DESERT HEALTHCARE DISTRICT
BOARD MEETING
Board of Directors
October 27, 2020
5:30 P.M.

In accordance with the current State of Emergency and the Governor's Executive Order N- 25-20, of March 12, 2020, revised on March 18, 2020, teleconferencing will be used by the Board members and appropriate staff members during this meeting. In lieu of attending the meeting in person, members of the public will be able to participate by webinar by using the following link:
https://us02web.zoom.us/j/86502382178?pwd=eTdBeVM4ZUdOZ0dObFdKMTFqWmJoQT09
Password: 420834
Participants will need to download the Zoom app on their devices. Members of the public may also be able to participate by telephone, using the follow dial in information:
Dial in #: (669) 900-6833 To Listen and Address the Board when called upon:
Webinar ID: 865 0238 2178
Password: 420834

You may also email ahayles@dhcd.org with your public comment no later than 4 p.m., Tuesday, 10/27.

Page(s)	AGENDA *Any item on the agenda may result in Board Action*	*Item Type*
	A. CALL TO ORDER – President De Lara Roll Call ____Director Shorr____Director Zendle, MD____Director PerezGil____ Director Rogers, RN____ Director Matthews____ Vice-President/Secretary Borja____President De Lara	
	B. PLEDGE OF ALLEGIANCE	
1-3	**C. APPROVAL OF AGENDA**	**Action**
	D. PUBLIC COMMENT At this time, comments from the audience may be made on items *not* listed on the agenda that are of public interest and within the subject-matter jurisdiction of the District. **The Board has a policy of limiting speakers to no more than three minutes.** The Board cannot take action on items not listed on the agenda. Public input may be offered on agenda items when they come up for discussion and/or action.	
	E. CONSENT AGENDA All Consent Agenda item(s) listed below are considered routine by t Board of Directors and will be enacted by one motion. There will be no separate discussion of items unless a Board member so requests, in which event the item(s) will be considered following approval of the Consent Agenda.	**Action**

1. BOARD MINUTES

4-18 a. Board of Directors – September 22, 2020

19-21 b. Special Meeting of the Board of Directors Workshop – September 23, 2020

2. FINANCIALS

22-45 a. Approval of the September 2020 Financial Statements – F&A Approved October 13, 2020

F. DESERT HEALTHCARE DISTRICT CEO REPORT – Conrado E. Bárzaga, MD

46-125	1. Local Area Formation Commission (LAFCO) Municipal Services Review (MSR) Review Update and Recommendation – file:///C:/Users/andre/Downloads/5.b.%20LAFCO%202019-12-3,4&5-%20Countywide%20MSR%20&%20SOI%20HCDs%20(1).pdf	Information
126-127	2. Consideration to authorize the CEO to apply for a vacancy and appointment to the Association to of California Healthcare Districts (ACHD) Board of Directors	**Action**
128-129	3. Coordination of Efforts to Ensure Community Access to COVID-19 Testing and Healthcare	Information
130	4. Community Health Needs Assessment and Health Improvement Plan Focus Groups Update	Information
131	5. Lift to Rise Rental Assistance Program Update	
	6. Consideration to appoint Director Les Zendle, MD and Director Carole Rogers, RN to the Desert Regional Medical Center (DRMC) Governing Board of Directors	**Action**
	7. Housing as a Social Determinant of Health Workshop – November 5, 2020	Information
132	8. California Special Districts Association (CSDA) and Association of California Healthcare Districts (ACHD) Joint Virtual Legislative Tour – December 8	Information
	9. Greater Coachella Valley Chamber of Commerce Candidate Forum	Information

G. DESERT REGIONAL MEDICAL CENTER CEO REPORT – Michele Finney, CEO — Information

H. DESERT REGIONAL MEDICAL CENTER GOVERNING BOARD OF DIRECTORS REPORT – Director Les Zendle, MD, and Director Carole Rogers, RN — Information

I. 1. PROGRAM COMMITTEE – Chair/Director Evett PerezGil, Vice-President Karen Borja, and Director Carol Rogers, RN

133-137	1. Draft Meeting Minutes – October 13, 2020	Information
138-144	2. Funding Requests	Information
145-156	3. Progress and Final Report Schedule	Information
157	4. Grants Payment Schedule	Information
	5. Policy Map – Website Placement	Information

	2.	**FINANCE, LEGAL, ADMINISTRATION & REAL ESTATE COMMITTEE –** Chair/Treasurer Mark Matthews, President Leticia De Lara, and Director Arthur Shorr	
158-161	1.	Draft Meeting Minutes – October 13, 2020	Information
162	2.	Gary Dack, Managing Partner, Lund & Guttry LLP – FY 2020 Audit Reports – District & Retirement Protection Plan (RPP)	Information
163-167	a.	Communication Letter & Internal Controls Report	Information
168-211	b.	District Audit Report	**Action**
212-229	c.	Retirement Protection Plan Audit Report	**Action**
230-243	d.	Desert Healthcare Foundation (Informational Purposes)	Information
244-246	3.	LPMP Landscape Renovation and Fire Alarm Electrical Re-bidding	Information
	J.	**OLD BUSINESS**	
	1.	Workshop and Training on Governance and Policies – Upcoming Board and Staff & Communications Policies Committee – November 9, 2020	Information
247-250	2.	Coachella Valley Association of Governments (CVAG) – CV Link Q3 Quarterly Progress Report	Information
	K.	**NEW BUSINESS**	
	1.	Communications and Media Updates	
	a.	DHCD and Volunteers In Medicine (VIM) Eastern Coachella Valley Vaccination Event	Information
	b.	DHCD and Borrego Health Alpha Media COVID-19 Live Stream Event	Information
	L.	**LEGAL**	
251-253	1.	Legislative Update – SB 855: Wiener: Health Coverage for Mental Health and Substance Abuse Disorder	Information
	M.	**IMMEDIATE ISSUES AND BOARD COMMENTS**	
	N.	**ADJOURNMENT**	

If you have any disability which would require accommodation to enable you to participate in this meeting, please email Andrea S. Hayles, Special Assistant to the CEO and Board Relations Officer, at ahayles@dhcd.org or call (760) 323-6110 at least 24 hours prior to the meeting.

DESERT HEALTHCARE DISTRICT
BOARD OF DIRECTORS MEETING MINUTES
MEETING MINUTES
September 22, 2020

Directors Present – Video Conference	District Staff Present – Video Conference	Absent
President Leticia De Lara Vice-President/Secretary Karen Borja Treasurer Mark Matthews Director Carole Rogers, RN Director Les Zendle, MD Director Arthur Shorr	Conrado E. Bárzaga, MD, CEO Chris Christensen, CAO Donna Craig, Chief Program Officer Will Dean, Marketing and Communications Director Alejandro Espinoza, Program Officer and Outreach Director Eric Taylor, Accounting Manager Meghan Kane, Programs and Research Analyst Vanessa Smith, Special Projects and Program Manager Erica Huskey, Administrative and Program Assistant Andrea S. Hayles, Clerk of the Board <u>Legal Counsel</u> Jeff Scott	Director Evett PerezGil

AGENDA ITEMS	DISCUSSION	ACTION
A. Call to Order **Roll Call**	President De Lara called the meeting to order at 5:30 p.m. The Clerk of the Board called the roll with all Directors' present except Director PerezGil.	
B. Pledge of Allegiance	President De Lara asked those in attendance to join in the Pledge of Allegiance.	
C. Approval of Agenda	President De Lara asked for a motion to approve the agenda.	**#20-91 MOTION WAS MADE by Director Zendle and seconded by Director Matthews to approve the agenda.** **Motion passed unanimously.** **AYES – 6 President De Lara, Vice-President Borja, Director Matthews, Director Rogers, Director Zendle, and Director Shorr** **NOES – 0** **ABSENT – 1 Director PerezGil**

D. Public Comment	There was no public comment for items not listed on the agenda.	
Consent Agenda **1. BOARD MINUTES** **a. Board of Directors – July 28, 2020** **b. Special Meeting of the Board of Directors – August 25, 2020** **2. FINANCIALS** **a. Approval of the July and August 2020 Financial Statements – F&A Approved September 08, 2020** **3. LAS PALMAS MEDICAL PLAZA** **a. Service Agreement Addendum - Magdalena Martinez dba Personnel 411 HR Consulting – $833.33 per month** **b. LPMP Lease Agreement – LABCORP – 3 Year Lease** **c. LPMP – Early Lease Termination Agreement – Dennis Spurgin** **d. LPMP - Temporary Lease Agreement – Arrowhead Evaluation Services, Inc.**	President De Lara asked for a motion to approve the consent agenda with the Clerk of Board noting corrections to the August 25, Special Meeting of the Board Minutes for Motion 20-96 passing 5-2 with Director Zendle abstaining.	**#20-92 MOTION WAS MADE by Director Shorr and seconded by Director Rogers to approve the consent agenda with the amendment to the minutes. Motion passed unanimously.** **AYES – 6 President De Lara, Vice-President Borja, Director Matthews, Director Rogers, Director Zendle, and Director Shorr** **NOES – 0** **ABSENT – 1 Director PerezGil**
F. Desert Healthcare District CEO Report **1. Local Area Formation Commission (LAFCO) Municipal Services Review (MSR) Review Update** **2. Coordination of DHCD efforts to ensure community access**	Conrado E. Bárzaga, MD, CEO, described the update of the Local Area Formation Commission (LACFO) Municipal Services Review and the comprehensive report of the District and Desert Regional Medical Center. Dr. Bárzaga, CEO, explained the access to healthcare by federally qualified health	

to COVID-19 testing and healthcare	centers (FQHC) for COVID-19 testing, describing the stigma and legal liabilities with the farm working community and coordination with other community partners. Director Zendle thanked the CEO and recommended the polymerase chain reaction (PCR) tests that is used by the county, obtaining the testing numbers, a narrative from the county on how they are using the information, if it's helpful in the District's role, and antidotes of the positive effects of community members testing, such as positive tests, isolation, and treatment. Stories from the community could assist others, explaining the possibility of inviting them to the next Board meeting. President De Lara thanked Director Zendle and the CEO for the recent editorial on testing to inform the community, including the meeting hosted by the County Supervisor for input and questions, and highlighting the need for policies with the safety and the health of the public as the number one priority.	
3. Community Health Needs Assessment and Health Improvement Plan – Timeline Update	Dr. Bárzaga, CEO, explained that Health Assessment and Research for Communities (HARC) has begun to engage the community with focus	

	groups that are coordinated and scheduled. A rough draft report is available for guidance on the facts and data, how the community will react to the data, and to continue working with community participation as much as possible. President De Lara explained that she reached out to the CEO concerning involvement and if the Board has thoughts about organizations or individuals that are not included in the focus groups to contact the CEO. Director Zendle inquired on outreach to city council members and other elected officials to provide feedback with Dr. Bárzaga explaining that the school districts have been contacted, and he will discuss other mechanisms with HARC.	
4. Regional Access Project Foundation (RAP) COVID-19 Emergency Collaborative Update	Dr. Bárzaga, CEO, explained the organizations benefiting from the Regional Access Projects' (RAP) COVDI-19 emergency collaborative funding and the funding impact with organizational operations.	
5. DHCD 20-Year Historical Grant Report	Dr. Bárzaga, CEO, provided an overview of the District's 20-year historical grant report, explaining that staff has worked on the report, which is available to the public and	

	published on the website. Approximately $80M in grants has been awarded to the community over 20-years.	
5. Lift to Rise Rental Assistance Program – Updates and Enrollment Events	Dr. Bárzaga, CEO, described the report that Lift to Rise provided to address the economic instability due to COVID-19, securing over $13M, and distributing $1M to over 4,000 households. Alejandro Espinoza, Program Officer and Outreach Director is working with Lift to Rise and is assisting with reviewing applications and providing feedback to the community. Public Comments: Tayor Libolt Varner, Regional and Affordable Housing Planner, Lift to Rise, thanked the District and Board, explaining the high housing costs and personal struggles of the rent burdened. Rubyd Olvera, Community and Engagement Coordinator, Lift to Rise, extended her gratitude to the District for their support as an option during the pandemic. Heather Vaikona, President & CEO, reiterated the comments of the Lift to Rise staff and thanked Alejandro Espinoza, Program Officer and Outreach Director, for his assistance.	

7. Association of California Healthcare Districts (ACHD) Annual "Virtual" Meeting – September 23-25	Dr. Bárzaga, CEO, described the Association of California Healthcare Districts (ACHD) virtual annual meeting taking place this week.	
8. Special Meeting of the Board – Board and Communications Workshop with Rauch Communications – September 23	Dr. Bárzaga, CEO, provided an overview of the upcoming Workshop on Board development and governance in terms of working together, and programs to respond to the needs of the community.	
9. California Special Districts Association (CSDA) – DHCD Certification Presentation, Chris Palmer, Senior Public Affairs Field Coordinator, CSDA	Dr. Bárzaga, CEO, explained the California Special Districts Association (CSDA) certification program the District recently received, introducing Chris Palmer, Senior Public Affairs Field Coordinator, CSDA. Mr. Palmer described the requirements listed on the District's website, such as the financials, Board minutes, and packets, and going above and beyond with the District's outreach with emails to the constituents and community members, including transparency and accountability. On behalf of the CSDA, Mr. Palmer presented the District with its certificate of certification. President De Lara thanked the staff and the community for their work and interest in the District's endeavors.	
G. Desert Regional Medical Center CEO Report	Michele Finney, CEO, Desert Care Network, Desert Regional	

	Medical Center, provided an update explaining the fabulous work of the District and congratulating to the Board and Staff on their CSDA certification. The COVID positivity and PUI census are in the single digits, there is not an influx from the holiday, and several units have returned to standard operations. Pediatrics reopened to admissions and is currently staffed with Loma Linda University Medical Center pediatric hospitalist. The Acute Rehab Unit was moved back to its home location, and the Family Residence program is resuming the backpack medicine program and visiting those in need at parks and churches. DRMC welcomed a new Assistant Chief Nursing Officer, Kathleen Moore, with 20-years of ICU, ED, and Pediatrics experience. Ms. Moore will focus on working with the Quality and Safety Officers on clinical practice and protocol advancement to elevate the overall practice of nursing. The county is moving from Tier 1 to Tier 2 for reopening with DRMC monitoring the trend and reevaluating some of the visitor restrictions, including tier two's impact. The Emergency Room refurbishment with paint, flooring, and laminates is nearing completion. As the flu season approaches, DRMC is	

	partnering with the county and other health care facilities to stress the importance of the flu vaccination, which is strongly recommended as appropriate. DRMC will be vaccinating the hospital employees and physicians starting October 5. Early indications are counties that couple flu vaccinations with masking, distancing, and handwashing are, thus far, experiencing a mild flu season. Historically, only 45% of U.S. adults receive the vaccination, and everyone needs to do their part to avoid a possible Twin-Demic. Symptoms of the flu and COVID have many similarities; thus, DRMC is prepared to test for both. Director Rogers explained the county tiers and shared a press release from the city of Palm Springs detailing the colored tiers. Greg Rodriguez, Government Relations and Public Policy Advisor, Supervisor Perez's Office, explained that over 100 people attended the Supervisor's meeting concerning reopening the economy, and the matter may be on the agenda at the October 6 meeting.	
H. Desert Regional Medical Center Governing Board of Directors Report	Director Rogers provided an overview of the Governing Board meeting explaining that the meeting agenda items for financial standards, quality	

	reports, medical staffing, and the new approval of Dr. Levinsons' credentials to the psychiatry staff for behavioral health purposes. The four tiers from Riverside County have explained, as well as the news release from the city of Palm Springs.	
I.1. Program Committee **1. Draft Meeting Minutes - September 08, 2020** **2. Funding Requests** **3. Progress and Final Report** **4. Grants Payment Schedule**	Donna Craig, Chief Program Officer, inquired on any questions concerning the meeting minutes, explaining the funding requests withdrawals due to operations and COVID. Vice-President Borja explained the committees request to add a line item for the grant program funding strategic areas.	
5. Consideration to approve Grant #1139 – California State University San Bernardino Palm Desert Campus (CSUSB-PD) Street Medicine Program - $50,000	Donna Craig, Chief Program Officer, described the one-year project for the nursing students, the street medicine partnerships, program outreach, and learning and reaching out to vulnerable populations.	**#20-93 MOTION WAS MADE by Director Zendle and seconded by Director Borja to approve Grant #1139 – California State University San Bernardino Palm Desert Campus (CSUSB-PD) Street Medicine Program - $50,000 Motion passed unanimously. AYES – 6 President De Lara, Vice-President Borja, Director Matthews, Director Rogers, Director Zendle, and Director Shorr NOES – 0 ABSENT – 1 Director PerezGil**
I.2. Finance & Administration **1. Draft Meeting Minutes – September 08, 2020**	Director Matthews described the F&A Committee meeting minutes, explaining the Retirement Protection Plan Actuarial Valuation Report,	

2. Retirement Protection Plan - Actuarial Valuation Report – June 30, 2020	and the other matters approved in the consent agenda.	
3. Consideration to approve the Consulting Services Agreement – Strategies 360 – Voter Education Project – NTE $30,000	Director Matthews explained the failed motion in the F&A Committee meeting, permitting Dr. Bárzaga, CEO, to describe the specifics of the consulting services agreement. Dr. Bárzaga described the specifics of the consulting services agreement discussed in the F&A Committee, and at the request of the Board, with Vice-President Borja's recommendation to use $30k of unexpended funding for the unopposed zones towards District education in Zone 3. Public Comments: Heather Vaikona, President and CEO, Lift to Rise, described the disconnect on the ballot, discissions that affect the Valley long-term, the sense of confusion, fear of going to the polls, and she supports the use of funding for educating the public. After a lengthy discussion as a responsible authority, voting safely, involvement in the District, staff's past education in the community not associated with the election, educating in the entire District boundaries, the timing and impact, sponsoring a virtual town hall meeting on	**#20-94 MOTION WAS MADE by Director Rogers and seconded by Vice-President Borja to approve Consulting Services Agreement – Strategies 360 – Voter Education Project – NTE $30,000** **Motion failed 3-3.** **AYES – 3 President De Lara, Vice-President Borja, and Director Rogers** **NOES – 3 Director Matthews, Director Zendle, and Director Shorr** **ABSENT – 1 Director PerezGil**

	education with members of the community providing feedback, and the importance of educating the community, Director Rogers motioned to approved the service agreement with Strategies 360.	
J. Old Business **1. 2020 Census – Coachella Valley – September 30, count end date**	Barrett Newkirk, Communications Manager, Alianza, described the response rate, the goal of reaching the 2010 response rate, especially in the Valley due to the challenges with this particular Census, such as fears with citizenship and immigration, and with COVID, the approach was changed, further describing the due date and having an as accurate account as possible. Maria Lemus, Executive Director, Vision y Compromiso, provided an update on the promotoras on the project and the continuing outreach efforts. Greg Rodriguez, Government Relations and Public Policy Advisor, Office of Supervisor Perez, explained that the county implemented an aggressive program for a direct shelter count and the outreach workers performing the census in homeless encampments.	

	President De Lara thanked the organizations for their outreach in a different and challenging climate with COVID and the anti-immigration policies, applauding their efforts.	
2. Update on the District's History Book	Will Dean, Communications and Marketing Director, explained the draft history book, the committee's review, and feedback, the second draft, and the committees current review with notes compiled for the writer. The history book is on track for completion in early 2021.	
3. Coachella Valley Association of Governments (CVAG) – CV Link Quarterly (Q2) Progress Report	Erica Felci, Governmental Projects Manager, Coachella Valley Association of Governments (CVAG), described the quarterly report with the most recent updates and the goal of completing 20 miles in 2020. Director Shorr specified that although the District has committed to the CVLink financial contribution, CVAG has not received the entire funding from the District to date, suggesting revising the list on the financial report for the project to committed funding as it misrepresents the District, which is more accurate.	
K. New Business		
1. Consideration to approve a four (4) month no-cost grant	Donna Craig, Chief Program Officer, provided an overview	**#20-95 MOTION WAS MADE by Director Zendle and seconded**

extension for Grant #1124 – UCR School of Medicine – COVID-19 Testing for Farm working Communities in the Eastern Coachella Valley	of the no-cost grant extension with UCR School of Medicine for COVID-19 testing in farm working communities due to the challenges early-on to continue the work through February 2021.	**by Director Matthews to approve a four (4) month no-cost grants extension for Grant #1124 – UCR School of Medicine – COVID-19 Testing for Farm working Communities in the Eastern Coachella Valley Motion passed unanimously. AYES – 6 President De Lara, Vice-President Borja, Director Matthews, Director Rogers, Director Zendle, and Director Shorr NOES – 0 ABSENT – 1 Director PerezGil**
L. Legal **1. Legislative Update**	Jeff Scott, Legal Counsel, described the recent legislation, including SB 758 and SB 977 that failed in the state senate. Donna Craig, Chief Program Officer, inquired on SB 855 – Wiener: health coverage for mental health and substance abuse disorders. Mr. Scott will follow the bill and provided an update.	
M. Immediate Issues and Comments	Director Zendle would like the board to support and get involved in the Ivy project – an old hotel on Palm Canyon housing people experience homelessness, and the importance of continuing to support the issue of homelessness when the matter comes forth to the city of Palm Springs. President De Lara would like to send an official letter from	

	the Board to the City supporting the Ivy project. Dr. Bárzaga, CEO, suggests a Workshop on affordable housing given the complex and broad issue that includes a conversation to dig deeper, and how the work of the city of Palm Springs fits with the issues of the District, such as a regional approach than merely supporting one matter. Public Comments: Greg Rodriguez, Government Relations and Public Policy Advisor, Office of Supervisor Perez, explained that the project is 85-units that includes some efficiency components, and a letter from the District would assist, including a broader scope that Dr. Bárzaga has mentioned. It is a county project working in partnership with the city. Due to the CARES Act requestions, funding must be expended by December 30. Heather Vaikona, President and CEO, Lift to Rise, explained that the organization would be thrilled to participate in a session on the projects in the Coachella Valley, and the Housing Collaborative Network (CAN) contribution in the workshop. The Board's consensus is to send a letter to the City supporting the Ivy project for	

	housing and establish a Workshop with Lift to Rise. President De Lara requests a policy on issues concerning the District, the options, and when it is appropriate for the CEO to act, when it is appropriated for the Board to act as a whole, and signature authority, or consensus for adherence by the Board. Director Zendle reminded and encouraged everyone to obtain a flu shot.	
N. Adjournment	President De Lara adjourned the meeting at 7:48 p.m. in memory of Supreme Court Justice Ruth Bader Ginsburg, her life and work, noting that she will be missed.	***Audio recording available on the website at http://dhcd.org/Agendas-and-Documents***

ATTEST: _____
Karen Borja, Vice-President/Secretary
Desert Healthcare District Board of Directors

Minutes respectfully submitted by Andrea S. Hayles, Clerk of the Board

DESERT HEALTHCARE DISTRICT & FOUNDATION

DESERT HEALTHCARE DISTRICT
SPECIAL MEETING OF THE BOARD OF DIRECTORS
WORKSHOP MEETING MINUTES
September 23, 2020

Directors Present	District Staff Present	Absent
President Leticia De Lara Vice-President/Secretary Karen Borja Treasurer Mark Matthews Director Carole Rogers, RN Director Evett PerezGil Director Les Zendle, MD Director Arthur Shorr	Conrado E. Bárzaga, MD, CEO Chris Christensen, CAO Donna Craig, Chief Program Officer Andrea S. Hayles, Clerk of the Board Legal Counsel Jeff Scott	

AGENDA ITEMS	DISCUSSION	ACTION
A. Call to Order **Roll Call**	President De Lara called the meeting to order at 5:05 p.m. The Clerk of the Board called the roll with all Directors present.	
B. Pledge of Allegiance	President De Lara asked those in attendance to recite the Pledge of Allegiance.	
C. Approval of Agenda	President De Lara asked those in attendance to join in the Pledge of Allegiance.	**#20-95 MOTION WAS MADE by Director Zendle and seconded by Director Matthews to approve the agenda** **Motion passed unanimously.** **AYES – 7 President De Lara, Vice-President Borja, Director Matthews, Director PerezGil, Director Rogers, Director Zendle, and Director Shorr** **NOES – 0** **ABSENT – 0**
D. Public Comment	There was no public comment.	
E. Workshop and Training on Governance and Policies **1. Facilitated workshop discussion on training and planning of governance and policy issues, Martin Rauch, President, Senior Consultant, Rauch Communication Consultants, Inc.**	Conrado Bárzaga, MD, CEO, provided an overview of the prior Workshop in January and the approved service agreement with Rauch Communications for meetings once per quarter. Martin Rauch, President, Senior Consultant, Rauch Communications Consultants, commenced the meeting with a slide presentation	

	on Governance and Setting Clear Policy Direction. Mr. Rauch provided an overview of developing a workplan for progress on governance and setting clear policy direction. Good progress has been made, but there is a tendency to reopen old decisions. Progress and minimizing setbacks, recommending a more active approach to track progress every other month or every month, and clearly defining progress with separate governance changes from policy direction. In Mr. Rauch's judgement the District has a good Board that works together, and well within their scope with a continuous improvement process to become great by working towards a general approach to continuous Board improvement, reviewing the work plan from the last workshop, and a summary of the interviews. Training on best practices i good governance, such as identifying issues for the Board to deal with, including ideas from the self-assessment questions, sharing the results, and developing a list of current issues and a simple workplan. Reviewing and discussing policies will be brought to the Board next month, including discussing an outline with a proposed plan for continuous improvement. The Board and staff communications and policy committee should track progress and suggest changes with the Board President working with the CEO to	

	track progress, a placeholder in the agenda every other meeting on the topic, a post Workshop meeting, integrating new materials into the existing workplan, conducting full board assessments with review, discussion, response, and quarterly workshops. The Board provided comments, such as a newly elected Board Member in December as Director Matthews retires from the Board, and orientations co-defined not just for new Directors.	
J. Adjournment	President De Lara adjourned the meeting at 9:00 p.m.	***Audio recording available on the website at http://dhcd.org/Agenda-Board-of-Directors***

ATTEST: _____

Karen Borja, Vice-President/Secretary
Desert Healthcare District Board of Directors

Minutes respectfully submitted by Andrea S. Hayles, Clerk of the Board

DESERT HEALTHCARE DISTRICT
SEPTEMBER 2020 FINANCIAL STATEMENTS
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DESERT HEALTHCARE DISTRICT
YEAR TO DATE VARIANCE ANALYSIS
ACTUAL VS BUDGET
THREE MONTHS ENDED SEPTEMBER 30, 2020

Scope: $25,000 Variance per Statement of Operations Summary

	YTD		Over(Under)	
Account	**Actual**	**Budget**	**Budget**	**Explanation**
4000 - Income	$ 1,635,673	$ 1,936,485	**$ (300,812)**	Lower interest income and market fluctuations (net) from FRF investments $290k; lower grant income $13k; higher misc income $2k
5000 - Direct Expenses	$ 267,190	$ 420,915	**$ (153,725)**	Lower wage related expenses $80k due to open positions;lower board expenses $24k; lower education expense $22k; lower health insurance expense $20k; lower retirement expense $6k; lower workers comp expense $2k
6445 - LPMP Expense	$ 239,594	$ 293,865	**$ (54,271)**	Lower landscaping expense $42k; lower tenant improvement depreciation expense $7k, higher plumbing expense $3k, lower marketing expense $4k, lower various $4k
6500 - Professional Fees Expense	$ 118,896	$ 314,658	**$ (195,762)**	Lower Professional Services expense $188k; lower PR/Communications expense $29k; higher legal expense $21k
7000 - Grants Expense	$ 537,283	$ 1,020,999	**$ (483,716)**	Budget of $4 Million for fiscal year is amortized straight-line over 12-month fiscal year.
Las Palmas Medical Plaza - **Net**	$ 73,088	$ 3,366	**$ 69,722**	LPMP expenses lower $54k; LPMP revenue higher $15k

Desert Healthcare District
Profit & Loss Budget vs. Actual
July through September 2020

		TOTAL								
		Sep 20		Budget		$ Over Budget		Jul - Sep 20	Budget	$ Over Budget
Income										
	4000 · Income	526,118		645,495		(119,377)		1,635,673	1,936,485	(300,812)
	4500 · LPMP Income	103,214		99,077		4,137		312,682	297,231	15,451
	4501 · Miscellaneous Income	750		950		(200)		2,250	2,850	(600)
Total Income		630,082		745,522		(115,440)		1,950,605	2,236,566	(285,961)
Expense										
	5000 · Direct Expenses	93,272		140,305		(47,033)		267,190	420,915	(153,725)
	6000 · General & Administrative Exp	48,761		47,495		1,266		123,207	142,485	(19,278)
	6325 · CEO Discretionary Fund	0		2,083		(2,083)		0	6,249	(6,249)
	6445 · LPMP Expenses	84,515		97,955		(13,440)		239,594	293,865	(54,271)
	6500 · Professional Fees Expense	67,607		104,886		(37,279)		118,896	314,658	(195,762)
	6700 · Trust Expenses	7,576		8,792		(1,216)		28,492	26,376	2,116
Total Expense		301,731		401,516		(99,785)		777,379	1,204,556	(427,177)
7000 · Grants Expense		53,631		340,333		(286,702)		537,283	1,020,999	(483,716)
Net Income		**274,720**		**3,673**		**271,047**		**635,943**	**11,011**	**624,932**

Desert Healthcare District

Profit & Loss Budget vs. Actual

July through September 2020

	TOTAL					
	Sep 20	Budget	$ Over Budget	Jul - Sep 20	Budget	$ Over Budget
Income						
4000 · Income						
4010 · Property Tax Revenues	516,447	516,447	0	1,549,341	1,549,341	0
4200 · Interest Income						
4220 · Interest Income (FRF)	74,795	86,965	(12,170)	284,152	260,895	23,257
9999-1 · Unrealized gain(loss) on invest	(72,309)	33,333	(105,642)	(212,969)	99,999	(312,968)
Total 4200 · Interest Income	2,486	120,298	(117,812)	71,183	360,894	(289,711)
4300 · DHC Recoveries	3,554	1,750	1,804	7,105	5,250	1,855
4400 · Grant Income	3,631	7,000	(3,369)	8,044	21,000	(12,956)
Total 4000 · Income	526,118	645,495	(119,377)	1,635,673	1,936,485	(300,812)
4500 · LPMP Income	103,214	99,077	4,137	312,682	297,231	15,451
4501 · Miscellaneous Income	750	950	(200)	2,250	2,850	(600)
Total Income	630,082	745,522	(115,440)	1,950,605	2,236,566	(285,961)
Expense						
5000 · Direct Expenses						
5100 · Administration Expense						
5110 · Wages Expense	75,270	113,645	(38,375)	213,970	340,935	(126,965)
5111 · Allocation to LPMP - Payroll	(5,161)	(5,166)	5	(15,483)	(15,498)	15
5112 · Vacation/Sick/Holiday Expense	10,287	10,000	287	28,913	30,000	(1,087)
5114 · Allocation to Foundation	(24,392)	(37,196)	12,804	(73,176)	(111,588)	38,412
5115 · Allocation to NEOPB	(3,631)	(7,571)	3,940	(8,044)	(22,713)	14,669
5119 · Allocation to RSS/CVHIP-DHCF	0	(1,431)	1,431	(903)	(4,293)	3,390
5120 · Payroll Tax Expense	5,175	8,694	(3,519)	17,188	26,082	(8,894)
5130 · Health Insurance Expense						
5131 · Premiums Expense	12,280	16,795	(4,515)	35,802	50,385	(14,583)
5135 · Reimb./Co-Payments Expense	424	3,000	(2,576)	3,834	9,000	(5,166)
Total 5130 · Health Insurance Expense	12,704	19,795	(7,091)	39,636	59,385	(19,749)
5140 · Workers Comp. Expense	441	1,193	(752)	1,679	3,579	(1,900)
5145 · Retirement Plan Expense	6,168	7,848	(1,680)	17,709	23,544	(5,835)
5160 · Education Expense	70	7,250	(7,180)	70	21,750	(21,680)
Total 5100 · Administration Expense	76,931	117,061	(40,130)	221,559	351,183	(129,624)
5200 · Board Expenses						
5210 · Healthcare Benefits Expense	3,264	5,834	(2,570)	9,200	17,502	(8,302)
5230 · Meeting Expense	350	1,667	(1,317)	350	5,001	(4,651)
5235 · Director Stipend Expense	2,310	4,410	(2,100)	4,830	13,230	(8,400)
5240 · Catering Expense	0	708	(708)	0	2,124	(2,124)
5250 · Mileage Reimbursment Expense	0	208	(208)	0	624	(624)
5270 · Election Fees Expense	10,417	10,417	0	31,251	31,251	0
Total 5200 · Board Expenses	16,341	23,244	(6,903)	45,631	69,732	(24,101)
Total 5000 · Direct Expenses	93,272	140,305	(47,033)	267,190	420,915	(153,725)

Desert Healthcare District
Profit & Loss Budget vs. Actual
July through September 2020

	TOTAL		
	Sep 20	Budget	$ Over Budget	Jul - Sep 20	Budget	$ Over Budget
6000 · General & Administrative Exp						
6110 · Payroll fees Expense	174	208	(34)	522	624	(102)
6120 · Bank and Investment Fees Exp	9,605	9,833	(228)	28,560	29,499	(939)
6125 · Depreciation Expense	1,102	1,167	(65)	3,306	3,501	(195)
6126 · Depreciation-Solar Parking lot	15,072	15,072	0	45,216	45,216	0
6130 · Dues and Membership Expense	12,155	3,337	8,818	14,332	10,011	4,321
6200 · Insurance Expense	2,343	2,417	(74)	7,029	7,251	(222)
6300 · Minor Equipment Expense	0	42	(42)	0	126	(126)
6305 · Auto Allowance & Mileage Exp	462	600	(138)	1,386	1,800	(414)
6306 · Staff- Auto Mileage reimb	0	625	(625)	56	1,875	(1,819)
6309 · Personnel Expense	750	1,167	(417)	1,800	3,501	(1,701)
6310 · Miscellaneous Expense	0	42	(42)	0	126	(126)
6311 · Cell Phone Expense	420	776	(356)	1,869	2,328	(459)
6312 · Wellness Park Expenses	0	83	(83)	0	249	(249)
6315 · Security Monitoring Expense	0	42	(42)	233	126	107
6340 · Postage Expense	0	417	(417)	472	1,251	(779)
6350 · Copier Rental/Fees Expense	0	458	(458)	788	1,374	(586)
6351 · Travel Expense	0	1,667	(1,667)	0	5,001	(5,001)
6352 · Meals & Entertainment Exp	0	875	(875)	0	2,625	(2,625)
6355 · Computer Services Expense	2,748	3,775	(1,027)	5,278	11,325	(6,047)
6360 · Supplies Expense	1,365	2,167	(802)	3,110	6,501	(3,391)
6380 · LAFCO Assessment Expense	144	208	(64)	432	624	(192)
6400 · East Valley Office	2,421	2,517	(96)	8,818	7,551	1,267
Total 6000 · General & Administrative Exp	48,761	47,495	1,266	123,207	142,485	(19,278)
6325 · CEO Discretionary Fund	0	2,083	(2,083)	0	6,249	(6,249)
6445 · LPMP Expenses	84,515	97,955	(13,440)	239,594	293,865	(54,271)
6500 · Professional Fees Expense						
6516 · Professional Services Expense	18,595	77,198	(58,603)	43,925	231,594	(187,669)
6520 · Annual Audit Fee Expense	1,313	1,313	0	3,939	3,939	0
6530 · PR/Communications/Website	1,013	11,375	(10,362)	4,828	34,125	(29,297)
6560 · Legal Expense	46,686	15,000	31,686	66,204	45,000	21,204
Total 6500 · Professional Fees Expense	67,607	104,886	(37,279)	118,896	314,658	(195,762)
6700 · Trust Expenses						
6720 · Pension Plans Expense						
6721 · Legal Expense	0	167	(167)	0	501	(501)
6725 · RPP Pension Expense	2,500	7,500	(5,000)	22,500	22,500	0
6728 · Pension Audit Fee Expense	5,076	1,125	3,951	5,992	3,375	2,617
Total 6700 · Trust Expenses	7,576	8,792	(1,216)	28,492	26,376	2,116
Total Expense Before Grants	301,731	401,516	(99,785)	777,379	1,204,556	(427,177)
7000 · Grants Expense						
7010 · Major Grant Awards Expense	50,000	333,333	(283,333)	529,239	999,999	(470,760)
7027 · Grant Exp - NEOPB	3,631	7,000	(3,369)	8,044	21,000	(12,956)
Total 7000 · Grants Expense	53,631	340,333	(286,702)	537,283	1,020,999	(483,716)
Net Income	**274,720**	**3,673**	**271,047**	**635,943**	**11,011**	**624,932**

Las Palmas Medical Plaza
Profit & Loss Budget vs. Actual
July through September 2020

	MONTH			TOTAL		
	Sep 20	Budget	$ Over Budget	Jul - Sep 20	Budget	$ Over Budget
Income						
4500 · LPMP Income						
4505 · Rental Income	75,195	71,672	3,523	227,037	215,016	12,021
4510 · CAM Income	28,019	27,372	647	85,645	82,116	3,529
4513 · Misc. Income	0	33	(33)	0	99	(99)
Total 4500 · LPMP Income	103,214	99,077	4,137	312,682	297,231	15,451
Expense						
6445 · LPMP Expenses						
6420 · Insurance Expense	2,599	2,750	(151)	7,797	8,250	(453)
6425 · Building - Depreciation Expense	21,487	21,879	(392)	64,461	65,637	(1,176)
6426 · Tenant Improvements -Dep Exp	14,916	16,833	(1,917)	43,618	50,499	(6,881)
6427 · HVAC Maintenance Expense	2,414	1,333	1,081	3,625	3,999	(374)
6428 · Roof Repairs Expense	0	208	(208)	0	624	(624)
6431 · Building -Interior Expense	0	833	(833)	0	2,499	(2,499)
6432 · Plumbing -Interior Expense	0	333	(333)	4,588	999	3,589
6433 · Plumbing -Exterior Expense	0	208	(208)	0	624	(624)
6434 · Allocation Internal Prop. Mgmt	5,161	5,166	(5)	15,483	15,498	(15)
6435 · Bank Charges	1,249	1,125	124	3,405	3,375	30
6437 · Utilities -Vacant Units Expense	257	83	174	736	249	487
6439 · Deferred Maintenance Repairs Ex	0	833	(833)	0	2,499	(2,499)
6440 · Professional Fees Expense	10,117	10,472	(355)	30,351	31,416	(1,065)
6441 · Legal Expense	0	83	(83)	0	249	(249)
6455 · Bad Debt Expense	5,543			5,543		
6458 · Elevators - R & M Expense	1,593	1,000	593	4,693	3,000	1,693
6460 · Exterminating Service Expense	440	333	107	615	999	(384)
6463 · Landscaping Expense	0	14,167	(14,167)	850	42,501	(41,651)
6467 · Lighting Expense	0	500	(500)	0	1,500	(1,500)
6468 · General Maintenance Expense	0	83	(83)	0	249	(249)
6471 · Marketing-Advertising	0	1,250	(1,250)	0	3,750	(3,750)
6475 · Property Taxes Expense	6,000	6,008	(8)	18,000	18,024	(24)
6476 · Signage Expense	0	125	(125)	0	375	(375)
6480 · Rubbish Removal Medical Waste E	1,675	1,583	92	3,188	4,749	(1,561)
6481 · Rubbish Removal Expense	2,227	2,250	(23)	6,681	6,750	(69)
6482 · Utilities/Electricity/Exterior	588	625	(37)	1,192	1,875	(683)
6484 · Utilties - Water (Exterior)	919	625	294	2,529	1,875	654
6485 · Security Expenses	7,319	7,167	152	21,939	21,501	438
6490 · Miscellaneous Expense	11	100	(89)	300	300	0
6445 · LPMP Expenses	84,515	97,955	(13,440)	239,594	293,865	(54,271)
Net Income	**18,699**	**1,122**	**17,577**	**73,088**	**3,366**	**69,722**

Desert Healthcare District
Balance Sheet
As of September 30, 2020

	Sep 30, 20
ASSETS	
Current Assets	
Checking/Savings	
1000 · CHECKING CASH ACCOUNTS	1,800,727
1100 · INVESTMENT ACCOUNTS	58,928,790
Total Checking/Savings	60,729,517
Accounts Receivable	30,173
Other Current Assets	
1204.1 · Rent Receivable-Deferred COVID	201,414
1270 · Prepaid Insurance -Ongoing	48,207
1279 · Pre-Paid Fees	14,440
1281 · NEOPB Receivable	8,043
1295 · Property Tax Receivable	1,558,479
Total Other Current Assets	1,830,583
Total Current Assets	62,590,273
Fixed Assets	
1300 · FIXED ASSETS	4,913,164
1335-00 · ACC DEPR	(2,075,876)
1400 · LPMP Assets	6,813,634
Total Fixed Assets	9,650,922
Other Assets	
1700 · OTHER ASSETS	2,909,152
Total Other Assets	2,909,152
TOTAL ASSETS	**75,150,347**

Desert Healthcare District
Balance Sheet
As of September 30, 2020

	Sep 30, 20
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
2000 · Accounts Payable	73,634
2001 · LPMP Accounts Payable	3,460
Total Accounts Payable	77,094
Other Current Liabilities	
2002 · LPMP Property Taxes	18,000
2131 · Grant Awards Payable	2,427,627
2133 · Accrued Accounts Payable	173,028
2141 · Accrued Vacation Time	56,974
2188 · Current Portion - LTD	11,103
2190 · Investment Fees Payable	27,000
Total Other Current Liabilities	2,713,732
Total Current Liabilities	2,790,826
Long Term Liabilities	
2170 · RPP - Pension Liability	4,626,754
2171 · RPP-Deferred Inflows-Resources	370,700
2280 · Long-Term Disability	28,809
2281 · Grants Payable - Long-term	6,660,000
2286 · Retirement BOD Medical Liabilit	64,764
2290 · LPMP Security Deposits	59,395
Total Long Term Liabilities	11,810,422
Total Liabilities	14,601,248
Equity	
3900 · *Retained Earnings	59,913,158
Net Income	635,943
Total Equity	60,549,101
TOTAL LIABILITIES & EQUITY	**75,150,347**

Desert Healthcare District
Balance Sheet
As of September 30, 2020

	Sep 30, 20
ASSETS	
Current Assets	
Checking/Savings	
1000 · CHECKING CASH ACCOUNTS	
1010 · Union Bank - Checking	1,455,797
1046 · Las Palmas Medical Plaza	344,430
1047 · Petty Cash	500
Total 1000 · CHECKING CASH ACCOUNTS	1,800,727
1100 · INVESTMENT ACCOUNTS	
1130 · Facility Replacement Fund	57,686,334
1135 · Unrealized Gain(Loss) FRF	1,242,456
Total 1100 · INVESTMENT ACCOUNTS	58,928,790
Total Checking/Savings	60,729,517
Accounts Receivable	
1201 · Accounts Receivable	
1204 · LPMP Accounts Receivable	27,888
1205 · Misc. Accounts Receivable	3,229
1211 · A-R Foundation - Exp Allocation	(944)
Total Accounts Receivable	30,173
Other Current Assets	
1204.1 · Rent Receivable-Deferred COVID	201,414
1270 · Prepaid Insurance -Ongoing	48,207
1279 · Pre-Paid Fees	14,440
1281 · NEOPB Receivable	8,043
1295 · Property Tax Receivable	1,558,479
Total Other Current Assets	1,830,583
Total Current Assets	62,590,273
Fixed Assets	
1300 · FIXED ASSETS	
1310 · Computer Equipment	94,034
1315 · Computer Software	68,770
1320 · Furniture and Fixtures	33,254
1325 · Offsite Improvements	300,849
1331 · DRMC - Parking lot	4,416,257
Total 1300 · FIXED ASSETS	4,913,164
1335-00 · ACC DEPR	
1335 · Accumulated Depreciation	(213,757)

Desert Healthcare District
Balance Sheet
As of September 30, 2020

	Sep 30, 20
1336 · Acc. Software Depreciation	(68,770)
1337 · Accum Deprec- Solar Parking Lot	(1,643,019)
1338 · Accum Deprec - LPMP Parking Lot	(150,330)
Total 1335-00 · ACC DEPR	(2,075,876)
1400 · LPMP Assets	
1401 · Building	8,705,680
1402 · Land	2,165,300
1403 · Tenant Improvements -New	2,197,477
1404 · Tenant Improvements - CIP	129,550
1406 · Building Improvements	
1406.1 · LPMP-Replace Parking Lot	676,484
1406.2 · Building Improvements-CIP	66,704
1406 · Building Improvements - Other	1,559,534
Total 1406 · Building Improvements	2,302,722
1407 · Building Equipment Improvements	364,891
1409 · Accumulated Depreciation	
1410 · Accum. Depreciation	(7,468,015)
1412 · T I Accumulated Dep.-New	(1,583,971)
Total 1409 · Accumulated Depreciation	(9,051,986)
Total 1400 · LPMP Assets	6,813,634
Total Fixed Assets	9,650,922
Other Assets	
1700 · OTHER ASSETS	
1731 · Wellness Park	1,693,800
1740 · RPP-Deferred Outflows-Resources	1,204,238
1741 · OPEB-Deferrred Outflows-Resourc	11,114
Total Other Assets	2,909,152
TOTAL ASSETS	**75,150,347**

Desert Healthcare District
Balance Sheet
As of September 30, 2020

	Sep 30, 20
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
2000 · Accounts Payable	73,634
2001 · LPMP Accounts Payable	3,460
Total Accounts Payable	77,094
Other Current Liabilities	
2002 · LPMP Property Taxes	18,000
2131 · Grant Awards Payable	2,427,627
2133 · Accrued Accounts Payable	173,028
2141 · Accrued Vacation Time	56,974
2188 · Current Portion - LTD	11,103
2190 · Investment Fees Payable	27,000
Total Other Current Liabilities	2,713,732
Total Current Liabilities	2,790,826
Long Term Liabilities	
2170 · RPP - Pension Liability	4,626,754
2171 · RPP-Deferred Inflows-Resources	370,700
2280 · Long-Term Disability	28,809
2281 · Grants Payable - Long-term	6,660,000
2286 · Retirement BOD Medical Liabilit	64,764
2290 · LPMP Security Deposits	59,395
Total Long Term Liabilities	11,810,422
Total Liabilities	14,601,248
Equity	
3900 · *Retained Earnings	59,913,158
Net Income	635,943
Total Equity	60,549,101
TOTAL LIABILITIES & EQUITY	**75,150,347**

Desert Healthcare District
A/R Aging Summary
As of September 30, 2020

	Current	1 - 30	31 - 60	61 - 90	> 90	TOTAL	COMMENT
Desert Healthcare Foundation-	24,392	(25,336)	0	0	0	(944)	Due from Foundation
Desert Oasis Healthcare Medical Group	(2,177)	0	0	0	0	(2,177)	Prepaid
Desert Regional Medical Center	0	5,310	0	0	0	5,310	Slow pay
Hassan Bencheqroun, M.D.	(2,580)	0	0	0	0	(2,580)	Prepaid
Laboratory Corporation of America	0	(4,774)	0	0	0	(4,774)	Prepaid
Mark Matthews	0	0	0	0	979	979	Director Premiums
Sovereign	750	750	0	750	0	2,250	Slow pay
Steven Gundry, M.D.	(5,471)	0	0	0	0	(5,471)	Prepaid
Tenet HealthSystem Desert, Inc	0	6,066	0	0	0	6,066	Slow Pay
Tenet HealthSystem Desert, Inc.	0	31,515	0	0	0	31,515	Slow Pay
TOTAL	**14,914**	**10,684**	**2,847**	**750**	**979**	**30,173**	

Desert Healthcare District
Deposit Detail
September 2020

Type	Date	Name	Amount
Deposit	**09/01/2020**		**156,761**
Payment	09/01/2020	Desert Healthcare Foundation-	(156,761)
TOTAL			(156,761)
Deposit	**09/02/2020**		**1,749**
		T-Mobile	(1,749)
TOTAL			(1,749)
Deposit	**09/14/2020**		**1,115**
		State Compensation Insurance Fund	(1,115)
TOTAL			(1,115)
Deposit	**09/18/2020**		**56**
		California Business Bureau, Inc.	(56)
TOTAL			(56)
Deposit	**09/30/2020**		**1,749**
		T-Mobile	(1,749)
TOTAL			(1,749)
		TOTAL	**161,430**

DESERT HEALTHCARE DISTRICT

PROPERTY TAX RECEIPTS FY 2020 - 2021

RECEIPTS - TWELVE MONTHS ENDED JUNE 30, 2021

	FY 2019-2020 Projected/Actual					FY 2020-2021 Projected/Actual				
	Budget %	**Budget $**	**Act %**	**Actual Receipts**	**Variance**	**Budget %**	**Budget $**	**Act %**	**Actual Receipts**	**Variance**
July	2.5%	$ 168,407	1.3%	$ -	$ (168,407)	2.5%	$ 154,934	0.0%	$ -	$ (154,934)
Aug	1.6%	$ 107,780	1.3%	$ 207,292	$ 99,512	1.6%	$ 99,158	2.4%	$ 149,547	$ 50,390
Sep	2.6%	$ 175,143	2.4%	$ -	$ (175,143)	2.6%	$ 161,131	0.0%	$ -	$ (161,131)
Oct	0.0%	$ -	0.0%	$ 158,895	$ 158,895	0.0%	$ -	0.0%		
Nov	0.4%	$ 26,945	0.0%	$ -	$ (26,945)	0.4%	$ 24,789	0.0%		
Dec	16.9%	$ 1,138,429	17.8%	$ 1,222,723	$ 84,294	16.9%	$ 1,047,354	0.0%		
Jan	31.9%	$ 2,148,868	19.7%	$ 2,228,697	$ 79,829	31.9%	$ 1,976,959	0.0%		
Feb	0.0%	$ -	13.9%	$ 69,468	$ 69,468	0.0%	$ -	0.0%		
Mar	0.3%	$ 20,209	0.7%	$ 71,486	$ 51,277	0.3%	$ 18,592	0.0%		
Apr	5.5%	$ 370,495	5.9%	$ 405,506	$ 35,012	5.5%	$ 340,855	0.0%		
May	19.9%	$ 1,340,517	20.3%	$ 101,619	$ (1,238,897)	19.9%	$ 1,233,275	0.0%		
June	18.4%	$ 1,239,473	22.3%	$ 2,695,867	$ 1,456,394	18.4%	$ 1,140,315	0.0%		
Total	**100%**	**$ 6,736,264**	**105.6%**	**$ 7,161,553**	**$ 425,289**	**100.00%**	**$ 6,197,363**	**2.4%**	**$ 149,547**	**$ (265,676)**

Las Palmas Medical Plaza
Deposit Detail - LPMP
September 2020

Type	Date	Name	Amount
Deposit	**09/03/2020**		**2,580**
Payment	09/03/2020	Hassan Bencheqroun, M.D.	(2,580)
TOTAL			(2,580)
Deposit	**09/04/2020**		**3,864**
Payment	09/01/2020	Quest Diagnostics Incorporated	(3,864)
TOTAL			(3,864)
Deposit	**09/08/2020**		**7,140**
Payment	09/08/2020	Desert Family Medical Center	(3,570)
Payment	09/08/2020	Desert Family Medical Center	(3,570)
TOTAL			(7,140)
Deposit	**09/09/2020**		**3,166**
Payment	09/08/2020	Quest Diagnostics Incorporated	(3,166)
TOTAL			(3,166)
Deposit	**09/09/2020**		**22,754**
Payment	09/08/2020	Pathway Pharmaceuticals,Inc.	(2,296)
Payment	09/08/2020	Aijaz Hashmi, M.D., Inc.	(2,803)
Payment	09/08/2020	Brad A. Wolfson, M.D.	(3,430)
Payment	09/08/2020	Cohen Musch Thomas Medical Group	(4,261)
Payment	09/08/2020	Ramy Awad, M.D.	(3,246)
Payment	09/08/2020	Palmtree Clinical Research	(6,717)
TOTAL			(22,754)
Deposit	**09/11/2020**		**8,930**
Payment	09/10/2020	Derakhsh Fozouni, M.D.	(5,969)
Payment	09/10/2020	Cure Cardiovascular Consultants	(2,962)
TOTAL			(8,930)

Las Palmas Medical Plaza
Deposit Detail - LPMP
September 2020

Type	Date	Name	Amount
Deposit	**09/14/2020**		**4,232**
Payment	09/14/2020	Peter Jamieson, M.D.	(3,232)
Payment	09/14/2020	Arrowhead Evaluation Services, Inc.	(1,000)
TOTAL			(4,232)
Deposit	**09/18/2020**		**7,079**
Payment	09/18/2020	EyeCare Services Partners Management LLC	(7,079)
TOTAL			(7,079)
Deposit	**09/22/2020**		**4,774**
Payment	09/22/2020	Laboratory Corporation of America	(4,774)
TOTAL			(4,774)
Deposit	**09/30/2020**		**7,648**
Payment	09/30/2020	Steven Gundry, M.D.	(5,471)
Payment	09/30/2020	Desert Oasis Healthcare Medical Group	(2,177)
TOTAL			(7,648)
Deposit	**09/30/2020**		**2,580**
Payment	09/30/2020	Hassan Bencheqroun, M.D.	(2,580)
TOTAL			(2,580)
		TOTAL	**74,748**

Desert Healthcare District
Check Register
As of September 30, 2020

Type	Date	Num	Name	Amount
1000 · CHECKING CASH ACCOUNTS				
1010 · Union Bank - Checking				
Liability Check	09/03/2020		QuickBooks Payroll Service	(39,689)
Check	09/08/2020	Auto Pay	Calif. Public Employees'Retirement System	(12,733)
Bill Pmt -Check	09/08/2020	16122	Boyd & Associates	(125)
Bill Pmt -Check	09/08/2020	16123	Graphtek Interactive	(413)
Bill Pmt -Check	09/08/2020	16124	HARC, INC.	(9,012)
Bill Pmt -Check	09/08/2020	16125	Image Source	(151)
Bill Pmt -Check	09/08/2020	16126	Lund & Guttry LLP	(1,000)
Bill Pmt -Check	09/08/2020	16127	Palm Desert Chamber of Commerce	(225)
Bill Pmt -Check	09/08/2020	16128	Palm Springs Chamber of Commerce	(250)
Bill Pmt -Check	09/08/2020	16129	Rauch Communication Consultants	(429)
Bill Pmt -Check	09/08/2020	16130	Rogers, Carole - Stipend	(420)
Bill Pmt -Check	09/08/2020	16131	So.Cal Computer Shop	(810)
Bill Pmt -Check	09/08/2020	16132	The Nyhart Company	(4,618)
Bill Pmt -Check	09/08/2020	16133	Verizon Wireless	(575)
Bill Pmt -Check	09/08/2020	16134	First Bankcard (Union Bank)	(2,100)
Bill Pmt -Check	09/08/2020	16135	Mangus Accountancy Group, A.P.C.	(500)
Bill Pmt -Check	09/08/2020	16136	Staples Credit Plan	(188)
Bill Pmt -Check	09/08/2020	16137	State Compensation Insurance Fund	(118)
Bill Pmt -Check	09/14/2020	16138	So.Cal Computer Shop	(275)
Bill Pmt -Check	09/14/2020	16139	Time Warner Cable	(250)
Bill Pmt -Check	09/14/2020	16140	State Compensation Insurance Fund	(862)
Bill Pmt -Check	09/15/2020	16141	Southern California Grantmakers	(5,067)
Liability Check	09/17/2020		QuickBooks Payroll Service	(39,396)
Bill Pmt -Check	09/21/2020	16142	California Chamber of Commerce	(649)
Bill Pmt -Check	09/21/2020	16143	CoPower Employers' Benefits Alliance	(2,151)
Bill Pmt -Check	09/21/2020	16144	Frazier Pest Control, Inc.	(60)
Bill Pmt -Check	09/21/2020	16145	Principal Life Insurance Co.	(1,575)
Bill Pmt -Check	09/24/2020	ACH 092420	US Environmental Protection Agency	(35,099)
Bill Pmt -Check	09/24/2020	16146	Jeff Crider	(200)
Bill Pmt -Check	09/25/2020	ACH 092520	Law Offices of Scott & Jackson	(11,588)
Check	09/25/2020		Bank Service Charge	(605)
Bill Pmt -Check	09/30/2020	16147	Eric Taylor	(23)
Bill Pmt -Check	09/30/2020	16148	Frazier Pest Control, Inc.	(30)
Bill Pmt -Check	09/30/2020	16149	Image Source	(107)
Bill Pmt -Check	09/30/2020	16150	Ready Refresh	(50)
Bill Pmt -Check	09/30/2020	16151	Regional Access Project Foundation	(2,421)
Bill Pmt -Check	09/30/2020	16152	Shred-It	(192)

Desert Healthcare District
Check Register
As of September 30, 2020

Type	Date	Num	Name	Amount
Bill Pmt -Check	09/30/2020	16153	Tri-Star Risk Management	(576)
Bill Pmt -Check	09/30/2020	16154	Leticia De Lara - Stipend	(735)
Bill Pmt -Check	09/30/2020	16155	Zendle, Les - Stipend	(525)
Bill Pmt -Check	09/30/2020	16156	Verizon Wireless	(625)
TOTAL				**(176,417)**

Desert Healthcare District

Details for credit card Expenditures

Credit card purchases - August 2020 - Paid September 2020

Number of credit cards held by District personnel -2

Credit Card Limit - $10,000

Credit Card Holders:

Conrado Bárzaga - Chief Executive Officer

Chris Christensen - Chief Administration Officer

Routine types of charges:

Office Supplies, Dues for membership, Computer Supplies, Meals, Travel including airlines and Hotels, Catering, Supplies for BOD meetings, CEO Discretionary for small grant & gift items

	Statement							
	Month	Total		Expense				
Year	Charged	Charges		Type	Amount	Purpose	Description	Participants
		$ 2,529.80						
Chris' Statement:								
2020	**August**	**$ 2,099.80**		**District**				
				GL	Dollar	Descr		
				6360	$ 12.90	Zoom Webinar Upgrade to 500 Attendees		
				6355	$ 26.62	Premiere Global Services		
				6355	$ 1,155.00	Dropbox Annual Plan for 11 Licenses		
				6360	$ 154.99	Zoom Videoconference/Webinar Expense		
				6309	$ 512.76	Advertising for Senior Program Officer		
				6309	$ 237.53	Advertising for Senior Program Officer		
					$ 2,099.80			
Conrado's Statement:								
2020	**August**	**$ 430.00**		**District**				
				GL	Dollar	Descr		
				5160	$70.00	ACHD Registration - Conrado		
				5230	$280.00	ACHD Registration - Lety, Carole, Evett & Les		
				5230	$ 80.00	ACHD Registration - Karen		
					$430.00	* utilized outstanding credit from May 2020 Statement		

Las Palmas Medical plaza
Check Register - LPMP
As of September 30, 2020

Type	Date	Num	Name	Amount
1000 · CHECKING CASH ACCOUNTS				
1046 · Las Palmas Medical Plaza				
Bill Pmt -Check	09/08/2020	10232	Desert Air Conditioning Inc.	(755)
Bill Pmt -Check	09/08/2020	10233	Desert Water Agency - VOID	0
Bill Pmt -Check	09/08/2020	10234	Imperial Security	(3,400)
Bill Pmt -Check	09/08/2020	10235	KC's Plumbing	(1,278)
Bill Pmt -Check	09/08/2020	10236	Desert Water Agency	(965)
Bill Pmt -Check	09/08/2020	10237	Palm Springs Disposal Services Inc	(2,227)
Bill Pmt -Check	09/08/2020	10238	Cohen, Musch, Thomas Med Group	(28,800)
Bill Pmt -Check	09/14/2020	10239	Imperial Security	(1,785)
Bill Pmt -Check	09/21/2020	10240	Desert Air Conditioning Inc.	(2,414)
Bill Pmt -Check	09/21/2020	10241	Frazier Pest Control, Inc.	(350)
Bill Pmt -Check	09/21/2020	10242	Frontier Communications	(228)
Bill Pmt -Check	09/21/2020	10243	Imperial Security	(1,964)
Bill Pmt -Check	09/21/2020	10244	Southern California Edison	(845)
Bill Pmt -Check	09/24/2020	10245	INPRO-EMS Construction	(10,117)
Check	09/24/2020		Bank Service Charge	(1,249)
Bill Pmt -Check	09/30/2020	10246	Amtech Elevator Services	(1,365)
Bill Pmt -Check	09/30/2020	10247	Imperial Security	(1,785)
Bill Pmt -Check	09/30/2020	10248	Desert Water Agency	(919)
TOTAL				**(60,446)**

DESERT HEALTHCARE
DISTRICT & FOUNDATION

MEMORANDUM

DATE: October 13, 2020

TO: F&A Committee

RE: Retirement Protection Plan (RPP)

Current number of participants in Plan:

	Aug	Sep
Active – still employed by hospital	98	96
Vested – no longer employed by hospital	61	62
Former employees receiving annuity	7	7
Total	**166**	**165**

The outstanding liability for the RPP is approximately **$4.0M** (Actives - $2.6M and Vested - $1.4M). US Bank investment account balance $4.8M. Per the June 30, 2020 Actuarial Valuation, the RPP has an Unfunded Pension Liability of approximately **$4.6M**. A monthly accrual of $10K is being recorded each month as an estimate for FY2021.

The payouts, excluding monthly annuity payments, made from the Plan for the Three (3) months ended September 30, 2020 totaled **$202K.** Monthly annuity payments (7 participants) total **$1.0K** per month.

DESERT HEALTHCARE DISTRICT
OUTSTANDING GRANTS AND GRANT PAYMENT SCHEDULE
As of 9/30/20
TWELVE MONTHS ENDED JUNE 30, 2021

Grant ID Nos.		Name	Approved Grants - Prior Yrs	Current Yr 2020-2021	6/30/2020 Bal Fwd/New	Total Paid July-June	Open BALANCE
2014-MOU-BOD-11/21/13		Memo of Understanding CVAG CV Link Support	**$ 10,000,000**		$ 8,330,000	$ -	$ 8,330,000
2018-974-BOD-09-25-18		HARC - 2019 Coachella Valley Community Health Survey - 2 Yr	$ 399,979		$ 39,999	$ -	$ 39,999
2019-985-BOD-03-26-19		Coachella Valley Volunteers in Medicine - Primary Healthcare & Support Services - 1 Yr	$ 121,500		$ 12,150	$ 12,150	$ -
2019-986-BOD-05-28-19		Ronald McDonald House Charities - Temporary Housing & Family Support Services - 1 Yr	$ 200,000		$ 20,000	$ 20,000	$ -
2019-997-BOD-05-28-19		Martha's Village & Kitchen - Homeless Housing With Wrap Around Services - 1 Yr	$ 200,896		$ 20,090	$ 20,090	$ -
2019-989-BOD-05-28-19		Pegasus Riding Academy - Cover the Hard Costs of Pegasus Clients - 1 Yr	$ 109,534		$ 10,954	$ 10,954	$ -
2019-994-BOD-05-28-19		One Future Coachella Valley - Mental Health College & Career Pathway Development - 2 Yr	$ 700,000		$ 385,000	$ 78,750	$ 306,250
2019-1000-BOD-05-28-19		Voices for Children - Court Appointed Special Advocate Program - 1 Yr	$ 24,000		$ 2,400	$ 2,400	$ -
2019-1017-BOD-09-24-19		Jewish Family Services - Case Management Services for Homeless Prevention - 1 Yr	$ 90,000		$ 9,000	$ -	$ 9,000
2019-1023-BOD-10-22-19		CVRM - Transportation for Seniors & Homeless Hospital Discharge Referrals - 1 Yr	$ 216,200		$ 118,910	$ 97,290	$ 21,620
2019-1021-BOD-11-26-19		Neuro Vitality Center - Community Based Adult Services Program - 6 Months	$ 143,787		$ 79,083	$ 50,323	$ 28,760
		Unexpended funds Grant #1021					$ (28,760)
2020-1045-BOD-03-24-20		FIND Food Bank - Ending Hunger Today, Tomorrow, and for a Lifetime - 1 Yr	$ 401,380		$ 311,069	$ 90,311	$ 220,758
2020-1129-BOD-05-26-20		Coachella Valley Volunteers In Medicine - Response to COVID-19	$ 149,727		$ 149,727	$ 149,727	$ -
2020-1085-BOD-05-26-20		Olive Crest Treatment Center - General Support for Mental Health Services	$ 50,000		$ 27,500	$ -	$ 27,500
2020-1057-BOD-05-26-20		Desert Cancer Foundation - Patient Assistance Program	$ 150,000		$ 82,500	$ -	$ 82,500
2020-1124-BOD-06-23-20		Regents of UCR - COVID-19 Testing & Health Education for Eastern Valley - 5 Months	$ 149,976		$ 149,976	$ 149,976	$ -
2020-1134-BOD-07-28-20	1	Desert Healthcare Foundation - Addressing Healthcare Needs of Black Communities		$ 500,000	$ 500,000	$ 500,000	$ -
2020-1139-BOD-09-22-20	1	CSU San Bernardino Palm Desert Campus Street Medicine Program - 1 Yr		$ 50,000	$ 50,000	$ -	$ 50,000
TOTAL GRANTS			**$ 13,106,979**	**$ 550,000**	**$ 10,298,358**	**$ 1,181,971**	**$ 9,087,627**

Amts available/remaining for Grant/Programs - FY 2020-21:							
Amount budgeted 2020-2021				$ 4,000,000		G/L Balance:	**9/30/2020**
Amount granted through June 30, 2021:				$ (550,000)		2131	$ 2,427,627
Mini Grants:		1132		$ (5,000)		2281	$ 6,660,000
Financial Audits of Non-Profits		8/15/20		$ (3,000)			
Net adj - Grants not used:		1021		$ 28,760		**Total**	**$ 9,087,627**
Matching external grant contributions				$ -			**$ (0)**
Balance available for Grants/Programs				**$ 3,470,760**			
	Strategic Focus Areas FY20-21:		**Grant Budget**	**Granted YTD**	**Available**		
	1	Healthcare Infrastructure and Services	$ 1,500,000	$ (526,240)	$ 973,760		
	2	Behavioral Health/Mental Health	$ 500,000		$ 500,000		
	3	Homelessness	$ 500,000		$ 500,000		
	4	Vital Human Services to People with Chronic Conditions	$ 1,000,000		$ 1,000,000		
	5	Economic Protection, Recovery and Food Security	$ 500,000	$ (3,000)	$ 497,000		
		Balance available for Grants/Programs	**$ 4,000,000**	**$ (529,240)**	**$ 3,470,760**		

Chief Administration Officer's Report

October 2020

Lund & Guttry has completed the FY2020 Audit reports. The reports will be presented by Gary Dack, CPA, for the Committee's review and consideration for approval at today's meeting.

Staff recently released a Notice Inviting Bids for the landscaping project at the Las Palmas Medical Plaza. A public bid opening was performed on October 6, 2020. Results will be presented at today's meeting.

Las Palmas Medical Plaza - Property Management:

Occupancy:
See attached unit rental status report.

92% currently occupied –

Total annual rent including CAM fees is **$1,227,376.**

Leasing Activity:

Leasing activity has continued to be slow due to the COVID-19 virus. Rob Wenthold, the broker staff is working with, indicated prospective tenants are apprehensive during this period of time.

Las Palmas Medical Plaza
Unit Rental Status
As of October 1, 2020

Unit	Tenant Name	Deposit	Lease Dates		Term	Unit	Percent	Monthly	Annual	Rent Per	Monthly	Total Monthly	Total Annual
			From	To		Sq Feet	of Total	Rent	Rent	Sq Foot	CAM	Rent Inclg CAM	Rent Inclg CAM
											$ 0.62		
3W, 101	Vacant					1,656	3.36%						
2W, 107	Vacant					1,024	2.07%						
1W, 204	Vacant					1,280	2.59%						
Total - Vacancies						**3,960**	**8.02%**						
Total Suites-33 - 31 Suites Occupied		**$ 59,395.10**				**49,356**	**92.0%**	**$ 74,262.26**	**$ 891,147.12**	**$ 1.64**	**$ 28,019.04**	**$ 102,281.30**	**$ 1,227,375.60**

Summary - All Units		
Occupied	45,396	92.0%
Vacant	3,960	8.0%
Pending	0	0%
Total	49,356	100%

DESERT HEALTHCARE
DISTRICT & FOUNDATION

Date: October 27, 2020

To: Board of Directors

Subject: CEO Report – LAFCO MSR Update

Staff Recommendation: Information only

Background:

- In January, the District was informed that Riverside Local Agency Formation Commission (LAFCO) would be completing a Municipal Services Review (MSR) of three special districts, including the Desert Healthcare District.
- LAFCO has completed its Countywide Municipal Service Review and Sphere of Influence Reviews and Potential Amendments of Healthcare Districts, which include Desert Healthcare District, Palo Verde Healthcare District and San Gorgonio Memorial Healthcare District
- LAFCO also has a finding of exemption pursuant to the California Environmental Quality Act (CEQA) and is considering the adoption of a resolution making CEQA exemption determinations on the proposal.
- The draft of the MSR was released for public review on 9/22/2020.
- LAFCO has indicated they do not anticipate concerns with the MSR regarding DHCD, but there are a couple of issues with the other districts they need to resolve.
- It is anticipated that a final approval for the three MSRs will be by November or December.
- Attached, you will find a copy of the final report on Desert Healthcare District.

Fiscal Impact:
N/A

RIVERSIDE LAFCO

5.b.
10/22/2020

TO: **Local Agency Formation Commission**

FROM: **Joshua Altopp, Local Government Analyst III**

SUBJECT: **LAFCO 2019-12-3,4 & 5 COUNTYWIDE MUNICIPAL SERVICE REVIEW AND SPHERE OF INFLUENCE REVIEWS AND POTENTIAL AMENDMENTS HEALTHCARE DISTRICTS**

BACKGROUND. In 2000, the State Legislature established an analytical tool for LAFCOs called municipal service reviews (MSRs), which are designed to evaluate service provisions provided within a special district, in this case the three-healthcare districts within the County. After conducting the reviews, the Commission must prepare a written statement of determinations addressing seven (7) factors, which include population projections, disadvantaged unincorporated communities, present and planned capacities, financial ability to provide services, status of shared facilities, accountability for community service needs, and any other effective or efficient opportunities. In addition to the MSR process is the opportunity to review the spheres of influences for each district.

This is the first time the Commission has reviewed and made determinations on a Healthcare Municipal Service Review. Staff has hired Policy Consulting Associates, who prepared the MSR and will be providing a presentation and more detailed review of the determinations and recommendation at the Commission meeting.

CEQA COMPLIANCE. The LAFCO Commission, as lead agency under the California Environmental Quality Act (CEQA), has found the MSR to be exempt pursuant to Section 15306, Class 6, basic data collection, research, and resource evaluation activities which do not result in a serious or major disturbance to an environmental resource.

COMMENTS. Healthcare service providers provided input throughout the development of the MSR. The draft MSR was made available for additional agency comment during a formal review period. Following the agency review, a revised public review draft was issued for public review and comment. All relevant comments will be incorporated into the final draft of the MSR.

DETERMINATIONS. Each of the three-healthcare districts that were reviewed have their own set of determinations of the seven factors

along with sphere of influence recommendations. Desert Healthcare District determinations/SOI update can be found on Pages 62-65 of the report. It is recommended that the sphere of influence remain coterminous due to a recent expansion of the district in 2018. Determinations for Palo Verde Healthcare District can be found on Pages 98-101. It is being recommended that their SOI be expanded to include the communities of Desert Center, Eagle Mountain, Lake Tamarisk, and the rest of the territory between Desert and Palo Verde districts. San Gorgonio Memorial Healthcare District required set of determination are on Pages 137-141 and it is recommended that their SOI be expanded to include the missing portions of the Cities of Calimesa, Beaumont, and their spheres.

SPECIFIC RECOMMENDATIONS. Based upon the factors outlined above, IT IS RECOMMENDED that the Commission adopt a resolution taking the following actions:

1. Conduct the hearing on the Municipal Service Review.

2. Find the 2020 Healthcare District Municipal Service Review is exempt from California Environmental Quality Act (CEQA) pursuant to Section 15306, Class 6, basic data collection, research, and resource evaluation activities which do not result in a serious or major disturbance to an environmental resource.

3. Adopt the statement of determinations for each Healthcare District within the Municipal Service Review.

4. Amend the Palo Verde and San Gorgonio Healthcare Districts Healthcare District as recommended in the Municipal Service Review report.

5. Receive and file the Healthcare Municipal Service Review - **LAFCO 2019-12-3, 4, & 5 Countywide Municipal Service Review and Sphere of Influence Reviews for the Healthcare Districts.**

Respectfully submitted,

Joshua Altopp
Local Government Analyst III

Attachment: The 2020 Healthcare District Municipal Service Review

RIVERSIDE COUNTY HEALTHCARE DISTRICTS MUNICIPAL SERVICE REVIEW & SPHERE OF INFLUENCE UPDATE PUBLIC REVIEW DRAFT

September 24, 2020

Prepared for the
Riverside Local Agency Formation Commission
by Policy Consulting Associates, LLC.

TABLE OF CONTENTS

LIST OF FIGURES

ACRONYMS AND DEFINITIONS

AAA Repairs:	abdominal aortic aneurysm repairs
AB:	Assembly Bill
ACA:	Affordable Care Act
ACHC:	Accreditation Commission for Health Care
ADA:	Americans with Disabilities Act
ALS:	amyotrophic lateral sclerosis
CABG:	coronary artery bypass graft surgery
CAH:	critical access hospital
CAO:	Chief Administration Officer
CEO:	Chief Executive Officer
CEQA:	California Environmental Quality Act
CFD:	community facilities district
CHA:	California Hospital Association
CHAP:	Community Health Accreditation Program
CHHS:	California Health and Human Services Agency
CHIP:	Community Health Improvement Plan
CHNA:	Community Health Needs Assessment
CIHQ:	Center for Improvement in Healthcare Quality
CIP:	Capital Improvement Plan or Program
CKH:	Cortese-Knox-Hertzberg Local Government Reorganization Act of 2000
CMS:	Centers for Medicare and Medicaid Services
CPO:	Chief Program Officer
CPSP:	Comprehensive Perinatal Services Program
CVAG:	Coachella Valley Agency Governments
CY:	Calendar year
DHD:	Desert Healthcare District
DHCS:	Department of Health Care Services
DMHC:	Department of Managed Health Care
DNV:	Det Norske Veritas
DNVHC:	DNV Healthcare, Inc.
DPH:	Department of Public Health
DPPS:	Department of Public Social Services
DRMC:	Desert Regional Medical Center
DSH:	disproportionate-share hospital
DUC:	disadvantaged unincorporated community
ED:	emergency department
EMS:	emergency medical service
FPPC:	Fair Political Practices Commission
FTE:	full-time equivalent
FY:	Fiscal year
GIS:	Geographic Information Systems
HARC:	Health Access Resource Center
HCAHPS:	Hospital Consumer Assessment of Healthcare Providers and Systems
HFAP:	Healthcare Facilities Accreditation Program

HHS:	U.S. Department of Health and Human Services
HMO:	Health Maintenance Organization
HPSA:	Health Care Professional Shortage Areas
HQAA:	Healthcare Quality Association on Accreditation
HQAF:	hospital quality assurance fee
ICU:	intensive care unit
IMI:	inpatient mortality indicators
JC:	Joint Commission
JPA:	Joint Powers Authority or Agency
LDR:	labor, delivery, and recovery
LAFCO:	Local Agency Formation Commission
MD:	medical doctors
Medi-Cal:	California Medical Assistance Program
MUA:	medically underserved area
NP:	nurse practitioner
NPC:	Non-Structural Performance Category
OPEB:	other postemployment benefits
OSHPD:	Office of Statewide Health Planning & Development
PA:	physician's assistant
PCI:	percutaneous coronary intervention
PPACA:	Patient Protection and Affordable Care Act
PQI:	Prevention Quality Indicators
PRIME:	Public Hospital Redesign and Incentives in Medi-Cal
PVHD:	Palo Verde Healthcare District
RAP:	Regional Access Project
RN:	registered nurse
SB:	Senate Bill
SCAG:	Southern California Association of Governments
SCHIP:	State Children's Health Insurance Program
SGMH:	San Gorgonio (Pass) Memorial Hospital
SGMHD:	San Gorgonio Memorial (Pass) Healthcare District
SOI:	Sphere of influence
SPC:	Structural Performance Category
TCPI:	Transforming Clinical Practice Initiative
UCR:	University of California in Riverside

PREFACE

Prepared for the Local Agency Formation Commission of Riverside County (LAFCO), this report is a Municipal Service Review (MSR) and Sphere of Influence (SOI) Update for the Desert, Palo Verde, and San Gorgonio Memorial Healthcare Districts.

CONTEXT

Riverside LAFCO is required to prepare this Service Review by the Cortese-Knox-Hertzberg Local Government Reorganization Act of 2000 (CKH), (Government Code §56000, et seq.), which took effect on January 1, 2001. The MSR examines services provided by public agencies whose boundaries and governance are subject to LAFCO. Those agencies providing healthcare services in Riverside County are the focus of this review. In order to provide comprehensive information on service provision, other service providers—private healthcare providers—are mentioned for context in this Service Review.

CREDITS

The authors extend their appreciation to those individuals at the agencies that provided planning and financial information and documents used in this report. The contributors are listed individually at the end of this report.

LAFCO staff provided project coordination and GIS support. This report was prepared by Policy Consulting Associates, LLC, and was co-authored by Oxana Wolfson, Jennifer Stephenson, and Jill Hetland. Oxana Wolfson served as project manager.

1. EXECUTIVE SUMMARY

This report is a municipal service review report on healthcare services prepared for Riverside LAFCO. A service review is a State-required comprehensive study of services within a designated geographic area, in this case, the County of Riverside. The service review requirement is codified in the CKH (Government Code Section 56000 et seq.).

The intent of this municipal service review is to conduct comprehensive Sphere of Influence (SOI) updates for each of the subject healthcare districts. The proposed MSR and SOI Update determinations, as well as SOI recommendation, are located at the end of each district's chapter in this report.

PROVIDERS

This report covers three healthcare districts—Desert Healthcare District, Palo Verde Healthcare District, and San Gorgonio Memorial Healthcare District. These three districts provide healthcare services and programs in varying structures and manners.

- Desert Healthcare District (DHD) owns and maintains a hospital facility and medical clinics that are leased to providers. Revenues are used to issue grants for healthcare programs.
- Palo Verde Healthcare District (PVHD) owns and directly operates a hospital facility.
- San Gorgonio Memorial Healthcare District (SGMHD) owns and maintains a hospital facility and Behavioral Health Center and contracts for management and operations of the facilities.

The location of the districts is shown in Figure 1-1.

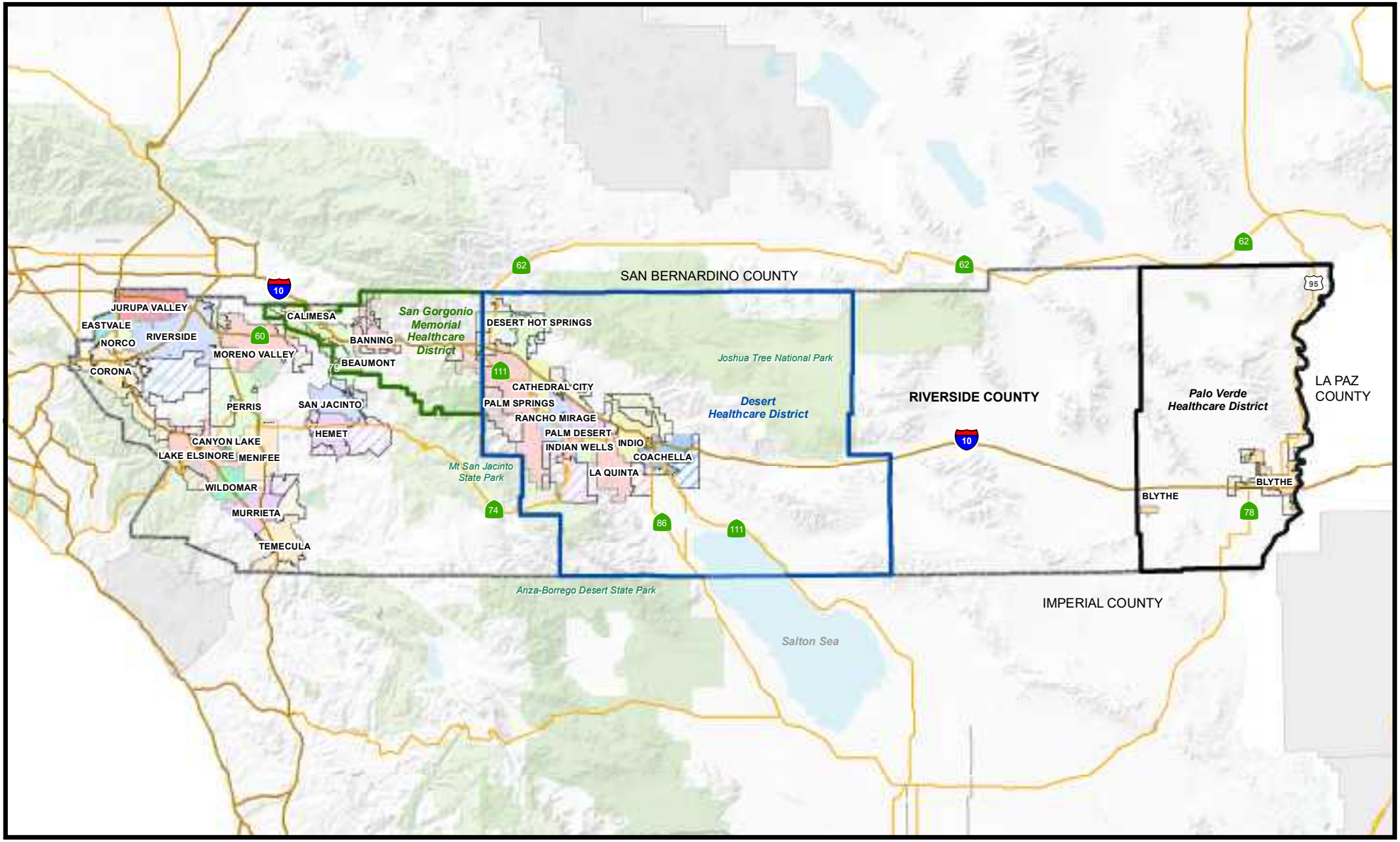
GOVERNANCE AND ACCOUNTABILITY

The healthcare districts reviewed in the MSR meet Brown Act requirements including noticing and posting of meetings and agendas, communication and outreach to residents, and websites that provide links to meeting information, contacts, and documents including financial reports.

There are extensive website requirements for healthcare districts as outlined in Senate Bill 929, Assembly Bill 2257, and Assembly Bill 2019. The districts generally meet the requirements outlined; however, it is recommended that they ensure compliance and continue to practice diligence to ensure that all relevant and recent documents and reports are up-to-date and readily available to the public on their websites.

All districts demonstrated accountability and transparency in their disclosure of information and cooperation during the process of this MSR. The districts generally responded in a timely manner to the questionnaires and cooperated with document requests; however, follow up attempts with PVHD to gather remaining missing information were unsuccessful.

Figure 1-1: Riverside County Healthcare Districts



Data Sources: County of Riverside; LAFCo

0 2.5 5 10 15 20 Miles

N

Legend

- Desert Healthcare District
- Palo Verde Healthcare District
- San Gorgonio Memorial Healthcare District
- Riverside Couinty Boundary

Disclaimer: The information shown is intended to be used for reference and general display purposes only and is not to be used as an official map.

Healthcare services provided for District residents

Map Created on 9/14\2020

PLANNING AND MANAGEMENT

Significant planning documents for many healthcare districts are the Community Healthcare Needs Assessment (CHNA) and Community Healthcare Implementation Plan (CHIP) that are required as part of the Affordable Care Act. Both DHD and SGMHD have compiled or are in the process of compiling CHNA and CHIP reports. As an alternative, PVHD has developed a strategic plan and annual strategic goals to guide future program and service efforts.

GROWTH AND POPULATION PROJECTIONS

The districts vary greatly by size and degree of urbanization. DHD and SGMHD serve expansive areas comprised of multiple cities with greater potential for growth and development. PVHD serves a largely rural area. Future growth as projected by the Southern California Association of Governments ranges from one percent in DHD and PVHD to 1.6 percent in SGMHD.

Figure 1-3: District Populations and Growth Projections

District	Population (2020)	Projected Annual Growth Rate	Projected Population (2030)	Projected Population (2045)
Desert Healthcare District	445,721	1%	501,332	571,695
Palo Verde Healthcare District	21,376	1%	24,785	30,049
San Gorgonio Memorial Healthcare District	105,556	1.6%	123,714	156,561

FINANCING

Financing is frequently a significant challenge for healthcare districts in the State as they struggle to compete with for-profit providers and dedicate high levels of funding to charity care in an attempt to address the problem of the underserved population. The three districts reviewed in this MSR are no exception. They all generally struggle with the uncertainty of the existing funding sources, limited additional financing options, and high capital improvement costs.

Despite these challenges, all three districts consistently operate with operational surpluses and balanced budgets, and have positive net positions indicating stability with ongoing operations. All the districts were determined to have sufficient cash on hand to operate for several months or more, have low or no pension, retirement and OPEB obligations, possess sufficient liquidity to pay liabilities as they become due, and have healthy financial reserves.

SPHERE OF INFLUENCE RECOMMENDATIONS

All three districts have SOIs that are coterminous with their boundaries. DHD's SOI was last updated in 2018 when it conducted a large land expansion through special legislation of the State legislature. The SOIs of PVHD and SGMHD were last updated in 2005 and confirmed as coterminous at that time.

The following SOI update recommendations are made for the Commission's consideration for the districts resulting from the comprehensive review and analysis in this report:

- DHD has undergone a recent SOI change and annexation that more than doubled the District's boundary area and its population. The District does not currently have adequate capacity to accommodate or plan for additional growth. It is recommended that the Commission maintain a coterminous SOI for DHD.
- The communities of Desert Center, Eagle Mountain and Lake Tamarisk are currently not included in any healthcare district and located between DHD and PVHD. Given that the area around Desert Center is considered PVHD's secondary service area, DHD's lack of existing capacity to extend services further, and the distance from Desert Center to the DHD's hospital, it is recommended that PVHD's SOI be expanded to include the territory between DHD and PVHD.
- At present, the cities of Calimesa and Beaumont are only partially included in SGMHD's boundary and SOI. One of LAFCO's objectives is to eliminate illogical boundaries and associated service inefficiencies, such as the areas in question. It is recommended that SGMHD's SOI be expanded to include the entirety of the cities of Calimesa and Beaumont and their SOIs in order to address the divided communities of interest, lack of inclusion of some of the District's patrons within its boundaries, and illogical boundaries.

2. BACKGROUND

This report is prepared pursuant to legislation enacted in 2000 that requires LAFCO to conduct a comprehensive review of municipal service delivery and update the spheres of influence (SOIs) of all agencies under LAFCO's jurisdiction. This chapter provides an overview of LAFCO's powers and responsibilities. It discusses legal requirements for preparation of the municipal services review (MSR), and describes the process for MSR review, MSR approval and SOI updates.

LAFCO OVERVIEW

LAFCO regulates, through approval, denial, conditions and modification, boundary changes proposed by public agencies or individuals. It also regulates the extension of public services by cities and special districts outside their boundaries. LAFCO is empowered to initiate updates to the SOIs and proposals involving the dissolution or consolidation of special districts, mergers, establishment of subsidiary districts, and any reorganization including such actions. Otherwise, LAFCO actions must originate as petitions or resolutions from affected voters, landowners, cities or districts.

The composition of LAFCO Commissions varies from county to county. Riverside LAFCO consists of members who represent all levels of local government. They include two County supervisors selected by the Board of Supervisors, two city council representatives selected by the City Selection Committee within Riverside County, two special district board members selected by the Special District Selection Committee within Riverside County, and one public member selected by the other members of the Commission. For each category of commissioner represented (county, city, special district, and public) there is one alternate. Alternate members may attend LAFCO meetings but only vote on items when a regular member from their category is absent. Each Commission member serves a four-year term.

MUNICIPAL SERVICES REVIEW LEGISLATION

The CKH requires LAFCO review and update SOIs not less than every five years and to review municipal services before updating SOIs. The requirement for service reviews arises from the identified need for a more coordinated and efficient public service structure to support California's anticipated growth. The service review provides LAFCO with a tool to study existing and future public service conditions comprehensively and to evaluate organizational options for accommodating growth, preventing urban sprawl, and ensuring that critical services are provided efficiently.

Government Code §56430 requires LAFCO to conduct a review of municipal services provided in the county by region, sub-region or other designated geographic area, as appropriate, for the service or services to be reviewed, and prepare a written statement of determination with respect to each of the following topics:

- Growth and population projections for the affected area;
- The location and characteristics of any disadvantaged unincorporated communities within or contiguous to the SOI (effective July 1, 2012);

- Present and planned capacity of public facilities and adequacy of public services, including infrastructure needs or deficiencies (including needs or deficiencies related to sewers, municipal and industrial water, and structural fire protection in any disadvantaged unincorporated communities within or contiguous to the SOI);
- Financial ability of agencies to provide services;
- Status of, and opportunities for shared facilities;
- Accountability for community service needs, including governmental structure and operational efficiencies; and
- Any other matter related to effective or efficient service delivery, as required by commission policy.

MUNICIPAL SERVICES REVIEW PROCESS

The MSR process does not require LAFCO to initiate changes of organization based on service review findings, only that LAFCO identify potential government structure options. However, LAFCO, other local agencies, and the public may subsequently use the determinations to analyze prospective changes of organization or reorganization or to establish or amend SOIs. Within its legal authorization, LAFCO may act with respect to a recommended change of organization or reorganization on its own initiative (e.g., certain types of consolidations), or in response to a proposal (i.e., initiated by resolution or petition by landowners or registered voters).

MSRs are exempt from California Environmental Quality Act (CEQA) pursuant to §15306 (information collection) of the CEQA Guidelines. LAFCO's actions to adopt MSR determinations are not considered "projects" subject to CEQA.

SPHERE OF INFLUENCE UPDATES

The Commission is charged with developing and updating the SOI for each city and special district within the county.[1] SOIs must be updated every five years or as necessary. In determining the SOI, LAFCO is required to complete an MSR and adopt the seven determinations previously discussed.

An SOI is a LAFCO-approved plan that designates an agency's probable future boundary and service area. Spheres are planning tools used to provide guidance for individual boundary change proposals and are intended to encourage efficient provision of organized community services and prevent duplication of service delivery. Territory cannot be annexed by LAFCO to a city or a district unless it is within that agency's sphere.

The purposes of the SOI include the following: to ensure the efficient provision of services, discourage urban sprawl and premature conversion of agricultural and open space lands, and prevent overlapping jurisdictions and duplication of services.

LAFCO cannot regulate land use, dictate internal operations or administration of any local agency, or set rates. LAFCO is empowered to enact policies that indirectly affect land use decisions. On a regional level, LAFCO promotes logical and orderly development of

[1] The initial statutory mandate, in 1971, imposed no deadline for completing sphere designations. When most LAFCOs failed to act, 1984 legislation required all LAFCOs to establish spheres of influence by 1985.

communities as it considers and decides individual proposals. LAFCO has a role in reconciling differences between agency plans so that the most efficient urban service arrangements are created for the benefit of current and future area residents and property owners.

The Cortese-Knox-Hertzberg (CKH) Act requires LAFCOs to develop and determine the SOI of each local governmental agency within the county and to review and update the SOI every five years. LAFCOs are empowered to adopt, update and amend the SOI. They may do so with or without an application and any interested person may submit an application proposing an SOI amendment.

LAFCO may recommend government reorganizations to particular agencies in the county, using the SOIs as the basis for those recommendations.

In addition, in adopting or amending an SOI, LAFCO must make the following determinations:

- Present and planned land uses in the area, including agricultural and open-space lands;
- Present and probable need for public facilities and services in the area;
- Present capacity of public facilities and adequacy of public service that the agency provides or is authorized to provide;
- Existence of any social or economic communities of interest in the area if the Commission determines these are relevant to the agency; and
- Present and probable need for water, wastewater, and structural fire protection facilities and services of any disadvantaged unincorporated communities within the existing SOI.

By statute, LAFCO must notify affected agencies 21 days before holding the public hearing to consider the SOI and may not update the SOI until after that hearing. The LAFCO Executive Officer must issue a report including recommendations on the SOI amendments and updates under consideration at least five days before the public hearing.

DISADVANTAGED UNINCORPORATED COMMUNITIES

On October 7, 2011, Governor Brown signed SB 244, which makes two principal changes to the CKH. SB 244 requires LAFCOs to: (1) deny any application to annex to a city territory that is contiguous to a disadvantaged unincorporated community (DUC) unless a second application is submitted to annex the disadvantaged community as well; and (2) evaluate disadvantaged unincorporated communities in a MSR upon the next update of a SOI after June 30, 2012.

The intent of the statute is to encourage investment in disadvantaged unincorporated communities that often lack basic infrastructure by mandating cities and LAFCOs to include them in land use planning.

SB 244 defines a DUC as any area with 12 or more registered voters, or as determined by commission policy, where the median household income is less than 80 percent of the statewide annual median.

SB 244 also requires LAFCOs to consider disadvantaged unincorporated communities when developing spheres of influence. Upon the next update of a SOI on or after July 1, 2012, SB 244 requires LAFCO to include in an MSR (in preparation of a SOI update): 1) The location and characteristics of any disadvantaged unincorporated communities within or contiguous to the sphere; and 2) The present and planned capacity of public facilities, adequacy of public services and infrastructure needs or deficiencies including needs or deficiencies related to sewers, municipal and industrial water, and structural fire protection in any DUC within or contiguous to the SOI.

In determining spheres of influence, SB 244 authorizes LAFCO to assess the feasibility of a reorganization and consolidation of local agencies to further orderly development and improve the efficiency and affordability of infrastructure and service delivery. LAFCOs should revise their local policies to include the requirements imposed by SB 244 to ensure they fulfill their obligations under this legislation.

3. OVERVIEW

CALIFORNIA HEALTHCARE DISTRICTS

The Local Hospital District Law was originally enacted in 1945 (Division 23, Section 32000 et seq. of the Health and Safety Code, now referenced as the "Local Health Care District Law"). The law enabled local communities to establish special districts and utilize public financing options for construction and operation of local community hospitals and healthcare institutions in rural, low income areas without access to acute-care hospital facilities, and to recruit physicians for medically unserved areas. Formed by voter approval, local hospital districts were empowered to impose property taxes, enter into contracts, purchase property, exercise the power of eminent domain, issue debt, and hire staff.

Following the establishment of local hospital districts in the 1940's and 1950's, many of the previously rural service areas have grown into highly populated urban and suburban communities. The current residents of these urbanized communities may now have multiple options for local and regional health care facilities and health care service opportunities from both private and public providers.

During the 1970s and 1980s, the nonprofit health care market dramatically changed with the advent of Health Maintenance Organizations (HMO), which introduced managed care and created large health systems comprised of network-affiliated hospitals, physician groups, and medical service providers that pool resources and direct patients to preferred facilities and groups. The conglomeration of health care providers and incentivized patient referrals within affiliated health system networks placed independent fee-for-service hospitals at a competitive disadvantage for attracting patients.

In response to the competitive market environment, the focus of hospital districts expanded from primarily owning and operating local acute-care hospital facilities to also supporting community healthcare and healthcare-related programs and services within their service areas. In 1994, the State Legislature broadened the scope of hospital districts and renamed the statute to its current reference, "The Local Health Care District Law.'' This action redesignated hospital districts to healthcare districts to better reflect the diverse healthcare services provided in addition to operation of local hospital facilities.

The 1994 legislative update also expanded the definition of healthcare facilities as improvements in technology have allowed many medical procedures and services that previously required acute-care facilities and services to be handled on an out-patient basis. Authorized services granted to healthcare districts under current law includes, but is not limited to:

- Operating healthcare facilities such as hospitals, clinics, skilled nursing facilities, adult day health centers, nurses' training school, and childcare facilities.
- Operating ambulance services within and outside of the district.
- Operating programs that provide chemical dependency services, health education, wellness and prevention, rehabilitation, and aftercare.
- Carrying out activities through corporations, joint ventures, or partnerships.

- Establishing or participating in managed care.
- Contracting with and making grants to provider groups and clinics in the community.
- Other activities that are necessary for the maintenance of good physical and mental health in communities served by the district.

The move towards managed care and large healthcare systems with preferred providers created significant financial sustainability problems for many stand-alone healthcare district hospitals in the State.

While many healthcare districts receive a portion of local property taxes, the enactment of Proposition 13 in 1978 resulted in restricted access to property tax revenues for local public agencies, including healthcare district. Healthcare districts can utilize bonded debt financing to fund capital projects such as hospital construction. Issuance of General Obligation bonds requires approval by two-thirds of the local electorate, and revenue bonds are backed by user fees. Healthcare districts may also issue promissory notes and receive loans from state and federal governments.

Healthcare districts have generally evolved to meet the changing healthcare market demands; however, many have been dissolved and only about half of the ones remaining still operate hospitals.

To retain their local acute-care hospital facilities and services, many healthcare districts have created nonprofit corporations to transfer or sell their local hospital facilities and/or contract their hospital facility operations with for-profit or nonprofit health systems. The divestitures of district hospital facilities and/or operations are allowed under current law, and approval by local voters is required when certain thresholds of district assets are proposed for transfer or sale.

Regulatory Environment

Federal

The U.S. Department of Health and Human Services (HHS) is the U.S. federal government's principal healthcare agency. The Centers for Medicare and Medicaid Services (CMS), a component of HHS, administers Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and most aspects of the Patient Protection and Affordable Care Act (PPACA) of 2010. Medicare and Medicaid together provide healthcare insurance for one in four Americans.

Medicare is a national social insurance program, administered by the U.S. federal government since 1966. Medicare is the nation's largest health insurer, handling more than one billion claims per year. Medicare uses approximately 30 private insurance companies across the United States to provide health insurance for Americans aged 65 and older who have worked and paid into the system. Medicare also provides health insurance to younger people with disabilities, end stage renal disease and amyotrophic lateral sclerosis (ALS).

The Social Security Administration is responsible for determining Medicare eligibility and for determining eligibility for and payment of Extra Help/Low Income Subsidy payments. Reimbursement to healthcare providers averages approximately 48 percent of the charges for the patients enrolled in Medicare. The remaining approved healthcare

charges are the responsibility of the Medicare patient and are generally covered with supplemental insurance or with another form of out-of-pocket coverage.

Medicaid is a social health care program for U.S. families and individuals with low income and limited resources. Medicaid recipients must be U.S. citizens or legal permanent residents, and may include low-income adults, their children, and people with certain disabilities. Medicaid is jointly funded by the state and federal governments and is the largest source of funding for medical and health-related services for people with low income in the United States. Medicaid is a means-tested program managed by the states, with each state currently having broad discretion to determine eligibility and for implementation of the program. All states currently participate in the program but are not required to do so.

The Patient Protection and Affordable Care Act (PPACA), known as the Affordable Care Act (ACA), is a United States federal statute signed into law by President Barack Obama on March 23, 2010. The ACA is regarded as the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965. Enactment of the ACA was intended to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of healthcare for individuals and the government.

The ACA requires healthcare insurance companies to cover all applicants within new minimum standards and offer the same rates regardless of pre-existing conditions or sex. The ACA introduced mechanisms like subsidies, and insurance exchanges, and restructured Medicare reimbursements.

The ACA expanded both eligibility for and federal funding of Medicaid by qualifying all U.S. citizens and legal residents with income up to 133 percent of the poverty line, including adults without dependent children; however, some states have declined the expansion and continue their previously existing Medicaid eligibility requirements and funding levels.

State

The California Health and Human Services Agency (CHHS) is the state agency responsible for administration and oversight of "state and federal programs for healthcare, social services, public assistance and rehabilitation" in California. CHHS oversees 11 departments and boards, and four offices that provide a wide range of healthcare services, social services, mental health services, alcohol and drug treatment services, public health services, income assistance, and services to people with disabilities.

The California Department of Health Care Services (DHCS) is department within the CHHS that finances and administers a number of individual healthcare service delivery programs, including Medi-Cal, which provides healthcare services to people with low incomes.

The California Medical Assistance Program (Medi-Cal) is the name of the California implementation of the federal Medicaid program that serves low-income families, seniors, persons with disabilities, children in foster care, pregnant women, and certain low-income adults. Approximately 30 percent of California's population is enrolled in Medi-Cal. Medi-Cal is jointly administered by the California DHCS and the federal CMS, with many services implemented at the local level by the counties of California.

Covered California is the health insurance marketplace in California, the state's implementation of the American Health Benefit Exchange provisions of the PPACA. Beginning in 2014, those with family incomes up to 138 percent of the federal poverty level became eligible for Medi-Cal, and individuals with higher incomes and some small businesses may choose a plan in Covered California with potential federal subsidies.

The California Office of Statewide Health Planning & Development (OSHPD) was created in 1978 to review and report on the structure and function of healthcare delivery systems in California. OSHPD collects and disseminates healthcare data and information about California's healthcare infrastructure, monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities, and provides loan insurance to not-for-profit healthcare facilities.

The Alfred E. Alquist Seismic Safety Act of 1983 (California Health and Safety Code Section 129675 et. seq.) provides a seismic safety building standards program under OSHPD's jurisdiction for hospitals built on or after March 7, 1973. The Act was originally established in response to the loss of life from the collapse of hospitals during the Sylmar earthquake of 1971. Following the Northridge earthquake in 1994, Senate Bill (SB) 1953 was enacted which amended the Alquist Act to require that all licensed acute-care hospitals in California be capable of remaining operational after a seismic event or other natural disaster with an initial compliance deadline of 2013.

SB 1953 required OSHPD to develop seismic performance categories for evaluating both the seismic resistance of the hospital structures as well as the adequate anchorage and bracing of non-structural features such as electrical, mechanical, plumbing and fire safety systems for their continued use following a disaster event. Hospitals are required to prepare both a comprehensive evaluation report and compliance plan to attain the specified structural and nonstructural performance categories.

Subsequent changes to the legislation have established a final compliance deadline of 2030, by which any licensed acute-care hospital facilities not in compliance with seismic safety standards must be replaced or cease acute-acre operations.

Private Health Care Providers in the state are licensed and regulated by the California Department of Managed Health Care (DMHC). The DMHC oversees full-service health plans, including all California HMOs, as well as specialized plans such as dental and vision. Health plans are required to apply for and maintain a license from the DMHC to operate as a health plan in California. The DMHC reviews all aspects of the plan's operations to ensure compliance with California law. This includes, but is not limited to, Evidences of Coverage, contracts with doctors and hospitals, provider networks, and complaint and grievance systems. Overall, the DMHC regulates more than 90 percent of the commercial healthcare marketplace in California.

County

The County of Riverside Department of Public Social Services (DPSS) is responsible for providing a broad range of health and social services in Riverside County. The DPSS includes seven primary program areas, which cover the various aspects of health and social services including adult services, children's services, self-sufficiency, in-home supportive services, continuum of care, family resources, and community outreach. Services are provided

through five departments: Administration, Adult Services, Children's Services, Self-Sufficiency and Public Authority.

The Riverside DPSS is responsible for providing county-administered health and social programs related to welfare in California, such as Medi-Cal, CalFresh (food stamps), CalWORKs, and the Low-Income Health Program (ACA).

SETTING

The study area of this Municipal Service Review (MSR) covers four healthcare districts in Riverside County that include Desert Healthcare District (DHD), Palo Verde Healthcare District (PVHD), San Gorgonio Memorial Healthcare District (SGMHD), and Valley Health System Healthcare District (VHSHD).

VHSHD is an inactive district and does not currently provide any services. The District covers vast 882 square mile territory in the greater San Jacinto and Menifee Valley areas and includes the cities of Hemet and San Jacinto. VHSHD was formed in 1946 to provide healthcare services to an existing 18-bed hospital, at that time, in the City of Hemet but after providing services for many decades filed for Chapter 9 bankruptcy protection in 2007. VHSHD had completed sale of all its assets by the end of 2010 and terminated all of its employees. Riverside LAFCO approved the adoption of a "zero" sphere of influence (SOI) designation in 2019 and the district dissolution on June 25, 2020.

The three other healthcare districts in Riverside County remain operational and continue to serve their respective communities. DHD, PVHD, and SGMHD were formed in 1948, 1948, and 1947, respectively, bringing these underserved areas located away from urban centers vital and convenient healthcare options.

The DHD service area represents the largest service area of all three districts. The 2018 boundary expansion more than doubled the geographic and demographic size of the District to include almost the entirety of the Coachella Valley region. Population within DHD fluctuates seasonally due to tourism and second homes in this resort area and represents the largest served population among the three active healthcare districts. DHD's western boundary is adjacent to that of San Gorgonio Memorial District, which claims the western portions of the cities of Palm Springs and Desert Hot Springs in its boundaries and SOI. The eastern boundary of DHD stretches to include the unincorporated community of Chiriaco Summit as well as portions of Joshua Tree National Park and the Salton Sea. The District is bound by the San Bernardino county border in the north and the San Diego and Imperial county lines in the south.

PVHD is located to the east of DHD; however, the two districts do not share a boundary. The stretch of land between PVHD and DHD includes the unincorporated communities of Desert Center, Eagle Mountain and Lake Tamarisk, just about 20 miles east of DHD's eastern boundary and uninhabited areas characterized by rough terrains including Eagle Mountains, Chuckwalla Valley and Chuckwalla Mountains. The PVHD's boundaries generally include the City of Blythe and surrounding unincorporated communities. The District covers the entirety of Riverside County land in the north, east and south; its western border is marked by the Blythe's western boundary. Although the unincorporated communities of Desert Center, Eagle Mountain and Lake Tamarisk that are not located in any healthcare district are generally closer to DHD's eastern boundary, PVHD considers these areas its secondary

service area, presumably because the Palo Verde Hospital is much closer to these communities than the Desert Regional Medical Center owned by DHD.

In comparison to DHD and PVHD, SGMHD's boundaries cover the smallest area. However, because the territory within the District is largely urban (particularly in its western portions) served population is disproportionately large, especially compared to mostly rural PVHD. The SGMHD's boundary area generally stretches to include most of the cities of Beaumont and Calimesa in the west and small portions of the cities of Palm Springs and Desert Hot Springs in the east. The eastern portion of the District between the cities of Banning and Palm Springs is largely unincorporated with a more rural character and lower population density. SGMHD also provides services to the secondary service area outside of its boundaries that include the cities of San Jacinto and Hemet, previously served by Valley Health System Healthcare District.

The rest of Riverside County to the west of SGMHD is not included in the boundaries of any healthcare district.

The spheres of influence for all three reviewed districts are currently coterminous, which means they are the same as their respective boundaries.

SERVICES

Each healthcare district reviewed in this MSR offers an array of services, whether they be medical care, preventive programs or providing funding for healthcare programs and services.

Although DHD owns the Desert Regional Medical Center (DRMC), the District does not operate the hospital directly and has a lease for the facility with Tenet Health Systems, Inc. DHD's direct services include providing grant funding for community health initiatives within its boundary area. The District supports a variety of health-related programs, through financial assistance to nonprofit entities and public agencies. DHD has taken a leadership role in the collective efforts in the areas of access to healthcare, medically underserved populations, shortage of healthcare workers, health disparities, homelessness, behavioral health, socioeconomic determinants of health, and public health issues.

Despite not being the direct hospital service provider, the Desert Healthcare District Board of Directors retains significant oversight responsibilities over the Desert Regional Medical Center. This medical facility is a 385-bed hospital that provides comprehensive medical care covering a number of serious medical conditions that include but are not limited to advanced brain and spinal injuries, stroke, cancer, heart disorders and others in its inpatient and outpatient departments that are fully equipped with state-of-the-art medical technology.

SGMHD, similar to DHD, is not a direct hospital service provider. The District does, however, own a hospital, which is managed by the SGMH Corporation under contract. The District itself works hand in hand with its foundation to help provide funding through grants, donations, and fundraising for hospital related services. From orthopedic care and obstetrics, to emergency services, cardiac rehabilitation, and behavioral health, San Gorgonio Memorial Hospital (SGMH) offers comprehensive medical care and related health and wellness programs. While some of these services take place at the hospital itself, there

is also a Women's Center on the hospital's campus, and the San Gorgonio Memorial Medical Clinic located in the city of Banning.

Currently a small facility of 79 hospital beds, SGMH is undergoing continuous expansion. Upon completion, renovations will ultimately add more bed capacity and functional space for a variety of needs.

Unlike DHD and SGMHD, Palo Verde Healthcare District provides hospital services directly. PVHD owns and operates a small facility of 51 hospital beds. The hospital offers a full range of services from maternity to end of life palliative and/or hospice care. A variety of low or no-cost services are also provided to the community such as medical and wellness education programs, medical screenings, and support groups.

In comparison to the other two districts however, Palo Verde Hospital (PVH) serves a relatively small population throughout a largely rural community, which is reflected in more limited service offerings. For instance, the hospital does not perform invasive, interventional cardiac or surgical procedures, and pediatric patients or newborns in need of intensive care services are transferred from the hospital's emergency department to other facilities capable of fulfilling those needs.

KEY FINDINGS

Service Needs and Challenges

Overall, this MSR has found that all three districts reviewed offer valuable and needed services in Riverside County through providing and/or financing a range of hospital, clinic and other healthcare related services in their respective communities.

However, despite their very different roles and locations, all three districts face similar challenges related to underserved residents as reflected by extensive medically underserved areas (MUAs) and Primary Care Health Care Professional Shortage Areas (HPSA) in all three districts and racial and ethnic disparities in health outcomes and in access to healthcare services.[2] The chronic disease and behavioral health burden in Riverside County is significant, there are not enough nurses and physicians, and a high percentage of the population is uninsured.

There are concerns that if the Affordable Care Act (ACA) is repealed the situation will be dramatically exacerbated as high ratios of people in the reviewed healthcare districts currently rely on the ACA for their health coverage. The loss of coverage for a significant fraction of the population would in turn place additional financial burden on the districts that are already financially challenged.

Overall, medical care in Riverside County appears to be comparable to the rest of the state based on Prevention Quality Indicators (PQIs). Figure 3-1 shows that Riverside County's PQI rates do not largely differ from statewide rates. When a person receives early and proper treatment for specific medical conditions, disease complications may be reduced or eliminated, disease progression may be slowed, and hospitalization may be prevented.

[2] Riverside County recognizes higher rates of diabetes in African Americans (11 percent) and Hispanics (10 percent), than whites (7 percent). Hispanics experience a higher rate of teen pregnancy than whites. 89 percent of whites have health insurance coverage, compared with 75 percent of Hispanics.

For uncontrolled diabetes and asthma in young adults, the Riverside County rates are lower than statewide rates by a larger margin than all other indicators, suggesting that residents in the County have better access to outpatient care for these diseases compared to statewide. The short-term diabetes complications and community acquired pneumonia rates in Riverside County, on the other hand, were higher than statewide rates by a large margin. Riverside County Department of Public Health (DPH) reports that Riverside County residents generally struggle with such health issues as diabetes, COPD and heart disease.

Figure 3-1: Risk Adjusted Rates per 1,000 Population

Year	Region	Diabetes Short-term Complications	Diabetes Long-Term Complications	COPD or Asthma in Older Adults (Ages 40+)	Hypertension	Heart Failure	Community-Acquired Pneumonia	Urinary Tract Infection
2017	Statewide	38.4	90.6	299.1	40.5	330.4	108.4	101.3
	Riverside	41.9	89.5	286	37.7	292.5	115.1	104
	Difference with statewide	9%	-1%	-4%	-7%	-11%	6%	3%
2018	Statewide	58.1	88.4	229	41.5	335.4	107	93.3
	Riverside	67.4	92.9	208.3	41.2	309.5	125.1	98.9
	Difference with statewide	16%	5%	-9%	-1%	-8%	17%	6%

Year	Region	Uncontrolled Diabetes	Asthma in Young Adults (Ages 18-39)	Lower-Extremity Amputations Among Patients with Diabetes	Overall Composite	Acute Composite	Chronic Composite	Diabetes Composite
2017	Statewide	31.9	19.5	24.7	947.1	209.7	736.3	172.5
	Riverside	26	16.5	23.1	905.6	219.6	683.6	168.2
	Difference with statewide	-18%	-15%	-6%	-4%	5%	-7%	-2%
2018	Statewide	30.3	18.5	25.9	919.6	200.3	718.3	189.8
	Riverside	26.1	15.7	25.8	916	224.2	689.7	196.8
	Difference with statewide	-14%	-15%	0%	0%	12%	-4%	4%

Source: The Office of Statewide Health Planning and Development (OSHPD)

Financing

As was mentioned in the *California Healthcare Districts* section, financing is frequently a significant challenge for healthcare districts in the state as they struggle to compete with for-profit providers and dedicate high level of funding to charity care in an attempt to address the problem of underserved population. The three districts reviewed in this MSR are no exception. They all generally struggle with the uncertainty of the existing funding sources, limited additional financing options and high capital improvement costs.

Despite these challenges, all three districts consistently operate with operational surpluses and balanced budgets, and have positive net positions indicating stability with ongoing operations. Figure 3-2 depicts the comparison of the three districts in regard to several financial indicators. Although the information for PVHD was not available for FY 18-19[3] the data available for FY 17-18 nevertheless allows for general conclusions regarding the District's financial health. As can be seen in Figure 3-2, all the districts have sufficient cash on hand to operate for several months or more, have low or no pension, retirement and OPEB obligations, and possess sufficient liquidity to pay liabilities as they become due. DHD and SGMHD additionally have healthy financial reserves.

[3] PVHD conducts biennial audits. The next audit will be performed for both, FYs 18-19 and 19-20.

Figure 3-2: Healthcare District Financial Health

Category	*DHD (FY 18-19)*	*PVHD (FY 17-18)*	*SGHD (FY 18-19)*
Balanced Budget (Net Operating Revenue)	$ 2,121,249	$ 1,323,494	$ 6,951,059
Operating Ratio (op rev/exp incl debt&deprec)	0.5	1.1	1.1
Unrestricted Net Position/Operating Revenues	521%	30%	55%
Net Position	$ 55,207,356	$ 7,154,718	$ 7,313,647
Current Ratio (Short-term Liquidity)	3.3	2.8	4.6
Months Cash on Hand (current cash assets/expenses incl debt)	24	10	6
Change in Net Depreciable Capital Assets (FY 18-FY 19)	-5%	-18%	-5%
Total Reserves (% of op. expend)	942%	NP	50%
Pension and Retirement Liabilities as % of Revenues	6%	0.4%	0%
OPEB Liability Payments as % of revenue	0.2%	0%	0%

Notes: NP = Not Provided

Besides San Gorgonio Memorial Healthcare District, the other two districts have very low or no long-term debt. However, SGMHD took on significant amount of debt to finance the legally required capital improvement requirements, which DHD and PVHD would also need to address. These infrastructure upgrades would also potentially offset the depreciation of capital assets which is depicted in Figure 3-2.

OSHPD has developed a Structural Performance Category (SPC 1-5) rating for hospitals that indicates the building's compliance with seismic safety standards and a Non- Structural Performance Category (NPC 1-5) rating that indicates the hospital facility's equipment and systems conformance with seismic standards for adequate anchorage and bracing of non-structural features such as electrical, mechanical, plumbing and fire safety systems for their continued use following a disaster event. State law allows general acute care hospitals until 2030 to achieve seismic compliance.

Both DHD and PVHD require significant upgrades to achieve compliance with SPC and NPC requirements. The districts are yet to develop plans as to what capital improvements are required and potential sources of funding to finance them.

Service Demand

All three reviewed districts currently own general acute care hospitals, although PVHD has applied to be designated critical access hospital (CAH). The decision on this application is currently pending. Out of the three districts, only PVHD operates its hospital directly. The two other districts outsource the operation of their facilities to other operators: DHD – to a for-profit corporation and SGMHD – to a nonprofit corporation. Figure 3-2 depicts hospital service demand and utilization comparison data for the calendar year (CY) 2019 for the three reviewed healthcare districts. As can be seen in the table, hospitals owned by PVHD and SGMHD are much smaller than the one owned by DHD. The sizes directly correspond to the range of services provided by the three hospitals. The DRMC has a wider range of hospital bed types and provides a greater array of services.

Figure 3-3: Hospital Service Demand and Utilization

2019 Hospital Utilization						
Facility	***Type of Hospital***	***Hospital Beds***	***ED Encounters***	***Discharges***	***Average Length of Stay***	***Ambulatory Surgery***
Desert Regional Medical Center	General Acute	385	63,314	22,265	4.5	10,539
Palo Verde Hospital	General Acute	51	8,653	618*	3.2	218
San Gorgonio Memorial Hospital	General Acute	79	41,372	3,134	3.4	1,989
2019 Hospital Discharge Data						
Type of Care	***DRMC***		***PVH***		***SGMH***	
Acute Care	21,257	95.47%	618	100%	3,134	100%
Physical Rehabilitation Care	224	1.01%				
Skilled Nursing/Intermediate Care	784	3.52%				
Total	**22,265**	**100%**	**618***	**100%**	**3,134**	**100%**
2019 Hospital Discharges by Payer						
2019 Discharges by payer	***DRMC***		***PVH***		***SGMH***	
County Indigent Programs	1	0%				
Medi-Cal	7,686	34.52%	254	41.10%	1,103	35.19%
Medicare	8,300	37.28%	186	30.10%	1,270	40.52%
Private Coverage	5,364	24.09%	160	25.89%	627	20.01%
Self Pay	263	1.18%	18	2.91%	56	1.79%
Workers Compensation	52	0.23%			9	0.29%
Other Government	415	1.86%			68	2.17%
Other Indigent	107	0.48%				
Other Payer	77	0.35%			1	0.03%
Total	**22,265**	**100%**	**618***	**100%**	**1,134**	**100%**

Notes: *Discharge data for PV Hospital has been approximated since the information is only avaiable for the period of 1/1/2019-6/30/2019.

DRMC also serves the greatest number of patients, while Palo Verde Hospital the lowest number as reflected by the total volume of hospital discharges, discharges per hospital bed and emergency room visits. In fact, PVHD's hospital utilization is much lower than of the other two providers, which is attributed to the Palo Verde Hospital's rural remote location and a limited selection of medical services offered. This is also supported by the average length of stay data, which suggests that for more complicated conditions and procedures people generally stay at a hospital longer.

In addition, Figure 3-3 shows that the largest ratio of patients served by all three hospitals are covered by the government programs – Medi-Cal and Medicare, followed by private insurance and self-pay. This may be due to the general assumption that older, disabled and vulnerable and disadvantaged populations that are covered by these government programs inherently make greater use of hospital services.

Service Adequacy

Services provided by all three hospitals were generally found to be satisfactory. As shown in Figure 3-3, all three hospitals are accredited by various accreditation institutions, which indicates high level of service provision. Hospitals are not required to be accredited in order to operate. Accreditation generally recognizes outstanding performance by a healthcare provider. Another service adequacy indicator is ambulance diversion hours, which shows the amount of time the hospital's emergency department was unavailable to incoming ambulance traffic. Ambulance diversion may occur due to emergency room closure, inability to accommodate the incoming volume of patients or the inability to transfer admitted patients from the ED to inpatient beds. Ambulance diversion has been found unsafe for

patients because it increases transport times, which interferes with continuity of care, causes delays, and increases mortality for severe trauma patients.[4] Generally, all three hospitals are largely able to accommodate the incoming volume of patients at all times. Overall, all three hospitals also appear to be performing adequately in terms of inpatient mortality indicators (IMIs) that measure inpatient mortality rates for individual hospitals against state averages for specific medical conditions and surgical procedures. In terms of the hospital readmission rate, all the reviewed hospitals are likewise comparable to the statewide average readmission rate, which indicates satisfactory performance. Generally, the more adequately a patient is treated for a specific condition the less likely that patient would have to be readmitted for the same condition.

However, in terms of patient satisfaction, DRMC and SGMH outperform the Palo Verde Hospital as can be seen in Figure 3-4. Only 23 percent of patients that patronize Palo Verde Hospital would recommend this hospital to others.

Figure 3-4: Hospital Service Adequacy

Hospital Service Adequacy

Service Adequacy Indicator	*Desert Regional Medical Center*	*Palo Verde Hospital*	*San Gorgonio Memorial Hospital*
Hospital Accredication	Accredited	Accredited	Accredited
Percentage of patients that would recommend the hospital	70%	23%	66%
Amulance Diversion Hours (2018)	0	9	0
Inpatient Mortality Indicators	Worse than statewide only for acute myocardial infraction	Not statistically different than statewide	Not statistically different than statewide
Hospital Readmission Rate	15.6%	15%	15.8%

In addition to owning a hospital DHD also actively engages in grant funding as was described in the *Services* section. The DHD's grant funding services were found to be adequate based on community outreach and transparency in its operations, District resident satisfaction and particularly in terms of following best management practices with regard to grant approval and management. The other two districts do not provide grant funding in their respective communities.

COVID-19 Pandemic

Residents of all the three districts, as well as districts' financing, service demand and service adequacy have been affected by the currently ongoing COVID-19 disease pandemic caused by SARS-CoV-2 virus. All the districts reported that generally hospital and clinic utilization and demand for medical services have decreased since many people currently

[4] *Reducing Ambulance Diversion in California: Strategies and Best Practices*, California Healthcare Foundation, July 2009 https://www.chcf.org/wp-content/uploads/2017/12/PDF-ReducingAmbulanceDiversionInCA.pdf

choose or are directed to avoid visiting medical establishments if possible and postpone elective surgeries and other procedures. The reduction in utilization, in turn, is negatively affecting hospitals' and clinics' revenues, which is causing temporary staff layoffs and furloughs. The hospitals' financial health has also been impacted by the increased costs associated with the pandemic. Hospitals had to purchase additional equipment, such as ventilators and prepare their ICU units and other departments for a possible influx of COVID-19 patients.

Apart from the financial impacts, hospitals and other healthcare providers within the healthcare districts have been struggling with obtaining COVID-19 tests and reagents and in many cases necessary protective equipment, which are problems of national concern.

Medical professionals also had to transition to providing services via telehealth systems and the districts' Boards of Directors had to adjust to holding their regular meetings electronically similar to most other public agency Boards in California.

4. DESERT HEALTHCARE DISTRICT

DISTRICT OVERVIEW

Desert Healthcare District			
Contact Information			
Contact:	Chris Christensen, Chief Administration Officer		
Address:	1140 N. Indian Canyon Dr Palm Springs, CA 92262	*Website:*	www.dhcd.org
Phone:	760-323-6365	*Email:*	https://www.dhcd.org/Contact-Us
Formation Information			
Date of Formation:	1948	*District type:*	Independent Special District
Governing Body			
Governing Body:	Board of Directors	*Members:*	7
Manner of Selection:	Election by voting district	*Length of term:*	4 years
Meeting Location:	Regional Access Project Foundation Building, 41550 Eclectic Street, Palm Desert, CA, 92260	*Meeting date:*	4th Tuesday of the month at 5:30 p.m.
Mapping and Population			
GIS Date:	7/30/19	*Population (2020):*	445,721
Purpose			
Enabling Legislation:	Local Healthcare District Law Health and Safety Code §32000-32492.	*Empowered Services:*	Medical services, emergency medical, ambulance, and services relating to the protection of residents' health and lives
Services Provided	Hospital (30-year lease with Tenet Health Systems that expires 5/30/2027), grant funding, leasing of medical offices and park.		
Area Served			
Size:	2,275 square miles	*Location:*	Central Riverside County (Coachella Valley)
Current SOI:	2,275 square miles	*Most recent SOI update:*	2018
Facilities			
Hospital Name:	Desert Regional Medical Center (DRMC)	*Location:*	1150 N. Indian Canyon Dr, Palm Springs, CA 92262
Number of Licensed Beds:	385	*Other Facilities:*	Las Palmas Medical Plaza, Wellness Park

Boundaries

Desert Healthcare District's (DHD's) boundaries encompass approximately 2,275[5] square miles. The most recent boundary change occurred in 2018 through special legislation. AB 2414, signed into law by the Governor in 2016, increased the size of the District from 515 square miles to 2,275 square miles[6] to include the entire Coachella Valley region. The annexed area included the eastern Coachella Valley to expand access to healthcare services by the underserved population that suffers from a higher than average prevalence of preventable disease. As required by the new law, LAFCO was obligated to approve the annexation application submitted by the District. In addition, the County Board of Supervisors were mandated to place the approval of the District expansion on the ballot for voter approval. Voters of the annexed area have subsequently approved the annexation.

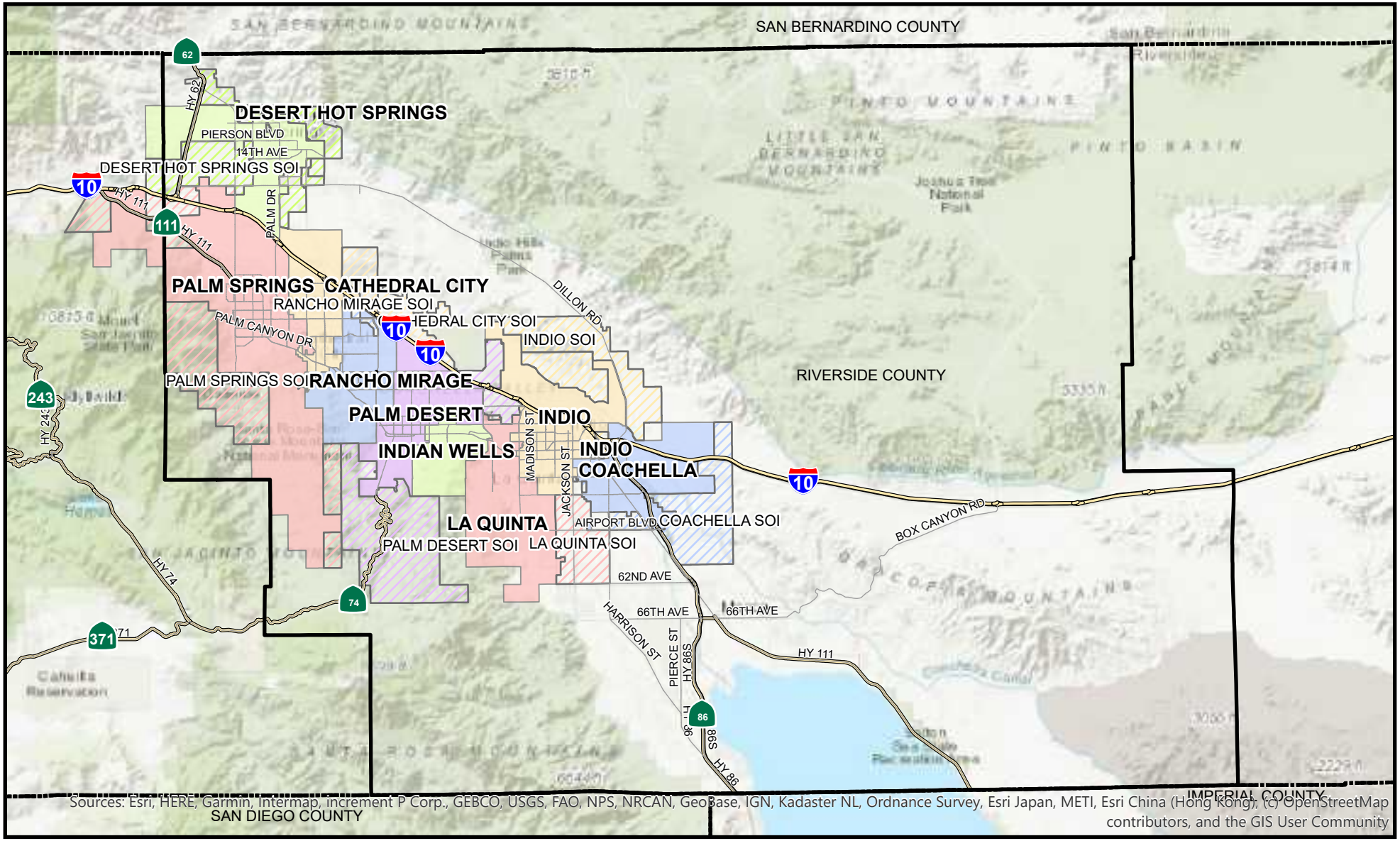
DHD's current boundaries are shown in Figure 4-1.

Sphere of Influence

The District's current SOI is coterminous with its boundaries. The last SOI amendment took place in 2018 concurrently with the boundary expansion described above. The SOI expansion and concurrent annexation included the territory east from the previous DHD boundaries near Cook Street in Palm Desert to an area east of Chiriaco Summit and west of Eagle Mountain and Desert Center, extending to the northern and southern County boundaries, encompassing all or the remaining portions of the cities of Rancho Mirage, Palm Desert, Indian Wells, La Quinta, Indio and Coachella and the unincorporated communities of Bermuda Dunes, Vista Santa Rosa, Thermal, Mecca, Oasis, North Shore, and Chiriaco Summit, as well as portions of Joshua Tree National Park and the Salton Sea.[7]

[5] Desert Healthcare District Plan of Services, 2017, p. 1
[6] LAFCO Staff Report, 4/26/2018, Executive Summary from George J. Spiliotis, Sphere of Influence Amendment to the Desert Healthcare District
[7] LAFCO Staff Report, 4/26/2018, Executive Summary from George J. Spiliotis, Sphere of Influence Amendment to the Desert Healthcare District

Figure 4-1: Desert Healthcare District and Sphere of Influence



Data Sources: County of Riverside; LAFCO

9 4.5 0 9 Miles

N

Legend

Desert Healthcare District**

** SOI is coterminous with District Boundary

Disclaimer: The information shown is intended to be used for reference and general display purposes only and is not to be used as an official map.

Healthcare services provided for District residents

Author: Crystal M. Craig

Map Created on 7/30/19

ACCOUNTABILITY AND GOVERNANCE

DHD is organized as a special district, meaning it is a form of local government that is guided by its own Board of Directors in order to serve the particular healthcare needs of the community it represents. From its formation in 1948 to January 2019, the District was governed by a five-member Board elected by the residents of the communities within its boundaries. In 2018, however, following the expansion of the District's boundaries, DHD was divided into seven voting districts with the representation in accordance with demographic and geographic factors of the entire area, pursuant to AB 2414. Each Board member is to be elected by voters within their respective voting districts. The initial extra two board members were appointed by the five-member District's Board of Directors that was in place at that time. The first elections to replace the appointed Board members will take place on November 3rd, 2020.

The District's Board of Directors consists of a President, a Vice-President/Secretary, a Treasurer, and four Directors. There are no current vacancies on the Board. The term of office for Board members is four years and the terms are staggered for election cycles every two years. Additionally, there are five committees that meet to provide more specified leadership in certain areas. These five committees include: 1) Finance, Administration, Real Estate and Legal, 2) Hospital Lease Oversight, 3) Program, 4) Strategic Planning, and 5) the Board and Staff Policies Committee. Each committee is run by three Directors; however, the Program Committee is comprised of four community members as well.

The District reported that the Board and designated staff have all completed and filed Form 700 for 2020 as required by the California Fair Political Practices Commission (FPPC). Form 700 is a Statement of Economic Interests that is required to be submitted annually by elected officials and public employees who are influential in governmental decisions to allow for transparency and accountability about potential personal and financial conflicts of interest. The District also indicated that all Board members are current on ethics and harassment training, with the latest training having been completed in February 2020.

Per district policy, the regular District Board meetings are scheduled on the fourth Tuesday of each month, except during the month of August. These meetings are held at 5:30 p.m. in the Regional Access Project (RAP) Foundation Building, located at 41550 Eclectic Street, Palm Desert, California, 92260, unless otherwise designated in the meeting Agenda. If the regular meeting date falls on a legal holiday or the required number of Board Directors are unavailable, the meeting will be held at the same time on the next business day. The meeting location may change, as long as it is held within the District's service boundaries, and a notification of such a change is posted on the District's website. Since March 2020, in accordance with the Governor's Executive Order No. N-25-20 related to COVID-19, all meetings of the Board have been conducted via teleconferencing.

Meeting agendas are posted on the District's website under the "Agendas & Documents" tab in the menu as well as on the home page at least 72 hours prior to the meeting. Likewise, all Board approved minutes are also available in the District office and on the District's website, including audio recordings, for public access.

As mentioned, DHD maintains a website with information readily available for the public. The Special District Transparency Act (SB 929), signed into law in 2018, requires special

districts in California to have websites by January 1st, 2020. The website is mandated to clearly list the district's contact information in addition to the recommended agendas and minutes, budgets and financial statements, compensation reports, and other relevant public information and documents. A district may be exempt from the law by a resolution adopted by a majority vote of its governing body declaring detailed findings regarding a hardship that prevents the district from establishing or maintaining a website. The resolution must be adopted annually as long as the hardship exists.[8] The District's website meets the requirements of SB 929.

In 2016, the State Legislature enacted Assembly Bill (AB) 2257 (Government Code §54954.2) to update the Brown Act with new requirements governing the location, platform and methods by which an agenda must be accessible on the agency's website for all meetings occurring on or after January 1, 2019. AB 2257 provides two options for compliance. Under the first option, an agency that maintains a website must post a direct link to the current agenda on its primary homepage. The link may not be placed in a "contextual menu," such as a drop-down tab, that would require a user to perform an action to reveal the agenda link. Additionally, the agenda must be: (a) downloadable, indexable, and electronically searchable by common internet browsers; (b) platform independent and machine readable; and (c) available to the public, free of charge and without restrictions that might interfere with the reuse or redistribution of the agenda. Under the second option, an agency may implement an "integrated agenda management platform," meaning a dedicated webpage that provides the necessary agenda information. The most current agenda must be located at the top of the page. Under this option, a direct link to the current agenda does not need to be posted on the homepage; however, the agency *is* required to post a link to the platform containing the agenda information. Again, this link may not be hidden in a contextual menu.[9] DHD is compliant with the AB 2257 requirements as it has a dedicated webpage that provides the required agenda information.

AB 2019, signed into law in 2018 by Governor Jerry Brown, imposes additional posting requirements on California's healthcare districts. Healthcare districts must now post the following information on their websites:

- the district's annual budget,
- a list of current board members,
- information regarding public meetings,
- recipients of grant funding or assistance provided by the district,
- the district's policy for providing grants or assistance, and
- audits, financial reports and MSRs or LAFCO studies, if any, or a link to another government website containing this information.

DHD currently meets all posting requirements of AB 2019.

There are additional requirements outlined in this bill for healthcare districts that provide assistance or grant funding, which are discussed in more detail in the *Service*

[8] California Government Code, §6270.6 and 53087.8
[9] https://www.jdsupra.com/legalnews/ab-2257-new-brown-act-requirements-for-35346/

Adequacy section. AB 2019 also requires all healthcare districts to notify LAFCO if they file for bankruptcy.

In order to facilitate communication with the public and encourage voter interest, district staff and Board members actively support community involvement. DHD frequently holds meetings to solicit public engagement in various district initiatives. Notices of all public meetings are published on the District's website and emailed to the public through Constant Contact, an email marketing tool.

The District largely conducts public outreach online, including its own website, Constant Contact, Facebook, Twitter, and Instagram social media channels, as well as an e-newsletter. In addition, the District advertises in local publications and newspapers and takes part in various health fairs and promotional events.

The public may submit comments or complaints on the District's website through a "Contact Us" link. In accordance with District Policy #OP-07, when a complaint is received regarding the Desert Regional Medical Center (DRMC) by either administration or a board member, the complaint is referred to the District CEO who forwards a copy of the complaint to the CEO and Compliance Officer of DRMC with a request to address the complaint in writing and provide copies to the Board of Directors. Hospital administration reviews the complaint, and the response is addressed at a subsequent public board meeting. When legal complaints are received, they are referred to the District's General Counsel. During the 2019 CY, the District indicates there were no complaints received in relation to district operations, and there were two complaints related to the hospital.

DHD is a recipient of the Association of California Healthcare District's (ACHD) certification of Best Practices in Governance and the California Special Districts Association's (CSDA) District Transparence Certificate of Excellence, which speaks to the District's commitment to accountability and transparency.

The District has also demonstrated transparency and accountability throughout the MSR process by responding promptly and thoroughly to requests for information, other means of communication, and reviewing draft reports comprehensively.

GROWTH AND POPULATION PROJECTIONS

The population of the District is difficult to estimate since Coachella Valley is a resort destination, and the number of people in the area fluctuates between 200,000 in the summer and 800,000 in the winter. The population of the District significantly increased after the annexation of 2018, adding an estimated 240,000 residents and more than doubling the number of residents within DHD.

It is challenging to estimate the current population of the District, since Census 2020 data will not be available until after the adoption of this report. The most recent population estimates for the cities within DHD is available for 2020; however, unincorporated level population data is hard to categorize at the district level as it generally dates from 2010 when the last Census occurred. In 2020, the population in the incorporated portion of the District was approximately 386,767, as reported by the Department of Finance. In order to determine the unincorporated portion of the District's population, the report makes use of the Census County Division level estimates for 2018, which is the most recent districtwide population estimate available. It was estimated that the number of residents within the

entirety of the District as of 2018 was 439,765, which equates to an unincorporated population of 57,689, based on Department of Finance city population estimates at that time. Department of Finance estimates show 2.2 percent growth in unincorporated Riverside County between 2018 and 2020, resulting in an estimated total population of 445,721 within the District as of January 1, 2020.

Figure 4-2: Desert Healthcare District Population Estimate, 2018-2020

	Population Estimate 1/1/2018	Population Estimate 1/1/2019	Population Estimate 1/1/2020
DHD Incorporated	382,076	384,836	386,767
DHD Unincorporated	57,689	58,504	58,954
Total	439,765 [1]	443,340	445,721

Source: Department of Finance
Notes:
(1) U.S. Census Bureau (2018). American Community Survey 5-year estimates. Retrieved from Census Reporter Profile page for Palm Springs CCD, Riverside County, CA <http://censusreporter.org/profiles/06000US0606592340-palm-springs-ccd-riverside-county-ca/>E36

Overall, since the end of the Great Recession, Coachella Valley displayed relatively low population growth rates of close to one percent annually.[10] Slow growth is expected to continue based on the Southern California Association of Governments (SCAG) forecast conducted in 2020. According to SCAG, the population of Riverside County will grow by 30 percent between 2020 and 2045 or approximately one percent annually. The projected annual growth for each of the cities and the unincorporated area in DHD is one percent, with the exception of the cities of Coachella and Desert Hot Springs, which are estimated to grow by four and three percent a year, respectively. Based on the average growth rates of all the cities and unincorporated county territory, the annual growth rate in the District is estimated to be about one percent.[11] Based on these estimates, the District's population is projected to be approximately 501,332 in 2030 and 571,695 in 2045.

The District reported that based on available information, it is anticipated that there will be a significant increase of the population over 65 years of age, while the age groups of 15 to 44 and 0 to 14 are estimated to grow at a moderate and slow rate respectively over the next 10 years.[12]

DISADVANTAGED UNINCORPORATED COMMUNITIES

LAFCO is required to evaluate disadvantaged unincorporated communities as part of this service review, including the location and characteristics of any such communities.

The purpose of SB 244 (Wolk, 2011) is to begin to address the complex legal, financial, and political barriers that contribute to regional inequity and infrastructure deficits within disadvantaged unincorporated communities (DUCs). Identifying and including these communities in the long-range planning of a city or a special district is required by SB 244.

Government Code §56033.5 defines a DUC as 1) all or a portion of a "disadvantaged community" as defined by §79505.5 of the Water Code, and as 2) "inhabited territory" (12 or

[10] Innovate, The Greater Palm Springs Economic Report, 2019 http://cvep.com/wp-content/uploads/2019/11/CVEP_2019_EconomicReport_FINAL.pdf
[11] Southern California Association of Governments, *Demographics and Growth Forecast*, Technical Report, Adopted on May 7, 2020 https://www.connectsocal.org/Documents/Adopted/fConnectSoCal_Demographics-And-Growth-Forecast.pdf.
[12] Desert Healthcare District Plan of Services, 2017, p. 4

more registered voters), as defined by §56046, or as determined by commission policy. The statute allows some discretion to LAFCOs in the determination of DUCs.

In 2012, Riverside County LAFCO adopted a policy for Disadvantaged Unincorporated Communities. The guidelines for identifying DUCS are described as interim in this policy, since it was anticipated that the methods of identifying and analyzing DUCs would evolve over time. LAFCO will be revising its guidelines when Census 2020 data becomes available.[13]

According to the 2012 guidelines, a DUC in Riverside County is defined as a community of a minimum of 50 dwellings or 50 registered voters, whichever is less. LAFCO has also clarified the definition of an "inhabited area" by excluding vacant land, non-residential land and freeway/state highway rights of way on the periphery of residential areas from DUCs. Since the smallest geographic area with available median income information is a Census Block Group, LAFCO further determined that in identifying DUCs it will make an effort to differentiate between areas within a block group that are likely to have income above the specified criteria and exclude such areas from the DUC. Factors that could be considered include markedly different housing types or densities in portions of the block group.[14]

Riverside LAFCO has identified that there are 40 disadvantaged unincorporated communities in Riverside County within or near cities' spheres of influence. There are 13 DUCs in DHD including:

- San Miguel Drive, Tri Palm Estates Country Club and Ivey Ranch near Cathedral City,
- 54th Avenue/Harrison Street, Thermal, Fillmore Street/54th Street, and Fillmore Street/Airport Boulevard around Coachella,
- Dillon Drive/North Indian Canyon drive (2 communities in North Palm Springs), Mission Lakes Country Club and Palm Drive/Dillon Road surrounding Desert Hot Springs, and
- Carver Tract near Indio, and Dillon Road/North Indian Canyon Drive (Carefree MHP) around Palm Springs.[15]

[13]SB 244 Implementation-Interim Policy for Disadvantaged Unincorporated Communities, 3/22/12, https://lafco.org/wp-content/uploads/documents/archives/7.SB_244_Interim_Policy_3_22_12.pdf

[14] LAFCO, SB 244 Implementation-Interim Policy for Disadvantaged Unincorporated Communities, 3/22/12, https://lafco.org/wp-content/uploads/documents/archives/7.SB_244_Interim_Policy_3_22_12.pdf

[15] https://lafco.org/wp-content/uploads/documents/ducs/RIVCO%20Master%20DUC%20Chart.pdf

FINANCIAL ABILITY TO PROVIDE SERVICES

The financial ability of agencies to provide services is affected by available financing sources and financing constraints. This section discusses the major financing constraints faced by DHD and identifies the revenue sources currently available to the District.

The District's operations that consists of grant funding for community health initiatives are funded by property taxes, income from medical office building leases, interest on investments, and grants and contributions from other public and private sources.[16] With an annual operating budget of roughly $9 million, DHD provides grant funding of over $3.5 million a year.[17] Additionally, the District has passed a resolution that declared the District's commitment of spending $6 million over 20 years ($300,000 annually) to support programs and services in the areas that were annexed in 2018.[18] More details regarding the District's financial health are available in Figure 4-3 and in the next several sub-sections.

[16] Desert Healthcare District Request for Information, February 11, 2020
[17] Desert Healthcare District Request for Information, February 11, 2020
[18] Desert Healthcare District Plan of Services, 2017

Figure 4-3: Desert Healthcare District Financial Overview, FY 18-19

Desert Healthcare District Financial Overview		
Category		***FY 18-19***
Balanced Budget (rev/exp incl debt)		
Total Operating Revenues	$	8,301,823
Total Operating Expenditures (incl debt)	$	6,180,574
Net	$	2,121,249
Operating Ratio (op rev/exp incl debt&deprec)		1.3
Operating Revenues	$	8,301,823
Operating Expenditures (excl. depr. and debt)	$	5,543,200
Debt Service	$	-
Depreciation	$	637,374
Total Expenses	$	6,180,574
Current Assets		
Cash and cash equivalents	$	12,052,794
Investments	$	13,491,775
Accounts receivable	$	193,311
Prepaid items and deposits	$	55,883
Total current assets	$	25,793,763
Current Liabilities		
Accounts payable and accrued liabilities	$	387,096
Grants payable	$	7,409,355
Compensated absences	$	31,110
Disability claims, reserve, current portion	$	14,803
Total current liabilities	$	7,842,364
Long-term Liabilities		
Grants payable	$	5,400,000
Long-term disability claims reserve	$	40,626
net pension liability	$	3,395,623
Net OPEB liability	$	87,973
Deposits payable	$	58,517
Total long-term liabilities	$	8,982,739
Unrestricted Net Position/Operating Revenues		521%
Net Position	$	55,207,356
Unrestricted Net Position	$	43,234,798
Operating Revenues	$	8,301,823
Current Ratio (Short-term Liquidity)		3.3
Current Assets	$	25,793,763
Current Liabilities	$	7,842,364
Months Cash on Hand (current cash assets/expenses incl debt)		24
Current Cash Assets	$	12,052,794
Operating Expenditures (inc. debt)	$	6,180,574
Operating expenditures per day	$	16,933
Change in Net Depreciable Capital Assets (FY 18-FY 19)		-3%
Net Capital Assets, FY 18	$	12,382,164
Net Capital Assets, FY 19	$	11,972,558
Total Assets being depreciated (FY 19)	$	22,348,945
Depreciation	$	637,373
Total Reserves (% of op. expend)		942%
Reserve	$	58,231,372
Pension Liabilities as % of Revenues		6%
Total Pension Liability	$	8,309,530
Unfunded Pension Liability	$	3,395,623
% Pension Liability Funded		59%
Total Payments FY 17-18 (funded+unfunded)	$	511,792
OPEB Liabilities (as of June 30, 2019)	$	67,364
OPEB Liability Payments as % of revenue		0.2%
Unfunded OPEB Liability	$	67,364
Total OPEB Payments	$	20,321

Financial Planning and Reporting

The California Office of Statewide Health Planning and Development (OSHPD) produces annual financial disclosure reports that provide audited data on hospital revenues, expenditures, net operating margins, and other measures of fiscal performance. Healthcare districts are also required to submit annual financial disclosure reports to the California State Controller, which uses the submitted financial data to produce an Annual Special Districts Report that provides detailed financial information by fiscal year (FY) regarding special district revenues, expenditures, property taxes, and bonded debt. The County of Riverside Auditor and Controller produces a detailed summary of local tax information for each FY that identifies the amount of property tax allocated to the healthcare districts and reports any bonded indebtedness held by the districts. The annual healthcare district and hospital financial disclosure reports produced by the California State Controller, the County of Riverside, and OSHPD provide the public with a comprehensive overview of the annual financial status of a healthcare district, as well as the hospital facilities the district owns and/or operates.

DHD's internal financial planning efforts include the annual budget and annually audited financial statements. The District, under its umbrella, makes use of the Desert Healthcare Foundation as its operational component. The Foundation's financial information is generally included as a component of DHD's financials; however, the Foundation is considered a Private-Purpose Trust Fund fiduciary fund type for accounting purposes and separate financial statements and a budget are also available for this fund.

Balanced Budget

The District receives revenue from property taxes, investment income from the Facility Replacement Fund that was established to provide working capital in the event that the lease with Tenet Health System is terminated prematurely or for future seismic retrofit needs, and rental income from Las Palmas Plaza. DHD's primary income source is property taxes, as can be seen from Figure 4-4. Rental income is derived from renting out commercial office suites at Las Palmas Plaza subject to lease terms ranging from three to five years and includes the base monthly rental payments plus the common area maintenance fee.

Figure 4-4: Desert Healthcare District Revenues and Expenditures, FY 18-19, FY 17-18 and FY 16-17

Desert Healthcare District Revenues and Expenditures						
Category	***FY 18-19***	***%***	***FY 17-18***	***%***	***FY 16-17***	***%***
Operating Revenue	**$ 8,301,823**	**100%**	**$ 7,839,945**	**100%**	**$ 7,474,009**	**100%**
Property Tax Revenue	$ 6,972,196	84.0%	$ 6,559,800	83.7%	$ 6,082,391	81.4%
Rental Income	$ 1,203,940	14.5%	$ 1,113,241	14.2%	$ 1,178,485	15.8%
Other income	$ 125,687	1.5%	$ 166,904	2.1%	$ 213,133	2.9%
Operating Expenditures	**$ 6,180,574**	**100.0%**	**$ 8,144,735**	**100.0%**	**$ 5,631,036**	**100.0%**
Grant allocations	$ 3,626,871	58.7%	$ 5,076,039	62.3%	$ 3,453,749	46.2%
General expenses	$ 560,859	9.1%	$ 1,187,283	14.6%	$ 436,175	5.8%
Rental expenses	$ 941,062	15.2%	$ 904,904	11.1%	$ 894,421	12.0%
Salaries and benefits	$ 304,560	4.9%	$ 329,056	4.0%	$ 190,859	2.6%
Legal Fees	$ 235,836	3.8%	$ 250,443	3.1%	$ 117,593	1.6%
Depreciation	$ 193,276	3.1%	$ 194,483	2.4%	$ 194,979	2.6%
Other	$ 208,410	3.4%	$ 199,606	2.5%	$ 146,333	2.0%
Election fees	$ 109,347	1.8%	$ -	0.0%	$ 196,467	2.6%
Security	$ 353	0.0%	$ 2,921	0.0%	$ 460	0.0%
Net Operating Income	**$ 2,121,249**		**$ (304,790)**		**$ 1,842,973**	
Debt Service	**$ -**		**$ -**		$ -	
Net Operating Income After Debt	**$ 2,121,249**		**$ (304,790)**		**$ 1,842,973**	
Non-operating Income and Expenditures						
Investment Income	$ 1,245,953		$ 111,318		$ 30,049	
Loss on Disposal of Capital Assets	$ (727)		$ -		$ -	
Investment Expenses	$ (113,967)		$ (119,055)		$ (118,550)	
Total Non-operating income (loss)	$ 2,131,259		$ (7,737)		$ (88,501)	
Net After Non-Operating Income/Expenditures	**$ 4,252,508**		**$ (312,527)**		$ 1,754,472	
Beginning Net Position	**$ 50,954,848**		**$ 51,276,755**		**$ 49,522,283**	
Ending Net Position	**$ 55,207,356**		**$ 50,954,848**		**$ 51,276,755**	

The District's primary expense is grant allocations. Grant awards not fully funded in the current FY are carried over to the subsequent FY. As can be seen from Figure 4-4, the District experienced an operational deficit in FY 17-18; however, in FYs 16-17 and 18-19, it had operational surpluses. The deficit in FY 17-18 occurred as a result of the DHD Board awarding approximately $1.5 million in additional grant funding; grants are accrued at 100 percent when awarded although are usually disbursed over time.

For any agency, recurring operating deficits are a warning sign. In the short-term, reserves can backfill deficits and maintain services. However, ongoing deficits eventually will deplete reserves. In the case of DHD, however, the deficit that the District experienced in FY 17-18 does not appear to be a persisting issue. In FYs 16-17 and 18-19, the District operated in the black. The FY 19-20 budget similarly shows a projected positive operating balance.

Fund Balances, Reserves and Liquidity

Fund balances and reserves should include adequate funds for cash flow and liquidity, in addition to funds to address longer-term needs. The District's FY 18-19 financial statements report a total of $25,793,763 in current assets out of which $12,052,794 is cash or cash equivalents with $7,842,364 of current liabilities,[19] as shown in Figure 4-3. The District has enough cash on hand to cover about 24 months of its operating expenditures.

The District has no outstanding bond debt and has not issued bonds since prior to the lease of the hospital in 1997. DHD's long-term liabilities include grants payable, long-term

[19] Audited Financial Statements, FY 18-19, p. 8.

disability claims reserve, pension and OPEB liabilities, and deposits payable, as shown in Figure 4-3.

The District also established a reserve fund (Replacement Facility Reserve Fund) of $58,231372 (as of June 30, 2019) to cover grant liabilities, hospital operating expenses for a short period of time should the lease with Tenet Health Systems terminate prior to May 30, 2027, and seismic and other facility costs. The hospital will be required to meet SB 1953 and OSHPD regulations for seismic retrofit standards by 2030, as is described in more detail in the *Infrastructure Needs* section later in this report. The District is currently assessing the seismic retrofit needs and costs, which may be substantial and reviewing options for timely completion of the seismic upgrades.[20] While the reserve fund balance is significant in terms of the percentage of the operating expenditures and provides a substantial safeguard to the District, it would provide only a portion of the projected required financing that may be needed in case Tenet terminates the lease.[21]

Net Position

An agency's "Net Position" as reported in its audited financial statements represents the amount by which assets (e.g., cash, capital assets, other assets) exceed liabilities (e.g., debts, unfunded pension and OPEB liabilities, other liabilities). A positive Net Position provides an indicator of financial soundness over the long-term. The FY 18-19 ending net position for the District was $55,207,356 indicating stability with its ongoing general operations. However, as was already mentioned before, if the District has to take over the operations of the hospital the DHD's current financial resources may only cover its operations in the short-term.

DHD reported that it is unlikely that Tenet will terminate the lease with only seven years remaining on a 30-year lease and since the DRMC is one of the most profitable hospitals in its network.

Pension and OPEB Liabilities

Unfunded pension and OPEB liabilities present one of the most serious fiscal challenges facing many special districts in California today.

In 2014, the District converted from a 401(k) retirement plan to a 457(B) and 401(A) retirement plans. DHD contributes a dollar for dollar match for the first four percent of employee salary deferral. However, additionally, in 1971, the Desert Hospital Corporation (discussed later in the *Healthcare Services* section) established a defined benefit pension plan covering eligible employees of the DRMC. All the participants of the plan have been 100 percent vested since 1997. At the end of FY 18-19, 183 employees were covered under this plan. There have been no contribution requirements by the District since that time. It was estimated that at the end of FY 18-19 unfunded pension liability was $3,395,623. The District's Board of Directors elected not to fund the plan in FY 17-18 or FY 18-19. At the end of FY 18-19, 59 percent of the liability was funded, as shown in Figure 4-3.

The District has a separate investment account of approximately $5 million specifically for this defined pension plan. The account is reportedly sufficient to pay all of the

[20] Audited Financial Statements, FY 18-19 and RFI.
[21] Desert Healthcare District Plan of Services, 2017

participants' principal balances. Per Government Accounting Standards Board (GASB) 67 & 68, the total pension liability of $8,309,530 is based on the present value of annuity payments for the actuarial life of the participants. The actuarial present value creates the $3,395,623 net pension liability, which must be reported in the District's financial statements. However, the practice of the District is to disburse 100 percent of the participant's funds when employment is terminated from the hospital, which means that there are no actual lifetime annuities.

Total annual pension payments and potential changes in current District pension costs do not appear to be a significant adverse factor relative to its total budget, as can be seen in Figure 4-3.

The District's defined benefit OPEB (other postemployment benefits) plan provides OPEB for the two retired Board directors of the DHD. The plan is a single employer defined benefit OPEB plan administered by the District. The plan provides lifetime medical and dental coverage for directors and their dependents. The District contributes 100 percent with no cap.[22] In regard to its OPEB liabilities, the District uses pay-as-you-go approach.[23] As shown in Figure 4-3, the total District's OPEB liability at the end of FY 18-19 was $67,364.[24] With the annual payments at the current level (which amount to about 0.2 percent of the District's operating revenues), the District will largely pay off the liability in about three years.

Capital Assets

Capital assets must be adequately maintained and replaced over time and expanded as needed to accommodate future demand and respond to regulatory and technical changes.

As a general indicator, the California Municipal Financial Health Diagnostic compares changes in the value of assets and asset improvements.[25] Persistent and substantially negative trends, particularly without a reasonable plan for stabilizing declines, raise caution and warning signs. This negative condition can occur if repairs and replacements do not keep pace with aging infrastructure.

Depreciation typically spreads the life of a facility over time to calculate a depreciation amount for accounting purposes. The actual timing and amount of annual capital investments require detailed engineering analysis and will differ from the annual depreciation amount, although depreciation is a useful initial indicator of sustainable capital expenditures.

The District's capital assets include land (which is non-depreciable) and buildings and improvements, as well as furniture and equipment (which all depreciate). The depreciation expense consists of operating expense depreciation (30 percent) and rental expense depreciation (70 percent). At June 30, 2019 the District had $22,348,945 in capital assets (depreciable and non-depreciable) and $10,376,387 in accumulated depreciation, resulting

[22] Audited Financial Statement, FY 18-19, p. 30.
[23] Total Compensation Systems Inc., *Desert Health Care District Actuarial Study of Retiree Health Liabilities Under GASB 74/75*, December 20, 2019, p. 2.
[24] Total Compensation Systems Inc., *Desert Health Care District Actuarial Study of Retiree Health Liabilities Under GASB 74/75*, December 20, 2019, p. 10.
[25] The California Municipal Financial Health Diagnostic: Financial Health Indicators, League of California Cities, 2014.

in $11,972,558 net capital assets.[26] The value of depreciable capital assets decreased by about three percent from FY 17-18 to FY 18-19, as shown in Figure 4-3. The District's FY 18-19 financial statements do not show enough additions to depreciable asset value to offset the depreciation of $637,373 (after deducting depreciation attributed to retired assets)[27] for that year.

The District does not have a Capital Improvement Plan (CIP) for its Las Palmas Plaza property. However, DHD has recently completed a number of upgrades at Las Palmas Plaza and no other infrastructure needs have been identified at this time, as is described in more detail in the *Infrastructure Needs* section. The infrastructure needs for the hospital facility are also discussed in the *Infrastructure Needs* section later in this report.

Hospital Financing

In 1997, the District entered into a 30-year lease of the DRMC with Tenet Health System. Terms of the lease included payment by Tenet of the hospital revenue certificates of participation issued in 1990 and 1992 (approximately $80,000,000) as prepaid rent. Tenet also paid the District $15,400,000 cash, representing additional prepaid rent.[28]

In the event that Tenet or the District decide to terminate the lease, the District would be responsible for operating the hospital, which would require upfront operating capital of approximately $125,000,000 to maintain the operations without interruption during the transition period. The District, recognizing this obligation, established an investment fund, with a net value of $58,231,372 as of June 30, 2019, identified as the facility replacement fund.[29]

The lease agreement contains provisions in the event the lease terminates prior to May 30, 2027. According to the agreement, Tenet has a number of options to terminate or abandon the lease prior to its expiration, including if seismic upgrades exceed $12.5 million. In the event that Tenet elects to terminate or abandon the lease, the District would be legally obligated to reimburse Tenet for prepaid rent. However, as of June 30, 2020, the prepaid lease balance was $2,835,230 and will be zero by June 30, 2021.

Additionally, according to the 1997 lease, at the end of the lease term in 2027 or at the time of lease termination, the District is required to purchase the termination assets, which are assets constructed or installed by Tenet Health Systems in the hospital during the lease period. The purchase can also be satisfied with a five-year promissory note. The lease also provides the option of lease extension if the termination assets exceed $10 million. The current value of the termination assets are estimated to be approximately $50 million.

The DRMC's financial ability to provide services and its financial health are not discussed in this report as the hospital's operations are entirely privately financed. Extensive financial information relating to Desert Regional Medical Center is available to the public on the Office of Statewide Health Planning and Development (OSHPD) website.

[26] Audited Financial Statement, FY 18-19, p. 6.
[27] Audited Financial Statement, FY 18-19, p. 6.
[28] Audited Financial Statements, FY 18-19, p. 14.
[29] Audited Financial Statements, FY 18-19.

HEALTHCARE SERVICES

Service Overview

Background

Desert Hospital District (later renamed Desert Healthcare District) was formed in 1948 to provide hospital services in the western Coachella Valley. DHD built and operated the hospital, now known as the Desert Regional Medical Center (DRMC), until 1986 when the facility was leased to Desert Hospital Corporation—a not-for-profit organization formed by local residents to operate the hospital. The Desert Hospital Foundation (created in 1967 as a subsidiary of the Desert Hospital Corporation) conducted fundraising activities for the hospital. The Foundation was later absorbed by the District. In the 1990s, the hospital struggled financially, and the District's Board of Directors decided to lease the facility to the for-profit Tenet Health Systems for a term of 30 years.[30]

Services

Currently, the District supports a variety of health-related programs, primarily through grants and similar assistance to nonprofit entities and public agencies. Assistance can be provided in the form of one-time grants or multi-year commitments.[31] The District provides funding for community health initiatives and grants of over $3.5 million annually. The District's grant funding is linked to the fulfillment of a comprehensive strategic plan, which focuses on enhancing and optimizing the health of district residents.[32] In FY 18, the District adopted a three-year strategic plan with four community health focus areas that include homelessness, primary care and behavioral health access, healthy eating and active living, and quality, safety, accountability and transparency.[33]

The District has taken a leadership role in the collective efforts in the areas of access to healthcare, medically underserved populations, shortage of healthcare workers, health disparities, homelessness, behavioral health, social determinants of health, and public health issues. An example of such efforts is the recent Homelessness Initiative. In conjunction with the efforts conducted by the Coachella Valley Association of Governments (CVAG), the District has allocated funding of up to $3 million in matching grants to local cities in the Coachella Valley. Another major initiative in recent years has been the District's focus on improving access to primary care, particularly in underserved areas of the District. The District helped establish the UCR School of Medicine's Family Residency Program. The first group of family practice residents arrived at DRMC in 2014. Today there are residency programs in internal medicine, neurosurgery, and emergency medicine with more in development. Ten family medicine physicians are now in place. Also funded by the District, a new 13,000-square foot UCR primary care clinic is open with physicians seeing hundreds of patients, regardless of ability to pay.[34]

[30] Desert Healthcare District Website, Desert Healthcare District Request for Information, February 11, 2020
[31] LAFCO Staff Report, 4/26/2018, Executive Summary from George J. Spiliotis, Sphere of Influence Amendment to the Desert Healthcare District
[32] Desert Healthcare District Request for Information, February 11, 2020
[33] Audited Financial Statements, FY 2018-2019, p. 7.
[34] Desert Healthcare District Request for Information, February 11, 2020

District funding has also helped create a number of new and expanded clinics to increase access to care, including dental and family care clinics in Desert Hot Springs, Cathedral City and Palm Springs. The number of dental providers who accept MediCal and new patients has doubled. The District has also provided funding to more than double the size of the Borrego Community Health Foundation's family care clinic in Cathedral City, as well as added mobile clinic outreach to remote areas to serve the disadvantaged and those most in need.[35]

The Desert Hospital Foundation, now under the umbrella of DHD, has also developed numerous programs and services over time to address community health needs. More than three decades ago, the Foundation launched a free breast screening program, now operated by the Desert Cancer Foundation. The Foundation also created the Smile Factory mobile dental clinic that visits local schools to provide free and reduced cost dental screening and treatment, now operated by Borrego Community Health Foundation. With funding from the California Endowment, the Foundation created the Health Access Resource Center (HARC) to launch the triennial community health survey to identify health status and priority needs. The District continues as its primary funder to this day.[36]

Although the District is no longer responsible for operating the DRMC, as the facility owner, DHD retains significant oversight responsibilities and must ensure that Tenet maintains the hospital in good condition, that the hospital has appropriate accreditations, valid licenses, is adequately insured, and that essential services to the community are maintained.

Collaboration and Partnerships

The District participates extensively in various partnerships and collaborations, locally and regionally. DHD partners with over 35 community-based organizations and agencies, including the three Coachella Valley school districts, the College of the Desert, UCR, California State University in San Bernardino, Loma Linda University, the three Valley hospitals, local and regional government agencies, and state and national foundations, such as the California Endowment. Other nonprofit organizations that have partnered with the District on projects comprise Borrego Community Health Foundation, Clinicas de Salud del Pueblo, Desert AIDS Project, CV Volunteers in Medicine, Catholic Charities, Planned Parenthood of the Pacific Southwest, Boys and Girls Club of Palm Springs, and YMCA of the Desert.[37]

Examples of partnerships and funding support are shown in Figure 4-5.

[35] Desert Healthcare District Request for Information, February 11, 2020
[36] Desert Healthcare District Request for Information, February 11, 2020
[37] Desert Healthcare District Request for Information, February 11, 2020

Figure 4-5: Desert Healthcare District Grand Funding

Grant Receiver	Amount	Term	Purpose
Act for Multiple Sclerosis	$368,228	Two-year	Grant for program offering strength training and professional therapeutic massage to maintain mobility for Coachella Valley residents. Services provided at designated local facilities, and in-home when necessary.
Angel View	$144,600	Two-year	Grant to support at least 25 families with special needs children in the Coachella Valley and High Desert, including transportation and case management.
Arrowhead Neuroscience Foundation	$373,540	Two-year	Grant for a fellowship program in interventional neurology to train the next generation of physician sub-specialists at Desert Regional Medical Center's Advanced Comprehensive Stroke Center. Researches cures for stroke, brain tumors, Alzheimer's, Parkinson's and other conditions that alter brain and spinal cord function.
Boys and Girls Club of Cathedral City	$150,000		For clubhouse improvements. This non-profit provides all day after school care, including transportation from schools, for 700 youth members in Cathedral City and neighboring areas. Programs promote academic success, healthy lifestyles, good character and citizenship.
CVAG	$10,000,000		For support of CV Link, a 52-mile alternative transportation corridor along the Whitewater River for bicyclists, pedestrians and low-speed electric vehicles. Corridor will connect all nine Coachella Valley cities, providing a safe route to schools, improved air quality and healthier lifestyles.
Coachella Valley Economic Partnership	$500,000	Three-year	For CV/iHub Accelerator Campus, an incubator that provides office space, administrative support and incentives to start-up businesses focused on medical technology, clean technology and renewable energy.
Coachella Valley Economic Partnership	$737,900	Two-year	Grant for Mental Health College and Career Pathways Development Initiative to increase opportunities for college students from the Coachella Valley to obtain exposure, experience and mentoring to further their health career pursuit and increase their commitment to become health leaders and professionals serving the Valley.
CV Volunteers in Medicine Clinic in Indio	$120,798		To provide access to healthcare post-implementation of the Affordable Care Act at Coachella Valley's only free clinic for those without insurance.

Source: LAFCO Request for Information, Responded to by Desert Healthcare District

Figure 4-5: Desert Healthcare District Grand Funding (cont.)

Grant Receiver	Amount	Term	Purpose
Desert AIDS Project	$498,625	Three-year	Grant for the Get Tested Coachella Valley, a region-wide, bilingual, public health campaign dedicated to dramatically reducing the spread of HIV by making voluntary HIV testing a routine medical practice and ensuring linkage to care.
Desert AIDS Project	$800,000	Three-year	Grant for sexually transmitted infection clinic at The DOCK in Palm Springs. Services include free HIV testing, and testing and treatment for other diseases, including syphilis, gonorrhea, chlamydia, HPV, and Hepatitis B and C; and well-woman exams. Service regardless of the ability to pay.
Desert Cancer Foundation	$187,000		For cancer-related medical costs such as outpatient services for uninsured clients, co-insurance, Medi-Cal monthly share of cost, prescriptions, inpatient hospital costs and insurance premiums for about 700 residents within the District.
FIND Food Bank	$390,151		For the Hunger to Health program. FIND, based in Indio, is the only regional food bank in Southern California that serves eastern Riverside County and southern San Bernardino County, distributes more than 10 million pounds of food to about 90,000 people per month, works with soup kitchens, senior centers, homeless shelters and schools.
Health Assessment and Research for Communities	$499,955	Three-year	Grant for the Community Health Monitor, a phone survey conducted every three years to gather data on health and well-being in the Coachella Valley. The information is used to design programs and services to meet health needs in the Valley.
Health Assessment and Research for Communities	$11,425	Three-year	Grant for a health evaluation component of @LIKE - the Linking Innovation, Knowledge and Employment program, which reconnects adults ages 18 to 24 to education and/or stable employment.
HealthCorps	$555,968	24-month support	For coordinators to teach wellness-related classes at high-need high schools in the Coachella Valley and give students the tools to make healthier living choices.
Hidden Harvest	$102,800		For a produce recovery program that employs low-income farm workers to salvage produce left behind in fields and orchards after harvest. The grant supports free distribution of the produce to senior citizens and families whose children attend schools in high poverty areas in the Coachella Valley.

Source: LAFCO Request for Information, Responded to by Desert Healthcare District

Figure 4-5: Desert Healthcare District Grant Funding (cont.)

Grant Receiver	Amount	Term	Purpose
Jewish Family Services of the Desert	$570,000	Three-year	Grant for mental health counseling services to adults, couples, families, children, adolescents and seniors from throughout the greater Coachella Valley.
LGBT Center of Palm Springs	$140,000	Three-year	Grant for a clinic that provides low-cost counseling for individuals, couples and families.
Mizell Senior Center	$403,300	Two-year	Grant for a fall prevention program for individuals over 50 in the Coachella Valley. The course includes education about falls, support group activities and basic core-strength exercises to maintain health and independence.
Pegasus Therapeutic Riding Academy	$102,544		For Hippo Therapy Helping to Heal program, which provides equine therapy and transportation for more than 210 special, needs riders of all ages from across the Coachella Valley.
Ranch Recovery Centers	$21,500		To purchase electronic records management system for facilities in Desert Hot Springs that provide alcohol and drug treatment, detox and transition to sober living for men and women.
United Cerebral Palsy of Inland Empire	$178,894	Two-year	Grant for Skill Builders, which offers after-school and summer programs to 66 children across the Coachella Valley to improve socialization, independence, communication, safety and health.
Visiting Nurses Association of California	$125,000		For point-of-care McKesson technology upgrade for this non-profit that provides in-home care, palliative services and hospice throughout the Coachella Valley.
Desert Healthcare Foundation	$110,000		To develop a strategic plan for the Desert Highland Gateway Community Health & Wellness initiative affecting 800 minority families in north Palm Springs.
Neuro-Vitality Center	$261,340		To support operations related to improving the quality of life of individuals and their families living with stroke and related neurological conditions by offering rehabilitation, prevention and resources.
UC Riverside School of Medicine	$70,899		For equipment and set-up costs for a volunteer-staffed Street Medicine Clinic offering free primary care to the homeless and underserved in north Palm Springs.
Well in the Desert	$44,800		For daily hot meals, emergency food assistance, weekly supplemental food distribution, transportation and other services for the poor in western Coachella Valley.

Source: LAFCO Request for Information, Responded to by Desert Healthcare District

Additional grant funding has been utilized in the District's service area to provide greater opportunities for healthy living through collaborative partnerships and include:[38]

- Working with the City of Desert Hot Springs to design and build a clinic in conjunction with a gym in the Boys and Girls Club.
- Funding a two-year fellowship program at the Comprehensive Stroke Center at DRMC that has changed the way stroke victims are assessed and treated thus improving their outcomes.
- Funding certified enrollment counselors to educate and connect residents to affordable insurance and local care.
- Increasing the number of local physicians and enhancing the regional medical workforce by funding UCR Medical School residency programs.
- Fostering the next generation of healthcare workers by financing K-12 school-based health care academies, mentoring, internships, and scholarship programs.
- Supporting the Health and Medical Innovations Center, which offers a coordinated regional approach to attracting healthcare-related businesses to the Coachella Valley.
- Partnering with the City of Palm Springs for the Ready, Set, Swim! Program, which combines physical activity, nutrition education and water safety for children.
- Supporting CVHip.com—the Coachella Valley Health Information Portal—an online directory of resources such as health insurance, medical care, dental care, shelter, food pantries, recreation, behavioral health care and counseling.

The District has also historically funded the Arthritis Foundation, Borrego Community Health Foundation, Cathedral City clinic, California State University San Bernardino, Palm Desert Campus, College of the Desert Public Safety Academy, El Sol Neighborhood Educational Center, Family Services of the Desert, Loma Linda University Institute for Community Partnerships, Riverside County Office on Aging, San Gorgonio Memorial Hospital (SGMH) Behavioral Health Center, and UCR School of Medicine Primary Care Residency Program at DRMC.[39]

Memberships and Regional Partnerships

The District takes active part in the work of many regional organizations that dedicate their time to public health and well-being. One example of such collaboration is with CVAG. One of the CVAG's initiatives that DHD participates in is the Homeless Committee that was designed to combat the problem of homelessness in the Coachella Valley. DHD also collaborates with CVAG on the development of CV Link — a 52-mile alternative transportation corridor for bicyclists, pedestrians and low-speed electric vehicles connecting all of the Coachella Valley cities.[40] This collaboration includes developing an updated health assessment tool/plan that will determine the long-term health benefits of CV-Link

[38] Desert Healthcare District Request for Information, February 11, 2020
[39] Desert Healthcare District Request for Information, February 11, 2020
[40] Desert Healthcare District Request for Information, February 11, 2020

DHD has also been participating as a major partner in OneFutureCoachella Valley's Regional Plan for College and Career Success since 2012 (originally called Coachella Valley Economic Partnership Workforce Excellence). The plan aims to advance college attendance through a variety of initiatives. The District's partnership entails matching funds for scholarships and building out the healthcare academies and pipelines.[41]

Another regional plan the District has been a major partner in is the Lift To Rise Regional Plan (originally founded as Collaborating for Clients) since 2014. The goal of the plan is to address income disparities, the social determinants of health, and associated impacts on housing, health, food security, and transportation. The District's partnership entails representation as a "collective impact" participant in various collaborative action networks.[42]

The District is also a major partner in a regional plan to develop and implement an Emergency Communication Plan related to prevention, mitigation, and emergency preparedness associated with airborne environmental hazards in the eastern Coachella Valley. The District partnership entails the convening and support of partners and providing funding support.[43]

Additionally, DHD has participated in the regional expansion of the UCR and California State University in San Bernardino campuses to Coachella Valley. The District's goal is to strengthen the region's healthcare workforce by adding nurses and physicians.[44]

Contract Services

In 1997, DHD entered into a lease contract with Tenet Health Systems to operate the DRMC for the term of 30 years. Although the District is no longer responsible for operating the hospital, the hospital is still owned by the District and pursuant to the lease agreement, DHD Board retains significant oversight responsibilities. For example, two DHD Board Members sit on the hospital's governing board. The District has established a Hospital Lease Oversight Committee, which includes three DHD Board Members and DHD staff. The District also must ensure that Tenet maintains the facility in good condition, which includes compliance with California Hospital Seismic Safety Law (SB 1953), and the hospital has appropriate accreditations, valid licenses and adequate insurance and that essential services to the community are maintained.[45]

Pursuant to the terms of the 1997 Lease, Tenet has a number of options to terminate or abandon the lease prior to its expiration, including an option to terminate if seismic upgrades exceed $12.5 million. In the event Tenet elects to terminate or abandon the lease, the District will be legally obligated to reimburse Tenet for prepaid rent. However, the original $92 million reimbursement obligation has been reduced to $2.8 million as of June 2020. In addition, the District is obligated to pay the fair market value of unamortized improvements that Tenet has made to the hospital, which are currently estimated to be $50 million.[46]

In July 2019, Tenet provided the District with a proposal to purchase the DRMC for $120 million with the commitment to comply with the 2030 seismic regulations and a

[41] Desert Healthcare District Request for Information, February 11, 2020
[42] Desert Healthcare District Request for Information, February 11, 2020
[43] Desert Healthcare District Request for Information, February 11, 2020
[44] Desert Healthcare District Request for Information, February 11, 2020
[45] Desert Healthcare District Plan of Services, 2017
[46] Desert Healthcare District Request for Information, February 11, 2020

commitment to making future investments in healthcare services and capital projects over the next eight years. After reviewing the proposal and receiving public input at a public meeting, the District Board recommended that the proposal be resubmitted with more substantial financial considerations as well as the specifics of the future configuration of the hospital and additional specifics of the proposed investments in healthcare series and capital projects in the entire Coachella Valley. To date, Tenet has not returned with an amended proposal for consideration by the District. It is anticipated that, due to impacts of the COVID-19 pandemic, sale of the hospital will not occur in the near future, and renewal of the lease is more likely. However, should the sale occur, the District reported that it would create more financial resources which would enable the District to offer expanded services to its residents. Pursuant to the applicable provisions of the Health and Safety Code, any sale of Desert Regional would be subject to voter approval.[47] Similarly, if the District were to extend the lease for another 30 years, it would require another vote of District residents.[48]

At the end of the lease term, in 2027, if DHD chooses to take over the operations of the hospital, the District would need to finance a minimum of 90-days' worth of working capital, which is approximately $105 million. In addition, the District will have to complete significant capital improvements, which are discussed later in the *Infrastructure Needs* section.

Service Demand

As previously mentioned, in 2018, the territory of the District was greatly expanded to include incorporated and unincorporated areas of eastern Coachella Valley. The rationale for the boundary expansion was to promote the extension of healthcare services to the underserved population that suffers from a higher than average prevalence of preventable disease. Many residents in the eastern Coachella Valley are low-income and experience more significant health disparities compared to residents in western Coachella Valley. Residents of eastern Coachella Valley are also more likely to be uninsured compared to the rest of the State, and have a higher incidence of obesity, diabetes and childhood asthma. The District expansion, that was finalized two years ago, was undertaken to improve access to healthcare programs in this underserved area and narrow some of the disparities.[49]

Overall, a large portion of the entire District's population is Hispanic. Since the Hispanic population statistically has a higher incidence of diabetes, heart disease and obesity, DHD typically experiences a high demand for cardiovascular services, endocrinology, gastroenterology and orthopedics. Additionally, Riverside County generally has higher mortality rates from cancer, Alzheimer's disease, coronary heart disease, unintentional injuries, stroke, suicide, motor vehicle accidents, and for infants when compared to the State overall. There are also higher rates of high blood pressure, smoking and low-birth-weight infants.[50] This implies demand for services such as primary care, cardiovascular, neurosciences, oncology, general surgery, orthopedics, pulmonary medicine, urology, obstetrics and perinatology, neonatology, pediatrics and chronic disease management.[51]

[47] Desert Healthcare District Request for Information, February 11, 2020
[48] Desert Healthcare District Plan of Services, 2017
[49] Desert Healthcare District Plan of Services, 2017
[50] Desert Healthcare District Plan of Services, 2017
[51] Desert Healthcare District Plan of Services, 2017

As was previously discussed in the *Growth and Population* section, the population over 65 years of age is projected to experience the highest growth in the next 10 years within the District. As the population ages, the community and its healthcare providers are likely to experience an increased demand for services such as internal medicine, cardiovascular services, gastroenterology, neurosciences, oncology, orthopedics, pulmonary medicine and urology, and see a greater need for chronic disease management. Moderate growth of the 15 to 44 years of age population indicates that demand for elective sub-specialty care and obstetrics is also anticipated to grow. The District also estimates that the demand for inpatient and outpatient pediatric services will remain approximately the same, due to anticipated slow growth in the population between 0 and 14 years old.[52]

Hospital Service Demand

Figure 4-6 shows service demand at the Desert Regional Medical Center between 2014 and 2018.

Figure 4-6: Desert Regional Medical Center Utilization Data

Desert Regional Medical Center Utilization				
2018	***2017***	***2016***	***2015***	***2014***
Total Licensed Bed Days				
140,525	140,525	140,910	140,525	141,133
Total Census Days				
101,543	92,724	97,083	88,849	87,775
Total Discharges				
25,003	19,621	20,200	19,725	19,241
Emergency Department Total Traffic				
73,426	75,098	74,952	71,937	67,971
Ambulance Diversion Hours				
0	5	0	678	0
Inpatient Surgeries Operating Room Minutes				
637,477	632,406	726,615	624,555	628,470
Outpatient Surgeries Operating Room Minutes				
272,447	271,157	262,095	226,395	218,595
Inpatient Surgical Operations				
4,691	4,657	5,487	5,258	4,348
Outpatient Surgical Operations				
3,004	2,844	2,641	2,476	2,366

Source: The Office of Statewide Health Planning and Development (OSHPD)

As is shown in Figure 4-6, the utilization data indicates that service demand at the DRMC stayed relatively constant with slight variations over the course of five years, with only a minimal steady increase over time for some indicators (licensed bed days, census days, ED use, and outpatient surgeries).

The ambulance diversion hours indicator shows the emergency room unavailability over the course of the year. It appears that in four out of five years the DRMC's emergency room largely remained open and accepting ambulance transport full time; in 2015, the hospital's emergency room diverted ambulance transport for 678 hours or 28 days.

Figure 4-7 depicts patient demand information for the DRMC in 2018 (the most recent complete year of information available at the time of drafting of this report). The Figure shows the breakdown of the hospital licensed beds by type and service demand for each bed type. It appears that intensive care beds experience the highest demand per bed, followed by perinatal beds.

[52] Desert Healthcare District Plan of Services, 2017

Figure 4-7: Hospital Service Demand, 2018

Inpatient Bed Utilization			
Licensed Bed Classification / Designation	***Licensed Beds (incl. in susp.)***	***Patient Days***	***Hospial Discharges***
Medical/Surgical Acute (includes GYN/DOU)	238	63,626	16,836
Perinatal (includes LDRP, excludes nursery)	28	7,976	3,159
Pediatric Acute	14	1,109	629
Intensive Care	23	8,571	2,731
Coronary Care	8	1,446	105
Acute Respiratory Care	0	0	0
Burn Center	0	0	0
Intensive Care Newborn Nursery	30	7,668	510
Rehabilitation Center	12	2,628	197
Sub-total - General Acute Care	**353**	**93,024**	**24,167**
Acute Psychiatric	0	0	0
Chemical Dependency Recovery Hospital (CDRH)	0	0	0
Intermediate Care	0	0	0
Intermediate Care/Developmentally Disabled	0	0	0
Skilled Nursing	32	8,519	836
Hospital Total	**385**	**101,543**	**25,003**
Source: The Office of Statewide Health Planning and Development (OSHPD)			

Figure 4-8 further demonstrates the highest demand for intensive care and perinatal beds. The Figure also indicates that patients generally stay longer in the intensive care newborn nursery and rehabilitation center units.

Figure 4-8: Hospital Service Demand by Inpatient Bed Type, 2018

Inpatient Bed Utilization			
Licensed Bed Classification / Designation	***Average Length of Stay***	***Licensed Bed Days***	***Licensed Bed Occupancy Rate (%)***
Medical/Surgical Acute (includes GYN/DOU)	3.8	86,870	73%
Perinatal (includes LDRP, excludes nursery)	2.5	10,220	78%
Pediatric Acute	1.8	5,110	22%
Intensive Care	1.7	8,395	102%
Coronary Care	1.6	2,920	50%
Acute Respiratory Care	0.0	0	0%
Burn Center	0.0	0	0%
Intensive Care Newborn Nursery	14.3	10,950	70%
Rehabilitation Center	13.3	4,380	60%
Sub-total - General Acute Care	**3.8**	**128,845**	**72%**
Acute Psychiatric	0.0	0	0%
Chemical Dependency Recovery Hospital (CDRH)	0.0	0	0%
Intermediate Care		0	0%
Intermediate Care/Developmentally Disabled		0	0%
Skilled Nursing	9.3	11,680	73%
Hospital Total		**140,525**	**72%**
Source: The Office of Statewide Health Planning and Development (OSHPD)			

Planning and Management

As part of the District's ongoing strategic planning efforts, the District regularly reviews and utilizes a wide range of information about the communities it serves. DHD collects and analyzes demographic and market data to assess, evaluate and plan for future health needs in the community. The most recent Service Plan was completed at the time of the 2018 annexation to illustrate how the District was planning to serve the annexed area.[53]

The DHD has additionally completed annual reports over the years that described to the community the annual investments the District had made through grant funding to many nonprofit and community-based organizations that serve the healthcare needs of district residents.[54]

As DHD does not provide direct services, but rather funds nonprofit and community-based organizations that do provide various healthcare services, performance measures such as progress and program deliverables and outcomes are collected by the District and utilized to determine the impact on DHD residents. Also, the DHD Board of Directors approved a community engagement policy to ensure that key stakeholders across the Coachella Valley have a voice to influence the development of policies and strategies that will affect their lives and inform the way in which District and Foundation services are planned and implemented.[55]

DHD's long term objectives and goals are determined and established by the Board of Directors with input from the CEO and staff. The District's Strategic Plan guides and informs the focus areas for program and service implementation.

The District forecasts community service needs through various data-driven sources, including a regional triennial community health monitor/survey, Riverside County health rankings, Office of Statewide Health Planning and Development (OSHPD), and others. The District is in the process of conducting a valley-wide Community Health Needs Assessment (CHNA) and a 10-year Community Health Improvement Plan (CHIP) that will assist the District and all community partners (funders, nonprofits, cities, legislature, etc.). These planning efforts will help determine the magnitude of the needs, guide the District's strategic plan and grant awards, and aid DHD in improving the health of district residents.[56] The CHNA process has been delayed due to the COVID-19 pandemic creating challenges in conducting meetings aimed at obtaining involvement of community stakeholders. Presently, the District is planning to have CHNA process complete by March 2021, in order to inform grant funding and budgeting in FY 21-22. In the meantime, DHD has identified some areas of focus for FY 20-21 to address immediate needs.

The District has identified a number of deficiencies affecting Coachella Valley residents' health and wellbeing, including homelessness, insufficient behavioral health services, environmental hazards, lack of evidence-based knowledge and solutions to healthcare challenges, insufficient school-based healthcare services and preventative care, and the lack of healthcare workforce.[57]

[53] Desert Healthcare District Plan of Services, 2017
[54] Desert Healthcare District Request for Information, February 11, 2020
[55] Desert Healthcare District Request for Information, February 11, 2020
[56] Desert Healthcare District Request for Information, February 11, 2020
[57] Desert Healthcare District Request for Information, February 11, 2020

Staffing

The District employs 10 full-time equivalents (FTE), of which approximately seven FTEs are engaged in Foundation activities, which is under the umbrella of the District. The Foundation, which is now a part of the District's overall organizational structure, was once a subsidiary of DHD with its own Board of Directors. It was first created in 1967 to support the activities of and conduct fundraising for the DRMC. In 1997, when the hospital became a for-profit facility and was leased to Tenet Health Systems, the need for fundraising activities aimed at supporting the medical center ceased. In 2003, the Foundation Board was dissolved, and the District Board assumed responsibility. Currently, the roles of the Foundation include fiscal sponsor and incubator of new collaborative projects.[58]

The District's staff consists of a chief executive officer (CEO), chief administrative officer, chief program officer (CPO), program officer and director of outreach, director of communications and marketing, special assistant to the CEO and Board Relations Officer, program and research analyst, special programs project manager, accounting manager, and administrative and program assistant. The District performs employee evaluations of all its staff annually. The employee's supervisor performs the evaluations. The Chief Administration Officer (CAO) and CPO evaluate employees in their respective departments. The CEO evaluates the performance of the CAO, CPO, and Assistant to the CEO/Board Liaison. The Board of Directors performs the evaluation of the CEO.[59]

In relation to the DRMC, the staffing information for 2017 (the most recent available year as of the drafting of this report) is included in Figure 4-9. The medical center staff are employees of Tenet Healthcare Systems, not DHD.

Figure 4-9: DRMC Staffing, 2017

Desert Regional Medical Center Staff	
Clinical Specialty	***Number***
Active Medical Staff - Non-Hospital Based - Board Certified	
Other Specialties	83
Pediatric-Cardiology	2
Pediatric Medicine	9
Plastic & Reconstructive Surgery	7
Physical Medicine/Rehabilitation	3
Podiatry	2
Urology	4
Psychiatry	1
Thoracic Surgery	3
Pulmonary Disease	2
Vascular Surgery	4
Internal Medicine	37
Neurology	14
General Surgery	12
Neurological Surgery	9
Ophthalmology	11
Orthopedic Surgery	12
Obstetrics and Gynecology	13
Oral Surgery (Dentists Only)	5
Occupational Medicine	1
Oncology	5
Otolaryngology	4
Allergy and Immunology	1
Gastroenterology	7
Colon and Rectal Surgery	1
Cardiovascular Diseases	10
General/Family Practice	25
Dermatology	2
Active Medical Staff - Hospital Based - Board Certified	
Pathology	6
Diagnostic Radiology	22
Anesthesiology	21
Medical Students - Residents and Fellows	
Neurology	10.56
Neurological Surgery	6.86
Internal Medicine	15.82
Other Specialties	14.8
General/Family Practice	19.35

Source: The Office of Statewide Health Planning and Development (OSHPD)

[58] https://www.dhcd.org/Foundation
[59] Desert Healthcare District Request for Information, February 11, 2020

Facilities

The District owns a hospital, the Las Palmas Medical Plaza, and the Wellness Park.

The District's hospital—Desert Regional Medical Center (DRMC)—was established in 1948 on what was a portion of the grounds of the El Mirador Hotel in Palm Springs. Initially, the hospital was a 33-bed facility, but in 1970s the District purchased the remainder of the hotel property and built what is now the 385-bed acute care medical center. In 1986, the District leased the hospital to the nonprofit Desert Hospital Corporation; in 1997, DHD entered into a lease agreement with Tenet Healthcare Systems, which continues to operate the hospital.

DRMC provides comprehensive medical care and has the only designated trauma center in the 8,000-square mile region from the San Gorgonio Pass to the Arizona border, as well as Coachella Valley's only neonatal intensive care unit. The Institute of Clinical Orthopedics and Neurosciences at DRMC features advanced brain and spinal care treatment and rehabilitation. The hospital also contains an expanded certified comprehensive Stroke Center with new technology and runs a new medical fellowship program. DRMC has a state-of-the-art linear accelerator for radiation therapy in cancer treatment and the Coachella Valley's only Joint Commission (JC) -certified program in hip and knee replacement. The DRMC's Advanced Congestive Heart Failure Program is the only robotic system for the treatment of atrial fibrillation and other heart disorders in the Coachella Valley. The hospital treats a number of other serious medical conditions in its Comprehensive Cancer Center, El Mirador Imaging Center, the Pulmonary Laboratory, the Center for Weight Management, and inpatient and outpatient rehabilitation departments.

Additionally, the District owns and operates the Las Palmas Medical Plaza, which it leases to various healthcare providers. Las Palmas, located adjacent to the DRMC, is an approximately 50,000-square foot professional medical office complex. It houses a 13,000-square foot family medical clinic, pharmacy, labs, urology, OB/GYN, cardiology, surgery, and other specialists. The DRMC's outpatient surgery center is also located in the El Mirador Medical Plaza.

DHD also owns the Wellness Park, which is a 5.5-acre park located across the street from the DRMC. It consists of walkways, landscaping, a fitness course, park benches, and water fountains. This neighborhood park is maintained by the City of Palm Springs under a lease agreement with DHD.

Facility Sharing

As described, the District practices facility sharing by leasing the DRMC and Las Palmas Medical Plaza to healthcare providers, as well as through its maintenance agreement with the City of Palm Springs for the Wellness Park.

The District anticipates that future facility sharing opportunities will be identified during the development of the CHNA, which will guide facility needs in the eastern portion of the District. Depending on the needs identified, the structure may resemble the existing Las Palmas Medical Plaza set up, where DHD makes available affordable clinic space.

Infrastructure Needs

Over the last 23 years, Tenet Health Systems has invested over $165 million into the DRMC, including capital upgrades and improvements in technology and equipment.[60] The hospital requires additional significant capital improvements in order to comply with 2030 seismic requirements. In this regard, the DRMC's North Wing and East Tower have both been re-evaluated under HAZUS to SPC-2 ratings,[61] giving the facility until January 1, 2030, to be brought into compliance. In January 2019, the District commissioned a comprehensive Seismic Evaluation and Compliance Planning Study, which estimated that seismic compliance costs would range from $119 to $180 million.[62] Actual capital costs will greatly depend on the degree to which the District plans to make use of the hospital facility in the long term, which will be determined by facility needs identified in the CHNA in progress. The plan for financing the seismic retrofit will likely be from two sources—income from the lease renewal or sale of the hospital and/or general obligation bonds. Additionally, there is the potential that the State could postpone the deadline for addressing seismic needs until 2037.[63] Postponement would allow DHD to complete the CHNA, resolve whether to sell or lease the hospital, and then address seismic infrastructure needs.

With regard to the Las Palmas Medical Plaza, many upgrades have been completed in the recent years, including replacement of the parking lot and replacement of the public restrooms to ensure Americans with Disabilities Act (ADA) compliance. Additionally, there is a property maintenance company on site to maintain the facility promptly and on a daily basis. No further infrastructure needs were identified.

Capacity

The recent expansion of DHD more than doubled the District's service area and the population; however, the expansion has not resulted in any additional funding sources. The District has increased its fundraising efforts to cope with additional demand. As the population of DHD continues to grow, the District is anticipating that additional funding sources will be essential to increase grant funding and other efforts to address the healthcare needs of district residents. It was reported by DHD that the CHNA will identify the projected needs as well as duplicative healthcare services and facilities. Additionally, the CHIP, which will be informed by the Assessment, will guide efforts to create efficiencies and collaboration in meeting the healthcare needs of district residents. DHD also reports that it has sufficient current and planned staffing capacity to develop continued grant funding opportunities and other collaborative programs.[64]

[60] Desert Healthcare District Request for Information, February 11, 2020
[61] OSHPD has developed a Structural Performance Category (SPC 1-5) rating for hospitals that indicates the building's compliance with seismic safety standards; and a Non- Structural Performance Category (NPC 1-5) rating that indicates the hospital facility's equipment and systems conformance with seismic standards for adequate anchorage and bracing of non-structural features such as electrical, mechanical, plumbing and fire safety systems for their continued use following a disaster event. Structural/Non-Structural Performance Category 4-5 designations indicate facility conformance with the seismic standards; SPC/NPC 1-3 designations indicate nonconformance with seismic standards and include specific required deadlines to achieve conformance.
[62] Desert Healthcare District Request for Information, February 11, 2020
[63] Senate Bill 758 would extend the deadline to January 1, 2037.
[64] Desert Healthcare District Request for Information, February 11, 2020

The District is presently recruiting a Senior Development Officer to help secure funding and resources on a large scale to advance a collective impact approach and leverage funding from foundations, government, and corporate fundraising. Other potential revenue streams include creation of a community facilities district (CFD) or joint powers authority (JPA) and future hospital lease revenue.[65]

In regard to DRMC's capacity, Figure 4-8 in the *Service Demand* section indicates that in 2018, there was overall sufficient capacity to accommodate patient demand for its inpatient services based on the occupancy rate of licensed beds. However, it appears that the ICU is over capacity with an occupancy rate of 102 percent of available beds throughout the year, indicating that DRMC lacks sufficient intensive care beds to address demand. The District reported that due to the seasonal impact of tourism to the area during winter months creating peaks in demand, that there may be high usage during those periods, but overall there has not been a long-term strain on intensive care beds throughout Coachella Valley. However, the potential need for additional intensive care beds, as well as placement, will be addressed as part of the CHNA.

Although there appears to be overall sufficient capacity in terms of hospital beds, the presence of MUAs and healthcare shortage areas within the District discussed in the *Challenges* section indicates that medical staffing increases are necessary in the District's service area. DHD is aware of the problem and has reported that one of its grant funding efforts is to increase the availability of healthcare professionals within the District and expand healthcare into the underserved areas.

While the District has greatly increased in size in the last two years, this has not inherently led to an increase in demand for existing services, as district facilities are available to non-residents and draw patients from the entire region. However, there is now greater demand to provide expanded services to new district residents, such as locating new facilities or funding of services in the newly annexed territory. As mentioned, no additional funding was allocated to the District to accommodate the increase in demand, which dilutes the existing revenue across a significantly larger territory, which poses a constraint on the District's capacity to provide services.

Future district services will need to address anticipated needs resulting in changes in demographics, such as an aging population. The District reports that it is aware of demographic trends and already provides services to fulfill needs of the various age groups, such as funding and resources to senior care nonprofit organizations. Further service needs will be identified and fulfilled as part of the CHNA.

Challenges

DHD reported that residents in many areas of the District, particularly in the eastern Coachella Valley are significantly underserved. The District is challenged with identifying the gaps in services, facilities and providers in these areas. To address this challenge, DHD is currently developing The CHNA and CHIP that will provide more clarity on the issues. The

[65] Desert Healthcare District Request for Information, February 11, 2020.

District also reported that it is struggling with developing additional funding sources to address the needs in the expanded service area.[66]

The District stresses that the needs of the community it is serving have changed significantly since its formation due to demographic changes and advances in healthcare. Previously, the District was serving a smaller population with a lower life expectancy and healthcare needs that frequently required long hospitalization periods. DHD's services are now oriented towards a much larger population with a longer life expectancy and mostly ambulatory healthcare needs. Consequently, the District largely focuses on building local and regional partnerships and grant funding for healthcare providers that help address these needs.

Racial and ethnic disparities in health outcomes and in access to healthcare services are highly prevalent in the District, especially in the newly annexed areas. These disparities result in significant complexities that the District is projected to be challenged with as the population continues to grow.[67]

The California Office of Statewide Health Planning and Development (OSHPD) produces maps for all California counties that define MUAs and HPSAs. MUAs are based on the evaluation criteria established through federal regulation to identify geographic areas or population groups based on percentage of population at 100 percent below poverty, population over 65 years old, infant mortality rate, and primary care physicians per 1,000 people. HPSAs are identified for primary care, nursing, mental health, and dental healthcare professionals. OSHPD has identified three MUAs and four primary care HPSAs within the District's boundaries, as can be seen in Figures 4-10, 4-11, 4-12.

There are significant concerns for district residents should the ACA be repealed. The hospital has a high ratio of patients receiving healthcare through the ACA, and although DHD does not operate the hospital, the District would need to address how healthcare could be offered to all district residents, particularly given a loss of coverage.

[66] Desert Healthcare District Request for Information, February 11, 2020
[67] Desert Healthcare District Request for Information, February 11, 2020

Figure 4-10: Shortage Areas in Desert Healthcare District

Medically Underserved Areas and Health Care Professional Shortage Areas in Desert Healthcare District	
Medically Underserved Area	**Chairaco Summit/Desert Center Service Area 00256**
Census Tract	469
Census Tract	9810
Medically Underserved Area	**Riverside Service Area 04012**
Census Tract	456.04
Census Tract	456.06
Census Tract	456.08
Census Tract	456.09
Medically Underserved Area	**Riverside Service Area 00380**
Census Tract	456.04
Census Tract	456.06
Census Tract	456.08
Census Tract	456.09
Primary Care Health Care Professional Shortage Area	**MSSA 126&127/Blythe/ Chiriaco Summit**
Census Tract	459
Census Tract	461.01
Census Tract	461.02
Census Tract	461.03
Census Tract	462
Census Tract	469
Census Tract	470
Census Tract	9401
Census Tract	9810
Primary Care Health Care Professional Shortage Area	**Low Income - MSSA 129.2/Indio North**
Census Tract	452.09
Census Tract	452.16
Census Tract	452.17
Census Tract	452.22
Census Tract	452.28
Census Tract	452.33
Census Tract	453.02
Census Tract	453.03
Census Tract	453.04
Census Tract	455.02
Census Tract	494
Census Tract	514
Primary Care Health Care Professional Shortage Area	**Low Income - MSSA 129.3/Agua Caliente**
Census Tract	448.04
Census Tract	448.05
Census Tract	448.07
Census Tract	449.16
Census Tract	450
Census Tract	9405
Census Tract	9407
Census Tract	9408
Census Tract	9409
Census Tract	9410
Census Tract	9411
Primary Care Health Care Professional Shortage Area	**MSSA 130/Idyllwild/ Pine Cove**
Census Tract	444.02
Census Tract	444.03
Census Tract	444.04
Census Tract	444.05

Figure 4-11: Medically Underserved Area Map

Figure 4-12: Primary Care Health Care Professional Shortage Area Map

Many government agencies, as well as communities in California have been impacted by the COVID-19 pandemic. Although DHD has not yet seen the full effect of the pandemic on its revenues and operations, the District is continuously monitoring the ongoing changing scenarios. DHD reported, however, that many healthcare providers within the District boundaries have experienced significant revenue reductions. This in turn has created additional demand for DHD funding. Some of the increased demand has shifted from traditional programmatic needs to new necessities that include personal protective equipment, disinfectant wipes, thermometers, and food.[68]

Desert Healthcare District conducted a local survey with the participation of numerous community partners. Through this assessment, the District was able to identify community needs and respond accordingly. Over the weeks that followed the COVID-19 outbreak the District awarded over $2.5million to local nonprofit organizations. The funds were primarily destined to cover ongoing access to healthcare for the underserved through three Federally Qualified Health Centers including Borrego Community Health Foundation, Desert AIDS Project and Clinicas de Salud del Pueblo. Additionally, the Coachella Valley Volunteers in Medicine and the University of California Riverside, School of Medicine were also awarded grants to serve farmworkers in the easternmost areas of the District. DHD also purchased COVID-19 tests to distribute among healthcare partners and allow mobile testing sites. These efforts have been coordinated with the County Department of Public Health. [69]

In addition, the District has partnered with a local foundation to establish a collective impact fund and made small grants, up to $10,000 available to 20 organizations. Since DHD expects the impact of COVID-19 pandemic to be ongoing and long-lasting the District has allocated a grant-making budget of over $4 million for the current fiscal year (FY 20-21). [70]

The Desert Regional Medical Center has also been impacted by the pandemic. The hospital followed all the required protocols early in the pandemic while preparing for a potential surge. The early measures included temporarily closing and/or reducing hours of operation of multiple procedural and outpatient areas, which have since been resumed. Based on the closure/reduction of some services during the early months of the pandemic, DRMC reallocated clinical staff where possible to provide additional manpower in the areas of greatest need. DRMC also secured travelers for nursing and respiratory therapy to ensure adequate coverage and allow for hospital staff some flexibility with time off. [71]

Since the beginning of the pandemic, the DRMC had seen the decline in emergency room visits and demand for elective surgeries. Although the demand has gradually recovered it remains lower than in the previous year. The hospital has launched a "safe care" campaign to educate the community on the need to seek care for episodes such as stroke, heart attack, accidents or other needs requiring immediate medical attention. [72]

Desert Regional Medical Center maintains an Emergency Operations Center Plan for all types of disasters/episodes that may require operations above and beyond the normal functioning of the hospital. The hospital's focus moving into the fall of 2020 is to ensure that all COVID-19 protocols are followed, vaccinate hospital staff for flu in a timely manner while

[68] Desert Healthcare District Request for Information, COVID-19 Questionnaire, August 6, 2020.
[69] Desert Healthcare District Request for Information, COVID-19 Questionnaire, August 6, 2020.
[70] Desert Healthcare District Request for Information, COVID-19 Questionnaire, August 6, 2020.
[71] Desert Healthcare District Request for Information, COVID-19 Questionnaire, August 6, 2020.
[72] Desert Healthcare District Request for Information, COVID-19 Questionnaire, August 6, 2020.

educating the community to do the same, and continue its collaboration with other hospitals and clinics throughout the County. The DRMC has also, as usual for the winter season, planned for adequate staffing through travelers so that it can appropriately respond to any changes/fluctuations in census.[73]

Additionally, the challenge that both the District and the hospital are currently experiencing is with testing supplies/reagents. The lack of COVID-19 tests and reagents at the DRMC results in longer wait times for lab result, which is a problem of national concern. To mitigate reagent shortages, DRMC is using three testing methodologies to have the ability to process in-house lab tests based on supply availability. DRMC also uses Lab Corp as a back-up while conserving in-house supplies for in-house patients.[74]

The District, on the other hand, supports access to COVID-19 tests for traditionally underserved communities by providing financial assistance/grants to local community clinics or Federally Qualified Health Centers. Accessing these tests has been very challenging given the limited availability of tests nationwide. Finding personal protective equipment (PPE) for essential workers (farm workers, healthcare and service workers, and those serving the homeless) has been almost impossible as supply is prioritized for hospital workers only. However, the District has been able to secure access to face shields and masks to distribute among its community partners.[75]

Service Adequacy

Grant Funding

Since DHD does not directly provide healthcare services and instead largely operates as a financing mechanism for projects and programs managed by other agencies by providing grant funds, the District's service adequacy assessment is based on 1) public outreach and accountability efforts, 2) grant management practices, and 3) resident satisfaction.

Essential in issuing grants, is follow up and review with the agency receiving the funds to 1) ensure that the money is used appropriately, 2) confirm that funded projects are carried out to completion, 3) review project challenges and outcomes to make appropriate improvements/changes to successive project approvals, and 4) guarantee that the grantee organization continues to viably operate during the course of the project.

There are several best management practices with regard to grant approval and management discussed briefly in Appendix A. It is recommended that all grant funding healthcare districts follow these guidelines.

DHD is extensively involved in the community and engages its residents in the assessment of service needs and service planning. The District maintains the website where it posts a large volume of material to keep its constituents informed of the District's activities, including the required information in compliance with SB 929, AB 2257 and AB 2019 as was previously described in the *Accountability and Governance* section. AB 2019, however, in addition to the website posting obligations, has set out additional requirements for the districts that provide assistance or grant funding. The bill requires these healthcare districts

[73] Desert Healthcare District Request for Information, COVID-19 Questionnaire, August 6, 2020.
[74] Desert Healthcare District Request for Information, COVID-19 Questionnaire, August 6, 2020.
[75] Desert Healthcare District Request for Information, COVID-19 Questionnaire, August 6, 2020.

to adopt annual policies that include certain elements in addition to the current requirement that the policy describe the nexus between the assistance or grant funding and the district's mission. The new requirements include:

- the requisites that a grant recipient must meet, such as grant contract terms and conditions, fiscal and programmatic monitoring by the district, and reporting to the district,
- the district's plan for distributing grant funds for each FY
- a process for providing, accepting and reviewing grant applications and
- a prohibition against individual meetings regarding grant applications between a grant applicant and a district board member, officer or staff member outside of the district's established awards process.

AB 2019 also requires districts to develop additional grant guidelines for all of the following by January 1, 2020:

- awarding grants to underserved individuals and communities and the organizations that serve them,
- evaluating the financial need of applicants,
- considering the types of programs eligible for funding,
- considering the circumstances under which grants may be provided to prior grant recipients,
- funding other government agencies, and
- awarding grants to, and limiting funds for, foundations that are associated with a separate grant recipient.

DHD complies with the new requirements and has adopted all the necessary policies and guidelines including a grant oversight process, last updated in 2020.[76] All of DHD's grant investments are vetted and evaluated by the District's standing committees and the Board of Directors. The grantee agencies submit progress and final reports and budget reports, delivering the outcomes and measurements of the District's investments in their projects and programs.[77]

Based on the absence of complaints in 2019, District residents appear to be generally satisfied with DHD performance and services in the community.

Hospital Services

There are several benchmarks that may define the level of healthcare service provided by a hospital. Indicators of service adequacy discussed here include 1) PQIs, 2) IMIs, 3) hospital volume indicators, 4) EMS ambulance diversion rates, 5) the extent to which residents go to other hospitals for service, 6) patient satisfaction, 7) hospital safety, and 8) accreditation.

[76] Grant & Mini-Grant Policy, Desert Healthcare District Board, Approved 3/24/2020
https://www.dhcd.org/media/1116/Board%20Policies_Grants_OP5.pdf
[77] Desert Healthcare District Request for Information, February 11, 2020

Although this data is not available specifically for DHD or even for Coachella Valley, it is important to discuss PQIs.[78] Figure 4-13 shows that overall Riverside County's rates do not largely differ from statewide rates. For uncontrolled diabetes and asthma in young adults, the Riverside County rates were lower than statewide rates by a larger margin than all other indicators, suggesting that residents in the County have better access to outpatient care for these diseases compared to statewide. When a person receives early and proper treatment for specific medical conditions, disease complications may be reduced or eliminated, disease progression may be slowed, and hospitalization may be prevented. The short-term diabetes complications and community acquired pneumonia rates in Riverside County, on the other hand, were higher than statewide rates by a large margin.

[78] The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions" in adult populations. These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. The Prevention Quality Indicators represent hospital admission rates for 4 ambulatory care sensitive conditions.

Figure 4-13: Risk Adjusted Rates per 1,000 Population

Year	Region	Diabetes Short-term Complications	Diabetes Long-Term Complications	COPD or Asthma in Older Adults (Ages 40+)	Hypertension	Heart Failure	Community-Acquired Pneumonia	Urinary Tract Infection
2017	Statewide	38.4	90.6	299.1	40.5	330.4	108.4	101.3
	Riverside	41.9	89.5	286	37.7	292.5	115.1	104
	Difference with statewide	9%	-1%	-4%	-7%	-11%	6%	3%
2018	Statewide	58.1	88.4	229	41.5	335.4	107	93.3
	Riverside	67.4	92.9	208.3	41.2	309.5	125.1	98.9
	Difference with statewide	16%	5%	-9%	-1%	-8%	17%	6%

Year	Region	Uncontrolled Diabetes	Asthma in Young Adults (Ages 18-39)	Lower-Extremity Amputations Among Patients with Diabetes	Overall Composite	Acute Composite	Chronic Composite	Diabetes Composite
2017	Statewide	31.9	19.5	24.7	947.1	209.7	736.3	172.5
	Riverside	26	16.5	23.1	905.6	219.6	683.6	168.2
	Difference with statewide	-18%	-15%	-6%	-4%	5%	-7%	-2%
2018	Statewide	30.3	18.5	25.9	919.6	200.3	718.3	189.8
	Riverside	26.1	15.7	25.8	916	224.2	689.7	196.8
	Difference with statewide	-14%	-15%	0%	0%	12%	-4%	4%

Source: The Office of Statewide Health Planning and Development (OSHPD)

IMIs reflect quality of care by measuring inpatient mortality rates for individual hospitals against state averages for specific medical conditions and surgical procedures. Evidence suggests that high mortality rates may be associated with deficiencies in the quality of hospital care provided. The most recent information regarding IMIs is available from OSHPD for 2015 (January-September).[79] The information available includes risk-adjusted mortality rates for six medical conditions treated (Acute Stroke, Acute Myocardial Infarction, Heart Failure, Gastrointestinal Hemorrhage, Hip Fracture and Pneumonia) and six procedures performed (Abdominal Aortic Aneurysm Repair, Carotid Endarterectomy, Craniotomy, Esophageal Resection, Pancreatic Resection, Percutaneous Coronary Intervention (PCI) in California hospitals. DRMC's mortality rates for all but one medical conditions and procedures were not statistically different from the statewide rates. The DRMC had a higher than an average mortality rate compared to hospitals statewide in regard to the acute myocardial infraction.

The ambulance diversion rate is another indicator of a hospital's service adequacy. Ambulance diversion may occur due to emergency room closure, inability to accommodate the incoming volume of patients or the inability to transfer admitted patients from the ED to inpatient beds. Ambulance diversion has been found unsafe for patients because it increases transport times, which interferes with continuity of care, causes delays, and increases mortality for severe trauma patients.[80] Figure 4-6 in the *Service Demand* section indicates that in one out of five years shown the DRMC's ED was unable to receive patients for a significant number of hours (678 hours or 28 days). In all other years, the hospital's ED was largely able to accommodate the incoming volume of patients at all times.

The adequacy of hospital facilities and services in meeting the needs of district residents can be gauged by the extent to which residents travel outside their region to receive hospital

[79] Data is reported for January-September due to coding changes for diagnosis and procedures, which began on October 1, 2015.
[80] *Reducing Ambulance Diversion in California: Strategies and Best Practices*, California Healthcare Foundation, July 2009 https://www.chcf.org/wp-content/uploads/2017/12/PDF-ReducingAmbulanceDiversionInCA.pdf

services. The rates were calculated based on patient origin discharge data from OSHPD.[81] Residential location was approximated by the zip codes. About 35 percent of residents who live within DHD boundaries patronize the DRMC for needed services based on the data available for 2016 and 2017.

The hospital volume indicators measure the number of medical procedures of a given type that are performed by a hospital within the one-year reporting period. OSHPD states that higher hospital volumes for some complex surgical procedures may be associated with better patient outcomes such as lower mortality rates; however, OSHPD does not recommend the use of volume indicators as stand-alone measures of hospital quality. The data is available for six selected inpatient procedures, including esophageal resection,[82] pancreatic resection,[83] abdominal aortic aneurysm repairs (AAA Repairs),[84] carotid endarterectomy,[85] coronary artery bypass graft surgery (CABG),[86] and PCI[87] performed in California hospitals. The most recent information as of the drafting of this report was available for 2017. Based on the data from 2016 and 2017, DRMC performs consistently high volumes of the aforementioned procedures, particularly for CABG and PCI. The lowest volume is attributed to esophageal resection and pancreatic resection.[88]

Cal Hospital Compare is a performance reporting initiative that was established for the purposes of developing a statewide hospital performance reporting system using publicly available data sources. The data includes measures for clinical care, patient safety, and patient experience for all acute care hospitals in California. In FY 18-19, DRMC received an overall Patient Experience Rating of below average. Patient responses further indicate that 70 percent would recommend DRMC services, which is comparable to the statewide average of 71 percent. The hospital had a 15.6 percent (rated as average) readmission rate[89] compared to the statewide average of 15 percent. For indicators of clinical care and patient safety, DRMC's scores appear to be largely consistent with statewide average levels.[90]

The Leapfrog Group is another independent nonprofit organization that provides hospital safety grading. Its scores are based on infection rates, problems with surgery, safety problems, and performance of doctors, nurses and hospital staff. According to Leapfrog Group ratings, the DRMC has a safety rating of C as of spring 2020.[91] The rating details are shown in Figure 4-14.

[81] Discharge data includes discharges from ambulatory surgery center, emergency department, inpatient discharges, and inpatient discharges that originated in the emergency department.
[82] Surgical removal of the esophagus due to cancer
[83] Surgical removal of the pancreas/gall bladder due to cancer
[84] Surgical repair of abdominal aneurysm
[85] Surgical removal of plaque within the carotid artery
[86] Surgical heart artery procedure
[87] Non-surgical heart artery procedure
[88] https://data.chhs.ca.gov/dataset/number-of-selected-inpatient-medical-procedures-in-california-hospitals
[89] The readmission rate is considered to be better the lower it is
[90] https://calhospitalcompare.org/hospital/?id=106331164&n=Desert+Regional+Medical+Center
[91] https://www.hospitalsafetygrade.org/h/desert-regional-medical-center?findBy=hospital&hospital=Desert+Regional+Medical+Center&rPos=124&rSort=grade

Figure 4-14: Leapfrog Group Safety Grade for the Desert Regional Medical Center

Infections						
Indicator	*MRSA Infection* [1]	*C. Diff Infection* [2]	*Infection in the Blood*	*Infection in the Urinary Tract*	*Surgical Site Infection after Colon Surgery*	
Score	Below Average	Average	Below Average	Average	Above Average	
Complications with Surgery						
Indicator	*Dangerous Object Left in Patient's Body*	*Surgical Wound Splits Open*	*Deaths from Serious Treatable Complications*	*Collapsed Lung*	*Serious Breathing Problem*	*Dangerous Blood Clot*	*Accidental Cuts and Tears* [3]
Score	Above Average	Below Average	Below Average	Below Average	Below Average	Below Average	Above Average
Practices to Prevent Errors						
Indicator	*Doctors Order Medications through Computer* [4]	*Safe Medication Administration* [5]	*Handwashing*	*Communication about Medicines*	*Communication about Discharge*	*Staff Collaboration to Prevent Errors*
Score	Above Average	Above Average	Above Average	Above Average	Below Average	Above Average
Safety Problems						
Indicator	*Dangerous Bed Sores*	*Patient Falls and Injuries*	*Air or Gas Bubble in the Blood*	*Track and Reduce Risks to Patients* [6]		
Score	Below Average	Above Average	Above Average	Below Average		
Practices to Prevent Errors						
Indicator	*Effective Leadership to Prevent Errors* [7]	*Sufficient Qualified Nurses* [8]	*Specialty Trained Doctors Care for ICU Patients*	*Communication with Nurses*	*Communication with Doctors*	*Responsiveness of Hospital Staff*
Score	Above Average	Above Average	Above Average	Below Average	Below Average	Below Average

Notes:
(1) Methicillin-resistant Staphylococcus aureus (MRSA)
(2) Clostridium difficile (C. diff)
(3) For procedures of the abdomen and pelvis, there is a chance that the patient will suffer an accidental cut or tear of their skin or other tissue. This problem can happen during surgery or a procedure where doctors use a tube to look into a patient's body.
(4) Hospitals can use Computerized Physician Order Entry (CPOE) systems to order medications for patients in the hospital, instead of writing out prescriptions by hand. Good CPOE systems alert the doctor if they try to order a medication that could cause harm, such as prescribing an adult dosage for a child. CPOE systems help to reduce medication errors in the hospital.
(5) Using barcodes on medications, nurses can scan the medication and then the patient's ID bracelet to make sure the patient is receiving the right medications. If the bar codes do not match, this signals there is an error, giving nurses and doctors the chance to confirm they have the right patient, right medication, and right dose. Bar code medication administration (BCMA) systems are proven to reduce the risk that a hospital accidentally gives the wrong medication to a patient.
(6) Hospitals should be aware of all potential errors that could harm patients. Hospital leaders should evaluate their hospital's record of past errors to prevent the same error from happening again. If all hospital staff is aware of safety risks, they can work together and take all possible action to prevent harm.
(7) Errors are much more common if hospital leaders don't make patient safety a priority. Leaders must make sure that all hospital staff knows what they need to work on and that they are held accountable for improvements. The hospital should also budget money towards improving safety.
(8) Patients receive most of their care from nurses, not doctors. When hospitals do not have enough nurses or the nurses don't have the right training, patients face a much greater risk of harm. Without enough qualified nurses, patients might face more complications, longer hospital stays, and even death.

There are several major healthcare-related accreditation organizations in the United States, including Healthcare Facilities Accreditation Program (HFAP), JC, Community Health Accreditation Program (CHAP), Accreditation Commission for Health Care (ACHC), The Compliance Team – Exemplary provider programs, Healthcare Quality Association on Accreditation (HQAA), and DNV Healthcare, Inc. (DNVHC). For the State of California, the primary accreditation organization is the Joint Commission (JC). The JC is a not-for-profit organization that accredits and certifies more than 19,000 health organizations and programs in the country. Accreditation can be earned by an entire healthcare organization, for example, hospitals, nursing homes, office-based surgery practices, home care providers, and laboratories. In California, the JC is part of the joint survey process with State authorities.

Hospitals are not required to be accredited in order to operate. Accreditation generally recognizes outstanding performance by a healthcare provider.

DRMC is fully licensed by the Department of Health Services and accredited by the JC on Accreditation of Healthcare Organizations and the California Medical Association. According to the JC Quality Report for October 2018 – September 2019, DRMC's performance is comparable to hospital performance nationwide.[92]

[92] https://www.qualitycheck.org/quality-report/?bsnId=10009

DESERT HEALTHCARE DISTRICT MSR DETERMINATIONS

Growth and Population Projections

- The population of DHD is difficult to estimate since Coachella Valley is a resort destination. Based on Department of Finance estimates for 2020, the number of permanent residents within the District is approximately 445,721.
- According to SCAG, the annual growth rate in the District is estimated to be about one percent through 2045.[93] Based on these estimates, the District's population is projected to be approximately 501,332 in 2030 and 571,695 in 2045.
- There is anticipated to be a significant increase of the population over 65 years of age, while the age groups of 15 to 44 and 0 to 14 are estimated to grow at a moderate and slow rate respectively over the next 10 years.

The Location and Characteristics of Disadvantaged Unincorporated Communities Within or Contiguous to the Agency's SOI

- Riverside LAFCO has identified 40 disadvantaged unincorporated communities in Riverside County within or near cities' spheres of influence, 13 of which are within or adjacent to DHD's boundaries.

Present and Planned Capacity of Public Facilities and Adequacy of Public Services, Including Infrastructure Needs and Deficiencies

- Present capacity of the District's services is constrained by finite funding and lack of sufficient medical staffing. Additional challenges to providing services consist of the presence of MUAs and healthcare shortage areas.
- The greatest impact on the District's capacity to provide services is the addition of significant territory and population from annexation in 2018, which resulted in greater demand to provide expanded services to new district residents with no additional funding. The District is working to address this issue by securing funding and resources on a large scale to advance a collective impact approach and leverage funding from foundations, government, and corporate fundraising.
- In regard to DRMC's capacity, there is overall sufficient capacity to accommodate patient demand for its inpatient services. However, it appears that the ICU is at maximum capacity. The potential need for additional intensive care beds, as well as placement, will be addressed as part of the CHNA that is underway.

[93] Southern California Association of Governments, *Demographics and Growth Forecast*, Technical Report, Adopted on May 7, 2020, https://www.connectsocal.org/Documents/Adopted/fConnectSoCal_Demographics-And-Growth-Forecast.pdf.

- Future district services will need to address anticipated needs resulting in changes in demographics, such as an aging population. Future service needs will be identified and fulfilled as part of the CHNA.
- Service adequacy of healthcare districts that provide grant funding is defined by public outreach and accountability efforts, grant management practices, and resident satisfaction. Based on these indicators, DHD provides adequate services. In particular, DHD excels at issuing grant funds and follows best management practices with regard to grant approval and management.
- Service adequacy of hospital services are defined by 1) PQIs, 2) IMIs, 3) hospital volume indicators, 4) EMS ambulance diversion rates, 5) the extent to which residents go to other hospitals for service, 6) patient satisfaction, 7) hospital safety, and 8) accreditation. Based on these indicators, the DRMC's services appear to be mostly adequate and comparable to similar providers statewide.
- The hospital requires additional significant capital improvements, estimated between $119 and $180 million, in order to comply with 2030 seismic requirements. Actual capital costs will greatly depend on the degree to which the District plans to make use of the hospital facility in the long term, which will be determined by facility needs identified in the CHNA.

Financial Ability of Agencies to Provide Services

- The District has the financial ability to provide services. The District generally operates with an operational surplus, has established a reserve fund to meet infrastructure and other contingency needs, has sufficient reserves to operate for approximately two years, maintains limited debt, and has low pension and OPEB liabilities.
- Given the stability of the District's existing revenue sources, and the District's conservative budgeting practices, it appears that DHD is low risk for financial distress.
- Despite its strong financial position, the District may face challenges presented by hospital infrastructure needs, the potential necessity to take over the operations of the hospital, and the need to fund and extend healthcare services to the underserved areas of the recently annexed territory.

Status of, and Opportunities for, Shared Facilities

- The District practices facility sharing by leasing the DRMC and Las Palmas Medical Plaza to healthcare providers, as well as through its maintenance agreement with the City of Palm Springs for the Wellness Park.
- The District anticipates that future facility sharing opportunities will be identified during the development of the CHNA, which will guide facility needs, and thus sharing opportunities, in the eastern portion of the District.

Accountability for Community Service Needs, Including Governmental Structure and Operational Efficiencies

- The District primarily conducts outreach via its website, which makes available comprehensive information and documents to the public and solicits input from customers. The website complies with SB 929, AB 2257, and AB 2019 requirements.
- Accountability is best ensured when contested elections are held for governing body seats, constituent outreach is conducted to promote accountability and ensure that constituents are informed and not disenfranchised, and public agency operations and management are transparent to the public. The District demonstrated accountability with respect to these factors.
- No governance structure options were identified over the course of this review with regard to DHD.

DESERT HEALTHCARE DISTRICT SPHERE OF INFLUENCE UPDATE

Existing Sphere of Influence

Desert Healthcare District's (DHD's) current SOI is coterminous with its boundaries. The last SOI amendment took place in 2018 concurrently with the boundary expansion. The current SOI expands west to include most of the cities of Desert Hot Springs and Palm Springs, east to include portions of Joshua Tree National Park and the Salton Sea, north to the San Bernardino County border and south to the San Diego and Imperial county borders. To the west, DHD shares the border with San Gorgonio Healthcare District, while in the east it borders Eagle Mountains, Chuckwalla Valley and Chuckwalla Mountains, which are all situated between DHD and PVHD.

Sphere of Influence Options

Two options were identified with respect to DHD's SOI.

Option #1: Maintain coterminous SOI

Should the Commission wish to continue to reflect the existing service boundary, then a coterminous SOI would be appropriate.

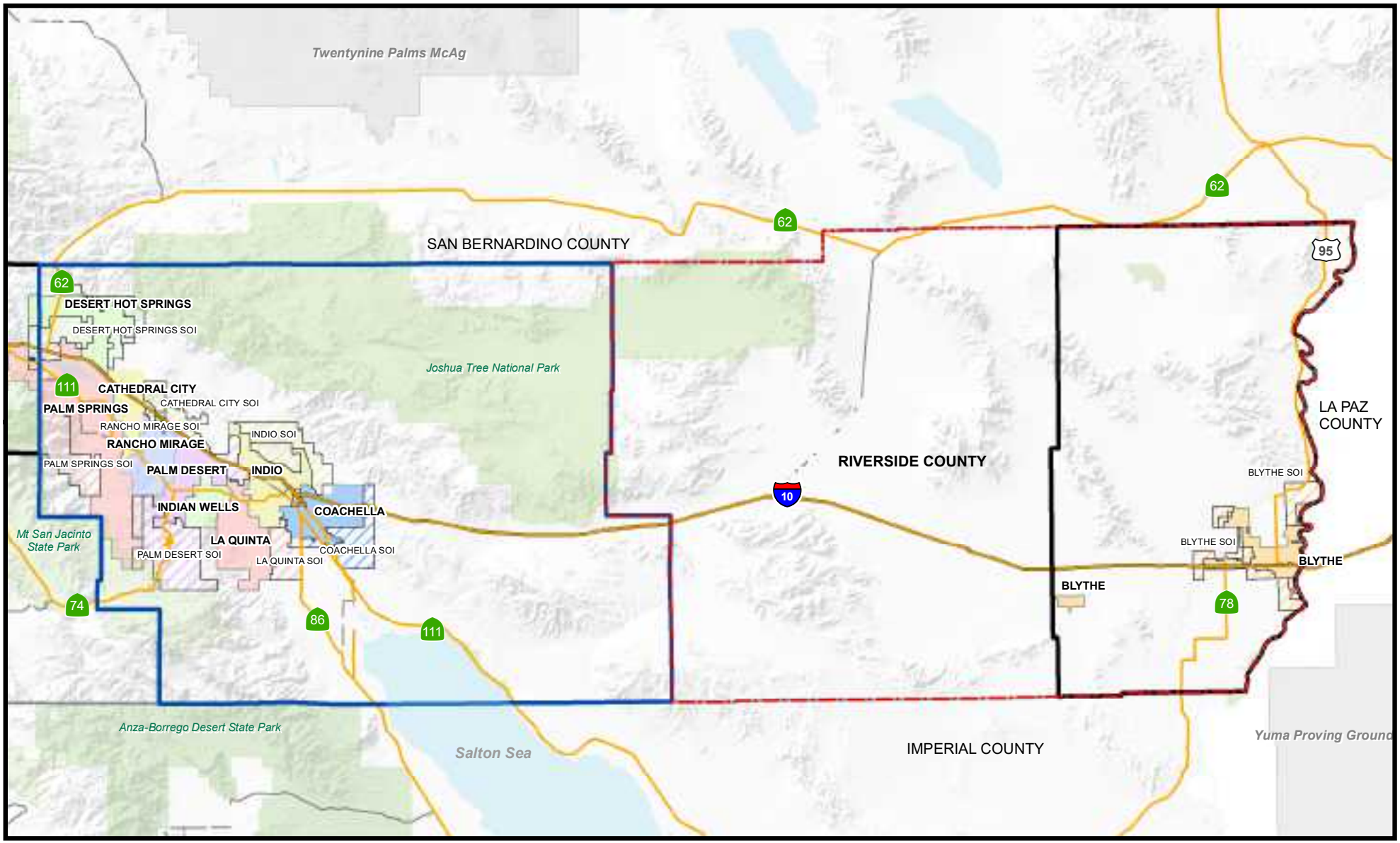
Option #2: Expand the current SOI to add the communities of Desert Center, Eagle Mountain, Lake Tamarisk and the rest of the territory between DHD and PVHD.

If the Commission decides that it would be prudent to close the gap between the borders of DHD and PVHD and annex the areas between the two healthcare districts into the DHD's boundaries to promote logical boundaries, then extension of the District's SOI would be appropriate to indicate the future annexation intent.

Sphere of Influence Analysis and Recommendations

DHD has undergone a recent SOI change and annexation that more than doubled the District's boundary area and its population. The District does not currently have adequate capacity to accommodate or plan for additional growth. Additionally, PVHD considers the area around the community of Desert Center its secondary service area, which means that it may be more appropriate to consider including these communities in the PVHD's SOI, as is shown in Figure 4-15. It is recommended that the Commission adopt Option #1 and maintain a coterminous SOI for DHD.

Figure 4-15: Desert Healthcare District and Palo Verde Healthcare District



Data Sources: County of Riverside; LAFCo

0 1.5 3 6 9 12 Miles

N

Disclaimer: The information shown is intended to be used for reference and general display purposes only and is not to be used as an official map.

Healthcare services provided for District residents

Legend

- Palo Verde Healthcare District
- Palo Verde HealthCare District Proposed Sphere of Influence
- Desert Healthcare District

Map Created on 9/14\2020

Sphere of Influence Determinations

Nature, location, extent, functions, and classes of services provided

- DHD provides support to a variety of health-related programs, primarily through grants and similar assistance to nonprofit entities and public agencies within the District boundaries that encompass Coachella Valley and stretch from the cities of Palm Springs and Desert Hot Springs in the west to Joshua Tree National Park and Salton Sea in the east. DHD additionally provides oversight of the DRMC, which is currently privately operated by Tenet Health System under a lease agreement.
- While services are provided only within the District's boundaries, they benefit both DHD residents and non-residents through the use of district funded facilities and programs.

Present and planned land uses, including agricultural and open-space lands

- DHD encompasses all land uses designated by the cities within its boundaries and the County of Riverside including agricultural and open space land.
- DHD's SOI does not conflict with planned land uses; the District has no authority over land use, and both urban and agricultural areas within the District are in need of the services offered by DHD.
- Hospital and healthcare services are needed in all areas, and do not, by themselves induce or encourage growth on agricultural or open space lands.

Present and probable need for public facilities and services

- As indicated by DHD's service demand and projected growth, there is a present and anticipated continued need for healthcare funding and hospital oversight services offered by the District.
- The areas that were annexed into DHD in 2018 are significantly underserved and require the extension of healthcare services to accommodate demand.

Present capacity of public facilities and adequacy of public services that the agency provides or is authorized to provide

- Present capacity of the District's services is constrained by finite funding and lack of sufficient medical staffing. Additional challenges to providing services consist of the presence of MUAs and healthcare shortage areas.
- The greatest impact on the District's capacity to provide services is the addition of significant territory and population from annexation in 2018, which resulted in greater demand to provide expanded services to new district residents with no additional funding. The District is working to address this issue by securing funding and resources on a large scale to advance a collective impact approach and leverage funding from foundations, government, and corporate fundraising.
- Future district services will need to address anticipated needs resulting in changes in demographics, such as an aging population. Future service needs will be identified and fulfilled as part of the CHNA.

- The hospital, owned by DHD and operated by Tenet Health System, requires additional significant capital improvements, estimated between $119 and $180 million, in order to comply with 2030 seismic requirements. Actual capital costs will greatly depend on the degree to which the District plans to make use of the hospital facility in the long term, which will be determined by facility needs identified in the CHNA.
- The District provides adequate services based on public outreach and accountability efforts, grant management practices, and resident satisfaction. DHD excels at issuing grant funds and follows best management practices related to grant approval and management.

Existence of any social or economic communities of interest

- All the areas inhabited by District residents represent social and economic communities of interest, as DHD residents pay for its services through property taxes.
- Seasonal tourists and area visitors also use District services and have an interest in adequacy of such services.
- Additionally, MUAs and healthcare shortage areas within DHD boundaries represent particular social and economic interest since they are underserved and require increased attention from the District.

DESERT HEALTHCARE
DISTRICT & FOUNDATION

Date: October 27, 2020

To: Board of Directors

Subject: Association of California Healthcare Districts (ACHD) Vacancy and Appointment to the Board of Directors

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Staff Recommendation: Consideration for the Chief Executive Officer (CEO) to apply for an appointment to the Association of California Healthcare Districts (ACHD) Board of Directors

Background:

- The ACHD is seeking nominations from member healthcare districts to immediately fill a vacant Director position on the Board of Directors.
- The ACHD Chief Executive Officer, Cathy Martin, invited and encouraged the DHCD CEO to apply for the appointment.
- A recent requirement necessitates a letter of support from the Board President of all nominees.
- Other prerequisites are that no member district may be represented on the Board by more than one (1) voting director at the same time; the nominee's healthcare district is either currently a Certified Healthcare District or commits to becoming Certified within their first year on the Board, the Board of Directors from which the nominee serves, must support the nomination in writing; and individual Directors serve three (3) year terms, up to two (2) terms, and their appointment becomes effective upon approval by the Board.
- A resume or statement of qualifications to accompany the Board President's letter of support is November 13, 2020.

Fiscal Impact:
The potential for in-person meetings will require airfare, lodging, and transportation.

DESERT HEALTHCARE
DISTRICT & FOUNDATION

October 27, 2020

Association of California Healthcare Districts
1215 K St. #2005
Sacramento, CA 95814

Re: Letter of Support

Dear Governance Committee:

It is with pleasure that I submit this letter of support for Conrado E. Bárzaga, MD, Chief Executive Officer, Desert Healthcare District and Foundation. I have had the privilege to work directly with Dr. Bárzaga in a number of activities with the District, including the current Board approval of financial support to organizations supporting communities devastated by COVID-19, and advancing the District's role in communities of color in the Coachella Valley.

Dr. Bárzaga has been an exceptional and active leader with the District and in the Coachella Valley, continuing to exhibit leadership throughout involvement in committees and health and wellness Board appointments.

It is well-deserved and with great pleasure that I support Dr. Bárzaga's nomination to the Board of Directors of the Association of California Healthcare Districts.

Sincerely,

Leticia De Lara
Board President
Desert Healthcare District and Foundation

DESERT HEALTHCARE
DISTRICT & FOUNDATION

Date: October 27, 2020

To: Board of Directors

Subject: Coordinating community access to COVID-19 testing, healthcare and social support services - COVID-19 Collaborative Update

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Staff Recommendation: Information only

Background:

- DHCD had a rapid response to the COVID-19 outbreak in March 2020.
- The District approved emergency funding grants to various partners to ensure low-income and vulnerable populations access to COVID-19 tests and needed healthcare services.
- Three Federally Qualified Health Centers (FQHCs), including Borrego Community Health Foundation, Desert AIDS Project, and Clínicas de Salud del Pueblo, along with University of California Riverside School of Medicine, and Coachella Valley Volunteers in Medicine are the main grant-recipients in this category. Each organization received a $150,000 grant. Additionally, a $350,000 grant was approved to equip the FQHCs with rapid testing technology.
- Thanks to these District grants, thousands of community members have had access to COVID-19 tests, some of which have been deployed in the less densely populated areas of the district, where the healthcare infrastructure lacks.
- But more was clearly needed.
- The County of Riverside Department of Public Health reached out to the District and requested assistance in coordinating COVID-19 outreach, education, contact tracing and social support efforts in Coachella Valley, and especially in eastern Coachella Valley.
- The District, through its Foundation will help coordinate these efforts and re-grant CARES dollars provided by the County.
- Community-based organizations (CBOs) will be subrecipients of these funds. They will access CARES funds through a streamlined grant process with DHCF.
- The CBO members of this Collaborative will join existing DHCD grantees in their efforts to increase the deployment of COVID-19 resources in the community.
- There are persistent differences in COVID-19 test positivity among some communities in the Valley, some of which also overlap with race and likelihood of employment as essential workers.
- To ensure an equity lens, priority will be given to census tracts in the lowest quartile of the Healthy Places Index. Interactive map link: https://countyofriverside.maps.arcgis.com/apps/webappviewer/index.html?id=08b3fa52b06a4837b8544ff3111fdd53
- Targeting these communities aims at reducing the disproportionate impact of the disease on the most vulnerable and reducing disease transmission in all communities.

Coordinating efforts and obtaining timely results

- District staff will facilitate regular meetings with new and existing grantees and coordinate efforts to ensure there is ample communication amongst the community partners.
- Ensure that existing barriers to COVID-19 tests are removed by giving access to social support services, including assistance with medical care, cash, rent, utilities, and food.
- The County of Riverside will ensure testing and contact tracing protocols are in place, and that these efforts are also coordinated with the CV COVID-19 Collaborative.
- In the meantime, two of our existing grantees, UCR School of Medicine and Borrego Health will continue to offer COVID-19 testing Friday and Saturday morning at 46605 Dillon Rd, Coachella, and Friday and Saturday evenings at the AMPM Travel Center on Avenue 66th in Thermal.

Fiscal Impact:
N/A

DESERT HEALTHCARE
DISTRICT & FOUNDATION

Date: October 27, 2020

To: Board of Directors

Subject: Community Health Needs Assessment and Health Improvement Plan (CHNA/CHIP) Update

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Background:

- On June 23, 2020, the Board of Directors were notified that due to the COVID-19 pandemic, the staff and HARC made the decision to delay the completion of the CHNA/CHIP until March 2021.
- Staff and HARC have identified virtual focus groups to be the most safe, meaningful method to engage Coachella Valley residents this fall with financial incentives to ensure community participation.

Information:

- Since the beginning of September, HARC has engaged the Advisory Council to recruit participants and help identify appropriate dates, times, and language for virtual focus group. As of October 21, the following has transpired:
    - A total of 18 focus groups have been conducted with 90 community participants.
        - 58 community participants in English-speaking focus groups (64.4%) and 32 participants in Spanish-speaking focus groups (35.6%).
    - There is a total of 6 focus groups scheduled in the next few weeks, and 9 focus groups in the planning stages.
- In order to capture a representative community voice, focus groups will be extended into November to reach a higher number of resident participants across various subpopulations.
- HARC has secured additional health workforce data, specific to the Coachella Valley, from Desert Care Network.
- Staff continues to inform HARC about the District's intent and objectives of a community-driven, community-informed process, and specific data needs.

Fiscal Impact:

- N/A.

DESERT HEALTHCARE
DISTRICT & FOUNDATION

Date: October 27, 2020

To: Board of Directors

Subject: CEO Report – Lift to Rise Economic Protection Efforts – United Lift Rental Assistance Update

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Staff Recommendation: Information only

Background:

- In response to the onset of COVID-19 pandemic, Desert Healthcare District joined other funders in the region and along with The RAP Foundation, Inland Southern California United, and Riverside County approved $500,000 in emergency funding to support economic protection efforts by Lift to Rise. The District allocation included $100,000 (20%) for Cash Assistance to families affected by COVID-19; the remaining $400,000 (80%) was allocated to Rental Assistance efforts.
- To ensure we keep our friends and neighbors housed, Lift to Rise has secured to-date $14 million and disbursed more than $2 million in emergency cash assistance and $8 million in rental assistance -and counting...
- Rental assistance is expected to reach 3,500 households by December.
- By the end of October Lift to Rise expects that more than 2,800 households will have received rental assistance, totaling more than $8 million disbursed.
- Data on the rental assistance have provided important findings about the impact of COVID-19 in our community:
    - 70% of the applicants are females head of households
    - 45% have a child aged 0-5
    - 75% of applicant have a school-aged child
    - 20% are black, while less than 3% of the Valley population are black.
- District staff has been supporting Lift to Rise staff with outreach efforts through rental assistance mobile pop-up events.

Fiscal Impact:

N/A

DESERT HEALTHCARE
DISTRICT & FOUNDATION

Date: October 27, 2020

To: Board of Directors

Subject: CSDA & ACHD Virtual Legislative Tour for Special Districts

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Staff Recommendation: Information Only

Background:

- The Desert Healthcare District will be one of two California healthcare districts participating in an annual legislative tour of special districts, on December 8, 2020.
- The California Special Districts Association and the Association of California Healthcare Districts have joined forces this year to present the fifth annual legislative tour of special districts. Unlike past years, and due to the coronavirus pandemic, the tour will occur virtually via Zoom.
- The purpose of the tour, whose invitees will include staff from state and federal legislative offices representing California, is to increase visibility and awareness by educating legislators about the work of special districts. This year, because the tour theme is *health and wellness*, emphasis will be given to how special districts have responded to COVID-19.
- Organizers expect the tour will be well-attended, in part because having a virtual event removes the travel challenges some legislative staff experienced in the past.
- The tour will include a Special Districts 101 presentation, an ACHD overview, and 8-minute presentations by the Desert Healthcare District and Foundation, Mayers Memorial Hospital District, and Shasta Mosquito and Vector Control District. The Mosquito and Vector Control Association of California also will provide an overview.
- Each district's presentation will include a 3-minute video as an overview of the district's mission and impact, and a 5-minute speech or address by a district representative. CEO Conrado Barzaga will represent the Desert Healthcare District and Foundation.
- An overview of each district and question-and-answer session will follow the presentations. The entire tour is expected to last about one hour.

Fiscal Impact:
N/A

DESERT HEALTHCARE DISTRICT & FOUNDATION

DESERT HEALTHCARE DISTRICT
PROGRAM COMMITTEE MEETING
MEETING MINUTES
October 13, 2020

Directors & Community Members Present via Video Conference	District Staff Present via Video Conference	Absent
Chair Evett PerezGil Vice-President Karen Borja Director Carole Rogers, RN Luciano Crespo, Community Member Allen Howe, Community Member	Conrado E. Bárzaga, MD, Chief Executive Officer Chris Christensen, Chief Administration Officer Donna Craig, Chief Program Officer Alejandro Espinoza, Program Officer and Director of Outreach Meghan Kane, Programs and Research Analyst Erica Huskey, Administrative and Programs Assistant Andrea S. Hayles, Clerk of the Board	Nicolas Behrman, Community Member Thomas Thetford, Community Member

AGENDA ITEMS	DISCUSSION	ACTION
I. Call to Order	The meeting was called to order at 12:00 p.m. by Chair PerezGil.	
II. Approval of Agenda	Chair PerezGil asked for a motion to approve the agenda.	**Moved and seconded by Vice-President Borja and Director Rogers to approve the agenda. Motion passed unanimously.**
III. Meeting Minutes **1. September 08, 2020**	Chair PerezGil asked for a motion to approve the September 08, 2020 meeting minutes.	**Moved and seconded by Community Member Crespo and Community Member Howe to approve the September 08, 2020 meeting minutes. Motion passed unanimously.**
IV. Public Comment	There was no public comment	
V. Old Business **1. Funding Requests**	Chair PerezGil summarized the funding requests, answering questions from the committee and community members.	
2. Progress and Final Reports Schedule	Vice-President Borja referenced the Public Health Institute (PHI) in the accomplishments section concerning assistance with translation into Spanish, inquiring on the need for help, or if the Institute is asking the District for translation services.	

	Alejandro Espinoza, Program Officer and Director of Outreach, explained that the PHI is requesting additional assistance, and there is no additional cost, which is included in the budget for the Spanish translation. Vice-President Borja described the District's translation to Purepecha for COVID-19 testing and education, and to take into consideration the translation of the most vital parts of the grant for community purpose. Mr. Espinoza explained that he will work with Will Dean, Communications and Marketing Director, including the translator for a summary report in Purepecha related to the key findings. Additionally, Vice-President Borja explained that for goal #2 with PHI under accomplishments, there is research information, but it lacks comments about CAL FIRE in the Eastern Coachella Valley. Travel time to the ER at JFK Memorial Hospital is 40 minutes; thus, residents forgo the ER, and contact the fire station directly, which is closer. Mrs. Borja expressed speaking with PHI to contact CAL FIRE in the unincorporated areas, and in Coachella about asthma attacks and Calfire's response concerning air quality. Vice-President Borja thanked Jewish Family Service of the	

3. Grants Payment Schedule	Desert for assisting the community as a much-needed resources for matters, such as mental health services and monetary assistance. Director Rogers inquired on grants in the Grant Payment Schedule from earlier in the year, such as Volunteers in Medicine asking about the drawdown process. Donna Craig, Chief Program Officer, explained that some grants are at 10% retention until the final reports are received and reviewed for instance Neuro Vitality's grant is closed with removal at the end of the year. Ms. Craig also reviewed the budgeted items for mini grants with the committee.	
VI. Program Staff Updates **1. Community Health Needs Assessment (CHNA) and Health Improvement Plan (CHIP)**	Meghan Kane, Programs and Research Analyst provided an update on the Community Health Needs Assessment (CHNA) explaining that to date, 13 focus groups have been conducted with members throughout the community for residents, and no service providers at this time, as they will have a say in the Health Improvement Plan focus groups. The 13 focus groups included 66 participants with 41 from English speaking residents and 25 from Spanish speakers. The mix has been 50/50 Spanish versus English, and in the next two weeks, there are eight more focus groups with nine	

	upcoming. Staff will continue targeting and explaining any gaps for all populations throughout the community.	
2. Lift to Rise Rental Assistance Program – enrollment events	Alejandro Espinoza, Program Officer and Director of Outreach explained his participation in Lift to Rise's rental assistance program events hosted in Indio, Desert Hot Springs, North Shore, and Cathedral City. An average of 100 families are completing the application process, with another event this week, including Saturday at the Coachella Library. The application capacity has been reached, and the program has been a huge success, including enrollment via the internet and telephonic applications; however, Lift to Rise is canceling the remaining events due to the high demand in Riverside County.	
3. Coachella Valley Health Information Place (CVHIP) and Marketing Efforts	Alejandro Espinoza, Program Officer and Director of Outreach described the Coachella Valley Health Information Place (CVHIP) Newsletter, new website features, and keeping the community update to date on the platform, such as advertisements and radio announcements. The CVHIP Facebook page continues to highlight community resources with an average of two publications per week.	

4. Policy Map – website placement and demonstration	Alejandro Espinoza, Program Officer and Director of Outreach provided a demonstration of the website for the data mapping with Policy Map on the District page that includes data points and layers within the widget, which also displays a video illustrating to the community and community partners, methods to utilize the data tool.	
VII. Committee Members Comments	Vice-President Borja described the upcoming 4th Annual Eastern Coachella Valley Pride event this Friday, 10/16 with additional information available on the Facebook site through Alianza.	
V. Adjournment	Chair PerezGil adjourned the meeting at 12:35 p.m.	***Audio recording available on the website at http://dhcd.org/Agendas-and-Documents***

ATTEST: _____

Evett PerezGil, Chair/Director
Program Committee

Minutes respectfully submitted by Andrea S. Hayles, Clerk of the Board

FUNDING REQUESTS UPDATE for October 2020 (please see October updates in this color)

Information only – status update of new letters of interest and pending applications

Grant funding for the 2019-2020 fiscal year ending June 30, 2020, has officially closed. New grantmaking guidelines, as approved by the Desert Healthcare District and Foundation Board on May 26 in response to the COVID-19 pandemic, were published on the website in August prior to a grantmaking process webinar that was held August 10, 2020. The new grant-funding period began August 1, 2020.

The five (5) strategic focus areas for FY 2020-2021 are:

1. **Healthcare Infrastructure and Services**
2. **Behavioral Health/Mental Health**
3. **Homelessness**
4. **Vital Human Services to People with Chronic Conditions**
5. **Economic Protection, Recovery, and Food Security**

PLEASE NOTE: Due to the COVID-19 pandemic, some LOI's and Applications had been put on hold and subsequently withdrawn from the grants management system as their requests were not relevant due to the many changes organizations had endured. Some are temporarily closed as mandated by state, county and local governments.

Without compromising the rules of AB2019, an email was sent to these organizations encouraging them to visit the website and review the District's FY 20/21 One Year Gap Funding Focus Areas and a revamped Letter of Interest and grant application.

Letters of Interest				
Agency	**Staff Notes**	**Status & Staff Notes**	**Funding Allocation**	**Strategic Focus Areas FY 2020-2021**
Alzheimer's Association	LOI received requesting $66,500 to support core services	**UPDATE FOR OCTOBER:** The grants team will be conducting a future proposal conference	District	Vital Human Services to People with Chronic Conditions
Healing California	LOI received requesting $19,786 to support mobile dental and vision	**UPDATE FOR OCTOBER:** The grants team will be conducting a	District	Healthcare Infrastructure and Services

	services to residents of Eastern Coachella Valley	proposal conference on October 12th.		
Youth Leadership Institute	LOI received requesting $30,000 Que Madre Program	**UPDATE FOR OCTOBER:** Proposal conference resulted in YLI to review and reevaluate the number of dollars requested and the budget and will come back to the grants team for further discussion		Behavioral Health/Mental Health
Joslyn Center	LOI received requesting $112,350 to support Wellness Center programs	**UPDATE FOR OCTOBER:** Proposal conference resulted in Joslyn to review and reevaluate number of dollars requested and the budget and will come back to the grants team for further discussion.		Behavioral Health/Mental Health
The LGBT Community Center of the Desert	LOI received requesting $10,000 to support the organization's Buddy to Buddy Program	**UPDATED FOR OCTOBER:** Proposal review and emails generated with the Grants team review: DECLINED the LOI for the following reasons: the program was described with conflicting and undecided goals and evaluation with an	District	Behavioral Health/Mental Health

		incomplete and weak training system of a program that was first described inconsistently as a "pilot" program and then as an "expanded" program.		
Elder Love USA	LOI mini grant received requesting $5,000 for Senior In-Home Caregiving Services	**UPDATED FOR OCTOBER:** After review by the grants team, it was determined to decline this request for the following reasons: The service provided is targeted to "middle class older adults who make too much money to qualify for "free" assistance." The services offered are more of that of a concierge service (errands, dog walking, cooking, cleaning, shopping, etc.) rather than actual health care services. There is no mention of the licensing and bonding of the caregivers. The services offered are offered at a reduced rate – if grant dollars are not received to reduce	District	Vital Human Services to People with Chronic Conditions

		the rate, the agency states that they will raise the rates to be sustainable. Further research by staff of For-Profit caregiving services show rates lower than Elder Care.		
United Way of the Desert	LOI received requesting a $25,000 "gift" used to alleviate COVID-19 financial burdens among CV families through UW COVID Recovery Program	**OCTOBER UPDATE:** LOI was declined for the following reasons: Duplicative of efforts with Lift To Rise, of which the District has invested $600,000. This would be pass-through funding of DHCD taxpayers' dollars as the money would be given to Jewish Family Service of the Desert and Galilee Center to determine the funding allocations to identified families. DHCD gives grants directly to JFSOD and Galilee.		
Martha's Village & Kitchen	LOI received requesting $200,896 to support the resources necessary to serve an expanded number of homeless	The grants team conducted a Zoom proposal conference on September 24th and reviewed the LOI. It was noted that the proposal was	District	Homelessness

	individuals from within the DHCD's Western borders with evidence based best practices such as Housing First	an exact cut and paste of the past approved request, indicating serving residents from the Western Coachella Valley rather than the entire CV. Stage 2, the application, was generated, and MVK will concentrate the request on Housing First, the workforce of youth employment and training as well as wrap around services that are given at the Mecca and Desert Hot Springs satellite offices. It is anticipated to bring the full request to the November Program Committee meeting.		
Jewish Family Service of the Desert	LOI received requesting $80,000 for Mental Health Counseling services	Withdrawn by grantee as the organization currently has an open grant with the District	District	Listed Healthcare Infrastructure and Services – SHOULD BE Behavioral Health
Pending Applications				
Grantee	**Staff Notes**	**Status**	**Funding Allocation**	**Strategic Focus Area FY 20/21**
Hope Through Housing	LOI received requesting $10,000	The grants team conducted a Zoom	District	Economic Protection,

	for their Family Resilience program for a 4-month time period.	proposal conference and **<u>suggested the request be increased to $20,000 for a one year time period</u>** to allow for additional time to conduct and evaluation and impact of the program. **UPDATE for October:** Stage 2 – the application – has been received; however, numbers served, and evaluation goals are not in line with the application. Another proposal meeting is scheduled for October 20th and the request is planned for the November Program Committee meeting for review.		Recovery, and Food Security
Inland Empire Ronald McDonald House	LOI received requesting $200,000 for Temporary Housing and Family Support Services (same as previous request)	The grants team conducted a September 2nd Zoom proposal conference and suggested the request be <u>decreased to $100,000</u> to more accurately reflect the reality and impacts of COVID-19 on the organization's	District	Healthcare Infrastructure and Services

		operations and budget. **UPDATE for October:** Stage 2 – the application – has been received too late for the October Program Committee meeting. The application is in the process of being reviewed and scored by the Grants Team and the request is anticipated to be before the November Program Committee meeting for review.		

Update for SEPTEMBER AND OCTOBER 2020

Progress Reports			
Applicant	**Staff Notes**	**Program/Project Tracking Status**	**Source**
Volunteers in Medicine #1038 Affordable and Accessible Healthcare Services for East Valley Residents	**Grant term: 2/1/20 – 1/31/21** **Original Approved Amount: $50,000** **1st progress report covering the time period from 2/1/20 – 7/31/20** **Progress Outcomes:** We have provided 410 medical or dental visits (12 month grant goal of 600) to 273 unique patients. Additionally, other healthcare services were provided to this same group of patients totaling 717 contacts for case management, social service/community referrals, etc.. COVID testing was provided in the community to an additional and unique 64 patients. Therefore we provided a total of 474 medical/dental visits and COVID tests to a total of 337 unique patients. (The grant goal only states numbers of visits, not other contacts nor the number of patients.)	Grantee states that the program is on track; however: ***Please describe any specific issues/barriers in meeting the desired outcomes:*** COVID 19, however we seem to be on track of meeting our goal of providing a total of 600 medical or dental visits. Also, because we largely moved to teleheath visits after COVID, we have not been successful in obtaining patient satisfaction surveys as the patients have not been in the clinic. The same holds true for volunteer surveys as our number of volunteers has dropped significantly. ***What is the course correction if the project/program is not on track?*** We will continue to provide medical and dental visits to East Valley residents. We will attempt to conduct a telephone survey of both patients and volunteers for the final reporting period.	Original ECV funding allocation
City of Palm Springs	**Grant term: 12/1/19 – 11/30/20** **Original Approved Amount: $225,000**	The grantee states that the program is on track; however:	Desert Healthcare Foundation

#1034: Homelessness Crisis Teams and Wrap Around Services	**1st progress report covering the time period from 12/1/19 – 5/30/20** **Progress Outcomes:** Pursuant to the Desert Healthcare Foundation Grant Agreement (Agreement) for matching funds for the Desert Healthcare Foundation's West Valley Homelessness Initiative, commencing December 1, 2019, by and between the City of Palm Springs and the Desert Healthcare District Foundation, the following information is being provided on the progress of the services provided under the Agreement. Results for services provided for the 1st Six Months ending May 31, 2020, are provided below. Housing Placements goal of 200 placements, 118 actual placements, 59% of goal. Employment goal of 75 hires, 23 actual hires, 30.7% of goal. Mainstream Benefit goal of 725 benefits attained, 452 actual benefits attained, 62.3% of goal. Behavioral/Substance Placement goal of 30, 9 actual placements, 30% of goal.	***Please describe any specific issues/barriers in meeting the desired outcomes:*** With the onset of the COVID-19 Pandemic the City of Palm Springs will need modify its level of participation in Homeless Outreach Services and Wrap-Around Services. ***Describe any unexpected successes during this reporting period other than those originally planned:*** The number of individuals placed in housing and provided with mainstream benefits are trending higher than anticipated.	Homelessness Initiative funds
Coachella Valley Rescue Mission #1023 Transportation for Seniors and	**Grant term: 11/1/19 – 10/31/20** **Original Approved Amount: $216,200**	The grantee states that the program is on track. ***Describe any unexpected successes during this reporting period other***	Desert Healthcare District

Homeless Hospital Discharge Patients	**3rd progress report covering the time period from 5/1/20 – 8/1/20** **Progress Outcomes:** CVRM's Transportation for Seniors and Homeless Hospital Discharges Project received 79 homeless hospital discharges, 47 were age 24-54; 14 were age 55+; 16 were age 65+, and two were over 75+. CVRM uses the designated vehicles provided by Desert Healthcare District to transport the seniors to and from their medical or behavioral appointments. COVID-19 allowed CVRM's Staff to transport clients during our shelter in place mandate to professionals working with CVRM client barriers. Barriers reported by Clients include Alcohol Abuse, Chronic Health Condition, Developmental Disability, Drug Abuse, HIV/AIDS, Serious Mental Illness, Physical Disability. Sheltering in place with the seniors provided an opportunity to work with our clients closer. Seniors staying at CVRM are in two age categories 50-59 and 60+. CVRM provided shelter for 457 clients in these categories.	***than those originally planned:*** One success is that we have more time with the seniors that are sheltering in place to build trust and develop a support system of wrap around services.	
Pueblo Unido #1036 Fostering Healthy Communities	**Grant term: 2/10/20 – 2/9/21** **Original Approved Amount: $50,000** **1st progress report covering the time period from 2/1/20 – 7/31/20**	The grantee states that the program is on track; however: ***Please describe any specific issues/barriers in meeting the desired outcomes:*** Since March 2020, we discovered many challenges due to the	Original ECV funding allocation

	Progress Outcomes: Pueblo Unido is on track with the deliverable tasks and goals. We continue to hold monthly meetings with the mobile home park communities. This includes residents from Oasis MHP who continue to raise their concerns about the quality of water in their homes. Early 2020, Pueblo Unido and Leadership Counsel for Justice and Accountability held a series of workshop meetings to discuss best solutions and listen to the resident's concerns. This came after the U.S. Environmental Protection Agency notified the owner and tenants that the water being provided was contaminated with arsenic. After a series of meetings, the residents involved where able to mobilize a temporary solution to supply safe drinking water. This requires the collaboration of CVWD and Riv County officials and local organizations. While the concerns are on-going, we are optimistic that we might be able to find a middle ground to install a temporary and reliable solution to supply drinking water. Other mobile home parks in the area continue to be challenged in the same way. Pueblo Unido continues to meet with Polanco mobile home parks managers and residents to install point of use reverse osmosis filtration systems. These planning activities (meetings) have been impacted due to current and ongoing public heath	COVID 19 health crisis and all the social restrictions associated. The stay at home order cancelled most public meetings and direct face to face engagements. This included the disadvantage communities task force meetings as well as the engagements with public officials and community members. Polanco meetings and other mobile home park direct engagements were also canceled and slowed our progress to plan and supply safe drinking water. While community meetings were held via phone and online, there was a significant drop in participation and organizing from community members. Due to the limitations in interaction, we postponed all in-home water testing and maintenance work that was scheduled during the months of April-August. Slowly, we continue to serve peoples homes, when residents permit, obviously following all recommended guidelines and social distancing orders. ***What is the course correction if the project/program is not on track?*** We continue to be on track with our work, however we do anticipate some delays in the installation of the filtration systems. This is due to the social distancing and residents concern of our technician doing work in their homes. ***Describe any unexpected successes during this reporting period other than those originally planned:*** July 2020, Pueblo Unido was awarded a	

	crisis. Due to the Covid 19 social distancing orders, Pueblo Unido's community outreach campaign was forced to cancel all in-person meetings and find alternative solutions to hold planning meetings. A digital organizing campaign has been put into effect to inform our constituents about their public and environmental concerns. Now that the County is allowing for more social interaction (with some restrictions), Pueblo Unido will work to identify potential new Mobile homes and mobile home parks who are struggling with water contaminations and to potentially install the filtration systems. During April- July, Pueblo Unido and partnerships were able to supply bottled water to an estimated 1500 residents of Mobile home parks who were struggling to find bottled water during the pandemic's scarcity of essential items; including drinking water.	$25,000 grant from Cal EPA to build capacity to support and implement a reliable and cost-effective solution to help people access clean drinking water immediately in areas where centralized infrastructure is and will not be feasible for years. Pueblo Unido intends to use the funds to develop a circuit-writing program and install at least 25 point-of-use units, serving an estimated population of 150 residents. Pueblo Unido will do this by building on our success of working with the mobile home park communities and improve their understanding about arsenic contamination that affect their health.	
Public Health Institute #1046 Coachella Air Quality and Health Analysis	**Grant term: 3/1/20 – 2/28/23** **Original Approved Amount: $250,000** **1st progress report covering the time period from 3/1/20 – 9/1/20** **Progress Outcomes:** During the reporting period, we have accomplished the following in relation to our proposed goals and evaluation plan:	The grantees states that the program is on track; however: ***Please describe any specific issues/barriers in meeting the desired outcomes:*** Goals 2 and 3 (analysis of patient data and air pollution data) are on track. We anticipate delays in conducting the survey (Goal 1) due to pandemic-related prohibitions on work in the field and travel	Avery Trust fund

	Goal #1: In Year 1, conduct a sample survey of 250 respondents in English and Spanish by mobile device to estimate prevalence of undiagnosed and physician-diagnosed asthma and cardiovascular disease among permanent residents of the Coachella Valley, with oversampling of vulnerable communities in the Eastern portion of the valley and of tribal populations. **Accomplishments**: We have consulted with a statistician to re-examine our sample size assumptions and to design a survey which would oversample vulnerable populations. To increase the precision of our estimates and allow for non-response, the sample size target will more likely be around 700 participants. We are also investigating ways of contacting hard to reach populations, such as communities in Mecca and Thermal, with techniques such as snowball sampling. We have completed a draft survey instrument which will assess asthma symptoms and severity, and cardiovascular symptom risk. When finalized, we plan to conduct pilot testing of the instrument. We will reach out to DHCF for assistance of translation into Spanish. Due to the COVID-19 pandemic, we have been unable to makes plans to administer the survey in person. Though we are investigating remote techniques to conduct the survey—such as by phone and text alerts to an internet survey—	from the Public Health Institute. We are investigating a remote approach in conducting the survey but have high concerns that this approach may miss vulnerable populations. We therefore are planning on moving this activity to Year 2. Similarly, we may be delayed in installing our samplers for the source apportionment (Goal 4) due to restrictions by the South Coast AQMD on assessing their monitoring sites for colocation. We are monitoring the situation closely in case we have to modify our timeline. ***What is the course correction if the project/program is not on track?*** If we are unable to get out in the field this calendar year due to COVID-19, we are planning on moving the activities for Goals 1 and 4 to Year 2. ***Describe any unexpected successes during this reporting period other than those originally planned.*** We have been receiving support from the South Coast AQMD to help on the source apportionment activities.	

	we have concerns about reaching vulnerable populations with this approach. We have been in touch with HARC, Inc. on recommendations for surveys and also are aware of the phone bank work that Communities for a New California conduct. **Goal #2**: In Year 1, conduct an analysis of current and historic emergency room visits and hospitalizations for asthma and cardiovascular disease by zip code and comparable Indian Health Service data for the DHDF areas. **Accomplishments:** We have completed a preliminary analysis of hospitalization and emergency room visits for the Coachella Valley by ZIP code, including diagnoses of asthma, COPD, bronchitis, pneumonia, heart disease, and myocardial infarction. We have produced age-specific rates (<18 yrs. and 18+ years), and gender-specific rates, and overall age-adjusted rates, and have computed rates for California as a whole for comparison. **Goal #3**: In Year 1, conduct an analysis of available PM2.5, PM10, and ozone air pollution data for the DHDF areas, including seasonal trends, federal exceedances, and health benchmarks. **Accomplishments**: We have completed an inventory of the air monitoring sites, monitored		

	pollutants, and years of data available for the Coachella Valley. This list includes government regulatory monitors and monitoring done on Native American lands. We have also contacted tribal representatives who are conducting monitoring to obtain the most accurate information. We will be commencing analysis of the available data in the near future. **Goal #4**: During Years 1-3, conduct source apportionment monitoring at one primary site in the Coachella valley for a 12-month period to improve understanding of the sources of particulate matter in the Valley, with additional targeted PM2.5 and PM10 measurements at locations of interest, such as where high pollution levels are expected and where vulnerable populations are located. **Accomplishments:** The project partner, Berkeley Air Monitoring Group, has completed a draft Coachella Source Apportionment Monitoring Plan. This work will improve our understanding of the sources of particulate matter Coachella Valley residents are exposed to, which will aid in proposing practical policy solutions. Two gravimetric samplers will be installed at a local ambient air monitoring station. We have completed forms requested by the South Coast Air Quality Management District to locate the samplers at either their Mecca or		

	Indio sites for the duration of the sampling period. The South Coast AQMD currently has limited access to their monitoring sites due to the COVID-19 pandemic. In the case that these sites are not accessible due to the pandemic, we have identified a backup site, which is part of the IVAN monitoring network. Berkeley Air Monitoring Group expects to receive the gravimetric samplers which they have ordered in 1-2 months. Installation could begin as early as this Fall, depending on the course of the pandemic. **Goal #5:** By the project completion, produce a white paper outlining results of the monitoring and analyses, and summarize practical policy options to mitigate sources and reduce exposures harmful to health. **Accomplishments:** We have not started working on this goal at present.		
Jewish Family Service of the Desert #1017 Preventing Homelessness Among Coachella Valley Residents with Low Incomes by supporting salaries for case management staff	**Grant term: 10/1/19 – 9/30/20** **Original Approved Amount: $90,000** **2nd progress report covering the time period from 3/1/20 – 8/31/20** **Progress Outcomes:** During the reporting period from March 1, 2020 to August 31, 2020, the following progress was made toward proposed goals:	Grantee states that the program is on track; however: ***Please describe any specific issues/barriers in meeting the desired outcomes:*** While requests for JFS case management services have increased dramatically due to COVID-19, the need for financial support is far greater than can be offered by JFS alone. Many clients have been connected to United Lift, where upwards of $3,500 in	Desert Healthcare District

	Goal #1: By December 2019, JFS will hire an additional full-time case manager. This will increase the organization's capacity to meet demand for the expanding case management program. **Result**: This goal was completed during the first progress reporting period, when JFS hired an additional full-time case manager, increasing the organization's capacity to meet demand for the program. **Goal #2:** By September 30, 2020, at least 1,311 individuals will be served through the expanded case management program. **Result:** During the reporting period (3/1/20 to 8/31/20), a total of 829 Coachella Valley residents received case management screenings to help improve financial stability and prevent homelessness. This brings the cumulative number served between 10/1/19 to 8/31/20 to 1,831 (140% of the 1,311 overall client target number) with more to be served in September 2020, the final month of the project period. Of the 829 served in the reporting period, 270 (33%) were seniors, 116 were female heads of household (14%, exceeding the projection of 2%) and 124 were disabled (15%, exceeding the projection of 2%). **Goal #3:** By September 30, 2020,	support is offered, in lieu of JFS support amounting to far less. ***What is the course correction if the project/program is not on track?*** While some traditional sources of "pass-through" financial support are no longer available or postponed (e.g., due to the COVID-19 pandemic's financial implications, cities and foundations that traditionally provide funds towards rental and/or utility assistance are not currently granting funds), JFS has sought emerging or newly discovered sources of direct financial support for clients. ***Describe any unexpected successes during this reporting period other than those originally planned:*** The migrant community concern regarding "public charge"—an immigration ruling related to not being able to become a U.S. Citizen based on receiving public benefits—has been stated as a reason for migrant individuals and families not seeking connection to available JFS case management and emergency assistance services. Previously, the exact nature of public charge was not understood, so staff counsel to clients was uncertain. JFS has since engaged with a law firm specializing in migrant services, and its understanding of public charge has improved, leading to better counsel for members of the migrant community.	

	JFS will provide 542 clients (out of 1,311 case management clients) with emergency financial assistance. **Result:** A total of 200 clients receiving case management services were also provided with emergency financial assistance during the reporting period. This represents 37% of the client target and, combined with the 251 served in the previous reporting period represents 83% of the total project period goal of 542, with one more month left in the project period. **Goal #4**: By September 30, 2020, 70% of clients who receive emergency financial assistance will report that emergency financial assistance has helped to resolve their immediate financial crisis. **Result**: In a sample survey of 47 clients receiving emergency financial assistance, 98% reported that their emergency crisis was resolved. **Goal #5:** By September 30, 2020, 60% of clients who receive emergency assistance will report an increase in their quality of life. **Result:** In a sample survey of 47 clients receiving emergency financial assistance, 37 (79%) reported an increase in their quality of life.		

Final Grant Reports			
Applicant	**Staff Notes**	**5 things to be done differently if you were to implement this service or program again**	**Source of Funding**
No final reports have been received at this time			

DESERT HEALTHCARE DISTRICT
OUTSTANDING GRANTS AND GRANT PAYMENT SCHEDULE
As of 9/30/20
TWELVE MONTHS ENDED JUNE 30, 2021

Grant ID Nos.		Name	Approved Grants - Prior Yrs	Current Yr 2020-2021	6/30/2020 Bal Fwd/New	Total Paid July-June	Open BALANCE
2014-MOU-BOD-11/21/13		Memo of Understanding CVAG CV Link Support	**$ 10,000,000**		$ 8,330,000	$ -	$ 8,330,000
2018-974-BOD-09-25-18		HARC - 2019 Coachella Valley Community Health Survey - 2 Yr	$ 399,979		$ 39,999	$ -	$ 39,999
2019-985-BOD-03-26-19		Coachella Valley Volunteers in Medicine - Primary Healthcare & Support Services - 1 Yr	$ 121,500		$ 12,150	$ 12,150	$ -
2019-986-BOD-05-28-19		Ronald McDonald House Charities - Temporary Housing & Family Support Services - 1 Yr	$ 200,000		$ 20,000	$ 20,000	$ -
2019-997-BOD-05-28-19		Martha's Village & Kitchen - Homeless Housing With Wrap Around Services - 1 Yr	$ 200,896		$ 20,090	$ 20,090	$ -
2019-989-BOD-05-28-19		Pegasus Riding Academy - Cover the Hard Costs of Pegasus Clients - 1 Yr	$ 109,534		$ 10,954	$ 10,954	$ -
2019-994-BOD-05-28-19		One Future Coachella Valley - Mental Health College & Career Pathway Development - 2 Yr	$ 700,000		$ 385,000	$ 78,750	$ 306,250
2019-1000-BOD-05-28-19		Voices for Children - Court Appointed Special Advocate Program - 1 Yr	$ 24,000		$ 2,400	$ 2,400	$ -
2019-1017-BOD-09-24-19		Jewish Family Services - Case Management Services for Homeless Prevention - 1 Yr	$ 90,000		$ 9,000	$ -	$ 9,000
2019-1023-BOD-10-22-19		CVRM - Transportation for Seniors & Homeless Hospital Discharge Referrals - 1 Yr	$ 216,200		$ 118,910	$ 97,290	$ 21,620
2019-1021-BOD-11-26-19		Neuro Vitality Center - Community Based Adult Services Program - 6 Months	$ 143,787		$ 79,083	$ 50,323	$ 28,760
		Unexpended funds Grant #1021					$ (28,760)
2020-1045-BOD-03-24-20		FIND Food Bank - Ending Hunger Today, Tomorrow, and for a Lifetime - 1 Yr	$ 401,380		$ 311,069	$ 90,311	$ 220,758
2020-1129-BOD-05-26-20		Coachella Valley Volunteers In Medicine - Response to COVID-19	$ 149,727		$ 149,727	$ 149,727	$ -
2020-1085-BOD-05-26-20		Olive Crest Treatment Center - General Support for Mental Health Services	$ 50,000		$ 27,500	$ -	$ 27,500
2020-1057-BOD-05-26-20		Desert Cancer Foundation - Patient Assistance Program	$ 150,000		$ 82,500	$ -	$ 82,500
2020-1124-BOD-06-23-20		Regents of UCR - COVID-19 Testing & Health Education for Eastern Valley - 5 Months	$ 149,976		$ 149,976	$ 149,976	$ -
2020-1134-BOD-07-28-20	1	Desert Healthcare Foundation - Addressing Healthcare Needs of Black Communities		$ 500,000	$ 500,000	$ 500,000	$ -
2020-1139-BOD-09-22-20	1	CSU San Bernardino Palm Desert Campus Street Medicine Program - 1 Yr		$ 50,000	$ 50,000	$ -	$ 50,000
TOTAL GRANTS			**$ 13,106,979**	**$ 550,000**	**$ 10,298,358**	**$ 1,181,971**	**$ 9,087,627**

Amts available/remaining for Grant/Programs - FY 2020-21:							
Amount budgeted 2020-2021				$ 4,000,000		G/L Balance:	**9/30/2020**
Amount granted through June 30, 2021:				$ (550,000)		2131	$ 2,427,627
Mini Grants:		1132		$ (5,000)		2281	$ 6,660,000
Financial Audits of Non-Profits		8/15/20		$ (3,000)			
Net adj - Grants not used:		1021		$ 28,760		**Total**	**$ 9,087,627**
Matching external grant contributions				$ -			**$ (0)**
Balance available for Grants/Programs				**$ 3,470,760**			
	Strategic Focus Areas FY20-21:		**Grant Budget**	**Granted YTD**	**Available**		
	1	Healthcare Infrastructure and Services	$ 1,500,000	$ (526,240)	$ 973,760		
	2	Behavioral Health/Mental Health	$ 500,000		$ 500,000		
	3	Homelessness	$ 500,000		$ 500,000		
	4	Vital Human Services to People with Chronic Conditions	$ 1,000,000		$ 1,000,000		
	5	Economic Protection, Recovery and Food Security	$ 500,000	$ (3,000)	$ 497,000		
		Balance available for Grants/Programs	**$ 4,000,000**	**$ (529,240)**	**$ 3,470,760**		

DESERT HEALTHCARE DISTRICT & FOUNDATION

DESERT HEALTHCARE DISTRICT
FINANCE, ADMINISTRATION, REAL ESTATE, LEGAL, AND COMMITTEE
MEETING MINUTES
October 13, 2020

Directors Present	District Staff Present	Absent
Chair/Treasurer Mark Matthews President Leticia De Lara, MPH Director Arthur Shorr	Conrado E. Bárzaga, MD, Chief Executive Officer Chris Christensen, Chief Administration Officer Eric Taylor, Accounting Manager Andrea S. Hayles, Clerk to the Board	

AGENDA ITEMS	DISCUSSION	ACTION
I. Call to Order	Chair Matthews called the meeting to order at 3:30 p.m.	
II. Approval of Agenda	Chair Matthews asked for a motion to approve the agenda.	**Moved and seconded by Director Shorr and President De Lara to approve the agenda.** **Motion passed unanimously.**
III. Public Comment	There was no public comment.	
IV. Approval of Minutes **1. F&A Minutes – Meeting September 08, 2020**	Chair Matthews motioned to approve the September 08, 2020 minutes.	**Moved and seconded by President De Lara and Director Shorr to approve the September 08, 2020 meeting minutes.** **Motion passed unanimously.**
V. CEO Report	There was no CEO report.	
VI. Chief Administration Officer's Report	Chair Matthews reviewed the CAO report with the committee with no questions or concerns of the members.	
VII. Financial Reports **1. District and LPMP Financial Statements** **2. Accounts Receivable Aging Summary** **3. District – Deposits** **4. District – Property Tax Receipts** **5. LPMP Deposits** **6. District – Check Register** **7. Credit Card – Detail of Expenditures** **8. LPMP – Check Register** **9. Retirement Protection Plan Update**	Chair Matthews thoroughly reviewed and discussed the financials with the committee, including Chris Christensen, CAO, describing the retirement protection plan reduction with two retirees reduced from 98 to 96 still employed by the hospital, a net of one increase with the vested, and one payout.	**Moved and seconded by Director Shorr and President De Lara to approve the September 2020 District Financial Reports - Items 1-10 and to forward to the Board for approval.** **Motion passed unanimously.**

10. Grant Payment Schedule		
VIII. Other Matters **1. Gary Dack – Lund & Guttry LLP – FY 2020 Audit Reports – District & RPP** **a. Communication Letter & Internal Controls Report** **b. District Audit Report** **c. RPP Audit Report** **d. Desert Healthcare Foundation (Informational Purposes Only, Approval during the Foundation's F&A Committee meeting)**	Chair Matthews introduced Gary Dack, CPA, Managing Partner, Lund & Guttry to provide an overview of the audit reports. Mr. Dack provided a summary of the audit, which included no audit adjustments, congratulating Chris Christensen, CAO, and the District for accurate accounting. Mr. Dack described the communication and independent auditor letters with no findings or deficiencies to discuss with a clean opinion presented fairly in all financial aspects. The Statements of Net Position that cover the assets and liabilities, including cash and investments, were highlighted with Mr. Christensen providing an overview of the net pension liability as recorded in the auditor's report. President De Lara and Director Shorr inquired on the significant upsurge for salaries and increases and the sizable retirement adjustment from the actuarial with Mr. Christensen suggesting Lund and Guttry break out retirement expense of the Retirement Protection Plan from the salaries and benefits as a separate line item.	

	President De Lara inquired on the lifetime healthcare duration of benefits. Chair Matthews explained that it pertained to prior directors Mr. and Mrs. Supple suggesting that Lund & Guttry drop "current" from the description of the retiree benefit plan since it applies to prior directors. Concluding the overview of the audit, Chair Matthews, for transparency purposes requested that Mr. Dack provide his contact number to the committee members for any additional questions or concerns. Mr. Dack provided an overview of the Foundation audit, such as the assets grants receivable, liabilities, revenues and expenses, and total investments. Mr. Dack provided a summary of the retirement plan investment audit reports, also answering questions of the committee. Chair Matthews explained that the committee should approve and recommend approval to the Board, and the District and Retirement Protection Plan audit reports as presented.	**Moved and seconded by Director Shorr and President De Lara to approve the FY 2020 District and Retirement Protection Plan Audit Reports and forward to the Board for approval.** **Motion passed unanimously.**
2. LPMP Landscape Renovation and Fire Alarm Electrical Bid	Chris Christensen, CAO, explained the approval of the landscape architect for a complete renovation, describing the bids for the fire	

	alarm and electrical work, explaining that staff met with legal counsel, Jeff Scott and the architect to discuss possible options. At the recommendation of staff, the committee suggested to forward option C to the Board for approval to reject all bids and rebid the project with similar specifications, including Class B licensed contractor and combined landscape renovation and the fire alarm electrical connection. President De Lara motioned, and Director Shorr seconded to recommend approval of option C. Director Matthews recommended confirming with the District's legal counsel if the rebid could commence without full Board approval. Since the Board previously approved the bidding process, legal counsel, Jeff Scott authorized the committee's recommendation for rebidding coinciding with the initial Board's approval of the bidding process.	
IV. Adjournment	Chair Matthews adjourned the meeting at 4:34 p.m.	***Audio recording available on the website at http://dhcd.org/Agendas-and-Documents***

ATTEST: _____
Mark Matthews, Chair/Treasurer Finance & Administration Committee
Desert Healthcare District Board of Directors

Minutes respectfully submitted by Andrea S. Hayles, Clerk of the Board

DESERT HEALTHCARE
DISTRICT & FOUNDATION

Date: October 27, 2020

To: Board of Directors

Subject: Lund & Guttry LLP – FY2020 Audit Reports – District & RPP

Staff Recommendation: Consideration to approve the FY2020 Audit reports for the Desert Healthcare District and the Retirement Protection Plan (RPP).

Background:

- At the February 25, 2020 meeting, the Board of Directors approved Lund & Guttry LLP as the chosen audit firm to complete the FY2020 Audit Reports for the District, Foundation and RPP.
- During the COVID-19 pandemic staff worked with Gary Dack, the managing partner, to remotely provide the necessary information to complete the FY2020 Audit.
- Staff's work was greatly increased due to the transition to a new audit firm and the remote field work required during the pandemic to maintain safety for staff of the District and Lund & Guttry.
- *It is important to note, the audits received unmodified opinions, with no exceptions*.
- Gary Dack, CPA, will be presenting the following reports for your review and consideration for approval:

    1. Communication Letter
    2. Internal Controls Report
    3. District Audit Report
    4. Retirement Protection Plan (RPP) Audit Report
    5. Desert Healthcare Foundation Audit Report (Information only. To be approved during the Foundation's Board of Directors' meeting)

- At the October 13, 2020 Finance & Administration Committee meeting, the Committee approved the audit reports and recommended forwarding to the Board for consideration of approval.
- Staff recommends approval of the FY2020 Audit Reports for the Desert Healthcare District and Retirement Protection Plan.

Fiscal Impact:
None.

LUND & GUTTRY LLP / CERTIFIED PUBLIC ACCOUNTANTS
36917 COOK STREET • SUITE 102 • PALM DESERT, CALIFORNIA 92211
Telephone (760) 568-2242 • Fax (760) 346-8891
www.lundandguttry.com

COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

October 13, 2020

To the Honorable Board of Directors
Desert Healthcare District, Desert Healthcare Foundation and Desert Hospital Retirement Protection Plan (the Entities)
Palm Springs, California

We have audited the financial statements of Desert Healthcare District, Desert Healthcare Foundation and Desert Hospital Retirement Protection Plan ("the Entities") for the year ended June 30, 2020, and have issued our report thereon dated October 13, 2020. Professional standards require that we provide you with information about our responsibility under generally accepted auditing standards and *Government Auditing Standards*, as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our letter to you dated April 23, 2020. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Findings

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the entities are described in Note 1 to the financial statements. No new accounting policies were adopted and the application of existing policies was not changed during 2020. We noted no transactions entered into by the Entities during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

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

- Accounts Receivable and Taxes Receivable – Management's estimate of accounts receivable and taxes receivable is based on historical revenues and analysis of the collectability of individual accounts.

- Useful Life of Capital Assets – Management's estimate of the useful life of capital assets is based on the historical asset life for the entities capital assets and industry standards, in order to determine the value and period of time over which individual capital assets are to be depreciated.

- RPP and OPEB Plans – The funding progress and footnote disclosures are based on consultant's estimates.

We evaluated the key factors and assumptions used to develop these estimates in determining that they are reasonable in relation to the financial statements taken as a whole.

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

Difficulties Encountered in Performing the Audit

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

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. We are pleased to report that no misstatements were identified during our audit.

Disagreements with Management

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

Management Representations

We have requested certain representations from management that are included in the management representation letter dated October 13, 2020.

Management Consultations with Other Independent Accountants

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

Other Audit Findings or Issues

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

Other Matters

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

This information is intended solely for the information and use of the members of the Board of Directors and Management and should not be used for any other purpose.

Very truly yours,

Lund & Guttry

Lund & Guttry LLP

LUND & GUTTRY LLP / CERTIFIED PUBLIC ACCOUNTANTS
36917 COOK STREET • SUITE 102 • PALM DESERT, CALIFORNIA 92211
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INDEPENDENT AUDITOR'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Honorable Board of Directors
Desert Healthcare District, Desert Healthcare Foundation and Desert Hospital Retirement Protection Plan (the Entities)
Palm Springs, California

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the business activities and the fiduciary funds financial statements of Desert Healthcare District, the financial statements of the Desert Healthcare Foundation and Desert Hospital Retirement Protection Plan (the entities), as of and for the year ended June 30, 2020, and the related notes to the financial statements, and have issued our report thereon dated October 13, 2020.

Internal Control over Financial Reporting

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

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

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

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

Purpose of this Report

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

Lund & Guthry

October 13, 2020

DESERT HEALTHCARE DISTRICT

PALM SPRINGS, CALIFORNIA

INDEPENDENT AUDITORS' REPORT AND FINANCIAL STATEMENTS

JUNE 30, 2020 AND 2019

DESERT HEALTHCARE DISTRICT

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LUND & GUTTRY LLP / CERTIFIED PUBLIC ACCOUNTANTS
36917 COOK STREET • SUITE 102 • PALM DESERT, CALIFORNIA 92211
Telephone (760) 568-2242 • Fax (760) 346-8891
www.lundandguttry.com

INDEPENDENT AUDITORS' REPORT

To the Honorable Board of Directors
of the Desert Healthcare District
Palm Springs, California

We have audited the accompanying financial statements of the business type activities and the fiduciary fund financial statements of the Desert Healthcare District (District) as of and for the year ended June 30, 2020, and the related notes to the financial statements, which collectively comprise the District's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and *Government Auditing Standards*, issued by the Comptroller General of 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 District'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 opinions.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business type activities and the fiduciary fund financial statements of the District as of June 30, 2020, and the respective changes in financial position and cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis and budgetary comparison information on pages 3 - 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 of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit 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.

Report on Summarized Comparative Information

The financial statements of Desert Healthcare District for the year ended June 30, 2019, were audited by other auditors whose report dated October 1, 2019, expressed an unmodified opinion on those statements. The summarized comparative information presented herein as of and for the year ended June 30, 2019, is consistent, in all material respects, with the audited financial statements from which it was derived.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated October 13, 2020, on our consideration of Desert Healthcare District's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Desert Healthcare District's internal control over financial reporting and compliance.

Lund & Guthry

October 13, 2020

DESERT HEALTHCARE DISTRICT

MANAGEMENT'S DISCUSSION AND ANALYSIS

JUNE 30, 2020 AND 2019

The Desert Healthcare District (the District) has issued its financial statements for the fiscal years ended June 30, 2020 and June 30, 2019 in conformity with the format prescribed by the provisions of Government Accounting Standards Board Statement 34 (GASB 34). This report, Management's Discussion and Analysis, is an overview of the financial activities for the fiscal years and is an integral part of the accompanying Basic Financial Statements.

ACCOUNTING METHOD

The District's revenues and expenses are recognized on a full accrual basis; revenues are recognized in the period incurred. All assets and liabilities associated with the activity of the District are included on the Statement of Net Position.

THE BASIC FINANCIAL STATEMENTS

The Basic Financial Statements reflect the activities of two funds. The Financial Statements include the Statement of Net Position, Statement of Revenues, Expenses, and Changes in Net Position (Income Statement) and Statement of Cash Flows, and the Agency Fund, which is the Desert Healthcare Foundation's Statement of Fiduciary Net Position and Statement of Changes in Fiduciary Net Position. Together with this report, these Financial Statements provide information about the significant events, assumptions and decisions which resulted in the financial performance reflected in those statements.

The Statement of Net Position provides information regarding the financial position of the District, including its capital assets and debts.

The Statement of Revenues, Expenses, and Changes in Net Position (Income Statement) provide information regarding the revenues received by the District, and the expenses incurred in carrying out the District's programs.

The Statement of Cash Flows provides information regarding the sources and uses of the cash which flowed into and out of the District as a result of its operations and financing decisions.

FINANCIAL ACTIVITIES & FISCAL YEAR 2020 HIGHLIGHTS

Desert Healthcare District ("the District") is a government entity operating under the Local Health Care District Law. The District was created by the state of California in 1948 for the purpose of providing hospital services to the residents of the District. The District was responsible for building Desert Hospital, now known as Desert Regional Medical Center. In 1997, the Board of Directors voted to lease the hospital to Tenet Health System Desert, Inc. for 30 years. Since 1997, the District provides funding and access to programs and services to residents of the healthcare district. By a vote of the public in November 2018, the District boundaries expanded to include the entire Coachella Valley, more than doubling its population and service area. The Board of Directors was increased from 5 to 7 members.

The Statement of Net Position

A condensed version of the Statements of Net Position is presented in Table A below and the changes which occurred between Fiscal Year 2020 and 2019.

Table A

	6/30/2020	6/30/2019	Change
Assets:			
Cash and cash equivalents	$ 7,613,546	$ 12,052,794	$ (4,439,248)
Investments	54,366,920	48,228,320	6,138,600
Capital assets, net	11,464,523	11,972,558	(508,035)
All Other Assets	457,128	249,194	207,934
Total Assets	$ 73,902,117	$ 72,502,866	$ 1,399,251
Deferred Outflows:			
GASB 68 Reporting for Pension Plans	$ 1,204,238	$ 1,159,189	$ 45,049
GASB 75 Reporting for OPEB Plans	11,114	14,147	(3,033)
Total Deferred Outflows	$ 1,215,352	$ 1,173,336	$ 42,016
Liabilities:			
Grants payable	$ 9,748,358	$ 12,809,355	$ (3,060,997)
Net Pension Liability	4,604,254	3,395,623	1,208,631
All Other Liabilities	480,999	620,125	(139,126)
Total Liabilities	$ 14,833,611	$ 16,825,103	$ (1,991,492)
Deferred Inflows:			
GASB 68 Reporting for Pension Plans	$ 370,700	$ 1,643,743	$ (1,273,043)
Total Deferred Inflows	$ 370,700	$ 1,643,743	$ (1,273,043)
Net Assets:			
Net investment in capital assets	$ 11,464,523	$ 11,972,558	$ (508,035)
Unrestricted	48,448,635	43,234,798	5,213,837
Restricted	-	-	-
Total Net Position	$ 59,913,158	$ 55,207,356	$ 4,705,802

The $4,705,802 increase in Total Net Position is due to the net income of $4,705,802 for the current fiscal year ended June 30, 2020. This compares to a net income of $4,252,508 for the fiscal year ended June 30, 2019. The increase is primarily due to a net combination of increased Property Tax Revenue of $194,387, increased Contributions received of $150,000, increased RPP Pension Expense of $460,555, decreased Election Fees of $109,347, and decreased Grant Expense of $452,819. The $4,439,248 decrease in Cash and cash equivalents and $6,138,600 increase in Investments is due primarily to an increase in the Investment account. The $508,035 decrease in Capital Assets is due primarily to depreciation of capital assets. The $207,934 increase in All Other Assets is due primarily to Rent Receivable deferred because of COVID-19. The $3,060,997 decrease in Grants Payable is due primarily to larger grant disbursements than new accrued grants. The $1,208,631 increase in Net Pension Liability is due primarily to a change in actuarial assumptions. The $139,126 decrease in All Other Liabilities is due primarily to a decrease in Accounts Payable. The $1,273,043 decrease in Deferred Inflows is due to a timing difference in the actuarial valuation for GASB 68 reporting for the RPP.

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

The District's business is comprised of two major segments:

- Revenues – The District receives from the County of Riverside an apportionment of the property taxes paid by the residents of the District. Additional revenues include, the investment income the District receives from the Facility Replacement Fund, which was established to provide working capital in the event that the lease with Tenet Health System Desert, Inc. is terminated prematurely or for future seismic retrofit needs; and rental income from the Las Palmas Medical Plaza which is owned and managed by the District.

- Grant Program – The District administers a grant and preventative health initiatives programs that donate a significant portion of the District's annual property tax revenues to health-related programs serving residents of Desert Hot Springs, Thousand Palms, Palm Springs, Cathedral City, Rancho Mirage, Palm Desert, Indian Wells, La Quinta, Indio, Coachella, Thermal, Mecca, North Shore, and unincorporated areas of the County that are within the District's boundaries.

Table B, below, is a condensed version of the Statements of Revenues, Expenses, and Changes in Net Position; it summarizes the District's revenue and expenses, and compares Fiscal Year 2020 results to Fiscal Year 2019.

Table B

	6/30/20	6/30/19	Change
Revenue:			
Property Tax Revenue	$ 7,166,583	$ 6,972,196	$ 194,387
Rental income	1,218,339	1,203,940	14,399
All other income	237,070	125,687	111,383
Total Revenue	$ 8,621,992	$ 8,301,823	$ 320,169
Expenses:			
Grants program	$ 3,174,052	$ 3,626,871	$ (452,819)
Administrative Expense	2,892,970	2,553,703	339,267
Total Expense	$ 6,067,022	$ 6,180,574	$ (113,552)
Nonoperating Income(Expenses)	$ 2,150,832	$ 2,131,259	19,573
Net Income	$ 4,705,802	$ 4,252,508	$ 453,294

Revenue

Property taxes are the District's primary source of operating revenues. The property tax revenue for the fiscal year ended June 30, 2020 was $7,166,583, which was an increase of $194,387 from the fiscal year ended June 30, 2019.

Rental income of $1,218,339 for the fiscal year ended June 30, 2020 was $14,399 higher than the fiscal year ended June 30, 2019.

All other income for the fiscal year ended June 30, 2020 increased $111,383 compared to the fiscal year ended June 30, 2019. The increase was due primarily to external contributions received.

Expenses

Grant Program expense for the fiscal year ended June 30, 2020 decreased by $452,819 compared to the fiscal year ended June 30, 2019. This is due primarily to decreased approved grants. Grants are recorded in the fiscal year that they are approved by the District's Board of Directors.

Administrative expenses for the fiscal year ended June 30, 2020 increased $339,223 from the fiscal year ended June 30, 2019. The increase is due to various expenses including higher Retirement Protection Plan Pension Expense of $452,503 and lower election fees expense of $109,347.

CAPITAL ASSETS

At June 30, 2020, the District had $22,435,784 in capital assets and $10,971,261 accumulated depreciation, resulting in $11,464,523 net capital assets. At June 30, 2019, the District had $22,348,945 in capital assets and $10,376,387 in accumulated depreciation, resulting in $11,972,558 net capital assets.

A summary of the activity and balances in capital assets is presented in Table C:

Table C

	Balance 6/30/18	Net Additions	Net Retirements	Balance 6/30/19	Net Additions	Net Retirements	Balance 6/30/20
Cost	$ 22,121,177	$ 230,526	$ (2,758)	$ 22,348,945	$ 132,325	$ (45,486)	$ 22,435,784
Acc. Depreciation	(9,739,013)	(639,405)	2,031	(10,376,387)	(640,360)	45,486	(10,971,261)
Capital Assets, Net	$ 12,382,164	$ (408,879)	$ (727)	$ 11,972,558	$ (508,035)	$ -	$ 11,464,523

DEBT ADMINISTRATION

The District has no outstanding debt.

ECONOMIC OUTLOOK AND MAJOR INITIATIVES

The Fiscal Year 2021 budget reflects revenues of $8,946,270 and operating expenses of $8,902,204. Capital expenditures are budgeted at $485,000. The Desert Healthcare District/Foundation adopted a 1-Year Strategic Plan, with five Community Health Focus Areas: Healthcare Infrastructure/Services, Behavioral/Mental Health, Homelessness, Vital Human Services to People with Chronic Conditions, and Economic Protection/Recovery/Food Security. The District/Foundation continues to work on connecting District residents to programs and services to meet their healthcare needs. In November 2018, the residents of the Eastern Coachella Valley voted to expand the Desert Healthcare District to all cities and unincorporated areas of the Coachella Valley. The expansion more than doubled the population and service area. However, the expansion did not include a funding source. The District will be seeking resources to fund the access to programs and services; and grant funding for the residents of the expanded area.

During the fiscal year ended June 30, 2020, the District awarded $3,201,070 in new grants and distributed grants in the amount of $6,140,621. Projected new grants to be awarded for the fiscal year 2020–2021 amount to $4,000,000 and distributions for grants could possibly total $6,718,150 due to the existing grant liability as of June 30, 2020 and the projected grant awards.

The District has also established a reserve fund of approximately $59,000,000 to cover grant liabilities, hospital operating expenses for a short period should the lease with Tenet Health System Desert, Inc. terminate prior to May 30, 2027, and seismic or other related facilities costs.

The Hospital will be required to meet SB 1953 and OSHPD regulations for seismic retrofit standards by 2030. The District conducted an assessment of the seismic retrofit needs and costs, which ranges between $119,000,000 and $180,000,000, and is reviewing options for timely completion of the seismic upgrades.

Termination Assets are assets constructed or installed by Tenet Health System in the hospital during the lease period with a net book value or fair market value at the termination of the lease. In accordance with the 1997 Lease, the District is required to purchase the Termination Assets at the lesser of net book value or fair market value. The 1997 Lease provides that the purchase can be satisfied with a 5-year promissory note and also provides the option of a possible extension of the lease if the Termination Assets exceed $10,000,000.

CONTACTING THE DISTRICT'S MANAGEMENT

Desert Healthcare District
1140 N. Indian Canyon Drive
Palm Springs, CA 92262
(760) 323-6113 Office
(760) 323-6825 Fax
www.dhcd.org Website

DESERT HEALTHCARE DISTRICT

STATEMENTS OF NET POSITION
JUNE 30, 2020 AND 2019

	2020	2019
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ 7,613,546	$ 12,052,794
Investments	15,681,020	13,491,775
Accounts receivable, net	386,593	193,311
Prepaid items and deposits	70,535	55,883
Total current assets	23,751,694	25,793,763
NON-CURRENT ASSETS		
Investments	38,685,900	34,736,545
Capital assets, net	11,464,523	11,972,558
Total non-current assets	50,150,423	46,709,103
DEFERRED OUTFLOWS		
Deferred Outflows of Resources		
Pension plans	1,204,238	1,159,189
OPEB	11,114	14,147
Total deferred outflows of resources	1,215,352	1,173,336
TOTAL ASSETS	75,117,469	73,676,202
LIABILITIES		
CURRENT LIABILITIES		
Accounts payable and accrued liabilities	259,877	387,096
Grants payable	3,088,358	7,409,355
Compensated absences	48,184	31,110
Disability claims, reserve, current portion	14,803	14,803
Total current liabilities	3,411,222	7,842,364
NON-CURRENT LIABILITIES		
Grants payable	6,660,000	5,400,000
Long-term disability claims reserve	28,809	40,626
Net pension liability	4,604,254	3,395,623
Net OPEB liability	67,364	87,973
Deposits payable	61,962	58,517
Total non-current liabilities	11,422,389	8,982,739
DEFERRED INFLOWS		
Deferred Inflows of Resources		
Pension plans	370,700	1,643,743
Total deferred inflows of resources	370,700	1,643,743
TOTAL LIABILITIES	15,204,311	18,468,846
NET POSITION		
Net investment in capital assets	11,464,523	11,972,558
Unrestricted	48,448,635	43,234,798
TOTAL NET POSITION	$ 59,913,158	$ 55,207,356

(The accompanying notes are an integral part of these financial statements)

DESERT HEALTHCARE DISTRICT

STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN NET POSITION
FOR THE YEARS ENDED JUNE 30, 2020 AND 2019

	2020	2019
OPERATING REVENUES		
Property taxes	$ 7,166,583	$ 6,972,196
Rental income	1,218,339	1,203,940
Contributions	150,000	-
Other income	87,070	125,687
Total revenues	8,621,992	8,301,823
OPERATING EXPENSES		
Grant allocations	3,174,052	3,626,871
General expenses	518,876	560,859
Rental expenses	967,727	941,062
Salaries and benefits	898,326	861,504
Retirement benefits-other	(96,389)	(556,944)
Legal fees	176,873	235,836
Depreciation	188,833	193,276
Other	238,724	208,763
Election fees	-	109,347
Total operating expenses	6,067,022	6,180,574
Income from operations	2,554,970	2,121,249
NONOPERATING INCOME (EXPENSES)		
Investment income	2,273,515	2,245,953
Loss on disposal of capital assets	-	(727)
Investment expenses	(122,683)	(113,967)
Total nonoperating income (loss)	2,150,832	2,131,259
Increase in net position	4,705,802	4,252,508
NET POSITION		
Beginning of year	55,207,356	50,954,848
End of year	$ 59,913,158	$ 55,207,356

(The accompanying notes are an integral part of these financial statements)

DESERT HEALTHCARE DISTRICT

STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED JUNE 30, 2020 AND 2019

	2020	2019
CASH FLOWS FROM OPERATING ACTIVITIES		
Cash received from County	$ 7,161,553	$ 6,975,239
Cash received from grantor and donors	224,181	79,234
Cash received from rentals and other operating revenues	1,124,722	1,244,087
Cash payments to suppliers for goods and services	(1,594,546)	(2,879,404)
Cash payments to employees for services and benefits	(1,000,016)	(899,033)
Cash payments to grantee	(6,235,049)	(2,471,615)
Net cash provided (used) by operating activities	(319,155)	2,048,508
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchases of capital assets	(132,325)	(230,526)
Net cash used by capital and related financing activities	(132,325)	(230,526)
CASH FLOWS FROM INVESTING ACTIVITIES		
Net investment sales (purchases) - net	(3,987,768)	8,230,077
Net cash (used) provided by investing activities	(3,987,768)	8,230,077
Net increase (decrease) in cash	(4,439,248)	10,048,059
CASH AND CASH EQUIVALENTS		
BEGINNING OF YEAR	12,052,794	2,004,735
END OF YEAR	$ 7,613,546	$ 12,052,794

-Continued-

(The accompanying notes are an integral part of these financial statements)

DESERT HEALTHCARE DISTRICT

STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED JUNE 30, 2020 AND 2019

-Continued-

	2020	2019
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Income from operations	$ 2,554,970	$ 2,121,249
Adjustments to reconciliation of income from operations to net cash provided (used) by operating activities:		
Depreciation	640,360	639,406
Changes in assets, deferred outflows, liabilities and deferred inflows:		
Accounts receivables	(193,282)	(3,263)
Prepaid items and deposits	(14,652)	(10,156)
Deferred outflow-pension	(45,049)	(101,347)
Deferred outflow-OPEB	3,033	7,997
Net pension liabilities	1,208,631	117,830
Net OPEB liabilities	(20,609)	(20,714)
Accounts payable and accrued liabilities	(127,219)	(1,259,511)
Grants payable	(3,060,997)	1,155,256
Deposits payable	3,445	-
Compensated absences	17,074	(8,675)
Long-term disability claims reserve	(11,817)	(11,117)
Deferred inflow - pension	(1,273,043)	(578,447)
NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES	$ (319,155)	$ 2,048,508

(The accompanying notes are an integral part of these financial statements)

DESERT HEALTHCARE DISTRICT

STATEMENTS OF FIDUCIARY NET POSITION
DESERT HEALTHCARE FOUNDATION
JUNE 30, 2020 AND 2019

	2020	2019
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ 1,145,289	$ 945,995
Grants receivable	-	1,000,000
Prepaid expenses	3,000	3,500
Accrued interest and dividends receivable	18,931	17,732
Total current assets	1,167,220	1,967,227
OTHER ASSETS		
Contributions receivable - charitable remainder trusts	187,298	189,239
Investments	5,020,682	5,853,791
Total other assets	5,207,980	6,043,030
TOTAL ASSETS	6,375,200	8,010,257
LIABILITIES		
LIABILITIES		
Current liabilities		
Accounts payable	100,467	70,955
Grants payable - current	2,694,224	3,384,450
Total current liabilities	2,794,691	3,455,405
Long-term liabilities		
Grants payable - long-term	1,600,000	2,260,000
Total long-term liabilities	1,600,000	2,260,000
TOTAL LIABILITIES	4,394,691	5,715,405
NET POSITION	$ 1,980,509	$ 2,294,852

(The accompanying notes are an integral part of these financial statements)

DESERT HEALTHCARE DISTRICT

STATEMENT OF CHANGES IN FIDUCIARY NET POSITION
DESERT HEALTHCARE FOUNDATION
FOR THE YEARS ENDED JUNE 30, 2020 AND 2019

	2020	2019
ADDITIONS		
Contributions	$ 73,222	$ 30,748
Grants and bequests	264,668	1,266,188
Interest and dividends	184,904	115,058
Investment gains (losses)	41,026	386,648
Change in value - charitable trusts	(1,940)	310
TOTAL SUPPORT AND REVENUE	561,880	1,798,952
DEDUCTIONS		
Grants and services	508,667	1,536,658
Management and general	367,556	246,663
TOTAL EXPENSES	876,223	1,783,321
INCREASE (DECREASE) IN NET POSITION	(314,343)	15,631
NET POSITION, BEGINNING OF YEAR	2,294,852	2,279,221
NET POSITION, END OF YEAR	$ 1,980,509	$ 2,294,852

(The accompanying notes are an integral part of these financial statements)

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The basic financial statements of the Desert Healthcare District (District) have been prepared in conformity with generally accepted accounting principles (GAAP) as applied to governmental agencies. The Governmental Accounting Standards Boards (GASB) is the accepted standard setting body for establishing governmental accounting and financial reporting principles. The more significant of the District's accounting policies are described below.

Financial Reporting Entity

The District was organized on December 14, 1948, by a Resolution adopted by the Board of Supervisors, County of Riverside, under the provisions of The Local Hospital District Law (Sections 32000-32314 of the California Health and Safety Code) to provide and operate health care facilities within the area known as the Western Coachella Valley.

Each of the seven members of the District's Board of Directors holds office for a four-year term, which is staggered against the other terms. Elections are by popular vote of the constituents within the designated zone boundaries.

Effective June 29, 1986, the District transferred control of Desert Hospital and all related assets and liabilities to Desert Health Systems, Inc. (System) under the terms of a master lease agreement. The purpose of the transfer was to permit the hospital to operate more competitively and efficiently by becoming a private not-for-profit entity. On December 8, 1988, the System merged with Desert Hospital Corporation (Corporation), the surviving entity. This transaction had no impact with respect to the District.

Until June 1, 1997, the District served as a pass-through entity between the Corporation and the trustee of Hospital Revenue Certificates of Participation issued in 1990 and 1992 and as a recipient of District tax revenues. The District annually pledged the tax revenues it received to the Corporation to be utilized for general corporate purposes. Historically, tax revenues were used to support capital improvement programs.

Effective May 30, 1997, the District entered into a 30-year lease of Desert Hospital with Tenet Health System Desert, Inc. (Tenet). Terms of the lease included payment by Tenet of the Hospital Revenue Certificates of Participation issued in 1990 and 1992 (approximately $80,000,000) as prepaid rent. Tenet also paid the District $15,400,000 cash, representing additional prepaid rent. (See Note 2)

As a result of AB2414 and a vote of the residents of the Eastern Coachella Valley in November 2018, the District expanded its boundaries and service area to encompass the broader Coachella Valley. The District has and continues to assess the healthcare needs of the Coachella Valley. The District makes grants to healthcare providers who provide needed healthcare services.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES - Continued

Financial Reporting Entity – Continued

As required by GAAP, these financial statements present the District and its component unit entity for which the District is considered to be financially accountable. Blended component units, although legally separate entities, are, in substance, part of the District's operations and so data from these units are combined with data of the District. Component units should be included in the reporting entity financial statement using blending method if either of the following criteria are met:

- The component unit's governing body is the same as the governing body of the District
- The component unit provides services entirely, or almost entirely, to the District or otherwise exclusively, or almost exclusively, benefits the District even though it does not provide services directly to it.

Included within the reporting entity as a blended component unit is the following:

Desert Healthcare Foundation (Foundation)

The Foundation is a health and welfare organization created to identify the health care needs of the Desert Healthcare District and to work toward alleviating those needs through various programs and services. The Foundation operates primarily in the Coachella Valley area of Southern California and, as such, is subject to market conditions, which could affect charitable giving and the realization of recorded assets values at various times.

The foundation's condensed financial statements are included in the these financial statements as a Private-Purpose Trust Fund fiduciary fund type.

Complete financial statements of the Foundation can be requested from the District, 1140 North Indian Canyon Drive, Palm Springs, California 92262.

Basis of Accounting and Measurement Focus

Business-Type Activities

The basic financial statements include a Statement of Net Assets, Statement of Activities and Changes in Net Assets, and a Statement of Cash Flows. These statements present summaries of business-type activities for the District.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES - Continued

Basis of Accounting and Measurement Focus – Continued

These basic financial statements are presented on an "*economic resources*" measurement focus and the accrual basis of accounting. Accordingly, all of the District's assets and liabilities, including capital assets and long-term liabilities, are included in the accompanying Statement of Net Assets. The Statement of Revenues, Expenses and Changes in Net Assets presents changes in net assets for the year. Under the accrual basis of accounting, revenues are recognized in the period in which they are earned while expenses are recognized in the period in which the liability is incurred. All proprietary funds are accounted for on a cost of services of "*economic resources*" measurement focus. This means that all assets and liabilities (whether current or noncurrent) associated with the activity are included on the Statement of Net Assets. Their reported fund equity presents total net assets. The Statement of Revenues, Expenses and Changes in Net Assets present increases (revenues) and decreases (expenses) in total net assets. The Statement of Cash Flows is presented with cash, cash equivalents and investments.

Fiduciary Fund Financial Statements

Fiduciary Fund Financial Statements include a Statement of Net Position and a Statement of Changes in Fiduciary Net Position. The District's Fiduciary fund includes Private Purpose Trust Funds, which account for resources that are being held for the benefits of the District. The Fiduciary fund is accounted for using the accrual basis of accounting.

Use of Restricted/Unrestricted Net Position

When an expense is incurred for purposes for which both restricted and unrestricted net assets are available, the Foundation's policy is to apply restricted net assets first.

Cash, Cash Equivalent and Investments

All cash and cash equivalents are considered to be demand deposits, money market funds and short-term investments with original maturities of three months or less from the date of acquisition. Investments are stated at fair value. Highly liquid market investments with maturities of one year or less at time of purchase are stated at amortized cost. All other investments are stated at fair value. Market value is used as fair value for those securities for which market quotations are readily available.

Prepaid Items and Deposits

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

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES - Continued

Capital Assets

Capital assets are valued at historical cost or estimated historical cost if actual historical cost was not available. Donated fixed assets are valued at their estimated fair market value on the date donated. Depreciation is recorded on a straight-line basis over estimated useful lives of the assets as follows:

Buildings and Improvements	40 – 50 years
Furniture and Equipment	3 – 7 years

Compensated Absences

Employees have vested interests in varying levels of vacation and sick leave based on their length of employment. Sick leave is payable only when an employee is unable to work due to personal or family illness. Unused sick leave does not vest and is forfeited upon termination.

Property Tax

The County of Riverside (the County) bills and collects property taxes on behalf of numerous special districts and incorporated cities, including the District. The District's collections of current year's taxes are received through periodic apportionments from the County.

The County's tax calendar is from July 1 to June 30. Property taxes attach as a lien on property on January 1. Taxes are levied on July 1 and are payable in two equal installments on November 1 and February 1, and become delinquent after December 10 and April 10, respectively.

Since the passage of California's Proposition 13, beginning with fiscal year 1978-79 general property taxes are based either on a flat 1% rate applied to the 1975-1976 full value of the property or on 1% of the sales price of any property sold or of the cost of any new construction after the 1975-1976 valuation. Taxable values on properties (exclusive of increases related to sales and new construction) can rise at a maximum of 2% per year.

The Proposition 13 limitation on general property taxes does not apply to taxes levied to pay the debt service on any indebtedness approved by the voters prior to June 6, 1978 (the date of passage of Proposition 13).

Property tax revenue is recognized in the fiscal year for which the taxes have been levied. Property taxes received after this date are subject to accrual and considered available as a resource that can be used to finance the current year operations of the District.

Income Taxes

The District is a political subdivision of the State of California and, as such, is exempt from federal and state income taxes.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES - Continued

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Fair Value Measurement

The District and Foundation apply Generally Accepted Accounting Principles (GAAP) for fair value measurements of financial assets that are recognized or disclosed at fair value in the financial statements on a recurring basis in accordance with GASB Statement Nos. 31 and 40.

Net Assets

Net Investment in Capital Assets – this amount consists of capital assets net of accumulated depreciation and reduced by outstanding debt that attributed to the acquisition, construction, or improvement of the assets.

Restricted Net Position – This amount is restricted by external creditors, grantors, contributors, or laws of regulations of other governments.

Unrestricted Net Position – This amount is all net assets that do not meet the definition of "net investment in capital assets," or "restricted net position."

Deferred Outflows and Inflows of Resources

Pursuant to GASB Statement No. 65, the District recognizes deferred outflows of resources. A deferred outflow of resources is defined as a consumption of net position by the government that is applicable to a future reporting period. Refer to Notes 9 and 14 for a detailed listing of the deferred outflow of resources that the District has recognized.

Pursuant to GASB Statement No. 65, the District recognizes deferred inflows of resources. A deferred inflow of resources is defined as an acquisition of fund balance/net position by the government that is applicable to a future reporting period. Refer to Note 14 for a detailed listing of the deferred inflow of resources that the District has recognized.

2. LEASE AGREEMENT – TENET HEALTH SYSTEM DESERT, INC.

The District, as described in the Summary of Significant Accounting Policies, entered into a thirty (30) year lease agreement for Desert Regional Medical Center (Hospital) with Tenet Health System Desert, Inc. (Tenet). In the event that Tenet or the District decide to terminate the lease, the District would be responsible for operating the Hospital which would require upfront operating capital of approximately $125,000,000 to maintain the operations without interruption during the transition period. The District, recognizing this obligation, established an investment fund, with a net value of $58,887,967 as of June 30, 2020, identified as the Facility Replacement Fund. The lease agreement contains provisions in the event the lease terminates prior to May 30, 2021. If the lease terminates for reasons such as default by the lessor to perform obligations

2. LEASE AGREEMENT – TENET HEALTH SYSTEM DESERT, INC. - Continued

within a sixty day period or the premises are totally destroyed and repairs are not feasible between the dates of June 1, 2019 and May 30, 2021, the District may be obligated to repay Tenet beginning June 1, 2019 the unamortized prepaid rent as defined in the lease agreement which decreases annually through May 2021. However, the District does not expect these conditions to occur during the term of the lease and therefore recorded the full amount of the payments received to income in fiscal year ended June 30, 1997. The lease agreement was amended to allow the District to provide the funding for the cost of preapproved capital improvements that will reduce the amount of the prepaid rent schedule by a ratio of $3 for each $1 spent, and in some cases a ratio of $3.50 for each $1 spent.

The $4,387,240 construction cost and credit received from Desert Regional Medical Center for lower electrical costs of the hospital parking lot provided for a $3 for $1 reduction amounting to $14,042,229 to the prepaid lease schedule. An additional $4,589,200 reduction to the prepaid lease schedule was due to a $3.50 for $1 reduction per a 10 year facility lease agreement between the District and Hospital for facility space at the District's medical office building to be occupied by the Hospital.

As of June 30, 2020 the prepaid lease balance is $2,835,230. This amount will decrease annually by $3,066,667 per terms of the lease agreement. By May 31, 2021, the remaining prepaid lease balance will be zero.

3. CASH AND INVESTMENTS

The cash and investments are classified in the financial statements as shown below:

	June 30, 2020	June 30, 2019
District's Statement of Net Position:		
Cash and cash equivalents	$ 7,613,546	$ 12,052,794
Investments	54,366,920	48,228,320
Fiduciary Statement of Net Position:		
Cash and cash equivalents	1,145,289	945,995
Investments	5,020,682	5,853,791
Total Cash and Investments	$ 68,146,437	$ 67,080,900

3. CASH AND INVESTMENTS - Continued

Cash and Investments consist of the following:

	June 30, 2020	June 30, 2019
Cash on Hand	$ 700	$ 700
Cash in Bank-District	3,091,999	2,049,242
Cash in Bank-Foundation	998,158	810,227
Money Market Funds	4,667,978	10,138,620
Investments	59,387,602	54,082,111
Total Cash and Investments	$ 68,146,437	$ 67,080,900

Investments Authorized by the California Government Code and the District's Investment Policy

The table below identifies the investment types that are authorized for the Desert Healthcare District (District) by the California Government Code (or the District's investment policy, where more restrictive). The table also identifies certain provisions of the California Government Code (or the District's investment policy, where more restrictive) that address interest rate risk, credit risk, and concentration of risk. This table does not address investments of debt proceeds held by bond trustee that are governed by the provisions of debt agreements of the District, rather than the general provisions of the California Government Code or the District's investment policy.

Authorized Investment Type	Maximum Maturity	Maximum Percentage of Portfolio	Maximum Investment in One Issuer
Local Agency Bonds	5 years	None	None
Local Agency Investment Fund (State Pool)	N/A	None	$65 million
U.S. Treasury Obligations	5 years	None	None
U.S. Government Agency Issues	5 years	None	None
Reverse Repurchase Agreements	92 days	20% of base	None
Repurchase Agreements	1 year	None	None
Bankers' Acceptance (must be dollar denominated)	180 days	40%	30%
Commercial Paper – Pooled Funds	270 days	40%	10%
Commercial Paper – Non-Pooled Funds	270 days	25%	10%
Negotiable Time Certificates of Deposit	5 years	30%	None
Non-negotiable Time Certificates of Deposit	5 years	None	None
State of California and Local Agency Obligations	5 years	None	None
Placement Service Certificates of Deposit	5 years	30%	None
Medium-Term Notes	5 years	30%	None
Mutual Funds and Money Market Mutual Funds	N/A	20%	None

3. CASH AND INVESTMENTS - Continued

Investments Authorized by the California Government Code and the District's Investment Policy (Continued)

Authorized Investment Type	Maximum Maturity	Maximum Percentage of Portfolio	Maximum Investment in One Issuer
Collateralized Bank Deposits	5 years	None	None
Mortgage Pass-Through Securities	5 years	20%	None
County Pooled Investments Funds	N/A	None	None
Joint Powers Authority Pool	N/A	None	None
Voluntary Investment Program Fund	N/A	None	None
Supranational Obligations	5 years	30%	None

Disclosures Relating to Interest Rate Risk

Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in the market interest rates. One of the ways that the District manages its exposure to interest rate risk is by purchasing a combination of shorter term and longer term investments and by timing cash flows from maturities so that a portion of the portfolio is maturing or coming closer to maturity evenly over time as necessary to provide the cash flow and liquidity needed for distributions.

Information about the sensitivity of the fair values of the District's investments to market interest rate fluctuations is provided by the following table that shows the distribution of the District's investments by maturity:

As of June 30, 2020

		Remaining Maturity (in Months)				
Investment Type	Carrying Amount	12 Months Or Less	13 to 24 Months	25 – 36 Months	37 – 48 Months	More than 49 Months
Corporate Bonds*	$ 1,581,765	$ 64,845	$ 104,496	$ 238,816	$ 131,685	$ 1,041,923
U.S. Government Agencies	14,954,820	5,569,590	7,225,250	2,159,980	-	-
U.S. Government Agencies*	117,910	-	-	-	-	117,910
U.S. Treasury Notes	39,412,100	10,111,430	15,183,725	11,519,850	2,597,095	-
U.S. Treasury Notes*	1,172,774	40,182	257,158	159,345	84,129	631,960
Mutual Funds-Open Ended*	269,060	269,060	-	-	-	-
Domestic Common Stock*	1,879,173	1,879,173	-	-	-	-
Total	$59,387,602	$17,934,280	$22,770,629	$14,077,991	$ 2,812,909	$ 1,791,793

*Held by Foundation

3. CASH AND INVESTMENTS - Continued

Disclosures Relating to Interest Rate Risk (Continued)

As of June 30, 2019

Investment Type	Carrying Amount	Remaining Maturity (in Months) 12 Months Or Less	13 to 24 Months	25 – 36 Months	37 – 48 Months	More than 49 Months
Corporate Bonds*	$ 1,410,937	$ 50,074	$ 73,371	$ 70,047	$ 251,864	$ 965,581
U.S. Government Agencies	22,160,590	7,486,335	5,519,485	7,066,850	2,087,920	-
U.S. Government Agencies*	867,003	-	105,004	173,290	109,954	478,755
U.S. Treasury Notes	26,067,730	6,005,440	7,064,840	7,868,280	5,129,170	-
U.S. Treasury Notes*	418,965	62,881	101,210	-	52,612	202,262
Mutual Funds-Open Ended*	1,204,392	1,204,392	-	-	-	-
Domestic Common Stock*	1,952,494	1,952,494	-	-	-	-
Total	$54,082,111	$16,761,616	$12,863,910	$15,178,467	$ 7,631,520	$ 1,646,598

*Held by Foundation

Disclosure Relating to Credit Risk

Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of rating by a national recognized statistical rating organization. Presented below is the minimum rating required by the California Government Code and the District's investment policy, and the actual rating as of the fiscal year end for each investment type.

As of June 30, 2020

Investment Type	Carrying Amount	Minimum Legal Rating	Exempt From Disclosure	Rating as of Fiscal Year End AAA/AA	A	BBB/BB	Not Rated
Corporate Bonds*	$ 1,581,765	N/A	$ -	$ 201,620	$ 642,662	$ 737,483	$ -
U.S. Government Agencies	14,954,820	N/A	-	14,954,820	-	-	-
U.S. Government Agencies*	117,910	N/A	-	117,910	-	-	-
U.S. Treasury Notes	39,412,100	N/A	39,412,100	-	-	-	-
U.S. Treasury Notes*	1,172,774	N/A	1,172,774	-	-	-	-
Mutual Funds-Open Ended*	269,060	N/A	-	-	-	-	269,060
Domestic Common Stock*	1,879,173	N/A	-	-	-	-	1 ,879,173
Total	$59,387,602		$40,584,874	$15,274,350	$ 642,662	$ 737,483	$ 2,148,233

*Held by Foundation. No Foundation policy establishing minimum legal rating

3. CASH AND INVESTMENTS - Continued

Disclosure Relating to Credit Risk (Continued)

As of June 30, 2019

Investment Type	Carrying Amount	Minimum Legal Rating	Exempt From Disclosure	Rating as of Fiscal Year End			
				AAA/AA	A	BBB/BB	Not Rated
Corporate Bonds*	$ 1,410,937	N/A	$ -	$ 242,228	$ 464,545	$ 704,164	$ -
U.S. Government Agencies	22,160,590	N/A	-	22,160,590	-	-	-
U.S. Government Agencies*	867,003	N/A	-	867,003	-	-	-
U.S. Treasury Notes	26,067,730	N/A	26,067,730	-	-	-	-
U.S. Treasury Notes*	418,965	N/A	418,965	-	-	-	-
Mutual Funds-Open Ended*	1,204,392	N/A	-	-	-	-	1,204,392
Domestic Common Stock*	1,952,494	N/A	-	-	-	-	1,952,494
Total	$54,082,111		$26,486,695	$23,269,821	$464,545	$ 704,164	$ 3,156,886

*Held by Foundation. No Foundation policy establishing minimum legal rating

Concentration of Credit Risk

The investment policy of the District contains limitations on the amount that can be invested in any one issuer.

There are three investments at June 30, 2020 that represent 5% or more of total District investments (other than U.S. Treasury Notes). These investments are:

Federal Home Loan Banks: $4,189,420 with various maturity dates through June 30, 2023, and interest rates of 1.875-3.625%.

Federal Home Loan Mortgage Corporation: $3,141,550 with various maturity dates through June 30, 2023, and interest rates of 2.375-2.750%.

Federal National Mortgage Association: $7,623,850 with various maturity dates through June 30, 2022, and interest rates of 1.250-2.000%.

There are three investments at June 30, 2019 that represent 5% or more of total District investments (other than U.S. Treasury Notes). These investments are:

Federal Home Loan Banks: $6,615,025 with various maturity dates through June 30, 2023, and interest rates of 1.375-4.500%.

Federal Home Loan Mortgage Corporation: $5,058,980 with various maturity dates through June 30,2023, and interest rates of 1.250-2.750%.

Federal National Mortgage Association: $10,486,585 with various maturity dates through June 30, 2022, and interest rates of 1.250-2.000%.

3. CASH AND INVESTMENTS - Continued

Custodial Credit Risk

Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, a government will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The California Government Code and the District's investment policy do not contain legal or policy requirements that would limit the exposure to custodial credit risk for deposits, other than the following provision for deposits: The California Government Code requires that a financial institution secure deposits made by state or local governmental units by pledging securities in an undivided collateral pool held by a depository regulated under state law (unless so waived by the governmental unit). The fair value of the pledged securities in the collateral pool must equal at least 110% of the total amount deposited by the public agencies. California law also allows financial institutions to secure the District's deposits by pledging first trust deed mortgage notes having a value of 150% of the secured public deposits.

As of June 30, 2020 and 2019, the District's deposits with financial institutions in excess of federal depository insurance limits are legally required by the California Government Code, to collateralize the District's deposits as noted above.

Fair Value Measurements

The District categorizes its fair value measurements within the fair value hierarchy established by generally accepted accounting principles. These principles recognize a three-tiered fair value hierarchy, as follows:

- Level 1: Investments reflect prices quoted in active markets;
- Level 2: Investments reflect prices that are based on similar observable asset either directly or indirectly, which may include inputs in markets that not considered active;
- Level 3: Investments reflect prices based upon unobservable sources.

3. CASH AND INVESTMENTS - Continued

Custodial Credit Risk

The District has the following recurring fair value measurements;
At June 30, 2020 and 2019, the District's cash, cash equivalents, and investments classified by risk category consisted of the following:

As of June 30, 2020

		Fair Value Measurement Using		
Investments by fair value	Total	Quoted Prices in Active Markets For Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Debt Securities				
Corporate Bonds	$ 1,581,765	$ 1,581,765	$ -	$ -
U.S. Government Agencies	15,072,730	15,072,730	-	-
U.S. Treasury Notes	40,584,874	40,584,874	-	-
Mutual Funds-Open Ended	269,060	269,060	-	-
Domestic Common Stock	1,879,173	1,879,173	-	-
	$ 59,387,602	$ 59,387,602	$ -	$ -

As of June 30, 2019

		Fair Value Measurement Using		
Investments by fair value	Total	Quoted Prices in Active Markets For Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Debt Securities				
Corporate Bonds	$ 1,410,937	$ 1,410,937	$ -	$ -
U.S. Government Agencies	23,027,593	23,027,593	-	-
U.S. Treasury Notes	26,486,695	26,486,695	-	-
Mutual Funds-Open Ended	1,204,392	1,204,392	-	-
Domestic Common Stock	1,952,494	1,952,494	-	-
	$ 54,082,111	$ 54,082,111	$ -	$ -

4. CAPITAL ASSETS

Business-Type Activities

At June 30, 2020 and 2019 the capital assets of the business-type activities consisted of the following:

June 30, 2020

	Balance July 1, 2019	Additions	Deletions	Balance June 30, 2020
Non-depreciable assets:				
Land and CIP	$ 3,988,650	$ 58,704	$ -	$ 4,047,354
Total non-depreciable assets	3,988,650	58,704	-	4,047,354
Depreciable assets:				
Building and improvements	18,177,558	60,300	(45,486)	18,192,372
Furniture and equipment	182,737	13,321	-	196,058
Total depreciable assets	18,360,295	73,621	(45,486)	18,388,430
Less accumulated depreciation	(10,376,387)	(640,360)	45,486	(10,971,261)
Total depreciable assets, net	7,983,908	(508,035)	-	7,417,169
Total capital assets, net	$11,972,558	$ (508,035)	$ -	$ 11,464,523

Depreciation expense consists of operating expense depreciation of $188,833 and rental expense depreciation of $451,527.

June 30, 2019

	Balance July 1, 2018	Additions	Deletions	Balance June 30, 2019
Non-depreciable assets:				
Land	$ 3,988,650	$ -	$ -	$ 3,988,650
Total non-depreciable assets	3,988,650	-	-	3,988,650
Depreciable assets:				
Building and improvements	17,955,981	222,077	(500)	18,177,558
Furniture and equipment	176,546	8,449	(2,258)	182,737
Total depreciable assets	18,132,527	230,526	(2,758)	18,360,295
Less accumulated depreciation	(9,739,013)	(639,405)	2,031	(10,376,387)
Total depreciable assets, net	8,393,514	(408,879)	(727)	7,983,908
Total capital assets, net	$ 12,382,164	$ (408,879)	$ (727)	$ 11,972,558

Depreciation expense consists of operating expense depreciation of $193,276 and rental expense depreciation of $446,129.

5. RESTRICTED NET POSITION

The District had $0 of restricted net position at June 30, 2020 and 2019.

6. SPLIT INTEREST AGREEMENTS - FOUNDATION

At June 30, 2020 and 2019, the split interest agreements of the fiduciary fund consisted of the following:

	2020	2019
Contribution receivable – charitable remainder trusts	$ 187,298	$ 189,239

Charitable Reminder Trusts

The Foundation was named beneficiary to two additional charitable remainder unitrusts (whose trustees are someone other than the Foundation), all of which are recorded at fair market value. The general terms of the trusts are as follows:

Trust 4 (dated October 3, 1989): The lesser of the trust income or 8% of the net fair market value of trust assets is to be distributed to the life beneficiary annually. Upon the death of the life beneficiary, 50% of the principal and income not required to have been distributed to the life beneficiary shall become the property of the Foundation, to be used for cancer treatment, or for general purposes if a cure for cancer has been found. At December 31, 2018, which is the most current information available, the estimated present value of future cash flows was $126,022.

Trust 7 (dated May 17, 1990): 8.5% of the net fair market value of trust assets is to be distributed to the life beneficiary annually. Upon the death of the life beneficiary, all of the principal and income not required to have been distributed to the life beneficiary shall become the property of the Foundation, to be used for general purposes. The estimated present value of future cash flows at June 30, 2020 and 2019 was $61,276 and $63,217, respectively.

7. GRANTS

The District has granted awards to various healthcare providers that provide needed healthcare services. Awards not fully funded in the current fiscal year are carried over to the subsequent fiscal year. At June 30, 2020 and 2019, the total grant awards payable were $9,748,358 and $12,809,355, respectively. Total grants expense for the years ended June 30, 2020 and 2019 amounted to $3,174,052 and $3,626,871, respectively.

The Foundation has granted awards to various healthcare providers that provide needed healthcare services. At June 30, 2020 and 2019, the total grant awards payable were $4,294,224 and $5,644,450, respectively. Total grants and services expense for the years ended June 30, 2020 and 2019 amounted to $508,667 and $1,536,658, respectively.

8. LONG-TERM DISABILITY CLAIMS RESERVE

Long-term disability claims were self-insured by the Corporation. Claimants' payments are administered by the District who processes payments made pursuant to the plan. Claimants are paid either to age 65 or until they return to work. At June 30, 2020 and 2019, the long-term disability claims reserves were as follows:

	Balance at July 1, 2019	Claims Paid	Changes in Estimates	Balance at June 30, 2020	Due Within One Year
Claims payable	$ 55,429	$ (14,803)	$ 2,986	$ 43,612	$ 14,803

	Balance at July 1, 2018	Claims Paid	Changes in Estimates	Balance at June 30, 2019	Due Within One Year
Claims payable	$ 66,546	$ (14,803)	$ 3,686	$ 55,429	$ 14,803

9. POSTEMPLOYEMENT (HEALTH INSURANCE) BENEFITS

A. General Information about the OPEB Plan

Plan Description – The District's defined benefit OPEB plan, provided OPEB for the two retired Board of Directors of the District. The plan is a single employer defined benefit OPEB plan administered by the District. No assets are accumulated in a trust that meets the criteria in paragraph 4 of Statement 75.

Benefits Provided – Following is a description of the retiree benefit plan:

	Board Members
Benefit types provided	Medical and dental
Duration of benefits	Lifetime
Dependent coverage	Yes
District contribution %	100%
District cap	None

Employees Covered by Benefit Terms – At June 30, 2020, the following employees were covered by the benefit terms:

Inactive employees receiving benefits	2
Inactive employees entitled to but not yet receiving benefit payments	0
Active employees	0

9. POSTEMPLOYEMENT (HEALTH INSURANCE) BENEFITS - Continued

B. Total OPEB Liability

The District's total OPEB liability of $67,364 was measured as of June 30, 2019 and was determined by an actuarial valuation as of that date.

*Actuarial Assumptions and Other Inp*uts – The total OPEB liability in the June 30, 2019 actuarial valuation was determined using the following actuarial assumptions and other inputs, applied to all periods included in the measurement, unless otherwise specified:

Inflation	2.75 percent
Investment return/discount rate	3.50 percent net of expenses. Based on the Bond Buyer 20 Bond Index
Healthcare cost trend rates	4.00 percent
Payroll increase	2.75 percent
The mortality assumptions	Based on the 2009 CalPERS Mortality for Retired Miscellaneous Employees table created by CalPERS. CalPERS periodically studies mortality for participating agencies and establishes mortality tables that are modified versions of commonly used tables. This table incorporates mortality projection as deemed appropriate based on CalPERS analysis.
Cost for retiree coverage	Based on actual employer contribution. Liabilities for active participants are based on the first year costs. Subsequent years' costs are based on first year costs adjusted for trend and limited by any District contribution caps.

C. Changes in the Total OPEB Liability

Balance at June 30, 2019	$ 87,973
Changes for the fiscal year	
Service cost	-
Interest	2,957
Changes of benefit terms	-
Differences between expected and actual experience	(3,680)
Changes in assumptions or other inputs	435
Benefit payments	(20,321)
Net changes	67,364
Balance at June 30, 2020	$ 67,364

9. POSTEMPLOYEMENT (HEALTH INSURANCE) BENEFITS – Continued

C. Changes in the Total OPEB Liability (Continued)

Sensitivity of the Total OPEB Liability to Changes in the Discount Rate – The following presents the total OPEB liability of the District, as well as what the District's total OPEB liability would be if it were calculated using discount rate that is 1 percentage point lower or 1 percentage point higher than the current discount rate:

	Discount Rate 1% Lower	Valuation Discount Rate	Discount Rate 1% Higher
Net OPEB liability	$68,865	$67,364	$65,941

Sensitivity of the Total OPEB Liability to Changes in the Healthcare Cost Trend Rates – The following present the total OPEB liability of the District, as well as what the District's total OPEB liability would be if it were calculated using healthcare cost trend rates that are 1 percentage point lower or 1 percentage point higher than the current healthcare cost trend rate:

	Trend 1% Lower	Valuation Trend	Discount Rate 1% Higher
Net OPEB liability	$65,934	$67,364	$68,843

D. OPEB Expense, Deferred Outflows of Resources and Deferred Inflows of Resources Related to OPEB

There were no amounts reported as deferred outflows of resources and deferred inflows of resources related to OPEB that will be recognized in OPEB expenses in the future.

10. INSURANCE

The District is exposed to various risks of loss related to torts; theft of, damage to and destruction of assets; error and omissions; and natural disasters for which the District carries commercial insurance. The District purchases commercial insurance to cover the risk of loss for property, business liability, and medical payments.

11. RENTAL INCOME

The District rents commercial office suites subject to lease terms ranging from three to five years. Rental income includes the base monthly rental payments plus the common area maintenance fee. Rental income consisted of the following for the years ended June 30, 2020 and 2019:

	2020	2019
Base rent	$ 879,153	$ 863,595
Common area maintenance	339,186	340,345
	$1,218,339	$1,203,940

The five fiscal year minimum rental schedule follows:

	2021	2022	2023	2024	2025
Base rent	$ 914,262	$ 929,472	$ 755,093	$ 392,442	$ 159,861
Common area maintenance	343,569	339,204	272,504	139,299	55,665
	$ 1,257,831	$ 1,268,676	$ 1,027,597	$ 531,741	$ 215,525

12. COMMITMENT AND CONTINGENCIES

Earthquake Retrofit

Senate Bill 1953 imposes certain requirements that acute care hospitals would be required to meet within a specified time. These requirements include conducting seismic evaluations. The deadline was extended to January 1, 2030. After January 1, 2030, all hospitals must be determined to be in compliance.

Litigation

In the ordinary course of operations, the District is subject to other claims and litigation from outside parties. After consultation with legal counsel, the District believes the ultimate outcome of such matters will not materially affect its financial condition.

13. 401(K) RETIREMENT PLAN

The District converted from a 401(k) retirement plan to a 457(B) and 401(A) retirement plans. A 457(B) (employee contribution) and 401(A) (employer contribution) retirement plans were determined to be more appropriate for a governmental agency. The 401(K) plan was terminated during the fiscal year and the 457(B) and 401(A) retirement plans became effective October 1, 2014.

The District contributes a dollar for dollar match for the first 4% of employee salary deferral and two dollars match for each additional dollar of the next 2% of employee salary deferral. The District's match contribution for the fiscal years ended June 30, 2020 and 2019 were $64,172 and $47,285, respectively.

14. DESERT HOSPITAL RETIREMENT PROTECTION PLAN

Effective July 1, 1971, Desert Hospital Corporation (Corporation) established a defined benefit pension plan (Plan) covering eligible employees of Desert Hospital. The Corporation was dissolved as of May 31, 1997 and the Plan has been frozen as of that date. The Desert Healthcare District (the "District") has assumed sponsorship of the Plan. Refer to the Plan's separate statements for more detail information.

Vesting
All participants of the Plan have been 100% vested since May 31, 1997.

Account Balances
All participants of the Plan are eligible to request a distribution or rollover of their account balance upon retirement or termination of their employment from Desert Regional Medical Center.

Contributions
There have been no contribution requirements by the District since May 31, 1997. Participant contributions to the Plan are not permitted. In the most recent actuarial valuation as of June 30, 2020, the Plan's independent actuary determined that the actuarial value of the Plan's net pension liability was $4,604,254 at June 30, 2020 and $3,395,623 at June 30, 2019. In the report it was recommended that an actuarially determined contribution of $366,275 as of June 30, 2020 and $288,378 as of June 30, 2019, should be made. The District's board of directors elected not to fund the Plan during 2020. The plan was funded in the amount of $0 during 2020 and 2019.

Distributions
Although the pension liability is determined by calculating the present value of future annuity payments, it is the practice of the District to disburse 100% of the participant's funds at the time the participant leaves employment of Desert Hospital. The disbursements are in the form of either a roll over to an IRA or a direct disbursement to the participant.

Administration and Trustee
The Plan is administered by the District's Finance and Administrative Committee (the Committee). The Committee is selected by the District's board of directors. All administrative expenses are paid by the Plan or at the discretion of the District.

Pursuant to the terms of the Plan, the District entered into a trust agreement with US Bank N. A. to provide for the investment, reinvestment, administration and distribution of contributions made under the Plan.

14. DESERT HOSPITAL RETIREMENT PROTECTION PLAN - Continued

Schedule of Funding Progress

Actuarial Valuation Date (1)	Actuarial Value of Assets (a)	Actuarial Accrued Liability (AAL) (b)	Unfunded AAL (UAAL) (b-a)	Funded Ratio (a/b)	Covered Payroll (c)	UAAL as a % of Covered Payroll ((b-a)/c)
6/30/2006	$ 5,236,383	$ 9,566,663	$ 4,330,280	55%	N/A	N/A
6/30/2007	N/A	N/A	N/A	N/A	N/A	N/A
6/30/2008	4,552,074	9,312,581	4,760,507	49%	N/A	N/A
6/30/2009	3,351,366	9,141,403	5,790,037	37%	N/A	N/A
6/30/2010	N/A	N/A	N/A	N/A	N/A	N/A
6/30/2011	3,522,125	7,921,342	4,399,217	45%	N/A	N/A
6/30/2012	N/A	N/A	N/A	N/A	N/A	N/A
6/30/2013	2,797,614	7,357,700	4,560,086	38%	N/A	N/A
6/30/2014	2,656,607	10,603,012	7,946,405	25%	N/A	N/A
6/30/2015	2,405,256	10,149,205	7,743,949	24%	N/A	N/A
6/30/2016	1,924,238	11,568,940	9,644,702	17%	N/A	N/A
6/30/2017	5,344,173	8,219,294	2,875,121	65%	N/A	N/A
6/30/2018	5,189,834	8,467,627	3,277,793	61%	N/A	N/A
6/30/2019	4,913,907	8,309,530	3,395,623	59%	N/A	N/A
6/30/2020	4,783,963	9,388,217	4,604,254	51%	N/A	N/A

No actuarial report or estimation using actuarial methodology were prepared for June 30, 2012, 2010, and 2007.

General Information about the Desert Hospital Retirement Protection Plan (Plan) Pension Plan

Plan Description

Effective July 1, 1971, Desert Hospital Corporation (Corporation) established a defined benefit pension plan (Plan) covering eligible employees of Desert Hospital. The Corporation was dissolved as of May 31, 1997 and the Plan has been frozen as of that date.

Employees Covered

At June 30, 2020 and 2019, the following employees were covered by the benefit terms:

	Miscellaneous	
	2020	2019
Inactive plan members if beneficiaries currently receiving benefits	8	8
Inactive plan members entitled to but not yet receiving benefits	61	61
Active plan members	114	114
Total Employees Covered	183	183

14. DESERT HOSPITAL RETIREMENT PROTECTION PLAN – Continued

General Information about the Desert Hospital Retirement Protection Plan (Plan) Pension Plan (Continued)

Net Pension Liability

The District's net pension liability for the Plan is measured as the total pension liability, less the pension plan's fiduciary net position. A summary of principal assumptions and methods used to determine the net pension liability is shown below.

Actuarial Assumptions
The total pension liability in the June 30, 2020 actuarial valuations were determined using the following actuarial assumptions:

Inflation	2.75%
Discount rate	3.77% net of pension plan investment expense, including inflation.
Measurement date	June 30, 2020, based on valuation date of June 30, 2019.
Ad hoc cost-of-living increases	Not applicable
Mortality	Pre-Retirement: None Post-Retirement: Pub G Sex distinct mortality tables projected generationally with Scale MP-2018
Experience study	Given the size of the plan, there is not enough data available to conduct a credible experience study. The assumptions are not anticipated to produce significant cumulative actuarial gains or losses over time. The liabilities and data are analyzed each year in order to identify any trends of experience deviating from the actuarial assumptions. The plan is frozen to new participants and benefit accruals.
Retirement	100% retirement at age 65.
Termination	Participants* are assumed to work for the Desert Regional Medical Center operated by Tenet Health System Desert, Inc. until Normal Retirement Age.
Other assumptions	See actuarial assumptions provided in the June 30, 2020 funding valuation for other relevant assumptions.

*Former Desert Hospital employees employed with Tenet Health System Desert, Inc.

14. DESERT HOSPITAL RETIREMENT PROTECTION PLAN – Continued

General Information about the Desert Hospital Retirement Protection Plan (Plan) Pension Plan (Continued)

Net Pension Liability (Continued)

Actuarial Assumptions (Continued)

Discount Rate

The discount rate used to measure the total pension liability was 3.77 percent. To determine whether the municipal bond rate should be used in the calculation of a discount rate for each plan, the Plan stress tested plans that would most likely result in a discount rate that would be different from the actuarially assumed discount rate. Based on the testing, none of the tested plans run out of assets. Therefore, the current 3.77 percent discount rate is adequate and the use of the municipal bond rate calculation is not necessary. The long-term expected discount rate of 6.82 percent is applied to all plans in the Plan. The stress test results are presented in a detailed report called "GASB Crossover Testing Report" that can be obtained at the Districts' website under the GASB 68 section.

According to Paragraph 30 of Statement 68, the long-term discount rate should be determined without reduction for pension plan administrative expense. The 3.77 percent investment return assumption used in this accounting valuation is net of administrative expenses. Administrative expenses are assumed to be 15 basis points. An investment return excluding administrative expenses would have been 3.92 percent. Using this lower discount rate has resulted in a slightly higher total pension liability and net pension liability. The Plan checked the materiality threshold for the difference in calculation and did not find it to be a material difference.

The Plan expects to continue using a discount rate net of administrative expenses for GASB 67 and 68 calculations through the 2019-20 fiscal year. The Plan will continue to check the materiality of the difference in calculation until such time as they have changed their methodology.

The long-term expected rate of return on Plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of Plan investment expense and inflation) are developed for each major asset class.

14. DESERT HOSPITAL RETIREMENT PROTECTION PLAN – Continued

General Information about the Desert Hospital Retirement Protection Plan (Plan) Pension Plan (Continued)

Net Pension Liability (Continued)

The expected rate of return was set by calculating the single equivalent expected return that arrived at the same present value of benefits for cash flows as the one calculated using both short-term and long-term returns. The expected rate of return was then set equivalent to the single equivalent rate calculated above and rounded down to the nearest one quarter of one percent.

Expected Rate of Return

The table below reflects long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation. These geometric rates of return are net of administrative expenses.

Asset Class		Target Allocation		Long-term expected real rate of return
Domestic fixed income securities		36.0%		2.50%
Domestic equities		45.0		5.50
International equities		15.0		6.50
International Fixed Income Securities		2.0		2.50
Cash		2.0		0.00

14. DESERT HOSPITAL RETIREMENT PROTECTION PLAN – Continued

Changes in the Net Pension Liability

The changes in the Net Pension Liability for the Plan follows:

	Increase (Decrease)		
	Total Pension Liability (a)	Plan Fiduciary Net Position (b)	Net Position Liability/(Asset) (c) = (a) – (b)
Balance, June 30, 2019	$ 8,309,530	$ 4,913,906	$ 3,395,624
Changes in Recognized for the Measurement Period:			
Employer Contributions	-	-	-
Interest on the Total Pension Liability	374,170		374,170
Differences between Expected and Actual Experience	-	-	-
Changes in Assumptions	912,601	-	912,601
Net Investment Income **	-	109,665	(109,665)
Benefit Payments, including Refunds of Employee Contributions	(208,084)	(208,084)	-
Administrative Expenses	-	(31,524)	31,524
Net Changes during 2019-20	1,078,687	(129,943)	1,208,630
Balance, June 30, 2020 *	$ 9,388,217	$ 4,783,963	$ 4,604,254

* The fiduciary net position includes receivables for employee service buybacks, deficiency reserves, fiduciary self-insurance and OPEB expense. This may differ from the plan assets reported in the funding actuarial valuation report.
** Net of administrative expenses.

Sensitivity of the Net Pension Liability to Changes in the Discount Rate

The Following presents the net pension liability/(asset) of the Plan as of the measurement date, calculated using the discount rate of 3.77 percent, as well as what the net pension liability/(asset) would be if it were calculated using a discount rate that is 1 percentage-point lower (2.77 percent) or 1 percentage-point higher (4.77 percent) than the current rate:

	1% Decrease (2.77%)	Current Discount Rate (3.77%)	1% Increase (4.77%)
Net pension liability	$ 5,988,086	$ 4,604,254	$ 3,471,841

Plan Fiduciary Net Position

Detailed information about the pension plan's fiduciary net position is available in the separately issued financial reports.

14. DESERT HOSPITAL RETIREMENT PROTECTION PLAN – Continued

Changes in the Net Pension Liability (Continued)

The Plan's Pension Expenses and Deferred Outflows/Inflows of Resources Related to Pensions

For the fiscal year ended June 30, 2020, the District recognized pension expense of ($109,461). At June 30, 2020, the District reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ -	$ (267,370)
Net differences between projected and actual Earnings on pension plan investments	260,292	(103,330)
Changes in assumptions	943,946	-
Total	$ 1,204,238	$ (370,700)

Amounts reported as deferred outflows and deferred inflows of resources related to pensions will be recognized in future pension expense as follows:

Fiscal Year Ended June 30,	Deferred Outflows (Inflows) of Resources
2021	$ 357,812
2022	355,644
2023	70,105
2024	49,977
Total	$ 833,538

15. RELATED PARTY TRANSACTIONS

The Desert Healthcare District and the Desert Healthcare Foundation are related parties. The Foundation is organized to provide health and welfare assistance to Coachella Valley residents in need. The District donated funds of $200,000 to the Foundation, to help fulfill their purpose. The District also provided the Foundation with office space and personnel of $305,676.

16. UNCERTAINTIES

As a result of the COVID-19 coronavirus pandemic, economic uncertainties have arisen which could have an impact on the operations of the District and Foundation. The related financial impact and duration cannot be reasonably estimated at this time.

17. SUBSEQUENT EVENTS

The District and Foundation evaluated all potential subsequent events as of October 13, 2020 when the financial statements were authorized and available to be issued. No subsequent events or transactions were identified after June 30, 2020 or as of October 13, 2020 that require disclosure to the financial statements.

REQUIRED SUPPLEMENTAL INFORMATION

DESERT HEALTHCARE DISTRICT

REQUIRED SUPPLEMENTAL INFORMATION

JUNE 30, 2020

Prepared for the Desert Healthcare District, a Single-Employer Defined Benefit Pension Plan as of June 30, 2020

Note 1 – Schedule of Changes in the Net Pension Liability and Related Ratios – Last 10 Years*

	2020	2019	2018	2017	2016	2015
Measurement Period	2018-2019	2018-2019	2016-2017	2016-2017	2014-2015	2013-2014
Total Pension Liability						
Interest on total pension liability	$ 374,170	$ 385,951	$ 399,298	$ 321,990	$ 397,980	$ 418,035
Differences between expected and actual experience	-	(802,110)	-	(437,093)	(493,455)	(537,276)
Changes in assumptions	912,601	769,854	315,705	(2,852,163)	1,944,607	-
Benefit payments, including refunds of employee contributions	(208,084)	(511,792)	(466,670)	(382,380)	(459,397)	(304,566)
Net change in total pension liability	1,078,687	(158,097)	248,333	(3,349,646)	1,389,735	(423,807)
Total pension liability - beginning	8,309,530	8,467,627	8,219,294	11,568,940	10,179,205	10,603,012
Total pension liablity - ending (a)	9,388,217	8,309,530	8,467,627	8,219,294	11,568,940	10,179,205
Plan fiduciary net position						
Employer contributions	-	-	-	3,400,000	-	-
Net investment income	109,665	268,701	347,969	426,828	(6,638)	71,101
Benefit payments	(208,084)	(511,792)	(466,670)	(382,380)	(459,397)	(304,566)
Administrative expenses	(31,524)	(32,836)	(35,638)	(24,513)	(14,983)	(17,886)
Net change in plan fiduciary net position	(129,943)	(275,927)	(154,339)	3,419,935	(481,018)	(251,351)
Plan fiduciary net position - beginning	4,913,907	5,189,834	5,344,173	1,924,238	2,405,256	2,656,607
Plan fiduciary net position - ending (b)	4,783,963	4,913,907	5,189,834	5,344,173	1,924,238	2,405,256
Net pension liability - ending (a) - (b)	$ 4,604,254	$3,395,623	$ 3,277,793	$ 2,875,121	$ 9,644,702	$7,773,949
Plan fiduciary net position as percentage of the total pension liability	50.96%	59.14%	61.29%	65.02%	16.63%	23.63%
Covered - employee payroll	N/A	N/A	N/A	N/A	N/A	N/A
Net pension liability as a percentage of covered - employee payroll	N/A	N/A	N/A	N/A	N/A	N/A

Notes to Schedule

Changes in Assumptions:

- 2017 to 2018 Investment rate of return, including inflation, and net of investment expenses changed from 5.00 % to 4.70%.
- 2017 to 2018 Discount Rate changed from 5.00% to 4.70%.
- 2018 to 2019 Discount Rate changed from 4.70% to 4.56%.
- 2018 to 2019 Investment rate of return, including inflation, and net of investment expenses changed from 4.70% to 4.56%.
- 2019 to 2020 Discount Rate changed from 4.56% to 3.77%.

* Fiscal year 2015 was the first year of implementation, therefore only six years are shown.

DESERT HEALTHCARE DISTRICT

REQUIRED SUPPLEMENTAL INFORMATION

JUNE 30, 2020

Note 2 – Schedule of Changes in Net OPEB Liability and Related Rations – Last 10 Fiscal Years*

Measured Period	6/30/2020	6/30/2019	6/30/2018
Total OPEB Liability			
Service Cost	$ -	$ -	$ -
Changes in assumptions	(3,245)	(908)	-
Interest on the Total Pension Liability	2,957	3,684	4,057
Benefit Payments	(20,321)	(23,490)	(22,587)
Net Change in total Pension Liability	(20,609)	(20,714)	(18,530)
Total OPEB Liability - Beginning	87,973	108,687	127,217
Total OPEB Liability - Ending (a)	$ 67,364	$ 87,973	$ 108,687
Plan Fiduciary Net Position			
Contribution from the Employer	$ 20,321	$ 23,490	$ 22,587
Net investment income	-	-	-
Benefit Payments	(20,321)	(23,490)	(22,587)
Administrative Expenses	-	-	-
Net Change in Plan Fiduciary Net Position	-	-	-
Plan Fiduciary Net Position - Beginning	-	-	-
Plan Fiduciary Net Position - Ending (b)	$ -	$ -	$ -
Net OPEB Liability - Ending (a) - (b)	$ 67,364	87,973	108,687
Plan Fiduciary Net Position as a Percentage of the Total OPEB Liability	0.00%	0.00%	0.00%
Covered - Employee Payroll	N/A	N/A	N/A
Net OPEB Liability as Percentage of	N/A	N/A	N/A

Notes to Schedule:

Changes of Assumption: Investment/Discount rate changed from 3.80% to 3.50% from 2018 to 2019 measurement period.

*Fiscal year 2018 was the first year of implementation, therefore only three years are shown.

DESERT HOSPITAL
RETIREMENT PROTECTION PLAN

PALM SPRINGS, CALIFORNIA

INDEPENDENT AUDITORS' REPORT,
FINANCIAL STATEMENTS AND
SUPPLEMENTARY INFORMATION

JUNE 30, 2020 AND 2019

LUND & GUTTRY LLP / CERTIFIED PUBLIC ACCOUNTANTS
36917 COOK STREET • SUITE 102 • PALM DESERT, CALIFORNIA 92211
Telephone (760) 568-2242 • Fax (760) 346-8891
www.lundandguttry.com

INDEPENDENT AUDITORS' REPORT

To the Honorable Board of Directors
of the Desert Hospital Retirement Protection Plan
Palm Springs, California

We have audited the accompanying financial statements of Desert Hospital Retirement Protection Plan (the Plan) which comprise the statement of net assets available for benefits and of accumulated plan benefits as of June 30, 2020 and the related statement of changes in net assets available for benefits and changes in accumulated plan benefits for the year then ended, and the related notes to the financial statements, which collectively comprise the Plan's 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 of America; 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 audit. We conducted our audit in accordance with generally accepted auditing standards accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of 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 Plan'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 Plan'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.

Basis for Qualified Opinion

Due to the Plan's status as a "frozen plan" as of May 31, 1997 (Note 1), certain disclosures and supplemental schedules required for the financial statements to be in accordance with generally accepted accounting principles in the United States of America are not included in the accompanying financial statements.

Qualified Opinion

In our opinion, except for the omission of the information discussed in the preceding paragraph, the financial statements referred to above present fairly, in all material respects, the financial status of the Plan as of June 30, 2020, and the changes in financial status for the fiscal year then ended, in conformity with generally accepted accounting principles in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards.*

Other Matters

Other Report Required by Government Auditing Standards
In accordance with *Government Auditing Standards,* we have also issued our report dated October 13, 2020 on our consideration of the Plan's internal control over financial reporting and on our tests of compliance with laws and regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Plan's internal control over financial reporting.

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

Report on Comparative Information

The financial statements of Desert Hospital Retirement Protection Plan for the year ended June 30, 2019 were audited by other auditors whose report dated October 1, 2019, expressed a qualified opinion on those statements for the reason described in the first paragraph above.

Lund & Guthry

October 13, 2020

DESERT HOSPITAL RETIREMENT PROTECTION PLAN

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS AND OF ACCUMULATED PLAN BENEFITS
JUNE 30, 2020 AND 2019

	2020	2019
ASSETS		
Cash	$ 305,423	$ 63,564
Investments, at fair value		
U.S. Government securities	745,008	852,161
Corporate equity securities	494,184	405,507
Corporate debt securities	748,676	716,638
Mutual funds	2,488,266	2,872,938
Total investments	4,476,134	4,847,244
Interest and dividends receivable	10,001	11,287
LIABILITIES		
Accrued trustee fees	7,595	8,189
NET POSITION RESTRICTED FOR PENSION	$ 4,783,963	$ 4,913,906

(The accompanying notes are an integral part of these financial statements)

DESERT HOSPITAL RETIREMENT PROTECTION PLAN

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS AND CHANGES IN ACCUMULATED PLAN BENEFITS
FOR THE YEARS ENDED JUNE 30, 2020 AND 2019

	2020	2019
ADDITIONS		
Contributions	$ -	$ -
Investment income		
Net appreciation in fair value of Plan assets	98,401	125,149
Interest, dividends and other investment income	115,080	126,183
Net gain (loss) from sale of investments	(104,280)	17,367
Total additions	109,201	268,699
DEDUCTIONS		
Distributions of benefits to participants	207,620	511,792
Administrative expenses	31,524	32,836
Total deductions	239,144	544,628
NET DECREASE IN NET POSITION	(129,943)	(275,929)
NET POSITION RESTRICTED FOR PENSION:		
BEGINNING OF YEAR	4,913,906	5,189,835
END OF YEAR	$ 4,783,963	$ 4,913,906

(The accompanying notes are an integral part of these financial statements)

DESERT HOSPITAL RETIREMENT PROTECTION PLAN

NOTES TO FINANCIAL STATEMENTS

JUNE 30, 2020 AND 2019

1. PLAN STATUS

From June 1986 to May 1997, the Desert Hospital Corporation (the Corporation), a California not for profit public benefit corporation, operated Desert Hospital under a lease agreement with the Desert Healthcare District (the District). The District is a hospital district under California law, created under California's Health and Safety Code.

On May 31, 1997, after the Corporation and the District discontinued their lease agreement for the operation of Desert Hospital, the Corporation dissolved, and the District entered into a lease agreement with Tenent Health System Desert, Inc. concerning the operation of Desert Hospital, which is now known as Desert Regional Medical Center. As part of the dissolution process, the Corporation transferred certain assets and liabilities to the District, and the District assumed sponsorship of the Desert Hospital Retirement Protection Plan (the Plan). The Plan has been frozen since May 31, 1997.

The District is a political subdivision of the State of California, as identified in section 4021(b)(2) of the Employee Retirement Income Savings Act (ERISA). Accordingly, the Plan is excluded from coverage under section 4021(b)(2) of ERISA.

A final Form 5500 was filed for the fiscal year ended June 30, 1998.

The Plan has reported to the California State Controller's Office beginning with the fiscal year ended June 30, 1999.

2. PLAN DESCRIPTION

General

As discussed in note 1 above, the Plan has been frozen since May 31, 1997. The Plan was originally established in 1971 as a defined benefit plan covering all eligible employees of Desert Hospital.

Vesting

All participants of the Plan have been 100% vested since May 31, 1997.

Account Balances

All participants of the Plan are eligible to request a distribution or rollover of their account balance upon retirement or termination of their employment from Desert Regional Medical Center.

2. PLAN DESCRIPTION – (Continued)

Contributions

There have been no contribution requirements by the District since May 31, 1997. Participant contributions to the Plan are not permitted. The most recent actuarial valuation as of June 30, 2020 by the Plan's independent actuary determined that the actuarial value of the Plan's net pension liability was $4,604,254 and $3,395,624 at June 30, 2020 and 2019, respectively. The actuary recommended to the District an actuarially determined contribution of $366,275 and $288,378 as of June 30, 2020 and 2019, respectively.

Distributions

Although the pension liability is determined by calculating the present value of future annuity payments, it is the practice of the District to disburse 100% of the participant's funds at the time the participant leaves employment of Desert Hospital. The disbursements are in the form of either a roll over to an IRA or a direct disbursement to the participant.

Administration and Trustee

The Plan is administered by the District's Finance and Administrative Committee (the Committee). The Committee is selected by the District's board of directors. All administrative expenses are paid by the Plan or at the discretion of the District.

Pursuant to the terms of the Plan, the District entered into a trust agreement with U.S. Bank N. A. to provide for the investment, reinvestment, administration and distribution of contributions made under the Plan.

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

The accompanying financial statements have been prepared in accordance with generally accepted accounting principles in the United States of America. In that respect, the statements are presented on an accrual basis.

Use of Estimates

The preparation of the Plan's financial statements in conformity with generally accepted accounting principles in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, and changes therein, and when applicable, disclosures of contingent assets and liabilities. Actual results could differ from those estimates. Management believes that the estimates are reasonable.

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES – (Continued)

Federal Income Taxes

The Committee obtained an updated determination letter in March 2007 from the Internal Revenue Service stating that the Plan and its amendments are exempt from Federal income taxes under section 410(a) of the Internal Revenue Code (the IRC) as a qualified plan. Therefore, no provision for income taxes has been provided in the Plan's financial statements.

Reporting

Due to the Plan's status as a "frozen Plan", certain disclosures and supplemental schedules have been omitted from the accompanying financial statements.

4. CASH AND INVESTMENTS

Cash and securities held in the investment portfolio are in the custody of U.S. Bank, N.A., the Plan's trustee. State statute and Board policies allow investments consisting of government, corporate and international bonds, domestic and international equities, mutual funds and other investments.

Investments of the Plan are stated at fair value as confirmed by the trustee as of the date of the statement of plan net assets.

The Plan's investments are categorized below:

	2020		2019	
Investment Type	Cost	Fair Value	Cost	Fair Value
Cash	$ 305,423	$ 305,423	$ 63,564	$ 63,564
Investments				
U. S. Government securities	713,103	745,008	848,667	852,161
Corporate equity securities	346,110	494,184	307,796	405,507
Corporate debt securities	733,689	748,676	722,751	716,638
Mutual funds	2,133,627	2,488,266	2,412,793	2,872,938
Investments total	3,926,529	4,476,134	4,292,007	4,847,244
Total cash and investments	$ 4,231,952	$ 4,781,557	$ 4,355,571	$ 4,910,808

4. CASH AND INVESTMENTS – (Continued)

Disclosure relating to Interest Rate Risk

Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in the market interest rates. One of the ways that the Plan manages its exposure to interest rate risk is by purchasing a combination of shorter term and longer term investments and by timing cash flows from maturities so that a portion of the portfolio is maturing or coming closer to maturity evenly over time as necessary to provide the cash flow and liquidity needed for distributions.

Information about the sensitivity of the fair values of the Plan's investments to market interest rate fluctuations is provided by the following table that shows the distribution of the Plan's investments by maturity:

As of June 30, 2020

		Remaining Maturity (in Months)				
Investment Type	Carrying Amount	12 Months Or Less	13 to 24 Months	25 – 36 Months	37 – 48 Months	More than 49 Months
Equity Based Mutual Funds	$ 2,267,093	$ 2,267,093	$ -	$ -	$ -	$ -
Fixed Income Mutual Funds	221,173	221,173	-	-	-	-
Corporate Bonds	748,676	201,793	157,187	52,207	218,268	119,221
U.S. Government Agencies	534,465	-	51,667	-	-	482,798
U.S. Treasury Note	210,543	50,860	51,113	-	108,570	-
Foreign Stock	33,722	33,722	-	-	-	-
Domestic Common Stock	460,462	460,462	-	-	-	-
Total	$ 4,476,134	$ 3,235,103	$ 259,967	$ 52,207	$ 326,838	$ 602,019

As of June 30, 2019

		Remaining Maturity (in Months)				
Investment Type	Carrying Amount	12 Months Or Less	13 to 24 Months	25 – 36 Months	37 – 48 Months	More than 49 Months
Equity Based Mutual Funds	$ 2,673,134	$ 2,673,134	$ -	$ -	$ -	$ -
Fixed Income Mutual Funds	199,804	199,804	-	-	-	-
Corporate Bonds	716,638	100,257	202,170	154,292	50,682	209,237
U.S. Government Agencies	597,094	-	-	50,739	-	546,355
U.S. Treasury Note	255,067	49,948	50,420	50,496	-	104,203
Foreign Stock	30,812	30,812	-	-	-	-
Domestic Common Stock	374,695	374,695	-	-	-	-
Total	$ 4,847,244	$ 3,428,650	$ 252,590	$ 255,527	$ 50,682	$ 859,795

4. CASH AND INVESTMENTS – (Continued)

Disclosures Relating to Credit Risk

Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of rating by a nationally recognized statistical rating organization. Presented below is the minimum rating required by the California Government Code and the Plan's investment policy, and the actual rating as of fiscal year end for each investment type.

As of June 30, 2020

Investment Type	Carrying Amount	Minimum Legal Rating	Exempt From Disclosure	Rating as of Fiscal Year End: AAA/AA	A	BBB	Not Rated
Equity Based Mutual Funds	$ 2,267,093	N/A	$ -	$ -	$ -	$ -	$ 2,267,093
Fixed Income Mutual Funds	221,173	N/A	-	-	-	-	221,173
Corporate Bonds	748,676	A	-	263,265	366,190	119,221	-
U.S. Government Agencies	534,465	A	-	51,667	482,798	-	-
U.S. Treasury Note	210,543	N/A	210,543	-	-	-	-
Foreign Stock	33,722	N/A	-	-	-	-	33,722
Domestic Common Stock	460,462	N/A	-	-	-	-	460,462
Total	$ 4,476,134		$ 210,543	$ 314,932	$ 848,988	$ 119,221	$ 2,982,450

As of June 30, 2019

Investment Type	Carrying Amount	Minimum Legal Rating	Exempt From Disclosure	Rating as of Fiscal Year End: AAA	AA	A	Not Rated
Equity Based Mutual Funds	$ 2,673,134	N/A	$ -	$ -	$ -	$ -	$ 2,673,134
Fixed Income Mutual Funds	199,804	N/A	-	-	-	-	199,804
Corporate Bonds	716,638	A	-	-	358,632	358,006	-
U.S. Government Agencies	597,094	A	-	50,739	-	546,355	-
U.S. Treasury Note	255,067	N/A	255,067	-	-	-	-
Foreign Stock	30,812	N/A	-	-	-	-	30,812
Domestic Common Stock	374,695	N/A	-	-	-	-	374,695
Total	$ 4,847,244		$ 255,067	$ 50,739	$ 358,632	$ 904,361	$ 3,278,445

4. CASH AND INVESTMENTS – (Continued)

Concentration of Credit Risk

The investment policy of the Plan contains limitations on the amount that can be invested in any one issuer. There are three investments at June 30, 2020 that represent 5% or more of total Plan investments. These investments are:

1695 shares of IShares S&P 500 Growth Etf valued at $351,696
2795 shares of IShares S&P 500 Value Etf valued at $302,447
6754 shares of Vanguard Ftsc Developed Etf valued at $261,988

There are three investments at June 30, 2019 that represent 5% or more of total Plan investments. These investments are:

1,695 Shares of IShares S&P 500 Growth Etf valued at $303,812
3,245 Shares of IShares S&P 500 Value Etf valued at $378,270
4,275 Shares of IShares Msci Eafe Etf valued at $280,996

Custodial Credit Risk

Custodial credit risk for deposits is the risk that, in the event of failure of a depository financial institution, a government will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The California Government Code and the Plan's investment policy do not contain legal or policy requirements that would limit the exposure to custodial credit risk for deposits, other than the following provision for deposits:

As of June 30, 2020, there were no District deposits with financial institutions in excess of federal depository insurance limits.

The custodial credit risk for investments is the risk that, in the event of the failure of the counterparty (e.g., broker-dealer) to a transaction, a government will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The California Government Code and the Plan's investment policy do not contain legal or policy requirement that would limit the exposure to custodial credit risk for investments. With respect to investments, custodial credit risk generally applies only to direct investments in marketable securities.

4. CASH AND INVESTMENTS – (Continued)

Fair Value Measurements

The plan categorizes its fair value measurements within the fair value hierarchy established by generally accepted accounting principles. These principals recognize a three-tiered fair value hierarchy, as follows

- Level 1: Investments reflect prices quoted in active markets;
- Level 2: Investments reflect prices that are based on a similar observable asset either directly or indirectly, which may include inputs in markets that are not considered active; and,
- Level 3: Investments reflect prices based upon unobservable sources.

The Plan has the following recurring fair value measurements as of June 30, 2020:

		Fair Value Measurement Using		
Investment by fair value	Total	Quoted prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Debt Securities				
US Government Issues	$ 745,008	$ 210,543	$ 534,465	$ -
Corporate Issues	748,676	-	748,676	-
Mutual Funds – Equity	2,267,093	2,267,093	-	-
Mutual Funds – Fixed Income	221,173	25,793	195,380	-
Domestic Common Stock	460,462	460,462	-	-
Foreign Stock	33,722	33,722	-	-
Total	$ 4,476,134	$ 2,997,613	$ 1,478,521	$ -

4. CASH AND INVESTMENTS – (Continued)

Fair Value Measurements – (Continued)

The Plan has the following recurring fair value measurements as of June 30, 2019:

		Fair Value Measurement Using		
Investment by fair value	Total	Quoted prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Debt Securities				
US Government Issues	$ 852,161	$ 255,067	$ 597,094	$ -
Corporate Issues	716,638	-	716,638	-
Mutual Funds – Equity	2,673,134	2,673,134	-	-
Mutual Funds – Fixed Income	199,804	-	199,804	-
Domestic Common Stock	374,695	374,695	-	-
Foreign Stock	30,812	30,812	-	-
Total	$ 4,847,244	$ 3,333,708	$ 1,513,536	$ -

5. ACTUARIAL ASSUMPTIONS

The total pension liability as of June 30, 2020 was determined using the following actuarial assumptions:

Inflation	2.75%
Discount rate	3.77%, net pension plan investment expense, including inflation.
Measurement date	June 30, 2020, based on a valuation date of June 30, 2019.
Ad hoc cost-of-living increases	Not applicable
Mortality	Pre-Retirement: None Post-Retirement: Pub G–2010 Sex distinct mortality tables projected generationally with Scale MP-2018
Experience Study	Given the size of the plan, there is not enough data available to conduct a credible study. The assumptions are not anticipated to produce significant cumulative actuarial gains or losses over time. The liabilities and data are analyzed each year in order to identify any trends of experience deviating from the actuarial assumptions. The plan is frozen to new participants and benefit accruals.
Retirement	100% retirement at age 65.

5. ACTUARIAL ASSUMPTIONS – (Continued)

Termination	Participants* are assumed to work for the Desert Regional Medical Center operated by Tenet Health System Desert, Inc. until Normal Retirement Age.
Other assumptions	See actuarial assumptions provided in the June 30, 2020 funding valuation for other relevant assumptions.

*Former Desert Hospital employees employed with Tenet Health System Desert, Inc.

6. NET PENSION LIABILITY OF THE PLAN

Schedule of Changes in Net Pension Liability and Related Ratios

Total pension liability:	**2020**	**2019**
Service Cost	$ -	$ -
Interest	374,170	385,951
Changes of benefit terms	-	
Differences between expected and actual experience	-	(802,110)
Changes of assumptions	912,601	769,854
Benefit payments, including refunds of member contributions	(208,084)	(511,792)
Net change in total pension liability	1,078,687	(158,097)
Total pension liability – beginning	8,309,530	8,467,627
Total pension liability – ending (a)	$ 9,388,217	$ 8,309,530
Plan fiduciary net position		
Contributions – employer	$ -	$ -
Net investment income	109,665	268,699
Benefit payments, including refunds of member contributions	(208,084)	(511,792)
Administrative expenses	(31,524)	(32,836)
Net change in plan fiduciary net position	(129,943)	(275,929)
Plan fiduciary net position – beginning	4,913,906	5,189,835
Plan fiduciary net position – ending (b)	4,783,963	4,913,906
Net pension liability – ending (a) – (b)	$ 4,604,254	$ 3,395,624
Plan fiduciary net position as a percentage of the total pension liability	50.96%	59.14%
Covered – employee payroll	N/A	N/A
Net pension liability as percentage of covered – employee payroll	N/A	N/A

6. NET PENSION LIABILITY OF THE PLAN - (Continued)

Discount Rate and Net Pension Liability Sensitivity

1. Discount Rate

The discount rate used to measure the total pension liability was 3.77%. The projection of cash flows used to determine the discount rate assumed that plan member contributions will be made at the current contribution rate and that contributions will be made at rates equal to the difference between the actuarially determined contribution rates and member rates. Professional judgement on future contributions has been applied in those cases where contribution patterns deviate from the actuarially determined rates. Based on those assumptions, the pension plan's fiduciary net position was projected to be depleted for current members during the 2037 fiscal year. Therefore, the long-term expected rate of return 6.82% was used to discount funded projected benefit payments and the municipal bond rate 2.45% was used to discount unfunded projected benefit payments to determine the total pension liability. The single effective discount rate was 3.77%.

2. Sensitivity of the Net Pension Liability to Changes in the Discounted Rate

The following presents the net pension liability, calculated using the discount rate of 3.77%, as well as what the net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower (2.77%) or 1-percentage-point higher (4.77%) than the current rate:

	1% Decrease (2.77%)	Current Discount Rate (3.77%)	1% Increase (4.77%)
Net pension liability	$ 5,988,086	$ 4,604,254	$ 3,471,841

Summary

Plan membership

The total pension liability was determined based on the plan membership as of June 30,	2020	2019
Inactive plan members if beneficiaries currently receiving benefits	8	8
Inactive plan members entitled to but not yet receiving benefits	61	61
Active plan members	114	114
	183	183

6. NET PENSION LIABILITY OF THE PLAN - (Continued)

Summary – (Continued)

Net Pension Liability

The components of the net pension liability at June 30,	2020	2019
Total pension liability	$ 9,388,217	$ 8,309,530
Plan fiduciary	(4,783,963)	(4,913,906)
Net pension liability	$ 4,604,254	$ 3,395,624
Plan fiduciary net position as a % of the total pension liability	50.96%	59.14%

Actuarial Assumptions

The total pension liability was determined using the following actuarial assumptions	2020	2019
Inflation	2.75%	2.75%
Salary Increases	N/A	N/A
Investment rate of return	6.82%	6.82%
Discount rate	3.77%	4.56%

7. SUBSEQUENT EVENTS

The Plan evaluated all potential subsequent events as October 13, 2020 when the financial statements were authorized and available to be issued. No subsequent events or transaction were identified after June 30, 2020 or as of October 13, 2020 that require disclosure to the financial statements.

SUPPLEMENTARY INFORMATION

DESERT HOSPITAL RETIREMENT PROTECTION PLAN

SCHEDULE OF FUNDING PROGRESS

JUNE 30, 2020 AND 2019

Actuarial Valuation Date	Actuarial Value of Assets (a)	Actuarial Accrued Liability (AAL) (b)	Unfunded AAL (UAAL) (b-a)	Funded Ratio (a/b)	Covered Payroll	UAAL as a % of Covered Payroll
6/30/2006	$ 5,236,383	$ 9,566,663	$ 4,330,280	55%	N/A	N/A
6/30/2007	N/A	N/A	N/A	N/A	N/A	N/A
6/30/2008	4,552,074	9,312,581	4,760,507	49%	N/A	N/A
6/30/2009	3,351,366	9,141,403	5,790,037	37%	N/A	N/A
6/30/2010	N/A	N/A	N/A	N/A	N/A	N/A
6/30/2011	3,522,125	7,921,342	4,399,217	45%	N/A	N/A
6/30/2012	N/A	N/A	N/A	N/A	N/A	N/A
6/30/2013	2,797,614	7,357,700	4,560,086	38%	N/A	N/A
6/30/2014	2,656,607	10,603,012	7,946,405	25%	N/A	N/A
6/30/2015	2,405,256	10,149,205	7,743,949	24%	N/A	N/A
6/30/2016	1,924,238	11,568,940	9,644,702	17%	N/A	N/A
6/30/2017	5,344,173	8,219,294	2,875,121	65%	N/A	N/A
6/30/2018	5,189,835	8,467,627	3,277,792	61%	N/A	N/A
6/30/2019	4,913,906	8,309,530	3,395,624	59%	N/A	N/A
6/30/2020	4,783,963	9,388,217	4,604,254	51%	N/A	N/A

No actuarial reports or estimation using actuarial methodology were prepared for June 30, 2012, 2010 and 2007.

DESERT HEALTHCARE FOUNDATION

PALM SPRINGS, CALIFORNIA

INDEPENDENT AUDITORS' REPORT AND FINANCIAL STATEMENTS

JUNE 30, 2020 AND 2019

DESERT HEALTHCARE FOUNDATION

TABLE OF CONTENTS

LUND & GUTTRY LLP / CERTIFIED PUBLIC ACCOUNTANTS
36917 COOK STREET • SUITE 102 • PALM DESERT, CALIFORNIA 92211
Telephone (760) 568-2242 • Fax (760) 346-8891
www.lundandguttry.com

INDEPENDENT AUDITORS' REPORT

To the Honorable Board of Directors
of the Desert Healthcare Foundation
Palm Springs, California

We have audited the accompanying financial statements of Desert Healthcare Foundation (Foundation), a not-for-profit organization and a component unit of the Desert Healthcare District, which comprise the statement of financial position, as of June 30, 2020, and the related statements of activities, functional expenses and cash flows for the year 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 of America; 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 audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. 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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Desert Healthcare Foundation as of June 30, 2020, and the changes in its net assets and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated October 13, 2020, on our consideration of the Foundation's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing on internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Foundation's internal control over financial reporting and compliance.

Report on Summarized Comparative Information

The financial statements of Desert Healthcare Foundation for the year ended June 30, 2019 were audited by other auditors whose report dated October 1, 2019, expressed an unmodified opinion on those statements. The summarized comparative information presented herein as of and for the year ended June 30, 2019, is consistent, in all material respects, with the audited financial statements from which it was derived.

October 13, 2020

DESERT HEALTHCARE FOUNDATION

STATEMENT OF FINANCIAL POSITION
JUNE 30, 2020

WITH COMPARATIVE TOTALS FOR JUNE 30, 2019

	Totals	
	2020	2019 (Memorandum Only)
ASSETS		
ASSETS		
Cash and cash equivalents	$ 1,145,289	$ 945,995
Grants receivable	-	1,000,000
Prepaid expenses	3,000	3,500
Accrued interest and dividend receivable	18,931	17,732
Total current assets	1,167,220	1,967,227
OTHER ASSETS		
Contributions receivable - charitable remainder trusts	187,298	189,239
Investments	5,020,682	5,853,791
	5,207,980	6,043,030
TOTAL ASSETS	$ 6,375,200	$ 8,010,257
LIABILITIES AND NET POSITION		
LIABILITIES		
Current liabilities		
Accounts payable and accrued payroll	$ 100,467	$ 70,955
Grants payable - current	2,694,224	3,384,450
Total current liabilities	2,794,691	3,455,405
Long-term liabilities		
Grants payable - long-term	1,600,000	2,260,000
Total long-term liabilities	1,600,000	2,260,000
TOTAL LIABILITIES	4,394,691	5,715,405
NET POSITION		
Without donor restrictions	1,776,489	2,096,517
With donor restrictions	204,020	198,335
Total net position	1,980,509	2,294,852
TOTAL LIABILITIES AND NET POSITION	$ 6,375,200	$ 8,010,257

(The accompanying notes are an integral part of these financial statements)

DESERT HEALTHCARE FOUNDATION

STATEMENT OF ACTIVITIES
FOR THE YEAR ENDED JUNE 30, 2020

WITH COMPARATIVE TOTALS FOR THE YEAR ENDED JUNE 30, 2019

	Without Donor Restricitons	With Donor Restrictions	Totals 2020	Totals 2019 (Memorandum Only)
REVENUES AND GAINS				
Contributions	$ 46,753	$ 26,469	$ 73,222	$ 30,748
Grants and bequests	264,668	-	264,668	1,266,188
Interest and dividends	184,904	-	184,904	115,058
Investment gains (losses)	41,026	-	41,026	386,648
Change in value - charitable trust	-	(1,940)	(1,940)	310
Net assets released from restrictions	18,844	(18,844)	-	-
Total revenues and gains	556,195	5,685	561,880	1,798,952
EXPENSES				
Grants and social services	508,667	-	508,667	1,536,658
Mangement and general	367,556	-	367,556	246,663
Total expenses	876,223	-	876,223	1,783,321
INCREASE (DECREASE) IN NET POSITION	(320,028)	5,685	(314,343)	15,631
NET POSITION, BEGINNING OF YEAR	2,096,517	198,335	2,294,852	2,279,221
NET POSITION, END OF YEAR	$ 1,776,489	$ 204,020	$ 1,980,509	$ 2,294,852

(The accompanying notes are an integral part of these financial statements)

DESERT HEALTHCARE FOUNDATION

STATEMENT OF FUNCTIONAL EXPENSES
FOR THE YEAR ENDED JUNE 30, 2020

WITH COMPARATIVE TOTALS FOR THE YEAR ENDED JUNE 30, 2019

	Grants and Services	Management and General	Totals 2020	Totals 2019 (Memorandum Only)
Grants and social services	$ 508,667	$ -	$ 508,667	$ 1,536,658
Management and general expenses	-	367,556	367,556	246,663
TOTAL FUNCTIONAL EXPENSES	$ 508,667	$ 367,556	$ 876,223	$ 1,783,321

(The accompanying notes are an integral part of these financial statements)

DESERT HEALTHCARE FOUNDATION

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED JUNE 30, 2020

WITH COMPARATIVE TOTALS FOR THE YEAR ENDED JUNE 30, 2019

	2020	2019 (Memorandum Only)
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase (decrease) in net position	$ (314,343)	$ 15,631
Adjustments to reconcile increase (decrease) in net position to net cash provided (used) by operating activities:		
Unrealized gains on investments	(41,026)	(386,648)
Increase (decrease) in operating assets:		
Grants receivable	1,000,000	30,829
Prepaid expenses	500	40
Charitable remainder trusts	1,941	(310)
Accrued interest and dividends receivable	(1,199)	(3,945)
Increase (decrease) in operating liabilities		
Accounts payable and accrued payroll	29,512	(13,025)
Grants payable	(1,350,226)	823,283
Net cash provided (used) by operating activities	(674,841)	465,855
CASH FLOWS FROM INVESTING ACTIVITIES		
Net investment activity	874,135	(2,967,857)
Net cash provided (used) by investing activities	874,135	(2,967,857)
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	199,294	(2,502,002)
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR	945,995	3,447,997
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 1,145,289	$ 945,995

(The accompanying notes are an integral part of these financial statements)

DESERT HEALTHCARE FOUNDATION

NOTES TO FINANCIAL STATEMENTS

JUNE 30, 2020 AND 2019

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Nature of Activities

Desert Healthcare Foundation (Foundation), a not-for-profit organization, is a health and welfare organization created to identify the health care needs of the Desert Healthcare District (District) and to work toward treating those needs through various programs and services. The Foundation is a component unit of the District due to the nature and significance of their relationship with the District. The Foundation operates primarily in the Coachella Valley area of Southern California and, as such, is subject to market conditions, which could affect charitable giving and the realization of recorded asset values at various times.

Basis of Accounting

The Foundation uses the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America. Under this method, revenues are recognized when earned and expenses are recorded at the time liabilities are incurred, regardless of the timing of related cash flows.

Financial Statement Presentation

The accompanying financial statements of the Foundation have been prepared on the accrual basis in accordance with accounting principles generally accepted in the United States of America. Net position and revenues, and gains and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, the net positions of the Foundation and changes therein are classified as follows:

Net position without donor restrictions: Net position that is not subject to donor-imposed restrictions and may be expended for any purpose in performing the primary objectives of the Foundation. The Foundation's board may designate assets without restrictions for specific operational purposes from time to time.

Net position with donor restrictions: Net position subject to stipulations imposed by donors, and grantors. Some donor restrictions are temporary in nature; those restrictions will be met by actions of the Non-Profit Organization or by the passage of time. Other donor restrictions are perpetual in nature, whereby the donor has stipulated the funds be maintained in perpetuity. The Foundation has net position with donor restrictions of $204,020 at June 30, 2020. (See note 6)

Donated Facilities and Services

The District has provided to the Foundation the use of its office facilities at no charge. For the fiscal year ended June 30, 2020 the District allocated to the Foundation $305,676 related to personnel charges. The value of the on-site facilities is not reflected in these statements, as they do not meet the criteria for recognition. (See note 7)

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES – (Continued)

Contributions

Unconditional contributions are recognized when pledged and recorded as net position without donor restrictions or net position with donor restrictions, depending on the existence and/or nature of any donor-imposed restrictions. Conditional promises to give are recognized when the conditions on which they depend are substantially met. Gifts of cash and other assets are reported with donor restricted support if they are received with donor stipulations that limit the use of the donated assets.

When a restriction expires, that is, when a stipulated time restriction ends or a purpose restriction is accomplished, net position with donor restrictions are reclassified to net position without donor restrictions and reported in the statement of activities as net position released from restrictions. Donor-restricted contributions whose restrictions are met in the same reporting period are reported as net position without donor restriction support.

Cash and Cash Equivalents

Cash and cash equivalents include all monies in banks and highly liquid investments with maturity dates of less than three months. The carrying value of cash and cash equivalents approximates fair value because of the short maturities of those financial instruments.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Investments

Investments are stated at fair market value. Realized and unrealized gains and losses on investments are recognized as changes in net assets in the periods in which they occur.

Income Taxes

The Foundation is a not-for-profit organization that is exempt from federal income taxes under Internal Revenue Code Section 501(c)(3), and from California franchise taxes under related state tax regulations and classified by the Internal Revenue Service as other than a private foundation. The Foundation may be subject to tax on income from any unrelated business operations. The Foundation does not currently have any unrelated business operations. The federal and State income tax returns are subject to examination over three and four years, respectively.

Memorandum Totals

The financial statements include certain prior-year summarized comparative information in total but not by net asset class. Such information does not include sufficient detail to constitute a presentation in conformity with generally accepted accounting principles. Accordingly, such information should be read in conjunction with the Foundation's financial statements for the prior year, from which the summarized information was derived.

2. FAIR VALUE MEASUREMENTS

The Foundation applies Generally Accepted Accounting Principles (GAAP) for fair value measurements of financial assets that are recognized or disclosed at fair value in the financial statements on a recurring basis.

GAAP establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that the Foundation has the ability to access at the measurement date.
- Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.
- Level 3 inputs are unobservable inputs for the asset or liability.

The level in the fair value hierarchy within which a fair measurement in its entirety falls is based on the lowest level input that is significant to the fair value measurement in its entirety.

At June 30, 2020, all investments are measured at fair value on a recurring basis and were valued at Level 1 inputs (quoted prices in active markets for identical assets). Fair value for investments at June 30, 2020 was $5,020,682. (See Note 3)

3. CASH AND INVESTMENTS

Demand Deposits

The carrying amounts at June 30, 2020, of the Foundation's cash deposits were $998,358, and money market funds were $146,931. Bank balances were $1,151,126 at June 30, 2020. Occasionally, the Foundation's cash balance in banks exceeds the Federal Deposit Insurance Corporation's insurance limits but management does not expect any significant credit risk relating to cash.

Investments

At June 30, 2020, investments consisted of the following:

	Cost	Fair Value	Unrealized Gain
Corporate bonds	$ 1,481,003	$ 1,581,765	$ 100,762
U.S. Government agencies	1,174,835	1,290,684	115,849
Mutual funds	261,168	269,060	7,892
Marketable securities	1,657,861	1,879,173	221,312
Total Investments	$ 4,574,867	$ 5,020,682	$ 445,815

4. CHARITABLE REMAINDER TRUSTS

The Foundation was named beneficiary to two charitable remainder unitrusts (whose trustees are someone other than the Foundation), all of which are recorded at fair value. The balances at June 30, 2020 amounted to $187,298 and general terms of the trusts are as follows:

Trust 4 (dated October 3, 1989): The lesser of the trust income or 8% of the net fair market value of trust assets is to be distributed to the life beneficiary annually. Upon the death of the life beneficiary, 50% of the principal and income not required to have been distributed to the life beneficiary shall become the property of the Foundation, to be used for cancer treatment, or for general purposes if a cure for cancer has been found. At December 31, 2018, which is the most current information available, the estimated present value of future cash flows was $126,022.

Trust 7 (dated May 17, 1990): 8.5% of the net fair market value of trust assets is to be distributed to the life beneficiary annually. Upon the death of the life beneficiary, all of the principal and income not required to have been distributed to the life beneficiary shall become the property of the Foundation, to be used for general purposes. The estimated present value of future cash flows at June 30, 2020 was $61,276.

5. GRANTS PAYABLE

Grants payable consisted of the following for the fiscal years ended June 30:

	2020	2019
Behavioral Health Initiative Collective Fund	$ 1,952,000	$ 1,985,200
Avery Trust – Pulmonary	919,801	1,000,000
West Valley Homelessness Initiative	711,383	2,125,712
East Valley Grant Funding	419,156	225,000
Grant for Swim Lessons	174,279	70,573
Grant for Health Portal	110,105	131,898
Galilee Center – Emergency	7,500	41,250
California Endowment and School District	-	64,817
	$ 4,294,224	$ 5,644,450

6. NET POSITION – WITH DONOR RESTRICTIONS

Donor restricted net position consists of the following purposes as of June 30:

	2020	2019
Subject to expenditure for specified purpose:		
Summer Homeless Survival Fund	$ 16,722	$ 9,096
Charitable Remainder Trust	126,022	126,022
	142,744	135,118
Subject to the passage of time:		
Charitable Remainder Trust	61,276	63,217
Net Position – with donor restrictions	$ 204,020	$ 198,335

7. RELATED PARTY TRANSACTIONS

The Foundation and the Desert Healthcare District are related parties. The Foundation is organized to provide health and welfare assistance to Coachella Valley residents in need. The District donated funds of $200,000 to the Foundation during the year ended June 30, 2020 to help fulfill their purpose. The District also provided the Foundation with office space and personnel of $305,676.

8. LIQUIDITY AND AVAILABILITY

Financial assets available for general expenditure, that is, without donor or other restrictions limiting their use, within one year of June 30 are as follows:

	2020	2019
Financial assets:		
Cash	$ 1,145,289	$ 945,995
Investments	5,020,682	5,853,791
Grants receivable	-	1,000,000
Accrued interest and dividend receivable	18,931	17,732
Contributions receivable – CRT	187,298	189,239
Total financial assets	6,372,200	8,006,757
Less financial assets held to meet donor-imposed restrictions:		
Purpose-restricted net assets (Note 5)	(4,294,224)	(5,644,450)
Interest in charitable remainder trust (Note 4)	(187,298)	(189,239)
Donor-restricted funds (Note 6)	(16,722)	(9,096)
Amount available for general expenditures within one year	$ 1,873,956	$ 2,163,972

The above table reflects donor-restricted and board-designated funds as unavailable because it is the Foundation's intention to invest resources for the long-term support of the organization. However, in the case of need, the Board of Directors could appropriate resources from the purpose-restricted funds available for general use. As part of the Foundation's liquidity management plan, they invest cash in excess of daily requirements in short-term investments (Note 3).

9. UNCERTAINTIES

As a result of the COVID-19 coronavirus pandemic, economic uncertainties have arisen which could have an impact on the operations of the Foundation. The related financial impact and duration cannot be reasonably estimated at this time.

10. SUBSEQUENT EVENTS

The Foundation evaluated all potential subsequent events as of October 13, 2020 when the financial statements were authorized and available to be issued. No subsequent events or transactions were identified after June 30, 2020 or as of October 13, 2020 that require disclosure to the financial statements.

DESERT HEALTHCARE
DISTRICT & FOUNDATION

Date: October 27, 2020

To: Board of Directors

Subject: Las Palmas Medical Plaza (LPMP) Landscape Renovation and Fire Alarm Electrical Bid Update

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Staff Recommendation: The rebid process for the LPMP Landscape Renovation and Fire Alarm Electrical project is underway and anticipated to be brought to the Finance & Administration Committee and Board of Directors in November 2020 (informational).

Background:

- The Las Palmas Medical Plaza is a medical office building owned and operated by the Desert Healthcare District.
- Over the years, the landscaping at LPMP has experienced challenges and deterioration, mostly due to the drought conditions, which required removal of grass and irrigation issues.
- Recently, the fire sprinkler infrastructure was installed at LPMP, which damaged more of the plant life on Tachevah.
- The Board approved the Landscape Plans, Cost Estimates, and Phasing Plan prepared by a local landscape design architect at the March 24, 2020 meeting.
- The Cost Estimate was $313,000 for labor and materials for the landscape component.
- An electrical component, which also needs to be completed per city requirements, was added to the project for the electrical connection of the fire alarm system of the six buildings.
- Staff and the architect, Chris Mills, believed it was best to enlist a general contractor due to the nature of the medical plaza with heavy vehicle and pedestrian traffic.
- For a general contractor with a Class B license, the estimate could be over $400,000.
- On October 6, 2020, a public bid opening was held with four (4) sealed bids received.
- The bids ranged from $386,700 to $1,222,000, with the second low bid at $565,000.
- The Bid Results Tabulation is included in the packet.
- A review of the low bidder's bid documents determined the contractor possesses a Class C27 (landscaper) contractor's license, not the Class B general contractor's license that was a requirement in the bid documents. Therefore, the bid was rendered non-responsive.
- Staff met with District counsel, Jeff Scott, and the architect to discuss possible options. The following options were discussed.

A. Reject the low bid and accept the second low bid of $565,000, which is substantially higher than the estimate of $400,000.

B. Reject all bids and rebid the project with separate landscape and electrical contractors.

   Pro: This could create a lower cost overall.

   Cons:
   1) A significant risk exists with the coordination of the electrical connection component and the landscape work, presenting the possibility of one contractor pointing the finger at the other for possible errors.

   2) The oversight of a general contractor with regard to the traffic at the medical plaza would be significantly lost.

C. Reject all bids and rebid the project with similar specifications, including the Class B licensed contractor and combined landscape renovation and fire alarm electrical connection.

   Pro: Confidence of a coordinated effort to complete both components of work with the oversight of a general contractor.

   Con: Potentially result in cost greater than the estimate of $400,000. However, there is the possibility that contractors may reduce their bid to remain competitive.

- At the October 13, 2020 Finance & Administration Committee meeting, the Committee reviewed the request and approved Staff's recommendation of Option C to reject all bids and perform a rebid.
- Staff confirmed with the District's legal counsel to move forward with the rebid process.
- A Notice inviting Bids was released on October 16th, 2020 with a public bid opening at 2:00pm on November 4, 2020.

Fiscal Impact:
Estimated Cost presently unclear, but could be in the $450,000 to $550,000 range.

Bid Tabulation

LPMP Landscape Renovation & Fire Alarm Electrical

Desert Healthcare District — **October 6, 2020**

Bidder	Base Bid	Alternate 1	Add	W/C	Bond	Subs	N/C	Iran
THREE PEAKS	1,222,000	81,000	X	X	X	X	X	X
FAST TRACK CONST	596,000	54,000	X	X	X	X	X	X
CONSERVE LANDSCAPE	386,700	84,900	X	X	X	X	X	X
MARUHA	565,000	103,350	X	X	X	X	X	X

COACHELLA VALLEY ASSOCIATION OF GOVERNMENTS
73-710 Fred Waring Dr., Suite 200, Palm Desert, CA 92260 · (760) 346-1127 · www.cvag.org
CVAG

Date: October 9, 2020

DHCD Progress Report #2020-3 for reporting period July 1, 2020 to September 30, 2020

Grantee: Coachella Valley Association of Governments (CVAG)

Project Title: CV Link Project

Project Manager/ Contact: Martin Magaña, CVAG Director of Transportation (mmagana@cvag.org) or Erica Felci, Assistant to the Executive Director (efelci@cvag.org)

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1. Provide a brief summary of the organization and the objectives of the project.

The Coachella Valley Association of Governments (CVAG) is a regional Joint Powers Authority that serves the nine cities, the County of Riverside, and three Indian Tribes within the Coachella Valley. CVAG's jurisdiction stretches across eastern Riverside County, and its membership includes the City of Blythe on the California-Arizona border.

CV Link is an alternative transportation corridor that runs generally along the levee of the Whitewater River that will ultimately stretch from the northwest corner of the CVAG area (Desert Hot Springs) to the southeast corner (the Salton Sea). The core project will generally stretch from the City of Palm Springs to the City of Coachella. The project approved under the Final Environmental Impact Report is more than 40 miles but does not extend through the Cities of Rancho Mirage or Indian Wells. It will provide significant environmental, health, and economic benefits to generations of current and future residents and visitors. CV Link will connect users to employment centers, shopping centers, schools, and recreational opportunities. Dual paths are planned to accommodate bicycles, low-speed electric vehicles and pedestrians. This alternative transportation corridor will enable healthier lifestyles, spur economic innovation, and make the Coachella Valley a more sustainable and appealing place to live, work and play.

2. Summarize work completed during reporting period.

The third quarter of 2020 continued the project's momentum.

In July, the City of Palm Desert approved a construction contract with Granite Construction Company for the part of the CV Link route that runs on-street in the City. This portion runs along Painters Path from the Bump and Grind trail head to Park View Drive; Park View Drive from Highway 111 to Monterey Avenue; Monterey Avenue from Park View Drive to

Magnesia Falls Drive; and Magnesia Falls Drive from Monterey Avenue to Deep Canyon Road. The contract was for $5.58 million, plus contingency. The city conducted its bidding according to the terms of a cooperative agreement between CVAG and the City, which means that CVAG reimburses the City for the work.

Construction in Palm Desert commenced in September 2020. Project signs identify several funding sources being used for that segment, including the Desert Healthcare District/ Foundation and the South Coast Air Quality Management District.

CVAG this quarter also completed the bidding process for the remainder of the 2020 construction plans. Since CVAG received an allocation of $29.447 million in Active Transportation Program and State Transportation Improvement Program for construction of CV Link from the California Transportation Commission (CTC) in January of this year, CVAG has been working with their construction manager, Anser Advisory Group, to prepare the construction plans for the next segment of CV Link to go out to bid. This encompasses about 13.5 miles in the cities of Palm Springs, Palm Desert, La Quinta, Indio, and Coachella as well as unincorporated Riverside County. In addition, CVAG identified three bid alternatives that add additional miles onto the contract, dependent on finalizing right-of-way approval with the State.

Six bids were received by the August 10th deadline, with four of them competitively priced. Based on a review of the bid amounts and required, CVAG has issued an intent to award a contract to Ames Construction, Inc. In order to approve the contract, as well as take some related actions related to construction progress, CVAG has announced a special joint meeting of the Executive and Transportation Committees that will be held by Zoom on October 19th at 4:30 p.m.

These miles will be completed over the next 18-to-24 months and will provide additional access to the 3.5 miles of the project that have already been built in the cities of Cathedral City and Palm Springs. At the same time, CVAG continues to work with the County of Riverside's Economic Development Agency (EDA) on acquiring right-of-way for the remainder of the project. CVAG has obtained additional right-of-way in this reporting period, which is what allows for the previously mentioned bid alternatives.

3. What challenges and opportunities have you encountered in accomplishing this portion of your Scope of Work?

Right-of-way continues to be a lengthy process, particularly in terms of finalizing easements for access on land owned by tribal allottees. CVAG and our partners continue to make headway through this complicated process, and CVAG secured easements and access to several additional parcels in the third quarter of 2020. CVAG is now working with Caltrans

to finalize another right-of-way certification, which can allow CVAG to add additional miles as identified in the contract bid alternatives.

The COVID-19 pandemic continues to create unique working conditions. CVAG staff has started to transition back into the office. But even though most of the team is working remotely, the project was not stalled or delayed. CVAG is highly mindful that keeping large construction projects like CV Link on schedule is an important part of helping the economy rebound. This unprecedented public health crisis also further demonstrated how vital it is for our community to have access to safe routes for walking, biking, or riding in golf carts and low-speed neighborhood electric vehicles. Projects like CV Link are wide enough to allow for social distancing while encouraging people, who are wearing facial coverings, to get out and stay active and stay healthy. CVAG staff anticipates coming back to work in the office on a limited basis and will provide an update on this in the next quarterly report.

4. Is your project on schedule?

Yes. The project schedule was revised with the CTC in January 2020 to establish a segmenting plan. CVAG's schedule called for about seven miles to be built this year. With the October 19 contract award, CVAG will be starting construction on more miles than initially anticipated in 2020.

5. Provide an update on the financial report for the project.

CVAG has funding commitments from an array of sources, which is reflective of the broad support the project has. That includes:

State Active Transportation Program:	$21,692,000
CVAG Transportation Funds:	$20,000,000
State Transportation Improvement Program:	$18,655,000
South Coast Air Quality Mitigation District:	$17,400,000
Federal Congestion Mitigation and Air Quality:	$12,600,000
Desert Healthcare District:	$10,000,000
California Strategic Growth Council:	$1,000,000
Riverside County Parks:	$750,000
Bicycle Transportation Account Grant:	$748,500 (secured w/Cathedral City)
Caltrans Environmental Justice Grant:	$291,000 (secured w/Palm Desert)

6. Work planned for next reporting period.

In the next reporting period, CVAG anticipates the following milestones:

1. Continue construction in the City of Palm Desert for approximately 3 miles of CV Link that are along city streets.

2. Award a contract for work on the next segment of CV Link: 13.5 miles in the cities of Palm Springs, Palm Desert, La Quinta, Indio, and Coachella as well as unincorporated Riverside County. In addition, the contract will identify three bid alternatives that add additional miles onto the contract, dependent on finalizing right-of-way approval with the State.

3. Start construction on the additional construction work valley wide.

4. Acquire additional right of way for future segments of CV Link.

With progress continuing, CVAG anticipates that the FY 2020/2021 invoice to the DHCD will reflect construction-related expenses. As always, CVAG welcomes input on any of these issues, as your feedback as a participatory partner in the project is important to our progress and the finalization of the right of way and construction of CV Link.

Because the COVID-19 pandemic has altered working conditions, CVAG staff continues to work both in-office and remotely. Martin Magaña, Transportation Director can best be reached at (760) 831-3215 or at mmagana@cvag.org and Erica Felci, Assistant to the Executive Director, can also be reached at (760) 534-1546 or at efelci@cvag.org.

LAW OFFICES OF

JEFFREY G. SCOTT

16935 WEST BERNARDO DRIVE, SUITE 170
SAN DIEGO, CA 92127

(858) 675-9896
FAX (858) 675-9897

JEFFREY G. SCOTT

Of Counsel
JAMES R. DODSON

DATE: October 22, 2020

TO: Board of Directors
Conrado Barzaga, Chief Executive Officer
Chris Christensen, Chief Administrative Officer

FROM: Jeffrey G. Scott, General Counsel

RE: Legislative Report – Governor Finishes Taking Actions on Bills

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The 2019/2020 session is now officially over ending one of the strangest years on record. The Governor had 513 bills reach his desk--signing 457 and vetoing 56. There were not many surprises in the actions he took but, in reading some of the messages on the bills he vetoed, the Governor noted the costs associated with the bills. This is a cautious note looking ahead to next year and the continued budget deficit that will undoubtedly be at the center of discussions in 2021. Below is a recap of bills discussed over the year and their outcome.

SB 855 (Wiener) – Signed by the Governor – This bill significantly expands what mental health and substance use disorders are considered "medically necessary." Current law requires health plans to cover medically necessary treatment of just nine serious mental illnesses; the new law would expand that coverage to include a much broader array of mental health issues and substance use disorder conditions under the same terms and conditions applied to other medical conditions. The law would also prohibit a health plan or disability insurer from limiting benefits or coverage for mental health and substance use disorder to short-term or acute treatment.

AB 2537 (Rodriguez) – **Signed by Governor** - This is one of the PPE bills that would require hospitals by January 1, 2021, to keep an inventory of PPE equivalent to three months of normal consumption. PPE is defined as N95 filtering facepiece respirators; powered air-purifying respirators with high efficiency particulate air filters; elastomeric air-purifying respirators and appropriate particulate filters or cartridges; surgical masks; isolation gowns; eye protection; shoe coverings.

SB 275 (Pan) – **Signed by Governor** - This is the other PPE bill that requires hospitals by January 1, 2023, to have 45 days of PPE for surge consumption during a health emergency or pandemic. Surge consumption is not defined. The bill does call for a committee to be formed that will advise the Department of Public Health on the various types and amount of PPE to be required during a health emergency.

- The timelines on the two PPE bills are slightly different so the provisions in AB 2537 (Rodriguez) will start first and then will be updated when the regulations are put in place as the result of SB 275 (Pan)

AB 890 (Wood) – **Signed by Governor** - This bill would allow nurse practitioners to practice without physician supervision when meeting certain qualifications. This bill was one of the most lobbied bills in the health care area at the end of session with numerous physician groups opposing. This same bill has been defeated multiple times over the past eight years. This year, legislators seemed to be swayed by arguments that the bill would help improve access to care in rural areas.

SB 852 (Pan) – Signed by Governor –In January 2020, the Governor put forward his desire to leverage California's purchasing power to increase generic drug manufacturing as one solution to the prescription drug affordability crisis. The state has already begun to identify potential target medications and develop a strategic plan to promote state-led generic drug purchasing and manufacturing. This law allows the California Health and Human Services Agency (CHHS) to develop manufacturing partnerships to produce or distribute generic prescription drugs, making essential medications affordable and accessible to more patients. The Governor stated, "It would also inject much needed competition into markets that have driven up prices for consumers and help address critical drug shortages."

SB 1159 (Hill) – **Signed by Governor** - This bill codifies the Governor's executive action stating if an employee contracted COVID before July 6, 2020, it would be presumed to have occurred at work. For situations after July 6, 2020, the bill would say for certain front-line health care workers such as firefighters, EMTs, paramedics, physicians, and nurses in certain health facilities who tested positive, the presumption would continue to be they contracted COVID at work. For employees who are not covered by the above, the presumption would apply if there was an "outbreak" at the employer. Outbreak is defined as:

- 4% of the workforce tested positive for employers with 100 or more employees, or
- More than 4 employees test positive for employers with less than 100 employees

AB 685 (Reyes) – Signed by Governor - This bill requires employers to take the following actions within one business day upon notification of an employee testing positive including:

- Provide written notice to all employees;

- Provide all employees who have been exposed with information regarding all COVID-19 related benefits the employee may be entitled;
- Notify all employees on disinfection and safety plan the employer plans to implement per CDC guidelines.

The bill also requires, if three workers test positive within 14 days, which is the Public Health definition of an outbreak, the employer must report it to the local public health department.

AB 1867 (Committee on Budget) – **Signed by Governor** - This bill was a last minute "gut and amend" that would require hospitals to provide COVID-19 supplemental sick leave for food sector workers, active firefighters, and healthcare providers.

AB 992 (Mullin) – Signed by the Governor – This bill relates to public officials' use of social media and amends the Brown Act to clarify that public officials may communicate on social media platforms to answer questions, provide information to the public, or to solicit information from the public regarding matters within the subject matter jurisdiction of the legislative body. However, the latter types of communications are only allowed as long as a majority of the members of the legislative body do not use any social media platforms to "discuss among themselves" official business. According to AB 992, this includes making posts, commenting, and even using digital icons that express reaction to communications (i.e., emojis) made by other members of the legislative body. To do so would be a violation of the Brown Act.

These last two bills below did not make it to the Governor but were significant health bills I wanted to include. I would expect the policy in both of these bills to be reintroduced in 2021.

SB 758 (Portantino) – This is the seismic bill with California Hospital Association (CHA) sponsoring the bill. The author and CHA were not able to get new amendments into the bill after the Assembly Appropriations Committee forced in amendments reducing the extension from seven years to only two years and removing an advisory committee that would have looked at the specific seismic standards to suggest changes. SEIU and the California Nurses Association had been opposing the bill. The author and CHA decided not to pursue this bill and will re-group on pursuing another bill next year. This continues to be a main priority for CHA.

SB 977 (Monning) – This bill did not come up for a vote thus it died. The Attorney General had been working on Assembly members the last week of session but could not get the votes to secure its passage. This bill would have given the Attorney General additional powers to review and possibly deny acquisition or change in control transactions between health care systems and hedge funds or private equity groups.