DESERT HEALTHCARE DISTRICT

DESERT HEALTHCARE DISTRICT
BOARD MEETING
Board of Directors
October 23, 2018
6:00 P.M.

University of California Riverside
Building B – Room B114/117
75080 Frank Sinatra Drive, Palm Desert, California 92211
This meeting is handicapped-accessible

Page(s)	**AGENDA**	***Item Type***
	Any item on the agenda may result in Board Action	

A. CALL TO ORDER – President Zendle, MD

Roll Call

____Director Wortham, DrPH____Director Hazen_____Director Matthews
_____Vice-President/Secretary Rogers, RN _____President Zendle, MD

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 **Action**

All Consent Agenda item(s) listed below are considered to be routine by the 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.

1. BOARD MINUTES

4-10 a. Special Meeting of the Board of Directors – Public Forum - September 25, 2018

11-23 b. Board of Directors Meeting - September 25, 2018

2. FINANCE AND ADMINISTRATION

24-46 a. Approval of September 2018 Financial Statements - F&A Approved October 9, 2018

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F. RESOURCES AND PHILANTHROPY

47-73 1. Consideration to Approve Joslyn Center: Joslyn Wellness Senior Behavioral Health Services Program Grant - $112,050 — **Action**

74-102 2. Consideration to Approve Desert Arc: Desert Arc Healthcare Program Grant - $164,738 — **Action**

103-117 3. Consideration to Approve Ready Set Swim Grant to the Desert Healthcare Foundation - $136,000 — **Action**

G. NEW PROVIDERS, FACILITIES, PROGRAMS, AND SERVICES AD HOC COMMITTEE – Chair/Treasurer Mark Matthews and President Les Zendle

118-246 1. Desert Regional Medical Center Appraisal Report – Colin McDermott, Managing Director, VMG Health — Information & Discussion

H. DESERT HEALTHCARE DISTRICT CEO REPORT – Chris Christensen, Interim CEO

247-250 1. Priorities-Milestones-Progress Measures Update — Information

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

J. DESERT REGIONAL MEDICAL CENTER GOVERNING BOARD OF DIRECTORS' REPORT – President Les Zendle, MD and Vice-President/Secretary Carole Rogers, RN — Information

K. 1. FINANCE, ADMINISTRATION, REAL ESTATE AND LEGAL COMMITTEE – Chair/Director Mark Matthews and Director Jennifer Wortham, DrPH

251-254 a. Minutes of September 11, 2018

255-256 b. CFO Report & Las Palmas Leasing Update

c. FY 2018 Audit Reports — **Action**

257-266
- Management Letter, Communication Letter, Internal Controls Report

267-309
- Desert Healthcare District Audit Report

310-327
- Retirement Protection Plan Audit Report

328-349 d. LPMP Lease Extension – Suite 2W 203 – Desert Family Medical — **Action**

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350-352	e. LPMP Lease Addendums – Dr. Awad	**Action**
353	f. Proposed Vacation Cash Out Option	**Action**
354-355	g. Proposed District & Foundation Alternative Workweek	**Action**

2. HOSPITAL GOVERNANCE AND OVERSIGHT COMMITTEE – Chair/Vice-President Carole Rogers, RN and President Les Zendle, MD

356-361	a. Minutes of September 20, 2018	Information
	b. 2018 Patient Safety and Quality Initiatives	Information
362-375	c. Hospital Safety and Compliance Inspections	Information

4. BOARD AND STAFF COMMUNICATIONS AD HOC COMMITTEE – Chair/Director Hazen and Director Wortham

L. NEW BUSINESS

M. OLD BUSINESS

N. LEGAL COMMENTS & REPORT

376-377	1. AB 2329 - Directors Compensation and Ribakoff Case on Public Comments	Information

O. INFORMATIONAL ITEMS

378-381	1. CV Link Q3 2018 Progress Report	Information

P. DIRECTORS' COMMENTS, REPORTS, & STAFF DIRECTION AND GUIDANCE

382-417	1. Association of California Healthcare Districts (ACHD) 66th Annual Meeting – President Zendle, MD	Information
	2. California Special District Association (CSDA) Annual Conference – Carole Rogers, RN	Information

Q. 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

DESERT HEALTHCARE DISTRICT
BOARD OF DIRECTORS
SPECIAL MEETING OF THE BOARD OF DIRECTORS
September 25, 2018

Directors Present	District Staff Present	Absent
President Zendle, MD Vice-President/Secretary Carole Rogers, RN Treasurer Mark Matthews Director Kay Hazen Director Jennifer Wortham, DrPH	Chris Christensen, Interim CEO, CFO Lisa Houston, COO Donna Craig, Senior Program Officer Alejandro Espinoza, Program Officer and Outreach Director Will Dean, Communications and Marketing Director Stephen Huyck, Accounting Manager Meghan Kane, Community Health Analyst Annalisa Wurm, Health Policy Analyst Andrea S. Hayles, Clerk of the Board Legal Counsel Jeff Scott	Vanessa Smith, Health Educator

AGENDA ITEMS	DISCUSSION	ACTION
A. Call to Order **Roll Call**	President Zendle called the meeting to order at 4:01 p.m. The Clerk of the Board called the roll with all Directors present except for Director Matthews. Director Matthews arrived at 4:07 p.m.	
C. Approval of Agenda	President Zendle asked for a motion to approve the agenda.	**#18-98 MOTION WAS MADE by President Zendle and seconded by Vice-President Rogers to approve the agenda.** **Motion passed unanimously.**
D. Public Comment	None	
E. Convene to Closed Session of the Desert Healthcare District Board of Directors REPORT INVOLVING TRADE SECERTS pursuant to Health & Safety Code 32106 – concerning proposed new facilities, programs, and services. (Discussion only, no action will be taken). Estimated		

dated of public disclosure: March 2019.		
F. Reconvene to Open Session of the Desert Healthcare District Board of Directors		
G. Report After Closed Session	The Board in closed session discussed potential providers, facilities, programs, and services in the context of an expanded District and took no action.	
H. Public Forum **1. Desert Healthcare District Education Forum on Expansion in the Eastern Coachella Valley**	Chris Christensen, Interim CEO, gave a presentation on Measure BB – the proposed expansion outlining the District's mission and vision, grant funding, the three-year strategic plan and priorities, healthcare disparities, significant issues affecting the Coachella Valley, the annexation/expansion timeline, and a map of the proposed area. **Public Comments** Steve Brown, City Councilmember, City Coachella, explained that the City of Coachella appreciates the work of the Board to move the Measure to the ballot. The city will provide a resolution of support for the measure. Linda Evans, Mayor, City of La Quinta also confirmed the city will provide a resolution of support. Leticia Delara, CEO, Regional Access Project (RAP) Foundation, explained that RAP is appreciative of the Board, Staff, and the District and described the letter of support RAP Foundation provided during the process, and once again thanked the Board.	

	Michele Finney, CEO, Desert Regional Medical Center, Desert Care Network, provided a letter of support to the District. Mrs. Finney read the letter indicating Tenet's support of the expansion early on to connect residents to programs and services in the expanded boundaries. (See attached letter of support). Councilmember Shelley Kaplan inquired on the population in the current district versus the proposed expanded area. Chris Christensen, Interim CEO, explained that the current boundary population is 200,000 and the expanded boundary population would be 240,000 – 1,760 square miles. Ezra Kaufman, District Resident, inquired on the District's Fact Sheet insert in the Strategic Plan's 2017-2020 brochure that states *the residents voted to lease to the hospital to for-profit Tenet Healthcare*. Jeff Scott, Legal Counsel, explained that the District residents did not vote to lease the hospital to Tenet, it was determined that the language is incorrect, and Mr. Christensen stated that Staff would make the appropriate correction. Mr. Kaufman asked Mr. Christensen to elaborate on the history and the extent of the robust lease compliance process with Tenet to ensure transparency for the public. President Zendle explained that the Tenet lease is not the current topic of the public forum and Mr. Kaufman is welcome to inquire during the 6 p.m. Board of Directors meeting.	

	Mr. Kaufman explained that he believes the expansion is about capturing 100% of parcels to pay for the fact that the district only has approximately $33M at its disposal to rebuild facilities. Further, Mr. Kaufman explained that according to the Riverside County Assessor, the District would raise $9M at $100 per parcel tax in the expanded area. The current boundaries have the same valuation with $100 per parcel tax, which equates to $18M per year. If the District is not expanded the parcel tax revenue is approx. $9M per year. Mr. Kaufman explained that the District should be researching lease revenue to pay for the expansion and that no lease revenues for expansion funding should be used. Mr. Christensen explained that Measure BB does not have a funding mechanism, and although all Coachella Valley residents pay the same property tax, there will be no allocation of the expanded area's residents property taxes redistributed to the District. The funding is from the current District resident's property taxes, and the District and Foundation has committed to funding $300k per year to the expansion. Vice-President Rogers described her conversation with Jan Pye, Councilmember, Desert Hot Springs, expressing her desire for assurance that taxpayer funding from the west is not spent on programs in the east. Vice-President Rogers explained the discussion and that the Board would	

	be diligent on spending similar to current funding to organizations such as Martha's Village and Coachella Valley Rescue Mission. Further, Vice-President Rogers confirmed to Councilmember Pye and members of the public that no allocation of West Valley resident's property taxes would be redistributed to the newly expanded area if voters pass the measure. Leticia Delara, CEO, Regional Access Project (RAP) Foundation asked if the measure passes what steps would the Board take to gain input and understand the community needs and how it affects the Strategic Plan. President Zendle explained that Mr. Christensen, Interim CEO, will provide details on the timeline for expanding the Board.	
2. Appointment Process for the Potential of 2 New Directors	Chris Christensen, Interim CEO, described the new Board member appointment process and timeline that would commence with a process of appointment in January 2019. Mr. Christensen also detailed the terms of the resolution to increase the number of Board members effective on the date of and subject to any conditions specified in the resolution. **Public Comments** Kimberly Barranza, District Representative, Assemblymember Eduardo Garcia's Office, expressed her gratitude and that the Assemblymember looks forward to the expansion.	

3. Zone Mapping Process for the Potential New District Boundaries – 7 Zones	Chris Christensen, Interim CEO, explained the most recent rezoning process of the current boundaries, and the timeline (March 2019 – October 2019) and process to increase the zones from 5 to 7 in the proposed expanded area. President Zendle explained that the Board meetings would be moved to a central location in the east possibly at UCR Palm Desert, which is one way that the Board will ensure community input and involvement in the monthly meetings. President Zendle described the two years and four-year terms of the potentially new Board members – a complex process the Board will undertake.	
F. Adjournment	President Zendle adjourned the meeting at 5:52 p.m.	***Audio recording available on the website at http://dhcd.org/Agenda-Board-of-Directors***

ATTEST: _____
Carole Rogers, Vice-President/Secretary
Desert Healthcare District Board of Directors

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

DESERT CARE NETWORK | DESERT REGIONAL MEDICAL CENTER
HI-DESERT MEDICAL CENTER
JFK MEMORIAL HOSPITAL

HEALTH BLOOMS

September 25, 2018

Les Zendle, MD
President, Board of Directors
Desert Healthcare District
1140 N. Indian Canyon Drive
Palm Springs, CA 92262

Re: **Expansion of the Desert Healthcare District – Support of Measure BB**

Dear President Zendle:

This is a letter of support for Measure BB, to expand the access to health care providers and services to connect residents to programs through community-based organizations across all of the Coachella Valley through the expansion of the boundaries for the Desert Healthcare District.

We have been part of the journey to successfully get Measure BB on the ballot this November. Through attendance and participation at the initial meetings with Assemblyman Eduardo Garcia for AB2414, to Special District Board meetings, to Riverside County Board of Supervisors meetings – which included a significant Lease Amendment between Tenet and the District - to the final LAFCO Public Hearing, our support remains strong to ensure access to quality healthcare for all residents.

Through the growth of our services and care delivery system throughout the Desert Care Network, we have always served ALL patient populations; whether indigent, Medi-Cal, Seniors, or insured. We recognize our obligation to meet the needs of the community – our *entire* community – and continue to do so with quality care and positive patient outcomes. The successful passing of Measure BB will allow the Desert Healthcare District to do the same – provide and connect access to care and services to our entire community.

We support the vision for "One Coachella Valley", and will continue to partner in this endeavor to evaluate our valley's health needs, strengthen health outcomes, and engage our residents as we collectively improve the health status of the Coachella Valley. Thank you.

Sincerely,

Michele Finney
CEO, Desert Regional Medical Center
& Group CEO, Tenet SoCal Market

Gary L. Honts
CEO, JFK Memorial Hospital

Cc: Desert Healthcare District Board of Directors
Chris Christensen, Interim CEO, Desert Healthcare District & Desert Healthcare Foundation

DESERT HEALTHCARE DISTRICT

DESERT HEALTHCARE DISTRICT
BOARD OF DIRECTORS
MEETING MINUTES
September 25, 2018

Directors Present	District Staff Present	Absent
President Zendle, MD Vice-President/Secretary Carole Rogers, RN Treasurer Mark Matthews Director Kay Hazen Director Jennifer Wortham, DrPH	Chris Christensen, Interim CEO, CFO Lisa Houston, COO Donna Craig, Senior Program Officer Alejandro Espinoza, Program Officer and Outreach Director Will Dean, Communications and Marketing Director Andrea S. Hayles, Clerk of the Board <u>Legal Counsel</u> Jeff Scott	

AGENDA ITEMS	DISCUSSION	ACTION
A. Call to Order **Roll Call**	President Zendle called the meeting to order at 6:01 p.m. The Clerk of the Board called the roll with all Directors present.	
B. Pledge of Allegiance	President Zendle asked Director Matthews to lead the pledge of allegiance. President Zendle introduced the two candidates for zones 4 – Cathedral City Councilman Kaplan and Community Health Worker Evett Perezgil. President Zendle also explained that Vice-President Rogers' name will not appear on the ballot (no contest) as the elected incumbent.	
C. Approval of Agenda	President Zendle asked for a motion to approve the agenda.	**#18-99 MOTION WAS MADE by Director Matthews and seconded by Vice-President Rogers to approve the agenda.** **Motion passed unanimously.** **AYES – 5 President Zendle, Vice-President Rogers, Director Matthews, Director Hazen, and Director Wortham** **NOES – 0** **ABSENT – 0**

		ABSTAIN – 0
D. Public Comment	No public comment.	
E. Consent Agenda **E.1. Board Minutes** **a. Special Meeting of the Board of Directors – Closed Session – July 24, 2018** **b. Special Meeting of the Board Study Session** **c. Board of Directors Meeting – July 24, 2018** **E.2. a. Approval of July and August 2018 Financial Statements F&A Approved September 11, 2018**	President Zendle pulled item E.1.c. – the minutes of the July 24, 2018 Board of Directors meeting for a correction to the Governing Board of Directors' Report.	**#19-01 MOTION WAS MADE by Vice-President Rogers and seconded by Director Matthews to pull item E.1.c. – the July 24, 2018 Board of Directors Minutes from the Consent Agenda.** **Motion passed unanimously.** **AYES – 5 President Zendle, Vice-President Rogers, Director Matthews, Director Hazen, and Director Wortham** **NOES – 0** **ABSENT – 0** **ABSTAIN – 0** **#19-02 MOTION WAS MADE by Director Wortham and seconded by Vice-President Rogers to approve the changes to the Consent Agenda.** **Motion passed unanimously.** **AYES – 5 President Zendle, Vice-President Rogers, Director Matthews, Director Hazen, and Director Wortham** **NOES – 0** **ABSENT – 0** **ABSTAIN – 0**
F. Resources and Philanthropy **1. Progress and Final Reports on Current Grants**	Donna Craig, Senior Program Officer, described the Progress and Final Reports of the current proactive grant structure that includes Letters of Interest and Grant Applications.	
2. Proposed New Grant Structure	Lisa Houston, CFO, explained the proposed new grant structure as it relates to the three-year Strategic Plan. The new structure includes moving to a quarterly grant cycle,	**#19-03 MOTION WAS MADE by President Zendle and seconded by Vice-President Rogers to approve the proposed new grant structure**

	increased proactive grants driven by initiatives and four new community focus health areas, AB 2019 consideration, and evolving the policies to reflect the new grant structure. Mrs. Houston elaborated on the scoring structure to remove any potential bias such as alignment with the strategic plan, capacity, engagement with Board members and other platforms through the RFP process with a common structure and strategy that will consist of two Board members and community members. Vice-President Rogers expressed her objections to the Board not allowing community members to participate in the grant structure process. Mrs. Rogers explained the Community Advisory Committee at her former board position in northern California as a form of training and mentoring and proposes the inclusion of five community members and five community members to the Finance, Administration, Real Estate, and Legal Committee (F&A). Director Matthews explained the current and prior makeup of the community members of the F&A Committee, stating that he has no issue appointing additional community members. Director Hazen explained the advantages and disadvantages of the new structure – guiding future accomplishments and proactive community engagement. Further,	**and revisit in 6 months for possible modifications.** **Motion passed unanimously.** **AYES – 4 President Zendle, Vice-President Rogers, Director Matthews, and Director Hazen** **NOES – 0** **ABSENT – Director Wortham** **ABSTAIN – 0**

	Director Hazen explained that the scoring structure is different than in the past and possibly requires a broader view of the scoring that would be advantageous to include community input for gaining insight; reviewing the options and discussing assignments for point value and criteria. Director Hazen stated that the structure is a complex system and she is concerned about the Staff capacity and execution due to the lengthy process. Director Wortham exited the meeting at 6:27 p.m.	
3. Consideration to Approve Grant #974 – Health Assessment and Research for Communities (HARC): 2019 Coachella Valley Community Health Survey - $399,979 with contingencies over a maximum of three (3) years to cover the costs of developing the triennial survey.	Donna Craig, Senior Program Officer, described the Health Assessment and Research for Communities (HARC) application for $399,979 for three years to cover the costs of the Community Health Monitor that the District has supported in the past with a difference in funding for this grant that includes five contingencies. Janet Collins, board president, HARC, explained that as the prior Chronic Disease Director, Center or Disease Control and Prevention (CDC), she is amazed by the local data in the Valley to help, design, focus, and identify at-risk populations. The partnership will continue to grow over time with the interaction between the District and HARC. Karen Borja, board member, HARC, detailed her prior work with HARC data such as the revisions to the	**#19-04 MOTION WAS MADE by Director Wortham and seconded by Director Matthews to approve Grant #974 – Health Assessment and Research for Communities (HARC): 2019 Coachella Valley Community Health Survey Motion passed unanimously.** **AYES – 4 President Zendle, Vice-President Rogers, Director Matthews, Director Hazen, and** **NOES – 0** **ABSENT – Director Wortham** **ABSTAIN – 0**

	North Shores Sunline Transit Agency route to assist with transportation needs in the east valley. Ms. Borja also explained the various requests from students for health data that she helps in connecting to HARC's annual report. Teresa Hodgkins, board treasurer, HARC, explained the vital support of the District for the survey to point to the needs of the community. Bill Ballas, board member, HARC, and CEO of Help to Hope Clinics, commended the District for investing in the project that will produce greater results in the future as outlined in the proposed proposal. Brett Klein, Clinics Marketing Specialist, Eisenhower Medical Center, explained that Eisenhower is in favor of the grant and the data. Mr. Klein has worked with HARC and other agencies over the years whose data has helped train and assist physicians in programs and improve the communities understanding of the need based on the data.	
4. Ready Set Swim to Desert Recreation District Update	Lisa Houston, COO, described the preliminary aspects of working with Desert Recreation District to take possession of the Ready Set Swim grant program; however, due to the 30% indirect costs that are above the government standard of operating costs, Staff requests not moving forward and suspending	

	the program for the 2017-2018 year. Mrs. Houston requests board guidance on the next steps. Director Hazen inquired on the impact of continuing with the grant, which would require adjustments in District staffing and reallocations to staffing time. Director Hazen suggested that the District continue with the program while searching for a new operator, contractor, sponsor, or partnership that the District has done in the past and maintain program operations while continuing to search. Director Matthews expressed his concern with underlining financial matters at the Desert Recreation District and the District paying the Desert Recreation District to fulfill the obligation – expressing that he will not support the program and prefers the $110,000 funding for 2017/2018.	**#19-05 MOTION WAS MADE by Director Hazen and seconded by Vice-President Rogers to authorize up to $145,000 – the current level of funding to continue to invest in the Ready, Set, Swim program. Motion passed 3-1.** **AYES – 3 President Zendle, Vice-President Rogers, and Director Hazen** **NOES – Director Matthews** **ABSENT – Director Wortham** **ABSTAIN – 0**
G. Desert Healthcare District CEO Report **1. Priorities-Milestones-Progress Measures Update** **2. November 27 and December 18 Holiday Schedules**	Chris Christensen, Interim CEO, summarized the updates of the Priorities, Milestones, and Progress Measures also explaining that work continues with the potential expansion. Chris Christensen, Interim CEO, explained the upcoming holiday season and outlined the November meeting date the week after Thanksgiving, and proposing the December 18 meeting due to the December 25 Christmas holiday.	

H. Desert Regional Medical Center Governing Board Report	President Zendle explained that the Governing Board reviewed and discussed the open and closed cases from the California Department of Public Health, evaluated the quality measures focusing on three components, and the review of credentialing and re-credentialing.	
I. Desert Regional Medical Center CEO Report – Michele Finney, CEO, Desert Regional Medical Center, Desert Care Network	Michele Finney, CEO, Desert Regional Medical Center, Desert Care Network, described several updates at Desert Regional Medical Center (DRMC) that include the capital investment of a new less invasive pacemaker; expansion in the GI lab such as additional ultrasounds; more treatment bays were approved and licensed; licensure related to cardiac patients in the Stergios Building; new surgical robots; Governance Committee conversations for additional resources for medically trained individuals with the hearing-impaired community; and two new urgent care centers. As reported last month, the Chief Nursing Officer (CNO) transferred to the Bay Area, and DRMC recruited an internal transfer from AZ that will begin as the new CNO in October. Details about the second patient safety officer hiring were provided. $5M for capital expenditures and completing the physical plan assessment in the next month were detailed, and the completion of rebuilding the Sinatra One elevator and the repairs for Sinatra Five are underway.	

I. Finance, Administration, Real Estate, and Legal Committee		
a. CFO Report & Las Palmas Leasing Update	Director Matthews outlined the CEO Report and Las Palmas Leasing Update.	
b. District and Desert Hospital Retirement Plan (RPP) Investment Report 2Q18	Director Matthews also described the aspects of the District and Hospital Retirement Plan Investment Report and the Retirement Protection Plan Actuarial Valuation Report as of June 30, 2018.	
c. Retirement Protection Plan Actuarial Valuation Report – 06/30/18		
d. Kaufman Hall Service Agreement Addendum #2	Director Matthews explained the coordination of work between Kaufman Hall and Desert Regional Medical Center on the seismic upgrade requirements due by 2030 and the valuable work of Kaufman Hall to extend those services with a second addendum.	**#19-06 MOTION WAS MADE by Director Matthews and seconded by Vice-President Rogers to approve the Kaufman Hall Service Agreement Addendum #2.** **Motion passed unanimously.** **AYES – 4 President Zendle, Vice-President Rogers, Director Matthews, Director Hazen, and** **NOES – 0** **ABSENT – Director Wortham** **ABSTAIN – 0**
e. Auditor Firm 5 Year Consideration for RFP	Director Mathews explained that normally after 5 years the District would begin an RFP process for a new firm. However, due to the extensive work the District is undertaking such as the expansion and rezoning, the F&A Committee feels that a one-year extension of the current firm is adequate. Vice-President Rogers requested that at some point the auditing firm give an in-person overview to the full board.	**#19-07 MOTION WAS MADE by Director Matthews and seconded by Vice-President Rogers to approve a one-year extension of the current firm until the end of the November election.** **Motion passed unanimously.** **AYES – 4 President Zendle, Vice-President Rogers, Director Matthews, and Director Hazen** **NOES – 0** **ABSENT – Director Wortham** **ABSTAIN – 0**

f. Proposed Desert Healthcare District Hours of Operation	Chris Christensen, Interim CEO, explained the discussion amongst staff for a possible 9/80 or 4/10 schedule as outlined in the Staff Report options including the positive aspects of an alternative workweek. The F&A Committee recommended a 4/10 workweek instead of alternating staff schedules and office hours that could potentially confuse the public. Director Matthews moved to approve the proposed hours of operation and re-evaluate the policy in one year. Questions concerning mandatory participation in a 9/80 or 4/10 schedule for exempt and non-exempt staff was discussed and agreed upon to table the matter until Staff brings forth a policy for Board review.	**#19-08 MOTION WAS MADE by Director Matthews and seconded by Vice-President Rogers to table the proposed District Hours of Operation and for Staff to present a policy with a one-year trial. Motion passed unanimously. AYES – 4 President Zendle, Vice-President Rogers, Director Matthews, and Director Hazen NOES – 0 ABSENT – Director Wortham ABSTAIN – 0**
J. 2. Hospital Governance and Oversight Committee **1. Desert Regional Medical Center 2017-2018 Annual Report**	Vice-President Rogers explained Desert Regional Medical Center's 2017-2018 Annual Report that was presented to the Hospital Governance and Oversight Committee – a lease compliance requirement.	
J.3. New Providers, Facilities, Programs, and Services Ad Hoc Committee **1. Phase O Seismic Results Presentation and Phase 1 Updated – Kevin Moore, Senior Principal, Simpson, Gumpertz & Heger (SGH)**	Chris Christensen, Interim CEO, explained that Phase 0 has been completed with the estimated costs and introduced Kevin S. Moore, Senior Principal, Simpson, Gumpertz & Heger (SGH). Kevin S. Moore, Senior Principal, SGH, described his report on Desert Regional Medical Center's seismic results explaining that most of the hospital is compliant. Mr. Moore	

	outlined the structural building challenges of Desert Regional Medical Center and the retrofit due by 2030.	
J.4. Board and Staff Communications Ad Hoc Committee	Director Hazen explained the role of the Committee and the comprehensive and broad framework to strengthen Board and Staff communications. Director Hazen requested that Staff develop a workshop/special meeting of the board in October to review the policies for improved content and new suggestions. The workshop will set aside time for a full discussion and Board input.	
K. New Business		
1. Chief Executive Officer Recruitment Process	Chris Christensen, Interim CEO, explained the potential for new board members, outlined the timeline and process for recruiting the new CEO, and proposed waiting until the first of the year to bring forth an executive search firm to recruit a new CEO. The Board acknowledged that the CEO may have a new set of expectations, recommends a firm that specializes in special districts, and to wait for the new board to make the final determination.	**#19-09 MOTION WAS MADE by President Zendle and seconded by Director Hazen to approve waiting until the new board is seated and bring back a timeline in January 2019 with recommendations for a search firm.** **Motion passed unanimously.** **AYES – 4 President Zendle, Vice-President Rogers, Director Matthews, and Director Hazen** **NOES – 0** **ABSENT – Director Wortham** **ABSTAIN – 0**
2. Board Meeting Schedule	Chris Christensen, Interim CEO, explained that due to the rezoning and expansion the District moved to the 6 p.m. start time to allow more public accessibility to the meetings. Staff requests consideration to revise the Board meeting start time to 4 p.m., which	**#19-10 MOTION WAS MADE by Director Hazen and seconded by Director Matthews to table changing the Board meeting schedule time change until the new Board members can participate in the discussion.** **Motion passed unanimously.**

	would still allow for public participation. Director Hazen cautioned that the meeting time change may be difficult for the public to attend. The change to 6 p.m. was to increase engagement from the public. The new Board members may not agree and determine that the 6 p.m. time will suffice, which could potentially change again – reiterating that now is not the time to change the meeting schedule. Bruce Underwood, Board Member, Coachella Valley Cemetery District and Desert Recreation District, explained that most public participants are unable to attend before 5 p.m. – also taking commute time into account.	**AYES – 4 President Zendle, Vice-President Rogers, Director Matthews, Director Hazen, and** **NOES – 0** **ABSENT – Director Wortham** **ABSTAIN – 0**
L. Old Business **1. Communications and Marketing Plan**	Will Dean, Director Communications and Marketing, described the Communications and Marketing Plan that has been revised to lay the foundation for a robust communications and marketing system. The plan includes individual projects with staff recommendations for approval. Director Hazen explained that the plan is a good framework, but internal communications should be included in the plan. Director Hazen suggested possibly having a separate plan for internal communications that outlines internal communications for staff to stay informed. Further, Director	**#19-11 MOTION WAS MADE by Director Hazen and seconded by Vice-President Rogers to approve the Communications and Marketing Plan.** **Motion passed unanimously.** **AYES – 4 President Zendle, Vice-President Rogers, Director Matthews, Director Hazen, and** **NOES – 0** **ABSENT – Director Wortham** **ABSTAIN – 0**

	Hazen would like more content on the website while Staff works to devise the new website. Vice-President Rogers explained that recent legislation requires that certain information is published to the website.	
2. Policy Manual/Bylaws Timeline	Lisa Houston, COO, explained the Policy Manual/Bylaws Timeline outlining the changes and tying the communications with the Ad Hoc Committee on Board and Staff Communications. Legal Counsel, Jeff Scott, suggested that the Board incorporates the Policy Manual/Bylaws Timeline into the workshop/special meeting of the board discussion on policies and communication. At the direction of Director Hazen, she recommended that the Board direct Staff to move the item to the Ad Hoc Committee on Board and Staff Communications for review and discussion at the workshop.	
M. Legal Comments & Reports	Jeff Scott, Legal Counsel, explained the AB 2019 (Aguiar-Curry) new grant policy guidelines and requirements. AB 2123 (Cervantes) California Voters Rights Act amendment to permit public agencies to extend the period for the rezoning process with an extension of 180 days.	
N. Directors' Comments, Reports, Staff Direction, and Guidance		
1. Association of California Healthcare Districts	Vice-President Rogers outlined the aspects of her written report from her attendance at the Association	

Wellness Summit (ACHD) **2. Association of California Healthcare Districts (ACHD) 66th Annual Meeting – President Zendle, MD and Vice President Rogers, RN**	of California Healthcare District (ACHD) Wellness Summit that included an overview of the speakers and informative topics such as preventable causes of death. President Zendle explained that he and Vice-President Rogers attended the Association of Healthcare Districts 66th Annual meeting and will provide a copy of the PowerPoint slides to the Staff and public at the October meeting. President Zendle also explained that he presented Staff with the report on the state of psychiatric beds in California that may assist with the Districts Behavioral Health Initiative.	
O. Adjournment	President Zendle adjourned the meeting at 8:14 p.m.	***Audio recording available on the website at http://dhcd.org/Agenda-Board-of-Directors***

ATTEST: _____
Carole Rogers, Vice-President/Secretary
Desert Healthcare District Board of Directors

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

DESERT HEALTHCARE DISTRICT
SEPTEMBER 2018 FINANCIAL STATEMENTS
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DESERT HEALTHCARE DISTRICT
YEAR TO DATE VARIANCE ANALYSIS
ACTUAL VS BUDGET
THREE MONTHS ENDED SEPTEMBER 30, 2018

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

Account	YTD Actual	YTD Budget	Over(Under) Budget	Explanation
4000 - Income	$ 1,759,541	$ 1,690,296	$ 69,245	Interest income (net) from FRF investments 81k; lower NEOPB Grant Income 12k.
5000 - Direct Expenses	$ 407,201	$ 370,086	$ 37,115	Higher wage and payroll tax $61K due primarily to 1. $72K CEO severance pay & 2. $10K lower CEO vacancy and straight-line amortization of salaries and 5.0% incentive pool, and vacations taken charged to vacation accrual; lower Medical insurance and reimbursement of $10K; Lower retirement plan expense of $3K; Lower various $1K.
6700 - Trust Expenses	$ 31,254	$ 63,372	$ (32,118)	RPP actuarial valuation required lower monthly expense accrual
7000 - Grants Expense	$ 417,983	$ 897,501	$ (479,518)	Budget of $3.5 Million for fiscal year is amortized straight-line over 12-month fiscal year.

Desert Healthcare District

Cumulative Profit & Loss Budget vs. Actual

July through September 2018

	MONTH			TOTAL		
	Sep 18	Budget	$ Over Budget	Jul - Sep 18	Budget	$ Over Budget
Income						
4000 · Income	421,767	563,432	(141,665)	1,759,541	1,690,296	69,245
4500 · LPMP Income	99,408	99,088	320	297,687	297,265	422
4501 · Miscellaneous Income	750	950	(200)	2,250	2,850	(600)
Total Income	521,925	663,470	(141,545)	2,059,478	1,990,411	69,067
Expense						
5000 · Direct Expenses	92,102	123,362	(31,260)	407,201	370,086	37,115
6000 · General & Administrative Exp	36,108	41,085	(4,977)	108,093	123,255	(15,162)
6325 · CEO Discretionary Fund	-	417	(417)	-	1,251	(1,251)
6445 · LPMP Expenses	71,711	82,970	(11,259)	229,944	248,910	(18,966)
6500 · Professional Fees Expense	187,019	73,583	113,436	228,553	220,748	7,805
6700 · Trust Expenses	10,418	21,124	(10,706)	31,254	63,372	(32,118)
Total Expense Before Grants	397,358	342,541	54,817	1,005,045	1,027,622	(22,577)
7000 · Grants Expense	410,158	299,167	110,991	417,983	897,501	(479,518)
Net Income	**(285,592)**	**21,762**	**(307,354)**	**636,449**	**65,288**	**571,161**

Desert Healthcare District

Cumulative Profit & Loss Budget vs. Actual

July through September 2018

	MONTH			TOTAL		
	Sep 18	Budget	$ Over Budget	Jul - Sep 18	Budget	$ Over Budget
Income						
4000 · Income						
4010 · Property Tax Revenues - Other	550,348	550,348	-	1,651,044	1,651,044	-
4200 · Interest Income						
4220 · Interest Income (FRF)	57,013	104,000	(46,987)	312,618	312,000	618
9999-1 · Unrealized (gain)loss on invest	(192,522)	(100,000)	(92,522)	(219,372)	(300,000)	80,628
Total 4200 · Interest Income	(135,509)	4,000	(139,509)	93,246	12,000	81,246
4305 · Patient Related Collections						
4350 · Rental - Airways	1,749	1,583	166	5,247	4,749	498
4405 · Grant - NEOPB	5,179	7,500	(2,321)	10,004	22,500	(12,496)
Total 4000 · Income	421,767	563,431	(141,664)	1,759,541	1,690,293	69,248
4500 · LPMP Income						
4505 · Rental Income	71,178	70,775	403	212,998	212,325	673
4510 · CAM Income	28,230	28,230	-	84,690	84,690	-
4513 · Misc. Income		83	(83)		249	(249)
Total 4500 · LPMP Income	99,408	99,088	320	297,687	297,264	423
4501 · Miscellaneous Income	750	950	(200)	2,250	2,850	(600)
Total Income	521,925	663,469	(141,544)	2,059,478	1,990,407	69,071
Expense						
5000 · Direct Expenses						
5100 · Administration Expense						
5110 · Wages Expense	54,484	82,047	(27,563)	303,523	246,141	57,382
5111 · Allocation to LPMP - Payroll	(4,420)	(4,420)	-	(13,260)	(13,260)	-
5112 · Vacation/Sick/Holiday Expense	5,918	6,923	(1,005)	16,054	20,769	(4,715)
5114 · Allocation to Foundation	(17,668)	(17,668)	-	(53,004)	(53,004)	-
5115 · Allocation to NEOPB	(4,701)	(7,797)	3,096	(8,621)	(23,391)	14,770
5119 · Allocation to RSS/CVHIP-DHCF	(1,099)		(1,099)	(5,602)		(5,602)
5120 · Payroll Tax Expense	4,645	6,277	(1,632)	18,114	18,831	(717)
5130 · Health Insurance Expense						
5131 · Premiums Expense	11,611	11,435	176	31,366	34,305	(2,939)
5135 · Reimb./Co-Payments Expense		2,500	(2,500)		7,500	(7,500)
Total 5130 · Health Insurance Expense	11,611	13,935	(2,324)	31,366	41,805	(10,439)
5140 · Workers Comp. Expense	2,622	861	1,761	2,622	2,583	39
5145 · Retirement Plan Expense	4,401	5,301	(900)	12,877	15,903	(3,026)
5160 · Education Expense	179	625	(446)	348	1,875	(1,527)
Total 5100 · Administration Expense	55,972	86,084	(30,112)	304,417	258,252	46,165
5200 · Board Expenses						

Desert Healthcare District

Cumulative Profit & Loss Budget vs. Actual

July through September 2018

	MONTH			TOTAL		
	Sep 18	Budget	$ Over Budget	Jul - Sep 18	Budget	$ Over Budget
5210 · Healthcare Benefits Expense						
5211 · Health Insurance Expense	3,270	6,665	(3,395)	9,811	19,995	(10,184)
5224 · Retired Board - Medical Expense	1,274	1,237	37	3,821	3,711	110
Total 5210 · Healthcare Benefits Expense	4,544	7,902	(3,358)	13,632	23,706	(10,074)
5230 · Meeting Expense	3,114	667	2,447	3,178	2,001	1,177
5235 · Director Stipend Expense	-	-	-	400	-	400
5240 · Catering Expense	139	333	(194)	572	999	(427)
5250 · Mileage Reimbursment Expense		42	(42)		126	(126)
5270 · Election Fees Expense	28,333	28,333	-	84,999	84,999	-
Total 5200 · Board Expenses	36,130	37,277	(1,147)	102,781	111,831	(9,050)
Total 5000 · Direct Expenses	92,102	123,361	(31,259)	407,198	370,083	37,115
6000 · General & Administrative Exp						
6110 · Payroll fees Expense	164	292	(128)	480	876	(396)
6120 · Bank and Investment Fees Exp	9,305	9,833	(528)	28,379	29,499	(1,120)
6125 · Depreciation Expense	1,149	1,181	(32)	3,447	3,543	(96)
6126 · Depreciation-Solar Parking lot	15,072	15,072	-	45,216	45,216	-
6130 · Dues and Membership Expense	766	2,275	(1,509)	3,948	6,825	(2,877)
6200 · Insurance Expense	1,412	917	495	4,236	2,751	1,485
6300 · Minor Equipment Expense		42	(42)		126	(126)
6305 · Auto Allowance & Mileage Exp	385	1,017	(632)	1,708	3,051	(1,343)
6306 · Staff- Auto Mileage reimb	210	313	(103)	924	939	(15)
6309 · Personnel Expense		104	(104)	53	312	(259)
6310 · Miscellaneous Expense	60	42	18	60	126	(66)
6311 · Cell Phone Expense	650	777	(127)	1,950	2,331	(381)
6312 · Wellness Park Expenses		167	(167)		501	(501)
6315 · Security Monitoring Expense	108	36	72	137	108	29
6340 · Postage Expense	1,005	542	463	1,285	1,626	(341)
6350 · Copier Rental/Fees Expense	394	458	(64)	824	1,374	(550)
6351 · Travel Expense	1,580	917	663	1,492	2,751	(1,259)
6352 · Meals & Entertainment Exp	394	417	(23)	1,064	1,251	(187)
6355 · Computer Services Expense	1,342	3,352	(2,010)	3,747	10,056	(6,309)
6360 · Supplies Expense	627	1,833	(1,206)	4,690	5,499	(809)
6380 · LAFCO Assessment Expense	1,484	1,500	(16)	4,452	4,500	(48)
Total 6000 · General & Administrative Exp	36,108	41,087	(4,979)	108,093	123,261	(15,168)
6325 · CEO Discretionary Fund		417	(417)		1,251	(1,251)
6445 · LPMP Expenses	71,711	82,968	(11,257)	229,945	248,904	(18,959)
6500 · Professional Fees Expense						
6516 · Professional Services Expense	170,527	39,167	131,360	171,637	117,501	54,136

Desert Healthcare District

Cumulative Profit & Loss Budget vs. Actual

July through September 2018

	MONTH			TOTAL		
	Sep 18	Budget	$ Over Budget	Jul - Sep 18	Budget	$ Over Budget
6520 · Annual Audit Fee Expense	1,492	1,499	(7)	4,476	4,497	(21)
6530 · PR/Communications/Website		17,917	(17,917)	3,401	53,751	(50,350)
6560 · Legal Expense	15,000	15,000	-	49,040	45,000	4,040
Total 6500 · Professional Fees Expense	187,019	73,583	113,436	228,554	220,749	7,805
6700 · Trust Expenses						
6711 · Disability Admin. Fee Expense		537	(537)		1,611	(1,611)
6720 · Pension Plans Expense						
6721 · Legal Expense		167	(167)		501	(501)
6725 · RPP Pension Expense	10,000	20,000	(10,000)	30,000	60,000	(30,000)
6728 · Pension Audit Fee Expense	418	420	(2)	1,254	1,260	(6)
Total 6700 · Trust Expenses	10,418	21,124	(10,706)	31,254	63,372	(32,118)
Total Expense Before Grants	397,358	342,540	54,818	1,005,044	1,027,620	(22,576)
7000 · Grants Expense						
7010 · Major Grant Awards Expense	404,979	291,667	113,312	407,979	875,001	(467,022)
7027 · Grant Exp - NEOPB	5,179	7,500	(2,321)	10,004	22,500	(12,496)
Total 7000 · Grants Expense	410,158	299,167	110,991	417,983	897,501	(479,518)
Net Income	**(285,592)**	**21,762**	**(307,354)**	**636,449**	**65,288**	**571,161**

Las Palmas Medical Plaza

Cumulative Profit & Loss Budget vs. Actual

July through September 2018

	MONTH			TOTAL		
	Sep 18	Budget	$ Over Budget	Jul - Sep 18	Budget	$ Over Budget
Income						
4500 · LPMP Income						
4505 · Rental Income	71,178	70,775	403	212,998	212,325	673
4510 · CAM Income	28,230	28,230	-	84,690	84,690	-
4513 · Misc. Income		83	(83)		249	(249)
Total 4500 · LPMP Income	99,408	99,088	320	297,688	297,264	424
Expense						
6445 · LPMP Expenses						
6420 · Insurance Expense	1,283	1,083	200	3,849	3,249	600
6425 · Building - Depreciation Expense	20,834	22,019	(1,185)	62,502	66,057	(3,555)
6426 · Tenant Improvements -Dep Exp	17,850	14,853	2,997	53,550	44,559	8,991
6427 · HVAC Maintenance Expense	2,398	1,333	1,065	2,754	3,999	(1,245)
6428 · Roof Repairs Expense		208	(208)		624	(624)
6431 · Building -Interior Expense		208	(208)	859	624	235
6432 · Plumbing -Interior Expense		208	(208)	2,794	624	2,170
6433 · Plumbing -Exterior Expense		208	(208)		624	(624)
6434 · Allocation Internal Prop. Mgmt	4,420	4,420	-	13,260	13,260	-
6435 · Bank Charges	1,038	917	121	3,091	2,751	340
6437 · Utilities -Vacant Units Expense	171	208	(37)	425	624	(199)
6439 · Deferred Maintenance Repairs Ex		1,000	(1,000)	844	3,000	(2,156)
6440 · Professional Fees Expense	10,117	10,472	(355)	30,351	31,416	(1,065)
6441 · Legal Expense		83	(83)		249	(249)
6458 · Elevators - R & M Expense	1,491	1,000	491	3,194	3,000	194
6460 · Exterminating Service Expense	180	417	(237)	360	1,251	(891)
6463 · Landscaping Expense	(6,714)	2,250	(8,964)	1,300	6,750	(5,450)
6467 · Lighting Expense		2,917	(2,917)		8,751	(8,751)
6468 · General Maintenance Expense		83	(83)		249	(249)
6471 · Marketing-Advertising		1,458	(1,458)		4,374	(4,374)
6475 · Property Taxes Expense	6,000	6,000	-	18,000	18,000	-
6476 · Signage Expense		250	(250)		750	(750)
6480 · Rubbish Removal Medical Waste E	1,188	1,442	(254)	2,576	4,326	(1,750)
6481 · Rubbish Removal Expense	2,123	2,123	-	6,369	6,369	-
6482 · Utilities/Electricity/Exterior	513	708	(195)	1,083	2,124	(1,041)
6484 · Utilties - Water (Exterior)	1,342	583	759	3,300	1,749	1,551
6485 · Security Expenses	7,478	6,417	1,061	19,355	19,251	104
6490 · Miscellaneous Expense		100	(100)	130	300	(170)
Total 6445 · LPMP Expenses	71,712	82,968	(11,256)	229,946	248,904	(18,958)
Net Income	**27,696**	**16,120**	**11,576**	**67,742**	**48,360**	**19,382**

Desert Healthcare District
Balance Sheet
As of September 30, 2018

	Sep 30, 18
ASSETS	
Current Assets	
Checking/Savings	
1000 · CHECKING CASH ACCOUNTS	1,321,059
1100 · INVESTMENT ACCOUNTS	52,910,346
Total Checking/Savings	54,231,405
Accounts Receivable	
1201 · Accounts Receivable	45,295
Other Current Assets	
1270 · Prepaid Insurance -Ongoing	27,141
1279 · Pre-Paid Fees	34,319
1281 · NEOPB Receivable	10,041
1295 · Property Tax Receivable	1,476,335
Total Other Current Assets	1,547,836
Total Current Assets	55,824,536
Fixed Assets	
1300 · FIXED ASSETS	4,893,652
1335-00 · ACC DEPR	(1,650,841)
1400 · LPMP Assets	7,280,838
Total Fixed Assets	10,523,649
Other Assets	2,751,642
TOTAL ASSETS	**69,099,827**
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
2000 · Accounts Payable	3,060
2001 · LPMP Accounts Payable	3,589
Total Accounts Payable	6,649
Other Current Liabilities	
2002 · LPMP Property Taxes	18,000
2131 · Grant Awards Payable	1,111,907
2133 · Accrued Accounts Payable	437,749
2141 · Accrued Vacation Time	21,999
2186 · Retired BOD Medical - Current	16,303
2188 · Current Portion - LTD	11,103
2190 · Investment Fees Payable	27,000
Total Other Current Liabilities	1,644,060

Desert Healthcare District
Balance Sheet
As of September 30, 2018

	Sep 30, 18
Total Current Liabilities	1,650,709
Long Term Liabilities	
2170 · RPP - Pension Liability	3,307,793
2171 · RPP-Deferred Inflows-Resources	2,222,190
2280 · Long-Term Disability	51,743
2281 · Grants Payable - Long-term	10,147,646
2286 · Retirement BOD Medical Liabilit	69,933
2290 · LPMP Security Deposits	58,517
Total Long Term Liabilities	15,857,822
Total Liabilities	17,508,531
Equity	
3900 · *Retained Earnings	50,954,846
Net Income	636,449
Total Equity	51,591,295
TOTAL LIABILITIES & EQUITY	**69,099,827**

Desert Healthcare District
Balance Sheet
As of September 30, 2018

	Sep 30, 18
ASSETS	
Current Assets	
Checking/Savings	
1000 · CHECKING CASH ACCOUNTS	
1010 · Union Bank - Checking	1,158,726
1046 · Las Palmas Medical Plaza	161,833
1047 · Petty Cash	500
Total 1000 · CHECKING CASH ACCOUNTS	1,321,059
1100 · INVESTMENT ACCOUNTS	
1130 · Facility Replacement Fund	54,161,537
1135 · Unrealized Gain(Loss) FRF	(1,251,191)
Total 1100 · INVESTMENT ACCOUNTS	52,910,346
Total Checking/Savings	54,231,405
Accounts Receivable	
1201 · Accounts Receivable	
1204 · LPMP Accounts Receivable	(21,817)
1205 · Misc. Accounts Receivable	67,113
Total Accounts Receivable	45,295
Other Current Assets	
1270 · Prepaid Insurance -Ongoing	27,141
1279 · Pre-Paid Fees	34,319
1281 · NEOPB Receivable	10,041
1295 · Property Tax Receivable	1,476,335
Total Other Current Assets	1,547,836
Total Current Assets	55,824,536
Fixed Assets	
1300 · FIXED ASSETS	
1310 · Computer Equipment	80,692
1315 · Computer Software	68,770
1320 · Furniture and Fixtures	27,085
1325 · Offsite Improvements	300,849
1331 · DRMC - Parking lot	4,416,257
Total 1300 · FIXED ASSETS	4,893,652
1335-00 · ACC DEPR	
1335 · Accumulated Depreciation	(196,068)
1336 · Acc. Software Depreciation	(68,251)
1337 · Accum Deprec- Solar Parking Lot	(1,281,291)
1338 · Accum Deprec - LPMP Parking Lot	(105,231)
Total 1335-00 · ACC DEPR	(1,650,841)
1400 · LPMP Assets	

Desert Healthcare District
Balance Sheet
As of September 30, 2018

	Sep 30, 18
1401 · Building	8,705,680
1402 · Land	2,165,300
1403 · Tenant Improvements -New	2,141,711
1404 · Tenant Improvements - CIP	129,550
1406 · Building Improvements	
1406.1 · LPMP-Replace Parking Lot	676,484
1406 · Building Improvements - Other	1,364,337
Total 1406 · Building Improvements	2,040,821
1407 · Building Equipment Improvements	350,663
1409 · Accumulated Depreciation	
1410 · Accum. Depreciation	(6,999,864)
1412 · T I Accumulated Dep.-New	(1,253,024)
Total 1409 · Accumulated Depreciation	(8,252,888)
Total 1400 · LPMP Assets	7,280,838
Total Fixed Assets	10,523,649
Other Assets	
1700 · OTHER ASSETS	
1731 · Wellness Park	1,693,800
1740 · RPP-Deferred Outflows-Resources	1,057,842
Total Other Assets	2,751,642
TOTAL ASSETS	**69,099,827**
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
2000 · Accounts Payable	3,060
2001 · LPMP Accounts Payable	3,589
Total Accounts Payable	6,649
Other Current Liabilities	
2002 · LPMP Property Taxes	18,000
2131 · Grant Awards Payable	1,111,907
2133 · Accrued Accounts Payable	437,749
2141 · Accrued Vacation Time	21,999
2186 · Retired BOD Medical - Current	16,303
2188 · Current Portion - LTD	11,103
2190 · Investment Fees Payable	27,000
Total Other Current Liabilities	1,644,060
Total Current Liabilities	1,650,709
Long Term Liabilities	

Desert Healthcare District
Balance Sheet
As of September 30, 2018

	Sep 30, 18
2170 · RPP - Pension Liability	3,307,793
2171 · RPP-Deferred Inflows-Resources	2,222,190
2280 · Long-Term Disability	51,743
2281 · Grants Payable - Long-term	10,147,646
2286 · Retirement BOD Medical Liabilit	69,933
2290 · LPMP Security Deposits	58,517
Total Long Term Liabilities	15,857,822
Total Liabilities	17,508,531
Equity	
3900 · *Retained Earnings	50,954,846
Net Income	636,449
Total Equity	51,591,295
TOTAL LIABILITIES & EQUITY	**69,099,827**

Desert Healthcare District
A/R Aging Summary
As of September 30, 2018

	Current	1 - 30	31 - 60	61 - 90	> 90	TOTAL	Comments
Cohen Musch Thomas Medical Group	-	(6,866)	-	-	-	(6,866)	Prepaid
Desert Family Medical Center	-	(3,500)	-	-	-	(3,500)	Prepaid
Desert Healthcare Foundation-	18,767	20,282	-	19,557	-	58,606	Due from Foundation
Desert Oasis Healthcare Medical Group	-	(1,993)	-	-	-	(1,993)	Prepaid
Kay Hazen-	779	779	-	779	4,671	7,007	Director Insurance Accrual
Laboratory Corporation of America	-	(4,664)	154	-	286	(4,224)	Prepaid
Sovereign	750	750	-	-	-	1,500	Slow Pay
Steven Gundry, M.D.	-	(5,235)	-	-	-	(5,235)	Prepaid
TOTAL	**20,296**	**(447)**	**154**	**20,336**	**4,957**	**45,295**	

Desert Healthcare District
Deposit Detail
September 2018

Type	Date	Name	Amount
Deposit	**09/05/2018**		**1,749**
		T-Mobile	(1,749)
TOTAL			(1,749)
Deposit	**09/21/2018**		**155,626**
		Riverside County Treasurer- Property Tax	(155,626)
TOTAL			(155,626)
Deposit	**09/21/2018**		**578**
		State Compensation Insurance Fund	(578)
TOTAL			(578)
Deposit	**09/27/2018**		**4,369**
		Riverside County Treasurer- NEOPB	(4,369)
TOTAL			(4,369)
		Total Deposits	**162,322**

DESERT HEALTHCARE DISTRICT
PROPERTY TAX RECEIPTS FY 2018 - 2019
RECEIPTS - TWELVE MONTHS ENDED JUNE 30, 2019

	FY 2016-2017 Projected/Actual					FY 2017-2018 Projected/Actual				
	Budget %	Budget $	Act %	Actual Receipts	Variance	Budget %	Budget $	Act %	Actual Receipts	Variance
July	2.5%	$ 157,242	1.3%	$ 107,591	$ (49,652)	2.5%	$ 165,105	1.3%	$ 87,106	$ (77,998)
Aug	1.6%	$ 100,635	1.7%	$ 76,625	$ (24,010)	1.6%	$ 105,667	1.6%	$ 104,633	$ (1,034)
Sep	2.6%	$ 163,532	2.4%	$ 149,702	$ (13,830)	2.6%	$ 171,709	2.4%	$ 155,626	$ (16,083)
Oct	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%		
Nov	0.4%	$ 25,159	0.0%	$ 47,069	$ 21,910	0.4%	$ 26,417	0.0%		
Dec	16.9%	$ 1,062,958	17.6%	$ 1,121,658	$ 58,700	16.9%	$ 1,116,106	0.0%		
Jan	31.9%	$ 2,006,413	33.0%	$ 2,097,033	$ 90,621	31.9%	$ 2,106,733	0.0%		
Feb	0.0%	$ -	0.8%	$ 50,855	$ 50,855	0.0%	$ -	0.0%		
Mar	0.3%	$ 18,869	0.2%	$ 14,782	$ (4,087)	0.3%	$ 19,813	0.0%		
Apr	5.5%	$ 345,933	5.8%	$ 371,495	$ 25,562	5.5%	$ 363,230	0.0%		
May	19.9%	$ 1,251,649	19.9%	$ 1,258,864	$ 7,215	19.9%	$ 1,314,232	0.0%		
June	18.4%	$ 1,157,304	16.8%	$ 1,319,289	$ 161,985	18.4%	$ 1,215,169	0.0%		
Total	**100%**	**$ 6,289,695**	**99.6%**	**$ 6,614,963**	**$ 325,268**	**100.00%**	**$ 6,604,180**	**5.3%**	**$ 347,365**	**$ (95,115)**

Las Palmas Medical Plaza
Deposit Detail - LPMP
September 2018

Type	Date	Name	Memo	Amount
Deposit	**09/04/2018**		**Deposit**	**3,470**
Payment	09/04/2018	Cohen Musch Thomas Medical Group		(3,470)
TOTAL				(3,470)
Deposit	**09/04/2018**		**Deposit**	**16,476**
		Stericycle, Inc.		(332)
Payment	09/04/2018	Peter Jamieson, M.D.		(2,932)
Payment	09/04/2018	EyeCare Services Partners Management LLC		(6,030)
Payment	09/04/2018	Steven Gundry, M.D.		(5,235)
Payment	09/04/2018	West Pacific Medical Laboratory		(1,947)
TOTAL				(16,476)
Deposit	**09/04/2018**		**Deposit**	**3,772**
Payment	09/04/2018	Quest Diagnostics Incorporated		(3,772)
TOTAL				(3,772)
Deposit	**09/05/2018**		**Deposit**	**11,802**
Payment	09/05/2018	Derakhsh Fozouni, M.D.		(5,716)
Payment	09/05/2018	Palmtree Clinical Research		(6,086)
TOTAL				(11,802)
Deposit	**09/05/2018**		**Deposit**	**11,236**
Payment	09/05/2018	Ramy Awad, M.D.		(2,324)
Payment	09/05/2018	Aijaz Hashmi, M.D., Inc.		(2,688)
Payment	09/05/2018	Brad A. Wolfson, M.D.		(3,387)
Payment	09/05/2018	Cure Cardiovascular Consultants		(2,837)
TOTAL				(11,236)
Deposit	**09/10/2018**		**Deposit**	**2,202**
Payment	09/10/2018	Pathway Pharmaceuticals,Inc.		(2,202)
TOTAL				(2,202)

Las Palmas Medical Plaza
Deposit Detail - LPMP
September 2018

Type	Date	Name	Memo	Amount
Deposit	**09/18/2018**		**Deposit**	**2,738**
Payment	09/18/2018	Dennis Spurgin, D.C.		(2,738)
TOTAL				(2,738)
Deposit	**09/19/2018**		**Deposit**	**3,470**
Payment	09/19/2018	Cohen Musch Thomas Medical Group		(3,470)
TOTAL				(3,470)
Deposit	**09/24/2018**		**Deposit**	**4,664**
Payment	09/24/2018	Laboratory Corporation of America		(4,664)
TOTAL				(4,664)
Deposit	**09/27/2018**		**Deposit**	**5,492**
Payment	09/27/2018	Desert Family Medical Center		(3,500)
Payment	09/27/2018	Desert Oasis Healthcare Medical Group		(1,993)
TOTAL				(5,492)
Deposit	**09/28/2018**		**Deposit**	**8,705**
Payment	09/28/2018	Steven Gundry, M.D.		(5,235)
Payment	09/28/2018	Cohen Musch Thomas Medical Group		(3,470)
TOTAL				(8,705)
		Total Deposits		**74,028**

Desert Healthcare District
Check Register
September 2018

Type	Date	Num	Name	Amount
1000 · CHECKING CASH ACCOUNTS				
1010 · Union Bank - Checking				
Bill Pmt -Check	09/04/2018	15106	Graphtek Interactive	(225)
Bill Pmt -Check	09/04/2018	15107	Jennifer Wortham	(100)
Bill Pmt -Check	09/04/2018	15108	Mark Matthews.	(100)
Bill Pmt -Check	09/04/2018	15109	Ready Refresh	(48)
Bill Pmt -Check	09/04/2018	15110	Stephen Huyck-	(13)
Bill Pmt -Check	09/04/2018	15111	Underground Service Alert of Southern Cal	(5)
Bill Pmt -Check	09/04/2018	15112	Vanessa Smith-	(397)
Check	09/05/2018	Auto Pay	Calif. Public Employees'Retirement System	(13,630)
Liability Check	09/06/2018		QuickBooks Payroll Service	(30,831)
General Journal	09/07/2018	03-01	401a payment - 9/07/18 payroll	(1,355)
General Journal	09/07/2018	03-01	457b payment - 9/07/18 payroll	(1,968)
Bill Pmt -Check	09/07/2018	15113	Anthem Blue Cross	(105)
Bill Pmt -Check	09/07/2018	15114	Hidden Harvest Corporation	(9,500)
Bill Pmt -Check	09/07/2018	15115	Law Offices of Scott & Jackson	(15,420)
Bill Pmt -Check	09/07/2018	15116	Mangus Accountancy Group, A.P.C.	(500)
Bill Pmt -Check	09/07/2018	15117	Simpson, Gumpertz & Heger	(85,500)
Bill Pmt -Check	09/11/2018	15118	First Bankcard (Union Bank)	(3,040)
Bill Pmt -Check	09/11/2018	15119	Frazier Pest Control, Inc.	(60)
Bill Pmt -Check	09/11/2018	15120	Vanessa Smith-	(67)
Bill Pmt -Check	09/11/2018	15121	Xerox Financial Services	(394)
General Journal	09/17/2018	03-05	Sept 2018 LTD Payment - Jena Marie Van Earl	(1,234)
Bill Pmt -Check	09/17/2018	15122	KaufmanHall	(447)
Bill Pmt -Check	09/17/2018	15123	Palm Desert Chamber of Commerce	(200)
Bill Pmt -Check	09/17/2018	15124	Regents - University of California	(516)
Bill Pmt -Check	09/17/2018	15125	So.Cal Computer Shop	(980)
Bill Pmt -Check	09/17/2018	15126	Staples Credit Plan	(477)
Bill Pmt -Check	09/17/2018	15127	The Nyhart Company	(3,300)
Liability Check	09/20/2018		QuickBooks Payroll Service	(30,764)
Bill Pmt -Check	09/20/2018	15128	CoPower Employers' Benefits Alliance	(2,100)
Bill Pmt -Check	09/20/2018	15129	Donna Den Bleyker.	(144)
Bill Pmt -Check	09/20/2018	15130	Mizell Senior Center	(90,068)
Bill Pmt -Check	09/20/2018	15131	State Compensation Insurance Fund	(3,199)
Bill Pmt -Check	09/20/2018	15132	VMG Health	(53,158)
General Journal	09/21/2018	03-06	401a payment - 9/21/18 payroll	(1,352)
General Journal	09/21/2018	03-06	457b payment - 9/21/18 payroll	(1,966)
Bill Pmt -Check	09/21/2018	15133	Loma Linda University	(40,054)
Bill Pmt -Check	09/21/2018	15134	Pitney Bowes Purchase Power	(1,005)

Desert Healthcare District
Check Register
September 2018

Type	Date	Num	Name	Amount
Check	09/25/2018		Service Charge	(613)
Bill Pmt -Check	09/28/2018	15135	Chris Christensen	(49)
Bill Pmt -Check	09/28/2018	15136	Christopher Cardona	(200)
Bill Pmt -Check	09/28/2018	15137	Coachella Valley Economic Partnership	(73,790)
Bill Pmt -Check	09/28/2018	15138	Desert AIDS Project	(17,500)
Bill Pmt -Check	09/28/2018	15139	Eisenhower Medical Center--	(25,112)
Bill Pmt -Check	09/28/2018	15140	MSA Consulting, Inc.	(2,284)
Bill Pmt -Check	09/28/2018	15141	Principal Life Insurance Co.	(1,234)
Bill Pmt -Check	09/28/2018	15142	Senior Advocates of the Desert	(5,000)
Bill Pmt -Check	09/28/2018	15143	Shred-It	(88)
Bill Pmt -Check	09/28/2018	15144	Simpson, Gumpertz & Heger	(20,000)
Bill Pmt -Check	09/28/2018	15145	Stephen Huyck-	(18)
Bill Pmt -Check	09/28/2018	15146	Time Warner Cable	(221)
Check	09/30/2018	Auto Pay	Principal Financial Group-	(1,014)
Check	09/30/2018	Auto Pay	Principal Financial Group-	(679)
General Journal	09/30/2018	03-10	Record Medical Reimb - September 2018	(37)
TOTAL				**(541,754)**

Desert Healthcare District

Details for credit card Expenditures

Credit card purchases - Aug 2018 - Paid Sept 2018

Number of credit cards held by District personnel -2

Credit Card Limit - $5,000

Credit Card Holders:

Chief Executive Officer

Chris Christensen - Chief Financial 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
		$ 3,039.74					
Chris' Statement:							
2018	**Aug**	**$ 3,039.74**		**District**			
				GL	Dollar	Descr	
				6130	$ (1,000.00)	Dropbox credit	
				6360	$ 60.07	Tripod & memory card	
				6352	$ 22.13	Qtrly Legislative Breakfast - Chris	
				5230	$ 2,000.00	Directors Zendle & Rogers ACHD Registration	
				6130	$ 600.00	Dropbox fee	
				5230	$ 150.00	Directors Zendle & Hazen Palm Springs State of the City	
				5160	$ 75.00	Chris - Palm Springs State of the City	
				6352	$ 22.13	Qtrly Legislative Breakfast - Hazen	
				5230	$ 75.00	Director Wortham Palm Springs State of the City	
				6360	$ 17.45	Conference call expense	
				5230	$ 48.00	Director Rogers 2018 CSDA	
				6352	$ 278.91	Staff lunch	
				5230	$ 325.00	Director Rogers 2018 CSDA	
				5160	$ 104.00	Lisa CSDA	
				6360	$ 61.43	Conference call expense	
				5240	$ 138.75	Ad Hoc Committee-New Providers, Facilities, Programs, & Services	
				6360	$ 48.16	Conference call expense	
				6360	$ 13.71	Interest charge	
					$ 3,039.74		

Las Palmas Medical Plaza
Check Register
September 2018

Type	Date	Num	Name	Amount
1000 · CHECKING CASH ACCOUNTS				
1046 · Las Palmas Medical Plaza				
Bill Pmt -Check	09/04/2018	9891	Imperial Security	(1,466)
Bill Pmt -Check	09/07/2018	9892	Desert Air Conditioning Inc.	(202)
Bill Pmt -Check	09/07/2018	9893	Desert Water Agency	(1,047)
Bill Pmt -Check	09/07/2018	9894	Imperial Security	(1,466)
Bill Pmt -Check	09/07/2018	9895	INPRO-EMS Construction	(844)
Bill Pmt -Check	09/07/2018	9896	Palm Springs Disposal Services Inc	(2,123)
Bill Pmt -Check	09/07/2018	9897	Roto-Rooter Plumbers	(2,269)
Bill Pmt -Check	09/11/2018	9898	Imperial Security	(1,613)
Bill Pmt -Check	09/11/2018	9899	Southern California Edison	(683)
Bill Pmt -Check	09/11/2018	9900	Stericycle, Inc.	(1,520)
Bill Pmt -Check	09/17/2018	9901	Desert Air Conditioning Inc.	(2,398)
Bill Pmt -Check	09/20/2018	9902	Frazier Pest Control, Inc.	(180)
Bill Pmt -Check	09/21/2018	9903	Frontier Communications	(211)
Bill Pmt -Check	09/21/2018	9904	Imperial Security	(1,466)
Bill Pmt -Check	09/21/2018	9905	INPRO-EMS Construction	(10,117)
Bill Pmt -Check	09/28/2018	9906	Amtech Elevator Services	(1,280)
Bill Pmt -Check	09/28/2018	9907	Desert Water Agency	(1,342)
Bill Pmt -Check	09/28/2018	9908	Imperial Security	(1,466)
Check	09/30/2018		Service Charge	(1,038)
TOTAL				**(32,733)**

DESERT HEALTHCARE DISTRICT

Doing Healthy Deeds

MEMORANDUM

DATE: October 9, 2018

TO: F&A Committee

RE: Retirement Protection Plan (RPP)

Current number of participants in Plan:

Active – still employed by hospital	123
Vested – no longer employed by hospital	61
Former employees receiving annuity	10
Total	**194**

The outstanding liability for the RPP is approximately **$4.5M** (Actives - $3.2M and Vested - $1.3M). US Bank investment account balance $5.2M. Per the June 30, 2018 Actuarial Valuation, the RPP has an Unfunded Pension Liability of approximately **$3.3M**. A monthly accrual of $10K is being recorded each month as an estimate for FY2019.

The payouts, excluding monthly annuity payments, made from the Plan for the Three (3) months ended September 30, 2019 totaled **$146K.** Monthly annuity payments (10 participants) total **$1.2K** per month.

DESERT HEALTHCARE DISTRICT
OUTSTANDING GRANTS AND GRANT PAYMENT SCHEDULE
As of 09/30/18
TWELVE MONTHS ENDED JUNE 30, 2019

Grant ID Nos.	Name	Approved Grants - Prior Yrs	Current Yr 2018-2019	6/30/2018 Bal Fwd/New	Total Paid July-June	Open BALANCE
2013-759-BOD 02/26/13	Desert Hot Springs Wellness FDN - Oversampling - HARC -3yr	$ 30,000		$ 15,000	$ -	$ 15,000
2014-MOU-BOD-11/21/13	Memo of Understanding CVAG CV Link Support	**$ 10,000,000**		$ 10,000,000	$ -	$ 10,000,000
2015-866-BOD-4-28-15	The LGBT Center of PS - Desert Low-Cost Counseling Clinic - 3 yr	$ 140,000		$ 32,000	$ 18,000	$ 14,000
2015-875-BOD-6-23-15	Desert AIDS Project - Sexually Transmitted Infection Clinic - 3 Yr	$ 800,000		$ 17,500	$ 17,500	$ -
2015-876-BOD-6-23-15	Arrowhead Neuroscience Fndtn-NeuroInterventional & NeuroCritical Care Fellowship 2 Yr	$ 373,540		$ 121,401	$ 84,047	$ 37,354
2016-886-BOD-9-22-15	B&G Club of Cathedral City - Main Club House Capital Improvements - 1 Yr	$ 150,000		$ 15,000	$ -	$ 15,000
2016-887-BOD-9-22-15	CVEP - Mental Health College & Career Pathways Development Initiative - 2 Yr-ext 9/18	$ 737,900		$ 73,790	$ 73,790	$ -
2016-889-BOD-10-27-15	HARC - 2016 Community Health Monitor - 3 Yr	$ 499,955		$ 49,996	$ -	$ 49,996
2016-891-BOD-11-17-15	Jewish Family Services of the Desert - Mental Health Outpatient Treatment - 3 Yr	$ 570,000		$ 131,089	$ 58,500	$ 72,589
	Unexpended funds from Year 1 of Grant #891			$ (75,792)		$ (75,792)
2016-908-BOD-06-28-16	Angel View Support for the Outreach Stabilization Program - 2 Yr	$ 144,600		$ 14,460	$ 12,411	$ 2,049
2016-920-BOD-10-25-16	LifeStream Blood Bank - Support Protate Cancer Treatment Program	$ 60,000		$ 6,000	$ -	$ 6,000
2016-927-BOD-12-20-16	SafeHouse of the Desert - "What's Up" Crisis Texting Application - 3 Yr	$ 679,357		$ 373,646	$ 101,904	$ 271,743
2017-929-BOD-05-23-17	Gilda's Club Desert Cities: HeLP - Healthy Living Program - 1 Yr	$ 142,000		$ 14,200	$ 14,200	$ -
2017-934-BOD-07-25-17	Well in the Desert - New Vans for Client Pickup & Deliveries	$ 84,798		$ 8,480	$ -	$ 8,480
2017-936-BOD-07-25-17	Hidden Harvest - Senior Markets & Healthy Fairs	$ 95,000		$ 9,500	$ 9,500	$ -
2017-938-BOD-07-25-17	Mizell Senior Center - A Matter of Balance Phase 2 - 2 Yr	$ 400,300		$ 220,165	$ 90,068	$ 130,098
2017-939-BOD-07-25-17	Loma Linda University - Dream Homes Initiative - 16 months	$ 178,016		$ 57,855	$ 40,054	$ 17,802
2017-947-BOD-09-26-17	Coachella Valley Volunteers in Medicine - Primary Healhcare & Support Services - 1 Yr	$ 121,500		$ 12,150	$ -	$ 12,150
2017-948-BOD-09-26-17	Pegasus Hippo Therapy - Equine Therapy for District Residents - 1 Yr	$ 93,829		$ 9,383	$ -	$ 9,383
2017-953-BOD-11-28-17	FIND Food Bank - Project Produce - 1 Yr	$ 387,068		$ 212,887	$ 87,090	$ 125,797
2017-954-BOD-11-28-17	CVRM - Emergency Food, Shelter with Wrap Around Services for West CV Homeless 1Yr	$ 100,000		$ 55,000	$ 45,000	$ 10,000
2017-955-BOD-11-28-17	Martha's Village & Kitchen - Heatlh in Housing: Emergency Housing With Wrap Around 1Yr	$ 186,150		$ 102,383	$ 83,768	$ 18,615
2018-960-BOD-02-27-18	Desert Cancer Foundation - Patient Assistance and Suzanne Jackson Breast Cancer	$ 200,000		$ 110,000	$ -	$ 110,000
2018-962-BOD-03-27-18	EMC - CV Collaborative Program-Antibiotic Resistance Prevention Partnership(3yr w/ 1st yr fu	$ 55,805		$ 30,693	$ 25,112	$ 5,581
2018-967-BOD-05-22-18	The City of DHS-Public Safety Emergency Response Program - Purchase AEDs	$ 30,000		$ 30,000	$ 27,000	$ 3,000
2018-968-BOD-05-22-18	One Future Coachella Valley - Health Career Connection Summer Intern at DHCD/F	$ 7,314		$ 7,314	$ 6,583	$ 731
2018-974-BOD-09-25-18	HARC - 2019 Coachella Valley Community Health Survey - 3 Yr		$ 399,979	$ 399,979	$ -	$ 399,979
				$ -	$ -	$ -
				$ -	$ -	$ -
TOTAL GRANTS		**$ 16,267,132**	**$ 399,979**	**$ 12,054,078**	**$ 794,525**	**$ 11,259,553**
Amts available/remaining for Grant/Programs - FY 2018-19:						
Amount budgeted 2018-2019			$ 3,500,000		G/L Balance:	**9/30/2018**
Amount granted through June 30, 2019:			$ (399,979)		2131	$ 1,111,907
Mini Grants:	972; 973		$ (8,000)		2281	$ 10,147,646
Net adj - Grants not used:					**Total**	**$ 11,259,553**
Balance available for Grants/Programs			**$ 3,092,021**		**Difference - Rdg**	**$ (0)**

DESERT HEALTHCARE DISTRICT

Date: October 23, 2018

To: Board of Directors

Subject: RESOURCES AND PHILANTHROPY PROGRAM
Community Health Focus Area: *Primary Care & Behavioral Health Access*

Grant Request: Joslyn Center: *Joslyn Wellness Center Senior Behavioral Services Program* - $112,050

Staff Team Recommendation: an award of $112,500 be approved to support the Behavioral Services Program at the Joslyn Wellness Center.

Nexus to Community Health Focus Area Primary Care and Behavioral Health Access by supporting programs, services and workforce development efforts that increase access to primary care and behavioral health services for Coachella Valley residents: The Joslyn Senior Wellness Center is based around four pillars of need: Mental Health, Healthy Aging, Exercise and Active Living, and Nutritional and Health Education. The Joslyn Wellness Center is designed to help aging individuals meet the emerging challenges of living longer, such as disappearing retirement plans; the rising costs of daily living expenses; and coping with at least one chronic health condition, to name a few.

Use of Funds: Desert Healthcare District funds will support the core components of four main *evidence-based programs* – The Aging Mastery Program; Problem Solving Cognitive Behavior Therapy; Brain Boot Camp, and Go4Life – delivered by a Licensed Clinical Social Worker, two behavioral health program interns, and a certified personal trainer. HARC will conduct an evaluation of the programs' effectiveness and adherence to goals in conjunction with the outcomes set by each of the evidence-based programs.

Background: The Joslyn Wellness Center has been a priority of the Joslyn Center Board of Directors for the past three years. Prior to embarking on the project, a great deal of research was accomplished on emerging and existing evidence-based programs upon which to base a holistic-based wellness program. The four programs listed above were gradually introduced and expanded upon over the past years.

With the preliminary success of the pilot program, Joslyn is moving forward to expand the programs by creating a robust community engagement plan that will draw in younger senior participants as the aging process inevitably begins and facing those challenges that could lead to poor physical and mental health.

Fiscal Impact: allocated from the approved FY 2018/2019 Grant Budget.

Proposal to Desert Healthcare District
From the Joslyn Center

Background: Brief history of the organization, mission, purpose, key accomplishments, etc

Founded in 1981, the mission of the Joslyn Center is to provide health, recreational, educational and social programs along with information, referral, volunteer and support services for adults age 50+ in the communities of Indian Wells, Palm Desert and Rancho Mirage. We also provide services to underserved communities in surrounding East Valley cities and unincorporated areas. The Joslyn Center is a nonprofit organization that provides all services without discrimination regardless of religion, age, income, gender, ethnicity, national origin, disability, or sexual orientation. For 37 years, the Joslyn Center has provided programs, services and activities to improve the quality of life for local seniors. Many of these programs are free or low cost in order to be financially accessible to the low income seniors we serve. The Center offers over 50 activities and programs each week including, but not limited to the following: exercise and physical fitness, education, wellness programs and education, social engagement events, entertainment, social services such as free tax and legal consultations, free flu shots, and blood pressure testing. The Joslyn Center also provides outreach and support to low income and isolated seniors who are facing food insecurity. Our Meals on Wheels Program serves frail, homebound seniors throughout the cities of Rancho Mirage, Palm Desert and Indian Wells. Last year, we served 13,613 home delivered meals delivered by 34 volunteer drivers to 107 unduplicated clients. Our Penny's Pantry food program served 2,300 bags of groceries to low income seniors. In our previous fiscal year, we had over 45,000 visits from local seniors taking advantage of our programs and services that are designed to reduce social isolation among our 2,036 individual members. In January, 2017 we launched the Joslyn Wellness Center. The Senior Wellness Center is based around four pillars of need: Mental Health, Healthy Aging, Exercise and Active Living, and Nutritional and Health Education. The challenges of aging have changed remarkably since the last generation entered into retirement. For many seniors traditional retirement plans are disappearing, daily living expenses continue to rise, and more than 84% of people aged 65+ are coping with at least one chronic health condition and quite often over many years. As a result, most older adults are unprepared for the challenges they might face as they live longer. The Joslyn Wellness Center is designed to help meet these emerging challenges.

Strategic Link
Goal 2: Facilitate access to and availability of health and wellness services for District Residents-
2.2 Support access to and availability of mental health services

Program Title:

Joslyn Wellness Center Senior Behavioral Health Services Program

Project Description: Briefly describe your service or program, including: a) what specific challenge or opportunity does this address; b) is this a new service or program; c: is this the expansion of a new service or program; and d) is this strengthening that component of the service or program you are requesting the District to fund

In 2017, The Board of Directors of The Joslyn Center approved the development of the Joslyn Wellness Center to address the emerging needs of the "baby boomer" generation. The Wellness Center is based around four pillars of need for seniors: Mental Health, Healthy Aging, Exercise and Active Living, and Nutritional and Health Education. The challenges of aging have changed dramatically since the last generation entered into retirement. For many seniors traditional retirement plans are disappearing, daily living expenses continue to rise, and more than 85% of people ages 65 and older are coping with at least one chronic health condition, including mental health issues. As a result, most older adults are living longer than their predecessors and are unprepared for physical, emotional and financial challenges they will confront.

The Joslyn Center Senior Behavioral Health Services program is designed to help meet these emerging challenges. The program addresses the challenge of providing mental health services while reducing stigma for seniors and older adults. This program integrates new and existing services into a unique comprehensive approach and builds capacity for the Joslyn Wellness Center programs. The program provides broad based, inter-related components in an innovative manner in order to provide the resources for seniors to improve their health, fitness, behavioral health and overall wellness. Core components include the Aging Mastery Program, Problem Solving Cognitive Behavior Therapy, Brain Boot Camp, and Go4Life. Together, these components create a holistic and unique approach to mental health wellness in the Valley's aging population. The program is provided in a welcoming atmosphere that is familiar to participants while utilizing evidence-based interventions led by degreed professionals and certified trainers to deliver the core program components.

Program One: *The Aging Mastery Program (AMP)* is an evidence-based program developed by the National Council on Aging (NCOA). AMP provides a comprehensive approach to aging well by focusing on key aspects of health, finance, relationships, personal growth, and community involvement. The program uses a proven model of behavioral change with incentives. The program's primary emphasis is on motivating people to take actions to improve their lives and can become the foundation component for the remaining programs.

The AMP core curriculum combines evidence-based approaches to knowledge sharing with goal-setting and feedback routines, daily practice, peer support, and small rewards. The program is provided over the course of 10 sessions, which are led by trained expert speakers who help participants gain the skills and tools they need to manage their health, remain economically secure, and contribute actively to society.

The overarching program goal is to provide participants with an overview of the challenges encountered while navigating life in old age and offer support to master new skills to overcome these challenges. Core classes include: Navigating Longer Lives- Basics of Aging Mastery, Exercise and You, Importance of Sleep, Healthy Eating and Hydration, Financial Fitness, Advance Planning, Healthy Relationships, Medication Management, Community Engagement, and Falls Prevention. Additional program goals include: 1) reducing the stigma in seeking mental health services by addressing triggers for anxiety and depression through the Aging Mastery curriculum; 2) providing mature adults with a sense of social connectedness; 3) increasing physical activity and healthy eating habits; and 4) providing advanced planning and financial tools.
The Aging Mastery Program is delivered in ten sessions over the course of five weeks. Initially, the program will be offered in November and January. Additional courses will be offered as the interns

are trained for the course. Following training of the interns, up to two courses can be offered during the months of March, April and May. With the anticipated summer slow-down, we will offer courses in June and August and resume offering two monthly courses for the months of September and October. Based on this schedule we would offer a total of 12 Aging Mastery 10 Session Courses.

Program Two: *Problem Solving Cognitive Behavioral Therapy*, or Problem Solving Therapy (PST), is an evidence-based cognitive behavioral health program intervention under SAMHSA Center for Mental Health Services guidelines. Problem Solving Therapy involves patients learning or reactivating problem solving skills. These skills can then be applied to specific life problems associated with psychological and somatic symptoms. Cognitive Behavioral Therapy examines relationships between thoughts, feelings and behaviors. Therapists and patients work together to identify patterns of thinking that lead to self-destructive actions and the beliefs that direct these thoughts. Through treatment, patients can modify patterns of thinking to improve coping. The therapeutic model is problem-focused and goal-directed in addressing the challenging symptoms of behavioral health issues. PST has been shown to be effective for many common mental health conditions including depression and anxiety. In randomized controlled trials, when delivered by trained therapists to patients experiencing major depression, PST has been shown to be more effective than placebo and equally as effective as antidepressant medication. We have determined that the Problem Solving Therapy approach is effective and complementary therapeutic model that works effectively in conjunction with the Aging Mastery Program.

PST is client centered and is ideal for Aging Mastery graduates since that program helps to identify situations and problems that can interfere with active, healthy aging and thereby lead to depression and anxiety. Our approach is focused on encouraging individuals to become active and engaged in their community and to participate in programs and services outside of the home as the most effective way to combat isolation and depression.

With Problem Solving Therapy, the individual identifies their problem and works with the therapist/mental health professional to develop and implement their own approach to addressing the problem that is causing their depression or anxiety. Additionally, we see the value of an in-home assessment in engaging an appropriate client in the therapeutic process and will implement in-home assessments for the purposes of client engagement and appropriateness of the client for the program. We currently have a Telephone Safety Net Program that reaches out to approximately 120 clients who would be initially contacted for an in-home assessment. If the client is unable to participate in the program, a referral would be made to the appropriate resource.

Problem Solving Therapy will be offered continually throughout the grant year and will expand with the additional intern hours. Problem Solving Therapy can be offered one-on-one or in a group setting. Both approaches will be used.

Program Three: *Brain Boot Camp* is a proactive program that addresses concerns about brain health and Alzheimer's and other forms of dementia. Created by Dr. Gary Small, Director of the UCLA Longevity Center and Dr. Karen Miller, Program Director, Brain Boot Camp is designed for people who want to improve and maintain their memory abilities. A Certified Memory Trainer teaches Brain Boot Camp in a small classroom setting or on an individual basis. Brain Boot Camp is an interactive, research-based training experience that provides participants with tools and

lifestyle tips to keep their brains vital and healthy. The program examines how memory works, the relationship between physical health and memory, ways to boost memory performance, and the impact of nutrition and exercise on cognition. Participants learn basic and advanced strategies for improving concentration and attention, word finding, increasing memory capacity, developing good memory habits, and applying memory strategies to everyday memory challenges, among other topics. While Brain Boot Camp is designed as a one-time, three-hour session to help people with mild age-related memory concerns or mild cognitive impairment, we have determined that two three hour sessions is more beneficial for our clientele.

During the course of the grant year, we will offer a minimum of one Brain Boot Camp program per month. With the training of the interns, we will evaluate the capacity for increasing this program.

Program Four: *Go4Life*, is an evidence-based exercise and physical activity campaign from the National Institute on Aging at the National Institutes of Health (NIH), and is designed to help participants fit exercise and physical activity into their daily life. The core premise of the program is to engage in a variety of exercise in four categories, including endurance, strength, balance, and flexibility. The goal is to make physical activity a cornerstone of healthy aging as being physically active is vital for maintaining health and independence as individuals age. The program was developed to be offered on-site in order to utilize a certified personal trainer and to introduce participants to the other Wellness Center Programs. Additionally, group exercise has been shown to help reduce isolation and depression among the participants.

Go4Life is offered Monday, Tuesday, Wednesday, and Thursday of each week. These are basic one hour classes focusing on one or two of the core components of strength, endurance, flexibility and balance. We will offer additional advanced classes focusing on at least one of these core components in order to reach program goals and to provide "graduates" of the introductory courses more advanced options as they increase their exercise capacity.

Target Population

The Coachella Valley is the epicenter of a rapidly growing senior population in California. The California Department of Aging reports that Riverside County is among the fastest growing counties with a projected growth of up to 300% from 1990 to 2020 of those over age 60. Riverside County is also showing similar growth of seniors over age 85. According to Health Assessment & Research for Communities' (HARC) Coachella Valley Health Monitor 2016, 41% of the Valley's adult population of 307,234 were adults age 55 and older. To compare, in California generally, the US Census 2015 estimate of those 65 and older was just over 13%. The vast majority of Valley seniors were White (85.0%) and 18.8% were Hispanic/Latino. Slightly more than half (51.8%) of older adults were female and 48.2% male. HARC reported that 49.2% of Valley seniors lived in households with annual incomes of less than $50,000. Nearly 3 in 10 (29.0%) seniors had had household incomes at 200% or less of the Federal Poverty Level (FPL), including 15.1% at 100% FPL or less. HARC's 2014 report on Senior Health in the Coachella Valley noted that poverty levels increased significantly for those aged 75 and older.

There is a strong correlation between mental health issues among seniors and quality of life, degree of isolation, economic needs, and barriers to care and daily living. Seniors are living longer, struggling to get by with fewer resources, and overwhelmed by changes in their life that they feel helpless to control. Mental Health America in collaboration with the National Council on Aging

(NCOA) reported the lack of support system and feelings of social isolation can be contributing factors to mental health issues. HARC's 2014 report on Senior Health noted that "the presence of a significant other can have many positive effects on an individual's health due to the social interaction they provide, support, companionship and love." However, nearly 40% of older adults in the Valley were widowed, divorced, separated or single. HARC reports that this can have negative health implications. According to HARC, "In general, older adults who are widowed or divorced have poorer physical functioning, greater mortality risk, lower self-rated health, and more symptoms of depression than their married counterparts." There is also a high rate of undiagnosed mental health disorders among this population, including depression and dementia.

The HARC report noted that mental health issues are a major problem among the senior population with 22.3% of local seniors (28,450 people) diagnosed with one or more mental health disorders. Depressive disorder affected nearly 13% of seniors. More than 20% of seniors reported emotional, mental, and behavioral problems such as stress, anxiety or depression and approximately 58% felt the problems were sufficiently severe to seek professional help. Nearly 16% of seniors who felt they needed professional help with their emotional or behavioral problems did not know where to seek help. The most common treatment for mental health concerns is medication with 46% reporting use of medication as their primary form of treatment. Depression in seniors can be hard to recognize, and often goes untreated. Many people are unaware of the symptoms of depression or of the symptoms of depression in seniors, which can differ from those of younger individuals. According to the American Psychological Association, depression symptoms in older adults can manifest in memory problems, confusion and social withdrawal, loss of appetite and weight loss. Irritability, complaints of pain and inability to sleep can also occur. Some depressed seniors many exhibit constant complaining and demanding behavior. In addition, depression can often express itself through physical symptoms such as being very tired and sluggish, having frequent headaches and stomachaches and chronic pain. Many physicians do not recognize depression in their elderly patients and many people assume that depression is a normal part of aging and that nothing can be done. In addition to overcoming the burden of depression itself, older adults encounter widely held stigmas regarding depression and seeking mental health support. Public negative stereotypes about people, especially older adults, with mental illness are pervasive making seeking support even more difficult.

Age group:
55+ seniors

Individuals with issues (how many District residents affected by issue/challenge):
28450

District Participant Number: How many District residents will be served by program?
155

Geographic area:
All district areas

Total Participant Number: Does program serve residents outside District boundaries? If so approximately how many and in what Valley Cities.

Approximately 20 residents who currently reside outside of District boundaries in portions of Palm Desert east of Cook Street and in Indian Wells will be served by this program.

Core Know How: What specific expertise does your organization have that will allow you to achieve success of this service or program.

Since 1981, The Joslyn Center has been providing a variety of social and support services to the senior community in the Coachella Valley. Our membership has grown to over 2000 members with nearly 50,000 visits each year from members and community residents participating in over 50 programs. Our Meals on Wheels program operates only on community support and served 13, 613 meals to 107 unduplicated frail, homebound seniors in the last fiscal year. Penny's Pantry provides over 2300 bags of groceries to low income seniors each year. Our Telephone Safety Net makes over 2600 calls each year to lonely, isolated seniors. The Joslyn Center has worked with community organizations in providing counseling, grief support groups, and Alzheimer's support groups. In late, 2017, the Joslyn Center began offering evidence based programming for exercise through our newly established Wellness Center through the Go4Life Program. The evidence based Aging Mastery Program has been providing regular 10 session class series since March of 2018 in a pilot program and Brain Boot Camp launched in June 2018 with 18 participants in the most recent class. We have retained Terry Cummings, LCSW who is a Diplomat in Clinical Social Work to manage program components. Mr. Cummings has a long history of working in a variety of clinical settings from providing consulting on quality of care for mental health patients at Preferred Health Care in Irvine to providing Masters level supervision for therapists in a community based setting. He has also been a lecturer and supervisor of Masters Level social workers at Cal State University Long Beach. His experience includes supervision and development of programs for Michael's House and ABC Recovery Centers, and well as a variety of work with family and youth behavioral health clinics. Mr. Cummings has been trained in the evidence based Aging Mastery Program as well as the UCLA Brain Boot Camp programs.

Past Achievement

What related accomplishments has the organization achieved in the past three years?

The Joslyn Wellness Center has been a priority of the Joslyn Center Board of Directors for the past three years. Prior to embarking on the project, a great deal of research was accomplished on emerging and existing evidence based programs upon which to base a holistic based wellness program. The programs began with an expansion of senior exercise programs with growth from one regular program for Calisthenics to expanding to Aerobics, Strength and Stretch, Balance Conditioning, and a weekly 4 part Go4Life exercise series. In addition, The Joslyn Center has become a site for the A Matter of Balance program. In the last fiscal year, there were 41,717 participant hours in these various exercise programs. Medical education programs began in 2016 with guest lectures from Desert Regional Medical Center. This program expanded in 2017 with the addition of lectures from Eisenhower Health and a collaboration with UC Riverside Medical School Residency Program for health checks and lectures in late 2017. In January 2018, the Go4Life Exercise Program was launched with four weekly classes focusing on strength, flexibility, endurance, and balance. The Go4Life program logged nearly 2000 participant hours in just six months. The Aging Mastery Program was launched in March, 2018 and consists of a ten (10)

session course over a period of five (5) weeks. In the first four sessions, we have graduated 31 participants who have reported a high level of satisfaction with the course. Many graduates have continued to participate in an ongoing support group to share their progress and continue to seek support from their fellow graduates. Brain Boot Camp was implemented in July 2018 with a beta group of 8 participants who reported a high satisfaction level. The most recent course had 18 participants registered. During the summer months and continuing, we have added healthy cooking classes and nutritional seminars provided by Residents from, the UCR Medical School program. As programs and services have been added to the Joslyn Wellness Center programming, we have received growing community support from area medical providers, UC Medical School Residency Program and participants. Current funders of various aspects of the program include the Regional Access Project Foundation, Coachella Valley Wellness Foundation, the Grace Helen Spearman Charitable Foundation, and the Newman's Own Foundation. The Desert Healthcare District provided a $5,000 grant to support the nutritional and educational aspects of the program.

Sustainability: How will you financially sustain this service or program once the grant term ends?

The Joslyn Center Board of Directors has given the Joslyn Wellness Center its highest priority in launching an effective program and maintaining the program. The Joslyn Center has varied funding sources that provide a strong basis of financial support and reduce our vulnerability to the loss or reduction from any one funding sources, including grants, fundraising and membership, and from contributions from the cities of Rancho Mirage, Indian Wells and Palm Desert'. Much of our funding is unrestricted allowing us the flexibility to provide additional support to the Wellness Center as needed. In it's current pilot program stage, foundation support has been very favorable with support from the Regional Access Project Foundation, The Auen Foundation, Coachella Valley Wellness Foundation, The Grace Helen Spearman Foundation, and Newman's Own Foundation. With the preliminary success of the pilot program, we will move forward on a creating a more established funding base by exploring other grant opportunities to continue supporting the program and will reapply to funders currently supporting the program as grant periods expire. We will continue to expand our grant efforts from corporations, foundations and municipal funding sources. Wellness Center Director Terry Cummings, LCSW, will soon begin the application process and identify requirements to provide Medicare reimbursable mental health services for the Problem Solving Therapy Program, which will strengthen our financially ability to sustain the overall program. Additionally, The Joslyn Center is building our development efforts to bring in more private contributions to support the Wellness Center. We have initiated new fundraising events that have proved successful and are building our Cornerstone Club for major donors and on-going support.

We are working closely with local medical providers and the UC Riverside School of Medicine for In-kind services for wellness checks and education on nutrition and other health matters. These efforts in building and solidifying community support will help insure the sustainability of the program as stakeholders become more committed.

Results Statement: Provide the specific benefits or tangible effects that will be achieved at the end of program period?

At the conclusion of the 12 month grant period projected to end October 31, 2019, the Joslyn Wellness Center Senior Behavioral Health Services Program will achieve the following objectives: 1) Build upon the initial success of the pilot program to establish an integrated wellness program that will serve a combined minimum of 175 unduplicated older adults age 55 and older; 2) a minimum of 100 clients will participate in the Aging Mastery Program component, with 60% successfully completing a minimum of seven of ten sessions; 3) a minimum of 120 clients will participate in the Brain Boot Camp component with 67% successfully completing both sessions; 4) a minimum of 70 clients will participate in Problem Solving Therapy, with 60% achieving treatment goals; and 5) a minimum of 100 clients will participate in in Go4Life with 65% participating in regular exercise sessions.

At the conclusion of the 12 month grant period, the program will achieve the following outcomes:
Aging Mastery Program: 1) 50% of participants who successfully complete the Aging Mastery Program will demonstrate improvement in well being as measured by the World Health Organization's Wellbeing Index, which includes five items rated on a 6 point Likert scale;
2) 60% of participants who successfully complete the Aging Mastery Program will report making a change that improves quality of life in one of the ten core curriculum areas;
3) 50% of participants who successfully complete the Aging Mastery Program will report that program participation has had a positive impact on relationships with others;

Brain Boot Camp: 1) 60% of Brain Boot Camp participants will report that the program better helped them understand relationships between brain health and physical health and activity;
2) 60% of Brain Boot Camp participants will report that they have learned new techniques to improve memory;

Problem Solving Therapy: 1) 50% of clients who participate in Problem Solving Therapy will report improved confidence in their ability to solve their own problems; and

Go4Life: 1) 65% of participants in Go4Life will report that they are regularly engaging in exercise.

HARC:
Evaluation of each of the programs driven by outcomes set by each of the evidence base programs as captioned above.

Intern Hours: Two interns under the direction, guidance, and supervision under the LCSW will have gained at least 500 hours each to be applied against their required hours for licensing.

Marketing and Advertising Plan: Create and implement marketing plan to enable the attraction of new senior members of the community to participate in the four programs.

Tracking: How will you measure the progress of the program? Please use a 12 month timeline, outlining key activities, and outcomes associated with each month.

In November 2018, upon notice of grant approval, the Joslyn Center will increase hours for LCSW consultant, develop a three month calendar for programs and develop a marketing plan for effective marketing and recruitment of program participants. The LCSW Consultant will complete

final job descriptions and begin recruitment of counseling interns to provide counseling. The LCSW consultant will begin research on counseling program requirements and potential billing of Medicare for Cognitive Behavioral/Problem Solving Therapy. Recruit presenters for upcoming Aging Mastery Program and produce and conduct Aging Mastery and Brain Boot Camp Programs.

In December 2018, we will begin promotion of programs, recruitment of participants, and set advertising schedule for programs; continue recruitment and begin interviews of interns for counseling and for delivering the Aging Mastery Program and Brain Boot Camp; and set January date for Aging Mastery Program. Complete evaluation materials for all programs.

In January 2019, we will complete interview and background checks for interns and begin training and scheduling for programs. Complete schedule for Brain Boot Camp and Aging Mastery Programs through June, 2019. Complete advertising schedule to conform with marketing for scheduled classes and programs. Review and assess budget and expenditures to ensure budget compliance.
In February 2019, we will assess counseling interns schedule and make any necessary adjustments to counseling schedule and schedule for Aging Mastery and Brain Boot Camp. We will review Go4Life exercise schedule and add afternoon classes to expand reach of the program. We will schedule and promote dates for upcoming programs. Assess marketing plan and program registrations. Adjust marketing plan in required.

In March, April, and May 2019, we will assess schedules of classes and programs and continue promotion; begin scheduling additional Aging Mastery Program classes and assess effectiveness of promotion and class participation; review evaluations for various programs and make any adjustments that would improve program delivery and effectiveness; review program funding from other sources and develop approach to secure additional and on-going funding; review program participation to evaluate if participants are engaging in other aspects of the program such as regular exercise, educational programs and counseling as needed; and assess if the holistic approach is achieving desired results.

In June 2019, the LCSW provides report on counseling program and preparations on potential billing of Medicare for counseling under Problem Solving Cognitive Behavioral Therapy. We will review schedule and deliverables of first six months of program and make any necessary adjustments to insure program deliverables are met. We will complete the schedule for remaining months of program and plan to insure program goals and participation is on track; review number of counseling hours provided by interns and report on progress; assess Go4Life program and participation; and review program assessment tools to insure Go4Life remains on track.

In July, August, September 2019, we will review and modify as necessary program promotion and advertising; ensure programs are being scheduled and delivered in accordance with program plan; continue assessment of evaluations; begin obtaining testimonials from program participants for use in promotion and in approaching potential financial supporters; and begin application process for potential billing of Medicare to selected insurance providers for counseling under Problem Solving Therapy.

In October 2019, we will review program participation and evaluations from participants; work with HARC in developing a final evaluation review and documentation; conduct focus groups with program participants to determine the extent and experiences in program participation and whether they participated in more than one aspect of the overall program such as exercise, counseling, Aging Mastery and/or Brain Boot Camp; and assess and evaluate participant comments and suggestions.

1. Number of residents served: 155 unduplicated for the grant period.

Cost implications: if there are unanticipated costs associated with this service or program, how will they be covered?

It is unlikely that this program will be faced with unanticipated costs. However, given that a significant portion of program services are provided by contracted clinicians, mental health interns and certified trainers, the program has a built in scalability that allows for a reduction of services in case of emergency financial situations without detriment to the program. However, in the event of funding shortfall, the Joslyn Center is prepared to allocate additional funds from our general operating reserves in order to meet as much of the community needs as possible.

Organizational Change Required: Describe any critical changes to the organization, policy or staffing that are required to successfully implement this service or program. Will there be additional staff hired?

Additional staff will be hired as interns for the behavioral health component of this proposal as well as the expanding of the time commitment of our LCSW consultant. Additional staff training will be necessary in connection with the counseling component in terms of maintaining confidentiality and in maintaining records in compliance with HIPAA requirements. We already comply with HIPAA in other areas such as Meals on Wheels and in the Aging Mastery Program. However, appointment scheduling processes and staffing the separate reception area for the Wellness Center will be required. We anticipate engaging an individual to provide training to all staff with respect to maintaining confidentiality with the counseling program and in providing a safe and welcoming atmosphere for individuals who may be experiencing anxiety, depression, or other concerns that will be accessing the program.

Key Partners: are any partners or intermediaries critical to success? Is so, what role must they play and what is evidence that they are committed to play it?

The Joslyn Wellness Center has already received a Letter of Support from the UC Riverside School of Medicine Residency Program and we have been working with them in providing education and wellness checks. We are also working with local medical providers including Desert Oasis Healthcare, Eisenhower Health and Desert Regional Medical Center (Desert Care Partners) in providing experts for the Aging Mastery Program as well as referring their patients to the Aging Mastery Program. We have utilized sleep physicians from Eisenhower Health for that section of the Aging Mastery Program as well as staff from the UC Riverside School of Medicine Family Health Center in providing other expert assistance in various aspects of Aging Mastery including healthy relationships and nutrition. These relationships are ongoing and we are in the process of securing Memorandums of Understanding to continue in this role. In addition, the Joslyn Center has close collaborations with local community-based organizations that enable us to provide broad-

based support for our clients without duplicating existing services in the community. We work closely with the Neuro Vitality Center, Mizell Senior Center, Alzheimer's Association, Jewish Family Service of the Desert, Arthritis Association, Dementia Help Center, Riverside County's Departments of Adult Protective Services and the Office on Aging, Senior Advocates of the Desert, the Salvation Army, the Indio Senior Center, the Cathedral City Senior Center, and Catholic Charities, among others.

DESERT HEALTHCARE DISTRICT GRANT AGREEMENT

This agreement is entered into by the Desert Healthcare District ("DISTRICT"), a California health care district organized and operating pursuant to Health and Safety Code section 32000 et seq., and The Joslyn Center ("RECIPIENT") and is effective upon execution by both parties.

1. Grant

Purpose and Use of Grant: Joslyn Wellness Center Senior Behavioral Health Services Program

Amount: $112,050.00

2. Term of Agreement

The term of this agreement is from November 1, 2018 through October 31, 2019 , subject, however, to earlier termination as provided in this agreement.

3. Legal Responsibility/Liability

In authorizing execution of this agreement, the governing body of RECIPIENT accepts legal responsibility to ensure that the funds provided by DISTRICT are allocated solely for the purpose for which the grant was intended. RECIPIENT agrees to be knowledgeable of the requirements of this agreement and to be responsible for compliance with its terms. In no event shall DISTRICT be legally responsible or liable for RECIPIENT's performance or failure to perform under the terms of the grant or this agreement.

RECIPIENT agrees that DISTRICT may review, audit, and/or inspect DISTRICT-funded program operated by RECIPIENT under this agreement for compliance with the terms of this agreement.

4. Reduction/Reimbursement of Awarded Funds

DISTRICT may reduce, suspend, or terminate the payment or amount of the grant if the District determines in its sole discretion that RECIPIENT is not using the grant for the intended purposes or meeting the objectives of the grant. RECIPIENT hereby expressly waives any and all claims against DISTRICT for damages that may arise from the termination, suspension, or reduction of the grant funds provided by DISTRICT.

DISTRICT _____ RECIPIENT _____

RECIPIENT further agrees to reimburse any funds received from DISTRICT, where the DISTRICT determines that grant funds have not been utilized by RECIPIENT for their intended purpose.

5. Other Funding Sources

If requested by DISTRICT, RECIPIENT shall make information available regarding other funding sources or collaborating agencies for the programs or services provided by RECIPIENT.

6. Attribution Policy

RECIPIENT agrees to comply with the DISTRICT'S attribution policy, which is attached to this agreement as Exhibit "A."

7. Payment Schedule

Unless RECIPIENT and DISTRICT agree upon alternative arrangements, grant funds shall be allocated and paid according to the schedule and requirements described on Exhibit "B." In the event RECIPIENT fails to provide report(s) and/or appropriate supporting documentation in a timely manner, RECIPIENT may be subject to a delay or discontinuance of funding, at DISTRICT'S sole discretion.

8. Program Budget

RECIPIENT shall also submit, prior to the DISTRICT entering into this agreement, a program budget, which shall be subject to review and approval of DISTRICT. A copy of RECIPIENT'S program budget shall be attached to this agreement as Exhibit "C."

9. Scope of Services/Recipient Activities

Prior to the DISTRICT entering into this agreement, RECIPIENT shall include in its application, subject to review and approval by the DISTRICT, details of the RECIPIENT'S scope of service(s), activities or program(s) proposed for funding.

10. Evaluation/Outcomes Reporting

Prior to the District entering into this agreement, RECIPIENT shall include in its application, subject to review and approval of the DISTRICT, details of its plan for evaluation and reporting.

RECIPIENT shall cooperate in efforts undertaken by DISTRICT to evaluate RECIPIENT'S effectiveness and use of the grant funds. RECIPIENT shall participate in and comply with all on-site evaluation and grant monitoring procedures including interviews with RECIPIENT'S staff by DISTRICT. RECIPIENT, at the request of the DISTRICT, shall also provide progress reports to DISTRICT according to the schedule contained on Exhibit "B" in a format to be provided by DISTRICT.

11. Use of Subcontractors

RECIPIENT may not subcontract any portion of the duties and obligations required by this agreement without the written consent of the DISTRICT. A copy of the proposed subcontract between RECIPIENT and the subcontractor shall be provided to DISTRICT for review. In the event DISTRICT consents to subcontract, the subcontractor shall be required to execute an agreement assuming all rights and obligations of this agreement, including the DISTRICT'S right to inspect the subcontractor's books and records and the right to monitor and evaluate the effectiveness of the use of the grant funds. Notwithstanding the forgoing, RECIPIENT shall remain primarily responsible for compliance with all terms and conditions of this agreement.

12. Use of Funds

The funds received pursuant to this agreement may not be used by RECIPIENT for general operating expenses or any other programs or services provided by RECIPIENT without the written consent of DISTRICT.

Upon request, RECIPIENT shall make available for the DISTRICT and members of the public, a detailed description of the program(s) and/or service(s) funded by DISTRICT. This program description may be a separate document or may be incorporated into the overall program materials developed by the RECIPIENT.

13. Prevailing Wages.

If the funds received are used to pay for any portion of an applicable "public works" or "maintenance" project, as defined by the Prevailing Wage Laws (Labor Code sections 1720 et seq. and 1770 et seq.), and if the project cost is $1,000 or more, RECIPIENT agrees to fully comply with such Prevailing Wage Laws, if applicable. RECIPIENT shall require any contractor or subcontractor performing work on an applicable "public works" or "maintenance" project to fully comply with all Prevailing Wage Laws, including but not limited to the payment of prevailing wages, registration with DIR, and maintenance of certified payroll records."

14. Independent Contractor Status

The relationship between DISTRICT and RECIPIENT, and the agents, employees, and subcontractors of RECIPIENT in the performance of this agreement, shall be one of independent contractors, and no agent, employee, or subcontractor of RECIPIENT shall be deemed to be an officer, employee, or agent of DISTRICT.

15. Use of Funds for Lobbying or Political Purposes

RECIPIENT is prohibited from using funds provided by DISTRICT herein for any political campaign or to support attempts to influence legislation by any governmental body.

16. Compliance with Applicable Law and Regulations

RECIPIENT shall comply with all federal, state, and local laws and regulations, including but not limited to labor laws, occupational and general safety laws, and licensing laws. All licenses, permits, notices, and certificates as are required to be maintained by RECIPIENT shall be in effect throughout the term of this agreement.

Where medical records, and/or client records are generated under this agreement, RECIPIENT shall safeguard the confidentiality of the records in accordance with all state and federal laws, including the provisions of the Health Insurance Accountability and Portability Act of 1996 (HIPAA), and the laws and regulations promulgated subsequent thereto.

RECIPIENT shall notify DISTRICT in writing within 5 (five) days if any required licenses or permits are canceled, suspended, or otherwise terminated, or if RECIPIENT becomes a party to any litigation or investigation by a regulatory agency that may interfere with the ability of RECIPIENT to perform its duties under this agreement.

17. Changes or Modifications to the Use of DISTRICT Grant Funds

RECIPIENT shall submit to DISTRICT, in writing, any requests for proposed changes in the use of DISTRICT grant funds. DISTRICT must receive such requests at least thirty (30) days prior to the date the proposed changes are to be implemented and the proposed changes shall be subject to DISTRICT Board approval.

Notwithstanding the foregoing, requests for transfers between budget categories or line items less than ten percent (10%) of the total grant amount that do not change the total grant amount or generate additional line items may be directed to the DISTRICT's Program Department for consideration.

18. No-Cost Grant Extensions

Any request by the RECIPIENT to extend a grant's project period without additional funding from the DISTRICT will be processed pursuant to the DISTRICT's No-Cost Grant Extension Policy. Any no-cost grant extension request shall be subject to DISTRICT Board approval.

19. Conflict of Interest/Self Dealing

RECIPIENT and RECIPIENT'S officers and employees shall not have a financial interest or acquire any financial interest, direct or indirect, in any business entity or source of income that could be financially affected by, or otherwise conflict in any manner or degree with, the performance of programs or services required under this agreement.

20. Indemnity and Hold Harmless

RECIPIENT agrees to indemnify, defend, and hold harmless DISTRICT and its officers, agents, employees, volunteers, and servants from any and all claims and losses accruing or resulting to any and all employees, contractors, subcontractors, laborers, volunteers, and any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this agreement and from any and all claims and losses accruing or resulting to any person, firm, or corporation who may be injured or damaged by RECIPIENT in the performance or execution of this agreement, or in the expenditure of grant funds provided by DISTRICT.

21. Fiscal/Accounting Principles

RECIPIENT shall maintain an accounting system that accurately reflects and documents all fiscal transactions for which grant funds are used. The accounting system must conform to generally accepted accounting principles and upon request, DISTRICT shall have the right to review, inspect and copy all books and records related to the accounting system.

22. Documentation of Revenues and Expenses

RECIPIENT shall maintain full and complete documentation of all revenue and expenses (including subcontracted, overhead, and indirect expenses) associated with use of the grant funds covered by this agreement. During the term of this agreement and thereafter, DISTRICT or its authorized representative(s) shall have the right to review all RECIPIENT financial records including records related to the use or disbursement of the grant funds, upon request by DISTRICT. DISTRICT shall also have the right to audit, if necessary, RECIPIENT'S use of grant funds and any and all programs or services that were provided through the use of the DISTRICT funds. In the event of an audit or financial review,

RECIPIENT agrees to provide DISTRICT access to all of RECIPIENT'S books and records.

23. Records Retention

All records of RECIPIENT pertaining to the use of grant funds shall be maintained at RECIPIENT'S main local office for at least five (5) years following the year in which grant funds were first provided by DISTRICT.

24. Governing Law

This agreement shall be governed by and construed in accordance with the laws of the State of California.

25. Assignment or Transfer

RECIPIENT may not assign or transfer any interest in this agreement or entitlement to grant funds without the written consent of District.

26. Entire Agreement, Amendment

This agreement contains the entire understanding and agreement of the parties with respect to the subject matter hereof and supersedes all prior and contemporaneous agreements not contained herein. This agreement may only be amended or modified by a writing signed by both parties.

27. Notices

Any notice required or permitted pursuant to this agreement may be given by a party to the other party at the address set forth in the signature block of this agreement. Either party may change its address for purposes of notice by complying with the requirements of this section.

28. Signatories

The persons executing this agreement on behalf of the RECIPIENT have been designated by the governing body or fiscal agent of the RECIPIENT as the official signatories of this agreement and all related documents. At least one of these persons is a member of the RECIPIENT'S governing board, and both persons have the authority to execute this agreement on behalf of RECIPIENT.

RECIPIENT:
The Joslyn Center
73-750 Catalina Way
Palm Desert, CA 92262

Name: President/Chair of RECIPIENT Governing Body

_____
PLEASE PRINT

_____
SIGNATURE

_____
DATE

Name: Executive Director

_____
PLEASE PRINT

_____
SIGNATURE

_____
DATE

Authorized Signatory for Desert Healthcare District:

Name: Chris Christensen
Title: Interim Chief Executive Officer

_____
SIGNATURE

_____
DATE

Desert Healthcare District
1140 N. Indian Canyon Dr.
Palm Springs, CA 92262

EXHIBIT A

DESERT HEALTHCARE DISTRICT ATTRIBUTION POLICY

1. Attribution Wording

Attribution for District-funded programs shall be as follows:
"Made possible by funding from Desert Healthcare District" / "Echo possible por medio de fondos de Desert Healthcare District" or "Funded by Desert Healthcare District" / "Fondado por Desert Healthcare District"

2. Educational Materials

Educational materials are items such as brochures, workbooks, posters, videos, curricula, or games. Materials (in print or electronic formats) produced and distributed for Desert Healthcare District-funded programs shall include the approved wording.

3. Promotional Materials

District attribution shall be included on promotional items such as flyers, banners and other types of signage. However, acknowledgement may be omitted when space limitation is an issue (e.g., buttons, pencils, pens, etc.)

4. Media Materials and Activities

Attribution to the District shall be included in any information distributed to the media for the purpose of publicizing a District-funded program. This information may include news releases and advisories, public service announcements (PSAs), television and radio advertisements, and calendar/event listings.

Media and publicity activities, such as news conferences, story pitching, press interviews, editorial board meetings and promotional events shall include reference to the District's program support. As a courtesy, the District would appreciate notification of these activities at least two (2) weeks in advance, whenever possible. Please send to the District copies of any press coverage of District-funded programs.

5. Logo Usage

Use of the Desert Healthcare District logo is permitted and encouraged. Logos can be provided in print and electronic formats. Logos will be provided by DISTRICT upon initial grant funding and at RECIPIENT's request thereafter. Graphic standards for logos shall be adhered to as provided by DISTRICT. Requests for logo should be directed to the Program Department of Desert Healthcare District.

6. Photograph Consent

RECIPIENT shall permit photographs of District-funded program to be taken by District-designated photographer at District expense, and consents to usage of such photographs on District Web site and other materials designed to inform and educate the public about District.

DISTRICT _____ RECIPIENT _____

EXHIBIT B

PAYMENT SCHEDULE, REQUIREMENTS & DELIVERABLES

Project Title	*Start/End*
Joslyn Wellness Center Senior Behavioral Health Services Program	11/1/2018 10/31/2019

PAYMENTS:

(2) Payments: $50,422.500
10% Retention: $11,205.00

Total request amount: $112,050.00

PAYMENT SCHEDULE REQUIREMENTS:

Scheduled Date	Grant Requirements for Payment	Payment
11/01/2018	Signed Agreement submitted & accepted	Advance of $50,422.50 for time period 11/01/2018 – 4/30/2019
05/01/2019	1st six-month (11/01/2018 – 4/30/2019) progress and budget reports submitted & accepted	Advance of $50,422.50 for time period 5/01/2019– 10/31/2019
11/01/2019	2nd six-month (5/01/2019 – 10/31/2019) progress and budget reports submitted and accepted	$0
11/30/2019	Final report (11/01/2018 – 10/31/2019) submitted & accepted	$11,205.00 (10 % retention)

TOTAL GRANT AMOUNT: $112,050.00

DELIVERABLES:

At the conclusion of the 12 month grant period projected to end October 31, 2019, the Joslyn Wellness Center Senior Behavioral Health Services Program will achieve the following objectives: 1) Build upon the initial success of the pilot program to establish an integrated wellness program that will serve a combined minimum of 175 unduplicated older adults age 55 and older; 2) a minimum of 100 clients will participate in the Aging Mastery Program component, with 60% successfully completing a minimum of seven of ten sessions; 3) a minimum of 120 clients will participate in the Brain Boot Camp component with 67% successfully completing both sessions; 4) a minimum of 70 clients will participate in Problem Solving Therapy, with 60% achieving treatment goals; and 5) a minimum of 100 clients will participate in in Go4Life with 65% participating in regular exercise sessions.

At the conclusion of the 12-month grant period, the program will achieve the following outcomes:

Aging Mastery Program: 1) 50% of participants who successfully complete the Aging Mastery Program will demonstrate improvement in wellbeing as measured by the World Health Organization's Wellbeing Index, which includes five items rated on a 6-point Likert scale;
2) 60% of participants who successfully complete the Aging Mastery Program will report making a change that improves quality of life in one of the ten core curriculum areas;
3) 50% of participants who successfully complete the Aging Mastery Program will report that program participation has had a positive impact on relationships with others;

Brain Boot Camp: 1) 60% of Brain Boot Camp participants will report that the program better helped them understand relationships between brain health and physical health and activity;
2) 60% of Brain Boot Camp participants will report that they have learned new techniques to improve memory;

Problem Solving Therapy: 1) 50% of clients who participate in Problem Solving Therapy will report improved confidence in their ability to solve their own problems; and

Go4Life: 1) 65% of participants in Go4Life will report that they are regularly engaging in exercise.

HARC:
Evaluation of each of the programs driven by outcomes set by each of the evidence base programs as captioned above.

Intern Hours: Two interns under the direction, guidance, and supervision under the LCSW will have gained at least 500 hours each to be applied against their required hours for licensing.

Marketing and Advertising Plan: Create and implement marketing plan to enable the attraction of new senior members of the community to participate in the four programs.

EXHIBIT C

PROGRAM BUDGET ATTACHED AS SUPPLEMENTAL PAGE(S)

Line Item Budget - Sheet 1 Operational Costs
Proposed One Year Budget

Approved budgets are the basis for reporting all grant expenditures. Line items may not be added or changed without grant amendment. Prior authorization is required for transfering funds (<10%) between existing line items. Describe budget narrative in cell B38. You may insert rows or create additional worksheets if more space is needed to fully describe your budget.

PROGRAM OPERATIONS		Total Program Budget	Funds from Other Sources Detail on sheet 3	Amount Requested from DHCD
Total Labor Costs	Detail on sheet 2	$134,800.00		$86,300.00
Equipment (itemize)				
1	Exercise Training Program Supplies	$3,000.00		$2,000.00
2				
3		$0.00		
4		0		
Supplies (itemize)				
1	Memory Training - Aging Mastery - Licensing Fees	$3,000.00		$1,000.00
2	Office Supplies/equipment	$2,000.00		$500.00
3	Marketing Brochures	$1,000.00		$500.00
4	Meeting Supplies - Participant Snacks	$500.00		$150.00
Printing/Duplication		$500.00		$250.00
Mailing/Postage/Delivery		$250.00		$100.00
Travel (program and training)				
Facilities (Detail)				
Office/Rent/Mortgage (Allocation)		$6,000.00		$2,000.00
Meeting Room Rental		$0.00		
Telephone/Fax/Internet		$1,500.00		$1,000.00
Utilities		$2,500.00		$1,250.00
Insurance		$3,000.00		$1,250.00
Maintenance/Janitorial				
Other Facility costs (itemize)				
1		0		
2		0		
3		0		
4		0		
Other Program Costs not described above (itemize)				
1	Marketing and Advertising	$12,000.00		$8,000.00
2	Employee Taxes and Benefits	$1,500.00		$750.00
3	Indirect Costs @ 8%	$14,000.00		$7,000.00
4		$0.00		
Total Program Budget		$185,550.00	$75,500.00	$112,050.00

Line Item Budget - Sheet 1 Operational Costs
Proposed One Year Budget

Budget Narrative	**Strength Training Gym Supplies:** Exercise supplies and equipment including light weight dumbells, floor exercise mats, and stretch bands . **Memory Training, Aging Mastery Curriculum and supplies:** The licensing fees for these evidence based programs as well as printed course materials, cirriculum and training **Office Supplies:** General office supplies, printer cartridges, paper, pens, writing tablets, etc. **Marketing Brochures:** Purchase of brochures for evidence based programs as well as designing and printing of class brochures **Meeting Supplies and Participant Snacks:** Flip charts, pens, paper pads, and snacks for participants in Evidence based programs **Printing/Duplication:** printing and duplication of course materials, flyers, etc. **Mailing/Postage/Delivery:** cost of postage and mailing of contracts, letters to clients and general mailing and delivery costs **Education/Training (Aging Mastery, Memory Course):** Licensing fees, training costs for evidence based courses **Office Rent:** Allocation of dedicated space for counseling rooms, exercise area, and program office **Telephone/FAX/Internet:** Costs of telephones for office space, internet access for email **Utilities:** allocated cost of utilities for office space dedicated to program, on separate thermostats **Insurance:** allocated cost of insurance and cost of insurance for personal trainers and counseling **Marketing and Advertising:** Print advertising in publications with a large senior and older adult readership **Employee Taxes and Benefits:** Cost of employee taxes, benefits, and insurance

Line Item Budget
Sheet 2 - Labor Costs

Staff Salaries Employee Position/Title		Annual Salary	% of Time Allocated to Program	Actual Program Annual Salary	Amount of Salary Paid by DHCD Grant
1	Executive Director	$96,000.00	5	$4,800.00	$4,800.00
2	Program Intake Coordinator	$13,250.00	50	$13,520.00	$10,000.00
3					
4					
5					
6					
7					
8					
Enter this amount in Section 1, Employee Salaries				Total ›	$14,800.00
Budget Narrative	**LCSW Wellness Center Director:** Salary of Wellness Center Director LCSW licensed to allow for counseling (.75FTE) **Program Director:** Portion of salary of Joslyn Center Program Director for coordinating exercise classes and programming relating to exercise programs and education programs.				

Consultants/Contractors Consultant/Contractor Name		Hourly Rate	Hours/ Week	Monthly Fee	Amount of Salary Paid by DHCD Grant
1	LCSW Wellness Center Director	$60.00	22	$5,760.00	$45,000.00
2	Certified Personal Trainer	$50.00	10	$2,000.00	$12,500.00
3	Behavioral Health Prog. Interns(2)	$25.00	10	$2,000.00	$10,000.00
4	HARC Evaluation				$4,000.00
5					
6					
7					
8					
Enter this amount in Section 1, Professional Services/Consultants				Total ›	$71,500.00
Budget Narrative	**Certified Personal Trainer: Hourly rate for personal trainer to deliver Go4Life program classes and train individuals on the safe and appropriate use of exercise equipment Behavioral Health Program Interns (2): Two interns supervised by LCSW to deliver low/no cost counseling. The interns would be trained by the LCSW in delivering the Aging Mastery Program, Brain Boot Camp, and Problem Solving Therapy. Interns would earn up to 500+ hours each toward their licensing requirements. HARC Evaluation: Cost of HARC Evaluation of program effectiveness and adherance to goals.**				

Line Item Budget - Other Program Funds

Funding for this program received from other sources			Amount
Fees			$5,000.00
Donations			
Grants (List Organizations)			
	1	Regional Access Project Foundation	$18,000.00
	2	Auen Foundation	$20,000.00
	3	Grace Helen Spearman Foundation	$15,000.00
	4	Coachella Valley Wellness Foundation	$10,000.00
Fundraising (describe nature of fundraiser)			
	Allocation from fundraising events		$7,500.00
Other Income, e.g., bequests, membership dues, in-kind services, investment income, fees from other agencies, etc. (Itemize)			
	1		
	2		
	3		
	4		
Total funding in addition to DHCD request			$75,500.00

Budget Narrative

Fees: Projected participant income generated from program participation and class fees **Regional Access Project Foundation:** Includes Approved amount from Regional Access Project Foundation for Wellness Center with expectation of renewed funding. **Auen Foundation:** Projected amount and request to the Auen Foundation for Wellness Center programs for FY 2018 - 19 **Grace Helen Spearman Foundation:** Committment projected for 2018 19 fiscal year for Wellness Center Programming **Newman's Own Foundation:** Commitment projected for 2018-19 for Wellness Center Programming.

DESERT HEALTHCARE DISTRICT

Date: October 23, 2018

To: Board of Directors

Subject: RESOURCES AND PHILANTHROPY PROGRAM
Community Health Focus Area: *Primary Care & Behavioral Health Access*

Grant Request: Desert Arc: *Desert Arc Health Care Program* - $167,738

Staff Recommendation: an award of $167,738 be approved to support the Desert Arc Health Care Program at Desert Arc.

Nexus to Community Health Focus Area Primary Care and Behavioral Health Access by supporting programs, services and workforce development efforts that increase access to primary care and behavioral health services for Coachella Valley residents:
The Desert Arc Health Care Program provides health and wellness services for adults with disabilities who would otherwise not be able to participate in the Adult Day Center Program and the Behavior Management Program. These programs serve adults with severe disabilities and support Desert Arc staff with specialized training to ensure clients have the opportunity to participate fully in programs at Desert Arc.

Use of Funds: Desert Healthcare District funds will support the two Licensed Vocational Nurses that attend to the medical needs of the vulnerable clients and if necessary, to Desert Arc staff; allow an attending physician consultant to oversee the medical license requirements for the Adult Day Center Program; and to provide specialized training to Desert Arc staff in the Behavior Management Program.

Background: The Adult Day Center Program design has its foundational roots in sensory exploration and sensory integration and designed to assist the severely disabled adults in learning daily living skills as well as social and communication skills while promoting community-based instruction and client independence. The LVNs have been an integral part of the program since 1990.

The Behavioral Management Program, with staff training provided by a behavioral specialist that came on board in 2003, is divided into two components: the first includes a program modeled after the Adult Day Center Program with an emphasis on addressing behavioral challenges of clients while the second component is designed to provide paid vocational training to individuals with significant behavioral challenges. Both components have enhanced staffing ratios, and staff participates in additional training by the specialist to learn how to deal with aggressive behaviors.

Both the Adult Day Center and Behavioral Management Programs are regulated by Community Care Licensing.
Fiscal Impact: to be allocated from the approved FY 2018/2019 Grant Budget.

Improving District Lives

Organization

REQUESTING ORGANIZATION

Organization Name Desert Arc

Address 73255 Country Club Drive

City Palm Desert

State CA

ZIP 92260

Tax ID# 956006700

Primary Phone Number (760) 346 1611

Website URL www.desertarc,org

Organization Type

Nonprofit

Background

Brief history of the organization, mission, purpose, accomplishments, etc. (limit = 100 words)

Desert Arc's mission is to enhance the lives and create opportunities for people with disabilities. The agency was created in 1959 by a group of concerned parents who wished to expand the horizons of their children with developmental and intellectual disabilities. The agency was incorporated in 1971. As the agency enters its 60^{the} year of service it remains the only non-profit agency in the area that provides comprehensive services for adults with disabilities that include vocational training, job training/employment; social/recreational activities, lunch/nutrition, support for independent living; case management, advocacy with community integration; and adult day care.

Organization Sustainability

What predicts your sustainability as an organization? Please speak to financial, program factors and strategic direction (word limit - 500)

Desert Arc has operated within its budget parameters for the past fiscal year. The year-to-date revenue was over budget, and offset some expenses were above budget mainly due to the minimum wage increases and higher than expected fuel costs.
Desert Arc client enrollment at the end of the fiscal year was increased by 33 clients with four new clients in the Adult Day Program and two new clients in the Behavior Management Program. Desert Arc has implemented a new 3-year strategic plan that includes step to obtain full cost reimbursement rates for all programs. To develop a strategy for robust and diversified funding to sustain and grow the organization. To develop and

implement a marketing strategy, and to develop and implement efficient operational practices. The strategic plan is included in the application packet.

Contact Information

PRIMARY CONTACT FOR THE ORGANIZATION

If request, contact differs from organization Executive Director.

Prefix Mr.

First Name Richard

Last Name Balocco

Title President/CEO

Office Phone (760) 346 1611

Extension 207

E-mail rbalocco@desertarc.org

PRIMARY CONTACT FOR THIS REQUEST

Same as Organization Primary Contact

Prefix Ms.

First Name Liz

Last Name Nabie

Title Director of Grant Development

Office Phone (760) 346 1611

Extension 422

Email lnabie@desertarc.org

ADDITIONAL CONTACT - GRANT WRITER

If different from Primary Contact

Prefix

First Name

Last Name

Title

Office Phone

Extension

E-mail

Request Summary

DESCRIBE BASIC DETAILS OF YOUR REQUEST

Note: following pages will ask for specific additional details

Strategic Link

What objective of the District's Strategic Plan does this request seek to address? (4 Community Focus areas: Homelessness; Access to Primary and Behavioral Health Care; Healthy Eating/Active Living; Safety, Quality, Accountability and Transparency)

Desert Arc is addressing the District's Strategic Plan priority #3 and the Community Health and Wellness focus area relating to primary care and behavioral health access. The Desert Arc request is for funding for support and services for clients in the Adult Day Center Program and clients in the Behavior Management Program, as well as health and wellness services for clients participating in the Work Activity Program and the Supported Employment.

Project Title

Desert Arc Health Care Program

Project Description (Two Part Question)

1. Describe your project or program; 2. Specifically, what are you asking the District to fund? (word limit = 100 words)

1. The Desert Arc Health Care Program provides health and wellness services for adults with disabilities who would otherwise not be able to participate in the Adult Day Center Program and the Behavior Management Program. These programs serve adults with severe disabilities and staff need specialized training to ensure clients have the opportunity to participate fully in programs at Desert Arc.
2. The request is for $109,412 for salaries for licensed vocational nurses, $6,000 for the consultant fees for the attending physician associated with Adult Day Center, and $49,326 for the training cost for staff in the Behavior Program.

Issue/Challenge

What specific health issue or challenge does this address? (limit = 100 words)

The nurses, under Dr. Eric Presser's medical license, administer medications to vulnerable clients that need supervised care such as by mouth or via a gastric tube; and feeding via gastric

tubes; perform blood sugar checks; provide VNS Therapy; perform daily maintenance procedures for catheters; and provide breathing treatments. They provide wound care for decubitus, diabetic foot wounds, as well as cuts/scrapes. They monitor vital sign checks for clients feeling sick. The nurses provide both non-emergency and emergency procedures for all clients/staff participating in on-site, and make the determination if further medical treatment is needed. The Behavior Management Program challenges are client behavior issue with disabilities. Staff training offers ways to overcome these obstacles.

Individuals with Issue/Challenge

How many District residents overall are affected by this health issue or challenge?

Desert Arc serves 246 clients in the DHCD district in the cities of Cathedral City, Desert Hot Springs, Palm Desert, Palm Springs, Rancho Mirage and Thousand Palms. This represents 35% of the clients participating in Desert Arc programs.

Program Area/Type of Support

What type of support is requested?

Program support for access to primary and behavioral health care

Term of Project

How long (# of months) is the program or project?

This program in an on-going program and is available for clients 12-months a year. Desert Arc is requesting support for one year of funding.

Project Start Date

When does this program or project begin?

November 1, 2018

Project End Date

When does this program or project end?

October 31, 2019

Project Budget

What is the total cost of the program or project (including the amount requested from DHCD)?

$181,349

Request Amount

How much are you requesting from DHCD?

$164,738

Core Know How

For the specific program area for which you seek our support what is your core know-how? What do you know how to do especially well? (word limit = 100)

The program began 35 years ago and the licensed vocational nurses began 28 years ago, and the Behavior Specialist began in 2003. Desert Arc employs licensed vocational nurses and contracts a licensed behavior specialist consultant who are

building the core-know and the capacity of the staff through training programs centered at preventing and/or diverting actions that could be detrimental to the health and wellness of the client. The core know-how for providing services to clients at Desert Arc is built upon the expertise of these licensed professionals who train staff in health and wellness procedures and behavior modification techniques.

Past Achievement

What have you achieved in the past three years for persons in your programs that are most like the project for which you seek our support? (word limit = 100)

Two programs funded demonstrate achievements for clients in the Adult Day Center: 1) Grants received from the Webb Foundation, Champions Volunteer Foundation and the Knights of Columbus funded the introduction of mini iPads for clients who are non-verbal/limited verbal to increase their communication skill. 2)The Community Foundation Tucker Fund provided funding to purchase equipment needed for clients to transfer from a wheelchair to a changing station or a recliner that both minimize the effort needed for movement and allowed the client to sit up in the recliner while participating in activities that helped the them feel part of the group.

Project or Program Sustainability

After the initial investment, how will this project or program be financially sustained? (word limit = 100)

After the initial investment, this program's financial sustainability is addressed in the Desert Arc 3-year strategic plan's action steps that are implemented for the 2018-2020 fiscal years by the Board and staff. These action steps include the implementation and the evaluation goals and objectives to obtain full cost reimbursement rates for all programs. To develop a strategy for robust and diversified funding to sustain and grow the organization. To develop and implement a marketing strategy, and to develop and implement more efficient operational practices.

Participants

DESCRIBE DISTRICT RESIDENTS WHO WILL BENEFIT

Participant Number

How many District residents will be served by this program or project?

246

Geographic Area Served

Where do they live?

Cathedral City, Desert Hot Springs, Palm Desert, Palm Springs, Rancho Mirage and Thousand Palms

Age Group

18-55+

Participant Community

What characteristics differentiate your participants from the community in general? (word limit = 200)

All clients are independent adults with development and intellectual disabilities. The primary diagnosis of clients includes a broad range of disabilities including 49% diagnosed with mild intellectual disabilities, 24% with moderate intellectual disabilities, 10% with severe intellectual disabilities, 4% with profound intellectual disabilities, as well many with multiple disabilities including 8% with autism, 12% with severe seizure disorder, 8% with Cerebral Palsy and less than 1% with Down Syndrome. The living arrangements of the adult clients are unique. Sixty- seven percent (67%) live with family members, 20% live independently (these clients are not in the Adult Day Center of Behavior Management programs), 13% live in residential care. In addition, 15% of the clients are non-English speakers. The range of client ages served is also unique. Thirty-three percent (33%) of the clients are between the ages of 18-29; 29% of the clients are between the ages of 30-39; 18% of the clients are between the ages of 40-49; 13% of the clients are between the ages of 50-59, and 7% of the clients are sixty years plus. The clients who are the target population for this request do not have the ability to care for themselves or obtain independent employment.

Similar Groups

What similar groups or services are available to these individuals? What differentiates you from them? (word limit = 200)

There are no similar groups or services for clients with severe disabilities and behavior limitations in the Coachella Valley. Desert Arc is the only area non-profit providing comprehensive services for adults with developmental and intellectual disabilities. The agency designs programs to meet the needs of its clients that include nutrition services that provides a daily breakfast, lunch and snack; social and recreational programs; case management and personalized coordination of services; and advocacy for community integration; and transportation services. In addition, the Adult Day Center provides specialized programs for clients who have severe developmental and intellectual disabilities, as well as specialized a program to meet the needs of clients in the Behavior Management Program that provides vocational training, job development, job placement and employment programs. The Desert Arc Adult Day Center is the only area agency of this size that can accommodate a large number of clients, and there is no other Behavior Management Program in the Coachella Valley.

BARRIERS: For the following questions, please define how many of the total

number of District Residents you will serve (participants) that will encounter: minimal obstacles to succeeding (few barriers), a moderate number of obstacles to succeeding (moderate barriers) and a large number of obstacles (many barriers). Please define these obstacles and give an example of a District Resident who would represent each category (please do not use names.)

Number of Participants with Few Barriers

Of the total number of participants, how many will face few factors that will impede with their success in this project or program?

96

Number of Participants with Few Barriers Description

Describe the few factors that will impede this group of participants. (word limit = 50)

Some clients who participate in the Work Activity and Supported Employment have mobility problems and several have health issues relating to their age and disability. These clients need medication administered, sugar level tested, and first aid treatment for cuts and sprains. They have mild to moderate developmental and intellectual disabilities.

Participant Example 1

Please give an example of a participant with few barriers to success.

A man in his early forties with Down Syndrome has been hospitalized many times for heart and breathing problems. The nurse administers a daily breathing treatment for him and provides the breathing treatment equipment he needs to perform the breathing treatment at home during the weekends. This client lives independently and participates in the Work Activity Program. The nurses provide him with the health and wellness services he needs to be able to attend program, as well as live an independent life in the community where he resides.

Number of Participants with Moderate Barriers

Of the total number of participants, how many will face a moderate number of factors that will impede with their success in this project or program?

62

Number of Participants with Moderate Barriers Description

Describe the moderate set of factors that will impede this group of participants. (word limit = 50)

These are clients in the Behavior Modification Program. These clients need behavior intervention, as well as medication administered, sugar level tested, and first aid treatment for cuts and sprains. Several have medical issues relating to their age and disability. They have mild to moderate developmental and intellectual disabilities.

Participant Example 2

Please give an example of a participant with moderate barriers to success.

A man in his early forties with Down Syndrome had to be transferred from the Work Activity Program to the Behavior Management Program because as he has gotten older he can no longer always control his temper when he is upset. He is doing very well in the Behavior Management Program that provides an environment for him that helps him maintain his volatile tendency because of the specialized

training of the staff. He has been with Desert Arc for 20 years, and for most of that time participated in the Work Activity Program. Over the past 5 years he began demonstrating his inability to control his temper. Working offsite at a restaurant as part of the Work Activity Program he displayed unacceptable behavior to the restaurant staff. He was then no longer part of the offsite work group and participated in the fulfillment jobs in the Work Activity Program. Once again he displayed unacceptable behavior on two occasions. At this point he was transferred to the Behavior Management Program. He is doing well both at Desert Arc and in his personal life. He lives with his parents and is very active in his church.

Number of Participants with Many Barriers

Of the total number of participants, how many will face many factors that will impede with their success in this project or program?

88

Number of Participants with Many Barriers Description

Describe the large set of factors that will impede this group of participants. (word limit = 50)

The program provides services for Adult Day Center clients who would otherwise not be able to participate in Desert Arc programs. The licensed vocational nurses are responsible for the most fragile and severely disabled clients. These clients require the nurses' services daily to meet both routine and non-routine medical needs.

Participant Example 3

Please give an example of a participant with many barriers to success.

A man in his early thirties is diagnosed with severe developmental and intellectual disabilities and Cerebral Palsy. He has Petit and Grand Mal Seizures. He has been part of the Adult Day Center program for the past 10 years. He is NPO nothing by mouth and therefore he requires assistance from the nurses to be fed via a gastric tube. This is down twice a day, once in the morning and again in the afternoon. This man is happy when being fed by the nurses and shows it with a big smile in his face every day. Not only do the nurses ensure of his well-being in program, but have also formed a strong connection with him. He relies on the expertise of the licensed vocational nurses to provide him with the health and wellness services he needs to be able to participate in programs at Desert Arc. He is able to participate in the community outings program, and would be confined to his family home if Desert Arc was not available for him to attend.

Results

WHAT WILL THE DISTRICT GET FOR ITS INVESTMENT?

Results Statement

Provide the specific health benefits or tangible effects that will be achieved? (word limit = 400).

- The past program results documented are the indicators of what achievements will be met in 2018-19.
- The Health Care Program is estimated to provide 12,000 medical services serving 2,500 duplicated clients averaging 50-75 clients per day with 30 clients needed daily medication.
- A daily wellness check of each client in the Adult Day Center Program is performed by staff and if a problem is noted the nurses decide if they client remain in program or not. If conditions such as ring worm, Conjunctivitis or flu-like symptoms are detected, the client is sent home with directions to see their own physician (a doctor's release is required to return to program).
- A rigid reporting system for attendance of each client in the Adult Day Center and the Behavior Management Program is use as an indicator to evaluate the program response by the clients. The numbered served by the daily attendance record is a benchmark for the programs.
- The staff and nurses maintain the wellness records of each client in the Adult Day Center and the Behavior Management programs using best practices methods.
- All clients in the Adult Day Center and the Behavior Management programs have annual physicals conducted by their own physicians and the nurses monitored to be sure they are completed on time.
- All 286 Desert Arc staff receive an TB test performed by the nurse, and staff HEP –B vaccines are provided by the nurse as needed.
- The nurses are also responsible for training 26 Adult Day Center staff, keeping all agency first aid kits updated, and maintaining contact with clients' physicians in all on-site programs at Desert Arc ensuring all client medical needs are met.
- The Behavior Specialist is available to train the 22 staff in the Behavior Modification Program. Training programs available include both 1:1 training and group training, as well as the creation of behavior plans for the 90 clients in the program.

Number Who Will Achieve This/These Result(s)

How many individuals will achieve this/these result(s)?

246

Results No Program

How many would achieve results regardless of the program?

0

Results Verification

How will you know if results are achieved? (word limit = 100)

- The reasons for absenteeism are tracked ensuring that clients are not missing program because of health conditions that can be treated at Desert Arc.
- The staff and nurses will maintain the wellness records of each client served using best practices methods and report annually a summary of all services performed and number of clients served.
- The report provides an evaluation of client satisfaction, quality, effectiveness and efficiency of programs.
- Data is collected and the progress of the client to the program objectives is evaluated.

Broader Gains

What broader gains and benefits will be achieved if you are successful that we should include in our assessment of "return on investment"? (word limit = 200)

Desert Arc has a responsibility to provide health and wellness services for adults with disabilities who otherwise would not be able to attend Desert Arc programs The nurses make all decisions for both clients and staff regarding first aide treatment and the need for Urgent Care or calling 911 which reduces the cost for emergency action that is not needed. The nurses and the Specialist do not receive any state reimbursement, therefore, must be funded by grants and contributions. There is no other access to this type of health services for clients. Without these program clients in the Adult Day Center and the Behavior Management programs would be confined to a State Development Center or their residence with little interaction with others. The Department of Developmental Disabilities reaffirms the high cost for clients in a State Developmental Center is $280,706 annually. The cost to attend Desert Arc programs annually is $16,801 per client. The difference becomes the responsibility of the tax payer. An indirect benefit for the programs is clients attend Desert Arc a minimum of six hours a day for 251 program days and this gives a "respite" for parents and caretakers while clients are at Desert Arc programs.

Project Tracking

Milestones

Throughout your project or program, how will you know if participants are on course to achieve results? What key behaviors or accomplishments are good predictors of achieving the final project result? (word limit = 200)

Each program manager submits a report for inclusion in the monthly Program Highlights that is included in the monthly Board Packet. This report lists the key objective of the program. It reports current and planned enrollment. Any program issues or corrective action needed are recorded in this report. This report along with the actual verses budgeted attendance records that show any deviations to the budgeted attendance must be followed up immediately. There is a revenue component attached to the attendance that also requires a follow-up report if below the budgeted amount. This information helps predict the behavior of clients based on their attendance and directly the accomplishments of the program that are based on clients being able to attend Desert Arc programs, specifically the Adult Day Center and the Behavior Management program the focus of this application.

Tracking

How will you measure your progress throughout the project or program? (word limit = 200)

Desert Arc reports on a monthly basis the number of clients that attend program versus the budgeted number of clients who should attend program. The Adult Day Center program has a budgeted attendance of 85%. The Behavior Management Program has a budgeted attendance of 80%. Clients who do not attend program are contacted and the reason for missing program is evaluated. Deviation from budgeted attendance rates is one of the milestones to evaluate the achievements of the Desert Arc Healthcare Program. Additionally, a comprehensive evaluation is completed annually for each client. In that evaluation session clients are given the opportunity to discuss their accomplishments in five categories: Satisfaction; Quality, Efficiency, Effectiveness, and Progress. The evaluation for each client is considered confidential, but a report of overall achievements in the program can be issued.

Result Longevity

How long will results achieved from this program be maintained? What will you do to help insure the staying power of accomplishment? (word limit = 100)

The length of time clients participates in programs range from 42.6% of clients participating for 1-5 years, 26.8% participating for 6-15 years, and over 12 % participating for 16-25 years. These statistics indicate the longevity of the client programs. Clients in the Adult Day Center do not change programs due to the severity of their disabilities, and benefit from the licensed vocational nurse for their entire life. Clients in the Behavior Management Program entered the program and stay with the program, except for clients from the Developmental Center who learn coping skills and then transfer outside the area.

Learning Questions

What do you most want to learn from this project or program? (word limit = 100)

Staff in the Adult Day Center and Behavior Management programs require special skills. Learning the skills provide the necessary tools needed to be successfully employed in the Adult Day Center and the Behavior Management programs. The licensed vocational nurses and the Behavior Specialist train staff to leverage their time and provide the best care possible for clients with the most severe or debilitating disabilities is the expected outcome for staff.

Project Approach

What approach (step-by-step) are you using to achieve the stated results? (word limit = 200)

Step 1The licensed vocational nurses come highly skilled to perform all the health and wellness procedures needed to ensure clients can attend program. Step 2 The nurses also provide training for the staff in a variety of topics to increase the staff skills in caring for the clients who are very disables.

Step 1 The Behavior Specialist, highly skilled in working with clients with developmental disabilities, assist staff in identifying behavior characteristics that need to be adjusted so the client can function in the program. 2. The Specialist conducts staff trainings including 1:1 and group sessions. 3. The Specialist assist the staff in creating behavior plans for each client. Step 4 The staff implements the plans.

Project Evidence

Is your approach backed by evidence of success? If so, what is it? What are specific deliverables from this project? (word limit = 200)

Desert Arc has provided the Adult Day Center program for over 25 years. Client numbers have grown over the years, with capacity of the licensed program renewed to now accommodate 150 clients. The Behavior Management Program is estimated to started about 15 years ago. It is licensed to accommodate the 90 clients in the program. Both of these programs are unique, both in being available and offering many programs to assist these clients integrate into the community. There are 30 clients from the Behavior Management Program who leave the Palm Desert facility and go work at the Recycling Center. Other clients from this program are part of the janitorial crew and recycling crew at the Palm Desert facility. The clients in the Adult Day Center volunteer in many community activities with food collection from Starbucks and distribution to the Rescue Mission, pack food at food banks, provide general janitorial services to other nonprofits, and deliver food to homebound seniors working with Well of the Desert.

Project Assumptions

What assumptions do you make about the needed intensity and duration of your program to insure results for participants? What assumptions may impact or limit success? (word limit = 200)

Clients in the Adult Day Center and the Behavior Management programs have no alternate program in the Coachella Valley if Desert Arc cannot accommodate them. Desert Arc has increased client enrollment in both the programs. It developed a space plan to increase the space needed for the programs. The space plan included the construction of the new Building 2 to create more space for the Adult Day Center program. It included creating space in Building 3 to accommodate the Behavior Management program. Both programs are close to capacity and more space in Building 3 is being opened up for the Behavior Management Program. Additionally, space in Building 1 is being evaluated, but this is a construction project and will not be completed in the near future. The only impact to the programs is facility size to accommodate all clients wanting to attend program at Desert Arc.

Key Project Lead

Who is the person who will lead the project to its results? What factors in that leader most predict success?

Liz Nabie, the Director of Grant Development is the lead person to ensure all program results are met and reported. She has had this role at Desert Arc for 12 years.

Key Implementors

Who are the key persons who will deliver the service and what factors most suggest that they can help people to get to the intended results?

Ruth Goodsell, Consumer Services Director, has 20 years' experience with Desert Arc. She has the ultimate responsibility for each client participating in Desert Arc programs, as well as oversees the Adult Day Care Center and Behavior Management Department. Lynn De Anda, Assistant Director of the Adult Day Care Center and Behavior Management Department. She has 10 years' experience with Desert Arc.

Liz Nabie, Director of Grant Development has been with Desert Arc for 12 years.

Key Partners

Are any partners or intermediaries critical to your success? If so, what role must they play and what is the evidence that they are committed to play it?

The licensed vocational nurses and the Behavior Specialist work independently from outside partners. The only exception is a relationship with the attending physician consultant, Eric Presser, MD who allows the licensed vocational nurses to operate under his medical license (a medical doctor's license is needed to purchase TB and. HEP –B vaccines). All clients at Desert Arc are referred by the Regional Centers (Inland Regional refers the highest number because it is the regional center for the area, however clients from other regional centers are also referred) or the Department of Rehabilitation. There is no accommodation for walk-ins. The Canyon Springs Development Center places clients through the Regional Center referral system in the Behavior Management Program at Desert Arc. They transport clients from the Canyon Springs Development Center on a daily basis. The program at Desert Arc is meant to assist clients from this facility to become able to integrate back into their home communities to participate in a work activity or other program for adults with developmental disabilities. Angel View clients have attended the Adult Day Center program at Desert Arc since its inception. They are transported from an Angel View group home to Desert Arc daily. These clients also go through the referral process at Inland Regional Center.

Individual authorized to submit this request on behalf of the organization

I personally attest to the veracity of information contained herein and approve submission of this request.

Electronic Signature

Name and Title of approving authority

Richard Balocco

President/CEO

DESERT HEALTHCARE DISTRICT GRANT AGREEMENT

This agreement is entered into by the Desert Healthcare District ("DISTRICT"), a California health care district organized and operating pursuant to Health and Safety Code section 32000 et seq., and Desert Arc ("RECIPIENT") and is effective upon execution by both parties.

1. Grant

Purpose and Use of Grant: Desert Arc Health Care Program

Amount: $164,738.00

2. Term of Agreement

The term of this agreement is from November 1, 2018 through October 31, 2019, subject, however, to earlier termination as provided in this agreement.

3. Legal Responsibility/Liability

In authorizing execution of this agreement, the governing body of RECIPIENT accepts legal responsibility to ensure that the funds provided by DISTRICT are allocated solely for the purpose for which the grant was intended. RECIPIENT agrees to be knowledgeable of the requirements of this agreement and to be responsible for compliance with its terms. In no event shall DISTRICT be legally responsible or liable for RECIPIENT's performance or failure to perform under the terms of the grant or this agreement.

RECIPIENT agrees that DISTRICT may review, audit, and/or inspect DISTRICT-funded program operated by RECIPIENT under this agreement for compliance with the terms of this agreement.

4. Reduction/Reimbursement of Awarded Funds

DISTRICT may reduce, suspend, or terminate the payment or amount of the grant if the District determines in its sole discretion that RECIPIENT is not using the grant for the intended purposes or meeting the objectives of the grant. RECIPIENT hereby expressly waives any and all claims against DISTRICT for damages that may arise from the termination, suspension, or reduction of the grant funds provided by DISTRICT.

RECIPIENT further agrees to reimburse any funds received from DISTRICT, where the DISTRICT determines that grant funds have not been utilized by RECIPIENT for their intended purpose.

5. Other Funding Sources

If requested by DISTRICT, RECIPIENT shall make information available regarding other funding sources or collaborating agencies for the programs or services provided by RECIPIENT.

6. Attribution Policy

RECIPIENT agrees to comply with the DISTRICT'S attribution policy, which is attached to this agreement as Exhibit "A."

7. Payment Schedule

Unless RECIPIENT and DISTRICT agree upon alternative arrangements, grant funds shall be allocated and paid according to the schedule and requirements described on Exhibit "B." In the event RECIPIENT fails to provide report(s) and/or appropriate supporting documentation in a timely manner, RECIPIENT may be subject to a delay or discontinuance of funding, at DISTRICT'S sole discretion.

8. Program Budget

RECIPIENT shall also submit, prior to the DISTRICT entering into this agreement, a program budget, which shall be subject to review and approval of DISTRICT. A copy of RECIPIENT'S program budget shall be attached to this agreement as Exhibit "C."

9. Scope of Services/Recipient Activities

Prior to the DISTRICT entering into this agreement, RECIPIENT shall include in its application, subject to review and approval by the DISTRICT, details of the RECIPIENT'S scope of service(s), activities or program(s) proposed for funding.

10. Evaluation/Outcomes Reporting

Prior to the District entering into this agreement, RECIPIENT shall include in its application, subject to review and approval of the DISTRICT, details of its plan for evaluation and reporting.

RECIPIENT shall cooperate in efforts undertaken by DISTRICT to evaluate RECIPIENT'S effectiveness and use of the grant funds. RECIPIENT shall participate in and comply with all on-site evaluation and grant monitoring procedures including interviews with RECIPIENT'S staff by DISTRICT. RECIPIENT, at the request of the DISTRICT, shall also provide progress reports to DISTRICT according to the schedule contained on Exhibit "B" in a format to be provided by DISTRICT.

11. Use of Subcontractors

RECIPIENT may not subcontract any portion of the duties and obligations required by this agreement without the written consent of the DISTRICT. A copy of the proposed subcontract between RECIPIENT and the subcontractor shall be provided to DISTRICT for review. In the event DISTRICT consents to subcontract, the subcontractor shall be required to execute an agreement assuming all rights and obligations of this agreement, including the DISTRICT'S right to inspect the subcontractor's books and records and the right to monitor and evaluate the effectiveness of the use of the grant funds. Notwithstanding the forgoing, RECIPIENT shall remain primarily responsible for compliance with all terms and conditions of this agreement.

12. Use of Funds

The funds received pursuant to this agreement may not be used by RECIPIENT for general operating expenses or any other programs or services provided by RECIPIENT without the written consent of DISTRICT.

Upon request, RECIPIENT shall make available for the DISTRICT and members of the public, a detailed description of the program(s) and/or service(s) funded by DISTRICT. This program description may be a separate document or may be incorporated into the overall program materials developed by the RECIPIENT.

13. Prevailing Wages.

If the funds received are used to pay for any portion of an applicable "public works" or "maintenance" project, as defined by the Prevailing Wage Laws (Labor Code sections 1720 et seq. and 1770 et seq.), and if the project cost is $1,000 or more, RECIPIENT agrees to fully comply with such Prevailing Wage Laws, if applicable. RECIPIENT shall require any contractor or subcontractor performing work on an applicable "public works" or "maintenance" project to fully comply with all Prevailing Wage Laws, including but not limited to the payment of prevailing wages, registration with DIR, and maintenance of certified payroll records."

14. Independent Contractor Status

The relationship between DISTRICT and RECIPIENT, and the agents, employees, and subcontractors of RECIPIENT in the performance of this agreement, shall be one of independent contractors, and no agent, employee, or subcontractor of RECIPIENT shall be deemed to be an officer, employee, or agent of DISTRICT.

15. Use of Funds for Lobbying or Political Purposes

RECIPIENT is prohibited from using funds provided by DISTRICT herein for any political campaign or to support attempts to influence legislation by any governmental body.

16. Compliance with Applicable Law and Regulations

RECIPIENT shall comply with all federal, state, and local laws and regulations, including but not limited to labor laws, occupational and general safety laws, and licensing laws. All licenses, permits, notices, and certificates as are required to be maintained by RECIPIENT shall be in effect throughout the term of this agreement.

Where medical records, and/or client records are generated under this agreement, RECIPIENT shall safeguard the confidentiality of the records in accordance with all state and federal laws, including the provisions of the Health Insurance Accountability and Portability Act of 1996 (HIPAA), and the laws and regulations promulgated subsequent thereto.

RECIPIENT shall notify DISTRICT in writing within 5 (five) days if any required licenses or permits are canceled, suspended, or otherwise terminated, or if RECIPIENT becomes a party to any litigation or investigation by a regulatory agency that may interfere with the ability of RECIPIENT to perform its duties under this agreement.

17. Changes or Modifications to the Use of DISTRICT Grant Funds

RECIPIENT shall submit to DISTRICT, in writing, any requests for proposed changes in the use of DISTRICT grant funds. DISTRICT must receive such requests at least thirty (30) days prior to the date the proposed changes are to be implemented and the proposed changes shall be subject to DISTRICT Board approval.

Notwithstanding the foregoing, requests for transfers between budget categories or line items less than ten percent (10%) of the total grant amount that do not change the total grant amount or generate additional line items may be directed to the DISTRICT's Program Department for consideration.

18. No-Cost Grant Extensions

Any request by the RECIPIENT to extend a grant's project period without additional funding from the DISTRICT will be processed pursuant to the DISTRICT's No-Cost Grant Extension Policy. Any no-cost grant extension request shall be subject to DISTRICT Board approval.

19. Conflict of Interest/Self Dealing

RECIPIENT and RECIPIENT'S officers and employees shall not have a financial interest or acquire any financial interest, direct or indirect, in any business entity or source of income that could be financially affected by, or otherwise conflict in any manner or degree with, the performance of programs or services required under this agreement.

20. Indemnity and Hold Harmless

RECIPIENT agrees to indemnify, defend, and hold harmless DISTRICT and its officers, agents, employees, volunteers, and servants from any and all claims and losses accruing or resulting to any and all employees, contractors, subcontractors, laborers, volunteers, and any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this agreement and from any and all claims and losses accruing or resulting to any person, firm, or corporation who may be injured or damaged by RECIPIENT in the performance or execution of this agreement, or in the expenditure of grant funds provided by DISTRICT.

21. Fiscal/Accounting Principles

RECIPIENT shall maintain an accounting system that accurately reflects and documents all fiscal transactions for which grant funds are used. The accounting system must conform to generally accepted accounting principles and upon request, DISTRICT shall have the right to review, inspect and copy all books and records related to the accounting system.

22. Documentation of Revenues and Expenses

RECIPIENT shall maintain full and complete documentation of all revenue and expenses (including subcontracted, overhead, and indirect expenses) associated with use of the grant funds covered by this agreement. During the term of this agreement and thereafter, DISTRICT or its authorized representative(s) shall have the right to review all RECIPIENT financial records including records related to the use or disbursement of the grant funds, upon request by DISTRICT. DISTRICT shall also have the right to audit, if necessary, RECIPIENT'S use of grant funds and any and all programs or services that were provided through the use of the DISTRICT funds. In the event of an audit or financial review,

RECIPIENT agrees to provide DISTRICT access to all of RECIPIENT'S books and records.

23. Records Retention

All records of RECIPIENT pertaining to the use of grant funds shall be maintained at RECIPIENT'S main local office for at least five (5) years following the year in which grant funds were first provided by DISTRICT.

24. Governing Law

This agreement shall be governed by and construed in accordance with the laws of the State of California.

25. Assignment or Transfer

RECIPIENT may not assign or transfer any interest in this agreement or entitlement to grant funds without the written consent of District.

26. Entire Agreement, Amendment

This agreement contains the entire understanding and agreement of the parties with respect to the subject matter hereof and supersedes all prior and contemporaneous agreements not contained herein. This agreement may only be amended or modified by a writing signed by both parties.

27. Notices

Any notice required or permitted pursuant to this agreement may be given by a party to the other party at the address set forth in the signature block of this agreement. Either party may change its address for purposes of notice by complying with the requirements of this section.

28. Signatories

The persons executing this agreement on behalf of the RECIPIENT have been designated by the governing body or fiscal agent of the RECIPIENT as the official signatories of this agreement and all related documents. At least one of these persons is a member of the RECIPIENT'S governing board, and both persons have the authority to execute this agreement on behalf of RECIPIENT.

RECIPIENT:
Desert Arc
73255 Country Club Drive
Palm Desert, CA 9226

Name: President/Chair of RECIPIENT Governing Body

_____
PLEASE PRINT

_____
SIGNATURE

_____
DATE

Name: Executive Director

_____
PLEASE PRINT

_____
SIGNATURE

_____
DATE

Authorized Signatory for Desert Healthcare District:

Name: Chris Christensen
Title: Interim Chief Executive Officer

_____
SIGNATURE

_____
DATE

Desert Healthcare District
1140 N. Indian Canyon Dr.
Palm Springs, CA 92262

DISTRICT _____ RECIPIENT _____

EXHIBIT A

DESERT HEALTHCARE DISTRICT ATTRIBUTION POLICY

1. Attribution Wording

Attribution for District-funded programs shall be as follows:
"Made possible by funding from Desert Healthcare District" / "Echo possible por medio de fondos de Desert Healthcare District" or "Funded by Desert Healthcare District" / "Fondado por Desert Healthcare District"

2. Educational Materials

Educational materials are items such as brochures, workbooks, posters, videos, curricula, or games. Materials (in print or electronic formats) produced and distributed for Desert Healthcare District-funded programs shall include the approved wording.

3. Promotional Materials

District attribution shall be included on promotional items such as flyers, banners and other types of signage. However, acknowledgement may be omitted when space limitation is an issue (e.g., buttons, pencils, pens, etc.)

4. Media Materials and Activities

Attribution to the District shall be included in any information distributed to the media for the purpose of publicizing a District-funded program. This information may include news releases and advisories, public service announcements (PSAs), television and radio advertisements, and calendar/event listings.

Media and publicity activities, such as news conferences, story pitching, press interviews, editorial board meetings and promotional events shall include reference to the District's program support. As a courtesy, the District would appreciate notification of these activities at least two (2) weeks in advance, whenever possible. Please send to the District copies of any press coverage of District-funded programs.

5. Logo Usage

Use of the Desert Healthcare District logo is permitted and encouraged. Logos can be provided in print and electronic formats. Logos will be provided by DISTRICT upon initial grant funding and at RECIPIENT's request thereafter. Graphic standards for logos shall be adhered to as provided by DISTRICT. Requests for logo should be directed to the Program Department of Desert Healthcare District.

6. Photograph Consent

RECIPIENT shall permit photographs of District-funded program to be taken by District-designated photographer at District expense, and consents to usage of such photographs on District Web site and other materials designed to inform and educate the public about District.

DISTRICT _____ RECIPIENT _____

EXHIBIT B

PAYMENT SCHEDULE, REQUIREMENTS & DELIVERABLES

Project Title	*Start/End*
Desert Arc Health Care Program	11/1/2018 10/31/2019

PAYMENTS:

(2) Payments: $74,132.10
10% Retention: $16,473.80

Total request amount: $164,738.00

PAYMENT SCHEDULE REQUIREMENTS:

Scheduled Date	Grant Requirements for Payment	Payment
11/01/2018	Signed Agreement submitted & accepted	Advance of $74,132.10 for time period 11/01/2018 - 4/30/2019
05/01/2019	1st six-month (11/01/2018 - 4/30/2019) progress and budget reports submitted & accepted	Advance of $74,132.10 for time period 5/01/2019- 10/31/2019
11/01/2019	2nd six-month (5/01/2019 - 10/31/2019) progress and budget reports submitted and accepted	$0
11/30/2019	Final report (11/01/2018 - 10/31/2019) submitted & accepted	$16,473.80 (10 % retention)

TOTAL GRANT AMOUNT: $164,738.00

DELIVERABLES:

- The Health Care Program is estimated to provide 12,000 medical services serving 2,500 duplicated clients averaging 50-75 clients per day with 30 clients needed daily medication.
- A daily wellness check of each client in the Adult Day Center Program is performed by staff and if a problem is noted the nurses decide if they client remain in program or not. If conditions such as ring worm, Conjunctivitis or flu-like symptoms are detected, the client is sent home with directions to see their own physician (a doctor's release is required to return to program).
- A rigid reporting system for attendance of each client in the Adult Day Center and the Behavior Management Program is use as an indicator to evaluate the program response by the clients. The numbered served by the daily attendance record is a benchmark for

the programs.

- The staff and nurses maintain the wellness records of each client in the Adult Day Center and the Behavior Management programs using best practices methods.
- All clients in the Adult Day Center and the Behavior Management programs have annual physicals conducted by their own physicians and the nurses monitored to be sure they are completed on time.
- All 286 Desert Arc staff receive an TB test performed by the nurse, and staff HEP -B vaccines are provided by the nurse as needed.
- The nurses are also responsible for training 26 Adult Day Center staff, keeping all agency first aid kits updated, and maintaining contact with clients' physicians in all on-site programs at Desert Arc ensuring all client medical needs are met.
- The Behavior Specialist is available to train the 22 staff in the Behavior Modification Program. Training programs available include both 1:1 training and group training, as well as the creation of behavior plans for the 90 clients in the program.

EXHIBIT C

PROGRAM BUDGET ATTACHED AS SUPPLEMENTAL PAGE(S)

Line Item Budget - Sheet 1 Operational Costs

Approved budgets are the basis for reporting all grant expenditures. Line items may not be added or changed without grant amendment. Prior authorization is required for transfering funds (<10%) between existing line items. Describe budget narrative in cell B38. You may insert rows or create additional worksheets if more space is needed to fully describe your budget.

Desert Arc Healthcare Program		Total Program Budget	Funds from Other Sources Detail on sheet 3	Amount Requested from DHCD
Total Labor Costs	Detail on sheet 2	109,412		109,412
Otther (itemize)				
1	Attending Physician	6,000		6000
2	Behavior Specialist	16,611		
3		0		
4		0		
Supplies (itemize)				
1		0		
2		0		
3		0		
4		0		
Printing/Duplication		0		
Mailing/Postage/Delivery		0		
Travel		0		
Education/Training		0		
Behavior Management Staff Training (Detail)				
1:1 Training		10,000		10,000
Group Training		23,222		23,222
Client Behavior Plan Creation		16,104		16,104
Total Training Cost = 49,326				
Other Facility costs (itemize)				
1		0		
2		0		
3		0		
4		0		
Other Program Costs not described above (itemize)				
1				
2		0		
3		0		
4		0		
Total Program Budget		181349	0	**164,738**

Line Item Budget - Sheet 1 Operational Costs

Budget Narrative	Training 1:1 - 1.42hrs X $80/hr X 88 clients = $9,997 ($10,000) When a client exhibits a behavior issue that disrupts the activity in progress and the staff cannot assist the client in correcting the behavior, the Behavior Specialist is asked to review the behavior and then work 1:1 with the staff to implement needed adjustments for the client to participate again with the group. Group Training - 145 training X $160/training = $23,200 Group trainings are established training sessions for staff on topics developed by the staff and the Behavior Specialist. These are usually not crisis intervention, but rather attempts to prevent behavior problems from happening using preventive techniques. Client Plan Creations - 88 plans X $183/plan = $16,104 The staff and Behavior Specialist create a behavior plan for each client in the program when they enter the program. The plan is revised as needed. All training costs are negotiated in the contract with the Specialist.

Line Item Budget
Sheet 2 - Labor Costs

Staff Salaries Employee Position/Title		Annual Salary	% of Time Allocated to Program	Actual Program Salary	Amount of Salary Paid by DHCD Grant
1	LVN - Full-time Wages	93,600	100	93,600	93,600
2	LVN - Overtime Wages	234	100	234	234
3	LVN - Payroll Taxes	7,178	100	7.178	7,178
4	LVN - Unemployment Expenses	480	100	480	480
5	LVN Health Insurance	4,178	100	4,178	4.178
6	Dental Insurance	274	100	274	274
7	Worker's Comp Insurance	3,468	100	3,468	3,468
8					
Enter this amount in Section 1, Employee Salaries				Total ›	109,412
Budget Narrative	LVN 1 Full-time Wages 50,700 Lvn 2 Full Time Wages 42,900 LVN 1 O/T 234 LVN 2 O/T 0 LVN 1 Payroll Taxes 3,896 LVN 2 Payroll Taxes 3,286 LVN 1 UnEmpl 261 LVN 2 Unempl 219 LVN 1 Health Insurance 2,089 LVN 2 Health Insurance 2,089 LVN 1 Dental 137 LVN Dental 137 LVN 1 Worker's Comp 1,882 LVN 2 Worker's Comp 1,586				

Consultants/Contractors Consultant/Contractor Name		Monthly Rate	Hours/ Week	Annual Fee	Amount of Salary Paid by DHCD Grant
1	Attending Physician	500		6,000	6,000
2					
3					
4					
5					
6					
7					
8					
Enter this amount in Section 1, Professional Services/Consultants				Total ›	6,000
Budget Narrative	The Attending Physican Consultant oversee the medical license requirements for the Adult Day Care program.				

Line Item Budget - Other Program Funds

Funding for this program received from other sources			Amount
Donations			
Grants (List Organizations)			
	1	United Way of the Desert (2017-18)	6,000
	2		
	3		
	4		
Fundraising (describe nature of fundraiser)			
Other Income, e.g., bequests, membership dues, in-kind services, investment income, fees from other agencies, etc. (Itemize)			
	1		
	2		
	3		
	4		
Total funding in addition to DHCD request			6000

Budget Narrative	The United Way has funded the costs of the nurses' salary at $6,000 for 2018-19.

DESERT HEALTHCARE DISTRICT

Date: October 23, 2018

To: Board of Directors -District

Subject: Ready Set Swim Program

Staff Recommendation:

Consideration to approve a grant to the Desert Healthcare Foundation to fund the 2018/19 Ready Set Swim Program as guided at the September 25, 2018 Board meeting.

Background:

- September 25, 2018 Board Meeting – staff brought forth the challenges of a proposed grant from the Desert Recreation District.
- Board guided staff to determine an alternative solution, including maintaining program in-house, to ensure program did not have a year of downtime (Budget not to exceed $145,000).

Update:

- Staff has determined a mutually agreeable contract for services between the Desert Healthcare Foundation and Desert Recreation District.
- Program Start Date: October 22, 2018.
- Total budget for the program including allocation of DHCD/F staff, as performed in the previous year, will not exceed $136,000.
- Program will serve 672 students this school calendar year and will end June 1, 2019.
- Alejandro Espinoza will be the staff liaison for the program at .15 FTE.
- Staff recommends approval of the grant to the Desert Healthcare Foundation.

Discussion & Board Direction:

- Future of Ready Set Swim Junior.
- If Measure BB passes, do we expand our program(s)?
- Future of the current Nutrition Education and Obesity Prevention program that compliments Ready Set Swim and Ready Set Swim Junior currently.

Fiscal Impact;

Budget not to exceed $136,000.

DESERT HEALTHCARE DISTRICT GRANT AGREEMENT

This agreement is entered into by the Desert Healthcare District ("DISTRICT"), a California health care district organized and operating pursuant to Health and Safety Code section 32000 et seq., and Desert Healthcare Foundation ("RECIPIENT") and is effective upon execution by both parties.

1. Grant

Purpose and Use of Grant: Ready Set Swim Program

Amount: $136,000.00

2. Term of Agreement

The term of this agreement is from October 25, 2018 through June 30, 2019, subject, however, to earlier termination as provided in this agreement.

3. Legal Responsibility/Liability

In authorizing execution of this agreement, the governing body of RECIPIENT accepts legal responsibility to ensure that the funds provided by DISTRICT are allocated solely for the purpose for which the grant was intended. RECIPIENT agrees to be knowledgeable of the requirements of this agreement and to be responsible for compliance with its terms. In no event shall DISTRICT be legally responsible or liable for RECIPIENT's performance or failure to perform under the terms of the grant or this agreement.

RECIPIENT agrees that DISTRICT may review, audit, and/or inspect DISTRICT-funded program operated by RECIPIENT under this agreement for compliance with the terms of this agreement.

4. Reduction/Reimbursement of Awarded Funds

DISTRICT may reduce, suspend, or terminate the payment or amount of the grant if the District determines in its sole discretion that RECIPIENT is not using the grant for the intended purposes or meeting the objectives of the grant. RECIPIENT hereby expressly waives any and all claims against DISTRICT for damages that may arise from the termination, suspension, or reduction of the grant funds provided by DISTRICT.

DISTRICT _____ RECIPIENT _____

RECIPIENT further agrees to reimburse any funds received from DISTRICT, where the DISTRICT determines that grant funds have not been utilized by RECIPIENT for their intended purpose.

5. Other Funding Sources

If requested by DISTRICT, RECIPIENT shall make information available regarding other funding sources or collaborating agencies for the programs or services provided by RECIPIENT.

6. Attribution Policy

RECIPIENT agrees to comply with the DISTRICT'S attribution policy, which is attached to this agreement as Exhibit "A."

7. Payment Schedule

Unless RECIPIENT and DISTRICT agree upon alternative arrangements, grant funds shall be allocated and paid according to the schedule and requirements described on Exhibit "B." In the event RECIPIENT fails to provide report(s) and/or appropriate supporting documentation in a timely manner, RECIPIENT may be subject to a delay or discontinuance of funding, at DISTRICT'S sole discretion.

8. Program Budget

RECIPIENT shall also submit, prior to the DISTRICT entering into this agreement, a program budget, which shall be subject to review and approval of DISTRICT. A copy of RECIPIENT'S program budget shall be attached to this agreement as Exhibit "C."

9. Scope of Services/Recipient Activities

Prior to the DISTRICT entering into this agreement, RECIPIENT shall include in its application, subject to review and approval by the DISTRICT, details of the RECIPIENT'S scope of service(s), activities or program(s) proposed for funding.

10. Evaluation/Outcomes Reporting

Prior to the District entering into this agreement, RECIPIENT shall include in its application, subject to review and approval of the DISTRICT, details of its plan for evaluation and reporting.

RECIPIENT shall cooperate in efforts undertaken by DISTRICT to evaluate RECIPIENT'S effectiveness and use of the grant funds. RECIPIENT shall participate in and comply with all on-site evaluation and grant monitoring procedures including interviews with RECIPIENT'S staff by DISTRICT. RECIPIENT, at the request of the DISTRICT, shall also provide progress reports to DISTRICT according to the schedule contained on Exhibit "B" in a format to be provided by DISTRICT.

11. Use of Subcontractors

RECIPIENT may not subcontract any portion of the duties and obligations required by this agreement without the written consent of the DISTRICT. A copy of the proposed subcontract between RECIPIENT and the subcontractor shall be provided to DISTRICT for review. In the event DISTRICT consents to subcontract, the subcontractor shall be required to execute an agreement assuming all rights and obligations of this agreement, including the DISTRICT'S right to inspect the subcontractor's books and records and the right to monitor and evaluate the effectiveness of the use of the grant funds. Notwithstanding the forgoing, RECIPIENT shall remain primarily responsible for compliance with all terms and conditions of this agreement.

12. Use of Funds

The funds received pursuant to this agreement may not be used by RECIPIENT for general operating expenses or any other programs or services provided by RECIPIENT without the written consent of DISTRICT.

Upon request, RECIPIENT shall make available for the DISTRICT and members of the public, a detailed description of the program(s) and/or service(s) funded by DISTRICT. This program description may be a separate document or may be incorporated into the overall program materials developed by the RECIPIENT.

13. Prevailing Wages.

If the funds received are used to pay for any portion of an applicable "public works" or "maintenance" project, as defined by the Prevailing Wage Laws (Labor Code sections 1720 et seq. and 1770 et seq.), and if the project cost is $1,000 or more, RECIPIENT agrees to fully comply with such Prevailing Wage Laws, if applicable. RECIPIENT shall require any contractor or subcontractor performing work on an applicable "public works" or "maintenance" project to fully comply with all Prevailing Wage Laws, including but not limited to the payment of prevailing wages, registration with DIR, and maintenance of certified payroll records."

DISTRICT _____ RECIPIENT _____

14. Independent Contractor Status

The relationship between DISTRICT and RECIPIENT, and the agents, employees, and subcontractors of RECIPIENT in the performance of this agreement, shall be one of independent contractors, and no agent, employee, or subcontractor of RECIPIENT shall be deemed to be an officer, employee, or agent of DISTRICT.

15. Use of Funds for Lobbying or Political Purposes

RECIPIENT is prohibited from using funds provided by DISTRICT herein for any political campaign or to support attempts to influence legislation by any governmental body.

16. Compliance with Applicable Law and Regulations

RECIPIENT shall comply with all federal, state, and local laws and regulations, including but not limited to labor laws, occupational and general safety laws, and licensing laws. All licenses, permits, notices, and certificates as are required to be maintained by RECIPIENT shall be in effect throughout the term of this agreement.

Where medical records, and/or client records are generated under this agreement, RECIPIENT shall safeguard the confidentiality of the records in accordance with all state and federal laws, including the provisions of the Health Insurance Accountability and Portability Act of 1996 (HIPAA), and the laws and regulations promulgated subsequent thereto.

RECIPIENT shall notify DISTRICT in writing within 5 (five) days if any required licenses or permits are canceled, suspended, or otherwise terminated, or if RECIPIENT becomes a party to any litigation or investigation by a regulatory agency that may interfere with the ability of RECIPIENT to perform its duties under this agreement.

17. Changes or Modifications to the Use of DISTRICT Grant Funds

RECIPIENT shall submit to DISTRICT, in writing, any requests for proposed changes in the use of DISTRICT grant funds. DISTRICT must receive such requests at least thirty (30) days prior to the date the proposed changes are to be implemented and the proposed changes shall be subject to DISTRICT Board approval.

Notwithstanding the foregoing, requests for transfers between budget categories or line items less than ten percent (10%) of the total grant amount that do not change the total grant amount or generate additional line items may be directed to the DISTRICT's Program Department for consideration.

18. No-Cost Grant Extensions

Any request by the RECIPIENT to extend a grant's project period without additional funding from the DISTRICT will be processed pursuant to the DISTRICT's No-Cost Grant Extension Policy. Any no-cost grant extension request shall be subject to DISTRICT Board approval.

19. Conflict of Interest/Self Dealing

RECIPIENT and RECIPIENT'S officers and employees shall not have a financial interest or acquire any financial interest, direct or indirect, in any business entity or source of income that could be financially affected by, or otherwise conflict in any manner or degree with, the performance of programs or services required under this agreement.

20. Indemnity and Hold Harmless

RECIPIENT agrees to indemnify, defend, and hold harmless DISTRICT and its officers, agents, employees, volunteers, and servants from any and all claims and losses accruing or resulting to any and all employees, contractors, subcontractors, laborers, volunteers, and any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this agreement and from any and all claims and losses accruing or resulting to any person, firm, or corporation who may be injured or damaged by RECIPIENT in the performance or execution of this agreement, or in the expenditure of grant funds provided by DISTRICT.

21. Fiscal/Accounting Principles

RECIPIENT shall maintain an accounting system that accurately reflects and documents all fiscal transactions for which grant funds are used. The accounting system must conform to generally accepted accounting principles and upon request, DISTRICT shall have the right to review, inspect and copy all books and records related to the accounting system.

22. Documentation of Revenues and Expenses

RECIPIENT shall maintain full and complete documentation of all revenue and expenses (including subcontracted, overhead, and indirect expenses) associated with use of the grant funds covered by this agreement. During the term of this agreement and thereafter, DISTRICT or its authorized representative(s) shall have the right to review all RECIPIENT financial records including records related to the use or disbursement of the grant funds, upon request by DISTRICT. DISTRICT shall also have the right to audit, if necessary, RECIPIENT'S use of grant funds and any and all programs or services that were provided through the use of the DISTRICT funds. In the event of an audit or financial review,

RECIPIENT agrees to provide DISTRICT access to all of RECIPIENT'S books and records.

23. **Records Retention**

All records of RECIPIENT pertaining to the use of grant funds shall be maintained at RECIPIENT'S main local office for at least five (5) years following the year in which grant funds were first provided by DISTRICT.

24. **Governing Law**

This agreement shall be governed by and construed in accordance with the laws of the State of California.

25. **Assignment or Transfer**

RECIPIENT may not assign or transfer any interest in this agreement or entitlement to grant funds without the written consent of District.

26. **Entire Agreement, Amendment**

This agreement contains the entire understanding and agreement of the parties with respect to the subject matter hereof and supersedes all prior and contemporaneous agreements not contained herein. This agreement may only be amended or modified by a writing signed by both parties.

27. **Notices**

Any notice required or permitted pursuant to this agreement may be given by a party to the other party at the address set forth in the signature block of this agreement. Either party may change its address for purposes of notice by complying with the requirements of this section.

28. **Signatories**

The persons executing this agreement on behalf of the RECIPIENT have been designated by the governing body or fiscal agent of the RECIPIENT as the official signatories of this agreement and all related documents. At least one of these persons is a member of the RECIPIENT'S governing board, and both persons have the authority to execute this agreement on behalf of RECIPIENT.

RECIPIENT:
Desert Healthcare Foundation
1140 N. Indian Canyon Drive,
Palm Springs, CA 92262

Name: President/Chair of RECIPIENT Governing Body

_____
PLEASE PRINT

_____
SIGNATURE

_____
DATE

Name: Executive Director

_____
PLEASE PRINT

_____
SIGNATURE

_____
DATE

Authorized Signatory for Desert Healthcare District:

Name:
Title: Chief Executive Officer

_____
SIGNATURE

_____
DATE

Desert Healthcare District
1140 N. Indian Canyon Dr.

DISTRICT _____ RECIPIENT _____

Palm Springs, CA 92262

EXHIBIT A

DESERT HEALTHCARE DISTRICT ATTRIBUTION POLICY

1. **Attribution Wording**
Attribution for District-funded programs shall be as follows:
"Made possible by funding from Desert Healthcare District" / "Echo possible por medio de fondos de Desert Healthcare District" **or** "Funded by Desert Healthcare District" / "Fondado por Desert Healthcare District"

2. **Educational Materials**
Educational materials are items such as brochures, workbooks, posters, videos, curricula, or games. Materials (in print or electronic formats) produced and distributed for Desert Healthcare District-funded programs shall include the approved wording.

3. **Promotional Materials**
District attribution shall be included on promotional items such as flyers, banners and other types of signage. However, acknowledgement may be omitted when space limitation is an issue (e.g., buttons, pencils, pens, etc.)

4. **Media Materials and Activities**
Attribution to the District shall be included in any information distributed to the media for the purpose of publicizing a District-funded program. This information may include news releases and advisories, public service announcements (PSAs), television and radio advertisements, and calendar/event listings.

Media and publicity activities, such as news conferences, story pitching, press interviews, editorial board meetings and promotional events shall include reference to the District's program support. As a courtesy, the District would appreciate notification of these activities at least two (2) weeks in advance, whenever possible. Please send to the District copies of any press coverage of District-funded programs.

5. **Logo Usage**
Use of the Desert Healthcare District logo is permitted and encouraged. Logos can be provided in print and electronic formats. Logos will be provided by DISTRICT upon initial grant funding and at RECIPIENT's request thereafter. Graphic standards for logos shall be adhered to as provided by DISTRICT. Requests for logo should be directed to the Program Department of Desert Healthcare District.

6. **Photograph Consent**
RECIPIENT shall permit photographs of District-funded program to be taken by District-designated photographer at District expense, and consents to usage of such photographs on

District Web site and other materials designed to inform and educate the public about District.

EXHIBIT B

EXHIBIT C

PROGRAM BUDGET ATTACHED AS SUPPLEMENTAL PAGE(S)

Line Item Budget - Sheet 1 Operational Costs

Approved budgets are the basis for reporting all grant expenditures. Line items may not be added or changed without grant amendment. Prior authorization is required for transferring funds (<10%) between existing line items. Describe budget narrative in cell B38. You may insert rows or create additional worksheets if more space is needed to fully describe your budget.

PROGRAM OPERATIONS		Total Program Budget	Funds from Other Sources Detail on sheet 3	Amount Requested from DHCD
Total Labor Costs	Detail on sheet 2	$ 20,812.02		$ 20,812.02
Equipment (itemize)				
1		0		
2		0		
3		0		
4		0		
Supplies (itemize)				
1	SNACKS/ TOWELS/ MISC	$ 4,807.98		$ 4,807.98
2	STATIONARY/ OFFICE SUPPLIES	$ 450.00		$ 450.00
3				
4		0		
Printing/Duplication		0		
Mailing/Postage/Delivery		0		
Travel		$ 750.00		$ 750.00
Education/Training		$ -		
Facilities (Detail)				
Office/Rent/Mortgage		$ -		
Meeting Room Rental		$ -		
Telephone/Fax/Internet		$ -		
Utilities		$ -		
Insurance		$ 600.00		$ 600.00
Maintenance/Janitorial		$ -		
Other Facility costs (itemize)				
1	POOL COST- DHS/PALM SPRINGS	$ 24,500.00		$ 24,500.00
2		$ -		
3		$ -		
4		$ -		
Other Program Costs not described above (itemize)				
1	CONTRACT DRD	$ 80,000.00		$ 80,000.00
2	BOYS AND GIRLS CLUB FEES	$ 4,080.00		$ 4,080.00
3		0		
4		0		
Total Program Budget		$ 136,000.00	0	$ 136,000.00

Line Item Budget - Sheet 1 Operational Costs

Budget Narrative	Ready Set Swim program has been a successful flagship program of the Desert Healthcare Foundation since 2014. Budget is representative of a continued collaboration between DHCD/F, Desert Recreation District, Palm Springs Unified School District, Palm Springs Boys and Girls Club, Cathedral City Boys and Girls Club and the city of Desert Hot Springs. The program will commence October 22, 2018 and will continue till June 14, 2019. Swim sessions will be offered to all grade 3 students at 14 Schools and the projected attendance will be 48 student per-school. The program consists of 8 1 hour swim lessons and 1 hour in the class nutrition education classes.

Line Item Budget
Sheet 2 - Labor Costs

Staff Salaries Employee Position/Title		Annual Salary	% of Time Allocated to Program	Actual Program Salary	Amount of Salary Paid by DHCD Grant
1	Program Cordinator/ Outreach Director	$ 96,990.40	15%	$ 14,548.56	$ 14,548.56
2	Accounting Manager	$ 65,520.00	2%	$ 982.80	$ 982.80
3					
4					
5					
6					
7	Benefits 34%				$ 5,280.66
8					
	Enter this amount in Section 1, Employee Salaries			Total ›	$ 20,812.02

Budget Narrative	

Consultants/Contractors Consultant/Contractor Name		Hourly Rate	Hours/ Week	Monthly Fee	Amount of Salary Paid by DHCD Grant
1					
2					
3					
4					
5					
6					
7					
8					
Enter this amount in Section 1, Professional Services/Consultants				Total ›	0

Budget Narrative	Fully describe costs listed above in this cell (B24).

VMG HEALTH

Desert Regional Medical Center

VALUATION DATE: August 28, 2018
DISTRIBUTION DATE: October 15, 2018

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Desert Regional Medical Center

EXECUTIVE SUMMARY

Executive Summary

Valuation Overview

Value Management Group, LLC d/b/a VMG Health ("VMG") has been engaged by Desert Healthcare District (the "District) & Desert Healthcare Foundation to provide a third party, independent fair market value ("FMV") analysis of Desert Regional Medical Center (the "Hospital").

The intended user of this analysis is Desert Healthcare District and the Desert Healthcare Foundation and its duly authorized representatives. Our valuation analysis does not constitute a fairness opinion or investment advice in that we will not conduct all of the steps necessary to issue such an opinion. The term FMV means the price at which property would change hands between a willing buyer and willing seller when the former is not under any compulsion to buy and the latter is not under any compulsion to sell, both parties having reasonable knowledge of the relevant facts.

VMG has not taken any steps in auditing the financials statements provided. We have relied upon the representation that the latest internal financial statements are accurate and represent the financial and operational assets of the Hospital in a reasonable manner. The obligation of VMG is solely a corporate obligation, and no officer, principal, director, employee, agent, shareholder, or controlling person shall be subjected to any personal liability whatsoever to any person or entity, nor will any such claim be asserted by or on behalf of any other party to this agreement or any person relying on the opinion. Where appropriate, VMG considered the factors set forth in Revenue Ruling 59-60, 1959-1, C.b. 237, including:

- The nature of the business and the history of the enterprise from its inception;
- The economic outlook in general and the condition and outlook of the specific industry in particular;
- The book value of the stock and the financial condition of the enterprise;
- The earning capacity of the enterprise;
- The dividend-paying capacity of the enterprise;
- Whether or not the enterprise has goodwill or other intangible value;
- Prior sales of the stock and the size of the block of stock to be valued; and,
- The market price of stock of corporations engaged in the same or a similar line of business, having their stocks actively traded on an exchange or over-the-counter market.

Qualifying Assumptions

The valuation opinion presented in this report is contingent on the following list of qualifying assumptions.

1. Desert Healthcare District (the "District" or "Lessor") is a political subdivision of the State of California. The District was established to own and operate an acute-care hospital located at 1150 N. Indian Canyon Dr. in Palm Springs, CA, which is now commonly known as Desert Regional Medical Center (the "Hospital"). The District entered into a Hospital Lease Agreement (the "Hospital Lease") on May 30, 1997 with a subsidiary of Tenet Healthcare, Inc. ("Tenet" or "Lessee") for a 30 year term whereby Tenet would lease from the District all real property and personal property ("Leased Premises") which were used in the operation of the Hospital and its related activities including outpatient centers, clinics, physician practices, and medical office buildings (collectively, the "Desert Business").

2. The Hospital Lease included provisions related to termination by Lessee or Lessor during, or at expiration of the 30 year lease period. Upon expiration or early termination of the Hospital Lease, all alterations, additions or improvements to the leased premises made by Lessee, including any additional or replacement items of personal property acquired by the Lessee during the term of the Hospital Lease (collectively, the "Termination Assets"), would be transferred to the Lessor; provided, however, that the Lessor would purchase and pay Lesse the cumulative fair market value or net book value, whichever is less, of the identified Termination Assets upon termination or expiration. VMG was not provided a list of the specific Termination Assets and their associated net book values, nor has VMG provided an opinion on their current fair market value, however, we acknowledge the potential for adjustments related to the Termination Assets' where appropriate in this report.

3. Seismic renovation and retrofit activities in California hospitals are dictated by a broad legislative and regulatory framework, all of which originated with California SB 1953. This legislation established seismic safety goals for California hospitals and mandated compliance for hospital structural support systems by January 2030. VMG was provided a copy of the Phase 0 Seismic Evaluation Services Report of September 2018 prepared by Simpson, Gumpertz & Heger, which evaluated both structural and non-structural requirements, and estimated a range between $84 million and $141 million (“Seismic Upgrade Costs”). A more detailed Phase 1 report is scheduled to be completed in December 2018. The Hospital Lease term is set to expire in 2027, prior to the January 2030 compliance deadline established by California SB 1953. VMG understands the Hospital Lease dictates that the Lessee is only responsible for costs to comply with California SB 1953 during the term of the Hospital Lease, and if the Hospital Lease is terminated or allowed to expire, the District would be required to pay any remaining costs to comply with the law. Where appropriate, this report acknowledges the potential impact of Seismic Upgrade Cost and the uncertainty regarding the estimate indicated in the Seismic and PML Assessment, but VMG does not have an opinion as to the amount of Seismic Upgrade Costs.

4. VMG understands the District is evaluating its strategic options, given the above pending seismic upgrade requirements, the remaining lease term, and has requested VMG provide a current Fair Market Value ("FMV") opinion for the Hospital as of a current date. Accordingly, VMG estimated the Fair Market Value of the Business Enterprise Value ("BEV") of the Hospital. Given that the BEV estimate does not account for the impact of the remaining Hospital Lease term and other factors specific to the Hospital and the District, we have acknowledged "placeholder" adjustments detailed further on the following pages in order to assist the District with understanding the estimated value of their current ownership position.

5. Tenet has provided VMG with unaudited internal financial statements for the reporting entity "694 - Desert Regional Medical Center." Tenet provided Income Statement data for the fiscal year ("FY") periods ended December 31, 2015, 2016, 2017 and the trailing twelve months ("TTM") ended May 31, 2018 and Balance Sheet data for FY 2017 and as of May 31, 2018. VMG has not independently audited or confirmed the accuracy of the data provided and we are relying on the data as materially true and correct. To the extent that the information provided to VMG is inaccurate, we reserve the right to amend our analysis accordingly.

6. We understand the financial statements provided by Tenet do not include allocation of certain corporate overhead and management-related costs which would typically be incurred at the Hospital level. Tenet provided a list of certain costs typically directly charged to its facilities as well as a list of pooled allocations typically charged to its facilities. VMG was not provided a specific list of corporate overhead charges currently included in the TTM 2018 financials or the actual amounts incurred in any period, but we have discussed with Tenet the items currently captured at the corporate level and included an estimated Management Fee in the Normalized Base Year Income Statement which is applicable to those charges not currently included in the TTM 2018 period. The selected Management Fee of 2.0% of Net Revenue is based on proprietary data obtained by VMG and is detailed further in this report.

7. VMG understands the Hospital is currently operated by a large public company as a part of the Desert Care Network, which includes JFK Memorial Hospital and Hi-Desert Medical Center. The Hospital may benefit operationally and financially from this affiliation through network management, improved contracting strength or expense management. If the Hospital is not affiliated with Tenet or the Desert Care Network, the future impact, if any, to its financial performance is unknown.

8. VMG understands that the Hospital financial statements do not include revenues and expenses associated with certain physician practice operations which contribute to the operations of the Hospital. These entities are captured under separate financial statements, which were provided to VMG for the most recent TTM 2018 period. VMG has calculated the net loss during the TTM 2018 period and adjusted the Normalized Base Year Income Statement to include the TTM 2018 losses of approximately $6.8 million. These adjustments are detailed further in this report.

9. VMG understands the Hospital participates in the Hospital Qualify Assurance Fee ("HQAF") program which provides a supplemental source of revenue to participating California hospitals which serve Medi-Cal and uninsured patients. The Hospital also incurs related assessment fees associated with participation in the HQAF program. These costs are typically accrued for on a monthly basis by the Hospital, but the TTM 2018 Income Statement has been adjusted in the Normalized Base Year to eliminate the impact of an accrual which occurred for a full twelve month period during FYE 2017. These adjustments are detailed further in this report.

10. El Mirador Medical Plaza is an MOB owned by the District and leased to Tenet. VMG understands that a majority of the suites in the MOB are owner occupied and that El Mirador Medical Plaza will revert back to the District along with the Hospital at the expiration of the Lease. Additionally, VMG understands that the Stergios Building, where the District's office is located, will also revert back to the District at the expiration of the Lease. VMG has not included any adjustments to this analysis for these properties.

11. Three distinct approaches to estimate the BEV were explored - Cost, Market, & Income Approaches. Ultimately, VMG relied upon the Income Approach in determining value due to the ability to factor a discrete cash flow projection unique to the Hospital and the lack of available directly comparable transaction data to be utilized in the Market Approach. Additionally, it was our determination that the Cost Approach did not provide adequate consideration to the going concern value of the Hospital.

12. BEV, reflects the value of the Hospital operations inclusive of a normalized level of cash-free working capital. Working capital includes accounts receivables and other current assets less non-interest bearing current liabilities that permit a business to conduct daily operations and maintain liquidity. Normalized net working capital is estimated at approximately 8.0% of net operating revenue based the observed net working capital for comparable publicly traded companies which further detailed in this analysis.

Executive Summary

Business Enterprise Value Recommendation

Based on and subject to the facts, limiting conditions, and assumptions presented in this report and the attached exhibits, as of a current date, the FMV of the business enterprise value ("BEV") of the Hospital is reasonably represented in a range between approximately **$580 million and $640 million**.

Range of Fair Market Value, BEV Level	Low (5.0%)	Midpoint	High (+5.0%)
Fair Market Value Indication, Business Enterprise Level	$580,000,000	$610,000,000	$640,000,000

Implied Market Multiples	Financial Metric ($)	Low	Mid	High
BEV/ NBY EBITDA	96,468,473	6.01x	6.32x	6.63x
BEV/ NBY Revenue	544,133,376	1.07x	1.12x	1.18x
BEV/ Year 1 EBITDA	94,983,961	6.11x	6.42x	6.74x
BEV/ Year 1 Revenue	559,522,715	1.04x	1.09x	1.14x

Business Enterprise Value reflects the value of the Hospital inclusive of a normalized level of cash-free net working capital. Net working capital includes accounts receivables and other current assets less non-interest-bearing current liabilities that permit a business to conduct daily operations and maintain liquidity. Normalized net working capital is estimated to be 8.0% of net operating revenue. Incremental net working capital requirements are projected at 8.0% of net operating revenue throughout the projection period.

Please refer to the following pages for further detail regarding adjustments to the Midpoint BEV presented above.

Adjustments to Business Enterprise Value

The adjustments to the BEV presented below have been identified and calculated, where appropriate, based on parameters of the Hospital Lease. The midpoint BEV of $610 million is inclusive of a normalized level of net working capital which is controlled by the lessee.

The BEV reflects the value of the Hospital and its associated cash flows into perpetuity. Given that the District would not have access to the cash flow generated by the Hospital until the expiration in approximately nine years, the present value of the projected cash flows during the first nine years of the Income Approach's Discounted Cash Flow Projection are included below as a reduction to the BEV. These cash flows are estimated at approximately $299 million and result in a BEV (less working capital and the remaining lease term value) of approximately $267 million.

Two adjustments below are included as placeholders ("TBD") due to the uncertainty regarding the current value of these items. The District would be required to incur the necessary Seismic upgrade costs to comply with state requirements. Additionally, Termination Assets, as defined in the Hospital Lease, must be purchased by the District upon Termination of the Hospital Lease.

ADJUSTMENTS TO BEV	
Value Indication, Business Enterprise Value (Including Working Capital)	$610,000,000
Less: Normalized Working Capital included in Business Enterprise Calculation	*(44,000,000)*
Subtotal - Business Enterprise Value, less Working Capital (rounded)	$566,000,000
Less: Value Indication for Total Year 1 - Year 9 Present Value of Cash Flows	($299,231,472)
Subtotal - Business Enterprise Value, Adjusted for Remaining Lease Term & Working Capital	$267,000,000
Less: Seismic Upgrade Cost	*TBD*
Less: Termination Assets	*TBD*
BEV Adjusted for Remaining Lease Term, Seismic Requirements, Working Capital & Termination Assets	TBD

Executive Summary

Situational Analysis

Desert Regional Medical Center was initially established in 1948 and was operated by the District until the establishment of the Hospital Lease which allowed Tenet to take over the operations and bring it into their portfolio of health care facilities in the region. The Hospital is located in Palm Springs, CA, and is a member of Desert Care Network which was established by Tenet Healthcare. Desert Care Network includes Desert Regional Medical Center, High Desert Medical Center, and John F. Kennedy Memorial Hospital as well as four skilled nursing facilities, eight physician practices, two ambulatory surgery centers, and two urgent care facilities.

During the trailing twelve months ended ("TTM") May 31, 2018, the Hospital generated total net operating revenue of approximately $562.9 million, an increase of 4.6% from FYE 2017 net operating revenue of approximately $538.2 million. Overall, earnings before interest, taxes, depreciation, and amortization ("EBITDA") was approximately $133.1 million (23.6% of net operating revenue) in TTM 2018 and approximately $112.1 million (20.8% of net operating revenue) in FYE 2017. The Hospital's admissions remained relatively constant compounded annually from 19,738 in FYE 2015 to 19,694 in TTM 2018. The Hospital's patient days increased 1.6% compounded annually from 88,855 in FYE 2015 to 92,271 in TTM 2018.

During TTM 2018, the largest payors as a percentage of net collections were Commercial (33.9%) and Medicare (16.1%). Other payors include Managed Medicare (15.9%) and Medicaid (13.4%). Desert also is largest provider of charity care in its community. According to staffing data provided by hospital management, the Hospital employs approximately 1,933 full-time equivalent ("FTE") employees. The average FTE per adjusted occupied bed was 5.3 in TTM 2018, and the average hourly salary per FTE was approximately $46.49 during TTM 2018.

As previously mentioned, the Hospital is located in Palm Springs, California, which is in Riverside County. Recent population estimates indicate that the population of Riverside County increased 2.6% compounded annually, from approximately 1,558,985 residents in 2000 to approximately 2,423,266 residents in 2017. The Hospital is situated in an area with a seasonal population change in which the overall population usually decreases during the summer months and experiences an increase in population during the winter months. The Hospital's closest competitors in terms of proximity are Eisenhower Medical Center and John F. Kennedy Memorial Hospital. As mentioned above John F. Kennedy Memorial Hospital is also a part of the Desert Care Network operated by Tenet.

This engagement was conducted in accordance with generally accepted valuation methodologies. In the valuation of a privately-held business, three general approaches are considered in the determination of value: Cost Approach, Market Approach, and the Income Approach. The nature and characteristics of the business and the objective of the engagement indicate which approach, or approaches, are most applicable for valuation purposes. The Income Approach was fully relied upon, the applicability of which is discussed later in this report.

Desert Regional Medical Center

MARKET OVERVIEW

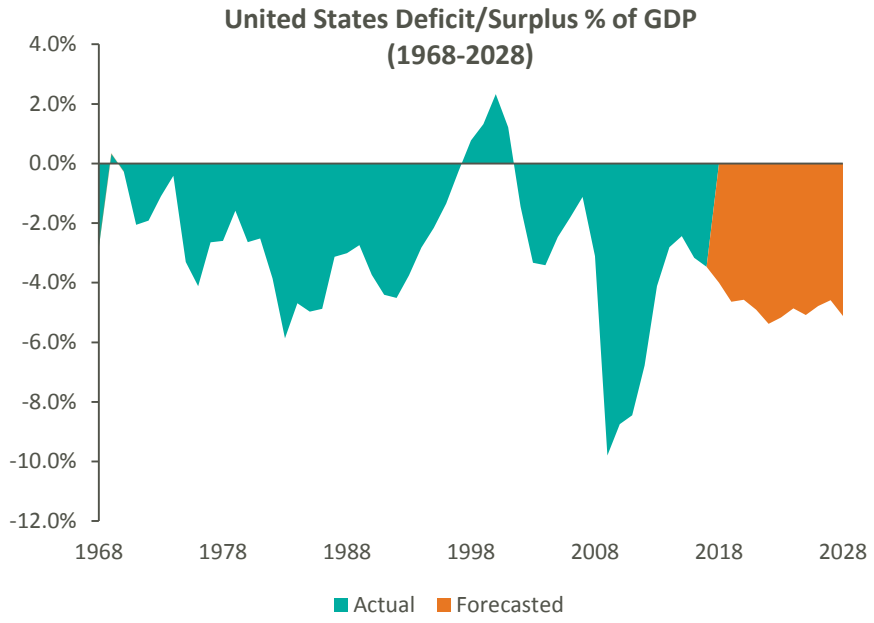
Desert Regional Medical Center

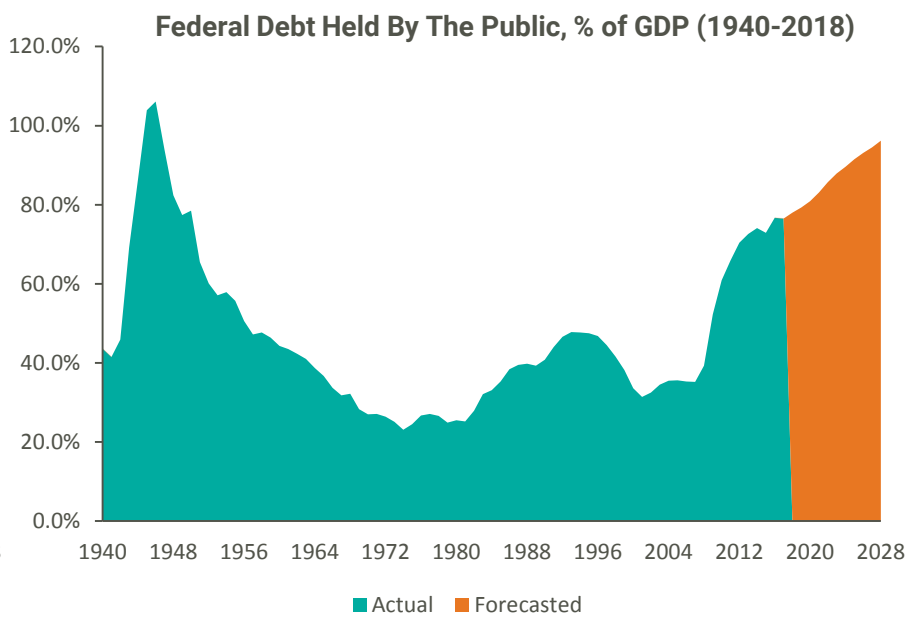
ECONOMIC ANALYSIS

Market Overview

Economic Analysis

The federal budget deficit continues to be an area of concern for lawmakers. According to estimates from the Congressional Budget Office ("CBO"), the federal deficit as a percent of GDP increased from -3.2% of GDP in 2016 to -3.5% of GDP in 2017. The CBO projects that the federal deficit as a percentage of GDP will increase to -4.0% in 2018 increasing further to -5.4% by 2022. As a result, the federal debt held by the public as a percentage of GDP is projected to increase from 76.5% in 2017 to 85.7% in 2022. The increased deficits are projected to be driven by declines in revenue as a result of the Tax Cuts and Jobs Act of 2017. In its report, the CBO notes the increased uncertainty associated with estimating the economic impact of recent changes in fiscal policy. Deficit reduction has been identified as a priority of the Trump administration. However, in order to accomplish this revenue reductions resulting from the Tax Cuts and Jobs Act of 2017 must be off-set by economic growth and/or additional spending cuts.

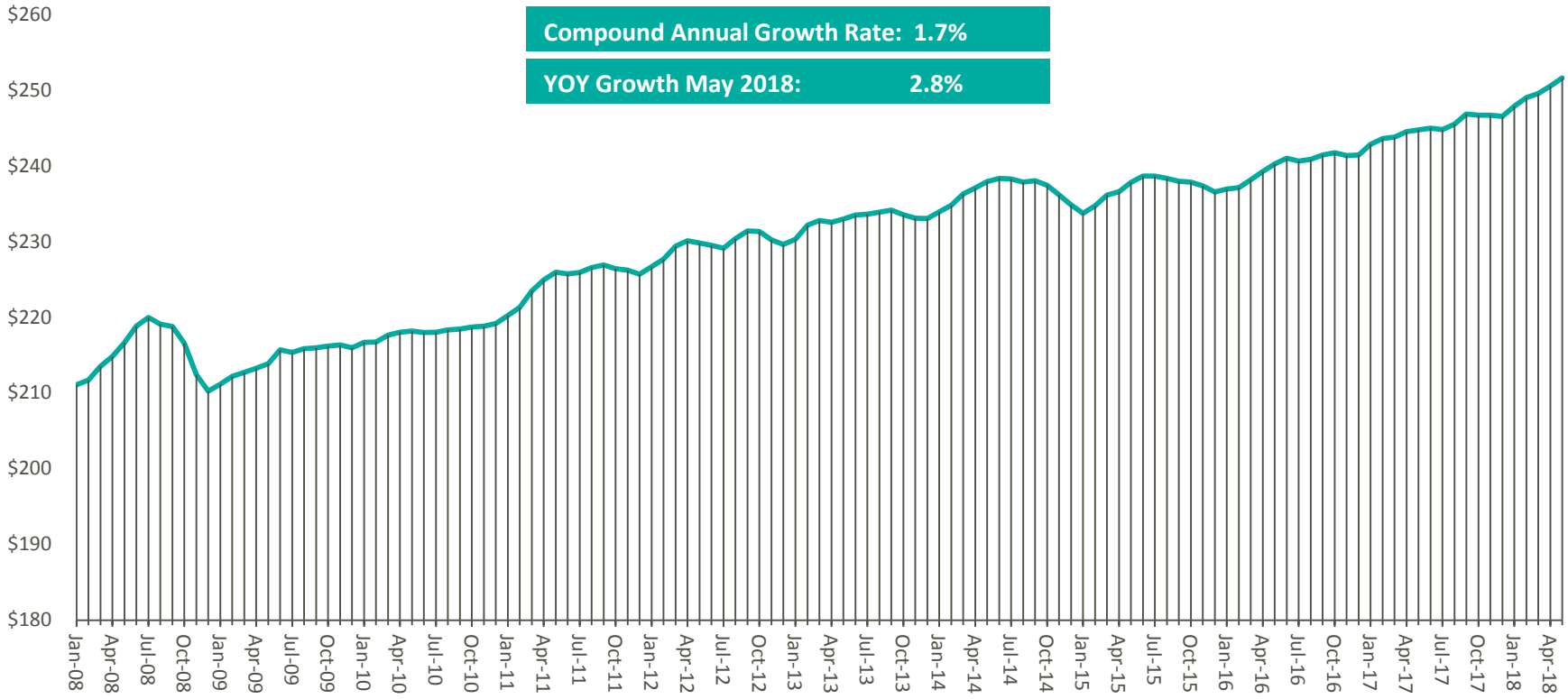




Source: The Budget and Economic Outlook: 2018 to 2028 published by the Congressional Budget Office

Presented in the chart below is the Consumer Price Index for Urban Consumers ("CPI-U") from April 2008 to April 2018. The CPI-U measures the average change in price for a market basket of goods and services over time for urban consumers. The percentage change in the CPI-U is commonly used to measure the general inflation in the price of goods and services for urban consumers in the United States. From January 2008 to May 2018, CPI-U increased at a compound annual rate of approximately 1.7%. More recently, CPI-U has increased 2.8% from May 2017 to May 2018.

Unadjusted Consumer Price Index For Urban Consumers



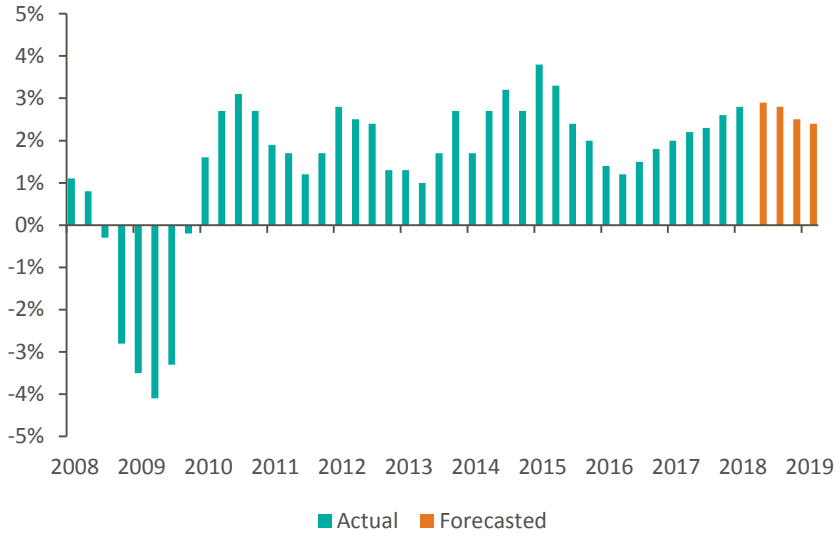
Source: Bureau of Labor Statistics

Market Overview

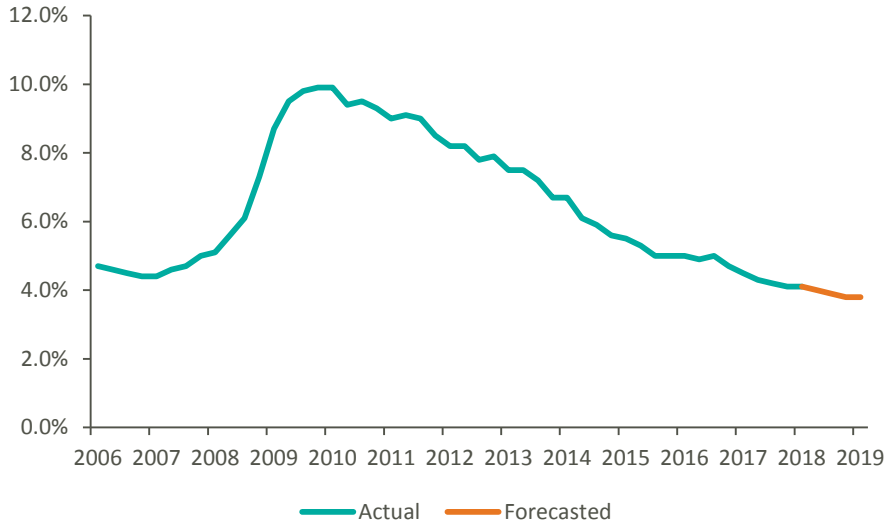
Economic Analysis

Since the recovery from the recession in 2008 and 2009, annual real GDP growth has ranged from a low of 1.0% in Q1 of 2013 to a high of 3.8% in Q1 of 2015. For Q1 of 2018, YOY growth in real GDP was 2.8%. Overall, YOY quarterly real GDP growth has averaged 2.5% over the past four quarters. According to the Survey of Professional Forecasters, real GDP growth is expected to grow at an average rate of 2.7% over the next four quarters. The unemployment rate reached 10% in October of 2009, the highest rate in over 30 years. Since that time, the unemployment rate has declined to 4.1% as of March 2018 and is expected to decrease over the next three quarters according to the Survey of Professional Forecasters.

Year Over Year Growth Real GDP
Quarterly From Q1 2008 to Forecast Q1 2019



Unemployment Rate
Quarterly from Q1 2006 to Forecast Q1 2019

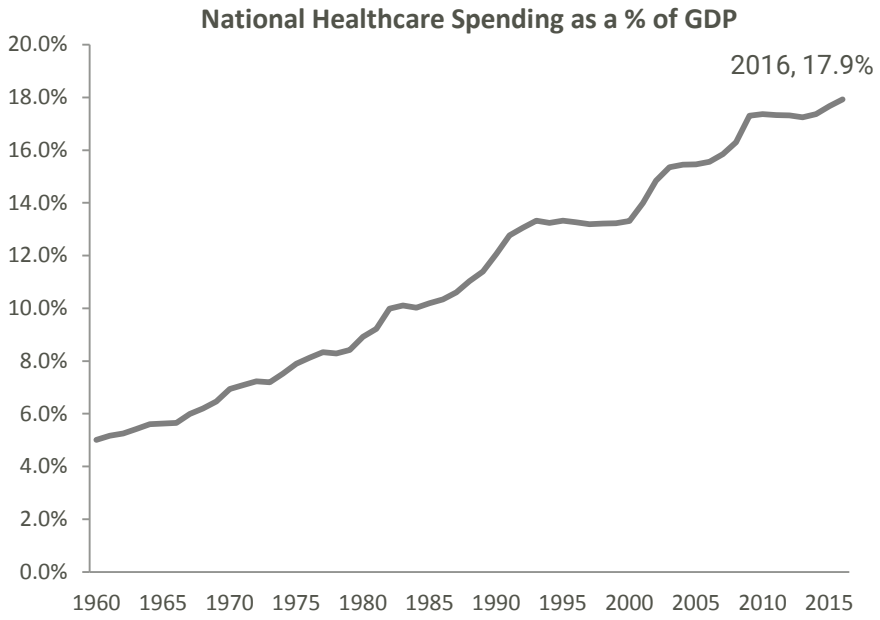


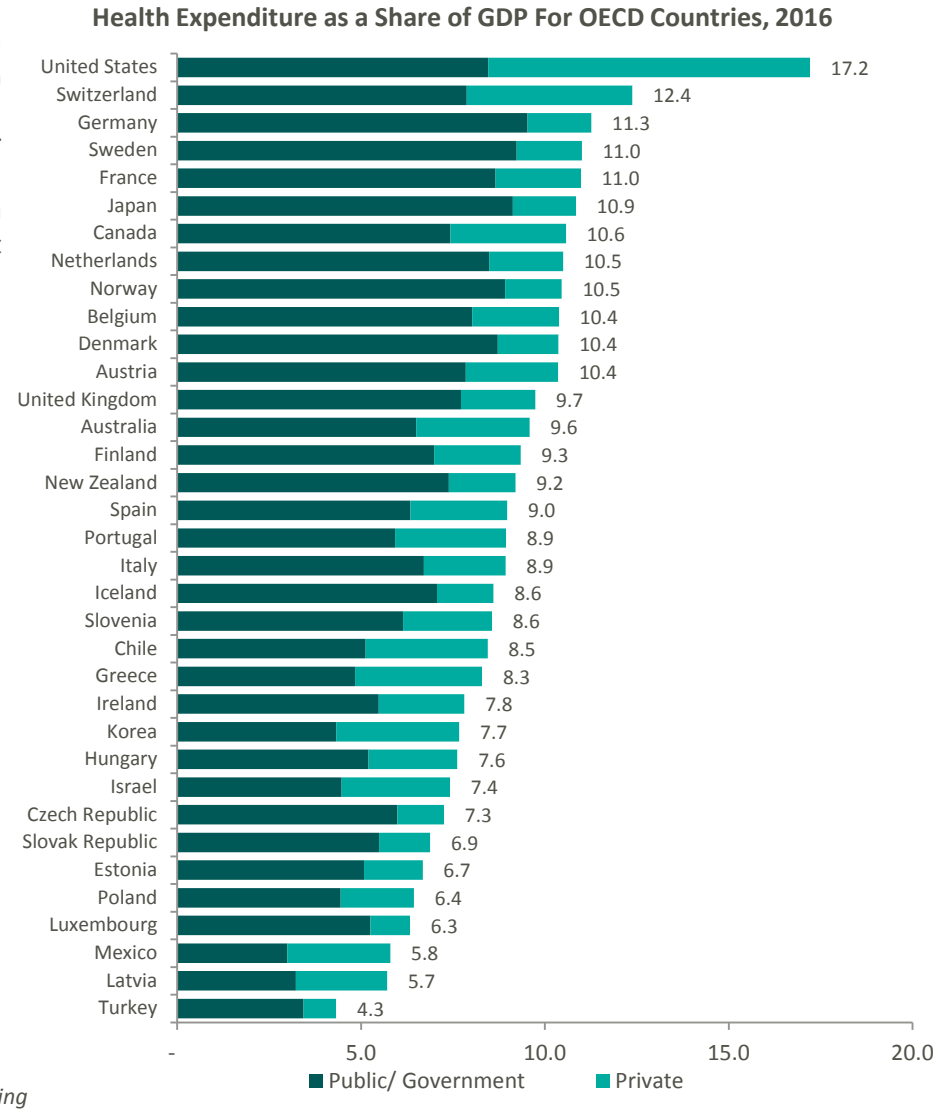
Source: Federal Reserve Bank of St. Louis, United States Bureau of Labor Statistics, and the Survey of Professional Forecasters

Market Overview

United States Healthcare System

According to the Center for Medicare and Medicaid Services ("CMS") healthcare spending as a percentage of GDP has increased from 5.0% in 1960 to 17.9% in 2016. More recently, healthcare expenditures as a percentage of GDP increased from 17.2% in 2013 to 17.9% in 2016 after remaining relatively flat for the previous five years. According to the OECD, the United States spends more on healthcare, both per capita, and as a share of GDP, than any other country in the world as illustrated in the chart on the right.





Source: CMS and Bureau of Economic Analysis & *OECD.Stat Health Expenditure & Financing*

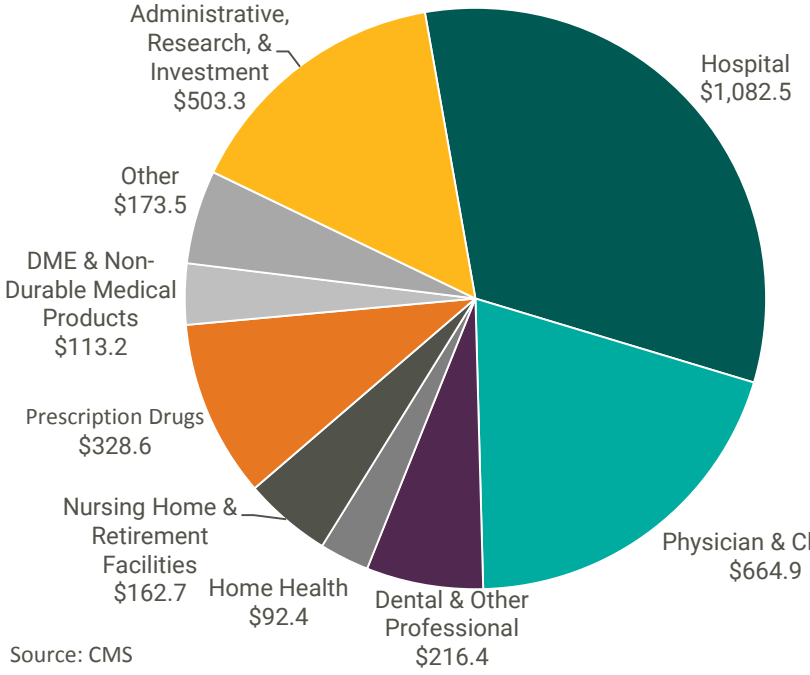
Market Overview

United States Healthcare System

Healthcare spending growth in the United States moderated in 2016 as compared to 2014 and 2015 when ACA coverage expansions and double digit growth in prescription drug spending caused overall healthcare spending to increase more than 5.0% annually. Overall, from 2015 to 2016 total national health expenditures increased 4.3% from approximately $3.2 trillion in 2015 to approximately $3.3 trillion in 2016. In 2016 hospital care and physician & clinical services were the largest spending categories accounting for $1,082.5 billion (33.8% of total) and $664.9 billion (20.7% of total) of the total health expenditures, respectively. From 2010 to 2016 hospital services and prescription drugs have experienced the largest growth in spending with an average annual growth rate of 4.7% and 4.4%, respectively. According to CMS, the increase in hospital spending is primarily attributable to an increase in overall utilization and acuity of services. While the large increase in prescription drug spending is the result of a shift from small molecule drugs to specialty pharmaceuticals which are more expensive. It should be noted that spending on prescription drugs increased just 1.3% in 2016 due to fewer new drug approvals, slower growth in brand-name drug spending, and pricing decreases for generic drugs.

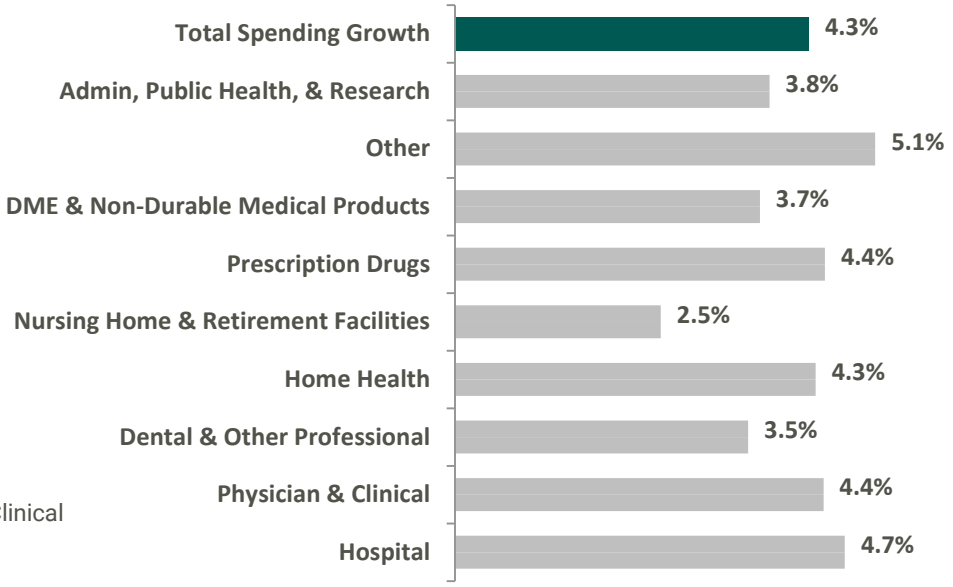
National Health Expenditures by Category 2016 (in Billions)

Total 2016 Spending $3.3 Trillion



Source: CMS

Annual Healthcare Spending Growth by Category 2010-2016



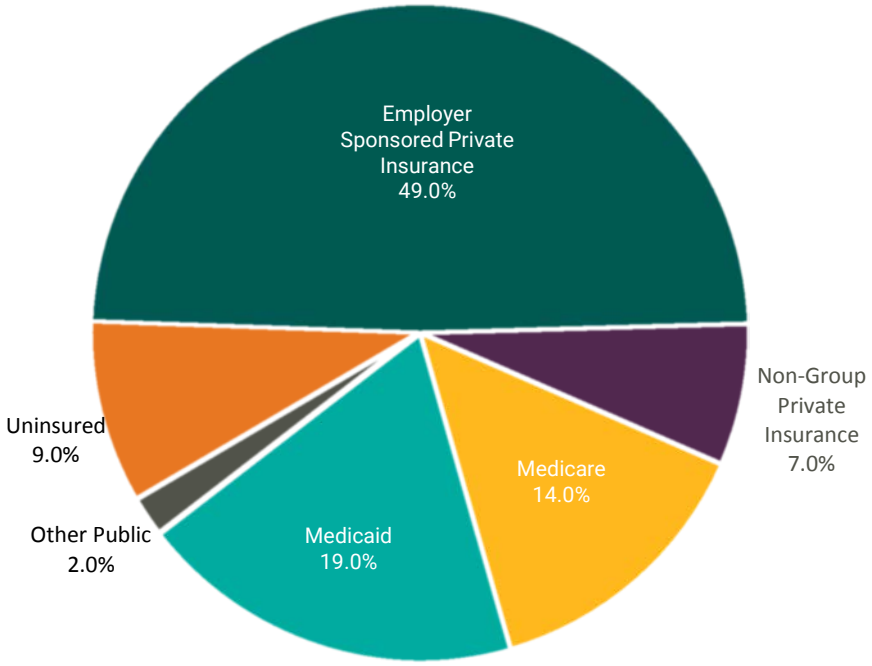
Market Overview

United States Healthcare System

A number of private and public sources combine to finance healthcare expenditures in the United States. The majority of Americans under the age of 65 have health coverage through a private insurance provider. According to the Kaiser Family Foundation, during 2016 approximately 49% of Americans had employer based private insurance while approximately 7.0% obtained private insurance through the individual plan market. The largest government payors, Medicaid and Medicare covered approximately 19.0% and 14.0% of Americans, respectively. According to CMS, private health insurance accounted for approximately 35.0% of total national health expenditures in 2016. Over the same time period, Medicare and Medicaid accounted for 21.0% and 18.2% of total spending, respectively.

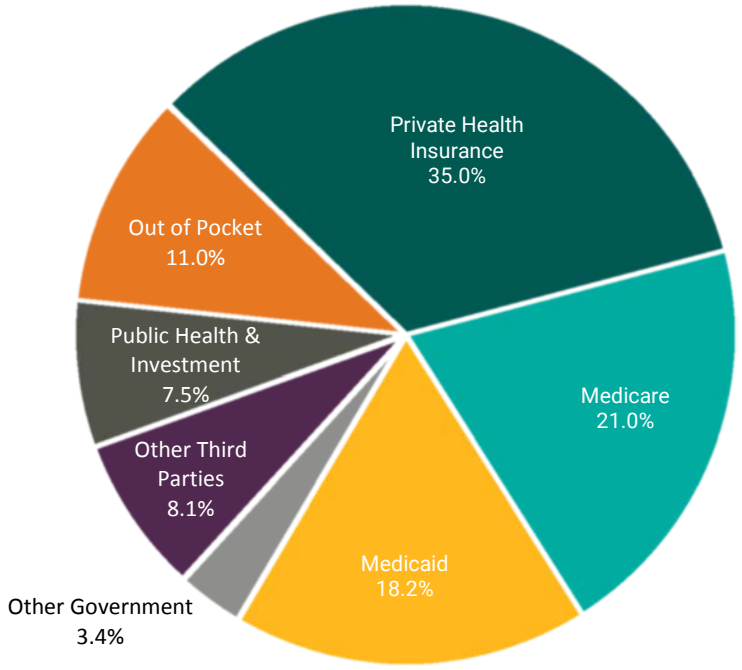
Health Coverage by Payor 2016

Percentage of Total Population



National Healthcare Expenditures by Payor 2016

Total 2016 Spending $3.3 Trillion

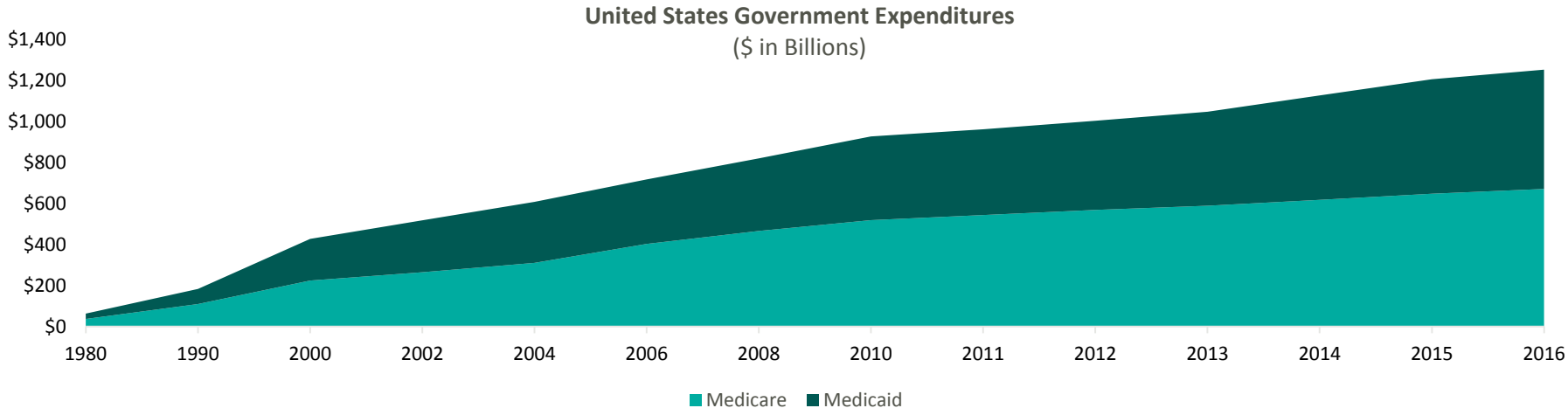


Sources: Kaiser Family Foundation and CMS

Government Funding

During 2016 Medicare provided federal health insurance for approximately 57.1 million[1] people who are elderly, disabled, have end-stage renal disease, or amyotrophic lateral sclerosis (also known as Lou Gehrig's disease). Individuals become eligible for Medicare on the basis of age when they reach 65 while disabled individuals become eligible for Medicare 24 months after they become eligible for benefits under the Social Security Disability Insurance program. Since 1980, Medicare spending has grown 8.4% compounded annually from approximately $37.4 billion in 1980 to approximately $672.1 billion in 2016. More recently total Medicare spending growth has slowed, increasing 4.4% compounded annually from $519.8 billion in 2010 to $672.1 billion in 2016.

Medicaid is a joint federal–state program that pays for healthcare services for a variety of low-income individuals. The Medicaid program, created in 1965 by the same legislation that created Medicare, replaced an earlier program of federal grants given to states to provide medical care to low income residents. As of 2016, approximately 75.0 million[2] people were enrolled in the Medicaid program. It should be noted that certain individuals, often referred to as "dual-eligible," are covered by both Medicaid and Medicare. Since 1980, Medicaid spending has grown 9.0% compounded annually from approximately $26.0 billion in 1980 to approximately $582.4 billion in 2016[3]. More recently Medicaid expenditures increased 8.3% compounded annually from $458.9 billion in 2013 to $582.4 billion in 2016 due to the expansion of coverage resulting from The Patient Protection and Affordable Care Act.

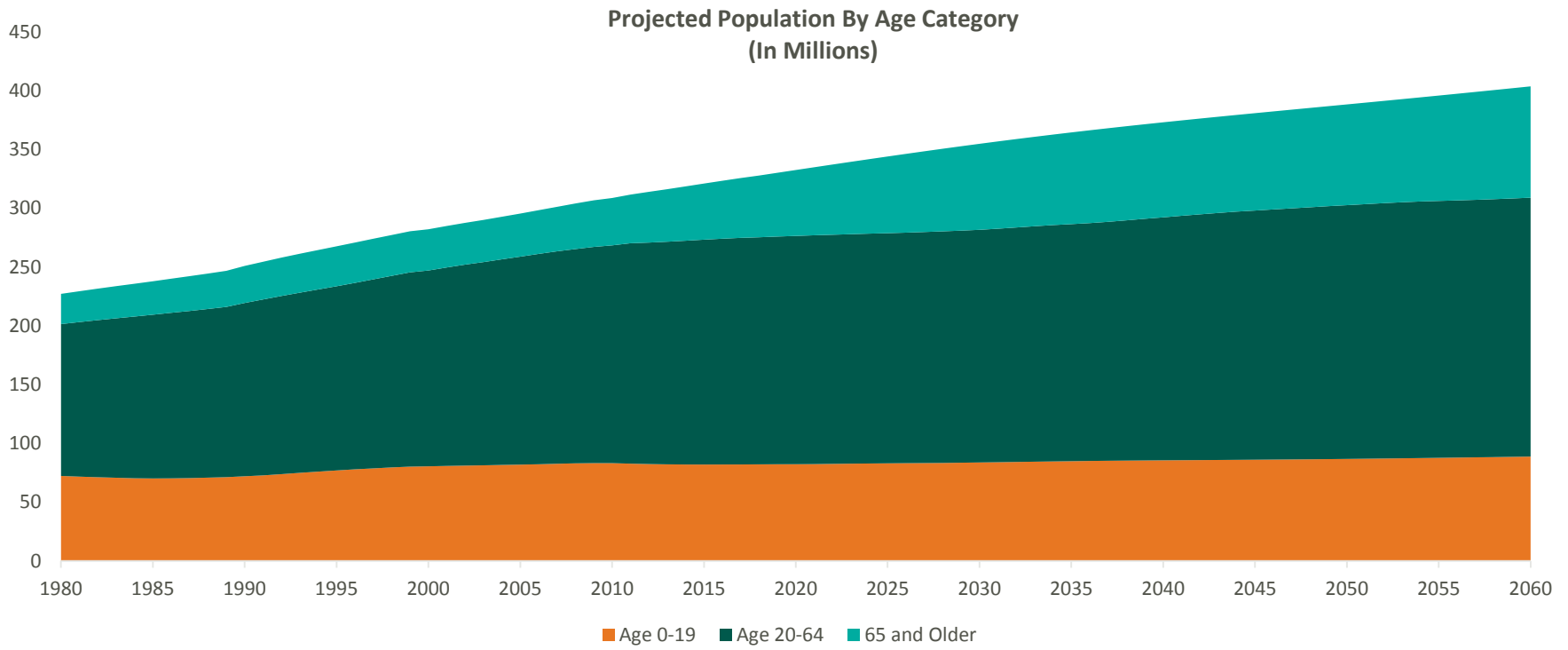


1. Medicare Enrollment Dashboard published by CMS
2. Medicaid & Children's Health Insurance Program ("CHIP") monthly applications, eligibility determinations, and enrollment report published by CMS
3. Healthcare Expenditure data published by CMS

Market Overview

Demographic Analysis

Presented in the chart below is a summary of the United States' historical and projected population by age category from 1980 to 2060 provided by the U.S. Census Bureau. As of 2017, there were approximately 50.8 million Americans (15.6% of the total population) 65 years of age or older. In addition, there are approximately 63.3 million Americans (19.5% of the total population) between the ages of 50 and 64 who will become eligible for Medicare over the next 10-15 years. Based on projections published by the U.S. Census Bureau, the total percentage of the United States' population over the age of 65 is projected to increase from 15.6% in 2017 to 19.7% by 2027 and 21.6% by 2037. The aging of the United States' population is projected to drive increased demand for a variety of healthcare services. However, the projected increase in the number of Medicare beneficiaries and the historical increases in spending per beneficiary is forcing policy makers to re-evaluate how Medicare pays for healthcare services.



Source: United States Census Bureau

Market Overview

Local Demographics

The Hospital is located in Palm Springs, California, which is in Riverside County. Recent population estimates indicate that the population of Riverside County increased 2.6% compounded annually, from approximately 1,558,985 residents in 2000 to approximately 2,423,266 residents in 2017. Approximately 13.9% of the population of Riverside County is over the age of 65 (Source: United States Census Bureau). According to the United States Department of Labor, the June unemployment rate for the Riverside-San Bernardino-Ontario, CA metropolitan statistical area ("MSA") was 4.7%. Furthermore, according to the Centers for Medicare and Medicaid Services, Riverside County had 352,217 people enrolled in Medicare.

In addition, the 2016 median household income of Riverside County, California, was $59,951, which is 10.0% lower than the 2016 California state median income of $66,637.

Population Estimates	1990	2000	2005	2010	2011	2012	2013	2014	2015	2016	2017
RIVERSIDE COUNTY	1,193,156	1,558,985	1,931,785	2,202,001	2,235,890	2,264,804	2,291,406	2,321,738	2,352,080	2,386,522	2,423,266
**CAGR since 1990*	*N/A*	*2.7%*	*3.3%*	*3.1%*	*3.0%*	*3.0%*	*2.9%*	*2.8%*	*2.8%*	*2.7%*	*2.7%*
**CAGR since 2000*		*N/A*	*4.4%*	*3.5%*	*3.3%*	*3.2%*	*3.0%*	*2.9%*	*2.8%*	*2.7%*	*2.6%*
**CAGR since 2010*				*N/A*	*1.5%*	*1.4%*	*1.3%*	*1.3%*	*1.3%*	*1.4%*	*1.4%*

**CAGR = Compounded annual growth rate.*

Source: U.S. Census Bureau Population Finder for RIVERSIDE COUNTY, CALIFORNIA

Population estimates are from July 1st of that year.

According to the United States Census Bureau, the top five industries in Riverside County are listed below:

- Educational services, and healthcare and social assistance (20.6%);
- Retail trade (13.0%);
- Arts, entertainment, and recreation, and accommodation and food services (11.4%)
- Professional, scientific, and management, and administrative and waste management services (10.2%); and,
- Manufacturing (8.9%).

According to the United States Department of Labor Bureau of Labor Statistics, the April 2016 Metropolitan Area Occupational Employment and Wage Estimate relevant for the Hospital is detailed below:

SOC Code	Occupation Title	Employment(1)	Median Hourly	Mean Hourly	Mean Annual(2)	Mean RSE(3)
29-1141	Registered Nurses	27,720	$45.72	$46.88	$97,520	2.0%
29-2034	Radiologic Technologists	1,620	$34.19	$33.57	$69,820	2.0%
29-2061	Licensed Practical and Licensed Vocational Nurses	7,210	$23.11	$23.26	$48,390	1.9%
29-2071	Medical Records and Health Information Technicians	1,740	$19.24	$22.46	$46,720	3.1%
29-2099	Health Technologists and Technicians, All Other	2,760	$19.94	$20.32	$42,260	2.1%
31-1014	Nursing Assistants	7,120	$14.61	$15.87	$33,000	2.9%
31-9092	Medical Assistants	8,600	$14.31	$14.92	$31,040	1.4%
31-9093	Medical Equipment Preparers	540	$22.46	$22.57	$46,940	2.8%
31-9094	Medical Transcriptionists	310	$22.00	$21.12	$43,940	7.5%

(1) Estimates for detailed occupations do not sum to the totals because the totals include occupations not shown separately. Estimates do not include self-employed workers.

(2) Annual wages have been calculated by multiplying the hourly mean wage by a "year-round, full-time" hours figure of 2,080 hours; for those occupations where there is not an hourly mean wage published, the annual wage has been directly calculated from the reported survey data.

(3) The relative standard error (RSE) is a measure of the reliability of a survey statistic. The smaller the relative standard error, the more precise the estimate.

Market Overview

Overview of Hospital Types

Hospital is general term used to describe a facility which provides a wide variety of inpatient and outpatient healthcare services to patients. The most common hospital type is a general short term acute care hospital, however there are different types of general acute care hospitals and other specialty hospitals (rehabilitation, behavioral, long term, and children's). Most of the hospitals operate as part of a network of hospitals and outpatient facilities designed to provide comprehensive health services to patients within the community. Below is a brief description of the different types of hospitals.

- General Acute Care Hospitals – Also known as short terms hospitals, these hospitals provide a wide range of medical and surgical services including inpatient, intensive, trauma, neo-natal, cardiac, and other specialty care along with emergency diagnostic services. Care is intended to be on a short term basis with most hospital stays lasting three to six days. In addition, general acute care hospitals provide a wide range of outpatient services including surgery, physician services, primary care services, laboratory, diagnostic imaging, cardiology, and physical therapy among others. Outpatient services can be provided in hospital outpatient departments, freestanding facilities, or combination of the two. General acute care hospitals are generally separated into two categories: urban and rural hospitals. Urban hospitals tend to be larger as measured in terms of total revenue and number of beds. In addition, urban hospitals are more likely to have additional designations for trauma, cardiology, neurology, or other types of specialty emergency services. Of the almost 7,000 Medicare licensed hospitals as of 2017, 3,399 (49.2% of the total Medicare licensed hospital) were general acute care hospitals. This includes a segment of general acute care hospitals that specialize in one line of care such as surgery, cardiac care, or orthopedics.

- Critical Access Hospital – The "Critical Access Hospital" designation was created by the Balanced Budget Act of 1997 in response to a string of rural hospital closures. In order for a hospital to be classified as a Critical Access Hospital, it must meet the following requirements: the hospital must have 25 acute care inpatient beds or fewer, provide emergency care services 24/7, maintain an annual average length of stay of 96 hours or fewer, and be located at least 35 miles away from another hospital. The primary advantage of the Critical Access Hospital designation is that the provider is reimbursed on a cost-based methodology as opposed to a prospective payment system. In general, critical access hospitals can provide a limited range of services as compared to general acute care hospitals. Patients requiring intensive emergency or specialty care must be transferred to larger urban hospitals. In 2017, there were 1,346 Medicare licensed critical access hospitals (19.5% of the total Medicare licensed hospitals).

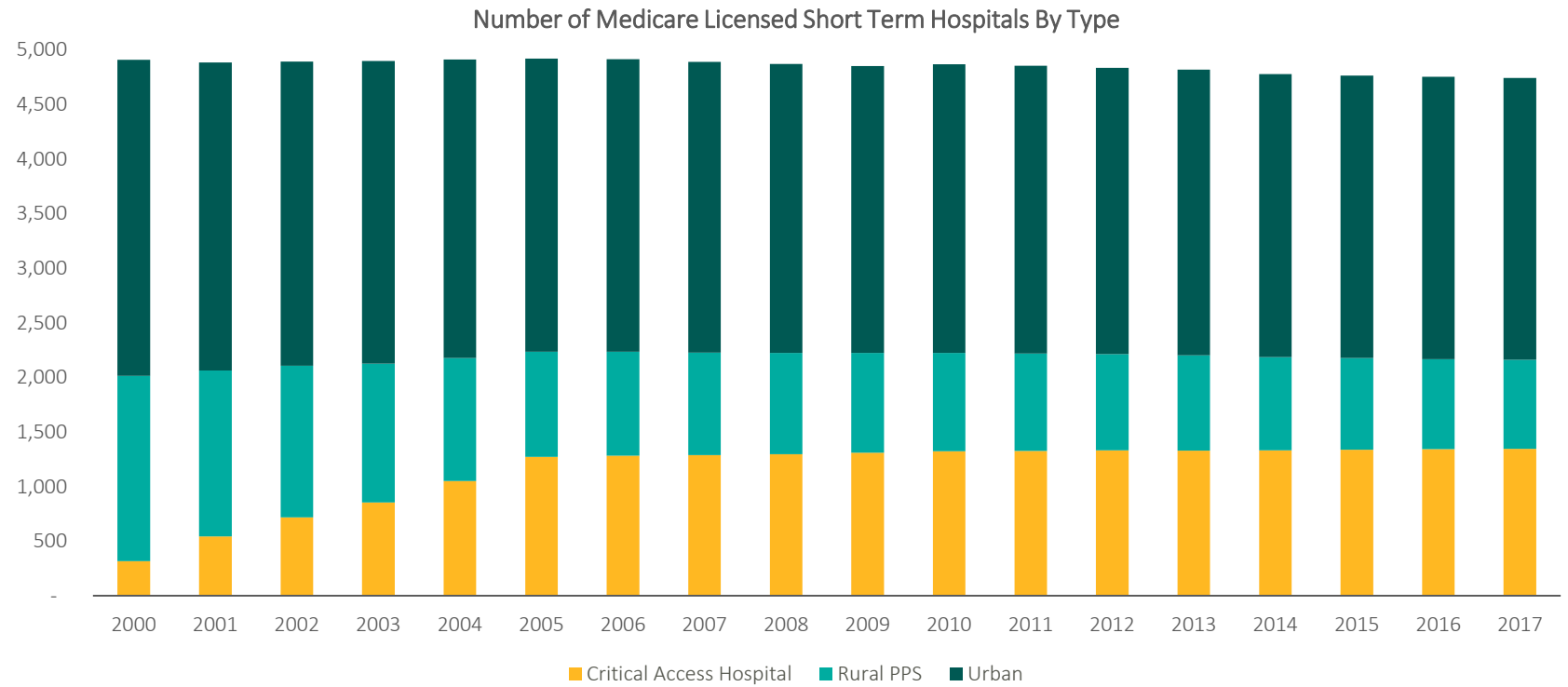
- Non-Participating Provider – A non-participating hospital accepts Medicare patients but does not agree to accept the Medicare approved amount as full payment. However, there are limits on the amounts that non-participating providers can charge for services. There are approximately 783 non-participating hospitals as of 2017 (11.3% of the total Medicare licensed hospitals). A majority of these hospitals are operated by the Department of Veteran Affairs or the Indian Health Service.

- Rehabilitation Hospital – Also known as an inpatient rehabilitation facility ("IRF"), is a specialized facility type focused on restoring patient's physical and cognitive abilities. Patients in these hospitals have significant physical and cognitive disabilities due to an array of medical conditions such as strokes, hip fractures, brain injuries, spinal cord injuries, orthopedic problems, neuromuscular disease, and debilitating neurological conditions. IRFs can operate as a freestanding hospital or a hospital within a hospital ("HIH"). A HIH is a facility which will lease space from a general acute care hospital and then operate as a separately licensed hospital, while freestanding IRFs operate independently. The majority of rehab hospital patients are transferred from general acute care hospitals. IRFs differ from general acute care hospitals in that their patients typically have a longer length of stay with conditions that require rehabilitative services on an inpatient basis. In addition, IRFs tend to have an older patient base as compared to acute care hospitals. CMS reimburses IRFs based on a separate fee schedule known as the IRF Prospective Payment System ("IRF PPS"). In order to be reimbursed under the IRF PPS, the facility must meet a number of criteria regarding the severity of patients that are admitted to the hospital. As of 2017 there were approximately 282 freestanding IRFs (4.1% of total the Medicare licensed hospitals).
- Behavioral Hospital – Specialize in the treatment of individuals with mental illness and behavioral issues. For behavioral hospitals, there are often different types of facilities that treat patients with different mental or behavioral problems. An acute inpatient psychiatric facility provides high levels of care to patients with mental illness. Sometimes these patients may be a harm to others or themselves, therefore, there is 24-hour monitoring and treatment by a psychiatrist. Special treatment facilities treat patients with specific or severe behavioral disorders, such as an eating disorder. These facilities classify and treat patients by severity of condition. Comprehensive treatment centers specialize in the use of medication and abstinent-based treatment. This treatment when combined with behavioral therapy are used to help patients with substance abuse problems and addiction. Residential treatment centers treat patients in a non-hospital setting. This includes social activities and outdoor programs, making these facilities less intensive and demanding. As of 2017 there were approximately 584 inpatient behavioral hospitals (8.5% of the total Medicare licensed hospitals).
- Long Term Acute Care Hospital ("LTACH") – These hospitals are designed to meet the needs of patients with serious medical problems that require a longer hospital stay and more focused medical treatment. The average patient stay at an LTACH is between 20-30 days. As with IRFs, LTACHs can operate as a HIH or freestanding facility. Both types of LTACHs receive their patients on referral from general acute care hospitals. These patients have serious and complex medical issues usually stemming from complex infectious disease, heart failure, respiratory failure, pulmonary disease, renal disease, trauma, or a complex surgery that requires a long recovery. As of 2017 there were approximately 411 LTACHs (6.0% of the total Medicare licensed hospitals).
- Children's Hospital – Focus on the care and treatment of children (this includes any patient from infancy to 18 years of age). All medical physicians working within the hospital have experience caring for children and all doctors are specially trained. As of 2017 there were approximately 98 children's hospitals (1.4% of the total Medicare licensed hospitals).

Market Overview

Total Medicare Licensed Facilities

Presented in the chart below is the number of Medicare licensed general acute care hospitals by type from 2000 to 2017, excluding specialty hospitals and nonparticipating providers as defined on the previous page. As of 2017, there were a total of 4,743 general acute care hospitals. Of the total licensed hospitals, approximately 54.4% were urban hospitals and 45.6% were rural hospitals. Rural hospitals are further segmented into rural hospital hospitals that bill under the prospective payment system (herein referred to as "Rural PPS" hospitals) and Critical Access Hospitals which are reimbursed on a cost basis. Overall, the total number of Medicare licensed hospitals has declined 0.2% compounded annually from 4,911 in 2000 to 4,743 in 2017. Over the same time period the number of urban hospitals declined 0.7% compounded annually while the number of rural hospitals increased 0.4% compounded annually. The number of critical access hospitals increased significantly from 2000 to 2006 as rural hospitals converted to the newly created critical access designation. It should be noted that multiple hospitals can be operated under a single Medicare certification.



Source: 2017 Medicare Provider of Services File

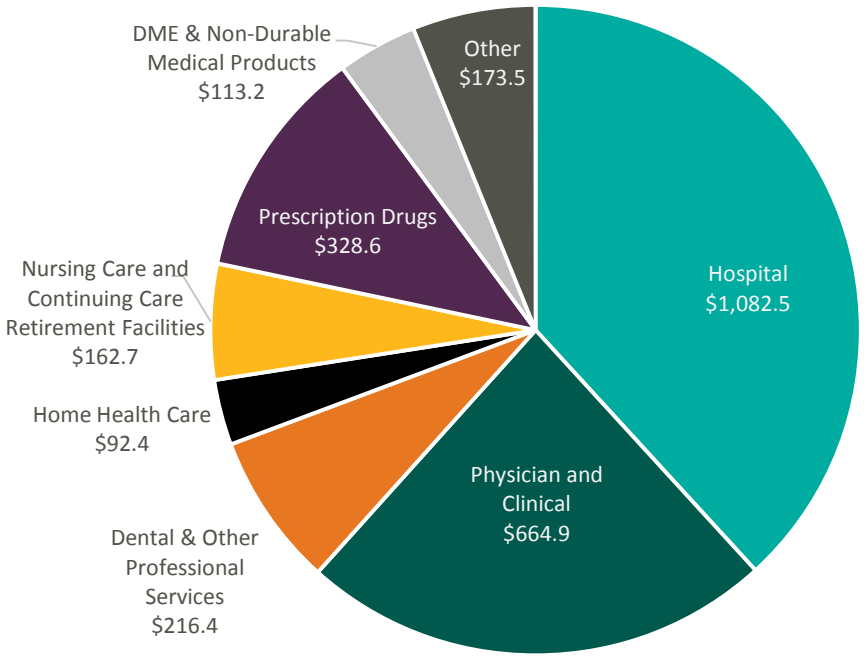
Market Overview

Analysis Of Total Hospital Spending

According to the national health expenditure data published by CMS, spending on hospital services accounted for the largest percentage of total personal health expenditures. Personal health expenditures represents health expenditures spent directly for patient care. During 2016 total expenditures on hospital services were approximately $1.1 trillion or approximately 38.2% of total national personal health expenditures. Total hospital spending has increased 4.7% compounded annually from $822.3 billion in 2010 to $1.1 trillion in 2016. The growth in hospital spending has accounted for a significant portion of growth in total national healthcare expenditures in recent years.

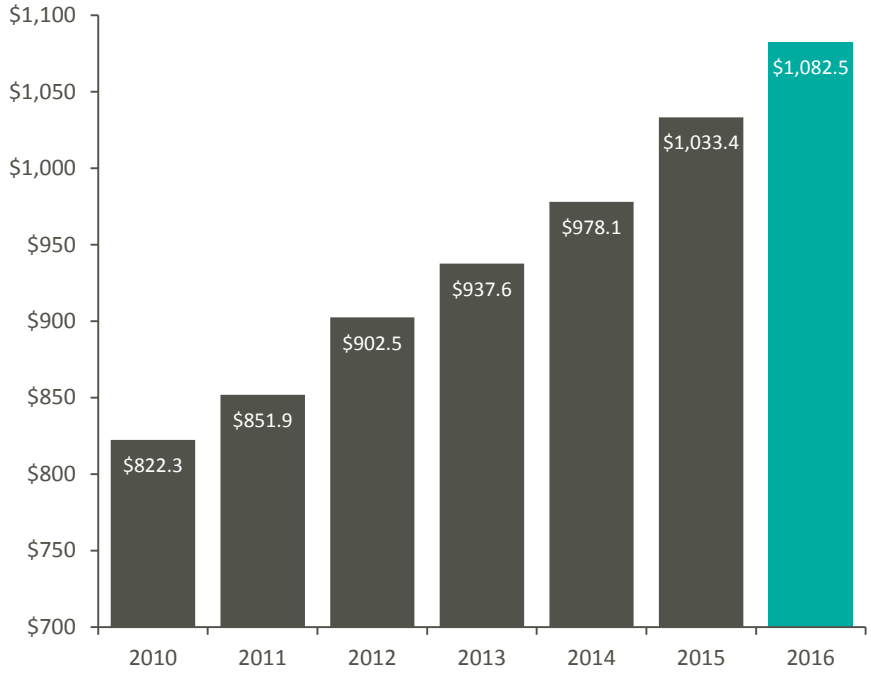
Personal Health Expenditures By Service (In Billions)

Total 2016 Expenditures: $2.8 Trillion



Growth in Hospital Spending (In Billions)

CAGR: 4.7%

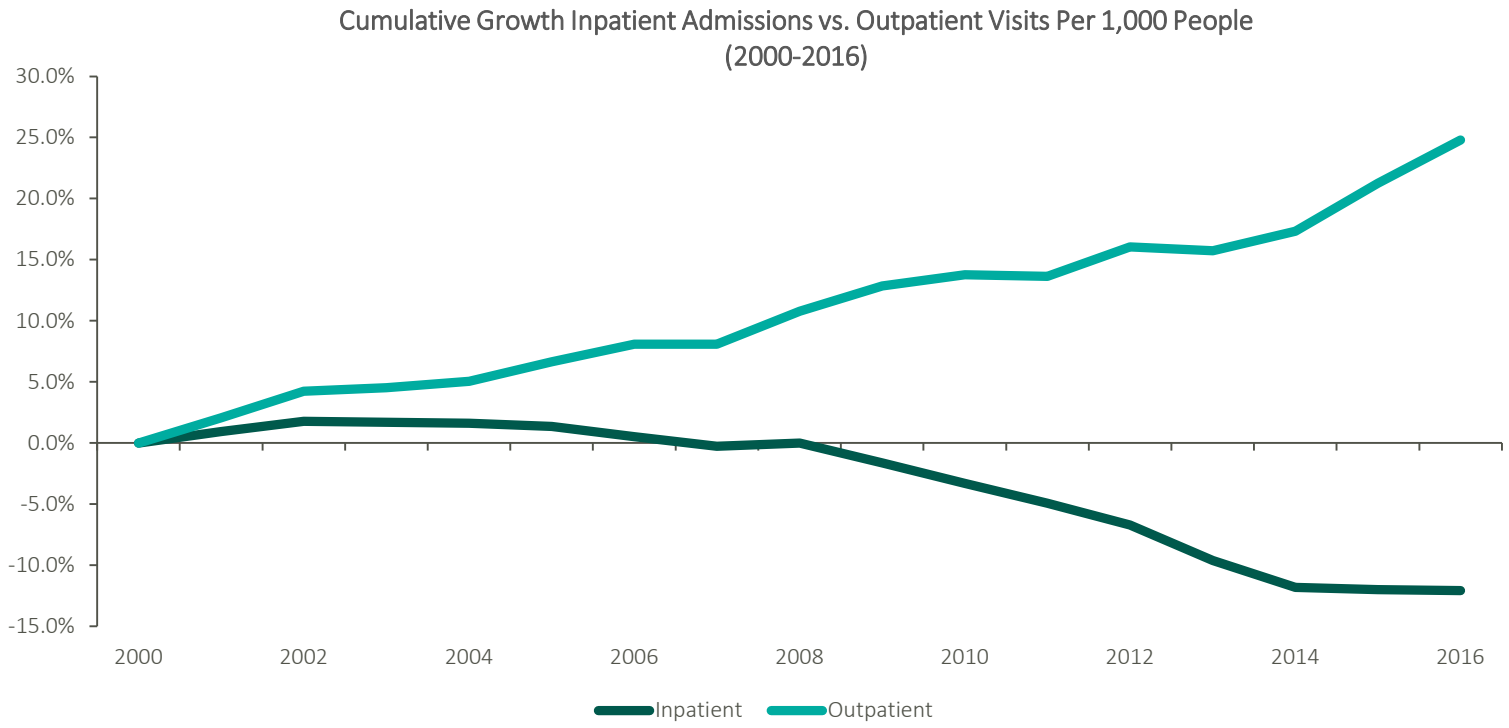


Source: CMS

Market Overview

Analysis of Utilization Trends

As mentioned previously, acute care hospitals provide a variety of inpatient and outpatient services. Presented in the chart below is the cumulative growth in inpatient admissions vs. outpatient visits per 1,000 people from 2000 to 2016 based on data published by the American Hospital Association. Since 2000, the number of inpatient admissions per 1,000 people has decreased 12.1% cumulatively. Over the same time period, the total number of outpatient visits per 1,000 individuals has increased 24.8% cumulatively from 2000 to 2016. These volume trends are the result of an increased migration of services from the inpatient setting to the outpatient setting due to technological advances and pressure from payors to reduce costs.

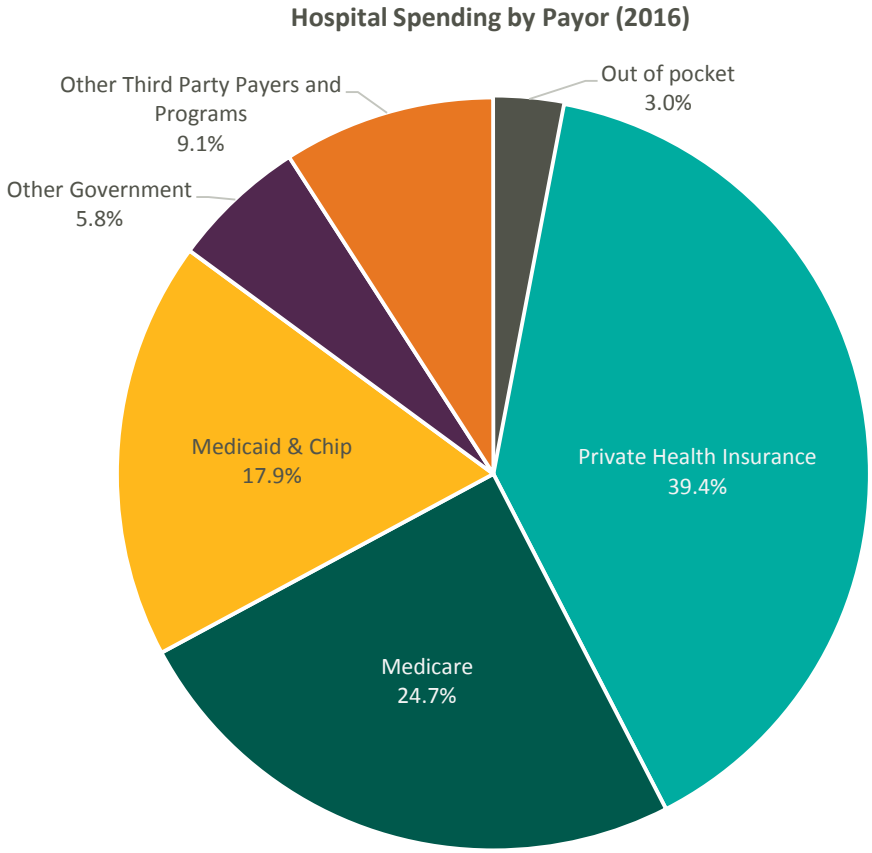


Source: American Hospital Association

Market Overview

Analysis Of Hospital Payor Mix

Presented in the chart below is the percentage of total hospital spending by payor for 2016 based on data published by CMS. As illustrated in the chart the below, hospital spending was comprised primarily of private health insurance, Medicare, and Medicaid which accounted for approximately 39.4%, 24.7%, and 17.9%, respectively of the total 2016 hospital spending. Payment rates from private health insurers are negotiated with the individual payors and typically are paid a predetermined rate per diagnosis, per-diem, discount of charges, or other contractual arrangements. The following pages give additional detail on the Medicare reimbursement methodology.



Source: CMS

Healthcare Overview

The Patient Protection and Accountable Care Act ("PPACA") and the Health Care and Education Reconciliation Act, signed into law on March 23, 2010, have significantly changed the way that healthcare services in the United States are covered, delivered, and reimbursed. The overall goal of this comprehensive legislation is to extend health coverage to millions of uninsured legal U.S. residents through a combination of private sector health insurance reforms and public program expansion. In order to fund the expansion of insurance coverage, PPACA contains measures designed to promote quality and cost efficiency in health care delivery in order to generate budgetary savings for the Medicare & Medicaid programs. The statutes and regulations of the PPACA have been the subject of various administrative appeals and lawsuits, however some of the key provisions of the legislation include:

Individual Mandate: The legislation contains an "Individual Mandate" which requires most Americans to maintain "minimum essential" health insurance coverage. Those that do not comply with the mandate will be required to make a "shared responsibility payment" to the federal government in the form of a tax penalty. The tax penalty for non-exempt individuals without health coverage in 2014 was the greater of 1.0% of income or $95 per individual and increased to 2.5% of income or $695 per individual in 2016. For individuals under the age of 18 the tax penalty is reduced 50%.

Health Exchanges: To assist individuals who are not exempt from the individual mandate and who do not receive health insurance through an employer or government program in obtaining insurance coverage, PPACA established health exchanges. Health exchanges are government regulated organizations which provide competitive markets for buying health insurance for individuals and small employers. Certain states have established their own health exchanges while other states have chosen to utilize the federal government's health insurance exchange. Individuals who purchase a plan through the exchange may be eligible for a premium credit or cost sharing subsidy.

Employer Mandate: The employer mandate provision of PPACA requires the imposition of penalties on employers with over 50 employees that do not offer affordable health insurance to employees working 30 or more hours per week. In February of 2014, the implementation of the employer mandate was delayed until January 1, 2016 for companies with 50 to 100 employees. For companies with more than 100 employees, the percentage of full-time workers required to be covered was reduced to 70% in 2014 & 2015. In 2016 and subsequent years employers with over 100 employees must offer health coverage to 95% of employees. Affordable health insurance is defined as premiums of no more than 9.5% of an employee's income and the employer must pay 60% of the actuarial value of a worker's coverage. Companies that fail to comply with the employer mandate can face fines of up to $2,000 for each employee not covered.

Medicaid Expansion: PPACA extended eligibility under Medicaid to almost all individuals under the age of 65 with incomes up to 138% of the Federal Poverty Limit ("FPL") beginning in 2014. Under PPACA the federal government will pay 100% of the cost of Medicaid expansion in 2014 through 2016. Federal funding will be reduced to 90% over the course of a four year period from 2017 through 2020 and will remain at 90.0% after 2021. Historically, the income levels for Medicaid eligibility were determined by the state and were typically around 106% of the FPL. Initially, PPACA required all states to expand Medicaid coverage or face possible reductions in existing funding for the Medicaid programs. However, the constitutionality of this mandate was challenged in September of 2011 in the court case of the National Federation of Independent Businesses vs. Sebelius (Secretary of the Department of HHS). The Supreme Court ruled that Congress had no authority to require the states to expand their respective Medicaid programs. Congress may offer grants to the individual states for expanding Medicaid coverage but existing Medicaid funding cannot be threatened. As a result of the ruling, the individual states were given the choice to expand Medicaid coverage. Please see the following page for additional detail on the states that elected to expand Medicaid and the resulting increase in enrollment.

PPACA also contains a number of provisions designed to improve the quality and efficiency of medical care provided to Medicare and Medicaid beneficiaries. These provisions include: the prohibition of Medicare or Medicaid funds from paying for the treatment of Hospital-Acquired Conditions ("HACs"); reductions in reimbursement for hospitals with excessive readmissions; creation of the Medicare value-based purchasing program; and the creation of the Center for Medicare & Medicaid Innovation to further explore potential hospital payment bundles.

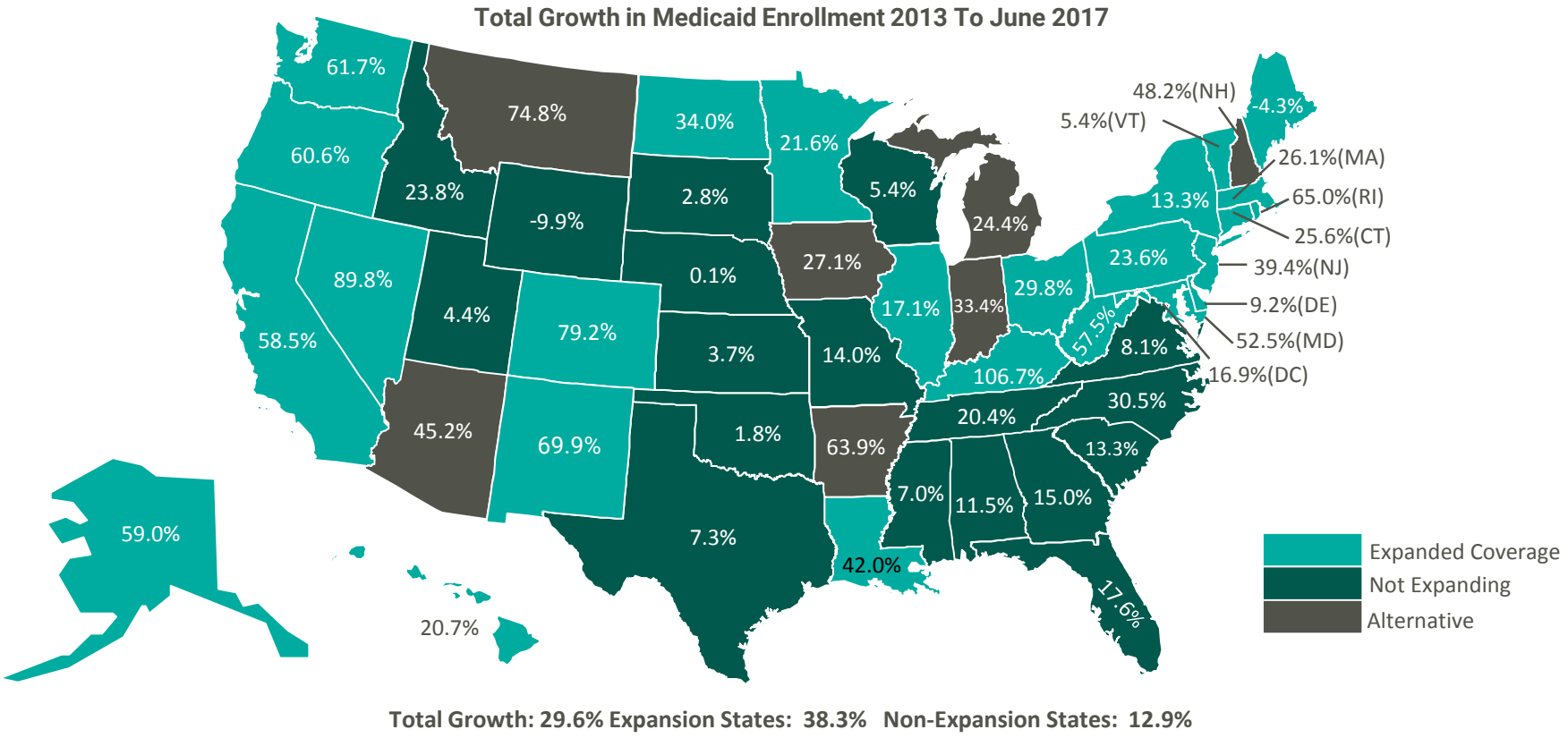
PPACA also establishes a number of additional health insurance reforms including:

- Establishes a minimum medical loss ratio of 85% for large group plans and 80% for small group plans.
- Health insurers may not establish lifetime or annual limits on the dollar value of benefits.
- May not rescind coverage of any enrollee except in instances of fraud.
- Health insurers must reimburse hospitals for emergency services provided to enrollees without the need for prior authorization and without regard to whether or not there is an existing contract with the provider.
- Extends dependent coverage until the age of 26

Market Overview

Healthcare Overview (Continued)

Presented in the chart below is the total growth in Medicaid enrollment by state from 2013 through June 2017. Medicaid enrollment in states that have chosen to expand Medicaid coverage has increased 38.3% from 2013 to 2017. Over the same time period, Medicaid enrollment in states that have not elected to expand Medicaid coverage has increased 12.9% from 2013 to 2017.



Total Growth: 29.6% Expansion States: 38.3% Non-Expansion States: 12.9%

Source: CMS Enrollment Report June 2017

PPACA also contains a number of provisions designed to reduce Medicare and Medicaid program spending. These provisions include negative adjustments to the annual inflation updates for the Medicare fee schedules and reductions to the Medicare and Medicaid Disproportionate Share Hospital Payments ("DSH"). Beginning in 2010, CMS has made negative adjustments to the annual market basket updates for Medicare's IPPS, OPPS, LTACH PPS, and IRF PPS fee schedules. Below is a summary of the proposed changes to the Medicare and Medicaid DSH programs:

Medicare DSH Payments: In addition to payments made under the inpatient prospective payment system for services provided directly to beneficiaries, Medicare makes payments to hospitals which treat a disproportionately high share of low-income patients. Prior to October 31, 2013, Medicare DSH payments were made based on statistical information defined by CMS and calculated as a percentage add-on to the MS-DRG payments. PPACA revised the DSH adjustment effective for discharges occurring on or after October 31, 2013. Under the revised methodology, hospitals will receive 25% of the amount they previously would have received under the pre-PPACA formula. This portion is referred to as the "Empirically Justified Payment".

Hospitals that qualify for the Empirically Justified Payment are also eligible to receive additional payments for uncompensated care, referred to as the "UC DSH Payment". The UC DSH payment comprises the remaining 75% of the total DSH payments that would have been paid under the historical formula. Each eligible hospital will receive a UC DSH payment based on its share of uninsured low income days (which is the sum of the Medicaid days and Medicare SSI days). The total UC DSH payments are calculated at 75% of DSH payments that would have been made under previous methodology and will be reduced annually by the percentage change in uninsured individuals under the age of 65.

Medicaid DSH Payments: In addition, CMS makes Medicaid DSH payments to states who then determine the methodology for distributing the payments to the individual hospitals. Federal law requires that state Medicaid programs make DSH payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. In the fiscal year 2016 Medicaid DSH payments totaled approximately $19.1 billion. PPACA called for reductions in Medicaid DSH payments beginning in 2014. However, the decision not to expand Medicaid coverage by certain states have resulted in several delays in the Medicaid DSH cuts. Most recently, The Bipartisan Budget Act of 2018 pushed Medicaid DSH reductions back to FY 2020. In FY 2020 Medicaid DSH payments are scheduled to be reduced by $4.0 billion increasing to $8.0 billion annually from FY 2020 to FY 2025.

Sources: MedPac and Medicaid & CHIP Payment and Access Commission

Market Overview

Medicare Payment Overview

Medicare payments for inpatient services are made per the Inpatient Prospective Payment System, known as (“IPPS”). Under the IPPS, hospitals are paid a pre-determined amount for each hospital discharge based on the patient’s diagnosis, called a Diagnosis Related Group (”DRG”). DRG payments are based on national averages and not on specific hospitals costs, but DRG payments are adjusted by a predetermined geographic adjustment factor assigned to the hospital’s locale. DRG rates are adjusted by an update factor each federal fiscal year, which begins October 1st. The index used to adjust the DRG rates is referred to as the market basket index. This index gives consideration to the inflation experienced by hospitals in purchasing its required goods and services.

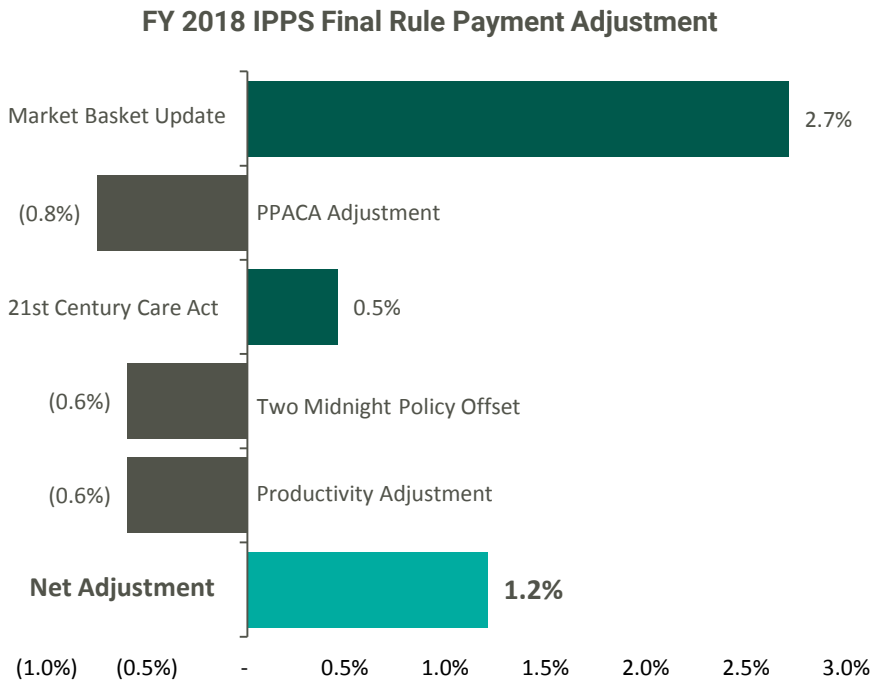
The majority of hospital outpatient services furnished to patients are paid by Medicare through the Outpatient Prospective Payment System (“OPPS”). These outpatient services are classified into Ambulatory Payment Classifications (“APCs”). A patient may be assigned into a single or multiple APCs depending on the service ordered during the patient encounter. Medicare pays a set price for each group, regardless of the actual costs incurred in providing care. Medicare sets the payment rate for each APC based on historical median cost data and adjusts the payment for geographic location. Similar to the payments based on DRGs, APC payments are updated each federal fiscal year based on the market basket index. The following services are paid based on other fee schedules established by Medicare: physical, occupational and speech therapy; durable medical equipment; diagnostic laboratory services; and services at freestanding surgical centers and diagnostic facilities.

CMS adopted a final rule on August 22, 2007 that established Medicare Severity DRGs (“MS-DRGs”). The rule’s goal was to refine the DRG weighting system to fully capture differences in severity of illness among patients, replacing 538 DRGs with 745 MS-DRGs. The switch to the MS-DRG system was intended to be budget neutral in that total Medicare payments to hospitals should not increase or decrease solely due to changes in documentation and coding practices. In order to ensure that improvements in coding and documentation do not lead to an increase in aggregate payments without a corresponding growth in patient severity, CMS will initiate a negative coding adjustment every fiscal year.

IPPS FY 2018 Final Rule

On August 2, 2017 the Centers for Medicare and Medicaid Services released the Inpatient Prospective Payment System fiscal year (FY) 2018 final rule which called for a **1.2% increase** in hospital operating payments for hospitals reporting all quality metrics. The increase is slightly below the proposed increase of 1.6%. The increase is the result of the following adjustments:

- Market Basket Update (Inflation) – The hospital market basket update for FY 2018 of positive 2.7%.
- PPACA Reduction – The ACA mandated reduction for FY 2018 of negative 0.8%.
- 21st Century Care Act – One time increase mandated by 21st Century Care Act of positive 0.5%
- Two-Midnight Policy Offset – One time adjustment to offset the previous increase related to Two-Midnight Rule of negative 0.6%.
- Productivity Adjustment – The productivity adjustment for FY 2018 of negative 0.6%.



Changes to DSH Payments

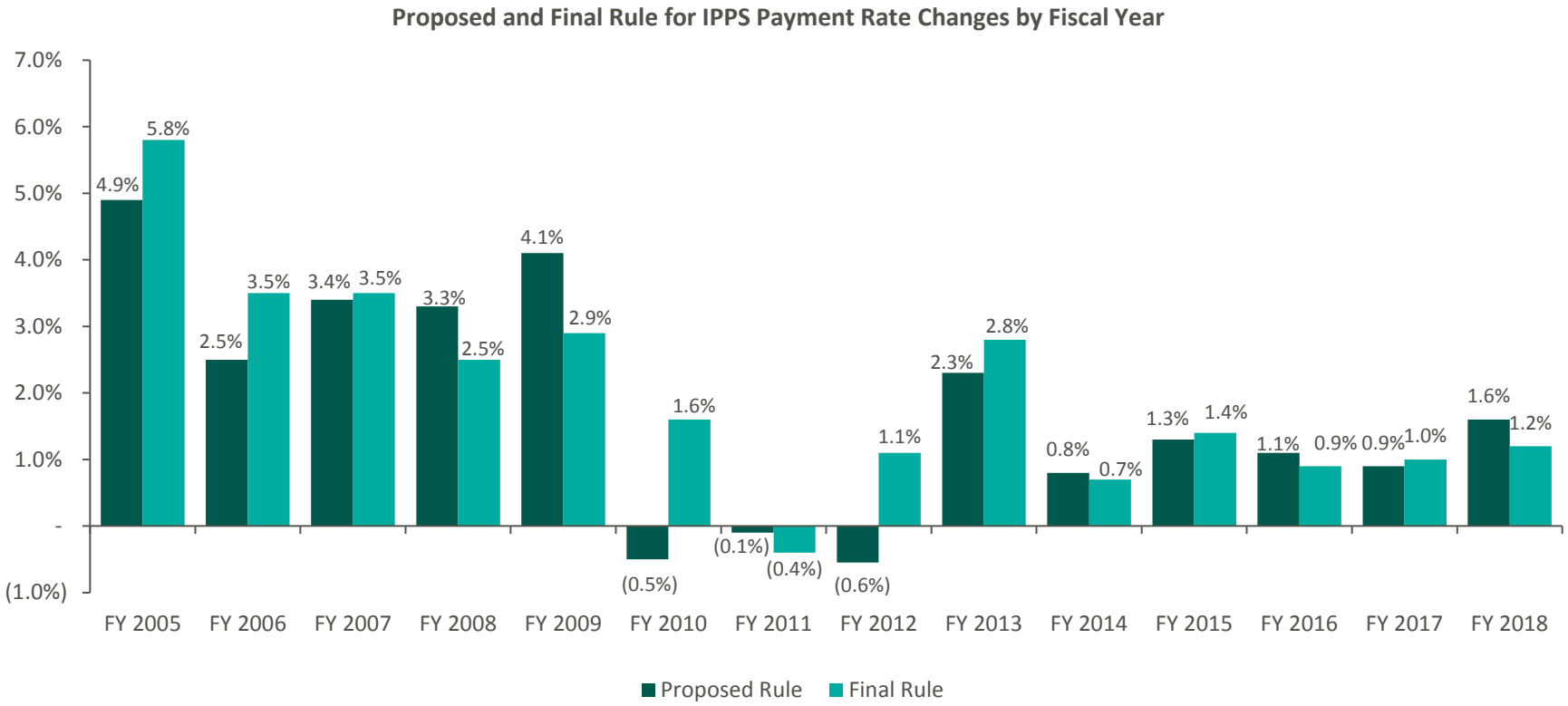
Medicare is making two changes to the calculation for uncompensated care payments to DSH hospitals. First, CMS finalized the proposal to incorporate data from the National Health Expenditure Accounts into its estimate of the percentage change in the rate of uninsurance. The percentage change in the rate of uninsurance is utilized in calculating the total amount of uncompensated care payments available to be distributed. In addition, CMS will incorporate uncompensated care cost data from worksheet S-10 of the FY 2014 cost reports, in combination with the Medicare and Medicaid low income days, to determine the distribution of uncompensated care payments to individual hospitals.

Based on these changes, CMS estimates that it will distribute roughly $6.8 billion in uncompensated care payments in FY 2018, an increase of approximately $800 million from FY 2017. As required by the ACA and subsequent legislation, this amount is equal to 75% of what otherwise would have been paid as Medicare DSH payments under the original formula, adjusted for the change in uninsured individuals and other factors.

Sources: CMS FY 2018 IPPS Final Rule Fact Sheet

Historical IPPS Reimbursement

Presented in the chart below are the net proposed and final IPPS payment increases for the past thirteen years. Since FY 2010 the average annual payment increase has been approximately 1.1% which is below the average annual increase for the five prior years of 3.6%. The decrease in the annual updates is primarily due to the productivity adjustment mandated by the PPACA and the documentation and coding adjustment mandated by the American Taxpayer Relief Act. It should be noted that payment increases presented below do not reflect any DSH or outlier payment adjustments.



Source: CMS Proposed and Final Rule Factsheets

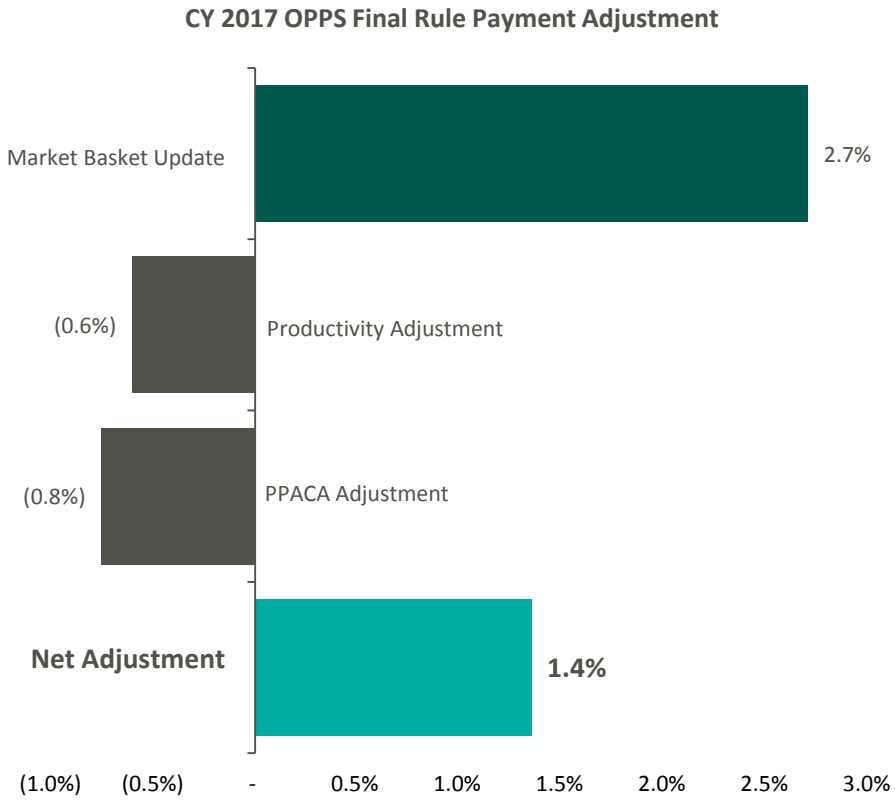
OPPS CY 2017 Final Rule

On November 1, 2016, CMS released the CY 2017 OPPS final payment update which resulted in an **increase of 1.4%** for hospital outpatient departments ("HOPDs"). The increase is the result of the following adjustments:

- Inflation Update – The OPPS market basket update for CY 2017 is positive 2.7%.
- Productivity Adjustment – The multi-factor productivity adjustment for CY 2017 is negative 0.6%.
- PPACA Reduction – The PPACA mandated reduction for CY 2017 is negative 0.8%.

Other miscellaneous payment provisions from the CY 2017 ruling include:

- Certain provider-based departments that started billing under the OPPS on and/or after November 2, 2015 will no longer be paid for most services under the OPPS. On January 1, 2017 these facilities will be reimbursed at a site neutral rate. Services provided in a dedicated emergency department will continue to be paid under the OPPS.



Sources: CMS CY 2017 OPPS Final Rule Fact Sheet

Desert Regional Medical Center

HISTORICAL OPERATIONS ANALYSIS

Executive Summary

Selected Financial Data

Selected Financial Data	FYE 2015	FYE 2016	FYE 2017	TTM 2018
Total Net Operating Revenue	491,063,987	549,132,545	538,194,797	562,925,293
Operating Expenses	367,253,350	423,350,259	426,119,146	429,861,588
EBITDA	123,810,637	125,782,286	112,075,651	133,063,705
Earnings before Taxes	109,090,945	110,351,215	95,837,470	117,226,839
Percentage of Net Revenue:				
Operating Expenses	74.8%	77.1%	79.2%	76.4%
EBITDA	25.2%	22.9%	20.8%	23.6%
Earnings before Taxes	22.2%	20.1%	17.8%	20.8%

The summary above presents certain operating results for FYE 2015, 2016, 2017, and TTM 2018. Net operating revenue increased 5.8% compounded annually, from approximately $491.1 million in FYE 2015 to approximately $562.9 million in TTM 2018. More recently, net operating revenue increased 4.6%, from approximately $538.2 million in FYE 2017 to approximately $562.9 million in TTM 2018.

Operating expenses increased 6.7% compounded annually, from approximately $367.3 million in FYE 2015 to approximately $429.9 million in TTM 2018. More recently, operating expenses increased 0.9%, from approximately $426.1 million in FYE 2017 to approximately $429.9 million in TTM 2018.

As a result of the operating expenses growth rate exceeding the net operating revenues growth rate, EBITDA as a percentage of net revenue decreased from approximately 25.2% in FYE 2015 to 23.6% in TTM 2018.

Note: Detailed Income Statement can be found in the Appendix.

Income Statement Analysis – FYE 2017 vs. TTM 2018

Net Operating Revenue:

Net operating revenue increased 4.6%, from approximately $538.2 million in FYE 2017 to approximately $562.9 million in TTM 2018. The increase in net operating revenue is detailed below:

- Total Net Patient Revenue increased 1.5%, from approximately $484.1 million in FYE 2017 to approximately $491.3 million in TTM 2018;
- Total Supplemental Payments increased 34.1% from approximately $53.3 million in FYE 2017 to approximately $71.5 million in TTM 2018.

Operating Expenses:

Operating expenses increased 0.9%, from approximately $426.1 million in FYE 2017 to approximately $429.9 million in TTM 2018. The Hospital's operating expenses as a percentage of net operating revenue fluctuated as follows:

- Employee salaries & wages expense for TTM 2018 was 33.2% of net operating revenue (below 34.8% in FYE 2017);
- Employee benefits expense for TTM 2018 was 9.1% of net operating revenue (below 9.5% in FYE 2017);
- Occupancy costs for TTM 2018 were 1.0% of net operating revenue (same as in FYE 2017);
- Drugs & medical supplies expense for TTM 2018 was 13.6% of net operating revenue (below 14.0% in FYE 2017);
- Other medical costs for TTM 2018 were 6.7% of net operating revenue (above 6.6% in FYE 2017);
- Insurance expense for TTM 2018 was 1.2% of net operating revenue (below to 1.4% in FYE 2017); and,
- General & administrative expenses for TTM 2018 were 11.6% of net operating revenue (below 12.0% in FYE 2017).

As a result of the higher increase in net operating revenue compared to the slight increase in operating expenses as a percentage of net operating revenue, the Hospital's EBITDA margin increased from 20.8% in FYE 2017 to 23.6% in TTM 2018.

Executive Summary

Volume Analysis

Total Hospital Volume:	FYE 2015	FYE 2016	FYE 2017	TTM 2018
Utilization Statistics:				
Admissions	19,738	20,184	19,650	19,694
Growth		2.3%	(2.6%)	0.2%
Adjusted Admissions	28,041	28,740	28,669	28,622
Growth		2.5%	(0.2%)	(0.2%)
Patient Days	88,855	97,083	92,724	92,271
Growth		9.3%	(4.5%)	(0.5%)
Adjusted Patient Days	126,233	138,239	135,282	134,100
Growth		9.5%	(2.1%)	(0.9%)
Outpatient Visits	159,534	164,406	168,102	167,037
Growth		3.1%	2.2%	(0.6%)
Census Data:				
Average Daily Census	243.44	265.25	254.04	252.80
Other Key Statistics:				
Case Mix Index	n/a	1.57	1.54	1.61

Illustrated above are the Hospital's volume statistics for FYE 2015, 2016, 2017, and TTM 2018. The Hospital's admissions remained relatively constant compounded annually from 19,738 in FYE 2015 to 19,694 in TTM 2018. More recently, the Hospital's admissions increased 0.2% from 19,650 in FYE 2017 to 19,694 in FYE 2017.

The Hospital's patient days increased 1.6% compounded annually from 88,855 in FYE 2015 to 92,271 in TTM 2018. More recently, patient days decreased 0.5% from 92,724 in FYE 2017 to 92,271 in TTM 2018.

Executive Summary

Staffing Analysis

Historical Staffing Summary	FYE 2015	FYE 2016	FYE 2017	TTM 2018
Hospital Employed FTEs	1,720	1,976	1,951	1,933
Growth		14.9%	(1.3%)	(0.9%)
Paid Hours	3,577,600	4,110,080	4,058,080	4,020,640
Growth		14.9%	(1.3%)	(0.9%)
Paid Hours per Adjusted Patient Day	28.3	29.7	30.0	30.0
Growth		4.9%	0.9%	(0.0%)
FTEs per Adjusted Occupied Bed	5.0	5.2	5.3	5.3
Growh		5.2%	0.6%	(0.0%)
Average Hourly Salary per FTE	$45.14	$46.39	$46.13	$46.49
Growth		2.8%	(0.6%)	0.8%
Average Hourly Benefits per FTE	$12.34	$12.09	$12.54	$12.75
Growth		(2.1%)	3.7%	1.7%

As shown above, the Hospital's staff currently consists of approximately 1,933 full-time equivalent ("FTE") employees as of TTM 2018, a 0.9% decrease from 1,951 employees in FYE 2017.

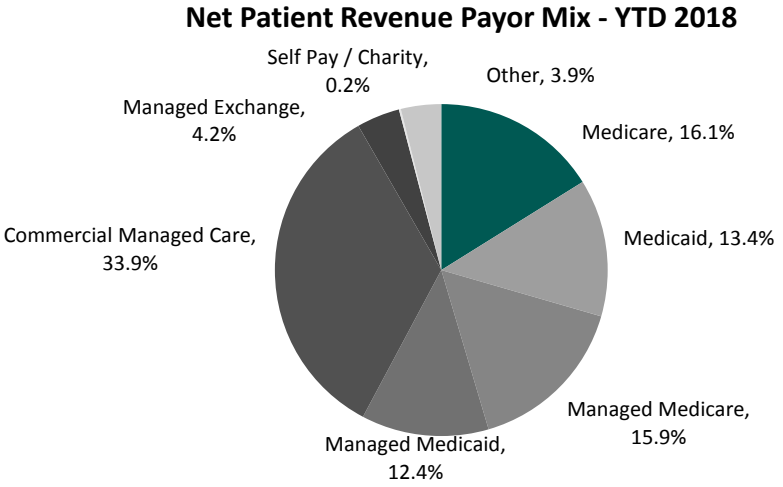
The average hourly salary per FTE was approximately $46.49 during TTM 2018, which represented a 0.8% increase over the FYE 2017 average hourly salary per FTE of approximately $46.13. The average FTE per adjusted occupied bed was 5.3 in TTM 2018.

Historical Operations Analysis

Payor Mix Analysis

Historical Payor Mix Expressed as % of Net Patient Revenue	FYE 2015	FYE 2016	FYE 2017	YTD 2018
Medicare	14.2%	14.5%	15.7%	16.1%
Medicaid	14.0%	12.7%	14.1%	13.4%
Managed Medicare	15.6%	16.9%	17.3%	15.9%
Managed Medicaid	12.7%	13.7%	13.5%	12.4%
Commercial Managed Care	31.7%	34.0%	30.5%	33.9%
Managed Exchange	4.9%	4.0%	4.3%	4.2%
Self Pay / Charity	1.3%	1.4%	1.3%	0.2%
Other	5.7%	2.9%	3.4%	3.9%
Total	100.0%	100.0%	100.0%	100.0%

Source: Hospital's payor mix report which is reported in terms of net patient revenue.



Illustrated above is the Hospital's payor mix based on net collections for FYE 2015, 2016, 2017, and YTD 2018. During YTD 2018, the largest payors as a percentage of net collections were Commercial Managed Care (33.9%) and Medicare (16.1%). Other payors include Managed Medicare (15.9%) and Medicaid (13.4%).

Desert Regional Medical Center

Valuation Overview

IRS Revenue Ruling 59-60 is a landmark ruling by the IRS that provides general guidelines for the valuation of closely held companies. We define FMV as established by IRS Revenue Ruling 59-60 as "the amount at which property would change hands between a willing seller and a willing buyer when neither is acting under compulsion and when both have reasonable knowledge of all relevant facts and circumstances." IRS Revenue Ruling 59-60 calls for examination of the following elements in connection with the subject Hospital:

- The nature and history of the Hospital from inception;
- The economic outlook in general and the outlook for the specific specialty area and market area of the Hospital;
- The financial condition of the Hospital;
- The earning capacity of the Hospital;
- The dividend paying capacity of the Hospital;
- The goodwill or other intangible value of the Hospital;
- Prior sales of the stock and the size of the block of stock to be valued; and,
- The market prices of Hospitals in the same or similar specialty areas.

In light of the general guidelines set forth in IRS Revenue Ruling 59-60, VMG's investigation and analysis includes the following:

- Interviews with management concerning past, present and prospective operating results of the Hospital;
- Analysis of the financial condition and historical operating and financial performance of the Hospital;
- Consideration of the economic outlook in general and the outlook for the specific specialty area and market area of the Hospital;
- With the assistance of Hospital personnel, our analysis estimates the earning and dividend paying capacity of the Hospital; and,
- Consideration of the Cost, Market, and Income Approaches to value.

As discussed, we have considered the use of the Cost, Market and Income Approaches to value. The following briefly describes each approach:

- Cost Approach - estimates the cost to recreate a business;
- Market Approach - estimates value by examining the value of similar businesses in a free and open market; and,
- Income Approach - estimates value by projecting a future income stream attributable to a business and then discounts those earnings back to present value.

Each approach is suitable in different situations. The subsequent sections of this report provide the benefits and challenges of using the three approaches.

Valuation Overview

Selection of the Income Approach

While we have considered the use of each approach to value, we have relied on the Income Approach to value the Hospital. Unlike the Cost and Market Approach, the Income Approach evaluates the future economic income stream that is specific to the Hospital. In determining the applicability of the Cost or Market Approach, we considered the following difficulties:

- Cost Approach
  - The book value of the Hospital's identified tangible assets may not reflect market value.
  - Does not consider the going-concern, goodwill, or other intangible value of the Hospital.

- Market Approach
  - Similar publicly traded companies have diversified business lines and are not "pure play" acute care hospital operators and are not comparable to the Subject Hospital from a size or growth standpoint.
  - Many of the private transactions involve hospitals with low or negative profitability. Additionally, there are very few transaction observations involving California Hospitals which have a similar dependence on the revenue generated through the Hospital Quality Assurance Fee program.

It should be noted that Market Approach results were considered in the determination of the selected value indication as the results support the Income Approach.

The following sections discuss in more detail the application of the Cost, Market, and Income Approaches to the Hospital.

Desert Regional Medical Center

Cost Approach

Cost Approach

General Assumptions

The Cost Approach, also known as the asset or build-up approach, is a method that attempts to value a business by identifying and valuing each tangible and intangible asset. The valuation premise used in this method may be one of the following:

- Value in continued use as part of a going concern;
- Value in place as part of a mass assemblage of assets;
- Value in exchange as part of an orderly disposition or forced liquidation.

The Cost Approach can be considered to provide a "floor" or lowest minimum value related to a business. This method may be an appropriate method when the Market Approach and Income Approach produce a value lower than the Cost Approach. In determining the applicability of the Cost Approach, we must also consider the earnings generated by the business as indicated in its historical and projected financial statements.

Under this approach, the identified tangible and intangible assets are valued based on the cost associated with "recreating" each asset. The asset components are examined and the related valuation assumptions for each are noted in the appendix.

Identified Tangible Assets:

Non Cash Net Working Capital - We have determined the normalized net working capital excluding cash to be 26.6% of net operating revenue, or approximately $43.5 million.

Net Fixed Assets – The value of net fixed assets was determined to be $93.1 million based on either the balance sheet as of May 31, 2018, or a fair market value analysis as of May 31, 2018.

As a result, the BEV of the Hospital under the cost approach is estimated at approximately $136.6 million. VMG has **not relied upon** the value indication produced by the Cost Approach as the book value of the Hospital's identified tangible assets does not consider the going-concern, goodwill, or other intangible value of the Hospital.

Desert Regional Medical Center

Market Approach

Market Approach

General Assumptions

The Market Approach estimates value by comparing the subject entity to similar businesses, business ownership interests, securities, or other assets that have been purchased or sold. The underlying premise of the Market Approach to valuation is the economic principle of substitution— assets of similar utility should have similar relative value. The Market Approach relies on observable market data to estimate indications of value. Appropriate market comparisons can provide some evidence of the value of a business or a business interest. The Market Approach uses relative value measures called "multiples" where selected fundamental financial or operational variables (typically revenue and/or EBITDA) are multiplied to derive a value indication.

In our application of the Market Approach, we considered two distinct methods: the Guideline Public Company Method ("GPCM") and the Merger & Acquisition Method ("M&A Method"). These methods are summarized below and discussed in greater detail on the following pages.

- **Guideline Public Company Method:** is a method whereby market multiples are derived from the market prices of stocks of companies that are engaged in the same or similar lines of business and actively traded on a free and open public market. Market multiples are developed by dividing the value of a publicly traded company's stock or invested capital by a financial measure, such as revenue, EBITDA or net income—these multiples provide an indication of how much a knowledgeable investor in the marketplace is willing to pay for an ownership interest in a company. The selected market multiples are then applied to the financial measure of the subject to provide a value indication. The selected guideline public companies should be similar to the subject business in terms of industry, product, market, growth and risk.

- **Merger & Acquisition Method:** is a method whereby pricing multiples are derived from transactions of ownership interests in companies engaged in the same or similar lines of business. This method reviews published data regarding actual transactions in either publicly traded or privately held companies. Similar to the GPCM, market multiples are developed by dividing the TIC paid by the seller by the financial metrics of the target company. In judging whether a reasonable basis for comparison exists, consideration must be given to certain factors, such as the similarity of ownership interest acquired, investor characteristics, the extent to which reliable data is known about the selected transactions (i.e. ownership interest acquired, consideration paid, and target company financial information) and whether the price paid for the guideline companies was negotiated at an arms-length transaction and not forced/distressed sale.

Source: The Market Approach to Valuing a Business – Second Edition by Shannon Pratt

Market Approach

Guideline Public Company Method

The GPCM derives a value for the subject company by applying the observed market multiples for similar publicly traded companies. These similar companies are referred to as "guideline" companies. The TIC for the guideline companies is estimated by adding the market value of firm's equity plus the book value of the firm's outstanding debt, non-controlling interest, and preferred equity. Non-controlling interests ("NCI") represent the estimated value of the minority shareholders ownership interest in the firm's consolidated businesses. It is common for healthcare guideline companies to operate facilities in partnership with third parties including physicians and non-profit health systems. In this case, the entities' consolidated financial statements include 100% of the assets, liabilities, revenue and expenses of the facilities in which the guideline companies have sufficient ownership and rights to assert "significant influence" over the facility operations as defined by accounting standards. The value of the NCI is recorded on the balance sheets of the guideline companies at the fair value at the time of acquisition adjusted annually by net income attributable to the NCI less distributions to the NCI.

The BEV value indication derived for the guideline companies are then divided by the firm's consolidated revenue and EBITDA to derive applicable market multiples for the subject entity. It should be noted that consolidated EBITDA has been adjusted to account for the earnings in unconsolidated affiliates (i.e. partnerships of the guideline company which are accounted for under the equity method of accounting). Based on the publicly available financial statements for the guideline companies, VMG is unable to adjust the consolidated revenue to account for the unconsolidated affiliates. Since the TIC value indications presented for the guideline companies include the estimated equity values of NCI, VMG has not reduced the consolidated EBITDA by the net income attributable to NCI.

In order to utilize this approach, similar businesses must be identified that have publicly available data. When selecting guideline companies, several factors are considered, including but not limited to the following:

- Similarity of services offered by the subject company;
- Size of the subject company, in terms of revenue, assets, number of operating locations, etc.;
- Product/service line diversification;
- Geographic diversification;
- Profitability of the company;
- Capital structure;
- Historical and prospective growth rates of the company; and
- Financial risk of the company.

Please see the following pages for a description of companies considered for the GPCM.

Public Company Comparables

A variety of public companies specialize in the ownership and operation of acute care hospitals. The companies we have identified are traded on the NYSE and NASDAQ. We have provided a brief description of the companies below.

- **Community Health Systems, Inc. (CYH):** Community Health Systems, Inc., together with its subsidiaries, owns, leases, and operates general acute care hospitals in the United States. It offers general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric, and rehabilitation services, as well as skilled nursing and home care services. The company also provides outpatient services at urgent care centers, occupational medicine clinics, imaging centers, cancer centers, ambulatory surgery centers, and home health and hospice agencies. As of December 31, 2016, it owned or leased 155 hospitals, including 152 general acute care hospitals and 3 stand-alone rehabilitation or psychiatric hospitals with an aggregate of 26,222 licensed beds in 21 states. The company was founded in 1985 and is headquartered in Franklin, Tennessee.
- **HCA Healthcare, Inc. (HCA):** HCA Healthcare, Inc., through its subsidiaries, provides health care services in the United States and England. The company operates general, acute care hospitals that offer medical and surgical services, including inpatient care, intensive care, cardiac care, diagnostic, and emergency services; and outpatient services, such as outpatient surgery, laboratory, radiology, respiratory therapy, cardiology, and physical therapy services. It also operates psychiatric hospitals, which provide therapeutic programs comprising child, adolescent and adult psychiatric care, and adolescent and adult alcohol and drug abuse treatment and counseling. In addition, the company operates outpatient health care facilities consisting of freestanding ambulatory surgery centers, freestanding emergency care facilities, urgent care facilities, walk-in clinics, diagnostic and imaging centers, rehabilitation and physical therapy centers, radiation and oncology therapy centers, physician practices, and various other facilities. As of December 31, 2016, it operated 166 general, acute care hospitals with 43,778 licensed beds; 3 psychiatric hospitals with 412 licensed beds; and 1 rehabilitation hospital, as well as 118 freestanding surgery centers. The company was formerly known as HCA Holdings, Inc. HCA Healthcare, Inc. was founded in 1968 and is headquartered in Nashville, Tennessee.
- **Quorum Health Corporation (QHC):** Quorum Health Corporation provides hospital and outpatient healthcare services in the United States. Its general hospital and outpatient healthcare services include general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetric, diagnostic, psychiatric, and rehabilitation services. Quorum Health Corporation offers its healthcare services through its hospitals and affiliated facilities, including urgent care centers, diagnostic and imaging centers, physician clinics, and surgery centers. The company, through its subsidiary, Quorum Health Resources, LLC, provides management advisory and consulting services to non-affiliated hospitals. As of December 31, 2016, it owned or leased 36 hospitals with an aggregate of approximately 3,459 licensed beds in 16 states. The company was incorporated in 2015 and is headquartered in Brentwood, Tennessee.

Source: S&P Capital IQ, www.capitaliq.com

- **LifePoint Health, Inc. (LPNT):** LifePoint Health, Inc., through its subsidiaries, owns and operates community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities in the United States. Its hospitals offer a range of medical and surgical services, such as general surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care, rehabilitation, and pediatric services, as well as specialized services, including open-heart surgery, skilled nursing, psychiatric care, and neuro-surgery. The company's hospitals also provide various outpatient services comprising same-day surgery, laboratory, X-ray, respiratory therapy, imaging, sports medicine, and lithotripsy. In addition, it owns and operates schools of nursing and other allied health professions. As of December 31, 2016, the company operated 72 hospital campuses, including 9,424 licensed beds in 22 states. The company was formerly known as LifePoint Hospitals, Inc. and changed its name to LifePoint Health, Inc. in May 2015. LifePoint Health, Inc. was founded in 1997 and is based in Brentwood, Tennessee.
- **Tenet Healthcare Corp. (THC):** Tenet Healthcare Corporation, together with its subsidiaries, operates as a diversified healthcare services company. It operates in three segments: Hospital Operations and Other, Ambulatory Care, and Conifer. The company's general hospitals offer acute care services, operating and recovery rooms, radiology and respiratory therapy services, clinical laboratories, and pharmacies. It also provides intensive and critical care, and coronary care units; physical therapy, orthopedic, oncology, and outpatient services; tertiary care services, including open-heart surgery, neonatal intensive care, and neurosciences; quaternary care in heart, liver, kidney, and bone marrow transplants areas; tertiary and quaternary pediatric, and burn services; and limb-salvaging vascular procedures, acute level 1 trauma services, intravascular stroke care, minimally invasive cardiac valve replacement, imaging technology, and telemedicine access for various medical specialties. In addition, the company offers ambulatory surgery and urgent care centers, imaging centers, and short-stay surgical hospitals, as well as Aspen's hospitals and clinics; healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions; and microhospitals, physician practices, and health plans. Further, it provides accounts receivable and health information management, and revenue integrity and patient financial services; patient communications and engagement services; and clinical integration, financial risk management, and population health management services. As of February 27, 2017, the company operated 80 general acute care hospitals, 20 short-stay surgical hospitals, and approximately 470 outpatient centers, as well as 239 ambulatory surgery, 34 urgent care, and 21 imaging centers in the United States; and 9 private hospitals and clinics in the United Kingdom. Tenet Healthcare Corporation was founded in 1967 and is headquartered in Dallas, Texas.
- **Universal Health Services (UHS):** Universal Health Services, Inc., through its subsidiaries, owns and operates acute care hospitals, behavioral health facilities, and ambulatory centers. The company's hospitals offer general and specialty surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care, pediatric services, pharmacy services, and/or behavioral health services. As of February 28, 2017, it owned and/or operated 26 inpatient acute care hospitals, 4 free-standing emergency departments, 1 surgical hospital, and 319 inpatient and 33 outpatient behavioral health care facilities located in 37 states, Washington, D.C.; the United Kingdom; Puerto Rico; and the U.S. Virgin Islands. The company was founded in 1978 and is headquartered in King of Prussia, Pennsylvania.

Source: S&P Capital IQ, www.capitaliq.com

Market Approach

Guideline Public Company Method

The table below summarizes the key valuation multiples for the identified publicly traded hospital companies. Due to Community Health Systems, Inc. ("CYH") and Quorum Health Corporation ("QHC") being an outlier in relation to TTM EBITDA multiples, VMG has calculated multiples both with and without CYH & QHC. The mean trailing twelve month ("TTM") revenue multiples with and without CYH & QHC are 1.1x and 1.3x, respectively, while the median multiples are 1.0x and 1.3x, respectively. The mean TTM EBITDA multiples with and without CYH & QHC are 11.3x and 8.5x, respectively, while the median multiples are 9.2x and 8.6x, respectively. This data was sourced on August 22, 2018, and the TTM is as of the last reported quarter.

Company Name	Ticker	Market Capitalization	Total Debt	Minority Interest	Preferred Equity	Cash & Short-Term Investments	Business Enterprise Value
Community Health Systems, Inc.	CYH	$340,818	$13,715,000	$590,000	-	$208,000	$14,437,818
HCA Healthcare, Inc.	HCA	$44,401,162	$33,192,000	$1,864,000	-	$913,000	$78,544,162
LifePoint Health, Inc.	LPNT	$2,499,732	$2,928,400	$135,400	-	$143,800	$5,419,732
Quorum Health Corporation	QHC	$120,236	$1,199,412	$17,013	-	$2,822	$1,333,839
Tenet Healthcare Corporation	THC	$3,276,718	$14,867,000	$2,159,000	-	$403,000	$19,899,718
Universal Health Services, Inc.	UHS	$11,467,395	$3,990,464	$78,968	-	$76,886	$15,459,941

		Operating Revenue			*Operating EBITDA*		
Company Name	Ticker	TTM Revenue	FY + 1 Revenue	FY + 2 Revenue	TTM EBITDA	FY + 1 EBITDA	FY + 2 EBITDA
Community Health Systems, Inc.	CYH	$13,975,000	$13,923,850	$13,220,249	$825,000	$1,603,707	$1,552,429
HCA Healthcare, Inc.	HCA	$45,210,000	$46,199,801	$48,372,743	$8,481,000	$8,768,293	$9,239,939
LifePoint Health, Inc.	LPNT	$6,239,000	$6,304,101	$6,427,871	$660,700	$741,383	$763,346
Quorum Health Corporation	QHC	$1,858,462	$1,944,077	$1,982,244	$80,722	$148,978	$169,200
Tenet Healthcare Corporation	THC	$18,769,000	$18,140,912	$18,028,498	$2,663,000	$2,602,447	$2,655,960
Universal Health Services, Inc.	UHS	$10,553,520	$10,819,941	$11,348,893	$1,701,019	$1,770,035	$1,872,305

		Implied Multiples					
Company Name	Ticker	TTM Revenue	FY + 1 Revenue	FY + 2 Revenue	TTM EBITDA	FY + 1 EBITDA	FY + 2 EBITDA
Community Health Systems, Inc.	CYH	1.0x	1.0x	1.1x	17.5x	9.0x	9.3x
HCA Healthcare, Inc.	HCA	1.7x	1.7x	1.6x	9.3x	9.0x	8.5x
LifePoint Health, Inc.	LPNT	0.9x	0.9x	0.8x	8.2x	7.3x	7.1x
Quorum Health Corporation	QHC	0.7x	0.7x	0.7x	16.5x	9.0x	7.9x
Tenet Healthcare Corporation	THC	1.1x	1.1x	1.1x	7.5x	7.6x	7.5x
Universal Health Services, Inc.	UHS	1.5x	1.4x	1.4x	9.1x	8.7x	8.3x
Market Multiples	*Mean:*	*1.1 x*	*1.1 x*	*1.1 x*	*11.3 x*	*8.4 x*	*8.1 x*
	Median:	*1.0 x*	*1.1 x*	*1.1 x*	*9.2 x*	*8.8 x*	*8.1 x*
Market Multiples - Excluding CYH & QHC	*Mean:*	*1.3 x*	*1.3 x*	*1.2 x*	*8.5 x*	*8.2 x*	*7.8 x*
	Median:	*1.3 x*	*1.3 x*	*1.2 x*	*8.6 x*	*8.2 x*	*7.9 x*

Market Approach

Guideline Public Company Method

Although the concept of using publicly traded guideline companies as surrogates is intended to be based on comparability, it is often not possible to identify public companies similar to the subject business. There are many key differences between small to mid-size companies similar to the Hospital and publicly traded companies, such as commercial payor negotiating leverage, service mix, patient mix, access to capital, and geographic diversification. In addition, external microeconomic and macroeconomic events cause fluctuations in the prices of public company common stock prices, which will result in changes in the calculated public company market caps and enterprise values.

With consideration to the mentioned disadvantages of the guideline company method, we believe that the key differences identified above are applicable in the consideration of the Hospital's value under this method. For these reasons, the guideline companies do not reflect comparable market multiples for valuing the Hospital. We **have not relied** upon the pricing multiples and subsequent value indications generated by the guideline company method to establish the value of the Hospital.

Market Approach

Merger & Acquisition Method

The M&A Method relies on the observation of recent transactions involving the sale of businesses or business units that are similar to the subject Hospital ("Guideline Transactions"). The general notion of the M&A Method is consistent with the GPCM in that a relationship is developed between the price of transactions to a fundamental financial variable which can be used to arrive at an indication of value. These multiples may be stated as BEV to revenue, BEV to EBITDA, or another relevant relationship. In order to utilize this approach, Guideline Transactions must be identified which have available, reliable and relevant data.

In order to identify Guideline Transaction multiples, we have extensively reviewed and analyzed information on transactions involving **Hospitals**. In performing this analysis, VMG utilized the following multi-tiered approach:

- Reviewed Market Commentary: Considered public commentary from Hospital operators regarding the current M&A environment. This commentary provides background regarding the range of multiples buyers are utilizing to price transactions, the volume of M&A activity and the motivations for all involved parties.

- Gathered Generally Comparable Publicly Announced M&A Transactions: VMG reviewed available data for publicly announced Hospital transactions published by Irving Levin Associates, Capital IQ, and the Securities and Exchange Commission ("SEC").

- Proprietary Transaction Information: VMG has developed extensive knowledge of factors driving Hospital transaction pricing. In addition, VMG maintains an internal database of all Hospital valuations performed by VMG.

Public Transaction Database

In order to apply the M&A method for the Hospital, VMG has created a database of acquisition multiples for publicly announced transactions. Sources of information initially include Irving Levin and Capital IQ, but additional sources are utilized to refine and verify public data available, including American Hospital Directory, Electronic Municipal Market Access, U.S. Securities & Exchange Commission (8-K reports, 10-K reports, etc.), attorney general offices, and online / general research. In certain instances, proprietary information obtained by VMG is utilized. The sample set below primarily consists of independent single-site acute care hospitals and large health systems. VMG has omitted transactions where insufficient data was publicly available, or where the multiples calculated were unreliable (primarily involving multiples of EBITDA). In addition, VMG has excluded transactions involving the affiliation or merger of two or more entities as these transactions do not produce accurate acquisition multiples. VMG has presented below the consolidated data for all acute care hospital transactions of non-distressed hospitals since January 2014:

VMG Complete Data Set

Metric	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	0.6x	8.6x
Mean	0.7x	8.8x
25th Percentile	0.4x	7.0x
75th Percentile	1.0x	9.9x
High	1.7x	20.4x
Low	0.1x	0.8x
Number of Observations with Reported Statistics	119	70

For all observed transaction multiples, the BEV to revenue multiples ranged from a low of 0.1x to a high of 1.7x, with a median multiple of 0.6x and a mean multiple of 0.7x. The BEV to EBITDA multiples ranged from a low of 0.8x to a high of 20.4x, with a median multiple of 8.6x and a mean multiple of 8.8x.

Market Approach

Merger & Acquisition Method

Additionally, VMG considered transaction multiples from a subset of the transactions presented on the prior page in order to develop an understanding of market multiples in relation to target hospital profitability. We have applied the following criteria in order to obtain additional information from a set of transactions similar to the subject Hospital:

EBITDA Margin Greater than 5.0%

Metric	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	0.7x	8.4x
Mean	0.8x	8.2x
25th Percentile	0.6x	6.7x
75th Percentile	1.1x	9.4x
High	1.7x	20.4x
Low	0.1x	0.8x
Number of Observations with Reported Statistics	53	51

EBITDA Margin Greater than 10.0%

Metric	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	1.0x	7.9x
Mean	1.0x	7.4x
25th Percentile	0.8x	6.2x
75th Percentile	1.3x	8.9x
High	1.7x	10.7x
Low	0.1x	0.8x
Number of Observations with Reported Statistics	26	24

EBITDA Margin Greater than 15.0%

Metric	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	1.3x	7.6x
Mean	1.1x	6.9x
25th Percentile	0.6x	5.3x
75th Percentile	1.4x	8.7x
High	1.7x	9.6x
Low	0.1x	3.3x
Number of Observations with Reported Statistics	10	8

In each chart above certain transactions were eliminated (based on the target's EBITDA margin) to illustrate the relationship between profitability and the implied valuation multiples. As the charts above indicate, as profitability increases, the implied transaction BEV / EBITDA multiples declines.

Market Approach

Merger & Acquisition Method

Based on the observed transaction multiples of the merger and acquisition method, as well as consideration of the unique characteristics of the subject Hospital, it is our opinion that the appropriate BEV to revenue multiple is reasonably represented in a range between approximately **1.1x and 1.3x** and a BEV to EBITDA multiple is reasonably represented in a range between approximately **5.5x and 7.5x** for an interest in an acute care hospital similar to the Hospital.

Multiple	Range of Multiple Selections (Control Level)			Year 1	Value Indication (Rounded)		
	Low		High		Low		High
BEV/Revenue	1.1x	to	1.3x	$506,850,753	$560,000,000	to	$660,000,000
BEV/EBITDA	5.5x	to	7.5x	$94,983,961	$520,000,000	to	$710,000,000
Selected Multiple Range					$ 520,000,000	to	$ 710,000,000
Midpoint (BEV/EBITDA) & (BEV/Revenue)					$610,000,000		

As illustrated in the chart, we applied the selected range of revenue and EBITDA multiples to the Hospital's Year 1 revenue and EBITDA. Based on the average of the revenue and EBITDA multiple selections, VMG has calculated a blended average BEV for the Hospital of approximately **$610 million**. We have utilized the Market Approach to corroborate the results of the Income Approach.

Desert Regional Medical Center

Income Approach

Income Approach

General Assumptions

The Income Approach provides for two general methods for determining value: the capitalization of a single period's net cash flow or the discounting of several future periods' net cash flow. We have employed the multi-period method (the discounted cash flow method) which allows for the forecasting of a finite period of annual net cash flows. An important assumption of any method of the Income Approach is that the business or asset being valued remains a going concern.

The first step of the discounted cash flow methodology is to estimate the net cash flows available to the firm (total invested capital level). For purposes of the discounted cash flow methodology employed in our analysis, we have defined net cash flow as follows:

- Earnings before interest, taxes, depreciation, and amortization ("EBITDA")
- Less: depreciation, amortization, and other applicable non-cash expenses
- Less: applicable federal and state income taxes payable
- Plus: depreciation, amortization, and other applicable non-cash expenses
- Less: incremental capital expenditure requirements
- Less: incremental working capital requirement
- Equals: net cash flow to invested capital

Because we are calculating net cash flow to invested capital, we have eliminated interest expense in the projection period. Estimated net cash flows are projected for five years and then into perpetuity. The projected or future net cash flows are then discounted to arrive at a present value. The discount rate (also known as the required rate of return, cost of capital, or hurdle rate) incorporates the estimated time value of money, inflation, and the risks associated with the business entity. As mentioned before, this approach is based on the fundamental valuation principle that the value of a business is equal to the present value (or worth) of the future benefits of ownership.

Please see the following pages for more detail on the application of the Income Approach.

Income Approach

General Assumptions

Discount rate	12.0%
Terminal growth rate	3.0%
Tax rate	28.0%
Inflation Rate	3.0%
Incremental Non-Cash Net Working Capital requirements	8.0%
Terminal Capital Expenditures	2.5%

- **Discount rate:** The discount rate above refers to the estimated weighted average cost of capital ("WACC"). This discount rate is an after-tax rate and is described in detail, along with the WACC calculations, on the following pages.
- **Terminal growth rate:** The rate that operating revenue and expenses are expected to grow beyond Year 5 of our projections and into perpetuity.
- **Tax rate:** The blended federal and state income tax rate applicable to businesses operating in California.
- **Inflation rate ("CPI"):** The estimated rate of inflation, as reflected by the Consumer Price Index.
- **Incremental non-cash net working capital requirements:** Non-cash net working capital is current assets (accounts receivable, inventory, etc.) less current liabilities (accounts payable and other accrued expenses) and is required to conduct day-to-day operations, maintain liquidity, and to recognize revenue and expenses on an accrual accounting basis. Please note the net working capital value does not include cash. Although these items are not reported on the income statement, an increase in non-cash net working capital should be considered as a use of cash. We are projecting incremental non-cash net working capital to be 8.0% of incremental net operating revenue. In other words, for every $1 increase in net operating revenue, non-cash net working capital will increase by $0.08.
- **Forecast Development:** All forecast assumptions were based on input from Hospital management and reviewed by VMG along with the District's financial consultants.
- **Terminal Capital Expenditures:** The estimated level of capital expenditures allowing the Hospital to maintain operations into perpetuity.

The income statement used to formulate the normalized base year is the income statement for the fiscal year ended May 31, 2018. Non-recurring and non-operational items are adjusted out of the normalized income statement to give a clearer picture of the entity's operations. In addition, the normalized income statement applies federal and state income taxes and eliminates interest expense. All these adjustments are made to make the normalized base year income statement a more accurate base from which to project the income statement in Year 1.

Income Approach

Development of the Normalized Base Year

Non-recurring and non-operational items are adjusted out of the TTM 2018 income statement to give a clearer, more accurate picture of the Hospital's operations from which to project the income statement in Year 1.

Major adjustments include the following:

1. Management indicated several one-time or non-recurring expenses were included in the Hospital's TTM 2018 income statement. Please refer to Appendix Normalized Base Year Schedule 1 for additional detail;
2. Medicaid Supplemental - Income Provider' and 'Medicaid Supplemental - Assessment Provider' accounts are related to the Hospital's participation in the Hospital Qualify Assurance Fee ("HQAF") program Please refer to Appendix Normalized Base Year Schedule 2 for additional detail regarding this adjustment.

Normalized Base Year	Footnotes	TTM 2018	Adjustments	Normalized Base Year
Hospital Operating Revenue				
Patient Revenue				
Gross Inpatient Revenue		$2,562,224,502	-	$2,562,224,502
Inpatient Contractual	*1*	(2,220,650,822)	$2,653,632	(2,217,997,190)
Net Inpatient Revenue		341,573,680	2,653,632	344,227,312
Gross Outpatient Revenue	*1*	1,161,536,693	($1,870,000)	1,159,666,693
Outpatient Contractual		(1,009,294,506)	-	(1,009,294,506)
Net Outpatient Revenue		152,242,187	(1,870,000)	150,372,187
Net Patient Revenue before Bad Debt		$493,815,867	$783,632	$494,599,499
Bad Debt	*1*	(2,546,776)	($585,481)	(3,132,257)
Total Net Patient Revenue		$491,269,091	$198,151	$491,467,242
Supplemental Payments				
Medicaid DSH		7,203,734	-	7,203,734
Medicaid Supplemental - Income Provider	*2*	97,750,754	(28,134,779)	69,615,975
Medicaid Supplemental - Assessment Provider	*2*	(33,794,251)	9,144,711	(24,649,540)
Electronic Health Record Incentives		301,700	-	301,700
Total		71,461,937	(18,990,068)	52,471,869
Other Revenue				
Rental Income		-	-	-
Other Revenue		194,265	-	194,265
Total		194,265	-	194,265
Total Net Operating Revenue		$562,925,293	($18,791,917)	$544,133,376
Total Operating Expenses	*3,4*	429,861,588	17,803,316	447,664,904
EBITDA		133,063,705	(36,595,232)	96,468,473

Income Approach

Development of the Normalized Base Year

Non-recurring and non-operational items are adjusted out of the TTM 2018 income statement to give a clearer, more accurate picture of the Hospital's operations from which to project the income statement in Year 1.

Major adjustments include the following:

3. Management Fees not captured in the Hospital's TTM 2018 Income Statement have been estimated at 2.0% of revenue. Please refer to Appendix Normalized Base Year Schedule 3, which provides support for the selected level of revenue;
4. Physician losses not captured in the TTM 2018 financial statements have been added in the Normalized Base Year. Please refer to Appendix Normalized Base Year Schedule 4 for supporting calculations.

Normalized Base Year	Footnotes	TTM 2018	Adjustments	Normalized Base Year
Hospital Operating Revenue				
Patient Revenue				
Gross Inpatient Revenue		$2,562,224,502	-	$2,562,224,502
Inpatient Contractual	*1*	(2,220,650,822)	$2,653,632	(2,217,997,190)
Net Inpatient Revenue		341,573,680	2,653,632	344,227,312
Gross Outpatient Revenue	*1*	1,161,536,693	($1,870,000)	1,159,666,693
Outpatient Contractual		(1,009,294,506)	-	(1,009,294,506)
Net Outpatient Revenue		152,242,187	(1,870,000)	150,372,187
Net Patient Revenue before Bad Debt		$493,815,867	$783,632	$494,599,499
Bad Debt	*1*	(2,546,776)	($585,481)	(3,132,257)
Total Net Patient Revenue		$491,269,091	$198,151	$491,467,242
Supplemental Payments				
Medicaid DSH		7,203,734	-	7,203,734
Medicaid Supplemental - Income Provider	*2*	97,750,754	(28,134,779)	69,615,975
Medicaid Supplemental - Assessment Provider	*2*	(33,794,251)	9,144,711	(24,649,540)
Electronic Health Record Incentives		301,700	-	301,700
Total		71,461,937	(18,990,068)	52,471,869
Other Revenue				
Rental Income		-	-	-
Other Revenue		194,265	-	194,265
Total		194,265	-	194,265
Total Net Operating Revenue		$562,925,293	($18,791,917)	$544,133,376
Total Operating Expenses	*3,4*	429,861,588	17,803,316	447,664,904
EBITDA		133,063,705	(36,595,232)	96,468,473

Income Approach

Revenue Assumptions

REVENUE ASSUMPTIONS:		Normalized Base Year	Projection Period				
			Year 1	Year 2	Year 3	Year 4	Year 5
INPATIENT REVENUE							
Volume Assumptions							
Admissions per year		19,694	19,792	19,891	19,991	20,091	20,191
Growth		-	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*
Inpatient Reimbursement (per Admission)							
Gross Inpatient Charge per Admission	% of NBY Charges	$130,102	$132,704	$135,358	$138,065	$140,826	$143,643
Inpatient Contractual per Admission	86.6%	(112,623)	(114,875)	(117,173)	(119,516)	(121,907)	(124,345)
Average Net Inpatient Revenue per Admission		$17,479	$17,828	$18,185	$18,549	$18,920	$19,298
Growth		*0.8%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Inpatient Gross Charges		$2,562,224,502	$2,626,536,337	$2,692,462,399	$2,760,043,205	$2,829,320,290	$2,900,336,229
Estimated Inpatient Contractual		(2,217,997,190)	(2,273,668,919)	(2,330,738,009)	(2,389,239,533)	(2,449,209,446)	(2,510,684,603)
Net Inpatient Revenue		**$344,227,312**	**$352,867,418**	**$361,724,390**	**$370,803,672**	**$380,110,844**	**$389,651,626**
Growth		*0.8%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*

Hospital inpatient admissions are projected to increase 0.5% per year throughout the projection period. Therefore, admissions are projected to increase from 19,694 in the NBY to 20,191 in Year 5.

Gross inpatient charge per admission is projected to increase by 2.0% in each year throughout the projection period. Inpatient Contractual Allowances are projected to remain at the NBY level as a percentage of gross inpatient charges. Net Inpatient Revenue per Admission is projected to increase at 2.0% annually from approximately $17,479 in the NBY to $19,298 in Year 5.

Based on these assumptions, net inpatient revenue is projected to increase by approximately 2.5% compounded annually throughout the projection period, from approximately $344.2 million in the NBY to approximately $389.7 million in Year 5.

Income Approach

Revenue Assumptions

REVENUE ASSUMPTIONS:		Normalized Base Year	Projection Period				
			Year 1	Year 2	Year 3	Year 4	Year 5
OUTPATIENT REVENUE							
Outpatient Volume							
Outpatient Visits per year		167,037	171,213	175,493	179,881	184,378	188,987
Growth		-	*2.5%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*
Outpatient Reimbursement							
Gross Charge per Outpatient Visit	% of NBY Charges	$6,943	$7,081	$7,223	$7,368	$7,515	$7,665
Outpatient Contractual per Admission	87.0%	(6,042)	(6,163)	(6,286)	(6,412)	(6,540)	(6,671)
Average Net Revenue per Outpatient Visit		$900	$918	$937	$955	$974	$994
Growth		*(1.2%)*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Outpatient Gross Charges		$1,159,666,693	$1,212,431,528	$1,267,597,162	$1,325,272,833	$1,385,572,747	$1,448,616,307
Estimated Outpatient Contractual		(1,009,294,506)	(1,055,217,406)	(1,103,229,798)	(1,153,426,754)	(1,205,907,671)	(1,260,776,470)
Net Outpatient Revenue		**$150,372,187**	**$157,214,122**	**$164,367,364**	**$171,846,079**	**$179,665,076**	**$187,839,837**
Growth		*(1.2%)*	*4.5%*	*4.6%*	*4.6%*	*4.5%*	*4.5%*

Hospital outpatient visits are projected to increase 2.5% per year throughout the projection period. Therefore, outpatient visits are projected to increase from 167,037 in the NBY to 188,987 in Year 5.

Gross outpatient charges per visit are projected to increase by 2.0% in each year throughout the projection period. Outpatient Contractual Allowances are projected to remain at the NBY level as a percentage of gross outpatient charges. Net Outpatient Revenue per Visit is projected to increase at 2.0% annually from approximately $900 in the NBY to $994 in Year 5.

Based on these assumptions, net outpatient revenue is projected to increase by approximately 4.5% compounded annually throughout the projection period, from approximately $160.4 million in the NBY to approximately $187.8 million in Year 5.

Income Approach

Revenue Assumptions

HOSPITAL OPERATING REVENUE SUMMARY							
Total Patient Revenue							
Total Gross Charges (IP & OP)		3,721,891,195	3,838,967,865	3,960,059,561	4,085,316,038	4,214,893,037	4,348,952,536
Total Contractuals (IP & OP)		(3,227,291,696)	(3,328,886,325)	(3,433,967,807)	(3,542,666,287)	(3,655,117,117)	(3,771,461,073)
Net Patient Revenue before Bad Debt		494,599,499	510,081,539	526,091,754	542,649,751	559,775,920	577,491,463
Net Inpatient Revenue		$344,227,312	$352,867,418	$361,724,390	$370,803,672	$380,110,844	$389,651,626
Net Outpatient Revenue		$150,372,187	$157,214,122	$164,367,364	$171,846,079	$179,665,076	$187,839,837
Net Patient Revenue before Bad Debt		$494,599,499	$510,081,539	$526,091,754	$542,649,751	$559,775,920	$577,491,463
Growth		*0.2%*	*3.1%*	*3.1%*	*3.1%*	*3.2%*	*3.2%*
	NBY % of Total Gross Charges						
Bad Debt	0.1%	(3,132,257)	(3,230,786)	(3,332,694)	(3,438,107)	(3,547,156)	(3,659,977)
Growth		*23.0%*	*3.1%*	*3.2%*	*3.2%*	*3.2%*	*3.2%*
Total Net Patient Revenue		491,467,242	506,850,753	522,759,060	539,211,644	556,228,764	573,831,486
Growth		*0.0%*	*3.1%*	*3.1%*	*3.1%*	*3.2%*	*3.2%*
Supplemental Payments							
Medicaid DSH	*No Growth*	7,203,734	7,203,734	7,203,734	7,203,734	7,203,734	7,203,734
Medicaid Supplemental - Income Provider	*No Growth*	69,615,975	69,615,975	69,615,975	69,615,975	69,615,975	69,615,975
Medicaid Supplemental - Assessment Provider	*No Growth*	(24,649,540)	(24,649,540)	(24,649,540)	(24,649,540)	(24,649,540)	(24,649,540)
Electronic Health Record Incentives	*No Growth*	301,700	301,700	301,700	301,700	301,700	301,700
Total		52,471,869	52,471,869	52,471,869	52,471,869	52,471,869	52,471,869
Growth		*-26.6%*	-	-	-	-	-
Other Revenue							
Other Revenue	*Increase at CPI*	194,265	200,093	206,096	212,279	218,647	225,206
Total		194,265	200,093	206,096	212,279	218,647	225,206
Growth		*0.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*
Total Net Operating Revenue		**$544,133,376**	**$559,522,715**	**$575,437,025**	**$591,895,792**	**$608,919,280**	**$626,528,561**
Growth		*(3.3%)*	*2.8%*	*2.8%*	*2.9%*	*2.9%*	*2.9%*

Total net patient revenue before bad debt is projected to increase at 3.1% compounded annually, from approximately $494.6 million in the NBY to approximately $577.5 million in Year 5. Bad debt is projected to increase 3.1% compounded annually, from approximately $3.1 million in the NBY to approximately $3.7 million in Year 5. Supplemental payments (including Medicaid payments) have no growth projected. Furthermore, other revenue is projected to increase at the CPI (3.0%) throughout the projection period.

Based on the aforementioned volume and reimbursement growth assumptions, total net operating revenue is projected to increase at a 2.9% compounded annual growth rate, from approximately $544.1 million in the NBY to approximately $626.5 million in Year 5.

Income Approach

Expense Assumptions & Capital Expenditures

Total operating expenses as a percentage of revenue are projected to decrease from 82.3% in the NBY to 86.1% in Year 5 based on expense projections provided by Hospital management. Employee salaries & wages, medical supplies, and general & administrative expenses comprise the majority of the operating expense over the projection period.

	Normalized Base Year	Projection Period				
		Year 1	Year 2	Year 3	Year 4	Year 5
Operating Expenses:						
Employee Salaries & Wages	34.4%	34.8%	35.2%	35.7%	36.1%	36.6%
Employee Benefits	9.5%	9.6%	9.7%	9.8%	10.0%	10.1%
Occupancy Costs	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Supplies	14.1%	14.3%	14.4%	14.6%	14.8%	15.0%
Medical Costs	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%
Insurance	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
General & Administrative	15.2%	15.2%	15.2%	15.2%	15.2%	15.2%
Total Operating Expenses	82.3%	83.0%	83.8%	84.5%	85.3%	86.1%

It should be noted that operating expenses as a percentage of revenue increase throughout the projection period. The estimated operating expenses imply an EBITDA margin of between 17.7% in the Normalized Base Year and 13.9% in Year 5 consistent with the observed comparable hospital EBITDA margins presented in the Supplemental D-Exhibits.

Capital Expenditures

Capital expenditures are investments in equipment and other long-term tangible assets that are necessary for the operation of the Hospital. These items are usually recorded on the balance sheet but must be recognized as cash consumption for the purposes of the Income Approach. Desert Regional Medical Center management provided capital expenditure estimates for Years 1 through 3. Capital expenditures are projected at 2.5% of net operating revenue in Year 4 and Year 5. Terminal capital expenditures are projected at approximately 2.5% of net operating revenue, as illustrated in the chart below:

DEPRECIATION SCHEDULE:	Projection Period				
	Year 1	Year 2	Year 3	Year 4	Year 5
Capital Expenditures Projection Detail (provided by Hospital Management):	*Note: Years 2018, 2019 and 2020 Capital Expenditures were provided by Management in the "3.0 DRMC Capital Plan.pptx" document. Years 2021 forward are projected as a percent of revenue at 2.5%.*				
Equipment - Replacement	2,386,000	2,374,000	-		
Business Development	2,217,000	1,500,000	3,380,000		
Facility Maintenance (Infrastructure)	3,077,000	4,860,000	2,700,000		
ALCM (Replacement Equipment and Replacement of Pumps)	3,200,000	3,279,000	4,050,000		
Other Capital	3,027,000	2,423,000	3,249,000		
Total Capital Expenditures	13,900,000	14,400,000	13,400,000	15,200,000	15,700,000
% of Revenue (Rounded)	*2.5%*	*2.5%*	*2.3%*	*2.5%*	*2.5%*

Income Approach

Discount Rate Assumptions

The selection of an appropriate discount rate is an integral part of the valuation process. Two factors must be considered in estimating the present value of any projected cash flow stream:

- Financial Risk: The risk inherent in an entity's financial structure (i.e., the utilization of debt vs. equity financing).
- Business Risk: The uncertainty associated with the economy, operations and specific risk profile.

The WACC is a discount rate that takes into account the required rate of return necessary to justify investment based on the prevailing economic, market, industry and specific company risks, as well as the capital structure, as of the valuation date.

Most business entities have a capital structure consisting of both debt and equity. The party lending debt capital to a business requires a return on the debt, which comes out of the business in the form of interest payments. Lenders have a higher claim against assets of a business and therefore, are exposed to less risk than are the equity investors. Because of the lower risk level, the cost of debt is less than the cost of equity. Also, the interest payments are tax deductible to the business entity, which further lowers the cost of debt.

Equity investors require a higher rate of return on their investment than do debt holders, because their claim on a facility's assets are secondary to that of the debt holder. In addition, a business entity is not required to pay dividends, whereas interest payments are usually fixed over the term of the debt.

The WACC incorporates the claims of both the debt and equity holders in proportion to their relative capital contribution. To estimate an enterprise's WACC, both the subject entity's capital structure and the prevailing industry averages are examined as of the valuation date.

In estimating the WACC for this valuation, we relied on the capital asset pricing model ("CAPM"). The basic formula for computing the after-tax WACC is as follows:

$$WACC = (K_e * W_e) + (K_d * [1 - t] * W_d)$$

WACC = Weighted average cost of capital
K_e = Cost of common equity capital
K_d = Cost of debt capital
W_e = Equity as a percentage of total capital
W_d = Debt as a percentage of total capital
t = Blended federal and state income tax rate

The equity portion of the WACC was calculated by using the CAPM. The basic formula for computing the equity portion is as follows:

$$K_e = R_f + (R_m * B_i) + R_s + R_u$$

K_e = Expected rate of return on the subject security
R_f = Rate of return on a risk free security
R_m = Risk premium associated with the market
B_i = Beta for related companies in the industry
R_s = Risk premium associated with a small company
R_u = Risk premium associated with the specific company

Please see the following pages and Appendix B for more detail on each component utilized in the CAPM and development of the WACC.

CAPM - Risk Free Rate ("R_f")

The "risk-free rate" is a proxy for the return available on a security that the market generally regards as free of default risk. The rate of return on a risk-free security was found by looking at the yields of U.S. Treasury securities. Ideally, the duration of the security used as an indication of the risk-free rate should match the horizon of the projected cash flows, which are being discounted (which is into perpetuity in the present case). We used a 20-year Treasury rate, which was equal to 3.1% as of August 22, 2018.

CAPM – Equity Risk Premium ("R_m")

The equity risk premium is the additional return an investor expects to receive to compensate for the risk associated with investing in equities as opposed to investing in riskless assets. The market risk premium utilized was based on figures provided in the *Duff & Phelps 2017 Valuation Handbook – Guide to Cost of Capital ("2017 Valuation Handbook")* published by Duff & Phelps, LLC. Per the *2017 Valuation Handbook,* the market risk premium utilized for the Hospital was 6.0%.

CAPM - Beta ("B_i")

The beta is a measure of statistical volatility, or systemic risk, of an industry in comparison to the market as a whole. Beta is used to measure the price sensitivity of a company, or in this case an industry, in relation to changes in overall market prices. The levered beta utilized was 0.635 based on the average unlevered beta of 0.429 as reported by Capital IQ for the following select guideline companies: Community Health Systems, Inc. (CYH), HCA Healthcare, Inc. (HCA), LifePoint Health, Inc. (LPNT), Quorum Health Corp. (QHC), Tenet Healthcare Corp. (THC), and Universal Health Services (UHS).

CAPM – Small Company Premium ("R_s")

The small company or small size premium is the additional return an investor expects to receive to compensate for the additional risk associated with investing in a small and inherently more risky company. Per the *2017 Valuation Handbook,* the small company risk premium utilized for the Hospital was 5.6%.

Specific Company Risk Premium ("R_u")

The final common component of the CAPM model is the specific company risk premium. The specific company risk quantifies the risk associated with the specific operations of the company or the "unsystematic" risk of the company. Our selection of a company specific risk premium adjusts not only for the additional risks inherent in the operations, but also accounts for the mitigating factors present in the operations. These risks are relative to the public markets from which the market equity risk premium, industry risk premium and small company risk premium were derived. The specific company premium selected was based on certain factors that included the margin of the Hospital as compared to other comparable California Hospitals and the Hospitals significant dependence on government subsidies and particall. The specific company risk is estimated to be approximately 5.0%.

Cost of Equity Conclusion ("K_e")

Based on the aforementioned factors, the cost of equity derived through the CAPM method is presented in the schedule on the following page and in Appendix B.

Source: Cost of Capital – Estimation and Applications 2nd Edition by Shannon P. Pratt.

Cost of Equity Calculation	
Market Risk Premium (RM)[5]	6.0%
x Subject Company Re-levered Beta	0.635
= Adjusted Market Risk Premium	3.8%
+ Risk-Free Rate of Return (RF)[6]	3.1%
+ Size Premium[7]	5.6%
+ Specific Company Risk Premium[8]	5.0%
= **Cost of Equity**	**17.5%**

Federal & State Income Tax Rate ("t")

To calculate the after-tax cost of debt component in the WACC formula, we utilized the blended state and federal income tax rate applicable to the Hospital, which was approximately 28.0%.

Cost of Debt ("K_d")

The cost of debt utilized in the calculation of the WACC was based on the available Moody's yield on seasoned corporate bonds, rating Baa, as of the valuation date, which was approximately 4.8%.

Capital Structure ("W_e" and "W_d")

We reviewed capital structures for public companies operating in the industry, the current capital structure of the Hospital, and our experience with similar businesses in selecting the capital structure utilized in the WACC analysis. Please see the following page for further detail.

Income Approach

Discount Rate Assumptions

WACC Conclusion

BETA CALCULATION

Ticker	Company Name	Levered 5 Year [1]	S&P Credit Rating	Market Capitalization	Total Debt	Cash & ST Investments	Minority Interest	Debt/ BEV[2]	Debt/ Equity	Effective Tax Rate	Unlevered Beta
CYH	Community Health Systems, Inc.	1.058	CCC+	$340,818	$13,715,000	$208,000	$590,000	93.6%	1473.4%	n/a	
HCA	HCA Healthcare, Inc.	0.634	BB+	$44,401,162	$33,192,000	$913,000	$1,864,000	41.8%	71.7%	33.1%	0.423
LPNT	LifePoint Health, Inc.	0.661	BB-	$2,499,732	$2,928,400	$143,800	$135,400	52.6%	111.1%	28.5%	0.342
QHC	Quorum Health Corporation	0.389	B-	$120,236	$1,199,412	$2,822	$17,013	89.7%	873.9%	n/a	
THC	Tenet Healthcare Corporation	1.181	B	$3,276,718	$14,867,000	$403,000	$2,159,000	73.2%	273.5%	45.0%	0.472
UHS	Universal Health Services, Inc.	0.603	BB+	$11,467,395	$3,990,464	$76,886	$78,968	25.7%	34.6%	29.1%	0.480
Average		**0.754**									**0.429**
Median		**0.647**									**0.448**

Average Unlevered Beta for Comps	0.429
D/E, Target Company	66.7%
Federal & State Income Tax Expense	28.0%
Re-Levered Beta, Subject Company[4]	**0.635**

WACC

Market Risk Premium (RM)[5]	6.0%
x Subject Company Re-levered Beta	0.635
= Adjusted Market Risk Premium	3.8%
+ Risk-Free Rate of Return (RF)[6]	3.1%
+ Size Premium[7]	5.6%
+ Specific Company Risk Premium[8]	5.0%
= **Cost of Equity**	**17.5%**
x Equity as a Percent of Total Capital	60.0%
= **Cost of Equity Portion**	**10.5%**
Cost of Debt[9]	4.8%
x Tax Rate[10]	28.0%
= **After-Tax Cost of Debt**	**3.5%**
x Debt as a Percent of Total Capital	40.0%
= **Cost of Debt Portion**	**1.4%**

WACC	11.9%
Selected WACC	12.0%

Footnotes:

(1) Capital IQ - Levered Beta 5 Year computed taking the slope of a weekly regression line of the percentage change of the stock relative to the percentage price change in the S&P 500 as of August 22, 2018.

(2) Capital IQ - average of public companies debt structure as of August 22, 2018.

*(3) Unlevered Beta = Levered Beta / (1 + ((D/E) * (1 - T)) + P/E)*

*(4) Re-levered Beta = Unlevered Beta * (1 + ((D/E) * (1 - T)) + P/E)*

(5) The equity risk premium of 6.0% was selected based upon VMG's review of published articles and academic studies that attempt to quantify the expected market risk premium for U.S. common stocks by utilizing both historical and forward looking sources. The selected 6.0% equity risk premium was considered to reasonably represent a consensus viewpoint of the market equity risk premium.

(6) Yield of 20-year U.S. Treasury securities as of August 22, 2018, as published by Federal Reserve Statistical Release.

(7) Duff & Phelps: 2017 Valuation Handbook, Market Cap

(8) Risk associated with the specific operations of the company or the "unsystematic" risk of the company.

(9) Moody's yield on seasoned corporate bonds, rating Baa as of August 22, 2018, as published by Capital IQ.

(10) Blended State and Federal Tax rate for California.

Company Specific Risk Premium	Capital Structure (Debt to BEV) 40.0%	50.0%	60.0%
4.0%	11.3%	10.0%	8.7%
5.0%	11.9%	10.5%	9.1%
6.0%	12.5%	11.0%	9.5%
7.0%	13.1%	11.5%	9.9%

Income Approach

Valuation Conclusion

In utilizing the assumptions for volume, revenues, expenses, net working capital and capital expenditures, we have estimated the after-tax free cash flows of the Hospital for the next five years. An estimated after-tax WACC of 12.0% was applied to the future after-tax free cash flows to arrive at a present value.

Goodwill, including all intangible assets, is created in a transaction when the purchase price exceeds the value of the working capital and fixed assets purchased by the buyer. Depending on the structure of the transaction, asset purchases and some stock purchases may result in an allocation of the purchase price to goodwill for tax purposes. The buyer's ability to amortize the goodwill for tax purposes results in an additional tax shield that is not reflected in the discounted cash flow. The Tax Amortization Benefit ("TAB") is simply the present value of the tax savings from this additional tax shield. We have applied this TAB to the control level valuation.

The FMV indication of the business enterprise value of the Hospital with the tax amortization benefit is approximately **$610.0 million.** We **have fully relied** on the Income Approach to value the Hospital.

Desert Regional Medical Center

Valuation Reconciliation & Summary

Valuation Reconciliation & Summary

Valuation Reconciliation

After obtaining value indications under the Cost, Market, and Income Approaches, we examined the value outcomes based on the following factors:

- **Cost Approach:** The Cost Approach utilizes book values for certain fixed assets and may not reflect fair market value. Based on this factor, **we have not relied** on the Cost Approach to generate a value indication.

- **Market Approach:** Typically, the M&A method is a reasonable approach to apply in acute care hospital valuations when the appropriate diligence has been performed to understand and accurately calculate market multiples. However, given the specific facts and circumstances surrounding the Hospital, we **have not relied** upon the pricing multiples and value indications generated by the M&A method to establish the value of the Hospital. We have utilized the Market Approach to corroborate the results of the Income Approach.

- **Income Approach:** Unlike the Cost and Market Approach, the Income Approach evaluates the future economic income stream that is specific to the Hospital. Accordingly, we **have fully relied** on the Income Approach value indication.

Reconciliation of Valuation Approaches	Value	Weight	Conclusion
Income Approach Value Indication (Midpoint)	$610,000,000	100.0%	$610,000,000
Cost Approach Value Indication	n/a	-	-
Market Approach Value Indication (Midpoint)	$610,000,000	-	-
Fair Market Value Indication, Business Enterprise Level			$610,000,000

Based on and subject to the facts, limiting conditions, and assumptions presented in the report and attached exhibits, it is our opinion that the FMV of the Hospital at the business enterprise level is reasonably represented as approximately **$610.0 million.**

Valuation Reconciliation & Summary

Valuation Summary

Based on and subject to the facts, limiting conditions, and assumptions presented in this report and attached exhibits, as of a current date, the FMV of the business enterprise value ("BEV") of the Hospital is reasonably represented in a range between approximately **$580 million and $640 million**.

Range of Fair Market Value, BEV Level	Low (5.0%)	Midpoint	High (+5.0%)
Fair Market Value Indication, Business Enterprise Level	$580,000,000	$610,000,000	$640,000,000

Business Enterprise Value reflects the value of the Hospital inclusive of a normalized level of cash-free net working capital. Net working capital includes accounts receivables and other current assets less non-interest-bearing current liabilities that permit a business to conduct daily operations and maintain liquidity. Normalized net working capital is estimated to be 8.0% of net operating revenue. Incremental net working capital requirements are projected at 8.0% of net operating revenue throughout the projection period.

Desert Regional Medical Center

Statement of Limiting Conditions & Appraisers' Certification

Statement of Limiting Conditions

Statement of Limiting Conditions

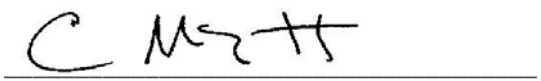
The value recommendations contained in this report are qualified as follows:

- The facts described in this report were provided by management or obtained from independent third parties including the Center's accountants, published sources, and commercial databases. We have accepted this information without further verification. Our value recommendations assume this information is materially true and correct.
- The value recommendations assume competent management in the context of a going concern.
- Neither our employment nor the fee for this assignment is contingent upon the reported value(s). No professional involved in this assignment has any financial interest in the property appraised.
- Certain matters are outside the purview of our expertise. As a result, our value recommendations assume: (1) The company complies fully with all federal, state, and local laws and ordinances; (2) Funding for pensions and health care liabilities, if any, is adequate; and (3) There are no undisclosed factors that might render the company materially more or less valuable. Any statements in this report about the above issues are based on management representations. The user is responsible for independent investigation of these matters, and his own determination of their impact on the recommended value(s).
- Nothing contained in the report should be construed as either investment, legal, or tax advice. This valuation is intended only for the use of the addressee and only for the purpose described. All other uses of this report are unauthorized and prohibited. The report may not be distributed, either in whole or part, to any third party, and mere possession of the report does not convey a right of reliance.
- VMG Health has not, as part of this assignment, examined either the historical, interim, or prospective financial statements according to generally accepted auditing standards, and so expresses no opinion thereon in this valuation report.
- Any estimates of future performance described in this report (or the exhibits hereto), pertain to a specific valuation method. This method matches performance scenarios with their associated risk rates as a means of quantifying the value parameters. Use of either the future performance scenarios or the discount rate separately or outside the valuation context is unauthorized and prohibited. Actual operating results may vary materially from those described.
- The fee for this assignment is provided only for the preparation of this report for the specific valuation date. All other services including updates of value for any other date; preparation and testimony in court or before governmental agencies; or meetings about the valuation report after its delivery will be provided at additional cost for fees and expenses.

Appraisers' Certification

Appraisers' Certification

- Neither VMG Health nor any individuals signing or associated with this report have any present or future contemplated interest in the assets being appraised.
- Neither our employment nor our compensation in connection with this report is in any way contingent upon the conclusions reached or values estimated.
- The report analysis, opinions, and conclusions are limited by the reported assumptions and limiting conditions and represent our unbiased professional analysis, opinions, and conclusions.
- We have not made a personal inspection of the property that is the subject of this report, but have extensively discussed the operations of the business with management.
- No persons other than the undersigned or those acknowledged in this report prepared analysis, values, and conclusions set forth in this report.
- To the best of our knowledge and belief, the statements of fact contained in this report are true and correct.



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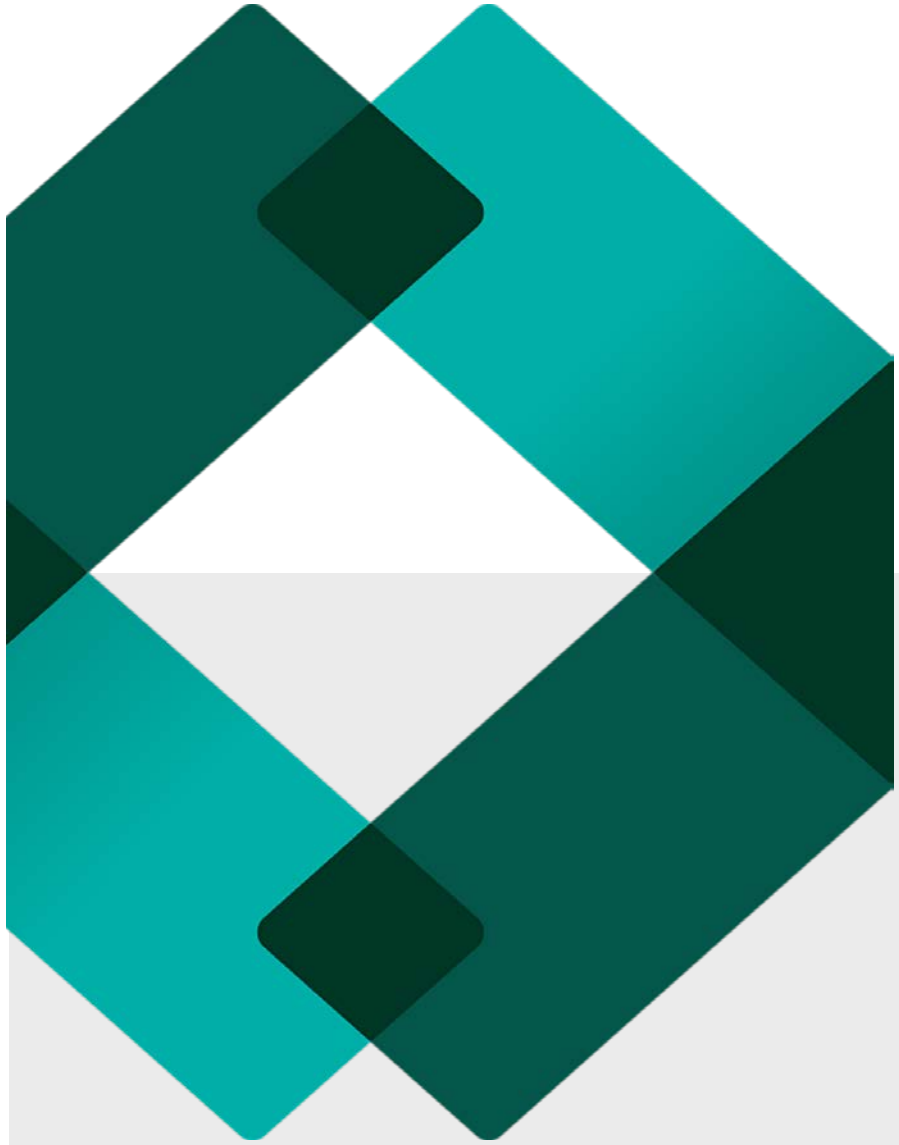


VMG HEALTH

Desert Regional Medical Center

Valuation Exhibits

Distributed on Thursday, October 18, 2018

Desert Regional Medical Center

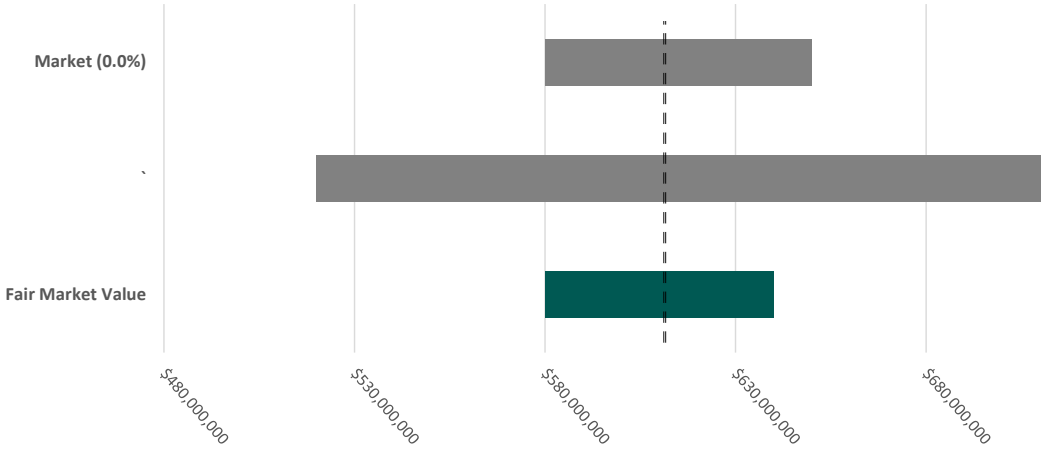
Executive Summary

FINAL REPORT

Reconciliation of Valuation Approaches	Value	Weight	Conclusion
Income Approach Value Indication (Midpoint)	$610,000,000	100.0%	$610,000,000
Cost Approach Value Indication	n/a	-	-
Market Approach Value Indication (Midpoint)	$610,000,000	-	-
Fair Market Value Indication, Business Enterprise Level			$610,000,000

**The value indications above are inclusive of a normalized level of cash-free net working capital.*

Reconciliation of Valuation Approaches - BEV Level



Range of Fair Market Value, BEV Level	Low (5.0%)	Midpoint	High (+5.0%)
Fair Market Value Indication, Business Enterprise Level	$580,000,000	$610,000,000	$640,000,000

Implied Market Multiples	Financial Metric ($)	Low	Mid	High
BEV/ NBY EBITDA	96,468,473	6.01x	6.32x	6.63x
BEV/ NBY Revenue	544,133,376	1.07x	1.12x	1.18x
BEV/ Year 1 EBITDA	94,983,961	6.11x	6.42x	6.74x
BEV/ Year 1 Revenue	559,522,715	1.04x	1.09x	1.14x

FINAL REPORT

ADJUSTMENTS TO BEV	
Value Indication, Business Enterprise Value (Including Working Capital)	$610,000,000
Less: Normalized Working Capital included in Business Enterprise Calculation	*(44,000,000)*
Subtotal - Business Enterprise Value, less Working Capital (rounded)	$566,000,000
Less: Value Indication for Total Year 1 - Year 9 Present Value of Cash Flows	($299,231,472)
Subtotal - Business Enterprise Value, Adjusted for Remaining Lease Term & Working Capital	$267,000,000
Less: Seismic Upgrade Cost	*TBD*
Less: Termination Assets	*TBD*
BEV Adjusted for Remaining Lease Term, Seismic Requirements, Working Capital & Termination Assets	TBD

Notes:
1. Calculated on the prior page.
2. Calculated on the Working Capital page in Exhibit A.
3. Calculations based on an assumed nine year period until the current Hospital Lease Agreement expires at May 30, 2027. Given that the financial data provided to VMG was through a historical period ended May 30, 2018, there are an estimated nine years remaining in the lease term.

Desert Regional Medical Center

Historical Financials & Operations

DESERT REGIONAL MEDICAL CENTER
HISTORICAL RESTATED BALANCE SHEET

FINAL REPORT

Fiscal Year End December 31,	FYE 2017	May-31 2018	FYE 2017	May-31 2018
ASSETS:				
Current Assets:				
Cash & Equivalents	$65,218	$2,750	0.0%	0.0%
Net Patient Receivables	109,933,068	110,424,102	31.1%	32.9%
Prepaid Expenses	2,343,626	1,943,633	0.7%	0.6%
Inventory	6,838,808	6,796,874	1.9%	2.0%
Physician / Group Guarantees & Other Receivable	28,447,822	26,147,270	8.1%	7.8%
Other Current Assets	(258,627)	5,398,848	(0.1%)	1.6%
Medicaid Supplemental Payment Receivable	91,174,585	69,620,022	25.8%	20.8%
Total Current Assets	238,544,500	220,333,499	67.6%	65.7%
Property, Plant & Equipment:				
Buildings & Improvements	134,701,822	137,519,653	38.1%	41.0%
Capitalized Leases	16,732,230	17,052,582	4.7%	5.1%
Equipment	92,243,711	94,946,925	26.1%	28.3%
Land & Land Improvements	6,194,989	6,194,989	1.8%	1.8%
Construction in Progress	1,238,020	2,042,061	0.4%	0.6%
Accumulated Depreciation	(159,158,131)	(164,664,039)	(45.1%)	(49.1%)
Net Property, Plant & Equipment	91,952,641	93,092,171	26.0%	27.8%
Other Non-current Assets:				
Investments and Other Long-Term Assets	315,210	291,094	0.1%	0.1%
Net Intangible Assets	22,319,818	21,733,298	6.3%	6.5%
Total Other Non-current Assets	22,635,028	22,024,392	6.4%	6.6%
Total Assets	353,132,169	335,450,062	100.0%	100.0%

DESERT REGIONAL MEDICAL CENTER
HISTORICAL RESTATED BALANCE SHEET

FINAL REPORT

Fiscal Year End December 31,	FYE 2017	May-31 2018	FYE 2017	May-31 2018
LIABILITIES:				
Current Liabilities:				
Accounts Payable	16,556,550	15,741,196	4.7%	4.7%
Accrued Liabilities	13,469,021	15,786,094	3.8%	4.7%
Other Current Liabilities	5,668,468	4,957,592	1.6%	1.5%
Current Portion of Capital Lease Obligation	4,441,205	4,788,363	1.3%	1.4%
Estimted Physician / Group Guarantee Liability	24,046,504	25,208,543	6.8%	7.5%
Medicaid Assessment Payable	30,107,689	13,966,633	8.5%	4.2%
Total Current Liabilities	94,289,437	80,448,421	26.7%	24.0%
Long-Term Liabilities:				
Capitalized Lease Obligation, net of Current Portion	3,197,158	2,951,612	0.9%	0.9%
Deferred Income	615,522	541,894	0.2%	0.2%
Other Long-Term Liabilities	2,095,906	2,162,166	0.6%	0.6%
Total Long-Term Liabilities	5,908,586	5,655,672	1.7%	1.7%
Total Liabilities	100,198,023	86,104,093	28.4%	25.7%
EQUITY AND INTERCOMPANY:				
Intercompany Accounts	(177,670,315)	(265,661,759)	(50.3%)	(79.2%)
Common Stock and Additional Paid-in Capital	118,624,448	254,864,205	33.6%	76.0%
Retained Earnings	311,980,013	260,143,523	88.3%	77.6%
Total Equity and Intercompany	252,934,146	249,345,969	71.6%	74.3%
Total Liabilities & Equity and Intercompany	$353,132,169	$335,450,062	100.0%	100.0%

Sources: Balance Sheet detail provided for entity "694 - Desert Regional Medical Center" for the fiscal year ended December 31, 2017 ("FYE 2017") and as of May 31, 2018.
Note: FYE 2017 period information is based on the "Period 13 2017" Balance Sheet detail provided.

DESERT REGIONAL MEDICAL CENTER
HISTORICAL WORKING CAPITAL ANALYSIS

FINAL REPORT

ACTUAL WORKING CAPITAL CALCULATION ($)		FYE 2017	May 31 / TTM 2018	Normalized Base Year
Current Assets:				
Cash & Equivalents	*Excluded from cash-free working capital*	-	-	-
Net Patient Receivables		109,933,068	110,424,102	110,424,102
Prepaid Expenses		2,343,626	1,943,633	1,943,633
Inventory		6,838,808	6,796,874	6,796,874
Physician / Group Guarantees & Other Receivable		28,447,822	26,147,270	26,147,270
Other Current Assets		(258,627)	5,398,848	5,398,848
Medicaid Supplemental Payment Receivable		91,174,585	69,620,022	69,620,022
Total Current Assets		238,479,282	220,330,749	220,330,749
Current Liabilities:				
Accounts Payable		16,556,550	15,741,196	15,741,196
Accrued Liabilities		13,469,021	15,786,094	15,786,094
Other Current Liabilities		5,668,468	4,957,592	4,957,592
Current Portion of Capital Lease Obligation	*Excluded from working capital*	-	-	-
Estimted Physician / Group Guarantee Liability		24,046,504	25,208,543	25,208,543
Medicaid Assessment Payable		30,107,689	13,966,633	13,966,633
Total Current Liabilities		89,848,232	75,660,058	75,660,058
Total Working Capital (Rounded)		148,631,000	144,671,000	144,671,000
Total Net Operating Revenue (Rounded)		538,195,000	562,925,000	544,133,000
Working Capital as a % Total Net Operating Revenue (Rounded)		**27.6%**	**25.7%**	**26.6%**

Normalized Working Capital Calculation	
NBY Net Operating Revenue	$544,133,376
Times: Required Net Working Capital Level	8.0%
Equals: Normalized Net Working Capital (Rounded)	**$43,530,000**

FINAL REPORT

Net Working Capital (Excluding Cash) as a % of Revenue											
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	High	Low	Average	Median	Desert Regional Medical Center
FYE - 2	11.0%	8.0%	7.4%	15.6%	3.4%	6.9%	**15.6%**	**3.4%**	**8.7%**	**7.7%**	**n/a**
FYE - 1	10.8%	6.7%	7.1%	11.8%	3.6%	4.5%	**11.8%**	**3.6%**	**7.4%**	**6.9%**	**n/a**
FYE	7.7%	7.4%	6.8%	10.5%	4.0%	4.0%	**10.5%**	**4.0%**	**6.8%**	**7.1%**	**27.6%**
TTM	10.5%	7.8%	7.5%	9.7%	3.3%	4.6%	**10.5%**	**3.3%**	**7.2%**	**7.7%**	**25.7%**
Average	**9.8%**	**7.7%**	**7.9%**	**9.9%**	**4.0%**	**6.8%**	**12.4%**	**5.6%**	**7.7%**	**7.6%**	**26.7%**
Median	**10.5%**	**7.8%**	**7.4%**	**10.5%**	**3.6%**	**4.6%**	**11.8%**	**3.6%**	**7.4%**	**7.7%**	**26.7%**

Other Related Working Capital Statistics											
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	High	Low	Average	Median	Desert Regional Medical Center
FY Total Asset Turnover	0.8x	1.3x	1.0x	1.0x	0.8x	1.0x	**1.3x**	**0.8x**	**1.0x**	**1.0x**	**1.7x**
FY Accounts Receivable Turnover	5.1x	7.1x	7.7x	5.5x	6.0x	7.1x	**7.7x**	**5.1x**	**6.4x**	**6.5x**	**5.1x**
FY Inventory Turnover	22.0x	17.6x	30.5x	22.9x	39.2x	46.5x	**46.5x**	**17.6x**	**29.8x**	**26.7x**	**11.3x**
FY Avg. Days Inventory Out.	16.7 Days	20.8 Days	12.0 Days	16.0 Days	9.3 Days	7.9 Days	**20.8 Days**	**7.9 Days**	**13.8 Days**	**14.0 Days**	**5.8 Days**
FY Days Cash on Hand	5.4 Days	7.1 Days	6.2 Days	4.7 Days	15.1 Days	1.5 Days	**15.1 Days**	**1.5 Days**	**6.7 Days**	**5.8 Days**	**0.0 Days**
FY Avg. Days Sales Out.	71.3 Days	51.8 Days	47.6 Days	66.0 Days	60.8 Days	51.4 Days	**71.3 Days**	**47.6 Days**	**58.2 Days**	**56.3 Days**	**82.0 Days**
FY Avg. Days Payables Out.	35.7 Days	31.7 Days	18.0 Days	41.6 Days	39.8 Days	26.2 Days	**41.6 Days**	**18.0 Days**	**32.2 Days**	**33.7 Days**	**13.4 Days**

Source: Capital IQ as of August 22, 2018.

DESERT REGIONAL MEDICAL CENTER
HISTORICAL RESTATED INCOME STATEMENT

FINAL REPORT

Fiscal Year End December 31,	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year
Hospital Operating Revenue										
Patient Revenue										
Gross Inpatient Revenue	2,172,776,766	2,466,134,357	2,508,873,783	2,562,224,502	2,562,224,502	442.5%	449.1%	466.2%	455.2%	470.9%
Inpatient Contractual	(1,856,157,763)	(2,106,525,179)	(2,167,492,991)	(2,220,650,822)	(2,217,997,190)	(378.0%)	(383.6%)	(402.7%)	(394.5%)	(407.6%)
Net Inpatient Revenue	316,619,003	359,609,178	341,380,792	341,573,680	344,227,312	64.5%	65.5%	63.4%	60.7%	63.3%
Gross Outpatient Revenue	914,018,727	1,045,447,306	1,151,497,930	1,161,536,693	1,159,666,693	186.1%	190.4%	214.0%	206.3%	213.1%
Outpatient Contractual	(775,273,263)	(892,476,375)	(998,786,817)	(1,009,294,506)	(1,009,294,506)	(157.9%)	(162.5%)	(185.6%)	(179.3%)	(185.5%)
Net Outpatient Revenue	138,745,464	152,970,931	152,711,113	152,242,187	150,372,187	28.3%	27.9%	28.4%	27.0%	27.6%
Net Patient Revenue before Bad Debt	455,364,467	512,580,109	494,091,905	493,815,867	494,599,499	92.7%	93.3%	91.8%	87.7%	90.9%
Bad Debt	(14,573,495)	(14,301,275)	(10,016,605)	(2,546,776)	(3,132,257)	(3.0%)	(2.6%)	(1.9%)	(0.5%)	(0.6%)
Total Net Patient Revenue	440,790,972	498,278,834	484,075,300	491,269,091	491,467,242	89.8%	90.7%	89.9%	87.3%	90.3%
Supplemental Payments										
Medicaid DSH	8,436,631	7,962,995	7,402,065	7,203,734	7,203,734	1.7%	1.5%	1.4%	1.3%	1.3%
Medicaid Supplemental - Income Provider	62,013,094	68,421,637	67,523,469	97,750,754	69,615,975	12.6%	12.5%	12.5%	17.4%	12.8%
Medicaid Supplemental - Assessment Provider	(26,897,084)	(30,390,480)	(21,947,306)	(33,794,251)	(24,649,540)	(5.5%)	(5.5%)	(4.1%)	(6.0%)	(4.5%)
Electronic Health Record Incentives	1,020,542	497,371	301,700	301,700	301,700	0.2%	0.1%	0.1%	0.1%	0.1%
Total	44,573,183	46,491,523	53,279,928	71,461,937	52,471,869	9.1%	8.5%	9.9%	12.7%	9.6%
Other Revenue	5,699,832	4,362,188	839,569	194,265	194,265	1.2%	0.8%	0.2%	0.0%	0.0%
Total Net Operating Revenue	**491,063,987**	**549,132,545**	**538,194,797**	**562,925,293**	**544,133,376**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

DESERT REGIONAL MEDICAL CENTER
HISTORICAL RESTATED INCOME STATEMENT

FINAL REPORT

Fiscal Year End December 31,	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year
Operating Expenses:										
Employee Salaries & Wages										
Employee Salaries & Wages	161,480,723	190,660,210	187,195,604	186,925,096	186,925,096	32.9%	34.7%	34.8%	33.2%	34.4%
Total	161,480,723	190,660,210	187,195,604	186,925,096	186,925,096	32.9%	34.7%	34.8%	33.2%	34.4%
Employee Benefits										
Payroll Taxes	11,763,690	14,067,020	13,885,432	13,998,001	13,998,001	2.4%	2.6%	2.6%	2.5%	2.6%
Employee Benefits	32,383,647	35,607,391	36,987,851	37,264,605	37,577,605	6.6%	6.5%	6.9%	6.6%	6.9%
Total	44,147,337	49,674,411	50,873,283	51,262,606	51,575,606	9.0%	9.0%	9.5%	9.1%	9.5%
Occupancy Costs										
Rent / Lease - Real Property	715,595	852,565	877,241	785,280	785,280	0.1%	0.2%	0.2%	0.1%	0.1%
Utilities	3,899,993	3,330,300	3,499,157	3,678,255	3,678,255	0.8%	0.6%	0.7%	0.7%	0.7%
Property Taxes	1,242,032	1,193,427	1,271,050	1,147,173	1,147,173	0.3%	0.2%	0.2%	0.2%	0.2%
Total	5,857,620	5,376,292	5,647,448	5,610,708	5,610,708	1.2%	1.0%	1.0%	1.0%	1.0%
Supplies										
Medical Supplies	38,219,014	42,323,381	40,338,078	41,083,832	41,083,832	7.8%	7.7%	7.5%	7.3%	7.6%
Drugs & Pharmaceuticals	26,510,658	30,850,978	30,247,697	31,110,577	31,110,577	5.4%	5.6%	5.6%	5.5%	5.7%
Non-medical Supplies	5,721,203	4,824,614	4,536,075	4,518,902	4,518,902	1.2%	0.9%	0.8%	0.8%	0.8%
Total	70,450,875	77,998,973	75,121,850	76,713,311	76,713,311	14.3%	14.2%	14.0%	13.6%	14.1%
Medical Costs										
Other Clinical Expenses	15,880	10,538	1,173,820	1,403,631	1,403,631	0.0%	0.0%	0.2%	0.2%	0.3%
Medical Fees	22,918,405	28,155,709	32,217,548	34,086,074	34,086,074	4.7%	5.1%	6.0%	6.1%	6.3%
Physician Income Assist	1,531,647	1,490,747	1,974,964	2,002,993	2,002,993	0.3%	0.3%	0.4%	0.4%	0.4%
Total	24,465,932	29,656,994	35,366,332	37,492,698	37,492,698	5.0%	5.4%	6.6%	6.7%	6.9%
Insurance										
Malpractice Insurance	3,986,073	7,591,366	6,394,474	5,692,256	5,692,256	0.8%	1.4%	1.2%	1.0%	1.0%
Other Insurance	676,531	842,166	900,543	949,693	949,693	0.1%	0.2%	0.2%	0.2%	0.2%
Total	4,662,604	8,433,532	7,295,017	6,641,949	6,641,949	0.9%	1.5%	1.4%	1.2%	1.2%
General & Administrative										
Advertising	1,391,452	1,554,035	1,466,182	1,110,287	1,110,287	0.3%	0.3%	0.3%	0.2%	0.2%
Information Technology	7,562,988	8,179,456	9,697,950	9,480,068	9,480,068	1.5%	1.5%	1.8%	1.7%	1.7%
Charitable Contributions	864,838	1,145,921	972,447	1,561,160	1,561,160	0.2%	0.2%	0.2%	0.3%	0.3%
Equipment Rent / Lease Expense	953,797	1,584,208	1,502,505	1,330,460	1,330,460	0.2%	0.3%	0.3%	0.2%	0.2%
Non-medical Professional Fees	3,217,597	3,291,038	4,713,103	4,299,393	4,299,393	0.7%	0.6%	0.9%	0.8%	0.8%
Conifer Collection Fees	12,705,711	13,447,841	13,027,365	13,114,847	13,114,847	2.6%	2.4%	2.4%	2.3%	2.4%
License Fees	858,407	899,169	836,289	769,873	769,873	0.2%	0.2%	0.2%	0.1%	0.1%
Other Controllable Expenses	13,375,934	15,129,997	16,342,488	16,561,992	16,311,992	2.7%	2.8%	3.0%	2.9%	3.0%
Other Non-medical Expenses	7,705,587	8,261,334	7,421,385	7,713,207	7,713,207	1.6%	1.5%	1.4%	1.4%	1.4%
Repairs & Maintenance	7,551,948	8,056,848	8,639,898	9,273,933	9,273,933	1.5%	1.5%	1.6%	1.6%	1.7%
Management Fees	-	-	-	-	10,882,668	-	-	-	-	2.0%
Physician Subsidy	-	-	-	-	6,857,648	-	-	-	-	1.3%
Total	56,188,259	61,549,847	64,619,612	65,215,220	82,705,536	11.4%	11.2%	12.0%	11.6%	15.2%
Total Operating Expenses	367,253,350	423,350,259	426,119,146	429,861,588	447,664,904	74.8%	77.1%	79.2%	76.4%	82.3%
EBITDA	123,810,637	125,782,286	112,075,651	133,063,705	96,468,473	25.2%	22.9%	20.8%	23.6%	17.7%
Depreciation & Amortization Expense	14,211,402	14,814,437	15,734,886	15,442,515	15,442,515	2.9%	2.7%	2.9%	2.7%	2.8%
Operating Income	109,599,235	110,967,849	96,340,765	117,621,190	81,025,958	22.3%	20.2%	17.9%	20.9%	14.9%
Other Income (Expense)	(221,558)	(254,082)	(107,895)	(540)	-	(0.0%)	(0.0%)	(0.0%)	(0.0%)	-
Interest Expense	286,732	362,552	395,400	393,811	-	0.1%	0.1%	0.1%	0.1%	-
Earnings Before Income Taxes	109,090,945	110,351,215	95,837,470	117,226,839	81,025,958	22.2%	20.1%	17.8%	20.8%	14.9%
Federal & State Income Tax Expense	-	-	-	-	22,673,980	-	-	-	-	4.2%
Earnings After Income Taxes	$109,090,945	$110,351,215	$95,837,470	$117,226,839	$58,351,978	22.2%	20.1%	17.8%	20.8%	10.7%

Sources: Management provided financials for the fiscal years ended December 31, 2015, 2016, and 2017 and the trailing twelve month period ended May 31, 2018.
Normalized Base Year based on the trailing twelve month period ended May 31, 2018. Normalized Base Year eliminates any unusual or nonrecurring items from revenue and expenses.

FINAL REPORT

Fiscal Year End December 31st	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year
						% / $ Growth			
Utilization Statistics									
Acute Admissions	18,508	18,945	18,565	18,641	18,641	2.4%	(2.0%)	0.4%	-
Psych Admissions	-	1	2	-	-	n/a	100.0%	(100.0%)	n/a
Rehab Admissions	200	217	190	178	178	8.5%	(12.4%)	(6.3%)	-
SNF Admissions	1,030	1,021	893	875	875	(0.9%)	(12.5%)	(2.0%)	-
Admissions	**19,738**	**20,184**	**19,650**	**19,694**	**19,694**	**2.3%**	**(2.6%)**	**0.2%**	**-**
Avg Length of Stay ("ALOS")	4.5	4.8	4.7	4.7	4.7	6.8%	(1.9%)	(0.7%)	-
Patient Days	88,855	97,083	92,724	92,271	92,271	9.3%	(4.5%)	(0.5%)	-
Outpatient ER Visits	61,248	63,484	63,875	63,650	63,650	3.7%	0.6%	(0.4%)	-
Outpatient Surgeries	2,476	2,641	2,786	2,731	2,731	6.7%	5.5%	(2.0%)	-
Other Outpatient Visits	95,810	98,281	101,441	100,656	100,656	2.6%	3.2%	(0.8%)	-
Total Outpatient Visits	**159,534**	**164,406**	**168,102**	**167,037**	**167,037**	**3.1%**	**2.2%**	**(0.6%)**	**-**
Outpatient Equivalent Factor	1.4	1.4	1.5	1.5	1.5	0.2%	2.5%	(0.4%)	(0.1%)
Adjusted Patient Days	126,233	138,239	135,282	134,100	134,033	9.5%	(2.1%)	(0.9%)	(0.1%)
Adjusted Admissions	28,041	28,740	28,669	28,622	28,608	2.5%	(0.2%)	(0.2%)	(0.1%)
Census Data									
Beds in Service	372	372	372	372	372	-	-	-	-
Calendar Days	365	366	365	365	365	0.3%	(0.3%)	-	-
Avg Daily Census ("ADC")	243.4	265.3	254.0	252.8	252.8	9.0%	(4.2%)	(0.5%)	-
Percent Occupancy	65.4%	71.3%	68.3%	68.0%	68.0%	9.0%	(4.2%)	(0.5%)	-
Percent Adjusted Occupancy	93.0%	101.5%	99.6%	98.8%	98.7%	9.2%	(1.9%)	(0.9%)	(0.1%)
Consumer Price Index									
Charity	n/a	1.4516	1.4888	1.5845		n/a	2.6%	6.4%	-
Medicare	n/a	1.7136	1.654	1.8102		n/a	(3.5%)	9.4%	-
Medicare Managed Care	n/a	1.5929	1.6078	1.5799		n/a	0.9%	(1.7%)	-
Medicaid	n/a	1.7468	1.7158	1.8701		n/a	(1.8%)	9.0%	-
Medicaid Managed Care	n/a	1.4111	1.3595	1.4421		n/a	(3.7%)	6.1%	-
Self Pay / Uninsured	n/a	1.2718	1.4366	1.3823		n/a	13.0%	(3.8%)	-
Commercial / Other	n/a	1.8479	2.0029	1.7573		n/a	8.4%	(12.3%)	-
Managed Care	n/a	1.465	1.3696	1.4996		n/a	(6.5%)	9.5%	-
Managed Exchange	n/a	1.445	1.5389	1.4712		n/a	6.5%	(4.4%)	-
Total CMI	**n/a**	**1.5681**	**1.5365**	**1.6085**		**n/a**	**(2.0%)**	**4.7%**	**-**

FINAL REPORT

Fiscal Year End December 31st	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year
						% / $ Growth			
Other Key Statistics									
Total Emergency Room Visits	72,981	75,940	76,250	76,700	76,700	4.1%	0.4%	0.6%	-
Emergency Room Admits	11,733	12,456	12,375	13,050	13,050	6.2%	(0.7%)	5.5%	-
Total Surgeries	7,734	8,128	8,166	8,114	8,114	5.1%	0.5%	(0.6%)	-
Inpatient Surgeries	5,258	5,487	5,380	5,383	5,383	4.4%	(2.0%)	0.1%	-
Outpatient Surgeries	2,476	2,641	2,786	2,731	2,731	6.7%	5.5%	(2.0%)	-
Gross Charge & Net Revenue Statistics									
Gross Charge Ratios									
Gross Inpatient Charge per Admission	110,081	122,183	127,678	130,102	130,102	11.0%	4.5%	1.9%	-
Gross Inpatient Charge per Patient Day	24,453	25,402	27,057	27,768	27,768	3.9%	6.5%	2.6%	-
Gross Outpatient Charge per Visit	5,729	6,359	6,850	6,954	6,943	11.0%	7.7%	1.5%	(0.2%)
Net Patient Revenue Ratios									
Net Inpatient Revenue per Admission	16,041	17,817	17,373	17,344	17,479	11.1%	(2.5%)	(0.2%)	0.8%
Net Inpatient Revenue per Patient Day	3,563	3,704	3,682	3,702	3,731	4.0%	(0.6%)	0.5%	0.8%
Net Outpatient Revenue per Visit	870	930	908	911	900	7.0%	(2.4%)	0.3%	(1.2%)
Total Net Patient Revenue per Adj. Admission	15,719	17,337	16,885	17,164	17,180	10.3%	(2.6%)	1.7%	0.1%
Total Net Patient Revenue per Adj. Patient Day	3,492	3,604	3,578	3,663	3,667	3.2%	(0.7%)	2.4%	0.1%
Total Operating Expense Ratios									
Per Adj. Admission	13,097	14,730	14,864	15,019	15,648	12.5%	0.9%	1.0%	4.2%
Per Adj. Patient Day	2,909	3,062	3,150	3,206	3,340	5.3%	2.9%	1.8%	4.2%

FINAL REPORT

Fiscal Year End December 31st	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year
						% / $ Growth			
Historical Staffing Ratios									
Employed FTE's	1,720	1,976	1,951	1,933	1,933	14.9%	(1.3%)	(0.9%)	-
Paid Hours	3,577,600	4,110,080	4,058,080	4,020,640	4,020,640	14.9%	(1.3%)	(0.9%)	-
Paid Hours per Adj. Patient Day	28.3	29.7	30.0	30.0	30.0	4.9%	0.9%	(0.0%)	0.1%
FTEs per Adj. Occupied Bed	5.0	5.2	5.3	5.3	5.3	5.2%	0.6%	(0.0%)	0.1%
P/L Salary	$45.14	$46.39	$46.13	$46.49	$46.49	2.8%	(0.6%)	0.8%	-
P/L Benefits	$12.34	$12.09	$12.54	$12.75	$12.83	(2.1%)	3.7%	1.7%	0.6%
Employee Salaries & Wages:									
Employee Salaries & Wages	161,480,723	190,660,210	187,195,604	186,925,096	186,925,096	18.1%	(1.8%)	(0.1%)	-
% of Revenue	*32.9%*	*34.7%*	*34.8%*	*33.2%*	*34.4%*				
Employee Benefits & Taxes:									
Payroll Taxes	11,763,690	14,067,020	13,885,432	13,998,001	13,998,001	19.6%	(1.3%)	0.8%	-
% of Salaries & Wages	*7.3%*	*7.4%*	*7.4%*	*7.5%*	*7.5%*				
Employee Benefits	32,383,647	35,607,391	36,987,851	37,264,605	37,577,605	10.0%	3.9%	0.7%	0.8%
% of Salaries & Wages	*20.1%*	*18.7%*	*19.8%*	*19.9%*	*20.1%*				
Occupancy Costs:									
Rent / Lease - Real Property	715,595	852,565	877,241	785,280	785,280	19.1%	2.9%	(10.5%)	-
% of Revenue	*0.1%*	*0.2%*	*0.2%*	*0.1%*	*0.1%*				
Utilities	3,899,993	3,330,300	3,499,157	3,678,255	3,678,255	(14.6%)	5.1%	5.1%	-
% of Revenue	*0.8%*	*0.6%*	*0.7%*	*0.7%*	*0.7%*				
Property Taxes	1,242,032	1,193,427	1,271,050	1,147,173	1,147,173	(3.9%)	6.5%	(9.7%)	-
% of Revenue	*0.3%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*				

FINAL REPORT

Fiscal Year End December 31st	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year
						% / $ Growth			
Supplies									
Medical Supplies	38,219,014	42,323,381	40,338,078	41,083,832	41,083,832	10.7%	(4.7%)	1.8%	-
% of Revenue	*7.8%*	*7.7%*	*7.5%*	*7.3%*	*7.6%*				
Per Adj. Admission	1,363	1,473	1,407	1,435	1,436	8.0%	(4.5%)	2.0%	0.1%
Per Adj. Patient Day	303	306	298	306	307	1.1%	(2.6%)	2.7%	0.1%
Drugs & Pharmaceuticals	26,510,658	30,850,978	30,247,697	31,110,577	31,110,577	16.4%	(2.0%)	2.9%	-
% of Revenue	*5.4%*	*5.6%*	*5.6%*	*5.5%*	*5.7%*				
Per Adj. Admission	945	1,073	1,055	1,087	1,087	13.5%	(1.7%)	3.0%	0.1%
Per Adj. Patient Day	210	223	224	232	232	6.3%	0.2%	3.8%	0.1%
Non-medical Supplies	5,721,203	4,824,614	4,536,075	4,518,902	4,518,902	(15.7%)	(6.0%)	(0.4%)	-
% of Revenue	*1.2%*	*0.9%*	*0.8%*	*0.8%*	*0.8%*				
Per Adj. Admission	204	168	158	158	158	(17.7%)	(5.7%)	(0.2%)	0.1%
Per Adj. Patient Day	45	35	34	34	34	(23.0%)	(3.9%)	0.5%	0.1%
Medical Costs									
Other Clinical Expenses	15,880	10,538	1,173,820	1,403,631	1,403,631	(33.6%)	11038.9%	19.6%	-
% of Revenue	*0.0%*	*0.0%*	*0.2%*	*0.2%*	*0.3%*	*(5,342)*	*1,163,282*	*229,811*	-
Medical Fees	22,918,405	28,155,709	32,217,548	34,086,074	34,086,074	22.9%	14.4%	5.8%	-
% of Revenue	*4.7%*	*5.1%*	*6.0%*	*6.1%*	*6.3%*	*5,237,304*	*4,061,839*	*1,868,526*	-
Physician Income Assist	1,531,647	1,490,747	1,974,964	2,002,993	2,002,993	(2.7%)	32.5%	1.4%	-
% of Revenue	*0.3%*	*0.3%*	*0.4%*	*0.4%*	*0.4%*	*(40,900)*	*484,217*	*28,029*	-
Insurance									
Malpractice Insurance	3,986,073	7,591,366	6,394,474	5,692,256	5,692,256	90.4%	(15.8%)	(11.0%)	-
% of Revenue	*0.8%*	*1.4%*	*1.2%*	*1.0%*	*1.0%*				
Other Insurance	676,531	842,166	900,543	949,693	949,693	24.5%	6.9%	5.5%	-
% of Revenue	*0.1%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*165,635*	*58,377*	*49,150*	-

FINAL REPORT

Fiscal Year End December 31st	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year
						% / $ Growth			
General & Administrative									
Advertising	1,391,452	1,554,035	1,466,182	1,110,287	1,110,287	11.7%	(5.7%)	(24.3%)	-
% of Revenue	*0.3%*	*0.3%*	*0.3%*	*0.2%*	*0.2%*				
Information Technology	7,562,988	8,179,456	9,697,950	9,480,068	9,480,068	8.2%	18.6%	(2.2%)	-
% of Revenue	*1.5%*	*1.5%*	*1.8%*	*1.7%*	*1.7%*				
Charitable Contributions	864,838	1,145,921	972,447	1,561,160	1,561,160	32.5%	(15.1%)	60.5%	-
% of Revenue	*0.2%*	*0.2%*	*0.2%*	*0.3%*	*0.3%*				
Equipment Rent / Lease Expense	953,797	1,584,208	1,502,505	1,330,460	1,330,460	66.1%	(5.2%)	(11.5%)	-
% of Revenue	*0.2%*	*0.3%*	*0.3%*	*0.2%*	*0.2%*	*630,411*	*(81,703)*	*(172,045)*	-
Non-medical Professional Fees	3,217,597	3,291,038	4,713,103	4,299,393	4,299,393	2.3%	43.2%	(8.8%)	-
% of Revenue	*0.7%*	*0.6%*	*0.9%*	*0.8%*	*0.8%*	*73,441*	*1,422,065*	*(413,710)*	-
Conifer Collection Fees	12,705,711	13,447,841	13,027,365	13,114,847	13,114,847	5.8%	(3.1%)	0.7%	-
% of Revenue	*2.6%*	*2.4%*	*2.4%*	*2.3%*	*2.4%*				
License Fees	858,407	899,169	836,289	769,873	769,873	4.7%	(7.0%)	(7.9%)	-
% of Revenue	*0.2%*	*0.2%*	*0.2%*	*0.1%*	*0.1%*				
Other Controllable Expenses	13,375,934	15,129,997	16,342,488	16,561,992	16,311,992	13.1%	8.0%	1.3%	(1.5%)
% of Revenue	*2.7%*	*2.8%*	*3.0%*	*2.9%*	*3.0%*				
Other Non-medical Expenses	7,705,587	8,261,334	7,421,385	7,713,207	7,713,207	7.2%	(10.2%)	3.9%	-
% of Revenue	*1.6%*	*1.5%*	*1.4%*	*1.4%*	*1.4%*	*555,747*	*(839,949)*	*291,822*	-
Repairs & Maintenance	7,551,948	8,056,848	8,639,898	9,273,933	9,273,933	6.7%	7.2%	7.3%	-
% of Revenue	*1.5%*	*1.5%*	*1.6%*	*1.6%*	*1.7%*	*504,900*	*583,050*	*634,035*	-
Net Operating Revenue	491,063,987	549,132,545	538,194,797	562,925,293	544,133,376	11.8%	(2.0%)	4.6%	(3.3%)
% of Revenue	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*				
Total Operating Expenses	367,253,350	423,350,259	426,119,146	429,861,588	447,664,904	15.3%	0.7%	0.9%	4.1%
% of Revenue	*74.8%*	*77.1%*	*79.2%*	*76.4%*	*82.3%*				
EBITDA	**123,810,637**	**125,782,286**	**112,075,651**	**133,063,705**	**96,468,473**	**1.6%**	**(10.9%)**	**18.7%**	**(27.5%)**
% of Revenue	*25.2%*	*22.9%*	*20.8%*	*23.6%*	*17.7%*				

FINAL REPORT

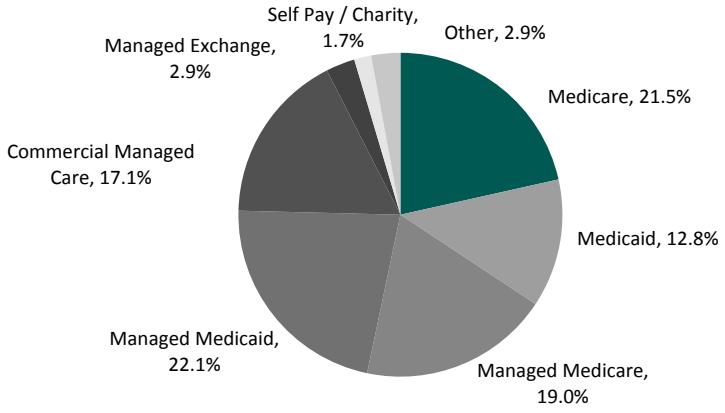
Historical Payor Mix Expressed as % of Gross Charges	FYE 2015	FYE 2016	FYE 2017	YTD 2018
Medicare	21.0%	20.8%	21.6%	21.5%
Medicaid	15.6%	13.6%	12.6%	12.8%
Managed Medicare	18.7%	19.0%	20.1%	19.0%
Managed Medicaid	19.4%	21.7%	21.2%	22.1%
Commercial Managed Care	16.9%	17.8%	16.2%	17.1%
Managed Exchange	2.6%	2.4%	2.9%	2.9%
Self Pay / Charity	1.3%	1.7%	1.7%	1.7%
Other	4.5%	3.0%	3.7%	2.9%
Total	100.0%	100.0%	100.0%	100.0%

Source: Hospital's payor mix report which is reported in terms of gross charges.

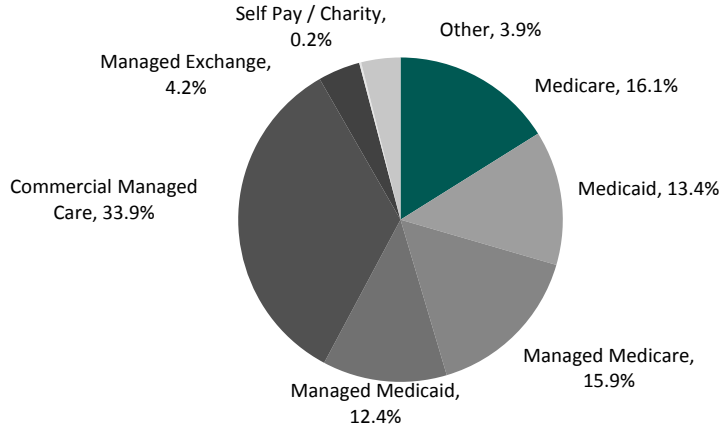
Historical Payor Mix Expressed as % of Net Patient Revenue	FYE 2015	FYE 2016	FYE 2017	YTD 2018
Medicare	14.2%	14.5%	15.7%	16.1%
Medicaid	14.0%	12.7%	14.1%	13.4%
Managed Medicare	15.6%	16.9%	17.3%	15.9%
Managed Medicaid	12.7%	13.7%	13.5%	12.4%
Commercial Managed Care	31.7%	34.0%	30.5%	33.9%
Managed Exchange	4.9%	4.0%	4.3%	4.2%
Self Pay / Charity	1.3%	1.4%	1.3%	0.2%
Other	5.7%	2.9%	3.4%	3.9%
Total	100.0%	100.0%	100.0%	100.0%

Source: Hospital's payor mix report which is reported in terms of net patient revenue.

Gross Charges Payor Mix - YTD 2018



Net Patient Revenue Payor Mix - YTD 2018



Sources: Management provided payor mix reports for FYE 2015, FYE 2016, FYE 2017 and for the year-to-date period ended May 31, 2018.

Desert Regional Medical Center

Income Approach Analysis

DESERT REGIONAL MEDICAL CENTER
NORMALIZED INCOME STATEMENT

FINAL REPORT

Normalized Base Year	Footnotes	TTM 2018	Adjustments	Normalized Base Year	TTM 2018	Normalized Base Year
Hospital Operating Revenue						
Patient Revenue						
Gross Inpatient Revenue		$2,562,224,502	-	$2,562,224,502	455.2%	470.9%
Inpatient Contractual	*1*	(2,220,650,822)	$2,653,632	(2,217,997,190)	(394.5%)	(407.6%)
Net Inpatient Revenue		341,573,680	2,653,632	344,227,312	60.7%	63.3%
Gross Outpatient Revenue	*1*	1,161,536,693	($1,870,000)	1,159,666,693	206.3%	213.1%
Outpatient Contractual		(1,009,294,506)	-	(1,009,294,506)	(179.3%)	(185.5%)
Net Outpatient Revenue		152,242,187	(1,870,000)	150,372,187	27.0%	27.6%
Net Patient Revenue before Bad Debt		$493,815,867	$783,632	$494,599,499	87.7%	90.9%
Bad Debt	*1*	(2,546,776)	($585,481)	(3,132,257)	(0.5%)	(0.6%)
Total Net Patient Revenue		$491,269,091	$198,151	$491,467,242	87.3%	90.3%
Supplemental Payments						
Medicaid DSH		7,203,734	-	7,203,734	1.3%	1.3%
Medicaid Supplemental - Income Provider	*2*	97,750,754	(28,134,779)	69,615,975	17.4%	12.8%
Medicaid Supplemental - Assessment Provider	*2*	(33,794,251)	9,144,711	(24,649,540)	(6.0%)	(4.5%)
Electronic Health Record Incentives		301,700	-	301,700	0.1%	0.1%
Total		71,461,937	(18,990,068)	52,471,869	12.7%	9.6%
Other Revenue						
Rental Income		-	-	-	-	-
Other Revenue		194,265	-	194,265	0.0%	0.0%
Total		194,265	-	194,265	0.0%	0.0%
Total Net Operating Revenue		$562,925,293	($18,791,917)	$544,133,376	100.0%	100.0%

DESERT REGIONAL MEDICAL CENTER
NORMALIZED INCOME STATEMENT

FINAL REPORT

Normalized Base Year	Footnotes	TTM 2018	Adjustments	Normalized Base Year	TTM 2018	Normalized Base Year
Operating Expenses:						
Employee Salaries & Wages						
Employee Salaries & Wages		186,925,096	-	186,925,096	33.2%	34.4%
Total		186,925,096	-	186,925,096	33.2%	34.4%
Employee Benefits						
Payroll Taxes		13,998,001	-	13,998,001	2.5%	2.6%
Employee Benefits	*1*	37,264,605	313,000	37,577,605	6.6%	6.9%
Total		51,262,606	313,000	51,575,606	9.1%	9.5%
Occupancy Costs						
Rent / Lease - Real Property		785,280	-	785,280	0.1%	0.1%
Utilities		3,678,255	-	3,678,255	0.7%	0.7%
Property Taxes		1,147,173	-	1,147,173	0.2%	0.2%
Total		5,610,708	-	5,610,708	1.0%	1.0%
Supplies						
Medical Supplies		41,083,832	-	41,083,832	7.3%	7.6%
Drugs & Pharmaceuticals		31,110,577	-	31,110,577	5.5%	5.7%
Non-medical Supplies		4,518,902	-	4,518,902	0.8%	0.8%
Total		76,713,311	-	76,713,311	13.6%	14.1%
Medical Costs						
Other Clinical Expenses		1,403,631	-	1,403,631	0.2%	0.3%
Medical Fees		34,086,074	-	34,086,074	6.1%	6.3%
Physician Income Assist		2,002,993	-	2,002,993	0.4%	0.4%
Non-patient Provisions		-	-	-	-	-
Total		37,492,698	-	37,492,698	6.7%	6.9%
Insurance						
Malpractice Insurance		5,692,256	-	5,692,256	1.0%	1.0%
Other Insurance		949,693	-	949,693	0.2%	0.2%
Total		6,641,949	-	6,641,949	1.2%	1.2%
General & Administrative						
Advertising		1,110,287	-	1,110,287	0.2%	0.2%
Information Technology		9,480,068	-	9,480,068	1.7%	1.7%
Charitable Contributions		1,561,160	-	1,561,160	0.3%	0.3%
Non-medical Contracted Departments		-	-	-	-	-
Equipment Rent / Lease Expense		1,330,460	-	1,330,460	0.2%	0.2%
Non-medical Professional Fees		4,299,393	-	4,299,393	0.8%	0.8%
Conifer Collection Fees		13,114,847	-	13,114,847	2.3%	2.4%
License Fees		769,873	-	769,873	0.1%	0.1%
Other Controllable Expenses	*1*	16,561,992	(250,000)	16,311,992	2.9%	3.0%
Other Non-medical Expenses		7,713,207	-	7,713,207	1.4%	1.4%
Repairs & Maintenance		9,273,933	-	9,273,933	1.6%	1.7%
Management Fees	*3*	-	10,882,668	10,882,668	-	2.0%
Physician Subsidy	*4*	-	6,857,648	6,857,648	-	1.3%
Total		65,215,220	17,490,316	82,705,536	11.6%	15.2%
Total Operating Expenses	*3,4*	429,861,588	17,803,316	447,664,904	76.4%	82.3%

DESERT REGIONAL MEDICAL CENTER
NORMALIZED INCOME STATEMENT

FINAL REPORT

Normalized Base Year	Footnotes	TTM 2018	Adjustments	Normalized Base Year	TTM 2018	Normalized Base Year
EBITDA		133,063,705	(36,595,232)	96,468,473	23.6%	17.7%
Depreciation & Amortization Expense		15,442,515	-	15,442,515	2.7%	2.8%
Operating Income		117,621,190	(36,595,232)	81,025,958	20.9%	14.9%
Other Income (Expense)	*5*	(540)	540	-	(0.0%)	-
Interest Expense	*6*	393,811	(393,811)	-	0.1%	-
Earnings Before Income Taxes		117,226,839	(36,200,881)	81,025,958	20.8%	14.9%
Federal & State Income Tax Expense	*7*	-	22,673,980	22,673,980	-	4.2%
Earnings After Income Taxes		$117,226,839	($58,874,861)	$58,351,978	20.8%	10.7%

Sources: Management provided financials for the trailing twelve month period ended May 31, 2018.
Normalized Base Year based on the trailing twelve month period ended May 31, 2018. Normalized Base Year eliminates any unusual or nonrecurring items from revenue and expenses.

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Footnotes to Normalized Base Year Income Statement	
Footnote	Description
1	Management indicated several one-time or non-recurring expenses were included in the Hospital's TTM 2018 income statement. Please refer to Normalized Base Year Schedule 1 for additional detail.
2	Medicaid Supplemental - Income Provider' and 'Medicaid Supplemental - Assessment Provider' accounts are related to the Hospital's participation in the Hospital Qualify Assurance Fee ("HQAF") program Please refer to Normalized Base Year Schedule 2 for additional detail regarding this adjustment.
3	Management Fees not captured in the Hospital's TTM 2018 Income Statement have been estimated at 2.0% of revenue. Please refer to Normalized Base Year Schedule 3, which provides support for the selected level of revenue.
4	Physician losses not captured in the TTM 2018 financial statements have been added in the Normalized Base Year. Please refer to Normalized Base Year Schedule 4 for supporting calculations.
5	Eliminated Other Income (Expense) to projected only recurring patient service revenue.
6	Eliminated interest expense to derive debt-free operations.
7	Calculated a blended federal and state income tax rate for California businesses to be applied to the earnings before taxes.

DESERT REGIONAL MEDICAL CENTER
NORMALIZED BASE YEAR SUPPORTING SCHEDULE 1 - NON-RECURRING ITEMS IDENTIFIED BY MANAGEMENT

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Period	January-18	February-18	February-18	March-18	April-18	June-18	June-18	Total 2018 Other Normalizing Adjustments	Adjustments Included in NBY
	Valuation Acct Chng	IEHP OP PCR Adj	IEHP True-Up Q1 '18	Pension 2017 True-UP	CDHP Penalties Q2 '18	Allianz Sttlmnt Q2 '18	PCR / Historical Q2 '18		
	Note 1	*Note 2*	*Note 3*	*Note 4*	*Note 5*	*Note 6*	*Note 7*		
Adjustment to Account									
Inpatient Contractual			$2,653,632					$2,653,632	$2,653,632
Gross Outpatient Revenue		($1,037,000)					($833,000)	($1,870,000)	($1,870,000)
Bad Debt	($261,000)					($324,481)		($585,481)	($585,481)
Total Operating Revenue Adjustment	*($261,000)*	*($1,037,000)*	-	-	-	*($324,481)*	*($833,000)*	*$198,151*	*$198,151*
Operating Expenses									
Employee Benefits	-	-	-	$313,000	-	-	-	$313,000	$313,000
Other Controllable Expenses	-	-	-	-	($250,000)	-	-	($250,000)	($250,000)
Total Operating Expenses	-	-	-	*$313,000*	*($250,000)*	-	-	*$63,000*	*$63,000*
Total Adjustments	($261,000)	($1,037,000)	-	($313,000)	$250,000	($324,481)	($833,000)	$135,151	$135,151

Notes:

1) *Valuation Acct Chng - Management changed the bad debt methodology to align with the 2019 uncollectible valuation. The new approach begins "aging" while patients are in-house vs. the Hospital's historical practice of aging once accounts receivable exceeds 30 days. Management adjusted the reserve percentages under this new method, which impacted the Hospital's bottom line outside the normal operation.*

2) *IEHP OP PCR Adj – Management revisited the cancer center outpatient percent to charge ratio during Q1 to account for the trend of higher reimbursement specific to radiation oncology and chemo patients. The Hospital's rate increase from historical PCR reflected paid claims from Oct. '17 to Feb '18. Over this time period, the PCR increased from 20.37 to 24.1%.*

3) *IEHP True-Up Q1 '18 – In Oct. '17 we had a discussion with IEHP regarding the available funds for the quality risk pool. We understood at that time they had $7.5M in funds for DRMC based on 4 metrics. This was in line with the 2016/2017 fund disbursements. When we received the actual cash for Q1 & Q2 2017 in Feb. 2018 (due to IEHP delayed payment trending) we received <$1.1> less than anticipated. We clarified immediately with IEHP in March and understood $7.5M was their total pool of which DRMC was eligible to receive 5.2% on our percentage of the total. Total funds in 2016 were $84M which dropped to $30.7M in 2017. We reduced our estimate for Q3 & Q4 2017 in March 2018 for <$965K>. In addition, we are taking a monthly "hit" to forecast and to prior 2018 month reserves.*

4) *Pension 2017 True-Up – Management allocates annually the final "matching" for employees upon meeting certain eligibility requirements. Management uses a per pay period matching estimate for all employees. In March this estimated expense accrual is trued-up to the actual funds transferred to 401k accounts.*

5) *CDHP Penalties Q2 '18 – Management was notified by CDHP in April that the Hospital was going to be paying a minimum of two $125K penalties, which were accrued.*

6) *Allianz Sttlmnt Q2 '18 – Allianz is an insurance company that Management settled prior year claims, which netted the facility with a favorable net revenue adjustment.*

7) *PCR / Historical Q2 '18 – Management updated the Hospital's Managed OP Historical PCR based on current 6 month trending $204K balance along with a $629K "credit" balance for prior period paid claims. The Hospital's historical practice of applying a PCR*

DESERT REGIONAL MEDICAL CENTER
NORMALIZED BASE YEAR SUPPORTING SCHEDULE 2 - MEDICAID SUPPLEMENTAL PAYMENT & ASSESSMENT FEE ADJUSTMENT

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Medicaid Supplemental - Income Provider' and 'Medicaid Supplemental - Assessment Provider' accounts are related to the Hospital's participation in the Hospital Qualify Assurance Fee ("HQAF") program which provides funding for supplemental payments to California hospitals that serve Medi-Cal and uninsured patients. The Hospital accrues Supplemental Revenue and related Assessment Fees as detailed in teh exhibits below.

Source Income Statement Account	VMG Income Statement Account	FYE 2017 - Janaury	FYE 2017 - February	FYE 2017 - March	FYE 2017 - April	FYE 2017 - May	TTM 2018 FYE 2017 - June	TTM 2018 FYE 2017 - July	TTM 2018 FYE 2017 - August	TTM 2018 FYE 2017 - September	TTM 2018 FYE 2017 - October	TTM 2018 FYE 2017 - November	TTM 2018 FYE 2017 - December	TTM 2018 FYE 2017 - Period 13	FYE 2017 Total	Note:
4791 - Medicaid Supplemental - Income Provider Fee State	Medicaid Supplemental - Income Provider	-	-	-	-	-	-	-	-	-	-	-	63,654,523	3,868,946	67,523,469	1
4796 - Medicaid Supplemental - Assessment Provider Fee State	Medicaid Supplemental - Assessment Provider	-	-	-	-	-	-	-	-	-	-	-	(25,352,385)	3,405,079	(21,947,306)	1

Source Income Statement Account	VMG Income Statement Account	TTM 2018 YTD 2018 - January	TTM 2018 YTD 2018 - February	TTM 2018 YTD 2018 - March	TTM 2018 YTD 2018 - April	TTM 2018 YTD 2018 - May	FYE 2017 Total Accrued	TTM 2018 Total Accrued	TTM 2018 Months Accrued	FYE 2017 Months to Eliminate	FYE 2017 Avg Monthly Accrual	Adjustment	Normalized Base Year	
4791 - Medicaid Supplemental - Income Provider Fee State	Medicaid Supplemental - Income Provider	6,045,457	6,045,457	6,045,457	6,045,457	6,045,457	67,523,469	97,750,754	17 Months	5 Months	5,626,956	28,134,779	125,885,533	2
4796 - Medicaid Supplemental - Assessment Provider Fee State	Medicaid Supplemental - Assessment Provider	(2,369,389)	(2,369,389)	(2,369,389)	(2,369,389)	(2,369,389)	(21,947,306)	(33,794,251)	17 Months	5 Months	(1,828,942)	(9,144,711)	(42,938,962)	2

Notes:
(1) During December 2017, Medicaid Supplemental Income & Assessment Fee accrual occurred for the full FYE 2017 period. The TTM 2018 Income Statement is overstated as a result as it included the December 2017 accruals.
(2) The Adjustment above eliminates an estimated 5 month period of accruals from FYE 2017 based on the Average accrued Income and Assessment Fee per month during FYE 2017.

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Summary of VMG Data for Management Fees Observed for Acute Care Hospitals

Comparable Facility	Selected Comparable ("X")	Fee % of Net Revenue
Comparable #1		2.2%
Comparable #2	X	1.1%
Comparable #3	X	2.2%
Comparable #4		1.1%
Comparable #5	X	2.9%
Comparable #6	X	1.9%
Comparable #7		3.0%
Comparable #8		3.8%
Comparable #9	X	2.5%
Comparable #10	X	2.5%
Comparable #11	X	2.0%
Comparable #12	X	4.4%
Comparable #13	X	0.5%
Comparable #14	X	2.0%
Comparable #15	X	1.9%
Comparable #16	X	2.5%
Comparable #17		1.0%
Comparable #18		1.0%
Comparable #19		2.0%
Comparable #20	X	2.0%
Comparable #21		0.6%
Comparable #22		n/a
Comparable #23		n/a
Interview Response #1		1.3%
Interview Response #2		n/a
Interview Response #3		0.8%
Interview Response #4		1.8%
Third Party Quote		2.0%

Summary Data - All Data Points

Low	High	Mean	Median
0.5%	4.4%	1.9%	2.0%

Note: Please refer to the supplemental exhibits for a list of management services provided by Tenet at the Hospital.

DESERT REGIONAL MEDICAL CENTER
NORMALIZED BASE YEAR SUPPORTING SCHEDULE 4 - PHYSICIAN PRACTICE FOUNDATION SUBSIDY CALCULATION

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Line Item	FYE 2017	YTD May 2017	YTD May 2018	TTM 2018
Gross Patient Revenue	12,585,570	4,493,209	7,796,591	15,888,952
Revenue Deductions	9,167,991	3,013,359	5,880,135	12,034,767
Total Net Patient Revenue	**3,417,579**	**1,479,850**	**1,916,456**	**3,854,185**
Other Revenue	1,488,390	454,419	945,477	1,979,448
Total Net Operating Revenue	**4,905,969**	**1,934,269**	**2,861,933**	**5,833,633**
Bad Debt	109,954	43,247	(4,719)	61,988
Total Operating/Collectible Revenue	**4,796,015**	**1,891,022**	**2,866,652**	**5,771,645**
Salaries, Wages, & Benefits	90,150	2,002	159,709	247,857
Supplies	408,279	87,786	246,436	566,929
Medical & Clinical Fees	5,873,174	2,785,368	2,941,254	6,029,060
Other Professional Fees	171,226	75,641	171,618	267,203
Other Fees & Services	2,364,466	879,495	1,932,093	3,417,064
Utilities & Telephones	208,374	79,508	111,298	240,164
Repairs, Maintenance, & Equipment Rental	171,720	70,987	76,503	177,236
Total OCE	289,422	121,111	143,769	312,080
Rent & REIT	961,969	334,623	655,308	1,282,654
Other NCE	113,373	26,836	59,195	145,732
EHR Incentive	(27,460)	(1,960)	-	(25,500)
Depreciation & Amortization	619	350,828	317,752	(32,457)
Interest Expense	612	188	847	1,271
Total Expenses	**10,625,924**	**4,812,413**	**6,815,782**	**12,629,293**
Total Pre-Tax Income	**(5,829,909)**	**(2,921,391)**	**(3,949,130)**	**(6,857,648)** *

Note: Pre-tax income above was provided for the Physician Practice operations applicable to the operations of Desert Regional Medical Center. These Physician Practice's are accounted for under the Desert Foundation and have not historically been included in the Hospital Income Statements provided. The above Pre-tax Income (Loss) is applied as an expense for the Hospital in the NBY.

FINAL REPORT

DISCOUNTED CASH FLOW - ASSUMPTIONS

Incremental Working Capital Requirements	8.0%	
Normalized Working Capital	8.0%	$43,531,000 = x Normalized Base Year Revenue
Standard Inflation Rate (CPI)	3.0%	
Terminal Growth Rate	3.0%	
CA - Income Tax Rate (Blended Federal & State)	28.0%	CA

VOLUME GROWTH	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5
Inpatient Admissions	n/a	2.3%	(2.6%)	0.2%	-	0.5%	0.5%	0.5%	0.5%	0.5%
Outpatient Visits	n/a	3.1%	2.2%	(0.6%)	-	2.5%	2.5%	2.5%	2.5%	2.5%
Total Adj. Patient Days	126,233	138,239	135,282	134,100	134,033	135,538	137,072	138,635	140,228	141,851
Growth	*n/a*	*9.5%*	*(2.1%)*	*(0.9%)*	*(0.1%)*	*1.1%*	*1.1%*	*1.1%*	*1.1%*	*1.2%*

NET REVENUE GROWTH	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5
Net Inpatient Revenue per Inpatient Admissions	n/a	11.1%	(2.5%)	(0.2%)	0.8%	2.0%	2.0%	2.0%	2.0%	2.0%
Net Outpatient Revenue per Outpatient Visits	n/a	7.0%	(2.4%)	0.3%	(1.2%)	2.0%	2.0%	2.0%	2.0%	2.0%
Avg. Net Patient Revenue Revenue per Adj. Patient Day	$3,492	$3,604	$3,578	$3,663	$3,667	$3,740	$3,814	$3,889	$3,967	$4,045
Growth	*n/a*	*3.2%*	*(0.7%)*	*2.4%*	*0.1%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*

SUPPLIES ASSUMPTIONS: *Supplies per Adj. Patient Day Growth*		FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5
Total Adj. Patient Days		126,233	138,239	135,282	134,100	134,033	135,538	137,072	138,635	140,228	141,851
Medical Supplies per Adj. Patient Day	*Increase at CPI*	$302.76	$306.16	$298.18	$306.37	$306.52	$315.72	$325.19	$334.94	$344.99	$355.34
Total Medical Supplies		$38,219,014	$42,323,381	$40,338,078	$41,083,832	$41,083,832	$42,791,627	$44,574,153	$46,434,855	$48,377,346	$50,405,416
Growth		*n/a*	*10.7%*	*(4.7%)*	*1.8%*	-	*4.2%*	*4.2%*	*4.2%*	*4.2%*	*4.2%*
Total Adj. Patient Days		126,233	138,239	135,282	134,100	134,033	135,538	137,072	138,635	140,228	141,851
Drugs & Pharmaceuticals per Adj. Patient Day	*Increase at CPI*	$210.01	$223.17	$223.59	$231.99	$232.11	$239.07	$246.25	$253.63	$261.24	$269.08
Total Drugs & Pharmaceuticals		$26,510,658	$30,850,978	$30,247,697	$31,110,577	$31,110,577	$32,403,798	$33,753,609	$35,162,619	$36,633,563	$38,169,311
Growth		*n/a*	*16.4%*	*(2.0%)*	*2.9%*	-	*4.2%*	*4.2%*	*4.2%*	*4.2%*	*4.2%*

FTE/STAFFING COMPENSATION ASSUMPTIONS:		FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5
Total FTEs		1,720.0	1,976.0	1,951.0	1,933.0	1,933.0	1,954.7	1,976.8	1,999.4	2,022.3	2,045.7
Paid Hours per Adj. Patient Day		28.3	29.7	30.0	30.0	30.0	30.0	30.0	30.0	30.0	30.0
Growth		*n/a*	*4.9%*	*0.9%*	*(0.0%)*	*0.1%*	-	-	-	-	-
Average Salary per FTE					$96,702	$96,702	$99,603	$102,591	$105,669	$108,839	$112,104
Growth	*3.0% Annual Growth*				*n/a*	-	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*
Total FTE Salaries					$186,925,096	$186,925,096	$194,695,301	$202,805,516	$211,271,423	$220,109,460	$229,336,865
Payroll Taxes	*% of salaries*	*7.5%*			$13,998,001	$13,998,001	$14,579,878	$15,187,216	$15,821,191	$16,483,033	$17,174,032
Employee Benefits	*% of salaries*	*20.1%*			$37,264,605	$37,577,605	$39,139,651	$40,770,050	$42,471,954	$44,248,667	$46,103,655
Total Employee Salaries, Wages & Benefits					$238,187,702	$238,500,702	$248,414,830	$258,762,783	$269,564,568	$280,841,160	$292,614,553
per Adj. Patient Day					$1,776	$1,779	$1,833	$1,888	$1,944	$2,003	$2,063
Growth					*n/a*	*0.2%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*

REVENUE ASSUMPTIONS:		FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5
INPATIENT REVENUE											
Volume Assumptions											
Admissions per year		19,738	20,184	19,650	19,694	19,694	19,792	19,891	19,991	20,091	20,191
Growth		*n/a*	*2.3%*	*(2.6%)*	*0.2%*	-	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*
Average Length of Stay ("ALOS")		4.5	4.8	4.7	4.7	4.7	4.7	4.7	4.7	4.7	4.7
Patient Days		88,855	97,083	92,724	92,271	92,271	92,732	93,196	93,662	94,130	94,601
Inpatient Reimbursement (per Admission)											
Gross Inpatient Charge per Admission	% of NBY Charges	$110,081	$122,183	$127,678	$130,102	$130,102	$132,704	$135,358	$138,065	$140,826	$143,643
Inpatient Contractual per Admission	86.6%	(94,040)	(104,366)	(110,305)	(112,758)	(112,623)	(114,875)	(117,173)	(119,516)	(121,907)	(124,345)
Average Net Inpatient Revenue per Admission		$16,041	$17,817	$17,373	$17,344	$17,479	$17,828	$18,185	$18,549	$18,920	$19,298
Growth		*n/a*	*11.1%*	*(2.5%)*	*(0.2%)*	*0.8%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Inpatient Gross Charges		$2,172,776,766	$2,466,134,357	$2,508,873,783	$2,562,224,502	$2,562,224,502	$2,626,536,337	$2,692,462,399	$2,760,043,205	$2,829,320,290	$2,900,336,229
Estimated Inpatient Contractual		(1,856,157,763)	(2,106,525,179)	(2,167,492,991)	(2,220,650,822)	(2,217,997,190)	(2,273,668,919)	(2,330,738,009)	(2,389,239,533)	(2,449,209,446)	(2,510,684,603)
Net Inpatient Revenue		**$316,619,003**	**$359,609,178**	**$341,380,792**	**$341,573,680**	**$344,227,312**	**$352,867,418**	**$361,724,390**	**$370,803,672**	**$380,110,844**	**$389,651,626**
Growth		*n/a*	*13.6%*	*(5.1%)*	*0.1%*	*0.8%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*
OUTPATIENT REVENUE											
Outpatient Volume											
Outpatient Visits per year		159,534	164,406	168,102	167,037	167,037	171,213	175,493	179,881	184,378	188,987
Growth		*n/a*	*3.1%*	*2.2%*	*(0.6%)*	-	*2.5%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*
Outpatient Reimbursement											
Gross Charge per Outpatient Visit	% of NBY Charges	$5,729	$6,359	$6,850	$6,954	$6,943	$7,081	$7,223	$7,368	$7,515	$7,665
Outpatient Contractual per Admission	87.0%	(4,860)	(5,428)	(5,942)	(6,042)	(6,042)	(6,163)	(6,286)	(6,412)	(6,540)	(6,671)
Average Net Revenue per Outpatient Visit		$870	$930	$908	$911	$900	$918	$937	$955	$974	$994
Growth		*n/a*	*7.0%*	*(2.4%)*	*0.3%*	*(1.2%)*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Outpatient Gross Charges		$914,018,727	$1,045,447,306	$1,151,497,930	$1,161,536,693	$1,159,666,693	$1,212,431,528	$1,267,597,162	$1,325,272,833	$1,385,572,747	$1,448,616,307
Estimated Outpatient Contractual		(775,273,263)	(892,476,375)	(998,786,817)	(1,009,294,506)	(1,009,294,506)	(1,055,217,406)	(1,103,229,798)	(1,153,426,754)	(1,205,907,671)	(1,260,776,470)
Net Outpatient Revenue		**$138,745,464**	**$152,970,931**	**$152,711,113**	**$152,242,187**	**$150,372,187**	**$157,214,122**	**$164,367,364**	**$171,846,079**	**$179,665,076**	**$187,839,837**
Growth		*n/a*	*10.3%*	*(0.2%)*	*(0.3%)*	*(1.2%)*	*4.5%*	*4.6%*	*4.6%*	*4.5%*	*4.5%*

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REVENUE ASSUMPTIONS:		FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5
HOSPITAL OPERATING REVENUE SUMMARY											
Total Patient Revenue											
Total Gross Charges (IP & OP)		$3,086,795,493	3,511,581,663	3,660,371,713	3,723,761,195	3,721,891,195	3,838,967,865	3,960,059,561	4,085,316,038	4,214,893,037	4,348,952,536
Total Contractuals (IP & OP)		(2,631,431,026)	(2,999,001,554)	(3,166,279,808)	(3,229,945,328)	(3,227,291,696)	(3,328,886,325)	(3,433,967,807)	(3,542,666,287)	(3,655,117,117)	(3,771,461,073)
Net Patient Revenue before Bad Debt		455,364,467	512,580,109	494,091,905	493,815,867	494,599,499	510,081,539	526,091,754	542,649,751	559,775,920	577,491,463
Net Inpatient Revenue		$316,619,003	$359,609,178	$341,380,792	$341,573,680	$344,227,312	$352,867,418	$361,724,390	$370,803,672	$380,110,844	$389,651,626
Net Outpatient Revenue		$138,745,464	$152,970,931	$152,711,113	$152,242,187	$150,372,187	$157,214,122	$164,367,364	$171,846,079	$179,665,076	$187,839,837
Net Patient Revenue before Bad Debt		$455,364,467	$512,580,109	$494,091,905	$493,815,867	$494,599,499	$510,081,539	$526,091,754	$542,649,751	$559,775,920	$577,491,463
Growth		*n/a*	*12.6%*	*(3.6%)*	*(0.1%)*	*0.2%*	*3.1%*	*3.1%*	*3.1%*	*3.2%*	*3.2%*
	NBY % of Total Gross Charges										
Bad Debt	0.1%	(14,573,495)	(14,301,275)	(10,016,605)	(2,546,776)	(3,132,257)	(3,230,786)	(3,332,694)	(3,438,107)	(3,547,156)	(3,659,977)
Growth		*n/a*	*(1.9%)*	*(30.0%)*	*(74.6%)*	*23.0%*	*3.1%*	*3.2%*	*3.2%*	*3.2%*	*3.2%*
Total Net Patient Revenue		440,790,972	498,278,834	484,075,300	491,269,091	491,467,242	506,850,753	522,759,060	539,211,644	556,228,764	573,831,486
Growth		*n/a*	*13.0%*	*(2.9%)*	*1.5%*	*0.0%*	*3.1%*	*3.1%*	*3.1%*	*3.2%*	*3.2%*
Supplemental Payments											
Medicaid DSH	*No Growth*	8,436,631	7,962,995	7,402,065	7,203,734	7,203,734	7,203,734	7,203,734	7,203,734	7,203,734	7,203,734
Medicaid Supplemental - Income Provider	*No Growth*	62,013,094	68,421,637	67,523,469	97,750,754	69,615,975	69,615,975	69,615,975	69,615,975	69,615,975	69,615,975
Medicaid Supplemental - Assessment Provider	*No Growth*	(26,897,084)	(30,390,480)	(21,947,306)	(33,794,251)	(24,649,540)	(24,649,540)	(24,649,540)	(24,649,540)	(24,649,540)	(24,649,540)
Electronic Health Record Incentives	*No Growth*	1,020,542	497,371	301,700	301,700	301,700	301,700	301,700	301,700	301,700	301,700
Total		44,573,183	46,491,523	53,279,928	71,461,937	52,471,869	52,471,869	52,471,869	52,471,869	52,471,869	52,471,869
Growth		*n/a*	*4.3%*	*14.6%*	*34.1%*	*-26.6%*	-	-	-	-	-
Other Revenue											
Other Revenue	*Increase at CPI*	5,699,832	4,362,188	839,569	194,265	194,265	200,093	206,096	212,279	218,647	225,206
Total		5,699,832	4,362,188	839,569	194,265	194,265	200,093	206,096	212,279	218,647	225,206
Growth		*n/a*	*-23.5%*	*-80.8%*	*-76.9%*	*0.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*
Total Net Operating Revenue		**$491,063,987**	**$549,132,545**	**$538,194,797**	**$562,925,293**	**$544,133,376**	**$559,522,715**	**$575,437,025**	**$591,895,792**	**$608,919,280**	**$626,528,561**
Growth		*n/a*	*11.8%*	*(2.0%)*	*4.6%*	*(3.3%)*	*2.8%*	*2.8%*	*2.9%*	*2.9%*	*2.9%*

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REVENUE SUMMARY: *Footnotes:*	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5
Revenue:										
Total Patient Revenue	455,364,467	512,580,109	494,091,905	493,815,867	494,599,499	510,081,539	526,091,754	542,649,751	559,775,920	577,491,463
Bad Debt & Other Deductions	(14,573,495)	(14,301,275)	(10,016,605)	(2,546,776)	(3,132,257)	(3,230,786)	(3,332,694)	(3,438,107)	(3,547,156)	(3,659,977)
Supplemental Payments	44,573,183	46,491,523	53,279,928	71,461,937	52,471,869	52,471,869	52,471,869	52,471,869	52,471,869	52,471,869
Other Revenue	5,699,832	4,362,188	839,569	194,265	194,265	200,093	206,096	212,279	218,647	225,206
Total Net Operating Revenue	**$491,063,987**	**$549,132,545**	**$538,194,797**	**$562,925,293**	**$544,133,376**	**$559,522,715**	**$575,437,025**	**$591,895,792**	**$608,919,280**	**$626,528,561**
Growth	*n/a*	*11.8%*	*(2.0%)*	*4.6%*	*(3.3%)*	*2.8%*	*2.8%*	*2.9%*	*2.9%*	*2.9%*
Implied Volume Statistics										
Outpatient Equivalency Factor	1.42	1.42	1.46	1.45	1.45	1.46	1.47	1.48	1.49	1.50
Admissions	19,738	20,184	19,650	19,694	19,694	19,792	19,891	19,991	20,091	20,191
Growth	*n/a*	*2.3%*	*(2.6%)*	*0.2%*	*-*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*
Adj. Admissions	28,041	28,740	28,669	28,622	28,608	28,929	29,256	29,590	29,930	30,276
Growth	*n/a*	*2.5%*	*(0.2%)*	*(0.2%)*	*(0.1%)*	*1.1%*	*1.1%*	*1.1%*	*1.1%*	*1.2%*
Patient Days	88,855	97,083	92,724	92,271	92,271	92,732	93,196	93,662	94,130	94,601
Growth	*n/a*	*9.3%*	*(4.5%)*	*(0.5%)*	*-*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*
Adj. Patient Days	126,233	138,239	135,282	134,100	134,033	135,538	137,072	138,635	140,228	141,851
Growth	*n/a*	*9.5%*	*(2.1%)*	*(0.9%)*	*(0.1%)*	*1.1%*	*1.1%*	*1.1%*	*1.1%*	*1.2%*
Implied Reimbursement Statistics										
Net Patient Revenue per Adj. Admission	15,719	17,337	16,885	17,164	17,180	17,521	17,868	18,223	18,584	18,953
Growth	*n/a*	*10.3%*	*(2.6%)*	*1.7%*	*0.1%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Net Operating Revenue per Adj. Admission	17,512	19,107	18,773	19,668	19,021	19,341	19,669	20,003	20,345	20,694
Growth	*n/a*	*9.1%*	*(1.7%)*	*4.8%*	*(3.3%)*	*1.7%*	*1.7%*	*1.7%*	*1.7%*	*1.7%*
Net Patient Revenue per Adj. Patient Day	3,492	3,604	3,578	3,663	3,667	3,740	3,814	3,889	3,967	4,045
Growth	*n/a*	*3.2%*	*(0.7%)*	*2.4%*	*0.1%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Net Operating Revenue per Adj. Patient Day	3,890	3,972	3,978	4,198	4,060	4,128	4,198	4,269	4,342	4,417
Growth	*n/a*	*2.1%*	*0.2%*	*5.5%*	*(3.3%)*	*1.7%*	*1.7%*	*1.7%*	*1.7%*	*1.7%*

EXPENSE ASSUMPTIONS:	*Footnotes:*	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5
Operating Expenses:											
Employee Salaries & Wages											
Employee Salaries & Wages	*See Assumptions Summary*	$161,480,723	$190,660,210	$187,195,604	$186,925,096	$186,925,096	$194,695,301	$202,805,516	$211,271,423	$220,109,460	$229,336,865
Employee Benefits											
Payroll Taxes	*See Assumptions Summary*	11,763,690	14,067,020	13,885,432	13,998,001	13,998,001	14,579,878	15,187,216	15,821,191	16,483,033	17,174,032
Employee Benefits	*See Assumptions Summary*	32,383,647	35,607,391	36,987,851	37,264,605	37,577,605	39,139,651	40,770,050	42,471,954	44,248,667	46,103,655
Occupancy Costs											
Rent / Lease - Real Property	*Increase at CPI*	715,595	852,565	877,241	785,280	785,280	808,838	833,104	858,097	883,840	910,355
Utilities	*Increase at CPI*	3,899,993	3,330,300	3,499,157	3,678,255	3,678,255	3,788,603	3,902,261	4,019,329	4,139,908	4,264,106
Property Taxes	*Increase at CPI*	1,242,032	1,193,427	1,271,050	1,147,173	1,147,173	1,181,588	1,217,036	1,253,547	1,291,153	1,329,888
Supplies											
Medical Supplies	*See Assumptions Summary*	38,219,014	42,323,381	40,338,078	41,083,832	41,083,832	42,791,627	44,574,153	46,434,855	48,377,346	50,405,416
Drugs & Pharmaceuticals	*See Assumptions Summary*	26,510,658	30,850,978	30,247,697	31,110,577	31,110,577	32,403,798	33,753,609	35,162,619	36,633,563	38,169,311
Non-medical Supplies	*Increase at CPI*	5,721,203	4,824,614	4,536,075	4,518,902	4,518,902	4,654,469	4,794,103	4,937,926	5,086,064	5,238,646
Medical Costs											
Other Clinical Expenses	*% of Revenue*	15,880	10,538	1,173,820	1,403,631	1,403,631	1,443,329	1,484,381	1,526,838	1,570,751	1,616,175
Medical Fees	*% of Revenue*	22,918,405	28,155,709	32,217,548	34,086,074	34,086,074	35,050,106	36,047,024	37,078,049	38,144,449	39,247,545
Physician Income Assist	*% of Revenue*	1,531,647	1,490,747	1,974,964	2,002,993	2,002,993	2,059,642	2,118,224	2,178,810	2,241,474	2,306,295
Insurance											
Malpractice Insurance	*Increase at CPI*	3,986,073	7,591,366	6,394,474	5,692,256	5,692,256	5,863,024	6,038,914	6,220,082	6,406,684	6,598,885
Other Insurance	*Increase at CPI*	676,531	842,166	900,543	949,693	949,693	978,184	1,007,529	1,037,755	1,068,888	1,100,954
General & Administrative											
Advertising	*Increase at CPI*	1,391,452	1,554,035	1,466,182	1,110,287	1,110,287	1,143,596	1,177,903	1,213,241	1,249,638	1,287,127
Information Technology	*Increase at CPI*	7,562,988	8,179,456	9,697,950	9,480,068	9,480,068	9,764,470	10,057,404	10,359,126	10,669,900	10,989,997
Charitable Contributions	*% of Revenue*	864,838	1,145,921	972,447	1,561,160	1,561,160	1,605,313	1,650,973	1,698,194	1,747,036	1,797,558
Equipment Rent / Lease Expense	*% of Revenue*	953,797	1,584,208	1,502,505	1,330,460	1,330,460	1,368,088	1,407,001	1,447,244	1,488,868	1,531,924
Non-medical Professional Fees	*Increase at CPI*	3,217,597	3,291,038	4,713,103	4,299,393	4,299,393	4,428,375	4,561,226	4,698,063	4,839,005	4,984,175
Conifer Collection Fees	*% of Revenue*	12,705,711	13,447,841	13,027,365	13,114,847	13,114,847	13,485,765	13,869,336	14,266,029	14,676,334	15,100,758
License Fees	*Increase at CPI*	858,407	899,169	836,289	769,873	769,873	792,969	816,758	841,261	866,499	892,494
Other Controllable Expenses	*% of Revenue*	13,375,934	15,129,997	16,342,488	16,561,992	16,311,992	16,773,333	17,250,411	17,743,810	18,254,139	18,782,029
Other Non-medical Expenses	*Increase at CPI*	7,705,587	8,261,334	7,421,385	7,713,207	7,713,207	7,944,603	8,182,941	8,428,430	8,681,282	8,941,721
Repairs & Maintenance	*Increase at CPI*	7,551,948	8,056,848	8,639,898	9,273,933	9,273,933	9,552,151	9,838,716	10,133,877	10,437,893	10,751,030
Management Fees	*% of Revenue*	-	-	-	-	10,882,668	11,190,454	11,508,740	11,837,916	12,178,386	12,530,571
Physician Subsidy	*% of Revenue*	-	-	-	-	6,857,648	7,051,598	7,252,164	7,459,592	7,674,137	7,896,065
Total Operating Expenses		$367,253,350	$423,350,259	$426,119,146	$429,861,588	$447,664,904	$464,538,754	$482,106,693	$500,399,255	$519,448,398	$539,287,578
Growth		*n/a*	*15.3%*	*0.7%*	*0.9%*	*4.1%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*
Operating Expense Per Adj. Patient Day		$2,909	$3,062	$3,150	$3,206	$3,340	$3,427	$3,517	$3,609	$3,704	$3,802
Per Adj. Patient Day Growth		*n/a*	*5.3%*	*2.9%*	*1.8%*	*4.2%*	*2.6%*	*2.6%*	*2.6%*	*2.6%*	*2.6%*

DEPRECIATION SCHEDULE:		Projection Period				
		Year 1	Year 2	Year 3	Year 4	Year 5
Capital Expenditures Projection Detail (provided by Hospital Management):		*Note: Years 2018, 2019 and 2020 Capital Expenditures were provided by Management in the "3.0 DRMC Capital Plan.pptx" document. Years 2021 forward are projected as a percent of revenue at 2.5%.*				
Equipment - Replacement		2,386,000	2,374,000	-		
Business Development		2,217,000	1,500,000	3,380,000		
Facility Maintenance (Infrastructure)		3,077,000	4,860,000	2,700,000		
ALCM (Replacement Equipment and Replacement of Pumps)		3,200,000	3,279,000	4,050,000		
Other Capital		3,027,000	2,423,000	3,249,000		
Total Capital Expenditures		13,900,000	14,400,000	13,400,000	15,200,000	15,700,000
% of Revenue (Rounded)		*2.5%*	*2.5%*	*2.3%*	*2.5%*	*2.5%*
Depreciation Assumptions						
Net Initial Fixed Assets (Book Value) Less Land	$86,897,182					
Straight-line Depreciation Years (Initial Assets)	15.0					
Depreciation of Initial Net Fixed Assets		$5,793,145	$5,793,145	$5,793,145	$5,793,145	$5,793,145
Capital Expenditures per Year		13,900,000	14,400,000	13,400,000	15,200,000	15,700,000
Straight-line Depreciation Yrs (New Assets)	10.0	695,000	1,390,000	1,390,000	1,390,000	1,390,000
			720,000	1,440,000	1,440,000	1,440,000
				670,000	1,340,000	1,340,000
					760,000	1,520,000
						785,000
Total Depreciation		**6,488,145**	**7,903,145**	**9,293,145**	**10,723,145**	**12,268,145**

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	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Terminal Year
Hospital Operating Revenue																			
Net Inpatient Revenue	316,619,003	359,609,178	341,380,792	341,573,680	344,227,312	352,867,418	361,724,390	370,803,672	380,110,844	389,651,626									
Net Outpatient Revenue	138,745,464	152,970,931	152,711,113	152,242,187	150,372,187	157,214,122	164,367,364	171,846,079	179,665,076	187,839,837									
Net Patient Revenue before Bad Debt	455,364,467	512,580,109	494,091,905	493,815,867	494,599,499	510,081,539	526,091,754	542,649,751	559,775,920	577,491,463									
Bad Debt & Other Deductions	(14,573,495)	(14,301,275)	(10,016,605)	(2,546,776)	(3,132,257)	(3,230,786)	(3,332,694)	(3,438,107)	(3,547,156)	(3,659,977)									
Total Net Patient Revenue	440,790,972	498,278,834	484,075,300	491,269,091	491,467,242	506,850,753	522,759,060	539,211,644	556,228,764	573,831,486									
Supplemental Payments	44,573,183	46,491,523	53,279,928	71,461,937	52,471,869	52,471,869	52,471,869	52,471,869	52,471,869	52,471,869									
Other Revenue	$5,699,832	$4,362,188	$839,569	$194,265	$194,265	$200,093	$206,096	$212,279	$218,647	$225,206									
Total Net Operating Revenue	**491,063,987**	**549,132,545**	**538,194,797**	**562,925,293**	**544,133,376**	**559,522,715**	**575,437,025**	**591,895,792**	**608,919,280**	**626,528,561**	**645,324,418**	**664,684,150**	**684,624,675**	**705,163,415**	**726,318,318**	**748,107,867**	**770,551,103**	**793,667,636**	**817,477,665**
Growth %	n/a	11.8%	(2.0%)	4.6%	(3.3%)	2.8%	2.8%	2.9%	2.9%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Operating Expenses:																			
Employee Salaries & Wages	161,480,723	190,660,210	187,195,604	186,925,096	186,925,096	194,695,301	202,805,516	211,271,423	220,109,460	229,336,865									
Employee Benefits	44,147,337	49,674,411	50,873,283	51,262,606	51,575,606	53,719,529	55,957,266	58,293,145	60,731,700	63,277,687									
Occupancy Costs	5,857,620	5,376,292	5,647,448	5,610,708	5,610,708	5,779,029	5,952,400	6,130,972	6,314,901	6,504,348									
Supplies	70,450,875	77,998,973	75,121,850	76,713,311	76,713,311	79,849,895	83,121,865	86,535,399	90,096,973	93,813,373									
Medical Costs	24,465,932	29,656,994	35,366,332	37,492,698	37,492,698	38,553,077	39,649,629	40,783,696	41,956,674	43,170,015									
Insurance	4,662,604	8,433,532	7,295,017	6,641,949	6,641,949	6,841,207	7,046,444	7,257,837	7,475,572	7,699,839									
General & Administrative	56,188,259	61,549,847	64,619,612	65,215,220	82,705,536	85,100,715	87,573,573	90,126,783	92,763,117	95,485,449									
Total Operating Expenses	367,253,350	423,350,259	426,119,146	429,861,588	447,664,904	464,538,754	482,106,693	500,399,255	519,448,398	539,287,578									
Growth %	n/a	15.3%	0.7%	0.9%	4.1%	3.8%	3.8%	3.8%	3.8%	3.8%									
EBITDA	**123,810,637**	**125,782,286**	**112,075,651**	**133,063,705**	**96,468,473**	**94,983,961**	**93,330,331**	**91,496,537**	**89,470,882**	**87,240,983**	**89,858,213**	**92,553,959**	**95,330,578**	**98,190,495**	**101,136,210**	**104,170,297**	**107,295,406**	**110,514,268**	**113,829,696**
EBITDA %	25.2%	22.9%	20.8%	23.6%	17.7%	17.0%	16.2%	15.5%	14.7%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%
Depreciation & Amortization Expense	14,211,402	14,814,437	15,734,886	15,442,515	15,442,515	6,488,145	7,903,145	9,293,145	10,723,145	12,268,145	13,859,801	15,497,312	17,183,948	18,226,183	18,600,535	13,260,422	13,728,746	14,139,019	19,757,394
Operating Income	109,599,235	110,967,849	96,340,765	117,621,190	81,025,958	88,495,816	85,427,186	82,203,392	78,747,737	74,972,838	75,998,412	77,056,648	78,146,630	79,964,313	82,535,675	90,909,874	93,566,660	96,375,248	94,072,301
Other Income (Expense)	(221,558)	(254,082)	(107,895)	(540)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Interest Expense	286,732	362,552	395,400	393,811	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Earnings Before Income Taxes	109,090,945	110,351,215	95,837,470	117,226,839	81,025,958	88,495,816	85,427,186	82,203,392	78,747,737	74,972,838	75,998,412	77,056,648	78,146,630	79,964,313	82,535,675	90,909,874	93,566,660	96,375,248	94,072,301
Federal & State Income Tax Expense @ 28.0%	-	-	-	-	22,673,980	24,764,315	23,905,602	23,003,468	22,036,452	20,980,099	21,267,092	21,563,224	21,868,240	22,376,893	23,096,453	25,439,856	26,183,320	26,969,264	26,324,817
Earnings After Income Taxes	109,090,945	110,351,215	95,837,470	117,226,839	58,351,978	63,731,501	61,521,584	59,199,923	56,711,285	53,992,739	54,731,320	55,493,424	56,278,390	57,587,419	59,439,222	65,470,019	67,383,340	69,405,984	67,747,485

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DISCOUNTED CASH FLOW ANALYSIS - INCOME APPROACH

FINAL REPORT

	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Terminal Year
Earnings After Income Taxes	109,090,945	110,351,215	95,837,470	117,226,839	58,351,978	63,731,501	61,521,584	59,199,923	56,711,285	53,992,739	54,731,320	55,493,424	56,278,390	57,587,419	59,439,222	65,470,019	67,383,340	69,405,984	67,747,485
Cash Flow Adjustments:																			
Plus: Depreciation & Amortization						6,488,145	7,903,145	9,293,145	10,723,145	12,268,145	13,859,801	15,497,312	17,183,948	18,226,183	18,600,535	13,260,422	13,728,746	14,139,019	19,757,394
Less: Required Annual Capital Expenditures						(13,900,000)	(14,400,000)	(13,400,000)	(15,200,000)	(15,700,000)	(16,133,110)	(16,617,104)	(17,115,617)	(17,629,085)	(18,157,958)	(18,702,697)	(19,263,778)	(19,841,691)	(19,757,394)
Less: Incremental Working Capital Requirements						(1,231,147)	(1,273,145)	(1,316,701)	(1,361,879)	(1,408,742)	(1,503,669)	(1,548,779)	(1,595,242)	(1,643,099)	(1,692,392)	(1,743,164)	(1,795,459)	(1,849,323)	(1,904,802)
Net Discretionary Cash Flow						55,088,499	53,751,585	53,776,367	50,872,552	49,152,142	50,954,342	52,824,853	54,751,479	56,541,417	58,189,407	58,284,580	60,052,849	61,853,990	65,842,682
Terminal Value																			731,585,361
						0.5	1.5	2.5	3.5	4.5	5.5	6.5	7.5	8.5	9.5	10.5	11.5	12.5	12.5
Present Value Factor (mid-point convention)						0.9449	0.8437	0.7533	0.6726	0.6005	0.5362	0.4787	0.4274	0.3816	0.3407	0.3042	0.2716	0.2425	0.2425
Present Value of Cash Flows						52,053,739	45,348,637	40,508,523	34,215,307	29,516,261	27,320,087	25,288,388	23,402,415	21,578,115	19,827,717	17,732,274	16,312,719	15,001,768	177,435,177

Sum of Present Values (Year 1 to Year 13)	368,105,950
Present Value of Terminal	177,435,177
Fair Market Value Indication (Business Enterprise Level)	**$545,541,127**

Net Fixed Assets & Normalized Working Capital Value	136,600,000				
Indicated Intangible Asset Value	408,941,127				
Tax Amortization Benefit	63,533,379				
Fair Market Value Indication (Business Enterprise Level) with Tax Amortization Benefit	**$610,000,000**	**6.4x**	**Year 1 EBITDA**	**1.1x**	**Year 1 Revenue**

Terminal Growth Rate \ Discount Rate	11.0%	11.5%	12.0%	12.5%	13.0%
2.5%	670,000,000	630,000,000	600,000,000	570,000,000	540,000,000
3.0%	690,000,000	**650,000,000**	**610,000,000**	**580,000,000**	550,000,000
3.5%	700,000,000	660,000,000	620,000,000	590,000,000	560,000,000

DESERT REGIONAL MEDICAL CENTER
DISCOUNTED CASH FLOW ANALYSIS - INCOME APPROACH

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		FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Terminal Year
Hospital Operating Revenue																				
Net Inpatient Revenue		64.5%	65.5%	63.4%	60.7%	63.3%	63.1%	62.9%	62.6%	62.4%	62.2%									
Net Outpatient Revenue		28.3%	27.9%	28.4%	27.0%	27.6%	28.1%	28.6%	29.0%	29.5%	30.0%									
Net Patient Revenue before Bad Debt		92.7%	93.3%	91.8%	87.7%	90.9%	91.2%	91.4%	91.7%	91.9%	92.2%									
Bad Debt & Other Deductions		(3.0%)	(2.6%)	(1.9%)	(0.5%)	(0.6%)	(0.6%)	(0.6%)	(0.6%)	(0.6%)	(0.6%)									
Total Net Patient Revenue		89.8%	90.7%	89.9%	87.3%	90.3%	90.6%	90.8%	91.1%	91.3%	91.6%									
Supplemental Payments		9.1%	8.5%	9.9%	12.7%	9.6%	9.4%	9.1%	8.9%	8.6%	8.4%									
Other Revenue		1.2%	0.8%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%									
Total Net Operating Revenue		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Operating Expenses:																				
Employee Salaries & Wages		32.9%	34.7%	34.8%	33.2%	34.4%	34.8%	35.2%	35.7%	36.1%	36.6%									
Employee Benefits		9.0%	9.0%	9.5%	9.1%	9.5%	9.6%	9.7%	9.8%	10.0%	10.1%									
Occupancy Costs		1.2%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%									
Supplies		14.3%	14.2%	14.0%	13.6%	14.1%	14.3%	14.4%	14.6%	14.8%	15.0%									
Medical Costs		5.0%	5.4%	6.6%	6.7%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%									
Insurance		0.9%	1.5%	1.4%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%									
General & Administrative		11.4%	11.2%	12.0%	11.6%	15.2%	15.2%	15.2%	15.2%	15.2%	15.2%									
Total Operating Expenses		74.8%	77.1%	79.2%	76.4%	82.3%	83.0%	83.8%	84.5%	85.3%	86.1%									
EBITDA		25.2%	22.9%	20.8%	23.6%	17.7%	17.0%	16.2%	15.5%	14.7%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%
Depreciation & Amortization Expense		2.9%	2.7%	2.9%	2.7%	2.8%	1.2%	1.4%	1.6%	1.8%	2.0%	2.1%	2.3%	2.5%	2.6%	2.6%	1.8%	1.8%	1.8%	2.4%
Operating Income		22.3%	20.2%	17.9%	20.9%	14.9%	15.8%	14.8%	13.9%	12.9%	12.0%	11.8%	11.6%	11.4%	11.3%	11.4%	12.2%	12.1%	12.1%	11.5%
Other Income (Expense)		(0.0%)	(0.0%)	(0.0%)	(0.0%)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Interest Expense		0.1%	0.1%	0.1%	0.1%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Earnings Before Income Taxes		22.2%	20.1%	17.8%	20.8%	14.9%	15.8%	14.8%	13.9%	12.9%	12.0%	11.8%	11.6%	11.4%	11.3%	11.4%	12.2%	12.1%	12.1%	11.5%
Federal & State Income Tax Expense @	28.0%	-	-	-	-	4.2%	4.4%	4.2%	3.9%	3.6%	3.3%	3.3%	3.2%	3.2%	3.2%	3.2%	3.4%	3.4%	3.4%	3.2%
Earnings After Income Taxes		22.2%	20.1%	17.8%	20.8%	10.7%	11.4%	10.7%	10.0%	9.3%	8.6%	8.5%	8.3%	8.2%	8.2%	8.2%	8.8%	8.7%	8.7%	8.3%

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US$ in thousands

BETA CALCULATION

Ticker	Company Name	Levered 5 Year [1]	S&P Credit Rating	Market Capitalization	Total Debt	Cash & ST Investments	Minority Interest	Preferred Equity	Debt/ BEV[2]	Debt/ Equity	Effective Tax Rate	Unlevered Beta
CYH	Community Health Systems, Inc.	1.058	CCC+	$340,818	$13,715,000	$208,000	$590,000	-	93.6%	1473.4%	n/a	
HCA	HCA Healthcare, Inc.	0.634	BB+	$44,401,162	$33,192,000	$913,000	$1,864,000	-	41.8%	71.7%	33.1%	0.423
LPNT	LifePoint Health, Inc.	0.661	BB-	$2,499,732	$2,928,400	$143,800	$135,400	-	52.6%	111.1%	28.5%	0.342
QHC	Quorum Health Corporation	0.389	B-	$120,236	$1,199,412	$2,822	$17,013	-	89.7%	873.9%	n/a	
THC	Tenet Healthcare Corporation	1.181	B	$3,276,718	$14,867,000	$403,000	$2,159,000	-	73.2%	273.5%	45.0%	0.472
UHS	Universal Health Services, Inc.	0.603	BB+	$11,467,395	$3,990,464	$76,886	$78,968	-	25.7%	34.6%	29.1%	0.480
Average		**0.754**										**0.429**
Median		**0.647**										**0.448**

Average Unlevered Beta for Comps	0.429
D/E, Target Company	66.7%
Federal & State Income Tax Expense	28.0%
Re-Levered Beta, Subject Company[4]	**0.635**

WACC

	Market Risk Premium (RM)[5]	6.0%
x	Subject Company Re-levered Beta	0.635
=	Adjusted Market Risk Premium	3.8%
+	Risk-Free Rate of Return (RF)[6]	3.1%
+	Size Premium[7]	5.6%
+	Specific Company Risk Premium[8]	5.0%
=	**Cost of Equity**	**17.5%**
x	Equity as a Percent of Total Capital	60.0%
=	**Cost of Equity Portion**	**10.5%**
	Cost of Debt[9]	4.8%
x	Tax Rate[10]	28.0%
=	**After-Tax Cost of Debt**	**3.5%**
x	Debt as a Percent of Total Capital	40.0%
=	**Cost of Debt Portion**	**1.4%**

WACC	11.9%
Selected WACC	12.0%

Footnotes:

(1) *Capital IQ- Levered Beta 5 Year computed taking the slope of a weekly regression line of the percentage change of the stock relative to the percentage price change in the S&P 500 as of August 22, 2018.*

(2) *Capital IQ- average of public companies debt structure as of August 22, 2018.*

(3) *Unlevered Beta = Levered Beta / (1 + ((D/E) * (1 - T)) + P/E)*

(4) *Re-levered Beta = Unlevered Beta * (1 + ((D/E) * (1 - T)) + P/E)*

(5) *The equity risk premium of 6.0% was selected based upon VMG's review of published articles and academic studies that attempt to quantify the expected market risk premium for U.S. common stocks by utilizing both historical and forward-looking sources. The selected 6.0% equity risk premium was considered to reasonably represent a consensus viewpoint of the market equity risk premium.*

(6) *Yield of 20-year U.S. Treasury securities as of August 22, 2018, as published by Federal Reserve Statistical Release.*

(7) *Duff & Phelps: 2017 Valuation Handbook, Market Cap*

(8) *Risk associated with the specific operations of the company or the "unsystematic" risk of the company.*

(9) *Moody's yield on seasoned corporate bonds, rating Baa as of August 22, 2018, as published by Capital IQ.*

(10) *Blended State and Federal Tax rate for California.*

Company Specific Risk Premium	*Capital Structure (Debt to BEV)*		
	40.0%	50.0%	60.0%
4.0%	11.3%	10.0%	8.7%
5.0%	11.9%	10.5%	9.1%
6.0%	12.5%	11.0%	9.5%
7.0%	13.1%	11.5%	9.9%

Desert Regional Medical Center

Market Approach Analysis

DESERT REGIONAL MEDICAL CENTER
MARKET APPROACH INDICATION - SUMMARY

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Multiple	Range of Multiple Selections (Control Level)			Year 1	Value Indication (Rounded)		
	Low		High		Low		High
BEV/Revenue	1.1x	to	1.3x	$506,850,753	$560,000,000	to	$660,000,000
BEV/EBITDA	5.5x	to	7.5x	$94,983,961	$520,000,000	to	$710,000,000
Selected Multiple Range					$ 520,000,000	to	$ 710,000,000
Midpoint (BEV/EBITDA) & (BEV/Revenue)					$610,000,000		

VMG Complete Data Set

Metric	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	0.6x	8.6x
Mean	0.7x	8.8x
25th Percentile	0.4x	7.0x
75th Percentile	1.0x	9.9x
High	1.7x	20.4x
Low	0.1x	0.8x
Number of Observations with Reported Statistics	119	70

State of California Transactions

	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	0.7x	n/a
Mean	0.7x	n/a
25th Percentile	0.7x	n/a
75th Percentile	0.7x	n/a
High	0.7x	n/a
Low	0.7x	n/a
Number of Observations with Reported Statistics	1	n/a

EBITDA Margin Greater than 5.0%

Metric	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	0.7x	8.4x
Mean	0.8x	8.2x
25th Percentile	0.6x	6.7x
75th Percentile	1.1x	9.4x
High	1.7x	20.4x
Low	0.1x	0.8x
Number of Observations with Reported Statistics	53	51

EBITDA Margin Greater than 10.0%

Metric	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	1.0x	7.9x
Mean	1.0x	7.4x
25th Percentile	0.8x	6.2x
75th Percentile	1.3x	8.9x
High	1.7x	10.7x
Low	0.1x	0.8x
Number of Observations with Reported Statistics	26	24

EBITDA Margin Greater than 15.0%

Metric	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	1.3x	7.6x
Mean	1.1x	6.9x
25th Percentile	0.6x	5.3x
75th Percentile	1.4x	8.7x
High	1.7x	9.6x
Low	0.1x	3.3x
Number of Observations with Reported Statistics	10	8

VMG Observations:

1) Limited information was available for transactions occurring in California.
2) VMG's Complete data set was reviewed and eliminated to determine the impact of the acquired hospital's EBITDA margin (as reported) on the reported transaction multiples (BEV / Revenue and BEV / EBITDA).
3) As EBITDA margins increase from at least 5.0%, at least 10.0%, and to at least 15.0%, the BEV / Revenue multiples show an upward trend.
4) As EBITDA margins increase from at least 5.0%, at least 10.0%, and to at least 15.0%, the BEV / EBITDA multiples show a downward trend.

Notes & Sources

Source: Irving Levin Associates, Capital IQ, online articles and VMG internal data. Data set includes transactions that occurred from January 01, 2014 to June 30, 2018.

DESERT REGIONAL MEDICAL CENTER
PUBLIC GUIDELINE COMPANY COMPARABLES

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Capitalization Data

Company Name	Ticker	Market Capitalization	Total Debt	Minority Interest	Preferred Equity	Cash & Short-Term Investments	Business Enterprise Value
Community Health Systems, Inc.	CYH	$340,818	$13,715,000	$590,000	-	$208,000	$14,437,818
HCA Healthcare, Inc.	HCA	$44,401,162	$33,192,000	$1,864,000	-	$913,000	$78,544,162
LifePoint Health, Inc.	LPNT	$2,499,732	$2,928,400	$135,400	-	$143,800	$5,419,732
Quorum Health Corporation	QHC	$120,236	$1,199,412	$17,013	-	$2,822	$1,333,839
Tenet Healthcare Corporation	THC	$3,276,718	$14,867,000	$2,159,000	-	$403,000	$19,899,718
Universal Health Services, Inc.	UHS	$11,467,395	$3,990,464	$78,968	-	$76,886	$15,459,941

		Operating Revenue			*Operating EBITDA*		
Company Name	Ticker	TTM Revenue	FY + 1 Revenue	FY + 2 Revenue	TTM EBITDA	FY + 1 EBITDA	FY + 2 EBITDA
Community Health Systems, Inc.	CYH	$13,975,000	$13,923,850	$13,220,249	$825,000	$1,603,707	$1,552,429
HCA Healthcare, Inc.	HCA	$45,210,000	$46,199,801	$48,372,743	$8,481,000	$8,768,293	$9,239,939
LifePoint Health, Inc.	LPNT	$6,239,000	$6,304,101	$6,427,871	$660,700	$741,383	$763,346
Quorum Health Corporation	QHC	$1,858,462	$1,944,077	$1,982,244	$80,722	$148,978	$169,200
Tenet Healthcare Corporation	THC	$18,769,000	$18,140,912	$18,028,498	$2,663,000	$2,602,447	$2,655,960
Universal Health Services, Inc.	UHS	$10,553,520	$10,819,941	$11,348,893	$1,701,019	$1,770,035	$1,872,305

Implied Multiples

Company Name	Ticker	TTM Revenue	FY + 1 Revenue	FY + 2 Revenue	TTM EBITDA	FY + 1 EBITDA	FY + 2 EBITDA
Community Health Systems, Inc.	CYH	1.0x	1.0x	1.1x	17.5x	9.0x	9.3x
HCA Healthcare, Inc.	HCA	1.7x	1.7x	1.6x	9.3x	9.0x	8.5x
LifePoint Health, Inc.	LPNT	0.9x	0.9x	0.8x	8.2x	7.3x	7.1x
Quorum Health Corporation	QHC	0.7x	0.7x	0.7x	16.5x	9.0x	7.9x
Tenet Healthcare Corporation	THC	1.1x	1.1x	1.1x	7.5x	7.6x	7.5x
Universal Health Services, Inc.	UHS	1.5x	1.4x	1.4x	9.1x	8.7x	8.3x
Market Multiples	*Mean:*	*1.1 x*	*1.1 x*	*1.1 x*	*11.3 x*	*8.4 x*	*8.1 x*
	Median:	*1.0 x*	*1.1 x*	*1.1 x*	*9.2 x*	*8.8 x*	*8.1 x*
Market Multiples - Excluding CYH & QHC	*Mean:*	*1.3 x*	*1.3 x*	*1.2 x*	*8.5 x*	*8.2 x*	*7.8 x*
	Median:	*1.3 x*	*1.3 x*	*1.2 x*	*8.6 x*	*8.2 x*	*7.9 x*

Footnotes:

1) *Source: Capital IQ as of August 22, 2018.*
2) *Business Enterprise Value ("BEV") is defined as Market Value of Equity plus Interest-bearing Debt and minority interest less Cash and Cash Equivalents.*

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Revenue Growth								
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	Mean	Median
FYE - 2	4.3%	7.5%	16.3%	2.0%	12.2%	10.2%	8.7%	8.8%
FYE - 1	(5.1%)	4.6%	22.0%	(2.2%)	5.3%	8.0%	5.4%	4.9%
FYE	(16.7%)	5.1%	(1.1%)	(3.1%)	(2.3%)	6.6%	(1.9%)	(1.7%)
TTM	(9.0%)	3.7%	(0.8%)	(10.3%)	(2.1%)	1.4%	(2.9%)	(1.5%)
Year 1	(0.4%)	2.2%	1.0%	4.6%	(3.3%)	2.5%	1.1%	1.6%
Year 2	(5.1%)	4.7%	2.0%	2.0%	(0.6%)	4.9%	1.3%	2.0%
Year 3	0.9%	4.7%	1.0%	0.9%	3.9%	4.0%	2.5%	2.4%

EBITDA Growth								
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	Mean	Median
FYE - 2	(3.7%)	6.6%	16.7%	(2.7%)	17.7%	12.4%	7.8%	9.5%
FYE - 1	(17.0%)	3.8%	8.7%	(53.2%)	6.3%	2.4%	(8.2%)	3.1%
FYE	(54.8%)	0.2%	(8.5%)	(12.8%)	(1.6%)	1.8%	(12.6%)	(5.0%)
TTM	(10.0%)	3.0%	(1.3%)	(16.3%)	10.8%	(1.6%)	(2.6%)	(1.4%)
Year 1	94.4%	3.4%	12.2%	84.6%	(2.3%)	4.1%	32.7%	8.1%
Year 2	(3.2%)	5.4%	3.0%	13.6%	2.1%	5.8%	4.4%	4.2%
Year 3	(0.9%)	4.7%	(0.4%)	0.8%	3.6%	3.7%	1.9%	2.2%

EBITDA Margins								
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	Mean	Median
FYE - 2	12.6%	19.9%	12.9%	10.8%	12.3%	18.3%	14.5%	12.7%
FYE - 1	11.0%	19.8%	11.5%	5.2%	12.4%	17.4%	12.9%	12.0%
FYE	6.0%	18.9%	10.6%	4.7%	12.5%	16.6%	11.5%	11.6%
TTM	5.9%	18.8%	10.6%	4.3%	14.2%	16.1%	11.7%	12.4%
Year 1	11.5%	19.0%	11.8%	7.7%	14.3%	16.4%	13.4%	13.1%
Year 2	11.7%	19.1%	11.9%	8.5%	14.7%	16.5%	13.7%	13.3%
Year 3	11.5%	19.1%	11.7%	8.5%	14.7%	16.4%	13.7%	13.2%

Capital Expenditures as a % of Revenue								
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	Mean	Median
FYE - 3	4.6%	5.9%	4.6%	3.2%	5.6%	4.8%	4.8%	4.7%
FYE - 2	4.9%	6.0%	5.3%	2.7%	4.5%	4.2%	4.6%	4.7%
FYE - 1	4.0%	6.7%	6.3%	3.7%	4.5%	5.3%	5.1%	4.9%
FYE	3.7%	6.9%	7.5%	3.0%	3.7%	5.6%	5.1%	4.6%
TTM	4.2%	7.3%	7.3%	2.6%	3.3%	6.5%	5.2%	5.4%

Net Working Capital (Including Cash) as a % of Revenue								
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	Mean	Median
FYE - 3	11.9%	10.3%	14.7%	13.9%	3.0%	6.1%	10.0%	11.1%
FYE - 2	12.0%	10.0%	12.9%	15.6%	5.3%	7.6%	10.6%	11.0%
FYE - 1	12.1%	8.4%	8.6%	13.0%	7.2%	4.8%	9.0%	8.5%
FYE	11.4%	9.2%	8.6%	10.7%	7.2%	4.8%	8.7%	8.9%
TTM	12.0%	9.9%	9.8%	9.9%	5.4%	5.3%	8.7%	9.8%

Cash Free Net Working Capital as a % of Revenue								
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	Mean	Median
FYE - 3	9.1%	8.6%	10.4%	13.8%	1.9%	5.7%	8.2%	8.8%
FYE - 2	11.0%	8.0%	7.4%	15.6%	3.4%	6.9%	8.7%	7.7%
FYE - 1	10.8%	6.7%	7.1%	11.8%	3.6%	4.5%	7.4%	6.9%
FYE	7.7%	7.4%	6.8%	10.5%	4.0%	4.0%	6.8%	7.1%
TTM	10.5%	7.8%	7.5%	9.7%	3.3%	4.6%	7.2%	7.7%

Capital Structure - Debt / BEV								
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	Mean	Median
FYE - 3	71.2%	47.1%	39.4%	n/a	67.8%	22.5%	49.6%	47.1%
FYE - 2	81.6%	51.2%	44.4%	n/a	72.3%	22.2%	54.4%	51.2%
FYE - 1	92.2%	51.6%	54.4%	84.1%	77.1%	28.5%	64.6%	65.7%
FYE	92.8%	50.1%	57.6%	85.5%	78.5%	27.2%	65.3%	68.1%
TTM	93.6%	41.8%	52.6%	89.7%	73.2%	25.7%	62.8%	62.9%

Additional Comparable Data (as a % of FYE Revenue)								
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	Mean	Median
SW&B	47.7%	46.1%	48.1%	55.7%	47.5%	48.4%	48.9%	47.9%
Supplies	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
COGS	65.1%	62.8%	67.8%	67.8%	63.8%	59.2%	64.4%	64.4%
SG&A	2.5%	n/a	1.1%	3.2%	1.7%	1.0%	1.9%	1.7%
D&A	5.4%	4.9%	5.4%	4.0%	4.4%	4.2%	4.7%	4.6%

Footnotes:

1) Source: Capital IQ as of August 22, 2018.

Guideline Company	Company Description
CYH	Community Health Systems, Inc., together with its subsidiaries, owns, leases, and operates general acute care hospitals in the United States. It offers general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric, and rehabilitation services, as well as skilled nursing and home care services. The company also provides outpatient services at urgent care centers, occupational medicine clinics, imaging centers, cancer centers, ambulatory surgery centers, and home health and hospice agencies. As of December 31, 2016, it owned or leased 155 hospitals, including 152 general acute care hospitals and 3 stand-alone rehabilitation or psychiatric hospitals with an aggregate of 26,222 licensed beds in 21 states. The company was founded in 1985 and is headquartered in Franklin, Tennessee.
HCA	HCA Healthcare, Inc., through its subsidiaries, provides health care services in the United States and England. The company operates general, acute care hospitals that offer medical and surgical services, including inpatient care, intensive care, cardiac care, diagnostic, and emergency services; and outpatient services, such as outpatient surgery, laboratory, radiology, respiratory therapy, cardiology, and physical therapy services. It also operates psychiatric hospitals, which provide therapeutic programs comprising child, adolescent and adult psychiatric care, and adolescent and adult alcohol and drug abuse treatment and counseling. In addition, the company operates outpatient health care facilities consisting of freestanding ambulatory surgery centers, freestanding emergency care facilities, urgent care facilities, walk-in clinics, diagnostic and imaging centers, rehabilitation and physical therapy centers, radiation and oncology therapy centers, physician practices, and various other facilities. As of September 30, 2017, it owned and operated 177 hospitals and 119 freestanding surgery centers. The company was formerly known as HCA Holdings, Inc. HCA Healthcare, Inc. was founded in 1968 and is headquartered in Nashville, Tennessee.
LPNT	LifePoint Health, Inc., through its subsidiaries, owns and operates community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities in the United States. Its hospitals offer a range of medical and surgical services, such as general surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care, rehabilitation, and pediatric services, as well as specialized services, including open-heart surgery, skilled nursing, psychiatric care, and neuro-surgery. The company's hospitals also provide various outpatient services comprising same-day surgery, laboratory, X-ray, respiratory therapy, imaging, sports medicine, and lithotripsy. In addition, it owns and operates schools of nursing and other allied health professions. As of December 31, 2016, the company operated 72 hospital campuses, including 9,424 licensed beds in 22 states. The company was formerly known as LifePoint Hospitals, Inc. and changed its name to LifePoint Health, Inc. in May 2015. LifePoint Health, Inc. was founded in 1997 and is based in Brentwood, Tennessee.
QHC	Quorum Health Corporation provides hospital and outpatient healthcare services in the United States. Its general hospital and outpatient healthcare services include general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetric, diagnostic, psychiatric, and rehabilitation services. Quorum Health Corporation offers its healthcare services through its hospitals and affiliated facilities, including urgent care centers, diagnostic and imaging centers, physician clinics, and surgery centers. The company, through its subsidiary, Quorum Health Resources, LLC, provides management advisory and consulting services to non-affiliated hospitals. As of January 5, 2018, it owned or leased 31 hospitals with an aggregate of approximately 3,000 licensed beds. The company was incorporated in 2015 and is headquartered in Brentwood, Tennessee.
THC	Tenet Healthcare Corporation, together with its subsidiaries, operates as a diversified healthcare services company. It operates in three segments: Hospital Operations and Other, Ambulatory Care, and Conifer. The company's general hospitals offer acute care services, operating and recovery rooms, radiology and respiratory therapy services, clinical laboratories, and pharmacies. It also provides intensive and critical care, and coronary care units; physical therapy, orthopedic, oncology, and outpatient services; tertiary care services, including open-heart surgery, neonatal intensive care, and neurosciences; quaternary care in heart, liver, kidney, and bone marrow transplants areas; tertiary and quaternary pediatric, and burn services; and limb-salvaging vascular procedures, acute level 1 trauma services, intravascular stroke care, minimally invasive cardiac valve replacement, imaging technology, and telemedicine access for various medical specialties. In addition, the company offers ambulatory surgery and urgent care centers, imaging centers, and short-stay surgical hospitals, as well as Aspen's hospitals and clinics; healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions; and microhospitals, physician practices, and health plans. Further, it provides accounts receivable and health information management, and revenue integrity and patient financial services; patient communications and engagement services; and clinical integration, financial risk management, and population health management services. As of February 27, 2017, the company operated 80 general acute care hospitals, 20 short-stay surgical hospitals, and approximately 470 outpatient centers, as well as 239 ambulatory surgery, 34 urgent care, and 21 imaging centers in the United States; and 9 private hospitals and clinics in the United Kingdom. Tenet Healthcare Corporation was founded in 1967 and is headquartered in Dallas, Texas.
UHS	Universal Health Services, Inc., through its subsidiaries, owns and operates acute care hospitals, behavioral health facilities, and ambulatory centers. The company's hospitals offer general and specialty surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care, pediatric services, pharmacy services, and/or behavioral health services. As of February 28, 2017, it owned and/or operated 26 inpatient acute care hospitals, 4 free-standing emergency departments, 1 surgical hospital, and 319 inpatient and 33 outpatient behavioral health care facilities located in 37 states, Washington, D.C.; the United Kingdom; Puerto Rico; and the U.S. Virgin Islands. The company was founded in 1978 and is headquartered in King of Prussia, Pennsylvania.

Source: Capital IQ as of August 22, 2018.

Desert Regional Medical Center

Supplemental Exhibits

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**The list of services below was provided to VMG by Tenet*

Directly Charged Corporate Services - Potentially Included in EBITDA

Accounting & Tax
- Annual audit support
- Property taxes and appeals
- Physical asset inventory
- Records retention

Conifer Health Solutions
- Patient access
- Billing
- Call center and patient communications
- Collections
- Claim adjudication
- Claim follow-up
- Maintenance of systems & applications
- Patient & physician satisfaction management and reporting
- Performance analysis and reporting

Contracted Services
- Food and nutrition services (Sodexo or Morrison)
- Environmental services (Crothall or Aramark)
- Security (US security or Universal Protection)
- Document management (Dex Imaging)
- Dialysis (Davita or Fresenius)
- Waste management
- Linen

Human Resources
- Applicant tracking and background screening
- Health insurance and benefit plans
- Human resources business systems
- Recruitment and retention
- Labor relations
- Learning and development tools (includes .edu)
- Worker's compensation
- 401(k) matching
- AIP (non c suite)
- Employee surveys

Information Services
- Core applications - licensing and support for corporate clinical and financial systems

Operations
- Accreditation compliance
- Business development application and tools
- Clinical quality program implementation administration costs
- Health Information Patient Protection Act costs
- Insurance (property, auto, earthquake, and other)
- Lease administration costs
- Legal fees
- Malpractice expenses
- Patient safety survey supply rebates
- Dues and subscriptions (AHA, FAH, etc.)

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Corporate Services Included in Pooled Allocation

Accouting / Business Office
- Development of accounting policies and procedures
- Maintenance of general ledger chart of accounts (additions, deletions, changes)
- Maintenance of transaction code (posting) table
- Maintenance of corporate Chargemaster (additions, deletions, changes)
- Maintenance of appropriate Information Decision Support Systems

Accounts Payable
- Check printing and distribution to vendors/hospitals
- Annual 1099 report preparation
- Set up of new vendors

Business Development

Cash Management
- Set up new bank accounts
- Handle any wire transfers
- Sweeping of accounts to corporate concentration account
- Reconciliation of accounts payable/payroll disbursement accounts
- Management of cash flow

Communications and Public Relations
- Provide support through all media in crisis situations
- Provide support with local advertising and public relations efforts

Compliance
- Compliance program management and oversight for ethics, training, policies and procedures
- Privacy and security program management and oversight
- Coding/billing compliance management and oversight

Construction and Design
- Project oversight and review
- Physical plant oversight and management
- Environmental safety and controls
- Utility management
- Preventive maintenance

Human Resources
- Hospital C-suite AIP
- Employee benefit design, including legal review, evaluation of cost and preparation of commuication materials
- Employee benefits administration, including:
  - *Payroll/Benefit interface issues*
  - *Processing communication materials*
  - *Claims processing*
  - *Retirement processing*
  - *Retirement plan non-discrimination testing*
- Employee compensation support function, including:
  - *Market review*
  - *Merit process*
- Answering employee questions and assisting employees with benefit issues
- Workers compensation risk management consulting
- Policies and procedures drafting and production, including employee handbook
- Human Resources Customer Services support for general HR operations and policy interpretation

Internal Audit
- Periodic audits/site visits to ensure adherence to policies/procedures and GAAP guidelines

Legal
- Routine legal services performed by in-house counsel, but not legal services provided by outside counsel
- Review and provide language recommendations for non-physician contracts
- Draft standard contracts for various services

Managed Care Contracting
- Standard contracting for HMOs, PPOs, risk, etc.
- Evaluation of risk arrangements

Miscellaneous Other Items
- Real estate manager review of purchases and lease terms

Patient Care Operations
- Complete outcomes assessments
- Provide quality assurance support to facility quality assurance personnel

Payroll
- Filing and administration of payment of all payroll taxes: FICA, federal, state, local, FUI, SUI
- Generation of W-2s annually
- Check printing and distribution to hospitals

Purchasing
- Development and execution of corporate purchasing contracts
- Provide assistance with IMMS systems problems/issues

Reimbursement (Government Programs)
- Preparation and filing of annual Medicare, Medi-Cal, and other cost reports
- Provide assistance in maintenance and operation of Medicare log system and monthly contractual allowables
- Recording of receivables/reserves on all cost reports
- Filing and follow-up administration of appeals
- Maintenance of corporate chargemaster (additions, deletions, changes)

Risk Management
- Risk manager support on all risk management issues
- Review of patient and visitor incident reporting, lawsuits, etc.

Tax
- Preparation and filing of all federal and state tax returns
- Preparation and filing of all franchise tax returns
- Handle procurement of federal tax ID numbers
- Provide tax advice and research

Fixed Assets
- Maintain fixed asset system
- Reconciliation of fixed asset system to general ledger

Governmental Affairs
- Keep facilities apprised of status on state and federal legislative actions

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Facility Name	County	Type of Entity	Owner	Total Revenue ($)	EBITDA ($)	EBITDA % Revenue
RIVERSIDE COMMUNITY HOSPITAL	Riverside County	For Profit	HCA INC.	481,047,690	135,576,014	28.2%
PARADISE VALLEY HOSPITAL	San Diego County	For Profit	PRIME HEALTHCARE INC.	138,361,286	(1,845,668)	(1.3%)
UC SAN DIEGO HEALTH HILLCREST - HILLCREST MED CTR	San Diego County	Other	UNIVERSITY OF CALIFORNIA	1,553,151,142	177,592,067	11.4%
GROSSMONT HOSPITAL	San Diego County	Hospital District of Authority	SHARP HEALTHCARE	733,270,951	75,784,020	10.3%
EL CENTRO REGIONAL MEDICAL CENTER	Imperial County	Local Government	NA	134,611,951	7,518,921	5.6%
SAN GORGONIO MEMORIAL HOSPITAL	Riverside County	Hospital District of Authority	NA	84,854,800	13,918,048	16.4%
ST JOSEPH HOSPITAL	Orange County	Church	ST JOSEPH HEALTH SYSTEM	621,526,486	36,761,717	5.9%
SCRIPPS MERCY HOSPITAL	San Diego County	Nonprofit	SCRIPPS HEALTH	768,710,640	80,700,954	10.5%
COMMUNITY HOSPITAL OF SAN BERNARDINO	San Bernardino County	Nonprofit	DIGNITY HEALTH	246,888,612	3,540,754	1.4%
COMMUNITY HOSPITAL OF HUNTINGTON PARK	Los Angeles County	For Profit	AVANTI HOSPITALS LLC	42,932,059	(1,517,497)	(3.5%)
WEST COVINA MEDICAL CENTER, INC	Los Angeles County	For Profit	NA	10,561,520	(225,626)	(2.1%)
SAN ANTONIO REGIONAL HOSPITAL	San Bernardino County	Other	NA	302,673,469	14,804,584	4.9%
SHARP MEMORIAL HOSPITAL	San Diego County	Other	SHARP HEALTHCARE	1,207,797,609	271,362,235	22.5%
PARKVIEW COMMUNITY HOSPITAL MEDICAL CENTER	Riverside County	Nonprofit	NA	164,094,073	11,970,332	7.3%
WHITE MEMORIAL MEDICAL CENTER	Los Angeles County	Church	ADVENTIST HEALTH SYSTEM	428,003,728	51,061,884	11.9%
SAINT FRANCIS MEDICAL CENTER	Los Angeles County	Church	VERITY HEALTH SYSTEM	458,953,563	47,750,525	10.4%
PALOMAR HEALTH DOWNTOWN CAMPUS	San Diego County	Hospital District of Authority	PALOMAR POMERADO HEALTH	543,078,376	97,925,739	18.0%
TRI-CITY MEDICAL CENTER	San Diego County	Hospital District of Authority	NA	336,628,574	818,613	0.2%
ST BERNARDINE MEDICAL CENTER	San Bernardino County	Nonprofit	DIGNITY HEALTH	355,939,536	(29,984,308)	(8.4%)
SAN GABRIEL VALLEY MEDICAL CENTER	Los Angeles County	Physician Ownership	AHMC HEALTHCARE INC	180,269,581	5,445,248	3.0%
CITY OF HOPE HELFORD CLINICAL RESEARCH HOSPITAL	Los Angeles County	Other	CITY OF HOPE DEVELOPMENT CENTER	931,465,137	174,664,470	18.8%
ST JUDE MEDICAL CENTER	Orange County	Church	ST JOSEPH HEALTH SYSTEM	495,834,901	39,168,994	7.9%
PRESBYTERIAN INTERCOMMUNITY HOSPITAL	Los Angeles County	Nonprofit	INTERHEALTH	621,726,807	63,248,608	10.2%
ST MARY MEDICAL CENTER	Los Angeles County	Church	DIGNITY HEALTH	286,693,613	(4,887,066)	(1.7%)
SHARP CHULA VISTA MEDICAL CENTER	San Diego County	For Profit	SHARP HEALTHCARE CORPORATION	371,747,006	18,887,790	5.1%
HOAG MEMORIAL HOSPITAL PRESBYTERIAN	Orange County	Nonprofit	ST. JOSEPH HEALTH SYSTEM	971,311,925	126,873,200	13.1%
AHMC ANAHEIM REGIONAL MEDICAL CENTER	Orange County	Nonprofit	AHMC HEALTHCARE INC	214,312,233	3,653,539	1.7%
GARDEN GROVE HOSPITAL & MEDICAL CENTER	Orange County	For Profit	PRIME HEALTHCARE INC	86,282,898	5,040,961	5.8%
POMONA VALLEY HOSPITAL MEDICAL CENTER	Los Angeles County	Nonprofit	NA	535,610,935	67,119,919	12.5%
SHARP CORONADO HOSPITAL AND HLTHCR CTR	San Diego County	For Profit	SHARP HEALTHCARE	96,156,828	13,533,001	14.1%
METHODIST HOSPITAL OF SOUTHERN CA	Los Angeles County	Nonprofit	NA	306,095,350	45,486,196	14.9%
GLENDALE ADVENTIST MEDICAL CENTER	Los Angeles County	Nonprofit	ADVENTIST HEATLH	410,471,694	8,772,502	2.1%
ARROWHEAD REGIONAL MEDICAL CENTER	San Bernardino County	Local Government	NA	626,599,356	106,666,961	17.0%
REDLANDS COMMUNITY HOSPITAL	San Bernardino County	Federal Government	NA	183,972,149	21,300,936	11.6%
HI-DESERT MEDICAL CENTER	San Bernardino County	Hospital District of Authority	TENET HEALTHCARE CORP	58,475,860	3,607,288	6.2%
ALHAMBRA HOSPITAL MEDICAL CENTER	Los Angeles County	For Profit	NAME:	205,828,578	25,943,840	12.6%
RIVERSIDE UNIVERSITY HEALTH SYSTEM-MEDICAL CENTER	Riverside County	Local Government	NA	540,551,729	59,993,060	11.1%
ST MARY MEDICAL CENTER	San Bernardino County	Nonprofit	ST JOSEPH HEALTH SYSTEM	335,525,969	55,514,826	16.5%
SCRIPPS MEMORIAL HOSPITAL LA JOLLA	San Diego County	Other	SCRIPPS HEALTH	584,332,489	136,510,464	23.4%
CORONA REGIONAL MEDICAL CENTER	Riverside County	For Profit	UHS OF DELAWARE INC.	170,166,912	12,107,489	7.1%
PIONEERS MEMORIAL HEALTHCARE DISTRICT	Imperial County	Hospital District of Authority	NA	115,922,925	5,993,830	5.2%
UNIVERSITY OF CALIFORNIA IRVINE MED CENTER	Orange County	Local Government	THE REGENTS OF THE UNIVERSITY OF CAL	1,044,731,823	94,193,729	9.0%
BEVERLY HOSPITAL	Los Angeles County	Nonprofit	NA	178,624,363	12,430,122	7.0%
CITRUS VALLEY MEDICAL CENTER-IC CAMPUS	Los Angeles County	For Profit	CITRUS VALLEY HEALTH PARTNERS	404,024,601	28,320,155	7.0%
HEMET VALLEY MEDICAL CENTER	Riverside County	Physician Ownership	PHYSICIANS FOR HEALTHY HOSPITALS	151,225,108	9,573,425	6.3%
PIH HOSPITAL - DOWNEY	Los Angeles County	Nonprofit	INTERHEALTH	162,904,938	6,716,725	4.1%
SCRIPPS GREEN HOSPITAL	San Diego County	Nonprofit	SCRIPPS HEALTH	404,408,620	91,378,869	22.6%
WEST ANAHEIM MEDICAL CENTER	Orange County	For Profit	PRIME HEALTHCARE INC	102,231,617	1,206,929	1.2%

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Facility Name	County	Type of Entity	Owner	Total Revenue ($)	EBITDA ($)	EBITDA % Revenue
LONG BEACH MEMORIAL MEDICAL CENTER	Los Angeles County	Other	MEMORIAL HEALTH SERVICES	684,899,570	94,142,504	13.7%
SCRIPPS MEMORIAL HOSPITAL - ENCINITAS	San Diego County	Nonprofit	SCRIPPS HEALTH	277,870,528	33,135,249	11.9%
VICTOR VALLEY GLOBAL MEDICAL CENTER	San Bernardino County	Nonprofit	NA	91,465,627	16,509,948	18.1%
HUNTINGTON BEACH HOSPITAL	Orange County	For Profit	PRIME HEALTHCARE INC	45,507,938	(2,977,874)	(6.5%)
JOHN F KENNEDY MEMORIAL HOSPITAL	Riverside County	For Profit	TENET HEALTHCARE CORP	116,831,585	234,975	0.2%
COLLEGE HOSPITAL COSTA MESA	Orange County	For Profit	COLLEGE HEALTH ENTERPRISES	87,656,691	25,918,740	29.6%
FAIRVIEW DEVELOPMENTAL CENTER	Orange County	Local Government	CA DEPARTMENT OF DEVELOPMENTAL SERVI	132,429,048	(7,256,843)	(5.5%)
LOS ALAMITOS MEDICAL CENTER	Orange County	For Profit	TENET HEALTHCARE	213,158,448	31,916,314	15.0%
MISSION HOSPITAL REGIONAL MED CENTER	Orange County	Nonprofit	ST JOSEPH HEALTH SYSTEM	573,294,579	52,902,196	9.2%
FOUNTAIN VALLEY REGIONAL HOSPITAL & MEDICAL CENTER	Orange County	For Profit	TENET HEALTHCARE CORP.	410,711,698	97,650,554	23.8%
EISENHOWER MEDICAL CENTER	Riverside County	For Profit	NA	698,126,344	55,628,333	8.0%
LA PALMA INTERCOMMUNITY HOSPITAL	Orange County	For Profit	PRIME HEALTHCARE INC	53,761,232	(1,905,728)	(3.5%)
LAKEWOOD REGIONAL MEDICAL CENTER	Los Angeles County	For Profit	TENET HEALTHCARE CORP	189,897,458	24,990,415	13.2%
CHINO VALLEY MEDICAL CENTER	San Bernardino County	For Profit	PRIME HEALTHCARE INC	101,454,090	11,725,803	11.6%
SAN DIMAS COMMUNITY HOSPITAL	Los Angeles County	For Profit	PRIME HEALTHCARE INC	63,847,060	4,968,534	7.8%
PLACENTIA LINDA HOSPITAL	Orange County	For Profit	TENET HEALTHCARE CORP	97,997,622	22,811,496	23.3%
FOOTHILL PRESBYTERIAN HOSPITAL	Los Angeles County	Nonprofit	CITRUS VALLEY HEALTH PARTNERS	90,062,423	10,296,187	11.4%
SADDLEBACK MEMORIAL MEDICAL CENTER	Orange County	Nonprofit	MEMORIAL HEALTH SERVICES	371,662,851	56,350,564	15.2%
POMERADO HOSPITAL	San Diego County	Hospital District of Authority	PALOMAR HEALTH	180,982,235	39,596,983	21.9%
EAST LOS ANGELES DOCTORS HOSPITAL	Los Angeles County	For Profit	AVANTI HOSPITALS LLC	72,491,073	6,254,685	8.6%
LOS ANGELES COMMUNITY HOSPITAL	Los Angeles County	For Profit	ALTA HOSPITALS SYSTEM LLC	152,068,944	43,855,892	28.8%
ORANGE COAST MEMORIAL MEDICAL CENTER	Orange County	For Profit	MEMORIAL HEALTH SERVICES	306,606,238	28,905,230	9.4%
MENIFEE VALLEY MEDICAL CENTER	Riverside County	Physician Ownership	PHYSICIANS FOR HEALTHY HOSPITALS	39,639,009	(2,141,870)	(5.4%)
KECK HOSPITAL OF USC	Los Angeles County	Other	NA	799,378,303	(38,226,216)	(4.8%)
SOUTHWEST HEALTHCARE SYSTEM	Riverside County	For Profit	UHS OF DELAWARE INC.	283,012,754	57,639,224	20.4%
DESERT VALLEY HOSPITAL	San Bernardino County	For Profit	PRIME HEALTHCARE SERVICES INC.	138,103,427	16,270,085	11.8%
COMMUNITY HOSPITAL OF LONG BEACH	Los Angeles County	Nonprofit	MEMORIAL HEALTH SERVICES	70,234,113	(1,482,862)	(2.1%)
WHITTIER HOSPITAL MEDICAL CENTER	Los Angeles County	For Profit	AHMC HEALTHCARE INC	129,000,118	16,533,640	12.8%
MONTEREY PARK HOSPITAL	Los Angeles County	For Profit	AHMC HEALTHCARE INC	108,202,371	17,805,644	16.5%
GARFIELD MEDICAL CENTER	Los Angeles County	For Profit	AHMC HEALTHCARE INC.	300,578,013	13,494,534	4.5%
GREATER EL MONTE COMMUNITY HOSPITAL	Los Angeles County	Nonprofit	AHMC HEALTHCARE INC.	78,247,343	10,462,801	13.4%
ANAHEIM GLOBAL MEDICAL CENTER	Orange County	For Profit	KPC HEALTHCARE INC	69,432,681	5,684,443	8.2%
CHAPMAN GLOBAL MEDICAL CENTER	Orange County	For Profit	INTEGRATED HEALTHCARE HOLDINGS INC.	49,432,776	6,679,313	13.5%
ORANGE COUNTY GLOBAL MEDICAL CENTER	Orange County	For Profit	INTEGRATED HEALTHCARE HOLDINGS INC.	189,370,651	45,191,951	23.9%
SOUTH COAST GLOBAL MEDICAL CENTER	Orange County	For Profit	INTEGRATED HEALTHCARE HOLDINGS INC.	56,344,502	2,282,033	4.1%
ALVARADO HOSPITAL MEDICAL CENTER	San Diego County	For Profit	PRIME HEALTHCARE INC	134,841,300	(7,148,127)	(5.3%)
MONTCLAIR HOSPITAL MEDICAL CENTER	San Bernardino County	Nonprofit	PRIME HEALTHCARE INC	48,147,032	2,282,523	4.7%
COAST PLAZA HOSPITAL	Los Angeles County	For Profit	AVANTI HOSPITALS LLC	43,381,532	(3,435,737)	(7.9%)
TEMECULA VALLEY HOSPITAL	Riverside County	For Profit	UHS OF DELAWARE INC.	116,283,061	26,298,270	22.6%
COLLEGE MEDICAL CENTER	Los Angeles County	For Profit	COLLEGE HEALTH ENTERPRISES INC	123,650,526	15,315,941	12.4%
MARTIN LUTHER KING, JR. COMMUNITY HOSPITAL	Los Angeles County	Nonprofit	NA	213,511,423	39,414,408	18.5%

Source: cms.gov; CMS Cost Report Data and Medicare Provider of Services File. Includes identified hospitals located within a 100 mile radius of Desert Regional Medical Center excluding certain outliers when reported EBITDA was below -10% or above +30%, or in instances in which a hospital EBITDA was not reported.

Metric	EBITDA % Revenue
Average	9.6%
Median	10.2%
High	29.6%
Low	(8.4%)
25th %	4.5%
75th %	14.9%

FINAL REPORT

Population Estimates	1990	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Riverside	1,170,413	1,558,985	1,616,634	1,687,147	1,771,656	1,856,542	1,931,785	2,012,370	2,075,183	2,109,712	2,146,725	2,189,641	2,236,146	2,264,919	2,291,452	2,322,455	2,352,892	2,387,741
**CAGR since 1990*	*n/a*	*2.9%*	*3.0%*	*3.1%*	*3.2%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.3%*	*3.2%*	*3.2%*	*3.1%*	*3.0%*	*3.0%*	*2.9%*	*2.8%*	*2.8%*
**CAGR since 2000*		*n/a*	*3.7%*	*4.0%*	*4.4%*	*4.5%*	*4.4%*	*4.3%*	*4.2%*	*3.9%*	*3.6%*	*3.5%*	*3.3%*	*3.2%*	*3.0%*	*2.9%*	*2.8%*	*2.7%*

**CAGR = Compounded annual growth rate.*

Source: United States Census Bureau Population Finder for Riverside

DESERT HEALTHCARE DISTRICT

October 23, 2018

CEO Report - Priorities - Milestones - Progress Measures

#1 Milestone: Successful Implementation of Strategic Plan

Staff is currently focused on the following work in support of the strategic plan and Board priorities:

1. Homelessness Initiative
2. Behavioral Health Initiative
3. Implementation of the grant structure and new grant software platform
4. Policy update and operational process and procedures
5. Accreditation requirements
6. Implementation of Communications and Marketing Plan
7. CVHIP

#2 Milestone: Up-to-Date Policy Manual and Timely Review

Staff has continued its work with Communications Ad Hoc committee and has prepared documentation for the October 25, 2018 Workshop.

Priority: Operations

#3 Milestone: Successful implementation of public relations program highlighting the work of the District and Foundation

Staff is working from the approved Communications and Marketing plan (September 25, 2018) and is building out a comprehensive project timeline for each of the proposed subsections of the overarching plan. I.e. website development, brand identification (post-election)

Priority: Operations

#4 Milestone: Successful implementation of Office restructuring with support for both new and continuing employees

Staff continues to work through the process of policy review and the implementation of a proposed timeline to obtain trainings for both staff and the Board of Directors to achieve the "Certified Healthcare District" from The Association of California Healthcare Districts (ACHD) and "District of Distinction" from Special District Leadership Foundation (SDLF) a division of California Special District Association (CSDA) – timeline will be presented at the November Board meeting.

"Priority: Operations

#5 Milestone: Expanded utilization of cvHIP by both residents and professionals throughout the Coachella Valley"

Staff has prepared a report to the Board for review and discussion at the October 23, 2018 Foundation meeting. Staff has met with Inland Empire Health Plan (IEHP) and a request for further guidance will be presented during the staff report.

"Priority: Operations

#6 Milestone: Complete Association of California Healthcare Districts Certification"

Staff is working to meet certification requirements concurrently with the implementation of policy review, grant Structure, communications and marketing (Website redesign), and Strategic Plan Implementation. As stated above, staff will present timeline at the November Board meeting. This will also be reflective of the decisions made at the October 25, 2018 Workshop meeting.

"Priority: Strategy and Programs

#7 Milestone: Implementation of Hospital Governance and Oversight Policy with increased focus on quality issues"

Under the District's Lease Compliance Policy, a Hospital Governance and Oversight (HGOC) standing committee was created in January 2017. Monthly meetings have included current updates from Michele Finney, CEO of DRMC, regarding status of any issues, improvements, and developments within the hospital. Additionally, hospital rating scores, such as Leapfrog, CMS and Hospital Compare, have been presented to the Committee and communicated with the Board, including action plans for improving subpar scoring. The Committee will develop a hospital inspection plan to perform quarterly inspections of the hospital facilities. The Committee continues to bring transparency to hospital governance and oversight issues.

"Priority: Strategy and Programs

#8 Milestone: Continued focus on Homelessness Initiative with CVAG and Coachella Valley local governments (cities and county), as well as appropriate recognition of DHCD/F efforts"

Staff has prepared a report of the up-to-date work with Barbara Poppe and Associates (BPA) and preparation for the November 7th and 8th onsite meeting. This report is included in the Foundation board package for review.

"Priority: Strategy and Programs

#9 Milestone: Development of a strategy to address behavioral health issues in the Coachella Valley with primary and expedited focus on inpatient psychiatric resources"

Staff continues to work with Subject Matter Specials work and Green Ribbon Committee to help identify strategies and concepts for both programs, funding and legislation.

Staff has been reviewing and holding conversations with front line staff to understand the story behind the Data.

It is the staff's intent to finalize the work with BPA on homelessness, work as a team to identify strengths and weaknesses from the process, and create lessons learned information piece to help guide the upcoming Behavioral Health Initiative work. Timeline proposed is January 2019.

A staff report for the October 23, 2018 Foundation Board of Directors meeting provides further detail.

"Priority: Strategy and Programs

#10 Milestone: Develop a strategy to address acute hospital bed resources throughout the CV with specific decisions about how to address seismic of existing facilities and other facilities issues at DRMC"

Board and Staff have been working with our consultant, Kaufman Hall, to develop guidance to the Board for decisions regarding the hospital facility, in light of the underlying seismic retrofit 2030 compliance issue. A current seismic ASCE 41 assessment is underway to provide detailed assessment of estimated costs and process to meet the compliance issue. Phase 0 (high level assessment) is complete and was presented at the September 25, 2018 Board of Directors meeting. Estimated completion of the ASCE 41 – Phase 1 report - is December 2018.

"Priority: Strategy and Programs

#11 Milestone: Develop, with Board, contingency plans for remainder of lease without an extension to Tenet Health"

Through the work and development underway with Kaufman Hall, the District will be developing a contingency plan, following the Seismic Assessment and further analysis. Estimated completion of the Contingency Plan is May 2019.

"Priority: Strategy and Programs

#12 Milestone: Providers, Facilities, Programs, and Services plans for 2018 in light of changing federal actions. Establish sustainable funding for Providers, Facilities, Programs, and Services. "

The New Providers, Facilities, Programs, and Services Committee and Staff, along with guidance from Kaufman Hall, will be developing a plan (Apr-Jun 2019) for how to proceed with the hospital with regard to seismic retrofit and to define a transaction with the hospital operator (i.e. new hospital lease) by May 2027.

"Priority: Expansion

#13 Milestone: Establish a sustainable funding mechanism to include in expansion vote with LAFCO application"

Program team work continues to identify potential funding for two Key Initiatives – Homelessness and Behavioral Health. Through this process we are mapping potential funding sources to help supports efforts and programs that serve the Coachella Valley as a whole.

This includes our efforts mentioned above in the Homelessness and Behavioral Health Initiative work. Staff is currently focused on the Salton Sea Bond and the allocation of 10 million to Health, Prop 63 funds and programs being offered by Riverside County in the CV, HEAP funding coming from the state that requires either shovel ready capital programs or programs that meet the emergency needs for the chronic homeless.

"Priority: Expansion

#14 Milestone: Secure successful LAFCO vote"

The Annexation was approved at the April 26, 2018 LAFCO meeting and ordered the Board of Supervisors to set an election at the November 6, 2018 election. Measure BB, the ballot measure for the annexation, was approved and finalized by the Registrar of Voters.

"Priority: Expansion

#15 Milestone: Preparation for and successful vote to expand DHCD/F in November 2018"

Staff has completed Power Point presentations for Board member use to support efforts to bring clarity to the community on expansion.

Staff is working to encourage public attendance and participation at the October Board Meetings (Public Forums).

"Priority: Expansion

#16 Milestone: Plan for expansion of DHCD/F Board if ballot initiative passes, as well as begin preparations for “district” elections."

At the September 25, 2018 Board meeting, a timeline and process for selection of 2 additional Board members and for rezoning to a 7 zone election was approved, should the expansion initiative pass.

DESERT HEALTHCARE DISTRICT

DESERT HEALTHCARE DISTRICT
FINANCE, ADMINISTRATION, REAL ESTATE AND LEGAL COMMITTEE
MEETING MINUTES
September 11, 2018

Directors Present	District Staff Present	Absent
Chair/Treasurer Mark Matthews Director Jennifer Wortham, DrPH Arthur Shorr, Community Member	Chris Christensen, Interim CEO and CFO Stephen Huyck, 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 3:08 p.m.	
II. Approval of Agenda	Chair Matthews asked for a motion to approve the Agenda.	**It was moved and seconded (Director Wortham, Community Member Shorr) to approve the agenda.** **Motion passed unanimously.**
III. Public Comment		
IV. Approval of Minutes	Chair Matthews asked for a motion to approve the minutes of July 10, 2018.	**It was moved and seconded (Director Wortham, Community Member Shorr) to approve the minutes.** **Motion passed unanimously.**
V. CEO Report	None	
VI. Chief Financial Officer's Report **1. LPMP Leasing Update**	**VI.1.** Chris Christensen, Interim CEO, explained that the financial audits are being finalized and will be presented	

	at the October F&A Committee meeting.	
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** **10. Grant Payment Schedule**	**VII.1.-10.** The Financial Reports were reviewed with Chris Christensen, Interim CEO. The current occupancy rate at Las Palmas Medical Plaza is 95%. Mr. Christensen also indicated that the A/R Aging for Sovereign Group is now up-to-date with all payments established from the financial commitment.	**It was moved and seconded (Community Member Shorr, Director Wortham) to approve the August and September 2018 District Financial Reports - Items 1-10 and to forward to the Board for approval. Motion passed unanimously.**
Public Comment		
VIII. Other Matters **1. District & RPP Investment Reports 2Q18 – Keith Stribling, High Mark Capital**	**VIII.1.** Chris Christensen, Interim CEO, introduced Keith Stribling, CFA, Vice President, Senior Portfolio Manager, Highmark Capital. Mr. Stribling provided details on his background and experience and explained the specifics of the Desert Hospital Retirement Plan and the Facilities Replacement Fund.	
2. RPP Actuarial Valuation Report	**VIII.2.** Chris Christensen, Interim CEO, detailed the roll forward Retirement Protection Plan report. The net pension as of June 30, 2018 is $3.3M.	
3. Service Agreement Addendum #2 – Kaufman Hall	**VIII.3.** Chris Christensen, Interim CEO, described the endeavors of the Ad Hoc Committee on New Providers, Facilities, Programs, and Services, seismic assessment of Desert Regional Medical	**It was moved and seconded (Director Wortham, Community Member Shorr) to forward to the Board for discussion with no recommendation of the Service Agreement Addendum #2 – Kaufman Hall.**

	Center, appraisal of Desert Regional Medical Center, and the efforts of the demands for the potential expansion. Director Wortham explained that the District is aware of the options, and Kaufman Hall is not providing any additional information that the District has not already identified. Director Wortham also expressed concerns with the costs-to-date. Chair Matthews described the impending costs of the seismic issues, the potential sale of the hospital, and recommended forwarding the Kaufman Hall amendment to the board for discussion in a closed session. Chair Matthews requested that Staff speak with the chair of the Board concerning the options such as tabling the matter based on Director Wortham's issues and concerns. Chair Matthews explained that he is acceptable with postponing the work until after the November election.	
4. Audit Firm – 5 Year Review of District/Foundation Audit Firm	**VIII.4.** Chris Christensen, Interim CEO, described the current audit firms work over the past five years, the reclassification of the cash flow statement for the net pension liability for accruals (non-cash item) for better representation in the report, and that the auditors have completed an overall job well done. Chair Matthews explained the current aspects of the District	**It was moved and seconded (Chair Matthews, Director Wortham) to continue with the current audit firm and forward to the Board for approval.** **Motion passed unanimously.**

	related to the current audit and the tremendous undertakings of the District. Chair Matthews suggested a recommendation to defer a new firm for one year and continue with the auditors that are experienced and familiar with the District.	
5. Proposed DHCD Hours of Operation	**VIII.5.** Chris Christensen, Interim CEO, explained the internal discussions between staff and the favorability of the 9/80 work schedule that would continue to boost morale and provide staff with an additional day off every other week for appointments. Mr. Christensen presented the options with the office hours unaffected for the public and would allow staff an extra hour of productivity. Director Wortham proposed the 4/10 schedule and Chair Matthews explained that it is more productive for staff and staggering the cycle could become confusing to the public.	**It was moved and seconded (Community Member Shorr, Director Wortham) to recommend a 4/10 work schedule and forward to the Board for approval. Motion passed unanimously.**
IV. Adjournment	Chair Matthews adjourned the meeting at 4:09 p.m.	***Audio recording available on the website at http://dhcd.org/Finance-and-Administration***

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

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

Chief Financial Officer's Report

October 9, 2018

Audit Reports for the District, Foundation, and Retirement Protection are included in the F&A Committee packet and will be presented by Craig Hartzheim of Moss, Levy, Hartzheim LLP.

Las Palmas Medical Plaza - Property Management:

Occupancy:
See attached unit rental status report.

95.8% currently occupied –

Total annual rent including CAM fees is **$1,231,836.**

Leasing Activity:
Suite 3W-105 & 2W-107 – Dr. Awad desires to relocate from 2W-107 to 3W-105. A request for the relocation is included in the packet.

The two additional vacant suites (1W104 & 105) are adjacent and each are approximately 1,000 sq ft.

Las Palmas Medical Plaza
Unit Rental Status
As of October 1, 2018

Unit	Tenant Name	Deposit	Lease Dates From	Lease Dates To	Term	Unit Sq Feet	Percent of Total	Monthly Rent	Annual Rent	Rent Per Sq Foot	Monthly CAM	Total Monthly Rent Inclg CAM	Total Annual Rent Inclg CAM
											$ 0.62		
1W, 104	Vacant					1,024	2.07%						
1W, 105	Vacant					1,060	2.15%						
Total - Vacancies						**2,084**	**4.22%**						
Total Suites-33 - 29 Suites Occupied		**$ 58,516.90**				**49,356**	**95.8%**	**$ 73,470.82**	**$ 881,649.84**	**$ 1.55**	**$ 29,182.16**	**$ 102,652.98**	**$ 1,231,835.76**

Summary - All Units		
Occupied	47,272	95.8%
Vacant	2,084	4.2%
Total	49,356	100%

DESERT HEALTHCARE DISTRICT,
DESERT HEALTHCARE FOUNDATION AND
DESERT HOSPITAL RETIREMENT PLAN

MANAGEMENT REPORT
AND
AUDITOR'S COMMUNICATION LETTER

JUNE 30, 2018

DESERT HEALTHCARE DISTRICT,
DESERT HEALTHCARE FOUNDATION AND
DESERT HOSPITAL RETIREMENT PLAN

JUNE 30, 2018

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

In planning and performing our audit of the financial statements of the Desert Healthcare District, Desert Healthcare Foundation and Desert Hospital Retirement Plan (the entities), as of and for the fiscal year ended June 30, 2018, in accordance with auditing standards generally accepted in the United States of America, we considered the entities' internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions 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.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be significant deficiencies or material weaknesses and, therefore, there can be no assurance that all such deficiencies have been identified.

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

A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

During our audit, we noted no matters involving internal controls and their operations that are required to be reported under Government Auditing Standards, except for a potential of inadequate segregation of duties due to the small staff of the entities. This appears to be mitigated by the strong oversight of the Board of Directors in the operations of the entities.

We have included in this letter a summary of communications with the members of the Board of Directors as required by professional auditing standards. We would like to thank the entities' management and staff for the courtesy and cooperation extended to us during the course of our engagement.

The accompanying communications and recommendations are intended solely for the information and use of management, the members of the Board of Directors, and others within the entities, and is not intended to be, and should not be, used by anyone other than these specified parties.

Moss, Levy & Hartzheim, LLP
Culver City, California
October 1, 2018

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

We have audited the financial statements of the financial statements of the Desert Healthcare District, Desert Healthcare Foundation and Desert Hospital Retirement Plan (the entities) of the entities for the fiscal year ended June 30, 2018, and have issued our report thereon dated October 1, 2018. Professional standards require that we provide you with the information about our responsibilities under auditing standards generally accepted in the United States of America 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 dated May 29, 2018. 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 of the notes to the basic financial statements.

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

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

The most sensitive estimates affecting the financial statements were the estimated historical cost and useful lives of certain capital assets, the net fair market value of the charitable remainder trusts, the funding progress of the District's RPP plan and OPEB plan, and the estimate of an allowance for uncollectable receivables. Management's estimates of the estimated historical cost and useful lives of certain capital assets are based on historical data and industry guidelines, while the funding progress of the RPP plan and OPEB plan, and are based on consultants' estimates. The amount of estimated allowance for uncollectable receivables is based on historical data. We evaluated the key factors and assumptions used to develop these estimates and determined that they are reasonable in relation to the financial statements taken as a whole.

Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the financial statements were:

The estimates for the Defined Benefit Pension Plan are in the footnotes to the financial statements.
The estimates for the OPEB Plan are in the footnotes to the financial statements.

We evaluated the key factors and assumptions used to develop these estimates and determined that they are reasonable in relation to the financial statements taken as a whole. The financial statement disclosures are neutral, consistent, and clear.

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. Management has corrected all such misstatements, if any. In addition, none of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to each opinion unit's financial statements taken as a whole.

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 our audit.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated October 1, 2018.

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 District's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues

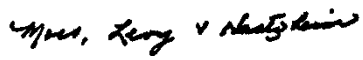
We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the entities' auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were 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.

Restriction on Use

This information is intended solely for the use of the members of the Board of Directors and management of the entities and is not intended to be and should not be used by anyone other than these specified parties.



Moss, Levy & Hartzheim, LLP
Culver City, California
October 1, 2018

CURRENT YEAR RECOMMENDATIONS

Other Matters

None

STATUS OF PRIOR YEAR RECOMMENDATION

None

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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, of the Desert Healthcare District,
Desert Healthcare Foundation and Desert Hospital Retirement 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, the fiduciary fund financial statements of the Desert Healthcare District, and the financial statements of the Desert Healthcare Foundation and Desert Hospital Retirement Plan (the entities), as of and for the fiscal year ended June 30, 2018, and the related notes to the financial statements, which collectively comprise the entities' basic financial statements, and have issued our report thereon dated October 1, 2018.

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 opinions 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 entities' 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.

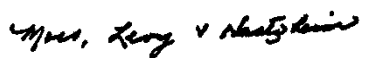
Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or, significant deficiencies. Given these limitations, during our audit we did not 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 entities internal control or on compliance. This report is an integral part of an audit performed in accordance with Government Auditing Standards in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.



MOSS, LEVY & HARTZHEIM, LLP
Culver City, California
October 1, 2018

DESERT HEALTHCARE DISTRICT

PALM SPRINGS, CALIFORNIA

INDEPENDENT AUDITOR'S REPORT AND FINANCIAL STATEMENTS

JUNE 30, 2018

DESERT HEALTHCARE DISTRICT

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INDEPENDENT AUDITOR'S REPORT

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

Report on Financial Statements

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 fiscal year ended June 30, 2018, 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 assessments of the risks of material misstatements 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 on the District'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.

Opinions

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, 2018, and the respective changes in financial position and cash flows for the fiscal 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 1, 2018, 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.

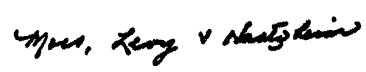
Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 3 through 7 and the Schedule of Changes in the Net Pension Liability and Related Ratios on page 37 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 Comparative Summarized Information

We have previously audited the District's 2017 financial statements, and our report dated October 5, 2017 expressed unmodified opinions on those audited financial statements. In our opinion, the summarized comparative information presented herein as of and for the fiscal year ended June 30, 2017, is consistent, in all material respects, with the audited financial from which it has been derived.



Moss, Levy & Hartzheim, LLP
Culver City, California
October 1, 2018

DESERT HEALTHCARE DISTRICT

MANAGEMENT'S DISCUSSION AND ANALYSIS

JUNE 2018 AND 2017

The Desert Healthcare District (the District) has issued its financial statements for the fiscal years ended June 30, 2018 and June 30, 2017 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 2018 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.

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 2018 and 2017.

Table A

Assets:	6/30/2018	6/30/2017	Change
Cash and cash equivalents	$ 2,004,735	$ 1,431,371	$ 573,364
Investments	54,326,412	54,644,090	(317,678)
Capital assets, net	12,382,164	12,792,784	(410,620)
All Other Assets	235,775	340,068	(104,293)
Total Assets	$ 68,949,086	$ 69,208,314	$ (259,228)
Deferred Outflows:			
GASB 68 Reporting for Pension Plans	$ 1,057,842	$ 1,234,531	$ (176,689)
GASB 75 Reporting for OPEB Plans	$ 22,144	$ -	$ 22,144
Total Deferred Outflows	$ 1,079,986	$ 1,234,531	$ (154,545)
Liabilities:			
Grants payable	$ 11,654,099	$ 12,449,038	$ (794,939)
Net Pension Liability	3,277,793	2,883,995	393,799
All Other Liabilities	1,920,142	590,996	1,329,145
Total Liabilities	$ 16,852,034	$ 15,924,029	$ 928,005
Deferred Inflows:			
GASB 68 Reporting for Pension Plans	$ 2,222,190	$ 3,242,061	$ (1,019,871)
Total Deferred Inflows	$ 2,222,190	$ 3,242,061	$ (1,019,871)
Net Assets:			
Net investment in capital assets	$ 12,382,164	$ 12,792,784	$ (410,620)
Unrestricted	38,572,684	37,474,591	1,098,093
Restricted	-	1,000,000	(1,000,000)
Total Net Position	$ 50,954,848	$ 51,267,375	$ (312,527)

The $312,527 decrease in Total Net Position is due to the net loss of $312,527 for the current fiscal year ended June 30, 2018. This compares to a net income of $1,754,472 for the fiscal year ended June 30, 2017. The decrease is primarily due to a net combination of increased property tax revenue of $477,409, increased grant expenses of $1,622,290 and increased professional fees and legal expense of $897,850. The $317,678 decrease in Investments is due primarily to increase in Cash and cash equivalents of $573,364 available for payment of current liabilities. The $410,620 decrease in Capital Assets is due primarily to depreciation of capital assets. The $104,293 decrease in All Other Assets is due primarily to a decrease in property tax and grants receivables. The $176,689 decrease in Deferred Outflows is due to timing difference in the actuarial valuation for GASB 68 reporting for the Retirement Protection Plan (RPP). The $794,939 decrease in Grants Payable is due primarily to higher grant disbursements than new accrued grants. The $393,799 increase in Net Pension Liability is due primarily to a change in actuarial assumptions. The $1,307,002 increase in All Other Liabilities is due primarily to a $1,000,000 transfer to the Foundation. The $1,019,871 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; 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 and Palm Desert (West of Cook Street) 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 2018 results to Fiscal Year 2017.

Table B

	6/30/18	6/30/17	Change
Revenue:			
Property Tax Revenue	$ 6,559,800	$ 6,082,391	$ 477,409
Rental income	1,113,241	1,178,485	(65,244)
All other income	166,904	213,133	(46,229)
Total Revenue	$ 7,839,945	$ 7,474,009	$ 365,936
Expenses:			
Grants program	$ 5,076,039	$ 3,453,749	$ 1,622,290
Administrative Expense	3,068,696	2,177,287	891,409
Total Expense	$ 8,144,735	$ 5,631,036	$ 2,513,700
Nonoperating Income(Expenses)	$ (7,737)	$ (88,501)	80,765
Net Income (Loss)	$ (312,527)	$ 1,754,472	$ (2,066,999)

Revenue

Property taxes are the District's primary source of operating revenues. The property tax revenue for the fiscal year ended June 30, 2018 was $6,559,800 which was an increase of $477,409 from the fiscal year ended June 30, 2017.

Rental income of $1,113,241 for the fiscal year ended June 30, 2018 was $65,244 lower than the fiscal year ended June 30, 2017.

All other income for the fiscal year ended June 30, 2018 decreased $46,229 compared to the fiscal year ended June 30, 2016. The decrease was due primarily to a decrease in NEOPB grant income and solar rebate.

The Statements of Revenues, Expenses, and Change in Net Position (Continued)

Expenses

Grant Program expense for the fiscal year ended June 30, 2018 increased by $1,622,290 compared to the fiscal year ended June 30, 2017. This is due primarily to increased 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, 2018 increased $891,409 from the fiscal year ended June 30, 2017. The increase is due to various expenses including higher professional fees expense of $764,069 for consulting services for expansion, future planning, hospital seismic and appraisal assessments; and higher legal expense of $133,782.

CAPITAL ASSETS

At June 30, 2018, the District had $22,121,177 in capital assets and $9,739,013 accumulated depreciation, resulting in $12,382,164 net capital assets. At June 30, 2017, the District had $21,939,868 in capital assets and $9,147,084 in accumulated depreciation, resulting in $12,792,784 net capital assets.

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

Table C

	Balance 6/30/16	Net Additions	Net Retirements	Balance 6/30/17	Net Additions	Net Retirements	Balance 6/30/18
Cost	$ 21,936,462	$ 4,929	$ (1,523)	$ 21,939,868	$ 233,243	$ (51,934)	$ 22,121,177
Acc. Depreciation	(8,514,981)	(632,916)	812	(9,147,084)	(643,863)	51,934	(9,739,013)
Capital Assets, Net	$ 13,421,481	$ (627,987)	$ (711)	$ 12,792,784	$ (410,620)	$ -	$ 12,382,164

DEBT ADMINISTRATION

The District has no outstanding debt.

ECONOMIC OUTLOOK AND MAJOR INITIATIVES

The Fiscal Year 2019 budget reflects revenues of $8,019,542 and operating expenses of $7,975,519. Capital expenditures are budgeted at $495,396. The Desert Healthcare District/Foundation adopted a new 3-Year Strategic Plan in fiscal year 2018, with four Community Health Focus Areas: Homelessness; Primary Care and Behavioral Health Access; Healthy Eating and Active Living; and Quality, Safety, Accountability, and Transparency. The District/Foundation continues to work on connecting District residents to programs and services to meet their healthcare needs.

During the fiscal year ended June 30, 2018, the District awarded $3,958,624 in new grants and distributed grants in the amount of $4,666,084. Projected new grants to be awarded for the fiscal year 2018–2019 amount to $3,500,000 and distributions for grants could possibly total $15,087,491 due to the existing grant liability as of June 30, 2018 and the projected grant awards.

The District has also established a reserve fund of approximately $55,000,000 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 is conducting due diligence to assess the seismic retrofit needs and costs, which may be substantial, and 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

STATEMENT OF NET POSITION
JUNE 30, 2018

WITH COMPARATIVE TOTALS AS OF JUNE 30, 2017

	2018	2017
CURRENT ASSETS		
Cash and cash equivalents	$ 2,004,735	$ 1,431,371
Investments	10,036,100	17,257,100
Accounts receivable - net	190,048	293,905
Prepaid items and deposits	45,727	46,164
Total current assets	12,276,610	19,028,540
NON-CURRENT ASSETS		
Investments	44,290,312	37,386,990
Capital assets, net	12,382,164	12,792,784
Total non-current assets	56,672,476	50,179,774
DEFERRED OUTFLOWS		
Deferred Outflows of Resources:		
Pension plans	1,057,842	1,234,531
OPEB	22,144	-
Total deferred outflows of resources	1,079,986	1,234,531
TOTAL ASSETS AND DEFERRED OUTFLOWS	70,029,072	70,442,845
CURRENT LIABILITIES		
Current liabilities:		
Accounts payable and accrual liabilities	1,646,607	317,854
Grants payable	1,506,453	1,993,397
Compensated absences	39,785	46,835
Disability claims, reserve, current portion	14,803	14,803
Retired directors medical benefits, current portion	-	23,000
Total current liabilities	3,207,648	2,395,889
NON-CURRENT LIABLILITIES		
Grants payable	10,147,646	10,455,641
Long-term disability claims reserve	51,743	62,215
Long-term retired director's medical benefits	-	72,250
Net pension liability	3,277,793	2,883,995
Net OPEB liability	108,687	-
Deposits payable	58,517	54,039
Total non-current liabilities	13,644,386	13,528,140
DEFERRED INFLOWS		
Deferred Inflows of Resources:		
Pension plans	2,222,190	3,242,061
Total deferred inflows of resources	2,222,190	3,242,061
TOTAL LIABILITIES AND DEFERRED INFLOWS	19,074,224	19,166,090
NET POSITION		
Net investment in capital assets	12,382,164	12,792,784
Restricted	-	1,000,000
Unrestricted	38,572,684	37,483,971
TOTAL NET POSITION	$ 50,954,848	$ 51,276,755

The accompanying notes are an integral part of these financial statements

DESERT HEALTHCARE DISTRICT

STATEMENT OF REVENUES, EXPENDITURES, AND CHANGES IN NET POSITION
FOR THE FISCAL YEAR ENDED JUNE 30, 2018

WITH COMPARATIVE TOTALS FOR THE FISCAL YEAR ENDED JUNE 30, 2017

	2018	2017
OPERATING REVENUES		
Property taxes	$ 6,559,800	$ 6,082,391
Rental income	1,113,241	1,178,485
Other income	166,904	213,133
Total revenues	7,839,945	7,474,009
OPERATING EXPENSES		
Grant allocations	5,076,039	3,453,749
General expenses	1,187,283	436,175
Rental expenses	904,904	894,421
Salaries and benefits	329,056	190,859
Legal fees	250,443	117,593
Depreciation	194,483	194,979
Other	199,606	146,333
Election fees	-	196,467
Security	2,921	460
Total expenditures	8,144,735	5,631,036
Income (loss) from operations	(304,790)	1,842,973
NONOPERATING INCOME (EXPENSES)		
Investment income	111,318	30,049
Investment expenses	(119,055)	(118,550)
Total nonoperating income (loss)	(7,737)	(88,501)
Increase (decrease) in net position	(312,527)	1,754,472
NET POSITION		
Beginning of fiscal year	51,276,755	49,522,283
Prior period adjustments	(9,380)	-
Net position at beginning of fiscal year, restated	51,267,375	49,522,283
End of fiscal year	$ 50,954,848	$ 51,276,755

The accompanying notes are an integral part of these financial statements

DESERT HEALTHCARE DISTRICT

STATEMENT OF CASH FLOWS
FOR THE FISCAL YEAR ENDED JUNE 30, 2018

WITH COMPARATIVE TOTALS FOR THE FISCAL YEAR ENDED JUNE 30, 2017

	2018	2017
CASH FLOWS FROM OPERATING ACTIVITIES		
Cash received from County	$ 6,614,964	$ 6,080,531
Cash received from Grantor	156,209	134,297
Cash payments to suppliers for goods and services	(766,587)	(1,406,821)
Cash payments to unfunded pension liability	-	(3,400,000)
Cash payments to employees for services and benefits	(814,049)	(657,184)
Cash payments to grantee	(5,870,978)	(5,030,622)
Rental and other operating revenues	1,177,107	1,601,291
Net cash provided (used) by operating activities	496,666	(2,678,508)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchases of capital assets	(233,243)	(4,929)
Net cash provided (used) by capital and related financing activities	(233,243)	(4,929)
CASH FLOWS FROM INVESTING ACTIVITIES		
Investment earnings	579	100
Net investment sales (purchases)	309,362	2,783,726
Net cash provided by investing activities	309,941	2,783,826
Net increase in cash	573,364	100,389
CASH AND CASH EQUIVALENTS, BEGINNING OF FISCAL YEAR	1,431,371	1,330,982
CASH AND CASH EQUIVALENTS, END OF FISCAL YEAR	$ 2,004,735	$ 1,431,371
RECONCILIATION OF CASH AND CASH EQUIVALENTS TO THE STATEMENT OF NET POSITION		
Cash and cash equivalents	$ 2,004,735	$ 1,431,371

The accompanying notes are an integral part of these financial statements

DESERT HEALTHCARE DISTRICT

STATEMENT OF CASH FLOWS
FOR THE FISCAL YEAR ENDED JUNE 30, 2018

WITH COMPARATIVE TOTALS FOR THE FISCAL YEAR ENDED JUNE 30, 2017

RECONCILIATION OF OPERATING INCOME (LOSS) TO NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES	2018	2017
Income from operations	$ (304,790)	$ 1,842,973
Adjustments to reconciliation of income from operations to net cash provided (used) by operating activities:		
Depreciation	643,863	632,916
Changes in assets and liabilities:		
Accounts receivable	103,857	348,140
Prepaid items and deposits	437	22,269
Deferred outflow-pension	176,689	413,468
Deferred outflow-OPEB	443	-
Net pension liabilities	393,798	(6,760,707)
Net OPEB liabilities	(18,530)	-
Accounts payable and accrued liabilities	1,328,753	(66,413)
Grants payable	(794,939)	(1,576,873)
Deposits payable	4,478	(6,031)
Compensated absences	(7,050)	(33,973)
Gain on disposition of fixed assets	-	710
Long-term disability claims reserve	(10,472)	(9,863)
Deferred inflow - pension	(1,019,871)	2,524,751
Retired director's medical liability	-	(9,875)
Net cash provided (used) by operating activities	$ 496,666	$ (2,678,508)

The accompanying notes are an integral part of these financial statements

DESERT HEALTHCARE DISTRICT

STATEMENT OF FIDUCIARY NET POSITION
DESERT HEALTHCARE FOUNDATION
JUNE 30, 2018

WITH COMPARATIVE TOTALS AS OF JUNE 30, 2017

	Private- Purpose Trust Fund	
	2018	2017
CURRENT ASSETS		
Cash and cash equivalents	$ 3,447,997	$ 2,017,563
Grants receivable	1,030,829	14,477
Prepaid items	3,540	2,500
Accrued interest and dividend receivable	13,787	11,532
Total current assets	4,496,153	2,046,072
OTHER ASSETS		
Contributions receivable - charitable remainder trusts	188,929	185,939
Assets held in charitable remainder trusts	-	86,207
Investments	2,499,286	2,410,881
Total other assets	2,688,215	2,683,027
TOTAL ASSETS	7,184,368	4,729,099
LIABILITIES		
Current liabilities:		
Accounts payable	83,980	16,312
Deferred grant income	-	2,000,000
Grants payable - current portion	3,621,167	217,292
Total current liabilities	3,705,147	2,233,604
Long-term liabilities:		
Grants payable - long-term	1,200,000	200,000
Total long-term liabilities	1,200,000	200,000
Total liabilities	4,905,147	2,433,604
NET POSITION	$ 2,279,221	$ 2,295,495

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 FISCAL YEAR ENDED JUNE 30, 2018

WITH COMPARATIVE TOTALS FOR THE FISCAL YEAR ENDED JUNE 30, 2017

	Private-Purpose Trust Fund	
	2018	2017
ADDITIONS		
Contributions	$ 226,403	$ 4,980
Grants	5,339,347	120,306
Interest and dividends	65,341	57,334
Investment gains and losses	(49,499)	58,111
Sale of mineral rights	-	55,000
Miscellaneous income	-	18,406
Change in value - charitable trusts	3,506	(10,605)
Total support and revenue	5,585,098	303,532
DEDUCTIONS		
Grants and services	5,314,610	60,590
Management and general	286,762	54,617
Total expenses	5,601,372	115,207
INCREASE (DECREASE) IN NET POSITION	(16,274)	188,325
NET POSITION, BEGINNING OF FISCAL YEAR	2,295,495	2,107,170
NET POSITION, END OF FISCAL YEAR	$ 2,279,221	$ 2,295,495

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 five 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 District's 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)

The District has and continues to assess the healthcare needs of the Western 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 U.S. 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 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 Position, Statement of Revenues, Expenditures, and Changes in Net Position, 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 Position. The Statement of Revenues, Expenses and Changes in Net Position presents changes in net position 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 Position. Their reported fund equity presents total net position. The Statement of Revenues, Expenses and Changes in Net Position present increases (revenues) and decreases (expenses) in total net position. 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 benefit 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 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 (U.S. 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 Assets — This amount is restricted by external creditors, grantors, contributors, or laws of regulations of other governments.

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

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 Note 15 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 by the government that is applicable to a future reporting period. Refer to Note 15 for a detailed listing of the deferred outflow of resources that the District has recognized.

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

The District, as described in Note 1, 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 $72,000,000 to maintain the operations without interruption during the transition period. The District, recognizing this obligation, established an investment fund, with a net value of $55,344,906 as of June 30, 2018, 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 within a sixty day period or the premises are totally destroyed and repairs are not feasible between the dates of June 1, 2018 and May 30, 2021, the District may be obligated to repay Tenet beginning June 1, 2018 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 previously 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 $4,680,743 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 rent 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, 2018, the prepaid lease balance is $8,968,564. This amount will decrease annually by $3,066,667 per terms of the lease agreement. Should the lease terminate early, the prepaid lease repayment may be made in full or over a period of five years.

3. CASH AND INVESTMENTS

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

	June 30, 2018	June 30, 2017
District's Statement of Net Position:		
Cash and cash equivalents	$ 2,004,735	$ 1,431,371
Investments	54,326,412	54,644,090
Fiduciary Statement of Net Position:		
Cash and cash equivalents	3,447,997	2,017,563
Investments	2,499,286	2,410,881
Total Cash and Investments	$ 62,278,430	$ 60,503,905
Cash and Investments consist of the following:		
Cash on Hand	$ 700	$ 700
Cash in Bank-District	985,741	231,484
Cash in Bank-Foundation	3,421,500	1,984,693
Money Market Funds	1,044,791	1,232,057
Investments	56,825,698	57,054,971
Total Cash and Investments	$ 62,278,430	$ 60,503,905

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.

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
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
Collateralized Bank Deposits	5 years	None	None
Mortgage Pass-Through Securities	5 years	20%	None
County Pooled Investment 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.

3. CASH, AND INVESTMENTS - Continued

Disclosures Relating to Interest Rate Risk (Continued)

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, 2018

		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*	$ 999,329	$ 89,873	$ -	$ 41,882	$ 19,265	$ 848,309
U.S. Government Agencies	24,864,624	4,055,362	7,515,586	5,417,235	6,858,290	1,018,151
U.S. Treasury Notes	30,015,893	6,010,220	2,991,450	7,960,870	7,658,902	5,394,451
Municipal Bonds	205,182	10,000	19,876	39,920	14,859	120,527
Domestic Common Stock*	740,670	740,670				
Total	$ 56,825,698	$ 10,906,125	$ 10,526,912	$ 13,459,907	$ 14,551,316	$ 7,381,438

* Held by Foundation

As of June 30, 2017

		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*	$ 891,720	$ 44,204	$ 35,215	$ 37,712	$ 91,133	$ 683,456
U.S. Government Agencies	26,678,586	9,185,840	4,109,620	7,620,245	2,582,706	3,180,175
U.S. Treasury Notes	28,664,630	8,071,240	6,204,884	2,145,900	6,127,190	6,115,416
Municipal Bonds	94,228		20,101			74,127
Domestic Common Stock*	725,807	725,807				
Total	$ 57,054,971	$ 18,027,091	$ 10,369,820	$ 9,803,857	$ 8,801,029	$ 10,053,174

* Held by Foundation

3. 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, 2018:

				Rating as of Fiscal Year End			
Investment Type	Carrying Amount	Minimum Legal Rating	Exempt From Disclosure	AAA	AA	A	Not Rated
Corporate Bonds*	$ 999,329	A	$ -	$ 35,005	$ 96,961	$ 867,363	$ -
U.S. Government Agencies	24,864,624	A		24,864,624			
U.S. Treasury Notes	30,015,893	N/A	30,015,893				
Municipal Bonds	205,182	N/A		57,737	147,445		
Domestic Common Stock*	740,670	N/A					740,670
Total	$ 56,825,698		$ 30,015,893	$ 24,957,366	$ 244,406	$ 867,363	$ 740,670

* Held by Foundation

As of June 30, 2017:

				Rating as of Fiscal Year End			
Investment Type	Carrying Amount	Minimum Legal Rating	Exempt From Disclosure	AAA	AA	A	Not Rated
Corporate Bonds*	$ 891,720	A	$ -	$ -	$ 142,370	$ 749,350	$ -
U.S. Government Agencies	26,678,585	A		26,678,585			
U.S. Treasury Notes	28,664,630	N/A	28,664,630				
Municipal Bonds	94,229	N/A		10,682	63,566	19,981	
Domestic Common Stock*	725,807	N/A					725,807
Total	$ 57,054,971		$ 28,664,630	$ 26,689,267	$ 205,936	$ 769,331	$ 725,807

* Held by Foundation

3. CASH AND INVESTMENTS - Continued

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, 2018 that represent 5% or more of total District investments (other than U.S. Treasury Notes). These investments are:

Federal Home Loan Banks: $7,544,505 with various maturity dates through June 30, 2023, and interest rates of 1.375-4.500%.
Federal Home Loan Mortgage Corporation: $4,953,650 with various maturity dates through June 30, 2022, and interest rates of 1.250-3.750%.
Federal National Mortgage Association: $12,263,445 with various maturity dates through June 30, 2022, and interest rates of 1.250-2.000%.

There are three investments at June 30, 2017 that represent 5% or more of total District investments (other than U.S. Treasury Notes). These investments are:

Federal Home Loan Banks: $6,702,445 with various maturity dates through June 30, 2020, and interest rates of 1.375-5.000%.
Federal Home Loan Mortgage Corporation: $9,155,460 with various maturity dates through June 30, 2022, and interest rates of 1.250-5.500%.
Federal National Mortgage Association: $10,556,105 with various maturity dates through June 30, 2022, and interest rates of 1.250-4.600%.

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, 2018 and 2017, 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.

3. CASH AND INVESTMENTS – Continued

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

The District has the following recurring fair value measurements;

As of June 30, 2018		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	$ 999,329	$ 999,329	$ -	$ -
U.S. Government Agencies	24,864,624	24,864,624		
U.S. Treasury Notes	30,015,893	30,015,893		
Municipal Bonds	205,182	205,182		
Domestic Common Stock	740,670	740,670		
	$ 56,825,698	$ 56,825,698	$ -	$ -

As of June 30, 2017		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	$ 891,720	$ 891,720	$ -	$ -
U.S. Government Agencies	26,678,586	26,678,586		
U.S. Treasury Notes	28,664,630	28,664,630		
Municipal Bonds	94,228	94,228		
Domestic Common Stock	725,807	725,807		
	$ 57,054,971	$ 57,054,971	$ -	$ -

4. CAPITAL ASSETS

Business-Type Activities

At June 30, 2018 and 2017, the capital assets of the business-type activities consisted of the following:

June 30, 2018

	Balance July 1, 2017	Additions	Deletions	Balance June 30, 2018
Non-depreciable assets				
Land	$ 3,988,650	$ -	$ -	$ 3,988,650
Total non-depreciable assets	3,988,650			3,988,650
Depreciable assets:				
Buildings and improvements	17,779,595	228,320	(51,934)	17,955,981
Furniture and equipment	171,623	4,923		176,546
Total	17,951,218	233,243	(51,934)	18,132,527
Less accumulated depreciation	(9,147,084)	(643,863)	51,934	(9,739,013)
Total depreciable assets, net	8,804,134	(410,620)		8,393,514
Total Capital Assets, Net	$ 12,792,784	$ (410,620)	$ -	$ 12,382,164

June 30, 2017

	Balance July 1, 2016	Additions	Deletions	Balance June 30, 2017
Non-depreciable assets				
Land	$ 3,988,650	$ -	$ -	$ 3,988,650
Total non-depreciable assets	3,988,650			3,988,650
Depreciable assets:				
Buildings and improvements	17,777,623	1,972		17,779,595
Furniture and equipment	170,189	2,957	(1,523)	171,623
Total	17,947,812	4,929	(1,523)	17,951,218
Less accumulated depreciation	(8,514,981)	(632,916)	813	(9,147,084)
Total depreciable assets, net	9,432,831	(627,987)	(710)	8,804,134
Total Capital Assets, Net	$ 13,421,481	$ (627,987)	$ (710)	$ 12,792,784

5. RESTRICTED NET POSITION

The District had $1,000,000 of restricted net position at June 30, 2017 consisting of a contribution received during the June 30, 2012 year restricted to pulmonary research and rehabilitation and/or for the purchase and/or construction of facilities used for these purposes. The $1,000,000 was contributed during the current fiscal year, to the Foundation, for similar use. The balance of restricted net position at June 30, 2018 is $0.

6. SPLIT INTEREST AGREEMENTS – FOUNDATION

At June 30, 2018 and 2017, the split interest agreements of the fiduciary fund consisted of the following:

	2018	2017
Contributions receivable - charitable remainder trusts	$ 188,929	$ 185,939
Assets held in charitable remainder trust	-	86,207
Total	$ 188,929	$ 272,146

Charitable Remainder Trusts

The Foundation was named trustee in one charitable remainder unitrust in which the trustee has a fiduciary responsibility to maintain and invest the trust assets prudently.

Trust 1 (dated April 12, 1989): Upon the death of the donor, 100% of the principal and income of the trust that is not required to have been distributed to the life beneficiary shall become the property of the Foundation. The donor passed away on May 30, 2015. The Foundation may use these assets for general purposes, as outlined in the trust agreement.

At June 30, 2018 and 2017, the estimated fair value of the trust was approximately $0 and $86,207, respectively.

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 two 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, 2017 and 2016, which is the most current information available, the estimated present value of future cash flows was $122,540 and $119,011, respectively.

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, 2018 and 2017 was $66,389 and $66,928, 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, 2018 and 2017, the total grant awards payable were $11,654,099 and $12,449,038, respectively. Total grant expense for the fiscal years ended June 30, 2018 and 2017 amounted to $5,076,039 and $3,453,749, respectively.

The Foundation has granted awards to various healthcare providers that provide needed healthcare services. At June 30, 2018 and 2017, the total grant awards payable were $4,821,167 and $417,292, respectively. Total grants and services expense for the years ended June 30, 2018 and 2017 amounted to $5,314,610 and $60,590, respectively.

8. LONG-TERM DISABILITY CLAIMS RESERVE

Long-term disability claims were self-insured by the Corporation. Claimants' payments are administered internally and made pursuant to the plan. Claimants are paid either to age 65 or until they return to work. At June 30, 2018 and 2017, the long-term disability claims reserves were as follows:

	Balance at July 1, 2017	Claims Paid	Changes in Estimates	Balance at June 30, 2018	Due Within One Year
Claims payable	$ 77,018	$ (14,803)	$ 4,331	$ 66,546	$ 14,803

	Balance at July 1, 2016	Claims Paid	Changes in Estimates	Balance at June 30, 2017	Due Within One Year
Claims payable	$ 86,881	$ (14,803)	$ 4,940	$ 77,018	$ 14,803

9. POSTEMPLOYMENT (HEALTH INSURANCE) BENEFITS

A. General Information about the OPEB Plan

Plan Description – The District's defined benefit OPEB plan, provides OPEB for the three 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 current 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, 2018, the following employees were covered by the benefit terms:

Inactive employees receiving benefits	3
Inactive employees entitled to but not yet receiving benefits payments	0
Active employees	0

B. Total OPEB Liability

The District's total OPEB liability of $108,687 was measured as of June 30, 2017 and was determined by an actuarial valuation as of that date.

Actuarial Assumptions and Other Inputs – The total OPEB liability in the June 30, 2017 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 are 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 are 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.

9. POSTEMPLOYMENT (HEALTH INSURANCE) BENEFITS (CONTINUED)

C. Changes in the Total OPEB Liability

Balance at June 30, 2017	$ 127,217
Changes for the fiscal year	
Service cost	-
Interest	4,057
Changes of benefit terms	-
Differences between expected and actual experience	-
Changes in assumptions or other inputs	-
Benefit payments	(22,587)
Net changes	(18,530)
Balance at June 30, 2018	$ 108,687

No plan assets at June 30, 2018

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 a 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	$111,842	$108,687	$105,727

Sensitivity of the Total OPEB Liability to Changes in the Healthcare Cost Trend Rates – 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 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	Trend 1% Higher
Net OPEB liability	$105,713	$108,687	$111,796

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

For the fiscal year ended June 30, 2018, the District recognized OPEB expense of $4,057. At June 30, 2017, the District reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	Deferred Outflows Of Resources
Benefit payments subsequent to measurement date	$ 22,144

There were no amounts reported as deferred outflows of resources and deferred inflows of resources related to OPEB 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 fiscal years ended June 30, 2018 and 2017:

	2018	2017
Base rent	$ 798,450	$ 854,111
Common area maintenance	314,791	324,374
Total Rental Income	$ 1,113,241	$ 1,178,485

The five year fiscal year minimum rental schedule follows:

	2019	2020	2021	2022	2023
Base rent	$ 858,530	$ 706,523	$ 660,092	$ 671,862	$ 545,255
Common area maintenance	339,641	276,188	252,385	249,210	199,673

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.

13. 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 financial statements for more detailed 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 (dated as of June 30, 2018), the Plan's independent actuary determined that the actuarial value of the Plan's net pension liability was $3,277,793 at June 30, 2018 and $2,883,995 at June 30, 2017. In the report it was recommended that an actuarially determined contribution of $288,378 as of June 30, 2018 and $928,460 as of June 30, 2017, should be made. The District's board of directors elected not to fund the Plan during 2018. The plan was funded in the amount of $3,400,000 during 2017.

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.

13. 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

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

14. 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, 2018 and 2017 were $55,242 and $39,173, respectively.

15. PENSION PLAN

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

Plan Description

The Plan was originally established in 1971 as a defined benefit plan covering all eligible employees of Desert Hospital. The plan has been frozen since May 31, 1997.

Employees Covered

At June 30, 2018 and 2017, the following employees were covered by the benefit terms:

	Miscellaneous	
	2018	**2017**
Inactive plan members if beneficiaries currently receiving benefits	16	16
Inactive plan members entitled to but not yet receiving benefits	60	60
Active plan members	141	141
Total Employees Covered	217	217

Contributions

There have been no contribution requirements by the District since May 31, 1997. Participant contributions to the Plan are not permitted.

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, 2018 actuarial valuations were determined using the following actuarial assumptions:

Inflation	2.75%
Discount rate	4.70%, net of pension plan investment expense, including inflation.
Measurement date	June 30, 2018, based on a valuation date of June 30, 2017.
Ad hoc cost-of-living increases	Not applicable
Mortality	Pre-Retirement: None Post-Retirement: 2017 Annuitant Mortality Table
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, 2017 funding valuation for other relevant assumptions.

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

15. PENSION PLAN (Continued)

Net Pension Liability (Continued)

Discount Rate

The discount rate used to measure the total pension liability was 4.70 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 4.70 percent discount rate is adequate and the use of the municipal bond rate calculation is not necessary. The long-term expected discount rate of 4.82 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 4.70 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 4.85 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 2017-18 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.

In determining the long-term expected rate of return, staff took into account both short-term and long-term market return expectations as well as the expected pension fund cash flows. Such cash flows were developed assuming that both members and employers will make their required contributions on time and as scheduled in all future years. Using historical returns of all the funds' asset classes, expected compound (geometric) returns were calculated over the long-term (11-60 years) using a building-block approach. Using the expected nominal returns for both short-term and long-term, the present value of benefits was calculated for each fund. 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

15. PENSION PLAN (Continued)

Net Pension Liability (Continued)

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

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, 2017 (VD)	$ 8,219,294	$ 5,344,173	$ 2,875,121
Changes in Recognized for the Measurement Period:			
Employer Contributions			
Interest on the Total Pension Liability	399,298		399,298
Differences between Expected and Actual Experience			
Changes in Assumptions	315,705		315,705
Net Investment Income **		347,969	(347,969)
Benefit Payments, including Refunds of Employee Contributions	(466,670)	(466,670)	-
Administrative Expenses		(35,638)	35,638
Net Changes during 2017-18	248,333	(154,339)	402,672
Balance, June 30, 2018 (MD) *	$ 8,467,627	$ 5,189,834	$ 3,277,793

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

** Net of administrative expenses.

15. PENSION PLAN (Continued)

Changes in the Plan's Net Pension Liability

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 4.70 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 (3.70 percent) or 1 percentage-point higher (5.70 percent) than the current rate:

	1% Decrease (3.70%)	Current Discount Rate (4.70%)	1% Increase (5.70%)
Net pension liability	$ 4,568,608	$ 3,277,793	$ 2,217,791

Plan Fiduciary Net Position

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

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

For the fiscal year ended June 30, 2018, the District recognized pension expense of $(440,510). At June 30, 2018, 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	$ -	$ (523,443)
Net differnces between projected and actual earnings on pension plan investments	1,014,623	(1,426,081)
Changes in assumptions	43,219	(272,666)
Total	$ 1,057,842	$ (2,222,190)

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
2019	$ (620,794)
2020	(519,151)
2021	(5,741)
2022	(18,662)
Total	$ (1,164,348)

16. PRIOR PERIOD ADJUSTMENT

Prior period adjustments in the amount of $9,380 are due to implementation of GASB statement No. 75 OPEB liabilities.

REQUIRED SUPPLEMENTARY INFORMATION

DESERT HEALTHCARE DISTRICT

REQUIRED SUPPLEMENTARY INFORMATION

JUNE 30, 2018

Prepared for the Desert Healthcare District, a Single-Employer Defined Benefit Pension Plan as of June 30, 2018

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

	2018	2017	2016	2015
Measurement Period	2017-2018	2016-2017	2014-2015	2013-2014
Total Pension Liability				
Interest on total pension liability	$ 399,298	$ 321,990	$ 397,980	$ 418,035
Differences between expected and actual experience		(437,093)	(493,455)	(537,276)
Changes in assumptions	315,705	(2,852,163)	1,944,607	
Benefit payments, including refunds of employee contributions	(466,670)	(382,380)	(459,397)	(304,566)
Net change in total pension liability	248,333	(3,349,646)	1,389,735	(423,807)
Total pension liability - beginning	8,219,294	11,568,940	10,179,205	10,603,012
Total pension liability - ending (a)	8,467,627	8,219,294	11,568,940	10,179,205
Plan fiduciary net position				
Employer contributions		3,400,000		
Net investment income	347,969	426,828	(6,638)	71,101
Benefit payments	(466,670)	(382,380)	(459,397)	(304,566)
Administrative expenses	(35,638)	(24,513)	(14,983)	(17,886)
Net change in plan fiduciary net position	(154,339)	3,419,935	(481,018)	(251,351)
Plan fiduciary net position - beginning	5,344,173	1,924,238	2,405,256	2,656,607
Plan fiduciary net position - ending (b)	5,189,834	5,344,173	1,924,238	2,405,256
Net pension liability - ending (a) - (b)	$ 3,277,793	$ 2,875,121	$ 9,644,702	$ 7,773,949
Plan fiduciary net position as a percentage of the total pension liability	61.29%	65.02%	16.63%	23.63%
Covered - employee payroll	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

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%.

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

DESERT HEALTHCARE DISTRICT

REQUIRED SUPPLEMENTARY INFORMATION

JUNE 30, 2018

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

Measurement period	6/30/2017
Total OPEB Liability	
Services Cost	$ -
Interest on the Total Pension Liability	4,057
Benefit Payments	(22,587)
Net Change in Total Pension Liability	(18,530)
Total OPEB Liability - Beginning	127,217
Total OPEB Liability - Ending (a)	$ 108,687
Plan Fiduciary Net Position	
Contribution from the Employer	$ 22,587
Net investment income	-
Benefit Payments	(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)	$ 108,687
Plan Fiduciary Net Position as a Percentage of the Total OPEB Liability	0.00%
Covered - Employee Payroll	N/A
Net OPEB Liability as Percentage of Covered-Employee Payroll	N/A

Notes to Schedule:

Changes of Assumption: There were no changes of assumption

*Fiscal year 2018 was the first year of implementation, therefore only one year is shown.

DESERT HOSPITAL
RETIREMENT PROTECTION PLAN

PALM SPRINGS, CALIFORNIA

INDEPENDENT AUDITOR'S REPORT,
FINANCIAL STATEMENTS, AND
SUPPLEMENTARY INFORMATION

JUNE 30, 2018

MOSS, LEVY & HARTZHEIM LLP
CERTIFIED PUBLIC ACCOUNTANTS

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INDEPENDENT AUDITOR'S REPORT

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

We have audited the accompanying financial statements of Desert Hospital Retirement Protection Plan (the Plan) which comprise the statements of fiduciary net position as of June 30, 2018 and the related statement of changes in fiduciary net position for the fiscal year then ended, and the related notes to the financial statements.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audits 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.* 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 fiduciary net position of the Plan as of June 30, 2018, and the changes in fiduciary net position for the fiscal year then ended, in conformity with accounting principles generally accepted 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

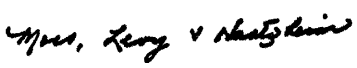
In accordance with *Government Auditing Standards,* we have also issued our report dated October 1, 2018 on our consideration of the Plan's internal control over financial reporting and on our tests of compliance with laws and regulations, contracts, and grant agreements and other matters. The purpose 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 Summarized Information

We have previously audited the Plan's 2017 financial statements, and our report dated October 5, 2017 expressed a qualified opinion on those audited financial statements. In our opinion, the summarized comparative information presented herein as of and for the fiscal year ended June 30, 2017, is consistent, in all material respects, with the audited financial statements from which it has been derived.



Moss, Levy & Hartzheim, LLP
Culver City, California
October 1, 2018

DESERT HOSPITAL RETIREMENT PROTECTION PLAN

STATEMENT OF FIDUCIARY NET POSITION

JUNE 30, 2018

WITH COMPARATIVE TOTALS FOR JUNE 30, 2017

	2018	2017
ASSETS		
Cash	$ 47,112	$ 64,991
Investments, at fair value		
U.S. Government securities	947,425	755,911
Corporate equity securities	377,175	462,385
Corporate debt securities	899,038	927,457
Mutual funds	2,911,510	3,121,560
Total investments	5,135,148	5,267,313
Interest and dividends receivable	16,220	11,869
LIABILITIES		
Accrued trustee fees	8,645	8,874
NET POSITION RESTRICTED FOR PENSION		
Net position restricted for pension	$ 5,189,835	$ 5,335,299

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

DESERT HOSPITAL RETIREMENT PROTECTION PLAN

STATEMENT OF CHANGES IN FIDUCIARY NET POSITION

FOR THE FISCAL YEAR ENDED JUNE 30, 2018

WITH COMPARATIVE TOTALS FOR THE FISCAL YEAR ENDED JUNE 30, 2017

	2018	2017
ADDITIONS:		
Contributions	$ -	$ 3,400,000
Investment income:		
Net appreciation in fair value of Plan assets	226,431	347,913
Interest, dividends, and other investment income	130,184	78,916
Net income	356,615	3,826,829
DEDUCTIONS:		
Distributions of benefits	466,670	382,380
Administrative expenses	35,409	33,388
Total deductions	502,079	415,768
NET INCREASE (DECREASE) IN NET POSITION	(145,464)	3,411,061
NET POSITION RESTRICTED FOR PENSION:		
BEGINNING OF THE FISCAL YEAR	5,335,299	1,924,238
END OF THE FISCAL YEAR	$ 5,189,835	$ 5,335,299

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

DESERT HOSPITAL RETIREMENT PROTECTION PLAN

NOTES TO FINANCIAL STATEMENTS

JUNE 30, 2018

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, 2018 by the Plan's independent actuary determined that the actuarial value of the Plan's net pension liability was $3,277,793 at June 30, 2018 and $2,875,121 at June 30, 2017 and recommended to the District an actuarially determined contribution of $288,378 as of June 30, 2018 and $928,460 as of June 30, 2017.

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 accounting principles generally accepted 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 accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, and 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.

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.

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

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:

	2018		2017	
Investment Type	Cost	Fair Value	Cost	Fair Value
Cash	$ 47,112	$ 47,112	$ 64,991	$ 64,991
Investments				
U.S. Government securities	973,848	947,425	756,073	755,911
Corporate equity securities	307,499	377,175	418,008	462,385
Corporate debt securities	929,318	899,038	929,318	927,457
Mutual funds	2,494,392	2,911,510	2,800,692	3,121,560
Investments total	4,705,057	5,135,148	4,904,091	5,267,313
Total cash and investments	$ 4,752,169	$ 5,182,260	$ 4,969,082	$ 5,332,304

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 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.

4. CASH AND INVESTMENTS (Continued)

Disclosures Relating to Interest Rate Risk (Continued)

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, 2018

		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	$ 2,722,118	$ 2,722,118	$ -	$ -	$ -	$ -
Fixed Income Mutual Funds	189,392	189,392				
Corporate Bonds	899,038	99,863	99,376	300,808	149,646	249,345
U.S. Government Agencies	648,935	1,170			49,344	598,421
U.S. Treasury Note	298,490	50,017	49,578	49,500	49,434	99,961
Foreign Stock	18,185	18,185				
Domestic Common Stock	358,990	358,990				
Total	$ 5,135,148	$ 3,439,735	$ 148,954	$350,308	$ 248,424	$ 947,727

As of June 30, 2017

		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	$ 2,737,981	$ 2,737,981	$ -	$ -	$ -	$ -
Fixed Income Mutual Funds	383,579	383,579				
Corporate Bonds	927,457		100,940	101,605	310,242	414,670
U.S. Government Agencies	553,136	1,199	4,232			547,705
U.S. Treasury Note	202,775		50,494	50,359	50,971	50,951
Foreign Stock	29,307	29,307				
Domestic Common Stock	433,078	433,078				
Total	$ 5,267,313	$ 3,585,144	$ 155,666	$151,964	$ 361,213	$ 1,013,326

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, 2018:

				Rating as of Fiscal Year End			
Investment Type	Carrying Amount	Minimum Legal Rating	Exempt From Disclosure	AAA	AA	A	Not Rated
Equity Based Mutual Funds	$ 2,722,118	N/A	$ -	$ -	$ -	$ -	$ 2,722,118
Fixed Income Mutual Funds	189,392	N/A					189,392
Corporate Bonds	899,038	A			350,225	548,813	
U.S. Government Agencies	648,935	A				648,935	
U.S. Treasury Note	298,490	N/A	298,490				
Foreign Stock	18,185	N/A					18,185
Domestic Common Stock	358,990	N/A					358,990
Total	$ 5,135,148		$ 298,490	$ -	$ 350,225	$ 1,197,748	$ 3,288,685

As of June 30, 2017:

				Rating as of Fiscal Year End			
Investment Type	Carrying Amount	Minimum Legal Rating	Exempt From Disclosure	AAA	AA	A	Not Rated
Equity Based Mutual Funds	$ 2,737,981	N/A	$ -	$ -	$ -	$ -	$ 2,737,981
Fixed Income Mutual Funds	383,579	N/A					383,579
Corporate Bonds	927,457	A			310,600	616,857	
U.S. Government Agencies	553,136	A		51,049		502,087	
U.S. Treasury Note	202,775	N/A	202,775				
Foreign Stock	29,307	N/A					29,307
Domestic Common Stock	433,078	N/A					433,078
Total	$ 5,267,313		$ 202,775	$ 51,049	$ 310,600	$ 1,118,944	$ 3,583,945

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, 2018 that represent 5% or more of total Plan investments. These investments are:

1,695 Shares of IShares S&P 500 Growth Etf valued at $275,624
3,245 Shares of IShares S&P 500 Value Etf valued at $357,372
4,615 Shares of IShares Msci Eafe Etf valued at $309,067

There are six investments at June 30, 2017 that represent 5% or more of total Plan investments. These investments are:

4,375 Shares of IShares S&P 500 Growth ETF valued at $324,334.
3,100 Shares of IShares S&P 500 Value ETF valued at $325,376.
5,750 Shares of IShares Msci Eafe ETF valued at $374,900.
1,575 Shares of IShares Russell 2000 ETF valued at $221,949.
3,900 Shares of IShares Msci Eafe Value ETF valued at $201,630.
2,750 Shares of IShares Msci Eafe Growth ETF valued at $203,390

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 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, 2018, 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 requirements 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 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 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, 2018:

		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	$ 947,425	$ 298,490	$ 648,935	$ -
Corporate Issues	899,038		899,038	
Mutual Funds- Equity	2,722,118	2,722,118		
Mutual Funds- Fixed Income	189,392		189,392	
Domestic Common Stock	358,990	358,990		
Foreign Stock	18,185	18,185		
Total	$ 5,135,148	$ 3,397,783	$ 1,737,365	$ -

The Plan has the following recurring fair value measurements as of June 30, 2017:

		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	$ 755,911	$ 755,911	$ -	$ -
Corporate Issues	927,457		927,457	
Mutual Funds- Equity	2,737,981	2,737,981		
Mutual Funds- Fixed Income	383,579		383,579	
Domestic Common Stock	433,078	433,078		
Foreign Stock	29,307	29,307		
Total	$ 5,267,313	$ 3,956,277	$ 1,311,036	$ -

5. ACTUARIAL ASSUMPTIONS

The total pension liability as of June 30, 2018 was determined using the following actuarial assumptions:

Inflation	2.75%
Discount rate	4.70%, net of pension plan investment expense, including inflation.
Measurement date	June 30, 2018, based on a valuation date of June 30, 2017.
Ad hoc cost-of-living increases	Not applicable
Mortality	Pre-Retirement: None Post-Retirement: 2017 Annuitant Mortality Table
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, 2017 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:	**2018**	**2017**
Service cost	$ -	$ -
Interest	399,298	321,990
Changes of benefit terms		
Differences between expected and actual experience		(437,093)
Changes of assumptions	315,705	(2,852,163)
Benefit payments, including refunds of member contributions	(466,670)	(382,380)
Net change in total pension liability	248,333	(3,349,646)
Total pension liability - beginning	8,219,294	11,568,940
Total pension liability - ending (a)	$ 8,467,627	$ 8,219,294
Plan fiduciary net position		
Contributions - employer	$ -	$ 3,400,000
Net investment income	347,969	426,828
Benefit payments, including refunds of member contributions	(466,670)	(382,380)
Administrative expenses	(35,638)	(24,513)
Net change in plan fiduciary net position	(154,339)	3,419,935
Plan fiduciary net position - beginning	5,344,173	1,924,238
Plan fiduciary net position - ending (b)	5,189,834	5,344,173
Net pension liability - ending (a) - (b)	$ 3,277,793	$ 2,875,121
Plan fiduciary net position as a percentage of the total pension liability	61.29%	65.02%
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 4.70%. 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 the member rate. 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 3.50% was used to discount unfunded projected benefit payments to determine the total pension liability. The single effective discount rate was 4.70%.

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

The following presents the net pension liability, calculated using the discount rate of 4.70%, as well as what the net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower (3.70%) or 1-percentage-point higher (5.70%) than the current rate:

	1% Decrease (3.70%)	Current Discount Rate (4.70%)	1% Increase (5.70%)
Net pension liability	$ 4,568,608	$ 3,277,793	$ 2,217,791

Summary

Plan membership

The total pension liability was determined based on the plan membership as of June 30,	2018	2017
Inactive plan members if beneficiaries currently receiving benefits	16	16
Inactive plan members entitled to but not yet receiving benefits	60	60
Active plan members*	141	141
	217	217

6. NET PENSION LIABILITY OF THE PLAN (Continued)

Summary (Continued)

Net Pension Liability

The components of the net pension liability at June 30,	2018	2017
Total pension liability	$ 8,467,627	$ 8,219,294
Plan fiduciary net position	(5,189,834)	(5,344,173)
Net pension liability	$ 3,277,793	$ 2,875,121
Plan fiduciary net position as a % of the total pension liability	61.29%	65.02%

Actuarial Assumptions

The total pension liability was determined using the following actuarial assumptions.	2018	2017
Inflation	2.75%	2.75%
Salary increases	NA	NA
Investment rate of return	6.82%	6.82%
Discount rate	4.70%	5.00%

SUPPLEMENTARY INFORMATION

DESERT HOSPITAL RETIREMENT PROTECTION PLAN

SCHEDULE OF FUNDING PROGRESS

JUNE 30, 2018

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

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

DESERT HEALTHCARE DISTRICT

Date: October 23, 2018

To: Board of Directors

Subject: Lease Agreement – Desert Family Medical Center 2W 203

Staff recommendation: Consideration to approve the draft lease agreement for Desert Family Medical Center at the Las Palmas Medical Plaza.

Background:

- Desert Family Medical Center has been a long standing tenant of the Las Palmas Medical Plaza
- Desert Family Medical Center would like to renew a 5 year lease with base rent of $1.74/sf.
- Tenant Improvement of $15/sf ($22,200).
- At the October 9, 2018 F&A Committee meeting, the Committee recommended forwarding to the Board for approval.
- Staff recommends approval of the draft lease agreement
- Draft lease agreement is attached for your review.

Fiscal Impact:

Estimated revenue from Rent and CAMs for life of the lease - $219,121

Estimated cost of Tenant Improvement Allowance ($15.00/sf) - $22,200

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OFFICE BUILDING LEASE

This Lease between Desert Healthcare District, doing business as Las Palmas Medical Plaza hereinafter referred to as "Landlord", and Erik G. Palmer, D.O., a Medical Corporation d.b.a. Desert Family Medical Center, referred to as "Tenant", and is dated January 1, 2019.

1. LEASE OF PREMISES.

In consideration of the Rent (as defined at Section 5.4) and the provisions of this Lease, Landlord leases to Tenant and Tenant leases from Landlord the Premises described in Section 2L. The Premises are located within the Building and Project described in Section 2m. Tenant shall have the non-exclusive right (unless otherwise provided herein) in common with Landlord, other tenants, subtenants, and invitees, to use of the Common Areas (as defined at Section 2e).

2. DEFINITIONS.

As used in this Lease, the following terms shall have the following meanings:

a. *Base Rent (Initial)*: **$ Thirty-Thousand Nine-Hundred Two & 40/100 (30,902.40)** per year.

b. *Base Year:* The calendar year of **January 1 to December 31**.

c. *Broker(s):*

Landlord's: N/A.

Tenant's: N/A.

In the event that N/A. represents both Landlord and Tenant, Landlord and Tenant hereby confirm that they were timely advised of the dual representation and that they consent to the same, and that they do not expect said broker to disclose to either of them the confidential information of the other party.

d. *Commencement Date*: **January 1, 2019**.

e. *Common Areas*: The building lobbies, common corridors and hallways, restrooms, parking areas, stairways, elevators and other generally understood public or common areas. Landlord shall have the right to regulate or restrict the use of the Common Areas.

f. *Expiration Date*: **December 31, 2023**, unless otherwise sooner terminated in accordance with the provisions of this Lease.

g. *Landlord's Mailing Address*: **1140 N. Indian Cayon Dr. Palm Springs, CA 92262**.

Tenant's Mailing Address: **555 E. Tachevah Dr. 2W-203 Palm Springs, CA 92262**.

h. *Monthly Installments of Base Rent (initial)*: **$ Two-Thousand, Five-Hundred Seventy-Five and 20/100 Dollars ($2,575.20)** per month.

i. *Project Operating Costs (CAMS)*: Currently **Sixty-two Cents ($.62)** per square foot per month.

j. *Tenant Improvement Allowance (TI)*: **Fifteen Dollars ($15.00) per square foot or Twenty-Two Thousand two hundred & 00/100 Dollars ($22,200.00)**.

k. *Parking*: Tenant shall be permitted, to park **7** cars on a non-exclusive basis in the area(s) designated by Landlord for parking (for Staff - generally in the back of the parking area, perimeter streets, and Wellness Park parking lot). Tenant shall abide by any and all parking regulations and rules established from time to time by Landlord or Landlord's parking operator.

l. *Premises*: That portion of the Building containing approximately **1480** square feet of Rentable Area, located in Building 2W and known as Suite 203.

m. *Project*: The building of which the Premises are a part (the "Building") and any other buildings or improvements on the real property (the "Property") located at **555 E. Tachevah Drive, Palm Springs, California 92262**. The Project is known as **The Las Palmas Medical Plaza**.

n. *Rentable Area*: As to both the Premises and the Project, the respective measurements of floor area as may from time to time be subject to lease by Tenant and all tenants of the Project, respectively, as determined by Landlord and applied on a consistent basis throughout the Project.

o. *Security Deposit (Section 7): $* ___ Tenant will carry over from previous lease in the amount of Two-Thousand Four-Hundred Forty-Two Dollars and 00/100 ($2,442.00).

p. *State:* the State of California.

q. *Tenant's First Adjustment Date (Section 5)*: The first day of the calendar month following the Commencement Date plus 12 months.

r. *Tenant's Proportionate Share*: __3.00__ %. Such share is a fraction, the numerator of which is the Rentable Area of the Premises and the denominator of which is the Rentable Area of the Project, as determined by Landlord from time to time. The Project consists of **six** building(s) containing a total Rentable Area of __49,356__ square feet.

s. *Tenant's Use Clause (*Article 8): General office use consistent with and use the City may allow under the City of Palm Springs zoning, subject to Landlord's reasonable approval.

t. *Term*: The period commencing on the Commencement Date and expiring at midnight on the Expiration Date.

3. EXHIBITS AND ADDENDA.

The exhibits and addenda listed below (unless lined out) are incorporated by reference in this Lease:
a. Exhibit "A" Rules and Regulations.
b. Addenda*****

***See Addendum attached hereto and by this reference made a part hereof.**

4. DELIVERY OF POSSESSION.

If for any reason Landlord does not deliver possession of the Premises to Tenant on the commencement Date, Landlord shall not be subject to any liability for such failure, the Expiration Date shall not change and the validity of this Lease shall not be impaired, but Rent shall be abated until delivery of possession, "Delivery of possession" shall be deemed to occur on the date Landlord completes Landlord's Work as defined in Addendum. If Landlord permits Tenant to enter into possession of the Premises before the Commencement Date, such possession shall be subject to the provisions of this Lease, including, without limitation, the payment of Rent.

5. RENT.

5.1 *Payment of Base Rent:* Tenant agrees to pay the base rent for the premises. Monthly installments of Base Rent shall be payable in advance on the first day of each calendar month of the term. If the term begins (or ends) on other than the first (or last) day of a calendar month, the Base Rent for the partial month shall be prorated on a per diem basis. Tenant shall pay Landlord the first Monthly Installment of Base Rent when Tenant executes the Lease.

5.2 *Adjusted Base Rent*:
a. The Base Rent (and the corresponding monthly installments of Base Rent) set forth at Section 2a shall be adjusted annually (the "Adjustment Date"), commencing on Tenant's First Adjustment Date.
b. Such adjustment shall be the greater of 3% over the preceding year or Consumer Price Index.
c.

5.3 *Project Operating Costs(CAMs)*:
a. In order that the Rent payable during the Term reflect Project Operating Costs, Tenant agrees to pay to Landlord as Rent, Tenant's Proportionate Share of all costs, expenses and obligations attributable to the Project and its operation as set forth in 2i, all as provided below.

b. If, during any calendar year during the Term, Project Operating Costs exceed the Project Operating Costs for the Base Year, Tenant shall pay to Landlord, in addition to the Base Rent and all other payments due under this lease, an amount equal to Tenant's Proportionate Share of such excess Project Operating Costs in accordance with the provisions of this Section 5.3b.

(1.) The term "Project Operating Costs" shall include all those items described in the following subparagraphs (a) and (b).

(a.) All taxes, assessments, water and sewer charges and other similar governmental charges levied on or attributable to the Building or Project or their operation, including without limitation, (i) real property taxes or assessments levied or assessed against the Building or Project, (ii) assessments or charges levied or assessed against the Building or Project by any redevelopment agency, (iii) any tax measured by gross rentals received from the leasing of the Premises, Building or Project, excluding any net income, franchise, capital stock, estate or inheritance taxes imposed by the State or federal government or their agencies, branches or departments; provided that if at any time during the Term any governmental entity levies, assesses or imposes on Landlord any (1) general or special, ad valorem or specific, excise, capital levy or

other tax, assessment, levy or charge directly on the Rent received under this lease or on the rent received under any other leases of space in the Building or Project, or (2) and license fee, excise or franchise tax, assessment, levy or charge measured by or based, in whole or in part, upon such rent, or (3) any transfer, transactions, or similar tax, assessment, levy or charge based directly or indirectly upon the transaction represented by this Lease or such other leases, or (4) any occupancy, use, per capita or other tax, assessment, levy or charge based directly or indirectly upon the use or occupancy of the Premises or other premises within the Building or Project, then any such taxes, assessments, levies and charges shall be deemed to be included in the term Project Operation Costs. If at any time during the Term the assessed valuation of, or taxes on, the Project are not based on a completed Project having at least eighty-five percent (85%) of the Rentable Area occupied, then the "taxes" component of Project Operating Costs shall be adjusted by Landlord to reasonably Approximate the taxes, which would have been payable if the Project were completed and at least eighty-five percent (85%) occupied.

(b.) Operating costs incurred by Landlord in maintaining and operating the Building and Project, including without limitation the following: costs of (1) utilities; (2) supplies; (3) insurance (including public liability, property damage, earthquake, and fire and extended coverage insurance for the full replacement cost of the Building and Project as required by Landlord or its lenders for the Project; (4) services of independent contractors; (5) compensation (including employment taxes and fringe benefits) of all persons who perform duties connected with the operation, maintenance, repair or overhaul of the Building or Project, and equipment, improvements and facilities located within the Project, including without limitation engineers, janitors, painters, floor waxers, window washers, security and parking personnel and gardeners (but excluding persons performing services not uniformly available to or performed for substantially all Building or Project tenant); (6) operation and maintenance of a room for delivery and distribution of mail to tenants of the Building or Project as required by the U.S. Postal Service (including, without limitation, an amount equal to the fair market rental value of the mail room premises); (7) management of the Building or Project, whether managed by Landlord or an independent contractor (including, without limitation, an amount equal to the fair market value of any on-site manager's office); (8) rental expenses for (or a reasonable depreciation allowance on) personal property used in the maintenance, operation or repair of the Building or Project; (9) costs, expenditures or charges (whether capitalized or not) required by any governmental or quasi-governmental authority; (10) amortization of capital expenses (including financing costs) (i) required by a governmental entity for energy conservation or life safety purposes, or (ii) made by landlord to reduce Project Operating Costs; and (11) any other costs or expenses incurred by Landlord under this Lease and not otherwise reimbursed by tenants of the Project. If at any time during the Term, less than eighty-five percent (85%) of the Rentable Area of the Project is occupied, the "operating costs" component of Project Operating Costs shall be adjusted by Landlord to reasonably approximate the operating costs which would have been incurred if the Project had been at least eighty-five percent (85%) occupied.

(2.) Tenant's Proportionate Share of Project Operating Costs shall be payable by Tenant to Landlord as follows:

(a.) Beginning with the calendar year following the Base Year and for each calendar year thereafter ("comparison Year"), Tenant shall pay Landlord an amount equal to Tenant's Proportionate Share of the Project Operating Costs incurred by Landlord in the Comparison Year which exceeds the total amount of Project Operating Costs payable by Landlord for the Base Year. This excess is referred to as the "Excess Expenses."

(b.) To provide for current payments of Excess Expenses, Tenant shall, at Landlord's request, pay as additional rent during each Comparison Year, an amount equal to Tenant's Proportionate Share of the Excess Expenses payable during such Comparison Year, as estimated by Landlord from time to time. Such payments shall be made in monthly installments, commencing on the first day of the month following the month in which Landlord notifies Tenant of the amount it is to pay hereunder and continuing until the first day of the month following the month in which Landlord gives Tenant a new notice of estimated Excess Expenses. It is the intention hereunder to estimate from time to time the amount of the Excess Expense for each Comparison Year and Tenant's Proportionate Share thereof, and then to make an adjustment in the following year based on the actual Excess Expenses incurred for that Comparison Year.

(c.) On or before April 1 of each Comparison Year after the first Comparison Year (or as soon thereafter as is practical), Landlord shall deliver to Tenant a statement setting forth Tenant's Proportionate Share of the Excess Expenses for the preceding Comparison Year. If Tenant's Proportionate Share of the actual Excess Expenses for the previous Comparison Year exceeds the total of the estimated monthly payments made by Tenant for such year, Tenant shall pay Landlord the amount of the deficiency within ten (10) days of the receipt of the statement. If such total exceeds Tenant's Proportionate Share of the actual Excess Expenses for such Comparison Year, then Landlord shall credit against Tenant's next ensuing monthly installment(s) of additional rent an amount equal to the difference until the credit is exhausted. If the credit is due from Landlord on the Expiration Date, Landlord shall pay Tenant the amount of the credit. The obligations of Tenant and Landlord to make payments required under this Section 5.3 shall survive the Expiration Date.

(d.) Tenant's Proportionate Share of Excess Expenses in any Comparison Year having less than 365 days shall be appropriately prorated.

(e.) If any dispute arises as to the amount of any additional rent due hereunder, Tenant shall have the right after reasonable notice and at reasonable times to inspect Landlord's accounting records at Landlord's accounting office and, if after such inspection Tenant still disputes the amount of additional rent owed, a certification as to the proper amount shall be made by Landlord's certified public accountant, which certification shall be final and conclusive. Tenant agrees to pay the cost of such certification unless it is determined that Landlord's original statement overstated Project Operating Costs by more than five percent (5%).

(f.) If this Lease sets forth an Expense Stop at Section 2f, then during the Term, Tenant shall be liable for Tenant's Proportionare Share of any actual Project Operating Costs which exceed the amount of the Expense Stop. Tenant shall make current payments of such excess costs during the Term in the same manner as is provided for payment of Excess Expenses under the applicable provisions of Section 5.3(2)(b) and (c) above.

5.4 *Definition of Rent*: The Rent shall be paid to the Building manager (or other person) and at such place, as Landlord may from time to time designate in writing, without any prior demand therefore and without deduction or offset, in lawful money of the United States of America.

5.5 *Rent Control*: If the amount of Rent or any other payment due under this Lease violates the terms of any governmental restrictions on such Rent or payment, then the Rent or payment due during the period of such restrictions shall be the maximum amount allowable under those restrictions. Upon termination of the restrictions, Landlord shall, to the extent it is legally permitted, recover from Tenant the difference between the amounts received during the period of the restrictions and the amounts Landlord would have received had there been no restrictions.

5.6 *Taxes Payable by Tenant*: In addition to the Rent and any other charges to be paid by Tenant hereunder, Tenant shall reimburse Landlord upon demand for any and all taxes payable by Landlord (other than net income taxes) which are not otherwise reimbursable under this Lease, whether or not now customary or within the contemplation of the parties, where such taxes are upon, measured by or reasonably attributable to (a) the cost or value of Tenant's equipment, furniture, fixtures and other personal property located in the Premises, or the cost or value of any leasehold improvements made in or to the Premises by or for Tenant, other than Building Standard Work made by Landlord, regardless of whether title to such improvements is held by Tenant or Landlord; (b) the gross or net Rent payable under this Lease, including, without limitation, any rental or gross receipts tax levied by any taxing authority with respect to the receipt of the Rent hereunder; (c) the possession, leasing , operation, management, maintenance, alteration, repair, use or occupancy by Tenant of the Premises or any portion thereof; or (d) this transaction or any document to which Tenant is a party creating or transferring an interest or an estate in the Premises. If it becomes unlawful for Tenant to reimburse Landlord for any costs as required under this Lease, the Base Rent shall be revised to net Landlord the same net Rent after imposition of any tax or other charge upon Landlord as would have been payable to Landlord but for the reimbursement being unlawful.

5.7 *Tenant Improvement Allowance*: In recognition for Tenant completing all improvements, including fire sprinklers, to the premises as mutually agreed by Landlord and Tenant, Landlord shall provide Tenant with a total Tenant improvement allowance not to exceed that set forth in Section 2j upon completion of agreed tenant improvements. This allowance will be reimbursed to tenant upon satisfactory receipt of paid invoices and inspection by Property Management that work has been satisfactorily completed. Any additional tenant improvements will be at the sole expense of the Tenant. Improvements shall conform to a high quality of design approved by Landlord prior to commencement of work, and shall be performed by a licensed General Contractor approved by Landlord in advance. Tenant shall submit plans and specifications for any and all improvements to Landlord, and where necessary, the City of Palm Springs and other applicable government agencies for their required approval (if any) prior to commencement of work. Tenant and the General Contractor shall indemnify and hold Landlord and it officers, agents and employees harmless from any liability resulting from the tenant improvement work and shall be named as an additional insured on the insurance policy of both the Tenant and the General Contractor. All costs shall be subject to prevailing wages and if construction costs exceed $25,000, then the tenant improvements shall also be subject to California competitive bid statutes.

6. INTEREST AND LATE CHARGES.

If Tenant fails to pay when due any Rent or other amounts or charges which Tenant is obligated to pay under the terms of this Lease, the unpaid amounts shall bear interest at the maximum rate then allowed by law. Tenant acknowledges that the late payment of any Monthly Installment of Base Rent will cause Landlord to lose the use of that money and incur costs and expenses not contemplated under this Lease, including without limitation, administrative and collection costs and processing and accounting expenses, the exact amount of which is extremely difficult to ascertain. Therefore, in addition to interest, if any such installment is not received by Landlord within five (5) days from the date it is due, Tenant shall pay Landlord a late charge equal to ten percent (10%) of such installment. Landlord and Tenant agree that this late charge represents a reasonable estimate of such costs and expenses and is fair compensation to Landlord for the loss suffered from such nonpayment by Tenant. Acceptance of any interest or late charge shall not constitute a waiver of Tenant's default with respect to such nonpayment by Tenant nor prevent Landlord from exercising any other rights or remedies available to Landlord under this Lease.

7. SECURITY DEPOSIT.

Tenant agrees to deposit with Landlord the Security Deposit set forth at Section 2.0 upon execution of this Lease, as security for Tenant's faithful performance of its obligations under this Lease. Landlord and Tenant agree that the Security Deposit may be commingled with funds of Landlord and Landlord shall have no obligation or liability for payment of interest on such deposit. Tenant shall not mortgage, assign, transfer or encumber the Security Deposit without the prior written consent of Landlord and any attempt by Tenant to do so shall be void, without force or effect and shall not be binding upon Landlord.

If Tenant fails to pay Rent or other amount when due and payable under this Lease, or fails to perform any of the terms hereof, Landlord may appropriate and apply or use all or any portion of the Security Deposit for Rent payments or any other amount then due and unpaid, for payment of any amount for which Landlord has become obligated as a result of Tenant's default or breech, and for any loss or damage sustained by Landlord as a result of Tenant's default or breach, and Landlord may so apply or use this deposit without prejudice to any other remedy Landlord may have by reason of Tenant's default or breach. If Landlord so uses any of the Security Deposit, Tenant shall, within ten (10) days after written demand therefore, restore the Security Deposit to the full amount originally deposited; Tenant's failure to do so shall constitute an act of default hereunder and Landlord shall have the right to exercise any remedy provided for at Article 27 hereof. Within fifteen (15) days after the Term (or any extension thereof) has expired or Tenant has vacated the Premises, whichever shall last occur, and provided Tenant is not then in default on any of its obligations hereunder, Landlord shall return the Security Deposit to Tenant, or, if Tenant has assigned its interest under this Lease, to the last assignee of Tenant. If Landlord sells its interest in the Premises, Landlord may deliver this deposit to the purchaser of Landlord's interest and thereupon be relieved of any further liability or obligation with respect to the Security Deposit.

8. TENANT'S USE OF THE PREMISES

Tenant shall use the Premises solely for the purposes set forth in Tenant's Use Clause. Tenant shall not use or occupy the Premises in violation of law or any covenant, condition or restriction affecting the Building or Project or the certificate of occupancy issued for the Building or Project, and shall, upon notice from Landlord, immediately discontinue any use of the Premises which is declared by any governmental authority having jurisdiction to be a violation of law or the certificate of occupancy. Tenant, at Tenant's own cost and expense, shall comply with all laws, ordinances, regulations, rules and/or any directions of any governmental agencies or authorities having jurisdiction which shall, by reason of the nature of Tenant's use or occupancy of the Premises, impose any duty upon Tenant or Landlord with respect to the Premises or its use or occupation. A judgment of any court of competent jurisdiction or the admission by Tenant in any action or proceeding against Tenant that Tenant has violated any such laws, ordinances, regulations, rules and/or directions in the use of the Premises shall be deemed to be a conclusive determination of that fact as between Landlord and Tenant. Tenant shall not do or permit to be done anything, which will invalidate or increase the cost of any fire, extended coverage or other insurance policy covering the Building or Project and/or property located therein, and shall comply with all rules, orders, regulations, requirements and recommendations of the Insurance Services Office or any other organization performing a similar function. Tenant shall promptly upon demand reimburse Landlord for any additional premium charged for such policy by reason of Tenant's failure to comply with the provisions of this Article. Tenant shall not do or permit anything to be done in or about the Premises which will in any way obstruct or interfere with the rights of other tenants or occupants of the Building or Project, or injure or annoy them, or use or allow the Premises to be used for any improper, immoral, unlawful or objectionable purpose, nor shall Tenant cause, maintain or permit any nuisance in, on or about the Premises. Tenant shall not commit or suffer to be committed any waste in or upon the Premises.

9. SERVICES AND UTILITIES.

Provided that Tenant is not in default hereunder, Landlord agrees to furnish to the Premises during generally recognized business days, and during hours determined by Landlord in its sole discretion, and subject to the Rules and Regulations of the Building or Project, electricity for normal desk top office equipment and normal copying equipment, and heating, ventilation and air conditioning ("HVAC") as required in Landlord's judgment for the comfortable use and occupancy of the Premises. If Tenant desires HVAC at any other time, Landlord shall use reasonable efforts to furnish such service upon reasonable notice from Tenant and Tenant shall pay Landlord's charges therefore on demand. Landlord shall also maintain and keep lighted the common stairs, common entries and restrooms in the Building. Landlord shall not be in default hereunder or be liable for any damages directly or indirectly resulting from, nor shall the Rent be abated by reason of (I) the installation, use or interruption of use of any equipment in connection with the furnishing of any of the foregoing services, (ii) failure to furnish or delay in furnishing any such services where such failure or delay is caused by accident or any condition or event beyond the reasonable control of Landlord, or by the making of necessary repairs or improvements to the Premises, Building or Project, or (iii) the limitation, curtailment or rationing of, or restrictions on, use of water, electricity, gas or any other form of energy serving the Premises, Building or Project. Landlord shall not be liable under any circumstances for a loss of or injury to property or business, however occurring, through or in connection with or incidental to failure to furnish any such services. If Tenant uses heat generating machines or equipment in the Premises which affect the temperature otherwise maintained by the HVAC system, Landlord reserves the right to install supplementary air conditioning units in the Premises and the cost thereof, including the cost of installation, operation and maintenance thereof, shall be paid by Tenant to Landlord upon demand by Landlord.

Tenant shall not, without the written consent of Landlord, use any apparatus or devise in the Premises, including without limitation, electronic data processing machines, punch card machines or machines using in excess of 120 volts, which consumes more electricity than is usually furnished or supplied for the use of premises as general office space, as determined by Landlord. Tenant shall not connect any apparatus with electric current except through existing electrical outlets in the Premises. Tenant shall not consume water or electric current in excess of that usually furnished or supplied for the use of premises as general office space (as determined by Landlord), without first procuring the written consent of Landlord, which Landlord may refuse, and in the event of consent, Landlord may have installed a water meter or electrical current meter in the Premises to measure the amount of water or electric current consumed. The cost of any such meter and of its installation, maintenance and repair shall be paid for by the Tenant and Tenant agrees to pay to Landlord Promptly upon demand for all such water and electric current consumed as shown by said meters, at the rates charged for such services by the local public utility plus any additional expense incurred in keeping account of the water and electric current so consumed. If a separate meter is not installed, the excess cost for such water and electric current shall be established by an estimate made by a utility company or electrical engineer hired by Landlord at Tenant's expense.

Nothing contained in this Article shall restrict Landlord's right to require at any time separate metering of utilities furnished to the Premises. In the event utilities are separately metered, Tenant shall pay promptly upon demand for all utilities consumed at utility rates charged by the local public utility plus any additional expense incurred by Landlord in keeping account of the utilities so consumed. Tenant shall be responsible for the maintenance and repair of any such meters at it sole cost.

Landlord shall furnish elevator service, lighting replacement for building standard lights, restroom supplies, window washing and janitor services of common area in a manner that such services are customarily furnished to comparable office buildings in the area.

10. CONDITION OF THE PREMISES.

Tenant's taking possession of the Premises shall be deemed conclusive evidence that as of the date of taking possession of the Premises are in good order and satisfactory condition, except for such matters as to which Tenant gave Landlord notice on or before the Commencement Date. No promise of Landlord to alter, remodel, repair or improve the Premises, the Building or the Project and no representation, express or implied, respecting any matter or thing relating to the Premises, Building, Project or this Lease (including, without limitation, the condition of the Premises, the Building or the Project) have been made to Tenant by Landlord or its Broker or Sales Agent, other than as may be contained herein or in a separate exhibit or addendum signed by Landlord and Tenant.

11. CONSTRUCTION, REPAIRS AND MAINTENANCE.

a. *Landlord's Obligations*: Landlord shall maintain in good order, condition and repair the Building and all other portions of the Premises not the obligation of Tenant or of any other tenant in the Building.

b. *Tenant's Obligations*:
(1.) Tenant shall perform Tenant's Work to the Premises as described in an exhibit specific to Tenant Improvements, if applicable."

(2.) Tenant at Tenant's sole expense shall, except for services furnished by Landlord pursuant to Article 9 hereof, maintain the Premises in good order, condition and repair, including the interior surfaces of the ceilings, walls and floors, all doors, all interior windows, all plumbing, pipes and fixtures, electrical wiring, switches and fixtures, Building Standard furnishings and special items and equipment installed by or at the expense of Tenant.

(3.) Tenant shall be responsible for all repairs and alterations in and to the Premises, Building and Project and the facilities and systems thereof, the need for which arises out of (i) Tenant's use or occupancy of the Premises, (ii) the installation, removal, use or operation of Tenant's Property (as defined in Article 13) in the Premises, (iii) the moving of Tenant's Property into or out of the Building, or (iv) the act, omission, misuse or negligence of Tenant, its agents, contractors, employees or invitees.

(4.) If Tenant fails to maintain the Premises in good order, condition and repair, Landlord shall give Tenant notice to do such acts as are reasonably required to so maintain the Premises. If Tenant fails to promptly commence such work and diligently prosecute it to completion, then Landlord shall have the right to do such acts and expend such funds at the expense of Tenant as are reasonably required to perform such work. Any amount so expended by Landlord shall be paid by Tenant promptly after demand with interest at the prime commercial rate then being charged by Bank of America NT & SA plus two percent (2%) per annum, from the date of such work, but not to exceed the maximum rate then allowed by law. Landlord shall have no liability to Tenant for any damage, inconvenience, or interference with the use of the Premises by Tenant as a result of performing any such work.

c. *Compliance with Law*: Landlord and Tenant shall each do all acts required to comply with all applicable laws, ordinances, and rules of any public authority relating to their respective maintenance obligations as set forth herein.

d. *Waiver by Tenant*: Tenant expressly waives the benefits of any statute now or hereafter in effect which would otherwise afford the Tenant the right to make repairs at Landlord's expense or to terminate this Lease because of Landlord's failure to keep the Premises in good order, condition and repair.

e. *Load and Equipment Limits*: Tenant shall not place a load upon any floor of the Premises which exceeds the load per square foot which such floor was designed to carry, as determined by Landlord or Landlord's structural engineer. The cost of any such determination made by Landlord's structural engineer shall be paid for by Tenant upon demand. Tenant shall not install business machines or mechanical equipment which cause noise or vibration to such a degree as to be objectionable to Landlord or other Building tenants.

f. Except as otherwise expressly provided in this Lease, Landlord shall have no liability to Tenant nor shall Tenant's obligations under this Lease be reduced or abated in any manner whatsoever by reason of any inconvenience, annoyance, interruption or injury to business arising from Landlord's making any repairs or changes which Landlord is required or permitted by this Lease or by any other tenant's lease or required by law to make in or to any portion of the Project, Building or the Premises. Landlord shall nevertheless use reasonable efforts to minimize any interference with Tenant's business in the Premises.

g. Tenant shall give Landlord prompt notice of any damage to or defective condition in any part or appurtenance of the Building's mechanical, electrical, plumbing, HVAC or other systems serving, located in, or passing through the Premises.

h. Upon the expiration or earlier termination of this Lease, Tenant shall return the Premises to Landlord clean and in the same condition as on the date Tenant took possession, except for normal wear and tear. Any damage to the Premises, including any structural damage, resulting from Tenant's use or from the removal of Tenant's fixtures, furnishings and equipment pursuant to Section 13b shall be repaired by Tenant at Tenant's expense.

12. ALTERATIONS AND ADDITIONS.

a. Tenant shall not make any additions, alterations or improvements to the Premises without obtaining the prior written consent of Landlord. Landlord's consent may be conditioned on Tenant's removing any such additions, alterations or improvements upon the expiration of the term and restoring the Premises to the same condition as on the date Tenant took possession. All work with respect to any addition, alteration or improvement shall be done in a good and workmanlike manner by properly qualified and licensed personnel approved by Landlord, and such work shall be diligently prosecuted to completion. Landlord may, at Landlord's option, require that any such work be performed by Landlord's contractor in which case the cost of such work shall be paid for before commencement of the work. Tenant shall pay to Landlord upon completion of any such work by Landlord's contractor, an administrative fee of fifteen percent (15%) of the cost of the work.

b. Tenant shall pay the costs of any work done on the Premises pursuant to Section 12a, and shall keep the Premises, Building and Project free and clear of liens of any kind. Tenant shall indemnify, defend against and keep Landlord free and harmless from all liability, loss, damage, costs, attorneys' fees and any other expense incurred on account of claims by any person performing work or furnishing materials or supplies for Tenant or any person claiming under Tenant.

Tenant shall keep Tenant's leasehold interest, and any additions or improvements which are or become the property of Landlord under this Lease, free and clear of all attachment or judgment liens. Before the actual commencement of any work for which a claim or lien may be filed, Tenant shall give Landlord notice of the intended commencement date a sufficient time before that date to enable Landlord to post notices of non-responsibility or any other notices which Landlord deems necessary for the proper protection of Landlord's interest in the Premises, Building or the Project, and Landlord shall have the right to enter the Premises and post such notice at any reasonable time.

c. Landlord may require, at Landlord's sole option, that Tenant provide to Landlord, at Tenant's expense, a lien and completion bond in an amount equal to at least one and one-half (1.5) times the total estimated cost of any additions, alterations or improvements to be made in or to the Premises, to protect Landlord against any liability for mechanic's and material men's liens and to insure timely completion of the work. Nothing contained in this Section 12c shall relieve Tenant of its obligations under Section 12b to keep the Premises, Building and Project free of all liens.

d. Unless their removal is required by Landlord as provided in Section 12a, all additions, alterations and improvements made to the Premises shall become the property of Landlord and be surrendered with the Premises upon the expiration of the Term; provided, however, Tenant's equipment, machinery and trade fixtures which can be removed without damage to the Premises shall remain the property of Tenant and may be removed, subject to the provisions of Section 13b.

13. LEASEHOLD IMPROVEMENTS; TENANT'S PROPERTY.

a. All fixtures, equipment, improvements and appurtenances attached to or built into the Premises at the commencement of or during the Term, whether or not by or at the expense of Tenant ("Leasehold

Improvements"), shall be and remain a part of the Premises, shall be the property of Landlord and shall not be removed by Tenant, except as expressly provided in Section 13b.

b. All movable partitions, business and trade fixtures, machinery and equipment, communications equipment and office equipment located in the Premises and acquired by or for the account of Tenant, without expense to Landlord, which can be removed without structural damage to the Building, and all furniture, furnishings and other articles of movable personal property owned by Tenant and located in the Premises (collectively "Tenant's Property") shall be and shall remain the property of Tenant and may be removed by Tenant at any time during the Term; provided that if any of Tenant's Property is removed, Tenant shall promptly repair any damage to the Premises or to the Building resulting from such removal.

14. RULES AND REGULATIONS.

Tenant agrees to comply with (and cause its agents, contractors, employees and invitees to comply with) the rules and regulations attached hereto as Exhibit "D" and with such reasonable modifications thereof and additions thereto as Landlord may from time to time make. Landlord shall not be responsible for any violation of said rules and regulations by other tenants or occupants of the Building of Project.

15. CERTAIN RIGHTS RESERVED BY LANDLORD.

Landlord reserves the following rights, exercisable without liability to Tenant for (a) damage or injury to property, person or business, (b) causing an actual or constructive eviction from the Premises, or (c) disturbing Tenant's use or possession of the Premises:

a. To name the Building and Project and to change the name or street address of the Building or Project;

b. To install and maintain all signs on the exterior and interior of the Building and Project;

c. To have pass keys to the Premises and all doors within the Premises, eluding Tenant's vaults and safes;

d. At any time during the Term, and on reasonable prior notice to Tenant, to inspect the Premises, and to show the Premises to any prospective purchaser or mortgagee of the Project, or to any assignee of any mortgage on the Project, or to others having an interest in the Project or Landlord, and during the last six months of the Term, to show the Premises to prospective tenants thereof; and

e. To enter the Premises for the purpose of making inspections, repairs, alterations, additions or improvements to the Premises or the Building (including, without limitation, checking, calibrating, adjusting or balancing controls and other parts of the HVAC system), and to take all steps as may be necessary or desirable for the safety, protection, maintenance or preservation of the Premises or the Building or Landlord's interest therein, or as may be necessary or desirable for the operation or improvement of the Building or in order to comply with laws, orders or requirements of governmental or other authority. Landlord agrees to use its best efforts (except in an emergency) to minimize interference with Tenant's business in the Premises in the course of any such entry.

16. ASSIGNMENT AND SUBLETTING.

No assignment of this Lease or sublease of all or any part of the Premises shall be permitted, except as provided in this Article 16.

a. Tenant shall not, without the prior written consent of Landlord, assign or hypothecate this Lease or any interest herein or sublet the Premises or any part thereof, or permit the use of the Premises by any party other than Tenant. Any of the foregoing acts without such consent shall be void and shall, at the option of Landlord, terminate this Lease. This Lease shall not, nor shall any interest of Tenant herein, be assignable by operation of law without the written consent of Landlord.

b. If at any time or from time to time during the Term Tenant desires to assign this Lease or sublet all or any part of the Premises, Tenant shall give notice to Landlord setting forth the terms and provisions of the proposed assignment or sublease, and the identity of the proposed assignee or subtenant. Tenant shall promptly supply Landlord with such information concerning the business background and financial condition of such proposed assignee or subtenant as Landlord may reasonably request. Landlord shall have the option, exercisable by notice given to Tenant within twenty (20) days after Tenant's notice is given, either to sublet such space from Tenant at the rental and on the other terms set forth in this Lease for the term set forth in Tenant's notice, or, in the case of an assignment, to terminate this Lease. If Landlord does not exercise such option, Tenant may assign the Lease or sublet such space to such proposed assignee or subtenant on the following further conditions:

(1.) Landlord shall have the right to approve such proposed assignee or subtenant, which approval shall not be unreasonably withheld;

(2.) The assignment or sublease shall be on the same terms set forth in the notice given to Landlord;

(3.) No assignment or sublease shall be valid and no assignee or sub lessee shall take possession of the Premises until an executed counterpart of such assignment or sublease has been delivered to Landlord;

(4.) No assignee or sub lessee shall have a further right to assign or sublet except on the terms herein contained; and

(5.) Any sums or other economic consideration received by Tenant as a result of such assignment or subletting, however denominated under the assignment or sublease, which exceed, in the aggregate, (i) the total sums which Tenant is obligated to pay Landlord under this Lease (prorated to reflect obligations allocable to any portion of the Premises subleased), plus (ii) any real estate brokerage commissions or fees payable in connection with such assignment or subletting, shall be paid to Landlord as additional rent under this Lease without affecting or reducing any other obligations of Tenant hereunder.

c. Notwithstanding the provisions of paragraphs a and b above, Tenant may assign this Lease or sublet the Premises or any portion thereof, without Landlord's consent and without extending any recapture or termination option to Landlord, to any corporation which controls, is controlled by or is under common control with Tenant, or to any corporation resulting from a merger or consolidation with Tenant, or to any person or entity which acquires all the assets of Tenant's business as a going concern, provided that (i) the assignee or sub lessee assumes, in full, the obligations of Tenant under this Lease, (ii) Tenant remains fully liable under this Lease, and (iii) the use of the Premises under Article 8 remains unchanged.

d. No subletting or assignment shall release Tenant of Tenant's obligations under this Lease or alter the primary liability of Tenant to pay the Rent and to perform all other obligations to be performed by Tenant hereunder. The acceptance of Rent by landlord from any other person shall not be deemed to be a waiver by Landlord of any provision hereof. Consent to one assignment or subletting shall not be deemed consent to any subsequent assignment or subletting. In the event of default by an assignee or subtenant or any successor of Tenant in the performance of any of the terms hereof, Landlord may proceed directly against Tenant without the necessity of exhausting remedies against such assignee, subtenant or successor. Landlord may consent to subsequent assignments of the Lease or sub lettings or amendments or modifications to the Lease with assignees of tenant, without notifying Tenant, or any successor of Tenant, and without obtaining its or their consent thereof and any such actions shall not relieve Tenant of liability under this Lease.

e. If Tenant assigns the Lease or sublets the Premises or requests the consent of Landlord to any assignment or subletting or if Tenant requests the consent of Landlord for any act that Tenant proposes to do, then Tenant shall, upon demand, pay Landlord an administrative fee of One Hundred Fifty and No/100 Dollars ($150.00) plus any attorney's fees reasonably incurred by Landlord in connection with such act or request.

17. HOLDING OVER.

If after expiration of the Term, Tenant remains in possession of the Premises with Landlord's permission (express or implied), Tenant shall become a tenant from month to month only, upon all the provisions of this Lease (except as to term and Base Rent), but the "Monthly Installments of Base Rent" payable by Tenant shall be increased to one hundred fifty percent (150%) of the Monthly Installments of Base Rent payable by Tenant at the expiration of the Term. Such monthly rent shall be payable in advance on or before the first day of each month. If either party desires to terminate such month-to-month tenancy, it shall give the other party not less than thirty (30) days advance written notice of the date of termination.

18. SURRENDER OF PREMISES.

a. Tenant shall peaceably surrender the Premises to Landlord on the Expiration Date, in broom-clean condition and in as good condition as when Tenant took possession, except for (i) reasonable wear and tear, (ii) loss by fire or other casualty, and (iii) loss by condemnation. Tenant shall, on Landlord's request, remove Tenant's Property on or before the Expiration Date and promptly repair all damage to the Premises or Building caused by such removal.

b. If Tenant abandons or surrenders the Premises, or is dispossessed by process of law or otherwise, any of Tenant's Property left on the Premises shall be deemed to be abandoned, and, at Landlord's option, title shall pass to Landlord under this Lease as by a bill of sale. If Landlord elects to remove all or any part of such Tenant's Property, the cost of removal, including repairing any damage to the Premises or Building caused by such removal, shall be paid by Tenant. On the Expiration Date Tenant shall surrender all keys to the Premises.

19. DESTRUCTION OR DAMAGE.

a. If the Premises or the portion of the Building necessary for Tenant's occupancy is damaged by fire, earthquake, act of God, the elements, or other casualty, Landlord shall, subject to the provisions of this Article, promptly repair the damage, if such repairs can, in Landlord's opinion, be completed within ninety (90) days. If Landlord determines that repairs can be completed with ninety (90) days, this Lease shall remain in full force and effect, except that if such damage is not the result of the negligence or willful misconduct of Tenant or Tenant's agents, employees, contractors, licensees, or invitees, the Base Rent shall be abated to the extent Tenant's use of the Premises is impaired, commencing with the date of damage and continuing until completion of the repairs required of Landlord under Section 19d.

b. If in Landlord's opinion, such repairs to the Premises or portion of the Building necessary for Tenant's occupancy cannot be completed within ninety (90) days, Landlord may elect, upon notice to Tenant given within thirty (30) days after the date of such fire or other casualty, to repair such damage, in which event this Lease shall continue in full force and effect, but the Base Rent shall be partially abated as provided in Section 19a. If Landlord does not so elect to make such repairs, this Lease shall terminate as of the date of such fire or other casualty.

c. If any other portion of the Building or Project is totally destroyed or damaged to the extent that in Landlord's opinion repair thereof cannot be completed within ninety (90) days, Landlord may elect upon notice to Tenant given within thirty (30) days after the date of such fire or other casualty, to repair such damage, in which event this Lease shall continue in full force and effect, but the Base Rent shall be partially abated as provided in Section 19a. If Landlord does not so elect to make such repairs, this Lease shall terminate as of the date of such fire or other casualty.

d. If the Premises are to be repaired under this Article, Landlord shall repair at its cost any injury or damage to the Building and Building Standard Work in the Premises. Tenant shall be responsible at its sole cost and expense for the repair, restoration, and replacement of any other Leasehold Improvements and Tenant's Property. Landlord shall not be liable for any loss of business, inconvenience or annoyance arising from any repair or restoration of any portion of the Premises, Building, or Project as a result of any damage from fire or other casualty.

e. This Lease shall be considered an express agreement governing any case of damage to or destruction of the Premises, Building, or Project by fire or other casualty, and any present or future law which purports to govern the rights of Landlord and Tenant in such circumstances in the absent of express agreement, shall have no application.

20. EMINENT DOMAIN.

a. If the whole of the Building or Premises is lawfully taken by condemnation or in any other manner for any public or quasi-public purpose, this Lease shall terminate as of the date of such taking, and Rent shall be prorated to such date. If less than the whole of the Building or Premises is so taken, this Lease shall be unaffected by such taking, provided that (i) Tenant shall have the right to terminate this Lease by notice to Landlord given within ninety (90) days after the date of such taking if twenty percent (20%) or more of the Premises is taken and the remaining area of the Premises is not reasonably sufficient for Tenant to continue operation of its business, and (ii) Landlord shall have the right to terminate this Lease by notice to Tenant given within ninety (90) days after the date of such taking. If either Landlord or Tenant so elects to terminate this Lease, the Lease shall terminate on the thirtieth (30th) day after either such notice. The Rent shall be prorated to the date of termination. If this Lease continues in force upon such partial taking, the Base Rent and Tenant's Proportionate Share shall be equitably adjusted according to the remaining Rentable Area of the Premises and Project.

b. In the event of any taking, partial or whole, all of the proceeds of any award, judgment, or settlement payable by the condemning authority shall be the exclusive property of Landlord, and Tenant hereby assigns to Landlord all of its right, title, and interest in any award, judgment, or settlement from the condemning authority. Tenant, however, shall have the right, to the extent that Landlord's award is not reduced or prejudiced, to claim from the condemning authority (but not from Landlord) such compensation as may be recoverable by Tenant in its own right for relocation expenses and damage to Tenant's personal property.

c. In the event of a partial taking of the Premises which does not result in a termination of this Lease, Landlord shall restore the remaining portion of the Premises as nearly as practicable to its condition prior to the condemnation or taking, but only to the extent of Building Standard Work. Tenant shall be responsible at its sole cost and expenses for the repair, restoration, and replacement of any other Leasehold improvements and Tenant's Property.

21. INDEMNIFICATION.

a. Tenant shall indemnify and hold Landlord harmless against and from liability and claims of any kind for loss or damage to property of Tenant or any other person, or for any injury to or death of any person, arising out of: (1) Tenant's use and occupancy of the Premises, or any work, activity, or other things allowed or suffered by Tenant to be done in, on, or about the Premises; (2) any breach or default by Tenant of any of the Tenant's obligations under this Lease; or (3) any negligent or otherwise tortuous act or omission of Tenant, its agents, employees, invitees, or contractors. Tenant shall at Tenant's expense and by counsel satisfactory to Landlord, defend Landlord in any action or proceeding arising from any such claim and shall indemnify Landlord against all costs, attorneys' fees, expert witness fees, and any other expenses incurred in such action or proceeding. As a material part of the consideration for Landlord's execution of this Lease, Tenant hereby assumes all risk of damage or injury to any person or property in, on, or about the Premises from any cause.

b. Landlord shall not be liable for injury or damage which may be sustained by the person or property of Tenant, its employees, invitees, or customers or any other person in or about the Premises, caused by or resulting from fire, steam, electricity, gas, water, or rain which may leak or flow from or into any part of the Premises, or from the breakage, leakage, obstruction, or other defects of pipes, sprinklers, wires, appliances, plumbing, air conditioning,

or lighting fixtures, whether such damage or injury results from conditions arising upon the Premises or upon other portions of the Building or Project or from other sources. Landlord shall not be liable for any damages arising from any act or omission of any other tenant of the Building or Project.

22. TENANT'S INSURANCE.

a. All insurance required to be carried by Tenant hereunder shall be issued by responsible insurance companies acceptable to Landlord and Landlord's lender and qualified to do business in the State. Each policy shall name Landlord, and at Landlord's request any mortgagee of Landlord, as an additional insured, as their respective interests may appear. Each policy shall contain (i) a cross-liability endorsement, (ii) a provision that such policy and the coverage evidenced thereby shall be primary and non-contributing with respect to any policies carried by Landlord and that any coverage carried by Landlord shall be excess insurance, and (iii) a waiver by the insurer of any right of subrogation against Landlord, its agents, employees, and representatives, which arises or might arise by reason of any payment under such policy or by reason of any act or omission of Landlord, its agents, employees, or representatives. A copy of each paid up policy (authenticated by the insurer) or certificate of the insurer evidencing the existence and amount of each insurance policy required hereunder shall be delivered to Landlord before the date Tenant is first given the right of possession of the Premises, and thereafter within thirty (30) days after any demand by Landlord therefore. Landlord may, at any time and from time to time, inspect and/or copy any insurance policies required to be maintained by Tenant hereunder. No such policy shall be cancelable except after twenty (20) days written notice to Landlord and Landlord's lender. Tenant shall furnish Landlord with renewals or "binders" of any such policy at least ten (10) days prior to the expiration th4ereof. Tenant agrees that if Tenant does not take out and maintain such insurance, Landlord may (but shall not be required to) procure said insurance on Tenant's behalf and charge the Tenant the premiums together with a twenty-five percent (25%) handling charge, payable upon demand. Tenant shall have the right to provide such insurance coverage pursuant to blanket policies obtained by the Tenant, provided such blanket policies expressly afford coverage to the Premises, Landlord, Landlord's mortgagee, and Tenant as required by this Lease.

b. Beginning on the date Tenant is given access to the Premises for any purpose and continuing until expiration of the Term, Tenant shall procure, pay for and maintain in effect policies of casualty insurance covering (i) all Leasehold Improvements (including any alterations, additions, or improvements as may be made by Tenant pursuant to the provisions of Article 12 hereof), and (ii) trade fixtures, merchandise, and other personal property from time to time in, on, or about the Premises, in an amount not less than one hundred percent (100%) of their actual replacement cost from time to time, providing protection against any peril included within the classification "Fire and Extended Coverage" together with insurance against sprinkler damage, vandalism, and malicious mischief. The proceeds of such insurance shall be used for the repair or replacement of the property so insured. Upon termination of this Lease following a casualty as set forth herein, the proceeds under (i) above be paid to Landlord, and the proceeds under (ii) above be paid to Tenant.

c. Beginning on the date Tenant is given access to the Premises for any purpose and continuing until expiration of the Term, Tenant shall procure, pay for, and maintain in effect worker's compensation insurance as required by law and comprehensive public liability and property damage insurance with respect to the construction of improvements on the Premises, the use, operation, or condition of the Premises, and the operations of Tenant in, on, or about the Premises, providing broad form property damage coverage for not less than Five Hundred Thousand Dollars ($500,000) per person and One Million Dollars ($1,000,000) each occurrence, and property damage liability insurance with a limit of not less than Two Hundred Fifty Thousand Dollars ($250,000) each accident.

d. Not less than every three (3) years during the Term, Landlord and Tenant shall mutually agree to increases in all of Tenant's insurance policy limits for all insurance to be carried by Tenant as set forth in this Article. In the event Landlord and Tenant cannot mutually agree upon the amounts of said increases, then Tenant agrees that all insurance policy limits as set forth in this Article shall be adjusted for increases in the cost of living in the same manner as is set forth in Section 5.2 hereof for the adjustment of the Base Rent.

23. WAIVER OF SUBROGATION.

Landlord and Tenant each hereby waive all rights or recovery against the other and against the officers, employees, agents, and representatives of the other, on account of loss by or damage to the waiving party of its property or the property of others under its control, to the extent that such loss or damage is insured against under any fire and extended overage insurance policy which either may have in force at the time of the loss or damage. Tenant shall, upon obtaining the policies of insurance required under this Lease, give notice to its insurance carrier or carriers that the foregoing mutual waiver of subrogation is contained in this Lease.

24. SUBORDINATION AND ATTORNMENT.

Upon written request of Landlord, or any first mortgagee or first deed of trust beneficiary of Landlord, or ground lessor of Landlord, Tenant shall, in writing, subordinate its rights under this Lease to the lien of any first mortgage or first deed of trust, or to the interest of any lease in which Landlord is lessee, and to all advances made or thereafter to be made thereunder. However, before signing any subordination agreement, Tenant shall have the right to obtain from any lender or lessor or Landlord requesting such subordination, an agreement in writing providing that, as long as Tenant is not in default hereunder, this Lease shall remain in effect for the full Term. The holder of any security interest may, upon

written notice to Tenant, elect to have this Lease prior to its security interest regardless of the time of the granting or recording of such security interest.

In the event of any foreclosure sale, transfer in lieu of foreclosure, or termination of the lease in which Landlord is lessee, Tenant shall attorn to the purchaser, transferee, or lessor, as the case may be, and recognize that party as Landlord under this Lease provided such party acquires and accepts the Premises subject to this Lease.

25. TENANT ESTOPPEL CERTIFICATE.

Within ten (10) days after written request from Landlord, Tenant shall execute and deliver to Landlord or Landlord's designee, a written statement certifying (a) that this lease is unmodified and in full force and effect, or is in full force and effect as modified and stating the modifications; (b) the amount of Base Rent and the date to which Base Rent and additional rent have been paid in advance; (c) the amount of any security deposited with Landlord; and (d) that Landlord is not in default hereunder or, if Landlord is claimed to be in default, stating the nature lf any claimed default. Any such statement may be relied upon by a purchaser, assignee, or lender. Tenant's failure to execute and deliver such statement within the time required shall at Landlord's election be a default under this Lease and shall also be conclusive upon Tenant that: (1) this Lease is in full force and effect and has not been modified except as represented by Landlord; (2) there are no uncured defaults in Landlord's performance and that Tenant has not right of offset, counter-claim, or deduction against Rent; and (3) not more than one month's Rent has been paid in advance.

26. TRANSFER OF LANDLORD'S INTEREST.

In the event of any sale or transfer by Landlord of the Premises, Building, or Project, and assignment of this Lease by Landlord, Landlord shall be and is hereby entirely freed and relieved of any and all liability and obligations contained in or derived from this Lease arising out of any act, occurrence, or omission relating to the Premises, Building, Project, or Lease occurring after the consummation of such sale or transfer, providing the purchaser shall expressly assume all of the covenants and obligations of Landlord under this Lease. If any security deposit or prepaid Rent has been paid by Tenant, Landlord may transfer the security deposit or prepaid Rent to Landlord's successor and upon such transfer, Landlord shall be relieved of any and all further liability with respect thereto.

27. DEFAULT.

27.1. *Tenant's Default*. The occurrence of any one or more of the following events shall constitute a default and breach of this Lease by Tenant:

a. If Tenant abandons or vacates the Premises; or

b. If Tenant fails to pay any Rent or any other charges required to be paid by Tenant under this Lease and such failure continues for five (5) days after such payment is due and payable; or

c. If Tenant fails to promptly and fully perform any other covenant, condition, or agreement contained in this lease and such failure continues for thirty (30) days after written notice thereof from Landlord to Tenant; or

d. If a writ of attachment or execution is levied on this Lease or on any of Tenant's Property; or

e. If Tenant makes a general assignment for the benefit of creditors, or provides for an arrangement, composition, extension or adjustment with its creditors; or

f. If Tenant files a voluntary petition for relief or if a petition against Tenant in a proceeding under the federal bankruptcy laws or other insolvency laws is filed and not withdrawn or dismissed within forty-five (45) days thereafter, or if under the provisions of any law providing for reorganization or winding up of corporations, any court of competent jurisdiction assumes jurisdiction, custody, or control of Tenant or any substantial part of its property and such jurisdiction, custody, or control remains in force unrelinquished, unstayed, or unterminated for a period of forty-five (45) days; or

g. If in any proceeding or action in which Tenant is not a party, a trustee, receiver, agent, or custodian is appointed to take charge of the Premises or Tenant's Property (or has the authority to do so) for the purpose of enforcing a lien against the Premises or Tenant's Property; or

h. If Tenant is a partnership or consists of more than one (1) person or entity, if any partner of the partnership or other person or entity is involved in any of the acts or events described in subparagraphs d through g above.

27.2. *Remedies*. In the event of Tenant's default hereunder, then, in addition to any other rights or remedies Landlord may have under any law, Landlord shall have the right, at Landlord's option, without further notice or demand of any kind to do the following:

a. Terminate this Lease and Tenant's right to possession of the Premises and re-enter the Premises and take possession thereof, and Tenant shall have no further claim to the Premises or under this Lease; or

b. Continue this Lease in effect, re-enter and occupy the Premises for the account of Tenant, and collect any unpaid Rent or other charges which have or thereafter become due and payable; or

c. Re-enter the Premises under the provisions of subparagraph b and thereafter elect to terminate this Lease and Tenant's right to possession of the Premises.

If Landlord re-enters the Premises under the provisions of subparagraph b or c above, Landlord shall not be deemed to have terminated this Lease or the obligation of Tenant to pay any Rent or other charges thereafter accruing, unless Landlord notifies Tenant in writing of Landlord's election to terminate this Lease. In the event of any re-entry or retaking of possession by Landlord, Landlord shall have the right, but not the obligation, to remove all or any part of Tenant's Property in the Premises and to place such property in storage at a public warehouse at the expense and risk of Tenant. If Landlord elects to relet the Premises for the account of Tenant, the rent received by Landlord from such reletting shall be applied as follows: first, to the payment of any indebtedness other than Rent due hereunder from Tenant to Landlord; second, to the payment of any costs of such reletting; third, to the payment of the cost of any alterations or repairs to the Premises; fourth, to the payment of Rent due and unpaid hereunder; and the balance, if any, shall be held by Landlord and applied in payment of future Rent as it becomes due. If that portion of rent received from the reletting, which is applied against, the Rent due hereunder is less than the amount of the Rent due, Tenant shall pay the deficiency to Landlord promptly upon demand by Landlord. Such deficiency shall be calculated and paid monthly. Tenant shall also pay to Landlord, as soon as determined, any costs and expenses incurred by Landlord in connection with such reletting or in making alterations and repairs to the Premises, which are not covered by the rent received from the reletting.

Should Landlord elect to terminate this Lease under the provisions of subparagraph a or c above, Landlord may recover as damages from Tenant the following:

(1.) *Past Rent*. The worth at the time of the award of any unpaid Rent which had been earned at the time of termination; plus

(2.) *Rent Prior to Award*. The worth at the time of the award of the amount by which the unpaid Rent which would have been earned after termination until the time of award exceeds the amount of such rental loss that Tenant proves could have been reasonably avoided; plus

(3.) *Rent After Award*. The worth at the time of the award of the amount by which the unpaid Rent for the balance of the Term after the time of award exceeds the amount of the rental loss that Tenant provides could be reasonably avoided; plus

(4.) *Proximately Caused Damages*. Any other amount necessary to compensate Landlord for all detriment proximately caused by Tenant's failure to perform its obligations under this Lease or which in the ordinary course of things would be likely to result therefrom including, but not limited to, any costs or expenses (including attorneys' fees) incurred by Landlord in (a) retaking possession of the Premises, (b) maintaining the Premises after Tenant's default, (c) preparing the Premises for reletting to a new tenant, including any repairs or alterations, and (d) reletting the Premises, including broker's commissions.

"The worth at the time of the award@ as used in subparagraphs 1 and 2 above is to be computed by allowing interest at the rate of ten percent (10%) per annum." The worth at the time of the award@ as used in subparagraph 3 above is to be computed by discounting the amount at the discount rate of the Federal Reserve Bank situated nearest to the Premises at the time of the award plus one percent (1%).

The waiver by Landlord of any breach of any term, covenant, or condition of this Lease shall not be deemed a waiver of such term, covenant, or condition or of any subsequent breach of the same or any other term, covenant, or condition. Acceptance of Rent by Landlord subsequent to any breach hereof shall not be deemed a waiver of any preceding breach other than the failure to pay the particular Rent so accepted, regardless of Landlord's knowledge of any breach at the time of such acceptance of Rent. Landlord shall not be deemed to have waived any term, covenant, or condition unless Landlord gives Tenant written notice of such waiver.

27.3 *Landlord's Default*. If Landlord fails to perform any covenant, condition, or agreement contained in this Lease within thirty (30) days after receipt of written notice from Tenant specifying such default, or if such default cannot reasonably be cured within thirty (30) days, if Landlord fails to commence to cure within that thirty (30) day period, then Landlord shall be liable to Tenant for any damages sustained by Tenant as a result of Landlord's breach; provided, however, it is expressly understood and agreed that if Tenant obtains a money judgment against Landlord resulting from any default or other claim arising under this Lease, that judgment shall be satisfied only out of the rents, issues, profits, and other income actually received on account of Landlord's right, title, and interest in the Premises, Building, or Project, and no other real, personal, or mixed property of Landlord (or of any of the partners which comprise Landlord, if any) wherever situated, shall be subject to levy to satisfy such judgment. If, after notice to Landlord of default, Landlord (or any first mortgagee or first deed of trust beneficiary of Landlord) fails to cure the default as provided herein, then Tenant shall have the right to cure that default at Landlord's expense. Tenant shall not have the right to terminate this Lease or to withhold, reduce, or

offset any amount against any payments of Rent or any other charges due and payable under this Lease, except as otherwise specifically provided herein.

28. BROKERAGE FEES.

Tenant warrants and represents that it has not dealt with any real estate broker or agent in connection with this Lease or its negotiation except those noted in Section 2.c. Tenant shall indemnify and hold Landlord harmless from any cost, expenses, or liability (including costs of suit and reasonable attorneys' fees) for any compensation, commission, or fees claimed by any other real estate broker or agent in connection with this Lease or its negotiation by reason of any act of Tenant.

29. NOTICES.

All notices, approvals, and demands permitted or required to be given under this Lease shall be in writing and deemed duly served or given if personally delivered or sent by certified or registered U.S. mail, postage prepaid, and addressed as follows: (a) if to Landlord, to Landlord's Mailing Address and to the Building manager, and (b) if to Tenant, to Tenant's Mailing Address; provided, however, notices to Tenant shall be deemed duly served or given if delivered or mailed to Tenant at the Premises. Landlord and Tenant may from time to time by notice to the other designate another place for receipt of future notices.

30. GOVERNMENT ENERGY OR UTILITY CONTROLS.

In the event of imposition of federal, state, or local government controls, rules, regulations, or restrictions on the use or consumption of energy or other utilities during the Term, both Landlord and Tenant shall be bound thereby. In the event of a difference in interpretation by Landlord and Tenant of any such controls, the interpretation of Landlord shall prevail, and Landlord shall have the right to enforce compliance therewith, including the right of entry into the Premises to effect compliance.

31. RELOCATION OF PREMISES.

Landlord shall have the right to relocate the Premises to another part of the Building in accordance with the following:

a. The new premises shall be substantially the same in size, dimension, configuration, decor and nature as the Premises described in this Lease, and if the relocation occurs after the Commencement Date, shall be placed in that condition by Landlord at its cost.

b. Landlord shall give Tenant at least thirty (30) days written notice of Landlord's intention to relocate the Premises.

c. As nearly as practicable, the physical relocation of the Premises shall take place on a weekend and shall be completed before the following Monday. If the physical relocation has not been completed in that time, Base Rent shall abate in full from the time the physical relocation commences to the time it is completed. Upon completion of such relocation, the new premises shall become the "Premises" under this Lease.

d. All reasonable costs incurred by Tenant as a result of the relocation shall be paid by Landlord.

e. If the new premises are smaller than the Premises as it existed before the relocation, Base Rent shall be reduced proportionately.

f. The parties hereto shall immediately execute an amendment to this Lease setting forth the relocation of the Premises and the reduction of Base Rent, if any.

32. QUIET ENJOYMENT.

Tenant, upon paying the Rent and performing all of its obligations under this Lease, shall peaceably and quietly enjoy the Premises, subject to the terms of this Lease and to any mortgage, lease, or other agreement to which this Lease may be subordinate.

33. OBSERVANCE OF LAW.

Tenant shall not use the Premises or permit anything to be done in or about the Premises which will in any way conflict with any law, statute, ordinance or governmental rule or regulation now in force or which may hereafter be enacted or promulgated. Tenant shall, at its sole cost and expense, promptly comply with all laws, statutes, ordinances and governmental rules, regulations or requirements now in force or which may hereafter be in force, and with the requirements of any board of fire insurance underwriters or other similar bodies now or hereafter constituted, relating to, or affecting the condition, use or occupancy of the Premises, excluding structural changes not related to or affected by

Tenant's improvements or acts. The judgment of any court of competent jurisdiction or the admission of Tenant in any action against Tenant, whether Landlord is a party thereto or not, that Tenant has violated any law, ordinance or governmental rule, regulation or requirement, shall be conclusive of that fact as between Landlord and Tenant.

34. FORCE MAJEURE.

Any prevention, delay or stoppage of work to be performed by Landlord or Tenant which is due to strikes, labor disputes, inability to obtain labor, materials, equipment or reasonable substitutes therefore, acts of God, governmental restrictions or regulations or controls, judicial orders, enemy or hostile government actions, civil commotion, fire or other casualty, or other causes beyond the reasonable control of the party obligated to perform hereunder, shall excuse performance of the work by that party for a period equal to the duration of that prevention, delay or stoppage. Nothing in this Article 34 shall excuse or delay Tenant's obligation to pay Rent or other charges under this Lease.

35. CURING TENANT'S DEFAULTS.

If Tenant defaults in the performance of any of its obligations under this Lease, Landlord may (but shall not be obligated to) without waiving such default, perform the same for the account at the expense of Tenant. Tenant shall pay Landlord all costs of such performance promptly upon receipt of a bill therefore.

36. SIGN CONTROL.

Tenant shall not affix, paint, erect or inscribe any sign, projection, awning, signal or advertisement of any kind to any part of the Premises, Building or Project, including without limitation, the inside or outside of windows or doors, without the written consent of Landlord. Landlord shall have the right to remove any signs or other matter, installed without Landlord's permission, without being liable to Tenant by reason of such removal, and to charge the cost of removal to Tenant as additional rent hereunder, payable within ten (10) days of written demand by Landlord.

37. MISCELLANEOUS.

a. *Accord and Satisfaction; Allocation of Payments*: No payment by Tenant or receipt by Landlord of a lesser amount than the Rent provided for in this Lease shall be deemed to be other than on account of the earliest due Rent, nor shall any endorsement or statement on any check or letter accompanying any check or payment as Rent be deemed an accord and satisfaction, and Landlord may accept such check or payment without prejudice to Landlord's right to recover the balance of the Rent or pursue any other remedy provided for in this Lease. In connection with the foregoing, Landlord shall have the absolute right in its sole discretion to apply any payment received from Tenant to any account or other payment of Tenant then not current and due or delinquent.

b. *Addenda*: If any provision contained in an addendum to this Lease is inconsistent with any other provision herein, the provision contained in the addendum shall control, unless otherwise provided in the addendum.

c. *Attorneys' Fees:* If any action or proceeding is brought by either party against the other pertaining to or arising out of this Lease, the finally prevailing party shall be entitled to recover all costs and expenses, including reasonable attorneys' fees, incurred on account of such action or proceeding.

d. *Captions, Articles and Section Numbers*: The captions appearing within the body of this Lease have been inserted as a matter of convenience and for reference only and in no way define, limit or enlarge the scope or meaning of this Lease. All references to Article and Section numbers refer to Articles and Sections in this Lease.

e. *Changes Requested by Lender*: Neither Landlord or Tenant shall unreasonably withhold its consent to changes or amendments to this Lease requested by the lender on Landlord's interest, so long as these changes do not alter the basic business terms of this Lease or otherwise materially diminish any rights or materially increase any obligations of the party from whom consent to such charge or amendment is requested.

f. *Choice of Law*: This Lease shall be construed and enforced in accordance with the laws of the State of California.

g. *Consent*: Notwithstanding anything contained in this Lease to the contrary, Tenant shall have no claim, and hereby waives the right to any claim against Landlord for money damages by reason of any refusal, withholding or delaying by Landlord of any consent, approval or statement of satisfaction, and in such event, Tenant's only remedies therefore shall be an action for specific performance, injunction or declaratory judgment to enforce any right to such consent, etc.

h. *Corporate Authority*: If Tenant is a corporation, each individual signing this Lease on behalf of Tenant represents and warrants that he is duly authorized to execute and deliver this lease on behalf of the corporation, and that this Lease is binding on Tenant in accordance with its terms. Tenant shall, at Landlord's request, deliver a certified copy of a resolution of its board of directors authorizing such execution.

i. *Counterparts*: This Lease may be executed in multiple counterparts, all of which shall constitute one and the same Lease.

j. *Execution of Lease; No Option*: The submission of this Lease to Tenant shall be for examination purposes only, and does not and shall not constitute a reservation of or option for Tenant to lease, or otherwise create any interest of Tenant in the Premises or any other premises within the Building or Project. Execution of this Lease by Tenant and its return to Landlord shall not be binding on Landlord notwithstanding any time interval, until Landlord has in fact signed and delivered this Lease to Tenant.

k. *Furnishing of Financial Statements; Tenant's Representations*: In order to induce Landlord to enter into this Lease, Tenant agrees that it shall promptly furnish Landlord, from time to time, upon Landlord's written request, with financial statements reflecting Tenant's current financial condition. Tenant represents and warrants that all financial statements, records and information furnished by Tenant to Landlord in connection with this Lease are true, correct and complete in all respects.

l. *Further Assurances*: The parties agree to promptly sign all documents reasonably requested to give effect to the provisions of this Lease.

m. *Mortgagee Protection*: Tenant agrees to send by certified or registered mail to any first mortgagee or first deed of trust beneficiary of Landlord whose address has been furnished to Tenant, a copy of any notice of default served by Tenant on Landlord. If Landlord fails to cure such default within the time provided for in this Lease, such mortgagee or beneficiary shall have an additional thirty (30) days to cure such default; provided that if such default cannot reasonably be cured within that thirty (30) day period, then such mortgagee or beneficiary shall have such additional time to cure the default as is reasonably necessary under the circumstances.

n. *Prior Agreements; Amendments*: This Lease contains all of the agreements of the parties with respect to any matter covered or mentioned in this Lease, and no prior agreement or understanding pertaining to any such matter shall be effective for any purpose. No provisions of this Lease may be amended or added to except by an agreement in writing signed by the parties or their respective successors in interest.

o. *Recording*: Tenant shall not record this Lease without the prior written consent of Landlord. Tenant, upon the request of Landlord, shall execute and acknowledge a "short form" memorandum of this Lease for recording purposes.

p. *Severability*: A final determination by a court of competent jurisdiction that any provision of this Lease is invalid shall not affect the validity of any other provision, and any provision so determined to be invalid shall, to the extent possible, be construed to accomplish its intended effect.

q. *Successors and Assigns*: This Lease shall apply to and bind the heirs, personal representatives, and permitted successors and assigns of the parties.

r. *Time of the Essence:* Time is of the essence of this Lease.

s. *Waiver*: No delay or omission in the exercise of any right or remedy of Landlord upon any default by Tenant shall impair such right or remedy or be construed as a waiver of such default.

t. *Compliance*: The parties hereto agree to comply with all applicable federal, state and local laws, regulations, codes, ordinances and administrative orders having jurisdiction over the parties, property or the subject matter of this Agreement, including, but not limited to, the 1964 Civil Rights Act and all amendments thereto, the Foreign Investment In Real Property Tax Act, the Comprehensive Environmental Response Compensation and Liability Act, and The Americans With Disabilities Act.

The receipt and acceptance by Landlord of delinquent Rent shall not constitute a waiver of any other default; it shall constitute only a waiver of timely payment for the particular Rent payment involved.

No act or conduct of Landlord, including, without limitation, the acceptance of keys to the Premises, shall constitute an acceptance of the surrender of the Premises by Tenant before the expiration of the Term. Only a written notice from Landlord to Tenant shall constitute acceptance of the surrender of the Premises and accomplish a termination of the Lease.

Landlord's consent to or approval of any act by Tenant requiring Landlord's consent or approval shall not be deemed to waive or render unnecessary Landlord's consent to or approval of any subsequent act by Tenant.

Any waiver by Landlord of any default must be in writing and shall not be a waiver of any other default concerning the same or other provision of the Lease.

The parties hereto have executed this Lease as of the dates set forth below.

Date: _____ Date: _____

_____ District _____ Recipient

Landlord:	Desert Healthcare District	Tenant:	
	dba: Las Palmas Medical Plaza		
By:	Chris Christensen	By:	
Signature:		Signature:	
Title:	Interim CEO	Title:	

CONSULT YOUR ADVISORS This document has been prepared for approval by your attorney. No representation or recommendation is made as to the legal sufficiency or tax consequences of this document or the transaction to which it relates. These are questions for your attorney.

In any real estate transaction, it is recommended that you consult with a professional, such as a civil engineer, industrial hygienist or other person, with experience in evaluating the condition of the property, including the possible presence of asbestos, hazardous materials and underground storage tanks.

EXHIBIT "A"

RULES AND REGULATIONS

1. No sign, placard, pictures, advertisement, name or notice shall be inscribed, displayed or printed or affixed on or to any part of the outside or inside of the Building without the written consent of Landlord first had and obtained and Landlord shall have the right to remove any such sign, placard, picture, advertisement, name or notice without notice to and at the expense of Tenant.

   All approved signs or lettering on doors shall be printed, painted, affixed, or inscribed at the expense of Tenant by a person approved by Landlord outside the Premises; provided, however, that Landlord may furnish and install a Building standard window covering at all exterior windows. Tenant shall not, without prior written consent of Landlord, cause or otherwise sunscreen any window.

2. The sidewalks, halls, passages, exits, entrances, elevators and stairways shall not be obstructed by any of the tenants or used by them for any purpose other than for ingress and egress from their respective Premises.

3. Tenant shall not alter any lock or install any new or additional locks or any bolts on any doors or windows of the Premises.

4. The toilet rooms, urinals, wash bowls and other apparatus shall not be used for any purpose other than that for which they were constructed and no foreign substance of any kind whatsoever shall be thrown therein and the expense of any breakage, stoppage or damage resulting from the violation of the rule shall be borne by the Tenant who, or whose employees or invitees, shall have caused it.

5. Tenant shall not overload the floor of the Premises or in any way deface the Premises or any part thereof.

6. No furniture, freight or equipment of any kind shall be brought into the Building without the prior notice to Landlord and all moving of the same into or out of the Building shall be done at such time and in such manner as Landlord shall designate. Landlord shall have the right to prescribe the weight, size and position of all safes and other heavy equipment brought into the Building and also the times and manner of moving the same in and out of the Building. Safes or other heavy objects shall, if considered necessary by Landlord, stand on supports of such thickness as is necessary to properly distribute the weight. Landlord will not be responsible for loss of or damage to any such safe or property from any cause and all damage done to the Building by moving or maintaining any such safe or other property shall be repaired at the expense of Tenant.

7. Tenant shall not use, keep or permit to be used or kept any foul or noxious gas or substances in the Premises, or permit or suffer the Premises to be occupied or used in a manner offensive or objectionable to the Landlord or other occupants of the Building by reason of noise, odors and/or vibrations, or interfere in any way with other tenants or those having business therein, nor shall any animals or birds be brought in or kept in or about the Premises of the Building.

8. No cooking shall be done or permitted by any Tenant on the Premises, nor shall the Premises be used for storage of merchandise, for washing clothes, for lodging or for any improper, objectionable or immoral purposes.

9. Tenant shall not use or keep in the Premises or the Building any kerosene, gasoline or inflammable or combustible fluid or material, or use any method of heating or air conditioning other than that supplied by Landlord.

10. Landlord will direct electricians as to where and how telephone and telegraph wires are to be introduced. No boring or cutting for wires will be allowed without the consent of the Landlord. The location of telephones, call boxes and other office equipment affixed to the Premises shall be subject to the approval of Landlord.

11. On Saturdays, Sundays and legal holidays, and on other days between the hours of 6:00 p.m. and 8:00 a.m. the following day, access to the Building or to the halls, corridors, elevators or stairways in the Building, or to the Premises may be refused unless the person seeking access is known to the person or employee of the Building in charge and has a pass or is properly identified. The Landlord shall in no case be liable for damages for any error with regard to the admission to or exclusion from the Building of any person. In case of invasion, mob, riot, public excitement, or other commotion, the Landlord reserves the right to prevent access to the Building during the continuance of the same by closing of the doors or otherwise, for the safety of the tenants and protection of property in the Building and the Building.

12. Landlord reserves the right to exclude or expel from the Building any person who, in the judgment of Landlord, is intoxicated or under the influence of liquor or drugs, or who shall in any manner do any act in violation of any of the rules and regulations of the Building.

13. No vending machine or machines of any description shall be installed, maintained or operated upon the Premises without the written consent of the Landlord.

_____ District _____ Recipient

14. Landlord shall have the right, exercisable without notice and without liability to Tenant, to change the name and street address of the Building of which the Premises are a part.

15. Tenant shall not disturb, solicit, or canvass any occupant of the Building and shall cooperate to prevent same.

16. Without the written consent of Landlord, Tenant shall not use the name of the Building in connection with or in promoting or advertising the business of Tenant except as Tenant's address.

17. Landlord shall have the right to control and operate the public portions of the Building, and the public facilities, and heating and air conditioning, as well as facilities furnished for the common use of the tenants, in such manner as it deems best for the benefit of the tenants generally.

18. All entrance doors in the Premises shall be left locked when the Premises are not in use, and all doors opening to public corridors shall be kept closed except for normal ingress and egress from the Premises.

_____ Landlord's Initials

_____ Tenant's Initials

ADDENDUM

Addendum to that certain Office Building Lease dated _____ by and between Desert Healthcare District doing business as the Las Palmas Medical Plaza, as Landlord and _Erik G. Palmer, D.O., a Medical Corporation d.b.a. Desert Family Medical Center _, as Tenant for the property commonly known as Las Palmas Medical Plaza located 555 E. Tachevah Drive, Palm Springs, California 92262.

In the event of any inconsistency between the Addendum language and the body of the Lease, the Addendum language shall prevail.

1. **Commencement Date:** January 1, 2019

2. **Expiration Date:** December 31, 2023

3. **Rent Schedule:**

1/1/2019-12/31/2019	$2575.20	
1/1/2020-12/31/2020	$2652.46	Greater of 3% or CPI
1/1/2021-12/31/2021	$2732.03	Greater of 3% or CPI
1/1/2022-12/31/2022	$2813.99	Greater of 3% or CPI
1/1/2023-12/31/2023	$2898.41	Greater of 3% or CPI

4. **CAMs:** **Currently $.62 per square foot.**

5. **Security Deposit:** **Carryover from previous lease in the amount of Two-Thousand Four-Hundred Forty-Two Dollars and 00/100 ($2,442.00)**.

The foregoing is hereby agreed to and accepted:

Date:	_____	Date:	_____
Landlord:	Desert Healthcare District	Tenant:	Erik G. Palmer, D.O. a Medical Corporation
	dba: Las Palmas Medical Plaza		dba: Desert Family Medical Center
By:	Chris Christensen	By:	_____
Signature:	_____	Signature:	_____
Title:	Interim CEO	Title:	_____

DESERT HEALTHCARE DISTRICT

Date: October 23, 2018

To: Board of Directors

Subject: Addendum #2 – Dr. Ramy Awad 2W-107 – Early Termination
Addendum #2 – Dr. Ramy Awad 3W-105 – Commencement Date

Staff recommendation: Consideration to approve the draft addenda for Dr. Ramy Awad at the Las Palmas Medical Plaza.

Background:

- Dr. Ramy Awad is a current tenant of the Las Palmas Medical Plaza
- Dr. Awad entered into a 3-year lease for suite 2W-107 on December 1, 2017
- On July 24, 2018, District Board approved Dr. Awad's lease agreement to lease suite 3W-105 with a commencement date of October 1, 2018
- Dr. Awad is requesting an early termination for suite 2W-107, effective December 31, 2018 to relocate into Suite 3W-105
- Dr. Awad is requesting the Commencement Date be revised to January 1, 2019
- At the October 9, 2018 Committee meeting, the Committee recommended allowing the CEO the discretion to handle minor lease changes with lessee without formal presentation to the Committee
- At the October 9, 2018 F&A Committee meeting, the Committee recommended forwarding to the Board for approval
- Staff recommends approval for both addenda
- Draft addenda for corresponding leases are attached for your review

Fiscal Impact:

Suite 2W-107: Suite will not provide rental income until new tenant is found (current monthly rent $2,325)

Suite 3W-105: Foregone rent (1 month) due to commencement date change - $3,180

ADDENDUM #2

Addendum to that certain Office Building Lease dated December 1, 2017 by and between Desert Healthcare District doing business as the Las Palmas Medical Plaza, as Landlord and Dr. Ramy Awad, as Tenant for the property commonly known as Las Palmas Medical Plaza located 555 E. Tachevah Drive, Palm Springs, California 92262.

In the event of any inconsistency between the Addendum language and the body of the Lease, the Addendum language shall prevail.

Dr. Awad is leasing Suite 3W-105, which is a larger suite, with a Commencement Date November 1, 2018 and will terminate the lease in Suite 2W-107 early.

1. **Early Termination Date:** Termination of lease December 31, 2018.

The foregoing is hereby agreed to and accepted:

Date:	_____	Date:	_____
Landlord:	Desert Healthcare District	Tenant:	_____
	dba: Las Palmas Medical Plaza		
By:	D. Chris Christensen	By:	Dr. Ramy Awad
Signature:	_____	Signature:	_____
Title:	Interim CEO	Title:	_____

ADDENDUM #2

Addendum to that certain Office Building Lease dated August 1, 2018 by and between Desert Healthcare District doing business as the Las Palmas Medical Plaza, as Landlord and Dr. Ramy Awad, as Tenant for the property commonly known as Las Palmas Medical Plaza located 555 E. Tachevah Drive, Palm Springs, California 92262.

In the event of any inconsistency between the Addendum language and the body of the Lease, the Addendum language shall prevail.

1. **Commencement Date:** Revised Commencement Date to read "The earlier of Certificate of Occupancy or ~~October 1, 2018~~ January 1, 2019.

The foregoing is hereby agreed to and accepted:

Date:	_____	Date:	_____
Landlord:	Desert Healthcare District	Tenant:	_____
	dba: Las Palmas Medical Plaza		
By:	D. Chris Christensen	By:	Dr. Ramy Awad
Signature:	_____	Signature:	_____
Title:	Interim CEO	Title:	_____

DESERT HEALTHCARE DISTRICT

Date: October 23, 2018

To: Board of Directors

Subject: Proposed One-Time Vacation Cash Out for One Employee

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Staff Recommendation: Consideration to approve a One-Time vacation cash payout for one employee.

Background:

- The Desert Healthcare District's policy in the Employee Handbook - Section (g) in the approved vacation policy states: "No employee will be eligible to have more than a maximum of four (4) weeks of accrued vacation at any time. Once an employee reaches the four (4) week maximum, the employee will cease accruing any additional vacation pay."
- Additionally, Section (c) in the vacation policy states: "Full-time employees with ten (10) years or more employment can take four (4) weeks of paid vacation per year. Accrual rate of 6.16 hours per pay period."
- District employees are encouraged to use the opportunity to enjoy time away from work to help balance their lives. However, during the present time where many activities are requiring staff time, it is difficult to schedule vacation time.
- Presently, one employee has reached the 160 hour maximum and is forced to take time off, to avoid losing vacation accrual.
- A one-time payout would reduce the accrued vacation hours to a manageable level.
- Management will encourage staff to utilize their future vacation time.
- Staff requests consideration to approve a One-Time vacation cash out of 80 hours.
- At the October 9, 2018 F&A Committee meeting, the Committee recommended forwarding to the Board for approval.

Fiscal Impact:

One-Time payout for 80 hours = $4,316

DESERT HEALTHCARE DISTRICT

Date: October 23, 2018

To: Board of Directors

Subject: Proposed Alternative Workweek Schedule Policy

Staff Recommendation: Consideration to approve an Alternative Workweek Schedule policy.

Discussion:

- The Desert Healthcare District and Foundation's current hours of operation are Monday-Friday and a 40 hour workweek.
- At the September 25, 2018, a request for consideration to convert to a 4/10 alternative workweek schedule was presented.
- The request was tabled and staff was directed to prepare a policy to bring back to the Board.
- California Labor Code Section 511 allows an alternative workweek schedule to be adopted, if approved by at least a two-thirds written vote of the District's employees.
- Staff is currently conducting an internal secret ballot survey to allow staff to vote for an alternative workweek schedule to include a 4/10 work week or a 9/80 work cycle. A 14-day notice period is required.
- Once the survey is completed on October 23, 2018, Staff will develop the guidelines for an alternative workweek schedule and avoid closure of the office during any weekday.
- Staff requests consideration for approval of the Alternative Workweek Schedule policy included in the packet.
- At the October 9, 2018 F&A Committee meeting, the Committee recommended forwarding to the Board for approval.

Fiscal Impact:

None

Alternative Workweek Schedule

All District employees, including non-exempt employees who are subject to the Fair Labor Standards Act ("FLSA") wage and hour laws and are eligible for overtime compensation, shall be allowed to work an alternative workweek schedule. The alternative workweek schedule shall comply with all State and Federal FLSA laws and shall be adopted only if approved by at least a two-thirds written vote of the District employees in accordance with California Labor Code §511.

The CEO shall have the discretion to allow an employee to work a traditional five (5) day, eight (8) hour work schedule if the adopted alternative workweek schedule would conflict with a religious belief, cause a significant hardship, or due to extenuating circumstances for the affected employee.

DESERT HEALTHCARE DISTRICT

HOSPTIAL GOVERNANCE AND OVERSIGHT COMMITTEE MEETING
MEETING MINUTES
September 20, 2018

Directors Present	District Staff Present	Absent
Chair, Carole Rogers, RN President, Les Zendle, MD	Chris Christensen, Interim CEO, CFO Stephen Huyck, Accounting Manager Andrea S. Hayles, Clerk of the Board	

AGENDA ITEMS	DISCUSSION	ACTION
I. Call to Order	The meeting was called to order at 9:31 a.m. by Chair Rogers.	
II. Introductions	Chair Rogers invited all in attendance to introduce themselves, and Chris Christensen, Interim CEO, introduced Stephen Huyck, the new Accounting Manager.	
III. Approval of Agenda	Chair Rogers asked for a motion to approve the agenda explaining that the meeting minutes should state July – not June.	**Moved and seconded by President Zendle and Chair Rogers to approve the agenda as amended. Motion passed unanimously.**
IV. Public Comment	Stephanie Salters, RN, District Resident, explained that in the neonatal intensive care unit a spider crawled on baby, and that there also layoffs in the unit according to a nurse Mrs. Salters spoke with that wishes to remain anonymous. However, a report will be available. Dr. Zendle explained that any safety issues should be immediately reported, including contacting the hospital administrator if necessary. Chair Rogers reminded Mrs. Salters of the confidential phone line the nurses can call for reporting. Michele Finney, CEO, Desert Care Network, Desert Regional Medical Center, explained that Ecolab is the contracted vendor for the hospital on a regular schedule and staff will follow up to determine if extermination services need to be addressed.	

	Ezra Kaufman, District Resident, explained that in the past meetings the committee focused on hospital quality and reporting systems with suggestions for improvement; yet, there have been no results. Staffing issues have been brought forward for the emergency room and hospital floors stating that he is unsure of the purpose of the Hospital Governance and Oversight Committee.	
V. Approval of Meeting Minutes	Chair Rogers asked for approval of the July 21, 2018 Meeting Minutes.	**Moved and seconded by President Zendle and Chair Rogers to approve the agenda.** **Motion passed unanimously.**
VI. Old Business	None	
VII. New Business **1. Desert Regional Medical Center 2017-2018 Annual Report**	Michele Finney, CEO, Desert Care Network, Desert Regional Medical Center, explained the compliance of the facility based on the lease provisions for a June 2017– May 2018 reporting cycle. All real and property taxes including any levies against the facility are paid. The hospital is maintained as an acute care facility - in compliance with nursing staff patient ratios. There were no material improvements of more than $1M, no selling of District assets, sustained earthquake insurance, and disclosure of any material damage to the building such as the underground flooding of the business office that resulted in remediation and air quality improvements. Southern California Edison replaced the transformer due to failure that was previously reported to the committee, hazardous material	

	management is adequately complied with, and the hospital has no discrimination in servicing with the best interest of the community and not moving core services to JFK Memorial Hospital. There has been no subletting, and any subletting is disclosed to the District. The Joint Commission Accreditation is sufficiently maintained for the Medicaid and Medi-Cal program. Four fines by the California Department of Public Health that were previously discussed throughout the year have been remedied. A functioning Governing Board is maintained (full list of members is included in the report); no altering of the primary mission and charity policies; and Mrs. Finney outlined the other required reporting documents such as the capital expenditures that exceed $1M, and a copy of the hospital license. Core services for patient day statistics are included in the report and will not match OSPHD's number since OSHPD reports on a calendar year and the hospital operates on a fiscal year.	
Public Comment	Ezra Kaufman, District Resident, inquired if there is a particular reason why the annual report cannot match the annual calendar of OSHPD. Mrs. Finney explained that the lease component is for the date the lease was entered that specifies the reporting period, and it is at the discretion of the District's governing body. President Zendle requested that Chris	

	Christensen, Interim CEO, research the lease concerning the annual report fiscal and calendar year dates. Ezra Kaufman, District Resident, reviewed the hospitals Governing Board Members list explaining that two are ex officio from the District's board of directors, and inquired why the two board members from the District are not listed on the disclosure report with the Office of State Health Care and Planning and Development. Chair Rogers and President Zendle explained that the lease necessitates two board members of the District for appointment to the hospitals Governing Board, and they will inquire on the Governing Board members list submission to the Office of State Health Care and Planning. Ezra Kaufman, District Resident, explained that section 14.9 of the lease does not mention reporting penalties as described in Mrs. Finney annual report of compliance. Mr. Kaufman explained section 14.9 of the lease and efforts to undertake and complete such future capital projects in the three years subsequent to the lease date, and the submission of those capital projects. According to Mr. Kaufman, Tenet performed some capital improvements equal to the amount of Desert Hospital expenses from 1995-1997. Mr. Kaufman also feels that the hospital states this information	

	incorrectly, resulting in an admission of $18M plus for capital expenditures that would give legislative authority from the board as a leased hospital subject to the Brown Act. Chris Christensen, Interim CEO, stated that staff will research the matter and respond accordingly. Chair Rogers inquired on the update of the hospital lease compliance seismic standards. President Zendle explained that the hospital follows the 2020 standards and the 2030 compliance is for safety after a significant earthquake. The District in cooperation with the hospital is performing an analysis for repairs for the 2030 standards that is now in phase 2 and will be available to the public in December. President Zendle described the role of the Hospital Governance and Oversight Committee explaining the preliminary Leapfrog score – a B that will be available in November. In January Desert Regional Medical Center will announce the new star rating. Chair Rogers explained that at the Association of California Health Care District (ACHD) Annual meeting she inquired about other districts with hospital leases such as Grossmont that use tools/templates for hospital inspections to monitor specific areas. President Zendle	

	requested that Chris Christensen, Interim CEO, follow-up with ACHD to obtain the hospital inspection template or similar for guidance. Ezra Kaufman, District Resident, stated that instead of bemoaning other quality systems the committee should examine how the hospital operates with the current staffing issues. Medicare patients spend 5.5 days on average length of stay, and Managed Care patient's length of stay is 7.3 days. Patients that fill up bed days creates pressure on staffing to maximize revenue – outlining an OSPHD summary report of over 300 pages that is available.	
VIII. Adjournment	Chair Rogers adjourned the meeting at 10:10 a.m.	***Audio recording available on the website at http://dhcd.org/Hospital-Governance-Oversight-Committee***

ATTEST: Carole Rogers

Carole Rogers, Chair/Vice-President/Secretary
Hospital Governance and Oversight and Committee

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

LAW OFFICES

SCOTT & JACKSON

16935 WEST BERNARDO DRIVE, SUITE 170
SAN DIEGO, CA 92127

(858) 675-9896
FAX (858) 675-9897

JEFFREY G. SCOTT
BLAISE J. JACKSON

Of Counsel
JAMES R. DODSON

DATE: October 13, 2018

TO: Governance & Oversight Committee
Chris Christensen, Interim CEO

FROM: Jeffrey G. Scott, General Counsel

RE: Hospital Inspections

The Grossmont Healthcare District (GHD), leases its' hospital to Sharp Healthcare. The GHD Board has created a Facilities Committee which is similar to the Desert Healthcare District's (DHD's) Governance and Oversight Committee.

The GHD Facilities Committee is composed of two Board members and a retained facilities consultant with expertise in evaluating the condition of hospital facilities. The facilities consultant is typically a contractor or an engineer. As part of monitoring the condition of Grossmont Hospital, the GHD Facilities Committee conducts inspections of specific areas of the hospital each quarter. The inspections are conducted with the consent and cooperation of the Lessee (Sharp Healthcare) and are led by representatives from the hospital including the Director of Engineering.

The hospital and the Facilities Committee have an agreed upon inspection schedule which specifies the areas of the hospital that are inspected in a particular quarter. The schedule is broken into 8 Blocks (including an annual inspection of the parking structures). Consequently, it takes two years to complete a full inspection of the hospital. Attached is a copy of the Grossmont Hospital Quarterly Inspection Schedule for 2017-2018.

After an inspection, an ongoing matrix is updated, noting the areas in an inspection Block which need attention. As the items are addressed and completed the matrix is updated. Attached are copies the matrix for the April 2018 and July 2018 quarterly inspections. The inspection schedule and matrix are shared and discussed with the Board and public at the Board meetings. Also attached are the minutes of the August 24, 2018 Facilities Committee inspection.

GROSSMONT HOSPITAL QUARTERLY INSPECTION SCHEDULE 2017- 2018

Grossmont Healthcare District
Grossmont Hospital Quarterly Inspection Schedule
2017 - 2018

QTR	Area		
07/28/17	**BLOCK 1**		
	Cancer Center / CVI	Upper Level	CVI / Conference Rms
	Cancer Center / CVI	Lower Level	Cancer Center / Physician's Grp
	South Tower	1st Flr	Main Lobby, Gift Shop, Admitting, Bus Office/Acct
10/27/17	**BLOCK 2**		
	West Tower (ED/CCU)	B-Level	Basement/Mechanical
	West Tower (ED/CCU)	A-Level (1st Flr)	Emerg. Dept
	West Tower (ED/CCU)	Level 1 (2nd Flr)	Level 1 (2nd Flr) - SICU
	West Tower (ED/CCU)	Level 2 (3rd Flr)	MICU
	West Tower (ED/CCU)	Level 4 (4th Flr)	4 West: Acute Care
	West Tower (ED/CCU)	Level 5 (5th Flr)	5 West: Acute Care
01/26/18	**BLOCK 3**		
	East Tower	A-Level	Kitchen / Cafeteria
	East Tower	B-Level	Supply Chain, Sterile Processing, SPD (Sterile Processing), Bio-Med, Envir. Services, Receiving Dock, Linen Room.
	Engineering Bldg		Offices, Maint Shop, Carp. Shop, Cntrl Pnt
	Cntrl Plant & Em. Generator Bldg		
04/27/18	**BLOCK 4**		
	North Tower	1st Flr	COS, Dr. Lounge, Library/Med Staff
	North Tower	2nd Flr	2 North: Acute Care
	North Tower	3rd Flr	3 North: Transitional Care Unit (TCU)
	South Tower	1st Flr	Post Anestheia Care (PACU)
	East Tower	1st Flr	Surgery (as available)
8/24/18	**BLOCK 5**		
	South Tower	A-Level	Hyperbaric, Wound Care, Pulminary Equip
	South Tower	2nd Flr	ED Obs (Observation), Pulminary Mgmt
	South Tower	3rd Flr	3 South: Acute Care Overflow
	East Tower	A-Level	Imaging (Radiology, CT); EDD Emergency Dept (STAD); Cath-Lab; Ambilitory Care
	East Tower	2nd Flr	2 East: Acute care
	East Tower	3rd Flr	3 East: Oncology
	East Tower	4th Flr	4 East: Acute Care, Telemetry
	East Tower	5th Flr	5 East: Stroke Unit
10/26/18	**BLOCK 6**		
	East Tower	1st Flr	Lab; Pharmacy; Endoscopy; Pediatrics; Perinatal
	North Tower	1st Flr	Administration
	Medical Records Bldg		Med Records/Volun. Services; Auditorium
	Outpatient Clinic (Brierpatch)		

Grossmont Healthcare District
Grossmont Hospital Quarterly Inspection Schedule
2017 - 2018

01/25/19	**BLOCK 7**		
	Behavioral Health Services		Open / Locked / Administration
	Physical Rehabilation		PT - Grossmont Rehab Center (GRC); Hydrotherpy
	Women's Center	Level 1 (Lower)	OB
	Women's Center	Level 2 (Upper)	LDR, OR's, NICU

Annually

10/27/18	**GHD Facilities**	
	Parking Structure 1	(adj to West Tower)
	Parking Structure 2	(adj to Main Entrance)

APRIL 2018 GROSSMONT HOSPITAL QUARTERLY INSPECTION SCHEDULE MATRIX

***Bold Items** are complete and will be removed from subsequent reports.*

REPORTED ITEMS:		
ITEM		**RESPONSE**
Women's Center		
(see prior inspection reports for entries under this topic prior to October 28, 2016) 10/28/16 – Upper level feasibility studies scheduled to be completed by January 2, 2017, at which time it will be submitted to Administration for review. 01/27/17 – Under review 01/26/18 – Budget approved for $3.85 million. Improvements are phased over the next couple of years, commencing this year, and are expected to be completed sometime in 2019. 04/27/18 – Same as previously reported.		
Nurses Station (Outside of Pediatrics adjacent to Prenatal Clinic Scheduling)		
16-02	Nurses Station plastic laminate in need of repair.	08/26/16 – First reported 10/28/16 – In progress 01/27/17 – In progress; tied to other projects. 04/27/18 – As previously reported.
Women's Center		
16-03 16-04	Passage between Prenatal & Women's Center: carpet requires cleaning or replacement (16-03); carpet base in need of replacement or refinishing (16-04).	08/26/16 – First reported 10/28/16 – In progress 01/27/17 – In progress; tied to other projects 01/26/18 – Will be addressed by Upper Level improvement project. 04/27/18 – As previously reported.
4 East		
16-06	Fire door near nurses station delaminating	10/28/16 – First reported 01/27/17 – In progress; tied to other projects. 04/27/18 – As previously reported.

REPORTED ITEMS:		
ITEM		**RESPONSE**
Parking Structure #2		
17-04	Exterior, west elevation: the bamboo planter is in need of pruning and/or cleaning out.	10/27/17 – First reported. 01/26/18 – SGH checking **04/27/18 – Completed**
17-05	Exterior, west side: the entry road, from Center Drive to the parking area in front of the hospital, is in need of having the curb marking repainted (similar to what has recently been done around the main entrance).	10/27/17 – First reported. 01/26/18 – SGH checking 04/27/18 – Pending.
17-06	Level A, near elevator entrance, FEC (194) needs replacement	10/27/17 – First reported. 01/26/18 – SGH checking **04/27/18 – Completed** (Cabinet replaced)
Parking Structure #1		
17-07	Elevator 18: permit expired 5/17/2017 Elevator 17: permit expired 5/17/2017.	10/27/17 – First reported. 01/26/18 – SGH checking 04/27/18 – Pending. Hospital's request for inspection covers the permit. Waiting on the State to schedule inspection.
17-08	Level 3, South east corner, FEC needs to be repaired/ replaced.	10/27/17 – First reported. 01/26/18 – SGH checking **04/27/18 – Completed** (Cabinet replaced)
Women's Center Driveway		
17-09	Entrance drive and parking area at the front entrance of the Women's Center in need of an asphalt seal coat (or overlay) and re-striping.	10/27/17 – First reported. 01/26/18 – SGH checking. 04/27/18 – Pending. Hospital looking into the condition of the asphalt.
ED/CCU		
17-10	Level 1, SICU, outside door #1250 – Ceiling tile	10/27/17 – First reported.

REPORTED ITEMS:		
ITEM		**RESPONSE**
	delaminating.	01/26/18 – SGH checking. **04/27/18 – Completed**
17-11	Level 1, SICU, Pod A – A number of ceiling lights are out.	10/27/17 – First reported. 01/26/18 – SGH checking. **04/27/18 – Completed**
17-12	Level 1, SICU, Pod A – A number of 'Up' lights are out at the column.	10/27/17 – First reported. 01/26/18 – SGH checking. **04/27/18 – Completed**
17-13	Level 1 – door closer to exterior courtyard in need of adjustment. Also missing a cover.	10/27/17 – First reported. 01/26/18 – SGH checking. **04/27/18 – Completed**
Kitchen		
18-01	Leaking large floor steam kettle	01/26/18 – First reported. 04/27/18 – Being placed on capital replacement list by Dietary.

AUGUST 2018 GROSSMONT HOSPITAL QUARTERLY INSPECTION SCHEDULE MATRIX

Bold Items are complete and will be removed from subsequent reports.

REPORTED ITEMS:		
ITEM		**RESPONSE**
Women's Center		
(see prior inspection reports for entries under this topic prior to October 28, 2016) 10/28/16 – Upper level feasibility studies scheduled to be completed by January 2, 2017, at which time it will be submitted to Administration for review. 01/27/17 – Under review 01/26/18 – Budget approved for $3.85 million. Improvements are phased over the next couple of years, commencing this year, and are expected to be completed sometime in 2019. 04/27/18 – Same as previously reported. 08/24/18 – Same as previously reported.		
Nurses Station (Outside of Pediatrics adjacent to Prenatal Clinic Scheduling)		
16-02	Nurses Station plastic laminate in need of repair.	08/26/16 – First reported 10/28/16 – In progress 01/27/17 – In progress; tied to other projects. 04/27/18 – As previously reported. 08/24/18 – As previously reported.
Women's Center		
16-03 16-04	Passage between Prenatal & Women's Center: carpet requires cleaning or replacement (16-03); carpet base in need of replacement or refinishing (16-04).	08/26/16 – First reported 10/28/16 – In progress 01/27/17 – In progress; tied to other projects 01/26/18 – Will be addressed by Upper Level improvement project. 04/27/18 – As previously reported. 08/24/18 – As previously reported.

4 East		
16-06	Fire door near nurses station delaminating	10/28/16 – First reported 01/27/17 – In progress; tied to other projects. 04/27/18 – As previously reported. 08/24/18 – As previously reported.
Parking Structure #2		
17-05	Exterior, west side: the entry road, from Center Drive to the parking area in front of the hospital, is in need of having the curb marking repainted (similar to what has recently been done around the main entrance).	10/27/17 – First reported. 01/26/18 – SGH checking 04/27/18 – Pending 08/24/18 – As previously reported.
Parking Structure #1		
17-07	Elevator 18: permit expired 5/17/2017 Elevator 17: permit expired 5/17/2017.	10/27/17 – First reported. 01/26/18 – SGH checking 04/27/18 – Pending. Hospital's request for inspection covers the permit. Waiting on the State to schedule inspection. 08/24/18 – As previously reported.
Women's Center Driveway		
17-09	Entrance drive and parking area at the front entrance of the Women's Center in need of an asphalt seal coat (or overlay) and re-striping.	10/27/17 – First reported. 01/26/18 – SGH checking. 04/27/18 – Pending. Hospital looking into the condition of the asphalt. 08/24/18 – As previously reported.
Kitchen		
18-01	Leaking large floor steam kettle	01/26/18 – First reported. 04/27/18 – Being placed on capital replacement list by Dietary. 08/24/18 – As previously reported.

AUGUST 24, 2018 FACILITIES COMMITTEE MINUTES

FACILITY AND GROUNDS INSPECTION OF GROSSMONT HOSPITAL – GROSSMONT HEALTHCARE DISTRICT FACILITIES COMMITTEE AUGUST 24, 2018 – 11:00 A.M.

Inspection Party:

Director Virginia Hall, Chair
Director Randy Lenac, Member
Barry Jantz, CEO
George Kvaas, Facilities Consultant
Sharp Grossmont Hospital Representatives:
Paul Fice, Director of Engineering
Jill Scorza, Project Manager
Scott Aveldson, Project Manager

Location: Commencing in Cafeteria of Sharp Grossmont Hospital

Review of Prior Inspection Report:

The Committee reviewed the minutes/inspection report of the April 27, 2018, meeting. The open items remaining on the Inspection Matrix are all pending the completion of renovations slated for their respective areas, or are being checked by Sharp Grossmont Hospital staff, with any updates to be reported to the District.

Mr. Jantz noted that Jason Potter and Joe Burdenski had most recently provided updates at prior meetings. Mr. Fice will pursue updates on the open items.

Discussion/Areas Inspected:

The Committee inspected these areas:

- 3 North Transitional Care Unit (TCU) – Looked at current conditions vs. areas that are being refreshed, which is in progress; then 3 South will follow.
- South Tower (Levels A, 2 and 3) – Including Observation Unit, Progressive Care Unit, Pulmonary, Hyperbaric and Wound Care.
- East Tower (Floors 4 and 5) – Acute Care, Telemetry, Stroke Unit

All areas inspected were found to be in good order and presentable to the public.

Ms. Scorza will provide an updated list of departments/areas throughout the Hospital, so the District can update its inspection schedule.

Any new inspection items to be added to the Inspection Matrix below will be provided by Mr. Kvaas.

Schedule for Next Meetings:

- September 28, 2018 – Regular Facilities Committee (Non-Hospital Inspection – TBD if needed)
- October 26, 2018, 11:00 a.m. – Quarterly Inspection of Grossmont Hospital

Adjournment: 12:15 p.m.

See Inspection Matrix on next page

LAW OFFICES

SCOTT & JACKSON

16935 WEST BERNARDO DRIVE, SUITE 170
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JEFFREY G. SCOTT
BLAISE J. JACKSON

Of Counsel
JAMES R. DODSON

DATE: October 23, 2018

TO: Board of Directors
Chris Christensen, Interim CEO
Desert Healthcare District

FROM: Jeffrey G. Scott, General Counsel

RE: AB 2329 Related to Directors Compensation &
Ribakoff Case Related to Public Comments

AB 2329 (Obernolte): The bill was passed, signed by the Governor, and will be effective January 1, 2019. The bill affects the compensation of healthcare district directors in the future.

As enacted, the bill amends Health & Safety Code section 32103 and provides for an increase in the number of compensable meetings for board members from five to six. In order to take advantage of the increase, the board on an annual basis would need to adopt a written policy describing, based on findings supported by substantial evidence, why more than five meetings per month are necessary for the effective operation of the district.

Most importantly, the bill incorporates provisions in the Water Code that allows for an increase of 5% per year in the compensation amount. In order to implement AB 2329, the board would need to consider adopting a resolution increasing compensable meetings from 5 to 6 and annually adopt a policy substantiating the increase in the number of eligible activities.

The incorporated provisions of the Water Code allow the board to adopt 5% per year increases, provided notice of the public hearing at which the increase will be considered is published in a local newspaper, and the board approves the increase by passage of an ordinance that is also published in a local newspaper after the increase is approved. The 5% increase can be cumulative and will not be effective until 60 days after the passage of the ordinance.

Ribakoff case: A California appellate court recently held that a transit board's restriction of public comment to three minutes per person, per agenda item, does not violate the Brown Act open meeting requirements. The decision in *Ribakoff v. City of Long Beach*, (2018) 27 Cal.App. 5, 150, seeks to balance the public's right to attend and participate in meetings of public agencies, while also considering the ability of a public entity to manage meetings in an efficient manner. Accordingly, special districts may place a reasonable time restriction on public comment at meetings, so long as the time restriction is content neutral and simply limits the amount of time an individual may speak and not what is said by that person.

Joe Ribakoff, a frequent attendee at meetings of the Long Beach Transit Company Board of Directors, filled out a public speaker's card and spoke on agenda item 10 at the board's August 24, 2015, meeting for the three minutes allowed each public speaker on an agenda item. When he rose to speak a second time on the same agenda item it was during the board's deliberation and voting period. He was not permitted to speak, and, after a short exchange with the chair of the board, left the speaker's podium with the verbal assistance of a Long Beach Police Officer who routinely provided security for meetings. Later, Ribakoff filed suit, alleging that the board's three-minute limit on public speakers is contrary to the Brown Act and First Amendment free speech principles.

The Second District Court of Appeal held that the three-minute time restriction, in accordance with the transit board's adopted policy, was reasonable and did not violate the Brown Act or the First Amendment. The court looked at the express authorization under the Brown Act to place reasonable restrictions on the amount of time a speaker may comment at a meeting (Gov. Code, § 54954.3), and concluded that the three-minute restriction is reasonable. Moreover, the restriction does not violate the First Amendment because it is "content neutral" and does not restrict what the speaker may say.

Additionally, the court held that the board had reasonable justification for treating invited staff and invited speakers differently. Limiting presentations by staff and guests who are invited to speak based on their expertise to the same extent as members of the public ignores the information function served by staff and invited experts. The court noted that, "the number of staff and invited guests speaking on a topic will clearly be limited; the potential for public speakers is potentially extensive and needs some reasonable limitation." Lastly, the court concluded that speech at government meetings is not unlimited and public entities can limit speech at meetings based on time and even certain limited types of content, such as requiring a speaker to address only the topic or agenda item at issue.

COACHELLA VALLEY ASSOCIATION OF GOVERNMENTS
73-710 Fred Waring Dr., Suite 200, Palm Desert, CA 92260 · (760) 346-1127 · www.cvag.org

Date: October 10, 2018

DHCD Progress Report #2018-3 for reporting period: July 1, 2018 to September 30, 2018

Grantee: Coachella Valley Association of Governments (CVAG)

Project Title: CV Link Project

Project Manager/ Contact: Martin Magaña, Director of Transportation (mmagana@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. Blythe is not part of this project.

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 that is going through design, engineering and environmental will stretch from the City of Palm Springs to the City of Coachella. The project approved under the Final Environmental Impact Report is approximately 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.

Construction is ninety-five percent complete on the 2.3 mile stretch of CV Link between Vista Chino in Palm Springs and Ramon Road in Cathedral City. All furnishings (shade structures, benches, trash cans, water fountains and landscaping) have been installed.

CVAG continues to work with Cathedral City staff to complete a punch list of items on the path. One of the biggest items is the construction of fencing around a well site adjacent to the CV Link path near Ramon Road in Cathedral City. The material was scheduled to be delivered in August and installed in September 2018. However, the manufacturer was late in meeting the delivery schedule due to a shortage of fencing material, so the delivery date was pushed back. The fencing material was delivered in early October 2018 and is currently being installed. Once the fence is constructed, a final walk through will take place

In the last quarterly report, it was mentioned that the City of Palm Springs was going to rebid the Tahquitz Creek Levee Reconstruction Project to change the path from its original design of asphalt to meet CV Link standards. CVAG agreed to pay for the difference in cost between the original design and the CV Link design. The City rebid the project and the City Council awarded a construction contract to Spiess Construction in May 2018. The City held a pre-construction meeting in June 2018 and it was anticipated that construction would start by the end of July 2018. However, due to construction scheduling conflicts and operations related to Tahquitz Creek Golf Course, construction started in late August 2018. The path in this area is approximately 50% complete and is anticipated to be completed in November 2018.

CVAG continues to work with the County of Riverside Economic Development Agency (EDA) on right-of-way services. In the last quarterly report, it was reported that EDA had obtained appraisals and was with CVAG's legal counsel to draft offer packages to property owners. On September 24, 2018, CVAG's Executive Committee authorized the Executive Director to be delegated as the official representative to take any and all actions required, pursuant to federal and state law, to complete the Right-of-Way acquisition process and license agreement process for construction for CV Link. The Executive Director was also authorized to spend up to $50,000 for expenditures related to Right-of-Way and construction activities for CV Link. Since then, EDA has sent out offer packages to property owners for right-of-way acquisition. EDA is awaiting responses to the offer packages. It is anticipated that by the next progress report, substantial Right-of-Way will be acquired in hope to record easements and pursue construction of CV Link.

CVAG staff and consultants continue to work with member jurisdictions, especially Palm Desert and Palm Springs, to finalize the design of the approved project route, including meeting with local stakeholders to evaluate the regional and local access points. The 100% plans are anticipated to be completed by late 2018.

In the last quarterly report, it was mentioned that the additional progress had been made on the environmental review documents needed to comply with the National Environmental Policy Act (NEPA). CVAG has been working with Caltrans to finalize the NEPA document. In late July 2018, Caltrans approved the NEPA document which allows CVAG to proceed and complete final design and complete construction documents and specifications for construction bidding of CV Link. Part of finalizing the NEPA document entailed finalizing the mitigation for impacts to the survey area for Casey's June Beetle (CJB). The beetle, which is federally listed as an endangered species is not one of the twenty-seven (27) species covered by the Coachella Valley Multiple Species Habitat Conservation Plan. As outlined in the certified CV Link Environmental Impact Report, a CJB Habitat Conservation Plan has been submitted to the U.S. Fish and Wildlife Service (USFWS) that proposes establishing restoration and conservation easements in the City of Palm Springs. USFWS has reviewed the Habitat Conservation Plan and provided comments to CVAG. CVAG has addressed USFW's concerns. The USFWS has issued a favorable Biological Opinion related to Casey's June Beetle on CV Link. In addition, a Federal Register Notice was published by the USFWS on the Habitat Conservation Plan for CJB and no comments were received. CVAG is working with USFWS to complete the process.

3. What challenges and opportunities have you encountered in accomplishing this portion of your Scope of Work?

The acquisition of Right-of-Way continues to be challenging due to multiple property owners (private, public and tribal) but CVAG and EDA continue to work on additional appraisals and in preparing offer packages since the CVAG Executive Committee approved the appraisals and authorized the Executive Director to send out offer packages to property owners for the acquisition of Right-of-Way for CV Link. As part of the action taken on September 24, 2018, the license agreements for property owned and operated by the Coachella Valley Water District (CVWD) and Riverside County Flood Control and Water Conservation District (RCFC&WCD) were also approved. It is anticipated that CVWD and RCFC&WCD will take these license agreements to their respective boards for approval by the end of October 2018. This will be a major milestone in that it will provide a significant amount of Right-of-Way for construction of CV Link. It is anticipated that significant Right-of-Way will be acquired by early 2019 and CVAG will not have to request an extension on the Right-of-Way funds and instead, request an allocation for construction funds from the California Transportation Commission (CTC) in the Spring of 2019.

4. Is your project on schedule?

There was a delay in the schedule due to Caltrans' process in approving the NEPA document. As mentioned above, now that the NEPA document has been approved by Caltrans, this presents another major milestone in that CVAG can proceed with final design of CV Link and complete construction and specifications documents for construction bidding.

Right-of-way activities continue, as scheduled, as additional appraisals are prepared. Offer packages will continue to be sent out to property owners to acquire the Right-of-Way for CV Link construction.

5. Provide an update on the financial report for the project.

CVAG has received funding from various sources related to CV Link (Strategic Growth Council, Riverside County Parks Department, ATP, SB1, South Coast Air Quality Management District, Congestion Air Quality & Management, Desert Healthcare District, State Transportation Improvement Program, State Bicycle Transportation account, CVAG). To date, CVAG has received approximately $100 million in funding for CV Link. To date, CVAG has received approximately $100 million in funding for CV Link.

6. Work planned for next reporting period.

In the next reporting period, CVAG anticipates near completion of the 4,100 lineal foot segment of CV Link in the City of Palm Springs along the top of the Tahquitz Creek Levee between Demuth Park and Gene Autry Trail.

CVAG will continue to work with Cathedral City on completing the punch list of outstanding items on the 2.3-mile CV Link segment in the cities of Cathedral City and Palm Springs by late 2018.

CVAG will continue to send out offer packages and acquire the necessary Right-of-Way for CV Link. In addition, CVAG will continue to work with Alta Planning & Design to complete final design, construction documents and specifications for bidding of CV Link in early 2019.

State of the State Behavioral Health

ACHD
September 12 – 14, 2018
Pismo Beach, CA

CALIFORNIA HOSPITAL ASSOCIATION

So What's New?

- Everyone Cares
- Political Pressure to Do Something
  - Opioid Epidemic
  - Homelessness
  - Mass Shootings
  - Jail/Prison Reform
  - Suicide Rate

Incidence and Prevalence

- 1 in 5 adults experience a mental health issue in any given year
- 1 in 25 adults live with serious mental illness
- 1 in 10 young people experience a major episode of depression in any given year
- ½ of all chronic mental illness begins by age 14; ¾ by age 24

Incidence and Prevalence

- California suicide rate in 2016 was 12.1 per 100,000 and 50% had no known mental health condition
- 13% of adults live with substance dependence or abuse
- 18% of adults live with anxiety disorder
- 5% of adults live with major depression
- 25% of adults living in shelters have a serious mental illness

Barriers to Care

- Lack of Understanding
- Lack of Hope
- Lack of Knowledge
- Stigma

Barriers to Care

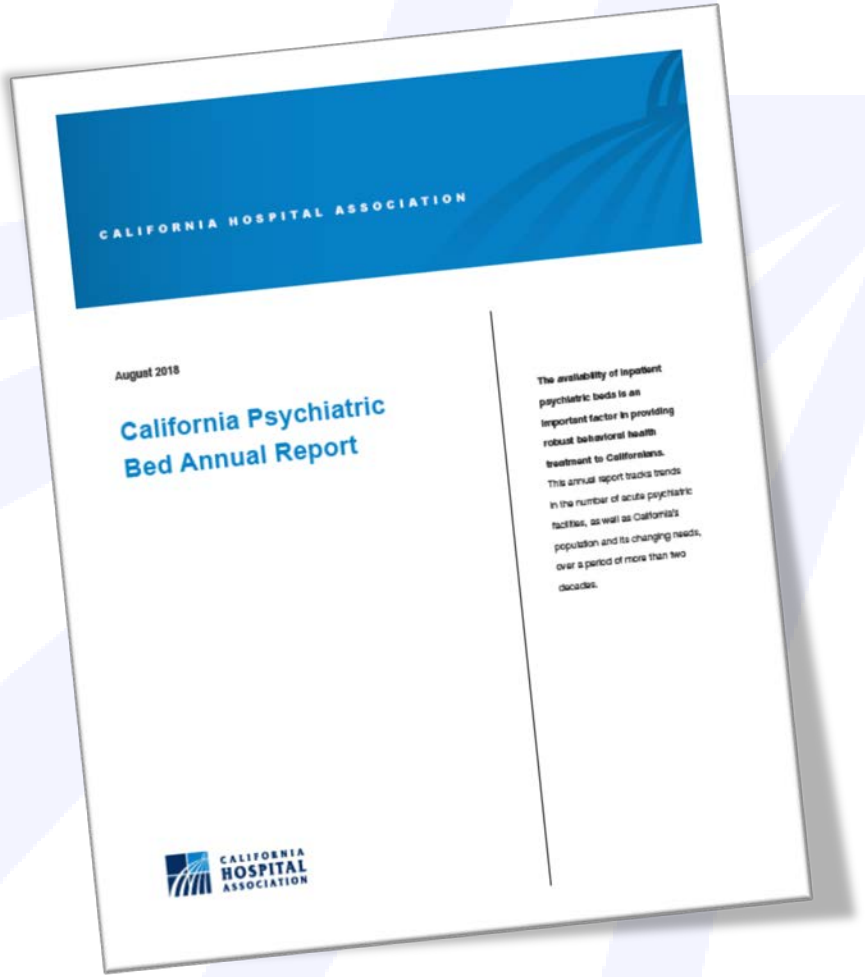
- People cannot connect to the right care in the right place when they need it
- Fragmentation and health care silos
- Disparities and inequities in geographic service availability
- Available care is not always delivered optimally

Moving Forward

- California Psychiatric Bed Report
- Behavioral Health Action
- Resources for Hospitals
- Key Legislative Bills – End of Session

California Psychiatric Data

- Handout
- Will be updated with 2017 data in early 2019.



Recommended Actions

- California's fragmented behavioral health delivery system leads to unequal access to care
  - *Recommended Action:* California should implement a comprehensive, statewide approach for delivering behavioral health services, including the appointment of a behavioral health "czar."
- The availability of acute-care inpatient behavioral health services must be balanced by an adequate and robust array of community-based outpatient programs
  - *Recommended Action:* A statewide inventory of all community-based behavioral health programs should be developed.
- The stigma and misunderstandings that surround a behavioral health diagnosis must end
  - *Recommended Action:* Lawmakers must develop a plan to improve access to care and ensure effective treatments for the behavioral health needs of all Californians.

Current Affairs

440 Hospitals in California

- Inpatient Psychiatric Bed Data
  - 2016 OSHPD Data
  - www.calhospital.org/PsychBedData
  - 6702 beds for 39.3 million people
    - 2650 beds in 32 Acute Psychiatric Hospitals (APH) – no physical health medical services
    - 3584 beds in 79 dedicated psych units in General Acute Care Hospitals (GACH)
    - 468 beds in 26 Psychiatric Health Facilities (PHF) – no physical health medical services
    - Does not include approximately 2000 beds in State Hospitals

Psychiatric Bed Loss/Gain

Between 1995 and 2016:

- Decrease of 20.4% in facilities
- Decrease of 28.3% in beds
- Increase of 24% in population

Since 2013

- New beds opened: 781
- New beds planned/projected: 737

County Breakdown

Acute Care Inpatient Psychiatric Bed Distribution

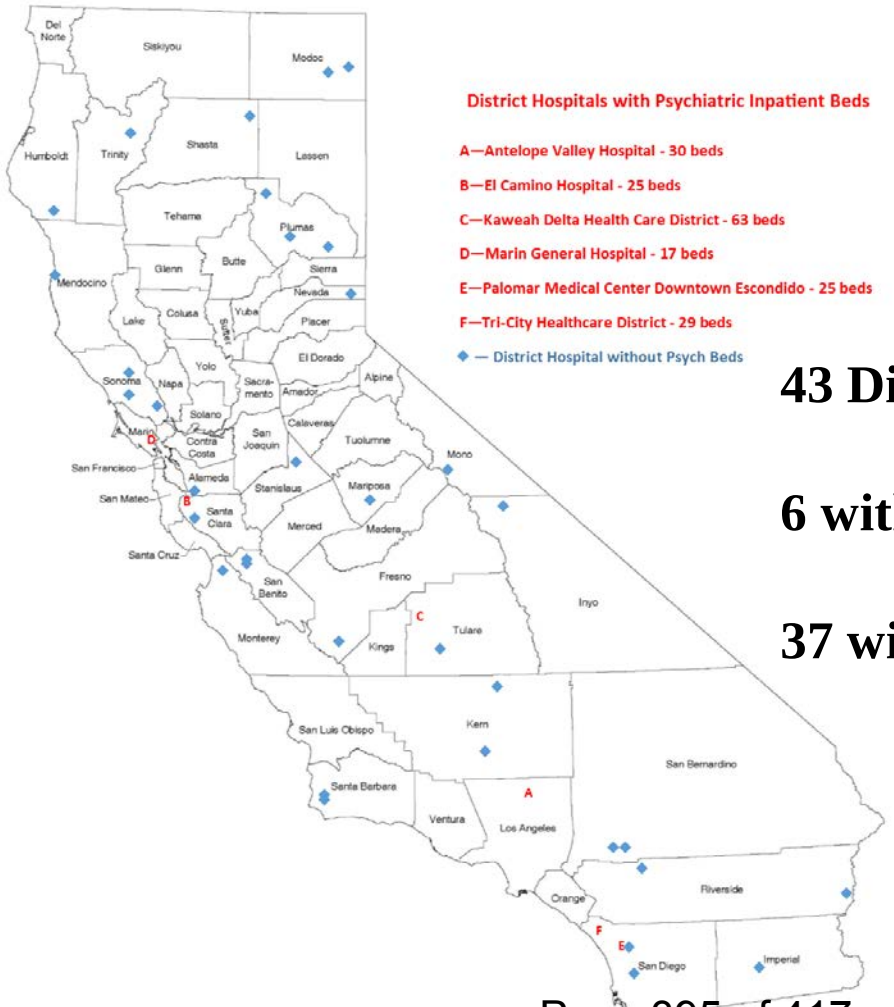
Not all beds are available to individuals on LPS involuntary holds. Does not include data from state-operated hospitals.

County	Population	Total Psych	Adult	Child /Adol	Gero-Psych[4]	Psych IC**	PHF***[1]	Chem/ Dep[1]	Beds per 100k[2]	Beds Needed[3]
Alameda	1,647,704	349	279	70	0	0	42	74	21.18	824
Alpine	1,071	0	0	0	0	0	0	0	0.00	1
Amador	37,383	0	0	0	0	0	0	0	0.00	19
Butte	226,864	46	46	0	0	0	16	0	20.28	113
Calaveras	45,171	0	0	0	0	0	0	0	0.00	23
Colusa	21,588	0	0	0	0	0	0	0	0.00	11
Contra Costa	1,135,127	108	84	24	0	0	0	0	9.51	568
Del Norte	27,540	0	0	0	0	0	0	0	0.00	14
El Dorado	185,625	16	16	0	0	0	16	0	8.62	93
Fresno	979,915	93	77	16	0	0	32	0	9.49	490
Glenn	28,085	0	0	0	0	0	0	0	0.00	14
Humboldt	136,646	16	16	0	0	0	16	0	11.71	68
Imperial	180,883	0	0	0	0	0	0	0	0.00	90
Inyo	18,144	0	0	0	0	0	0	0	0.00	9
Kern	884,788	218	189	29	0	0	16	12	24.64	442
Kings	149,785	0	0	0	0	0	0	0	0.00	75
Lake	64,116	0	0	0	0	0	0	0	0.00	32
Lassen	30,870	0	0	0	0	0	0	0	0.00	15
Los Angeles	10,157,915	2,301	1984	231	0	86	48	251	22.70	5,069
Madera	154,697	0	0	0	0	0	0	0	0.00	77
Marin	260,651	17	17	0	0	0	0	0	6.52	130
Mariposa	17,410	0	0	0	0	0	0	0	0.00	9
Mendocino	87,628	0	0	0	0	0	0	0	0.00	44
Merced	268,672	16	16	0	0	0	16	0	5.96	134
Modoc	8,795	0	0	0	0	0	0	0	0.00	4
Mono	13,981	0	0	0	0	0	0	0	0.00	7
Monterey	435,252	40	40	0	0	0	0	0	9.19	218
Napa	142,166	37	37	0	0	0	0	0	26.03	71
Nevada	99,107	0	0	0	0	0	0	0	0.00	50
Orange	3,172,532	448	416	32	0	0	0	100	14.12	1,586
Placer	380,531	16	16	0	0	0	16	0	4.20	190
Plumas	18,627	0	0	0	0	0	0	0	0.00	9
Riverside	2,387,741	199	178	12	0	9	16	131	8.33	1,194
Sacramento	1,514,460	400	343	57	0	0	82	0	26.41	757
San Benito	59,414	0	0	0	0	0	0	0	0.00	30
San Bernardino	2,140,096	359	283	76	0	0	0	18	16.77	1,070
San Diego	3,317,749	706	492	65	0	149	0	49	21.28	1,659
San Francisco	870,887	319	237	35	47	0	0	4	36.63	435
San Joaquin	733,709	50	50	0	0	0	16	1	6.81	367
San Luis Obispo	282,887	16	16	0	0	0	16	0	5.66	141
San Mateo	764,797	118	79	15	24	0	0	0	15.43	382
Santa Barbara	446,170	36	36	0	0	0	16	0	8.07	223
Santa Clara	1,919,402	246	229	17	0	0	40	0	12.82	960
Santa Cruz	274,673	16	16	0	0	0	16	0	5.83	137
Shasta	179,631	37	37	0	0	0	16	0	20.60	90
Sierra	2,947	0	0	0	0	0	0	0	0.00	1
Siskiyou	43,603	0	0	0	0	0	0	0	0.00	22
Solano	440,207	61	48	13	0	0	0	0	13.86	220
Sonoma	503,070	95	75	20	0	0	0	0	18.88	252
Stanislaus	541,560	67	67	0	0	0	0	4	12.37	271
Sutter	96,851	32	32	0	0	0	32	0	33.11	48
Tehama	63,276	0	0	0	0	0	0	0	0.00	32
Trinity	12,782	0	0	0	0	0	0	0	0.00	6
Tulare	460,437	63	63	0	0	0	0	0	13.68	230
Tuolumne	53,804	0	0	0	0	0	0	0	0.00	27
Ventura	849,738	130	96	34	0	0	0	0	15.30	425
Yolo	215,802	31	31	0	0	0	0	0	14.37	108
Yuba	75,275	0	0	0	0	0	0	0	0.00	38
TOTALS	**State Population**	**Total Psych**	**Adult**	**Child Adol**	**Gero-Psych**	**Psych IC**	**PHF[1]**	**Chem/ Dep[1]**	**Beds per 100k[2]**	**Beds Needed**
	39,250,017	**6,702**	**5,641**	**746**	**71**	**244**	**468**	**644**	**406.75**	**16,847**

County Breakdown

- 25 Counties have 0 Adult beds (45% of state)
- 42 Counties have 0 Child/Adolescent beds (72%)
- 56 Counties have 0 Gero-Psych beds (97%)
- 55 Counties have 0 Psych Intensive Care beds (95%)
- 48 Counties have 0 Chemical Dependency beds (83%)
- **25 Counties have NO inpatient psych services (45% of state)**

California's District Hospitals



43 District Hospitals

6 with 189 inpatient psychiatric beds

37 without inpatient psychiatric beds

Behavioral Health Action (BHA): A Conversation Begins

- Co-leaders: CHA / NAMI CA
- Facilitator: Sacramento Mayor Steinberg

CALIFORNIA HOSPITAL ASSOCIATION

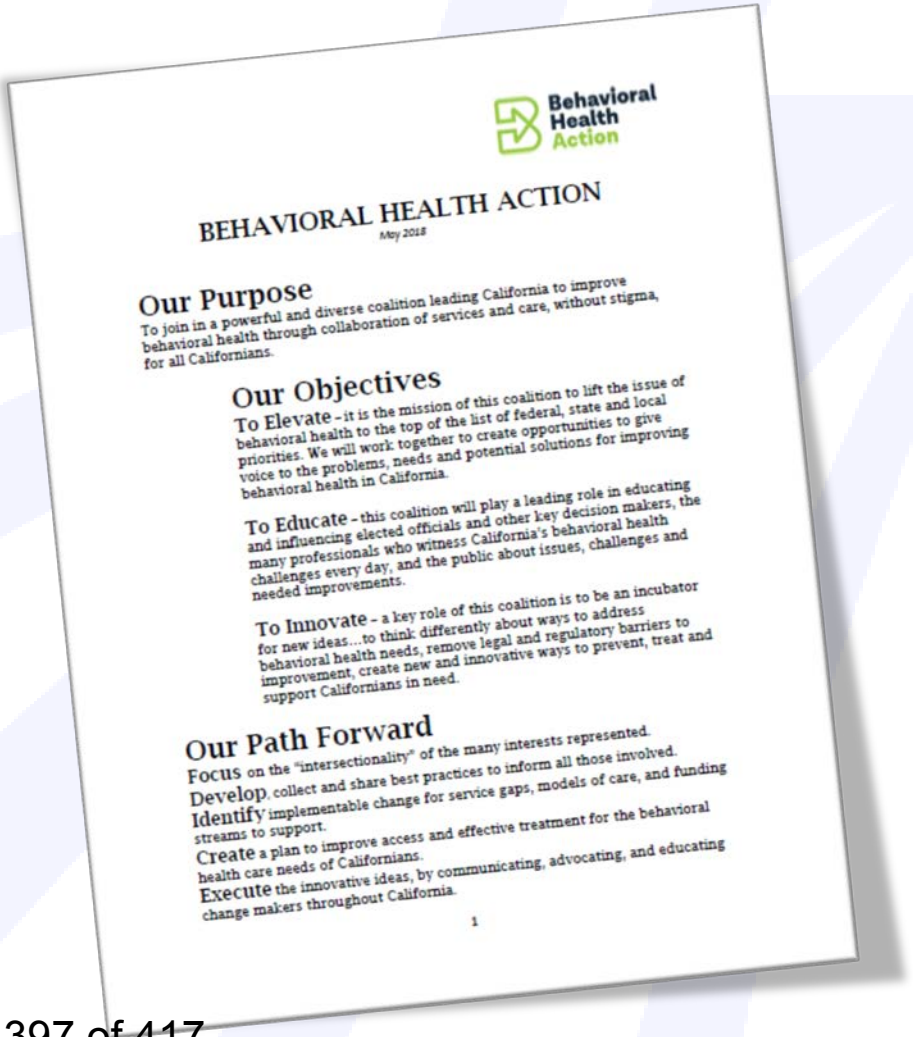
Providing Leadership in Health Policy and Advocacy

NAMI California

National Alliance on Mental Illness

BHA: A Coalition is Born

- Purpose & Objectives
  - Elevate
  - Educate
  - Innovate



Behavioral Health Action

BEHAVIORAL HEALTH ACTION

May 2018

Our Purpose

To join in a powerful and diverse coalition leading California to improve behavioral health through collaboration of services and care, without stigma, for all Californians.

Our Objectives

To Elevate - it is the mission of this coalition to lift the issue of behavioral health to the top of the list of federal, state and local priorities. We will work together to create opportunities to give voice to the problems, needs and potential solutions for improving behavioral health in California.

To Educate - this coalition will play a leading role in educating and influencing elected officials and other key decision makers, the many professionals who witness California's behavioral health challenges every day, and the public about issues, challenges and needed improvements.

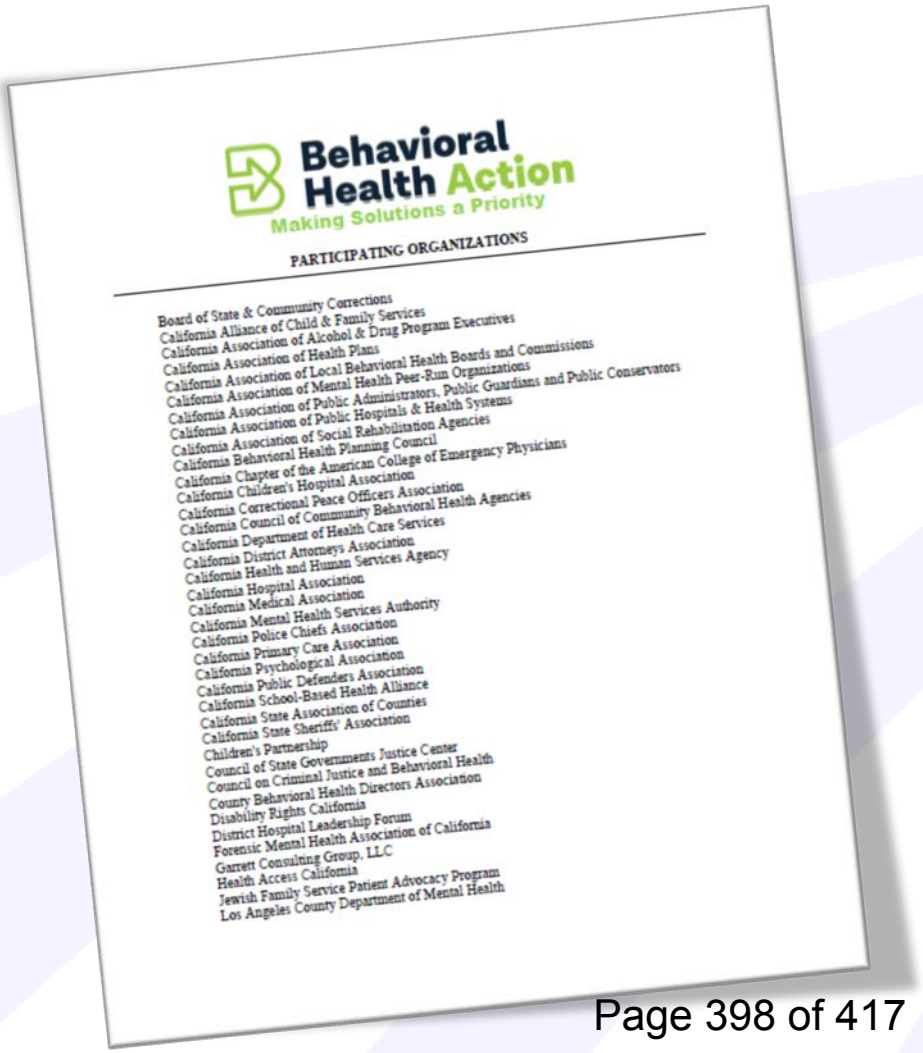
To Innovate - a key role of this coalition is to be an incubator for new ideas...to think differently about ways to address behavioral health needs, remove legal and regulatory barriers to improvement, create new and innovative ways to prevent, treat and support Californians in need.

Our Path Forward

Focus on the "intersectionality" of the many interests represented.
Develop, collect and share best practices to inform all those involved.
Identify implementable change for service gaps, models of care, and funding streams to support.
Create a plan to improve access and effective treatment for the behavioral health care needs of Californians.
Execute the innovative ideas, by communicating, advocating, and educating change makers throughout California.

1

BHA: A Coalition is Born



Behavioral Health Action
Making Solutions a Priority

PARTICIPATING ORGANIZATIONS

Board of State & Community Corrections
California Alliance of Child & Family Services
California Association of Alcohol & Drug Program Executives
California Association of Health Plans
California Association of Local Behavioral Health Boards and Commissions
California Association of Mental Health Peer-Run Organizations
California Association of Public Administrators, Public Guardians and Public Conservators
California Association of Public Hospitals & Health Systems
California Association of Social Rehabilitation Agencies
California Behavioral Health Planning Council
California Chapter of the American College of Emergency Physicians
California Children's Hospital Association
California Correctional Peace Officers Association
California Council of Community Behavioral Health Agencies
California Department of Health Care Services
California District Attorneys Association
California Health and Human Services Agency
California Hospital Association
California Medical Association
California Mental Health Services Authority
California Police Chiefs Association
California Primary Care Association
California Psychological Association
California Public Defenders Association
California School-Based Health Alliance
California State Association of Counties
California State Sheriffs' Association
Children's Partnership
Council of State Governments Justice Center
Council on Criminal Justice and Behavioral Health
County Behavioral Health Directors Association
Disability Rights California
District Hospital Leadership Forum
Forensic Mental Health Association of California
Garrett Consulting Group, LLC
Health Access California
Jewish Family Service Patient Advocacy Program
Los Angeles County Department of Mental Health

50+ Statewide Organizations

BHA Common Agenda – Three Priorities

- Prevention and Early Intervention
- Crisis Prevention and Response
- Workforce Development

Behavioral Health Action

Behavioral Health Action

Elevate: Statewide Voter Polling

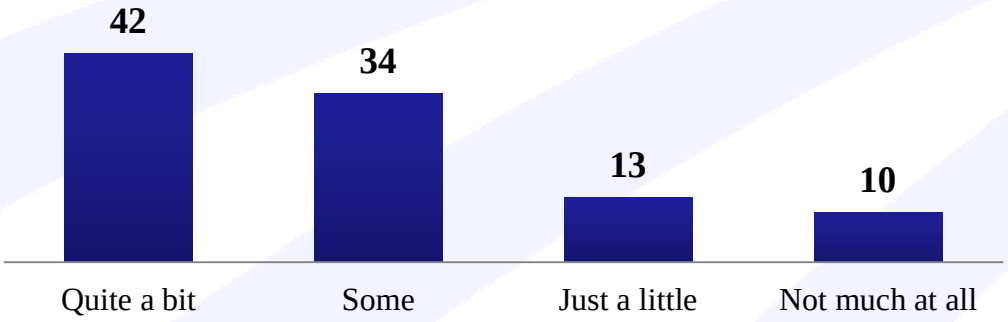
METHODOLOGY

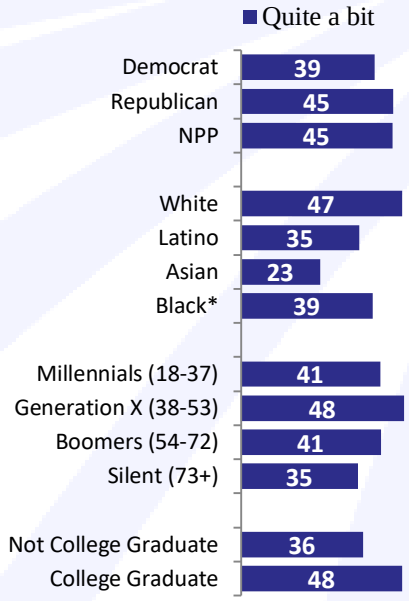
- David Binder Research surveyed 800 California voters, estimated as likely to vote in November 2018
- The Survey was conducted June 6 – 11, 2018
  - 53% of interviews were conducted by landline and 47% by cell phone
  - Interviews were conducted in English and Spanish

Elevate: Statewide Voter Polling

Forty-two percent of voters say they know quite a bit about mental illness and drug and alcohol use disorders

Q7. How much do you know about mental illness and drug and alcohol use disorders – quite a bit, some, just a little, or not much at all?



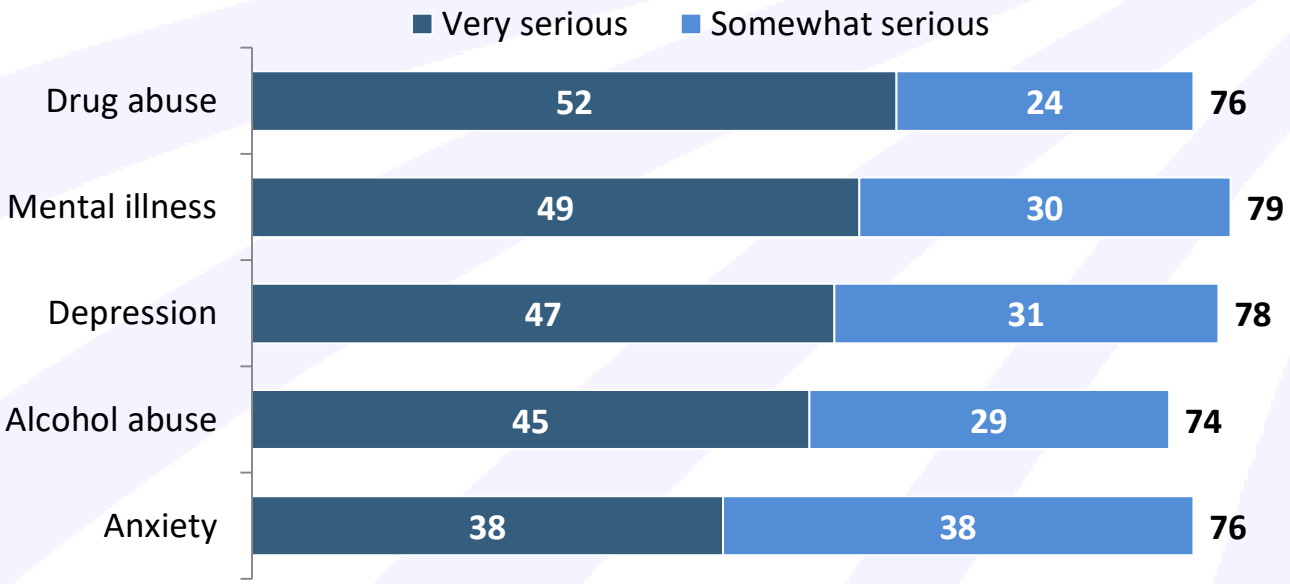


Whites, Gen Xers, and College Graduates are most likely to say they know quite a bit

Elevate: Statewide Voter Polling

Around 3 in 4 voters say several mental health and substance abuse disorder issues are either very or somewhat serious

Q8-Q12. Thinking about people you know and work with in your community, how serious are the following mental illness and substance use disorder issues? Are these issues very serious, somewhat serious, not very serious, or not serious at all?



Elevate: Statewide Voter Polling

Drug abuse is a top concern across most groups; Millennials and Bay Area voters are slightly more likely to say mental illness and depression are very serious

Q8-Q12. Thinking about people you know and work with in your community, how serious are the following mental illness and substance use disorder issues? Are these issues very serious, somewhat serious, not very serious, or not serious at all?

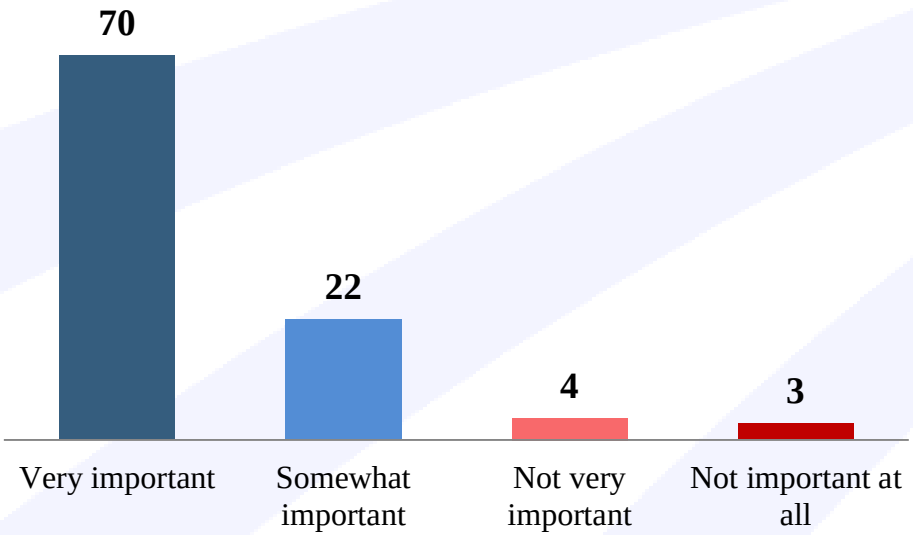
% Very serious	Democrat	Republican	No Party Preference	Female	Male	White	Latino	Asian	Black*
Drug Abuse	53	56	50	58	46	53	58	36	64
Mental Illness	52	46	49	57	41	47	55	37	47
Depression	53	37	48	53	39	44	56	29	58
Alcohol Abuse	48	43	45	52	38	44	54	29	50
Anxiety	43	30	41	47	29	37	45	29	36

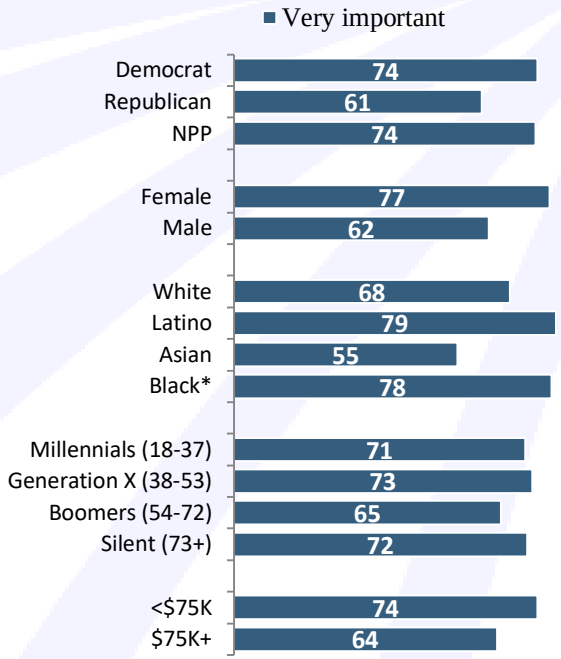
% Very serious	Millennials (18-37)	Generation X (38-53)	Boomers (54-72)	Silent (73+)	Bay Area	So Cal	Sac/ Valley	<$75K	$75K+	Not College Graduate	College Graduate
Drug Abuse	48	58	53	49	42	54	57	56	50	53	51
Mental Illness	53	55	47	35	44	50	53	51	48	51	48
Depression	54	53	41	32	44	49	43	49	43	46	46
Alcohol Abuse	46	47	45	43	35	47	51	51	40	49	42
Anxiety	48	40	34	25	40	40	32	40	36	38	38

Elevate: Statewide Voter Polling

Seven in ten say it is very important for California to address mental health and drug and alcohol use disorders

Q13. Compared to other issues facing voters, how important is it for California to address mental health and drug and alcohol use disorders?

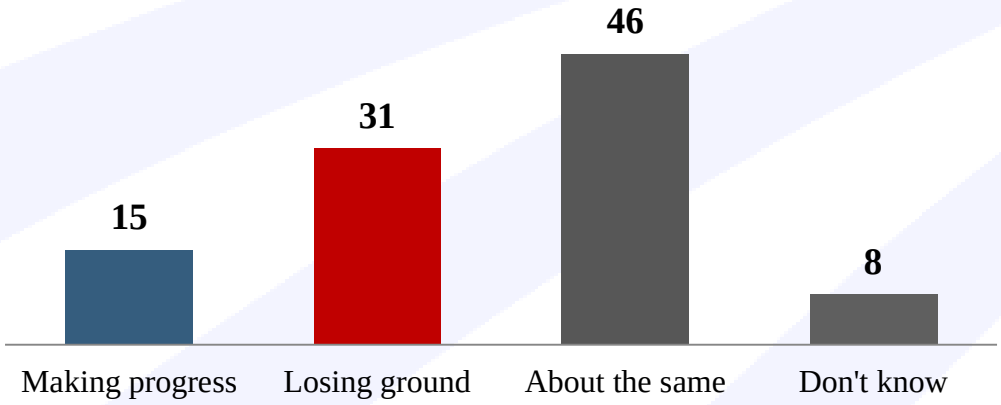


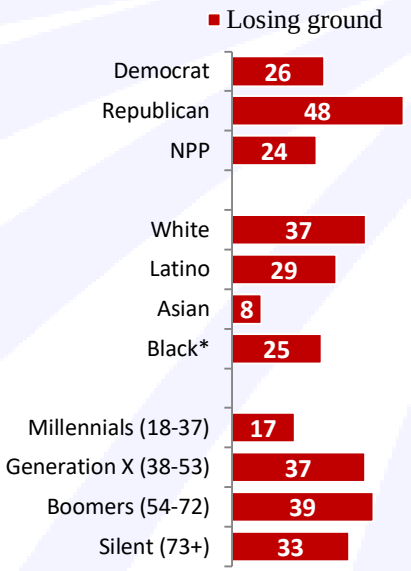


Elevate: Statewide Voter Polling

Only 15% say California is making progress in dealing with these issues; 31% say the state is losing ground

Q14. In dealing with mental illness and drug and alcohol use disorders, do you think California is making progress, losing ground, or are things about the same as they have been?



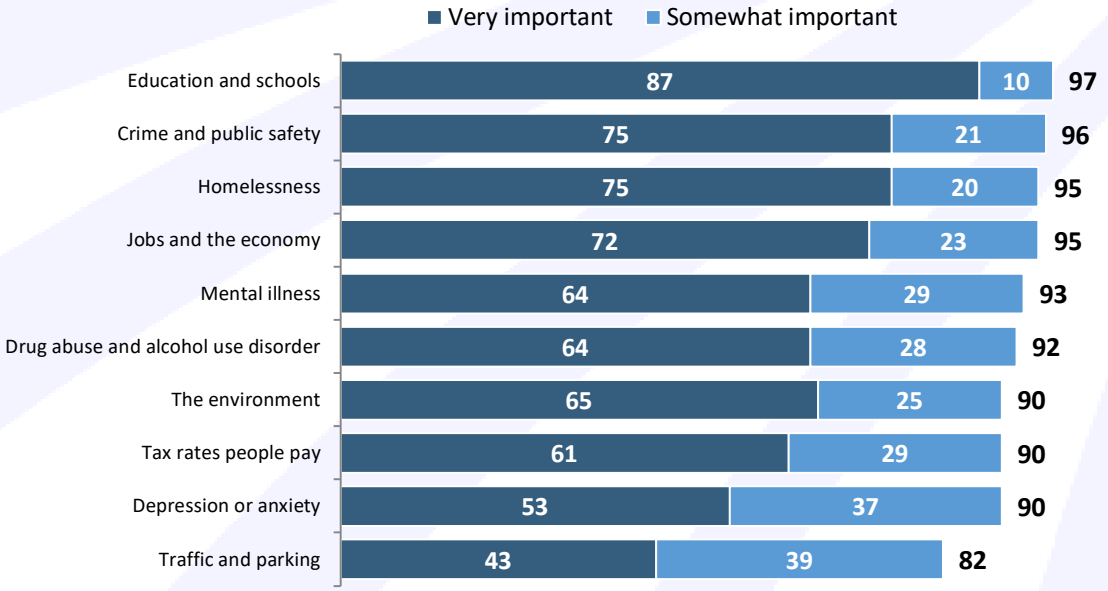


Whites and Republicans are among the most likely to say the state is losing ground

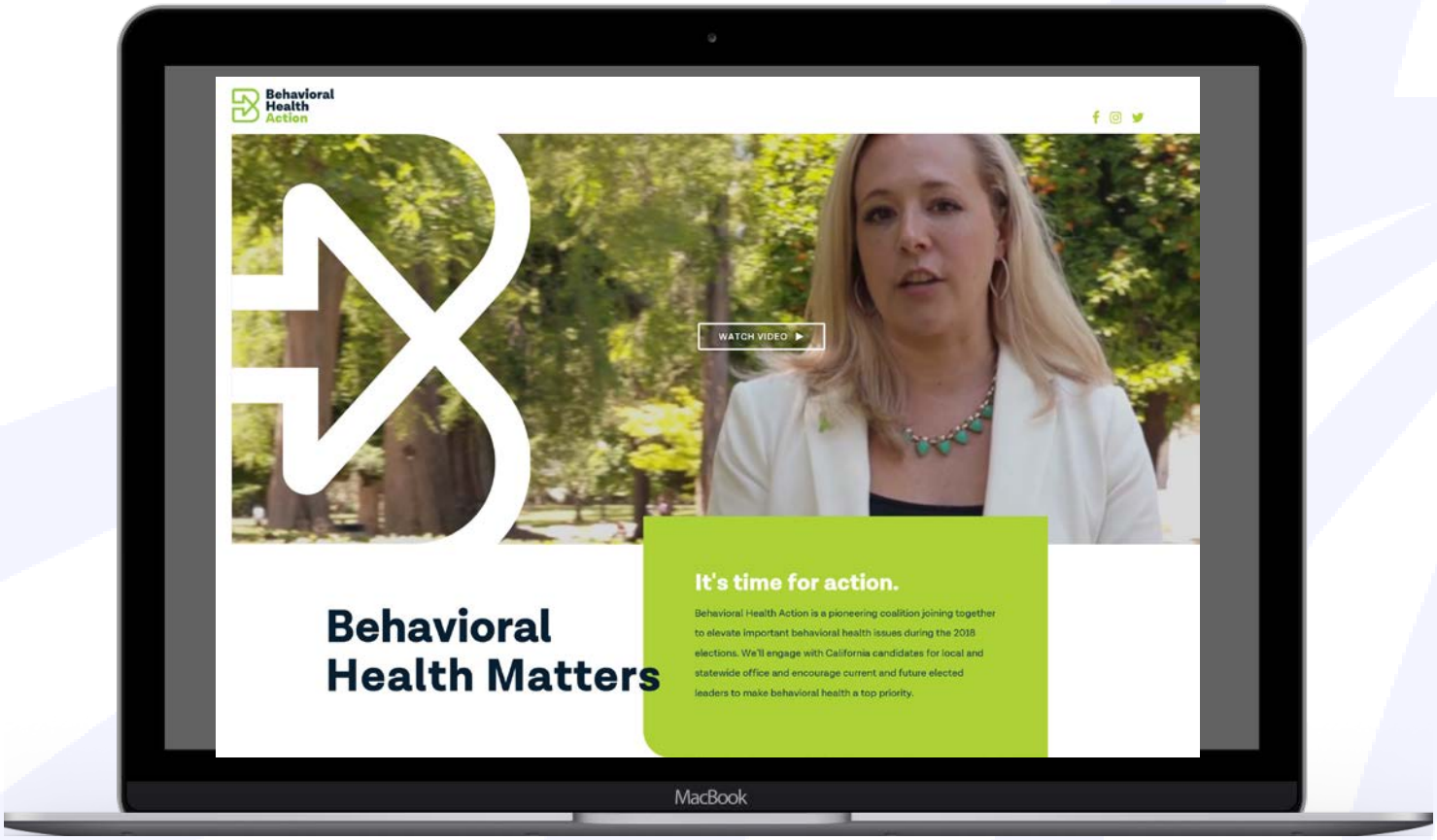
Elevate: Statewide Voter Polling

Nine in ten voters say mental illness, drug abuse and alcohol use disorder, and depression or anxiety are important issues facing the state

Q15-Q24. Thinking of various issues facing California, please tell me how important you think each is. Is it very important, somewhat important, not very important, or not important at all?



Educate: Website



www.behavioralhealthaction.org

Innovate

- Continued coalition leadership
- Identify best practices
- Incubate new ideas
- Remove legal and regulatory barriers

BHA: Next Steps

- Candidate Outreach
  - Engage Gavin Newsom, Lt. Governor
    - Behavioral health-focused event
  - Engage legislative leaders
    - Speaker: Anthony Rendon
    - Senate President Pro Tem: Toni Atkins
    - Assembly Republican Leader: Brian Dahle
    - Senate Republican Leader: Pat Bates

BHA: Next Steps

- Outreach to every state
  - Senate, Assembly, Statewide and Federal candidates – approximately 300
  - Urge candidates to provide their views on behavioral health for BHA website
- Op-eds in major newspapers
- Editorial boards at top 30 major daily newspapers
- Social media
  - Our Health California – www.ourhealthcalifornia.org

2017-2018 Legislative Session

- There is political interest
- Problem: “Band-Aids on Amputations”
- Flurry of bills:
  - Homeless
  - Grave Disability
  - Alternate Destination
  - Bed Registry
  - Involuntary Holds
    - Gun Ownership
  - Maternal Mental health
  - Crisis Funding Grants
  - MHSA Prop 63 Funding Transparency
  - Mental health in Workplace
  - Safe Inspection Sites
  - Early Intervention

CHA 2018 Legislative Highlights

Resources & Educational Opportunities

- www.calhospital.org/education
- CHA Behavioral Health Care Symposium
  - Dec. 10-11, 2018, Riverside, CA
- CHA Ligature Webinar
  - Oct. 2, 2018 – 10:00 – 11:30 a.m. Pacific
- www.calhospital.org/manuals
  - Mental Health Law Manual
  - EMTALA Manual

Questions

Thank You – Contact Info

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