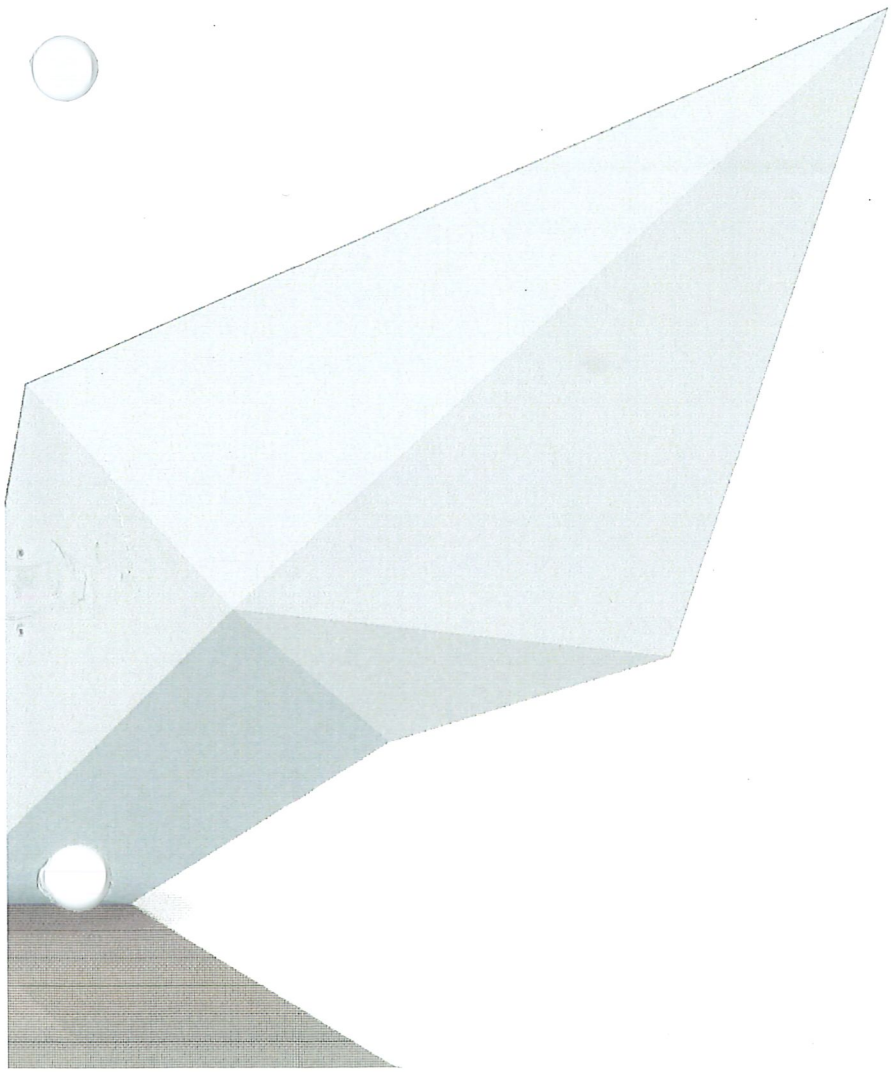
Item 9.I

Del Puerto Health Care District

Financial Statements and Required Supplementary Information

Years Ended June 30, 2021 and 2020



Del Puerto Health Care District

Years Ended June 30, 2021 and 2020

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Independent Auditor's Report

Board of Directors
Del Puerto Health Care District
Patterson, California

Report on the Financial Statements

We have audited the accompanying financial statements of Del Puerto Health Care District (the "District"), which comprise the statements of net position as of June 30, 2021 and 2020, and the related statements of revenues, expenses, and changes in net position and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

WIPFLI

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the District as of June 30, 2021 and 2020, and the changes in its financial position and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States.

Required Supplementary Information

Accounting principles generally accepted in the United States require that the management's discussion and analysis on pages 3 through 7 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audits of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Wipfli LLP

December 2, 2021
Oakland, California

Del Puerto Health Care District

Management's Discussion and Analysis

Years Ended June 30, 2021, 2020, and 2019

Our discussion and analysis of the financial performance of Del Puerto Health Care District (the "District") provides an overview of the District's financial activities for the fiscal years ended June 30, 2021, 2020, and 2019. Please read it in conjunction with the District's financial statements, which begin on page 8.

Financial Highlights

- The District's net position increased by $236,000 in the past year from $6,102,000 at June 30, 2020, to $6,339,000 at June 30, 2021. In the prior year, the District's net position increased by $435,000 from $5,667,000 at June 30, 2019, to $6,102,000 at June 30, 2020.
- Gross patient revenue increased 3% from $10,619,000 in fiscal year 2020 to $10,973,000 in fiscal year 2021. In the prior year, gross patient revenue increased 6% from $10,043,000 in fiscal year 2019 to $10,619,000 in fiscal year 2020.
- Revenue deductions increased 5% in the past year from $5,830,000 to $6,148,000. In the prior year, revenue deductions increased 3% from $5,636,000 in fiscal year 2019 to $5,830,000 in fiscal year 2020.
- Operating expenses increased 1% in the past year from $5,671,000 in fiscal year 2020 to $5,713,000 in fiscal year 2021. In the prior year, operating expenses increased 6% from $5,326,000 in fiscal year 2019 to $5,671,000 in fiscal year 2020.

Using This Annual Report

The District's financial statements consist of three statements—statements of net position; statements of revenues, expenses, and changes in net position; and statements of cash flows. These financial statements and related notes to the financial statements provide information about the activities of the District, including resources held by the District.

The Statements of Net Position and Statements of Revenues, Expenses, and Changes in Net Position

The District's financial statements begin on page 8. One of the most important questions asked about the District's finances is, "Is the District as a whole better or worse off as a result of the year's activities?" The statements of net position and statements of revenues, expenses, and changes in net position report information about the District's resources and its activities in a way that helps answer this question. These statements include all assets and liabilities using the accrual basis of accounting. All of the current year's revenues and expenses are taken into account regardless of when cash is received or paid.

The two statements referred to above report the District's net position and its changes. The District's net position—the difference between assets and liabilities—is one way to measure the District's financial health or financial position. Over time, increases or decreases in the District's net position are indicators of whether its financial health is improving or deteriorating. Readers should also consider other nonfinancial factors, such as changes in the District's patient base, measures of quality of service it provides to the community, and local economic factors to assess the overall health of the District.

The Statements of Cash Flows

The final required statement is the statement of cash flows. This statement reports cash receipts, cash payments, and changes in cash balances resulting from operating, investing, and financing activities. It provides answers to such questions as, "Where did cash come from?", "What was cash used for?", and "What was the change in cash balances during the reporting period?"

The District's Net Position

The District's net position is the difference between the assets and liabilities reported in the statements of net position on pages 8 and 9. The District's net position increased by $236,000 from June 30, 2020, to June 30, 2021, and increased by $435,000 from June 30, 2019 to June 30, 2020, as detailed in the following table:

Condensed Statements of Net Position at June 30, (In Thousands)

	2021	2020	2019	2021-2020 Change	2020-2019 Change
Assets:					
Other assets	$ 3,838	$ 3,827	$ 3,565	$ 11	$ 262
Capital assets	5,177	5,392	5,284	(215)	108
Total assets	$ 9,015	$ 9,219	$ 8,849	$ (204)	$ 370
Liabilities:					
Other liabilities	$ 409	$ 459	$ 349	$ (50)	$ 110
Long-term liabilities	2,268	2,658	2,833	(390)	(175)
Total liabilities	2,677	3,117	3,182	(440)	(65)
Net position:					
Net investment in capital assets	2,901	2,734	2,451	167	283
Restricted for debt service	123	119	107	4	12
Unrestricted	3,314	3,249	3,109	65	140
Total net position	6,338	6,102	5,667	236	435
TOTAL LIABILITIES AND NET POSITION	$ 9,015	$ 9,219	$ 8,849	$ (204)	$ 370

Condensed Statements of Revenues, Expenses, and Changes in Net Position for the Years Ended June 30, (In Thousands):

	2021	2020	2019	2021-2020 Change	2020-2019 Change
Operating revenue:					
Gross patient service revenue	$ 10,973	$ 10,619	$ 10,043	$ 354	$ 576
Contractual adjustments	(6,148)	(5,830)	(5,636)	(318)	(194)
Provision for bad debts	(961)	(836)	(437)	(125)	(399)
Net patient service revenue	3,864	3,953	3,970	(89)	(17)
Other operating revenue	99	53	225	46	(172)
Total operating revenue	3,963	4,006	4,195	(43)	(189)
Operating expenses:					
Salaries and wages	2,475	2,456	2,233	19	223
Employee benefits	660	677	496	(17)	181
Professional fees	799	790	861	9	(71)
Purchased services	447	476	449	(29)	27
Supplies	176	185	163	(9)	22
Utilities	67	65	64	2	1
Rental and lease	10	11	11	(1)	-
Insurance	333	305	376	28	(71)
Repairs and maintenance	87	101	133	(14)	(32)
Depreciation	291	305	278	(14)	27
Other	368	300	262	68	38
Total operating expenses	5,713	5,671	5,326	42	345
Loss from operations	(1,750)	(1,665)	(1,131)	(85)	(534)
Nonoperating revenue	1,986	2,100	1,656	(114)	444
Excess of revenue over expenses	236	435	525	(199)	(90)
Net position - At beginning of year	6,102	5,667	5,142	435	525
Net position - At end of year	$ 6,338	$ 6,102	$ 5,667	$ 236	$ 435

Operating Revenue

Gross patient service revenue increased by $354,000 compared with an increase of $318,000 in revenue deductions. The increase in revenue deductions is commensurate with the increase in gross charges.

Total operating expenses increased by $42,000 from $5,671,000 in fiscal year 2020 to $5,713,000 in fiscal year 2021. This change is primarily because of increases in other operating expenses of $68,000. Other operating expenses increased primarily due to the increase in software and license expense.

Nonoperating Revenue

For fiscal year 2021, nonoperating revenue consisted primarily of tax revenue and provider relief funds. The District received $1,730,000 in tax revenue. During 2020, tax revenue received by the District totaled $1,663,000. In addition, the District received rental income of $143,000 in fiscal year 2021 and $182,000 in fiscal year 2020.

During 2021 and 2020, the District earned $100,000 and $347,000 in grant funding from the HHS Provider Relief Fund, which was established as a result of the CARES Act. Based on the terms and conditions of the grant, the District earns the grant by incurring healthcare-related expenses attributable to COVID-19 that another source has not reimbursed and is not obligated to reimburse, or by incurring lost revenues, defined as a negative change in year over-year net patient revenue. These funds are included in grants under nonoperating revenue in the statements of revenues, expenses and changes in net position.

The District's Cash Flows

Changes in the District's cash flows are consistent with changes in operating revenue and nonoperating revenue and expenses discussed earlier.

Capital Assets and Accumulated Depreciation

As of June 30, 2021, the District had $5,177,000 invested in capital assets, net of accumulated depreciation. The historical cost and additions to capital assets and the changes in accumulated depreciation are detailed in the following table:

Capital Assets and Accumulated Depreciation for the Year Ended June 30, 2021 (In Thousands):

	Balance 2020	Additions	Disposals	Transfers and Adjustments	Balance 2021
Land and improvements	$ 311	$ -	$ -	$ 428	$ 739
Buildings and leasehold improvements	5,037	9	-	-	5,046
Fixed and moveable equipment	2,024	61	(126)	-	1,959
Subtotal	7,372	70	(126)	428	7,744
Less: Accumulated depreciation	(2,403)	(291)	126	-	(2,568)
Subtotal	4,969	(221)	-	428	5,176
Construction in progress	423	6	-	(428)	1
Capital assets - Net	$ 5,392	$ (215)	$ -	$ -	$ 5,177

Noncurrent Liabilities

At June 30, 2021, the District's noncurrent liabilities consisted of USDA notes payable totaling $1,567,000 and a bank loan for real property in the amount of $701,000, for aggregate outstanding total liabilities of $2,268,000. Of this amount, $124,000 is due in installments over the next 12-month period.

Contacting the District's Financial Management

This financial report is designed to provide our patients, creditors, and members of our community with a general overview of the District's finances and to show the District's accountability for the money it receives. For questions about this report or for additional financial information, please contact the Administrative Director/Chief Executive Officer at Del Puerto Health Care District, 875 E Street, Patterson, CA 95363.

Del Puerto Health Care District

Statements of Net Position

June 30,	2021	2020
Current assets:		
Cash and cash equivalents:		
Cash	$ 2,867,637	$ 3,058,355
Restricted cash	122,887	118,839
Receivables:		
Patient accounts - Net	526,129	283,552
Estimated third-party payor settlements	85,408	124,688
Other receivables	3,509	7,661
Inventory	53,157	40,049
Prepaid expenses	33,245	47,210
Total current assets	3,691,972	3,680,354
Noncurrent assets:		
Board-designated cash and cash equivalents	146,264	146,250
Capital assets:		
Nondepreciable capital assets	740,373	734,467
Depreciable capital assets - Net	4,436,877	4,657,127
Capital assets - Net	5,177,250	5,391,594
Total noncurrent assets	5,323,514	5,537,844
TOTAL ASSETS	$ 9,015,486	$ 9,218,198

Del Puerto Health Care District

Statements of Net Position (Continued)

June 30,	2021	2020
Current liabilities:		
Current portion of long-term debt	$ 123,733	$ 107,177
Accounts payable	194,664	135,636
Deposits held for others	-	9,955
Unearned revenue	-	95,516
Accrued compensation and related liabilities	214,051	217,510
Total current liabilities	532,448	565,794
Noncurrent liabilities:		
Long-term debt - Less current portion	2,143,867	2,550,480
Total liabilities	2,676,315	3,116,274
Net position:		
Net investment in capital assets	2,901,435	2,733,937
Restricted for debt service	122,887	118,839
Unrestricted	3,314,849	3,249,148
Total net position	6,339,171	6,101,924
TOTAL LIABILITIES AND NET POSITION	$ 9,015,486	$ 9,218,198

See accompanying notes to financial statements.

Del Puerto Health Care District

Statements of Revenues, Expenses, and Changes in Net Position

Years Ended June 30,	2021	2020
Operating revenue:		
Net patient service revenue	$ 3,864,421	$ 3,953,515
Other operating revenue	99,434	52,759
Total operating revenue	3,963,855	4,006,274
Operating expenses:		
Salaries and wages	2,474,515	2,456,432
Employee benefits	660,424	677,100
Professional fees	799,281	790,192
Purchased services	447,111	475,797
Supplies	176,218	184,932
Utilities	66,812	65,369
Rental and lease	9,856	11,256
Insurance	332,807	304,576
Repairs and maintenance	86,666	100,788
Depreciation	290,631	305,456
Other	368,407	299,513
Total operating expenses	5,712,728	5,671,411
Loss from operations	(1,748,873)	(1,665,137)
Nonoperating revenue (expenses):		
Property taxes	1,729,617	1,662,831
Rental income	142,935	181,615
Grants	204,567	360,212
Interest earnings	6,609	19,568
Interest expense	(60,009)	(62,240)
Other	(37,599)	(61,584)
Total nonoperating revenue - Net	1,986,120	2,100,402
Excess of revenue over expenses	237,247	435,265
Net position - Beginning of year	6,101,924	5,666,659
Net position - End of year	$ 6,339,171	$ 6,101,924

See accompanying notes to financial statements.

Del Puerto Health Care District

Statements of Cash Flows

Years Ended June 30,	2021	2020
Cash flows from operating activities:		
Receipts from and on behalf of patients	$ 3,661,124	$ 4,322,871
Receipts from other operating revenue	103,586	45,989
Payments to employees	(3,138,398)	(3,091,451)
Payments to suppliers	(2,235,488)	(2,283,854)
Net cash used in operating activities	(1,609,176)	(1,006,445)
Cash flows from noncapital financing activities:		
Property taxes received	1,729,617	1,662,831
Other nonoperating revenue	71,452	389,705
Net cash provided by noncapital financing activities	1,801,069	2,052,536
Cash flows from capital and related financing activities:		
Principal payments on long-term debt	(390,057)	(174,960)
Interest payments on long-term debt	(60,009)	(62,240)
Purchase of capital assets	(68,072)	(413,518)
Net cash used in capital and related financing activities	(518,138)	(650,718)
Cash flows from investing activities:		
Net increase in cash received from rental activities	132,980	193,274
Interest received	6,609	19,568
Net cash provided by investing activities	139,589	212,842
Net increase (decrease) in cash and cash equivalents	(186,656)	608,215
Cash and cash equivalents - Beginning of year	3,323,444	2,715,229
Cash and cash equivalents - End of year	$ 3,136,788	$ 3,323,444
Reconciliation of total cash:		
Cash and cash equivalents	$ 2,867,637	$ 3,058,355
Restricted cash and cash equivalents	122,887	118,839
Board-designated cash and cash equivalents	146,264	146,250
Total cash and cash equivalents	$ 3,136,788	$ 3,323,444

Del Puerto Health Care District

Statements of Cash Flows (Continued)

Years Ended June 30,	2021	2020
Reconciliation of loss from operations to net cash used in operating activities:		
Loss from operations	$ (1,748,873)	$ (1,665,137)
Adjustments to reconcile loss from operations to net cash used in operating activities:		
Depreciation	290,631	305,456
Provision for uncollectible accounts	961,024	839,927
Change in assets and liabilities:		
Receivables:		
Patient accounts	(1,203,601)	(629,201)
Estimated third-party payor settlements	39,280	163,114
Taxes and other	4,152	(6,770)
Inventory	(13,108)	4,134
Prepaid expenses	13,965	(21,672)
Accounts payable	50,813	(38,332)
Unearned revenue	-	(45)
Accrued compensation and related liabilities	(3,459)	42,081
Total adjustments	139,697	658,692
Net cash used in operating activities	$ (1,609,176)	$ (1,006,445)
Noncash investing activity:		
Puchase of property and equipment through accounts payable	$ 8,215	$ -

See accompanying notes to financial statements.

Del Puerto Health Care District

Notes to Financial Statements

Note 1: Summary of Significant Accounting Policies

Reporting Entity

Del Puerto Health Care District (the "District") is a public entity organized under the Local Health Care District Law as set forth in the Health and Safety Code of the State of California. The District operates a federally designated rural health clinic (RHC), providing physician and related healthcare services, and an advanced life support ambulance service for the community of Patterson and the surrounding area. As a political subdivision of the State of California, the District is generally not subject to federal or state income taxes. The Board of Directors consists of five residents of the District elected or appointed to four-year terms.

The District provides healthcare services to patients in western Stanislaus County, California. The services provided include adult, pediatric, and industrial health services, as well as healthcare education, diabetes education for the public, laceration treatment, and asthmatic treatment programs. The ambulance service offers 24-hour emergency medical services, as well as event standby services. As part of the future growth plan, the District purchased a building in June 2016, which it currently operates and leases to 75% healthcare-related tenants (physical therapy and orthodontics) until such time as it may be needed for operational purposes.

Basis of Accounting

The accounting policies of the District conform to generally accepted accounting principles (GAAP) as applicable to proprietary funds of governments. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body in the United States for establishing governmental accounting and financial reporting principles.

The District uses enterprise fund accounting. Revenue and expenses are recognized on the accrual basis using the economic resources measurement focus.

Use of Estimates in Preparation of Financial Statements

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

Cash Equivalents

The District considers cash and investments with an original maturity of three months or less to be cash equivalents.

Board-Designated Cash and Cash Equivalents

Noncurrent cash and cash equivalents include designated assets set aside by the Board of Directors for certain debt agreements over which the Board of Directors retains control and which it may, at its discretion, use for other purposes.

Note 1: Summary of Significant Accounting Policies (Continued)

Patient Accounts Receivable and Credit Policy

Patient accounts receivable are uncollateralized patient obligations that are stated at the amount management expects to collect from outstanding balances. These obligations are primarily from local residents, most of whom are insured under third-party payor agreements. The District bills third-party payors on the patients' behalf, or, if a patient is uninsured, the patient is billed directly. Once claims are settled with the primary payor, any secondary payor is billed, and patients are billed for copay and deductible amounts that are the patients' responsibility. Payments on patient accounts receivable are applied to the specific claim identified on the remittance advice or statement. The District does not have a policy to charge interest on past due accounts. Patient accounts receivable are recorded in the accompanying statements of net position net of contractual adjustments and an allowance for doubtful accounts, which reflects management's estimate of the amounts that will not be collected. Management provides for contractual adjustments under terms of third-party reimbursement agreements through a reduction of gross patient service revenue and a credit to patient accounts receivable.

In addition, management provides for probable uncollectible amounts, primarily for uninsured patients and amounts patients are personally responsible for, through a reduction of gross revenue and a credit to a valuation allowance.

In evaluating the collectibility of patient accounts receivable, the District analyzes past results and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for uncollectible accounts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts.

Specifically, for receivables associated with services provided to patients who have third-party coverage, the District analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for uncollectible accounts for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely.

For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the District records a significant provision for uncollectible accounts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates, if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

Note 1: Summary of Significant Accounting Policies (Continued)

Inventories

Inventories consist of pharmaceutical, medical-surgical, and other supplies and are valued at the lower of cost or net realizable value, determined on the average-cost method.

Capital Assets and Equipment

Property and equipment acquisitions are recorded at cost if purchased or, if donated, at acquisition value at the date of donation. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method.

Depreciation and amortization have been computed using the straight-line method over the following estimated useful service lives:

Land improvements	10 to 15 years
Buildings and improvements	10 to 40 years
Fixed and major moveable equipment	3 to 15 years
IT equipment and software	3 to 10 years

Unearned Revenue

Unearned revenue consists of proceeds from grants or contributions, classified as voluntary nonexchange transactions, where revenue is not recognized until all eligibility requirements have been met.

Net Position

Net position is reported in three categories:

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

Restricted for debt service: This category consists of noncapital assets whose use is restricted, reduced by liabilities and deferred inflows of resources related to those assets. Net position is reported as restricted when limitations are imposed on its use through external restrictions imposed by creditors, grantors, laws, or regulations of other governments or imposed by law through constitutional provisions or enabling legislation.

Unrestricted: This category consists of the remaining net position that does not meet the definition of the two preceding categories, including amounts the Board has designated for specific purposes.

When both restricted and unrestricted resources are available for use, it is the District's policy to use externally restricted resources first, at the discretion of the District and in compliance with provisions outlined as such.

Note 1: Summary of Significant Accounting Policies (Continued)

Operating Revenue and Expenses

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

Net Patient Service Revenue

The District recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. Certain third-party payor reimbursement agreements are subject to audit and retrospective adjustments. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

The provision for uncollectible accounts is offset by recoveries that are received on prior-year bad debts from patient payments.

Excess of Revenue over Expenses

The accompanying statements of revenues, expenses, and changes in net position include excess of revenue over expenses, which is considered the operating indicator. Changes in unrestricted net position that are excluded from the operating indicator include assets acquired using contributions that, by donor restriction, were to be used for the purpose of acquiring such assets.

Grants and Contributions

The District receives grants, as well as contributions. Revenue from grants and contributions (including contributions of capital assets) is recognized when all eligibility requirements, including time requirements, are met. Grants and contributions may be restricted for either specific operating purposes or capital purposes. Amounts that are unrestricted or are restricted to a specific operating purpose are reported as nonoperating revenue. Amounts restricted to capital acquisitions are reported after nonoperating revenue (expenses).

Tax Status

The District is a local agency of the State of California within the meaning of Section 56054 of the California Government Code (CGC). Accordingly, the District is exempt from federal income and state income, property, and franchise taxes.

Note 1: Summary of Significant Accounting Policies (Continued)

Reclassifications

Certain reclassifications of 2020 amounts have been made in the accompanying financial statements to conform to the 2021 presentation. Such reclassifications had no effect on the previously reported net position.

Note 2: Cash and Cash Equivalents

Custodial Credit Risk: The risk that, in the event of a bank failure, the District's deposits might not be recovered. The District has collateralization agreements with local banks that mitigate custodial credit risk. The District maintains depository relationships with area financial institutions that are Federal Deposit Insurance Corporation (FDIC) insured institutions. Depository accounts at these institutions are insured by the FDIC up to $250,000 for demand deposits and an additional $250,000 for time deposits. The remaining balance of the District's funds held in deposits and not considered federally insured funds were collateralized in accordance with the CGC, except for federally insured funds.

Under the provisions of the CGC, California banks and savings and loan associations are required to secure the District's deposits by pledging government securities as collateral. The market value of pledged securities must equal at least 110% of the District's deposits. California law also allows financial institutions to secure deposits by pledging first trust deed mortgage notes having a value of 150% of the District's total deposits. The pledged securities are held by the pledging financial institution's trust department in the name of the District.

Currently, all investments are held in money market accounts with maturities of less than three months and are considered cash and cash equivalents and are not rated by the national credit ratings agencies.

Cash and cash equivalents consisted of the following as of June 30:

	2021	2020
Demand deposits	$ 2,619,970	$ 2,810,964
Cash on hand	340	340
Local government investment pool	516,478	512,140
Total cash and cash equivalents	$ 3,136,788	$ 3,323,444

Note 2: Cash and Cash Equivalents (Continued)

The composition of cash and cash equivalents consisted of the following as of June 30:

	2021	2020
Current:		
Unrestricted cash and cash equivalents	$ 2,867,637	$ 3,058,355
Restricted for debt service	122,887	118,839
Noncurrent:		
Board-designated cash and cash equivalents	146,264	146,250
Total cash and cash equivalents	$ 3,136,788	$ 3,323,444

Restricted for Debt Service: Under the terms of the U.S. Department of Agriculture (USDA) Rural Development loan, the District is required to maintain a separate debt service reserve fund equal to an average annual loan installment, which will be accumulated at the rate of one-tenth of the monthly payment until the required level is met.

Board-designated Cash and Cash Equivalents: This is a board designated holding account for mitigation fees.

Note 3: Reimbursement Arrangements With Third-Party Payors

The District has agreements with third-party payors that provide for payments to the District at amounts different from established rates. A summary of the basis of reimbursement from major third-party payors by enterprise operation is as follows:

Health Center

Medicare - The District's health center is designated as a RHC. Under this designation, ambulatory patient care and professional services provided by physicians and other clinicians are paid for on a cost-reimbursement methodology, subject to a maximum rate per visit that is updated annually based on the Medicare Economic Index.

Medi-Cal - Fee-for-service and managed-care patient encounters are reimbursed based on prospectively determined fee schedules per eligible visit.

Others - The District's health center has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the District under these agreements includes fee for service, discounts from established charges, and others.

Note 3: Reimbursement Arrangements With Third-Party Payors (Continued)

Ambulance

Medicare - Emergency medical transport services are provided to Medicare beneficiaries at a fee-for-service rate. The rate is predetermined by the government and pays a set rate per transport plus mileage.

Medi-Cal - The District provides services to both fee-for-service and managed-care beneficiaries. Fee-for-service transports are later settled through the Ground Emergency Medical Transport (GEMT) supplemental reimbursement, which pays 50% of uncompensated cost. Medi-Cal transports provided to managed-care beneficiaries are not eligible for the GEMT program.

Others - The District's ambulance service does not contract or enter into payment agreements with any commercial insurance carriers, health maintenance organizations, or preferred provider organizations. However, most commercial insurance pays the amount it has independently determined as reasonable. The District must pursue reimbursement from the third-party payor or bill the patient for the balance.

Accounting for Contractual Arrangements

The District is reimbursed for health center cost items by submission of annual cost reports with the respective Medicare Administrative Contractor (MAC). Estimated provisions to approximate the final expected settlements after audit or review are included in the accompanying financial statements. The District's cost reports have been final settled through 2020.

Under State of California Department of Health Center Services (DHCS) regulations, RHC's are reimbursed on an interim basis for certain visits insured under Medi-Cal managed care plans. An annual reconciliation is required for Medi-Cal taking into account total visits, the final PPS rate, and interim payments received. Reconciliations for 2019 to 2021 remain open to adjudication and final audit by DHCS. The District has recorded estimated receivables as third-party payor settlements in the accompanying statements of net position.

Compliance

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and billing regulations.

Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayment for patient services previously billed. While no significant regulatory inquiries have been made of the District, compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Note 3: Reimbursement Arrangements With Third-Party Payors (Continued)

The Centers for Medicare and Medicaid Services (CMS) uses recovery audit contractors (RAC) to search for potentially inaccurate Medicare payments. RACs search for potentially inaccurate Medicare payments that might have been made to healthcare providers and were not detected through existing CMS program integrity efforts. Once a RAC identifies a claim it believes is inaccurate, the RAC makes a deduction from or addition to the provider's Medicare reimbursement in an amount estimated to equal the overpayment or underpayment. The District will then have the opportunity to appeal the adjustment before final settlement of the claim is made.

The District's policy is to adjust revenue for decreases in reimbursement from the RAC reviews when these amounts are estimable and to adjust revenue for increases in reimbursement from the RAC reviews when the increase in reimbursement is agreed on. As of June 30, 2021, the District had not been notified of any potential reimbursement adjustments.

Note 4: Patient Accounts Receivable

Patient accounts receivable consisted of the following at June 30, 2021:

	Ambulance	Clinic	Total
Receivables from patients and their insurance carriers	$ 638,360	$ 51,006	$ 689,366
Receivables from Medicare	46,725	55,720	102,445
Receivables from Medi-Cal	90,809	452,001	542,810
Total patient accounts receivable	775,894	558,727	1,334,621
Less:			
Allowance for contractual adjustments	(99,573)	(214,624)	(314,197)
Allowance for doubtful accounts	(490,106)	(4,189)	(494,295)
Net patient accounts receivable	$ 186,215	$ 339,914	$ 526,129

Note 4: Patient Accounts Receivable (Continued)

Patient accounts receivable consisted of the following at June 30, 2020:

	Ambulance	Clinic	Total
Receivables from patients and their insurance carriers	$ 618,152	$ 29,424	$ 647,576
Receivables from Medicare	33,612	12,730	46,342
Receivables from Medi-Cal	78,962	62,542	141,504
Total patient accounts receivable	730,726	104,696	835,422
Less:			
Allowance for contractual adjustments	(237,836)	(28,447)	(266,283)
Allowance for doubtful accounts	(285,587)	-	(285,587)
Net patient accounts receivable	$ 207,303	$ 76,249	$ 283,552

Note 5: Accrued Compensation and Related Liabilities

Employees of the District earn vacation and sick hours at varying rates as provided by the District's employee benefit policies. The District's policy is to permit employees to accumulate paid time-off (PTO). Employees are paid for accumulated PTO benefits, but do not receive payment of accumulated sick leave upon termination or retirement. Accrued vacation liabilities for the years ended June 30, 2021 and 2020, were $146,476 and $145,224, respectively, and are included in accrued compensation and related liabilities on the statements of net position.

Note 6: Capital Assets

Capital asset balances and activity for the year ended June 30, 2021, consisted of the following:

	Balance July 1, 2020	Additions	Retirements	Transfers	Balance June 30, 2021
Nondepreciable capital assets:					
Land	$ 310,914	$ -	$ -	$ 427,630	$ 738,544
Construction in progress	423,553	5,906	-	(427,630)	1,829
Total nondepreciable capital assets	734,467	5,906	-	-	740,373
Depreciable capital assets:					
Buildings and leasehold improvements	5,036,620	9,456	-	-	5,046,076
Equipment	2,023,687	60,925	(125,982)	-	1,958,630
Total depreciable capital assets	7,060,307	70,381	(125,982)	-	7,004,706
Total capital assets before depreciation	7,794,774	76,287	(125,982)	-	7,745,079
Less - Accumulated depreciation	(2,403,180)	(290,631)	125,982	-	(2,567,829)
Capital assets - Net	$ 5,391,594	$ (214,344)	$ -	$ -	$ 5,177,250

At June 30, 2021, construction in progress (CIP) consisted of costs for legal fees related to exploring financing options for a design build of a potentially new admininstration building. Cost estimates of the building project have not been determined and have not been Board approved. Therefore, no estimated completion date could be determined. The estimated remaining cost to complete projects in CIP is $0.

Note 6: Capital Assets (Continued)

Capital asset balances and activity for the year ended June 30, 2020, consisted of the following:

	Balance July 1, 2019	Additions	Retirements	Transfers	Balance June 30, 2020
Nondepreciable capital assets:					
Land	$ 310,914	$ -	$ -	$ -	$ 310,914
Construction in progress	392,967	260,953	-	(230,367)	423,553
Total nondepreciable capital assets	703,881	260,953	-	(230,367)	734,467
Depreciable capital assets:					
Buildings and leasehold improvements	4,927,190	109,430	-	-	5,036,620
Equipment	1,750,185	43,135	-	230,367	2,023,687
Total depreciable capital assets	6,677,375	152,565	-	230,367	7,060,307
Total capital assets before depreciation	7,381,256	413,518	-	-	7,794,774
Total accumulated depreciation	(2,097,724)	(305,456)	-	-	(2,403,180)
Capital assets - Net	$ 5,283,532	$ 108,062	$ -	$ -	$ 5,391,594

Del Puerto Health Care District

Notes to Financial Statements

Note 7: Long-Term Debt

A schedule of changes in the District's long-term debt obligations for 2021 follows:

Direct borrowings:	Balance July 1, 2020	Additions	Reductions	Balance June 30, 2021	Amounts Due Within One Year
USDA note payable, 3.75% interest, monthly principal/interest payments of $10,060; matures in 2039; secured by property	$ 1,627,783	$ -	$ 60,711	$ 1,567,072	$ 63,027
Bank note payable, 4.25% interest, monthly principal/interest payments of $7,442; matures in 2023; secured by property	1,029,874	-	329,346	700,528	60,706
Totals	$ 2,657,657	$ -	$ 390,057	$ 2,267,600	$ 123,733

A schedule of changes in the District's long-term debt obligations for 2020 follows:

Direct borrowings:	Balance July 1, 2019	Additions	Reductions	Balance June 30, 2020	Amounts Due Within One Year
USDA note payable, 3.75% interest, monthly principal/interest payments of $10,060; matures in 2039; secured by property	$ 1,686,263	$ -	$ 58,480	$ 1,627,783	$ 60,716
Bank note payable, 4.25% interest, monthly principal/interest payments of $7,442; matures in 2023; secured by property	1,146,354	-	116,480	1,029,874	46,461
Totals	$ 2,832,617	$ -	$ 174,960	$ 2,657,657	$ 107,177

Note 7: Long-Term Debt (Continued)

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

	Principal	Interest	Total
2022	$ 123,733	$ 86,288	$ 210,021
2023	705,258	81,252	786,510
2024	68,096	75,848	143,944
2025	69,843	71,236	141,079
2026	72,545	65,546	138,091
2027 - 2031	406,936	234,273	641,209
2032 - 2036	491,988	111,612	603,600
2037 - 2041	329,201	18,815	348,016
Totals	$ 2,267,600	$ 744,870	$ 3,012,470

Note 8: Net Patient Service Revenue

Net patient service revenue consisted of the following for the year ended June 30, 2021:

	Ambulance	Clinic	Total
Gross patient service revenue	$ 9,019,990	$ 1,953,183	$ 10,973,173
Less:			
Contractual allowances	6,122,474	25,254	6,147,728
Provision for uncollectible accounts	828,299	132,725	961,024
Net patient service revenue	$ 2,069,217	$ 1,795,204	$ 3,864,421

Net patient service revenue consisted of the following for the year ended June 30, 2020:

	Ambulance	Clinic	Total
Gross patient service revenue	$ 8,570,963	$ 2,047,463	$ 10,618,426
Less:			
Contractual allowances	5,868,543	(39,075)	5,829,468
Provision for uncollectible accounts	815,452	19,991	835,443
Net patient service revenue	$ 1,886,968	$ 2,066,547	$ 3,953,515

Note 8: Net Patient Service Revenue (Continued)

The following table reflects the percentage of gross patient service revenue by payor source for the year ended June 30, 2021:

	Ambulance	Clinic
Medicare	41.6 %	7.8 %
Medi-Cal	33.2	57.9
Other third-party payors	18.5	33.0
Self-pay	6.7	1.3
Totals	100.0 %	100.0 %

The following table reflects the percentage of gross patient service revenue by payor source for the year ended June 30, 2020:

	Ambulance	Clinic
Medicare	40.9 %	5.7 %
Medi-Cal	36.1	71.8
Other third-party payors	17.5	21.8
Self-pay	5.5	0.7
Totals	100.0 %	100.0 %

Note 9: Property Tax Revenue

The District received approximately 28.60% and 26.69% of its financial support from property taxes in the years ended June 30, 2021 and 2020, respectively. Property taxes are levied by the District and collected by the Stanislaus County Treasurer for operations. Taxes estimated to be collectible are recorded as revenue in the year of the levy. No allowance for doubtful taxes receivable is considered necessary. Taxes levied are recorded as nonoperating revenue and are intended to finance the District's activities of the same fiscal year. Amounts of tax levied are based on assessed property values as of the first day of January for the fiscal year for which the taxes are levied.

The funds used to support operations were $1,729,617 and $1,662,831 for the years ended June 30, 2021 and 2020, respectively.

Note 10: Charity Care

Consistent with the mission of the District, care is provided to patients regardless of their ability to pay, including providing services to those persons who cannot afford health insurance because of inadequate resources or who are underinsured. The District has a sliding scale fee discount program based on the Federal Poverty Scale determined by patient household size and income.

Note 10: Charity Care (Continued)

Healthcare services to patients under government programs, such as Medi-Cal are also considered part of the District's benefit provided to the community, since a substantial portion of such services are reimbursed at amounts that are less than the costs of providing care.

Note 11: Risk Management

Risk Management

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

Medical Malpractice Claims

The District obtains medical malpractice insurance through BETA Healthcare Group (BETA), which offers the District a professional and general liability policy on a claims-made basis, with primary limits of $5,000,000 per claim and an annual aggregate limit of $15,000,000, and a $5,000 deductible.

No liability has been accrued for future coverage of acts, if any, occurring in this or prior years. Also, it is possible that claims may exceed coverage available in any given year.

Note 12: Concentration of Credit Risk

The District grants credit without collateral to its patients and third-party payors. Patient accounts receivable from government agencies represent the only concentrated group of credit risk for the District, and management does not believe there are any credit risks associated with these government agencies. Contracted and other patient accounts receivable consist of various payors, including individuals who are involved in diverse activities, are subject to differing economic conditions, and do not represent any concentrated credit risks to the District. Concentration of patient accounts receivable at June 30, 2021 and 2020, was as follows:

	2021	2020
Medicare	8 %	9 %
Medi-Cal	40	23
Other third-party payors	12	21
Self-pay	40	47
Totals	100 %	100 %

Note 13: Commitments and Contingencies

Operating leases - The District leases various pieces of equipment under operating leases expiring at various dates. Total equipment leases and rent expense for the years ended June 30, 2021 and 2020, was $9,856 and $11,256, respectively.

Future minimum lease payments, for leases with a term greater than one year at inception are:

Years Ending June 30,		
2022	$	1,515
2023		631
Total	$	2,146

In March 2020, the World Health Organization declared the outbreak of the novel coronavirus (COVID-19) as a pandemic, which continues to spread throughout the United States. As a result of the pandemic, there are evolving federal and state regulatory requirements and laws that will affect the District's operations. The District is incorporating processes to comply with the evolving regulatory requirements and laws. At this time, it is unclear what the prolonged economic impact of COVID-19 will have on the District's operations.

Note 14: Retirement Plans

The District sponsors and administers a 414(h) defined contribution retirement plan covering substantially all of the District's employees. In a defined contribution plan, benefits depend solely on amounts contributed to the plan plus investment earnings. The District contributed to the plan at a rate of 3%, which increased to 4% on September 1, 2019, of eligible compensation, which is defined by the plan. The District's contributions to the plan were $75,931 and $90,894 for the years ended June 30, 2021 and 2020, respectively.

The District also sponsors and administers an optional 457(b) defined contribution retirement plan that matches employee contributions of up to 6% of their wages at a rate of 50%. The maximum contribution by the District is an additional 3%. The District's contributions become fully vested after five years of continuous service. The District's contributions to this plan were $45,241 and $45,717 for the years ended June 30, 2021 and 2020, respectively.

Note 15: Collective Bargaining Agreement

The District has a collective bargaining agreement covering certain employees within its ambulance services (approximately 25 employees). The contract covering EMTs and paramedics expired on March 30, 2016, and negotiations concluded on September 30, 2019, with the District entering into a four-year contract that includes a 3% annual cost of living adjustment (COLA) for base wages, a 1% increase in employer retirement contributions, establishment of a labor management committee, an increase in the number of hours required for part-time employees to remain active, and restoration of many management rights.

Note 16: COVID-19 Relief Funds and Grant Revenue

During the years ending June 30, 2021 and 2020, Del Puerto received $100,000 and $347,414, respectively, in grant funding from the United States Department of Health and Human Services (HHS) Provider Relief Fund, which was established as a result of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Based on the terms and conditions of the grant, Del Puerto earns the grant by incurring healthcare-related expenses attributable to COVID-19 that another source has not reimbursed and is not obligated to reimburse, or by incurring lost revenues, defined as a negative change in year-over-year net patient revenue. During 2021 and 2020, Del Puerto recognized $100,000 and $347,414, respectively, in grant revenue related to this program, which reflects management's estimate of the amount of the grant earned, including consideration for uncertainties related to reporting guidance still developing as of the date the financial statements were available to be issued.

Item 9.F

California Health Care District Financing Techniques

Across the nation, the delivery of health care services is undergoing a period of transformation. Much of this change is being driven by The Affordable Care Act signed into law in 2010.

Many hospital facilities in California are aging and need to be renovated or replaced in order to address the evolving regulatory and insurance environment, seismic upgrades for acute care facilities required under California law or other needs in the community. Health care districts in California are authorized to incur various types of debt, including general obligation bonds that are paid from *ad valorem* property taxes levied on property within the district, as well as debt secured by district revenues. The issuance of bonds or incurrence of other debt by health care districts involves the interplay of a number of laws, including California statutes, the California Constitution, federal securities laws and federal tax laws.

General Obligation Bonds

General obligation bonds are voter-approved long-term debt instruments which are secured by the legal obligation to levy and collect *ad valorem* property taxes sufficient to pay annual debt service on the bonds. Because general obligation bonds are secured by the taxing power of the health care district, they are considered to pose the lowest risk to the investor and, therefore, provide the lowest borrowing cost to the health care district when compared to any of the other types of debt financing that a health care district is authorized to use under California law.

By voting to approve a general obligation bond measure, voters are also approving an increase in *ad valorem* property taxes sufficient to pay the debt service on the bonds. Thus, this financing technique incorporates the means for its own repayment, and general obligation bonds should not cause any reduction in other health care district financial resources. However, voter approval must be obtained and, with the rise of scrutiny over municipal finance practices, it is essential to have a defendable bond program to gain such approval. Components of a defendable program include a clear need to build, expand or modernize facilities, a specific project list to be financed and accountability measures (e.g., independent audits and citizen oversight).

Voter approval of a bond measure creates what has sometimes been called a "contract" between the health care district and the voters. While this "contract" is not a separate document of the financing, it nevertheless limits the health care district's authority with respect to the bonds. This agreement with the voters consists of the constitutional and statutory law authorizing the election and the issuance of the bonds, the resolution calling the election and the specific language contained in the ballot measure itself. The assenting vote of the electorate completes the agreement.

If a ballot measure is too specific with regard to the projects to be financed (e.g., "construction of a hospital on Jefferson Street"), the health care district board may be bound to build what it has promised to the voters and may not be able to change its plans (e.g., "construction of a hospital on Main Street") in the future despite changes in health care district priorities or circumstances. Accordingly, when drafting a ballot measure and resolution calling an election, health care districts must carefully balance the need for specificity and the desire for flexibility to ensure that the measure is specific enough to permit the bond proceeds to be used for their intended purposes without eliminating all flexibility of the health care district to handle changing priorities or circumstances.

Accordingly, the preparation of a bond measure requires a deliberate balancing of a number of important factors to help the likelihood that the measure attracts sufficient votes to pass while preserving flexibility for the health care district to handle changing circumstances. It is critical that a health care district review its various options and any proposed bond with competent counsel and other advisors prior to placing a measure on the ballot.

Debt Secured By District Revenues

Health care districts are also authorized by California law to incur various forms of debt that are payable from revenues of the district. These revenue-based forms of debt carry a higher interest rate than general obligation bonds, but do not require voter approval. In addition, the specific statutes authorizing debt secured by district revenues can limit the borrowing size and the term of the debt.

Federal Tax-Exemption

While the issuance of bonds or incurrence of debt by health care districts is a matter of California law, the exclusion of interest on such obligations from income for purposes of federal income taxation is governed by federal tax law. The Internal Revenue Code of 1986, and the regulations thereunder, contain an intricate set of requirements that must be complied with in order for a health care district to issue bonds or other debt that are tax-exempt. Additionally, in order for the bonds or other debt to retain their tax-exemption, the health care district must continue to comply with certain requirements after the bonds or other debt are issued or incurred.

The benefit of issuing tax-exempt debt is that tax-exempt financing offers lower interest rates than taxable debt. Because interest paid on tax-exempt debt is exempt from federal income tax (and the income tax of California), the investor requires less interest to produce the same after-tax return as taxable debt would produce. The difference varies from time to time based on market factors but is usually 2 to 4 percentage points less than comparable taxable debt. Given the current low interest rate environment, the difference between tax-exempt and taxable rates is smaller, around 1 to 2 percentage points. In any event, lower interest rates reduce the debt service payments to be made by the health care district.

For example, interest rates on 30-year general obligation bonds sold around May 1, 2016 were roughly as follows:

Ratings[1]	Tax-Exempt Bonds	Revenue Bonds
AAA	2.61%	3.68%
AA	2.81%	3.76%
A	3.13%	4.18%
BBB	3.45%	4.84%

Federal Securities Law

The offering and sale of securities is regulated by federal laws codified primarily in the Securities Act of 1933 (the "Securities Act") and the Securities and Exchange Act of 1934 (the "Exchange Act"). Health care district general obligation bonds and revenue bonds constitute "securities" for purposes of the Securities Act and the Exchange Act. For most corporate securities, a public offering must be preceded by filing a registration statement with the SEC pursuant to the Securities Act, and the corporation is required to make periodic reports to the SEC pursuant to the Exchange Act. Municipal securities, on the other hand, including those of health care districts, are exempt from the registration requirements of the Securities Act and from the reporting requirements of the Exchange Act. However, the offering and sale of health care district securities is not exempt from the anti-fraud provisions of the Securities Act or the Exchange Act. In addition, the SEC's rules governing underwriters of municipal bonds effectively require health care districts to make periodic disclosure of certain information relevant to the security of their bonds unless certain exemptions apply. In contrast, if the form of debt incurred by the health care district does not constitute a security, but instead is treated as a loan, then the requirements of the Securities Act and the Exchange Act, as well as the rules of the Municipal Securities Rulemaking Board of the SEC, do not apply.

Summary Comparison of Health Care District Financing Techniques

The following table illustrates the main financing techniques available to California health care districts as of May 2016. Nothing in this table should be construed or relied upon as legal advice. Instead, this chart is intended to serve as an overview of the financing options applicable to California health care districts, from which better informed requests for advice, legal and financial, can be formulated. Advice from competent counsel can help districts analyze which financing technique best suits the needs of the district.

Contact Us

For additional information concerning any health care district financing needs, please contact Jenna Magan or Don Field. Jenna and Don are partners with the global law firm of Orrick, Herrington & Sutcliffe LLP. Jenna focuses on all aspects of municipal and health care financing, including the issuance of general obligation bonds and revenue bonds by health care districts. Don has extensive experience—as both bond counsel and disclosure counsel—in the areas of general obligation bonds and election laws.

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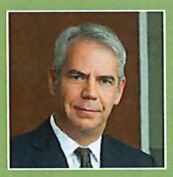

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[1] Ratings refer to independent appraisals of the credit quality of the bonds and the likelihood of their repayment performed by one or more of the credit rating agencies: Standard & Poor's Rating Services, Moody's Investors Service or Fitch. The ratings are expressed as letter grades AAA, AA, A, BBB (expressed as Aaa, Aa, A and Baa by Moody's) from highest to lowest investment grade ratings, with +/- or numerical subcategories. Ratings are considered very important by investors in determining what interest rates will induce them to purchase the bonds. Bonds may be sold with or without a rating, although usually at materially higher interest rates.

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SUMMARY COMPARISON OF HEALTH CARE DISTRICT FINANCING TECHNIQUES

	General Obligation Bonds	Revenue Bonds	Certificates of Participation (COP)	Cal-Mortgage Insured Revenue Bonds[2]
Statutory Authority	Health & Safety Code Section 32300 and following; Government Code Section 53506 and following	Health & Safety Code Section 32315 and following	Health & Safety Code Section 32121	Health & Safety Code Sections 32127.2 and 129000 and following
What Can Be Financed?	Real property and improvements only (no equipment) described in ballot measure; costs of issuance and capitalized interest (no reserve fund)	Generally any real or personal property; costs of issuance; capitalized interest; reserve fund	Generally any real or personal property; costs of issuance; capitalized interest; reserve fund	Generally any real or personal property; costs of issuance; capitalized interest; reserve fund; insurance costs
Are Additional Revenues Generated?	Yes, bonds payable from certain *ad valorem* property taxes	No, bonds payable from revenues of the District	No, COPs payable from revenues of the District[3]	No, bonds payable from revenues of the District
Is Voter Approval Required?	Yes, at least 2/3rd of the qualified electors voting on the ballot measure	No, but resolution must be adopted by 4/5th of District board	No	No
What Is the Maximum Maturity?	40 years	40 years	Useful life of property sold	30 years (subject to economic life of the health facility)
What Is the Maximum Interest Rate?	12%	12%	Generally, none	Generally, none
May Negotiated Sale Be Used?	Yes	Yes, but bond purchase contract is subject to referendum	Yes	Yes
What Are the Most Important Advantages?	Low cost; simplicity; self-supporting	Flexibility; no vote required	Flexibility; no vote required	Flexibility; no vote required; priced on credit of the State of California General Obligation Bonds
What Are the Most Important Disadvantages?	Vote required	Higher interest cost than general obligation bonds; Referendum risk; principal amount limited to 50% of average of District's gross revenues for last 3 years	Higher interest cost than general obligation bonds; reserve fund, insurance and capitalized interest may be required	Reserve fund based on MADS and deed of trust on facilities required by Cal-Mortgage; insurance costs; covenants in regulatory agreement

[2] Health care districts are also authorized to incur FHA insured debt under Health & Safety Code Section 32127.3.
[3] COPs can be secured by parcel taxes with voter approval.

	Negotiable Promissory Notes	Line of Credit with Commercial Lender	Capital Lease	Lease Purchase
Statutory Authority	Health & Safety Code Section 32130.2	Health & Safety Code Section 32130.6	Health & Safety Code Section 32130.6	Health & Safety Code Section 32130.6
What Can Be Financed?	Any District purpose	Any District purpose	Equipment	Real property, buildings and facilities
Are Additional Revenues Generated?	No, notes are payable from revenues of the District	No, secured in whole or in part with accounts receivable or other intangible assets of the District	No, but security interest in equipment may be granted	No, lease purchase payments are payable from revenues of the District
Is Voter Approval Required?	No, but resolution must be adopted by a majority of the District board	No, but resolution must be adopted by a majority of the District board	No, but resolution must be adopted by a majority of the District board	No, but resolution must be adopted by a majority of the District board
What Is the Maximum Maturity?	10 years (subject to useful life of the financed property)	Must be repaid within 5 years from each separate borrowing or draw under the line of credit (take-out financings are permitted)	10 years	10 years
What Is the Maximum Interest Rate?	12%	Generally, none	Generally, none	Generally, none
May Negotiated Sale Be Used?	Yes	Yes	Yes	Yes
What Are the Most Important Advantages?	Proceeds can be used for any purpose, including working capital	Proceeds can be used for any purpose, including working capital	Flexible financing for equipment	Flexible financing for real property and equipment
What Are the Most Important Disadvantages?	Total aggregate amount of notes outstanding at any one time shall not exceed 85% of all estimated income and revenue for the current fiscal year	5 year term limits size of borrowing	Not available for financing real estate	10 year term limits size of borrowing

Item 10.D

ACHD Legislative Report

Access to Care

AB 4 *Arambula D* Medi-Cal: eligibility.
Extends full-scope Medi-Cal benefits to income-eligible adults age 18 years or older, regardless of their immigration status.
Status: 8/27/2021-Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. SUSPENSE FILE on 7/5/2021)(May be acted upon Jan 2022)
Position: Support

AB 14 *Aguiar-Curry D* Communications: California Advanced Services Fund: deaf and disabled telecommunications program: surcharges.
Funds and prioritizes the deployment of broadband infrastructure in California's most vulnerable, and underserved communities.
Status: 10/8/2021-Approved by the Governor. Chaptered by Secretary of State - Chapter 658, Statutes of 2021.
Position: Support

AB 32 *Aguiar-Curry D* Telehealth.
Makes permanent the current telehealth flexibilities put in place during the COVID-19 pandemic, to thereby ensuring all patients continue to have this increased access to care moving forward.
Status: 7/14/2021-Failed Deadline pursuant to Rule 61(a)(11). (Last location was HEALTH on 6/9/2021)(May be acted upon Jan 2022)
Position: Support

97 *Nazarian D* Health care coverage: insulin affordability.
Prevents insurance policies from imposing a deductible on insulin prescription drugs.
Status: 8/27/2021-Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. on 8/17/2021)(May be acted upon Jan 2022)
Position: Support

AB 368 *Bonta D* Food prescriptions.
Establishes the Food Prescription pilot program, to directly address racial and ethnic health disparities related to nutrition insecurity among Medi-Cal beneficiaries.
Status: 1/21/2022-Failed Deadline pursuant to Rule 61(b)(2). (Last location was 2 YEAR on 5/25/2021)
Position: Support

AB 410 *Fong R* Licensed registered nurses and licensed vocational nurses: Nurse Licensure Compact.
Enters California into the Nurse Licensure Compact (NLC), allowing nurses from out of state to fill gaps in nursing care especially during natural disasters or other emergencies.
Status: 1/14/2022-Failed Deadline pursuant to Rule 61(b)(1). (Last location was 2 YEAR on 4/30/2021)
Position: Support

AB 443 *Carrillo D* Physicians and surgeons: fellowship programs: special faculty permits.
Establishes an international medical graduates assistance program within the Office of Statewide Health Planning and Development (OSHPD) to address the shortage of health care professionals in the state of California.
tus: 7/14/2021-Failed Deadline pursuant to Rule 61(a)(11). (Last location was B., P. & E.D. on 6/9/2021)(May be ed upon Jan 2022)
Position: Support

AB 849 *Reyes* *D* Skilled nursing facilities: intermediate care facilities: liability.
Establishes a $500 penalty per violation instead of per case, for actions brought against skilled nursing facilities (SNFs) under Health & Safety Code 1430 (b), which are not covered by liability insurance.
Status: 10/4/2021-Approved by the Governor. Chaptered by Secretary of State - Chapter 471, Statutes of 2021.
Position: Oppose

AB 852 *Wood* *D* Nurse practitioners: scope of practice: practice without standardized procedures.
Clarifies existing law (AB 890, 2020) to ensure that nurse practitioners are recognized as independent providers will help
close the provider gap and reduce health disparities.
Status: 7/14/2021-Failed Deadline pursuant to Rule 61(a)(11). (Last location was B., P. & E.D. on 6/3/2021)(May be acted upon Jan 2022)
Position: Support

AB 882 *Gray* *D* Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program.
Requires Proposition 56 loan assistance payments to be awarded to Medi-Cal physicians and dentists who maintain a patient caseload composed of at least 30% Medi-Cal beneficiaries and asserts additional verification requirements

Status: 9/10/2021-Failed Deadline pursuant to Rule 61(a)(15). (Last location was APPR. SUSPENSE FILE on 4/28/2021)(May be acted upon Jan 2022)
Position: Support

AB 935 *Maienschein* *D* Telehealth: mental health.
Expands access to mental health for pregnant and postpartum mothers and children through increased utilization of telehealth.
Status: 1/21/2022-Failed Deadline pursuant to Rule 61(b)(2). (Last location was APPR. on 1/15/2022)
Position: Support

AB 1015 *Rubio, Blanca* *D* Board of Registered Nursing: workforce planning: nursing programs: clinical placements.
Requires the Board of Registered Nursing to incorporate regional data into its workforce forecast and identify a plan to address these shortages and increase clinical placement slots.
Status: 10/6/2021-Approved by the Governor. Chaptered by Secretary of State - Chapter 591, Statutes of 2021.
Position: Support

AB 1064 *Fong* *R* Pharmacy practice: vaccines: independent initiation and administration.
Allows pharmacists to independently initiate and administer any vaccine authorized by the United States Food and Drug Administration (FDA).
Status: 10/8/2021-Approved by the Governor. Chaptered by Secretary of State - Chapter 655, Statutes of 2021.
Position: Support

AB 1264 *Aguiar-Curry* *D* Project ECHO (registered trademark) Grant Program.
Establishes a Project ECHO Grant Program to be administered through the Office of Statewide Health Planning and Development to children's hospitals for the purpose of behavioral health.
Status: 1/21/2022-Failed Deadline pursuant to Rule 61(b)(2). (Last location was 2 YEAR on 5/25/2021)
Position: Support

AB 1306 *Arambula D* Health Professions Careers Opportunity Program.
Updates existing Health Professions Careers Opportunity Program code to address the shortage of health care professionals in the state of California.
Status: 8/27/2021-Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. SUSPENSE FILE on 8/16/2021)(May be acted upon Jan 2022)
Position: Support

SB 40 *Hurtado D* Health care workforce development: California Medicine Scholars Program.
Establishes a pilot program within the Office of Statewide Health Planning and Development to implement regional pipeline programs for community college students to pursue premedical training and enter medical school
Status: 8/27/2021-Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. on 7/6/2021)(May be acted upon Jan 2022)
Position: Support

SB 56 *Durazo D* Medi-Cal: eligibility.
Extends full-scope Medi-Cal benefits to all income-eligible adults 65 years of age or older, regardless of their immigration status.
Status: 8/27/2021-Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. on 6/22/2021)(May be acted upon Jan 2022)
Position: Support

SB 316 *Eggman D* Medi-Cal: federally qualified health centers and rural health clinics.
Allows Federally Qualified Health Center (FQHCs) and Rural Health Clinics (RHCs) to bill Medi-Cal for two visit if a patient is provided mental health services on the same day they receive other medical services.
Status: 9/10/2021-Failed Deadline pursuant to Rule 61(a)(15). (Last location was INACTIVE FILE on 9/9/2021)(May be acted upon Jan 2022)
Position: Support

SB 365 *Caballero D* E-consult service.
Makes e-consult services reimbursable under the Medi-Cal program for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).
Status: 10/6/2021-Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.
Position: Support

SB 743 *Bradford D* Housing developments: broadband adoption: grant program.
Establishes grants to expand broadband infrastructure in affordable housing developments.
Status: 8/27/2021-Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. SUSPENSE FILE on 8/19/2021)(May be acted upon Jan 2022)
Position: Support

Community Health

AB 234 *Ramos D* Office of Suicide Prevention
Removes provisions limiting the State Department of Public Health to perform duties under the Office of Suicide Prevention.
Status: 1/21/2022-Failed Deadline pursuant to Rule 61(b)(2). (Last location was 2 YEAR on 5/25/2021)
Position: Support

AB 270 *Ramos D* Core Behavioral Health Crisis Services System.
Creates the Core Behavioral Health Crisis Services System to establish and implement behavioral health services including the "988" Suicide Prevention and Behavioral Health Crisis Hotline and Mobile Crisis teams.
Status: 9/10/2021-Failed Deadline pursuant to Rule 61(a)(15). (Last location was HEALTH on 1/28/2021)(May be acted upon Jan 2022)
Position: Support

AB 285 *Holden D* State Department of Education: state school nurse consultant.
Requires the State Department of Education to create a state school nurse consultant to promote school health programs and quality school nursing services.
Status: 9/10/2021-Failed Deadline pursuant to Rule 61(a)(15). (Last location was APPR. SUSPENSE FILE on 4/14/2021)(May be acted upon Jan 2022)
Position: Support

AB 368 *Bonta D* Food prescriptions.
Establishes the Food Prescription pilot program, to directly address racial and ethnic health disparities related to nutrition insecurity among Medi-Cal beneficiaries.
Status: 1/21/2022-Failed Deadline pursuant to Rule 61(b)(2). (Last location was 2 YEAR on 5/25/2021)
Position: Support

AB 988 *Bauer-Kahan D* Mental health: 988 crisis hotline.
Creates the Core Behavioral Health Crisis Services System to establish and implement behavioral health services including the "988" Suicide Prevention and Behavioral Health Crisis Hotline and Mobile Crisis teams.
Status: 9/10/2021-Failed Deadline pursuant to Rule 61(a)(15). (Last location was E. U., & C. on 6/24/2021)(May be acted upon Jan 2022)
Position: Support

AB 1331 *Irwin D* Mental health: Statewide Director of Crisis Services.
Establishes a full-time Statewide Director of Crisis Services to assist in addressing the behavioral health crisis in California.
Status: 1/3/2022-Consideration of Governor's veto pending.
Position: Support

SB 395 *Caballero D* Excise tax: electronic cigarettes: Health Careers Opportunity Grant Program: Small and Rural Hospital Relief Program.
Imposes a tax on the sale of electronic cigarettes and creates the Health Careers Opportunity Grant Program within OHSPD for the purpose of improving access to diverse students to health profession programs. The bill also designates 10% of the new funds to OSHPD to provide grants to small, rural and critical access hospitals, to assist in their seismic safety retrofit requirements.
Status: 10/4/2021-Approved by the Governor. Chaptered by Secretary of State. Chapter 489, Statutes of 2021.
Position: Support

SB 682 *Rubio D* Childhood chronic health conditions: racial disparities.
Requires the California Health and Human Services Agency (HHS) to implement a plan to reduce racial disparities in health outcomes in chronic conditions relating to children by 50% by 2030.
Status: 10/4/2021-Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.
Position: Support

Emergency, Pandemic & Disaster Preparedness

AB 418 *Valladares* *R* Emergency services: grant program.
Establishes the Community Power Resiliency Program to support local governments in improving resiliency in response to deenergization events.
Status: 1/3/2022-Consideration of Governor's veto pending.
Position: Support

Labor Relations

AB 650 *Muratsuchi* *D* Employer-provided benefits: health care workers: COVID-19: hazard pay retention bonuses.
Mandates hazard bonuses for specified health care workers, including those employed by district hospitals, imposing a new significant unfunded cost on those impacted health care providers. While AB 650 exempts some public entities, public healthcare districts, including the smallest, most rural hospitals in the state are included.
Status: 6/4/2021-Failed Deadline pursuant to Rule 61(a)(8). (Last location was INACTIVE FILE on 6/3/2021)(May be acted upon Jan 2022)
Position: Oppose

AB 1465 *Reyes* *D* Workers' compensation: medical provider networks study.
Establishes the state-run California Medical Provider Network, which would reduce the quality of medical care in California's workers' compensation system, increase costs on employers as they struggle to expand California's economy as we come out of the COVID-19 pandemic, and wipe away important prior reforms that were the subject of negotiations between labor and management.
Status: 7/14/2021-Failed Deadline pursuant to Rule 61(a)(11). (Last location was L., P.E. & R. on 6/16/2021)(May be acted upon Jan 2022)
Position: Neutral

SB 213 *Cortese* *D* Workers' compensation: hospital employees.
Creates a workers' compensation presumption for hospital employees who provide direct patient care, with infectious disease, cancer, musculoskeletal injury, post-traumatic stress disorder, and respiratory disease claims.
Status: 1/25/2022-Read third time and amended. Ordered to second reading.
Position: Oppose

SB 270 *Durazo* *D* Public employment: labor relations: employee information.
Creates new types of damages in litigation against public agencies.
Status: 9/27/2021-Approved by the Governor. Chaptered by Secretary of State. Chapter 330, Statutes of 2021.
Position: Oppose

SB 335 *Cortese* *D* Workers' compensation: liability.
Fundamentally alters longstanding rules and timeframes for determining eligibility for workers' compensation claims by substantially cutting the amount of time available to California employers to review whether claimed workplace injuries are, in fact, related to work.
Status: 7/14/2021-Failed Deadline pursuant to Rule 61(a)(11). (Last location was INS. on 6/10/2021)(May be acted upon Jan 2022)
Position: Oppose

SB 606 *Gonzalez* *D* Workplace safety: violations of statutes: enterprise-wide violations: egregious violations.
Creates a new system of penalties on employers, potentially 100 times higher than the present, greatly broadens CalOSHA's scope of enforcement into the Labor Code and Health and Safety Code, and creates additional anti-retaliation protections that will lead to litigation for employers.
Status: 9/27/2021-Approved by the Governor. Chaptered by Secretary of State. Chapter 336, Statutes of 2021.
Position: Oppose

SB 788 *Bradford D* Workers' compensation: risk factors.
Prohibits consideration of race, religious creed, color, national origin, gender, marital status, sex, sexual identity, or sexual orientation, for the purposes of apportionment of permanent disability within the workers compensation system.
Status: 9/28/2021-Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.
Position: Neutral

Local Government

AB 339 *Lee D* Local government: open and public meetings.
Requires large cities and counties, through December 31, 2023, to provide both in-person and teleconference options for the public to attend their meetings.
Status: 1/3/2022-Consideration of Governor's veto pending.
Position: Neutral

AB 361 *Rivas, Robert D* Open meetings: state and local agencies: teleconferences.
Allows local agencies to continue to use teleconferencing for public meetings without complying with all requirement in the Ralph M. Brown Act during a declared state of emergency.
Status: 9/16/2021-Approved by the Governor. Chaptered by Secretary of State - Chapter 165, Statutes of 2021.
Position: Support

AB 903 *Frazier D* Los Medanos Community Healthcare District.
Dissolves the Los Medanos Community Healthcare District.
Status: 7/14/2021-Failed Deadline pursuant to Rule 61(a)(11). (Last location was GOV. & F. on 5/19/2021)(May be acted upon Jan 2022)
Position: Oppose

AB 1271 *Ting D* Surplus land.
Creates new requirements for certain transactions by local jurisdictions under the Surplus Lands Act.
Status: 1/14/2022-Failed Deadline pursuant to Rule 61(b)(1). (Last location was 2 YEAR on 4/30/2021)
Position: Neutral

SB 813 *Committee on Governance and Finance* Local Government Omnibus Act of 2021.
Recasts the provisions of Health and Safety Code 32133 to modernize the publication of healthcare districts audited financials and align with current practice.
Status: 9/23/2021-Chaptered by Secretary of State. Chapter 224, Statutes of 2021.
Position: Support

Public Works & Facilities

AB 279 *Muratsuchi D* Intermediate care facilities and skilled nursing facilities: COVID-19.
Prohibits a Skilled Nursing Facility, Intermediate Care Facility, or Intermediate Care Facility from ceasing to deliver or making significant changes to the nature of residential care services, or from transferring a resident to another facility, during the COVID 19 emergency, except if the owner files for bankruptcy.
Status: 1/3/2022-Consideration of Governor's veto pending.
Position: Neutral

AB 1130 *Wood D* California Health Care Quality and Affordability Act.
Creates a state Office of Affordability.
Status: 7/14/2021-Failed Deadline pursuant to Rule 61(a)(11). (Last location was HEALTH on 6/16/2021)(May be acted upon Jan 2022)
Position: Oppose unless Amended

AB 1131 *Wood* *D* Health information network.
Establishes a single statewide health information network.
Status: 1/21/2022-Failed Deadline pursuant to Rule 61(b)(2). (Last location was APPR. SUSPENSE FILE on 1/15/2022)
Position: Oppose unless Amended

AB 1464 *Arambula* *D* Hospitals: seismic safety.
Requires hospitals to report to the Office of Statewide Health Planning and Development (OSHPD) services provided in buildings that have not met the 2030 state seismic mandate.
Status: 1/14/2022-Failed Deadline pursuant to Rule 61(b)(1). (Last location was 2 YEAR on 4/30/2021)
Position: Support

SB 371 *Caballero* *D* Health information technology.
Establishes a framework to leverage existing HIE networks by supporting interoperability for providers to advance to application of national standards for health information exchange and encourages the state to pursue funding these advancements.

Status: 7/14/2021-Failed Deadline pursuant to Rule 61(a)(11). (Last location was HEALTH on 6/3/2021)(May be acted upon Jan 2022)
Position: Support

SB 605 *Eggman* *D* Medical Device Right to Repair Act.
Requires manufacturers of critical medical equipment to provide parts and service information necessary for repair to hospital technicians and other independent repair providers on fair and reasonable terms.
Status: 1/21/2022-Failed Deadline pursuant to Rule 61(b)(2). (Last location was 2 YEAR on 5/25/2021)
Position: Support

SB 650 *Stern* *D* Skilled nursing facilities.
Requres a skilled nursing facility or operator of a skilled nursing facility to post their audited financials, with specified criteria.
Status: 10/4/2021-Approved by the Governor. Chaptered by Secretary of State. Chapter 493, Statutes of 2021.
Position: Neutral

Total Measures: 48
Total Tracking Forms: 48

1/26/2022 9:33:23 AM

Item 10.D

AAA 2022 Legislative Priorities

WRITTEN BY SHAWN-BAIRD ON JANUARY 26, 2022. POSTED IN BALANCE BILLING, COST DATA COLLECTION, GOVERNMENT AFFAIRS, LEGISLATIVE, MEDICAID.

Yesterday, the American Ambulance Association Board of Directors approved the Association's advocacy priorities for 2022. Our key initiatives reflect the challenges we face this year, including short-sighted threats to EMS balance billing, a worsening workforce shortage, the expiration of the temporary Medicare increases, and potential sequestration cuts.

We also continue to fight for you as you care for people first on the frontlines of the COVID-19 pandemic. We will sustain our efforts at securing additional funding for ground ambulance services to help address the increased costs of providing medical care and transport during the Public Health Emergency.

To achieve our collective goals, the AAA Board will need to mobilize the full voice of influence of the EMS community this year. If you have not already sent an email using the AAA advocacy system to your members of Congress, please do so today!

Staff will be reaching out to you at key points later in the year about letter writing for specific individual policy requests. But it is important that they hear from you now on all the top issues for ground ambulance services. They are:

Top AAA Advocacy Priorities for 2022

EMS WORKFORCE SHORTAGE

With the persistent shortage of ground ambulance service field personnel raising to a crisis level with the COVID-19 pandemic, the AAA moved the issue to a top policy priority. The AAA is currently working with key Congressional Committees of jurisdiction to hold hearings on the EMS workforce shortage. We are also developing legislation to specifically target increasing access for ground ambulance service organizations to federal programs and funding for the retention and training of health care personnel.

BALANCE BILLING

The AAA successfully educated the Congress on the role of local government oversight and other unique characteristics of providing ground ambulance service organizations. As a result, the Congress directed the establishment of a Ground Ambulance and Balance Billing Advisory Committee to address the issue. The Committee is in the process of being formed and then has 180 days in which to make recommendations to the Congress. The AAA will be involved with the Committee and advocating that the Congress implement policies that meet the needs of our members.

ADDITIONAL COVID-19 FINANCIAL ASSISTANCE

The AAA is advocating for additional financial assistance for ground ambulance service organizations to help address the increased costs of labor and other higher costs associated with providing health care during the COVID-19 pandemic.

MEDICARE AMBULANCE RELIEF

The temporary Medicare ambulance increases of 2% urban, 3% rural and the super rural bonus payment expire at the end of the year. The AAA will continue to push for passage of the provisions of the Preserving Access to Ground Ambulance Medical Services Act (S. 2037, H.R. 2454) before the provisions expire as well as for the adoption of language to ensure truly rural areas remain rural following changes to geographical designations based on the 2020 census.

SEQUESTRATION CUTS

The Congress delayed the additional 4% sequestration cut for only one yea. The AAA is working with other EMS and health care provider and supplier groups to permanently prevent the cut from going into effect as well as further extending the moratorium on the long-standing 2% cut.

AMBULANCE COST DATA COLLECTION

With the 2-year delay of ambulance data collection due to the pandemic, the Medicare Payment Advisory Committee (MedPAC) will have little to no data to analyze in March 2023 in which to make recommendations to the Congress on Medicare ambulance payment policy and rates. The AAA is asking the Congress to push back the date of the MedPAC report and also expand the modified data collection timeline of two years to the intended four years.

On behalf of my fellow board members, I again thank you for your continued membership and participation. We look forward to serving you for many years to come.

We also encourage all of our AAA members to contact their members of Congress through our online advocacy tool.

Should you have any questions regarding our advocacy priorities, please contact AAA Senior Vice President of Government Affairs Tristan North at tnorth@ambulance.org.

Item 10.D

CSDA Bill Tracking - Healthcare

AB 389 (Grayson D) **Ambulance services.**
Current Text: Chaptered: 10/5/2021
Introduced: 2/2/2021
Status: 10/4/2021-Approved by the Governor. Chaptered by Secretary of State - Chapter 460, Statutes of 2021.
Location: 10/4/2021-A. CHAPTERED
Summary:
The Prehospital Emergency Medical Care Personnel Act authorizes a local EMS agency to create one or more exclusive operating areas in the development of a local plan, if a competitive process is utilized to select the provider of the services pursuant to the plan, except as specified. This bill would specify that a county is authorized to contract for emergency ambulance services with a fire agency, as defined, that will provide those services, in whole or in part, through a written subcontract with a private ambulance service.

Position: Watch
Assigned: ATannehill
District Type: Fire
Subject Area: Health and Safety
Issues: Public Safety
Working Group: Governance
Public Notes: 3/8/2021 I-2/2/2021 to: Watch
CSDA SUMMARY:

AB 532 (Wood D) **Health care: fair billing policies.**
Current Text: Chaptered: 10/5/2021
Introduced: 2/10/2021
Status: 10/4/2021-Approved by the Governor. Chaptered by Secretary of State - Chapter 465, Statutes of 2021.
Location: 10/4/2021-A. CHAPTERED
Summary:
Current law requires a hospital, as defined, to maintain an understandable written policy regarding discount payments for financially qualified patients as well as a written charity care policy, and requires a hospital to negotiate the terms of a discount payment plan with an eligible patient, as specified. Current law requires each hospital to provide patients with written notice about the availability of the hospital's discount payment and charity care policies, including information about eligibility and contact information for a hospital employee or office from which the patient may obtain further information about the policies. This bill would additionally require the written patient notice to include the internet address of a specified health consumer assistance entity and information regarding Covered California and Medi-Cal presumptive eligibility.

Position: Watch
Assigned: AAvery, DGibbons
District Type: Hospital/Healthcare
Subject Area: Health and Safety
Issues: Healthcare
Working Group: Governance
Public Notes: 3/8/2021 I-2/10/2021 to: Watch

CSDA Bill Tracking - Healthcare

CSDA SUMMARY:

AB 789 (Low D) **Health care services.**
Current Text: Chaptered: 10/5/2021
Introduced: 2/16/2021
Status: 10/4/2021-Approved by the Governor. Chaptered by Secretary of State - Chapter 470, Statutes of 2021.
Location: 10/4/2021-A. CHAPTERED
Summary:
Current law provides for the licensure and regulation of health facilities and clinics, including primary care clinics, by the State Department of Public Health. A violation of these provisions is a crime. This bill would require an adult patient receiving primary care services in a facility, clinic, unlicensed clinic, center, office, or other setting, as specified, to be offered a screening test for hepatitis B and hepatitis C to the extent these services are covered under the patient's health insurance, based on the latest screening indications recommended by the United States Preventive Services Task Force, unless the health care provider reasonably believes certain conditions apply that include, among others, the patient lacks the capacity to consent to the screening test.

Position: Watch
Assigned: AAvery, DGibbons
District Type: Hospital/Healthcare
Subject Area: Health and Safety
Issues: Healthcare
Working Group: Governance
Public Notes: 3/8/2021 I-2/16/2021 to: Watch

CSDA SUMMARY:

AB 852 (Wood D) **Nurse practitioners: scope of practice: practice without standardized procedures.**
Current Text: Amended: 4/21/2021
Introduced: 2/17/2021
Status: 7/14/2021-Failed Deadline pursuant to Rule 61(a)(11). (Last location was B., P. & E.D. on 6/3/2021)(May be acted upon Jan 2022)
Location: 7/14/2021-S. 2 YEAR
Summary:
Current law authorizes a nurse practitioner who meets certain education, experience, and certification requirements to perform, in certain settings or organizations, specified functions without standardized procedures, including, but not limited to, conducting an advanced assessment; ordering, performing, and interpreting diagnostic procedures, as specified; and prescribing, administering, dispensing, and furnishing controlled substances. Current law, beginning January 1, 2023, authorizes a nurse practitioner to perform the functions described above without standardized procedures outside of the specified settings or organizations, in accordance with certain conditions and requirements, if the nurse practitioner holds an active certification issued by the board. This bill would refer to practice protocols, as defined, instead of individual protocols and would delete the requirement to obtain physician consultation in the case of acute decompensation of patient situation. The bill would revise the requirement to establish a

referral plan, as described above, by requiring it to address the situation of a patient who is acutely decompensating in a manner that is not consistent with the progression of the disease and corresponding treatment plan.

Position: Support 3
Assigned: ATannehill
District Type: Hospital/Healthcare
Subject Area: Health and Safety
Issues: Healthcare
Working Group: Human Resources
Public Notes: 3/26/2021 I-2/17/2021 to: Support 3
CSDA SUMMARY: This bill updates the laws governing nurse practitioners scope of practice that were passed with ACHD and CSDA support last year to refer to practice protocols instead of individual protocols provided by a physician and would delete the requirement to obtain physician consultation in the case of acute decompensation of patient situation. (*updated 8.3.21*)

AB 1071 **(Rodriguez D) Office of Emergency Services: tabletop exercises.**
Current Text: Amended: 6/28/2021
Introduced: 2/18/2021
Status: 9/10/2021-Failed Deadline pursuant to Rule 61(a)(15). (Last location was APPR. SUSPENSE FILE on 7/15/2021)(May be acted upon Jan 2022)
Location: 9/10/2021-S. 2 YEAR
Summary:
Current law establishes the Office of Emergency Services (OES) within the office of the Governor and sets forth its powers and duties relating to responsibility over the state's emergency and disaster response services for natural, technological, or manmade disasters and emergencies, including responsibility for activities necessary to prevent, respond to, recover from, and mitigate the effects of emergencies and disasters to people and property. This bill would require OES to biennially convene key personnel and agencies that have emergency management roles and responsibilities to participate in tabletop exercises in which the participant's emergency preparedness plans are discussed and evaluated under various simulated catastrophic disaster situations, as specified.

Position: Watch
Assigned: ASilhi
District Type: General
Subject Area: Health and Safety
Issues: Public Safety
Working Group: Governance
Public Notes: 3/29/2021 A-3/25/2021 to: Watch
CSDA SUMMARY:

AB 1229 **(Rodriguez D) Advisory task force: ambulance services.**
Current Text: Amended: 4/19/2021
Introduced: 2/19/2021

CSDA Bill Tracking - Healthcare

Status: 9/10/2021-Failed Deadline pursuant to Rule 61(a)(15). (Last location was APPR. SUSPENSE FILE on 5/12/2021)(May be acted upon Jan 2022)
Location: 9/10/2021-A. 2 YEAR
Summary:
Would require the Director of the Emergency Medical Services Authority to appoint and convene an advisory task force, and would further require the director to recommend a project plan for the advisory task force that includes an evaluation relating to ambulance patient offload delays due to the COVID-19 pandemic, as specified, and an evaluation of adopting technologies to allow EMS systems to better manage resources and improve response times. The bill would require the director to transmit the evaluations conducted by the advisory task force to the authority, in a manner that allows for their timely inclusion in an existing reporting requirement from the authority to the Commission on Emergency Medical Services, and to specified legislative committees.

Position: Watch
Assigned: ATannehill
District Type: Fire, Hospital/Healthcare
Subject Area: Health and Safety
Issues: Public Safety
Working Group: Governance
Public Notes: 3/29/2021 I-2/19/2021 to: Watch
CSDA SUMMARY:

AB 1400 (Kalra D) **Guaranteed Health Care for All.**
Current Text: Amended: 1/24/2022
Introduced: 2/19/2021
Status: 1/25/2022-Read second time. Ordered to third reading.
Location: 1/25/2022-A. THIRD READING
Summary:
Current law provides for the regulation of health insurers by the Department of Insurance. Current law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. The bill, among other things, would provide that CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including the federal Children's Health Insurance Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program.

Assigned: AAvery
District Type: General, Hospital/Healthcare
Subject Area: Health and Safety
Issues: Healthcare

CSDA Bill Tracking - Healthcare

Working Group: Human Resources
Public Notes: 1/12/2022 I-2/19/2021 to:

CSDA SUMMARY:

AB 1585 **(Committee on Health) Health care.**
Current Text: Chaptered: 9/16/2021
Introduced: 3/11/2021
Status: 9/16/2021-Approved by the Governor. Chaptered by Secretary of State - Chapter 181, Statutes of 2021.
Location: 9/16/2021-A. CHAPTERED
Summary:
Current law provides for the licensure and regulation of health facilities, including skilled nursing facilities, by the State Department of Public Health. Current law requires a skilled nursing facility to have a full-time, dedicated Infection Preventionist (IP), who is a registered nurse or licensed vocational nurse. A violation of these provisions is a misdemeanor. This bill would revise the required qualifications for the IP to require an IP to have primary professional training as a licensed nurse, medical technologist, microbiologist, epidemiologist, public health professional, or other health care related field.

Position: Watch
Assigned: AAvery, DGibbons
District Type: Hospital/Healthcare
Subject Area: Health and Safety
Issues: Healthcare
Working Group: Governance
Public Notes: 4/30/2021 A-4/5/2021 to: Watch

CSDA SUMMARY:

ACA 11 **(Kalra D) Taxes to fund health care coverage and cost control.**
Current Text: Introduced: 1/5/2022
Introduced: 1/5/2022
Status: 1/6/2022-From printer. May be heard in committee February 5.
Location: 1/5/2022-A. PRINT
Summary:
Would impose an excise tax, payroll taxes, and a State Personal Income CalCare Tax at specified rates to fund comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of every resident of the state, as well as reserves deemed necessary to ensure payment, to be established in statute. The measure would authorize the Legislature, upon an economic analysis determining insufficient amounts to fund these purposes, to increase any or all of these tax rates by a statute passed by majority vote of both houses of the Legislature.

Assigned: AAvery
District Type: Hospital/Healthcare
Subject Area: Health and Safety
Issues: Healthcare
Working Group: Human Resources

CSDA Bill Tracking - Healthcare

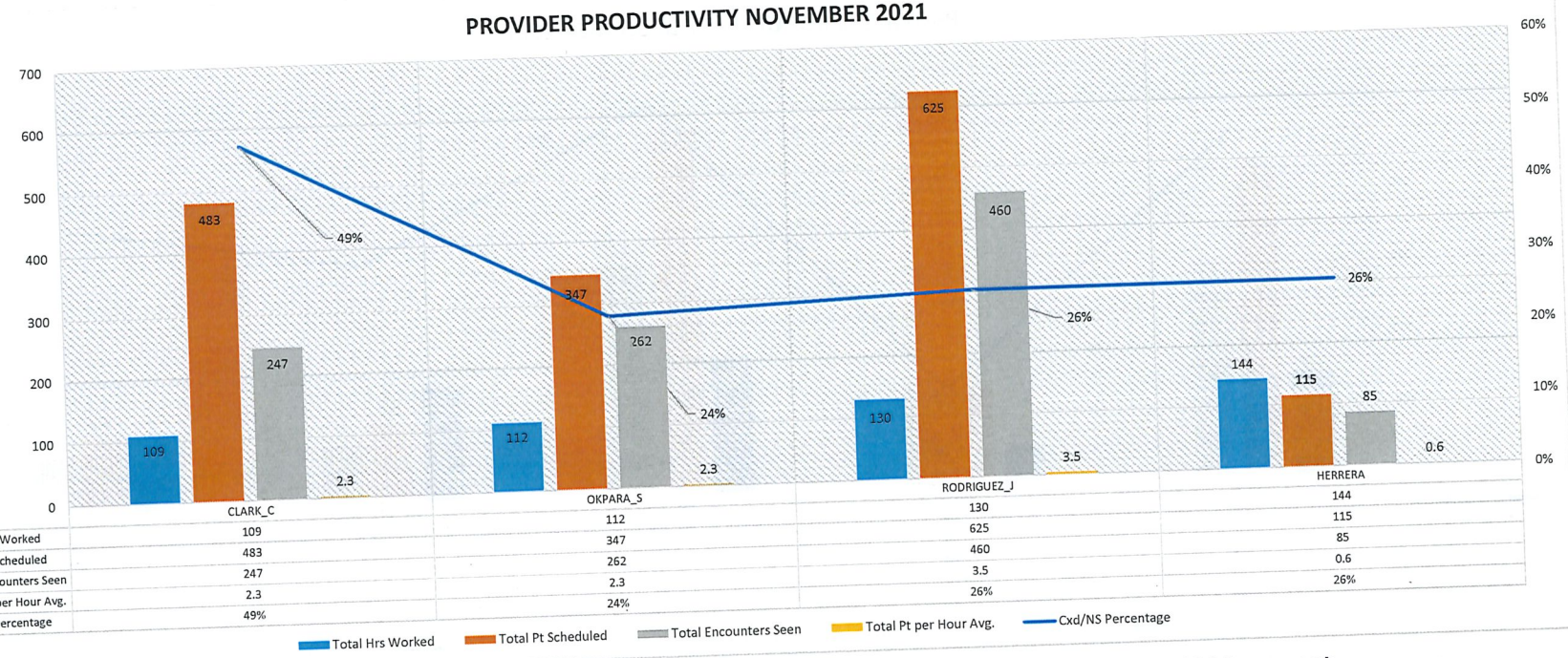
Public Notes: 1/12/2022 I-1/5/2022 to:
CSDA SUMMARY:

SB 418 (Laird D) **Pajaro Valley Health Care District.**
Current Text: Amended: 1/24/2022
Introduced: 2/12/2021
Status: 1/25/2022-Read second time. Ordered to third reading.
Location: 1/25/2022-A. THIRD READING
Summary:
Existing law, the Cortese-Knox-Hertzberg Local Government Reorganization Act of 2000, provides the authority and procedures for the initiation, conduct, and completion of changes of organization and reorganization of cities and districts by local agency formation commissions.This bill would create the Pajaro Valley Health Care District, as specified, except that the bill would authorize the Pajaro Valley Health Care District to be organized, incorporated, and managed, only if the relevant county board of supervisors chooses to appoint an initial board of directors. This bill contains other related provisions.
Attachments:
Senate Bill 418 (Laird) Asm Local Government Committee - Support
Senate Bill 418 (Laird) Author - Support

Position: Support 3
Assigned: ATannehill
District Type: Hospital/Healthcare
Subject Area: Formation and Reorganization, Health and Safety
Issues: Healthcare
Working Group: Formation
Public Notes: 1/18/2022 A-1/14/2022 to: Support 3
CSDA SUMMARY:

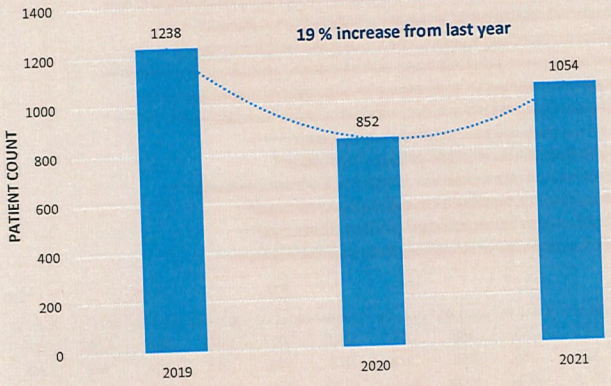
Item

PROVIDER PRODUCTIVITY NOVEMBER 2021

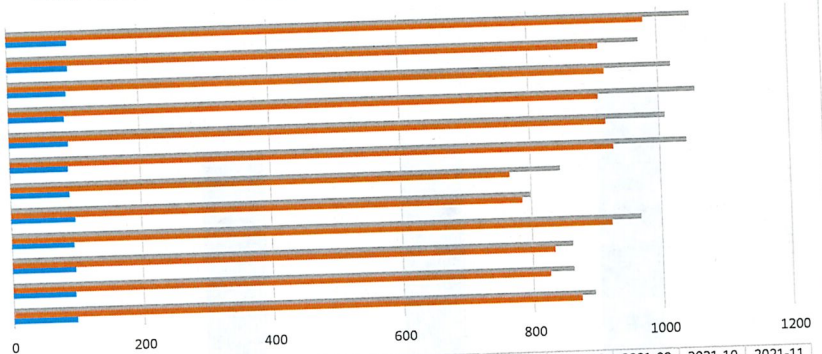


	CLARK_C	OKPARA_S	RODRIGUEZ_J	HERRERA
Total Hrs Worked	109	112	130	144
Total Pt Scheduled	483	347	625	115
Total Encounters Seen	247	262	460	85
Total Pt per Hour Avg.	2.3	2.3	3.5	0.6
Cxd/NS Percentage	49%	24%	26%	26%

TOTAL PATIENTS NOVEMBER 2019-2021



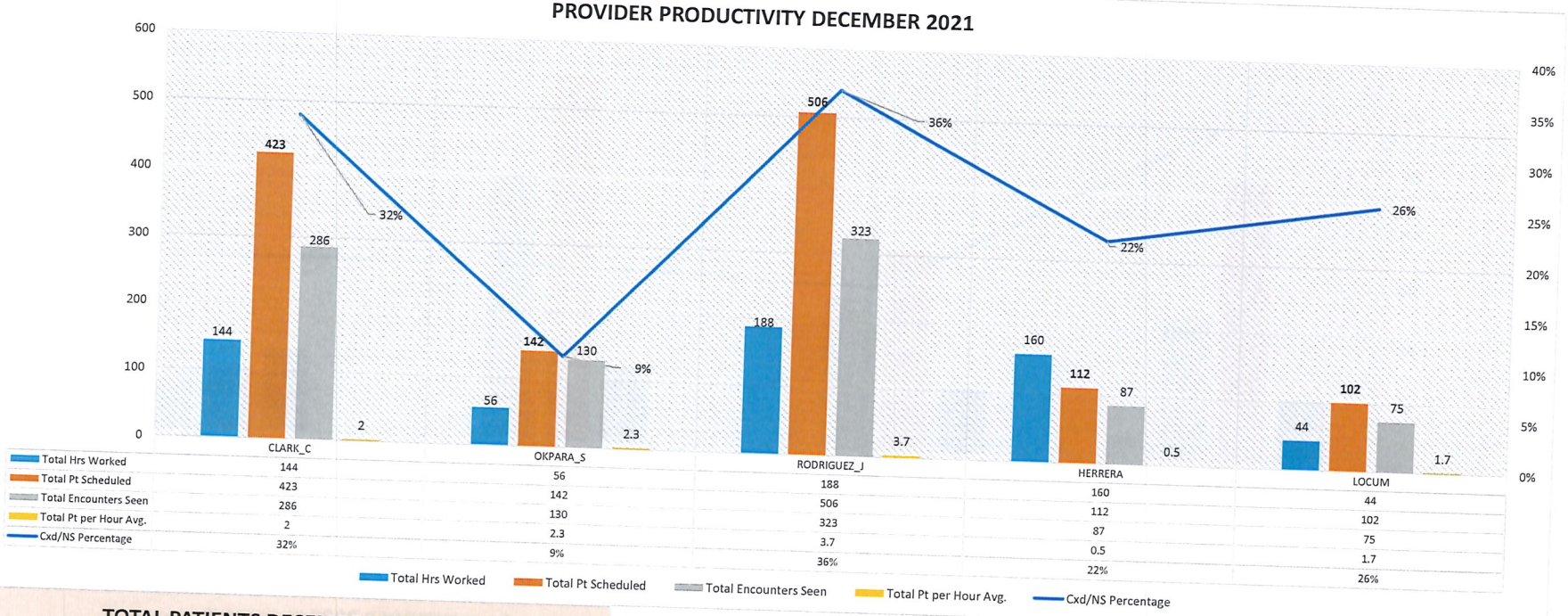
Total Encounters from OCTOBER 2020 to present



	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11
Total Encounters	895	863	862	969	799	846	1,042	1,010	1,057	1,021	972	1,052
Same Day Closes	874	827	835	924	786	768	929	918	908	918	910	980
Same Day Encounter Close Rate	97.65	95.83	96.87	95.36	98.37	90.78	89.16	90.89	85.9	89.91	93.62	93.16

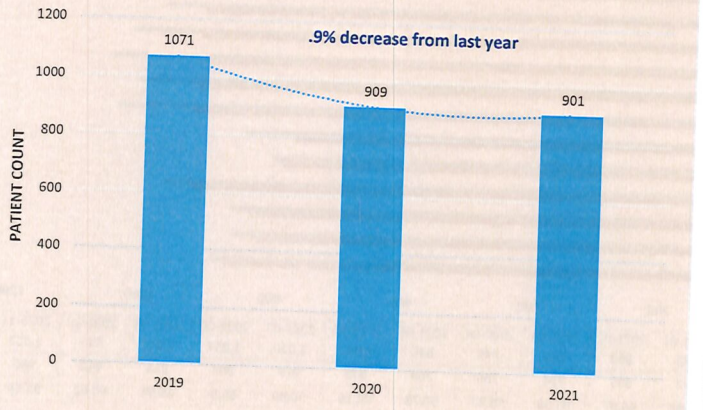
Total Encounters Same Day Closes Same Day Encounter Close Rate

PROVIDER PRODUCTIVITY DECEMBER 2021

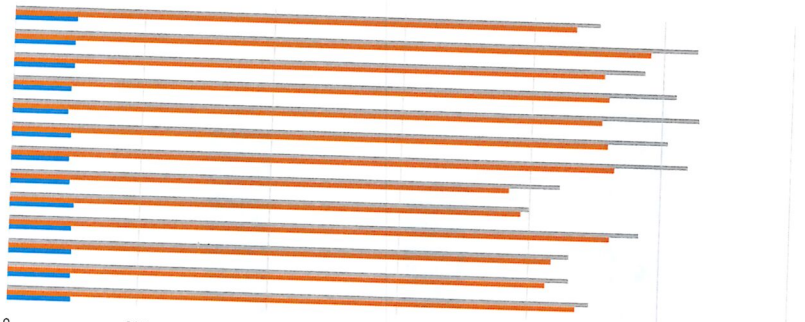


	CLARK_C	OKPARA_S	RODRIGUEZ_J	HERRERA	LOCUM
Total Hrs Worked	144	56	188	160	44
Total Pt Scheduled	423	142	506	112	102
Total Encounters Seen	286	130	323	87	75
Total Pt per Hour Avg.	2	2.3	3.7	0.5	1.7
Cxd/NS Percentage	32%	9%	36%	22%	26%

TOTAL PATIENTS DECEMBER 2019-2021



Total Encounters from OCTOBER 2020 to present



	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
Total Encounters	895	863	862	969	799	846	1,042	1,010	1,057	1,021	972	1,052	901
Same Day Closes	874	827	835	924	786	768	929	918	908	918	910	980	865
Same Day Encounter Close Rate	97.65	95.83	96.87	95.36	98.37	90.78	89.16	90.89	85.9	89.91	93.62	93.16	96.11

Total Encounters Same Day Closes Same Day Encounter Close Rate

Item 10.1

Del Puerto Health Care District

PHS Alumni, Jessica Herrera serves community at Del Puerto Health Care Center

Neil Vento

Jan 27, 2022

Del Puerto Health Care Center has started to provide Behavioral Health Services Programs to go alongside its many other services it offers the Patterson community. The program, which is designed to provide support for patients who may be experiencing mental health troubles such as anxiety and depression, is overseen by Patterson High School class of 2010 Alumni, Jessica Herrera.

"I am a Licensed Clinical Social Worker here at Del Puerto Health Center," said Herrera. "Essentially, when the doctors have patients that they have screened for certain mental health concerns, they are given the option [to see me]."

Herrera says that she provides therapy and assessments for patients and together they start working towards a goal and treatment which usually lasts about five months.

"[During the assessment]. I'll learn about what their stressors are, what they are concerned about and we create a goal and focus on treatment," said Herrera. "I also provide case management for people who may need it and community resources. It's not just mental health."

A class of Patterson High School 2010 graduate, Herrera and her family moved to Patterson from the Bay Area in 2007. She played soccer all four years at PHS and afterwards she attended UC Santa Cruz where she graduated with her Bachelors in Sociology before heading off to graduate school in Los Angeles.

"I got my Masters in Social Work from CSU Long Beach. Then after that I had to complete clinical supervised hours to then take my exam to become a licensed clinical social worker."

Herrera found herself interested in helping others after receiving help herself at the young age of thirteen.

"I actually received counseling when I was younger. I participated in therapy and I think that experience for me was a very positive one. I learned a lot about myself and how to communicate with my family. I felt freedom to express myself without judgment and I knew I wanted to do something very similar where I could help."

Before starting at Del Puerto Health, Herrera worked for Stanislaus County under the Behavioral Health and Recovery Services sector through the Juvenile Justice Program. After her time there, she provided mental health services for a non-profit in Los Angeles where she got to work with at-risk youth.

"I started working with kids right before my Masters program and I knew that was the population that I wanted to work with."

Now, Herrera finds herself in one her most rewarding positions, serving the Patterson community.

"It's been pretty great so far because I am from here and I do see a lot of familiar faces. I think it's pretty awesome that I get to work with some of my acquaintances' kids and I think that because it's such a small-knit community, it feels very welcoming."

While Herrera enjoys working with the youth, her services don't stop there. Her patients range in age from six years to older adults.

"I work with a whole range of populations and I think it's such a great value to experience working with different populations."

Patients of the Del Puerto Health Center have another asset to add to the plethora of resources that are already available to them.

"Mental health is as important as our physical health, and at times it's intertwined. Small things like regularly checking-in with our emotions, engaging in meaningful activities and exercise can go a long way in maintaining our health," said Herrera. "Let's continue to talk about mental health to break down the stigmas and encourage people to talk about their experience and obtain unconditional support and guidance to improve wellbeing."

Del Puerto Health Center is located at 1700 Keystone Pacific Parkway, Unit B and is part of the Del Puerto Health Care District which provides healthcare to the community through its Health Center and Patterson District Ambulance. For more information on what they do, and how they can help, please visit: www.dphealth.org.

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Local boards are the reason, and really the only reason, why local control is local. Special district boards are the voices of the community. The truth is that every elected or appointed public official needs to worry about governance because governance is what boards do. It's what they bring to the table. Governance is taking the wishes, needs, and desires of the community and transforming them into policies that govern the district. Survival of special districts depends in large part on how well run the boards are.

Attendees will learn:

- How to work as a team
- The roles of board and staff
- Attributes and characteristics of highly effective boards
- How culture, norms, values, and operating style influence the district
- Specific jobs the board must perform
- How individual values, skills, and knowledge help to shape how effective boards operate
- The importance of moving from "I" to "we" as the governance team
- The board's role in setting direction for the district; the board's role in finance and fiscal accountability
- And more!

COST

EARLY BIRD REGISTRATION*		REGULAR REGISTRATION	
CSDA Member	$600	CSDA Member	$675
Non-member	$900	Non-member	$1,010

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CSDA Member	$400	CSDA Member	$475
Non-member	$600	Non-member	$715

HOTEL ROOM RESERVATIONS

SAN DIEGO - Room reservations are available at the CSDA rate of $181 plus tax, single or double occupancy. The room reservation cut off is March 3, 2022; however, space is limited and may sell out before this date.

NAPA - Room reservations are available at the rate of $189 plus tax, single or double occupancy. The room reservation cut-off is August 29, 2022; however, space is limited and may sell out before this date.

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Information can be found in the *Workshop* section of this catalog, beginning on page 16, indicated by an SDLA logo, The cost to attend each module is:
$175 CSDA Member
$260 Non-member

SDLA Module 1 - Governance Foundations
February 16 and 17, 2022 (9:00 a.m. – 3:30 p.m. each day)

SDLA Module 2 - Setting Direction / Community Outreach
March 9 and 10, 2022 (9:00 a.m. – 12:00 p.m. each day)

SDLA Module 3 - Board's Role in Finance and Fiscal Accountability
April 18 and 19, 2022 (9:00 a.m. – 12:00 p.m. each day)

SDLA Module 4 - Board's Role in Human Resources
May 4 and 5, 2022 (9:00 a.m. – 12:00 p.m. each day)

SDLA