	Chronic Kidney Disease	5.3%	Acquired Hypothyroidism	6.4%
Anxiety Disorders	4.9%	Hypertension	8.5%	Tobacco Use	5.0%	Alcohol Use Disorders	5.4%

35–64 Females

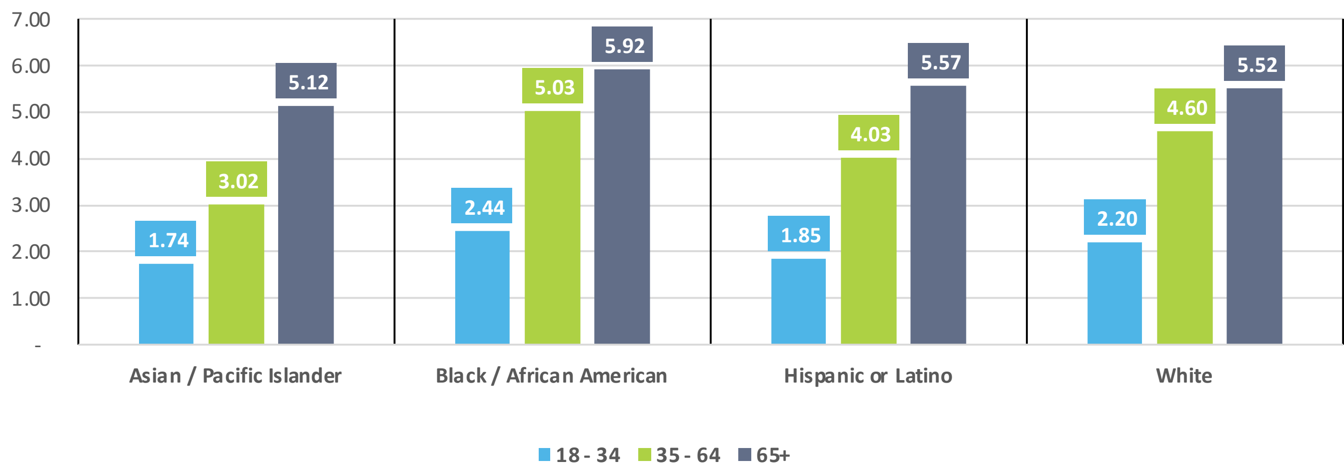
Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	39.1%	Hypertension	63.9%	Hypertension	43.6%	Hypertension	45.8%
Anemia	31.3%	Anemia	37.8%	Diabetes	33.6%	Obesity	27.0%
Diabetes	23.8%	Chronic Kidney Disease	36.0%	Anemia	31.3%	Anemia	24.9%
Hyperlipidemia	22.0%	Diabetes	34.5%	Obesity	30.8%	Depression	23.9%
Chronic Kidney Disease	20.8%	Obesity	33.3%	Chronic Kidney Disease	25.2%	Diabetes	23.2%
Obesity	11.6%	Hyperlipidemia	25.8%	Hyperlipidemia	21.8%	Depressive Disorders	22.2%
Asthma	10.4%	Heart Failure	22.4%	Depression	17.1%	Anxiety Disorders	22.1%
Acquired Hypothyroidism	10.2%	Tobacco Use	19.2%	Depressive Disorders	15.7%	Hyperlipidemia	21.0%
Ischemic Heart Disease	8.5%	Anxiety Disorders	14.7%	Anxiety Disorders	15.7%	Tobacco Use	19.6%
Depression	8.5%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	14.6%	Asthma	11.6%	Chronic Kidney Disease	19.1%

65+ Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**
Hypertension	87.4%	Hypertension	88.6%	Hypertension	81.6%	Hypertension	76.0%
Chronic Kidney Disease	45.1%	Chronic Kidney Disease	50.9%	Diabetes	50.9%	Chronic Kidney Disease	40.1%
Diabetes	44.8%	Anemia	47.0%	Anemia	44.9%	Hyperlipidemia	39.8%
Anemia	44.6%	Diabetes	43.2%	Chronic Kidney Disease	44.9%	Anemia	38.9%
Hyperlipidemia	44.4%	Hyperlipidemia	40.6%	Hyperlipidemia	41.8%	Acquired Hypothyroidism	28.6%
Heart Failure	32.3%	Heart Failure	38.9%	Heart Failure	28.7%	Diabetes	28.5%
Ischemic Heart Disease	25.8%	Ischemic Heart Disease	31.4%	Acquired Hypothyroidism	24.8%	Heart Failure	28.3%
Rheumatoid Arthritis / Osteoarthritis	17.1%	Rheumatoid Arthritis / Osteoarthritis	23.1%	Ischemic Heart Disease	23.9%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	26.4%
Acquired Hypothyroidism	16.5%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	22.9%	Rheumatoid Arthritis / Osteoarthritis	20.6%	Rheumatoid Arthritis / Osteoarthritis	23.3%
Chronic Obstructive Pulmonary Disease and Bronchiectasis	15.2%	Obesity	22.1%	Obesity	17.8%	Ischemic Heart Disease	23.2%

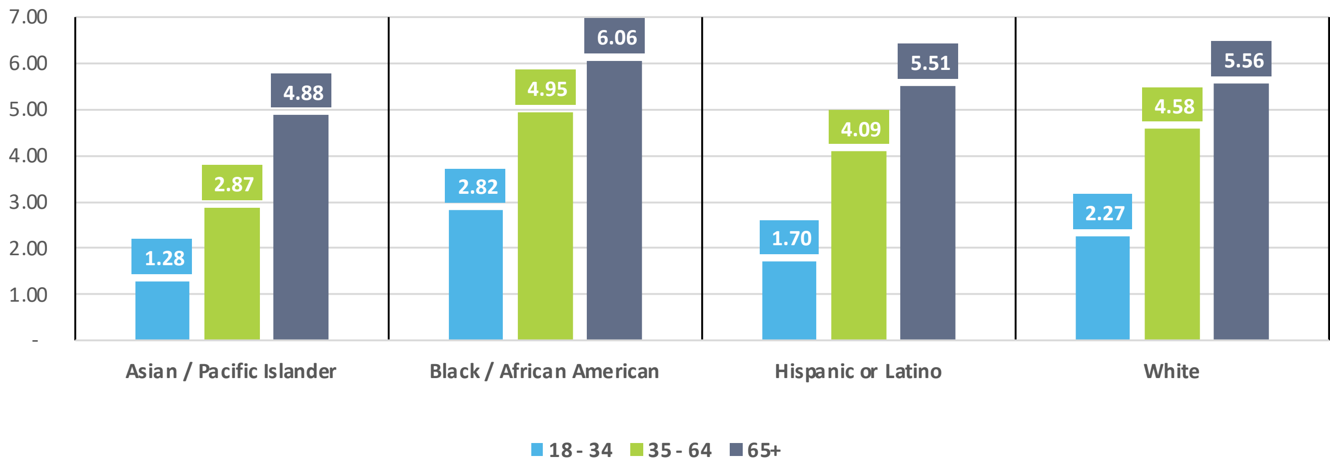
Black/African American, Hispanic/Latina and White females over age 65 in the Redlands Community Hospital PSA had the highest numbers of chronic conditions — on average, per individual — from 2016 to 2019. Black/African American had the highest number in the 35–64 age group.

Female Average Number of Chronic Conditions by Race and Age Range 2016–2019 Discharges



The rate of chronic conditions in Black/African American females age 65+ increased to 6.06 on average, per individual, in 2020. Black/African American females ages 35–64 have the highest number of conditions among the ethnic in that age groups. The numbers for Hispanic/Latina females decreased slightly in 2020, but the numbers in the 18–34 White population grew.

Average Number of Chronic Conditions by Race and Age Range 2020 Discharges



Redlands Community Hospital PSA Chronic Conditions — Youth

For females 0–17 in the Redlands Community Hospital PSA, the most common chronic conditions in all ethnicities are depression, depressive disorders, asthma and anxiety; the depression rate in White females was especially high compared to the other ethnic groups. For all male youth, asthma, anemia and depression are the most common conditions.

1–17 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Depression	26.9%	Depression	29.9%	Depression	31.6%	Depression	46.5%
Depressive Disorders	24.6%	Depressive Disorders	28.4%	Depressive Disorders	30.6%	Depressive Disorders	44.2%
Asthma	20.8%	Asthma	27.5%	Asthma	20.8%	Anxiety Disorders	21.0%
Intellectual Disabilities and Related Conditions	15.4%	Anemia	24.5%	Epilepsy	14.2%	Asthma	13.4%
Epilepsy	10.8%	Epilepsy	15.5%	Anemia	13.9%	Drug Use Disorders	10.2%
Anemia	10.0%	Sickle Cell Disease	13.1%	Anxiety Disorders	13.2%	Epilepsy	9.4%
Autism Spectrum Disorders	8.5%	Intellectual Disabilities and Related Conditions	11.6%	Intellectual Disabilities and Related Conditions	12.8%	ADHD Conduct Disorders and Hyperkinetic Syndrome	8.9%

1–17 Females (continue)

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Anxiety Disorders	8.5%	ADHD Conduct Disorders and Hyperkinetic Syndrome	11.0%	Obesity	12.7%	Obesity	7.5%
Cerebral Palsy	7.7%	Cerebral Palsy	10.4%	Cerebral Palsy	10.2%	Anemia	6.8%
Learning Disabilities	6.2%	Anxiety Disorders	10.1%	Chronic Kidney Disease	9.1%	Intellectual Disabilities and Related Conditions	6.7%

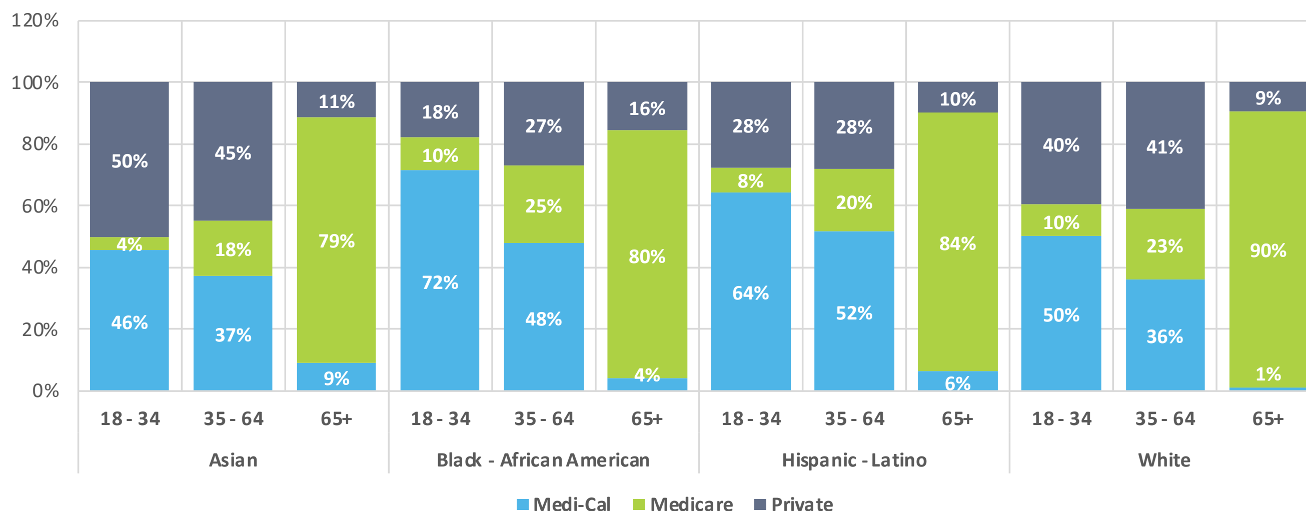
1–17 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Asthma	20.9%	Anemia	28.0%	Asthma	24.9%	Depression	27.9%
Depression	16.3%	Asthma	27.1%	Depression	20.9%	Depressive Disorders	26.6%
Intellectual Disabilities and Related Conditions	15.5%	Depressive Disorders	18.2%	Depressive Disorders	20.2%	ADHD Conduct Disorders and Hyperkinetic Syndrome	20.2%
Depressive Disorders	15.5%	Depression	18.2%	Epilepsy	14.0%	Asthma	18.9%
Leukemias and Lymphomas	14.7%	Sickle Cell Disease	17.3%	Intellectual Disabilities and Related Conditions	12.8%	Drug Use Disorders	11.3%
Epilepsy	14.7%	ADHD Conduct Disorders and Hyperkinetic Syndrome	17.0%	ADHD Conduct Disorders and Hyperkinetic Syndrome	12.5%	Anxiety Disorders	10.4%
Anemia	10.9%	Epilepsy	16.4%	Obesity	11.7%	Epilepsy	10.2%
Hypertension	9.3%	Other Developmental Delays	10.3%	Cerebral Palsy	10.6%	Anemia	8.7%
Chronic Kidney Disease	9.3%	Intellectual Disabilities and Related Conditions	10.3%	Anemia	9.7%	Intellectual Disabilities and Related Conditions	8.4%
ADHD Conduct Disorders and Hyperkinetic Syndrome	8.5%	Drug Use Disorders	10.3%	Other Developmental Delays	8.3%	Autism Spectrum Disorders	6.9%

Redlands Community Hospital PSA — Payer and Avoidable ED visits

Medi-Cal is the primary payer for adults 18–34 and 35–44 for more Black/African American and Hispanic/Latino patients in the Redlands Community Hospital PSA. Asian/Pacific Islander and White populations in these age groups have the highest rates of private insurance.

Percent Primary Payer by Race/Ethnicity and Age Range



The charts below show avoidable hospitalizations associated with social determinants as identified by Z codes using the New York University algorithm, the tool most widely used to evaluate use of emergency services. Medi-Cal is the highest volume payer for avoidable ED visits in the Redlands Community Hospital PSA. The highest users are people 18–34 and 35–64. The primary determinants driving these visits are primary support group and family, and other psychosocial circumstances (crime, incarceration, release from prison, legal issues, etc.). The left side of the below charts shows the number of avoidable hospitalizations, and the right side shows the percentage of total ED visits that were considered avoidable. Social determinant Z codes are severely under-reported.

	Visits by Volume					Avoidable Visits				
Category	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
PSA Total	105,163	664,846	683,844	550,739	-14,901	52%	52%	52%	52%	-4
Top 5 Payers by Volume	**2017**	**2018**	**2019**	**2020**	**2019–2020 Vol Change**	**2017**	**2018**	**2019**	**2020**	**Point Change**
Medicaid (Medi-Cal)	52,337	48,488	48,885	37,655	-11,230	57%	56%	56%	51%	-5
Health Maintenance Organization (HMO) Medicare Risk	18,347	18,250	18,844	16,476	-2,368	48%	48%	47%	45%	-3
Health Maintenance Organization (HMO)	10,711	11,277	11,962	12,602	640	48%	49%	49%	46%	-2
Preferred Provider Organization (PPO)	7,638	7,445	7,880	7,088	-792	48%	47%	49%	46%	-2
Self-Pay	6,836	6,842	7,314	6,978	-336	47%	48%	50%	46%	-1
Age Groups	**2017**	**2018**	**2019**	**2020**	**2019–2020 Vol Change**	**2017**	**2018**	**2019**	**2020**	**Point Change**
Under 1 Year	2,795	347,197	344,961	257,199	-858	64%	63%	64%	57%	-7
1–17 Years	19,625	102,832	107,626	94,372	-7,288	57%	56%	57%	50%	-6
18–34 Years	27,696	72,678	80,421	67,675	-2,292	51%	50%	51%	47%	-4

Age Groups (continued)	2017	2018	2019	2020	2019 – 2020 Vol Change	2017	2018	2019	2020	Point Change
35 – 64 Years	36,289	42,582	45,792	39,899	(2,251)	51%	52%	52%	48%	-3
65 Years or Greater	18,758	37,259	36,678	28,674	(2,212)	48%	48%	47%	44%	-3

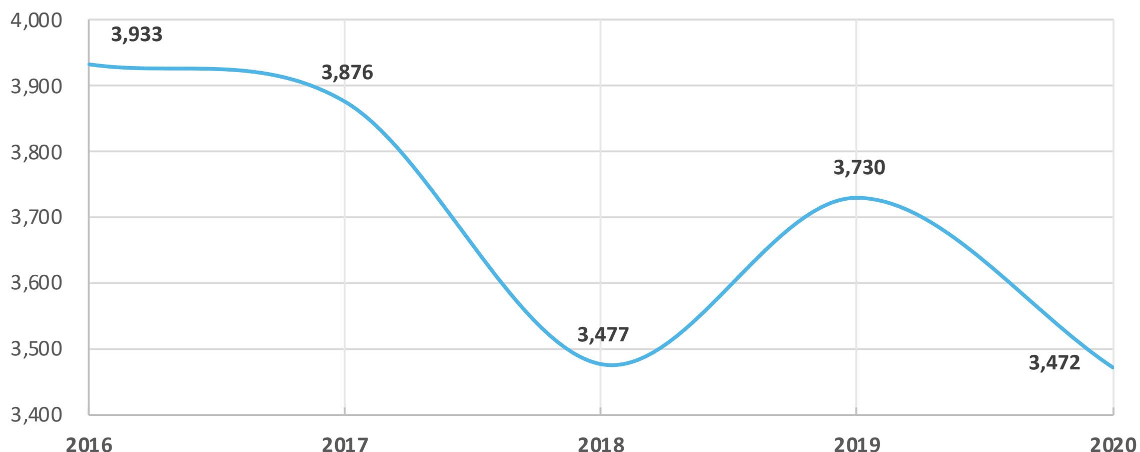
Social Determinants	2017	2018	2019	2020	2019 – 2020 Vol Change	2017	2018	2019	2020	Point Change
Housing and Economic	437	199	81	77	-4	41%	41%	36%	25%	-17
Primary Support Group and Family	21	39	35	54	19	33%	26%	29%	30%	-4
Upbringing	42	38	36	31	-5	29%	34%	25%	29%	0
Occupational Risk	45	30	23	25	2	11%	10%	4%	8%	-3
Other Psychosocial Circumstances	8	9	12	22	10	25%	11%	25%	18%	-7
Social Environment	7	15	14	19	5	29%	27%	7%	26%	-2
Employment	6	7	11	9	-2	33%	29%	55%	33%	0
Education and Literacy	1	5	3	2	-1	100%	20%	0%	0%	-100%
Psychosocial Circumstances	-	1	3	-	-3	0%	100%	67%	0%	0

Social Determinants	2017	2018	2019	2020	2019 – 2020 Vol Change	2017	2018	2019	2020	Point Change
Asian / Pacific Islander	3,501	3,551	3,579	3,100	-479	51%	53%	52%	48%	-4
Black / African American	10,529	10,443	10,703	8,322	-2,381	55%	55%	56%	53%	-3
Hispanic or Latino	39,060	38,392	40,096	34,449	-5,647	55%	55%	55%	50%	-6
White	48,316	46,031	45,476	39,100	-6,376	49%	48%	48%	45%	-4

Redlands Community Hospital PSA Mental Health ED Visits

ED Visits for Mental Health Conditions

Mental health ED primary diagnoses in the Redlands Community Hospital PSA dropped in 2018, rose in 2019 and dropped to 2018 levels in 2020.



San Antonio Regional Hospital

San Antonio Regional Hospital PSA
Chronic Conditions — Males

For males 18–34 in the San Antonio Regional Hospital PSA, the most common chronic conditions in all ethnicities are drug use disorders, tobacco use and schizophrenia and other psychotic disorders. Leading chronic conditions in males 35–64 and 65+ are hypertension, kidney disease, diabetes and hyperlipidemia.

18–34 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Tobacco Use	25.1%	Drug Use Disorders	40.1%	Drug Use Disorders	32.1%	Drug Use Disorders	37.7%
Drug Use Disorders	22.8%	Schizophrenia and Other Psychotic Disorders	30.2%	Tobacco Use	21.6%	Tobacco Use	29.0%
Hypertension	21.2%	Tobacco Use	27.0%	Schizophrenia and Other Psychotic Disorders	17.4%	Depression	22.4%
Schizophrenia and Other Psychotic Disorders	18.9%	Anemia	21.9%	Chronic Kidney Disease	17.2%	Depressive Disorders	19.0%
Chronic Kidney Disease	18.2%	Hypertension	21.7%	Depression	17.1%	Schizophrenia and Other Psychotic Disorders	17.4%
Depression	18.0%	Chronic Kidney Disease	20.3%	Alcohol Use Disorders	17.0%	Alcohol Use Disorders	17.2%
Obesity	17.1%	Schizophrenia	19.4%	Hypertension	15.7%	Anxiety Disorders	15.2%
Anemia	16.6%	Asthma	15.9%	Obesity	15.6%	Chronic Kidney Disease	12.8%
Depressive Disorders	16.1%	Depression	14.3%	Depressive Disorders	14.8%	Hypertension	12.7%
Schizophrenia	15.0%	Diabetes	12.1%	Anemia	14.4%	Bipolar Disorder	12.0%

35–64 Males

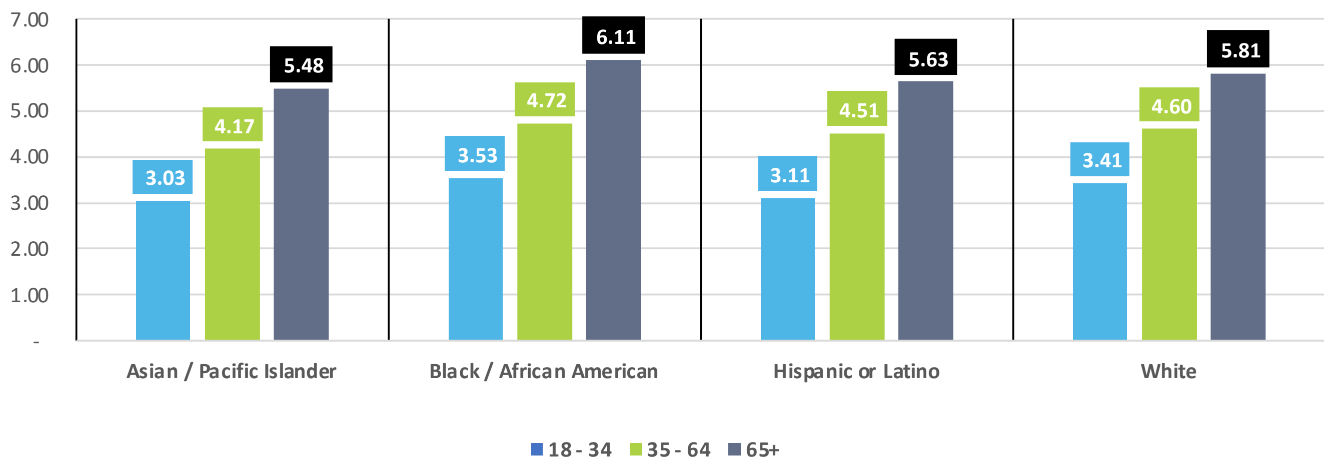
Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	61.5%	Hypertension	67.6%	Hypertension	58.3%	Hypertension	56.3%
Diabetes	42.0%	Chronic Kidney Disease	41.9%	Diabetes	44.1%	Hyperlipidemia	31.2%
Hyperlipidemia	41.9%	Diabetes	34.9%	Chronic Kidney Disease	40.4%	Chronic Kidney Disease	29.6%
Chronic Kidney Disease	40.4%	Anemia	29.5%	Hyperlipidemia	31.5%	Diabetes	29.1%
Anemia	32.5%	Hyperlipidemia	28.6%	Anemia	28.2%	Tobacco Use	22.6%
Ischemic Heart Disease	23.4%	Tobacco Use	22.2%	Obesity	22.2%	Anemia	22.0%
Tobacco Use	16.4%	Heart Failure	19.9%	Ischemic Heart Disease	16.5%	Obesity	21.7%
Heart Failure	15.9%	Obesity	18.9%	Liver Disease, Cirrhosis and Other Liver Conditions (Except Viral Hepatitis)	16.1%	Ischemic Heart Disease	18.5%
Obesity	13.8%	Ischemic Heart Disease	18.2%	Alcohol Use Disorders	15.7%	Drug Use Disorders	14.8%
Liver Disease, Cirrhosis and Other Liver Conditions (Except Viral Hepatitis)	12.3%	Drug Use Disorders	17.2%	Tobacco Use	15.3%	Heart Failure	14.3%

65+ Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**
Hypertension	82.3%	Hypertension	85.7%	Hypertension	79.5%	Hypertension	77.9%
Chronic Kidney Disease	55.8%	Chronic Kidney Disease	60.8%	Diabetes	55.1%	Hyperlipidemia	50.9%
Hyperlipidemia	52.4%	Anemia	51.4%	Chronic Kidney Disease	54.0%	Chronic Kidney Disease	48.9%
Diabetes	52.2%	Hyperlipidemia	50.4%	Hyperlipidemia	46.2%	Anemia	42.3%
Anemia	48.5%	Diabetes	50.0%	Anemia	45.4%	Ischemic Heart Disease	40.1%
Ischemic Heart Disease	39.3%	Ischemic Heart Disease	34.8%	Ischemic Heart Disease	34.0%	Diabetes	37.8%
Benign Prostatic Hyperplasia	27.6%	Heart Failure	30.6%	Heart Failure	28.0%	Heart Failure	30.5%
Heart Failure	26.9%	Peripheral Vascular Disease (PVD)	24.4%	Benign Prostatic Hyperplasia	25.1%	Benign Prostatic Hyperplasia	25.6%
Chronic Obstructive Pulmonary Disease and Bronchiectasis	17.1%	Benign Prostatic Hyperplasia	23.5%	Peripheral Vascular Disease (PVD)	19.9%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	25.1%
Peripheral Vascular Disease (PVD)	16.4%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	21.5%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	14.9%	Peripheral Vascular Disease (PVD)	19.1%

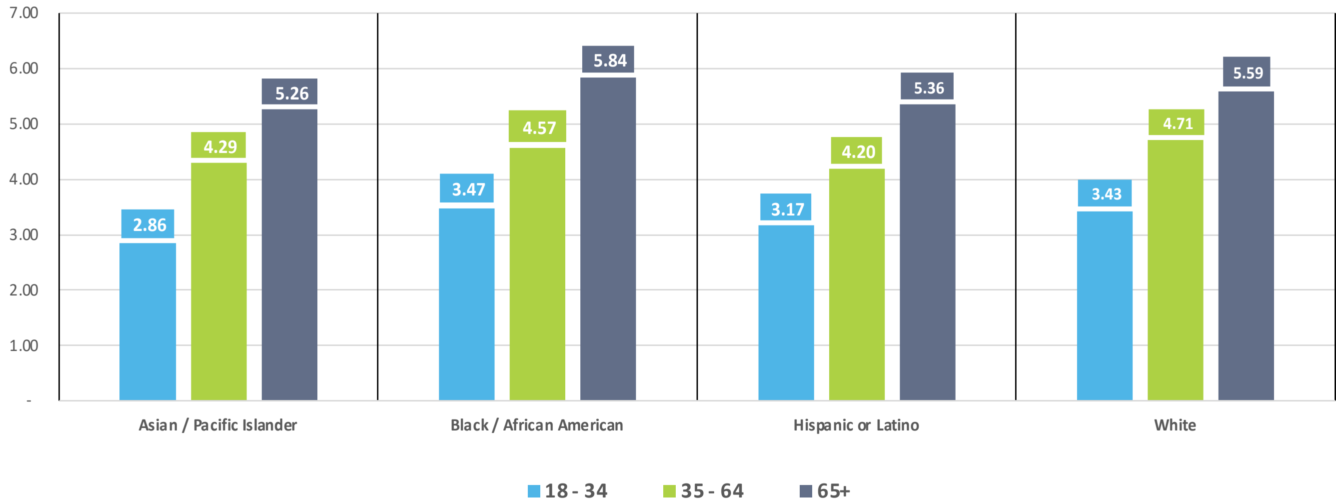
From 2016 to 2019, Black/African American males over age 65 in the San Antonio Regional Hospital PSA had 6.11 chronic conditions per individual, on average; this is higher than the other hospital PSAs in this CHNA. Black/African American males ages 35–64 also have higher numbers, followed by White and Hispanic/Latino males.

Male Average Number of Chronic Conditions by Race and Age Range 2016–2019 Discharges



Chronic conditions among males in most ethnic groups declined somewhat in 2020, except for the Asian / Pacific Islander and White 35–64 groups.

Male Average Number of Chronic Conditions by Race and Age Range 2020 Discharges



San Antonio Regional Hospital PSA Chronic Conditions — Female

From 2016 to 2019, the top chronic conditions for females ages 18–24 in all ethnic groups in the San Antonio Regional Hospital PSA were anemia and obesity, followed by asthma, depression and substance use disorders. Obesity was especially prevalent in the Black/African American and Hispanic/Latina groups. Hypertension was the most common condition in both of the older groups. Anemia, diabetes, kidney disease and obesity were also issues for all females 35 and above.

18–34 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Anemia	24.5%	Anemia	35.1%	Obesity	31.9%	Obesity	22.1%
Obesity	13.2%	Obesity	25.6%	Anemia	22.8%	Anemia	19.5%
Acquired Hypothyroidism	12.5%	Asthma	19.9%	Depression	11.0%	Depression	18.7%
Depression	8.7%	Drug Use Disorders	16.1%	Anxiety Disorders	10.7%	Anxiety Disorders	18.6%
Depressive Disorders	7.8%	Depression	16.0%	Asthma	10.0%	Depressive Disorders	16.4%
Asthma	6.8%	Depressive Disorders	13.9%	Depressive Disorders	9.9%	Drug Use Disorders	15.7%
Anxiety Disorders	6.2%	Anxiety Disorders	13.5%	Drug Use Disorders	8.5%	Asthma	13.2%
Viral Hepatitis (General)	4.1%	Sickle Cell Disease	9.0%	Chronic Kidney Disease	7.3%	Tobacco Use	11.1%
Chronic Kidney Disease	4.1%	Tobacco Use	8.7%	Diabetes	6.4%	Chronic Kidney Disease	8.5%
Hyperlipidemia	3.7%	Hypertension	8.5%	Hypertension	4.9%	Diabetes	8.1%

35–64 Females

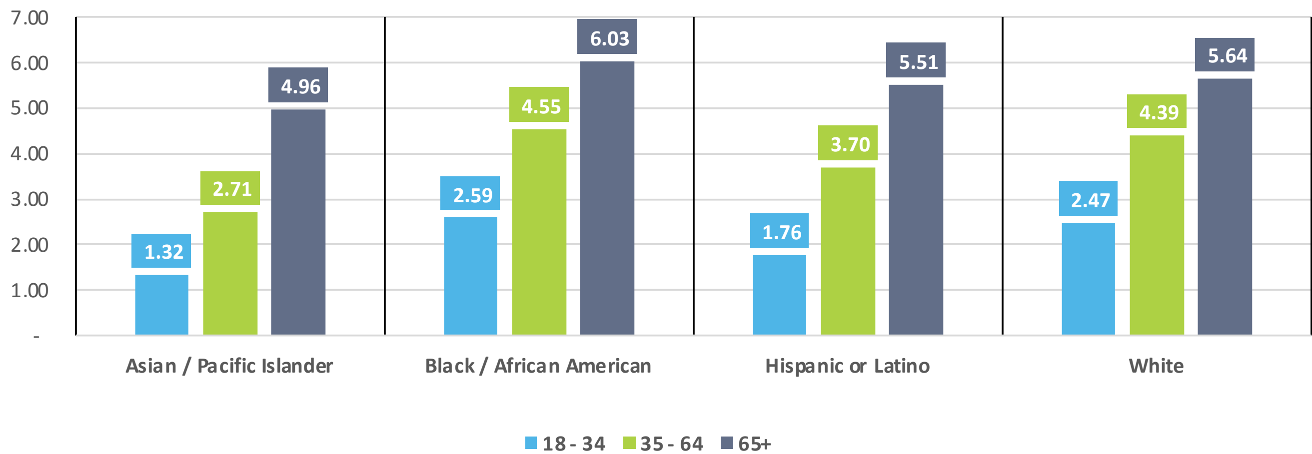
Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**
Hypertension	36.4%	Hypertension	60.1%	Hypertension	42.9%	Hypertension	44.1%
Anemia	31.3%	Anemia	35.9%	Diabetes	33.9%	Obesity	27.2%
Hyperlipidemia	23.1%	Obesity	32.4%	Obesity	30.5%	Anemia	24.5%
Diabetes	21.5%	Chronic Kidney Disease	28.6%	Anemia	30.1%	Hyperlipidemia	23.8%
Chronic Kidney Disease	19.5%	Diabetes	28.6%	Chronic Kidney Disease	28.2%	Diabetes	22.2%
Obesity	12.7%	Hyperlipidemia	26.4%	Hyperlipidemia	25.8%	Chronic Kidney Disease	22.0%
Acquired Hypothyroidism	12.2%	Anxiety Disorders	16.1%	Anxiety Disorders	14.3%	Anxiety Disorders	21.1%
Anxiety Disorders	8.2%	Heart Failure	15.0%	Depression	13.4%	Depression	21.1%
Asthma	7.0%	Depression	15.0%	Depressive Disorders	12.4%	Depressive Disorders	19.2%
Ischemic Heart Disease	6.4%	Fibromyalgia and Chronic Pain and Fatigue	14.5%	Acquired Hypothyroidism	11.9%	Acquired Hypothyroidism	17.5%

65+ Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**
Hypertension	81.7%	Hypertension	87.4%	Hypertension	81.3%	Hypertension	75.9%
Hyperlipidemia	50.1%	Chronic Kidney Disease	55.1%	Diabetes	52.4%	Hyperlipidemia	44.3%
Anemia	49.4%	Anemia	53.2%	Chronic Kidney Disease	49.3%	Anemia	44.1%
Diabetes	47.8%	Diabetes	48.2%	Anemia	47.4%	Chronic Kidney Disease	40.7%
Chronic Kidney Disease	47.3%	Hyperlipidemia	46.8%	Hyperlipidemia	45.9%	Diabetes	30.8%
Ischemic Heart Disease	25.0%	Heart Failure	31.9%	Heart Failure	25.8%	Acquired Hypothyroidism	28.1%
Heart Failure	24.6%	Ischemic Heart Disease	28.4%	Ischemic Heart Disease	24.4%	Heart Failure	25.8%
Rheumatoid Arthritis / Osteoarthritis	17.0%	Rheumatoid Arthritis / Osteoarthritis	23.5%	Acquired Hypothyroidism	21.8%	Ischemic Heart Disease	25.2%
Acquired Hypothyroidism	15.4%	Peripheral Vascular Disease (PVD)	20.7%	Rheumatoid Arthritis / Osteoarthritis	21.7%	Rheumatoid Arthritis / Osteoarthritis	24.7%
Peripheral Vascular Disease (PVD)	12.9%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	20.3%	Obesity	17.9%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	24.2%

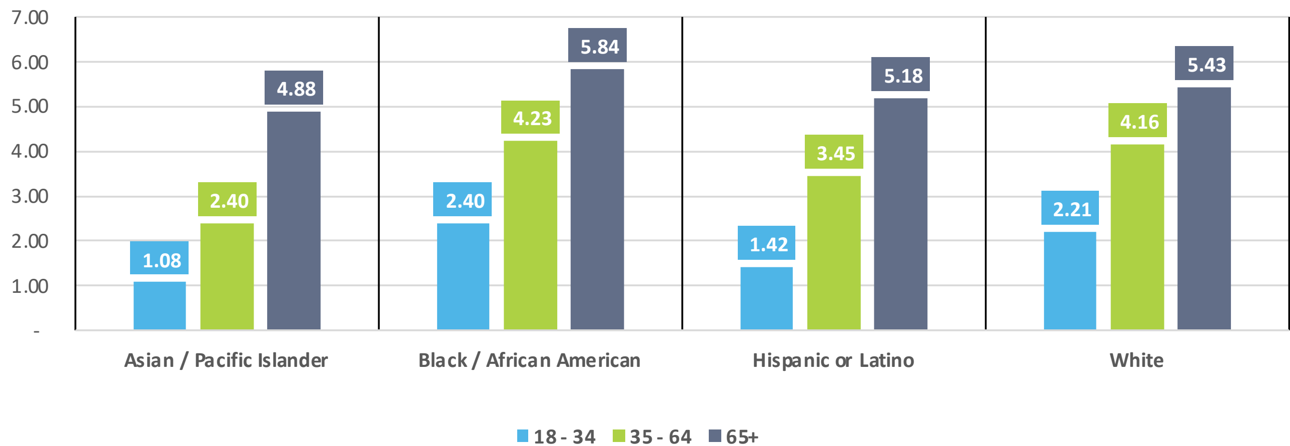
Black/African American females ages 65+ in the San Antonio Regional Hospital PSA had an average of 6.03 chronic conditions per individual from 2016 to 2019, followed by White and Hispanic/Latina females. For ages 35-64, Black/African American and White females had the highest numbers of conditions.

Female Average Number of Chronic Conditions by Race and Age Range 2016–2019 Discharges



In 2020, Black/African American females over 65 had an average of 5.84 chronic conditions per individual; Asian/Pacific Islanders had the lowest rate in that age group at 4.88. Black/African American females also had the highest number in the 35–64 age group.

Female Average Number of Chronic Conditions by Race and Age Range 2020 Discharges



San Antonio Regional Hospital PSA
Chronic Conditions — Youth

For young females in all ethnic groups in the San Antonio Hospital PSA, depression and depressive disorder are the most common conditions, followed by anxiety and asthma. Young males also had high rates of depression and seemed to have higher rates of asthma than females.

1 – 17 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**
Depressive Disorders	19.4%	Depression	27.0%	Depression	24.1%	Depression	36.7%
Depression	19.4%	Depressive Disorders	25.5%	Depressive Disorders	22.6%	Depressive Disorders	35.0%
Anemia	13.7%	Asthma	19.6%	Asthma	12.3%	Anxiety Disorders	14.4%
Asthma	11.6%	Anemia	17.9%	Anemia	9.8%	Asthma	11.8%
Anxiety Disorders	8.5%	Anxiety Disorders	9.8%	Anxiety Disorders	9.3%	Anemia	8.4%
Chronic Kidney Disease	8.0%	ADHD Conduct Disorders and Hyperkinetic Syndrome	7.5%	Obesity	8.1%	Drug Use Disorders	7.5%
Hypertension	7.2%	Sickle Cell Disease	7.1%	Epilepsy	6.2%	Epilepsy	7.4%
Epilepsy	4.7%	Schizophrenia and Other Psychotic Disorders	6.4%	Drug Use Disorders	5.2%	ADHD Conduct Disorders and Hyperkinetic Syndrome	7.3%
Intellectual Disabilities and Related Conditions	3.6%	Diabetes	6.0%	Chronic Kidney Disease	5.0%	Obesity	5.9%
Obesity	2.6%	Drug Use Disorders	5.7%	Intellectual Disabilities and Related Conditions	4.7%	Schizophrenia and Other Psychotic Disorders	4.7%

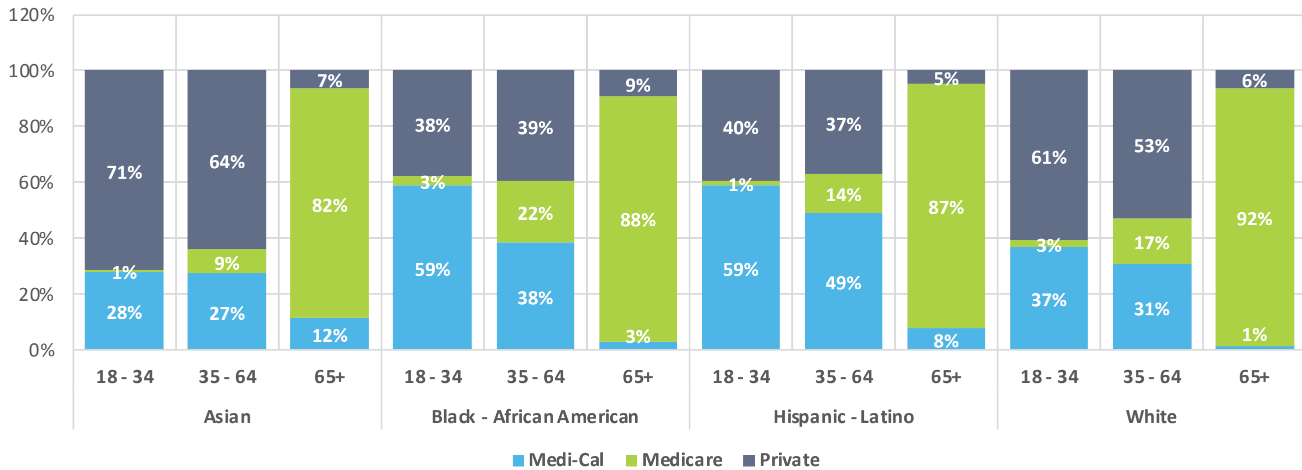
1 – 17 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**
Asthma	14.6%	Asthma	28.0%	Asthma	17.4%	Depression	21.6%
Anemia	11.1%	Depression	18.8%	Depression	13.0%	Depressive Disorders	19.9%
Depression	10.9%	Depressive Disorders	16.6%	Depressive Disorders	12.2%	Asthma	15.7%
Depressive Disorders	10.0%	Anemia	14.3%	Epilepsy	9.6%	ADHD Conduct Disorders and Hyperkinetic Syndrome	11.3%
Epilepsy	7.9%	ADHD Conduct Disorders and Hyperkinetic Syndrome	11.0%	Anemia	8.9%	Epilepsy	9.9%
Intellectual Disabilities and Related Conditions	7.1%	Chronic Kidney Disease	7.9%	Intellectual Disabilities and Related Conditions	7.2%	Anxiety Disorders	7.9%
Chronic Kidney Disease	6.1%	Epilepsy	7.6%	Obesity	6.3%	Drug Use Disorders	7.7%
Anxiety Disorders	5.4%	Drug Use Disorders	7.1%	Cerebral Palsy	5.8%	Anemia	7.3%
Other Developmental Delays	4.2%	Schizophrenia and Other Psychotic Disorders	5.8%	Drug Use Disorders	5.7%	Intellectual Disabilities and Related Conditions	5.3%
Autism Spectrum Disorders	4.2%	Obesity	5.8%	Chronic Kidney Disease	5.6%	Autism Spectrum Disorders	4.8%

San Antonio Regional Hospital PSA
Payers and ED Visits

Medi-Cal is the primary payer for Black/African American and Hispanic/Latino groups under age 65 in the San Antonio Regional Hospital PSA. Asian/Pacific Islander and White adults under age 65 have the highest rates of private insurance.

Percent Primary Payer by Race/Ethnicity and Age Range



The chart below shows avoidable hospitalizations associated with social determinants as identified by Z codes using the New York University algorithm, the tool most widely used to evaluate use of emergency services. The primary payer for avoidable ED visits in the San Antonio Regional Hospital PSA is Medi-Cal; the most frequent users are adults 18–34 and 35–64. The primary determinants linked to these visits are primary support group and family, housing and economic, followed by employment and other psychosocial conditions (crime, incarceration, release from prison, legal issues, etc.). It is important to note that the Z codes for social determinants are significantly under-reported.

	Visits by Volume					Avoidable Visits				
Category	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
PSA Total	265,460	266,312	281,471	220,847	-60,624	52%	52%	52%	48%	-4

Top 5 Payers by Volume	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
Medicaid (Medi-Cal)	117,406	115,637	117,757	85,293	-32,464	57%	56%	56%	52%	-5
Health Maintenance Organization (HMO)	47,627	48,031	52,206	44,810	-7,396	51%	51%	53%	48%	-4
Health Maintenance Organization (HMO) Medicare Risk	35,343	36,149	39,921	32,412	-7,509	48%	48%	49%	47%	-1
Self-Pay	19,047	19,189	20,418	15,377	-5,041	50%	49%	51%	47%	-3
Preferred Provider Organization (PPO)	15,211	15,353	16,321	12,982	-3,339	49%	49%	49%	46%	-3

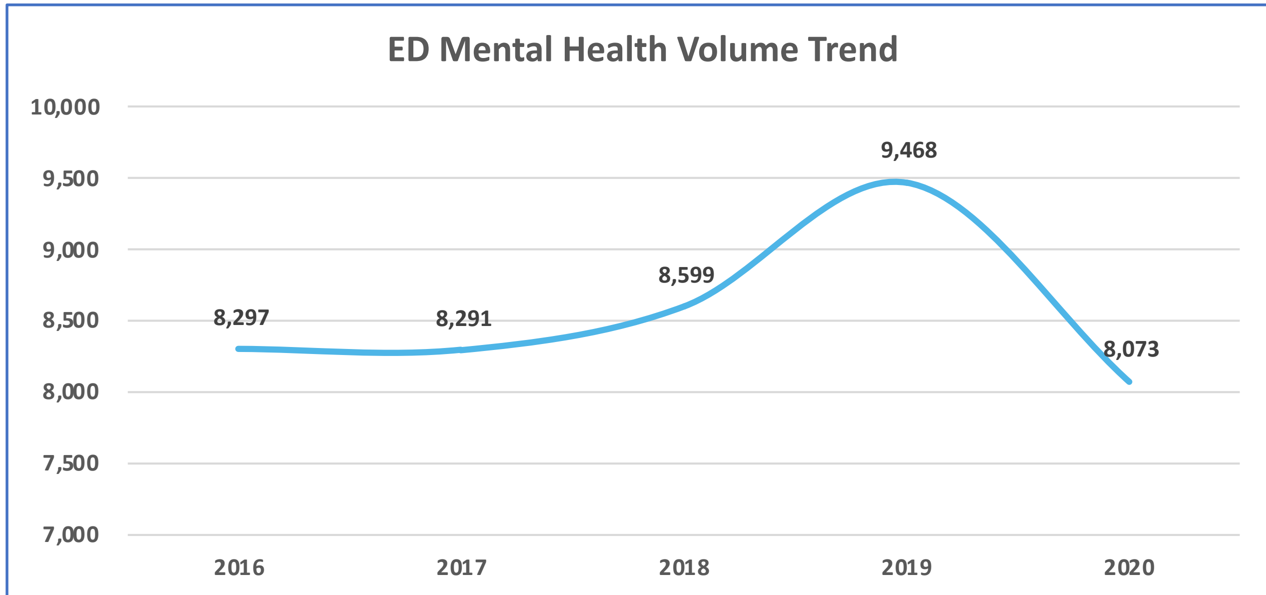
	Visits by Volume					Avoidable Visits				
Age Groups	**2017**	**2018**	**2019**	**2020**	**2019–2020 Vol Change**	**2017**	**2018**	**2019**	**2020**	**Point Change**
Under 1 Year	7,430	6,984	7,462	4,067	-3,395	66%	65%	64%	60%	-6
1–17 Years	55,448	52,510	55,232	30,729	-24,503	57%	56%	57%	51%	-6
18–34 Years	73,985	74,443	77,971	65,901	-12,070	50%	50%	50%	46%	-4
35–64 Years	92,443	94,605	98,575	86,774	-11,801	52%	52%	52%	49%	-3
65 Years or Greater	36,154	37,770	42,231	33,376	-8,855	48%	48%	49%	47%	-2

Social Determinants	**2017**	**2018**	**2019**	**2020**	**2019–2020 Vol Change**	**2017**	**2018**	**2019**	**2020**	**Point Change**
Other Psychosocial Circumstances	43	140	576	395	-181	40%	26%	31%	31%	-8
Primary Support Group and Family	68	104	149	155	6	28%	30%	33%	32%	4
Housing and Economic	556	321	132	147	15	33%	38%	35%	33%	0
Employment	18	26	47	85	38	39%	23%	32%	35%	-4
Social Environment	42	61	103	47	-56	26%	34%	30%	34%	8
Upbringing	35	45	44	44	-	26%	20%	23%	14%	-12
Occupational Risk	37	32	22	22	-	14%	9%	14%	18%	5
Psychosocial Circumstances	2	2	11	11	-	50%	50%	27%	36%	-14
Education and Literacy	3	7	6	9	3	100%	14%	17%	22%	-78

Race/Ethnicity	**2017**	**2018**	**2019**	**2020**	**2019–2020 Vol Change**	**2017**	**2018**	**2019**	**2020**	**Point Change**
Asian / Pacific Islander	11,172	11,782	12,816	10,238	-2,578	51%	50%	51%	47%	-4
Black / African American	27,377	27,580	29,082	22,710	-6,372	54%	54%	54%	51%	-3
Hispanic or Latino	146,840	146,968	156,746	122,485	-34,261	54%	54%	54%	50%	-5
White	65,951	63,998	64,599	50,377	-14,222	47%	47%	47%	44%	-3

ED Visits for Mental Health Conditions

Mental health ED primary diagnoses in the San Antonio PSA peaked in mid-2019 but dropped in 2020.



San Gorgonio Memorial Hospital

San Gorgonio Memorial Hospital PSA Chronic Conditions — Males

The primary chronic conditions in males in the San Gorgonio Memorial Hospital PSA vary by age. Young males of all ethnicities have substance use disorders, followed by mental health and tobacco use. Hypertension is the primary chronic condition for males 35-64, followed by diabetes, kidney disease and hyperlipidemia. This is the same for males 65+, many of whom also have heart disease and prostate issues.

18–34 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Anemia	27.3%	Tobacco Use	37.2%	Drug Use Disorders	32.5%	Drug Use Disorders	38.9%
Drug Use Disorders	22.7%	Schizophrenia and Other Psychotic Disorders	33.9%	Tobacco Use	28.1%	Tobacco Use	35.2%
Chronic Kidney Disease	22.7%	Drug Use Disorders	33.3%	Alcohol Use Disorders	19.6%	Alcohol Use Disorders	18.8%
Tobacco Use	18.2%	Schizophrenia	27.2%	Diabetes	19.4%	Hypertension	17.7%
Schizophrenia and Other Psychotic Disorders	18.2%	Diabetes	26.7%	Chronic Kidney Disease	17.6%	Depression	16.4%
Schizophrenia	13.6%	Chronic Kidney Disease	18.9%	Depression	16.0%	Diabetes	15.1%
Liver Disease, Cirrhosis and Other Liver Conditions (Except Viral Hepatitis)	13.6%	Depression	17.2%	Schizophrenia and Other Psychotic Disorders	15.8%	Schizophrenia and Other Psychotic Disorders	14.8%
Intellectual Disabilities and Related Conditions	13.6%	Bipolar Disorder	16.7%	Hypertension	15.8%	Anxiety Disorders	13.8%
Alcohol Use Disorders	13.6%	Hypertension	15.6%	Depressive Disorders	13.5%	Depressive Disorders	13.5%
Sensory — Deafness and Hearing Impairment	9.1%	Depressive Disorders	15.6%	Anxiety Disorders	13.1%	Chronic Kidney Disease	12.4%

35–64 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	75.4%	Hypertension	71.8%	Hypertension	62.9%	Hypertension	59.0%
Chronic Kidney Disease	49.7%	Chronic Kidney Disease	52.8%	Diabetes	45.9%	Diabetes	31.0%
Hyperlipidemia	47.7%	Diabetes	38.5%	Chronic Kidney Disease	38.1%	Hyperlipidemia	28.1%
Diabetes	45.7%	Anemia	30.0%	Anemia	29.2%	Tobacco Use	27.1%
Anemia	29.6%	Hyperlipidemia	28.6%	Hyperlipidemia	28.8%	Chronic Kidney Disease	26.9%
Ischemic Heart Disease	27.6%	Heart Failure	28.6%	Obesity	18.8%	Obesity	21.8%
Peripheral Vascular Disease (PVD)	14.6%	Tobacco Use	22.4%	Heart Failure	17.8%	Ischemic Heart Disease	21.4%
Tobacco Use	12.6%	Obesity	19.0%	Ischemic Heart Disease	17.8%	Anemia	20.1%

35–64 Males (continued)

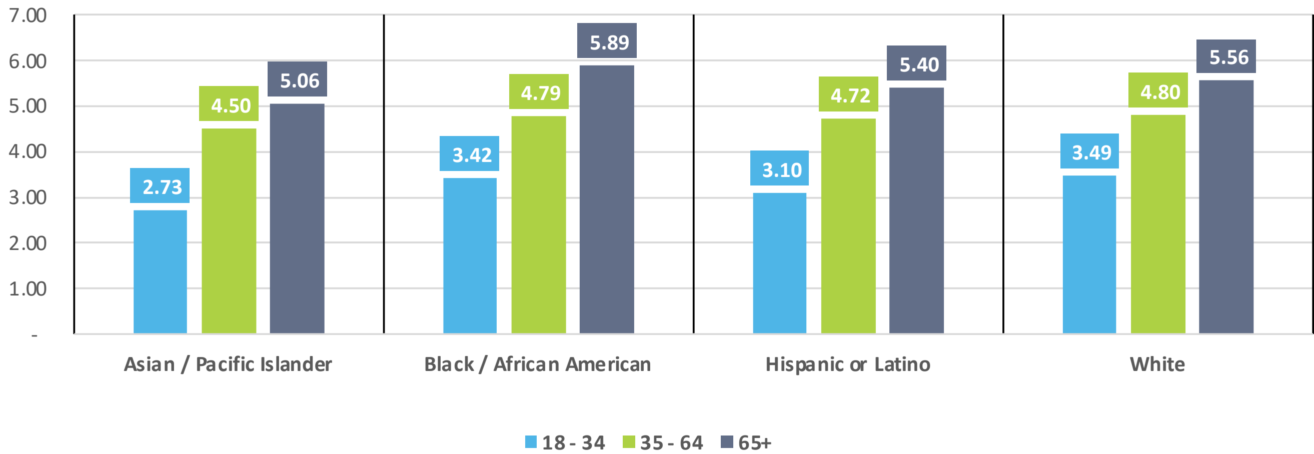
Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Heart Failure	11.1%	Ischemic Heart Disease	16.8%	Tobacco Use	16.4%	Heart Failure	18.7%
Obesity	10.1%	Drug Use Disorders	14.1%	Alcohol Use Disorders	14.7%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	17.1%

65+ Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Hypertension	79.9%	Hypertension	81.4%	Hypertension	81.3%	Hypertension	76.3%
Chronic Kidney Disease	55.4%	Chronic Kidney Disease	54.2%	Diabetes	51.7%	Chronic Kidney Disease	46.2%
Diabetes	49.6%	Anemia	51.0%	Chronic Kidney Disease	47.9%	Hyperlipidemia	44.3%
Anemia	42.9%	Hyperlipidemia	46.7%	Hyperlipidemia	43.4%	Ischemic Heart Disease	39.9%
Ischemic Heart Disease	40.2%	Diabetes	46.7%	Anemia	39.7%	Anemia	36.1%
Hyperlipidemia	37.5%	Heart Failure	33.0%	Ischemic Heart Disease	33.8%	Diabetes	34.4%
Heart Failure	33.9%	Ischemic Heart Disease	29.2%	Benign Prostatic Hyperplasia	29.1%	Heart Failure	29.8%
Benign Prostatic Hyperplasia	26.8%	Benign Prostatic Hyperplasia	27.5%	Heart Failure	28.5%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	28.3%
Chronic Obstructive Pulmonary Disease and Bronchiectasis	18.3%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	22.3%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	18.3%	Benign Prostatic Hyperplasia	28.1%
Peripheral Vascular Disease (PVD)	11.6%	Rheumatoid Arthritis / Osteoarthritis	16.9%	Rheumatoid Arthritis / Osteoarthritis	15.0%	Rheumatoid Arthritis / Osteoarthritis	17.5%

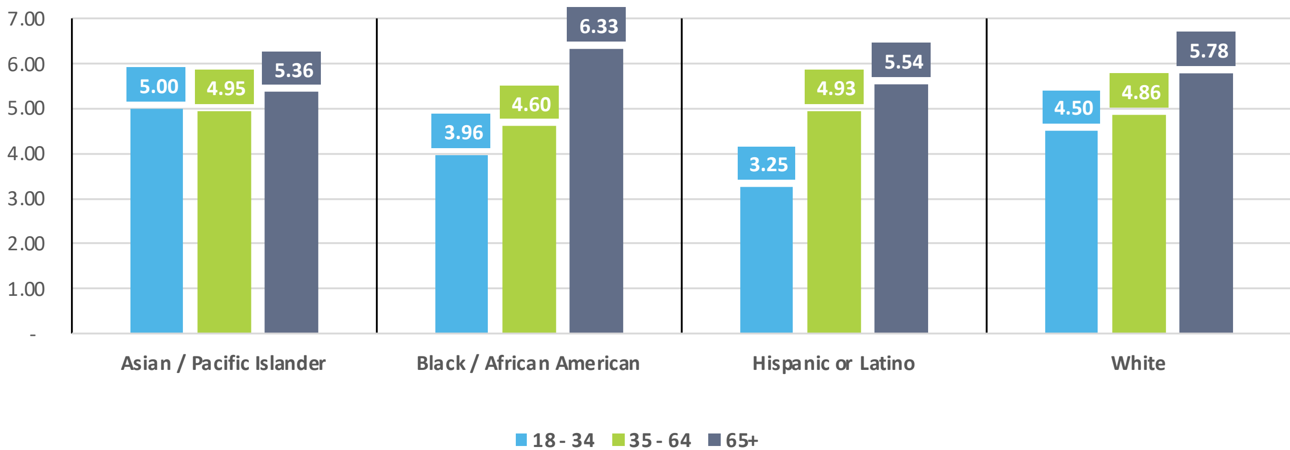
Black/African American males 65+ in the San Gorgonio Memorial Hospital PSA had an average of 5.89 chronic conditions from 2016 to 2019. Black/African American, Hispanic/Latino and White males had similar rates of disease in the 35–64 age group. Males 65+ averaged the highest number of chronic conditions across all ethnic groups.

Male Average Number of Chronic Conditions by Race and Age Range 2016–2019 Discharges



In 2020, the distribution among race/ethnicity groups was higher than in 2016–2019, especially in Black/African American males 65+. Overall, the number of conditions in Asian/Pacific Islander males rose significantly, especially in the 18–34 age group, which jumped from 2.73 to 5.00.

Male Average Number of Chronic Conditions by Race and Age Range 2020 Discharges



San Gorgonio Memorial Hospital PSA
Chronic Conditions — Female

The top chronic conditions for females in the 18–34 age group were anemia and obesity, followed by depression and anxiety. Hypertension levels were high in females 35–64 and 65+, followed by diabetes, obesity, anemia, depression and kidney disease.

18–34 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**
Anemia	34.5%	Anemia	41.2%	Anemia	37.0%	Anemia	31.1%
Chronic Kidney Disease	13.3%	Asthma	24.7%	Obesity	26.2%	Obesity	21.1%
Obesity	12.4%	Obesity	19.8%	Anxiety Disorders	9.8%	Depression	13.2%
Hypertension	10.6%	Drug Use Disorders	14.9%	Asthma	9.4%	Asthma	12.9%
Depression	10.6%	Depression	12.5%	Drug Use Disorders	8.8%	Depressive Disorders	12.0%
Depressive Disorders	9.7%	Tobacco Use	12.2%	Depression	8.7%	Anxiety Disorders	11.5%
Acquired Hypothyroidism	9.7%	Anxiety Disorders	11.9%	Depressive Disorders	8.2%	Drug Use Disorders	10.8%
Heart Failure	7.1%	Sickle Cell Disease	11.6%	Diabetes	7.3%	Tobacco Use	9.7%
Schizophrenia and Other Psychotic Disorders	5.3%	Diabetes	11.6%	Chronic Kidney Disease	6.1%	Hypertension	5.4%
Hyperlipidemia	5.3%	Depressive Disorders	11.0%	Tobacco Use	5.2%	Acquired Hypothyroidism	5.4%

35–64 Females

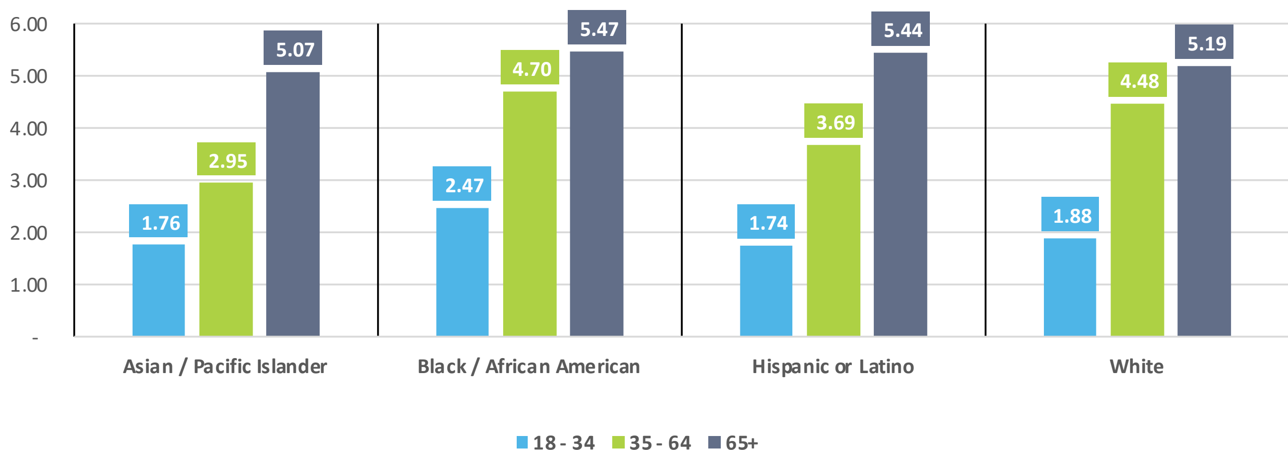
Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**
Hypertension	41.5%	Hypertension	63.7%	Hypertension	41.7%	Hypertension	45.4%
Anemia	30.2%	Diabetes	38.7%	Diabetes	32.5%	Obesity	26.6%
Hyperlipidemia	25.9%	Chronic Kidney Disease	35.0%	Obesity	29.6%	Depression	23.0%
Diabetes	24.4%	Obesity	34.2%	Anemia	29.6%	Anemia	22.3%
Chronic Kidney Disease	24.4%	Anemia	33.0%	Chronic Kidney Disease	22.0%	Diabetes	22.1%
Heart Failure	9.3%	Tobacco Use	23.4%	Hyperlipidemia	20.3%	Anxiety Disorders	22.1%
Obesity	8.8%	Hyperlipidemia	23.2%	Depression	15.7%	Tobacco Use	21.7%
Asthma	8.3%	Heart Failure	20.4%	Depressive Disorders	14.5%	Depressive Disorders	21.3%
Tobacco Use	7.8%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	15.7%	Anxiety Disorders	14.1%	Hyperlipidemia	19.7%
Fibromyalgia and Chronic Pain and Fatigue	7.8%	Ischemic Heart Disease	15.5%	Liver Disease, Cirrhosis and Other Liver Conditions (Except Viral Hepatitis)	12.7%	Fibromyalgia and Chronic Pain and Fatigue	18.8%

65+ Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**
Hypertension	85.9%	Hypertension	87.3%	Hypertension	81.4%	Hypertension	74.1%
Anemia	46.4%	Chronic Kidney Disease	51.4%	Diabetes	51.2%	Hyperlipidemia	38.5%
Diabetes	46.1%	Anemia	46.1%	Chronic Kidney Disease	41.5%	Chronic Kidney Disease	37.7%
Chronic Kidney Disease	44.6%	Diabetes	41.6%	Anemia	41.1%	Anemia	36.6%
Hyperlipidemia	39.5%	Hyperlipidemia	38.5%	Hyperlipidemia	39.9%	Acquired Hypothyroidism	26.5%
Heart Failure	32.6%	Heart Failure	33.6%	Heart Failure	27.3%	Diabetes	25.5%
Ischemic Heart Disease	26.6%	Ischemic Heart Disease	25.4%	Ischemic Heart Disease	25.1%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	25.4%
Chronic Obstructive Pulmonary Disease and Bronchiectasis	21.3%	Rheumatoid Arthritis / Osteoarthritis	24.3%	Rheumatoid Arthritis / Osteoarthritis	22.2%	Heart Failure	24.7%
Acquired Hypothyroidism	17.7%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	20.9%	Acquired Hypothyroidism	21.4%	Rheumatoid Arthritis / Osteoarthritis	23.5%
Rheumatoid Arthritis / Osteoarthritis	16.2%	Obesity	16.5%	Chronic Obstructive Pulmonary Disease and Bronchiectasis	19.0%	Ischemic Heart Disease	22.4%

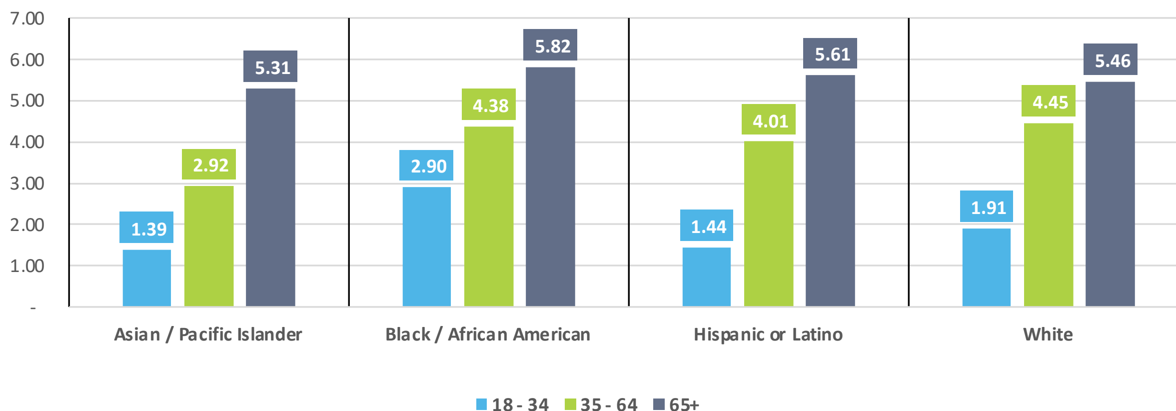
Older Black/African American females in the San Gorgonio Memorial Hospital PSA had an average of 5.47 chronic conditions from 2016 to 2019; their numbers were also the highest for ages 35–64. For all ethnicities, the number of chronic conditions in females 65+ ranged from 5.07 to 5.47. Younger (18–34) Hispanic/Latina and Asian/Pacific Islander women had the lowest numbers of chronic conditions.

Female Average Number of Chronic Conditions by Race and Age Range 2016–2019 Discharges



The average number of chronic conditions increased across all races for the 65+ group in 2020. Both Asian/Pacific Islander and Hispanic or Latina females in the 18–34 group saw decreases in the number of chronic conditions while Black/African American and White females in that age group saw increases.

Female Average Number of Chronic Conditions by Race and Age Range 2020 Discharges



San Gorgonio Memorial Hospital PSA Chronic Conditions — Youth

Asthma was the most common chronic condition in males ages 0–17, followed by depression, drug use disorders and certain mental/behavioral health issues such as ADHD and bipolar disorders. For females, the most common conditions were depression/anxiety, followed by asthma and anemia. Young Asian/Pacific Islander males had a high rate of chronic kidney disease.

1–17 Males

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**	**Chronic Condition**	**%**
Chronic Kidney Disease	30.0%	Asthma	36.4%	Asthma	25.5%	Asthma	25.1%
Sensory — Deafness and Hearing Impairment	23.3%	ADHD Conduct Disorders and Hyperkinetic Syndrome	32.5%	Depression	20.7%	Depression	24.2%
Intellectual Disabilities and Related Conditions	23.3%	Drug Use Disorders	22.1%	Depressive Disorders	19.7%	Depressive Disorders	23.8%
Obesity	13.3%	Bipolar Disorder	22.1%	ADHD Conduct Disorders and Hyperkinetic Syndrome	15.6%	ADHD Conduct Disorders and Hyperkinetic Syndrome	17.7%
Depressive Disorders	13.3%	Epilepsy	19.5%	Obesity	10.8%	Anemia	12.1%
Depression	13.3%	Depressive Disorders	18.2%	Epilepsy	10.5%	Epilepsy	11.3%
Asthma	13.3%	Depression	18.2%	Drug Use Disorders	9.9%	Drug Use Disorders	11.3%
Epilepsy	10.0%	Schizophrenia and Other Psychotic Disorders	11.7%	Autism Spectrum Disorders	9.2%	Intellectual Disabilities and Related Conditions	9.1%
Cerebral Palsy	6.7%	Anemia	11.7%	Anemia	8.3%	Anxiety Disorders	9.1%
Traumatic Brain Injury and Nonpsychotic Mental Disorders Due to Brain Damage	3.3%	Intellectual Disabilities and Related Conditions	10.4%	Spina Bifida and Other Congenital Anomalies of the Nervous System	7.3%	Autism Spectrum Disorders	8.7%

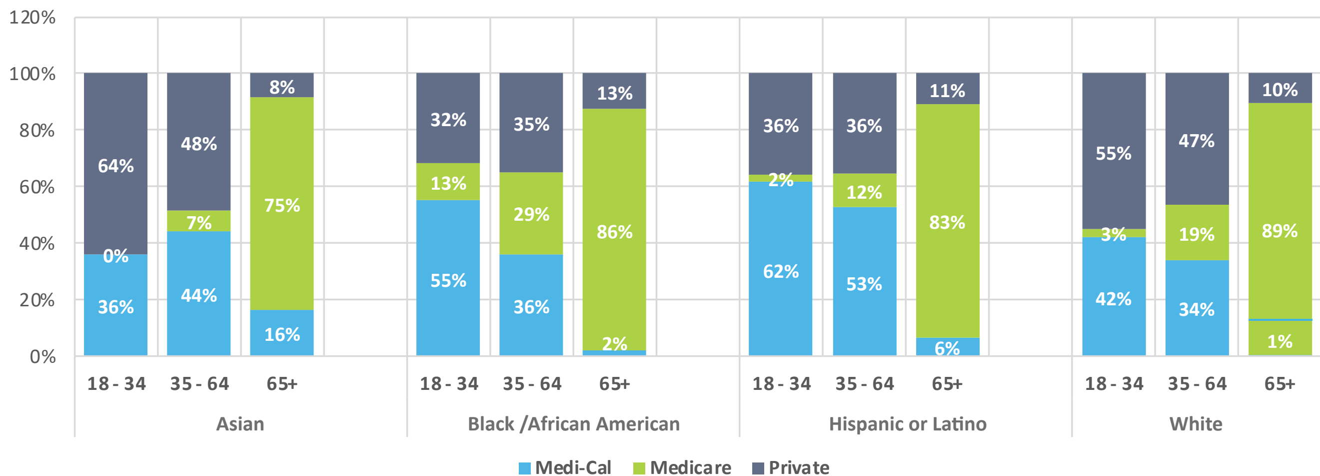
1–17 Females

Asian / Pacific Islander		Black / African American		Hispanic or Latino		White	
Chronic Condition	%	Chronic Condition	%	Chronic Condition	%	Chronic Condition	%
Asthma	29.2%	Depression	52.5%	Depression	35.7%	Depression	40.4%
Depressive Disorders	20.8%	Depressive Disorders	46.3%	Depressive Disorders	35.4%	Depressive Disorders	38.3%
Depression	20.8%	Asthma	28.8%	Anemia	17.0%	Anxiety Disorders	18.3%
Anemia	16.7%	Epilepsy	22.5%	Anxiety Disorders	15.0%	Asthma	13.6%
Mobility Impairments	12.5%	ADHD Conduct Disorders and Hyperkinetic Syndrome	18.8%	Asthma	13.6%	Epilepsy	11.5%
Intellectual Disabilities and Related Conditions	12.5%	Drug Use Disorders	15.0%	Chronic Kidney Disease	10.9%	Drug Use Disorders	9.8%
Acquired Hypothyroidism	12.5%	Anxiety Disorders	11.3%	Obesity	9.9%	ADHD Conduct Disorders and Hyperkinetic Syndrome	9.8%
Spina Bifida and Other Congenital Anomalies of the Nervous System	8.3%	Other Developmental Delays	10.0%	Leukemias and Lymphomas	7.5%	Intellectual Disabilities and Related Conditions	9.4%
Schizophrenia and Other Psychotic Disorders	8.3%	Intellectual Disabilities and Related Conditions	10.0%	ADHD Conduct Disorders and Hyperkinetic Syndrome	7.5%	Migraine and Chronic Headache	6.4%
Muscular Dystrophy	8.3%	Schizophrenia and Other Psychotic Disorders	6.3%	Drug Use Disorders	7.1%	Anemia	6.4%

San Gorgonio Memorial Hospital PSA Payer and Avoidable ED Visits

Medi-Cal is the primary payer for Hispanic or Latino and Black/African American patients ages 18–34 and 35–64 in the San Gorgonio Memorial Hospital PSA. People over age 65 in all ethnic groups are generally covered by Medicare, with a small percentage of Medi-Cal payers in people 65+.

Percent Primary Payer by Race/Ethnicity and Age Range



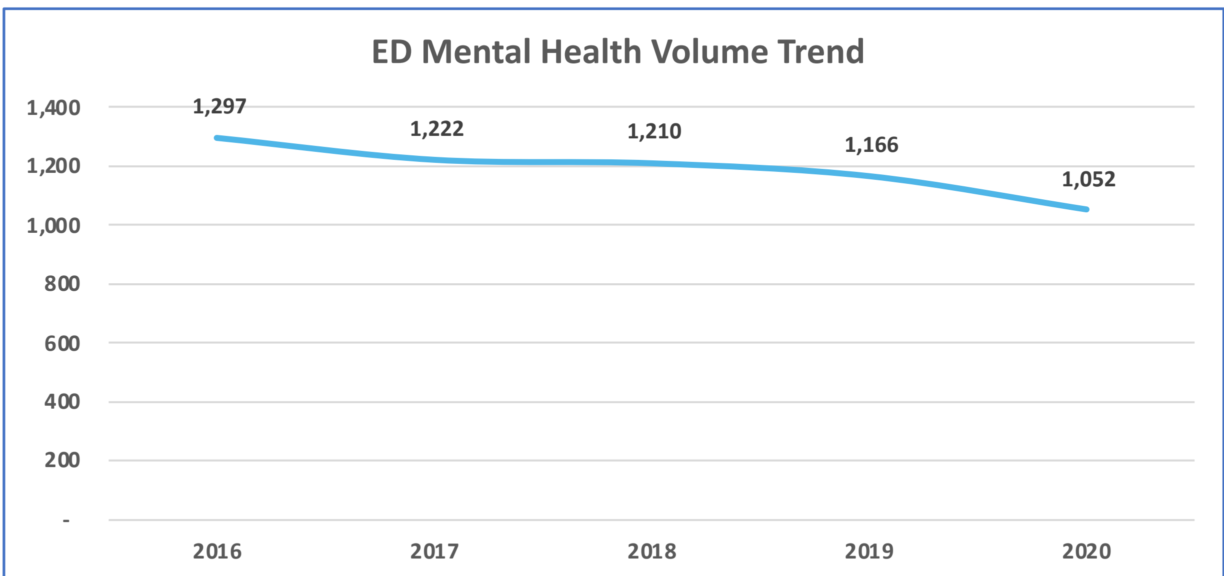
The charts below show avoidable hospitalizations associated with social determinants as identified by Z codes using the New York University algorithm, the tool most widely used to evaluate use of emergency services. The top payer for avoidable ED visits at San Gorgonio Memorial Hospital is Medi-Cal, followed by Medicare HMOs. Youth 1–17 have been the greatest users of the ED, but the numbers declined slightly in 2020, as did visits for all age groups. The numbers for the social drivers for these ED visits are very low, likely due to tracking methodology. Z codes, which are used to identify social determinants, are severely underreported (as with other hospitals). Hispanic/Latino people have the highest rate of ED use.

	Visits by Volume					Avoidable Visits				
Category	2017	2018	2019	2020	2019–2020 Vol Change	2017	2018	2019	2020	Point Change
PSA Total	40,287	39,684	40,760	31,882	-8,878	52%	53%	53%	52%	0
Top 5 Payers by Volume	**2017**	**2018**	**2019**	**2020**	**2019–2020 Vol Change**	**2017**	**2018**	**2019**	**2020**	**Point Change**
Medicaid (Medi-Cal)	20,448	19,336	19,445	13,700	-5,745	58%	57%	57%	52%	-6
Health Maintenance Organization (HMO) Medicare Risk	8,380	8,500	8,756	7,167	-1,589	48%	48%	47%	45%	-3
Health Maintenance Organization (HMO)	2,189	2,476	2,764	3,144	380	48%	51%	50%	45%	-2
Preferred Provider Organization (PPO)	3,202	3,119	3,471	2,377	-1,094	50%	49%	50%	47%	-3
Self-Pay	2,330	2,349	2,399	2,034	-365	49%	49%	49%	44%	-4
Age Groups	**2017**	**2018**	**2019**	**2020**	**2019–2020 Vol Change**	**2017**	**2018**	**2019**	**2020**	**Point Change**
Under 1 Year	1,120	984	974	568	-406	63%	67%	68%	63%	1
1 – 17 Years	8,320	7,740	8,197	4,630	-3,567	58%	58%	58%	52%	-6
18 – 34 Years	9,776	9,371	9,534	7,869	-1,665	53%	51%	51%	47%	-6
35 – 64 Years	12,858	13,160	13,417	11,394	-2,023	52%	52%	52%	49%	-3
65 Years or Greater	8,213	8,429	8,638	7,421	-1,217	48%	48%	47%	45%	-4
Social Determinants	**2017**	**2018**	**2019**	**2020**	**2019–2020 Vol Change**	**2017**	**2018**	**2019**	**2020**	**Point Change**
Housing and Economic	80	67	10	11	1	44%	52%	50%	18%	-26
Primary Support Group and Family	2	9	9	10	1	50%	11%	22%	40%	-10
Other Psychosocial Circumstances	3	-	1	10	9	0%	0%	0%	30%	30
Upbringing	5	5	2	5	3	20%	60%	50%	40%	20
Occupational Risk	6	4	6	4	-2	17%	25%	17%	0%	-17
Social Environment	2	3	3	-	-3	0%	33%	0%	0%	0
Employment	1	2	1	-	-1	0%	0%	0%	0%	0
Education and Literacy	1	4	2	-	-2	100%	0%	0%	0%	-100

Race/Ethnicity	2017	2018	2019	2020	2019 – 2020 Vol Change	2017	2018	2019	2020	Point Change
Asian / Pacific Islander	1,212	1,185	1,269	918	-351	54%	55%	53%	51%	-3
Black / African American	4,256	4,291	4,325	3,171	-1,154	55%	56%	56%	52%	-4
Hispanic or Latino	15,308	15,258	15,783	12,336	-3,447	56%	55%	55%	50%	-6
White	18,179	17,682	17,863	14,147	-3,716	50%	49%	49%	46%	-4

ED Visits for Mental Health Conditions

Mental health ED primary diagnoses in the San Gorgonio Memorial Hospital PSA have dropped since 2016, and most significantly in 2020.



Appendix Q: Listening Session Report

Community Listening Session Report

May 10, 2022

Project Description: The Inland Empire Health Plan, HC² Strategies and regional hospitals conducted a collective health and equity needs assessment to identify systems and policy improvements with dedicated resource flows to address inequities in San Bernardino and Riverside counties. HC² engaged The Social Impact Artists (SIA) on April 6, 2022, to conduct seven focus groups in under-resourced areas to talk with residents and workers who do not typically engage in traditional regional needs assessments, including immigrants, youth, working-class individuals and those identifying as BIPOC (Black, indigenous and people of color). Focal points of our community-participatory process included health care access and usage, humane housing, mental health needs, substance use, and chronic disease. To effectively engage BIPOC people, whose opinions, experiences, and proposed solutions are vital to addressing systemic inequity, SIA deployed four immigrant, bilingual community engagement workers who are well-trained in effectively and compassionately conducting outreach to and dialoguing with underserved communities in Spanish and English. SIA trained the team about project goals, with a particular focus on incorporating the Vital Conditions for Well-Being Framework and Framework of Disease.

Executive Summary: To better understand the root causes of disease and inequity as well as the lived experience of residents and health care end users (or future users) in the Inland Empire, SIA conducted eight focus groups across the Inland region with a total of 49 unique participants from April 11 to May 9, 2022 (see Figure 1). SIA conducted 22 hours of outreach to target underrepresented, under-engaged people living in hard-to-reach or isolated geographic areas, including specific underserved neighborhoods (Transformative Climate Communities zone in Ontario, California). When possible, SIA also used its trusted network of resident leaders and community-based organizations to work strategically, timely and effectively.

Youth and adult residents and workforce members made up the focus groups with outreach and research occurring in the geographic areas of:

- San Bernardino County: Ontario, Rialto, Big Bear/Arrowhead, Victorville/Hesperia
- Riverside County: Hemet, Perris, Menifee, Moreno Valley, Homeland (unincorporated area)

SIA also conducted outreach in Needles, California, but the execution of quality focus groups in this area proved to be unattainable within the timeline specified by the Stakeholder Committee for the project.

SIA designed the project to improve the understanding of the following:

- Current experiences and viewpoints of health care end users not usually "heard" in traditional regional needs assessment processes
- Current needs and tenable solutions in areas without or with sub-optimal services

- How to incorporate residents' voices to support regional conditions for well-being and improved resource flows
- How residents might co-create a collective health stewardship model for the Inland region

Across the region, focus group participants — outside of the few who were born and raised in the region — shared that they moved to the Inland Empire area because housing was affordable, and the area was peaceful and more "calm" than Los Angeles or other urban areas from which they came. One participant who has lived in Moreno Valley for 25 years said, *"[She] saw that children were on their bikes in the streets, and it was peaceful, and the schools were great."*

Participants made it clear during the conversations that they are invested in the region, clearly see the need for improvements and want to take some level of leadership to improve it for themselves and for their children and/or grandchildren. P*articipants were adamant that fundamental, actionable changes in their community are needed immediately*. The immediacy seemed partially related to having just exited what participants hoped would be the worst part of the COVID-19 pandemic and related to their perceptions that their communities are unhealthy and that immediate solutions are critical.

Participants also expressed that over the last five years [see pages below for data]:

- Youth quality of life must be improved at all levels; need more youth interventions.
- Anxiety, stress, depression and mental health issues have become the number one priority.
- Systemic discrimination against individuals identifying as Black/African American and Latinx persists.
- The region has become too crowded and there are too many factories/warehouses.
- Health care: need facilities, better quality of care, faster response and warmer interactions.
- Traffic has become unbearable.
- Homelessness has become a significant public health issue.
- Violence and crime have increased and adults fear for their children's safety and future.
- There has been a steady and significant decline in free or low-cost community-based programming with a simultaneous decrease in social cohesion.

Participants resoundingly expressed high levels of commitment to improving their communities, and prioritized the following health issues:

- Improved youth programming: mental health, health, schools, arts and entertainment.
- Access to health care with improved user experiences.
- Diabetes, obesity, high blood pressure and cancer.
- Free and low-cost mental health and substance use recovery resources.

- Addressing the affordable housing shortage
- Improving safety in their communities

Because the region is experiencing growth while recovering from the economic and social impacts of the COVID-19 pandemic, participants also demonstrated *frustration, disillusionment, fatigue and a general mistrust of government and systems.* They made it clear that they want to see improvements across the following domains:

- Free or low-cost mental health resources embedded in neighborhoods and within traditional health care settings coupled with better training for school-based counselors
- Increased affordable housing stock and/or rental assistance programs
- Appropriate, quality and person-centered health care services that are geographically equitable
- Improved access to and more positive user experiences in health care
- More *health* and youth programming at schools, within community centers and in health care
- Investments in community cohesion programs and a return of robust Healthy Communities programming (provided through the San Bernardino County – Department of Public Health)
- Safer and more walkable communities; also explore localized transportation options
- Traffic remediation solutions
- Increased access to healthy foods (fresh, affordable produce) and nutrition and fitness education
- More resources, higher accountability and better training for teachers and school staff
- More community safety investments

1. **Methodology:** This study employed focus groups to examine the experiences and opinions of residents and workforce in the Inland Empire. The SIA team conducted extensive outreach and then held eight focus group conversations led by five Inland region residents, three of whom are female multilingual immigrants who are trained and experienced community engagement leaders and community health workers. Evette De Luca, who holds a master's degree in social impact and has led multilingual community engagement work in the Inland Empire and South L.A. for 17 years, spearheaded the project and conducted three sessions to train focus group leaders on the objectives, focus group tools, regional logistics and record keeping.

   SIA conducted in-person outreach to engage participants in Big Bear, Lake Arrowhead, Hemet, Perris, Ontario, Moreno Valley and Rialto. The organization conducted outreach through email and social media in Needles, Perris, Menifee and Rialto. They used their trusted partner network to take a system approach to outreach, including National CORE Renaissance, El Sol Neighborhood Educational Center and Rim Family Services.

a. **Instrument Development:** HC² Strategies provided a list of questions and a focus group script. SIA translated the script and questions into Spanish and developed a training curriculum to quickly train its team. The organization then beta-tested the script and questions within its team of resident leaders, and then within Focus Group #1 conducted in Ontario, California. SIA developed flyers for outreach, notetaking tools and protocol and focus group checklists; and purchased gift cards and refreshments.

b. **Site Selection:** Sites were selected using three criteria: 1) at least two were located within geographic priority areas; 2) all were easily accessible to the community participants (walking prioritized at the apartment complex and libraries; 3) all were able to be scheduled with focus groups occurring before the May 9, 2022, cut-off date. SIA conducted five focus groups *in-person* at libraries, community centers and an affordable housing complex; and three *virtual* focus groups. Participants received free refreshments, incentives and a $20 gift card for their participation. Virtual participants received electronic gift cards.

c. **Participant Selection:** SIA's team conducted extensive outreach through phone calls, emails, social media, at health fairs, hospitals, pharmacies, laundromats and libraries, and by door-to-door visits to businesses and dwellings. Participants were selected based on the following criteria: 1) Residents or workforce who had lived/worked in the Inland region for at least one year; 2) Residents or workforce who lived and/or worked in at least two of the low-service prioritized neighborhoods of the Mountain Communities, Perris, Hemet, Needles, Barstow, Trona or Blythe; 3) Spanish-speaking and BIPOC residents who sought services at libraries and affordable housing complexes; 4) English- and Spanish-speaking patients from Mountain community hospitals; 5) Residents who attended free health fairs; and 6) Youth or youth-serving organizations, including IE Immigrant Youth Coalition.

d. **Limitations:** As with all methodologies, qualitative research has benefits and limitations. Qualitative research allows for detailed, in-depth examinations of issues. In contrast to quantitative research, which aims at being generalizable across populations, qualitative research seeks to add texture and dimension through data collection focused on the nuances of human experience. As a complement to quantitative research, qualitative research can afford deeper insight into complex issues. The present study has several limitations that readers should consider while interpreting the results. First, the number of total focus group participants (n=49) only represents less than 1% of the approximately 4 million people who live in the region. Second, SIA asked individuals to participate in the focus groups based on their interest, willingness and availability. This may have introduced some degree of self-selection bias. Lastly, due to the project timeline stipulated by the Stakeholder Committee, the organization had about 30 days to execute. This timeline created some constraints regarding optimal adult and especially youth participation.

e. **Focus Groups:** SIA held eight focus groups addressing 12 questions.

This report describes the insights gathered from eight focus group discussions, cross-cutting themes and geographic variations. It also includes recommendations for the Stakeholder Committee. Additionally, SIA engagement team members are well-rooted and embedded deeply in their communities. The outreach team used their personal and professional networks to engage residents to participate in the focus groups.

Date/Time	Location	Language/ Target Audience	Outreach: # of People	# of People in Focus Group
April 11, 2022 12:30 p.m.	Ontario Ovitt Library	English and Spanish Adults	27	9
May 3, 2022 10 a.m.	Rialto: Citrus Grove & Vista Cascade Affordable apartments (National CORE)	Spanish	192 residents	6
May 4, 2022 8 a.m.	Mountain Communities, Rim Family Services/ Virtual	English Adults	36 businesses	9
May 5, 2022 12 p.m.	Valley Vista Community Center, Hemet	#1 Spanish #2 English	39 Hemet youth and adults	3 5
May 6, 2022 11 a.m.	Perris Library	Spanish Adults	128 (Perris Health Fair)	6
May 7, 2022 10 a.m	Menifee/Homeland — Virtual	English Youth	22	3
May 9, 2022 6 p.m.	Moreno Valley/ Victorville/Hesperia — Virtual	Spanish	48	8
Totals			**492**	**49**

Figure 1. Focus Group Information

2. **Participant Profiles:** All participants were residents of the Inland Empire with a range of 1–50+ years as Inland Empire renters or homeowners. Most participants work in the Inland Empire.

3. **Demographics:** All participants were residents of the Inland Empire with a range of 1–50+ years as Inland Empire renters or homeowners. Most participants work in the Inland Empire.
   a) Number of focus group participants: 49
   b) Age range: 1) three youth, ages 24 or younger; 2) 46 adults, ages 25 or older
   c) Gender: 90% (43) female; 10% (5) male.
   d) Other: SIA facilitated four English focus groups, four Spanish focus groups and one focus group in English and Spanish.

4. **Discussion Results:** In this summary, SIA focuses on the high-level, cross-cutting themes that emerged across communities in its key areas of inquiry. In addition, SIA details the most important community-specific findings that emerged in these conversations by city. Finally, the organization summarizes the most frequently discussed ideas for improvement raised by participants, shares salient community quotes by city and presents community recommendations. Two tables below summarize community health problems and challenges.

Community Health Problems (ranked in order of most responses)

Ontario	Perris	Mountain Communities	Rialto	Hemet (Two Focus Groups)	Moreno Valley/ Victorville	Menifee
Mental health Diabetes Obesity Homelessness/ housing Cardiovascular disease	Diabetes High blood pressure Depression Substance abuse Allergies	Substance abuse Mental health/ anxiety/ childhood trauma (especially youth and seniors) High blood pressure COPD (especially seniors) Allergies	Diabetes Heart disease Mental health High blood pressure Cancer	Mental health/ childhood trauma Substance abuse Domestic violence/ community violence High blood pressure Cancer	Diabetes Mental health Cancer Allergies Effects of COVID-19	Anxiety Depression Substance abuse/ vaping Stress Overweight/ obesity

Figure 2. Community Health Problems

Environmental and Community Issues (ranked in order of most responses)

Ontario	Perris	Mountain Communities	Rialto	Hemet (Two Focus Groups)	Moreno Valley/ Victorville	Menifee
More factories/ poor air quality Affordable housing shortages Homelessness Increased crime Need substance abuse support groups	More factories Increased traffic Illegal dumping in abandoned lots Poor air quality Excessive marijuana dispensaries	Affordable housing crisis (effect of Airbnb and short-term rentals) Access to health care (higher quality health care) Lack of community/ youth center Need substance abuse support groups Low-quality schools / school under enrollment (decrease from 1,200 to 900 students)	Homelessness Increased crime/violence (theft/shootings) Poor air quality Increased community violence High cost of healthy food	*The top six issues of both focus groups are combined below.* Community and school-based violence Domestic violence Low-quality schools (low educational attainment; quality of teachers and programs; low-quality food) Affordable housing (especially for seniors) Access to health care (higher quality health care) High cost of healthy food	Increased crime Increased community violence Excessive marijuana dispensaries, alcohol outlets, smoke shops (including e-cigarettes and paraphernalia) Homelessness Illegal dumping	Poor public transportation Lack of accessible outlets for youth School issues: lack of training for teachers and aids to cope with youth behavioral issues/ lack of effective mental health resources and youth campaigns Lack of entertainment for youth Lack of sidewalks and walkability

Figure 3. Environmental & Community Issues

**SIA held two focus groups in Hemet. They listed the top six issues due to the high number of responses in this category.*

General Overall Viewpoints

Assets: Most residents shared that they moved to the Inland Empire area because housing was affordable and the area was peaceful and more "calm" than Los Angeles or other urban areas from which they relocated (including Mexico City). One participant who has lived in Moreno Valley for 25 years said, *"[She] saw that children were on their bikes in the streets, and it was peaceful, and the schools were great."* Most participants would still recommend that friends and family move to the Inland region *"because there are many job opportunities, affordable homes, and it is peaceful."* They reported that the Inland region is still economically attractive even as the majority stated that there has been a steady decline in community safety, quality of life and services. *"You get more for your money. In Los Angeles, houses are smaller, older and more expensive."* Many participants also stated that the Inland region is attractive because the employment market is desirable. *"It is easy to find a job here, but more and more jobs are in warehouses… that is a problem."* Most participants worked in the Inland Empire and did not have to commute to Los Angeles, thus they felt more rooted in the community in which they lived.

Faith-based organizations: arose as vibrant assets across all regions and focus groups, both as maintainers of community fabric and providers of free resources and support. Several stated that they turn to their pastors and church families for mental health counseling and resilience support.

Improvements in the built environment: Ontario, Rialto and Menifee residents mentioned that they have seen growth in certain parts of their communities, especially related to green spaces, additional or renovated parks, walking paths and new food retail outlets.

Youth and adult residents and workforce members made up the focus groups with outreach and research occurring in the geographic areas of Ontario, Perris, mountain communities, Rialto, Hemet, Moreno Valley, Victorville/Hesperia and Menifee.

Community Assets

Ontario: Participants view their largest assets as the free Zumba classes and programming that community centers provide, strong faith-based organizations, great recreation centers and programming for children, good park systems and good schools and services. "You get more for your money. In Los Angeles, houses are smaller, older and more expensive." Many participants also stated that the Inland region is attractive because the employment market is desirable. "It is easy to find a job here, but more and more jobs are in warehouses…. that is a problem." Most participants worked in the Inland Empire and did not have to commute to Los Angeles, thus they felt more rooted in the community in which they lived.

Health Care: Participants stated that lack of health insurance is still a challenge in the city, primarily due to residents who do not have citizenship status. Several stated that they use urgent care facilities located in Ontario to access health care. Others used Kaiser Permanente Ontario Medical Center and expressed satisfaction with services. Access to mental health and dental services arose as the most significant needs.

Community: Mental health (anxiety, panic attacks and depression) referrals and services are most needed. One participant talked about 211 and the gaps in quality referrals, stating, *"211 is not enough. The referrals aren't very helpful. We need more. OMSD [Ontario Montclair School District] used to provide referrals and help, but they don't anymore."* Another mentioned domestic violence and that she had called House of Ruth, a local community-based organization, for help *"a month ago and they have not called me back."*

Solutions: 1) One participant mentioned how impactful Healthy Ontario had been and hoped *"that the city or another organization would bring the programs back. I wish the city had not gone away [sic] with Healthy Ontario."* 2) Another participant requested more peer support groups ("similar to 12 steps") for mental health, substance abuse and domestic violence; 3) Participants said it is too expensive to live in Ontario, and that assistance programs are needed (rent, utilities, food and affordable housing). 4) All participants requested more family and youth programming in the community.

Perris: Participants expressed reserved appreciation for the growth in their community. *"There are more shops, more fast-food restaurants and more factories." "The community has grown and progressed, and there are better schools." "I would persuade people to move here because it is a safe community." "It is a good area; I have been out at 2 a.m. by myself and do not feel afraid."* One participant mentioned the historical and systemic discrimination against Blacks and Latinos that persists in the city.

Health Care: Residents stated that they prefer to access health care at local clinics, with several saying that they go to Riverside clinics. However, many participants stated that they must wait at least three weeks to receive an appointment to see their doctor, which makes usage of emergency services more viable, *"unless I go to emergency and in emergency, I have to wait eight hours or longer."* One resident stated that she had IEHP for about 20 years, but when she turned 65, she switched to Kaiser. She said she missed IEHP because she *"preferred to get brand name medication and with Kaiser, she only gets generic brands."* She also stated that IEHP providers delivered better specialty care services.

Community Voices: Participants shared differing views about safety in their community. *"Five years ago, my neighborhood was calm; now every week there are shootings and parties." "My street has become a freeway. People do not respect the speed limit, cars are going more than 80 miles an hour and residents cannot even go outside for walks."* They also stated that youth have limited job opportunities. *"Yes, there are more jobs being created, but many times companies bring their own workers from other communities, which excludes locals living in Perris."*

Solutions: 1) Residents would like a community or resource center in Perris where they can access exercise and health education classes, especially exercise, nutrition and 12-step programs. *"Currently there are senior centers for the elderly and teen centers for the youth, but no centers for people ages 20–50. Currently, the closest center is Riverside or San Bernardino, and we would like to have a center in Perris. To go to these centers, we need transportation. There is no transportation that can take us to and from the centers." "[We] need more places where residents who want to better their lives, health, and recover from an addiction can attend. For example, there is an AA center, but only one."*

Mountain Communities: Participants view their largest assets as their neighbor and faith-based networks and stated that *"we have a lot of churches, and they take care of people."* A housing crisis exists for locals with many youths and adults *"couch surfing."* Due to supply shortages, residents are having to rely on Amazon as their supplier of personal and household items.

Health Care: All participants agreed that health care access and quality of care need to be improved in the mountain communities. Half stated that they either access virtual services through Kaiser Permanente or had to drive down to the Valley for emergency services at Loma Linda or Kaiser Permanente, but *"were grateful for KP's ability to meet online."* When discussing Bear Valley Community Hospital, participants became very energized. One stated that *"Bear Valley is hit or miss."* When discussing Mountains Community Hospital, one stated, *"Let's be honest, it is the joke on the mountain. It's better to wait for an ambulance at the hospital to take you down the mountain, than to get medical attention at the hospital."* A participant mentioned, and the group agreed, that the Mountain community needs more clinics and one member stated that she would like more *"clinics in grocery stores."*

Community Voices: Participants expressed frustration and low-level anger about the changes their communities are experiencing due to the impact of Airbnb and short-term rentals, as well as the increase in retail establishments that sell alcohol to the tourist trade. They feel like the *"ground has literally been taken out from under us."* They also expressed that youth are experiencing high stress and mental health issues. *"Schools could be more involved. Freshman students used to have a health class, where they would focus a whole unit on mental health, [we] need to bring these types of classes back to the curriculum…It is battle with funding and district employees."*

"Housing [shortages] have become chronic. Many people are 'couch surfing' and others have multiple generations living in one small place. Locals are struggling because rent is so high, and it is hard for them to find an affordable place to live…it used to be that it was cheaper to live up here on the mountains. That's no longer the case."

Solutions: 1) School enrollment at Rim schools has decreased by 25% due to a shift in home-schooling. A participant stated that all health classes have been eliminated at Rim schools. She suggested that adding health classes and youth Mental Health Days back into the school curriculum would benefit the community. Another stated that youth are *"over"* Zoom. They need to meet face-to-face, and interventions need to happen at school during the school programming. 2) One participant shared that Big Bear has no youth centers and requested that IEHP create a youth center like the resource centers that they have created in other areas. 3) Participants requested more support groups, community programming, town events and parades for locals, and community-based mental health programs.

Rialto: Participants view their community as generally healthy, especially new developments such as Renaissance Market Place and recently renovated parks. *"[There are] Excellent changes. [I'm] happy that there are more options in terms of shopping and places to eat nearby. Grateful for the new Renaissance Market Place and happy that is it nearby. I love it; I go often to get something to eat." "[The city] added several parks, and renovated parks off of Easton, [and] added a walking path."* However, one participant stated that community violence has increased greatly: *"Don't come here, if I can get away, I am gone. It is outrageous; there are too many people here."* She stated that she had seen a lot of community violence, crime and that there are growing issues with the homeless people.

Health Care: All participants agreed that health care access and quality of care were relatively good in their community and that they didn't have to travel far for quality medical care. Pinnacle Medical Group/Urgent Care and Rialto Clinica Medica were listed as clinics that provided generally positive health care services. Participants mentioned Western Dental as a local resource for dental health care. Participants had many questions about IEHP, and the SIA team provided contact information for IEHP.

Community Voices: Participants stated that the price of food is *"very high and it is harder and harder to afford to buy groceries and the healthy food is too expensive."* Another stated, *"I can only afford the unhealthy stuff because the healthy stuff is so expensive. If they make the healthy stuff affordable a lot of us would not have a lot of health problems that we have."*

"Find something to do for the kids…. Kids need to focus on something else instead of being bad."

(When probed about what *"being bad"* meant, she mentioned that the youth in her apartment complex acted out due to anger and depression.)

Solutions: 1) Free youth mental health programming, art programs and sports programs. 2) Like many other communities, participants requested free Zumba classes, more community centers and free adult mental health counseling.

Hemet: Participants view their largest assets as affordable homes, peaceful, natural spaces with lots of areas where youth can bike and be active. *"The houses are cheaper than L.A., but the school district is not good." "The air is cleaner in Hemet. My son had allergies when we lived in L.A. They went away when we moved here."* Participants prioritized youth programming to alleviate community violence. *"It's quiet here but we need more than that. We need more programs for the kids. They are bored. But the existing programs are too expensive. We can't afford $800. And there are 200 kids in every program."*

Health Care: All participants agreed that health care access and quality of care need to be improved in Hemet. Emergency care is a priority: Three participants expressed that they had to drive at least 30 minutes for their emergency care. *"We want a Kaiser emergency room here. I can go to the Target and make Kaiser appointments, but I must go to Murrieta or Temecula for emergency services."* Another stated that she and her family also had Kaiser, but the price is too high for her: *"We have Kaiser, but we have to pay $350 per week for Kaiser. It is not fair!"*

Other participants had Medicare and went to Innercare at Hemet, but not recently. For dental services, some participants accessed low-cost care at Health System Inc.

Behavioral health services are desperately needed in the community: *"There is a place on Ramona Expressway where people with a mental health emergency can go, but they only receive medication and then they are sent back home. Moises Ponce had a clinic with occupational therapy. People suffering a mental health illness could learn artwork…. learn how to crochet and make scarfs, which they can later sell."*

Community Voices: All participants expressed appreciation for the open space and parks in the city, but also expressed that disillusionment, violence and crime prevented full access to these spaces. Significant attention must be paid to address school-based violence, participants said. "see bold quoted below" *"We are too fragmented. People don't show up to meetings. They aren't engaged." "In Hemet, people don't care. They don't want to help people." "We see violence, domestic violence in the families, and substance abuse, but our kids don't want us to tell anyone about these." "We urgently need a domestic violence treatment program here. Three of my daughters' friends' families are experiencing this now."*

"We want an IEHP resource center here. I've heard that IEHP made resource centers in other cities. Maybe in San Jacinto? But Hemet would be best."

"All we have here is food. We need activities. There is a skating park here, but it is $20 per person. We can't afford it."

We have beautiful parks here, but people are afraid to come here because of the violence."

"The city doesn't have enough funds to keep the city services going. The funds are not there, so the streets aren't clean."

"My family moved here a year ago. Moved from L.A. County. I feel disappointed. The school is not good. My son said this is not what he wanted. We are planning to move back to L.A. if things don't get better. I couldn't afford to live in LA. But am I investing in a house, but not my child's education? I was renting a two-bedroom apartment for $1,475. It's cheaper here, but the education here is low. My kids finish their schoolwork in class, and they are bored. The other kids are not listening, playing around and the teachers don't care. My kids call the schools 'ratche.' My kids won't eat the food at school. They say it is 'nasty.'"

"I already see my son getting into trouble. He wasn't like this before. He had a cut on his arm, and he wouldn't tell me how it happened at school. I noticed on Friday that he was hiding from me, was in a bad mood and went in his room and wouldn't talk to me. He said, 'Kids are just bullies here. You need to defend yourself.' But he said: 'Don't tell anyone, Mom.' I don't know what to do. Bad things are happening in school, and the parents don't even know."

Solutions: 1) Residents would like more free programs *("like there once was")*, including ESL classes for adults, computer classes for adults, mental health education in schools and free counseling at all levels. 2) More programs for the youth: mental health, sports, arts, entertainment. 3) Domestic violence and youth violence treatment programs or community-based programming. 4) An IEHP resource center or other community center. 5) Healthier school-based food options. 6) Improved teacher training: behavioral issues. 7) More health care facilities, especially emergency or urgent care facilities.

Moreno Valley: Participants view their largest assets as the economic benefits of Moreno Valley. *"I recommend [people] to move to Moreno Valley because there are many job opportunities, affordable housing, and it is peaceful. You get more for your money. In Los Angeles County houses are more expensive, smaller and older."* Participants stated that schools, churches and the city departments are large assets in their community. Community violence is increasing.

Health Care: Participants stated that they access health care at Kaiser Permanente, Riverside University Health System Medical Center and private clinics. Some residents said that they have to travel to Riverside, because there are better medical and dental clinics there than those located in Moreno Valley, and these are far away.

Community Voices: Participants expressed that the peaceful qualities of their community are changing due to increases in traffic, poorer air quality, increased crime and increased outlets that sell marijuana and other substances. *"There should be more police surveillance, due to the fact that crime has increased. For example, in 2010 the case of Norma Lopez that was [sic] killed and her body was found in an abandoned lot. In one resident's neighborhood there was a drug raid last week. This used to be a tranquil and safe place."*

Solutions: 1) Residents request more public pools and a community center where residents can exercise. 2) Increased safety measures in the community. 3) Free after-school programs for youth.

Victorville/Hesperia: Participants view their largest assets as *"more affordable homes and cleaner air."* One participant who has lived in Victorville for 32 years stated that he *"decided to move to here, because housing was more affordable than it was in Los Angeles and the fact that I thought it was a safer place to raise my children. I saw a lot of gang activity in Los Angeles, and I didn't want my children to grow up around that. I also enjoyed the weather here when I first came."*

Health Care: Several participants accessed care at Kaiser Permanente and expressed satisfaction in the services and patient care. Others accessed care at local low-income medical clinics where *"the consultation and lab work are free."* Participants stated that there are no local dental clinics for low-income families and that local low-cost mental health support is desperately needed.

Community Voices: In general, residents see community changes as good. However, several stated that there have been *"bad"* changes to the community, such as increases in violence, (i.e., *"residents being assaulted with a gun at hand [sic] to take their personal belongings, teens between the ages of 14 and 15 years old are found dead after being reported missing").* Residents reported that they do feel unsafe.

Like other communities, crowding is occurring: *"We only have one freeway, so traffic has increased."*

"There has been an incredible increase in homeless, vandalism, crime inside and outside of the mall, hate crimes against the African American community, increases in suicide rates, [and] illegal car racing on streets."

Menifee: Youth viewed their largest community assets as safety, clean communities, a growing economy and that *"people seem to respect their neighborhoods."* One youth whose family moved from Ontario to Menifee because housing was less expensive said she *"hated Menifee at first. There was nothing to do. Now there are too many people*." Youth said that they also appreciated that there were a lot of places to get food, but that there are not enough places for entertainment. Another stated that *"if you don't drive, nothing is accessible*." A primary concern is that *"[youth] have too much stress without enough outlets."* School-based counselors are not effective in combating mental illness. Although awareness seems to be increasing, vaping and substance abuse are issues.

Health Care: Youth said that their experiences with health care was *"OK."* One stated that her doctor wasn't *"warm or friendly."* She said that she felt judged when she met with her doctor and asked about STD testing. Another said that her experience *"felt like a transaction, like getting my mom's oil changed. I didn't feel like the doctor really cared about me*.*"* Another who has accessed care at Kaiser Permanente since a young child stated, *"It's stressful to go to the doctor and our co-pay is high. The lab work is expensive. The costs are high and unexpected. I see random people and I don't feel comfortable."*

Community Voices: One participant began working at Starbucks at age 16 and has had 20 free mental health sessions annually as one of her benefits. She stated that she wished all youth could have a similar benefit and wished similar resources were offered in schools. Another mentioned that she and her friends don't want to get driver's licenses even though Menifee is not a walkable community, because *"traffic causes us too much anxiety and stress. I don't want to get on the freeway*.*"*

"In my generation, most youth have anxiety and depression. A lot smoke to feel better."

"In my high school there was a designated drug bathroom. It was very easy to get drugs."

"High school counselors aren't the best to share with…They aren't trained to handle the mental health needs of students. They aren't helpful with listening and don't have the resources to really help us."

"So many people are vaping because they are anxious. They would even vape in class…. but what else is there to do out here? [Vaping] is a casual, fun, petty thing.*"*

"We have a lot of mental health problems because of social media and because of drugs. Anxiety is most prominent."

"There is a stigma that youth can't take things seriously. Also, adults designed the mental health campaigns, and they were too campy." When probed to unpack the term *"campy,"* the participant said the campaigns were *"dumb"* and trying too hard to be *"cool."* They mentioned that school-based youth mental health resources are *"superficial," "they do nothing to help us actually treat our problems*." She also shared that the school-based mental health outreach campaigns are ineffective and seem designed by adults *"or popular kids who don't understand the problems kids like us are really facing."*

"Youth have a betrayal mentality. If they confide in you and you share with an adult, they feel betrayed. Because they feel it's shameful to get [mental health] help. I remember in middle school, friendships would end if you shared about your friends' mental health problems."

Solutions: 1) Free quality therapy (can be virtual if needed) within schools or an increase in training resulting in more qualified school counselors. 2) More community and school-based arts programming and events. 3) Create peer support groups and programming in schools and communities. 4) More sidewalks in Menifee and surrounding areas. 5) More libraries, movie theaters and entertainment venues for youth and young adults.

5. **Recommendations: Community Care Model.** The idea of community care, essentially, is to use individual and collective power, privilege and resources to support people who are both in and out of one's scope of reach. That can be a friend, a neighbor, a colleague or a member of an organization that one frequents. It can also look like activism, practicing anti-racism, calling out injustices, donating to organizations or simply asking someone, "What do you need and how can I help you?" In turn, people also receive help from the very community they are a part of. Community care is the foundation of togetherness; by cultivating it, people are better able to support their well-being and that of their neighbors, co-workers and loved ones.

   This model is a meaningful solution given the observations that residents shared about the decline in community resources and services. While this model can run counter to the American cultural conditioning of independence over interdependence, even the most "conservative" of focus group participants ("conservative" was the word that Mountain Community participants used to describe themselves and their community) seemed interested in growing community cohesion and care. One Big Bear participant said, *"We've lost our connectedness. We want our sense of community back."* A Hemet participant who moved from Los Angeles County because she and her family could afford a home in Hemet, said, *"I don't think [Hemet] is healthy. We are too fragmented. People don't show up to meetings. They aren't engaged."* This model also makes sense given that many participants stated that their neighborhood and faith-based networks were the largest assets in their area. Participants in Ontario, the Mountain Communities and Hemet agreed that faith-based networks were one of their largest community assets. *"Churches are the only groups taking care of people."*

6. **Challenges and Pain Points:**

   Decline in Community Services: Across all focus groups, community members who had lived in the region for at least 10 years or more mentioned that they have experienced a steady decline in free community-based programming such as mental health and health resources for youth, ESL classes for adults, computer classes, school-based health and mental health education and civic education classes. This decline arose as a consistent pattern across all focus groups. This reflects a steadily increasing national trend of privatization of community services that were previously firmly in the hands of public entities. Participants stated that this is hurting their families and communities.

   Community Safety: Nearly all participants mentioned (or ranked) increased community violence (including domestic violence) and increased traffic and significant concerns in their communities with an overall perception of feeling unsafe in their communities. Parents expressed deep concern for the safety of their children. Many participants correlated the increase in violence with an increase in substance abuse and homelessness.

School-Based Issues: Many participants, including teachers who participated, stated that schools are no longer community hubs or assets, but have become accelerators of stress, anxiety, depression and even violence. One teacher stated that teachers and aides do not receive appropriate training to effectively address children's, youths' — and their own — mental health and behavioral issues. Parents, especially in the Mountain Communities and Hemet, echoed this opinion. One Hemet parent shared how violence has increased significantly at her son's school. Several participants share about increases in inappropriate sexual activities on school campuses.

Loss of Community: These decreases in service were coupled with a resounding opinion, most pointedly articulated in the Mountain Communities Focus Group, that the region has lost its "sense of community." At least two participants in each focus group articulated that they would like to see more community events tailored especially to residents with the goal of fostering deeper ties in the community with less focus on tourism. This point was most fervent in the Mountain Communities due to the negative impact that short-term rentals, such as Airbnb, have had on the mountain communities.

Cannabis/Marijuana: Nearly all participants described the increase of smoke retail outlets and "excessive use of marijuana" as both a negative community impact and a corollary with increased violence, homelessness, and substance abuse. *"There are many marijuana dispensaries and that is affecting the community. One resident called the police because she was ill, and her neighbors were using marijuana. The police came and told her there is nothing they can do because marijuana is legal and if she did not like it, she had to move elsewhere."* [Perris]

Fast-Food Retail Outlets: All participants stated (or agreed with statements made by the group) that there were too many fast-food retail outlets in their community. "[Victorville] *is unhealthy due to obesity, and nutrition education is much needed. There are many fast-food restaurants, and all foods have chemicals."* [Victorville]

7. Conclusion:

Decline in Community Services: Inland Empire residents and workforce are invested in the region, clearly see the need for improvements and want to take some level of leadership to improve it for themselves and for their children and/or grandchildren. *Participants were adamant that fundamental, actionable changes in their community are needed immediately*. The immediacy seemed partially related to having just exited what participants hoped would be the worst part of the COVID-19 pandemic and related to their perceptions that their communities are unhealthy and that immediate solutions are critical.

Investments in the recommendations listed below coupled with stewardship and investments in a community care model may help to alleviate the pain points and stressors identified in this report and augment the identified assets.

1. Invest in school-based health education and interventions that augment the capacity and quality of school education. Hire BIPOC administrators, teachers and counselors.

2. Engage BIPOC youth to co-design these strategies.

3. Provide walkable communities and improved local transportation systems to alleviate traffic, stress and anxiety.

4. Improve customer service when patients access health care facilities, including EDs (make interactions less “transactional”).

5. Adult residents have become very comfortable with technology. Make virtual health-care services more accessible when possible.

6. Provide walkable communities and improved local transportation systems to alleviate traffic, stress and anxiety.

7. Increase community centers, resource centers and policies, environmental improvements, interventions and programs that connect local communities and bring cohesion.

8. Increase youth and family programming, centralized youth entertainment venues, libraries and theaters (arts programming).

9. Provide quarterly art programming and “night markets” tailored to neighborhood profiles, interests and demographics. Participants across the region requested more community parades and celebrations.

10. Improve mental health training, resource flows and accountability at local schools; return health education and programming for youth.

11. Improve the food retail environment with outlets that sell fresh produce and natural foods (less chemicals).

One final point is clear: Effective community engagement and resident leadership may be the most sustainable solution to combat the myriad of issues that negatively impact the Inland Empire. Investing in future and regular community conversations and engaging the leadership of residents will be impactful solutions for the region.

Appendix R: Consultant Qualifications

HC² Strategies, Inc.

HC² stands for Healthy Connected Communities. HC² Strategies is a team of influential health system and public health trailblazers. They are experts and thought leaders who are devoted to helping hospitals, health systems, community-based organizations and communities nurture holistic strategies that support community well-being and population health.

HC² Strategies goal is to integrate the clinical and social aspects of community health to ensure health equity and optimize community vitality. HC² Strategies services include strategy, innovation, community engagement, leadership development and executive coaching.

Institute for People, Place, and Possibility (IP3)

The mission of IP3 is to build capacity for communities to make real, lasting change. IP3 provides knowledge and know-how surrounding data and technology, rooted in a deep passion for community partnerships. The institute has a long history of working with large and small organizations to provide data and reporting tools to assess community needs, prioritize investment areas and efforts, share stories for inspiration and develop implementation plans for community improvement.

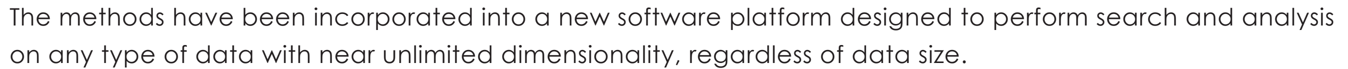
Over a decade ago, IP3 was privileged to take part in the many national community improvement efforts sparked by the CDC, the Robert Wood Johnson Foundation, Kaiser Permanente, the W.K. Kellogg Foundation, Y-USA, United Way and others. The organization became leaders in the Healthy Communities movement through developing and making publicly available, an online, public-good website bringing community data and stories of success to inspire and drive community change: CommunityCommons.org.

IP3 | Assess, which was used in this CHNA, is a web-based platform that allows the user to easily combine and compare data from multiple sources, surface community insights, align data across organizations and sectors, and move straight into concerted community action. The platform can also create reports that meld secondary quantitative data with primary qualitative data.

SpeedTrack, Inc.

SpeedTrack believes that human intelligence and its capacity for problem identification and resolution exceed the capacity of machines alone. When people are given access to relevant data, combined with SpeedTrack technology, they see data that have been transformed into useable information. This allows greater confidence in attacking and solving the most difficult problems that organizations and communities may be facing.

Over the past 10 years, SpeedTrack's scientific and research and development team has been led by Jerzy Lewak, PhD, a theoretical physicist. The team has invented and patented a series of computer methods that enable people to view, explore and discover information in any data regardless of size, structure or location.



The methods have been incorporated into a new software platform designed to perform search and analysis on any type of data with near unlimited dimensionality, regardless of data size.

For the purposes of this Community Health Needs Assessment, SpeedTrack compiled and stratified data from California's Department of Health Care Access and Information (HCAI), CMS, AHRQ, HCUP and the California Department of Finance to support quantitative analyses of population health trends associated with acute care inpatient discharges and ED visits.

These efforts create streams of information — not just numbers — that enable the discovery of key insights that are often overlooked.

The Social Impact Artists, Inc.

The Social Impact Artists, Inc. encourage positive transformation of local communities and the world through the development of strategic health and social impact strategies. Their goal is to make the world a better place.

They specialize in digital storytelling, proposal writing, social media-based fundraising, research and experience impact design, community engagement and outreach, network weaving, social research testing, search engine organization and the development of positive community-based health equity strategies. They work to simplify social complexities through film, visual design, digital content, the development of health strategies and narrative storytelling.

Appendix S: Glossary of Terms

Avoidable ED visits

Avoidable hospital Emergency Department (ED) visits are defined as conditions managed in the ED that likely could have been treated in a primary care setting.

Benchmark

A benchmark is a measurement that serves as a standard by which other measurements and/or statistics may be measured or judged. A "benchmark" indicates a standard by which a community can determine whether the community is performing well in comparison to the standard for specific health outcomes.

Burden of disease

These data focus on hospital inpatient and emergency department utilization; top causes of death; morbidities (health conditions); and communicable and chronic disease burdens.

Community health needs assessment (CHNA)

A CHNA uses systematic processes to evaluate a community's assets and identify priorities for action.

Community resources

Community resources include organizations, people, partnerships, facilities, funding, policies, regulations and a community's collective experience. Any positive aspect of the community is an asset that can be leveraged to develop effective solutions.

Federal Poverty Level (FPL)

The Federal Poverty Level (FPL) is the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the U.S. Department of Health and Human Services and used to determine financial eligibility for certain federal programs. To view and calculate 2022 poverty levels, go to https://aspe.hhs.gov.

Federally Qualified Health Center

Federally Qualified Health Centers are community-based health care providers that receive funds from the Health Resources & Services Administration Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients. They must also accept Medi-Cal and Medicare. Types of Federally Qualified Health Centers vary; they may be community health centers, migrant health centers, health care for the homeless and health centers for residents of public housing.

Food insecurity

Food insecurity is a lack of consistent access to food resulting in reduced quality, variety or desirability of diet, or multiple indications of disrupted eating patterns and reduced food intake.

Health indicator

A single measure that is reported on regularly and that provides relevant and actionable information about population health and/or health system performance and characteristics. An indicator can provide comparable information as well as track progress and performance over time.

Healthy People 2020

Healthy People 2020 provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time to encourage collaborations across communities and sectors, empower individuals toward making informed health decisions and measure the impact of prevention activities.

Housing cost burden

Housing cost burden measures the percentage of household income spent on mortgage costs or gross rent. The U.S. Department of Housing and Urban Development currently defines housing as affordable if housing for that income group costs no more than 30% of the household's income. Families who pay more than 30% of their income for housing are considered cost burdened; families who pay more than 50% of their income for housing are severely cost burdened.

Humane housing

Humane housing is about stable, safe places to live, and living in diverse, vibrant communities that lead to full, productive lives. Housing that is not considered humane has one or more of the following characteristics:

- Is dilapidated
- Does not have operable indoor plumbing
- Does not have a usable flush toilet inside the unit for the exclusive use of a family
- Does not have a usable bathtub or shower inside the unit for the exclusive use of a family
- Does not have electricity, or has inadequate or unsafe electrical service
- Does not have a safe or adequate source of heat
- Should, but does not, have a kitchen
- Has been declared unfit for habitation by an agency or unit of government

Inequity

Deep-seated, health, racial and socioeconomic injustice or unfairness. May also be called disparities.

Infant mortality rate

Infant mortality rate is expressed as a rate per 1,000 births, this is defined as the death of a child prior to its first birthday (should be read, for example, as 7.8 infant deaths for every 1,000 births).

IP3 | Assess

IP3 | Assess is a web-based data solution to community assessment and action with a robust list of indicators, interactive maps and simple, shareable reporting. Two of its frameworks are used in this report: Burden of Disease and Vital Conditions for Well-Being.

Key informant interviews

Key informant interviews are one-on-one interviews with selected community members and leaders with questions related to the components of a healthy community as well as issues in the community. For this CHNA, the questions also included the issues of housing, access to care, mental health and substance use.

Low birth weight

Expressed as a rate per 1,000 births, this refers to infants born with a weight between 1,500 and 2,500 grams or between 3.3 and 5.5 pounds. Very low birth weight infants are born with a weight less than 1,500 grams.

Morbidities

Morbidities are defined as a disease or a symptom of disease, or the amount of disease within a population. Morbidities may also refer to medical problems caused by treatments.

Mortality

Mortality refers to the state of being subject to death or death itself, especially on a large scale.

Prenatal care

Adequacy of prenatal care calculations is based on the Adequacy of Prenatal Care Utilization (APNCU) Index, which measures the utilization of prenatal care on two dimensions and four categories. The first dimension measures the timing of initiation of prenatal care. The second dimension is the adequacy of received services. The two dimensions are grouped into four categories:

Adequate-Plus: Prenatal care begun by the fourth month of pregnancy and 110% or more of recommended visits received.

Adequate: Prenatal care begun by the fourth month of pregnancy and 80%–109% of recommended visits received.

Intermediate: Prenatal care begun by the fourth month of pregnancy and 50%–79% of recommended visits received.

Inadequate: Prenatal care begun after the fourth month of pregnancy or less than 50% of recommended visits received.

Prevention Quality Indicators (PQIs)

Prevention Quality Indicators (PQIs) are a set of measures that are derived from inpatient discharge data to identify the quality of care for ambulatory care sensitive conditions (ACSC). These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

Primary data

Primary data are new data collected or observed directly from first-hand experience. They are typically qualitative (not numerical) in nature. For this CHNA, primary data were collected through listening sessions and key informant interviews.

Primary service area (PSA)

A primary service area (PSA) is a geographic area that covers the majority of patients served by a particular hospital.

Public health

Public health comprises federal, state and local government entities that are focused on disease prevention and health promotion.

Secondary data

Secondary data are data that were collected and published by another party. Typically, secondary data in CHNAs are quantitative (numerical) in nature and collected by a local or state department of health, the Centers for Disease Control and Prevention (CDC) or a state department of education.

SpeedTrack, Inc

SpeedTrack, Inc provides a platform that enables people to view, explore and discover information in any data regardless of size, structure or location. For the purposes of this CHNA, SpeedTrack focuses on hospital inpatient discharges and ED visits.

Teen birth rate

Teen birth rate is expressed as a rate per 1,000 births. This refers to the quantity of live births by teenagers who are between the ages of 15 and 19.

Thriving natural world

A thriving natural world is defined as clean air, water and land as well as a well-functioning ecosystem.

Vital conditions

Vital conditions are community conditions that we encounter throughout our lives. They strongly shape the way each person experiences the world. The IP3 | Assess Vital Conditions for Well-Being framework brings together major determinants of health, exposing how multi-faceted parts of a system produce population well-being.

- Basic needs for health and safety
- Lifelong learning
- Humane housing
- Meaningful work and wealth
- Reliable transportation
- Thriving natural world
- Belonging and civic muscle

Z codes

Hospitals can capture data on the social needs of their patient populations through "Z codes." These codes identify non-medical factors that may influence a patient's health status. These data are valuable not only for understanding a patient's health status but also for identifying unmet social needs in a community, which can inform and support community health investments.

TAB N

SAN GORGONIO MEMORIAL HOSPITAL
Medical Staff Services Department
M E M O R A N D U M

DATE: November 16, 2022

TO: Susan DiBiasi, Chair
Governing Board

FROM: Sherif Khalil, M.D., Chairman
Medical Executive Committee

SUBJECT: **MEDICAL EXECUTIVE COMMITTEE REPORT**

At the Medical Executive Committee held this date, the following items were approved, with recommendations for approval by the Governing Board:

Approval Item(s):

2022 Annual Approval of Policies & Procedures
The attached list of policies & procedures is recommended for approval (See attached)

Informational(s):

Medical Board of California – Accusation/Notification of Decision
A physician was the subject of an MBC investigation which reached a stipulated settlement on November 3, 2022 (See attached).

The physician was placed on probation for three (3) years, effective November 10th, 2022.

In accordance with the Medical Staff Bylaws, Article VIII, Section 8.4-1 (c), "whenever a practitioner is placed on probation by the applicable licensing or certifying authority, his/her Membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term."

The Medical Executive Committee requires that he/she provide us copies of all completed educational documents, (i.e., prescribing, medical record keeping, ethics courses and monitoring practices) that is forwarded to the Medical Board of California.

SAN GORGONIO MEMORIAL HOSPITAL

2022 ANNUAL APPROVAL – POLICIES & PROCEDURES

Title	Policy Area	Revised?
Assessment Of Skin Integrity Upon Arrival to Emergency Department	Emergency Department	Revised
Centrifuges, Refrigerators, Freezers and Safety Eyewash	Clinical Laboratory	Unchanged
Coding Query Scanning and Placement as Part of the Legal Medical Record	Medical Records	Revised
Communication, Case Management, and Coordination of Care	Behavior Health	Revised
Corrective Actions for Deficiencies Identified Through Quality Control Measures	Clinical Laboratory	Unchanged
Diagnostic Imaging Policy for Ordering Exams	Diagnostic Imaging	Revised
Diagnostic Imaging: Release of Records - Conditions	Diagnostic Imaging	Revised
Equipment Management Plan	Clinical Laboratory	Unchanged
Exposure to Blood Borne Pathogens	Clinical Laboratory	Unchanged
Fetal Biophysical Profile Ultrasound	Diagnostic Imaging	Unchanged
MRI FOOT/ANKLE	Diagnostic Imaging	Revised
MRI HAND/WRIST	Diagnostic Imaging	Revised
MRI MRCP	Diagnostic Imaging	Revised
MRI SHOULDER	Diagnostic Imaging	Revised
MRI Thoracic Spine with and without contrast	Diagnostic Imaging	Revised
OR - Prevention of Retained Surgical Items - Surgical Counts	Surgical Services	Revised
PACU - Pain Assessment and Management	Surgical Services	Revised
Pleural Effusion Ultrasound	Diagnostic Imaging	Revised
Procedure for After Hour Availability for Arrowhead Radiology Medical Group	Diagnostic Imaging	Revised
Rapid Response Team (RRT) - Standardized Procedure	Nursing	Revised
Required Testing Every 6 Months in Addition to Daily Quality Control	Clinical Laboratory	Revised
Retroperitoneal Space Ultrasound	Diagnostic Imaging	Revised
Special Procedures - Use and Disposal of Cidex OPA Solution	Surgical Services	Revised
Spleen Ultrasound	Diagnostic Imaging	Revised
Sterile Processing - Storing Handling and Monitoring Sterile Supplies	Surgical Services	Revised
Sterile Processing - Transport of Sterilized Immediate Use Instruments	Surgical Services	Revised
Surgery Services - Attire	Surgical Services	Revised
Surgical Services - Staffing Schedule and PTO Guidelines	Surgical Services	Revised
Surgical Services - Standard & Isolation Precautions	Surgical Services	Revised
Upper Extremity Arterial Ultrasound	Diagnostic Imaging	Revised

TAB O

POLICIES AND PROCEDURES FOR BOARD APPROVAL - Hospital Board Meeting December 6, 2022

	Title	Policy Area	Owner	Workflow Approval
1	Acuity and Staffing Plan for Nursing	Nursing	Freude, Gayle: Nursing Director Med/Surg	Ariel Whitley for Hospital Board of Directors
2	Assessment Of Skin Integrity Upon Arrival To Emergency Department	Emergency Department	Brady, Angela: ED Director	Ariel Whitley for Hospital Board of Directors
3	Bedside Therapeutic Bronchoscopy	Respiratory Therapy	Hudson, Tracie: Director Nursing Resources	Ariel Whitley for Hospital Board of Directors
4	Centrifuges, Refrigerators, Freezers and Safety Eyewash	Clinical Laboratory	Hazley, Byron: Director Laboratory	Ariel Whitley for Hospital Board of Directors
5	Clean Linen Handling	Environmental Services	Nutter, Coda: Director Environmental Services	Ariel Whitley for Hospital Board of Directors
6	Clinical Duties of the Technical Consultant Include	Clinical Laboratory	Hazley, Byron: Director Laboratory	Ariel Whitley for Hospital Board of Directors
7	Coding Query Scanning and Placement as Part of the Legal Medical Record	Medical Records	Cornwall, Connie: HIM Manager	Ariel Whitley for Hospital Board of Directors
8	Communication, Case Management, and Coordination of Care	Behavior Health	Maciel, Christian: Director of BHC	Ariel Whitley for Hospital Board of Directors
9	Corrective Actions for Deficiencies Identified Through Quality Control Measures	Clinical Laboratory	Hazley, Byron: Director Laboratory	Ariel Whitley for Hospital Board of Directors
10	Critical Test Results	Diagnostic Imaging	Chamberlin, Krystal: Director Diagnostic Imaging	Ariel Whitley for Hospital Board of Directors
11	CT Angiography (CTA) Brain	Diagnostic Imaging	Chamberlin, Krystal: Director Diagnostic Imaging	Ariel Whitley for Hospital Board of Directors
12	Cuff Care of Patients Requiring Mechanical Ventilation	Respiratory Therapy	Hudson, Tracie: Director Nursing Resources	Ariel Whitley for Hospital Board of Directors
13	Diagnostic Imaging Policy for Ordering Exams	Diagnostic Imaging	Chamberlin, Krystal: Director Diagnostic Imaging	Ariel Whitley for Hospital Board of Directors
14	Diagnostic Imaging: Release of Records - Conditions	Diagnostic Imaging	Chamberlin, Krystal: Director Diagnostic Imaging	Ariel Whitley for Hospital Board of Directors
15	Equipment Management Plan	Clinical Laboratory	Hazley, Byron: Director Laboratory	Ariel Whitley for Hospital Board of Directors

POLICIES AND PROCEDURES FOR BOARD APPROVAL - Hospital Board Meeting December 6, 2022

	Title	Policy Area	Owner	Workflow Approval
16	Expanded Scope of Practice (Standardized Procedure)	Nursing	Freude, Gayle: Nursing Director Med/Surg	Ariel Whitley for Hospital Board of Directors
17	Exposure to Blood Borne Pathogens	Clinical Laboratory	Hazley, Byron: Director Laboratory	Ariel Whitley for Hospital Board of Directors
18	Fetal Biophysical Profile Ultrasound	Diagnostic Imaging	Chamberlin, Krystal: Director Diagnostic Imaging	Ariel Whitley for Hospital Board of Directors
19	High Flow Oxygen System	Respiratory Therapy	Hudson, Tracie: Director Nursing Resources	Ariel Whitley for Hospital Board of Directors
20	Incentive Spirometer	Respiratory Therapy	Hudson, Tracie: Director Nursing Resources	Ariel Whitley for Hospital Board of Directors
21	Linearity, Calibration, Reportable Range Testing (LCR Testing)	Respiratory Therapy	Hudson, Tracie: Director Nursing Resources	Ariel Whitley for Hospital Board of Directors
22	Manual Ventilation	Respiratory Therapy	Hudson, Tracie: Director Nursing Resources	Ariel Whitley for Hospital Board of Directors
23	Missed And Refused ABGs	Respiratory Therapy	Hudson, Tracie: Director Nursing Resources	Ariel Whitley for Hospital Board of Directors
24	MRI FOOT/ANKLE	Diagnostic Imaging	Chamberlin, Krystal: Director Diagnostic Imaging	Ariel Whitley for Hospital Board of Directors
25	MRI HAND/WRIST	Diagnostic Imaging	Chamberlin, Krystal: Director Diagnostic Imaging	Ariel Whitley for Hospital Board of Directors
26	MRI MRCP	Diagnostic Imaging	Chamberlin, Krystal: Director Diagnostic Imaging	Ariel Whitley for Hospital Board of Directors
27	MRI SHOULDER	Diagnostic Imaging	Chamberlin, Krystal: Director Diagnostic Imaging	Ariel Whitley for Hospital Board of Directors
28	MRI Thoracic Spine with and without contrast	Diagnostic Imaging	Chamberlin, Krystal: Director Diagnostic Imaging	Ariel Whitley for Hospital Board of Directors
29	Nasopharyngeal Airway	Respiratory Therapy	Hudson, Tracie: Director Nursing Resources	Ariel Whitley for Hospital Board of Directors
30	Nasotracheal Tube Care	Respiratory Therapy	Hudson, Tracie: Director Nursing Resources	Ariel Whitley for Hospital Board of Directors

POLICIES AND PROCEDURES FOR BOARD APPROVAL - Hospital Board Meeting December 6, 2022

	Title	Policy Area	Owner	Workflow Approval
31	OR - Prevention of Retained Surgical Items - Surgical Counts	Surgical Services	Goodner, Jayme: Director Surgical Services	Ariel Whitley for Hospital Board of Directors
32	Oral Endotracheal Tube Care	Respiratory Therapy	Hudson, Tracie: Director Nursing Resources	Ariel Whitley for Hospital Board of Directors
33	Oxygen Mask Without Reservoir Bag	Respiratory Therapy	Hudson, Tracie: Director Nursing Resources	Ariel Whitley for Hospital Board of Directors
34	PACU - Pain Assessment and Management	Surgical Services	Goodner, Jayme: Director Surgical Services	Ariel Whitley for Hospital Board of Directors
35	Pleural Effusion Ultrasound	Diagnostic Imaging	Chamberlin, Krystal: Director Diagnostic Imaging	Ariel Whitley for Hospital Board of Directors
36	Pre-operative - Surgical Screening Requirements	Surgical Services	Goodner, Jayme: Director Surgical Services	Ariel Whitley for Hospital Board of Directors
37	Procedure for After Hour Availability for Arrowhead Radiology Medical Group	Diagnostic Imaging	Chamberlin, Krystal: Director Diagnostic Imaging	Ariel Whitley for Hospital Board of Directors
38	Rapid Response Team (RRT) - Standardized Procedure	Nursing	Freude, Gayle: Nursing Director Med/Surg	Ariel Whitley for Hospital Board of Directors
39	Registry Requirements for Respiratory Care Practitioner	Respiratory Therapy	Hudson, Tracie: Director Nursing Resources	Ariel Whitley for Hospital Board of Directors
40	Required Testing Every 6 Months in Addition to Daily Quality Control	Clinical Laboratory	Hazley, Byron: Director Laboratory	Ariel Whitley for Hospital Board of Directors
41	Retroperitoneal Space Ultrasound	Diagnostic Imaging	Chamberlin, Krystal: Director Diagnostic Imaging	Ariel Whitley for Hospital Board of Directors
42	Special Procedures - Use and Disposal of Cidex OPA Solution	Surgical Services	Goodner, Jayme: Director Surgical Services	Ariel Whitley for Hospital Board of Directors
43	Spleen Ultrasound	Diagnostic Imaging	Chamberlin, Krystal: Director Diagnostic Imaging	Ariel Whitley for Hospital Board of Directors
44	Sputum Induction	Respiratory Therapy	Hudson, Tracie: Director Nursing Resources	Ariel Whitley for Hospital Board of Directors
45	Sterile Processing - Storing Handling and Monitoring Sterile Supplies	Surgical Services	Goodner, Jayme: Director Surgical Services	Ariel Whitley for Hospital Board of Directors

POLICIES AND PROCEDURES FOR BOARD APPROVAL - Hospital Board Meeting December 6, 2022

	Title	Policy Area	Owner	Workflow Approval
46	Sterile Processing - Transport of Sterilized Immediate Use Instruments	Surgical Services	Goodner, Jayme: Director Surgical Services	Ariel Whitley for Hospital Board of Directors
47	Suctioning Non Intubated Patients	Respiratory Therapy	Hudson, Tracie: Director Nursing Resources	Ariel Whitley for Hospital Board of Directors
48	Surgery Services - Attire	Surgical Services	Goodner, Jayme: Director Surgical Services	Ariel Whitley for Hospital Board of Directors
49	Surgical Services - Staffing Schedule and PTO Guidelines	Surgical Services	Goodner, Jayme: Director Surgical Services	Ariel Whitley for Hospital Board of Directors
50	Surgical Services - Standard & Isolation Precautions	Surgical Services	Goodner, Jayme: Director Surgical Services	Ariel Whitley for Hospital Board of Directors
51	Tracheostomy Collar	Respiratory Therapy	Hudson, Tracie: Director Nursing Resources	Ariel Whitley for Hospital Board of Directors
52	Transport of Intubated Patient	Respiratory Therapy	Hudson, Tracie: Director Nursing Resources	Ariel Whitley for Hospital Board of Directors
53	Upper Extremity Arterial Ultrasound	Diagnostic Imaging	Chamberlin, Krystal: Director Diagnostic Imaging	Ariel Whitley for Hospital Board of Directors

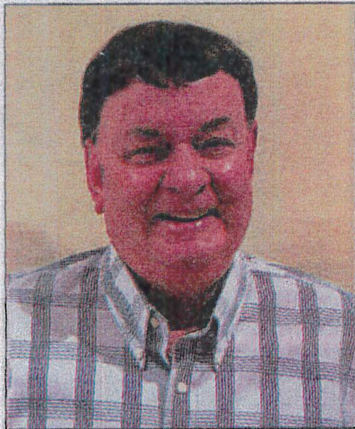
TAB P

Record Gazette - 10/28/2022
Pg 1

Five candidates vie for two seats on healthcare district board

Three incumbents declined to run to retain their seats on the governing board that oversees the property and fixed assets of San Gorgonio Memorial Hospital. Five candidates qualified to run for three spots on the San Gorgonio Memorial Healthcare District's five-member board of directors.

Here is a look at the candidates:



Ron Rader

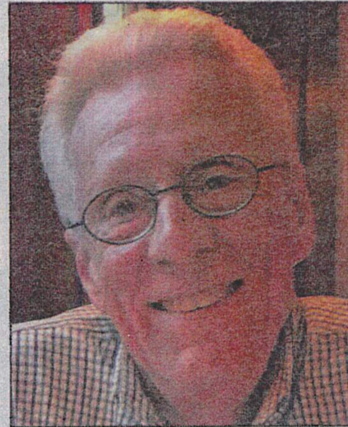
Past hospital board chairman Ron Rader has witnessed San Gorgonio Memorial Hospital's growth and milestones for nearly 10 years, such as the addition of specialty doctors and the DaVinci robotic surgery program, to partnerships that have made San Gorgonio Memorial a teaching hospital for the University of California, Riverside's School of Medicine, and a significant $5.6 million grant from the Morongo Band of Mission Indians to coordinate a stroke center.

He served on the hospital's oversight committees for the $108 million Measure A facilities bond, and the Measure D parcel tax program, and was initially appointed to the hospital's board in 2014.

The difference between the San Gorgonio Memorial Hospital board, which he currently serves on, and the San Gorgonio Memorial Healthcare District that he is running for, is that the hospital board governs operations, while the healthcare district oversees fixed assets and equipment.

He holds a degree in marketing and business administration from Cypress College.

"With the dedication of our heroes at San Gorgonio Memorial Hospital, we have come through the worst of COVID. I will not only work to move our hospital forward, but take on any challenges that confront me as your healthcare district board director, and I will strive to make sure San Gorgonio Memorial Hospital is the quality healthcare destination of our residents of the Pass area deserve."



Steve Rutledge

One of the reasons current hospital board member Steve Rutledge retired to the Pass area is because it has a hospital — which ended up providing him medical treatment at one point.

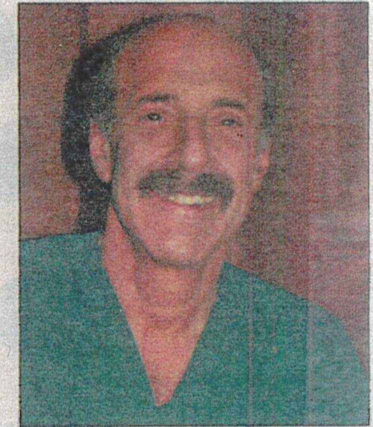
Four years ago he was appointed to serve on the hospital's board (which oversees operations). Now, he's running for a seat on the San Gorgonio Memorial Healthcare District board, which governs the hospital's fixed assets and equipment.

"Beaver Medical Group has filled all the gaps that used to exist in its roster of physicians and specialists" since he joined the hospital's board, Rutledge says, pointing out, for instance, "When we moved here in 2012 Beaver didn't have a urologist on its roster, for a community that contains as many seniors as Banning and Beaumont does."

Since Rutledge has come aboard, the hospital has experienced improved relations between the two governing boards, and recruited quality physicians and specialists over the past few years.

Rutledge, who holds an MBA with a concentration in healthcare administration from National University, hopes to bring his professional experience to the healthcare district's board: he served as director of marketing and communications, and was chief compliance and privacy officer, for Children's Hospital of Los Angeles. He also served as manager of public relations for Holy Cross Medical Center.

He is active with the Neighborhood Watch and Emergency Preparedness programs at Four Seasons, and, if elected, intends to continue "to advocate against anything that diminishes the access to the healthcare we all deserve, including the addition of warehouses too close to seniors, and inhibiting access to the hospital by clogging traffic and making it difficult for ambulances to transport patients."



Lanny Swerdlow

Former San Gorgonio Memorial Healthcare District board member Lanny Swerdlow was previously elected in 2018, though he resigned in December 2020.

A registered nurse by profession, Swerdlow approaches healthcare with "a holistic view of our patients," and is concerned that there are no other nurses on the board providing that perspective, noting, "Nurses are the backbone of not just the hospital, but all of our community's healthcare services."

Swerdlow hopes to bring back his experience to help govern, particularly since,

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HEALTHCARE

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"With COVID funding coming to an end the hospital will face new and continuing financial challenges that will need to be addressed."

He points out that there are 85 healthcare districts statewide, and Swerdlow believes that "Their primary directive in most instances is to support the community-based hospital," and expects that San Gorgonio Memorial Hospital should increase its approach for grant opportunities to implement community-based health and wellness programs, such as dental care.

When he previously resigned from the board without explanation, he told the Record Gazette that he was experiencing personal problems at the time, though he is confident that he can "become active in politics again, and would like to resume the work I was doing on the healthcare district's board," having come out of retirement to assist in providing vaccinations, testing and treatment during the pandemic.

Shannon McDougall

As an active member of the Hospital Association of Southern California, and chief safety officer and executive director with oversight of the Office of Occupational Safety and Health, Environment of Care, and the Office of Emergency Management and Business Continuity at City of Hope in Duarte, Beaumont resident Shannon McDougall is pursuing her first elected public office as a candidate for the San Gorgonio Memorial Healthcare District board.

She holds a doctorate in business from Capella University, as well as an MBA from University of Phoenix. She hopes to bring her experience in education and in working with nonprofit, as well as for-profit healthcare settings, to the board.

"I have an understanding of our community's needs," McDougall says. She hopes to apply her skillsets and experience "to drive change toward helping expand and improve healthcare services while promoting the health and wellness to our communities. I am a transformational and collaborative leader who seeks to understand by listening to the voices of those I intend to serve."

If elected, she intends to "work to further develop, improve and expand healthcare services while striving for excellence."

Darrell Petersen

Darrell K. Petersen, an assistant professor of pathology and human anatomy at Loma Linda University's School of Medicine, serves as director of Anatomical Services at the university.

He has lived in Beaumont since 2008, and is eager to become more involved in his community.

"I am not a politician. This is my first time running for any type of office," he says. In 2006 he won an R.R. Hawkins Award, bestowed upon those who exhibit outstanding scholarly works in the arts and sciences.

"If elected I would proudly serve and represent my community," he says.

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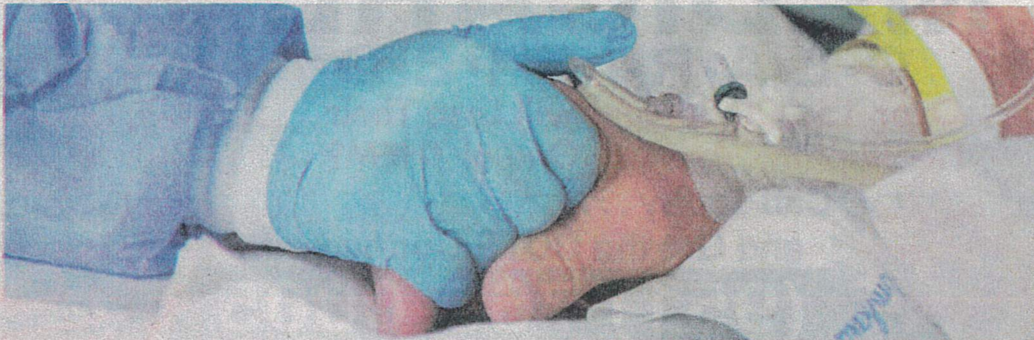

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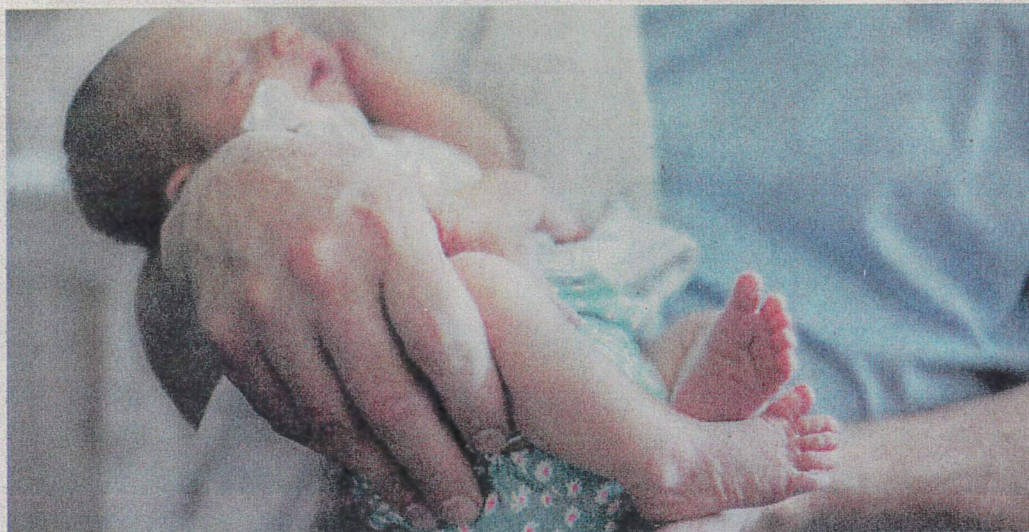

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Healthcare board

In the election for three seats on the San Gorgonio Memorial Healthcare District Shannon McDougall (22.83 percent), Lanny Swerdlow (21.83 percent) and Steve Rutledge (18.89 percent) were the leading candidates. Ronald K. Rader was close behind with 18.44 percent.

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