MARIN HEALTHCARE DISTRICT

100-B Drake's Landing Road, Suite 250, Greenbrae, CA 94904 Telephone: 415-464-2090 Fax: 415-464-2094
www.marinhealthcare.org info@marinhealthcare.org

TUESDAY, MAY 11, 2021

5:00 PM: REGULAR OPEN MEETING

Board of Directors:
Chair: Jennifer Rienks, PhD
Vice Chair: Brian Su, MD
Secretary: Ann Sparkman, RN/BSN, JD
Directors: Edward Alfrey, MD
Larry Bedard, MD

Staff:
David Klein, MD, CEO
Eric Brettner, CFO
Colin Coffey, District Counsel
Louis Weiner, Executive Assistant

Location:
Via ZOOM video conference:
https://mymarinhealth.zoom.us/join
Meeting ID: 926 0603 4865
Passcode: 94904
Or via ZOOM telephone conference:
1-669-900-9128

AGENDA

5:00 PM: REGULAR OPEN MEETING

1.	Call to Order and Roll Call	Rienks	
2.	General Public Comment *Any member of the audience may make statements regarding any items NOT on the agenda. Statements are limited to a maximum of three (3) minutes. Please state and spell your name if you wish it to be recorded in the minutes.*		
3.	Approval of Agenda (action)	Rienks	
4.	Approval of Minutes of Regular Meeting of April 13, 2021 (action)	Rienks	#1
5.	Review and Approve Marin Healthcare District 2020 Report of Independent Auditors, as Recommended by the MHD Finance & Audit Committee on April 27, 2021	Klein/Brettner	
	A. Audit Results Presentation		#2
	B. Report of Independent Auditors and Financial Statements for the Year Ended December 31, 2020 (action)		#3
	C. Communication with the Board of Directors		#4
6.	Review MarinHealth Medical Center Performance Metrics and Core Services 2020 Annual Report	Klein	#5
7.	Review "District Health News, 2020 Annual Report"	Klein	#6
8.	COVID Report and Vaccine Administration	Klein	

The agenda for the meeting will be posted and distributed at least 72 hours prior to the meeting.
In compliance with the Americans with Disabilities Act, if you require accommodations to participate in a District meeting please contact the District office at 415-464-2090 (voice) or 415-464-2094 (fax) at least 48 hours prior to the meeting.
Meetings open to the public are recorded and the recordings are posted on the District web site.

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TUESDAY, MAY 11, 2021

5:00 PM: REGULAR OPEN MEETING

9. COVID Task Force Report	Su	
10. ACHD Governance Toolkit, Session 3: Board Orientations	Klein	#7
11. Committee Reports		
A. Finance & Audit Committee *(met April 27)*	Bedard	
B. Lease & Building Committee *(to meet TBA)*	Sparkman	
12. Reports		
A. District CEO's Report	Klein	
(1) Retreat Planning		
B. Hospital CEO's Report	Klein	
C. Chair's Report	Rienks	
D. Board Members' Reports	All	
13. Agenda Suggestions for Future Meetings	All	
14. Adjournment of Regular Meeting	Rienks	

Next Regular Meeting: Tuesday, June 8, 2021, 5:00 p.m.

The agenda for the meeting will be posted and distributed at least 72 hours prior to the meeting.
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Tab 1

MARIN HEALTHCARE DISTRICT
BOARD OF DIRECTORS

REGULAR MEETING

Tuesday, April 13, 2021 @ 5:30 pm
Via Zoom Teleconference

MINUTES

1. **Call to Order and Roll Call**
   Chair Rienks called the Regular Meeting to order at 5:31 pm.

   Board members present: Chair Jennifer Rienks; Vice Chair Brian Su, MD; Secretary Ann Sparkman; Director Edward Alfrey, MD; Director Larry Bedard, MD
   Staff present: David Klein, MD, CEO; Eric Brettner, CFO; Louis Weiner, Executive Assistant
   Counsel present: Colin Coffey

2. **Disclosure of Action Taken in Closed Session**
   Chair Rienks reported that, in the Closed Session immediately preceding this meeting, the Board unanimously approved the denial of application for a late claim by sub-contractor BEI Construction.

3. **General Public Comment**
   There was no public comment.

4. **Approval of Agenda**
   Dr. Bedard moved to approve the agenda as presented. Ms. Sparkman seconded. **Vote: all ayes.**

5. **Approval of Minutes of Regular Meeting of March 9, 2021**
   Ms. Sparkman moved to approve the minutes as presented. Dr. Bedard seconded. **Vote: all ayes.**

6. **League of Women Voters of Marin County: Redistricting Survey**
   Ms. Rienks presented (Tab #2) a survey from the Marin League of Women voters pertaining to the upcoming change to by-zone elections of MHD Board members. Regarding the options given for forming a Citizens Advisory Commission, Mr. Coffey added that another option that is most frequently used is to not have such a Commission: This Board has public meetings and forums, in required observance of the Brown Act, that invite and include public involvement and can do so for this purpose regarding the election process change. Dr. Klein and all agreed with Mr. Coffey's suggestion to not have such a Commission.

   The District would use its existing website for public communication on the redistricting issue, with a distinct designated section for information, documents, web links, etc. This will be done before the end of the year after the census is verified probably in September or October.

   Ms. Rienks asked for a motion to approve her submitting MHD's response to the League of Women Voters. Dr. Alfrey moved to approve. Dr. Bedard seconded. **Vote by roll call: all ayes.**

7. **MarinHealth Diversity, Equity, and Inclusion Program**
Dr. Klein presented a PowerPoint giving an update of MarinHealth's Diversity, Equity and Inclusion (DEI) program.
   - MH is partnering with consulting firm "Enact Leadership" to create a roadmap for awareness and action on DEI throughout the organization. Enact's benchmark approach focuses on processes of awareness, alignment, action and accountability. Through 2021 the program will gather data, set strategy for solutions, and develop training, with implementation in place in early 2022.
   - Concurrently, work has begun for 2022 certification by Healthcare Equality Index, a national LGBTQ benchmarking tool that evaluates equity and inclusion for patients, visitors and employees.
   - Signage in the hospital is being changed to reflect DEI.
   - The Gender Affirmation Surgery Program is growing.
   - MH is a founding charter member of "Waggl Healthcare Learning Consortium" that helps leadership and staff work together for solutions to shared challenges. In 2021 the focus is on DEI and burnout.

   Ms. Rienks asked about implicit bias training in the hospital, and Dr. Klein agreed to check on the status of it.

8. **COVID Report and Vaccine Administration**
Dr. Klein reported that COVID numbers are declining and today there are no Covid-positive patients in the hospital. Marin County leads the state in vaccination rate per county. As of yesterday, 68.5% of Marin residents over 16 years of age have had at least their first shot. Of 65 and older, 7% are unvaccinated. COVID-positivity rates are in the low 10-15% range. Our vaccination team shifted to the County pod in early April, thanks in part to MHD funding. The J&J single-dose vaccine is on hold; when released it will be used for Emergency Dept patients and inpatients. Fewer than 20% of hospital employees have declined or delayed being vaccinated, and more are receiving it each week.

9. **COVID Task Force Report**
Dr. Su reported that the Task Force met on March 23, the one-year anniversary of the project. With increased vaccinations, the work of this Team is shifting and easing. $313k reimbursement from FEMA is expected soon. Nursing facilities are now doing their own testing and vaccinating, and the Team's mobile van will be decommissioned. After-care treatment in the nursing facilities is complete at an expense of about $100k; this is less than allocated and the balance has shifted to vaccination efforts. There are ample testing facilities for the public. Over 500 triage kits have been distributed and no more will be ordered as the need has abated. As of March 23, the per-day vaccination doses in Marin are 3,700. The Task Force has funded about $250k for staffing for the vaccine distribution center for 4 months to mid-June; at the current pace, it may conclude sooner. For virus variants, we have arranged to process samples at UCSF.

   Dr. Klein commented that discussions are underway to work with the high schools for student vaccination.

10. **ACHD Governance Toolkit, Session 2: Balancing Governance & Management**
ACHD (Association of California Healthcare Districts) has produced a series of 6 governance toolkit presentations. The Board viewed the second video, "Balancing Governance & Management" (Tab #3).

After viewing, Dr. Klein remarked that this subject pertains to the Hospital Board as well, and he may share it with them.

11. Committee Meeting Reports

A. *Finance & Audit Committee*

Dr. Bedard reported that the committee met on March 16. They reviewed and discussed the District financial reports and budgets for December 2020 (month and year-end) and January 2021.

B. *Lease & Building Committee*

Ms. Sparkman reported that the committee met on March 24 and April 5, both of which covered planning for the "Teen Mental Health in the Time of COVID" public webinar scheduled for April 21. The March 24 meeting, a special study session of the full Board, included 9 mental health practitioners discussing the focus and goal of the webinar. The April 5 meeting included 3 of the practitioners to agree on the format and agenda of the webinar. Ms. Rienks will be host and moderator of the webinar on Zoom on April 21.

The March 24 meeting also included Dr. Klein's update of the Hospital Board Bylaws review process now underway. No action has yet been taken, the Hospital Board will review and approve, then legal review, and then the District Board will review and approve.

12. Reports

A. *District CEO's Report*

OSHPD is currently reviewing 2 open items which should be closed soon. Remaining construction work will be under new permits. McCarthy's "punch list" items for final construction should be completed by the end of this month. The construction trailers will be removed within the next 4-6 weeks and landscaping and fencing restored.

The Oak Pavilion has won the Healthcare Design and Building Award from the San Francisco Business Times.

The County Planning Commission is proceeding toward final approval of the Ambulatory Services Building. After approval, the decision will be made about when and how to move forward on the project.

Dr. Bedard asked about an IJ news report mentioning a possible State fine of the hospital regarding COVID response. Dr. Klein explained an appeal has been filed against the allegation.

B. *Hospital CEO's Report*

Dr. Klein reported that Chief Nursing Officer Karin Reese has resigned her position and interim leadership is in place while the search is on for CNO and COO.

MarinHealth Medical Network has hired an interim President, Andrew Botschner, and Network leadership is being realigned.

The Hospital Board is completing its Strategic Plan and the Board and the Strategic Planning Committee will finalize it at a retreat this weekend. It will then be shared with this District Board.

DRAFT

Hospital volumes are gradually returning to pre-COVID levels. Emergency volumes are up and surgeries are increasing. January and February financial operations were challenging but March shows to be better as volumes increase. Working with Huron Consulting, operational and clinical efficiency initiatives are proceeding well.

Epic/APeX Electronic Health Record (EHR) system is now underway beginning with the lab system, the largest and most complex part of the EHR system. Total cost over time for APeX is approx. $110M, the first tranche being approx. $40M.

C. *Chair's Report*

Ms. Rienks reported that she attended the recent "Impact Marin" virtual seminar and commended Dr. Klein for his panel presentation.

Now that each of the Board members is vaccinated, she will work with Dr. Klein on planning an in-person annual retreat for the Board. In-person and hybrid regular Board and committee meetings are also in the offing.

D. *Board Members' Reports*

Dr. Alfrey reported that a hospital employee, who is a PhD student doing a research project with the Braden Diabetes Center for her thesis, found that 70% of newly-onset diabetic patients have primary care at Marin Community Clinics, or no primary care. At issue is hospital discharge/followup process, and readmissions. He suggested the hospital improve connection with MCC to improve the processes.

There were no other reports.

13. <u>Agenda Items Suggested for Future Meetings</u>

Ms. Rienks suggested that Dr. Alfrey invite the PhD student to report her findings to the Board.

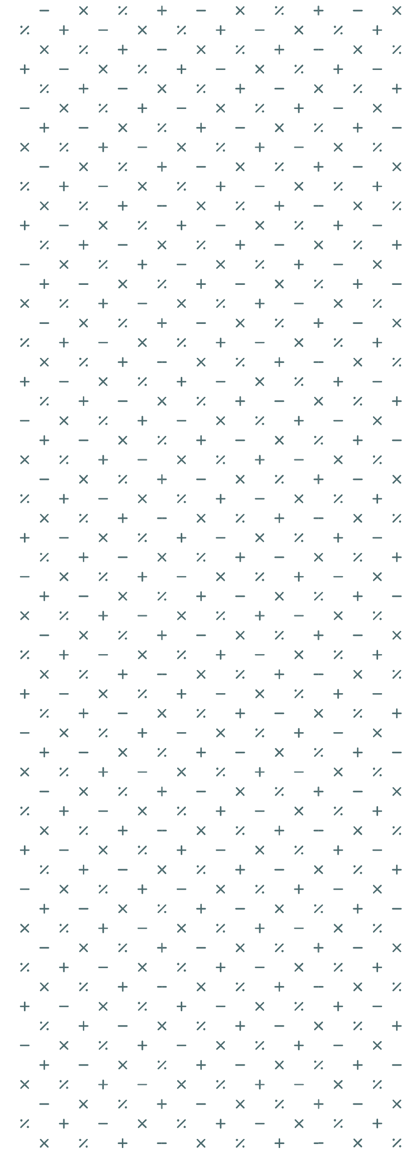
14. <u>Adjournment</u>

Chair Rienks adjourned the meeting at 6:55 pm.

DRAFT

Tab 2

2020 Audit Results: Marin Healthcare District



Finance & Audit Committee and Board of Directors

Marin Healthcare District

Dear Finance & Audit Committee Members & Board of Directors:

Thank you for your continued engagement of Moss Adams LLP. We are pleased to have the opportunity to meet with you to discuss the results of our audit of the financial statements of Marin Healthcare District ("the District") for the year ended December 31, 2020.

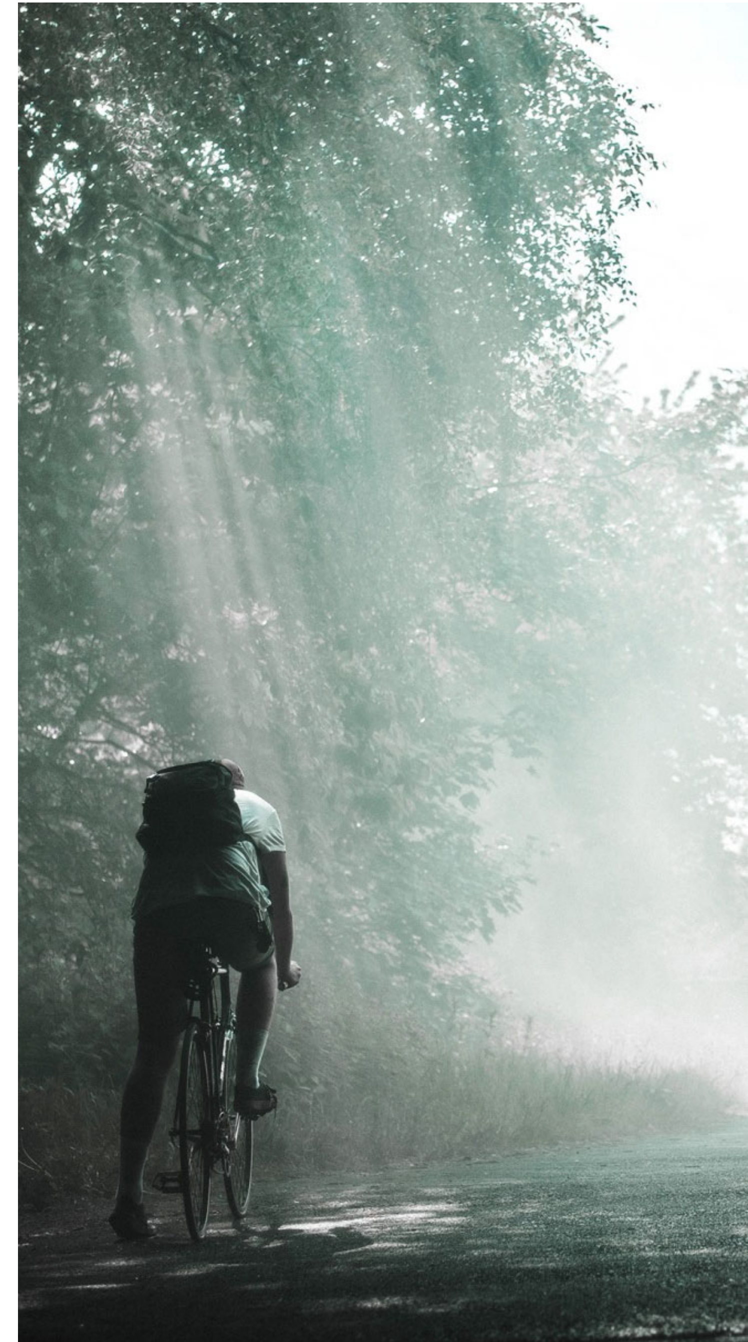
The accompanying report, which is intended solely for the use of the Finance & Audit Committee, Board of Directors and management, presents important information regarding the District's financial statements and our audit that we believe will be of interest to you. It is not intended and should not be used by anyone other than these specified parties.

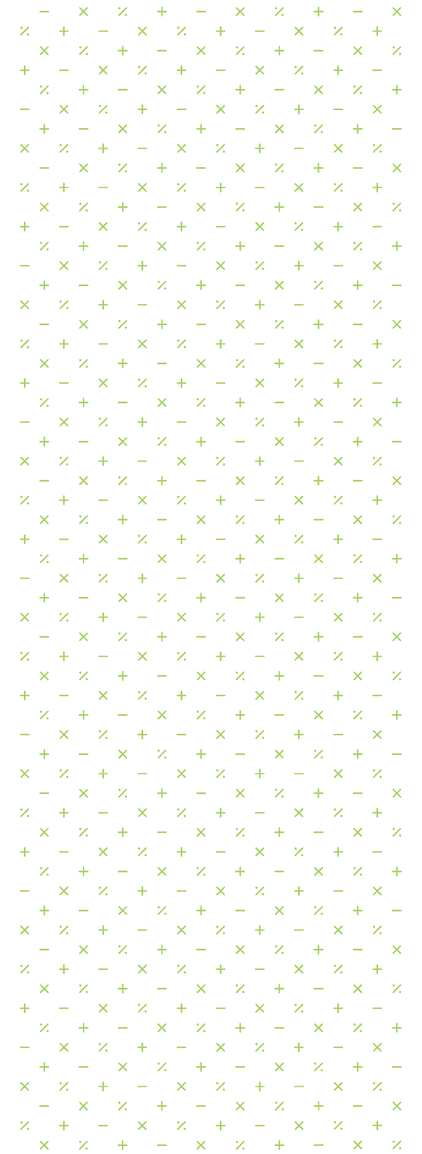
We conducted our audit with the objectivity and independence that you expect. We receive the full support and assistance of the District's personnel. We are pleased to serve and be associated with the District as its independent public accountants and look forward to our continued relationship.

We look forward to discussing our report or any other matters of interest with you during this meeting.

Agenda

- Auditor Opinion and Report
- Communication with Those Charged with Governance
- Financial Ratios and Metrics
- Accounting Update
- Industry Focus





Auditor Opinion & Report

Scope of Services

We have performed the following services for the District:

- Annual financial statement audit as of and for the year ended December 31, 2020.

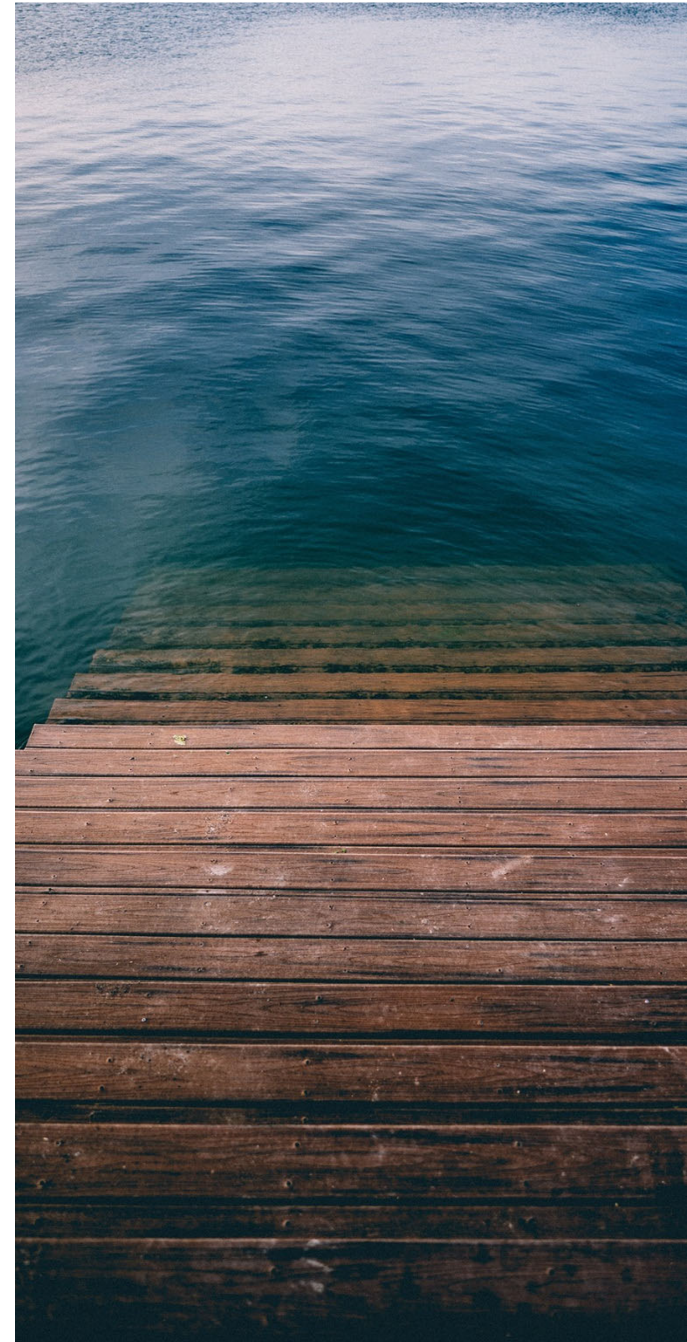
We have also performed the following nonattest services:

- Assisted in the drafting the financial statements of the District
- Assisted in the preparation of the Special Districts Transaction Reports

Auditor Report on the Financial Statements

Unmodified Opinion

- Financial statements are presented fairly and in accordance with US GAAP



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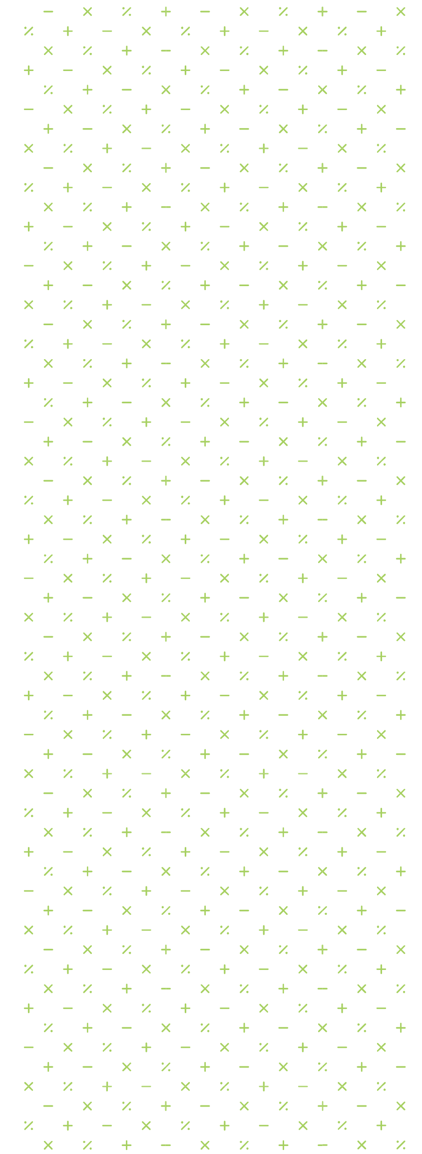
Audit Objectives and Areas of Audit Emphasis



COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

Areas of Audit Emphasis

- Tax Assessment Receivables and Revenues - Cutoff
- Capital Assets
- Commitments and Contingencies
- Management Override of Control via Manual Journal Entries

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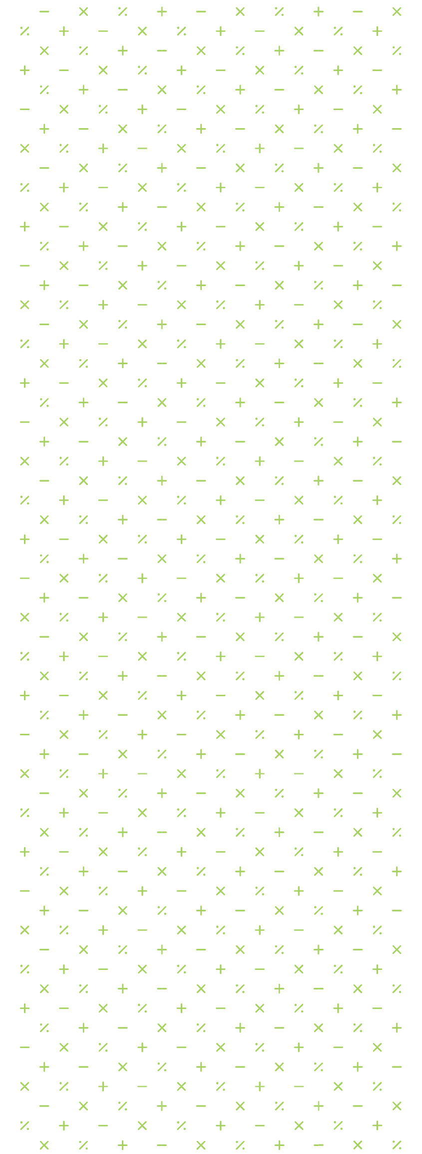
Financial Ratios and Metrics



Assets (in thousands)

- 2018 = $503,478
- 2019 = $503,976
- 2020 = $480,585

	2018	2019	2020
Cash and Cash Equivalents	2,081	2,196	797
Investments	1,059	3,211	4,015
Accounts Receivable	4,426	0	0
Capital Assets, net	313,704	441,531	444,272
Tax Revenue Receivable	5,184	4,213	6,507
Bond Assets Held In Trust	175,145	52,668	24,958
Due From Related Parties and Deposits	1,879	157	36

Y-axis: $0, $50,000, $100,000, $150,000, $200,000, $250,000, $300,000, $350,000, $400,000, $450,000, $500,000

Liabilities and Net Assets (in thousands)

- 2018 = $503,478
- 2019 = $503,976
- 2020 = $480,585

	2018	2019	2020
Accounts Payables, Accrued Expenses, and Due To Related Parties	4,060	893	360
Accrued Construction Costs	44,274	46,312	16,040
Note Payable	1,040	0	0
Bond Payable	399,203	391,582	390,415
Accrued Interest Expense	6,483	6,481	6,369
Net Assets	48,418	58,707	67,401

Y-axis: $0, $50,000, $100,000, $150,000, $200,000, $250,000, $300,000, $350,000, $400,000, $450,000

Revenues (in thousands)

- 2018 = $53,517
- 2019 = $13,109
- 2020 = $17,292

	2018	2019	2020
Net Patient Service Revenues	25,000	0	0
Lease Income	521	531	544
Support from Marin General Hospital (MGH)	15,412	0	0
Tax Revenue	12,575	11,647	16,497
Other Income and Interest and Investment Income	9	931	251

$30,000 · $25,000 · $20,000 · $15,000 · $10,000 · $5,000 · $0

Expenses (in thousands)

- 2018 = $42,191
- 2019 = $2,820
- 2020 = $8,598

	2018	2019	2020
Salaries and Benefits	31,743	0	0
Rent	3,010	0	0
Purchased Services	3,016	275	701
Depreciation and Amort	1,570	1,416	4,048
Supplies	1,463	0	0
Bond Interest Expense	0	0	3,577
Charitable Contributions and Other	1,389	1,129	272

Y-axis: $0, $5,000, $10,000, $15,000, $20,000, $25,000, $30,000, $35,000

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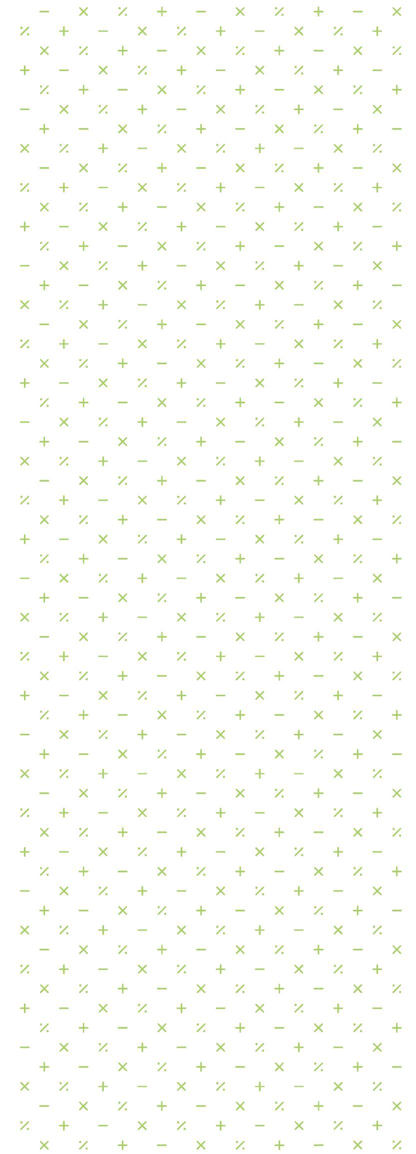
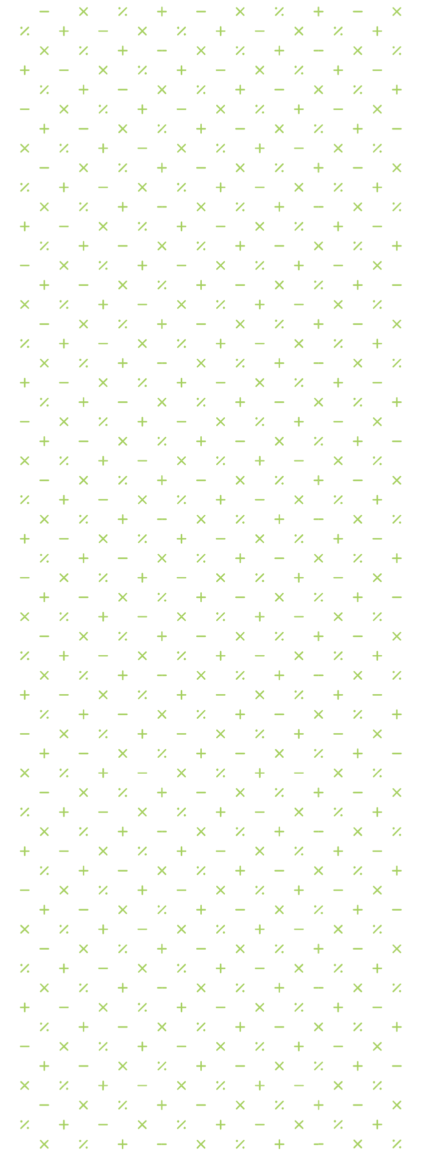
Communication with Those Charged with Governance



Communication with Those Charged with Governance

- Planned scope and timing of audit
- Significant accounting policies
- Accounting estimates are reasonable
- No material corrected adjustments
- No uncorrected audit adjustments
- No issues discussed prior to our retention as auditors
- No disagreements with management
- No material weaknesses identified
- No consultation with other accountants
- No awareness of instances of fraud or noncompliance with laws and regulations
- Other matters

Accounting Update

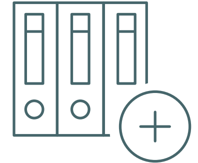


Accounting Standards Updates

GASB Standard –
Implemented and Upcoming

In May 8, 2020, the GASB issued Statement No. 95 (GASB 95) *Postponement of Dates of Certain Authoritative Guidance*. This guidance was effective immediately and postpones by one year the effective dates of Statements 83, 84, 88, 89, 90, 91, 92, and 93. Additionally the Statement postpones the effective dates of the following pronouncements by 18 months: Statement No. 87 and Implementation Guide No. 2019-3 *Leases*. The GASB encourages and permits earlier application of these standards to the extent specified in each pronouncement as originally issued.

Accounting Standards Updates

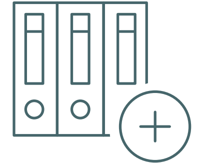


GASB Standard – Implemented and Upcoming

- In June 2017, the GASB issued Statement No. 87 (GASB 87), *Leases*. The objective of this statement is to better meet the information needs of financial statement users by improving accounting and financial reporting for leases by governments. It establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. Under this statement, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset, and a lessor is required to recognize a lease receivable and a deferred inflow of resources, thereby enhancing the relevance and consistency of information about governments' leasing activities. GASB 87 is effective for reporting periods beginning after June 15, 2021. The District is currently evaluating the impact of this standard on the financial statements.

- In June 2018, the GASB issued Statement No. 89 (GASB 89), *Accounting for interest cost incurred before the end of construction period*. The objective of this statement is to enhance the relevance and comparability of information about capital assets and the cost of borrowing for a reporting period. It also simplifies accounting for interest cost incurred before the end of a construction period. For financial statements prepared using the economic resources measurement focus, interest cost incurred before the end of a construction period should be recognized as an expense in the period in which the cost is incurred. Such interest cost should not be capitalized as part of the historical cost of a capital asset. GASB 89 is effective for reporting periods beginning after December 15, 2020. The District is currently evaluating the impact of this standard on the financial statements.

Accounting Standards Updates

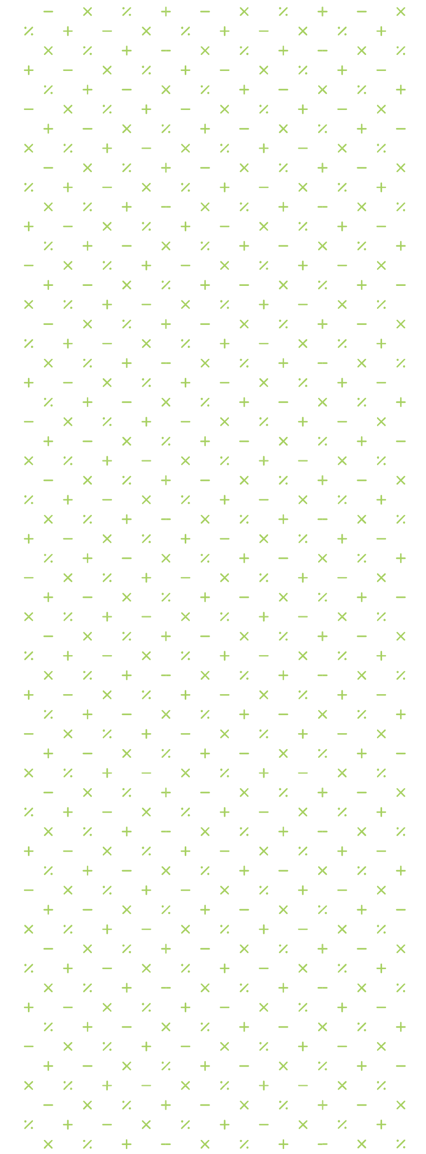


GASB Standard – Implemented and Upcoming

- In May 2019, the GASB issued Statement No. 91 (GASB 91), *Conduit Debt Obligations*. This Statement achieves those objectives by clarifying the existing definition of a conduit debt obligation; establishing that a conduit debt obligation is not a liability of the issuer; establishing standards for accounting and financial reporting of additional commitments and voluntary commitments extended by issuers and arrangements associated with conduit debt obligations; and improving required note disclosures. The requirements of GASB 91 are effective for reporting periods beginning after December 15, 2021. The District is currently evaluating the impact of this standard on the financial statements.

- In April 2018, the GASB issued Statement No. 88 (GASB 88), *Certain Disclosures Related to Debt, including Direct Borrowings and Direct Placements*. The objective of this statement is to improve the information that is disclosed in notes to government financial statements related to debt, including direct borrowings, and direct placements. It also clarifies which liabilities governments should include when disclosing information related to debt. The requirements of GASB 88 are effective for reporting periods beginning after June 15, 2018. There was no material impact on the District's financial statements as a result of adopting this standard.

Industry Focus



District and Health Systems

Moss Adams serves more than 200 Districts and health systems, ranging in size from 15 to over 1,000 beds. We offer tailored solutions and health care consulting services to our for-profit, government, and not-for-profit entities. Our clients include:

- Integrated health systems
- University-based Districts
- Tertiary-care teaching Districts
- Community and sole community Districts
- District Districts
- Critical access Districts
- Pediatric Districts

Additional Services

Audit and tax are vital. But you have complex needs that go beyond these core functions. Our dedicated health care consulting team provides a range of services to address all your needs—both now and in the future.

Health Care Consulting

COST REIMBURSEMENT

- Medicare & Medicaid
- Provider-based Licensure & Certification
- Medical Education
- Uncompensated Care

STRATEGY & INTEGRATION

- Provider Risk Analysis, Contracting & Operational Design
- M&A Support
- Feasibility Studies
- Market Intelligence & Benchmarking
- Service Line Enhancement
- Strategic Planning & Implementation

GOVERNMENT COMPLIANCE

- Regulatory Compliance
- Coding Validation
- Coding Department Redesign
- EHR Internal Controls
- Corporate Compliance

INFORMATION TECHNOLOGY

- HIPAA Security and Privacy
- Network Security & Penetration Testing
- HITRUST Assessment & Certification
- SOC Pre-Audit Gap Analysis & Readiness
- SOC Audits

OPERATIONAL IMPROVEMENT

- Revenue Cycle Enhancement
- Claims Recovery
- Litigation Support
- Employer Health Benefits
- Lean Consulting

Connect With Us

In today's fast-paced world, we know how precious your time is. We also know that knowledge is key. These resources offer what you need to know, when you need to know it, and is presented in the format that fits your life.

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Assurance, tax, and consulting offered through Moss Adams LLP. Wealth management offered through Moss Adams Wealth Advisors LLC. Investment banking offered through Moss Adams Capital LLC.

THANK YOU

Tab 3

Report of Independent Auditors and Financial Statements

Marin Healthcare District

December 31, 2020 and 2019

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Statements of Cash Flows 12

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Management's Discussion and Analysis

This section of Marin Healthcare District's (the District) financial statements presents management's discussion and analysis of the financial activities of the District for fiscal years ended December 31, 2020 and 2019. We encourage the reader to consider the information presented here in conjunction with the financial statements as a whole.

INTRODUCTION TO THE FINANCIAL STATEMENTS

This discussion and analysis is intended to serve as an introduction to the District's audited financial statements. This annual report is prepared in accordance with the Governmental Accounting Standards Board (GASB) Statement No. 34, Basic Financial Statements – and Management's Discussion and Analysis – for State and Local Governments.

The required financial statements include the statement of net position, the statement of revenues, expenses, and changes in net position, and the statement of cash flows. The notes to financial statements, and this summary, provide support to these statements. All information must be considered together to obtain a complete understanding of the financial picture of the District.

Statement of Net Position

This statement includes all assets and liabilities using the accrual basis of accounting as of the statement date. The difference between the two classifications is represented as "net position" this section of the statement identifies major categories of restrictions on these assets and reflects the overall financial position of the District as a whole.

Statement of Revenues, Expenses, and Changes in Net Position

This statement presents the revenues earned and the expenses incurred during the year using the accrual basis of accounting. Under the accrual basis, all increases or decreases in net position are reported as soon as the underlying event occurs, regardless of the timing of the cash flow. Consequently, revenues and/or expenditures reported during this fiscal year may result in changes to cash flows in a future period.

Statement of Cash Flow

This statement reflects inflows and outflows of cash, summarized by operating, capital and noncapital and related financing, and investing activities. The direct method was used to prepare this information, which means gross rather than net amounts were presented for the year's activities.

Notes to Financial Statements

This additional information is essential to a full understanding of the data reported in the financial statements. The District is a political subdivision of the state of California. It is the sole member of Marin General Hospital, dba MarinHealth Medical Center (MHMC) and is governed by a publicly-elected Board of Directors.

ANALYTICAL REVIEW

The statement of net position and statement of revenues, expenses, and changes in net position present a summary of the District's activities.

Condensed Statements of Net Position

	December 31,		
	2020	2019	2018
Current and other assets	$ 36,313,761	$ 62,444,589	$ 189,772,393
Capital assets, net of accumulated depreciation	444,271,644	441,531,179	313,704,244
Total assets	$ 480,585,405	$ 503,975,768	$ 503,476,637
Current portion of bond payable	$ 430,000	$ 190,000	$ 6,645,000
Other current liabilities	22,768,542	53,687,121	55,846,433
Bond payable, net of current portion	389,985,067	391,391,492	392,557,917
Long-term debt and other long-term liabilities	-	-	9,333
Total liabilities	413,183,609	445,268,613	455,058,683
Net position			
Net investment in capital assets	62,774,429	56,305,759	45,371,757
Unrestricted	4,627,367	2,401,396	3,046,197
Total net position	67,401,796	58,707,155	48,417,954
Total liabilities and net position	$ 480,585,405	$ 503,975,768	$ 503,476,637

Total assets decreased by 5% or $23,390,363 as of December 31, 2020, compared to December 31, 2019, primarily due to decrease in assets limited to use – bond funds. Total assets increased by 0.1% or $499,131 as of December 31, 2019, compared to December 31, 2018, primarily due to capital asset additions.

Liabilities decreased by 7% or $32,085,004 as of December 31, 2020, compared to December 31, 2019, primarily due to reduction in accrued construction costs. Liabilities decreased by 2% or $9,790,070 as of December 31, 2019, compared to December 31, 2018, as a result of $6,645,000 in bond payments and the absorption of notes payables by Marin Health Medical Center (MHMC) from the healthcare clinics (Clinics) transfer of operations.

The overall changes to net position is an increase of $8,694,641, resulting in a December 31, 2020, balance of $67,401,796. An unrestricted net position of $4,627,367 exists for the year ended December 31, 2020, as a result of resources in excess of net investments in capital assets.

Condensed Statement of Revenue, Expenses, and Changes in Net Position

	Years ended December 31,		
	2020	2019	2018
Operating revenues	$ 582,339	$ 531,124	$ 25,521,423
Operating expenses	5,020,327	1,764,623	42,188,820
Operating loss	(4,437,988)	(1,233,499)	(16,667,397)
Support from MHMC	-	-	15,412,259
Bond issuance costs	-	-	(1,884)
Tax revenue	16,497,711	11,647,284	12,574,707
Bond interest expense	(3,577,456)	-	-
Interest expense	-	-	(339)
Interest and investment income	212,374	160,244	9,304
Total nonoperating revenues, net	13,132,629	11,807,528	27,994,047
Gain on sale of Clinics assets	-	770,096	-
Transfer of payment for sale of Clinics assets to MHMC	-	(1,054,924)	-
Total special and extraordinary items	-	(284,828)	-
Increase in net position	$ 8,694,641	$ 10,289,201	$ 11,326,650

Operating Revenues and Expenses

For the years ending December 31, 2020 and 2019, operating losses were primarily due to the depreciation incurred by the District. For year ending December 31, 2018, the operating loss was primarily due to the losses incurred from the 1206(b) clinics. The 1206(b) clinic operating deficits were funded by MHMC.

Nonoperating Revenues and Expenses

Tax revenue represents property tax assessments by Marin County on District property owners, which will be used to make bond interest and principal payments in the future. Property tax assessments are based upon expected debt service for the following year and vary depending on scheduled bond principal and interest payment amounts. For the year ending December 31, 2018, under terms of an agreement with the District, MHMC provided support to the District equal to the losses incurred by the 1206(b) clinics.

ECONOMIC OUTLOOK AND MAJOR INITIATIVES

The Hospital Facilities Seismic Upgrade Act (SB 1953)

The District has assumed responsibility for compliance with the Hospital Facilities Seismic Upgrade Act (SB 1953) classification SPC2 and through Hazus 2010. The District has received an extension to 2030.

Business Segment Disposal

In January 2019 the District entered into an agreement with Prima Medical Foundation, dba MarinHealth Medical Network (MHMN) and University of California, San Francisco (UCSF), whereby the Clinic's physicians rendered their services and professional service agreements to the UCSF academic license 1206(g). As part of the agreement, MHMN gained control and operation of the Clinics, and assumed responsibility of all the District's prepaid assets, intangible assets, property leases, and notes payable related to the Clinics. Furthermore, on January 1, 2019, the District entered into a purchase and sale agreement with MHMN for the purchase of capital assets and inventory.

Measure F

On November 5, 2013, the voters of the District passed Measure F, which authorized the District to issue $394,000,000 in bonds to improve the MHMC facility and related facilities with new construction, acquisitions, and renovations.

In November 2015, the District issued $170,000,000 of bonds, at a premium, resulting in total proceeds of $178,687,120. A portion of those proceeds were used to reimburse MHMC for the construction of a parking structure and for design and site improvements preparatory to the commencement of construction of the new hospital facility.

In September 2017, the District issued $224,000,000 of bonds, at a premium, resulting in total proceeds of $243,612,033. The proceeds continue to be used for the construction of the new hospital facility.

BUDGET RESULTS

The Board of Directors approves the operating budget of the District. The budget remains in effect the entire period, but is updated as needed for internal management use to reflect changes in activity and approved variances. A budget comparison and analysis for the year ended December 31, 2020, is presented below.

	Actual	Budget
Operating revenues	$ 582,339	$ 541,215
Operating expenses	5,020,327	9,193,352
Operating loss	(4,437,988)	(8,652,137)
Tax revenue	16,497,711	12,731,482
Bond interest expense	(3,577,456)	-
Interest and investment income	212,374	3,000
Nonoperating revenues	13,132,629	12,734,482
Change in net position	$ 8,694,641	$ 4,082,345

The budget above is for the operations of the District, which includes bond-related revenue and expenses.

Operating revenues – The majority of the District's operating revenues are comprised of rental revenue earned from MHMC, with a trivial amount of other revenue, and were in excess of budget by $41,124.

Operating expenses – The District conducts programs such as community healthcare education and support for hospital programs. The District's operating expenses were $4,173,025 under budget, due to interest expense related to the bonds that no longer qualifies for capitalization as the hospital facility was completed on September 30, 2020.

Tax revenue – The District earned tax revenue, which represents property tax assessments by Marin County on District property owners, which will be used to make bond interest and principal payments in the future.

Interest and investment income – The District earned interest and dividend income from the accounts in which the investments are held.

CAPITAL ASSETS

As of December 31, 2020, the District had $444,271,644 invested in a variety of capital assets, as reflected in the following schedule, which represent a net increase (additions less depreciation) of $2,740,465 from December 31, 2019. The increases in year ended December 31, 2020, is the result of the construction of the new hospital facility which was completed and moved to depreciable capital assets on September 30, 2020.

	Balance at	
	December 31, 2020	December 31, 2019
Land and improvements	$ 865,701	$ 865,701
Construction in progress	-	412,438,343
Building	474,174,562	54,948,220
Equipment	18,784,416	18,784,416
Less accumulated depreciation	(49,553,035)	(45,505,501)
Capital assets, net of accumulated depreciation	$ 444,271,644	$ 441,531,179

CONTACTING THE DISTRICT'S FINANCIAL MANAGEMENT

This financial report is intended to provide citizens, taxpayers, and creditors with a general overview of the District's finances. Questions about this report should be directed to Marin Healthcare District to the attention of the chief financial officer or the chair of the finance and audit committee at 415-464-2090.

Report of Independent Auditors

To the Board of Directors
Marin Healthcare District

Report on Financial Statements

We have audited the accompanying financial statements of Marin Healthcare District (the District), which comprise the statements of net position as of December 31, 2020 and 2019, 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 California Code of Regulations, Title 2, Section 1131.2, State Controller's Minimum Audit Requirements for California Special Districts. 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 judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the District's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the 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 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 Marin Healthcare District as of December 31, 2020 and 2019, and the changes in its financial position and its cash flows for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that management's discussion and analysis on pages 1 through 6 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, which considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Sacramento, California
, 2021

Financial Statements

Marin Healthcare District
Statements of Net Position
December 31, 2020 and 2019

	2020	2019
ASSETS		
Current assets		
Cash and cash equivalents	$ 797,054	$ 2,196,243
Investments	4,015,498	3,210,664
Current portion of bond assets held in trust	8,917,852	10,164,146
Tax revenue receivable	6,507,631	4,212,709
Due from related parties	-	120,788
Total current assets	20,238,035	19,904,550
Deposits	36,000	36,000
Capital assets, net of accumulated depreciation	444,271,644	441,531,179
Bond assets held in trust, net of current portion	16,039,726	42,504,039
Total assets	$ 480,585,405	$ 503,975,768
LIABILITIES		
Current liabilities		
Accounts payable	$ -	$ 496
Accrued expenses	243,410	28,416
Accrued construction costs	16,039,726	46,312,113
Accrued interest expense	6,369,271	6,481,604
Due to related parties	116,135	864,492
Current portion of bonds payable	430,000	190,000
Total current liabilities	23,198,542	53,877,121
Bonds payable, net of current portion	389,985,067	391,391,492
Total liabilities	413,183,609	445,268,613
NET POSITION		
Net investment in capital assets	62,774,429	56,305,759
Unrestricted	4,627,367	2,401,396
Total net position	67,401,796	58,707,155
Total liabilities and net position	$ 480,585,405	$ 503,975,768

See accompanying notes.

	2020	2019
OPERATING REVENUES		
Lease income	$ 543,991	$ 531,124
Other income	38,348	-
Total operating revenues	582,339	531,124
OPERATING EXPENSES		
Purchased services	700,767	275,203
Depreciation and amortization	4,047,534	1,415,652
Charitable contributions	53,285	-
Other	218,741	73,768
Total operating expenses	5,020,327	1,764,623
OPERATING LOSS	(4,437,988)	(1,233,499)
NONOPERATING REVENUES (EXPENSES)		
Tax revenue	16,497,711	11,647,284
Interest and investment income	212,374	160,244
Bond interest expense	(3,577,456)	-
Total nonoperating revenues, net	13,132,629	11,807,528
SPECIAL AND EXTRAORDINARY ITEMS		
Gain on sale of healthcare clinics (Clinics) assets	-	770,096
Transfer of payment for sale of Clinics assets to MHMC	-	(1,054,924)
Total special and extraordinary items	-	(284,828)
INCREASE IN NET POSITION	8,694,641	10,289,201
NET POSITION, beginning of year	58,707,155	48,417,954
NET POSITION, end of year	$ 67,401,796	$ 58,707,155

See accompanying notes.

Marin Healthcare District
Statements of Cash Flows
Years Ended December 31, 2020 and 2019

	2020	2019
CASH FLOWS FROM OPERATING ACTIVITIES		
Receipts from tenants	$ 582,339	$ 531,124
Receipts from patients	-	4,426,206
Payments to suppliers and others	(1,385,864)	(2,770,530)
Net cash (used in) provided by operating activities	(803,525)	2,186,800
CASH FLOWS FROM NONCAPITAL AND RELATED FINANCING ACTIVITIES		
Payments from MHMC for operations	-	(75,562)
Net cash used in noncapital and related financing activities	-	(75,562)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Proceeds on sale of Clinics assets	-	1,054,924
Purchases of capital assets	(26,628,843)	(115,595,295)
Principal payments on bonds payable	(190,000)	(6,645,000)
Tax revenue related to general obligation bonds	14,202,789	12,618,835
Payment of notes payable to physicians	-	(4,302)
Transfer of payment for sale of Clinics assets to MHMC	-	(1,054,924)
Interest payments on bonds payable	(15,097,757)	(15,555,850)
Net cash used in capital and related financing activities	(27,713,811)	(125,181,612)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of investments	(4,206,046)	(2,095,601)
Proceeds from sales and maturities of Investments	3,591,915	-
Purchase of bond assets held in trust	(20,293,189)	(19,267,009)
Proceeds from sales and maturities of bond assets held in trust	47,818,692	144,444,363
Earnings on investments	206,775	103,927
Net cash provided by investing activities	27,118,147	123,185,680
NET CHANGE IN CASH AND CASH EQUIVALENTS	(1,399,189)	115,306
CASH AND CASH EQUIVALENTS, beginning of year	2,196,243	2,080,937
CASH AND CASH EQUIVALENTS, end of year	$ 797,054	$ 2,196,243

See accompanying notes.

	2020	2019
RECONCILIATION OF OPERATING LOSS TO NET CASH FROM OPERATING ACTIVITIES		
Operating loss	$ (4,437,988)	$ (1,233,499)
Adjustments to reconcile operating loss to net cash from operating activities:		
Depreciation and amortization	4,047,534	1,415,652
Changes in certain assets and liabilities:		
Patient accounts receivable	-	4,426,206
Prepaid expenses	-	253,792
Due from related parties	120,788	-
Deposits	-	33,633
Intangibles	-	457,827
Accounts payable	(496)	22,686
Accrued expenses	214,994	(3,189,497)
Due to related parties	(748,357)	-
Net cash (used in) provided by operating activities	$ (803,525)	$ 2,186,800
SUPPLEMENTAL NONCASH ACTIVITIES INFORMATION		
Gain on sale of healthcare clinics (Clinics) assets	$ -	$ 770,096

NOTE 1 – BASIS OF PRESENTATION AND ACCOUNTING POLICIES

Reporting entity – Marin Healthcare District (the District) is a political subdivision of the state of California. District directors are elected officials whose sole mission is to promote the health and welfare of the residents of the communities served by the District. The District operated the Marin General Hospital facility (the Hospital Facility) until 1985, when it reorganized in compliance with local hospital district law of the state of California.

The District's principal asset is hospital property, plant, and equipment. The Hospital Facility is a general acute-care facility located in Marin County, California, and provides inpatient and outpatient healthcare services. Inpatient facilities consist of medical-surgical, pediatrics, maternity, nursery, intensive care, coronary, psychology, radiology, and laboratory services. The Hospital Facility is leased to Marin General Hospital, dba MarinHealth Medical Center (MHMC). The financial information of MHMC is not included in these financial statements.

Effective June 30, 2010, the District became the sole member of MHMC and appointed its initial Board of Directors. The MHMC Board is responsible for oversight of the operations of MHMC and the District has certain ongoing reserve powers and governance oversight responsibilities.

The District is also a forum for discussion of local healthcare issues, promotes healthcare services within the community, and acts on behalf of the public as an advocate of high quality, reasonably priced healthcare services.

Business segment disposal – On January 1, 2019, the District entered into an agreement with Prima Medical Foundation, dba MarinHealth Medical Network (MHMN) and University of California, San Francisco (UCSF), whereby the Clinic's physicians rendered their services and professional service agreements to the UCSF academic license 1206(g). As part of the agreement, MHMN gained control and operation of the Clinics, and assumed responsibility of all the District's prepaid assets, intangible assets, property leases, and notes payable related to the Clinics. Furthermore, on January 1, 2019, the District entered into a purchase and sale agreement with MHMN for the purchase of capital assets and inventory. Refer to Note 11 for additional information.

In August 2017, California Healthcare Medical Billing, Inc. (CHMB), assumed the billing and collection services for the 1206(b) Clinics of the District, which as of January 1, 2019, was assumed by MHMN.

Proprietary fund accounting – The activities of the District are accounted for as an Enterprise Fund. Enterprise Funds are accounted for on the flow of economic resources measurement focus and use the accrual basis of accounting. Under the method, revenues are recorded when earned and expenses are recorded at the time obligations are incurred. Tax revenue is recognized in the period in which the property tax is levied. Tax revenue is collected by the County for payment, when due, of the principal and interest on the bonds.

Accounting standards – Pursuant to Government Accounting Standards Board (GASB) Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 Financial Accounting Standards Board (FASB) and American Institute of Certified Public Accountants (AICPA) Pronouncements,* the District's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989, and the California Code of Regulations, Title 2, Section 1131.2, State Controller's Minimum Audit Requirements for California Special Districts and the State Controller's Office prescribed reporting guidelines.

Proprietary fund operating revenues, such as charges for services, result from exchange transactions associated with the principal activity of the fund. Exchange transactions are those in which each party receives and gives up essentially equal values. Nonoperating revenues, such as subsidies, property tax revenue, and investment earnings, result from nonexchange transactions or ancillary activities.

The District may fund programs with a combination of cost-reimbursement grants, categorical block grants, and general revenues. Thus, both restricted and unrestricted net positions may be available to finance program expenditures. The District's policy is to first apply restricted grant resources to such programs, followed by general revenues, if necessary.

New accounting standards – In May 2020, the GASB issued Statement No. 95 (GASB 95), *Postponement of Dates of Certain Authoritative Guidance*. This guidance postpones by one year the effective dates of Statements 83, 84, 88, 89, 90, 91, 92, and 93 to provide relief to governments and other stakeholders in light of the COVID-19 pandemic. Additionally the Statement postpones the effective dates of the following pronouncements by 18 months: Statement No. 87 and Implementation Guide No. 2019-3 *Leases*. The GASB encourages and permits earlier application of these standards to the extent specified in each pronouncement as originally issued. There was no material impact on the District's financial statements as a result of adopting GASB 95 in 2020.

Use of estimates – The financial statements have been prepared in conformity with U.S. generally accepted accounting principles, and as such, include amounts based on informed estimates and judgments of management with consideration given to materiality. Actual results could differ from those estimates.

Net position – Net position is the excess of all the District's assets over all its liabilities, regardless of fund. Net position is divided into three components. These captions apply only to net position, which is determined only at the government-wide level and are described below:

Net investment in capital assets: The portion of the net position that is represented by the current net book value of the District's capital assets, less the outstanding balance of any debt issued to finance these assets.

Restricted: The portion of net position that is restricted as to use by the terms and conditions of agreements with outside parties, governmental regulations, laws, or other restrictions, which the District cannot unilaterally alter. The District has no restricted net positions.

Unrestricted: The portion of net position that is not restricted to use.

Cash and cash equivalents – Cash and cash equivalents include cash in bank checking, money market funds, and investments in highly liquid debt instruments with a maturity of three months or less when purchased.

Investments – Investments consist of mutual funds and are stated at fair value. Realized gains and losses, unrealized gains and losses, and interest are included in the statements of revenue, expenses, and changes in net position as other revenue. Interest of $4,338 and $8,325, and realized and unrealized gains of $208,036 and $151,919 for the years ended December 31, 2020 and 2019, respectively, are included in interest and investment income on the statement of revenues, expenses and change in net position.

Bond assets held in trust – The District reports all investments at fair value. The fair value of investments is based on published market prices and quotations from major investment brokers. Realized and unrealized gains of $185,103 and $2,700,797 offset capitalized interest which is included in capital assets on the statement of net position as of December 31, 2020 and 2019, respectively.

Capital assets – Capital assets are recorded at cost. Depreciation is provided for on the straight-line basis over the estimated useful lives of the assets. The capitalization threshold is $5,000.

Capital assets are considered impaired when their service utility declines significantly and unexpectedly. An impairment loss is recognized for the difference between the carrying value of the asset and its fair value or adjusted depreciated value, depending on the nature of the impairment. No impairment was recorded for the year ended December 31, 2020 and 2019.

Asset impairment – The District also evaluates the carrying value of its long-lived assets other than capital assets for potential impairment. The evaluations address the estimated recoverability of the assets' carrying value. When events or changes in circumstances indicate that the carrying value may not be recoverable, the excess of the carrying value over the fair value is recorded as impairment. No impairment was recorded for the year ended December 31, 2020 and 2019.

Risk management – The District is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; errors and omissions; and natural disasters for which the District carries commercial insurance.

Lease income – The District recognizes lease income and reimbursement of operating expenses when earned. The District derives all of its lease income from MHMC (see Note 5).

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 leasing the Hospital Facility to MHMC. Nonexchange revenues, including taxes, grants, and contributions received for purposes other than capital asset acquisition, are reported as nonoperating revenues. Operating expenses are all expenses incurred in order to lease the Hospital Facility.

Grants and contributions – The District may periodically receive grants and contributions from other governmental entities, individuals, or private organizations; revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements, are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as nonoperating revenues. Amounts restricted to capital acquisitions are reported after nonoperating revenues and expenses.

Amortization of bond premiums – Premiums arising from the issuance of bonds are capitalized and amortized using the straight-line amortization method, which approximates the effective interest method.

NOTE 2 – CASH, CASH EQUIVALENTS, INVESTMENTS, AND BOND ASSETS HELD IN TRUST

The District's cash, cash equivalents, investments, and bond assets held in trust as of December 31, were as follows:

	2020	2019
Cash in bank	$ 473,401	$ 1,876,567
State of California's Local Agency Investment Fund (LAIF)	323,653	319,676
Cash and cash equivalents	797,054	2,196,243
Investments		
Mutual funds	2,055,703	3,210,664
Money market funds	610,110	-
U.S. fixed income commingled funds	1,349,685	-
	4,015,498	3,210,664
Bond assets held in trust		
Money market funds	13,887,949	13,965,766
U.S. Treasury obligations	11,069,629	38,702,419
	24,957,578	52,668,185
Total	$ 29,770,130	$ 58,075,092

Cash balances from all funds are combined and invested, to the extent possible, pursuant to the District Board's approved Investment Policy and Guidelines and Statement Government Code. The District's investments are carried at fair value.

Cash in bank – Cash in the bank represents amounts held in the District's general operating accounts.

LAIF – The District places certain funds with the LAIF. The District is a voluntary participant in LAIF, which is regulated by California Government Code Section 16429 under the oversight of the Treasurer of the state of California and the Pooled Money Investment Board. The state Treasurer's office pools these funds with those of other governmental agencies in the state and invests the cash. The fair value of the District's investment in this pool is reported in the accompanying financial statements based upon the District's pro-rata share of the fair value provided by LAIF for the entire LAIF portfolio (in relation to the amortized cost of that portfolio). The monies held in the pooled investment funds are not subject to categorization by risk category. The balance available for withdrawal is based on the accounting records maintained by LAIF, which are recorded on the amortized cost basis. Funds are accessible and transferable to the master account with 24 hours' notice. Financial statements for LAIF can be obtained from the California State Treasurer's Office, 915 Capitol Mall, Suite 110, Sacramento, California, 95814.

The management of the state of California Pooled Money Investment Account has indicated to the District that as of December 31, 2020 and 2019, the estimated market value of the pool (including accrued interest) was $29,719,484 and $29,214,977, respectively. The District's proportionate share of that value is $323,653 and $319,676 as of December 31, 2020 and 2019, respectively.

Mutual funds and money market funds – The District's mutual funds and money market funds are primarily invested in government and corporate debt, asset backed securities, U.S. Treasury securities, and global debt. The objective of these funds is to provide steady cash flow to investors.

U.S. fixed income commingled funds – This class includes investments in commingled funds that invest primarily in domestic equity or debt securities. The objective of these investments is to capture similar market returns in their respective indices. The funds' underlying positions are all marketable and priced regularly, but the majority of the funds themselves are priced monthly on a net asset value basis. U.S. fixed income commingled funds are accessible for full liquidity on a daily basis.

Bond assets held in trust – Investments from proceeds of bond issuances are restricted by applicable California law and the various bond resolutions associated with each issuance, generally, to certain types of investments. These investments include obligations of the United States of America, Federal Housing Administration debentures, obligations of government-sponsored agencies, unsecured certificates of deposits, demand deposits, time deposits and bankers' acceptances, deposits the aggregate amount of which are fully insured by the Federal Deposit Insurance Corporation in banks, commercial paper, money market funds, state obligations, the Marin County Investment Pool, and LAIF.

The District's investments include amounts held in trust by the paying agent. The District currently invests in money market funds, and U.S. Treasury obligations, and management regularly monitors the credit rating of the investment companies issuing the investments as part of monitoring the District's exposure to credit risk.

Investment risk factors – Many factors can affect the value of investments such as credit risk, custodial credit risk, and concentration of credit risk.

Credit risk – Credit risk is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. The District's investment policy requires that, to be eligible for investment, the investments shall be rated "AAm" or "AAm-G" by S&P or better and the investment pool maintained by the county in which the District is located or other investment pools, in either case, so long as such pool is rated in one of the two highest rating categories by S&P and Moody's. As of December 31, 2020 and 2019, the investments held are all considered investment grade and are rated equal to or greater than AAm or AAm-G by S&P and Moody's.

Custodial credit risk – Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, the District will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The custodial credit risk for investments is the risk that, in the event of the failure of the counterparty (e.g., broker-dealer) to a transaction, the District will not be able to recover the value of its investment or collateral securities that are in the possession of another party.

California law requires banks and savings and loan associations to pledge government securities with a market value of 110% of the District's cash on deposit or first trust deed mortgage notes with a value of 150% of the deposit as collateral for these deposits. Under California law, this collateral is held in the District's name and places the District ahead of general creditors of the institution.

Concentration of credit risk – Concentration of credit risk is the risk associated with a lack of diversification, such as having substantial investments in a few individual issuers, thereby exposing the District to greater risks resulting from adverse economic, political, regulatory, geographic, or credit developments. The securities the District is invested in as of December 31, 2020 and 2019, are subject to the quality, diversification, and other requirements of Rule 2a-7 under the Investment Company Act of 1940, as amended and other rules of the Securities and Exchange Commission. The District will only purchase securities that present minimal credit risk.

NOTE 3 – FAIR VALUE OF MEASUREMENTS

GASB 72, Fair Value Measurement and Application, defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. GASB 72 also establishes a fair value hierarchy that requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1 – Quoted prices in active markets for identical assets

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices in active markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets.

Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets.

The following tables present information about the District's assets measured at fair value on a recurring basis as of December 31:

	2020			
	Fair Value at Reporting Date Using			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Money market funds	$ 14,498,059	$ -	$ -	$ 14,498,059
U.S. treasury obligations	11,069,629	-	-	11,069,629
Mutual funds				
Govt/Corp intermediate	1,386,245	-	-	1,386,245
Corp/Pref-high yield	669,458	-	-	669,458
Total mutual funds	2,055,703	-	-	2,055,703
	27,623,391	-	-	27,623,391
U.S. fixed income commingled funds*	-	-	-	1,349,685
Total investments	$ 27,623,391	$ -	$ -	$ 28,973,076

*The amounts of marketable securities measured at net asset value (NAV) presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the statement of net position.

	2019			
	Fair Value at Reporting Date Using			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Money market funds	$ 13,965,766	$ -	$ -	$ 13,965,766
U.S. treasury obligations	38,702,419	-	-	38,702,419
Mutual funds				
Asset backed securities	478,021	-	-	478,021
Global debt	963,681	-	-	963,681
Govt/Corp intermediate	1,449,820	-	-	1,449,820
Corp/Pref-high yield	319,142	-	-	319,142
Total mutual funds	3,210,664	-	-	3,210,664
Total investments	$ 55,878,849	$ -	$ -	$ 55,878,849

During 2020 and 2019, there was no activity in Level 3 investments.

Commingled funds are reported at fair value as reported by the fund managers based on discounted cash flows, estimated market values, and other unobservable inputs. The commingled funds report fair value using a calculated NAV. There are no redemption limitations, except as noted below, or unfunded commitments at December 31, 2020.

Commingled Fund	Redemption	Redemption Notice Period	Redemption Availability
U.S. fixed income commingled funds	Any business day of each month	2 business days prior to trade date	Within 2 business days after trade date (subject to liquidity limitations)

GASB Statement No. 40 requires the District to disclose the maturities of its investments (other than U.S. government obligations or obligations guaranteed by the U.S. government). A summary of scheduled maturities by investment type as of December 31, follows:

	2020			
	Investment maturities (in years)			
	Fair Value	Less than 1	1 to 5	More than 5
Money market funds	$ 14,498,059	$ 14,498,059	$ -	$ -
U.S. treasury obligations	11,069,629	11,069,629	-	-
	25,567,688	$ 25,567,688	$ -	$ -
Mutual funds	2,055,703			
U.S. fixed income commingled funds	1,349,685			
	$ 28,973,076			

	2019			
	Investment maturities (in years)			
	Fair Value	Less than 1	1 to 5	More than 5
Money market funds	$ 13,965,766	$ 13,965,766	$ -	$ -
U.S. treasury obligations	38,702,419	38,702,419	-	-
	52,668,185	$ 52,668,185	$ -	$ -
Mutual funds	3,210,664			
	$ 55,878,849			

NOTE 4 – CAPITAL ASSETS

The following is a summary of changes in capital assets during the years ended December 31, 2020 and 2019:

	Life (Years)	Balance December 31, 2019	Additions	Deletions	Transfers	Balance December 31, 2020
Nondepreciable						
Land	N/A	$ 865,701	$ -	$ -	$ -	$ 865,701
Construction in progress	N/A	412,438,343	11,937,273	(5,149,274)	(419,226,342)	-
Total nondepreciable		413,304,044	11,937,273	(5,149,274)	(419,226,342)	865,701
Depreciable						
Hospital buildings	40	53,570,325	-	-	419,226,342	472,796,667
Equipment	3 to 20	18,784,416	-	-	-	18,784,416
Leasehold improvements	40	1,377,895	-	-	-	1,377,895
Total depreciable		73,732,636	-	-	419,226,342	492,958,978
Accumulated depreciation						
Hospital buildings	N/A	(25,343,190)	(4,047,534)	-	-	(29,390,724)
Equipment	N/A	(18,784,416)	-	-	-	(18,784,416)
Leasehold improvements	N/A	(1,377,895)	-	-	-	(1,377,895)
Total accumulated depreciation		(45,505,501)	(4,047,534)	-	-	(49,553,035)
Total depreciable, net		28,227,135	(4,047,534)	-	419,226,342	443,405,943
Total capital assets, net		$ 441,531,179	$ 7,889,739	$ (5,149,274)	$ -	$ 444,271,644

	Life (Years)	Balance December 31, 2018	Additions	Deletions	Transfers	Balance December 31, 2019
Nondepreciable						
Land	N/A	$ 865,701	$ -	$ -	$ -	$ 865,701
Construction in progress	N/A	283,039,426	129,511,725	(112,808)	-	412,438,343
Total nondepreciable		283,905,127	129,511,725	(112,808)	-	413,304,044
Depreciable						
Hospital buildings	40	53,570,325	-	-	-	53,570,325
Equipment	3 to 20	18,784,416	-	-	-	18,784,416
Leasehold improvements	40	1,377,895	-	-	-	1,377,895
1206B leasehold improvements	40	35,939	-	(35,939)	-	-
1206B Clinic equipment	3 to 20	2,572,899	-	(2,572,899)	-	-
Total depreciable		76,341,474	-	(2,608,838)	-	73,732,636
Accumulated depreciation						
Hospital buildings	N/A	(23,927,538)	(1,415,652)	-	-	(25,343,190)
Equipment	N/A	(18,784,416)	-	-	-	(18,784,416)
Leasehold improvements	N/A	(1,377,895)	-	-	-	(1,377,895)
1206B leasehold improvements	N/A	(35,941)	-	35,941	-	-
1206B Clinic equipment	N/A	(2,416,567)	-	2,416,567	-	-
Total accumulated depreciation		(46,542,357)	(1,415,652)	2,452,508	-	(45,505,501)
Total depreciable, net		29,799,117	(1,415,652)	(156,330)	-	28,227,135
Total capital assets, net		$ 313,704,244	$ 128,096,073	$ (269,138)	$ -	$ 441,531,179

Depreciation expense of capital assets was $4,047,534 and $1,415,652 for the years ended December 31, 2020 and 2019, respectively.

Construction and other capital commitments – As of December 31, 2020 and 2019, the District spent $419,226,342 and $412,438,343, respectively, related to various construction and other capital projects in progress. As of December 31, 2020 and 2019, the District has outstanding commitments with contractors for approximately $16,039,726 and $46,312,113 related to these projects, respectively.

NOTE 5 – LEASE OF MARIN HEALTHCARE DISTRICT FACILITY

Annual rental payments – Effective December 1, 1985, the District leased the Hospital Facility to MHMC for a term of 30 years pursuant to Section 32126 of the Local Hospital District Law. The lease matured on December 1, 2015, and a new lease was executed in August 2014 with an effective date of December 2, 2015 for a term of 30 years. The base rent is $500,000 annually, plus an annual Consumer Price Index (CPI) increase. Additional rent is conditional on MHMC achieving certain financial benchmarks. The total rent received for the years ended December 31, 2020 and 2019, was $543,991 and $531,124, respectively.

The minimum future rental income under the agreement, exclusive of any increases related to the CPI, is as follows:

Years Ending December 31,	
2021	$ 500,000
2022	500,000
2023	500,000
2024	500,000
2025	500,000
Thereafter	9,958,333
	$ 12,458,333

NOTE 6 – NOTES PAYABLE AND ACQUISITION

In July 2015, in accordance with the agreement between the District and MHMC, MHMC loaned $80,000 to cover the District's payment to a physician who is associated with the Marin Urology Center Clinic. A portion of the loan will be forgiven each month over the five-year term of the contract with the physician. As of January 1, 2019, the balance for the note payable was transferred to MHMN as part of the sale of the Clinics.

In January 2017, in accordance with the agreement between the District and MHMC, MHMC loaned $30,000 to cover the District's payment to a physician who is associated with the Marin Endocrinology Group. A portion of the loan will be forgiven each month over the three-year term of the contract with the physician. As of January 1, 2019, the balance for the note payable was transferred to MHMN as part of the sale of the Clinics.

NOTE 7 – BONDS PAYABLE

On November 10, 2015, the District issued $157,385,000 of Marin Healthcare District General Obligation Bonds, Election of 2013, Series 2015A, and $12,615,000 of Marin Healthcare District General Obligation Bonds, Election of 2013, Series 2015B. The 2015A and 2015B bonds bear interest at rates of 2.00% to 5.00% and 0.40%, respectively. Interest on the bonds will accrue from the date of delivery and is payable semiannually on February 1 and August 1 each year, commencing on February 1, 2016. Principal amounts will be paid on August 1.

On September 7, 2017, the District issued $224,000,000 of Marin Healthcare District General Obligation Bonds, Election of 2013, Series 2017A. The 2017A bonds bear interest at rates of 2.00% to 5.00%. Interest on the bonds will accrue from the date of delivery and is payable semiannually on February 1 and August 1 each year, commencing on February 1, 2018. Principal amounts will be paid on August 1.

The bonds were authorized at an election held in the District on November 5, 2013, at which more than two-thirds of the qualified electors voting on the proposition voted to authorize the issuance and sale of up to $394,000,000 principal amount of general obligation bonds of the District (Measure F). The bond proceeds are authorized to be used to make seismic upgrades to MHMC to meet stricter California earthquake standards; to expand and enhance emergency and other medical facilities; to provide the latest lifesaving medical facilities for treatment of heart, stroke, and other diseases, to reduce emergency room wait times; to improve MHMC and related facilities with new construction, acquisitions, and renovations; and to pay all necessary legal, financial, engineering, and contingent costs in connection therewith.

The Series 2015A Bonds maturing on or before August 1, 2025, are not subject to redemption prior to their respective stated maturity dates. The Series 2015A Bonds maturing on or after August 1, 2026, are subject to redemption prior to their respective stated maturity dates, at the option of the District, from any source of funds, in whole or in part, on August 1, 2025, or on any date thereafter at par amount thereof, without premium, together with interest accrued thereon to the date of redemption. The Series 2015A Bonds maturing on August 1, 2040, and on August 1, 2045, shall be subject to redemption prior to maturity, without a redemption premium, in part by lot, from mandatory sinking fund payments, beginning August 1, 2036, and August 1, 2041, respectively. The Series 2015B Bonds are not subject to redemption prior to maturity.

The Series 2017A Bonds maturing on or before August 1, 2027, are not subject to redemption prior to their respective stated maturity dates. The Series 2017A Bonds maturing on or after August 1, 2028, are subject to redemption prior to their respective stated maturity dates, at the option of the District, from any source of funds, in whole or in part, on August 1, 2027, or on any date thereafter at par amount thereof, without premium, together with interest accrued thereon to the date of redemption.

The District incurred interest costs related to the General Obligation Bonds of $14,313,625 and $14,579,425 for the years ended December 31, 2020 and 2019, respectively. In accordance with GASB 62, the District capitalized $10,431,543 and $11,878,628 in interest for the years ended December 31, 2020 and 2019, respectively, due to the ongoing construction; offset by $185,103 and $2,700,797 of investment gains for the years ended December 31, 2020 and 2019, respectively.

The general obligation bonds represent the general obligation of the District. The Board of Supervisors of the County has the power and is obligated to cause annual ad valorem taxes to be levied upon all property within the District, subject to taxation by the District, and collected by the County for payment, when due, of the principal and interest on the bonds.

The activity for bonds payable for the year ended December 31, 2020 and 2019, was as follows:

	Outstanding December 31, 2019	Issued	Matured / Redeemed During Year	Outstanding December 31, 2020	Due Within One Year
General obligation bonds					
Series 2015 bonds	$ 154,740,000	$ -	$ (190,000)	$ 154,550,000	$ 430,000
Series 2017 bonds	211,305,000	-	-	211,305,000	-
Plus					
Series 2015 premium	7,463,756	-	(296,573)	7,167,183	-
Series 2017 premium	18,072,736	-	(679,852)	17,392,884	-
Total	$ 391,581,492	$ -	$ (1,166,425)	$ 390,415,067	$ 430,000

	Outstanding December 31, 2018	Issued	Matured / Redeemed During Year	Outstanding December 31, 2019	Due Within One Year
General obligation bonds					
Series 2015 bonds	$ 154,740,000	$ -	$ -	$ 154,740,000	$ 190,000
Series 2017 bonds	217,950,000	-	(6,645,000)	211,305,000	-
Plus					
Series 2015 premium	7,760,329	-	(296,573)	7,463,756	-
Series 2017 premium	18,752,588	-	(679,852)	18,072,736	-
Total	$ 399,202,917	$ -	$ (7,621,425)	$ 391,581,492	$ 190,000

A summary of debt service requirements for the next five years and to maturity as of December 31, 2020, is as follows:

Years Ending December 31,	Principal	Interest
2021	$ 430,000	$ 15,286,250
2022	680,000	15,275,500
2023	955,000	15,255,100
2024	1,250,000	15,216,900
2025	1,570,000	15,166,900
2026 – 2030	19,590,000	74,176,500
2031 – 2035	47,115,000	66,964,750
2036 – 2040	84,525,000	54,271,300
2041 – 2045	136,790,000	32,076,450
2046 – 2047	72,950,000	4,435,400
	$ 365,855,000	$ 308,125,050

NOTE 8 – COMMITMENTS AND CONTINGENCIES

Compliance with the Hospital Facilities Seismic Upgrade Act – The District has assumed responsibility for compliance with the Hospital Facilities Seismic Upgrade Act (SB 1953) classification SPC2 and through Hazus 2010. The District has received an extension to 2030.

Regulatory environment – The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations is subject to periodic government review, interpretation, and audits, as well as regulatory actions unknown and unasserted at this time.

Litigation – The District is party to various claims and legal actions in the normal course of business. In the opinion of management, the District has substantial meritorious defenses to pending or threatened litigation and, based upon current facts and circumstances, the resolution of these matters is not expected to have a material adverse effect on the District's financial statements.

Recent Developments – COVID-19 – On March 11, 2020, the World Health Organization declared the outbreak of a novel coronavirus (COVID-19) as a pandemic, and on March 13, 2020, the United States declared the pandemic to be a national emergency. Subsequent to the declaration of a pandemic, a variety of federal, state, and local governments have taken actions in response to the pandemic, which have ranged by jurisdiction, but are generally expected to result in a variety of negative economic consequences, the scope of which are not currently know or quantifiable. The duration and intensity of the impact of the COVID-19 and resulting impact to the District is unknown.

NOTE 9 – RELATED-PARTY TRANSACTIONS

The District had payables of $32,438 and $57,458 due to MHMC, as of December 31, 2020 and 2019, respectively, included in the statements of net position.

The District had payables of $83,697 and $807,034 due to MHMN, as of December 31, 2020 and 2019, respectively, included in the statements of net position. The District had receivables of $0 and $120,788 due from MHMN, as of December 31, 2020 and 2019, respectively, included in the statements of net position.

NOTE 10 – PROPERTY TAXES

The county treasurer acts as an agent to collect property taxes levied in the county for all taxing authorities. Taxes are levied annually on approximately October 1 based upon assessed property values as of January 1 of the preceding year. Assessed values are established by the county assessor at 100% of fair market value. Taxes are due in two equal installments on December 10 and April 10. Collections are distributed as collected to the District by the county treasurer.

The District is permitted by law to levy up to 1% of assessed property values for general district purposes. The District may also levy taxes at a lower rate. Further amounts of tax need to be authorized by the vote of the people.

For 2020 and 2019, the District did not have a regular tax levy. There is a voter-approved tax levy for service of the general obligation bonds. For 2020 and 2019, the tax levy for bond service was $16,497,711 and $11,647,284, respectively.

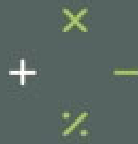
Property taxes are recorded as receivables when levied. Because state law allows for sale of property for failure to pay taxes, no estimate of uncollectible taxes is made.

NOTE 11 – SALE OF CLINICS ASSETS

On January 1, 2019, the District entered into a purchase and sale agreement for $1,054,924 with MHMN for the purchase of capital assets and inventory. The sale resulted in the District recording a $770,096 gain based upon the sale of $269,137 in capital assets, net of accumulated depreciation and inventory of $15,692 as of December 31, 2019. See Note 1 for further information in regards to MHMN assuming control of administrative and operational services of the Clinics.

Furthermore, as part of the District’s lease and operating agreement of the Clinics with MHMC, the District returned $1,000,000 in advanced funds used to operate the Clinics to MHMC as of December 31, 2019. In accordance with the purchase and sale agreement proceeds of $1,054,924 received for the Clinics capital assets and inventory was transferred to MHMC as of December 31, 2019.

Tab 4



Communication with
The Board of Directors

Marin Healthcare District

Years Ended December 31, 2020 and 2019

MOSSADAMS

Communication with The Board of Directors

To the Board of Directors
Marin Healthcare District

We have audited the financial statements of Marin Healthcare District (the "District") as of and for the years ended December 31, 2020 and 2019, and have issued our report thereon dated May XX, 2021. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility Under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated September 15, 2020, our responsibility, as described by professional standards, is to form and express an opinion about whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

Our responsibility is to plan and perform the audit in accordance with auditing standards generally accepted in the United States of America and to design the audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free from material misstatement. An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing 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 over financial reporting. Accordingly, we considered the District's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you with the planning communications letter on December 31, 2020.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. New accounting policies, related to the implementation of GASBTB 2020-1, *Accounting and Financial Reporting Issues Related to the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and Coronavirus Diseases,* and GASB 95 – *Postponement of Dates of Certain Authoritative Guidance,* were adopted and there were no changes in the application of existing policies during the year ended December 31, 2020. We noted no transactions entered into by the District during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

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

- Management's estimate of the useful lives of capital assets based on the intended use. We have evaluated the key factors and assumptions used by management and determined that they are reasonable in relation to the financial statements taken as a whole.

- Management's estimate of the fair market value of the investments are based on a valuation report obtained from a third party. We have evaluated the key factors and assumptions used to develop the estimate in determining that it is reasonable in relation to the financial statements taken as a whole.

For the above estimates, we evaluated the key factors and assumptions used to develop the accounting estimates in determining they are reasonable in relation to the financial statements as a whole.

Financial Statement Disclosures

The disclosures in the financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the financial statements was:

Commitments and Contingencies – Information regarding the District's commitments and contingencies are provided in Note 8 to the financial statements.

Property Taxes – Information regarding the District's property taxes are provided in Note 10 to the financial statements.

Sale of Clinics Assets – Information regarding the District's sale of Clinics assets are provided in Note 11 to the financial statements.

Significant Difficulties Encountered in Performing the Audit

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

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management.

There were no material corrected misstatements.

There were no uncorrected misstatements.

Disagreements with Management

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

Management Representations

We have requested certain representations from management which are included in the attached management representation letter dated May XX, 2021.

Management's Consultations with Other Independent Accountants

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

Other Significant Audit Findings or Issues

We discussed a variety of matters, including the application of accounting principles and auditing standards, with management prior to retention as Marin Healthcare District's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

This information is intended solely for the use of the Board of Directors and management of Marin Healthcare District, and is not intended to be, and should not be, used by anyone other than these specified parties.

Sacramento, California
May XX, 2021

Tab 5

MarinHealth Medical Center

Performance Metrics
and
Core Services Report

Annual Report 2020

May 4, 2021

250 Bon Air Road, Greenbrae, CA 94904 | O 1-415-925-7000

www.mymarinhealth.org

MarinHealth Medical Center (Marin General Hospital)

Performance Metrics and Core Services Report: **ANNUAL REPORT 2020**

TIER 1 PERFORMANCE METRICS

In accordance with Tier 1 Performance Metrics requirements, the MGH Board is required to meet each of the following minimum level requirements:

		Frequency	Status	Notes
(A) Quality, Safety and Compliance	1. MGH Board must maintain MGH's Joint Commission accreditation, or if deficiencies are found, correct them within six months.	Quarterly	In Compliance	Joint Commission granted MGH an "Accredited" decision with an effective date of May 24, 2019 for a duration of 36 months.
	2. MGH Board must maintain MGH's Medicare certification for quality of care and reimbursement eligibility.	Quarterly	In Compliance	MGH maintains its Medicare Certification.
	3. MGH Board must maintain MGH's California Department of Public Health Acute Care License	Quarterly	In Compliance	MGH maintains its license with the State of California.
	4. MGH Board must maintain MGH's plan for compliance with SB 1953.	Quarterly	In Compliance	MGH remains in compliance with SB 1953 (California Hospital Seismic Retrofit Program).
	5. MGH Board must report on all Tier 2 Metrics at least annually.	Annually	In Compliance	4Q 2020 (Annual Report) was presented to MGH Board and to MHD Board in May 2021.
	6. MGH Board must implement a Biennial Quality Performance Improvement Plan for MGH.	Annually	In Compliance	MGH Performance Improvement Plan for 2021 was presented for approval to the MGH Board in March 2021.
	7. MGH Board must include quality improvement metrics as part of the CEO and Senior Executive Bonus Structure for MGH.	Annually	In Compliance	CEO and Senior Executive Bonus Structure includes quality improvement metrics.
(B) Patient Satisfaction and Services	MGH Board will report on MGH's HCAHPS Results Quarterly.	Quarterly	In Compliance	**Schedule 1**
(C) Community Commitment	1. In coordination with the General Member, the MGH Board must publish the results of its biennial community assessment to assess MGH's performance at meeting community health care needs.	Annually	In Compliance	**Schedule 2**
	2. MGH Board must provide community care benefits at a sufficient level to maintain MGH's non-profit tax exempt status.	Quarterly	In Compliance	MGH continues to provide community care and has maintained its tax exempt status.
(D) Physicians and Employees	MGH Board must report on all Tier 1 "Physician and Employee" Metrics at least annually.	Annually	In Compliance	**Schedule 3** **Schedule 4**
(E) Volumes and Service Array	1. MGH Board must maintain MGH's Scope of Acute Care Services as reported to OSHPD.	Quarterly	In Compliance	All services have been maintained.
	2. MGH Board must maintain MGH's services required by Exhibit G to the Loan Agreement between the General Member and Marin County, dated October 2008, as long as the Exhibit commitments are in effect.	Quarterly	In Compliance	All services have been maintained.
(F) Finances	1. MGH Board must maintain a positive operating cash-flow (operating EBITDA) for MGH after an initial phase in period of two fiscal years, and then effective as a performance metric after July 1, 2012, with performance during the phase in period monitored as if a Tier 2 metric.	Quarterly	In Compliance	**Schedule 5**
	2. MGH Board must maintain revenue covenants related to any financing agreements or arrangements applicable to the financial operations of MGH.	Quarterly	In Compliance	**Schedule 5**

MarinHealth Medical Center (Marin General Hospital)

Performance Metrics and Core Services Report: **ANNUAL REPORT 2020**

TIER 2 PERFORMANCE METRICS

In accordance with Tier 2 Performance Metrics requirements, the General Member shall monitor and the MGH Board shall provide necessary reports to the General Member on the following metrics:

		Frequency	Status	Notes
(A) Quality, Safety and Compliance	MGH Board will report on efforts to advance clinical quality efforts, including performance metrics in areas of primary organizational focus in MGH's Performance Improvement Plan (including Clinical Quality Reporting metrics and Service Line Quality Improvement Goals as developed, e.g., readmission rates, patient falls, "never events," process of care measures, adverse drug effects, CLABSI, preventive care programs).	Quarterly	In Compliance	**Schedule 6**
(B) Patient Satisfaction and Services	1. MGH Board will report on ten HCAHPS survey rating metrics to the General Member, including overall rating, recommendation willingness, nurse and physician communication, responsiveness of staff, pain management, medication explanations, cleanliness, room quietness, post-discharge instruction.	Quarterly	In Compliance	**Schedule 1**
	2. MGH Board will report external awards and recognition.	Annually	In Compliance	**Schedule 7**
(C) Community Commitment	1. MGH Board will report all of MGH's cash and in-kind contributions to other organizations.	Quarterly	In Compliance	**Schedule 8**
	2. MGH Board will report on MGH's Charity Care.	Quarterly	In Compliance	**Schedule 8**
	3. MGH Board will maintain a Community Health Improvement Activities Summary to provide the General Member, providing a summary of programs and participation in community health and education activities.	Annually	In Compliance	**Schedule 2**
	4. MGH Board will report the level of reinvestment in MGH, covering investment in excess operating margin at MGH in community services, and covering funding of facility upgrades and seismic compliance.	Annually	In Compliance	**Schedule 5**
	5. MGH Board will report on the facility's "green building" status based on generally accepted industry environmental impact factors.	Annually	In Compliance	**Schedule 9**
(D) Physicians and Employees	1. MGH Board will provide a report on new recruited physicians by specialty and active number of physicians on staff at MGH.	Annually	In Compliance	**Schedule 10**
	2. MGH Board will provide a summary of the results of the Annual Physician and Employee Survey at MGH.	Annually	In Compliance	**Schedule 3** **Schedule 4**
	3. MGH Board will analyze and provide information regarding nursing turnover rate, nursing vacancy rate, and net nursing staff change at MGH.	Quarterly	In Compliance	**Schedule 11**
(E) Volumes and Service Array	1. MGH Board will develop a strategic plan for MGH and review the plan and its performance with the General Member.	Annually	In Compliance	The updated MGH Strategic Plan was presented to the MGH Board on April 17, 2021.
	2. MGH Board will report on the status of MGH's market share and Management responses.	Annually	In Compliance	MGH's market share and management responses report was presented to the MGH Board on March 2, 2021.
	3. MGH Board will report on key patient and service volume metrics, including admissions, patient days, inpatient and outpatient surgeries, emergency visits.	Quarterly	In Compliance	**Schedule 5**
	4. MGH Board will report on current Emergency services diversion statistics.	Quarterly	In Compliance	**Schedule 12**
(F) Finances	1. MGH Board will provide the audited financial statements.	Annually	In Compliance	The MGH 2020 Independent Audit was completed on April 22, 2021.
	2. MGH Board will report on its performance with regard to industry standard bond rating metrics, e.g., current ratio, leverage ratios, days cash on hand, reserve funding.	Quarterly	In Compliance	**Schedule 5**
	3. MGH Board will provide copies of MGH's annual tax return (Form 990) upon completion to General Member.	Annually	In Compliance	The MGH 2019 Form 990 was filed on November 13, 2020.

Schedule 1: HCAHPS

(Hospital Consumer Assessment of Healthcare Providers & Systems)

- **Tier 1, Patient Satisfaction and Services**
  The MGH Board will report on MGH's HCAHPS Results Quarterly.
- **Tier 2, Patient Satisfaction and Services**
  The MGH Board will report on ten HCAHPS survey rating metrics to the General Member, including overall rating, recommendation willingness, nurse and physician communication, responsiveness of staff, pain management, medication explanations, cleanliness, room quietness, post-discharge instruction.

Marin General Hospital
Overall Hospital HCAHPS
Trending by Quarter

Scores displayed here are based on interviews from CMS submitted data for the selected time periods.
Mode adjustments and ESTIMATED Patient Mix Adjustments have been applied to the dimension scores.
Scores for the individual questions do not have adjustments applied.

FFY 2022 VBP Thresholds				Q1 2020	Q2 2020	Q3 2020	Q4 2020
73.37	81.04	87.18	**Overall rating**	**75.53**	**78.89**	**70.37**	**74.40**
			Would Recommend	**82.35**	**79.43**	**75.54**	**78.10**
83.38	88.02	91.73	**Communication with Nurses**	**78.76**	**81.80**	**77.52**	**78.32**
			Nurse Respect	84.40	86.53	84.33	83.87
			Nurse Listen	79.15	80.87	76.08	77.38
			Nurse Explain	72.73	78.00	72.15	73.71
82.52	87.04	90.65	**Communication with Doctors**	**81.23**	**80.26**	**82.10**	**81.60**
			Doctor Respect	84.81	83.95	84.69	87.40
			Doctor Listen	80.99	80.81	82.13	81.10
			Doctor Explain	77.89	76.01	79.46	76.28
66.75	75.27	82.09	**Responsiveness of Staff**	**67.19**	**71.05**	**68.71**	**70.44**
			Call Button	68.53	71.06	66.29	69.27
			Bathroom Help	65.85	71.04	71.12	71.62
65.29	71.25	76.01	**Communication about Medications**	**65.19**	**73.08**	**56.92**	**66.62**
			Med Explanation	81.12	90.74	66.90	78.12
			Med Side Effects	49.26	55.41	46.94	55.12
71.16	78.91	85.11	**Hospital Environment**	**59.47**	**67.18**	**61.00**	**67.17**
			Cleanliness	61.35	68.81	66.21	70.73
			Quiet	57.60	65.54	55.78	63.60
88.82	91.50	93.65	**Discharge Information**	**91.76**	**90.07**	**86.17**	**85.54**
			Help After Discharge	89.55	88.24	83.77	84.32
			Symptoms to Monitor	93.96	91.91	88.56	86.75
52.29	58.63	63.71	**Care Transition**	**52.61**	**50.74**	**47.50**	**44.13**
			Care Preferences	43.96	43.12	39.44	34.30
			Responsibilities	54.29	51.21	47.60	46.37
			Medications	59.57	57.89	55.46	51.71
			Number of Surveys	**288**	**301**	**301**	**254**

Thresholds Color Key:
National 95th percentile
National 75th percentile
National average, 50th percentile

Scoring Color Key:
At or above 95th percentile
At or above 75th percentile
At or above 50th percentile
Below 50th percentile

Official VPB (Value-Based Purchasing) monthly trending HCAHPS results are distributed by MGH Quality Management on the 15th of each month.

Schedule 2: Community Health & Education

- **Tier 1, Community Commitment**
  In coordination with the General Member, the Board must publish the results of its triennial community survey to assess MGH's performance at meeting community health care needs.
- **Tier 2, Community Commitment**
  The Board will maintain a Community Health Improvement Activities Summary to provide the General Member, providing a summary of programs and participation in community health and education activities.

Community Health Improvement Services		
Event	**Description**	**Recipients**
Braden Diabetes Center	Free diabetes support groups, Fall Fest, lunch and learn, National Diabetes Day, education and screenings	General public
Breastfeeding Telephone Support Line	Free education, counseling and breastfeeding support	Breastfeeding women
Integrative Wellness Center	Education and support group events (yoga, healthy weight, Qi Dong, breast cancer support group, etc.)	General public
Community Dietary/Nutrition Telephone Support Line	Free advice line open to the community for nutrition information	General public
Compassionate Discharge Prescriptions and Transportation	Covered cost of discharged medications and transportation for underserved patients	Uninsured patients
COVID-19 Communications	Public information on COVID	General public
Disaster Training	Medical disaster training and first aid	Boy Scouts
Health Connection e-Newsletter and Podcasts	Free monthly newsletter and quarterly podcasts on a variety of health topics	General public
Shuttle Program for Seniors	Free shuttle service for seniors in the Behavioral Health program	Seniors in need
The Mom's Group	Free support group that discusses newborn care, breastfeeding, parenting, etc.	General public
The New Father Class	Free class for new fathers to learn to care for newborns	General public
Transportation	Free transportation	General public

Schedule 2, continued

Health Professions Education		
Event	**Description**	**Recipients**
Grand Rounds	Education programs open to community health providers	Physicians
Nursing Student Supervision	Supervision and training hours	Student Nurses
Nutrition Students	Training hours provided by staff	Dietitian Students
Occupational Therapy Students	Supervision and training hours	Occupational Therapy students
Paramedic Emergency Department Clinical Rotations	Supervision and training hours	Paramedics
Pharmacy Student Clinical Rotations	Supervision and training hours	Pharmacy students
Radiology Student Internships	Supervision and training hours	Radiology students
Respiratory Therapy Student Internships	Supervision and training hours	Respiratory Therapy students

The complete 2020 Annual Community Benefit Report is available at
https://www.mymarinhealth.org/about-us/community-benefit/

Schedule 3: Physician Engagement

- **Tier 1, Physicians and Employees**
  The Board must report on all Tier 1 Physician and Employee Metrics at least annually.
- **Tier 2, Physicians and Employees**
  The Board will provide a summary of the results of the Annual Physician and Employee Survey at MGH.

Overall MarinHealth 2020 Provider Engagement Survey Results
Source: Professional Research Consultants, Inc.

Asked of Providers:
"OVERALL, WOULD YOU RATE THE QUALITY OF CARE AT MARINHEALTH:"

Rank	*# Responses*	*% of Responses*
Excellent	**81** [53 in 2019]	**37%** [27% in 2019]
Very Good	**93** [83 in 2019]	**42%** [42% in 2019]
Good	**34** [44 in 2019]	**15%** [22% in 2019]
Fair	**10** [13 in 2019]	**5%** [7% in 2019]
Poor	**2** [5 in 2019]	**1%** [2% in 2019]

Percentile Ranking: 44th [23rd in 2019]
Total Number of Responses: 220 (51%) [198 in 2019]

Asked of Providers:
"OVERALL, WOULD YOU RATE MARINHEALTH AS A PLACE TO PRACTICE MEDICINE:"

Rank	*# Responses*	*% of Responses*
Excellent	**68** [51 in 2019]	**31%** [26% in 2019]
Very Good	**78** [58 in 2019]	**36%** [29% in 2019]
Good	**44** [48 in 2019]	**20%** [24% in 2019]
Fair	**20** [33 in 2019]	**9%** [17% in 2019]
Poor	**9** [7 in 2019]	**4%** [4% in 2019]

Percentile Ranking: 31st [21st in 2019]
Total Number of Responses: 219 (51%) [197 in 2019]

Schedule 4: Employee Engagement

- **Tier 1, Physicians and Employees**
  The Board must report on all Tier 1 Physician and Employee Metrics at least annually.
- **Tier 2, Physicians and Employees**
  The Board will provide a summary of the results of the Annual Physician and Employee Survey at MGH.

Overall MHMC 2020 Employee Engagement Study Results

Source: MHMC Employee Engagement Pulse Survey

Asked of Employees:
"OVERALL, AS A PLACE TO WORK, WOULD YOU SAY MARINHEALTH MEDICAL CENTER IS:"

Rank	*# Responses*	*% of Responses*
Excellent	**201** [130 in 2019]	**26%** [19% in 2019]
Very Good	**225** [197 in 2019]	**29%** [29% in 2019]
Good	**178** [179 in 2019]	**23%** [26% in 2019]
Fair	**116** [122 in 2019]	**15%** [18% in 2019]
Poor	**54** [61 in 2019]	**7%** [9% in 2019]

Total Number of Responses: 774 (43%) [689 (38%) in 2019]

Schedule 5: Finances

- **Tier 1, Finances**
  The MGH Board must maintain a positive operating cash-flow (operating EBIDA) for MGH after an initial phase in period of two fiscal years, and then effective as a performance metric after July 1, 2012, with performance during the phase in period monitored as if a Tier 2 metric. The MGH Board must maintain revenue covenants related to any financing agreements or arrangements applicable to the financial operations of MGH.
- **Tier 2, Volumes and Service Array**
  The MGH Board will report on key patient and service volume metrics, including admissions, patient days, inpatient and outpatient surgeries, emergency visits.

Financial Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Total 2020
EBIDA $ (in thousands)	(5,163)	(10,182)	(7,977)	519	519
EBIDA %	-4.77%	-5.10%	-2.6%	0.1%	0.1%
Loan Ratios					
Annual Debt Service Coverage	0.18	(1.31)	(0.97)	(0.24)	(0.24)
Maximum Annual Debt Service Coverage	0.15	(1.08)	(0.80)	(0.21)	(0.21)
Debt to Capitalization	51%	52.1%	52.5%	53.2%	53.2%
Key Service Volumes					
Acute discharges	1,930	1,671	1,900	2,006	7,507
Acute patient days	9,705	7,976	9,200	6,381	33,262
Average length of stay	5.03	4.72	4.74	4.43	4.43
Emergency Department visits	6,763	4,833	10,338	7,301	29,235
Inpatient surgeries	375	303	340	375	1,393
Outpatient surgeries	955	505	896	950	3,306
Newborns	263	285	317	281	1,146

Schedule 5, continued

- **Tier 2, Community Commitment**
  The Board will report the level of reinvestment in MGH, covering investment in excess operating margin at MGH in community services, and covering funding of facility upgrades and seismic compliance.

MHMC
Major Capital Expenditure Report
For the period January - December 2020

Major Capital Expenditures	
VAPOTHERM, INC. #40341	105,470
ULTRASOUND FOR 2ND EP LAB PROJECT	117,527
TRIANIM HEALTH SERVICES- PARAPAC PLUS W CASE	126,998
PAGEWRITER TC70 CARDIOGRAPH	131,779
GE HEALTHCARE - CCW SOFTWARE AGREEMENT	133,638
STRYKER MEDICAL PARTS #28337	142,979
GE HEALTHCARE- Quote PR12-C138840	151,760
Parts and Labor to upgrade Generator Control System	158,366
GENEXPERT 6 COLOR Modules	172,106
ADVANCED STERILZATION PRODUTS SRVS	180,477
BRAINLAB INC	186,721
COVIDIEN LP- VENTILATOR	192,623
Philips- Mobile Diagnost cDR Upgrade	195,313
Sonopet IQ Ultrasonic Aspirator Console	219,457
Philips- EPIQ Cvxi Ultrasound System	304,565
KYOCERA DOCUMENT SOLUTIONS	318,879
Banyan Hardware PLUS	366,668
HILL ROM COMPANY	422,528
Philips- Chapter -USMS	535,312
USCAN CAMBO LAB ALTIX UPGRADE	539,571
Banyan Hardware	1,443,333
AZURION 7 M20	1,527,826
DA VINCI ROBOT	1,870,917
Other Capital Projects under $100k	749,133
Total Major Capital Expenditures	10,293,945
Major Construction in Progress Expenditures	
Marin Gastroenterology	108,484
EPIC Conversion	116,081
2020 IT APPLICATION	204,918
75 Rowland Way Optimization	221,272
Redwood Pavilion Central Feed Tank	233,057
2020 IT END USER DEVICES	266,410
Banyan Integration	303,644
Urgent Care/Walk in project	325,535
MGH 2.0 IT Infrastructure	328,402
West Wing Elevator	375,941
2019 Application Upgrades	385,219
Backfill MGH Master Planning	588,643
Capitalized Interest - Series B	924,151
2016 MDF West Wing (closed with 1251.9288)	1,269,878
Capitalized Interest - Series A	2,189,929
2019 Behavioral Health Reclassification	2,305,360
Pyxis Medstation	2,923,542
Other CIP under $100k	617,853
Total Construction in Progress	13,688,319
Total Capital Expenditures	23,982,264

Schedule 6: Clinical Quality Reporting Metrics

- **Tier 2, Quality, Safety and Compliance**
  The MGH Board will report on efforts to advance clinical quality efforts, including performance metrics in areas of primary organizational focus in MGH's Performance Improvement Plan (including Clinical Quality Reporting metrics and Service Line Quality Improvement Goals as developed, e.g., readmission rates, patient falls, "never events," process of care measures, adverse drug effects, CLABSI, preventive care programs).

CLINICAL QUALITY METRICS DASHBOARD

Metrics are publicly reported on

CalHospital Compare (www.calhospitalcompare.org)

and

Centers for Medicare & Medicaid Services (CMS)
Hospital Compare (www.medicare.gov/care-compare/)

MarinHealth Medical Center
CLINICAL QUALITY METRICS DASHBOARD
Publicly Reported on CalHospital Compare (www.calhospitalcompare.org)
and Centers for Medicare & Medicaid Services (CMS) Hospital Compare (www.hospitalcompare.hhs.gov/)

Hospital Inpatient Quality Reporting Program Measures

	METRIC	CMS**	2019	Q1 -2020	Q2 -2020	Q3 -2020	Q4-2020	Q4-2020 Num/Den	Rolling 2020 YTD	2020 YTD Num/Den
	♦ **Stroke Measures**									
STK-4	Thrombolytic Therapy	100%	**94%**	100%	100%	**56%**	100%	1/1	**75%**	12/16
	♦ **Sepsis Measure**									
SEP-01	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	81%	**55%**	**53%**	**58%**	**47%**	**42%**	39/93	**50%**	211/420
	♦ Perinatal Care Measure									
PC-01	Elective Delivery +	0%	**2%**	0%	0%	0%	**4%**	1/24	**1%**	1/92
	♦ **ED Inpatient Measures**									
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients +	99***	**122.00**	**129.00**	**112.00**	**128.00**	**162.00**	63--Cases	**126.50**	584--Cases
	♦ **Psychiatric (HBIPS) Measures**									
IPF-HBIPS-2	Hours of Physical Restraint Use +	0.38	0.15	0.11	0.11	0.01	0.08	N/A	0.08	N/A
IPF-HBIPS-3	Hours of Seclusion Use +	0.29	0.11	0.00	0.99	0.39	0.03	N/A	0.06	N/A
IPF-HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	99%	**96%**	100%	**95%**	**93%**	**79%**	11/14	**92%**	56/61
	♦ **Substance Use Measures**									
SUB-2	2-Alcohol Use Brief Intervention Provided or offered	100%	100%	100%	100%	100%	100%	5/5	100%	10/10
SUB-2a	Alcohol Use Brief Intervention	100%	100%	100%	100%	100%	100%	5/5	100%	10/10
	♦ **Tobacco Use Measures**									
TOB-2	2-Tobacco Use Treatment Provided or Offered	100%	**92%**	100%	100%	**93%**	100%	8/8	**97%**	35/36
TOB-2a	2a-Tobacco Use Treatment	88%	**67%**	100%	100%	**86%**	100%	8/8	94%	33/35
TOB-3	3-Tobacco Use Treatment Provided or Offered at Discharge	99%	**69%**	100%	100%	100%	100%	8/8	100%	33/33
TOB-3a	3a-Tobacco Use Treatment at Discharge	71%	**23%**	**25%**	100%	77%	88%	7/8	79%	26/33
	METRIC	CMS**	2019	Q1 -2020	Q2 -2020	Q3 -2020	Q4-2020	Q4-2020 Num/Den	Rolling 2020 YTD	Rolling Num/Den
	♦ **Transition Record Measures**									
TRSE	Transition Record with Specified Elements Received by Discharged Patients	99%	**93%**	**95%**	**92%**	**92%**	**90%**	127/141	**92%**	487/528
TTTR	Timely Transmission of Transition Record	98%	**91%**	**91%**	**92%**	**91%**	**87%**	122/141	**90%**	476/528
	♦ **Metabolic Disorders Measure**									
SMD	Screening for Metabolic Disorders	Benchmark To Be Established	97%	99%	99%	99%	97%	103/106	98%	363/369
	METRIC	CMS**	2017	2018	2019				2020	Rolling Num/Den
IPF-IMM-2	Influenza Immunization	100%	88%	**98%**	**90%**				**92%**	279/302

** CMS Top Decile Benchmark CMS Reduction Program (shaded in blue) + Lower Number is better

MarinHealth Medical Center
CLINICAL QUALITY METRICS DASHBOARD
Publicly Reported on CalHospital Compare (www.calhospitalcompare.org)
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Hospital Outpatient Quality Reporting Program Measures

	METRIC	CMS**	2019	Q1 -2020	Q2 -2020	Q3 -2020	Q4-2020	Q4-2020 Num/Den	Rolling 2020 YTD	2020 YTD Num/Den
	♦ ED Outpatient Measures									
OP-18	Median Time from ED Arrival to ED Departure for Discharged Patients +	142***	168.50	191	169	166	175	90--Cases	176	369--Cases
	♦ Outpatient Stroke Measure									
OP-23	Head CT/MRI Results for STK Pts w/in 45 Min of Arrival	72%***	85%	86%	50%	50%	33%	1/3	63%	10/16

*** National Average + Lower Number is better

MarinHealth Medical Center
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♦ Healthcare Personnel Influenza Vaccination

	METRIC	CMS National Average	Oct 2014 - Mar 2015	Oct 2016 - Mar 2017	Oct 2016 - Mar 2017	Oct 2017 - Mar 2018
IMM-3	Healthcare Personnel Influenza Vaccination	90%	**81%**	89%	89%	92%

♦ Surgical Site Infection +

	METRIC	National Standardized Infection Ratio (SIR)	Apr 2018 - Mar 2019	July2018 - June 2019	Oc 2018 - Sep 2019	Jan 2019 - Dec 2019
HAI-SSI-Colon	Surgical Site Infection - Colon Surgery	1	not published**	not published**	not published**	0.98
HAI-SSI-Hyst	Surgical Site Infection - Abdominal Hysterectomy +	1	not published**	not published**	not published**	not published**

♦ Healthcare Associated Device Related Infections

	METRIC	National Standardized Infection Ratio (SIR)	Apr 2018 - Mar 2019	July2018 - June 2019	Oc 2018 - Sep 2019	Jan 2019 - Dec 2019
HAI-CLABSI	Central Line Associated Blood Stream Infection (CLABSI)	1	**0.54**	0.57	0.71	0.30
HAI-CAUTI	Catheter Associated Urinary Tract Infection (CAUTI)	1	**0.95**	0.49	0.90	0.98

♦ Healthcare Associated Infections +

	METRIC	National Standardized Infection Ratio (SIR)	Apr 2018 - Mar 2019	July2018 - June 2019	Oc 2018 - Sep 2019	Jan 2019 - Dec 2019
HAI-C-Diff	Clostridium Difficile	1	0.99	**1.01**	**1.22**	**1.18**
HAI-MRSA	Methicillin Resistant Staph Aureus Bacteremia	1	0.00	0.00	0.00	0.00

♦ Agency for Healthcare Research and Quality Measures (AHRQ-Patient Safety Indicators) +

	METRIC	Centers for Medicare & Medicaid Services (CMS) National Average	July 2014 - Sept 2015	Nov 2015 - June 2017	July 2016 - June 2018	July 2017 - June 2019
PSI-90 (Composite)	Complication / Patient Safety Indicators PSI 90 (Composite)	0.9	No different than the National Rate	No different than the National Rate	No different than the National Rate	No different than the National Rate

***** National Average + Lower Number is better**

MarinHealth Medical Center
CLINICAL QUALITY METRICS DASHBOARD
Publicly Reported on CalHospital Compare (www.calhospitalcompare.org)
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	METRIC	Centers for Medicare & Medicaid Services (CMS) National Average	July 2014 - Sept 2015	Nov 2015 - June 2017	July 2016 - June 2018	July 2017 - June 2019
PSI-4	Death Among Surgical Patients with Serious Complications +	136.48 per 1,000 patient discharges	No different then National Average	No different then National Average	No different then National Average	No different then National Average
	♦ Surgical Complications +					
		Centers for Medicare & Medicaid Services (CMS) National Average	**July 2014 - March 2016**	**April 2014 - March 2017**	**April 2015 - March 2018**	**April 2016 - March 2019**
Surgical Complication	Hip/Knee Complication: Hospital-level Risk- Standardized Complication Rate (RSCR) following Elective Primary Total Hip/Knee Arthroplasty +	2.4%	2.7%	2.5%	**2.7%**	**3.0%**
	♦ Acute Care Readmissions - 30 Day Risk Standardized +					
	METRIC	**Centers for Medicare & Medicaid Services (CMS) National Average**	**July 2013- June 2016**	**July 2014- June 2017**	**July 2015 - June 2018**	**July 2016 - June 2019**
READM-30-AMI	Acute Myocardial Infarction Readmission Rate	16.1%	15.20%	14.80%	14.09%	**16.30%**
READM-30-HF	Heart Failure Readmission Rate	21.9%	20.19%	19.80%	20.80%	21.60%
READM-30-PN	Pneumonia Readmission Rate	16.6%	16.80%	15.90%	15.10%	13.80%
READM-30-COPD	COPD Readmission Rate	19.60%	18.70%	**20.49%**	19.20%	19.60%
READM-30-THA/TKA	Total Hip Arthroplasty and Total Knee Arthroplasty Readmission Rate	4.00%	4.00%	4.10%	3.90%	**4.40%**
READM-30-CABG	Coronary Artery Bypass Graft Surgery (CABG)	12.70%	**14.30%**	**13.70%**	**13.80%**	11.70%
READM-30-STR	Stroke Readmission Rate		9.90%	10.40%	Not Published	Not Published
	METRIC	**Centers for Medicare & Medicaid Services (CMS) National Average**	**July 2015 - June 2016**	**July 2016 - June 2017**	**July 2015 - June 2018**	**July 2018 - June 2019**
HWR Readmission	Hospital-Wide All-Cause Unplanned Readmission (HWR) +	15.6%	15.00%	**15.40%**	14.7%	13.7%

MarinHealth Medical Center
CLINICAL QUALITY METRICS DASHBOARD
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and Centers for Medicare & Medicaid Services (CMS) Hospital Compare (www.hospitalcompare.hhs.gov/)

	♦ Mortality Measures - 30 Day +					
	METRIC	**Centers for Medicare & Medicaid Services (CMS) National Average**	**July 2013- June 2016**	**July 2014- June 2017**	**July 2015 - June 2018**	**July 2016 - June 2019**
MORT-30-AMI	Acute Myocardial Infarction Mortality Rate	12.7%	12.90%	12.80%	12.50%	10.90%
MORT-30-HF	Heart Failure Mortality Rate	11.3%	11.70%	10.30%	9.70%	8.00%
MORT-30-PN	Pneumonia Mortality Rate	15.4%	**15.90%**	**15.90%**	15.30%	14.20%
MORT-30-COPD	COPD Mortality Rate	8.40%	7.96%	**9.30%**	**8.80%**	**9.20%**
MORT-30-STK	Stroke Mortality Rate	13.80%	11.70%	12.70%	13.70%	13.60%
CABG MORT-30	CABG 30-day Mortality Rate	3.00%	**3.46%**	**3.60%**	**3.40%**	3.00%
	♦ Cost Efficiency +					
	METRIC	**Centers for Medicare & Medicaid Services (CMS) National Average**	**Jan 2016 - Dec 2016**	**Jan 2017 - Dec 2017**	**Jan 2018 - Dec 2018**	**Jan 2019 - Dec 2019**
MSPB-1	Medicare Spending Per Beneficiary (All)	0.99	**0.99**	0.98	0.97	0.97
			July 2013- June 2016	**July 2014- June 2017**	**July 2015- June 2018**	**July 2016- June 2019**
MSPB-AMI	Acute Myocardial Infarction (AMI) Payment Per Episode of Care	$25,526	$21,192	$21,274	$23,374	**$27,327**
MSPB-HF	Heart Failure (HF) Payment Per Episode of Care	$17,670	**$16,904**	**$16,632**	$16,981	$17,614
MSPB-PN	Pneumonia (PN) Payment Per Episode of Care	$18,322	**$17,429**	**$17,415**	$17,316	$17,717
	METRIC	**Centers for Medicare & Medicaid Services (CMS) National Average**		**July 2013 - June 2016**	**April 2014 - March 2017**	**April 2015 - March 2018**
MSPB-Knee	Hip and Knee Replacement	$20,959		$22,502	$21,953	$20,263

***** National Average + Lower Number is better**

MarinHealth Medical Center
CLINICAL QUALITY METRICS DASHBOARD
Publicly Reported on CalHospital Compare (www.calhospitalcompare.org)
and Centers for Medicare & Medicaid Services (CMS) Hospital Compare (www.hospitalcompare.hhs.gov/)

♦ Outpatient Measures (Claims Data) +

	METRIC	Centers for Medicare & Medicaid Services (CMS) National Average	July 2015 - June 2016	July 2016 - June 2017	July 2017 - June 2018	July 2018 - June 2019
OP-8	Outpatient with Low Back Pain who had an MRI without trying Recommended Treatments First, such as Physical Therapy	38.20%	Not Available	Not Available	Not Available	Not Available
OP-9	Outpatient who had Follow-Up Mammogram, Ultrasound, or MRI of the Breast within 45 days following a Screening Mammogram	8.90%	6.80%	7.00%	6.80%	Not Published
OP-10	Outpatient CT Scans of the Abdomen that were “Combination” (Double) Scans	6.40%	5.60%	4.80%	4.50%	6.10%
OP-11	Outpatient CT Scans of the Chest that were “Combination” (Double) Scans	1.40%	0.10%	0.20%	0.20%	Not Published
OP-13	Outpatients who got Cardiac Imaging Stress Tests Before Low-Risk Outpatient Surgery	4.20%	3.30%	3.50%	3.20%	3.20%
OP-14	Outpatients with Brain CT Scans who got a Sinus CT Scan at the Same Time	1.20%	0.40%	0.40%	0.30%	Not Published
	METRIC	**Centers for Medicare & Medicaid Services (CMS) National Average**	**Jan 2014 - Dec 2014**	**Jan 2015 - Dec 2015**	**Jan 2016 - Dec 2016**	**Jan 2018 Dec 2018**
OP-22	Patient Left Emergency Department before Being Seen	2.00%	1.00%	1.00%	1.00%	2.00%

+ Lower Number is better

Schedule 7: External Awards & Recognition

- **Tier 2, Patient Satisfaction and Services**
  The Board will report external awards and recognition.

External Awards and Recognition – 2020
Healthgrades: *America's 100 Best Hospitals for Cardiac Care & Cardiac Care Excellence Award. Five-Star Distinctions in: treatment of pneumonia for 4 years in a row, treatment of sepsis for 9 years in a row, treatment of heart failure for 3 years in a row, coronary intervention procedures, treatment of heart attack, hip fracture treatment, spinal fusion surgery, and treatment of diabetic emergencies.*
American Heart/Stroke Association: *Get With the Guidelines-Stroke Gold Plus Quality Achievement Award (2011-2020)*
Emergency Nurses Association: *Lantern Award for demonstrating exceptional and innovative performance in leadership, practice, education (2018 – 2021)*
American College of Surgeons: *Level III Trauma Center Verification (2019 – 2021)*
Intersocietal Accreditation Commission: *3-Year Echocardiography Accreditation (2018 – 2021)*
The Joint Commission: *Primary Stroke Center Certification (2018-2020); Gold Seal of Approval (2019-2022)*
Commission on Cancer: *3-Year Accreditation with Commendation (2020 – 2023)*
United Nations International Children's Fund/World Health Organization: *Baby Friendly Designation (2017 – 2022)*
The National Accreditation Program for Breast Centers: *Breast Center Accreditation (2019-2022)*
California Medical Association Institute for Medical Quality: *Accreditation of Continuing Medical Education (2020 – 2024)*
Blue Distinction: *Center for Maternity Care (2020)*
American Health Association: *Type II Diabetes Honor Roll (2020)*
BETA Healthcare Group: *Excellence in OR (2014-2020)*
California Department of Public Health: *Antimicrobial Stewardship Honor Roll (2020-2022)*
Marin County Emergency Medical Services Agency: *MarinHealth Medical Center has earned the esteemed designation of an Emergency Department Approved for Pediatrics (EDAP) from Marin County Emergency Medical Services Agency.*
The Pacific Sun: *Best Local Hospital (2020)*
Marin Independent Journal: *Reader's Choice Award for Best Hospital (2020)*

Schedule 8: Community Benefit Summary

- **Tier 2, Community Commitment**
  The Board will report all of MGH's cash and in-kind contributions to other organizations.
  The Board will report on MGH's Charity Care.

Cash & In-Kind Donations
(These figures are not final and are subject to change)

	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Total 2020
Brain Injury Network (Schurig Center)	$ 1,050	0	0	0	$ 1,050
Buckelew	26,250	0	0	0	26,250
Community Action Marin	10,500	0	0	0	10,500
Community Institute for Psychotherapy	15,750	0	0	0	15,750
ExtraFood.org	0	0	0	5,250	5,250
Homeward Bound	157,500	0	0	0	157,500
Hospice by the Bay	0	0	0	5,250	5,250
Huckleberry Youth Programs	10,500	0	0	0	10,500
Jewish Family and Children's Services	10,500	0	0	0	10,500
Marin Center for Independent Living	26,250	0	0	0	26,250
Marin Community Clinics	105,000	0	0	0	105,000
MHD 1206B Clinics	6,524,273	8,692,426	5,623,735	7,063,036	27,903,470
North Marin Community Services	10,500	0	0	0	10,500
Operation Access	21,000	0	0	0	21,000
Ritter Center	26,250	0	0	0	26,250
RotaCare Free Clinic	15,750	0	0	0	15,750
San Geronimo Valley Community Center	5,250	0	0	0	5,250
Spahr Center	15,750	0	0	0	15,750
Summer Solstice	2,153	0	0	0	2,153
West Marin Senior Services	10,500	0	0	0	10,500
Whistlestop	15,750	0	0	0	15,750
Total Cash Donations	**$ 7,020,976**	**$ 8,692,426**	**$ 5,623,735**	**$ 7,073,536**	**$ 28,410,673**
Meeting room use by community based organizations for community-health related purposes.	2,781	0	0	0	2,781
Food donations	987	987	987	987	3,948
Total In Kind Donations	**$ 15,521**	**$ 15,338**	**$ 13,140**	**$ 11,005**	**$ 55,004**
Total Cash & In-Kind Donations	**$ 7,036,497**	**$ 8,707,764**	**$ 5,636,875**	**$ 7,084,541**	**$ 28,465,677**

Schedule 8, continued

Community Benefit Summary

(These figures are not final and are subject to change)

	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Total 2020
Community Health Improvement Services	$ 86,116	$ 62,009	$ 62,696	$ 653,850	$ 64,671
Health Professions Education	517,015	350,811	81,714	692,763	1,642,303
Cash and In-Kind Contributions	7,036,497	8,707,764	5,636,875	7,084,541	28,465,677
Community Benefit Operations	6,300	5,513	7,225	5,942	24,980
Community Building Activities	0	0	0	0	0
Traditional Charity Care **Operation Access total is included*	470,995	289,175	388,929	280,379	1,429,478
Government Sponsored Health Care *(includes Medi-Cal & Means-Tested Government Programs)*	6,784,847	6,734,333	8,794,129	7,912,832	30,226,141
Community Benefit Subtotal (amount reported annually to State & IRS)	**$14,901,770**	**$16,149,605**	**$14,971,568**	**$16,630,307**	**$ 62,653,250**
Unpaid Cost of Medicare	20,131,921	16,777,396	18,216,928	16,527,290	71,653,535
Bad Debt	550,915	428,464	408,548	422,359	1,810,286
Community Benefit, Community Building, Unpaid Cost of Medicare and Bad Debt Total	**$35,584,606**	**$33,355,465**	**$33,597,044**	**$33,579,956**	**$136,117,071**

Operation Access

Though not a Community Benefit requirement, MHMC has been participating with Operation Access since 2000. Operation Access brings together medical professionals and hospitals to provide donated outpatient surgical and specialty care for the uninsured and underserved.

	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Total 2020
*Operation Access charity care provided by MHMC (waived hospital charges)	$ 5,513	$ 191,460	$ 754,668	$ 201,852	$ 1,153,493
Costs included in Charity Care	966	33,567	131,784	35,389	201,706

Schedule 9: "Green Building" Status

- **Tier 2, Community Commitment**
  The Board will report on the facility's "green building" status based on generally accepted industry environmental impact factors.

Leadership in Energy and Environmental Design (LEED)

Leadership in Energy and Environmental Design (LEED) is a third-party nationally accepted certification program that consists of a suite of rating systems for the design, construction and operation of high performance "green buildings." This ensures that the buildings are environmentally compatible, provide a healthy work environment, and are profitable.

LEED-certified buildings are intended to use resources more efficiently when compared to conventional buildings simply built to code. LEED-certified buildings often provide healthier work and living environments, which contributes to higher productivity and improved employee health and comfort.

MHMC LEED Status
MGH Hospital Replacement Project is registered with the United States Green Building Council (USGBC) as a New Construction Project
MGH Hospital Replacement Project has retained Thornton Tomasetti, specializing in LEED requirements
All key members of the Design Team are LEED certified
Through Construction Documents of the Hospital Replacement Project, the Project has maintained LEED Silver status

Schedule 10: Physicians on Staff

- **Tier 2, Physicians and Employees**
  The Board will provide a report on new recruited physicians by specialty and active number of physicians on staff at MGH.

As of December 31, 2020, there were a total of 554 physicians on MHMC staff:

- 253 Active
- 52 Consulting
- 20 Courtesy
- 52 Office-Based
- 119 Provisional
- 6 Telemedicine
- 52 Allied Health Professionals

New Physician Appointments January 1, 2020 – December 31, 2020				
	Name		Appointment Date	Specialty
1	Abadie	Brianna	7/28/2020	Rad-Telemedicine
2	Aharonian	Artin	1/28/2020	Rad-Telemedicine
3	Al-Balas	Hassan	1/28/2020	Rad-Telemedicine
4	Aldahhan	Nadine	1/28/2020	Family Medicine
5	Anand	Neil	1/28/2020	Rad-Telemedicine
6	Bajwa	Meera	7/28/2020	Med-Nephrology
7	Benedict	Matthew	7/28/2020	Rad-Telemedicine
8	Blanchard	Julie	3/24/2020	PA-Physician Assistant
9	Burch	Shane	3/24/2020	Orthopedic Surgery
10	Chen	Henry	7/28/2020	Radiology
11	Coast	Reed	2/25/2020	Surg-Podiatry
12	Colby	John	7/28/2020	Radiology
13	Coll	Jonathan	1/28/2020	Rad-Telemedicine
14	Conte	Michael	1/28/2020	Surg-Vascular
15	Curran	Shannon	2/25/2020	Surg-Podiatry
16	Davies	Laura	7/28/2020	Psychiatry
17	DeSon	Amanda	8/25/2020	OBGYN
18	Desruisseau	Andrew	1/28/2020	Med-Infectious Disease
19	Doan	Lien	7/28/2020	Rad-Telemedicine
20	Douglas	Trent	1/28/2020	Surg-Plastic
21	Drotman	Spencer	5/26/2020	Anesthesiology
22	Duggirala	Chandra	5/26/2020	Hospital Medicine
23	Edwards	Sara	11/24/2020	Orthopedic Surgery
24	Eichler	Charles	4/28/2020	Surg-Vascular
25	Evitts	Matthew	10/27/2020	Rad-Telemedicine

Schedule 10, continued

26	Farrell	Robert	1/28/2020	Rad-Telemedicine
27	Frederiksen	Ryan	1/28/2020	Rad-Telemedicine
28	Frencher	James	7/28/2020	Rad-Telemedicine
29	Furubayashi	Jill	1/28/2020	Rad-Telemedicine
30	Garcia-Rojas	Xavier	1/28/2020	Rad-Telemedicine
31	Gasper	Warren	1/28/2020	Surg-Vascular
32	Gaudet	Ross	1/28/2020	Anesthesiology
33	Gin	Amy	4/28/2020	Cardiovascular Services
34	Gore	Nikita	9/29/2020	Family Medicine
35	Green	Deanna	3/24/2020	Med-Internal Medicine
36	Higgins	Brennan	8/25/2020	Pedi-Hospitalist
37	Hobart	Edward	1/28/2020	Rad-Telemedicine
38	Hollis	Richard	7/28/2020	Rad-Telemedicine
39	Hwang	Janice	1/28/2020	Rad-Telemedicine
40	Iannuzzi	James	1/28/2020	Surg-Vascular
41	Jamison	Emma	9/29/2020	OBGYN
42	Jang	Brittany	5/26/2020	PA-Physician Assistant
43	Johnk	Dorien	3/24/2020	PA-Physician Assistant
44	Joshi	Sonali	11/24/2020	Anesthesiology
45	Karachalios	Michael	1/28/2020	Rad-Telemedicine
46	Kato	Kambrie	1/28/2020	Rad-Telemedicine
47	Kazem	Fatima	1/28/2020	Rad-Telemedicine
48	Klenow	Megan	4/28/2020	Pedi-Hospitalist
49	LaBourene	Jay	12/1/2020	Surg-Cardiothoracic
50	Leal	Deborah	1/28/2020	RNP-Nurse Practitioner
51	Lee	David	1/28/2020	Rad-Telemedicine
52	Lin	Michael	7/28/2020	Rad-Telemedicine
53	Lorents	Evelyn	1/28/2020	Rad-Telemedicine
54	Lotan	Roi	1/28/2020	Rad-Telemedicine
55	Macari	Candice	9/29/2020	PA-Physician Assistant
56	MacPherson	Liane	10/27/2020	CNM
57	Martin	Andrew	1/28/2020	Rad-Telemedicine
58	Martinez	Marisol	1/28/2020	PA-Physician Assistant
59	Meckel	Moya	2/25/2020	RNP-Nurse Practitioner
60	Mischiu	Oana	7/28/2020	Rad-Telemedicine
61	Newhauser	Nicole	10/27/2020	PA-Physician Assistant
62	Obembe	Olufolajimi	1/28/2020	Rad-Telemedicine
63	Peel	Avanee	7/28/2020	Rad-Telemedicine
64	Peysakhovich	Anya	9/29/2020	PA-Physician Assistant
65	Pollock	Max	1/28/2020	Rad-Telemedicine
66	Riad	Shareef	1/28/2020	Rad-Telemedicine

Schedule 10, continued

67	Roeder	Zachary	1/28/2020	Rad-Telemedicine
68	Santiago	Jayson	3/24/2020	RNP-Nurse Practitioner
69	Schoellerman	Manal	1/28/2020	Rad-Telemedicine
70	Segev	Tamar	4/28/2020	OBGYN
71	Shah	Vatsal	9/29/2020	Hospital Medicine
72	Sherifi	Ines	2/25/2020	Cardiovascular Services
73	Shukla	Pinak	7/28/2020	Orthopedic Surgery
74	Simpson	Dustin	1/28/2020	Rad-Telemedicine
75	Slayden	Edward	4/28/2020	Hospital Medicine
76	Sloan	Steven	10/27/2020	Surg-Otolaryngology
77	Smith	Peter	7/28/2020	Radiology
78	Sohal	Ravinder	10/27/2020	Rad-Telemedicine
79	St. Germain	Sunny	10/27/2020	RNP-Nurse Practitioner
80	Sternbach	Joshua	7/28/2020	Med-eICU Intensivist
81	Thalken	Gregory	1/28/2020	Rad-Telemedicine
82	Thomson	Matthew	1/28/2020	Rad-Telemedicine
83	Tjerandsen	Carl	5/26/2020	PA-Physician Assistant
84	Tkac	Anthony	5/26/2020	PA-Physician Assistant
85	Tran	Michelle	10/27/2020	RNP-Nurse Practitioner
86	Uzquiano	Nelson	3/24/2020	Rad-Telemedicine
87	Vila	Molly	11/24/2020	Anesthesiology
88	Vila	Peter	11/24/2020	Surg-Otolaryngology
89	Vridhachalam	Sanjeevi	1/28/2020	Rad-Telemedicine
90	Ward	Derek	4/28/2020	Orthopedic Surgery
91	Wu	I-Kung	7/28/2020	Med-Phys Med & Rehab
92	Yamamoto	Shota	1/28/2020	Rad-Telemedicine
93	Yuen	Edwin	8/25/2020	Hospital Medicine
94	Yuh	Theresa	1/28/2020	Rad-Telemedicine
95	Zhang	Lucy	1/28/2020	Surg-Ophthalmology
96	Ziolkowski	Susan	2/25/2020	Med-Nephrology

Schedule 11: Nursing Turnover, Vacancies, Net Changes

- **Tier 2, Physicians and Employees**
  The MGH Board will analyze and provide information regarding nursing turnover rate, nursing vacancy rate, and net nursing staff change at MGH.

Turnover Rate

Period	Number of Clinical RNs	Separated		Rate
		Voluntary	Involuntary	
Q1 2020	523	23	1	4.59%
Q2 2020	531	11	1	2.26%
Q3 2020	521	17	8	4.80%
Q4 2020	515	19	1	3.88%

Vacancy Rate

Period	Open Per Diem Positions	Open Benefitted Positions	Filled Positions	Total Positions	Total Vacancy Rate	Benefitted Vacancy Rate of Total Positions	Per Diem Vacancy Rate of Total Positions
Q1 2020	20	67	523	610	14.26%	10.98%	3.28%
Q2 2020	17	62	531	610	12.95%	10.16%	2.79%
Q3 2020	22	72	521	610	14.59%	11.80%	3.61%
Q4 2020	24	75	515	610	15.57%	12.30%	3.93%

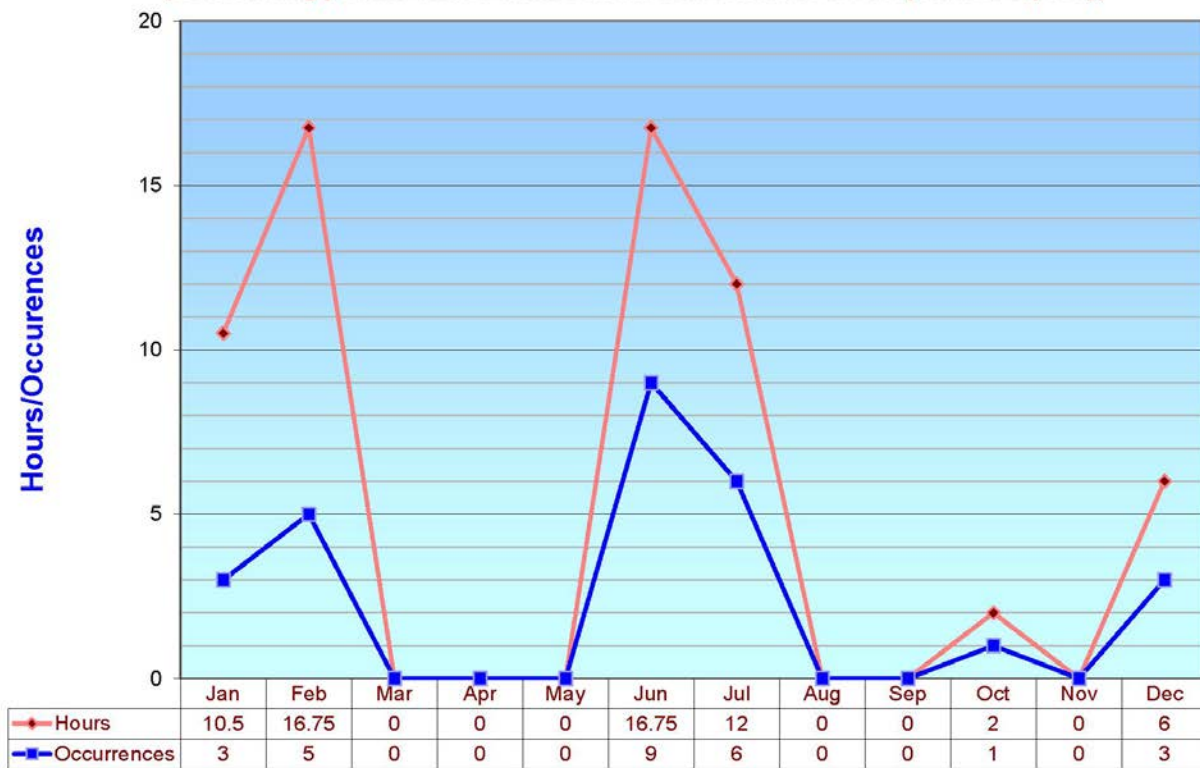
Hired, Termed, Net Change

Period	Hired	Termed	Net Change
Q1 2020	8	24	(16)
Q2 2020	21	12	9
Q3 2020	11	25	(14)
Q4 2020	15	20	(5)

Schedule 12: Ambulance Diversion

- **Tier 2, Volumes and Service Array**
  The MGH Board will report on current Emergency services diversion statistics.

Quarter	Date	Time	Diversion Duration	Reason	Waiting Room Census	ED Admitted Patient Census
Q4 2020	Oct 4	17:59	2’01”	ED	18	6
	Dec 15	19:22	2’01”	ED	15	9
	Dec 24	03:08	2’01”	ED	2	7
	Dec 26	16:12	2’01”	ED	15	9



Tab 6

Marin Healthcare District

2020 ANNUAL REPORT

DISTRICT HEALTH NEWS

Marin Healthcare District. Creating a Healthier Marin Together.

Dear Friends, Neighbors, and Community Members,

2020 was a challenging year for the country, our community, and our hospital. I joined MarinHealth® in the middle of the pandemic, just in time for the opening of our new building. I've presided over the launch of three new hospitals in my career, but I'm proud to say our Oak Pavilion is by far the most state of the art. Our first day exceeded our expectations. Care teams were in the building and ready to get to work an hour and a half ahead of schedule, and we delivered our first baby that very day!

Since my first week on the job, I was proud to join Marin Healthcare District Board's COVID-19 Task Force, created to assess and address the community's most pressing COVID-19 related needs. We have supported a variety of key initiatives, including:

- **Triage kits** for those quarantining at home to measure their oxygen saturation and temperature
- **Personal protective equipment (PPE) and staffing personnel** for skilled nursing and residential facilities in the event of an outbreak
- **Temporary housing for COVID-19 patients** whose living situation makes it impossible for them to isolate
- **Contact tracing**
- **Population antibody testing**
- **Mobile testing centers**
- **Community vaccination clinics**

Meanwhile, I have been working with the Marin Healthcare District Board and the MarinHealth Medical Center Board to develop a new strategic plan. Some of the topics being explored include growth opportunities within our current services, potential future offerings, physician recruitment, and finding new ways to leverage our alliance with UCSF Health.

In closing, I'd like to share how pleased I am to be a part of MarinHealth. As an independent hospital with a great track record and a strong academic affiliation, we are in a position to adjust quickly to changing community needs. I look forward to a brilliant future for our hospital, our medical network, and this wonderful community.

Sincerely,

David G. Klein, MD, MBA

Chief Executive Officer

Marin Healthcare District Board of Directors

The residents of the District elect the directors of Marin Healthcare District at large. Directors serve four-year terms.

Current board members

Jennifer Rienks, PhD
Chair

Brian W. Su, MD
Vice-Chair

Ann Sparkman, RN/BSN, JD
Secretary

Edward J. Alfrey, MD
Director

Larry Bedard, MD
Director

Contact Us

1-415-464-2090
info@MarinHealthcare.org
www.MarinHealthcare.org

Putting Our COVID-19 Task Force to the Test

On April 5, 2020, our Marin Healthcare District Board of Directors declared a state of emergency in the District and voted to commit funds to help protect the health of our community during the COVID-19 pandemic. In order to assess pandemic-related needs and make funding recommendations, we formed a COVID-19 Task Force.

We implemented a wide range of measures, but testing quickly emerged as a clear and pressing need, particularly in group housing situations. To address that, we established mobile testing "centers"– vans equipped with testing materials and personal protective equipment (PPE). Each mobile center is staffed by one physician plus three physician extenders (nurse practitioners and/or physician assistants). Now, we are able to regularly test residents and staff members of Marin's 10 skilled nursing facilities, 50 residential care facilities for the elderly, and 2 behavioral health facilities. Regular repeat testing at these facilities will be conducted throughout the pandemic to help us get ahead of any potential outbreaks.

There have been areas of outbreak among the homeless and in underserved communities such as Marin City and the Canal area in San Rafael. We have deployed mobile testing centers to these communities.

COMMUNITY HEALTH SEMINARS

Information and Education for Healthy Living

Our ongoing Health Seminars are designed to help keep the community informed on valuable health topics. We started our 2020 series with *Women and Cardiometabolic Health*, which focused on the number one cause of death in US women: heart disease. Attendees learned about cardiometabolic risk factors and their role in increasing a woman's risk for vascular events and/or developing diabetes.

After that popular seminar, we adjusted our program to keep people informed about COVID-19. Our June lecture, *COVID-19*: *What is Happening & How Is Marin Responding?* focused on the surge in new COVID-19 cases that Marin was experiencing at the time. We presented timely information on the pandemic, our community response, and how to best protect oneself from exposure to the virus. Our September lecture, *The Latest on COVID-19 in Marin*, provided an update on the latest science and safety measures.

Visit www.MarinHealthcare.org for the most up-to-date information on our seminar series.

New Oak Pavilion Takes Healthcare to the Next Level

As Marin's only full-service, acute-care hospital, MarinHealth Medical Center has always been the community's premier healthcare resource.

With its beautiful healing environment, smart technologies, and top-of-the-line equipment, the new Oak Pavilion has enhanced patient care, comfort, and safety in a multitude of ways:

- The Emergency Department (ED) & Trauma Center receives 70% of the county's ambulance traffic and provides lifesaving stroke and heart attack care. The new ED is three times the size of the old one, with five trauma bays and 20 private patient rooms, including negative pressure and decontamination rooms to safely care for infectious patients. There is a separate entrance and treatment area for psychiatric, and high-security patients, and a dedicated check-in and waiting area for children.

©2021 Tim Griffin

Multiplaform procedure room

Exterior view of the Emergency Department

- The Intensive Care Unit (ICU) has 19 spacious private rooms, each with its own private bathroom. ICU rooms have lifts to safely move patients on and off the bed. Special e-ICU technology allows patients and providers to communicate virtually if needed.

- Imaging & Radiology is equipped with the most advanced X-ray, CT, MRI, molecular imaging, and ultrasound equipment, all coupled with state-of-the-art computer technology. The department's new central location makes it much easier for radiologists to collaborate with the emergency, surgery, and intensive care Departments.

- Surgery & Procedures boasts three large new operating rooms with plenty of space to accommodate the latest equipment. Two of these rooms can be equipped for robotic surgery with the latest-generation da Vinci Xi® surgical system. Three additional multiuse suites can be used for both traditional surgery and interventional procedures such as electrophysiology, cardiac catheterization, and interventional radiology. There is also a specially equipped Heart Room for open cardiovascular surgeries.

- Maternity Care features 15 large all-private labor, delivery, recovery, and postpartum (LDRP) rooms with private baths, allowing mothers and babies to stay in the same place throughout labor and delivery. Two side-by-side C-section procedure rooms are aways at the ready for planned or emergency cesareans, with an operating team onsite 24/7. The new Level II NICU has seven private patient rooms and is staffed around-the-clock with an in-house pediatric hospitalist who specializes in neonatology. Newborns and their families also have 24-hour access to neonatologists from UCSF Benioff Children's Hospital.

One of our spacious maternity LDRP rooms

Find a clinic in a city near you!

Great care for every part of you in every part of the North Bay.

Marin is renowned for its natural beauty, active lifestyle,and health-conscious community. To help you get and stay healthy, MarinHealth | UCSF Health Clinics offer access to expert specialists and primary care providers throughout the North Bay.

Santa Rosa
Vascular Medicine

Petaluma
Urology

Sonoma
Cardiovascular Medicine
Orthopedic Surgery
Pediatric Care
Primary Care
Urogynecology
Urology
Vascular Medicine

Napa
Cardiovascular Medicine
Urology

Novato
Adult Acute Care
Cardiovascular Medicine
Cardiovascular Performance Center
Endocrine & Diabetes Care
Family Medicine
General Surgery
Internal Medicine
Neurology
Obstetrics, Gynecology & Midwifery
Orthopedic Surgery
Primary Care
Psychiatry
Rheumatology
Urogynecology
Urology
Vascular Medicine

San Rafael
Family Medicine
Pediatric Care
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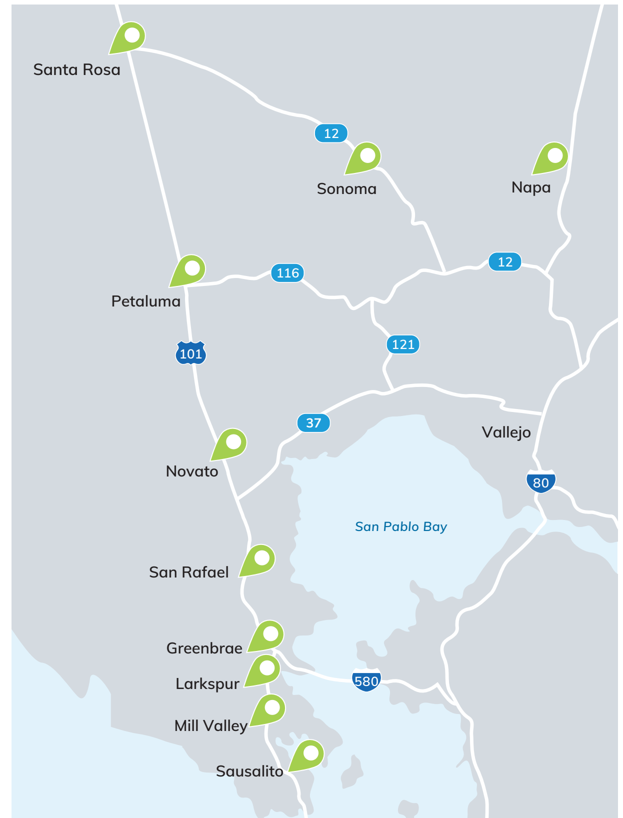

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Tab 7

Session 3: Board Orientations Discussion Guide

Watch the **Board Orientations** Webinar Here

Download the Session Slides Here

Prepared by
James A. Rice, Ph.D.
Brian E. Rice, MHA

Series Preface:

This discussion guide is part of an "**ACHD Governance Toolkit**" composed of a series of six recorded webinars organized by the Association of California Healthcare District (ACHD) to encourage and support healthcare district boards of directors to further enhance the performance of their governance models and practices. The six topics addressed are:

1. Community Engagement
2. Balancing Governance & Management
3. Board Orientations
4. Strategic Planning
5. Board Self-Assessments
6. Board Education Programming

The six programs consist of an approximately 15-minute video with a downloadable slide deck, and a short discussion guide to stimulate healthy conversations between the CEO and the board about practical ways they can collaborate for more effective and efficient board decision making in each topic. The programs are also intended to help encourage healthcare districts to consider the successful completion of ACHD Certification.

The ACHD Certified Healthcare District Program promotes good governance for healthcare districts by creating a core set of accountability and transparency standards. This core set of ACHD standards is known as *Best Practices in Governance* and districts that demonstrate compliance are designated by ACHD as a **Certified Healthcare District** for a period of three years. Find more information on our website.

ACHD Governance Toolkit

Each of the six webinars can be optimized when the Board Chair and CEO collaborate to organize a five-step program of education for the coming year.

The five-step process for your board-CEO conversation to address these topics is suggested to be:

1. The CEO and Board Chair reaffirm their shared commitment to the continuous enhancement of the board's education and capacity development. Jointly express this commitment at the beginning of each year.
2. Adopt a board policy of continuous board development that embraces:
    - Periodic CEO briefing materials on topics relevant to the strategic plans and challenges of the healthcare district.
    - A calendar of speakers in routine board meetings on hot topics to help the district's vitality.
    - Organization of a "Symposium" on board best practices with other community organizations and associations for joint learning and community leader networking.
    - Participation in small groups of district board members at ACHD or other state conferences on strategic issues and trends.
    - Organization of customized educational readings or mentors for each board member based on their unique needs and requests.
3. Organize a 30-minute educational session during a Spring and Fall board meeting to focus on one or more of the six Webinar topics. Ask one board member to team with a member of management and/or the staff to jointly present and help guide the discussion around the webinar and this Discussion Guide. This team approach helps build interest, ownership and shared responsibility among the board for its ongoing development.
4. Encourage all board members to watch to the short video recording of the webinar before the scheduled discussion session. All should come to the discussion session ready to contribute in these ways:
    - Assess how well this topic is being addressed in your healthcare district;
    - Bring questions and ideas about how your district might better address this topic in the future; and
    - Bring some suggested resources that might help your healthcare district enhance its learning and planning for this topic.
5. Conduct a collegial assessment of each program to see how its value to your district could best be optimized in the coming year. Share your ideas with the ACHD staff.

Thank you again for all you do for the people of your healthcare district, and for the enhanced performance of your healthcare district board work!

Contact ACHD staff at any time with questions, or contact us at jim_rice@governakadimi.org

Let's begin moving though this discussion guide.

Board Orientations

Introduction

Thank you for your interest in exploring how your healthcare district board might better understand and develop its capacity for enhanced ***board orientations***. We know that effective and timely board orientations lead to enhanced board effectiveness, a more efficient decision-making process with better results, and expanded board member pride.

This discussion guide is not a stand-alone document. The guide is to be used in conjunction with the corresponding **recorded webinar** and **slide deck**. We encourage your board and CEO to collaborate in conversations and shared strategic thinking and planning to support your board members, individually and collectively, to be more effective in establishing and nurturing ***new strategies and structures for more interesting and effective board orientations.***

This discussion guide is organized to answer these questions:

- What is a "board orientation"?
- Why is a good orientation important?
- Common issues or challenges?
- What can boards do to be more successful?
- Where to secure resources for further educational insights on this topic?

Within each of these five sections, we pose a series of questions to guide your conversations about how best to develop board orientations as a means to accomplish the mission of your healthcare district.

1. What is a "board orientation"?

Elected healthcare district board members want to do their board work wisely and well, as soon as they are elected to serve. Unfortunately, some districts have not recently updated their orientation process or program materials. A good orientation program helps the board member understand the scope and nature of their role and responsivities within the unique context found at the intersection of the board's culture and bylaws, the California Brown Act, and regulatory guidelines from state and federal payers. Our work with healthcare district boards suggests a good orientation has at least these five characteristics:

- **Prompt:** The orientation should be conducted within 30 days of being sworn into board service
- **Professional**: The onboarding process should have orientation content that is tied to the board member's job description, plans, and "Authority Matrix" adopted by the healthcare district. It usually involves a tour of district facilities and the organization's strategic plans.
- **Promotional**: The orientation should focus on work that enables the board member to be an effective champion for the mission/vision of the healthcare district.
- **Packaged:** The orientation process needs to accommodate the needs of each unique member; utilize multi-media, modular content, and multiple speakers. It should not just be the CEO that welcomes and orients the new board member to their work and service in the governance of the healthcare district.
- **Passionate**: To avoid the orientation process becoming flat, dull or boring, the program should weave in stories that humanize and personalize the work of the board to the needs of real people that are being met by real people employed by the district.

We encourage the continuous improvement of your board orientation process and content by asking and answering these questions:

- When and how was the healthcare district's board orientation process and program developed?
- What is the relative priority your orientation should assign to each of these possible topics?
  - Board member job description and code of conduct
  - District by-laws
  - Demographic patterns and health needs of the district
  - Strategic plan for the next 3-5 years
  - Profile of all unique community health partnerships
  - Capital and operating budgets
  - Organizational chart of legal entities and management teams
  - Statistical profile of 3 years of:
    - Services provided, quality, market share by service, financial ratios
    - Provider and staff morale surveys
    - Philanthropy and community support

- Profiles of physicians and providers
- Sample of recent board meeting minutes
- Board policies and procedure manual and use of web-based board meeting portals

2. Why is a good orientation important?

Welcoming a new board member into your governance model is the best way to help ensure that all members are on a balanced footing to more successfully journey as a team to achieve your mission. Good board work is a team sport. As in any good team, whether a chamber chorale, a soccer team, or an orchestra, one weak member can throw off the balance and quality of collaboration among all on the team. We have found in over twenty years of governance work that key benefits of a good orientation are:

- More effective & efficient decision making by the board
- Less wasted time in meetings and better dialogues
- Enhanced messaging & brand enhancement in the district
- Expanded engagement & pride with providers, staff, public and donors due to a positive culture established at the top of the organization
- Increased ROI probability of the plans and budgets

As your board explores how best to refresh and update your board member orientation, engage with the CEO and other board members to answer these questions:

- How would you hope the knowledge and behaviors of a new board member would be enhanced by their participation in your orientation program? What are the proxy indicators that the orientation was a success for the person, and for the board?
- What might be the value of inviting current and experienced board members to participate in the orientation program?

3. Common issues or challenges?

Too many boards miss the opportunity for launching a new member's effectiveness and pride in their board service by under-appreciating the benefits of a good board member orientation. This frustration is a function of several issues, especially when:

- The Chair and CEO may not prioritize the orientation process
- New members think they already have all the answers - they were elected into the position
- The CEO tries to do it all alone, rather than engage a team of staff and providers and other board members in the orientation effort
- The process is boring and time consuming, and fails to bring the heritage and plans of the organization to life with stories and modern, multi-media learning techniques and content

- The orientation content is narrow and does not map to the district health needs, the mission, and the strategic and financial plans.

To help you overcome these obstacles to great orientations, engage the board and CEO to pose and answer these questions:

- Identify the top 2-3 weak spots of your current orientation process, in terms of topics addressed, the depth of information and quality of the content in each of these topics, and the style of multi-media tools used to share the content with a new member. How can these be enhanced in the coming year?
- How might you invite new ideas for your orientation from other management staff?

4. What can Boards do to be more successful?

Your board can take action to build upon your current board orientation process by discussing how to consider these strategies:

- Make board member orientation a priority via the “Five Ps” of section 1 above
- Make your orientation program engaging visually, animated, and tailored to the new member
- Make it a team sport by having the CEO include other staff, a Board-Buddy or Mentor, and even a patient, constituent or community leader
- Make the learning experience digital and easily accessible 24/7 on your board portal
- Make it comprehensive & interesting:
    - Real patient case stories (but HIPPA compliant)
    - Real physician and nurse stories
    - Map to “Balanced Score Card” type metrics that visually help “Make Data Sing”
    - Include touring with planned presentations by staff
    - Encourage “Q Factor” by board members. The Q factor is a technique of asking questions that cannot be answered by a simple “yes” or “no”, but rather ask questions such as: why, what, why not, when, how, how much?

How might your board step-back from your current orientation activities, and refine your process by engaging in conversations around your answers to these questions:

- How might your onboarding process best improve its content and learning methods?
- How might your board orientation programming best integrate into your broader board annual education programming?

5. Where to secure resources for further educational insights on this topic?

We believe the following resources will support your efforts to strengthen your board orientation programming. What other ideas might you have to enhance your board onboarding session?

- Consider ACHD Certification criteria checklist
- BoardEffect checklists save time
- See Association Checklists for Topics
- Dashboard Graphics: Stimulate Thinking is Key
- Map to Board Member Handbook links

Thank You

Thank you again for all you are doing to build your boards orientation programming.

Please click here to evaluate this board development discussion guide and its webinar to help us improve support for your board's continuous development and effectiveness.

And thank you for all you do for the people you exist to serve in your healthcare district!

ACHD Governance Toolkit

Board Session 3

SMART Board Orientations

Jim Rice: 1-612-703-4687 jim_rice@ajg.com

ACHD Governance Series

Effective Board Work for Enhanced Service and Performance

Six Short Programs for use by ACHD Members

1. Community Engagement
2. Balancing Governance & Management
3. **Board Orientations**
4. Strategic Planning
5. Board Self-Assessments
6. Board Education Programming

Good Board Work: Better Service. Better Performance.

Jim Rice: Governance Adviser

Experienced. Practical. Responsive.

Jim Rice, PhD, FACHE is Senior Adviser with the Governance & Leadership service line of Gallagher's Human Resources & Compensation Consulting practice, and Chairman of the Akadimi Foundation. Having served on many boards, Jim focuses his consulting work on strategic governance structures and systems for high performing medical groups, hospitals, credit unions and integrated care systems. He is often engaged for enhanced strategic alliances and mergers for large and small not-for-profit organizations; as well as leadership development programming for Physicians, Boards and C-Suite Senior Leaders.

Dr. Rice holds a masters and doctoral degree in management and health policy from the University of Minnesota. He has received the University of Minnesota, School of Public Health Distinguished Alumni Leadership Award; a National Institute of Health Doctoral Fellowship; a US Public Health Service Traineeship in Hospital Management; a Bush Leadership Fellowship at Stanford and the National University of Singapore; and the American Hospital Association's Corning Award for Excellence in Hospital Planning. He is a Fellow in the American College of Healthcare Executives (ACHE) and has worked in over 35 countries in North America, Asia, Africa and Latin America.

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Board Orientations

Focus of Session:

1. What is a good "Board Orientation"?
2. Why is it important?
3. Common issues or challenges?
4. What can Boards do to be more successful?
5. Resources for further insights?

1. What is a good "Board Orientation"?

- Prompt: within 30 days
- Professional: Tied to Position Description, Plans, & Matrix
- Promotional: Champion the Mission/Vision
- Packaged: Multi-media. Modules. Multiple Speakers
- Passionate: Weave in Stories to Make Data Sing

2. Why is it important?

- More Effective & Efficient Decision Making
- Less Wasted Time in Meetings
- Enhanced Messaging & Brand in District
- Expanded Engagement & Pride with providers, staff, public and donors
- Increased ROI Probability

3. Common issues or challenges?

- Chair and CEO do not prioritize the Orientation
- New Members think they already have all the answers
- CEO tries to do it all alone, rather than a team effort
- Process is boring and time consuming
- Content is narrow and does not map to District health needs, the mission, and the strategic and financial plans

4. What can Boards do to be more successful?

- Make it a priority via the “Five Ps” of slide 5
- Make it engaging visually, animated, tailored to Member
- Make it a team sport: Staff, Board-Buddy, Mentor
- Make it digital and 24/7
- Make it comprehensive & interesting:
  - Real Patient Case Stories (But HIPPA Compliant)
  - Real Physician and Nurse Stories
  - Map to ”Balanced Score Card” type metrics: Make Data Sing
  - Include touring with planned presentations by staff
  - Encourage “Q Factor” by Board Members

5. Resources for further insights:

- Consider ACHD Certification Criteria Checklist
- BoardEffect checklists save time
- See Association Checklists for Topics
- Dashboard Graphics: Stimulate Thinking is Key
- Map to Board Member Handbook links

Thank you for all you do for the people in your healthcare district!

We hope this short program stimulates your continuous pursuit of enhanced board work to strengthen your healthcare district's support for ***health care*** and ***health gain*** in challenging times.

Please contact ACHD to access their many other board support resources.

Jim Rice: 1-612-703-4687 jim_rice@ajg.com