West Side Health Care District

119 Adkisson Way Taft, CA 93268 (661) 765 - 7234

Board Meeting Agenda

Thursday, June 23, 2022 at 2:00 pm

1. **Call to Order/Pledge of Allegiance**

2. **Public Input**

This is the time for public comment. Members of the public may be heard on any item on the agenda. A person addressing the Board will be limited to five minutes unless the Chairperson grants a longer period of time. Comments by members of the public on an item on the agenda will only be allowed during consideration of the item by the Board. When the item is called, please raise your hand or stand if you desire to address the Board.

Members of the public may also, at this time only, address the Board on any non-agenda items, your comments will be limited to five minutes. You should raise your hand or stand at this time. Although Board Members may ask questions for clarification, the Board will not debate issues with the speaker. Non-emergency items may be rescheduled for a discussion at a later date. Please note, the Board may take action on non-agenda items only in emergency circumstances.

After the comments, the public is allowed to remain and listen or may leave at any time.

AMERICANS WITH DISABILITIES ACT (Government Code Section 54943.2) The West Side Health Care District is accessible to persons with disabilities. Disabled individuals who need special assistance to attend or participate in a meeting of the West Side Health Care District may request assistance at 119 Adkisson Way Taft, California, or by calling (661) 765-7234. Reasonable effort will be made to accommodate individuals with disabilities by making meeting materials available in alternative formats. Requests for assistance should be made five (5) working days in advance of a meeting whenever possible.

3. **Approval of Minutes**
   Board Meeting Minutes – Thursday, May 26, 2022

4. **Financial Review**
   District CPA's, Kelly Hohenbrink, Rick Jackson and Nathan Doty will join the meeting via telephone.
   A. Review and Discussion /Approval the May 2022 Financial Reports
   B. Review and Discussion/Approval 2022-2023 Proposed Budget
   C. Review and Discussion/Approval 2021-2022 Audit

5. **Annual Review and Approval of Policy and Procedures**
   A. West Side Family Health Care- Miscellaneous Policies

6. Administrative Staff Reports

A. May 2021, General Information- Attached for informational purposes only. No Action.

7. Committee Updates

A. **Finance Committee**
Eric Cooper or Ginny Miller

B. **Facilities Committee**
Eric Cooper or Darren Walrath

C. **Community Outreach**
Jan Ashley or Darren Walrath

D. **Personnel Committee**
Adele Ward or Jan Ashley
Discussion, Committee Meeting in July

E. **Additional Board Member Input**
This Portion of the meeting is reserved for Board Members to present information, announcements, or other items that have come to their attention. A Board member may request that an item is placed on the agenda for consideration at a future meeting or refer an item to the Executive Director for a formal report. The Board will take no formal action at this time.

8. Items for Future Agendas

9. Adjournment

The next Regular Board Meeting is set for Thursday, July 28, 2022, at 2:00 pm

ITEM 3

West Side Health Care District

119 Adkisson Way, Taft, CA 93268 (661) 765-7234

BOARD MEETING MINUTES

Thursday, May 26, 2022, at 2:00 pm

1. CALL TO ORDER

Board President, Eric Cooper, called the meeting to order at 2:02pm. Eric Cooper led the Pledge of Allegiance. Those present were:

Eric Cooper	Board President
Adele Ward	Board Vice President
Ginny Miller	Board Secretary/Treasurer
Jan Ashley	Board Member
Ryan Shultz	Executive Director
Robyn Melton	District Manager

Board Member, Darren Walrath was excused. In attendance Clinic Director, Summer Wood-Luper was present at the meeting.

2. PUBLIC INPUT- Rene Adamo from the West Side Parks and Recreation Department was here and summarized the events and programs that the Rec department provides for the active senior program. Mrs. Adamo described how the donated funds from the West Side Health Care District are used to provide fun incentives to encourage the seniors to stay active. There are about 50 seniors enrolled in the program.

3. APPROVAL OF MINUTES

The meeting minutes were reviewed. After discussion, the Minutes of Thursday, April 28, 2022, were approved by the Board of Directors.

4. FINANCIAL REVIEW

The Financial Statements of April 2022 were reviewed by CPA, Kelly Hohenbrink, via telephone. After discussion a motion was made by Ginny Miller to approve the April 2022 financial statements. Adele Ward seconded. Motion carried.

5. ANNUAL REVIEW AND APPROVAL OF POLICY AND PROCEDURES

After review and discussion, Jan Ashley made a Motion to approve the policies and procedures. Adele Ward seconded. Motion carried. The West Side Family Health Care Policy and Procedures that were reviewed were: Registering Patient Complaints, Billing Practices, Sliding Fee Scale, Registration of New Patient, Billing Personnel-Organization, Website Patient Portal Information, Communicable Disease Reporting, and Medical Records.

6. ADMINISTRATIVE STAFF REPORTS
April 2022, General Information- Attached for informational purposes only.
No action.

7. BOARD COMMITTEE REPORTS
a. Finance Committee-Nothing further at this time.
b. Facilities Committee- Nothing further at this time. Discussions included placing tint on the front clinic windows to help cut down the temperatures inside the lobby.
c. Community Outreach Committee- Nothing further at this time.
c. Personnel Committee- Nothing further at this time.
d. Additional Board Member Input-
Ginny Miller- A friend used the clinic for an emergency. The staff was wonderful, helpful and kind. Thanks to the staff.

8. ITEMS FOR FUTURE AGENDA
Nothing at this time.

11. ADJOURNMENT
At 3:04PM, Jan Ashley made a motion to Adjourn, Ginny Miller seconded. Motion carried.
The Board Meeting of May 26, 2022 was adjourned.

Respectfully Submitted: _____
Adele Ward, Board Vice President

The next regular Board Meeting is scheduled for Thursday, June 23, at 2:00 pm

ITEM 4A

West Side Family Health Care Patient Census 2021-2022

	July 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	March 2022	April 2022	May 2022	June 2022
1	68	31	111	74	94	96	54	112	82	82	38	0
2	50	72	86	39	109	84	62	88	72	45	74	0
3	43	74	124	57	98	73	119	69	60	40	90	0
4	24	78	61	108	81	46	109	90	76	86	87	0
5	52	67	60	105	82	30	119	40	40	104	70	0
6	73	58	68	86	59	108	117	58	35	82	73	0
7	80	32	129	81	42	104	120	80	83	74	31	0
8	78	39	121	67	97	108	88	101	85	69	51	0
9	49	73	96	52	98	65	97	98	80	52	114	0
10	38	73	101	33	80	98	132	65	56	42	87	0
11	35	79	68	84	47	40	114	75	75	80	91	0
12	66	73	59	80	84	48	145	42	37	72	120	0
13	70	71	115	109	39	82	138	37	38	71	71	0
14	68	34	128	80	45	99	106	79	94	77	54	0
15	59	36	101	77	108	76	64	84	99	56	60	0
16	65	60	86	39	93	53	66	77	83	41	96	0
17	30	96	84	51	62	77	134	84	71	34	118	0
18	37	63	56	117	65	57	120	77	79	73	115	0
19	65	60	58	94	76	31	148	41	49	99	77	0
20	96	64	112	100	37	78	138	35	41	94	79	0
21	72	56	117	84	41	75	103	47	83	66	50	0
22	59	53	90	90	98	67	64	109	93	73	50	0
23	53	90	92	36	76	59	77	87	79	39	87	0
24	42	110	80	49	71	27	142	67	56	35	109	0
25	44	89	37	96	23	17	101	78	73	95	81	0
26	82	96	58	98	59	48	118	39	32	101	99	0
27	77	96	112	94	44	64	108	35	43	93	85	0
28	72	57	92	79	52	84	100	87	94	87	48	0
29	51	47	104	70	93	66	48	0	92	74	50	0
30	60	122	89	40	104	67	62	0	95	52	65	0
31	37	130	0	37	0	63	98	0	65	0	88	0
M/AVG	1795	2179	2695	2306	2157	2090	3211	1981	2140	2088	2408	0
D/AVG	58	70	90	74	72	67	104	71	69	70	78	0
NSOT	10	6	12	10	7	14	31	21	26	22	0	0
X-RAYS	76	61	57	65	66	64	56	46	62	57	55	0

	YTD	M/AVG
	25050	2277
	822	75
	159	14
	665	60.45

Year	July	August	September	October	November	December	January	February	March	April	May	June	YTD	M/AVG	X-RAY
2021	1791	2176	2691	2305	2121	2073	1530	1351	1437	1616	1724	1677	22492	1874	840
2020	1258	1196	1095	1283	1341	1509	1790	1697	1385	902	1043	1140	15639	1303	788
2019	1034	1188	1334	1440	1338	1565	1470	1554	1453	1150	1290	1024	15840	1320	1250
2018	1002	1282	1284	1377	1187	1184	1632	1543	1347	1287	1310	1115	15550	1296	1286
2017	1016	1166	1243	1410	1324	1421	1348	1238	1204	1199	1238	1168	14975	1248	974
2016	1084	1319	1289	1389	1248	1420	1364	1403	1288	1260	1236	1102	15402	1284	
2015	836	989	1169	1276	1323	1411	1345	1063	1111	1090	987	833	13433	1119	
2014	784	867	1046	1006	966	1021	1391	994	1080	968	959	868	11950	996	
2013	697	1009	834	883	812	925	926	975	1047	885	893	0	9886	824	

ITEM 4B

Line Item	Unit	Descrption	Code	Draft Budget 2022-2023
		Visits		25451
		Xrays		900
1	4083.49	Outpatient Clinic Gross Revenues	24.00	$ 5,601,569.10
2	4083.51	Bad Debt Recovery	27.00	$ 2,500.00
3	4083.60	Contractual Adjustments	24.00	$ (1,018,358.02)
4	4083.90	Flu shot, Lab income, physicals	24.00	$ 4,800.00
5	4083.91	Medical Records copy fees	27.00	$ 4,400.00
6	4083.99	Settlement Revenue	24.00	$ -
7	7083.09	Other salaries and wages	28.00	$ (2,185,869.47)
8	7083.10	Payroll taxes	28.10	$ (172,944.80)
9	7083.12	Vacation, Holiday and Sick Leave	28.10	$ (148,403.10)
10	7083.13	Group Health & Welfare Insurance	28.10	$ (235,888.00)
11	7083.14	Group Life Insurance	28.10	$ (5,489.00)
12	7083.15	Pension and Retirement	28.10	$ (43,354.28)
13	7083.16	Workers Compensation insurance	28.10	$ (30,294.75)
14	7083.18	Other payroll related benefits	28.10	$ (31,400.00)
15	7083.20	Medical - Physicians	29.10	$ (622,480.00)
16	7083.22	Consulting and Management fees	29.00	$ (5,000.00)
17	7083.23	Legal	29.00	$ (2,500.00)
18	7083.26	Other contracted services	29.00	$ (100,000.00)
19	7083.38	Pharmaceuticals	31.00	$ (75,000.00)
20	7083.41	Other Medical Care Materials and Supplies	31.00	$ (275,000.00)
21	7083.43	Food	31.00	$ (5,000.00)
22	7083.44	Linens	31.00	$ (28,000.00)
23	7083.45	Cleaning supplies	31.00	$ (500.00)
24	7083.46	Office and Administrative supplies	31.00	$ (25,000.00)
25	7083.47	Employee wearing apparel	31.00	$ (5,000.00)
26	7083.48	Instruments and Minor Medical Equipment	31.00	$ (10,000.00)
27	7083.50	Maintenance Supplies and labor	31.00	$ (15,000.00)
28	7083.62	Repairs and Maintenance Grounds	32.00	$ (75,000.00)
29	7083.65	Collection Agencies	30.00	$ (351,532.29)
30	7083.69	Other purchased services	30.00	$ (25,000.00)
31	7083.72	Depreciation - Bldgs & Improvements	38.00	$ (111,000.00)
32	7083.75	Copier Lease	33.00	$ (13,000.00)
33	7083.80	Utilities - Electrical, Gas, Water, other	34.00	$ (85,000.00)
34	7083.81	Insurance - Malpractice	36.00	$ (37,366.00)
35	7083.83	Licenses and Taxes	37.00	$ (3,148.00)
36	7083.84	Advertising (billboards, photography)	37.00	$ (10,000.00)
37	7083.85	Telephone and Communications	34.00	$ (15,000.00)
38	7083.86	Dues and Subscriptions	37.00	$ (15,000.00)
39	7083.87	Outside Training	35.00	$ (10,000.00)
40	7083.88	Travel costs	35.00	$ (6,000.00)

41	7083.89	Recruiting	35.10	$	(15,000.00)
42	8610.09	Other salaries and wages	28.00	$	(342,212.27)
43	8610.10	Payroll taxes	28.10	$	(29,301.73)
44	8610.12	Vacation, Holiday and Sick Leave	28.10	$	(24,810.39)
45	8610.13	Group Health & Welfare Insurance	28.10	$	(23,520.00)
46	8610.14	Group Life Insurance	28.10	$	(958.00)
47	8610.15	Pension and Retirement	28.10	$	(6,604.25)
48	8610.16	Workers Compensation insurance	28.10	$	(4,622.97)
49	8610.18	Other payroll related benefits	28.10	$	(18,600.00)
50	8610.22	Consulting and Management Fees	29.00	$	(4,500.00)
51	8610.23	Legal	29.00	$	(2,500.00)
52	8610.24	Accounting /Audit Fees	29.00	$	(100,000.00)
53	8610.43	Food	31.00	$	(2,000.00)
54	8610.46	Office and Administrative Supplies	31.00	$	(16,000.00)
55	8610.62	Repairs and Maintenance Grounds	32.00	$	(15,000.00)
56	8610.69	Other purchased services	30.00	$	(2,500.00)
57	8610.75	Rental/lease equipment	33.00	$	(14,000.00)
58	8610.80	Utilities	34.00	$	(13,000.00)
59	8610.81	Community Outreach	37.00	$	(25,000.00)
60	8610.82	Insurance	36.00	$	(78,000.00)
61	8610.83	Licenses and Taxes	37.00	$	(800.00)
62	8610.84	Security	30.00	$	(6,000.00)
63	8610.85	Telephone and communications	34.00	$	(2,500.00)
64	8610.86	Dues and Subscriptions	37.00	$	(15,000.00)
65	8610.87	Outside Trainings	35.00	$	(15,000.00)
66	8610.88	Travel	35.00	$	(15,000.00)
67	8610.90	Other Direct Expenses	37.00	$	(2,500.00)
68	8620.90	Other	37.00	$	(6,000.00)
69	9060.00	Income, Gains and losses from investments	27.00	$	16,000.00
70	9160.00	Property Tax Revenues	40.00	$	1,200,000.00
71	9261.90	Dowden Electric Rental	25.00	$	4,800.00
72	9400.00	Miscellaneous Income	27.00	$	58.26
73	9520.62	Repairs and Maintenance Grounds	32.00	$	(5,000.00)
74		Expenses Over Revenue			230,670

WSHCD Fiscal Year 2022-2023 Budget
Projected Visits

Line Item	Payor	**Per Visi Rate	% of Census	Projected Census FY 22-23	Projected Net Revenue	**Gross Charges	Contractual
1	Cigna/Kaiser Global	130.00	2.85%	725	94250.00	130,681	(36,431)
2	Commercial	65.00	20.60%	5244	340860.00	945,231	(604,371)
3	Medi/Medi	221.21	4.09%	1040	230053.20	246,376	(16,323)
4	MediCal (PPS Rate)	221.21	64.04%	16300	3605641.50	3,861,470	(255,829)
5	MediCare	116.25	4.39%	1117	129851.25	218,597	(88,746)
6	Self Pay	150.00	3.71%	944	141600.00	145,848	(4,248)
8	WC	157.73	0.32%	81	12776.13	13,766	(990)
9	Radiology	31.31	3.42%	900	28179.00	39,600	(11,421)
10	Total Non Xray			25451			
11	Total			26351	4,583,211	5,601,569	(1,018,358)

*Forecasts based on historic patient volumes and insurance payer mix

**Reimbursements and gross charges based on established fee schedule and accounts recievables

Title	Rate Type	Pay Rate 1	Pay Rate 2	Hours	FTE	Hours	Gross Pay	SS& MCR	Other Tax	Health, Dental Vision	Life	Work Comp	Additional Benefits	1099 Comp	Projected Visits	Accrued PTO	Pension	Total
RN	FT	44.23	47.33	2,080	1.00	2,080	98,438	7,531	898	8,808	167	1,378	-	-	-	6,623.88	1969	125,813
LVN	FT	32.50	34.78	2,080	1.00	2,080	72,332	5,533	660	1,800	167	1,013	-	-	-	4,867.20	1447	87,819
LVN	FT	29.00	31.03	2,080	0.90	1,872	58,088	4,444	530	10,800	167	813	-	-	-	3,908.74	1162	79,913
LVN	PD	30.45	32.58	2,080	0.50	1,040	33,885	2,592	309	10,800	167	474	-			2,280.10	678	51,185
CD	FT (S)	67.05	71.74	2,080	1.00	2,080	149,226	11,416	1,362	10,080	167	2,089	9,000	-	-	11,993.90	2985	198,319
MA	FT	17.80	19.05	2,080	0.90	1,872	35,654	2,728	325	10,300	167	499	-	-	-	2,399.16	713	52,785
CC	FT	23.00	24.61	2,080	0.90	1,872	46,070	3,524	420	10,800	167	645	-	-	-	3,100.03	921	65,648
MA	PD	19.55	20.92	2,080	0.25	520	10,878	832	99		167	152	-	-	-	15,311.34	218	27,657
MA	FT	20.80	22.26	2,080	0.90	1,872	41,663	3,187	380	7,812	167	583	-	-	-	2,803.51	833	57,430
MA	FT	18.69	20.00	2,080	0.90	1,872	37,437	2,864	342	8,628	167	524	-	-	-	1,994.30	749	52,704
MA	FT	18.65	19.96	2,080	0.90	1,872	37,357	2,858	341	10,800	167	523				1,990.03	747	54,782
MC	PD	17.00	18.19	2,080	0.08	166	3,027	232	28	9,168	167	42	-	-	-	161.24	61	12,885
MC	FT	18.50	19.80	2,080	0.90	1,872	37,056	2,835	338	9,168	167	519				1,974.02	741	52,798
LMA	FT	23.00	24.61	2,080	0.90	1,872	46,070	3,524	420	10,800	167	645	-	-	-	3,100.03	921	65,648
LMA (V)	FT	23.00	24.61	2,080	0.90	1,872	46,070	3,524	420	10,800	167	645	-	-	-	2,454.19	921	65,002
MA (V)	FT	22.00	23.54	2,080	0.90	1,872	44,067	3,371	402	10,800	167	617	-	-	-	2,965.25	881	63,271
CC (V)	FT	23.00	24.61	2,080	0.90	1,872	46,070	3,524	420	10,800	167	645	-	-	-	3,100.03	921	65,648
MA (V)	FT	22.00	23.54	2,080	0.90	1,872	44,067	3,371	402	10,800	167	617	-	-	-	2,965.25	881	63,271
MA	FT	19.00	20.33	2,080	0.90	1,872	38,058	2,911	347	4,800	167	533	-	-	-	2,560.90	761	50,138
MA	PD	17.82	19.07	2,080	0.50	1,040	19,830	1,517	181		167	278	-	-	-	1,334.36	397	23,704
MA	PD	18.99	20.32	2,080	0.25	520	10,566	808	96	-	167	148	-	-	-	710.99	211	12,708
MA	PD	17.80	19.05	2,080	0.50	1,040	19,808	1,515	181		167	277	-	-	-	1,332.86	396	23,677
MA	PD	17.82	19.07	2,080	0.50	1,040	19,830	1,517	181	-	167	278	-	-	-	1,334.36	397	23,704
FO&BM	FT	25.40	27.18	2,080	1.00	2,080	56,530	4,325	516	10,800	167	791	1,200	-	-	3,803.90	1131	79,264
AMA-B	FT	19.74	21.12	2,080	1.00	2,080	43,933	3,361	401	10,800	167	615	-	-	-	2,956.26	879	63,112
Sup X-Ray	FT	39.00	41.73	2,080	0.90	1,872	78,119	5,976	713	10,800	167	1,094	-	-	-	5,256.58	1562	103,687
X-Ray Tech	FT	35.06	37.51	2,080	0.90	1,872	70,227	5,372	641	1,700	167	983	-	-	-	4,725.53	1405	85,220
X-Ray Tech	PD	33.99	36.37	2,080	0.08	166	6,052	463	55	-	-	85	-	-	-	407.23	-	7,062
X-Ray Tech	PD	33.99	36.37	2,080	0.08	166	6,052	463	55	-	-	85	-	-	-	407.23	-	7,062
X-Ray Tech	PD	33.99	36.37	2,080	0.08	166	6,052	463	55	-	-	85	-	-	-	407.23	-	7,062
ED	FT (S)	64.91	69.45	2,080	1.00	2,080	144,464	11,051	1,318	10,800	312	2,022	9,000	-	-	11,611.10	2889	193,468
DM/HR	FT (S)	31.21	33.39	2,080	1.00	2,080	69,461	5,314	634	1,920	312	972	8,400	-	-	5,582.84	1389	93,985
AC	FT	26.50	28.36	2,080	1.00	2,080	58,978	4,512	538		167	826	1,200	-	-	4,740.32	1180	72,141
Recep (V)	FT	17.00	18.19	2,080	1.00	2,080	37,835	2,894	345	10,800	167	530	-	-	-	1,838.72	757	55,167
CM	FT	32.00	34.24	2,080	1.00	2,080	71,219	5,448	650	6,600	312	997	1,200	-	-	4,792.32	1424	92,643
Maint	PT	15.00	16.05	2,080	0.25	520	8,346	638	76	-	-	117	-	-	-	444.60	167	9,789
Maint	PT	20.00	21.40	2,080	0.25	520	11,128	851	102	-	-	156	-	-	-	592.80	223	13,052

Title	Rate Type	Pay Rate 1	Pay Rate 2	Hours	FTE	Hours	Gross Pay	SS& MCR	Other Tax	Health, Dental Vision	Life	Work Comp	Additional Benefits	1099 Comp	Projected Visits	Accrued PTO	Pension	Total
RN	FT	44.23	47.33	2,080	1.00	2,080	98,438	7,531	898	8,808	167	1,378	-	-	-	6,623.88	1969	125,813
LVN	FT	32.50	34.78	2,080	1.00	2,080	72,332	5,533	660	1,800	167	1,013	-	-	-	4,867.20	1447	87,819
LVN	FT	29.00	31.03	2,080	0.90	1,872	58,088	4,444	530	10,800	167	813	-	-	-	3,908.74	1162	79,913
LVN	PD	30.45	32.58	2,080	0.50	1,040	33,885	2,592	309	10,800	167	474	-			2,280.10	678	51,185
CD	FT (S)	67.05	71.74	2,080	1.00	2,080	149,226	11,416	1,362	10,080	167	2,089	9,000	-	-	11,993.90	2985	198,319
MA	FT	17.80	19.05	2,080	0.90	1,872	35,654	2,728	325	10,300	167	499	-	-	-	2,399.16	713	52,785
CC	FT	23.00	24.61	2,080	0.90	1,872	46,070	3,524	420	10,800	167	645	-	-	-	3,100.03	921	65,648
MA	PD	19.55	20.92	2,080	0.25	520	10,878	832	99		167	152	-	-	-	15,311.34	218	27,657
MA	FT	20.80	22.26	2,080	0.90	1,872	41,663	3,187	380	7,812	167	583	-	-	-	2,803.51	833	57,430
MA	FT	18.69	20.00	2,080	0.90	1,872	37,437	2,864	342	8,628	167	524	-	-	-	1,994.30	749	52,704
MA	FT	18.65	19.96	2,080	0.90	1,872	37,357	2,858	341	10,800	167	523				1,990.03	747	54,782
MC	PD	17.00	18.19	2,080	0.08	166	3,027	232	28	9,168	167	42	-	-	-	161.24	61	12,885
MC	FT	18.50	19.80	2,080	0.90	1,872	37,056	2,835	338	9,168	167	519				1,974.02	741	52,798
LMA	FT	23.00	24.61	2,080	0.90	1,872	46,070	3,524	420	10,800	167	645	-	-	-	3,100.03	921	65,648
LMA (V)	FT	23.00	24.61	2,080	0.90	1,872	46,070	3,524	420	10,800	167	645	-	-	-	2,454.19	921	65,002
MA (V)	FT	22.00	23.54	2,080	0.90	1,872	44,067	3,371	402	10,800	167	617	-	-	-	2,965.25	881	63,271
CC (V)	FT	23.00	24.61	2,080	0.90	1,872	46,070	3,524	420	10,800	167	645	-	-	-	3,100.03	921	65,648
MA (V)	FT	22.00	23.54	2,080	0.90	1,872	44,067	3,371	402	10,800	167	617	-	-	-	2,965.25	881	63,271
MA	FT	19.00	20.33	2,080	0.90	1,872	38,058	2,911	347	4,800	167	533	-	-	-	2,560.90	761	50,138
MA	PD	17.82	19.07	2,080	0.50	1,040	19,830	1,517	181		167	278	-	-	-	1,334.36	397	23,704
MA	PD	18.99	20.32	2,080	0.25	520	10,566	808	96	-	167	148	-	-	-	710.99	211	12,708
MA	PD	17.80	19.05	2,080	0.50	1,040	19,808	1,515	181		167	277	-	-	-	1,332.86	396	23,677
MA	PD	17.82	19.07	2,080	0.50	1,040	19,830	1,517	181	-	167	278	-	-	-	1,334.36	397	23,704
FO&BM	FT	25.40	27.18	2,080	1.00	2,080	56,530	4,325	516	10,800	167	791	1,200	-	-	3,803.90	1131	79,264
AMA-B	FT	19.74	21.12	2,080	1.00	2,080	43,933	3,361	401	10,800	167	615	-	-	-	2,956.26	879	63,112
Sup X-Ray	FT	39.00	41.73	2,080	0.90	1,872	78,119	5,976	713	10,800	167	1,094	-	-	-	5,256.58	1562	103,687
X-Ray Tech	FT	35.06	37.51	2,080	0.90	1,872	70,227	5,372	641	1,700	167	983	-	-	-	4,725.53	1405	85,220
X-Ray Tech	PD	33.99	36.37	2,080	0.08	166	6,052	463	55	-	-	85	-	-	-	407.23	-	7,062
X-Ray Tech	PD	33.99	36.37	2,080	0.08	166	6,052	463	55	-	-	85	-	-	-	407.23	-	7,062
X-Ray Tech	PD	33.99	36.37	2,080	0.08	166	6,052	463	55	-	-	85	-	-	-	407.23	-	7,062
ED	FT (S)	64.91	69.45	2,080	1.00	2,080	144,464	11,051	1,318	10,800	312	2,022	9,000	-	-	11,611.10	2889	193,468
DM/HR	FT (S)	31.21	33.39	2,080	1.00	2,080	69,461	5,314	634	1,920	312	972	8,400	-	-	5,582.84	1389	93,985
AC	FT	26.50	28.36	2,080	1.00	2,080	58,978	4,512	538		167	826	1,200	-	-	4,740.32	1180	72,141
Recep (V)	FT	17.00	18.19	2,080	1.00	2,080	37,835	2,894	345	10,800	167	530	-	-	-	1,838.72	757	55,167
CM	FT	32.00	34.24	2,080	1.00	2,080	71,219	5,448	650	6,600	312	997	1,200	-	-	4,792.32	1424	92,643
Maint	PT	15.00	16.05	2,080	0.25	520	8,346	638	76	-	-	117	-	-	-	444.60	167	9,789
Maint	PT	20.00	21.40	2,080	0.25	520	11,128	851	102	-	-	156	-	-	-	592.80	223	13,052

ITEM 4C

Audited Financial Statements

WEST SIDE
HEALTH CARE DISTRICT

JWT & Associates, LLP
June 30, 2021

Audited Financial Statements

WEST SIDE HEALTH CARE DISTRICT

June 30, 2021

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Management's Discussion and Analysis

WEST SIDE HEALTH CARE DISTRICT

June 30, 2021

The management of the West Side Health Care District (the District) has prepared this annual discussion and analysis in order to provide an overview of the District's performance for the fiscal year ended June 30, 2021 in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments.* The intent of this document is to provide additional information on the District's historical financial performance as a whole in addition to providing a prospective look at revenue growth, operating expenses, and capital development plans. This discussion should be reviewed in conjunction with the audited financial statements for the fiscal year ended June 30, 2021 and accompanying notes to the financial statements to enhance one's understanding of the District's financial performance.

Financial Summary

- Total assets increased by $55,224 from the fiscal year ended June 30, 2020.
- Total cash and cash equivalents for operations increased by $189,135 over the prior year. Capital assets increased by $407,341 over the prior year, all purchased from operating cash.
- Net patient accounts receivable were at $257,732 as collections averaged approximately 80% of gross patient revenues. Net days in patient accounts receivable were 31.26 at June 30, 2021.
- Current assets decreased by $309,810 from the prior fiscal year while current liabilities also decreased by $95,458 from the prior fiscal year. This resulted in a current ratio of 23.85 to 1 where as the industry norm is around 2 to 1.
- Net operating revenues increased by $190,658 as the rural health care clinic added revenue due to increased rates for visits.
- Operating expenses increased by $1,032,478 as operations ramped up during the COVID pandemic.
- The increase in net position (or income for the year) was $430,801.

Cash and Investments

For the fiscal year ended June 30, 2021, the District's operating cash and cash equivalents and short-term investments totaled $2,952,593 as compared to $3,745,334 in fiscal year 2020 At June 30, 2021, days cash on hand was 187.38 as compared to industry goals of 100 days cash on hand. The majority of the District's cash is deposited with local banks and in the local agency investment fund or LAIF with the State of California.

Current Liabilities

As previously noted, current liabilities of the District decreased by $95,458. The significant changes were related to decreases in accounts payable and accrued expenses of $64,228 and decreases in accrued payroll and related liabilities of $31,230.

Capital Assets

During the year, the District reinvested $530,534 in construction-in-progress (CIP) towards the new clinic, while experiencing depreciation expense of $123,193 for a net gain of $407,161. Total CIP as of June 30, 2021 amounted to $10,085,799, all funded by the District's cash flow.

Volumes

- Total outpatient care visits were 16,954 for the year ended June 30, 2021 for a daily average of 46.57 a day. Visit counts for the past several years are as follows: 2020 - 16,263; 2019 - 16,485; 2018- 15,351; 2017- 15,536; and 2016 - 14,657.

Patient Revenues

Gross Patient Charges: The District charges all its patients equally based on its established pricing structure for the services rendered. The charge master is evaluated on an ongoing basis to ensure that all only allowable charges are billed to comply with Medicare and Medi-cal regulations.

Deductions From Revenue: Deductions from revenue are deductions based on the difference between (1) gross charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare and Medi-Cal and other third party payors such as Blue Cross, and (2) provisions for bad debts on self-pay financial classes.

Deductions from revenue (as a percentage of gross patient service charges) were approximately 19% for fiscal year 2021. The deductions from revenue decreased from the prior year due to the increase in the PPS rate.

Net Patient Service Revenues: Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. Net patient service revenues were $3,009,509 for 2021 as compared to $2,818,851 in fiscal year 2020.

Operating Expenses

Total operating expenses were $5,874,558 for 2021 as compared to $4,842,080 for 2020. The following changes were noteworthy:

- A $250,652 increase in salaries, wages and benefits due mainly to an increase in FTE's, salary rate increases for the year, and volume increases.
- A $75,792 increase in supplies due to COVID treatments for patients.
- A $416,871 increase in purchased services
- All other expenses were generally comparable to the prior year.

Economic Factors and Next Fiscal Year's Budget

The District's Board approved the fiscal year July 1, 2021 through June 30, 2022 budget at a recent Board meeting. For fiscal year 2022, the significant contributing factors to this budgeted income are:

- The District tax revenues are projected to be $1.0 million for 2022. The District is budgeting slight increases in net patient revenues due to the increased reimbursement rates of the rural health clinic. Total projected revenues are budgeted at approximately $3.1 million.
- Expenses are budgeted at approximately $4.1 million for 2022.

The District is looking forward to completing construction on a new clinic and expanding the District's facilities according to the master plan presented to the public in an effort to provide excellent health care to the residents in the Taft area.

JWT & Associates, LLP

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Report of Independent Auditors

The Board of Directors
West Side Health Care District
Taft, California

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

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits 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 judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the District's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the 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 opinion.

Opinion

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

Supplementary Information

Management's discussion and analysis is not a required part of the financial statements but is supplementary information required by accounting principles generally accepted in the United States of America. We have applied limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and express no opinion on it.

Other Reporting Required by Governmental Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated April 25, 2022, on our consideration of the District's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the District's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the District's internal control over financial reporting and compliance.

JWT & Associates, LLP

Fresno, California
April 25, 2022

Statements of Financial Position

WEST SIDE HEALTH CARE DISTRICT

	June 30 2021	June 30 2020
Assets		
Current assets:		
Cash and cash equivalents	$ 1,385,960	$ 1,196,825
Short-term investments	1,566,633	2,548,509
Patient accounts receivable, net	257,732	137,412
Grant and other receivables	161,186	171,462
Estimated third party payor settlements	2,237,875	1,817,976
Prepaid expenses and other current assets	35,804	82,816
Total current assets	5,645,190	5,955,000
Capital assets, net of accumulated depreciation	11,963,406	11,556,065
	$ 17,608,596	$ 17,511,065
Liabilities		
Current liabilities:		
Accounts payable and accrued expenses	$ 49,588	$ 113,816
Accrued payroll and related liabilities	187,061	218,291
Total current liabilities	236,649	332,107
Deferred revenues	100,000	337,812
Total liabilities	336,649	669,919
Net position		
Invested in capital assets	11,963,406	11,556,065
Unrestricted	5,308,541	5,285,081
Total net position	17,271,947	16,841,146
	$ 17,608,596	$ 17,511,065

See accompanying notes and auditor's report

Statements of Revenues, Expenses and Changes in Net Position

WEST SIDE HEALTH CARE DISTRICT

	Year Ended June 30	
	2021	2020
Operating revenues		
Net patient service revenue	$ 3,009,509	$ 2,818,851
Other contracted revenues	1,478,001	277,311
Rental income	16,046	9,960
Other operating revenue	8,468	3,808
Total operating revenues	4,512,024	3,109,930
Operating expenses		
Salaries and wages	2,562,982	2,312,330
Employee benefits	376,896	332,180
Professional fees	992,789	981,148
Supplies	347,936	272,144
Purchased services	852,411	435,540
Repairs and maintenance	156,307	77,230
Rents and operating leases	94,858	36,297
Utilities and phone	125,909	57,805
Insurance	99,550	99,652
Depreciation and amortization	123,193	122,110
Travel, meetings and conferences	22,923	18,214
Other operating expenses	118,804	97,430
Total operating expenses	5,874,558	4,842,080
Operating loss	(1,362,534)	(1,732,150)
Nonoperating revenues		
District tax revenues	1,477,097	1,316,848
COVID Grants and other contributions	296,621	1,442,707
Investment income	19,617	69,285
Total nonoperating revenues	1,793,335	2,828,840
Increase (decrease) in net position	430,801	1,096,690
Net position at beginning of the year	16,841,146	15,744,456
Net position at end of the year	$ 17,271,947	$ 16,841,146

See accompanying notes and auditor's report

Statements of Cash Flows

WEST SIDE HEALTH CARE DISTRICT

	Year Ended June 30 2021	2020
Cash flows from operating activities:		
Cash received from patients and third-parties on behalf of patients	$ 3,549,728	$ 1,795,687
Cash received from other operating sources	1,730,051	253,378
Cash payments to suppliers and contractors	(3,171,167)	(2,797,087)
Cash payments to employees and benefit programs	(2,531,752)	(2,241,118)
Net cash (used in) operating activities	(423,140)	(2,989,140)
Cash flows from noncapital financing activities:		
District tax revenues	1,477,097	1,316,848
Net cash provided by noncapital financing activities	1,477,097	1,316,848
Cash flows from capital financing activities:		
COVID grants and other contributions	355,429	1,442,707
Purchase and transfer of capital assets, net of disposals	(2,162,936)	(4,827,606)
Net cash (used in) capital financing activities	(1,807,507)	(3,384,899)
Cash flows from investing activities:		
Change in short-term investments	981,876	(1,190,392)
Investment income	19,617	69,285
Net cash provided by investing activities	1,001,493	1,259,677
Net increase (decrease) in cash and cash equivalents	189,135	(3,797,514)
Cash and cash equivalents at beginning of year	1,196,825	4,994,339
Cash and cash equivalents at end of year	$ 1,385,960	$ 1,196,825
Reconciliation of operating loss to cash used in operating activities:		
Operating (loss)	$ (1,362,534)	$ (1,732,150)
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation and amortization	123,193	122,110
Provision for bad debts	307,720	288,487
Changes in operating assets and liabilities:		
Patient accounts receivables, net	(187,400)	(264,183)
Grant and other receivables	(10,276)	(37,701)
Estimated third party payor settlements	419,899	(385,280)
Prepaid expenses and current assets	(47,012)	(12,545)
Accounts payable, accrued payroll and other	95,458	305,690
Deferred revenues	237,812	662,188
Net cash (used in) operating activities	$ (423,140)	$ (2,989,140)

See accompanying notes and auditor's report

NOTE A - ORGANIZATION AND ACCOUNTING POLICIES

Reporting Entity: The West Side Health Care District (the District) is a public entity organized under Local Health Care District Law as set forth in the Health and Safety Code of the State of California. The District is a political subdivision of the State of California and is generally not subject to federal or state income taxes. The District is governed by a five-member Board of Directors, elected from within the boundaries of the health care district to specified terms of office. The District owns and operates an outpatient clinic facility located in Taft, California, through which it provides health care services primarily to individuals who reside in the local geographic area. The District also recruits and retains clinical professionals which they then sub-contract to the City of Taft to fulfill the City's obligation under a contract with the Department of Corrections.

Basis of Preparation: The accounting policies and financial statements of the District generally conform with the recommendations of the audit and accounting guide, *Health Care Organizations*, published by the American Institute of Certified Public Accountants. The financial statements are presented in accordance with the pronouncements of the Governmental Accounting Standards Board (GASB). For purposes of presentation, transactions deemed by management to be central to the provision of health care services are reported as operational revenues and expenses.

Risk Management: The District is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and medical malpractice. Commercial insurance coverage is purchased for claims arising from such matters.

Cash and Cash Equivalents: The District considers cash and cash equivalents to include certain investments in highly liquid debt instruments, when present, with an original maturity of a short-term nature or subject to withdrawal upon request. Exceptions are for those investments which are intended to be continuously invested. Investments in debt securities are reported at market value. Interest, dividends and both unrealized and realized gains and losses on investments are included as investment income in nonoperating revenues when earned.

Short -Term Investments: Short-term investments are funds invested local banks and in the State of California's administered Local Agency Investment fund (LAIF). The State invests transferred funds from various political subdivisions within the State into various government secured investment pools with readily determinable fair values and therefore the District's short-term investments are measured at fair value at June 30, 2021 and 2020. Investment income or losses (including realized and unrealized gains and losses on investments, interest and dividends) are included in nonoperating revenues under investment income.

Patient Accounts Receivable: Patient accounts receivable consist of amounts owed by various governmental agencies, insurance companies and private patients. The District manages its receivables by regularly reviewing the accounts, inquiring with respective payors as to collectibility and providing for allowances on their accounting records for estimated contractual adjustments and uncollectible accounts. Significant concentrations of patient accounts receivable are discussed further in the footnotes

NOTE A - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Use of Estimates: The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amount of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Capital Assets: Capital assets consist of property and equipment and are reported on the basis of cost, or in the case of donated items, on the basis of fair market value at the date of donation. Routine maintenance and repairs are charged to expense as incurred. Expenditures which increase values, change capacities, or extend useful lives are capitalized. Depreciation of property and equipment and amortization of property under capital leases are computed by the straight-line method for both financial reporting and cost reimbursement purposes over the estimated useful lives of the assets, which range from 3 to 40 years, depending upon the capital asset classification.

Compensated Absences: The District's employees earn vacation benefits at varying rates depending on years of service. Employees also earn sick leave benefits. Both benefits can accumulate up to specified maximum levels. Employees are not paid for accumulated sick leave benefits if they leave either upon termination or before retirement. However, accumulated vacation benefits are paid to an employee upon either termination or retirement. Accrued vacation liabilities (PTO) as of June 30, 2021 and 2020 was $154,090 and $154,361, respectively.

Net Position: Net position can be presented in three categories. The first category is net position "invested in capital assets, net of related debt". This category of net position consists of capital assets (both restricted and unrestricted), net of accumulated depreciation and reduced by the outstanding principal balances of any debt borrowings that were attributable to the acquisition, construction, or improvement of those capital assets.

The second category is "restricted" net position. This category consists of externally designated constraints placed on those net position by creditors (such as through debt covenants), grantors, contributors, law or regulations of other governments or government agencies, or law or constitutional provisions or enabling legislation.

The third category is "unrestricted" net position. This category consists of net position that does not meet the definition or criteria of the previous two categories.

Net Patient Service Revenues: Net patient service revenues are reported in the period at the estimated net realized amounts from patients, third-party payors and others including estimated retroactive adjustments under reimbursement agreements with third-party programs. Normal estimation differences between final reimbursement and amounts accrued in previous years are reported as adjustments of current year's net patient service revenues.

NOTE A - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Revenue Recognition: As previously stated, net patient service revenues are reported at amounts that reflect the consideration to which the District expects to be entitled in exchange for patient services. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and include variable consideration for retroactive revenue adjustments due to settlement of third-party payor audits, reviews, and investigations. Generally, the District bills the patients and third-party payors several days after the patient receives healthcare services at the District. Revenue is recognized as services are rendered.

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. Payment arrangements include prospectively determined rates per day, discharge or visit, reimbursed costs, discounted charges and per diem payments. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Gifts of long-lived assets such as land, buildings, or equipment are reported as net assets without donor restrictions unless explicit donor stipulations specify how the donated asset must be used. Gifts of long-lived assets with explicit donor restrictions that specify how the asset is to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as net assets with donor restrictions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived asset is placed in service. Cash received in excess of revenue recognized is deferred revenue.

Contributions are recognized as revenue when they are received or unconditionally pledged. Donor stipulations that limit the use of the donation are recognized as contributions with donor restrictions. When the purpose is accomplished, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported as net assets released from donor restrictions. Donor restricted contributions whose restriction expire during the same fiscal year are recognized as net assets without donor restrictions. Absent donor imposed restrictions, the District records donated services, materials, and facilities as net assets without donor restrictions.

From time to time, the District receives grants from various governmental agencies and private organizations. Revenues from grants are recognized when all eligibility requirements, including time requirements are met. Grants may be restricted for either specific operating purposes or capital acquisitions. These amounts, when recognized upon meeting all requirements, are reported as components of the statement of revenues, expenses and changes in net position.

Charity Care: The District accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies of the District. Essentially, these policies define charity services as those services for which no payment is anticipated. Because the District does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenues. Services provided are recorded as gross patient service revenues and then written off as an adjustment to net patient service revenues

NOTE A - ORGANIZATION AND ACCOUNTING POLICIES (continued)

District Tax Revenues: The District receives much of its financial support from parcel taxes. These funds are used to support operations and meet required debt service agreements. They are classified as non-operating revenue as the revenue is not directly linked to patient care. Parcel taxes are levied by the County on the District's behalf during the year, and are intended to help finance the District's activities during the same year. The County has established certain dates to levy, lien, mail bills, and receive payments from property owners during the year. Parcel taxes are considered delinquent on the day following each payment due date.

Operating Revenues and Expenses: The District's statement of revenues, expenses and changes in net position distinguishes between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services, which is the District's principal activity. Operating expenses are all expenses incurred to provide health care services, other than financing costs. Nonoperating revenues and expenses are those transactions not considered directly linked to providing health care services.

Statements of Cash Flows: For purposes of the statements of cash flows, all highly liquid investments with original maturities of three months or less are considered to be cash equivalents.

Reclassifications: Certain financial statement amounts as presented in the prior year financial statements have been reclassified in these, the current year financial statements, in order to conform to the current year financial statement presentation.

NOTE B - CASH AND CASH EQUIVALENTS

As of June 30, 2021 and 2020, the District had deposits invested in various financial institutions in the form of cash and cash equivalents in the amounts of $1,384,628 and $1,195,492 respectively. All of these funds were held in deposits, which are collateralized in accordance with the California Government Code (CGC), except for $250,000 per account that is federally insured.

The CGC and the District's investment policy do not contain legal or policy requirements that would limit the exposure to custodial risk for deposits. Custodial risk for deposits is the risk that, in the event of the failure of a depository financial institution, the District would not be able to recover its deposits or will not be able to recover collateral securities that are in possession of an outside party.

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

NOTE C - SHORT-TERM INVESTMENTS AND INVESTMENT POLICY

The District's investment policy authorizes investments in the LAIF investment pool administered by the State of California. The State's Treasurer's Office reports its investments at fair market value. The fair market value of investments in the State Treasurer's pooled investment program, including LAIF, is generally based on quoted market prices. The State Treasurer's Office performs a quarterly fair market valuation of the pooled investment program portfolio. In addition, the State Treasurer's Office performs a monthly fair market valuation of all the investments held against carrying cost. These valuations and financial statements are posted to the State Treasurer's Office website. The District's investment policy does not contain any specific provisions intended to limit the District's exposure to interest rate risk, credit risk, and concentration of credit risk.

The policy also authorizes short-term investments deposited with local banks in cash and cash equivalents (sweep accounts). These are also stated at fair value at June 30, 2021 and 2020. Short-term investments as of June 30, 2021 and 2020 were comprised of the following:

	2021	2020
Various pooled investments in LAIF	$ 1,566,633	$ 2,548,509

NOTE D - NET PATIENT SERVICE REVENUES

The District had agreements with third-party payors that provide for payments at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare: Payments for rural health care services rendered to Medicare beneficiaries are paid on an interim rate during the year with final settlement based on cost report submission.

Medi-Cal: For Medi-Cal services are paid on a prospective payment system (PPS) rate for rural health care services rendered to Medi-Cal beneficiaries with final settlement based on the PPS reconciliation and audit process conducted by the State of California.

Other: Payments for services rendered to other than Medicare and Medi-Cal patients are based on established rates or on agreements with certain commercial insurance companies, health maintenance organizations and preferred provider organizations which provide for various discounts from established rates.

NOTE D - NET PATIENT SERVICE REVENUES - continued

Net patient service revenues percentages for the years ended June 30, 2021 and 2020 are summarized below:

	2021	2020
Medicare	8%	5%
Medi-Cal (traditional and managed care)	68%	74%
Other third party payors	22%	18%
Self pay and other	2%	3%
Gross patient service revenues	100%	100%
Less deductions from revenue and related allowances	(44%)	(54%)
Net patient service revenues	56%	46%

Medicare and Medi-Cal revenue accounts for approximately 76% of the District's net patient revenues for each year. Laws and regulations governing the Medicare and Medi-Cal programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

NOTE E - CONCENTRATION OF CREDIT RISK

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

	2021	2020
Medicare	10%	4%
Medi-Cal (traditional and managed care)	65%	65%
Other third party payors	24%	19%
Self pay and other	1%	12%
Gross patient accounts receivable	100%	100%

NOTE E - CONCENTRATION OF CREDIT RISK - continued

Financial Instruments: Financial instruments, potentially subjecting the District to concentrations of credit risk, consist primarily of bank deposits in excess of the Federal Deposit Insurance Corporation (FDIC) limits of $250,000. Although deposits exceed the limit in certain bank accounts, management believes that the risk of loss is minimal due to the high financial quality of the bank with which the District does business. Management further believes that there is no risk of material loss due to concentration of credit risk with regards to investments as the District has no investments in equity funds, closed-end funds, exchange-traded products, or other perceived "at risk" alternatives as of June 30, 2021 and 2020.

District Tax Revenues - The District receives approximately 23% of their revenues from Kern County under the parcel taxing program. These funds are used to support the operations of the District in providing healthcare to the local region. Parcel taxes are levied by the County on the District's behalf during the year. Parcel taxes are secured by properties within the District and because of this feature, management believes that there is no credit risk associated with these parcel taxes once an assessment has been made. Many of parcels with the District are assessed based upon oil reserves within each parcel and the assessed value is therefore contingent upon the price of oil in the market at the time of assessment. It is because of these market conditions that district tax revenues can vary widely from year-to-year.

NOTE F - OTHER RECEIVABLES

Other receivables as of June 30, 2021 and 2020 were comprised of the following:

	2021	2020
Accrued contracted receivables	$ 39,167	$ 163,337
Kern County district taxes and other	122,019	8,125
	$ 161,186	$ 171,462

NOTE G - RETIREMENT PLANS

The District, beginning July 1, 2015, offers a deferred compensation plan (the Plan) to eligible employees. The Plan allows participants to defer income during peak years and set it aside as retirement savings. The employee funds set aside are pre-tax dollars and therefore reduce the amount of current income taxable to the employee. The District has established certain requirements in order for employees to qualify for the Plan. All contributions are voluntary by the employee and they are 100% vested at inception

NOTE H - CAPITAL ASSETS

Capital assets as of June 30, 2021 and 2020 were comprised of the following:

	Balance at June 30, 2020	Transfers & Additions	Retirements	Balance at June 30, 2021
Land and land improvements	$ 486,950			$ 486,950
Buildings and improvements	2,212,747			2,212,747
Furniture and equipment	533,771			533,771
Construction-in-progress	9,555,263	530,534		10,085,799
Totals at historical cost	12,788,732	530,534		13,319,267
Less accumulated depreciation	(1,232,667)	(123,193)		(1,355,861)
Capital assets, net	$ 11,556,065	$ 407,341	$	$ 11,963,406

	Balance at June 30, 2019	Transfers & Additions	Retirements	Balance at June 30, 2020
Land and land improvements	$ 428,029	$ 58,921		$ 486,950
Buildings and improvements	2,212,747			2,212,747
Furniture and equipment	533,771			533,771
Construction-in-progress	4,786,578	4,768,685		9,555,263
Totals at historical cost	7,961,125	4,827,606		12,788,731
Less accumulated depreciation	(1,110,556)	(122,110)		(1,232,666)
Capital assets, net	$ 6,850,569	$ 4,705,496	$	$ 11,556,065

Capital assets consist of property and equipment and are reported on the basis of cost, or in the case of donated items, on the basis of fair market value at the date of donation. Routine maintenance and repairs are charged to expense as incurred. Expenditures which increase values, change capacities, or extend useful lives are capitalized. Depreciation of property and equipment and amortization of property under capital leases are computed by the straight-line method for both financial reporting and cost reimbursement purposes over the estimated useful lives of the assets, which range from 10 to 40 years for buildings and improvements, and 3 to 20 years for furniture and equipment.

NOTE I - COMMITMENTS AND CONTINGENCIES

Construction-in-Progress: As of June 30, 2021, the District has $10,085,799 recorded as construction in progress which are commitments under way at year end for various expansion and other projects for various remodeling and major repair on the District's premises. No interest has been capitalized into these various projects as of June 30, 2021.

Operating Leases: The District leases various equipment and facilities under operating leases expiring at various dates. Total building and equipment rent expense for the years ended June 30, 2021 and 2020, were $94,858 and $36,297, respectively. Future minimum lease payments for the succeeding years under operating leases as of June 30, 2021 and 2020 are not considered material. District lease or rent agreements that have initial or remaining lease terms in excess of one year, again, are not considered material.

Litigation: The District may from time-to-time be involved in litigation and regulatory investigations which arise in the normal course of doing business. After consultation with legal counsel, management estimates that matters existing as of June 30, 2021 will be resolved without material adverse effect on the District's future financial position, results from operations or cash flows.

Medical Malpractice Insurance: The District maintains commercial malpractice liability insurance coverage under a claims made and reported policy covering losses up to $1 million per claim and $3 million in the annual aggregate, with a per claim deductible of $5,000. The District plans to maintain the insurance coverage by renewing its current policy, or by replacing it with equivalent insurance.

Workers Compensation Program: The District is a participant in the Beta Risk Management Authority (the Fund) which administers a self-insured worker's compensation plan for participating entity employees of its member entities. The District pays premiums to the Fund which are adjusted annually. If participation in the Fund is terminated by the District, the District would be liable for its share of any additional premiums necessary for final disposition of all claims and losses covered by the Fund.

Regulatory Environment: The District is subject to several laws and regulations. These laws and regulations include matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medi-Cal fraud and abuse. Government activity has increased with respect to possible violations of statues and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the District is in compliance with all applicable government laws and regulations and is not aware of any future actions or unasserted claims for the years ended June 30 2021 and 2020.

NOTE J -INVESTMENTS

The District's investment balances and average maturities were as follows at June 30, 2021 and 2020:

		Investment Maturities in Years		
As of June 30, 2021	Fair Value	Less than 1	1 to 5	Over 5
Local agency investment fund	$ 1,566,633	$ 1,566,633		
Total investments	$ 1,566,633	$ 1,566,633	$ -0-	$ -0-

		Investment Maturities in Years		
As of June 30, 2020	Fair Value	Less than 1	1 to 5	Over 5
Local agency investment fund	$ 2,548,509	$ 2,548,509		
Total investments	$ 2,548,509	$ 2,548,509	$ -0-	$ -0-

The District's investments are reported at fair value as previously discussed. The District's investment policy allows for various forms of investments generally set to mature within a few months. Policies generally identify certain provisions which address interest rate risk, credit risk and concentration of credit risk.

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 market interest rates. One of the ways an entity 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 position of the portfolio is maturing or coming close to maturity evenly over time as necessary to provide the cash flow and liquidity needed for District operations. Information about the sensitivity of the fair values of the District's investments to market interest rate fluctuations is provided by the preceding schedules that shows the distribution of the District's investments by maturity.

Credit Risk: Credit risk is the risk that the issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of a rating by a nationally recognized statistical rating organization, such as Moody's Investor Service, Inc. Generally an entity's investment policy for corporate bonds and notes would be to invest in companies with total assets in excess of $500 million and having a "A" or higher rating by agencies such as Moody's or Standard and Poor's.

NOTE J -INVESTMENTS (continued)

Custodial Credit Risk: Custodial credit risk is the risk that, in the event of the failure of the counterparty (e.g. broker-dealer), an entity would not be able to recover the value of its investment or collateral securities that are in the possession of another party. An entity's investments are generally held by broker-dealers or in the case of many healthcare district's, in government-pooled short-term cash equivalents such as mutual funds.

Concentration of Credit Risk: Concentration of credit risk is the risk of loss attributed to the magnitude of an entity's investment in a single issuer. An entity's investment policy generally allows for different concentrations in selected investment portfolios such as government-backed securities, which are deemed to be lower risk.
The Hospital's investments are reported at fair value as previously discussed. The Hospital's investment policy allows for various forms of investments generally held with government agencies. Policies generally identify certain provisions which address interest rate risk, credit risk and concentration of credit risk.

Investment Hierarchy - The District categorizes the fair value measurements of its investments based on the hierarchy established by generally accepted accounting principles. The fair value hierarchy, which has three levels, is based on the valuation inputs used to measure an asset's fair value: Level 1 inputs are quoted prices in active markets; Level 2 inputs are significant other observable inputs; Level 3 inputs are significant other unobservable inputs. The District's investments are solely measured by Level 1 inputs and does not have any investments that are measured using Level 2 or 3 inputs.

NOTE K - SIGNIFICANT UNUSUAL TRANSACTIONS

CARES Act Funding - The COVID-19 pandemic, whose effects first became known in January 2020, had a broad and negative effect disrupting both the domestic and global economies. During the fiscal years 2021 and 2020, the District noted the adverse impact on District operations with revenue declines and additional labor, supply and other costs. These declines were a direct result of the impact of the pandemic, forcing federal and state requirements to restrict travel, require social distancing, and enhanced infection control practices, leading to reduced patient contacts and a reduced availability of on-site workforce.

The District has received $501,515 in COVID-19 related funding. Usage of these funds are being reported via the "Reporting Portal" developed by the federal department of Health Resources & Services Administration (HRSA). The first report was submitted at the end of November, 2021 where the District reported on the usage of the first period of funding of $442,707 received starting from April 10, 2020 through June 30, 2020. Other funds received after June 30, 2020 in the amount of $58,808, will be reported on via the portal in future required reporting periods. In addition, the District is not required to have a "single audit" performed on the usage of the funds as the $750,000 threshold was not met which triggers single audits.

NOTE L - SUBSEQUENT EVENTS

Management evaluated the effect of subsequent events on the financial statements through April 25, 2022, the date the financial statements are issued, and determined that there are no material subsequent events that have not been disclosed.

JWT & Associates, LLP

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Independent Auditors 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

The Board of Directors
West Side Health Care District
Taft, 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-type activities of the West Side Health Care (the District) as of and for the years ended June 30, 2021 and 2020, and the related notes to the financial statements, which collectively comprise the District's financial statements, and have issued our report thereon dated April 25, 2022.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered the District's 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 opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

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

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given those 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 District's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statement. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

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

JWT & Associates, LLP

Fresno, California
April 25, 2022

ITEM 5

WEST SIDE HEALTH CARE DISTRICT
WEST SIDE FAMILY HEALTH
POLICY AND PROCEDURES

POLICY: Autoclave Spore Testing	REVIEWED: 1/28/16; 3/1/17; 2/28/18; 10/25/18; 9/27/19, 06/07/22
SECTION: Infection Control	REVISED: 6/8/16; 3/1/17
EFFECTIVE: 06/23/2022~~10/24/19~~	MEDICAL DIRECTOR:

Objective: To prevent the spread of nosocomial infections, and assure sterility of all sterile products autoclaved, spore testing will be performed daily.

Response Rating: Mandatory

Required Equipment: Autoclave, EZTest biological indicators

Procedure:

1. EZTest biological indicators will be utilized to monitor every sterilizer load.

2. Utilize two EZTest units in each sterilizer load.

   A. In a horizontal position with the items being sterilized.

   B. In least lethal locations in the load

3. Document the load on the autoclave log.

4 Select the required cycle and process the load.

5 Remove the load and EZTest biological indicators from the sterilizer and allow to cool for at least 10 minutes.

6. Retrieve the cooled EZTest biological indicators for incubation.

   A. Activate the media by placing the indicator in an upright position in a plastic crusher.

   B. Gently squeeze the crusher to break the glass ampoule.

   C. Place the activated sterilized indicator in the incubator rack and incubate immediately for a minimum of 24 hours at 55-60 degrees Celsius.

7. Review the EZTest chemical and biological indicators.

A. Confirm the chemical indicator on the label has changed from blue to black.
   i. Indicator should turn from blue to black when exposed to steam.
   ii. Black color of the label does not indicate acceptable sterilization.

B. Examine the biological media indicator at periodic intervals for color change.
   i. The incubation time is 24 hours minimum per US FDA/RIT protocol.
   j. The appearance of a yellow color indicates bacterial growth. No color change indicates adequate sterilization.
   k. Record incubation results at minimum 24 hours after incubation time on the autoclave load log.

8. Act on a positive test (a color change of yellow) as soon as the color change is noted. Notify Clinic Director and do not release the load.

   A. Retest the sterilizer with several EZTest biological indicators if a positive test is noted.

   B. Dispose of positive media indicators in biohazard, to be incinerated.

9. Abnormal results are to be reported to the Clinic Director immediately. The unit will be tagged and removed from service until device is determined to be functioning correctly and/or needs servicing by a Licensed Service Technician.

10. If service is required, complete a maintenance request form and present it to the Clinic Director.

11. Clinic Director will schedule servicing for the equipment or will delegate that responsibility to a staff member.

12. Daily Media Controls.

   A. Place an activated, un-sterilized EZTest biological indicator in the incubator daily as a positive growth control.

   B. Examine the biological media indicator at regular periods for color change.

   C. The incubation time is minimum 24 hours per US FDA/RIT protocol.

   D. The yellow color is evidence of bacterial growth.

   E. Record incubation results at minimum 24 hours after incubation time on the autoclave spore testing daily log.

F. Remove all positive indicators as the yellow color is noticed, and dispose of in biohazard waste.

G. If the positive control does not grow, stop use of units from open box and notify Clinic Director.

H. Clinic Director or designee will contact MesaLabs to confirm that remaining EZTest biological indicator of current box should be discarding or retained for use.

I. EZTest products are stored at room temperature.

J. Do not store indicators near sterilants or other chemicals.

K. EZTest products have a shelf-life designated on each box.

L. After sterilization, the contents of the EZTest biological indicator are hot and under pressure. Always allow to cool for at least 10 minutes. Failure to cool at least 10 minutes may cause the glass ampule to burst and may result in injury from hot liquid.

13. Should the user observe yellow media in the biological indicator upon removal from the product box, this unit should be discarded in the biohazard waste container.

WEST SIDE HEALTH CARE DISTRICT
WEST SIDE FAMILY HEALTH CARE
POLICY AND PROCEDURES

POLICY: Kern Health Systems Linguistic Services	REVIEWED: 5/26/16; 6/1/17; 6/4/18; 4/20/19; 7/7/20; 06/07/22
SECTION: Administration	REVISED: 06/07/22
EFFECTIVE: 06/23/2022 ~~7/23/20~~	MEDICAL DIRECTOR:

Subject: Linguistic services will be provided in accordance with the statutory, regulatory, and contractual requirements outlined in Clinic agreement(s) with Kern Health Systems as well as Title VI of the Civil Rights Act of 1964.

Objective: To provide guidelines for the provision of linguistic services including access to interpretive services for Kern Health Systems members.

Response Rating: Mandatory

Required Equipment:

Definitions:

Limited English Proficient (LEP): A limited ability or inability to speak, read, write, or understand the English language at a level that permits the person to interact effectively with health care providers or social service agencies.

Limited English Proficient Members: Any KHS member who is considered limited English proficient, including those who speak a language other than one of the threshold languages identified by the Department of Health Services for Kern County.

Threshold Languages: Languages spoken by LEP population groups that meet a numeric threshold of 3,000 eligible beneficiaries residing in a county and/or languages spoken by a population of eligible LEP beneficiaries residing in a county, who meet the concentration standard of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.

Procedure:

1. Access

   A. Interpreters must be made available as needed by face to face or telephone encounters with physicians, physician extenders, registered nurses, or other personnel who provide medical or health care advise to members. -

B. Interpreter services are available for KHS members 24 hours a day.

C. Clinic personnel may not require or suggest to patients that they must provide their own interpreters.

D. Family members and/or friends are discouraged from performing interpretive services for patients. The use of family or friends may jeopardize the quality and/or accuracy of information that is relayed to patients and may also present a hardship if the family member of friend must deliver confidential information.

i. If the patient refuses interpreter services from someone other than family or friend, staff will ask the patient to complete and sign the Interpreter Choice by Patient form.

ii. Completed form will be placed in the patient's medical record.

E. Providers and/or Clinic staff that are designated as qualified interpreters should assist patients with their language needs.

F. In the event that the patient's language needs are not met by on-site Clinic personnel Kern Health Systems will provide interpreter services.

i. KHS has a contract with AT&T Language Line to provide assistance in ~~140~~ 200 different languages, 24 hours a day, seven days a week.

G. Telephone service

i. During regular business hours (Monday through Friday 0800-1700) the Clinic may contact KHS Member Services Department to reach a staff interpreter or may request access to services through AT&T Language Line.

ii. After regular business hours (Monday through Friday 1701 – 0759, Saturday and Sunday, Holidays) the Clinic may contact the KHS 24 hour Telephone Triage Line and request to be connected to the AT&T Language Line. Use of the Language Line is documented and forwarded to KHS.

H. One-on-One Services

i. KHS members or Clinic personnel may request one-on-one interpreting services. During regular business hours the Clinic may contact KHS Member Services to arrange for one-on-one interpreting services.

I. Documentation

i. All providers are required to document the KHS member's language in the medical record. Requests or refusals for interpreter services by KHS members must also be indicated in the member's medical record.

Reference: Kern Health Systems Policies and Procedures Cultural and Linguistic Services (Index Number-3.71~~11.01-E~~) ~~issued January 31, 1996~~effective November 18, 2015.

WEST SIDE HEALTH CARE DISTRICT
WEST SIDE FAMILY HEALTH
POLICY AND PROCEDURES

POLICY: Chronic Pain Management	REVIEWED: 3/2/16; 2/15/17; 7/10/18; 6/16/19; 6/19/20; 06/07/22
SECTION: Clinical	REVISED: 7/10/18
EFFECTIVE: ~~7/25/19~~06/23/2022	MEDICAL DIRECTOR:

Subject: Chronic Pain Management

Objective: California State Medical Board mandates that every time a controlled medication is prescribed, the treating Practitioner must first log into the CURES system to verify how much and how frequently and where the patient has received prior controlled medications.

Medical practitioners play a vital role in ensuring effective pain management including prescribing opioid analgesics. The goal of pain management is primarily to improve and maintain the function of the patient. Practitioners are urged to individualize therapy based in review of the patient's potential risks, benefits, side effects and functional assessment and to monitor ongoing therapy accordingly (AAFP, 2013, MBC, ~~2007~~2014). Clinic patients will be treated for acute, episodic pain but will be referred to pain management specialists for the treatment of chronic pain issues.

Response Rating:

Required Equipment:

Definitions:

Procedure:

West Side Health Care District Clinic(s) will follow the California Medical Board guidelines on prescribing controlled substances for pain. The California Board of Medicine expects physicians and surgeons to follow the standard of care in managing pain patients (MBC, ~~2007~~2014).

History/Physical Examination

1. A medical history and physical examination must be accomplished. This includes an assessment of the pain, physical and psychological function; a substance abuse history; history of prior pain treatment; an assessment of underlying or coexisting diseases or conditions; and documentation of the presence of a recognized medical indication for the use of a controlled substance.

    a. The prescribing of controlled substances for pain may require referral to one or more consulting physicians.

b. The complexity of the history and physical examination may vary based on the practice location. In an urgent care setting, at night or on the weekends, the practitioner may not always be able to verify the patient's history and past medical treatment. In continuing care situations for chronic pain management, the practitioner should have a more extensive evaluation of the history, past treatment, diagnostic tests and physical exam.

Treatment Plan, Objectives

1. The treatment plan should state objectives by which the treatment plan can be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if any further diagnostic evaluations or other treatments are planned. The practitioner should tailor pharmacological therapy to the individual medical needs of each patient. Multiple treatment modalities and/or a rehabilitation program may be necessary if the pain is complex or is associated with physical and psychosocial impairment.

    a. Practitioners may use control of pain, increase in function, and improved quality of life as criteria to evaluate the treatment plan.

    b. When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors to physical findings, practitioners who make a clinical decision to withhold opioid medications should document the basis for their decision.

Informed Consent

1. The practitioner should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian.

    a. A written consent or pain agreement for chronic use is not required but may make it easier for the practitioner to document patient education, the treatment plan, and the informed consent. Patient, guardian, and caregiver attitudes about medicines may influence the patient's use of medications for relief from pain.

Periodic Review

1. The practitioner should periodically review the course of pain treatment of the patient and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the practitioner's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the practitioner should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

    a. Patients with pain who are managed with controlled substances should be seen monthly, quarterly, or semiannually as required by the standard of care.

    b. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment.

Consultation

1. The practitioner should consider referring the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Complex pain problems may require consultation with a pain medicine specialist.

2. Practitioners should give special attention to those pain patients who are at risk for misusing their medications including those whose living arrangements pose a risk for medication misuse or diversion.

    a. Coordination of care in prescribing chronic analgesics is of paramount importance.

    b. In situations where there is dual diagnosis of opioid dependence and intractable pain, both of which are being treated with controlled substances, protections apply to practitioners who prescribe controlled substances for intractable pain provided the physician complies with the requirements of the general standard of care and California Business and Professions Code sections 2241 and 2241.5.

Records

1. The practitioner should keep accurate and complete records according to items above, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan.

    a. Documentation of the periodic reviews should be done at least annually or more frequently as warranted.

    b. Pain levels, levels of function, and quality of life should be documented. Medical documentation should include both subjective complaints of patient and caregiver, and objective findings by the practitioner.

Compliance with Controlled Substances Laws and Regulations

1. To prescribe controlled substances, the practitioner must be appropriately licensed in California, have
a valid controlled substances registration and comply with federal and state regulations for issuing controlled substances prescriptions. Practitioners are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and the Medical Board's Guidebook to Laws Governing the Practice of Medicine by Physicians and Surgeons for specific rules governing issuance of controlled substances prescriptions.

    a. There is not a minimum or maximum number of medications which can be prescribed to the patient under either federal or California law.

    b. Physicians and surgeons who supervise Physician Assistants (PA's) or Nurse Practitioners (NP's) should carefully review the respective supervision requirements.

2. PA's are able to obtain their own DEA number to use when writing prescriptions for drug orders for controlled substances. Current law permits physician assistants to write and sign prescription drug orders when authorized to do so by their supervising physician for Schedule II-IV. Further, a PA may

only administer, provide or transmit a drug order for Schedule II through V controlled substances with the advanced approval by a supervising physician for a specific patient unless a physician assistant completes an approved education course in controlled substances and if delegated by the supervising physician. To ensure that a PA's actions involving the prescribing, administration, or dispensing of drugs is in strict accordance with the directions of the physician, every time a PA administers or dispenses a drug or transmits a drug order, the physician supervisor must sign and date the patient's medical record or drug chart within seven days. (Section 1399.545(f) of Title 16, California Code of Regulations)

3. NP's are allowed to furnish Schedule II-V controlled substances under written protocols.

4. While it is lawful under both federal and California law to prescribe controlled substances for the tr
eatment of pain - including intractable pain - there are limitations on the prescribing of controlled substances to or for patients for the treatment of chemical dependency (see Sections 11215-11222 of the California Health and Safety Code). In summary, a provider must follow the same standard of care when prescribing and/or administering a narcotic controlled substance to a "known addict" patient as he or she would for any other patient.

5. The practitioner must:

   a. Perform an appropriate prior medical examination;

   b. Identify a medical indication;

   c. Prescribe the smallest possible quantity of medication in order to address the patient's acute condition;

   d. Keep accurate and complete medical records, including treatments, medications, periodic reviews of treatment plans, etc;

   e. Provide ongoing and follow-up medical care as appropriate and necessary.

6. The Medical Board emphasizes the above issues, both to ensure practitioners know that a patient in pain who is also chemically dependent should not be deprived of appropriate pain relief, and to recognize the special issues and difficulties associated with patients who suffer both from drug addiction and pain. The Medical Board expects that the acute pain from trauma or surgery will be addressed regardless of the patient's current or prior history of substance abuse. This postscript should not be interpreted as a deterrent for appropriate treatment of pain.

Suggested guideline by AAFP, suggest current pain management training for family physicians. In order to improve skills in-: understanding pathophysiology of chronic pain, evaluating opioid abuse using a risk assessment tool, establishing opioid contracts, interpreting toxicology screens, performing chart reviews and adjusting treatment plans based on review, treating and monitoring patients at high risk of abuse, prescribing narcotic ~~alternatives ,~~alternatives, performing selected joint injections—to read more on this, link is in the reference.

Administration of Controlled Medications in the Clinics

1. All practitioners should have a co-signature from another licensed person.

2. Mid-levels should have a co-signature from a physician.

3. All practitioners will be expected to follow the current guidelines for maximum dosages.

4. All practitioners administering controlled medications will document in the EMR as outlined in the medication administration policy.

Wasting of Controlled Medications in the Clinics

1. If all or part of a controlled medication has to be wasted, the waste has to be documented and witnessed by a second clinic personnel (Practitioner, RN, LVN, MA) ~~licensed person.~~ in the Med-Dispense.

2. The waste of controlled medication is to be documented in the Med-Dispense at the time the medication is wasted.

3. All practitioners should have a co-signature from another ~~licensed~~ clinic personnel (Practitioner, RN, LVN, MA.

References:

American Academy of Family Physicians (2013). American Academy of Family Physicians Pain Management and Opioid Use: A Public Health Concern. Position Paper. Executive Summary. Retrieved from http://www.aafp.org/patient-care/public-health/pain-opioids.html

Medical Board of California (~~2007~~2014) .Guidelines for Prescribing Controlled Substances for pain. Department of Consumer Affairs. Retrieved from ~~http://www.mbc.ca.gov/pain_guidelines.html~~https://www.mbc.ca.gov/Download/Publications/pain-guidelines.pdf

WEST SIDE HEALTH CARE DISTRICT
WEST SIDE FAMILY HEALTH
POLICY AND PROCEDURES

POLICY: Autoclave Use ~~And~~and Maintenance	REVIEWED: 6/20/16; 6/25/17; 6/4/18, 06/07/22
SECTION: Infection Control	REVISED: 7/3/17; 9/16/19
EFFECTIVE: ~~09/26/19~~06/23/2022	MEDICAL DIRECTOR:

Subject: Autoclave Use and Maintenance

Objective: To safely sterilize, by steam, instruments and other utensils, and to ensure integrity of the sterilization procedure. No cold sterilization will be utilized at this facility.

Response Rating: Mandatory

Required Equipment: Autoclave, sterilization pouches (assorted sizes), and biologic proof vial.

Procedure:

1. Prior to instrument scrubbing, clinical staff members are to don PPE (gown, heavy duty gloves, eye shield).

2. All instruments, equipment and medicine cups for laceration trays or I&D trays should be scrubbed with approved enzymatic cleaner only.

3. After cleaning the instruments, they are placed in approved disinfectant for 5 minutes, rinsed and then placed for 30 seconds in lubricant in the hinged position Do not rinse lubricant off.

4. Allow instruments to air dry in hinged position.

4. Instruments will be placed into sterilization pouches.

5. Packets will be labeled with name of instrument and date of sterilization. Steam indicator will be inserted inside all self-sealing pouches.

6. Place packets on shelf in autoclave. DO NOT STACK ITEMS.

7. For every cycle place two EZTest Biological Indicators in a horizontal position with items to be sterilized.

8. Select and press appropriate preprogrammed button.

9. Press the start button.

10. Record autoclave load on the autoclave log.

11. Once load is complete and has cooled for at least 10 minutes, retrieve the EZTest biological indicators.

12. Examine the steam chemical indicator for color change on the EZTest biological indicators, activate the media by crushing the ampule, and incubate for a minimum of 24 hours at 55 – 60 degrees Celsius.

13. Refer to policy Autoclave Spore Testing for guidance relative to chemical and biological indicators and required guidance.

AUTOCLAVE MAINTENANCE

Weekly:

1. Clean external surfaces with a soft dry cloth and occasionally with a damp cloth and mild detergent.

2. Wipe internal surfaces with damp cloth.

3. Drain water from reservoir using drain tube on front of unit. Drain into large basin.

4. Using Speed-Clean Autoclave Cleaner and distilled water, wash inside of chamber, trays, door, door gasket, and door gasket mating surface. Examine door gasket for possible damage that could prevent a good sealing surface.

5. Refill reservoir with clean distilled water.

6. Record cleaning on Autoclave Log.

Monthly:

1. Flush system-drain reservoir and fill with clean distilled water. Add 1 oz. of Speed-Clean Sterilizer to a cool chamber.

2. Run one pouch cycle. Instrument **WILL NOT** be done with this cycle.

3. Drain cleaning solution from reservoir. Refill reservoir with clean distilled water and run one unwrapped cycle.

4. Drain reservoir and allow unit to cool.

5. Remove door and dam gaskets from gasket housing channel. Clean channel and gaskets using a mild soap or Speed-Clean Sterilizer Cleaner and clean distilled water. A small stiff brush will aid procedure. After cleaning gaskets, inspect for damage, shrinkage, or swelling and replace if necessary. Press gasket into the channel and reinstall dam gasket.

6. Remove trays, tray rack, and tray plate. Pressing downward on top band of tray rack pull upward on

end of tray plate and slide assembly of the chamber.

7. Locate chamber filters on bottom and back of chamber. Grasp filter and pull outward while twisting slightly. If ~~necessary~~necessary, a pair of pliers may be used. Filer may be cleaned with mild soap or Speed-Clean Sterilizer Cleaner and clean distilled water. If cleansing methods do not effectively clean the filter, replacement may be necessary. Reinstall filters by pressing inward and twisting slightly.

8. DO NOT OPERATE UNIT WITHOUT FILTERS.

9. Wipe off all trays, tray rack, and tray plate. Reinstall assembly by placing back edge of tray plate in chamber. Pushing downward on top of tray rack, slowly push assembly into chamber.

10. Angles on end of plate must be toward back of chamber to prevent interference with temperature probe in back of chamber.

11. Fill the reservoir with clean distilled water.

12. Sterilizer is now ready for use.

13. Record cleaning on Monthly Autoclave Quality Control Log.

WEST SIDE HEALTH CARE DISTRICT
WEST SIDE FAMILY HEALTH CARE
POLICY AND PROCEDURES

POLICY: Kern Health Systems (KHS) Prior Authorization Of Services And Procedures	REVIEWED: 5/20/16; 6/25/17; 6/4/18; 4/20/19, 06/07/22
SECTION: Administration	REVISED: 5/8/19; 06/07/22
EFFECTIVE: 06/23/2022 ~~5/23/19~~	MEDICAL DIRECTOR:

Subject: Kern Health Systems (KHS) prior authorization of services and procedures

Objective: To ensure compliance with Kern Health Systems (KHS) procedures relative to the need for prior authorization for specific services and procedures rendered to KHS members.

Response Rating: Mandatory

Required Equipment:

Procedure:

1. KHS requires authorization paperwork for services listed on the KHS Prior Authorization list. The Clinic is responsible for determining whether prior authorization is required and will utilize the most current KHS list as a reference/source of truth for this purpose.
   i. KHS Prior Authorization list can be accessed via the KHS website http://www.Kernfamilyhealthcare.com/files/PA_List.pdf
2. ~~2.~~ If the service or procedure required is not found on the KHS Prior Authorization list, the Clinic will directly refer the patient for services without submitting a Referral/Prior Authorization Form to the KHS Utilization Management Department.
   i. Referrals can be submitted to KHS Utilization Management Department via online provider portal or fax at (661) 664-5190.
3. Clinic staff will schedule patient appointments and/or make necessary arrangements for eligible KHS members to receive services from KHS contracted providers.
4. Clinic staff will utilize KHS current resources to ensure KHS members are referred to KHS contracted providers.
5. Specific additional services are identified by KHS as automatically paid if certain restrictions are met. Clinic staff will utilize KHS current resources to determine which services fall into this category. ~~As of the writing of this policy, family planning and pregnancy care are among the services included in this category by KHS.~~
   i. Additional services that are automatically paid include Abortion Services Prior authorization required for inpatient hospitalization, Family Planning-Medi-cal members may see any qualified contracted or non-contracted provider. Pregnancy Care-The provider must comply with the utilization protocols related to authorization of additional care scheduled after the member's

WEST SIDE HEALTH CARE DISTRICT
WEST SIDE FAMILY HEALTH
POLICY AND PROCEDURES

POLICY: Peer Review	REVIEWED: 1/28/16; 2/16/17; 8/25/17; 7/22/18; 6/16/19; 06/07/22
SECTION: Medical Staff	REVISED: 8/25/17
EFFECTIVE: 06/23/2022 ~~7/25/19~~	MEDICAL DIRECTOR:

Subject: Peer Review

Objective: Peer review will be conducted for the Clinic in accordance with guidelines established by the ~~District~~ Medical Director. Those guidelines will be reviewed regularly and revised as deemed necessary.

Response Rating:

Required Equipment: None

Procedure

1. The Medical Director in collaboration with the Clinic practitioners will develop criteria for the selection of clinic medical records for the completion of Peer Review. ~~chart review~~. ~~Peer review will be accomplished~~
2. Per the agreed upon criteria, clinic charts will be selected and presented to the Medical Director or ~~his~~ designee(s) for review.
3. Chart review will be completed and documented using the Clinic Peer Review data capture tool or other appropriate worksheet. Peer review will be confidential within the Medical/provider group and reports thereof will be summarized and reported in a confidential manner through QAPI reports to the Board.
4. Medical Director may modify the selection criteria at any time. Peer review may be performed by qualified physicians from outside the District at the direction of the Medical Director and with approval of the Executive Director.
5. Medical Director may alter the data capture tool utilized for Peer Review at their discretion.
6. The results of the Peer Review process will be shared and distributed to each provider whose work was reviewed.
7. After review by the Medical Director, the results of the Peer Review process will be maintained with other pertinent Medical Staff information.
8. Peer review results will be considered during scheduled practitioner performance evaluation periods.

WEST SIDE HEALTH CARE DISTRICT
WEST SIDE FAMILY HEALTH
POLICY AND PROCEDURES

POLICY: After Hours Telephone Management	REVIEWED: 2/5/16; 2/15/17; 2/23/18; 8/2/19; 6/19/20; 06/07/22
SECTION: Administration	REVISED: 2/23/18; 6/19/20; 06/07/22
EFFECTIVE: 06/23/2022~~; 6/25/20~~	MEDICAL DIRECTOR:

Subject: After Hours Telephone Management

Objective: To ensure after hours calls placed by patients are answered and appropriate guidance is provided to callers, after the end of the business day, the Clinic will activate the after-hours on-call service staffed by Clinic practitioners and linked to the AthenaNet EMR using the Call My Doc app.

Response Rating:

Required Equipment:

Procedure:

At the end of the business day, the clinic phone system will automatically switch over to our CallMyDoc after hours phone system. ~~Clinic Director or designee will access the phone system and activate call forwarding according to the current instructions provided by the Call My Doc app vendor.~~

At the start of the business day, the clinic phone system will automatically switch off call forwarding and end the use of the after hours CallMyDoc app. ~~Clinic day, the Clinic Director or designee will deactivate the call forwarding so that incoming calls may be answered by Clinic staff.~~

Reports providing information relative to the number of calls received, the response times for those calls and other metrics are available through the Call My Doc app website.

The practitioner schedule for coverage of the on-call service is the responsibility of the Medical Director or designee. ~~managed by the Medical Affairs Coordinator and implemented with the approval of the Medical Director.~~

ITEM 6

West Side Health Care District

June 9, 2022

TO: Board of Directors

FROM: Ryan Shultz, Executive Director

SUBJECT: May General Information

The enclosed information highlights notable activities and projects of West Side Health Care District (WSHCD) and West Side Family Health Care (WSFHC) for the month of May.

- Providers and staff continue to work extremely hard to delivery patient care services. **The clinic reported more than 2400 patient encounters and a Rural Health Clinic Payer Mix of 71%.**
- **The Clinic is partnering with Taft High School to provider sports physicals for student athletes on June 17th**. Appointments for physicals are made through the High School and will be completed at the clinic.
- **The Clinic is promoting back-to-school physicals for students.** A limited number of appointments will be reserved for these services between June 27th and July 8th. Physicals will continue to be provided outside of these dates subject to provider availability.
- Management will present the **Fiscal Year 2022-2023 Budget** at the June board meeting.
- WSHCD contracted Independent Auditor JDT & Associates will present the **FY 2020-2021 Financial Audit** at the June board meeting.
- **Stockdale Radiology is the new Radiologist for WSFHC**. Services began on May 16th.
- Management is investigating the performance of the HVAC system servicing the clinic lobby. The board will be updated once improvement options are identified.