SAN GORGONIO MEMORIAL HOSPITAL

**AGENDA**

**REGULAR MEETING OF THE BOARD OF DIRECTORS**
**Tuesday, April 2, 2024 – 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].

Angela Brady will participate remotely at Via Nazionale, 12-50123 – Florence, Florence

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.

**OLD BUSINESS**

III. ***Proposed Action - Approve Minutes** — S. DiBiasi
- March 5, 2024, Regular Meeting — A

San Gorgonio Memorial Hospital
Board of Directors Regular Meeting
April 2, 2024

**NEW BUSINESS**

| | | | |
|---|---|---|---|
| IV. | Hospital Board Chair Monthly Report | S. DiBiasi | verbal |
| V. | CEO Monthly Report | S. Barron | verbal |
| VI. | *** Proposed Action – Recommend Approval of the SEVA Professional Services Agreement to the Healthcare District Board**<br>▪ **ROLL CALL** | Staff | B |
| VII. | April, May, & June Board/Committee Meeting Calendars | S. DiBiasi | C |
| VIII. | Quarterly Foundation Report | V. Hunter | D |
| IX. | Committee Reports: | | |
| | • Finance Committee<br>o March 26, 2024, regular meeting minutes<br>*** Proposed Action – Approve February 2024 Financial Statement (Unaudited**<br>▪ **ROLL CALL** | S. DiBiasi/<br>D. Heckathorne | E |
| X. | *** Proposed Action – Recommend Approval to the Healthcare District Board of Policies and Procedures**<br>▪ **ROLL CALL** | Staff | F |
| XI. | Chief of Staff Report – Recommendations of the Medical Executive Committee – Informational | R. Sahagian, MD<br>Chief of Staff | G |
| XII. | Community Benefit events/Announcements/ and newspaper articles | S. DiBiasi | H |
| XIII. | 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)*
- Receive Quarterly EOC/Life Safety/Utility Management Report *(Health & Safety Code §32155)*

XIV**.** **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.**

San Gorgonio Memorial Hospital
Board of Directors Regular Meeting
April 2, 2024

**RECONVENE TO OPEN SESSION**

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

XV. **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 March 29, 2024, 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 March 29, 2024

Ariel Whitley

Ariel Whitley, Executive Assistant

# TAB A

MINUTES: Not Yet Approved by Board

REGULAR MEETING OF THE
SAN GORGONIO MEMORIAL HOSPITAL
BOARD OF DIRECTORS

March 5, 2024

The regular meeting of the San Gorgonio Memorial Hospital Board of Directors was held on Tuesday, March 5, 2024, in Modular C meeting room, 600 N. Highland Springs Avenue, Banning, California.

Members Present: Susan DiBiasi (Chair), Perry Goldstein, Shannon McDougall, Darrell Petersen, Ron Rader, Steve Rutledge, Randal Stevens, Lanny Swerdlow

Members Absent: Dennis Tankersley

Required Staff: Steve Barron (CEO), Raffi Sahagian, MD (Chief of Staff), Daniel Heckathorne (CFO), Ariel Whitley (Executive Assistant), Angie Brady (CNE), John Peleuses (VP Ancillary and Support Services)

| AGENDA ITEM | | ACTION / FOLLOW-UP |
|---|---|---|
| **Call To Order** | Chair, Susan DiBiasi, called the meeting to order at 4:11 pm. | |
| **Public Comment** | John – talked about his experience as a hospital patient. | |
| **OLD BUSINESS** | | |
| **Proposed Action - Approve Minutes**<br><br>**February 6, 2024, regular meeting.** | Chair, Susan DiBiasi, asked for any changes or corrections to the minutes of the February 6, 2024, regular meeting.<br><br>There we none. | **The minutes of the February 6, 2024, regular meeting will stand correct as presented.** |
| **NEW BUSINESS** | | |
| **Hospital Board Chair Monthly Report** | Chair, DiBiasi reported that she experienced patient rounding with Angela Brady, CNE, and had a pleasant experience. | |
| **CEO Monthly Report** | Steve Barron, CEO, reported that the ED Physician Group that is contracted with SGMH is leaving California. We have begun the RFP process and hope to have a recommendation to the board by the April board meeting. | |
| **March, April, & May Board/Committee meeting calendars** | Calendars for March, April, and May, were included on the board tablets. | |
| **Bi-Monthly Patient Care Services Report** | Angela Brady, CNE, gave the Bi-Monthly Patient Care Services Report as included on the board tablets. | |

<table>
<tr><th>AGENDA ITEM</th><th></th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td colspan="3">COMMITTEE REPORTS:</td></tr>
<tr><td>Finance Committee<br><br>Proposed Action – Approve January 2024 Financial Statement (Unaudited).</td><td>Dan Heckathorne, CFO, reviewed the Executive Summary of the January 2024 Financial report which was included on the board tablet. A copy of the Finance Committee's February 27, 2024, meeting minutes were also included on the board tablet. It was noted that the Finance Committee recommends approval of the January 2024 Financial report as presented.<br><br>It is noted that approval is recommended by the Finance Committee.<br><br>BOARD MEMBER ROLL CALL:<br><br>
<table>
<tr><td>DiBiasi</td><td>Yes</td><td>Goldstein</td><td>Yes</td></tr>
<tr><td>McDougall</td><td>Yes</td><td>Petersen</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>Swerdlow</td><td>Yes</td></tr>
<tr><td>Tankersley</td><td>Absent</td><td colspan="2">Motion carried.</td></tr>
</table></td><td>M.S.C., (Rader/Stevens), the SGMH Board of Directors approved the January 2024 Financial Statement as presented.</td></tr>
<tr><td>Proposed Action – Recommend approval to the Healthcare District Board to enter a consulting arrangement with Craneware for provision of the Trisus Pricing Analyzer and Transparency Service</td><td>As of July 1, 2024, the federal CMS law will require price transparency reporting which includes many multiples of reporting in contrast to the existing law. Craneware will be terminating the existing transparency model and has developed a much more comprehensive model needed to comply with the new CMS regulations.<br><br>BOARD MEMBER ROLL CALL:<br><br>
<table>
<tr><td>DiBiasi</td><td>Yes</td><td>Goldstein</td><td>Yes</td></tr>
<tr><td>McDougall</td><td>Yes</td><td>Petersen</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>Swerdlow</td><td>Yes</td></tr>
<tr><td>Tankersley</td><td>Absent</td><td colspan="2">Motion carried.</td></tr>
</table></td><td>M.S.C., (Rader/Rutledge), the SGMH Board of Directors voted to recommend approval to the Healthcare District Board to enter a consulting arrangement with Craneware for provision of the Trisus Pricing Analyzer and Transparency Service as presented.</td></tr>
<tr><td>Proposed Action – Recommend Approval to the Healthcare District Board of Policies and Procedures</td><td>There were nine (9) policies and procedures presented for recommended approval to the Healthcare District Board.<br><br>BOARD MEMBER ROLL CALL:<br><br>
<table>
<tr><td>DiBiasi</td><td>Yes</td><td>Goldstein</td><td>Yes</td></tr>
<tr><td>McDougall</td><td>Yes</td><td>Petersen</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>Swerdlow</td><td>Yes</td></tr>
<tr><td>Tankersley</td><td>Absent</td><td colspan="2">Motion carried.</td></tr>
</table></td><td>M.S.C., (Stevens/Petersen), the SGMH Board of Directors voted to recommend approval to the Healthcare District board of the policies and procedures as submitted.</td></tr>
<tr><td>Community Benefit events/Announcement</td><td>Chair DiBiasi announced to the board that there will be an announcement for a large donation from the Morongo Band of Mission Indians on</td><td></td></tr>
</table>

| AGENDA ITEM | | ACTION / FOLLOW-UP |
|---|---|---|
| **s/and newspaper articles** | March 14th at San Gorgonio Memorial Hospital.<br><br>*Chair, Susan DiBiasi, made a motion to recess at 5:15 pm.*<br>*The meeting returned from recess at 5:33 pm.* | |
| **Future Agenda Items** | • None | |
| **Adjourn to Closed Session** | Chair, DiBiasi reported the items to be reviewed and discussed and/or acted upon during Closed Session will be:<br><br>➢ Recommend approval to the Healthcare District Board – Medical Staff Credentialing<br>➢ Receive Quarterly Infection Prevention and Control Report<br>➢ Participate in a telephone conference with legal counsel regarding pending litigation.<br><br>The meeting adjourned to Closed Session at 5:34 pm. | |
| **Reconvene to Open Session** | The meeting adjourned from closed session at 5:45 pm.<br><br>Chair DiBiasi reported on the actions taken/information received during the Closed Session as follows:<br><br>➢ Medical Staff Credentialing will be addressed and approved by the Healthcare District Board only. No action was taken to recommend approval.<br>➢ Received Quarterly Infection Prevention and Control Report as informational.<br>➢ Participated in a telephone conference with legal counsel regarding pending litigation. | |
| **Chief of Staff Report**<br><br>**Recommendations of the Medical Executive Committee – Informational** | A discussion was held regarding the recommendations of the Medical Executive Committee. The report was provided as informational. | |
| **Adjourn** | The meeting was adjourned at 6:08 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 B

## Whitley, Ariel

**From:** Barron, Steven
**Sent:** Thursday, March 28, 2024 4:12 PM
**To:** Whitley, Ariel
**Cc:** Brady, Angela; Heckathorne, Daniel; Peleuses, John; Karam, Annah; DiBiasi, Susan; McDougall, Shannon
**Subject:** RE: Process for replacing the ED contract

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**From:** Barron, Steven
**Sent:** Thursday, March 21, 2024 1:44 PM
**To:** Whitley, Ariel <AWhitley@sgmh.org>
**Cc:** Brady, Angela <abrady@sgmh.org>; Heckathorne, Daniel <DHeckathorne@sgmh.org>; Peleuses, John <JPeleuses@sgmh.org>; Karam, Annah <TKaram@sgmh.org>; DiBiasi, Susan <SDiBiasi@sgmh.org>; McDougall, Shannon <SMcDougall@sgmh.org>
**Subject:** Process for replacing the ED contract

We heard rumors in January that Envision was thinking of leaving CA.

Our ED contract is with a friendly PC (physician group) called California EM one. Everyone refers to them as Envision but Envision is only the MSO. In CA there is a prohibition against the corporate practice of medicine which is why our contract is with the medical group, not the management company. California EM one is owned by Dr. Tomongin. He practices in Lakewood at a Tenet hospital. California EM one provides Doctors, PA's etc. for a few hospitals other than ours. It is a complicated structure.

When Dr. Tomongin heard that Envision was leaving CA by June 30th he started looking around for another MSO. After some time, he gave up and started looking for alternative Companies. He identified 8 potential candidates and sent out RFP's. Each of these companies had NDA"s. Some declined, others were ruled out for various reasons.

When Dr. Tomongin was ready, we met in February, and he shared what he had found. Now that we had been given formal notification, we informed the Board and the MEC. We narrowed the search down to three good choices and met with each one. At the first meeting it was just the CEO, and the CNE. Dr. Singh was never involved in any part of the process. After we decided that all three were interested and viable, we asked for formal proposals from each and gave them our own RFP to guide them.

A second interview/presentation was scheduled with the CEO, The CNE, The CFO, The VP for Ancillary Services, the District Board Chair, and the Hospital Board Chair. After the meeting each of the 6 attendees filled out a scoring sheet. We gave each member of the interview committee several days to think about the presentations and submit their sheets. The scores were summarized.

The three groups were Seva, Vituity, and Sound. Seva is a new company formed by our existing doctors and PA's.

Seva scored the highest on everyone's card. I think generally our group felt that going with the existing group would be the least disruptive to the organization, and result in the best care.

We plan to present the recommendation to the board at the April board meeting.

*Thank you*,

**Steve Barron**
**Chief Executive Officer**
**Office: 951.769.2101**
**Fax: 951.845.2836**
**www.sgmh.org**

# SAN GORGONIO MEMORIAL HOSPITAL

# Request for Proposal For ED Physician Services

San Gorgonio Memorial Hospital
600 N Highland Springs Ave.
Banning, CA 92220

**Table of Contents**

# A. Introduction, Background, and Scope of Services

## 1. Introduction

San Gorgonio Memorial Hospital (SGMH) is requesting proposals from medical groups qualified to provide comprehensive emergency medicine services at our facility. SGMH is dedicated to delivering high quality emergency care to our community and is committed to partnering with a group that shares our values and commitment to excellence. The target commencement date for the services is July 1, 2024, subject to the negotiation of a final contract.

## 2. Background

SGMH is a California nonprofit public benefit corporation organized for the charitable purpose of providing healthcare services. It operates the 79-bed general acute care hospital in Banning, California, owned by the San Gorgonio Memorial Healthcare District (the "District"). SGMH leases the hospital from the District under a long term lease, and SGMH holds the licenses and permits to provide healthcare services on behalf of the District.

SGMH serves a rapidly growing community with a diverse patient population and provides a wide range of emergency medical services. Our facility is equipped with state-of-the-art technology and staffed by a dedicated team of healthcare professionals. The SGMH Emergency Department ("ED") volume has increased substantially in recent years. Currently, ED patient volume is approximately 42,000 visits annually.

Hospital-wide Payer mix is as follows:

| | |
|---|---|
| Medi-Cal: | 48.1 |
| Straight Medicare : | 7.3 |
| Managed Medicare: | 12.8 |
| Managed Care: | 8.2 |
| Contract commercial: | 18.8 |
| CA Blue Shield: | 2.5 |
| CA Blue Cross: | 4.5 |
| TriCare/Champus: | 1.4 |
| Commercial: | 8.1 |
| Self-pay: | 3.9 |
| Other: | 2.5 |

## 3. Scope of Services

- Staffing the ED with qualified physicians and advanced practice providers (physician assistants and/or nurse practitioners) to ensure 24/7 coverage.
- Delivering timely and efficient emergency medical care to patients presenting with a variety of acute illnesses and injuries.
- Collaborating with hospital staff, including nurses, technicians, and ancillary services, to optimize patient outcomes and satisfaction.
- Adhering to evidence-based clinical guidelines and best practices in emergency

medicine.
- Participating in quality improvement initiatives and performance metrics monitoring to enhance the delivery of emergency care.
- Contractor's ED Providers shall be board certified in emergency medicine or shall be in active candidacy and shall possess and maintain certification in ACLS and PALS.
- The contractor shall provide a Physician who shall act as a Medical Director for the ED and as the primary point of contact for the Medical Staff, Hospital administration and other departments within the Hospital.

## B. Contract Term

The term of the resulting agreement is expected to be 36 months from contract execution. SGMH may extend the contract, upon the agreement of the parties, if SGMH determines such an extension is in its best interest.

## C. Minimum Qualifications

Proposers must satisfy the minimum qualifications listed below to be eligible for a contract award. Failure to meet the following requirements by the proposal submission deadline will be grounds for SGMH to deem a proposer nonresponsive, and SGMH may choose not to further review proposals that fail to meet these requirements. A proposer may demonstrate the requisite qualifications through the combined qualifications of the proposer and its subcontractor's qualifications. The subcontractor(s) is (are) responsible for meeting the overall requirements of the RFP along with the requirements for each of those areas of responsibility.

**Each proposer must satisfy the following minimum qualifications:**

**1.** Proposers must certify they have read and are willing to comply with all proposed terms and conditions addressed in the RFP.

**2.** Proposers must be qualified to conduct business in California, must maintain all applicable professional licenses and certifications in good standing, and must be participating providers in the Medi-Cal and Medicare programs.

**3.** Proposers must certify, and be able to demonstrate, they are financially stable, solvent and have adequate cash reserves to meet all financial obligations during the term of the proposed agreement.

**4.** Proposers must supply, before contract execution, and proof of liability insurance.

## D. Proposal Requirements

**Each proposer must include the following in its proposal:**

### 1. Transmittal Letter

Submit a letter (a) expressing the proposer's commitment to perform the services described within this RFP, (b) providing an executive summary explaining why the proposer believes it is best qualified to perform the required services, (c) certifying

that the proposer meets the minimum qualifications set forth in this RFP, (d) providing the name, title, contact information and signature of the person authorized to make the representations required by the RFP, and (e) include proposal presentation.

**2. Proposer Capability**

a) Provide a brief history and background of the proposer.

b) Describe recent experience that qualifies the proposer to undertake the requested services, including, but not limited to, the experience of the individual members of the leadership team that will manage the delivery of the requested services.

c) Describe recent experience that demonstrates the proposer's ability to establish and maintain effective working relationships with the leadership of SGMH, the SGMH Medical Staff, EMS, government entities, and other community stakeholders.

**3. Resources Assigned to SGMH**

a) Submit a detailed description of the resources the proposer will assign to performing the services required under this RFP, including the total number, role, title and experience of the resources for the ED. Specify whether and how mid-level providers would be used.

b) Describe the process and identify the individual who will be responsible for preparing work schedules, obtaining coverage for planned or unexpected absences, and monitoring and updating work schedules.

**4. Quality Improvement & Management Plan**

Submit proposer's plan for measuring (including specific metrics to be used), improving and managing clinical quality, including, but not limited to, proposers approach to making improvements in performance in the following areas:

- Provider communication
- Transition between providers
- Length of stay
- Patient safety
- Patient satisfaction
- Documentation
- ED wait times

**5. Cost**

Submit a price quote for the first year of the contract. Proposals for price escalation for subsequent terms may also be submitted.

**6. Subcontractors**

List any subcontractors that the proposer intends to utilize in connection with the services performed in response to this RFP.

**7. Litigation**

Provide a summary of any litigation filed against proposer in the last three years that relates to the services provided by proposer.

**8. Disciplinary or Regulatory Action**

Provide a summary of any final or pending disciplinary or regulatory action against the proposer, the proposer's physicians or agents, by any hospital, governmental agency, licensing body, involving the delivery of professional services.

**9. Exceptions to General Terms and Conditions**

After the RFP is awarded, the winning proposer will be required to execute a contract using the general terms and conditions set forth in Exhibit A. Submit any exception, and specific replacement language proposed, for any individual provision of the general terms and conditions. Replacement of the general terms and conditions in their entirety will be deemed nonresponsive.

## E. Timeline

Release of RFP: March 7, 2024
Submission Deadline: March 15, 2024
Evaluation Period: March 15, 2024 through March 27, 2024

## F. Submission of Proposals

Submit one original and one electronic copy (in PDF format, via email). Proposers must submit proposals to SGMH no later than **5:00 pm on March 15, 2024.** Proposals must be submitted to:

Steven Barron
San Gorgonio Memorial Hospital
600 N Highland Springs Ave.
Banning, CA 92220
SBarron@sgmh.org

## G. Firm Offer

All proposals submitted in response to this RFP are firm offers and may not be withdrawn for 120 days following the proposal submission deadline.

## H. Proposal Evaluation Criteria and Procedure

The evaluation of proposals will be based on, but not be limited to:

- Qualifications and experience of the emergency physician group.
- Alignment with the hospital's mission, values, and quality standards.
- Effectiveness of the proposed staffing model and clinical care delivery approach.
- Demonstrated commitment to patient-centered care, safety, and quality improvement.
- Value proposition, including cost-effectiveness and efficiency of services.

SGMH reserves the right to evaluate information from any other sources, including information and/or recommendations submitted by professional references, Hospital leadership or committees, public comment, or from any other source. SGMH will award the contract to the proposer who, in the opinion of SGMH, has proposed services in the best interest of SGMH. The award will not necessarily be made to the proposer with the lowest cost proposal.

The SGMH Chief Executive Officer, taking into consideration input from such sources as described above, will recommend a contract to the SGMH Board of Directors. The Board of Directors shall not be bound by the recommendation of the Chief Executive Officer. The final decision to award the contract will be made by the Board of Directors, which may include direction to the Chief Executive Officer to conduct further negotiations with any or all proposers, or to award no contract.

## I. Public Release of Proposals

No proposal materials will be released to the public, nor shall the public have access to such proposal materials during the RFP process, until such time as the contract is awarded by the Board of Directors. The use of the term phrase "the public" shall not include SGMH staff or committees, including committees of the Medical Staff. Thereafter, proposals submitted in response to this RFP will be made accessible to the public and will be disclosed to any member of the public upon the request of such person.

In the event that a proposer deems any portion of its proposal confidential or proprietary or otherwise contains business or trade secrets, then those specific portions must be plainly marked as "Confidential," "Proprietary," or "Trade Secret." SGMH will notify the proposer if disclosure of these materials is sought, and it shall be the proposer's obligation to seek a protective order. SGMH shall not be liable, or in any way responsible for the disclosure of such information, including any disclosure made pursuant to the California Public Records Act.

## J. Proposal Costs

Costs for developing proposals are entirely the responsibility of the proposer and shall not be charged to SGMH.

## K. Reservation of Rights

In addition to the rights discussed elsewhere in this RFP, SGMH reserves the following rights:

- Modify any date or deadline appearing in this RFP.
- Issue clarification notices, addenda, alternate RFP instructions, forms, etc.
- Waive any RFP requirement or instruction at any time for all proposers, including after the proposal submission deadline.
- Remedy any RFP error or defect at any time, including after the proposal submission deadline.
- Waive minor irregularities in responses received.
- Allow proposers to submit questions about any RFP change, correction or addenda.
- If SGMH decides, before or on the proposal due date, to extend the submission deadline, SGMH may choose to notify potential proposers of the extension by fax, email, or by telephone.
- Negotiate with any or all proposers.
- Reject any or all proposals, or cancel this RFP at anytime.

| | CRITERIA | Guidelines for Criteria Scoring | Seva | | Vituity | | Sound | |
|---|---|---|---|---|---|---|---|---|
| | | | Cumulative Points | Total Points Possible | Cumulative Points | Total Points Possible | Cumulative Points | Total Points Possible |
| **Step 1. Technical Proposal (Envelope A)** | | | | | | | | |
| 1 | Qualifications and Experience | •Assess the emergency physician group's credentials, certifications, and licensure.<br>•Review the group's experience in providing emergency medicine services, including the number of years in operation and previous partnerships with healthcare facilities.<br>•Consider any specialized training or expertise relevant to emergency care, such as trauma certification or advanced life support training. | 55 | *60* | 57 | *60* | 51 | *60* |
| 2 | Clinical Care Delivery Model | •Evaluate the proposed staffing model, including the number and qualifications of physicians and advanced practice providers (APPs) allocated for coverage.<br>•Assess the group's approach to patient flow management, triage protocols, and coordination with hospital staff to optimize efficiency and patient outcomes.<br>•Review the group's strategies for ensuring timely and appropriate care delivery, including response times, assessment protocols, and treatment protocols. | 57 | *60* | 50 | *60* | 47 | *60* |
| 3 | Commitment to patient-centered care, safety, and quality improvement. | •Examine the group's commitment to quality assurance and performance improvement initiatives, including adherence to evidence-based guidelines and clinical protocols.<br>•Evaluate mechanisms for monitoring and improving key performance indicators related to emergency care, such as door-to-provider times, length of stay, and patient satisfaction scores.<br>•Consider the group's track record in achieving quality metrics and outcomes in previous partnerships or collaborations. | 117 | *120* | 107 | *120* | 106 | *120* |
| 4 | Cost-Effectiveness and Value Proposition | •Evaluate the cost structure proposed by the emergency physician group in relation to the value of services provided.<br>•Consider factors such as staffing costs, overhead expenses, and any additional services or resources included in the proposal.<br>•Assess the group's ability to deliver high-quality emergency care in a cost-effective manner, maximizing value for the hospital and patients. | 55 | *60* | 41 | *60* | 33 | *60* |
| 5 | Alignment with Hospital's Mission and Goals | •Assess the alignment between the emergency physician group's values, mission, and goals and those of the hospital or healthcare organization.<br>•Consider the potential for collaboration and partnership in achieving shared objectives related to patient care, quality improvement, and community outreach.<br>•Evaluate the group's capacity to contribute to the hospital's strategic initiatives and enhance its reputation as a provider of exceptional emergency care services. | 118 | *120* | 96 | *120* | 98 | *120* |
| **SUBTOTAL – Technical Proposal** | | | 402 | ***420*** | 351 | ***420*** | 335 | ***420*** |
| **Step 2. Oral Presentation and Interview** | | | | | | | | |
| 6 | Oral Presentation and Interview | Relevant examples and information and thorough answers | 115 | *120* | 106 | *120* | 107 | *120* |
| **Step 3. Fee Proposal (Envelope B)** | | | | | | | | |
| 7 | Cost | | 42 | ***60*** | 34 | ***60*** | 33 | ***60*** |
| **GRAND TOTAL** | | | 559.0 | ***600.0*** | 491.0 | ***600.0*** | 475.0 | ***600.0*** |

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**Scoring Guide**

| Category | | Description |
|---|---|---|
| Poor | 0-200 points | Minimally addresses the component, but one or more major considerations of the component are not addressed. |
| Fair | 201-300 points | The response addresses some aspects of the component, but minor considerations may not be addressed. |
| Good | 301-400 points | The response addresses the component and provides a reasonably good quality solution. |
| Very Good | 401-500 points | There is a high degree of confidence in the proponent's response as a proposed solution to address the component |
| Exceptional | 501-600 points | The proposed solution goes above and beyond the requirements as well as provides a high degree of confidence in its effectiveness. |

# PROFESSIONAL SERVICES AGREEMENT

This Professional Services Agreement ("***Agreement***") is made and executed with an effective date of _____ (the "***Effective Date***"), by and between:

San Gorgonio Memorial Hospital, a California _____, ("***Hospital***"),

and,

MD Karan Singh PC., dba, Seva Medical Group, a California professional corporation (collectively "***SMG***").

Individually, the Hospital and SMG may be referred to herein as a "***Party***" and collectively as the "***Parties***."

## BACKGROUND

**A.** SMG provides comprehensive physician services to hospitals, including, without limitation, arranging for physician coverage for hospital emergency departments;
**B.** SMG employs or contracts with physicians ("***Physicians***") and advanced practitioners ("***Advanced Practitioners***," and together with Physicians, the "***Providers***") with experience caring for patients;
**C.** The Hospital operates a duly licensed hospital providing a comprehensive range of outpatient and inpatient services, including emergency medical services in its Emergency Department ("***Emergency Department***"), to the residents of Banning, California and its surrounding communities and
**D.** The Parties desire to enter into this Professional Services Agreement so that SMG may provide emergency department services to the Hospital.

In consideration of the mutual covenants set forth herein and for other good and valuable consideration, the receipt and legal sufficiency of which are hereby acknowledged, the Parties hereby agree as follows:

1. **Engagement**. The Hospital hereby engages SMG to exclusively perform the services as set forth on Schedule A ("***Services***") on the terms and conditions set forth herein, and SMG hereby accepts such engagement.

2. **Services**. SMG will furnish qualified Providers to perform the Services on the terms and conditions set forth in this Agreement. SMG shall designate a qualified Provider to be Medical Director of the Emergency Department ("***Medical Director***"), whose duties are set forth on Schedule B. The Medical Director shall be responsible for managing the Emergency Department issues on a day-to-day basis, as described under this Agreement.

3. **Duties and Responsibilities of SMG**. SMG represents and warrants as follows:

(a) SMG shall, and shall cause its Providers to, comply with all of the duties, obligations, and restrictions imposed upon SMG and its Providers under this Agreement, as well

as those defined in the Hospital Medical Staff Bylaws, Rules, Regulations, and Policies (copies of which shall be provided to the Providers).

(b) SMG shall, and shall cause its Providers to, participate in the Medicare and Medicaid programs and all other payor programs in which the Hospital participates.

(c) SMG shall cause its Providers to engage in and cooperate with periodic evaluations with input from the Hospital and or its designees.

(d) SMG shall, and shall cause its Providers to, participate in the Hospital's emergency and disaster programs when possible.

(e) SMG shall, and shall cause its Providers to, render Services in a competent, professional, and ethical manner at all times, in accordance with prevailing standards of medical practice, and all applicable statutes, regulations, rules, orders and directives of federal, state, local and other governmental and regulatory bodies having competent jurisdiction.

(f) SMG shall, and shall cause its Providers to, participate in and cooperate with any utilization review, quality assurance, risk management, medical care evaluation, ordering pattern analysis (including appeal processes with financial intermediaries), or other similar programs of study to review the professional performance of staff physicians as may be reasonably required by the Hospital, Medical Staff, governmental agencies, professional review organizations, accrediting bodies, or third-party payors;

(g) Qualifications. At all times during the Term, SMG shall cause each Provider performing the Services hereunder to:

(i) be duly licensed and in good standing in the State of California, and said license has not been suspended, revoked, or restricted in any manner;

(ii) maintain the current State of California controlled substances registration and Drug Enforcement Administration registration, which registrations have not been surrendered, suspended, revoked, or restricted in any manner;

(iii) be board-certified or eligible for certification as Providers who are qualified by ability, training, and experience to render high-quality emergency medicine services in accordance with established standards of emergency medicine;

(iv) to satisfy the requirements at the Hospital for clinical privileges appropriate to the Services and maintain membership in good standing on the Hospital's Medical Staff ("***Medical Staff***") with clinical privileges in emergency medicine at all times while providing the Services; provided, however, that this Agreement is not, and shall not be construed as, any form of guarantee or assurance by the Hospital that the Provider shall receive necessary membership or privileges on the Medical Staff for purposes of discharging the responsibilities hereunder; and further provided that application, appointment, reappointment, and granting of privileges shall be governed solely by the Hospital Medical Staff Bylaws, Rules, Regulations, and Policies then in effect; and

(v) not be and not have been excluded from participation in any federally funded health care program, including Medicare and Medicaid. SMG agrees to immediately notify Hospital of any notice of any threatened, proposed, or actual exclusion from any federally funded health care program, including Medicare and Medicaid.

(h) SMG shall, and shall cause its Providers, to comply with all requirements of The Emergency Medical Treatment and Labor Action ("***EMTALA***"), all regulations promulgated thereunder, and the interpretive guidelines articulated in the Medicare State Operations Manual regarding EMTALA and any and all written directives, opinions, policies and advisories regarding EMTALA.

4. **Insurance**. SMG shall maintain professional liability insurance covering the Providers in the amount of at least One Million Dollars ($1,000,000.00) for each occurrence, with a per annum aggregate limit of at least Three Million Dollars ($3,000,000.00). The Hospital shall maintain general liability insurance in commercially reasonable amounts, as well as professional liability insurance in commercially reasonable amounts for any Hospital employees and shall assure that all agents, or non-SMG independent contractors providing services to the Hospital's patients, have such current professional liability insurance. The Hospital will further maintain insurance which includes coverage for the Medical Director while performing the services of the Medical Director hereunder. Upon request of either Party, the other Party shall produce a copy of the certificate of insurance or other appropriate evidence of such insurance outside of the Effective Date.

5. **Billing and Compensation**.

(a) The Parties acknowledge that the Hospital shall compensate SMG in accordance with the fee schedule set forth in Schedule C (the "***Support Fee***") for the purpose of enabling SMG to engage Providers to provide the Services.

(b) SMG will have the exclusive right to bill all patients and/or appropriate third-party payors directly for any professional medical services provided by the Providers. The Hospital will have the exclusive right to bill all patients and/or appropriate third-party payors for the use of facilities, personnel, equipment, supplies, and such other facilities and support services provided by the Hospital.

(c) The amounts of Support Fee to be paid by the Hospital hereunder represent the value as established by arms-length negotiations and have not been determined in any manner that takes into account the volume or value of any potential referrals between the Parties. No amount paid hereunder is intended to be, nor shall it be construed to be, an inducement or payment for referral of patients by any Party to any other Party. Further, it is agreed that neither Party shall refer or attempt to influence the referrals of any patients to any particular program; such decision shall rest exclusively with the patients and their respective physicians.

6. **Duties and Responsibilities of the Hospital.**

(a) The Hospital shall furnish the Providers with the use of facility space, clerical support, supplies, equipment and such other facilities and services suitable to their position and reasonably necessary for the performance of their duties hereunder. SMG hereby acknowledges and agrees that such space, supplies, equipment and employees shall be utilized by the Providers

exclusively for the performance of the Services. The Hospital shall be responsible for the interviewing, selection, orientation and training, work scheduling, performance evaluation and discipline of the Hospital employees.

(b) The Hospital shall be responsible for assuring that the physical facilities of the Department meet plant safety standards of The Joint Commission and OSHA. Hospital shall, on a daily basis, electronically transfer to SMG, or its designees, patient records, including, without limitation, registration, admission, and discharge documentation in a secure HL 7 format on a mutually agreed upon timeline. The Hospital shall also provide SMG with a complete electronic medical record in a CCA or CCD format, including but not limited to physician and nursing notes, continuation sheets, code/trauma forms, and all appropriate patient records, in order to obtain patient information and other documentation deemed necessary by SMG and/or its billing company to bill for services provided by Providers and/or provide additional services. The Hospital shall establish the abovementioned electronic interfaces prior to the Effective Date of this Agreement to enable SMG to capture all charges as of the first day of providing services at the Hospital. If the Hospital does not establish the required interface by the Effective Date of the Agreement, the Hospital agrees that it shall pay SMG a revenue guarantee equal to the revenue the SMG should have received from the professional services performed by the Providers but did not receive due to the lack of documentation it needs to bill the patients for professional services, less any collections received by SMG for those professional services.

(c) The Hospital shall cause Hospital employees to comply with all requirements of EMTALA, all regulations promulgated thereunder, and the interpretive guidelines articulated in the Medicare State Operations Manual regarding EMTALA and any and all written directives, opinions, policies and advisories regarding EMTALA.

7. **Term**. The term of this Agreement shall begin on the Effective Date and continue for a period of three (3) years from the Effective Date (the "***Term***") and shall automatically renew for additional successive one (1) year terms thereafter unless otherwise terminated.

8. **Termination**.

(a) Termination by Either Party for Breach. Either Party may terminate this Agreement immediately upon written notice to the other Party:

(i) If the other Party breaches any term of this Agreement and fails to cure that breach within thirty (30) days after receipt of written notice specifying the alleged breach.

(ii) The Hospital may terminate this Agreement immediately for SMG's failure to promptly bar any Provider from performing services under this Agreement after written notice from the Hospital if that Provider: (i) engages in conduct which materially jeopardizes the health, safety, or welfare of any person or the safety, or regular functions of the Hospital or the Services; (ii) resigns, is expelled, is suspended from the Medical Staff, is disciplined, loses clinical privileges or has his or her license to practice medicine in the state where Services are rendered suspended or revoked; (iii) is convicted of any crime punishable as a felony; or, (iv) does not meet the qualifications required by this Agreement. Further, in the event that the Hospital permits another

provider to provide the exclusive Services hereunder, or the Hospital provides the Services itself, SMG may immediately terminate this Agreement.

(b) Either Party may terminate this Agreement with seven (7) days' notice upon the other Party's general assignment for the benefit of creditors, the other Party's petition for relief in bankruptcy or similar laws for the protection of debtors, upon the initiation of such proceedings against the other Party if the same are not dismissed within forty-five ( 45) days of service, or upon notice of a finding that the other Party is insolvent under applicable law.

(c) In the event that Hospital fails to pay SMG's Compensation as set forth herein and fails to cure such failure within fifteen (15) days following a written notice from SMG, SMG terminate this Agreement at the end of such fifteen (15) calendar day cure period by providing notice of such termination to Hospital.

(d) Either Party may terminate this agreement without cause upon one hundred and twenty (120) days' notice to the other Party;

(e) The Parties may terminate this Agreement upon the mutual written agreement of the Parties.

9. **Effect of Termination**.

(a) Upon the effective date of termination of this Agreement, neither Party shall have any further obligation hereunder, except for: (i) obligations accruing prior to the date of termination; and (ii) obligations, promises, or covenants contained herein which are expressly made to extend beyond termination, including, without limitation, any indemnities and maintenance of records.

(b) Upon termination of this Agreement, the Providers shall immediately deliver to the Hospital sole custody and exclusive and complete use of the Hospital's premises, equipment, records and supplies with respect to the Services.

(c) SMG agrees and will make known in writing to each Provider providing Services hereunder that the extension of Medical Staff privileges shall automatically terminate upon termination of this Agreement for any reason; provided, further, that the privileges of any individual Provider shall automatically terminate if such Provider is removed by the Hospital pursuant to any term of this Agreement or terminated by SMG.

10. **Documentation**. SMG shall, and shall require its Providers to, timely prepare appropriate clinical records in accordance with the Hospital's Medical Staff Bylaws, Rules and Regulations, and Policies, including, but not limited to, medical record entries concerning all examinations, procedures, and other services performed by them hereunder.

11. **Non-Discrimination**. SMG will require that Providers, in the course of performing the Services, hereby agree to accept and treat any and all persons, including the Hospital patients, regardless of the person's age, sex, sexual orientation, race, creed, color, national origin or sponsor, ancestry, religion, marital status, disability, insurance coverage or ability to pay.

12. **Governing Statutes, Rules and Regulations**. Notwithstanding anything in this Agreement to the contrary, it is expressly agreed and understood by and between the Parties that any and all rights and obligations of the Parties shall at all times be subject to applicable federal and state statutes, rules and regulations.

13. **Indemnification**. The Hospital hereby agrees to defend, hold harmless and indemnify SMG, its affiliates and their past, present and future trustees, governors, officers, agents, contractors and employees from and against any and all claims, suits, liabilities, damages, judgments, costs and expenses, including, without limitation, reasonable attorney's fees, incurred, (together, the "***Claims***") that may be imposed upon, or suffered or incurred by, any of them arising out of, deriving from or pertaining to any breach of this Agreement by the Hospital or any other willful misconduct or negligent acts or omissions of the Hospital or any of its past, present or future trustees, officers, agents, contractors or employees. SMG hereby agrees to defend, hold harmless and indemnify the Hospital and its past, present and future members, trustees, officers, agents, contractors and employees from and against any and all Claims that may be imposed upon, or suffered or incurred by, any of them arising out of, deriving from or pertaining to any breach of this Agreement or any other willful misconduct or negligent acts or omissions of SMG or any of its past, present or future directors, officers, agents, contractors or employees. The provisions of this Section 13 shall survive the expiration or termination of this Agreement for any reason.

Except as otherwise provided herein, the indemnifying party shall have sole control over the defense and settlement of any claim for which it must provide indemnification and to retain counsel of its choice. The indemnifying party shall provide a diligent defense against and/or settlement of, any such claims that is the subject of its indemnification obligations, whether such claims are rightfully or wrongfully brought or filed. The indemnifying party shall have the right to settle claims at the indemnifying party's sole expense. Notwithstanding, in no event shall the indemnifying party admit fault on behalf of any one or more of the indemnified parties without the relevant indemnified party's written permission; such permission shall not be unreasonably withheld, conditioned, or delayed.

**IN NO EVENT SHALL EITHER PARTY BE LIABLE FOR ANY CONSEQUENTIAL, INDIRECT, INCIDENTAL, SPECIAL, EXEMPLARY, PUNITIVE, OR ENHANCED DAMAGES, LOST PROFITS OR REVENUES OR DIMINUTION IN VALUE, ARISING OUT OF, OR RELATING TO, OR IN CONNECTION WITH ANY BREACH OF THIS AGREEMENT, REGARDLESS OF (A) WHETHER SUCH DAMAGES WERE FORESEEABLE, (B) WHETHER OR NOT A PARTY WAS ADVISED OF THE POSSIBILITY OF SUCH DAMAGES, (C) THE LEGAL OR EQUITABLE THEORY (CONTRACT, TORT OR OTHERWISE) UPON WHICH THE CLAIM IS BASED, AND (D) THE FAILURE OF ANY AGREED OR OTHER REMEDY OF ITS ESSENTIAL PURPOSE.**

14. **Notices**. Notices or communications required or permitted to be given under this Agreement shall be in writing and shall be effective on delivery, if personally delivered, if delivered by a nationally recognized overnight delivery service, if delivered by electronic mail (e-mail) to the e-mail address listed below for the applicable Party, or if by registered or certified mail, as provided herein:

To SMG: Seva Medical Group
27475 Ynez Rd PMB 747,
Temecula CA 92591
Attn: CEO

To THE HOSPITAL: San Gorgonio Memorial Hospital
600 N Highland Springs Ave,
Banning, CA 92220
Attn: Steve Barron, CEO

15. **General Provisions**.

(a) Section Headings. The section headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

(b) Non-Solicitation. Each Party, on behalf of itself, its affiliates and each of their respective officers, directors, agents, employees, successor or assigns agree that neither party shall directly or indirectly solicit, employ, engage or otherwise permit any other person or entity to solicit, employ, engage or use in any manner whatsoever any current, future or former employee, contractor or agent employed or engaged by the other party or the other party's affiliates during the Term and for twelve (12) months after the termination or expiration of this Agreement without concurrent renewal. It is specifically understood and agreed that any breach of this provision of the Agreement by either party will result in irreparable injury to the other party, that the remedy at law alone will be an inadequate remedy for such breach and that, in addition to any other remedies in law, equity or otherwise it may have, the non-breaching party shall be entitled to enforce the specific performance of this Agreement by the breaching party in whole or in part responsible for that breach and to seek both temporary and permanent injunctive relief, without the necessity of proving actual damages or the posting of a bond, but without limitation of their rights to recover such damages.

(c) Restrictive Covenant. Notwithstanding the provisions of Section 15(b), SMG may, in its sole discretion, elect to waive the provisions of Section 15(b) for any Provider subject to such provision, provided, however, that SMG shall be compensated for each such Provider in the amount to be negotiated by the Parties in good faith but in no event shall such compensation be less than fifty percent (50%) of the Provider's actual or anticipated annual salary.

(d) Governing Law. This Agreement has been executed and delivered and shall be construed and enforced in accordance with the laws of the State of California without reference to its conflict of laws principles.

(e) Agreement Solely for the benefit of Parties. This Agreement is intended to be for the exclusive benefit of the Parties and shall not be construed to create any right or benefit to any other party whatsoever.

(f) Assignment. The Hospital may not assign this Agreement without the prior written consent of SMG. SMG may assign this Agreement to an affiliate or subsidiary of SMG and SMG shall be released of its obligations hereunder if the assignee agrees to be bound by all terms and conditions of this Agreement.

(g) Entire Agreement. This Agreement supersedes and terminates all previous contracts or agreements between the Parties with respect to the subject matter contained herein, including, without limitation the Emergency Department Services Agreement (collectively the "***Prior Agreements***"), other than any obligations which by their express terms survive the termination of any such Prior Agreements and this Agreement constitutes the entire agreement between the Parties with respect to the subject matter hereof, any and all prior correspondence, conversations or memoranda being merged herein and replaced and being without effect hereon. No promises, covenants, or representations of any character or nature other than those expressly stated herein have been made to induce either Party to enter into this Agreement. The Parties acknowledge and agree that neither Party has any Claim pertaining to any breach of any Prior Agreements or any other misconduct or negligent acts or omissions of either Party with respect to any Prior Agreements.

(h) Amendments. This Agreement may be amended only by an instrument in writing duly signed by both Parties.

(i) Counterparts; Electronic Delivery. This Agreement may be executed in any number of counterparts and by different Parties on separate counterparts, each of which counterparts, when so executed and delivered, shall be deemed to be an original and all of which counterparts, taken together, shall constitute but one and the same agreement. This Agreement shall become effective upon the execution of a counterpart hereof by each of the Parties. The exchange of copies of this Agreement and of signature pages by facsimile transmission, electronically or in Portable Document Format ("***PDF***") shall constitute effective execution and delivery of this Agreement as to the Parties and may be used in lieu of the original for all purposes. Signatures of the Parties may be executed by hand or by any electronic signature complying with the U.S. federal ESIGN Act of 2000, as amended (the "***ESIGN Act***") and shall be deemed to be their original signatures for any purposes whatsoever. All executed counterparts, whether original, facsimiles, electronic transmission, PDF, or a combination, shall be construed together and shall constitute one and the same agreement binding on both Parties, notwithstanding that both Parties have not signed the same counterpart. Neither Party may raise the use of signature complying with the ESIGN Act as a defense to the enforcement of this Agreement. Slight variations in the form of signature page counterparts executed by either Party (including different footnotes or document numbers) shall be considered immaterial and shall not invalidate any such counterpart signature. In making proof of this Agreement, it shall not be necessary to produce or account for more than one such counterpart executed by the Party against whom enforcement of this Agreement is sought.

(j) Incorporation. The schedules, attachments, and exhibits referenced in and attached to this Agreement are incorporated herein and shall be considered a part of this Agreement for all purposes as if fully set forth herein.

(k) Changes in Law. In the event that there are changes or clarifications of statutes, regulations or rules which materially affect either Party's obligations or performance hereunder,

or reimbursement from third parties for Services rendered under this Agreement, such Party may, by notice to the other Party, propose that the compensation arrangements of this Agreement be reopened for renegotiation. If such notice is given but the Parties are unable to agree, within thirty (30) days thereafter despite good faith negotiations, on new compensation arrangements, then either Party may terminate this Agreement by giving sixty (60) days' notice to the other Party.

(l) Independent Contractors. It is understood that both Parties to this Agreement are independent contractors and engage in the operation of their own respective businesses. Neither Party is, or is to be considered as, the agent or employee of the other Party for any purposes whatsoever. Neither Party has the authority to enter into contracts or assume any obligations for the other Party or to make any warranties or representations on behalf of the other Party, except as specifically provided herein. Nothing in this Agreement shall be construed to establish a relationship of co-partners or joint venturers between the two Parties. Each Party agrees to be responsible for the acts of its own agents or employees and the payment of their employee benefits and compensation, including employment taxes, workers' compensation, and other similar taxes and requirements associated with employment.

(m) Confidentiality. Except as may otherwise be agreed to by the Parties in writing, or may be required by law, each Party hereto agrees to retain in strictest confidence and not disclose or otherwise make known to any other person or entity the provisions of this Agreement, the relationship of the Parties hereunder and any data, materials, manuals; business plans, software, marketing plans, financial information, patient records and other information that is not in the public domain, is received from the other Party and relates to that Party's business or operations. The Parties shall at all times comply with the Health Insurance Portability and Accountability Act of 1996 ("***HIPAA***") and the Privacy Rule and the Security Rule promulgated thereunder at 45 C.F.R. Parts 160 and 164 as currently drafted and as subsequently amended or revised. The provisions of this Section 16(j) shall survive the expiration or termination of this Agreement for any reason.

(n) Access to Books and Records. Pursuant to 42 U.S.C. 1395x(v)(l)(I) to the extent applicable, until the expiration of four (4) years after the termination of this Agreement, SMG shall make available for Medicare audit purposes, this Agreement and the books, documents and records of SMG that are necessary to certify the nature and extent of sums paid to SMG for the Services provided by SMG pursuant to this Agreement, upon the written request of the Secretary of the Department of Health and Human Services of the United States, or upon request of the Comptroller General of the United States, or any of their duly authorized representatives. If applicable, a provision similar to this Section 16(k) shall be included in all agreements between SMG and any subcontractors engaged by SMG for the purpose of providing the Services under this Agreement. The provisions of this Section 16(k) shall survive the expiration or termination of this Agreement for any reason.

(o) Severability. If any provision of this Agreement or the application thereof to any person or circumstance is held to be illegal, invalid or unenforceable for any reason, such illegality, invalidity or unenforceability shall not affect any other provision of this Agreement that can be given effect in the absence of the illegal, invalid or unenforceable provision of application. To this end, all provisions of this Agreement are declared to be severable.

(p) Waiver. The failure of any Party to enforce any term or provision of this Agreement on one or more occasions shall not serve as a waiver of such term or provision or relinquishment of such Party's right to enforce such term or provision at any future time.

[ *Signature page follows.*]

The undersigned attest to their ability to bind their respective organizations to the terms of this Agreement, which the undersigned, by attesting to have provided full effect to the terms of this Agreement.

| | |
|---|---|
| **SMG**<br>**Seva Medical Group** | **Hospital**<br>**San Gorgonio Memorial Hospital** |
| _____ | _____ |
| By:<br>Title:<br>Date: | By:<br>Title:<br>Date: |

## Schedule A

### Services

a) SMG will furnish Providers to perform the Services in a professional and timely manner, consistent with the needs of the Hospital and in accordance with prevailing standards of medical practice and all applicable statutes, regulations, rules, orders and directives of any and all applicable governmental and regulatory bodies having competent jurisdiction. Activities of Advanced Practitioners will at all times be subject to monitoring and oversight by Physicians. A Physician will be either physically present or on call at all times. SMG will provide an administrative on-call person to be available to the Emergency Department.

b) SMG will provide Services twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year. SMG will ensure adequate staffing of Providers to satisfy all of the emergency medical service needs of patients in the Emergency Department in a competent manner, on a continuous, uninterrupted basis. SMG will be responsible for the recruitment of Providers, from time to time, as may be required to staff the Emergency Department in accordance with this Agreement adequately.

c) The Hospital and SMG acknowledge that coverage hereunder shall be adjusted from time to time by mutual agreement of the Parties to account for changes in the Emergency Department's volume or case mix.

d) SMG will designate a Physician to be the Emergency Department Medical Director to perform the tasks in Schedule B.

e) All Providers providing Services in the Emergency Department will meet SMG and the Hospital employment standards.

f) All Providers providing Services in the Emergency Department will attend any onboarding and/or orientation programs as reasonably required by the Hospital.

g) SMG and the Hospital will participate in quarterly administrative meetings to review quality, cost and performance metrics related to Emergency Department services at the Hospital.

## Schedule B

### Medical Director Duties

Qualified Physician shall serve as Emergency Department Medical Director to perform the duties set forth hereunder and under the Hospital Medical Staff Bylaws, Rules and Regulations, and Policies. The appointment of such Medical Director shall be approved by the Hospital, which approval shall not be unreasonably withheld. In addition, the Medical Director will be responsible for the following:

a) Maintain an effective working relationship with Medical Staff, referring physicians, the Hospital executive team and the Hospital departments.

b) Document ongoing reviews of the quality and appropriateness of services rendered as reasonably required by any of the Hospital's patient care evaluation program.

c) Participate in in-service education programs for all Emergency Department personnel.

d) Review patient care and charts of the Emergency Department as necessary to ensure quality, safety, and appropriateness of care.

e) Require that Providers (i) appropriately document in the medical record the treatment provided and the instructions given each patient; and (ii) comply with any applicable to the Hospital Medical Staff Bylaws, Rules and Regulations, and Policies concerning medical records.

f) Supervise, schedule, and evaluate Providers' performance annually.

g) Conduct regular meetings with Emergency Department personnel.

h) Evaluate patient survey results and take necessary action in conjunction with the Hospital to improve areas identified as needing improvement.

i) Attend and participate in monthly meetings that require representation from the Medical Director of the Emergency Department.

j) Coordinate Provider coverage schedule.

k) Address patient complaints involving Providers.

## Schedule C

### Support Fee

Annual Support Fee

SMG has calculated an annual "***Support Fee***" of Two Hundred Ninety-Seven Thousand and Seventeen Dollars ($297,017). The Administrative Fee shall be paid within five (5) business days of the Effective Date and on each anniversary of the Effective Date for the term of this Agreement by the Hospital to SMG.

Payment Programs with Third Parties.

The Parties agree and acknowledge that the compensation set forth above is based on the assumption that the Providers will not participate with managed care plans and medical insurers other than Medicare, Medicaid, and other governmental payors and will bill all other payors ("***Non-Participating Payors***") at SMG's normal charges. The Clinicians will not become participating providers with such Non-Participating Payors. The Hospital agrees and acknowledges that SMG will bill patients for all appropriate deductibles and copays and for any unpaid amounts up to such normal charges, regardless of payor, as permitted by applicable law. The Hospital hereby agrees that it will not require Providers to participate with any Non-Participating Payors during the term of this Agreement unless the Provider agrees to participate in so in writing. The Hospital further agrees that it will not enter into an arrangement with a Non-Participating Payor which directly affects the Provider's professional reimbursement without SMG's written consent. In the event the Provider's lack of participation with such Non-Participating Payors is no longer acceptable to the Hospital, SMG agrees to consider Clinician participation with 'such Non-Participating Payors provided that the Parties are able to negotiate a modification of the compensation set forth above taking into account such participation.

The Parties agree that the fees provided hereunder shall be at fair market value and only that amount reasonably necessary for SMG's provision of the services economically self-sustaining.

# TAB C

SAN GORGONIO MEMORIAL HOSPITAL

# April 2024

## Board of Directors Calendar

| Sun | Mon | Tue | Wed | Thu | Fri | Sat |
|---|---|---|---|---|---|---|
| | 1 | 2<br>**4:00 pm Hospital Board Meeting**<br>**6:00 pm Healthcare District Board Meeting** | 3<br>*Women's 2024 Economic I-10 Forum Hosted by Banning Chamber* | 4<br>*5:30 pm Taste of the Pass hosted by San G Pass Rotary Club* | 5 | 6 |
| 7 | 8 | 9<br>*Stroke Education w/ Guillermo @9AM—Chatigny Center (SGMH Speaker) | 10 | 11 | 12<br>Beaumont Chamber Breakfast @7:30 AM | 13<br>*7:00 am Bogart Fishing Derby (for kids)* |
| 14<br>*7:00 am Bogart Fishing Derby (for adults)* | 15 | 16 | 17<br>**9:00 am HR Committee Meeting**<br>Administrative Professionals Day | 18<br>*Sun Lakes Health Fair @1:00PM | 19 | 20<br>**8:00 am Community Planning Committee—Strategic Planning Session** |
| 21 | 22 | 23 | 24 | 25 | 26<br>*5:30 pm Banning Chamber Regional Mixer* | 27 |
| 28 | 29 | 30<br>**9:00 am Finance Committee** | | | | |

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

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

SAN GORGONIO MEMORIAL HOSPITAL

# May 2024

## Board of Directors Calendar

| Sun | Mon | Tue | Wed | Thu | Fri | Sat |
|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 |
| 5   | 6<br>**National Nurses Day!** | 7<br>**4:00 pm Hospital Board Meeting**<br>**6:00 pm Healthcare District Board Meeting** | 8 | 9 | 10<br>Beaumont Chamber Breakfast @7:30 AM | 11 |
| 12   | 13 | 14 | 15<br>**5:00 Measure H Mtg**<br>**5:15 Measure A Mtg** | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27<br>Memorial Day!<br>Administration is Closed! | 28<br>**9:00 am Finance Committee** | 29 | 30 | 31 | |

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

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

SAN GORGONIO
MEMORIAL HOSPITAL

# June 2024

## Board of Directors Calendar

| Sun | Mon | Tue | Wed | Thu | Fri | Sat |
|---|---|---|---|---|---|---|
| | | | | | | 1<br>Cherry Festival Parade |
| 2 | 3 | 4<br>**4:00 pm Hospital Board Meeting**<br>**6:00 pm Healthcare District Board Meeting** | 5 | 6 | 7 | 8 |
| 9 | 10 | 11 | 12 | 13 | 14<br>Beaumont Chamber Breakfast @7:30 AM | 15 |
| 16<br>  | 17 | 18 | 19 | 20 | 21 | 22 |
| 23 | 24 | 25<br>**9:00 am Finance Committee** | 26 | 27 | 28 | 29 |
| 30 | | | | | | |

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

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

# TAB D

# SGMH Foundation report as of March 25, 2024

## Foundation Finances

| | | |
|---|---|---|
| HCN Bank Checking Acct: | $259,675.87 | **February 2024** |
| HCN Money Market Acct: | $128,480.83 | **February 2024** |
| I.E. Community Foundation Acct: | $94,351.00 | **(current amount)** |
| Total | $482,507.70 | |

## Foundation Report

- SGMH Foundation is creating a strategic plan which will focus on raising dollars for the Women and Family Center. Currently, there is a group of women forming from the Altis retirement community and a group of women of color representing the Pass Area both, wanting to create a speaker's bureau that will address topics such as:
  - Working together to reduce black maternal mortality.
  - Resources for low-income families.
  - Black women physicians speak out on health issues.
  - How to teach kindness – "A workshop". This workshop has been used on television shows such as: MTV.
  - How men can support their partners through Perimenopause and Menopause.
  - Postpartum depression – Symptoms, causes, and care.

- The Foundation will actively be looking for grants to support the Women and Family center.

# TAB E

MINUTES: Not Yet Approved by Committee

REGULAR MEETING OF THE
SAN GORGONIO MEMORIAL HOSPITAL
BOARD OF DIRECTORS

FINANCE COMMITTEE
March 26, 2024

The regular meeting of the San Gorgonio Memorial Hospital Board of Directors Finance Committee was held on Tuesday, March 26, 2024, in the Administration Boardroom, 600 N. Highland Springs Avenue, Banning, California.

Members Present: Ron Rader, Steve Rutledge

Members Absent: Susan DiBiasi (Chair), Darrell Petersen

Required Staff: Steve Barron (CEO), Daniel Heckathorne (CFO), John Peleuses (VP, Ancillary & Support Services), Ariel Whitley (Executive Assistant), Angela Brady (CNE)

| AGENDA ITEM | DISCUSSION | ACTION / FOLLOW-UP |
|---|---|---|
| **Call To Order** | Steve Rutledge called the meeting to order at 9:03 am. | |
| **Public Comment** | No public present. | |
| **OLD BUSINESS** | | |
| **Proposed Action - Approve Minutes**<br><br>**February 27, 2024, regular meeting** | Steve Rutledge asked for any changes or corrections to the minutes of the February 27, 2024, regular meeting. There were none. | **The minutes of the February 27, 2024, regular meeting will stand correct as presented.** |
| **NEW BUSINESS** | | |
| **Proposed Action – Recommend Approval to Hospital Board of Directors - Monthly Financial Report (Unaudited) – February 2024** | Daniel Heckathorne, CFO, reviewed the Unaudited February 2024 finance report as informational.<br><br>As there was no quorum, no action was taken. | |
| **Future Agenda Items** | • None. | |
| **Next Meeting** | The next regular Finance Committee meeting will be held on April 30, 2024 @ 9:00 am. | |
| **Adjournment** | The meeting was adjourned at 9:57 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
## BANNING, CALIFORNIA

**Unaudited Financial Statements**

**for**

**EIGHT MONTHS ENDING FEBRUARY 29, 2024**

**FY 2024**

**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: 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 February, 2024 and Eight Months Ended February 29, 2024 (Unaudited)

**Profit/Loss (EBIDA) Summary (MTD) Negative and (YTD) Negative (comparisons to Budget)**

**Month** - The month of February resulted in negative $2.05M Earnings before Interest, Depreciation and Amortization (EBIDA) compared to budgeted negative EBIDA of $1.45M vs. a negative $3.30M Flex Budget.
**YTD –** Eight months ending in February resulted in negative $20.34M Earnings before Interest, Depreciation and Amortization (EBIDA) compared to budgeted negative EBIDA of $9.64M and a Flex Budget loss of $15.57M.

Note: If the unaccrued Supplemental funds, projected DSH and P4P funds, along with provision for lease principal payments were booked, the YTD EBIDA would be a negative $8.54M compared to the actual negative booked $20.34M.

**Month –** Adjustments and Items of Note:

- Patient Days, Emergency, and Surgery volumes were all below budget.
- Several Balance Sheet items were impacted, including the first repayment of the QIP Bridge loan, payoff of the Mindray patient monitors, funding of IGT payments, receipt of Supplemental Funding advances, and a draw from the Line of Credit. (See Balance Sheet/Cash Flow section.)

**Month** – February's inpatient average daily census was 20.1, and under the budgeted 24.2. Conversely, the Adjusted Patient Days were 0.5% over budget (1,852 vs. 1,841), while Patient Days were 17% under budget (582 vs. 702). Emergency Visits were 6.6% under budget (3,329 vs. 3,564), and Surgeries were 24% under budget (89 vs. 117).
**YTD** - Inpatient average daily census was 22.0 compared to the budgeted 23.2, and Patient Days were 5.5% below budget (5,357 vs. 5,668). Adjusted Patient Days are basically on target, Emergency Visits were 6.2% under budget (28,182 vs. 30,033) and Surgeries were 21% under budget (810 vs. 1,018) which was 14% below the previous YTD's 946 cases.

**Patient Revenues (MTD) Negative Variance (YTD) Negative Variance**
**Month** - Net Patient Revenues in February were $4.71M, or $350K under budget. Other items of note included the fact that gross Inpatient Revenues were 19% ($2.92M) under budget, while gross Outpatient Revenues were 7.1% ($1.78M) over budget. As discussed in the past, Inpatient Revenues pay about 16.8% of charges, compared to Outpatient Revenues which pay about 9.6% of charges.
**YTD** – Net Patient Revenues through February were $35.3M compared to budgeted $43.4M (-19%) In November there was a $504K favorable adjustment to Deductions from Revenues Expense to reverse estimated Medicare Outlier Repayments payable, and there was a one-time $3.52M negative adjustment for Contractual Allowance Reserves, which was based on the latest reconciliation of cash collections compared to previously estimated collections. Finally, the impact of Surgeries being 21% below budget also has impacted the Net Patient Revenues variance.

**Total Operating Revenues (MTD) Negative Variance & (YTD) Negative Variance**
**Month** – Operating Revenue in February was $406K under budget. This is impacted by the Net Patient Revenues being $350K under budget and the Non-Patient Revenues being $56K under budget.
**YTD** - Operating Revenue through February was $8.75M under budget, impacted by the Net Patient Revenues being $8.15M under budget and the Non-Patient Revenues being $601K under budget.

**Operating Expenses (MTD) Negative & (YTD) Negative Variance**

**Month** - Operating Expenses in February were $7.38M, which was over budget by $201K and over the Flex Budget by $321K. Key items that impacted Expenses were: 1) Salaries, Wages, Benefits, and Contract Labor were collectively $44K over budget and $114K over the Flex budget. This was impacted by a) Wages and Benefits being $4K over budget, which included a) the 3.0% salary increase implemented in October, b) Contract Labor being $$40K over budget, and c) the Adjusted Patient Days workload being at budget; 2) Physician Fees were $70K over budget driven by variances of $47K in anesthesia expense and $24K for Radiology services; 3) Purchased Services were $29K over budget in spite of the Legal Fees being $122K under budget, as several service agreements in Diagnostic Imaging and Lab were incurred in February; 4) Supplies were $57K below budget due in large part to low inpatient and surgery volumes; 5) Repairs and Maintenance were $21K over budget as we are preparing for the upcoming inspection; and 6) Other Expenses were $135K over budget including payment of the annual District Hospital Leadership dues of $79K.

**Year-to Date –** Operating Expenses through February were $61.00M and were over budget by $1.95M and over the Flex Budget by $2.48M. Key items that impacted Expenses were: 1) Salaries and Wages, Benefits, and Contract Labor were collectively $2.20M over budget and $2.14M over the Flex budget. This was driven by the following: a) The $527K State Mandated California Paid Sick Leave program that was accrued in July plus the additional $985K additional accrual in January; b) Contract Labor was over budget by $665K due to several nurse staffing vacancies in OB and ER along with orientation of 2 new grads in the ER; and c) an additional $153K increase for re-valuing the PTO bank to reflect the 3.0% Wage increase in late October; 2) Physician Fees are $469K over budget largely impacted by the $510K anesthesia expense reconciliation in December; 3) Purchased Services are $619K over budget which included Legal Fees exceeding budget by $647K; 4) Supplies are the most notable item under budget by $665K, again reflected by lower than anticipated intensities of services, including Surgeries and Emergency visits being under budget; and 5) Repairs and Maintenance are over budget by $139K largely to significant maintenance work occurring in September, October, and January.

**Balance Sheet/Cash Flow**

Patient cash collections in February totaled $5.82M compared to $4.75M in December and November's $4.51M. Gross Accounts Receivable Days in February were 61.6 compared to January's 66.1 and December's 64.1. Cash Balances were $11.40M compared to $14.06M in January and $6.17M in December. The main reason for the increase was receipt of a $4M advance from a local health plan against upcoming Supplemental funds that are due to the District. Net Accounts Receivable decreased to $8.73M compared to $9.87M in January and $9.52M in December.

Other changes of note included receipt of $1.33M from the Foundation/Morongo for payment of the Mindray Heart Monitors. Accounts Payable decreased to $8.74M in February compared to $8.89M in January and $10.08M in December. Assets Whose Use is Limited increased by $8.91M mostly attributable to the IGT advances of $9.16M for future Rate Range, QIP and HQAF income. The first repayment ($1.41M) for the QIP Bridge loan was made in February, and the outstanding Line of Credit balance was increased to $12M, up from $8M in January. Finally, a liability is in place $1.5M for FY 2022 payable to Medicare for estimated overpayments for outliers and sequestration funds.

**Summary**

**Positive takeaways**:

1) Adjusted Patient Days met budget in spite of other workloads being below budget.
2) Cash balances have been sufficient to meet IGT and Loan repayment requirements.

**Negative takeaways:**

1) Labor costs were over budget in February mostly due to Contract Labor costs.
2) Surgeries continue to lag behind budget and prior year levels.
3) February's EBIDA, adjusted for pending Supplemental Income, DSH & P4P offset by reserving for Cash Payments required for Leases was a negative $487K, and the YTD is a negative $8.54M.

## SGMH FEBRUARY 2024 SIGNIFICANT EXTRAORDINARY ITEMS IMPACTING EBIDA

3/20/2024

| EXPENSE | | INCOME | | GAIN/(LOSS) |
|---|---|---|---|---|
| **SALARIES / BENEFITS/ CONTRACT LABOR** | | **REVENUES** | | |
| TOTAL LABOR OVER BUDGET | 44,084 | NET REVENUES UNDER BUDGET | (350,216) | |
| **OTHER EXPENSE** | | | | |
| RADIOLOGY FEES OVER BUDGET | 24,000 | | | |
| ANESTHESIA FEES OVER BUDGET | 47,400 | **OTHER REVENUES** | | |
| PURCHASED SERVICES OVER BUDGET | 29,256 | OTHER REVENUES UNDER BUDGET | (55,327) | |
| REPAIRS/MAINTENANCE OVER BUDGET | 20,925 | | | |
| OTHER EXPENSE - DHLF ANNUAL DUES | 79,041 | | | |
| SUPPLIES UNDER BUDGET | (57,511) | | | |
| **EXTRAORDINARY NEGATIVE EXPENSES** | **187,195** | **EXTRAORDINARY POSITIVE (NEGATIVE) REVENUES** | **(405,543)** | **(592,738)** |

Note: These variances are not intended to account for all variances, but are meant to highlight key or unusual variations.

## STATISTICS

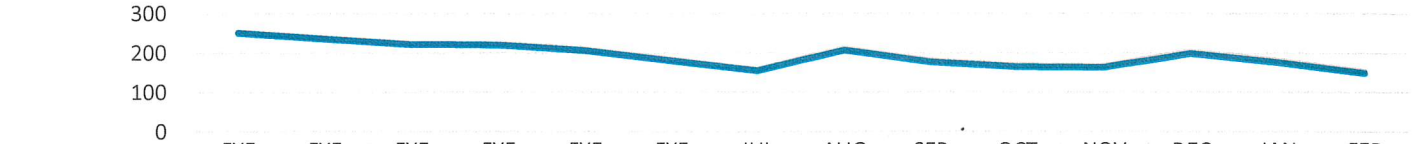
| | |
|---|---|
| Inpatient Admissions/Discharges (Monthly Average) | Represents number of patients admitted/discharged into and out of the hospital. |
| Patient Days (Monthly Average) | Each day a patient stays in the hospital is counted as a patient day. This count is normally done at midnight. |
| 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

| | |
|---|---|
| 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. |

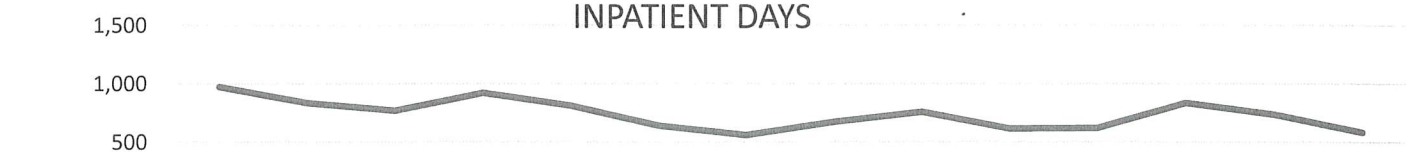
# SAN GORGONIO MEMORIAL HOSPITAL

## INPATIENT DISCHARGES




| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FYE 22/23 | JUL 2023 | AUG 2023 | SEP 2023 | OCT 2023 | NOV 2023 | DEC 2023 | JAN 2024 | FEB 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DISCHARGES | 253 | 238 | 224 | 222 | 209 | 182 | 157 | 210 | 180 | 168 | 166 | 202 | 179 | 153 |

## INPATIENT DAYS




| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FYE 22/23 | JUL 2023 | AUG 2023 | SEP 2023 | OCT 2023 | NOV 2023 | DEC 2023 | JAN 2024 | FEB 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PAT. DAYS | 969 | 833 | 767 | 917 | 808 | 636 | 559 | 670 | 754 | 611 | 617 | 831 | 733 | 582 |

## AVERAGE LENGTH OF STAY

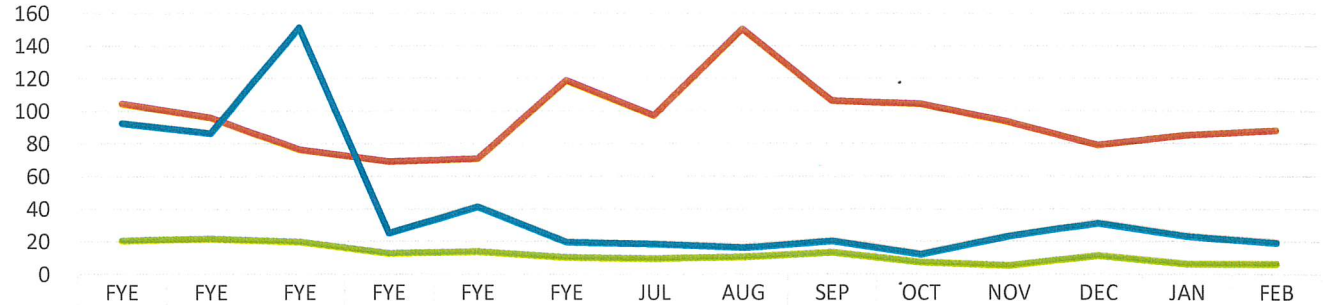

| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FYE 22/23 | JUL 2023 | AUG 2023 | SEP 2023 | OCT 2023 | NOV 2023 | DEC 2023 | JAN 2024 | FEB 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ALOS | 3.83 | 3.50 | 3.43 | 4.13 | 3.87 | 3.49 | 3.56 | 3.19 | 4.19 | 3.64 | 3.72 | 4.11 | 4.09 | 3.80 |

## EMERGENCY VISITS


| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FYE 22/23 | JUL 2023 | AUG 2023 | SEP 2023 | OCT 2023 | NOV 2023 | DEC 2023 | JAN 2024 | FEB 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| VISITS | 3,714 | 3,641 | 3,500 | 2,775 | 3,281 | 3,485 | 3,271 | 3,584 | 3,502 | 3,585 | 3,489 | 3,836 | 3,586 | 3,329 |

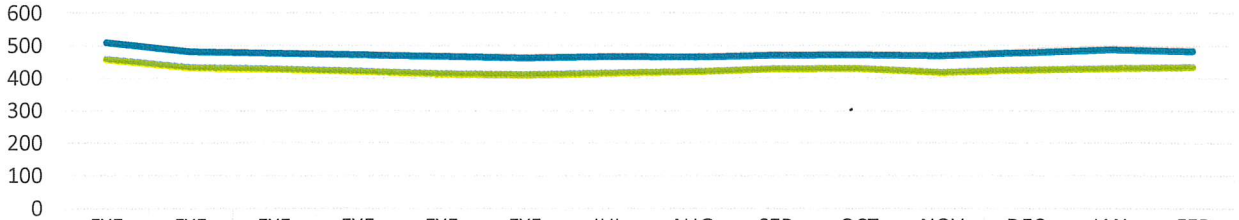
# SAN GORGONIO MEMORIAL HOSPITAL

## SURGERY CASES, G.I. CASES, N/B DELIVERIES



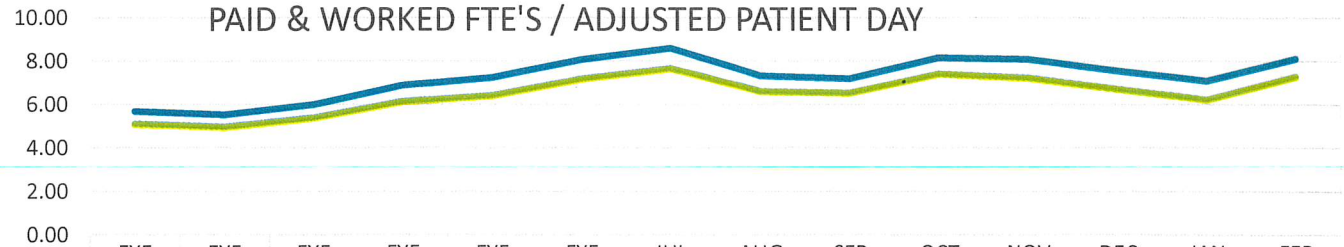

| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FYE 22/23 | JUL 2023 | AUG 2023 | SEP 2023 | OCT 2023 | NOV 2023 | DEC 2023 | JAN 2024 | FEB 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SURG. | 105 | 97 | 77 | 70 | 71 | 119 | 98 | 151 | 107 | 105 | 94 | 80 | 86 | 89 |
| G.I. CASES | 93 | 87 | 152 | 26 | 42 | 20 | 19 | 17 | 21 | 13 | 24 | 32 | 24 | 20 |
| BIRTHS | 21 | 22 | 21 | 13 | 15 | 11 | 10 | 11 | 14 | 8 | 6 | 12 | 7 | 7 |

## PAID & WORKED FTE'S




| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FYE 22/23 | JUL 2023 | AUG 2023 | SEP 2023 | OCT 2023 | NOV 2023 | DEC 2023 | JAN 2024 | FEB 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| P FTE's | 511 | 484 | 479 | 474 | 470 | 465 | 470 | 468 | 475 | 475 | 472 | 482 | 492 | 487 |
| W FTE's | 461 | 436 | 431 | 425 | 417 | 414 | 420 | 423 | 433 | 433 | 422 | 429 | 434 | 438 |

## PAID & WORKED FTE'S / ADJUSTED PATIENT DAY



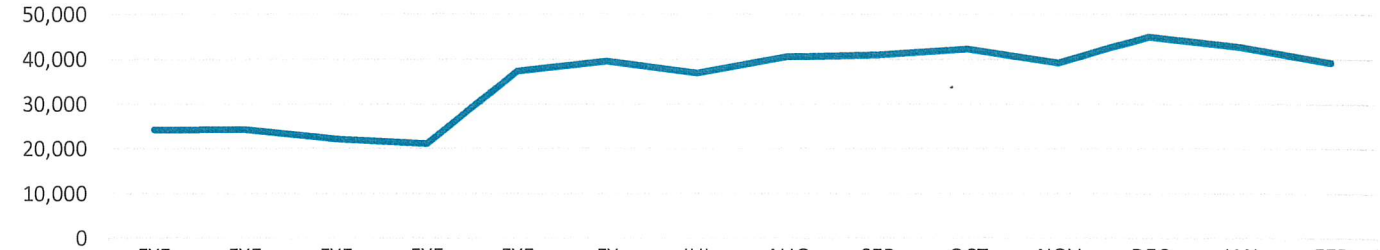

| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FYE 22/23 | JUL 2023 | AUG 2023 | SEP 2023 | OCT 2023 | NOV 2023 | DEC 2023 | JAN 2024 | FEB 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PFTES/APD | 5.69 | 5.55 | 6.01 | 6.89 | 7.27 | 8.10 | 8.62 | 7.35 | 7.21 | 8.19 | 8.12 | 7.59 | 7.13 | 8.16 |
| WFTES/APD | 5.13 | 5.00 | 5.41 | 6.18 | 6.45 | 7.21 | 7.70 | 6.65 | 6.57 | 7.46 | 7.26 | 6.77 | 6.28 | 7.33 |

**INCOME STATEMENT**

| | |
|---|---|
| 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. |

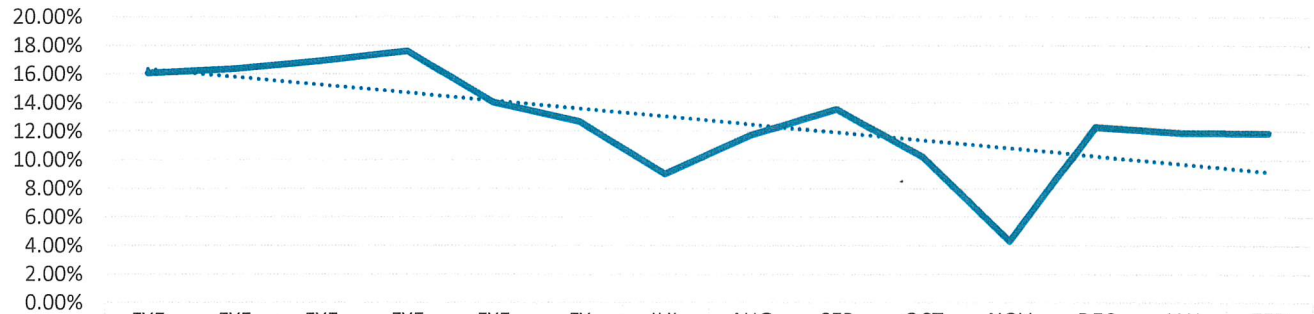
# SAN GORGONIO MEMORIAL HOSPITAL

## GROSS PATIENT REVENUE (000's)



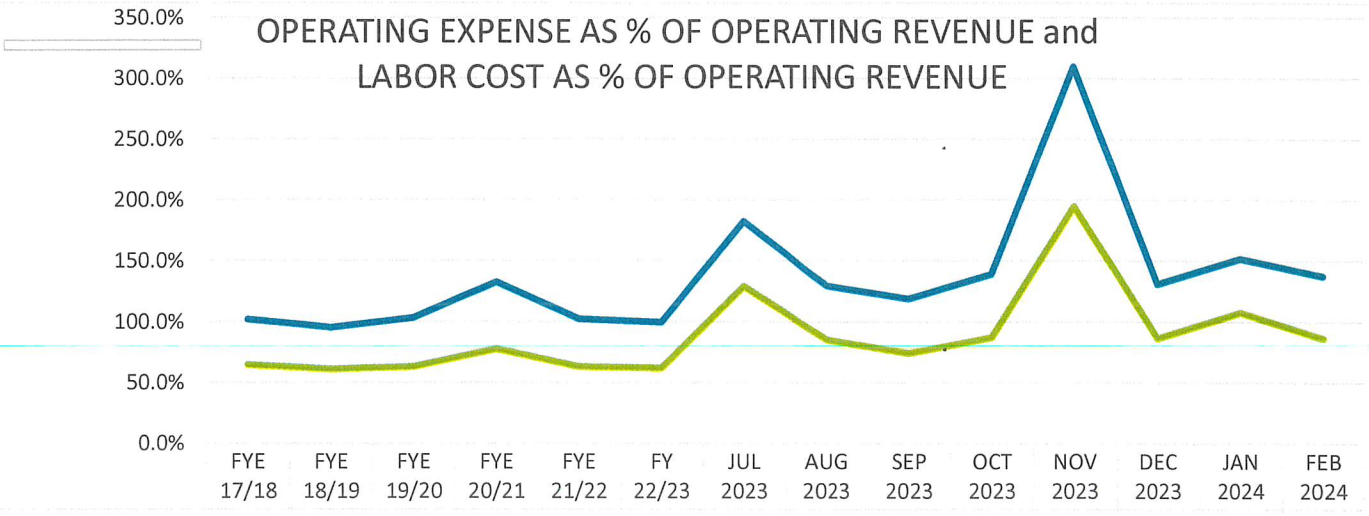

| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FY 22/23 | JUL 2023 | AUG 2023 | SEP 2023 | OCT 2023 | NOV 2023 | DEC 2023 | JAN 2024 | FEB 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GPR | 24,382 | 24,433 | 22,416 | 21,265 | 37,535 | 39,748 | 37,092 | 40,735 | 41,124 | 42,496 | 39,371 | 45,203 | 42,997 | 39,459 |

## NET PATIENT REVENUE AS % OF GROSS



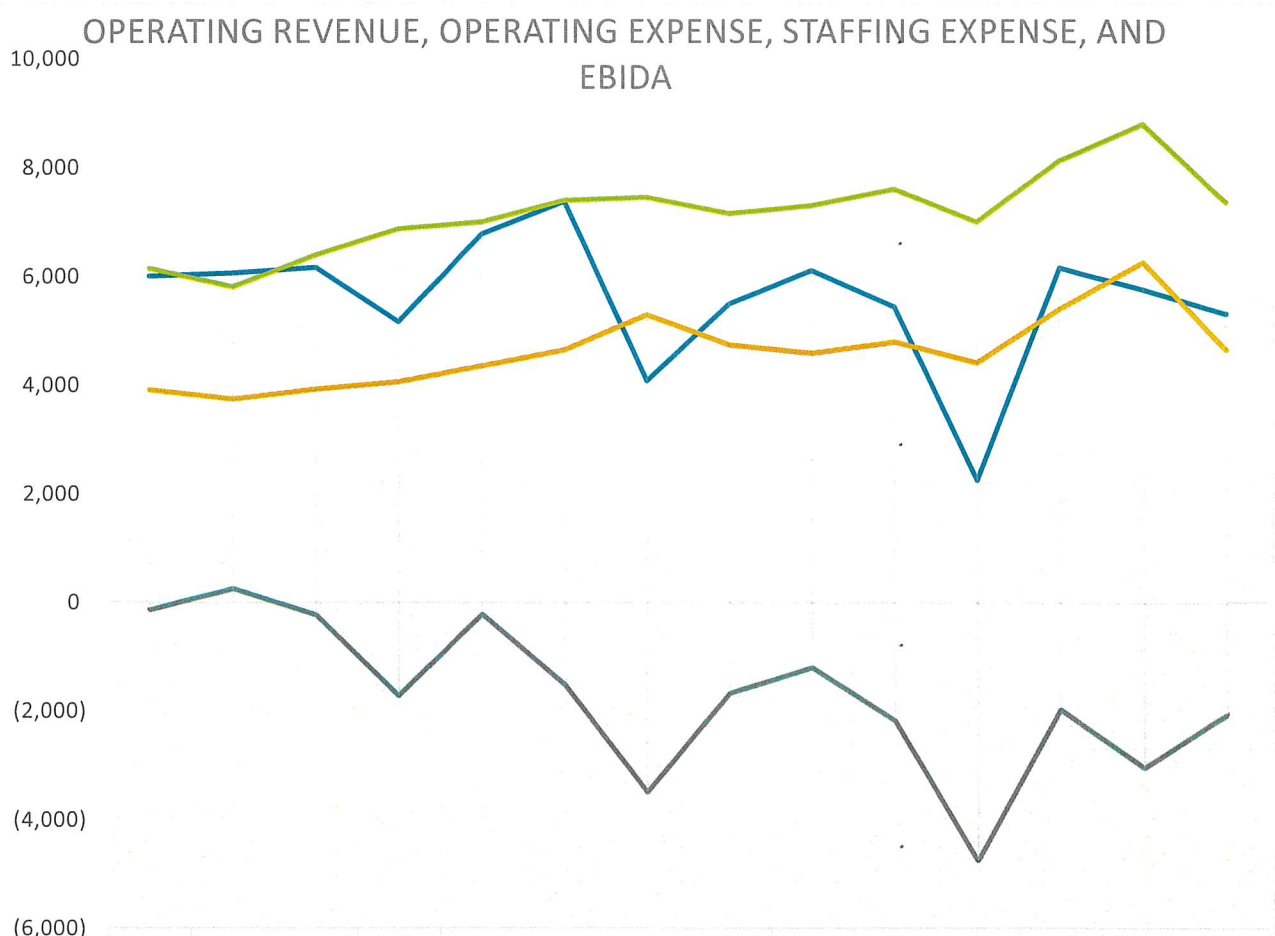

| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FY 22/23 | JUL 2023 | AUG 2023 | SEP 2023 | OCT 2023 | NOV 2023 | DEC 2023 | JAN 2024 | FEB 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NPR%GROSS | 16.08% | 16.38% | 16.93% | 17.61% | 14.05% | 12.72% | 9.05% | 11.78% | 13.59% | 10.27% | 4.38% | 12.36% | 11.97% | 11.94% |

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

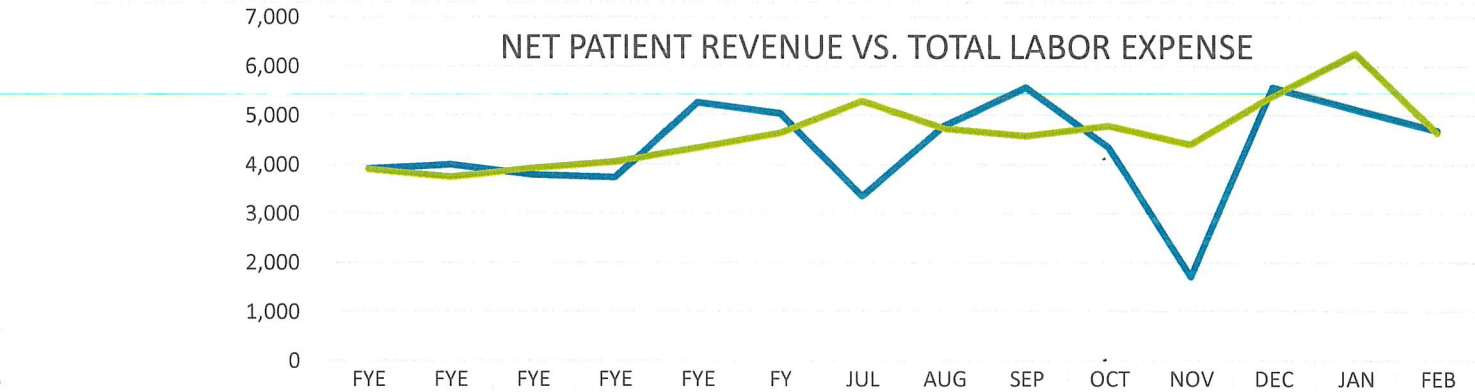



| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FY 22/23 | JUL 2023 | AUG 2023 | SEP 2023 | OCT 2023 | NOV 2023 | DEC 2023 | JAN 2024 | FEB 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| OP EXP%OP REV | 102.3% | 95.8% | 103.8% | 133.3% | 103.2% | 100.2% | 183.0% | 130.4% | 119.5% | 139.8% | 310.6% | 131.9% | 152.7% | 138.6% |
| LABOR%OP REV | 65.2% | 61.9% | 63.8% | 78.8% | 64.1% | 63.0% | 130.1% | 86.4% | 75.1% | 88.2% | 195.7% | 87.7% | 108.8% | 87.5% |

# SAN GORGONIO MEMORIAL HOSPITAL

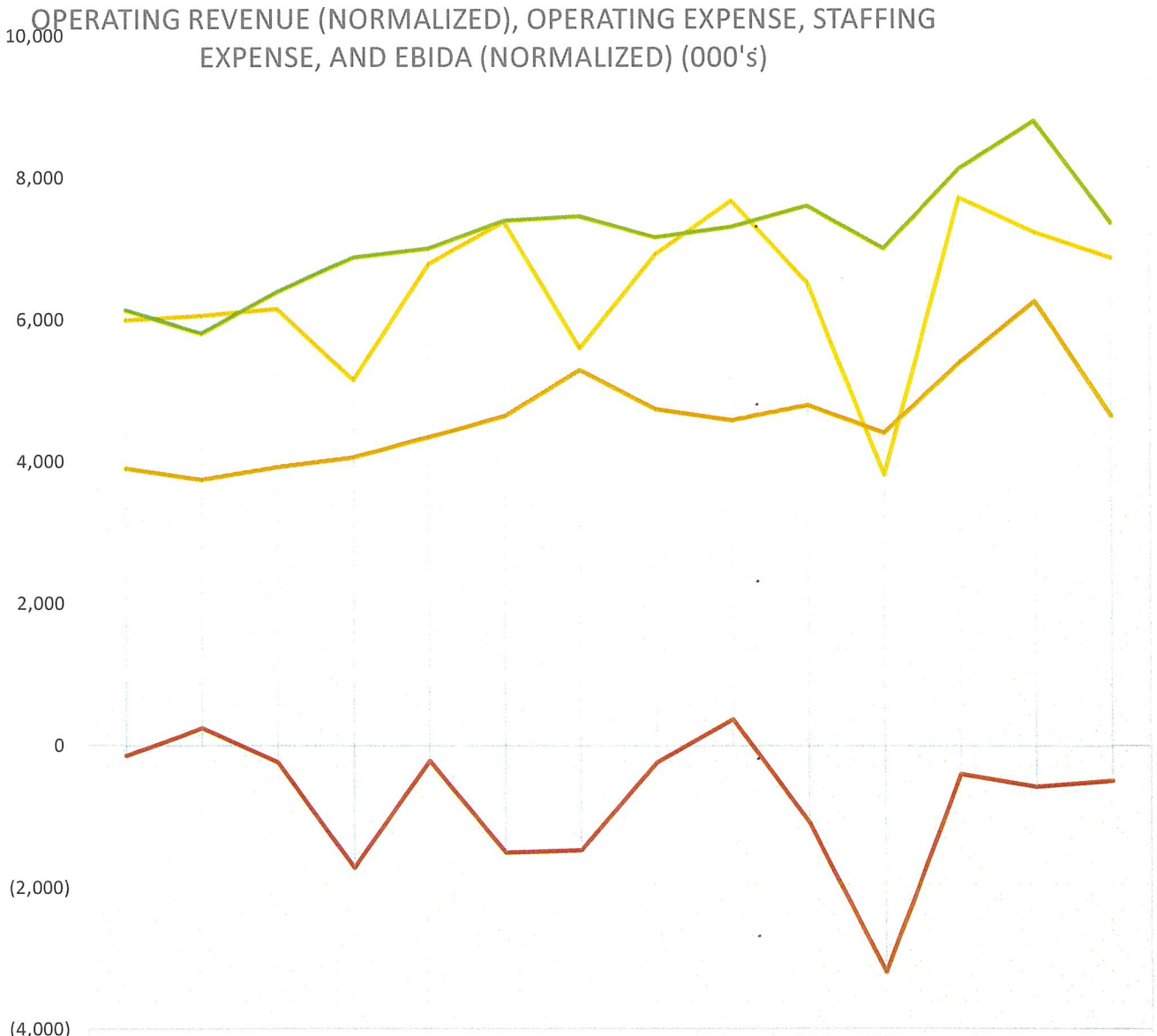



| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FY 22/23 | JUL 2023 | AUG 2023 | SEP 2023 | OCT 2023 | NOV 2023 | DEC 2023 | JAN 2024 | FEB 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| OP REV | 6,006 | 6,069 | 6,165 | 5,160 | 6,791 | 7,391 | 4,078 | 5,495 | 6,118 | 5,442 | 2,256 | 6,167 | 5,772 | 5,325 |
| OP EXP | 6,147 | 5,817 | 6,398 | 6,878 | 7,007 | 7,403 | 7,461 | 7,164 | 7,310 | 7,610 | 7,006 | 8,132 | 8,811 | 7,378 |
| STAFF EXP | 3,915 | 3,755 | 3,932 | 4,065 | 4,354 | 4,654 | 5,303 | 4,746 | 4,593 | 4,802 | 4,416 | 5,411 | 6,277 | 4,662 |
| EBIDA | (141) | 252 | (233) | (1,719 | (216) | (1,512 | (3,483 | (1,668 | (1,192 | (2,168 | (4,750 | (1,965 | (3,029 | (2,053 |




| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FY 22/23 | JUL 2023 | AUG 2023 | SEP 2023 | OCT 2023 | NOV 2023 | DEC 2023 | JAN 2024 | FEB 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NET PAT REV | 3,921 | 4,003 | 3,795 | 3,744 | 5,275 | 5,057 | 3,358 | 4,799 | 5,587 | 4,366 | 1,723 | 5,588 | 5,145 | 4,712 |
| LABOR EXP | 3,915 | 3,755 | 3,932 | 4,065 | 4,354 | 4,654 | 5,303 | 4,746 | 4,593 | 4,802 | 4,416 | 5,411 | 6,277 | 4,662 |

# SAN GORGONIO MEMORIAL HOSPITAL




| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FY 22/23 | JUL 2023 | AUG 2023 | SEP 2023 | OCT 2023 | NOV 2023 | DEC 2023 | JAN 2024 | FEB 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| REV NORMAL | 6,006 | 6,069 | 6,165 | 5,160 | 6,791 | 7,391 | 5,609 | 6,925 | 7,684 | 6,527 | 3,822 | 7,734 | 7,245 | 6,892 |
| OP EXP | 6,147 | 5,817 | 6,398 | 6,878 | 7,007 | 7,403 | 7,461 | 7,164 | 7,310 | 7,610 | 7,006 | 8,132 | 8,811 | 7,378 |
| LABOR EXP | 3,915 | 3,755 | 3,932 | 4,065 | 4,354 | 4,654 | 5,303 | 4,746 | 4,593 | 4,802 | 4,416 | 5,411 | 6,277 | 4,662 |
| EBIDA NORMAL | (141) | 252 | (233) | (1,719) | (216) | (1,499) | (1,469) | (238) | 374 | (1,083) | (3,184) | (398) | (571) | (487) |

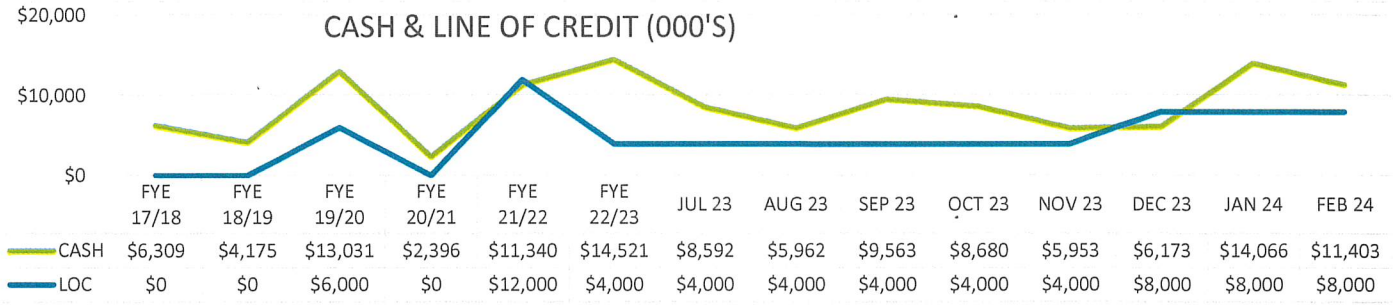
**SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT & HOSPITAL - BANNING, CA** | **Month-to- Month FYE June 30, 2024** | **Statement of Revenue and Expense**

| | FYE18/19 | FYE19/20 | FYE 20/21 | FYE 21/22 | FYE 22/23 | FYE 23/24 | FYE 23/24 | FYE 23/24 | FYE 23/24 | FYE 23/24 | FYE 23/24 | FYE 23/24 | FYE 23/24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | MONTHLY AVE. | MONTHLY AVE. | MONTHLY AVE. | MONTHLY AVE. | 12 MONTHLY AVE. | 7/31/2023 | 8/31/2023 | 9/30/2023 | 10/31/2023 | 11/30/2023 | 12/31/2023 | 1/31/2024 | 2/29/2024 |
| **Gross Patient Revenue** | | | | | | | | | | | | | |
| Inpatient Revenue | $ 7,667,883 | $ 7,401,282 | $ 9,331,371 | $ 16,603,390 | $ 14,171,780 | $ 12,272,477 | $ 13,826,953 | $ 15,201,247 | $ 14,429,560 | $ 13,489,069 | $ 19,103,480 | $ 14,920,563 | $ 12,466,980 |
| Inpatient Psych/Rehab Revenue | 0 | 0 | 0 | 0 | | - | - | - | - | - | - | - | - |
| Outpatient Revenue | 16,765,365 | 15,067,104 | 11,933,682 | 20,932,075 | 25,575,741 | 24,819,128 | 26,907,760 | 25,923,098 | 28,065,983 | 25,881,729 | 26,099,576 | 28,076,461 | 26,992,400 |
| Long Term Care Revenue | 0 | 0 | 0 | 0 | | - | - | - | - | - | - | - | - |
| Home Health Revenue | 0 | 0 | 0 | 0 | 0 | - | - | - | - | - | - | - | - |
| **Total Gross Patient Revenue** | 24,433,247 | 22,468,386 | 21,265,053 | 37,535,465 | 39,747,521 | 37,091,605 | 40,734,713 | 41,124,345 | 42,495,543 | 39,370,798 | 45,203,056 | 42,997,024 | 39,459,380 |
| **Deductions From Revenue** | | | | | | | | | | | | | |
| Discounts and Allowances | (19,588,148) | (17,845,730) | (16,635,734) | (31,267,149) | (33,545,205) | (32,843,917) | (34,825,978) | (34,572,937) | (37,124,786) | (36,796,629) | (38,595,300) | (36,989,290) | (33,921,141) |
| Bad Debt Expense | (858,023) | (653,280) | (824,395) | (1,045,570) | (1,047,941) | (864,969) | (964,980) | (950,573) | (901,941) | (808,712) | (924,718) | (847,519) | (776,660) |
| GI HMO Discounts | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Charity Care | (56,168) | (86,517) | (41,362) | (136,947) | (97,443) | (24,281) | (144,312) | (13,958) | (103,164) | (42,458) | (94,878) | (15,178) | (49,310) |
| **Total Deductions From Revenue** | (20,502,339) | (18,585,527) | (17,501,490) | (32,449,666) | (34,690,589) | (33,733,167) | (35,935,270) | (35,537,468) | (38,129,891) | (37,647,799) | (39,614,896) | (37,851,987) | (34,747,111) |
| | -83.9% | -82.7% | -82.3% | -86.5% | -87.3% | -90.9% | -88.2% | -86.4% | -89.7% | -95.6% | -87.6% | -88.0% | -88.1% |
| **Net Patient Revenue** | 3,930,908 | 3,882,859 | 3,763,563 | 5,085,799 | 5,056,932 | 3,358,438 | 4,799,443 | 5,586,877 | 4,365,652 | 1,722,999 | 5,588,160 | 5,145,037 | 4,712,269 |
| **Non- Patient Revenues** | | | | | | | | | | | | | |
| Supplemental Revenues | 1,485,337 | 1,157,326 | 869,707 | 501,407 | 941,881 | 35,377 | 136,446 | 0 | 481,713 | 0 | 0 | 93,504 | 0 |
| Grants & Other Op Revenues | 205,590 | 750,434 | 505,190 | 725,066 | 986,421 | 115,377 | 158,046 | 129,370 | 193,230 | 131,437 | 177,703 | 131,682 | 211,609 |
| Clinic Net Revenues | 22,382 | 15,743 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Tax Subsidies Measure D | 196,524 | 199,469 | 209,744 | 229,405 | 213,402 | 246,994 | 246,994 | 246,994 | 246,994 | 246,994 | 246,994 | 246,994 | 246,994 |
| Tax Subsidies Prop 13 | 115,388 | 114,061 | 142,552 | 146,104 | 189,707 | 154,500 | 154,500 | 154,500 | 154,500 | 154,500 | 154,500 | 154,500 | 154,500 |
| Tax Subsidies County Suplmtl Funds | 16,159 | 9,064 | 16,163 | 25,561 | 2,308 | 167,258 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Non-Patient Revenues** | 2,041,381 | 2,246,097 | 1,743,355 | 1,627,542 | 2,333,719 | 719,506 | 695,986 | 530,864 | 1,076,437 | 532,931 | 579,197 | 626,680 | 613,103 |
| **Total Operating Revenue** | 5,972,289 | 6,128,956 | 5,506,919 | 6,713,341 | 7,390,651 | 4,077,944 | 5,495,429 | 6,117,741 | 5,442,089 | 2,255,930 | 6,167,357 | 5,771,717 | 5,325,372 |
| **Operating Expenses** | | | | | | | | | | | | | |
| Salaries and Wages | 2,941,226 | 3,104,224 | 3,125,159 | 3,420,974 | 3,634,721 | 4,119,595 | 3,674,360 | 3,550,566 | 3,776,105 | 3,194,719 | 4,333,628 | 5,126,248 | 3,539,249 |
| Fringe Benefits | 702,477 | 752,708 | 856,889 | 830,599 | 938,301 | 1,013,089 | 970,221 | 848,892 | 1,033,920 | 978,795 | 955,047 | 1,005,066 | 994,090 |
| Contract Labor | 106,628 | 59,516 | 114,886 | 99,977 | 81,255 | 170,728 | 101,775 | 193,746 | 176,561 | 242,190 | 122,459 | 145,922 | 129,020 |
| Physicians Fees | 246,631 | 331,858 | 350,783 | 330,533 | 299,739 | 280,402 | 260,382 | 307,954 | 290,783 | 282,650 | 798,595 | 462,618 | 382,672 |
| Purchased Services | 513,857 | 691,337 | 772,336 | 892,521 | 863,657 | 840,396 | 941,985 | 1,007,492 | 1,002,184 | 1,078,252 | 802,077 | 936,912 | 929,948 |
| Supply Expense | 685,518 | 751,025 | 903,883 | 995,446 | 953,253 | 700,018 | 814,829 | 906,328 | 861,780 | 762,898 | 650,227 | 648,726 | 832,331 |
| Utilities | 75,471 | 80,680 | 92,287 | 111,192 | 93,037 | 104,939 | 107,960 | 76,274 | 88,098 | 97,211 | 115,692 | 103,927 | 91,014 |
| Repairs and Maintenance | 58,325 | 58,592 | 139,712 | 77,524 | 76,806 | 61,860 | 69,232 | 147,878 | 136,677 | 92,822 | 44,993 | 141,551 | 102,566 |
| Insurance Expense | 85,267 | 103,277 | 110,683 | 112,745 | 119,548 | 185,434 | 133,116 | 147,115 | 138,116 | 128,116 | 146,380 | 38,130 | 130,918 |
| All Other Operating Expenses | 70,922 | 160,745 | 148,752 | 101,142 | 151,928 | 59,602 | 47,639 | 68,331 | 55,072 | 93,494 | 117,737 | 173,637 | 218,160 |
| IGT Expense | 58,743 | 109,484 | 172,366 | 0 | 91,499 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Leases and Rentals | 76,150 | 79,233 | 79,424 | 37,952 | 99,514 | 25,370 | 42,245 | 55,457 | 50,740 | 54,691 | 45,049 | 28,370 | 28,370 |
| 1206 (b) CLINIC | 98,810 | 94,628 | 34,096 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Operating Expenses** | 5,720,023 | 6,377,306 | 6,901,255 | 7,010,605 | 7,403,258 | 7,561,433 | 7,163,744 | 7,310,033 | 7,610,036 | 7,005,838 | 8,131,884 | 8,811,107 | 7,378,338 |
| **EBIDA** | 252,266 | (248,351) | (1,394,337) | (297,264) | (12,606) | (3,483,489) | (1,668,315) | (1,192,292) | (2,167,947) | (4,749,908) | (1,964,527) | (3,039,390) | (2,052,966) |
| **Interest, Depreciation, and Amortization** | | | | | | | | | | | | | |
| Depreciation Expense | 497,808 | 506,497 | 494,721 | 472,317 | 495,039 | 514,671 | 515,528 | 605,920 | 571,451 | 569,523 | 577,088 | 640,273 | 626,702 |
| Interest & Amortization Expense | 418,193 | 422,094 | 447,994 | 391,606 | 484,663 | 434,111 | 445,099 | 383,794 | 405,597 | 370,607 | 369,556 | 442,597 | 453,676 |
| **Total Interest, Depr, & Amort.** | 916,000 | 928,591 | 942,715 | 863,923 | 979,702 | 948,782 | 960,627 | 989,714 | 977,048 | 940,130 | 946,644 | 1,082,870 | 1,080,378 |
| **Non-Operating Revenue:** | | | | | | | | | | | | | |
| Contributions & Other | 7,745 | 27,759 | 7,121 | 25,068 | 132,587 | 13,926 | 1,225,118 | 21,774 | 13,626 | 415,400 | 13,626 | 465,626 | 224,765 |
| Tax Subsidies for GO Bonds - M-A | 692,457 | 666,966 | 598,410 | 616,059 | 660,979 | 627,353 | 627,353 | 627,353 | 627,353 | 627,353 | 627,353 | 627,353 | 627,353 |
| **Total Non Operating Revenue/(Expense)** | 700,202 | 694,725 | 605,531 | 641,127 | 793,566 | 641,279 | 1,852,471 | 649,127 | 640,979 | 1,042,753 | 640,979 | 1,092,979 | 852,118 |
| **Total Net Surplus/(Loss)** | 36,467 | (482,217) | (1,731,521) | (520,060) | (198,742) | (3,790,992) | (776,471) | (1,532,879) | (2,504,016) | (4,647,285) | (2,270,192) | (3,029,281) | (2,281,226) |
| Change in Interest in Foundation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Extra-ordinary Loss | 0 | (689,574) | (650) | (284,792) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Increase/(Decrease in Unrestricted Net Assets** | $ 36,467 | $ (1,171,791) | $ (1,732,171) | $ (804,852) | $ (198,742) | $ (3,790,992) | $ (776,471) | $ (1,532,879) | $ (2,504,016) | $ (4,647,285) | $ (2,270,192) | $ (3,029,281) | $ (2,281,226) |
| **Total Profit Margin** | 0.6% | -7.9% | -31.4% | -7.7% | -2.7% | -93.0% | -14.1% | -25.1% | -46.0% | -206.0% | -36.8% | -52.5% | -42.8% |
| **EBIDA %** | 4.2% | -4.1% | -25.3% | -4.4% | -0.2% | -85.4% | -30.4% | -19.5% | -39.8% | -210.6% | -31.9% | -52.7% | -38.6% |
| **Actual EBIDA for Month** | | | | | | (3,483,489) | (1,668,315) | (1,192,292) | (2,167,947) | (4,749,908) | (1,964,527) | (3,039,390) | (2,052,966) |
| **Adjustments to EBIDA to account for Cash Impact of GASB Lease Reclassification** | | | | | | (55,132) | (55,132) | (55,132) | (55,132) | (55,132) | (55,132) | (55,132) | (55,132) |
| **Adjustment for Normalization of Supplemental Income Incl DSH & P4P (Net of Current Month Receipts)** | | | | | | 1,586,070 | 1,485,001 | 1,621,447 | 1,139,734 | 1,621,447 | 1,621,447 | 1,527,943 | 1,621,447 |
| **Effective EBIDA after Normalization of Supplementals & Adjustments for Cash Outlays for Leases** | | | | | | (1,952,551) | (238,446) | 374,023 | (1,083,345) | (3,183,593) | (398,212) | (1,566,579) | (486,651) |
| | | | | | | YTD | (2,190,997) | (1,816,973) | (2,900,318) | (6,083,911) | (6,482,123) | (8,048,701) | (8,535,352) |

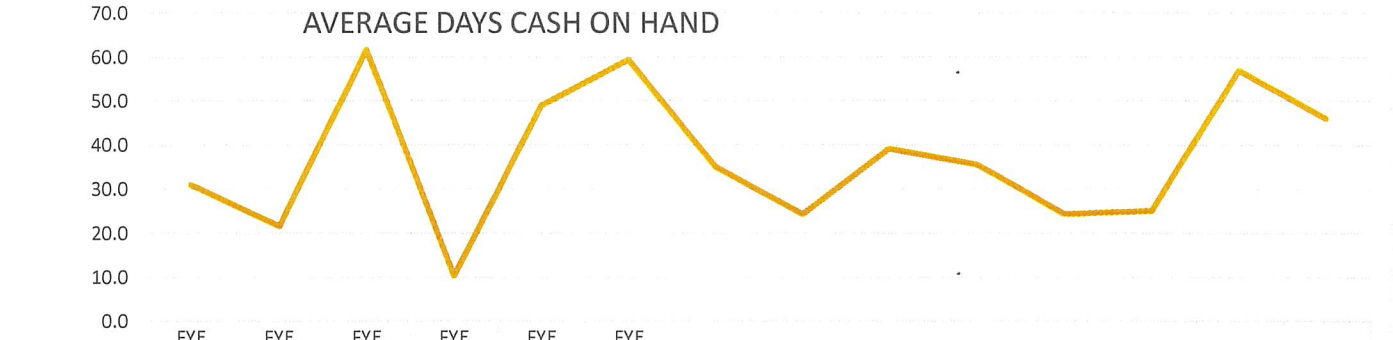
**BALANCE SHEET (Period End)**

| | |
|---|---|
| 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. |

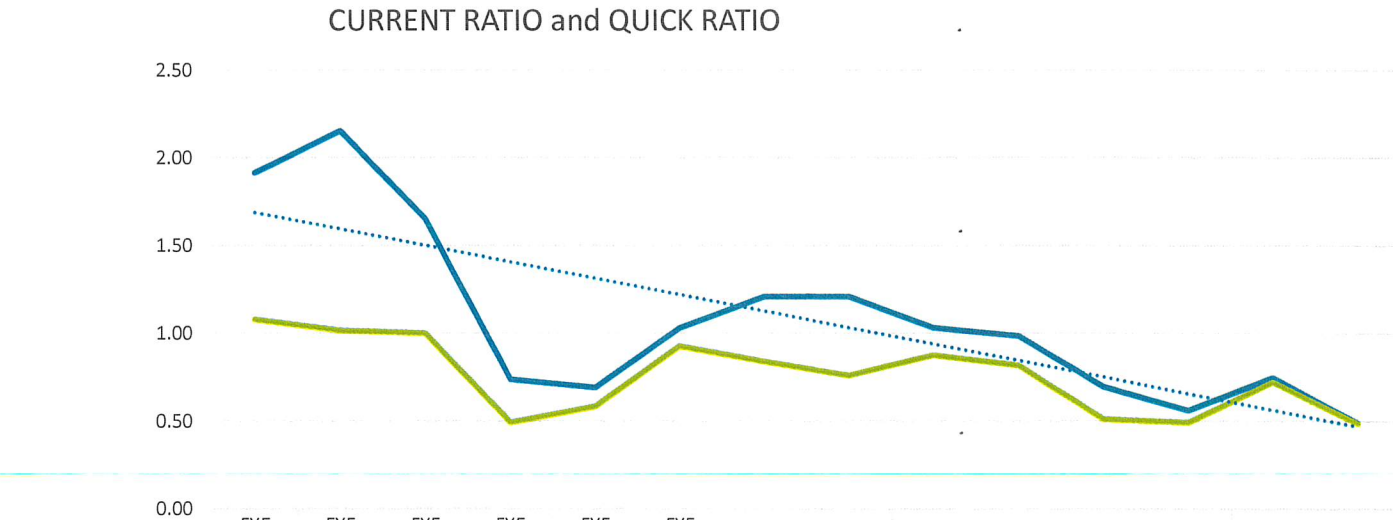
# SAN GORGONIO MEMORIAL HOSPITAL




| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FYE 22/23 | JUL 23 | AUG 23 | SEP 23 | OCT 23 | NOV 23 | DEC 23 | JAN 24 | FEB 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CASH | $6,309 | $4,175 | $13,031 | $2,396 | $11,340 | $14,521 | $8,592 | $5,962 | $9,563 | $8,680 | $5,953 | $6,173 | $14,066 | $11,403 |
| LOC | $0 | $0 | $6,000 | $0 | $12,000 | $4,000 | $4,000 | $4,000 | $4,000 | $4,000 | $4,000 | $8,000 | $8,000 | $8,000 |



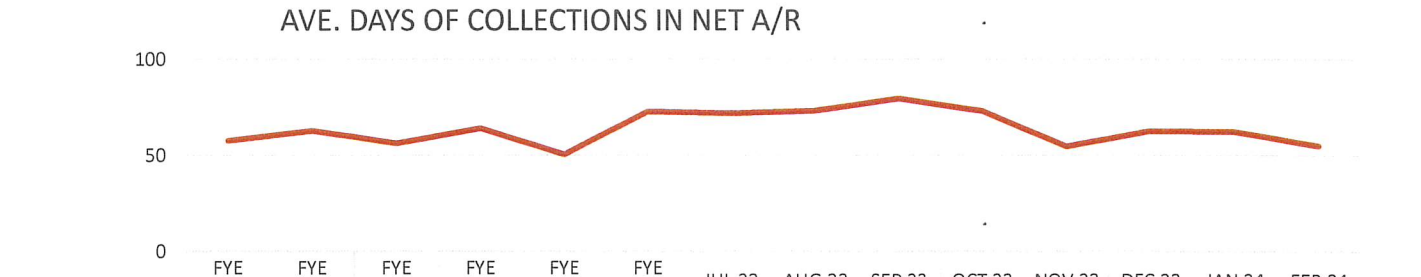

| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FYE 22/23 | JUL 23 | AUG 23 | SEP 23 | OCT 23 | NOV 23 | DEC 23 | JAN 24 | FEB 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DCOH | 31.2 | 21.8 | 62.0 | 10.6 | 49.2 | 59.7 | 35.3 | 24.6 | 39.4 | 35.8 | 24.6 | 25.4 | 57.3 | 46.3 |



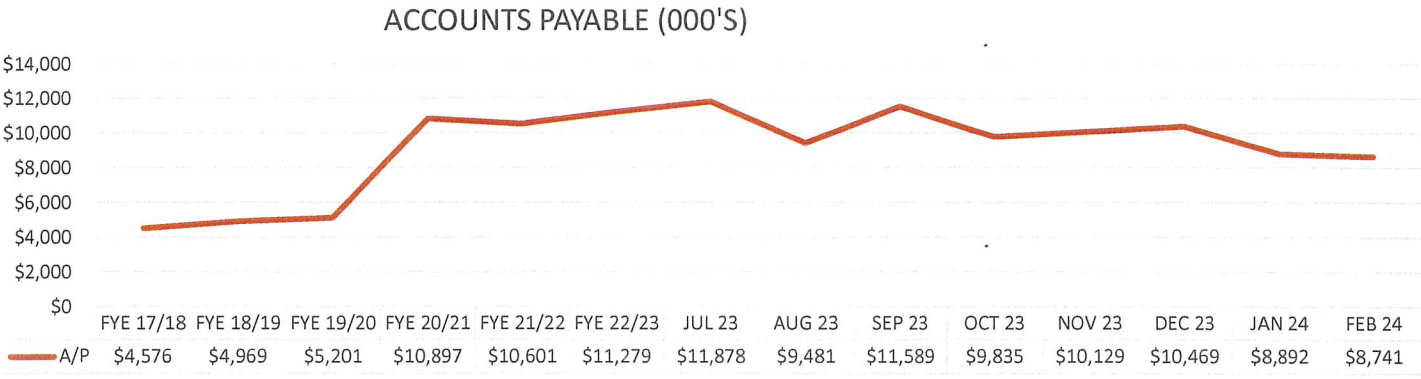

| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FYE 22/23 | JUL 23 | AUG 23 | SEP 23 | OCT 23 | NOV 23 | DEC 23 | JAN 24 | FEB 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CURRENT | 1.92 | 2.16 | 1.66 | 0.74 | 0.70 | 1.03 | 1.21 | 1.21 | 1.04 | 0.99 | 0.70 | 0.57 | 0.75 | 0.50 |
| QUICK | 1.08 | 1.02 | 1.00 | 0.50 | 0.59 | 0.93 | 0.84 | 0.76 | 0.88 | 0.82 | 0.52 | 0.50 | 0.73 | 0.49 |

# SAN GORGONIO MEMORIAL HOSPITAL

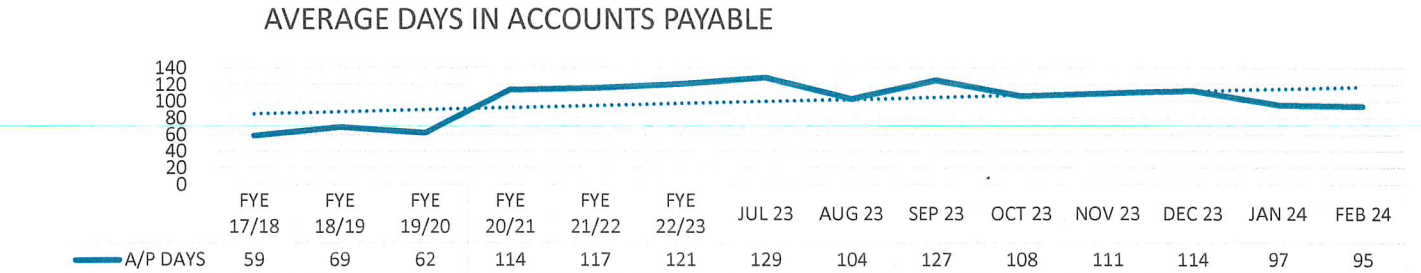

| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FYE 22/23 | JUL 23 | AUG 23 | SEP 23 | OCT 23 | NOV 23 | DEC 23 | JAN 24 | FEB 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NET A/R | $7,470 | $8,330 | $7,089 | $7,939 | $8,495 | $12,177 | $11,706 | $11,869 | $13,045 | $11,872 | $8,544 | $9,922 | $9,875 | $8,728 |




| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FYE 22/23 | JUL 23 | AUG 23 | SEP 23 | OCT 23 | NOV 23 | DEC 23 | JAN 24 | FEB 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NET DAYS | 58 | 63 | 57 | 64 | 51 | 73 | 72 | 74 | 80 | 74 | 55 | 63 | 63 | 55 |




| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FYE 22/23 | JUL 23 | AUG 23 | SEP 23 | OCT 23 | NOV 23 | DEC 23 | JAN 24 | FEB 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A/P | $4,576 | $4,969 | $5,201 | $10,897 | $10,601 | $11,279 | $11,878 | $9,481 | $11,589 | $9,835 | $10,129 | $10,469 | $8,892 | $8,741 |




| | FYE 17/18 | FYE 18/19 | FYE 19/20 | FYE 20/21 | FYE 21/22 | FYE 22/23 | JUL 23 | AUG 23 | SEP 23 | OCT 23 | NOV 23 | DEC 23 | JAN 24 | FEB 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A/P DAYS | 59 | 69 | 62 | 114 | 117 | 121 | 129 | 104 | 127 | 108 | 111 | 114 | 97 | 95 |

| | A | B | C | D | E | F | G | H | I | J |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT & HOSPITAL** | | | | | | | | | |
| 2 | **INCOME STATEMENT** | **FEBRUARY 2024 BUDGET** | **FEBRUARY 2024 ACTUAL** | **VARIANCE FEBRUARY ACTUAL TO BUDGET** | **VARIANCE PER CENTAGE** | | **FEBRUARY 2024 YTD BUDGET** | **FEBRUARY 2024 YTD ACTUAL** | **VARIANCE FEBRUARY YTD ACTUAL TO BUDGET** | **YTD VARIANCE PER CENTAGE** |
| 3 | **NET INCOME** | (1,801,726) | (2,281,226) | **(479,500)** | **-26.6%** | | (8,155,622) | (20,832,342) | (12,676,720) | **-155.4%** |
| 4 | **EBIDA** | (1,446,544) | (2,052,966) | **(606,422)** | **-41.9%** | | (9,638,944) | (20,344,155) | (10,705,211) | **-111.1%** |
| 5 | | | | | | | | | | |
| 6 | **TOTAL OPERATING REVENUE** | 5,730,915 | 5,325,372 | (405,543) | -7.1% | | 49,412,504 | 40,653,579 | (8,758,925) | -17.7% |
| 7 | NET PATIENT REVENUE | 5,062,485 | 4,712,269 | (350,216) | -6.9% | | 43,436,828 | 35,278,875 | (8,157,953) | -18.8% |
| 13 | OTHER OPERATING REVENUE | 668,430 | 613,103 | (55,327) | -8.3% | | 5,975,676 | 5,374,704 | (600,972) | -10.1% |
| 20 | | | | | | | | | | |
| 21 | **TOTAL OPERATING EXPENSE** | 7,177,459 | 7,378,338 | 200,879 | 2.8% | | 59,051,448 | 60,997,734 | (1,946,286) | -3.3% |
| 34 | | | | | | | | | | |
| 35 | **NON-OPERATING REVENUE & EXPENSE** | 655,777 | 852,118 | 196,341 | 29.9% | | 9,221,471 | 7,412,685 | (1,808,786) | -19.6% |
| 39 | TOTAL INTEREST & DEPRECIATION | 1,010,959 | 1,080,378 | 69,419 | 6.9% | | 7,738,149 | 7,900,872 | (162,723) | -2.1% |
| 42 | | | | | | | | | | |
| 43 | Page 1 of 1 | Wednesday, March 20, 2024 4:54:04 PM | | | | | | | | |

| | A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|---|
| 1 | **SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT & HOSPITAL** | | | | | | |
| 2 | **BALANCE SHEET** | **JUNE 2023** | **DECEMBER 2023** | **JANUARY 2024** | **FEBRUARY 2024** | **VARIANCE JANUARY TO FEBRUARY** | **VARIANCE PERCENTAGE** |
| 3 | **TOTAL ASSETS** | **112,558,570** | **104,958,733** | **112,391,784** | **116,795,348** | **4,403,564** | **3.9%** |
| 4 | **CURRENT ASSETS** | 29,638,354 | 19,794,071 | 24,748,448 | 20,163,177 | (4,585,271) | -18.5% |
| 16 | ASSETS WHICH USE IS LIMITED | 9,102,770 | 13,828,639 | 16,738,243 | 25,652,223 | 8,913,980 | 53.3% |
| 17 | NET PROPERTY, PLANT, AND EQUIPMENT | 73,452,527 | 71,482,689 | 71,054,280 | 71,131,575 | 77,295 | 0.1% |
| 24 | OTHER ASSETS | 364,919 | (146,666) | (149,187) | (151,627) | (2,440) | 1.6% |
| 25 | | | | | | | |
| 26 | **TOTAL LIABILITIES & FUND BALANCE** | **112,558,570** | **104,958,668** | **112,391,706** | **116,795,275** | **(4,403,569)** | **-3.9%** |
| 27 | **TOTAL LIABILITIES** | **148,421,077** | **164,602,704** | **175,065,023** | **181,749,818** | **(6,684,795)** | **-3.8%** |
| 28 | **CURRENT LIABILITES** | 28,682,871 | 32,185,743 | 32,865,186 | 40,708,106 | (7,842,920) | -23.9% |
| 39 | **LONG TERM LIABILITIES** | 119,738,206 | 132,416,961 | 142,199,837 | 141,041,712 | 1,158,125 | 0.8% |
| 41 | **NET ASSETS** | (35,862,507) | (59,644,036) | (62,673,317) | (64,954,543) | 2,281,226 | -3.6% |
| 45 | | | | | | | |
| 46 | Page 1 of 1 | | | | | | |

41

# SAN GORGONIO MEMORIAL HOSPITAL

| | | FY23 | FY 24 | FY 24 | | FY 23 | FY 24 | FY 24 | | FY 23 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 02/28/23 | 02/29/24 | 02/29/24 | | 2023 | 2024 | 2024 | | 2023 |
| | | ACTUAL | ACTUAL | BUDGET | | 8 MOS YTD ACTUAL | 8 MOS YTD ACTUAL | 8 MOS.YTD BUDGET | | YR END TOTAL |
| | | | | | | | | | | |
| [1] | Total Acute Patient Days | 597 | 582 | 702 | | 5,431 | 5,357 | 5,668 | | 7,636 |
| [2] | Average Daily Census | 21.3 | 20.1 | 24.2 | | 22.3 | 22.0 | 23.2 | | 20.9 |
| [3] | Average Acute Length of Stay | 3.7 | 3.8 | 3.9 | | 3.6 | 3.8 | 3.5 | | 3.5 |
| [4] | Patient Discharges | 162 | 153 | 181 | | 1,512 | 1,415 | 1,612 | | 2,186 |
| [5] | Adjusted Patient Days | 1,644 | 1,852 | 1,841 | | 14,513 | 15,244 | 15,267 | | 21,460 |
| [6] | Observation Days | 264 | 346 | 269 | | 2,084 | 2,519 | 2,269 | | 3,160 |
| [7] | Total Emergency Room Visits | 2,956 | 3,329 | 3,564 | | 28,115 | 28,182 | 30,033 | | 41,821 |
| [8] | Average ED Visits Per Day | 106 | 115 | 123 | | 116 | 116 | 123 | | 115 |
| [9] | Total Surgeries (Excluding G.I.'s) | 107 | 89 | 117 | | 946 | 810 | 1,018 | | 1,433 |
| [10] | Deliveries/Births | 11 | 7 | 10 | | 96 | 75 | 101 | | 131 |

8/

| | A | B | C | D | E | F | G | H | I | J |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT & HOSPITAL** | | | | | | | | | |
| 2 | **INCOME STATEMENT** | **FEBRUARY 2024 BUDGET** | **FEBRUARY 2024 ACTUAL** | **VARIANCE FEBRUARY ACTUAL TO BUDGET** | **VARIANCE PER CENTAGE** | | **FEBRUARY 2024 YTD BUDGET** | **FEBRUARY 2024 YTD ACTUAL** | **VARIANCE FEBRUARY YTD ACTUAL TO BUDGET** | **YTD VARIANCE PER CENTAGE** |
| 3 | **NET INCOME** | (1,801,726) | (2,281,226) | **(479,500)** | **-26.6%** | | (8,155,622) | (20,832,342) | (12,676,720) | **-155.4%** |
| 4 | **EBIDA** | (1,446,544) | (2,052,966) | **(606,422)** | **-41.9%** | | (9,638,944) | (20,344,155) | (10,705,211) | **-111.1%** |
| 5 | | | | | | | | | | |
| 6 | **TOTAL OPERATING REVENUE** | 5,730,915 | 5,325,372 | (405,543) | -7.1% | | 49,412,504 | 40,653,579 | (8,758,925) | -17.7% |
| 7 | NET PATIENT REVENUE | 5,062,485 | 4,712,269 | (350,216) | -6.9% | | 43,436,828 | 35,278,875 | (8,157,953) | -18.8% |
| 8 | GROSS REVENUE FROM PATIENT SERVICES | 40,597,327 | 39,459,380 | (1,137,947) | -2.8% | | 338,119,298 | 328,476,464 | (9,642,834) | -2.9% |
| 9 | TOTAL INPATIENT REVENUE | 15,387,064 | 12,466,980 | (2,920,084) | -19.0% | | 125,873,399 | 115,710,329 | (10,163,070) | -8.1% |
| 10 | TOTAL OUTPATIENT REVENUE | 25,210,263 | 26,992,400 | 1,782,137 | 7.1% | | 212,245,899 | 212,766,135 | 520,236 | 0.2% |
| 11 | DEDUCTIONS FROM REVENUE | (35,534,842) | (34,747,111) | 787,731 | -2.2% | | (294,682,470) | (293,197,589) | 1,484,881 | -0.5% |
| 12 | | | | | | | | | | |
| 13 | OTHER OPERATING REVENUE | 668,430 | 613,103 | (55,327) | -8.3% | | 5,975,676 | 5,374,704 | (600,972) | -10.1% |
| 14 | OTHER REVENUE - RATE RANGE | 0 | 0 | 0 | 0.0% | | 0 | 0 | 0 | 0.0% |
| 15 | OTHER REVENUE - OTHER SUPPLEMENTALS | 0 | 0 | 0 | 0.0% | | 434,000 | 481,713 | 47,713 | 11.0% |
| 16 | OTHER REVENUE - DSH | 0 | 0 | 0 | 0.0% | | 56,236 | 99,536 | 43,300 | 77.0% |
| 17 | OTHER REVENUE - P4P | 0 | 8,283 | 8,283 | 0.0% | | 138,000 | 214,608 | 76,608 | 55.5% |
| 18 | OTHER REVENUE - OTHER | 258,603 | 203,326 | (55,277) | -21.4% | | 2,068,824 | 1,199,637 | (869,187) | -42.0% |
| 19 | OPERATNG TAX REVENUES | 409,827 | 401,494 | (8,333) | -2.0% | | 3,278,616 | 3,379,210 | 100,594 | 3.1% |
| 20 | | | | | | | | | | |
| 21 | **TOTAL OPERATING EXPENSE** | 7,177,459 | 7,378,338 | 200,879 | 2.8% | | 59,051,448 | 60,997,734 | (1,946,286) | -3.3% |
| 22 | TOTAL LABOR EXPENSE | 4,618,275 | 4,662,359 | 44,084 | 1.0% | | 38,191,388 | 40,395,991 | (2,204,603) | -5.8% |
| 23 | WAGES | 3,539,986 | 3,539,249 | (737) | 0.0% | | 29,481,686 | 31,314,470 | (1,832,784) | -6.2% |
| 24 | EMPLOYEE BENEFITS | 989,689 | 994,090 | 4,401 | 0.4% | | 7,993,281 | 7,799,120 | 194,161 | 2.4% |
| 25 | CONTRACT LABOR | 88,600 | 129,020 | 40,420 | 45.6% | | 716,421 | 1,282,401 | (565,980) | -79.0% |
| 26 | PHYSICIAN FEES | 312,187 | 382,672 | 70,485 | 22.6% | | 2,497,496 | 3,066,056 | (568,560) | -22.8% |
| 27 | PURCHASED SERVICES | 900,692 | 929,948 | 29,256 | 3.2% | | 7,039,558 | 7,539,246 | (499,688) | -7.1% |
| 28 | SUPPLY EXPENSE | 889,842 | 832,331 | (57,511) | -6.5% | | 7,426,647 | 6,177,137 | 1,249,510 | 16.8% |
| 29 | UTILITIES | 100,148 | 91,014 | (9,134) | -9.1% | | 851,957 | 785,115 | 66,842 | 7.8% |
| 30 | REPAIRS AND MAINTENANCE | 81,641 | 102,566 | 20,925 | 25.6% | | 660,082 | 797,579 | (137,497) | -20.8% |
| 31 | INSURANCE | 146,289 | 130,918 | (15,371) | -10.5% | | 1,170,312 | 1,047,326 | 122,986 | 10.5% |
| 32 | OTHER EXPENSES | 83,011 | 218,160 | 135,149 | 162.8% | | 851,016 | 833,672 | 17,344 | 2.0% |
| 33 | LEASE AND RENTALS | 45,374 | 28,370 | (17,004) | -37.5% | | 362,992 | 355,612 | 7,380 | 2.0% |
| 34 | | | | | | | | | | |
| 35 | **NON-OPERATING REVENUE & EXPENSE** | 655,777 | 852,118 | 196,341 | 29.9% | | 9,221,471 | 7,412,685 | (1,808,786) | -19.6% |
| 36 | OTHER NON-OPERATING REVENUE | 28,424 | 224,765 | 196,341 | 690.8% | | 4,202,647 | 2,393,861 | (1,808,786) | -43.0% |
| 37 | NON-OPERATING TAX REVENUE | 627,353 | 627,353 | 0 | 0.0% | | 5,018,824 | 5,018,824 | 0 | 0.0% |
| 38 | EXTRAORDINARY REVENUE | 0 | 0 | 0 | 0.0% | | 0 | 0 | 0 | 0.0% |
| 39 | TOTAL INTEREST & DEPRECIATION | 1,010,959 | 1,080,378 | 69,419 | 6.9% | | 7,738,149 | 7,900,872 | (162,723) | -2.1% |
| 40 | DEPRECIATION | 572,172 | 626,702 | 54,530 | 9.5% | | 4,227,853 | 4,595,835 | (367,982) | -8.7% |
| 41 | INTEREST & AMORTIZATION | 438,787 | 453,676 | 14,889 | 3.4% | | 3,510,296 | 3,305,037 | 205,259 | 5.8% |
| 42 | | | | | | | | | | |
| 43 | Page 1 of 1 | Wednesday, March 20, 2024 4:54:04 PM | | | | | | | | |

| | A | B | C | D | E | F | G | H | I | J |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT & HOSPITAL** | | | | | | | | | |
| 2 | **INCOME STATEMENT** | **FEBRUARY 2024 FLEX BUDGET** | **FEBRUARY 2024 ACTUAL** | **VARIANCE FEBRUARY ACTUAL TO FLEX BUDGET** | **VARIANCE PER CENTAGE** | | **FEBRUARY 2024 YTD FLEX BUDGET** | **FEBRUARY 2024 YTD ACTUAL** | **VARIANCE FEBRUARY YTD ACTUAL TO FLEX BUDGET** | **YTD VARIANCE PER CENTAGE** |
| 3 | **NET INCOME** | (3,653,696) | (2,281,226) | 1,372,470 | **37.6%** | | (14,077,556) | (20,832,342) | (6,754,786) | **-48.0%** |
| 4 | **EBIDA** | (3,299,557) | (2,052,966) | 1,246,591 | **37.8%** | | (15,570,773) | (20,344,155) | (4,773,382) | **-30.7%** |
| 5 | | | | | | | | | | |
| 6 | **TOTAL OPERATING REVENUE** | 3,757,747 | 5,325,372 | 1,567,625 | -41.7% | | 42,940,219 | 40,653,579 | (2,286,640) | 5.3% |
| 7 | NET PATIENT REVENUE | 3,089,317 | 4,712,269 | 1,622,952 | -52.5% | | 36,621,472 | 35,278,875 | (1,342,597) | 3.7% |
| 8 | GROSS REVENUE FROM PATIENT SERVICES | 37,915,246 | 39,459,380 | 1,544,134 | -4.1% | | 323,303,632 | 328,476,464 | 5,172,832 | -1.6% |
| 9 | TOTAL INPATIENT REVENUE | 12,701,112 | 12,466,980 | (234,132) | 1.8% | | 119,542,203 | 115,710,329 | (3,831,874) | 3.2% |
| 10 | TOTAL OUTPATIENT REVENUE | 25,214,134 | 26,992,400 | 1,778,266 | -7.1% | | 203,761,429 | 212,766,135 | 9,004,706 | -4.4% |
| 11 | DEDUCTIONS FROM REVENUE | (34,825,929) | (34,747,111) | 78,818 | 0.2% | | (286,682,160) | (293,197,589) | (6,515,429) | -2.3% |
| 12 | | | | | | | | | | |
| 13 | OTHER OPERATING REVENUE | 668,430 | 613,103 | (55,327) | 8.3% | | 6,318,747 | 5,374,704 | (944,043) | 14.9% |
| 14 | OTHER REVENUE - RATE RANGE | 0 | 0 | 0 | 0.0% | | 0 | 0 | 0 | 0.0% |
| 15 | OTHER REVENUE - OTHER SUPPLEMENTALS | 0 | 0 | 0 | 0.0% | | 889,571 | 481,713 | (407,858) | 45.8% |
| 16 | OTHER REVENUE - DSH | 0 | 0 | 0 | 0.0% | | 56,236 | 99,536 | 43,300 | -77.0% |
| 17 | OTHER REVENUE - P4P | 0 | 8,283 | 8,283 | 0.0% | | 138,000 | 214,608 | 76,608 | -55.5% |
| 18 | OTHER REVENUE - OTHER | 258,603 | 203,326 | (55,277) | 21.4% | | 1,956,324 | 1,199,637 | (756,687) | 38.7% |
| 19 | OPERATNG TAX REVENUES | 409,827 | 401,494 | (8,333) | 2.0% | | 3,278,616 | 3,379,210 | 100,594 | -3.1% |
| 20 | | | | | | | | | | |
| 21 | **TOTAL OPERATING EXPENSE** | 7,057,304 | 7,378,338 | 321,034 | -4.5% | | 58,510,992 | 60,997,734 | (2,486,742) | 4.3% |
| 22 | TOTAL LABOR EXPENSE | 4,548,650 | 4,662,359 | 113,709 | -2.5% | | 38,260,765 | 40,395,991 | (2,135,226) | 5.6% |
| 23 | WAGES | 3,504,928 | 3,539,249 | 34,321 | -1.0% | | 29,773,360 | 31,314,470 | (1,541,110) | 5.2% |
| 24 | EMPLOYEE BENEFITS | 971,145 | 994,090 | 22,945 | -2.4% | | 7,870,422 | 7,799,120 | 71,302 | -0.9% |
| 25 | CONTRACT LABOR | 72,577 | 129,020 | 56,443 | -77.8% | | 616,983 | 1,282,401 | (665,418) | 107.9% |
| 26 | PHYSICIAN FEES | 378,853 | 382,672 | 3,819 | -1.0% | | 2,597,495 | 3,066,056 | (468,561) | 18.0% |
| 27 | PURCHASED SERVICES | 877,402 | 929,948 | 52,546 | -6.0% | | 6,919,843 | 7,539,246 | (619,403) | 9.0% |
| 28 | SUPPLY EXPENSE | 796,624 | 832,331 | 35,707 | -4.5% | | 6,841,934 | 6,177,137 | 664,797 | -9.7% |
| 29 | UTILITIES | 100,148 | 91,014 | (9,134) | 9.1% | | 851,957 | 785,115 | 66,842 | -7.8% |
| 30 | REPAIRS AND MAINTENANCE | 81,354 | 102,566 | 21,212 | -26.1% | | 658,854 | 797,579 | (138,725) | 21.1% |
| 31 | INSURANCE | 146,289 | 130,918 | (15,371) | 10.5% | | 1,170,312 | 1,047,326 | 122,986 | -10.5% |
| 32 | OTHER EXPENSES | 82,621 | 218,160 | 135,539 | -164.0% | | 846,880 | 833,672 | 13,208 | -1.6% |
| 33 | LEASE AND RENTALS | 45,363 | 28,370 | (16,993) | 37.5% | | 362,952 | 355,612 | 7,340 | -2.0% |
| 34 | | | | | | | | | | |
| 35 | **NON-OPERATING REVENUE & EXPENSE** | 655,777 | 852,118 | 196,341 | -29.9% | | 9,221,471 | 7,412,685 | (1,808,786) | 19.6% |
| 36 | OTHER NON-OPERATING REVENUE | 28,424 | 224,765 | 196,341 | -690.8% | | 4,202,647 | 2,393,861 | (1,808,786) | 43.0% |
| 37 | NON-OPERATING TAX REVENUE | 627,353 | 627,353 | 0 | 0.0% | | 5,018,824 | 5,018,824 | 0 | 0.0% |
| 38 | EXTRAORDINARY REVENUE | | | | | | 0 | 0 | 0 | 0.0% |
| 39 | TOTAL INTEREST & DEPRECIATION | 1,009,916 | 1,080,378 | 70,462 | -7.0% | | 7,728,254 | 7,900,872 | (172,618) | 2.2% |
| 40 | DEPRECIATION | 571,129 | 626,702 | 55,573 | -9.7% | | 4,217,958 | 4,595,835 | (377,877) | 9.0% |
| 41 | INTEREST & AMORTIZATION | 438,787 | 453,676 | 14,889 | -3.4% | | 3,510,296 | 3,305,037 | 205,259 | -5.8% |
| 42 | | | | | | | | | | |
| 43 | Page 1 of 1 | | | | | | | | | |

20

| | A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|---|
| 1 | **SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT & HOSPITAL** | | | | | | |
| 2 | **BALANCE SHEET** | **JUNE 2023** | **DECEMBER 2023** | **JANUARY 2024** | **FEBRUARY 2024** | **VARIANCE JANUARY TO FEBRUARY** | **VARIANCE PERCENTAGE** |
| 3 | **TOTAL ASSETS** | **112,558,570** | **104,958,733** | **112,391,784** | **116,795,348** | **4,403,564** | **3.9%** |
| 4 | **CURRENT ASSETS** | 29,638,354 | 19,794,071 | 24,748,448 | 20,163,177 | (4,585,271) | -18.5% |
| 5 | CASH & EQUIVALENTS | 14,521,085 | 6,174,780 | 14,066,154 | 11,403,144 | (2,663,010) | -18.9% |
| 6 | NET PATIENT ACCOUNTS RECEIVABLE | 12,177,379 | 9,521,666 | 9,874,552 | 8,727,661 | (1,146,891) | -11.6% |
| 7 | HOSPITAL ACCOUNTS RECEIVABLE | 86,192,181 | 90,684,885 | 93,057,632 | 86,742,095 | (6,315,537) | -6.8% |
| 8 | LESS: ALLOWANCE FOR BAD DEBTS | (74,014,802) | (81,163,219) | (83,183,080) | (78,014,434) | 5,168,646 | -6.2% |
| 9 | OTHER CURRENT ASSETS | 2,939,890 | 4,097,625 | 807,742 | 32,372 | (775,370) | -96.0% |
| 10 | TAXES RECEIVABLE | 2,263,620 | 3,192,397 | (127,692) | (891,616) | (763,924) | 598.3% |
| 11 | MISC RECEIVABLE | 64,052 | (693,350) | (864,269) | (905,410) | (41,141) | 4.8% |
| 12 | DUE FROM 3RD PARTIES | (1,097,349) | (1,188,457) | (1,180,265) | (1,139,145) | 41,120 | -3.5% |
| 13 | INVENTORIES | 1,311,782 | 1,952,252 | 2,029,198 | 2,055,785 | 26,587 | 1.3% |
| 14 | PREPAID EXPENSES | 397,785 | 834,783 | 950,770 | 912,758 | (38,012) | -4.0% |
| 15 | | | | | | | |
| 16 | ASSETS WHICH USE IS LIMITED | 9,102,770 | 13,828,639 | 16,738,243 | 25,652,223 | 8,913,980 | 53.3% |
| 17 | NET PROPERTY, PLANT, AND EQUIPMENT | 73,452,527 | 71,482,689 | 71,054,280 | 71,131,575 | 77,295 | 0.1% |
| 18 | PROPERTY, PLANT, AND EQUIPMENT | 166,692,035 | 167,745,456 | 167,809,768 | 168,379,784 | 570,016 | 0.3% |
| 19 | LAND & LAND IMPROVEMENTS | 4,828,182 | 4,828,182 | 4,828,182 | 4,828,182 | 0 | 0.0% |
| 20 | BUILDINGS & BUILDING IMPROVEMENTS | 129,281,491 | 129,281,491 | 129,281,491 | 129,281,491 | 0 | 0.0% |
| 21 | FIXED EQUIPMENT | 29,262,127 | 29,228,687 | 29,253,252 | 29,539,960 | 286,708 | 1.0% |
| 22 | CONSTRUCTION IN PROGRESS | 3,320,235 | 4,407,096 | 4,446,843 | 4,730,151 | 283,308 | 6.4% |
| 23 | LESS: ACCUMULATED DEPRECIATION | 364,919 | (146,666) | (149,187) | (151,627) | (2,440) | 1.6% |
| 24 | OTHER ASSETS | 364,919 | (146,666) | (149,187) | (151,627) | (2,440) | 1.6% |
| 25 | | | | | | | |
| 26 | **TOTAL LIABILITIES & FUND BALANCE** | **112,558,570** | **104,958,668** | **112,391,706** | **116,795,275** | **(4,403,569)** | **-3.9%** |
| 27 | **TOTAL LIABILITIES** | **148,421,077** | **164,602,704** | **175,065,023** | **181,749,818** | **(6,684,795)** | **-3.8%** |
| 28 | **CURRENT LIABILITES** | 28,682,871 | 32,185,743 | 32,865,186 | 40,708,106 | (7,842,920) | -23.9% |
| 29 | ACCOUNTS PAYABLE | 11,278,786 | 10,083,644 | 8,892,365 | 8,741,320 | 151,045 | 1.7% |
| 30 | PAYROLL PAYABLES | 6,484,769 | 5,557,165 | 7,099,787 | 6,762,104 | 337,683 | 4.8% |
| 31 | SALARIES & WAGES PAYABLE | 579,682 | (774,910) | 277,264 | 161,843 | 115,421 | 41.6% |
| 32 | PAYROLL TAXES & DEDUCTIONS PAYABLE | 3,235,802 | 3,604,352 | 4,094,800 | 2,902,043 | 1,192,757 | 29.1% |
| 33 | ACCRUED PTO & SICK DAYS PAYABLE | 2,669,285 | 2,727,723 | 2,727,723 | 3,698,218 | (970,495) | -35.6% |
| 34 | LINE OF CREDIT | 4,043,719 | 8,054,535 | 8,056,337 | 12,058,140 | (4,001,803) | -49.7% |
| 35 | OTHER CURRENT LIABILITIES | 6,875,597 | 8,490,399 | 8,816,697 | 13,146,542 | (4,329,845) | -49.1% |
| 36 | ACCRUED INTEREST PAYABLE | 1,609,780 | 3,581,044 | 3,941,980 | 4,302,917 | (360,937) | -9.2% |
| 37 | OTHER CURRENT LIABILITIES | 5,265,817 | 4,909,355 | 4,874,717 | 8,843,625 | 3,968,908 | 81.4% |
| 38 | | | | | | | |
| 39 | **LONG TERM LIABILITIES** | 119,738,206 | 132,416,961 | 142,199,837 | 141,041,712 | 1,158,125 | 0.8% |
| 40 | | | | | | | |
| 41 | **NET ASSETS** | (35,862,507) | (59,644,036) | (62,673,317) | (64,954,543) | 2,281,226 | -3.6% |
| 42 | NET ASSETS - UNRESTRICTED | (35,862,507) | (59,644,036) | (62,673,317) | (64,954,543) | 2,281,226 | -3.6% |
| 43 | NET ASSETS - BEGINNING OF PERIOD | (33,723,881) | (44,122,201) | (44,122,201) | (44,122,201) | 0 | 0.0% |
| 44 | CURRENT YEAR NET GAIN/(LOSS) | (2,138,626) | (15,521,835) | (18,551,116) | (20,832,342) | (2,281,226) | 12.3% |
| 45 | | | | | | | |
| 46 | Page 1 of 1 | | | | | | |

12

| | B | C | D | E | F | G | J |
|---|---|---|---|---|---|---|---|
| 1 | **SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT & HOSPITAL** | | | | | | **CASH FLOW** |
| 2 | | | | | | | |
| 3 | | | | | | **Current Month** | **Y-T-D** |
| 4 | | | | | | **2/29/2024** | **2/29/2024** |
| 5 | **BEGINNING CASH BALANCES** | | | | | | |
| 6 | | Cash: Beginning Balances- Hospital | | | | $ (801,381) | $ 10,775,913 |
| 7 | | Cash: Beginning Balances- District | | | | 14,867,535 | 2,808,453 |
| 8 | | Cash: Beginning Balances Totals | | | | **$ 14,066,154** | **$ 13,584,366** |
| 9 | | | | | | | |
| 10 | **Receipts** | | | | | | |
| 11 | | | Patient Collections | | | $ 5,823,367 | $ 38,721,514 |
| 12 | | | Tax Subsidies/Measure D/Prop 13 | | | 401,494 | $ 3,211,952 |
| 13 | | | Misc Tax Subsidies | | | - | $ 167,258 |
| 14 | | | Donations/Grants/Loans | | | 1,325,795 | $ 11,527,869 |
| 15 | | | Supplemental Funding (Rate Range, Etc.) | | | 4,000,000 | $ 4,653,536 |
| 16 | | | Draws/(Paydown) of LOC Balances | | | 4,000,000 | $ 4,000,000 |
| 17 | | | Other Revenues/Receipts/Transfers | | | 225,186 | $ 6,447,443 |
| 18 | **TOTAL RECEIPTS** | | | | | **$ 15,775,842** | **$ 68,729,572** |
| 19 | | | | | | | |
| 20 | **Disbursements** | | | | | | |
| 21 | | | Wages, Benefits, & Contract Labor | | | $ 4,662,359 | $ 39,311,274 |
| 22 | | | Other Operating Costs | | | 3,075,979 | $ 21,005,698 |
| 23 | | | Capital Spending | | | 599,153 | $ 1,671,784 |
| 24 | | | Debt Service Payments | | | 2,547,795 | $ 2,798,778 |
| 25 | | | Other - Changes in Accounts Payable, Other | | | 7,553,566 | $ 6,123,260 |
| 26 | **TOTAL DISBURSEMENTS** | | | | | **$ 18,438,852** | **$ 70,910,794** |
| 27 | | | | | | | |
| 28 | **TOTAL CHANGE in CASH** | | | | | **$ (2,663,010)** | **$ (2,181,222)** |
| 29 | | | | | | | |
| 30 | **ENDING CASH BALANCES** | | | | | | |
| 31 | | Ending Balances- Hospital | | | | $ 4,036,356 | $ 7,491,349 |
| 32 | | Ending Balances- District | | | | 7,366,788 | 3,911,795 |
| 33 | | Ending Balances- Totals | | | | **$ 11,403,144** | **$ 11,403,144** |
| 34 | | | | | | | |
| 35 | | | | | | | |
| 36 | | | | | | | |
| 37 | LOC Current Balances | | | | | $ 12,000,000 | $ 8,000,000 |
| 38 | LOC Interest Expense Incurred | | | | | 27,200 | $ 121,217 |
| 39 | | | | | | | |
| 40 | | | | | | | |

DISTRICT HOSPITAL
LEADERSHIP FORUM

March 11, 2024

Megan Brubaker
Department of Health Care Access and Information
Office of Health Care Affordability
2020 West El Camino Avenue, Suite 1200
Sacramento, CA 95833
Email: OHCA@hcai.ca.gov

**Subject: DHLF Comments on the Proposed Statewide Health Care Spending Target Recommendations to the Board**

Dear Ms. Brubaker:

On behalf of California's 33 district and municipal hospitals, the District Hospital Leadership Forum (DHLF) appreciates the opportunity to provide comments on the Office of Health Care Affordability (OHCA) staff recommendation for a proposed statewide health care spending target. **OHCA staff's recommendation does not adequately consider the factors driving health care spending growth, nor does it consider significant investments needed in health care (e.g., Medi-Cal program). Unfortunately, if the OHCA Board were to adopt the proposed staff recommendation of a 3% annual target over 2025-2029, underserved communities would experience reductions of essential health care services, potentially exacerbating health disparities and perpetuating inequality for low-income Californians.**

District and municipal hospitals, with publicly elected Boards of Directors; are proud to be local governments responsible for providing the health care needs of their communities. Over two-thirds are considered rural, and more than half have a critical access hospital (CAH) designation. On an annual basis, approximately 50% of their inpatient days are for services provided to Medi-Cal beneficiaries, collectively they deliver 20,000 babies, and provide over 3.5 million outpatient visits. They serve as the safety-net providers in their communities with few alternatives—providing health care services to significant levels of uninsured and Medi-Cal patients.

District and municipal hospitals are grateful for the Administration and Legislature's swift action in 2023 to establish the Distressed Hospital Loan Program (DHLP). ***More than 30% of district and municipal hospitals qualified as distressed and received DHLP loans totaling more than 50% of the available funds in the program.*** Given that district and municipal hospitals only represent 8% of hospitals statewide, qualifying for this level of support with short-term loans should provide a current financial status for these providers and the inherent risk of access to health care in the communities they serve. The concerns from our hospital leaders stated below are not intended to paint worst case scenarios—they are concerns founded on this reality for health care in many rural and underserved communities in our state.

***OHCA's proposed 3% annual target fails to account for the impact to access and quality of health care for Californians—especially, those in underserved areas that district and municipal hospitals serve.***

Feedback from district and municipal hospital leaders is clear—adopting a 3% annual target will have *dire effects* on the health of communities in which they serve. Fundamentally, if the OHCA Board adopts a 3% annual target they are assuming that all existing health care spending and investments occurring today are happening in the right place and at the right levels. That means, funding for programs like Medi-Cal—which provides health care to more than 1 out of 3 Californians or 1 out of 2 children in California—are at sustainable levels today.

As evident by the Governor himself with the most recent budget proposals, this could not be further from the truth. ***Significant new spending is needed to transform the Medi-Cal program and place it on a sustainable pathway moving forward.*** This is precisely why the Administration and Legislature passed AB 119 (Chapter 13, Statutes of 2023) which required the Department of Health Care Services (DHCS) to pursue the implementation of a new Managed Care Organization (MCO) Tax, raising more than $32 billion off managed care plans over a 3.75-year period. The federal government approved the proposal in December, and now the Governor is proposing to use a portion of the new tax proceeds to support more than $25 billion in new Targeted Provider Rate (TRI) increases for the Medi-Cal program. The Administration and DHCS have even acknowledged publicly, the proposed new TRI investments do not provide enough added resources to raise the level of Medi-Cal provider reimbursement for all, and instead are *targeting these investments in areas and for providers that need them the most.*

Adopting a statewide 3% annual target across all payers beginning in CY 2025, will effectively lock California into these existing inequities which will have irreversible and detrimental impacts to the future of health care in communities that need help the most. Proposed investments like TRI, or significant expansions to existing "self-financed" Medi-Cal supplemental payments, would be restricted and force providers into tough decisions as they evaluate whether they can afford to continue to maintain existing levels of participation in the Medi-Cal program. As result, our hospital leaders believe there will be a direct correlation in the implementation of an annual 3% spending target that does not acknowledge or allow for significant Medi-Cal investments and the reduction of essential health care services for underserved communities across the state. Specifically, it means scaling back on specialized care for chronic conditions, such as diabetes management or prenatal care, which are crucial for maintaining overall health and well-being for their communities. Any discretionary investments that happen today in community outreach programs and supportive services aimed at supporting the Governor's CalAIM initiatives and addressing social determinants of health may be at risk of being slashed, further deepening the impact on these underserved populations.

Maintaining access to essential health care in many underserved communities across California relies heavily on public providers like district and municipal hospitals. ***They are the safety-net providers in their communities and provide more than just life-saving care***. Even though many hospitals/health systems may have recovered from the COVID-19 pandemic—some large health systems even acquiring other hospitals—unfortunately, the district and municipal hospitals are not in that same position. Simply put, they have not fully recovered—they are experiencing

significant workforce challenges, and their current financial state is not sustainable as evident by the high proportion needing DHLP loans. The bottom line, capping overall growth in health care spending to 3% on annual basis, assumes health care spending in their communities is in the right place and currently is at satisfactory levels. The reality is this decision will force these communities to reevaluate what services can be provided. District and municipal hospitals will have to explore ways to reduce costs (e.g., new investments, staffing), and the concerns raised by leaders are, this will lead to an increased risk in hospital bankruptcies (e.g., Hazel Hawkins) and/or closures (e.g., Madera)—targeting those underserved communities in California that need help the most.

***OHCA's proposed methodology fails to consider known factors that influence health care spending (e.g., demographic factors, delivery system investments, medical inflation and pharmaceutical pricing, labor costs, and new health care policies) and the treatment of Medi-Cal supplemental payments.***

The OHCA staff's recommendation to base the annual growth target on the 20-year historical period of median household income in California, does not consider the statutory requirements when establishing a methodology defined in Health and Safety Code (HSC) 127502(d). More specifically, the methodology does not consider any of the provisions summarized below:

> *(d)(3)—Trends & COVID: Historical trends in Medi-Cal, Medicare, and Commercial Health Coverage. Differential treatment of 2020 and 2021 calendar years due to the impacts of COVID-19.*
>
> *(d)(4)—Factors, including, but not limited to: health care employment cost index, labor costs, consumer price index for urban wage earners and clerical workers, impacts due to known emerging diseases, trends in the price of health care technologies, provider payer mix, state or local mandates such as required capital improvement projects, and any relevant state and federal policy changes impacting covered benefits, provider reimbursement, and costs.*
>
> *(d)(5)(A)—Medi-Cal: the provision of nonfederal share associated with Medi-Cal payments.*
>
> *(d)(5)(B)(i)—Medi-Cal: supplemental payments for Medi-Cal services and underinsured patients.*
>
> *(d)(5)(B)(ii)—Medi-Cal: nonfederal share and fees (e.g., Hospital Tax 24% Fee for Children's Coverage, 20% Administrative Fees on Intergovernmental Transfers).*
>
> *(d)(5)(B)(iii)—Medi-Cal: health care-related taxes (e.g., MCO Tax, Hospital Tax)*
>
> *(d)(5)(C)—Medi-Cal: Methodology that cannot jeopardize federal requirements for federal financial participation (e.g., actuarial soundness requirements when developing Medi-Cal capitations).*

The Legislature carefully considered and ensured in the authorizing legislation these requirements for any OHCA annual target to take into consideration the interactions with the Medi-Cal program. Unfortunately, the OHCA staff's recommendation completely disregarded the statutory required consideration of the Medi-Cal program and clearly did not acknowledge the specific importance of Medi-Cal supplemental payments and health care related taxes which serve to support the Medi-Cal program. Today, the Medi-Cal program accounts for roughly 30% of all health care spending in the state on an annual basis. In state fiscal year 2023-24, the Medi-Cal Program has an annual budget totaling more than $150 billion, with nearly $24 billion or ***25% of the annual budget supported by non-federal sources that are not attributed to the state***

***General Fund*** (e.g., MCO Taxes, Skilled Nursing Facility Fees, Ground Emergency Medical Transportation Quality Assurance Fees, Private Hospital Taxes, Public Hospital Certified Public Expenditures, or Intergovernmental Transfers, etc.)[1]. The interaction this critical revenue source plays on the California health care market—supporting 15 million Californians—cannot be understated. ***It also means, when a district or municipal hospital receives funding for Medi-Cal services, that it is likely to be Medi-Cal revenue supported by the governmental entity rather than the state General Fund.*** When it shows up in the Medi-Cal budget or what the Medi-Cal managed care plans will report to OHCA later this year as total payments, for the provider, that's not actually the net patient revenue the hospital can count on—rather OHCA will be seeing it from a gross revenue perspective. This further adds to the importance and why the Legislature wrote into statue the requirement for the OHCA annual spending target methodology to take these factors into account.

Medi-Cal safety-net providers, including district and municipal hospitals who primarily provide services to Medi-Cal and Medicare beneficiaries (75%+ government payer mix), are concerned by how the proposed annual spending target will reconcile with anticipated spending growth over the next few years, which is projected for Medi-Cal to grow between 5-6% annually (projections by DHCS and the Legislative Analyst's Office[2]).

The proposed methodology also fails to consider known factors that influence health care spending (e.g., demographic factors, delivery system investments, medical inflation and pharmaceutical pricing, labor costs, and new health care policies).

***Aging population—***Not only does the proposed methodology lock in existing spending inequities, but also fails to consider an aging population in California. While California's overall population has stagnated recently (~40 million people), the Department of Finance projects the proportion of Californians aged 65+ will continue to grow relative to the under 65-year-old populations. Our leaders are shocked to see this important demographic factor completely omitted. Health care spending in an aging society will place more of a burden on the health care system which will apply more pressure on annual per capita spending, especially over an extended period (e.g., 2025-2029). The trend of aging populations choosing to move/retire in more rural communities due to housing affordability, is something that has been happening for the past several decades and will disproportionally impact the communities in which district and municipal hospitals serve. Additionally, DHCS also expects significant changes in the low-income dual eligible populations with the implementation of a D-SNP requirements for all Medi-Cal managed care plans by 2027. For the reasons stated above—aging societal demands on health care system especially in underserved communities and the changing dual-eligible market dynamics going live soon—hospital leaders do not understand how any credible target chooses to ignore these factors.

***Medical inflation and pharmaceutical pricing—***Absent from the proposed methodology, are adjustments for well-known factors and uncontrollable medical inflation—pharmaceuticals, medical devices, and new technologies. According to the U.S. Department of Health and Human Services[3], pharmaceutical prices for essential medications increased by 15.2% over the period between January 2022 to January 2023. Unfortunately, these significant increases place a heavy

[1] November 2023 Medi-Cal Local Assistance Estimate (Link)
[2] December 2023 Legislative Analyst Office Medi-Cal Fiscal Outlook (Link)
[3] October 2023 Report, Assistant Secretary for Planning and Evaluation (ASPE), HHS (Link)

burden on patients and the health care systems who cannot control these prices. This does not include other significant increases in costs for medical devices such as prosthetics or implantable devices, or other advancements in medical technology. Unlike payers (HSC 127500.2(o)), full integrated delivery systems (HSC 127500.2(h), providers (HSC 127500.2(q), physician organizations (HSC 127500.2(p), and health care entities (HSC 127500.2(k), pharmaceutical and medical device manufactures, and technology industry, are not subject to any oversight or enforcement under the current purview of the OHCA. Not only will this create a division across the industry as we collectively strive to improve health care affordability for the consumers of California, but leaving out this factor or ignoring the rapid growth in the annual spending targets will force the entities subject to enforcement actions by OHCA to cut other "controllable" areas of spending (e.g., services, staffing, new investments). Effectively, it will create a race to the bottom and areas of investment, or "*good spending*" will suffer.

***Labor costs and new health care policies—***The proposed methodology also fails to consider other required adjustments contemplated carefully by the legislature (*HSC 127502(d)(4)*) which would account for the rising labor costs and other state or legislatively-required health care policies. District and municipal hospitals are no different than the rest of the hospital industry—a sizable portion of their overall cost structure is attributed to salaries and wages for their staff. For our critical access district hospitals (CAHs), that staff may also include physicians who are employed. The collective impact from recent statutory requirements like Senate Bill 525 (Chapter 890, Statutes of 2023) which increases health care worker minimum wage and the outstanding costs of complying with the state's 2030 seismic standards, cannot be ignored. Statewide, these policy decisions will add *billions* in new health care spending over the next few years, and for district and municipal hospitals the impact will be significant. The proposed methodology fails to consider these realities and other state mandated policies. Without clear acknowledgment and consider of these factors in the first annual spending target, leaders are worried this will create a precedent that sends a message to the Legislature that similar actions that increase future health care costs do not impact spending.

### *Legislation allows for the OHCA Board to adopt a single year target—there is no requirement to adopt a five-year target.*

It is not clear to district and municipal hospital leaders why the OHCA staff believe a five-year recommendation fixed at 3% is best for "*improving health care affordability, access, and equity of health care for Californians (HSC 127500.5).*" Especially, when OHCA staff's recommendation will enact irreparable harm to underserved communities by failing to comply with statutory requirements, ignoring the importance of Medi-Cal and the necessary investments proposed by the Governor, and lastly failing to consider factors outside the control of those being regulated by this new office.

We urge the OHCA Board—*a Board that the Legislature envisioned would be independent*—to evaluate the timelines within the authorizing legislation and not rush towards creating enforceable spending targets without a data-driven and more credible target-setting process. This important decision by the OHCA Board to establish the first annual spending target will create precedence for years to come and should not ignore critical factors that influence health care spending.

***We urge the OHCA Board to specifically consider the following:***

- Use the March 27th OHCA Board meeting to publicly review and discuss with OHCA staff the feedback collected through this public comment process. Be transparent!

- Return the recommendation back to OHCA staff and have them revise the methodology only to assume CY 2025. This work to revise the methodology can be done between the March 27th and April 24th OHCA Board meetings. In April, request for OHCA staff to return with a revised CY 2025 recommendation that satisfies the statutory requirements, adjustments for factors that influence spending, and intent of the legislation.

- Approve only a CY 2025 target during the May 22nd OHCA Board meeting. Additionally, request the OHCA staff present their proposed workplan for developing the CY 2026 target and request they take into account the actual data that will be collected by the Office later this year.

We appreciate the opportunity to provide our comments and stand ready to assist the OHCA staff in developing a thoughtful, data-driven approach to establishing spending target that does not sacrifice the delivery of health care in underserved communities across California.

Sincerely,

Ryan Witz
Senior Vice President, Finance Policy

Cc:
Elizabeth Landsberg, Director, Department of Health Care Access and Information (HCAI)
Vishaal Pegany, Deputy Director, HCAI OHCA
Members of the Health Care Affordability Board:

David M. Carlisle, MD, PhD
Secretary Dr. Mark Ghaly
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Dr. Richard Pan

Michelle Baass, Director, Department of Health Care Services (DHCS)
Lindy Harrington, Assistant Medicaid Director, DHCS
Sarah Brooks, Chief Deputy Director, Health Care Programs, DHCS
Rafael Davtian, Deputy Director, Health Care Financing, DHCS

Press Releases

# Health Systems near their breaking point. Labor costs continue to increase while dollars collected from payers decrease.

HFMA

Like

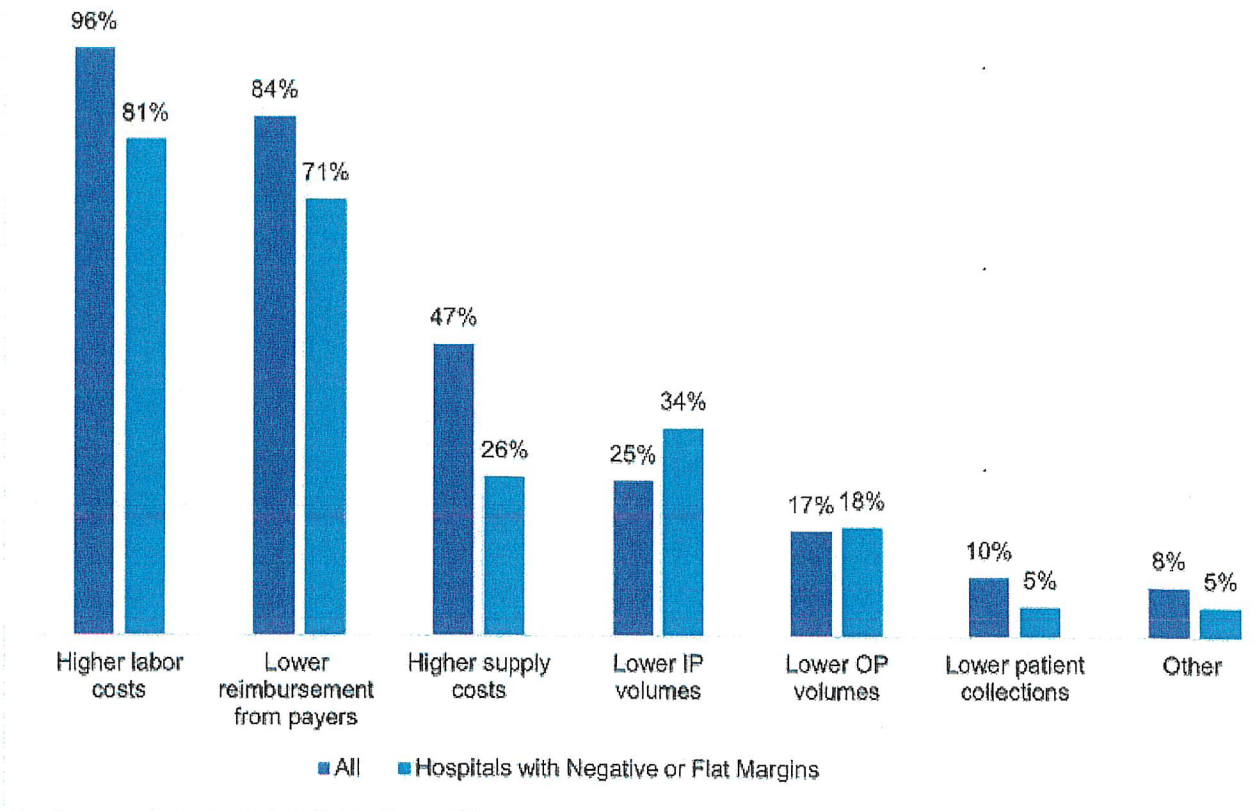
March 6, 2024 7:00 am

**CHICAGO — March 6, 2024 —** Eighty four percent of health systems cite lower reimbursement from payers as a top cause of low operational margins, according to a report published by the Healthcare Financial Management Association (HFMA) and Eliciting Insights, a healthcare strategy and market research company.

Further confounding health system margin struggles is the increased administrative burden placed on providers by payers. 82% of CFOs said payer denials have increased significantly since pre-pandemic levels. 19% of health systems have discontinued at least one Medicare Advantage plan and 61% are planning to or considering dropping Medicare Advantage payers, the top offenders of administrative burden.

**Top Causes of Margin Pressure Among Health Systems**

29




Higher labor costs are the biggest drivers of margin pressure based on 96% of health system CFOs, with 99% of CFOs indicating that nursing is the top driver of labor shortages. Other roles such as lab technicians and radiology technicians are also experiencing shortages.

Most systems are looking at traditional cost reduction methods such as reducing labor costs, optimizing supply chain and delaying technology implementations. These methods are not enough to move the needle on margin, leaving health systems looking for other cost savings. The report finds health systems are paring back on capital and real estate investments (40%), reducing less profitable service lines (32%), and 26% are looking to outsource revenue cycle roles.

Reducing operational costs is one piece of the puzzle, but health systems need more revenue to truly improve margins.

"Recovering from the pandemic, we have seen a slight overall improvement in average operating margins over the past three years," said HFMA Chief Partnership Executive Todd Nelson FHFMA, MBA. "However, this study validates that there are many health systems still struggling to find a positive margin. While health plans are modestly increasing reimbursement, they are also ratcheting up prior authorization requirements and denials, which raises the overall cost to collect for health systems."

Ninety percent of health systems cite denials as the top challenge for Revenue Cycle teams. 62% of health systems report Medicare Advantage as "significantly more difficult to work with" relative to Commercial or Medicare plans. Medicare Advantage plans often have different clinical policies than Medicare and other commercial plans which leads to more denials. Health systems are frustrated; 19% have already dropped one or more Medicare Advantage plan.

30

When it comes to maximizing payer reimbursement, "It's all about denials," says Trish Rivard, CEO of Eliciting Insights. "We are hearing loud and clear that health systems are struggling with denials — 82% of health systems tell us their denial rate is up relative to 2019. This is a tremendous opportunity for the RCM vendor community to develop advanced tools that create solutions leveraging robotic process automation, AI and advanced analytics.

While margins remain tight, *HFMA Health System CFO Pain Points 2024: Margin Challenges & Opportunities for Vendors*, reveals that over 15% of health systems are expecting large budget increases for key areas such as cybersecurity and automation.

The report provides actionable insights into the health system CFO pain points, as well as 2026 budget and labor predictions, and is based on survey responses of 135 health system Chief Financial Officers and qualitative interviews with CFOs conducted in the first quarter of 2024.

The 42-page report is available for purchase online from Eliciting Insights or HFMA. It will be provided to HFMA Peer Review customers as an added benefit.

## About HFMA

The Healthcare Financial Management Association (HFMA) equips its more than 110,000 members to navigate a complex healthcare landscape. Finance professionals in the full range of work settings, including hospitals, health systems, physician practices and health plans, trust HFMA to provide the guidance and tools to help them lead their organizations, and the industry, forward. HFMA is a not-for-profit, nonpartisan organization that advances healthcare by collaborating with other key stakeholders to address industry challenges and providing guidance, education, practical tools and solutions, and thought leadership. We lead the financial management of healthcare.

## About Eliciting Insights

Eliciting Insights is a healthcare strategy and market research firm that leverages decades of experience in HCIT, digital health and RCM, and a proprietary panel of thousands of healthcare executives to deliver bespoke insights to help investors and technology firms make strategic business decisions.

## Press inquiries should be directed to:

Brad Dennison
Healthcare Financial Management Association
630-386-2945
bdennison@hfma.org

31

# TAB F

| | Title | Policy Area | Owner | Workflow Approval |
|---|---|---|---|---|
| 1 | Adult Total Parenteral Nutrition Solution Protocol | Pharmacy | Lopez, Jose: Director Pharmacy | Ariel Whitley for Hospital Board of Directors |
| 2 | At-Will Employment | Human Resources | Karam, Annah: Chief Human Resources Officer | Ariel Whitley for Hospital Board of Directors |
| 3 | Automated Dispensing Cabinet Distribution System | Pharmacy | Lopez, Jose: Director Pharmacy | Ariel Whitley for Hospital Board of Directors |
| 4 | Binding Employment Arbitration Policy | Human Resources | Karam, Annah: Chief Human Resources Officer | Ariel Whitley for Hospital Board of Directors |
| 5 | Cervidil Vaginal Insert For Cervical Ripening | Obstetrics | Garcia, Antonia: Director of OB Services | Ariel Whitley for Hospital Board of Directors |
| 6 | Communicating with Non-English Speaking, Limited English Proficiency, Visually or Hearing Impaired Patients and Visitors | Administration | Brady, Angela: Chief Nursing Executive | Ariel Whitley for Hospital Board of Directors |
| 7 | CT Rectal Contrast Dosing - Gastrografin Per Protocol | Diagnostic Imaging | Chamberlin, Krystal: Director Diagnostic Imaging | Ariel Whitley for Hospital Board of Directors |
| 8 | Damaged Food Products | Dietary | Hawthorne, Lakeisha: Director Food and Nutrition | Ariel Whitley for Hospital Board of Directors |
| 9 | Dietary Pest Control | Dietary | Hawthorne, Lakeisha: Director Food and Nutrition | Ariel Whitley for Hospital Board of Directors |
| 10 | Dobutamine Stress Echocardiogram | EKG Echo | Garewal, Cheri: Echo Technician | Ariel Whitley for Hospital Board of Directors |
| 11 | Echocardiogram | EKG Echo | Garewal, Cheri: Echo Technician | Ariel Whitley for Hospital Board of Directors |
| 12 | Echocardiography with the use of Optison (enhancing agent) | EKG Echo | Garewal, Cheri: Echo Technician | Ariel Whitley for Hospital Board of Directors |
| 13 | Egg Handling | Dietary | Hawthorne, Lakeisha: Director Food and Nutrition | Ariel Whitley for Hospital Board of Directors |
| 14 | Emergency Disaster Menu- Main | Dietary | Hawthorne, Lakeisha: Director Food and Nutrition | Ariel Whitley for Hospital Board of Directors |

| | Title | Policy Area | Owner | Workflow Approval |
|---|---|---|---|---|
| 15 | Employment of Relatives | Human Resources | Karam, Annah: Chief Human Resources Officer | Ariel Whitley for Hospital Board of Directors |
| 16 | Equal Employment Opportunity | Human Resources | Karam, Annah: Chief Human Resources Officer | Ariel Whitley for Hospital Board of Directors |
| 17 | Fall Risk | Nursing | Freude, Gayle: Director Med/Surg/CM and SW and P&P Chairperson | Ariel Whitley for Hospital Board of Directors |
| 18 | Grill Cleaning | Dietary | Hawthorne, Lakeisha: Director Food and Nutrition | Ariel Whitley for Hospital Board of Directors |
| 19 | Holiday and After-Hours Nutrition Support | Dietary | Hawthorne, Lakeisha: Director Food and Nutrition | Ariel Whitley for Hospital Board of Directors |
| 20 | Lockers | Security | Hunter, Joey: Director Emergency Preparedness, EOC & Security | Ariel Whitley for Hospital Board of Directors |
| 21 | Medical Office Building (MOB) Tenant Rent | Accounting | Kammer, Margaret: Controller | Ariel Whitley for Hospital Board of Directors |
| 22 | Microwave Cooking | Dietary | Hawthorne, Lakeisha: Director Food and Nutrition | Ariel Whitley for Hospital Board of Directors |
| 23 | Misoprostol (Cytotec) for Induction of a Confirmed Missed Abortion | Obstetrics | Garcia, Antonia: Director of OB Services | Ariel Whitley for Hospital Board of Directors |
| 24 | Nutritional Screening and Assessment | Dietary | Hawthorne, Lakeisha: Director Food and Nutrition | Ariel Whitley for Hospital Board of Directors |
| 25 | PACU - Discharge Criteria Following Moderate/Deep Sedation or Monitored Anesthesia Care | Surgical Services | Goodner, Jayme: Director Surgical Services | Ariel Whitley for Hospital Board of Directors |
| 26 | Participation in Graduate Medical Education Program | Medical Staff | Stafford, Susan: Medical Education Coordinator | Ariel Whitley for Hospital Board of Directors |
| 27 | Patient Linen Change | Nursing | Freude, Gayle: Director Med/Surg/CM and SW and P&P Chairperson | Ariel Whitley for Hospital Board of Directors |

| | Title | Policy Area | Owner | Workflow Approval |
|---|---|---|---|---|
| 28 | Patient Rights-Therapeutic Diets | Dietary | Kielhold, Jean: Dietician | Ariel Whitley for Hospital Board of Directors |
| 29 | Pediatric Emergency Disaster Menu | Dietary | Hawthorne, Lakeisha: Director Food and Nutrition | Ariel Whitley for Hospital Board of Directors |
| 30 | Pharmacy Oversight of Materials Management of IV Solutions | Pharmacy | Lopez, Jose: Director Pharmacy | Ariel Whitley for Hospital Board of Directors |
| 31 | Prohibited Conduct | Human Resources | Karam, Annah: Chief Human Resources Officer | Ariel Whitley for Hospital Board of Directors |
| 32 | Prohibition of Harassment, Discrimination and Retaliation | Human Resources | Karam, Annah: Chief Human Resources Officer | Ariel Whitley for Hospital Board of Directors |
| 33 | Recipes | Dietary | Hawthorne, Lakeisha: Director Food and Nutrition | Ariel Whitley for Hospital Board of Directors |
| 34 | Refusal of Drugs, Treatments or Procedures | Nursing | Freude, Gayle: Director Med/Surg/CM and SW and P&P Chairperson | Ariel Whitley for Hospital Board of Directors |
| 35 | Sterile Supplies | Emergency Department | Phillippi, Kathryn: Director of Emergency Department | Ariel Whitley for Hospital Board of Directors |
| 36 | Surgical Services - Specimens Excluded from Routine Pathology Examination, Anatomical Pathology | Surgical Services | Goodner, Jayme: Director Surgical Services | Ariel Whitley for Hospital Board of Directors |
| 37 | Taste Testing | Dietary | Hawthorne, Lakeisha: Director Food and Nutrition | Ariel Whitley for Hospital Board of Directors |
| 38 | USP 800: Associate Handling of Hazardous Drugs | Pharmacy | Lopez, Jose: Director Pharmacy | Ariel Whitley for Hospital Board of Directors |
| 39 | Work Related Injury / Illness | Employee Health | Lagrimas, Nina: Employee Health Coordinator | Ariel Whitley for Hospital Board of Directors |

# TAB G

**SAN GORGONIO MEMORIAL HOSPITAL**
***Medical Staff Services Department***
**M E M O R A N D U M**

**DATE:** March 20, 2024

**TO:** Chair
Governing Board

**FROM:** Raffi Sahagian, 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):**

**Pharmacy & Therapeutics**

Medication Stop Order Policy

To promote the safe and efficacious use of antibiotics, an automatic stop order is established (See attached).

ASP Update

Antibiotic stewardship is the effort to optimize how antibiotics are used and is a core strategy to combat antimicrobial resistance. The goals have been to track broad spectrum antibiotic use and identify trends in antibiotic prescription practices. Pharmacy monitors drug cultures and recommends step down therapy when appropriate with physicians. The goal is to be under 500 days of therapy. In 2022 SGMH had 3 months in the calendar year above 500, none in 2023 (See attached).

Medication Order Set & Formulary

A list of the medication order set and formulary includes the methodology used to evaluate clinical and medical literature and the approach for selecting medications for different diseases, conditions, and patients (See attached).

Potassium Update

This is a list of high-risk/high-alert medication categories which require two (2) signatures from licensed nurses for verification of administration (See attached)

**Performance Improvement**

2024 Performance/Process Improvement Project Prioritization Grid

The Prioritization Grid includes factors such as deadlines, impact, resources required, complexity, and strategic alignment. The criteria are defined to create a structured framework for evaluating and comparing tasks or projects (See attached).

**Sepsis Data**

**Peer Review Committee Report**

There were sixteen (16) cases reviewed for quality and appropriateness of care;

- 2 deemed "Level 1 – No Concerns"
- 2 deemed "Level 2 – Acceptable, not Optimal"
- 5 – Attending MD will be asked for clarification of care
- 2 – Behavioral (1 – requested a letter of clarification and 1 will be informed that monitored.
- 3 – cases resulted in letter to be forwarded to Administration regarding OB cases
- 1 – will be forwarded for outside review
- 1 – behavioral; physician no longer on staff

**Medical Staff Quality Council Committee Report**

The following discussions took place:

- Future agenda items
- Performance Improvement Grid
- CIHQ regulations
- Measures submitted by department.
- Mortality and Sepsis rates

**Adapted Diet**

This high protein modified cardiac diet was established to reduce the risk of cardiovascular disease (See attached).

**2024 Annual Approval of Policies & Procedures**

The attached list of policies & procedures is recommended for approval (See attached).

**Medication Stop Order Policy:** CMS Condition of Participation for medications to have durations when applicable. Antibiotics for antibiotic stewardship program, pain meds, and sedatives associated with ADE. EHR defaults to 365 days. Can we update sedatives, opioids, and antibiotics set to 7 days or less? Any exceptions , pharmacy to dose consult on Vancomycin therapy for severe infection, osteomyletis ; IDSA guidelines for Azithromycin total dose of 1500mg for atypical pneumonia coverage ( Azithromycin 500mg Daily x 3 days max ). Pharmacist has a daily antibiotic report reviewed for cultures, and renal dosing. Any other exceptions?

Status Draft PolicyStat ID 14191251

SAN GORGONIO MEMORIAL HOSPITAL

| | |
|---|---|
| Origination | N/A |
| Approved | N/A |
| Last Revised | N/A |

Policy Area Pharmacy

# Medication Stop Orders

## Policy:

~~The purpose of medication stop orders is to provide a mechanism whereby orders for dangerous and additive medications are automatically stopped unless renewed by the physician.~~

~~By action of the Executive Committee of the Medical Staff, the following policy regarding medication stop orders is adopted.~~

It is the policy of San Gorgonio Memorial Hospital to place a stop order on medication classes outlined in this policy. Providers shall reassess therapy according to this policy.

## Procedure:

1. Medication classes requiring a stop order:
    a. ~~Narcotics that are ordered without time limitations of dosage shall be automatically stopped after four days.~~
    b. ~~Sedatives~~Narcotics that are ordered without time limitations of dosage shall be automatically stopped after seven days.
    c. ~~Antibiotics~~Sedatives (benzodiapepines ) that are ordered without time limitations of dosage shall be automatically stopped after seven days.
    d. ~~Anticoagulant drugs (excluding Coumadin )~~Antibiotics that are ordered without time limitations of dosage shall be automatically stopped after seven days.
    e. All other medications that are ordered without time limitations of dosage shall be automatically stopped after ~~30~~365 days.
    f. ~~Certain medications may require various stop limitations based on~~If the drug manufacturer requires that a medication be stopped after a certain time, period the manufacturers recommendations~~. If the manufacturer requires that a medication~~ will be ~~stopped after a certain time period the manufacturers recommendations will be~~ followed. ~~An example of this is Toradol: The manufacturer recommends that the~~

~~medication not be used over 5 days.~~

~~Drugs should not be discontinued without notifying the responsible practitioner.~~

g. Evidence based guidelines may be used as a standard to determine if a shorter stop date if appropriate.

h. Medications should not be discontinued without notifying the responsible providers.

2. Prior to automatic discontinuation of a medication, the provider will receive an alert in the patient electronic health record.

3. ~~Prior to automatic discontinuation of a~~If a new order to continue the medication~~, the pharmacy will place a "Stop Order Notice" in the patient's chart to inform the practitioner. If a new order to continue the medication~~ is not written, the medication in question will be discontinued.

4. ~~All previous orders are cancelled when patients go to surgery and must be re-written.~~

5. ~~All previous orders which are to be continued must be rewritten when patients are transferred out of the Intensive Care Unit to another unit and out of the DOU to another unit.~~

6. When a patient is transfered in between levels of acuity or to Surgery Department ,previous medication orders are canceled and must be re-entered.



## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|

ASP: Antibiotic Use Tracking
Pharmacy & Therapeutics
February 26, 2024

**Plan:** Track broad spectrum antibiotic use and identify trends in antibiotic prescription practices.

**Do**: Pharmacist to monitor drug cultures and recommend step down therapy when appropriate with physicians.

**Check:** Goal to be under 500 days of therapy. In 2022 we had 3 months in calendar year above 500, none in 2023

**Act:** Report quarterly to P&T committee and PI. Goal is to reduce use of broad spectrum agents and Vancomycin which are associated with ADE;

| Duration of Broad Spectrum Antibiotic Therapy | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Antibiotics | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Cefepime | 77 | 53 | 77 | 96 | 60 | 99 | 63 | 116 | 140 | 67 | 121 | 134 |
| Meropenem | 77 | 91 | 45 | 54 | 79 | 60 | 64 | 64 | 104 | 70 | 68 | 95 |
| Zosyn | 107 | 172 | 115 | 126 | 62 | 107 | 114 | 133 | 154 | 99 | 96 | 128 |
| Vancomycin IV | 185 | 148 | 113 | 156 | 111 | 157 | 173 | 188 | 159 | 132 | 201 | 232 |
| Antibiotic days | 446 | 464 | 350 | 432 | 312 | 423 | 414 | 501 | 557 | 368 | 486 | 589 |
| Patient days | 988 | 967 | 994 | 952 | 1011 | 908 | 1007 | 1172 | 1178 | 1160 | 1131 | 1219 |
| DOT | 451 | 480 | 352 | 454 | 309 | 466 | 411 | 427 | 473 | 317 | 430 | 483 |

ASP Assessment: Evidence Based Guidelines
Pharmacy & Therapeutics
February 26, 2024

**ASP Reduction in HAI CDI Rate:** Goal met for 2022 Standardized Infection Ratio less than 1. Less infections than predicted by NHSN algorithm. Nursing homes, patients demographic used in algorithm calculation.

| Time | 2023 Q1 | 2023 Q2 | 2023 Q3 | 2023 Q4 | 2023 |
|---|---|---|---|---|---|
| HAI CDI | 3 | 0 | 0 | 2 | 5 |
| NHSN Expected | 1.75 | 1.32 | 1.15 | 1.25 | 5.488 |
| SIR | 1.71 | 0 | 0 | 1.6 | 0.911 |

**Pharmacy & Therapeutics Committee**
**Antibiotic Steward Program**

**Department / Service:Pharmacy Dept**
**Director: Jose Lopez**
**Prepared by:**

**Reporting Date:**
**Reporting Period:**

| Measure | Previous Year | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adherence to ASP Best Practice CDI | | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | - | | | #VALUE! | | | 100.00% |
| Goal | | | | | | | | | | | | | |
| CDI Patient 1st line Drug therapy | | 3 | 2 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| CDI Patient | | 3 | 2 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Quarter Summary | | | | 100.00% | | | 100.00% | | | | | | 100.00% |
| | | | | Quarter 1 | | | Quarter 2 | | | Quarter 3 | | | Quarter 4 |

ASP Assessment: Evidence Based Guidelines
Pharmacy & Therapeutics
February 26, 2024
**2023 SIR** 3/ 4.18 = 0.72 based on info NHSN provided ( Jan-Sep 2023). 5 total HAI CDI for 2023.

**Reduction of HAI CDI**

**Plan:** Use NHSN database to calculate expected HAI CDI rate for facility and submit HAI CDI data

**Do:** ASP interventions improve antibiotic practices and infection control related policies and procedures to decrease the spread CDI throughout the hospital.

**Check**: ASP chair reviews HAI CDI for appropriateness. Infection Control Director vacant in early 2023 , no review done by IC prior to submitting NHSN; 3 HAI CDI in 2023 cases not reviewed and assessed properly. Will update NHSN.

**Act**: Monitor HAI CDI at facility. Use NHSN data surveillance as a tool to identify gaps in ASP practices. Use NHSN data as a tool to communicate prescriber's patterns in antibiotic prescription practices.

**Assessment:**

Retrospective audit on all HAI CDI to verify if IDSA guidelines and best practices were followed: All 5 patients had first line CDI treatment with appropriate duration; all 5 had broad spectrum antibiotics DC/; had ID consult. Difficid is first line , Vancomycin suitable alternative if Difficid is not available.

**ASP 2024 Quality Improvement:**
IDSA CDI guidelines were verified and SGMH is following evidenced based guidelines for CDI treatment.
Community acquired pneumonia order set has the IDSA evidenced based guidelines for therapy options, will work with ID physician in reviewing the CAP patients. In 2023 Quarter 4 , there was 32 patients that were prescribed Azithromycin IV Daily order, 9 of the patients had regimens of 4 days or greater. IDSA guidelines recommend 3 days for Azithromycin therapy. Updating the order set will reduce antibiotic days of therapy, nursing administration of Azithromycin, and pharmacy related IV compounding.

**SAN GORGONIO MEMORIAL HOSPITAL**
**ANTIBIOGRAM CHART 01-01-2023 to 12-31-2023**
**"Percent Susceptible (%S) Isolates"**
**(All Body Sites, All Location)**

| ORGANISMS | TOTAL ISOLATES | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **GRAM NEGATIVES** | | | | | | | | | | | | | | | | | | | | | | |
| Enterobacter cloacae complex | 46 | 100 | R | R | R | 100 | 78 | 78 | 98 | | 100 | | 98 | 100 | 98 | | 48 | | 80 | | 98 | 91 | |
| Klebsiella aerogenes | 24# | 100 | R | R | R | 96 | 92 | 88 | 92 | | 100 | | 100 | 96 | 92 | | 25 | | 88 | | 96 | 96 | |
| Klebsiella oxytoca: 9 % ESBL | 34 | 100 | R | 71 | 53 | 91 | 91 | 91 | 94 | | 100 | | 94 | 100 | 94 | | 95 | | 88 | | 94 | 91 | |
| Klebsiella pneumoniae: 10% ESBL | 292 | 100 | R | 82 | 87 | 91 | 90 | 90 | 90 | | 100 | | 94 | 100 | 91 | | 39 | | 90 | | 94 | 89 | |
| Escherichia coli: 13 % ESBL | 1504 | 100 | 50 | 63 | 81 | 87 | 87 | 87 | 76 | | 100 | | 90 | 100 | 75 | | 97 | | 97 | | 89 | 73 | |
| Proteus mirabilis | 180 | 100 | 81 | 90 | 94 | 94 | 94 | 94 | 72 | | 100 | | 93 | | 76 | | R | | 100 | | 94 | 77 | |
| Pseudomonas aeruginosa | 134 | 100 | R | R | | 95 | 96 | R | 89 | | | | 99 | 94 | 86 | | | | 97 | | 99 | R | |
| **GRAM POSITIVES** | | | | | | | | | | | | | | | | | | | | | | |
| COAGULASE NEG STAPH | 318 | | | | | | | | 63 | 66 | | 36 | 93 | | 73 | 100 | 100 | 15 | | 81 | | | 100 |
| S. aureus: 42 % MRSA | 96 | | | | | | | | 13 | 61 | | 13 | 87 | | 13 | 100 | 100 | 0 | | 83 | | 99 | 100 |
| S. aureus: 58 % MSSA | 134 | | | | | | | | 84 | 76 | | 69 | 99 | | 84 | 100 | 100 | 31 | | 94 | | 93 | 100 |
| Enterococcus faecalis: 1 % VRE | 137 | R | 100 | | R | R | R | R | 91 | R | | | R | | 91 | 100 | 100 | 100 | | | | R | 99 |
| Enterococcus faecium: 63% VRE | 19# | R | 16 | | R | R | R | R | 16 | R | | | R | | 11 | 100 | 50 | 16 | | | | R | 37 |
| Streptococcus pneumoniae | 8# | | | | | | | 100 m 100 p | | 50 | | 50 | | | 100 | 100 | | 75 m 100 p | | | | | 100 |
| Streptococcus agalactiae | 251 | | | | | | | 100 | | 38 | | 34 | | | 98 | 100 | | 100 | | | | | 100 |
| Streptococcus pyogenes | 76 | | | | | | | 100 | | 82 | | 80 | | | 99 | 100 | | 100 | | | | | 100 |

**Abbreviations:** R denotes intrinsic resistance # denotes less than 30 isolates m meningitis p pneumonia

**Notes:**
1. Nitrofurantoin reported for urine isolates only.
2. Meropenem is available as substitute for Imipenem.
3. The antibiogram of percent susceptible organisms represent only the current patterns in this hospital and is based solely upon retrospective analysis of in-vitro test reports in the laboratory. This information on a few select and significant organisms have been extracted from a more comprehensive and cumulative laboratory data consisting of MIC (Mean Inhibitory Concentration) values. For additional information or questions, please contact Microbiology at ext. 6215 or the Pharmacy at ext. 4888.

Drug Formulary Approval
Pharmacy & Therapeutics
February 26, 2024

| GenericItemName | ScanCodeTypeName |
|---|---|
| abacavir + lamiVUDine + zidovudine 300 mg-150 mg-300 mg Tablet | NDC |
| abacavir + lamiVUDine 600 mg-300 mg Tablet | NDC |
| acarbose 50 mg Tablet | NDC |
| acebutolol 200 mg Capsule | NDC |
| acetaminophen + butalbital + caffeine 300 mg-50 mg-40 mg Capsule | NDC |
| acetaminophen + codeine 120 mg-12 mg/5 mL Oral Liquid | NDC |
| acetaminophen + codeine 300 mg-30 mg Tablet | NDC |
| acetaminophen + HYDROcodone 325 mg-10 mg Tablet | NDC |
| acetaminophen + HYDROcodone 325 mg-5 mg Tablet | NDC |
| acetaminophen + HYDROcodone 325 mg-7.5 mg Tablet | NDC |
| acetaminophen + HYDROcodone 325 mg-7.5 mg/15 mL Injection | NDC |
| acetaminophen + oxyCODONE 325 mg-10 mg Tablet | NDC |
| acetaminophen + oxyCODONE 325 mg-5 mg Tablet | NDC |
| acetaminophen 1000 mg/100 mL Injection | NDC |
| acetaminophen 120 mg Suppository | NDC |
| acetaminophen 160 mg/5 mL Oral Suspension | NDC |
| acetaminophen 325 mg Suppository | NDC |
| acetaminophen 325 mg Tablet | NDC |
| acetaminophen 500 mg Tablet | NDC |
| acetaminophen 500 mg/15 mL Oral Liquid | NDC |
| acetaminophen 650 mg Suppository | NDC |
| acetaZOLAMIDE 250 mg Tablet | NDC |
| acetaZOLAMIDE 500 mg Injection | NDC |
| acetylcysteine 10% 30 mL Solution | NDC |
| acetylcysteine 20% 30 mL Injection | NDC |
| acetylcysteine 20% 30 mL Solution | NDC |
| acetylcysteine 20% 4 mL Oral Solution | NDC |
| acetylcysteine 500 mg Effervescent Tablet | NDC |
| aclidinium 400 mcg/inh Powder for Inhalation | NDC |
| acyclovir + hydrocortisone topical 5%-1% Cream | NDC |
| acyclovir 1000 mg/20 mL Injection | NDC |
| acyclovir 200 mg Capsule | NDC |
| acyclovir 50 mg Tablet | NDC |
| acyclovir 500 mg/10 mL Injection | NDC |
| acyclovir 800 mg Tablet | NDC |

The entire file is available in Amelia Frazier Medical Staff Services Director Office

Medication Order Set Approval
Pharmacy & Therapeutics
February 26, 2024

| |
|---|
| CORE. Peripheral Parenteral Nutrition (Peripheral Line) OS |
| Vitamin C Sepsis Combination Protocol |
| MED. Admission Orders for Hip Fracture |
| SURG. Post Op Orders for Hip or Knee Replacement |
| ED. Suspected UTI w/o Fever |
| Andexxa (Andexanet Alfa) Low Dose Order Set |
| ED. Common Orders |
| MED. Wound Care Orders |
| CORE. Vasopressor Protocol |
| Remdesivir IVPB OS |
| ED. Geriatric Fall |
| Pharmacy Charges - ADULT Emergency Code Cart Tray |
| PULM. Critical Care Order Set |
| ED. Needle Stick / Blood Exposure |
| MED. Paracentesis Lab Order Set |
| Heparin Drip Protocol |
| CHRG. Labor and Delivery/Nursery Charges |
| CARD. Heart Failure |
| CRIT. Therapeutic Hypothermia Orders |
| ED. Gonorrhea |
| STK. Stroke/TIA Admission Orders |
| ED. Shortness of Breath |
| ANES. PACU Orders |
| Acetylcysteine for Tylenol Overdose |
| SURG. General Post Op Orders |
| Blood Culture Orders, Indwelling Line Draw |
| Gentamicin IVPB with Peak and Trough |
| MED. General Admission Order Set |
| CHRG. Anesthesia Charges |
| COMMON. Labs |
| CHRG. PICC Line Charges |
| Tube Feeding Order Set |
| MED. Bronchoscopy Order Set |
| Blood Culture Orders, Peripheral Line Draw |
| Bowel Management Protocol |
| ED. Common Meds |
| CORE. Patient Controlled Analgesia |
| ED. Extremity Injury/Fracture |
| Pharmacy Charges - PEDIATRIC Emergency Code Cart Tray |
| COMMON. Blood Products |
| PULM. Admission Orders for patient with Community Acquired Pneumonia (CAP) |

K

Medication Order Set Approval
Pharmacy & Therapeutics
February 26, 2024

| |
|---|
| ED. Altered Mental Status |
| ED. Med Clearance Psychiatric Admission/Eval |
| OB. Labor and Delivery Admission Orders |
| ED. GI Bleed |
| NEUR. Acute Ischemic Stroke |
| CORE. Sepsis Orders |
| COMMON. Diet Orders |
| ED. Headache |
| NEW Acetylcysteine for Tylenol Overdose |
| ED. Patients on Coumadin with Bleeding |
| Cardiac Enzyme Screen Orders (every 8 hrs x 3) |
| CHRG. Cardiology Charges |
| Propofol Infusion Protocol |
| PULM. COPD Admission |
| CRIT. Ventilator Adults |
| ED. Palpitations |
| ED. Suspected Pneumonia |
| COMMON. Diagnostic Imaging Studies |
| CHRG. Cardiac Rehab Charges |
| Diet Order |
| PEDS. Newborn Nursery Admission |
| ED. DKA Panel |
| CORE. VTE Medical Prophylaxis |
| ED. Hip Fracture Panel (R/L) |
| MED. GI Bleed Admission |
| Lexiscan with Electrocardiogram |
| ED. Fever - Pediatric Pts (Under Age 14) |
| NON-ICU Insulin Sliding Scale |
| CHRG. Occupational Therapy Charges |
| CRIT. Diabetic Ketoacidosis |
| ICU Electrolyte Protocol |
| CORE. Telemetry Protocol |
| ED. Imaging Studies |
| OB. Induction of Labor Protocol |
| Andexxa (Andexanet Alfa) High Dose Order Set |
| ED. Drug Levels |
| Vancomycin IVPB Premix with Trough |
| ED. Chest Pain |
| MED. PICC or Midline Post-Insertion Orders |
| Amiodarone Protocol Bolus plus Infusion |
| Argatroban Protocol |

Medication Order Set Approval
Pharmacy & Therapeutics
February 26, 2024

| |
|---|
| MED. Paracentesis Lab Order Set. |
| CORE. Insulin Therapy |
| Amiodarone Bolus plus Infusion |
| CRIT. Stroke withOUT TPA Admission |
| CORE. Terminal Wean Protocol |
| BHU. Common Labs |
| CRIT. Stroke with TPA Admission |
| Vancomycin IVPB with Trough |
| ED. Procedural Sedation |
| Blood Culture Orders, Percutaneous Draw |
| MED. Physician Orders for Comfort Care |
| Heparin Protocol |
| NON-ICU Electrolyte Protocol |
| ED. Suspected Overdose |
| MED. COVID ICU |
| Obtain Consent for Procedure |
| CORE. Total Parenteral Nutrition (Central Line) OS |
| ED. Trauma |
| ICU Admission Protocol |
| Pre-Procedure Order Set |

Medication Order Set Approval
Pharmacy & Therapeutics
February 26, 2024

| OrderSetName |
|---|
| ED. Thyroid Panel |
| ED. Hyperkalemia |
| Consult |
| ED. Sepsis |
| Diet Orders |
| Nephrology Order Set |
| CHRG. Behavioral Health Clinic Charges |
| Cardiac Enzyme Screen Orders |
| ED. Vaginal Bleeding |
| Lumbar Puncture Order Set |
| CRIT. Pulmonary Embolism Admission |
| SURG. Post Op Orders for Fractured Hip |
| PROC. General Post-Procedure Orders |
| ED. COVID Panel |
| ED. Abdominal Pain |
| ED. Suspected Stroke |
| ICU Glucose Control Protocol Adult |
| Arthrocentesis Order Set |
| ED. Vasopressor Protocol |
| CORE. Discharge Orders |
| MED. Thoracentesis Lab Order Set |
| CHRG. Speech Therapy Charges |
| ED. Severe Vomiting and Diarrhea |
| CORE. Epidural/Spinal Narcotic & Infusion Order set |
| ED. Lumbar Puncture |
| ED. Lacerations |
| MED. Thoracentesis Lab Order Set. |
| CRIT. Alteplase IV tPA Physician Order Set - Thrombolysis for Pulmonary Embolism (PE) |
| CHRG. Physical Therapy Charges |
| CHRG. Pre-Operative and Post-Operative Charges |
| OB. Pre-Ecclampsia Labs |
| ED. New Onset Seizures |
| CHRG. PACU Charge Set |
| ED. Nausea |
| Blood Culture Orders, Central Line Draw |
| MED. COVID NON-ICU |
| CHRG. Respiratory Charge Set |
| ICU Insulin Sliding Scale |
| Sodium Bicarbonate Infusion |
| OB. Postpartum Orders |

**Potassium and Magnesium Policies:** Magnesium policy specific to OB Dept; for KCl and Mag electrolyte protocol and SGMH Injectable Medication Manual

3. The following high-risk/high-alert medication categories shall require 2 signatures from licensed nurses for verification and administration.

A. Potassium Chloride, Concentrated Vials

a. Concentrated vials of potassium chloride (KCL) are not permitted in any clinical area. Only pre-mixed bags of KCl are allowed in clinical areas.

b. Mixing of KCL on the floor is not allowed at SGMH.

c. Standardized protocols for the administration of KCL infusion have been developed and are available as guidelines.

B. Insulin

| Drug Name | ER / ICU/DOU | | | Medical/Surgical/OB | | | Administration / Comments |
|---|---|---|---|---|---|---|---|
| | IVPush | IVPB | CI | IVPush | IVPB | CI | |
| Potassium Chloride<br>High Alert Med | NO | YES | YES | NO | YES | YES | • All IV forms-High Alert. **NEVER GIVE IV PUSH**<br>• Infuse at 10meq/hr for peripheral lines<br>• Max rate of 20meq/hr ICU only , Central line only |
| Magnesium Sulfate<br>High Alert Med | YES | YES | YES | NO | YES | NO | • IV push: must dilute first and should not be given over150mg/min. Hypotension, heart block and asystole may occur with rapid administration.<br>• Max rate of infusion: 2 gm/hour to avoid hypotension. Severe eclampsia/seizure: can be given at higher rate<br>• CAUTION in RENAL INSUFFICIENCY. Neuro checks ever 4hrs<br>• Continuous Infusion only in OB |

Ready To Use KCL: 20meq/100ml ; 40meq/100ml;
KCL Prepped by Pharmacy: KCl 40meq/250ml , 80meq/500ml.

More details in Kaiser Infusion Manual:

KCL Infusion Guidelines : Kaiser

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Potassium Chloride | Electrolyte/ mineral replacement | DO NOT GIVE IV PUSH | X | C | | A | **I. General guidelines:**<br>- Unless otherwise specified by physician, 0.9% NaCl will be used as the solution for all potassium admixtures.<br>- Any infusion rate greater than 10mEq potassium per hour requires continuous cardiac monitoring.<br>- All central line solutions containing potassium require an infusion controlling device.<br>- All small volume I.V. (100ml or smaller) potassium solutions require an infusion controlling device.<br>- A potassium level must be ordered STAT after any K-rider, and each day for patients receiving 80mEq or more of potassium intravenously a day.<br>-Intravenous TPN may have a maximum concentration of 80mEq of potassium per liter, not to exceed a rate of 10mEq/hour.<br><br>**II. Maximum Potassium concentration and infusion rates:**<br>A. Critical Care area (ICU/CCU/IMC/PACU/ED/Pre-Op holding)<br>1. LARGE VOLUME (>100ml)<br>a. Peripheral line 40mEq/Liter 10mEq/hour<br>b. Central line 80mEq/Liter 20mEq/hour<br>2. SMALL VOLUME (100ml or less)<br>a. Peripheral line 10mEq/50ml 10mEq/hour<br>b. Central line 40mEq/100ml 20mEq/hour<br>B. All Other Care Areas (except NICU)<br>1. LARGE VOLUME (>100ml)<br>a. Peripheral line 40mEq/Liter 10mEq/hour<br>b. Central line 80mEq/Liter 10mEq/hour<br>2. SMALL VOLUME (100ml or less)<br>a. Peripheral line 10mEq/50ml 10mEq/hour<br>b. Central line 10mEq/50ml 10mEq/hour |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Magnesium sulfate | Electrolyte/mineral replacement | | X | RR | | A | For hypomagnesaemia: typical dose of 1 – 4 g in IVPB. Administer 1g over 30 to 60 minutes.<br><br>For management of eclampsia:<br>- May give loading dose of 4 to 6 g over 20 to 30 minutes, respectively.<br>- followed by 1 to 2 g/h continuous infusion<br>- Discontinue infusion immediately if patient experiences difficulty breathing. | X |

## NON-ICU Electrolyte Protocol

**Allergies:** _____

**This protocol will supersede all other electrolyte supplementation orders**

1. For hemodialysis patients, delete section 4A. Do NOT use the protocol on the day of dialysis. Electrolytes will be adjusted by nephrology via the dialysate.
2. ALL critical lab values MUST be communicated to the prescriber.

3. **CALCIUM**

   Correct serum calcium level based on serum albumin with the following equation:
   [(4 – albumin) X (0.8)] + calcium = _____ (adjusted calcium level)
   Level A. If adjusted calcium 7.5-8.4…give Calcium Gluconate 3 amps IV over 1 hour
   Level B. If adjusted calcium 7.4 or below--give Calcium Gluconate 6 amps IV over 2 hour (Max 15g/24 hr)

4. **POTASSIUM**
   Level A. If potassium 2.9-3.2 …give potassium chloride 40 mEq PO/OG/NG.
   If NPO, give potassium chloride 40 mEq IVPB over 4 hours
   Do NOT supplement dialysis patients unless potassium level below 3
   Level B. If potassium is 2.8 or below …give potassium chloride 80 mEq IVPB over 8 hours.
   (Max 400mEq/24 hr with continuous cardiac monitoring required)

5. **MAGNESIUM**
   Level A. If magnesium 1.3-1.5 …give magnesium sulfate 2 gm IVPB over 2 hours
   Level B. If magnesium 1.2 or below …give magnesium sulfate 4 gm IVPB over 4 hours (Max 12g/24 hr)

6. **PHOSPHOROUS**
   If phosphorous is 1-2.4 …give PHOS-Nak (Neutraphos) 2 packets PO/OG/NG every 6 hours for 4 doses.
   If pt NPO, use IV orders below:
   Level A. If phosphorous 2.0-2.4 …give sodium phosphate 15 mM IVPB over 4 hours
   Level B. If phosphorous 1.9 or below …give sodium phosphate 30 mM IVPB over 6 hours

7. Repeat Laboratory Values

   A. If electrolyte replacement is Level A, repeat lab in AM
   B. If electrolyte replacement is Level B, repeat lab in 2 hours after replacement infusion complete or 4 hours after last PO dose.
   C. If the lab values remain abnormal, repeat replacement X 1 and notify prescriber.

| ☐ RBTO/RBO | Dr. Name | Nurse's Signature | Date & Time |
|---|---|---|---|
| | Physician's Signature | Date | Time |

**SAN GORGONIO MEMORIAL HOSPITAL**
600 NORTH HIGHLAND SPRINGS AVENUE
BANNING, CALIFORNIA 92220
(951) 845-1121

**PT. ID LABEL**

ALLERGIES:

1. For hemodialysis patients, delete section 6A. Do NOT use the protocol on the day of dialysis. Electrolytes will be adjusted by nephrology via the dialysate.
2. Other supplemental electrolyte doses written by any prescriber after the institution of the protocol will result in cancellation of the protocol and the prescriber will be notified.
3. Only two doses of <u>any single</u> supplemental electrolyte may be issued per protocol within a single day. The prescriber must be notified if further doses are necessary.
4. All critical lab values must be communicated to the prescriber.
5. **CALCIUM**
   A. Correct serum calcium level based on serum albumin with the following equation:
   [(4 - albumin) x (0.8)] + calcium = _____ (adjusted calcium level)
   B. If adjusted calcium 7.5-8.4
      — Central line: $CaCl_2$ 1 gm IVPB over 1 hour
      — No central line: CaGluconate 3 amps IV over 1 hour
      (0.465 mEq/mL $Ca^{++}$; 1 amp = 10% 10 mL vial)
   C. If adjusted calcium 6.5-7.4
      — Central line: $CaCl_2$ 2 gm IVPB over 2 hours (1.36 mEq/mL $Ca^{++}$)
      — No central line: CaGluconate 6 amps IV over 2 hours
   D. If adjusted calcium less than or equal to 6.4
      — Central line: $CaCl_2$ 2 gm IVPB over 2 hours
      — No central line: CaGluconate 6 amps IV over 2 hours AND notify M.D.
6. **POTASSIUM**
   A. If potassium 2.9-3.2 ... give potassium chloride 40 mEq PO/NG
   If NPO, give potassium chloride 40 mEq IVPB over 4 hrs
   B. Do NOT supplement dialysis patients unless potassium level below 3
   C. If potassium 2.5-2.8 ... give potassium chloride 80 mEq IVPB over 8 hrs
   D. If potassium less than or equal to 2.4 ... give potassium chloride 80 mEq IVPB over 8 hrs
   AND notify MD
7. **MAGNESIUM**
   A. If magnesium 1.3-1.5 ... give magnesium sulfate 2 gm IVPB over 1 hr
   B. If magnesium 1-1.2 ... give magnesium sulfate 4 gm IVPB over 2 hrs
   C. If magnesium below 1 ... give magnesium sulfate 2 ugm IVPB over 2 hrs
   AND notify MD
8. **PHOSPHOROUS**
   A. If phosphorous 1-2.4 ... give Neutraphos 2 packet PO/NG QID for 4 doses
   If pt NPO, use IV orders below
   B. If phosphorous 2-2.4 ... give sodium phosphate 15 mM IVPB over 3 hrs
   C. If phosphorous 1-1.9 ... give sodium phosphate 30 mM IVPB over 6 hrs
   AND notify MD
   D. If phosphorous below 1 ... give sodium phosphate 30 mM IVPB over 6 hrs
   AND notify MD
9. Repeat the electrolyte level <u>4 hrs after</u> a single PO/NG dose or 2 hrs after an IV is completed. Repeat phosphorous at the end of the series for PO/NG phosphate.
10. Repeat steps as above based on follow-up lab.

☐ RBTO/RBO  Dr. Name _____  Nurse's Signature _____  Date & Time _____

Physician's Signature _____  Date _____  Time _____

**SAN GORGONIO MEMORIAL HOSPITAL**
600 NORTH HIGHLAND SPRINGS AVENUE
BANNING, CALIFORNIA 92220

PT. ID LABEL

30-0130 (11/22)

**ICU ELECTROLYTE PROTOCOL (ICU PATIENTS ONLY)**

Status **Active** PolicyStat ID **8173747**

SAN GORGONIO MEMORIAL HOSPITAL

| | | | |
|---|---|---|---|
| Origination | 02/2002 | Policy Area | Obstetrics |
| Approved | 04/2021 | | |
| Last Revised | 04/2018 | | |

# Magnesium Sulfate Administration

## Policy:

Magnesium sulfate is used for seizure prophylaxis for the antepartum, intrapartum, or postpartum patient with preeclampsia. It may be used in the preterm labor patient for short-term tocolysis, to allow for the administration of antenatal corticosteroids, antibiotics, and/or maternal transport to a higher level of care. Magnesium sulfate may also play a role in neuroprotection of the preterm infant and may be indicated for women laboring before 34 weeks.

Because magnesium sulfate is a high-alert medication, certain safety mechanisms must be in place during administration:

- An infusion pump must be used for the bolus and maintenance magnesium sulfate infusions.
- The bolus dose should be from a separate IV bag (not from the maintenance IV). Both bags are premixed by the pharmacy, and are checked by two nurses before administration.
- Respiratory status is continually monitored, using pulse oximetry.
- IV tubing is labeled and traced from the patient to the bag with each hand-off shift change.

## Procedure:

1. Verify the absence of contraindications to magnesium sulfate administration, including hypocalcemia, myasthenia gravis or renal failure.
2. Educate patient about common transient side effects of magnesium sulfate (maternal flushing, lethargy, headache, muscle weakness, neonatal hypotonia), and safety measures used to avoid potentially serious adverse drug reactions.
3. Equipment: Vital signs monitor, infusion pump and IV tubing, reflex hammer, equipment for measurement of strict intake and output, foley catheter with urometer, stethoscope, external fetal monitor, medication and antidote, limited visitors signs, oxygen set-up, suction equipment, tongue blades, cardiopulmonary resuscitation equipment.
4. Obtain standard concentration magnesium sulfate IV infusion bag and the premixed bolus bag

from the pharmacy.

5. Perform a baseline magnesium assessment and document before administration:

- Blood pressure
- Respiratory rate
- Deep tendon reflexes
- Presence/absence of clonus
- Level of consciousness
- Pulse oximeter reading
- Breath sounds
- Intake and output
- Fetal heart rate

6. Obtain the following labs: Complete blood count, glucose, complete metabolic panel, magnesium level, urinalysis, type, screen and hold blood, coagulation panel, renal panel.

7. Program an infusion pump to run the bolus dose as ordered (typically 4 to 6 grams over 20-30 minutes). A second RN must verify the correct medication and dose, and check all pump settings and tubing connections before administration.

8. Connect the magnesium sulfate bolus IV as an intravenous piggyback into the mainline at the closest port to the primary venipuncture site.

9. Remain at the bedside during the bolus dose to monitor the woman for side effects and adverse drug reactions.

11. At the completion of the bolus dose, disconnect the IV tubing used for the magnesium sulfate bolus, and then perform another magnesium assessment.

12. Prepare the infusion pump to administer the maintenance magnesium sulfate infusion as ordered (typically 1 to 3 grams/hour). Piggyback maintenance magnesium sulfate IV into mainline fluid at the closest port to the primary venipuncture site. A second RN must verify the correct medication and dose and check all pump settings and tubing connections prior to administration.

13. Notify physician immediately about:

- Absent deep tendon reflexes
- Urine output less than 30 ml/hr
- Respirations less than 12 breaths per minute
- Oxygen saturation less than 90%

14. Monitor for signs of toxicity such as severe respiratory depression, decreased level of consciousness, respiratory arrest, and cardiac arrest. If present:

- Notify physician immediately
- Discontinue magnesium sulfate

- Draw a stat serum magnesium level
- Obtain calcium gluconate for immediate administration (antidote for magnesium sulfate toxicity, typically 1 Gm/10ml, 10% solution, 10-15 ml given over 1-3 minutes)

15. Monitor postpartum mother for signs of uterine atony, such as boggy uterus, elevated fundus level or excessive lochia.

16. Magnesium level should be drawn 4 hours after initiation of therapy and every 12 hours thereafter.

- 1.8 – 2.4 = Normal
- 4.0 – 8.0 = Therapeutic
- 10.0 – 12.0 = Loss of DTR's
- 12.0 – 15.0 = Respiratory depression
- 15+ = Cardiac arrest

Assessing Reflexes

| DEGREE | GRADING | CLINICAL SIGNIFICANCE |
|---|---|---|
| Hyperactive response Very brisk clonus | 4+ | Pt. Not responding to med as desired may be accompanied by apprehension, notify MD, consider mag bolus |
| More than normal/ Brisk | 3+ | Restlessness, excitability, assess for impending seizure, notify MD |
| Normal | 2+ | Pt responding, continue to check Frequently |
| Low response/hypo-Active | 1+ | Therapeutic level |
| No response | 0 | Notify MD for orders. Turn off Mag drip, change to KVO solution Prepare antidote for infection |

Assessing Edema

| GRADING | ASSESSMENT |
|---|---|
| 1+ | Slight, disappears readily, pedal/pretibial |
| 2+ | Noticeable/marked, 10-15 sec, lower extremities, pitting |
| 3+ | Deep indent, 2 min to disappear, face, hands abdomen, vulva, sacrum |
| 4+ | Marked, 5 min to disappear, anasarca, generalized with acites. |

Resources:

American College of Obstetricians and Gynecologists. (2003: reaffirmed 2011). Management of preterm labor (Practice Bulletin No. 42) Obstetrics and Gynecology, 101, 1039-1047.

American College of Obstetricians and Gynecologists. (2010, March). Magnesium sulfate before anticipated preterm birth for neuroprotection (Committee Opinion No. 455). Obstetrics and Gynecology, 115, 669-671.

Doyle, L.W., Crowther, C.A. Middleton, P., & Marret S. (2009). Antenatal magnesium sulfate and neurologic outcome in preterm infants: A systematic review. Obstetrics and Gynecology, 113, 1327-1333.

Institute for Safe Medication Practices. (June, 2006). Preventing magnesium toxicity in obstetrics. Nurse Advise-ERR, 4(6), 1. Retrieved from: http://www.ismp.org/Newsletters/nursing/Issues/NurseAdviseERR200606.pdf

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Hospital Board of Directors | Ariel Whitley: Executive Assistant | 04/2021 |
| Medical Executive Committee | Amelia Frazier: Director Medical Staff Services | 03/2021 |
| Surgery Committee | Amelia Frazier: Director Medical Staff Services | 03/2021 |
| Pharmacy & Therapeutics Committee | Jose Lopez: Director Pharmacy | 03/2021 |
| Policy & Procedure Committee | Gayle Freude: Nursing Director Med/Surg | 09/2020 |
| | Carrie Echols: Nursing OB Director | 09/2020 |

## SAN GORGONIO MEMORIAL HOSPITAL

### 2024 Performance/Process Improvement Project Prioritization Grid

**Approved by Executive Team:** _____ **Date:** 2/26/2024

**Approved by Medical Executive Committee:** _____ **Date:** _____

**Approved by Governing Board:** _____ **Date:** _____

| Projects | Reason for Inclusion Check all that Apply | | | | | Significance of Issue | | | Severity of Issue | | | Prevalance of Issue | | | Total Points | Ranking | Outcome Check One | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | High Risk = 1 pt | Problem Prone = 1 pt | Improved Outcomes = 1 pt | Patient Safety = 1 pt | Quality of Care = 1 pt | Low Significance = 1 pt | Moderate Significance = 2 pt | High Significance = 3 pt | Low Severity = 1 pt | Moderate Severity = 2 pts | High Severity = 3 pts | Isolated & Localized = 1 pt | Multiple Areas = 2 pts | Organization Wide = 3 pts | Enter Total Number of Points | Highest to Lowest Point Total | Project Approved | Project Tabled | Project Not Approved | Other |
| Inland Empire Health Plan (IEHP) Beta Heart HQI Cares Program | 1 | 1 | 1 | 1 | 1 | | | 3 | | | 3 | | | 3 | 14 | #1 | | | | |
| Beta HEART Program Team Response to Adverse Events Organization-wide | 1 | 1 | 1 | 1 | 1 | | | 3 | | | 3 | | | 3 | 14 | #1 | | | | |
| **Stroke Program 2024** | 1 | 1 | 1 | 1 | 1 | | | 3 | | | 3 | | | 3 | 14 | #1 | | | | |
| Patient Experience Multidisciplinary Committee Continued from 2020 | | 1 | 1 | 1 | 1 | | | 3 | | | 3 | | | 3 | 13 | #2 | | | | |
| Management of Sepsis - Multidisciplinary Team **(Patient Safety & Problem-Prone)** Continued from 2020 | 1 | | 1 | 1 | 1 | | | 3 | | | 3 | | | 3 | 13 | #2 | | | | |
| Leapfrog Hospital Survey/ Hospital Safety Grade **Spring and Fall of 2024** | 1 | 1 | 1 | 1 | 1 | | | 3 | | 2 | | | | 3 | 13 | #2 | | | | |
| Quality Incentive Pool (QIP)Program - **5 Measure sets for PY7 Year 2024** | 1 | 1 | 1 | 1 | 1 | | | 3 | | | 3 | | 2 | | 13 | #2 | | | | |
| IEHP Pay 4 Performance Programs for **2024** | | 1 | 1 | 1 | 1 | | | 3 | | 2 | | | 2 | | 11 | #3 | | | | |
| Homeless Patient Discharge Process **(State Law)** Continued from 2020 | 1 | 1 | 1 | 1 | 1 | | 2 | | | 2 | | | 2 | 3 | 11 | #3 | | | | |
| Patient & Family Engagement Process Multidisciplinary Team **(CMS Regulation/Patient Safety)** | | 1 | 1 | 1 | 1 | | 2 | | | 2 | | | | 3 | 11 | #4 | | | | |
| Antiobiotic Stewardship - Appropriate Antibiotic UseTeam - **Ongoing Inpatient & Outpatient** | 1 | | 1 | 1 | 1 | | 2 | | | 2 | | | 2 | | 10 | #4 | | | | |
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Modifications in cardiac diet

# High protein, modified cardiac

- INDICATIONS: This diet provides a high protein diet and avoids the sodium, cholesterol and fat menu options for those with high protein needs but needing a heart healthy lifestyle.
- DESCRIPTIONS: Allows for extra entrée proteins to increase protein but avoids high sodium, fat, cholesterol options. It does not quantify the restriction of sodium or cholesterol but provides the foods associated with lower sodium/cholesterol diet.

NUTRITIONAL ADEQUACY: This diet meets the specified nutrients from the Dietary Reference Intakes of the National Academy of Sciences. It provides approx 2300 calories and 145 grm protein.

| Food Group | Food Allowed | Foods to Avoid |
|---|---|---|
| Milk, fresh (serving size = 1 cup | Up to 4 serving/day, low or non fat milk or yogurt, low sodium milk as desired. | Whole milk, reduced milk buttermilk, chocolate milk, malted milk, eggnog, milkshakes, cocoa drinks, all other types of milk including sweetened condensed milk. |
| Meat, Poultry, Fish, Cheese and Meat Substitute (serving size = 1 oz) | Up to 6 oz /meal. Very low fat and sodium beef, veal, pork, lamb chicken turkey, liver, fish, tofu. Other food low Na & fat tuna, peanut butter, cottage cheese, Swiss cheese not more than 2oz/day. | Brains or kidneys; salted, smoked, cured or canned meat, fish or poultry, (i.e bacon, sausage, ham, Canadian bacon, bologna, luncheon meats, hotdogs, corned beef, dried beef); shellfish, kosher meat, frozen fish fillets; frozen dinners, cheese in excess of >3.0 oz a day; salted peanut butter, commercial vegetarian substitute |
| Egg (serving size=1) | Egg substitute and egg whites as desired. Not more than 3 whole eggs/wk | Not more than 3 whole eggs/week |
| Breads (serving size = one slice | Up to 6 servings per day wheat bread or corn tortillas. Up to one serving a day of cornbread, biscuits, pancakes, waffles, flour tortillas and all other regular baked goods. | Regular bread and bread products excess of allowed amounts. Regular crackers. |

Modified cardiac diet

| Food Group | Food Allowed | |
|---|---|---|
| Cereals and Starches (serving size-1/2 cup) | Puffed wheat or puffed rice, shredded wheat; limit other dry cereal to 1 cup a day. Slow or quick cooked hot cereals. Rice and pasta cooked in unsalted water; unsalted popcorn, pretzels, and chips: tapioca, cornstarch | Dry cereals in excess of allowed amount; instant hot cereals; seasoned rice, noodle and stuffing mixes; salted popcorn, pretzels and chips. |
| Fruits (serving size = ½ cup) | 6 or more servings a day fresh, frozen. Limit not more than 3 serving of canned fruit or fruit juice; raisins or prunes | Fruits dried with sodium sulfite, crystallized or glazed fruit, maraschino cherries |
| Vegetables (serving size= ½ cup) | 4-6 servings/day fresh, frozen or unsalted canned vegetables expect those on the avoid list; plain instant mash potato mix; dried beans, split peas and lentils, low sodium tomato and V-8 juice | All regular canned vegetables; regular tomato and V-8 juice; sauerkraut and other pickled vegetables; potato mixes; frozen vegetables with added salt |
| Fats (serving size= 1 tsp. | Limit to 3 tsp/day butter, margarine, cooking oils, French dressing, oil and vinegar dressing, mayonnaise, and avocados. Limit to 1 Tbsp cream/day (sour cream, cream cheese or non dairy creamer) | Regular butter, margarine and mayonnaise in excess of allowed amounts; regular salad dressings, bacon fat, salt pork, gravies prepared from salted bouillon or instant mixes; cream, sour cream, cream cheese and non-dairy creamer in excess of 2 Tbsp a day |

**SAN GORGONIO MEMORIAL HOSPITAL**

**2024 POLICIES & PROCEDURES**

| | Title | Policy Area | Revised? |
|---|---|---|---|
| 1 | Automated Dispensing Cabinet Distribution System | Pharmacy | Revised |
| 2 | Dobutamine Stress Echocardiogram | EKG Echo | Revised |
| 3 | Echocardiogram | EKG Echo | Revised |
| 4 | Echocardiography with the use of Optison (enhancing agent) | EKG Echo | Revised |
| 5 | Fall Risk | Nursing | Revised |
| 6 | PACU - Discharge Criteria Following Moderate/Deep Sedation or Monitored Anesthesia Care | Surgical Services | Revised |
| 7 | Pharmacy Oversight of Materials Management of IV Solutions | Pharmacy | Revised |
| 8 | Rapid Response Team (RRT) Standardized Procedure | Nursing | Revised |
| 9 | Refusal of Drugs, Treatments or Procedures | Nursing | Revised |
| 10 | USP 800: Associate Handling of Hazardous Drugs | Pharmacy | Revised |

# TAB H

taste of the real world. Employers interviewed each student for 15 minutes. The first 10 minutes asked students a series of questions, such as "How do you work under pressure?" and "Tell me about a time you took on a leadership role?" The remaining five minutes provided verbal and written feedback; a luxury rarely, if ever, offered in a "real" job interview.

"This event is about giving students tips on how to prepare for the real world," [illegible] simply unaware that these are avoidable mishaps during an interview. But they knew at the end thanks to a feedback form that included scoring for professional attire.

"I'm hoping this will shed some light on areas I need to work on," explained high school senior Christopher Morant as he sat in the bleachers waiting for his turn to interview. But he also left the possibility open for something more. "It would be a nice surprise to land a job."

Nearby, Maya Calderon


Photo courtesy of Beaumont Unified School District

Beaumont Library District President Luren Dickinson interviews a Beaumont High School student.

The and ho inexpe strugg half-pa tioning real v often ence. way Schoo throu allowi make Wh will k befo their

# Morongo tribe gives $5 million to San Gorgonio Memorial Hospital Foundation

**The donation will help establish a comprehensive women's health program; it follows Morongo's record-breaking $5.6 million donation in 2022.**

The Morongo Band of Mission Indians presented a $5 million donation to the San Gorgonio Memorial Hospital Foundation on March 14 to help the hospital establish a comprehensive Women's Health Program and enhance its obstetrics, gynecology, breast health and women's wellness programs.

The $5 million donation is the second largest donation ever received by the foundation, following Morongo's record-breaking $5.6 million contribution to the foundation in 2022.

Photo courtesy of Morongo Band of Mission Indians

Dr. Karan Singh of the San Gorgonio Memorial Hospital speaks at a ceremony where the Morongo Band of Mission Indians announced a $5 million donation to help establish a comprehensive Women's Health Program at the hospital.

"San Gorgonio Memorial Hospital is profoundly grateful for Morongo's generous $5 million donation," said Foundation President Allen Koblin. "This $5 million donation is a testament to Morongo's commitment to the health and wellness of our community and will bring transformative change to the wellbeing of women and families across the San Gorgonio Pass."

Most of the tribe's donation will be dedicated to establishing a comprehensive Women's Health Program at San Gorgonio Memorial Hospital. This program will offer specialized services, including obstetrics and gynecology, breast health, family services and women's wellness programs. The donation will also upgrade critical patient monitoring systems, with $1.4 million dedicated to enhancing technological capabilities and patient care efficiency.

"Morongo is delighted to be building on our partnership with the San Gorgonio Memorial Hospital Foundation to advance healthcare in the pass," said Morongo Tribal Chairman Charles Martin. "It is crucial that we continue to support new advancements at our community hospital to ensure women, mothers and families have access to high-quality care that addresses their unique healthcare needs."

Dr. Karan Singh of San Gorgonio Memorial Hospital highlighted the significance of the tribe's donation, saying, "Today's gift by the Morongo Band of Mission Indians will bring profound and positive changes to local healthcare, allowing us to expand our services and improve the wellbeing of women of all ages in our community. Morongo is helping us set a new standard for healthcare excellence across the San Gorgonio Pass."

San Gorgonio Memorial Hospital Board Chair Susan DiBiasi also thanked the tribe for the donation, saying, "Words can't express our thanks to Morongo and for the incredible support you continue to offer to our foundation and our hospital. This donation will improve the lives of women and children across the pass communities and puts our hospital in a position to provide innovative new healthcare services to our patients."

The donation not only fortifies the San Gorgonio Memorial Hospital's capabilities but also underscores a shared commitment to fostering healthier, more resilient communities across Riverside and San Bernardino counties.

This latest donation aligns with Morongo's long-standing tradition of supporting vital community resources and services. Over the past decade, Morongo has given over $20 million to support local and regional nonprofit organizations that help seniors, families, veterans, youth and those in need.


The Elks Riders gather for a fundra Warriors Pr

## Beer and bikes for W

On Saturday, March 23, the Ban #1839 joined forces with the Craf Beaumont Avenue in Beaumont Wounded Warriors Project.

Despite the weather the group c to raise over $1,000 through raffl from Stone Brewing, which will charity. The owner of the Craft Lou veteran himself, donated a portio and also arranged for local busi Cigar Lounge, Dee's Kitchen, Pera Lakes blues band, "The Bluesaus the crowd.